Identifying Best Practices In Public Housing For People Who Are Homeless and Have A Mental Disability: The Role Of Engagement and Collaboration

A survey of Public Housing Authorities
and PATH programs in four states.

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Acknowledgements

This paper was written by staff of State Mental Health agencies that fund services for persons who are homeless and have a serious mental illness. Over the course of one year, (2000-2001) they developed data collection measures, collected and compiled information, and examined how people with psychiatric disabilities could increase their access to mainstream affordable housing. The views contained in this report are those of the authors and do not necessarily represent the opinions of their respective agencies or any other governmental organizations.

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The PATH Program[1]

Every night, an estimated 600,000 people are homeless in America. Of these, about one-third are single adults with serious mental illnesses.

The Stewart B. McKinney Homeless Assistance Amendments Act of 1990 authorized a Federal grant program to deal with the needs of people who are homeless and have serious mental illnesses. The program -- known as Projects for Assistance in Transition from Homelessness (PATH) -- funds community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services.

In FY 2000, the PATH program distributed nearly $31 million through formula grants to each State, the District of Columbia, Puerto Rico, and the U.S. Territories to provide services to people with serious mental illnesses -- including those with co-occurring substance use disorders -- who are homeless or at risk of becoming homeless. The formula is based on the urban population in the jurisdiction compared to the total U.S. urban population, with minimum grants of $300,000 per year to each State. Latest available data indicate that in Fiscal Year 1999, States engaged 366 local organizations in the provision of services. These organizations reported more than 59,000 enrollments for PATH- supported services.

The PATH program is administered by the Center for Mental Health Services, a component of the Substance Abuse and Mental Health Services Administration, one of eight Public Health Service agencies within the U.S. Department of Health and Human Services.

PATH providers serve people with mental illnesses who are homeless

Local PATH-supported agencies reported they delivered services to more than 59,000 people in fiscal year 1999. Demographic data reveal the following for the clients for whom information was obtained.

- More than half the clients served (61 percent) were male.
- More than half the clients (56 percent) were Caucasian. Nearly a third (32 percent) were African American; 8 percent were of Hispanic origin; the rest represented Asian, Native American, and other racial groups.
- Nearly 92 percent of the people served were between the ages of 18 and 64.
- PATH clients have some of the most disabling mental disorders. Among clients for whom a diagnosis was reported, nearly 43 percent had schizophrenia and other psychotic disorders and 36 percent had affective disorders such as depression.
- At least 58 percent of the clients had a substance use disorder in addition to a serious mental illness.

[1] From http://www.pathprogram.com - Reprinted with permission.

PATH projects involve a broad range of service providers

The PATH program involves a wide network of State and local agencies that contribute comprehensive community-based services for people who are homeless and have serious mental illnesses. PATH providers have succeeded in putting experience and expertise to work to meet the needs of homeless people who have mental illnesses by engaging the services of community mental health centers and other mental health providers, community-based social service agencies, health care providers, and substance abuse service providers.
PATH providers offer a spectrum of critical services:

Local PATH-supported organizations provide a wide range of services to people who are homeless. Among the services eligible for funding under PATH are:

- outreach services,
- screening and diagnostic services,
- habilitation and rehabilitation services,
- community mental health services,
- alcohol or drug treatment services (for people with mental illnesses and co-occurring substance use disorders),
- case management services,
- supervisory services in residential settings and
- a limited set of housing services and services to help client's access housing resources.

In addition, virtually all States use PATH funds to provide outreach services to contact and engage people who have not sought services. FY 1999 data reveal the following: Nearly 86 percent of all providers offer outreach to people who are homeless.

Seventy-nine percent of providers offer case management services.

More than 72 percent of providers use PATH funds to assist clients in accessing primary health care services, job training, education services, and housing. States also use PATH funds to train local provider staff on effective strategies to assist persons who are homeless and have mental illnesses. In many States, PATH funds are the only dollars available for outreach services within the mental health system. Staff is designated within units of the state government mental health and/or substance abuse authority (State PATH Contacts) to administer the allocation of PATH funds to providers of services.

PATH program funds stimulate state and local contributions:

PATH funds represent over 25 percent of the total dollar amount earmarked by provider agencies for serving homeless people with mental illnesses. These funds are worth more than their face value because they must be matched by State and local resources. For every $3 in Federal funds, State or local agencies must put forward $1 in cash or in-kind services. At a minimum, a $26 million Federal allocation would result in an $8.6 million match. However, in FY 1999, States matched over $15 million in State and local funds against the $26 million Federal allocation. In some States, PATH funds and the State and local match are the only commitment of resources targeted to homeless people with serious mental illnesses.

The PATH Mainstream Services Work Group

The federal Center for Mental Health Services (CMHS), through its technical assistance contractor, Advocates for Human Potential, Inc. (AHP), facilitates a number of work groups composed of PATH State Contacts to identify and address issues of concern to the PATH community. People with mental illness who are homeless need health care, safe, and affordable housing and employment opportunities. Many have co-occurring mental illness and substance abuse problems, and are in need of both treatment and support services to overcome these disabilities. To be part of society's mainstream, they need to gain access to mainstream services. State Path Contacts agreed that people with serious mental illness who are homeless need better access to mainstream services and formed the "Mainstream Services PATH Work Group" to address the causes and effects of lack of access to mainstream services for people served in PATH programs.

The Work Group collects data, identifies and examines trends and issues, and provides policy and program recommendations to the Center for Mental Health Services. It also identifies current or emerging best practices that allow homeless consumers to obtain services needed for successful community integration.

During the 2000/2001 year, the Work Group addressed barriers and strategies related to accessing affordable housing, particularly in Public Housing (PHA). It designed and administered a data collection instrument and gathered information from over 150 PATH programs and over 300 Public Housing Authorities in four states. The material it collected in its one-year effort offers valuable information for advocates, policymakers, and programs on the significant barriers faced by homeless people with mental illness in obtaining a home in Public Housing. It also offers insight into ways that some PATH providers and PHAs have worked together to make access to affordable housing a reality for PATH participants. It suggests that there is much more to be done in this area, including a wider data collection effort and is a call to action for advocates, consumers and programs to explore ways to increase utilization of PHA units by people with psychiatric disabilities who are homeless. After it issues its final report in September 2002, the Work Group will identify another mainstream service issue it will address in 2002/2003.

Public Housing

Public housing agencies (PHAs), also known as "Public Housing Authorities", were created by law to provide subsidized housing for low-income families within local communities. PHAs are public and corporate in structure, which means they are a part of municipal government, but can act independently. PHAs are governed by a Board of Commissioners, which is either elected by the voters or appointed by local officials. The Board of Commissioners appoints the Executive Director, who is responsible for the daily administration of the PHA and its housing resources.

Public housing agencies provide two kinds of subsidized housing:

- Conventional Public Housing units (sometimes referred to as "projects") which are owned and managed by the PHA; and
- Section 8 rental assistance (e.g. vouchers)

These two resources generally account for almost two-thirds of the available subsidized housing options in most communities. In most small communities, the PHA usually operates only a small number (50-100) of public housing units. In larger communities, PHAs typically operate several large public housing projects and administer a large number of section 8 vouchers. With the "deregulation" of public housing authorities over the past five years, PHAs are focusing more of their attention on developing more mixed income, and market rate housing, both rental and homeownership.

Housing for People with Disabilities

Along with a mandate to serve individuals and families with low incomes, PHAs are expected to provide housing for the disabled and the elderly. This is often accomplished through the designation of specific buildings for elderly and disabled individuals, through preferences in their public housing and Section 8 voucher programs, or through set-asides of specific units within PHA complexes.

Since 1990, PHAs and other public and private subsidized housing owners have had the option to designate certain subsidized housing projects as "elderly only". Previously, the definition of elderly family included individuals under the age of 55 with disabilities. Many owners have opted for this designation; therefore, the overall supply of available affordable units for individuals with disabilities has diminished.

Planning Mandates

Public housing agencies are required to develop two planning documents that direct the allocation of federal housing resources. These include the Public Housing Agency Plan and the Consolidated Plan (ConPlan).

The Public Housing Agency Plan, recently mandated by federal law, dictates how PHAs allocate resources in their communities, in particular the Section 8 voucher and public housing programs.

The Consolidated Plan or "ConPlan" serves as an application to the U.S. Department of Housing and Urban Development (HUD) for specific federal funds. These funds include:

- HOME
- Community Development Block Grant (CDBG)
- Emergency Shelter Grant (ESG)
- Housing Opportunities for Persons With AIDS (HOPWA)

All PHAs that provide public housing and/or section 8 vouchers are required to prepare a PHA Plan, however, only large public housing agencies in designated jurisdictions prepare a Consolidated Plan.

Both plans contain a number of public participation mandates and are thus important documents for individuals with disabilities and those who are homeless. Both require community input and thus are valuable tools for ensuring that a "fair share" of resources are directed to these groups.

In many communities, market rate housing is out of the reach of individuals with disabilities, many of who rely on Supplemental Security Income (SSI) and/or Social Security Disability Income (SSDI). PHAs typically do not have enough resources to assist all individuals and families that qualify. In some cities, the waiting list for section 8 vouchers may be several years. PHAs may or may not provide a "preference" for people who are homeless or have a disability. Increasingly, these individuals must wait for assistance for many months or years, even though the provision of affordable housing could substantially increase their ability to live independently in the community. Individuals with disabilities and disability advocates have an opportunity, through these two planning processes, to advocate for and ensure that not only are accommodations made in program policies, but that a "fair share" of resources are provided.

The Housing Crisis for People Who are Homeless and Have Disabilities

This crisis of affordability for people with disabilities has been well documented in the Technical Assistance Collaborative publication "Priced Out in 1998"[2]. This publication documents the housing crisis for people with disabilities through an analysis of SSI benefits and fair market rents (FMRs) on a citywide and statewide basis. According to the report, there was not one county or metropolitan area in the United States in 1998

[2] Edgar, E., O'Hara, Ann, Smith, Brian, and Zovistoski, Andrew, (1999). Priced Out in 1998. The Technical Assistance Collaborative, Inc. and The Consortium for Citizens with Disabilities Housing Task Force.

where a person receiving SSI benefits could afford a one-bedroom unit while paying 30 percent of their monthly income for rent. Instead, as a national average, a person with a disability must spend 69 percent of his or her SSI monthly income to rent a modest one-bedroom apartment priced at the U.S. Department of Housing and Urban Development (HUD) Fair Market Rent. This is an important finding because the federal government considers any very low income household paying more than 50 percent of income for rent to have a severe rent burden, and to have "worst" case" housing needs.

In addition to affordability, individuals who are homeless and who have disabilities face additional barriers to accessing public housing and section 8 tenant based assistance. The Government Accounting Office's (GAO) report titled "Homelessness – Barriers to Using Mainstream Programs" discusses barriers in stark detail. [3]

Barriers to accessing public housing include the following:

- Scarcity
- Change in federal preferences (to local preferences)
- Changes in admission and occupancy rules
- Communication difficulties

Barriers to using section 8 vouchers include the following:

- Scarcity (at least scarcer than public housing units)
- Landlords not required to accept section 8 vouchers
- Market forces
- Changes in admission and occupancy rules
- Communication difficulties (no phone, no permanent address, lack of reliable transportation, etc.)
- Multiple disabilities along with homelessness
- Stigma

Summary

Public housing agencies control as much as two-thirds of the subsidized housing resources available to individuals with low-incomes who are homeless and/or have disabilities. Despite a limited number of affordable units and rental assistance vouchers, PHAs must work with multiple stakeholders in allocating resources, while complying with numerous federal mandates.

Clearly, individuals who are homeless and have disabilities, as well as service agencies, must collaborate with PHAs to:

[3] United States General Accounting Office, (2000), Homelessness: Barriers to Using Mainstream Programs, GAO/RCED-00-184.

- Ensure that the housing needs of individuals who are homeless with special needs are included in major planning documents;
- Promote the allocation of a fair share of resources to those populations;
- Craft policies and procedures that support and accommodate the needs of all special populations; and
- Ensure that a forum exists for the identification and removal of barriers to housing access that may exist.

Analysis of the Survey Data

The PHA and PATH Surveys

Questionnaires, including a cover letter explaining the project, were mailed to 300 Public Housing Authorities (PHAs) and 150 PATH agencies in four states: Texas, Virginia, Utah, and Kentucky. Data collection focused on PHAs and PATH agencies because they were the only agencies collecting the requested information. Additionally, focusing on PHAs and PATH agencies enabled the comparison of perceptions of the barriers to accessing public housing and engagement practices between agencies.

Two survey instruments were developed—one for PHAs and another for PATH agencies in order to focus questions on the specific activities of each agency. The questionnaires were created by the Mainstream Services Work Group and reviewed by PHA and housing experts prior to distribution. The survey questions were organized into five categories: capacity, population being served, engagement practices, best practices, and barriers to housing.

The survey data were sorted and cleaned. Respondents to mailed surveys often "skip" questions that are not applicable to them. Skipped questions are usually coded as non-responses; however, this is not always the most logical interpretation. For example, in a series of yes/no questions, a skipped question could also be interpreted as a "no", particularly if the respondent otherwise completes the whole questionnaire. Similarly, when a question requires a fill-in-the-blank response for a list of quantities (e.g. the number of housing units of various types) the respondent might leave blanks for zeros. Where it seemed reasonable based on other answers the respondent made and would not distort the data, we interpreted blanks as either zeros or "no's". This allowed us to include the maximum number of respondents in the analysis.

Overview of PHA Respondents

The response rate for PHAs was 65.7 percent. Texas had the most PHA respondents with 61.9 percent followed by Kentucky with 26.4 percent, Virginia with 7.1 percent, and Utah with approximately 4.5 percent of the total respondents.

Of the PHA respondents, 86.8 percent administered public housing and 49.7 percent administered Section 8.

The average PHA respondent is a small to very small agency overseeing less than 300 units. The agency administers both public housing and Section 8 and has an active waiting list and current vacancies for both programs. The average wait for public housing is 8.5 months and 12.7 months for Section 8 units. The agency does <u>not</u> provide support services on site and does <u>not</u> receive funding for *Mainstream*, *Welfare to Work*, or *ROSS* programs.

Capacity of PHAs

Capacity reflects an organization's ability to productively achieve its goals. For PHAs and similar housing organizations, capacity can be partially measured by the number of units an agency provides. In addition, capacity relative to need can be measured by vacancy rates and the waiting time required before individuals occupy a unit.
PHA respondents range from the very small (less than 100 units) to the very large (more than 5,000 units). For ease of presentation, we categorized PHAs by size accordingly:

Very Small = <100 Units
Small = 100-299 Units
Medium = 300-999 Units
Large = 1000-4999 Units
Very Large = 5,000 + Units

Of the PHA respondents, the majority of agencies are classified as very small or small.

Very Small = 36 percent
Small = 27.9 percent
Medium = 21.8 percent
Large = 10.2 percent
Very Large = 4.1 percent

Since agency size is likely to affect a number of topics addressed in this survey, we present most of the survey results according to agency size.

Responding PHAs oversee 141,260 total housing units. Although small and very small PHAs account for two-thirds of the respondents, they provide a small minority of the units. Conversely, the few large and very large PHAs provide a majority of the units. Very small agencies provide 2.3 percent of total units, small agencies 6.1 percent of total units, medium agencies 17.2 percent of total units, large agencies 27.0 percent of total units, and very large agencies 47.4 percent of total units.

Overall, more units, 62.2 percent, are provided under the Section 8 program than public housing or other programs. Public housing provides 34.8 percent of total units and only 3.0 percent are other subsidized units. Section 8 units constitute most of the units provided by medium (65.4%), large (68.8%), and very large agencies (64.7%). The majority of units provided by very small and small agencies are public housing (88.7% and 67.9% respectively). Small agencies are the only group with more than five percent of total units comprised of other subsidized units (6.3%).

Slightly over half of responding PHAs have vacant units (55.4%). Of the PHAs with vacancies, 83.3 percent have vacancies in public housing units and 46.1 percent have

vacancies in Section 8 units. Very large agencies are most likely to have housing vacancies. In fact, all of the very large PHAs had vacancies in both public housing and Section 8 units. More than half of all other agencies had housing vacancies. Very small agencies had the fewest vacancies with 40.1 percent of these agencies having vacancies in public housing units and only 3.1 percent having vacancies in Section 8 units.

Overall, 94.4 percent of respondents have a waiting list for housing units. Of these respondents with waiting lists, only 10.8 percent currently have closed waiting lists. The average wait time for Section 8 units to become available is over one year and the average wait to receive a public housing unit is over eight months. Although more likely to have vacancies, very large agencies have longer waiting periods before a unit is available.

Slightly more than half (51.3%) of the responding PHAs have selected local preferences for tenant selection. The local preferences most commonly selected were:

- Employed/has income (41.4%)
- Local residency (36.4%)
- Disabled/special needs/handicap (32.3%)
- Elderly (29.3%)
- Families (26.3%)

Population Served

Responding PHAs serve a diverse population that includes homeless, disabled, elderly, non-elderly low-income, and severely low-income individuals (see Table-1). Several of these categories are not mutually exclusive. For instance, an individual earning less than 30 percent of the area median family income (AMFI) may also be disabled and elderly and therefore counted in all three groups. Consequently, the number of individuals served cannot be summed across categories to obtain the total number of individuals served. Additionally, there is some ambiguity in the interpretation of "population" and "individuals". Usually, housing programs keep statistics on units (or households) rather than on people, even those units (households) might be classified as elderly, disabled, homeless, or under 30% of AMFI. In all likelihood, the responses about the population served were in terms of units rather than total people.

Table-1, Population Served by PHAs

Population being served	% of PHAs serving this group	Number of individuals served
Homeless	52.9%	9,470
<30% AMFI	80.6%	60,253
Non-elderly	95.5%	47,876
Elderly	95.5%	23,302
Disabled	92.3%	14,389

Given the lack of mutually exclusive categories in the population served categories, the best indicator of total capacity is the number of units reported by the PHA. In order to calculate the percent distribution for the population served categories, we used total units as the denominator. Again, since these categories are not mutually exclusive, the sum of these percents could exceed 100. Also, since vacant units are included in the total number of housing units and some respondents did not provide complete data on the population served, the sum of the percents could be less than 100. Nonetheless, the distributions show the relative size of each population served as a percent of the total number of units available.

The majority of people served by PHAs are very poor and have incomes less than 30 percent of AMFI (42.7%). Non-elderly is the second most widely served group (33.8%) followed by elderly (16.5%), disabled (10.2%), and finally homeless (6.7%).
Across all categories of agency size, the groups most widely served were low-income persons earning less than 30 percent of AMFI and non-elderly (see Table-2). Except in very large agencies where homeless represented 11.6 percent of the total population served, homeless individuals comprised less than five percent of the population served. The disabled as a percent of total units was 9 percent for small, large and very large agencies, but 13 percent and 16.5 percent for medium and very small agencies.

Table-2, Population Served by Agency Size

Agency Size	Homeless	Income <30 AMFI	Non-elderly	Elderly	Disabled
Very small	4.2%	36.3%	39.0%	31.2%	16.5%
Small	2.5%	30.2%	28.2%	23.7%	9.3%
Medium	4.0%	48.1%	45.3%	17.5%	13.4%
Large	1.0%	31.0%	38.1%	9.6%	9.2%
Very large	11.6%	49.2%	27.9%	18.4%	9.4%

Engagement

Engagement is the formal or informal process whereby a homeless or disability service organization is involved in a relationship with a PHA or other housing agency. This involvement includes shared communications, collaboration, planning, or other activities designed to address housing needs.

Responding PHAs identified several engagement practices. For all PHAs, the two most prevalent indicators of engagement were "collaborates with disability service providers" (79.5%) and "solicits involvement of disability community" (61.2%). Other engagement indicators implemented by PHAs were "engages in outreach to private landlords" (54.1%), "provides information to landlords about disabled" (41.8%), and "provides on-site support services" (18.4%). The engagement indicators that occurred less often were "participates in ROSS program" (11.7%) and "participates in HOPE VI program" (5.1%).

The most common method for soliciting the involvement of individuals with disabilities and disability service providers was by public notice (79.2%). Other solicitation methods were direct mailings (39.2%) and direct contact with disabled tenants (34.4%) and disability providers (34.4%).

The most common forms of engagement with landlords among responding PHAs were "provides information to applicants concerning potential landlords" (64.5%) and "provides information to landlords about individuals with disabilities" (17.2%). Information provided to applicants concerning potential landlords includes "provides lists of landlords/units/properties" (52.7%) and "verbal information" (31.5%). Very few PHAs indicated the type of information provided to landlords about individuals with disabilities.

Some PHAs provided incentives to landlords to participate in the Section 8 program (12.2%) or to house individuals with disabilities (10.1%). The most popular incentive for landlords participating in the Section 8 program was "rent paid on time" (29.2%). Other incentives provided by PHAs varied. The most popular incentive to landlords for housing individuals with disabilities was "adjustment of rent payment" (40%). Similarly, some PHAs provided information to landlords about individuals who are homeless and have serious mental illness (7.1%). However, the type of information provided varied considerably.

Less than 10 percent of PHAs received Section 8 or HUD ROSS or Hope VI funding to participate in *Welfare to Work* (5.6%), *Mainstream* (8.7%), or *Family Unification* (6.7%) programs. Also, only 23.9 percent of responding PHAs had a mandatory *Family Self Sufficiency* (FSS) program.

Overall, very small agencies typically had the fewest PHAs engaging in outreach to landlords, service providers, and the disabled community while large and very large agencies had the most. The most common engagement indicator for agencies of all size was "collaborates with disability service providers" with 100 percent of very large agencies implementing this practice. The second most common engagement indicator for agencies of all size was "solicits involvement of disability community" followed by "engages in outreach to landlords". The least common engagement indicator for agencies of all size was "participates in Hope VI program" however the proportions of agencies using this indicator vary substantially. While less than five percent of very small, small, and medium agencies were involved with this engagement practice it was used in over 37 percent of very large agencies.

Large agencies had the highest proportion of on-site support service (55%) followed by very large agencies (50%) and medium size agencies (23.2%). Less than 20 percent of small (16.4%) and very small agencies (2.8%) had on-site services.

Only very large agencies had a high proportion of PHAs participating in the ROSS program (75%).

The most common form of solicitation for agencies of all size to attract disability service providers and the disabled community was by public notice. Very small agencies had the most PHAs that used this form of solicitation (90.6%) while large agencies had the fewest agencies soliciting by public notice (57.9%). Direct mail solicitation was the second most common form of solicitation for agencies of all size.

The most common form of engagement with landlords by agency size was "provides information to applicants concerning potential landlords" with 95 percent of large agencies providing this service followed by 87.5 percent of very large agencies, 81.4 percent of medium agencies, 65.5 percent of small agencies, and 42.9 percent of very small agencies. The type of information provided most often by medium (68.6%), large (78.9%) and very large agencies (71.4%) was a list of landlords/units/properties. Verbal information was the most popular form of information provided by very small (50%) and small (41.7%) agencies.

While the numbers are low, agencies of all size provided incentives to landlords for participating in Section 8 and programs to house individuals with disabilities. Large and very large agencies had the most PHAs that provided incentives for participation in the Section 8 program (25% each) while less than 3.0 percent of very small agencies provided incentives to Section 8 participants. Medium (21%) and large (20%) agencies had the most PHAs providing incentives to landlords participating in programs to house individuals with disabilities.

Agencies engage in multiple forms of engagement. In order to reflect this, we calculated a PHA Engagement Index by combining (summing) the individual involvement and engagement indicators. The Engagement Index provides a composite indicator that includes the total indices for each indicator to create a more concise measure of engagement.

The overall mean score for PHAs was seven points out of a maximum of 50 points. Large and very large agencies had the highest mean Engagement Index scores with twelve points each followed by medium agencies with eight points, small agencies with seven points, and very small agencies with four points. Only 8.6 percent of very small agencies had an Engagement Index score of ten points or greater while 80 percent of large agencies and 75 percent of very large agencies had a score of 10 points or greater.

PHA Best Practices

PHA best practices increase access to or the provision of public housing for people who are homeless and/or have a disability. Like engagement indicators, best practices also measure the effectiveness in coordinating services between PHAs and PATH agencies.

Of all PHAs surveyed, 33.8 percent were involved in best practice with the disability community. Of these agencies, 82.2 percent participated in initiatives that involved homeless individuals with mental illness, 66.1 percent had formal partnerships with either community mental health centers, homeless service providers, or disability services providers, 54.8 percent had initiatives that assist individuals with criminal, substance abuse and bad credit histories, and 48.4 percent participated in formal agreements with disability providers.

Formal partnerships are a joint effort between PHAs and other service providers in a program and/or a funded activity involving shared responsibilities formalized in a contract. For example, a non-profit organization might partner with a PHA to run a housing program where the PHA provides grant writing, administration of section 8 vouchers, and technical assistance while the non-profit provides oversight and day-to-day administration of the program. Formal agreements imply a mutual understanding about certain activities, usually in the form of practices or policies. These activities may or may not involve shared responsibilities, but they usually specify certain "obligations". For example, a service agency might have an agreement with the local PHA to accept "bruised credit" applicants from their agency because all clients are involved in an extensive fiscal responsibility program.

Of the formal partnerships between PHAs and disability providers, 78 percent of these partnerships were with homeless service providers, 63.4 percent were with disability service providers, and 56.1 percent were with community mental health centers.

We asked respondents to describe their most successful initiative in providing housing for individuals who are homeless and have a mental and/or other disability. The following were the most common responses.

- Working relationships with other agencies (54.9%)
- Support services to ensure housing stability (23.5%)
- Collaborative projects using multiple programs (23.5%)
- Cooperative agreements (21.6%)
- Units set aside for SMI or homeless (17.6)
- Maximized use of Mainstream Program (9.8%)
- Use of satellite/outreach staff (7.8%)
- Shelter Plus care (7.8%)
- Local preferences that prioritize SMI or homeless (7.8%)

These themes reveal an emphasis on coordinating services among PHAs and other service providers.

Looking at best practices in working with service providers and the disability community by agency size shows that involvement in best practices increases directly with agency size. Very large agencies had the most PHAs (83.3%) involved in collaborative work considered to be a best practice. Involvement in best practices declined steadily as size decreased, with only 18.7 percent of very small agencies participating in best practices work (see Table-3).

Table-3, Best Practices by Agency Size

Agency Size	Involved in Best Practices
Very small	18.7%
Small	34.6%
Medium	40.5%
Large	52.6%
Very large	83.3%

The most common best practice was service to homeless with mental illness. Small agencies had the lowest participation rate for this practice with just over 72 percent of PHAs participating (72.2%) while very small agencies had 75 percent of PHAs participating, medium agencies had 88.2 percent, and large agencies had 90 percent participating in this practice. All PHAs in very large agencies participated in initiatives involving homeless with mental illness. Agencies of all size had a high proportion of PHAs engaging in formal partnerships with other service providers. Very small and small agencies had 50 percent of PHAs each engaging in formal partnerships, large and very large agencies had 80 percent of PHAs involved in formal partnerships, and medium agencies had 82 percent of PHAs engaged in formal partnerships. Large agencies had the highest proportion of PHAs assisting individuals with criminal, substance abuse, and bad credit histories (80%) while all other agency sizes only had between 40-60 percent of PHAs participating in this practice.

Similar to the Engagement Index in purpose, the Best Practices Index was compiled to create a simple measure of best practice among PHAs. Out of a maximum of 17 points, the mean score for all respondents was two points. Very large agencies had the highest mean score of all agencies with six points followed by large agencies with three points, medium agencies with two points, and small and very small agencies with one point each.

Barriers to Successful Housing Provision

PHA respondents were asked to identify barriers to successful housing provision from a list of barriers provided in the questionnaire. The most frequently identified barriers for PHAs were:

- Poor tenant history (66.8%)
- Criminal history (59.7%)
- Waiting list too long (38.8%)
- Poor credit history (35.7%)
- Notification of status difficult (31.1%)

While the five most frequently identified barriers for PHAs were fairly consistent across agency size, there were important variations. Very large agencies selected both "criminal history" and "market rents higher allowed" most often as a barrier to housing (62.5%), followed by "poor credit history", "poor tenant history", and "stigma toward population" (50% each). Among large agencies, "stigma toward population" was the third most frequently listed barrier to housing provision.

Respondents were also asked to rate each of the barriers listed in the questionnaire on a one-to-five scale, with one the highest. The barriers most often given a "one" were:

- Waiting list too long (23.4%)
- Criminal history (19.0%)
- Poor tenant history (10.9%)
- Scarcity of public housing and private subsidized units (10.2%)

PATH Respondents

The analysis of the responses from PATH agencies was limited because very few PATH agencies completed and returned the survey. Only 19 of the 150 surveys sent to PATH agencies were returned. Texas had the most PATH agency respondents with 52.6 percent followed by Virginia with 42.1 percent and Utah with 5.3 percent of the total respondents. There were no PATH agency respondents from Kentucky. Consequently, only a descriptive analysis of PATH agency engagement, best practices and barriers to housing provision for homeless with mental illness and/or other disabilities is provided given the low response rate.

The average PATH respondent does <u>not</u> participate in the various required planning processes at their local PHA but they do maintain a collaborative relationship with their local PHA.

PATH Engagement

As stated earlier, engagement is the formal or informal process whereby a homeless or disability service organization is involved in a relationship with a PHA or other housing agency. This involvement includes shared communications, collaboration, planning, or other activities designed to address housing needs.

Of the responding PATH agencies, 94.7 percent were engaged in collaborative relationships with local PHAs and 84.2 percent of PATH agencies engaged in outreach to private landlords. The most common forms of engagement with PHAs and/or private landlords were:

- Provides information to landlords about housing and support needs of individuals with disabilities (78.9%)
- Member of the local PHA affordable housing task force/coalition (68.4%)
- Provides mental health or other support services on site at local PHAs (42.1%)
- Contributes to the PHA mental health services plan (42.1%)

Only one PATH agency participated in either the federal ROSS or Hope VI programs.

Participation in the required planning processes for local PHAs is seen as a valuable tool for securing resources directed to individuals with disabilities and severe mental illness (see "planning mandates" section). The participation of disability providers and the disabled community in these planning processes increases the amount of resources directed to individuals with mental illness and other disabilities.

Only 10.5 percent of responding PATH agencies participated in the planning process for the PHA Plan at their local PHA. However, 47.4 percent of PATH agencies participated in the planning process for the Consolidated Plan—a plan required for large PHAs in designated jurisdictions. PATH agencies were also involved in other housing planning processes in their local community (42.1%).

Only one PATH agency participated in the planning process for the local Section 8 Administrative Plan.

The main form of participation in these planning processes by PATH agency staff was to attend planning meetings (63.2%). PATH agency staff also collaborated on joint programs or funding projects (47.4%) and provided written comments (36.8). PATH agencies also participated in other activities (42.1% of agencies) such as the Continuum of Care program (21%).

The Engagement Index for PATH agencies was compiled using the 15 involvement and engagement indicators. The mean score for all PATH agency respondents was seven points. Only 21 percent of PATH agencies scored ten or more points.

PATH Best Practices

PATH agency best practices enhance the provision of support services to people in public housing that are formerly homeless and/or disabled. Like engagement indicators, best

practices are another measure of the effectiveness in coordinating services between the PATH agencies and PHAs.

The majority of responding PATH agencies (68.4%) were involved in collaboration with PHAs. The most common best practices for these agencies were providing alternative means to meet eligibility including support for criminal, substance abuse, and bad credit histories (53.8%), formal partnerships with PHAs (46.1%), and formal written agreements with housing agencies (46.1). Fewer PATH agencies were involved in formal partnerships with private housing agencies (15.4%).

Participation in formal written agreements was most commonly with PHAs (66.6%) and local government housing departments (50%).

The Best Practices Index for PATH agencies was compiled from the nine best practices indicators. The mean score for all PATH agency respondents was two points.

PATH Barriers

Major barriers to housing provision can often vary depending on the individual's needs. With this in mind, PATH agency respondents were asked to identify major barriers to housing for specific population groups.

Entire homeless population

The top five barriers for homeless individuals were:

- Waiting list too long (78.9%)
- No vacancies (68.4%)
- Poor credit history prevents placement (47.4%)
- Poor tenant history prevents placement (42.1%)
- Notification of applicant by phone or mail is difficult (36.8%)

Homeless with serious mental illness

The top barriers for homeless individuals with serious mental illness were:

- Poor credit history prevents placement (42.1%)
- Difficult for applicant to maintain stable housing (42.1%)
- Poor tenant history prevents placement (36.8%)

Homeless with substance abuse history

The top barriers for homeless individuals with histories of substance abuse were:

- Difficult for applicant to maintain stable housing (47.4%)
- Poor credit history prevents placement (42.1%)
- Exclude applicants with criminal histories (36.8)

Homeless with physical disabilities

The top barriers for homeless individuals with physical disabilities were:

- No vacancies (21.1%)
- Waiting list too long (21.1)

Other barriers significant to these groups were:

- Stigma toward population
- Scarcity of public housing

There are some similarities overall between the barriers to housing cited by PHAs and PATH agencies, however, each agency places highest significance on different barriers. Significant barriers to housing provision for homeless individuals (as a whole) as identified by PATH agencies are more program-related concerns while PHA barriers focus more on applicant-related issues. However, when the homeless population is distinguished by need, homeless individuals with serious mental illness and substance abuse histories cite applicant-related barriers as most significant while homeless with disabilities find program-related barriers the most significant inhibitors to housing provision.

Multivariate Analysis

This study is the first to investigate the role of public housing agencies in assisting homeless individuals with mental illness and/or other disabilities and in this respect, both the analysis and findings should be considered exploratory. In addition to agency size, other factors measured in the survey could be instrumental in influencing PHA engagement activities and best practices for collaborative work with other service agencies. In turn, we expect that these activities aid in the provision of housing to homeless individuals with mental illness or other disabilities. Because of the exploratory nature of the study and the lack of previous research, there is no clear indication of the factors that might influence PHA involvement with federal programs, engagement with other service providers, and best practices in providing services. Consequently, we selected multivariate models based on the measures in the survey that appeared to us to have a potentially logical link to PHA performance.

In addition to the survey variables, we included the population of the jurisdictions served by each responding PHA to look at whether community size is associated with PHA housing provision to homeless individuals with mental illnesses. We found that the size of the PHA (measured by total units) is closely interrelated with the size of the

community served by the PHA, making it impossible to statistically distinguish between the effects of community size and PHA size. Therefore, only agency size is used in the regression models reported here, but should be interpreted as also reflecting community size.

PHA Engagement

PHA scores for the Engagement Index are positively related to agency size, whether the PHA administers Section 8 units, and PHA scores for best practices (see Table-4). The regression model itself is statistically significant and has an R^2 ("explained variation") of 47.7 percent. Thus, the variables in the model are associated with nearly half of the variation in engagement.

It is logical that agency size is related to engagement since larger agencies typically have additional resources that enable them to outreach to other agencies and the disability community. In addition, larger communities are likely to present more opportunities for engagement. The association between Section 8 and engagement scores appears to be related in part to the size of the agency. As noted in the "Capacity" section of this report, the majority of units administered by larger agencies are Section 8 units. Similarly, the majority of agencies with engagement scores greater than ten points are larger agencies. Nonetheless, administering Section 8 units appears to have an additional association with engagement. Whether administering Section 8 units adds an important dimension to the capability of larger PHAs to engage with other service providers and the disability community remains to be determined. The statistical association could be spurious.

Engagement can be viewed as a precursor to best practices. PHAs engaged in outreach with other agencies are more likely to coordinate services and actively pursue working relationships with other service providers and the disabled community. However, since the survey could not measure engagement and best practices over time, temporal sequence and causal relationships cannot be determined. As a result, we included the Best Practices Index in the engagement model and vice versa. Consistent with our expectation, best practices and engagement are statistically significant in both models. The models show the association between engagement and best practices but cannot identify the causal relationship between the two.

Local preferences, funding from HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and participation in a mandatory Family Self Sufficiency program could identify agencies that are more likely to engage in outreach. However, the relationships are statistically insignificant and in the case of ROSS/HOPE VI in the opposite direction than expected. PHAs participating in these programs are no more likely to be engaged with disability service providers and the disabled community than agencies that do not participate in these programs, controlling for the other variables in the model.

Table-4, Coefficients Table-Engagement Score

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	3.115	0.427		7.293	0.000
Total units	4.038E-04	0.000	0.124	1.942	0.054
PHA administers Section 8	4.462	0.554	0.481	8.060	0.000
PHA has selected Local Preferences	0.604	0.503	0.065	1.201	0.231
HUD ROSS/Hope VI	-2.301E-05	0.000	-0.036	-0.657	0.512
Agency has a mandatory FSS Program	0.640	0.652	0.058	0.981	0.328
PHA best practices index score	0.383	0.103	0.225	3.710	0.000

a Dependent Variable: PHAENGIND

* Funding for Welfare to Work, Mainstream and/or Family Unification programs

PHA Best Practices

PHA scores for the Best Practices Index are positively related to agency size, funding from HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and PHA Engagement Index scores (see Table-5). Again, the overall model is statistically significant, but with a substantially smaller R^2 of 28.6 percent. Much less of the variation among PHAs in best practices is associated with these variables (including engagement) than is the case with engagement.
As with engagement scores, the association between agency size and best practices is apparent since larger agencies typically have increased capacity both in terms of number of units the agency oversees (implying that more are available to individuals with disabilities) and the range of support services it offers to the community.

PHA scores for the Best Practices Index are not related to whether the agency administers Section 8 units, controlling for other variables. Once the association of engagement with best practices is considered, administering Section 8 provides no additional association with best practices. Local preferences and a mandatory FSS have no association with best practices, although participation in ROSS/HOPE VI does. ROSS/HOPE VI could provide PHAs resources related to best practices (or could themselves reflect best practices).

Table-5, Coefficients Table-Best Practices

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	3.820E-02	0.332		0.115	0.908
	PHA administers Section 8	-0.128	0.441	-0.024	-0.292	0.771
	PHA has selected Local Preferences	0.186	0.346	0.034	0.539	0.590
	HUD ROSS/Hope VI*	5.597E-05	0.000	0.148	2.366	0.019
	Agency has a mandatory FSS Program	0.479	0.447	0.074	1.072	0.285
	PHA engagement index score	0.180	0.048	0.307	3.710	0.000
	Total units	5.074E-04	0.000	0.267	3.650	0.000

a Dependent Variable: PHABPIND

* Funding for Welfare to Work, Mainstream and/or Family Unification programs

PHA Involvement with the Disability Community

PHA solicitation of involvement of individuals from the disability community and/or disability service providers is included in the Engagement Index. Solicitation of involvement was pulled out of the Engagement Index for this portion of the analysis. Because the solicitation of involvement is specifically for participation in required planning processes that allocate funding to PHAs and other disability service providers that affect housing provision and support services, we thought it warranted examination on its own. PHA solicitation of involvement of individuals from the disability community and/or disability service providers is positively related to engagement (see Table-6) but not to any of the other variables in the analysis. (Since this is a yes/no measure, Table-6 shows the results of a logistic regression analysis.)

In addition, PHA solicitation of involvement of individuals from the disability community and/or disability service providers is negatively related at a marginally significant level to local preferences. Again, the local preferences measure did not distinguish the type of preferences, but was used as a possible identifier of PHA sensitivity to local needs.

PHA solicitation of involvement is not related to agency size, whether the agency receives funding from HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and the number of homeless and disabled individuals served. Since there are certain planning requirements for all PHAs regardless of size, solicitation of involvement is a concern for all PHAs not just the large agencies. Similarly, since the reason for an agency to solicit the involvement of the disabled community and disability service providers is not influenced by agency capacity, funding for specialized programs and the number of homeless and disabled individuals served are not significant to the model.

Table-6, PHA Solicits the Involvement of Disabled Community

	B	S.E.	Wald	df	Sig.	Exp(B)
Total Units	0.000	0.000	0.139	1	0.709	1.000
PHA has selected Local Preferences	-0.596	0.365	2.660	1	0.103	0.551
HUD ROSS/Hope VI	0.181	0.657	0.076	1	0.783	1.199
Homeless + Disabled population	0.001	0.001	0.352	1	0.553	1.001
PHA engagement index score (minus Inv1)	0.171	0.058	8.753	1	0.003	1.186
Constant	-0.156	0.749	0.043	1	0.835	0.856

Variable(s) entered on step 1: TOTUNITS, LOCPREF, HUDROSH, HMLSDIS, ENGMNINV.

* Funding for Welfare to Work, Mainstream and/or Family Unification programs

Number of Homeless and Disable Individuals Served

The number of homeless and disabled individuals served by PHAs is positively related to agency size, the Engagement Index, and ROSS/HOPE VI (only marginally significant), and negatively associated with the Best Practices Index (see Table-7). The overall model is statistically significant with an R^2 of 38.7 percent. The association between the number of homeless and disabled individuals served and agency size again reflects agency capacity. Similarly, higher engagement in outreach activities, which range from providing information to service providers and the disabled community to on-site support services, is associated with greater provision of housing for homeless and disabled individuals.

The negative association of the Best Practice Index with the number of homeless and disabled individuals served is counter intuitive. As mentioned above, best practices typically follow engagement so a positive association with engagement would suggest a similar association with best practices. This finding probably reflects the complexities involved in both the Best Practices and Engagement Indexes and indicates the need for more case studies regarding PHA best practices. At best, the finding suggests that the impact of best practices is based more on the quality of services provided than the number of people served. Or the finding might reflect the need for better measures of best practices. The best practices section of the survey relied heavily on respondent input instead of providing a more complete list of predetermined best practices for respondents to select. Some agencies, if asked directly if they engaged in a best practice listed by someone else, might have responded positively if given the option.

Somewhat surprisingly, administering Section 8 units and local preferences were not associated with an increase in the number of homeless and disabled individuals served. Administering Section 8 units even has the opposite (negative) than anticipated sign. Further study is required to determine why administering Section 8 units somehow acts to decrease service to the homeless and disabled.

One-third of the PHAs had local preferences for disabled/special needs/handicap and several PHAs identified units set aside and local preferences for SMI or homeless as their

most successful initiatives in providing housing for individuals who are homeless and/or have a mental or other disability. However, local preferences had no impact on the number of homeless and disabled served. (The "local preferences" measure simply identified if the PHA adopted local preferences but did not identify those preferences.)

Table-7, Coefficients Table-Number of Homeless & Disabled Served

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-40.588	52.079		-.779	.437
	Total units	.174	0.028	.565	6.246	.000
	PHA administers Section 8	-89.616	68.085	-.112	-1.316	.190
	PHA has selected Local Preferences	-.693	54.519	-.001	-.013	.990
	HUD ROSS/Hope VI	130.827	90.742	.114	1.442	.152
	PHA engagement index score	17.884	7.626	.208	2.345	.020
	PHA best practices index score	-23.814	11.053	-.169	-2.155	.033

a Dependent Variable: HMLSDIS

* Funding for Welfare to Work, Mainstream and/or Family Unification programs

Summary of Findings

The average PHA respondent administers fewer than 300 units of both public housing and Section 8; has an active waiting list and current vacancies for both programs; and an average wait of 8.5 months for public housing and 12.7 months for Section 8 units. The average agency does not provide support services on site and does not receive funding for *Mainstream*, *Welfare to Work*, or *ROSS* programs. Although small and very small PHAs account for two-thirds of the respondents, large and very large agencies account for three-fourths of the total units.

For all PHAs, the two most prevalent characteristics of engagement with the disabilities community were "collaborates with disability service providers" (79.5%) and "solicits involvement of disability community" (61.2%). The engagement indicators that occurred less often were "participates in ROSS program" (11.7%) and "participates in HOPE VI program" (5.1%).

Less than 10 percent of PHAs received Section 8 or HUD ROSS or Hope VI funding to participate in *Welfare to Work* (5.6%), *Mainstream* (8.7%), or *Family Unification* (6.7%) programs. Also, only 23.9 percent of responding PHAs had a mandatory *Family Self Sufficiency* (FSS) program.

Less than 10 percent of very small agencies had an Engagement Index score of 10 points or greater while 80 percent of large agencies and 75 percent of very large agencies had a score of 10 points or greater. Large agencies had the highest proportion of on-site support service (55%) followed by very large agencies (50%) and medium size agencies (23.2%). Only very large agencies had a high proportion of PHAs participating in the ROSS program (75%).

The most common form of solicitation for agencies of all size to attract disability service providers and the disabled community was by public notice. Direct mail solicitation was the second most common form of solicitation for agencies of all size.

PHA scores for the Engagement Index are positively related to agency size, whether the PHA administers Section 8 units, and PHA scores for best practices. Larger agencies typically have additional resources that enable them to outreach to other agencies and the disability community. In addition, larger communities are likely to present more opportunities for engagement. Whether administering Section 8 units adds an important dimension to the capability of larger PHAs to engage with other service providers and the disability community remains to be determined.

PHAs engaged in outreach with other agencies are more likely to coordinate services and actively pursue working relationships with other service providers and the disabled community. Consistent with our expectation, best practices and engagement are significantly interrelated, but the exact causal relationship cannot be determined by this study.

PHAs participating in HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and mandatory Family Self Sufficiency program are no more likely to be engaged with disability service providers and the disabled community than agencies that do not participate in these programs, controlling for the other variables.

Of the responding PATH agencies, 94.7 percent were engaged in collaborative relationships with local PHAs and 84.2 percent engaged in outreach to private landlords. The most common forms of engagement with PHAs and/or private landlords were:

- Provides information to landlords about housing and support needs of individuals with disabilities (78.9%)
- Member of the local PHA affordable housing task force/coalition (68.4%)
- Provides mental health or other support services on site at local PHAs (42.1%)
- Contributes to the PHA mental health services plan (42.1%)

Only 10.5 percent of responding PATH agencies participated in the planning process for the PHA Plan at their local PHA. However, 47.4 percent of PATH agencies participated in the planning process for the Consolidated Plan. The main form of participation in these planning processes by PATH agency staff was to attend planning meetings (63.2%). PATH agency staff also collaborated on joint programs or funding projects (47.4%) and provided written comments (36.8).

Of all PHAs surveyed, 33.8 percent were involved in best practices with the disability community. Of these agencies, 82.2 percent participated in initiatives that involved homeless individuals with mental illness, 66.1 percent had formal partnerships with either community mental health centers, homeless service providers, or disability services providers, 54.8 percent had initiatives that assist individuals with criminal, substance abuse and bad credit histories, and 48.4 percent participated in formal agreements with disability providers.

PHAs emphasized coordination with other service providers in the initiatives they identified as successful in providing housing for individuals who are homeless and have a mental and/or other disability. The most often cited activities were:

- Working relationships with other agencies (54.9%)
- Support services to ensure housing stability (23.5%)
- Collaborative projects using multiple programs (23.5%)
- Cooperative agreements (21.6%)
- Units set aside for SMI or homeless (17.6)

Very large PHAs were the most likely (83.3%) to be involved in collaboration, while only 18.7 percent of very small agencies participated in best practices work.

PHA best practices are positively related to agency size, funding from HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and PHA Engagement Index scores. As with engagement scores, the association between agency size and best practices is apparent since larger agencies typically have increased capacity both in terms of number of units the agency oversees (implying that more are available to individuals with disabilities) and the range of support services it offers to the community. ROSS/HOPE VI could provide PHAs resources related to best practices (or could themselves reflect best practices).

PHA solicitation of involvement of individuals from the disability community and/or disability service providers is positively related to engagement but negatively related at a marginally significant level to local preferences. PHA solicitation of involvement is not related to agency size, whether the agency receives funding from HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and the number of homeless and disabled individuals served. Since there are certain planning requirements for all PHAs regardless of size, solicitation of involvement is a concern for all PHAs not just the large agencies. Similarly, since the reason for an agency to solicit the involvement of the disabled community and disability service providers is not influenced by agency capacity, funding for specialized programs and the number of homeless and disabled individuals served are not significant to the model.

The most common best practices for PATH agencies were providing alternative means to meet eligibility including support for criminal, substance abuse, and bad credit histories (53.8%), formal partnerships with PHAs (46.1%), and formal written agreements with housing agencies (46.1%).

In general, PATH agencies were more likely to cite program-related barriers to housing provision for homeless individuals, while PHAs were more likely to cite applicant-related issues. However, PATH agencies cited applicant-related barriers as most significant for homeless individuals with serious mental illness and substance abuse histories.

The most frequently identified barriers to successful housing provision identified by PHAs were:

- Poor tenant history (66.8%)
- Criminal history (59.7%)
- Waiting list too long (38.8%)
- Poor credit history (35.7%)
- Notification of status difficult (31.1%)

PATH agency respondents were asked to identify major barriers to housing for specific population groups. The top five barriers identified by PATH agencies for homeless individuals were:

- Waiting list too long (78.9%)

- No vacancies (68.4%)
- Poor credit history prevents placement (47.4%)
- Poor tenant history prevents placement (42.1%)
- Notification of applicant by phone or mail is difficult (36.8%)

The top barriers identified by PATH agencies for homeless individuals with serious mental illness were:

- Poor credit history prevents placement (42.1%)
- Difficult for applicant to maintain stable housing (42.1%)
- Poor tenant history prevents placement (36.8%)

The top barriers identified by PATH agencies for homeless individuals with histories of substance abuse were:

- Difficult for applicant to maintain stable housing (47.4%)
- Poor credit history prevents placement (42.1%)
- Exclude applicants with criminal histories (36.8)

The top barriers identified by PATH agencies for homeless individuals with physical disabilities were:

- No vacancies (21.1%)
- Waiting list too long (21.1)

Except in very large agencies where homeless represented 11.6 percent of the total population served, homeless individuals comprised less than five percent of the population served. The disabled as a percent of total units was 9 percent for small, large and very large agencies, but 13 percent and 16.5 percent for medium and very small agencies.

The number of homeless and disabled individuals served by PHAs is positively related to agency size, the Engagement Index, and ROSS/HOPE VI (only marginally), and negatively associated with the Best Practices Index. The association between the number of homeless and disabled individuals served and agency size reflects agency capacity. Similarly, higher engagement in outreach activities, which range from providing information to service providers and the disabled community to on-site support services, is associated with greater provision of housing for homeless and disabled individuals. Local preferences have no impact on the number of homeless and disabled served.

Recommendations

As an exploratory study, our primary goal was to document the engagement between PHAs and the disability community, best practices in serving the homeless with

disabilities, and barriers to successful housing. Nonetheless, this study provides some basis for recommendations, however preliminary.

If the goal is to increase the number of homeless and disabled individuals served, strategies should focus on agency size and engagement. Larger agencies have greater capacity to provide services and more community resources to do so. In smaller communities, regional approaches and technical assistance could offset the lack of local capacity. PATH agencies in particular should examine opportunities for providing technical assistance in smaller PHAs and communities.

Engagement works! Although it has become almost commonplace to boast about the advantages of collaboration, partnership and networking, they produce results. Engagement not only is associated with serving larger numbers of homeless and disabled individuals, it is associated with the adoption of best practices. The latter in turn can boost the quality of services provided. Further study is needed to determine if the negative relationship of best practices with the number of homeless and disabled served is reliable, and if so, why best practices reduces the number served.

HUD ROSS/Hope VI programs for Welfare to Work, Mainstream or Family Unification programs, and mandatory Family Self Sufficiency program are not effective conduits for engagement with disability service providers and the disabled community. Similarly, local preferences have no measurable impact on engagement, best practices or numbers served. If advocates expect these programs to promote engagement, adjustments in their design or administration might be needed.

Finally, further research is needed. For any subsequent quantitative surveys, measurements can be improved and higher response rates might be possible (particularly among the PATH agencies). Qualitative research could add to our understanding of the nuances and relationships that promote higher levels of service. As important, practitioners and advocates can document and share their successes and failures in collaborating and increasing the quality and quantity of services.

Implications

Policy Implications for housing and services

For State PATH coordinators and local providers of PATH services, the challenge is not necessarily how to identify and assist persons who are without stable housing. The challenge is how do they create a "good fit" between consumers with complicated needs and scarce resources.

Many PATH providers participate in local service coalitions or other local stakeholder groups. These activities may focus on housing, mental health and substance abuse treatment providers, emergency shelters, veteran services, downtown business owners, non-profit organizations, or Public Housing Authorities (PHAs). Such relationships are critical and must be maintained. The importance of maintaining an open dialogue with PHAs cannot be overemphasized.

Public Housing Authorities face numerous challenges. Aging housing stock, limited participation by landlords, insufficient numbers of vouchers, outdated fair market rent guidelines, and increasing administrative costs further complicate their mission. However, their mission can be achieved through local partnerships with the disability community. These partnerships can lead to the development of local strategic plans that can not only address limited housing stock, but also ensure that their customers are receiving the community support and services that they need.

With the advent of deinstitutionalization in the 1970's, many community mental health centers felt overwhelmed with the intensive needs of persons who were leaving state hospitals and institutions (O'Hara, 2001).[4] Consumers were often relegated to inadequate boarding homes and congregate living situations that were unqualified to care for people with mental illness. This continues even today, as many consumers leaving institutional settings do not have adequate choices for housing. These vulnerable consumers are burdened with limited income, stigma, a lack of safe, decent, and affordable housing stock, and a nationwide lack of resources to fund mental health services.

Boarding homes and the culture of poverty that they represent have not faded away or improved much over time. However, we have learned that there are alternatives. Supportive behavioral health service models that address housing needs are essential for a successfully recover from debilitating brain disease.[5] Without stable housing, gains made from treatment will deteriorate. With supportive services and stable, affordable housing consumers can experience an increased level of functioning, extended community tenure,

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[4] O'Hara, Ann (2001). Priced Out in 2000: The Crisis Continues. Technical Assistance Collaborative. Boston, MA.

[5] Department of Health and Human Services, (1999). Mental Health: A Report of the Surgeon General. Online at URL http://www.surgeongeneral.gov/library/mentalhealth/home.html.

improved quality of life, economic well being, health and social relationships, and decreased hospitalization.[6]

Affordable housing and mental health supportive services also result in improved outcomes for people who are homeless and mentally ill, such as increasing employment opportunities, mental health treatment and support services, and education.

Implications/Challenges/Actions For State PATH Contacts

Supported housing allows consumers to choose, get, and maintain community-based, integrated housing. It encourages long-term community tenure and increases consumers well-being and quality of life. It decreases costs to the taxpayers in terms of reduced hospitalizations, increased community tenure, and reduced incarcerations. **It makes sense**. If the goal is to help persons recover from their illnesses, then the State Mental Health Authorities and PATH state contacts must address housing and supports. These entities must seek to support their customers and the citizens of their state to obtain accessible and affordable housing. The alternative, which is readily observable in too many communities, is a more expensive reactive system of "non-care". This system of non-care leads to overwhelmed emergency rooms, misdirection of law enforcement activities, and accentuates the severity of psychosocial stressors that persons face as they struggle to recover from neurobiological diseases

The challenge is to identify the existing resources and existing deficits in housing and supports, bring those issues to the attention of state legislators and community stakeholders and then to develop a comprehensive plan to address the need for stable housing. With stable housing, the SMHA is then able to bring the current technologies offered by behavioral health care to focus upon the rehabilitative needs of consumers. Such initiatives as supported housing, in-home and family support, supported employment, and Assertive Community Treatment (ACT) have been shown to improve client–level outcomes.

What State Path Contacts Can Do

- **Identify key staff at state housing agencies in order to create a partnership to expand access to housing for persons with disabilities**. One activity could be to review their states inventory of housing stock and in particular public housing stock.

- **Encourage members of the disability community to apply for funds that the state housing agency offers. One example is the use of HOME tenant-based**

[6] Burek, S., Toprac, M., Mason, M., Olsen, M. (1994). TXMHMR Supported Housing Evaluation: Year One Findings. Austin, TX. Texas Department of Mental Health Mental Retardation.

rental assistance funds for persons with disabilities. These funds are used for rental assistance for up to 24 months. The SMHA can offer matching support service funds or assistance with moving expenses for persons who currently reside in boarding homes or assisted living facilities. The key is to create information distribution lists in order to rapidly communicate that an opportunity for funding exists and that the PATH state contact facilitates providers to apply for funding.

- **Advocate for Supported Housing services by incorporating and paying for those services through the community mental health system of performance contracts**. For example, the Texas Department of Mental Health and Mental Retardation requires the state's 42 community mental health centers to assign 4.25% of all adults served to Supported Housing services.

- **Encourage the state housing agency and public housing agencies to re-institute preferences for persons who are elderly or disabled**. Some Public Housing Agencies are able to eliminate the costs of such "preference lists' by dispensing with the list (and thus the costs) altogether. State PATH contacts could facilitate the creation of mutually beneficial workgroups that would seek to identify administrative funds by which these lists and preferences could be maintained.

- **Encourage non-profit organizations and PHAs to apply for specialized funds**. Funding sources such as HUD's 811 Supported Housing Program for Persons with Disabilities or HUD's Section 202 Supported Housing Program for the Elderly are invaluable aids to meeting the need.

- **Create and support a statewide advisory committee that will continuously scan the environment for funding and service opportunities**. Such expert panels can increase the effectiveness of the intent of SMHA staff by serving as a comprehensive and powerful voice for system change.

What Local PATH Providers Can Do:

- **Open a dialogue with the PHAs Board of Commissioners by offering informational presentations; training's on mental illnesses and best practices such as Supported Housing and in-vivo treatment alternatives**. Part of the presentation could emphasize how local mental health provider staff can be an additional resource to stabilize and increase housing tenure by providing support services.

- **Participate in the development of the Public Housing Agency Plan and in the Consolidated Plan (for larger PHAs) that PHAs are required to produce**. Both of these plans require public input. Participation should not be limited to

staff. Local PATH providers should make every effort to include those that will actually use the serves in the planning, design and implementation of the Public Housing and Consolidated plans.

- **As these local plans are developed, PATH providers should ensure that issues related to reasonable accommodations and that a "fair share" of scare resources is addressed**. Another issue of importance to persons in the disability community is the issue of "visitability". Universal access designs include such issues as whether there is a t least one no-step entrance to the home, lowered light switches, levered door handles, and grab bars in the shower.

- **Ensure that changes in admission and occupancy rules are addressed in Housing Plans**. Many persons with co-occurring psychiatric and substance use disorders have found themselves excluded from public housing due to prior convictions for drug possession and/or use. While the exclusion of these persons from Public Housing is an option for PHAs, states often make this mandatory. In working with the PHAs, background checks can be negotiated and smaller crimes, such as shoplifting, can be waived.

- **Request that an ombudsman function be created by the PHA**. The ombudsman can serve to investigate reported complaints from consumers, report findings, or to help achieve equitable settlements when housing discrimination issues arise.

- **Create a community campaign that focuses on increasing the number of landlords who are willing to accept Section 8 or other types of housing vouchers**. These efforts could include "meet and greet" activities, at which local mental health provider staff can emphasize their intent to enhance community tenure for consumers.

- **Address the stigma and myths of mental illness through education**. This can be accomplished by making presentations to business groups, merchant associations, neighborhood associations, or providers of services to low-income persons.

Implications And Challenges For PHAs

- PHAs should seek broad-based inclusion from members of the disability community and the organizations that serve them in the development of the Public Housing Plan and the Consolidated Plan.

- PHAs should seek to increase their housing stock through a targeted campaign towards landlords.

- PHAs should review their admission and occupancy rules to insure that undue exclusion does not occur. PHAs must make every effort to open opportunities for public housing, not to close them.

- PHAs should create a partnership with local organizations to discover and capture additional sources of funding to enhance existing housing stock and to enhance supportive serves for public housing residents. Such partnerships could include innovative program designs such as the existence of on-site professional or paraprofessional support.

Recommendations/Next Steps

- Short-term needs, problems and opportunities
- Long-term needs
- Recommendations for further study/how information can be used & expanded
- MOU with PATH providers and PHAs
- Exemplary practices with PATH Providers in working with people who are homeless and mentally ill