Possibilities for Health-Conscious Assisted Housing Mobility

By

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ABSTRACT

Many poor, segregated, urban neighborhoods are rife with risks to health, which contributes to stark racial and geographic disparities in health. Fighting health disparities requires buy-in from non-health professionals whose work directly impacts the way cities are designed and governed. This thesis provides a case study of one non-health initiative, assisted housing mobility, with clear relevance to health disparities. Research suggests that moving from high- to lower-poverty neighborhoods may confer a range of health benefits on individuals; however, assisted housing mobility programs are, to date, relocation-only interventions. Could these programs more deliberately promote health, and should they do so? Through interviews and a review of counseling materials, I examine how nine assisted housing mobility programs are linked to health, how health is understood by program staff, and how managers might offer more health-conscious programming.

Based on a review of pathways between health and housing and neighborhoods, I identified five areas of intervention around which managers could build healthful programs: housing units, neighborhoods, health behavior and awareness, social connectedness, and access to health services. For each area of intervention, I detail possibilities for active versus passive approaches, and document relevant practices from the profiled programs. I then explore practitioner attitudes towards integrating health into mobility programs. Although most practitioners see their work as disconnected from health, their programs actually play a promising mediating role. Concerns about mandate, privacy, legality, liability, and capacity hinder programs from exploring health. So does limited understanding of how to incorporate health appropriately. Yet, most staff members are encouraged that their work may improve client health, and many want to do more.

I recommend steps programs could take to provide better health-related information and discuss health more openly throughout housing counseling so families can make deliberate choices. I provide a preliminary assessment of relative costs and benefits of each step. I note that program managers will require technical and collegial support in order to implement the suggested changes well. The Poverty & Race Research Action Council, which helped guide my research, could provide needed support.

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"Of the 10 families I met, 9 had at least one member who suffered from a serious health problem before the move that required either medication or hospitalization. Of the 16 people in these families who had health problems, 12 told me that they felt better in significant ways -- either their symptoms were less severe so that they no longer required hospitalization, or they were taking less medication. Their health problems included severe asthma, diabetes, high blood pressure, liver cirrhosis and eczema. Emergency-room visits for the asthmatic kids virtually stopped, and some adults with high blood pressure or diabetes reduced the doses of their medications. This was hardly a rigorous scientific experiment. There was no control group, and I was not able to check medical records. Nevertheless, I was stunned by what people told me. These people felt better, and moving appeared to have made all the difference. If moving out of southwest Yonkers were a drug, I would bottle it, patent it and go on cable TV and sell it."

- Helen Epstein, "GHETTO MIASMA: Enough To Make You Sick?"[1]

Introduction

Public health researchers have long studied the links between living environments and health outcomes. Many poor, segregated, urban neighborhoods are rife with risks to health, including substandard housing contaminated with lead paint, high rates of violence, an excess of fast food and liquor outlets, poorly performing schools and high unemployment rates (hindering economic progress for residents) and a paucity of health care resources. The cumulative impacts of these and other hazards result in stark geographic disparities in health, with disadvantaged urban neighborhoods carrying excess disease burdens in metropolitan areas across the country.

While this is not news to academics in the public health field, awareness of this massive societal injustice is just now building among non-health professionals and members of general public. Mainstream media outlets such as the New York Times Magazine, which published the article quoted above in 2003, and PBS, which only months ago began airing a seven-part series on health, neighborhoods, socioeconomic status, and race,[2] are helping to spread the important message that place and health are inextricably, and often unfairly, linked. Media attention to these issues is powerful. Moving a discussion of urban health disparities further into the mainstream is important because changing current

[1] Helen Epstein. "GHETTO MIASMA: Enough To Make You Sick?" New York Times Magazine, 12 October 2003.
[2] Unnatural Causes: Is inequality making us sick? Prod. California Newsreel. PBS 2008.

conditions will require buy-in and cooperation from non-health professionals whose work directly impacts the way cities are designed and governed.

Urban planning as a discipline is rich with opportunities to combat health disparities; housing-related programs and policies are especially relevant to many of the factors driving negative health outcomes among the urban poor. This thesis aims to provide a case study of one non-health initiative, assisted housing mobility, with clear relevance to health disparities. I examine how assisted housing mobility programs are linked to health and how health is understood by program staff. This work has two main goals: most immediately, it will feed into a manual for Housing Choice Voucher program administrators currently being prepared by the Poverty & Race Research Action Council (PRRAC), hopefully helping managers think through if and how their programs could better consider health. More broadly, it seeks to comment on the process of integrating health into traditionally non-health spheres, identifying both opportunities and barriers.

Study Justification

The idea that residential mobility impacts health is not new. Research on both the Gautreaux and Moving to Opportunity (MTO) regional housing mobility programs suggests that moving from high-poverty, public housing projects to lower-poverty neighborhoods may confer a range of physical and mental health benefits on individuals. Further, significant gains among program "compliers" (relocatees), such as decreased rates of depression and obesity, have been unrelated to any specific health interventions. That is, regional housing mobility programs are, to date, relocation-only interventions. These findings have prompted many public health practitioners to argue that regional housing mobility programs serve as important vehicles for improving health, and that such programs could be even more effective if deliberately designed to promote health. However, there are, for now, no documented examples of health interventions tied to such programs that can serve as sources of best practices or lessons learned, including lessons about barriers to doing more and doing better.

This thesis seeks to examine the current state of practice in housing mobility program administration with the goal of documenting the ways in which health has been considered by various programs. Specifically, I profile a sample of assisted housing mobility programs operated through the federal Housing Choice Voucher Program, and understand through interviews what each one's experience has been in linking mobility to health. Additionally, I summarize the needs of program administrators as they move forward implementing health-promoting interventions.

Research Question and Report Outline

What kinds of health interventions, if any, have local managers tied to regional housing mobility programs, and what barriers do they face to integrating health and housing assistance to benefit housing voucher holders?

To answer such questions, this thesis is organized as follows:

- Chapter 1 offers a review of relevant literature from the fields of public housing policy, civil rights litigation and theory, and public health in order to contextualize how assisted housing mobility programs have come into existence and how, through research on the Gautreaux program and Moving to Opportunity (MTO) experiment, they are thought impact relocatees.

- Chapter 2 presents five areas of potential health intervention for assisted housing mobility practitioners, addressing how the housing unit, the neighborhood, health behavior and awareness, social connectedness, and access to health services are impacted by program content. This chapter delves into current public health literature on each topic area, presenting options for both very aggressive, as well as "hands off" approaches to each.

- Chapter 3 presents nine currently operational assisted housing mobility programs, profiling each program in terms of origins and content offered. This sample is limited to voucher-based, also known as "tenant-based," programs, not the rarer unit-based mobility programs, such as those that have operated through

"scattered-site" public housing since the late 1960s (Briggs 1997; Turner and Williams 1995). I limited the study in this way because the voucher program is by far the nation's largest expenditure on the housing needs of low-income families and likely to be the principal mechanism for expanding health promotion through expanded regional housing opportunity in the years ahead. Chapter 3 also documents health-related content present in the various programs. In a few cases, this content was added deliberately with an eye towards health, but more often, initiatives designed for non-health reasons are discussed because they appear to have plausible links to health.

- Chapter 4 summarizes and synthesizes in-depth qualitative interviews with assisted housing mobility program staff in order to explore commonly held attitudes towards linking health and assisted housing mobility. It also organizes programs into four typologies based on level of service provision, and then suggests which "targets of opportunity" (or specific health interventions) presented in Chapter 2 most naturally fit with each typology.

- Chapter 5, the concluding chapter, summarizes findings from previous sections of the report. It also presents key questions and conceptual tensions in the universe of programs profiled, drawing on long-standing themes from the housing and human services field for context. It then reflects on lessons learned from this research project for broader efforts to reconnect the disciplines of public health and urban planning. Finally, the chapter offers a consolidated list of health-oriented next steps for assisted housing mobility practitioners.

This thesis is intended as a resource for PRAAC as it develops its manual for Housing Choice Voucher Program Administrators, but also as a reference for individual assisted housing mobility practitioners hoping to advance health-related content in their programs.

Chapter 1 – Literature Review and Background

Introduction

There are several bodies of research that inform a discussion of assisted housing mobility programs and the ways in which they currently do, or eventually could, consider health. This chapter presents a brief review of relevant literature from the fields of public housing policy, civil rights litigation and theory, and public health with the goal of contextualizing future discussions on attitudes and practices in linking health and assisted housing mobility.

I discuss housing policy first, explaining how the nation transitioned from a builder and maintainer of public housing to a provider of rent subsidies that are used in the private market. I then address the relationships of these different supply- and demand-side approaches to civil rights and fair housing law, eventually discussing the role of litigation in the formation of assisted housing mobility programs. Having established how and why they have traditionally been created, I then delve into literature on health outcomes related to these housing mobility programs. Finally, I offer a broader review of hypotheses for how and why residential mobility seems to impact health. This final piece focuses mainly on neighborhood effects on health.

Public Housing Assistance and the Formation of the Housing Choice Voucher Program

Public housing priorities and policies have shifted since 1937 when public housing was first introduced under the U.S. Housing Act as a piece of the New Deal. These shifts have leaned heavily towards tenant-based subsidies in recent history, and even more recently, resulted in declining support for families hoping to use their subsidies in low-poverty "opportunity areas."

From its beginning through 1974, funding for low-income housing assistance was overwhelmingly directed towards "supply-side" assistance, or the construction of new

public housing units.[3] Section 8 of the Housing and Community Development Act of 1974 allowed for the provision of "demand-side" assistance through tenant-based rent subsidies, building upon programs such as the Section 23 Leased Housing Program and the Experimental Housing Allowance Program, both of which had previously flirted with public housing authority use of private housing stock.[4] The creation of Section 8 in 1974 signaled the beginning of a new approach to dealing with public housing assistance; the nation essentially stopped building new public housing units and started to rely on private housing stock, in addition to the public housing stock that had already been built, to meet the needs of very low income families. Throughout the 1970s and 1980s, conditions in public housing deteriorated as a result of often well-intentioned federal policies that "skewed public housing admissions to favor the least advantaged applicants."[5] These policies, as housing expert Lawrence Vale outlines [footnote: Lawrence Vale: *Reclaiming Public Housing*], served to concentrate impoverished and minority tenants (which incidentally further politically marginalized the public housing program and made it harder to fund).[6] Local public housing authorities (PHAs) also often encouraged poverty concentration and residential segregation through their tenant and site selection processes.[7]

By 1989, physical and social conditions in many of the large PHA's urban complexes had gotten so bad that Congress established the National Commission on Severely Distressed Public Housing. In 1992, this commission estimated that 6% of all public housing stock was "severely distressed." It recommended that Congress establish the HOPE VI Program and spend several billions of dollars on renovations and several hundreds of millions of dollars on demolition in order to eradicate "severely distressed" public

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[3] William G. Grigsby and Stephen C. Bourassa, "Section 8: The Time for Fundamental Program Change?," *Housing Policy Debate*, Vol. 15 Iss. 4 (2004).
[4] "Section 8 History," Minneapolis Public Housing Authority, 21 May 2008, <http://www.mphaonline.org/section8.cfm>.
[5] Lawrence J. Vale. Reclaiming Public Housing: A Half Century of Struggle in Three Public Housing Neighborhoods (Cambridge, Massachusetts: Harvard University Press, 2002) 6.
[6] See Arnold Hirsch, Making the Second Ghetto: Race and Housing in Chicago 1940 -1960 (New York: Cambridge University Press, 1983).
[7] Michael H. Schill, "Distressed Public Housing: Where Do We Go from Here?," The University of Chicago Law Review, Vol. 60 No. 2 (1993) 497-554.

housing from the United States.[8] With renovation costs often exceeding original total development costs of these distressed complexes, a lack of public confidence in the conventional public housing program, and increasing attention to the negative impacts of concentrated poverty, public housing funding in the 1990s was directed even further away from project-based assistance and towards providing rent subsidies and incentivizing the construction of new mixed-income developments.[9] Vouchers were widely seen as a potentially cost effective way to "replace" demolished public housing while increasing neighborhood quality for families displaced from those public buildings.[10] In practice, these new funding priorities often resulted in the involuntary relocation of families from conventional public housing, and the transition of these families to the Section 8 Program. Research on the HOPE VI Program suggests that involuntary relocation can be enormously stressful for families, as it often entails changes to social networks, household budgeting, and routines.[11] Relocation and its impacts on mental health are discussed further in Chapter 2. Section 8's tenant-based program eventually grew into the largest and most important form of low-income housing assistance available today: the Housing Choice Voucher Program (HCVP).[12] A comparison to conventional public housing reveals the scale of the HCVP; there are about one million public housing units and two million housing vouchers in use at any given time.

Congress authorized the consolidation of the Section 8 voucher and certificate programs into the Housing Choice Voucher Program in 1998 with the passage of the Quality Housing and Work Responsibility Act. Housing Choice Vouchers work in the same way Section 8 vouchers did; families lease private apartments, contributing between 30% and

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[8] Ibid.; "Demolition Grants," U.S. Department of Housing and Urban Development, 21 May 2008, <http://www.hud.gov/offices/pih/programs/ph/hope6/grants/demolition/>

[9] Susan J. Popkin et al, "The Hope VI Program: What about the Residents?," Housing Policy Debate, Vol.15 No. 2 (2004) 385 – 414.

[10] Schill, op. cit.

[11] Susan J. Popkin et al, "HOPE VI Panel Study: Baseline Report," The Urban Institute Metropolitan Housing and Communities Policy Center, UI No. 07032, September 2002.

[12] "Introduction to the Housing Voucher Program," Center on Budget and Policy Priorities, 21 May 2008, <http://www.centeronbudget.org/5-15-03hous.htm>

40% of their adjusted monthly incomes towards rent.[13] Housing Choice Vouchers can be used to make up the difference in rent as long as the unit is decent and safe (as evidenced by passing the HUD Housing Quality Standards inspection), and can be rented at a fair market rate (as determined by HUD). HUD distributes federal funds for these vouchers to local PHAs, which then administer the subsidies to families in their jurisdictions. The very stipulations that HUD uses to ensure that families lease decent and affordable units, however, can cause headaches and limit the supply of private apartments available to program participants. Housing Quality Standards (HQS) are difficult to administer and enforce evenly, and often provoke complaints from landlords who stop receiving voucher payments if their unit falls out of compliance and may be left to make expensive repairs before they are paid rent again. Chapter 2 will address HQS more thoroughly, but it should also be noted that the requirements are minimal compared to many other "healthy housing" guidelines available. The original intent of the standards was to prevent the occupation by tenants and financial support by government of "substandard" housing, a concept dating back to the tenement slums of the 19th century, not to ensure that families had healthful housing. Fair market rent, which is set at 40% of the local median rent as determined by HUD rent surveys, is often criticized as too low to secure quality units in tight rental markets.

In the context of this study on housing mobility, a key characteristic of housing choice vouchers is that they are "portable," or can be used anywhere in the nation. The portability feature makes the Housing Choice Voucher Program a potentially powerful tool for desegregation. This application of the program, however, is not on of its main goals. Although locational choice has been touted as an advantage of vouchers over public housing or other supply-side interventions, the core objective of the HCVP is to reduce rent burden on low-income families.[14] I discuss the role of HUD, local PHAs, and other government entities in both creating and combating residential segregation below, with the aim of better understanding how assisted housing mobility programs have

[13] "Housing Choice Vouchers Fact Sheet," U.S. Department of Housing and Urban Development, 21 May 2008, <http://www.hud.gov/offices/pih/programs/hcv/about/fact_sheet.cfm>

[14] Jill Khadduri, "Comment on Victoria Basolo and Mai Thi Nguyen's 'Does Mobility Matter? The Neighborhood Conditions of Housing Voucher Holders by Race and Ethnicity,'" Housing Policy Debate, Vol.16 Iss.3/4 (2005) 325.

evolved and are functioning today.

Civil Rights, Residential Segregation, and Housing Mobility

In 1955, Charles Abrams' book *Forbidden Neighbors: A Study of Prejudice in Housing*, was published. One of the first and most important contributions to the literature on residential segregation, it specifically implicated the federal and local governments in the promotion of segregation through racial zoning, restrictive covenants, racist deed restrictions, and discriminatory lending practices.[15]

Despite Abrams' clear presentation of government's role in promoting segregation, both unequal access to decent housing and the policies that promoted such inequity remained in place and unaddressed by the federal government until the 1968 release of the Report of the National Advisory Commission on Civil Disorders, better known as the Kerner Commission Report.[16] A reaction to the race riots of 1967 in Detroit and Newark, the Kerner Commission Report investigated causes of then recent "civil disorders" across the country, finding that inadequate housing was in the "first tier" of "deeply held grievances" among African Americans. It echoed Abrams' complaint that government policies exacerbated residential segregation and urban ghettoization, and recommended that combating these trends be a top priority for the nation:

> "*Federal housing programs must be given a new thrust aimed at overcoming the prevailing patterns of racial segregation. If this is not done, those programs will continue to concentrate the most impoverished and dependent segments of the population into the central-city ghettos where there is already a critical gap between the needs of the population and the public resources to deal with them.*"[17]

It also suggested, long before the establishment of the Section 8 program or litigation-driven assisted housing mobility initiatives, that private market housing stock could effectively be leveraged to make strides towards less segregated cities; the Commission

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[15] Charles Abrams. Forbidden Neighbors (New York: Harper and Brothers, 1955)
[16] National Advisory Commission on Civil Disorders. Report of the National Advisory Commission on Civil Disorders (New York: Bantam Books, 1968).
[17] Ibid. 474.

called for "demand-side" housing solutions, and more specifically urged that "... rent supplements should be, wherever possible, be used in nonghetto areas...."[18] Its approach, favoring dispersal as a response to the problems facing the segregated, impoverished neighborhoods it investigated, would later become a controversial tactic for reasons discussed briefly below and in Chapter 2 of this thesis.

The acknowledgement by a government panel that race-based inequities in housing did exist, were perpetuated through government policies and programs, and should be confronted officially and aggressively, fostered public policy and, perhaps more importantly, legal discussions about residential segregation. In fact, it was a landmark class action lawsuit filed against the Chicago Housing Authority (CHA) and HUD[19] (filed two years before and partially settled eight years after the publishing of the Kerner Commission Report) that first operationalized one of the Kerner Commission's prescriptions for change: using government-provided rent supplements as a tool for desegregating cities and better matching "the needs of the population" to the "public resources to deal with them." According to Legal scholar Florence Roisman's law review article on the history of public housing desegregation litigation, Gautreaux should be seen as an outgrowth of the civil rights litigation of the 1940s and 1950s, which had, until then, helped eliminate restrictive covenants but was not successful in targeting the segregation of public housing.[20]

The Role of the Judiciary – Landmark and Demonstration Projects

In 1966, Dorothy Gautreaux and 40,000 others reliant on public housing assistance in Chicago filed a class action law suit against CHA and HUD to protest how new public housing complexes were sited in the city. They successfully argued that "CHA had deliberately chosen its sites to avoid placing black families in white neighborhoods" and that "HUD had violated the fifth amendment by approving and funding CHA's

[18] Ibid. 482.
[19] Hills v. Gautreaux, 425 U.S. 284 (1976).
[20] Florence Wagman Roisman, "Long Overdue: Desegregation Litigation and Next Steps To End Discrimination and Segregation in the Public Housing and Section 8 Existing Housing Programs," Cityscape, Vol. 4 No.3 (1999).

discriminatorily selected sites."[21] The case reached the U.S. Supreme Court. In 1976 the parties came to a partial settlement and the Court issued a consent decree that resulted in the creation of the Gautreaux Housing Mobility Program.[22] Under this program, CHA relocated over 7,000 black, public housing families (present or past tenants and those on waiting lists) in non-poor, non-black neighborhoods and provided Section 8 vouchers to supplement rent. Since this time, civil rights organizations and public housing residents have brought suits against HUD and local PHAs across the country in (often successful) efforts to win similar remedies.

With the judicial branch playing a vital role in residential desegregation efforts, much has been written on the legal obligations of the federal and state governments to prevent racial discrimination in housing. Florence Roisman, a long-time observer of civil rights litigation in housing, reviews the legal context for desegregation lawsuits. Roisman outlines the 1866, 1954, 1964, 1968, 1994, and 1996 legislative, executive, and judicial directives prohibiting racial discrimination, but concludes that, "Despite this plethora of legal requirements, housing programs administered by Federal, State, and local government agencies consistently have been characterized by pervasive racial discrimination and segregation."[23] It is no surprise then, that HUD and local PHAs have repeatedly been the targets of litigation. Philip Tegeler, Executive Director of the Poverty and Race Research Action Council described HUD in the early 1990s as facing a "seemingly bottomless well of liability, with public housing desegregation lawsuits pending in numerous cities...."[24] Much of this liability was resolved by President Clinton's first HUD Secretary, Henry Cisneros, who acknowledged HUD's culpability in promoting segregation and settled many of the pending lawsuits. These settlements resulted in measures such as assisted housing mobility programs or new Section 8 voucher allocations, both addressing the plaintiffs' complaints and forwarding the

[21] Alexander Polikoff, "The Seventh Circuit Symposium: The Federal Courts and the Community: Gautreaux and Institutional Litigation," Chi.-Kent. Law Review, Vol. 64 (1988) 451.
[22] Hills v. Gautreaux, 425 U.S. 284 (1976)
[23] Roisman 1999, op. cit. 171.
[24] Philip Tegeler, "Back to Court: The Federal Role in Metropolitan Housing Segregation," Shelterforce Online, Iss.140 (March/April 2005).

Clinton administration's own agenda to deconcentrate poverty in urban areas.[25] However, HUD under the Bush Administration has shifted back into defensive mode, choosing to fight civil rights organizations and public housing tenants in court rather than settle or voluntarily create programs that would proactively tackle segregation. In fact, it has imposed budget cuts that have reduced the number and value of vouchers available to many local PHAs, in addition to other assaults on deconcentration and desegregation programming.

Despite these different legacies, legal action has been crucial for securing assisted housing mobility funding under both, and previous, administrations. In the words of Roisman, "When the Section 8 existing housing program was created in 1974, it offered perhaps the best opportunity for avoiding racial and economic concentration, for Section 8 certificates and (later) vouchers theoretically enabled individual households to move into developments and neighborhoods where their race did not predominate. ... Unfortunately, this use of Section 8 for desegregation and deconcentration has been very rare. It almost always was so used only in the context of litigation."[26] While this study is limited to tenant-based (i.e., voucher-based) mobility programs, it is important to note that unit-based mobility programs have existed since the 1960s in the form of scattered-site public housing.[27]

Chapter 3 offers profiles of nine currently operating tenant-based assisted housing mobility programs, most of which were the result of some legal action or threat of legal action. This group includes Baltimore's Thompson mobility program, the initiative that originally motivated this study. The rare examples of voluntary and demonstration programs created during and since the 1990s have been important too, however. The most famous of these programs was Moving to Opportunity (MTO), a 1992 demonstration authorized by Congress to advance an understanding of the impacts mobility programs had on participants. MTO and other thoroughly studied mobility

[25] Ibid.
[26] Florence Wagman Roisman, "Keeping the Promise: Ending Racial Discrimination and Segregation in Federally Financed Housing," Howard Law Journal, Vol. 48 No. 3 (2005).
[27] James Hogan, "Scattered-site housing: Characteristics and consequences," (Washington, DC: U.S. Department of Housing and Urban Development, 1996).

programs are discussed below as an introduction to key research findings on the benefits and limitations of housing mobility for movers, with a focus on health outcomes. This background elucidates current thinking among mobility practitioners on how health should be considered by assisted housing mobility programs.

MTO and Mobility Research Findings

As the first of its kind in the nation, no one was quite sure how successful the Gautreaux Housing Mobility Program would be in improving the lives of participating families. By the early 1990s, however, several studies found high rates of satisfaction among participants, as well as employment and educational gains. Bolstered by these positive findings, but concerned that the design of the Gautreaux program hindered researchers from understanding whether moves to the suburbs actually *caused* any benefits, advocates and academics convinced Congress to fund an experimental mobility program in five cities. In the words of the HUD-commissioned Interim Impacts Evaluation report on MTO, the program was "...designed to be the experiment that directly and rigorously tests whether moves to low-poverty areas can bring about positive changes in the lives of poor families."[28] MTO allowed for such research because it randomly assigned participants to one of three study groups, including a control group. It also took place in five cities, increasing the generalizability of the results, and, unlike Gautreaux, it examined health deliberately. Specifically, *adult and child physical and mental health* was included as one of six study domains. Health-related findings from MTO studies are considered some of the most robust available for these reasons, although other research also informs this discussion.

In 2004, a team of researchers from Harvard reviewed all available empirical evaluations of domestic housing policies that addressed health outcomes, drawing on studies of the Gautreaux program, MTO (Boston, New York, Los Angeles, and Chicago sites), the Cincinnati Special Mobility Program, general Section 8 program evaluation, and the

[28] Larry Orr et al., "Moving to Opportunity for Fair Housing Demonstration : Interim Impacts Evaluation" (Washington, DC: U.S. Department of Housing and Urban Development, September 2003).

Yonkers evaluation of scattered site housing (a unit-based mobility program).[29] Only evaluations that had a comparison group were included, which increases confidence in the conclusions of the review, but the authors still acknowledged varying levels of methodological strength across the studies. Despite these data caveats, the evidence as a whole suggests that housing mobility policies "may contribute to improving child, adolescent and adult health outcomes and health behaviors" even though mobility policies were never designed as health interventions.[30] Some statistically significant improvements were seen among groups of movers (as opposed to control group members) in the areas of anxiety, depression, problem behavior, cigarette smoking, drug use, and violence. Results on alcohol consumption were mixed, and access to health care and services was worse among movers, in some cases. The impacts of moving were also shown to vary across ages and genders.

Another review of the evidence, by Orr et al. in 2003, summarizes that MTO's "experimental" (opportunity) movers relocated to better, safer neighborhoods,[31] children were less likely drop out of school, and girls were more likely to enjoy better mental health. Boys, on the other hand, exhibited increased rates of smoking, more problem behavior, and worse mental health outcomes. There is also evidence that MTO's Section 8 and experimental groups also experienced significantly lower rates of obesity as compared to the control group.[32]

There are still debates in the field about whether gains such as those outlined above will persist into the future, whether these gains outweigh the stress and other negative aspects of moves, what the impact of moving is on social ties, and what a move means in different lifestages, special vulnerable populations, or different genders. However, the

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[29] Dolores Acevedo-Garcia et al., "Does Housing Mobility Policy Improve Health?," Housing Policy Debate, Vol. 15 No.1 (2004).
[30] Ibid. 80.
[31] In fact, families in the experimental group moved from neighborhoods that were over 50% poor, on average, and suffered rates of violent crime orders of magnitude higher than metropolitan averages. For more information on safety and crime, see G. Thomas Kingsley, and K Pettit, "Have MTO Families Lost Access to Opportunity Neighborhoods Over Time?," (2008) Available at <http://www.urban.org/url.cfm?ID=411637>
[32] Orr, op. cit.

conclusions outlined in this section are those most likely to influence program manager thinking on health and mobility, regardless of the objective validity of any of the widely read studies. That being said, the summary of evidence emphasizes the passive benefits of moving from the inner city to "opportunity areas" (and sometimes just moving with a Section 8 voucher) especially as related to mental health, exposure to violence, and obesity.

Common frameworks for assessing pathways between health and housing are discussed below, as this literature may inform how mobility practitioners understand potential areas of intervention for their programs in the context of health.

Housing and Health

Conventional wisdom dictates that housing and health outcomes are linked, however, there is limited evidence on exactly what causal pathways and mechanisms connect the two, and how. Acevedo-Garcia et al. offer three main types of pathways hypothesized to impact health: 1) housing units as "immediate living environments," including sources of environmental exposures, 2) housing quality as a proxy for, and influencer of, socioeconomic status, and 3) housing location as determinant of physical and social environments and access to services.[33] Because this study focuses on housing mobility, whose explicit goal is to change conditions grouped under pathway type 3, it is important to outline some relevant research on this point. Chapter 2 will delve into questions of housing unit quality and exposures. This thesis mainly ignores pathway type 2, for reasons explained in Chapter 2.

Impacts to health caused by the physical and social environments tied to housing location are generally termed "neighborhood effects." Neighborhood effects are different than, although notoriously difficult to fully untangle from, effects of individual or family socioeconomic status. Ingrid Ellen [footnote: Ingrid Ellen et al.: Neighborhood Effects on Health] neatly summarizes models for thinking about neighborhood effects, offering

[33] Acevedo-Garcia 2004, op. cit.

four main causal mechanisms that operate in both short- and long-term timeframes.[34] This section uses Ellen's logic and findings to create context for subsequent chapters.

1) Neighborhood Institutions and Resources

Housing location largely determines the types of goods and services available to families. Most obviously impacting health are health care facilities, but outlets of healthy food and safe, accessible facilities for physical activity are also important. Less tangibly, neighborhoods offer different degrees of opportunity for social interaction and civic engagement. Crime rates and transportation systems determine, in part, how people use these types of resources.

While all neighborhoods are unique, researchers have repeatedly shown that poor urban neighborhoods often suffer from disinvestment in recreational facilities, a lack of grocery stores ("urban food deserts") targeted marketing from fast food, cigarette, and alcohol companies, land uses that foster or harbor criminal activity, and poorly maintained sidewalks and street trees that might otherwise encourage physical activity.[35]

2) Physical Stresses in the Neighborhood Environment

Neighborhoods are also sources of exposure to physical stressors. Environmental exposures to pollutants may occur across several media: indoor and outdoor air, which can be contaminated by vehicle emissions, industrial land uses, or pests such as cockroaches; soils, paints, or other ingestible solids which could contain lead and other metals; and water, whose quality might be impacted by municipal infrastructure or, more commonly in poor rural areas, contaminated ground water. Physical stressors can also include decaying infrastructure that increases the chances of injury or accidents. Quality and maintenance of urban parks and playgrounds are important considerations in this regard.

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[34] Ingrid Ellen et al., "Neighborhood Effects on Health: Exploring the Links and Assessing the Evidence," Journal of Urban Affairs, Vol. 23 No.3/4 (2001).

[35] For a review of many of these factors, see Russell Lopez and HP Hynes, "Obesity, physical activity, and the urban environment: public health research needs," Environ Health Vol. 5 No. 25, (2006).

3) Social Stresses in the Neighborhood Environment

In addition to physical stressors, neighborhoods largely determine exposure to psychological and social stressors. Witnessing acts of violence or living with constant stress caused by other types of social insecurity is thought to create an "allostatic load," or disruption in the healthy functioning of physiological stress responses, which in turn may cause disease.[36] Crime can be a particularly powerful social stressor in poor urban environments.[37]

4) Neighborhood-based Social Networks

Finally, social networks impact the health-related information people share, the social norms and health behaviors that are acceptable in a community, and the social support or social stress acting upon members of those networks. Everything from diet to sexual risk-taking can therefore be influenced by social ties, as can mental health outcomes linked to social isolation. Ellen's article reviews findings that the geographic extent of social networks in poorer communities is generally more limited than it is in richer communities (meaning that the influence of local conditions would be magnified in poorer neighborhoods) and that feelings of isolation and hopelessness are more common in these disadvantaged areas.

Built on this background on how health and neighborhoods are intertwined, Chapter 2 dives more deeply into literature on the various pathways between the two, and opportunities for assisted mobility programs to intervene for health-promotion.

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[36] Bruce S. McEwen, "Stress, Adaptation, and Disease: Allostasis and Allostatic Load," Ann NY Acad Sci, Vol. 840 (1998)

[37] Lauren J. Krivo and R Peterson, "Extremely Disadvantaged Neighborhoods and Urban Crime," Social Forces, Vol. 75, No. 2 (1996).

Chapter 2 – Health and Housing Mobility: Targets of Opportunity

Introduction

With MTO research uncovering some significant health gains in participating families, and researchers increasingly focused on understanding how neighborhoods influence health,[38] professionals from the health, housing, and civil rights fields are starting to ask how assisted housing mobility programs can help families maximize health benefits from "opportunity moves." Underscoring interest in these issues are two recent relevant events; the Baltimore Regional Housing Campaign hosted a national forum in Baltimore on Housing Mobility and Health in May 2007, which addressed this question, and the Interdisciplinary Consortium on Urban Planning and Public Health hosted a workshop in Cambridge, Massachusetts in April 2008 specifically to discuss how housing desegregation programs can better consider health. However, the question of whether, and how, mobility programs can take an active role in promoting health beyond solely helping families move to better neighborhoods is still relatively new. Nothing has been written specifically on the mediating role assisted mobility programs potentially could, or currently do, play along the causal pathways between neighborhoods and health. This thesis begins exploring possibilities for that role, examining various areas of interest for public health within the context of "opportunity," or mobility, moves.

In order to frame subsequent discussions on the current state of health-related practices in assisted housing mobility programs, this chapter identifies areas of interest for health, focusing on variables that 1) will or could change for a family as it makes a mobility move, and 2) present opportunities for public health responses (see figure 1). For each area of interest, the chapter then presents options for extreme forms of both disengagement and intervention. This exercise aims to illustrate the range of influence a program could have over health-related variables, depending on its approach. It is important to preface this section with a few clarifying notes:

[38] Margery Austin Turner "Why Housing Mobility? The Research Evidence Today," Poverty and Race, (January/February 2005).

- As discussed in Chapter 1, there is not always consensus among researchers on what constitutes a healthful neighborhood, or a healthful move. Some factors are widely accepted as desirable, such as clean outdoor air; others are controversial, such as the maintenance of social ties in the old neighborhood; and still others are still under investigation, such the impact of new norms. I cannot resolve the empirical, ethical, or other debates on some of these big questions, but my thesis aims to outline them clearly and weigh some of the options.
- In addition to inconclusive or contradictory evidence surrounding some of the ways in which neighborhoods impact health, there is a also controversy surrounding the proper role of assisted housing mobility programs in clients' lives, or whether such programs even have the capacity to involve themselves in health. This debate will be discussed in chapter 4, with recommendations to follow in chapter 5. This chapter simply attempts to outline what it would look like for a program to consider health as comprehensively as reasonably possible, regardless of whether doing so would be advisable. The comprehensive approach presented for each area of interest simply falls on the more interventionist – not necessarily better – end of a spectrum of involvement.
- I chose not to address variables that are already prioritized by other goals of assisted housing mobility programs. For example, one of the most important ways high-poverty neighborhoods may impact health over time is by limiting socioeconomic attainment, a variable that has been strongly correlated with poor health outcomes. Programs to promote educational and economic attainment, which might include vocational assessment and training, job placement, school choice assistance, or academic enrichment, for example, will not be addressed here.[39] These domains, while not addressed significantly through direct service in most mobility programs, are at least well understood and have long been studied.

[39] Chapter 1, I presented three pathways hypothesized to run between housing and health. This paragraph refers to the exclusion of pathway 2, "housing quality as a proxy for, and influencer of, socioeconomic status."

Research and Organization

I relied on interviews with key national informants and the Chapter 1 literature review to inform both my categorization of interest areas, and my presentation of the comprehensive approaches associated with each one. Interviews and advice from Dr. Dolores Acevedo-Garcia, Dr. Susan Popkin, and Dr. Gary Adamkiewicz, were key resources in this task, as were Urban Institute publications, referenced below as needed. The five areas of interest listed below capture an array of causal pathways, mechanisms, and potential areas of intervention, but are not mutually exclusive categories or necessarily parallel. Rather they simply attempt to name the broad factors an assisted housing mobility program seeking to comprehensively consider health might want to influence.

The five "targets of opportunity" are:

- The unit;
- The neighborhood;
- Health behavior and awareness;
- Social connectedness; and
- Access to health services.

Across these categories cut special "lifestage" concerns, which I address at the end of the chapter.

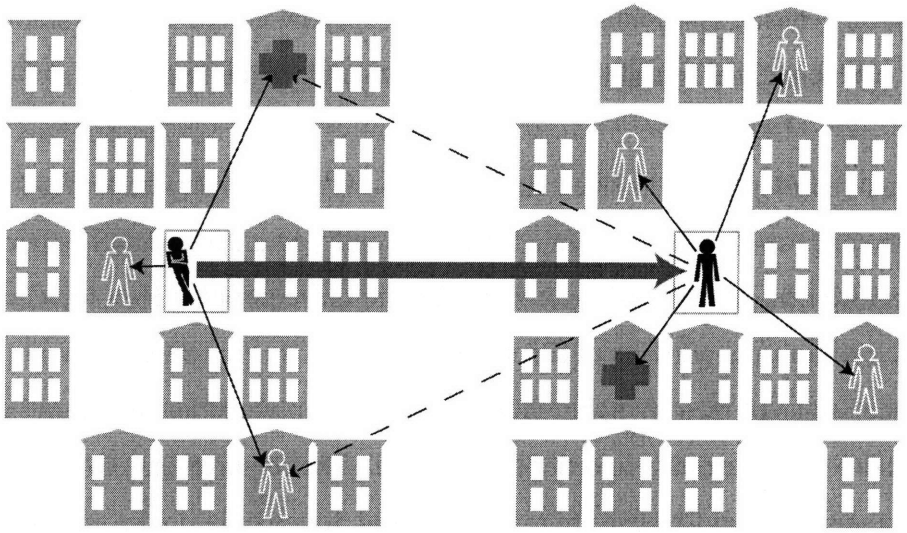

Figure 2-1

Figure 2-1 sketches the relationship of clients to the various areas, showing that after an opportunity move, families will certainly be living in a **new housing unit** in a **new neighborhood**, probably with changes to their **social ties** and **health service** resources, possibly influenced by **new health behaviors and levels of health awareness**. For each of these variables, there is a plausible and relevant public health response possible, as discussed below.

Targets of Opportunity

The Housing Unit

Housing stock can impact health in multiple ways: positively, for example, by providing protection from the elements; negatively, on the other hand, by exposing tenants to unhealthy air or water. These exposures fall under the "housing units as 'immediate living environments'" pathway introduced in Chapter 1, and may be most recognizable to the general public as factors contributing to "sick building syndrome."[40] Health experts have long recognized substandard and deteriorating housing a public health threat, emphasizing the risks posed by indoors allergens, lead-based paint, combustion appliances, pest infestation, and poor temperature control among others; researchers have

[40] Acevedo-Garcia 2004, op. cit..

repeatedly found strong associations between such housing conditions and brain damage, respiratory problem (such as asthma), developmental delays, and injury.[41]

Even the least interventionist assisted housing mobility programs must confront unit-based health concerns thanks to HUD's Housing Quality Standards (HQS), which dictate the basic requirements units must meet to be eligible for rent with a Housing Choice Voucher. Local housing authorities can supplement HUD's guidelines with more stringent regulations of their own, but HQS provide the only guaranteed set of health-related checks a unit must pass in order to be rented. The requirements, while protective of health in the sense that they ensure a "decent" unit, touch only on the most basic aspects of housing unit healthfulness. For example, stipulations include that windows are functional and intact, electrical outlets are present, walls and ceilings are "sound and free from hazardous defects," locks are present on exterior doors, and smoke detectors are installed. A sample HQS checklist is provided as Appendix A.

In contrast, there are a host of housing resources and guidelines that far exceed HQS in terms of healthfulness, aspects of which could potentially be adopted or championed by mobility programs. Healthy housing expert Gary Adamkiewicz points to several resources that are accepted and respected by environmental health professionals as health-promoting. First, the Centers for Disease Control and Prevention (CDC) and HUD have produced a Healthy housing reference manual that aims much higher than ensuring "decent" housing, saying:

"*The principal function of a house is to provide protection from the elements. Our present society, however, requires that a home provide not only shelter, but also privacy, safety, and reasonable protection of our physical and mental health. A living facility that fails to offer these essentials through adequately designed and properly maintained interiors and exteriors cannot be termed "healthful housing."*[42]

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[41] Samiya A. Bashir. "Home is where the harm is: inadequate housing as a public health crisis," Am J Public Health, Vol. 92 No. 5 (2002). Also see Megan Sandel et al., "Is child health at risk while families wait for housing vouchers?," Am J Public Health, Vol. 91 (2001).

[42] Centers for Disease Control and Prevention and U.S. Department of Housing and Urban Development, Healthy housing reference manual, (Atlanta: US Department of Health and Human Services, 2006) 6-1.

In its guidance, therefore, the manual touches upon nuanced issues, such as pests and alternatives to chemical control measures; indoor air, including pollens, other allergens, mold, volatile organic compounds from paints and varnishes; radon; asbestos; and arsenic from building materials.

Secondly, the Center for Healthy Housing analyzed the healthfulness of various green building guidelines, and found that such guidance "offers a significant opportunity to achieve public health benefits."[43] Applicable guidelines include LEED standards and Enterprise Community Partner's Green Communities. The LEED rating system rewards use of non-toxic pest control and moisture load control, and penalizes units with attached garages, which may become contaminated with exhaust from cars housed there. The Enterprise Community Partner's Green Communities Criteria, for example, encourages the use of low-VOC paints and primers, urea Formaldehyde-free composite wood, vapor barriers under all basement and concrete slabs, and non-vinyl, non-carpet floor coverings in all rooms.[44]

Finally, the Asthma Regional Council of New England also provides well-respected guidance for asthma-free homes, echoing many of the "green building" suggestions above but also adding specific pest-reduction suggestions such as sealing utility openings with non-corrosive materials, and offering advice on preventing negative air pressures which can draw contaminants into homes, for example by sealing forced air ductwork on the return (suction) side.[45]

Between the two extremes of adhering only to the most basic HQS regulations and limiting apartment listings for clients to units only in LEED certified buildings, for example, there is a range of positions assisted housing mobility programs could take on unit-based exposures. From giving preferential listings to healthful units, to exploring

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[43] "Green Analysis," National Center for Healthy Housing, 5 April 2008, <http://www.centerforhealthyhousing.org/html/green_analysis.htm>.
[44] "Enterprise Community Partner's Green Communities Checklist," Green Communities, 7 April 2008, <http://www.greencommunitiesonline.org/tools/criteria/green_criteria_checklist.pdf>.
[45] Guidance for Healthy Homes, (Dorchester, MA: Asthma Regional Council of New England, 2006), 7 April 2008, <http://www.asthmaregionalcouncil.org/about/documents/BuildingGuidanceJuly312006.pdf>.

whether it might be possible to secure higher payment standards for "green" units, programs could incorporate healthy housing into their agenda. A low-involvement, yet potentially effective approach could entail educating families on how to spot healthy housing on their own.

The Neighborhood

A neighborhood, as discussed in Chapter 1, can impact health through myriad, complicated ways, ranging from access to grocery stores, to school quality, to norms and "collective efficacy." Neighborhood safety, however, is one of the key areas of interest for assisted housing mobility programs. As noted in my review of MTO findings, drastically lower exposure to crime and violence after moving to a new neighborhood was an extremely important aspect of the program for many experimental movers, as supported by significant gains in mental health.

Even the least interventionist assisted housing mobility programs must consider neighborhood quality, which impacts health, to some degree through its own definition of "opportunity." This definition is generally articulated in the contract a PHA enters into with the entity administering its mobility program, and is used to delineate "what counts" as an opportunity move. The definition is based, at the very least, on one measure of opportunity – most commonly the percent of families living below the poverty line in a given census tract. And while this one measure may act as a proxy for many other indicators of neighborhood quality, a more interventionist approach would explicitly incorporate additional dimensions when defining opportunity areas. In fact, many experts in the field argue that metrics of poverty and race alone are not at all satisfactory proxies for what makes a good place to live and raise children, and recommend that housers take up more nuanced view of opportunity.[46]

[46] Xavier de Souza Briggs and Margery Austin Turner, "Assisted Housing Mobility and the Success of Low-Income Minority Families: Lessons for Policy, Practice and Future Research", 1 NW J. L. & Soc. Pol'y 25, at http://www.law.northwestern.edu/journals/njlsp/v1/n1/2/ (2006).

Ohio State University's Kirwan Institute, which has provided opportunity maps as evidence in several desegregation class action lawsuits, considers crime rates, jobs, school quality, proximity to parks and open space, hazardous waste sites, and health care facilities, among other factors, when it attempts to define opportunity.[47]

The Urban Institute's National Neighborhood Indicators Partnership also provides models for thinking about the healthfulness of neighborhoods more richly. One study to come out of this initiative tested the strength of relationships between various measures of neighborhood quality and health outcomes, offering potentially powerful guidance on how to define opportunity for maximum positive health impact. Specifically, this study found relationships between health and age of housing, people per unit, home values, violent and property crime rates, renter occupancy, vacancy rate, and mobility rate.[48] Each of these indicators is available through U.S. Census data.

Between the two extremes of defining opportunity based solely on a simple measure of percent poverty, and creating a complex algorithm to model degrees of opportunity, there is a range of ways programs can grapple with the question "to which neighborhoods will we steer our clients?" Even if opportunity is defined simplistically in a contract or consent decree, programs can (and sometimes do) choose to focus efforts on, or heavily promote, neighborhoods that meet a minimal definition plus other, more comprehensive standards. These enhanced definitions of opportunities do not always have to be complex; they could consist of as little as adding a consideration of proximity to high quality schools.

Health Behavior and Awareness

Health behavior and awareness refers to the choices people make that affect their health, and the level of information they have while making those choices. Even the least

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[47] "Opportunity Mapping Methodology," The Kirwan Institute for the Study of Race and Ethnicity, 7 April 2008, <http://kirwan.gripserver3.com/research/gismapping/opportunity-mapping/opportunity-mapping-methodology.php>.

[48] Kathryn Pettit et al., Neighborhoods and Health: Building Evidence for Local Policy, (U.S. Department of Health and Human Services, 2003), 7 April 2008, <http://aspe.hhs.gov/hsp/neighborhoods-health03>.

interventionist assisted housing mobility programs generally interface with health awareness to some degree, providing a *Disclosure of Information on Lead-Based Paint and/or Lead-Based Paint Hazards* form to families upon lease-up of pre-1978 units. HUD also requires programs to distribute lead education pamphlets in these cases.

Programs seeking to maximize their involvement in health-promotion would encounter a wealth of opportunities in this interest area, although they would be also be entering one of the more controversial realms of mobility counseling (more in Chapter 4). As noted in Chapter 1, there is an extensive body of literature on neighborhood effects and health, and norms and "collective efficacy" as causal pathways between the two.[49] There are several ways mobility counseling programs could intervene to reinforce specific norms found in new neighborhoods, or reframe thinking about health behaviors vis-à-vis the new environment. For example, readiness workshops meant to prepare clients for life in low-poverty neighborhoods with private landlords could be peppered with health and hygiene content. From instructing families on housekeeping routines to highlighting landlord preferences for non-smoking clients, life skills training and other preparation programs provide entry points for health behavior modification.

Programs could also take an active role in directing their clients in how to interact with their new neighborhoods. Very hands-on orientations during which program staff introduce clients to places to eat, play, and relax all provide occasions to push specific behaviors or privilege particular habits over others. This type of active direction could also take the form of education about health concerns families might face in the new neighborhoods. Clients encountering high levels of pollen, or living with a family pet for the first time, for example, could potentially benefit from information on these unfamiliar asthma triggers.

Finally, neighborhood orientation materials could ask families to re-examine old routines in the context of their new neighborhoods, envisions Dr. Dolores Acevedo-Garcia. For

[49] Ingrid Ellen and Margery Austin Turner, "Do neighborhoods matter and why?" Choosing a Better Life? Evaluating the Moving to Opportunity Social Experiment, Eds J. Goering and J. D. Feins, (Washington, DC: The Urban Institute Press).

example, an interventionist program could remind families that although TV and video games might have been logical after school activities in a dangerous neighborhood, parents might try giving kids more freedom to play outside in their new area.[50] In a similar vein, programs could push clients to take advantage of increased healthy food options in new areas.

There is expansive middle ground between limiting health content in counseling programs to HUD pamphlets on lead and attempting to control clients' lifestyles choices. Chapters 3 and 4 examine this complicated issue of mobility counseling content further.

Social Connectedness

Social connectedness impacts mental health outcomes in two main ways: 1) through specific social relationships, and 2) through the nature of the community to which a family may belong. In terms of social relationships, multiple studies have shown that women exhibit both positive and negative mental health effects as a result of strong social ties. Social ties may provide buffers against stress and/or may create stress for those in traditional care giving roles when they are called upon to support others[58]. Individual social ties are embedded within larger social networks (a concept that creates a foundation for theories of "social capital"), and these ties may be geographically-based. Research on the HOPE VI Program suggests that disruption to such neighborhood-based social ties may leave some families without sufficient social support, creating stress and threatening mental health.[51] However, in the case of assisted housing mobility programs, other families may choose to leave a neighborhood precisely so they might shed destructive (not simply stressful) social connections with friends and relatives.[52] Examples of destructive relationships include peers that encourage drug-use or criminal behavior, or relatives that threaten housing stability.

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[50] Interview with Dolores Acevedo-Garcia. February 15, 2008.
[51] Popkin 2002 et al., op. cit. 5-7.
[52] Susan J Popkin et al., Families in Transition: A Qualitative Analysis of the MTO Experience, Final Report (Washington, D.C.: Urban Institute for the U.S. Department of Housing and Urban Development. U.S. Department of Housing and Urban Development, 2002); Leonard S. Rubinowitz and James E. Rosenbaum, Crossing the Class and Color Lines: From Public Housing to White Suburbia (Chicago: The University of Chicago Press, 2000); Briggs, op. cit.

In addition to specific interpersonal relationships as sources of social support or stress, a family may also be dependent on its community to define what is "home," and to provide a sense of comfort and belonging. The sense of loss people often feel for their neighborhoods after relocation has been likened to mourning by psychologists. Research on the experiences of Boston's West End residents who lost their homes to urban renewal showed that many displaced women actually reacted with, "a grief syndrome similar to that evidenced in bereavement," displaying emotional and physical symptoms of grief up to two years after the displacement, according to psychologists.[53] The experience of losing a community, and its resulting impacts on mental health, has been explored thoroughly by psychiatrist Dr. Mindy Fullilove, who describes the aftermath as "root shock."[54] Fullilove posits that residents relocated from their communities are vulnerable, unable to immediately make sense of their new surroundings without interventions that connect them to vital physical and social resources. Involuntary relocation and community loss can also result in longer-term reactions such as anger, depression, and anxiety.

Because at least neighborhood-based ties are extremely likely to be interrupted by a long-distance mobility move,[55] and because such ties have strong impacts on mental health and the sharing of social norms, social connectedness is an important area of interest for public health. It is also a particularly sensitive political topic, as evidenced by recent debates around how to best help affected families and neighborhoods recover after Hurricane Katrina.[56] Researchers and advocates who oppose poverty deconcentration initiatives, such as assisted housing mobility programs, often do so for a variety of

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[53] Berton H. Kaplan, et al., "Social Support and Health," Medical Care, Supplement: Issues in Promoting Health Committee Reports of the Medical Sociology Section of the American Sociological Association, Vol. 15, No. 5, (May, 1977) 47-58.

[54] Mindy J. Fullilive, Root Shock: How Tearing up City Neighborhoods Hurts America, and What We Can Do About It, (New York: One World Ballantine Books, 2006).

[55] Rosenbaum and colleagues found that distance and access to transportation did have impacts on social ties. Leonard S. Rubinowitz and James E. Rosenbaum, Crossing the Class and Color Lines: From Public Housing to White Suburbia (Chicago: The University of Chicago Press, 2000).

[56] Xavier de Souza Briggs, "Maximum Feasible Misdirection: A Reply to Imbroscio," Journal of Urban Affairs, Vol. 30 No. 2 (2008); David Imbroscio, "'(U)nited and Actuated by Some Common Passion': Challenging the Dispersal Consensus in American Housing Policy Research," Journal of Urban Affairs, Vol. 30 No. 2 (2008);

reasons that focus on what's best for the neighborhood as an entity. Critics point to risks of gentrification, displacement, minority political disempowerment, and neighborhood destabilization, among others.[57] A particularly emotional and persuasive case against mobility can be constructed by invoking the painful consequences, outlined above, of community destruction. When grappling with the complicated, often polarized literature on this topic, it is important for program managers to be conscious of the difference between voluntary and involuntary relocation. That is, while assisted housing mobility programs may be able to glean from the lessons of urban renewal and HOPE VI how to better protect and promote social connectedness, managers should not expect that consequences for families opting-out of neighborhoods will be the same as they have been for those involuntarily displaced. Managers might also want to consider familiarizing themselves with the literature on mental health and relocation and displacement in anticipation of challenges to their programs on these grounds.

There does not appear to be any minimal level of involvement assisted housing mobility programs must have in terms of clients' social connectedness, however, there are multiple ways programs can intervene in this area. Depending on conceptualizations of healthful social ties and case-specific knowledge, an interventionist program might want to either encourage or discourage families from maintaining connections, generally or with specific networks, in the old neighborhood. Working from the assumption that ties can sometimes help and sometimes harm, families might even benefit from guidance on how to manage new and old relationships in the face of a move. This could take a range of forms, ranging from formal counseling from social workers to roundtable discussions with previous movers on issues such as coping with houseguests or babysitting. Programs could also exert their influence through transportation assistance (provision of, or information on), or by fostering the formation of substitute (or 'add-on') ties in the new neighborhood. These types of services could be particularly vital for true social isolates that are moving from neighborhoods where they have no real social ties and perhaps only weak family ties. A move, with the right support services, could be an

[57] Inbroscio, op. cit. 114.

opportunity for such people to start cultivating healthful relationships for themselves and children.

"Gold standards" and practical guidance do not exist on how to comprehensively approach the issue of social connectedness in relocating families, however there is a body of literature on social ties and mental health, as well as on the feasibility and efficacy of various social support interventions. Based on this body of literature, we know that programs could justifiably attempt initiatives ranging from the construction of social support groups for relocating families, to the nurturing of organic support networks.[58] Programs towards the interventionist end of the spectrum might host neighborhood orientation events or other activities that help make a newly arrived family feel comfortable enough to go out and seek their own social relationships. They could also encourage connectivity to a child's school, or to civic groups, under this area of interest. Any type of intervention of this nature falls somewhere in the so-called middle ground; low-intervention programs have the option of doing nothing, and extremely interventionist programs do not have well-established guidance to follow. In short, programs with either intention would be experimenting if they ventured into the realm of addressing social connectedness.

Access to health services

This area of interest comprises not only proximity to and accessibility of health care resources in new neighborhoods, but perhaps also examining the personal questions of when it makes sense for families to switch health facilities after a move, and if so, to which ones. Truly ensuring 'access to health services' could be conceptualized as a logic model under which 1) clients' current level of access is assessed (and preferably not disrupted unless this level could be matched or exceeded in a new neighborhood), 2) new neighborhoods offer affordable and accessible quality services from which to choose, 3) clients have the right information needed to make meaningful choices about these

[58] Ichiro Kawachi and Lisa Berkman, "Social ties and mental health," J Urban Health, Vol. 78 No. 3 (2001).

services, and finally, 4) conditions allow and enable clients to operationalize their choices and continuing using their preferred services into the future.

There does not appear to be any minimal level of involvement assisted housing mobility programs *must* have in terms of health services utilized by clients, however, even the least interventionist programs might reasonably become involved in number of ways. On the low-involvement end of the spectrum, programs might limit their role to ensuring that clients have medical insurance or can access a directory of emergency health services in their new communities.

Again, while there is not complete and accepted guidance on this issue such as is seen surrounding healthy housing, comprehensive approaches could expand into several areas, perhaps thinking about how various initiatives might correspond to the logical model presented above. First, and most interventionist, programs could help clients think through how an opportunity move might impact their overall network of medical care. This would likely include addressing any specific health service dependency issues, such as reliance on a dialysis clinic, as well as an assessment of whether the client is currently has a true "medical home," a gold standard of medical care, where she lives. The National Center of Medical Home Initiatives defines a medical home as primary care that is accessible, family-centered, continuous, comprehensive, coordinated, culturally sensitive, and compassionate.[59] It would be important to know if a family or individual was established within a functional medical home before making recommendations on whether to switch to health providers in the new neighborhood (step 1 of the logic model). The National Center of Medical Home Initiatives provides checklists to help assess if current medical services constitute a true medical home.

Beyond this assessment phase, more comprehensive programs might help connect families to medical providers in their new neighborhoods. These connections would not necessarily have to take the form of program staff recommending doctors, but could

[59] "The National Center of Medical Home Initiatives for Children with Special Needs," 8 April 2008, <http://www.medicalhomeinfo.org/tools/gen_med_materials/2006WebPromo.pdf>.

instead be advice shared neighbor-to-neighbor in a forum established by the mobility program. This type of intervention could complement education or reference manuals on the types of health care resources available in the new neighborhoods. Changes in how assisted housing mobility programs think about "opportunity areas," perhaps expanding beyond a poverty-only definition to one that considers quality and availability of services, is also a part of improving access to health services.

As with the social connectedness area of interest, any type of intervention of this nature falls somewhere in the so-called middle ground; low-intervention programs have the option of doing nothing, and extremely interventionist programs do not have well-established guidance to follow.

Considering Cross-cutting Life Stage Issues

Across these five areas of interest, programs seeking to more actively involve themselves in health might also consider the special needs associated with various life stages. Children are a particularly important demographic to recognize, given that most clients participating in assisted housing mobility programs are moms with kids. As mentioned in Chapter 3, some programs have begun to involve themselves somewhat in school-related issues, but the list below echos

Drawing on presentations given at the Anne E. Casey Foundation's two mobility forum on health and education, as well as an interview with Dr. Dolores Acevedo-Garcia, I propose the following are additional measures higher involvement programs might consider:

- Incorporate school quality into definitions of opportunity;
- Take an inventory of health services used by all members of the family, not just head of household, so program staff can help teens or youth replace services they lose in the course of a move;
- Offer education or extra support to help adolescent boys prepare for and adjust to new behavior expectations;

- Create a plan with parents to get children tested by guidance services upon entering a new school. Help parents coordinate Individualized Education Plans with old school records, school health services, and school guidance or mental health offices;
- Help clients compare across several communities the free services that would be available to, and easy to take advantage of for, each family member now and in the future mindful that children age out of various programs and into others ;[60]
- Help parents establish realistic, but high, expectations for their children's education and health;[61] and
- Help families prepare to transfer their children's medical care, perhaps by providing a tool similar to that produced by the Massachusetts Department of Public Health.[62] This example guide is included as Appendix B.

Conclusion

These five targets of opportunity, and the special lifestage concerns that I propose cut across each one, offer an organizational scheme for thinking about health-related interventions and assisted housing mobility. Within each target there is ample room for creative approaches, and for a wide range of practice theories from the uninvolved to the extremely interventionist. Chapter 3 provides profiles of nine assisted housing mobility programs and examines the degree to which they are currently working in any of these areas.

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[60] One interviewee suggested that relocating moms have reported finding fewer free services for their children in low-poverty areas.

[61] A major theme expressed during the Anne E. Casey education and mobility forum was that relocating families have trouble adjusting their definitions of school success from old neighborhoods (where safety is a primary concern) to new neighborhoods (where parents can expect much more of schools). Similarly, physicians working with families on public housing assistance have noted that low expectations for health or disease control is prevalent and can preventing parents from acting on asthma symptoms that could be lessened, for example.

[62] "Directions: Resources for Your Child's Care,Chapter 6: Your Child's Everyday Care," Massachusetts Department of Public Health, 25 April 2008, <http://www.mass.gov/?pageID=eohhs2subtopic&L=6&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Family+and+Community+Health&L4=Children+and+Youth+with+Special+Health+Needs&L5=Directions%3a+Resources+for+Your+Child's+Care&sid=Eeohhs2>.

Chapter 3 – Program Profiles and Current Practices in Housing Mobility Counseling Programs

Introduction

Despite interest in, and speculation about, how health can be better integrated in housing mobility programs, there are, for now, no documented examples of health interventions tied to such programs that can serve as sources of best practices or lessons learned, including lessons about barriers to doing more and doing better. The bulk of original research conducted for this thesis comprised interviews with program administrators and housing mobility counselors in order to uncover exactly these types of examples, if any did indeed exist. To do this, I first identified housing mobility programs operating across the country, a task complicated by the effects of major federal budget cuts for such programs since 2002. These cuts eliminated many mobility programs and changed the ways in which others operate, but researchers have yet to document exactly what happened to the affected cities and who now makes up the network of mobility programs across the country. After identifying as many operating programs as possible, I attempted to understand through interviews what each one's experience has been in linking mobility to health, with the goal of surfacing useful examples of integration. This chapter presents my research methodology, housing mobility program profiles, and examples of programs working in the housing mobility and health nexus vis-à-vis the potential health pathways outlined in Chapter 2.

Methodology

In 1998, Margery Austin Turner, a leading analyst and advocate of housing mobility programs, published a paper entitled "Moving Out of Poverty: Expanding Mobility and Choice through Tenant-Based Housing Assistance," in which she identified cities with tenant-based housing mobility programs. Because this was the last comprehensive list of mobility programs published, I used Turner's inventory as a starting point of investigation. After updating Turner's catalogue through collaboration with the Poverty

& Race Research Action Council to exclude programs that have closed since 1998, I contacted the following mobility programs with interview requests.

- The Baltimore-based *Special Mobility Housing Choice Voucher Program*
- The Chicago-based *Housing Opportunity Program*
- The Chicago-based *Opportunity Counseling for Voucher Holders*
- The Chicago-based Oak Park Regional Housing Center
- The Cincinnati-based Housing Opportunities Made Equal's Mobility Services
- The Dallas-based *Mobility Assistance Program*
- The Hartford-based *North Central Mobility Program*
- The New Haven-based *Housing Counseling and Regional Mobility Programs*
- The Yonkers-based *Enhanced Section 8 Outreach Program*

From this list, I was able to interview program administrators and/or mobility counselors at each program except the Oak Park Regional Housing Center and Housing Opportunities Made Equal in Cincinnati. In the course of interviews with key national informants and representatives from the above programs (see Appendix C for a complete list), I identified two additional programs; the Bridgeport-based Family Services of Woodfield's Family Assets mobility counseling program and the Greater Buffalo Community Housing Center, run by Housing Opportunities Made Equal (HOME). Representatives from both these agencies also participated in interviews.
In the course of interviews I also learned that some cities identified by Turner in 1998 are currently operating different programs than they were at the time of her publishing. The Housing Education Resource Center in Hartford, for example, has operated four distinct mobility programs since 1992 and the program I profile in this paper, the North Central Mobility Program, is distinct from that Turner identified in 1998. It should be clear from the program profiles below exactly which programs are currently operating.

I shared with each program a project description document and interview guide and prior to our discussions, and structured questions around themes from these materials (Exhibit 1). Where agencies reported producing original mobility counseling materials, or

customizing existing generic materials, I attempted to obtain copies. Agencies shared both print and electronic materials for diverse audiences, including resources aimed at participating families, landlords, and board of directors and decision-makers (e.g., annual reports). A sampling of materials I collected is available as Appendix D.

Exhibit 1. Project Information

Background: On May 22, 2007, the Baltimore Regional Housing Campaign hosted a national forum in Baltimore on Housing Mobility and Health. The forum, organized by the Poverty & Race Research Action Council, brought together program administrators, policy makers, researchers, and activists to develop new approaches to improving family health and health care access for families participating in Baltimore's Thompson mobility program. The richness of information exchanged at this forum demonstrated that program administrators had much to share regarding how they understood, experienced, and/or worked within the housing mobility and health intersection. This research project is an attempt to build on the conversations that took place in Baltimore, and uncover, through interviews with managers and housing mobility experts across the country, the current state of practice in housing mobility program administration as related to health.

Objectives: This project comprises two main objectives. The first objective is to create an inventory of the cities currently operating mobility programs through the federal Housing Choice Voucher Program. Federal budget cuts in the early part of this decade eliminated many mobility programs and changed the ways in which others operate; this project seeks to document exactly what happened to the affected cities and who now makes up the network of mobility programs across the country.

The second objective is to understand, for as many mobility programs as possible, what each one's experience has been as related to health. This could cover anything from whether pre-existing health problems have ever complicated moves for families, to health-specific interventions programs have tried to implement, to the fact that health has not been an area of particular concern for the program.

Additionally, I supplemented my research on each program with peer-reviewed journal articles, program evaluations, policy documents, program websites, annual reports, and news articles, where possible. These outside sources were useful mainly for background and context; attitudes and opinions about health and housing mobility came directly from interviews unless explicitly noted otherwise.

The programs profiled below do not represent the universe of mobility programs nationwide but rather a purposively drawn sample of known and respected work. This sample of programs illustrates key prevailing attitudes and practices related to linking health and mobility programs.

Exhibit 1 cont. – Interview Guide

What is the purpose of interview?
This interview is being conducted as part of a research project on regional housing mobility programs. It will hopefully result in an understanding of: 1) your mobility program's operations over the last decade, and 2) experiences your program has had relating health to housing mobility.

How were respondents identified?
Project advisors Phil Tegeler of PRRAC and Xavier de Souza Briggs of MIT's Department of Urban Studies and Planning helped develop the initial interviewee list, drawing on their knowledge of the regional housing mobility field. Additional interviewees suggested by members of this original list were also added.

What will the interview cover?
The interview will cover six main topics, but will allow ample flexibility for you to focus on what you find most important or interesting. The topics are as follows:

- A brief history of your mobility program, including how it was impacted by any funding cuts since 2002.
- Major health issues facing participating families (program clients), and how these have changed over time.
- Your agency's and your own views of how housing mobility is related to health.
- An overview of attempted health interventions for movers (if any), and the impetus for such attempts.
- Results of any health interventions, including implementation successes and failures and barriers to successful integration with health promotion.
- The information, funding, regulatory reform, or other resources you view as important to effectively promoting health through housing mobility programs.

Glossary of Key Terms

Consent decree:	A voluntary agreement among parties to a lawsuit that satisfies the plaintiffs in exchange for an end to litigation. A consent decree can settle all or part of a suit.

Fair Housing Act: Title VIII of the Civil Rights Act of 1968 (Fair Housing Act), as amended, prohibits discrimination in the sale, rental, and financing of dwellings, and in other housing-related transactions, based on race, color, national origin, religion, sex, familial status (including children under the age of 18 living with parents of legal custodians, pregnant women, and people securing custody of children under the age of 18), and handicap (disability).[63]

Fair Market Rent: The rent "limit" calculated annually by HUD for all areas of the country that establishes the maximum monthly Section 8 tenant-based rental assistance subsidy that eligible recipients may receive, pursuant to Section 8(c) of the United States Housing Act of 1937. This limit includes rent, utilities, and all maintenance and management charges.[64]

Program Profiles

Baltimore, MD: *The Special Mobility Housing Choice Voucher Program* - The Special Voucher

Baltimore's Special Voucher Program, housed within the Special Mobility Housing Choice Voucher Program, (hereafter referred to the *Thompson* mobility program) came from a partial settlement of *Thompson v. HUD*, a 1994 Baltimore public housing desegregation class action lawsuit. Six families in public housing and the Maryland ACLU filed the suit, alleging that HUD, the Baltimore City Housing Authority, and the City of Baltimore had promoted residential segregation through their housing policies. A 1996 partial consent decree resolved some but not all of the plaintiffs claims, providing funding for vouchers to move families to low-poverty, racially integrated neighborhoods.[65] In 2003, *Thompson v. HUD* was brought to trial, concluding in a 2005 ruling, again in the favor of the plaintiffs. The parties are still awaiting a remedy order, which could include funding for the continuation and expansion of the mobility program.

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[63]Taken verbatim from "Fair Housing Laws and Presidential Executive Orders," U.S. Department of Housing and Urban Development, 21 May 2008, < http://www.hud.gov/offices/fheo/FHLaws/>.

[64] Taken verbatim from "HUD Glossary of Terms," U.S. Department of Housing and Urban Development, 21 May 2008, <http://www.futurocommunities.org/ED/hudglossaryofterms.htm#f>.

[65] This included 1,342 tenant-based vouchers, 646 project-based (in the sense that they were assigned to specific neighborhoods) vouchers, and 163 homeownership vouchers.

Although vouchers have been available through the *Thompson* mobility program since 1996, only about 70 families successfully moved during the first five years of the program. This low success rate indicated, according to Jim Evans of Metropolitan Baltimore Quadel (MBQ), that the original program design relied too heavily on portability alone as a means achieve desegregation. In 2001, Evans' company, MBQ, was contracted to administer the mobility program, introducing a host of new supports and services aimed at reducing barriers to low poverty neighborhoods for families using public housing assistance. Since its involvement beginning in 2001, MBQ has successfully administered 868 tenant-based vouchers, 260 "project-based" (neighborhood-specific) vouchers, and 4 homeownership vouchers. In total, 1,132 families have moved to "opportunity areas" through the Thompson program since 2001. MBQ is a subsidiary of the Quadel Consulting Corporation, a national, private consulting firm specializing in affordable housing. Quadel manages voucher programs in a number of cities, as a contractor.

MBQ's Special Voucher Program consists of pre- and post-move services. Counselors work with families for up to a year before a move, conducting "readiness workshops" on tenant rights and responsibilities, leading community tours of suburban neighborhoods, and providing budgeting and credit repair assistance, housing search assistance with escorted apartment visits, and security deposit assistance. MBQ stays involved with clients after relocation, conducting at least five home visits in two years. The first home visit generally takes place within one week of relocation and consists of a neighborhood orientation and a battery of administrative tasks, including making sure all children are registered in their new school district. During the second home visit, usually about four months later, counselors check on how the family is adjusting and make referrals for particular services a family may need. Counselors also remind families of housekeeping and budgeting tips at this time, if needed. Subsequent involvement includes helping families establish connections in their new neighborhoods. Through a grant from the Anne E. Casey Foundation, MBQ provides "enhanced" post move counseling to approximately 75 families. In partnership with the Baltimore Regional Housing Campaign and MBQ, Thompson families have attended "neighbor to neighbor" dinners

where they can meet some of their neighbors. The Baltimore Regional Initiative Developing Genuine Equality (BRIDGE), a faith-based social justice organization, has been the lead organizer of many faith-based initiatives; BRIDGE members have helped welcome Thompson families to Baltimore's suburban areas and have assisted with transportation or other needs after relocation. MBQ provides relocatees with a binder of information about resources in their new communities. Families receive at least two years of active post-move counseling visits and support. After two years, there are no additional planned home visits; however, the family continues to receive monthly housing assistance as well as counseling support.

Bridgeport, CT: State-Funded *Mobility Counseling and Search Assistance Program*

Family Services Woodfield (FSW), which has operated in Bridgeport for over 100 years, administers a housing mobility program called the *Mobility Counseling and Search Assistance Program*. With in-house welfare to work programs, financial education and credit repair debt services programs, youth services, services for persons infected by HIV/AIDS, literacy volunteers, and a walk-in clinic providing psychological and counseling services, among other programs, FSW is a multi-service non-profit with an eight year history of providing mobility counseling.

FSW first began offering mobility counseling in 2000 as part of Bridgeport's *Pequonnock Replacement Housing Program*. Represented by Legal Services of Connecticut, former residents of the Pequonnock public housing complex sued the City of Bridgeport after the demolition of the Pequonnock complex, forcing the city to provide housing choice vouchers, mobility counseling, and scattered site housing for 185 displaced residents. Since that time, all the funds from the lawsuit have been exhausted and services to city-issued voucher holders have stopped. A more recent pre-litigation agreement rising out of a fair housing administrative complaint against Connecticut Department of Social Services (DSS) now provides funding for FSW to administer mobility counseling for Bridgeport-area residents using state-issued (DSS) vouchers through its *Mobility Counseling and Search Assistance Program*. These state-issued vouchers were originally structured to provide access to more expensive, suburban sections of the Bridgeport

metropolitan area by recognizing that rents are higher in many of these suburban zones. Due to federal budget cuts, this component has been scaled back for Housing Choice Vouchers, although it remains in place for rental assistance vouchers. Housing counseling at FSW is offered to anyone holding DSS-provided Housing Choice Vouchers, Rental Assistance Program (RAP) certificates, or Transitionary Rental Assistance Program (T-RAP) certificates, all of which are administered by J. D'Amelia & Associates. As part of its program, FSW reaches out to tenants who have just received these vouchers and certificates for the first time, those undergoing recertification, or families coming from units that are in abatement (that is, when the state refuses to continue paying rent because of landlord failures to comply with Housing Quality Standards or other contract stipulations).

Families taking advantage of FSW's mobility services attend tenant education sessions and workshops on tenant land lord responsibilities, and to complete FSW intake paperwork that asks clients to identify family goals. After meeting these requirements, families work one-on-one with a mobility counselor on credit repair, budgeting, housing searches, and other personalized tasks relevant to family goals named during intake. For example, clients hoping to earn a GED might be referred to tutors and testing information, according to Cynthia Maignan and Michelle Walker of FSW. Counselors also offer skill-building and informational workshops, with past topics including resume writing and finding summer camps for kids. FSW also manages a bridge loan fund that provides low- or no-interest loans for families falling behind on rent.

Buffalo, NY: Mobility Counseling at the Greater Buffalo Community Housing Center

Buffalo's housing mobility story began in 1989 with the filing of the class action desegregation lawsuit *Comer vs. Cisneros*. In this suit, public housing residents and Buffalo-area legal aid agencies took HUD and the Buffalo Municipal Housing Authority to court for administering essentially two separate and unequal public housing systems in the Buffalo region, one for whites and lesser system for blacks. Segregation affected both Buffalo's public housing complexes and its Section 8 voucher program, with "a

perfect exclusion of minorities from the suburban program," according to Mike Hanley of Empire Justice. In practice, this meant that due to a residency preference the suburban Section 8 program, which offered shorter waiting lists and better services, had only 2% participation by blacks while the less desirable urban system nearly exclusively served black clients. *Comer vs. Cisneros* was settled in favor of the plaintiffs through a series of consent decrees from 1997 to 2002. One aspect of the court-ordered remedies included $3.5 million in funding over five years for a Community Housing Center to provide mobility counseling services for families reliant on public housing assistance. Housing Opportunities Made Equal (HOME), a Buffalo-based civil rights organization that provides fair housing enforcement and education in addition to mobility counseling, was selected in a national search to run this center in 1998. HOME's Community Housing Center opened for operations in April 1999 and provides services for families hoping to stay in the City of Buffalo as well as those interested in opportunity moves.

Although it was awarded both federal (HUD) and local (Buffalo Municipal Housing Authority) support as part of the consent decrees, HOME and its partner agency, the Buffalo Federation of Neighborhood Housing Centers, did not received any city funding for the first five years of the program. After exhausting HUD funds, HOME was compelled to twice sue the City of Buffalo for non-payment of the court-ordered funding. HOME, which operated on a budget of $700,000 per year during the beginning of its program, now subsists on the $368,000 it was awarded by the city three years ago. With this funding about to run out, HOME is now paying the salary of its only remaining mobility counselor with funds from a philanthropic grants and is looking for additional funding.

Since 1998, 2,617 families and individuals have found housing with HOME's assistance, with 227 clients relocating during 2007. Forty seven percent of these clients lived in low poverty areas before coming to the Community Housing Center (CHC), and roughly 70% moved to "opportunity areas" (defined by the consent decrees as census tracts with fewer than 35% of families living in poverty) after counseling. Of those making opportunity

moves, nearly 40% relocated to tracts with less than 20% of households below the poverty level.

HOME's services, which have been drastically reduced since federal funding from the *Comer* settlement was exhausted in 2005, now include small group sessions at the CHC to discuss fair housing, the benefits of moving to low-poverty areas, creating a budget, identifying sources of perspective housing, marketing yourself to prospective landlords, and practice completing lease applications. After these small group sessions, HOME's mobility counselor provides an individual counseling session to talk about the needs of each family and that family's particular goals. The counselor provides lists of available housing, with a focus on low-poverty areas, and makes weekly calls to each family searching for housing as a means of support. As a general community resource, the CHC also provides a library that families can peruse onsite of information on communities in Erie County.

After a family locates housing, HOME may submit a request for tenancy approval to generate an inspection of the unit, and help find subsidies for application fees. Families choosing to move to opportunity areas can also receive $250 towards a security deposit, a benefit not available to those staying within high-poverty areas of the city. Post-move follow-up includes making sure children are enrolled in schools (and helping with this process if the family needs it) and asking if families need any referrals.

Chicago, IL: CHAC's *Housing Opportunity Program*

Chicago's Housing Choice Voucher Program, one of the largest of its kind in the country,[66] has been administered by the Chicago-based company CHAC since 1995. CHAC is, like Baltimore's MBQ, a subsidiary of the affordable housing consulting firm Quadel. In addition to administering Chicago Housing Authority Housing Choice Vouchers, CHAC managed the Chicago Moving to Opportunity demonstration from 1996 to 1998, and currently runs an expanded voluntary mobility program founded in

[66]Mary K. Cunningham and N Sawyer, "Moving to Better Neighborhoods with Mobility Counseling," Metropolitan Housing and Communities Center Brief, No. 8, (2005), 28 April 2008, <http://www.urban.org/UploadedPDF/311146_Roof_8.pdf>.

1998. The history of CHAC's mobility initiatives through 2002 has already been documented by Mary Cunningham and Sue Popkin as part of an Urban Institute assessment. An update of operations through 2005 can be found in a March, 2005, Urban Institute brief by Cunningham and Sawyer. Today, CHAC continues to run its award-winning *Housing Opportunities Program*, with 3,344 families having moved from high- to low-poverty neighborhoods from 2000 through 2006.

Because CHAC has extensive and reliable funding for its mobility program from the both Chicago Housing Authority and HUD (as part of the Moving to Work demonstration), the *Housing Opportunities Program* generally offers higher levels of services to clients than other programs are able to provide. CHAC's eight opportunity counselors offer workshops on tenant and landlord rights and responsibilities, community tours, housing search assistance and transportation to view available units, zero-interest loans towards security deposits, and budgeting and credit repair counseling. Upon entering the program, families also get a copy of CHAC's guide to the Housing Choice Voucher Program, which includes information on Fair Housing law and other tenant protections, descriptions of a range of CHAC and social services, and educational materials about lead poisoning. Opportunity counselors provide post-move support that is overwhelmingly focused on helping families make connections in their new neighborhoods. Counselors, for example, have introduced families to neighbors over coffee and have attended community meetings with clients to help them establish ties in the new neighborhood. In addition, CHAC employs landlord-outreach counselors to obtain additional listings for its property database and increase acceptance of Housing Choice Voucher families in and around Chicago.

Chicago, IL: *Opportunity Counseling for Voucher Holders* by Housing Choice Partners

Housing Choice Partners of Illinois, Inc. (HCP) has been providing housing mobility counseling to Section 8 and Housing Choice Voucher holders since 1995. It began administering its current opportunity counseling program for Chicago families impacted

by the Chicago Housing Authority's "Plan for Transformation" in 2003.[67]

HCP's counseling services include education for families about the benefits of opportunity moves, information on tenant and landlord rights and responsibilities, housing search assistance, credit repair and budgeting assistance, and a series of life skills and readiness workshops and print material. Participating families earn $15 - $30 gift cards to grocery and drug stores for attending each workshop, whose topics include housekeeping, presenting yourself to a landlord, and choosing a school for your child. HCP also offers post-move support services related to transportation, childcare, job training, and educational opportunities. Heartland Alliance for Human Needs & Human Rights is contracted to provide these and additional social services for participating families. I was unable to interview Heartland Alliance for Human Needs & Human Rights because of its Internal Review Board standards.

Dallas: Inclusive Communities Project's *Mobility Assistance Program*

In 1985 a class of African American participants in and applicants for the public housing Section 8 programs, which were administered by the Dallas Housing Authority, filed a housing discrimination lawsuit against the Dallas Housing Authority, HUD and ultimately the City of Dallas in the case of *Walker v. HUD*. Part of the remedy in the case funds a housing mobility program that consists of Housing Choice Vouchers with purchasing powers of 125% of fair market rent (called "Walker Settlement Vouchers") and housing mobility counseling. Since 2005 the Inclusive Communities Project (ICP), a local fair housing focused non-profit, has provided housing mobility counseling to over 1,000 clients but does not administer the *Walker* vouchers. (The Dallas Housing Authority continues to administer the vouchers.)

As part of its mobility services, ICP assists clients with housing searches in low-poverty census tracts; conducts fair housing counseling; offers financial assistance for moves and takes part in landlord negotiations. ICP has a special focus on helping families move to

[67] "About Housing Choice Partners," Housing Choice Partners, 28 May 2008, <http://www.hcp-chicago.org/hcp/>.

high-opportunity areas around the Dallas region, while defining "opportunity" more stringently than required by *Walker v. HUD*. In particular ICP's definition uses a lower poverty rate than does the Walker definition and includes school performance and family median income indicators. Much of ICP's work is aimed at affording children access to good schools, and its post-move services are primarily education-related.
A limited discussion of ICP is included in this thesis.

Hartford, CT: *The North Central Mobility Program*

Hartford area residents holding Connecticut Department of Social Services (DSS) Housing Choice Vouchers administered by J. D'Amelia & Associates may elect to access mobility counseling through the Housing Education Resource Center's (HERC) *North Central Mobility Program*. Services are also available to those receiving Rental Assistance Program (RAP) and Transitional Rental Assistance Program (T-RAP) certificates from the State. These vouchers share the rent structure, designed to provide access to suburban zones around Hartford, described in the Bridgeport FSW program profile. The State of Connecticut also provides funding for this program under the same agreement that supports FSW's mobility counseling in Bridgeport (see above).

HERC, a local non-profit agency focused on housing issues, was established in 1980. It has provided housing counseling and assistance services since 1983, with its first housing mobility program opening in 1992. Since 1992, HERC has operated four distinct mobility programs. The first, the *Hartford Section 8 Mobility Program* (1992 – 1996) was the fourth mobility program in the nation, and only the second voluntary program. In 1996 HERC was contracted to become a Regional Opportunities Counseling (ROC) site (1996 – 2001), and later operated the *Charter Oak Terrace Mobility Program* (1999 – 2002). From 2002 through today, HERC has been administering the *North Central Mobility Program* under the agreement with Connecticut's DSS noted above. Roughly 400 households have received services through this program over the past six years.

HERC provides tenant education, budgeting advice, credit repair assistance, housing search assistance, information on Fair Housing protections, tips and techniques for

moving with a Housing Choice Voucher, distributes counseling booklets to clients, and conducts one-on-one family needs assessments. HERC also conducts landlord outreach, which involves negotiating lower rents for families, and explaining the security deposit guarantee program and inspection process. It may also initiate the Request for Tenancy Approval paperwork. There are no routine post-move services provided, but clients can request support after relocating.

New Haven, CT: *Housing Counseling and Regional Mobility Programs* at HOME

New Haven area residents holding Connecticut Department of Social Services (DSS) Housing Choice Vouchers administered by J. D'Amelia & Associates may elect to access mobility counseling through Housing Operation Management Enterprises, Inc (HOME). The State of Connecticut provides funding for this program under the same agreement that supports FSW's mobility counseling in Bridgeport and HERC's mobility program in Hartford (see above). These vouchers also share the rent structure, designed to provide access to suburban zones around New Haven, described in the Bridgeport FSW program profile.

HOME offers services to any interested voucher holders who have completed a "generic" intake form and attended a two hour educational workshop. Although counselors educate clients about the option to make opportunity moves, HOME provides services to families staying in the city in addition to those moving to the suburbs. Clients work one-on-one with a housing counselor to address specific needs, which often includes credit repair and budgeting. Families also receive apartment listings in their desired areas and may attend tours of opportunity neighborhoods, with transportation provided. HOME, which has suffered from budget cuts in recent years strives to provide services to 70 families per year, but faces financial constraints that limit the extent of help it can offer clients. All participants receive a book on resources in their new communities (including schools, churches, and medical services) and copies of relevant print material produced by Legal Aid.

Yonkers, NY: The *Enhanced Section 8 Outreach Program* (ESOP)

In the early 1990s, Westchester Legal Services in White Plains, NY and private Wall Street law firm Sullivan and Cromwell filed a federal desegregation lawsuit against a number of New York public housing authorities and HUD. At the start of the litigation, plaintiffs made a demand to the defendants that the remedy in the lawsuit be the establishment of an independent housing mobility office that would provide the housing outreach for Section 8 participants. (Note: Although the federal government no longer labels the voucher program "Section 8," I have retained the label here because of the local program's name and the field's still-common use of that long-standing label.) The Enhanced Section 8 Outreach Program (ESOP) was formed in November 1994 under this consent decree. It was operated under the consent decree for five years and has been funded by the Yonkers Housing Authority and New York State DHCR on a voluntary basis since then.

ESOP presently has two employees, 112 families currently leased up, and assists 10 to 15 people per week on referral. Since its formation, it has helped over 500 families move. Although ESOP does not currently issue housing choice vouchers, it has the capacity to receive vouchers from other public housing authorities, meaning it administers the subsidy. In addition to housing search assistance, ESOP's primary function, the program focuses on finding quality housing in economically and racially mixed neighborhoods for families. The program, run by two attorneys, serves clients by securing higher payment and providing housing outreach. It also provides legal advocacy in securing, when eligible, rent security deposits, moving expenses, day care, food stamps and health insurance benefits from governmental agencies. Clients working with ESOP do not receive housing mobility counseling in the sense of life skills and budgeting sessions meant to prepare families for a transition to the suburbs, but they are advised of where they will find good area schools and may be reminded to connect with a guidance counselor immediately after relocating. Additionally, ESOP coaches families in communicating with landlords and will follow-up with landlords if the families aren't successful in resolving issues on their own.

Connections to Health

Explicit Attempts to Integrate Health

Conversations with architects of the programs profiled above, current program administrators, and mobility counselors revealed a wide gap in the amount of knowledge about, and interest in, the links or potential links between housing mobility programs and health. Two interviewees revealed a deep knowledge of the literature on housing mobility and health in the course of their interviews, citing the work of Marge Turner, Sue Popkins, Dolores Acevedo-Garcia, and others on these issues. On the opposite end of the spectrum, several respondents seemed unaware that or unsure of whether academic research had been conducted on health and neighborhoods, let alone health and housing mobility specifically. Most interviewees fell somewhere in the middle, having read Helen Epstein's 2003 New York Times Magazine article, "GHETTO MIASMA; Enough To Make You Sick?" or viewed a powerpoint presentation that touched briefly on this topic, for example. There was also a wide range of interest in the potential to incorporate health into these programs, varying from near disdain for the idea to strong enthusiasm.

Despite this range of knowledge and interest, programs varied very little in terms of explicit health-related content; only two programs offered any content at all that their staff *recognized* as health-related. The first example comes from Chicago's CHAC, which at times combines its Moving to Work money with mobility counseling and family self-sufficiency resources to help job seeking mobility clients get optical and dental care, according to Jennifer O'Neil. While this creative practice has obvious health benefits, it was conceived of as a way to help make some of CHAC's clients more attractive to employers. Dental problems cause embarrassment and sometimes shyness on the part of jobseekers, and may elicit discrimination from employers, according to O'Neil. Also, poor vision and squinting can hinder job performance. CHAC was able to find an innovative way to address several needs of its clients at once with this initiative. The second intervention was implemented by Batlimore's MBQ after its program director, Jim Evans, attended a May 2007 forum on housing mobility and health hosted by the Anne E. Casey foundation. After learning about the difficulties families have transferring public benefits after making opportunity moves, Evans invited a speaker from the State of

Maryland to train counselors in how to help families navigate the bureaucratic health systems in both the City of Baltimore and surrounding counties in terms of transferring health benefits and records.

With the exception of these two initiatives, no other manager or counselor replied "yes" when asked whether she had ever implemented a health-related intervention or component into her program.

Accidental Forays into the Realm of Health

When prompted further, for example with questions on a list of possible health-related content (Exhibit 2), nearly all interviewees recognized that at least one program aspect was indeed related to health. Interviewees may have failed to mention some of these program components at first because of confusion over how to limit their replies; some may have only mentioned content that was *unique* to the mobility program, excluding any service offered to all Housing Choice Voucher holders. CHAC, for example, did not note that its innovative partnership with the Chicago Department of Public Health offers free vaccinations and lead screening for any child less than six years of age—all as part of its voucher program. Aside from this type of confusion, interviews uncovered truly accidental, though perhaps predictable, ventures into public health territory.

Chapter 2 presented possible pathways from housing mobility-related variables to health outcomes, specifically discussing

- the **unit** and indoor environmental exposures (including "sick buildings");
- the **neighborhood**, including outdoor environmental exposures, neighborhood levels of violence, presence of stressors, and access to healthful assets;
- **health awareness and behavior** (including efforts through health education), which emphasizes how families may utilize resources available to them or adjust behaviors around perceptions of their neighborhoods;
- **social connectedness** and supports, especially as related to mental health and stress;

- special **family and children's health** needs, especially in terms of how well different interventions impact health at different life stages; and
- **health care access**, including access to quality care and the establishment or maintenance of a true "medical home."

Exhibit 2. Prompts for Exploring Health-related Content

Local Service Quality
- Access to food
- Access to greenspace and recreational resources
- Access to health care resources and providers
- Access to emergency response services

Health Behavior/Shared Norms
- Orientation to walking routes
- Connecting movers to health-promoting networks (e.g., Road Runner clubs)
- Providing resources to help movers stay connected to support networks in old neighborhood
- Connecting movers to support networks in new neighborhood

Crime, Violence, Security
- Orientation *to* local law enforcement agency (e.g., introduce capacity, personnel)
- Orientation *for* local law enforcement agency personnel

Passive Environmental Exposure
- Presence of indoor toxins or allergens (e.g., asbestos, lead, cockroaches)
- Ventilation, indoor air quality
- Presence of outdoor toxins or allergens
- Outdoor air quality

Physiologic Needs
- Crowding of unit
- Appropriateness of unit for disabled family members
- Adequacy of space for exercise and for children to play

Source: Modified from CDC's Healthy Homes

After exploring the details of the mobility programs' services, several main types of health connections emerged. First, and most obviously, all programs assure a basic level of decency in the physical unit through the enforcement of HUD's Housing Quality Standards (HQS). Moving into a unit that has been inspected and meets HQS may actually have a health benefit for some families, despite the notoriously low bar set by HQS. Mike Hanley of the Empire Justice Center explains that HCV-initiated inspections

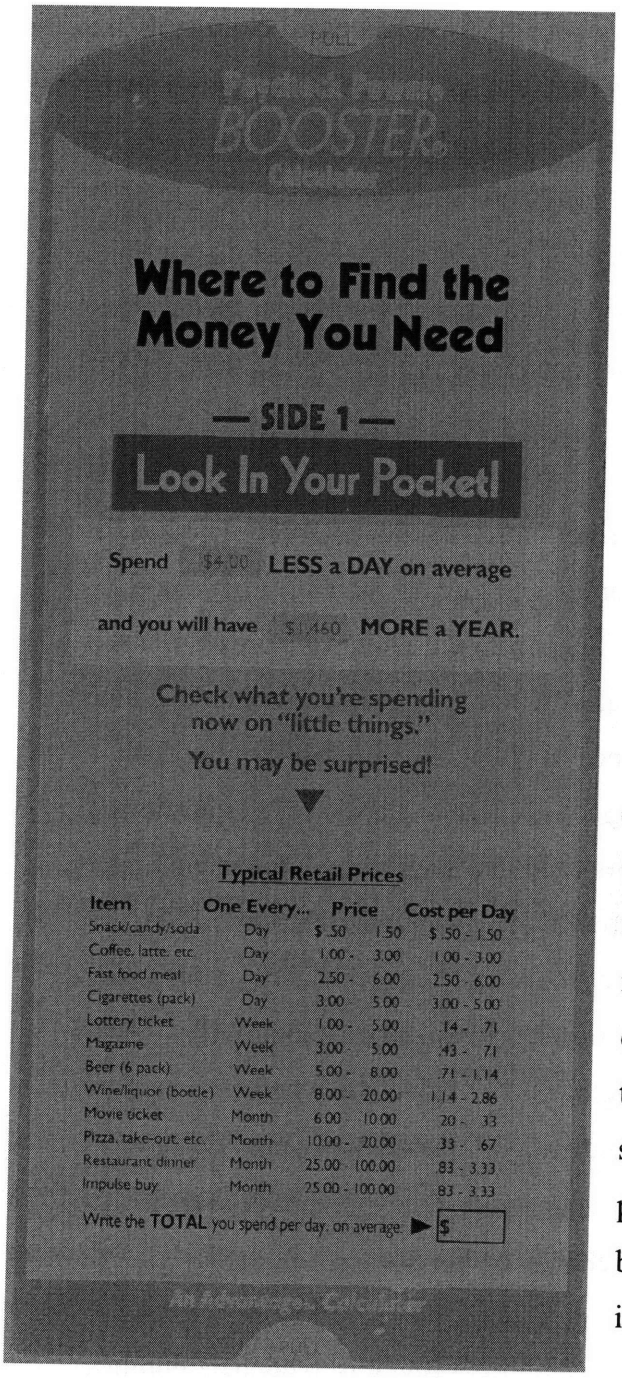
of private apartments have been a very important mechanism for identifying and removing residential lead hazards in Rochester, NY. According to Hanley, families living in units that undergo HQS scrutiny may be less likely to encounter lead hazards than are families living in other low-income private housing because there is no minimal screening of private low-income housing conducted at all. This point, that HQS is actually an important tool that ensures safer and less crowded units for many families, has been made by other housing experts as well.[68] Although these inspections are not unique to mobility programs, they do impact families making opportunity moves and provide a potential area of intervention or study. Given the influence of physical stressors on health (especially prenatal, neonatal and early childhood health and development), HUD might consider partnering with a research organization to study the effectiveness of HQS at preventing harmful environmental exposures, with a focus on women and children. This type of research could help housing policy decision-makers and public housing assistance clients begin assessing potential tradeoffs between housing unit quality and neighborhood quality (given the hypothesis that HCVs may buy better units in cheaper, presumably lower quality neighborhoods).

A second finding is that mobility programs offered extensive housekeeping and hygiene advice to clients (see Appendix D). The aim of these initiatives is generally to prevent landlord complaints over conditions in their units, but this intervention is health relevant. Housekeeping manuals and presentations instruct families on how and how often to vacuum, control pests, and change and wash linens and curtains, for example. Though designed to improve landlord satisfaction with mobility families, these instructions align well with advice on how to reduce indoor allergen loads and prevent asthma symptoms. Additional instructions on preventing household odors (by cleaning out the refrigerator and storing food properly), and the safe use of indoor household cleaners could also easily reinforce good public health advice on food safety and indoor environmental exposures. While mobility programs are perhaps not in a position to be dispensing health advice (addressed in Chapter 4), program administrators might want to at least make sure their housekeeping tips do not encourage unsafe behaviors that could arise when families

[68] Khadduri, op. cit.

are trying to comply with housekeeping manuals. For example, various products recommended in materials I reviewed included oven cleaner, pesticides, insect traps, and bleach cleaners, all of which might be unadvisable to use especially around children.

Figure 3-1 MBQ Budgeting Tool



Where to Find the Money You Need

— SIDE 1 —

Look In Your Pocket!

Spend $4.00 LESS a DAY on average

and you will have $1,460 MORE a YEAR.

Check what you're spending now on "little things."

You may be surprised!

Typical Retail Prices

Item	One Every...	Price	Cost per Day
Snack/candy/soda	Day	$ .50 - 1.50	$ .50 - 1.50
Coffee, latte, etc.	Day	1.00 - 3.00	1.00 - 3.00
Fast food meal	Day	2.50 - 6.00	2.50 - 6.00
Cigarettes (pack)	Day	3.00 - 5.00	3.00 - 5.00
Lottery ticket	Week	1.00 - 5.00	.14 - .71
Magazine	Week	3.00 - 5.00	.43 - .71
Beer (6 pack)	Week	5.00 - 8.00	.71 - 1.14
Wine/liquor (bottle)	Week	8.00 - 20.00	1.14 - 2.86
Movie ticket	Month	6.00 - 10.00	.20 - .33
Pizza, take-out, etc.	Month	10.00 - 20.00	.33 - .67
Restaurant dinner	Month	25.00 - 100.00	.83 - 3.33
Impulse buy	Month	25.00 - 100.00	.83 - 3.33

Write the TOTAL you spend per day, on average ► $

Third, budgeting and credit repair advice often creep into lifestyle discussions when families are forced to confront their spending habits. Without ever intending to dispense health advice, housing counselors for MBQ's Thompson program encourage clients to replace expensive recreational outings to the movies or aquarium with walking on the suburban greenways, or going to the playground. They also encourage clients to cut back on "candy/snacks/soda," fast food meals, cigarettes, beer, "wine/liquor," pizza, take-out, and restaurant dinners in order to save money, with success (Figure 3-1).[69] One MBQ counselor reported that her clients react well to the budgeting tool and seem not to feel judged discussing their consumption habits in a financial rather than moral or health-related context. More so than lessons learned for housing practitioners from this example, health behaviorists might be interested to take inspiration from these types of approaches.

[69] From MBQ's "Paycheck Power Booster Calculator," a budgeting tool distributed to all *Thompson* families.

In addition to any diet or nutritional impact from these types of budgeting tools, helping families economize may create an impact by freeing up more household resources for medical or other healthful spending.

Fourth, intake, initial screening assessments, or initial home visits can result in identification of health needs that may have gone previously unaddressed in a family. Jennifer O'Neil of CHAC noted that counselors first discover any health issues serious enough to hinder a move during initial home visits. Shella Runlett of HOME (New Haven) mentioned that intake forms are usually her first clue as to whether a client is living with a disability. She also noted, however, that experienced counselors may "pick up through verbal and non-verbal clues the possibility of underlying issues, such as mental health or substance abuse" during one-on-one intake or the Tenant Education Workshop.

Mobility counselors may observe or be informed of untreated mental or physical health problems as they begin working closely with families to find housing, creating a potential space for help and intervention, if appropriate. Staff from the Thompson program noted that conditions commonly disclosed during intake included asthma, lead poisoning, and pregnancy. In HOME's (New Haven) experience "a client may disclose an important issue they have been trying to deal with" through "sensitive and open-ended questions and conversations with counselors." Counselors can then "pursue the topic, including discussing the various services available and providing appropriate referrals." FSW provides clients a low-pressure way to inform staff of substance dependency issues; the intake form asks what might present "barriers" to a successful move and provides "substance abuse" a check box option. Although I did not delve into whether the clients in these cases were already receiving appropriate medical attention, my interviews suggest that it might be worth training mobility counselors in how to approach disclosures of medical conditions and discuss relevant resources.

Fifth, community tours can be an opportunity for mobility programs to connect families to healthful assets in their new neighborhoods. It is well recognized that proximity to

parks and grocery stores, for example, does not guarantee that families will actually take advantage of these resources. Rather, some mobility programs have learned that they must actively connect people with these new resources. Both CHAC and MBQ offer community tours that highlight grocery stores and outdoor recreation facilities. While not all programs are in a financial position to provide this service, those that do operate tours could consider easily adjusting content to better advertise physical activity opportunities, such as a safe walking route to school, as well as healthier food options. Of course, fostering real connections would have to go beyond one tour, but this presents another possible area of intervention for mobility programs.

To organize myriad overlaps between current practices and health, the matrix below maps how the mobility program components I investigated can be categorized by the broad intervention types discussed in Chapter 2. Interventions targeted to specific life stages are in bold.

	Unit	Neighborhood	Behavior/ Education	Social ties	Access to Health Services
Baltimore: Thompson	HQS	Algorithm considers poverty, crime, jobs, schools, etc.	Budgeting, housekeeping, community tours, **reframing of TV and recreation**	BRIDGE	Workshop on navigating systems, discussion of current providers
Bridgeport: FSW	HQS	Poverty	Budgeting		Provides in-house mental health services
Buffalo: HOME	HQS	Poverty	Budgeting		
Chicago: CHAC	HQS, Lead testing for kids under 6 in cooperation with DPH	Poverty plus schools	Budgeting, housekeeping, community tours	Connect families to new neighbors and civic organizations	Vaccinations in cooperation with DPH
Chicago: HCP	HQS	Poverty	Budgeting, housekeeping, **post-move childcare resources**		
Dallas: ICP	HQS	Poverty plus schools			
Hartford: HERC	HQS	Poverty	Budgeting, housekeeping		
New Haven: HOME	HQS	Poverty	Budgeting, community tours		
Yonkers: ESOP	HQS	Poverty	**Helps find subsidies for childcare**		Makes sure families are on public health care plan

Summary and Conclusions

My investigation of these nine programs revealed several important themes in addition to operational details about each organization. First and foremost, assisted housing mobility programs are inherently health-related operations. From the universe of nine programs, I was able to glean examples of health-related content in all five targets of opportunity, several of which were sensitive to life stage. The most obvious mechanism of influence to program staff, and perhaps the most objectively important mechanism, is the change in neighborhood environment programs seek to facilitate. By deliberately relocating families to opportunity areas, each one is at the very least acting upon the "neighborhood effects on health" outlined in Chapter 1. Many of the programs with which I spoke used a simple definition of "opportunity," often measuring this by poverty rates alone. Improving how programs target neighborhoods, which would entail considering crime and violence, access to and quality of goods and services, school quality, and job opportunity, among other factors, would be an important health-promoting step.

Another important finding is that no programs pursue housing unit healthfulness above HQS inspections (even for families with histories of asthma or other medical problems), despite the fact that more aspirational guidance is available. Many programs do work with disabled clients to locate or modify housing units appropriately, however, suggesting that foundations of systems that consider what types of units are health-promoting for which clients are already present.

Third, many programs offered content that could be considered, or easily modified into, useful health education. While this idea may be very appealing to some programs and not at all appealing to others, there appear to be strong, natural consistencies between life skills and readiness training and healthful guidance on basic hygiene, housekeeping, and nutrition.

Fourth, some programs made active attempts to help families make connections in their new neighborhoods, influencing perhaps both health behavior and awareness and social

ties (which can impact mental health). This important work should be explored further and perhaps be framed more explicitly in terms of health to garner support for further investigation.

Fifth, one program recognized, and is acting to mitigate, the disruption residential mobility can cause to health care systems. MBQ's workshop for counselors on transferring benefits is a great example of how programs could better help families protect their health and access to the resources that currently support positive health outcomes. Programs could go much further, however, as outlined in Chapter 2.

Conversations with staff and national informants also surfaced attitudes towards health and the role of assisted housing mobility programs in influencing health outcomes; these views are potentially more important in determining how programs will actually act on integrating health than is public health literature supporting more purposeful health-oriented content. Chapter 4 attempts to summarize and organize these attitudes and the practice theories that accompany them.

Chapter 4 – Attitudes towards Health-Conscious Assisted Housing Mobility

Introduction

The previous two chapters examined possible areas of health interventions in assisted housing mobility programs and discussed current health-related practices in these programs. Although many areas of potential intervention do exist, housing mobility practitioners have tough questions as to whether it is appropriate or helpful to act in any of them. How managers and counselors think through such questions falls into a larger discussion of attitudes among program staff towards providing "mobility plus" services more generally, and the appropriate role of housing mobility counseling in clients' lives. This chapter will address the considerations interviewees, including key national informants, raised when asked about their experiences with (or future plans for) linking health to mobility programs. These include conceptual concerns, as well as thoughts on feasibility and implementation.

This chapter teases out common views on health and assisted mobility counseling that could be either confronted or built upon in order to enable progress towards more comprehensive programs, and then characterizes the level of services currently provided by each program. There are several things this chapter does *not* do. First, it does not capture the totality of any program's views on these issues. Each interviewee expressed a range of views, some of which appear contradictory. Secondly, it does not attribute any theme below to any one program. Finally, it does not assume that attitudes expressed determined the levels of services provided by each program. Many other variables, such as funding or institutional capacity, impact a program's ability to implement the services it would like to.

The purpose of the chapter, therefore, is two fold. First it is to understand what types of evidence, guidance, and arguments might be most effective if making the case that health considerations should be further integrated into mobility counseling. The second part of the chapter moves away from uncovering general attitudes and characterizes each program profiled according to how amenable and prepared it might be to add health

content, and what type of content it might be in position to best incorporate, regardless of why this is so.

Arguments against Adding Health Content

1) "I don't have a mandate to spend money or time on this"

Most programs I profiled were formed as a result of desegregation litigation, crafted to perform the very specific task of improving access to integrated neighborhoods for families on public housing assistance. Several programs felt that attempting to influence health outcomes was too far outside the scope of their primary legal responsibilities to justify the time or resources such interventions would require. The Inclusive Communities Project in Dallas eloquently summarized why it is currently uninvolved in health, saying, "ICP does not currently target health-related issues as part of its services, in part because of its emphasis on securing the rights provided by the lawsuit to move into lower poverty, less segregated areas. Positive outcomes in terms of health, while perhaps a by-product of those moves, are not required for ICP to consider its litigation-driven program successful." The basic argument made in this statement was echoed by other programs, all of which expressed to some degree that their first priorities were getting families to better neighborhoods. For programs with limited resources, interviewees were concerned that adding a health dimension to their programming would come at the expense of their basic services or the number of families they could serve. Interviewees seemed especially concerned that the efficacy of additional services in improving overall health outcomes is unproven. Lacking a directive to tackle tangential dimensions of well-being, and strapped for resources sufficient to address litigation-based concerns alone, it does not make sense to expand into health interventions under this line of reasoning.

These concerns imply that some programs would want clear direction written into a consent decree or voluntary agreement before they would feel comfortable expending resources on health interventions. Alternatively, an argument that residential mobility is generally disruptive to health (e.g., through disruption of routines, transfer of medical

records, identification of new providers or different commutes to old ones, displaced investment of time families might otherwise spend attending to care needs and healthy habits, and overall exposure to stress of the relocation process, for example) frames health-related interventions as necessary mitigation, rather than extra, optional services.

Suggestions on how health could be considered without much expense or time commitment would also be useful; no program seemed opposed to the idea that their work would have health benefits but they did not want to cultivate these benefits at the expense of other program aspects. Finally, empirical evidence that adding explicit health content to assisted housing mobility programs does improve outcomes might also persuade these managers that spending on health is not a gamble with settlement money, but instead an investment in improved outcomes.

2) "Health takes care of itself"

Some interviewees familiar with the public health literature on neighborhoods and assisted housing mobility programs noted that health benefits enjoyed by relocatees in mobility studies were simply passive. That is, families become healthier after moving because living in a new and better neighborhood allows them to benefit from factors such as cleaner air, better access to healthy foods, and less stress. This led some interviewees to conclude that there was no real need for their programs to incorporate any or much additional health content. Quadel Vice President Gene Rizor, who helped design MBQ's program explained that research findings have suggested that "people benefit from a move because their new area is less stressful." He continued, saying that aside from connecting families to health services and public health benefits in the new neighborhoods, "program administrators don't need to do much," related to health. Jerold Levy of ESOP seconded this point of view, saying simply, "the move itself takes care of most of the problems."

Because there has never been a study of health outcomes vis-à-vis explicit health interventions incorporated into assisted mobility programs, or the unintentional health content common in mobility counseling programs, these interviewees were correct in

their interpretation of the literature. It is still possible, however, that programs actively working to promote health would see health gains beyond those caused by passive benefits alone. It is also possible that mobility counseling, even in its most generic form, has some health impact on families regardless of whether counselors are aware of it. I did not engage interviewees in a discussion on these possibilities, but their comments indicate that perhaps such conversations would need to happen before programs would consider adding a health-focus.

3) "Clients' health is none of our business"

A number of interviewees expressed concerns over integrating health-related content because it seemed too intrusive or judgmental. Shella Runlett of HOME (New Haven) believed that clients would be justified in feeling irritated if counselors started asking about health status. Clients come to HOME for help with housing searches, and there is no obvious reason a counselor would need to involve herself in someone's health, said Runlett. "There would have to be a known purpose to asking health questions that would make sense to those coming to our agencies for help with finding an apartment. In other words, why would they [clients] disclose this type of personal information when all they want is helping finding safe – a key word – affordable housing?" Jerrold Levy, simply stated that ESOP would never want to give health advice, nor tell people how to live more healthily, saying "You can't push people to do things."

Other interviewees specified that it was delving into mental health in particular that became uncomfortable or inappropriate. Susan Harkett-Turley of HERC stated that she would like to stay far away from "the assessment of health and treatment needs, particularly related to mental health." Adding a caveat with which many other interviewees would likely agree, she continued, "however, if a client stated they had a particular disability (physical or mental) and requested help in locating treatment resources accessible from potential relocation areas, we would certainly provide this assistance."

These themes were raised even by enthusiastic supporters of increased attention to health, revealing that any urging to do more around health issues would have to also address how to do so appropriately and respectfully.

4) "We aren't qualified or equipped to do health"

One of the most common concerns discussed was that programs are not well-positioned to tackle health. HERC director Susan Harkett-Turley summarized this when responding to a question of whether health was taking its place along side education and employment as an important area of intervention. Ms. Harkett-Turley replied to the question, saying, "I have some concerns with mobility and health. Education and employment needs are very clear cut. We are just not qualified to assess health and treatment needs through our program." Many other interviewees spoke about how they would need to hire health professionals or social workers to create a meaningful intervention, while a portion felt that any health intervention would have to be conducted in partnership with a hospital or health researchers. Jim Evans of MBQ, while very supportive of the idea of incorporating health assessments into his mobility program, worried about implementation, saying "no one on our staff is qualified to do health assessments. It's way beyond our scope."

While this intuition may be accurate if talking about providing direct medical services, hesitant managers may overestimate the level of qualification needed to address some of the areas of intervention outlined in Chapters 2 and 3. Specifically, changes to any print material, such as intake forms or housekeeping booklets, would not require any on-going help from a health professional, nor would planning adjusted community tours or teaching clients about transferring health benefits to a new municipality. Providing concrete examples of what can be done, cross-referenced by the qualifications needed to provide that service, might help program administrators understand their options.

Arguments for Adding Health Content

5) *"This program has the capacity to do more and wants to do more."*

The quote above from FSW's Cynthia Maignan captures a sentiment expressed by several organizations with successful records of addressing health and human services needs, and presents a direct contrast to the view that "housers" are not qualified to look at health. These programs, noting that their mobility clients generally need services beyond simple housing search assistance and higher payment standards, seem eager to leverage their expertise in other types of social services to help improve outcomes. Maignan explained that at FSW, "there are a lot of services that clients can utilize and you want to see your clients get all the services they can." FSW, a multi-service non-profit, is currently looking at centralizing intake so that everyone coming in for services will complete the same intake questionnaire that is currently used in its "Empowering People" program which provides counselors an overall picture of health, financial health, literacy. This shift would help counselors better understand what else FSW could offer clients beyond mobility counseling and then connect them to those resources.

For now, however, mobility counseling intake is much more limited. FSW did not seem concerned that such a change to intake would make its clients uncomfortable, as predicted by other programs. Ms. Maignan explained that in other areas of the organization "we ask people questions about their health, their kids' health, if they've had counseling in the past, violent relationships, substance abuse, reading ability, the number of languages they speak, and grade attainment." She felt confident that "this kind of assessment can be done – we do already do it. We are talking about people who have been marginalized so it's all about how you ask the questions." Ms. Maignan anticipates adding questions to the intake process on whether families are aware of the appropriate vaccination schedule for their kids, and the last time they themselves have seen a doctor. These changes are currently under study and would be implemented late summer, 2008.

CHAC's Jennifer O'Neil noted that her program is "not a Chevy, it's very close to a Cadillac," with the housing authority incredibly committed to providing the support CHAC needs. She would like to take advantage of these resources to improve how CHAC "looks at the family holistically" and to do more related to health. CHAC, like FSW, has experience administering a wide range of services and has experienced success

working with the Department of Public Health on lead and vaccination issues, suggesting that past experiences with health-related work may make a program amenable to doing more in the future.

6) "Health Content could reinforce other aspects of our program"

Many interviewees appreciated, and expressed interest in exploiting, the natural consistency health interventions could have with existing aspects of their programs. This was true at a with very small-scale program components as well as larger, overall program goals. When Christine Klepper of HCP asked why I requested detailed information about her program's housekeeping advice, I replied that I was hoping to document commonalities with asthma prevention techniques. Ms. Klepper commented that giving multiple reasons for vacuuming, for example, could certainly increase overall compliance with this particular instruction and would be interested in considering such an addition. On a larger scale, many interviewees expressed that clients' overall wellbeing affects chances of success, and that they would invest in health interventions because better health would support more successful moves. Scott Gehl of HOME (Buffalo) explained why he supported adding non-housing services to mobility programs, with some focus on health, saying "There is value in even a bare bones program, which exposes people to greater opportunities; however, it's far more effective to provide additional services which equip people to succeed." He continued, likening health's importance to that of better understood themes, such as education. According to Mr. Gehl, health could be seen in the same way as "marrying the idea of housing mobility with educational assistance or financial literacy" once was. He continued, "Although I've recently read about health impacts, I was not aware of them at the time we I wrote the program design. In my view, they make perfect sense."

Varying Levels of Services

I found varying levels of services provided across the programs I researched. While managers' attitudes about services likely influence the types of services offered, available funding, contract stipulations, and organization type play a huge role in determining what

programs can and cannot offer. Therefore, I do not attribute the typologies below to any specific cause, rather I offer them as potentially useful categories when trying to assess how receptive a program might be incorporating different types of health content.

Referrals

The least social services-oriented program, ESOP which seems to interpret its directive to desegregate most narrowly, focuses nearly all its energy on providing housing search assistance, fighting for higher payment standards, conducting landlord outreach, educating tenants about fair housing law, and removing financial barriers to a move (e.g., providing security deposit loans or finding public subsidies for the families in the new areas). Additional health or human services needs are addressed through **referrals**, if at all.

ESOP is the only program I profiled that truly seems to fit in the referrals category. ESOP's Jerrold Levy readily admits that he "is not a big fan of housing counseling," and feels that the main problem facing the families is that they can't find housing themselves in racially and economically mixed areas. The chief priority for assisted mobility programs, in Levy's view, is providing high enough subsidies so that the families can afford housing in the mixed areas, and providing outreach assistance, not doubling as a social services agency. In terms of health specifically, Levy explained that if client wanted information on health services in her new area, for example, ESOP would make sure that person had health insurance and then suggest she call the insurance company to get a list of doctors in their new neighborhood. This program, and others like it, would likely want to stay away from health completely, aside from ensuring public benefits are in place.

As I address further in Chapter 5, however, this is not to say that programs functioning under such a model cannot provide opportunities for very healthful moves. With pathways between assisted housing mobility and health running specifically from neighborhood quality to outcomes, a services-light program that gets people to drastically better areas may be quite beneficial for the *some* clients.

Connections

A second type of program expands a bit further into health and social services by moving beyond referrals to attempting to **connect clients** with agencies or resources that might be useful. This includes hosting community tours that highlight libraries, playgrounds, and shopping districts, for example. ICP, which notifies families of school enrollment periods, helps with the enrollment process, and identifies additional resources kids might need to participate in after-school activities, provides other examples of creating connections. ICP even helps families access funds to buy sports uniforms or musical instruments, if needed, in order to help create connections. Programs in this category may offer budget and credit repair advice in-house, as these dimensions have direct implications for whether clients pass landlord screenings. Beyond this type of direct service provision, however, most other health and human service needs are directed outside the agency.

In addition to ICP, I would place HERC, HOME (Buffalo), and HOME (New Haven) in this category. Although HOME (Buffalo) is currently running its program under a "referrals" model because of budget cuts, the program fit under a "connections" umbrella for most of its nine years. Until recently mobility counselors would take clients on private escorted tours of neighborhoods, for example, and when additional funding is available, HOME's Community Housing Center plans to return to its more service-intensive programming. In fact, director Scott Gehl is investigating the possibility of hiring a social worker and adding more post-move services than the Community Housing Center has ever offered.

"Connections" programs seem well-positioned to go beyond ensuring that families can access public benefits. They may be able to help families think through which health resources might benefit them most in their new neighborhoods.

Connections plus Education

Programs in this category generally provide the same types connections as those discussed above, but couple this with education and/or personal development workshops in-house, which are meant to prepare clients for moves. Baltimore's Thompson program, for example, makes extraordinary attempts to connect families to both institutional and social support networks, arranging dinners and social events where its families can meet each other and new neighbors, as well as accompanying families to community meetings for the first time to ensure clients feel comfortable. Beyond this, clients also take part in up to a year of readiness training. HCP in Chicago, which admittedly has a unique arrangement by which clients are partnered with the social services agency Heartland Alliance for Human Needs & Human Rights, also offers **readiness education and life skills training** in a series of three workshops.

This type of program, which has already crossed into working with clients on a number of personal issues, such as how to keep house or dress when meeting landlords, might be better equipped to handle more sensitive health-related content than are programs in the previous two categories. As Cynthia Maignan of FSW indicated, a program in this category might be open to, and capable of, integrating health questions into its intake process. Additionally, it is this group of programs that might want to review its life skills and readiness workshop material with public health professionals for natural areas of reinforcement or conflict.

Service Provision

CHAC of Chicago and FSW of Bridgeport are the only programs I categorize as providing excellent access to **extensive in-house services** for clients. Although the content of CHAC's Housing Opportunities Program operates much like the programs in the "Connections plus Education" category, the "special programs department" within the larger organization provides additional resources that mobility families can access if they so choose. Among these, Family Self Sufficiency program offers "skills assessment, GED preparation, career planning, computer literacy and skills training, money management workshops, child care referrals and a host of employment services such as monthly job club meetings, referrals and recruitment sessions with employers," according

to CHAC's Housing Choice Voucher Program Participant Guide. Clients participating in the Family Self Sufficiency program also participate in a savings program that records when they earn salary increases. CHAC then matches the pay raise and deposits this amount into an escrow account. CHAC's program guide explains that "once FSS members achieve all of their established goals, including maintaining full-time employment, they receive all of the money in the account, plus interest." In addition to the Family Self Sufficiency program, mobility families can access a homeownership program, which offers financial and educational support in the home buying process. On top of this, all CHAC voucher holders can take advantage of lead testing and vaccinations for young children offered in partnership with the Department of Public Health, as mentioned in Chapter 3.

FSW's services-oriented approach is similarly comprehensive; program participants can access a host of in-house social, financial, and health-related services. A recent FSW annual report, which featured one mobility client's story in her own words, captures FSW's view that housing counseling and other services can, and often should, be integrated for success. Below is an excerpt of the client's story. This mom writes of her history of drug abuse, time spent in prison, and family cycles of child neglect and abuse, and then moves into a description of the services she has used at FSW to help her cope.

"In 1998 in order to stay on public assistance, I had to join a job training program called Family Strengthening Team at FSW. There, I also took advantage of their Mental Health Services, where I have remained connected since then. Although my counselors have changed, they have all been caring, sensitive, and wonderful. Because of their help, I have been stable for 13 years. My daughters, now 22, 16, and 13 have a normal, loving family. FSW helped me address the causes of my depression and taught me new ways to cope.

- *I learned about Section 8 vouchers at an FSW workshop: I moved my children to a safer neighborhood.*
- *I regained custody of my 15 year old daughter, removing her from the home of her abusive father. She sees an FSW counselor on her own. I am a positive role model for my younger sister, who has started counseling at FSW to address her problems.*
- *I received budget counseling for 6 months...*

I see my counselor weekly and remain on methadone to keep me straight. I registered for GED preparation classes..."[70]

FSW's proposed centralized intake proposal would help it better match mobility program client needs with it own internal capabilities.

CHAC, FSW, and other programs of this nature would be appropriate early adopters of the most intensive forms health programming.

Summary and Conclusion

At first glance, the field of assisted housing mobility seems to comprise very little variation in how programs integrate health into their agendas. Explicit health-related programming is limited across the board, and the handful of programs that do make an attempt to influence health outcomes view their involvement as limited. Unpacking this seemingly uniform treatment of health, however, reveals a range of views on how residential mobility influences health, the appropriate role of assisted mobility programs in clients' lives, and the degree to which social or health services are necessary components of health-promoting programs. In short, several different "practice theories" are at work in the field. These can be explored, in part, through the lens of some classic housing and services questions, addressed in Chapter 5.

The opinions outlined above are important to understand before encouraging an increased health focus in assisted housing mobility programs. They can be broadly synthesized into several take-home messages: 1) Most programs seem excited to be part of something that improves health (usually conceived of as passive gains from opportunity moves). I could not find opponents of good health or health-promotion; rather I heard different interpretations of how to promote health and of the role housers should play in that process. 2) Some programs are enthusiastic about better integrating health-related services into their agendas, but are seeking partners or guidance from public health

[70] See Appendix D for fully story.

practitioners or medical professionals because they are worried about privacy, liability, or staff qualifications. 3) Many program staff members, including some that champion a greater emphasis on health, have serious concerns about "mission creep," implementation, and feasibility. Any coordinated effort by an advocacy or research organization to push for more health-related content in assisted housing mobility programs would need to address arguments made against such a shift.

There are adequate responses, however, that advocates could provide, at least to help program managers think through the big questions. First, they could review debates within the legal field surrounding the scope of desegregation remedies and the fundamental meaning of "rights." As part of this discussion, they could contextualize for managers the practice of providing extra services for clients who need them in order to take advantage of rights the program was originally designed to provide. According to interviews with national experts, qualitative research from both Gautreaux and MTO suggest that it is extremely important to consider a client's level of functioning, not just her rights, in assisted housing mobility programs. That is, programs are not simply compliance devices; they seek results and rely on clients to be agents on their own behalves. This requires enabling, as well as providing for some versatility in the way different clients are served.

Linking services with housing programs is not new, nor is grappling with how to adjust service provision based on client needs. Chapter 5, the next and final piece of this thesis, explores assisted housing mobility programs in the context of this long tradition, discussing key tensions that run through both this specific type of housing program and housing programs more generally.

Chapter 5 – Conclusions

Preceding chapters of this thesis have presented conceptual models for thinking about health and housing mobility, including: 1) causal pathways between neighborhoods (and housing stock) and health from the literature; 2) models of intervention and disengagement in five "targets of opportunity"; and 3) assisted housing mobility program typologies. Chapters 3 and 4 profiled nine assisted housing mobility programs and commonly held attitudes towards health and service provision by their staff. Interspersed throughout prior chapters were examples of health interventions illustrative of what could be practically undertaken by the various types of programs.

This final chapter summarizes findings from earlier sections and introduces new areas of analysis. It presents key questions and conceptual tensions in the universe of programs profiled, drawing on long-standing themes from the housing and human services field for context. It then reflects on lessons learned from this research project for broader efforts to reconnect the disciplines of public health and urban planning. Finally, the chapter offers a consolidated list of health-oriented next steps for assisted housing mobility practitioners.

Summary and Implications of Key Findings

So far, this thesis has argued three main points: assisted housing mobility programs are inherently health-related ventures and should be thought of as such; programs can be grouped into useful categories for an examination of each one's relationship to health; and programs have different natural strengths vis-à-vis health promotion that they should exploit.

1. Available literature on housing mobility suggests that moves from high-poverty, racially segregated neighborhoods to "opportunity areas" impact families in myriad ways. Though moving itself is thought to be harmful to health because of the highly stressful nature of the process, according to the HOPE VI Panel Study, housing

mobility advocates hope and believe that risks posed are outweighed by potential gains. Research to date has focused on passive health impacts of moves. However, nothing has been written explicitly about health impacts from assisted housing mobility programs themselves. Effects could occur through two different pathways: the influence of counseling on locational outcomes,[71] and/or the exposure of clients to various program components (e.g., counselor advice, print materials, workshops, or interactions with other clients).

Given their inevitable links to health, all assisted housing mobility practitioners should be aware of and deliberate about how they design and run their programs in the context of health. The deliberate treatment of health would start with education for both staff and clients on the possible health risks and rewards associated with opportunity moves, a recognition of what counseling materials (if any) could influence clients' health behavior or health awareness, and a conscious decision on the part of program managers regarding whether and how to handle the transition of health care services and public benefits across jurisdictions.

2. Despite superficial similarities in the degree to which programs generally integrate health (meagerly, if at all), the field of assisted housing mobility actually includes a diversity of ideas and approaches towards this issue. Additionally, programs have major differences in their origins (litigation-based versus voluntary), funding streams (secure or insecure; discretionary or strictly controlled), administrative arrangements with PHAs (acting as voucher administrators versus counselors), and the agency type within which they are situated (multi-service nonprofit or private consulting firm), for example. There are no standard forms of assisted housing mobility programs; each is unique in multiple dimensions. Despite such diversity and a small sample size, it is important apply meaningful categorization to the universe of programs. Organizing programs by their approach to services provision, as I did in Chapter 4, makes it easier to match appropriate health-related interventions to specific types of assisted housing mobility programs.

[71] Briggs, op. cit. 32.

3. Each program type has a different set of comparative advantages when it comes to acting in Chapter 2's "targets of opportunity." Overlaying program typologies with targets of opportunity suggests that "referrals" programs would probably be at their best tackling locational outcomes and housing unit quality, while "service provision" programs might excel at improving health behavior and awareness, for example. All programs could therefore make strides towards improving health outcomes for clients, therefore, without adjusting their basic modes of operation. Managers of "referrals" programs do not have to become more service oriented to make strides towards more healthful moves; deepening the definition of an "opportunity area" to include factors beyond poverty and race could be an equally, if not more, powerful step.

Themes and Tensions within the Assisted Housing Mobility Field

These key findings, summarized from previous sections of this thesis, merely comment on current conditions in the field of assisted housing mobility. The thesis has not yet addressed the tensions that underlie these conditions, nor has it contextualized these tensions as classic themes from the fields of housing and human services. In this final chapter I return to the notion that various "practice theories" are at work across the various programs. The tensions discussed below are not new in the literature on housing and services or non-profit management, however, their consequences for the health of families relocating under assisted housing mobility programs may be.

Targeting people

Program administrators in the field of housing and human services have long grappled with the questions on when and how to target people to receive services. Many experts believe organizations should hone in on clients who are ready to take advantage of whatever opportunities the organization has to offer, focusing on families are most likely

to succeed and benefit from a given intervention.[72] This is especially true in the field of assisted housing mobility where it does more harm than good to move someone into a new neighborhood who is not equipped to succeed or stay long enough to enjoy any real benefits from the relocation. Aside from negative individual effects, this is a waste of public (or settlement) resources.

If programs operate under the "referrals" model, however, with few services that could benefit families with deep needs, "targeting" starts to sound a lot like "creaming." Creaming, the practice of skimming the most functional families off the top of the applicant pool (and running very successful, services-light programs) is a long-standing practice in the field of housing and human services. Ideally, [see footnote: Briggs and Turner: Assisted Housing Mobility and the Success of Low-Income Minority Families], families would have access to services to help them prepare to take advantage of residential mobility, and those already prepared for such a move would have different services and opportunities for meaningful relocation. In my sampling, a few programs illustrate this tension well. On one end, Yonkers' ESOP focuses on helping families make moves to drastically different neighborhoods, mostly resulting in moves to suburban areas. However these families move mainly in the absences of any kind of life skills or self sufficiency training. Because of this, ESOP might not be a great fit for families with deep health or mental health problems, those with very little capability to manage the stress and other challenges of a move, or those needing to resolve long-standing personal issues before they could take advantage of a new neighborhood.

On the other hand, FSW Bridgeport works with former drug addicts, those with low education or literacy, and families with mental health needs. Chicago's CHAC also offers extensive services and supports for clients. Both CHAC and FSW offer valuable services to clients with more embedded problems, but there is circumstantial evidence that this service-intensive model hinders a program's ability to provide true opportunity moves to those who are already very high-functioning. CHAC, for example, mainly moves families shorter distances to better neighborhoods within Chicago instead of to

[72] Briggs, op. cit.

truly different neighborhoods. Whether there has to be, or generally is, a tradeoff between service provision and locational outcomes should be researched in greater depth. In the context of health, an addition dimension to the targeting question tension is whether and how to prioritize families who could either benefit most or those who medically need a move most (because of severe asthma or high risk of sexual violence, for example).

Interpreting mission

How do program staff members interpret their mission at various levels of an organization? Do, or should, all programs have highly conceptualized, highly reflective stances on how they operate, and why? Some program staff members with whom I spoke presented comprehensive visions for their organizations and fit their approaches to service provision, targeting families, and relationship to health neatly within those contexts. Others seemed to be "muddling through" to a greater degree, often overwhelmed, and administering housing counseling to both regular voucher holders and those interested in opportunity moves. This latter group of managers did not, unlike their counterparts, offer explanations of how their mobility counseling program related back to the original mission of Section 8 or civil rights. They more often saw mobility movers as self-starting families who, for whatever reason, were willing to "give it a shot out in the suburbs" (and with no car – how do they do it?!), and themselves simply as the people who would provide apartment listings outside the city. This is not to say that all managers who chose not to advocate strongly for mobility moves lacked highly conceptualized ideas about their programs and roles; rather, some felt that fair housing agencies should never pressure people to make specific housing choices. Regardless of where mangers ultimately decide they stand, it is important for programs to be deliberate about their treatment of health.

The degree to which managers can hold highly conceptualized ideas on mobility and health, a prerequisite for thoughtful, deliberate action, depends on the information available to them and the opportunities they have to participate in a professional

community with other practitioners. There are very big questions surrounding the integration of health into assisted housing mobility programs, as this thesis outlines, and staff members need time, space, and resources to sufficiently deal with them. This is addressed further under "next steps."

A second related and important question surrounds the degree to which "front-line" redefinition of programs takes place among mobility counselors unbeknownst to program managers. Arguments from Lipsky's *Street-Level Bureaucracy* - that "on the ground" staffers who interact with clients use their discretion to cope with limited resources and myriad, non-uniform demands - seem applicable in many of the programs I surveyed. In some cases, such as those described above, the original mission of assisted housing mobility programs got buried. In other cases, counselors are expanding their program's scope beyond that expected by managers; they are actually working in areas that health researchers are just now identifying as important. In Baltimore, for example, MBQ manager Jim Evans recognized a formal need to host a training session for counselors on transferring benefits across jurisdictions in Maryland after attending an Anne E. Casey mobility forum. However, after the training session it was apparent that some counselors had already discovered and been serving this need for some time.

Lessons Learned for Reconnecting Health and Planning

The most fundamental purpose of this thesis was to provide a case study of how the disciplines of urban planning and public health are currently linked and how they could be better integrated to fight health disparities. Although the two disciplines co-evolved in the late 19th century to tackle infectious diseases in newly industrializing urban areas, health and planning diverged throughout the 20th century.[73] Scholars attribute this split in part to specialization within each field, an increasing biomedical focus within the health field (including a emphasis on people over places), and greater attention to suburbs than cities with the planning field. In recent years, as planners turn their attention back

[73] Jason Corburn, "Confronting the Challenges in Reconnecting Urban Planning and Public Health," American Journal of Public Health, Vol 94, No. 4 (2004).

towards cities and health disparities, there has been a push to reconnect the two fields. This study's focus on the Housing Choice Voucher program provides an opportunity to look specifically at housing-related health issues, yet its most basic function is to explore lessons that could be broadly applicable to other intersections of planning and health.

My primary observation is that the actors in this case are still largely "siloed" within their own professions, and that this would likely remain a barrier to interdisciplinary initiatives, including health-intensive initiatives. Housers function in a world where payment standards, portability, the regionalization of public housing authorities, and landlord outreach, for example dominate their list of concerns. Housing counselors, often trained social workers or case managers who work with or for the housers, grapple with the targeting dilemma discussed above, often trying to work with deeply needy clients within an incentive structure that rewards rapid throughput and lease-up of clients, not intensive service provision. Finally, the public health practitioners are the most apart, measuring stress by biomarkers in saliva samples, not by asking a counselor how the clients seem to be handling a move, and favoring interventions that allow for rigorous quantitative research. These silos, without effective bridges between them, are problematic.

The different vocabularies employed across disciplines make communication or self-education about the other fields difficult. While many housing- and services-oriented interviewees knew there was published public health literature on residential mobility, most seemed to get their best information from digestible powerpoint presentations aimed at non-health professionals, or through popular print media. One manager said she wished her counselors would read more about health and neighborhoods or the MTO health findings, for example, but she was at a loss for what materials to even share without overwhelming her staff. The inaccessibility of many public health research publications to a housing counselor, for example, may contribute to the mystique of public health for housers and service providers. Nearly all mobility program staff members with whom I spoke were concerned about venturing into health for fears of liability, legality, or a lack of qualification. Despite a broad willingness to address

education and employment, few programs seem confident that they are capable or allowed to make even small strides towards health-related content. Instead of hiring a health practitioner on staff (as programs have often done with social workers or lawyers) program managers seem more interested in partnering with outside health researchers to reduce liability and ensure proper qualifications. This type of arrangement could work well, but may not be necessary to make powerful health-promoting changes in program content. In addition to vocabulary and an almost palatable fear among managers of getting too close to health, different bureaucracies and different standards of evidence hinder the ability of people from the various silos to come together.

Health-Oriented Next Steps

Given this summary of the assisted housing mobility field, which is populated by diverse programs operating at different scales with different practice theories, what are plausible next steps for advancing the treatment of health? What do program managers need in terms of support from PRRAC in order more successfully integrate health into their practices, and can PRRAC act as a bridge between the silos? The recommendations below are a synthesis of my own observations and ideas, suggestions from interviewees, and schemes inspired by readings. I first offer ideas for individual programs and then for PRRAC, the client for this study.

Individual programs

This following is a list of actionable steps programs might undertake as they pursue health-promotion. Items in bold aim to mitigate the disruptive effects of residential mobility on health, and I recommend all programs consider undertaking these or similarly-intentioned steps. All other items are 'optional;' they actively seek to promote health and maximize health benefits of opportunity moves rather than perform damage-control.

Orientation and intake

- **Openly present to clients health implications of opportunity moves at Housing Choice Voucher briefings of other orientation sessions;**
- Add optional health-related questions to intake forms to help counselors understand families' needs (e.g., do you need help locating a new dentist?). Add room for health-related answers to the goals sections of intake forms (e.g., add a checkbox under "goals" for reducing asthma symptoms or losing weight);

Life skills and readiness

- Revise housekeeping workshops and materials to be consistent and mutually reinforcing with public health guidance. Special emphasis could be placed on indoor allergens and asthma, proper use of household chemicals, and pest management. Ideally, advice could be customized according to health information disclosed on intake forms.
- Revise budgeting workshops and materials to mutually reinforce public health guidance. Emphasize free outdoor recreational opportunities and the financial benefits of reducing unhealthy food and drink options. Ideally, advice could be customized according to health information disclosed on intake forms;
- Connect families to other appropriate, healthful in-house services. Refer families to services outside the organization if needed;

Housing search assistance

- Strive to locate housing in healthful neighborhoods, which may require considering outdoor air quality, recreational infrastructure, access to food, and other factors.
- Consider individual health needs when providing search assistance (e.g., does this family need to live near a dialysis clinic?);
- Direct families towards healthful housing units, when possible, or educate clients about how to spot healthful housing for their own needs (e.g., supply advice that carpeting is thought to exacerbate asthma symptoms);

Pre-move support

- **Outline with clients the medical services each family member is currently using. Help form plans to replace these services or anticipate travel back to old providers;**

- **Ensure families know how to transfer their public benefits across jurisdictions successfully;**
- Empower families to take part in their own medical case management. Supply tools that help clients collect and organize records so they are easily transferred to new providers;[74]
- Help parents identify the new healthful resources in the new community they plan to enjoy. Discuss resources for kids, including the most basic – a safe neighborhood environment – and implications for restructuring play time (e.g., away from the TV and into the yard or park);
- Compile information on health care services available in opportunity areas;
- Be conscious of health when designing community tours (e.g., highlight healthful resources such as grocery stores and parks);

Post-move support

- **Check that public benefits have transferred properly;**
- Encourage the formation of healthful social ties by helping families make connections in new areas (e.g., neighbor to neighbor dinners or accompanying clients to community meetings);
- Help parents introduce schools to health issues affecting their children;
- Help parents set aspirational but realistic expectations for schools and health outcomes;
- Provide an avenue through which clients can report changes to their health so counselors can make referrals, if needed (e.g., depression, loneliness, discovery of new pollen allergies).

Each recommended action presents some degree of benefit to families and cost to assisted housing mobility programs. Costs include financial outlays, time investments, and threats to relationships with clients (inappropriately personal questions, for example).

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[74] For an example, see "Directions: Resources for Your Child's Care,Chapter 6: Your Child's Everyday Care," Massachusetts Department of Public Health, 25 April 2008, <http://www.mass.gov/?pageID=eohhs2subtopic&L=6&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Family+and+Community+Health&L4=Children+and+Youth+with+Special+Health+Needs&L5=Directions%3a+Resources+for+Your+Child's+Care&sid=Eeohhs2>.

Attempting to quantify benefits and costs of each action is futile, as pre-existing program characteristics so greatly determine if there is synergistic value to a specific intervention, or a particularly low cost of another due to previous work in that area. However, Appendix E indicates the general magnitude of the benefit using a scale of one to three, as well as the type and magnitude of cost (low, moderate, high). I assigned these rough scores based on interviewee comments and my public health literature review.

Poverty & Race Research Action Council

There are several ways PRRAC could support individual programs in their decisions to better integrate health into program content. The first item on the list pertains to a manual for Housing Choice Voucher Program administrators, which PRRAC is already developing.

- Add to the HCVP manual the following sections:
    - Digestible introduction to health and mobility: What does the research say?
        - Pros and cons
        - What are neighborhood effects on health?
        - How do housing units impact health?
    - Frequently Asked Questions
        - Privacy: What can I legally ask my clients about health?
        - Liability: To what extent can I legally advise my clients on health?
        - Mandate: What arguments can I make justifying my involvement in health?
    - Samples of effective counseling materials
        - Health-conscious intake form
        - Health-conscious housekeeping advice
        - Health-conscious intake budgeting tools
    - Inspiration from other programs
        - Vaccination and lead testing coordinated through the Department of Public Health

        - Training for counselors on health benefits rules, income limits, and transfer across jurisdictions
        - Vision and dental care for job seekers
    - Funding
        - Research organizations interested in partnerships
        - Mobility-friendly or public health foundations
        - Possibilities to fund health interventions through litigation

- Create an Online Community for practitioners. Multiple interviewees expressed a need for a website that served as
    - A forum for exchanges with others in the field, an important need for those managers too overextended or cash-strapped to attend conferences;
    - A repository for the latest research and literature on housing mobility,
    - A way to ask questions or email experts for technical support.

- Conduct a health-intensive pilot program in conjunction with an operating program. This pilot should result in very specific lessons learned on how to conduct pre- and post-move health assessments, including detailed information on staff responsibilities and levels of qualification needed for the undertaking. It should also contribute knowledge on how to construct health-conscious definitions of opportunity.

- Continue advocacy work to promote funding for assisted housing mobility programs, including higher payment standards for moves to opportunity areas, and the regionalization of public housing authorities.

Needs and Future Research

In sum, despite natural links and consistencies between the public health agenda and the work of assisted housing mobility programs, integration of health into these programs will not be seamless or easy. Program staff members have conceptual questions about their relationship to client health, and concerns about legality, capacity, privacy, and

mandate. However, many also realize the importance of working towards better health outcomes, both so clients can take advantage of their new opportunity neighborhoods, and because improving health outcomes is inline with the greater goals of proving access to opportunity to which mobility programs subscribe. Managers identified technical support and a cohesive professional community as key resources that could help them resolve their own questions about incorporating health-related initiatives. Fortunately, PRRAC may be in a position to meet some of these needs.

More research is needed in several areas to support deliberately healthful assisted housing mobility programs. First, health researchers should look at fundamental tradeoffs between neighborhood quality and unit quality in the context of the housing choice voucher program. Secondly, health researchers should attempt to quantify compliance rates or general levels of success in mobility counseling programs where housekeeping and budgeting advice is meted out. Third, planners should examine assisted housing mobility program typologies in an attempt to understand if great services and positive locational outcomes are necessarily (or tend to be) inversely related. Finally, the two disciplines should collaborate on an intensive pilot health intervention nested within a mobility program with a goal of producing guidance for others interested in similar arrangements.

Vouchers are not decreasing in importance any time soon, nor are the health disparities that disadvantage low-income, minority, urban families. Assisted housing mobility programs have a unique opportunity to influence client health outcomes for the better, potentially acting on many of the pathways that connect where you live and how healthy you are. Given the range of health-related options available to programs and the dedication of practitioners to their clients, I have faith that real progress can be made in area.

Appendix A: Housing Quality Standards (HQS) Inspection Form

Produced by U.S. Department of Housing and Urban Development Office of Community Planning and Development[75]

[75] "Housing Quality Standards (HQS) Inspection Form," U.S. Department of Housing and Urban Development, 21 May 2008, <http://www.hud.gov/offices/cpd/affordablehousing/library/forms/hqschecklist.pdf>.

Client # _____

HOUSING QUALITY STANDARDS (HQS) INSPECTION FORM

A. General Information

Date of Inspection: _____

Address of Inspected Unit: Street: _____

City: _____ County: _____ State: _____ Zip: _____

Name of Family: _____

_____

Current Address of Family: Street: _____

City: _____ County: _____ State: _____ Zip: _____

Current Telephone of Family: _____

B. How to Fill Out This Checklist

- ❑ Proceed through the inspection as follows:

Area	Checklist Category
Room by Room	1. Living Room 2. Kitchen 3. Bathroom 4. All Other Rooms Used for Living 5. All Secondary Rooms Not Used for Living
Outside	6. Building Exterior
Basement or Utility Room	7. Heating and Plumbing
Overall	8. General Health and Safety

- ❑ Each part of the checklist will be accompanied by an explanation of the item to be inspected.
- ❑ Important: For each item numbered on the checklist, check one box only (e.g., check one box only for item 1.4 "Security," in the Living Room).
- ❑ In the space to the right of the description of the item, if the decision on the item is "Fail," write what repairs are necessary.
- ❑ Also, if "Pass" but there are additional code items or items not consistent with rehab standards or area codes, write these in the space to the right.

1. LIVING ROOM **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
1.1	**LIVING ROOM PRESENT** Is there a living room?			
1.2	**ELECTRICITY** Are there at least two working outlets or one working outlet and one working light fixture?			
1.3	**ELECTRICAL HAZARDS** Is the room free from electrical hazards?			
1.4	**SECURITY** Are all windows and doors that are accessible from the outside lockable?			
1.5	**WINDOW CONDITION** Is there at least one window, and are all windows free of signs of severe deterioration or missing or broken out panes?			
1.6	**CEILING CONDITION** Is the ceiling sound and free from hazardous defects?			
1.7	**WALL CONDITION** Are the walls sound and free from hazardous defects?			
1.8	**FLOOR CONDITION** Is the floor sound and free from hazardous defects?			
1.9	**LEAD PAINT** Are all interior surfaces either *free* of cracking, scaling, peeling, chipping, and loose paint or *adequately treated and covered* to prevent exposure of the occupants to lead based paint hazards?			
1.10	**WEATHER STRIPPING** Is weather stripping present and in good condition on all windows and exterior doors?			
1.11	**OTHER**			
1.12	**OTHER**			

Notes: (Give Item #)

2. KITCHEN **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
2.1	**KITCHEN AREA PRESENT** Is there a kitchen?			
2.2	**ELECTRICITY** Is there at least *one* working electric outlet and *one* working, permanently installed light fixture?			
2.3	**ELECTRICAL HAZARDS** Is the kitchen free from electrical hazards?			
2.4	**SECURITY** Are *all* windows and doors that are accessible from the outside lockable?			
2.5	**WINDOW CONDITION** Are all windows free of signs of deterioration or missing or broken out panes?			
2.6	**CEILING CONDITION** Is the ceiling sound and free from hazardous defects?			
2.7	**WALL CONDITION** Are the walls sound and free from hazardous defects?			
2.8	**FLOOR CONDITION** Is the floor sound and free from hazardous defects?			
2.9	**LEAD PAINT** Are all interior surfaces either *free* of cracking, scaling, peeling, chipping, and loose paint or *adequately treated and covered* to prevent exposure of the occupants to lead based paint hazards?			
2.10	**STOVE OR RANGE WITH OVEN** Is there a working oven and a stove (or range) with top burners that work?			
2.11	**REFRIGERATOR** Is there a refrigerator that works and maintains a temperature low enough so that food does not spoil over a reasonable period of time?			

2.12	**SINK** Is there a kitchen sink that works with hot and cold running water?			
2.13	**SPACE FOR STORAGE AND PREPARATION OF FOOD** Is there space to store and prepare food?			
2.14	**WEATHER STRIPPING** Is weather stripping present and in good condition on all windows and exterior doors?			
2.15	**OTHER**			
2.16	**OTHER**			

Notes: (Give Item #)

3. BATHROOM **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
3.1	**BATHROOM (see description)** Is there a bathroom?			
3.2	**ELECTRICITY** Is there at least *one* permanently installed light fixture?			
3.3	**ELECTRICAL HAZARDS** Is the bathroom free from electrical hazards?			
3.4	**SECURITY** Are *all* windows and doors that are accessible from the outside lockable?			
3.5	**WINDOW CONDITION** Are all windows free of signs of deterioration or missing or broken out panes?			
3.6	**CEILING CONDITION** Is the ceiling sound and free from hazardous defects?			
3.7	**WALL CONDITION** Are the walls sound and free from hazardous defects?			
3.8	**FLOOR CONDITION** Is the floor sound and free from hazardous defects?			
3.9	**LEAD PAINT** Are all interior surfaces either *free* of cracking, scaling, peeling, chipping, and loose paint, or *adequately treated and covered* to prevent exposure of the occupants to lead based paint hazards?			
3.10	**FLUSH TOILET IN ENCLOSED ROOM IN UNIT** Is there a working toilet in the unit for exclusive private use of the tenant?			
3.11	**FIXED WASH BASIN OR LAVATORY IN UNIT** Is there a working, permanently installed wash basin with hot and cold running water in the unit?			
3.12	**TUB OR SHOWER IN UNIT** Is there a working tub or shower with hot and cold running water in the unit?			
3.13	**VENTILATION** Are there operable windows or a working vent system?			

3.14	**WEATHER STRIPPING** Is weather stripping present and in good condition on all windows and exterior doors?			
3.15	**OTHER**			
3.16	**OTHER**			

Notes: (Give Item #)

4. OTHER ROOMS USED FOR LIVING AND HALLS **For each item numbered, check one box only.**

Item #	Description	DECISION Yes, PASS	DECISION No, FAIL	Repairs Required
4.1	**ROOM CODE and ROOM LOCATION:** right/left _____ front/rear _____ floor level _____	ROOM CODES 1 = Bedroom or any other room used for sleeping (regardless of type of room) 2 = Dining Room, or Dining Area 3 = Second Living Room, Family Room, Den, Playroom, TV Room 4 = Entrance Halls, Corridors, Halls, Staircases 5 = Additional Bathroom 6 = Other		
4.2	**ELECTRICITY** If Room Code = 1, are there at least two working outlets or one working outlet and one working, permanently installed light fixture? If Room Code does not = 1, is there a means of illumination?			
4.3	**ELECTRICAL HAZARDS** Is the room free from electrical hazards?			
4.4	**SECURITY** Are *all* windows and doors that are accessible from the outside lockable?			
4.5	**WINDOW CONDITION** If Room Code = 1, is there at least one window? And, regardless of Room Code, are all windows free of signs of severe deterioration or missing or broken out panes?			
4.6	**CEILING CONDITION** Is the ceiling sound and free from hazardous defects?			
4.7	**WALL CONDITION** Are the walls sound and free from hazardous defects?			
4.8	**FLOOR CONDITION** Is the floor sound and free from hazardous defects?			
4.9	**LEAD PAINT** Are all interior surfaces either *free* of cracking, scaling, peeling, chipping, and loose paint, or *adequately treated and covered* to prevent exposure of the occupants to lead based paint hazards?			
4.10	**WEATHERSTRIPPING** Is weather stripping present and in good condition on all windows and exterior doors?			

4.11	OTHER			
4.12	OTHER			

Notes: (Give Item #)

5. ALL SECONDARY ROOMS NOT USED FOR LIVING **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
5.1	**NONE. GO TO PART 6**			
5.2	**SECURITY** Are *all* windows and doors that are accessible from the outside lockable in each room?			
5.3	**ELECTRICAL HAZARDS** Are all these rooms free from electrical hazards?			
5.4	**OTHER POTENTIALLY HAZARDOUS FEATURES IN ANY OF THESE ROOMS** Are all of these rooms free of any other potentially hazardous features? For each room with an "other potentially hazardous feature" explain hazard and means of control of interior access to room.			
5.5	**OTHER**			
5.6	**OTHER**			

Notes: (Give Item #)

6. BUILDING EXTERIOR **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
6.1	**CONDITION OF FOUNDATION** Is the foundation sound and free from hazards?			
6.2	**CONDITION OF STAIRS, RAILS, AND PORCHES** Are all the exterior stairs, rails and porches sound and free from hazards?			
6.3	**CONDITION OF ROOF AND GUTTERS** Are the roof, gutters and downspouts sound and free from hazards?			
6.4	**CONDITION OF EXTERIOR SURFACES** Are exterior surfaces sound and free from hazards?			
6.5	**CONDITION OF CHIMNEY** Is the chimney sound and free from hazards?			
6.6	**LEAD PAINT: EXTERIOR SURFACES** Are all exterior surfaces which are accessible to children under seven years of age *free* of cracking, scaling, peeling, chipping, and loose paint, or *adequately treated or covered* to prevent exposure of such children to lead based paint hazards?			
6.7	**MOBILE HOMES: TIE DOWNS** If the unit is a mobile home, it is properly placed and tied down? If not a mobile home, check "Not Applicable."			
6.8	**MOBILE HOMES: SMOKE DETECTORS** If unit is a mobile home, does it have at least one smoke detector in working condition? If not a mobile home, check "Not Applicable."			
6.9	**CAULKING** Are all fixed joints including frames around doors and windows, areas around all holes for pipes, ducts, water faucets or electric conduits, and other areas, which may allow unwanted air flow appropriately caulked.			
6.10	**OTHER**			
6.11	**OTHER**			

Notes: (Give Item #)

7. HEATING, PLUMBING AND INSULATION **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
7.1	**ADEQUACY OF HEATING EQUIPMENT** a. Is the heating equipment capable of providing adequate heat (either directly or indirectly) to all rooms used for living? b. Is the heating equipment oversized by more than 15%? c. Are pipes and ducts located in unconditioned space insulated?			
7.2	**SAFETY OF HEATING EQUIPMENT** Is the unit free from unvented fuel burning space heaters, or any other types of unsafe heating conditions?			
7.3	**VENTILATION AND ADEQUACY OF COOLING** Does this unit have adequate ventilation and cooling by means of operable windows or a working cooling system?			
7.4	**HOT WATER HEATER** Is hot water heater located, equipped, and installed in a safe manner?			
7.5	**WATER SUPPLY** Is the unit served by an approvable public or private sanitary water supply?			
7.6	**PLUMBING** Is plumbing free from major leaks or corrosion that causes serious and persistent levels of rust or contamination of the drinking water?			
7.7	**SEWER CONNECTION** Is plumbing connected to an approvable public or private disposal system, and is it free from sewer back up?			
7.8	**INSULATION** Are the attic and walls appropriately insulated for regional conditions?			
7.9	**OTHER**			
7.10	**OTHER**			

Notes: (Give Item #)

8. GENERAL HEALTH AND SAFETY **For each item numbered, check one box only.**

Item #	Description	DECISION		Repairs Required
		Yes, PASS	No, FAIL	
8.1	**ACCESS TO UNIT** Can the unit be entered without having to go through another unit?			
8.2	**EXITS** Is there an acceptable fire exit from this building that is not blocked?			
8.3	**EVIDENCE OF INFESTATION** Is the unit free from rats or severe infestation by mice or vermin?			
8.4	**GARBAGE AND DEBRIS** Is the unit free from heavy accumulation of garbage or debris inside and outside?			
8.5	**REFUSE DISPOSAL** Are there adequate covered facilities for temporary storage and disposal of food wastes, and are they approved by a local agency?			
8.6	**INTERIOR STAIRS AND COMMON HALLS** Are interior stairs and common halls free from hazards to the occupant because of loose, broken or missing steps on stairways, absent or insecure railings; inadequate lighting, or other hazards?			
8.7	**OTHER INTERIOR HAZARDS** Is the interior of the unit free from any other hazards not specifically identified previously?			
8.8	**ELEVATORS** Where local practice requires, do all elevators have a current inspection certificate? If local practice does not require this, are they working and safe?			
8.9	**INTERIOR AIR QUALITY** Is the unit free from abnormally high levels of air pollution from vehicular exhaust, sewer gas, fuel gas, dust, or other pollutants?			
8.10	**SITE AND NEIGHBORHOOD CONDITIONS** Are the site and immediate neighborhood free from conditions, which would seriously and continuously endanger the health or safety of the residents?			

8.11	**LEAD PAINT: OWNER CERTIFICATION** If the owner of the unit is required to treat or cover any interior or exterior surfaces, has the certification of compliance been obtained? If the owner was not required to treat surfaces, check "Not Applicable."			
8.12	**OTHER**			
8.13	**OTHER**			

Notes: (Give Item #)

Appendix B: Sample Case Management Tool[76]

Moving to a New Community

Moving is often a stressful time for families. The following list of tips and checklist will help you arrange for your child's health care during a move.

- **Contact your child's health insurance plan.** Give your new address and arrange services in your new community. Don't forget to tell your child's case manager about the move
- **Find a primary care provider (PCP) for your child in the new community.** Ask your child's **current** PCP to help you. Also, check with the Member Services Representative at your child's health plan. After you find a **new** PCP, ask the **current** PCP to speak with the **new** PCP about your child's medical history. Make sure the **current** PCP sends your child's medical records to the **new** PCP.
- **Tell your child's specialty health care providers about your move.** This includes any doctors, nurses, therapists, hospitals, and agency staff involved in your child's care. They may be able to contact other providers or agencies in your new community. Ask for complete copies of your child's records to take with you.
- **Ask the new health care providers and schools to accept your child's previous test results** until you are settled into your new home. Give them copies of current x-rays and test results. If possible, ask them not to repeat tests done recently.
- **Learn about support groups and parent organizations** in your new community. If possible, talk to them before you move. Ask them what to do and whom to contact before you move. Contact state agencies (like the Department of Public Health) to help you find support groups and parent organizations in your new community.

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[76] "Directions: Resources for Your Child's Care,Chapter 6: Your Child's Everyday Care," Massachusetts Department of Public Health, 25 April 2008, <http://www.mass.gov/?pageID=eohhs2subtopic&L=6&L0=Home&L1=Consumer&L2=Community+Health+and+Safety&L3=Family+and+Community+Health&L4=Children+and+Youth+with+Special+Health+Needs&L5=Directions%3a+Resources+for+Your+Child's+Care&sid=Eeohhs2>.

- **Contact your child's new school.** Bring or send copies of your child's school records to the new school. Give the school information about your child's special health care needs.
- **Make copies of everything!** This includes medical records, immunization records, school reports, care plans, and information about equipment and supplies. Give copies of these records and anything else related to your child's care to your child's new providers—and be sure to keep copies for yourself in Chapters 2 and 3 of this manual.
- **Refill your child's prescriptions a few days before your move** to make sure your child has enough medication during the move.
- **Get new written prescriptions** for all medications from your child's **current** PCP to bring with you when you move.
- **Get medical equipment set up in your new home.** If your child uses electric medical equipment, ask your new supplier to check if your new home can meet the equipment needs. Check that electrical outlets are grounded and conveniently located. Call an electrician if you're not sure or if you have questions. Ask the new supplier to set up the equipment before your child arrives.
- **Notify the electric and telephone companies of the date you will arrive.** Ask them to turn on the phone and electricity before you move in. Make sure the companies are aware of your child's special health needs (see **Contacting Community Emergency Service Providers in Your Community**).
- **Prepare for an emergency.** There are many ways to prepare and inform emergency service providers in your new community about your child's health care needs before you move in. Use the link to find out what they are.

Moving Checklist

As soon as you know when and where you will move:

- ☐ Contact your child's health insurance plan
- ☐ Ask all current health care providers to make referrals to new providers
- ☐ Contact the phone company for a phone book
- ☐ Contact local emergency medical services (EMS)
- ☐ Contact the local school system
- ☐ Contact the State Department of Education to learn about special education
- ☐ Contact the State Department of Public Health to learn about programs for children with special health needs
- ☐ Contact the Chamber of Commerce for information about your new community
- ☐ Visit the area and video tape it if possible
- ☐ Contact your current medical equipment supplier
- ☐ Learn about religious organizations and other special interest organizations in your area
- ☐ Locate a pharmacy that accepts your health insurance
- ☐ Contact parent organizations and support groups in the area
- ☐ Call another parent from the area

Two weeks before moving:

- ☐ Get new written prescriptions from your child's health care providers
- ☐ Contact new school again
- ☐ Send school reports
- ☐ Send medical records to new health care providers
- ☐ Notify electric company of moving date
- ☐ Call phone company to set up new phone number
- ☐ Call medical equipment supplier

Two days before moving:

- ☐ Refill prescriptions
- ☐ Make sure electricity is on in your new home
- ☐ Make sure phone is on in your new home
- ☐ Check supplies for trip
- ☐ Call new medical equipment supplier

Do you have copies of:

- ☐ Medical records
- ☐ School records
- ☐ IEPs, IFSPs, IHCPs, and other care plans
- ☐ Shots and immunization records
- ☐ List of medical supplies used
- ☐ Prescriptions
- ☐ Health insurance card
- ☐ Letter from PCP and specialty providers explaining your child's condition

New phone numbers:

Hospital_____

Health Care

Provider(s)_____

_____

Health Insurance Plan _____

_____

EMS_____

Fire Department_____

Police Department_____

Electric Company_____

Phone Company_____

Gas/Oil Company_____

School_____

Parent Support Group/Organizations_____

_____

_____

_____

State Department of Education_____

_____

State Department of Public Health_____

_____

_____

Equipment Supplier_____

_____

Pharmacy_____

_____

House of Worship_____

_____

Other_____

Appendix C: List of Interviews Conducted

Interviewee	Organization/Expertise	Interview Date	Notes
Amy Eppler-Epstein	New Haven Legal Assistance Association, Inc.	2/15/2008	
Cassandra Amosu	Metropolitan Baltimore Quadel	2/8/2008	
Christine Klepper	Housing Choice Partners of Illinois, Inc.	3/15/2008	
Cynthia Maignan	Family Services Woodfield	3/13/2008	
Demetria McCain	Inclusive Communities Project		Reviewed ICP program profile, no interview
Dolores Acevedo-Garcia	Harvard School of Public Health	2/15/2008	Thesis reader
Florence Roisman	Indiana University School of Law - Indianapolis	3/17/2008	
Gary Adamkiewicz	Harvard School of Public Health	4/7/2008	Email communication only
Gene Rizor	Quadel Consulting Corporation	2/8/2008	
Gerald Levy	Enhanced Section 8 Outreach Program	3/7/2008	
Jennifer O'Neil	CHAC, Inc.	1/25/2008	
Jim Evans	Metropolitan Baltimore Quadel	2/8/2008	
Michelle Walker	Family Services Woodfield	3/13/2008	
Mike Hanley	Greater Upstate Law Project	3/10/2008	
Philip Tegeler	Poverty & Race Research Action Council	4/17/2008	Thesis reader
Shella Runlett	Housing Operations Management Enterprises (HOME), Inc.,	3/4/2008	
Susan Harkett-Turley	Housing Education Resource Center	3/1708	
Susan Popkin	The Urban Institute	2/8/2008	
Xavier de Souza Briggs	MIT Department of Urban Studies and Planning	Weekly	Thesis advisor

Appendix D: Housing Counseling Materials Collected

Client overcomes challenges to build better life for her family

"Before coming to FSW, I suffered from depression. I am the oldest of 3 children and my mother was a single parent. While she took care of our physical needs, she was not attentive to our emotional needs. I dropped out of school in the 7th grade, hung out with negative peers and ran away from home.

I became a mother and a drug user at 16. I went to prison for drug possession with intent to sell. At age 21, pregnant with my 2nd child, I sought voluntary imprisonment to protect the baby. I continued abusing drugs and suffered from depression. My 19 year old brother committed suicide.

My turning point came in 1993 at age 23. After being imprisoned again on drug-related felonies, DCF gave my mother custody of my kids. I was fed up with my life and its affect on my daughters. I was determined to change but knew I needed help to overcome my depression and drug addiction. I sought out the prison's counseling services.

I became pregnant with my 3rd child at age 24, upon release from prison. I discovered my mother was abusing drugs, so I brought my kids home. My boyfriend, a positive influence, helped me with the children, but the relationship eventually ended. I continued to be depressed but tried to refrain from drugs. My mother died of a stroke. I struggled to make ends meet. I lived in one of the most violent neighborhoods in Bridgeport. Despite these stresses and losses, I took care of my daughters as best I could.

In 1998, in order to stay on public assistance, I had to join a job training program called Family Strengthening Team at FSW. There, I also took advantage of their Mental Health Services, where I have remained connected since then. While my counselors have changed, they have all been caring, sensitive and wonderful. Because of their help, I have been stable for 13 years. My daughters, now 22, 16, and 13, have a normal loving family. FSW helped me address the causes of my depression and taught me new ways to cope.

- ***I learned about Section 8 vouchers at an FSW workshop: I moved my children to a safer neighborhood.***
- ***I regained custody of my 15 year old daughter, removing her from the home of her abusive father. She sees an FSW counselor on her own. I am a positive role model for my younger sister, who has started counseling at FSW to address her problems.***
- ***I received budget counseling for 6 months: I can now budget my disability income, meet my living expenses, pay off debt and save money.***

I see my counselor weekly and remain on methadone to keep me straight. I registered for GED preparation classes. My goals are to become less dependent on medication and to become gainfully employed so I can continue to build a better life for my children."

Janet Hernandez,
Age 37, Bridgeport, CT

During the School Visit: Key Questions to Ask

Here are some helpful questions to ask during a school visit:

Mission and Community:

- Does this school have a particular philosophy and mission?
- What is this school's approach to student discipline and safety?
- How does this school monitor students' progress toward achieving standards?
- What professional development opportunities do teachers have? How do teachers collaborate?
- What are some of the school's greatest accomplishments? What are some of the biggest challenges it faces?
- Is there an active Parent Teacher Association (PTA)? What sorts of parent involvement take place at this school?
- How does this school communicate with parents? How can parents contact teachers?

Resources and Extracurricular Opportunities:

- What kinds of library resources are available to students?
- How is technology used to support teaching and learning at this school?
- Where do the arts fit into this school's curriculum? Is there a school choir, band or orchestra? Drama program? Art classes?
- What extracurricular opportunities (e.g., sports, clubs, community service or competitions) are available for students? How do students try out, sign up or get selected for these activities?
- How does this school support students who have academic, social or emotional difficulties?
- What strategies are used to teach students who are not fluent in English?
- How do students get to school? Is free school busing available?

Especially for Middle Schools:

- Are classes "tracked" according to levels (e.g., remedial or advanced)? If so, what criteria are used to determine student placement in classes? Will any credits count in high school?
- Are core classes integrated (e.g., math, science) or are they separate? Why? What are the benefits for students of the structure the school is using?
- Are counselors available to guide and prepare students for major academic decisions that will their option in high school and beyond?
- How often are students graded? How are parents informed about student progress?
- Are foreign language classes (French, Spanish) offered to students?
- What programs exist to help students with their social and emotional development?
- If the school is large, does it make an effort to create a sense of community?

The Business of Being A Tenant

APARTMENT INSPECTION CHECKLIST

I/we certify the following inspection was conducted on _____ for _____ .
date
(Address and unit #)

AREA/ITEM	CONDITION
KITCHEN	
Garbage disposal	
Faucet/Drain/Sink	
Hot/Cold Water	
Water Pressure	
Refrigerator	
Oven/Stove	
Cabinets	
Walls/Paint	
Floors/Carpet	
Windows	
Outlets	
DINING AREA:	
Light	
Floor/Carpet	
Walls/Paint	
Windows	
Outlets	
LIVING ROOM:	
Floor/Carpet	
Electrical Outlets	
Walls/Paint	
Windows	
Shades/Curtains	
Other (specify)	

AREA/ITEM	CONDITION
BEDROOM(S):	
Floor/Carpet	
Curtains/Shades	
Walls/Paint	
Electrical	
Windows	
Closet(s)	
Outlets	
BATHROOM(S):	
Walls/Ceiling	
Floor/Carpet	
Faucet/Drain/Sink	
Hot/Cold Water	
Toilet	
Shower/Bathtub	
Water Pressure	
Cabinets	
Mirror	
Towel Racks	
Windows	
Outlets	
GENERAL:	
Locks	
Ceiling	
Exposed Wiring	
Signs of Insects	
Heat (adequate)	

OTHER AREAS OF DEFECT OR CONCERN: (Attach separate sheets, if needed)

_____

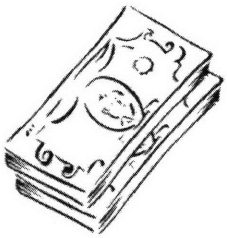
_____

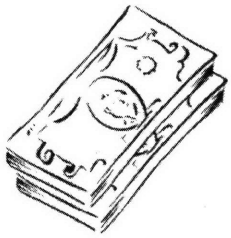
TENANT(S) SIGNATURE _____ LANDLORD(S) SIGNATURE _____

_____ _____

WHAT TO CLEAN AND HOW OFTEN

ROOMS	*TASKS*	DAILY	WEEKLY	PERIODICALLY
BEDROOM(S)	Make beds	✓		
	Clothes (hang-up, put in laundry basket, etc.)	✓		
	Vacuum, sweep, or dust floors		✓	
	Empty trash baskets	✓		
	Launder bedding sheets		✓	
	Arrange or straighten things on dressers	✓		
	Turn over mattress			✓
	Move furniture to clean floors		✓	
	Wipe lamps & light bulbs		✓	
	Dust pictures & dresser tops		✓	
	Clean closets			✓
BATHROOM	Wipe off & dry basin (sink), shower, or bath after use	✓		
	Scrub and disinfect shower or bath		✓	
	Clean mirror		✓	
	Sweep or wipe up loose hair	✓		
	Hang up towels	✓		
	Clean toilet bowl with disinfectant		✓	
	Wipe off outside/behind toilet	✓		
	Wash bathroom floor		✓	
	Wipe or wash shower curtain		✓	
	Wipe off tiles with disinfectant		✓	
	Wash throw rugs		✓	
	Arrange linens & towels in closet			✓
	Wash & hang up fresh towels		✓	
KITCHEN	Check refrigerator and dispose of old leftovers		✓	
	Clean dish drainer		✓	
	Wash dishes	✓		
	Clean top of stove, especially the burners		✓	
	Scrub & wash floor		✓	
	Sweep floor	✓		
	Defrost refrigerator and clean inside/out			✓
	Cover and put away food	✓		
	Wipe table, stove, & counter tops	✓		
	Clean silverware tray		✓	
	Empty trash & wash waste basket	✓	✓	
	Clean oven with oven cleaner			✓
LIVING ROOM	Sort mail and put it away	✓		
	Tidy magazines or newspapers	✓		
	Remove clothing and put it in proper area	✓		
	Vacuum, sweep or dust floor		✓	
	Dust tables and lamps		✓	
	Shampoo rugs			✓
	Clean television screen, VCR, and radio		✓	
	Wash down walls		✓	
	Wash windows			✓
	Vacuum the upolstery		✓	
	Clean blinds			✓





MONEY GOBBLERS

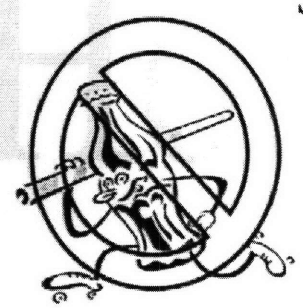
Do you ever wonder where your money went? Circle some items that eat away cash. By identifying your own gobblers you will become aware of where your money goes. You can decide how important or necessary each one is to your budget. You may be surprised at how many items gobble your cash.

ATM Fees
Beauty Parlor
Beepers
Beverages
Big Mac Attacks
Bike Accessories
Books
Bottled Water
Bounced Checks
Cable TV
Car Washes
Cash Advance Fees
CD's/Tapes
Cell Phones
Charitable Donations
Church
Cigarettes
Club Dues
Computer Software
Cosmetics
Dating
Day Trips
Dental
Dining Out
Dry Cleaning
Education
Film Developing
Gambling
Gardening
Gifts
Greeting Cards
Haircuts
Health Clubs
Health Food
Hobbies
Home Parties
Household Items
Ice Cream
Late Payment Fees
Licenses
Long Distance Calls
Lottery Tickets
Lunches Out
Magazines
Movie Rentals
Munchies
Music Lessons
Newspapers
Nights Out
On-Line Services
Over-Limit Fees
Parking Fees
Pet Costs
Postage
Premium TV Channels
Prescriptions
Sales
Souvenirs
Sporting Events
Sports
Stationary
Tolls
Vending Machines
Video Games

$$ Ways To Save Money $$

$ Pack your lunch 2 to 3 times a week $

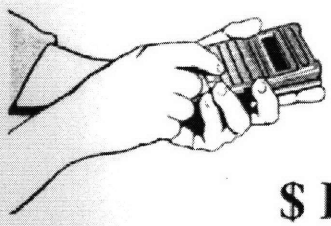
$ Buy products in bulk or on sale $



$ Drink water instead of soda $

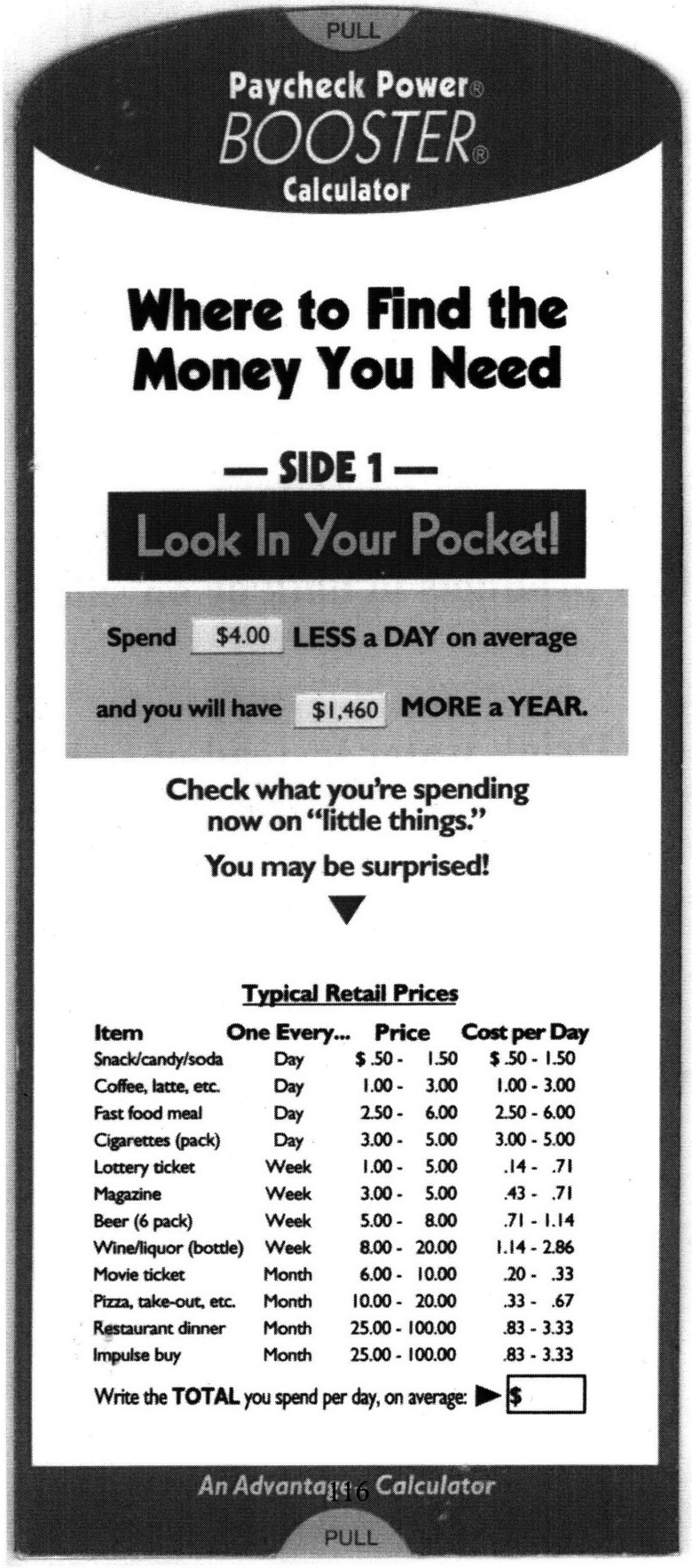
$ Cut back on cable/telephone services $

$ Have a tag or garage sale $



$ Rent fewer videos $

$ Keep track of your spending $


PULL
Paycheck Power®
BOOSTER®
Calculator
Where to Find the Money You Need
— SIDE 1 —
Look In Your Pocket!
Spend $4.00 LESS a DAY on average
and you will have $1,460 MORE a YEAR.
Check what you're spending now on "little things."
You may be surprised!
Typical Retail Prices
Item One Every... Price Cost per Day
Snack/candy/soda Day $ .50 - 1.50 $ .50 - 1.50
Coffee, latte, etc. Day 1.00 - 3.00 1.00 - 3.00
Fast food meal Day 2.50 - 6.00 2.50 - 6.00
Cigarettes (pack) Day 3.00 - 5.00 3.00 - 5.00
Lottery ticket Week 1.00 - 5.00 .14 - .71
Magazine Week 3.00 - 5.00 .43 - .71
Beer (6 pack) Week 5.00 - 8.00 .71 - 1.14
Wine/liquor (bottle) Week 8.00 - 20.00 1.14 - 2.86
Movie ticket Month 6.00 - 10.00 .20 - .33
Pizza, take-out, etc. Month 10.00 - 20.00 .33 - .67
Restaurant dinner Month 25.00 - 100.00 .83 - 3.33
Impulse buy Month 25.00 - 100.00 .83 - 3.33
Write the TOTAL you spend per day, on average: $
An Advantage Calculator
PULL

PULL

Paycheck Power®
BOOSTER®
Calculator

Where to Find the Money You Need

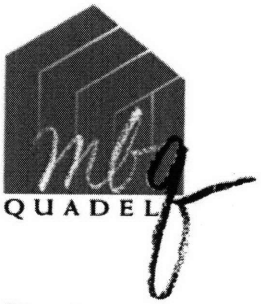
— SIDE 2 —

Add Up the Money!

SPENDING $4.00 **LESS a DAY***
will add up to this much in:

1 week	30 days	1 year	5 years	10 years	20 years
$28.00	$120	$1,460	$7,304	$14,608	$29,220

*on average



231 E. Baltimore Street
Suite 400
Baltimore, MD 21202
Phone: (410) 223 - 2222
Fax: (410) 752 - 3770

An Advantage Calculator

PULL

Appendix E: Recommendations with Associated Benefits and Costs

This table presents recommended actions for assisted housing mobility programs. It indicates the magnitude of benefit, using a scale of one to three, as well as the type and magnitude of cost (low, moderate, high), for each action. Cost types include financial outlays, time investments, or threats to relationships with clients (inappropriately personal questions, for example).

Intervention	Benefit	Cost (Type)	Cost
Orientation and intake			
Openly present to clients health implications of opportunity moves at Housing Choice Voucher briefings of other orientation sessions.	+ +	Staff time	Low
Add optional health-related questions to intake forms to help counselors understand families' needs (e.g., do you need help locating a new dentist?). Add room for health-related answers to the goals sections of intake forms (e.g., add a checkbox under "goals" for reducing asthma symptoms or losing weight).	+ + +	Trust	Moderate
Life skills and readiness			
Revise housekeeping workshops and materials to be consistent and mutually reinforcing with public health guidance. Special emphasis could be placed on indoor allergens and asthma, proper use of household chemicals, and pest management. Ideally, advice could be customized according to health information disclosed on intake forms.	+ +	Financial (one-time)	Moderate

Revise budgeting workshops and materials to mutually reinforce public health guidance. Emphasize free outdoor recreational opportunities and the financial benefits of reducing unhealthy food and drink options. Ideally, advice could be customized according to health information disclosed on intake forms.	+ +	Trust; financial (one-time)	Moderate; moderate
Connect families to other appropriate, healthful in-house services. Refer families to services outside the organization if needed;	+ + +	Trust; staff time	High; high
<u>Housing search assistance</u>			
Strive to locate housing in healthful neighborhoods, which may require considering outdoor air quality, recreational infrastructure, access to food, and other factors.	+ + +	Staff time; financial	High; high
Consider individual health needs when providing search assistance (e.g., does this family need to live near a dialysis clinic?);	+ +	Staff time	High
Direct families towards healthful housing units, when possible, or educate clients about how to spot healthful housing for their own needs (e.g., supply advice that carpeting is thought to exacerbate asthma symptoms);	+ +	Staff time; financial (one-time)	Moderate; low
<u>Pre-move support</u>			
Outline with clients the medical services each family member is currently using. Help form plans to replace these services or anticipate travel back to old providers;	+ + +	Trust; staff time	High; high
Ensure families know how to transfer their public benefits across jurisdictions	+ + +	Staff time	Moderate

Ensure families know how to transfer their public benefits across jurisdictions successfully;	+ + +	Staff time	Moderate
Empower families to take part in their own medical case management. Supply tools that help clients collect and organize records so they are easily transferred to new providers	+	Staff time	Low
Help parents identify the new healthful resources in the new community they plan to enjoy. Discuss resources for kids, including the most basic – a safe neighborhood environment – and implications for restructuring play time (e.g., away from the TV and into the yard or park);	+ +	Staff time	High
Compile information on health care services available in opportunity areas;	+	Staff time; financial	High (one-time) with low-cost maintenance
Be conscious of health when designing community tours (e.g., highlight healthful resources such as grocery stores and parks);	+	Staff time	Low
<u>Post-move support</u>			
Check that public benefits have transferred properly;	+ + +	Staff time	Low to high
Encourage the formation of healthful social ties by helping families make connections in new areas (e.g., neighbor to neighbor dinners or accompanying clients to community meetings);	+ +	Trust; staff time	Low; high

Help parents introduce schools to health issues affecting their children;	+ +	Trust; staff time	Moderate; high
Help parents set aspirational but realistic expectations for schools and health outcomes;	+ +	Staff time	Moderate
Provide an avenue through which clients can report changes to their health so counselors can make referrals, if needed (e.g., depression, loneliness, discovery of new pollen allergies).	+ +	Trust	Moderate