

*Permanent Supportive Housing in the City of Atlanta:  
Transitioning to a Comprehensive Housing First  
Approach*

*Ashley Bozarth  
Applied Research Paper  
Spring 2017  
Advisor: Dan Immergluck*

*Thank you to the many individuals dedicated to reducing homelessness in Atlanta, who took the time to speak with me and share their perspectives about supportive housing and Housing First. Thank you also to Professor Dan Immergluck for his support throughout this process and for his own passion and investment in building stronger affordable housing policy in Atlanta. Thank you to George Chidi of Central Atlanta Progress who introduced the Housing First model to me.*

# Abstract

Empirical evidence demonstrates that permanent supportive housing (PSH) with a “Housing First” (HF) approach results in higher rates of housing stability for chronically homeless populations, compared to the use of emergency shelters and transitional housing with sobriety and service requirements. The Housing First model prioritizes low-barrier permanent supportive housing with wraparound services for chronically homeless individuals regardless of disabilities, substance abuse disorders, or histories of eviction or criminal activity. In 2009, the federal government fully embraced the HF model by prioritizing homeless assistance funding for Housing First permanent supportive housing projects through the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH). In 2013, the City of Atlanta approved formation of a nonprofit, Partners for HOME, to oversee Atlanta’s continuum of care (CoC) for homeless services. Partners for HOME is currently working with other homeless service stakeholders to create a coordinated entry system and apply the Housing First model across supportive housing programs in Atlanta. Qualitative data gathered from interviews with PSH providers and other CoC stakeholders is used to evaluate the transition process.

The first part of the research paper defines chronic homelessness and explains the evolution and effectiveness of Housing First methods to reduce chronic homelessness. Next, the evolution of the federal government’s support of HF is described. In the second part of the paper, a brief history and current landscape of permanent supportive housing and Housing First in Atlanta are presented. Based on qualitative interview data and case studies from other CoCs in the United States, the research synthesizes current challenges in adapting an effective and comprehensive Housing First approach, including: (1) Implementing a comprehensive yet flexible coordinated entry system; (2) Obtaining Housing First buy-in from PSH stakeholders; (3) Aligning housing and services to the HF model; and (4) Supporting a balanced approach to expanding HF-PSH in Atlanta. These challenges inform recommendations for the City of Atlanta CoC, the Atlanta Housing Authority, State of Georgia stakeholders, and local PSH providers.

## Executive Summary

This paper focuses on Atlanta's transition to a comprehensive Housing First approach for permanent supportive housing (HF-PSH) providers to offer stability as they house chronically homeless individuals who have mental health illnesses, physical disabilities and/or substance abuse disorders.

Housing First is not only a philosophy that states that everyone has a fundamental right to housing without barriers and should be able to choose how and where they are housed, but also an evidence-based practice. Since the late 1990s, studies have revealed that stable, permanent housing with integrated wraparound services results in longer-term housing stability for the chronically homeless. Evidence also confirmed that HS-PSH programs result in lower rates of substance usage, emergency services, hospitalization, and jail-time for previously homeless individuals. Housing First emerged as an alternative to the traditional linear approach of initial emergency sheltering and intermediate transitional housing (TH), which require sobriety and treatment interventions. Core principles of the Housing First model include: prioritization based on vulnerability; client choice; low-barrier entry to permanent housing; community-based, mobile support services; and harm reduction case management.

The federal government officially adopted Housing First policies in the 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, which (1) prioritized homeless service funding for permanent supportive housing programs that employ Housing First principles, (2) required local continua of care (CoC) to establish a "coordinated entry" system that would prioritize housing for the highest-need populations; and (3) tweaked the definition of "chronic homelessness" to mean someone with a disabling condition who has been continuously homeless for one year or more or who has experienced four or more episodes of homelessness within the past three years.

Atlanta's comprehensive homeless policy started afresh in 2013 when the Tri-Jurisdiction CoC, comprised of the City of Atlanta, Dekalb County and Fulton County, broke apart and a new Atlanta Continuum of Care was formed. The City of Atlanta approved a new nonprofit called Partners for HOME to manage the Atlanta CoC. This

marked a major transition towards a comprehensive Housing First approach around homeless services in Atlanta, a city whose homeless policy traditionally depended on individual providers with different rules for and expectations of the people they served. Stakeholders in Atlanta determined that a nonprofit would improve transparency and accountability and be the best way to bring together the numerous and fragmented homeless service agencies, public-private partnerships, and funding streams. Since its formation, Partners for HOME has launched a pilot coordinated entry process and worked with HUD CoC-funded providers to align their housing and service policies to the Housing First model.

Discussions with PSH providers and other Atlanta CoC stakeholders brought to light certain challenges, and in turn, recommendations associated with creating a comprehensive city-wide HF policy:

1. Implementing a comprehensive yet flexible coordinated entry system
2. Obtaining Housing First buy-in from PSH providers
3. Aligning housing and services to the HF model
4. Supporting a balanced approach to expanding HF-PSH

First, while providers that receive HUD-CoC funding are required to participate in Atlanta's new coordinated entry system, there are currently hundreds of permanent supportive housing units subsidized through other funding streams that do not participate in coordinated entry. In addition, while coordinated entry prioritizes and houses those considered the "hardest to house," it makes it more difficult for those who qualify for PSH but who are relatively less vulnerable based on the scoring system, including young adults and people with criminal histories. Recommendations include:

- The Atlanta Housing Authority and the City of Atlanta should work with Partners for HOME to require that supportive housing providers funded through Section 8 Project-Based Rental Assistance (PBRA) and Housing Opportunities for Persons with AIDs (HOPWA) participate in the coordinated entry (CE) system. This would reduce duplication of client intake and provide housing in a streamlined process.
- There should be a distinct vulnerability assessment and designated assessment points for adolescents and young adults.
- Partners for HOME should conduct a "gap analysis" of the vulnerability assessment tool and adjust it (with HUD approval) to ensure housing for gap populations, including those with criminal histories.

Second, providers that receive funds from sources other than HUD CoC subsidies are not currently required to follow Housing First principles and often have

preconditions to housing, sobriety requirements, and required services. In parallel to participation in coordinated entry, PSH providers have no incentive to change the way they house tenants and deliver services unless policymakers who control funding distribution align their policies to the HF model. Recommendations include:

- The City of Atlanta should dedicate specific points to HF principles on the HOPWA application to align with points in the HUD CoC application.
- The Atlanta Housing Authority should adjust their corporate policies to a Housing First model by eliminating barriers to housing for those with drug-related evictions, as well as those who are active users. In addition, there should be no risk of eviction if tenants fail to comply with their service plans, unless they are a threat to others or have damaged the property.
- Once AHA and HOPWA policies are aligned to HF principles, the Atlanta CoC could work with providers to restructure their programs to stay in compliance. If organizations choose to maintain non-HF strategies, subsidy dollars would be reallocated towards HF-oriented providers. This process would happen over several years to give providers enough time to restructure or locate other funding.

Third, for the Housing First model to be truly effective, housing and service management must be aligned in order to provide an individual with the resources needed to achieve housing stability. While the physical home offers a safe and private place to be, wraparound services address the root cause of why an individual was homeless in the first place. If clients do not have access to appropriate services, the burden falls on the housing operators who may have no ability to affect such services. Seamless collaboration between housing and service provision is contingent upon aligning Housing First policies, accessing adequate funding, and building upon existing partnerships and programs. Recommendations include:

- PSH providers and Partners for HOME should continue working towards creating a streamlined lease agreement, incorporating standard HF policies.
- Partners for HOME should partner with the Atlanta Real Estate Collaborative “Open Doors” program to search for and locate one-bedroom or efficiency apartments to replace current two-bedroom master-lease units.
- Partners for HOME and/or the Department of Community Affairs should offer ongoing harm reduction training sessions and check-ins with housing and service providers as they transition to Housing First standards.
- Partners for HOME should work with DBHDD to curtail the possibility of changing to a “fee for service” payment structure for service providers, since this is not complementary to the Housing First model.
- Partners for HOME should work with the Atlanta Housing Authority to convert current Shelter Plus Care units and new PSH units to TBRA or PBRA Section 8 units and use restructured HUD funding towards service funding for integrated care teams.

Fourth, expanding PSH in the City of Atlanta is crucial, given the gap between the need for supportive housing and housing availability. In January and February of 2017 alone, 96 people were assessed and deemed chronically homeless and eligible for PSH. The turnover at most PSH properties is so low (a few each week at best) that the waiting list for PSH will only continue to grow. The City of Atlanta must comprehensively invest in expanding PSH through new developments, as well as master-lease and scattered-site units managed by housing and service providers held accountable to the same Housing First expectations. Complementary city and statewide policies are necessary to meet this objective. Recommendations include:

- The Department of Community Affairs should reinstate the supportive housing program and apply HOME funds, State Housing Trust funds, and others to fund new PSH development.
- In the next funding cycle, the Department of Community Affairs should allow small Low Income Housing Tax Credit (LIHTC) projects (~50 units or fewer) to include 100% supportive units so that it is feasible and attractive for developers to build more of this housing stock.
- To incentivize less concentrated development of PSH units, the City of Atlanta should enact mandatory inclusionary zoning policies that require supportive housing set-asides for luxury developments, especially in northern Atlanta where there is currently a paucity of supportive housing units.
- City of Atlanta council members should not support the proposed “Industrial Mixed Use District” in its current state, as it would create more barriers to future supportive housing development.
- The \$25 million offered by the City of Atlanta in the *Home Stretch* plan should come from discrete funding sources, modeled after other local funding sources such as the Seattle property tax levy, the New York luxury housing tax, or the Dade County food and beverage tax.
- Service providers should be provided with funding through the City of Atlanta to continue working with Atlanta Housing Authority FLOW voucher recipients in the case that more intensive case management is needed in the future.
- The Atlanta CoC and AHA should continue to build upon their relationship with the Atlanta Real Estate Collaborative’s Open Doors program and play a role in expanding the pilot rent guarantee program that will provide funding to landlords in the case of eviction or property damage.

Recommendations for the City of Atlanta CoC, the Atlanta Housing Authority, State of Georgia agencies, and PSH providers offer opportunities to build and strengthen new and existing policies and programs to reduce chronic homelessness. The answer could and should be: Housing First.

## Table of Contents

Abbreviations.....	9
Part One: Background of Chronic Homelessness, Housing First, and Federal Policy ....	11-18
Chronic Homelessness .....	11
The Housing First Model.....	12
Federal Support of the Housing First Model .....	16
Part Two: Policy in Atlanta.....	18-23
History of PSH and HF Policy in Atlanta .....	18
Transition to a Comprehensive HF Policy in Atlanta.....	20
Continuum of Care Transition.....	20
Provider-Specific Transition .....	23
Part Three: Challenges.....	24-43
1. Implementing a Comprehensive yet Flexible Coordinated Entry System.....	24
2. Obtaining Housing First Buy-in from PSH Stakeholders .....	27
3. Aligning Housing and Services to the HF Model.....	29
4. Supporting a Balanced Approach to Expanding HF-PSH .....	34
State of Georgia Policy .....	35
City of Atlanta Policy .....	38
Part Four: Opportunities.....	44-46
1. Implementing a Comprehensive yet Flexible Coordinated Entry System.....	44
2. Obtaining Housing First Buy-in from PSH Stakeholders .....	44
3. Aligning Housing and Services to the HF Model.....	45
4. Supporting a Balanced Approach to Expanding HF-PSH .....	45
Part Five: Conclusion .....	47-48
References.....	49
Personal Communication Sources.....	52
Appendix A: Determinants and Costs of Chronic Homelessness .....	54
Appendix B: HUD Definition of “Chronically Homeless” .....	56
Appendix C: Housing First—An Evidence-Based Approach.....	57
Appendix D: Single-Site, Scattered-Site, and Master-Lease Clusters.....	58
Appendix E: HF Prioritization in CoC Funding Applications .....	59
Appendix F: Recent History of PSH and HF Policies in Atlanta .....	60
Appendix G: List of Permanent Supportive Housing in Atlanta .....	62

## Abbreviations

**ACT:** Assertive Community Treatment (*Part of the original Housing First model. Teams include addiction and employment counselors, psychiatrists, nurses, and peer support specialists with a maximum 10-to-1 ratio of clients to service provider.*)

**AHAR:** Annual Homeless Assessment Report (*Prepared by HUD for Congress based on local point-in-time counts.*)

**AREC:** Atlanta Real Estate Collaborative (*Group of private individuals with real estate expertise; Created the “Open Doors” program that connects homeless housing providers with property owners in metro Atlanta who have offered a certain number of units for subsidized rent.*)

**CE:** Coordinated Entry (*A system whereby homeless individuals are referred to a central point to be evaluated using a HUD-approved vulnerability assessment tool, assigned a number, and then housed in order of vulnerability.*)

**CoC:** Continuum of Care (*In 1995, HUD mandated that communities submit a streamlined application for homeless service funding. In response, communities developed local Continua of Care to manage local homeless services and the HUD grant application process.*)

**DCA:** Department of Community Affairs (*Georgia agency that manages homeless supportive housing funding through HOPWA, Section 811 PRA Demonstration Program and the legacy Shelter Plus Care program.*)

**DESC:** Downtown Emergency Service Center (*Nonprofit-run HF-PSH program in Seattle, Washington.*)

**DBHDD:** Department of Behavioral Health and Developmental Disabilities (*Georgia agency that manages the Georgia Housing Voucher Program.*)

**FQHC:** Federally Qualified Health Center (*Provides care to homeless individuals through grant support from the Community Health Center program and/or the Health Care for the Homeless Program. Homeless individuals can receive health care services with or without income or benefits.*)

**GHVP:** Georgia Housing Voucher Program (*Provides rental assistance and bridge funding for people with severe and persistent mental illnesses and who are chronically homeless, leaving a state psychiatric hospital, in and out of jail or prison, or frequent users of emergency rooms. Administered by DBHDD and established in 2011 as a response to the Olmstead Settlement Agreement.*)

**HEARTH:** Homeless Emergency Assistance and Rapid Transition to Housing Act (*2009 update of the McKinney-Vento Homeless Assistance Act with changes including an update to HUD's definition of chronic homelessness.*)

**HF:** Housing First (*A philosophy and evidence-based approach to homeless services that everyone is “housing ready” and should be offered immediate permanent supportive housing without barriers to entry or service requirements once housed.*)

**HOPWA:** Housing Opportunities for Persons with AIDs (*HUD-funded program to provide housing assistance and supportive services for low-income people with HIV/AIDs and their families*)

**HUD:** United States Department of Housing and Urban Development

**NAEH:** National Alliance to End Homelessness (*United States-based partnership among public, private, and nonprofit organizations.*)

**PATH teams:** Projects for Assistance in Transition from Homelessness teams (*Street outreach teams funded by SAMHSA that conduct screening and diagnostic treatment, and substance abuse treatment, and refer clients to primary healthcare, job training, educational services, and housing. In Atlanta, PATH teams assist with the VI-SPDAT assessment or refer homeless individuals to the Gateway Center to be assessed.*)

**PBRA:** Project-based rental assistance (*Section 8 program through HUD involving contracts at multifamily rental properties for set-aside units for low-income families.*)

**PIT:** Point-In-Time (*Counts of sheltered and unsheltered homeless individuals on a single night in January. HUD requires local CoCs to conduct count each year to be eligible for ongoing funding.*)

**PSH:** Permanent supportive housing (*Long-term housing with wraparound services.*)

**RRH:** Rapid re-housing (*HUD program that allocates temporary housing and service funding to house homeless families.*)

**SAMHSA:** Substance Abuse and Mental Health Services Administration (*A federal agency within the U.S. Department of Health and Human Services charged with promoting behavioral health and reducing the impact of substance abuse and mental illness.*)

**TBRA:** Tenant-based rental assistance (*Section 8 program through HUD, whereby individuals receive vouchers to live in an apartment of their choice—contingent upon property owner approval—at a subsidized rate.*)

**USICH:** United States Interagency Council on Homelessness (*An independent federal agency within the executive branch, which is advised by a council comprised of heads of 19 federal agencies.*)

**VI-SPDAT:** Vulnerability Index and Special Prioritization Decision Assistance Tool (*Combination of two of the most commonly used tools by CoCs across the United States for vulnerability assessment and prioritization in coordinated entry programs.*)

# Part One: Background of Chronic Homelessness, Housing First, and Federal Policy

## Chronic Homelessness

In January 2016, point-in-time (PIT) counts around the country showed that 549,928 people were homeless on a given night.<sup>1</sup> Because there are many causes for and costs of homelessness, homeless people require individualized paths to housing to ensure long-term housing stability<sup>2</sup>. The majority of homeless individuals and families become and remain homeless for a few days or weeks often due to economic reasons before being re-housed through formal and informal networks of support. Chronically homeless adults, on the other hand, experience long-term homelessness with limited access to support services (Padgett et al., 2016). A 2015 Department of Housing and Urban Development (HUD) ruling updated the definition of a *chronically homeless individual* as an adult with a disabling condition, who has been continuously homeless for one year or more or who has experienced four or more episodes of homelessness within the prior three years (HUD, 2015).<sup>3</sup> This group includes an intersectionality of subpopulations including young adults, seniors, veterans, people with HIV/AIDs, LGBT individuals, etc. **This paper will focus on housing approaches specifically for chronically homeless adults with disabilities (physical, mental health, and/or substance abuse disorders).**

Figure 1 shows that 77,486 individuals in the United States were chronically homeless, a 25% drop in chronic homelessness since 2011. Despite this reduction, chronic homelessness remains to be 14% of total homelessness in the United States (HUD, 2016a). In addition, over two-thirds of chronically homeless individuals in 2016 were unsheltered, compared to about one-third of the total homeless population. The chronically homeless are more apt to live on the streets without access to services and

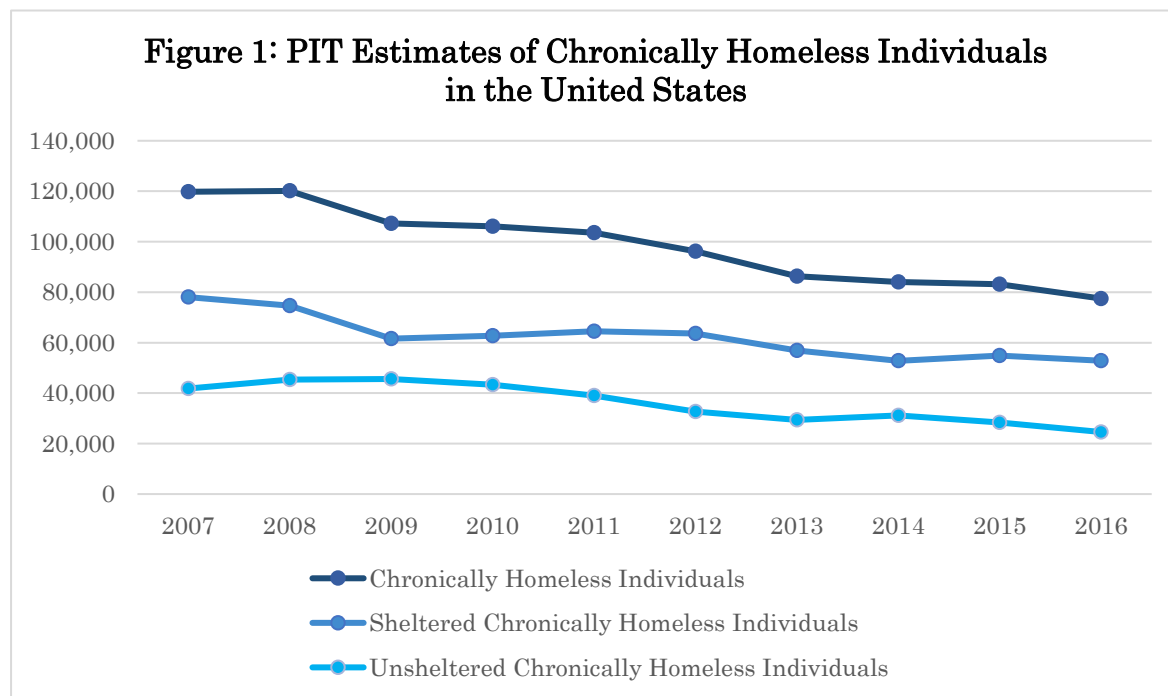
---

<sup>1</sup> The PIT count is the most comprehensive tool to quantify homelessness and is carried out in January when people are more likely to stay in shelters rather than on the streets. However, this is a static measurement system and most likely underestimates the total amount of homelessness at different points throughout in the year. It is also does not account for people who may be staying with family or friends, but who are technically homeless as well.

<sup>2</sup> See Appendix A for discussion of determinants and costs of homelessness.

<sup>3</sup> See Appendix B for HUD's complete updated definition, as well as the McKinney-Vento Homeless Assistance Act definition of a homeless person with a disability.

temporary shelter because they (by definition) have at least one disability and are much less likely to find stable housing on their own. The following section will describe the Housing First permanent supportive housing model (HF-PSH), which is both a philosophy and an evidence-based approach proven to generate higher rates of long-term housing stability among chronically homeless populations.

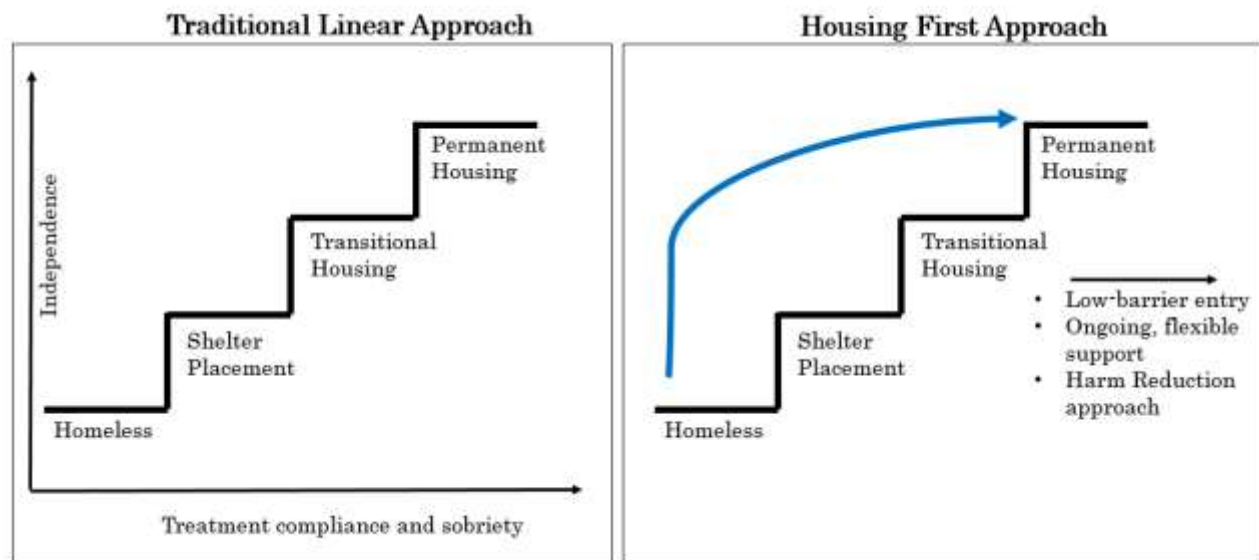


*Source: Recreated by author from (HUD, 2016a)*

## The Housing First Model

The Housing First (HF) approach means prioritizing permanent supportive housing for the highest-need populations with the notion that everyone is “housing ready” regardless of disabilities, substance abuse issues, or history of housing, financial or criminal problems. Housing First emerged in the 1990s as an alternative to the traditional linear approach of initial emergency sheltering and intermediate transitional housing (TH), which often require sobriety and treatment interventions (USICH, 2015).

**Figure 2: Traditional versus Housing First Approach to Homeless Housing**



*Source: Recreated by author from (Padgett et al., 2016)*

Housing First includes two program models. Housing First rapid re-housing (RRH) programs are broader in scope, used for a wide array of homeless individuals and families. These programs provide move-in and short-term rental assistance, as well as case management services until such time that the household is self-sufficient and stably housed. **This paper focuses on the second model: permanent supportive housing programs that target chronically homeless people with mental health illnesses, physical disabilities and/or substance abuse disorders and provide permanent rental assistance and wraparound support services (NAEH, 2016).**

Besides being a philosophy that everyone has a fundamental right to housing without barriers and should be able to choose how and where they are housed, HF is also an evidence-based practice. Since the late 1990s, studies have revealed that stable, permanent housing with integrated wraparound services results in longer-term housing stability for the chronically homeless. Evidence also confirmed that HF-PSH programs result in lower rates of substance usage, emergency services, hospitalization, and jail-time for previously homeless individuals. These public savings equal or exceed the cost of housing (Culthane et al., 2002; Larimer et al., 2009; Padgett et al., 2016).<sup>4</sup>

<sup>4</sup> See Appendix C for evidence of the effectiveness of the Housing First model

In 1992, Dr. Sam Tsemberis founded Pathways to Housing, Inc. in New York City to provide Housing First permanent supportive housing to chronically homeless individuals. The original Pathways model incorporated four principles: (1) consumer choice; (2) community-based, mobile support services; (3) permanent scattered-site housing; and (4) harm reduction. The final principle generates the most controversy since it emphasizes minimizing rather than completely abstaining from drug and alcohol use. In addition to housing people without barriers to entry, supportive services are strongly encouraged and available, but tenants are not required to use such services; instead, service providers work with clients to create individualized recovery plans. In the New York Pathways model, ACT (Assertive Community Treatment) teams provide the wraparound services and include addiction and employment counselors, psychiatrists, nurses, peer support specialists, and case managers on call 24/7 for emergency services. Team members collaborate to track clients' progress, with a maximum 10-to-1 ratio of clients to service providers (Padgett et al., 2016).

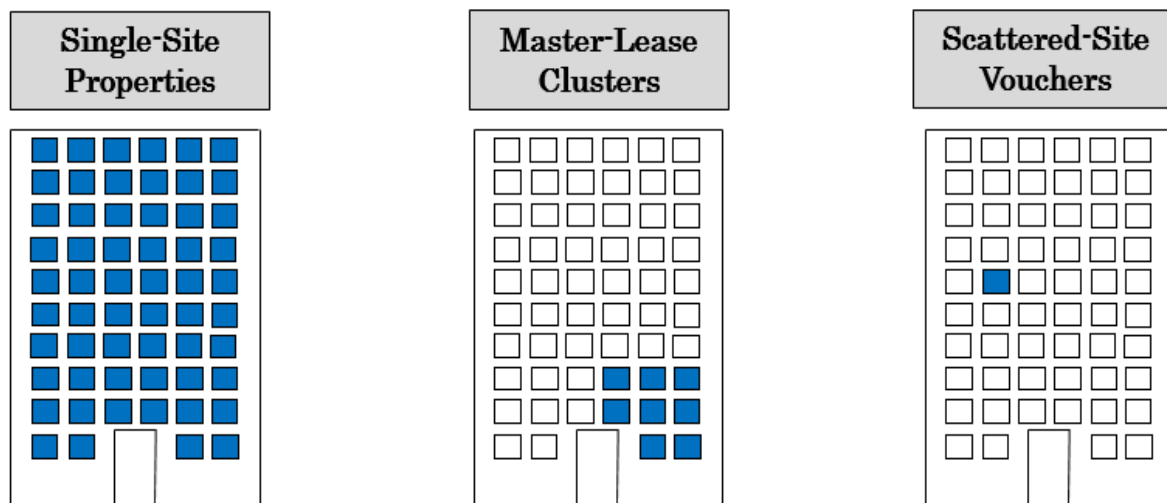
The HF model has been applied throughout the U.S. and beyond, but deviates from the original principles in two ways. First, in many other PSH programs around the country, ACT teams work with only the highest-need individuals. Standard PSH services include at a minimum on-site case management and sometimes on-site clinical services. Many programs with limited service funding refer clients to federal qualified health centers (FQHCs) for mental health and physical care, such as Mercy Care in Atlanta.

Second, many reputable organizations that operate Housing First PSH programs also house people within single-site buildings, meaning the provider owns the building and 100% of the units are supportive housing (also known as congregate housing). Some PSH providers also master lease a certain number of units with a specialized agreement with the property owner that these will be maintained as low-barrier supportive units. The residents pay rent (30% of income) to the PSH provider who pays rent directly to the property owner. Both of these models differ from Pathways' original scattered-site principle, where tenants receive rental subsidy vouchers and choose where they want to live contingent upon the property owners' acceptance. Each PSH

property type, displayed in Figure 3, can be a good fit for certain individuals, depending on their varying needs and *choices*, another key principle of Housing First.<sup>5</sup>

Whether scattered-site, master-lease clusters, or single-site, evidence of individual and community benefits are strong enough to make the case that HF-PSH programs offer a more effective way to stably house chronically homeless people compared to facilities with preconditions to entry and service requirements. At this point in time, the biggest opposition to HF programs stems from a moral argument about whether sobriety and treatment compliance should be required in exchange for receiving permanent housing. Since a significant portion of homeless assistance traditionally comes from faith-based programs, zero-tolerance policies remain common in localities throughout the United States. In addition, many case managers are trained for and accustomed to twelve-step sobriety programs, rather than harm reduction practices. As local CoCs reorganize to create comprehensive Housing First approaches due to the federal requirements discussed subsequently, organizations will have to shift towards the HF model or risk losing crucial funding.

**Figure 3: Three Options for Supportive Housing Design**



*Source: Created by author*

<sup>5</sup> See Appendix D for a discussion comparing single-site, master-lease and scattered-site housing design.

## Federal Support of the Housing First Model

The United States Congress and the Department of Housing and Urban Development (HUD) have invested in permanent supportive housing programs since the 1987 McKinney-Vento Homeless Assistance Act. This legislation was a response to the growing rate of homelessness around the United States and was the first federal legislation to allocate funding for state and local homeless assistance programs. Due to the flood of grant applications from individual providers throughout the country, in 1995 HUD began to require that communities submit one application for McKinney-Vento Homeless grants as a way to streamline the funding application process. In response, communities developed local Continua of Care (CoC) to manage local homeless services and the HUD grant application process.

It was not until the early 2000s, however, that federal support and funding prioritization shifted specifically towards Housing First PSH due to increased attention on the issue of chronic homelessness and the mounting evidence that HF programs provide housing stability for such populations (Pearson et al., 2007). In 2002, George W. Bush appointed Philip Mangano as head of the U.S. Interagency Council on Homelessness (USICH). Under his leadership, widespread promotion of the HF approach resulted in bipartisan support and allocation of \$35 million to reduce chronic homelessness across the United States, including the creation of HF programs in 11 cities (Padgett et al., 2016).

In 2009, the federal government fully embraced the HF model by prioritizing homeless assistance funding for HF-PSH programs through the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, an update to McKinney-Vento. In parallel to this addendum, the 2010 USICH *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* set an ambitious goal of ending chronic homelessness by 2015. By 2014, chronic homelessness had decreased by 21%, and *Opening Doors* was amended to reflect progress and extend the zero percent chronically homeless goal to 2017 (USICH, 2015).

Three noteworthy amendments in HEARTH will be described below, which prioritize HF-PSH and affect policy of local continua of care.

- (1) *HEARTH consolidated three HUD-administered homeless assistance programs into the Continuum of Care program (CoC)* (U.S.C. 11360(9), 2009), now the largest

federal homeless assistance program.<sup>6</sup> In 2016, approximately \$1.9 billion CoC funds were available for program competition allocation to local governments. The budget goals included 25,000 new units of permanent supportive housing (USICH, 2016). HUD awards local CoCs funding contingent upon *Opening Doors* Housing First goals, including engaging with landlords and property owners to identify potential PSH units, removing barriers to entry such as sobriety or poor credit history, and adopting client-centered service methods (HUD, 2016c).

Annual CoC applications must include a list of renewal projects and new projects, the latter of which can be created only by bonus funding or reallocation of funds for permanent supportive housing or rapid rehousing projects. The project list must be ranked by priority and separated into two tiers; Tier I projects will almost certainly receive HUD funding, while only higher ranked CoCs will receive funding for Tier II projects. HUD prioritizes funding first to renewal PSH and RRH (rapid re-housing) projects and then to new PSH and RRH projects. Funding for transitional housing comes after and has become much more difficult to access, reflecting HUD's prioritization of permanent housing programs.

To be eligible for new project or renewal funding from HUD's Continuum of Care funds, providers must illustrate how they employ or will employ the Housing First approach. Housing First principles represent 24 out of 115 total points granted on the application. Other point categories include applicant experience, quality of proposed project, services, population and performance measures, budget and financial plans, program monitoring, and overall quality of application (HUD, 2016c).<sup>7</sup>

- (2) *HEARTH mandated that communities funded through the CoC use a HUD-approved standardized "coordinated entry" (CE) tool that tracks length of homelessness and level of vulnerability in order to prioritize housing for the highest-need chronically homeless (HUD, 2016b).* HUD does not require use of one particular tool, just that the tool is valid, reliable, inclusive, user-friendly, transparent, and Housing-First oriented (HUD, 2015). The mostly commonly used

---

<sup>6</sup> The three consolidated programs are the Supportive Housing program, the Shelter Plus Care program, and the Moderate Rehabilitation/Single Room Occupancy program.

<sup>7</sup> See Appendix E for a discussion on how the CoC application distributes points based on the HF model.

tool, the VI-SPDAT, distributes up to 17 points (more points meaning more vulnerable). Clients must receive at least 10 points to qualify for permanent supportive housing. Questions for single adults cover history of housing and homelessness, risks, socialization and daily functions, and wellness.

- (3) *HEARTH updated the definition of Chronic Homelessness (see Appendix B), the need for which was motivated by a 2011 HUD study documenting that one third of permanent supportive housing was used for short-term homeless populations.* HUD wanted to prioritize the limited available PSH according to vulnerability and length of homelessness, in line with the federal goal of ending chronic homelessness. The new definition guarantees that individuals who experience short breaks of homelessness (90 days or fewer) in shelters or in institutions but meet all other definition criteria are still considered chronically homeless (HUD, 2016c).

## Part Two: Policy in Atlanta

### History of PSH and HF Policy in Atlanta

The federal HEARTH act meant many CoCs and the HUD-funded PSH providers within such CoCs around the United States would have to restructure how they operate in order to continue receiving HUD Continuum of Care funding. This restructuring would occur at varying levels based on the system already in place in each locality. For instance, some PSH providers within CoCs already were implementing Housing First principles and had to make only minor operational adjustments to ensure compliance. In addition, some CoCs were already using a coordinated entry system and just needed to tweak parts of the system to fulfill HEARTH requirements.

This was not the case in Atlanta, which had neither a coordinated entry system, nor a comprehensive way to hold providers accountable to Housing First techniques. In fact, the city's comprehensive homeless policy started afresh in 2013 when the Tri-Jurisdiction CoC, comprised of the City of Atlanta, Dekalb County and Fulton County, broke apart and a new Atlanta Continuum of Care was formed. The City of Atlanta approved a new nonprofit called Partners for HOME to manage Atlanta's CoC. After examining how to reform the CoCs based on HEARTH mandates, stakeholders in Atlanta determined that a nonprofit would improve transparency and accountability

and be the best way to manage the many public-private partnerships, funding streams, and homeless service agencies around Atlanta.

Prior to the formation of the new CoC, the city's attempts to expand PSH were rather sporadic and without a comprehensive policy through which providers could be held accountable to the Housing First model. At the time of a 2014 study, there were over 100 programs providing emergency shelter, transitional housing and PSH with varying missions and entrance criteria. Around half of homeless service funding stemmed from small contributions averaging \$100,000 from private providers (City of Atlanta Innovation Delivery Team, 2014). Existing PSH providers received referrals from a wide variety of sources: emergency shelters, transitional housing providers, PATH (Projects for Assistance in Transition from Homelessness) teams, case management teams, hospitals, jails, etc. PSH providers could choose which clients to accept into housing. Some agencies might turn away those with more severe mental illnesses or with histories of criminal activity and evictions, while other agencies might accept the most vulnerable populations. While picking and choosing the clients most apt to succeed in housing ensures higher success rates, this method does not conform to the principles of Housing First. PSH providers could also instill certain rules (such as sobriety or service requirements) that tenants had to follow to remain housed.

Starting in the early 2000s, there was increasing attention given to PSH in Mayor Shirley Franklin's *Blueprint to End Homelessness in Atlanta in Ten Years* plan, which suggested a 'Supportive Housing Production Task Force,' as well as building 65 additional PSH units. Soon after the *Blueprint*, the city established a Homeless Opportunity Fund and used an existing rental car tax to raise \$22 million in grant funding used to leverage other private funding to develop 437 permanent supportive housing units throughout Atlanta. The Atlanta Housing Authority (AHA) invested in homeless housing for the first time and provided project-based rental assistance (PBRA) supportive housing vouchers for the newly-developed units.

It was not until 2012, however, that Housing First was recognized as an effective evidence-based approach to reducing chronic homelessness as part of Mayor Kasim Reed's 2012 *Unsheltered No More* collective impact strategy. Since then, around 1,000 chronically homeless individuals (mainly veterans) have been housed thanks in part to HUD-VASH vouchers provided by AHA. In line with the Mayor's plan, the newly-

formed Atlanta CoC and its managing arm, Partners for HOME, is now tasked with building a comprehensive Housing First strategy to end homelessness.<sup>8</sup>

## Transition to a Comprehensive HF Policy in Atlanta

HEARTH Act requirements necessitate operational changes for the continuum of care as a whole, as well for individual PSH housing and service providers.

### Continuum of Care Transition

For the CoC as a whole, HEARTH mandates that all local continua of care use a Coordinated Entry system to ensure housing prioritization for the most vulnerable chronically homeless clients. In 2013, Atlanta's *Unsheltered No More* team carried out the City's first comprehensive Homeless Registry to count and assess 637 homeless people in a single night (City of Atlanta Innovation Delivery Team, 2014). Partners for HOME was able to build upon this list when it launched a pilot coordinated entry process, with the help of Atlanta's Regional Commission on Homelessness.

Currently, five PATH teams including Mercy Care, Community Friendship, Inc., HOPE, Community Advanced Practice Nurses, and CaringWorks conduct street outreach and either assess clients directly or refer clients to the Gateway Center, where two case managers conduct the vulnerability assessments using the VI-SPDAT tool. Gateway will soon employ a navigator who will help people prepare for housing once a vacancy opens. Homeless people can also call the United Way 2-1-1 service number to access the coordinated entry system. The clients' rankings based on the VI-SPDAT determine the order in which they are offered housing. There is typically a two- to three-month lag between a referral and housing availability and even more for people with lower vulnerability scores.

All PSH providers who receive HUD CoC grants (Shelter Plus Care and Supportive Housing funding) must participate in the coordinated entry system.<sup>9</sup> Each week, providers report vacancies and then receive referrals through the coordinated entry system. Clients arrive at the housing site to fill out the provider-specific housing

---

<sup>8</sup> See Appendix F for more details about the history of permanent supportive housing and Housing First policies in Atlanta since the early 2000s.

<sup>9</sup> HUD-funded Rapid Re-Housing providers must also participate in coordinated entry, but will not be discussed in this research.

application and providers explain the rent payment process, rules, and services offered when living there. Potential clients choose if this housing is a good fit for them and accept an apartment or not. When the coordinated entry process began in Atlanta, all HUD-funded PSH providers received Housing First and harm reduction training. Partners for HOME and PSH providers continue to meet once a month to discuss funding and the evolving process. For the providers who do participate in coordinated entry, the process has become much more efficient. One PSH program director shared,

*“We no longer have to... recruit and we know that individuals coming over already qualify. All we have to do is the intake. Before, I’d get calls from everywhere and I would have to spend time pre-screening over the phone and then we’d have to figure out how to get them connected to case management and documentation. [CE] really helps on the front end.”*

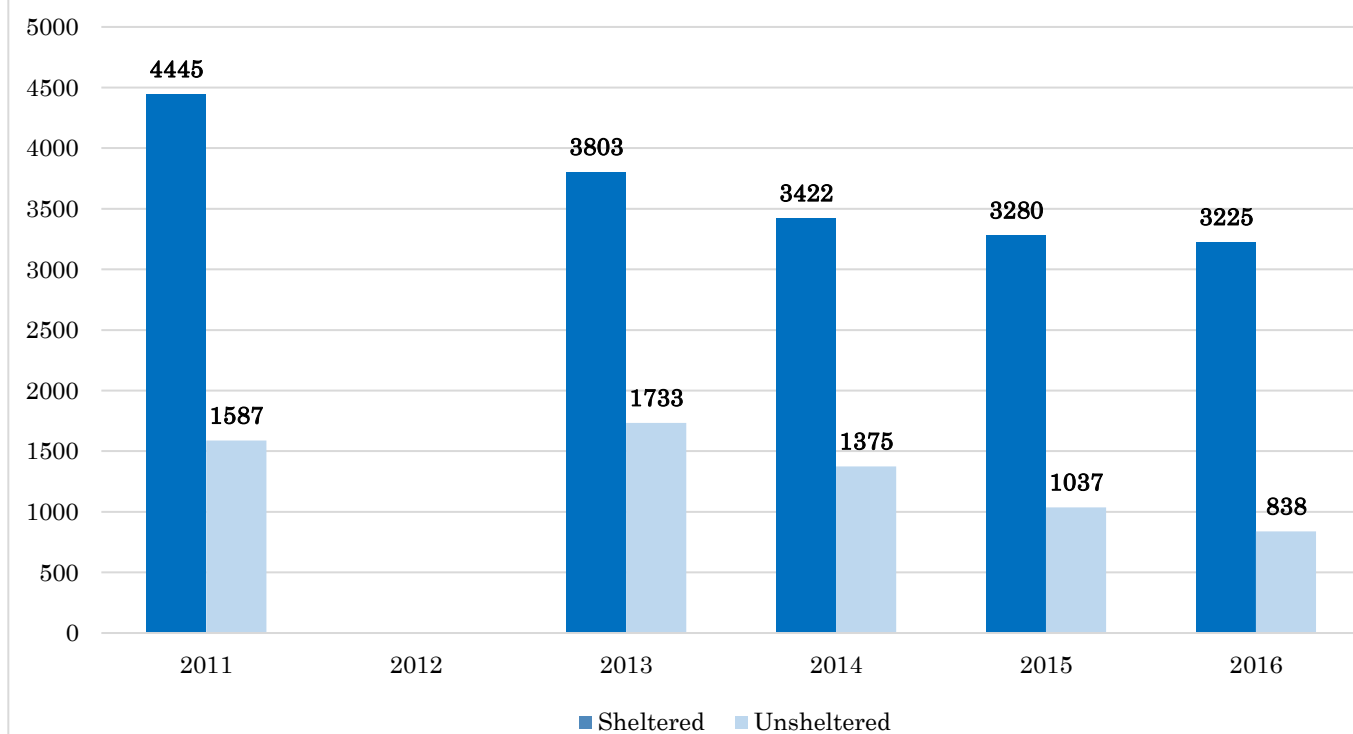
In addition to increasing efficiency of the housing referral process, Partners for HOME attributes the major drop in chronic homelessness to the new coordinated entry program, in addition to the City’s focus on housing homeless veterans (Partners for HOME, 2016). Since the initial homeless registry and the establishment of Partners for HOME in 2013, the total number of homeless individuals in Atlanta has declined by over a quarter (5,536 to 4,063), as seen in Figure 4. Figure 5 shows that chronic homelessness has fallen by as much as 75% since 2011 and 61% since 2013.

Notably, these reductions are likely exaggerated since PIT counts occur only once per year, miss individuals who are in hidden locations and sleeping with friends or relatives, and rely on volunteers who may not have experience searching and interacting with homeless populations.<sup>10</sup> In addition, in 2016, the homeless population was 86% black or African American, an overwhelming proportion given that only 52% of Atlanta’s population is black or African American (Partners for HOME, 2016a; United States Census Bureau, 2015). Despite limitations and ongoing challenges of the PIT however, there has without a doubt been some significant decline in chronic homelessness since 2011.

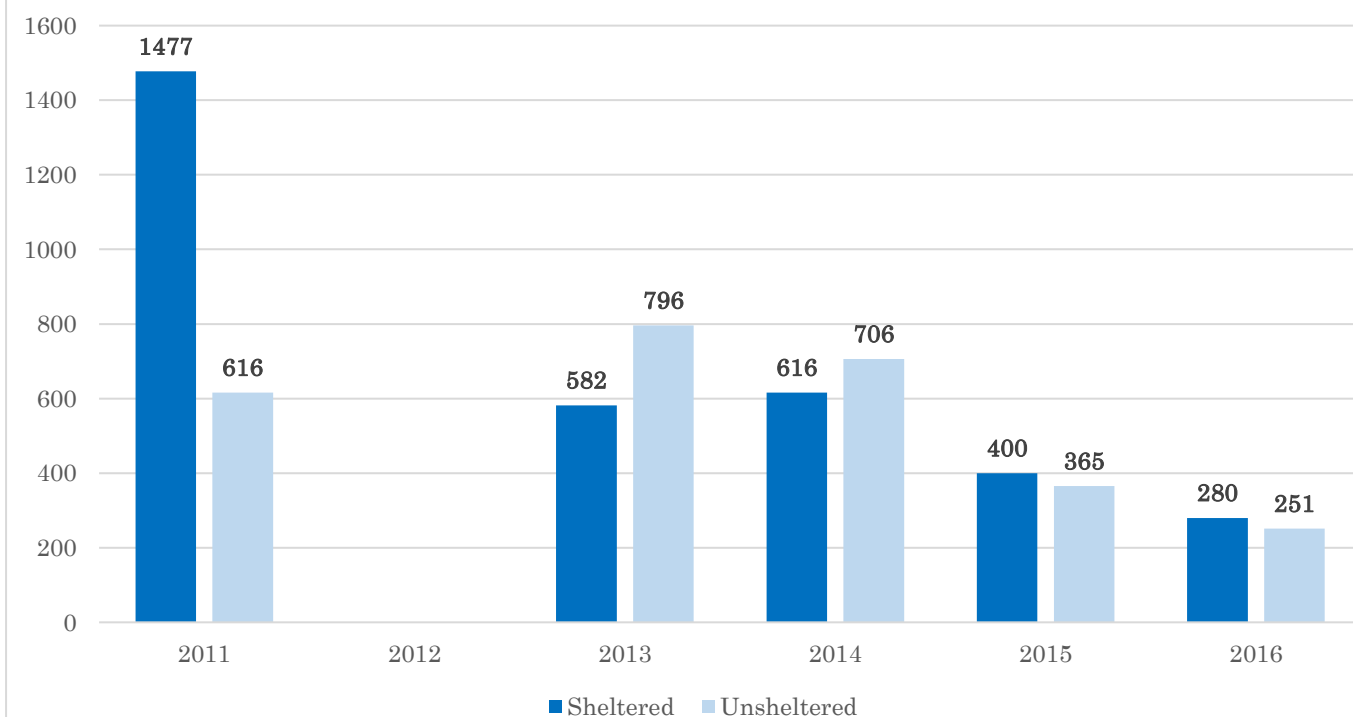
---

<sup>10</sup> A City of Atlanta 2015 report indicates that while the 2013 PIT count reported over 5,500 homeless people and over 1,300 chronically homeless, on an annual basis, 16,000 people are homeless, 4,000-4,200 of whom are chronically homeless (City of Atlanta, 2015). The annualized count is projected based on multipliers, or turnover rates, calculated using length of homelessness reported by homeless survey respondents, percent of respondents indicating each length, and minimum turnover rate for each length category (Parker, 2013).

**Figure 4: PIT Counts of Total Homeless Individuals in Atlanta\***



**Figure 5: PIT Counts of Chronically Homeless Individuals in Atlanta\***



*Source: Recreated by author from (Partners for HOME, 2016c)*

\*Note: No point-in-time count conducted in 2012

### **Provider-Specific Transition**

On the provider-specific level, all HUD-funded PSH providers have had to transition the way they operate to varying degrees to comply with HF policies. New tenants are apt to have more severe mental illnesses and/or substance abuse disorders. Case managers have to find creative strategies *to encourage rather than require* tenants to accept services. Applying a harm reduction approach to support clients who can keep using drugs and alcohol at their own discretion can be very difficult for case managers who are accustomed to twelve-step programs with abstinence requirements.

Appendix G lists all PSH providers who currently receive HUD Continuum of Care dollars, participate in coordinated entry and are in the process of adapting Housing First policies. Currently, there are 422 HUD COC-funded units dedicated to coordinated entry managed by 13 providers. This includes two young adult supportive housing providers (target ages ranging from 17 to 24). These organizations participate in coordinated entry, but also receive referrals primarily from other organizations, such as the juvenile justice system, mental health systems, and the Department of Family and Children's Services (DEFACS).

Appendix G also lists other providers and programs that do not currently participate in coordinated entry, and who are not required to follow the HF approach. There are at least 20 project-based providers, as well as three tenant-based voucher programs that provide PSH in the City of Atlanta. There are also long-term transitional housing units, managed by providers with variety of funding streams and housing approaches.

## Part Three: Challenges

Discussions with PSH providers and other Atlanta CoC stakeholders brought to light certain challenges associated with creating a comprehensive city-wide HF policy:

1. Implementing a comprehensive yet flexible coordinated entry system
2. Obtaining Housing First buy-in from PSH Providers
3. Aligning housing and services to the HF model
4. Supporting a balanced approach to expanding HF-PSH

These issues will be evaluated to inform recommendations for the Atlanta Continuum of Care, the City of Atlanta, the Atlanta Housing Authority, State of Georgia agencies, and local PSH providers.

### 1. Implementing a Comprehensive yet Flexible Coordinated Entry System

Partners for HOME's first challenge associated with implementing a coordinated entry (CE) system is working with permanent supportive housing providers to participate even if they do not depend on HUD CoC funding. Figure 6 indicates the ideal coordinated entry system, while Figure 7 reveals the current and rather fragmented referral system. There are currently hundreds of permanent supportive housing units for both single adults and families that do not participate in coordinated entry. The majority of these units are subsidized by either Section 8 PBRA distributed by the Atlanta Housing Authority (AHA) or from Housing Opportunities for Persons with AIDS (HOPWA) grants distributed by the City of Atlanta. AHA Section 8 PSH providers (e.g., the Imperial Hotel managed by National Church Ministries) do not have their own centralized referral system. Rather, each provider has its own individual waiting lists and referral systems. HOPWA PSH providers (e.g., Jerusalem House) receive referrals primarily from The Living Room, the centralized intake agency serving homeless individuals with HIV/AIDs. The Living Room receives referrals from the CoC's coordinated entry system (with which they voluntarily participate), but also from many other sources.

Figure 6: Planned Coordinated Entry System in Atlanta

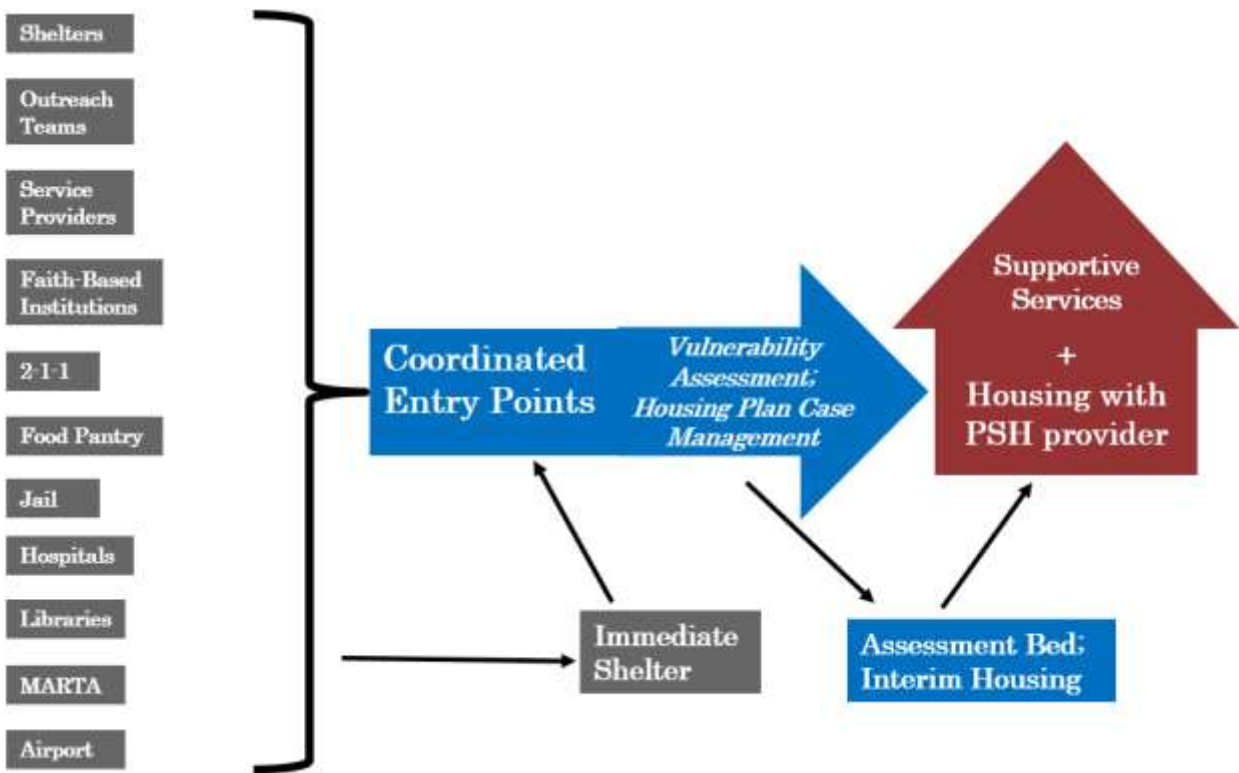
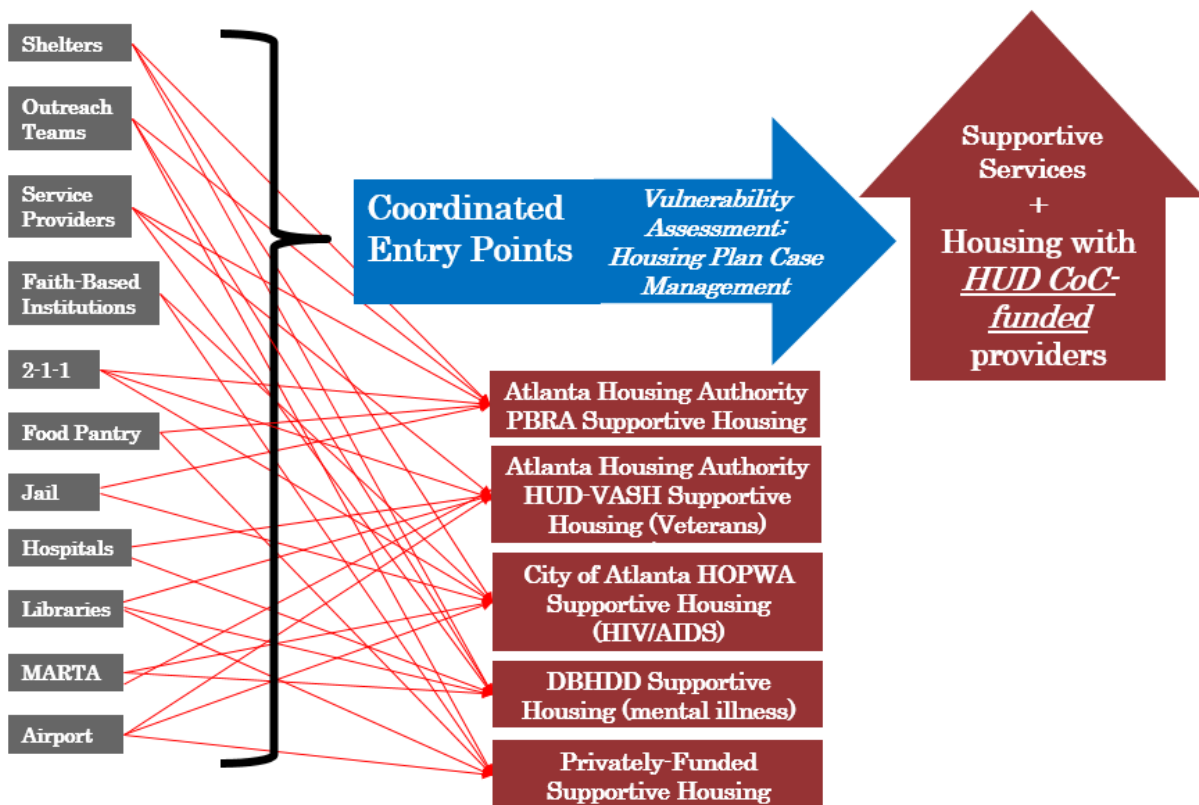


Figure 7: Current Coordinated Entry System in Atlanta



Source: Designed by author based on graphic created by Partners for HOME

To ensure that the most vulnerable individuals are housed first, AHA and HOPWA providers should participate in coordinated entry. Since providers have no incentive to do so on their own, the Atlanta Housing Authority and the City of Atlanta must require participation of their grantees. Many of the AHA- and HOPWA-funded providers cater to specific subpopulations (e.g. HIV/AIDS clients, young adults, seniors, single parents, veterans, etc.). Participating in coordinated entry does not mean that providers would have to change the subpopulation they serve; it would mean only that they would have to serve those ranked most vulnerable within that subpopulation. For example, Adamsville Green Senior Apartments would continue to house seniors with disabilities, but would fill future vacancies based on the CE ranking system for people that fit into that category.

As the CE system in Atlanta evolves, the process should vary based on the subpopulation. While coordinated entry prioritizes and houses those considered the “hardest to house,” it makes it more difficult for those who qualify for PSH but who are relatively less vulnerable. The highest vulnerability score in the VI-SPDAT is 17, and for someone who has a less severe disability and scores closer to 10 (10 or higher qualifies for PSH), the chances of receiving PSH are rather low given the slow turnover of units and limited capacity to expand PSH in Atlanta. In other words, by prioritizing certain individuals based on pre-determined vulnerability criteria, other populations are consequently deprioritized for housing.

For instance, young adults often do not fit the HUD definition of chronically homeless since they may come out of long-term care through DEFACS or the juvenile justice system. They should be ranked using a different vulnerability assessment system so they don’t continuously get bumped behind on the waiting lists. Young adult-serving agencies typically use a “long-term transitional housing” approach, where the goal is for youth to move out after a couple of years and live self-sufficiently. While these agencies technically do not align perfectly with permanent supportive housing, flexibility should be the norm due to the subpopulations they serve, which have different needs. As more funding is obtained for coordinated entry, Partners for HOME should also consider hiring more assessors who are accustomed to working with young people and at locations where young people feel comfortable and safe spending time (HUD, 2015).

In addition, the VI-SPDAT does not give a point for having a felony or other criminal history, thereby deprioritizing ex-offenders who already have more difficulty finding housing and jobs on their own because of actions for which they already served time. One stakeholder in the Atlanta coordinated entry system explained,

*“Felonies are a reason some people are chronically homeless because they can’t get a job and they can’t get housing. Sometimes an employer will be lenient and they can get a job, but not housing. Even after 10 years, housing agencies still look at that.”*

While the VI-SPDAT is the most commonly-used assessment tool, HUD does not endorse any one tool and supports any tools that are valid, reliable, inclusive, person-centered, user friendly, strength-based, transparent, sensitive to lived experiences, and have a Housing First orientation (HUD, 2015). Until recently for example, a PSH provider, Downtown Emergency Service Center (DESC) in Seattle, used a “Vulnerability Assessment Tool” (VAT) created and modified over time by DESC. A 2015 evaluation by the Canadian Housing First Assessment Taskforce rated DESC’s VAT as the best “brief screening tool available that can assist with prioritization of clients for Housing First programs” (Aubry et al., 2015). The VAT was so effective that it was adopted by the local Continuum of Care in 2006 to create a coordinated entry system. Since the 2012 HUD mandate that CoCs use a coordinated entry system for all PSH units, the Seattle CoC decided to transition to the widely-used VI-SPDAT tool. Stakeholders at DESC argue that the VI-SPDAT is much less comprehensive. The local CoC has since identified several weaknesses of VI-SPDAT and added components from the VAT (King, 2016). Like Seattle, the Atlanta CoC has the flexibility to adjust the tool and give points for criminal history and other characteristics that increase barriers to housing.

## **2. Obtaining Housing First Buy-in from PSH Stakeholders**

If AHA- and HOPWA-funded providers begin participating in coordinated entry, they will no longer be able to choose whom they serve and cannot enforce sobriety or other behavioral requirements. It is likely they will receive individuals who are still using, have a history of evictions or certain criminal activity, and/or require more intensive services. It is therefore critical that existing and future coordinated entry

participants have buy-in to Housing First and receive ongoing support transitioning to this model.

Providers that receive funds from sources other than HUD CoC subsidies are not currently required to follow Housing First principles and often have preconditions to housing, sobriety requirements, and required services. In parallel to participation in coordinated entry, PSH providers have no incentive to change the way they house tenants and deliver services. As aforementioned, the majority of supportive housing in Atlanta not funded by HUD CoC subsidies are funded through either Atlanta Housing Authority Section 8 PBRA or City of Atlanta HOPWA dollars. Transition to an HF approach requires that AHA and the City of Atlanta add more stringent HF requirements for funding distribution. While the HOPWA program highly encourages the adoption of the HF approach, funding applications do not dedicate specific points to HF principles as does the HUD CoC application (see Appendix E). Partners for HOME should work with the City of Atlanta to align the HOPWA's HF requirements with those of the CoC.

The Atlanta Housing Authority also has the opportunity to work with the Atlanta CoC not only by requiring its supportive housing properties participate in coordinated entry, but also by modifying their supportive housing policies to include a Housing First approach. According to current AHA policies, supportive housing providers can:

*“...deny admission or terminate PBRA assistance to a Supportive Housing Participant if it is determined that such Supportive Housing Participant A. Has been evicted from federally assisted housing for drug related criminal activity within the three year period preceding application” [or] B. Is currently engaging in the illegal use of drugs” (Atlanta Housing Authority, 2016, p. 57).*

Furthermore, each tenant must have a written Service Plan created by the Service Provider. According to AHA policy,

*“In the event that a Supportive Housing Participant voluntarily withdraws from the care of the Service Provider or fails to comply with the terms and conditions of the Service Plan which results in the participant's removal from the Service Provider's care, the rental assistance for such Supportive Housing Participant shall terminate and shall not be transferable” (Atlanta Housing Authority, 2016, p. 58).*

These mandates contradict the HF principles of client choice and harm reduction. In addition, it is also unclear if all of the AHA supportive housing is actually permanent. For instance, one property receives AHA PBRA dollars, but offers only temporary supportive housing for males.

When the Houston/Harris County Continuum of Care began implementing its comprehensive Housing First strategies and expanding PSH, the Houston and Harris County Housing Authorities stepped up to work with the CoC not only to offer housing vouchers, but also to apply the same HF strategies. Doing so involved changing certain policies such as requiring background checks before housing clients. Thanks to the alignment of the housing authority and CoC policies, providers across the region are held accountable to the same standards (Thibaudeau, 2017). While the Atlanta Housing Authority has taken on a significant role in ending homelessness in Atlanta, working to realign their policies to fit the CoC's Housing First model would facilitate a more comprehensive strategy across the city. This is especially true given the case that AHA has more flexibility due to its Moving to Work Agreement with HUD, which allows it to “establish special admissions criteria and preferences for special initiatives and other related housing arrangements in order to address urgent local needs, such as homelessness” (Partners for HOME, 2016b).

Once policies are aligned, the CoC and AHA could work with providers to restructure their programs to a Housing First approach. Some providers might prefer to maintain non-HF strategies such as sobriety requirements. If this is the case, subsidy dollars should not be renewed for those agencies and should be reallocated towards HF-oriented providers. This process would happen over several years to give providers enough time to restructure or locate other funding. The Houston/Harris County CoC and Housing Authority's work to restructure and reallocate dollars has been a key component in establishing standardized expectations in the region (Thibaudeau, 2017).

### **3. Aligning Housing and Services to the HF Model**

On the 2016 CoC application, the Atlanta CoC stated that 100% of [HUD-funded] PSH providers have adopted a Housing First approach, meaning “the project quickly houses clients without preconditions or service participation requirements” (Partners for HOME, 2016b, p.56). On paper, HUD-funded provider policies have

shifted to the Housing First model if they were not already doing so. In reality, this transition will take complex program restructuring over a longer period of time since receiving the “hardest to house” tenants through coordinated entry generates new challenges. As one PSH provider explained,

*“Housing First works best with **strong, effective case managers**. Housing First prevents providers from evicting people for using drugs or alcohol or not taking medication. All you are doing is encouraging, educating and reminding them.”*

Another provider shared that some tenants move in and do not even unpack their bags for three months. Some have grown used to living on the street and may even prefer to be homeless. This point is noteworthy, as it is easy to assume that every homeless person wants to be housed, but this is not true for a variety of reasons. Some people have had negative experiences in shelters, jails or institutions; some suffer from mental illnesses; some would rather stay on the street and use drugs; some receive SSI benefits and can stretch their income further without paying rent; and for some, the streets are simply just another form of home. Whatever the reason, once a new tenant chooses to move in to a PSH unit, it is up to the provider to work with the client not only to help the client stay housed, but to assist the client to *want* to stay housed. It is essential that housing and service providers receive the support they need to align their HF-oriented objectives. Challenges to do so vary based on the PSH providers’ housing and service strategies.

If the providing agency owns the property with 100% PSH units, then the property management is inherently aligned with the agency’s mission. If, on the other hand, the PSH organization master leases units, then it has no control over property management that may become increasingly hesitant to accept higher-need populations coming through coordinated entry. One PSH provider stated,

*“The CoC is very concerned with individuals not returning back to homelessness. With that, what they don’t appear to understand is that when [we] house individuals, we have to maintain relationships with landlords. You can’t have people going and tearing up places and turning apartments into crack houses. That is happening. Not a lot, but it is. Then you go back to the landlord with a voucher...they say, ‘Oh no.’ So I have to build those relationships. The biggest benefit for the property managers is that they receive constant rent for a certain number of apartments per month and the*

*people get case management. But then you have one or two bad apples. With a lot of these properties, older populations are living there, and they don't understand these programs. So we have to work with them, because any day we could receive a letter that says, 'Hey, we are not renewing your lease.'"*

PSH providers mitigate the risk of non-renewal by creating supportive services agreements with landlords who pledge to adhere to the Fair Housing Act, not use punitive measures with tenants, and not treat PSH tenants differently. Currently, all PSH providers have different lease agreements, whether they own the property or master lease units. The CoC is working on generating a streamlined application to ensure that all providers follow the same Housing First requirements.

While the traditional PSH housing structure is an efficiency or one-bedroom apartment, some of the PSH providers in Atlanta master lease two-bedroom units to house two single adults. Though some individuals may benefit from the peer support, some placed through coordinated entry may not be used to sharing spaces. Speaking of the increasing difficulty of shared apartments, one PSH provider stated,

*"With shared living, you have two people at different levels of recovery. One doesn't care...the other one is trying real hard. And it puts a huge burden on me and my staff. Our mission is to house people in decent, safe, and sanitary housing. If you got a roommate that is breaking things and kicking in doors, it's not safe."*

While it is more difficult to find a cluster of one-bedroom apartments in Atlanta, Partners for HOME should work with providers to locate and transition the majority of master-lease units to one-bedroom or efficiency apartments to give tenants more privacy, independence and stability as they adjust to long-term housing.

Other challenges arise depending on whether the PSH provider offers in-house case management services or if it contracts out to a separate provider. In the latter case, housing providers must ensure that the hired case managers are applying harm reduction techniques and not mandating compliance to services plans. In one PSH organization that contracts out case management, the property manager explained that the service provider has been so accustomed to a twelve-step model that it is hard for the agency to understand and accept Housing First. Further, because AHA does not mandate the HF approach to services, the case managers who work at properties with

both HUD-funded and AHA PBRA units do not follow uniform expectations. A PSH provider explained,

*“...if AHA comes on board and PBRA units have to follow similar requirements, it will be a bigger picture for [the service providers] and may be easier to deal with if they have to do [Housing First] for everyone.”*

In addition to uniform requirements, case managers have indicated that service providers would benefit from ongoing harm reduction training sessions and check-ins as they attempt to apply Housing First standards to their practices.

Many service providers receive funding from the Georgia Department of Behavioral Health and Development Disabilities (DBHDD). For some time now, DBHDD has considered changing to a “fee for service” model where service providers would receive payments based on the time spent with each client. Currently, service contractors receive one constant payment based on number of clients served in a given period. PSH providers worry that “fee for service” contradicts the Housing First model. If case managers opt out of services, then providers will not be paid for these “unused” hours. Fee for service also adds a lot of administrative work that puts an extra burden on smaller agencies to stretch their already limited resources. One PSH provider feared that if DBHDD adds fee for service, *“a lot of agencies may fall by the wayside.”*

Finally, the biggest issue of all is the lack of dollars available to provide sufficient services to clients. One PSH provider describes that,

*“HUD took a model that worked in New York City, a city with an abundance of homeless assistance resources, and tried to apply it everywhere around the country. The main objective of HF is to bring housing and services together, but the system is more fragmented than ever. If clients do not receive appropriate services, housing providers have more challenges to keeping tenants stably housed. [Our site] has been trying to obtain on-site services for the past 20 years, but still only has one case manager for around 12 hours per week.”*

HUD Shelter Plus Care dollars used to come with service dollars attached, but now are provided only for rental subsidies and require a local match for services. Medicaid and HRSA Health Center grants provide other federal funding opportunities for services, but are limited, especially in states that have not expanded their Medicaid programs. In these states, one of which is Georgia, single individuals under 65 without dependent children, who do not have SSI or SSDI or for whom substance abuse disorders are

considered the determinant of their disability, are ineligible for Medicaid programs (Post, 2008).

Service funding in Atlanta stems from the aforementioned DBHDD, as well as United Way and private donations. Some providers truly struggle to access even the minimal local funding. One newer PSH provider in Atlanta was promised service dollars through the City of Atlanta, but it never came to fruition. This organization relies on fundraising money from a different state to pay for the minimal case management for its tenants.

Most PSH providers in Atlanta have enough funding to provide one case manager per 20 to 30 clients who sees each client once or twice per month—not always enough care for formerly chronically homeless populations. CaringWorks stands out from other PSH providers as a core Medicaid provider that offers internal mental health services without having to refer clients elsewhere. Most PSH organizations do not have in-house services beyond case management and refer clients to Mercy Care, Atlanta’s Federally Qualified Health Center, or to Grady Hospital for clinical and primary health care services. Resources are so limited at these institutions that clinical services often translate to meeting with a psychiatrist once every three months to refill a prescription.

Lack of service dollars makes it more difficult to maximize rental subsidy funding. HUD prefers that PSH providers “overserve” the CoC dollars for rental subsidies, meaning stretching the grant towards more units than were technically allocated. One provider expressed frustration that while he could negotiate and receive lower rent and utility bills, the extra money could not be applied to leasing additional PSH units since there were inadequate service dollars to cover the new units. If providers end up with unused rental subsidy money, they have to send money back to HUD for “over performance” and potentially lose future grants.

The Atlanta CoC must look to other CoCs around the country to find more creative ways to access and preserve adequate service dollars for existing and future PSH units. In Houston and Harris County, providers previously relied on Shelter Plus Care dollars for rental subsidies. As the CoC was reorganizing to expand PSH, it non-renewed every unit with Shelter Plus Care dollars and transferred all of those units to Harris County/Houston Authority Housing Choice vouchers. The CoC also discovered

that HUD allows localities to apply for new project supportive housing funding and ask for only *supportive services* rather than rental subsidies contingent upon the local public housing authority agreeing to provide PBRA or TBRA rental dollars. Because the Houston and Harris County Housing Authorities agreed to provide the rental subsidies, the CoC now receives adequate service funding from the HUD CoC without having to rely heavily on state or local service dollars. Beyond case managers, these service dollars also pay for integrated care teams comprised of nurse practitioners, psychiatrists, community health workers, and peer specialists to work with clients across multiple PSH sites (Thibaudeau, 2017).

This example demonstrates how the partnership between the Atlanta Housing Authority and the Atlanta CoC might evolve if AHA provides more vouchers for existing and future PSH units. This would allow the CoC to restructure funding towards comprehensive care and alleviate the stress of securing funding from various fragmented sources. It would also provide dollars for more intensive and integrated care teams that could serve the tenants on site.

For instance, additional service funding could be used towards a mobile health care clinic (potentially in partnership with Mercy Care) that travels among PSH sites every few weeks to serve clients. In 2015, the Cleveland/Cuyahoga County HOUSING<sup>first</sup> project launched a “Health Care Mobile Clinic” that began circulation among the Housing First PSH buildings to provide primary health care services. A stakeholder of the Ohio program stated, “This is the last piece that’s been missing to provide wraparound care. It’s removing barriers to health care, such as public transportation, and increasing access.” The mobile clinic was funded through a \$478,000 grant from the Housing Investment Fund (HIF) distributed by the Ohio Housing Finance Agency (Washington, 2015).

#### 4. Supporting a Balanced Approach to Expanding HF-PSH

Varying approaches to PSH strategies across the country have spurred a debate about whether scattered-site vouchers versus single-site (congregate) properties offer more effective supportive housing opportunities.<sup>11</sup> While single-site properties offer higher capacity to expand and more efficient service provision, scattered-site units give

---

<sup>11</sup> See Appendix D for further discussion about this debate.

tenants the choice to live wherever they want, contingent upon acceptance by the property owner. Both master-lease and scattered-site options offer freedom to live among a mix of neighbors and escape the stigma of living only among individuals with mental illness and/or substance abuse disorders. Single-site, master-lease, and scattered-site units are beneficial in different ways to different individuals, and in an ideal world, there would be an endless supply of all housing types for clients to choose the best fit. In Atlanta and all around the country, however, there remains a critical lack of PSH and a continuous population of homeless individuals. Until the chronic homeless population is effectively zero, the priority should not be on choosing one type of PSH design over another, but rather on Housing First, which can fit into the single-site, scattered-site and master-lease cluster PSH models. Thus, policies that promote and maintain a balance of all three types will ensure both client choice and the capacity to preserve and expand PSH units.

### **State of Georgia Policy**

Consistent with the present federal HUD policy, State of Georgia policy currently favors scattered-site and master-lease projects over single-site construction. This is unlike before when, starting in the early 2000s, the Georgia Department of Community Affairs (DCA) funded new single-site projects through a supportive housing program. Through a mixture of HOME funds and State Housing Trust Funds, around 20 new PSH projects were built, including Phoenix House and O'Hern House (owned by Project Interconnections, Inc.) and a property owned by Quest Community Development Corporation. This program has since been terminated and state policies now actively discourage new single-site (congregate) housing. DCA's 2017 Qualified Allocation Plan for Low Income Housing Tax Credits (LIHTC) states:

*“DCA identifies both integrated and congregate housing as important healthy living options for Persons with Disabilities and seeks to allow Persons with Disabilities to choose what type of housing they prefer. Historically, a majority of the Georgia housing credit resources financing supportive housing have supported congregate housing development. Therefore, DCA’s commitment to providing a full range of housing options requires focusing supportive housing resources to develop supportive housing in an integrated setting. Therefore, DCA will not fund new construction of congregate housing under this QAP” (GA DCA, 2017, p.18).*

Because of this approach, only 20% of units in a LIHTC application may be dedicated to supportive housing. This limitation deters both developers and PSH providers from applying for LIHTC funding. One affordable housing developer said a PSH provider approached her about building a new supportive housing projects, but the developer decided against it upon learning about the 20% cap. This is likely because LIHTC funding is so competitive that developers with a mission of building PSH would not bother applying if only 20% of units could actually be supportive housing, especially for smaller projects. As one developer asserted, *“If a project only has 60 units, why go through the trouble for only 12 units of PSH?”*

The emphasis on integrated housing stems from the 2010 Olmstead settlement agreement ("United States of America v. The State of Georgia," 2010), following a complaint that Georgia was in violation of Title II of the Americans with Disabilities Act in failing to provide community-based housing for individuals with disabilities. As part of the settlement, the State of Georgia agreed to provide 2,000 supportive housing beds to people with severe and persistent mental illnesses (SPMIs) and who are (1) chronically homeless, (2) leaving a state psychiatric hospital, (3) in and out of jail or prison, and/or (4) frequent users of emergency rooms. The Agreement resulted in the Georgia Housing Voucher Program (GHVP), administered by DBHDD. Over 2,500 individuals with disabilities have received permanent supportive housing throughout Georgia since 2010. Currently, there are roughly 200 GHVP units in the City of Atlanta. The GHVP vouchers, along with HUD-VASH vouchers for veterans supplied by the Atlanta Housing Authority, have significantly increased the number of scattered-site units and created more of a balance between single- and scattered-site PSH.

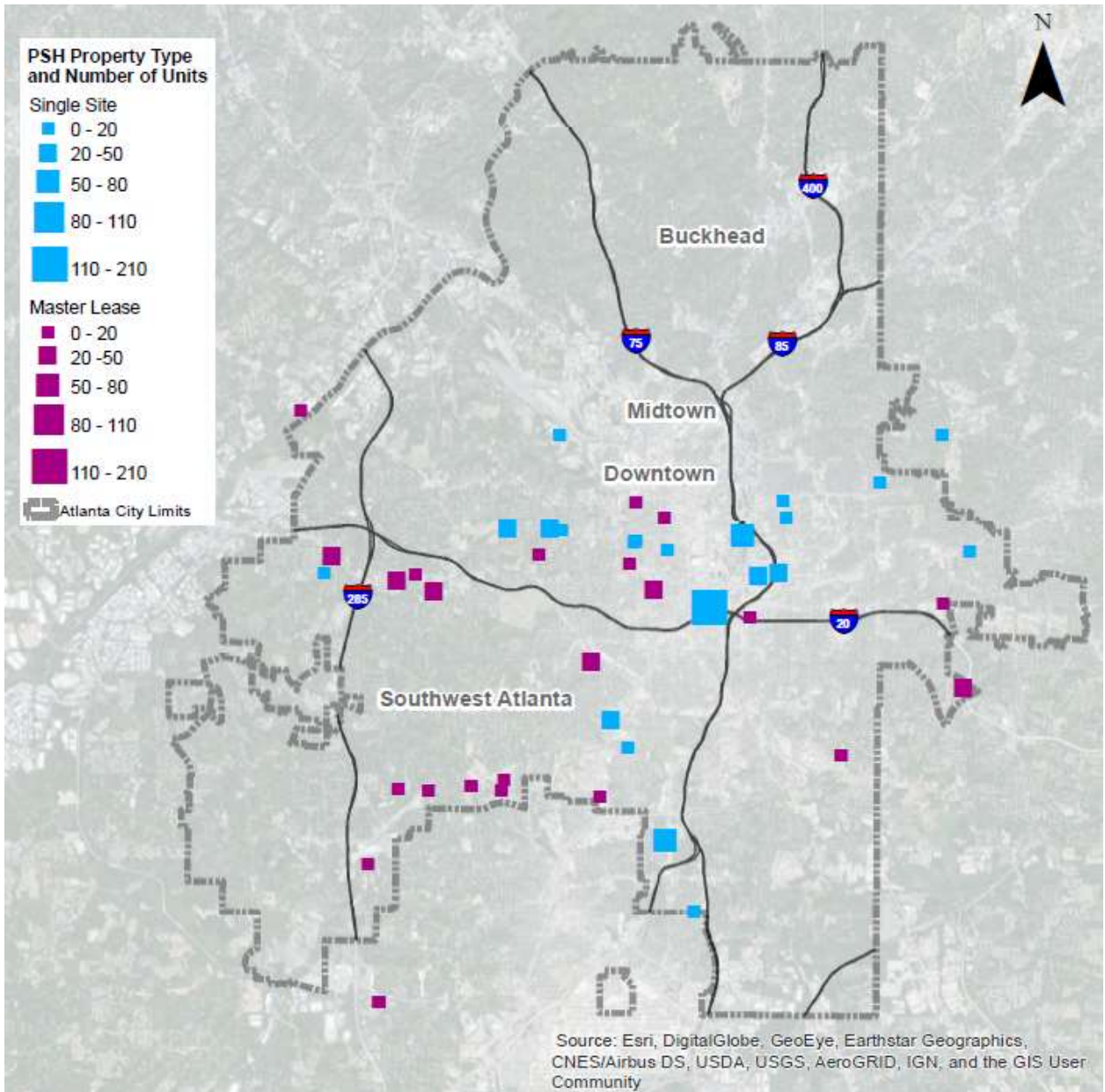
As seen in Map 1, even without accounting for GHVP and HUD-VASH vouchers, Atlanta already has a balance between single-site and master lease units.<sup>12</sup> Scattered-site units could not be mapped because individual voucher addresses were not available. When scattered-site units are accounted for in Table 1, the number of scattered-site/master-lease units is close to double that of single-site units.<sup>13</sup>

---

<sup>12</sup> Master-leased units count as scattered site if 20% or fewer units in the complex are supportive housing.

<sup>13</sup> See Appendix G for a comprehensive list of single-site, master-lease, and scattered-site PSH in Atlanta.

**Map 1: Master-Lease and Single-Site PSH Units in Atlanta by Unit Number**



*Source: Created by author based on information collected from PSH providers in Atlanta*

<b>Table 1: Count of Permanent Supportive Housing Units</b>	
Total Single-Site	878
Total Master-Lease	967
Total Scattered-Site	471
<b>Total PSH Units</b>	<b>2316</b>

If DCA truly *“identifies both integrated and congregate housing as important healthy living options for Persons with Disabilities and seeks to allow Persons with Disabilities to choose what type of housing they prefer”* then there should be funding made available for all housing types. Applying an “integrated housing only policy”—namely by ending the aforementioned supportive housing funding and by putting the 20% limitation on LIHTC developments—disrupts what is already a balanced approach.

Further, since DBHDD has met its goal established by the Olmstead settlement agreement, when the budget stabilizes, no new GHVP vouchers will be administered and only unit turnover (about 200 per year) will provide new supportive housing with DBHDD state funds. A stakeholder in Atlanta worries,

*“Since the state is not building any more supportive housing, and the GA Housing Voucher program will only offer housing as a result of turnover, we are going to be back in the same place that we were before the Olmstead Settlement Agreement. If we are right that demand is for about 1,000 vouchers a year and we are down to turnover, which is 200, then after the first year, you will have 5-year wait list and after the second year, you will have a 10-year wait list.”*

Integrated housing policy should be complemented by policies that support single-site and scattered-site housing in a balanced way. Allowing the pendulum to swing to one extreme has limited statewide resources available for chronically homeless individuals and therefore restricts what should be the foundational goals of these programs: eliminating homelessness. The Department of Community Affairs should therefore reinstate competitive funding for up to 100% smaller-scale supportive housing projects. For the LIHTC application in particular, points could be allocated in a way that supports comprehensive policy in local CoCs. In Michigan’s 2015 qualified allocation plan for instance, 25% of the state’s total credit ceiling was set aside for PSH projects. Extra points were specifically given for projects serving chronically homeless individuals, for offering supportive service funding commitments, for integrating Housing First approaches, for providing extra space for services, and for engaging the local Continuum of Care (Cooperation for Supportive Housing, 2016).

### **City of Atlanta Policy**

The City of Atlanta also limits the ability to construct new PSH projects with an ordinance asserting that no supportive housing “shall be within 2,000 feet...of any

Personal Care Home, Rehabilitation Center, Shelter, or other Supportive Housing Facility” (City of Atlanta, Smith, C. and Young, I., 2009, p. 2). This rule was enacted with the intention of deconcentrating supportive housing, shelters, and other care facilities. One supportive housing developer points out,

*“[The ordinance is] legitimate. We didn’t want the law, but I understand it. You pull the lens back a little bit...you are trying to bring [lower-income] neighborhoods back and not just house homeless people. You can’t put 3-4 homeless facilities in Pittsburgh just because land is cheap. That neighborhood would stay depressed forever.”*

As revealed in Map 1 of single-site and master-lease PSH locations in Atlanta, the majority of supportive housing properties are concentrated in South Atlanta. Not one unit exists in Buckhead or Midtown.

However, the 2,000 foot ordinance does not address the root of the issue: developers are disincentivized to build or set aside affordable units in affluent areas of Atlanta since they would receive a rental subsidy that is less than they can charge for luxury apartments. This is especially the case now that the housing market has recovered from the recession, land values have increased and vacancies are low. Even if developers did attempt to build in more affluent neighborhoods, there would be a lot more pushback from nearby homeowners with ‘not in my backyard’ (NIMBY) attitudes.

Rather than creating yet more barriers to building supportive housing, city policy should encourage PSH development in areas where it does not already exist. One possibility is enacting mandatory inclusionary housing policies that require set aside units of not only affordable, but also supportive housing. Because such a policy does not exist in Atlanta, PSH developers are severely limited in where they can actually afford to build supportive housing and even more so with the 2,000 foot ordinance. One PSH operator explained that her company had capital dollars lined up to build supportive housing for veterans, but the project never came to fruition because it was too close to another care facility by a matter of feet. Another PSH project that has taken almost 10 years to plan violates the 2,000 foot ordinance; developers hope that the city will grant a variance or they will be prevented from developing the project.

A recently proposed city policy would add another barrier to supportive housing. In February of 2017, the Atlanta City Council proposed an “Industrial Mixed Use

District” to replace some areas currently zoned for industrial use (it is not yet clear what or how much land would be converted). The district’s goal is to “blend low impact industrial uses with residential and neighborhood commercial uses” (City of Atlanta, Office of Zoning and Development, 2017). While the new zoning would allow for development of single-family homes, duplexes, and multifamily dwellings, supportive housing, single-room occupancies, and rooming houses would no longer be permitted as they currently are in industrial zoned areas. This is completely contradictory to the objective of the proposal and is a blatant move to curtail supportive housing in areas ripe for development.

Just as the State of Georgia should take a balanced approach to single- and scattered-site housing, the City of Atlanta should consider policies to support a more balanced geography of supportive housing. Effective city policies to preserve and expand PSH (and affordable housing in general) are especially crucial given the imminent federal budget cuts, including up to 15% of HUD homeless funding. Atlanta should consider ways to ensure an ongoing capacity to develop new PSH properties and to generate more scattered-site vouchers. Mayor Kasim Reed announced in February of 2017 that the City of Atlanta would match up to \$25 million in private funding raised through United Way and the Regional Commission on Homelessness. The program, known as *Home Stretch*, would not only create funding to build several low-barrier shelters, but also fund new PSH units (both new construction and renovation of existing stock).

However, some stakeholders worry that *Home Stretch* funding will be taken from dollars currently earmarked for other homeless service funds. *Home Stretch* must pull from discrete funding sources to be truly effective. In the Miami metro area, for instance, the Dade County Homeless Trust’s budget is funded by a 1% food and beverage tax used to leverage federal, state and private funding (Avino, 1994). The City of Seattle recently announced a five-year property tax levy that would raise \$275 million, \$185 million of which will go towards developing PSH facilities and rental subsidies (Coleman, 2017). In the past, New York City has levied a luxury housing tax on high-end condos and apartments to subsidize affordable housing development in other neighborhoods (Uhlfelder, 2017). Taxes such as these offer methods to generate

discrete city funds and to redistribute some of the profits generated from luxury construction for the betterment of the whole community.

Another effective way to generate new PSH units without the need for new funding is to transition PSH tenants who are no longer in need of intensive supportive services to other forms of subsidized units. The Atlanta Housing Authority is working with both Partners for HOME and DBHDD to move people from PSH units to Section 8 TBRA units.

First, the Atlanta Housing Authority created “FLOW” vouchers for HUD-funded PSH tenants who no longer need intensive services and who agree to move to another non-supportive apartment of their choice. Since units are either owned or master leased by the PSH providers and therefore tied to supportive housing subsidies, FLOW recipients are required to relocate to another apartment of their choice. Some tenants have chosen to remain in the same apartment complexes. FLOW recipients continue to receive “light touch” case management by the original service provider. To date, about 150 residents have successfully moved.

In addition, AHA collaborates with DBHDD to transition Georgia Housing Voucher Program tenants to Section 8 vouchers and free up state dollars for other individuals with severe and persistent mental illnesses in need of housing. Since these units are already scattered-site, tenants do not have to move with this subsidy conversion.

Although these conversion programs generate more PSH, they are faced with various challenges, especially the FLOW program. While clients are deemed eligible to live more independently, with the FLOW voucher they are still supposed to receive light touch case management from their original PSH service providers. Abstractly, this ensures that tenants can access a minimal level of support if needed. Service providers, however, do not receive additional funding for continuing the light touch case management and therefore must stretch their already limited funding further to maintain support services for FLOW clients. Keeping in mind that many of these clients have histories of mental illness or substance abuse, if they were to relapse, service providers would not have the capacity to support them as much as needed. Case managers specifically designated for FLOW recipients should be provided to fill this potential gap in services.

Further, given the declining stock of affordable housing in Atlanta, it is more and more difficult to find replacement apartments affordable enough and where the landlord accepts Section 8 vouchers. The available choices are often apartments that are less appealing than the PSH units where many of the tenants have been living for years. Understandably, FLOW recipients are not going to choose to move somewhere less kept up, further from transit, or more unsafe. Typically, tenants with FLOW vouchers receive 30 to 60 days to find a new apartment, but many have had to request an extension to locate a suitable apartment. AHA does provide tenants with maps of potential apartment complexes, but these resources are not updated regularly, according to some FLOW clients. AHA is currently considering ways to expand Section 8 voucher boundaries outside of Atlanta to Fulton County, which would give voucher recipients more flexibility to find an acceptable replacement apartment.

AHA and Partners for HOME are also partnering with the Atlanta Real Estate Collaborative (AREC) to facilitate FLOW transitions. AREC formed in 2012 and is comprised of private landlords committed to renting units to supportive housing and rapid re-housing tenants. Open Doors, a program under AREC, matches requests for supportive units with vacant units at these participating properties.<sup>14</sup> Open Doors currently works with 24 management companies who offer approximately 21,000 units at 100 properties throughout Metro Atlanta. AREC is also currently in the process of launching a pilot rent guarantee program that would provide up to \$1,500 to landlords in the case of eviction or property damage. This risk mitigation tactic will help open to the doors (literally) to new partnerships with property owners who might have been too hesitant to sign on before.

Similar to Map 1, Map 2 reveals that Open Doors' properties in Atlanta are concentrated in the south of the city. The affordability of the units in northern Atlanta is often well above the fair market rent (FMR) upon which HUD's rental subsidy is based. AREC is trying to get these properties to set aside five or so units priced at or a little under FMR so programs can afford to place individuals there. This is challenging, however, because the little affordable housing inventory that exists in northern Atlanta is dwindling due to several factors. Properties that were bought at low prices during the

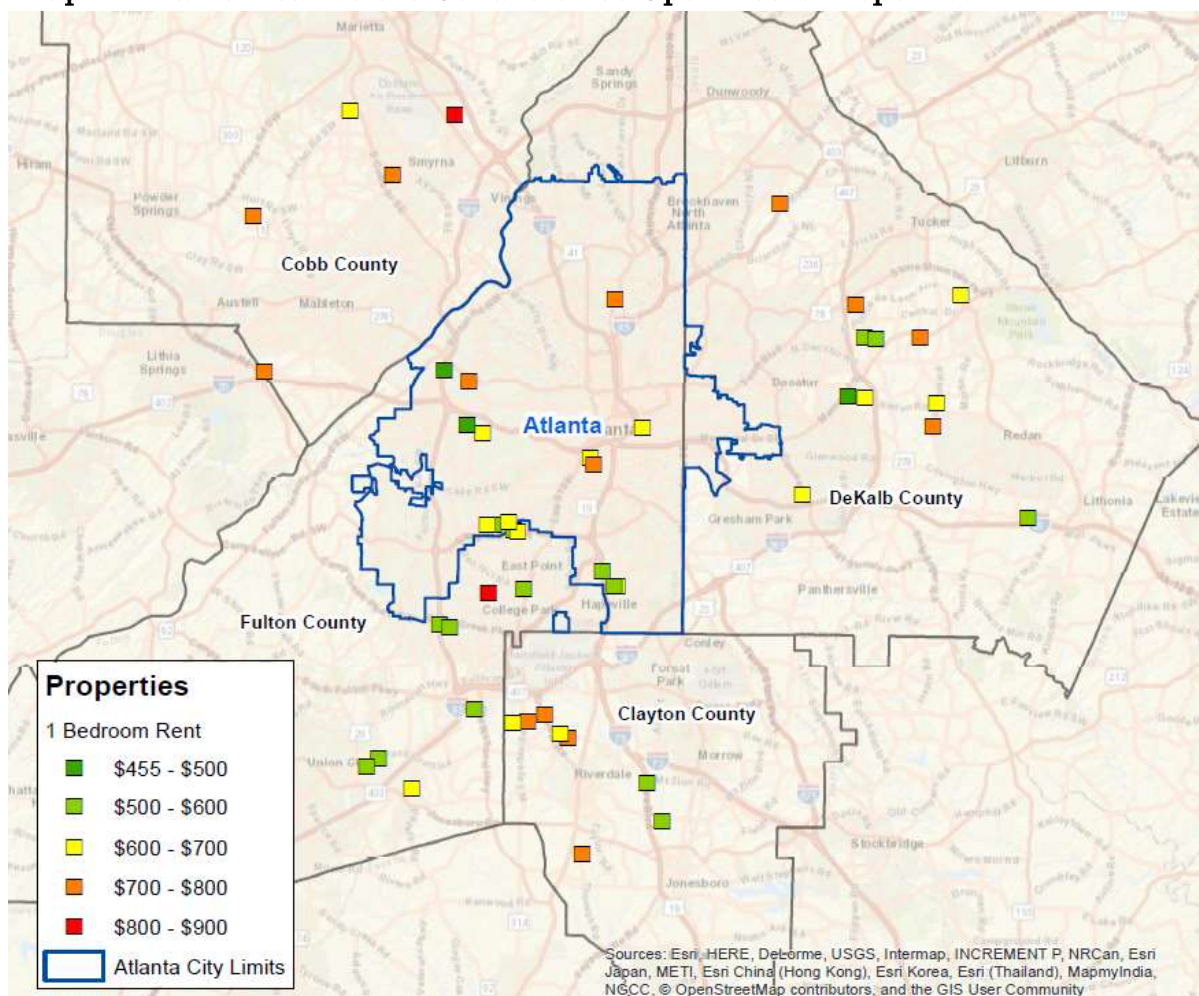
---

<sup>14</sup> <http://www.opendoorsatl.org/new-page/>

recent recession have since been sold at least once if not multiple times. Since there is currently much money to be made in luxury housing development, many of the formerly affordable housing properties are converted to higher-end housing after being sold. Rents are consequently increasing—as much as 15% to 25% over the last year.

A PSH provider shared that while their supportive housing master-lease units were originally located in North Atlanta, the agency had to relocate them twice in the last three years when the first two properties were sold and rents rose. The units are now located at an apartment complex in Southwest Atlanta. Whereas during the recession, property owners had an incentive to fill vacant units with Section 8 tenants, currently, vacancy is low enough and average rent is high enough that the only way owners in more affluent areas would agree to lose money and set aside units is if they are aligned enough with the mission of providing affordable and supportive housing.

**Map 2: Atlanta Real Estate Collaborative Open Doors Properties**



Source: Recreated by author from <http://www.opendoorsatl.org/>

## Part Four: Opportunities

The aforementioned challenges yield opportunities for PSH providers, the Atlanta CoC, the Atlanta Housing Authority, the City of Atlanta, and the State of Georgia to work together in ways that complement an evidence-based Housing First approach to reduce chronic homelessness. The following section summarizes recommendations based on the challenges associated with the four components of an effective comprehensive strategy.

### 1. Implementing a Comprehensive yet Flexible Coordinated Entry System

The coordinated entry (CE) system should prioritize housing for the most vulnerable chronically homeless, but also leave flexibility for populations that may not be quickly housed through this process.

- The Atlanta Housing Authority and the City of Atlanta should work with Partners for HOME to require that Section 8 PBRA and HOPWA properties participate in the coordinated entry system. CE becomes more effective when all homeless intake agencies in the CoC agree to use the tool so that no one is duplicating client intake and people are provided housing in a streamlined process.
- There should be a distinct vulnerability assessment and assessment points for adolescents and young adults.
- Partners for HOME should conduct a “gap analysis” of the vulnerability assessment tool and adjust it (with HUD approval) to more highly prioritize gap populations, including those with criminal histories

### 2. Obtaining Housing First Buy-in from PSH Stakeholders

Publicly funded PSH housing and service organizations should be required to apply the Housing First model and receive the appropriate support to transition to such an approach. To ensure that PSH providers do so, policymakers who control funding distribution must first align their policies to the HF model.

- The City of Atlanta should dedicate specific points to HF principles on the HOPWA application in line with points in the HUD CoC application.
- The Atlanta Housing Authority should adjust their corporate policies to a Housing First model by eliminating barriers to housing for those with drug-related evictions, as well as for those who are active users. In addition, there should be no risk of eviction if tenants fail to comply with their service plans, unless they are a threat to others or have damaged the property.
- Once AHA and HOPWA policies are aligned to HF principles, the Atlanta CoC could work with providers to restructure their programs to stay in compliance. If organizations choose to maintain non-HF strategies, subsidy

dollars would be reallocated towards HF-oriented providers. This process would happen over several years to give providers enough time to restructure or locate other funding.

### 3. Aligning Housing and Services to the HF Model

One of the main principles of Housing First is that housing and services work together in a seamless collaboration to provide an individual with the resources needed to achieve housing stability. While the physical home offers a safe and private place to be, wraparound services address the root cause of why an individual was homeless in the first place. If clients do not have access to appropriate services, the burden falls on the housing operators who may have no ability to affect such services. Alignment between housing and service provision is contingent upon standardizing Housing First policies, accessing adequate funding, and building upon existing partnerships and programs.

- PSH providers and Partners for HOME should continue working towards creating a streamlined lease agreement, incorporating standard HF policies.
- Partners for HOME should partner with the Atlanta Real Estate Collaborative “Open Doors” program to search and locate one-bedroom or efficiency apartments to replace current two-bedroom master-lease units.
- Partners for HOME and/or the Department of Community Affairs should offer ongoing harm reduction training sessions and check-ins with housing and service providers as they transition to Housing First standards.
- Partners for HOME should work with DBHDD to curtail the possibility of changing to a “fee for service” payment structure for service providers, since this is not complementary to the Housing First model.
- Partners for HOME should work with the Atlanta Housing Authority to convert current Shelter Plus Care units and new PSH units to TBRA or PBRA Section 8 units and use restructured HUD funding towards service funding for integrated care teams.

### 4. Supporting a Balanced Approach to Expanding HF-PSH

The capacity to expand PSH in the City of Atlanta is crucial. Although the number of chronically homeless individuals has declined according the past years’ PIT counts, the demand for PSH housing remains, especially when taking into account the much higher annualized homeless population. A 2014 City of Atlanta evaluation of gaps in homeless services stated that:

*“Atlanta has a large unsheltered population, at 1775 persons in 2013, with high levels of substance addictions. Over 300 veterans and nearly 800 chronic homeless persons were unsheltered. The CoC was successful in*

*securing funding for 115 new PSH beds but these will be able to house only 10% of the point-in-time population in need, less if annualized numbers are considered. The PSH supply is insufficient” (City of Atlanta, 2015).*

Today, the gap between need for supportive housing and housing availability persists. In January and February of 2017 alone, 96 of the 239 homeless people screened with the VI-SPDAT were deemed chronically homeless and eligible for PSH. The turnover at most PSH properties is so low (a few each week at best) that the waiting list for PSH will only continue to grow. Unit conversions from PSH to FLOW and from GHVP to Section 8 is not enough to lessen this demand. The City of Atlanta must comprehensively invest in expanding PSH through new developments, master-lease and scattered-site units managed by housing and service providers accountable to the same Housing First expectations. Complementary city and statewide policies are necessary to meet this objective.

- The Department of Community Affairs should reinstate the supportive housing program and apply HOME funds, State Housing Trust funds, and others to fund new PSH development.
- In the next funding cycle, the Department of Community Affairs should allow small LIHTC projects (50 units or fewer) to include 100% supportive units so that it is feasible and attractive for developers to build more of this housing stock.
- To incentivize less concentrated development of PSH units, the City of Atlanta should enact mandatory inclusionary zoning policies that require supportive housing set-asides for luxury developments, especially in northern Atlanta where there is currently a paucity of supportive housing units.
- City of Atlanta Council members should not support the proposed “Industrial Mixed Use District” in its current state, as it would create more barriers to future supportive housing development.
- The \$25 million offered by the City of Atlanta in the *Home Stretch* plan should come from discrete funding sources, modeled after other local funding sources, such as the Seattle property tax levy, the New York luxury housing tax, or the Dade County food and beverage tax.
- Service providers should be provided with funding through the City of Atlanta to continue working with Atlanta Housing Authority FLOW voucher recipients in case more intensive case management is needed in the future.
- The Atlanta CoC and AHA should continue to build upon their relationship with the Atlanta Real Estate Collaborative and the Open Doors program and play a role in expanding the pilot rent guarantee program which will provide funding to landlords in the case of eviction or property damage.

## Part Five: Conclusion

If the strength of a community were based on how it treats its most vulnerable community members, then providing permanent housing and healthcare services to chronically homeless individuals would be an uncontested line item in the annual city budget. So often however, the worth of a community is measured by the growth of its economy, and the number of high-paid jobs and large-scale development projects. As tower cranes dominate the landscape of Atlanta's Midtown and Buckhead, as the construction of the Mercedes Benz Stadium continues at a steady pace, as the Civic Center and Underground deals have closed, and as the BeltLine lays down its next concrete slab, it is clear where the City of Atlanta's priorities fall. Economic growth certainly brings benefits to a city, but who primarily profits from this growth? Certainly not the men and women living on the streets with disabilities who need Atlanta's help most of all.

For so long, Atlanta's homeless policy has been that of depending on individual providers to solve the "problem." Providers, with good intentions, have carried out their work with different rules and expectations for the people they serve. Resources are used inefficiently and people slip through the cracks of what is a frail and fragmented social safety net. A comprehensive Housing First permanent supportive housing policy will not end homelessness, but it will strengthen the safety net to catch the people who fall and support them as they endeavor to support themselves. The system will never be perfect—there will always be some people who return to homelessness and ironically, as a city's homeless resources expand, more homeless people will be attracted to the area. Homeless policy therefore should never be founded on an end goal, but on a plan to maintain and grow capacity of resources.

This capacity cannot grow without a complementary affordable housing policy. Atlanta is at a crossroads right now. Equitable housing strategies are needed to ensure truly affordable housing (below 50% AMI) with a proportion of that housing designated to homeless populations. This will involve locating new funding sources, aligning public resources and policies that complement one another, and supporting a balanced approach between project-based and tenant-based rental subsidy options. These

priorities become more crucial every day as more luxury housing comes online around the city and rents continue to rise.

We must ask ourselves what kind of city we want to live in. Do we want to be part of a community where the average rent is \$2000+ for a one-bedroom apartment? Where low-income households comprised primarily of people of color can no longer afford to live in gentrifying areas and get displaced? Where homeless people sleeping on the streets are awakened every morning by the Downtown Ambassador Force to ensure business isn't lost? And where the media sensationalizes news of a black, homeless man smoking crack and starting a fire under Interstate 85, rather than asking the question: why is he in that situation in the first place? I would argue no. We want to be a community with space for diverse incomes, colors and backgrounds, a community that doesn't think twice about providing services to those who need them most, and that seeks to find solutions to the roots of problems rather than the consequences of problems. The decision at hand is not about a lack of resources, but rather about how the City of Atlanta, the State of Georgia, and we as residents living within those boundaries decide to prioritize and organize resources. The answer could and should be: Housing First.

## References

- Atlanta Housing Authority. (2016). Amended and Restated Statement of Corporate Policies.
- Aubry, T., Bell, M., Ecker, J., & Goering, P. (2015). Screening for Housing First: Canadian Observatory on Homelessness: Mental Health Commission of Canada.
- Avino, J.G. (1994). Ordinance Creating the Dade County Homeless Trust, 94-66. Dade County Manager.
- Bolster, P. (2008). Atlanta's Homeless Opportunity Fund: Support Housing LLC. [PowerPoint Presentation].
- Brown, M., Malone, D., & Jordan, N. (2015). Tenant Satisfaction With a Single-Site Housing First Program. *Journal of Social Service Research*, 41(4), 498-507.
- City of Atlanta. (2015). Atlanta Homeless Continuum of Care 2015 Point-In-Time Count Totals
- City of Atlanta Innovation Delivery Team. (2014). Impact Report: Reducing Street Homelessness, 2012 to 2013.
- City of Atlanta, Office of Zoning and Development. (2017). Z-16-11: Amendment to Create Chapter 16 A I-MIX (Industrial Mixed-Use District).
- Coleman, V. (2017). Seattle gives first details on how \$275M homelessness levy would be spent, *The Seattle Times*.
- Collins, S. E., Malone, D. K., & Clifasefi, S. L. (2013). Housing retention in single-site housing first for chronically homeless individuals with severe alcohol problems. *American Journal of Public Health*, 103 (Suppl 2), S269-S274.
- Congressional Budget Office. (2015). Federal Housing Assistance for Low-Income Households.
- Cooperation for Supportive Housing. (2016). Housing Credit Policies in 2015 that Promote Supportive Housing.
- Culthane, D. P., Metreaux, S., & Hadley, T. (2002). Supportive Housing for homeless people with severe mental illness in supportive housing. *Housing Policy Debate*, 13, 107-163.
- Deloitte Consulting. (2003). Blueprint to End Homelessness in Atlanta in Ten Years. City of Atlanta.
- Department of Housing and Urban Development. (2015). Homeless Emergency Assistance and Rapid Transition to Housing: Defining "Chronically Homeless". *Federal Register*, 80(233), 75791-75806.
- Department of Housing and Urban Development. (2016a). The 2016 Annual Homeless Assessment Report (AHAR).
- Department of Housing and Urban Development. (2016b). Coordinated Entry Policy Brief.
- Department of Housing and Urban Development. (2016c). Notice of Funding Availability (NOFA) for the Fiscal (FY) 2016 Continuum of Care Program: Community and Planning Development.
- Edin, K., & Shaefer, H. L. (2016). 20 Years Since Welfare 'Reform', *The Atlantic*.
- Enterprise Community Partners. (2016). Housing First - Ending Chronic Homelessness in Cuyahoga County [PowerPoint presentation].
- Eyler, R. (2012). The Importance of COTS to Petaluma's Businesses: Economic Forensics and Analytics.
- Flaming, D., Burns, P., & Matsunaga, M. (2009). Where We Sleep: Costs when Homeless and Housed in Los Angeles: Los Angeles Homeless Services Authority.
- Georgia Department of Community Affairs. (2017). 2017 Qualified Allocation Plan.

- Immergluck, D., Carpenter, A., & Lueders, A. (2016). Declines in Low-Cost Rented Housing Units in Eight Large Southeastern Cities *Community & Economic Development* (Vol. 03-16). Atlanta Federal Reserve Bank.
- Kirst, M., Zerger, S., Misir, V., Hwang, S., & Stergiopoulos, V. (2015). The impact of a Housing First randomized controlled trial on substance use problems among homeless individuals with mental illness. *Elsevier*, 146, 24-29.
- Lamb, R., & Bachrach, L. (2001). Some Perspectives on Deinstitutionalization. *Psychiatric Services*, 52(8), 1039-1045.
- Larimer, M. E., Malone, D. K., Garner, M. D., Atkins, D. C., Burlingham, B., Lonezak, H. S., Tanzer, K., Ginzler, J., Clifasefi, S.L., Hobson W.G., and Marlatt, G. A. (2009). Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *The Journal of the American Medical Association*, 301(13), 1349-1357.
- Ly, A., & Latimer, E. (2015). Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature. *Canada Journal of Psychiatry*, 60(11), 475-487.
- Martinez, T. E., & Burt, M. R. (2006). Impact of Permanent Supportive Housing on the Use of Acute Care Health Services. *Psychiatric Services*, 57(7).
- National Alliance to End Homelessness. (2016). The State of Homelessness in America.
- National Health Care for the Homeless Council. (2011). Homeless & Health: What's the connection?
- O'Connell, J. J. E. (2004). The health care of homeless persons: A manual of communicable diseases and common problems in shelters and on the streets. Boston Health Care for the Homeless Program.
- Office of National Drug Control Policy. (2014). National Drug Control Strategy (pp. 19-24). Retrieved from [https://www.whitehouse.gov/sites/default/files/ndcs\\_2014.pdf](https://www.whitehouse.gov/sites/default/files/ndcs_2014.pdf).
- Padgett, D. K., Henwood, B. F., & Tsemberis, S. J. (2016). *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives*. New York: Oxford University Press.
- Padgett, D. K., Stanhope, V., Henwood, B., & Stefancic, A. (2011). Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs. *Community Ment Health Journal*, 47(2), 227-232.
- Parker, J. (2013). The 2013 Metro Atlanta Tri-Jurisdictional Collaborative Homeless Census. Prepared for The Metro Atlanta Tri-Jurisdictional Collaborative on Homelessness: Pathways Community Network Institute.
- Partners for HOME. (2016a). 2016 Homeless Point-In-Time Count.
- Partners for HOME. (2016b). GA-500 CoC Registration FY2016.
- Partners for HOME. (2016c). Homeless Point-In-Time Count.
- Pearson, C., Locke, G., Montgomery, A. E., & Buron, L. (2007). *The applicability of Housing First models to homeless persons with serious mental illness final report*. U.S. Dept. of Housing and Urban Development, Office of Policy Development and Research.
- Post, P. A. (2008). Defining and Funding the Support in Permanent Supportive Housing: National Health Care for the Homeless Council and Corporation for Supportive Housing.
- Ringheim, K. (1990). *At Risk of Homelessness: The Roles of Income and Rent*. New York: Praeger.
- Rosenheck, R., Kasprow, W., Frisman, L., & Liu-Mares, W. (2003). Cost-effectiveness of supportive housing for homeless persons with mental illness. *Arch Gen Psychiatry*, 60(9), 940-951.
- Sadowski, L. S., Kee, R. A., VanderWeele, T. J., & Buchanan, D. (2009). Effect of a Housing and Case Management Program on Emergency Department Visits and

- Hospitalizations Among Chronically Ill Homeless Adults. *The Journal of the American Medical Association*, 301(17), 1771-1778.
- Schwarcz, S. K., Hsu, L. C., Vittinghof, E., Vu, A., Bamberger, J. D., & Katz, M. H. (2009). Impact of housing on the survival of persons with AIDS. *Bmc Public Health*, 9(220).
- Smith, C. and Young Jr., I.L. (2009). Ordinance 405945. City of Atlanta City Council.
- Tsemberis, S., Gulcur, L., & Nakae, M. (2004). Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis. *American Journal of Public Health*, 94(4), 651-656.
- Tsemberis, S., Kent, D., & Respress, C. (2012). Housing stability and recovery among chronically homeless persons with co-occurring disorders in Washington, DC. *American Journal of Public Health*, 102(1), 13-6.
- U.S. Department of Housing and Urban Development. (2015). Coordinated Entry Policy Brief.
- U.S. Interagency Council of Homelessness. (2016). The President's 2016 Budget: Fact Sheet on Homelessness Assistance.
- U.S. Interagency Council on Homelessness. (2015). Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.
- U.S.C. 11360(9). (2009). *McKinney-Vento Homeless Assistance Act as amended by S. 896 HEARTH*.
- Uhlfelder, E. (2017). How Cities Should Take Care of Their Problems, *The New York Times*.
- United States Census Bureau. (2015). Comparative Demographic Estimates: American FactFinder.
- United States of America v. The State of Georgia, et al. (2010). Civil Action No. 1:10-CV-249-CAP. Settlement Agreement.
- Van de Water, A. (2003). Business Improvement Districts-Legislative Analyst Report (File No. 021934). San Francisco.
- Washington, R. (2015). Housing First's new mobile health clinic offers care to formerly homeless residents, *Cleveland.com*.
- Wrezel, O. (2009). Respiratory Infections in the Homeless. *UWO Medical Journal*, 78(2), 61-65.

## Personal Communication Sources

### *Stakeholders in Atlanta (In order of communication)*

- **Cathryn Marchman**, Executive Director, Continuum of Care, City of Atlanta (Conducted 2/3/2017)
- **Margaret Schuelke**, Executive Director, Project Community Connections, Inc. (Conducted 2/16/2017)
- **Katie Crippen**, Project Developer II, Mercy Housing Southeast, (Conducted 2/16/2017)
- **Jack Hardin**, Co-Chairman, Atlanta Regional Commission on Homelessness (Conducted 2/21/2017)
- **Brenda Newcom**, Program Manager, Grady Health System, (Conducted 2/21/2017)
- **Protip Biswas**, Vice President, Homelessness & Place Based Initiatives, United Way of Greater Atlanta, (Conducted 2/28/2017)
- **Tracey Scott**, Vice President of Strategy & Innovation, Atlanta Housing Authority, (Conducted 3/6/2017)
- **Bruce Gunter**, Progressive Redevelopment, Inc. (Conducted 3/6/2017)
- **Emily Brown**, Field Organizer, Georgia Equality (Conducted 3/8/2017)
- **Amanda van Dalen**, Director of Case Management and Coordinated Entry, Gateway Center (Conducted 3/10/2017)
- **Matt Herd**, Director, Open Doors, Atlanta Real Estate Collaborative (Conducted 3/15/2017)
- **Terrence Franklin**, Region Three AMH Case Expeditor, Department of Behavioral Health & Developmental Disabilities (Conducted 3/16/2017)
- **John Shereikis**, Special Needs Planning Manager, GA Department of Community Affairs (Conducted 3/22/2017)
- **Doug Scott**, *Former* Director of GA Housing Voucher Program, Department of Behavioral Health & Developmental Disabilities (Conducted 3/23/2017)
- **Jane Mara**, Grants and Communications Manager, Our House, Inc. (Email exchange 3/23/2017)
- **Talley Wells**, Director, Disability Integration Project, Atlanta Legal Aid Society, Inc. (Conducted 4/5/2017)

### *PSH Providers in Atlanta (In order of communication)*

- **Deldrick Wilson**, Director of PATH Outreach Program, HOPE Atlanta (Conducted 8/15/2016)
- **Paul Bolster**, CEO, Urban Residential Development Corporation (Conducted 12/21/2016)
- **Shirley Estelle**, Case Manager, Community Friendship, Inc. (Conducted 2/13/2017)
- **Kenneth Prince**, Chief Operating Officer, Quest Community Development Organization (Conducted 2/13/2017)
- **Darlene Schultz**, CEO, Project Interconnections, Inc. (Conducted 2/14/2017)
- **Colleen Bain**, Vice President of Supportive Housing at National Church Residences, Imperial Hotel (Conducted 2/20/2017)
- **Celeste Hurling**, Case Manager, Zion Hill CDC (Conducted 2/21/2017)
- **Kellie Glenn**, Director of Development, Covenant House Georgia (Conducted 2/21/2017)

- **Lisa Curia**, Director of Grants and Quality Insurance, Covenant House Georgia (Conducted 2/22/2017)
- **Keo Buford**, Director of Housing & Supportive Services, GA Rehabilitation Outreach (Conducted 2/22/2017)
- **Shawn Williams**, Quality Assurance Manager, CaringWorks (Conducted 2/24/2017)
- **Andre Johnson**, H.O.P.E Through Divine Intervention (Conducted 2/28/2017)
- **Steve Syers**, Essence of Hope, Inc. (Conducted 2/28/2017)
- **Derek Duncan**, Trinity Community Ministries (Conducted 3/2/2017)
- **Erika Parks**, Director of Supportive Housing, HOPE Atlanta (Conducted 3/6/2017)
- **Paulette Haase**, Director of HUD Supportive Housing, HOPE Atlanta (Conducted 3/8/2017)
- **Harvinder Makkar**, Director of HOPWA Supportive Housing, HOPE Atlanta (Conducted 3/9/2017)
- **Shamekela Bishop**, Director of Programs, The Living Room (Conducted 3/16/2017)
- **Renee Starrett**, Administrative & Social Media Manager, Jerusalem House, Inc. (Conducted 3/28/2017)
- **Alexis Blackmon**, Scattered Site II Manager, Jerusalem House, Inc. (Conducted 3/29/2017)
- **Katha Blackwell**, Vice President of Shelter Services and Supportive Housing, Partnership Against Domestic Violence (Conducted 3/30/2017)
- **Naomi Haynes**, Shelter-A-Family Program Coordinator, Families First (Conducted 4/10/2017)
- *Brief conversations with staff from Veterans Empowerment Organization, Chris180, Nicolas House, Legacy House/Village, Making a Way Housing, Inc.*

*PSH Stakeholders outside of Atlanta (In order of communication)*

- **Jeremy Weatherly**, Development Manager, Pathways DC, Washington, DC (Conducted 11/22/2016)
- **Margaret King**, Director of Housing, DESC, Seattle, WA (Conducted 11/22/2016)
- **Margot Antonetty**, Interim Director, DAH, San Francisco, CA (Conducted 11/29/2016)
- **Danielle Cosgrove**, Enterprise Community Partners, Cleveland, OH (Conducted 2/1/2017)
- **Eva Thibaudeau**, Director of Programs, Coalition for the Homeless, Houston, TX (Conducted 3/7/2017)

## Appendix A: Determinants and Costs of Chronic Homelessness

Individuals become and remain chronically homeless due to both individual, as well as community (economic/social/political) determinants. Chronic homelessness, in turn, generates costs to both the homeless individual *and* the community. It is important to note that determinants and costs are not mutually exclusive and exacerbate one another to varying degrees, reflected in the following discussion.

Individual determinants are inherently part of the definition of chronic homelessness, which includes having a disability. According to the McKinney-Vento definition, a disability could be a physical or mental impairment, including substance abuse, post-traumatic stress disorder, or brain injury (U.S.C. 11360(9), 2009). Approximately one-third of the chronically homeless suffer from a severe mental health disorders such as schizophrenia and depression, and around two-thirds have a substance abuse condition or another chronic health condition (Office of National Drug Control Policy, 2014).

Living on the streets exacerbates syndromes of mental disabilities and also contributes to higher rates of physical illness such as hypertension, asthma, HIV/AIDS, and liver disease, because chronically homeless people have limited access to outpatient care (National Health Care for the Homeless Council, 2011; Wrezel, 2009). Crowded shelters and street conditions also increase risk of communicable diseases such as tuberculosis (O'Connell, 2004). Chronically homeless individuals, and especially those with alcohol and other substance abuse conditions, also have relatively higher rates of mortality (Larimer et al., 2009).

Homelessness, especially for those unsheltered, limits access to treatment and outpatient preventative care, resulting in worsening health conditions and higher public costs for emergency services, hospitalization and incarceration. In Washington, DC for example, per person costs for social services, hospitalization, detox programs and jail time for those living on the streets average between \$40,000 and \$50,000 per year (Kaplan, 2014). Median costs in Seattle for chronically homeless adults without permanent housing and with severe alcohol problems are an annual \$50,000 per person (Larimer et al., 2009). A comprehensive study of 5,000 homeless people with severe mental illness in New York City found annual service costs per person to be \$40,500, much of which stemmed from inpatient psychiatric hospitals, emergency room care, and jail time (Culthane et al., 2002). Although chronically homeless people comprise about 20% of shelter space, they use the majority of health, social and justice services (Ly & Latimer, 2015). Municipal and state governments bear the majority of these costs.

Homelessness may also have significant impacts on the private sector. Although limited research has explored the correlation, it is possible that a high presence of homeless individuals near businesses deter foot traffic and reduce sales and profit. Eyler (2012) asserts that even the most minimum reductions in retail transactions, of just 1%, would result in dramatic decreases in business, as well in as state and local tax revenue. Business improvement districts (BIDs) in urban areas with high concentrations of homelessness allocate a large proportion of resources to deter negative impacts on businesses (Van de Water, 2003). For instance, every morning at 4:00 AM and 6:00 AM, Atlanta Downtown Improvement District (ADID) staff and off-duty City of Atlanta police officers wake up and relocate all homeless people sleeping on private property to ensure they are not present at the start of business hours.

As two-thirds of chronically homeless people are unsheltered and the majority have mental and/or substance abuse disorders, their high public visibility creates a social stigma and perpetuates stereotypes that homeless individuals have innate flaws, are at fault, and/or choose to be in such a state. It is true that some homeless people “choose,” for various reasons, to remain on the streets rather than transition into any sort of shelter or housing. These choices, however, are the results of individual constraints and the on-going failure of public support systems. Individuals may refuse housing due to mental health disorders, addiction, or past negative experiences in housing or with support services. Because of high rates of homeless-on-homeless crime and communicable disease in some shelters, individuals may actually feel safer on the streets. In addition, shelter and transitional housing with sobriety and treatment requirements constrain individual choice and lessen the likelihood that clients will remain stably housed and access the services they need (Collins et al., 2013).

Since the majority of chronically homeless individuals have mental and/or substance abuse issues, limited access to health care services also diminishes the chance of housing stability. Deinstitutionalization, starting in the 1950s and spanning over four decades, which reduced long-stay psychiatric hospitals without creating adequate community-based alternatives, leaves many of these populations on the streets without support and recovery options. For instance, severely mentally ill people who lack adequate case management services are more vulnerable to eviction as they are left alone to interact with landlords (Lamb & Bachrach, 2001).

Limited access to affordable housing further escalates risk of homelessness among extremely low-income individuals with or without disabilities. Currently, around 48 million people live at or below the poverty line in the United States and only one quarter of those eligible for subsidies actually receive assistance through federal programs (Congressional Budget Office, 2015). More than 6.6 million people in the U.S. pay more than 50% of their income toward housing (NAEH, 2016). The availability of low-cost units declined in the 1960s-1980s when thousands of single room occupancy (SRO) units in large cities including New York, Chicago and Seattle were demolished. Many of these buildings had housed mentally-ill individuals, some of whom had moved to them from the recently closed down state institutions (Ringheim, 1990). Welfare reform policy signed into law in the mid-1990s, which reduced both the total amount of welfare recipients *and* amount of subsidy received, further exacerbated the housing cost burden (Edin & Shaefer, 2016). Today, the number of low-cost units continues to decline, both because of unmaintained units becoming inhabitable and conversion to luxury units (Immergluck et al., 2016).

The aforementioned determinants and costs of chronic homelessness undergird the argument for permanent supportive housing with a Housing First model. In other words, long-term housing with wraparound services that incorporates client choice and low barriers to entry, generates housing stability for chronically homeless individuals with disabilities.

## Appendix B: HUD Definition of “Chronically Homeless”

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining “Chronically Homeless”

“(1) A *homeless individual with a disability*\*, who:

- i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- ii. Has been homeless and living as described in paragraph (1) (i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1) (i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

Or (2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility;

Or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless”

(HUD, 2015)

---

\*According to section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), a “*homeless individual with a disability*,” means an individual who is homeless and has a disability that—

(I)

- i. is expected to be long-continuing or of indefinite duration *and*
- ii. substantially impedes the individual's ability to live independently *and*
- iii. could be improved by the provision of more suitable housing conditions; *and*
- iv. is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

or (II) is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002);

or (III) is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome”

(McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)))

## Appendix C: Housing First—An Evidence-Based Approach

The effectiveness of Housing First permanent supportive housing was initially tested over a five-year period starting in 1997 by Pathways to Housing, Inc. in New York City. The study targeted homeless mentally ill people, 90% of whom had histories of drug or alcohol abuse. PSH participants lived independently in apartments in (relatively) affordable areas around New York City and received services through Assertive Community Treatment (ACT) teams (Tsemberis et al., 2012). Participants were required to contribute 30% of their income – usually supplemental security income (SSI)—to rent and to allow an ACT team member to visit their apartments weekly. Control group participants in the study lived in shelters, group homes, and transitional housing with shared kitchens and bathrooms that had sobriety stipulations and treatment requirements. The New York study concluded with 87% of PSH participants in stable, permanent housing. Throughout the study, PSH participants were stably housed 80% of the time compared to only 30% of the control group (Padgett et al., 2016; Tsemberis et al., 2004).

This study spurred other research proving that Housing First permanent supportive housing increases long-term housing stability for chronically homeless individuals with disabilities. For instance, in a three-year study of homeless veterans with psychiatric and/or substance abuse disorders, those who received scattered-site PSH with intensive case management remained housed 25% more days than groups receiving standard care (Rosenheck et al., 2003). Research also revealed that housing stability is intrinsically linked to other individual and community benefits. Individual benefits include reductions in rates of substance usage, medical needs, and mortality.

Critics of the “harm reduction” component of HF contend it would limit possibilities of recovery since clients could continue uncontrolled substance usage. Not only is there evidence that harm reduction does not increase alcohol use (Tsemberis et al., 2004), various studies also associate HF-PSH programs with alcohol reduction (Kirst et al., 2015; Larimer et al., 2009; Padgett et al., 2011). Rates of mortality have been shown to decrease, especially for populations suffering from chronic illnesses; one study found that homeless people with AIDS placed in HF-PSH saw an 80% reduction in mortality rate (Schwarcz et al., 2009).

Strong evidence shows that stable, permanent housing reduces hospitalization, as well as emergency and sobriety treatment services for previously homeless individuals accounting for public cost savings equal to or more than the cost of housing (Larimer et al., 2009; Martinez & Burt, 2006). For example, in a multi-year study of 407 homeless adults with chronic medical illnesses, those with stable housing had 2.7 fewer hospital days and 1.2 fewer emergency visits after 18 months (Sadowski et al., 2009). Lower usage of public services, arguably, will offset higher costs for intensive case management and ongoing housing subsidies in HF-PSH programs. A 2002 analysis of 4,679 homeless individuals with severe mental illness found that formerly homeless persons in stable permanent housing generated more than \$16,000 in public savings per housing unit (Culthane et al., 2002). A 2009 study of more than 10,000 homeless people in Los Angeles indicated that public cost of services for PSH tenants was over \$2,000 cheaper per month than for homeless individuals (Flaming et al., 2009).

## Appendix D: Single-Site, Scattered-Site, and Master-Lease Clusters

Critics of the single-site approach assert that it concentrates clients with severe mental health and substance abuse disorders and therefore generates negative environmental factors. For instance, single-site tenants interviewed at permanent supportive housing projects around the country indicated negative feelings about drug- and crime-related activity around their homes (Brown et al., 2015). By contrast, scattered-site housing may provide clients with more independence as these clients are detached from the stigma of group housing for disabled individuals. Clients in scattered-site units receive vouchers to choose where in the city/county they want to live, typically in units owned by private or nonprofit parties. Service providers work with clients to reduce usage, by meeting them where they are and giving them flexibility to set their own goals for recovery.

Although critics argue that single-site PSH reduces client agency, well-run single-site programs, such as the nationally renowned Downtown Emergency Service Center (DESC) in Seattle, WA, maintain high levels of housing stability of chronically homeless populations, the ultimate goal of Housing First. Single-site properties provide opportunities for peer support as neighbors have similar backgrounds of chronic homelessness and disabilities (Collins et al., 2013). Service providers operate more efficiently at one site with many units, rather than having to travel around to individual units. Agencies can also deliver more units at one time if they own the site, rather than relying on individual contracts with hesitant landlords. This proves true when examining the capacity of the Cleveland/Cuyahoga County HOUSING*first* initiative, which provides over 700 supportive housing units in ten buildings, all constructed since 2002 (Enterprise Community Partners, 2016). Pathways to Housing DC, a replication of the original New York scattered-site model that started in 2004, oversees only 250 units in comparison (Weatherly, 2016).

Additionally, scattered-site housing is contingent upon unit availability, landlord amenability, and cost of rent. Since voucher allocations have not risen at the same rate as rental prices in expensive housing markets such as Washington, DC, housing placement in scattered-site programs like Pathways DC become restricted to lower-cost neighborhoods, somewhat reducing client choice.

Master-lease clusters offer a third type of supportive housing design. The units are maintained and paid for upfront by a PSH provider, while tenants are able to live in a mix of supportive and non-supportive housing. However, preserving the units as PSH is ultimately contingent upon the landlord's amenability, which lessens when housing markets grow tighter and vacancies are fewer and farther between.

## Appendix E: HF Prioritization in CoC Funding Applications

For renewal and new project applications, HF-oriented questions include:

1. Describe how the project will implement a Housing First model. (*Only for new projects.*)
2. Will the project prioritize client selection based on duration of homelessness and vulnerability?
3. Will the project drug test prior to move in and/or while the client lives in the project?
4. Will the project require compliance with or enrollment in mental health treatment in order to be accepted?
5. Will the project accept clients regardless of criminal history?
6. Will the project accept clients regardless of income or financial resources?
7. Will the project use a harm-reduction model for drugs and/or alcohol use?
8. Will the project include mandatory case management and/or home visits as a condition of remaining in the program?
9. Please indicate which of the following will be required for clients to be accepted into this project: current employment; income; state issued identification; sobriety; no presenting of symptoms of mental illness; transportation; specific disabling condition (MH, SA, HIV/AIDS); medication compliance; order of protection, police involvement, or specified time separated from abuser/victims/survivors of domestic violence

Applications receive 3 points for sufficiently describing how the project will incorporate a HF model (first question above) and 1 point for pro-HF responses in questions 2-8, and 1 point for each factor not selected in question 9, except for “specified disabling condition.” The exception is contingent upon explanation, and leaves room for PSH providers who offer housing for one specified group, such as clients with HIV/AIDS.

(Partners for HOME, 2016b)

## Appendix F: Recent History of PSH and HF Policies in Atlanta

City of Atlanta support for expanding permanent supportive housing began in the early 2000s when Mayor Shirley Franklin requested that United Way of Metropolitan Atlanta convene a working group of stakeholders and experts on homelessness to create an action plan that would become the *Blueprint*. The authors recommended creating a “Regional Authority on Homelessness” to carry out long-term planning for homeless services, which became the unincorporated United Way Regional Commission on Homelessness spanning across seven counties in Metro Atlanta (Deloitte Consulting, 2003).

The *Blueprint* stressed the linear approach to housing, providing recommendations for emergency shelters, transitional housing, and permanent housing. Authors do place some emphasis on supportive housing, acknowledging, “There is a lack of supportive housing projects in development due to funding, service provider capacity and various site selection barriers” (p. 49). Three action plans around supportive housing include: (1) convening a “Supportive Housing Production Task Force” to develop a comprehensive 10-year supportive housing plan within 180 days of the *Blueprint’s* report; (2) building a 50-unit single room occupancy facility modeled after the O’Hern House to house individuals suffering from mental illness, addiction, or dually diagnosed; and (3) adding and supporting 15 SRO units at Santa Fe Villas, a permanent supportive housing site run by the Urban Residential Development Corporation (URDC). The fact that the “Supportive Housing Production Task Force” never formed, combined with the recommendation of a mere 75 additional PSH units, suggests no comprehensive commitment to expanding PSH in Atlanta. Further, there is no direct mention of Housing First in the *Blueprint* (Deloitte Consulting, 2003).

Thanks to the *Blueprint* however, the city established a Homeless Opportunity Fund and used an existing rental car tax to raise \$22 million in grant funding. The grants were used to leverage other private funding to develop 437 permanent supportive housing units throughout Atlanta. Supportive housing was limited to 40 units in each development, or 20% in larger projects. The Atlanta Housing Authority became a bigger player in homeless housing and provided Section 8 supportive housing vouchers (project-based rental assistance) for the developed units. In addition, the 24/7 Gateway Center was built in a former downtown Atlanta jail to provide 350 temporary beds and services to homeless people with the primary objective of assessing and connecting clients to transitional or permanent housing (Bolster, 2008).

During this time, the Georgia Department of Community Affairs (DCA) also managed a supportive housing program, which used a combination of HOME and State Housing Trust Funds to finance new PSH construction. This funded around 20 projects in Georgia over ten years, including Project Interconnections, Inc.’s O’Hern House and Phoenix House, as well as a Quest Community Development Organization property.

Although the number of permanent supportive housing units tripled between 2005 and 2014, individual providers were not held accountable to the same Housing First standards (City of Atlanta Innovation Delivery Team, 2014). While some PSH providers in Atlanta were using an HF approach since their founding, many others maintained barriers to entry (e.g., substance abuse, and history of eviction or crime) and/or had strict service requirements to remain in housing.

It was not until 2012 that ‘Housing First’ entered into the city’s vocabulary around homeless services. The City of Atlanta Innovation Delivery Team under Mayor Kasim Reed established a collective impact strategy called *Unsheltered No More*. The team recognized that policies to promote Housing First have contributed to reduced chronic homelessness in cities across America. *Unsheltered No More* also ran a cost analysis of chronic homelessness and found that, in 2012, there were 1,576 misdemeanor homeless arrests, 17,944 homeless jail stays, 26,352 homeless ER visits, and 5,270 homeless inpatient stays amounting to more than \$63 million in public costs. On the other hand, the cost of a PSH unit per year was estimated to be \$17,274 or just over \$3 million to house 200 chronically homeless individuals. The data argued in favor of expanding PSH units with a HF approach (City of Atlanta Innovation Delivery Team, 2014).

*Unsheltered No More* set a goal of housing 800 people by 2013. Between 2012 and 2013, over 1,000 homeless individuals were housed, included 754 veterans and family members, thanks in part to Mayor Reed participating in the Mayor’s Challenge to end Veteran’s homelessness. During 2013, the task force team helped create the “chronic implementation team” to carry out coordinated homeless outreach and PSH placement among nonprofits and state, county and city agencies (City of Atlanta Innovation Delivery Team, 2014).

## Appendix G: List of Permanent Supportive Housing in Atlanta

Provider	Property Name	Address	Number Beds	Number Units	Shared Unit?	Type	Coordinated Entry Participant	Targeted Population	Subpopulation	Primary Rental Subsidy	HF?	Permanent?
<b>PBRA for Chronic Single Adults (In Coordinated Entry)</b>												
Quest Community Development Organization	Quest Village I	891 Rock Street NW, Atlanta, GA, 30314	20	20	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Quest Community Development Organization	Quest Village II	868 Rock Street NW, Atlanta, GA, 30314	24	12	Yes	Single-Site Own	Yes	Single Adult Chronic	Veterans	HUD COC	Yes	Yes
Quest Community Development Organization	Quest Village III	879 Rock Street NW, Atlanta, GA, 30314	28	28	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC; AHA PBRA	Yes	Yes
Quest Community Development Organization	Quest Communities	882 Fox Street NW, Atlanta, GA, 30318	2	2	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Quest Community Development Organization	Park Vista Apartments	1940 Fisher Road SE, Atlanta, GA, 30315	40	40	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	Shamrock Garden Apartments	1988 Plaza Lane, Atlanta SW, GA 30311	10	10	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	West Lake Courts	1866 West Lake Court NW, Atlanta, GA 30318	4	4	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	Arbors of East Atlanta	1800 Memorial Drive SE, Atlanta GA 30318	10	10	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	Quest Communities	882 Fox Street NW, Atlanta, GA, 30318	13	13	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes

CaringWorks	Quest Enclave Apartments	630 Cameron Alxdr. Blvd., Atlanta, GA 30318	8	8	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	Quest Communities	Chicago Avenue NW, Atlanta, GA 30318	4	4	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
CaringWorks	Park Vista Apartments	1940 Fisher Road SE, Atlanta, GA, 30315	32	32	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Project Interconnections, Inc.	Phoenix House	1296 Murphy Avenue SW, Atlanta, GA, 30310	69	69	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Project Interconnections, Inc.	O'Hern House	16 WM Holmes Borders Dr. NE, Atlanta, GA, 30312	76	76	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Project Interconnections, Inc.	Presley Woods	265 Kirkwood Road, NE, Atlanta, GA, 30317	40	40	No	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Project Interconnections, Inc.	Welcome House	234 Memorial Drive SW, Atlanta GA, 30303	209	209	No - shared kitchen /LR	Single-Site Own	Partial	Single Adult Chronic		HUD COC; AHA PBRA; Tenants Pay	Yes	Yes
Project Interconnections, Inc.	Adams House Apartments	2280 Campbellton Road SW, Atlanta, GA, 30311	27	27	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Georgia Rehabilitation Outreach	Martin Manor Apartments	2950 MLK Jr. Blvd. SW, Atlanta, GA, 30331	58	29	Yes	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Georgia Rehabilitation Outreach	Adams House Apartments	2280 Campbellton Road SW, Atlanta, GA, 30311	20	10	Yes	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes

Georgia Rehabilitation Outreach	1890 House Apartments	1890 Myrtle Drive SW, Atlanta, GA, 30311	18	9	Yes	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Georgia Rehabilitation Outreach	Biscayne Apartments	5401 Old National Highway, College Park, GA, 30349	10	10	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
HOPE Atlanta	The Legends at Laura Creek	3871 Lakemont Drive, East Point, GA, 30337	10	10	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
HOPE Atlanta	The Park at Greenbriar	3000 Continental Colony Parkway, Atlanta SW, GA, 30331	10	10	No	Master Lease Cluster	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Urban Residential Development Corporation	Santa Fe Villas	2370 Metropolitan Parkway SW, Atlanta, GA, 30315	23	23	No - SRO shared kitchen	Single-Site Own	Yes	Single Adult Chronic		HUD COC	Yes	Yes
Urban Residential Development Corporation	Santa Fe Villas	2370 Metropolitan Parkway SW, Atlanta, GA, 30315	100	100	No - SRO shared kitchen	Single-Site Own	No	Single Adult Chronic	**Formerly homeless, but do not receive wraparound services	City of Atlanta Section 8 Housing Assistance Program	Yes	Yes
Trinity Community Ministries	Trinity Living - Eagles Nest Apartments	2900 Landrum Drive, SW, Atlanta, GA, 30311	16	8	Yes	Master Lease Cluster	Yes	Single Adult Chronic	Men: Veterans	HUD COC	Yes	Yes
HOPE Atlanta	The Legends at Laura Creek	3871 Lakemont Drive, East Point, GA, 30337	13	13	No	Master Lease Cluster	Yes	Single Adult Chronic	HIV/AIDS	HOPWA	Yes	Yes
HOPE Atlanta	Regal Heights Apartments	2640 Campbellton Road, SW, Atlanta, GA, 30311	2	2	No	Master Lease Cluster	Yes	Single Adult Chronic	HIV/AIDS	HOPWA	Yes	Yes

PBRA for Chronic Families (In coordinated entry)												
Veterans Empowerment Organization	Veterans Empowerment Organization	373 West Lake NW, Atlanta, GA 30318		14	Yes	Single-Site Own	Partial	Families Chronic	Veterans	HUD COC; Mixed	No	No
Families First	Shelter A Family	Cascade Road SW, Atlanta, GA 30331		39	Yes	Master-Lease Cluster	Yes	Families Chronic		HUD COC	Yes	Yes
Nicolas House, Inc.	Nicolas House			10	Yes	Master-Lease Cluster	Yes	Families Chronic		HUD COC	Yes	Yes
PBRA Mixed Chronic/Non-Chronic Populations (Partially in coordinated entry)												
National Church Ministries/Caring Works	Commons at Imperial Hotel	355 Peachtree Center Avenue NE, Atlanta, GA, 30310	90	90	No	Single-Site Own	No	Single Adult		AHA PBRA	Yes	Yes
Caring Works	Adamsville Green Senior Apartments	3537 MLK Jr. Drive SW, Atlanta, GA, 30331	46	46	No	Master Lease Cluster	No	Single Adult	Seniors with disabilities	AHA PBRA	No	Yes
Rainbow Housing	Seven Courts Apartments	2800 Martin Luther King Jr. Drive, Atlanta, GA, 30311		30	Yes	Master Lease Cluster	No	Mixed		AHA PBRA	No	Yes
Community Concerns, Inc.	Odyssey Villas	605 Spencer Street NW, Atlanta, GA, 30314		32	Yes	Single-Site Own	No	Family		AHA PBRA	No	Yes
HOPE Atlanta	Columbia Park Commons	150 Peyton Place SW, Atlanta, GA, 30311		42	Yes	Master Lease Cluster	No	Mixed	Seniors	AHA PBRA	Yes	Yes
HOPE Atlanta	Columbia Tower at MLK Village	380 Martin Street SE, Atlanta, GA 30312		39	Yes	Master Lease Cluster	No	Mixed		AHA PBRA	Yes	Yes
HOPE Atlanta	Columbia at Sylvan Hills	1150 Astor Avenue SW, Atlanta, GA 30310		39	Yes	Master Lease Cluster	No	Mixed		AHA PBRA	Yes	Yes

HOPE Atlanta	Donnelly Courts	1250 Donnelly Avenue SW, Atlanta, GA, 303010		52	Yes	Master Lease Cluster	No	Mixed		AHA PBRA	Yes	Yes
?	Oscars at Scholars Landing	130 Lawshe St SW, Atlanta, GA 30314		60	Yes	Master Lease Cluster	No	Mixed		AHA PBRA	No	Yes
Community Friendship, Inc.	Community Friendship, Inc.	395 Ponce De Leon Avenue NE, Atlanta, GA, 30308	20	10	Yes	Single-Site Own	No	Mixed		HUD?	No	Yes
Community Friendship, Inc.	Community Friendship, Inc.	88 Fairburn Road SW, Atlanta, GA, 30331	20	10	Yes	Single-Site Own	No	Mixed		HUD?	No	Yes
HOPE Atlanta	The Legends at Laura Creek	3871 Lakemont Drive, East Point, GA, 30337		10	Yes	Master Lease Cluster	No	Mixed	HIV/AIDS	HOPWA	Yes	Yes
Southside Medical Center	Legacy Village	309 Mt. Zion Road SW, Atlanta, GA, 30354	28	14	Yes	Single-Site Own	No	Mixed	HIV/AIDS	HOPWA	No	Yes
Southside Medical Center	Legacy House	510 Parkway Drive, Atlanta, GA, 30308	16	8	Yes	Single-Site Own	No	Mixed	HIV/AIDS	HOPWA	No	Yes
Mercy Care	The Edgewood	191 Edgewood Avenue SE, Atlanta, GA, 30303	46	46	No	Single-Site Own	No	Mixed	HIV/AIDS	HOPWA	?	Yes
Jerusalem House	Adult Program	Briarcliff Road NE, Atlanta, GA, 30306	23	23	No - SRO shared kitchen	Master Lease	No	Single Adult	AIDS	HOPWA	No	Yes
Jerusalem House	Family Program	North Decatur Road NE, Atlanta, GA, 30306		12	Yes	Single-Site Own	No	Family	HIV/AIDS; Single moms and kids	HOPWA	No	Yes
Jerusalem House	Scattered Site I			32	Yes	Master Lease	No	Mixed	HIV/AIDS	HOPWA	No	Yes

Jerusalem House	Scattered Site II			203	Yes	Master Lease	No	Mixed	HIV/AIDS; homeless or low income	HOPWA	No	Yes
<b>TBRA Voucher Programs (Not in coordinated entry)</b>												
Department of Behavioral Health and Development Disabilities	GA Housing Voucher Program		186	186	No	Scattered-site	No	Single Adult	Severe and Persistent Mental Illness; Re-entry from institutions	DBHDD	Yes	Yes
Atlanta Housing Authority/Department of Veterans Affairs	HUD-VASH Vouchers			270	Yes	Scattered-Site	No	Mixed	Veterans	AHA TBRA	Yes	Yes
<b>PBRA for Long-Term Transitional for Young Adults (Partially in coordinated entry)</b>												
Covenant House of GA	Covenant House of GA	1559 Johnson Road NW, Atlanta, GA, 30318		40	Yes	Single-Site Own	Partial	Young Adults	18-21 years old	HUD COC; Mixed	No	No
Covenant House of GA	Scattered Site			4	Yes	Scattered-Site	Partial	Young Adults	18-21 years old	HUD COC; Mixed	No	No
Chris180	Summit Trail	2045 Graham Circle SE, Atlanta, GA, 30316		44	Yes	Master Lease Cluster	Partial	Young Adults	17-24 years old	AHA PBRA	No	No
Atlanta Outreach Project	Next Level / Lighthouse			50	?	?	No	Young Adults		?	No	?
Atlanta Outreach Project	Hero's Haven			12	?	?	No	Young Adults		?	No	?
<b>PBRA Long-Term Transitional for Adults (Partially in coordinated entry)</b>												
Partnership Against Domestic Violence				10	Yes	Scattered-Site		Family	Single parent households feeling domestic violence	HUD COC	Yes	No
The Living Room	SNHAP			150	Yes	Scattered-Site	Partial	Mixed	HIV/AIDS	HOPWA	No	No
The Living Room	TBRA			150	Yes	Scattered-Site	Partial	Mixed	HIV/AIDS	HOPWA	Yes	No

Veterans Empowerment Organization	Veterans Empowerment Organization	373 West Lake NW, Atlanta, GA 30318	60	30	Yes	Single-Site Own	No	Single Adult	Men	VA (SSVF); Some tenants pay	No	No
Essence of Hope	Essence of HOPE	918 Byron Drive SW, Atlanta, GA, 30310	12	6	Yes	Single-Site Own	No	Single Adult		Mix; Some tenants Pay	No	No
Making a Way Housing, Inc.	Daniel's Place	377 Westchester Boulevard NW, Atlanta, GA, 30314	72	36	Yes	Single-Site Own	No	Single Adult		Mix; Some tenants Pay	No	No
HOPE Through Divine Intervention	Villas of H.O.P.E.	385 Holly Street NW, Atlanta, GA, 30316	36	36	No	Single-Site Own	No	Single Adult	Men	AHA PBRA	No	No