Critical Issues

The following pages describe the issues that were identified during the needs assessment process. Surveys of people living with HIV/AIDS, focus groups of people living with HIV/AIDS, interviews with key informants, and analysis of background data and documents inform this identification of critical issues.

Housing

While all of the critical issues identified in the needs assessment process are related to housing, the issues presented in this section relate directly to the affordability and accessibility of housing to people living with HIV/AIDS in the balance of state. The majority of the issues are not limited to people living with HIV/AIDS. In fact, most of these housing issues are relevant to people with low incomes and disabilities in general. Although these issues may impact the health status of people living with HIV/AIDS differently than others, people living with HIV/AIDS are not the only people affected by these issues.

Market Rate Housing

The housing issues cited most frequently were:

- A lack of affordable housing
- A shortage of rental housing of all types
- Problems with housing quality

Affordable housing is an issue for all low-income people in Oregon. Average rents vary considerably throughout the balance of state, but incomes also vary. As a result, every area can experience **affordability problems**. For example, housing in Union County is much cheaper than Benton County, with the Fair Market Rent (FMR) for a one-bedroom apartment in Union County just 75 percent of the FMR in Benton County.[61] However, in Union County the median income was only 69 percent of that in Benton County.[62] Therefore, housing affordability is still a concern for many residents, even where housing costs are cheaper. For people relying on SSI, as many people living with HIV/AIDS do, housing is even less affordable; the FMR for a studio apartment is equivalent to 73 percent of the maximum monthly payment.[63]

People living with HIV/AIDS who completed the Oregon HIV/AIDS housing survey reported paying a median of $300 per month for rent and a median of $95 for utilities. This meant that half of respondents were paying more and half were paying less in each of these categories. AIDS Housing of Washington calculated the percentage of survey respondents' income going to housing costs using the income and expense data reported by respondents. The U.S. Department of Housing and

---

[61] In 2001, the FMR for a one-bedroom apartment in Union was $373, while it was $499 in Benton County.
[62] In 2001, the median income in Union County was $38,900, and $55,700 in Benton County.
[63] Based on a maximum monthly SSI payment for a single adult living alone ($530 per month in 2001) and the statewide estimated FMR of $389 for a studio apartment in 2001.

Urban Development considers people who are paying more than half of their income toward housing costs to be "severely rent burdened." Thirty-six percent of survey respondents were paying more than half of their monthly income for housing, and can therefore be considered severely rent burdened.

Some areas have a **shortage of rental housing** at any price due to the high demand for existing housing. In some areas, specific types of units—such as those that are accessible to people with disabilities or can accommodate larger families—are in particularly short supply. Key informants in southern and central Oregon (Medford and Bend) reported that in-migration is changing the demographics of many communities, and increasing the demand for existing housing and services.

Many key informants identified **housing quality** as a concern for people living with HIV/AIDS. Often the housing that is more affordable for people with low incomes is older and/or poorly maintained. In some areas, people are living in housing that was not originally intended for year-round habitation, including housing built for farm workers or coastal summer vacationers. Quality problems have hidden costs, such as higher utility bills or health impacts from inadequate heating or cooling or air quality problems.

In more urban areas, including parts of Lane County, affordable housing tends to be in areas with drug and crime problems. Neighborhoods with considerable drug activity pose particular challenges for people trying to address their substance use issues.

Nonprofit and Other Subsidized Housing Resources

A variety of issues related to housing resources were identified, with some variation by region. People in need of permanent housing assistance often spend time on a waiting list, but have few options while they are waiting. Other people need housing assistance at transitional times in their lives, such as upon release from prison, treatment, or the hospital.

In most of the balance of state, **transitional housing and shelter options are very limited**, particularly when compared to the Portland metropolitan area. In some places, camping represents that end of the housing continuum, with the assistance available being camping equipment. However, few sources of funding are available to create new shelters. In addition, lower population numbers and fewer local funds make it unlikely that smaller cities and towns will have many emergency shelters or transitional housing programs. And in one Eastern Oregon town, individuals must pay a fee to access the only emergency shelter in the community, limiting access for those with no funds. For these reasons, access to and affordability of permanent housing are particularly important.

In many communities, housing authorities are a primary source of permanent housing resources, including public housing and the Section 8 program. Housing authority **waiting lists are often long**, and people may not have any options for assistance while they wait. In more competitive housing markets, such as Bend, **Section 8 vouchers can be difficult to use**, because landlords may not accept Section 8, vacancy rates are low, and available housing can be too costly for program limits.

Communities that have few housing resources available often prioritize the populations traditionally considered the most vulnerable—women and families with children. While the housing needs of

these segments of the population are undeniable, the result is that it can be difficult for a single man to access housing assistance.

A key informant involved with public housing indicated that their Section 8 local preferences had already been adjusted to prioritize certain vulnerable populations, and that these preferences could potentially be adjusted again if another population (such as people living with HIV/AIDS) emerged in need in that community.

In addition to housing authorities and the Section 8 program, Oregon has a **strong network of affordable housing developers** and related consultants who are working to develop affordable housing in all areas of the state. Although some areas are served by more or larger organizations than others, all key informants reported that statewide coverage by affordable housing developers was strong. In addition, Tribal Housing Authorities work to meet a range of housing needs for tribal members from very low-income rental housing to homeownership, both on and off tribal land.

Housing developers and service providers are working together in most areas of the state, and there is growing expertise about and capacity to develop special needs housing, even in smaller towns. Oregon Housing and Community Services (OHCS) promotes these linkages by requiring a resident services plan from applicants, emphasizing the importance of appropriate services.

It is **difficult for developers to assemble adequate financing**, particularly operating and service dollars, to develop a service-enriched project for extremely low-income people, and there is a lot of competition for the funding available. For example, OHCS was able to fund 13 projects out of 22 applications in the spring 2001 funding round.

Key informants report that **service providers don't always have an understanding of the complexity of housing development and operation**. For example, a service provider may attempt to acquire a housing facility without a thorough appreciation of what is involved or their capacity to undertake such a project.

Most key informants working in housing development indicated that they would be willing to consider **working with an AIDS service organization (ASO)**. In part, developers are looking for ways to improve the competitiveness of their applications for funding. Developers indicated that they would look for a clear sense from the ASO about the population to be served, what their housing needs are, and what the ASO can contribute to the project. Developers also indicated they would look for an on-going commitment from the ASO to provide services to residents. A developer advised service providers to "be aggressive about approaching us."

Finally, **confidentiality related to HIV/AIDS** was a concern raised by some key informants and consumers in relation to landlords and neighbors, particularly in relation to housing units dedicated to people living with HIV/AIDS. Most people initially think of "AIDS housing" as a facility completely dedicated to people living with HIV/AIDS; in practice, many facility-based AIDS housing models blend units for people living with HIV/AIDS into a larger facility for a mixed population.

Typically, the more rural the community, the more housing and service providers felt that people living with HIV/AIDS would be uncomfortable in such a facility, or that it would not be safe to live in dedicated housing. A service provider in a rural county indicated that such a facility could only work if it were in a confidential location, similar to a domestic violence shelter. At the same time,

other service providers interviewed thought a dedicated facility would be an appropriate option for a segment of the population.

When asked to compare living in a building solely for people living with HIV/AIDS to living in a building with a mixed population, the majority of survey respondents—77 percent—indicated that they would prefer living in a building that includes units for a mixed population. At the same time, nearly a quarter—23 percent—indicated that they would prefer a dedicated facility to mixed housing.[64]

Currently, the only dedicated HIV/AIDS housing in the balance of state is operated by On Track, Inc. in Medford. It includes a shared living and a more independent component, and reports good relationships with the neighbors and continuing full occupancy.

Barriers to Obtaining and Maintaining Housing

Although the affordability and availability of housing are primary concerns, people experience other barriers to getting into housing and staying in it. Many of these issues are not specific to people living with HIV/AIDS—other people experience them too—but these issues are increasingly affecting the lives of people living with HIV/AIDS.

The first is related to affordability; assembling enough **money for a deposit** can be a barrier for people with low incomes. Someone might have a Section 8 voucher or enough income to afford the rent in a particular apartment, but the deposit is an additional challenge. The availability of move-in assistance varies greatly, with some areas having no source of assistance. Thirty-nine percent of respondents reported that they had had trouble obtaining housing because they did not have enough money for the security deposit, and first and last months rent.

Other barriers to obtaining housing include **poor credit, a poor rental history, prior evictions, and/or criminal background**. Credit problems are not uncommon among people with low incomes, and were indicated as having been a housing issue for about a third (34 percent) of survey respondents. Many people living with HIV/AIDS have substance use issues, and people with substance use issues frequently have a related criminal background. Most property managers and management companies, ranging from private landlords to non-profit housing providers and housing authorities, screen out people who have any criminal offenses in their recent history. Some will screen out people who have ever had a conviction. Nine percent of survey respondents indicated that they had been discriminated against in trying to obtain housing due to their criminal history or prison record, and 40 percent reported a history of incarceration.[65]

Property managers use these screening criteria to reduce the risk that the property will be damaged and rents will go unpaid. This is particularly likely to be the case in tight housing markets, such as Bend's, where property owners and managers can more afford to be selective. In addition, some

---

[64] Please see the "Consumer Input" section for more complete information on this topic.

[65] Several areas of the state are offering renter readiness programs, such as the Second Chance Renter's program, that educate people about their rights and responsibilities as renters. For those who complete a series of classes, there is a fund that will guarantee for any damages that this person incurs in their next rental. Agencies offering these programs report that landlords have been willing to rent to graduates of this program to whom they would not have otherwise, largely due to the guarantee fund. Because of the education provided and the commitment required of participants to complete the program, agencies report that the guarantee funds have been tapped in extremely rare cases.

property managers may have concerns about the liability of housing someone with a criminal history, who they have reason to believe may be more likely to engage in future criminal activity.

Undocumented immigrants may also face barriers to accessing housing. In particular, undocumented immigrants are ineligible for some federally funded housing programs. In addition to language and cultural barriers, undocumented immigrants may also experience fear of the government and government agencies, as well as a sense of powerlessness, which prevent them from seeking assistance.

Finally, a number of service providers identified pets as a concern. Some people living with HIV/AIDS have pets that are very important in their lives, but property managers are often reluctant or unwilling to accept pets in rental units. Sometimes doctors will qualify pets as companion animals for people living with HIV/AIDS, which enables people to rent housing with their pet. However, even when a person is able to rent an apartment with their pet, there may be associated deposits and fees that may make the apartment or house unaffordable.

Support Services

People living with HIV/AIDS may be in need of, or already accessing, support services through a variety of systems. Most support service issues identified were in the areas of HIV/AIDS services, mental health, substance use treatment, and transportation. In some areas, such as Bend, all service systems are under pressure due to rapid population growth. Additional support service issues follow in the "Coordination of Multiple Systems" section.

HIV/AIDS Services

One concern mentioned about HIV/AIDS services was that **consumers may not be aware** of all the services that are available, partially because information and referral services are inconsistent. As a result, people may not learn of resources until experiencing a crisis that might have been avoided. Key informants point out that the service delivery is often geared toward crisis intervention because the growing number of people in need and the limited amount of resource mean that fully preventative financial assistance is not possible. Providing more outreach and information to people living with HIV/AIDS will be helpful, but it is also important for the system to plan for how limited resources will meet expanding demand.

Several key informants expressed concern that the level of HIV/AIDS services or outreach provided to **Latinos** is inadequate. Latino immigrants, in particular, may have concerns about accessing health care through the government. A provider also mentioned the difficulty of attracting highly qualified staff—bilingual, bicultural, educated, and credentialed—particularly to live and work in a poor rural county. A key informant commented that it is incumbent on service providers to reach out to the Latino community, rather than wait for consumers to fit into provider expectations. Community-based Latino organizations are likely to be focused on issues other than HIV/AIDS but can be a starting place for outreach.

HIV/AIDS service providers report seeing an increase in service requests from **people who are more than 50 years old** and who have known they were infected for long periods of time. In particular, providers report that people who have been living with HIV/AIDS for years are

increasingly experiencing depression and having difficulties maintaining the emotional, medical, and financial balances they have worked to maintain for long periods.

Service providers and consumers reported challenges related to the **Oregon Health Plan**. People in service jobs that pay $8 or $9 an hour may make too much to be eligible for OHP, but typically do not have private insurance and cannot afford to pay for health care. At the same time, the Oregon Health Plan is a vital resource for many people living with HIV/AIDS. Fifty-three percent of survey respondents indicated they were enrolled in the Oregon Health Plan, and many focus group participants mentioned its importance. Some focus group participants and survey respondents commented that they would like to increase their income from work but cannot afford to become ineligible for the Oregon Health Plan. Similarly, a recent study in Multnomah County found that people living with HIV/AIDS who were out of medical care frequently cited a lack of medical benefits as a barrier.

Mental Health and Substance Use Treatment

Most key informants reported good **access to mental health and substance use treatment** in their areas, with coordination of services ranging from referral networks to program-level integration. Coordination may be simpler where the county is the primary provider of HIV/AIDS, mental health, and substance use treatment services. An example of connections between systems is in Deschutes County, where there is an initiative to integrate mental health services into other health services, including HIV/AIDS services. There, the HIV/AIDS program, mental health services, and substance use treatment are all located under one roof.

Many key informants mentioned **people with dual diagnoses**—mental illness and substance use issues—as a population of concern. Nationally, people who have both mental illness and substance use issues are considered to be at higher risk for becoming infected.

Oregon recently completed a planning process focusing on identifying the needs of people with multiple diagnoses and how these could be met, but there are still gaps in services and housing. Even though there are people who would benefit from services in both the mental health and substance use treatment systems, there are cultural and philosophical differences between the systems that make bridging the gaps challenging. Where the expectations and requirements of the 2 systems are disconnected, people can fall between the cracks.

Most resources for **people with substance use issues** require participation in treatment. Oxford Houses are an excellent resource for people in recovery and are spread throughout the state. However, people who have substance use issues but are uninterested in treatment have few options. Some service providers thought that a "wet" housing[66] option could be helpful for some consumers, but in general service providers view this option with skepticism. The 2 areas of concern most frequently cited by providers were finding the capacity to develop and operate such a program and its efficacy as a treatment model. People with substance use issues are also more likely to have a criminal history, which is often an additional barrier to accessing housing and housing assistance.

[66] Meaning housing that incorporates some level of tolerance related to drug and alcohol use by residents.

Key informants reported that the HIV/AIDS service system is not as connected as it could be with **mental health services**. HIV/AIDS service providers are typically challenged by serving people with serious untreated mental health problems.

Ex-Offenders

Key informants reported that discharge planning for **people leaving prison** is inconsistent, and that having more prison discharge planners would be helpful. People being released from jail or prison, without family or friends to help them, may not have anywhere to go. People leaving prison may be provided with a 30-day or shorter motel stay, but are unlikely to have found a job and saved enough to get into an apartment at the end of 30 days. Most affordable options take longer to get into, and people with a criminal background may be screened out. In the case of jail stays—much shorter than prison sentences—prisoners are less likely to access any HIV-related care or to have assistance at discharge.

Ex-offenders may be sanctioned, i.e. locked up for 10 days, for violating conditions of their parole or probation (for example, if they fail a urinalysis). The result is that they lose their job and their housing, and are back to the beginning. Parole officers often have some discretion over the sanctions. Engaging parole officers in planning and services might help ex-offenders transition more successfully.

Finally, as discussed in the section called "Barriers to Obtaining and Maintaining Housing" above, a criminal background is often a barrier to accessing market-rate housing and housing assistance for years afterward. In some communities, incarceration at any point in a person's past, regardless of how long ago, makes a person ineligible for housing assistance.

Transportation

Transportation is a concern for all low-income people in rural areas. At times, people need to choose between having housing or a car, due to the expenses involved. In most instances, people will choose their car because they can both sleep in it and drive it. Affordable housing tends to be in more remote areas that are less accessible by public transportation. Even service providers report that their budgets can't cover the mileage it takes to get service providers out to people in need in more rural communities.

Reimbursement or funds for transportation to and from medical appointments, which is critical for many people, is often available. However, a key informant pointed out that transportation strategies were often designed for single people, and may not be as effective for people with children. Many areas have assistance available for other types of trips, such as social service van rides and volunteer transportation.

The access to, and cost of, transportation directly affects housing choices for consumers in most areas. Housing in more convenient locations is typically more expensive; more affordable housing typically has less access to transportation and services, and carries hidden costs of transportation.

Coordination of Multiple Systems

Most key informants described some instances where the various systems serving people living with HIV/AIDS do not work together, but also described efforts underway to improve coordination. **Systems integration** is clearly a priority in Oregon, and planning processes often include multiple systems. At least at a conceptual level, systems are interested in working together more closely.

However, some key informants report that systems are talking more about collaboration than they are actually doing at this point. In particular, they cite the **segmentation of eligible activities and populations to be served through particular fund sources**. There still is no truly inclusive cross-systems planning process or funding stream. Having numerous multiple-system planning processes gives an appearance of coordination, but may not result in the provision of more coordinated services.

Housing and service providers are generally well connected in much of the state. Many housing and service providers are at least acquainted, if not already working together. Relationships have varying degrees of formality. For instance, service providers may be acquainted with staff at the local housing authority, to whom they can make referrals, or they may have planned and manage a project together.

In multiple areas, key informants reported that **HIV/AIDS service providers** are not participating in housing and homelessness planning efforts to the extent that providers in other systems, such as mental health and substance use treatment, are. As a result, HIV/AIDS issues are often not part of the dialogue.

Oregon's counties have substantial autonomy in deciding which social and health services will be delivered, and how. Some nonprofit service providers outside of HIV/AIDS services reported challenges in **coordinating with counties**, due to the amount of discretion that counties have over providing services and accessing state funding. Because community-based organizations may compete with counties for funding, in some places there is a sense that county governments may not have an interest in supporting the activities of nonprofit organizations.

Moving To and Traveling To Metropolitan Areas

The Steering Committee identified movement in and out of the Portland metropolitan area as an issue of interest. Key informants generally **did not perceive migration to Portland as common or a topic of concern**, although many could cite examples of people who had moved. Service providers described a small, transient segment of the population that moved from place to place, not necessarily to or from urban areas. Service providers in smaller cities, including Eugene and Bend, were more likely to cite examples of consumers moving *into*, rather than *out of*, those areas.

Many people, regardless of HIV status, move to Portland from the balance of state for **employment and services opportunities**. This has always been true of metropolitan areas and continues at a steady rate. When service providers described a few consumers who had moved to the Portland area, they typically attributed the move to a desire for a **different cultural setting**, such as a more open gay community.

In an extremely limited number of cases, case managers reported having recommended certain individuals leave the area because the **specialized services** they needed—such as inpatient drug and alcohol treatment, hospice care, and daytime care—were not available. Case managers could recall individual cases from prior years that fell into this category; it did not appear to be common or a trend.

Service providers reported that some rural people resent the suggestion that they go to a more urban area, even a relatively small town, to access employment or services, because they **want to stay in their rural homes**. The challenge of competing in an urban job market, with higher expectations for education and skills, may keep some in rural areas. Similarly, focus group participants were asked if they had thought about moving to a larger city, and their opinion of this option. Most indicated that they felt they were at home and did not wish to leave. A number mentioned that they did not really need the services that one could access in an urban area.

It appears to be more common for people to **travel to metropolitan areas**—such as Eugene, Portland, Seattle, and San Francisco—in order to access specialized HIV/AIDS care than to move, even though travel can be difficult and rural consumers report cultural differences with urban providers. For example, a focus group participant reported taking the bus from eastern Oregon to Eugene—an 18-hour bus ride—twice a year for HIV/AIDS care. Service providers describe people who travel to access care as having more financial stability and a higher level of functioning.

Eastern Oregon and other Rural Communities

Many of the issues listed above apply to communities all over the state. There are additional issues that apply primarily to more rural communities, in eastern Oregon and other parts of the state. Generally, **shelter and transitional housing opportunities** are very limited in these areas, if available at all. People with no other options typically double up with friends or family.

Additionally, the population of rural communities tends to be **more conservative**. This affects the willingness of consumers to access needed services, the ability of service providers to provide services, and the openness of communities to addressing issues directly. For example, men who have sex with men and people who are living with HIV/AIDS stay fairly closeted because of the stigma. As a provider stated, "If you are gay, you are not openly so." As a result, it can be difficult for health care providers to know a lot about consumers' lives and needs, because they may be very private. A desire for privacy and confidentiality related to HIV status can be a barrier to accessing resources even if they are available.

The stigma associated with HIV/AIDS can lead to a **sense of denial** in communities, a sense that HIV/AIDS is not an issue in a community. Small numbers of affected people may also be a factor in the lack of awareness. However, although the numbers may be small compared to the entire population, cases of HIV/AIDS have been reported in 28 of the 31 counties in the balance of state.

Many key informants stated that people who live in rural areas tend to value their **independence and privacy**. Culturally, people avoid seeking assistance from others, and particularly the public sector, until it is unavoidable, either because of a crisis or court order (such as with substance use treatment). People who are very reluctant to seek services are easily turned off by inappropriate or insensitive service providers. Willingness to access services is often determined by word of mouth, to a greater extent in more rural communities than in urban communities. If a provider has a good

reputation and is known to be reliable through the personal experience of others, people will tend to access services too.

Outreach and services to the growing Latino population, described above in the section called "HIV/AIDS Services," were repeatedly identified as a concern in eastern Oregon.

Health care providers in rural communities have challenges that differ from those in urban areas. First, key informants from health departments in more rural counties, particularly in eastern Oregon, reported that people living with HIV/AIDS make up such a **small portion of their clients** that issues related to HIV/AIDS do not have a high profile, either at the health department or in the community. Although these health departments have access to Ryan White funds, they report challenges in using a specialized resource to serve a very small number of people.

Second, key informants report that the further out from metropolitan areas, the more challenging it is to **maintain up-to-date knowledge of the resources** that are available for people living with HIV/AIDS, and the issues of concern in other areas. For people in eastern Oregon, Boise is a more relevant reference point than Portland. As a service provider put it, "Portland might as well be a foreign country."

Third, community-based HIV/AIDS service organizations are very difficult to operate on a continuing basis, due to the small amount of operating funds available, and the relatively lower concentration of people in need of services. Although these organizations have and do exist in areas around the state, these organizations are dependent on the dedication of volunteers and typically have **limited or inconsistent capacity**.