THE RENTAL ASSISTANCE DEMONSTRATION PROJECT

February 2012

Human Impact Partners
Advancement Project
National People's Action

A HEALTH IMPACT ASSESSMENT


HUMAN IMPACT PARTNERS


ADVANCEMENT
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PRIMARY AUTHORS

HUMAN IMPACT PARTNERS

Kim Gilhuly
Saneta DeVuono-powell
Lili Farhang

ADVANCEMENT PROJECT

Alexi Nunn Freeman
Anita Sinha

NATIONAL PEOPLE'S ACTION

Liz Ryan Murray

ACKNOWLEDGMENTS

Human Impact Partners, Advancement Project, and National People's Action would like to thank the following organizations and their members for participation in this HIA's scoping process, focus groups, and surveys: Causa Justa::Just Cause in Oakland, Communities United for Action in Cincinnati, Community Voices Heard and Good Old Lower East Side in New York City, People Organized for Westside Renewal in Los Angeles, and the Right to the City Alliance. The insight and access they provided enabled this report to convey the voice and expertise of those most impacted by federal public housing policies.

We thank Leconte Dill, Laura Gottlieb, Marnie Purciel-Hill, Sara Satinsky and Maren Spolum for research and writing support and Caroline Fichtenberg and Megan Gaydos for their thoughtful review and feedback of this HIA. Finally, we thank the San Francisco Foundation and The California Endowment for funding provided for the project.

SUGGESTED CITATION

Human Impact Partners, Advancement Project, and National People's Action. The Rental Assistance Demonstration (RAD) Project: A Health Impact Assessment. February 2012.

For more information, please contact:

Kim Gilhuly, Human Impact Partners
www.humanimpact.org
510.452.9442

Alexi Nunn Freeman, Advancement Project
www.advancementproject.org
202.728.9557

Liz Ryan Murray, National People's Action
www.npa-us.org
312.243.3035

EXECUTIVE SUMMARY

WHAT IS THE ISSUE?

Today, there are 2.3 million people living in federally-funded public housing projects around the country, over half a million families who receive rental voucher assistance, and over one million people on public housing and rental voucher wait lists. While the demand for housing assistance has increased over time, funding for public housing has decreased substantially. Local public housing authorities around the country, faced with massive budget shortfalls and a deteriorating public housing stock, are unable to accommodate the need for subsidized housing, and various localities have begun to close their wait lists altogether.

In response to these significant challenges, multiple proposals to re-organize the funding and management of public housing and to bring forward additional funds have been debated at the federal level over the past few years. The most recent result of these debates is the Rental Assistance Demonstration (RAD) project, which is a pilot project approved in November 2011 that may lead to a significant re-structuring of America's public housing stock, such that the "public" aspect of public housing may no longer apply. Specifically, RAD could allow private and non-profit entities to take over lease and management responsibilities and would allow for private investment resources to be put directly into public housing. In addition, it is likely that RAD will promote movement from public housing into the private market through rental vouchers. Additional components are described in the sidebar.

Through all of these policy debates, health is seldom discussed. Given that public housing residents have vulnerable health status whose health may further be affected by RAD, and building on a body of evidence connecting housing and health, Human Impact Partners, Advancement Project, and National People's Action conducted a Health Impact Assessment (HIA) on RAD. This executive summary describes the background and findings of the HIA, and proposes recommendations to improve the impacts of RAD such that the health of public housing residents can be protected and promoted.

RAD COMPONENTS

RAD would allow for the following:

- **Investment of private resources into what was formerly solely a public asset**
- **Potential for ownership by a non-profit organization or for-profit organization using tax credits**
- **Restrictions on the properties limiting what the property can be used for and for how long it must remain "affordable"**
- **Potential for increased reliance on vouchers without any new vouchers created**
- **Potential for increased, and stricter, residency standards with new housing managers**
- **No guarantee of one-to-one replacement of hard units if demolition and renovation takes place**
- **Limited discussion of resident organizing and resident organizations**
- **Significant discretion left to HUD Secretary and many aspects dependent on funding**

WHY DOES THIS MATTER?

The potential impacts of RAD are vast; 2.3 million people living in 1.04 million housing units could be impacted if the pilot project is implemented more widely. The initial impact will be less since the project approved the conversion of 60,000 units of public housing. However, RAD is a pilot project, which means it is being implemented to test policies for the public housing system overall. Not only will this project impact the lives of residents of public housing, the principles included in RAD more broadly could impact the lives of individuals living on the edge of economic insecurity. With recent studies reporting that one in six Americans lives in poverty, and as the need for affordable housing is on the rise, proposals that re-structure the public housing stock should be measured in light of the reality that more and more individuals are living on the economic brink and need the stability and affordability that public housing provides.

In recent history, policymakers have focused intense resources on relocating residents out of public housing in attempts to improve their socioeconomic status and to deconcentrate poverty (e.g., Moving to Opportunity, HOPE VI, and the Gautreaux project). In all of these approaches, public agencies and housing advocates have generally not given much attention to the health impacts associated with such significant policy shifts. Current debates focus on the costs and benefits of these various approaches; few of those debates, however, adequately incorporate the health of residents and communities, most of whom are people of color, as part of that cost-benefit analysis.

This lack of attention to the potential health impacts is particularly striking given the vulnerable health status of many public housing residents and the relationship between housing and health. Scientific studies find that public housing residents report: poorer health; increased levels of asthma, hypertension, diabetes, obesity, depression, and smoking; decreased levels of physical activity; and exposure to poor indoor air quality and pests. Public housing residents are not to blame for these conditions. Various social, economic, and environmental factors interact to create poor health in populations: income and employment, neighborhood investment and quality, and access to retail goods and services have all been shown to determine health status and health disparities.

WHAT IS HEALTH IMPACT ASSESSMENT?

Health Impact Assessment (HIA) is a public engagement and decision-support tool that can be used to assess the health impacts of planning and policy proposals, and make recommendations to improve health outcomes associated with those proposals.

The fundamental goal of HIA is to ensure that health and health inequities are considered in decision-making processes using an objective and scientific approach, and engaging affected stakeholders in the process.

Policy decisions that affect health determinants such as housing quality, stability, and affordability must be viewed in the context of health needs. Without the consideration of health impacts, public housing reform efforts may exacerbate existing health vulnerabilities. The amount of discretion in RAD, as well as too few protections for long-term affordability, has raised concerns among low-income and public housing advocates around the country. Infusing private resources into a traditionally-government run program may bring forth additional (and much needed) funding, but may also incorporate the risks associated with private finance, potentially jeopardizing the permanent affordability and stability that public housing provides to its occupants.

To ensure that the evaluation of this pilot project comprehensively considers the health impacts of public housing-related policy decisions and to make recommendations for how to mitigate potential impacts for both the pilot period and the long-term, Human Impact Partners, Advancement Project, National People's Action, and a network of community-based organizations conducted a health analysis, or a "Health Impact Assessment" (HIA) of RAD.

This is the first HIA ever conducted of a federal housing proposal.

WHAT DID WE STUDY?

Human Impact Partners and Advancement Project determined that a HIA was warranted primarily because if RAD continues beyond the pilot period, it has significant potential to affect the health of all public housing residents (over two million individuals) as well as the increasing number of individuals and families in need of subsidized housing across many geographic areas. In addition, RAD could affect existing health disparities given that public housing residents experience poorer health outcomes when compared to the general population. Because methods existed to document the breadth of potential health impacts and numerous organizations were receptive to an analysis of health to be incorporated into housing policy debates, we were able to complete this HIA.

There is no single causal pathway for the relationship between public housing and health – health is impacted by various dimensions of housing, including conditions and quality, affordability, location, and stability. In determining the scope of research, partners for this HIA agreed that impacts on health would be assessed by examining impacts on several mediating factors (or "health determinants"), including: type of management, evictions, and resident organizing; housing affordability, stability, and quality; and social capital. Literature review, evaluations of prior housing relocation programs, focus groups and surveys, and available quantitative data were used to assess impacts on these elements. Given the potential for the policy to impact cities and communities across the United States, partners decided to focus this HIA in several "case study" cities, specifically New York City, Los Angeles, Cincinnati, and Oakland, as a way of grounding the findings and illustrating how components of RAD might impact specific populations.

WHAT DID WE FIND?

Overall, this HIA finds that RAD, as currently written, will have significant impacts on the health of public housing residents and communities, and the impacts are more negative than positive – especially if recommendations proposed in this HIA are not adopted. The areas of impact relate to type of management in public housing, evictions, and resident organizing; housing quality, affordability, and stability; and social capital.

These impacts will be more far-reaching if RAD is expanded beyond the pilot period. As currently written, most of the impacts on the health of public housing residents would be negative, either by introducing new negative impacts, such as decreasing social cohesion/social networks, or by exacerbating already poor health outcomes, such as increasing stress. Some positive impacts may result from RAD, particularly in the areas of crime and violence and housing maintenance.

Due to the lack of economic and social investment in many of these communities and the existing health vulnerabilities of many public housing residents, public housing provides an important safety net and source of stability that protects resident health. This HIA found that various dimensions of RAD would impact health in both direct and immediate, and indirect and long-term ways. The factors at play are various and not mutually exclusive – changes to any one of these factors will necessarily impact other factors that affect physical and mental health. Specific research findings and impact analyses (what we anticipate the impacts of the public housing reform policies to be on health) related to the health determinants studied in this HIA – types of public housing management, evictions, and resident organizing; housing quality, affordability, and stability; and social capital – are described below. Recommendations on how to mitigate negative health impacts follow our findings.

1. RESEARCH FINDINGS

Because RAD primarily targets the management and ownership structures of public housing – and because impacts on evictions and resident organizing; housing quality, affordability, and stability; and social capital are expected to result from changes in those management and ownership structures – we discuss our HIA research findings and impacts related to management first, and then follow with the assessment of the other determinants. Overall, there are many different outcomes that RAD could have – some are positive and some are negative – and they, at times, may seem to conflict. It is important to note the overarching category of impact and understand that HIA often highlights trade-offs between categories of impacts.

Type of Management, Evictions, and Resident Organizing

- Over the past several decades, public housing budgets have decreased by 48% while funding for vouchers has increased by 403%. More and more, the public housing stock in the U.S. is being privately managed.

- Since the 1980s, anti-crime laws have eroded protections for public housing residents and those receiving vouchers. For example, residency standards have resulted in the denial of residency for lower-income populations who are hard to house, including the elderly, large families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet work and/or school requirements.

- There is a dearth of studies evaluating the quality of privately-managed public housing and there is no national or readily available local data on the evictions resulting from implementation of residency requirements.

- Our HIA focus group participants overwhelmingly state that eviction is a main reason why people move out of public housing. These residents state that the risk of eviction, being caught breaking a rule, or a child/visiting friend/family member breaking a rule and risking eviction for the whole family, was stressful in their lives.

- Research shows that resident participation in public housing affairs has resulted in improved physical and living conditions, improved quality of life, greater sense of control, and increased community building. Participation is greatest among those who have resided in public housing longer.

- Historically, public housing residents have been able to organize and advocate through residents' associations. However, mechanisms to ensure that residents have a meaningful voice in decision-making could be stronger.

Housing Quality, Affordability, and Stability

Housing Quality

- Decades of inadequate investment in public housing have translated into many units being in disrepair. A U.S. Housing and Urban Development (HUD) inventory estimated the capital needs as $21 billion for the entire public housing stock.

- Substandard housing conditions cause stress and contribute to a variety of health impacts including respiratory disease, neurological disorders, chronic disease, and mental health.

- Results are conflicting with respect to whether resident relocation via housing mobility or relocation programs has led to health improvements.

Feelings about management are summed up by a focus group participant who stated,

"The stress levels residents face dealing with management is unbearable."

HIA Focus Group Participant

"……'cause it just has been run into the ground and not by just the folks that live there, but by not having money to keep it up. It feels like a project failed and the people in it feel that way, too. I think that's the reason no one takes pride in it anymore."

HIA Focus Group Participant

Housing Affordability

- Lack of income with which to pay for adequate housing can lead to adverse health outcomes associated with homelessness, overcrowding, and/or living in sub-standard housing. Housing insecurity has been associated with stress and there are significant associations between high housing costs and hunger, inadequate childhood nutrition, and poor childhood growth.

- There are numerous obstacles for public housing residents to transition into the private market, including discrimination against and exploitation of voucher holders, difficulty paying for and adjusting to utility bills, and lack of understanding about private markets, rent calculations, and security deposits.

- A recent HUD study found that 7.1 million households were found to have "worst case" housing needs in 2011 – an increase of 42% since 2001. These households are comprised of very low-income renters who either (1) pay more than one-half of their monthly income for rent; or (2) live in severely inadequate conditions, or both. The crisis is exacerbated by the large disparity between available public housing units and the number of households on wait lists, and the fact that fair market rents are significantly higher than what public housing residents can afford.

Housing Stability

- Public housing is found to provide residential stability. Because of this stability, living in public housing during childhood has been associated with increased employment, raised earnings, and reduced welfare use. Also, utilization of preventive health services among those living in public housing equaled or exceeded those of other city residents. This stability also facilitates development of social relationships.

- Studies document high levels of residential instability among voucher users. HUD data indicates that people who live in public housing reside there for nearly twice the length of time than voucher users reside in their housing.

- Participants in this HIA's focus groups cited stress about housing stability and permanence as a major concern.

"I have a great deal of medical expenses. So really, to have to pay $1500 or $1600 or $2200 a month in rent anywhere else… I couldn't afford it. I would be homeless."

HIA Focus Group Participant

"I have lived in public housing for 50 years … grew up here. That's where I intend to die. My choice. I love it."

HIA Focus Group Participant

Social Capital

Social Capital/Support and Stress

- Social support provides a buffer in stressful situations and prevents feelings of isolation. Neighborhoods in which residents feel social cohesiveness toward their neighbors tend to have lower mortality rates compared to neighborhoods lacking strong social bonds.

- Relocation out of public housing generally has negatively impacted social capital and networks by creating physical isolation, diminishing face-to-face interactions, and moving residents away from supports and services.

- Residents of public housing are living with high levels of stress. Most focus group participants in this HIA indicated that they or their neighbors experienced health issues, amongst the most commonly cited was stress associated with housing insecurity.

Racial and Ethnic Segregation and Poverty Concentration

- Living in racially segregated neighborhoods has been associated with higher infant mortality, overall mortality, and crime rates that cause injury and death. The concentration of poverty has been associated with high unemployment rates, high school dropout rates, and crime and violence. These are often reasons cited for demolishing public housing, even though many of these neighborhoods also lack critical social services that may ease these health risks and other consequences.

- Segregation is common in public housing. Nationally, there are three times as many African-Americans and one and a half times as many Latinos living in public housing as compared to the general population.

- Public housing relocation programs have had mixed results with respect to achieving stated goals of racial and ethnic integration and poverty deconcentration. Residents often re-concentrate into segregated and/or poor communities, and there is little improvement in individual income levels.

"Closeness to family and friends are important to our communities."

"I know my entire floor and at least somebody on every floor, [and] I have an investment and connection. All the old folks tell me hello, and they are invested and want to see me grow."

HIA Focus Group Participants

"I don't want to leave where I live; I want them to just take better care of it as if we lived with rich people now."

HIA Focus Group Participant

Crime and Violence

- Crime and violence are overwhelmingly stated as a concern among public housing residents. Crime is often discussed in tandem with comments about the communities in which public housing is located in and the inability of management to intervene.

- Housing relocation programs have, overall, reported positive impacts on crime and violence. Research assessing whether crime is displaced to other communities illustrates that crime decreases overall.

- However, the social cohesion people feel in public housing acts as a buffer to perceived crime, and this perception can have a protective effect for residents with respect to crime.

Stress

- Both the literature and our HIA focus group findings confirm that the residents of public housing are living with stress. Most of our focus groups participants indicated that they or their neighbors experienced some health issues, the most commonly cited being stress associated with crime and housing insecurity.

2. IMPACT ANALYSIS FINDINGS AND SUMMARY TABLE

Predictions of impacts were made based on the research findings included in the report, and on the "determinants of health outcomes" – i.e., type of management, evictions and resident organizing; housing quality, affordability, and stability; and social capital. Throughout the HIA, we demonstrate the connections between these determinants and health outcomes, and where possible we include future impacts on health. Predictions of how RAD will impact health determinants were qualitatively made using findings from the literature, existing conditions data, and focus group and survey results. Given the lack of detail in RAD, the predictions below reflect our best interpretation of the components of RAD.

"I feel stressed at times, cause it feels like things ain't getting better, they are getting worse. Also they are always talking about the projects are gonna be sold so I worry about that."

HIA Focus Group Participant

We predict that changes in the types of management, as currently written, *are likely to lead* to the following impacts:

- Improved housing conditions due to more responsive maintenance practices because of increased funding available from conversions. Health benefits include fewer injuries and improved mental and physical health (e.g., respiratory health). However, if funding is allocated to repair the least distressed housing stock (e.g., failing to prioritize the housing that is most in need of repairs) and/or if renovations are not completed using high-quality standards, health benefits associated with improved maintenance may be limited. Furthermore, if ongoing funds are not committed to maintenance over the long-term, any health benefits may not last.

- Improvements in safety, crime, and violence. As crime and violence decrease, health impacts would include fewer injuries and deaths, as well as decreased stress and stress-related health conditions.

- Increased stress among those who face increased housing costs, have fewer social networks and support, experience housing instability, and/or are evicted.

We predict that changes in the types of management, as currently written, *may lead* to the following impacts

- More tenuous relationships between residents and management, and stress associated with disrespectful treatment by management.

- Decreased strength of resident organizing protections, thereby limiting improvements in the physical conditions of housing, and decreases in quality of life, community building, and social capital.

- Decreased housing stability if financial impacts and time and use restrictions place the long-term permanence of the public housing stock at risk – leading to stress, housing cost burden, and the disruption of social networks and support.

- Increased residency standards and/or requirements that will lead to:

    - Increased evictions due to new rules and one-strike policies.

    - Housing denied to future tenants who cannot meet residency requirements, including those who have been arrested or incarcerated (or have a relative in this situation), have poor credit histories, or who are unable to meet work or school requirements.

    - Decreased social cohesion and support networks through eviction, relocation, and/or displacement.

    - Increased housing cost burden for residents renting at less affordable rates in the private market.

Potential promotion of mobility through tenant-based vouchers *is likely to lead* to the following impacts:

- Improved mental health and perceptions of neighborhood surroundings among adults.
- Housing in less racially segregated and poor communities, though not significantly less.
- Increased housing cost burden and associated health impacts (e.g., having fewer resources for other daily needs, poor quality housing conditions, overcrowding, and homelessness).
- Decreased housing stability and increased threat of eviction when renting through the private market, causing negative health impacts.
- Decreased social cohesion and support networks through the relocation process.
- Decreased ability to organize for better conditions.

There are several important caveats to consider in relation to these impacts:

- Any changes in public housing will have a disproportionate impact on "hard to house" populations – e.g., the elderly, large families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet work or school requirements.
- There is currently no funding for vouchers or additional vouchers being created through RAD. Therefore, mobility-based impacts will occur over the medium-to-long term only if more vouchers are provided.
- The impacts described above will vary over the short-to-long term. Some impacts will take time before manifesting in visible ways, while others may occur immediately. Furthermore, impacts that may initially be positive may change over time, and vice versa.
- **Many of the findings assessed in the report are in part based on evaluating past housing relocation programs, including MTO, HOPE VI, and the Gautreaux project. Research from these programs demonstrates limited positive impacts on health and health determinants.**

  RAD differs significantly from past programs in ways that could further limit positive impacts on health and health determinants. In particular, MTO provided extensive funding for vouchers where none is provided here and under HOPE VI, many public housing complexes were demolished and rebuilt, which is not anticipated in RAD.

The table below summarizes the impacts of RAD on health determinants prioritized in this HIA. Included is information on the direction, magnitude, and severity of impacts, which is defined below, as well as the strength of the evidence and any uncertainties regarding predictions.

HEALTH DETERMINANT	IMPACT	MAGNITUDE (HOW MANY?)	SEVERITY (HOW BAD?)	EVIDENCE STRENGTH	UNCERTAINTIES
Type of Management	~	Minor- Moderate	Low-Moderate	• •	Ability to informally implement stricter residency rules Resident organizing protections Strength of eviction protections Assuming funds target the most distressed housing stock How time and use restrictions will be implemented Unclear the extent to which tenant-based vouchers will be distributed
Eviction	-	Moderate	Moderate	• •	
Resident Organizing	~	Minor	Low	• •	
Housing Quality	+	Moderate-Major	High	• •	
Affordability	-	Moderate-Major	Moderate	• •	
Stability	-	Moderate-Major	Moderate	• •	
Social cohesion/ Social networks	-	Major	Moderate	• •	
Segregation	~	Minor- Moderate	Low-Moderate	•	
Concentration of poverty	~	Minor- Moderate	Low-Moderate	•	
Crime	+	Moderate-Major	High	• •	
Stress	~	Moderate-Major	High	• •	

Explanations:

Impact refers to whether the proposal will improve health (+), harm health (-), or whether results are mixed (~).

Magnitude reflects a qualitative judgment of the size of the anticipated change in health effect (e.g., the increase in the number of cases of disease, injury, adverse events): Negligible, Minor, Moderate, Major.

Severity reflects the nature of the effect on function and life-expectancy and its permanence: High = intense/ severe; Mod = Moderate; Low = not intense or severe.

Strength of Evidence refers to the strength of the research and evidence showing causal relationship between mobility and the health outcome: • = plausible but insufficient evidence; • •= likely but more evidence needed; • • • = causal relationship certain. A causal effect means that the effect is likely to occur, irrespective of the magnitude and severity.

WHAT DO WE RECOMMEND?

As described above, while RAD is likely to lead to some positive health impacts, negative impacts are likely to outweigh any positive impacts – especially without mitigation. Furthermore, there are a number of missed opportunities to improve health via RAD. To address these gaps, based on the research findings and impacts described, we identify a number of recommendations to improve RAD and any long-term policies that may result if it is continued beyond the pilot period. Overall, the goal of these recommendations is to mitigate identified negative impacts such that resident health can be protected and promoted.

Recommendations are written in such a way as to be feasible, actionable, measurable, and able to be monitored. Because of the number of unknowns related to implementation as well as the lack of overall positive health impacts that would result from implementation, we first propose a number of overarching recommendations for decision-makers to consider:

1. Prioritize funding to improving existing public housing stock rather than on relocating residents out of public housing.

2. Keep the "public" in public housing – require that public housing always remain a public asset under public ownership and control, particularly in times of risk such as foreclosure, bankruptcy, or default.

3. Require the preservation of the public housing stock by clarifying long-term sustainability plans for individual Public Housing Authorities (PHAs), developed by PHAs with oversight from and in collaboration with the resident organizations, public housing advocates, and HUD.

4. Designate adequate funding for services, support, and protections for those who are traditionally "hard to house." (e.g., the elderly, large families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet work or school requirements, etc.)

5. Develop an assessment, monitoring, and evaluation program in collaboration with resident organizations and public housing advocates, implemented by an independent third party to track implementation and effects of RAD, and to recommend changes that will need to be made if RAD is continued beyond the pilot period.[1]

6. Set up a Conversion Oversight Committee (COC) made up of existing leaders of PHA resident organizations, public housing advocates, and elected officials. The COC should be charged with reviewing: national residency standards; criteria for selecting which public housing receives RAD conversion status (including special consideration for public housing sites that provide housing for the "hard to house"); and national grievance policies, and should be required to provide twice yearly updates on implementation progress and evaluation program results.

7. Local resident associations should be a part of review and decision-making processes on topics including development and implementation of residency standards; development of disposition plans and relocation compensation and support; development and oversight of grievance policies; site maintenance workplans to address repair needs; new rules implemented within public housing complexes; and distance limits of new housing identified for residents.

The report includes about 35 specific recommendations. Below we highlight eight recommendations targeted directly at impacts predicted in the report related to topics such as ownership, management, eviction, tenant organizing, and social cohesion:

1. Prioritize that owners of converted properties always be a public entity, including in the event of foreclosure, bankruptcy, default, or transfer of contract.

2. Require environmentally sustainable rehabilitation using standards from Leadership in Energy and Environmental Design (LEED) or Enterprise Green Communities and ensure full implementation and enforcement of HUD Section 3 employment requirements.

3. Expand due process protections for public housing residents, such as by developing grievance policies.

4. Require 100% waivers for all units in all project-based pilot sites to ensure that income mixing requirements and the resulting displacement do not apply.

5. Require just cause evictions of residents in efforts to protect against retaliation for complaints made about housing quality.

6. Limit distance of how far residents are relocated based on unique characteristics of the city. For residents who relocate, provide relocation assistance per the Uniform Relocation Assistance Act, including moving costs, transportation costs, and job placement assistance.

7. Ensure the protection, repair, and maintenance of hard housing units, especially the most distressed units and units for "hard to house" residents. Limit the demolition and disposition of public housing units to those units that are beyond repair, as defined by criteria set with oversight from a Conversion Oversight Committee.

8. Require one-for-one replacement of lost or demolished public housing units (i.e., hard units).

WHERE DO WE GO FROM HERE?

Stakeholders from around the country have been meeting with HUD and elected officials to weigh in on RAD and its implementation both before and after it was signed into law in late November 2011. Our goals for this HIA are that:

1. **HUD and other officials responsible for the implementation of RAD directly incorporate specific recommendations included in this HIA in an effort to mitigate identified negative health impacts.**

2. **Stakeholders and decision-makers incorporate discussions of health impacts and health inequities as part of housing policy-making.**

Numerous questions remain to be answered to see whether these goals are met and whether health impacts will be allayed: Will public housing truly remain "public"? What will the conversion process look like? What role will residents and stakeholders play in the process? What support will be provided to residents through such significant policy shifts? What information and data will be tracked and made public about conversions, residency changes, and residents' experiences? Will public housing remain a permanent source of housing for those needing it most? Tracking the answers to these questions over time is essential and will help us understand the extent to which public health can look to public housing as an "intervention" to protect and promote the health of vulnerable populations.

Repeatedly, research has shown the importance of high quality, affordable, and stable housing to individual and community health and well-being – findings that residents and community stakeholders have known both physically and intuitively. For far too long, housing policies have at best minimized, and at worst excluded, discussions of health and how policies may exacerbate or improve health inequities, despite the fact that housing greatly affects health. This HIA was conducted in an attempt to address this major gap. Though there were a number of limitations – including lack of quantitative data on public housing conditions, little information regarding how RAD will actually be implemented, and mixed research with which to compare – we believe we are making an important and necessary contribution to ongoing debates on subsidized housing policy, and in the field of health impact assessment. We hope HUD and other officials draw upon our findings and recommendations to carefully monitor and measure the impact of RAD as well as help determine the future of public housing.

REPORT

INTRODUCTION

Today, there are 2.3 million individuals living in federally-funded public housing developments around the country, over half a million families who receive rental voucher assistance, and over one million people on public housing and rental voucher wait lists. The economic crisis of the past several years has yielded stark statistics that paint an even more challenging context for those seeking housing assistance: nearly one in six Americans lives in poverty (with higher rates among children and people of color),[2] [3] 1 out of every 200 homes will be foreclosed upon,[4] and nearly half of renters are moderately cost burdened (spend greater than 30% on their housing).[5]

Within this context, housing assistance is all the more needed. Unfortunately, while the demand has increased over time, funding for public housing has decreased substantially.[6] [7] Local public housing authorities around the country, faced with massive budget shortfalls and a deteriorating public housing stock, are unable to accommodate the need for subsidized housing, and various localities have begun to close their wait lists altogether. Although public housing continues to be the primary mechanism for addressing housing needs of many low-income families and individuals, it has also been critiqued as a model that concentrates poverty, leading to crime and violence, economic abandonment and disinvestment, and isolation of residents from services and opportunities.

With varied levels of success, the U.S. Department of Housing and Urban Development (HUD) has pursued multiple approaches to address its lack of funding, a deteriorating housing stock, and critiques of public housing. Through outright demolition of public housing and providing resources to residents to move to less poor areas, one approach gaining significant traction is the privatization of public housing. In this model, private companies are contracted to build and/or manage new housing developments, often demolishing existing units without replacing with new public housing in the process. The newly-built housing is often mixed income, with a large number of new market-rate units subsidizing the cost of building the low-income units. Far more often than not, the number of units designated for low-income families in the new development is significantly less than the units in the former public housing project it replaced.

A PRIMER ON PUBLIC HOUSING

"Public housing" is a term specifically associated with a government program that started over 70 years ago. Presently, there are 1.16 million public housing units located in about 14,000 developments in every state and several territories.[8] [9] About 1.04 million units are currently occupied, housing 2.3 million people.[10] Vacancies can result from disrepair; delay or failure of management to respond to maintenance problems making units inhabitable; evictions; tenant turnover; or transitions between converting the units to a new form of housing, such as mixed-income housing or through Hope VI.

For the purpose of this Health Impact Assessment, we focus on the impacts of RAD on these public housing units, not on the broader category of "affordable housing," which can take many forms (including public housing) and serves both renters and homeowners on a spectrum of income levels. Unlike many affordable housing programs, public housing traditionally has not relied upon the private market and serves only low-income renters. Public housing is distinct from affordable housing programs which can include "tenant-based" Section 8 housing vouchers, which help residents rent units in the private market, and "project-based" Section 8 and other federal programs that directly subsidize low-income people to live in affordable housing in the private market.

IN LATE NOVEMBER 2011, THE RENTAL ASSISTANCE DEMONSTRATION (RAD) PROJECT WAS SIGNED INTO LAW as part of a 2012 "minibus" appropriations bill in an effort to re-organize several of HUD's core housing policies. The general components of RAD include allowing the voluntary conversion of existing public housing to private and non-profit structures, renegotiating time and use restrictions on converted housing, and potentially promoting residential mobility out of public housing through the distribution of rental vouchers.

In both these recent as well as past debates around the reorganization of public housing, officials and housing advocates have generally not given much attention to the health impacts associated with significant policy shifts. However, it is well known that the type of housing we live in – and the communities our housing is located in – can have significant impacts on our health. For those living in public housing, the connections between housing and health are even more pronounced. Given the age and poor maintenance of the public housing stock in America, and the overall disinvestment in communities where public housing is located, resident exposure to poor housing conditions and housing instability are considerable. For example, housing that is not maintained properly can increase exposure to mold and other asthma and respiratory diseases triggering allergens, pests, and physical hazards that increase risk of injury. The affordability of housing can impact the amount of money a family has to spend on other necessities and can affect residential stability. Residential stability, in turn, impacts behavioral and educational outcomes in children, which can carry through into adulthood and lead to a shorter lifespan. Having to move often also affects the social ties and networks which can increase or diminish people's access to life-affirming resources, such as jobs, childcare, and emotional support. Management practices and residency rules in rental and public housing can have serious impacts on housing stability, quality of life, and social- and self-perception. Finally, the neighborhood conditions where people live impact their access to schools, transportation options, jobs, healthy food retail, and exposure to crime and perceptions of safety.

Many debates explored the costs and benefits of RAD, but few of those debates adequately incorporated health concerns of residents and communities, most of whom are people of color, as part of that cost-benefit analysis. The lack of attention to the potential health impacts of RAD is particularly striking given the vulnerable health status of many public housing residents and how closely housing is tied to one's health. In response, Human Impact Partners, Advancement Project, National People's Action, and a network of community-based organizations conducted a health analysis, or a "Health Impact Assessment" (HIA), of RAD between April and November 2011, to ensure that the evaluation of this pilot project comprehensively considers the health impacts of public housing-related policy decisions and to make recommendations for how to mitigate potential impacts for both the pilot period and the long-term.

THE REPORT IS ORGANIZED AS FOLLOWS: First, we describe the background of why housing matters to health, the proposal being assessed, the screening and scoping process of HIA, and assessment methods employed. Then we discuss the assessment findings, predictions, and recommendations related to the core components of this HIA: type of management, evictions and resident organizing; housing quality, affordability, and stability; and social capital. We next include a monitoring plan to track the impacts of this HIA, and then the conclusion follows.

A LOOK BACK ON PUBLIC HOUSING: DISINVESTMENT

Initially, public housing was created in response to the economic crisis of the Great Depression. Created relatively late in the New Deal period by the Wagner-Steagall Housing Act of 1937, public housing was to be built and run by local Public Housing Authorities (PHAs). Through this legislation, policymakers sought to adopt a housing and employment program to quell unrest during an economically unstable time and "head off any great outburst of protest or revolt" by the "multitudes left unemployed, impoverished, and often homeless."[11]

From the beginning, the public housing system received inadequate investment from the federal government. Because public housing units were first created at the start of World War II,[12] war needs diverted materials from housing construction, and public housing was predominately used as temporary housing for war industry workers, rather than for the poor.[13] After the war, construction of both permanent and emergency housing for "upwardly mobile" veterans became the priority – housing for the poor and people of color was not.[14] The Housing Act of 1949 authorized the construction of 810,000 public housing units (though not completed until the 1970s),[15] and provided federal subsidies for land through "urban renewal."[16] At this point, "public housing was built with more haste than care, and with a limited realization of (or concern with) what meeting its prospective residents' housing needs would actually have meant."[17]

Simultaneously, the Act created an incentive for housing authorities to evict higher-income residents.[18] This, coupled with Federal Housing Administration loans being doled out primarily to the White middle class,[19] caused the growth of working and middle class White suburbs on one side, and working class and poor Black urban areas on the other – a shift which helped shape the racial composition of public housing.

As the demographics of public housing changed, federal disinvestment worsened. The 1970s brought programs that attempted to use the private market to meet the need for affordable housing. In 1973, then-President Nixon froze federal funds for all housing programs and instituted a moratorium on the creation of additional public housing.[20] That same year, Congress enacted Section 8 of the 1937 Housing Act, which created project- and tenant-based vouchers to generate a private market system for affordable housing,[21] leaving public housing as the sole option remaining unaffected by the ever-fluctuating market.

In the 1980s, an era marked by the aggressive implementation of neo-liberal economic policies in the United States, the Reagan Administration "turned bureaucratic stinginess into deliberate curtailment of funds and support."[22] Decreasing spending on public housing was part of the massive budget cuts to social safety nets,[23] rendering the construction of public housing during this period almost nonexistent. Funding for the maintenance of existing public housing stock was also slashed, which caused many units to fall into disrepair. Remaining HUD funds were diverted to the Section 8 voucher program.[24] The Reagan Administration also created the Low-Income Housing Tax Credit program through the Tax Reform Act of 1986, which represented another program reliant on the private market system to generate affordable housing. Since then, no funds have been provided to build new public housing since the mid-1990s (with the exception of HOPE VI[25]); nearly all public housing developments have been built before 1985.[26] By 1991, HUD's budget had been reduced by $54.6 billion from the amount authorized at the beginning of the 1980s.[27]

A TIMELINE OF PUBLIC HOUSING POLICIES

1937

Wagner-Steagall Housing Act – post-Depression program which created public housing programs to quell unrest during economically unstable times.

1949

Housing Act of 1949 – authorized creation of 810,000 units of public housing and provided federal subsidies for land through "urban renewal." Public housing is built with more haste than care, compromising its quality from the outset.

1968

The Fair Housing Act – Title VIII of the Civil Rights Act of 1968 – provides protection against discrimination in the sale, rental, and financing of dwellings based on race, color, religion, sex, or national origin. Other populations that are often marginalized in housing programs, such as large families, or those who have been arrested or incarcerated, have poor credit histories, or who are unable to meet work or school requirements, do not have established protections.

1973

Section 8 of the 1937 Housing Act – utilized the private market to create affordable housing by using vouchers, which was meant to enable low-income residents to choose where they lived. This intention included the assumption that a landlord would always be willing to rent a unit at the price set by the local PHA and that there would not be discrimination by landlords against voucher holders.

Then-President Nixon places a **moratorium on all federally-funded housing programs.**

1976

1976–1998: Gautreaux project – residential mobility project where over 7,000 families voluntarily moved from inner city public housing in Chicago to more affluent areas.

1986

The Low Income Housing Tax Credit program (LIHTC) – created through the Tax Reform Act of 1986, gave tax credits to developers and businesses for constructing affordable housing, though not all of the new units had to be affordable – some could be market rate units – limiting the number of units accessible to the lowest-income people.

1990

The National Affordable Housing Act – decentralized HUD control, giving greater freedom to local housing authorities, and encouraged the involvement of resident- and community-based organizations.

1992

1992–2011: The Housing Opportunity for People Everywhere (HOPE VI) program – provided funding to local public housing authorities across the country to redevelop "severely distressed" public housing units. Typically involved displacing and relocating residents in order to make way for newly-constructed, mixed-income developments. While HOPE VI received funding in the 2011 budget, it did not receive any in the 2012 budget.

1992–1999: Moving To Opportunity – a voluntary, randomized control study where 4,600 families were randomized into three groups: a control group, a Section 8 group who received a voucher to relocate to a unit of their choice, and an experimental group who received a voucher that could only be used in low-poverty census tracts.

1996

HUD introduces guidelines around the "One-Strike Rule," which allows public housing authorities to evict residents if any member of their household or a guest is caught using illegal drugs or is involved in drug-related criminal activity on or near the premises, even if the resident was unaware of the activity.

1998

The Quality Housing and Work Responsibility Act (QWHRA) – established the Public Housing Operating Fund and Public Housing Capital Fund. With these new funding sources, PHAs were prohibited from using money from either source to create new public housing units if it would increase the number of public housing units of the PHA – essentially an amount that would exceed what was already constructed. The QHWRA also established the Community Service and Self-Sufficiency Requirement, which mandated that many public housing residents contribute eight hours per month of community service, participate in an economic self-sufficiency program, or risk not having their lease renewed.

2002

HUD v. Rucker – The U.S. Supreme Court unanimously upheld the "One-Strike Rule" in a case brought by four California residents.

2008

The National Affordable Housing Trust Fund – established permanent funding from Freddie Mac and Fannie Mae to provide for long-term investment in affordable rental housing for low-income people, though it did not provide for investment in public housing. This fund has been severely stalled by the economic downturn.

2009

American Recovery and Reinvestment Act (ARRA) – allocated $730 billion in the economy but only $4 billion for public housing improvements and repairs (compared to $475 billion for homeowners).

The Choice Neighborhood Initiative (CNI) – focused on revitalizing communities and surrounding infrastructure, including public transportation, schools, and businesses. The bulk of the funding was set aside for housing reform efforts that paralleled HOPE VI. CNI received almost double the funding in 2012 that it had in 2011, while HOPE VI was defunded.

2010

Rental Housing Revitalization Act (RHRA) – introduced by Representative Keith Ellison. RHRA came from two HUD proposals – Transforming Rental Assistance and the Preservation, Enhancement, and Transformation of Rental Assistance – and had the potential to reform the public housing system by allowing private and non-profit companies to own/manage the public housing stock.

2011

The Public Housing Reinvestment and Tenant Protection Act – introduced into the House of Representatives and would re-authorize CNI. It would also prohibit the demolition or sale of public housing unless the units are replaced on a one-for-one basis with "hard" housing units, with limited exceptions.

H.R. 2112 – "minibus" appropriations law signed into law by President Obama and includes the Rental Assistance Demonstration project, which is a pilot project with many components similar to RHRA.

THE RECENT HISTORY OF PUBLIC HOUSING
A PUSH TO PRIVATIZATION

In recent years, a major shift in public housing policy has been a push to privatization and deregulation with larger federal housing policy and programs such as HOPE VI, the Choice Neighborhood Initiative, and Moving to Work (MTW). The result has been a constant chipping away of the public housing system, causing a significant loss of actual public housing units.

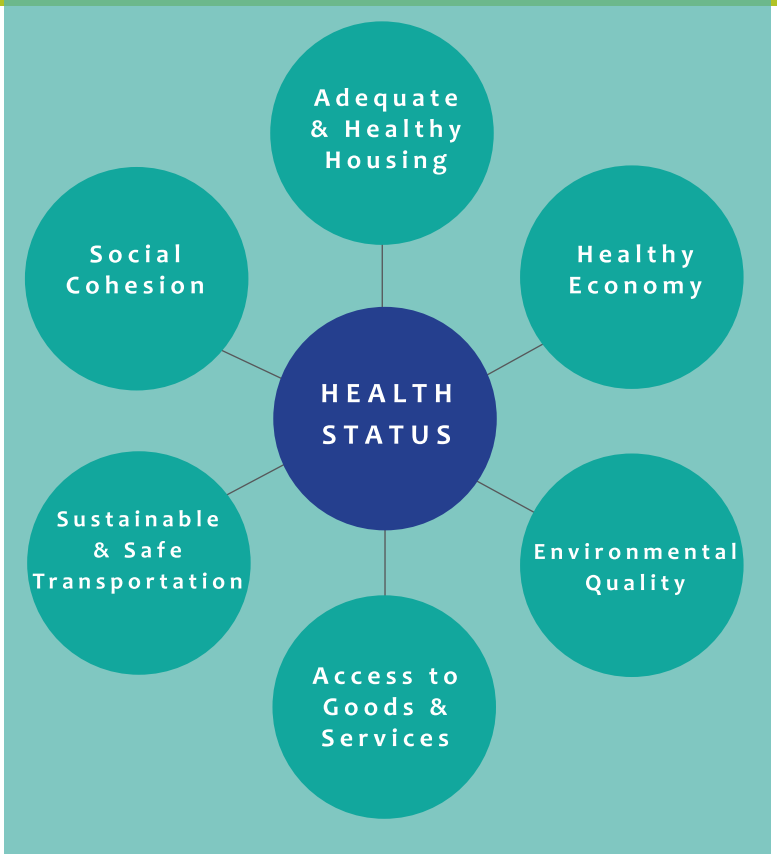
In particular, HOPE VI was a major factor that jumpstarted this change. The foundation for HOPE VI was laid in 1989 when Congress established the National Commission on Severely Distressed Public Housing, which was charged with identifying and eradicating "severely distressed" public housing and devising a plan to eradicate this stock. The Commission found that 86,000 units – 6% of the public housing stock – were severely distressed, and urged Congress to create a revitalization plan for these units. Congress' plan, HOPE VI, was aimed at transforming "severely distressed" public housing into "mixed-income" housing developments. To do this, public housing units would be either rehabilitated or demolished. Originally, however, if demolition was proposed, units had to be replaced on a one-for-one basis. HOPE VI, as initially devised and designed, was not created to diminish the number of units in the public housing system, but a law passed in 1996 eliminated this one-for-one replacement requirement. Even though no funding was taken away from HOPE VI, recipients of HOPE VI grants now were free to demolish units without replacing them with hard units. Thus far, HOPE VI funded the demolition of over 155,000 units, more than double the number designated. Only about 50,000 units demolished through HOPE VI have been or plan to be replaced with new public housing units and as of late 2007, only 32,000 replacement units have been built. Meanwhile, only about 57,000 former public housing families were given vouchers instead of public housing replacement units and between 1994 and 2004, 45,539 households (81%) did not return to redeveloped HOPE VI sites.

Deregulation – the elimination of federal rules and monitoring of PHAs – has also had an impact. Several recent policies exemplify this trend, including MTW. For example, with MTW, PHAs receive waivers that make them exempt from most of the existing statutes and regulations traditionally governing public housing and Section 8 vouchers, and are allowed to combine their funds for public housing and vouchers (e.g., public housing can be used toward vouchers). In many MTW locations, residents have faced higher rents, strict work requirements, and time limits to receiving housing assistance, and some studies have shown that MTW PHAs have fewer reporting requirements and that this lack of oversight has been problematic. Nonetheless, in 2009, the 30 MTW agencies signed new 10-year agreements.

In past decades, the federal government also shifted spending away from the public housing system and toward market-based subsidized housing programs such as voucher programs. Indeed, some 50-60% of lost public housing units are replaced with "tenant-based" Section 8 vouchers, which families use to help defray the cost of renting a unit of their choice in the private market. However, history has shown that there are some significant differences between vouchers and public housing, and that vouchers may not be effective alternatives to public housing. Problems that have surfaced with vouchers include: 1) evidence that vouchers are not cost-effective, as it is typically more cost-effective to preserve public housing than to provide vouchers for displaced residents; 2) vouchers require residents to find their own housing within a time period and if unsuccessful, they lose the subsidy; 3) the voucher program gives power to landlords who may evict residents without having to give a reason (i.e., no cause evictions); 4) there is no Section 8 manager on-site to answer questions; 5) vouchers separate residents from the supportive networks of public housing communities, including fellow residents and PHA staff; and 6) vouchers can be taken away from residents if they simply miss an appointment or are unable to pay a utility bill.

Due in part to these changes and new programs, from 1995 to 2008 more than 165,000 public housing units were lost and not replaced by new public housing, and tens of thousands of additional units have been removed from the stock since then. Yet, Congress has continued to underfund public housing. It is estimated that from 2002 to 2008, public housing lost nearly $3 billion in operating subsidies alone.

PUBLIC HOUSING AND HEALTH



Public housing residents face numerous and often interacting social, economic, and environmental challenges that place their health at risk. Income and employment, neighborhood investment and quality, and access to retail goods and services have all been shown to influence health *(see diagram to the right)*. As discussed on subsequent chapters, public housing conditions – such as the quality, affordability, and stability, as well as the social community support – directly impact the health of residents. Indeed, most major public health improvements in history have been due to improvements in living and working conditions.

Today, the health needs and vulnerabilities of public housing residents are not in question – formal studies comparing public housing residents to other populations have found much higher rates of hypertension, high cholesterol, asthma, diabetes, obesity, and depression.[44] [45] [46] Self-rated health also correlates strongly with actual health status; in the surveys conducted for this HIA, respondents rated their overall health on a scale ranging from excellent-good-fair-poor. The greatest proportion (47%) of respondents rated their health as fair; 12% felt their health was poor; 33% felt their health was good, and a mere 8% rated their health as excellent. In comparison, in the most recent nationwide health interview survey completed by the Centers for Disease Control and Prevention, far more respondents (61%) rated their health as excellent or very good; 27% rated their health as good; and 12% as fair or poor.[47]

Over time, policy-makers have focused intense resources on relocating residents out of public housing in attempts to improve their socioeconomic status. While these programs did not aim to improve health specifically, the available research describing how the health of residents changed as a result of participating in the MTO and HOPE VI programs *(see page 25 for program descriptions)* is particularly instructive for this HIA. In sum, analyses of these two programs illustrate limited significant and long-term improvements in the health of former public housing residents who moved out of public housing, regardless of whether resident relocation was voluntary or not. In fact, by some measures, the health of residents actually declined after relocation *(see summary of health findings on page 26)*.

Policy-makers are again motivated by the desire to improve the socioeconomic conditions of public housing residents and to address the funding and maintenance shortfalls of public housing through proposals aimed at changing the management structure of public housing.

While the intent of RAD may not be to directly improve public health, consideration of health impacts is particularly important given the health vulnerabilities of public housing residents.

HOUSING DEMONSTRATION PROGRAMS

This HIA draws heavily on research examining three major housing relocation policy initiatives:[48]
1) Gautreaux Project
2) Moving to Opportunity (MTO)
3) Housing Opportunities for People Everywhere (HOPE VI)

GAUTREAUX PROJECT

The Gautreaux residential mobility project moved poor, predominantly black, families who volunteered from inner city Chicago into more affluent neighborhoods. This program moved 7,000 families in public housing or on the waiting list for public housing from 1976-1998.[49] The Gautreaux project developed from a 1976 U.S. Supreme Court mandate directing the Chicago Housing Authority to develop a "metropolitan-wide mobility program" to partially compensate for its discriminatory practice of concentrating public housing in predominantly African-American areas.[50] Under Gautreaux, residents from severely distressed public housing developments could volunteer to move to predominantly White areas of Chicago or any of 115 suburbs with populations that were at least 70% White.[51] The Gautreaux project ran from 1976 to 1998, during which over 7,100 families were relocated from mostly all-Black urban neighborhoods to mostly White and middle-class neighborhoods in Chicago and its suburbs.[52]

MOVING TO OPPORTUNITY (MTO)

The Gautreaux project inspired Congress to authorize the MTO pilot program in 1992 in Baltimore, Boston, Chicago, Los Angeles, and New York City. MTO was a voluntary, randomized control study which mandated moves to lower-poverty neighborhoods. MTO participants (about 4,600 families) were randomized into three groups: a control group, a Section 8 group who received a voucher to relocate to a unit of their choice, and an experimental group who received a voucher that could only be used in low-poverty census tracts.[53] Eligible participants in MTO must have lived in project-based subsidized housing in "high-poverty" neighborhoods (census tracts with 40% or more of the population in poverty per the 1990 Census).[54] MTO vouchers could be used only in "low-poverty" neighborhoods (census tracts with 10% or less of the population living in poverty per the 1990 Census), and the relocated residents must remain in these low-poverty neighborhoods for at least one year.[55]

HOUSING OPPORTUNITIES FOR PEOPLE EVERYWHERE (HOPE VI)

Authorized in 1992, the HOPE VI program provided funding to local public housing authorities (PHAs) across the country to redevelop "severely distressed" public housing units. It typically involved displacing and relocating residents in order to make way for newly-constructed, mixed-income developments.[56] Different from Gautreaux and MTO, HOPE VI involved the complete demolition of housing projects and multi-year construction of new developments.[57] Another difference was that relocation in HOPE VI was mandatory, affecting those who both desired to move and those who did not.[58] [59] [60] [61]

MOVING TO OPPORTUNITY AND HOPE VI – HEALTH FINDINGS

Evaluations of MTO found that improvements to health were mixed.[62] Early reports appeared positive. For example, findings suggested that children in the experimental group had fewer asthma attacks and injuries requiring medical treatment. Adults and some children reported fewer depressive anxiety problems and that feelings of safety increased.[63] Another study found that 41% of voucher users stated that their physical health was better after moving than it was in public housing.[64] One study of participant perception of neighborhood, economic, and housing well-being after relocation from public housing found that residents living in houses or apartments with Section 8 housing vouchers were faring better than residents who moved to other public housing sites. A majority of voucher users believed their house, neighborhood, and overall global living situation had improved since relocation.[65]

Over time, however, positive impacts appeared more modest and some negative impacts emerged. For example, while female youth appear to have benefitted from the move in terms of mental health, male youth who moved were found to engage in more risky behaviors and to experience more physical and mental health problems than those who did not. While adults experienced a positive mental health impact and at least a temporary reduction in obesity, they showed no significant effects on general health, asthma, physical limitations, or hypertension.[66] In addition, a five-year, follow-up analysis found that receiving a voucher was associated with improvements in mental health among adults and reduced rates of marijuana use among adolescent girls, but increases in hypertension among adults (not statistically significant) and increases in alcohol and tobacco use among adolescent boys.[67] And in the MTO program, although 10% of children moved to schools with above-average achievement compared to the control group, the MTO treatment group showed no difference in test scores, school dropout rates, or self-reported measures of school engagement.[68]

Studies following HOPE VI showed even more negative outcomes, or no change in outcomes, as related to health. A study based on surveys of HOPE VI residents found that respondents were already a population with high health risks and that their health had not improved over time, despite the fact that they were living in less distressed environments with fewer associated health risks. Respondents who had relocated to the private market with vouchers or other assistance were living in better housing in safer neighborhoods, yet there was no sign of corollary improvements in health. Seventy-six percent of respondents reported no change or a negative change in their health between 2003 and 2005. Additionally a 2005 survey looked at the diagnosis of seven specific medical conditions (arthritis, asthma, obesity, depression, diabetes, hypertension, and stroke) and found that for every condition but obesity, the proportion of HOPE VI respondents reported being diagnosed was twice the rate of the comparison group. The study found that mental health, depression, and anxiety rates were also very high. From 2003 to 2005 the number of respondents who indicated health conditions that needed regular ongoing care had actually increased.[69] Another study that observed high rates of asthma and overall poor health among HOPE VI children before the study did not find any improvements in child health after relocation.[70]

THE RENTAL ASSISTANCE DEMONSTRATION PROJECT

The Rental Assistance Demonstration project, RAD, was signed into law in late November 2011 as part of a larger appropriations bill, H.R. 2112. RAD developed out of earlier proposals introduced by HUD in 2010, specifically the Transforming Rental Assistance (TRA) and the Preservation, Enhancement, and Transformation of Rental Assistance (PETRA) proposals. TRA and PETRA led to the introduction of the Rental Housing and Revitalization Act (RHRA), or H.R. 6468, by Representative Keith Ellison of Minnesota on December 1, 2010.[71] Initially, HUD received substantial pushback when it first started discussing PETRA and TRA,[72] so rather than reintroducing RHRA in 2011, the Obama Administration decided to create a pilot project – RAD.[73] RAD intends to fund a limited number of public housing developments through the "Section 8" rental assistance (voucher) program, rather than the public housing program.

Congressional reports for H.R. 2112 say that RAD aims to "conduct a demonstration designed to preserve and improve public housing and certain other multifamily housing through the voluntary conversion of properties with assistance" to project-based Section 8 contracts or project-based vouchers.[74] This means the ownership of public housing developments could be transferred directly to public housing authorities or private or non-profit organizations, under a contract attempting to guarantee that the public housing remains "public" – available to the low-income population that is HUD's mission to serve. Through a competitive process, the HUD Secretary will select properties to carry out the pilot; properties of various sizes in a broad range of locations and housing markets will be included. Testing a mobility option – an option that allows residents to move with housing-choice vouchers while the project-based assistance remains with the unit – is a likely component. This means that public housing residents in RAD housing developments may have the option of getting vouchers to use in the private market, but that also these public housing developments transferred to private or non-profit owners under RAD would retain the same amount of funding.

RAD requires that ownership or control of assisted units must be by a public or non-profit entity, except if the Secretary determines this is not feasible due to foreclosure, bankruptcy, or termination or transfer of the property's rental assistance because of material violations or default by the owner. In any of these cases, the Secretary must provide priority for ownership or control to go to a capable public entity, then to a capable entity. There is no

COMPONENTS OF RAD

- **Investment of private resources into what was formerly solely a public asset**
- **Potential for ownership by a non-profit organization or for-profit organization using tax credits**
- **Restrictions on the properties limiting what the property can be used for and for how long it must remain "affordable"**
- **Potential increased reliance on vouchers without any new vouchers created**
- **Potential for increased, and stricter, residency standards with new housing managers**
- **No guarantee of one-to-one replacement of hard units if demolition and renovation takes place**
- **Limited discussion of resident organizing and resident organizations**
- **Significant discretion left to HUD Secretary and many aspects dependent on funding**

more elaboration on what that other entity could be or what the process is for determining capability of entities. In addition, ownership could be transferred to a for-profit entity "to facilitate the use of tax credits only if the public housing agency preserved its interest in the property in a manner approved by the Secretary." There is no more elaboration on what that preservation interest could be. When the contract expires, the HUD Secretary must offer and the owner of the property must accept renewal of the contract, subject to the terms and conditions applicable at the time of renewal and the availability of funds.

During conversion, the Secretary must maintain rental assistance to the property and require long-term renewable use and affordability restrictions for assisted public housing units, meaning that the property and the contract must be used for low-income housing for a certain period of time. There is nothing on the length of the contracts, use agreements, or affordability restrictions, though 20 years has been discussed.[75] Generally, assistance can be transferred to replacement units that abide by the same requirements, like the number of units and ownership restrictions. One-for-one replacement of hard units does not seem to be required; instead it is likely that this can be overridden in some cases – though detail is not provided – with vouchers.

In terms of residents' rights, public housing residents in converting units cannot be rescreened, have their assistance terminated, or be evicted simply because of the conversion process. Residents will also maintain the rights they already have under law. For those residents whose property is up for conversion, they will be able to provide comments to the owners or public housing agencies in charge.

H.R. 2112 allows for 60,000 units to be converted, up until September 30, 2015.

Some overall evaluation measures are also already in place. The HUD Secretary must look at, and make available to the public, the impact of the conversion on the preservation and improvement of public housing, the amount of private sector leveraging as a result of conversion, and the effect of conversion on residents. Health factors are notably absent from the evaluation. In addition, there is no deadline or timeline for the evaluations; these assessments will likely only evaluate the proposal via short-term effects; and there is no explicit resident involvement for evaluation purposes.

The amount of discretion and the lack of protections for long-term affordability have raised concerns among public housing advocates. Infusing private resources and changing ownership into a traditionally-government run program may bring forth additional money, but may also incorporate the risks associated with private resources and outside entities getting involved in public housing. While an effort to "test" a drastically new idea is good, this HIA can be used to complement that assessment, point out any gaps, and more significantly, supplement it before the federal government takes more permanent steps to change how public housing is owned and managed in the long-term.

POLICY SIGNIFICANCE

The potential impact of something like RAD is vast; in the long-term, 2.3 million people living in 1.04 million housing units could be impacted. While RAD's initial impact will be smaller since the maximum number of public housing units that can be converted is 60,000 units of public housing, because this is a pilot project, it will have broad implications for future decisions on public housing policies. Not only will RAD impact the lives of residents of public housing, the principles included in it more broadly could impact the lives of individuals living on the edge of economic insecurity, and the communities in which public housing is located. With recent studies reporting that nearly one in six Americans lives in poverty,[76] proposals that re-structure the affordable housing stock should be considered in light of the reality that more and more individuals are living on the economic brink, and need the stability and affordability that public housing provides. Furthermore, with much of the public housing stock located in U.S. cities, the broader make-up of urban neighborhoods likely will be dramatically altered with the relocation and decentralization of thousands of public housing residents into other communities.

WHY DO HEALTH IMPACT ASSESSMENT?

Health Impact Assessment (HIA) is a public engagement and decision-support tool that can be used to assess planning and policy proposals, and make recommendations to improve health outcomes associated with those proposals. The fundamental goal of HIA is to ensure that health and health inequities are considered in decision-making processes using an objective and scientific approach, and engaging stakeholders in the process.

Because of the myriad and profound ways that where we live – our homes and communities – can impact health, RAD stands to have vast impacts on the millions of individuals currently living in public housing, particularly if it continues beyond the pilot period. Typically, public housing funding decisions are debated from an economic perspective: How much will change cost – financially? Elevating the discussion of how change may impact the health of millions of public housing residents and their communities is a vital perspective that many policy-makers often do not consider. This HIA seeks to answer the question: How much will change cost residents' social, emotional, and physical health?

WHAT IS A HEALTH IMPACT ASSESSMENT?

HIA is a flexible research process that typically involves six steps:

1. *Screening* involves determining whether or not a HIA is warranted and would be useful in the decision-making process;

2. *Scoping* collaboratively determines which health impacts to evaluate, the methods for analysis, and the workplan for completing the assessment;

3. *Assessment* includes gathering existing conditions data and predicting future health impacts using qualitative and quantitative research methods;

4. *Developing recommendations* engages partners by prioritizing evidence-based proposals to mitigate negative and elevate positive health outcomes of the proposal;

5. *Reporting* communicates findings; and

6. *Monitoring* evaluates the effects of a HIA on the decision and its implementation as well as on health determinants and health status.

SCREENING

Screening, the first step in HIA, establishes the value and feasibility of an HIA for a particular decision-making context. Screening informs the decision to conduct an HIA by answering three related questions:

1. Is the proposal associated with potentially significant health impacts that otherwise would not be considered or would be undervalued by decision-makers?

2. Is it feasible to conduct a relevant and timely analysis of the health impacts of the proposal?

3. Are the proposal and decision-making process potentially receptive to the findings and recommendations of a health impact analysis?

The screening step of this HIA was carried out in the winter of 2010. Human Impact Partners and Advancement Project determined the following:

- The proposals (which at that point included TRA and PETRA) had significant potential to affect the health of all public housing residents (over two million individuals) across many geographic areas. The proposals could also significantly affect existing health inequities given that public housing residents experience poorer health outcomes when compared to the general population.

- Methods existed to document the breadth and magnitude of potential health impacts associated with these proposals.

- This HIA could be completed in a timely manner in accordance with the legislative timeline.

- Numerous partners were receptive to an analysis of the health impacts of the proposal and were willing to integrate findings into discussions with decision-makers.

- Funding was available from The San Francisco Foundation and The California Endowment to conduct this HIA analysis.

Based on these facts, Human Impact Partners and Advancement Project agreed to work with National People's Action (NPA) to conduct this HIA. Other local partners involved in this HIA are described on page 33.

SCOPING

In the scoping stage of HIA, relevant stakeholders develop goals for the HIA and prioritize research questions and methods to guide the assessment. Project partners identified the following goals:

- HUD and other officials responsible for the implementation of RAD directly incorporate specific recommendations included in this HIA in an effort to mitigate identified negative health impacts in the pilot program and any extension and expansion of RAD.

- Stakeholders and decision-makers incorporate discussions of health impacts and health inequities as part of policy making on public and affordable

To support this process, Human Impact Partners developed a set of pathway diagrams that hypothesized the connections between the proposals and potential health outcomes (pathways are included in subsequent chapters for more detailed review). Based on these hypotheses and the most plausible potential impacts identified, the following elements were identified as core components of this HIA: type of management, evictions, and resident organizing; housing affordability, stability, and quality; and social cohesion and social capital. Research questions assessing the impact of RAD (and earlier proposals) on these elements were developed and indicators, data sources, and analytical methods to answer research questions were identified. The final scope is included as Appendix 1 and element-specific research questions are included in subsequent chapters. The pathways and research questions were reviewed and prioritized by HIA partners. Because low-income populations and communities of color reside in public housing and are most likely to be impacted by RAD (and earlier proposals), these populations were the primary populations of interest for this HIA.

Initial drafts of the scope were extensive and identified numerous research questions and indicators for which to collect quantitative data. However, given the limited funding for this HIA and the lack of readily available public housing data at the national level, very little quantitative data was gathered and reported in this HIA. Instead, authors prioritized a review of the literature (and in particular, findings from other housing relocation programs) and focus group and survey data from public housing residents as the core evidence on which to base this HIA's findings. Ultimately the scope focused on assessing the impacts of RAD on three broad domains: type of management, evictions, and resident organizing; housing quality, affordability, and stability; and social capital and cohesion (including poverty deconcentration, racial and ethnic segregation, and stress) in public housing. Due to the aforementioned reasons, neighborhood resources and location was ultimately excluded from the scope of research. See Appendix 1 for the scoping worksheet.

With the potential for RAD to impact cities and communities across the United States, the group also decided to focus this HIA in several "case study" cities, specifically New York City, Los Angeles, Cincinnati, and Oakland, as a way of grounding the findings and illustrating how RAD might impact specific populations in these cities. Findings are relevant for all communities across the U.S. where public housing is located.

PARTNERS IN THE HEALTH IMPACT ASSESSMENT

HUMAN IMPACT PARTNERS' (HIP) mission is to transform the policies and places people need to live healthy lives. HIP accomplishes this by increasing the consideration of health in decision-making arenas through the use of health impact assessment. HIP both conducts HIAs and works to build the capacity of others to do so, with a focus on communities facing health inequities. HIP has conducted HIAs on the local, state and federal levels – with experience in communities across the country, from California to Maine. Working in direct partnership with communities, public health and other agencies, and academic experts, HIP helps pinpoint tailored strategies to bring diverse stakeholders to the table, navigate the practical steps of conducting HIAs and determine how to understand and use their results so that the health needs of the community are met. Through training and mentorship we also build the capacity of impacted communities and their advocates, workers, public agencies, and elected officials to conduct HIA and use results to take action. www.humanimpact.org

ADVANCEMENT PROJECT is a next generation, multi-racial civil rights organization. Advancement Project tackles inequity with innovative strategies and strong community alliances. With a national office in Washington, DC and two offices in California, it combines law, communications, policy, and technology to create workable solutions and achieve systemic change. Advancement Project aims to inspire and strengthen movements that expand opportunity for all. Drawing from its work as first responders to the housing crisis in post-Katrina New Orleans, Advancement Project's Inclusive Development project strives to help lay the foundation for a movement to address the national public housing crisis that has displaced thousands of families in low-income communities around the country. Last year, Advancement Project co-authored a grassroots research-based report with the Right to the City Alliance, Urban Justice Center, and DataCenter that explored and analyzed the impact of public and subsidized housing policy on low-income residents, mostly of color, in key cities nationwide and proposed recommendations for reforming federal housing policy. www.advancementproject.org

NATIONAL PEOPLE'S ACTION (NPA) is a network of community power organizations from across the country that works to advance a national economic and racial justice agenda. NPA has over 200 organizers working to unite everyday people in cities, towns, and rural communities throughout the United States. NPA's campaign, Housing Justice Movement (HJM), is a coalition of grassroots organizing groups fighting for safe, decent, sanitary, and affordable housing for all. HJM's goals are to: 1) To preserve the social safety net that public and publicly subsidized housing provides for people; 2) Transform all forms of social housing into vibrant, sustainable communities for the 21st Century; 3) Create more opportunities for low-income residents to develop cooperative economies in their communities; 4) Create new and rehab existing social housing units in order to provide low-income residents living in social housing the opportunity to obtain job training and placement in jobs that pay a living wage; and 5) Directly confront the racialization and criminalization of people that live in social housing. Through strong local and national organizing, HJM has been able to win several significant victories such as securing unprecedented rights against displacement for public housing residents and section 8 residents, and defending the right to organize. HJM has been heavily involved in the discussions and activism around RAD and its predecessors. www.npa-us.org

NPA AND HJM ENGAGED THE FOLLOWING GROUPS TO ALSO PARTICIPATE IN THE HIA:

COMMUNITIES UNITED FOR ACTION (CUFA, Cincinnati) is a citywide, multi-issue community organization bringing together organizations and communities across Cincinnati. Since 1980, CUFA has brought together people of multiple cultural and ethnic backgrounds and different income levels so they can support each other in building their own communities and work together on common issues, which affect all neighborhoods. www.cufacincy.org

COMMUNITY VOICES HEARD (CVH, New York) is a base-building member organization of low-income people working to build power in New York to improve the lives of families and communities. CVH believes that the power of low-income people, particularly women, is built through an organization that low-income people control and lead. CVH's model develops low-income people into community leaders, has low-income people participate in the policy making process, wins concrete policies that improve members' lives, and creates a more fair and equitable community for everyone. CVH has four main theories guiding its work: building a people's organization, shifting the parameters of the debate, using a combination of strategies, seeking and building constituent-led coalitions, and engaging a broader movement. www.cvhaction.org

GOOD OLD LOWER EAST SIDE (GOLES, New York) is a neighborhood housing and preservation organization that has served the Lower East Side of Manhattan since 1977 that is dedicated to residents' rights, homelessness prevention, economic development, and community revitalization. GOLES' long-term goals are to 1) build the power of low-income residents on the Lower East Side to address displacement and gentrification; 2) preserve and expand the low-income housing stock; 3) assert community self-determination over the use of public space; and 4) ensure a clean and healthy environment where people live, work, and play. www.goles.org

PEOPLE ORGANIZED FOR WESTSIDE RENEWAL (POWER, Los Angeles) works with community members to cultivate a network of relationships with other non-profit organizations, childcare providers, schools, small businesses, and public and private institutions that serve as a vehicle for community improvement and involvement. POWER organizers work directly with local community members to help them address community concerns and revitalize their neighborhoods, and organizers train community members who want to become more involved with directly improving their community and the lives of their families. www.power-la.org

CAUSA JUSTA::JUST CAUSE (CJJC, Oakland) is a multi-racial, grassroots organization building community leadership to achieve justice for low-income San Francisco and Oakland residents. CJJC is committed to building a national and global movement for social justice. CJJC believes building a movement of working-class people of color in the San Francisco Bay Area must begin with the acknowledgement that these populations are impacted by greater patterns of systematic oppression and privilege. CJJC believes these communities have a powerful role to play in advancing greater solutions. To this end, CJJC engages in local grassroots organizing for the rights of low-income people of color most directly impacted by current inequities. CJJC actively promotes the political consciousness of members, encouraging them to participate in training sessions and inviting them to think critically about their needs and interests as part of a larger context. CJJC uses a three-pronged approach to grassroots leadership development based on: political education, active participation and collective struggle, and local-to-national alliance building. www.cjjc.org

ASSESSMENT METHODS

This HIA employed mixed research methods to assess the prioritized research questions. Specific methods included:

- **LITERATURE REVIEW.** Scientific evidence on the relationships between housing and health were gathered from the following databases: PubMed, Google Scholar, JSTOR, Sociological Abstracts, LexisNexis Academic, PsychINFO, and the Cochrane Library. About 130 studies were ultimately reviewed. In addition, HOPE VI evaluations, evidence from the Gautreaux project, and evaluations of the MTO project also supplied substantial information for this HIA. These three major efforts to change the way public housing is financed and alter the way residents are housed in the public arena each correlate with various elements in RAD. While the comparisons are not perfect, they offer valuable insight into how similar values RAD might impact residents. A description of these programs is on page 25.

- **FOCUS GROUPS AND SURVEYS.** In order to gather evidence on how public housing impacts residents in the case study cities, six focus groups were held with current and former public housing residents in New York, Los Angeles, Cincinnati, and Oakland. Focus groups ranged in attendance from five to fourteen participants for a total of 54 residents. In addition to participating in the focus group, participants completed a survey which asked about history of living in public housing, residency rules and standards, and neighborhood context. The demographics of those completing the survey were as follows: 34% of respondents lived in New York, 32% in Los Angeles, 25% in Cincinnati, and 9% in Oakland. In terms of race and ethnicity, 59% were African American, 37% were Latino, and 4% were White. Finally, the majority of respondents (55%) were between the ages of 45-64; 27% were over 65, and 18% were between 18-44 years of age. Additional demographic information on survey respondents and on public housing residents more generally is included in the Assessment section below. See Appendix 2 for the focus group guide and Appendix 3 for the survey. Short data profiles for each of the case study cities are included in Appendix 4.

- **QUANTITATIVE DATA.** Data on various aspects of public housing and demographics were gathered from: the 2010 Census, HUD, Housing Authority for the City of Los Angeles (HACLA), Oakland Housing Authority (OHA), Cincinnati Metropolitan Housing Authority (CMHA), New York City Housing Authority (NYCHA), the National Low Income Housing Coalition (NLIHC), and the National Law Center on Homelessness and Poverty.

ASSESSMENT FINDINGS, PREDICTIONS, & RECOMMENDATIONS

With limited information available regarding direct health impacts of housing policy *(see sidebar on page 24)*, the Assessment findings that follow focus on how RAD will impact health indirectly through impacts on:

A. Type of management, evictions and resident organizing;

B. Housing quality, affordability, and stability; and

C. Social capital and cohesion in public housing.

Because RAD most explicitly addresses public housing management structures, we assess impacts related to this issue first. It is based on these proposed changes that we go on to assess impacts related to housing quality, affordability, and stability, and then to social capital and cohesion. Impacts are primarily made on the "determinants of health outcomes" – i.e., type of management, evictions and resident organizing; housing quality, affordability, and stability; and social capital. Each chapter includes:

- *Pathway diagrams* providing a visual depiction of how the proposals will impact health.
- *Research questions* reflecting the priority research questions guiding the HIA.
- *Empirical analysis* including:
    - Literature that supports the connection of each element to health;
    - Limited data on existing conditions related to the element; and
    - Focus group and survey results describing what impacted residents say about the element and health.
- *Predictions* of how RAD will impact health related to that element. Predictions were qualitatively made using findings from the literature, existing conditions data, and focus group and survey results. Predictions reflect our best interpretation of the evidence and provide the following: direction of impact, magnitude of impact, severity of impact, the strength of the evidence, and any uncertainties in the predictions.
- *Recommendations* for how RAD could be improved to more positively impact health.

TYPE OF MANAGEMENT, EVICTIONS, & RESIDENT ORGANIZING

SUMMARY OF FINDINGS

RESEARCH FINDINGS:

- Over the past several decades, public housing budgets have decreased by 48% while funding for vouchers has increased by 403%. More and more, the public housing stock in the U.S. is being privately managed.

- Since the 1980s, anti-crime laws have eroded protections for public housing residents and those receiving vouchers. For example, residency standards have resulted in the denial of residency for lower-income populations who are hard to house, including the elderly, large families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet work and/or school requirements.

- There is a dearth of studies evaluating the quality of privately-managed public housing and there is no national or readily available local data on the evictions resulting from implementation of residency requirements.

- Our HIA focus group participants overwhelmingly state that eviction is a main reason why people move out of public housing. These residents state that the risk of eviction, being caught breaking a rule, or a child/visiting friend/family member breaking a rule and risking eviction for the whole family, was stressful in their lives. Feelings about management are summed up by a focus group participant who stated, "The stress levels residents face dealing with management is unbearable."

- Research shows that resident participation in public housing affairs has resulted in improved physical and living conditions, improved quality of life, greater sense of control, and increased community building. Participation is greatest among those who have resided in public housing longer.

- Historically, public housing residents have been able to organize and advocate through residents' associations. However, mechanisms to ensure that residents have a meaningful voice in decision-making could be stronger.

IMPACT ANALYSIS FINDINGS:

- The impacts of management changes on health are mediated through impacts on housing quality, evictions, affordability, stress, safety, and social cohesion. Various aspects of RAD – including the conversion of public housing to private or non-profit management structures, potential for increased residency standards, and limited discussion of resident organizing – may lead to both positive and negative impacts on health.

Positive impacts may include:

- Improved housing conditions due to more responsive maintenance practices.
- Improvements in safety and decreases in stress related to crime in the event of new residency standards.

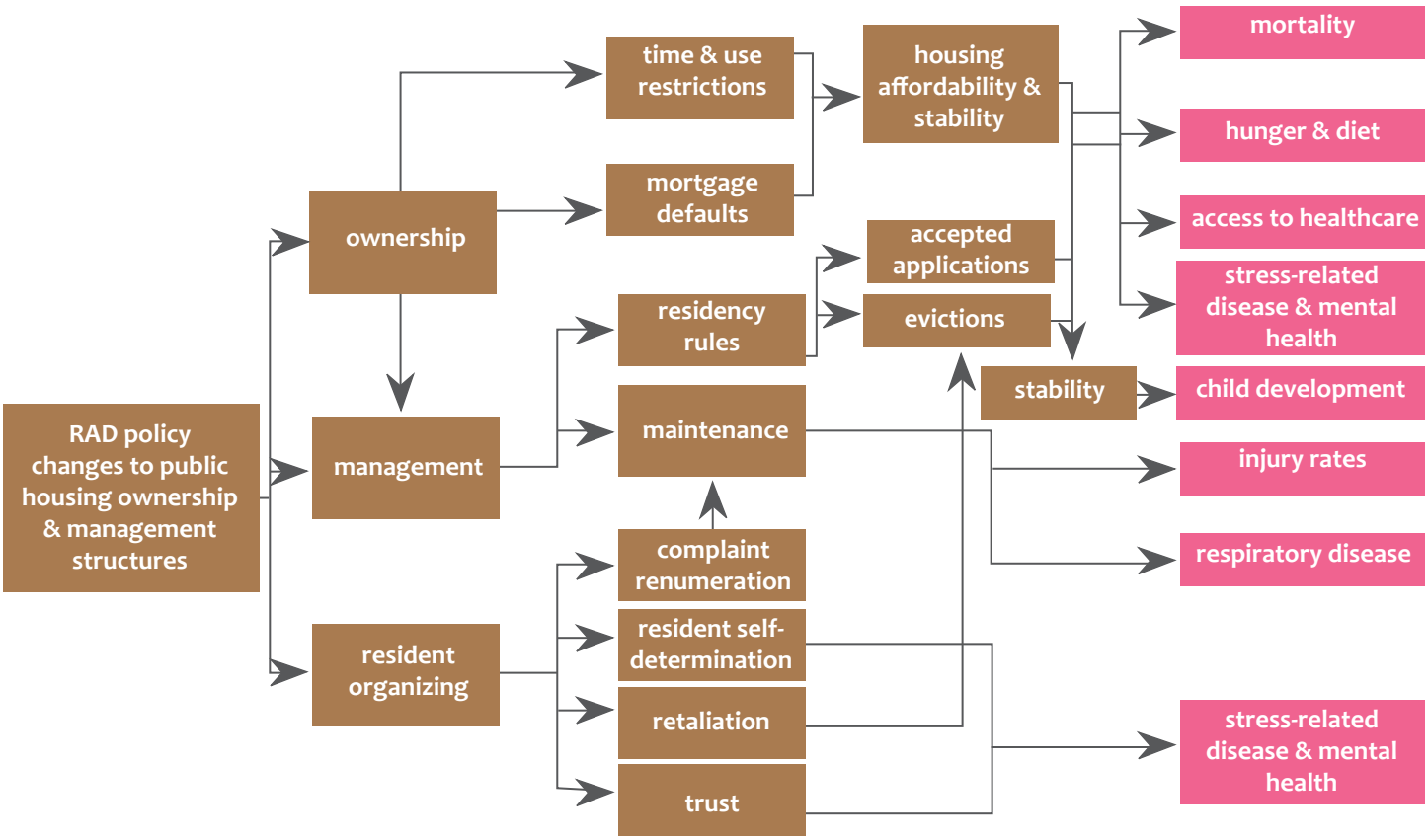
Negative impacts may include:

- More tenuous relationships with management given the potential for new residency standards, and stress associated with the threat of evictions and disrespectful treatment by management.
- Increased evictions among current residents in the event of new residency standards.
- Denial of housing for future residents who cannot meet requirements, including those who have been arrested or incarcerated, have poor credit histories, or who are unable to meet work or school requirements.
- Being forced to rent at less affordable rates as a result of using vouchers in the private market and/or as a result of being evicted in the event of increased residency requirements.
- Potential weakening of resident organizing protections and the associated benefits that result, including improvements in physical conditions, quality of life, community building, and social capital.

INTRODUCTION

Historic shifts in public housing ownership and management policies and practices at the local and national level have impacted the experience of living in, and access to, public housing. This section focuses on how management changes proposed in RAD may impact maintenance and housing quality, evictions, and resident organizing, and how these impacts may determine health outcomes.

TYPE OF MANAGEMENT, EVICTIONS, & RESIDENT ORGANIZING



The pathway diagram above illustrates the ways that changes in federal housing policy may affect health outcomes, as mediated through changes in the ownership, management, and governance of public housing. For example, changes in ownership of public housing may affect the availability of permanently affordable housing through changes in time and use restrictions placed on housing complexes. The resulting availability of permanently affordable housing is associated with both immediate and long-term health outcomes, including self-rated health and mortality, and health behaviors, such as diet, physical activity, taking medications as prescribed, and preventive care. Similarly, management structures affect public housing maintenance and repairs, which consequently could affect respiratory health and injuries. Management and ownership also dictate residency standards, which have implications for residency and evictions, and are associated with access to affordable housing and stability of housing, which is related to a wide-range of mental and physical health outcomes. In this section, we examine research questions related to management conditions, evictions, and resident participation and organizing.

TYPE OF MANAGEMENT, EVICTIONS, & RESIDENT ORGANIZING

HIA RESEARCH QUESTIONS

A. How will RAD impact type of management?

B How will RAD impact the threat of evictions?

C. How will RAD impact resident organizing?

FINDINGS

A. How will RAD impact type of management?

RAD primarily focuses on changes in the ownership and management structures of public housing. In this HIA, we focus on type of management (e.g., private versus public) changes as opposed to ownership changes as the majority of existing research focuses on the impacts of various management styles on public housing. Though new housing management programs have been implemented, PHA budgets have witnessed marked declines. Between 1976 and 2004, PHA budgets for the management and maintenance of units decreased by 48%, from $56.4 billion to $29.2 billion.[80] During this same time period, funding for housing choice vouchers increased 403%, to $37.3 billion, requiring PHAs to operate as private, for-profit entities, stretching their internal capacities and organizational missions.[81] Also during this time, funding formulas, contract terms, fair market rents, and regulations at the federal level changed multiple times, causing confusion and non-compliance at the local level.[82] In 1997, 7% of the U.S. public housing stock was privately managed,[83] and by 1999, a GAO report noted that 18% of large and very large public housing PHAs and some medium, small, and very small PHAs were privately managed.[84] While more recent data are unavailable, between 1999 and today, redevelopment programs have been implemented (e.g., HOPE VI) that utilize private management companies to manage public housing, and as a result, the overall percentage has undoubtedly increased since 1999.

There has been a dearth of studies evaluating the impact of the quality and style of public housing management in the context of conversion from public to private management. In 2000, Congress commissioned Harvard University to do a comprehensive "Public Housing Operating Cost" study.[85] In a presentation to the Public Housing Authority Directors Association in 2003,[86] report authors

HISTORICAL CONTEXT

The 1980s reflected the peak of physical distress of the U.S. public housing stock. During this decade, the Comprehensive Improvement Assistance Program (CIAP) was created to provide new funding to PHAs to renovate dilapidated housing.[77] The ongoing physical distress in public housing was compounded by neighborhood social distress that exacerbated the physical problems in public housing.[78] The time period from the 1980s to the present has been marked by experimentation with public housing, including the use of private management companies to develop and manage public housing. Multiple national and local efforts to deconcentrate poverty in public housing are reflected in demonstration projects such as MTO, Family Self Sufficiency (FFS), Jobs-Plus, HOPE VI, and MTW.[79] Collectively, these programs had the aims of: 1) encouraging public housing residents to obtain and retain jobs; 2) providing housing choice vouchers to relocate and secure subsidized housing in the private market; and 3) decoupling PHA actions from the HUD regulations.

transparently state, "Perhaps the greatest problem in public housing today is management." The authors' assertion is that centralized management systems, funding agencies instead of properties, and inexperienced management staff have led to a variety of poor outcomes. The authors posit that HUD's transition to private property management might support an alternative management model where the majority of staff is on-site, trained in how to fix property problems and serve residents, and given property budgets that they are responsible for (as opposed to having to advocate to a central authority for funds).

These changes in the function of PHAs have caused, in many instances, changes in resident occupancy standards and rules, which in turn has effectively resulted in the denial of housing for lower-income populations who are hard to house, including the elderly, larger families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet the work or school requirements. [87]

This HIA's survey findings provide insight into public housing residency requirements and standards. Over 80% of survey respondents reported that standards in public housing had changed over the years.

61% of survey participants stated that incarceration history disqualified admission into housing, 56% stated that prospective residents had to undergo a credit check, and 46% said that management looked into arrest records and the criminal history of all household members. Other standards included work requirements (35%) and home visits (24%). With regard to being admitted to public housing, several participants stated that work requirements, credit checks, and criminal history checks were new, and that "now they investigate you too much." Several respondents also stated that private management meant that they were paying more in rent and had to pay for maintenance. In terms of improvements, respondents said that residences were more "clean," management keeps the place up, and housing was ready for occupancy as repairs were done before arrival.

In a health impact assessment of HOPE VI redevelopments of two housing sites in San Francisco, the HIA found that many areas that impact the health of residents were ultimately controlled by management: timely response to requests for maintenance; rules for conduct and criteria for getting into public housing; arbitration around evictions; connection with outside agencies such as police and social services; and whether or not the management fostered resident participation in decisions.[88] The San Francisco HIA found that in HOPE VI redeveloped sites, management had often changed and more decisions were placed in private managements' purview, resulting in less accountability to and ultimately less control by, residents. Survey and focus groups participants in the San Francisco HIA contended that new management seemed more interested in evicting residents who had any connection with crime rather than keeping residents safe from criminal activity in the neighborhood, and that increased rule-making and surveillance by private management had resulted in a culture of fear and disconnection from neighbors.[89]

TYPE OF MANAGEMENT, EVICTIONS, & RESIDENT ORGANIZING

> **"The stress levels residents face dealing with management is unbearable."**
>
> **HIA Focus Group Participant**

A 2001 study evaluated the efficiency and effectiveness of publicly-managed public housing versus privately-managed public housing in over 3,000 units of public housing in Miami.[90] In this study, 53% of the public housing stock was privately managed and 47% was publicly managed. With respect to efficiency, the privately managed units experienced a 20% decrease in costs over a four-year period, where the publicly-managed units had a 3% increase in costs during this same period. In terms of effectiveness, the exterior conditions of privately-managed units were slightly better rated than the publicly-managed housing. The interior conditions were evaluated based on the number of violations (slightly lower in privately-managed units) and resident opinion surveys (slightly better in publicly-managed units). The discrepancy in resident opinion and the number of violations were explained by resident control over the timing of renovations in publicly- versus privately-managed units – the authors stated that residents living in publicly-managed units had more control over renovation timing. As for other concerns, residents were slightly more satisfied with how housing management staff treated them in publicly-managed units, while slightly more satisfied with responsiveness to maintenance calls in privately-managed units. Overall, in response to "who does a better job managing public housing," 74% of those who had lived in both publicly- and privately-managed housing said "public managers." Study authors recognize the contradiction in these findings and point to the comfort that public housing residents have with their current management structures (i.e., public) as a possible explanation.

With respect to treatment by management, there were numerous comments in this HIA's focus groups about poor treatment by management. Some focus group participants said they were made to feel sub-human simply because they were public housing residents. One participant stated, "The stress levels residents face dealing with management is unbearable." In relating changes since new management came in, another resident stated that, "Once they came in, the evictions for small infractions increased to the point where residents are afraid to leave their units."

The general sense was that management exercised preferential treatment and was disrespectful to public housing residents. Although residents noted that not all managers were bad, they felt that many were "terrible," applying rules inconsistently and pitting residents against each other. One participant stated, "Each management has their own rules. We don't see it in black and white. They enforce their own rules. They don't give it to you in writing." Another focus group participant from Cincinnati said, "I hate to be lied to. There's a whole lot of lying with management and CMHA [Cincinnati Metropolitan Housing Authority]." In Oakland, one resident who was also a property manager stated, "House rules are getting longer and longer and thicker and thicker but there is a lot of discretion. For example, the rules about residency; you know everyone has family member that needs a place to stay sometime… I don't mind having guests stay over until the guests become a nuisance and then I like having those rules to fall back on." In Oakland, where residents had gone through a process where a non-profit agency took ownership of approximately 3,300 public housing units, one focus group participant stated, "The only thing I noticed by the change in ownership is that slowly dilapidated units are being renovated and I write my check out to a different name."

Predicted impacts of RAD on health via type of management.

As described in greater detail in other sections of the report, the impacts of management on health are mediated through impacts on housing quality, evictions, affordability, stress, safety, and social cohesion. Given the research, impacts from RAD will be mixed:

1. Private or non-profit management of public housing may lead to improved housing conditions (and associated improvements in health, such as in respiratory conditions and injuries) due to more responsive maintenance practices.

2. Relationships with management (both private and public management) may be tenuous if new management attempts to create new (stricter) rules and residency standards. This could lead to increased evictions or fear of evictions among current residents, and an increased inability to enter housing for new (future) residents. The threat of evictions as well as disrespectful treatment by management may be associated with stress, anger, and anxiety among residents.

3. Limited time and use restrictions on properties may create uncertainty with ownership or affordability of units following foreclosure, bankruptcy, or default even though there are some protections in place to maintain ownership with a public entity first. This may create a risk of eviction and cause stress among residents.

4. If new residency standards are imposed, there may be improvements in safety levels and residents may experience a decrease in stress related to crime and violence, as well as actual crime and violence.

Because management impacts could be both positive and negative, and are mediated through other impacts discussed in this report, it is difficult to predict the magnitude and severity of impacts. Based on the evidence, however, we would anticipate the magnitude of the impacts would be minor-moderate and the severity would be low-moderate.

RECOMMENDATIONS.

1. Prioritize that owners of converted properties always be a public entity, including in the event of foreclosure, bankruptcy, default, or transfer of contract.

2. Develop a procedure in which residents can notify HUD if the owners of converted properties are implementing increased standards and/or failing to abide by all requirements, including those to maintain tenancy for current residents.

3. Remove owners if they are found to implement increased residency standards, evict residents, and/or make occupancy more difficult for residents upon conversion.

4. Require management to advise residents of residency standards and decision-making processes.

5 Require owners to be accountable to resident groups. This may be done by having several of the following review processes within the workings of a tenant association that has power, or some other tenant participation process: requiring resident review and approval of new residency standards if they arise, and requiring resident review and approval of decision-making processes that impact residents more broadly, such as decisions regarding disposition, mobility, and relocation.

B. How will RAD impact the threat of evictions?

Unfortunately, there is no national or readily available local data on the number of evictions from housing authorities or the reasons for evictions. However, in our HIA focus groups, residents of public housing overwhelmingly stated that eviction was one of the main reasons why people move away from public housing; 40% of those responding to our HIA survey said that others they knew had moved away due to being evicted. Many residents stated that the risk of being evicted, being caught not following rules, or a visiting friend or family member not following the rules was stressful in their lives. In Los Angeles, one focus group participant stated, "Residents are afraid because anything can get them evicted." Other reports assessing public housing have also highlighted a fear of evictions among residents.[91] [92]

HISTORICAL CONTEXT – PUBLIC HOUSING EVICTIONS

In the 1970 *Goldberg v. Kelly* case, the Supreme Court created a standard procedure for "due process" where a recipient of government benefits, including public housing, be given notification and an opportunity to file a grievance prior to termination of benefits.[93] This ruling required HUD and Congress to create mandates and directives that significantly shifted the way in which PHAs were managed, creating more accountability and protections for residents.[94] These requirements were short lived. In 1988, Congress passed the Anti-Drug Abuse Act, facilitating coordination between local law enforcement and federal agencies.[95] By targeting government benefits, including public housing, they provided funding to local PHAs to fight drug trafficking and drug production in public housing development, primarily through increasing building security and hiring security personnel.[96] Building on this authority, Congress passed the Cranston-Gonzalez National Affordable Housing Act in 1990, enabling PHAs to evict residents for "any criminal activity that threatens the health, safety, or right to peaceful enjoyment of other residents"[97] and essentially created a national policy for "one-strike evictions."[98] The Housing Opportunity Program Extension (HOPE) Act of 1996 provided PHAs with new authority to screen out potential residents with criminal and drug backgrounds, enforce lease terms strictly, and evict residents suspected of drug or criminal activity.[99] The Act also required that local police provide PHAs with criminal background information about public housing applicants or residents upon request. HUD incentivized PHAs who took a tough stance on evictions related to drugs or criminal activity, and extended such policies to other assisted housing programs, such as Section 8.[100] Households whose Section 8 benefits were terminated by a PHA were ineligible to receive these benefits for a period of three years.[101]

One-strike policies have extended termination of tenancy provisions to include instances where a "tenant, any member of the household, a guest, or another person under the tenant's control," engages in criminal activity.[102] As many public housing households are female-headed (36% in 2011[103]), such "no fault" or "strict liability" evictions disproportionately impact women, particularly women of color, even if they were not directly connected to or knowledgeable of the criminal activity.[104] [105] In 2002, the Oakland Housing Authority sought to evict 63-year-old Pearlie Rucker, who lived with her mentally disabled adult daughter, two grandchildren, and one great-grandchild, and whose daughter was arrested on drug charges three blocks away from the housing unit.[106] [107] In HUD v. Rucker,[108] the Supreme Court upheld "no fault" evictions.[109] The no-fault standards have been applied to other federal programs, including Section 8 housing policies.

> "A lot of people don't know that they have rights when it comes to being evicted."
>
> HIA Focus Group Participant

Many focus group participants talked about residents failing to know about their eviction rights. A Cincinnati focus group participant felt that, "A lot of people don't know that they have rights when it comes to being evicted." A New York participant stated that, "Eviction procedures are complicated… people who don't know about the process get evicted," and another said, "People who are confused and do not know how to go through the courts to fight evictions… they get evicted; but the people who are doing wrong things never get evicted." A third New York participant echoed the lack of education of residents about eviction rights, "People are confused – they don't know they can fight evictions through the courts, nor do they know how to do so. Then also, the people who are doing wrong things (like selling drugs) never seem to get evicted." In Cincinnati, one resident spoke for many when she said, "Some residents are afraid of the manager [around rules and management partiality in application of rules]. Some people think if they say anything they can be evicted. . . They move out of fear – 'ain't nobody going to help me' – rather than find out what's going on. The grievance policy is key. I'm thankful we at least have the grievance policy."

When asked where residents go when evicted, participants said that, "Some live with relatives, sometimes in worse conditions, and they can't afford market rate. Because no other building would accept them, they went into a rundown building, some become homeless or went to shelters. Bad credit means they can't go elsewhere."

Predicted impacts of RAD on health via evictions.

Given the history of increased evictions in the public housing stock, we anticipate that the impact of RAD on evictions will be negative, and will occur in two ways:

1. If owners are permitted to, or can get away with, increased residency standards, resident evictions among current residents may increase.

2. Through the potential provision of tenant-based vouchers and mobility of public housing residents into private rental housing, residents may be forced to rent at less affordable rates, and may face evictions due to housing cost burdens, as well as lack of just cause eviction protections.

Other reports that are similarly qualitative in nature support this conclusion. As described later in the *Housing Quality, Affordability, and Stability* chapter of this report, evictions can lead to housing instability, residents paying more than they can afford for rent (leaving less money for healthy food, medical care, and other expenses), overcrowding, and homelessness. Health impacts associated with all of these changes include: poor nutrition, injuries, stress, inability to access medical care, and increases in infectious disease.

The strength of the evidence for this question is strong given the history of laws leading to evictions from public housing and our qualitative data gathered. We anticipate the magnitude and severity of this impact would be moderate over the long-term, particularly if mobility is promoted and tenant-based vouchers are extensively funded, if restrictive residency standards make it more difficult to stay in public housing, and if RAD is continued beyond the pilot period. It is important to note, however, with no additional vouchers created, it is unlikely that residents would be able to take advantage of any mobility option in the short-to-medium term.

RECOMMENDATIONS

1. Require just cause evictions from public housing.
2. Expand due process protections for public housing residents, such as by developing grievance policies.
3. Clarify the entities that implement residency standards, put in place standards that are legal and equitable, and require oversight of restrictions.
4. Require the tracking and collection of evictions data and make data publicly available.

C. How will RAD impact resident organizing?

HISTORICAL CONTEXT

Historically, residents in public housing have been able to organize and advocate at local and national levels through residents' associations, PHAs, local housing commissions, and HUD. Public housing resident organizing in the U.S. dates back to the 1930s when the first resident organization was formed in New York City to plan social functions and increase communications about events among residents.[110] After World War II, veterans across the country formed independent organizations to pressure PHAs for more housing and for resident control of housing.[111] Resident organizing became characterized by more grassroots resident control during the 1960s-1970s when resident organizers demanded control of local public housing funds and policymaking.[112] From the 1970s-1990s, residents participating in Resident Management Councils were increasingly trained and charged with managing public housing, including often being directly responsible for maintenance, rent collection, and finances.[113]

The period from the mid-1990s to the present has been characterized by expanded participation among residents.[114] Regulations developed in 1994 (Section 964 of Title 24 in the Code of Federal Regulations) support resident organizing by establishing current resident participation policies in public housing.[115] The regulations define resident organizations and the roles and responsibilities of Housing Authorities and HUD with respect to those organizations.

The stated purpose of the 964 regulations is to "…recognize the importance of resident involvement in creating a positive living environment and in actively participating in the overall mission of public housing." In 964, resident participation begins with the formation of a resident council whose objective is "…to improve the quality of life and

resident satisfaction and participate in self help initiatives to enable residents to create a positive living environment for families…" Resident councils "may actively participate…with [the] Housing Authority to advise and assist in all aspects of public housing operations."[116] If a resident council meets established requirements, housing authorities must recognize them and they must be eligible to receive funds for participation activities.[117] Housing Authorities are required to support participation activities and meet regularly with resident councils as well as jurisdiction-wide resident councils (if created) "to discuss problems, plan activities and review progress."[118] Lastly, resident councils can also form relationships and partnerships with outside organizations.

In 1998, the Quality Housing and Work Responsibility Act affected the 964 regulations when it required Housing Authorities to draft one- and five-year plans in consultation with a resident advisory board.[119] Housing Authorities could only appoint residents to such a board if no resident council or jurisdiction-wide resident council exists.[120] In 2001, the 964 regulations received a boost when HUD strengthened a provision on funding for resident participation.[121] Among other provisions, regulations required that when funds are available they must be provided regardless of the Housing Authority's financial status to resident councils.

Importantly, the 964 regulations do not apply to voucher holders – so resident participation is weaker. There is no financial assistance allotted to residents with vouchers, and resident councils established by voucher holders do not have to be recognized by owners. In addition, overall voucher holders may have a harder time organizing because residents are less likely to be in close or direct proximity or contact with one another.

In recent assessments of public housing resident organizing, resident participation in the affairs of public housing has resulted in a number of benefits, including improved physical conditions of the units and overall living conditions, improved quality of life, greater sense of control of living conditions, and increased community building.[122] Participation is greatest among those residents who have resided in public housing longer and who have social ties to other people in the development.[123] However, a study of New York City public housing residents found that a majority of public housing residents do not participate in the official resident participation systems, suggesting that they either engage in external organizing strategies or remain disenfranchised from public housing policymaking systems. Of the 1,119 public housing residents surveyed, 47% did not know that their development had a resident association and only 17% participated in their resident association.[124]

A Right to the City Alliance report[125] looked in detail at resident experiences of participation in public housing decisions, concluding that even with laws and regulations mandating and protecting resident participation in the decision-making process, residents do not feel they have adequate input into decisions, and have difficulty holding HUD and PHAs accountable for their actions. The report found that HUD mechanisms to ensure that residents have a meaningful voice are lacking in strength, and conversations with hundreds of residents revealed that residents do not feel they have sufficient power in shaping decisions about where they live.[126]

Focus groups conducted for this HIA confirmed these findings, and found that even organized resident associations had difficulty interacting with management. Participants noted that management often did not "hear" residents or the resident councils – for example, "If you jump and holler, then they'll hear the resident councils." Whether or not councils are heard is "all based on your relationship with the manager. If you don't have a good relationship, he's not going to help or advocate for you." Even those participants who were closely involved in a Resident Advisory Board (RAB) were excluded from important decisions and ultimately, did not realize the power they yielded. One focus group participant who had been involved in a RAB in Oakland during disposition proceedings stated, "It seemed like there was time and space to give input if you were involved in the RAB, but then there was a period during which there were no RAB meetings, and this is when the disposition was decided on." While she felt like the PHA informed the board, she stated, "At that time I didn't know what advocacy was all about, so I wouldn't say that we [RAB] did anything. I see now that I could have been advocating for things, instead of just listening."

Many participants in our focus groups shared that they were well experienced in going "higher up" than management to get what they needed, for example to the Board of Commissioners or the Director of Public Housing. One participant spoke about the utility of resident organizations in this way, "Management 'malfunctions' when they deal with residents because of their lack of sensitivity or lack of willingness to listen. So, resident council listens to residents, talks with managers, and for some reason when it comes from the resident council president, management hears you more."

While there were multiple stories of public housing management practices and local PHAs disempowering resident organizing, research has illustrated that empowered resident organizations can have a significant impact on improving overall quality of life within public housing. Examples of programs and impacts brought on through resident organizations include: community centers, health clinics, tutoring programs for youth, day care, job placement centers, food banks, youth programs, recruitment and part ownership in a neighborhood grocery store, job training, reduced crime, and building improvements.[127] These changes, as well as the power that is built and the learning that comes from rich resident participation itself, were always supported financially and with staff resources.[128] Similarly, our HIA focus group participants agreed that participation in resident organizing could lead to positive change. In Cincinnati, nearly all participants were currently or had been involved in resident organizations and found it to be a great resource, and most had not experienced any retaliation for their involvement. In Los Angeles, the official resident councils worked with non-public housing affiliated advocacy organizations, which participants cited as a contributor to the council's ability to make positive change.

Predicted impacts of RAD on health via resident organizing.

Given the overall positive impacts of resident organizing on social capital, physical conditions, quality of life, community building, and actual housing resources, if a policy change does not reduce the rights of resident organizations, we would anticipate no negative impacts. As it stands now, RAD does not include any acknowledgement or support of resident organizations, though it states that residents will maintain their existing rights. Given that participation in resident organizations is greatest among those residents who have resided in public housing longer, potential mobility out of public housing (due to tenant-based vouchers) may lead to decreased resident organization power within public housing and in Section 8 housing. With no additional vouchers being created currently, however, this impact may not occur in the short-to-medium term. Additionally, public housing residents who choose to re-locate will not have the same protections to organize for improvements in living conditions, and may face the threat of evictions for organizing.

RECOMMENDATIONS

1. Define resident organizations such that management recognizes a wide range of resident organization types. Work with existing resident organizations, public housing advocates, and local elected officials to appropriately define resident organizations.

2. Expand due process protections for public housing residents, including for eviction, such as by tenant associations developing grievance policies.

3. Ensure that those funds that already exist for resident organizing continue to be seamlessly provided to upon the conversion process.

Summary of Predictions - Impacts on Health Determinants

HEALTH DETERMINANT	IMPACT	MAGNITUDE (HOW MANY?)	SEVERITY (HOW BAD?)	EVIDENCE STRENGTH	UNCERTAINTIES
Type of Management	~	Minor- Moderate	Low-Moderate	• •	Ability to informally implement stricter residency rules Strength of eviction protections Resident organizing protections
Eviction	-	Moderate	Moderate	• •	
Resident Organizing	~	Minor	Low	• •	

Explanations:

Impact refers to whether the proposal will improve health (+), harm health (-), or whether results are mixed (~).

Magnitude reflects a qualitative judgment of the size of the anticipated change in health effect (e.g., the increase in the number of cases of disease, injury, adverse events): Negligible, Minor, Moderate, Major.

Severity reflects the nature of the effect on function and life-expectancy and its permanence: High = intense/severe; Mod = Moderate; Low = not intense or severe.

Strength of Evidence refers to the strength of the research and evidence showing causal relationship between mobility and the health outcome: • = plausible but insufficient evidence; • •= likely but more evidence needed; • • • = causal relationship certain. A causal effect means that the effect is likely to occur, irrespective of the magnitude and severity.

HOUSING QUALITY, AFFORDABILITY, & STABILITY

SUMMARY OF FINDINGS

RESEARCH FINDINGS:

Housing Quality

- Decades of inadequate investment in public housing have translated into many units being in disrepair. A HUD inventory estimated the capital needs as $21 billion for the entire public housing stock.

- Substandard housing conditions cause stress and contribute to a variety of health impacts including respiratory disease, neurological disorders, chronic disease, and mental health.

- Results are conflicting with respect to whether resident relocation via housing mobility or relocation programs has led to health improvements.

Housing Affordability

- Lack of income with which to pay for adequate housing can lead to adverse health outcomes associated with homelessness, overcrowding, and/or living in sub-standard housing. Housing insecurity has been associated with stress and there are significant associations between high housing costs and hunger, inadequate childhood nutrition, and poor childhood growth.

- There are numerous obstacles for public housing residents to transition into the private market, including discrimination against and exploitation of voucher holders, difficulty paying for and adjusting to utility bills, and lack of understanding about private markets, rent calculations, and security deposits.

- A recent HUD study found that 7.1 million households were found to have "worst case" housing needs in 2011 – an increase of 42% since 2001. These households are comprised of very low-income renters who either (1) pay more than one-half of their monthly income for rent; or (2) live in severely inadequate conditions, or both. The crisis is exacerbated by the large disparity between available public housing units and the number of households on wait lists, and the fact that fair market rents are significantly higher than what public housing residents can afford.

Housing Stability

- Public housing is found to provide residential stability. Because of this stability, living in public housing during childhood has been associated with increased employment, raised earnings, and reduced welfare use. Also, utilization of preventive health services among those living in public housing equaled or exceeded those of other city residents. This stability also facilitates development of social relationships.

- Studies document high levels of residential instability among voucher users. HUD data indicates that people who live in public housing reside there for nearly twice the length of time than voucher users reside in their housing.

- Participants in this HIA's focus groups cited stress about housing stability and permanence as a major concern.

IMPACT ANALYSIS FINDINGS:

Positive impacts may include:

- RAD could impact housing quality and related health impacts (e.g., exposure to allergens, respiratory health, injuries) as they may lead to much needed improvements in the public housing stock. If funding is allocated to repair the least distressed housing stock and/or if renovations are not completed using high-quality standards, these health benefits may be limited.

- Because one of the major sources of concern cited by public housing residents is stress associated with housing instability (i.e., the threat of losing their housing), RAD may have positive impacts by providing a long-term funding approach or strategy to addressing public housing underfunding.

Negative impacts may include:

- Through the potential provision of vouchers and mobility of public housing residents into private housing, residents generally face less affordable rents and may experience associated health impacts (e.g., stress, fewer resources for other daily needs, overcrowding).

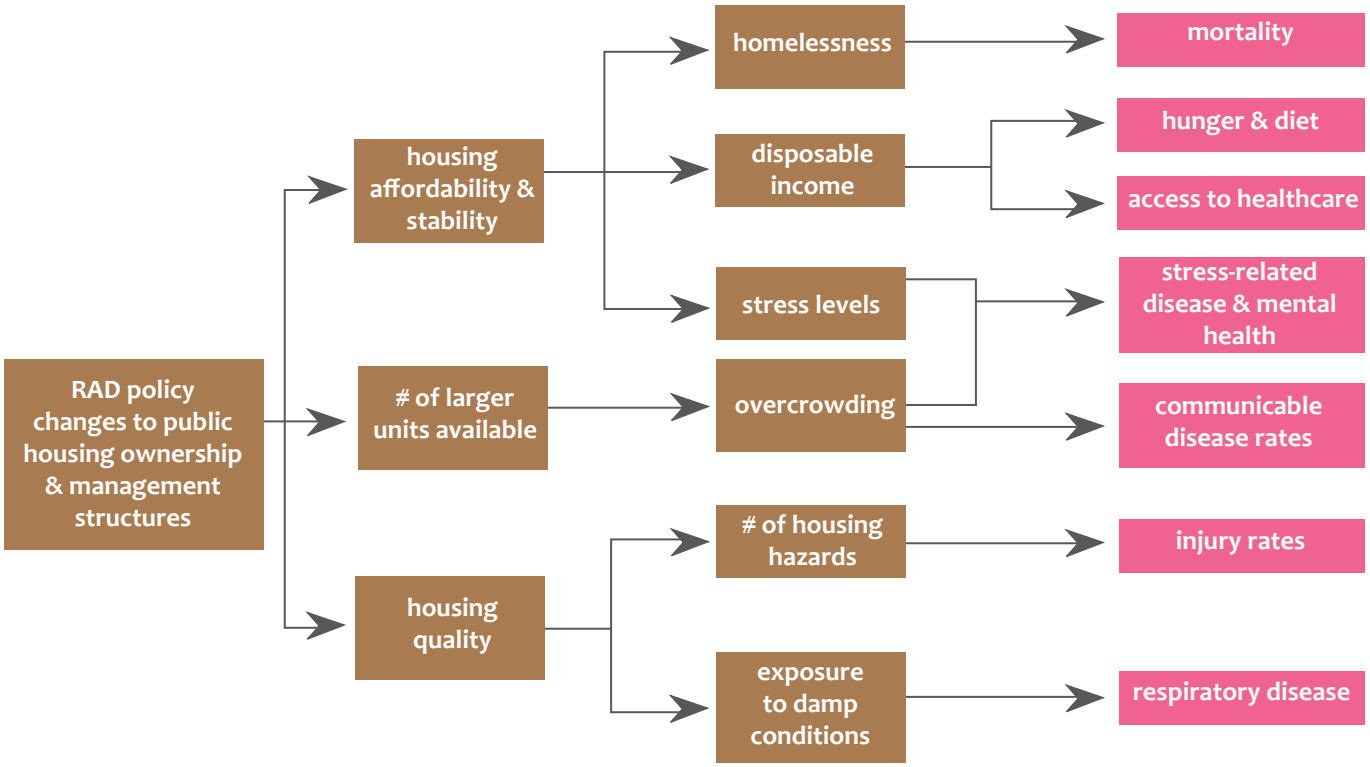
- With private and non-profit companies taking over contracts, financial impacts on operations and time and use restrictions may place the long-term permanence of the public housing stock at risk at a time when it is needed most. Changes in residency standards and enforcement may impact housing stability.

- Decreases in housing stability would be associated with stress and the disruption of social networks and social supports. The potential transition to vouchers and a stricter residency environment may obstruct the protective effects that permanently affordable housing provides.

INTRODUCTION

The quality, affordability, and stability of affordable housing is linked to health in a variety of ways. When a person or community does not have access to adequate and affordable housing, their health suffers. This section focuses on how RAD may impact the quality, affordability, and stability of low-income housing and how these changes will impact the health of public housing residents.

HOUSING QUALITY, AFFORDABILITY, & STABILITY



The pathway diagram above illustrates that impacts that RAD may have on health through policy changes that will affect the number of available public housing units, the quality of public housing, and the availability of affordable housing generally. There is no single causal pathway for the relationship between public housing and health; health is impacted by various dimensions of housing, including conditions and quality, affordability, location, and stability.[129] [130] Studies show that high housing costs relative to income threaten food and financial security, and lead to overcrowded living conditions, displacement, and acceptance of substandard housing conditions.[131] In turn, overcrowding and substandard housing conditions increase risks for mortality, infectious disease, poor mental health, and poor childhood development.[132] [133] [134] Residents of public housing are more often exposed to these conditions as well as other factors that lead to lower levels of health than non-publicly-housed populations. These exposures translate into specific health vulnerabilities that may be exacerbated by RAD. In scientific studies, public housing residents have reported poorer health; increased levels of asthma, hypertension, diabetes, obesity, depression, and smoking; decreased levels of physical activity; and exposures to poor indoor air quality and pests.[135] [136] For example, a study published in 2008 found that Boston public housing residents were more than four times as likely to have fair or poor health as other city residents.[137] Self-rated health is one of the most reliable predictors of health status.

All of these dimensions are potentially affected by the principles articulated in RAD, and will be explored in the following sections by reviewing the existing literature on the intersections between housing and health and the findings from our focus group and surveys.

RESEARCH QUESTIONS

A. How will RAD impact housing quality?

B. How will RAD impact housing affordability?

C. How will RAD impact housing permanence and stability?

FINDINGS

A. How will RAD impact housing quality?

Numerous studies examine the impacts of housing quality. Substandard housing and deteriorating housing cause stress and contribute to a variety of ailments, ranging from respiratory disease and neurological disorders, to chronic disease and psychological and behavioral dysfunction.[138] [139] Every year, injuries occurring at home result in an estimated 4 million emergency room visits and 70,000 hospital admissions. Contributing factors include structural features in homes, including steep staircases and balconies, lack of safety devices such as window guards and smoke detectors, and substandard heating systems.[140] Children living in dilapidated, poorly maintained inner-city housing may be at a particularly high risk for lead poisoning.[141] Substandard housing conditions, such as drafts, dampness, mold, old, deteriorated carpeting, lead paint, structural deficits, poor ventilation, crowding, and pest infestations are linked to recurrent headaches, fever, nausea, skin disease, sore throats, and are associated with high levels of indoor asthma triggers and higher rates of allergen sensitization.[142] [143] [144]

There has been little research linking the impacts of public housing physical structures on resident health. While it is known that public housing residents are in worse health than their non-public housing counterparts and that many public housing units are not in good condition,[145] [146] one recent study examining public housing residents found that voucher users were actually less satisfied with their housing compared to those living in public housing.[147] Researchers found that only 46% of voucher users felt that their current unit was in better condition than their previous unit located in a severely distressed project. Variation in housing satisfaction among voucher users was based on how tight the housing market was: the tighter the market, the lower the resident satisfaction.

A HOPE VI Panel Study,[148] which examined the impact of redevelopment and relocation on residents,[149] observed high rates of asthma and overall poor health among HOPE VI children before the study and did not find any improvements in child health after relocation. Lack of improvements to health and well-being may have resulted from the program's failure to relocate individuals to significantly improved environments. Research does indicate, however, that public housing residents are especially vulnerable to asthma. Even after adjusting for individual and neighborhood socioeconomic status factors and the presence of indoor asthma triggers, one study found that the odds of having asthma was higher in public than private housing.[150] One reason given was that less use of air conditioners led to higher exposure to outdoor air, which is more polluted in low-income communities.

> **"……'cause it just has been run into the ground and not by just the folks that live there, but by not having money to keep it up. It feels like a project failed and the people in it feel that way, too. I think that's the reason no one takes pride in it anymore."**
>
> **HIA Focus Group Participant**

Throughout the U.S., public infrastructure in many cities is currently outdated, used at a higher capacity than intended, and deteriorating due to a lack of investment.[151] Decades of inadequate investment in public housing has translated into many public housing units being in disrepair, and possibly substandard.[152] Studies have documented broken elevators, trash, rodents, mildew, and even worse problems.[153] [154]One focus group participant quoted in the Right to the City Alliance's report stated, "I had asked them for years to fix the outside of the building. Raw sewage had come up through people's toilets and flooded their houses and apartment. Mine was swollen in between the top and bottom floor and you could smell it."[155] Another participant in one of this HIA's focus groups stated, "You tell folks where you live and they say, what - you live there? It's embarrassing to see it now, 'cause it just has been run into the ground and not by just the folks that live there, but by not having money to keep it up. It feels like a project failed and the people in it feel that way, too. I think that's the reason no one takes pride in it anymore."

Recognizing the deteriorating quality of the public housing stock, HUD recently commissioned an inventory of capital needs in the nation's public housing stock using a representative sample of public housing, drawn from 1,205,198 units in 7,404 projects.[156] The capital needs examined included roof coverings, exterior walls, boilers, elevator shaftways, refrigerators, bathroom fixtures, landscaping, parking areas, electrical systems, wiring, lead paint abatement, disability access issues, and energy efficiency upgrades. The report estimated the average capital needs cost per unit to be $19,029, for a total of $21 billion for the entire public housing stock.[157] The report gives cost estimates based on the size of a public housing authority, the type of development (e.g., family vs. elderly developments), region of the country, and age of housing stock. The key repair costs were for windows, kitchens, and bathrooms, which accounted for nearly 40% of all existing capital needs. The study also looked at the accrual of capital needs in the future, estimating a total of $3.4 billion per year. Notably, the study excluded 86,896 units proposed for demolition, completed demolitions, dispositions, or under HOPE VI redevelopment implementation, and as a result, likely led to a lower estimate of overall cost needs.

According to our HIA focus groups, the quality of housing varies by region. In Los Angeles, there were few complaints about the physical quality of the housing itself, while in New York, five of the 6 respondents in one focus group cited concerns about black mold, asbestos, lead paint, and asthma. In another New York focus group, four of the ten residents also cited problems with rodents, exposed sewage, and asthma. One participant stated, "All my kids have asthma and now I got allergies and I never had them before and I have that black stuff in my bathroom." In Cincinnati, half of the participants reported having asthma and cited sanitation, fumes, mold, and flooding as problems. Five also mentioned bed bugs. In Oakland, two participants mentioned that there had been renovations that had addressed problems with mold and disrepair. A few participants in each focus group mentioned elevator maintenance as a problem. Despite these sorts of problems with physical conditions of housing and general concerns about building maintenance and management, the majority of focus group participants seemed generally satisfied with their housing, due to other factors such as affordability and stability as discussed in this HIA. Notably, PHAs around the country are well aware of the impacts of housing quality on respiratory health, particularly asthma.

For example, in Seattle, the PHA partnered with a local organization to build 60 "Breathe Easy" homes as part of a public housing redevelopment process. These homes were constructed in ways to help decrease the risk factors that cause asthma among low-income children.[158]

The San Francisco HIA discussed earlier found mixed results as to the benefits of redevelopment in terms of housing quality. In one site, residents stated that the overall housing development looked better from the outside, but was built with low-quality materials that broke and then needed repair. They felt developers had spent more time making the site look good from the outside and neglected to significantly improve the quality of the actual units. The other San Francisco site was less equivocal; they felt their redeveloped housing was far superior to their previous public housing; however, they felt that what they gained in housing quality was at the cost of more restrictive rules and admissions requirements.[159]

Predicted impacts of RAD on health via housing quality.

RAD could impact housing quality and related health impacts as it may lead to much needed improvements in the public housing stock. Based on our focus groups and the studies cited above, it is clear that many public housing units are currently inadequate, and these conditions place residents at increased exposure to health risks. If RAD leads to improved housing quality, we anticipate that these improvements will also have positive impacts on resident health, particularly in exposure to allergens, asthma, other respiratory illnesses, and lead poisoning.

While HOPE VI was initially intended to fund renovation of the nation's most distressed public housing, several analysts have argued that, in fact, distress played only a small role in the allocation of HOPE VI funds.[160] This trend is concerning in light of RAD's likely intention to provide vouchers to relocate residents to better housing conditions as well as provide the capital (via contracts with private or non-profit owners) to improve maintenance and renovation of current public housing stock. Given this, if funding is allocated to repair the least (and not the most) distressed housing stock, health benefits may be more limited. In addition, if renovations are not completed using high-quality materials standards, the overall quality of housing may not actually improve in any significant ways.

Assuming funds target the most distressed housing stock, we anticipate the magnitude of this impact would be moderate-major. Finally, given the severity of health impacts often resulting from exposure to poor quality housing, we also judge the nature of the impacts on life function and quality of life to be high.

RECOMMENDATIONS

1. Prioritize appropriated funding to target public housing sites experiencing the most serious disrepair in order to decrease exposure to health risks.

2. Require housing managers to pro-actively conduct site evaluations every 4 months and develop workplans to address identified repair needs, including how capital repairs and long-term needs will be prioritized. Have site evaluations available for public review on HUD's website, the property owner's website, and at the property owner's physical offices. Ensure secure and sustainable funding sources to implement plans. Have a tenant association participant take part in the repair evaluations.

3. Require just cause evictions of residents in efforts to protect against retaliation for complaints made about housing quality. See also #1 from Evictions recommendations.

4. Require environmentally sustainable rehabilitation using standards from Leadership in Energy and Environmental Design (LEED) or Enterprise Green Communities and ensure full implementation and enforcement of HUD Section 3 employment requirements.[161]

5. Include the Conversion Oversight Committee in targeting selection criteria for which housing complexes are in most serious disrepair. Give special consideration to public housing sites that provide housing for the "hard to house."

B. How will RAD impact housing affordability?

There are a variety of impacts to people's health when housing costs exceed a level they can afford. Lack of income with which to pay for adequate housing can lead to adverse health outcomes associated with homelessness (e.g., anxiety, depression, injuries, and premature mortality),[162] overcrowding (e.g., increased spread of infectious disease)[163] [164] and/or living in sub-standard housing (e.g., exposure to lead and asbestos). Housing insecurity has also been associated with psychological strain and stress,[165] [166] and there are significant associations between high housing costs and hunger, inadequate childhood nutrition, and poor childhood growth.[167] [168] For example, children in low-income families that lack housing subsidies are more likely to have iron deficiencies and to be underweight than children in similar families receiving housing subsidies.[169] Overcrowding, often caused by unaffordable housing, has been linked to increased mortality rates, meningitis, tuberculosis, respiratory and other infections, poorer self-rated health, noise, and increased stress.[170]

Researchers have studied the long-term effects of living in public housing; various and multiple studies have found that living in public housing during childhood was associated with increased employment, raised earnings, and reduced welfare use, although it had no effect on household earnings relative to the poverty line.[171] Some study authors posit that these beneficial effects may have arisen because public housing reduced residential mobility, improved physical living conditions, and/or enabled families to spend more of their income on items that benefit children's development. Another study showed that those living in public housing are less likely to suffer from overcrowding, and their children are less likely to have been held back in school than their counterparts.[172]

A study conducted in Boston found that public housing residents' access to and utilization of preventive services equaled or exceeded those of other city residents. Public housing residents were found to be only half as likely to be uninsured as other low-income city residents.[173] The authors hypothesized this might be due to public housing households having a greater portion of their income available for health-related expenses when compared to other low-income residents, or that health care resources were more accessible to public housing residents (given the location and concentration of public housing) than other low-income populations.[174] [175]

From a voucher perspective, research illustrates that mobility into non-public housing poses challenges from a financial perspective. A study that examined the transition to Section 8 housing in Chicago found that discrimination and limited finances prove to be an obstacle to securing housing. The study noted that financial challenges to

successfully transition to the private market include: lack of time to find housing, difficulty paying for and adjusting to utility bills, and lack of understanding about private markets, rent calculations, and security deposits. This study also found the lack of larger units available in the private market to be a barrier.[176] Other studies found that displaced residents who moved to the private rental market with Section 8 vouchers during HOPE VI experienced overwhelming tasks that many were not accustomed to, such as apartment hunting, interacting with private landlords, undergoing resident-screening criteria, and paying utilities.[177] [178]

The benefits of public housing from an affordability perspective are convincing, especially as more and more Americans are confronted with lower earnings and an unaffordable housing stock. In February 2011, HUD released its ongoing Worst Case Housing Needs report.[179] "Worst case needs" are renters with incomes below 50% of the area median income (AMI) who did not receive government housing assistance and paid more than half their income for rent or lived in severely inadequate conditions, or both. Nationally, 7.1 million households were found to have worst case needs – an increase of 20% from just two years earlier, and an increase of 42% since 2001. The primary problem affecting worst case needs was "rent burden" – i.e., insufficient incomes relative to housing rental costs. Two of every five very low-income renters were considered to be in worst case need.[180] People of color are disproportionately plagued by substandard housing conditions and severe rent burdens. For example, African-Americans and Latinos make up over 50% of the population with the greatest housing needs in the country, despite the fact that they represent only 25% of the total U.S. population.[181] Furthermore, from 2008 – 2009, the number of people living doubled up with family or friends out of economic necessity increased by 12% to over 6 million people.[182]

The HUD report begins, "High rents in proportion to renter incomes are an increasingly dominant cause of worst case needs. The vulnerability of our poorest households both to employment shocks and to the increased demand for the most affordable units illustrates the importance of housing assistance as an economic cushion."[183] In fact, there is high demand and greater competition for units that are kept affordable for the poorest renters. For example, the report found that:

- Higher-income renters occupy about 42% of the units that are kept affordable to extremely low-income renters (those earning less than 30% of the AMI). Due to this competition, there are only 3.2 units of affordable housing for every 10 extremely low-income renters.

- Higher-income renters occupy 36% of the units that are kept affordable to very low-income renters (30% - 50% of AMI). Due to this competition, there are only 6 units of affordable housing for every 10 very low-income renters.

- This situation has caused a more than 10% increase in average rents for very low-income renters, and the number of units available to extremely low-income renters has decreased by 370,000 nationally.[184]

"

"I have a great deal of medical expenses. So really, to have to pay $1500 or $1600, or $2200 a month in rent anywhere else... I couldn't afford it. I would be homeless."

HIA Focus Group Participant

To provide more localized context to findings included in the HUD report, table 1 includes available data on housing need and affordability levels in each of our case study cities. The data highlights several important factors:

1. There is a large disparity between the number of public housing units and the number of households on public housing wait lists.

2. Fair market rents are significantly higher than the average monthly cost of renting a public housing unit and what a resident of public housing can afford.

TABLE 1. PUBLIC HOUSING (PH) NEEDS AND AFFORDABILITY

	LOS ANGELES	NEW YORK CITY	CINCINNATI	OAKLAND	NATIONAL
# of PH units[1]	6,921	197,566	N/A	1,585	1,189,129
# of households on PH waitlist[2]	18,767	143,960	14,500	93,654*	N/A
Average monthly cost of PH rent[1]	$397	$544	N/A	N/A	$314
Fair market rent for a 2 bedroom[3]	$1,465	$1,403	$752	$1,393	$960
Annual income needed to afford FMR[3]	$58,600	$56,120	$30,080	$55,720	$38,400
Average income of PH resident[1]	$16,885	$22,293	N/A	N/A	$13,379
Citywide vacancy rate[4]	6.8%	7.8%	17.2%	9.4%	11.4%

Sources:
[1] HUD. 2011. Public Housing Resident Characteristics Reports: April 2010-July 31 2011. Available at: https://pic.hud.gov/pic/RCRPublic/rcrmain.asp
[2] Housing Authority of the City Los Angeles, http://www.hacla.org/pdocs/; New York City Housing Authority, http://www.nyc.gov/html/nycha/html/about/factsheet.shtml; WCPO.com, http://www.wcpo.com/dpp/news/local_news/hamilton-county-suburbs-could-get-more-public-housing; OaklandSeen, http://www.oaklandseen.com/2011/01/11/section-8-wait-list-to-open-lottery-to-follow/
[3] HUD. 2009. Worst Case Housing Needs. Available at: http://www.huduser.org/Publications/pdf/worstcase_HsgNeeds09.pdf
[4] Census. 2010. Available at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml
* Number submitting applications to both Section 8 and public housing waitlist.
N/A = data not available for city.

This HIA's survey findings from our case study cities confirm that residents of public housing have limited resources – more than 70% of participants earned $15,000 or less a year – and value public housing for its affordability. For example, in the focus groups, many participants often commented on what life might be like if confronted with more expensive housing. One Oakland participant stated, "I have a great deal of medical expenses. So really, to have to pay $1500 or $1600, or $2200 a month in rent anywhere else… I couldn't afford it. I would be homeless." Across all case study cities, participants stated that they liked that their housing was affordable. One participant from Los Angeles stated, "We have money to get by and invest in my children for their needs." Another stated, "I am thankful for public housing because I can't find the cheap rent I pay anywhere else." In Cincinnati, there was a sense that without public housing many people would end up homeless. Another resident in Cincinnati noted that not having to pay utilities was helpful. Many residents in all focus groups stated that living in public housing helped them economically.

Predicted impacts of RAD on health via housing affordability.

RAD could impact housing affordability for residents in several ways:

1. Through RAD's potential for tenant-based vouchers and mobility of public housing residents into private rental housing, residents may be forced to rent at less affordable rates. This is especially true given that housing costs in the private market include utilities and security deposits, whereas in public housing they do not.

2. If residents predominantly choose to remain in the converted housing stock and rents stay constant at the same levels over the long-term, housing affordability levels may not be impacted. However, given the lack of information on time and use restrictions, it is possible converted housing may not remain permanently affordable and residents will face increased rents over the long term.

While RAD provides some protections to keep the housing affordable, it still may lead to the loss of permanently affordable units and given the research cited above, we anticipate that public housing residents will experience increases in rents and/or an overall decrease in the number of affordable housing units. Negative health impacts related to stress and fewer resources for other daily needs, particularly for residents with income limitations (see *Social Capital* section) may result. Furthermore, many public housing residents are able to avoid overcrowding because their housing is affordable and the public housing stock contains larger family-sized units. If more families take advantage of tenant-based vouchers, it is possible that families will crowd into smaller units, leading to negative health impacts associated with overcrowding.

The strength of the evidence for this question is particularly strong given findings from the focus groups and other studies, and we anticipate the magnitude of this impact would be moderate-major over the long-term, particularly if tenant-based vouchers are extensively funded, time and use restrictions allow for higher rents, and if RAD is continued beyond the pilot period. It is important to note however, with no additional vouchers currently being created, it is unlikely that residents would be able to take advantage of the mobility option in the short-to-medium term.

RECOMMENDATIONS

1. If mobility via vouchers is promoted, increase the number and value of tenant-based vouchers based on a mandated review of the housing market in each participating city of any conversion plan.

2. Maximize contract subsidies and time and use agreements to ensure a permanently affordable housing stock, particularly for those who are traditionally "hard to house" and during times of foreclosure, bankruptcy, or default.

3. Ensure the protection, repair, and maintenance of hard housing units, especially the most distressed units and units for "hard to house" residents. Limit the demolition and disposition of public housing units to those units that are beyond repair, as defined by criteria set with oversight from a Conversion Oversight Committee.

C. How will RAD impact housing permanence and stability?

Families who lack affordable housing are more likely to move frequently and this movement has a variety of negative health impacts.[185] Increased mobility in childhood has been linked to stress, the risk of developing depression, academic delay, school suspensions, and emotional and behavioral problems.[186] [187] [188] For adults, displacement and relocation can disrupt social ties and result in job loss and loss of health protective social networks.[189] [190] Conversely, strong neighborhood ties, lower levels of perceived stress, and more positive health outcomes are associated with neighborhoods that have high levels of stability.[191] In some cases, where relocation leads to improved housing conditions, the health impacts for residents have been positive.[192]

Researchers have hypothesized that public housing provides greater residential stability than other forms of housing assistance, and this stability facilitates development of social relationships.

HUD data indicates that people who live in public housing reside there for nearly twice the length voucher users reside in their houses or apartments.[193] Currently, 21% of public housing residents nationally have lived in their homes for over 20 years, whereas only 2% of residents living in Section 8 programs have lived in their homes for over 20 years.[194] Respondents to our HIA surveys confirmed this trend, with the vast majority of public housing residents indicating that they have not moved in the past five years (78%).

"I have lived in public housing for 50 years … grew up here. That's where I intend to die. My choice. I love it."

HIA Focus Group Participant

Many participants in this HIA's focus groups cited stress about housing permanence as a major concern. In a New York focus group, uncertainty about future of public housing was cited as the second biggest reason for being stressed, after crime. One participant stated, "Unless I win the lottery I can't go. I have no one to will me anything or give me anything." Other participants said, "The older generation is afraid of being displaced;" "I'm concerned about the destiny of public housing, and the chance of being evicted;" and "The apartment I have is where I want to be now… ..if I can have stability and security there, I can die there." Many residents in each focus group talked about the sense of community and value of knowing your neighbors. For example, one participant stated, "I have lived in public housing for 50 years … grew up here. That's where I intend to die. My choice. I love it."

In contrast, studies have documented high levels of residential instability among voucher users. For example, researchers found that 40% of voucher users in the HOPE VI Panel Study had moved again within two years of their initial move. Interviews with former public housing residents in Atlanta and Chicago contained several examples of individuals who were forced to move when their vouchers were revoked on account of a lease violation, eviction, or failure on the part of a landlord to maintain eligibility of their unit.[195] [196]

Predicted impacts of RAD on health via housing stability.

RAD could impact housing stability for residents in several ways:

1. With private and non-profit companies allowed to take over contracts, financial impacts on their operations and time and use restrictions may place the long-term permanence and stability of the public housing stock at risk.

2. If owners are permitted to, or get away with, implementing increased residency standards, there may be negative impacts on housing stability due the displacement, eviction, and relocation process.

3. If RAD is associated with increased mobility due to the provision of tenant-based vouchers, there may be negative impacts on housing stability due to the relocation process.

4. Because one of the major sources of concern cited by public housing residents is stress associated with housing instability (i.e., the threat of losing their housing), RAD may have positive impacts by providing a long-term funding approach and strategy to addressing public housing underfunding.

Overall, we anticipate that decreases in housing stability would also be associated with negative health impacts, particularly as they relate to stress, and the disruption of social networks and social support (see *Social Capital* section). Given the protective effects that permanently affordable housing seems to provide to residents, the potential transition to vouchers and potential for a stricter residency environment may obstruct those protective effects.

The strength of the evidence for this question is strong given findings from the focus groups and other studies, and we anticipate the magnitude of this impact would be moderate-major over the long-term, particularly if tenant-based vouchers are extensively funded. With no new vouchers currently being created, it is unlikely that residents would be able to take advantage of the mobility option in the short-to-medium term.

RECOMMENDATIONS

1. Require one-for-one replacement of lost or demolished public housing units (i.e., hard units).
2. Ensure that vouchers are not taken from residents for minor or single infractions.
3. Track voucher use and ensure that tracking reports are publicly available.

Summary of Predictions-Impacts on Health Determinants

HEALTH DETERMINANT	IMPACT	MAGNITUDE (HOW MANY?)	SEVERITY (HOW BAD?)	EVIDENCE STRENGTH	UNCERTAINTIES
Type of Management	~	Minor-Moderate	Low-Moderate	• •	Assuming funds target the most distressed housing stock Ability to informally implement stricter residency rules How time and use restrictions will be implemented
Quality	-	Moderate	Moderate	• •	
Affordability	~	Minor	Low	• •	
Stability	+	Moderate-Major	High	• •	

Explanations:

Impact refers to whether the proposal will improve health (+), harm health (-), or whether results are mixed (~).

Magnitude reflects a qualitative judgment of the size of the anticipated change in health effect (e.g., the increase in the number of cases of disease, injury, adverse events): Negligible, Minor, Moderate, Major.

Severity reflects the nature of the effect on function and life-expectancy and its permanence: High = intense/severe; Mod = Moderate; Low = not intense or severe.

Strength of Evidence refers to the strength of the research and evidence showing causal relationship between mobility and the health outcome: • = plausible but insufficient evidence; • •= likely but more evidence needed; • • • = causal relationship certain. A causal effect means that the effect is likely to occur, irrespective of the magnitude and severity.

SOCIAL CAPITAL

SUMMARY OF FINDINGS

RESEARCH FINDINGS:

Social Capital/Support and Stress

- Social support provides a buffer in stressful situations and prevents feelings of isolation. Neighborhoods in which residents feel social cohesiveness toward their neighbors tend to have lower mortality rates compared to neighborhoods lacking strong social bonds.
- Relocation out of public housing generally has negatively impacted social capital and networks by creating physical isolation, diminishing face-to-face interactions, and moving residents away from supports and services.
- Residents of public housing live with high levels of stress. Most focus group participants in this HIA indicated that they or their neighbors experienced health issues, amongst the most commonly cited was stress associated with housing insecurity.

Racial and Ethnic Segregation and Poverty Concentration

- Living in racially segregated neighborhoods has been associated with higher infant mortality, overall mortality, and crime rates that cause injury and death. The concentration of poverty has been associated with high unemployment rates, high school dropout rates, and crime and violence. These are often reasons cited for demolishing public housing, even though many of these neighborhoods also lack critical social services that may ease these health risks and other consequences.
- Segregation is common in public housing. Nationally, there are three times as many African-Americans and one and a half times as many Latinos living in public housing as compared to the general population.
- Public housing relocation programs have had mixed results with respect to achieving stated goals of racial and ethnic integration and poverty deconcentration. Residents often re-concentrate into segregated and/or poor communities, and there is little improvement in individual income levels.

Crime and Violence

- Crime and violence are overwhelmingly stated as a concern among public housing residents. Crime is often discussed in tandem with comments about the communities in which public housing is located in and the inability of management to intervene.
- Housing relocation programs have, overall, reported positive impacts on crime and violence. Research assessing whether crime is displaced to other communities illustrates that crime decreases overall.
- However, the social cohesion people feel in public housing acts as a buffer to perceived crime and this perception can have a protective effect for residents with respect to crime.

Stress

- Both the literature and our HIA focus group findings confirm that the residents of public housing are living with stress. Most of our focus groups participants indicated that they or their neighbors experienced some health issues, the most commonly cited being stress associated with crime and housing insecurity.

IMPACT ANALYSIS FINDINGS:

Positive impacts may include:

- Based on evidence from other studies, crime and violence are likely to decrease in public housing. As crime and violence decrease, health impacts would include fewer injuries and deaths, as well as decreased stress and stress-related health conditions.

Negative impacts may include:

- If owners are able to implement RAD with increased residency standards and there is increased mobility through tenant-based vouchers, social cohesion and support networks may be negatively impacted through the displacement and relocation process.

- Given the limited success of other relocation programs, there will likely be little-to-no impact of RAD on racial and ethnic segregation and poverty deconcentration.

- RAD has the potential to impact resident stress levels via numerous pathways and could increase and decrease stress levels simultaneously. For example:

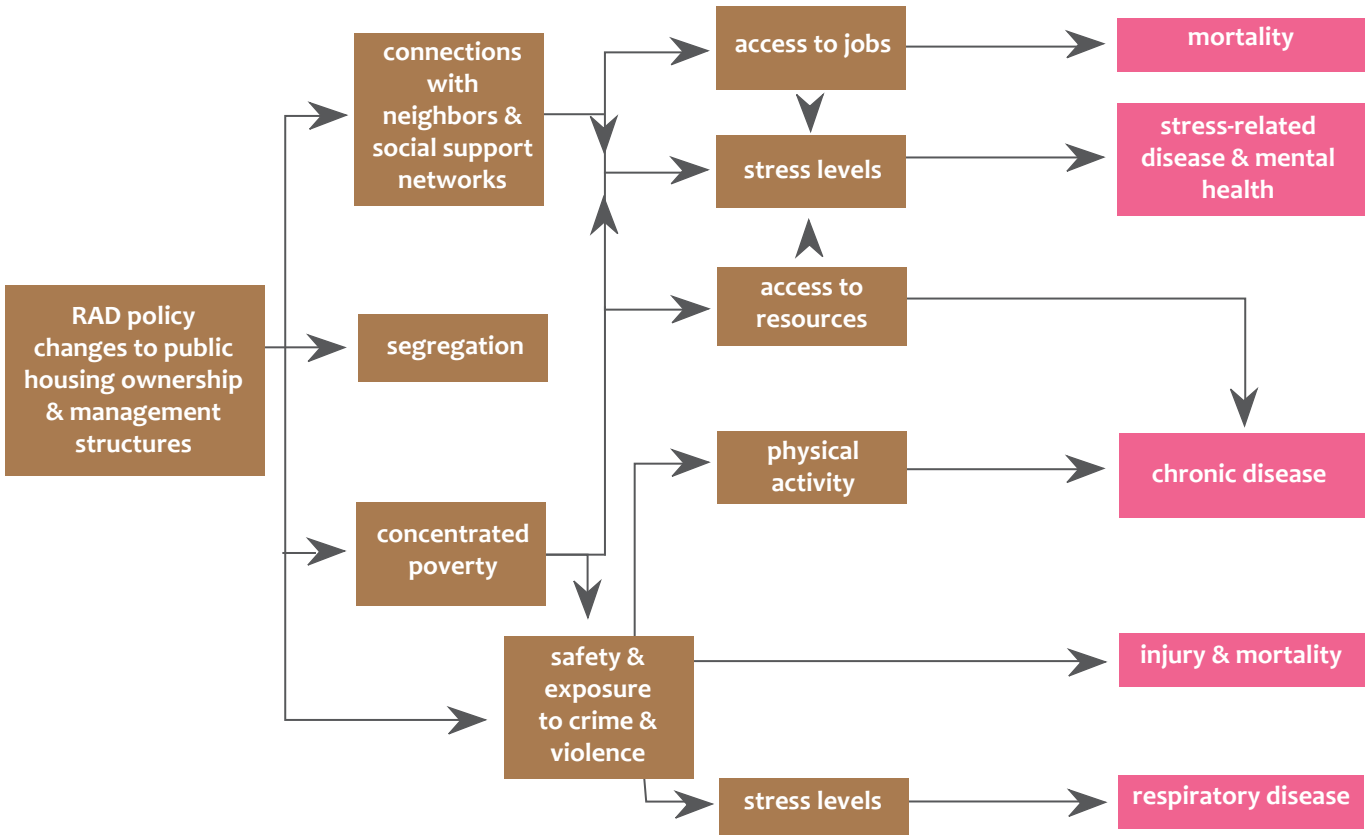
    - With anticipated improvements in safety levels due to RAD, residents will likely experience decreases in stress related to crime and violence.

    - With potential displacement due to evictions or increased housing costs due to moving into a more expensive housing stock, stress may increase for residents who are evicted and/or who are unaccustomed to renting in the private market.

INTRODUCTION

Declining socio-economic conditions in many urban neighborhoods over the past 70 years have greatly impacted the quality of life in communities and the social resources available to residents.[197] [198] [199] Research in this section focuses on how RAD may impact various attributes of social capital and how these impacts may determine various health outcomes.

SOCIAL CAPITAL



The pathway diagram above illustrates the ways that changes in federal housing policy may affect social capital and health outcomes, as mediated through changes in racial and ethnic and economic dynamics of the neighborhood, and through changes in the relationships and networks between residents. Public housing policies that affect these aspects of the social environment may impact residents' mental and physical health behaviors and outcomes, particularly stress, anxiety, depression, physical activity, and injury rates. In this section, we examine research questions related to social networks and cohesion, racial and ethnic segregation, concentrated poverty, crime and safety, and stress.

HIA RESEARCH QUESTIONS

A. How will RAD impact social isolation and social cohesion?

B. How will RAD impact resident connection to neighbors and social support networks?

C. How will RAD impact racial and ethnic segregation?

D. How will RAD impact the concentration of poverty?

E. How will RAD impact levels of safety, crime, and violence?

F. How will RAD impact levels of stress among residents?

FINDINGS

A. How will RAD impact social isolation and social cohesion?

B. How will RAD impact resident connection to neighbors and social support networks?

Social capital has been defined as "the aggregate of actual or potential resources linked to possession of a durable network of more or less institutionalized relationships."[200] This definition of social capital acknowledges that people's resources are embedded in networks and considers how people access these networked resources.[201] People's social networks differ in that there is unequal access to network-based resources, and these inequities appear along the lines of race, class, gender, age, and geography.[202] Such network-based social capital may include resources between residents or within institutional networks in the neighborhood that may be used by residents for individual or collective action.[203] [204]

The research questions above relate to various aspects of social capital, and the presence of social capital has been found to buffer the negative effects of poverty on health.[205] [206] For example, neighborhoods in which residents feel social cohesiveness toward their neighbors tend to have lower mortality rates compared to neighborhoods that do not have strong social bonds.[207]

Studies have also shown that support, perceived or provided, can provide a buffer in stressful situations, prevent feelings of isolation, and contribute to positive self-esteem.[208] In one study, people who self-reported severe lack of social support were 2.19 times more likely to report fair or poor health than people who did not lack social support.[209]

Social support and *social leverage* contribute to individual well-being.[210] [211] Social support helps people "get by," or cope with daily problems.[212] [213] Social leverage helps residents "get ahead," affording them access to information, such as referrals to jobs, that advances their social mobility.[214] [215] [216] Many public housing residents have been described as having strong social supports and weak social leverage.[217] *Informal social control* and *neighborhood organization participation* contribute to collective well-being. Informal social control refers to residents' ability to

collectively maintain order and keep the neighborhood safe from criminal and delinquent activity.[218] Neighborhood organization participation refers to residents' formally organized collective activity, such as neighborhood block clubs, for addressing neighborhood issues.[219] *Collective efficacy* refers to the shared expectations and mutual engagement of residents in local social control.[220] Collective efficacy can influence health outcomes by exercising informal social control over deviant behaviors, by increasing residents' involvement in general community issues and actions, and by increasing the ability of residents to access, leverage, and utilized resources.[221] [222]

Proponents of housing relocation argue that the networks of higher-income neighbors will lessen the social isolation that relocated public housing residents are accustomed to in high-poverty neighborhoods.[223] But there is some evidence that the dense social networks in urban neighborhoods, and particularly in public housing developments, provide a great deal of social support to residents.[224] [225] [226] For example, relocation creates a shift in social networks by: causing changes in residents' contact information; creating physical distance; diminishing face-to-face interactions of neighbors; taking away informal childcare or transportation arrangements among neighbors; and moving residents away from supportive services like food pantries, job training services, and youth programs.[227] [228] Previous studies have shown that relocated public housing residents were not able to access and leverage job leads and information in their new low-poverty neighborhoods,[229] or recreate social support networks lost during housing destruction and relocation.[230] [231] Additional studies of public housing residents' experiences with relocation highlight critical, geographically-anchored social networks may provide important health protective effects. Indeed, measures of community support among public housing residents have been associated with reduced odds of school expulsion among children and food insecurity among adults.[232]

> **"Closeness to family and friends are important to our communities."**
>
> **"I know my entire floor and at least somebody on every floor, [and] I have an investment and connection. All the old folks tell me hello, and they are invested and want to see me grow."**
>
> **HIA Focus Group Participant**

Looking at three public housing relocation programs (MTO, HOPE VI, and the Gautreaux project) can provide some insight into the effects on social support, social networks, and other forms of social capital. In theory, after HOPE VI redevelopment, the original residents would be able to return to their refurbished homes and enjoy a wide range of social and economic programs. However, by 2004 (twelve years since the launch of HOPE VI), of the 95,100 planned replacement units, only 48,800 of the planned units total were earmarked for very low-income families, and only 31,080 of the total planned units were completed.[233] A study of public housing residents' experiences, well-being, preferences, and needs prior to HOPE VI relocation highlighted that the physical distress of buildings was not always indicative of social distress within those buildings. Rather, researchers found people had deep ties to their public housing community, such that 65% of English speakers and 54% of speakers of other languages were unwilling to move.[234]

With MTO, study results indicate that relocation also did not enhance social capital for former public housing residents. Social networks were diminished compared to what residents had access to in public housing. There was very little interaction between relocated residents and homeowners and market-rate renters in relocation sites.[235]

In fact, MTO was halted prematurely precisely because residents in neighborhoods receiving relocated residents in Baltimore mobilized political resistance to it.[236] Relocated residents' satisfaction levels were greater than in low-poverty sites as to their housing quality and neighborhood conditions, but access to social networks and the benefits they provide were worse, showing a substantial drop in number of neighborhood social contacts and large reductions in the size of their neighborhood networks even three years after relocation.[237]

In relation to social support networks, in the Gautreaux project, women received transportation assistance; acts of neighborliness, such as responding personally to domestic disturbances or calling for help, picking up mail, or shoveling each others' snow; and reciprocal relationships related to childcare and neighbors' general concern and watchfulness.[238] A qualitative study of 25 individuals relocating from Chicago to eastern Iowa paints a more nuanced picture of some additional challenges faced by individuals moving substantial distances from their original public housing location. Researchers found a common theme was a sense of "rootlessness" resulting from the disruption of both social and place-based ties to former communities.[239] Despite some benefits of moving (e.g., access to higher quality schools), individuals also described the challenges of being accepted into new communities, such as being viewed as outsiders, being relegated to particular areas, and a lack of social support. Each of these new challenges has the potential of increasing stress and decreasing an individual's coping capabilities, both of which can negatively affect health by removing protective relationships in the context of continued social and geographic marginalization.[240]

Focus groups conducted for this HIA support the idea that public housing communities provide social networks and supports that are instrumental in having social capital. Participants discussed the benefits of their social connections in public housing, including the sense of community and value of knowing your neighbors. For example, one Cincinnati participant stated, "[Public housing] is where I'm comfortable. Where I like to live. That's my home. I don't look at this as no stepping stone." In Los Angeles and Cincinnati, there was a general sense of positive identity: "I have been here my whole life and have pride in my community." In the New York focus groups, participants told anecdotes about people watching each others' children and intergenerational living. One person stated, "Closeness to family and friends are important to our communities," while a young person talked about the encouragement he gets from social interaction, "The people that I have surrounded myself with are beyond motivating for me as the youngest in every room I go in." Participants noted the friendliness of living in public housing, especially when they have the ability to interact with people in less formal settings. For example, "when you're outside or grilling, neighbors come by and have a conversation and the kids play together." Another stated, "I know my entire floor and at least somebody on every floor, [and] I have an investment and connection. All the old folks tell me hello, and they are invested and want to see me grow." Several people specifically called out the protective factor of social interaction: "These connections are the reason I didn't get robbed one time – because they knew who I was;" "I'm connected through two parents' associations for grandchildren to others in my building. Now I'm less afraid to move around my building because I know the young people, and it gives me a sense of security."

Some residents noted, however, that there was not the same level of social cohesion as in the past. Participants in focus groups expressed nostalgia about how the neighborhoods and public housing used to be better and more of a community. One participant said, "I just got to public housing about 8 years ago. I remember being so excited that I had got an apartment in the projects, and I really liked it when I got it. I moved here from Virginia and it was nice to

have so many folks around. My neighbors talked when we was in the hallway." Participants from Oakland expressed longing for how neighborly it used to be and sorrow for how the general sense of community was now absent. In a New York focus group, these sentiments were echoed. A focus group made up of older residents shared how they felt that overall it was hard to get to know new residents and that the new types of residents in public housing were unfriendly and often involved in drugs and crime. Several people noted that there used to be more kids and families socializing outside and hanging out talking with each other.

Participants also worried about the impact that having tenant-based vouchers or the choice to move to another building with a voucher might have. One said, "I think if we switched to offering folks vouchers, it may get people to move quick and then the little bit of community that we do have will surely be gone." Another stated, "I think if vouchers came to public housing, it would pit residents against each other. Already there are Section 8 folks in my building and they don't have to wait years for repairs because [their repairs] had to be done right away. People got upset about that, and it's not their fault." Overall, there was concern that vouchers would break up the families in, and cultural benefits of, public housing, and that residents might move away from neighbors who have supported each other for many years.

Predicted impacts of RAD on health via social isolation and cohesion, resident connection to neighbors, and social support networks.

If RAD is implemented with increased residency standards and there is increased mobility due to the provision of tenant-based vouchers, given the findings above, we anticipate negative impacts on social cohesion and support networks through the displacement and relocation process. As these social cohesion and support networks can buffer stress, which is a significant predictor of health outcomes, we anticipate negative impacts on a wide range of stress-related health conditions (*see above for specific impacts*). Given that social connectedness can also impact access to resources, such as childcare, and buffer against crime, a decline in social connectedness due to relocation could conceivably exacerbate any negative health impacts. With no new vouchers currently being created, it is unlikely that disruption of social networks and cohesion would result in the short-to-medium term. Short-term disruption could primarily result through increased residency rules that could lead to eviction.

The strength of the evidence for these research questions is particularly strong given findings from other studies, and we anticipate the magnitude of this impact would be major over the long-term, particularly if RAD is continued beyond the pilot period.

RECOMMENDATIONS

1. Limit distance of how far residents are relocated based on unique characteristics of the city. For residents who relocate, provide relocation assistance per the Uniform Relocation Assistance Act, including moving costs, transportation costs, and job placement assistance.

2. Create, maintain, and encourage residents to use public spaces such as outdoor community spaces and community meeting rooms and centers.

3. Include residents in rule-making processes so that rules do not discourage or limit families and friends from gathering.

C. How will RAD impact levels of racial and ethnic segregation?

Residential segregation refers to the physical separation of racial and ethnic groups along geographic lines[241 242] and is a strong determinant of health status. Living in racially segregated neighborhoods has been associated with higher infant mortality,[243 244 245] overall mortality,[246 247 248] and crime rates[249] that cause injury and death. Historically, residential segregation was supported by explicit legislation, restrictive covenant policies, exclusionary zoning practices, and racially-charged violent acts that confined low-income, mostly African-American, populations to certain types of housing in specific neighborhoods.

The concentration of people of color in segregated urban neighborhoods, combined with macro-economic changes in these neighborhoods over the past 50 years, has had the effect of socially isolating many residents of color and poor residents from the institutions, resources, and networks afforded to residents in middle- and upper-class neighborhoods.[250 251 252] For example, residentially segregated neighborhoods often have limited and/or poor quality educational and employment opportunities, services, and networks.[253] Residents experiencing segregation are not only marked by the stigma of race and class, but also by the "blemish of place" that labels such urban landscapes at the "ghetto" and inhabitants there as "tainted" and "discounted."[254 255 256]

While studies show that residents of racially segregated neighborhoods have poorer health than other residents, what is unclear, however, is whether these negative health outcomes are actually caused by the racial segregation.

Some studies have indicated that health variation can be attributed to "quality of neighborhood environment, concentration of poverty," socioeconomic attainment, access to resources and opportunities, and the experience of racism.[257 258] Other studies suggest that residential segregation is "an institutional manifestation of racism," making policies aimed at integration difficult to implement.[259 260 261] Studies have noted that resistance from receiving communities may lead to social isolation, resegregation, or reclustering.[262 263 264] Additionally, despite clear evidence linking poor health outcomes to racial segregation, there is little evidence to show that policies designed to address segregation have had positive health impacts.[265 266 267 268]

Demographic data highlights that segregation is common throughout public housing across the U.S. For example, nationally, there are three times as many African-Americans living in public housing as there are in the general population, and one and a half times as many Latinos. Table 2 illustrates that each case study city also had varying degrees of segregation in public housing. In all cities, the proportion of non-Latino Blacks is much higher than that of the general public, and the proportion of non-Latino Whites living in public housing is much lower than in the general population.

TABLE 2. POPULATION BY RACE/ETHNICITY IN THE GENERAL PUBLIC AND IN PUBLIC HOUSING

	LOS ANGELES		NEW YORK CITY		CINCINNATI		OAKLAND		NATIONAL	
	General public[3]	PH[1]	General public[4]	PH[1]	General public[5]	PH[1]	General public[6]	PH[1]	General public[7]	PH[2]
Non-Latino White	53%	38%	44%	37%	49%	8%	35%	13%	72%	51%
Non-Latino Black	7%	57%	26%	58%	45%	91%	28%	83%	13%	45%
Latino	44%	32%	29%	41%	3%	1%	25%	6%	16%	24%
Asian	15%	4%	13%	4%	2%	0%	17%	3%	5%	2%
Native American/ Alaska Native	0.7%	0%	0.7%	0%	0.3%	0%	0.8%	1%	0.9%	1%

Sources:
1 HUD. 2011. Public Housing Resident Characteristics Reports: July 1, 2010-October 31 2011. Available at: https://pic.hud.gov/pic/RCRPublic/rcrmain.asp. Metropolitan area populations reported.
2 HUD. 2011. Public Housing Resident Characteristics Reports: July 1, 2010-October 31 2011. Available at: https://pic.hud.gov/pic/RCRPublic/rcrmain.asp. National population reported.
3 Census. 2010. Race and Hispanic or Latino Origin for the Los Angeles-Long Beach-Santa Ana Metro Area: 2010. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table.
4 Census. 2010. Race and Hispanic or Latino Origin for the five counties of New York City: 2010. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table.
5 Census. 2010. Race and Hispanic or Latino Origin for the city of Cincinnati: 2010. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table.
6 Census. 2010. Race and Hispanic or Latino Origin for the city of Oakland: 2010. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table.
7 Census. 2010. Race and Hispanic or Latino Origin for the United States: 2010. Available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?fpt=table.

While residential segregation is common in American cities, in some cases, residents living in segregated neighborhoods have voiced the desire to live in more integrated neighborhoods. Results of a study of the Gautreaux project indicated that Black families prefer to reside in mixed-race neighborhoods, noting that there was a strong tendency for Gautreaux families who were initially placed in neighborhoods at both ends of the spectrum (i.e., that averaged either 95% or 4% Black) to move to more racially-balanced neighborhoods (62% and 43% Black, respectively).[269] Several of our HIA focus group participants also stated that they appreciated the diversity of where they live. One participant shared, "One thing I really like is that there is a lot of diversity. My kids play with Blacks and Chinese and Latinos and they get to play with other cultures." The diversity was not without difficulties, however. One Cincinnati participant felt that there was a culture clash with new residents from Africa, and "there's nothing management or anyone is doing to make sure people come together." However, results of a study in Chicago looking at public housing residents who tried to move to Section 8 housing found that although some participants would prefer to live in a racially-integrated community, they faced obstacles in moving due to discrimination.[270]

After HOPE VI, relocated participants tended to spread out across many different neighborhoods, but significant clustering was found in a few neighborhoods with high concentrations of people of color – the average rate of people of color was 79% in the highly clustered tracts.[271] The results of HOPE VI relocation efforts mirror past research, which found that people given vouchers often stay in neighborhoods fairly similar to those they left.[272] Other recent studies have shown that most people continue to live in racially segregated areas.[273]

Indeed, trying to create, or actually successfully creating, more mixed-race and mixed-ethnicity communities has not necessarily led to integration. In the San Francisco HIA that assessed HOPE VI redevelopment at two sites, public housing residents stated that, "It's more multicultural now, but there is no integration." In other words, while there was an attempt through HOPE VI to physically co-locate different races and ethnicities, these populations had not gone as far as to socially integrate with each other. Residents also felt that there was an effort to have fewer African-Americans in the redeveloped housing and "to get Blacks out."[274]

Predicted impacts of RAD on health via segregation.

The proposals could impact racial and ethnic segregation through increased mobility into the private housing market through tenant-based vouchers. Impacts could be both positive and negative:

1. If mobility via vouchers is promoted, but residents predominantly choose to remain in the converted housing stock, there would likely be little-to-no impact of the proposals on racial and ethnic segregation as the population will largely remain unchanged. This assumes any new residency standards do not put residents at risk of displacement.

2. Conversely, if residents choose to take advantage of a mobility option and move into less racially and ethnically homogenous communities, segregation within public housing may decrease depending on who the replacement residents are. If replacement residents are of the same race and ethnicity as departing residents, there will be no change in racial and ethnic segregation. If new residents are from a wider range of race and ethnic populations, racial and ethnic segregation may decrease.

Past efforts through mobility programs to desegregate public housing in terms of race and ethnicity have resulted in some desegregation. Designated funding for moving populations out of the public housing stock aided in this process. Given the lack of additional tenant-based vouchers being created for residents by RAD, the current likelihood that residents will take advantage of a mobility option is low. As such, it is unlikely that racial and ethnic segregation, in the short-to-medium term, will be impacted by RAD. If conversion funds under this policy are used to support mobility via vouchers, based on the strength of the evidence from other studies, we anticipate that housing relocation into more heterogeneous communities would result. However, it is possible that residents cannot actually integrate into their new communities, and will be re-segregated within those new communities.

With respect to health specifically, evidence from past housing relocation programs shows that racism in new communities, as well as the stress from racism, can be an obstacle to realizing any positive benefit from integration. The research cited above also illustrates that studies are mixed as to the health benefits of racial integration.[275] [276] [277] Therefore, the ability to predict any specific impacts on the health outcomes associated with segregation, including

infant mortality, premature mortality, and injuries from crime, is limited. Given these mixed findings, as well as unknowns in RAD now and for the long-term and the number of variables associated with where a resident may choose to relocate, we anticipate that the magnitude of whatever impact there is will be minor-moderate, and the severity of that impact will be low-moderate.

RECOMMENDATIONS

1. If mobility via vouchers is promoted, for residents who relocate or who are considering relocation, provide counseling on the challenges of integrating into new communities during relocation – prior to relocation as well as ongoing counseling upon relocation.

2. Develop independent tracking system of residents, where they relocate to, and their experiences.

D. How will RAD impact the concentration of poverty?

Poverty and income are the strongest and most consistent predictors of health status. As income increases, overall life expectancy is higher.[278] [279] In addition, low-income individuals are at a higher risk for giving birth to low birth-weight babies, suffering injuries and violence, getting most cancers, and developing chronic health conditions.[280] Concentration of poverty has also been associated with larger social patterns, including high unemployment rates, high school dropout rates, and crime and violence.[281] As a result, public housing policies have focused on the "deconcentration of poverty," or moving low-income people to higher-income neighborhoods where residents are *supposed* to have better access to employment, housing, and educational opportunities and access to retail, public goods, and services.

Policies and projects designed to deconcentrate poverty for public housing residents have had mixed results, the biggest challenge being that when residents are displaced from their communities there is no concurrent improvement in their individual income levels – in other words, the community may become less impoverished by removing poor residents, but the individual does not see a corresponding increase in their income level. Additionally, many residents who move or are displaced from one high poverty area will re-concentrate into other high poverty neighborhoods elsewhere.[282]

Overall, income levels of participants completing our HIA survey highlighted the lower level incomes of those who currently and/or formerly resided in public housing. Over 70% of the public housing residents made less than $15,000 a year, 15% made between $15,000-$25,000 a year, and 15% made between $25,000-$55,000 a year. Nationally, the average annual income of public housing residents is $13,379,[283] lower than the 2009 federal poverty level of $14,570 for a family of two.[284] To reinforce our survey findings, tables 3 and 4 highlight the average annual income for public housing residents and the percent living below the poverty line in our case study cities.

TABLE 3. AVERAGE ANNUAL INCOME OF PUBLIC HOUSING RESIDENTS

NATIONAL	$13,379
CINCINNATI	$9,815
LOS ANGELES	$16,885
NEW YORK CITY	$22,293
OAKLAND	N/A

Source: HUD. 2011. Resident Characteristics Reports of Housing and Urban Development: April 2010-July 31 2011. Available at: https://pic.hud.gov/pic/RCRPublic/rcrmain.asp.

TABLE 4. PERCENT BELOW POVERTY LINE BY CASE STUDY CITY

CINCINNATI	29% of Males, 32% of Females
LOS ANGELES	20% of Males, 23% of Females
NEW YORK CITY	18% of Males, 22% of Females
OAKLAND	21% of Males, 23% of Females

Source: Census. 2010. Available at: http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml.

Focus group participants had multiple comments about the role that poverty deconcentration programs played in impacting their own individual poverty levels, and they challenged the idea that living in lower-poverty areas would impact their poverty levels. One participant stated, "They think if we move with rich folks, we'll be rich too, which is some bull…" while another said, "I don't want to leave where I live, I want them to just take better care of it as if we lived with rich people now." Another participant challenged the premise of poverty deconcentration programs and how such programs viewed public housing residents: "I think that those policies are based on the thinking that poor folks wanna stay poor and the only way they can get more money is if they live in places with people with money. That thinking is disrespect to hard working people in the projects." And another stated, "I'm not against living with other folks. I live around different folks now but I also don't feel like if I live by more folks with money it will change me."

Literature findings generally found that relocation programs led residents to live in less impoverished communities. For example, a study of Section 8 relocation as part of the HOPE VI program found that, overall, households did relocate to neighborhoods with lower concentrations of poverty, but some cities fared better than others.[285] In the HOPE VI program, the majority of relocated residents moved to neighborhoods that had lower poverty rates – the average poverty rate of their neighborhood of residence dropped from 61% to 27% after moving. But, while relocated participants tended to spread across many different neighborhoods, significant clustering was found. The largest share of the highly clustered census tracts had poverty rates ranging from 10-30% living in poverty.[286]

Among residents who moved to other public housing projects, both the HOPE VI Tracking Study and the HOPE VI Panel Study found small declines in the average neighborhood poverty rates (14% and 3%, respectively). For those relocating to private-market housing with vouchers, average neighborhood poverty rates declined more substantially (by 17% and 16%, respectively). Additionally, a national study of relocated HOPE VI residents who received vouchers found a 34% decline in average neighborhood poverty rate. Despite these improvements, however, the Tracking Study found that nearly 40% of voucher users and nearly 50% of all respondents still lived in neighborhoods that were traditionally classified as high poverty (more than 30% poor).[287]

> **"I don't want to leave where I live, I want them to just take better care of it as if we lived with rich people now."**
>
> **HIA Focus Group Participant**

It was also found that HOPE VI residents receiving vouchers faced many difficulties in relocating to lower poverty neighborhoods, including increased need to pay for utilities, lack of affordable and large family-sized units, and difficulty gathering security deposits.[288] As such, many voucher recipients were forced to secure apartments in other high-poverty and racially segregated neighborhoods, which the program was presumably meant to circumvent.[289] For those who were able to leave high-poverty, racially segregated neighborhoods, the stigma of their former residences continued to socially and economically exclude them from health-promoting resources.[290] [291] Additional studies from 2000 to 2005 in eight metropolitan areas focused on whether vouchers without restrictions on geographical destination and without intensive counseling supported the deconcentration of poverty. Across the cities, there was little evidence that voucher recipient clustering declined or that vouchers promoted the deconcentration of poverty and race and ethnicity.[292] Similarly, our HIA focus group participants commented on the ineffectiveness of Section 8 vouchers and that the emphasis was always on getting lower-income people to move out of poor areas, rather than bringing middle-income people in: "Where would we go?.....Why not get the middle class move to where we are?" Another person said, "If I could afford to live in a higher-income place, I would go. So, why not let them move where we are? Move people in the middle class in to improve everything."

Conversely, a 1995 study of the Gautreaux project found that the majority of residents who moved experienced improvements in neighborhood poverty levels and improvements in neighborhood quality.[293] However, the study's results should be understood while keeping in mind that the scale of the Gautreaux project was not very large and was comprised of families who volunteered for relocation. The study suggested that the program generally succeeded in moving participants into less segregated, higher socioeconomic, and lower crime neighborhoods. All but a handful of participants were able to move long term from their inner-city origin neighborhoods, and two-thirds of those who initially moved to the suburbs continued to live in the suburbs some six to 22 years after their initial moves. Compared with conditions in their origin neighborhoods, the participating families reported large and persistent improvements in neighborhood quality.[294]

In terms of impacts on individual poverty levels and associated indicators such as education and employment, findings from studies have been mixed. For example, 88% of Gautreaux children attended schools with above-average achievement,[295] and compared to city movers, Gautreaux children who moved to the suburbs were more likely to graduate from high school, attend four-year colleges (vs. two-year colleges), and if they were not in college, to be employed and to have jobs with better pay and with benefits.[296] Mothers who moved to the suburbs also had higher rates of employment than mothers who moved within the city, though not higher earnings.[297] Meanwhile, the Panel Study of HOPE VI redevelopment found a increase in the percent of households earning greater than $15,000 (from 32% to 42%) but also indicated that, despite these increases in income, many voucher users were having difficulty making ends meet due to increased housing costs. The study found that HOPE VI relocation did not result in increased employment rates.[298] In fact, study results found that "employed respondents living in their original public housing development were the most likely to have been in their current job for three years or longer (52%), while those no longer receiving housing assistance were the least likely (39%)," suggesting that the housing stability provided by public housing supported residents' long-term employment.[299]

Predicted impacts of RAD on health via deconcentration of poverty.

RAD could impact poverty deconcentration through increased mobility into the private housing market through tenant-based vouchers. Impacts could be both positive and negative:

1. If mobility via vouchers is promoted and residents predominantly choose to remain in the converted housing stock, there would likely be little-to-no impact of the policy on poverty deconcentration as the population will largely remain unchanged. This assumes any new residency requirements do not put residents at risk of displacement.

2. Conversely, if residents choose to take advantage of a mobility option and move into less poor communities, poverty concentration within public housing may decrease. However, if replacement residents are of the same poverty levels as departing residents, there will be no change in poverty concentration. If new residents are from a wider range of income levels, poverty concentration may decrease.

As with the racial and ethnic segregation analysis above, given the lack of new tenant-based vouchers being created, we do not anticipate increased housing choice and relocation and the current likelihood that residents will take advantage of a mobility option is low. As such, it is unclear the extent to which poverty deconcentration, in the short-to-medium term will be impacted via RAD. Again, if conversion funds are used to support mobility via vouchers, based on the strength of the evidence from other studies, we do not anticipate relocation into more economically-mixed communities. In terms of impacts on health, given HOPE VI and Gautreaux evaluations, it is unclear whether programs to deconcentrate poverty have been successful. Evidence of efforts to deconcentrate poverty show some success in changing community-level poverty: public housing residents who relocated tended to move into communities with lower poverty rates, and because of the mixed-income housing that was developed in many HOPE VI sites, complexes that were formerly 100% very low- and extremely-low income raised the average area level incomes. However, despite efforts to incorporate mixed-income housing into renovated public housing complexes, it is unclear whether individual poverty levels have changed for public housing residents. Therefore, given these findings, the ability to predict any specific impacts on the health outcomes associated with poverty,

including life expectancy, low birth weight births, crime and violence, and chronic health conditions is limited. Given the unknowns related to the implementation of RAD, whether it will be continued beyond the pilot period, as well as the number of variables associated with where a resident may choose to relocate, we anticipate that the magnitude of whatever impact there is will be minor-moderate, and the severity of that impact will be low-moderate.

RECOMMENDATIONS

1. Require 100% waivers for all units in all project-based pilot sites to ensure that income mixing requirements and the resulting displacement do not apply.

2. Provide counseling to residents with explicit focus on entrepreneurial skills, and employment and job training.

3. For residents who relocate or are considering relocation, develop, fund, and administer counseling and programming on topics related to living with vouchers and/or private landlords, budgeting and resident responsibilities, child care, employment, education, and integrating into new communities.

E. How will RAD impact levels of safety, crime, and violence?

Safety, crime, and violence are reported to be some of the most significant problems for public housing in the U.S. There are two coexisting perspectives on crime in public housing. First, crime is of clear concern to residents and managers of public housing sites; second, the social cohesion people feel in public housing acts as a buffer to perceived crime, and this perception can have a protective effect for residents with respect to crime. Below, we discuss findings related to both of these perspectives.

Safety, crime, and violence commanded significant attention in our HIA focus groups and surveys. When asked how their new neighborhoods are different from old neighborhoods, 58% of survey respondents said that crime had decreased. When asked what people wished was different about their public housing site, most of participants' complaints centered on crime in the community. "I don't like the [influx] of drugs and crime," one person said. In one of the New York focus groups, 100% of participants stated that people in public housing are stressed, and when asked why, housing insecurity and crime were cited as the foremost reasons. Another stated, "When I walk out of my apartment I don't know what I will walk into." In the Cincinnati focus groups, people talked about stress related to crime, drugs, and violence in their public housing complex, and that management does not do enough about it. One resident said, "I like my neighborhood because it's diverse, and I want to stay here but it's dangerous." Crime was often discussed in tandem with comments about the communities in which public housing is located in, the inability or inaction of management to intervene, and decrease in social interaction for neighbors to know each other.

Such sentiments were also found in the HOPE VI Panel Study from 2002: almost three-quarters of residents surveyed reported major problems with drug trafficking and sales, two-thirds reported shootings and violence as big problems, and half of the respondents did not feel safe just outside their own buildings.[300] The study found some

improvements in perceptions of neighborhood safety for those who had relocated.[301] Looking at public housing residents who elected to use vouchers, relocated HOPE VI residents in Chicago experienced "almost immediate improvements in . . . mental health, likely [as] a result of living in a safer neighborhood."[302] [303] In the Gautreaux project, relocating to lower poverty, more integrated areas had a mixed effect on delinquent behaviors and arrest rates of boys versus girls: suburban boys were much less likely to become involved in the criminal justice system, while girls who moved to the suburbs were more likely to be convicted for criminal offenses.[304] Studies of the MTO program found large improvements on feelings of safety for mothers and their children, as well as reductions in depression.[305] A study looking at crime in HOPE VI sites showed that in three of the four sites they studied, crime had decreased in the sites far more significantly than the city's crime rate had dropped.[306]

Notably, in the San Francisco HIA cited earlier, residents in one of the sites also felt safer after redevelopment, but had great concerns about the restrictive nature that new rules had on their ability to feel and act neighborly with other residents. In this housing site, some residents noted that people were not admitted back after redevelopment or were evicted after readmission if they had any criminal history.[307]

There is limited information about the extent to which crime is displaced to other communities, though research supports the hypothesis that crime actually decreases. For example, a 2011 study looked at change in crime in public housing sites and the surrounding areas, and attempted to answer the question about displacement of crime after redevelopment. This study found an indication that crime in all sites they examined had dropped and that redevelopment affected crime in the surrounding area, usually by decreasing it. The decrease in crime continued – at least for the study period, which was two years after HOPE VI redevelopment was completed.[308]

With respect to social cohesion, research has also shown, however, that former public housing residents felt safer in their original public housing developments due to their social support networks and place attachment.[309] Participants in our HIA focus groups felt that the social cohesion and interaction in their housing projects helped, to some extent, mitigate safety concerns. Several participants noted that they were protected from crime, and even the fear of crime, when they started reaching out and knowing their neighbors better. One participant stated that once she started to get to know the younger residents, she was less afraid to ride the elevator with them. In focus groups conducted as part of the Right to the City Alliance's report,[310] one person stated, "When you hear public housing (in the media) you think of gunshots, fires, crimes, and drugs, and murders, and killings. But they also do not tell you that the next-door neighbor is there for you. They got your back. These projects – they are considered a family. We call these projects home. That is what people really need to know. That's the positive side of it."

Media references to crime and violence may mask positive associations that residents have with public housing. The Right to the City Alliance's study included an analysis of over 400 newspaper articles documenting the media image of public housing. The analysis found that "guns" and "poverty" were the two most prevalent words found in articles. The study also included interviews and focus groups with hundreds of residents, finding that although most reporting focused on crime and violence in public housing projects, residents saw public housing as a vibrant community and a good place to live and raise a family.[311]

Predicted impacts of RAD on health via safety, crime, and violence.

Based on the evidence from other studies, crime and violence are likely to decrease in public housing. As crime and violence decrease, health impacts would include fewer injuries and deaths, as well as decreased stress and stress-related health conditions. We anticipate the magnitude of this impact would be moderate-major based on the strictness of rules implemented through the conversion process. Given the severity of injuries and stress often resulting from crime and violence, we also judge the nature of the impact on life function and quality of life to be high.

RECOMMENDATIONS

1. Implement principles of Crime Prevention through Environmental Design (CPTED) to increase natural surveillance of the environment and prevent crime. Among others, strategies include: re-designing streets to increase pedestrian and bicycle traffic, creating landscape designs that provide surveillance, using the least sight-limiting fencing, and creating good lighting design. *(CPTED is a multi-disciplinary approach to deterring crime through environmental design.)* [312]

2. Provide funding for PHAs, resident organizations, and local public housing advocates to work with local police departments to implement community policing strategies.

3. Require that "crimes" that lead to eviction are truly public safety crimes and do not include status offenses, and require that eviction because of a qualifying crime not be triggered by merely an arrest. This will also help mitigate eviction-related health impacts.

4. Allow and ensure that residents and resident organizations are represented in any crime prevention strategies implemented by PHAs.

5. Limit criminal background checks to heads of households.

F. How will RAD impact levels of stress among residents?

Feelings of stress over a long period of time can take a toll on mental and physical health. The body responds to stress by releasing stress hormones (e.g., cortisol) and these hormones can increase blood pressure, heart rate, and blood sugar levels. Long-term stress can cause a variety of health problems, including depression and anxiety, obesity, heart disease, high blood pressure, abnormal heartbeats, menstrual problems, and acne and other skin problems. The issue of stress is indirectly addressed through questions about segregation, poverty, and social capital. Here, the question of stress is directly addressed though the experience of both living in public housing and through the fear of being forced to leave public housing.

Both the literature and our HIA focus group findings confirm that the residents of public housing are living with stress. Most of our focus groups participants indicated that they or their neighbors experienced some health issues, the most commonly cited being stress associated with crime and housing insecurity. One participant stated, "I think people are stressed, it's depressing and stressful to wake up, go outside and your surroundings are like a big garbage." Another said, "I feel stressed at times, cause it feels like things ain't getting better, they are getting

worse. Also they are always talking about the projects are gonna be sold so I worry about that." In the Cincinnati focus group, all participants stated it as very stressful to live in public housing. The main reasons included crime and drug activity ("alcohol and drug activity off the charts"), management not doing enough about it, residents allowed in with mental health problems, and generally "younger people." One participant saw the other side of drug use, "I know people that have a habit because they can't deal with the stress." In New York, participants estimated that between 70% - 90% of the people living in public housing are stressed due to uncertainty of what will happen with their homes and the vulnerability of public housing, rude management, gunshots outside their home, and fear of crime (e.g., having to check hallways and staircases before leaving the apartment). Many seniors in Cincinnati and New York feared having to move to higher floors and that they would get sick and/or die, and no one would find them.

Both the literature and focus group findings confirm that proposed policies to move residents out of public housing creates stress for residents. The Right to the City Alliance's report found that the demolition of public housing had created a culture of fear and stress among public housing residents across the country.[313] As one former Chicago public housing resident stated in reference to being told she had six months to move, "Six months! That is like telling you that you have six months to live… some people couldn't adapt to that."[314] A study of Atlanta public housing residents prior to and after relocation supports the hypothesis that tenure increases the sense of place. Specifically, the longer the tenure in public housing, the greater the community attachment and the greater the probability of wanting to renovate the housing rather than relocate. It is possible that losing these ties through relocation may lead to increased stress and a lowered ability to cope in the new relocated environment. This, in turn, may explain the lack of consistent evidence concerning broader quality of life improvements among former public housing residents post relocation. Also, embodied in relocation is a real sense of loss. Dislocation can cause distress and "root shock," which is a term coined to describe the traumatic stress reaction to the destruction of all or part of one's emotional ecosystem. It can disrupt community and can be difficult for the relocated residents to create new communities and social ties – which may be one reason why so many former public housing residents move just a few miles from their public housing site.[315]

Predicted impacts of RAD on health via stress.

RAD has the potential to impact resident stress levels via numerous pathways and could increase and decrease stress levels simultaneously. We predict the impact of RAD on stress will likely be mixed based on the following:

1. With anticipated improvements in safety levels due to RAD, residents will likely experience decreases in stress related to crime and violence.

2. Unknowns associated with major changes and vulnerabilities in housing policy and rules associated with new management will likely increase stress levels for residents. As the conversion process is completed, uncertainty related to policy shifts may subside. Similarly, as residents become accustomed to new management structures, stress associated with new standards or different management may also subside – though concerns with violating rules will likely always exist.

3. With potential displacement due to evictions or increased housing costs due to moving into a more expensive housing stock, stress may increase for residents who are evicted and/or who are unaccustomed to renting in the private market.

4. With potential displacement due to new residency standards and mobility due to tenant-based vouchers, changes in social networks and cohesion may leave residents without the social supports that buffer stress, exacerbating any existing health conditions.

Based on the strength of the literature and focus group findings, we anticipate that RAD will not lead to significant reductions in stress and stress-related health conditions – and may, for some residents, lead to increases in stress levels. Given the significant role that stress plays in quality of life and life function, any additional stressors could have moderate-major impacts on health, particularly given that these populations already experience elevated stress levels when compared to the general population. Given the role that stress plays in determining health and mental health outcomes, the impacts severity of impacts may likely be high.

RECOMMENDATIONS

Overall, the interconnectedness of all the elements of this HIA is most evident in this section. Much of this HIA assesses impacts that lead to stress; by extension, implementing many of the above recommendations will mitigate the issues that lead to stress, and thereby decrease stress levels in the process.

Summary of Predictions-Impacts on Health Determinants

HEALTH DETERMINANT	IMPACT	MAGNITUDE (HOW MANY?)	SEVERITY (HOW BAD?)	EVIDENCE STRENGTH	UNCERTAINTIES
Social cohesion/ Social networks	-	Major	Moderate	• •	Unclear the extent to which tenant-based vouchers will be distributed Ability to informally implement stricter residency rules
Segregation	~	Minor-Moderate	Low-Moderate	•	
Concentration of poverty	~	Minor-Moderate	Low-Moderate	•	
Crime	+	Moderate-Major	High	• •	
Stress	~	Moderate-Major	High	• •	

Explanations:

Impact refers to whether the proposal will improve health (+), harm health (-), or whether results are mixed (~).

Magnitude reflects a qualitative judgment of the size of the anticipated change in health effect (e.g., the increase in the number of cases of disease, injury, adverse events): Negligible, Minor, Moderate, Major.

Severity reflects the nature of the effect on function and life-expectancy and its permanence: High = intense/ severe; Mod = Moderate; Low = not intense or severe.

Strength of Evidence refers to the strength of the research and evidence showing causal relationship between mobility and the health outcome: • = plausible but insufficient evidence; • •= likely but more evidence needed; • • • = causal relationship certain. A causal effect means that the effect is likely to occur, irrespective of the magnitude and severity.

OVERARCHING RECOMMENDATIONS

In addition to the specific recommendations listed throughout this HIA, because of the number of unknowns related to RAD implementation as well as the lack of overall positive health impacts that would result from implementation, we also propose a series of overarching recommendations for decision-makers to consider:

1. Prioritize funding to improving existing public housing stock rather than on relocating residents out of public housing.

2. Keep the "public" in public housing – require that public housing always remain a public asset under public ownership and control, particularly in times of risk such as foreclosure, bankruptcy, or default.

3. Require the preservation of the public housing stock by clarifying long-term sustainability plans for individual Public Housing Authorities (PHAs), developed by PHAs with oversight from and in collaboration with the resident organizations, public housing advocates, and HUD.

4. Designate adequate funding for services, support, and protections for those who are traditionally "hard to house." (e.g., the elderly, large families, people with disabilities, and those who have been arrested or incarcerated, have poor credit histories, or are unable to meet work or school requirements, etc.)

5. Develop an assessment, monitoring, and evaluation program in collaboration with resident organizations and public housing advocates, implemented by an independent third party to track implementation and effects of RAD, and to recommend changes that will need to be made if RAD is continued beyond the pilot period.[316]

6. Set up a Conversion Oversight Committee (COC) made up of existing leaders of PHA resident organizations, public housing advocates, and elected officials. The COC should be charged with reviewing: national residency standards; criteria for selecting which public housing receives RAD conversion status (including special consideration for public housing sites that provide housing for the "hard to house"); and national grievance policies, and should be required to provide twice yearly updates on implementation progress and evaluation program results.

7. Local resident associations should be a part of review and decision-making processes on topics including development and implementation of residency standards; development of disposition plans and relocation compensation and support; development and oversight of grievance policies; site maintenance workplans to address repair needs; new rules implemented within public housing complexes; and distance limits of new housing identified for residents.

HIA LIMITATIONS

Virtually all Health Impact Assessments face limitations as they are being conducted, and this HIA was no different. We list several of the more challenging limitations below. Importantly, however, none fundamentally restricted our ability to make predictions and recommendations regarding RAD. Specific limitations in this HIA include:

- **LIMITED FUNDING.** With more funding, we may have been able to assess impacts on a wider scope of issues and answer additional research questions. For example:

    - **Scope questions that went unanswered:** What are the impacts of changes in ownership structures (as opposed to management structures) on health? How would time and use restrictions and mortgage defaults impact this? What are the impacts of access to neighborhood resources on the health of public housing residents? What is the impact of changes in management and ownership on homelessness? These questions could be assessed by other researchers interested in looking at the relationships between RAD and health – as mediated through these factors.

    - **Questions about the nature and structure of our public resources:** Are there lessons learned from the privatization of other public resources to be considered as RAD is implemented? Conversely, are there lessons from RAD and the potential for private management of public housing for other public resources that face privatization?

- **CHANGING LEGISLATION.** There was an ever-changing alphabet soup of bills – including TRA, PETRA, RHRA, RAD, and S 1596 – that were initially the focus of this HIA. Tracking these various legislative proposals and revising our target was, at times, challenging and created uncertainties in what we were assessing. Ultimately, RAD was passed as the HIA was close to complete, and the focus for the HIA became to influence the RAD implementation process.

- **DIFFICULTY COMPARING TO OTHER STUDIES.** Conclusions in this HIA are often drawn from comparisons to MTO, HOPE VI, and Gautreaux studies. Unfortunately, these comparisons are imperfect – both because there are various elements of RAD that are new and untested, and because those programs focused primarily on vouchers, redevelopment, and relocation. For example, one specific difference that may limit comparability is that those who elected to use vouchers in these relocation programs likely differ from public housing residents who opted to stay in public housing, and these analyses focus on public housing residents and anticipated impacts on them. However, given limited studies of public housing residents with which to compare, these studies often provide the best source of information with which to draw conclusions.

- **LIMITED QUANTITATIVE DATA.** Due to an overall lack of public health and public housing tracking data, lack of funding, and difficulty in obtaining available data, we report very little quantitative data related to the public housing stock and public housing residents. Instead, we relied primarily on peer-review and grey literature and qualitative findings from our focus groups and surveys to generate findings and assess the impacts of RAD.

- **FOCUS GROUP MAKE-UP.** With only 54 participants in our focus groups, we recognize that our focus groups and the participant perspectives voiced are not representative of the entire public housing population. For example, our participants were older, had been in sites for longer than average, and were more involved in resident organizations than the general population.

MONITORING

The purpose of health impact assessment is to use research and recommendations to actually have an impact on decisions under review and on health and health determinants. Too often, research is conducted in such a way that it is unclear whether there are any resulting impacts of that research. To that end, HIA includes a step – monitoring – to track: 1) the impact of the HIA on the decision in question (including any amendments); 2) the implementation of the decision; and 3) any determinants of health that may change as a result of decision implementation.

In the case of RAD, we propose the following monitoring plan:

1. Monitoring the impact of this HIA on the decision: National People's Action will be responsible for tracking the progress of RAD to monitor if RAD has been amended according to this HIA's recommendations, and whether this HIA had any influence on the thinking of policy-makers in terms of the evaluation of RAD and the expansion of RAD beyond the pilot period into a permanent policy.

2. Monitoring decision implementation: RAD's evaluation process should include a Conversion Oversight Committee made up of resident organizations, public housing advocates, and elected officials to monitor RAD's implementation. Their monitoring will include tracking selection criteria for public housing complexes chosen for conversion, how decisions about selection are made, and allocation of funding for conversion, relocation counseling, and other programming or support services related to policy implementation. This information shall be reported out semi-annually for two years. If a Conversion Oversight Committee is not created, NPA and Advancement Project will try to work with HUD to report out these indicators semi-annually for two years.

3. Monitoring determinants of health: If RAD's evaluation process includes a Conversion Oversight Committee, the Committee will obtain information from HUD regarding the number of housing complexes and number of units "converted" from HUD ownership to another entity's ownership; the number of units that remain available for very low- and low-income residents; the number of management systems changed from public to private management; the number of any lost units; the number of evictions; and, the number of vouchers created and used. Impacts on health will be assessed via impacts on these changes. Longer-term impacts on health and tracking of impacts on residents will be monitored, ideally, via HUD evaluation of RAD implementation, or pending further funding.

CONCLUSION

Stakeholders from around the country have been meeting with HUD and elected officials to weigh in on RAD and its implementation both before and after it was signed into law in late November 2011.
Our goals for this HIA are that:

1. HUD and other officials responsible for the implementation of RAD directly incorporate specific recommendations included in this HIA in an effort to mitigate identified negative health impacts.

2. Stakeholders and decision-makers incorporate discussions of health impacts and health inequities as part of housing policy-making.

Until broader societal and economic conditions change, public housing will continue to be a source of permanent housing for those who need housing assistance most, and not as the transitional housing source it was initially conceived as being by policy-makers. In light of this, protection of the public housing stock as a resource takes on increased importance. Numerous questions remain to be answered to see whether these goals are met and whether health impacts will be allayed: Will public housing truly remain "public?" What will the conversion process look like? What role will residents and stakeholders play in the process? What support will be provided to residents through such significant policy shifts? What information and data will be tracked and made public about conversions, residency changes, and residents' experiences? Will public housing remain a permanent source of housing for those needing it most? Tracking the answers to these questions over time is essential and will help us understand the extent to which public health can look to public housing as an "intervention" to protect and promote the health of vulnerable populations.

Repeatedly, research has shown the importance of high quality, affordable, and stable housing provide to individual and community health and well-being – findings that residents and community stakeholders have known both physically and intuitively. For far too long, housing policies have at best minimized, and at worst excluded, discussions of health and how policies may exacerbate or improve health inequities, despite the fact that housing greatly affects health. This HIA was conducted in an attempt to address this major gap. Though there were a number of limitations – including lack of quantitative data on public housing conditions, little information regarding how RAD will actually be implemented, and mixed research with which to compare – we believe we are making an important and necessary contribution to ongoing debates on subsidized housing policy, and in the field of health impact assessment. We hope HUD and other officials draw upon our findings and recommendations to carefully monitor and measure the impact of RAD as well as help determine the future of public housing.

GLOSSARY OF TERMS

APPROPRIATIONS – process through which Congress and the President decide how much funding each item in the federal budget will be given.

ASSISTED UNITS (OR SUBSIDIZED UNITS) – housing units for which the federal government assists the tenant by paying the majority of the rent (typically 70%). These units are also called "subsidized" because the cost of renting them is subsidized by the federal government.

CONVERSION – when public housing units become project-based contracts or project-based vouchers under the Rental Assistance Demonstration project. Ownership may be by a public entity, a non-profit entity, or a for-profit entity.

DECONCENTRATION OF POVERTY – moving residents of public housing out of areas where there is a high proportion of individuals who live below the poverty line theoretically to areas where fewer individuals live below the poverty line.

DISPOSITION – when a Public Housing Authority transfers any interest in a public housing development, as permitted by various laws. In the 2000s, some public housing units were converted to ownership by non-profit agencies or otherwise "disposed of" through disposition plans. These specific dispositions could be seen as precursors to legislation such as the Rental Housing Revitalization Act and the Rental Assistance Demonstration project.

HARD TO HOUSE – tenants who are lower-income AND are elderly, have large families, have disabilities, have been arrested or incarcerated, have poor credit histories, or are unable to meet work or school requirements are considered "hard to house" because they have difficulty being accepted into the private housing market.

HARD UNITS – actual physical units of housing. In relation to public housing, the ideal is that no 'hard units' or physical units of housing are lost through redevelopment processes.

HEALTH DETERMINANTS – social, institutional, or environmental factors that determine health outcomes. For example, housing affordability is a health determinant in that the amount one pays for housing impacts stress and the amount of money available for health care and nutritious food.

HEALTH IMPACT ASSESSMENT – a public engagement and decision-support tool that can be used to assess the health impacts of planning and policy proposals, and make recommendations to improve health outcomes associated with those proposals.

HOUSING RELOCATION PROGRAMS – programs such as the Gautreaux project, Moving to Opportunity, and Housing for People Everywhere (HOPE VI) that result in moving residents of public housing to other neighborhoods.

HUD – the United States Department of Housing and Urban Development, which is the federal agency established in 1965 that subsidizes and oversees public housing and other low-income housing subsidy programs.

OCCUPANCY STANDARDS – entrance requirements or restrictions on admission or readmission to a public housing unit. Common occupancy requirements include not having been convicted of a crime, working or going to school for a certain number of hours, having an acceptable credit history, having no relatives who will be on the lease with criminal histories, and other standards that may be set by a specific housing authority or management company.

OWNERSHIP OF PUBLIC HOUSING – most public housing in the United States is owned by a local or state government entity that receives subsidies from the federal government. In a small number of cities, public housing has been "disposed" of in a disposition plan, and in these situations a non-profit organization typically owns the public housing.

PUBLIC HOUSING – housing that is subsidized by the federal government such that tenants pay 30% of their income – no matter what their income.

PHAS – Public Housing Authorities – the agency responsible for the maintenance and operations of public housing complexes in a specific locality.

PUBLICLY MANAGED – public housing that is managed by a government-funded entity such as a Public Housing Authority.

PRIVATELY MANAGED – public housing that is managed by a private company that is paid by the owner (be it a PHA, a non-profit entity, or a private entity).

RESIDENT COUNCILS/TENANT ASSOCIATIONS/ RESIDENT MANAGEMENT ASSOCIATIONS/RESIDENT ADVISORY BOARDS – terms which apply to a variety of types of tenant organizing bodies in public housing.

TAX CREDITS – these are awarded to private developers who then sell credits to investors to raise capital (or equity) for their projects, reducing the debt that the developer would otherwise have to borrow.

TIME AND USE RESTRICTIONS – once the ownership of a property is converted under the Rental Assistance Demonstration project, there may be a designated amount of *time* the units must by law remain available for *use* to those who qualify for public housing – some of the lengths of time that have been discussed include 20 years or 30 years; there are some locations across the country that have 99-year contracts wherein the property must remain available to those who qualify for public housing.

VOUCHERS – Housing Choice Vouchers, formerly called Section 8, is a federal program that enables individuals or families to be subsidized for renting in the private market. Qualified households can use vouchers to cover the difference between "Fair Market Rent" (FMR) and the rent that a voucher-holding household can afford, determined as 30 percent of household income. The two main types of vouchers are tenant-based and project-based vouchers. Tenant-based vouchers are vouchers that are given directly to individuals or families, who find and lease a unit and pay a reasonable rent based upon a percentage of their income. The local housing authority pays the owner the remaining rent, which is capped by the FMR. Project-based vouchers can only be used at particular private housing units. Landlords enter into contracts (typically 10 years) to make their housing units "project-based."

ENDNOTES

1 Evaluation information could include: who is on the Conversion Oversight Committee; conversion information (e.g., how long the conversion took, who the owners are, the owners' tax records, and length of contracts); pre/post information on number of hard units in RAD-funded sites and their condition, number of renovated units, and number of units demolished or disposed of; evidence of resident review of residency standards as well as pre/post list of standards in each public housing complex converted by RAD; funds supplied for resident organizations and how they were spent; evidence of notification of rules, evidence of a grievance policy, and notification to residents of both; rules and rule implementation processes and results; evictions data – how many, where, reason for eviction, and grievance processes followed; voucher data – how many, how many were added, # of tenant-based vs. project-based vouchers, and how they were used; actions proposed and/or requests of management by resident associations and what was done; site maintenance workplan evaluations to address repair needs and actions taken to fulfill them; counseling and relocation programming; tracking of all residents – even if they move out of public housing altogether – as to physical, mental, and financial health outcomes, which should include measuring social connections and integration/segregation issues; use of public spaces within public housing – who uses them, for what, and how many people participate in the uses; and, partnerships with local police departments and residents.

2 Fletcher, M. A. (2011, September 13). Nearly one in six in poverty in the U.S. *The Washington Post.* Retrieved November 9, 2011, from www.washingtonpost.com/.../us-poverty.../gIQApnMePK_story.html

3 Tavernise, S. (2011, September 13) Soaring Poverty Casts Spotlight on "Lost Decade." *New York Times.* Retrieved December 2, 2011, from http://www.nytimes.com/2011/09/14/us/14census.html?pagewanted=all.

4 NeighborWorks America. (n.d.) Foreclosure Statistics. Retrieved December 2, 2011, from www.fdic.gov/about/comein/files/foreclosure_statistics.pdf.

5 Joint Center for Housing Studies of Harvard University. (2011). *America's Rental Housing: Meeting Challenges, Building on Opportunities.* Retrieved on December 2, 2011, from http://www.jchs.harvard.edu/research/publications/americas-rental-housing-meeting-challenges-building-opportunities.

6 Steffen, B. L., Fudge, K., Martin, M., et al. (2011). *Worst case housing needs 2009: A report to Congress.* U.S. Department of Housing and Urban Development, Office of Policy Development and Research. Retrieved November 9, 2011, from http://www.huduser.org/Publications/pdf/worstcase_HsgNeeds09.pdf.

7 Fischer, W. (2011, September 16). *House bill's deep cuts in public housing would raise future federal costs and harm vulnerable low-income families.* Center on Budget and Policy Priorities. Retrieved November 9, 2011 from http://www.cbpp.org/cms/?fa=view&id=3583.

44 Digenis-Bury, E. C., Brooks, D. R., Chen, L., Ostrem, M., & Horsburgh, C. R. (2008). Use of a population-based survey to describe the health of Boston public housing residents. *American Journal of Public Health*, *98*(1), 85-91.

45 Fertig, A. R., & Reingold, D. A. (2007). Public housing, health, and health behaviors: Is there a connection? *Journal of Policy Analysis and Management 26*(4), 831-859.

46 Ruel, E., Oakley, D., Wilson, G. E., & Maddox, R. (2010). Is public housing the cause of poor health or a safety net for the unhealthy poor? *Journal of Urban Health, 87*(5), 827-838.

47 National Center for Health Statistics. (2010). Summary Health Statistics for US Adults: National Health Interview Survey, 2010. *Vital and Health Statistics.* Series 10, Number 252.

48 Goetz, E. G., & Chapple. K. (2010). You gotta move: Advancing the debate on the record of dispersal. H*ousing Policy Debate,* 20(2), 209-236.

49 Keels, M., Duncan, G .J., Deluca, S., Mendenhall, R., & Rosenbaum, J. (2005). Fifteen years later: Can residential mobility programs provide a long-term escape from neighborhood segregation, crime, and poverty? Demography, *42(1), 52-73.*

50 Goetz & Chapple, ibid.

51 Rosenbaum, J.E. (1995). Changing the geography of opportunity by expanding residential choice: Lessons from the Gautreaux program. H*ousing Policy Debate,* 6(1), 231-269.

52 Rubinowitz, L. S., & Rosenbaum, J. E. (2000). Crossing the class and color lines: From *public housing to white suburbia. Chicago: University of Chicago Press.*

53 Keene & Geronimus, (2011a), ibid.

54 Goetz & Chapple, ibid.

55 Goetz & Chapple, ibid.

56 Goetz & Chapple, ibid.

57 Popkin, S. J. (2006). The HOPE VI program: What has happened to the residents? In L. Bennett, J. L. Smith, & P. A. Wright. (Eds.). Where are poor people to live*? Transforming public housing communities, Armonk, NY: M. E. Sharpe.*

58 Goetz & Chapple, ibid.

59 Clampet-Lundquist, S. (2004). Moving over or moving up? Short-term gains and losses for relocated HOPE VI families. Cityscape: A *Journal of Policy Development and Research, 7(1), 57-80.*

60 Kleit, R. G., & Manzo, L.C. (2006). To move or not to move: Relationships to place and relocation choices in HOPE VI. Housing Policy *Debate, 17*(2), *271-308.*

61 Kingsley, G.T., & Pettit, K. L. S. (2003a). Concentrated poverty: A change in course. (No. 2). Washington, DC: The Urban Institute.

62 Keene, D. E, & Geronimus, A. T. (2011a). "Weathering" HOPE VI: The importance of evaluating the population health impact of public housing demolition and displacement. *Journal of Urban Health,* 88(3), 417-435.

63 Geronimus, A. T., & Thompson, J. P. (2004). To denigrate, ignore or disrupt: Racial inequality in health and the impact of a policy-induced breakdown of African American communities. D*ebois Review: Social Science Research on Race,* 1(2), 247-279.

64 Brooks, F., Zugazaga, C., Wolk, J., & Adams, M. A. (2005). Resident perceptions of housing, neighborhood, and economic conditions after relocation from public housing undergoing HOPE VI redevelopment. *Research on Social Work Practice,* 15(6), 481-490.

65 Brooks, et al., ibid.

66 Geronimus & Thompson, ibid.

67 Kling, J. R., Liebman, B. J., Katz, L., & Sanbonmatsu, L. (2007). Experimental analysis of neighborhood effects. Econometrica, *75(1), 83-119.*

68 Sanbonmatsu, L., Kling, J. R., Duncan, G. J., Brooks-Gunn, J. (2006). Neighborhoods and academic achievement: results from the Moving to Opportunity experiment. The Journal of *Human Resources, 41(4), 649-691.*

69 Manjarrez, C. A., Popkin, S. J., & Guernsey, E. (2008). Poor health: Adding insult to injury for *HOPE VI families 2007. Washington, DC: The Urban Institute.*

70 Keene & Geronimus, (2011a), ibid.

71 H.R. 6468, 111th Congress: Rental Housing Revitalization Act of 2010. (2010). Retrieved July 7, 2011, from http://thomas.loc.gov/cgi-bin/query/z?c111:H.R.6468.

72 Office of U.S. Congresswoman Maxine Waters. (2010, May 25). Congresswoman Waters expresses concerns about changes in public housing programs. [Press release]. Retrieved June 15, 2011, from http://waters.house.gov/News/DocumentSingle.aspx?DocumentID=187239.

73 National Low Income Housing Coalition. (2011, August 3). Rental Assistance Demonstration–TDS. [Proposal for legislative language]. Retrieved November 9, 2011, from https://www2398.ssldomain.com/nlihc/doc/RAD_Proposal_8-3-11.pdf.

74 Conference Report Accompanying H.R. 2112, 112th Congress: Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Programs for the Fiscal Year Ending September 30, 2012 and For Other Purposes. (2011). Retrieved November 28, 2011, from http://thomas.loc.gov/cgi-bin/cpquery/T?&report=hr284&dbname=112&.

75 National Housing Conference. (2011, September 15). Convening on HUD's Rental Assistance Demonstration proposal. [Webinar and conference call].

76 Fletcher, M. A. (2011, September 13). Nearly one in six in poverty in the U.S. *The Washington Post.* Retrieved November 9, 2011, from www.washingtonpost.com/.../us-poverty.../gIQApnMePK_story.html.

80 Kleit & Page, ibid.

81 Kleit & Page, ibid.

82 Kleit & Page, ibid.

83 Abt Associates. (1997, July). *Private management of public housing: A guidebook.* (Handbook 7460.8 REV-1). Washington DC: U.S. Department of Housing and Urban Development.

84 U.S. General Accounting Office. (1999). *Public housing: HUD has several opportunities to promote private management.* [Report to the subcommittee on VA, HUD, and Independent Agencies, Committee on Appropriations, US Senate]. (Publication No. GAO/RCED-99-210). Retrieved November 9, 2011, from http://www.gao.gov/archive/1999/rc99210.pdf.

85 Harvard University Graduate School of Design. (2003, June 6). *Public housing operating cost study*. Report prepared for the U.S. Department of Housing and Urban Development. Retrieved November 9, 2011, from http://internal.gsd.harvard.edu/research/research_centers/phocs/study_results.html.

86 Byrne, G. A., Day, K., & Stockard, J. (2003). *Taking stock of public housing*. [Excerpt from presentation to the Public Housing Authority Directors Association (PHADA)]. Retrieved November 9, 2011, from http://www.phada.org/tsph.pdf.

87 Popkin, S. J., Cunningham, M. D., & Burt, M. (2005). Public housing transformation and the hard-to-house. *Housing Policy Debate, 16*(1), 1-24.

88 University of California–Berkeley Health Impact Group. (2009). *HOPE VI to HOPE SF: San Francisco public housing redevelopment: A health impact assessment.* Retrieved November 9, 2011 from http://sites.google.com/site/ucbhia/projects-and-research.

89 University of California–Berkeley Health Impact Group, ibid.

90 Becker, F. W., Dluhy, M. J., & Topinka, J. P. (2001). Choosing the rowers: Are private managers of public housing more successful than public managers? *The American Review of Public Administration, 31,* 181–199.

91 Sinha, A., Villano, V., Waheed, S., et al. (2010). *We call these projects home: Solving the housing crisis from the ground up.* Right to the City Alliance. Retrieved November 9, 2011, from http://www.advancementproject.org/sites/default/files/publications/righttocitycolor.pdf.

92 University of California–Berkeley Health Impact Group, ibid.

93 Zmora, M. (2009). Between Ricker and a hard place: The due process void for Section 8 voucher holders in no-fault evictions. Northwestern U*niversity Law Review, 102(4), 1961-92.*

94 Zmora, ibid.

95 Zmora, ibid.

96 Zmora, ibid.

97 Zmora, ibid.

98 Hellegers, A. P. (1999). Reforming HUD's "one-strike" public housing evictions through tenant participation. T*he Journal of Criminal Law and Criminology,* 90(1), 323-362.

99 Zmora, ibid.

100 Zmora, ibid.

101 Zmora, ibid.

102 Hellegers, ibid.

103 U.S. Department of Housing and Urban Development. (2011). Resident characteristics reports of housing and urban development: April 2010-July 31 2011. *Retrieved November 9, 2011, from https://pic.hud.gov/pic/RCRPublic/rcrmain.asp.*

104 Cohen, M. A. (2009). Vindicating the matriarch: A fair housing act challenge to federal no-fault evictions from public housing. Michigan J*ournal of Gender & Law, 16, 251-269.*

105 Hellegers, ibid.

106 Cohen, ibid.

107 Zmora, ibid.

108 Zmora, ibid.

109 Zmora, ibid.

110 Villano, V., & Youdelman, S. (2010). Democracy (in)action: How HUD, NYCHA and official structures *undermine resident participation in New York City Public Housing. Community Voices Heard. Retrieved November 9, 2011, from http://www.cvhaction.org/sites/*default/files/Democracy%20(In)Action%20Full%20Report_0.pdf

111 Villano and Youdelman, ibid.

112 Baranski, J. (2007). Something to help themselves: Tenant organizing in San Francisco's public housing, 1965-1975. *Journal of Urban History,* 33 (3), 418-422.

113 Koebel, C.T., & Cavell, M.S. (1995). Tenant Organizations in Public Housing Projects: A Report on Senate Resolution No. 347. Blacksburg, VA: Virginia Center for Housing Research.

114 Villano & Youdelman, ibid.

115 U.S. Department of Housing and Urban Development, Office of Assistant Secretary for Public and Indian Housing. 24 CFR Ch. IX § 964.1 (1994).

116 Ibid., § 964.100.

117 Ibid., § 964.18.

118 Ibid., § 964.18, 964.105.

119 Hunt, L., Schullof, M., Holmquist, S., & Solomon, R. (1998, December). *Summary of the Quality Housing and Work Responsibility Act of 1998 (Title V of P.L. 105-276)* (p.7). U.S. Department of Housing and Urban Development, Office of Policy, Program and Legislative Initiatives, Office of Public and Indian Housing. Retrieved November 9, 2011, from http://portal.hud.gov/hudportal/documents/huddoc?id=titlev.pdf.

120 National Housing Law Project. (2004). *HUD housing programs: Tenants rights* (3rd. ed., p. 12/11, 12/12). San Francisco: The National Housing Law Project.

121 Villano & Youdelman, (2010), 20.

122 Ibid.

123 Conway, B. P., & Hachen, D. S. (2005). Attachments, grievances, resources, and efficacy: The determinants of tenant association participation among public housing tenants. *Journal of Urban Affairs,* 27(1), 25-52.

124 Villano & Youdelman, (2010), 20.

125 Sinha, et al., ibid.

126 Sinha, et al., ibid.

127 Civic Practices Network. (1997). *Community building in public housing: Ties that bind people and their communities.* Retrieved November 9, 2011, from http://www.cpn.org/tools/manuals/community/publichousing3.html

128 Civic Practice Network, ibid.

129 Pollack, C., Egerter, S., Sadegh-Nobari, T., Dekker, M., Braveman, P.. (2008, September). *Where we live matters for our health: The links between housing and health.* Robert Wood Johnson Foundation (Issue Brief No. 2). Retrieved June 2011, from http://www.rwjf.org/files/research/commissionhousing102008.pdf.

130 Jelleyman T., & Spencer N. (2008). Residential mobility in childhood and health outcomes: A systematic review. *Journal of Epidemiology and Community Health, 62*(7), 584-92.

131 Pollack, et al., ibid.

132 Krieger, J., & Higgins, D. L. (2002). Housing and health: time again for public health action. *American Journal of Public Health, 92*(5), 758-68.

133 Krieger, J. W., Takaro, T. K., & Rabkin J. C. (2011). Healthcare disparities at the crossroads with healthcare reform. In R. A. Williams (Ed.), *Breathing easier in Seattle: Addressing asthma disparities through healthier housing* (Ch. 19). New York: Springer.

134 Jacobs, D. E., Wilson, J., Dixon, S. L., Smith, J., & Evens, E. (2009). The relationship of housing and population health: A 30-year retrospective analysis. *Environmental Health Perspective, 117*(4), 597-604.

135 Digenis-Bury, et al., ibid.

136 Popkin, S. J., Katz, B., & Cunningham, M. K., et al. (2004, May) *A decade of Hope VI: Research findings and policy changes*. Washington, DC: The Urban Institute & The Brookings Institution.

137 Digenis-Bury, et al., ibid.

138 Sandel, M., J., Sharfstein, J., & Shaw, R. (1999). *There's no place like home: How America's housing crisis threatens our children.* San Francisco: Housing America. (ERIC Document Reproduction Service No. ED443520).

139 Ruel, et al., ibid.

140 Pollack, et al., ibid.

141 Bashir, S.A. (2001). Home is where the harm is: inadequate housing as a public health crisis. *American Journal of Public Health, 92*(5), 733-8.

142 Krieger & Higgins, ibid.

143 Jacobs, et al., ibid.

144 Krieger, et al., ibid.

145 Simning, A., van Wijngaarden, E., & Conwell, Y. (2011). Anxiety mood and substance use disorders in United States African American public housing residents. *Social Psychiatry and Psychiatric Epidemiology, 46*(10), 983-992.

146 Ruel, et al., ibid.

147 Buron, L., Popkin, S., Levy, D., Harris, L., & Khadurri, J. (2002). *The HOPE VI resident tracking study: A snapshot of the current living situation of original residents from eight sites*. Report prepared for the U.S. Department of Housing and Urban Development. Washington, D.C.: Abt Associates & The Urban Institute.

148 There are two HOPE VI large-scale evaluations thatthis report frequently relies upon for results: the 2002 HOPE VI Panel Study: Baseline Report and the 2002 HOPE VI Resident Tracking Study. Both were commissioned by HUD andprepared by the Urban Institute and Abt Associates. The evaluations were supported through federal HUD funds but also through a variety of nationally known foundations. The Panel Study (September 2002) looked at five HOPE VI redevelopment sites and focused on the longer-term location, neighborhood conditions, physical and mental health, and socioeconomic conditions of original residents of these sites. The questions fell under housing outcomes, neighborhood outcomes, social integration, health outcomes, child education and behavior, socioeconomic outcomes, and experience with relocation and supportive services. The Tracking Study (November 2002) looked at what happened to original residents of distressed public housing sites redeveloped under HOPE VI at eight properties two to seven years after the PHA was awarded a HOPE VI grant. The study looks at housing conditions, neighborhood conditions and perceptions of those conditions, employment, hardship, and health.

149 Keene & Geronimus, (2011a), ibid.

150 Northridge, J., Ramirez, O. F., Stingone, J. A., & Claudio, L. (2010). The role of housing type and housing quality in urban children with asthma. *Journal of Urban Health, 87*(2), 211-224.

151 Levin, R. B., Epstein, P. R., Ford, T. E., et al. (2002). U.S. drinking water challenges in the twenty-first century. *Environmental Health Perspectives, 110*(1), 43-52.

152 Ranny, D. C., & Wright, P. A. (2000). Race, class and the abuse of state power: The case of public housing in Chicago. *SAGE Race Relations Abstracts, 25*(3), 3-32. Abstract obtained from *EBSCO*, from http://www.ebscohost.com/academic/race-relations-abstracts.

153 Popkin, S. J., Harris, L., & Cunningham, M. (2002a). *Families in transition: A qualitative analysis of the MTO experience, final report*. Report prepared for the U.S. Department of Housing and Urban Development. Washington, DC: Abt Associates & The Urban Institute.

154 National Commission on Severely Distressed Public Housing. (1992, August). The final report of the National Commission on Severely Distressed Public Housing: A report to the Congress and the Secretary of Housing and Urban Development Retrieved November 9, 2011, from http://portal.hud.gov/hudportal/documents/huddoc?id=DOC_9836.pdf.

155 Sinha, et al., ibid.

156 Finkel, M., Lam, K., Blaine, C., et al. (2010, November 24). *Capital needs in the public housing program.* Report prepared for the U.S. Department of Housing and Urban Development. Washington, DC: Abt Associates.

157 Finkel, et al., ibid.

158 Seattle Housing Authority (2011). Breathe Easy Homes. Retrieved December 2, 2011 from http://www.seattlehousing.org/redevelopment/high-point/breathe-easy/.

159 University of California–Berkeley Health Impact Group, ibid.

160 Keene & Geronimus, (2011a), ibid.

161 For more information, visit: 1) Leadership in Energy and Environmental Design, United States Green Building Council at http://www.usgbc.org/DisplayPage.aspx?CMSPageID=222 and 2) Green Criteria, Enterprise Green Communities at http://www.greencommunitiesonline.org/tools/criteria/index.asp.

162 Zima, B. T., Wells, K. B., & Freeman, H. E. (1994). Emotional and behavioral problems and severe academic delays among sheltered homeless children in Los Angeles County. *American Journal of Public Health, 84*, 260-264.

163 Antunes, J. L. , & Waldman, E. A. (2001). The impact of AIDS, immigration and housing overcrowding on tuberculosis death in Sao Paulo, Brazil, 1994-1998. *Social Science and Medicine, 52*, 1071-1080.

164 Bhatia, R., & Guzman, C. (2004). *The case for housing impacts assessment: The human health and social impacts of inadequate housing and their consideration in CEQA policy and practice.* San Francisco Department of Public Health. Program on Health, Equity, and Sustainability. San Francisco: Department of Public Health.

165 Pollack, C. E., Griffin, B. A., & Lynch, J. (2010). Housing affordability and health among homeowners and renters. *American Journal of Preventive Medicine, 39*(6), 515-521.

166 Katz, L. F., Kling, J. R., & Liebman, J. B. (2001). Moving to Opportunity in Boston: Early results of a randomized mobility experiment. *The Quarterly Journal of Economics, 116*(2), 607–654.

167 Sandel, et al., ibid.

168 Sharfstein, J., Sandel, M., Kahn, R., & Bauchner, H. (2001). Is child health at risk while families wait for housing vouchers? *American Journal of Public Health, 91,* 1191–1192.

169 Meyers, A., Rubin, D., Napoleone, M., & Nichols, K. (1993). Public housing subsidies may improve poor children's nutrition. *American Journal of Public Health, 83*(1), 115-119.

170 Krieger & Higgins, ibid.

171 Newman, S. J., & Harkness, J. M. (2002). The long-term effects of public housing on self-sufficiency. *Journal of Policy Analysis and Management, 21*(1), 21-43.

172 Curie, J., & Yelowitz, A. (2000). Are public housing projects good for kids? *Journal of Public Economics*, *75*(1), 99-124.

173 Digenis-Bury, et al., ibid.

174 Digenis-Bury, et al., ibid.

175 Keene & Geronimus, (2011a), ibid.

176 Popkin, S. J., & Cunningham, M. K. (2000, February). *Searching for rental housing with Section 8 in Chicago.* Washington, DC: The Urban Institute.

177 Buron, L., Levy, D., & Gallagher, M. (2007). *Housing choice vouchers: How HOPE VI families fared in the private market.* Washington, DC: The Urban Institute.

178 Oakley, D., & Burchfield, K.. (2009). Out of the projects, still in the hood: The spatial constraints on public-housing residents' relocation in Chicago. *Journal of Urban Affairs*, *31*(5), 1-26.

179 Steffen, et al., ibid.

180 Steffen, et al., ibid.

181 National Law Center on Homelessness and Poverty. (2011). *Simply unacceptable: Homelessness and the human right to housing in the United States.* Retrieved November 9, 2011, from http://www.nlchp.org/content/pubs/SimplyUnacceptableReport1.pdf.

182 Sermons, M. W., & Witte, P. (2011, January). *State of homelessness in America: A research report on homelessness.* (p. 2). National Alliance to End Homelessness. Retrieved November 9, 2011 from http://www.endhomelessness.org/files/3668_file_SOH_report_FINAL_LOW_RES_NOT_embargoed.pdf.

183 National Law Center on Homelessness and Poverty, ibid.

184 Steffen, et al., ibid.

185 Pollack, C, et al., ibid.

186 Gilman, S. E., Kawachi, I., Fitzmaurice, G. M., & Bika, S. L. (2003). Socio-ecomonic status, family disruption and residential stability in childhood: relation to onset, recurrence and remission of major depression. *Psychological Medicine, 33*, 1341-55.

187 Guzman, C., Bhatia, R., & Durazo, C. (2005). Anticipated effects of residential displacement on health: Results from qualitative research. San Francisco: Department of Public Health. Retrieved November 9, 2011, from http://www.sfphes.org/publications/reports/Trinity_Focus_Groups.pdf.

188 Leventhal, T., & Newman, S. (2010). Housing and child development. *Children and Youth Services Review, 32*(9), 1165-1174.

189 Keene & Geronimus, (2011a), ibid.

190 Bhatia & Guzman, ibid.

191 Schulz, A., Zenk, S., Israel, B., et al. (2008). Do neighborhood economic characteristics, racial composition, and residential stability predict perceptions of stress associates with the physical and social environment? Findings from a multilevel analysis in Detroit. *Journal of Urban Health, 85*(5), 643-660.

192 Wells, N. M. (2000). Housing and well-being: A longitudinal investigation of low-income families transitioning to new dwellings. (Doctoral dissertation, University of Michigan, 2000). Retrieved May 26, 2011, from U.S. ProQuest Information & Learning Web Site: http://www.proquest.com/en-US/.

193 Keene & Geronimus, (2011a), ibid.

194 Sinha, et al., ibid.

195 Keene & Geronimus, (2011a), ibid.

196 Buron, et al., (2007), ibid.

197 Wilson, W. J. (1987). *The truly disadvantaged: The inner-city, the underclass, and public policy*. Chicago: University of Chicago Press.

198 Logan, J. R., & Molotch, H. L. (1987). *Urban fortunes: The political economy of place*. Berkeley and Los Angeles: University of California Press.

199 Carpiano, R. M. (2006). Toward a neighborhood resource-based theory of social capital for health: Can Bourdieu and sociology help? *Social Science & Medicine*, *62*, 165-175.

200 Bourdieu, P., & Richardson, J. (1986). The forms of capital. In J. G. Richardson (Ed.), *Handbook for theory and research for the sociology of education*. New York: Greenwood Press.

201 Carpiano, (2006), ibid.

202 Carpiano, (2006), ibid.

203 Carpiano R. M. (2008). Actual or potential neighborhood resources and access to them: Testing hypotheses of social capital for the health of female caregivers. *Social Science & Medicine, 67*(4), 568-582.

204 Sampson, R. J., Morenoff, J. D., & Gannon-Rowley, T. (2002). Assessing "neighborhood effects": Social processes and new directions in research. *Annual Review of Sociology, 28*, 443-478.

205 Berkman, L., & Kawachi, I. (2000). *Social epidemiology*. New York: Oxford University Press.

206 Carpiano, (2006), ibid.

207 Lochner, K. A., Kawachi, I., Brennan, R. T., & Buka, S. L. (2003). Social capital and neighborhood mortality rates in Chicago. *Social Science & Medicine, 56*(8), 1797-1805.

208 Cohen, S., Underwood, L. G., Gottlieb, B. H. (2000). *Social support measurement and intervention*. New York: Oxford University Press.

209 Berkman, L. F., & Kawachi, I. (2000). A historical framework for social epidemiology. In L. F. Berkman & I. Kawachi (Eds.). *Social epidemiology* (Ch. 1). New York: Oxford University Press.

210 Sampson, R. J., & Graif, C. (2009). Neighborhood social capital as differential social organization. *American Behavioral Scientist, 52*(11), 1579-1605.

211 Carpiano, (2006), ibid.

212 de Souza Briggs, X. (1998). Brown kids in white suburbs: Housing mobility and the many faces of social capital. *Housing Policy Debate, 9*(1), 177.

213 Stack, C. (1974). *All our kin: Strategies for survival in a black community*. New York: Harper & Row.

214 de Souza Briggs, X. (1998), ibid.

215 Small, M. L., Jacobs, E. M., & Massengill, R. P. (2008). Why organizational ties matter for neighborhood effects: Resource access through childcare centers. *Social Forces, 87*(1), 387-414.

216 Small et al, ibid.

ENDNOTES

217 Curley, A. M. (2005). Theories of urban poverty and implications for public housing. *Policy Journal of Sociology and Social Welfare, 32*, 97.

218 Sampson, R. J. (2001). Crime and public safety: Insights from community-level perspectives on social capital. In R. J. Sampson, S. Saegert, J. P. Thompson, & M. R. Warren (Eds.). *Social capital in poor communities*. New York: Russell Sage Foundation.

219 Saegert, S., & Winkel, G. (1998). Social capital and the revitalization of New York City's distressed inner-city housing. *Housing Policy Debate, 9*, 17-60.

220 Sampson, R. J., Morenoff, J. D., & Earls, F. (1999). Beyond social capital: Spatial dynamics of collective efficacy for children. *American Sociological Review, 64*, 633-660.

221 Berkman & Kawachi, ibid.

222 Tester, G., Ruel, E., Anderson, A., Reitzes, D. C., & Oakley, D. (2011). Sense of place among Atlanta public housing residents. *Journal of Urban Health, 88*(3), 436-453.

223 Tach, L. M. (2009). More than bricks and mortar: Neighborhood frames, social processes, and the mixed income redevelopment of a public housing project. *City & Community, 8*(3), 269-299.

224 Small et al, ibid.

225 Tach, ibid.

226 Kleit & Manzo, ibid.

227 Curley, A. M. (2009). Draining or gaining? The social networks of public housing movers in Boston. *Journal of Social and Personal Relationships, 26* (203), 227-247.

228 Kleit & Manzo, ibid.

229 Curley, (2009), ibid.

230 Clampet-Lundquist, S. (2004). Moving over or moving up? Short-term gains and losses for relocated HOPE VI families. *Cityscape: A Journal of Policy Development and Research, 7*(1), 57-80.

231 Fullilove, ibid.

232 Keene, D. E., & Geronimus, A. T. (2011b). Community-based support among African American public housing residents. *Journal of Urban Health, 88*(1), 41-53.

233 Popkin, et al. (2004), ibid.

234 Macintyre, S., & Ellaway, A. (2003). Neighborhoods and health: An overview. In: I. Kawashi & L. F. Berkman (Eds.). *Neighborhoods and Health*. New York: Oxford University Press; 20-42.

235 Greenbaum, S., Hathaway, W., Rodriguez, C., Spalding, A., & Ward, B. (2008). Deconcentration and social capital: Contradictions of a poverty alleviation policy. *Journal of Poverty, 12*(2), 201-228.

236 Moberg, D. (1995). No vacancy: Denial, fear and the rumor mill waged a war against Moving To Opportunity in Baltimore's suburbs. *NHI Shelterforce Online*, 79. Retrieved November 9, 2011, from http://www.nhi.org/online/issues/79/novacancy.html.

237 Greenbaum, et al., ibid.

238 Rosenbaum, J. E., DeLuca, S., & Tuck, T. (2005). New capabilities in new places: Low-income black families in suburbia. In: X. DeSouza Briggs (Ed.), *The Geography of opportunity: Race and housing choice in Metropolitan America.* Washington, DC: Brookings Institute Press.

239 Keene, D. E., Padilla, M. B., & Geronimus, A. T. (2010). Leaving Chicago for Iowa's "fields of opportunity": Community dispossession, rootlessness, and the quest for somewhere to "be ok." *Human Organization, 69*(3), 275-284.

240 Clark, S. L., McLoyd, V. C., Hill, N. E., Dodge, K. A, & Burton, L. M. (2005). Homeplace and housing in the lives of urban African Americans. In: V. C. MacLoyd, N. E. Hill, & K. A. Dodge (Eds.). *African American family life: Ecological and cultural diversity* (pp. 166-206). New York: Guilford Press.

241 Williams, D. R., & Collins, C. (2001). Racial residential segregation: A fundamental cause of racial disparities in Health. *Public Health Reports, 116*, 404-416.

242 Acevedo-Garcia, D., Lochner, K. A., Osypuk, T. L., & Subramanian, S. V. (2003). Future directions in residential segregation and health research: A multilevel approach. *American Journal of Public Health, 93* (2), 215-221.

243 LaVeist, T. A. (1993). Segregation, poverty, and empowerment: Health consequences for African Americans. *Milbank Quarterly, 71*, 41-64.

244 Polednak, A. P. (1991). Black-white differences in infant mortality in 38 standard metropolitan statistical areas. *American Journal of Public Health, 81*(11), 480-482.

245 Polednak, A. P. (1996). Trends in urban black infant mortality, by degree of residential segregation. *America Journal of Public Health, 86*(5), 723-6.

246 Fang, J., Madhaven, S., Bosworth, W., & Alderman, M. H. (1998). Residential segregation and mortality in New York City. *Social Science and Medicine, 47*, 469-476.

247 Collins, C. A., & Williams, D. R. (1999). Segregation and mortality: The deadly effects of racism? *Sociological Forum 14*(3), 495-523.

248 Hart, K. D., Kunitz, S. J., Sell, R. R., & Mukamel, D.B. (1998). Metropolitan governance, residential segregation, and mortality among African Americans. *American Journal of Public Health, 8*(88), 434-438.

249 Shihadeh, E. S., & Flynn, N. (1996). Segregation and crime: The effect of black isolation on the rates of black urban violence. *Social Forces, 74*, 1325-1352.

250 Wilson, (1987), ibid.

251 Tach, ibid.

252 Joseph, M. L., Chaskin, R. J., & Webber, H.S. (2007). The theoretical basis for addressing poverty through mixed income development. *Urban Affairs Review, 42*(3), 369-409.

253 Acevedo-Garcia, et al., (2003), ibid.

254 Wacquant, L. (2007). Territorial stigmatization in the age of advanced marginality. *Thesis Eleven, 91*, 66-77.

255 Keene, D. E., & Padilla, M. B. (2010). Race, class and the stigma of place: Moving to "opportunity" in Eastern Iowa. *Health & Place, 16*, 1216-1223.

256 Goffman, E. (1963). *Stigma: Notes on the management of a spoiled identity*. New York: Simon and Shuster.

257 Acevedo-Garcia, et al., (2003), ibid.

258 Kramer, M. R., & Hogue, C. R. (2009). Is segregation bad for your health? *Epidemiologic Reviews, 2009*, 178.

259 Williams & Collins, ibid.

260 Acevedo-Garcia, D., Osypuk, T., Werbel, R., et. al. (2004). Does housing mobility policy improve health? *Housing Policy Debate, 15*(1), 49.

261 Duke, J. (2009). Mixed income housing policy and public housing residents "right to the city." *Critical Social Policy, 29*(1), 100.

262 Varady, V. P., & Walker, C. C. (2003.) Housing vouchers and residential mobility. *Journal of Planning Literature, 18*, 17.

263 Curley, (2005), ibid.

264 Kramer & Hogue, ibid.

265 Anderson, L. M. (2003). Providing affordable family housing and reducing residential segregation by income: A systematic review. *American Journal of Preventative Medicine, 24*, 46.

266 Acevedo-Garcia, et al., (2004), ibid.

267 Williams & Collins, ibid.

268 Duke, ibid.

269 Keels, M. (2008). Second-generation effects of Chicago's Gautreaux residential mobility program on children's participation in crime. *Journal of Research on Adolescence, 18*(2), 305-352.

270 Popkin & Cunningham, (2000), ibid.

271 Kingsley, G. T., Johnson, J., & Pettit, K. S. (2003b). Patterns of Section 8 relocation in the Hope VI program. *Journal of Urban Affairs, 25*(4), 427-447.

272 Lowry, I. S. (1983). The supply experiment. In: J. Friedman & D. H. Weinberg (Eds). *The great housing experiment* (pp. 23–36). Beverly Hills, CA: Sage Publications.

273 Varady, D. P., & Walker, C. C. (2000). Vouchering out distressed subsidized developments: Does moving lead to improvements in housing and neighborhood conditions. *Housing Policy Debate, 11*(1), 115–162.

274 University of California–Berkeley Health Impact Group, ibid.

275 Kramer & Hogue, ibid.

276 Acevedo-Garcia, et al., (2004), ibid.

277 Anderson, ibid.

278 Kaplan, G. A., Pamuk, E., Lynch, J. W., Cohen, R. D., & Balfour, J. L. (1996). Income inequality and mortality in the United States: Analysis of mortality and potential pathways. *British Medical Journal 312*(7037), 999-1003.

279 Ross, N. A., Wolfson, M. C., Dunn, J. R., et al. (2000). Relation between income inequality and mortality in Canada and in the United States: Cross sectional assessment using census data and vital statistics. *British Medical Journal, 320*(7239), 898-902.

280 Yen, I. H., & Syme, S. L. (1999). The social environment and health: A discussion of the epidemiologic literature. *Annual Review of Public Health, 20*, 287-308.

281 Ruel, ibid.

282 Duke, ibid.

283 U.S. Department of Housing and Urban Development. (2011). Resident characteristics report, April 2010-July 31 2011. Retrieved November 9, 2011, from https://pic.hud.gov/pic/RCRPublic/rcrmain.asp.

284 U.S. Department of Health and Human Services. (2009). *The 2009 HHS poverty guidelines*. Retrieved November 9, 2011, from http://aspe.hhs.gov/poverty/09poverty.shtml.

285 Kingsley, et al., (2003b), ibid.

286 Kingsley, et al., (2003b), ibid.

287 Levy, D. K., & Wooley, M. (2007). Relocation is not enough: Employment barriers among HOPE VI families. The Urban Institute. Retrieved November 9, 2011, from http://www.urban.org/publications/311491.html.

288 Buron, et al., (2002), ibid.

289 Popkin, (2004), ibid.

290 Keene, ibid.

291 Wacquant, ibid.

292 Wang, X., Varady, D., & Wang, Y. (2008). Measuring the deconcentration of housing choice voucher program reciepients in eight U.S. metropolitan areas using hot spot analysis. *Cityscape: A Journal of Policy Development and Research, 10*(1), 65-90.

293 Keels, ibid.

294 Keels, ibid.

295 Geronimus, A. T. (2000). To mitigate, resist or undo: Addressing structural influences on the health of urban populations. *American Journal of Public Health, 90*(6), 867-872.

296 DeLuca, S., & Rosenbaum, J.E. (2003). If low-income blacks are given a chance to live in white neighborhoods, will they stay? Examining mobility patterns in a quasi-experimental program with administrative data. *Housing Policy Debate, 14*(3): 305-345. Retrieved November 9, 2011, from http://www.soc.jhu.edu/people/deluca/hpd_1403_deluca.pdf.

297 Rosenbaum, ibid.

298 Keene & Geronimus, (2011b), ibid.

299 Keene & Geronimus, (2011b), ibid.

300 Popkin, et al., (2004), ibid.

301 Popkin, S., Levy, K., Harris, L., Comey, J., & Cunningham, M. (2002b). HOPE VI panel study: Baseline report. Washington DC. Urban Institute.

302 Popkin, (2004), ibid.

303 Popkin, et al., (2002a), ibid.

304 Keels, ibid.

305 Kingsley, et al., (2003b), ibid.

306 Zielenbach, S., & Voith, R. (2010). HOPE VI and neighborhood economic development: The importance of local market dynamics. *Cityscape: A Journal of Policy Development and Research, 12*(1), 99-132.

307 University of California–Berkeley Health Impact Group, ibid.

308 Cahill, M., Lawry, S., & Downey, P.M. (2011). *Movin' out: Crime displacement and HUD's HOPE VI initiative*. Urban Institute Justice Policy Center. Retrieved November 9, 2011, from http://www.urban.org/UploadedPDF/412385-movin-out.pdf.

309 Greenbaum, S. (2008). Poverty and the willful destruction of social capital: displacement and dispossession in African American communities. *Rethinking Marxism, 20*(1), 42-54.

310 Sinha, et al., ibid.

311 Sinha, et al., ibid.

312 For more information, visit: http://en.wikipedia.org/wiki/Crime_prevention_through_environmental_design and International CPTED Association: http://www.cpted.net/

313 Sinha, et al., ibid.

314 Popkin, et al., (2002a), ibid.

315 Tester, G., Ruel, E., Anderson, A., Reitzes, D.C., & Oakley D. (2011). Sense of place among Atlanta public housing residents. *Journal of Urban Health, 88*(3), 436-453.

APPENDIX 1. SCOPING WORKSHEET

RAD LEGISLATION & BUDGET PILOT HIA

The Scoping Worksheet of an HIA is a tool used to consider all possible questions that could pertain to the policy at hand and how the policy would impact health outcomes or determinants of health. The Scoping Worksheet below contains the research questions about current conditions and how RAD would impact these conditions in the future. It then lists some indicators, or ways of measuring these outcomes. Other HIA scopes of research sometimes include potential data sources, methodology, and a prioritization process, but this scope does not include those items.

OVERARCHING PARAMETERS	
Aspects of the bill to focus on:	Increased rental vouchers
	Mixed-income housing model
	Conversion of public housing to privately-managed
	Time and use restrictions
	Mortgages and potential defaults
Geographic boundaries:	US overall, with a focus on 3 case study cities. Potential cities to include:
	New York (Community Voices Heard, GOLES)
	Oakland (Causa Justa:Just Cause)
	Cincinnati (Communities United for Action)
Health determinants:	Housing
	Affordability
	Conditions
	Quality
	Management
	Ownership
	Management
	Residential oversight
	Social cohesion
	Social support
	Segregation
	Concentrated poverty
	Exposure to crime and violence
	Housing location/neighborhood resources
	Access to goods & services
	Access to public transit
	Access to healthy food
	Environmental exposures
	Proximity to jobs
Vulnerable populations:	Public housing residents, people in poverty
Health outcomes:	Chronic diseases including cardiovascular disease and respiratory disease
	Communicable diseases
	Mortality
	Injury
	Mental health
	Hunger

HOUSING

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	HOUSING	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
PROXIMAL IMPACTS		
What is the supply and demand of Section 8 rental housing?	How will RAD impact Section 8 housing supply and demand?	1) # of Section 8 rental vouchers distributed, 2) # of Section 8 units on the market, 3) Geographic location/distribution of Section 8 housing stock, 4) Bedroom counts of Section 8 housing stock, 5) Average life on the rental market, 6) Average occupancy rate of Section 8 housing stock, 7) # of no-fault evictions from Section 8 housing, 8) # of people on wait list for Section 8
What is the supply and demand of permanently affordable rental housing?	How will RAD impact the supply and demand for permanently affordable rental housing?	1) # of permanently affordable housing units occupied, 2) # of permanently affordable housing units on the market, 3) Geographic location/distribution of permanently affordable housing units, 4) Bedroom counts of permanently affordable housing stock, 5) Average occupancy rate of permanently affordable housing units, 6) # of people on wait list for permanently affordable housing
What are affordability levels of Section 8 rental housing?	How will RAD impact affordability levels of Section 8 rental housing?	1) Average rent of Section 8 housing stock by bedroom count, 2) Average rent increase of Section 8 housing stock by bedroom count, 3) Average amount of Section 8 voucher, 4) Difference between average voucher amount and average Section 8 rent
What are affordability levels of permanently affordable rental housing?	How will RAD on impact affordability levels of housing?	1) Average rent of permanently affordable housing stock by bedroom count, 2) Average rent increase by bedroom count, 3) Average affordable and market-rate rents in mixed-income housing
What is the quality of the Section 8 housing stock?	How will RAD impact the quality of Section 8 housing stock?	1) Number and rate of housing code and habitability violations in Section 8 housing, 2) Types of maintenance problems in Section 8 housing, 3) Response times to maintenance complaints
What is the quality of the permanently affordable housing stock?	How will RAD impact the quality of the permanently affordable housing stock?	1) Number and rate of housing code and habitability violations, 2) Types of maintenance problems in permanently affordable housing, 3) Response times to maintenance complaints
What are the levels of homelessness? How much homelessness can be attributed to availability and/or affordability of housing?	How will RAD change levels of homelessness?	Homeless counts
What is the composition of Section 8 housing residents?	How will RAD impact the resident composition of the Section 8 housing stock?	1) Child/adult composition, 2) Race/ethnicity, 3) Household size, 4) Age, 5) Income levels/Poverty, 6) Overcrowding
What is the composition of permanently affordable housing residents?	How will RAD impact the resident composition of permanently affordable housing units?	1) Child/adult/family, 2) Race/ethnicity, 3) Household size, 4) Age, 5) Income levels/Poverty, 6) Overcrowding, 7) Compositional differences between mixed-income housing and permanently affordable housing

HOUSING (CONT.)

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	HOUSING	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
HEALTH IMPACTS		
What are existing rates of hunger and diet-related disease?	How will changes in housing affordability impact hunger and diet?	1) # of adults and children who skip meals, 2) # of people using food stamps, 3) Obesity rates, 4) Diabetes rates
What are existing rates of access to medical care?	How will changes in housing affordability impact access to medical care?	1) # of people on Medicaid, 2) # of people who delay medical care for financial reasons
What are existing measures of stress and rates of stress related disease, including mental health disease rates?	How will changes in housing affordability impact stress and stress related disease, including mental health?	1) Rates of stress, 2) Rates of mental health issues (e.g., depression)
What are current rates of respiratory disease?	How will changes in housing quality impact respiratory diseases?	1) Asthma rates, 2) Chronic obstructive pulmonary disease (COPD) rates
What are current levels of lead exposure?	How will changes in housing quality impact exposure to lead?	1) Lead exposure rates for children
What are current communicable disease rates?	How will changes in overcrowding impact communicable disease rates?	1) Communicable disease rates
What are existing measures of stress and rates of stress related disease, including mental health disease rates?	How will changes in overcrowding impact stress and stress related diseases, including mental health?	1) Rates of stress, 2) Rates of mental health issues (e.g., depression)
What are current rates of injury from hazards?	How will changes in housing quality impact rates of injury from hazards?	1) Injuries from fires, 2) Injuries from falls
What are mortality and morbidity levels for the homeless?	How will changes in homelessness impact mortality and morbidity levels?	1) Mortality from homelessness, 2) Infectious disease from homelessness, 3) Injury due to homelessness, 4) Morbidity due to exposure from homelessness

MANAGEMENT

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	MANAGEMENT	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
PROXIMAL IMPACTS		
Who currently owns public housing?	How will RAD change who owns housing available for low-income individuals?	1) % of current public housing units owned by federal or state governments
What are current time and use restrictions of public housing?	How will private ownership of housing for low-income individuals impact time and use restrictions?	1) Average length of time housing remains affordable by ownership status (public vs. private), 2) Number of permanently affordable housing units on the market over time, 3) Geographic location/distribution of permanently affordable housing units over time
How is public housing currently managed?	How will RAD impact ongoing management of formerly public affordable housing?	1) % of privately managed housing
What is the status of response to maintenance requests in public housing currently?	How will RAD impact maintenance of formerly public housing?	1) # of maintenance requests in several case study housing sites, 2) Average length of time required to respond, 3) % satisfactorily resolved
What types of rules and enforcement of rules exist in public housing currently?	How will RAD change rules and enforcement of rules?	1) # of refusals of admission to housing and reasons, 2) # of people applying to get housing, stratified by race and income level, 3) # of evictions due to rules violations
What is current eviction rate? What are common reasons for eviction and rates of eviction for those reasons?	How will eviction rate change due to RAD changes? How will eviction rate change specifically due to rules changes from changing management?	1) Eviction rates and reasons
What are standards for acceptance into public housing? What percentage of people are accepted?	How will rules around who gets into public housing change? Who (specifically) will get into "public" housing after RAD?	1)# of applicants 2) Acceptance rates
How do evictions and acceptance rates impact the stability of current public housing residents? How does stability impact child development?	How will stability of public housing residents change after RAD due to evictions and acceptance rates? How will this impact child development?	1) # of years in same unit, 2) # of moves (in and out of public housing) and # of places stayed, 3) # of schools children go to

MANAGEMENT (CONT.)

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	MANAGEMENT	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
Describe participation in tenant organizations	How will RAD change participation in tenant organizations?	1) # of public housing sites that have active tenant organizations, 2) # of residents on average participating in tenant organizations
What impacts do tenant organizations have on management of public housing? In what issues are they involved?	How will RAD change the impacts tenant organizations are able to have on issues they care about?	1) Successes and challenges of tenant organizations
How much control do residents feel they have over housing conditions and decisions?	How will RAD impact the sense of control residents feel they have over housing conditions and decisions?	1) Self-efficacy and collective efficacy levels
Do residents participating on tenant councils experience retaliation for raising issues? What form does that retaliation take?	How will retaliation for tenant council involvement change with RAD?	To be determined by focus group data
Do residents participating on tenant councils experience a change in trust with fellow tenants?	How will trust with fellow tenants due to participation on tenant councils change with RAD?	To be determined by focus group data
HEALTH IMPACTS		
Please see Housing tab (mortality, hunger, access to medical care, stress, and mental health issues)	Please see Housing tab	Please see Housing tab
What are existing rates of injury due to maintenance issues?	How will changes in management change rates of injury due to maintenance issues?	1) Injuries due to maintenance issues
What are existing rates of respiratory disease?	How will changes in management change rates of respiratory disease due to exposure to mold and allergens?	1) Rates of respiratory disease (asthma, chronic obstructive pulmonary disease, bronchial disease)
What are existing measures of stress and rates of stress related disease, including mental health disease rates?	How will changes in housing affordability impact stress and stress related disease, including mental health?	1) Rates of stress, 2) Rates of mental health issues (e.g., depression, anxiety)

SOCIAL COHESION

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	SOCIAL COHESION	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
PROXIMAL IMPACTS		
To what extent do public housing residents feel connected to their neighborhood? To their neighbors? What are the benefits of social connection?	How will RAD impact resident connection to the neighborhood and neighbors?	To be developed (e.g., trust in neighbors)
What types of social support do public housing residents receive from community members? (e.g., family, neighbors, etc.) What are the benefits of social support?	How will RAD impact residents' social support networks?	To be developed
What are existing levels of safety, crime, and violence?	How will RAD affect levels of safety, crime, and violence in the community?	Violent and non-violent crime counts and rates
What are levels of concentrated poverty?	How will RAD impact the concentration of poverty?	Concentrated poverty: Census tracts with greater than 50% living in poverty
What are levels of racial/ethnic segregation?	How will RAD impact levels of racial/ethnic segregation?	Segregation: Census tracts with one racial/ethnic group comprising greater than 50% of the total population, Diversity index
How do social networks impact safety, crime, and violence?	How will changes in social networks from RAD impact safety, crime, and violence?	1) Type and number of social contacts, 2) Crime and violence averted
How do social networks and segregation impact ability to find jobs?	How will changes in social networks impact employment?	Unemployment rates
How do social networks and segregation impact access to resources?	How will changes in social networks and segregation from RAD impact access to resources?	Access to resources

SOCIAL COHESION (CONT.)

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	SOCIAL COHESION	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
HEALTH IMPACTS		
What are existing measures of stress and rates of stress related disease, including mental health disease rates?	How will changes in social cohesion, segregation, and concentration of poverty impact stress and stress related disease, including mental health?	1) Rates of stress, 2) Rates of mental health issues (e.g., depression)
What are current rates of physical activity?	How will changes in crime and violence impact physical activity rates?	Physical activity rates
What are mortality rates?	How will mortality rates change as a result of changes in employment?	Premature mortality due to income levels
What are injury rates from crime and violence?	How will changes rates of injury from crime and violence change?	1) Homicides, 2) Assaults, 3) Rapes

NEIGHBORHOOD RESOURCES

PROJECT:	RAD HIA	
HEALTH DETERMINANT:	HOUSING LOCATION/ NEIGHBORHOOD RESOURCES	
EXISTING CONDITIONS RESEARCH QUESTIONS	IMPACT RESEARCH QUESTIONS	INDICATORS
PROXIMAL IMPACTS		
What is the distribution of public and private goods and services?	How will RAD impact the resident access to public and private goods and services?	1) Location, 2) Density and proximity to: parks, libraries, public schools, health clinics, day care centers, community centers, post offices, library, banks/credit unions, grocery stores, and local retail
What is the quality of the food retail environment?	How will RAD impact resident access to a high quality food retail environment?	1) Location, 2) Density and proximity to: fast food, corner store, supermarket, and grocery stores

What is current access to public transit?	How will RAD impact resident access to public transit?	1) Mode share, 2) Car ownership, 3) Proximity to public transit
What are current employment rates?	How will changes in housing location impact access to jobs and therefore employment rates?	Unemployment rates
What are current exposures to environmental pollutants (i.e., air, soil, water, noise)?	How will RAD impact exposures to environmental pollutants?	Exposures to air pollution, water pollution, soil pollution, and noise
HEALTH IMPACTS		
What are current rates of consumption of healthy food?	How will RAD impact consumption of healthy food?	1) Diabetes rates, 2) Obesity rates
What are current rates of respiratory disease?	How will changes in exposure to air pollution impact respiratory disease?	Asthma rates
What are mortality rates?	How will mortality rates change as a result of changes in employment?	
What are existing measures of stress and rates of stress related disease, including mental health disease rates?	How will changes in employment impact stress and stress related disease, including mental health?	1) Rates of stress, 2) Rates of mental health issues (e.g., depression)
What are current rates of physical activity?	How will changes in access to goods and services and public transit change physical activity rates?	Physical activity rates
What are current rates of disease related to soil and water pollution?	How will changes in exposure to soil and water pollutants impact health outcomes?	
What are current rates of disease related to noise?	How will changes in exposure to noise change disease rates?	1) Cardiovascular disease, 2) Loss of sleep

APPENDIX 2:
FOCUS GROUP MODERATOR'S GUIDE & QUESTIONS

Introduction

- Thank you for agreeing to participate in this focus group.

- **PURPOSE** – want to talk about participants' experience of living in public housing under changing ownership and management and the impact that has had on your life and health, as well as for your family and friends. The bigger picture is that, as you may know, public housing is increasingly being privatized, and we want to talk with you about how that might impact you and your neighbors.

- **WHY YOU?** You have been invited because you live or have lived in public housing, and we are focusing on gathering the experiences of people who have moved from large public housing complexes to smaller mixed-income or scattered site housing, live in public housing that has changed ownership or management, have moved from public housing to some kind of Section 8 (i.e., took a voucher option), and/or are currently involved in a tenant association.

- **OUR GOAL** – to create a narrative from public housing residents about how changes in ownership and management of public housing impacts their health. Your opinions and feedback will be used in a report that will feed into existing advocacy campaigns about a national strategy to change how public housing is owned and operated.

Logistics

Confidentiality

- Participation should be completely voluntary – folks can leave at any time.
- Discussion is totally confidential – we will not report/describe comments by name and will not keep any records of participants' names/addresses.
- You do not need to state full name – in fact, you can use any name you want.

Discussion

- There are no right or wrong answers so please feel free to be totally honest. We appreciate your input, and want to hear from all of you about experiences at work and how those experiences might relate to your health.
- We hope the information can help identify ways to save permanently affordable public housing.

Process

- We will ask a few broad questions, but we are really looking to hear from participants.
- My role is to guide the discussion – we will focus on some questions and let folks tell their stories.
- Sometimes, we might have to move folks onto another question so we can get through it and/or to give everyone a chance to speak. Please don't take it personally!
- Not everyone has had the same experience, which is why this is so valuable to us, but we want to remind everyone to respect others' experiences.
- We will be talking together for about two hours.
- Do we have permission to audiotape? We want an accurate description of what was said; we will also take notes, if that's ok with folks.
- If folks agree to audiotape, we will start recording after introductions.
- We will also hand out an information sheet with our contact information.

ANY QUESTIONS BEFORE STARTING?

GROUP INTRODUCTIONS

Let's go around the room and introduce ourselves.

- My name is X.
- I live in X.
- One thing I like about the place I live is:
- One thing I don't like as much about the place I live is:

QUALITY OF HOUSING

1. How would you describe the quality of your housing?
2. How is the area where you live maintained? Do you have a lot of problems or are things pretty good?
    - Any health problems associated with maintenance?
        - Probes: asthma or allergies due to mold or mildew; injuries due to broken stairs or porches; etc.
3. On a scale of 1 – 5, how stressful is your living situation? What things cause you the most stress?
    - Probes: The thought of having to move out; being unable to pay the rent; threat of eviction, etc.

MANAGEMENT & OWNERSHIP

1. At your site, who has ownership of your housing complex? How does this impact you? Has this changed? How and why?
2. Who manages your housing complex? How does this impact you? Does whoever manages your housing impact your friendships with neighbors? Has management changed?
    - Probes: Response to maintenance requests and ongoing maintenance; rules around who is allowed to live here; the types of rules put into place; enforcement of rules; who gets evicted; etc.)
3. What are some of the rules at your housing complex and how do they impact you and your neighbors? How are the rules communicated to you?
    - Probes: Extended family staying, trash, congregating, eviction, etc.
    - Probes: If evictions result, for what types of reasons? What do people do if they are evicted?

TENANT ORGANIZATIONS

1. Have you or anyone you've known participated in a tenant organization sponsored by the housing complex (as opposed to one sponsored by a tenant rights organization that is doing community organizing)? If so, what was the experience like?
    - Did you feel like the tenant association was heard by management?
    - What kinds of issues does the tenant association focus on?
    - Did your participation lead to positive change?
    - Is there any kind of retaliation by management or neighbors for participation?
    - Do you feel like people trust the residents who sit on the tenant organizations? Do you feel like the tenant associations represent the people who live in your building well?

SOCIAL COHESION

1. Do you feel connected to your neighbors in your housing? If so, how does that connection help you?
    - Probes: Networks, emotional support, babysitting, information on jobs or other resources, etc.
    - What are some barriers to connecting with your neighbors?
2. Is there anything negative about those connections for you?
    - Probes: Do you feel obligated, is it a time suck, do some neighbors have connections to negative influences, etc.?
3. There has been a lot of consideration given to policies that would relocate residents of public housing (while still supporting their need for affordable housing) into areas that are seen as having more of a range of income levels and races. What do you think about such policies?
    - Feel free to share personal experiences or friends' experiences, if you have them.

Note to notetaker: Create diagram identifying seat position/number and denoting gender, approximate age, race/ethnicity, and living situation of participants (to supplement survey results). Use seat position number to identify speaker during notetaking. This is so that the people doing the summary can understand the context of where people are coming from.

Public Housing and Health

1. City:

- ◯ Los Angeles
- ◯ Cincinnati
- ◯ New York
- ◯ Oakland

Your housing situation

Thank you for coming to this focus group about how housing can impact your health. We wanted to be as efficient as possible, so instead of asking you a lot of questions out loud, we have put some of them in a survey. Please fill this out, and ask if you have any questions whatsoever.

2. Has your housing situation changed (have you moved) in the last 5 years?

- ◯ Yes
- ◯ No

3. If yes, then how many times?

4. What type of housing do you live in now (please check all that apply)?

- ◯ public housing - large apartment complex
- ◯ public housing - scattered sites (spread across the city)
- ◯ public housing - small apartments
- ◯ Section 8 apartment
- ◯ Outside the public housing system (private housing)

Other (please specify)

Public Housing and Health

5. If your housing situation has changed, how? I moved from:

- ◯ public housing - large apartment complex
- ◯ public housing - scattered sites (spread across the city)
- ◯ public housing - small apartments
- ◯ Section 8 apartment
- ◯ Outside the public housing system (private housing)

Other (please specify)

People who move away

6. In your opinion, what is the main reason people move away?

7. If you know people who have moved away, on average about how far do they move? (how many miles, blocks, other)

8. Most commonly, when people move away is the neighborhood they move to very different from the neighborhood they move from?

- ◯ Yes
- ◯ No

Public Housing and Health

9. If yes, how is the neighborhood different?

	Better	Worse
Apartment itself	◯	◯
Housing Management	◯	◯
Affordability of housing	◯	◯
Access to friends	◯	◯
Access to family	◯	◯
Access to jobs	◯	◯
Access to health clinics/hospitals	◯	◯
Access to grocery stores	◯	◯
Access to schools	◯	◯
Access to transportation (transit or other)	◯	◯
Crime	◯	◯

Other (please specify)

People who move to your housing site

10. What are the current standards that people have to meet in order to move into your public housing site?

- ◯ Credit check
- ◯ Incarceration history
- ◯ Arrest record
- ◯ Home visits
- ◯ Work requirements
- ◯ Criminal history of all household members (not just the head of household)

Other (please specify)

11. Are the current standards different than the standards in the past?

- ◯ Yes
- ◯ No

Public Housing and Health

12. If yes, how are they different?

13. Of the following goods and services, which are the most important for you to have easy access to (rank your top 5, starting with 1 as the most important).

bank/credit union	
community center	
corner store	
day care center	
food pantry	
grocery store	
health care clinic	
park	
post office	
public school	
public transportation	

Access to specific resources and retail

14. Do you have easy access to enough of the kinds of foods you want to eat?

- ◯ Yes
- ◯ No

15. Are you currently employed or in school?

- ◯ Yes, I'm employed
- ◯ No, I'm not employed
- ◯ I'm in school
- ◯ I'm in school and employed

Other (please specify)

Public Housing and Health

16. If you are employed or go to school, how do you get there (check all that apply)?

- ◯ Walk
- ◯ Bus
- ◯ Bike
- ◯ Train (subway or other train)
- ◯ Drive
- ◯ Carpool
- ◯ Ferry

Other (please specify)

17. How many minutes does it take you to get to work or school?

You

We're going to ask a few questions and your identity is completely anonymous. These questions help us know who was here. We realize these are private questions, and you are entirely free to not answer them, but we hope you feel comfortable doing so.

18. In general, I would rate my health as:

- ◯ Excellent
- ◯ Good
- ◯ Fair
- ◯ Poor

19. In what age range do you fit?

- ◯ 18 - 24
- ◯ 25 - 34
- ◯ 35 - 44
- ◯ 45 - 54
- ◯ 55 - 64
- ◯ 65 - 74
- ◯ over 75

Public Housing and Health

20. About how much money do you make a year?

- ◯ $0 - $15,000
- ◯ $15,001 - $25,000
- ◯ $25,001 - $35,000
- ◯ $35,001 - $55,000
- ◯ $45,001 - $55,000
- ◯ More than $55,000

21. What is your race/ethnicity?

- ◯ White
- ◯ African-American
- ◯ Latino
- ◯ Asian
- ◯ Middle Eastern

Other (please specify)

APPENDIX 4: FINDINGS FROM RAD CASE STUDY CITIES

This document summarizes findings from surveys conducted in each of the four case study cities: New York, Los Angeles, Cincinnati, and Oakland. In total, 54 respondents completed the surveys. Demographic and health-related findings from the survey are presented below for each case study city.

CINCINNATI

Survey Demographics

In total, twelve respondents completed the survey. To summarize:

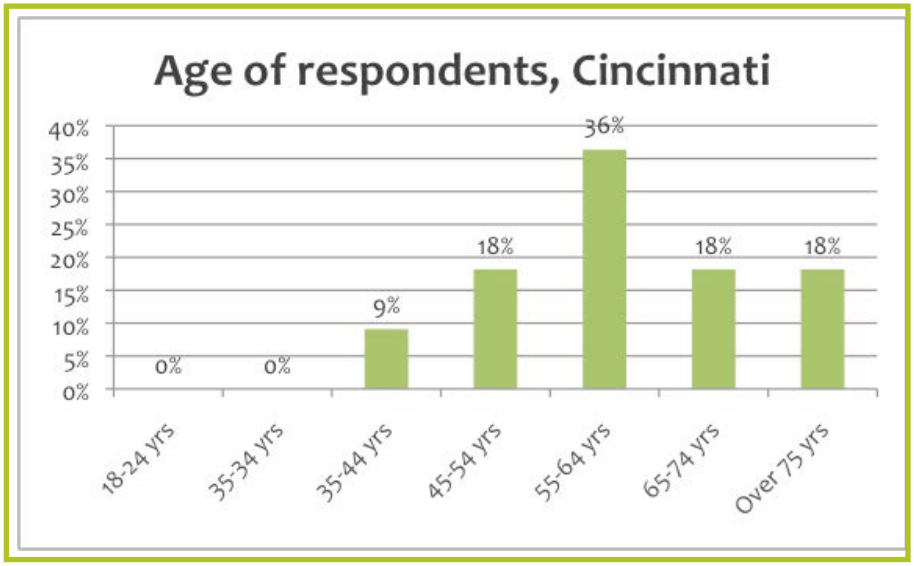
- 100% of respondents were African American
- The majority of respondents (92%) were 45 and older
- The majority of respondents earned in the lowest income category

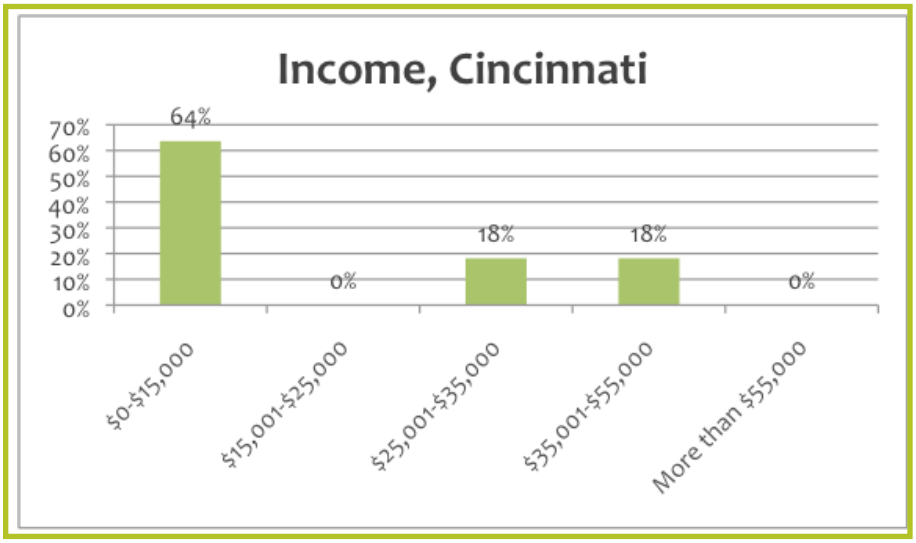
Health and Employment

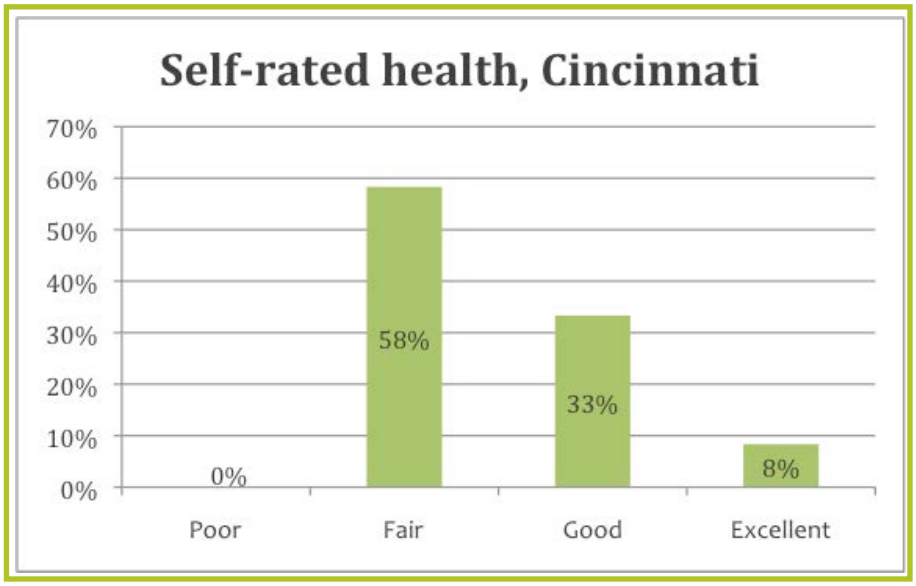
The majority of respondents rated their health as "fair."

The majority of respondents were not employed:

- 58% not employed
- 33% employed
- 8% retired







CINCINNATI

Housing Residence and Stability

31% of respondents (4) had moved in the last 5 years, and they had only moved once.

Respondents described that the following occupancy standards had to be met in order for individuals to move into their public housing site:

- Credit check (4 respondents)
- Incarceration history (9)
- Arrest record (6)
- Home visits (2)
- Work requirements (1)
- Criminal history of household members (6)
- Income preferences (2)

Almost all of the respondents felt that current occupancy standards are different than those of the past (one person did not respond and one felt they were the same).

Respondents offered the following ways that the occupancy standards were different from the past:

- Different rules
- Credit check
- Management keeps the site full

Housing Relocation

Respondents offered the following opinions as to why people move away:

- Nonpayment of rent or eviction was the most common reason (6 of 11 respondents, or 55%)
- A couple people mentioned drugs as a reason for moving
- A better neighborhood/environment was cited as a reason to move by 2 people (18%)

Most people felt that in general, when people move away, the neighborhood they move to is NOT very different from the neighborhood they move from:

- 62% (8 respondents) felt neighborhoods were similar
- 31% (4 respondents) felt neighborhoods were different

Of those who felt the neighborhoods were different, a majority felt the new neighborhoods were better in terms of the following characteristics:

- The apartment itself
- Housing management
- Affordability of housing
- Access to friends
- Access to family
- Access to jobs
- Access to health clinics/hospitals
- Access to grocery stores
- Access to schools
- Access to transportation (transit or other)

People were split about crime in new neighborhoods: 2 respondents felt new neighborhoods were better and 2 felt they were worse in terms of crime.

Most people thought that when people move away they stay fairly close:

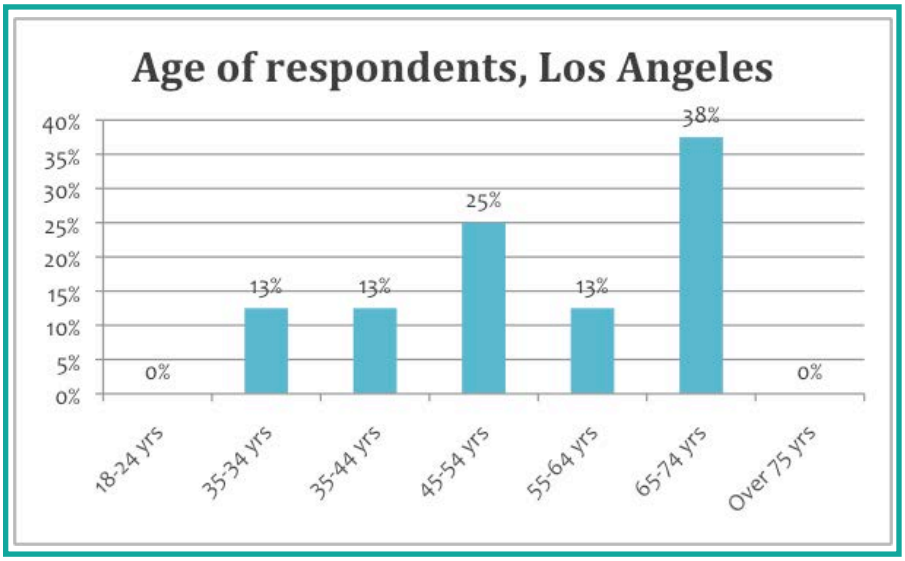
- 4 respondents thought people stayed within the same neighborhood or less than a mile away
- 5 respondents thought people moved less than 10 miles away
- 3 respondents thought people moved between 10 and 15 miles away

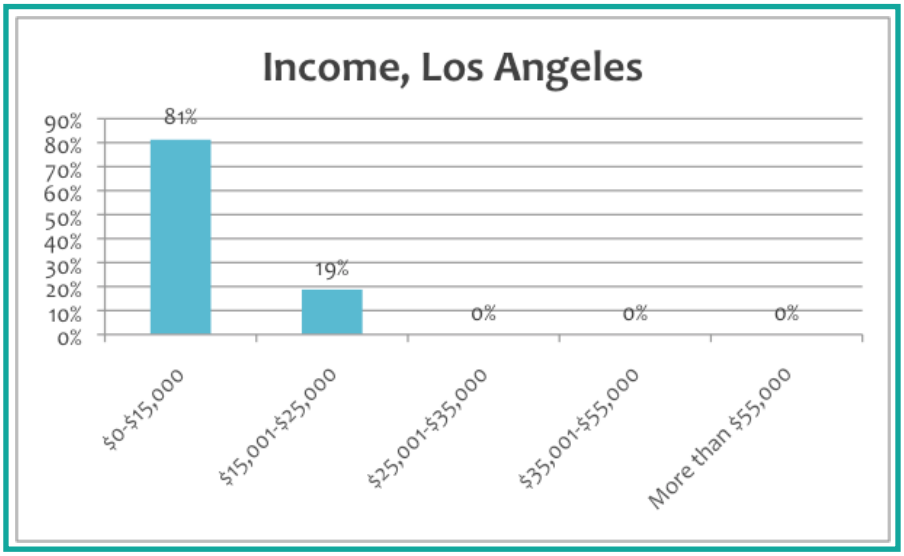
LOS ANGELES

Survey Demographics

In total, seventeen respondents completed the survey. To summarize:

- 100% of respondents were Latino (3 people did not indicate their race/ethnicity)
- The majority of respondents were 45 and older
- The majority of respondents earned in the lowest income category



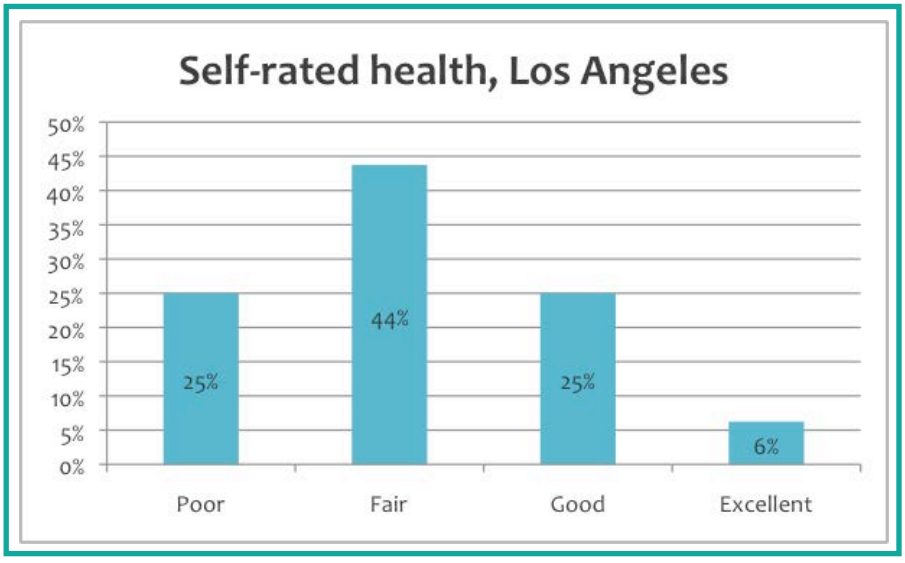


Health and Employment

Respondents rated their health as "fair."

The majority of respondents were not employed:

- 80% not employed
- 20% employed



Housing Residence and Stability

20% of respondents (3) had moved in the last 5 years (one had moved five times, one had moved once and one did not respond).

Respondents described that the following occupancy standards had to be met in order for individuals to move into their public housing site:

- Credit check (10 respondents)
- Incarceration history (9)
- Arrest record (6)
- Home visits (5)
- Work requirements (12)
- Criminal history of household members (8)

64% of respondents felt that current occupancy standards are different from those of the past.

Respondents offered the following ways they thought the occupancy standards were different from the past:

- Work requirements (3)
- They investigate you too much

Housing Relocation

Respondents offered the following opinions as to why people move away:

- Nonpayment of rent, children getting in trouble with the police, or eviction was the most common reason (9 or 82% of respondents mentioned)
- They feel pressured to move (2 or 18% of respondents)
- Buying a house or moving to a better situation (3 or 27% of respondents mentioned)

Most people felt that in general, when people move away, the neighborhood they move to IS very different from the neighborhood they move from:

- 77% (10 respondents) felt neighborhoods were different
- 23% (3 respondents) felt neighborhoods were similar

Of those who felt the neighborhoods were different, respondents thought the new neighborhoods were *better* in terms of the following characteristics:

- The apartment itself
- Access to friends
- Access to family
- Access to health clinics/hospitals
- Access to grocery stores
- Access to schools
- Access to transportation (transit or other)

Respondents thought the new neighborhoods were *worse* in terms of the following characteristics:

- Housing management
- Affordability of housing (only slightly more thought this was worse)
- Access to jobs
- Crime

People were mixed about how far they thought people moved when they move away:

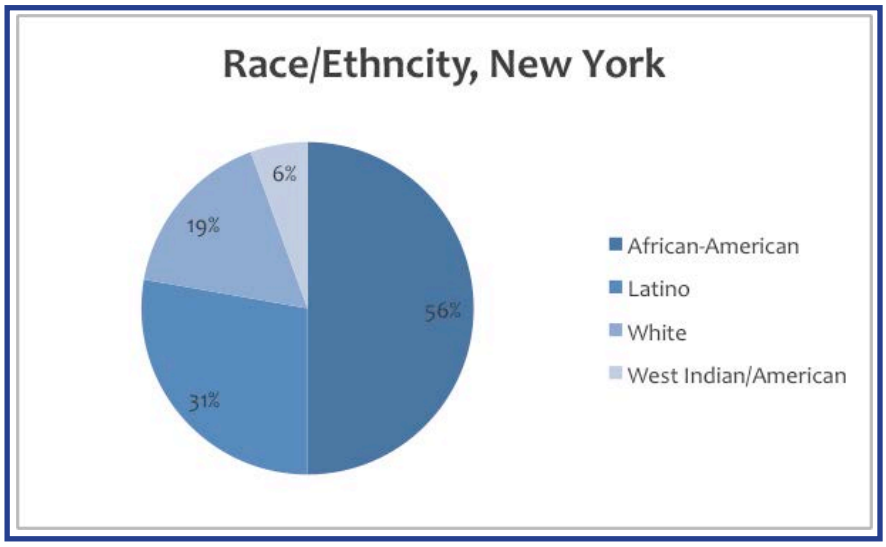
- 3 respondents thought people stayed within the same neighborhood or less than a mile away
- 1 respondent thought people moved less than 10 miles away
- 4 respondents thought people moved between 10 and 15 miles away

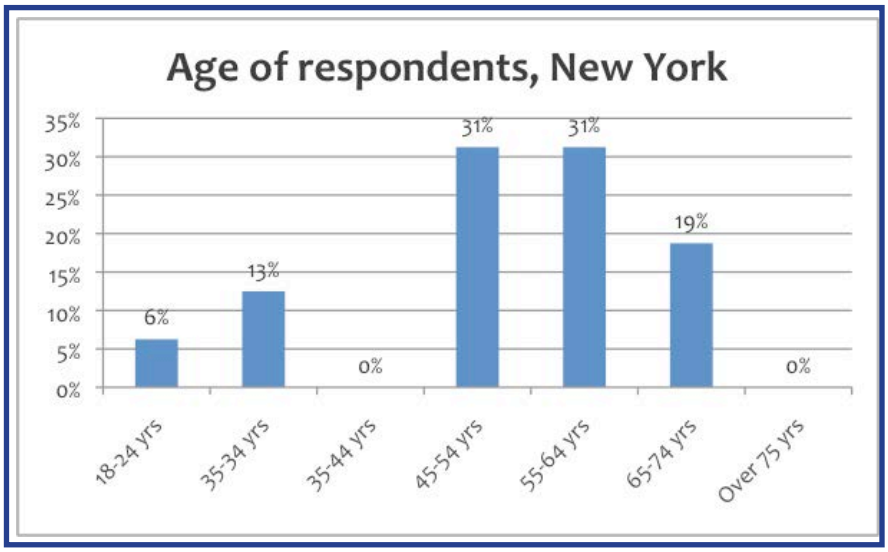
NEW YORK

Survey Demographics

In total, sixteen respondents completed the survey. To summarize:

- The majority of respondents were either African-American or Latino
- The majority of respondents were 45 and older
- The majority of respondents earned in the lowest income category



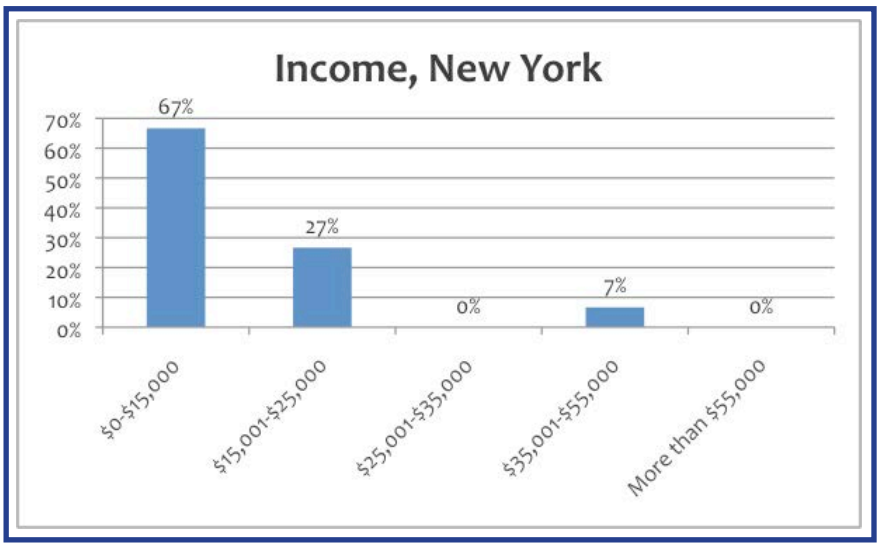


Health and Employment

The majority of respondents rated their health as "fair" or "good. "

The majority of respondents were not employed:

- 60% not employed
- 13% employed
- 27% retired



Housing Residence and Stability

13% of respondents (2) had moved in the last 5 years.

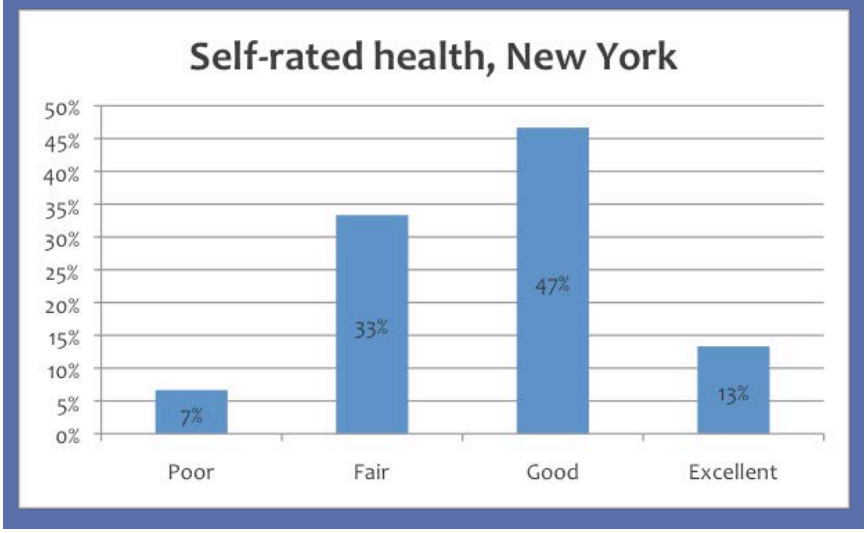
Respondents described that the following occupancy standards had to be met in order for individuals to move into their public housing site:

- Credit check (9 respondents)
- Incarceration history (10)
- Arrest record (10)
- Home visits (3)
- Work requirements (4)
- Criminal history of household members (3)

The majority of the respondents (83%) felt that current standards are different than those of the past.

Respondents offered the following ways that the standards were different from the past:

- Different rules - Credit check, home visits, criminal records, background check
- Rent has increased
- Some improvements – apartments were ready for occupancy with all repairs done and people are clean



Housing Relocation

Respondents offered the following opinions as to why people move away:

- They want more space/ they get better housing
- Buildings in need of maintenance and repairs
- Bad living conditions (e.g. crime, trash, vermin, bad people)
- Can't afford the rent

Most people felt that in general, when people move away, the neighborhood they move to IS very different from the neighborhood they move from:

- 83% (10 respondents) felt neighborhoods were different
- 17% (2 respondents) felt neighborhoods were similar

Of those who felt the neighborhoods were different, respondents thought the new neighborhoods were *better* in terms of the following characteristics:

- The apartment itself
- Housing management
- Affordability of housing
- Access to grocery stores
- Access to schools
- Access to transportation (transit or other)
- Crime

Respondents thought the new neighborhoods were *worse* in terms of the following characteristics:

- Access to friends
- Access to family
- Access to jobs (only slightly more people said this was worse)

Most people thought that when people move away they stay fairly close:

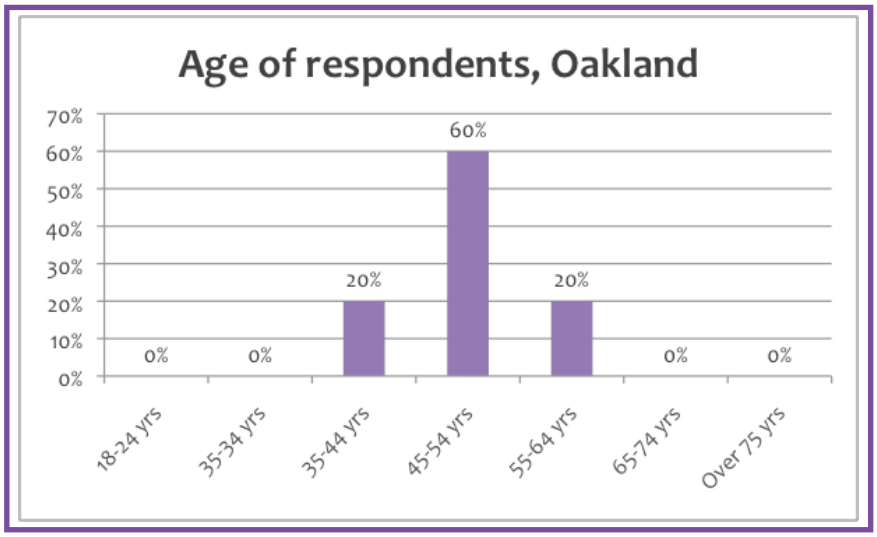
- 5 respondents thought people moved more than 10 miles away, but still in New York City
- 7 respondents thought people moved out of town or the state

OAKLAND

Survey demographics

In total, five respondents completed the survey. To summarize:

- 100% of respondents were African American
- The majority of respondents were 45 and older
- The majority of respondents earned in the lowest income category

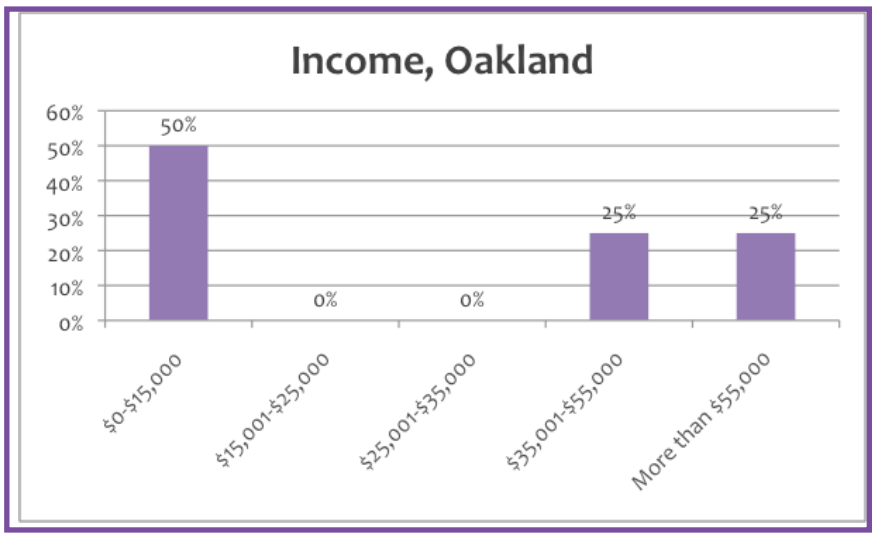


Health and Employment

The majority of respondents rated their health as "fair."

The majority of respondents were not employed:

- 60% (3) not employed
- 40% (2) employed

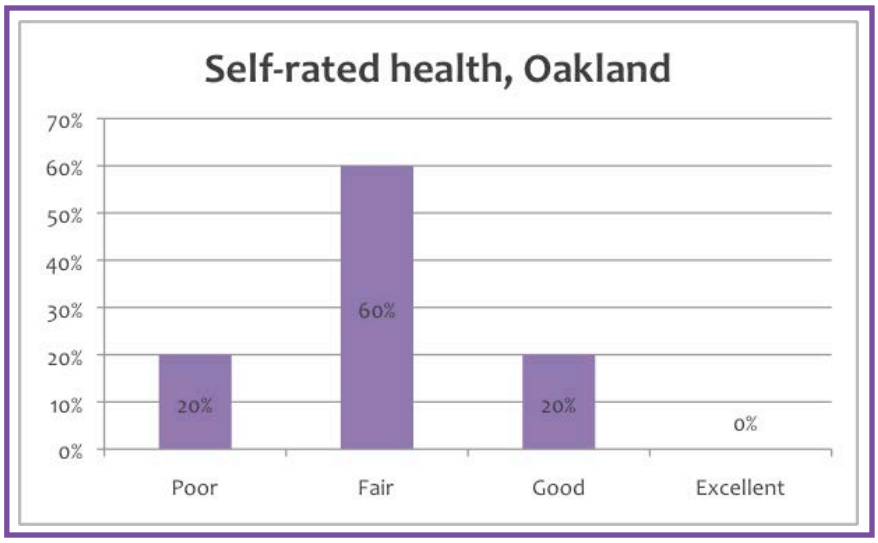


Housing Residence and Stability

40% of respondents (2) had moved in the last 5 years.

Respondents described that the following occupancy standards had to be met in order for individuals to move into their public housing site:

- Credit check (4 respondents)
- Incarceration history (1)
- Home visits (1)
- Criminal history of household members (4)



The majority of the respondents (100%) felt that current occupancy standards are different than those of the past.

Respondents offered the following ways that the occupancy standards were different from the past:

- Rent is now based on 1/3 of your income. As your income increases, so does your rent.

Housing Relocation

Respondents offered the following opinions as to why people move away:

- To get better or more affordable housing
- To be in a safer neighborhood
- Eviction

All respondents (100%) felt that, when people move away, the neighborhood they move to IS very different from the neighborhood they move from:

Of those who felt the neighborhoods were different, more respondents thought the new neighborhoods were *better* in terms of the following characteristics:

- The apartment itself
- Housing management
- Affordability of housing
- Access to friends
- Access to jobs
- Access to health clinics/hospitals
- Access to grocery stores
- Access to schools
- Access to transportation (transit or other)
- Crime

More respondents thought the new neighborhoods were *worse* in terms of the following characteristics:

- Access to family

Most people thought that when people move away they move far away (either 100 miles, 3,000 miles, or cities away). Only one person thought people moved relatively few miles away.