Historical and Contextual Influences on the U.S. Response to Contemporary Homelessness[1]

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Abstract

This paper reviews the nature of and responses to homelessness throughout the nation's history and the evolution of approaches to contemporary homelessness. The author notes that, in the past two decades, a de facto system of service has evolved to apply actions and services to a population experiencing homelessness, through a network of organizations that deliver services within a funding and policy context. He further states, however, that the system is not driven by specific legislation or theory. Instead of a coherent system, different approaches have been adopted by federal departments and the advocacy community. The author's assessment of progress and future opportunities focuses on the current emphasis on addressing chronic homelessness within the context of the proposed de facto system.

Introduction

Since the last National Symposium on Homelessness Research in 1998, much of our attention has focused on persons experiencing chronic homelessness and on efforts to end the longstanding national challenge of homelessness. Research, knowledge development, opportunity, and advocacy have each served to address our concerns, and the result has been a significant revitalization in our national response. Parallel advances suggest the emergence of a coherent, *de facto* system of service to address homelessness. While the system has yet to realize full expression, its easily identifiable components provide opportunities to focus our efforts and demonstrate that positive outcomes are occurring. The operational components of the de facto system, which will be discussed in this paper, challenge us to consider what further successes we might achieve with a *formal system* that strives to rectify homelessness.

The emergence of the *de facto* system has been fostered by at least four factors:

- a deepened empirical understanding of the heterogeneity within the population of people experiencing homelessness,

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- a growing store of effective service responses,

- service providers that are increasingly adept, and

- the development of multi-partner collaborations among providers that help address the multiple facets of homelessness.

Papers at the previous Symposium (see Fosberg & Dennis, 1999) acknowledged developments in these areas (see Rosenheck et al., 1999; McMurray-Avila et al., 1999; Dennis et al., 1999), and at least three of these factors receive attention in other papers in this Symposium. Before examining the proposed systemic response, this paper will discuss the history of homelessness in the United States. After a discussion of the changes in our approach, a section on the prevention of homelessness and another on global perspectives on homelessness will follow.

What Does History Tell Us About Addressing Homelessness in America?

Homelessness has been a persistent and enduring feature in American history, which provides invaluable context for considering our current response to its challenges. The resources listed below, and particularly the history provided by Kusmer (2002), facilitate the unsystematic review of homelessness in this country that follows:

- annotated bibliographies (Van Whitlock et al., 1994),

- complete histories (Kusmer, 2002),

- short reportorial histories (Caton, 1990),

- histories that apply anthropological theory to homeless patterns (Hopper & Baumohl, 1996),

- homelessness considered from changing legal and legislative perspectives (Peters, 1990, Handler, 1992, and Simon, 1992),

- history analyzed for advocacy purposes (Bassuk & Franklin, 1992), and

- homeless history analyzed in specific cities (Hopper, 1990, 1991).

While there have been temporary lulls, from colonial times forward there has been no period of American history free of homelessness. Writers such as Caton and Kusmer suggest there have been at least five waves of homelessness, including contemporary homelessness, that reached levels causing social concern. The periods for these consequential episodes of homelessness and selected similarities and differences across them are summarized in Exhibit 1.

Economic and Societal Changes

The consistent structural variable in America's homelessness history is economic performance. When business cycles turn downward and the economy falters or retreats, people get cut off from their livelihood. Sources such as Tull (1992) and Homebase (2005) place particular emphasis on the economic shifts from a manufacturing to service-based U.S. economy, and globalization as significant contributors to contemporary homelessness. No matter the specifics, looking across the episodes summarized in

Exhibit 1, homelessness appears either to increase during perturbations in the economy or to be more willingly acknowledged. As Burt and Aron (2000) have noted, the contemporary wave of homelessness has not subsided during good economic times. This suggests that economic performance is only one factor in a constellation of many other causes.

Although it may be an accident of labeling, each major wave of homelessness seems to be associated with a period when America was undergoing a significant redefinition of itself; for example, colonies in revolt and seeking their independence. Hopper and Baumohl (1996) and Hopper (2003) advocate for the use of the anthropological concept of *liminality* as a theoretical basis for understanding the condition of homelessness and our response to it. A liminal state represents a period between transitions from one life stage to another and is characterized by high levels of personal ambiguity and uncertainty. If large numbers of individuals do not successfully exit a liminal state, the consequences are socially unsettling and provoke a corrective response. Social and government programs are often created to correct or prevent difficult transitions.

It is interesting to extend the concept of liminality to the periods during which U.S. society itself, rather than an individual, undergoes a transition from one stage to another (colony to nation, manufacturing economy to service-based, etc.). It could be speculated that there are some types of societal transitions associated with leaving a large number of citizens behind—that is, those not making a successful transition. Homelessness may be one manifestation of such a jarring societal transition. If the concept has merit, there may be value in trying to determine what types of societal transitions are correlated with homelessness as a residual. Such understanding could have value in anticipating a future national episode of homelessness and in analyzing what interventions could contribute to leaving fewer citizens in a liminal state of homelessness.

Defining the Boundaries of Homelessness Cycles

None of the homelessness history material reviewed supports a conclusion that national episodes of homelessness have a definable beginning or end. Although it is clear that homelessness has existed without interruption in American history, its emergence as a recognized problem occurs over a period of years, not suddenly. The evidence examined further suggests that all prior waves have run their course and petered. All of the service interventions noted in Exhibit 1 operated as exigencies, and except for a decline in shantytown populations associated with the Federal Transient Service (Kusmer, 2002) and the benefits of an economic recovery in the late 1930s (Caton, 1990), the sources are silent on how the episode was resolved. This could be a matter of missing evidence or possibly an omission within the sources examined. The contemporary wave must be acknowledged for its watershed statement that homelessness can be ended—by a date as yet to be determined.

Distinct Responses to Homelessness

Until the 20th century responses, assistance to homeless populations does not appear to be distinct from assistance offered low-income people. During much of that century, citizens began to expect more of the federal government, both in the form of social insurance programs that buffered some of life's inevitable setbacks (e.g., New Deal and Great Society programs) and smoothed national economic performance (e.g., actions by the Federal Reserve Bank). Much of this expectation seems to have created a growth and differentiation of programs. The distinction of homeless assistance from poverty-focused assistance might be embedded within that pattern. Certainly, the contemporary wave is distinct from prior waves in the

Exhibit 1
Similarities and Differences Across Five Major Episodes of Homelessness in U.S. History[a]

	Consequential Homelessness Episode				
	Colonial Homelessness (1660s–1770s)	*Pre-Industrial Period (1820–1850)*	*Post-Civil War Period (1870–1900)*	*Great Depression (1929–1940)*	*Contemporary Period (1980–Present)*
Nature of homelessness	• Itinerant workers • "Wandering poor" • "Sturdy beggars"	Primarily unemployed working men	• The "vagabond" era, with large numbers of men "hopping" trains and wandering. "Tramp" and "bum" were the standard labels, derived from terms applied to provisions foraging by Civil War troops. • Some freed slaves, single and family	• Working class especially represented, with homelessness reaching into middle classes • Clear emergence of African Americans, women, families • Prevalence rates of 1–5 percent cited	• Homelessness persisted following Great Depression but associated almost exclusively with alcohol abuse among single men located in marginalized neighborhoods • Single people, with high incidence of behavioral disabilities • Families with children
Causal factors suggested	• Agricultural society required skilled and unskilled worker mobility • Continuing territorial skirmishes • Beginnings of business cycles • Immigration	• Bumpy business cycles • Mills, mines, and dock work complement agriculture, but with less employment security • Railroads and telegraph introduce pervasive societal changes	• Two severe economic downturns; employment near 40 percent • Immigration • Large number of Civil War veterans • Railroad penetration allowed for a subculture of "train hoppers"	• Severe economic instability • Immigration • Migration	• Poor economic performance during 1970s–early 1980s • Shift to service economy • Deinstitutionalization • Housing access and affordability • Changes in programs to assist poor/uninsured • Service access and adequacy
Service responses	• Vagrancy laws • Community "warning out" procedures • Work programs • Corporal punishment	• Charity-run almshouses and wayfarer lodges • Publicly run lodging houses • Obligation to return work for service • Little differentiation of homelessness responses from assistance to the poor and down on their luck • Jails commonly provide overnight accommodation • Toughened vagrancy laws • Imprisonment	• Skid rows, flophouses, and cage hotels are the modal response • Rhode Island Tramps Act of 1880 emulated by nearly every state; designed to arrest/convict homeless people • Municipal and charity-run shelters; bare bones lodging and modest rations • Shelters and services by Christian evangelical groups • Except for criminal justice interventions, little differentiation of homelessness responses from assistance to low-income people	• A quarter of cities surveyed in 1933 offered nothing to homeless persons • Breadlines, soup kitchens, shelters, and shantytowns • First federal assistance for homeless persons, federal Transient Service, focused on unemployed homeless; existed for 3 years, established "transient relief programs" providing housing, food, job training, and education in 47 of the 48 states • New Deal programs were to assist people who were homeless as well as other poor and needy people	• Initial ad hoc responses by cities, charities to address immediate shelter and food needs • Early federal intervention as service demonstrations and analysis of population • 1997 survey documents 40,000 homeless-serving programs in 21,000 locations • McKinney legislation and amendments establish and fund housing and service programs specific to homeless people
Other observations	• Tradition derived from English law that the community/parish was responsible for its poor people	• Residential segregation by class; working class increasingly concentrated near employment • Short-term residential approaches developed suited to rapid turnover of working class • First emergence of editorial and other writing that impugns homeless people	• Strong negative opinions about homeless populations softened later in the period as economic causes are better recognized • Inchoate professionalization of social work set stage for analytic examination of homeless and first formal research studies in early 1900s • Documentation that alcohol abuse among homeless population is recognized as a problem	• First advocacy group for homeless persons, National Committee on Care of Transient and Homeless, established in 1932 • Federal government promotes zoning by communities. Multi-family residential development more difficult and real estate on which much of the affordable multi-family housing is located becomes attractive for commercial uses.	• Strong advocacy group involvement as leadership, policy analysis, oversight • Increased private foundation interest over time • Challenge to end homelessness articulated in early 2000s substantially influenced by knowledge development and research

a Based substantially on Kusmer (2002) and Caton (1990)

scale and longevity of targeted homeless assistance and in the sustained differentiation of housing and service resources for homeless persons.

The primary locus for organizing a response to homelessness remains at the municipal and county level. Historians trace this tradition to the 17th century, when colonies adopted features of English law. Locally organized charity to homeless people engaged both civic and private sector partners for more than 200 years, and according to Kusmer's analysis, it is not until the 1930s that anyone speaks overtly to the complexity of multiple partners operating and the desirability of greater coordination. By the late 20th century, coordination again emerged as an even stronger theme. One of the legacies we may leave from addressing the contemporary wave of homelessness might be our progress and methodology for achieving coordination among the multiple service providers.

Housing Costs and Homelessness

Affordable housing for low-income people, and as housing to which homeless people could return, began to appear in the 19th century. In prior waves of homelessness, a gap between the incomes of the poorest households and the cost of rental housing was never identified as a causal factor for homelessness. Karr (1992) indicates that the quality of affordable housing was quite bad, especially in the 19th and early 20th centuries, but it was available in quantity. The contemporary wave is unique in identifying trends in housing costs (and not simply incomes) as an issue. Karr's analysis cites at least four circumstances that contributed to the scarcity of affordable housing:

- The federal government's promotion of zoning in the early 1920s would henceforth make multifamily housing more difficult to develop. It could be developed only in specifically designated areas and would be segregated from one- and two-family residential areas.

- The preference of the New Deal Federal Housing Administration, created in 1934, for underwriting owner-occupied, single-family property would further tilt development away from lower income and multifamily units.

- National housing acts passed in 1949 and 1954 endorsed the clearance of blighted and slum neighborhoods, which were often to be replaced with commercial rather than residential real estate. The consequence was the loss of more affordable units than would be replaced by government intervention in the affordable housing market with either public housing units or subsidies.

- Karr states there has been no "satisfactory" U.S. housing policy since the 1950s, and the manifestation of its absence is the worsening maldistribution of housing resources.

Such analyses remind us that the roots of the affordable housing problem go deep and that remedies will require a reckoning with more issues than simple production.

Attitudes Toward Homeless People

Every wave of homelessness in the United States has also been associated with negative attitudes toward homeless people. The negativity is variously expressed in legislation such as vagrancy laws, editorial writing, and personal attitudes. It may be stimulated by dominant cultural values, such as the disdain for idleness in colonial times, vague invocations of public safety, or in response to observed behaviors. Among the latter, the abuse of alcohol by homeless people began to receive attention following the Civil

War (Baumohl, 1989) and produced more pejorative labels and editorial posturing than services. Following the Great Depression, homelessness was associated almost exclusively with alcoholic single men, generally found in less respectable sections of town (Rossi, 1990). Service responses to this population were unobtrusive and almost entirely delivered by charity and faith-based programs.

During the contemporary wave of homelessness, the population is quite diverse, with the substance-abusing population continuing to be well represented. However, as the seeming epitome of what Katz (1990) has labeled the "undeserving poor," homeless people have been the target of a remarkable number of contemporary laws and ordinances that criminalize many aspects of their daily existence (Simon, 1992). Both the National Law Center on Homelessness and Poverty and the National Coalition for the Homeless Web sites cite many examples of such laws and ordinances.

The lesson from the review of the history of homelessness in the United States fits well with the analytic themes of the Symposium and reminds us that many of the contemporary causes and responses are not unique. History also reminds us that one day our actions, programs, and policies will be the subject of examination and analysis. We should be committed to leaving the best possible legacy of lessons while demonstrating that our responses were the best that our knowledge and resources enabled us to deliver.

Our Evolving Homeless System of Service in the United States

In the 1980s, as homelessness was increasingly recognized by the public and governments, the federal legislation proposed—the Homeless Persons Survival Act—offered responses in the areas of emergency, preventive, and long-term approaches. When finally passed in 1987, as the McKinney Homeless Assistance Act (now McKinney-Vento), only the emergency component was implemented. Under several titles, the legislation authorized the creation of programs that remain the foundation of our national response to homelessness. However, they were established in distinct departments of the executive branch, each with its own regulations, grant programs, and recipient organizations. Although the Homeless Persons Survival Act can be considered as an example of a comprehensive approach, at that time our understanding of the complexity of the population, services, and the abilities of providers was too rudimentary to have conceptualized the articulated, collaborative approaches we acknowledge today.

Much of the progress in addressing homelessness over the past two decades represents a response to our experiences addressing the multiple needs of homeless people and knowledge gained from research and evaluation efforts. Together, these have contributed to an evolving homeless system of service.[2] This

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[2]   In comments on this paper at the Symposium offered by William Breakey (2007), he suggested eight social developments have influenced the evolution and operation of a homeless system of services. Several of these factors are mentioned elsewhere in this paper and in other papers in the Symposium, but the list is valuable in summarizing them:

    a) increasing poverty
    b) an institutionalized response to homelessness
    c) the absence of an effective affordable housing policy
    d) the lack of a coherent health care system
    e) the movement from institutionally-based to community-based care
    f) increased influence by private philanthropy
    g) the successes of advocacy
    h) changes in the roles and rights of women

Symposium is a rare opportunity both to recognize the remarkable progress we have made without the benefit of a comprehensive, unifying approach and to question whether we can sustain momentum and achieve the goal of ending homelessness without one.

The proposed system of service has four components:

- a population experiencing homelessness,

- a set of actions and services that are offered to the population,

- organizations that deliver these services, and

- the network of funding, policies, and relationships in which these organizations operate

This evolving system of service has no legislation, explicit theory, values, or principles that define it. Homelessness services have not been guided by a cohesive or overarching theory, model, or policy, and neither the components nor the system itself have been fully realized. For our purposes, arranging our knowledge into a set of components and a system of service is a heuristic device that enables us to examine developments and suggest additional opportunities.
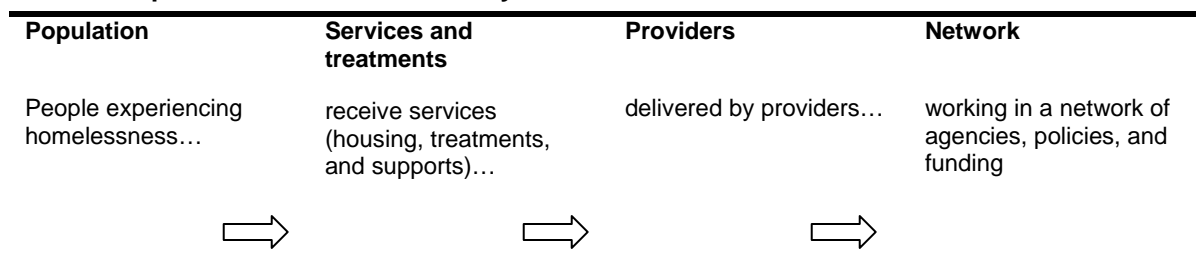
Vicissitudes of funding, differing approaches among federal departments, and unique territories staked out within the advocacy community have characterized the U.S. response to the contemporary wave of homelessness. The following are examples of the multiple approaches and models evident in the development of our current system:

- the original McKinney legislation implemented primarily an emergency response (Kondratas, 1991)

- a public health model was used in the early 1990s to address both homelessness and mental illness (Interagency Council on the Homeless [ICH], 1992), and

- the continuum of care approach (Burt et al., 2002) was introduced in the mid 1990s by the Department of Housing and Urban Development (HUD) as a grant funding requirement and initially emphasized a *community self-determination* model. As will be noted later, HUD has subsequently used this feature to shape the responses of communities, affecting considerably its self-determination features.

Current approaches may best be viewed as based in pragmatism—trying to assist homeless people with services offered by providers who function in a network of policies and funding. This pragmatism suggests the system of service shown in Exhibit 2 below.

Exhibit 2

Four Components of Our Homeless System of Service

Population	Services and treatments	Providers	Network
People experiencing homelessness…	receive services (housing, treatments, and supports)…	delivered by providers…	working in a network of agencies, policies, and funding

The exhibit demonstrates that we must:

- understand the nature of the population being served,

- offer appropriate services delivered by capable providers, and

- work within a network of agencies, policies, and funding that ideally present no barriers to progress.

Although there is some momentum toward agreement on what our system of service aims to achieve, we do not yet have consensus on our goals. This remains an area where additional efforts across the three government levels—local (municipal/county), state, and federal—would be helpful. For example, is the shared goal to end homelessness, end chronic homelessness, or substantially retool our efforts toward greater effectiveness? Such varying goals can be found in long-range plans offered by communities (National Alliance to End Homelessness [NAEH], 2006c).

Distinguishing Between a System of Service and a System of Care

The concept of a homeless system of service is borrowed from the concept of a *system of care*. The latter developed around addressing the complex service needs of families and children with serious emotional disturbance (Stroul & Friedman, 1986). A system of care is a philosophy rather than a program, and it emphasizes "a coordinated network of community-based services organized to meet the challenges of children and youth with serious mental health needs and their families" (http://systemsofcare.samhsa.gov/). It responds specifically to the needs of those served, in a culturally appropriate manner and with interagency collaboration. Program development, funding decisions, and the promotion of effective practices are all guided by this philosophy and the desire to create systems of care in all communities.

The "care" terminology does not fit well with housing, which is conceptually different from the types of care and services associated with health, welfare, employment, etc. As a result, the "system of service" terminology is used here since it is more inclusive and descriptive of an approach to serving homeless people. Therefore, while the terminology is different, the system concept is relevant in that it suggests an approach that is value-driven and used to synthesize and structure the response to the needs of the population being assisted. A system of service will be able to achieve accomplishments that exceed the capabilities of any one of its member components. The following is offered as a definition of a homeless system of service: *A coordinated, interrelated set of technologies, providers, policies, and funding streams that continually adapts to meet effectively the service needs of defined groups of persons experiencing or at risk of homelessness.*

System of Service Development at the Local Level

There are numerous examples of how our homeless system of service has been developing and operating at a local level:

- HUD's Continuum of Care (HUD, 2001) requires communities to marshal an array of partners to develop a comprehensive plan for housing and services suited to the community's needs and its homeless people.

- The Chronic Homelessness Initiative jointly sponsored by HUD, the Department of Health and Human Services (HHS), the Department of Veterans Affairs (VA), and the U.S.

Interagency Council on Homelessness (ICH) (HUD/HHS/VA, 2003) explicitly reflects a local system principle in its identification of specific partners and responsibilities to address chronic homelessness.

- Many of the 10-year plans currently adopted in over 260 cities and counties embrace a system principle (NAEH, 2006c). As communities track their homeless populations, such plans appear to contribute to reducing the prevalence of homelessness. In their July 11, 2006, webpage posting (ICH, 2006), the ICH cites data from 13 geographically dispersed cities, large and small, and all with articulated 10-year plans, indicating reductions in homelessness from 3.3 to 40 percent over a one- to three-year period.[3]

Factors Involved in the Development of the System of Service

Exhibit 3 provides an overview of the four system components. (See also Exhibits 4, 5, 7, and 8.) The factors involved in the development of the system of service are explored in more detail in the following sections. The Corporation for Supportive Housing has identified five indicators that reflect the evolution of a homeless system of service (Greiff et al., 2003). It is useful to keep these indicators in mind as the system components are considered:

- Power: Identified, designated positions with formal authority and responsibility

- Money: Routine or recurrent funding on which the activities can rely

- Habits: Interactions among the system participants to implement the activities of the system and which occur without mandates from authority

- Technologies/skills: Identification of skills in staff and services that were not previously common

- Ideas/values: New definitions for performance and success that are widely held among participants.

Homeless Individual and Family Populations

Targeting Chronic Homelessness

During the contemporary wave of homelessness, providers have recognized that the population is heterogeneous. Programs and services have been differentiated by age, gender, family status, and disability, to name a few. Even the terminology of "the homeless" was abandoned within the field, both for its connotations of uniformity and for its elimination of the person having the experience. Special populations within the larger homeless population were well recognized (e.g., Rosenheck et al., 1999), but the public health model, the values of the caring professions, and legislation contributed to decades of service approaches that emphasized assisting as many as possible (see Gladwell, 2006).

However, there is also a tradition of looking at that subset of users who account for a disproportionate amount of service use. For example, the Agency for Healthcare Research and Quality reported that in

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[3] Several of these communities are participating in the Chronic Homelessness Initiative, where a rigorous data collection requirement gives credence to these reductions. Since other cities not receiving Initiative funding also report reductions, specialized funding alone does not account for these changes.

Exhibit 3

An Evolving System of Service To Address Homelessness

Potential Goals of the Homeless System of Service:
- Deliver services to people experiencing homelessness
- Ameliorate the circumstances of homelessness
- End homelessness

Four Components of the System	System Aspect Examined			
	Significant Development	Consequences	Challenges	Future directions
Population People experiencing homelessness… ⬇	Focus on chronic homelessness	• Targeting specific intervention efforts • Stated goal of ending chronic homeless-ness • Demands a cohesive approach	• Availability of housing • Availability of treatment and support services • Concern about groups "left behind"	• Taxonomies that identify other targeted approaches
Services and Treatments Receive services (housing, treatments and supports)… ⬇	Evidence-based interventions with ACT and Housing First as potential candidates	• Ability to deliver services of proven effectiveness	• Thoroughness and quality of research findings not yet sufficient • Transferring knowledge successfully to the service providers	• Adopt a course of action to accumulate sufficient evidence • Borrow knowledge, transfer principles from translational research
Providers Delivered by providers… ⬇	Unknown: Possibility of adapting to change	• Realignment of services offered • Focus on staff skills to deliver services • Improved organizational effectiveness and efficiency	• Absence of data to track and analyze changes • Adapting to change	• Analyze grant program databases • Activities to support organizational change
Network Working in a network of agencies, policies, and funding.	Homeless councils and plans	• Engages previously uninvolved agencies • Marshals multiple services • Creates forum to facilitate change	• Funding and policy misalignments across partners • Accommodation of homeless people within mainstream assistance programs	• Documenting changes • Identifying and sharing best practices

2002, 5 percent of the U.S. non-institutionalized population accounted for 49 percent of the medical expenditures (Conwell & Cohen, 2005). Although this body of research was not systematically reviewed in this paper, looking at many of the published studies indicates that such high users have complex and debilitating physical conditions with frequent co-occurrence of psychological problems. Authors routinely conclude by recommending multidisciplinary, team-based care. Culhane and Kuhn (1998) were able to demonstrate that the field of homelessness has its high users of services. Specifically, examining unduplicated users of shelter services, they identified that approximately 10 percent of users accounted for 50 percent of the annual nights of shelter provided. This group was labeled "chronically homeless"

because of their prolonged spells of homelessness.[4] The study also revealed that levels of behavioral and primary health problems were higher for this group than for other shelter users. Many communities have proceeded to determine the extent of chronic homelessness within their homeless populations. For example, the Institute for the Study of Homelessness and Poverty published data from 24 states, covering more than 50 cities/counties, showing chronic homelessness ranging from a low of 7 percent to a high of 53 percent (Institute for the Study of Homelessness and Poverty, 2005).

As in the primary care field, looking at high-rate users raises good questions about how resources are being used and whether an improvement in services might benefit the client and the provider. The high service use by the chronically homeless led people in the field to ask: Is shelter doing this group any good if they continue to remain homeless for prolonged periods? Is this the best we can do with scarce resources? While no one would suggest that meeting basic needs for shelter and food for chronically homeless persons is misdirected, this was a moment when the field began to question whether we had over invested in shelter as a service, whether different types of approaches should be tried, and whether service dollars might go farther if we addressed chronic homelessness specifically.

In 2000, the National Alliance to End Homelessness (NAEH, 2000) published its plan—and its challenge to the field—to end homelessness in a decade. This goal and the paths to its realization have generated a substantial amount of interest and activity, noted throughout this paper. Partially in response to the Alliance's declared goal, Secretary of HUD Mel Martinez announced that a goal of HUD would be to end chronic homelessness. President Bush endorsed this goal in his submission of the FY2002 HUD budget to Congress. Other federal departments were soon to endorse this goal, as was the ICH, the federal coordinating body on homelessness.

HUD, HHS, and the VA collaboratively developed a definition for a chronically homeless person as:

> … an unaccompanied individual with a disabling condition who has been continuously homeless for a year or more or has experienced four or more episodes of homelessness over the last 3 years. A disabling condition is defined as a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions (HUD, 2006).

HUD's goal of ending chronic homelessness is reinforced in its annual competition for homelessness funding. Since these annual resources form the backbone of the service response to homelessness in the U.S., they have exerted considerable influence in moving communities to this focus. The focus has also been reinforced by a highly effective campaign by the ICH to get cities and counties to commit to the goal of ending homelessness and chronic homelessness. As of mid 2007, more than 300 communities have published plans reflecting such goals (see the ICH Web site at http://www.usich.gov/slocal/10-year-plan-communities.pdf), and many communities participate in Project Homeless Connect, offering a one-day, one-stop model that reaches substantial numbers of their homeless citizens.

Targeting specific populations with specific services existed in the homelessness world primarily as programs serving demographic subgroups; for example, runaway/homeless youth, families, or people with disabilities (such as homeless persons with mental illness). While targeting chronic homelessness is certainly a goal at the federal level, as states and communities have developed plans they have not

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[4]   The chronic homeless label was first articulated by the Institute of Medicine (1988).

necessarily targeted chronic homelessness. The NAEH review of more than 260 city/county plans (2006c) indicates that only about a third of the community plans focus on chronic homelessness.

A homeless system of service does not require targeting of homeless subgroups, but the concept will be used subsequently to show how "population" reverberates throughout the model and fosters goal attainment. However, one of the first considerations is whether targeting is effective. Targeting has received a good deal of attention from the World Bank in its concern for improving the health status of extremely low-income people. Gwatkin (2002) concludes there is mixed evidence for targeting of health programs, although often because the targeting is inaccurate. When targeting is well designed and well implemented, he indicates it can be highly successful in achieving health status improvements.

Targeting, however, can also lead to resentment that attention and resources to other needy groups are diminished. Indeed, both the National Coalition for the Homeless (2003) and the National Policy and Advocacy Council on Homelessness (n.d.) have objected to the federal chronic homelessness terminology and emphasis because of the many homeless people who are excluded. Baumohl (2006) indicates that the definition sets up a selection bias, ensuring that those included are already likely to be eligible, by nature of the disabling condition, for other resources such as income from SSI and services through Medicaid. A third concern is the use of limited resources. One of the promises stated by federal agencies addressing chronic homelessness was:

> By addressing the housing and service needs of persons who are chronically homeless, we will have more resources available to meet the needs of other homeless people (HUD/HHS/VA, 2003).

However, this promise has yet to be tested—whether funds can be freed up using this targeting and whether they can be retained within these programs to assist other homeless people.

Housing Concerns

Housing concerns in connection with targeting chronic homelessness are also significant. Some estimate that access to 150,000–200,000 units is required (NAEH, 2000). The creation of units is underway, stimulated by HUD funding incentives and the commitment of cities and counties to ending homelessness. The National Alliance identified 196,000 opportunities under development in recently analyzed plans (NAEH, 2006c). But both the production of units and the securing of subsidies and vouchers to place eligible persons in existing affordable units are formidable challenges. In addition to concerns about the sufficiency of voucher availability, there are concerns about the ability of the housing market to provide opportunities. A study for HUD (Finkel et al., 2003) reports that 71 percent of the Housing Choice Vouchers result in successful leases, down from an 81 percent rate in 1993 (Finkel & Buron, 2001). Affordable housing availability is addressed more fully in other Symposium papers and remains a significant challenge in ending chronic homelessness.

Availability of Services and Supports

In addition to housing, targeting requires the availability of services and supports to the residents. To date, of the service departments, only HHS has released a plan specifying how its services would contribute to ending chronic homelessness (HHS, 2003). The VA, which already integrates its homelessness activities within its health care system, is also responsive. But both these departments must work within the legislative parameters that determine how and to whom services may be offered. Perhaps as a consequence of gaps in implementation, the Senate Committee on Appropriations has regularly directed

the ICH to "submit a report to the House and Senate Committees on Appropriations on the efforts of every federal agency member of the ICH in ending and preventing homelessness" (Senate Committee, 2006).

Successes to Date

Despite these many and legitimate concerns, the momentum on addressing chronic homelessness is underway and appears to have more positive results than adverse ones.

- As noted above, an increasing number of cities are beginning to see measurable reductions in both chronic and general homelessness as a result of this mobilization.

- The development of nearly 200,000 permanent housing opportunities has been noted.

- The ICH routinely reports on commitments to the goal of ending chronic homelessness by the federal departments and municipalities (see http://www.ich.gov/index.html and "e-newsletter archive").

- States have become engaged in examining policies and internal collaborations that will address both chronic and family homelessness (see the Homeless Policy Academy Web site at www.hrsa.gov/homeless).

- The ICH has further encouraged states in their commitment to address homelessness by convening regional colloquies where states have shared experiences and ideas (ICH, 2005).

Tracking these developments also appears increasingly feasible. HUD requires its homeless assistance grantees to implement homeless management information systems (HMIS) and has created a methodology that will be able to report annually on changes in the population nationwide (HUD 2007). More than half of the HUD continuums of care have begun to implement HMIS, with many sites already operational. An active program of HMIS-specific technical assistance operates and numerous vendors exist to provide turnkey systems for communities. Many states have recognized the value of these systems and partner with communities to speed implementation, achieve economies of scale, and develop strong accountability systems for homelessness. Researchers also anticipate accessing HMIS data and being able to explore patterns of experience via time-series analyses.

HUD is candid about the capabilities and limitations of HMIS. Technology in all communities is still a hurdle. Such systems will generally cover only HUD-funded grantees and the persons who use them, and therefore the HMISs cannot be thought of as capturing the entire population. Where communities are each implementing stand-alone systems, there can be no undoing of duplication of users who cross municipalities. But the bottom line is that a technology is being widely implemented that will allow monitoring of this stated goal.

Future Opportunities for Targeted Action

Perhaps the most important aspect of focusing on chronic homelessness is the implication that the approach will be used to identify additional, future opportunities for targeted action. One fruitful direction, noted in the accountability paper in the Symposium (Culhane at al., 2007), is the development of a comprehensive intake assessment that leads to the unique specification of the services, providers, and

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Exhibit 4

**System Component:
Population**

Significant development:
- Focus on chronic homelessness

Consequences:
- Targeting specific intervention efforts
- Stated goal of ending chronic homelessness
- Demands a cohesive approach

Challenges:
- Availability of housing
- Availability of treatment and support services
- Concern about groups "left behind"

Future directions:
- Taxonomies that identify other targeted approaches

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networks with which each client will interact. Another direction continues to focus on taxonomies for homeless populations. New approaches will be needed here since those developed previously have relied mostly on demographic characteristics. Time-series approaches that were used to identify the chronic subgroup may not be sufficient for surfacing other subgroups. For example, factor and cluster analyses may be needed to chart out the complexities inherent in dealing with homeless families, where complex configurations of children at different developmental levels and parents with different presenting profiles are the norm. At least one recent survey, although limited to one city, found that each time the homeless population is assessed, it is aging (Hahn et al., 2006), and this suggests another example of the emergence of a complex profile of service needs that requires careful consideration. As with chronic homelessness, such subgroups identified for targeting may stimulate a focus on effective services for them, including housing, and the provider networks skilled at their delivery.

Services and Treatments

The Case for Evidence-Based Practices and Translational Research

As the homeless system of service continues to identify subgroups within the population, one correlate will be the need to identify specific services that are appropriate, responsive to their needs, and show results. These standards are some of the most serious challenges the field of homelessness services faces. As is evident in other papers in the Symposium, particularly those focused on subgroups and effective service responses, the accumulation of a compelling literature on service effectiveness is not substantial. The declaration that "we know what works" is often based on the popularity of an approach, *ex cathedra* assertions, or the concept of truthiness: "the quality of preferring concepts or facts one wishes to be true, rather than concepts or facts known to be true" (American Dialect Society, 2006). When challenged to embrace the prevailing concept of evidence-based practices, both providers and homelessness researchers are apt to give the concept a pass, noting the difficulty of rigorous study designs, the crisis nature of homelessness, and the suppression of innovation. These are serious considerations, but fields such as medicine have embraced evidence-based approaches without regarding these considerations as impediments.

As the country re-engages with the concept of health care coverage for the uninsured, the idea that covered services must be evidence based or otherwise demonstrably effective is a fundamental premise. Since health care coverage for homeless persons is often put forth as the twin panacea with affordable housing, the field of homeless services must be prepared to demonstrate that a core of treatments and services meets the standards of evidence based or demonstrably effective. A failure to do so risks disenfranchising homeless persons from full participation if health care coverage were extended to the uninsured in the future.

Although "evidence based" is only one of the standards that can be invoked to attest to effectiveness, it is useful to examine its applicability to homelessness treatments and services. Leff (2002) defines *evidence-based practices* as "practices that have been tested employing specified scientific methods and shown to be safe [acknowledging side effects], efficacious, and effective for most persons with a particular disorder or problem." Leff points out that services may coincide with treatment outcomes, both positive and negative, but that it is impossible to tell if the services produced the result or if it was the result of some other factor. Experiments, evaluations, peer-reviewed journal articles, practice guidelines, and voluntary review organizations contribute to reducing this "noise" and help determine if specific treatment procedures produce the desired outcome. More fields within health and human services are asking about acceptable evidence for the services being delivered. The intent is to ensure that the services are safe and have the intended effect. Standards that have been used in the past—professional judgment, experience, teaching, and anecdote—do not carry these assurances.

Several housing and treatment interventions hold considerable promise for demonstrable effectiveness. At least one behavioral health treatment—Critical Time Intervention (Herman et al., in press)—has been affirmed to be evidence based by SAMHSA's National Registry of Evidence-Based Programs and Practices (SAMHSA, 2007; http://nrepp.samhsa.gov/).[5] Also, many of the primary care treatments, albeit adapted to homeless clients, fall within the family of evidence-based medicine. Two other services that are receiving considerable attention, primarily in connection with the focus on chronic homelessness, are assertive community treatment (ACT) case management, and "housing first." Both show promise as effective services.

ACT and Housing First Interventions and Fidelity to Models

ACT, described in detail in other papers for this Symposium, is a unique approach characterized by intensive, in vivo services delivered by an interdisciplinary team, overseen by a physician and nurse. The services are treatment oriented but include some linkage with other services and client advocacy. Caseloads are small, and the interdisciplinary team adjusts the intensity of its work with the client over long periods based on how the client is doing.

Systematic reviews of case management interventions (Holloway & Carson, 2001) and their applicability to homelessness (Morse, 1999) conclude that experimental and evaluation evidence is particularly strong for ACT. In addition to its superior clinical outcomes, ACT has been shown to:

- reduce service costs among high users of mental health services (Chandler & Spicer, 2002),

- engage and retain clients better than other case management approaches (Herinckx et al., 1997),

- help homeless consumers sustain treatment gains when transferred to another case management approach (Rosenheck & Dennis, 2001), and

- effectively address co-occurring substance abuse and mental illness (Drake et al., 1998).

ACT's positive effects and its applicability to behavioral health problems of homeless persons make it a key ingredient in our services armamentarium. While the evidence is supportive, it is important to note

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[5] NREPP also lists a second intervention, the Trauma Recovery and Empowerment Model, as an evidence-based service applicable to homelessness.

that the services need to be delivered with fidelity to the documented intervention. ACT is sufficiently well developed to have training programs, toolkits, and measures of fidelity (see Allness & Knoedler, 2003; SAMHSA, 2003b).

Housing first is also described in detail in other papers for this Symposium. As originally described by Tsemberis (e.g., Tsemberis et al., 2004), this intervention allows a homeless person to be placed directly into a permanent housing opportunity that includes the availability of intensive treatment and support. Tsemberis found superior housing stability for those in housing first settings offering these key components.

The field has moved somewhat rapidly to adopt housing first as the preferred housing intervention, particularly in response to ending chronic homelessness, and it is widely implemented for both individuals and families (NAEH, 2006a). The model of implementation of housing first in multiple sites is not always clear, particularly whether it includes the key components itemized by Tsemberis or is simply a label for housing locations other than overnight emergency shelter.

Thus, while the interventions of ACT and housing first show promise, their implementation in practice identifies an additional feature of importance: *fidelity to the model*. Just as a health practitioner would not freely depart from the procedures in a medical protocol that contribute to its effectiveness, a homeless service should be implemented consistent with the procedures that contributed to its effectiveness. This is not meant to discourage innovations or local adaptations. But it is an explicit caution that the greater the departure from the model, the less a claim can be made that the effective intervention is being delivered. For the homeless service field to advance in the development of a cadre of effective services, there should be a more explicit recognition of the steps needed to ensure they are effective.

Ensuring Interventions Are Appropriate

Agree on the key components of the intervention. Bassuk and Geller (2006) have noted that housing first approaches for individuals and families are not necessarily implemented with a service component. Teague and colleagues (1998) found that in more than 50 applications of ACT, many differed significantly in the key components of this intervention. We can only move to evidence-based standards if there is agreement about the intervention being implemented and its critical components.

Evaluate the evidence. Leff indicates there are professional organizations, such as the Campbell Collaborative in the U.S., that employ documented procedures to determine if a practice receives an "imprimatur" as being evidence based. The NREPP cited above uses 16 criteria to evaluate and categorize the evidence base of programs (SAMHSA, 2006). Whatever evaluation methods are used, the quality of the evidence must be subjected to systematic examination to determine if an intervention causes the desired changes and is safe.

Address gaps. If the review of the evidence suggests gaps or barriers that impede the designation of evidence based (e.g., insufficient numbers of random assignment studies, too few participants to be conclusive), agreement is needed to invest in the necessary work to address the gaps and barriers. The community committed to correcting homelessness must move to incorporate more rigorous standards ensuring their interventions are solidly grounded, effective, and safe.

Translational Research

A relevant tool for ensuring that services are effective is *translational research.* Translational research is concerned with improving the movement of knowledge developed in basic research environments to clinical practice, with equal opportunity for movement from clinical practice to research (Marincola, 2003). This focus emerged primarily from recognition of delays and failures in the incorporation of research on effective treatment into service delivery. To ensure that the investment in research is yielding changes in treatment practices, the National Institutes of Health have included translational research as a key feature of the "roadmap" for accelerating a partnership between research and clinical medicine (Zerhouni, 2003).

Exhibit 5

**System Component:
Services and Treatments**

Significant development:
- Evidence based interventions with ACT and housing first as potential candidates

Consequences:
- Ability to deliver services of proven effectiveness

Challenges:
- Thoroughness and quality of research findings not yet sufficient
- Transferring knowledge successfully to the service provider

Future directions:
- Adopt a course of action to accumulate sufficient evidence
- Borrow knowledge transfer principles from translational research

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Translational activities do not necessarily wait for the same types of validation processes that characterize evidence-based practice. They may function and succeed best in dynamic environments and specialized centers where research/evaluation and clinical teams operate together, using checks and balances, internal review boards, and ethics guidelines. The goals are to ensure treatment protocols are being followed and client safety is continuously monitored while innovations are being tried.

The relevance of the translational research concept to homelessness is twofold. First, the concept directs us to be receptive to innovations homeless service providers are developing with their clients. These are opportunities to identify more effective and efficient services. Providers must be more willing to view themselves as the "specialized centers" noted above, where innovations are accompanied by evaluation, however basic.

The second reason translational research is relevant relates to the barriers we face in trying to ensure practitioners can incorporate these practices. After nearly a decade of innovative homeless service development, Manderscheid and Rosenstein (1992) noted that new treatment models in homelessness were not penetrating to the local level. Even today, resources, time, and attitudes do not always facilitate adoption of new practices. The mechanisms by which service providers can learn about new service developments could also function much better. Whether the mechanisms are technical assistance offerings, reports, toolkits, courses, or conferences, they are not always designed with translational research principles in mind.

Respectful relationships, particularly avoiding top-down and mandated approaches, have been a key ingredient, one consistently underscored in the Translating Research into Practice (TRIP) Initiative of the Agency for Healthcare Research and Quality (2001). Such features as factoring in adult learning, using multiple methods of sharing and disseminating the knowledge, developing an implementation plan in lockstep with the knowledge transfer, and trying to ensure a receptive home environment have also been used for effective transfer (Davis & Taylor-Vaisey, 1997).

As homeless assistance systems develop targeted responses to subgroups of homeless people, it becomes increasingly important for our service portfolio to be both varied and validated. Specific subgroups identified though taxonomy development or comprehensive intake assessments will require targeted services of known effectiveness. While we have a glimpse into housing and treatment services that are effective, much more needs to be done to develop a portfolio of effective services. As this effort engages, it will also be important to ensure that we are putting in place processes consistent with translational research principles.

Providers of Assistance

Homeless persons need to receive their services from someone or some organization. However, our knowledge of the provider component of the suggested system of service is minimal. Providers of homelessness assistance have evolved through significant changes. Responses to homelessness in the 1980s were often by individual, community-based programs, many of which were faith-based, communicating and coordinating informally with related providers (ICH, 1992). Over time, funding requirements and knowledge developments created circumstances that require these organizations to have more formal structures (e.g., data and accounting systems, boards of directors) and to define their operations within an increasingly organized local context.

Today, providers of homelessness assistance are functioning in the midst of increased targeting to reduce and end homelessness, a sharpened set of service tools, and a network of organizational collaborations (to be discussed in the next section). In addition to these dynamics, they are affected by changes occurring in the funding of homeless services. The budgets of most of the main federal programs providing funding specifically for homeless assistance have traditionally fared well or at least not seen cutbacks. Exhibit 6 shows these changes:

Exhibit 6

Homeless Assistance Program Funding

Program	FY2002	FY2007	Change
HUD's Homeless Assistance	$1,123B	$1,536	$+413M
VA expenditure on homeless services[6]	138M	244	+106M
Projects for Assistance in Transition from Homelessness	40M	54	+14M
Healthcare for the Homeless	116M	172	+56M
Education for Homeless Children and Youths	50M	62	+12M

In addition to these resources, the Department of Labor has also emphasized homelessness, with its homeless assistance webpage (http://www.dol.gov/dol/audience/aud-homeless.htm) indicating more than $65 million in 2006 awards.

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[6] These are approximations derived from estimated expenditures on medical care to homeless veterans as well as targeted homeless appropriations.

However, as providers seek out these resources, they must also respond to the conditions inherent in any awards received. We have only limited systematic data that give insight into how providers are responding to these dynamics (HUD, 2007). The 1996 National Survey on Homeless Assistance Providers and Clients (NSHAPC) (Burt et al., 1999) was the last opportunity to compile extensive data on the number, affiliation, and services offered by such providers. There are no current federal plans to repeat the data collection. The HMIS database, however, allows HUD to accumulate some data on providers that are submitted annually to Congress.

In its 2007 submission (HUD, 2007), HUD provided limited data comparing 1996 and 2005 for bed availability in emergency shelters, transitional and permanent housing. While 3600 programs have been added, bed growth came exclusively from permanent (211 percent increase) and transitional housing (68 percent increase), with emergency shelter beds declining by 38 percent. As HUD has focused on the goal of ending chronic homelessness, emphasized its role as a housing program, and used its annual homeless competitions to shape community behavior, these emphases have had consequences for providers as reflected in these bed data.

Other factors are undoubtedly influencing the performance of providers. For example, another emphasis by HUD is that grant applicants demonstrate access to other, non-HUD revenue sources for delivery of non-housing services. We currently lack data or analysis of how providers seeking HUD funding have responded and whether they have been successful in leveraging and matching such funds to support non-housing services. In addition, the explicit goals of ending homelessness/chronic homelessness, the development of action plans by State Interagency Councils, and the development of city/county plans in 300-plus jurisdictions are just a few of the factors that must be impacting how providers are conceptualizing their missions, services, and their personnel needs. Important as these trends may be, we continue to lack systematic data about how providers are responding.

These are fundamental data that are needed to develop and improve the operation of a homeless system of service. Without these data, we lack basic information on the universe of organizations that are homeless assistance providers and on such issues as the types and amounts of services they can offer, the numbers of people they can serve, the qualifications of their staff, the quality of their business and service procedures, and whether assertive action is needed to influence duplications or gaps in the existing configurations.

In comments on the paper offered at the Symposium, both Haggerty (2007) and Karnas (2007) raised issues associated with the provider community. Haggerty suggests that the current approaches to provider funding have resulted in an overly large number of providers without achieving the degree of *coordination* among provider that funders expect. She asked if the time had come for consolidation among homeless assistance providers and noted the substantial siphoning of resources into overhead when a large number of multiple providers are sustained. Karnas observed that provider growth had been stimulated by community self-determination inherent in the original continuum of care concept. Although self-determination had slowly been amended by an increasing number of conditions imposed by HUD, the laissez-faire approach of the past is no longer viable. Grantees must be directed toward certain actions since targeted homeless assistance will never be sufficient to meet needs. While subpopulation targeting might be one example, Karnas was explicit about the need for providers to capitalize on the services delivered by mainstream programs designed to assist low-income and disadvantaged persons. Both comments speak to the importance of having a more detailed understanding of provider characteristics than is currently available.

Exhibit 7

System Component:

Providers

Significant development:
- Unknown: Possibility of adapting to change

Consequences:
- Realignment of services offered
- Focus on staff skills to deliver services
- Improved organizational effectiveness and efficiency

Challenges:
- Absence of data to track and analyze changes
- Adapting to change

Future directions:
- Analyze grant program databases
- Activities to support organizational change

In addition to the absence of data, we must acknowledge that providers face substantial challenges connected to the translational research discussed above. If a program accepts evidence indicating an alternate service approach is superior and decides to change, complications lie ahead. Securing the funding for the service, finding time and resources to retrain staff, facing the possibility of having to replace staff, ensuring that the new service is delivered with fidelity to the model, and demonstrating to partners that the organization is effective are examples of the complications service managers address. Inherent resistance to change must also be acknowledged. Programs of technical assistance specifically associated with homelessness funding might usefully focus on how best to assist providers as they adapt to changes related to evolving goals, data requirements, types of services supported, and the multi-agency collaborations now required of them.

Some would argue that annual reporting to funders is a source for the information on providers. But as the history review reminds us, not all organizations that assist low-income and homeless persons are formal participants in such funding. Some of the problems are also associated with the legislative authorizations for homeless assistance programs. Eligibility for beneficiaries can be inconsistent across programs (e.g., the poverty level at which a person/family qualifies); the services supported with funding may be so prescribed that only limited aspects of clients' needs can be addressed; organizations may need to meet specific criteria to be eligible (e.g., through charter or certification); and the authorizing legislation itself may specify the frequency and type of reporting. These variations must be dutifully accounted for by responsible state and federal agencies and they result in reporting of varied content and time frames that can be difficult or impossible to reconcile.

Providers are an essential component of the system of services, but this section has argued that our knowledge base concerning providers is in need of further development. As the next section will make clear, the expectations imposed on providers are not confined to the provision of services. Stewardship over providers, whether by local, state, federal or nonprofit authorities, has moved many of them toward understanding their operation within a network of other relevant organizations.

Networks: Collaboration and Coordination to Address Homelessness

A critical component of a contemporary homeless system of service is a network of providers that cumulatively offers the array of services needed by those experiencing homelessness. Since the mid-1990s, there has been steady momentum toward affirming that only a collaboration of multiple agencies will succeed in addressing contemporary homelessness. This has been true because it is difficult for one agency, such as a housing program, to be expert in the multiple services a homeless person or family may need, or to secure the funding for these services. Establishing collaborations has become the currency by which these networks are being formed (SAMHSA, 2003a). These collaborations are often formalized in

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interagency bodies, memos of understanding, joint plans, and other manifestations that signal sharing of information, resources, and improved access to services.

One impetus to such collaboration began with HUD's implementation of the continuum of care concept in the mid 1990s (Burt et al., 2002). Since its introduction, the continuum concept has shown the resiliency to accommodate many different components. In its earliest introduction, it emphasized the *array of services*, primarily housing, that a homeless person may need to exit homelessness and move to self-sufficiency. HUD required that a community submit a request for funding that demonstrated how it would create this array. Importantly, the application for funding also had to show it had been developed in consultation with a specified panel of partners. Over time, the continuum concept has also been identified with the *infrastructure* that is implied if this panel of multiple partners formalizes its operations and functions to address homelessness in its community. HUD currently defines it as a *plan*:

> The Continuum of Care is a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness (HUD, 2001).

Having a continuum of care, both as a plan and an infrastructure, is a necessity to compete for HUD's homelessness resources. Consequently, this requirement has had extraordinary influence on localities and states, leading to the formation of collaborations with an assortment of interested parties. This goes well beyond service providers to include private developers, faith-based institutions, education programs, police, banks, and others.

HUD's evaluation of the continuum of care approach (Burt et al., 2002) noted that when it was introduced, the continuum concept had the greatest impact on communities that had done relatively little to collaborate on homelessness. The evaluation, while preselecting "high performing" continuums early in this decade, showed that effective continuums increase communication among the organizations involved, improve coordination among providers, and serve more homeless persons. For homeless programs funded by the VA, a somewhat parallel effect has been reported. McGuire et al. (2002) found that relationships (i.e., communication and access to services) between VA programs and the community were strongest in the VA programs that actively supported community programs versus those that operated in a stand-alone mode.

These collaborations have been shown to yield other benefits for homeless people. The 1998 Symposium included an opportunity to report on a set of findings from the Access to Community Care and Effective Services and Supports (ACCESS) study (Randolph et al., 2002)—a service/treatment evaluation looking at the creation of comprehensive systems of services to address homelessness and serious mental illness. However, several of the findings from the systems integration efforts of the ACCESS study are instructive here. Over the five years of support, all the communities in the study demonstrated increased systems integration, but in the subset of communities where integration was an intentional focus, it was more focused and partner-specific than in the comparison sites (Morrissey et al., 2002). Furthermore, high degrees of systems integration were beneficial for the homeless consumers served in the study. In settings where high system integration had been achieved, clients were better able to access and retain housing (Rosenheck et al., 2002).

With funding and policies, organizations can be motivated and supported to collaborate for the benefit of homeless people in the community. Collaborations may work best when they are expected to be focused and partner-specific since they may identify specific ways in which the organizations can coordinate their actions. Current homeless-specific funding places a priority on the delivery of a set of services to a designated homeless population, and collaborations are secondary. HUD's continuum of care is the exception. More could be done by programs and with amended legislation to support collaborations. In addition, several federal homelessness reports (ICH, 1992; HUD, 1994; U.S. General Accounting Office, 1999, 2000) have been instrumental in pointing out the importance of accessing a broader set of assistance programs to address homelessness.

Blended Funding Resources

The practice of blending both homeless-specific and broad assistance program resources began only in the past few years. This practice is one of the principal messages in the HHS plan (HHS, 2003) and is emphasized in HUD's latest annual funding competitions as the leveraging of additional service resources. The broader set of resources is often referenced as *mainstream programs* and covers broadly focused programs directed to helping those who are low-income or disabled with cash assistance, health coverage, training, education, and other forms of assistance (see CMS, 2003).

A series of Policy Academies for states (www.hrsa.gov/homeless), from 2001 to 2005, focused on helping states develop plans to address homelessness by tapping and coordinating these mainstream program resources. The ICH reports that 53 states and territories have begun to establish state-level interagency councils on homelessness where plans and blended resources are the focus. HUD's evaluation of continuums of care (Burt et al., 2002) also noted that engagement of mainstream services can be both independent of and embedded with the operation of local continuums. Both at the state and community levels, homeless systems of service increasingly recognize the need for collaboration and for the inclusion of mainstream programs in any collaborative network. For such networks to work most effectively, it is desirable for policies to be supportive and not hamper their functioning. There are several hurdles to overcome.

Eligibility policies. Most mainstream program eligibility policies are established explicitly at the federal or state level by statute or regulations, or implicitly by funding levels, thus limiting flexibility at the local level. The most apparent limitation that affects good network performance is eligibility differences across programs. Eligibility standards are typically established separately and legislatively for each program funding stream, and it is rare for exactly the same criteria to be used across funding streams. For example, while all are intended to provide assistance to poor individuals or families, TANF, Food Stamps, and Medicaid have separate eligibility requirements. The U.S. Government Office of Accountability has recommended that a common eligibility application might be a solution to these multiple requirements (U.S. General Accounting Office, 2000). Several states have implemented consolidated application forms. Texas uses a single form to determine eligibility for Medicaid, SCHIP, TANF, Food Stamps, and long-term care (National Governors Association, 2007). Information provided on the form for one program also can be used to determine eligibility for one or more other covered programs.

Available funding. Social Security, Medicare, and Medicaid represent over 40 percent of the federal budget (Riedl, 2006). Past and anticipated rates of growth in these programs have raised concerns in many quarters about their long-term sustainability (Walker, 2006). Current budget deficits have prompted some to propose substantial cuts in mainstream programs for low-income and middle class populations. For

example, the Stop Overspending Act of 2006 (S. 3521), while not enacted, proposed deep cuts in domestic discretionary and entitlement programs if spending containment targets were not met.

Barriers to participation. Concerned about growth in their outlays for Medicaid, the Kaiser Commission on Medicaid and the Uninsured/Kaiser Family Foundation reported that during 2004-2005 all states took action to control costs in Medicaid (Smith, et al., 2004). Goldstein (2006) cited such actions as states requiring that "members" sign compliance contracts or face penalties, imposing or increasing copayments, assigning patients to priority groups, and increasing documentation requirements. The Deficit Reduction Act of 2005 requires all Medicaid participants and applicants to provide proof of citizenship as a condition of eligibility. Missouri has passed a law to eliminate its current Medicaid program in 2008. Interestingly, states do not appear to be focusing their cost containment proposals on the 4 percent of Medicaid enrollees who account for nearly 49 percent of Medicaid expenditures (Sommers & Cohen, 2006, using data from the Kaiser Commission on Medicaid and the Uninsured).

Exhibit 8

System Component: Networks

Significant Development:
- Homeless councils and plans

Consequences:
- Engages previously uninvolved agencies
- Marshals multiple services
- Creates a forum to facilitate change

Challenges:
- Funding and policy misalignments across partners
- Long term viability of public assistance safety net

Future directions:
- Documenting changes
- Identifying/sharing best practices

Impacts of welfare reform. The welfare reforms of the mid-1990s have been closely monitored and systematically evaluated (Haskins, 2006). The Temporary Assistance for Needy Families program (TANF), created by the 1996 welfare reform law, shifted the focus of cash assistance away from aid to children in low-income families to temporary aid conditional on work. This created interesting parallels to the work requirements that accompanied charity in the 18th and 19th centuries. Since its implementation, TANF caseloads have declined by 60 percent, with 60–70 percent of women leaving welfare being employed (Haskins, 2006). Other research (e.g., Miles & Fowler, 2006) has found that some current and former TANF families cannot pay their rent (21–25 percent) and experience homelessness (7–44 percent). Interim final rules published in 2006 implementing changes in the TANF program, included in the Deficit Reduction Act of 2005, limit states' flexibility in addressing employment barriers for TANF recipients, including adults in homeless families. Advocates for public assistance have pointed out that these rules opt for restrictive interpretations within the latitude available to the HHS (e.g., Lower-Basch et al., 2006).

The issues are significant because they demonstrate the challenges of accessing mainstream public assistance resources within the context of a homeless system of service. Not only are there degrees of freedom restricted by legislation and regulation governing these programs, but the ground many of them are based on has begun to shift. Although many of these actions remain proposed rather than enacted, they bear close monitoring by those involved in homelessness because of their troubling implications for the resources and policies needed for effective assistance networks.

The developments are also important to the direction in which a homeless system of service might develop. If mainstream resources continue or increase in importance as a source of assistance to homeless persons, the system could be subsumed or function as a specialty subsystem within the generic

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approaches to assisting low-income, disadvantaged, and uninsured populations. This pattern characterized the U.S. approach to homeless assistance until the contemporary wave of homelessness. Such a direction may have appeal to critics who feel that addressing homelessness has become its own industry. However, if mainstream resources become more difficult to access for all eligible people, including homeless persons, it would be a *prima facie* argument that the homeless system of service needs continued growth, development, and funding as our principal hope for addressing and ending homelessness.

Affordable Housing and the Prevention of Homelessness

No matter how well developed and functional a homeless system of service, its success will be limited without an accompanying effort to prevent homelessness. Since the 1998 Symposium presentation on homelessness prevention (Shinn & Baumohl, 1999), no models or policies have emerged that would parallel the breakthroughs occurring in homeless service systems. Guidance documents from the ICH for developing 10-year plans on homelessness emphasize the inclusion of a prevention component and itemize such suggestions as:

- create discharge planning protocols from jails, substance abuse and mental health treatment facilities, foster care, etc.,

- dedicate housing resources for individuals discharged from inpatient psychiatric care, and

- centralize funding and service delivery to increase coordination (ICH dated).

Discharge planning receives frequent mention in state plans to address homelessness (see www.hrsa.gov/homeless) and is the only system-level prevention approach noted in the community plans analyzed by the National Alliance. However, when HHS undertook an exploratory study to determine if it was possible to evaluate the degree to which discharge planning prevented subsequent homelessness, the results were not encouraging (Moran et al., 2005). The study looked at documents, policies and procedures, and staff actions within a convenience sample drawn from four classes of institutional or custodial care:

- adult inpatient psychiatric treatment,

- residential treatment centers serving children and youth,

- residential treatment programs for adults with substance abuse disorders, and

- foster care independent living programs.

The study concluded that an evaluation of whether discharge planning prevented homelessness among exiting clients could not be conducted as yet. Discharge planning was not a distinct process in these settings, and discharge planning practices could not be separately identified from other program services. For persons in settings where there are long periods of custody and a distinct exit period, such as prisons, discharge planning processes are probably well developed and offer real possibilities for helping clients avoid homelessness as they reenter community life. But much remains to be done to clarify the contribution of discharge planning to the prevention of homelessness.

As is evident from the ICH list above, prevention also tends to cover a broad range of activities, and this contributes to a lack of focus and a lack of progress in moving from assertion to actual demonstration of preventive effects. The label of homelessness prevention is applied not only to processes, such as

discharge planning, but also to services that enhance housing stability or improve a person's level of functioning and to programs of social justice, such as access to affordable housing, living wages, and poverty reduction (e.g., NAEH, 2006b). Perhaps more progress could be made in addressing homelessness prevention if we were more explicit about the type of homelessness being prevented and the subgroup of people to which the prevention interventions were being applied. At least three distinct approaches to prevention can be identified in the literature:

- *Prevention through placement:* processes to secure housing and community integration for vulnerable groups exiting long periods of custodial care.

- *Prevention of relapse:* services, treatments, and supports specifically delivered to formerly homeless people and intended to prevent the reoccurrence of homelessness.

- *Tenancy preservation*: services and interventions directed to housed beneficiaries of social service programs who exhibit risk factors likely to lead to the loss of housing. As noted above, one study suggested that discharge planning remained too elusive a process in many settings to be assessed for its contribution to homelessness prevention. This only suggests the need for clarification and refinement so that it can be studied as the premiere example of the first item in the list above, a placement strategy.

Relapse prevention, the second item in the list above, has accumulated a substantial amount of literature, as attested to by the housing stability studies reviewed elsewhere in the Symposium. Much of the support has come from the applications of behavioral health case management approaches such as ACT and critical time intervention (CTI) (Herman et al., in press). But this literature is in need of a systematic review to help narrow the set of interventions that appear to contribute to relapse prevention and to determine what other populations might be assisted by these services.

While Shinn and Baumohl (1999) raised numerous and appropriate cautions about the feasibility of the third focus, it remains conceptually relevant (e.g., NAEH, 2006b). The history of homelessness in the United States tells us that the low-income populations who are the beneficiaries of these public assistance programs are the first to experience problematic homelessness. There is merit in trying to develop interventions that prevent them from losing their housing, but two components remain undeveloped.

First, we lack a refined set of indicators, whether clinical or situational, that denotes risk of this event (Burt et al., 2005). Second, the range of intervention options is so inclusive it keeps us from being able to focus on a potential set of actions to try, and from developing a cohesive prevention strategy (Burt et al., 2005). The following have been suggested as preventive approaches to housing loss (Burt et al., 2005):

- cash assistance,
- training in financial management,
- representative payees,
- mediation,
- training in household management,,

- clinical interventions, such as assertiveness training and trauma services,
- development of affordable housing
- training in household management,
- advocacy for a living wage.

To ensure substantive contributions to the topic of homelessness prevention at the next Symposium on Homelessness Research, there are clear challenges for leadership, improved conceptualization, and focused work on this topic.

Is the Issue Affordable Housing?

No discussion of homelessness prevention, however, can ignore the problem of affordable housing in the United States. As noted earlier, Karr (1992) has suggested that policies since the 1920s have either failed to emphasize the production of affordable housing or contributed to its loss. The Joint Center for Housing Studies (2006) recently indicated that between 1993 and 2003 the largest loss of rental housing stock occurred in the units accessed by the lowest income groups: "the number of units renting for $400 or less in inflation-adjusted terms fell by 13 percent—a loss of more than 1.2 million."

The study further indicated that among the nation's 34 million renters, 22 percent face a severe cost burden, paying 50 percent or more of their income for rent. However, *among the lowest income group*, 70 percent face a severe cost burden. Rapidly increasing housing costs in many communities have even led to proposals for the creation of "workforce housing" so that teachers and firemen can afford to live where they serve (Bell, 2002). But perhaps most compelling is data from HUD's report to Congress on worst case housing:

> In 2003, there were 78 rental units affordable to extremely low-income renters[7] for every 100 such households, but only 44 were available for these households (the remainder being occupied by higher-income households)" (HUD, 2003).

This severe shortage—availability of less than half of the needed number of affordable units—has extraordinary implications for any effort to prevent homelessness. Substantial numbers of extremely low-income renters face a severe cost burden, cannot find affordable housing, or are forced into homelessness or doubling up with others. For some households, this is a temporary situation from which they recover without ever interacting with the homeless system of service. For many others, *the situation guarantees a steady supply of customers flowing into the homeless service system*. Any prevention strategy must reckon with affordable housing, either in the production of units or in the adequacy of subsidies to help the poorest families and individuals with their rents.

Global Perspectives on Homelessness

This paper has suggested that the United States is demonstrating considerable progress in developing a homeless system of service, even if its development appears unintentional and unguided by policy. It has acknowledged the value of continued development of knowledge, policies, prevention approaches, and affordable housing access, but suggested the yield from such developments might be improved if they were guided by a comprehensive and accepted vision of the goals and operations of a homeless system of service. The remaining goal here is to consider these U.S. developments in relation to homelessness in other nations. When such a broader global perspective is adopted, the limited evidence we have suggests that larger forces are in play and should be factored into the approaches we take in this country.

In March 2005, the United Nations Commission on Human Rights was briefed by Special Rapporteur on Adequate Housing, Miloon Kothari. He reported that homelessness is a growing problem for virtually every country and conservatively estimated that 100 million people are homeless. According to a report

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[7] "Renters with incomes below a level that varies geographically but, on average, about the same as the federal definition of poverty."

issued by the United Nations Centre for Human Settlements (2000), nations were clustered into three groups:

- high-income, industrial countries including the United States, Western Europe, Canada, Australia, and Japan,

- other industrial countries with economies in transition, including Eastern and Central Europe and the Russian Federation, and

- developing countries, including many in Africa, Latin America, and much of Asia.

Allowing for varying definitions of homelessness based on culture and circumstance, the report notes that homelessness is unrelieved in countries in all three groups.[8]

Even Western European countries associated with well-developed systems of social services and social insurance for their citizens report prevalence of homelessness. For example, Finland, with guarantees of social security, access to health care, and government involvement in regulating the housing market, reported that .2 percent of its population remained homeless.

As noted earlier, access to affordable housing and health care for people who are uninsured are frequently offered as the two policies that would effectively address homelessness in the U.S. It is interesting to compare the estimated prevalence of homelessness in the U.S. with countries that have both policies in place. The expectation would be substantially lower prevalence of homelessness. Data from Canada, Great Britain, and France are presented in Exhibit 9.

Exhibit 9

Estimated Prevalence of Homelessness

Country[9]	Public Housing as a % of Total Households	Nationalized Health Care?	Prevalence of Homelessness
United States	1% (public housing)	No	1%
Canada	5% (public and 3rd sector housing)	Yes	.4-.8%
Great Britain	11 % (council housing)	Yes	.4%
France	16% (social housing)	Yes	.4%

The data suggest that these two policies have moderating effects on the prevalence of homelessness, but may not constitute the silver bullet we seek. In combination with information in the U.N. report, the data

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[8]   Varying definitions of homelessness are significant. During April/May 2007, the author participated in more than 30 interviews concerning homelessness in three of the U.S. Pacific Territories. Extended family continues to be the first line of defense on these islands. When a member experiences a significant setback such as chronic illness, housing loss, job loss, etc., families readily take that person/household into another household. Consequently, when applying the HUD definition of homelessness, the circumstance is rare to nonexistent since homeless persons are being sheltered by family members. Service providers are aware of the impacts of such accommodations on families and are eager to have homelessness acknowledged as the islands experience it. They identify fairly large numbers of family members as homeless, not just "at risk" of homelessness. But when constrained by the mainland/legislative definition, these persons cannot be counted and point-in-time data portray little prevalence of homelessness.

[9]   The prevalence data are estimates based on different years, although all during the 1990s. The public housing/household data are from 2000 and later.

suggest that other forces affect the extent to which accessible affordable housing and health care coverage protect against homelessness.

The report notes that the number of households in poverty in all three national clusters is growing faster than other households and that global reductions in homelessness are unlikely. The causes of global homeless are complex, much as are the causes of homelessness in the United States. Some have argued that economic globalization is at the heart of growing poverty and homelessness (Homebase, 2005), but these are matters for economists to sort out. What is clear from the U.N report is that economic factors cannot be eliminated.

Among the other causal factors noted in the report are:

- growing poverty,

- decreased government investment in social welfare and social security programs,

- inequalities in housing access,

- economic competition,

- land use policies that favor privatization,

- unplanned urban development,

- mass migrations, and

- weakened family support and child protection leading to rapid increases in street children.

Each of these factors strikes a chord of recognition for a parallel circumstance in the United States. The report concludes with 11 recommendations to combat homelessness, many consistent with the data, service, networking, and knowledge development suggestions offered here. Other recommendations, such as an emphasis on emergency shelter, remind us of how far we have progressed in the United States in our ability to advocate for placing primacy on permanent housing rather than emergency shelter.

Closing Note

What remains clear to many, however, is that individual action by a provider, while deeply inspiring, is a strategy of limited success. The contemporary wave of U.S. homelessness has proven to be enduring and complex. Its persistence has been accompanied by the gradual evolution of a system of service that may stimulate our thinking about how we can best continue to address the needs of people experiencing homelessness.

In past waves of homelessness, the moral imperative of responding to people in desperate circumstances has prevailed. Charity, church, kin, and compassion often did more to redress homelessness than civic administration. But in the face of complex contemporary homelessness, the force of government legislation, policy, and financial resources continue to be at the frontlines of our expectations and approaches to solve this crisis.

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