Homelessness in Rural Pennsylvania

By: Heather S. Feldhaus, Ph.D., and Avi Slone, Bloomsburg University

March 2015

EXECUTIVE SUMMARY

This research analyzed existing data on rural homelessness, surveyed professionals who work with the homeless, and summarized information gathered at two homelessness summits to develop a better understanding of homelessness and provide an overview of existing patterns of rural homelessness.

During their analyses, the researchers identified concerns about data quality, particularly data on rural communities, and indicated that existing data likely significantly undercount the rural homeless.

From the data that were available, the research showed clear differences related to the homeless in rural and urban areas and an increase in the number of homeless counted in rural areas. The research also indicated that the rural homeless exhibit high rates of health and substance abuse problems and receive services that emphasize prevention and nonresidential interventions.

The research also found regional differences between the rural parts of the state both overall and in regard to the rates of homelessness among veterans and the chronically homeless.

The survey results indicated a rise in homelessness in the past 5 years, particularly in rural counties. These results corresponded with the data patterns at the state and regional levels. The survey results also indicated slightly higher rates of mental health and substance abuse issues among rural clients. The survey respondents were concerned about the inconsistencies in the definitions of homelessness used by different agencies, organizations, and programs, and with the definitions that exclude clients who are living temporarily with family or friends. Finally, the survey respondents overwhelmingly reported that their own organizations keep accurate records on the homeless they encounter; however, the respondents also reported a wide range of record keeping formats and procedures. The research underscores the point that inconsistency in data collection methods represents a lost opportunity to use these large amounts of data to help increase the understanding of and the ability to track homelessness at the state and local levels.

Information from the homelessness summits confirmed the data weaknesses identified in the research. This information also supported evidence in the rural homelessness literature about problems associated with the lack of awareness of homelessness and the challenges associated with service delivery in rural areas. Attendees suggested that increased dialogue among service providers could be helpful in developing realistic solutions to service delivery that take into account the specific challenges associated with rural communities.

Based on the research findings, the researchers provided a number of recommendations that include the following:

- Develop a standard definition of homelessness that includes those who are doubled up;
- Consolidate state-level data collection under one methodology and Homeless Management Information System; and
- Develop data collection strategies specifically designed for rural areas.

The Center for Rural Pennsylvania
A Legislative Agency of the Pennsylvania General Assembly

This project was sponsored by a grant from the Center for Rural Pennsylvania, a legislative agency of the Pennsylvania General Assembly.

The Center for Rural Pennsylvania is a bipartisan, bicameral legislative agency that serves as a resource for rural policy within the Pennsylvania General Assembly. It was created in 1987 under Act 16, the Rural Revitalization Act, to promote and sustain the vitality of Pennsylvania's rural and small communities.

 For more information, contact the Center for Rural Pennsylvania, 625 Forster St., Room 902, Harrisburg, PA 17120, telephone (717) 787-9555, email: info@rural.palegislature.us, www.rural.palegislature.us.

Table of Contents

INTRODUCTION

Homelessness is always a complex problem to document since it is difficult to collect data on a population that is largely hidden, stigmatized, and transient. Obtaining accurate data on rural homelessness is particularly challenging.

Because rural communities do not have large populations, it may be difficult to justify the existence of a full range of services, such as a shelter, food bank, low-cost childcare, and jobs programs, for the homeless in every community. Instead, these services are spread over a relatively wide geographic area. Distance, and travel time and costs, make it challenging for consumers to use services effectively, and a lack of public transportation can make access to services difficult, if not impossible. Therefore many people do not receive services, use informal networks, such as friends, family, or religious groups, or receive only limited services, such as food but not shelter (Patton, 1987). This makes it difficult to collect necessary information and likely leads to missing or incomplete data (First et al., 1994).

Rural geography presents another problem. The most common means of collecting data on the homeless is the "Point-in-Time" count, where teams go to shelters and areas where the homeless are known to congregate and count them. In urban areas, where there are enough shelters to house many of the homeless and there are known areas where many homeless congregate, this method is effective. However, the Point-in-Time, or PiT, count in rural areas is difficult since there are often few or no shelter spaces, and the homeless are in other, more difficult to identify, locations. For example, the rural homeless often set up tents or other temporary structures in the woods, in agricultural areas not currently in seasonal use, or on land owned by family or friends. Finding all of these remote locations is nearly impossible and the costs of carefully canvassing these broad areas are prohibitive.

Finally, changing definitions of the homeless complicate efforts to effectively monitor the problem. The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 amended and reauthorized the McKinney-Vento Homelessness Assistance Act, and defined the homeless to include those living in housing so substandard as to not be considered "adequate" and those who are not yet homeless but are at great risk of becoming homeless. Individuals who are living temporarily with family and friends in "doubled-up" situations are not defined as homeless, but are considered at-risk of homelessness (Federal Register 76, 2011).

There are multiple provisions within the law that impact many different federal, state, and local agencies and programs in a variety of ways. Therefore, the actual implementation of each provision was on a slightly different timeline. The new definition took effect January 4, 2012, and the many organizational changes necessary to develop measures and programs that encompass the expanded definition were still underway at the time of this research. What is particularly significant for rural communities is that the new definition includes more common forms of homelessness in rural communities. These forms of homelessness remain difficult to identify, count, and track, but there is now a mandate to find better ways to do so.

The more inclusive definition mandated by the HEARTH Act changed and redirected the focus of certain programs. For example, while the focus of the U.S. Department of Housing and Urban Development's (HUD) programs was once primarily on emergency shelter, the HEARTH Act expanded that focus to include those at risk of homelessness, and therefore includes provisions for prevention efforts such as legal services, utility payments, and credit repair. This shift has largely been addressed through the modification of the Emergency Shelter Grants Program into the Emergency Solutions Grants Program, with an accompanying shift from a focus on shelter and outreach services to more services that target prevention, rapid-rehousing, housing search assistance, collaboration and mediation

with property owners, assistance with moving costs and utility payments, and legal services (Federal Register 76, 2011).

The changing and generally varied definitions of homelessness produce challenges for monitoring rates of homelessness. For example, before the implementation of the HEARTH Act definition of homelessness, people experiencing persistent housing instability were not defined as homeless (National Alliance to End Homelessness, 2012). The addition of individuals who experience persistent housing instability to the homeless counts inflates the number of homeless, so unless this specific category of homeless is being monitored, analysis of data does not make clear whether an increase in homelessness is due to an actual increase in the problem or the inclusion of this new group.

The HEARTH Act defines four broad categories of homeless including: literally homeless; imminent risk of homelessness; homeless under other statutes; and fleeing/attempting to flee domestic violence. Specific eligibility criteria and specific forms of evidence are required to establish eligibility for each category. This level of specificity is extremely useful for maintaining data quality and safeguarding the integrity of programs, but creates complicated intake paperwork and record keeping challenges for service providers. Many service providers use simplified definitions when working with programs that do not mandate the use of HUD definitions. Other federal agencies use modified definitions or even different definitions for different programs. The Co-Occurring and Homeless Activities Branch (CHAB) within the Substance Abuse and Mental Health Services Administration (SAMHSA) defines homeless persons as: those who lack a fixed, regular, adequate nighttime residence, including persons whose primary nighttime residence is (a) a supervised public or private shelter designed to provide temporary living accommodations, (b) a time-limited/non-permanent transitional housing arrangement for individuals engaged in mental health and/or substance abuse treatment, or (c) a public or private facility not designed for, or ordinarily used as, a regular sleeping accommodation. CHAB also explicitly notes that persons who are "doubled up" or temporarily staying with friends or family are considered homeless. However, Programs for Assistance in Transition from Homelessness (PATH), also administered under SAMHSA, defines homeless as "an individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing" (SAMHSA, 2014).

These changes in definitions and the use of multiple definitions means that data collected in different years and by different agencies cannot be used to effectively track homelessness because the datasets are not truly comparable. These inconsistent definitions also present problems for service providers as they must keep track of which definitions are used by which programs and collect different data for each program.

The definition of homelessness used and the type of data collected on the homeless are typically dependent on the program or agency funding source. It is therefore important to understand the range of funding sources typically used to combat homelessness.

The federal government funds multiple programs that provide both general and targeted support for programs to combat homelessness. For example:

- The Health Resources and Services Administration administers a program that provides a range of healthcare and outreach services to the homeless;
- SAMHSA administers multiple grant programs to assist states and other entities in providing services to homeless individuals and families whose housing struggles are related to mental illness or substance abuse;
- The Administration for Children and Families administers multiple programs that fund efforts to serve runaway and homeless youth and their families (U.S. Department of Health and Human Services, 2014);
- The U.S. Department of Education offers Education for Homeless Children and Youth Grants to states to support offices to coordinate education for homeless children and youth as well as programming for this population (U.S. Department of Education, 2014);
- The U.S. Department of Veterans Affairs funds the Supportive Services for Veteran Families Program (U.S. Department of Veterans Affairs, 2014); and
- The U.S. Department of Housing and Urban Development (HUD) administers a wide range of programs that target homelessness both generally and in specific populations.

Among the changes associated with the HEARTH Act is a consolidation of HUD's Supportive Housing Program, Shelter Plus Care Program, and Section 8 Moderate Rehabilitation SRO Program into one new Continuum of Care (CoC) Program designed to assist individuals in need of services as well as community planning efforts to reduce homelessness (U.S. Department of Housing and Urban Development, 2012). The

three HEARTH mandated programs are: the CoC Program, which provides funding to state and local governments as well as nonprofits; the Emergency Solutions Grants Program, which provides funding to states, urban counties, and metropolitan cities; and the Rural Housing Stability Assistance (RHSA) Program, which provides funding to rural counties, private nonprofit organizations, and units of local government. In addition to these more generalist programs, HUD also administers specific programs that target veterans including: the Defense Base Closure and Realignment Program, the HUD-Veterans Affairs Supportive Housing Program, and the Veterans Homelessness Prevention Demonstration Program. HUD also administers the Title V Program, which allows the use of federal surplus property to combat homelessness and the Housing Opportunities for Persons with AIDS Program (U.S. Department of Housing and Urban Development, 2014).

Federal funding for homelessness programs in rural areas has historically been low. For example, in 2008, only about 9.3 percent of HUD's funding for homelessness programs was awarded to communities defined by HUD as rural (U.S. Government Accountability Office, 2010). However, new provisions in the HEARTH Act created an added incentive to aggressively pursue a better understanding of rural homelessness. The act explicitly acknowledged the challenges faced by the rural homeless and those who serve them by creating a simplified set of criteria for assistance applications from rural areas and by specifying that rural applicants are scored relative to other rural applicants rather than urban applicants. These changes make applications from rural areas more viable and should serve as an incentive to look carefully at rural areas and how these funds may better assist these areas. Funding is available for both direct service and capacity building (Federal Register 76, 2011).

In terms of data collection and reporting, currently all programs funded through HUD's CoC and Emergency Solutions Grants programs, as well as programs funded through the VA's Supportive Services for Veteran Families, must enter data into the Homeless Management Information System. A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards. As of June 1, 2013, programs funded through the Substance Abuse and Mental Health Administration's Projects for Assistance in Transition to Homelessness Program are also now required to enter data. This leaves multiple programs that do not report to HMIS.

At the state level, the Pennsylvania Department of Human Services administers the Homeless Assistance Program (HAP) that provides each county with funds to provide homeless services (Pennsylvania Department of Human Services, 2014). HAP offers funding for shelter, case management, rental assistance, and bridge housing to assist in the transition from a shelter to more independent housing, and an Innovative Supportive Housing Service, which is designed to allow HAP agencies to create unique services that are outside the usual program guidelines (Pennsylvania Department of Human Services, 2014). The Homeowners Emergency Mortgage Assistance Program (HEMAP), funded by state appropriations, helps homeowners in danger of losing their home to foreclosure (Pennsylvania Housing Finance Agency, 2012).

The Pennsylvania Homeless Management Information System (HMIS), housed under the Department of Community and Economic Development (DCED), collects data on homelessness in Pennsylvania. DCED also leads the Statewide Homeless Steering Committee, which is charged with monitoring multiple aspects of the state's efforts to combat homelessness and advising DCED on homelessness (DCED, 2014).

The Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) supports county-level Local Housing Options Teams (LHOT), which are groups of professionals focused on improving housing options in their counties. The LHOTs each have their own mission and composition based on the specific needs of the region and groups who come forward to join the team. OMHSAS provides technical assistance and training, and specific programs or projects undertaken by the LHOTs are funded through a variety of sources, such as member organizations, grants, and donations (PA Housing Choices, 2014). As noted above, some but not all federal funding sources require data to be reported to HMIS. Depending on which funding stream supports a program, it may or may not report data systematically.

At the local level, there are many programs partly or entirely funded by federal and state programs and many programs that use a combination of funding sources. For example, a program might purchase a facility through a large federal grant, maintain that facility through smaller state grants, and operate programs

through various other grants from federal, state, or local governments, regional foundations, United Ways, and private donors. It is common for these organizations to report data to HMIS or other groups during the period when they are funded by a program that requires reporting, but not when those funds cease. So, a shelter might report to HMIS while its ESG funds are in use but not before or after this period. This pattern complicates data interpretation as there is likely to appear to be more homeless when there is more funding because more people are entering data on the homeless during those time periods.

There are also programs funded entirely through regional foundations, United Ways, faith-based groups, and private donors. For example, many faith-based organizations offer short-term housing or housing vouchers, places to shelter and shower during the day, goods or startup funds for those establishing a new household, or general support for individuals and families in crisis. These programs are particularly unlikely to use standard definitions of homeless or report data to state and federal databases because there is typically no mandate from their funding source to do so. Since these smaller programs are particularly common in rural areas, there are concerns about data quality from these regions.

What is known about the rural homeless suggests that they differ from the urban homeless in significant ways. While rural homelessness is less visible than urban homelessness, some estimates suggest that homelessness is more common in rural areas (Lawrence, 1995). Fitchen (1992) found that among the rural homeless, becoming homeless was often associated with a lack of transportation coupled with distance between low-income housing and available jobs (Fitchen, 1992). Burt et al.'s (1999) study found that the rural homeless were more likely than urban homeless to be homeless for the first time, to have jobs, to be living in the same county where they were born, and to be high school dropouts, and they were less likely to be in a shelter or on the streets (Burt et al. 1999). Post (2002) interviewed physicians about differences between rural and urban homeless clients and learned that the rural homeless tend to remain untreated longer than their urban counterparts.

The term "cost burdened" refers to a situation where an individual or family is paying more than 30 percent of their monthly income for housing costs. This is a common problem in rural areas where incomes are disproportionately low, with estimates suggesting that 30 percent of rural households are cost burdened (Housing Assistance Council, 2010). A relatively new pattern of homelessness facing residents of rural Pennsylvania is associated with natural gas development. The economic boom associated with this development brings new residents and income to an area. However, it may also cause an increased demand for housing and higher rental costs, which may lead to an increase in cost burden and a resulting increase in homelessness and housing instability (Williamson and Kolb, 2011).

GOALS AND METHODOLOGY

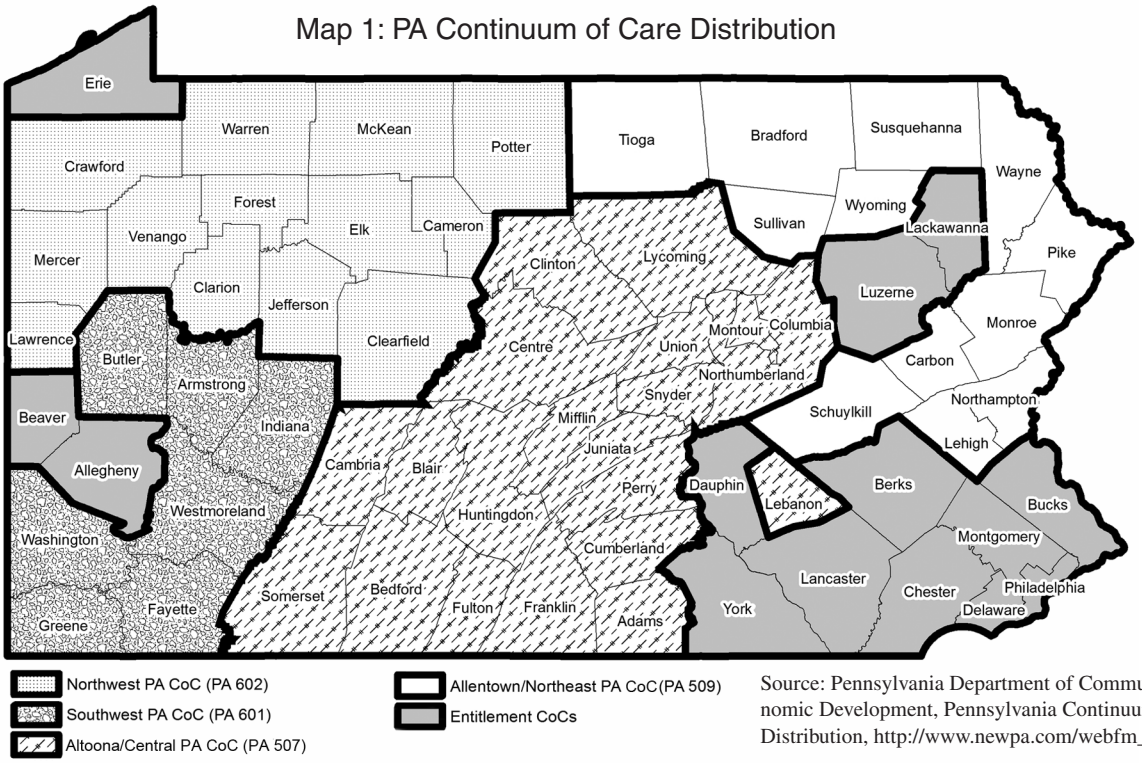
The research goal was to compile and analyze existing data on rural homelessness and develop a better understanding of the experiences and perceptions of professionals who come into contact with the homeless.

Analysis of Existing Data

The research began with an analysis of existing data on homelessness collected yearly by HUD through its CoC sites. These HUD data included PiT counts of information on the chronically homeless, substance abusers, persons with HIV/AIDS, the seriously mentally ill, veterans, victims of domestic violence, and youth, in sheltered and unsheltered settings. HUD data also include Housing Inventory Counts, which are counts of individuals and families in shelters, transitional housing, permanent supportive housing, and rapid rehousing beds available in each location.

These data are typically reported at the CoC level, which are either individual counties or groups of counties (See Map 1 on Page 6). Some urban counties are designated "Entitlement Communities," based on eligibility for Community Development Block Grant funds, and their data are typically reported at the county level. The rest of the counties, called the Balance of State, are divided into four CoCs grouped by region: central, northeast, southwest, and northwest. Data for these areas are typically reported at the CoC level with the exception of Lycoming and Snyder counties, for which HUD does list county-level data in its Homeless Data Exchange. While nearly all of the Balance of State counties meet the Center for Rural Pennsylvania's definition of rural (less than 284 persons per square mile), a few do not, so some urban counties are grouped with rural counties making interpretation of the data more complex.

This analysis also included Housing Inventory



Source: Pennsylvania Department of Community and Economic Development, Pennsylvania Continuum of Care (CoC) Distribution, http://www.newpa.com/webfm_send/2344.

Counts, conducted by HUD, to determine how many and what type of beds are available in each location at a specific date each year. These data are also reported at the CoC level.

The research also used HMIS data from the Balance of State counties.

The research also used smaller scale data, including Bradford County's Local Housing Opportunities Team (LHOT) and Columbia-Montour Homelessness Taskforce data. Both have been collecting basic data on requests for services in their areas to more accurately understand how many unduplicated requests for services their providers receive each month and year, the characteristics and needs of those requesting services.

Bradford County's LHOT began its efforts first and developed a methodology in which local organizations who provide services to the homeless would each have copies of a tracking form distributed to staff who answer phone calls or conduct intake interviews. The tracking sheet is brief and follows a format that mimics the typical flow of questions always asked of clients or potential clients by these organizations. This often allows the individual filling out the form to complete the form as part of his/her usual intake or screening process without adding an additional set of questions or procedures. These paper forms are collected at LHOT meetings and compiled into a spreadsheet by an LHOT member for distribution to and use by the group.

The Columbia-Montour Taskforce learned about Bradford County's efforts as it began its own data collection initiative. It adopted and modified the Bradford County tracking sheet to meet its own needs. The data were similar to the most basic data collected through the HMIS system, also known as the "Universal Data Elements" (U.S. Department of Housing and Urban Development, 2014). The Columbia-Montour Taskforce partners with Bloomsburg University for its data collection effort. Paper copies of the tracking sheets are delivered to a university representative at the monthly Taskforce meeting and a faculty/student research team enters the data into a spreadsheet and presents periodic reports on the findings to the taskforce.

For this project, analyses were performed on data from Bradford County for 2012 and on Columbia-Montour for July 1, 2013 to September 6, 2013. As these efforts amass long-term data and spread to other areas, they could become a more useful data source. At this time, they offer an opportunity to compare the data that local groups collect to the PiT and HMIS data.

Online Survey of Professionals

A second set of activities involved distributing an online survey to professionals throughout the state to report on patterns they have seen, challenges they face, and practices they have seen work successfully in identifying and serving rural clients in their areas.

The survey was administered online and the Housing Alliance of Pennsylvania (HAP) served as the base mailing list of professionals who regularly deal with the homeless. HAP's mailing list contained approximately 10,000 organizations, mostly those providing direct services to the homeless, but also includes other groups interested in housing, such as religious organizations, real estate agents, and land developers. This list was supplemented with multiple relevant professional organizations including medical professionals, educators, and law enforcement personnel, who informed their members/peers of the survey via e-mail, Twitter, website postings and newsletter articles.

Using email to contact potential respondents complicated the calculation of precise response rates, therefore all estimates of response rates presented here are rough estimates and interpretation of the data is done with caution since the response rate calculation is imprecise.

Overall, approximately 12,000 unique recipients were sent messages about the survey. Several professional organizations who distributed the survey reported that the "open rate" of those emails was about 10 to 15 percent. If this were true of most messages sent for this project, approximately 1,200 messages were received and opened by unique recipients; 220 chose to respond to the survey, resulting in a response rate of approximately 18 percent.

Responses were received from throughout the state by respondents who collectively cover every Pennsylvania county, including 18 professionals who have statewide service areas. Respondents reported county specific service areas in every county except Potter. Over half of the respondents served primarily urban areas (58 percent), and the remaining 42 percent served primarily rural areas. A range of professionals from different focus areas responded, including those from human services (38 percent), housing programs (27 percent), homeless shelters (17 percent), healthcare (16 percent), educational institutions (14 percent), women's shelters (14 percent), mental health services (13 percent), faith-based programs (9 percent), hunger prevention programs (8 percent), law enforcement (7 percent), veterans services (6 percent), and alcohol and drug treatment programs (5 percent) (See Table 1).

These data represent a convenience sample, meaning that a group of professionals who have an interest in homelessness and were willing to share their experiences responded. There is no reason to believe that these respondents are an accurate representation of all professionals who work with the homeless. It could be that this sample has a stronger interest in the issue or has other characteristics that make them different from their colleagues who did not respond to the survey. A larger sample and more accurate response rate would be necessary to conclude that this sample is representative of these professionals as a whole. While this sample does not allow for conclusions about the entire population of professionals that work with the homeless, it does provide insights from 220 professionals.

Table 1: Organizational Focus Area and Percent Responding

Focus Area or Respondent Organization	Percent of Respondents
Human Services	38%
Housing Programs	27%
Homeless Shelters	17%
General Healthcare	16%
Education	14%
Mental Health	13%
Faith-Based Programs	9%
Hunger Prevention	8%
Law Enforcement	7%
Veteran Services	6%
Alcohol and Drug Treatment	5%

Many respondents were involved with work in more than one focus category, so the percentages do not total 100%.

The survey questions focused on the context in which the respondent encounters the homeless (medical care, hunger prevention, educational setting), what kinds of service they provide, their service area, the demographic characteristics and basic housing situation of the homeless they work with, and their professional perceptions of the current programs and services offered.

Information from Homelessness Summits

The researchers also collected feedback from those who work directly with the homeless at two Homelessness Summits hosted in October 2012 and 2013. Both were attended by approximately 75 service providers from the central, eastern, and northern regions of Pennsylvania. Both summits were hosted by Bloomsburg University and sponsored by the Columbia/Montour Homelessness Taskforce and HAP, as well as local and state partners, including the Federal Reserve Bank of Philadelphia. Each summit included speakers who shared information about state and federal programs related to housing, current research on housing, and examples of best practices in service provision. There were also facilitated discussions among service providers on the challenges and opportunities related to their work. Researchers affiliated with this project attended

these discussions and produced a report for the service providers that summarized their discussions. These reports also inform the interpretation of the data in this report.

Data Limitations

The limitations associated with the available data on rural homelessness are substantial. Since urban counties are grouped with the rural counties within CoCs and data are seldom reported at the county level, it is difficult to interpret rural and urban distinctions within the data. Also, having the data grouped into these large blocks limits researchers' ability to perform more fine-grained analysis of differences within regions. For example, the counties most heavily impacted by shale gas development are divided into the northeast, central, and southwest CoCs and grouped with other counties that have seen no shale development, making it difficult to perform analyses of how the shale region differs from other regions. Due to this challenge, this project does not include an analysis of Pennsylvania counties that looks specifically at homelessness in the shale region. However, such an analysis is critical and should be performed in the future.

The PiT data on unsheltered homeless also present challenges. PiT counts are conducted by identifying a specific date and attempting to count all individuals who are sheltered or unsheltered on that date. The date is set during a period of cold weather because this increases the likelihood that many homeless will be seeking shelter at that time. Counting the number of persons in shelters or other forms of housing is a relatively simple process compared to identifying and counting those who are unsheltered. Communities use a variety of methods to find and count unsheltered homeless including working with regional social service providers, schools, and law enforcement to identify individuals who are homeless or places where the homeless tend to seek shelter. However, the practical challenges of putting together a team of people to go out searching for homeless individuals on a cold night are many. This is particularly so when you have a large geographic area to canvass and few areas where the homeless tend to congregate in large groups, as is often the case in rural areas. The service providers who provided information for this research consistently suggest that the unsheltered homeless are significantly undercounted.

The largest challenge in working with these data became apparent very quickly, as each report on the data comes with a disclaimer. For example, at the top of the annual CoC Dashboard Reports (2012) available from HUD, the following is included:

> *Important Notes About This Data: This report is based on information provided to HUD by Continuums of Care (CoCs) in the 2012 application for CoC Homeless Assistance Programs. HUD has conducted a limited data quality review but has not independently verified all of the information submitted by each CoC. The reader is therefore cautioned that since compliance with these standards may vary, the reliability and consistency of the Housing Inventory and Homeless Count data may also vary among CoCs. Additionally, a shift in the methodology a CoC uses to count the homeless may cause a change in homeless counts between reporting periods. For inquiries about data reported by a specific Continuum of Care, please contact that jurisdiction directly. CoC contact information can be found on the hudhre.info web site.*

This is a theme seen repeatedly with the agencies from which data were sought, from other researchers who were consulted, and from practitioners who collect and enter data into the various federal, state, and local databases. The core message has been that the existing data collection systems were not strong in the past and there are serious efforts to improve, but there is still a great deal of work to be done.

However, these data are also limited by data collection challenges. Perhaps the greatest weakness of this dataset is that only certain service providers enter data into the system. As noted earlier, some federal and state funding sources require that HMIS data be entered, but not all do so.

Another challenge with the HMIS system is that there is not one statewide database that contains all of the information for Pennsylvania in one dataset. This study analyzed the data from the four, large, predominantly rural CoCs. There were also 13 predominantly urban entitlement communities that each has its own HMIS database. Different databases administered by different organizations produces multiple research problems including datasets that do not match and significant research challenges in obtaining access to so many different datasets.

DCED made significant changes to the Pennsylvania HMIS system in 2010 that resulted in the system becoming more user-friendly and more agencies recording data in the system. In an ongoing effort to improve both the quantity and quality of data entered into the system, DCED frequently updates requirements for which service providers must enter data, provides education about the value of entering data, enforces data entry requirements, and specific data points that are to

be recorded.This will ultimately result in a much higher quality database that improves the ability to make data driven decisions. However, since data quality greatly varies from year to year, it makes interpretation of the data very challenging. What appears to be a shift in patterns of homelessness can instead be a shift in what data were collected and entered.

While the most recent HMIS data are far superior to past years, there are still concerns about the data. In talking informally with services providers, the researchers were told that the convention is still to only enter HMIS data when mandated to do so by a funding source, and even those data are less likely to be entered or might be entered with less care during certain times of year. For example, when the weather first becomes dangerously cold, service providers who deal with housing are often swamped with clients in need of emergency shelter and emergency heating assistance. Faced with the choice of meticulously entering data or finding a safe place for someone to sleep, service providers focus on the most critical tasks first.

Another challenge associated with HUD's PiT and housing inventory data and the HMIS data is the practicality of collecting data in real communities. Housing inventory data that detail the numbers of individuals and families in specific types of emergency and shelter housing each year are likely the most accurate data available because counting the number of available beds and the number of clients actually served is a relatively simple process. The main challenges with these data are identifying unduplicated cases (i.e. knowing whether you are looking at data on one client who was served by four agencies or four separate clients) and knowing how many of the service providers who offer services to the homeless are collecting data, ensuring data accuracy, and reporting those data to HUD.

The level of detail collected in the HMIS database is designed to address the challenge of identifying unduplicated cases, and this system has the potential to do so well as it is further refined.

The challenge of collecting data from all service providers has been partly addressed by making reporting data a requirement for more funding sources. However, the many small, local and/or privately funded service providers often have no incentive to collect and report data. The abundance of these smaller providers, such as groups that provide only daytime shelter, housing vouchers, or small amounts of financial assistance in rural areas raises particular concern for data on these areas. Based on this pattern, it is reasonable to expect that areas with more formal service provision sites and areas with more sites that receive funds from federal and state agencies that require HMIS data be collected will show higher rates of homelessness simply because they are more likely to enter data on the homeless they encounter.

Based on these data quality concerns, the researchers looked for additional data sources that could be used to supplement and corroborate the HUD data. However, most available reports were based on HUD data or employed such new or specialized datasets that their usefulness was limited.

The Pennsylvania Department of Education has started to collect data on homeless youth in schools. However, the data collection process is very new and data are reported in aggregates for eight regions. Given that HUD data are reported in the aggregate for the 17 CoCs, the two datasets will need to be reported at the county level rather than aggregate levels to be comparable. Another challenge in the Department of Education data was noted in its February 2013 Education for Children and Youth Experiencing Homelessness Program 2011-12 State Evaluation Report. The report indicated the new data collection requirements and methods resulted in some struggles as staff learned what data to collect and how. While the data quality for the 2011-2012 school year was much better than the previous year, the report indicates that improvements in the methodology must continue.

In addition, the Department of Education reports note the challenge of collecting accurate data on children in schools because parents often fear that if schools are aware that children are experiencing housing insecurity, they will alert the Office of Children, Youth and Families. While the dissolution of a family due to housing problems is unlikely, fear leads some parents to actively instruct their children to hide housing problems.

The work of Perlman and Willard (2012) is innovative in that it uses the anonymous school-based Youth Risk Behavior Assessment Survey data to assess rates of homelessness and housing insecurity, but that survey is currently only used regularly and on a widespread basis in select urban areas and does not help in understanding rural youth homelessness at this time.

The Department of Veterans Affairs also collects data on homeless veterans throughout the U.S. However, most of its reports are based on HMIS data and therefore subject to the same weaknesses as the HUD reports. One area of promise in the VA data comes from the Community Homelessness Assessment, Local Education and Networking Groups annual survey and report. While this survey uses a convenience sample and

is therefore not necessarily an accurate representation of the entire homeless veteran population, and is not an attempt to count homeless veterans, it does ask homeless or formerly homeless veterans about their experiences. These data are reported in the aggregate based on VA service areas rather than counties, which do not allow for comparisons with data from the Department of Education or HUD. However, the survey data are available for Pennsylvania and hold promise for future research on differences in how veterans in different locations experience homelessness.

The two smaller locally collected data sets from Bradford and Columbia-Montour counties analyzed here have distinct advantages over state and federal efforts. They typically involve a large number and range of service providers because participation is not tied to a specific funding stream or set of outside requirements. This means that large service providers who also enter data into HMIS participate, but so do small organizations and faith-based groups, who are often the primary service providers in rural areas but who do not typically enter data into HMIS.

These efforts are grounded in the desire of service providers to better understand the specific patterns in their own communities, to use their resources wisely, and to serve their clients well. The data collection procedures are user-friendly because they are designed by service providers for their own use. This results in substantial commitment to participation among service providers.

These local datasets do have weaknesses. Much like the HMIS data, these data are more complete in months when the service providers have less overall demand on their time. Also, when these efforts are truly local, they are not connected to one another methodologically, making it difficult to compare patterns across locations. Because only some communities are engaged in these efforts, data are not available for all areas.

Given the range of data concerns outlined here, this report follows the standard convention of urging caution in interpreting findings. This analysis was focused primarily on the most recent years. Wherever possible, evidence suggested by one dataset was corroborated through comparison to another, and this report focuses on both the findings of existing data and also many suggestions for improving data quality.

It is also important to note that, given the specific nature of the methodological concerns cited above, it is likely that the rural homeless are undercounted, not over-counted. The methodological problems suggested by existing literature on homelessness, and those that the researchers have identified, suggest that successfully identifying and collecting data on the true number and range of people experiencing homelessness is a problem. While counting the same person multiple times is a possibility, it is a relatively simple matter to identify those duplicate cases and account for them in analyses.

It is therefore reasonable to assume that if there are errors in the existing data, they are likely to be errors of omission. This is particularly true for populations where there are fewer social service providers to conduct counts, such as rural areas, at locations and times where social service agencies are understaffed, and in years where budget cuts have occurred. It is also true for populations that have an incentive to hide their homeless status, such as those in small towns where the stigma might be higher or among unaccompanied minors who fear the intervention of social service agencies.

RESULTS

Analysis of Existing Data

Patterns at the State Level

Table 2 uses PiT count data to illustrate changes in total homelessness in Pennsylvania between 2009 and 2013 for a variety of subpopulations. The numbers of sheltered homeless have stayed fairly stable and are likely the most accurate counts because the agencies that provide shelter can fairly easily report the number of people they are currently serving on a given night.

Unsheltered homelessness has shifted more dramatically, particularly from 2012 to 2013. It is difficult to tell how much of these changes are the result of changes in data collection. Regardless of the reason, a 26 percent increase in 1 year means there are either more unsheltered homeless, or there is now awareness of more unsheltered homeless. Either way, it is an indication of need that was previously undocumented.

Total homelessness, meaning sheltered and unsheltered homeless combined, has stayed fairly stable over this 5-year period. When looking specifically at homeless individuals compared to people who are part of a homeless family, the number of individuals who are homeless has shifted up and down with an overall 8 percent increase. The total number of persons in families who are homeless has also shifted over the years, with an overall 8 percent decrease in persons in families experiencing homelessness over this time period.

Patterns in homelessness among veterans showed

a particularly interesting pattern. The numbers suggest 2 years in which homelessness among veterans was actually decreasing, but then a dramatic jump in the number of homeless veterans from 2010 to 2011. However, this jump corresponds with efforts to increase the amount and accuracy of data entered into HMIS during this time, and is interesting given that the numbers stabilized in 2012 and 2013. Again, it is difficult to tell how much of this pattern may be attributed to a change in homelessness among veterans and a change in how data are collected. However, there is evidence of a previously undocumented need.

The overall trend in chronic homelessness is slightly downward. Federal guidelines define a person as chronically homeless if he/she has been homeless for a year or more or if he/she has had at least four incidents of homelessness in the past 3 years (U.S. Department of Housing and Urban Development, 2007). However, most of that downward movement happened between 2009 and 2011, with 2012 and 2013 showing increases.

Table 2: Pennsylvania Total PiT Counts, Rate per 10,000, and Change Since Previous Year, 2009-2013

	Total Change 2009-2013	2009	2010	2011	2012	2013
Sheltered Homeless	-1%	13,819 109* (-2%)	13,418 106* (-3%)	14,036 110* (5%)	13,660 108* (-3%)	13,727 108* (0%)
Unsheltered Homeless	6%	1,277 10* (-2%)	1,098 9* (-14%)	1,060 8* (-3%)	1,076 9* (2%)	1,359 11* (26%)
Total Homeless	0%	15,096 119* (-2%)	14,516 114* (-4%)	15,096 119* (4%)	14,736 116* (-2%)	15,086 119* (2%)
Total Individuals	8%	7,384 58* (-5%)	7,191 57* (-3%)	7,867 62* (9%)	7,295 57* (-7%)	7,973 63* (9%)
Total Persons in Families	-8%	7,712 61* (1%)	7,325 58* (-5%)	7,229 57* (-1%)	7,441 59* (3%)	7,113 56* (-4%)
Homeless Veterans	46%	1,000 8* (-9%)	889 7* (-11%)	1,392 11* (57%)	1,456 11* (5%)	1,462 12* (0%)
Chronically Homeless	-7%	1,798 14* (11%)	1,524 12* (-15%)	1,508 12* (-1%)	1,564 12* (4%)	1,681 13* (7%)

* Indicates rate per 100,000 Pennsylvania residents based on U.S. Census 2010 population counts.

Table 3: Total Point in Time Homeless Counts, Change from Previous Year, 5-Year Change, and Rate per 10,000 for Rural Continuums of Care

	Percent Change 2008-2013	2009	2010	2011	2012	2013
Sheltered Homeless	16%	2,582 54* (6%)	2,642 55* (2%)	2,514 52* (-5%)	2,652 55* (5%)	2,824 59* (6%)
Unsheltered Homeless	137%	157 3* (-13%)	163 3* (4%)	197 4* (21%)	197 4* (0%)	427 9* (117%)
Total Homeless	24%	2,739 57* (5%)	2,805 58* (2%)	2,711 56* (-3%)	2,849 59* (5%)	3,251 68* (14%)
Total Individuals	35%	1,218 25* (1%)	1,202 25* (-1%)	1,027 21* (-15%)	1,230 26* (20%)	1,628 34* (32%)
Total Persons in Families	15%	1,521 32* (8%)	1,603 33* (5%)	1,529 32* (-5%)	1,619 34* (6%)	1,623 34* (0%)
Homeless Veterans	25% (2011-2013)			238 5*	268 6* (13%)	297 6* (11%)
Chronically Homeless	66%	233 5* (2%)	224 5* (-4%)	245 5* (9%)	223 5* (-9%)	378 8* (70%)

* Indicates rate per 100,000 residents of rural CoC based on U.S. Census 2010 population counts.
Note: Data on homeless veterans were only available for 2011-2013.

Rural Homelessness

Table 3 illustrates patterns for rural CoCs only using PiT data. Map 1 (on Page 6) illustrates the CoC locations and boundaries, and lists the CoCs that are considered rural (507, 509, 601, and 602). There has been an increase in homelessness for every subpopulation. Both sheltered and unsheltered homelessness increased, with total homelessness increasing 24 percent. Most of the change occurred between 2011 and 2013. Much like with the overall state data, unsheltered homelessness increased most dramatically, with large jumps between 2010 and 2011, and between 2012 and 2013.

Homelessness among individuals increased 35 percent, again most significantly in more recent years. The number of people living in homeless families has also increased, but less dramatically and more gradually between 2009 and 2013.

Data on homeless veterans was only available for 2011 to 2013, but these data show an increase of 25 percent. Chronic homelessness has also been on a fairly steady rise since 2009, but with a dramatic increase between 2012 and 2013.

While the data show increases in every category of rural homelessness, it is important to remember that questions remain about whether there was an actual increase in the problem or in awareness of the problem. Either scenario, however, suggests real need. As noted above, undercounting, both formerly and presently, was the most likely form of error in the data.

Table 4 on Page 12 uses PiT data to provide a comparison of trends in total homelessness, rural homelessness, and urban homelessness by looking at year to year changes as well as an overall change since 2008 in rural and urban CoCs. Again, total homelessness

Table 4: Percent Change Each Year Compared to the Previous Year and Rate Per 100,000 Population

	Total Change since 2008	2009	2010	2011	2012	2013
Total Homeless	2%	2% 119*	-2% 119*	-4% 114*	4% 119*	-2% 116*
Rural Homelessness	24%	5% 57*	2% 58*	-3% 56*	5% 59*	14% 68*
Urban Homelessness	-7%	-3% 156*	-5% 148*	6% 157*	-4% 150*	0% 150*

* Indicates rate of homelessness per 100,000 total Pennsylvania residents, total residents of rural CoCs, and total residents of urban CoCs, respectively, based on U.S. Census 2010 population counts.

has stayed relatively stable. However, rural homelessness increased steadily from 2009 to 2012, and then dramatically from 2012 to 2013. Over that same time period, urban homelessness remained more stable with a general decrease of 7 percent.

The researchers used data from the Pennsylvania HMIS to look at the characteristics of the rural homeless documented by this dataset. The average rural client was 30 years old; nearly 24 percent had a disability; 27 percent had a mental health problem; 12 percent had a physical disability; and 10 percent had a chronic health condition. Rural clients had a fairly low incidence of HIV/AIDS at 0.25 percent.

The most common program type used by rural clients was Homelessness Prevention (33 percent). Service Only Programs, which offer only supportive services, such as food or healthcare, but not housing, were used by 22 percent of rural clients. It would be useful to know whether this prevalence was due to client need or to the kinds of services available in rural areas. Since there are fewer emergency shelters in rural areas, agencies may tend to put their focus on prevention and Service Only Programs as they simply don't have the option of offering shelter as readily.

Table 5: Point in Time Homeless Counts, Change Since the Previous Year, and 5-Year Change by Continuum of Care for all Rural Continuums

	Total Change Since 2008	2009	2010	2011	2012	2013
Rural Homeless Total	24%	2,739 (5%)	2,805 (2%)	2,711 (-3%)	2,849 (5%)	3,251 (14%)
Central	13%	1,170 (13%)	1,167 (0%)	961 (-18%)	1,005 (5%)	1,174 (17%)
Northeast	26%	738 (3%)	728 (-1%)	759 4%	747 (-2%)	907 (21%)
Southwest	29%	562 (-3%)	600 (7%)	683 14%	688 (1%)	750 (9%)
Northwest	49%	269 (-4%)	310 (15%)	308 (-1%)	409 (33%)	420 (3%)

* Indicates rate per 100,000 residents of the respective CoC based on U.S. Census 2010 population counts.

Nearly 12 percent of rural clients did not report or refused to report their prior residence and 13 percent of rural clients did not report or refused to report the length of prior residence. It is difficult to know whether these findings are due to clients' reluctance to answer the question or whether there was a data collection challenge.

Twenty-two percent of rural clients were at a high risk of losing their housing at the time of their entry into the program that reported data to HMIS.

Table 6: Homelessness Rate Per 100,000 and Unemployment Rate by Region

		2009	2010	2011	2012	2013
Central	Homeless rate	68*	68*	56*	58*	68*
	Unemployment rate	8.5	8.6	7.9	7.8	7.4
Northeast	Homeless rate	56*	55*	57*	56*	69*
	Unemployment rate	8.8	8.9	8.5	8.6	8.3
Southwest	Homeless rate	52*	55*	63*	63*	69*
	Unemployment rate	7.8	8.3	7.7	7.6	7.2
Northwest	Homeless rate	40*	47*	46*	61*	63*
	Unemployment rate	10.0	9.8	8.6	8.4	8.1

Homeless rate indicates the number of homeless per 100,000 residents of the respective CoC based on U.S. Census 2010 population. Unemployment data are from the U.S. Department of Labor.

Regional Differences

Returning to PiT count data, Table 5 offers comparisons between different regions, all of which are primarily rural. As with overall rural homelessness, the trend for all regions indicated an increase. However, the northwest region saw the most dramatic increase in homelessness, which occurred primarily between 2011 and 2012. The central region saw the least dramatic increase with a fairly significant dip in homelessness between 2010 and 2011.

Table 6 looks at the homelessness rate and the unemployment rate by region. This simple comparison does not suggest that homelessness and unemployment are following similar

patterns, however, more longitudinal analyses of the data should be conducted.

Housing Inventory Counts

Table 7 illustrates the total number of beds available each year including emergency, transitional, and safe haven beds, as well as overflow and voucher beds by year and location. The table also includes a calculation of the number of beds per homeless individual identified in the PiT count for each year and location. The ratio of beds to homeless individuals has declined in all locations since 2009, but more dramatically in the rural CoCs compared to the state totals.

Table 7: Housing Inventory Count and Number of Beds Per Homeless Residents by Year and Location

		2009	2010	2011	2012	2013
PA Total	Year-Round Beds	16,112	15,745	16,363	16,050	16,370
	Beds Per Homeless	1.06	1.08	1.09	1.09	1.09
	Overflow/Voucher	721	682	371	356	261
Central Region CoC	Year-Round Beds	1,909	1,546	1,247	1,264	1,332
	Beds Per Homeless	1.6	1.3	1.3	1.3	1.1
	Overflow/Voucher	73	42	34	6	9
Northeast Region CoC	Year-Round Beds	1,232	892	921	948	918
	Beds Per Homeless	1.7	1.2	1.2	1.3	1.0
	Overflow/Voucher	8	36	3	4	13
Southwest Region CoC	Year-Round Beds	992	733	742	791	806
	Beds Per Homeless	1.8	1.2	1.1	1.1	1.1
	Overflow/Voucher	46	30	32	13	37
Northwest Region CoC	Year-Round Beds	772	482	476	525	513
	Beds Per Homeless	2.9	1.6	1.5	1.3	1.2
	Overflow/Voucher	71	46	11	9	18

Homeless Veterans

Tables 8 and 9 look specifically at veterans experiencing homelessness. The data limited the analysis to changes between 2011 and 2013. Table 8 shows very little overall difference between rural CoCs and urban CoCs for these years. However, Table 9 compares rural regions to one another, illustrating a dramatic increase in the northeast region between 2012 and 2013. There is an actual decrease, though small, in the southwest. The relatively small total numbers in all areas can exaggerate percentage point differences; however there was a difference between regions in regard to homelessness among veterans. Again it is difficult to say whether these are differences in actual numbers or in changes to data collected.

Table 8: Homeless Veterans in Rural and Urban Continuum of Care by Year

		2011	2012	2013
Veterans	Rural CoC	10%	10%	10%
	Urban CoC	10%	10%	10%

Table 9: Percent Change from Previous Year, Total Percent Change from 2011-2013, and Change in Rate per 100,000 Residents for Homeless Veterans by Rural Region and Year

	Total Change Since 2011	2011	2012	2013
Rural Homeless Total	25%	238 5*	268 6* (13%)	297 6* (11%)
Central	8%	52 3*	56 3* (8%)	56 3* (0%)
Northeast	142%	33 2*	32 2* (-3%)	80 6* (150%)
Southwest	-4%	114 10*	120 11* (5%)	110 10* (-8%)
Northwest	31%	39 6*	60 9* (54%)	51 8* (-15%)

* Indicates rate per 100,000 residents of the respective CoC based on U.S. Census 2010 population counts.

Chronic Homelessness

Table 10 on Page 14 looks specifically at chronic homelessness by rural region. There were differences across regions with the southwest experiencing the greatest increase, followed by the northwest, and then the northeast. The central region saw an overall reduction, but that reduction occurred mostly between 2009 and 2011, with an actual increase between 2011 and 2013. While the southwest saw a fairly dramatic increase, there was a great deal of variation, with a large increase from 2010 to 2011, a fairly substantial decrease between 2011 and 2012, and another dramatic increase between 2012 and 2013. While it too showed an overall increase, the northwest followed a nearly opposite pattern, with its most dramatic increase between 2011 and 2012. The northeast, by comparison, was fairly stable for several years and then saw a dramatic decrease between 2012 and 2013.

Local Data Sets

To better understand differences between locally collected data and statewide data, the researchers compared Bradford County's LHOT data to HMIS data, PiT count data, and Annual Homeless Assessment Report (AHAR) estimates. In looking at every case from HMIS data for Bradford County that involved a service of any kind delivered during the year 2012, the re-

Table 10: Percent Change from Previous Year, Percent Change from 2008-2013, and Rate per 100,000 residents for Chronic Homelessness by Rural Region

	Total Change Since 2008	2009	2010	2011	2012	2013
Rural Homeless Total	66%	233 5* (2%)	224 5* (-4%)	245 5* (9%)	223 5* (-9%)	378 8* (70%)
Central	-4%	88 5* (10%)	83 5* (-6%)	49 3* (-41%)	57 3* (16%)	77 4* (35%)
Northeast	74%	57 4* (-21%)	48 4* (-16%)	48 4* (0%)	48 4* (0%)	125 9* (160%)
Southwest	149%	60 6* (28%)	64 6* (7%)	112 10* (75%)	65 6* (-42%)	117 11* (80%)
Northwest	103%	28 4* (-3%)	29 4* (4%)	36 5* (24%)	53 8* (47%)	59 9* (11%)

* Indicates rate per 100,000 residents of the respective CoC based on U.S. Census 2010 population counts.

search identified 15 cases. The PiT count for the entire 12-county northeast CoC identified 747 homeless on January 25, 2012, with just one individual from Bradford County. AHAR uses HMIS data to develop estimates of homelessness each year, using a formula that takes into account known available beds that are not entered into the HMIS system to develop estimates of the total homeless population for the year. For 2012, AHAR estimated 2,617 homeless in the 12-county northeast CoC. In 2012, Bradford County's 62,792 residents accounted for about 5 percent of the total northeast CoC population of 1,326,884. Therefore, the researchers estimated that the total number of homelessness should be about 5 percent of AHAR's 2,617 homeless estimate, which would be 131 people. The LHOT collected data on requests for services in Bradford County in 2012 and counted 324 total individuals for that year (See Table 11).

The Columbia/Montour Homelessness Taskforce collected data on requests for services between July 1 and September 6, 2013 in Columbia County. The taskforce identified 93 individuals who requested services related to homelessness in just over 2 months. The HMIS database did not include data from Columbia County for 2013, meaning that AHAR data would not be useful since it had no Columbia County baseline for estimates. The PiT count for the entire central region for 2013 was 1,174, with 35 of those individuals being counted in Columbia County.

These comparisons suggest that the homeless in at least these two rural counties were being significantly undercounted in statewide data collection efforts. More data on these counties, as well as other rural counties, using methodologies that involve a wider range of service providers and more general participation by service providers is needed. Such an undercount suggests that the need for services within these counties is underestimated and that data on the unique needs within these counties are urgently needed.

Table 11: Estimates and Counts of Homeless by Data Source for Bradford County, PA in 2012

Data Source	Estimate or Count
HMIS for 2012	15 individuals
Point in Time Count for January 25, 2012	1 individual
AHAR Estimate	131 individuals
LHOT Data	324 individuals

Table 12: Organizational Focus and Geographic Areas, Number of Respondents, and Percent of Respondents From Each Category[1]

Focus Area of Organization	Rural	Urban	Statewide	Percent of Respondents
Human Services	41	29	5	38%
Housing Programs	25	21	6	27%
Homeless Shelters	15	15	4	17%
General Healthcare	17	11	3	16%
Education	10	14	3	14%
Mental Health	12	11	2	13%
Faith Based Programs	6	8	4	9%
Hunger Prevention	6	7	2	8%
Law Enforcement	4	8	1	7%
Veteran Services	7	4	1	6%
Alcohol and Drug Treatment	2	6	1	5%

1. Many respondents were involved with work in more than one focus category, so the percentages do not total 100%. Respondents were categorized as urban or rural based on their organization's primary service area.

Summary of Analysis of Existing Data

This analysis shows a clear difference between urban and rural areas and an increase in the number of homeless counted in rural areas. Unsheltered homeless, homeless individuals, and homeless veterans are the groups that have seen the greatest increase.

The rural homeless tended to have high rates of general health, mental health and

disability concerns. The rural homeless represented here also received prevention and nonresidential interventions services frequently as opposed to housing. While there does not appear to be a strong relationship between homelessness and unemployment, the researchers suggest a need for more analysis in this area. There are regional differences between the rural parts of the state both overall and in regard to rates of homelessness among veterans and the chronically homelessness. Dramatic differences in the number of homeless counted or estimated by different datasets suggest that significant deficits in existing data exist and must be addressed.

Survey of Professionals

Survey responses were received from 220 professionals who encounter the homeless in their professional roles. Of these respondents, 58 percent serve urban areas and 42 percent serve rural areas. These respondents also represent a range of organizations with different focus areas (See Table 12).

The survey began with a series of questions about the demographic characteristics of the homeless the respondents typically encountered. Respondents were asked to estimate the percentage (0-20 percent, 21-40 percent, 41-60 percent, 61-80 percent, 81-100 percent) of their clients that fell into each of the demographic categories. Urban and rural respondents reported similar numbers of male and female homeless and the most common family types they encountered as single adults or single parents with children. The only demographic area in which there was a difference between urban and rural was in regard to age, with rural respondents encountering a slightly wider range of ages than urban respondents. The difference was not statistically significant.

The next set of questions focused on reasons for homelessness. Both rural (86 percent) and urban (85 percent) respondents overwhelmingly agreed that lack of affordable housing was a moderate to major cause of homelessness. Increases in the cost of rental housing were cited by both groups, with slightly more urban respondents (83 percent) than rural respondents (77 percent) citing this as a moderate to major cause of homelessness.

Lack of available jobs was another cause of homelessness cited by both rural and urban respondents with slightly more urban respondents (87 percent) than rural respondents (82 percent) citing this as a moderate to major cause. The difference was not statistically significant.

Interestingly, slightly more rural respondents (90 percent) that urban respondents (85 percent) cited the lack of job skills as a moderate to major cause of homelessness. The difference was not statistically significant.

There was a statistically significant difference between rural and urban respondents (90 percent vs. 68 percent, respectively) in regard to the challenges of finding transportation to work as a moderate to major cause of homelessness.

There is a statistically significant difference between rural and urban respondents (75 percent vs. 58 percent, respectively) in their perception of financial literacy as a moderate to major cause of homelessness. However, the two groups did not differ significantly in their perception of the lack of job skills as a moderate to major cause of homelessness (90 percent rural vs. 85 percent urban respondents).

There were no statistically significant differences between the experiences of rural and urban respondents in regard to health as a cause of homelessness, with both groups reporting mental health disorders (82 percent rural and 89 percent urban) and drug and alcohol problems (86 percent rural and 88 percent urban) as moderate to major causes of homelessness. Physical health problems were rated by both groups as minor or moderate causes of homelessness (82 percent rural and 79 percent urban).

Both rural and urban respondents rated family issues as slightly less salient than housing, employment, and health issues. However, 83 percent of urban respondents cited family breakdown as a moderate to major cause of homelessness compared to 71 percent of rural respondents. The difference was not statistically significant.

Another area of interest was where the homeless were currently living. Both urban and rural respondents most commonly encountered the homeless who were staying with friends or family. About 50 percent of both the urban and rural respondents reported that 41 percent to 100 percent of their clients were living with family or friends. This is interesting given that these “doubled up” people would not be classified as homeless by many definitions. Conversely, relatively few rural or urban respondents reported encountering large numbers of homeless living on the streets. Of the rural respondents, only 17 percent found that 41 percent to 100 percent of their clients were actually living on the streets compared to only 19 percent of urban respondents. Respondents in rural areas were more likely than their urban counterparts to have encountered the homeless

Table 13: Level of Intervention Needed by Typical Clients by Rural/Urban

		0-40%	41-60%	61-100%
Rural	Long-term intervention	49%	16%	35%
	Large-scale intervention	35%	21%	44%
	Short-term intervention	70%	19%	10%
	Small-scale intervention	77%	16%	9%
Urban	Long-term intervention	46%	20%	34%
	Large-scale intervention	47%	15%	39%
	Short-term intervention	78%	17%	5%
	Small-scale intervention	72%	20%	8%

living in non-residential structures, with a statistically significant 63 percent of urban respondents saying that less than 20 percent of their clients were living in these settings compared to 48 percent of rural respondents.

Both urban and rural respondents were more likely to report that they typically encountered homeless who they believed were in need of long-term and large-scale interventions as opposed to short-term or small-scale interventions. This suggests that the typical case they encountered could not be solved with a simple housing voucher or loan, but that larger, more involved interventions, such as life skills courses, healthcare, or additional education, were needed.

Table 13 illustrates the level of intervention needed by a typical client. A pattern was defined as typical if the respondent reported that 60 percent or more of their clients followed this pattern.

Another area with a slight, but not statistically significant, difference between rural and urban respondents was in changes they have seen over the past 5 years. The majority of both groups reported an increase in the homeless population in the past 5 years; however, 79 percent of rural respondents reported this increase compared to 67 percent of urban respondents. Both groups attributed the change primarily to changes in the job and housing markets.

In terms of the characteristics of the organizations in which the respondents were involved, the majority (60 percent) of both urban and rural respondent organizations were members of a local, state, or federal homeless coalition.

Twenty-nine percent of respondents said they do not keep records on the homeless. Of the respondents who keep records on the homeless, the majority (75 percent) indicated that their records were accurate or very accurate. Of those that keep records, 41 percent entered data into the HMIS database and 48 percent were involved with their area's PiT count. Many listed internal databases, client files, or other forms of specialized databases as their means of tracking homelessness. However, the diversity of databases cited indicates that organizations are collecting a great deal of data, but not consolidating it into a format that can be used effectively across organizations or locations.

Finally, respondents were asked about the definitions of homelessness used by their own organization and funding sources. Sixteen percent of both rural and urban respondents said their organization does not have a standard definition of homelessness. Of those that do, 12 percent of rural respondents and 8 percent of urban respondents said their definition was too narrow, while 4 percent of rural respondents and 3 percent of urban respondents said their definition was too broad. However, when asked about the definitions used by their funding sources, 42 percent of rural and 50 percent of urban respondents said funding agencies define the problem too narrowly. Only 4 percent of each group indicated that the definitions used by funding agencies were too broad.

When asked specifically about the problems associated with defining homelessness, the respondents said the lack of a shared definition across agencies creates multiple problems, including gaps where clients meet the McKinney Vento definition but do not meet the definitions used by programs and are thus not eligible for services. The most frequently noted challenge was that individuals and families who are "doubled up" do not meet most definitions of homeless, yet these are the people who are not typically in stable housing, need services, and do not qualify for many programs. As discussed in the Introduction, the newer McKinney Vento definition does not include those who are "doubled up," but other state and federal programs recognize this group as homeless.

This survey suggests that service providers in rural and urban areas share many of the same experiences and perceptions, but operate in somewhat different contexts. Rural respondents were more likely to report an increase in homelessness in the past 5 years, which corresponds with and supports the PiT count data, as does their indication of slightly higher rates of mental health and substance abuse problems among their clients.

The concerns surrounding the definitions of homelessness expressed by both rural and urban respondents highlight the challenges of working effectively with inconsistent definitions and definitions that exclude clients who are doubled up when that category of clients is the most commonly encountered group. Finally, as most respondents believe their own organizations keep accurate records and describe such a wide range of record keeping formats and procedures, it emphasizes the massive amount of work going into effective record keeping and also the lost opportunity to analyze large amounts of data because of the wide range of methodologies used.

Homelessness Summits

The two homelessness summits hosted at Bloomsburg University in Columbia County gave the researchers opportunities to talk with a range of professionals about the challenges and opportunities of their work. While the discussions were not centered on rural issues in particular, the majority of professionals at the summits served rural counties and the specific challenges of work in these regions were frequent topics. Invitations for both summits were sent to professionals on the Housing Alliance of Pennsylvania's mailing list as well as to universities, school district leadership, and social service providers in Columbia, Montour, Luzerne, Lycoming, Northumberland, Union, and Snyder counties. Approximately 200 people attended each summit; about half of these were service providers and community members. The other half were faculty, staff, and students from Bloomsburg University. Of the service providers who pre-registered to attend and provided information on their organization, most represented housing authorities, faith-based organizations, human service organizations, healthcare providers, county government, and banks. In 2013 there were representatives from the court system and criminal justice system in attendance, likely due to the inclusion of a specific presentation on prisoner re-entry issues.

In 2012, the summit had a generalist theme and the questions posed to participants were designed to encourage them to talk about their priorities and needs for the coming years. After breaking into smaller groups for discussion, each group reported to the larger group the issues they considered as priorities and these reports were compiled into an overall summary. The three areas of need identified by the group in 2012 were awareness, information gathering, and increased collaboration.

In regard to awareness, the group felt that many groups hold stereotypical views of the homeless that result in a lack of concern about homelessness and less willingness to help the homeless. The relative invisibility of homelessness in rural areas compared to urban areas was noted as a specific problem for many. Similarly, the group felt that there was a need to educate state and national groups about the specific needs of the homeless in rural areas. Finally, the group felt that there was a need to educate the homeless about available programs and to reduce their reluctance to seek services.

The group noted that it needed more information on a variety of topics, specifically the changes associated with the HEARTH Act, the availability of Emergency Solutions Grant Funds and the general availability of grant funds to serve this population. It also needed more information on existing programs and activities within members' respective regions, as this would allow them to more effectively work with clients and identify potential collaborative opportunities. Finally, the group members wanted to better understand the specific characteristics of clients in their communities so that they could refine their programs to better serve specific clients. The members recognized the deficits in existing data in regard to their own communities and wanted to see truly local reports on patterns among the homeless.

Finally, the group identified a need for greater collaboration. In many of the rural communities represented, there were not enough services or a wide enough range of services to meet the needs of all clients. Through better collaboration, the group felt that it could pool resources to better meet client needs, work to identify best practices in rural communities, engage in data collection and analysis to address some of the information needs noted above, and generally improve communication to help identify funding opportunities and housing options.

While systematically tracked outcomes data on the summits are not available, some organizations in attendance have informally reported that they have changed their data collection practices, engaged in more cross-agency and cross-location collaboration and created public relations committees to address the need to raise awareness. The Columbia-Montour Homelessness Taskforce (CMTF) developed a new data collection methodology to collect local homelessness data, and that effort allowed the researchers to analyze that data for this research. The CMTF also helped facilitate a successful regional multi-organization Emergency Solutions Grant that was facilitated by some informa-

tion gathered at the summit. Based on feedback from participants, the summit organizers agreed to make the summit an annual event at which regional professionals can gather to address the needs already identified, assess new needs, and generally engage in network building and maintenance.

The findings from the first summit were used to design the second summit, which was held in October 2013. That summit focused on three specific areas of regional interest: master leasing programs, prisoner re-entry issues, and renter education programs. State and regional speakers who designed and administered effective programs in each of the three target areas presented information on what they had done, how it was working, and what they recommended for other communities. The group then broke into three subgroups, each focused on one of the three issues, to discuss their own work on these issues and to engage in planning for the coming year.

One subgroup discussed master leasing programs. These are programs through which one entity, such as a housing authority, leases one or multiple properties on behalf of clients. These programs provide an incentive to landlords to rent to low-income clients or those with a history of housing problems by inserting a third party, which typically guarantees rent payments or payment for damages. The subgroup focused on the challenges surrounding funding that did not correspond with the actual costs of available housing in the region, concern about seemingly imminent funding cuts, landlord reluctance to get involved in these programs, lack of awareness surrounding homelessness in rural communities, and incomplete data on rural homelessness. In regard to data, some felt that conducting the PiT count during cold weather makes it harder to identify the rural homeless as more are doubled up and hard to identify during cold weather. The group discussed a regional symposium to further explore this issue, potential new funding streams, efforts to educate more landlords about the leasing program, and possible new data collection strategies including a warm weather PiT count.

The prisoner re-entry group identified funding shortfalls that limit the number of clients it can serve and that create years-long waiting lists for assistance, the need for better collaboration across the many services needed by many returning prisoners, and the availability of jobs and transportation. Most of the solutions identified were tied to the Department of Corrections' plans to expand the availability of halfway houses and training for its personnel in reentry issues and better collaboration between justice and housing agencies.

The renter education group noted that the diversity of needs among clients made it challenging to design effective one-size-fits-all programming. Requiring clients to participate in large long-term programs reduces participation in programs and is not an effective use of client or administrator time. However, there are not enough clients in many small communities with any one need to create a large group, and having instructors teach many different courses to very small groups of clients is not an effective use of resources. A potential solution discussed was collaboration across agencies where specialized courses could be offered and clients in need of that course could be gathered from the clientele of multiple agencies. However, many funding sources do not currently allow for such cross institution collaboration. Another solution discussed was designing overall programs but allowing clients to participate in only the parts that meet their specific needs. The group agreed that further discussion and resource sharing were needed.

These summits confirmed the data weaknesses identified in other analyses and also corroborated evidence suggested by literature on rural homelessness that points to problems surrounding the lack of awareness about homelessness and challenges associated with service delivery in rural areas. They suggested that increased dialogue among service providers is desired by many providers and a productive way to develop realistic solutions that address the specific challenges associated with specific communities.

CONCLUSIONS and CONSIDERATIONS

The research indicated that there are important differences in homelessness in rural and urban areas. Rates of homelessness in all categories have increased in rural areas compared to 5 years ago and at greater rates than in urban areas. These increases are most dramatic for the unsheltered homeless, individuals who are homeless, and homeless veterans. Professionals who work with the homeless in rural areas corroborated the research findings in describing their own experiences. These patterns vary in different regions of the state.

The research also indicated that many rural homeless have general health problems, mental health issues, drug and alcohol addiction, and disabilities. In addition, the rural homeless, and the professionals who serve them, must cope with a lack of transportation in rural areas and geographically dispersed employment oppor-

tunities, healthcare providers, and social services. These challenges are compounded by the relative invisibility of rural homelessness, the lack of data on the rural homeless, and the lack of understanding of the unique patterns of rural homelessness among funding agencies, state-level programs, and policymakers.

These data also suggest that the rural homeless are frequently offered services that focus on prevention or services but not housing. It is important to develop a better understanding of whether this pattern is due to the actual needs of the rural homeless or due to challenges in finding housing for the homeless.

The comparison of different data sources suggested a potentially dramatic undercount of the homeless. Since individuals who are doubled up are included in some definitions and not in others, it is likely that this accounts for some of the difference. More research is necessary to confirm and address this issue.

Information gathered at the homelessness summits suggested that increasing dialogue between service providers at the regional and local levels is an effective means of identifying models, refining existing programs, identifying and troubleshooting gaps in services, encouraging innovation and tailoring services to the specific communities in which they operate. However, to maximize the impact of such dialogue, these local and regional discussions should have some means of hearing and being heard by state level agencies, such as the Department of Community and Economic Development, the Department of Education, and the Department of Veteran's Affairs as well as policymakers.

Following are policy considerations based on the research findings.

Develop a Standard Definition of Homelessness that Includes Those Who are Doubled Up

A clear, shared definition of homelessness would simplify data collection, service delivery, and discussions. This definition should in some way include and account for individuals who are living with friends or family in a doubled up situation, as this is an extremely common pattern of homelessness in rural areas. Using the complex but thorough definitions provided within the McKinney Vento Act, with the addition of a provision for the inclusion of doubled up individuals, is a logical choice as it would keep Pennsylvania data compatible with federal data and allow service providers who collect data for both state and federal programs to use one definition.

If the major agencies who compile and manage data, including the Department of Community and Economic Development, Department of Education, and Department of Veterans Affairs could agree to core methodological practices, they could conserve resources and produce higher quality data. Simply developing and agreeing to use a shared definition of terms, such as "homeless," "at risk of homelessness," and "service," would allow for analyses that cross datasets.

Consolidate State-Level Data Collection Under One Methodology and HMIS

Consolidating state-level data collection under one shared methodology and HMIS would have greater benefits. Most groups who gather data on the homeless collect the same core set of data including location, age, sex, income, health, disability, veteran status, length of time homeless, and reasons for homelessness. If agencies that require data collection all used the same basic methodology, definitions, and HMIS, those collecting the data could enter the core data one time, into one system, to fulfill the requirements of multiple agencies at once. The data entry system could be set to ask additional questions based on the characteristics of the client being described. For example, people entering data from a school, food bank, and VA hospital would all be logging in to the same system and entering roughly the same data for each client; however, when the system recognizes that a client is at a VA hospital, it would prompt additional questions about the client's military record. Such a shared data system would reduce the burden of data entry on service providers by requiring only one data entry process that fulfills multiple requirements, thereby saving time and increasing compliance and data quality. This coordination could also reduce costs as one shared HMIS system would reduce duplication of staffing and technology at the state level. Finally, using a standard methodology would allow analyses that include larger quantities of data.

Increase Dialogue Between Data Collection Organizations and Those Serving the Homeless

Another important step in improving understanding of rural homelessness is to increase dialogue between those collecting data on homelessness, such as government agencies and researchers, and those who directly serve homeless populations. The information collected is only useful, and worth the expenditure of resources,

if it is a true reflection of reality. This involves using standard definitions and ensuring that all involved understand why the data are being collected and how they will be used. If analysts do not understand the context in which data are collected, and those collecting the data do not understand what the data will be used for, there is great potential for misinterpretation.

Educate Service Providers About the Value of High Quality Data

It is clear that many service providers do not enter data on their clients into available databases. Educating service providers about the value of doing so, and making it easier for them to do so, is another important step in improving data quality. The agencies that require data collection have the most incentive to obtain better data, are in contact with those who collect data, and can alter data collection and entry regulations, so they should spearhead education and innovation efforts. Collecting data as a client is initially entering a program works well for some settings, but might lead to less accurate data in settings where the client is fatigued or in shock. It is therefore worthwhile to work with service providers to identify the best times to collect data and to revise requirements for those settings. There is a great deal of "missing data" in the datasets, meaning that some, but not all, of the questions about the client were answered. This indicates a need to work with service providers to find out why these questions are not often answered and to revise methodologies accordingly. For example, data are often collected at the beginning of a program because an intake interview is part of the program requirements. However, there are often no data collected as clients exit a program because many leave before the program ends. Even those who do complete a program often have no incentive to sit for an exit interview. Collecting interim data on clients is one partial solution, as is building incentives to complete exit interviews into programs.

Develop Data Collection Strategies Specifically Designed for Rural Areas

The above suggestions focus on improving overall data quality that will help increase understanding of homelessness in all regions of the state including rural areas. To address the unique challenges of working with the rural homeless, more specific efforts are necessary. The smaller number of service providers, large geographic areas, and tendency to rely on service provision through private rather than public organizations are difficult challenges to overcome using traditional methods of data collection. Enticing more agencies to enter data into HMIS will improve data quality, but it would still miss the many homeless who do not encounter service providers. Developing a full picture of homelessness in rural Pennsylvania will require a new approach to gathering information.

In 2008, the state of Georgia began using a modified data collection method to document homelessness in its rural counties. It used a combination of the traditional PiT count and collaborations between the Georgia Office of Community Affairs, regional social service providers, a faculty researcher at a local university, and a private consulting firm. Acknowledging the impossibility of getting adequate data on all 152 counties in its more rural CoCs, it used U.S. Census data and statistical modeling techniques to identify clusters of counties that share important demographic characteristics, such as poverty and unemployment rates, average distance traveled to work, and demographics. It then selected one county from each cluster each year and employed an intensive data collection effort that included collaboration with service providers and researchers more directly canvassing the community. The findings on that one county could then be used to produce well-informed models of the likely patterns within the other counties in that cluster. Each year a different county from within each cluster is selected for the more intensive research. Over time, each county is carefully canvassed, and, each year, the new data are used to refine the model for the entire cluster (Georgia Department of Community Affairs, 2009; Priestley and Massey, 2011). In a presentation at a 2010 homelessness conference, the leaders of this innovative effort described the strengths of the project as grounded in knowledge of unique rural problems (Bassett et al., 2010). Applying this model in Pennsylvania would be challenging, but the state could develop its own version of the program.

Develop Ways to Actively Solicit Feedback from Professionals Who Work with the Homeless

One way to work around the challenges of collecting accurate information is to work with professionals who have direct experience with the homeless in their own communities for information on the patterns they see and effective interventions. However, simply asking service providers for general feedback is typically not enough. General requests for feedback or the asser-

tion that there are avenues through which professionals can offer feedback are typically used by only a few people and are often seen as useful only when there is a specific problem. More intentional and specific requests for collaboration are more useful, such as a request for feedback on how the problem should be defined, how data collection efforts can best be integrated into existing organizational practices, and what interventions already work well with specific populations.

Encourage State-Level Interagency Council on Homelessness to Lead Recommendations

Encourage the Statewide Homeless Steering Committee to lead the recommendations listed above. The council should also have the resources necessary to establish a statewide plan that addresses the problems of inconsistent definitions and methodologies.

Examine the Relationship Between Health and Homelessness in Rural Areas

The data on the rural homeless suggest high rates of health problems, particularly mental health and disabilities. It is therefore important to look carefully at healthcare delivery to the rural homeless to determine what role their health problems play in their housing problems. There is seldom a simple causal relationship in these situations. Inadequate or unsafe housing can cause health problems, but health problems can also create financial crises that lead to housing problems. Existing health problems can be made worse by poor housing and even the stress of housing insecurity. It is important to learn more about these relationships and how they function in rural communities.

Examine Reasons for the Rural Focus on Prevention and Service-Only Programs

Examine the reasons why rural clients are likely to use prevention and service-only programs. It is likely that these are the only services available in rural communities. However, services in all communities are often modeled on best practices in urban areas since there is more data available. This can result in less effective interventions in rural areas as the needs of these clients may differ from those in urban areas.

REFERENCES

Bassett, J., S. Charleston and A.D. Williams. (2010) "Rural Homelessness Roundtable" Presentation at the 2010 Homelessness Program Manages Training Conference, Washington, DC, March 16, 2010.

Burt, M.R., Y.A. Laudan, T. Douglas, J. Valente, E. Lee, and B. Iwen. (1999) Homelessness: Programs and the People They Serve. Findings of the National Survey of Homeless Assistance Providers and Clients: Technical Report. Washington, DC: Interagency Council on the Homeless.

First, R.J., J.C. Rife, and B. Toomey. (1994) "Homelessness in Rural Areas: Causes, Patterns, and Trends." Social Work 39: 97-108.

Fitchen, J. (1992) "On the Edge of Homelessness: Rural Poverty and Housing Insecurity." Rural Sociology 57: 173-193.

Georgia Department of Community Affairs. (2009) "2009 Report on Homelessness: Georgia's 21,000." http://www.dca.state.ga.us/housing/specialneeds/programs/documents/HomelessCountReport09web_000.pdf.

"Homeless Emergency Assistance and Rapid Transition to Housing: Defining 'Homeless'." (2011) Federal Register 76 (5 December 2011): 75994-76019.

Housing Assistance Council. (2010) "Housing in Rural America," retrieved September 5, 2012. http://www.ruralhome.org/storage/documents/housingamerica1010.pdf.

Lawrence, M. "Rural Homelessness: A Geography without a Geography," Journal of Rural Studies 11 (1995): 297-307.

(continued on next page)

References (continued)

National Alliance to End Homelessness. (2012) "Changes in the HUD Definition of 'Homeless'," retrieved June 4, 2014. http://www.endhomelessness.org/library/entry/changes-in-the-hud-definition-of-homeless.

Pennsylvania Housing Choices. "Local Housing Opportunities Teams," retrieved June 8, 2014. http://www.pa-housingchoices.org/housing-resources/local-housing-options-teams/.

Patton, L. (1987) The Rural Homeless. Washington, DC: Health Resources and Services Administration.

Pennsylvania Department of Community and Economic Development. "Pennsylvania Continuum of Care (CoC) Distribution," retrieved September 5, 2012. http://www.newpa.com/webfm_send/2344.

Pennsylvania Department of Community and Economic Development. "PA Homeless Management Information System," retrieved June 8, 2014. http://www.newpa.com/community/homeless-programs/pa-hmis.

Pennsylvania Department of Community and Economic Development. "Statewide Homeless Steering Committee," retrieved June 8, 2014. http://www.newpa.com/strengthen-your-community/homeless-programs/steering-committee.

Pennsylvania Department of Education. (2012) "Education for Children and Youth Experiencing Homelessness Program 2011-12 State Evaluation Report," retrieved June 7, 2014. http://homeless.center-school.org/providers/290/2011-12ECYEHStateEvaluationReport.pdf.

Pennsylvania Department of Education Task Force on Homeless Children's Education. (2014) "Meeting the Educational Needs of Pennsylvania's Homeless Children and Youth." http://www.portal.state.pa.us/portal/http;//www.portal.state.pa.us;80/portal/server.pt/gateway/PTARGS_0_123531_1404067_0_0_18/Homeless%20Task%20Force%20FINAL%20Report.pdf.

Pennsylvania Department of Human Services. (2012) "PA Homeless Assistance Program." http://www.dpw.state.pa.us/foradults/homelessassistance/index.htm.

Pennsylvania Department of Human Services. (2012) "PA Homeless Assistance Program," retrieved September 5, 2014, http://www.dpw.state.pa.us/foradults/homelessassistance/index.htm.

Pennsylvania Department of Human Services. "Homeless Assistance Programs" retrieved June 8, 2014. http://www.dpw.state.pa.us/foradults/homelessassistance/index.htm.

Pennsylvania Housing Finance Agency. (2012) "Homeowners Emergency Mortgage Assistance Program," retrieved September 5, 2013. http://www.phfa.org/consumers/homeowners/hemap.aspx.

Perlman, S. and J. Willard. (2012) Cost Analysis of Child Homelessness in Pennsylvania. Report prepared for People's Emergency Center. Philadelphia, PA.

Post, P.A. (2002) "Hard to Reach: Rural Homelessness and Health Care." National Health Care for the Homeless Council. http://www.nhchc.org/wp-content/uploads/2011/10/Rural-Homelessness.pdf.

Priestly, J.L., and J. Massey. (2011) "Counting the Impossible: A Research Note on Using Inferential Statistics to Enumerate Homelessness in Georgia." Journal of Public Management and Social Policy: 85-106.

Skott-Myhre, H., R. Raby, and J. Nikolaou. (2008) "Towards a Delivery System of Services for Rural Homeless Youth: A Literature Review and Case Study." Child and Youth Care Forum 37: 87-102.

Substance Abuse and Mental Health Services Administration. "Co-Occurring and Homeless Activities Branch Frequently Asked Questions", retrieved June 4, 2014, http://homeless.samhsa.gov/Super/Chab/FAQ.aspx.

U.S. Department of Education. "Education for Homeless Children and Youths Grants for State and Local Activities," retrieved June 8, 2014. http://www2.ed.gov/programs/homeless/index.html.

U.S. Department of Health and Human Services. "Homelessness Grants" retrieved June 8, 2014. http://www.hhs.gov/homeless/grants/#targeted.

U.S. Department of Housing and Urban Development. “HMIS Data Standards Manual,” retrieved June 8, 2014. https://www.onecpd.info/resources/documents/HMIS-Data-Standards-Manual.pdf.

U.S. Department of Housing and Urban Development. (2007) “Defining Chronic Homelessness: A Technical Guide for HUD Programs,” retrieved June 27, 2014. https://www.onecpd.info/resources/documents/Defining-ChronicHomeless.pdf.

U.S. Department of Housing and Urban Development. (2012) “Homeless Assistance,” retrieved September 5, 2012. http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless.

U.S. Department of Housing and Urban Development. (2012) “2012 CoC Dashboard Report – PA-509: Allentown/Northeast Pennsylvania CoC,” retrieved June 7, 2014. https://www.onecpd.info/reports/CoC_Dash_CoC_PA-509-2012_PA_2012.pdf.

U.S. Department of Veterans Affairs. (2014) “Department of Veterans Affairs Supportive Services for veteran families Program Guide,” retrieved June 8, 2014. http://www.va.gov/HOMELESS/ssvf/docs/SSVFUniversity/SSVF_Program_Guide_March31_2014.pdf.

U.S. Government Accountability Office. (2010) “Rural Homelessness: Better Collaboration by HHS and HUD Could Improve Delivery of Services in Rural Areas,” retrieved September 5, 2012. http://www.gao.gov/new.items/d10724.pdf.

Williamson, J. and B. Kolb. (2011) “Marcellus Natural Gas Development’s Effect on Housing in Pennsylvania,” Center for the Study of Community and the Economy, retrieved September 5, 2012. http://www.lycoming.edu/politicalScience/pdfs/CSCEMarcellusHousingFinalReport.pdf.

The Center for Rural Pennsylvania
625 Forster St., Room 902
Harrisburg, PA 17120
Phone: (717) 787-9555
Fax: (717) 772-3587
www.rural.palegislature.us
1P0315 – 400