CHRONIC HOMELESSNESS

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How has our understanding of chronic homelessness evolved?

Early perceptions of homelessness

Today, we understand homelessness in America as primarily a crisis that happens to people with poverty level incomes, which most individuals and families are able to resolve after a single shelter stay. However, this understanding is relatively recent. Early perceptions characterized homelessness as a permanent attribute rather than a temporary status. What we now recognize as a marker of chronic homelessness—long-term or repeated episodes of homelessness—was viewed as the norm, and the result of lifestyle preferences and a lifelong retreat from traditional social ties. That dominant perception, a holdover from the "skid row" era of research in the 1950s, was of homelessness as an entrenched condition resulting from "disaffiliation," or an individual's decision to isolate one's self from family, workplace, and other social networks.[1]

By the 1980s, homelessness was newly emergent and increasingly visible. These "new homeless" did not conform to existing preconceptions. They included families headed by younger women, young single adults, and a high percentage were minorities. They were not confined to a single neighborhood and did not seek shelter on skid row or in single-room occupancies, which were largely converted to other purposes, but instead stayed on the street and in new shelters that were opened to give people an alternative to sleeping on the street.[2] While social isolation continued to be seen as part of the problem, this changing face of homelessness required new explanations, including a lack of affordable housing, unemployment, and gaps in disability insurance and public assistance coverage.

Even with this expanding view of the drivers of homelessness, early research to understand its changing profile relied on cross-sectional data that over-represented people who had long-term stays in shelter. Efforts to develop typologies of affected groups often proved more confounding than illuminating, as researchers combined factors that might cause homelessness with factors related to the experience of homelessness and those resulting from homelessness, such as social connection and social network size, depression, and substance abuse.[3]

[1] Bahr, Howard M. *Skid Row: An Introduction to Disaffiliation.* 1973. New York: Oxford University Press.
[2] Burt, Martha. "Three Decades of Homelessness." In Burnes, Donald W. and David L. DiLeo, eds., *Ending Homelessness: Why We Haven't, How We Can.* 2016. Boulder, CO: Lynne Rienner Publishers, Inc.
[3] See, for example, Grisgby, Charles, Donald Baumann, Steven E. Gregorich, and Cynthia Roberts-Gray. Disaffiliation to Entrenchment: A Model for Understanding Homelessness. Journal of Social Issues. 1990; 43(4): 141-156; Mowbray, Carol T., Deborah Bybee, and Evan Cohen. Describing the Homeless Mentall Ill: Cluster Analysis Results. American Journal of Community Psychology. 1993; 21(1): 67-93; Humphreys, Keith. Sequential Validation of Cluster Analytics Subtypes of Homeless Veterans. American Journal of Community Psychology. 1995; 23(10): 75-98.

Towards a better understanding

Despite the limitations of early attempts to develop a typology of homelessness, by the mid-1980s and early 1990s several researchers had offered a conceptual framework. This model distinguished between three manifestations of homelessness:[4]

- *Transitional*, characterized by a single relatively brief shelter stay, younger clients who had been precariously housed, and a single episode of homelessness that was generally precipitated by a catastrophic event (this is also sometimes referred to as "crisis homelessness") ;[5]

- *Episodic*, characterized by short but frequent episodes in shelters and other institutions (e.g., inpatient treatment, detoxification services, or correctional institutions) and younger clients who were more likely than transitionally homeless individuals and families to have medical, mental health, and substance abuse problems and be chronically unemployed;[6] and

- *Chronic*, characterized by long shelter stays and older clients who were chronically unemployed and often suffered from disabilities and substance abuse problems.[7]

In 1998, the first empirical paper with longitudinal data on homelessness showed that 80 percent of shelter users fell in the transitional or "crisis homelessness" group. Using data from New York and Philadelphia, we learned that these individuals and families typically resolve their housing crises within 6 months, with an average of 25 days homeless. In a striking contrast, people experiencing chronic homelessness accounted for only 10 percent of those entering shelters in a given year, although they represented half of all people in shelters on any given day.[8]

This typology laid the groundwork for advocacy approaches that, since the late 1990s, have focused especially on chronic homelessness as a relatively small and "solvable" problem. Federal policy has increasingly recognized people experiencing chronic homelessness as a vulnerable population of adults

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[4] Kuhn, Randall and Dennis P. Culhane. Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data. American Journal of Community Psychology. 1998; 26(2): 207-232.

[5] Weitzman, Beth C., James R. Knickman, and Marybeth Shinn. Pathways to Homelessness Among New York City Families. Journal of Social Issues. 1990; 46(4): 125-140; Sosin, Michael, Irving Piliavin, and Herb Westerfelt. Toward a Longitudinal Analysis of Homelessness. Journal of Social Issues. 1990; 46(4): 157-174.

[6] Farr, Rodger K., Paul Koegel, and Audrey Burnam. A Survey of Homelessness and Mental Illness in the Skid Row Area of Los Angeles. 1986. Los Angeles County Department of Mental Health; Culhane, Dennis P., June M. Avert, and Trevor R. Hadley. The Treated Prevalence of Mental Health and Substance Use Disorders among Adults Admitted to the Philadelphia Shelter System: Results from the Integration of Longitudinal Data on Shelter and Mental Health Services Utilization. 1996. City of Philadelphia Office of Mental Health and the U.S. Center for Mental Health Services.

[7] Cohen, Carl I. and Jay Sokolovsky. 1989. *Old Men of the Bowery: Strategies for Survival Among the Homeless.* New York: Guilford; Rossi, Peter H. 1989. *Down and Out in America: The Origins of Homelessness.* Chicago: University of Chicago Press; Piliavin, Irving, Michael Sosin, Alex H. Westerfelt and Ross L. Matsueda. The Duration of Homeless Careers: An Exploratory Study. Social Service Review. 1993; 67(4): 576-598.

[8] Kuhn, Randall and Dennis P. Culhane. Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data. American Journal of Community Psychology. 1998; 26(2): 207-232.

with disabilities who have the potential to remain stably housed in housing provided they receive appropriate supports in finding and maintaining the housing. In 2000, Congress required HUD to spend at least 30 percent of McKinney-Vento funds on permanent housing for people experiencing homelessness, including those with chronic patterns of homelessness. Large municipal shelter systems, like those in New York City and Philadelphia, likewise have adopted strategies based on reducing shelter demand by moving long-term shelter users into permanent housing.

Who experiences chronic homelessness?

Incidence and characteristics of people experiencing chronic homelessness

On average, across a wide variety of geographies, about 10 to 15 percent of people entering homelessness will fall into the category of chronic homelessness. Most of these are individuals on their own, rather than members of a family with children, and they are much more likely to be staying in unsheltered locations such as cars or abandoned buildings than in shelters. Most people with chronic patterns of homelessness can be found in major cities (57%) or smaller cities or counties (33%), rather than rural areas.

On a single night in 2017, 86,962 individuals experienced chronic homelessness, accounting for 15.7 percent of all homeless people.[9] Another 8,457 people experienced chronic homelessness as part of a family with children, accounting for 5 percent of people in homeless families. As of the most recent Point-in-Time count, 70 percent of chronically homeless individuals stayed in unsheltered locations, compared with 35 percent of people experiencing homelessness overall and 48 percent of people experiencing homelessness as individuals. In 2010, the average age of people experiencing chronic homelessness was close to 50, and increasing.[10] As this population grows older over time, additional assistance will be needed to address emerging aging related health and disability issues.

Federal definition

A ‘‘chronically homeless’’ individual is defined to mean a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the ‘‘chronically homeless’’ definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven. (24 CFR Parts 91 and 578)

[9] Unless otherwise noted, all figures in this section are from Henry, Meghan, Rian Watt, Lily Rosenthal, and Azim Shivji. The 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness. December 2017. U.S. Department of Housing and Urban Development.

[10] Wilkins, Carol and Janice Elliott. Background Paper – Chronic Homelessness. 2010. United States Interagency Council on Homelessness.

The federal definition of chronic homelessness has evolved over time, and is now represented by a flowchart that includes questions about the head of household's disability status, current and prior place of residence, and duration of stay. Disability has been included in the definition from the outset, in part to mitigate the moral hazard of incentivizing longer shelter stays, but also because research shows that nearly all people experiencing chronic homelessness have documented disabilities which may create barriers to exit. Stays in transitional housing do not count towards the duration of homelessness to avoid including persons whose long stays are driven by program design rather than by personal barriers to exit, a criterion that has been the source of some frustration for people who are chronically homeless (or otherwise likely to be) but staying in transitional housing.

HUD adopted new standards in a final rule that went into effect in 2016 to help resolve confusion around what characterizes an "episode" of homelessness – a concept that is easier to measure in research than in practice. Changes effective in 2016 also require documentation of homelessness experiences that are not tracked in the Homeless Management Information System, such as a written observation by an outreach worker, referral by a housing or service provider, or discharge paperwork from an institutional facility.

What is the evidence base on chronic homelessness?

Contrasting experience of individuals and families

While families only make up a small share of households experiencing chronic homelessness, researchers have identified notable differences in their experiences relative to chronically homeless individuals. These differences relate to the use of mainstream services during an episode of homelessness as well as the characteristics of households who have long-term shelter stays.

- *Use of mainstream services.* Chronically homeless individuals tend to increase their mainstream service usage during episodes of homelessness and have lower dependency on acute services when they are in stable housing.[11] In contrast, when families with chronic patterns have an episode of homelessness, they tend to reduce their use of mainstream services such as inpatient medical care or mental health services—in effect substituting one system of care (mainstream services) for another (service-enriched shelters).

- *Characteristics of households with long-term shelter stays*. Individuals with long shelter stays tend to have the greatest barriers to exit, including higher rates of disability. This pattern does not hold for most families. While a small percentage of families with repeat episodes of homelessness have characteristics similar to individuals experiencing chronic homelessness, families with long shelter stays tend to be among the highest functioning clients. They are no more likely to have disabilities or behavioral health problems or to be unemployed or involved in the child welfare system than families who experience transitional or temporary homelessness.[12] This apparent paradox can be explained by attributing longer-term stays to recruitment of these families for

[11] Culhane, Dennis P. and Stephen Metraux. Rearranging the Deck Chairs or Reallocating the Lifeboats? Homelessness Assistance and its Alternatives. Journal of the American Planning Association. 2008; 74(1): 111-121.
[12] Culhane, Dennis P., Stephen Metraux, Jung Min Park, Maryanne Schretzman, and Jesse Valente. Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning. Housing Policy Debate. 2007; 18(1).

shelter and transitional housing programs that are designed to promote self-sufficiency through long-term engagement. Higher-functioning families may then be waiting to "graduate" from such programs and, as a result, exhibit long periods of homelessness.[13]

These differences have implications for resource allocation and how services are provided. Families with relatively low barriers to housing may be better- and more cost-effectively served by direct rental assistance and access to services on an "outpatient" basis than by long-term stays in service-intensive transitional housing. Individuals who experience chronic homelessness have also been demonstrated to benefit from treatment programming that enables them to reduce their reliance on emergency services and move to self-sufficiency, including to permanent supported housing.

Investing in solutions that work

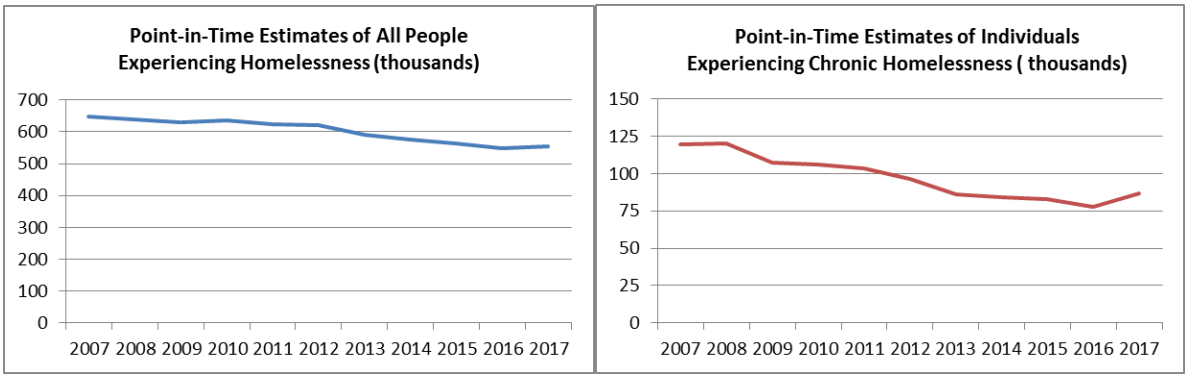
Early research and policy to address the needs of people experiencing chronic homelessness was dominated by psychiatrists and mental health professionals who did not see housing as part of the problem or the solution. Rather, the focus was on expanding services, especially shelter and shelter-based services. While supportive services play an important role in helping many households maintain stable housing, this approach failed to acknowledge the significance of household income levels and housing affordability in protecting against (and resolving) chronic homelessness.

Unfortunately, the health care coverage and income supplements available to people who are unable to work—Medicaid and Supplemental Security Income (SSI)—do not provide a sufficient safety net. The rent subsidies and supply of housing affordable to people who rely on SSI fall far short of the demand, and SSI is not available to all people with disabilities (e.g., those with substance abuse related disabilities). Emergency psychiatric bed capacity for people with severe mental illness is limited, and the community mental health system that replaced the state hospital system in the 1980s lacks the capacity to keep up with demand for service.

However, recent evidence from the Annual Homeless Assessment Reports to Congress (AHAR) clearly indicates what does work: sustained and significant investment in affordable housing and access to flexible and individualized social or clinical services when needed. While the most recent AHAR showed a slight increase in chronic homelessness (and homelessness overall), this uptick disrupts a nine-year trend of reductions in estimates of chronically homeless individuals that far exceeded declines among all people experiencing homelessness, on a percentage basis (see Exhibit 1). Between 2007 and 2017 the number of individuals experiencing chronic homelessness on a single night fell by 27.4 percent compared with a 14.5 percent reduction in homelessness overall, and more than one-third of the decline in overall homelessness during this period can be attributed to reductions in chronic homelessness.[14]

[13] Culhane, Dennis P., Jung Min Park, and Stephen Metraux. The Patterns and Costs of Services Use among Homeless Families. 2011. Journal of Community Psychology.
[14] Henry, Meghan, Rian Watt, Lily Rosenthal, and Azim Shivji. The 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 1: Point-in-Time Estimates of Homelessness. December 2017. U.S. Department of Housing and Urban Development.

Exhibit 1.



These declines coincided with a national commitment to increase investment and capacity to serve people experiencing chronic homelessness. In 2017, there were 149,005 permanent supportive housing (PSH) beds dedicated to people experiencing chronic homelessness, a fourfold increase from the 37,807 PSH beds for chronically homeless people available in 2007.[15] Efforts to target PSH to the most vulnerable people and to prioritize chronic homelessness in programmatic and policy responses also intensified in this period, and randomized-controlled trials demonstrated that PSH kept people with behavioral health issues from returning to homelessness.[16] Since 2004, Notices of Funding Availability for HUD Homeless Assistance Grants have encouraged or prioritized the creation of permanent supportive housing for chronically homeless individuals and families.

Data from New York City's HIV/AIDS Services Administration (HASA) provides further evidence of effective approaches to reducing homelessness among people with multiple barriers to housing. Between 1990 and 2003 the City created some 25,000 units of housing for people experiencing homelessness with an HIV/AIDS diagnosis—including 20,000 units assisted with tenant-based rent subsidies and 6,500 units of supportive housing—and provided access to supportive services. Most of the people served by HASA were injection drug users, almost half had a history of incarceration, and nearly one-third had been convicted of a felony. Despite these barriers, in a study of more than 2,000 clients of the HASA system almost two-thirds were stably housed and had moved one or fewer times over the past three years. These individuals had also experienced improvements in their connections to medical care and ability to adhere to a medical regimen.[17]

"Solving" chronic homelessness can be (but is not always) cost-neutral

Permanent affordable housing combined with access to on-site or mobile services has proven effective in reducing episodes of homelessness among individuals with chronic patterns of homelessness.[18] PSH has

[15] Ibid.
[16] Rosenheck, Robert, Wesley Kasprow, Linda Frisman, and Wen Liu-Mares. Cost-effectiveness of Supportive Housing for Homeless Persons With Mental Illness. Arch Gen Psychiatry. 2003; 60: 940-951.
[17] Shubert, Virginia, Hillary Botein, Suzanne Wagner, Stephen R. Poulin, Dennis P. Culhane. An Assessment of the Housing Needs of Persons with HIV/AIDS: New York City Eligible Metropolitan Statistical Area, Final Report. 2004. New York City Metropolitan Statistical Area and the U.S. Office of Housing and Urban Development Housing Opportunities for Persons with AIDS.
[18] Metraux, Stephen, Steven C. Marcus, and Dennis P. Culhane. The New York-New York Housing Initiative and Use of Public Shelters by Persons with Severe Mental Illness. Psychiatric Services. 2003; 54(1): 67-71.

also been associated with significant reductions in the use of expensive acute care services, including emergency shelters, hospital emergency rooms and inpatient care for medical or psychiatric treatment, detoxification and sobering centers, and institutional facilities such as jails or nursing homes.[19] Among the heaviest users of these services, PSH can be a cost-neutral investment, with the cost of housing subsidies and services offset by reductions in spending on these other public services.[20]

However, caution should be used when estimating the potential for cost savings, as studies with large and diverse samples find some net costs. For example, an analysis of 12-month outcomes among more than 700 chronically homeless individuals at 11 sites found that the vast majority of participants (95%) were able to maintain stable housing, despite high rates of medical and mental health problems and substance abuse. While average quarterly treatment costs per person fell by 51 percent during the 12-month study period, a reduction attributable largely to reduced inpatient costs, the net cost of providing housing and services was $3,376.[21] The New York/New York (NY/NY) initiative created 3,300 housing units and social support for people experiencing homelessness with a psychiatric diagnosis in New York City. While placement in NY/NY housing was associated with a $16,000 reduction in services use per housing unit per year, the program was still associated with an annual net cost per unit of $995.[22]

A quasi-experimental study in Seattle found similar results when using a Housing First approach to provide supportive housing to individuals with chronic patterns of homelessness and severe alcohol problems. Participants were drawn from a list of nearly 400 "high users" of hospital emergency services, the sobering center, and the county jail. The first 95 eligible individuals on the list who were "found" were offered immediate (or near-immediate) placement in supportive housing in which drinking was permitted, while 39 individuals on the waitlist served as a control group. The use and cost of services for participants placed in permanent supportive housing—including jail bookings, shelter and sobering center use, hospital-based medical services, publicly-funded detoxification and treatment, and emergency medical services—fell from a median of $4,066 per person per month in the year prior to the study to $1,492 after 6 months and $958 after 12 months, a 76 percent reduction. At the 6-month follow-up, total cost offsets for the treatment group, accounting for the cost of housing, averaged $2,449 per person per month relative to the control group.[23]

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[19] Wilkins, Carol and Janice Elliott. Background Paper – Chronic Homelessness. 2010. United States Interagency Council on Homelessness. See also, Summary of Studies: Medicaid/Health Services Utilization and Costs. 2009. Corporation for Supportive Housing.

[20] See summary evidence on cost savings from recent studies in Table 1 in Culhane, Dennis P. and Thomas Byrne. Ending Chronic Homelessness: Cost-Effective Opportunities for Interagency Collaboration. 2010. Penn School of Social Policy and Practice Working Paper. The National Alliance to End Homelessness has collected cost studies from communities around the country at https://endhomelessness.org/study-data-show-that-housing-chronically-homeless-people-saves-money-lives/.

[21] Mares, Alvin S. and Robert A. Rosenheck. Twelve-Month Client Outcomes and Service Use in a Multisite Project for Chronically Homeless Adults. Journal of Behavioral Health Services and Research. 2010; 37(2): 167-183.

[22] Culhane, Dennis P., Stephen Metraux, and Trevor Hadley. Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing. Housing Policy Debate. 2002; 13(1): 107-163.

[23] Larimer, Mary E. et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *Journal of the American Medical Association*. 2009. 301(13): 1349-1357.

Cost studies to date have only looked at relatively short follow up periods (e.g., 2 years), and costs incurred by heavy users of services tend to be "lumpy"– with high costs incurred in only one in every five years.[24] As a result, we do not yet know the potential for savings over a longer time horizon. The long-term payoff may still be positive. In the meantime, there are other reasons to focus on providing housing and services for the most vulnerable individuals and families, such as reductions in victimization, dehumanization, and other negative health and social outcomes, as well as improved social functioning, community integration, dignity, and well-being.

Where are the gaps?

Just as it's extremely difficult to predict which poor families will become homeless, we still have not identified the key risk factors to predict the likelihood that people experiencing transitional homelessness will become chronic. While disabilities can create barriers to housing, most people who experience homelessness and have behavioral health disabilities are only homeless for short periods of time, just as in the adult homeless population in general. Recent attempts[25] to create a more fine-grained typology of homelessness with ten categories do not appear likely to advance our ability to predict the incidence of chronic homelessness or to refine interventions like PSH or rapid re-housing, which is already tailored to the specific services needs of individual clients. Ultimately, tools that try to predict a shift from transitional to chronic homelessness may have perverse consequences. For example, they might create incentives for people without chronic patterns to remain in emergency shelter programs for longer durations. Not only would this add to costs, it could also have negative consequences for people's well-being. A preferable approach would be providing rapid rehousing to people without chronic patterns, with more sustained subsidies for those who continue to need supports or who become chronically homeless.

Implications for policy and practice

From the available evidence, we can draw some clear lessons for policy and practice:

- Coordinated entry and assessment can be used to differentiate the majority of people experiencing an acute housing crisis from the minority experiencing chronic homelessness, and to refer each group to the appropriate interventions. Accurate identification of those who are *most likely* to develop chronic patterns of homelessness in the future, in order to provide services to preempt this shift, is not feasible at this time.

- Treatment and care for people experiencing chronic homelessness should be the primary motivators for any intervention. However, communities that are also hoping to realize cost savings by addressing chronic homelessness will limit savings potential if they only focus on those who are already high-cost users of crisis response systems. Practitioners should consider referring all adults who are homeless with disabilities to rapid re-housing, with the option to

[24] Johnson, Tracy L., Deborah L. Rinehart, Josh Durfee, Daniel Brewer, Holly Batal, Joshua Blum, Carlos I. Oronce, Paul Melinkovich, and Patricia Gabow. For Many Patients Who Use Large Amounts of Health Care Services, The Need is Intense Yet Temporary. *Health Affairs*. 2015. 34(8): 1312-1319.
[25] McAllister, William, Li Kuang, and Mary Clare Lennon. Re-Thinking Research on Typologizing Homelessness. 2010. Working Paper No. 10-01. Columbia Population Research Center.

transition to PSH as continuing need is revealed, consistent with a Progressive Engagement approach (i.e., initially providing a small amount of assistance to resolve a housing crisis, and then additional assistance as needed after individual assessment).

- Among the current population of people experiencing chronic homelessness, PSH is still the best fit, possibly with rapid re-housing as a bridge.
- As individuals with chronic patterns age, they will need more medical services and assistance with activities of daily living rather than behavioral health services. Symptoms of severe mental illness or substance abuse may become less acute, but people develop other severe chronic health conditions.
- Scalable interventions should be part of the solution, including aggressive enrollment in SSI and shallow rent subsidies when PSH is not available.