Toward Understanding Homelessness:

The 2007 National Symposium on Homelessness Research

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Overview

On March 1–2, 2007, the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Housing and Urban Development (HUD) sponsored the second National Symposium on Homelessness Research. This publication is a compendium of the 12 papers prepared for and presented at the Symposium.

In 1998, the first National Symposium on Homelessness Research was held in Arlington, VA, bringing together researchers, policymakers, practitioners, and formerly homeless people to review and discuss what had been learned in the decade since the passage of the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77). The McKinney Act provided the first federal funds targeted specifically to address the needs of homeless people. Sponsored jointly by HHS and HUD, the two-day Symposium featured presentations by authors of 11 research papers and facilitated discussions to provide feedback to the authors and Symposium planners. The papers were then revised and published in a compendium titled *Practical Lessons: The 1998 National Symposium on Homelessness Research*.

Now, 10 years later, the landscape of homelessness research has evolved significantly. New models for housing and service delivery have emerged, and cutting edge research has expanded our understanding of the various populations that experience homelessness. Research on the dynamics of shelter use has yielded important information about the characteristics of single individuals experiencing homelessness and has brought focus to the population experiencing chronic homelessness. Efforts continue within and across federal agencies to standardize homeless-related data definitions and improve performance measurement activities, an example of which is HUD's Homeless Management Information System (HMIS). The Symposium held in 1998 focused primarily on housing and health and human services. While these issues are still central to the issue of homelessness, additional areas relating to employment, veterans, and the criminal justice system are increasingly important to understanding the complexity of homelessness in the 21st century.

Much research has been accomplished since 1998, but progress has not occurred equally across subject matter since that time. Certain subjects were ripe for analysis in 1998, and policy priorities frequently move research efforts in particular directions. In recognition of this evolution, HHS and HUD sponsored a second National Symposium in 2007 to provide a forum in which to present and synthesize the current state of the art knowledge pertaining to homelessness.

For the 2007 Symposium, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at HHS and the Office of Policy Development and Research (PD&R) at HUD contracted with Abt Associates Inc. and Policy Research Associates, Inc., to work with staff across several federal agencies and the U.S. Interagency Council on Homelessness to coordinate a second National Symposium, focusing on lessons learned from research and practice since the 1998 meeting. To guide the development of the Symposium, an expert panel was convened to provide input on the format for the event, paper topics, paper authors, and Symposium participants. The members of the expert panel also reviewed and provided comments on draft papers prior to the Symposium.

The members of the expert panel were:

Martha Burt, Urban Institute

Dennis Culhane, University of Pennsylvania

Meredith Deming, Bradenton County Coalition on Homelessness

Charlene Flaherty, Corporation for Supportive Housing

Paul Koegel, RAND Corporation

James O'Connell, Boston Health Care for the Homeless Program

Ann O'Hara, Technical Assistance Collaborative

Debra Rog, Westat

Nan Roman, National Alliance to End Homelessness

Phyllis Wolfe, Phyllis Wolfe and Associates, Inc.

Teams of authors consisting of leading researchers and practitioners were commissioned to prepare 10 papers for discussion at the Symposium, held March 1–2, 2007 in Washington, D.C. To supplement these 10 papers, the HHS Substance Abuse and Mental Health Services Administration (SAMHSA) sponsored two additional papers: an eleventh paper focusing on rural homelessness and a twelfth paper written by an "emerging researcher" (i.e., chosen from among individuals from underrepresented racial and ethnic groups, individuals with disabilities, or individuals from disadvantaged backgrounds) in order to increase diversity on a national or institutional basis in the field of homelessness research. The emerging researcher was competitively selected from a pool of current doctoral candidates and recent doctoral graduates to prepare a paper and presentation for the Symposium. At the Symposium, the paper authors presented their papers, and Symposium participants, comprising over 200 researchers, service providers, consumers and policymakers, provided feedback to the authors. The final drafts of the 12 papers are presented in this compendium.

Lessons of the Past Decade and Future Directions

While the papers commissioned for the 2007 Symposium cover a wide range of topics, two broad themes illustrate how the fields of homelessness research and practice have evolved since the 1998 Symposium.

The emergence and strengthening of new and existing collaborative efforts to address homelessness at all levels of government and among local providers and consumers is a distinguishing feature of the last decade of homeless assistance. This trend toward systems change and integration contributes to a more holistic view of interventions to mitigate and, ultimately, end homelessness. Examples include the growth and enhancement of continuums of care as organizing structures for combating homelessness, the development of Policy Academies as a tool for prioritizing and coordinating state efforts, the creation of local 10-year plans to end homelessness, and the engagement of mainstream service resources such as Medicaid to expand the services provided through homeless assistance programs. Such collaborative efforts often have other positive results, including attracting new stakeholders that had not previously been involved in homeless assistance networks, as well as increasing resources to fund services and produce housing. Given the fierce competition for the limited supply of low-cost housing for those who

are homeless as well as those who are poor and potentially at risk of homelessness, these resources—both organizational and financial—are critical to ending homelessness.

In order to prevent and end homelessness, we know that multiple service systems must work together, and we are beginning to understand effective strategies to make change happen within and across systems. For example, the nexus of incarceration and homelessness—and the movement between these two systems—demonstrates the critical need for collaborative efforts among the criminal justice, housing, and homeless assistance systems. Through coordination among housing, homeless assistance providers, and mainstream family support systems, new approaches are being developed to help families retain housing they may be at risk of losing or to transition quickly out of emergency shelters if they do become homeless. Similarly, practitioners and policymakers are addressing how to coordinate mainstream employment, training, and income support programs with interventions targeted specifically to people who are homeless to enhance work opportunities and increase incomes.

Despite the factors that are promoting collaboration, there remain challenges to true systems change. Homeless assistance services continue to be fragmented in some communities, and the prevalence of renewal grants in HUD programs may have the unintended effect of reinforcing this fragmentation. More broadly, change is hard. A relatively small number of communities have brought together the broad-based coalitions of homeless assistance providers, mainstream service providers, politicians, and the business community that are needed to develop a systemic approach to homelessness. Others have made more modest moves in this direction. Research to document and assess the outcomes of collaborative efforts on the people they serve and on homelessness overall is beginning to emerge, leading to the second theme of the past decade.

The increased emphasis on collecting and using data to understand better the characteristics and dynamics of homelessness is helping the homeless assistance field synthesize research findings, assess what we know, and outline what we still need to learn. The growing use of Homeless Management Information Systems (HMIS), cost-benefit analyses, and administrative data systems to learn more about what works for whom, and at what cost, is helping move the field from anecdotal to evidence-based approaches. We are better able to address questions about how people who are homeless differ from those who are poor, but domiciled. When fully implemented, HMIS will help document the number of people who are homeless, some of their characteristics, and how they use homeless assistance services over time. Analysis of service utilization and cost data from administrative systems has already furthered our understanding of patterns of homelessness and service use for unaccompanied adults with disabilities. The application of this type of analysis to other subpopulations—such as homeless families—may shed light on how homeless assistance programs can best target housing and service resources to meet the needs of other, less understood groups.

Research tools are evolving and more data are available now than at any time in the past. This allows programs to better target services and respond flexibly to individual needs. However, there is still much to learn. The usefulness of research on homelessness is often constrained by the lack of clear definitions and rigorous measurement of both the interventions (housing and services) and their beneficiaries. We strive to learn "what works for whom," but we often fall short in our efforts to measure the "what" and to characterize the "whom." There is a clear need for continued attention to data collection, to the importance of rigorous controlled studies to expand our knowledge, and to the mutual benefits of sharing information between researchers and the field.

The papers presented and discussed at the Symposium and compiled in this compendium are briefly previewed below. Collectively, they offer a cogent summary of how far we have come since the 1998 Symposium, and where we still need to go in homelessness research.

Synopses of 2007 Research Papers

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

Walter Leginski 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.

Changing Homeless and Mainstream Service Systems: Essential Approaches to Ending Homelessness

Martha Burt and Brooke Spellman focus on how federal policy and state and local action have stimulated the development of homeless assistance networks and how those networks are evolving to address ending homelessness. While little formal research has been done on this subject, the authors present frameworks for assessing system change as well as describe promising practices from the field. They describe factors that may influence the success of change efforts, including the local and state context, the interest and commitment of stakeholders, the scope of desired change, the governance and management structure for change, and the intended process for change. They also review mechanisms that help make change happen by reorienting local continuums of care, matching clients and services, retooling funding approaches, and using data to track implementation and outcomes.

Consumer Integration and Self-Determination in Homelessness Research, Policy, Planning, and Services

Susan Barrow, Lorraine McMullin, Julia Tripp, and Sam Tsemberis assess how the process and outcomes of research, policy, and service delivery change when they involve or are driven by people who have themselves experienced homelessness. The authors review the available evaluation literature and present lessons from the field on consumer integration in research, policy, and program implementation. They also describe the barriers to consumer integration and strategies for addressing the barriers. They further address what happens when people who are homeless make the decisions about the housing and services they need. The authors review findings on the individual- and system-level impacts of consumer-driven approaches to homeless assistance.

People Who Experience Long-Term Homelessness: Characteristics and Interventions

Carol Caton, Carol Wilkins, and Jacquelyn Anderson document the considerable efforts of the past decade to address the needs of people who are considered "chronically homeless; that is, unaccompanied adults with disabling conditions who experience long or numerous spells of homelessness. The authors detail the prevalence, characteristics, and service needs of adults who are chronically homeless and present a synthesis of recent research on service and housing interventions. Finally, they discuss the implications of the findings for services and for future research. The authors note that rigorous research on many interventions is lacking, but promising practices from the field may help guide the development of housing and services.

Homeless Families and Children

Debra Rog and John Buckner report that since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of families and children who become homeless, especially in understanding the heterogeneity within the population and whether a "typology" of families can be created (i.e., distinguishing families with greater needs for services and housing from those with lesser needs.) The authors review the findings from recent studies on homeless families and children and summarize the descriptive and outcome findings from evaluations of housing and service interventions and prevention efforts. With respect to children, research has focused on understanding and documenting the impact of homelessness on children. Rog and Buckner emphasize that that many of the challenges homeless families and children confront are also experienced by families that are very poor but not homeless, pointing to the need for further research on how to target assistance most efficiently to minimize the incidence and duration of homelessness for low-income families and children in general.

Homeless Youth in the United States: Recent Research Findings and Intervention Approaches

Paul Toro, Amy Dworsky, and Patrick Fowler cite research indicating that youth may be the single age group most at risk of becoming homeless, yet comparatively little research has been done in the past decade on this vulnerable population. Some important progress has been made, including longitudinal studies on youth "aging out" of foster care. After reviewing the characteristics of homeless youth, the authors review recent research findings on the homeless youth population and interventions developed to address their housing and service needs. These include interventions directed at youth themselves (education, employment, social skills training) as well as family-focused strategies. The authors conclude with future directions for both research and practice.

Characteristics of Help-Seeking Street Youth and Non-Street Youth

Alma Molino, a graduate student in Clinical Psychology at Rosalind Franklin University of Medicine and Science, was selected through a competitive process to prepare a paper on her research on runaway and homeless youth. The author used data collected from callers to the National Runaway Switchboard to describe the characteristics and issues facing a large national sample of youth who have run away or are in crisis, and to examine the associations between these issues and status as a street youth (runaway, throwaway or homeless) or non-street youth (considering running away or being in general crisis). The relationship between the type and number of issues and the frequency of running behavior is also assessed.

Rural Homelessness

For the 1998 Symposium on Homelessness Research, rural homelessness was not assigned as a paper topic in its own right. Due to its increasing significance, Marjorie Robertson, Natalie Harris, Nancy Fritz, Rebecca Noftsinger, and Pamela Fischer prepared a paper on rural homelessness for the 2007 Symposium. Given the somewhat limited formal research available, the authors supplemented their literature review with information from government documents and technical assistance materials as well as input from an expert panel of researchers and practitioners. The paper summarizes what is documented to date about the characteristics of people who are homeless in rural areas and examines whether rural homelessness and the service approaches to address it can be differentiated from urban homelessness. The authors identify gaps in current knowledge about rural homelessness and recommend new directions for research.

Incarceration and Homelessness

Stephen Metraux, Caterina Roman, and Richard Cho provide a synthesis of the emerging literature on the nexus between incarceration and homelessness. The authors explain how the increasing numbers of people leaving carceral institutions face an increased risk for homelessness and, conversely, how persons experiencing homelessness are vulnerable to incarceration. The authors review recent efforts to address reentry issues and review research results on studies of homelessness among prison and jail populations and research on incarceration among people who homeless. After reviewing common barriers to housing for people who have been incarcerated, the authors assess what is known about the effectiveness of services and housing interventions to address these barriers and outline needs for future research.

Housing Models

Gretchen Locke, Jill Khadduri, and Ann O'Hara provide an overview of housing and service models for programs serving people who are homeless and synthesize the research on the efficacy of the models, what is known about what works for whom, and the implications for preventing and ending homelessness. The authors review how changes in income support and housing assistance programs in the past decade have contributed to greater competition for scarce resources for low-income households—both those that are homeless and those that are not. The authors then discuss findings from research and practice on housing and service intervention for families and for unaccompanied adults with disabilities. Noting the continued lack of rigorous research on program implementation as well as impacts, the paper concludes with suggestions for future research.

Employment and Income Supports for Homeless People

David Long, John Rio, and Jeremy Rosen synthesize the findings of recent studies examining the role of mainstream programs such as Supplemental Security Income (SSI), Social Security Disability Income (SSDI), Temporary Assistance for Needy Families (TANF), and Workforce Investment Act (WIA) initiatives in enhancing employment and incomes for people who have experienced homelessness. The authors also describe the design and outcomes of targeted programs designed specifically to address employment and income support for people who are homeless. While some rigorous evaluations have been done on mainstream programs, the effects of the interventions on the subpopulation that has been homeless are often not addressed. Few rigorous studies have been done on targeted programs. The authors

draw several conclusions from the available evidence and outline future research directions to fill important gaps in the research literature.

Accountability, Cost-Effectiveness, and Program Performance: Progress Since 1998

Dennis Culhane, Wayne Parker, Barbara Poppe, Kennen Gross, and Ezra Sykes summarize the progress made in the past decade toward making homeless assistance programs more accountable to funders, consumers, and the public. The authors observe that research on the costs of homelessness and cost offsets associated with intervention programs has been limited to people who are homeless with severe mental illness. But this research has raised awareness of the value of this approach, such that dozens of new studies in this area are underway, mostly focused on "chronic homelessness." Less progress has been made in using cost and performance data to systematically assess interventions for families, youth, and transitionally homeless adults. The authors present case studies of promising practices from the State of Arizona and Columbus, Ohio, demonstrating innovative uses of client and program data to measure performance and improve program management toward state policy goals, such as increased housing placement rates, reduced lengths of homelessness, and improved housing stability.

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

Walter Leginski, PhD, Retired, U.S. Department of Health and Human Services, Washington, DC

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,

[1] The author wishes to thank the planners of the Symposium, Paul Koegel, Roseanne Haggerty, Fred Karnas, and William Breakey for their review of an earlier draft of this paper and Nancy McKenzie for her assistance editing later versions.

- 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

[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

[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

	System Aspect Examined			
Four Components of the System	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

[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

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

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

[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

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.

[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

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

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

[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

[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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Changing Homeless and Mainstream Service Systems: Essential Approaches to Ending Homelessness

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Abstract

Martha Burt and Brooke Spellman focus on how federal policy and state and local action have stimulated the development of homeless assistance networks and how those networks are evolving to address ending homelessness. While little formal research has been done on this subject, the authors present frameworks for assessing system change as well as describe promising practices from the field. They describe factors that may influence the success of change efforts, including the local and state context, the interest and commitment of stakeholders, the scope of desired change, the governance and management structure for change, and the intended process for change. They also review mechanisms that help make change happen by reorienting local Continuums of Care, matching clients and services, retooling funding approaches, and using data to track implementation and outcomes.

Introduction

In 1998, when the U.S. Departments of Health and Human Services (HHS) and Housing and Urban Development (HUD) sponsored the first National Symposium on Homelessness Research, the focus was primarily on describing the array of approaches to helping homeless people that had been developed during the previous decade, and how they worked. Few in the field had begun to address how a community might *end* homelessness.

Much has changed since that time. New programmatic approaches have evolved (e.g., Safe Havens), but more important, federal policy has stimulated the development of homeless assistance networks and systems. In 1995, after seven years of distributing McKinney Act Supportive Housing Program (SHP) funds through annual national competitions, HUD implemented the competitive continuum-of-care (CoC) approach for deciding who receives SHP support for transitional and permanent supportive housing. A CoC is a local or regional system for helping people who are homeless or at imminent risk of homelessness by providing housing and services appropriate to the whole range of homeless needs in the community—from homelessness prevention to emergency shelter to permanent housing. Each year, HUD

develops and publishes preliminary estimates of how much SHP funding each eligible community in the country would receive if it wrote a qualifying CoC grant application. To qualify, communities have to show that they have assessed needs and existing resources and identified gaps, and that the resources they are requesting from HUD will help fill the gaps that the community has identified as top priority. The entire process stimulated a new kind of communication among relevant programs and agencies, often leading to increased cooperation and program innovations and moving many communities closer to having a real "system" rather than a set of independently operating programs (Burt et al., 2002).

The processes of community organizing developed through the CoC process received a substantial boost beginning in 2000, when the National Alliance to End Homelessness (NAEH) developed and disseminated a plan to end homelessness for the whole nation in 10 years (NAEH, 2000). This plan incorporated a major shift in orientation and emphasis, from *managing* homelessness to *ending* it. This shift has been significant enough to be dubbed a "paradigm shift" in the nation's approach to homelessness (Burt et al., 2004), because it entails important new ways of thinking about homelessness and concomitant changes in who should be served, what approaches should be used, and how resources should be allocated.

This shift, and the expectation that it could succeed, was made on the basis of research evidence. Three pieces of information from research helped advocates make a convincing case that shifting the goal from managing homelessness to ending it was both the right thing to do and something that was possible to achieve:

1. **A finite group of homeless people on which to focus was identified.** Research by Kuhn and Culhane (1998) documented subgroups among homeless people characterized by transitional, episodic, and chronic patterns of homelessness. These researchers also documented the fact that the 10 to 15 percent of people with a chronic pattern of homelessness consumed half or more of system resources—in this case, shelter bed-nights—making them a very "expensive" group to continue serving in emergency shelter while not resolving their homelessness. A reliable estimate of homelessness nationwide based on the 1996 National Survey of Homeless Assistance Providers and Clients (Burt, Aron, & Lee, 2001) then made it possible to estimate the number of chronically homeless people—150,000 to 250,000—a number that proved to be small enough for policymakers to believe that a solution was possible.
2. **An effective service approach was identified.** Evidence accumulated that permanent supportive housing (PSH) worked to keep many formerly homeless people housed (Shern et al., 1997; Tsemberis & Eisenberg, 2000)—especially those who were chronically homeless and had appeared to be most resistant to leaving homelessness.
3. **The solution was economically worthwhile.** Research showed that PSH is cost-effective—that it compares favorably in cost to outlays for public crisis and emergency services used by long-term homeless people, but with a better outcome: ending their homelessness (Culhane, Metraux, & Hadley, 2002; Rosenheck, Kasprow et al., 2003).

By 2001, ending chronic homelessness in 10 years had become a goal of the present federal administration. The federal Interagency Council on Homelessness was revitalized in 2001, and federal agencies mobilized to do their share. Federal agencies worked together to organize Policy Academies to help states begin planning to end homelessness. Nine Policy Academies and one National Learning Meeting were held between November 2001 and November 2005, attracting teams of representatives from the mainstream state agencies whose resources and energies would have to be committed if the goal

of ending homelessness were to be achieved. Every state and two territories sent teams of state agency representatives to at least one of the five Policy Academies focused on ending chronic homelessness for individuals or the four Policy Academies focused on ending family homelessness. Almost every state created its own interagency council or task force on homelessness, and as of fall 2006, 13 states had adopted 10-year plans to end homelessness or chronic homelessness (Cunningham et al., 2006). Eight of these states were among the 17 that attended two Policy Academies, another indication of their commitment to do something serious about ending homelessness. Some attended two Policy Academies on ending chronic homelessness, while others attended one on ending chronic homelessness and another on ending family homelessness. The Policy Academies themselves, plus follow-up and technical assistance activities, laid the groundwork for mainstream state agencies, with their extensive resources, to become involved in state and local efforts to end homelessness.

HUD embraced the federal goal to end chronic homelessness by establishing a Government Performance and Results Act objective on homelessness, against which the Department is rated annually. Objective C.3. reads: "End chronic homelessness and move homeless families and individuals to permanent housing." To support departmental progress on this objective, HUD used tools such as the competitive CoC grant process to support local change. By 2001, the vast majority of cities, counties, and states were organized into one of the more than 450 continuums of care that HUD stimulated through the annual CoC funding process (Burt et al., 2002). HUD began prompting communities throughout the country to adopt the federal goal as their own by requiring a section on plans for ending chronic homelessness and another on addressing other homelessness as part of annual applications. An increasing number of state and local governments have joined the federal government in formally committing themselves to ending *chronic* homelessness in 10 years. The majority have gone further, taking on the broader task of ending *all* homelessness. In the National Alliance's analysis of the 90 10-year plans that are complete and have been accepted as state or local policy, 66 percent have the goal of ending *all* homelessness, with the remaining 34 percent focusing only on ending chronic homelessness (Cunningham et al., 2006).

We recount this history because it is directly pertinent to our task in this paper. A community can offer homeless assistance services for decades without needing, or getting, system change. System change can begin within the homeless assistance system, but the goal of *ending* either chronic or all homelessness will most likely also require commitment from mainstream public agencies. These agencies, be they city, county, state, or private, include mental health, substance abuse, welfare, health, child welfare, workforce development, criminal justice, and above all, subsidized housing and community development. Moreover, mainstream agency involvement must be *active*, as these systems themselves need to change if the goal of ending homelessness is to be reached. No community is likely to end either chronic or all homelessness without mapping out a multi-year strategy and moving toward it systematically. The resources and actions of mainstream service agencies are essential to the success of any such strategy. So system change—how to do it, how to know you've done it, and how to show that the changed system is succeeding in ending homelessness—has moved to the forefront of attention.

This paper looks at the process of system change and presents some lessons learned from "pioneers" in the effort to end homelessness that can be applied more broadly. The paper will also note early successes of system change related to the goal of ending homelessness. The paper does not discuss what an effective system to end homelessness should look like, for two primary reasons. First, system change efforts are still in early stages and we have much to learn before we can draw such conclusions. Second, a good argument can be made that the configuration of a changed system to end homelessness must be defined by local decision makers. Other papers in this Symposium may tell us "what works" for specific

populations, and local decision makers may pick and choose among the best. But the balance of system elements will still depend on local factors.

Synthesis of Research Literature

System change has interested people in many disciplines, in part because it is by all accounts so hard to do and hard to sustain. Corporations and businesses care about system change because a poorly functioning corporate system means lower profits. The most successful approaches to assuring improved educational outcomes for the most disadvantaged children rely on changing educational systems, from individual schools to whole districts, through "comprehensive school reforms" (Borman et al., 2003). Helping the most disadvantaged and hardest-to-serve welfare recipients to get and retain jobs has required system changes involving welfare and workforce development agencies, and sometimes mental health, substance abuse, and other agencies (Martinson & Holcomb, 2002). Children- and family-serving agencies have long sought system change to increase the effectiveness of service delivery systems (Burt, Resnick, & Novick 1998; Melaville & Blank, 1991). Is it any wonder that in the homelessness arena we also find ourselves in need of guidance to move systems toward greater responsiveness?

Our assignment is to summarize research knowledge about changing community systems into configurations that promote the goal of ending homelessness. It is important to note at the outset that significantly less relevant literature exists on this topic than on others at the Symposium. A Google search of "system change" + "homelessness" produces 66,000 items, but only a handful are research—most of the rest are plans, or advice. The research on which we base much of this paper comes from HUD-sponsored projects on communitywide strategies to end chronic street homelessness (Burt et al., 2004) and prevent homelessness (Burt, Pearson, & Montgomery, 2005); a Corporation for Supportive Housing evaluation of a project called Taking Health Care Home (THCH) that is designed to change community systems to promote development of permanent supportive housing (Burt & Anderson, 2006); and two research syntheses offering blueprints for changing systems, one by HHS's Center for Mental Health Services (2003) and one by the Corporation for Supportive Housing (Greiff, Proscio, & Wilkins, 2003) that has been the basis for many presentations at Policy Academies. Most of the research has focused on permanent supportive housing to end homelessness for persons with disabilities who have been homeless for a long time. Yet system change efforts related to homelessness reach well beyond this population and these interventions. Therefore, we also incorporate examples from our own experience working with communities to make change happen.

We will address several aspects of system change based on research and written reports that have become available since 1998: (1) documenting system change itself and how it has been brought about, (2) documenting the effects of such change on preventing and ending homelessness, and (3) describing how communities have used a variety of databases and feedback mechanisms to give themselves the information they need to set targets and keep themselves on track to meet them. We will not be able to recommend "best practices" substantiated by a strong evidence base, but we will be able to present approaches and practices that are widely recommended and seem to be promising.

How Shall We Describe Systems and System Change?

The literature offers a number of schemes for describing systems and system change. We use two in this paper. The first focuses on signs that systems *have* changed, and the second focuses on the types of

relationships among agencies that characterize systems at different stages of integration. Both schemes were used in the THCH evaluation (Burt and Anderson, 2006) to describe the changes occurring in the study communities.

Laying a New Foundation (Greiff, Proscio, & Wilkins, 2003, p. 7) identifies five signs by which one can recognize system change when it is complete, or nearly complete; change should be clear in all five areas (text in brackets [ ] is the present authors'):

- A change in *power:* There are designated positions—people with formal authority—responsible for the new activity (not just committed or skillful individuals who happen to care about it).
- A change in *money*: Routine funding is earmarked for the new activity in a new way—or, failing that, there is a pattern of recurring special funding on which most actors in the system can rely. [This could be new money, a shift in existing funding, or new priorities and criteria for accessing existing money].
- A change in *habits*: Participants in a system interact with each other to carry out the new activity as part of their normal routine—not just in response to a special initiative, demonstration, or project. If top-level authorities have to "command" such interactions to take place, then the system has not absorbed them, and thus has not yet changed. [Service delivery improvements fit in here, ranging from referral hotlines and simplified application procedures, through case-by-case provider sharing of resources, up to and including services integration (through multi-agency teams, co-location, and the like) or systems integration (such as universal applications, merged funding streams, multi-agency goal-setting and follow-through)].
- A change in *technology* or *skills*: There is a growing cadre of skilled practitioners at most or all levels in the delivery chain, practicing methods that were not previously common or considered desirable. These practitioners are now expert in the skills that the new system demands and have set a standard for effective delivery of the new system's intended results.
- A change in ideas or values: There is a new definition of performance or success, and often a new understanding of the people to be served and the problem to be solved [i.e., new goals]. The new definition and understanding are commonly held among most or all actors in the system, such that they are no longer in great dispute. [For instance, a whole CoC could reorient itself toward ending homelessness, or at least toward ending chronic homelessness. Either of these events would be system change if followed by actual changes in behavior to assure movement toward the goal.]

Since people who are homeless interact with many systems, including homeless-specific agencies and the health, mental health, corrections, child welfare and foster care, public benefits, employment, and housing systems (as documented by Culhane et al., 2002 and Koegel et al., 2004, among others), achieving integration of these systems can make a significant difference in the manner and speed with which a household's homelessness is resolved. *Services* and *systems* may be integrated to varying degrees, making it more or less simple to get individuals the range of services they need or to end homelessness through the combined, concerted, organized, and strategic actions of many different actors (Cocozza et al., 2000; Provan & Milward, 1995; Randolph et al., 2002). *Services integration* refers to the ability of a community to get any individual or family the services it needs, especially when the needs span two or more service

systems. Services integration may be accomplished in a number of ways—a common approach is the multi-agency casework team, whose members are able to marshal the resources of their respective departments efficiently and effectively to help individual clients. *Systems integration* refers to changes in two or more service systems that reorient the systems' activities toward more efficient and effective achievement of common goals—goals that may be new or long-standing.

The first author (Burt & Anderson 2006; Burt et al., 2000) has used a five-level scheme to describe integration stages—***isolation, communication***, ***coordination, collaboration***, and ***coordinated community response***. These stages can represent the initial status of a potential system and the relationship of its component parts, and also the movement toward changes that are likely to end homelessness.

One can use the integration stages described below to benchmark a community's progress from a situation in which none of the important parties even communicates, up to a point at which all relevant agencies and some or all of their levels (line worker, manager, CEO) accept a new goal, efficiently and effectively develop and administer new resources, and/or work at a level of services integration best suited to resolving the situation of homelessness for the largest number of people in the shortest period of time. The framework also recognizes the possibility of regression from one stage to previous ones if prevailing factors work against integration. Brief descriptions of these integration stages follow:

- **Isolation—**recognition of the need to communicate about the issues that require a system solution is lacking, as is any attempt to communicate. Even worse than isolation is hostile communication, suspicion, and distrust. This was the situation in many communities at the time that HUD instituted the continuum-of-care application process. It still prevails in some communities as the reality of relationships between homeless assistance providers and government funding agencies.
- **Communication**—talking to each other and sharing information in a friendly, helpful way is the first, most necessary, step. Communication must inform participants what their counterparts in other agencies do, the resources they have available to them, and the types of services they can offer. Communication may happen between front-line workers (e.g., a mental health worker and a housing developer), middle-level workers, and/or among agency leadership. It may occur among these personnel in two systems, three systems, and so on up to all the systems in a community. In many communities the parties who need to work together to create a coordinated system to end homelessness have not reached even this first stage. Everyone operates in isolation in hostile interactions that do not advance understanding or assistance for homeless people or the possibilities of preventing homelessness. Even when people know each other and sit on the same committees and task forces, they still may not communicate enough to share an understanding of the role each *could* play in ending homelessness. This latter situation is *the norm* in most communities—people know each other but have not really gotten down to the hard work of listening to and hearing each other.
- **Coordination—**staff from different agencies work together on a case-by-case basis and may even do cross-training to appreciate each other's roles and responsibilities. Again, coordination or cooperation may happen among front-line workers or middle-level workers, and/or involve policy commitments for whole agencies by agency leadership. It may occur among these personnel in two systems, three systems, and so on up to all the systems in a jurisdiction.

Coordination may also be *services integration*. Multi-agency teams that help specific individuals obtain appropriate services are examples of coordination, as are multi-service centers where a homeless person can connect with many different agencies but there is no overall case coordination. However, at this stage, no significant changes have occurred in the services each agency offers or how the agencies do business. Coordination does *not* involve major changes in eligibility, procedures, or priorities of any cooperating agency. It merely means they agree not to get in each other's way and agree to offer the services they have available when it is appropriate to do so, albeit sometimes in new locations or through new mechanisms such as a multi-agency team. It does not entail any significant rethinking of agency goals or approaches.

- **Collaboration**—collaboration adds the element of joint analysis, planning, and accommodation to the base of communication and coordination, toward the end of *systems integration*. Collaborative arrangements include joint work to develop shared goals, followed by protocols for each agency that let each agency do its work in a way that complements and supports the work done by another agency. Collaboration may occur between two or more agencies or systems, and usually does involve system change to varying degrees.

  Collaboration cannot happen without the commitment of the powers-that-be. In this respect it differs from communication and coordination. If agency leadership is not on board supporting and enforcing adherence to new policies and protocols, then collaboration is not taking place (although coordination may still occur at lower levels of organizations). Because collaboration entails *organizational commitments*, not just personal ones, when the people who have developed personal connections across agencies leave their position, others will be assigned to take their place. They will be charged with a similar expectation to pursue a coordinated response and will receive whatever training and orientation is needed to make this happen. Collaboration in this sense can be seen in many examples given throughout this paper, including Connecticut's three waves of integrated state funding for PSH, the ways the Massachusetts Department of Mental Health has developed partnerships to produce PSH, Minnesota's 10-year plan to end homelessness, Portland/Multnomah County, Oregon's three-way funding structure for PSH, Seattle/King County, Washington's funders group, and Columbus/Franklin County, Ohio's Rebuilding Lives initiative.

To the three stages that promote better services and supports for homeless people, we add a last stage, which is collaboration involving all of the critical and most of the desirable systems and actors in a community. This type of response has sometimes been called a ***coordinated community response (CCR)***, and we adopt that terminology here to distinguish this type of community-wide collaboration with the long-range goal of ending homelessness from collaboration among two or three agencies. Coordinated community response is system change and integration, going beyond collaboration in several directions.

- First, all of the systems in a community essential to preventing and ending homelessness must be involved. This includes homeless assistance providers and agencies providing housing subsidies, and also those promoting the development of affordable and special needs housing. It includes agencies that fund supportive services, most frequently mental health and substance abuse agencies, but also employment and health agencies, and others offering services that may be needed to address the underlying factors that contributed to homelessness. It includes agencies such as law enforcement and corrections, mental hospitals and private psychiatric units, and other institutions discharging vulnerable people with disabilities who are at risk of homelessness and need appropriate housing. It often involves

the business community, which is heavily impacted by street homelessness. Ideally, others will also be involved, including representatives of local elected bodies, funder representatives, and consumer representatives.

- Second, CCR involves a mechanism for seeing that individual clients or households receive the services they need—that is, it integrates services, through one or more of several mechanisms. The result of this streamlined service delivery at the client level should be improved client outcomes as well as more efficient and effective use of resources. In the context of addressing chronic homelessness, service integration involves connecting services and housing to help clients with long-term homelessness and one or more disabling conditions to find and keep housing and reduce use of expensive emergency public services. An important finding of the Access to Community Care and Effective Services and Supports (ACCESS) demonstration, which may seem obvious in hindsight but was not actually anticipated, was that people got housed only when the housing agencies were at the table (Rosenheck et al., 1998, 2001, 2003b). In the context of preventing or ending family homelessness, weekly cross-system case management meetings and pooled resources among homeless intake, child welfare, and income maintenance agencies may be used to move families coming into shelter rapidly back into housing or even to keep children with their parent in permanent housing instead of allowing the family to become homeless and removing the children to foster care. By working together and developing the mechanisms to respond to their clients' housing crises before a household becomes literally homeless, providers can intentionally serve all clients rather than opportunistically serve only those who come to them while others fall through the cracks.
- Third, CCR entails a functioning feedback mechanism. In many communities this is a monthly (or more frequent) meeting of those most actively involved in developing appropriate interventions or smoothing bureaucratic pathways. (This function should be different from a direct service meeting to facilitate matching clients with services and housing units, even though both meetings may involve the same players.) Some communities have also found that forcing themselves to collect data on their progress and then to review the data at the monthly meetings shows them what they have achieved, helps them identify and resolve bottlenecks, and provides a powerful positive incentive.
- Fourth, CCR includes an ongoing mechanism for thinking about what comes next, asking what needs to be done, how best to accomplish it, and, finally, what needs to change for the goals to be accomplished. This mechanism can take one or more forms, such as task force or council, regular stakeholder meetings, and quarterly retreats. Whatever the mechanism, it must translate into shared decision-making and strategic planning at multiple levels as well as the expectation that each part of the system will modify its own activities to support and complement the work of the other parts.
- Fifth, it is a great deal easier to maintain the first four elements of a CCR if someone is being paid to serve as coordinator to organize and staff the interagency working groups and committees necessary to accomplish community-wide goals.
- Finally, a coordinated community response is never a "done deal." If it is really doing everything expected, including identifying remaining gaps and continuing to seek ways to improve the system, it continues to evolve. We do not attempt to assess communities discussed in this paper using this framework except in a few examples, but changes from one

stage to another should be obvious from community changes described below. The evaluation section of the paper discusses how the framework can be used to measure the impact of system change efforts as they mature and evaluations are formalized.

It is most fruitful to use this scheme to characterize movement and change rather than a steady state or a comprehensive overview. We follow this principle in Exhibit 1 below, where we give brief examples of movement from one level to another, focusing sometimes on relatively narrow but still challenging integration efforts such as that of the Skid Row Homeless Healthcare Initiative in Los Angeles and sometimes on the broadest possible efforts to mobilize all elements of a community to address the ultimate goal of ending homelessness.

Factors Affecting the Likely Success of System Change Efforts

From the review of existing research and observations of local community practice, the authors have identified five major factors that affect system change:

- context of the local community and the state,
- interest and commitment of key stakeholders,
- scope of desired system change,
- governance and management structure for system change, and the
- identified process of system change.

The mix of factors will vary from one community to the next; thus, the pattern and success of system change will also vary. The review of current research suggests that no one factor of system change is more important than another, but there do appear to be cumulative impacts. That is, having multiple factors in place, such as strong state agency support and a dedicated staff member managing the system change activities, may help overcome obstacles to system change. Conversely, the absence of two or more factors may significantly hamper progress toward system change. Presumably, the more complete, strategic, and well-executed the process, the faster the goals will be realized and the greater will be the magnitude of the results.

Context of the Local Community and the State

The starting frame of reference of the local community will impact the speed of change and may affect a community's ability to mobilize stakeholders. The community leaders driving change will need to assess the current stage of the system (isolation, communication, coordination, collaboration, or coordinated community response). Readiness for change is affected by the occurrence of trigger events that mobilize community support, whether providers are content or dissatisfied with their current methods of addressing homelessness, prevailing philosophies and level of investment related to the current system, availability of data to compel change, the economic and social climate that may affect a community's ability or willingness to redirect resources to address homelessness, and commitments of those who control major resources beyond the community itself. For instance, if public agencies and homeless assistance providers alike acknowledge that current approaches are not effective in addressing homelessness, there is a shared context for discussing possible solutions that will probably involve system change. If no trigger events

Exhibit 1

Changes from Level to Level: Examples

From No Communication to Communication

Work in Rhode Island made "PSH" a recognizable concept to state legislators and agency officials, so they could begin to think about how to promote it. A parallel effort brought housing developers and operators and service providers together for the first time to develop potential teams to create more PSH.

Work in Portland, Oregon, and Seattle brought the agencies with mental health and substance abuse services funding to the table for the first time, to talk with housing development and operations agencies.

In Chicago, efforts to "change the way we do business" got people talking with each other in entirely new ways and brought new stakeholders into the process.

Work in Los Angeles' Skid Row brought the many agencies providing primary health care to homeless people to the same table for the first time, to talk about how to stop their patients from falling through the cracks.

From Communication to Coordination

In Los Angeles, the Skid Row Homeless Healthcare Initiative has developed a division of labor and coordination mechanisms among providers, established structures for obtaining specialty and recuperative care from clinics and hospitals beyond Skid Row, and created numerous additional mechanisms to assure better health care delivery and follow-through, including new funding mechanisms.

The primary public and private funders of homeless services in Indianapolis, Indiana, have been meeting regularly for years to discuss issues related to homelessness. They all agreed in principle with and supported the Blueprint to End Homelessness, but maintained their own allocation processes. Today, they are working on a master investment strategy that outlines how each funding source will be targeted to achieve the implementation of the Blueprint over the next five years. The investment strategy also talks about the use of mainstream funding, such as Medicaid, Indianapolis Housing Authority vouchers, Indiana Housing Trust Fund, and criminal justice funds, for the Blueprint.

From Coordination to Collaboration

In Chicago, the Illinois Department of Human Services–Division of Substance Abuse brought together multiple homeless and mainstream agencies that traditionally coordinated services with one another, and created a multidisciplinary, multi-agency outreach team to serve persons with chronic substance use disorders in response to a Substance Abuse and Mental Health Services Administration grant opportunity.

From No Communication to Collaboration

Three Los Angeles city agencies with responsibility for different aspects of housing had never worked together. They began meeting to develop an affordable housing plan for the city. From this modest beginning, they evolved to a joint RFP for the development of PSH that blends these agencies' resources to provide capital and operating funding commitments in the same package. This movement involved several "firsts"—first time working together, first time developing a shared goal, first time issuing a joint RFP, and first time blending funding. Still missing, however, is the county's part—the supportive services.

Moving toward a Coordinated Community Response

Portland and Seattle have brought the relevant parties together at several levels, from the commitments of local elected officials to the joint activities of PSH providers to the integrated funding strategies of relevant public agencies. Integrated work that began with a focus on chronically homeless individuals has spread in both communities to encompass plans, activities, and specialized funding for preventing and ending family homelessness, drawing in still more players.

Working in Reverse—Unintended Consequences

Changes in one system, undertaken for its own internal reasons, often cause changes in other systems that no one ever intended or even thought about. An example particularly relevant to ending homelessness comes from Markowitz's (2006) analysis of reductions in public mental hospital beds before 1990 leading to increased homelessness among people with mental illness and their subsequent increased probability of arrest and incarceration, with the result that the proportion of incarcerated people with major mental illnesses increased. One system's change is two other systems' disaster, which efforts to end homelessness are still trying to untangle.

have provided the impetus for change or if no data show that the current system is failing, then many may resist change altogether. If agencies are already collaborating, then they already have skills and experience working together on community solutions and will have an easier time taking the next step (Pindus et al., 2000; Martinson & Holcomb, 2002).

Trigger Events and Paradigm Shifts

A recent HUD-sponsored study examined seven communities making progress in ending chronic street homelessness (Burt et al., 2004).[1] The study identified the importance of a trigger event in mobilizing significant commitment to developing new approaches to ending homelessness for this most resistant segment of the homeless population. In most of the communities visited, a trigger event galvanized the observed approach. In Columbus and San Diego, the event was the desire to develop a part of downtown that had a high concentration of street homeless people. The business leaders who wanted the development became committed to assuring that it did not happen unless plans were in place to serve and house the homeless people it would displace. In Philadelphia and Birmingham the trigger event was a proposed anti-homeless city ordinance. Consumer and service provider protests in Los Angeles, Philadelphia, and San Diego stimulated responses in those communities, and an invitation to develop a pilot program for a new funding source prompted the Los Angeles County Sheriff and Mental Health Department to work together for the first time to create an integrated services program for homeless people with mental illness who were leaving the jail with no place to go. The two communities that already had strong organizational structures and leadership (Columbus and Philadelphia) were able to capitalize on these trigger events with relative ease and speed. But it is important to note that several communities and public agencies that *did not* have an organized leadership structure or well-developed public agency involvement and investment before the trigger event (for example, San Diego and two programs in Los Angeles) were able to use the event to re-examine their situation, decide to take action, organize themselves, mobilize resources, and make and carry out plans for approaches to address and reduce chronic street homelessness. Thus, these communities were able to turn these trigger events to their advantage and gain commitments to new goals and new resources, rather than allowing the event to worsen the circumstances of street homeless people. The event itself is often perceived locally as a watershed moment—the catalyst that began the process that resulted in the current commitment to reduce or end chronic street homelessness.

Frustration and Philosophy

If homeless assistance providers feel their current approaches are working to end homelessness, they may resist efforts at system change. Alternatively, some providers and some public agencies committed to a high-demand approach will not consider certain models that have been shown to work with very service-resistant homeless people but which conflict with their philosophical viewpoints. But if providers themselves are frustrated with the current models or feel that the current system is ineffective in engaging certain populations, they are more likely to welcome change. For instance, in Chicago it was the providers, not the city, that came back from national conferences saying “what we’re doing is not working, we have to do something different” and lobbied until they got a 10-year planning process under way. The process of change does not stop with a recognition that something different is needed, and even high frustration levels do not necessarily lead to change without other ingredients also being present. For

[1] To be included, a community had to be taking significant steps to end long-term street homeless and also had to have at least some data to prove that these efforts were making a difference. It was not easy to find communities that met both criteria.

instance, providers may not have the knowledge or organizational capacity to move to new approaches even if they want to, and funders may be stymied by contractual processes that are hard to shift or change. Later in this paper we give examples of system change efforts designed to help existing and potential new providers develop the skills needed to operate new kinds of programs. A communitywide system change effort will need to account for all of these factors as it moves forward and find ways to accommodate each stakeholder's current position while working toward a more effective overall system.

Using Data to Support Change

Accurate information is always a powerful weapon in the quest for change, but it is not always easy to find. Most critically, accurate information *about one's own community* is the most convincing to local decision makers, but often it does not exist. We began this paper with a fairly dramatic example of the use of data to effect change—how the National Alliance to End Homelessness along with other advocates used information about population size, the success of permanent supportive housing, and public costs avoided to promote a federal commitment to ending chronic homelessness. Local communities also generate and use data in a variety of ways to stimulate change and then sustain and expand the investment. Later in this paper we discuss ways that communities use information to *manage* change efforts, but here we want to offer some examples of how communities have made sure that they developed the *local* information they needed to prompt commitments to system change.

- In 1986, Columbus, Ohio, was one of the first communities in the country to develop and install a simple homeless management information system (HMIS) to track shelter use and get an accurate count of homeless people in the system (Burt et al., 2004). The Community Shelter Board director at the time, who insisted on installing the system, later said, "Once we had data, we stopped arguing about whether we had a problem and started working on how to solve it."
- Hennepin County, Minnesota, also developed its own data system for its homelessness prevention and rapid shelter exit programs for families. The county staff use the system daily to manage the programs and to assess system outcomes—specifically, whether families who receive program services become homeless or return to homelessness (Burt, Pearson, & Montgomery, 2005). Being able to show the program's excellent track record with homeless families entering shelter (reducing the number of families in shelter by half, halving lengths of stay, and keeping further loss of housing and return to shelter within 12 months down to only 12 percent) has been instrumental in keeping the program's state funding flowing.
- Portland, Oregon's Bureau of Housing and Community Development collected impact data on a pilot project that it hoped would become a model for future programming to end street homelessness. "Transitions to Housing" offers providers "whatever it takes" flexible funding to house and support the hardest-to-serve single homeless adults. Politicians were skeptical but willing to back a pilot. When the evaluation data showed clear success, it was the starting point for expanding the program and moving forward with more system-wide changes.
- In Seattle, a study by the county health department noted many deaths among single adult homeless people in King County. This study had a very powerful effect in generating political will because it got a lot of press in local newspapers. Public attitudes really drive the agenda at the state capital, and the study created strong public interest in reducing the vulnerability of homeless street people, for which permanent supportive housing was a clear solution. The study came at a time when the Taking Health Care Home (THCH) project was working to

develop more resources for PSH and had created a Funders Group to think through how this might be done. The THCH coordinator was asked to make a presentation to the state legislature using THCH data and the results of the Funders Group deliberations. This testimony provided valuable information to state legislators who were attempting to address homelessness across the state and ultimately helped promote major new appropriations and other legislative initiatives.

- California's very successful AB 2034 program (Burt & Anderson 2005; Mayberg, 2003) grew out of data from three initial pilot sites that showed significant reductions in time homeless and days hospitalized or incarcerated among homeless people with serious mental illness who participated in the program's "whatever it takes" funding approach. The evidence of success continued as the program expanded to 34 counties and was one of the key factors that prompted voter approval of Proposition 63 in 2005 and the consequent Mental Health Services Act in 2006, which is pouring major new service dollars into California communities.
- The San Diego Police Department gathered data to show the cost of one arrest and booking of a chronic alcoholic homeless street person, in an effort to develop support for a new approach. When decision makers learned that the cost of just one arrest (about $1,100) was more than one-third higher than the cost of one month of outpatient treatment and housing, San Diego's Serial Inebriate Program was born (Burt et al., 2004). Its success was one of the factors leading to HUD's new Housing for People Who Are Homeless and Addicted to Alcohol program, now funding 11 grants to 10 communities.

Economic and Social Climate

All of the factors just discussed are affected by the economic and social climate of the local community or state environment. The economic environment will affect the overall prevalence of poverty within a community and may affect a locality's revenue base available to address poverty issues. A poor job climate will make it even more challenging for homeless households to obtain living wage employment. An expensive housing market will expand the gap between market rents and incomes of households that are trying to avoid homelessness or re-enter the housing market, while in a depressed housing market, landlords are more willing to negotiate rents and payment plans to repay arrearages. A positive economic environment can present positive opportunities for system change to end homelessness, such as funds to support innovative service models or the development of subsidized and/or supportive housing.

The social environment can have an equally powerful effect. If there is significant social awareness and public support for social causes in general and ending homelessness in particular, community leaders may be very receptive to pursuing an agenda for change. If the community is negatively inclined toward social issues, the political leaders may be completely opposed to funding or even supporting change. Similarly, if the community is mobilized around different community issues, it may be difficult to secure public support for system change to end homelessness.

Interest and Commitment of Key Stakeholders

Various sets of public and private, homeless and mainstream system actors need to make commitments and play their parts for systems to change. A community is more poised for successful system change if all of the stakeholders share the goal of ending homelessness, are committed to bringing the goal to fruition, and are open to changing their own systems to make it happen. However, even if only a few

agencies are on board, the agencies may act as champions of the process to engage other stakeholders. Ideally the "founding" partners will be agencies that are pivotal to change, but the specific agencies involved will vary from community to community depending on the population being targeted and the structure of the community. For instance, if a community is targeting family homelessness, critical agencies may be the child welfare, TANF, and workforce development agencies; the public housing authority; and key homeless system leadership. If chronic street homelessness is the issue, law enforcement; the courts; and mental health, substance abuse, corrections, and public benefits agencies will likely be involved in addition to homeless assistance agencies and, sometimes, the business community.

It is likely that several of the key stakeholders will not be at the table at the beginning of the process, and they will need to be convinced to participate. All stakeholders do not have to be involved from the beginning, nor do all stakeholders need to be involved in all aspects of system change. Different communities have had success using different models. Some work on system change within the homeless system, slowly engaging one mainstream agency at a time; some work with several mainstream agencies to develop one component of a community system such as PSH; and some start with mainstream agencies and work on changing the homeless system in later stages. The local context and motivation for change will determine which strategy is likely to work best.

Need to Involve the Agencies with Resources and Decision-Making Authority

Local communities seldom control key resources or are in a position to make policy decisions essential to ending homelessness. A city will be dependent on cooperation from county agencies that control key resources such as public benefits and health and mental health services. Cities and counties will be dependent on state agencies and their policies, especially policies affecting resources essential to addressing homelessness, including housing, health care, mental health care, and substance abuse treatment. As homelessness is, at base, lack of housing and the ability to afford housing, a local effort to end homelessness will have a much better chance for success if the agencies that can offer housing or that control housing policy are at the table. These include public housing authorities, state housing finance agencies, and community and economic development agencies. Many of the critical housing agencies have an autonomous or semi-autonomous status, being neither city, county, nor state agencies in the usual sense, adding another layer of "who controls what" to the mix of agencies needed for success.

For the past three years, the first author has been involved in evaluating the multisite Taking Health Care Home (THCH) initiative of the Corporation for Supportive Housing (CSH).[2] This project is designed to move systems in a direction that will promote the development of permanent supportive housing, using a grant as its primary lever for moving systems. All THCH sites invested a portion of grant resources in a coordinator. A recent report (Burt & Anderson, 2006) examined the changes in the study communities at the two-year mark.

Three THCH communities (Portland/Multnomah County, Seattle/King County, and Maine) were the most "ready" for change, in that at least one public agency had already realized the importance of PSH and had taken its own steps to move more of its resources toward PSH development.[3] The most involved agency

[2] The communities involved were four states (Maine, Connecticut, Rhode Island, and Kentucky), two city/county sites (Los Angeles and Portland/Multnomah County, Oregon), and one multi-jurisdiction site (Seattle/King County, Spokane City and County, and the state of Washington).

[3] A fourth THCH community had these same characteristics initially, but a change in state leadership and direction reduced interest in PSH development and stiffened resistance to system change.

in each community took the lead in applying for THCH funds, usually on behalf of a large collaborative body that was already in existence or with the explicit commitment of at least one other agency to work toward system change. The early buy-in of these agencies laid the foundation for relatively rapid and successful system change once the THCH funding was received and a coordinator was assigned to manage the change process.

These three communities differed substantially in the degree to which state agencies were involved in their system change efforts. Portland/Multnomah County proceeded largely without state-level involvement, as the climate for such involvement was unfavorable to investment in homeless issues and no other communities in the state could be counted on to apply pressure to turn that resistance around. Seattle/King County might have found itself in the same situation, were it not for the THCH investment strategy that put resources into *both ends* of the state—in Seattle/King County and in Spokane. From the beginning, an element of the Washington strategy was to develop new state-level funding streams; generating pressure from areas of the state other than the largest population center of Seattle/King County would be critical for success. Another part of the strategy was to include state agency representatives in the Seattle/King County funders group. These representatives became very familiar with the arguments for ending chronic homelessness through permanent supportive housing, and were later instrumental in helping to design a strategy for new state legislation and getting that legislation passed. By the end of two years of organizing, the Washington legislature had approved new legislation that is now providing resources to combat homelessness in every county based on real estate transactions, plus resources to combat family homelessness, and new resources for substance abuse treatment. In Maine, the THCH project was located in a state agency, the housing finance agency, and the primary work of the project involved organizing agencies at the state level. Action at the state level to provide capital resources, facilitate operating resources, and match clients to supportive services through Medicaid and other mechanisms has supported the work of regional councils that do the bulk of local planning, and the work of local providers that develop and run the programs that deliver services to actual clients.

There are other examples of states that have developed state-level strategies and resources for combating or ending homelessness that facilitate local planning and implementation and make it easier for providers in local communities to meet the needs of individual clients.

- In 2004, Minnesota promulgated a state 10-year plan for ending long-term homelessness (Minnesota Departments of Human Services and Corrections, and Housing Finance Agency, 2004). The plan calls for the development of 4,000 new units of permanent supportive housing within seven years at an estimated cost of $540 million. State sources were projected to supply two-thirds of this amount, including capital resources ($90 million in general obligation bonds, $90 million in housing finance agency resources, and $60 million in tax credit financing) and supportive service resources ($120 million through the Department of Human Services, including state appropriations and various public benefits). The working group that developed the plan issues regular progress reports. As of fall 2006:
    - 1,091 of the 4,000 promised new units had received funding commitments and were underway.
    - The legislature appropriated and the Department of Human Services awarded the first $10 million in state funding for supportive services to seven multi-county consortia.

- California has recently passed several important pieces of legislation or voter initiatives that make new resources available for addressing homelessness and the disabilities that often keep people homeless for long periods of time. These include:
  - 2006—a new state housing bond issue for $2.85 billion to create affordable housing throughout the state, with a component aimed directly at developing permanent supportive housing for chronically homeless people.
  - 2005—Proposition 63, which became the Mental Health Services Act in 2006, provides close to $200 million a year statewide. Allocations are up to each county, but it is expected that a significant portion will be used to provide the supportive services that help keep people with severe and persistent mental illness in housing.
- In November 2005, New York announced a new wave of the New York/New York Initiative, known as New York/New York III, to create 9,000 new units of permanent supportive housing by the end of 2015. As did earlier waves, the first of which was signed in 1990, this third wave of combined state and city funding will focus on ending or preventing homelessness among single adults with severe and persistent mental illness. It will have a broader focus as well, serving single adults with substance abuse disorders or HIV/AIDS, families with a disabled head of household, and youth aging out of foster care.
- Investments in Connecticut and Massachusetts are described in more detail later in this paper.

These examples illustrate the importance of and potential results associated with involving agencies with resources and decision-making authority, particularly at the state level. Without their intimate involvement, it will be significantly harder to effect changes in power or money. With their involvement and support, these agencies may identify problems within their own systems and suggest solutions to address them. It is also important to note that some of these state-level changes focus on assisting the larger categories of "extremely poor people" or "people with a certain disability" rather than just people who have already become homeless. By implication, they also involve stakeholders who may not be directly involved in ending homelessness but who can be significant allies in securing policies that should reduce homelessness by reducing the likelihood that people in these categories will become homeless in the first place. Increasing the availability of affordable housing, whether through rent subsidies to low-income households or public investment to reduce capital costs, is probably the single biggest public policy that could affect levels of homelessness (Quigley, Raphael, & Smolensky, 2001; Dasinger & Spieglman, 2006). Assuring housing with supportive services to populations whose disabilities, coupled with extremely low incomes, are known to increase their vulnerability to becoming homeless is another non-homeless-specific strategy that could have a substantial impact in reducing the flow into homelessness.

Beyond "The Usual Suspects"

In the discussion above, we have talked mostly about the roles of "the usual suspects"—homeless assistance providers and government agencies whose missions connect to homelessness through funding, direct service, or both. Communities that have succeeded in involving a wider variety of stakeholders have found their presence to be useful in many ways. The participation of state and local elected officials can be critical to securing the funding needed to carry out the new plans, and also to helping interpret and champion the new plans to the general public. Business associations and business improvement districts have participated in developing and implementing plans to end homelessness, and have also contributed

significant resources and developed service structures of their own in Philadelphia; Denver; Washington, D.C.; Columbus, Ohio; and many other communities. Community leaders were the main participants in Reaching Home, Connecticut's public education campaign that sought to win public support for state investments needed to end chronic homelessness. Foundations, such as the Melville Charitable Trust in Connecticut, have played major leadership and funding roles in some communities. The Conrad F. Hilton Foundation is another example—the foundation recently invested $8 million in efforts in Los Angeles to reduce chronic homelessness among people with serious mental illness, and pursues a number of initiatives to stimulate the city and county to develop and implement approaches to ending homelessness that have a known track record of success.

Scope of Desired System Change

The extent to which there is a shared vision for ending homelessness is likely to affect the success of system change. For some communities, it is more strategic and feasible to focus on solutions for chronic homelessness; for others, it is important to establish a broader vision to bring critical partners to the table. Communities may need to consider the implications of the scope of their goal, and whether system change needs to be organized separately for different subpopulations or aspects of the goal.

Stakeholders in Jacksonville, Florida, mobilized to establish the Home Safe project to permanently house individuals with chronic alcohol addictions who had been living on the streets or in emergency shelter for extended periods.[4] The opportunity to apply for federal funds to address the issue provided impetus for the collaboration to form. The focus on alcohol addiction brought new partners to the table, many of whom had not previously been involved in addressing homelessness. The collaboration involves the homeless coalition, local sheriff, two state-funded substance abuse treatment providers, a key homeless assistance provider, and the mental health center—all of which are working together to address a shared problem. The project has resulted in shared funding, joint decision-making, and regular service planning across all of these partners. Although the collaborative is currently limited to this single project, it has provided a positive experience that can be leveraged for future system change efforts.

Conversely, Indianapolis, Indiana, chose to adopt a Blueprint to End Homelessness that defined strategies for preventing and ending all homelessness, including family and short-term homelessness as well as chronic homelessness for individuals (Indianapolis Housing Task Force, 2002). The leaders of this effort determined that establishing a goal of sweeping change affecting a broad constituency was a more appropriate strategy for engaging the wide range of stakeholders they thought would be needed to achieve system change. Ambitious goals multiply the amount of work needed to create change, but they also expand the pool of willing funders, advocates, and allies. There was concern that a narrower goal might alienate potential allies. System change is still underway, and the Blueprint has continued to maintain widespread support. The community has achieved several critical implementation milestones, including creating new permanent supportive housing units, establishing the Marion County Housing Trust Fund (www.ahomewithinreach.org) and a new affordable housing placement clearinghouse (www.IndianaHousingNow.org) to expand access to permanent housing, successfully piloting two new cross-disciplinary housing and services initiatives (use of HOME tenant-based rent assistance to move families out of shelter, use of a mental health system of care model to provide resource coordination to persons who are chronically homeless), and sponsoring cost studies to measure the primary and

[4] Jacksonville 2005 Grant Application to HUD's Housing for People Who Are Homeless and Addicted to Alcohol program.

behavioral health cost savings associated with the system-of-care pilot. Stakeholders are currently working on a detailed implementation plan that incorporates major funding shifts, investment of new resources from a broad range of mainstream housing and service agencies, and a carefully planned conversion of the homeless shelter system.

Governance and Management Structure for System Change

To achieve system change, communities will need to make decisions about the level of inclusion they need or intend in their processes, how the group will make decisions throughout the process of change, and how the group will manage the process of change. The structure will need to be closely related to the previously described factors of community context, commitment of key partners, and the goal that is established. Inevitably, the community can be more successful if its efforts are intentional and it establishes a leadership, decision-making, and management structure that fits its anticipated goal and process.

Leadership and decision-making structures can form from the top down or the bottom up, or can be a hybrid. Research indicates successes with all models, so the clear lesson about structure is that it should be what fits a given community. There is no "one size fits all"; attempts to impose one community's structure on another community will usually waste time and possibly delay or derail the process.

Communities with a strong funders network or other powerful actors may organize themselves to streamline access to resources through a central organizing body such as the Community Shelter Board in Columbus, Ohio. The resulting top-down structure uses its central control of resources to drive change to address homelessness, once the direction of change has been established through a process of communitywide input. Communities such as Indianapolis, on the other hand, which rely on privately funded faith-based providers to run all of the emergency shelters and the majority of transitional housing programs, may need to employ a more bottom-up engagement model.

In a process in which providers are driving change from the bottom up, it may be hard to get mainstream agencies to the table. For instance, providers in Kansas City formed the Mid-America Assistance Coalition (MAAC), a collaborative of providers, to manage efficient distribution of limited Emergency Shelter Grant and Emergency Food and Shelter Program funds. This collaboration has been an effective solution for the original problem; however, it has not been able to get mainstream agencies to the table or to leverage additional resources to achieve the level of system change needed to truly impact homelessness (Burt, Pearson, & Montgomery, 2005).

On the other hand, if the process is driven from the top down, whether by government or private entities, providers and even local public agencies may distrust the process and resist change. The Annie E. Casey Foundation's experience with its Building New Futures initiative, which gave $10 million, five-year grants to states and localities to promote extensive change in systems responsible for addressing the needs of high-risk youth, is an example in which the "top" is a private foundation with its own preferred vision of a changed system (Nelson, 1995). Federal government efforts to stimulate system change often face similar experiences. In the homelessness arena, for instance, local government agency partners in some HUD/HHS/VA and HUD/DOL Chronic Homeless Initiative projects faced the situation of having to comply with federal guidelines they had no hand in shaping. In some of these communities, a proposal was written with some official signoff from the participating public agencies but without the knowledge of the line staff who would have to be the collaborators. It took some time for the relationships to work

out, especially since the federal grant conditions and specifications sometimes conflicted with established procedures of both public agencies and private providers.

Most communities appear to have a collaborative approach to managing system change that works from both directions. Regardless of structure, communities poised for system change must recognize that change is difficult and there will be times when stakeholders will disagree. When this happens, will the group rely on a consensus model or one in which a majority rules? Does every stakeholder get a vote in decision-making or only those that control funding or regulations? It is essential to define and document a process for making decisions related to system change from the beginning, preferably as part of a memorandum of understanding, before becoming embroiled in the many difficult issues that are inevitable when a community truly intends to change systems.

Identified Process of System Change

The process by which a community implements its shared vision will vary depending on all of the previously mentioned factors, but perhaps will be most significantly affected by the beginning state of the system (proportion of elements operating in isolation, communication, coordination, or collaboration) and the scope of the community's vision. The process should focus on actions that will change power, money, habits, technology or skills, and ideas or values by concentrating on moving system elements from isolation to communication, from communication to coordination, and so on. These actions should be strategic and intentionally planned, though flexible enough to afford regular opportunities to revisit the course of action and redirect resources as needed.

A recent analysis by staff at the Corporation for Supportive Housing (Grieff, Proscio, & Wilkins, 2003) integrates the experiences of many communities to identify "lessons learned" about promoting policy reforms and developing coordinated systems of housing for long-term homeless adults with disabilities. The lessons are pertinent to all efforts at system change; they are presented "linearly" below, but they may occur in any order or simultaneously, and they work best if they are applied in continuing cycles of assessment and action. The Center for Mental Health Services (2003) incorporates many of the same steps in its guidance to communities on ending chronic homelessness for persons with serious mental illness. The steps are:

- fostering collaborative planning and consensus building;
- investing and leveraging resources;
- coordinating, streamlining, and integrating funding;
- building provider capacity;
- establishing and monitoring performance, quality assurance;
- building the case for system change through research and data;
- communicating and advocating: finding ways to make the need for system change compelling;
- cultivating leaders, champions, and advocates;
- capitalizing on trigger events that compel action; and
- designating an intermediary in the role of neutral catalyst, or coordinator.

The rest of this paper synthesizes the approaches and practices that research and our own experience working with communities indicate are promising ways to change systems for the purpose of preventing and ending homelessness.

Mechanisms That Facilitate Implementation of Change Goals

As hard as it is for communities to come together at the conceptual level to agree on new goals and new responsibilities, it is considerably harder to bring the new vision into being. Over the years communities that adopted the goal of ending *chronic* homelessness have developed a variety of mechanisms for implementing change. We focus here on four types:

- mechanisms that stimulate providers to bring their programs into line with the new goals;
- mechanisms that match homeless people to the most appropriate services and programs;
- funding mechanisms that help bring together the array of resources needed to develop and support homeless assistance programs and homeless people and support integration of mainstream and homeless systems; and
- the role of a coordinator to "bring it all together" and make these and many other things happen.

Re-Orienting the Continuum of Care

If communities are really going to "end homelessness in 10 years," everyone who now provides homeless assistance will have to change to varying degrees, and new participants will also have to join in the effort. One Portland informant described the process of reorienting their whole community toward ending homelessness as "turning the ocean liner"; another described the reality of how many small steps this takes:

> First, all of us working on the 10-year plan had to decide what the right thing to do was. After weeks of discussion, our decision was to develop PSH that prioritizes the hardest-to-serve people. Then we had to convince providers that they should adopt these priorities as their own. Even after they were convinced in theory, it soon became clear that providers did not really know what the change would mean in practice. That is, their habits had not changed. In their program structures and client recruitment practices they were violating the principles they had agreed to without even knowing it. It has required constant working on it, explaining it, and training for it, even with "convinced" providers. In addition, we still had to help providers move forward with implementation in the form of getting a proposal together, finding the various pots of money, developing a project plan, etc. This included helping them understand how to use the various new funding sources and mechanisms that were being put in place.

The signs of system change in Portland/Multnomah County involve changes in ideas (coming to agreement on "the right thing to do"), changes in how money is used (the three-point funding structure with assistance to access each funding element), changes in power (new commitments of local elected officials and public agency heads), and changes in habits (new approaches to getting the right clients into the newly opened units).

Chicago's Conversion Process

The process of implementing a 10-year plan to end homelessness in Chicago also relied on major program-level change efforts. The Chicago Continuum of Care Governing Board adopted the plan in 2002, and the mayor endorsed it in early 2003 (Chicago Continuum of Care, n.d.). The plan required a complete paradigm shift in the ways that homeless programs operated and worked in relation to each other. The CoC developed detailed descriptions of the new program models that articulated expectations for program outcomes. Many homeless assistance agencies were active champions of the plan and embraced the concepts of change; however, they still needed significant technical assistance to shift from their current practices to new ways of delivering services. To help, the CoC developed a self-assessment tool that agencies could use to assess whether their programs were consistent with the plan. The tool could also be used to help agencies decide how they wanted to change and to develop a plan for implementing change at the board, staff, and client levels. The CoC also hosted many training workshops for each program type, which were intended to help staff acquire new skills and develop peer support networks to jointly navigate the process of change. Simultaneously, the city and CoC began a multi-year process of using the city and CoC-controlled grant resources to phase in change, starting with incentives and culminating in mandating compliance with the plan in order to access funding. For instance, within the first couple of years of plan implementation, the CoC reduced the number of shelter and transitional beds funded in order to support greater investment in prevention, permanent housing with short-term supports, and permanent supportive housing for people who are chronically disabled.

System change in Chicago is beginning to be recognized for changes in how money is spent (reallocation of city and Continuum resources to support the Plan), changes in ideas (a paradigm shift about the community's ability to end homelessness), and changes in skills (retraining agency leadership and staff). The annual State of the Plan reports also document progress in building new permanent supportive housing units, among other process milestones.[5] Over time the expectation is that habits will also change (realization of cross-system service delivery) and that the cumulative impact of these changes will be realized in reduced numbers of people who experience homelessness, shorter durations of homelessness, and improved individual housing and behavioral outcomes.

Southern New England Training for Developer/Service Provider Teams

Recognizing that production goals for new permanent supportive housing would never be met without expanding the pool of housing developers and service providers who could create and run PSH, the Corporation for Supportive Housing's Southern New England office used THCH funding to create a training program to bring together potential partners and help them structure new projects. The training sought to change knowledge, skills, and ideas of appropriate ways to work together. The One Step Beyond Training Institute (OSB) began in 2004. It gets to the nitty-gritty of what it takes to develop PSH by training the agencies and people who will actually have to produce and operate it. Inspiration is also a part of this mix, as new players must be convinced to participate in PSH production if the goal of expanded PSH capacity is to be reached. OSB is designed to foster partnerships among housing developers and service providers, so that more organizations will get into the PSH business and those already in it will expand their capacity to develop and operate PSH. Each plan being developed involves

[5] State of the Plan reports and other relevant documents about the plan and its implementation can be downloaded from the Chicago Department of Housing Web site (www.cityofchicago.org. Click on Departments, then Housing, then "There's No Place Like a Home" section.)

collaborations among several agencies. The goal was for teams to have project plans and sites identified by the end of the training.

During OSB's second year, teams from Rhode Island included nonprofit housing developers for the first time. Their presence was a testament to system change in two senses. Getting these new players involved in PSH had been a major goal of THCH in Rhode Island. But it probably would not have happened, even with urging from THCH, if another change had not come first. Rhode Island Housing, the agency that controls HOME dollars, established new priorities that for the first time gave precedence to PSH development. If the nonprofit housing developers wanted HOME dollars, they were going to have to get involved in producing PSH. A power center, Rhode Island Housing, had changed the financial incentives, and changed behavior followed. Many of the teams that participated in OSB have since submitted funding proposals to state agencies, with considerable success.

The curriculum developed for OSB is enjoying continued life, as various CSH local offices are using it to stimulate new partnerships around the country. In Los Angeles, for instance, a training series using a curriculum based on OSB but modified for local conditions, called Opening New Doors, is about to begin a second year with a new set of partner teams. Teams from the first year are already writing applications to fund the projects they developed during the training.

Matching Homeless Clients with Appropriate Housing and Services

When a community is sufficiently advanced in creating appropriate housing and service models to end homelessness, it may encounter the problem of assuring that clients with multiple barriers or disabilities, who are most likely to fall through the cracks, get into the available new slots. Some communities hire staff to place clients into programs efficiently and appropriately; others use cross-agency communication protocols or direct service staffing meetings to identify and place clients; others have developed technology to support client referrals and manage waitlists; still others employ a single point of entry to triage clients. Research has not been conducted to assess whether one model is more or less effective than another. In the meantime, we present several examples that appear to be effective to illustrate how communities working on system change have addressed this issue and changed their habitual ways of doing things into new and more effective habits. In a broader sense, this section also illustrates how system change efforts cannot be limited to big picture policymaking, but must also consider and resolve even the smallest details if they are to realize positive benefits for clients.

We start with Portland, because staff there were especially articulate about the work still needing to be done even after everyone officially accepted the goal of serving the longest-term homeless people. We follow this discussion with descriptions of targeting mechanisms in several other communities as well as discharge planning efforts that are working to prevent homelessness.

Portland's Housing-Client Match Facilitator

In 2005, Portland/Multnomah County was sufficiently far along in creating PSH to have come up against a level of system change that does not become obvious until PSH units become available. The housing units are available, with operating and service supports in place, and there are people who need this housing. But the agencies with the people are not the agencies with the housing, so there is still the issue of getting the people with the most complex and challenging conditions into the available units. The issue was recognized and well defined, which local informants perceived to be a good part of the battle. A position was created within the Department of Community Health Services (DCHS) to coordinate this

client-level matchmaking and smooth the way with providers—a position that would not have been needed, possible, or realized without the explicit system change work that had been going on in Portland for the previous two years. The time was right for this development. THCH staff had done the matchmaking at the provider level, getting development, operations, and services providers together to create PSH units. But the last steps had yet to be taken. The agencies that know the clients often are not on "pick up the phone when you need to and just call" terms with the agencies that have the housing. That is where the new DCHS coordinator forges the necessary linkages. As further support for providers, Portland has changed recruitment and referral patterns, found new sources of support for landlords, and generated the trust of landlords by delivering on promised tenant supports. These strategies all work to ensure the hardest-to-serve people get the housing they need.

Philadelphia's Placement Approach for Supportive Housing

Some years ago, Philadelphia faced a situation in which permanent housing providers were reluctant to take some of the hardest-to-serve homeless people who needed housing, and there was no central or coordinated way to match people with housing. One result was that long-term homeless people did not get housed as quickly as possible, and providers also had relatively high vacancy rates, approaching about 10 percent of existing beds. The city's Office of Adult Services, which has responsibility for homeless programs, responded by taking over placements. It began sending specific people to a provider and asking the provider to take them. The result has been more of the hardest-to-serve homeless people receiving housing and services, and more efficient use of available resources (vacancy rates are now around 1 or 2 percent, just enough to leave some placement opportunities when new clients need housing).

Approaches for Reducing Family Homelessness

The emergency shelter system for homeless families in Washington, D.C., has been revamped over the past couple of years to reflect a triage or targeted approach to matching families with appropriate housing and services. In the past, all families were treated similarly regardless of their needs. As a result the system was overcrowded and even the crisis shelter frequently had a waiting list. Today, all families experiencing a housing crisis are directed to the central intake facility, where they undergo an assessment. Based primarily on the nature of each family's housing crisis, intake workers have three primary ways to assist the family. If the family needs a place to stay immediately, it is referred to a central crisis shelter until space opens in a more service-intensive apartment-style emergency shelter program that can help the family find permanent housing and link it with appropriate services. If the family is able to remain in its current housing for a few days and is fairly high functioning, the family is referred to the Community Care Grant program, which provides flexible housing assistance and case management to quickly rehouse families or support them in their current housing. If the family can remain in its housing for up to 30 days, workers attempt to avert homelessness by providing ongoing mediation to resolve family disputes and housing search assistance. Homeless prevention funds are also available through a community-based program in each ward of the city. Changes in D.C.'s homeless system are evident, reflecting a change in ideas (adopting the notion that family homelessness can be prevented), habits (old ways have been revamped through structured service delivery improvements), skills (staff are newly equipped to respond to families in different ways), and in the way money is spent (resources were reallocated to support a rapid rehousing approach).

Columbus, Ohio, uses a single point of entry coupled with careful screening and consideration of available prevention/diversion resources to determine which families can be helped to avoid homelessness and which need to enter a shelter. The system succeeds in helping about half the families who call to

avoid shelter entry. Hennepin County, Minnesota, has a similar screening mechanism for controlling shelter entry and diverting families with relatively simple housing problems to a network of prevention agencies.

Other efforts currently being planned are even broader. For example, Massachusetts's Department of Transitional Assistance (the state TANF agency), sponsored pilot projects several years ago to see whether a shallow rent subsidy offered to families facing housing crises would keep them from becoming homeless. The results (Friedman, 2006) were encouraging enough that the department strategized a statewide implementation; its future, however, depends on a new gubernatorial administration, epitomizing the fragility of even the most well-justified change efforts.

New York/New York III and Client Targeting

In the first two rounds of the New York/New York Initiative, which provides housing and supportive services to people with serious and persistent mental illness, providers had a lot of flexibility in choosing the people they would serve. New York/New York III, which began in 2006, sets specific population targets, including several groups of homeless people that providers have been somewhat reluctant to serve in the past. For the first time, New York City's Department of Homeless Services is expecting to take control of the placement process, including developing lists of "the neediest" homeless people in each target group and offering only these people to service providers. It remains to be seen how successful this new approach will be. But as the legislation governing New York/New York III is very explicit about who must be served, and as the Department of Homeless Services will be the entity paying providers to serve the targeted clients, some accommodation that meets the needs of all parties is likely to be reached.

Approaches to Preventing Homelessness at Institutional Discharge

A California state program to alleviate or prevent homelessness among people with serious mental illness, known as AB 2034 after the Assembly Bill that sponsored it, is being used in Los Angeles to assure that people with mental illness leaving the county jail do not end up homeless (Burt et al., 2004; Burt and Anderson, 2005). Eighteen nonprofit community mental health agencies receive the funding and work with the county jail to identify at-risk prisoners shortly before their release. The AB 2034 money allows providers to "do what it takes" to keep clients from being homeless; the resources have mostly been used for supportive services, with the programs becoming skilled at finding housing resources through partnerships with other providers in the community and Shelter Plus Care vouchers designated for Department of Mental Health clients.

In Massachusetts, the Department of Mental Health has spent years promoting the attitude that "housing is a clinical issue"—a significant change in ideas from previous ways of thinking. It has developed a way to identify clients who were homeless when they entered institutional care and who are at risk of homelessness at exit, which it couples with an elaborate discharge planning mechanism. Recognizing that discharge planning will only succeed in averting homelessness if housing is available, the department established housing coordinators in each service area and in its central office to help develop suitable independent and semi-independent housing in the community (Burt, Pearson, & Montgomery, 2005).

Funding Mechanisms

Most programs that serve homeless people are funded by a complex array of sources, forcing service provider executive and development directors to spend far too much time pursuing each piece of the ever-

changing funding puzzle. One of the most important signs of real system change is the easing of this patchwork funding burden. A few communities have simplified funding for all or most parts of their continuum of care, assembling all funding resources in one place and requiring providers to submit a single application that covers what they need by way of operating and services dollars (and capital dollars if relevant). Several other communities have accomplished a similar simplification for one component of their CoC—typically PSH—usually on an ongoing basis but sometimes as only a one-time effort. Exhibit 2 summarizes these arrangements in eight communities (based on research reported in Burt et al., 2004, and Burt & Anderson, 2006).

Funnel Mechanisms That Combine All Needed Funding Types in One Application

In 1986, public and private agencies and organizations in Columbus, Ohio, that were routinely approached to fund local homeless services were looking for a coherent way to structure their funding activities. They came together and created the nonprofit Community Shelter Board (CSB) to serve as the central planning, funding, and monitoring entity for homeless assistance programs in Columbus/Franklin County, and funneled all of their homeless-related funding through CSB. For about 10 years CSB presided over a system that gave homeless service providers the luxury of preparing only one application for all or most of their funding, but that did not seriously challenge the array of services the system was providing. In the late 1990s, downtown development plans sparked a concern about what would happen to homeless people and provided the impetus for self-study and ultimately for a paradigm shift in goals, from managing to ending homelessness. After due deliberation, the community launched the Rebuilding Lives initiative in 1998 to develop up to 800 units of permanent supportive housing for chronically homeless people (Burt et al., 2004). To identify and secure the resources needed for Rebuilding Lives, a Funders Collaborative was established, whose membership includes all the major public and private funders and potential funders in the area. Through the Collaborative, individual agencies pool their resources, establish common expectations about what outcomes are to be achieved, and specify what reporting requirements are needed to document progress. Armed with these resources, CSB funds individual projects that meet the goals and standards of the Collaborative. Providers apply for capital, operating, and services funding using one application, receive one grant, and write one report. This centralized funding mechanism is a powerful tool for enacting system change, since programs that do not conform to the new standards and way of "doing business" are not funded.

In Philadelphia, the Office of Adult Services orchestrates all homeless-related activities, coordinating with other key agencies in the process. The budget for emergency shelter is part of Adult Services, and a variety of public agencies (e.g., housing and community development, child welfare, and some mental health and substance abuse services) transfer funds to Adult Services to improve the integration of funding mechanisms and ease the proposal burden on providers. Adult Services also coordinates with mental health and substance abuse agencies that operate an array of community-based supportive housing as well as provide supportive services for homeless people in Philadelphia. The city also used the resources under its control to shift the emphasis of its investments from shelter to permanent supportive housing and outreach, in essence changing the allocation of money to follow the change in ideas on how best to end homelessness.

Starting in 1992, the State of Connecticut and the Corporation for Supportive Housing joined forces to promote the Connecticut Supportive Housing Demonstration Program, which ultimately produced 281 units of PSH in nine projects located in six mid-sized Connecticut cities. From the start the funding

Exhibit 2

Funding Mechanisms Facilitating Development of Homeless Assistance Programs and Services to End Homelessness

	Communities with Ongoing Funnel Mechanisms				One-time MOU	Communities with Ongoing Mechanisms to Assure that Projects Get All the Types of Funding They Need		
Funders	Columbus, OH	Philadelphia	Connecticut[1]	Seattle/ King County[1]	San Diego[1]	Portland, OR[1]	Maine[1]	Massachusetts DMH
Housing Finance Agency	C			C			C	C
Public Housing Authority	O		C			O		O
Development/Redevelopment Authority	C,O,S				C,O			C
Housing/Community Development Department	C,O,S	C,O,S	C	C,O	O	C		C,O
Homeless-Specific Office or Bureau	C,O,S[2]	C,O,S[2]		C,O,S	O,S			
Mental Health Agency	S	C,O,S	O,S through state budget line items	S	S	S		S
Substance Abuse Agency	S	C,O,S		S	S			
Medicaid Agency							S	S
Human Services/TANF/Child Welfare Agency/Departments		C,O						
Law Enforcement or Corrections							S	S
United Way	C,O,S			S				
Other Private Philanthropy	C,O,S			C,O,S				

Note: Codes for type of funding: C = capital, O = operating, S = services.

1 For permanent supportive housing only.

2 Many different government departments transfer money to the lead homeless agency for coordinated distribution. Contributing agencies are noted in the table. In Columbus, United Way and private philanthropic funds also flow through the lead homeless agency, which is a nonprofit corporation.

package combined capital, operating, and service dollars contributed by several state agencies and distributed the funds through a consolidated request for proposals. Recognizing the low probability of getting any more money until they could demonstrate to the legislature and state agencies that the first investment had paid off, CSH also raised money for an evaluation (Andersen et al., 2000). The evaluation showed that homeless people and people at very high risk of homelessness accepted this housing and remained stably housed for significant periods of time. Results of a public cost avoidance component of the study showed that tenants used fewer expensive crisis health services (mostly emergency room and medical inpatient services) and used more routine and appropriate health care such as home health and outpatient substance abuse treatment services. This switch from crisis health services to more preventive and routine care in clinic and office settings is one of the common goals of permanent supportive housing. Case managers help clients to attend to health problems earlier, before they become emergencies, which means that clients are able to use the more appropriate and less expensive clinic settings for health care. Because they were getting more routine and preventive care, tenants were also better able to avoid hospitalization. These results, which show both improved health outcomes *and* lower outlays for health care, have been parlayed into two additional rounds of state funding for PSH, now approaching about 1,000 units. Funding for each wave is ongoing, not one-time, as the resources to support projects are line items in state agency budgets. The Department of Mental Health and Addiction Services issues the request for proposals and funds operations and services from its own budget, which includes Shelter Plus Care resources. State housing finance and housing and economic development agencies provide capital resources that providers access through the single application process.

In summer 2006, the Seattle/King County Funders Group issued its first request for proposals to create supportive housing that combined capital, operating, and services funding. As the RFP says, "This is the first countywide public funding effort in King County to coordinate the application and allocation process for capital, operating and services funding for proposals that meet the goals of the 10 Year Plan to End Homelessness." The Funders Group was a structure deliberately created to promote system change under the Taking Health Care Home initiative (Burt & Anderson, 2006).

What these four communities do on an ongoing basis, San Diego did once, in 2003. Several agencies, including the redevelopment authority, which supplied funding for capital and operating expenses and administered the grant-making process, pooled their resources through memoranda of understanding and issued a joint request for proposals for new permanent supportive housing projects.

Funding Mechanisms Involving Facilitated Access to Resources from Several Agencies

Several communities involved in system change studies have not gone as far as those described above in integrating their funding streams for the purpose of simplifying provider applications and assuring adequate levels of operating and services resources. They have, however, gained a "commitment to fund" from the agencies controlling the resources that are most essential for supportive housing and have created mechanisms to help providers navigate their way through these agencies' funding processes. Portland, Oregon staff supported by THCH funding helped housing developers and service providers form viable projects, obtain capital resources from the housing and community development department and state resources (e.g., Low Income Housing Credit), operating resources (housing subsidies) from the public housing authority, and services funding from the mental health and substance abuse agency. In Maine, THCH staff facilitate meetings of a funders/coordinating group that has as one of its primary tasks finding the service match money for tenants of supportive housing projects that receive capital and operating resources from the state housing finance agency. And in Massachusetts, the Department of

Mental Health routinely brokers resources for housing projects to support its homeless and at-risk clients, offering its own service resources to leverage housing dollars from a wide variety of sources including HUD, the state housing finance agency, numerous local public housing authorities, and the Massachusetts Department of Housing and Community Development (Burt, Pearson, & Montgomery, 2005).

Mechanisms That Integrate Funding for Clients

Resource management innovations can do for clients what funnel mechanisms do for providers—enable them to get the care they need with someone else worrying about how to match dollars to services. In their simplest form, resource management systems are being used to match available resources with clients who need them. The systems are used to track resources at the client level to ensure that clients' needs are being met holistically and to ensure that the resources are managed efficiently and appropriately. One concept widely used in the children's mental health field, "system of care," (http://systemsofcare.samhsa.gov) is being adopted as part of the Indianapolis Blueprint to End Homelessness. A "system of care" assembles the resources to "do what it takes" from whatever system has relevant resources to meet client needs. This model involves two important paradigm shifts. The first is a recognition that agency "silos" do not meet client needs, as clients frequently fall through the cracks as they try to negotiate the mental health system to get mental health services, housing providers to get housing assistance, and so on. Instead, resources from each of these systems are pooled and managed by a resource coordinator to achieve the clients' goals. The second important change is that, in contrast to the funding practices of most mainstream systems, funds are available up front rather than having to be claimed and justified after service delivery through a cost-reimbursement process. The community or collaborative of funders identifies the approximate annual or one-time level of resources that different subpopulations are likely to need, and the resource coordinator uses this pool of funding in discretionary ways to purchase services, pay for housing, and support client-identified activities.

This "resource coordination" model is consistent with the literature cited earlier regarding the ability of certain interventions to help mainstream and homeless assistance systems avoid unnecessary costs. The key to its success is a community's ability to convince funders of its merits and to secure their commitment to participate in a "system of care" funding approach. Implementing this model would be a significant indication of system change, as it involves a change in power (change in control of expending resources), money (the act of pooling resources), habits (new ways of delivering services), technology/skills (new skills in working with clients to achieve goals), and ideas (breaking down the silos to deliver client-centered services). Resource management systems can also support dual purposes—direct service coordination and resource use documentation. A community could see the level of resources being used per client, how those resources vary or need to vary based on client characteristics and service requirements, and how the intervention (or involvement in the resource coordination model) changes the use of services. These integrative service delivery and funding systems can help a community understand and set resource allocation levels and measure whether application of funds in this way results in cost savings to other parts of the system.

Reallocation of Funds

The descriptions of Chicago, Columbus, and Philadelphia discuss how communities are using their resources to influence and leverage system change. Beginning with the 2005 CoC application, HUD provided a new tool, the Hold Harmless strategy, within the annual CoC application, to assist in this process. Communities can use the Hold Harmless provision to reallocate funds from poorly performing or lower priority projects to new permanent housing projects that target people who are chronically

homelessness. This approach to system change is likely to increase in practice as other CoCs gain greater understanding of how to use this new tool.

Having Someone Whose Job Is System Change—The Coordinator Role

Through many studies and many site visits, the authors have identified the critical importance of having one or more people facilitating, coordinating, stimulating, reminding, organizing, assessing progress, bringing in new players, and keeping the many actors moving in the right general direction. As mentioned in the framework, creating this position represents a change in power to support system change efforts. The THCH project clearly demonstrates this finding (Burt & Anderson, 2006). THCH funds have supported these essential functions in every THCH site.[6] Key informants consistently stressed how vitally these functions have contributed to progress and the role and effects of coordination were obvious everywhere and at every level of system change observed. The basic phrase heard repeatedly was, "it wouldn't have happened without [insert name of key THCH coordinator]."[7] Without it, even a community with a dedicated council, committee, task force, or other mechanism that in theory could assume leadership runs up against the reality that committee members have other jobs to do. With the best will in the world, they cannot take on the coordinating function.

In all likelihood providing someone to "mind the store" is the key way that THCH has been able to have such a strong influence in many of its communities in such a short period of time—***the grant pays the salary of someone whose job is to pay attention***. The THCH evaluation also addressed the issue of where a coordinator should be located to be most effective. Some THCH site coordinators were employees of government agencies, while others operated from independent CSH offices, two of which were newly created for THCH. So the "lever of change" in some THCH communities was internal to government and thus subject to government changes in direction and policy, while in others it was external to government and had a primary and continuing mission to promote system change.

The decision to place the THCH project within or outside government was not random, which complicates analysis. Four sites had government agencies that were very ready for change and had also taken significant steps of their own toward investing in interventions to end long-term homelessness. These are the sites with coordinators internal to government, as there was an obvious governmental "home" eager to receive and support them. However, governments change, so it is especially telling to note what happened in the one or two THCH communities where the coordinator role was not as strongly realized, or not realized as quickly or at the highest levels. System change in these communities happened

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[6] We discuss THCH findings on the value of the coordinator role because THCH focuses on homeless issues. Dennis, Cocozza, & Steadman (1999) reviewed earlier evidence for the coordinator's importance in creating integrated service systems, focusing mostly on ACCESS-related research. Further published research on ACCESS provides additional documentation (Rosenheck et al., 1998, 2001, 2003a and 2003b). Proscio (1997) discusses the coordinator's importance in developing an effective supportive housing development alliance, as do Greiff, Proscio, & Wilkins (2003). In addition, the experience of many other systems confirms this importance. See, for example, Burt, Resnick, & Novick (1998) with respect to services integration for high-risk youth, Burt et al. (2000) and Clark et al. (1996) with respect to serving women victims of violence, and Center for Mental Health Services (2003) and Huz et al. (1997) with respect to children and family services.

[7] Alternatively, guidance materials stress that participating agencies must give their staff time for the planning and coordinative work of system change, often advising that the key person be given "at least half time" to devote to system change activities (e.g., Proscio, 1997).

more slowly, or did not happen at all, because political or administrative changes (changes in power) occurred soon after THCH began, and hampered the coordinative function.

Two sites in which the THCH grant went to government agencies, Maine and Kentucky, began their grant period with their state housing finance agencies well positioned to involve other state agencies in expanded commitments to PSH development. A change of governors in Kentucky greatly reduced the potential coordinating function that THCH was able to play because agency priorities changed from ending homelessness to fostering recovery from substance abuse for people with housing. The Council on Homeless Policy, with its complement of state agency, provider, and advocate representatives, continued to meet, but operated mostly at the "communication" level, with some minimal "coordinating" activities. Each representative of a government agency operated in the context of his or her agency practices to facilitate PSH development. No one fulfilled a strong coordinator position urging new mechanisms, streamlined mechanisms, joint funding options, or changed policies and practices to stimulate even more PSH. Perhaps the time was not right in Kentucky for even the strongest coordinator or facilitator to pursue a PSH agenda with state agencies, and perhaps the results would have been the same whether someone was trying to fulfill this role from inside or outside of government. But the fact remains that without a strong coordinating influence the *need* for system change was not recognized or acted on.

The Maine State Housing Authority also had a commitment to PSH when THCH began, in a state that had already made significant commitments on paper to ending homelessness in the form of a statewide Action Plan. For various reasons unrelated to THCH, steps to endorse and then implement the Action Plan stalled. THCH stepped into these difficult circumstances; state housing finance agency staff proceeded to create an important multi-agency work group focused on PSH production. This group of mid-level government officials, working "below the radar screen" of agency heads but with their knowledge, made significant headway in moving projects toward realization through the commitment of new public resources (additional capital from the housing authority and Medicaid to pay for services from the Department of Human Services). When the state-level process began moving again and the new governor endorsed the Action Plan, THCH staff were in position to continue and expand their coordination activities. The governor also created a cabinet-level Director of Homeless Initiatives, making Maine the only state in the country to elevate the issue of homelessness to the cabinet level. This significant shift in power is leading to shifts in money and ideas.

The two remaining THCH sites with coordinators internal to government, Portland/Multnomah County and Seattle/King County, are prime examples of how far a person whose *job* is system change can move a system from a platform *inside* a government agency. Even when the system was ready to be moved, far less would have happened, in the opinion of key stakeholders, without the facilitation offered by the THCH coordinator. Having THCH money and someone in the coordinator position facilitated bringing everyone together, including politicians, agency heads, middle management, providers, and the clients in need of PSH units. With coordinators in place, these communities moved to establish one or more working groups. The groups had some common charges, including bringing more agencies to the table, finding more money for PSH, and smoothing the process of putting together PSH funding packages. In these communities, the agency responsible for mental health and substance abuse services was a primary target for inclusion, and both succeeded in bringing these very important agencies and their service-oriented resources on board. Law enforcement is also an important new partner in Portland.

Multi-agency groups in both communities have made great progress in identifying and committing public resources. These include completely new funding sources (e.g., Washington's bill 2163), more funding

and redirected funding from existing sources (e.g., use of state and local mental health dollars as service matches for PSH), and more streamlined funding mechanisms. They have also reduced bureaucratic entanglements that can slow the process of PSH development. Finally, these two THCH communities established new procedures for assuring that the hardest-to-serve long-term homeless adults were most likely to become tenants of new units.

The THCH sites in Los Angeles and Rhode Island were structured with coordinators in new CSH offices external to government because local government was not active in seeking solutions to homelessness. There was thus no obvious place to locate an internal coordinator. The external THCH coordinator's initial goals in these communities were to educate relevant stakeholders about PSH and demonstrate to public agencies that PSH could help them fulfill their own agency objectives. Working from their nongovernmental platforms, THCH staff in both sites sought a foothold in the most relevant committees, councils, or task forces and proceeded from there. They were also able to capitalize on activities of their affiliated CSH offices (California and Southern New England) to help mobilize these new communities.

In Los Angeles THCH resources were used to "staff" the Special Needs Housing Alliance (a task force of county agencies charged with assessing and then augmenting available special needs housing, including housing for homeless people). This staffing provided coordination and technical assistance to help the Alliance articulate its agenda, complete a countywide inventory of special needs housing, develop a strategic plan, and see important components of that plan funded by the County Board of Supervisors, including a new position of "housing and homelessness coordinator" under the county's Chief Administrative Officer—several "firsts" for Los Angeles County that in turn are leading to new developments and partnerships. In Rhode Island, THCH intervention helped make "PSH" a recognizable concept to key stakeholders (change in ideas), leading to a new state agency with a "housing and homelessness portfolio" that gathers most of the state's housing and homelessness-related funding streams into one coordinating office (change in power), staff to make it happen, a re-established interagency council, a partnership of philanthropy and government, and a first-ever public-private funding commitment for new units of PSH (change in money).

In the remaining THCH community, Connecticut, a good argument could be made that Connecticut had already "achieved" system change before THCH. But THCH staff in Connecticut see system change as an ongoing process and one that will always need some level of "tending." Systems can always be improved, new agencies and populations brought in, service approaches expanded and made more effective, new provider teams created, prevention tackled, and real public understanding and commitment to ending homelessness secured. Connecticut used its THCH resources to many of these and other ends. It is the best example within THCH, so far, of what might be called a "self-renewing" system—one that regularly reflects on where it is and where it wants to be and keeps moving forward. As the nongovernmental entity whose eyes are always on the PSH prize, THCH and CSH in Connecticut still find significant roles in promoting the means to end homelessness for people with disabilities who are unlikely to be able to manage on their own.

The issue of the most effective location for a coordinator as change agent has no simple answer. Internally placed coordinators may be extremely effective in communities where at least some agencies and providers are ready for and interested in change. However, they are vulnerable to alterations in political support, and if support shifts substantially, their internal position may make it difficult for them to continue facilitating and advocating for system change. An externally placed coordinator may remain single-focused through all political changes, but has no official clout to wield in the process of gaining

people's attention and beginning to influence their choices. Further, an externally placed coordinator must have a home somewhere, so an external organization must create and sustain that home. To be most effective, the external organization should be seen as neutral or nonpartisan but politically savvy, able to contribute expert knowledge and technical assistance, respectful of all parties, and good at listening and facilitating.

Documenting the Impact of System Change

Throughout this paper we have noted the importance of regularly assessing the progress of system change and redirecting efforts, as needed, to fulfill the goals of the community. Forward-looking communities create mechanisms to measure their impact from the beginning, ideally building upon infrastructure that can also advance the change itself. This section documents some of the successful efforts that communities have used to establish regular processes for assessing progress on system change. The discussion will cover two primary areas: system infrastructure components and evaluation processes.

System Infrastructure Components

Many communities have established infrastructure to improve the delivery of services to clients. If well designed, this same infrastructure can be used to collect data for evaluation purposes. For instance, an information and referral (I&R) system is a valuable asset for sharing information on available services and criteria to access those resources with case managers and clients who may need them. Some I&R systems also automate the referral process to expedite client access to resources and to reduce service under-use or duplication. I&R systems can also inventory system assets to permit monitoring over time. If a community sets a goal to increase the number of prevention resources, mainstream supportive service linkages, or permanent supportive housing units, the I&R database becomes an objective way to measure progress toward that goal.

A homeless management information system (HMIS) that collects client-level data to enable coordinated case management also yields extremely valuable longitudinal information on the extent and nature of homelessness episodes, service use patterns, and short- and long-term client outcomes. The State of Arizona's Homeless Evaluation project exemplifies the value of HMIS for case management and evaluation purposes. Arizona's structure encompasses three continuums of care, all of which have functional HMIS implementations. The homeless providers within each continuum use the HMIS to support case management and internal agency record-keeping. Client information is aggregated and analyzed at the continuum level for each community's planning purposes. The State of Arizona worked with the continuums to develop a Family Self-Sufficiency (FSS) matrix, which uses 13 domains to track a household's change in self-sufficiency. The FSS matrix has been incorporated into each continuum's HMIS, and case managers report on each of the 13 domains at program entry and exit, and sometimes more frequently. Case managers use the matrix during client assessment to develop a case plan for promoting greater family self-sufficiency. The Arizona Homeless Evaluation Project has begun to analyze the change in FSS results at the program and continuum levels and is using the initial findings to identify which programs are most successful with different client groups. Early results indicate the ability to predict client success in different program models from an initial client FSS assessment. Results are now being used to guide technical assistance, target appropriate client referrals, and develop baselines for program performance. Over time, the FSS measures will likely be integrated into an ongoing performance-based funding process.

In Philadelphia, the city has used HMIS data to understand client characteristics and patterns of shelter use (personal communication with Dennis Culhane and Rob Hess, Philadelphia's homeless "czar" for many years). This information shaped policy decisions that fueled the dramatic strides in building permanent supportive housing and targeted interventions for individuals and families who are homeless. In addition, the HMIS system has become a day-to-day tool for improving services to homeless clients across disciplines (e.g., homeless programs, child welfare services, and behavioral health treatment). For instance, as interventions for chronically homeless people are developed, outreach staff can use the HMIS to identify specific individuals who have experienced long-term homelessness and would benefit most from permanent supportive housing. City staff also use daily statistics to monitor and immediately fill shelter vacancies, manage caseloads, and redeploy case managers to assessment centers with significant numbers of families waiting to be served, among other operational uses. In the aggregate, this information is also used to allocate annual city-controlled grants, benchmark progress on the city's 10-year plan to end homelessness, and inform homeless policy decisions.

As with I&R, the HMIS is fulfilling two important roles—one for direct service, another for evaluation—both important tools that support system change. HMIS presents opportunities for the future by building predictive models using longitudinal system data, which in turn can be used to triage clients the first time they present with a housing crisis and direct them to the programs and services most likely to be effective given their circumstances. Conversely, the data collected over time about these clients can be used to assess the effectiveness of and make improvements in the community's interventions.

In most communities, only homeless providers and a handful of mainstream agencies participate in the HMIS. For HMIS to truly support and/or measure system change, the infrastructure will need to expand and achieve participation among providers from mainstream systems, or develop ways through data warehousing or other techniques to match and integrate data across systems.

Evaluation Processes

Communities have established a range of practices to measure progress and to influence further change, many of which rely on the infrastructure components described above. The primary methods include program-level evaluation, performance-monitoring and funding tied to performance, and benchmarking system progress. Many communities and providers note that having a process in place to measure their actions and results holds them more accountable, and therefore makes them work harder to be productive so they will be able to demonstrate results.

Program-Level Evaluation and Performance Monitoring and Accountability

Client records tracked in a longitudinal database, such as an HMIS, can be used systematically to understand program performance. The results can identify effective program practices or low-performing programs that need technical assistance to improve their performance. Of course, a community's ability to use HMIS information in this way is only possible if the database contains fields for the relevant outcomes and if providers are diligent about collecting and entering the relevant information.

The results of performance monitoring can be used to direct clients to the programs that appear to be most successful for people with similar characteristics and issues. They can also be used to direct funding to successful programs and divert limited community resources from less successful efforts. Communities across the country are putting these and other strategies in place in as part of their efforts to reduce or end

homelessness and to understand the processes of system change that can help them reach that ultimate goal. The earlier discussion of Philadelphia's approach provides one example, in addition to those below.

Columbus has implemented advanced processes for analyzing program effectiveness with HMIS data and uses the results to influence program funding. To support its process, the Community Shelter Board (CSB) has developed data quality assurance standards for all funded agencies to ensure that the community has reliable, complete data on which to base decisions. CSB has also developed comprehensive program standards and performance expectations for each program type, and incorporates these expectations into each agency's contract. Performance measures pertain to the number of clients served, average length of stay, housing and income outcomes at exit, return to homelessness, client movement toward agreed-upon goals, direct client assistance utilization, occupancy rates, housing stability and retention, and efficient use of funding resources (average per client costs). CSB clearly communicated to agencies that these outcomes were a priority in the homeless system. It identified measures to support performance-based funding and put them in place throughout the system of homeless assistance services. Over the years, tracking performance has helped to fuel program-level change to support these goals.

The Michigan Measurement Project was established in 2006 to develop a sophisticated program outcomes measurement system to track intermediate and long-term client outcomes by program type. Once implemented through the statewide HMIS, aggregate performance data will be viewable through the HMIS at the program, agency, CoC, and statewide levels. Programs can compare their own results to those of other like programs throughout the state to assess their own effectiveness and to identify strategies for improvement. CoCs and state agencies can use the outcome measures to inform community planning and resource allocation processes. Because it is a state-level activity, the Michigan Measurement Project is more focused on identifying promising program practices and benchmarking program progress than local evaluation processes might be. The latter might focus more on performance monitoring and performance-based funding.

The model of measuring system change at the program level is also being carried to the federal level (Khadduri, 2005). HUD is presently reconfiguring its Annual Progress Report to improve the quality of information it receives from continuum-of-care grantees on the activities and outcomes of HUD-funded programs in relation to its national goal and other related objectives. To reflect the diverse goals of homeless assistance programs, particularly in light of local system change efforts, HUD is contemplating establishing a range of performance measures from which funded programs could select when they apply for HUD funding. HUD would then use the selected measures to monitor each grantee's accomplishments. HUD can integrate the program-level results with two other primary sources to measure national progress toward the goal of ending chronic homelessness. First, HUD is analyzing HMIS data from a sample of communities across the country to produce Annual Homeless Assessment Reports on the extent and nature of homelessness and use of homeless services. Second, HUD asks CoCs to report numbers of sheltered and unsheltered persons in their annual CoC applications. Together, these sources help HUD understand better how homelessness is changing over time and suggest how programs funded through CoC Care grants are contributing to these changes.

System-Level Evaluation

Communities are also instituting processes to track their own effectiveness in achieving system change for the ultimate purpose of ending homelessness. Establishing an evaluation framework forces a community to set deliberate change goals and to identify strategies to accomplish them, from which it can

easily document progress related to its multi-year action plan. As noted earlier, evaluating the process may actually promote progress itself. The change goals and strategies become the outcomes and indicators of the effects of changing systems that are tracked over time. A comprehensive evaluation framework is likely to include process outcomes (what indicators will help the community know if it has completed the strategies that it anticipates are needed to effect system change), program outcomes that can be used to guide a program-level evaluation and performance-based funding process (what client outcomes are needed at the program level in order to achieve the system outcomes), and system outcomes (the domains that the community hopes will be impacted as a result of the efforts). If all of these components are in place, a community will be able to observe whether its intended system changes have occurred and if they are making an impact. If the expected effects are not observed, the community will also have data to help indicate whether it failed to meet its outcomes because plans were inadequately carried out, or whether the strategies the community thought would help were insufficient. The information can be used to improve their process over time, and the community can share effective strategies and/or pitfalls with others trying to accomplish similar things.

The Chicago continuum of care developed a series of system measures to assess progress in ending homelessness, including indicators of the number of people (overall and chronically homeless) who present for homeless assistance each year, the number of days it takes to help someone presenting with a housing crisis return to permanent housing placement, rates of permanent housing retention, and rates of recidivism. Program outcomes have been defined for each program type to help set common expectations for what is expected from each part of the system and to guide resource allocation. The CoC also developed process and efficiency measures, such as annual projections of units and services slots by year (some program types will increase, some will decrease over time), the vacancy rates of residential programs, user satisfaction rates, and indicators related to increasing resources for appropriate interventions. Chicago has been publishing semi-annual State of the Plan reports (available at www.cityofchicgao.org) that share accomplishments and annual outputs related to unit conversion and development targets as well as performance on the system measures.

Various formal methods exist to evaluate changes in system connectedness and integration, including changes in how people and agencies relate to each other, changes in how clients are referred among agencies, and changes in how funding does or does not flow among agencies. In the homeless arena, some of these methods were used in evaluating the Program on Chronic Mental Illness that began in the mid-1980s with support from the Robert Wood Johnson Foundation and HUD, and also the ACCESS demonstrations of the early 1990s (Morrissey et al., 1994, 2002; Rosenheck et al., 1998, 2001, 2002, 2003b). Modifications of the same methods are now being used to assess changes in system integration associated with the Collaborative Initiative on Chronic Homelessness (Greenberg & Rosenheck, 2006). These methods are available for use by communities seeking formal quantitative documentation of system change.

A community or researcher could also apply one or both frameworks presented in the beginning of this paper to measure process aspects of system change: the five indicators of change from *Laying a New Foundation,* and the five stages of integration. *Laying a New Foundation* indicators of change in money, ideas, habits, power, and skills/technology can be measured as process indicators. For instance, a community that sets a goal to shift system resources from shelters to permanent housing could track the percentage of resources going to each component of its homeless assistance system over time. Alternatively, a community could track the number of units/service slots in each program area over time. Changes in skills and habits could be measured by tracking first whether staff have acquired the skills and

tools they need to conduct business differently, and second whether the business practices have actually changed. For instance, are people being placed within 14 days or are staff continuing to work with clients using the old patterns of doing business? These measures need to be constructed locally depending on the ways in which the local systems need to change; however, the framework can provide useful categories to classify and set expectations for change.

The stages of integration and changes in money, ideas, habits, skills, and power are or should be interactive. That is, as a community progresses toward more collaboration and coordinated community response, one expects these changes in process to produce changes in money, power, ideas, etc. But it also works the other way, as changes in money, power, and so on can push systems to change more and cause more stakeholders to join the system change bandwagon. In addition to the usual approach involving qualitative methods to assess changes in stages of services and systems integration, the formal methods referenced above can be used to document changes in the flow of clients, ideas, and money. Some changes, such as changes in money or new housing units, are relatively easy to document (e.g., Burt & Anderson 2005, 2006).

Communities could commit themselves to assessing the extent of change in the level of integration across all the agencies in a whole system as well as between any two agencies or among any three or more agencies within a particular agency or system. Also relevant are the isolated or integrated activities of various divisions within large umbrella public agencies. For example, many Departments of Human Services include divisions responsible for income maintenance (TANF, food stamps), child care, child welfare, and sometimes mental health and homeless assistance. It is all too common that these divisions do not work together at all, despite all existing under a common roof.

One can use the framework to prescribe, as well as describe, changes in various systems that are expected to promote the goal of ending homelessness. A community can assess its initial or starting point of integration and set explicit goals as to where, along the continuum of integration stages, the systems should be in one year, two years, five years, and so on. In doing so, it is essential to realize that it would be very unusual for all the agencies and organizations in a community to be at the same place at the same time in this five-level framework. Rather, what usually happens is that some parts of a potential system begin moving toward increased integration early on and, if their progress is viewed as useful, begin to bring other elements on board and to expand the scope of activities. It is therefore most fruitful to use this framework to characterize movement and change rather than a steady state or a comprehensive overview. A community does not need all potentially relevant agencies on board at the start, but as ending homelessness will not happen without the substantial commitment of public resources, at least some major public agencies need to be committed at the outset for a community to be able to speak realistically about embarking on a campaign to end homelessness.

An illustrative example for a community deciding to work toward ending family homelessness is shown in Exhibit 3. The matrix in Exhibit 3 should really be three-dimensional, as the issue with integration is how one agency or system works with one or more other agencies or systems. This multi-agency nature of integration is reflected in the last column of Exhibit 3, where the “coordinated community response” cell is shown as including participation of six different systems.

Similar assessments of the current stage of integration can occur at subsequent time intervals, and the community can use the results to help assess whether the past actions were effective in meeting change goals. This type of evaluation does not replace the need to assess whether an increasingly integrated

system is reducing homelessness or positively affecting the problem that the community is targeting. Both the formative (process) and summative (end result) measures are required for communities to understand which strategies are most effective in meeting identified needs.

Some communities may also find it useful to think of how they might modify the "stages of change" framework used in the substance abuse treatment field for use in documenting community change. The stages of change framework classifies a person's willingness and progress in addressing a substance addiction. Such an approach recognizes the importance of assessing where an individual is relative to his/her understanding of a need to change and his/her commitment to the change process and identifies a predictable sequence of stages through which an individual passes during the process: precontemplation, contemplation, determination, action, maintenance, and relapse prevention (Prochaska et al, 1994). Programs that use a stages of change approach assess and respect where an individual is in that process and encourage and motivate movement. The strategies and actions that a treatment professional might use to engage an individual in treatment or the change process will vary depending on a determination of the person's current stage of acknowledgement and engagement. The stages in the addictions scheme are used over time to benchmark progress and regression. If one is willing to think of a whole community in terms of its acknowledgement of the need to change and its willingness to take steps to change, this model might be applicable. It would certainly be applicable to measuring changes in individual homeless people as they move toward leaving homelessness.

Implications for Preventing and Ending Homelessness

Research on the impacts of system change itself is relatively rare, compared to research on the effectiveness of particular program models to serve particular populations (e.g., PSH to serve long-term homeless people with disabilities). Although we are unable to speak definitively about the impact of system change, many communities are able to report process measures and some impact information; therefore, we can say the following:

- Most works cited in this paper attest to the fact that explicit system change efforts can get previously uninvolved agencies to the table and involved in developing more effective approaches to serving homeless people and ending their homelessness.
- ***Process results, with relevant outcomes:*** System change efforts can succeed in increasing funding for and production of supportive housing.
    - Most THCH sites stimulated significant new funding, and also brought new stakeholders to the table and strengthened and integrated the involvement of the original stakeholders (Burt & Anderson, 2006). ***Outcome:*** Added more PSH units to the pipeline in the first two years of their grants than they had expected to do in five years, and ended the homelessness of a corresponding number of chronically homeless people.
    - San Francisco's Direct Access to Housing (DAH) approach grew out of a "pipeline group" of relevant agencies. ***Outcome:*** Added thousands of units of PSH to the San Francisco portfolio of programs to end homelessness (Corporation for Supportive Housing, 2004), with corresponding reductions in street homelessness.

Exhibit 3

Sample Framework for Assessing and Advancing Stages of Integration Across Community Partners to Implement a Plan to End Family Homelessness

Community Partners	Isolation	Communication	Coordination	Collaboration	Coordinated Community Response
Family Homeless Service Providers		Today – most talk with each other, refer to each other	6 months – beginnings of agreed-upon specialization, partnering for specialized services	Year 1 – Collaborative project among several family homeless providers	Year 5 – Centralized intake and triage for housing placement; scaleable case management supported by full range of integrated service partners and pool of vouchers and flexible resources to meet family housing and service needs
Child Welfare	Today	Year 1 – communications established with family homeless providers, agree to work on reducing distrust, antagonistic relationships	Year 2 – develop system to identify common families and triage methods, identify child welfare resources to assist homeless families without threat of removal	Year 3 – Service Integration Pilot , family reunification project – includes homeless providers	
Family Court	Today	Year 1 – part of communications that include child welfare and homeless providers	Year 2 – work on court standards and expectations for working with homeless families		
Workforce Development Agencies	Today	Year 1 – Homeless Planning Partner	Year 2 – One-Stop Career Center staff co-located at family homeless programs		
Public Housing Authority		Today	Year 1 – Streamlined application for PHA resources	Year 2 – Dedicated vouchers for homeless families, support systems in PHA buildings to prevent homelessness, management of locally-supported short- and medium-term vouchers	
TANF/food stamps/Medicaid Agency	Today	Year 1 – Benefits Eligibility Analysis	Year 2 – Automated Benefits Screening by Homeless Providers	Year 5 – Automated Benefits Enrollment by Homeless Providers	Long-term – System of Care Pooled Resources Approach
Mental Health and Substance Abuse Agencies	Today	Year 1 – convince to come to table, recognize shared clients	Year 2 – negotiate access to specialized resources, develop partnering techniques	Year 3 – develop dedicated funding streams	
State Affordable Housing/Subsidies Funders (Housing Finance/Redevelopment Agencies, Legislature)	Today	Year 1 – start to make contacts	Year 2 – work on possible programs, legislation; convince with performance results	Year 3 – beginning of new resource availability	Long-term – new dedicated housing affordability resources to reduce need

  - A confluence of events and history put Philadelphia in a position to develop a great deal of PSH rapidly (Wong et al., 2006) and couple it with a redesigned outreach system to help move street homeless people into the new housing. ***Outcome:*** Major reductions in street homelessness.
  - Columbus, Ohio's Rebuilding Lives Initiative changed the local homeless assistance system toward one designed to end homelessness. ***Outcome:*** Created more than 200 short-term shelter beds and upwards of 600 new PSH units (so far) with a combination of new and redirected funding. Almost 800 single adults have secured housing and left homelessness (www.csb.org). Other parts of the system concentrated on prevention.

- ***Impact results:*** Communities that have invested in permanent supportive housing on a significant scale are beginning to see the effects in reduced counts of unsheltered homeless people; likewise, there is some evidence that communities that have instituted new, integrated ways to address family homelessness have seen reductions in family shelter use, because housing crises are being resolved before they progress to the stage in which a family becomes homeless.
  - Communities that have invested in permanent supportive housing are reporting reductions in street homelessness—San Francisco, down about 20 percent between 2004 and 2006; Portland, down 20 percent and 600 people moved into PSH in past two years; New York City down 13 percent from 2005 to 2006 (all as described in a federal Interagency Council on Homelessness electronic newsletter, available at www.ich.gov); Philadelphia down more than 75 percent over five or six years (as described in Burt et al., 2004). Outreach and other mechanisms deliberately focused on bringing street people into housing can help this process.
  - Integrated services that include housing can increase access to housing and successful housing outcomes for homeless people with serious mental illness (Mayberg, 2003; Rosenheck et al., 1998). Further, the effects last for some years (Burt & Anderson, 2005; Rothbard et al., 2004).
  - Communities such as Hennepin County, Minnesota; Washington, D.C.; and Columbus, Ohio, that have focused on strategies for shelter diversion can dramatically reduce the numbers of people entering shelter. Strategies in those communities to reduce lengths of stay in shelter have enabled them to reduce shelter beds and apply those resources to other housing and services.

The knowledge gained from years in the system change trenches is being applied widely, thanks to active promotion through advocacy and technical assistance (Center for Mental Health Services 2003; Corporation for Supportive Housing 2002, 2004, 2005; and many others). But systematic evaluation of these change efforts in the homelessness arena remains all too rare.

Recommendations for Future Research

Given the paucity of current documentation of system change and its effects, we cannot reliably identify "gaps in knowledge"; instead, we must point to a broad array of important questions for which we have mostly anecdotal answers. With more than 300 communities around the country developing 10-year plans to end homelessness (see Interagency Council on Homelessness Web site (www.ich.gov), and at least 90

of them promulgating those plans and taking some steps toward implementing them (Cunningham, et al., 2006), and independent efforts to change systems in many locations, there is great need to evaluate the impact of these efforts and the factors that were most important in shaping (or blocking) that impact. We know of no plans to do so, beyond the self-assessments that are likely to show up in annual applications for continuum-of-care funding in response to HUD requirements. It would indeed be a great shame if, at the third National Symposium on Homelessness Research 10 years from now, there is no more systematic research evidence for the impacts of system change than we have been able to report here.

This is an area where practitioners and advisors abound, but hard evidence is elusive. In this paper we have tried to lay out some basic answers to a preliminary question: How will we know that systems have changed? We must go on from there, to design and fund research that answers the following questions:

- Which actions were pivotal in achieving change?
- What level of effort, staffing, and political will is required to implement change?
- How will we know we are making progress toward ending homelessness, and will we be able to say with confidence that systems change contributed to any observed reductions?
- Are some systems more important to change than others in community efforts to end homelessness?
- How much of any change we observe will we be able to attribute to the introduction of more effective program approaches (e.g., adoption of best practices), compared to streamlining system processes?
- How much of any change we observe will we be able to attribute to the structure of the change effort? As one reviewer noted, the communities currently organizing for ending homelessness or chronic homelessness are using very different structures. The motive for seeking an answer to this question would be to help communities just starting on the process to select the "most effective" structure.[8] The suggested structures include:
  - A centralized, coordinated, state-to-local model (Utah),
  - A two-tier framework that aligns state with locals to implement state framework (Michigan, Missouri, North Carolina),

[8] The problem with attempting to submit different structures to an impact evaluation is that each is a unique product of its place, time, and circumstances. No community would ever be able to adopt a particular structure in its entirety, let alone expect it to function as it did in the community from which it was copied. These structures develop in response to the particular attitudes, histories, and cultures of their respective communities, as well as reflecting who cared the most and the agencies or organizations in which those people were situated when the need for mobilization occurred. Another community facing different conditions could not simply decide to adopt a particular structure; it would have to select the one with the best "fit," and then modify it until the fit meets community needs and capacities. It would be important to examine whether the *structure itself* affects what can be accomplished, or whether the strength or weakness of the structure reflects the willingness of local actors to submit themselves to its direction. It would also be important to examine how much power the structure is given and how it wields that power. Further, it would be important to examine the existence and scope of a coordinator role, and whether a clever and dedicated coordinator can make any structure work, albeit using different approaches depending on whether the structure is strong or weak. A good research design would include approaches for sorting out which factors are most important for system change and its ultimate effects, and what is different but does not make a difference.

- Integrated CoC and 10-year plan efforts (District of Columbia, Contra Costa County, California) that plan to implement across multiple populations all at once, and
- An incubator approach (Montana).

Individual communities can and should implement formative and summative evaluations using the frameworks and methods described in the Evaluation Processes section of this paper. In addition, a systematic system change-oriented multisite, multi-year research project similar to the ACCESS evaluation, set up to measure a spectrum of change processes and their impacts over time, could be very fruitful.

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Consumer Integration and Self-Determination in Homelessness Research, Policy, Planning, and Services

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Abstract

In this paper, the authors assess how the process and outcomes of research, policy, and service delivery change when they involve or are driven by people who have themselves experienced homelessness. They review the available evaluation literature and present lessons from the field on consumer integration in research, policy, and program implementation. Barriers to consumer integration and strategies for addressing these barriers are described. Barrow and her colleagues further address what happens when people who are homeless make the decisions about the housing and services they need. They conclude by reviewing findings on the individual- and system-level impacts of consumer-driven approaches to homeless assistance.

Introduction

In the 35 years since homelessness emerged as a social issue requiring public attention and policy responses, it has become institutionalized in government and civil structures at all levels. So many federal agencies are affected by issues related to homelessness that an interagency council has been created to coordinate their efforts. Our largest cities have full-blown homeless services departments; many not-for-profit agencies are wholly or heavily funded by contracts to provide housing and services to people who are homeless; and a cadre of academics now specialize in homelessness research. Against this background, the new language of "ending homelessness" announces a disruption of business as usual and issues a challenge to decades of conventional wisdom. Among the new approaches commanding attention are those that claim prominent roles for people who have been homeless—long the objects, but rarely the authors, of either research, policy, planning, or services developed to address homelessness or their own housing and service options.

This paper seeks to contribute to this Symposium's appraisal of knowledge about preventing and ending homelessness by addressing two questions: How are research, policy, and service delivery processes and outcomes changed when they involve or are driven by people who have themselves experienced homelessness? And what happens when people who are homeless make the decisions about the housing and services they need? Guided by these questions, we offer a synthesis and assessment of available information—some of it in the "fugitive" or "gray" literature of reports, newsletters, conference handouts, and web postings; some in peer-reviewed and published research—reporting on the involvement of people who are or were homeless in research, policy, planning, service delivery, and on consumer-driven, choice-based homeless services.

For the purposes of clarity in this paper, we use the term "consumer" to describe individuals who are currently or were formerly homeless. The term is controversial for several reasons, including its connotation that those experiencing homelessness can shop around for services among several available options as well as its links to an economic language of the marketplace. However, in the literature we review, it is the term most widely used to refer to people with current or past experiences of homelessness or those who have received system services. Other terms sometimes used instead of "consumer" in the mental health movement include "psychiatrically disabled" (Hensley, 2006) or "survivor" to indicate people who consider themselves "disabled" or who have survived psychiatric hospitalization or other trauma. However, these terms apply less broadly, since not all individuals impacted by homelessness have a history of psychiatric illness or hospitalizations or identify themselves as survivors of trauma. The term "peer" is currently used in the United States to identify people with a collective experience (for example, mental health and/or substance abuse recovery or homelessness) who are working and using their personal experiences and skills to assist others facing the same challenges. When reporting on programs that use the term "peer" in describing their staffing, we have retained this usage, but because we document participation by people who have experienced homelessness in research, policy, and planning, as well as in service delivery, the term "consumer" is a better fit than "peer" with the topic and intent of most parts of this paper.

Institutional and Policy Context

Decisions about and funding for research, policy, planning, and service delivery occur at national, state, and local levels, and are implemented in public, not-for-profit, and private organizational contexts. Several national-level government and advocacy organizations, notably the Interagency Council on Homelessness and the National Alliance to End Homelessness, have now adopted consumer-driven approaches as part of their push for 10-year plans to end homelessness, introducing choice-based housing and services in diverse locales. The National Association of State Mental Health Program Directors promotes state-level support for consumer self-determination of housing and services (NASMHPD, 2005).

Within federal departments that make policy and fund homelessness research, housing, and services, some agencies have strongly advocated consumer involvement. In the Department of Health and Human Services (HHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), which supports homeless services for people with mental health and substance problems and evaluates innovative approaches, has played a leading role. The Health Resources and Services Administration (HRSA) has set high standards for consumer participation in governance of community health centers, though less stringent standards apply to HRSA-funded Health Care for the Homeless programs. At the National Institutes of Health (NIH), which fund most academic research on homelessness, consumer

involvement has not been a priority. The Department of Housing and Urban Development (HUD) has endorsed consumer involvement in continuum-of-care (CoC) planning and in the implementation of Homeless Management Information Systems (HMIS). A HUD pilot program to develop consumer roles in HMIS led to a national training initiative on consumer involvement in HMIS implementation.

Changes Since 1998

In the last decade, a wave of initiatives and actions has involved consumers in research, policy, planning, and service delivery; given increased prominence to choice-based approaches to housing and services; and created a growing body of supporting research evidence. The current momentum of consumer-driven programs and expansion of consumer roles emerged in the context of broad social changes limiting the use of public resources to address poverty and homelessness. Activism driving consumer involvement arose from the consumer/survivor movement in mental health services and has carried over into homeless services and advocacy. Concerns about HIV/AIDS, managed care, and a shrinking safety net have also been energizing forces. Even under unlikely social conditions, consumers and their allies have found ways to advance a more consumer-centered agenda in homelessness policy and services.

The context for these developments is complex. Several broad social trends have converged in the last decade to force a reassessment of approaches to homelessness:

- Reduced public commitment to social spending has coincided with losses of affordable housing, growth of wealth and health disparities, escalating incarceration of minority and disabled individuals, and a failure to stem the growth of homelessness.
- Penetration of market principles and management technology into health care and public services has produced managed behavioral health care (Mechanic, 1999) as well as new attention by public agencies and providers to cost saving, outcomes-based management, and evidence-based practice (Nelson et al., 1995); at the same time, demands for "personal responsibility" on the part of vulnerable groups have increased (Bishop & Brodkey, 2006).

Even as these processes reflect and promote reductions in social welfare spending, consumers have turned them into new openings for activism:

- Consumers have adopted and reframed calls for personal responsibility to emphasize individual choice, encouraging people to act as agents on their own behalf (National Mental Health Consumers' Self-Help Clearing House, n.d.).
- The recovery paradigm in mental health, promoted by the consumer/survivor movement and its allies, is challenging old assumptions about capabilities of consumers and making recovery, self-determination, and choice defining principles (Anthony, 2000; Campbell, 2006a; Mueser et al., 2002).
- Recovery has entered the federal mental health agenda (New Freedom Commission, 2003; SAMHSA, 2005c; US Department of Veterans Affairs, 2005).
- Consumer-operated programs and choice-based program models (Campbell, 2006b; Teague et al., 2006; Tsemberis et al., 2003) are being developed, tested, and disseminated.

- Ten-year plans to end homelessness are expanding opportunities for consumer-focused and choice-based approaches.

Synthesis of the Literature: Findings and Discussion

The Nature of the Evidence[1]

We focus on two bodies of literature. One describes the roles consumers are undertaking in research, policy, planning, and service delivery; the other considers the evidence for choice-based, consumer-centered housing and service programs. Both bodies of literature include primary documents; Web sites; descriptive material on meetings, trainings, policies, and programs; research reports; conference proceedings; journal articles; and book chapters. The literature varies in the extent to which it is research-based and in the type and rigor of study design and methods. Research includes qualitative studies, surveys, case studies, controlled quasi-experimental outcome evaluations, and randomized clinical trials. Its focus also varies: people who are homeless versus related groups such as consumers of mental health services—who may or may not be homeless; or interventions aimed at homelessness versus those addressing clinical outcomes, employment, well-being, or recovery.

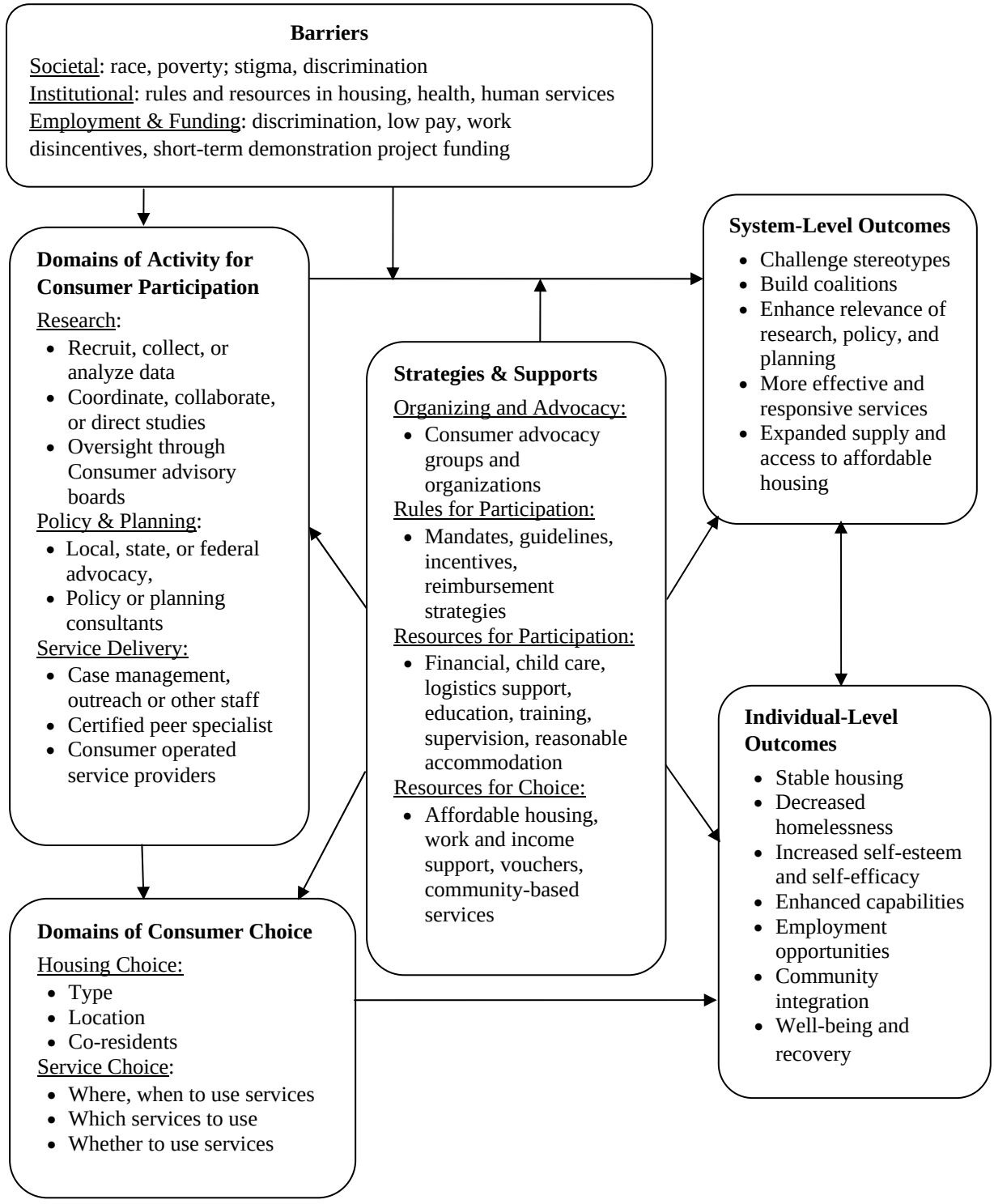
Although work in these two areas has proceeded independently, we argue that they are best understood as two dimensions of an overarching theme that is expressed in such concepts as self determination and agency. The first dimension (consumer involvement in research, policy, planning and service delivery) is concerned with consumer participation in the collective deliberations and actions that determine how homelessness is understood and addressed; the second focuses on identifying and assessing the

[1] The use of evidence-based practice (EBP) has become a well-established goal in social services, health care, and mental health services. Varied research designs (ranging from qualitative descriptions to various kinds of quasi-experimental research) can provide initial support for a promising practice. However, services are usually designated as "evidence-based" only if rigorous, randomized controlled trials (RCTs) demonstrate that the people they serve have better outcomes (for example, longer periods in stable housing) than similar people who did not receive such services. Because RCTs randomly assign participants to either experimental or alternative services and compare their outcomes, they can provide strong evidence that a practice actually causes good outcomes. The highest form of evidence, "meta-analysis," combines data from several RCTs of the same intervention (Institute of Medicine, 2001; Sackett et al., 2000).

Although we highlight instances of "higher level" evidence, such as RCTs, a growing literature contests uncritical acceptance of EBP criteria. Critics note that RCTs test interventions in populations and conditions rarely matched in the real world (as when studies of services for people who have experienced homelessness and psychiatric disabilities exclude those with co-occurring disorders); understudied approaches may not attract funding and thus have little chance to develop an evidence base; and EBPs often use a limited notion of "what works" (Sanderson, 2004; Tanenbaum, 2005). These critiques resonate with advocates of recovery-oriented services who worry that peer services may be undermined by random assignment and that experimental methods and existing measures fail to capture meaningful but hard to measure processes and goals (Anthony, Rogers, & Farkas, 2003; Clay, 2006; Jewell, Davidson, & Rowe, 2006).

As the uses of EBP expand from aiding clinical decision-making to guiding policy, further objections have been registered by those who understand policy-making as a process that incorporates considerations of power and values (e.g., the power to set research agendas; assumptions about valued outcomes) in addition to evidence-based understandings of "what works" (Nixon, Walker, & Baron, 2002). These concerns have particular relevance to consumer involvement in research, policy, and planning, where available metrics for assessing "outcomes" may not take appropriate measure of the goal of changing the balance of power between consumers and those who shape the policies that affect them.

Exhibit 1 Consumer Integration and Self-Determination



effectiveness of service and housing configurations that maximize individual choice and control among people who experience homelessness. Exhibit 1 offers a provisional model of the how these are related and the barriers and strategies that influence individual outcomes and system-level change.

We begin this review with a discussion of consumer involvement in research, policy, planning, and service delivery. To document *consumer involvement in research*, we draw on both publications describing consumer experiences in new research roles and studies that evaluate consumer performance as interviewers or assess the quality of research using participatory approaches. When we turn to *involvement in policy and planning*, there are no formal evaluations. The evidence lies in position papers, minutes of meetings posted on Web sites, conference slideshow presentations, and a few published conceptual articles. In contrast, work on *consumer involvement in service delivery* encompasses qualitative descriptions based on observations, focus groups, and interviews; quasi-experimental studies of effects of consumer staff on client outcomes; and randomized trials of consumer-delivered interventions.

Within each domain of involvement, our review documents both the roles consumers are assuming and the strategies that they and their allies have developed for moving beyond token participation toward full integration. We conclude the review of consumer integration in research, policy, planning, and service delivery with a discussion of common barriers that obstruct this effort, both at the societal level and within each domain's institutional structures, and current or proposed approaches to addressing them.

Since the purpose of consumer involvement in research, policy, planning, and service delivery is to ensure that decisions in these domains incorporate the experiences, perspectives, and preferences of those whose lives they affect, integration should lead to enhanced self-determination for individuals who are experiencing homelessness, creating the conditions for expanding their options and honoring their choices. In the second part of the paper we review the literature on choice-based services and housing. Here we describe surveys of housing and service preferences of people who are homeless and a number of quasi-experimental studies and randomized trials of a consumer-driven housing first model of supported housing. Other choice-based approaches are yet to be studied systematically, though we cite descriptive accounts of emerging practices.

Consumer Roles in Research, Policy, Planning, and Services

Reasons for Consumer Involvement

In her preface to a report on an advocacy and organizing project entitled *Adding Seats to the Table: A Community Based Approach to Family Homelessness*, Bassuk (2001) describes the project's emphasis on providing resources and support that enable families to shape the programs and policies that affect them as both the *right thing* and the *smart thing* to do. While briefs for involving consumers in research, policy, planning, and service delivery refer to both the ethical imperative (the right thing) and positive effects on service outcomes and consumer well-being (the smart thing), in an era of outcomes-based management and evidence-based programming, literature on consumer involvement increasingly argues wisdom rather than righteousness. Indeed, this paper focuses on compiling and assessing the research support, as demonstrated by improved outcomes, for the contention that involving people who have experienced homelessness and respecting their preferences and choices produces more relevant and effective services.

However, the fervor to demonstrate that consumer involvement is "smart" should not obscure compelling ethical and social justice reasons for promoting it. Boote and colleagues (2002), in a review of consumer

roles in health research, ask if consumer involvement is "fundamentally about increasing the quality and user satisfaction of the end product … or does it relate more to the empowerment of users and the democratization of the research process?" Their analysis suggests that the former goal emphasizes satisfaction and value for money, but typically entails passive strategies (e.g., satisfaction surveys, consultation) to respond to consumer demands and "does not necessarily include an obligation to enable consumers to make those demands" (Boote, Telford, & Cooper, 2002, p. 223; see also Salzer, 1997). In contrast, approaches like "participatory research" and "action research" can be a means for changing power relations and advancing equity and social justice.

A similar contrast is evident in approaches to managed care. One approach emphasizes efforts to involve consumers in support of managed care goals, recommending practices that will further quality assurance and persuade consumers of the legitimacy of cost containment, priority setting, and care rationing by managed care providers (Sabin & Daniels, 1999; 2001). In contrast, a legal advocacy guide frames consumer roles in contracting for managed care as a struggle for rights and justice involving contention with "other stakeholders … [who] are well-represented by powerful groups and can exert great influence on how the managed care contract is written, but their interests do not always overlap with those of consumers" (Bazelon, 1998, p. 11).

Although Boote and colleagues focus on consumer roles in health research, and the legal advocacy guide on consumer roles in contracting for managed care, the issues raised also apply to homelessness research and policy. Both the stigma of homelessness, with its associated barriers to services and personal opportunity, and the magnitude of power differentials between those experiencing homelessness and those who design and implement research, policy, and services demand particular attention to issues of social exclusion and "a special moral imperative" to involve consumers in planning and services (Rowe, 2007).

Philosophy and social theory provide a foundation for considering consumer self-determination and integration as essential for social justice. Fraser uses examples of race, gender, and sexual orientation in arguing that overcoming social injustice requires "participatory parity," that is, full inclusion in the process of determining how resources are distributed and diverse identities are valued (Fraser & Honeth, 2003). For Sen (1999) and others (see Hopper, in press; Nussbaum, 2000; Olsen, 2001) who use his concept of "capabilities" to characterize the combination of capacities and resources that enable people to achieve valued roles and identities, social injustices related to poverty, gender, race, and disability all entail capability deprivation. Redress requires organizing resources to ensure both well-being *and* the exercise of agency or self-determination (Sen, 1999; Hopper, in press; Nussbaum, 2000; Olsen, 2001). Social justice arguments for participatory parity and agency lend philosophical weight to the claim that fostering consumer integration is the "right" as well as the "smart" thing to do.

Strategies for Consumer Involvement in Research

Glasser's review of consumer involvement (1999) only briefly mentioned research roles for people with experiences of homelessness. Recently, in large multisite studies, people with experiences of homelessness, mental illness, and addiction dependency have been employed as recruiters, interviewers, or trackers and in administrative and coordinating positions—sometimes only after challenging researchers' stigmatizing preconceptions that consumers lacked ability to learn or use research skills or that their presence in research roles would destabilize others with mental illness (Campbell, 2006b; McMullin et al., 2006; Mockus et al., 2005).

Evaluations of consumer employment in homelessness research have not yet appeared in the literature; however, in studies of mental health services that employed consumers to administer treatment satisfaction surveys in both self-help and professional settings, interviews conducted by well-trained consumers met quality and accuracy standards (Howard & El Mallach, 2001; Lecomte et al., 1999), with small differences in responses to consumer versus professional interviewers (Nilsen et al., 2006). Consumer interviewers reported high job satisfaction, improved feelings about self, increased self-assurance, pride in working, high motivation, and new friends, despite the work involving difficult tasks and some stress (Lecomte et al., 1999).

Individual research centers and consumer-run agencies support consumer research involvement, but it has taken mandates from funding agencies to induce broader inclusion of consumers in academic research on homelessness. The Substance Abuse and Mental Health Services Administration (SAMHSA), with its several multisite services research initiatives related to homelessness, has been the institutional locus of much of this activity. An agency mission statement (SAMHSA, 2005a) emphasizes consumer involvement in all aspects of SAMHSA programming and includes a specific mandate that "[c]onsumers and families should be integrally involved in designing and carrying out all research and program evaluation activities. These activities include: determining research questions, adapting/selecting data collection instruments and methodologies, conducting surveys, analyzing data, and writing/submitting journal articles" (McMullin et al., 2006; SAMHSA, 2005a).

Making consumer participation a condition of funding has been an impetus for expanding consumer research roles. The process of implementing that mandate has revealed both barriers to effective consumer integration and strategies for addressing them. Based on experience in Phase I of SAMHSA's Homeless Families Program, a detailed "Guidance for Consumer Participation" advised applicants for Phase II on how to support consumer integration through selection, preparation, and compensation of consumers in the cross-site Steering Committee and local research projects (SAMHSA, 2001).

Through a series of SAMHSA initiatives (Supported Housing, Consumer-Operated Service Programs, Women with Co-occurring Disorders and Violence, Homeless Families Program), consumers have taken increasingly active roles as consumer panel (CP) members, as local site-based staff (recruiters, interviewers, trackers, data entry clerks, research directors, or principal investigators), as staff at the cross-site coordinating center that manages each initiative, and as participants in the cross-site steering committees that give scientific direction to the projects.

Publications policies initially recommended only that a CP member be present for cross-site presentations at professional meetings (SAMHSA/CMHS, 2000). Later initiatives addressed the need to support consumer travel and participation in such conferences (SAMHSA/CMHS, 2002), which allowed CP members to press for inclusion on study panels and to develop a proactive policy of submitting abstracts for presentations at national professional and policy meetings. Through presentations, journal articles, and books, consumers are reporting to both consumer and research communities their experiences and lessons learned about barriers to consumer involvement and effective strategies to enhance integration (Campbell, 2006a; Clay et al., 2006; McMullin & Reid, 2003; McMullin et al., 2006; Meyers, 2002; Mockus et al., 2005; Pennington & McMullin, 2004). McMullin and colleagues (2006), who described experiences of CP members in the Homeless Families Program, identified three sets of barriers to full consumer integration: tokenism; turnover in panel membership; and issues related to time, effort, and expense of

participation. They described 10 strategies that fostered effective consumer integration in this multisite project. (See Exhibit 2.)

Consumer panels for SAMHSA initiatives have documented a variety of research, service, and personal impacts of their involvement in research. The Homeless Families Program CP influenced conceptual models, study measures, data collection procedures, dissemination of study findings, and even theinterventions being tested (McMullin et al., 2006; McMullin & Pennington, 2005; McMullin & Reid, 2003). The Women with Co-occurring Disorders and Violence (WCDV) consumer panelists, identified as consumer/survivor/recovering (C/S/R) women, reported a strong impact on their study's instrumentation, particularly sections covering trauma and parenting, where they developed measures of the unaddressed aftermath of violence (Mockus et al., 2005). C/S/R women documented members' experiences through systematic debriefing interviews and focus groups, followed by qualitative thematic analysis, providing moving detail on the sometimes tense but ultimately rewarding process of finding a personal and collective voice and the individual transformations that ensued (Mockus et al., 2005).

Setting the research agenda. Although SAMHSA's initiatives provide a model for integrating consumers in various aspects of large multisite studies, consumers typically only enter the picture after a study's focus and design have been determined. In contrast, British health services researchers report that "consumers have been consulted, have collaborated and have controlled initiatives for setting research agendas across a wide range of topics in health and beyond," including homelessness. Consumers' impact is greatest when research organizations see political or commercial benefits and involve consumers in setting priorities, not just in assessing the merits of specific topics (EPPI-Centre, 2006). Moreover, "productive methods for involving consumers require appropriate skills, resources, and time to develop and follow appropriate working practices. The more … consumers are

Exhibit 2

Strategies and Mechanisms Used to Foster Consumer Integration in the SAMHSA Homeless Families Program

Federally mandated consumer participation and support

- Coordinating Center consumer staff
- Consumer included in all aspects of programs
- Federal project officers address integration barriers

Financial support to cover consumers' expenses

- Payments for time and expertise
- Travel advances covering travel and childcare costs

Consumer staff

- Coordinate work of consumer panel
- Consumer liaison for researchers and consumers
- Study recruiters, interviewers, trackers, and data entry

Travel logistics

- Identify and address travel barriers
- Hotel check-in without credit cards
- Alcohol free rooms and receptions

Consumer panel meetings

- Share strategies to overcome integration barriers
- Develop recommendations for steering committee
- Small group discussions with federal project officers

Steering committee meeting logistics

- Define research jargon as used
- Allowing time for consumer questions and input

Bridge communication and cultural gaps

- Trainings by consumers on study topics
- Continually addressing integration barriers
- Forum on hiring consumers as research staff

Communication between meetings

- Staff identified to address consumer integration
- Hard copies of emails and materials sent to consumers
- Monthly conference calls to review study materials

Reducing turnover and increasing retention of consumers

- Mentoring of new consumers
- Development of consumer advisory boards

Training

- Orientation
- Cross trainings on study topics
- Research methods and how to read and interpret data charts

involved in determining how this is to be done, the more research programmes will learn from consumers and about how to work with them" (Oliver et al., 2004).

A report on consumer involvement in the peer review process for clinical research at 16 NIH Institutes determined that consumers routinely participated in review panels at 4 Institutes, and only occasionally at another 3. Institutes that routinely used consumers on review panels did so to obtain perspectives of target populations, expertise regarding the feasibility of interventions in real-world situations, and advice on issues related to the use of "human subjects." These Institutes offered consumer review panel members adapted or specialized training, and generally one or two consumers participated in each review panel. In the absence of participants' accounts or data on decision-making processes and outcomes, however, it is unclear whether consumer participation extended beyond tokenism (Bartlett, 2006).

Community-based participatory research (CBPR). Public health research has long used a variety of approaches (action research, participatory research) that seek more equitable partnerships between researchers and members of communities in which research is carried out (Lewin, 1946; Freire, 1972). These approaches have recently been conjoined under the rubric CBPR (community-based participatory research), which incorporates and codifies many of the defining principles of these approaches: participatory process, cooperative engagement of community members and researchers, co-learning, system development, and community capacity building. As an empowering process that can increase participants' control over their lives, CBPR seeks a balance between research and action (Minkler & Wallerstein, 2003; Bridgman, 2006).

A recent review of CBPR projects in public health reports that, despite uneven data on the research process, many projects achieved community involvement in setting research priorities and generating hypotheses; several described improvements in research quality (recruitment, methods, measures, dissemination) related to collaboration; and a large majority of intervention studies described improvements to the intervention related to the CBPR approach (Viswanathan et al., 2004). CBPR proponents have begun to create methods not only for developing such partnerships but for assessing their fidelity to CBPR principles.

Recently CBPR has begun to appear in the arena of mental health (Wells et al., 2006; Nelson et al., 2006) and homelessness research (Bridgman, 2006; Wang, 2003). CBPR has often involved prevention studies conducted in neighborhoods with limited access to resources for health and mental health care, and neighborhood-based advocacy groups have been primary vehicles for research/community partnerships. Challenges result from CBPR's incompatibility with research development and funding structures that require the research problem, study design, and methods to flow directly from theory and prior research findings, leaving little room for the co-learning process that occurs through negotiation of research agendas, hypotheses, design, and methods of particular projects. While HHS has solicited advice on adapting application and funding processes to accommodate CBPR approaches (Viswanathan et al., 2004), both research funding and academic cultures remain challenged by CBPR.

The role and impact of people with personal experiences of homelessness in designing and conducting research have changed significantly since Glasser's review (1999), but these achievements have emerged from hard-won struggles. Even in settings that are committed to bringing in consumers, integration has not been easily achieved. Consumers who perform this groundbreaking work, particularly in academic research settings, can find their positions are a source of contention among staff; their experiences of

homelessness are stigmatized; their voices are ignored; and a variety of subtle discriminations, such as the absence of interactions with co-workers outside the work environment and a closing of ranks when uncomfortable topics are raised, exclude them from full participation. At the University of Massachusetts-Boston's Center for Social Policy (CSP), an early interest in consumer participation led to the creation of a constituent coordinator position with a broad job description that included the responsibility to engage people experienced in homelessness and poverty. That the actual tasks of this position were usually restricted to project-based activities was largely due to funding challenges for constituent engagement projects. Challenges around staff acceptance of the shift to include consumers can inhibit substantive integration. The CSP strategy was to form an ad hoc committee of committed staff persons, which was tasked with operationalizing constituent involvement. Over an eight-month period, this group defined a spectrum of consumer roles, a process culminating in a formal constituent internship within CSP. This program, launched in January, 2007, provided an opportunity for a person experienced in homelessness and/or poverty to work in one of several apprenticeship areas: applied research, clerical/office support, communications/marketing, or any combination. One of the Center's collaborating partners, One Family Scholar Program, provided a candidate to fill the position.

McMullin and colleagues (2006) described a progression from consumer tokenism, through consumer involvement, to consumer integration. (See Exhibit 3.) They noted that consumers with experiences of homelessness, mental illness, addiction, and justice involvement encounter stigma, no less in research settings than in communities, service programs, housing, and employment. Members of SAMHSA consumer panels have identified several exclusionary aspects of research practice and culture, ranging from the financing and logistics of collaboration to the use of research language that alienates consumers or mystifies the very issues on which consumers are experts. Consumers have developed skills and strategies to overcome stigma and other barriers to effective participation in research, but without mandates and support from funders, academic communities are unlikely to gain the benefits of consumer expertise. Consumer integration in research is still in the early stages, but models of integration currently being developed and disseminated offer a platform for further expansion.

Exhibit 3

Consumer Tokenism, Consumer Involvement and Consumer Integration in Research

Tokenism	Involvement	Integration
1–2 consumers invited to participate in limited or superficial roles	Small number of consumers invited	Significant number of consumers from diverse populations actively involved
1–2 consumer expected to represent all consumer perspectives	Limited roles	Key positions including management, research staff, serving on steering committees or oversight boards
No concrete decision making authority	Limited decision-making authority	Decision-making authority
Mostly volunteer time	Some compensation for time and expertise	Competitive compensation for time and expertise

Strategies for Consumer Involvement in Policy and Planning

Consumer involvement occurs across the varied venues where homelessness policy-making and planning take place. While Glasser (1999) included examples of consumer advisory boards (CABs) and of consumer members of advisory boards, newer initiatives with consumers present in meaningful numbers and in multiple roles (e.g., as CAB members, staff, trainers, and consultants) allow discussion not just of consumer involvement but consumer integration.

Local advocacy. At a local level, consumer advocacy groups use organizing and lobbying strategies to impact policies; planning bodies hire consumer consultants and employees; and CABs serve in monitoring, consultative, and decision-making capacities for local government or health care organizations.[2]

Homes for Families is an advocacy organization that brings together families that have experienced homelessness (half of its staff and half of its board of directors have experienced homelessness) with service providers and advocates across Massachusetts to press for policy changes that address root causes of homelessness. Consumer perspectives have priority in the development of the policy agenda, which thus far includes developing prevention programs, expanding housing options, training leaders, and addressing economic and social justice issues (Homes for Families, 2006).

Other local advocacy groups (Family Housing Solutions in Trenton, New Jersey; Humanity for Homeless in Denver, Colorado; and Warriors for Real Welfare Reform in Hartford, Connecticut), with support from the Better Homes Fund and the W.K. Kellogg Foundation, conducted organizing activities with families in their communities, created forums for dialogue on homelessness with elected officials, developed newsletters and educational programs, influenced state welfare-to-work policies, joined other groups to develop a shelter, changed local criteria for housing eligibility, and obtained guaranteed participation in HUD grants (Better Homes Fund, 2001). It is difficult to attribute specific policy outcomes to consumer advocacy, but sponsors of the effort viewed organizing families as a viable strategy for community change. The project reported on both challenges and organizing lessons. (See Exhibit 4.)

Exhibit 4

The Better Homes Fund and W.K. Kellogg Fund Findings

Challenges	Organizing Lessons
Welfare and shelter regulations	Value of coalition-building
Residential instability	Active participation by families
Isolation	Leadership training
Shame	Supporting women's roles as mothers
Uncooperative social service providers	Strategies for leveraging policy change
Limited resources and capacity	Generating individual and collective empowerment

[2] Advocacy groups described here are documented in media coverage or in Web sites or reports. We suspect much consumer activism goes unrecorded.

Protests around local issues have spurred the development of advocacy groups founded and led by people who have experienced homelessness. Examples include Rhode Island's People to End Homelessness, an organization committed to ending Rhode Island's homelessness crisis through affordable quality housing. This group has organized several highly visible protests to draw attention to growing homelessness in the state (People to End Homelessness, 2006). In New York, Picture the Homeless has organized campaigns to modify approaches to subsidizing housing for people leaving shelters; end selective enforcement of "quality of life" regulations that target people who are homeless; address barriers to housing; and challenge discriminatory supermarket practices that target recyclers (Picture the Homeless, 2006).

National policies on consumer involvement in local policy and planning processes. Since most funding for local homeless services and housing comes from federal grants, many policies are shaped nationally but carried out locally. At a national level, consumers represent local CABs on national consumer panels, serve individually on policy and planning boards or workgroups, and are employed by federal agencies as consultants, trainers, advisors, or administrative staff for policy initiatives. We describe here several approaches to consumer involvement in these national/local interactions.

SAMHSA. SAMHSA's previously cited policy on consumer involvement in research and evaluation is part of broader *Guidelines for Consumer and Family Participation* in all aspects of SAMHSA policy and program development—and particularly in projects funded through its grant programs. This guide comprehensively details expectations for consumer involvement in organizations and programs receiving SAMHSA grants (SAMHSA, 2005a.) (See Exhibit 5.) SAMHSA's policy on cultural issues for funded research and programs is outlined in *Guidelines for Cultural Competence* and addresses issues of training and staffing, language, materials, evaluation, community representation, and implementation (SAMHSA, 2005b).

HUD Continuum of Care (CoC). HUD funding is a primary source of support for housing and service programs addressing homelessness. HUD requires local continuum of care (CoC) planning committees to prioritize needs and assemble a single comprehensive application from each locale. Although HUD has begun to standardize governing processes for CoC planning committees, expectations for consumer involvement remain non-specific: CoCs should have a planning body that is broadly representative of stakeholder interests, with 65 percent private sector representation, including consumers who are homeless, or explain why they do not. Local agencies may win points for demonstrating consumer involvement in their HUD programs, for example through CABs, satisfaction surveys, or tenant councils, and for involving consumers in program design and creation (New York City CoC, 2006).

HUD Homeless Management Information Systems (HMIS). Since 1999, HUD has provided standards and technical assistance to phase in local HMIS systems, mandated by Congress to document the extent of homelessness and service usage by individuals who are homeless. HMIS has become a vehicle for expanding consumer participation in policy and planning, as an initial pilot program for involving consumers in HMIS planning and implementation has evolved into a training initiative introduced in communities across the country. Consumer involvement varies. HMIS raises key issues for consumers—both as a mechanism for making their needs known and as a potential threat to privacy and confidentiality.

The earliest proposals for HMIS implementation evoked challenges from providers and advocates around privacy issues. Over time, however, consumer advocacy and consumer-designed trainings on HMIS have

Exhibit 5

Guidelines for Consumer and Family Participation in SAMHSA Grant Programs

Mission	Reflect value of involving consumers and family to improve outcomes
Planning	*Consumer and family members involved in substantial numbers in:* • Conceptualization of initiatives • Identifying community needs, goals and objectives • Identifying innovation approaches to address needs • Developing budgets • Incorporating peer support methods
Training and Staffing	*Consumers and family members included as staff* • Consumer and family members hired as staff with pay parity • Substantive training for staff in consumer and family issues
Informed Consent	*Recipients of project services* • Informed of benefits and risks of services • Make voluntary decisions to receive or reject services
Rights Protection	*Consumer and family members fully informed of all rights including:* • Information disclosure • Choice of providers and plans • Access to emergency services • Participation in treatment decisions • Respect and non-discrimination • Confidentiality of healthcare information • Complaints and appeals • Consumer responsibilities
Administration, Governance, and Policy Determination	*Consumer and family members:* • Hired in key management roles • Provide project oversight and guidance • Sit on all boards of directors, steering committees, and advisory boards in meaningful numbers • Fully trained and compensated for activities
Evaluation	*Consumers and family members integrally involved in designing and carrying out all research and program evaluation activities including:* • Determining research questions • Adapting/selecting data collection instruments and methodologies • Conducting surveys • Analyzing data • Writing and submitting journal articles

promoted consumer involvement as a means to strengthen privacy protection and enhance the benefits the system promises. The Center for Social Policy (CSP) at U-Mass-Boston, which initially was a lone voice for consumer involvement in HMIS, envisioned a system that would be informed in part by the people receiving services, as opposed to program administrators and policymakers only. The Center demonstrated that consumer involvement can be part of an HMIS implementation and, in fact, that implementation could not be as effectively achieved without consumer involvement. Encryption, humaneinterview protocols, consumer perspective on data findings, and HMIS peer-to-peer trainings proved invaluable to implementation. For example, peer training presentations done by CSP consumer

staff in conjunction with other stakeholders identified varied roles for consumers (e.g., as peer trainers; advocates; consultants; and leaders of or participants in steering committees, discussion groups, and advisory panels) and individual benefits of consumer involvement (e.g., skills development, enhanced professional and career choices, employment, leadership development, participation in community decision-making groups). This initiative is described as a point "where public policy, HMIS, advocacy, and ending homelessness on a personal and systemic level converge" (Tripp, 2004, 2005). The training became a national model for communities to follow in local implementations.

Health Care for the Homeless (HCH). Administered by HRSA, HCH supports 182 local projects that annually provide health services for over half a million people experiencing homelessness. Since 1987, HCH has mandated consumer involvement in project governance. Although HCH programs typically obtain waivers of HRSA's requirement that community health centers have consumer majorities on their governing boards, they must document alternative means to ensure meaningful consumer input into program governance, which has typically been through CABs. In 2003, HCH's National CAB (elected by local CAB representatives at HCH's annual national meeting) developed a Consumer Advisory Board Manual (Dailey, 2003) to guide individual HCH programs. (See Exhibit 6.)

HCH's National Council also contracted with an organizing and advocacy group for a pilot project that used consumer-based outreach to collect and analyze data from surveys with 249 consumers at 13 sites. The project recommended: making the outreach/survey process a routine activity for local CABs, with data aggregated at the national level and findings fed back to local projects and CABs; National Council funding to support increased consumer involvement in outreach and HCH governance; clarification of local CAB functions, with incorporation of CABs "into the 'lifeblood' of HCH" at every level; pursuit of the vision of majority consumer boards of directors within HCH projects; and support for local HCH staff to be more involved in community organizing and advocacy (Boden & Lozier, 2005).

Exhibit 6

Consumer Advisory Board Guidelines for Health Care for the Homeless Projects

- Fit local projects needs
- Autonomous governance structure and procedures
- Clear organizational guidelines
- Membership represents all program constituents
- Conduct ongoing recruitment
- Support for meetings sites, facilitators, and transportation
- Strong relationships with governance boards and senior management

Ryan White Care Act (RWCA) planning councils. The RWCA, administered by HRSA, provides funding of health and supportive services for people living with HIV and AIDS. Localities must coordinate their RWCA applications through local planning councils, which have decision-making authority over allocations of funds. RWCA bylaws for cities with the greatest concentrations of people with HIV/AIDS have specific requirements to ensure planning council membership is representative of local populations affected by HIV/AIDS. At least 33 percent of members must be individuals who self-identify as being infected with HIV, who reflect the demographics of the populations with HIV, and who are not employees, consultants, or board members of RWCA Title I provider agencies. Consumers have a significant voice in RWCA funding and service planning.

Effects of consumer involvement in policy and planning. While federal agencies have become more proactive in promoting or even mandating consumer involvement in homelessness policy and planning,

documentation and evaluation of individual and program or system impacts remains thin. First-person accounts of experiences in homelessness policy and planning settings describe service improvements as well as transformative effects on consumers who are active participants (Tripp et al., 2005). Such accounts, which have appeared in broadcast, newsletter, and slideshow formats, provide critical technical information for consumers and preliminary evidence for the impact consumers have on policies and planning.

One qualitative study in an HCH program in Houston used participatory action research to describe policy and planning involvement of CAB members (Buck et al., 2004). An analysis of agendas, minutes, and transcripts identified four prominent themes: operational practices, roles, and processes involved in achieving CAB goals; emergence of group and individual identities; the salience of power hierarchies not only between individuals who are homeless and staff at shelters or service agencies but within the population experiencing homelessness; and a need for more respectful and comprehensive services. CAB members launched a specific project to disseminate information about existing services. Observed and reported impacts on participants included acquisition of new skills for inquiry, planning, and relationship management.

Controlled studies of approaches to consumer involvement in homelessness policy and planning have not been conducted. A Cochrane Collaboration review identified three controlled studies of the effects of consumer involvement in health policy. One compared phone or face-to-face contact versus mailed surveys in a study of consumer health priorities, and two examined effects of consumer consultation on written educational material prepared for patients. The interventions involved "passive" strategies—consumer consultation, rather than collaboration or control—and narrowly defined outcomes (readability of material, rankings of health priorities). The studies had methodological weaknesses and showed only modest effects of consumer involvement, but the authors conclude that randomized controlled trials can be used to assess consumer involvement in health policy and planning (Nilsen et al., 2006).

Strategies for Consumer Involvement in Service Delivery

Consumer involvement in homelessness service delivery arose in part because mental health programs failed to reach some people with mental illness who were experiencing homelessness, creating a service need that consumer providers addressed (Glasser, 1999). Homelessness programs have also drawn on a tradition of mutual aid and peer staffing long established in addiction recovery services (White, 1998).[3] In the last decade, examples of both consumer staffing and consumer-run programs have proliferated. At Housing Works, a minority-run agency that provides housing and services for New Yorkers who are homeless and living with HIV/AIDS, 25 percent of employees are people who are or were program clients. They work in diverse roles in the agency's housing and service programs and in its thrift shops, bookstore, and catering business (Housing Works, 2005). National Mental Health America (NMHA), a collaborative advocacy and service organization for people with mental illness that includes consumers throughout its staff and administrative structure, identifies 10 homeless assistance programs operated by local MHA affiliates across the country (NMHA, 2006). Solutions at Work, an agency in Cambridge, Massachusetts, led and run by people who are or were homeless, helps people transition out of

[3] Treatment services for alcohol and drug addiction have for decades relied on a large mutual support component represented in 12-step groups such as Alcoholics Anonymous and Narcotics Anonymous that often serve as an alternative, sometimes as an adjunct, to professionally delivered treatment (White 1998). In many programs, peer support is an integral part of addiction treatment for people who have experienced homelessness (Galanter 2000).

homelessness by providing tangible resources, including paid transitional employment, clothing, furniture, moving services, automobiles, computers, and leadership training (Solutions at Work, 2006).

The Consumer Involvement Workgroup, established by state-level administrators of SAMHSA's Projects for Assistance in Transition from Homelessness (PATH) program, recently surveyed the employment of mental health consumers with homelessness experience in 378 PATH programs in 41 states. One-quarter of the programs employed at least one consumer, mainly to deliver outreach (85 percent), referral (62 percent) or case management (58 percent) services. About two-thirds of these were mental health consumers who had experienced homelessness (PATH Consumer Involvement Work Group, 2006). We review below both studies of peer employment in homeless services and mental health programs and the growing body of research on service programs operated by mental health consumers.

Consumers as staff: Peer outreach/case management. A decade ago, Glasser presented a compelling case for the special abilities of consumers to engage people experiencing homelessness in services (Glasser, 1999). Drawing on work by Van Tosh (1993) and others, she summarized several aspects of consumers' experiences that facilitate effective outreach, including knowledge of streets and service systems, flexibility and openness to new approaches, understanding of and responsiveness to client preferences and needs, empathy and rapport with people who are homeless, and positive role modeling. Consumer staffing of homeless services has mainly been studied in outreach and case management programs. In a study of peer engagement of persons who are homeless, Fisk and Frey (2002) describe an 18-month supported socialization project that employed two peer outreach workers eight hours a week. After three months of training and orientation, peers were assigned to join existing staff on weekly outreach runs. The peer workers conducted outreach with 50 individuals who were homeless, working closely with 6 who had been previously unresponsive. They developed relationships with all 6 and successfully engaged 4 in mental health treatment and in moving to shelters or housing. These findings on engagement were extended in a larger experimental study comparing peer-based versus usual case management for people with mental illness, which demonstrated the effectiveness of peer engagement early in treatment. At six-month follow-up, participants perceived higher positive regard, understanding and acceptance from peer providers, and initially unengaged clients had increased contacts with peer case managers and decreased contacts with non-peer case managers. Positive regard, understanding, and acceptance at six months predicted motivation and involvement in psychiatric, alcohol, and drug treatment at 12 months (Sells et al., 2006).

The research literature also includes studies that address consumer integration into assertive community treatment (ACT) teams—the personal benefits and structural difficulties consumer staff experience and the effects of consumer staffing on housing and other outcomes. A study of consumer case managers in an ACT program for persons who are homeless identified challenges to consumer staff integration into conventional ACT teams and strategies to address those issues (Fisk et al., 2000). (See Exhibit 7.) This study extends findings on peer staffing in non-homeless mental health programs (Kirsch, 2000; Mowbray, Moxley, & Collins, 1998; White et al., 2003), documenting both individual benefits for peer staff (income, skills, safe and positive work situations) and stresses in the workplace environment (inadequate preparation and support, concerns about boundary issues, superficial supervision, and stigma).

Chinman and colleagues studied outcomes of 987 individuals at six ACCESS program sites employing consumer case managers (Chinman et al., 2000). Baseline data showed that people served at these sites had more difficulties (psychotic symptoms, depression, drug use, homelessness) than those at 12 other

Exhibit 7

Consumer Case Managers in Homeless Outreach Programs ACT Teams

Challenges	Strategies	Benefits
Consumer status can evoke discrimination	Educate and train staff	Enrich team functioning and undermine stereotypes
Peer staff face decisions about boundary-breaking service interactions	Ensure adequate individual supervision for peer staff	Challenge team members to reduce client-staff distances and improve services
Workplace discrimination occurs in staff interactions and in pay differentials	Clarify workplace issues requiring reasonable accommodations	

ACCESS sites. However, within consumer-staffed sites, persons with consumer case managers did not differ from those with non-consumer case managers in clinical, social functioning, or occupational outcomes; in movement to permanent housing; or in therapeutic alliance with a case manager. The findings indicate consumer case managers are as effective as non-consumer case managers, even at sites serving persons experiencing greater difficulties. The study extends evidence on effectiveness of peer support and case management in non-homeless assistance programs (Felton et al., 1995; O'Donnell et al., 1999; Herinckx et al., 1997; Solomon & Draine, 2001), adding support for consumer case management as an effective approach for addressing homelessness.[4]

Emerging practice: Certified Peer Specialists (CPS). Stable funding for peer employment has proven difficult to sustain (Glasser, 1999; Mowbray, Moxley, & Collins, 1998). Georgia's Certified Peer Specialist program offers an innovative resolution to this issue. The program combines consumer-provided services, consumer advocacy, and consumer influence on policy. It is open only to current or former recipients of mental health services "who openly identify as consumers and have had advocacy or advisory experience in addition to demonstrated effort at self-directed mental health recovery" (Sabin & Daniels, 2003, p. 497). Certification requires two week-long training modules, followed by oral and written examinations. CPSs act as change agents to model and support consumers in regaining control over their lives and their recovery through specific supportive activities (e.g., developing a wellness plan, supporting vocational choices, providing help utilizing community social support). CPS services are billable to Medicaid, and Georgia requires ACT teams, community support teams, and adult peer support programs to include CPS as a condition of reimbursement, providing unusual institutional support for recovery-focused services and peer employment.

Hawaii, South Carolina, Massachusetts, and Pennsylvania are among the states that have developed certification programs. Arizona, Iowa, Michigan, Washington, and Washington, D.C., have joined Georgia in providing Medicaid reimbursement for CPS services (National Mental Health Association of Southeastern Pennsylvania, 2006). The CPS approach has face validity (Sabin & Daniels, 2003), but as yet, research has not established the effectiveness of the selection and training aspects of the program, its impact on those who become certified, or its impact on ACT and other service models in which CPS staff

[4] RCTs are needed to make a more definitive case for effectiveness by ruling out the possibility that unmeasured characteristics related to case manager assignment might account for the equivalent outcomes.

are used. Accumulating evidence for consumer case managers in homeless assistance programs (Chinman et al., 2000) and evidence for effectiveness of the CPS model could significantly broaden the evidence-based options for consumer involvement in homeless service delivery.

Parallel efforts are emerging to train and deploy peer specialists in service programs for people with co-occurring disorders (Center for Substance Abuse Treatment, 2004) and to add addiction recovery coaches to the mutual support groups and professional treatment programs that currently dominate addiction services (White, 2004). Both emphasize inclusive, culturally sensitive approaches as well as "diverse pathways and styles of recovery, a preference for voluntary versus coerced participation, a focus on wellness/wellbriety/global health versus a singular focus on abstinence" (White, 2004, p. 6) There is no research on whether or how these interventions affect homelessness.

Organizational advantages of employing consumer staff. Effectively employing consumers in agencies supportive of consumer integration can be beneficial to both the agency as a whole and specific agency services. Consumer staff can bring expertise about system use and recovery to increase the overall balance of staff areas of competence. In addition, working alongside consumers as colleagues can open agency staff and administrators' eyes to the real possibilities of recovery for others using their services. As noted in the PATH Consumer Involvement Workgroup report (2006), "Successful integration of consumer practitioners into PATH programs sends an important message to traditional staff and to outside agencies and systems that individuals with serious mental illness who experience homelessness can and do recover, and they can play an important role in the delivery of mental health services to their peers."

Consumer-operated services. There are several descriptive accounts of consumer-run programs offering advocacy, housing, peer support, and drop-in services for people experiencing homelessness, but outcomes research on consumer-operated programs has rarely focused on homelessness. However, the processes underlying peer support—variously conceptualized as social support, experiential knowledge, modeling of confidence and coping behavior, and the "helper-therapy principle" (Solomon, 2004) or as a combination of emancipatory and caring functions (Campbell, 2006a)—address the kinds of disempowering circumstances that homelessness imposes.

Descriptive accounts: Diverse models and common principles. In the last decade researchers have studied diverse consumer-operated program models: consumer-run ACT teams and other forms of case management (Paulson et al., 1999; Herinckx et al., 1997; Solomon & Draine, 2001); employment programs (Miller & Miller, 1997); an array of drop-in and socialization services; advocacy and educational programs; and peer support services (Yanos, Primavera, & Knight, 2001; Nelson et al., 2006; Ochocka et al., 2006; Clay, 2006; Segal & Silverman, 2002; Nelson, Hall, & Walsh-Bowers, 1998). The best-documented consumer-operated programs are those providing peer support services to people with mental illness as either an adjunct or alternative to professional treatment services. SAMHSA's Center for Mental Health Services (CMHS) recently coordinated a national survey that identified 7,467 such groups and organizations, including 3,315 mutual support groups that reported 41,363 attendees at their last meetings; 3,019 self-help organizations with 1,005,400 members; and 1,133 consumer-operated services that serve 534,551 members/clients annually. While only 12 percent of mutual support groups reported that they helped participants with housing issues, 48 percent of self-help organizations and 58 percent of consumer-operated services did so (Goldstrom et al., 2006).

Given variations in program modalities and services, several schemas have been developed to identify core or defining features of consumer-operated program approaches. Glasser's (1999) report emphasized client-defined needs; voluntary participation; choice in degree of participation and program components; clients helping each other; service recipients' responsibility for overall program direction and financial and policy decisions; and program responsibility to clients—not to relatives, other providers, or funders (Mowbray, Wellwood, & Chamberlain, 1988). Solomon's research review proposed five service characteristics as defining ingredients of consumer-run services: mutual benefit, experiential learning, natural social support, voluntary services, and consumer control of services, though only the first three have been tested in rigorous outcome studies (Solomon, 2004). Campbell (2006a, pp. 38-39) identifies 10 emancipatory functions and 10 caring functions rooted in the philosophy of peer-run support programs that distinguish them from professional mental health services. (See Exhibit 8.) SAMHSA's Consumer Operated Service Programs (COSP) study defined eight "core principles" within five domains (see Exhibit 9) that distinguish COSP from usual treatment, and used them in outcome analyses reported below (Campbell, 2006b; Clay, 2006; Johnsen, Teague, & McDonel Herr, 2006). Particulars differ, but the themes of support, respect, choice, self-determination, and personal agency recur in the various accounts of distinctive features of consumer-operated services.

Exhibit 8

Distinguishing Peer-Run Support Programs from Traditional Mental Health Services

Emancipatory Functions	Caring Functions
• Autonomy • Equality • Advocacy • Empowerment • Self-definition of needs • Role modeling • Information dissemination • Inclusion in research and policy-making • Consciousness raising • Taking responsibility	• Empathic support • Non-pressured and non-judgmental support • Holistic approach • Responsiveness to diversity • Group support • Mutual respect • Experiential knowledge • Recovery orientation and hope • Personal growth in helping others • Safety in crisis

Exhibit 9

Core Principles Identified by SAMHSA's Consumer Operated Service Programs

Structure

- Consumer operated

Environment

- Safe from coercion

Belief system

- Peer principle
- Helper's principle
- Empowerment

Support

- Peer support

Education and advocacy

- Problem-solving strategies
- Self-advocacy

A study comparing consumer-operated case management teams with non-consumer teams in the same consumer-run agency used staff activity logs, focus groups, and participant observation to describe related differences in the "work culture" of the two kinds of teams. Consumer teams emphasized flexible boundaries, less often asserted authority to leverage client compliance, valued "being there" with clients over schedule and task-focused interactions, and less often described their work with clients as burdensome (Paulson et al., 1999).

Effectiveness of consumer-operated service programs: Outcome studies. Early studies established the feasibility of consumers of mental health services providing support and services for other consumers (Mowbray, Wellwood, & Chamberlain, 1988; Segal, Silverman, & Temkin, 1995). Recent review articles summarize several decades of outcomes research on peer support and consumer-operated programs for people with mental illness showing that participants have equivalent or better outcomes across several domains—including psychiatric

symptoms, rates and length of hospitalization, and social integration (Davidson et al., 1999; Davidson et al., 2006; Solomon & Draine, 2001; Campbell, 2006a; Solomon, 2004; Nelson et al., 2006).[5] Effects on homelessness have rarely been examined.

Two recent quasi-experimental studies support consumer-run programs as a promising practice. One study showed that participants in consumer-run services had better social functioning than those involved only in traditional mental health services; psychological variables were significantly associated with social functioning; and the relationship between involvement in consumer-run services and social functioning was partly mediated by the use of more problem-centered coping strategies (Yanos, Primavera, & Knight, 2001). The other found that active participants in Consumer Survivor Initiatives in Ontario, Canada, had less hospitalization, better social support, and equivalent clinical outcomes over the 18-month follow-up, compared to those who were inactive (Nelson et al., 2006).

Three experimental studies have examined consumer-run case management programs. An early study that randomly assigned participants to usual mental health treatment versus consumer-run vocational support in addition to professional vocational services found better vocational outcomes (employment, income, vocational status) for those receiving consumer support, but the design precludes sorting out the effects of peer supports from the professional vocational services (Kaufman, Schulberg, & Schooler, 1994). Solomon and Draine (1995) compared consumer versus non-consumer ACT teams and found consumer team members more often delivered face-to-face services in non-office settings; symptoms, clinical and social outcomes after two years were equivalent. A study that randomly assigned participants to consumer-run ACT teams, non-consumer ACT, or usual care found no differences in behavioral symptoms or clinical or social outcomes—including homelessness (Herinckx et al., 1997; Clarke et al., 2000).

SAMHSA's Consumer Operated Service Programs multisite research initiative. In 1998, SAMHSA launched the largest study of consumer-run services ever undertaken (*N*=1,827), designed to assess effectiveness of COSPs as adjuncts to traditional mental health services. Study participants were randomly assigned to traditional mental health services or traditional mental health services *plus* consumer-operated services and followed over 12 months using a common interview protocol and multiple outcome measures in existential, clinical, and objective domains. Consumers were involved at all levels of the project.

Three major categories of programs were included in the study: education/advocacy, drop-in, and peer support services. All met COSP criteria as administratively controlled and operated by mental health consumers, with an emphasis on self-help as the operational approach, and all were guided by principles and practices based on emancipatory and caring functions (Campbell, 2006a). To operationalize "consumer-operated services," address program diversity, and specify contrasts between the experimental

[5] Studies of self-help groups show those who attend have symptom outcomes similar to or better than non-attendees (Kaufman, Schulberg, & Schooler, 1994; Powell et al., 2001; Moos et al., 2001). Greater commitment to the group is associated with symptom improvements (Galanter, 1988; Raiff, 1984). Participants have the same or lower rates of hospitalization (Kurtz, 1988; Galanter, 1988; Kennedy, 1989; Rappoport, 1993; Edmondson, Bedell, & Gordon, 1984; Trainor et al., 1997; Trainor & Tremblay, 1992), and shorter duration of stay (Solomon & Draine, 2001). They are more socially integrated—as indexed by larger social networks (Rappaport et al., 1985; Roberts & Rappaport 1989), more pursuit of work and education (Kaufman, 1995), more involvement in formal social roles (Zimmerman et al., 1991); and they have better social functioning (Carpinello, Knight, & Janis, 1991; Galanter, 1998; Kaufman, 1995; Markowitz, DeMasi, & Carpinello, 1996).

and control conditions, the research team identified and defined COSP common ingredients, and developed feasible indicators with specified performance anchors. Outcome analysis to date has focused on "well-being," a construct developed from the validated scales measuring existential domains of experience—recovery, empowerment, quality of life, social inclusion and acceptance, meaning of life, hope. Analyses showed greater program use was significantly associated with greater well-being, and a strong relationship between increase in well-being and recovery-oriented program features.[6] Findings held up across the three COSP models (Teague et al., 2006; Campbell, 2006b).

Exhibit 10

Findings of Consumer/Survivor Initiatives in Ontario

Initiatives engaged in:

- Public education
- Political advocacy
- Community planning and collaboration
- Action research devoted to community planning activities

Changes in policy and practice, including:

- Use of peer support specialists and consumer councils in traditional mental health programs
- Increased referrals to Consumer/Survivor programs
- Increases in supportive housing
- Reinstatement of transportation subsidy
- Reversal of funding cuts for mental health services

The COSP initiative was not designed as a study of consumers who are homeless, though baseline data show that over 50 percent of study participants had previous homeless experiences, even more in the drop-in programs (Campbell, 2004). Current analyses are examining housing outcomes,[7] but since most participants, including those who had been homeless, had stable residences when they entered the study, investigators do not expect to find significant effects. The role COSPs can play in addressing homelessness remains to be established.

System impacts of consumer-operated programs. Although most consumer-operated programs provide direct services, some seek a broader systemic impact. One program, Staff Supporting Skills for Self Help, aimed to improve the competencies of mental health providers through manualized programs of education, clinician-client dialogues, technical assistance, and introducing self-help into clinical settings. A quasi-experimental study of the intervention found improved clinician competencies, increases in recovery-oriented services, and growing use of self-help in the experimental sites, though local community events appeared to have countered expected effects on stigma (Young et al., 2005).

Janzen and colleagues used mixed methods to study the system-level impacts of four consumer-run organizations referred to as Consumer/Survivor Initiatives (CSIs) in Ontario. Using staff activity logs,

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[6] Initial analyses showed improvement in well-being over time for both experimental and control groups, with significantly greater improvement in a subset of COSP sites, but failed to confirm the overall hypothesis. However, these analyses also showed that some participants "crossed over" from COSP to usual services during the course of the study. Because conventional "intent-to-treat analysis," which makes comparisons based on original group assignment, regardless of whether those randomly assigned to experimental and control groups actually participated in their assigned programs, may understate effects of program involvement, subsequent analyses employed an "as treated" approach. These analyses compared groups that actually participated in experimental or control services. "Propensity scoring" was used to divide the sample into homogeneous strata and compare outcomes for experimental and control participants within strata to avoid mistaking outcome differences that may occur because experimental and control programs attract different kinds of participants for those that result from program differences.

[7] Most consumers remained stably housed throughout the study, limiting the likelihood of showing significant effects of COSP on homelessness (Jean Campbell, personal communication, 8/8/06; Gregory Teague, personal communication, 8/8/06). Thus whether COSPs effectively address homelessness may remain an open question.

interviews, and focus groups, they identified activities and participant-assessed impacts. (See Exhibit 10.) Since this activity was collaborative, it is not possible to isolate the contribution of the CSI to most of these achievements, though interviews with non-CSI participants support participants' perspectives on system-level impacts (Janzen et al., 2006).

Our review of consumer involvement in service delivery finds accumulating examples of consumer staffing in programs that address housing and homelessness. Descriptive studies show that peer staff experience both personal benefits and structural difficulties. Quasi-experimental and experimental studies comparing consumer outreach/case management staff versus non-consumer staff find equivalent clinical and social outcomes among service recipients, lending support to the hiring of consumers in service delivery programs as a promising practice. Despite the long history of some consumer-operated programs that focus on housing and services for people who are homeless, there is virtually no research assessing the effects of these programs on homelessness. However, a growing body of work describes key principles of programs operated by consumers of mental health services, and the recently completed SAMHSA study of COSPs has reported improvements in well-being (a composite of recovery-related measures) associated with key principles of consumer-operated service delivery. Further research will be needed to determine whether such programs effectively address homelessness.

Barriers to and Strategies for Consumer Integration

Many barriers to meaningful consumer participation reflect the exclusionary processes and practices that produce homelessness; concentrate its effects on people already disadvantaged by racism, poverty, and disability; and undermine efforts to end homelessness. Homelessness research typically focuses on individual correlates and risk factors, but a large multidisciplinary literature reminds us of the social machinery that creates differential life chances for individuals and the social conditions that unevenly distribute the "risk of risk" (Link & Phelan, 1995). Various concepts—structural violence in public health (Farmer, 2004); structural racism in analyses of race and poverty (Hartman, 2001; Stone, 2006; Wilson, 1996); capability deprivation in developmental economics (Sen, 1999)—have been used to summarize processes that compound historical disadvantages and reproduce them in the structure of contemporary labor and housing markets, educational opportunities, safe environments, and access to health care. Consumer self-determination and integration into research, policy, planning, and service delivery will require acknowledging and addressing the range of constraints that marginalize the voices of those who have experienced homelessness.

Race, ethnicity, and poverty. The overrepresentation of people of color, and particularly African Americans, among those who experience homelessness is widely documented but rarely discussed in reports on homelessness. In one of the few analyses of this phenomenon, Hopper (2003) describes the market losses in affordable housing and decent work, mounting strains on extended families, growth of the drug trade, and continued failures of community-based mental health services that made homelessness among African Americans an all but foregone conclusion. Citing Ellison (1980), he notes that the "invisibility" of black homelessness is not an accident but the product of a determined refusal to see (Hopper, 2003, p. 171).

Earlier work on homelessness described a "Latino paradox" (Gonzalez Baker, 1996), noting low rates of homelessness despite high rates of poverty, poor housing conditions, and housing discrimination and suggesting that community networks were able to absorb those who would otherwise enter shelters. In many locales, this has changed. Moreover, Latinos who are immigrants encounter special barriers related

to accessing available services—including language, but also increasingly virulent discrimination and legal exclusions initiated under welfare reform legislation that deny eligibility for a variety of federal benefits (TANF, SSI) even to many documented immigrants (Broder, 2007).

Although the intertwined impacts of race, ethnicity, and poverty are not prominent in written accounts of consumer experiences in research, policy, and planning, individual members of consumer advisory groups confirm that these issues are discussed *within* consumer panels and in other interactions among consumers of color. Efforts to introduce these insights in research or policy discussions, however, are viewed as divisive and evoke denials from non-consumer professionals, effectively denying voice to consumers of color who want to bring deeply felt experiences into policy or research discussions. Until the structural nature of racial exclusion, reflected in excess disability and mortality, educational disadvantage, housing discrimination, labor market exclusions, and the stigmatizing assumptions that accompany it are recognized, progress in the effort to address homelessness will be limited.

Poverty has been more readily recognized as a barrier to consumer participation, and strategies to offset its immediate impact have been developed. The Homeless Families Program's consumer panel (CP) distributed prepaid phone cards to ensure that members attending steering committee meetings would be able to stay in touch with children's babysitters, and found that financial support for travel, childcare, per diems and other expenses were essential to sustain consumer participation (McMullin et al., 2006).

Stigma and discrimination. Reports identify stigma and discrimination as recurring features in homeless service settings, though they do not typically consider how homelessness, mental illness, race, substance addictions, HIV, and poverty are causative factors of stigma in these venues.

Link and Phelan (2001) view stigma as a set of interrelated processes—labeling, stereotyping, separation, status loss, and discrimination—that co-occur in a context of unequal power. They identify three broad categories of stigmatizing mechanisms that operate at individual, interpersonal, and structural levels. This conceptualization implies that effectively combating stigma and discrimination requires addressing not only labeling and stereotyping (interpersonal stigma), and the negative views adopted by stigmatized persons (self-stigmatizing perceptions) but also the discrimination perpetuated by disempowering institutional arrangements (structural stigma). Consumer accounts of personal experiences in homelessness research, policy, and service contexts provide examples of mechanisms that operate and diverse strategies for countering them (McMullin et al., 2006; Mockus et al., 2005).

Stigma and discrimination are particularly problematic for consumer staff who experience them both in the organizations that hire them and in their interactions with contracted provider agencies. (PATH Consumer Involvement Workgroup, 2006). Fisk and colleagues (2000) highlight the importance of recognizing and responding to both subtle and overt discrimination.

Disclosure of consumer status. The decision of employees to disclose their consumer status to employers, other agency staff, or clients is sometimes a personal decision, but at times it may be required as a condition of employment. Depending on the work situation, disclosure of consumer status can highlight an agency's commitment to the recovery model, which includes hiring consumers as staff. Disclosure of consumer status to an individual using agency services may stimulate hope of recovery on the part of the client, or it may aid both the consumer staff's and the client's recovery process. (PATH Consumer Involvement Workgroup, 2006)

Without clear administrative support of consumers as staff and the education of all staff about the value of including consumers on staff, disclosure can lead to difficulties in working conditions. Fisk and colleagues (2000) note that discrimination is likely to occur immediately after consumers make disclosures. In addition to education of all staff, they recommend individual supervision, which allows an opportunity to discuss workplace difficulties; provision of support as needed; and peer support groups, which give consumer staff opportunities to discuss challenges and successes, observe role models, build solidarity, and decrease feelings of isolation on the job.

Interpersonal stigma (harboring low expectations, negative stereotyping) has been both described and challenged by consumers across all domains of research, policy, and planning. In qualitative interviews conducted by a Homeless Families Program CP member, participants described hostile, disrespectful, and humiliating treatment when seeking help from shelter and social service staff. (Stainbrook, 2004, p. 23; Deming, 2002).

Consumer panel members on SAMHSA's research initiative on Women with Co-Occurring Disorders and Violence, who referred to themselves as consumer/survivor/recovering (C/S/R) women, wrote of their initial experiences at the initiative's Steering Committee meetings:

> It was confusing and disturbing to be identified with a label and to be asked to speak as a C/S/R woman. In talking about that early experience, one woman said it was like being "a performing monkey," another said she felt like "a sham," and others used words like "marginalized," "tokenism," "invisible," "discounted," and "not heard." …True discourse developed slowly over time. Other Steering Committee participants seemed to need time to develop better "hearing" so that C/S/R women were not discounted because of preconceived beliefs about who they were (Mockus et al., 2005, p. 522).

The women from this project collectively pressed for a variety of supports (including a scheduled place and time to meet together outside the formal steering committee sessions; a training academy in research methods; practical support—financial, child care—for attendance at meetings) that allowed them to find their individual and collective voice. As researchers became more willing to listen, C/S/R women's influence on the project grew.

Fisk and colleagues (2000) describe the subtly stigmatizing interactions that consumer staff experienced in integrated case management teams. They emphasize the importance of educational and training programs for non-consumer staff, individual supervision for consumer staff, and management intervention to create a more positive work environment.

For many people experiencing homelessness, stigma and discrimination are perpetuated by a mental health system that "considers every difficulty people with psychiatric problems experience as an indication of mental illness requiring professional expertise," so that even requests for practical assistance with a job or a place to live are handled within the context of disability (Campbell, 2006a, p. 38). Consumers recount experiences in research, policy, and planning settings, in which the recovery movement has served as both resource and strategy in challenging preconceived notions about the abilities of consumers who have experienced mental illness, recovery from addiction, and homelessness (McMullin, 2006; Clay, 2006).

Self-stigmatizing perceptions (lack of confidence, feeling worthless) arising from repeated experiences of powerlessness and discrimination may also inhibit consumer involvement in research, policy, and service delivery. Shih (2004) emphasizes resiliency and strategies individuals use to overcome stigma as well as distinguishing coping approaches, which may be psychologically draining, from empowering processes that produce resiliency and overcome adversity. In one report, families that became involved in organizing activities demonstrated that "active participation of homeless families reduces severe isolation, guilt, and shame and can provide critical support" (Better Homes Fund, 2001, p. 13). Tripp's presentations on opportunities for consumer involvement in HMIS also emphasize that the experience of participating, learning, and being effective evokes personal growth and improved self-image (Tripp, 2005). Some accounts suggest that individuals who are spurred to action to address the injustice of stigma at the level of individual identity often adopt an empowerment approach that leads to engagement in efforts aimed at removing stigma at the collective level (Corrigan & Watson, 2002).

Structural stigma (barriers to participation due to exclusionary social structures, power differentials, and poverty) can occur even when not directly linked to the negative stereotypes often understood to define stigma. The PATH Consumer Involvement Workgroup (2006) noted that eliminating pay differentials is only one aspect of treating staff equally and encouraged agencies to be sensitive to and address differences between consumer and non-consumer staff. The Homeless Families Program CP resolved issues around exclusionary practices, such as using credit cards to hold plane and hotel reservations, communicating by email, and scheduling conference calls and meetings in distant cities during the workday, which are so embedded in professional research culture that their effects on consumers often were ignored and unacknowledged by researchers. The CP coordinator, steering committee, and individual sites implemented CP recommendations to facilitate participation by CP members, including financial support, aid with travel logistics, and advance distribution of hard copies of written material (McMullin et al., 2006). As long as the larger inequities remain, such efforts are needed to offset their exclusionary effects.

Mainstream employment: Barriers and labor force development strategies. Research on employment of consumers with mental health and other disabilities has documented their strong interest in work but low rates of employment. A New Freedom Commission Subcommittee on Employment and Income Support reported that despite initiatives to reduce barriers to work, ineffective vocational services, workplace discrimination, and work disincentives perpetuate low employment rates of people with mental health disabilities (New Freedom Commission Subcommittee on Employment, 2003). Studies of peer employment show that the Americans with Disabilities Act has not had hoped-for effects on workplace discrimination (Fisk et al., 2000; Kirsch, 2000), and a qualitative study of consumer staff in a mental health agency describes mixed consequences of invoking ADA's reasonable accommodation provisions (Francis, Colson, & Mizzi, 2002). The Ticket to Work program, intended to enhance vocational skills, has served only a fraction of those in need, and "creaming," that is, serving only those who are easiest to serve, may result in limited access for people with mental illness (Employment Subcommittee, 2003). Few states have implemented a Medicaid Buy-In initiative to allow working consumers ongoing access to health insurance (Employment Subcommittee, 2003; Silverstein & Jensen, 2004).

Financing of peer staff positions through time-limited demonstration grants has also inhibited consumer employment (Mowbray, Moxley, & Collins, 1998; Center for Substance Abuse Treatment, 2004). Georgia's experiment with employing certified peer specialists, who have a mandated role in several Medicaid-reimbursable services, is a notable step in enhancing peer employment. While many states have

implemented training and certification programs, Georgia's reimbursement strategy has been less widely adopted, although there is growing support for increased use of Medicaid-reimbursable services. This is so despite recommendations that peer support services be integrated into the continuum of community care and that public and private funding mechanisms be made sufficiently flexible to allow access to these services, for example, through a carve-out from federal Community Mental Health Block Grant funding to support both integration of peer support services within the continuum of community care and procedures to encourage use of billable peer services under the Medicaid Rehabilitation Option (Employment Subcommittee, 2003; Center for Substance Abuse Treatment, 2004). Opposition to hiring certified peer specialists remains a reality in many organizations.

Funding issues. Funding issues pose additional barriers. Although early studies showed cost savings associated with peer support programs, in some cases this reflected use of peer volunteers or lower rates of pay for peer staff (Solomon & Draine, 2001). Consumers and researchers have criticized use of peer staffing to reduce personnel costs, emphasizing pay parity as a basic principle of consumer staffing, and noting that its benefits come from the value added to program services (Mowbray, Moxley, & Collins, 1998). This is especially critical at a time when cost-effectiveness is a central selling point in any effort to implement innovative services.

SAMHSA's recent research initiatives underscore a need to fund the supports that ensure peer integration through all of a project's phases and levels. This entails allocating resources for transportation and child care, consulting stipends, per diem expenses, and meetings/conference calls among consumers to ensure adequate discussion to clarify issues and formulate responses; contracts with consultants to provide assistance with group process, training in research methods, and advice on public presentations; and mailing expenses to distribute materials that researchers circulate by email (Campbell, 2006b; McMullin et al., 2006; Mockus, 2005). Overall amounts are not large, and a decision to earmark funds to enable consumers to participate as research, policy, and service delivery partners marks a move from token involvement toward consumer integration.

Consumer Self-Determination in Housing and Services

Service and Housing Priorities and Preferences

Since the early 1990s, research and other literature have consistently and unambiguously documented discrepancies between provider and consumer perspectives on how to prioritize housing and services, and on the kind of housing needed. A comprehensive array of outreach, transitional, and permanent housing programs is now well established at city and state levels through provider participation in the annual continuum of care application to HUD, which funds and shapes the direction of local services. While this broad offering of services provides some people who are homeless with options for exits from homelessness, point of entry into housing is usually not determined by consumers themselves, but by service providers. Housing providers often worry about the potential for disruptive and dangerous behavior, as well as the possibility of recurring homelessness, if people with mental illness and addiction problems are given independent housing before demonstrating that they are ready for it. Similarly, clinician beliefs in the limited ability of persons with mental illness to maintain independent housing can restrict the paths that consumers take into housing. Indeed, when surveyed about housing needs, providers more often recommend staffed settings with on-site treatment or supports (Bebout & Harris, 1992; Goering, Paduchak, & Durham, 1990; Goldfinger & Schutt, 1996). Therefore, in most programs across the country, approaches to housing and services for people who are homeless have reflected provider

perspectives, emphasizing outreach and shelter as first responses. They offer emergency supplies (food, clothing), support, and referrals to transitional settings such as drop-in centers and safe havens that offer support and treatment services to help consumers become "housing ready." In contrast, researchers and advocates studying consumer preferences in housing and consumers themselves all report that consumers who are homeless want housing *first*— housing on their own terms: independent, integrated into the community, with the support services an individual chooses available off site but not required (Carling, 1993; Howie the Harp, 1993; Tanzman, 1993).

While there are numerous examples of very successful "housing readiness" programs, the visibility of a highly vulnerable group of consumers who have been homeless for years has recently prompted researchers and other observers to focus attention on chronic homelessness and to join consumers in challenging the treatment-as-usual service approaches. Kuhn and Culhane (1998) found that among all who stay in shelters over the course of a year, a small group (about 10 percent) with long and repeated stays use half of all system resources (days of shelter use). Their work suggests that extensive engagement and contact with outreach, shelter, transitional housing, and clinical services have been very costly but ineffective for this group. Gladwell's (2006) poignant portrait of "Million Dollar Murray" highlights the experience of thousands of people who are chronically homeless. Gladwell provides a litany of well-intentioned but failed service efforts by outreach workers, police, detox and psychiatric emergency room staff, and many others who tried to help Murray leave the streets of downtown Reno, Nevada. Murray wanted a place of his own but no one believed that he was "ready" for it (in fact, he did well when he once briefly had a place, but without support services he soon lost it and there were no more chances after that). A tally of the cost of providing 12 years of failed services to Murray gave Gladwell a nickname for his anti-hero, and highlighted the need for new strategies.

In the last decade, new approaches emphasizing consumer choice and recovery (Deegan, 1988; Mead & Copeland, 2000; Ridgway & Press, 2004) have challenged traditional models requiring treatment and sobriety as preconditions for housing. What is shared by well-documented, consumer-driven approaches, such as wellness recovery action plans (WRAP) (Copeland, 1997), motivational interviewing (Miller & Rollnick, 2003), shared decision making (Deegan, 2007), and housing first (Tsemberis, 1999), is that programs must allow consumers to be equal partners in choosing providers and determining the type and sequence of services they receive, including the right to refuse services altogether (New Freedom Commission on Mental Health, 2003).

Approaches to housing and services cannot be neatly dichotomized between treatment and sobriety first providers on the one hand and housing first providers on the other. Although treatment and sobriety are common preconditions for accessing permanent housing, some homeless assistance programs make participation in treatment and support services optional once individuals meet initial treatment requirements for admission. Since the 1980s, community development activists and homeless advocates, who have viewed an expanded supply of permanent affordable housing as essential to any efforts to end homelessness, have collaborated to reclaim or replace disappearing housing stock by creating integrated housing developments (Hopper & Barrow, 2003).[8] These programs offer SRO accommodations or

[8] We use the term "integrated housing development," to refer to a type of supportive housing that accommodates diverse housing-needy individuals—among whom those with mental illness are not the majority—in single apartment or SRO units. Services are available on site but from a provider separate from the housing manager, and tenure is not contingent on sobriety or service involvement (Hopper & Barrow 2003).

efficiency apartments for diverse groups with housing needs, including people with mental illness, people living with HIV/AIDS, and other low-income members of local communities. Subsidies ensure affordability; standard leases ensure tenancy rights; and nonprofit service agencies make optional support services available on site, usually in inconspicuous locations, which tenants may use or not, as they wish. However, integrated housing development programs, like most congregate housing settings, often face challenges, juggling as they do to support individual tenants through periods of symptom or substance use relapse, maintain a viable environment for the tenant community as a whole, and keep admission requirements reasonable (Barrow, Soto Rodriguez, & Cordova, 2004; Hopper & Barrow, 2003).

Housing First: A Paradigm Shift in Homeless Services

The inclusion of consumer voices in the planning and implementation of housing and services has fostered a paradigm shift in homelessness interventions and moved outreach, engagement, treatment, and housing services to be more in line with consumer preferences. In the last decade, housing first, developed in partnership with consumers, has emerged as a well-documented practice that effectively provides permanent housing that is not contingent on prior services or "readiness" criteria. The housing first approach was pioneered by Pathways to Housing. By offering consumers an apartment of their own as a direct exit from homelessness, "Pathways fused several programmatic steps—outreach, engagement, and housing—into a single powerful and desirable invitation" (Tsemberis et al., 2003, p. 310). This approach is consistent with consumer priorities for an independent apartment of their own without requirements for psychiatric treatment or sobriety as a condition for housing entry or retention.

The pathways to housing model. The pathways to housing model emerged from an ongoing dialog among consumers, staff, and researchers (Shern et al., 2000; Lovell & Cohen, 1998; Tsemberis et al., 2003) who had developed an outreach and drop-in center program as an NIMH research demonstration project. An ethos of respect for consumers and their wishes was fostered by training staff in consumer-centric clinical approaches such as psychiatric rehabilitation (Anthony et al., 2002). In addition, several staff members were consumers themselves, and consumers shared responsibility for policy and program decisions. Howie the Harp, an early consultant, brought to the program a commitment to social justice and revolutionary fervor to change the mental health system (Tsemberis & Asmussen, 1999; Tsemberis & Eisenberg, 2000; Tsemberis et al., 2003).

In the drop-in center, neither status nor salary distinguished consumer staff from non-consumer staff, an approach that also blurred boundaries between staff and participants and fostered collaboration on the critical problem of access to housing. Staff and consumers witnessed how existing housing providers used the need for housing to leverage consumer acquiescence to unwanted treatment and abstinence requirements (Allen, 1996). After repeated failures to secure housing for consumers, the group began a trial and error process to design a housing program that would be desirable to consumers and manageable to staff. They determined that the scattered-site supported housing model met consumers' requirements for normal housing, tenancy rights, privacy, and an affordable rent contribution (30 percent). Consumers and staff collaboratively worked out operational details, occupancy policies, and program and consumer fiscal responsibilities, including a program account that required both staff and consumer signatures for checks to be cashed.

This collaborative plan evolved into the pathways to housing model, which focuses on ending homelessness by offering permanent, independent housing and comprehensive, consumer-driven supports without contingencies for treatment or sobriety. The pathways model, now called housing first, prompted

several programs and agencies around the country to adopt this approach in their efforts to end chronic homelessness. However, the Pathways program and the numerous replication sites are not the only programs that are described as housing first. Locke and colleagues (2007) identify several variations of housing first models with different housing and service approaches. Other examples of successful programs called housing first include Direct Access to Housing (DAH), operated by San Francisco's Department of Public Health, which is aimed at housing people who are homeless and frequent users of medical emergency rooms, and a housing program operated by Seattle's Downtown Emergency Service Center that provides immediate access to an SRO room for people who are living on the streets and suffer from addiction disorders. These programs vary in type of housing provided (single site buildings vs. scattered site) and how services are provided (on site vs. off site). This variability of housing first approaches offers communities seeking to serve individuals or families who are chronically homeless a variety of program models: from a few scattered-site units with off-site case management support services to single site options of various sizes with services on site. Despite their differences, housing first programs share many dimensions: immediate access to housing with no treatment preconditions; services are optional; housing is permanent and affordable. Thus more communities are beginning to include a housing first option in their menu of programs options in continuum of care plans (Locke et al., 2007).

In the discussion of choice-based housing and services that follows, we focus on the Pathways' model for several reasons. The Pathways program is well researched and well documented, while also offering housing in the most integrated settings. In addition, the Pathways model not only centers on consumer choice, but the program is consumer driven. Consumers are integrated into every dimension of the program: planning, operation, and policy. Pathways has sustained its consumer-centered character by attending to the importance of consumer presence and voice at every level of the organization. All services promote individual self-determination and social integration. Thus upon admission, consumers choose their apartment and neighborhood of residence, restricted only by the availability of affordable housing. Because the independent scatter site apartments are leased from existing units in the community and comprise less than 20 percent of any building, while all program services are off site, both housing and services are offered in the least restrictive and most socially integrated settings. Finally, consumers are encouraged to fashion their own path towards greater social inclusion, whether through employment, returning to school, or reuniting with children.

In addition, several practices promote consumer voice more broadly within the agency: (1) as tenants, consumers participate on an advisory committee that meets with agency heads to express tenant concerns and to provide programmatic input; (2) every officer of the organization has an open door policy to all tenants; (3) consumers are hired as service providers and managers and are elected as members of the agency board of directors; (4) in meetings, accommodations ensure full participation—appointing a moderator, taking turns speaking, and having an active, moderated, question and answer period; and (5) social and recreational events provide opportunities for staff and consumers to meet informally and expand the repertoire of their dialogue. Both the organizational environment and service approach foster empowerment for greater community, civic, and political participation.

Research on housing first. A series of increasingly rigorous studies, conducted over several years, in different settings and with different subsets of the homeless population have focused mainly on the pathways to housing model and its replications. The studies summarized here have begun to establish an evidence base for housing first as an effective approach to ending homelessness and achieving positive outcomes in mental health and other domains.

Early findings. Early work focused on Choices Unlimited, a drop-in center and forerunner of Pathways to Housing. The program was funded as one of six multisite NIMH-McKinney research demonstration projects. The goal was to test a psychiatric rehabilitation approach to engaging consumers. The program did not impose treatment requirements, predetermine lengths of stay, or require that services be used in a given sequence as conditions for drop-in center use. To test the effectiveness of the approach, potential participants were randomly assigned to either the experimental program or to traditional outreach and drop-in center programs focused on housing readiness. Over two years of follow-up, time spent on the street declined for both groups, but the 55 percent decrease for the experimental group was almost twice the decrease (28 percent) for the control group (Tsemberis et al., 2003). Those in the experimental group also found it easier to obtain food, find a place to sleep, and remain sober than did the control group; they participated in more services, including day programs and self-help groups; and they received more help with alcohol and drug problems, financial entitlements, and health insurance (Shern et al., 2000). However, after 24 months only 38 percent of participants had moved to permanent housing. This finding guided program developers to focus on reducing barriers to housing access more directly by providing immediate access to independent scattered-site apartments and services based on consumer choice.

Housing retention. The housing first approach, which evolved from the Pathways to Housing drop-in center work, was initially investigated in a study that used administrative data to compare housing retention of housing first tenants to housing retention of tenants in supportive housing programs that required treatment and sobriety as preconditions to housing. Controlling for the effects of client characteristics, this study showed that participants in housing first achieved better housing tenure than did the comparison group (Tsemberis & Eisenberg, 2000). After five years, 88 percent of housing first participants remained housed, compared to 47 percent of those in more traditional housing programs. However, in the absence of random assignment, it is impossible to be sure that the better outcomes were due to program effects rather than unmeasured participant characteristics.

A subsequent experimental and longitudinal study of the effectiveness of the housing first approach in New York City was conducted as part of a SAMHSA multisite study of homelessness prevention. In this four-year study, 225 participants with severe mental illness, who were literally homeless and many diagnosed with co-occurring substance use disorders, were randomly assigned to receive either housing first or services as usual. Participants were interviewed every six months to examine changes across a range of outcomes, including residential status, substance use, and psychiatric symptoms. After six months, 79 percent of housing first participants were living in stable housing compared to 27 percent of participants in the control group (Tsemberis et al., 2003); and throughout two years of follow-up, housing first participants spent more time in stable housing and showed far greater reductions in homelessness than the control group (Tsemberis, Gulcur & Nakae, 2004).[9]

[9] After one year, participants in the Housing First Program spent 85 percent of their time stably housed, compared with less than 25 percent for participants in the services-as-usual group (Tsemberis, Gulcur, & Nakae, 2004) and the effect endured: After two years, housing first participants still spent approximately 80 percent of their time stably housed, compared with only 30 percent for the control group. Rates of homelessness decreased dramatically for Housing First tenants, who had spent approximately 55 percent of the period before baseline literally homeless, dropping to 12 percent at one year, and less than 5 percent after two years. Reductions in homelessness were significantly slower and less dramatic for the control group, who were homeless about 50 percent of the time at baseline, 27 percent at one year, and 25 percent after two years.

Another experimental study examined housing retention among long-term shelter dwellers with psychiatric disabilities and often co-occurring addictions in a suburban county. Participants were randomly assigned to one of two programs using housing first approaches (Pathways to Housing or a local consortium) or a services-as-usual control group. Replicating and extending previous findings, this study demonstrated that participants assigned to housing first obtained permanent, independent housing at higher rates than the control group. A majority of consumers housed by both housing first programs retained their housing over four years, with78 percent of participants in Pathways to Housing remaining housed over that period (Stefancic & Tsemberis, in press). This suggests that housing first services can be successfully replicated in non-urban environments and with a population of homeless persons with extensive shelter histories. These findings have been replicated with shelter populations in Salt Lake City (Flynn, 2006) and Hartford (White, 2005).

In 2003, a Collaborative Initiative to Help End Chronic Homeless was coordinated by the Interagency Council on Homelessness (ICH) and funded by HUD, HHS (SAMHSA and HRSA), and the VA to provide housing and services to chronically homeless populations. Seven of the eleven programs funded used the Pathways housing first model to provide scattered-site housing and off-site support and treatment services. They achieved similar housing retention results, with approximately 80 percent stably housed after 12 months (Rosenheck, 2006), successfully replicating both the model and the findings on retention across diverse contexts.

In domains other than retention, the results of several of these studies, including two controlled trials, are building a case for housing first as an evidence-based practice for addressing homelessness: Participants in housing first obtained housing earlier and remained stably housed at higher rates than control groups receiving services as usual through more traditional housing and treatment programs (Tsemberis, Gulcur, & Nakae, 2004; Gulcur et al., 2003). Further, housing first participants spent significantly less time in psychiatric hospitals and incurred fewer residential costs than controls (Gulcur et al., 2003), though findings from another study showed modest increases in societal costs for housing first (Rosenheck et al., 2003), suggesting a need for further examination in this domain.

Psychiatric symptoms and consumer choice. Further analyses of the housing first experimental data focused on psychiatric symptoms. Although housing first participants used fewer psychiatric treatment services than control group participants at every time point, there were no significant differences in self-reported symptomatology (Padgett, Gulcur, & Tsemberis, 2006), suggesting that optional participation in treatment services is as effective as mandatory participation in services. An examination of the relationship between stable housing and psychiatric symptoms shows a reduction in psychiatric symptoms if the person has been stably housed for the preceding six months (Tsemberis & Fischer, under review). Separate analyses compared the impact of consumer choice, a principal component of housing first, on the mental health of housing first and control participants. Ratings of perceived choice were significantly higher for participants in housing first compared to those in the control group; and perceived choice significantly accounted for a decrease in psychiatric symptoms, a relationship that was partially mediated by mastery (perceptions of personal control) (Greenwood et al., 2005). This strong and inverse relationship between perceived choice and psychiatric symptoms supports expansion of all housing models that increase consumer choice, thereby enhancing mastery and decreasing psychiatric symptoms.

Substance use and consumer choice. In a recent study Milby and colleagues (2005) examined the effectiveness of providing direct access to housing to individuals who were homeless and experiencing

cocaine dependence disorder. A total of 196 participants were assigned to receive: a) abstinence-contingent housing; b) non-abstinence contingent housing; or c) no housing. Participants were followed for 24 weeks. While the abstinence housing group showed significantly higher rates of abstinence (as required by the housing program) than the non-abstinence contingent group, results for days housed showed that "the groups did not differ significantly from each other at any time point." The investigators' conclusion favors abstinence-contingent housing, and the study's findings have been described as contradicting the positive findings on housing first. However, the focus on abstinence as the critical outcome reflects the study's focus on treating addiction rather than ending homelessness and obscures the important findings on housing tenure. The data clearly show also that for individuals with addictive disorders, housing without abstinence contingency is as effective as abstinence-contingent approaches in addressing homelessness. In New York City, Project Renewal, one of the HUD Chronic Inebriates Initiative sites, obtained similar results. Using a housing first approach with people who were frequent users of their detox services, this program achieved an 80 percent housing retention rate for non-abstinence contingent housing (Ed Geffner, personal communication, October 31, 2006). In a later program intervention, as one of the HUD's chronic inebriate grantees, Project Renewal decided to vary their approach and required 90 days of abstinence and treatment prior to providing housing for their second HUD program (calling the approach "housing-second"). Results indicated that the number of people who lost housing due to relapse into alcoholism was higher in the housing-second program (Cowles, 2007).

At another HUD Chronic Inebriates site, Pathways to Housing DC (a Pathways replication site), 35 of 36 people who were chronically inebriated were still housed after the first six months, and there was a reduction in (average) expenditures on alcohol from $87.06 a month prior to entering the program to $17.90 per month after entering into housing. Furthermore, results indicated that consumers who chose to participate in drug treatment had significantly reduced their consumption (Kent, 2007).

The experimental study of 225 housing first participants also examined substance use outcomes. Analyses show that although the services-as-usual group utilized more substance use *treatment*, there were no significant differences in self-reported substance *use* between the control and Housing First groups. Moreover, though the control group's greater service use continued over the four-year follow-up period, absence of group differences in alcohol and drug *use* persisted over the four-year period as well (Padgett, Gulcur, & Tsemberis, 2006).

Consumer satisfaction and challenges. While evidence for housing first has been accumulating, many providers continue to view the approach as appropriate only for high functioning individuals. This issue was addressed in a quasi-experimental study that compared differences in housing, psychiatric outcome, and satisfaction of formerly homeless participants in housing first and another supported housing model *versus* those in structured, service-intensive community residences (Siegel et al., 2006). Because participants were not randomly assigned to housing groups, a statistical procedure called propensity scoring was used to categorize participants into three strata depending on how they ranked as candidates for supported housing. Regardless of stratum, individuals in supported housing remained stably housed, and housing type had no effect on tenure. However, at every follow-up point, participants in supported housing reported greater satisfaction in terms of autonomy and economic viability than those in community residences.

Some participants in this study who were in supported housing, but who were ranked as more likely candidates for community residences, reported greater isolation, a finding also supported by a qualitative

study of community integration of housing first consumers. The qualitative study found that, for most consumers, entering housing after a long period of homelessness was associated with improvements in several psychological aspects of integration (e.g., a sense of fitting in and belonging) as well as feelings of being "normal" or part of the mainstream human experience. However, the study also uncovered challenges faced by housing first participants, including difficulties in coping with loneliness, adjusting to living independently, feeling safe without any monitoring presence, and "fitting in" in the community (Yanos, Barrow, & Tsemberis, 2004).

The weight of the evidence. Participants in housing first obtain and maintain independent housing with consumer-chosen supports without negative effects on psychiatric or substance use symptoms. Housing retention rates remain around 80 percent for periods of four to five years. And consumers in housing first report higher levels of choice and residential satisfaction compared with participants of more traditional programs. Further, consumer choice—a key aspect of housing first services—positively affects psychiatric symptoms, a relationship that is mediated by mastery (perceived choice leads to increased mastery, which is associated with reduced psychiatric symptoms). Finally, providing housing first has been shown to be less costly than traditional residential treatment, though it may be associated with modest increases in societal costs. Further research is now underway on fidelity measures of housing first that define the model's key features and assess how closely they are approximated as this rapidly disseminating model is implemented in diverse contexts and with various consumer subgroups.

Harm Reduction, Choice, and Homelessness

The predominant approach of housing programs for people who are homeless and dually diagnosed requires psychiatric treatment and a period of sobriety as preconditions for permanent housing. Specific variants include therapeutic communities, modified therapeutic communities, residences for "mentally ill chemical abusers" (MICAs), and other abstinence-based housing programs. (For a recent review see Center for Substance Abuse Treatment, 2005.) This approach has a documented history of clinical success for consumers who choose or are able to complete the programs and is favored by providers because it limits liability risks and management problems, and is consistent with the widely held view that people with dual disorders are unlikely to maintain housing without first developing housing readiness.

The programs presented here are focused on how substance use affects the efforts of persons who are homeless to obtain housing as opposed to treatment. As noted previously, abstinence-contingent housing can serve to exclude subgroups of people with dual diagnoses, thus leaving a significant proportion of individuals chronically homeless. Abstinence-contingent housing and treatment models usually emphasize, if not mandate, participation in 12-step mutual support groups (AA or NA). Despite the overall strength of their peer-based approach, abstinence programs tend to be stringently and hierarchically structured, with consumer choice and input significantly circumscribed beyond the initial choice to participate. For these reasons, and because these models are not a new development in the last 10 years and thus beyond the scope of this report, we have not reviewed them as "choice-based" approaches. By eliminating sobriety and psychiatric treatment as a preconditions for housing, housing first programs have proven highly effective in housing—and keeping housed—people with addiction disorders and dual disorders who had repeatedly failed in or been rejected by other programs.

Consumer choice is the foundation of the harm reduction approach (Inciardi & Harrison, 2000), in which consumers define their needs and goals as well as the pace and sequence of services. Harm reduction has emerged as an alternative to the ubiquitous 12-step abstinence/sobriety models of drug use and addiction

(Marlatt, 1998). As applied to homelessness, this gradual approach of encouraging consumers to reduce substance use and related risks replaces the pervasive sobriety and psychiatric treatment requirements that prevent individuals who are homeless from attaining and retaining housing (Rowe, Hogue, & Fisk, 1996). It offers an individualized approach to assisting consumers' progress towards recovery but starting at their stage of readiness for change rather than insisting on abstinence as a prerequisite for housing (Tsemberis & O'Callaghan, 2004). Harm reduction is consumer driven and seeks to minimize personal harm and adverse societal effects of substance abuse while the consumer strives towards recovery.[10]

Although sobriety and abstinence are considered ideal outcomes of harm reduction, the model allows alternative paths to sobriety as long as they serve to contain or reduce the many risks or risk behaviors associated with addiction, such as drug overdose, incarceration, impoverishment, prostitution, malnourishment, chronic homelessness, and ill health. Consequently, consumers are offered a range of treatment alternatives, which can include AA/NA, and are supported in making positive steps towards recovery, whether it means striving for abstinence or making use less risky. Harm reduction approaches often incorporate DiClemente and Prochaska's transtheoretical model of addiction and recovery, often referred to as the "stages of change model,"[11] to help consumers and clinicians define and track gradual goals on the path to attaining the ideal of sobriety (DiClemente, 2003; Prochaska & DiClemente, 1992; Marlatt, 1998).

In treatment for dually diagnosed populations, harm reduction works particularly well with other evidence-based practices, such as integrated dual-diagnosis treatment (IDDT) (Mueser et al., 2003) and illness management recovery (IMR). When housing programs for individuals who are dually diagnosed require abstinence as a condition for obtaining housing or for remaining housed, consumers with histories of substance abuse who are at risk of relapse are also at risk for housing loss and continued homelessness. This fear of eviction inhibits consumers who begin to use drugs or to experience psychiatric symptoms from discussing their emerging problems with housing counselors. Housing first programs separate the terms and conditions for continued tenancy from treatment concerns and provide integrated services that encourage honest feedback from consumers, including disclosure that they are using drugs or alcohol or no longer taking their psychiatric medication without fear that this will lead to eviction (Tsemberis & Asmussen, 1999).

Harm reduction approaches to homelessness for consumers with dual diagnoses. In some locales, harm reduction is codified as public policy, which requires its application to housing approaches that address homelessness. Thus, for example, harm reduction principles are central to San Francisco's Direct Access to Housing program, which creates integrated SRO housing developments to address homelessness for people with dual diagnoses. A descriptive study found that in these contexts, tenants with addictions were not at elevated risk of housing loss, and 70 percent retained housing over two years (Barrow et al., 2004).

The housing first approach implemented by Pathways to Housing is the most extensively described and researched homelessness intervention based on harm reduction principles. As described above, Pathways

[10] Among its early applications, needle exchange programs designed to mitigate needle-related infectious disease transmission were prominent (Langendam et al., 2001). More recent applications include jail diversion programs to reduce the psychological, economic, and socially hazardous conditions incurred during incarceration (Klein, 1997).

[11] The stages of change are precontemplation, contemplation, preparation, action, and maintenance.

imposes neither abstinence nor treatment conditions for accessing or remaining in housing. The program offers consumers access to an interdisciplinary ACT team of skilled clinicians who offer integrated dual diagnosis treatment (IDDT) and other assistance on the person's own terms. Those who continue to use addictive substances or remain symptomatic may go in and out of treatment but they are not at risk of housing loss. Some newly housed consumers are motivated to reduce substance use or seek psychiatric treatment because they desperately want to avoid jeopardizing their newly-obtained housing (which, in some cases, is the first housing they have ever been able to call their own). Once survival is assured through housing, others may seek treatment for psychiatric symptoms or become ready to address other needs such as employment or family reunification (Tsemberis & O'Callaghan, 2004).

Previously cited evidence from experimental studies shows housing first participants have dramatically better homelessness outcomes and show equivalent levels of substance use compared to participants in services-as-usual programs that do not employ harm reduction (Padgett, Gulcur, & Tsemberis, 2006). While a specific test of abstinence-contingent housing versus non-abstinence contingent housing reported the unsurprising result of higher rates of abstinence in the housing program that required it, investigators report no difference in housing retention (Milby et al., 2006). Given that the most important outcomes for dually-diagnosed consumers who are homeless are either neutral or improved when harm reduction is employed, the study supports a harm reduction approach to homelessness and substance addictions among people with co-occurring addiction and mental illness.

Harm reduction approaches for consumers with long-term substance addictions. In 2006, a Health Care for the Homeless Council position statement endorsed including harm reduction models of addiction treatment in SAMHSA's best practices. The statement notes that programs that incorporate harm reduction strategies are "more likely to attract active users (and hence those most in need of resources for reducing drug-related harm), enhance motivation for positive change, improve retention in treatment, and reduce attrition and premature termination of services" (National Health Care for the Homeless Council, 2006). Canada Mortgage and Housing Corporation's brief review (2005) of homeless assistance programs that use harm reduction approaches describes a dozen programs in the United States, Canada, and the United Kingdom. Most provide permanent housing in dedicated units or scattered sites. To minimize harms associated with high-risk behaviors, programs emphasize helping residents reduce their usage, focusing on the strengths and capacities of the person rather than on the substances they consume, and encouraging changes in consumption habits (e.g., a move to less harmful substances, safe disposal of used syringes) or ensuring that there is not an increase in use. All emphasize the consumer-determined pace and content of services. Descriptions of harm reduction programs specifically addressing alcohol addiction among people with long-term homelessness include a Canadian report on a "managed alcohol" intervention (Podymow et al., 2006) and Anishinabe Wakiagun, a Minnesota program that provides permanent housing and case management services addressing health and support needs of men and women with late-stage chronic alcoholism and extensive homelessness (Canada Mortgage and Housing Corporation, 2005).

Research on programs that use harm reduction principles in housing for people with chronic homelessness and long-term alcohol dependence remains rudimentary (Hwang, 2006). A "managed alcohol" intervention was studied by Podymow and colleagues (2006), who used pre- and post- measures to assess changes in 17 program participants. They documented significant decreases in both emergency room visits and encounters with police. Participants also spent fewer days in the hospital and self-reported decreases in alcohol use. Such initial reports indicate that this harm reduction approach deserves serious attention in future research with this group.

Implications for Preventing and Ending Homelessness

In the last decade, people who have experienced homelessness have claimed increasingly active roles in research, policy, planning, and service delivery, and have furthered the expansion of choice-based alternatives to existing housing and service policies. We summarize here what the literature on these processes implies for the participating consumers; for homelessness research, policy, and service processes; and for efforts to end homelessness at a system or population level.

Implications of Consumer Involvement in Research, Policy, and Planning

Ethics and social justice argue for a prominent role for consumers who have experienced homelessness in research, planning, and policy-making, and a descriptive literature documents a large expansion of such roles. Qualitative accounts of experiences of consumers in these arenas make a persuasive case that, with adequate support, consumer involvement produces both benefits for consumers and improvements in research and policy.

Individual-Level Impacts on Consumers

- With appropriate support, participation in research, planning, and policy offers consumers practical benefits (employment, skills) as well as personal growth and improved self-confidence.

Implications for Research, Policy, and Planning Processes

- Effective consumer involvement in research, policy, and planning requires organizational support to address barriers, avoid tokenism, and authorize consumer decision-making.
- When supported, integration of consumers adds to the relevance, validity, and sensitivity of homelessness research, service planning and policy making.

Implications for Ending Homelessness at a Population Level

- Local consumer advocacy groups have pressed for the structural interventions (e.g., affordable housing) necessary to end homelessness at a population level. Consumer voices can make a unique contribution to leverage what must ultimately be a broad collaborative effort to restructure the systems that have thus far failed to do this.

Implications of Consumer Involvement in Service Delivery

Consumer employment has increased notably in homeless services as well as in self-help and consumer-operated programs for mental health consumers. Outcome studies show peer service delivery is effective and distinctive, but requires appropriate institutional support.

Implications for Service Recipients

- With adequate support and accommodation, peer staffing in homelessness programs is as effective as traditional services in helping service recipients spend less time homeless.

- Certified Peer Specialist (CPS) programs are expanding opportunities for consumer staffing, but as yet there is no research evaluating the effects of these programs on homelessness or other outcomes.
- New research on consumer-operated services shows that recovery-related program features are associated with improved well-being; but the research was not designed to examine effects on homelessness.

Implications for Service Processes and for Homeless Service Systems

- Consumer-provided services share distinctive emphases (e.g., respect, support, and agency) and a work culture emphasizing support and less use of authority to leverage compliance.
- Integrating consumer staff into traditional settings requires providing preparation, support, and supervision and addressing boundary issues, stigma, and discrimination.

Implications for Ending or Preventing Homelessness at a Population Level

- Consumer-staffed and consumer-run programs have not typically focused on the system-level changes required to end homelessness at a population level.

Implications of Consumer-Driven and Choice-Based Housing and Service Approaches

Over the last decade, consumer-driven approaches to homeless services—particularly the housing first model—have moved from the service and policy margins to a visible, and even central, place in many locales' 10-year plans to end homelessness.

Individual-Level Impacts on Homelessness

- Increasingly rigorous studies have shown that housing first produces better housing outcomes than alternatives that emphasize housing readiness for people with co-occurring disorders who experience homelessness. There is some research evidence that it reduces residential costs for participants.
- Harm reduction is integral to the housing first model. In studies of housing first, tenants have less contact with psychiatric and substance use services than do control groups engaged in usual services, but critics' fears of escalating substance use and psychiatric symptoms in the absence of treatment and abstinence requirements have proven unfounded.
- Research is needed on new harm reduction housing for people with chronic addictions, which as yet have only anecdotal support as a strategy for ending homelessness.

System-Level Impacts

- The endorsement of housing first in 10-year plans and the broad dissemination of this model currently underway implies significant change in homelessness policy and practice. Widespread adoption of the housing first model would both entail transformation of existing systems for delivering homeless services and housing.

- Since it relies on existing housing stock, any broad-based implementation of housing first in locales lacking adequate affordable housing must be accompanied by expansion of the supply of low-cost housing if it is to play a significant role in ending homelessness at the population level. This will require advocacy for affordable housing from broad sectors of society, extending well beyond those most affected by and concerned with homelessness.
- Because it challenges central features of current housing/service approaches (housing readiness, congregate housing, on-site services), widespread implementation must address the mismatch with existing funding and service models.

Research Recommendations and the Policy Issues They Address

Based on our review of the literature on consumer roles in research, policy, planning, and services delivery and our assessment of consumer-driven service/housing approaches, we offer the following inventory of unresolved policy issues and a set of recommendations about the research necessary to address them.

Can the lessons learned about approaches to and consequences of consumer integration in multisite research initiatives be extended to policy and planning settings? In what ways will policies developed with full integration of people who have experienced homelessness differ from policies made with more limited or no consumer involvement? Consumer voices were not prominent in the processes that led to current systems of homeless services. As a starting point to assess whether and how consumer integration changes not only the process of planning and policy-making but the direction of policy itself, we recommend using qualitative approaches (ethnography, oral history, elicited narratives) to document processes and impacts of consumer involvement on policy bodies, such as HUD continuum of care planning committees, HCH governing bodies, and other homelessness policy and planning venues. The work of the consumer panels of the several homelessness-related SAMHSA multisite research initiatives offers important lessons on the supports needed to overcome barriers to consumer integration as well as approaches to documenting process and impact of consumer participation.

How can efforts to expand consumer integration in homelessness research, policy, planning and services address the experiences of consumers of color and avoid replicating the exclusions and stigmatization that are structured by societal mechanism of racial exclusion and poverty? Structural mechanisms (racial exclusion, poverty, lack of housing) that promote homelessness and direct its impact to poor communities of color also inhibit consumer integration in homelessness research, policy, planning and service delivery. Multi-level research and advocacy collaborations are needed to explore the links between these systemic processes and the barriers consumers of color experience, educate all involved with homelessness about these links, and connect consumers and advocates with broader social movements that address racial exclusion.

Research shows peer-staffed programs provide clients who are homeless with equivalent services and achieve outcomes equivalent to those achieved by non-consumer teams. Will expansion of peer employment opportunities through policies to certify and obtain Medicaid reimbursement for peer services affect staffing in homeless services, and with what impact on outcomes of individuals receiving services? The recent growth of various types of certified peer specialist programs offers an important opportunity to assess the impact of key dimensions of variation (training, certification, Medicaid

reimbursement) on consumer employment in homeless service settings. In addition to documenting the range of program approaches deployed in these settings, research should address effects of CPS programs and other peer employment on peer staff as well as in promoting housing stability and other desired outcomes for persons who are homeless.

Experimental research on recovery-focused consumer-operated service programs has demonstrated effects on well-being. Can such services be effective in resolving homelessness and extending housing tenure? The research evidence for consumer-operated service programs has not specifically examined how such programs address homelessness and with what impact. Although findings are suggestive, there is need for research that specifically examines how consumer-operated services address homelessness and with what effects.

As housing first programs are replicated in different contexts and with new populations, what variations are introduced? How are outcomes affected? Much of the evidence for housing first is based on research on the Pathways to Housing program where the model originated. Fidelity studies currently in process will facilitate necessary further research on the model's effectiveness and cost effectiveness in varied contexts—with differently structured housing markets and contrasting service cultures as well as in diverse homeless subgroups (families, young adults aging out of foster care, and justice-involved individuals).

Is harm reduction housing a viable alternative to existing abstinence policies for people with long-term substance addictions and homelessness? While harm reduction has been part of the housing first approach as applied in programs for people with co-occurring mental illness and substance use, harm reduction housing for persons with histories of chronic homelessness and long-standing alcohol dependence or extensive drug use is relatively new and as yet untested. Descriptive studies are needed to document these interventions and their outcomes as are more rigorous controlled studies that evaluate their effectiveness in addressing homelessness and their impact on quality of life, health, and other outcomes. Anecdotal evidence supports the cost-effectiveness of these interventions; however little is known of outcomes and costs over time. Although the approach may remain controversial, it may offer new hope for those who have not found abstinence-focused programs to be a viable route to recovery.

A Final Note. As consumers increase their presence in the venues where decisions are made about homelessness research, policy, and service delivery, it is tempting to see consumer integration as the answer to homelessness. For many individuals who have been homeless, such participation will surely hasten personal recovery and social reintegration following homelessness, and their involvement will surely produce more responsive and effective policies. To expect that consumer integration or consumer-driven service programs alone will end homelessness at a societal level, however, is to overlook the multiple exclusionary processes—from global to local—that have generated homelessness by concentrating wealth, reducing the stock of affordable housing, skewing the distributions of opportunities for income and educational achievement, and marginalizing large segments of minority and poor populations in prisons or other institutions. Consumer voices will articulate priorities, create and validate useful service approaches, and energize the social resolve to address homelessness. If we are serious about ending homelessness, *all* voices must join together to demand the creation of housing and the other tools necessary to get the job done.

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People Who Experience Long-Term Homelessness: Characteristics and Interventions

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Abstract

Carol Caton, Carol Wilkins, and Jacquelyn Anderson document the considerable efforts of the past decade to address the needs of people who are considered "chronically homeless; that is, unaccompanied adults with disabling conditions who experience long or numerous spells of homelessness. The authors detail the prevalence, characteristics, and service needs of adults who are chronically homeless and present a synthesis of recent research on service and housing interventions. Finally, they discuss the implications of the findings for services and for future research. The authors note that rigorous research on many interventions is lacking, but promising practices from the field may help guide the development of housing and services.

Introduction

In the early years of the 21st century, homelessness continues to be a social problem of enormous public health significance. In mid-20th century America, observed homelessness was rare. However, in the late 1970s, homelessness increased sharply and has persisted for nearly three decades.

The Department of Housing and Urban Development's Annual Homeless Assessment Report to Congress (HUD, 2007) indicates that on a single day in January, 2005 there were 754,147 sheltered and unsheltered homeless persons in the United States. This point-in-time estimate represents less than 0.3 percent of the total population. When contrasted with prior estimates, findings suggest that the size of the homeless population has not changed significantly in the past decade.

The majority of people who ever experience homelessness are able to return to conventional housing within a brief period of time. In a study of shelter use in Philadelphia, Metraux et al. (2001) found that three-quarters of the people who used emergency shelters were homeless only once or twice, and most stayed for less than 60 days. A smaller number of people, however, remain homeless much longer. At any point in time, this group comprises a large proportion of the homeless population. The one-week prevalence estimate in the National Survey of Homeless Assistance Providers and Clients (NSHAPC) indicated that about one-fourth of the homeless population experienced spells of homelessness lasting over four years or had numerous homeless episodes (Burt et al., 2001). These chronically homeless individuals present a huge challenge for providers and policymakers because they use a disproportionate share of public services but remain vulnerable to continued homelessness.

Despite the daunting challenges presented by chronic homelessness, there is a glimmer of optimism that the winds of change in policy and program development are thrusting new energy into the search for viable solutions. New approaches to service delivery and provision of housing targeted at this population have been developed. Some of these interventions are becoming widely recognized as "evidence-based." In the last 5 to 10 years, there has been a convergence of opinion among advocates and policymakers at all levels of government that chronic homelessness need not exist in the United States. Momentum around this issue started to build in 2000 when the National Alliance to End Homelessness (NAEH) released a plan to end homelessness in 10 years. Shortly afterward, Secretary Mel Martinez of the U.S. Department of Housing and Urban Development (USDHUD) endorsed the goal of ending chronic homelessness, and the Bush Administration affirmed this goal in its FY2003 budget. In 2002, the Millennial Housing Commission, appointed by a bipartisan committee in Congress, called for ending chronic homelessness through the creation of 150,000 units of supportive housing, and the Administration reactivated the federal Interagency Council on Homelessness (ICH). Beginning in FY2003, the Collaborative Initiative to Help End Chronic Homelessness was launched with funding provided by the HUD, the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA) and the Department of Veterans Affairs (VA), with coordination by the ICH. Policy Academies on Chronic Homelessness in which teams implement a plan to address chronic homelessness have been established in every state and territory (see www.hrsa.gov/homeless).

Since 2003, a growing number of communities have developed policy and program strategies that are informed by more rigorous local estimates of the number of homeless individuals and an increased understanding of the nature of chronic homelessness. These efforts are starting to bear fruit. There are early signs that the number of chronically homeless people in shelters and in the streets is declining in some localities (NAEH, 2006a).

This manuscript is focused on chronically homeless single disabled adults, clearly a most vulnerable segment of the homeless population. While it is likely that some youth under the age of 18 also experience long-term homelessness, the lack of information on the course of youth homelessness underscores the need for further study of this population. Here we describe the numbers, characteristics, and service needs of adults who are chronically homeless, present a synthesis of the research literature on service and housing interventions, and discuss the implications of research findings for services and for future research on preventing and ending chronic homelessness. As a caveat, we note that most of the research on disabled homeless adults does not specify the extent of residential instability of study participants, although undoubtedly chronically homeless people have been included in such investigations. We present findings from studies of chronically homeless people when available, and extrapolate from studies of homeless people in general when homeless chronicity has not been specified.

Chronic Homelessness Defined

It is widely agreed that chronically homeless adults constitute a small but significant subgroup of the homeless population. The federal government's definition of chronic homelessness (reflected in policies and programs adopted by the Interagency Council on Homelessness, HUD, HHS, and the VA) is as follows: *"An unaccompanied homeless individual with a disabling condition who has either a) been continuously homeless for a year or more OR b) has had at least 4 episodes of homelessness in the past three years."* This definition of chronic homelessness also has been adopted by many states, while some have expanded this definition to also include families that meet the same criteria. Disabilities or disabling conditions often include severe and persistent mental illness, severe and persistent alcohol and drug abuse problems, and HIV/AIDS. There is little information available about the prevalence or characteristics of adults who experience long-term homelessness but do not have any identified disabling conditions, who are therefore excluded from the most widely used definitions of chronic homelessness.

The Prevalence of Chronic Homelessness

Estimates of the prevalence of chronic homelessness vary depending on the definition used, the duration of time observed, and the method of data analysis. Based on applications for homeless assistance submitted to HUD from local areas across the country, the National Alliance to End Homelessness (2006a) estimated that there were 150,000 to 200,000 chronically homeless individuals nationwide as of January 2005.

Overall, about 20 percent of sheltered homeless adults would qualify as chronically homeless according to the federal definition, which combines single long spells of homelessness with episodic or recurrent homeless spells. Kuhn and Culhane (1998) studied shelter utilization patterns based on administrative data in New York City and Philadelphia. A cluster analysis of the New York City data revealed that approximately 10 percent of shelter entrants were chronically homeless, remaining in the shelter for an average of over 630 days and experiencing an average of 2.26 episodes over the three years of the study. This group consumed half the total shelter days, despite their small number. Another 10 percent were episodically homeless, shuttling in and out of shelters and other institutions such as hospitals, substance abuse treatment programs, and jails. A cluster analysis of the one-week estimate in the NSHAPC study classified 27 percent as chronically homeless (Burt et al., 2001). This group had an average duration of homelessness in excess of four years. Kertesz et al. (2005) classified 22 percent of study participants as chronically homeless in a two-year follow-up study employing the two-dimensioned federal definition of homelessness. Similarly, a New York City study of first-time homeless sheltered single adults (Caton et al., 2005) found that about 20 percent of study participants remained continuously homeless over a follow-up period of 18 months.

Chronic Homelessness: Characteristics and Risk Factors

Clinical Characteristics

Chronic homelessness and its attendant consequences are experienced more often by those with psychological, physical, and social vulnerabilities. Although there is considerable heterogeneity in the clinical characteristics of people who experience homelessness (Burt et al., 2001), the profile of disabled homeless individuals, the group most likely to fall into chronic homelessness, has not changed much in the last decade. Psychiatric disability, substance abuse, and medical co-morbidities are widespread in the

chronically homeless population. In fact, disability resulting from psychiatric and substance use disorders is greater among the chronically homeless population than among other single adults who experience homelessness on a transitional or episodic basis (Kuhn & Culhane, 1998; Burt et al., 2001; Kertesz et al., 2005). Lifetime mental health problems have been found in over 60 percent of chronically homeless people, and greater than 80 percent have experienced lifetime alcohol and/or drug problems (cross-tabulation estimate, Burt et al., 2001). Similar high rates of mental health and substance abuse problems have been reported from housing and service programs designed to serve chronically homeless people (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). Included among the psychiatric disabilities experienced by homeless people are violent victimization and posttraumatic stress disorder (Metraux & Culhane, 1999).

Medical co-morbidities are commonly found among people who use services designed for people who are chronically homeless (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). Indeed, the excess morbidity due to mental illness, substance abuse, and medical conditions place homeless people at higher risk of mortality than their housed counterparts. A New York City study found that age-adjusted mortality rates for homeless men and women were approximately four times greater than those found in the general population. Chronicity of homelessness was found to be a strong predictor of mortality among men, even when adjustments were made for age and disability (Barrow et al., 1999). Mortality is greater among younger homeless women compared to those over age 45 years (Cheung & Hwang, 2004). HIV/AIDS is a factor in the increased mortality found in homeless populations. A San Francisco study found that HIV seroprevalence was greater among homeless and marginally housed adults than in the city overall (Robertson et al., 2004). A recent New York City study of the health of sheltered homeless people revealed that the death rate from HIV/AIDS was nine times higher among sheltered single women than among the general population (Kerker et al., 2005). Further evidence comes from the study of Culhane et al. (2001) indicating that people admitted to public shelters in Philadelphia had a three-year rate of subsequent AIDS diagnoses that was nine times that of the city's general population. Other serious infectious diseases such as hepatitis-C (Gelberg et al., 2004) and tuberculosis (Zolopa et al., 1994) and chronic conditions such as asthma and hypertension (Schanzer et al., in press) are found among street and sheltered homeless people.

Social Characteristics

In addition to serious disability, the lives of chronically homeless people are compromised by persistent unemployment (Caton et al., 2005), forcing dependence on public entitlements for sustenance, health care, and an eventual exit from homelessness. Few can rely on support from family and friends (Kertesz et al., 2005; Caton et al., 2005), increasing their isolation and decreasing their opportunities for social inclusion.

Veterans constitute about 20 percent of service-using homeless people nationwide (Mojtabai, 2005). The Veterans Administration estimates that about 194,000 veterans were homeless in the United States on a given night in 2005 (GAO, 2006). Approximately 25–30 percent can be classified as chronically homeless (Dougherty, 2006).

The client characteristics of people enrolled in programs designed to serve the chronically homeless population indicate that about three out of four are men (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic

Homelessness, 2006). The predominance of men among the ranks of homeless single adults is underscored by the NSHAPC study, in which men outnumbered women by about 4 to 1 (Burt et al., 2001).

Although numerically a minority, single homeless women have been found to experience a greater number of stressful life events compared to homeless single men and women with children, and to more often report histories of foster care placement during childhood, domestic violence, psychiatric hospitalization, and sexual violence in adulthood (Zugazaga, 2004). The majority of homeless women are mothers, but many are considered "single" or unaccompanied adults because they are no longer living with their children (Burt et al., 2001). Mothers who are homeless for more than a year are more likely to lose custody of their children, and therefore they are less likely to qualify for public entitlements (welfare) or other forms of support that may be available to families with children. Compared to other homeless mothers, those living without their children are more likely to have a current substance use disorder (Zlotnick, Robertson, & Tam, 2003; Zlotnick, Tam, & Bradley, 2006). The accumulation of traumas experienced in adulthood by homeless women, including physical assault, rape, incarceration, and long-term homelessness, has been found to be associated with living apart from their dependent children (Zlotnick, Tam, & Bradley, 2006).

Racial and ethnic minorities are overrepresented among sheltered homeless individuals (see NYCDHS, 2006; Kuhn & Culhane, 1998) as well as among users of homeless services (Burt et al., 2001). The client characteristics of people enrolled in programs designed to serve people who are chronically homeless indicate that about half are African American (Barrow, Soto, & Cordova, 2004). Recent studies have underscored the overrepresentation of African Americans among people who are homeless and mentally ill (Whaley, 2002; Folsom et al., 2005), and among those who experience shelter reentry (Min, Wong, & Rothbard, 2004).

Programs designed to serve people who are chronically homeless report that the average age of program participants is the mid to late 40s (Barrow, Soto, & Cordova, 2004; Robert Rosenheck, personal communication based on unpublished data; Collaborative Initiative to End Chronic Homelessness, 2006). There are indications that the population with long-term spells of homelessness is growing older (North et al., 2004; Hahn et al., 2006). In a serial cross-sectional study of homeless adults recruited from San Francisco service programs over a 14-year period, Hahn et al. (2006) reported that over this time span the median age of homeless adults increased significantly from 37 to 46 years, accompanied by a significant increase in the median time homeless from 12 months to more than 39 months.

Risk Factors for Chronic Homelessness

Few long-term studies of the course of homelessness following initial housing loss have been carried out. However, available information on the characteristics of those who end up homeless for long periods of time indicates that older age, persistent unemployment, poor family support, arrest history, poor functioning and coping skills, a history of placement in the child welfare system, and recent victimization are important factors in determining the risk for chronic homelessness.

Caton et al. (2005) examined risk factors for chronic homelessness among newly homeless men and women admitted to New York City shelters for single homeless adults. Participants were interviewed upon entry into the shelter and followed for 18 months. A longer duration of homelessness was related to older age, past or current unemployment, a lack of earned income, poorer coping skills, less adequate family support, a history of substance abuse treatment, and an arrest history. The most important

predictors of long-term homelessness were older age and arrest history. Park, Metraux, and Culhane (2005) reviewed administrative data on a cohort of over 11,000 sheltered homeless adults from the New York City Department of Homeless Services, the agency that oversees the shelter care system, and the New York City Administration for Children's Services, the agency responsible for placement of children through the child welfare system. A history of placement in the child welfare system was associated with an increased likelihood of repeat stays in the adult shelter system. Importantly, Lam and Rosenheck (1998) found that recent victimization negatively impacts both duration of homelessness and quality of life, suggesting a critically important role for trauma-informed services in homelessness prevention as well as in interventions for people who are chronically homeless.

Further understanding of chronic homelessness risk can be gleaned from studies of homelessness onset in which homeless people are contrasted with people who have never experienced housing loss. These studies identify how the characteristics of homeless people differ from the characteristics of other people who have extremely low incomes but seem to manage without becoming homeless. It has been suggested that mental illness may play a role in initiating homelessness for some people, but it is not likely that mental illness alone functions as a risk factor for future housing loss (Sullivan, Burhham, & Koege, 2000). Among factors that distinguish homeless people from stably housed people, substance abuse ranks high (Drake et al., 1991; Susser et al., 1991; Caton et al., 1994; Caton et al., 1995; Goering, 1998; Caton et al., 2000; Winkleby & White, 1992; Early, 2005; Folsom et al., 2005; Whaley, 2002).

In a study contrasting homeless people with a matched, never-homeless sample, North et al. (1998) found that *chronicity* of homelessness was associated with symptoms of alcohol use disorder, schizophrenia, and antisocial personality disorder, as well as an earlier age of onset of drug use disorder and Axis I and Axis II psychopathology. The association of homelessness and Axis I disorder has also been reported by Folsom et al. (2005). For people suffering from illnesses such as schizophrenia, for which ongoing use of services is indicated, homelessness has been found to be associated with decreased use of needed services (Caton et al., 1994). Family experiences, such as out-of-home placement in childhood (Susser et al., 1991; Caton et al., 1994; Winkleby & White, 1992; Park, Metraux, & Culhane, 2005), parental and family instability (Caton et al., 1994), poor care from a parent (Herman et al., 1997), and inadequate family support in adulthood (Caton et al., 2000) have been found to be another domain that has distinguished homeless people from those who are stably housed. In the Zugazawa (2004) study, nearly one-third of single homeless women had histories of foster care placement in childhood.

Finally, characteristics reflective of opportunity differences, such as educational achievement (North et al., 1998; Caton et al., 2000), have been found to distinguish homeless individuals from never homeless people in cross-sectional studies. Mojtabai (2005) studied self-reported reasons for homelessness among people defined as mentally ill in the NSHAPC study and those not defined as mentally ill. Both groups attributed their homelessness to inadequate income support, unemployment, and the lack of appropriate housing. Findings underscore the important role of structural solutions, such as expanding the availability of adequate and affordable housing, creating job training and work opportunities, and ensuring that entitlement income is at a level to meet basic needs, in the prevention of long-term homelessness.

Patterns of Service Utilization Among People Who Are Chronically Homeless

The health, personal, and economic challenges that chronically homeless individuals face and the lack of effective, coordinated services to address these problems often lead to a vicious circle of housing instability and further deterioration of well-being. These individuals are often prevented from stabilizing in housing by their health conditions, while their persistent homelessness impedes their access to needed

health and employment services. Consequently, they cycle through costly emergency-driven public systems, including emergency shelters, hospital emergency departments, detoxification centers, and criminal justice facilities, without getting the ongoing care they need to address severe mental illness, substance use disorders, or chronic health conditions (Proscio, 2000; Kushel, 2003; Kushel et al., 2005; Thornquist, 2002).

High Rates of Shelter Use, Inpatient Hospital Stays, and Emergency Room Visits

As would be expected given their long-term homeless status, people who are chronically homeless spend a disproportionate number of days in the shelter system compared to those who are homeless for shorter periods of time. Chronically homeless people are likely to be about half or more of individuals included in cross-sectional samples of homeless people living in shelters or on the streets, while they only comprise about 20 percent of all the people who use shelters over a three-year period (Metraux et al., 2001).

In addition, people who are chronically homeless are high utilizers of emergency and inpatient hospital services for medical, substance use, and mental health conditions. In Philadelphia, homeless mental health patients used more psychiatric acute care hospital days, outpatient emergency-crisis intervention services, substance abuse treatment, and inpatient hospital care for medical conditions than non-homeless mental health patients (Kuno et al., 2000). In San Diego, Folsom et al. (2005) found that homeless patients with severe mental illness were ten times more likely than housed consumers with severe mental illness to use crisis residential treatment and four times more likely to use inpatient psychiatric hospitals and psychiatric emergency units; however, they were less likely to use outpatient mental health services. In the same study, it was found that homeless people with schizophrenia who have a physical illness are less likely to be admitted to a hospital during the early, less severe phase of their illness and more likely to be admitted when the disease is more advanced and severe.

As the chronically homeless population ages, individuals are increasingly likely to visit a hospital emergency department or to have experienced an inpatient hospitalization for a medical problem in the prior year, reflecting increasing rates of chronic medical conditions in addition to high rates of mental health and substance use disorders (Hahn et al., 2006). Garibaldi, Conde-Martel, and O'Toole (2005) found that homeless persons over age 50 were 3.6 times more likely to report two or more chronic medical conditions, 2.4 times more likely to be dependent on heroin, and 1.8 times more likely to abuse alcohol.

Studies of frequent users of health care services also provide some additional clues that homelessness may lead to frequent and inappropriate use of hospital services. As part of the Frequent Users of Health Services Initiative, six California communities developed data on the number and characteristics of their frequent users.[1] Each community identified a core group of individuals who repeatedly used hospital emergency departments (in some cases weekly), often for medical crises that could have been avoided with appropriate, ongoing care. Sometimes the presenting issue is not a medical crisis, but is related to a chronic health condition, mental illness, or a psychosocial issue, such as drug or alcohol use. Analyses of data related to these patients found that while the prevalence of patient characteristics varied from one county to another, high rates of mental illness, substance abuse problems, and homelessness were common. Among frequent user patients, 25 percent to 58 percent were homeless or lacked stable housing. Many were hospitalized but often failed to receive follow-up care and the social supports that could lead

[1] The Frequent Users of Health Services Initiative is supported by grants from the California HealthCare Foundation and The California Endowment.

to genuine recovery (Corporation for Supportive Housing, 2005). In a study of frequent users of emergency department services at San Francisco General Hospital, 81 percent of study participants, who had five or more visits in the previous 12 months, were homeless. The majority had multiple serious medical illnesses that required ongoing health care (Shumway et al., in press).

Significant Involvement with the Criminal Justice System

Cycling through jail and prison is a common occurrence among people who experience chronic homelessness. Zugazawa's recent study (2004) of sheltered homeless adults, in which 82 percent of men and 52 percent of women had histories of incarceration, illustrates this fact. With changing patterns in systems of public mental health care for people with severe and persistent mental illness, the significance of the criminal justice system has grown more prominent (Freudenberg, 2001). Indeed, it has been suggested that jails are de facto assuming responsibility for the care of a seriously disabled group whose needs cross over multiple systems of care. Metraux and Culhane's (2004) analysis of administrative data on persons released from state prisons to New York City revealed that among persons released with a prior history of shelter use, 45 percent reentered the shelter system following release from prison. Most shelter reentries occurred within a one-month period following release. Homelessness occurring in the post-release period was apparent among former inmates with histories of mental health treatment. Kushel et al. (2005) have reported elevated health risks, including drug use, HIV infection, HIV risk behaviors, and mental illness among homeless and marginally housed former prisoners. McNiel, Binder, and Robinson (2005) have observed that incarcerated people with histories of homelessness, mental illness, and substance use disorders experience an increased duration of incarceration.

Low Rates of Engagement and Retention in Outpatient Mental Health Services, Substance Abuse Treatment, and Appropriate Health Care

While chronically homeless individuals have high rates of emergency service utilization, they are generally unable to access and engage in ongoing outpatient treatment for mental illness, chronic health conditions, and substance use disorders. According to Fortney et al. (2003), homeless people with mental illness are more likely than other mental health consumers to experience less continuity of care as measured by longer duration between encounters for mental health services, lower volume of service encounters, fewer types of services received, lower likelihood of receiving continuous care from the same facility/provider, and lower likelihood of having a case manager. The authors note that low continuity of outpatient care over time puts people who are homeless and mentally ill at risk for encounters with other less appropriate elements of the service system, such as hospitals and emergency departments, as well as placing them at risk for encounters with the criminal justice system. This is confirmed by other studies that consistently document inefficient patterns of utilization among homeless patients with mental illness—more days of acute psychiatric hospitalization, greater utilization of services in the psychiatric emergency units of hospitals, and more infrequent use of outpatient mental health services (Kuno et al., 2000; Rosenheck et al., 2003; Folsom et al., 2005).

Similarly, homeless individuals are more likely to cycle in and out of emergency and residential substance abuse treatment services and often find it difficult to maintain participation in outpatient settings. Homeless participants in substance abuse treatment services are more likely than other participants to receive detox or residential treatment and more likely to have had multiple episodes prior to the current treatment episode (Office of Applied Studies, SAMHSA, 2006). Homeless participants who enter substance abuse treatment programs are often unable or unwilling to complete the program. Studies of a range of treatment interventions found only about one-fourth (Castillo et al., 2005) to one-third (Orwin et

al., 1999) of participants complete substance abuse treatment programs, even when the programs are specifically designed for homeless people with serious substance use problems.

Providing housing in conjunction with treatment significantly increases client retention (Orwin et al., 1999) and improves treatment outcomes (Kertesz et al., 2006). The National Institute on Alcohol Abuse and Alcoholism Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Individuals tested 23 interventions in 14 sites. Eight of these sites offered some form of housing for one or more intervention groups, including residential treatment programs, supervised transitional housing, or other residential arrangements for treatment program participants. (This broad range of housing and treatment models included, but was not limited to, supportive housing, which is discussed later in this paper.) Discharge policies ranged from "zero tolerance to zero consequences" for relapse. Researchers found that all of the interventions lost two-thirds or more of participants prior to program completion, while residential interventions retained more individuals than nonresidential programs. In addition, homeless participants were more likely to complete treatment programs that are less intensive, more flexible, or designed as relatively brief (three to four months) interventions (Orwin et al., 1999). And while treatment-ready homeless clients may prefer intensive programs, others (the majority of chronically homeless people) are likely to stay longer in low-demand programs (Orwin et al., 1999).

In a study of long-term housing and work outcomes among homeless people who were using cocaine, Kertesz et al. (2006) compared outcomes for program participants who had been randomly assigned to live in a furnished apartment contingent upon drug abstinence, similar housing not contingent upon abstinence, and no housing during participation in a 6-month treatment program. Even though both housing interventions were available only during the 6-month period coinciding with treatment (a time frame significantly shorter than that allowed by most transitional housing programs), after 12 months participants who had received housing while in treatment had higher rates of both stable employment and stable housing, when compared to those who had not received housing assistance while in the same treatment program. Even so, the majority of treatment participants were unable to achieve stable housing after completing treatment.

Despite the individual barriers that homeless clients have, however, motivation may also play a key role in success in substance abuse treatment. Interventions to enhance motivation and readiness to change and seek treatment are likely to be helpful (Gonzalez & Rosenheck, 2002).

Among people living with HIV/AIDS, homelessness, active drug use, mental health problems, recent incarceration, and limited social support are all factors associated with an increased likelihood of delayed entry into appropriate medical care and dropping out of medical care, even after controlling for other demographic characteristics and risk factors. HIV-positive persons who are homeless are more likely to engage in high-risk sex and drug behaviors, and are more likely to have a high viral load, recent opportunistic infection, and hospitalization for HIV related disease (Aidala, 2006; Aidala & Needham-Waddell, 2006; Schubert & Botein, 2006).

High Public Costs for Ineffective Care

Emergency and inpatient health and psychiatric services carry a hefty price tag and are often more expensive than the ongoing outpatient and preventative treatment that people who are chronically homeless have a difficult time accessing. Including the costs of shelter use and incarceration, the public costs of chronic homelessness become exorbitant. Culhane et al. (2002) found that before placement into

permanent supportive housing, 4,679 homeless people with severe mental illness used about $40,451 per year per person in services. More than 85 percent of these costs were associated with health care and mental health services—primarily for care delivered in hospital settings. This is the largest study ever completed, but smaller studies in a range of communities found similarly high levels of costs for services to homeless (often chronically homeless) adults with disabilities.

A study of 151 homeless adults with serious mental illness in Baltimore found that total costs per person for in-patient and outpatient health care and treatment services averaged $26,193 to $33,827 (Lehman et al., 1999). Similarly, a pilot study of 35 chronically homeless adults with co-occurring mental illness and substance use problems in Portland, Oregon, estimated that pre-enrollment annual costs for health care and incarceration averaged $42,075 per person. More than 80 percent of total costs were associated with inpatient hospitalizations for medical care and emergency room visits (Moore, 2006). A study of Denver's Housing First Collaborative program (one of 11 projects funded in 2003 through the federal government's Collaborative Chronic Homelessness Initiative) found that the costs of health care services utilized in the two years before participants entered the program averaged $17,381 per participant, and 90 percent of these costs were associated with inpatient or emergency room care.

Studies of persons living on the streets and addicted to alcohol also show extremely high costs for health services (generally related to alcohol-related illness and injury), police intervention and incarceration, and detoxification services while homeless (Cox et al., 1998; Thornquist et al., 2002; Podymow et al., 2006). In San Diego's Serial Inebriate Program (SIP), rates of utilization of emergency room and inpatient hospital care among individuals served by the program were extraordinarily high. Charges for ambulance and hospital care provided to 529 SIP clients over a four-year period totaled $17.7 million, more than $8,000 per year per client (Dunford et al., 2006). Other studies of individuals among this population who were frequent users of detoxification services had very similar findings. In Seattle, medical charges for a sample of 298 people averaged more than $2.5 million per year during the three-year study, also more than $8,000 per year per person (Cox et al., 1998). In Minneapolis, Minnesota, the total annual charges for frequent users of detoxification services averaged $12,771 per person (Thornquist et al., 2002).

Research on Promising and Effective Strategies to Address Chronic Homelessness

The patterns of service use characteristic of chronically homeless people have prompted service innovation to improve the engagement of this vulnerable population in the treatment and housing support services needed to end their residential instability. Creative efforts directed at this objective have involved changing the locus of psychiatric and medical treatment from hospitals and clinics to the street, shelter, and housing settings where people vulnerable to chronic homelessness can be found. Outreach to homeless people living on the street and in shelters, delivery of case management and assertive community treatment services on site in shelters and community housing settings, integration of mental health and substance abuse treatment services, and permanent and transitional supportive housing are some of the innovative efforts to better meet the needs of this disabled population and engage them in a process of recovery and stable tenure in the community. As communities nationwide accelerate their efforts to address chronic homelessness, these innovative efforts can guide program development.

We note that some communities have already made significant strides in establishing a community-wide approach to program development for people who are chronically homeless. For example, the City of

Portland recently reported a 39 percent drop in the number of people sleeping outdoors (City of Portland, 2007). Other cities reporting reductions in street and chronic homelessness include Dallas; San Francisco; St. Louis; Atlanta; Norfolk, VA; and Quincy, MA (USICH, April 18, 2007). Communities that have made significant strides in reducing chronic homelessness have adopted clear goals that guide a communitywide approach that includes some or all of the following program elements, which are often implemented by multidisciplinary teams or multi-agency collaborative partnerships (Burt et al., 2004; City of Portland, 2007).

- **Outreach.** Outreach is a critical first step in connecting chronically homeless people with the services they need. Many communities have restructured these efforts to include multidisciplinary teams designed to increase engagement, develop positive relationships with clients, and more effectively link them with housing, treatment services, and other resources. A small but growing number of communities have empowered outreach workers to immediately offer chronically homeless people direct access to permanent housing, targeting housing opportunities to people who have been living on the streets or in shelters for the longest periods of time.
- **Housing.** Housing with attached supportive services is designed to help ensure residential stability for chronically homeless people coming directly from the streets or shelters. A range of different models provides this type of housing, including permanent supportive housing and Safe Havens. In addition, some housing is available for people who have not yet achieved sobriety or stability. These housing models do not require participation in treatment or other activities as a condition of entering or keeping housing if tenants are otherwise meeting the requirements of any leaseholder.
- **Discharge planning.** Given the frequency with which chronically homeless people cycle between institutions and life on the streets or in emergency shelters, effective processes for discharging people from jails, treatment facilities, and hospitals can provide opportunities for engaging chronically homeless people as well as preventing chronic homelessness for some of the most vulnerable homeless adults with disabilities. Effective strategies properly assess clients' service needs, help them make connections with service providers upon release, and arrange for appropriate post-release housing as an alternative to discharging people to the streets or emergency shelters.

In the following sections we describe the different approaches in services and housing that have been developed in the past decade and present findings on their efficacy.

The "Evidence-Based" Standard and the Quality of Available Evidence

Increasingly, policymakers have emphasized the value of research data on program efficacy as a necessary factor in the development of mental health services and systems of care. "Evidence-based care" is an approach to classifying research on service outcomes according to the amount and quality of evidence indicating that an intervention is effective (Sackett et al., 2000; Anthony, Rogers, & Farkas, 2004; Drake et al., 2003; Rog, 2004). Typically schemas for classifying evidence-based practices consider large, randomized clinical trials with adequate controls and unequivocal findings to be the highest standard of evidence required for an intervention to be considered evidence based. In fact, much of the recently published work on service innovation targeted at people who are homeless and severely mentally ill falls short of this standard, yet the relevance of the work is apparent in that it has emerged from practice experiences in response to sorely felt unmet needs.

Communities across the country have developed, implemented, and refined a wide range of program models and strategies to address chronic homelessness. Some of these models have been rigorously evaluated and others have been evaluated using less sophisticated methodologies. Some interventions have been implemented widely but little research exists to measure their effectiveness. New services for this population developed over the past decade include adaptations or modifications of established evidence-based interventions that were initially designed and tested for stably housed people with serious mental illness (Burns & Santos, 1995; Hwang et al., 2005), while other program innovations have shown promise based on non-experimental evaluations and have yet to be tested experimentally. Smaller studies of less rigorous design (e.g., comparisons of pre- and post-enrollment data for participants with no control group) and multiple case studies with reported outcomes, consensus of expert clinicians, and unpublished program evaluations, particularly when these sources produce a consistent pattern of findings, may also be considered as additional evidence to determine whether an intervention is considered evidence based (Rog, 2004). Accordingly, this paper will focus on a wide range of studies with relevance to the chronically homeless population, including studies with less rigorous methodologies and "practice-based evidence" emerging from the experience of providers and practitioners.

Effectiveness of Service Interventions in Breaking the Cycle of Homelessness

Outreach to People Who Are Homeless in Streets and Shelters

Outreach was one of the earliest strategies targeted at people residing in street locations, public parks, transportation depots, and other settings not meant for human habitation (Cohen, 1990). Street outreach teams employ an array of approaches to engage people who are mentally ill in a dialogue on eventual involvement in services (Tsemberis & Elfenbein, 1999). Despite anecdotal evidence of the value of street outreach in engaging people in needed treatment and support services and the widespread dissemination of street outreach services, there is as yet no specific strategy of engagement per se that can be considered evidence based. In many cases, repeated brief contacts to establish a relationship often precede an agreement to accept services. Strategies of initial engagement include the offering of food and other concrete services, medical care, and housing. Increasingly, outreach alone is viewed as having limited success potential unless it is combined with housing placement (Burt et al., 2004).

Lam and Rosenheck (1999) have reported that clients enrolled in the Access to Community Care and Effective Services (ACCESS) program (a multisite effort that evaluated the integration of service systems and its impact on outcomes for over 7,000 participants) initially engaged through street outreach, tended to be men with a psychotic disorder who were older and had longer durations of homelessness (living on the streets or in emergency shelter). Shern et al. (2000) conducted a randomized controlled trial to test a psychiatric rehabilitation program for street-dwelling homeless people that consisted of outreach and engagement; an invitation to join the "Choices Center," a low-demand day setting offering food, showers, socialization, and assistance combined with health, mental health, and other services if desired; respite housing in an informal church-based shelter or a staff-supervised YMCA room; and rehabilitation services both on site and in the community to assist individuals in finding and maintaining housing in the community. The control group had standard treatment that consisted of a range of programs including outreach, case management, drop-in centers, health and mental health services, and private and municipal shelters for homeless adults. Compared to the standard treatment group, those in the Choices Center program were more likely to attend a day program, spent less time in the streets and more time in community housing, had less difficulty meeting their basic needs, showed greater improvement in life satisfaction, and experienced a greater reduction in psychiatric symptoms. The research team found that housing was difficult to procure, forcing the Choices program ultimately to develop a supported

apartment program. A significant contribution of the Choices project was that it demonstrated a comprehensive approach to homeless people that began with the process of street outreach and was carried through until the person was successfully housed and off the streets.

Similarly, the provision of mental health and substance abuse treatment services "on site" in shelter settings as a means of engaging people in services has also gained wide currency. A recent study conducted by Bradford et al. (2005) focused on a shelter-based intervention targeted at homeless individuals with psychiatric and/or substance abuse problems. The program consisted of outreach by a psychiatric social worker and weekly visits by a psychiatrist. Findings revealed that individuals receiving the intervention were more likely to participate in substance abuse treatment services than subjects in the control group. Studies of outreach to homeless people living on the street and in shelters remain an important area for further research.

Services to Facilitate the Transition from Shelter to Housing

An innovative program for people who are homeless developed over the past decade, Critical Time Intervention (CTI), has focused on discharge planning for the shelter-based homeless population as a springboard for developing a more comprehensive package of services that includes housing placement and treatment support and post-release follow-up to assist program participants in working through issues in the transition from the shelter to a stable residence in the community. Susser et al. (1997) conducted a randomized controlled trial in which a 9-month time-limited case-management CTI intervention targeted at homeless men with severe mental illness was compared to usual care. Over the 18-month follow-up period, subjects in the CTI group had an average of 30 nights homeless, compared to 91 in the usual services group. The intervention was also found to be cost-effective, yielding a significantly greater net housing stability benefit compared to the control group (Jones et al., 2003). The success of CTI has led to its adaptation for other high-risk groups at critical junctures in their lives, such as discharge from mental institutions, jails, and prisons (Herman et al., in press). Controlled trials of adaptations of CTI are in progress.

Case Management and Assertive Community Treatment for Homeless People with Mental Illness

Various forms of case management and assertive community treatment have gained wide currency in the last quarter century (Morse, 1999). A common denominator of interventions classified as case management or assertive community treatment is that they all provide individualized treatment planning and long-term follow-up to clients with severe mental illness. However, there are important differences in how these programs are defined as well as the results they achieve. Traditional case managers are typically people with a bachelor's or master's degree in social work who provide limited direct care, brokering needed services on behalf of the individual from other providers in the community. In contrast, as originally developed by Stein and Test (see Morse, 1999), assertive community treatment (ACT) is characterized by comprehensive community-based treatment delivered *in situ* by a multidisciplinary team. The team is directed by a psychiatrist but other mental health care professionals provide vital elements of treatment and support. ACT teams have shared caseloads with a limited number of clients, and treatment is provided on a 24-hour open-ended basis, assisting the individual with symptom management, issues in the living environment, relationships with family and friends, and locating and maintaining stable employment.

Models similar to ACT, such as the Continuous Treatment Team (CTT) (see Johnsen et al., 1999), appear to share many elements in common. A study of the fidelity of four case management models to ACT

principles in the ACCESS study found that the four treatment variations were more alike than different (Johnsen et al., 1999). ACT has been studied experimentally and evidence has accumulated concerning its effectiveness in reducing hospitalization (Morse, 1999).

ACT has been applied to the management of people who are homeless and severely mentally ill. Morse et al. (1997) conducted a random assignment study focused on homeless mentally ill persons in which three types of case management were tried: broker case management in which the person's assessed needs were purchased from multiple providers, ACT alone in which services were provided by a treatment team for an unlimited period, and ACT with community workers who assisted with activities of daily living and were available for leisure activities. Findings revealed that both ACT interventions were superior to broker case management on a number of outcomes, including resource utilization, symptomatology, and client satisfaction. ACT alone was associated with longer time in stable housing. Further evidence for the usefulness of ACT for homeless mentally ill adults has been provided by Dixon et al. (1997), whose study demonstrated that this approach improved treatment compliance. In addition, Wolff et al. (1997), in a cost analysis of broker case management versus ACT, found that ACT has superior client outcomes at no greater cost than broker case management, and is therefore the more cost-effective of the two interventions. A meta-analysis of studies of assertive community treatment for homeless people with severe mental illness underscores its superiority over standard case management models in reducing homelessness and improving symptom outcomes (Coldwell & Bender, 2007).

Recent studies suggest that duration and intensity of services can be tailored to the clinical needs of the client. ACT is typically provided to all clients for an unlimited period of time. Rosenheck and Dennis (2001) conducted an analysis of the outcome of homeless patients with severe mental illness in the ACCESS study with varying durations of participation in ACT. Study findings suggested that clients could be discharged from the program to less intensive case management without losing gains in mental health status, control of substance use, housing stability, or employment. Min, Wong, and Rothbard (2004) found that use of vocational and rehabilitative services delivered through case management was associated with a lower probability of shelter reentry after termination in the ACCESS project, suggesting the need to emphasize rehabilitation in the prevention of recurrent homelessness. A study by Clark and Rich (2003) lends support to the notion that service intensity can be calibrated to the clinical needs of the individual without a negative result. This team studied a comprehensive housing program for people who were homeless and severely mentally ill, in which access to housing was guaranteed along with housing support services and case management. The comprehensive housing program was compared to case management only. This quasi-experimental investigation made use of propensity scoring to enable an analysis of how people with different levels of symptom severity fared in each type of program. Findings revealed that persons with high psychiatric severity and high substance use disorder achieved better outcomes with the comprehensive housing program. Persons with low to medium symptom severity and minimal alcohol or drug use did just as well with case management alone.

Adaptations of Assertive Community Treatment for People with Co-Occurring Mental Illness and Substance Use Disorders

Over time the ACT model has been adapted to better meet the needs of homeless people who have co-occurring mental illness and substance use disorders. The efficacy of integrated mental health and substance abuse treatment programs in the management of patients with co-occurring disorders is rapidly becoming established (Drake et al., 2004). Integrated treatment is characterized by treatment of the mental illness and the problem with substance abuse by the same clinician or clinical treatment team. This approach eliminates the need for the client to seek treatment for each disorder from different clinicians in

separate systems of care. Integrated dual diagnosis treatment would seem to be appropriate for people who are difficult to engage in services or who may have problems accessing services located in different sites. Morse et al. (2006) compared costs and outcomes of two types of assertive community treatment for homeless patients with dual disorders. In this investigation, ACT alone was compared to integrated ACT, a program in which treatment for severe mental illness and substance use disorders was provided by the same treatment team. Both treatments were compared to standard care. Patients in both types of ACT programs were more satisfied with their treatment and had more days in stable housing compared to controls. There were, however, no differences in psychiatric symptoms or patterns of substance use. The integrated ACT program had lower total costs than the ACT program alone, suggesting that the enriched ACT team approach is more cost-effective in treating homeless patients with dual disorders. In an another analysis from the same study, Calsyn et al. (2005) found that the treatment approaches had limited impact on criminal justice outcomes, suggesting the need for new, more specialized interventions to reduce criminal behavior among people with dual disorders.

Essock et al. (2006) conducted a random assignment study of two methods of community case management, ACT and standard case management, for delivering integrated mental health and substance abuse treatment services for consumers with dual disorders who were homeless or unstably housed. Clients receiving integrated dual diagnosis treatment in both the ACT and standard clinical case management venues showed steady reductions in substance use and improved in many areas over the course of the study, suggesting that integrated dual diagnosis treatment can be successfully delivered with either community case management approach.

Promising New Approaches to Managing Homeless People with Dual Disorders

In recent years new interventions for homeless people with co-occurring severe mental illness and substance use disorders have been developed. The very fact of their existence attests to the pressing need for approaches that can successfully engage clients in ongoing treatment of this devastating combination of afflictions. Three such innovative approaches, described below, are presented as promising new approaches despite the fact that they are not yet evidence-based.

Dyadic case management. Kirby et al. (1999) used a pair of case managers to address the service needs of homeless men and women with mental illness who were chronically debilitated due to alcohol and drug dependence. The dyadic case management model, developed by Denver's Arapahoe House, is geared to individual need and is characterized by techniques of recruitment and engagement, relationship and skills building, housing stabilization, and advocacy. It is contended that having two case managers builds on the professional strengths of two people rather than one, and that a duo of case managers can more readily ensure continuity of services and provide greater staff safety when carrying out street outreach. Although an evaluation of this intervention is planned, there is as yet no report of the program's efficacy in the scientific literature.

Modified therapeutic community. Therapeutic community models have achieved widespread utility in the treatment of people with serious problems with alcohol and drug abuse. Typically, therapeutic communities are residential settings in which a comprehensive array of services, including psychological, educational, medical, legal, and advocacy, are offered to facilitate a significant change in the lifestyle of the person afflicted with substance abuse and a concomitant reduction in substance use and criminality (De Leon, 2000). Skinner (2005) conducted a quasi-experimental study of a modified therapeutic community located in a homeless shelter serving men with mental illness and substance use disorders, comparing it with a general shelter program serving male veterans with the same co-occurring conditions.

Study data consisted of a retrospective review of closed case records for 70 subjects in each type of shelter. Although the modified therapeutic community showed no clear benefit in this analysis, the established success of this approach in other settings suggests that it may be promising and should be studied further.

Treatment as an alternative to incarceration. Collaborations involving mental health service providers, homeless services providers, and the criminal justice system are growing increasingly more common as it has become clear that these systems of care share a common caseload of clients who cycle among mental hospitals, emergency rooms, detox facilities, homeless shelters, and jails and prisons. San Diego's Serial Inebriate Program (SIP) targets individuals who are chronically homeless and intoxicated in public, often traveling a circuit from jails to emergency departments to a downtown "sobering" center. Service utilization costs for this population are extremely high. When police encounter intoxicated individuals who have had at least five transports to the local inebriate reception center within the past 30 days, they transport them to jail where, for each conviction after the first, they are given progressively longer sentences of time in jail (30 to 180 days). The SIP program offers an alternative to this experience. In lieu of custody, the client can participate in a six-month intensive outpatient clinical intervention program. While successful completion of the program satisfies the conditions of probation, clients who resume drinking or fail to complete treatment face a return to jail where they must complete their sentence. Dunford et al. (2006) conducted a retrospective review of health care utilization records of clients who did and did not participate in the SIP program. At the time of enrollment, the average participant had been homeless for more than 15 years. Treatment was offered to 268 individuals, but only 58 percent accepted. Clients typically accepted treatment only after repeated convictions with longer sentences. Participation in the SIP program was associated with a decline of more than 50 percent in utilization of ambulance, emergency room, and inpatient hospital care. Among those who rejected treatment, there was little change in patterns of health care utilization.

Housing Interventions

The social disability that often accompanies severe and persistent mental illness can interfere with the ability to sustain independent living. In recognition of this fact, supportive housing has evolved over the past two decades as a preferred housing approach for people with severe and persistent mental illness (Rog, 2004) and is now viewed as a best practice for ending chronic homelessness. Broadly defined, supportive housing is independent housing in the community coupled with support services (Rog, 2004). People who have been living on the streets or in shelters for long periods of time often need additional services to stabilize a psychiatric or substance abuse problem that, if left untreated, may inhibit residential stability. Moreover, chronically homeless individuals may find it extremely difficult to engage in a process of treatment without being housed. There is mounting evidence that the combination of housing and treatment is effective in facilitating both housing stability and treatment retention (Burt & Anderson, 2005) and that this approach is superior to treatment alone (Rosenheck et al., 2003). Housing and services combined appear to provide a synergy that helps people who have experienced chronic homelessness to achieve more stable and independent lives.

As defined by HUD's Homeless Assistance Programs, supportive housing includes both transitional and permanent supportive housing programs, as well as Safe Havens, which can function as either permanent or transitional housing. These programs are targeted to homeless individuals with disabilities, and many grants awarded in recent years are specifically targeted to projects that serve chronically homeless people. At this time only homeless people who are coming from the streets or emergency shelters are eligible to

move into permanent supportive housing that is funded through HUD's Homeless Assistance Programs, although supportive housing funded from other sources may have different eligibility provisions. Homeless people with disabilities and homeless families may be eligible for transitional housing. The Department of Veterans Affairs (VA) also funds transitional housing programs for homeless veterans, as well as supportive services coupled with HUD-funded rental assistance, in a program called HUD-VA Supported Housing or HUD-VASH. Other federal, state, and local government programs are also used to fund transitional or permanent supportive and affordable housing for people who are homeless or at risk of homelessness and for low-income people with disabilities or other special needs, including targeted programs that fund housing for adults with HIV/AIDS (often with co-occurring mental health and/or substance use problems).

Most frequently, research has focused on program models that combine housing and services that have been developed for adults with serious mental illness who are homeless or at risk of homelessness, and often study participants include people who also have co-occurring substance use problems or other health conditions. There is also some research that focuses on housing for adults with HIV/AIDS and housing for those with serious long-term problems with substance use, particularly a group that has been described as chronic public inebriates.

Increasingly, supportive housing programs have been adapted specifically to improve access and effectiveness for people who have experienced chronic homelessness. The housing models that are most directly relevant to the needs of chronically homeless people include transitional housing, permanent supportive housing, and Safe Havens. First, we describe these housing models and review their similarities and differences. Then we present evidence on their efficacy.

Common Characteristics of Supportive Housing Models

Supportive housing has become a key program model for homeless assistance and mental health systems throughout the country. Supportive housing can be provided in a single-site model where all or most of the units in an apartment or SRO building serve formerly homeless people and many of the services are provided on site; in a scattered-site model where tenants access rent-subsidized units on the open market and services are coordinated by case managers; and a hybrid model in which a single site mixes supportive housing with regular affordable housing (Corporation for Supportive Housing, 2004; Burt, 2005). Transitional and permanent supportive housing share the following characteristics:

- **Appropriate targeting.** Housing is targeted to people who are homeless or are at risk of homelessness and who are experiencing mental illness or other chronic health conditions or challenges that would affect their ability to achieve residential stability.

- **Affordability.** Tenants usually pay no more that 30-50 percent of their income in rent.

- **Range of services to meet a diversity of needs.** Services generally include coordinated case management, life skills, help in setting up a household, and tenant advocacy. Health and mental health treatment, substance use management and recovery, peer support, vocational and employment services, money management, and other supports may be provided directly or by facilitating linkages to appropriate community services.

Differences in Supportive Housing Models

Supportive housing models vary across a number of dimensions. Generally, variation along these dimensions exists between transitional and permanent models, although it often exists within models as well.

Housing first versus requiring housing readiness. The housing first model is generally defined as a program that places people directly into affordable housing without requiring that tenants be "housing ready" prior to entry. High-threshold housing readiness admission criteria require, for example, that prospective tenants demonstrate several months of sobriety, basic living skills and personal hygiene, and a high level of motivation to participate in treatment or case management services and to manage symptoms of mental illness. A known limitation of the housing readiness approach is that a majority of those who are chronically homeless, even among those who have participated in treatment or transitional programs that are intended to prepare them for housing, may not be able to meet these demands (Barrow & Soto, 2000; Barrow, Soto, & Cordova, 2004; Kertesz et al., 2006). Safe Havens use a housing first approach, and a growing number of permanent supportive housing programs are adjusting admission criteria to move toward a housing first approach (Burt et al., 2004; Burt, 2005; Tsemberis, 1999), although programs vary widely on this dimension.

The extent to which a "low demand" environment is created. Often implemented as part of a housing first model, a low demand approach does not place any requirements on a tenant that are outside of the normal conditions of tenancy, including paying the rent, not destroying property, and refraining from behavior that would harm other tenants. Housing programs that utilize a low demand approach strike a balance between helping individual tenants—even the most troubled—achieve housing stability, and enforcing rules that prohibit illegal activity and protect the safety of other tenants and their neighbors. This philosophy extends to the delivery of services in housing. Although participation is certainly encouraged in low demand programs, services are not mandatory and instead are based on consumer choice.

Some of the characteristics of housing-first/low demand models, in contrast to high demand housing models, are described in Exhibit 1. There is a wide spectrum of what constitutes "low demand." For example, some programs may require a low level of service participation (e.g., one or two meetings with a case manager every month), but not link that participation directly to tenants' ability to keep their housing. A low demand approach is used in Safe Havens as well as in many permanent supportive housing programs designed for people who are chronically homeless. There can be a range of approaches in permanent supportive housing (Burt, 2005; Lipton et al., 2000; Tsemberis, Gulcur, & Nakae, 2004). Transitional housing tends to be more structured and requires participation in treatment or work programs, regular appointments with case managers, and continued efforts to find permanent housing.

Intensity/richness of services. This dimension refers to the breadth and depth of services available to program participants and the staff/client ratios. Safe Havens tend to have a very rich set of services and low staff/client ratios, in part because of the small size of these programs. In permanent supportive housing and transitional housing models, service intensity can vary greatly from project to project depending on the target population, program goals, and service financing.

Permanency of housing. This dimension refers to whether participants/tenants may stay in housing indefinitely or whether they are encouraged or required to leave after a certain period of time. The goal of

Exhibit 1

Characteristics of Housing Programs That Serve Chronically Homeless Adults

Housing First/Low Demand	High Demand
1. How and when do chronically homeless people get into housing?	
• Sobriety and/or participation in treatment or other services *not* required as a condition of getting or keeping housing; consistent with consumer/homeless person's perspective that housing is an immediate need • "(Pathways) posits that providing a person with housing first creates a foundation on which the process of recovery can begin. Having a place of one's own may—in and of itself—serve as a motivator for consumers to refrain from drug and alcohol abuse" (Tsemberis, Gulcur, & Nakae, 2004) • Helping consumers to get and keep housing is seen as the top priority for program/staff • Minimize barriers to access (e.g., less complex application processes, no/few conditions impinge on autonomy); e.g., in some housing/Safe Havens programs designed for chronically homeless persons with serious mental illness or complex co-occurring health conditions, most tenants move into housing within 3 months of application • Tenants are assisted to develop skills for independent living while they live in permanent housing settings	• May require engagement with multiple programs at different stages as part of pathway out of homelessness; programs may be structurally segmented and/or transitionally oriented • Skills for independent living are developed in transitional settings; services focus on enhancing the homeless person's "readiness" for housing • Screening for willingness to participate in treatment or supportive services and to comply with program rules as a condition of entering housing
2. Service approach	
• Participation in services or structured activities not required • Services individualized and tailored to self-identified needs and goals using a "whatever it takes" approach • Assistance is offered for a range of needs and goals including practical material needs (food, clothing, etc.) before expecting that people will engage in more complex case management services (e.g., to establish eligibility for financial benefits) as well as clinical supports or treatment for health, mental health, substance use problems • Continuity of relationships with primary service provider or interdisciplinary team that directly provides most services needed • Peer-based recovery services emphasize consumer empowerment and self-direction	• May require participation in standardized program of services, or specified service intensity (e.g., frequency of contact with case manager or scheduled group activities or individual counseling) • Services may include monitoring and dispensing medications • Services may be provided directly by on-site staff and/or by brokering linkages to other community service providers • For persons with current or past substance use problems, participation in AA/NA groups may be strongly encouraged, with mandatory referral to detox or residential treatment programs in response to relapse • Peer-based recovery services emphasize sobriety
3. Housing characteristics and staffing	
• Legally binding leases • Housing management and supportive services roles are clearly separate and performed by different staff or organizations • Housing usually individual units (SRO or apartments in multi-unit building, or scattered-site units in privately owned buildings) • Buildings are more likely to have mixed tenancies (disabled and non-disabled tenants) • Tenants prepare their own meals in private or shared cooking facilities • Supportive services staff available during the day and some evenings and/or weekends; overnight staffing as needed for building security (not supportive services)	• Leases or occupancy agreements contain addenda that specify requirements for service participation, etc. • Housing management and supportive services functions may be blended and performed by the same staff or organization. • Housing is more likely to be licensed and/or exclusively serving people with identified special needs (e.g., serious mental illness) • Housing may be congregate (shared living arrangements) or rooms/apartments in multi-unit buildings • Meals often provided • Supportive services staff may be on-site 24 hours a day, 7 days a week

Exhibit 1 *continued*

Characteristics of Housing Programs That Serve Chronically Homeless Adults

Housing First/Low Demand	High Demand
4. Rules and requirements	

• High level of tolerance for behavior; responses to problem behaviors are graduated and individualized
• Evictions or other sanctions for rule violations or problem incidents primarily focus on violence or threats of violence against staff or other residents, attempting to make drug transactions, illegal or criminal activity at (or nearby) the housing or program facility, property damage or destruction, violations of visitor-related policies, serious problems with hygiene (personal and/or housing unit)
• Overnight guests permitted with limitations consistent with landlord-tenant law (e.g., limit number of days to avoid establishing occupancy/tenancy rights) and/or consideration of needs of other tenants
• Visitor policies including sign-in procedures and limits on visitors (e.g., number of guests or limits on overnight guests) are intended to protect safety and quiet enjoyment of premises by other tenants
	• Adherence to behavioral norms and/or sobriety and/or completion of treatment or transitional program may be required as condition of eligibility for housing and/or other benefits or opportunities
	• Some/all the following restrictions may be imposed as condition of tenancy:
	  • Curfews
	  • Overnight guests not permitted
	  • Money management mandatory
	  • Medications dispensed or monitored
	  • Attendance at structured day activity (work, day treatment, educational program) required for 20–30 hours a week
	• Occupancy or program participation may be terminated if tenants (clients) possess or consume alcohol and/or other drugs either on-site in their residence or off-site in the community. In some projects, termination or eviction is the sanction for failure to maintain complete abstinence, while in other projects multiple relapses will lead to eviction or termination

5. Significant modifications in some programs	
• Participation in money management required and tenants must meet with a staff member a minimum of twice a month (Pathways) • Other supportive housing programs may offer representative payee or money management services to tenants but do not require participation, or participation requirements are limited (e.g., during the initial occupancy period or to resolve lease violations related to non-payment of rent) • A majority of Safe Havens programs (responding to national survey) prohibit use of alcohol or other drugs on-site, although most do not prohibit use off the premises • Staff may be available 24 hours a day, 7 days a week to manage safety and security for all residents in the building, strengthen tenant confidence in staff availability to manage crises and emergencies, facilitate engagement with residents, and provide informal support to those who are not actively following a treatment plan	• Some of these characteristics/rules exist but may be applied more flexibly • Multiple warnings are provided and/or multiple episodes of problem behavior (e.g., multiple relapses) are tolerated before tenants are evicted
6. When are tenants expected to move?	
• Tenants are not required to relocate as their service needs or willingness to participate in supportive services change; respite facilities may be available and used during crises or to meet short-term needs for more intensive supports, while preserving tenants' rights to return to their supportive housing unit	• Tenants may be expected to move to more independent housing as their needs for intensive services and/or structure diminish over time • Services and/or housing may be terminated for failure to participate and/or make progress toward service or treatment goals

Citations: Barrow & Soto, 2000; Lipton et al., 2000; Shern et al., 2000; Northwest Resource Associates, 2002; Barrow, Soto, & Cordova, 2004; Tsemberis, Gulcur, & Nakae, 2004; Burt, 2005; Ward Family Foundation; 2005.

Safe Havens and transitional housing is to eventually move people into permanent housing in the community. Safe Havens, however, may function as either transitional or permanent housing and are generally flexible about letting participants stay until they have found other options. In contrast, transitional housing models usually have stricter time limits. For example, HUD-funded transitional housing programs generally expect residents to move within 24 months. Some transitional housing programs offer tenants the opportunity to "transition in place," meaning that tenants may remain in the same housing unit after their participation in a transitional housing program ends, as they assume responsibility for paying rent, and in some cases qualify for other types of ongoing rental assistance from other housing programs. Permanent supportive housing does not have time limits or requirements that tenants move to other settings. Permanent supportive housing programs may allow tenants with the most severe mental health or substance use disorders to maintain a home they can return to after a temporary hospitalization or a stay in a treatment facility.

Exhibit 1 outlines major differences between housing-first/low demand and high demand supportive housing models, elaborating on what has been discussed above. The most well-known, rigorously evaluated and widely replicated housing first / low demand program is Pathways to Housing (Tsemberis et al., 2004), which uses a scattered site model. Other site-based housing first / low demand programs for chronically homeless adults have been described, including Seattle's Lyon Building and 1811 Eastlake projects, California's Health, Housing and Integrated Services Network, and San Francisco's Direct Access to Housing Program. As shown in Exhibit 1, these programs share many characteristics but there is some variability in the implementation of these approaches.

Research and published reports often highlight the differences between these two models, but in practice many supportive housing projects incorporate elements of both housing first/low demand and high demand approaches. For example, a housing program may target people who have been living on the streets for many years, but may require that they first engage in case management services for a period before being offered housing. Some programs may require a low level of service participation (e.g., one or two meetings with a case manager every month), but not link that participation directly to tenants' ability to keep their housing. Some programs offer tenants opportunities for repeated short stays in interim or transitional housing, which may require that tenants leave the housing if they are disruptive or use alcohol or drugs on site, but allow tenants to return to housing again when they are willing to comply with program rules, and move on to more permanent housing as they achieve greater stability. Low demand housing programs often use a variety of strategies to assertively engage tenants in supportive services and strongly encourage participation, particularly when a tenant's behavior is disruptive to others or may lead to eviction, or when there are concerns that symptoms or problems related to health, mental health, or substance abuse are worsening.

Efficacy of Housing Interventions

Transitional housing. Transitional housing programs funded by HUD serve more than 20,000 chronically homeless people each year, approximately 20 percent of those served by these programs. Most of HUD's transitional housing programs primarily serve homeless families or adults who have been homeless for shorter periods of time (Mark Johnston, personal communication, November 2006). To date, very little information is available on the efficacy of this program model for chronically homeless adults. It is not presently known, for example, how many chronically homeless people move from transitional housing to other stable permanent housing. Information is also lacking on the characteristics of those for whom this program model is successful in contrast to those for whom this model has failed. Nearly all of the research on transitional housing has focused on programs that serve homeless families.

While most transitional housing programs primarily serve people who are not chronically homeless, some transitional housing programs have been adapted to engage chronically homeless people who are ambivalent about services and pique their interest in seeking housing. Two transitions are involved in these programs. The first transition is from the streets or emergency shelters into the program, and the second transition is from the program into permanent housing. In settings where permanent supportive housing has high threshold housing readiness requirements, transitional housing programs may provide opportunities for people who are chronically homeless to demonstrate that they are ready to leave the streets and undergo a period of documented sobriety and participation in supportive services in preparation for permanent housing.

Because transitional housing programs are designed to help homeless people move toward more permanent housing, they often require residents to attend treatment or work programs, meet regularly with case managers, and make progress toward achieving goals related to "housing readiness." While this structure may be effective for some people who are chronically homeless, others may be unable or unwilling to accommodate to these demands and requirements.

Some transitional housing programs that have been specifically designed or adapted for people who are chronically homeless have incorporated low demand program models that use program strategies including:

- assertive but patient engagement to overcome barriers resulting from mistrust, isolation, and the symptoms of mental illness or addiction;
- identification of participants' unmet needs, preferences, and goals;
- establishment of trusting relationships, which often begins by providing concrete support for basic needs (food, clothing, etc.);
- training or coaching in basic living skills and personal hygiene;
- mental health and substance abuse treatment services (provided directly or through close linkages to community services);
- allowing a series of short stays or moves between programs that offer varying levels of support and requirements for participation and sobriety;
- assistance with accessing benefits or income; and
- encouragement and help to find and meet eligibility requirements for permanent housing (Barrow & Soto, 1996; Barrow & Soto, 2000).

The intention of transitional programs that use this approach is to build trusting relationships and engage even the most chronically homeless individuals in the service system, thus facilitating access to needed care and treatment and preparation for permanent housing (Barrow, Soto, & Cordova, 2004). Transitional housing has also been used as a technique to increase the effectiveness of substance abuse treatment programs, even when housing is not conditional upon abstinence (Kertesz, 2006). Transitional housing programs have limited effectiveness in helping participants achieve housing stability when permanent housing programs have complex and stigmatizing admissions procedures and program requirements that include evidence of sustained sobriety or a willingness to participate in treatment or other structured activities as a condition of tenancy (Barrow & Soto, 2000; Barrow, Soto, & Cordova, 2004; Kertesz, 2006).

Permanent supportive housing. Permanent supportive housing has gained considerable attention from practitioners and policymakers in the last 10–15 years, in part because of numerous research studies demonstrating its effectiveness in increasing housing stability (Barrow, Soto, & Cordova, 2004; Rog, 2004; Lipton et al., 2000; Shern et al., 2000; Tsemberis & Eisenberg, 2000) and decreasing shelter use, incarceration, inpatient hospital stays, and visits to the emergency room (Culhane, 2002; Martinez & Burt, 2006; Rosenheck et al., 2003).

Permanent supportive housing is the combination of permanent, affordable housing with supportive services aimed at helping residents maintain housing stability. While not all such programs are the same, the shared components that are most likely to distinguish permanent supportive housing from transitional housing include the following:

- ***Voluntary services.*** Participation in services is usually not a condition of ongoing tenancy in permanent supportive housing.[2]

- ***Tenants hold a lease.*** The tenant has a lease or similar form of occupancy agreement so as not to set a limit on the length of time a person can stay in housing.

- ***Systems integration.*** A working partnership exists between the service providers, property owners or managers, and/or housing subsidy programs.

The New Freedom Commission on Mental Health (2003) recommended the creation of 150,000 units of permanent supportive housing to end chronic homelessness among people with mental illnesses and their families, and HUD established the goal of creating 40,000 new units of permanent supportive housing for chronically homeless people during the five-year period from 2005 to 2009. As states and communities across the nation developed their own plans to end homelessness, they adopted ambitious goals for creating additional affordable and supportive housing, including (as of November 2006) a total of 80,000 units of permanent supportive housing (NAEH, 2006b).

From 1996 to 2005 the number of units of permanent supportive housing for homeless people in the U.S. nearly doubled, from 114,000 to 208,700 (HUD, 2007). Between 2002 and 2006, approximately 37,500 units of permanent supportive housing were created using funding provided through HUD's McKinney-Vento Homeless Assistance Grants Programs. Eligibility for this housing is restricted to homeless persons with disabilities, which may include mental illness or substance abuse.[3] In recent years new supportive housing created through this program has been targeted to people who are chronically homeless.

Permanent supportive housing is also funded from other sources (including other "mainstream" federal and state housing programs as well as targeted programs funded by states and local governments). Some of this supportive housing, particularly housing funded by state and local mental health authorities and mainstream housing programs, serves people with disabilities who are homeless or at risk of homelessness, but not chronically homeless. Reflecting this variability in eligibility and target

[2] This is probably the most controversial component of supportive housing, and there are many philosophies about the best way to approach this issue and substantial variations in practice among permanent supportive housing programs.

[3] These include the Shelter Plus Care (SPC), Single Room Occupancy (SRO), and Supportive Housing—Permanent Housing (SHP-PH) Programs.

populations, survey results from a range of states and communities indicate that about a third of the permanent supportive housing units are occupied by people formerly chronically homeless (Burt, 2005).

1. ***Housing stability outcomes.*** Evaluations of permanent supportive housing have shown retention rates in the first year of 75–85 percent, even among chronically homeless adults with the most severe mental health and substance use disorders (Barrow, Soto, & Cordova, 2004; Burt et al., 2004; Martinez & Burt, 2006; Wong et al., 2006). About three-quarters of those who enter supportive housing stay for at least two years, and about half are still living there after three to five years (Wong et al., 2006; Lipton et al., 2000). Variability in retention rates reflects several factors, including characteristics of supportive housing tenants, housing, program structure, expectations, and requirements. Because most permanent supportive housing offers tenants the opportunity to return to a permanent housing unit (either the same unit or another apartment) after short stays in a hospital or treatment setting, and some chronically homeless people may return to spend time in shelters or on the streets for a few days as they become accustomed to living in housing, some researchers have also measured housing stability in terms of reductions in the number of days of homelessness or increases in the number of days in housing.

   The likelihood of moving out—often into unstable living arrangements—seems to be greatest during the first few months after tenants move into supportive housing, especially for residents who are living in supportive housing programs with a high degree of program structure and tenant expectations (Lipton et al., 2000). Older age seems to be associated with longer tenure in supportive housing. In some evaluations that consider a range of supportive housing program models, factors related to substance use, including a history of substance abuse and/or active substance use are associated with lower rates of housing stability, especially for homeless people who have moved into highly structured settings that are more likely to evict tenants for relapse in the use of alcohol or other drugs (Lipton et al., 2000; Wong et al., 2006).

2. ***Outcomes on service utilization and cost.*** Evaluations of permanent supportive housing have also attempted to measure changes in patterns of service utilization. Researchers from the University of Pennsylvania conducted a major study of the costs and utilization of public services, including hospitalizations and other Medicaid services, by more than 4,500 homeless adults with serious mental illness in New York City. The study included extensive regression analysis to determine both the costs of services used by homeless persons and the reductions that were attributable to placement in supportive housing. They found significant reductions in the total number of days that tenants spent in shelters (61 percent), inpatient psychiatric hospitals (61 percent), public hospitals (21 percent), VA inpatient hospitals (24 percent), prisons (85 percent), and jails (38 percent). While days in Medicaid-reimbursed inpatient services went down by 24 percent, the number of days of Medicaid-reimbursed outpatient services actually increased by 76 percent, which is probably a result of tenants having better access to more appropriate and preventive healthcare services while housed. Placement into supportive housing was associated with a reduction in services use of $16,281 per housing unit per year, and $14,413 of the service reduction savings resulted from the decrease in emergency and inpatient health and mental health services. The reduced costs associated with these changes in service utilization, when measured on a per diem basis, cover 95 percent of the cost of developing and operating supportive housing (Culhane, Metraux, & Hadley, 2002).

Other studies have shown similar findings:

- A study of two permanent supportive housing projects in San Francisco, targeted specifically to chronically homeless individuals, found significant reductions in the utilization of hospital emergency room and inpatient care. Study participants were 236 homeless adults who had been living on the streets or in emergency shelter for extended periods of time, a large majority (75 percent) of whom had co-occurring mental illness and substance abuse disorders. The study compared service utilization during the 12-month period before and after homeless persons moved into supportive housing. The researchers found a 57 percent reduction in the total number of emergency room visits for this group and a 45 percent reduction in the total number of inpatient admissions (Martinez & Burt, 2006).
- A study of the Connecticut Supportive Housing Demonstration Project also showed a reduction in Medicaid-reimbursed inpatient services while utilization of other services remained stable or increased (Arthur Andersen LLP, 1999).
- Total medical charges for residents in two Minnesota supportive housing programs for chronically homeless persons addicted to alcohol declined by 32 percent to 68 percent in comparisons between the year before and the year after program entry. Medical and hospital visits declined, particularly for visits related to alcohol or injury, and the median number of detox visits declined by 90 percent (Thornquist et al., 2002).
- Findings from Denver's Housing First Collaborative showed that utilization of emergency room services decreased by 34 percent in the two years after chronically homeless people entered the program, while the number of nights of inpatient hospitalization declined by more than 80 percent. Costs for outpatient care increased by 50 percent, resulting in a 45 percent net reduction in total health costs (Perlman & Parvensky, 2006).
- A random assignment evaluation of the HUD-VASH program found less robust reductions in service utilization. Overall the HUD-VASH program was 15 percent more costly than standard care—an average of $45 more for every additional day participants were housed. The program produced savings attributable to participants' decreased use of the shelter system and some changes in patterns of utilization of health services, but participants increased their utilization of mental health services, including homeless case management services provided as part of the program. Other positive outcomes for program group members included greater satisfaction with housing, higher housing quality, larger social networks, and reduced problems related to the use of alcohol or other drugs (Rosenheck et al., 2003; Cheng et al., in press).

3. ***Other health outcomes***. Research on the impact of supportive housing on the health and well-being of chronically homeless people with disabilities has been limited, although some improvements in health may be inferred from the significant reductions in hospitalizations and emergency room visits that have been reported. To date most of the research on supportive housing has measured housing outcomes and utilization of other public services, while there has been little investigation of other impacts such as changes in psychiatric symptomatology or the use of alcohol and drugs. These issues require further study and evaluation. Compelling findings are emerging from research about the relationship between housing and HIV/AIDS, for which measurements of viral load and CD4 cell counts provide objective measures of improved health outcomes. Among homeless people with HIV/AIDS, access to housing is associated with significant improvements in entry into and retention in appropriate medical care, significantly

reduced viral load (increased viral suppression), and increased CD4 count (Schubert, 2006) as well as reductions in high-risk sex and drug behaviors that are associated with transmitting HIV to others (Aidala, 2006; Schubert & Botein, 2006).

4. ***How do outcomes differ among program models and participants?*** Practitioners and policymakers want to know "what models of housing and services work best—and for whom." While findings are far from definitive, available research provides some important clues.

   Importantly, housing retention appears to be greatest when housing is combined with services, regardless of the specific model of housing (Lipton et al., 2000; Rog, 2004; Siegel et al., 2006). However, the duration and intensity of services required to sustain housing requires further study and evaluation.

   It appears that consumers prefer to live in housing that offers opportunities for integration and independence, while service providers more often believe that staffed group homes or other housing with a higher level of support would be more appropriate for consumers with greater clinical vulnerability. Goldfinger et al. (1999) examined the influence of staffed group living sites versus individual apartments for formerly homeless people with mental illness in a random assignment study. Individuals assigned to independent apartments experienced a greater number of days homeless compared to those in staffed group homes—among members of minority groups only. Substance abuse was the strongest individual-level predictor of days homeless. Individuals whom clinicians determined would do best with group living experienced more days homeless, regardless of the type of housing they received. Findings suggest that housing type should be geared to the clinical and social characteristics of consumers in order to achieve optimal housing outcomes. Consumers living in independent apartments report greater satisfaction with their housing and autonomy, but Siegel et al. (2006) found that they also experience greater feelings of isolation when compared to consumers who live in site-based supportive housing with more intensive services.

   There is also evidence that the manner in which housing and services are organized has a significant impact on housing tenure. In a random assignment study of integrated (case management and housing services provided by teams within a single agency) versus parallel housing services (case management services provided by mobile assertive community treatment teams and housing by routine community-based landlords) for adults with severe mental illness who were at high risk for homelessness, McHugo et al. (2004) found that integrated housing services led to more stable housing and life satisfaction compared to parallel housing services, particularly for male participants.

Safe Havens

The vast majority of Safe Havens serve people who are chronically homeless and have been described as "service-resistant." More than 300 Safe Haven programs nationwide have received funding from HUD's McKinney-Vento Homeless Assistance Programs. Safe Havens are generally small programs (on average about 16 residents and generally no more than 25) that may be designed to operate as either permanent or transitional housing (Ward Family Foundation, 2005). Transitional programs generally do not set rigid time limits for exit. These programs are usually implemented by, or in partnership, with a mental health center or agency, and about half of these receive some mental health services funding through contracts or grants from state, county, or city agencies.

Evidence About Housing First/Low Demand Models

Evaluations of housing first and low demand service models have shown increased levels of housing stability when compared with other more high demand models. In one of the most rigorous studies, Tsemberis, Gulcur, and Nakae (2004) randomly assigned participants in New York City with an Axis I diagnosis, a 6-month history of homelessness, and recent street living to receive housing immediately without a treatment prerequisite (housing first group) or to receive housing contingent on sobriety ("continuum of care" control group). Over a 24-month follow-up period, the housing first group spent less time homeless and more time stably housed compared to the control group. The two groups did not differ on psychiatric symptoms or alcohol and drug use. Findings indicated that participants in the housing first group were able to maintain community housing without jeopardizing psychiatric stability or showing symptoms of substance abuse.

Despite the fact that there were no differences in alcohol or drug use, Tsemberis, Gulcur, and Nakae (2004) found that the control group reported significantly greater use of substance abuse treatment compared to the housing first group. This difference increased over time. While rates of participation in available supportive services may be lower when participation is voluntary, studies show tenants in many low demand programs are likely to participate at fairly high rates if supportive services are tailored to their needs. In the evaluation of the Closer to Home Initiative in New York and California, Barrow, Soto, and Cordova (2004) found that even when service participation was not required, supportive housing tenants were engaged in a wide variety of activities including health care services (81 percent), mental health treatment (80 percent), substance abuse treatment (56 percent), money management (65 percent), assistance in applying for benefits (51 percent), and employment services (41 percent). Similarly, an evaluation of the Choices program in New York City found high rates of participation in the voluntary day program services, which included assistance accessing health care and social services and provided an opportunity for participants to socialize (Shern et al., 2000).

Lipton et al. (2000) provides additional evidence that consumer choice and control has a positive impact on client outcomes. The study examined the effectiveness of a variety of different approaches to supportive housing in New York City. The study followed 2,937 tenants and described their outcomes based on whether they were placed into high-, moderate-, or low-intensity housing. Intensity reflected the amount of structure of the program and the degree of independence that tenants had. High-intensity programs were defined as having the most structure and least amount of tenant independence. Although people were not randomly assigned to the different housing models—and some selection bias certainly exists—the study found that those placed in the high-intensity models had the lowest level of housing retention—37 percent after five years compared with 56 percent for moderate-intensity programs (mostly women) and 54 percent for low-intensity programs.

Most Safe Havens have a daily structure and offer activities related to behavioral health, including 12-step meetings, counseling, training in daily living skills, medication monitoring and dispensing, and case management services. However, most programs do not require that residents participate. Safe Havens are generally staffed 24 hours a day, 7 days a week. Programs also offer opportunities for residents to participate in program governance through regular meetings or feedback sessions.

Safe Havens operate under a housing first, low demand philosophy. Nearly all Safe Havens have admissions criteria that are designed to target people who are most likely to be chronically homeless. As such, prospective residents generally are not required to be clean and sober, are not excluded if they have a criminal record, and are not required to participate in developing and carrying out an appropriate treatment plan. While nearly all Safe Havens prohibit the use of alcohol or illegal drugs on the premises, most do not prohibit the use of alcohol or illegal drugs away from the facility, and most expect that a significant number of residents will continue to have problems related to substance abuse. Some Safe Havens require that residents participate in weekly meetings, and some programs have more demanding

service participation requirements. Program rules also prohibit verbal or physical abuse, violence toward other residents or staff, and illegal or criminal activity.

A primary goal of Safe Havens is to connect consumers to permanent housing, avoiding a return to the streets, shelter, hospital, or jail. While outcome data on the efficacy of Safe Havens is limited, one report has indicated that slightly over half of Safe Havens residents exit to permanent housing (Ward Family Foundation, 2005). According to the Ward Family Foundation report, Safe Havens that have achieved higher rates of referrals into permanent housing, compared to Safe Havens with lower referral rates, are:

- smaller programs that provide private accommodations (usually a private room, and often a private bathroom), and they nearly always operate at full capacity;
- more likely to serve homeless people coming from the streets, more likely to require a diagnosis of severe and persistent mental illness plus a co-occurring disorder, and more likely to have no limit on length of stay;
- more likely to provide a psychiatrist at the program and to provide treatment and supports for mental illness at the program site; more likely to have a higher staffing level (on average .5 full-time staff and .3 part-time staff for every resident);
- more likely to provide linkages to vocational and employment services; and
- more likely to exclude individuals with sexual offender criminal records (and a small minority exclude chronically homeless people with felony criminal records) (Ward Family Foundation, 2005).

Discharge Planning

For people with severe mental illness, substance abuse problems, or other disabilities, who do not have a place to live upon discharge from a hospital, jail, or foster care setting, planning for needed housing, treatment, and support services prior to discharge is critically important. Discharge planning efforts often utilize a team or collaborative approach that includes a comprehensive assessment of each individual's needs in advance of the time of discharge, an assessment of housing needs and identification of multiple options, arrangement for follow-up appointments and medications, the engagement and active involvement of the homeless individual in identifying needs and preferences and considering options, a plan that delineates clear responsibilities, and back-up or contingency plans. However, discharge planning has no "teeth" unless the needed housing and services are available in the community (Semansky et al., 2004), and successful discharge planning is contingent upon effective linkages to community housing and services that are available and accessible at the right time (Moran et al., 2005). For some chronically homeless people, the time of discharge offers an important opportunity for engagement, enhancing motivation to change behaviors or circumstances that led to a health crisis or institutionalization, and establishing linkages to housing and ongoing care in the community that can help sustain recovery. Critical Time Intervention (CTI) (Herman et al., in press) discussed previously, is currently being studied in the transition from jail and state hospital settings to the community; findings are not yet available.

Respite or recuperative car*e* is a promising approach to meeting the needs of chronically homeless people at the time of discharge from hospital or other health care facilities. For patients who are not homeless, our nation's health care delivery system has undergone significant changes in recent years. Increasingly surgery and other medical procedures may be performed on an outpatient basis, and hospital stays are shortened for all types of health care. Patients are frequently discharged from the hospital in

need of home-based rest and care (from family members or visiting health care providers) and compliance with complex instructions for wound care, medications, or post-surgery rehabilitation. Homeless patients are particularly vulnerable when discharged from hospitals after emergency or inpatient care, including surgery. A growing number of communities have established respite or recuperative care programs as an alternative to costly extended hospitalizations or discharging patients to the streets or shelters or a short-term stay in a motel room.

Respite or recuperative care programs serve homeless people who do not need to be hospitalized or in a nursing home, but are too ill to be on the streets or in shelters. Programs operate in a range of settings, including free-standing facilities, specialized shelters or transitional housing programs, and beds or units set aside in emergency or transitional housing programs with additional staffing and adaptations to requirements as needed For example, other shelter residents may be required to leave the facility during the day but those occupying respite beds may remain in the facility if they need bed rest. Generally these programs offer short-term housing (a few days or a few weeks) where participants can stay 24 hours a day as needed and receive meals and help with mobility and self-care. Some health care services are provided on site by nurses, a physician or mid-level practitioner, or other health care providers, but these services may be intermittent; for example, nurses may visit several times a day and be on call for emergencies, but limited health care staff are on site during much of the day. Programs also generally offer a range of supportive services and assistance with transportation to medical appointments, while seeking to facilitate long-term housing placements for clients.

One study of the effects of respite care (Buchanan et al., 2006) found a 49 percent reduction in hospital admissions among patients who received respite care, compared to similar patients who received usual care, after adjusting for gender, race, age, diagnosis, and previous utilization of health services. The average cost of respite per hospital day avoided was $706, approximately half the estimated cost of a day of hospital care.

Implications for “Best Practices” to End Chronic Homelessness

Across the country, the federal government, states, and communities have made a commitment to the goal of ending chronic homelessness. In so doing, a wide range of housing and service strategies tailored to the needs of people experiencing chronic homelessness have been developed.

Some important and influential research has been conducted in recent years, and a great deal of program development has been informed by evidence-based practice in the treatment of mental illness, co-occurring substance use disorders, and other health conditions. The development and implementation of innovative programs to address chronic homelessness, particularly for people with severe mental illness, substance abuse, and medical comorbidities, have outpaced the conduct of rigorously designed research studies that examine this population. As a result, while available research suggests promising approaches and implications for practice, it sometimes falls short of meeting the highest standards for defining evidence-based practice.

It will take a more substantial investment in research on homelessness to demonstrate with precision the efficacy of some of these promising practices, and to answer important questions about what works best for whom. Meanwhile, however, a growing number of practitioners and their partners in government and philanthropy are gaining experience in serving people who have had long and repeated spells of homelessness. In some cases consistent patterns and useful insights are emerging from available

information from research studies, administrative data, qualitative and quantitative program evaluations describing outcomes, and expert opinion to suggest "best practices" that can guide the development of housing and services for chronically homeless people. Formative evaluations of promising housing and services innovations can guide the development of randomized controlled trials to firmly establish their efficacy. Here we list best practices based on current evidence presented in prior sections of this manuscript.

Outreach to homeless people who are living on the street and in shelters is often a first step in the process of engagement in the service system for consumers with long histories of servicelessness, but outreach cannot end homelessness unless it is tied to housing placement and support. The transition process from chronic homelessness to permanent housing, however, is likely a critical period that requires further study and evaluation.

Discharge planning needs to be linked to appropriate short-term and permanent housing options and effectively targeted to those most at risk of long-term homelessness. While there is yet no evidence that adequate discharge planning can prevent long-term homelessness for people discharged from psychiatric hospitals, jails and prisons, or foster care settings, the critical juncture of institutional release remains an important area for research and for the development of effective interventions. As demonstrated by Critical Time Intervention, as well as emerging research on medical respite shelter linked to permanent supportive housing, a comprehensive program of housing placement and treatment combined with case management can assist in the transition from a shelter to stable residence in the community. Moreover, tenancy preservation efforts could be initiated in the discharge planning process to prevent homelessness onset when it is apparent that the existing living situation is unstable or inadequate.

Case management and assertive community treatment have been established as optimal techniques for the delivery of mental health and substance abuse treatment services to people with severe mental illness and histories of residential instability. Assertive community treatment that integrates the direct delivery of services to address substance use problems appears to be more cost-effective than assertive community treatment with linkages to parallel substance abuse treatment in the management of homeless people with dual disorders.

Permanent supportive housing increases housing stability and decreases use of costly institutional services such as shelters, hospitals, emergency departments, and jails and prisons.

Housing retention appears to be greatest when housing is combined with services, regardless of the specific model of housing. The needs and preferences of homeless people vary. Some will prefer to live in housing with on-site supportive services, while others may seek apartments that provide opportunities for community integration with people who do not have disabilities or recent experience with homelessness. Supportive services that are individualized and delivered to people in their homes and in community settings can help many people who were previously chronically homeless succeed in their own living setting, wherever that may be.

Housing type (e.g., supportive housing with on-site services or independent apartments) and program models (housing first/low demand or high demand) should be geared to the clinical and social characteristics and preferences of consumers in order to achieve optimal housing outcomes. People with long histories of homelessness, particularly men who have challenging behavior problems, may be more successful in supportive housing programs that are site based. The integration of housing and case management services (e.g., programs in which the housing provider shares the goal of helping program

participants maintain stable housing in spite of problems that might lead to eviction in private-market housing) may facilitate greater housing stability and life satisfaction, particularly for male consumers with greater clinical vulnerability.

Low demand models that include housing first (transitional housing, Safe Havens, and some permanent supportive housing) hold promise for engaging severely disabled chronically homeless individuals, who are often considered "service-resistant" and have longstanding substance abuse problems, in a process of recovery and eventual housing stability.

Recommendations for Future Research

The methodology of mental health services and housing research studies conducted over the past decade has grown increasingly more sophisticated. Several studies reported here illustrate the feasibility of conducting randomized controlled trials in real-world settings such as street outreach and engagement in housing and treatment support services (Shern et al., 2000), discharge planning and linking to community-based housing and treatment (Susser et al., 1997), assertive community treatment (Morse et al., 1997), and housing and treatment services (Rosenheck et al., 2003; McHugo et al., 2004). Fidelity measures have been developed to better describe an intervention and determine the degree to which a given program adheres to its critical elements. Strategies such as propensity scoring, which mimics randomization so that causal inferences can be facilitated, have been utilized when the study design is quasi-experimental (Siegel et al., 2006). Studies of housing programs that use lotteries to select tenants from a pre-screened pool of applicants can provide opportunities of de facto random assignment, with some homeless people randomly assigned to housing while others receive "usual care" but are likely to remain homeless (Martinez & Burt, 2006). Improved follow-up strategies have been implemented in longitudinal investigations to minimize attrition (Susser et al., 1997).

Despite these advances, empirical research on the efficacy of interventions targeted at chronic homelessness has lagged far behind the development of new interventions. As research on efforts to end chronic homelessness moves forward, a focus on the topics listed below would expand the science base on chronic homelessness.

The Characteristics and Needs of People Who Are at High Risk of Chronic Homelessness

New research efforts should distinguish prevention efforts geared toward people with mental illness or other disabilities who are *at risk of homelessness or who are newly homeless* from efforts addressed to those who are *already homeless or who have experienced long-stays in street or shelter locations.* Efforts intended for the latter will be most meaningful if they employ a consistent definition of chronic homelessness, such as the one recently adopted by the federal government for its interagency policy and program initiatives discussed previously in this report.

The overrepresentation of minorities, particularly African American men, among the ranks of people who are chronically homeless requires greater understanding to inform the development of appropriate, culturally competent, and effective housing and treatment approaches targeted for this group.

The high prevalence of childhood out-of-home placement among single homeless women, coupled with their greater exposure to victimization and violence, both in their childhood family histories and in

adulthood, suggests a need for research to document and evaluate the effectiveness of gender-specific interventions to ending and preventing homelessness for adult women. Recognizing that many single homeless women are mothers who have become separated from their children, research can guide the development of programs that preserve and reunify families.

More research is needed to better understand the dynamics and trends that are reflected in the increasing age of homeless single adults, and the factors that are influencing this trend. Additional research can help explain whether this pattern primarily reflects an aging cohort of adults who have been homeless for many years, or whether older adults are now at greater risk of becoming homeless for the first time, and remaining homeless for extended periods. A closer examination of this population could help identify risk and protective factors associated with homelessness among older adults and factors that may have influenced changes in this pattern over the past two decades.

A greater understanding of the impact of homelessness over the life course is needed to inform housing and service approaches specific to age groups, such as young adults with recent-onset severe mental illness and elderly people. As the population of people who end up chronically homeless is aging, more research is needed to better understand their health conditions and the costs and efficacy of health care and treatment approaches for this population.

More information is needed to examine the characteristics and needs of people who experience extended or repeated episodes of homelessness but who are not considered to be chronically homeless because they do not have identified disabilities.

A More Complete Understanding of the Outcomes Produced by Specific Housing and Services Interventions, and What Works Best for Whom

We know that for most people who are homeless today, rental assistance or access to affordable housing would end their homelessness. We also know that many people with disabilities can end chronic homelessness and overcome substantial barriers to housing stability if they receive supportive housing. But there is not enough research to guide practitioners and policymakers as they make assumptions about which homeless people with specific characteristics can achieve housing stability and other improved outcomes with rent subsidies or access to affordable housing alone, and which people are unlikely to end homelessness or achieve desired outcomes in other important areas of functioning without access to supportive housing. We do not know enough about how much service support is needed, and for how long, or which specific service strategies are most effective for which groups of homeless people. With limited research about which program models work most effectively for people with varying needs and challenges, decisions about which housing strategies and program options are most appropriate for individuals and communities are too often guided by assumptions and values instead of compelling evidence. Therefore, we recommend the following priorities for continued research:

It is apparent that strategies for eliminating chronic street homelessness are a high priority nationwide (USICH, 2003; USDHHS, 2003; Burt et al., 2004). However, there have been limited efforts to define evidence-based approaches to engaging street homeless individuals in the use of services to assist in coming in off the streets. Research efforts should be directed at this issue.

Research is needed to compare outcomes for homeless people with similar characteristics and needs who receive different well-defined types of housing and services interventions. In particular, more rigorous studies should compare the effectiveness of single-site and scattered-site supportive housing that use both

low demand and high demand service strategies. The studies should measure outcomes that include not only housing stability, but also improvements in employment, recovery from addiction, and health status, and examine whether outcomes vary by participant characteristics, including age, gender, race, and types of disabilities. More conclusive evidence about what works best for whom would help guide decisions that currently are too often shaped by value-laden assumptions.

There is a need for extended longitudinal follow-up of clients enrolled in various types of housing and treatment interventions targeted at people who are chronically homeless to gain a better grasp of the long-term effectiveness of the housing and interventions. For example, the typical duration of follow-up in the housing literature is one to two years. Program attrition at that point ranges from about 20 percent to 25 percent (Lipton et al., 2000; Martinez & Burt, 2006). Lipton et al. (2000) found that at the five-year mark, only 50 percent were still in supportive housing. More information is needed on people who move out (e.g., why they move out, where they go, whether they become homeless again).

There is a need to better understand the effectiveness of specific strategies such as "housing first" versus "treatment first" for engaging the most disabled homeless people living on the streets in the use of services and housing. While this is clearly a high priority among policymakers and many practitioners, investment in research that would define evidence-based practice in this area has been limited, and we need to better understand the characteristics and needs of those who have been unable or unwilling to enter available housing or residential programs as well as factors that contribute to motivation and readiness to change.

Outcomes in studies of the impact of housing and treatment services should be broadened to include cost outcomes, family relationships and child welfare, incarceration and public safety, high-risk behaviors and communicable disease, psychiatric symptoms, recovery from substance abuse, and social inclusion.

A Better Understanding of the Need for Ongoing Supportive Services and Long-Term Outcomes After Entering Housing

Research on promising efforts in the areas of supportive housing and Safe Havens should expand information on recruitment and tenant selection (e.g., who does and does not gain admission to the programs), program exits (e.g., who leaves and why), and transitions to other types of housing. More evidence is needed to better understand long-term needs for housing assistance, treatment, and supportive services for chronically homeless people who leave supportive housing.

Recent studies suggest that the duration and intensity of services can be tailored to the clinical needs of the client, and that some homeless people with disabilities who enter housing are able to maintain their housing and sustain other positive outcomes, with less intensive direct support and linkages to other community services, after a period of transitional support. However, the duration and intensity of services required to sustain housing requires further study and evaluation. The *Self-Sufficiency Matrix* developed by the Arizona Evaluation Project on Homelessness (Flaherty, 2004) could provide a useful tool in determining how clinical and support services can be tapered at the individual level without jeopardizing gains.

Better Information About How to Prevent Chronic Homelessness

A greater understanding of the role of family dynamics in the genesis of housing loss among people with mental illness or other disabilities that increase vulnerability could inform whether interventions

addressing the family unit could prevent the onset of homelessness, or prevent future adult homelessness among children living in high-risk families.

Research must be focused on dually disordered persons with criminal justice histories to assist them to better control their illnesses, remain stably housed, avoid recidivist involvement in the criminal justice system, obtain gainful employment, and be included in the life of society at large. Innovative efforts to link chronically homeless people with criminal justice involvement to treatment and housing services in the community at the point of release from jail or prison is needed to counteract repeated homelessness and dependence on institutional care.

Interventions designed to prevent homelessness among people with severe mental illness at risk but never homeless is an important and underdeveloped area. Issues to be considered include early preventive treatment of substance use disorders, treatment compliance, vocational and job training, socialization, and family support. Assisting people at risk for long-term homelessness to retain existing housing or obtain more appropriate housing should be part of a comprehensive strategy to ameliorate chronic homelessness. Such "upstream" interventions might include supportive housing for youth aging out of foster care (New York City Department of Health and Mental Hygiene, 2006), family-based interventions for people with mental illness residing with family members (Connery & Brekke, 1999), and tenancy preservation for those at-risk of homelessness to assist them in retaining existing housing through housing court and other advocacy measures (Burt et al., 2005).

In Sum

The last decade has seen a deliberate effort to focus service innovation on the small but significant group of people who experience chronic homelessness and consume a disproportionate share of public service dollars. Innovation in services and supportive housing has outpaced research designed to establish these efforts on a strong scientific basis. However, the practice-based evidence that has emerged from these creative efforts will inform the next generation of efficacy studies in this area. Expanded federal support for research on homelessness will be required to move the field forward in the next decade.

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Homeless Families and Children

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Abstract

Debra Rog and John Buckner report that since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of families and children who become homeless, especially in understanding the heterogeneity within the population and whether a "typology" of families can be created (i.e., distinguishing families with greater needs for services and housing from those with lesser needs.) The authors review the findings from recent studies on homeless families and children and summarize the descriptive and outcome findings from evaluations of housing and service interventions and prevention efforts. With respect to children, research has focused on understanding and documenting the impact of homelessness on children. Rog and Buckner emphasize that that many of the challenges homeless families and children confront are also experienced by families that are very poor but not homeless, pointing to the need for further research on how to target assistance most efficiently to minimize the incidence and duration of homelessness for low-income families and children in general.

Introduction

The Current Context of Homelessness for Families and Children

Homelessness among families continues to be an all too common occurrence in our nation. Beginning in the early 1980s, families with young children began to appear at shelters intended for single adults and quickly became a fast-growing segment of the homeless population. The best estimate is that families comprise 34 percent of the homeless population (23 percent children and 11 percent adults) on any given night (Burt et al., 1999). In a given year, this translates to about 420,000 families, including 924,000 children, experiencing homelessness in the United States. By extrapolation, about 1.8 percent of all families in this country spend at least one night homeless over the course of a year (Urban Institute, 2000). Among just low-income families, about 8 percent of households and 9 percent of children have been homeless during the past year. It is also believed that many more families are precariously housed, in doubled-up situations or in substandard housing.

It is important to recognize that there is a structural imbalance creating homelessness that helps to explain both geographic and temporal differences in rates of homelessness. The nature of the crisis in affordable

for viable solutions. New approaches to service delivery and provision of housing targeted at this population have been developed. Some of these interventions are becoming widely recognized as "evidence-based." In the last 5 to 10 years, there has been a convergence of opinion among advocates and policymakers at all levels of government that chronic homelessness need not exist in the United States. Momentum around this issue started to build in 2000 when the National Alliance to End Homelessness (NAEH) released a plan to end homelessness in 10 years. Shortly afterward, Secretary

housing varies from place to place. For example, the examination of worst case housing needs indicates that the suburbs experienced the greatest losses in units affordable to extremely low-income families in the 1990s as a consequence of growth in population and jobs (U.S. Department of Housing and Urban Development, 2000). Shortages in affordable housing and differences in fair market rents also vary geographically. Fair market rents, even averaged across entire states, are over twice as high in some states as in others; local variation is much greater (Pitcoff et al., 2003). In addition, the extent to which public housing and other housing assistance is available may have a role in explaining this variation. Recent analyses of the Fragile Families database, which comprises an at-risk sample of families from communities across the country whose mothers have recently given birth, reveals that among families living below 50 percent of the poverty level, homelessness is related to having no housing assistance or having lost that assistance or public housing. Residential stability among those in the poverty sample is strongly predicted by having or gaining public housing (Rog & Holupka, unpublished). Families living at the bottom rung of the income ladder have inadequate incomes to pay the fair market rents in literally all communities. Therefore, the role that the lack of affordable housing plays in creating the structural backdrop for why homelessness occurs points to its fundamental importance in creating long term solutions for preventing homelessness among families as well as individuals.

Even within the same locale, the characteristics of homeless families can change over time. Weinreb et al. (2006) recently compared the characteristics of two samples of similarly enrolled homeless families in Worcester, Massachusetts, based on studies conducted in the early 1990s and early 2000s. Demographic characteristics were fairly similar between the two samples. However, compared to the 1993 sample, homeless families in the 2003 study were poorer (adjusted for the effects of inflation) and reported more physical health limitations; psychological distress; and mental health disorders, especially major depression and posttraumatic stress disorder (PTSD). The most noteworthy finding was a fourfold higher rate of current depression in the 2003 study as compared to the earlier investigation. Reasons for this increase are unclear and the finding merits replication in other settings to determine whether it is part of a broader trend.

Recent Research and Evaluation Activity

Since the mid-1990s, there has been continued research and policy interest in understanding the characteristics and needs of families and their children who become homeless, especially in understanding the heterogeneity within the population and whether a “typology” of families can be created (i.e., distinguishing families with greater needs for services and housing from those with lesser needs). With respect to children, research has focused largely on understanding the impact of homelessness.

At federal and state levels, there also has been increased attention to the types of housing models needed by the array of families who become homeless (including transitional, permanent supportive housing, and permanent housing), the services that are needed to assist families and their children while they are homeless and after they exit, and strategies for preventing family homelessness and facilitating more rapid exits.

In this paper, we synthesize what we know in each of these areas, highlighting the relevant research studies and policy analyses that have been conducted since 1998 that shape our understanding. We begin with a methodological overview of the more recent research studies on the characteristics and needs of families and children, followed by a summary of the main findings. We then provide a more in-depth synthesis of the literature on the characteristics and needs of homeless families overall, and then on the

impact of homelessness on children. We follow with summaries of the descriptive and outcome findings from evaluations of various housing and service interventions and efforts to prevent homelessness. The final section outlines the research that is indicated to fill the gaps in knowledge that remain.

Research on the Characteristics and Needs of Homeless Families and Children: Summary of the Methodological Context and Key Findings

The body of research on homeless families has grown, though not dramatically, since the mid-1990s. More has been learned about the size and characteristics of homeless families, especially compared to equally low-income families who remain domiciled. Several key studies (Shinn et al., 1998; Rog et al., 1995a; Bassuk et al., 1996) had begun reporting results prior to the 1998 Symposium, though analyses continued. Two additional large studies were conducted following the Symposium: (1) the National Survey of Homeless Assistance Providers and Clients (NSHAPC), directed by Burt and colleagues (1999), which has contributed to our knowledge of basic characteristics of homeless families across the nation, and (2) analyses of administrative data sets in New York City and Philadelphia by Culhane and colleagues (1999), which have improved our understanding of families' use of shelter and the interconnection of homelessness with involvement in other services and systems.

Several more recent studies that are adding to the literature on the characteristics of families (some with publications underway or in press) include the evaluation of the five-year CMHS/CSAT Homeless Families Program (Rog, Rickards et al., in press); a secondary analysis of the Fragile Families and Child Well-Being dataset (Reichman et al., 2001) focused on comparing families at different levels of residential instability (Rog et al., 2007); and examinations of housing problems experienced by recipients of child welfare services (Courtney, McMurtry, & Zinn, 2004; Park et al., 2004).

With respect to homeless children in particular, the first studies were conducted in the mid- to late 1980s, not long after the issue of homelessness among families became apparent. The findings from these initial studies helped spawn a second generation of research studies on homeless children that were conducted in the early to mid-1990s (cf. Bassuk, Weinreb et al, 1997; Buckner & Bassuk, 1997; Buckner et al., 1999; Buckner, Bassuk, & Weinreb, 2001; Garcia Coll et al., 1998; Masten et al., 1993; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Schteingart et al., 1995; Weinreb et al., 1998; Zeismer, Marcoux, & Marwell, 1994). These studies were funded by the federal government (e.g., the National Institute of Mental Health), private foundations, and other agencies. A chief aim of many of these investigations was to further clarify the impact of homelessness on children. Compared to the earlier studies, these latter projects enrolled more study participants, included a greater breadth and quality of assessment instruments, and employed more advanced statistical techniques with which to analyze data.

The studies on homeless families and children have varied in definitions used, study designs, participant selection, and geographic context, all of which have contributed to differences and inconsistencies among the studies. In addition, examining and synthesizing the findings of studies over time is confounded by historical and structural changes in housing, improvements in shelter conditions over time (especially when examining the effects of homelessness on children), and effects of programs implemented through the McKinney-Vento Act (such as the educational programs serving as a buffer for children). Few studies have been longitudinal, only several have used comparison groups of other low-income families to contextualize the results, and the geographic areas have been limited.

Despite these limitations, the small body of emergent research has provided insights into the risk factors associated with family homelessness, the housing and service needs of homeless families and children, and the impact of homelessness on children. Among the most consistent findings are:

- The most common profile of a homeless family is one headed by a single woman in her late 20s with approximately two children, one or both under 6 years of age; those at greatest risk belong to ethnic minority groups.
- In the Northeast the vast majority of homeless families are headed by single-parent females (Bassuk et al., 1996), while in other parts of the country there is a greater mix, with a modest percentage being two-parent families or families headed by a single father (U.S. Conference of Mayors, 2005).
- The residential histories of homeless families typically reveal high mobility and instability, including living in a variety of doubled up and own housing arrangements.
- Family separations are a common occurrence, both before and after the homelessness episode.
- Homeless families are typically extremely poor, and mothers who are homeless lack human capital—useful skills and abilities—with respect to both education and employment.
- Conflict, trauma, and violence figure prominently in the lives of homeless families, as they do with equally poor but domiciled families.
- The health of mothers who are homeless is often poorer than the health of mothers who are domiciled, but mothers who are homeless typically report high rates of access to health care; in contrast, their mental health problems are comparable in rate and nature (e.g., typically depression) to poor women in general, and are typically unmet.
- Reports of substance abuse, though likely underestimates, are higher for mothers who are homeless than for other women in poor families, but lower than for single adults who are homeless.
- Both homeless and low-income housed children experience the negative effects of broad poverty-related adversities. Study findings suggest that although homelessness itself can have an additional detrimental impact on children's mental health, physical health, and school performance, particularly in the short term, the effects tend to dissipate over time once children are rehoused.

What Have We Learned About Families Who Become Homeless?

Factors That Place Families at Risk of Homelessness

Ethnicity. Homeless families are more likely than poor families, and both are substantially more likely than the general population, to be members of minority groups, in particular African Americans (Lowin et al., 2001; Rossi et al., 1987; Susser, Lin, & Conover, 1991; Rog et al, 2007; Rog & Holupka, unpublished; Whaley, 2002). This is also true of single adults who are homeless. For example, in the NSHAPC, 62 percent of families and 59 percent of single adults, compared to 24 percent of the general population, were members of minority groups (Burt et al., 1999). However, the particular minorities represented vary from city to city. Their race and ethnicity reflect the composition of the city in which

they reside, with minority groups invariably disproportionately represented (Breakey et al., 1989; D'Ercole & Struening, 1990; Rog et al., 1995a; Shinn, Knickman, & Weitzman, 1991; Lowin et al., 2001).

Resources. The incomes of mothers who are homeless are significantly below the federal poverty level (Bassuk, Buckner et al., 1996, 1997; Rog et al., 1995b; Shinn & Weitzman, 1996). Homeless families' incomes are slightly higher than homeless single adults' due to families having greater access to means-tested benefit programs such as TANF and more help from relatives and friends. Nonetheless, homeless families' incomes are almost always too low for the families to obtain adequate housing without subsidies (Burt et al., 1999). In the Worcester Family Research Project (WFRP), a study of 436 homeless and low-income housed single-parent female-headed families, more than half earned less than $8,000 per year, placing them at 63 percent of the poverty level for a family of three (Bassuk et al., 1996). Similarly, in the NSHAPC the median income in 1996 for a homeless family was only $418 per month, or 41 percent of the poverty line for a family of three (Burt et al., 1999).

In a recent reanalysis of the Fragile Families and Child Well-Being dataset focused on families living at 50 percent or below of the poverty level conducted as part of a larger project designed to inform a typology of homeless families (Rog et al, 2007), those families who remained residentially stable over three years without experiencing risk factors for homelessness (e.g., having utilities shut off) were more likely to have relatively higher incomes and have received housing assistance and to be living with a partner who was working. Having other adults living in the household appears to increase a mother's likelihood of remaining in stable housing.

Findings about the role of social networks of homeless families are mixed. Several studies have found that mothers in the midst of an episode of homelessness, compared to low-income housed women, have less available instrumental and emotional support, less frequent contact with network members, and more conflicted relationships (Bassuk & Rosenberg, 1988; Bassuk et al., 1996; Culhane, Metraux, & Hadley, 2001; Passero, Zax, & Zozus, 1991). One qualitative study found that the lack or withdrawal of support was a key factor in families becoming homeless (McChesney, 1995), but another study (Goodman, 1991) found no differences in support between homeless and housed mothers. In contrast Shinn, Knickman, and Weitzman (1991) found that newly homeless mothers report *more* recent contact with network members than low-income housed mothers, and over three-quarters had stayed with network members before turning to shelter. Moreover, more recent analysis of that dataset (Toohey, Shinn, & Weitzman, 2004) found that five years later the social networks of the (now) formerly homeless mothers in this sample were quite similar to those of their housed counterparts. Differences in study findings may be related to the timing of interviews of the mothers—in the months prior to a homelessness episode, a mother's contact with network members may increase, whereas by the time a mother and her children enter shelter, she may have depleted most of her social network resources.

There is some evidence that conflict in social support networks may be related to poorer symptoms and outcomes for families. In the WFRP, homeless mothers had smaller social networks that comprised nonprofessionals and reported more conflicted relationships in their networks than did housed women. Therefore, large social networks emerged as a protective factor for homelessness, but having a network marked by interpersonal conflict was a risk factor for homelessness (Bassuk, Buckner et al., 1997). Conflict with family and friends, especially sibling conflict, was related to impaired mental health (Bassuk et al., 2002). Similarly, in the recent CMHS/CSAT Homeless Families Program involving mothers with psychiatric and/or substance abuse issues, mothers reporting conflict in their networks over

the course of a 15-month follow-up showed less improvement in a number of outcomes—including mental health symptoms and functioning, trauma, and substance abuse, regardless of the type of intervention they received (Rog, Buckner et al., in press; Sacks et al., in press; Pearson et al., in press).

Young Children and Pregnancy. Not only are homeless families overwhelmingly headed by women, but they are disproportionately families with young (pre-school) children. The risk for homelessness is highest—and higher than the general population rate—among families with children under the age of six. Furthermore, the risk increases for younger children, with the highest rate of risk among families with children under the age of one year ("infants"), as approximately 4.2 percent of infants were homeless in 1995 (Culhane & Metraux, 1999). Having young children may place parents at a competitive disadvantage in terms of holding a job and being able to afford housing.

Pregnancy itself is a risk factor for homelessness (Shinn et al., 1998). In a comparison of homeless public assistance families in New York with a sample of housed families on public assistance, 35 percent of the homeless women were pregnant at the time of the study and 26 percent had given birth in the past year, while only 6 percent of the housed group were pregnant and 11 percent had given birth recently (Weitzman, 1989).

Other Needs and Problems Facing Homeless Families

Family separations and influence on family composition. In recent years, the extent to which families experience the temporary or permanent separation from a child when homeless or at various stages in their residential history has become more apparent (Cowal et al., 2002; Hoffman & Rosencheck, 2001). Parent-child separation among homeless families is part of a much broader issue. Because residents of family shelters must include at least one parent and at least one child, parents who are separated from their only child or all of their children are not welcome at family shelters and instead must find shelter in facilities meant for "single" adults. The NSHAPC reported that 60 percent of all homeless women in 1996 had children younger than 18 years, but only 65 percent of those women lived with any of their children (and often not all of their children); similarly, 41 percent of all homeless men had minor children, yet only 7 percent lived with any of them (Burt et al., 1999). Other studies yield similar findings (Cowal et al., 2002; Maza & Hall, 1988; North & Smith, 1993; Rossi, 1989; Zima et al., 1996). The residents of shelters intended for single adults include some individuals who would be in a family shelter if they were presently caring for their child(ren). This is borne out in a study conducted in Alameda County, California by Zlotnick, Robertson, and Wright (1999), who interviewed 171 homeless women drawn from a countywide probability sample. Of these women, 84 percent were mothers and 62 percent of these homeless mothers had a child under the age of 18 living either in foster care or some other out-of-home placement.

Among families with children, parent-child separation is sometimes the choice made by a parent, usually the mother, in deciding the best interests of a child; at other times, it can be a decision forced upon her by the child welfare system, shelter staff, or relatives (Cowal et al., 2002; Park et al., 2004). Cowal et al. (2002) conducted the most comprehensive investigation to date on this issue. Their study, conducted in New York City during the early 1990s, involved 543 low-income families, 251 of which had experienced homelessness at some point in the five prior years. They found that 44 percent of the homeless families had experienced a child separation, compared to only 8 percent of low-income never homeless families. Even when accounting for histories of mental health and substance abuse problems as well as domestic violence (directed at the mother), homelessness was strongly associated with a family experiencing such a

separation (Cowal et al., 2002). The reasons why the risk of parent-child separation increases when a family becomes homeless is not entirely clear, but it is likely due to multiple factors. The "fishbowl hypothesis" posits that parenting practices are under closer scrutiny when a family is in a shelter than when housed, posing a risk for child welfare placement (Park et al., 2004). Alternatively, in some cases, a soon-to-be-homeless mother will ask that a relative care for her child so that the child can continue attending the same school. In other instances, shelters may not allow adolescents, especially males, to stay in their shelter, thereby forcing a family-child separation.

Homelessness is not only a major factor in family separations; it also makes the reunification of separated families more difficult. Cowal and colleagues (2002) found that only a subset (23 percent) of the separated children were living with their mothers at the five-year follow-up (Cowal et al., 2002). In most studies, the majority of separated children lived with relatives, but a substantial minority were in foster care or had Child Protective Service (CPS) involvement (26 percent, Cowal et al., 2002; 6 percent, DiBlasio & Belcher, 1992; 15 percent, Zlotnick, Robertson, & Wright, 1999). In a five-year follow-up of a birth cohort of children in Philadelphia, being in a family that requested shelter was strongly related to CPS involvement and to foster care placement (Culhane et al., 2003). The risk for CPS involvement increased as the number of children in a family increased. Similarly, in another Philadelphia study there was a greater risk for child welfare involvement for those families with longer shelter stays, repeated homelessness, and with fewer adults in the family (Park et al., 2004).

The link between child homelessness and foster care is even more disturbing in light of the preponderance of research that has found childhood separation—and especially foster care involvement—to be a predictor of homelessness in adults (Bassuk, Buckner et al., 1997; Bassuk, Rubin, & Lauriat, 1986; Knickman & Weitzman, 1989; Susser, Lin, & Conover, 1991; Susser, Conover, & Struening, 1987) as well as future separation from one's own children (Nunez, 1993).

Human capital: Education, employment, and income. Adults in both homeless and other poor families generally have low levels of educational attainment and minimal work histories. Compared to the national average of 75 percent of adults having a high school diploma or GED, for example, high school graduation or GED rates for mothers in homeless families range from 35 percent to 61 percent across a number of studies (Bassuk et al., 1996; Burt et al., 1999; Lowin et al., 2001; Rog et al., 1995b; Rog, Rickards et al., in press; Shinn & Weitzman, 1996). Overall, the rates of educational attainment for homeless families are lower than for homeless single adults (47 percent versus 63 percent in the NSHAPC) (Burt et al., 1999) but similar to other low-income families.

Not surprisingly, most homeless mothers (84–99 percent) upon entry into shelter are not working (Bassuk et al., 1996; Lowin et al., 2001; Rog et al., 1995b; Rog, Rickards et al., in press.) The majority of homeless mothers have had some work experience, however, ranging from 67 percent in the Worcester study (Brooks & Buckner, 1996) to over 90 percent in the RWJF/HUD Homeless Families Program and the recent CMHS/CSAT Homeless Families Program (Rog et al., 1995b; Rog, Rickards et al., in press). Among homeless and housed low-income mothers in the Worcester study, becoming pregnant before the age of 18 significantly lowered a woman's chances of having been employed (Brooks & Buckner, 1996).

Partner violence and childhood abuse. Homeless mothers, like poor women in general, have experienced high rates of both domestic and community violence (Bassuk et al., 1996; Bassuk, Perloff, & Dawson, 2001; Browne & Bassuk, 1997). Many women report having been both victims and witnesses of violence over their lifetimes. In the WFRP, almost two-thirds of the homeless mothers had been severely

physically assaulted by an intimate partner and one-third had a current or recent abusive partner (Browne & Bassuk, 1997). More than one-fourth of the mothers reported having needed or received medical treatment because of these attacks (Bassuk et al., 1996). Supporting these findings, Rog and her colleagues (1995b) reported that almost two-thirds of their nine-city sample of homeless women described one or more severe acts of violence by a current or former intimate partner. Not surprisingly, many of these women reportedly lost or left their last homes because of domestic violence.

In addition to adult violent victimization, many homeless mothers experienced severe abuse and assault in childhood. The WFRP documented that more than 40 percent of homeless mothers had been sexually molested by the age of 12 (Bassuk et al., 1996). Women participating in the CMHS/CSAT study reported similar findings, with 44 percent reporting sexual molestation by a family member or someone they knew before the age of 18 (Sacks et al., in press). Sixty-six percent of the women in the WFRP experienced severe physical abuse, mainly at the hand of an adult caretaker. Other studies have found similar results (e.g., Rog, Rickards et al., 1995b; Sacks et al., in press; Rog et al., in press).

Health and dental needs. Homeless mothers and their families face a number of health challenges and problems, some that may stem from homelessness and others that may have contributed to becoming homeless. Mothers who are homeless, for instance, have more acute and chronic health problems than the general population of females under 45 years of age. Bassuk et al. (1996), for example, found that 22 percent of the mothers reported having chronic asthma (more than four times the general population rate), 20 percent chronic anemia (ten times the general population rate), and 4 percent chronic ulcers (four times the general rate). These rates among homeless mothers in Worcester were comparable to those found in a comparison group of low-income housed, never homeless mothers (Bassuk et al., 1996).

In the RWJF/HUD Homeless Families Program (Rog et al., 1995b), 26 percent of the mothers reported having two or more health problems in the past year, and 31 percent characterized their health as poor or fair. Likewise, in the more recent CMHS/CSAT Homeless Families study, 44 percent of the women reported their health as being only fair, poor, or very poor when they entered the study, and 43 percent indicated that they had needed some sort of medical services in the prior three-month period (Rog, Rickards et al., in press; Rog, 2004). Despite the reported poor health, in both of these studies most women report having had some access to health services while homeless: 75 percent in the RWJ Homeless Families Program, typically through Medicaid (Rog et al., 1995b), and 81 percent in the CMHS/CSAT Homeless Families Project (Rog, 2004).

A significant unmet health need among homeless families is dental services. The RWJF/HUD Homeless Families program found that 62 percent of the families needed dental services at baseline, while only 30 percent reported receiving services prior to entering the program (Rog & Gutman, 1997). Similarly, in the more recent CMHS/CSAT Homeless Families project, 44 percent of the families reported needing dental services at baseline, and only 28 percent of these families reported receiving dental services in the three months before entering the program (Rog, 2004).

Substance abuse and mental health. Studies differ on overall prevalence of substance abuse and mental health problems among mothers who are homeless and the extent to which these problems may function as risk factors, largely due to how they are defined and measured (including both the actual measure and the time period being assessed) (Shinn & Bassuk, 2004). Whatever the measurement, it is clear that the nature of the problems is far different than for single adults who are homeless.

Data from the WFRP indicates that homeless families are more likely than other low-income families, but less likely than individuals who are homeless, to report abusing substances (Bassuk, Buckner et al., 1997; Burt et al., 1999). Rates of reported lifetime use of substances range from 41 percent (Bassuk et al., 1996) to 50 percent (Rog et al., 1995b). Rates are much lower for current use as exemplified by a reported illicit drug use of 5 percent in the WFRP (Bassuk et al., 1996) and a 12 percent rate of illicit drug use in the past year in the Rog et al. 1995b study. Heavy use of alcohol or heroin over the prior two years was found to be a risk factor for homelessness in the WFRP (Bassuk, Buckner et al., 1997). Similarly, recent reanalyses from the Fragile Families dataset (involving low-income mothers who have recently given birth) suggest that substance abuse is a risk factor for homelessness, with families who report experiencing recent homelessness having higher rates of substance use than families who remain stably housed (Rog & Holupka, unpublished).

Depression among mothers who are homeless is relatively common, as it is for low-income women generally, while psychotic disorders are rare (Bassuk et al., 1998; Shinn and Bassuk, 2004). In the reanalysis of the Fragile Families data, reports of mental health issues were related to becoming homeless and their absence related to stability (Rog et al., 2007). Forty-six percent of families experiencing homelessness in Year 1 of the study reported feeling sad or depressed two or more weeks in a row, compared to 12 percent of the families who remained stably housed during that time. Comparable percentages were found at the Year 3 follow-up.

Given the high levels of stress and the pervasiveness of violence, it is not surprising that mothers who are homeless have high lifetime rates of posttraumatic stress disorder (PTSD) (3 times more than the general female population), major depressive disorder (2.5 times more than the general female population) and substance use disorders (2.5 times more than the general female population) (Bassuk et al., 1998). Bassuk and colleagues (1996, 1998) found, however, few differences between homeless and low-income housed mothers. Thirty-six percent of homeless mothers and 34 percent of low-income housed mothers had lifetime prevalence of PTSD and 18 percent of homeless mothers compared to 16 percent of low-income housed mothers reported current PTSD.

In addition, between one-quarter and one-third of mothers who are homeless report at least one lifetime suicide attempt (Bassuk et al., 1996; Rog et al., 1995b). In fact, Rog and Gutman (1997) reported that a majority of the mental health hospitalizations reported by women in the RWJF/HUD nine-city evaluation were related to suicide attempts.

Finally, it is important to recognize that many women who are homeless face multiple problems and issues. In the WFRP, the most common current co-occurring disorders found were major depression, substance use disorders, anxiety disorder, and PTSD (Bassuk et al., 1998; Shinn & Bassuk, 2004). In addition, Rog and her colleagues (1995b) noted that 80 percent of the homeless women had current needs in at least two of three areas examined: human capital (poor education or lack of a job), health, and mental health (including substance abuse and trauma-related issues). One-quarter of the women had issues in all three areas.

Residential instability. Family homelessness is perhaps most aptly described as a pattern of residential instability. Homeless episodes are typically part of a longer period of residential instability marked by frequent moves, short stays in one's own housing, and doubling up with relatives and friends. As an illustration, in the 18 months prior to entering a housing program for homeless families in nine cities, families moved an average of five times, spending 7 months in their own place, 5 months literally

homeless or in transitional housing, 5 months doubled up, and 1 month in other arrangements. Overall, one-half (53 percent) had been homeless in the past. It is important to note, however, that this sample of families was not random, but consisted of families selected for a variety of service needs, with prior homelessness a selection criterion at some of the study sites (Rog & Gutman, 1997).

Other studies document the lack of stability that the families experience both before and after experiencing homelessness. For instance, Shinn and colleagues (1988) documented that many families on the precipice of homelessness for the first time had never established themselves in stable permanent housing. Before entering shelter, doubling up with other families was common as were moves from one overcrowded living arrangement to another. At-risk families who had been able to obtain a housing subsidy were much more residentially stable and less likely to enter shelter. In a more recent study of newly homeless families in eight sites across the country who were screened as having mental health and/or substance abuse problems, the families spent less than one-half of the prior six months in their own homes (Rog, 2004). Staying with relatives or friends is often found to be the most common living situation prior to entering shelter (Lowin et al., 2001; Rog, 2004). The length of time families stay homeless is a function, in part, of shelter limits on stay and the availability of affordable housing. Families with limited incomes have few housing choices. As discussed later in this paper, there is substantial evidence that subsidized housing plays a major role in reducing homeless stays and in ending homelessness for a majority of families.

To date, there have not been any conceptual models developed, or research conducted, that help to explain the manner in which risk and protective factors for homelessness among families interrelate. Presumably, there is a class of distal as well as a class of proximal mediating variables that can be delineated in efforts to explain pathways into homelessness. Distal variables for a homeless mother could include history of childhood abuse, foster care placement, and other disruptive experiences early in life. These distal factors could affect mediating variables such as recent substance abuse, mental health issues, and conflict within the social network, which in turn play roles in affecting a person's vulnerability to becoming homeless. In addition, recent research (Rog & Holupka, unpublished) suggests that the absence of protective factors (e.g., having housing assistance, having another adult living in a household) combined with having mental health and substance abuse concerns makes it difficult for vulnerable families to stay residentially stable and heightens their risk of homelessness.

What is the Toll of Homelessness on Children Living With Their Families?

The year 1987 marked the beginning of published studies that focused on homeless children living with their families. Four years later, a sufficient amount of research had been conducted to warrant a review article by Rafferty and Shinn (1991). This "first generation" of research on homeless children called attention to a growing number of youngsters who were living in shelters and clearly at risk for developing problems. Unlike the studies of families that sought to understand what placed certain families at greater risk of homelessness, the focus of these studies was to determine the impact of homelessness on children. The early investigations documented demonstrable problems that children were having in various areas of functioning, such as health, developmental status, mental health and behavior, and academic performance (cf. Alperstein, Rappaport, & Flanigan, 1988; Bassuk & Rubin, 1987; Miller & Lin, 1988; Rescorla, Parker, & Stolley, 1991; Wood et al., 1990).

As noted earlier, the findings from these initial studies helped spawn a second generation of studies on homeless children, funded by a variety of public and private sources, conducted in the early to mid-1990s (cf. Bassuk, Weinreb et al., 1997; Buckner & Bassuk, 1997; Buckner et al., 1999; Buckner, Bassuk, & Weinreb, 2001; Garcia Coll et al., 1998; Masten et al., 1993; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Schteingart et al., 1995; Weinreb et al., 1998; Zeismer, Marcoux, & Marwell, 1994). As a group, these studies were stronger due to greater sample sizes and improved methodology. Again, their dominant focus was to further an understanding of the impact of homelessness on various dimensions of child functioning.

This second wave of studies on homeless children did not generate as clear a pattern of results as the first set of investigations. The most consistent and uniform finding across these studies was the detection of elevated problems among both homeless and low-income housed children compared to children in the general population (using normative data). This appears to be due to the effects of poverty-related risk factors that low-income children, whether currently homeless or in housing, have in common. What was not consistently found across this second wave of studies was an additional elevation in problems among homeless children in comparison to low-income housed children. In other words, these latter studies seldom found negative effects in children that could be attributable to the experience of homelessness, per se.

Impact on mental health and behavior. At least seven publications since 1993 have examined the impact of homelessness on the mental health and behavior of children. Of these studies, Masten et al. (1993) in Minneapolis, Ziesemer et al. (1994) in Madison, Wisconsin, and Schteingart et al. (1994) in New York City reported *no* differences between homeless study participants and their low-income housed counterparts on various indices of mental health, principally the Child Behavior Check List (CBCL) and the Children's Depression Inventory.

In the WFRP, Bassuk, Weinreb et al. (1997) found that homeless preschool-age children had higher elevated "externalizing" problem behaviors (e.g., aggressive behavior) as measured by the CBCL than low-income housed children, but did not find significant differences on the "internalizing" (e.g., depressive, anxious, and withdrawn behavior) subscale. Conversely, Buckner et al. (1999) found the opposite among school-age children in the Worcester study (significantly worse scores for homeless children on the internalizing subscale of the CBCL but not on the externalizing subscale). Assessing mental health problems in a diagnostic manner using DSM-III-R criteria, Buckner and Bassuk (1997) found that homeless and low-income children age 8 years and older in the Worcester study had nearly identical current prevalence rates for psychiatric disorders (about 32 percent), a rate much higher than the 19 percent prevalence found among children in the general population (Shaffer et al., 1996). So, while these second-generation studies of homeless children documented a poverty-related effect on children's mental health/behavior (i.e., data on low-income children, whether homeless or housed, looked worse than normative data), effects due specifically to homelessness-related factors were much harder to detect.

Impact on education-related problems. There has been a somewhat more consistent pattern of findings across studies in the realm of education-related problems and outcomes. When the crisis of family homelessness emerged in the 1980s, most school systems were unprepared to deal with the complex needs of homeless children. Many homeless children were denied access to education, with school districts claiming that families living in shelter did not meet permanent residency requirements and therefore were not eligible for enrollment (Rafferty, 1995). Other impediments to school attendance included immunization requirements, availability of records, and transportation to and from school

(Stronge, 1992). If homelessness causes children to miss school, such absence will likely be detrimental to their academic performance. As part of the Stewart B. McKinney Homelessness Assistance Act, which Congress passed in 1987, the Education of Homeless Children and Youth (EHCY) program was established to ensure that homeless children had the same access to public education as other children.

Studies of homeless children conducted prior to and shortly after the creation of the EHCY program have consistently documented disrupted school attendance and academic underperformance (Bassuk & Rubin, 1987; Masten et al., 1993; Masten et al., 1997; Rafferty, Shinn, & Weitzman, 2004; Rubin et al., 1996; Zima, Wells, & Freeman, 1994). Since then, the EHCY program has provided formula grants to state educational agencies to review and revise policies that may act as barriers to school enrollment and attendance in addition to funding direct services such as transportation and tutoring.

Anderson, Janger, and Panton (1995) conducted a national evaluation of the EHCY program and found that over 85 percent of homeless children and youth were regularly attending school, indicating a marked improvement in school access compared to pre-EHCY program attendance rates. Similarly, Buckner, Bassuk, and Weinreb (2001) found no evidence of higher school absenteeism or lower academic achievement scores among homeless school-age children in the Worcester study as compared to low-income housed children. Children in each group had missed an average of six days of school in the past year and scores on a composite measure of academic achievement were identical for both groups. Rates of school suspension, grade retention, and special classroom placement were actually higher in the housed comparison group. This lack of differences in the Worcester study on school- and education-related variables suggests that the EHCY program has been successfully implemented in that city, as evidenced by similar absenteeism rates between the homeless and housed school-age children. What this study illustrates is that the ability of researchers to detect an effect of homelessness on children may depend in part on the historical context; that is, the timing of the study in relation to the societal response that has arisen to address the problem.

Impact on development. This inconsistency in study results concerning the impact of homelessness extends to findings on the cognitive and motor development of young homeless children. Two of the three studies that have addressed this domain are first-generation studies and the third, a second-generation project. The first two studies (Wood et al., 1990: Bassuk & Rosenberg, 1990) found a greater proportion of developmental delays among the homeless preschool children than comparison groups of low-income housed children. Both used the Denver Developmental Screening Test, an instrument that focuses on reports about the child by a parent or guardian. The third study (Garcia Coll et al., 1998) employed the "gold standard" measure of developmental status in infants and young children, the Bayley Scales of Infant Development, which involves direct observation and interaction with a child by a tester who has undergone specialized training. In contrast to the earlier two studies, Garcia Coll et al. found no differences in developmental status between homeless and low-income housed infants/toddlers on the Bayley. Moreover, scores on the Vineland Screener (a measure of adaptive behavior that asks a parent about a child's communication, daily living, socialization and motor skills) were almost identical between the two groups.

Impact on health. The studies of Alperstein, Rappaport, and Flanigan (1988) in New York City and Miller and Lin (1988) and Wood et al. (1990) in Los Angeles represent the earliest studies of homeless children that assessed health outcomes. Each of these investigations found a higher prevalence of health-related problems compared to low-income housed children or children in the general population. A second-generation study (Weinreb et al., 1998) with more methodological rigor than prior studies

compared 293 homeless children ranging from 2 months to 17 years of age to 334 low-income housed (never homeless) children and also found greater frequency of health problems among homeless children. Only one study, Menke and Wagner (1997), did not show differences on health-related outcomes between homeless and low-income housed groups of children.

Summary of impact of homelessness. Past studies have been somewhat mixed in their findings on the impact of homelessness on children, especially when comparing homeless to low-income housed children. While the magnitude of severity of problems found among homeless (and low-income housed) children tends to be in the mild to moderate range in the short term, in virtually all instances these two groups of low-income children look worse on various outcome measures compared to children in the general population. Very little research has gauged the impact of homelessness over the longer term, but the evidence suggests that any short-term impact dissipates after several years. A two year follow-up of homeless children in the WFRP indicated that exposure to violence had a much more pronounced negative effect on school-age children's mental health than did history of homelessness (Buckner, Beardslee, & Bassuk, 2004). Similarly, Shinn et al. (in press) found, across a broad age range, that formerly homeless and housed children in New York City looked quite similar to each other on indices of health, mental health, IQ, and academic achievement approximately 55 months after the initial shelter entry of the homeless group. These investigators, however, did find elevated internalizing and externalizing behavior problems at follow-up among a subgroup of children who were homeless when they were infants and toddlers as compared to their housed counterparts.

Due to the lack of consistency across the studies that have been conducted, all that can be reasonably concluded from the scientific evidence at this stage is that homelessness (when meant as a stay in a family shelter) can have a detrimental short-term impact on children, but not in all instances. Homelessness can function as a "marker of risk" for children, meaning that children who are homeless are likely going to have a higher prevalence rate of problems than similar age youths in the general population, but not necessarily higher against a comparison of similarly poor, but housed children.

Differences among the studies from the first to second generation also suggest that some of the improvement in children's outcomes may be due to the much greater societal response to the problem of homelessness than was the case when the earliest studies were undertaken. The McKinney-Vento Act programs and improvements to family shelters have likely buffered some of the negative impact of homelessness.

In addition, the structural backdrop of homelessness, as noted, likely complicates what can be attributed to the impact of homelessness on children. Because homelessness among families is largely due to a structural imbalance between the supply and the demand for affordable housing, those most vulnerable to homelessness are those least able to compete for the scarce supply of available affordable housing (Buckner, 1991, 2004a; Shinn, 1992). In the beginning stages of a protracted housing shortage, it is likely that the most vulnerable families will become homeless first—those with significant problems or issues such as a mental health, substance use, or physical health disorder. As a structural problem worsens over time regarding the demand for affordable housing in relation to the supply, studies of homeless families would likely find differences in rates of problems between homeless and low-income housed families compared to findings of investigations conducted in the early stages of a tightening housing market. The implication this has for homelessness research is that, all other things being equal, in a gradually worsening housing market that takes many years to unfold, early studies may reveal greater problems among shelter residents (adults and children) than do later studies. In addition, if there are other factors

that determine which families entered shelter, these also could have a role in influencing children's mental health (or other aspects of child functioning). As a result, the status of being homeless, itself, may not be the reason or only reason for the heightened problems seen among children living in shelter.

Researchers who have examined the impact of homelessness on children have also had to grapple with the difficulty of trying to demarcate where the effects on children of poverty-related sources of risk end and homelessness-specific risks begin. Children from low-income families, whether homeless or housed, face an array of chronic strains (e.g., hunger, feeling unsafe) and acute negative life events (e.g., exposure to community and domestic violence) that stem from the broader conditions of poverty. In terms of exposure to such risk factors, homeless and low-income housed children differ far more from children in the general population than they do from one another. Despite their current housing status being dissimilar, homeless children and low-income housed children have many more similarities than differences in terms of the extent and nature of adversities to which they have been exposed (cf. Masten et al., 1993; Buckner et al., 1999). Even regarding housing status, it is important to note that homelessness is a temporary state through which people pass, not a permanent trait emanating from individual deficits (Shinn, 1997). Moreover, housed low-income children can often be found living in rundown and decrepit dwellings, thereby reducing the contrast between them and children living in shelter. When viewed in the context of a much broader range of adversities, it is apparent that *homelessness is but one of many stressors that children living in poverty all too frequently encounter*.

Ending Homelessness for Families: Evaluations of Different Housing Approaches

The research directly focused on housing interventions for homeless families has been largely limited to several descriptive evaluations, including evaluations of:

- housing and supports for families with histories of homelessness and other difficulties, such as the nine-city RWJF/HUD demonstration of services-enriched housing (Hambrick & Rog, 2000; Rog & Gutman, 1997; Rog et al., 1995a, 1995b), the Minnesota Supportive Housing and Managed Care Pilot (National Center on Family Homelessness, 2006, 2004a, 2004b), and the Charles and Helen Schwab Foundation Family Supportive Housing Initiative (Nolan, Magee, & Burt, 2004; Nolan et al., 2005);
- rapid housing programs for first-time or at-risk homeless families, including the Charles and Helen Schwab Foundation's Housing First Collaborative (LaFrance Associates, 2005); and
- transitional housing, including a descriptive review of a sample of transitional housing programs across the country (Burt, 2006) and an evaluation of the Gates Foundation's Sound Families Initiative (Northwest Institute for Children and Families, 2005).

In addition, findings that inform our understanding of how to improve the residential stability of families have emerged from longitudinal studies that examine factors related to increased stability. In this section, we highlight the main findings that emerge from these evaluations and research efforts.

The Role of Subsidies

Increasing the affordability of housing by affecting the supply and cost of housing or increasing disposable income by increasing wages or subsidizing costs of housing, childcare, food, and other

essentials would likely prevent homelessness among low-income families as well as end it for the majority who enter shelters. The findings of studies conducted during the 1990s with respect to the role of subsidies and affordable housing in ending family homelessness provide undeniable evidence for the role these supports can play.

In the WFRP, Bassuk, Buckner et al. (1997) found that, controlling for other explanatory variables, cash assistance in the form of AFDC and housing subsidies in the form of Section 8 vouchers or certificates were important protective factors. Ninety-three percent of low-income housed families had received cash assistance in the past year as compared to 72 percent of homeless families in the year prior to their homeless episode. For housing subsidies, these respective figures were 27 percent and 10 percent.

Other studies have indicated that the strongest predictor of exits out of homelessness for families is subsidized housing (Shinn et al., 1998; Zlotnick, Robertson, & Lahiff, 1999). In a longitudinal study of first-time homeless families and a comparison random sample of families on public assistance, residential stability five years after initial shelter entry was predicted only by receipt of subsidized housing (Shinn et al., 1998). Eighty percent of the formerly homeless families who received subsidized housing were stable (i.e., in their own apartment without a move for at least 12 months), compared to only 18 percent who did not receive subsidized housing (Shinn et al., 1998). Additional studies have found that families receiving subsidized housing upon discharge from shelter are less likely to return to shelter than families receiving some other type of placement (Stretch & Krueger, 1992; Wong, Culhane, & Kuhn, 1997). Similarly, after a policy of placing homeless families in subsidized housing was adopted in Philadelphia, the number of families entering shelter who previously had been in shelter dropped from 50 percent in 1987 to less than 10 percent in 1990 (Culhane, 1992).

Demonstration initiatives studying supportive housing with different intensities of services also found high stability rates, regardless of the intensity of the services received. In the nine-city RWJF/HUD study in which homeless families received both Section 8 certificates and various intensities of case management services across the nine sites, 88 percent of the families accessed and remained in permanent housing for up to 18 months (based on 601 families in six sites where follow-up data were available) (Rog & Gutman, 1997). This finding was replicated in a 31-site study of families in the Family Unification Program who received Section 8 certificates and child welfare services. Eighty-five percent or more of the families in each site were still housed after 12 months, despite different eligibility criteria and services across the sites, among other differences (Rog, Gilbert-Mongelli, and Lundy, 1998). Weitzman and Berry (1994), in a smaller study in New York City in the early 1990s, examined an intervention very similar to the RWJF/HUD intervention, involving subsidized housing coupled with short-term intensive case management compared to a group that received subsidized housing but no special services. At the end of a one-year follow-up period, the vast majority of families in both groups were housed, and less then 5 percent had returned to shelter. The type of subsidized housing received was the strongest single predictor of who would return to shelter, with families in buildings operated by the public housing authority more stable than those in an alternative city program (Weitzman & Berry, 1994).

The evaluation of the Welfare to Work Voucher Program (HUD, 2004; 2006) provides additional evidence for the effects of tenant-based rental assistance on self-sufficiency. Although the program is not specifically targeted to homeless families, it is targeted to families living on welfare who have a similar demographic profile. The study found that the program resulted in small but significant improvements in the quality of neighborhoods where people lived and that the vouchers greatly reduced a family's probability of becoming unstably housed or homeless.

Finally, examinations of transitional housing suggest that subsidies play an important role in successful transitions for many families. The preliminary evaluation of the Sound Families Initiative in the greater Seattle area indicated that 70 percent of families exiting did so with a Section 8 voucher (Northwest Institute for Children and Families, 2005). Moreover, the report concluded that nearly all families needed some type of housing subsidy to secure permanent housing, and in some cases families needed to stay in the transitional housing longer when there were reductions in voucher availability. In a review of 53 transitional housing programs across five communities, Burt (2006) found that, on average, 35 percent of those leaving transitional housing left with a subsidy (about half of those going into permanent housing). The percentage ranged by community, with the highest percentage being in Seattle/King County, coinciding with the Sound Families evaluation findings (Northwest Institute for Children and Families, 2005).

Although housing subsidies appear to be a critical resource for exiting or preventing homelessness, a small percentage of families go back to shelters after receiving subsidized housing. In the New York City follow-up study, 15 percent of 114 families who obtained housing subsidies returned to shelters at some point during the five-year follow-up period (Stojanovic et al., 1999); in the RWJF/HUD nine-site evaluation, 11 percent of the families entering shelter had previously received a subsidy. In the New York City study, reasons for leaving subsidized housing included serious building problems—safety issues, rats, fire or other disaster; condemnation; or the building's failure to pass the Section 8 inspection. In the RWJF/HUD study, informal discussions with city officials suggested that families may return to shelter because of failure to renew Section 8 certificates for a variety of reasons.

Need for More Information on Matching Interventions with Need

There have been no studies that compare the effectiveness of different types of housing approaches—transitional housing, permanent supportive housing, or permanent housing—for homeless families. The descriptive studies conducted to date focus on one approach and universally note the importance of affordability in housing. Almost all evaluations also describe the variability of implementation of the housing model. For example, as Burt (2006) notes, there is no standard model of transitional housing—the programs vary greatly with respect to who is served, services provided, the configuration of the housing, and the length of the programs, among other variables. Similarly, Rog and colleagues (1995a) found that even in a demonstration program that stipulated a services-enriched housing model, there was great variation among and within service sites as to the intensity of the case management provided. To date, there have been no studies examining the type of housing and service mix best suited to families with different needs. There have been no comparative studies of models, or studies that systematically varied the intensity of services. What does exist are descriptive evaluations of different housing models for specific subgroups of families, generally families with prior episodes of homelessness and other needs who may need supports. The most recent and current evaluations are described below.

The Minnesota Supportive Housing and Managed Care Pilot, a demonstration project funded by the state of Minnesota and administered by the Hearth Foundation, serves single adults and families with histories of homelessness exacerbated by other difficulties. The housing provides a range of supports to those living in the subsidized housing. A multi-pronged evaluation is being conducted by the National Center on Family Homelessness, and includes a multi-year qualitative study, a cost study, an adult outcome study, and a study on the children in the families. Preliminary data indicate dramatic increases in days spent in their own housing despite struggles with deep-seated problems (National Center on Family Homelessness, 2006, 2004b).

Similarly, in a descriptive evaluation of the Family Permanent Supportive Housing Initiative funded by the Charles and Helen Schwab Foundation (Nolan et al., 2005; Nolan, Magee, & Burt, 2004), which also targets families with substantial prior homelessness (an average of four prior episodes and four years homeless), families realized substantial subsequent residential stability, having lived in their current supportive housing residences for an average of 2.2 years at the time of the evaluation.

Finally, the Charles and Helen Schwab Foundation Housing First Initiative was designed to rapidly house and help maintain the stability of at-risk families who did not have a prior history of homelessness or significant barriers to housing (including active substance abuse, recent domestic violence experience). The evaluation of the initiative (LaFrance, 2005) found that 88 percent of the families targeted had been successfully housed in Section 8 or market rate housing, and the time it took to become housed had been significantly reduced. Year 1 outcomes indicated that only one family housed had lost the housing. This program also provided housing search assistance, move-in and other financial assistance, and home-based case management.

In sum, the evaluations to date of housing interventions all note improvements in housing stability, and often improvements in other outcomes (e.g., income; child school attendance), for the families they serve. However, without comparative information, we still lack knowledge of what level of housing and assistance is needed by whom to acquire and remain in housing.

Ameliorating the Problems Homeless Families Face

The major examination of services for homeless families that has occurred since 1998 is the Center for Mental Health Services (CMHS) and Center for Substance Abuse Treatment (CSAT) Homeless Families Program, a five-year, two-phased, multisite study initiated in 1999 to advance knowledge about the effectiveness of interventions for homeless mothers with psychiatric and/or substance abuse disorders who are caring for their dependent children (Rog, Buckner al., in press). It was specifically designed to be the first multisite evaluation of the effectiveness of innovative interventions, compared to services as usual or alternative interventions, in addressing the particular treatment and service needs of homeless families.

The focus of the target intervention in each site in the CMHS/CSAT Homeless Families Program was to be a time-limited (i.e., no more than a nine-month period of intensive services) intervention aimed at meeting the psychiatric, substance abuse, and/or trauma services needs of homeless women with children. The interventions were to be existing programs in the community, but could be enhanced. All target interventions were to be multifaceted, involving a combination of services focused on mental health treatment, substance abuse treatment, trauma recovery, securing and maintaining housing, parenting skills, household and money management, and goal setting.

Despite having a common set of core parameters, the target intervention models varied widely across the eight sites. Most sites involved some form of “intensive case management,” but combined that approach with other services in various settings. Three sites used more comprehensive service approaches, including (1) a multidimensional family assistance intervention in which families were provided with multisystemic therapy both in the shelter and in their residence (Henggeler et al., 1998), (2) multiple services (i.e., family-centered case management, home-based parent support, education and skills training, and child-focused interventions such as primary care) through a Comprehensive Family Health

Practice within a community health center, and (3) a family therapeutic community in a residential substance abuse treatment program that was enhanced with trauma recovery and aftercare components.

Results from the CMHS/CSAT initiative are currently being analyzed and reported. Overall, the study did not find any effects of the target interventions on a range of outcomes for the homeless families compared to services as usual (e.g., Pearson et al., in press; Rog, Buckner et al., in press; Sacks et al., in press). However, for substance abuse and mental health outcomes, having more on-site services in these areas was associated with greater improvements for all families, and especially for families with clinical-level need for substance abuse and mental health services (Pearson et al., in press; Rog, Buckner et al., in press) Homeless mothers in programs that provided more on-site mental health services, such as having a psychiatrist or psychologist on site and having designated mental health providers who could provide an array of mental health services in the shelter or other setting where the families resided (e.g., residential treatment), experienced a greater decrease in their mental health symptoms than mothers who were in programs that had fewer on-site services and/or relied on referral services. Similarly, homeless mothers in programs with on-site substance abuse services reported less substance use over time than mothers in programs with fewer on-site services.

In addition, because of the multisite study's longitudinal design, it was possible to examine trajectories of change over time and to examine the role of other time-varying conditions on families' outcomes. On most outcomes, families in both the target and comparison conditions on average had a positive rate of change. However, for each outcome, there was a substantial segment of families who started with mental health problems severe enough to warrant treatment and who did not show improvement over 15 months. Across outcomes, reports of ongoing trauma and network conflict were associated with less improvement, whereas employment was associated with more improvement (e.g., Pearson et al., in press; Rog, Buckner et al., in press; Sacks et al., in press). These findings suggest the need for not only understanding the history of problems families have as they enter shelter and other settings, but also the struggles they continue to experience that may be interfering with their ability to progress.

Interventions Focused on Homeless Children

There continue to be a limited number of evaluations of interventions that target homeless children (or their mothers) in an effort to improve their well-being. A few studies have evaluated school-based or summer program interventions for homeless children (Nabors, Weist et al., 2004; Nabors, Sumajin et al., 2004). More recently, Buckner et al. (in press), examined the effectiveness of multifaceted, mother-focused interventions on improving the behavior of children who participated in the eight-site CMHS/CSAT Homeless Families Program Initiative. Data were collected at four time points (an initial assessment followed by three similar assessments 3, 9, and 15 months later) on 1,103 children, ranging from 2 to 16 years of age, who were living with their mothers. Hierarchical linear modeling was used to examine whether intervention status, programmatic emphases, and other factors predicted rate of change in behavior problems over time. While the results indicated that, overall, children's problem behaviors improved over time, neither treatment status (target intervention versus comparison intervention group) nor programmatic emphases were associated with change in problem behaviors either within or across the eight sites. Consistent with previous research, measures of the mother's psychological distress as well as parenting practices were found to be good independent predictors of child behavior problems. Results from this study indicate that further research and program development are needed to identify effective strategies for addressing the mental health and behavioral needs of homeless and low-income children.

Preventing Homelessness

Targeting Families for Prevention

The importance of subsidies in reducing the risk of family homelessness among poor families strongly suggests that increasing the amount and access to these benefits to such families would likely result in a lower incidence rate of family homelessness. Policies to reduce the cost of housing, thereby making it more affordable, are also important. Broad-based efforts to help families pay the cost of housing and to lower such costs are needed to prevent family homelessness.

However, preventing family homelessness in a more targeted fashion by selecting low-income families who are most at risk to be recipients of a preventive intervention remains difficult at this time. This is due both to the difficulty of selecting families who have a very high risk of homelessness and the challenges of ameliorating those risks enough to substantially lower the probability of their becoming homeless.

Trying to broadly identify families who are most vulnerable to homelessness—even among extremely low-income people—may be inefficient. In the recent reanalysis of the Fragile Families study (Rog et al, 2007), a longitudinal study of a nationally representative birth cohort of new parents and their children, we found that even among women who are extremely poor (at or below 50 percent of the poverty level), the risk of being homeless is not as large as one might expect. Using a very broad definition of homelessness, fewer than 1 in 10 (8 percent) of the women in this poverty sample indicated that they had been homeless for even one night over a one- to three-year period. This number, however, is tempered by the fact that attrition could account for greater difficulty in locating homeless families or families experiencing residential instability at the time the interviews were being conducted. Despite at least 20 telephone or in-person attempts made with each eligible woman (Knab, personal communication), the study lost 11 percent of their baseline sample at Year 1, and 14 percent in Year 3, with only 6 percent missing both follow-ups. Approximately half of the missing cases were due to women refusing to be interviewed, being too ill to be interviewed, being incarcerated and unavailable to be interviewed, or being no longer eligible to be interviewed (e.g., parent or focus child was now deceased), while the rest were missing because they could not be located or had moved out of state[1]. If the assumption is made that the group of respondents who could not be located were all homeless, the upper bound for the percentage of women homeless increases to 23 percent for those who are in the poverty sample (Rog and Holupka, unpublished). Attrition analyses also indicated that among the factors that were significant predictors of missing data, several factors, including greater likelihood of reporting baseline substance use and domestic violence and less likelihood of receipt of TANF and/or Food Stamps at baseline, may suggest some level of vulnerability among those missing in Year 3 to being homeless. There are other factors, however, such as one site having greater attrition, that may have more to do with methodology and less with the personal characteristics of the individuals. Even with this upper bound of homelessness, however, fewer than one in four families living at 50 percent of the poverty level or less would be expected to experience homelessness within a three year period.

Similarly, Shinn and colleagues (1998), in their New York City study, needed 20 predictors to distinguish new applicants for shelter from the public assistance caseload in 1988. They were able to build a model

[1] For the Year 1 interview, 50 percent of the missing interviews were due to problems locating the respondent; in Year 3, 56 percent were missing for these reasons.

that correctly identified 66 percent of shelter entrants while targeting 10 percent of the public assistance caseload. With a large public assistance caseload, however, even 10 percent misidentified as needing services means that four families who would not become homeless would be identified for every family who would receive homeless services; thus 80 percent of services would be wasted. In addition, any model based on a single risk factor would do more poorly and a complicated model such as the one used by Shinn and her associates would be impractical.

Bassuk, Weinreb, Dawson, Perloff, & Buckner (1997), in their multivariate analyses of risk and protective factors that distinguished homeless from low-income housed families, also relied on a number of different variables. Their findings indicate that there are multiple sources of risk for family homelessness (in the realms of mental health, substance use, social supports, housing history and lack of subsidies) and that there is no one standout risk factor that, if ameliorated, would substantially lower the incidence rate of family homelessness.

Thus, targeting families based on their needs, such as domestic violence, mental health, and substance abuse, is likely not to be fruitful given the equally high rates for low-income families generally. In addition, none of these factors predicted shelter entry in New York, when other factors, primarily demographic characteristics and housing histories, were taken into account (Shinn et al., 1998).

Based on the research to date, two groups of families that may be at highest risk are young families and those who have experienced shelter in the past. As noted earlier, studies have consistently shown that homeless families are younger than other low-income families (Shinn & Weitzman, 1996). One possibility of identifying families at risk is to assess the housing assistance needs of pregnant women and mothers of newborns using health clinics serving low-income families. Housing loans and assistance to pregnant and new mothers, such as through WIC (the Women, Infant, and Children Food and Nutrition Information Program) and subsidized child care might help reduce burdens that contribute to financial problems that can lead to homelessness.

In addition, there is a small subgroup of families who return to shelter, even after receiving subsidized housing. In New York, families who left subsidized housing to return to shelter did so primarily because of serious building problems or safety issues (rats, fire or other disaster, condemnation, or the building's failure to pass the Section 8 inspection) (Stajonovic et al., 1999). Thus, efforts to assure the quality of housing to which families go might lower shelter return rates. Finally, poor families with many competing financial pressures may benefit from subsidies paid directly to landlords, to aid in making housing the first priority.

Another approach to preventing homelessness is to select families on the basis of the neighborhoods in which they live. In Philadelphia and New York, between three-fifths and two-thirds of families entering shelter over an extended period came from identifiable clusters of census tracts (Culhane, Lee, & Wachter, 1996). Geographic-based prevention could include a range of environmental- and individual-focused efforts, including housing construction or rehabilitation, job development and training, child care that permits mothers to take jobs, substance abuse treatment, and so forth.

Community-Wide Prevention

To learn about effective prevention strategies, the U.S. Department of Housing and Urban Development funded a study to identify communities that have implemented communitywide prevention strategies with

documented effectiveness and to describe and review these strategies and the supporting data (Burt, Pearson, & Montgomery, 2005). Six communities were ultimately selected, three for their primary prevention strategies for families: Hennipen County, Minnesota; Montgomery County, Maryland; and five counties in the Kansas City metropolitan area. These three communities targeted families with short-term problems that could be resolved with the resources they had available. Communities offered cash assistance to prevent eviction and pay back rent, utilities, and mortgage, as well as other in-kind assistance and counseling. Other strategies used included mediation services, which help families resolve conflict with various parties; rapid exit strategies, which get families into housing first (or exiting shelters quickly); and programs that use data and research to target families at highest risk of entering shelter for special outreach and assistance (Burt, Pearson, & Montgomery, 2005). The authors also note that there is ample evidence for housing subsidies as a prevention strategy from other studies, though not in their six-community review.

Overall, the study concluded that the most effective prevention efforts were in communitywide systems having elements that affect their ability to target families well (e.g., systems for sharing data); reflect the community motivation and obligation to serve this population; maximize resources, such as agency collaboration; and demonstrate community leadership in setting future direction. Of the three communities studied, Hennepin County was found to have most of the elements and thus had the best potential to prevent homelessness and document its success.

Recommendations for Future Research

Research on Homeless Families

Broader geographic samples. The research base on homeless families has grown over the last decade, but there continue to be significant gaps in knowledge that, if addressed, could bolster our understanding of the needs of families and strategies for preventing and reducing homelessness. One of the limitations of the current research base is that most of the rigorous studies are in selected cities across the country and several are targeted to specific subgroups of families, often those with heightened needs. Thus, there is a need for information on homeless families from broader geographic areas, especially in the Midwest and South and in rural areas. There is also an absence of research on key population groups, including families at risk for homelessness; moderate-need families; families who fall back into homelessness after receiving interventions; families who are working but continue to be homeless; two-parent families; families headed by a single father; families living in extended family networks; and single homeless adults who are noncustodial parents.

Longitudinal designs. Most studies to date, with a few recent exceptions, have had cross-sectional designs. Longitudinal studies are needed to explore the course of residential instability and homelessness over several years, and the individual, contextual, and intervention factors that influence this course. Longitudinal research of at-risk families would also help to differentiate distal risk factors for homelessness from proximal, mediating variables, which serve as risk and protective factors for family homelessness.

Research on housing affordability strategies. The core importance of housing affordability in mitigating homelessness among families and children calls for research on broad-scale housing and income policy interventions. For example, among the interventions that could be studied for effects on

rates of homelessness are varying amounts of housing subsidies; tying income supplements to housing vouchers; and any other mechanisms for increasing incomes and reducing housing costs for young families.

Intervention research. Finally, there is still a large need for research on the match between housing approaches and the needs of families. In particular, there is a need for rigorous data on the role of services in ameliorating the range of health, mental health, child welfare, substance abuse, and other service needs that families may have, especially in the context of providing housing. How much service is needed and by whom? The evaluations to date provide evidence that most tested housing approaches result in increases in housing stability, but there are no studies to date that offer comparative information on different housing and service models. These data are critical to understanding which families need what level of intervention to acquire and keep housing as well as to make strides in other outcome areas (e.g., employment).

The findings from the CMHS/CSAT Homeless Families Project indicate the challenges of devising effective interventions to address the mental health, substance abuse, and housing stability issues of mothers who are homeless (Rog, Buckner, & the CMHS/CSAT Homeless Families Program Steering Committee, in press). Additional intervention development work is needed to learn effective strategies that benefit homeless families in these realms.

Research on Children Who Are Homeless

Understanding the specific homeless experience and its impact. Research conducted to date on children who are homeless has illuminated a fair amount of knowledge on current needs and the impact of homelessness. It would be desirable for future research to address aspects of the homelessness experience that are particularly detrimental to children (Buckner, 2004b). This could help refine the question from *whether* homelessness has an effect to what *aspects* of homelessness are prone to creating problems in what age groups and in what domains. Shelter conditions are probably an especially important factor in moderating the impact of homelessness for a child and research is needed in this area. No doubt, this would be a challenging task and most previous studies have likely not encountered sufficient variability in shelter conditions to examine such issues. Nonetheless, it stands to reason that there are important qualities of shelters that may worsen or buffer a child's experience while living there. These could include the amount of privacy accorded to families, the crowdedness of the facility, the extent to which rules are strictly enforced, the warmth and skill level of shelter staff, the size of the facility, its location, and whether families are asked to leave during the day or may remain on the premises.

In addition, it would be useful to clarify the relative impact that homelessness can have on children in relation to a wider range of negative life events and chronic strains that children living in poverty experience. This would be helpful in better targeting treatment resources and preventive efforts to those low-income children (homeless and housed) most in need.

Research on subgroups of children who are homeless. Likewise, further research on whether there are special subgroups of homeless children with needs would help to determine whether it makes sense to more narrowly target intervention and treatment resources to select children living in shelters. Most of the research to date on children who are homeless has taken a *variable-centered* approach to analyses, focusing on specific areas such as mental health, behavior, and academic performance. Little if any attention has been paid to whether there are subgroups of children with quite different patterns of

functioning *across* these areas of domains. One study that did employ a *person-centered* approach (Huntington, Buckner, & Bassuk, in press) used cluster analysis to determine whether preschool and school-age homeless children could be classified into subgroups based on measures of behavior problems, adaptive functioning, and achievement. Interestingly, two very distinct subgroups were found within each age category: children who were doing reasonably well across each of the three domains (behavior, adaptive functioning, and achievement), and children who were consistently evidencing worse problems or lower functioning in these realms. These results warrant replication in other settings but suggest that children who are homeless, when compared across indices of functioning, are not a homogenous group.

Intervention research. Very little progress has been made in determining effective interventions that specifically target children who are homeless. Evaluations of the impact on children of interventions that primarily focus on the mother as the recipient of services have yet to yield promising leads. If homeless children are to benefit, it is likely that more child-centric intervention strategies will need to be developed and tested.

Parent-child separation. Parent-child separation is an important area that needs further research. The factors that account for child separation from families prior to shelter entrance need to be better delineated. Also, the effects of such separation on children have yet to be investigated. Mostly due to logistical reasons, research on homeless children to date has focused entirely on children who remain with their parent(s) and have not included children who have been separated.

Resilience. It is also worthwhile to understand factors both internal and external to a child that lead to positive outcomes despite the adversities of poverty. Such findings lend themselves to more strengths-based interventions that attempt to promote positive factors as opposed to trying only to eliminate risk factors. Buckner, Mezzacappa, and Beardslee (2003) found two characteristics of homeless and low-income children in Worcester that distinguished those who were resilient from those who were not doing nearly as well on multiple indicators of mental health and adaptive functioning. One of these factors was parental monitoring. A child whose parent(s) engaged in active awareness of where and with whom their child was on a daily basis tended to exhibit more resilience. Another, even more important, variable distinguishing resilient from non-resilient children was an internal set of cognitive and emotional regulation skills that researchers refer to as "self-regulation" (Baumeister & Vohs, 2004). Self-regulation helps an individual accomplish both short and longer term goals and can be important in coping effectively with stress. In the WFRP, children high in self-regulation looked much better across measures of mental health, behavior, adaptive functioning, and academic achievement than children low in self-regulation (Buckner, Mezzacappa, & Beardslee, n.d.). Furthermore, those high in self-regulation appeared to be better able to cope with stressors in their lives. Variables such as parental monitoring and self-regulation offer promising leads for strengths-based interventions to promote resilience in homeless and other low-income children.

Conclusion

This paper provides a summary of the literature on the risk factors and characteristics of homeless families and children as well as a synopsis of what has been learned through tested interventions to reduce homelessness, ameliorate its conditions, or prevent its occurrence. The paper highlights the implications of what has been learned for future prevention, intervention, and research efforts.

Overall, research to date has guided us in understanding the factors that heighten a family's vulnerability to homelessness—largely resources and life stage—and the problems faced by families who experience homelessness. Although certain problems, such as family separations, are greater for homeless families, most of the struggles experienced by homeless families are also experienced by families who are equally poor but remained domiciled. Similarly for children, studies involving both homeless and low-income housed children have consistently uncovered evidence for a "poverty-related" impact on children, that is, finding that both groups have more problem measures compared to children from non-poverty backgrounds. As such, homelessness serves as an important marker of risk for children. Detecting an additional, homelessness-specific, impact in different realms of child functioning has been more difficult.

What we know about intervening is that subsidies have a strong role in reducing homelessness and helping to end it for families who receive them. There has been much less research on strategies for dealing with risk factors or the struggles families cope with on a day-to-day basis. We need to know more about the housing and services that are needed to match the "typology" of families that exist. It may be most advantageous to develop interventions from the "ground up," examining the needs that families have and understanding the possibilities and constraints in the context of implementing different interventions. This may involve developing a theory of intervention based on what we know about the problems families are experiencing and the realities of what is available or can be made available. Clearly, targeting those most in need of services may be the most efficient and worthwhile approach to addressing psychosocial and substance abuse issues. Data collected thus far suggest that most families may improve over time with limited intervention, but there may be a subset of families living in shelters that require much more intensive interventions than are readily accessible.

The low incidence of homelessness even among those who have limited financial means suggests that there is more efficiency in mounting secondary, versus primary, prevention efforts targeted to families at imminent risk of homelessness. Strategies underway that warrant further study include conflict mediation, financial assistance strategies, and other context-specific strategies. This is not to rule out other prevention efforts, as it is clear that many families are living on the edge and precariously housed, but to acknowledge that prevention of imminent homelessness is likely best focused on those who request shelter.

Finally, more research is needed on the course of homelessness and its effects on families, especially on children. These studies need to strive to focus on broader populations of families (i.e., not just those with specified needs) to provide a greater understanding of the needs of various segments of the population and how they may be best met.

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Homeless Youth in the United States: Recent Research Findings and Intervention Approaches

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Abstract

In this paper, the authors cite research indicating that youth may be the single age group most at risk of becoming homeless, yet comparatively little research has been done in the past decade on this vulnerable population. Some important progress has been made, including longitudinal studies on youth "aging out" of foster care. After reviewing the characteristics of homeless youth, the authors review recent research findings on the homeless youth population and interventions developed to address their housing and service needs. These include interventions directed at youth themselves (education, employment, social skills training) as well as family-focused strategies. The authors conclude with future directions for both research and practice.

Introduction

Homelessness among adolescents and young adults is a major social concern in the United States. Robertson and Toro (1999) concluded that youth may be the single age group most at risk of becoming homeless. Nevertheless, most of the research that has been conducted over the last two decades has focused on homeless adults, including those with mental disorders and substance abuse problems. Studies that have examined homelessness among adolescents and young adults as well as other age groups, have often cast the problem as one of individual vulnerabilities rather than as a social phenomenon involving transactions between individuals and their environments (Haber & Toro, 2004; Shinn, 1992; Toro et al., 1991). This research has also been of limited value with respect to the development of public policies or empirically based interventions that either assist youth who are currently homeless or prevent homelessness among adolescents and young adults who are at risk (Shinn & Baumohl, 1999; Toro, Lombardo, & Yapchai, 2002).

These problems notwithstanding, some progress has been made since Robertson and Toro reviewed the literature on homeless youth over eight years ago for the 1998 National Symposium on Homelessness Research. Longitudinal studies, including research on youth "aging out" of foster care, have been an important source of information. Our knowledge about what works when it comes to prevention and programs that target homeless youth has also increased, although significant gaps remain. After briefly discussing some definitional issues and describing the homeless youth population and its constituent subgroups along a number of dimensions, we summarize what has been learned in recent years.

Definitional Issues. We begin with a fundamental question. What does it mean to say that a youth is homeless? Alternatively, who does the population of homeless youth include? The Runaway and Homeless Youth Act (RHYA) defines homeless youth as individuals who are "not more than 21 years of age … for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement." Implicit in this definition is the notion that homeless youth are not accompanied by a parent or guardian (Haber & Toro, 2004). The McKinney-Vento Homeless Assistance Act, the primary piece of federal legislation pertaining to the education of homeless children, provides a somewhat different definition. According to Subtitle B of Title VII of that legislation, youth are homeless if they "lack a fixed, regular, and adequate nighttime residence." In contrast to the RHYA, McKinney-Vento applies not only to unaccompanied youth but also to those who are homeless or doubled up with their families. Because homeless families with children are the focus of another paper in this Symposium, we will adopt a more restrictive definition that excludes youth who are homeless with a parent or other guardian and youth who are wards of the state.

Homeless youth can be distinguished from two other homeless populations: single adults, who are predominantly male and do not have children in their custody; and homeless families, typically comprising a mother and her children.[1] Homeless youth include *runaways*, who have left home without parental permission, *throwaways*, who have been forced to leave home by their parents, and *street youth*, who have spent at least some time living on the streets as well as *systems youth*—i.e., young people who become homeless after aging out of foster care or exiting the juvenile justice system (Farrow, et al., 1992). Although these categories reflect important distinctions among youth with respect to the reasons they are homeless and their experiences while homeless, they are neither static nor mutually exclusive (Hammer, Finkelhor, & Sedlak, 2002), and it can be difficult to determine which label best applies. Youth may perceive themselves as being thrown out by their parents, while parents may perceive their son or daughter as running away. In other cases, youth may be removed from their home by child welfare authorities and then run away from their out-of-home care placement or leave home by mutual agreement with their parents. Street youth often spend significant amounts of time in adult caregivers' homes, shelters, and temporary quarters with friends or other family (Greenblatt & Robertson, 1993). The one thing homeless youth have in common is that they are on their own without the supervision of an adult caretaker (Haber & Toro, 2004). In order to allow review of the full array of relevant literature, the present paper uses a broad definition, including all youth ages 12 to 25 who fit either the RHYA or McKinney-Vento definition (so long as they are "homeless on their own").

[1] In the U.S. and other developed nations, relatively few homeless families (12 to 20 percent) include children age 12 or older (Buckner, Bassuk, Weinreb, & Brooks, 1999; Burt et al., 2001), and children under age 12 are rarely found homeless on their own (Robertson & Toro, 1999). In fact, many shelters for homeless families exclude children age 12 or older who shelter staff fear might prey upon the younger ones. As a result, homeless families with older children are often compelled to leave their older children with friends or relatives before entering a shelter.

Homeless Youth: A Brief Summary of the Existing Research Literature

In this section, we briefly review how homeless youth have been studied in the past and what is known about homeless youth from this research (for a more comprehensive review, see Robertson & Toro, 1999).

Haber and Toro (2004) describe four basic approaches used by researchers to sample homeless youth. The first approach is to survey large groups of youth in the general population and identify those with a history of homelessness (e.g., Ringwalt et al., 1998; Windle, 1989). These methods may misrepresent the total homeless youth population because they do not include youth who are currently homeless, who may well have longer histories of homelessness and other negative characteristics. The second draws youth from service settings such as inner-city clinics (Kipke, Montgomery, & MacKenzie, 1993; Yates et al., 1988). Of course, youth seeking services may be different from those who do not seek help. The third approach samples youth from shelters (e.g., McCaskill, Toro, & Wolfe, 1998). Some of the youth these facilities serve have been brought to the shelter by their families or third parties such as the police. Many have never spent a night on the streets. Such youth are often younger and less likely to have extensive histories of homelessness than street youth (Robertson & Toro, 1999). The fourth approach involves sampling from street locations where homeless youth are known to congregate and/or from drop-in centers designed to serve street youth (e.g., Cauce et al., 1994; Kipke, O'Connor, Palmer, & MacKenzie, 1995; Roy et al., 1998). This method often yields a sample biased toward youth who are engaged in a variety of deviant behaviors, especially if the sample includes many youth who are 18 or older. Some recent studies have combined the four methods in an effort to obtain more representative samples (e.g., Heinze, Toro, & Urberg, 2004; Paradise et al., 2001; Toro & Goldstein, 2000; Unger et al., 1998; Whitbeck, Hoyt, & Yoder, 1999; Witken et al., 2005).

Prevalence and Geographical Distribution of Youth Homelessness

Just how many youth are homeless in a given year is difficult to know. Estimates vary widely depending on how "homeless" is defined and the age range that is used. Different sampling and estimation techniques can also yield different results. For example, Ringwalt and colleagues analyzed data collected from a representative U.S. household sample of nearly 6,500 youth, ages 12 to 17, as part of the Youth Risk Behavior Survey (YRBS) and found that approximately 7.6 percent had been homeless for at least one night during the past 12 months (Ringwalt et al., 1998). This would translate into approximately 1.6 million homeless youth each year. Similarly, the Second National Incidence Study of Missing, Abducted, Runaway and Thrownaway Children (NISMART II), which combined data from three different surveys (the National Household Survey of Adult Caretakers, the National Household Survey of Youth, and the Juvenile Facilities Study) estimated that approximately 1.7 million youth experienced a runaway or throwaway episode in 1999 (Hammer, Finkelhor, & Sedlack, 2002). Other studies have looked at the likelihood of ever becoming homeless during adolescence. According to one estimate, 15 percent of youth will become homeless at least once before age 18 (Ringwalt, Greene, & Iachan, 1994).

Homeless youth can be found in urban, suburban, and rural areas throughout the U.S., but tend to be most visible in major cities (Robertson & Toro, 1999). Moreover, although they may be an understudied population, homeless youth in rural areas have proven difficult to recruit (e.g., Heinze, Toro, & Urberg, 2004; Thrane & Yoder, 2000). Nevertheless, few differences have been found when urban, suburban, and rural homeless youth have been compared (Cauce et al., 2000; Thrane & Yoder, 2000). Studies

investigating street youth have generally been based in large metropolitan areas on the east and west coasts (e.g., Los Angeles, San Francisco, Seattle, and New York City), in part because researchers have not found large numbers of homeless street youth under age 18 in most midwestern and southern cities (Robertson & Toro, 1999).

Greenblatt and Robertson (1993) found both episodic and chronic patterns of homelessness among the youth they studied. However, the number of homeless episodes youth have experienced and the length of time they have been homeless seem to depend on whether shelter youth or street youth have been studied. Many youth in shelter samples are homeless for the first time and have not been homeless for very long (McCaskill, Toro, & Wolfe, 1998), whereas street youth tend to experience longer and more frequent episodes of homelessness (Whitbeck, Hoyt, & Yoder, 1999; Witken et al., 2005).

Age, Gender, Race/Ethnicity, Sexual Orientation, and Pregnancy

The vast majority of homeless youth are age 13 or older, although a few studies have identified small numbers of youth who are homeless on their own as young as 9 years old (Clark & Robertson, 1996; Robertson, 1991). Although at least one national survey of youth found that males were significantly more likely than females to report recent homelessness (Ringwalt et al. 1998), the distribution of males and females among homeless youth seems to vary depending on the source and age of the sample. Shelter samples tend to include either equal numbers of males and females or more females (e.g., Heinze, Toro, & Urberg, 2004). Samples of street youth or older homeless youth are disproportionately male (e.g., Cauce et al., 2000). There is also some evidence that during the transition from adolescence to young adulthood the risk of becoming homeless declines for females but rises for males (Boesky, Toro, & Bukowski, 1997).

There have been contradictory findings with respect to race/ethnicity. Neither Ringwalt et al. (1998) nor Hammer et al. (2002) found racial or ethnic differences in rates of homelessness among the youth they studied, and at least some research suggests that homeless youth tend to reflect the racial and ethnic make-up of the surrounding area. However, other studies indicate that racial and ethnic minority youth are over-represented (Cauce et al., 1994; McCaskill, Toro, & Wolfe, 1998; Owen et al., 1998).

Gay, lesbian, bisexual, and transgender (GLBT) youth comprise 6 percent of the homeless youth population according to the National Network of Runaway and Youth Services. However, other prevalence estimates range from 11 to 35 percent (Kruks, 1991; Tenner et al., 1998; Whitbeck et al., 2004). Compared to heterosexual homeless youth, GLBT homeless youth leave home more frequently and are exposed to greater victimization while on the streets (Cochran et al., 2002). In addition, these youth may experience more physical and sexual abuse from caretakers (Whitbeck et al., 2004). GLBT youth may be at particular risk for homelessness due to conflict with their family regarding their sexual orientation (Milburn, Ayala, Rice, Batterham, & Rotheram-Borus, 2006; Remafedi, 1987).

A significant percentage of homeless youth are pregnant or parenting. Greene and Ringwalt (1998) found that 48 percent of street youth and 33 percent of shelter youth had ever been pregnant or impregnated someone, compared to 10 percent of a nationally representative sample of housed youth. Research also suggests that approximately 10 percent of both street and shelter female youth are currently pregnant (Greene & Ringwalt, 1998; Solorio et al., 2006). The high rates of pregnancy in this population may

reflect the fact that many homeless youth engage in risky behaviors, including sex at an early age, survival sex, and inconsistent use of birth control.

Background Characteristics

Regardless of their pathways into homelessness, homeless youth share many background characteristics and experience many of the same psychosocial problems (MacLean, Embry, & Cauce, 1999). For example, they tend to come from low-income communities (McCaskill, Toro, & Wolfe, 1998) and their families are disproportionately poor or working class (Whitbeck et al., 1997). It is also not uncommon for homeless youth to report a history of family disruption. Many grew up in single-parent households or "blended" (i.e., stepparent) families (Boesky, Toro, & Wright, 1995; Greenblatt & Robertson, 1993), and a significant number of these youth have not had any contact with their non-custodial parent (Greenblatt & Robertson, 1993). The families of homeless youth also seem to have experienced far more residential moves than those of their housed peers (Cauce et al., 2000; Toro & Goldstein, 2000). In other words, their homelessness seems to be part of a longer pattern of residential instability.

Difficulties with School

Homeless youth often have a history of academic and school behavior problems. Between 25 and 35 percent of homeless youth report that they had to repeat a grade (Clark & Robertson, 1996; Robertson, 1989; Upshur, 1986; Young et al., 1983), and many have been suspended or expelled (Toro & Goldstein, 2000). Drop-out rates are also high (Thompson, Kost, & Pollio, 2003). Research suggests that at least some of these academic and school behavior problems may be attributable to attention deficit disorder (Cauce et al., 2000) or learning disabilities (Barwick & Siegel, 1996), which may be why homeless youth often report being placed in special education or remedial classes (Clark & Robertson, 1996; Robertson, 1989). Regardless of their cause, these academic and school behavior problems can be a source of family conflict and hence contribute to homelessness.

Family Conflict and Child Maltreatment

Youth consistently identify conflict with their parents as the primary reason for their homelessness (Whitbeck et al., 2002; Robertson & Toro, 1999), and they tend to report more family conflict than their peers who are housed (Toro & Goldstein, 2000; Wolfe, Toro, & McCaskill, 1999). These conflicts tend to reflect longstanding patterns rather than problems that arise just before youth leave home (Smollar, 1999). Conflicts related to step-parent relationships, sexual activity, pregnancy, sexual orientation, school problems, and alcohol or drug use seem to be the most common (Owen et al., 1998; Robertson & Toro, 1999; Whitbeck & Hoyt, 1999).

In addition to family conflict, many homeless youth have experienced child abuse and/or neglect (Boesky, Toro, & Wright, 1995; Molnar et al., 1998; Powers, Eckenrode, & Jacklitsh, 1990; Robertson, 1989; Rotherman-Borus et al., 1996; Rothman & David, 1985; Ryan et al., 2000; Tyler et al., 2001; Unger et al., 1998; Yates et al., 1988). In fact, homeless youth often cite physical or sexual abuse as their reason for leaving home (Robertson, 1989). Although the percentage of homeless youth who report a history of maltreatment varies widely across studies, research using comparison groups has found that homeless youth are more likely to have been abused and/or neglected than their peers who are housed (Wolfe, Toro, & McCaskill, 1999). This may also explain why homeless youth are more likely to have been verbally and physically aggressive toward their parents compared to their housed peers (Toro & Goldstein, 2000).

That is, their aggression may be in response to parental aggression directed at them (Haber & Toro, 2003).

Mental Health and Behavioral Disorders

Homeless youth seem to be at elevated risk for a variety of mental health problems, including mood disorders, suicide attempts, and posttraumatic stress disorder (Cauce et al., 2000; Clark & Robertson, 1996; Feitel et al., 1992; Fronczak & Toro, 2003; Greenblatt & Robertson, 1993; McCaskill, Toro, & Wolfe, 1998; Powers, Eckenrode, & Jaklitsch, 1990; Rew, Thomas, Horner, Resnick, & Beuhring, 2001; Rotheram-Borus, 1993; Robertson, 1989; Stewart et al., 2004; Toro & Goldstein, 2000, Yates et al., 1988). The risk of mental health problems may be particularly high among street youth, who tend to have experienced more stressful events and to exhibit more psychological symptoms than homeless youth who have not spent time on the streets (Robertson & Toro, 1999; Whitbeck & Hoyt, 1999).

Behavioral problems, such as conduct or oppositional defiant disorder, may be even more prevalent than mental health problems (Cauce et al., 2000; McCaskill, Toro, & Wolfe, 1998; Toro & Goldstein, 2000). Homeless youth also exhibit high rates of substance use disorders, including alcohol abuse or dependence and drug abuse or dependence (e.g., Baer, Ginzler, & Peterson, 2003; MacLean, Paradise, & Cauce, 1999; Robertson, 1989; Rotheram-Borus, 1993; Thompson, Sayfer, & Polio, 2001; Thompson, Kost, & Pollio, 2003; Van Leeuwen, 2002; Van Leeuwen et al., 2005; Yates et al., 1988).

Although the prevalence of some diagnoses (e.g., depression) has been consistent across studies, lower rates are found for other disorders (e.g., conduct disorder) when more rigorous assessments are used and when homeless youth are recruited from shelters rather than the streets (Robertson & Toro, 1999). Nevertheless, regardless of the sample or the assessment method used, mental health and behavioral disorders seem to be more prevalent among homeless youth than among matched housed peers or the general adolescent population (McCaskill, Toro, & Wolfe, 1998; Toro & Goldstein, 2000). Unfortunately, the reason for the high prevalence rates observed among homeless youth is far from clear (Robertson, 1992; Robertson & Toro, 1999; Toro, 1998). Mental health and behavioral disorders contribute to family conflict and thus to homelessness. However, causality could also be in the opposite direction (Cauce et al., 1994; MacLean, Embry, & Cauce, 1999). Alternatively, some other factor or combination of factors could be a cause of both.

Risky Behaviors and Victimization

A number of studies have found not only that many homeless youth are sexually active, but also that they engage in sexual behaviors that put them at high risk for both sexually transmitted diseases and pregnancy (Cauce et al., 1994; Kipke et al., 1995; Lombardo & Toro, 2004; Rotheram-Borus, 1991; Rotheram-Borus et al., 1992a, 1992b; Staller & Kirk, 1997; Toro & Goldstein, 2000; Whitbeck & Hoyt, 1999).

Homeless youth also report engaging in delinquent or illegal activities, including stealing, forcibly entering a residence, prostitution, and dealing drugs (Whitbeck, Hoyt, & Ackley, 1997). Youth who engage in these “deviant” behaviors often report that they do so to obtain money, food or shelter (Van Leeuwen, 2002; Van Leeuwen et al., 2005). In other words, these behaviors may be part of a survival strategy (Robertson & Toro, 1999).

Being on their own without adult supervision means not only that homeless youth are likely to behave in ways that are unsafe, but also that they comprise an especially vulnerable group. This is reflected in the high rates of physical and sexual victimization they report (Greenblatt & Robertson, 1993; Tyler et al., 2004). Research has found not only that homeless youth are far more likely to be victimized than their peers who are housed (Stewart et al., 2004; Yates et al., 1988) but that many homeless youth are victimized repeatedly (Whitbeck, Hoyt, & Ackley, 1997).

Service Utilization

Despite extensive demonstration of the needs of homeless adolescents, few studies have explicitly attempted to document the full range of service utilization among this needy group. In a recent study done in Detroit (described in more detail below), a majority of both homeless and matched housed youth failed to receive adequate services given their risks for disturbances in medical and psychosocial functioning (Toro & Goldstein, 2000). Only 2 percent of the homeless youth reported utilizing soup kitchen or outreach services, while 18 percent reported using inpatient or outpatient psychological services (Toro & Goldstein, 2000). Following youths for over two years showed that less than 1 percent reported using services after the initial interview.

New Areas of Research Since 1998

Several new areas of research on homeless youth have emerged since Robertson and Toro completed their review for the 1998 National Symposium on Homelessness Research. These areas include longitudinal studies of homeless youth, research on youth leaving the foster care and juvenile justice systems, and intervention and prevention research. Also there has been some development and evaluation of theoretical models explaining youth homelessness.

Longitudinal Studies

Tracking homeless youth over time can suggest both causes of and possible solutions to the problems they experience. Unfortunately, only a few such studies have been done to date (e.g., Cauce et al., 1994), and few of their findings have yet been published in peer reviewed journals. In part, this paucity of data reflects the fact that data in these longitudinal studies are still being collected. However, it also indicates a general lack of research on homeless youth (as compared to other homeless groups) and a particular lack of longitudinal research on this population.

In any event, we can draw some conclusions based on preliminary results from a study by Toro and his colleagues. A probability sample of 249 homeless youth from throughout the Detroit metropolitan area, plus a matched sample of 149 housed youth, were initially interviewed at ages 13 to 17 and have been followed since at six time-points over a seven-year period. The youth are now aged 20 to 24, and data collection is nearly complete. Most of the adolescents returned fairly quickly to their family of origin. Nearly all (93 percent) of the initially homeless adolescents in the sample were no longer homeless at the 4.5-year follow-up, with one-third living with their parents (33 percent), another third living on their own (34 percent), and still others living with friends or relatives (21 percent). At follow-up, the initially homeless adolescents also reported significantly less conflict with their family and fewer stressful events (Toro & Janisse, 2004). Such trends have also been observed in longitudinal studies of homeless adults (e.g., Toro et al., 1999). People who are sampled because they are currently homeless are often at a

particularly low point in their lives. Over time, many exit homelessness and thus appear to function at least somewhat better at follow-up, even though they often are not fully part of "mainstream society" and are likely to be at risk for future homelessness and/or other poor life outcomes.

Ahmed and Toro (2004) used data from the same longitudinal study to examine the relationship between several dimensions of religiosity and substance abuse outcomes over an 18-month follow-up period. Both cross-sectional and longitudinal analyses found that religiosity "buffered" the potentially harmful impact of stress on the outcomes. At the 4.5- year follow-up, greater spirituality protected African American, but not European American, young adults exposed to high levels of community violence or alcohol and drug abuse (Fowler, Ahmed et al., 2006).

Roy and her colleagues in Montreal have been studying various samples of street youth (age 14 to 25) and have followed one sample to observe various health outcomes, including HIV infection (Roy et al., 2003). They have, for example, found high mortality, with an annual death rate of 1 percent (Roy et al., 2004). The most common cause of death, by far, was suicide. This research group is now conducting another longitudinal study with more general purposes. Longitudinal findings will begin to be available in late 2007.

Milburn and her colleagues have followed homeless youth, aged 12 to 20, in Los Angeles (*N*=498) and in Melbourne, Australia (*N*=398), over a 12-month period (see Milburn, Rotheram-Borus et al., 2006; Witken et al., 2005). The longitudinal findings are just beginning to be reported in the professional literature (e.g., Milburn, Ayala, et al., 2006; Rosenthal et al., 2007).

Homelessness Among Former Foster Youth

Many homeless youth report a history of out-of-home care placement. The percentage who report being placed in foster care or an institutional setting varies across studies, but estimates range between 21 and 53 percent (Cauce et al., 1998; Robertson, 1989, 1991; Toro & Goldstein, 2000). A similar pattern has been observed among homeless adults (Firdion, 2004; Toro, Wolfe et al., 1999).

Of particular concern in this regard is the experience of youth who "age out" of foster care when they turn 18 or, in some states, 21. Although these youth are expected to live independently and support themselves once they leave the child welfare system, they often lack the financial, social, and personal resources needed to do so (Lindblom, 1996). As a result, this population is at high risk of becoming homeless after they age out. In fact, studies conducted in both Hollywood and San Francisco found that more than one-quarter of the street youth who had been discharged from state care spent their first night in a shelter or on the streets (Clark & Robertson, 1996; Robertson, 1989). Findings from several recent studies of youth aging out of foster care also illustrate this link.

The Foster Youth Transitions to Adulthood Study. Courtney et al. (2001) collected baseline survey data from 141 Wisconsin foster youth in 1995. The youth were 17 or 18 years old and had been in care for a minimum of 18 months. Eighty percent, or 113, of these foster youth were re-interviewed 12 to 18 months after they left care. These young adults were similar to the baseline sample with respect to gender, race/ethnicity, and placement region (Milwaukee vs. the balance of the state). Among the outcomes the researchers examined was homelessness. Twelve percent of the follow-up sample reported being homeless for at least one night within 12 months of aging out (Courtney et al., 2001).

Youth Aging Out of Foster Care in Metropolitan Detroit. Fowler, Toro et al. (2006) surveyed 264 youth from the total population of the 867 youth who had aged out over a two-year period from the foster care system in the three largest counties in the metropolitan Detroit area. The 264 youth were interviewed, on average, 3.6 years after exiting from foster care. At follow-up, the sample had an average age of 20.6 years; 52 percent were female; and 78 percent were African American. The follow-up sample of 264 was representative of the population of 867 in terms of demographic characteristics (e.g., gender, age, race/ethnicity) and foster care experiences (e.g., number of placements, age at entry, reason for placement). The purpose of the survey was to assess the functioning of these youth across various life domains since leaving foster care. The domains included housing, education, employment, emotional and behavioral well-being, substance abuse, risky sexual behavior, and victimization.

A total of 17 percent of the youth experienced literal homelessness during the follow-up period, including 3 percent who were literally homeless at the time they were interviewed. By comparison, the national five-year prevalence rate for literal homelessness among all adults in the United States was just 2 percent in 2001 (Tompsett et al., 2006). Those who experienced literal homelessness did so for an average of 61 days; the likelihood of experiencing literal homelessness did not vary by gender or race/ethnicity.

Just because youth were not literally homeless did not mean that they always had a stable place to live. On the contrary, one-third of the youth had spent time doubled up with other families or "couch surfing" among friends and relatives because they could not afford more permanent housing. This includes 12 percent who were precariously housed at the time of their interview. The mean number of times that these youth were precariously housed was 2.8 and the median duration of each episode was 13 months.

Most commonly, youth attributed their precarious housing or homelessness to economic factors such as a lack of employment, lack of affordable housing, termination of public assistance, or eviction. One-quarter of the youth who became homeless attributed their homelessness to problems with their families. In fact, this was the most common reason for becoming homeless immediately following exit from the foster care system.

Significant differences were found among the literally homeless, the precariously housed, and the continuously housed. Literally homeless youth reported significantly more personal victimization and deviant behavior than youth who were either continuously or precariously housed. However, both literally homeless and precariously housed youth experienced higher rates of psychological distress and alcohol or other drug abuse than continuously housed youth. In addition, literally homeless youth were more likely to report engaging in risky sexual behavior as compared to housed youth. Additional analyses suggested that both literal homelessness and precarious housing increased the risk of personal victimization, which in turn, increased the likelihood of other negative outcomes, such as psychological distress, deviant behavior, and marijuana use, even after controlling for age, gender, and race.

There was also some evidence that becoming homeless immediately post-discharge may have particularly negative effects. Youth who experienced homelessness right after they left care reported greater psychological distress, victimization, and deviant behavior than those who did not become homeless until later. The former were also less likely to have a high school diploma or GED and less likely to have received additional schooling since leaving care. What is not clear is whether the youth who became homeless immediately were already more vulnerable at the time they exited, or whether they became more vulnerable as a result of becoming homeless so quickly.

In many cases, the youth who experienced housing problems after exiting foster care did not receive services to address their needs. Less than one-third received services at homeless shelters and only 3 percent received help from outreach services. Although nearly two thirds reported going a whole day without food, just 15 percent received assistance from soup kitchens. Likewise, 70 percent of these youth had clinically significant mental health, substance abuse, or behavioral problems, but only 21 percent received psychological services. In contrast, 88 percent of these precariously housed and homeless youth received medical care since aging out of the system. Many of the youth were able to take advantage of Medicaid eligibility allowed under state foster care policy in order to get medical care.

The Midwest Evaluation of the Adult Functioning of Former Foster Youth. The relationship between homelessness and out-of-home care placement is also being examined by an ongoing three-state longitudinal study that is following a sample of 732 foster youth from Iowa (63 youth), Wisconsin (195), and Illinois (474) as they age out of the child welfare system and transition into adulthood (Courtney et al., 2005). All of these youth had been victims of child maltreatment and entered foster care before age 16. The youth were initially interviewed at age 17 or 18, while they were still state wards, and then again at age 19. Just over half (321) of the 603 foster youth who completed a follow-up interview were no longer in care, and their mean time since leaving care was 14.5 months.

Although few of these youth were currently living on the streets, 14 percent (45) had been homeless for at least one night since they aged out. Homelessness was defined as sleeping "in a place where people weren't meant to sleep," sleeping "in a homeless shelter," or not having "a regular residence in which to sleep." Two-thirds of the ever-homeless group had become homeless within six months of exiting and more than half (54 percent) had experienced more than one homeless episode.

A multivariate analysis using logistic regression showed that the best predictor of becoming homeless after aging out was whether a youth had repeatedly run away from an out-of-home care placement. Running away more than once was associated with an almost ninefold increase in the odds of becoming homeless. There was also a positive relationship between the odds of becoming homeless and the number of delinquent behaviors in which the youth had engaged. By contrast, feeling very close to at least one family member reduced the odds of becoming homeless by nearly 80 percent.

Homelessness Among Youthful Offenders

Every year, approximately 200,000 juveniles and young adults ages 10 to 24 years are released from secure detention or correctional facilities and reenter their communities. Most of these individuals are not high school graduates and most have never held a job. Many have physical, mental health, or substance abuse problems. A recent study of 1,800 arrested and detained youth found that nearly two-thirds of males and nearly three-quarters of females met diagnostic criteria for one or more psychiatric disorders (Teplin, Abram, McClelland, Dulcan, & Mericle, 2002). Yet, few youth will have received high quality services while in custody. Moreover, as if their transition back into society were not difficult enough, they are often returning to neighborhoods with high rates of poverty, unemployment, and crime (Mears & Travis, 2004).

Although relatively little is known about the process of reentry among this population, Altschuler and Brash (2004) have identified a number of challenges they are likely to confront, including problems with family and living arrangements. Some youth return to supportive homes; others do not. Still others are

precluded from doing so by policies that prohibit individuals who have been convicted of certain drug offenses and other crimes from living in public or Section 8 housing (Popkin & Cunningham, 2001). Without a positive support network or stable living arrangement to which they can return, these juvenile and young adult offenders are at high risk of becoming homeless after their release. Once homeless, they may find themselves engaging in prostitution, selling or using drugs, or participating in other activities that could lead to their re-arrest.

There are no good estimates of the number of juveniles or young adults who become homeless upon release from detention or incarceration. Covenant House, a shelter for homeless youth in New York City, reports that approximately 30 percent of the youth they serve have been detained or incarcerated (New York City Association, 2005). These data also indicate that 68 percent had been living with family or guardians before incarceration. Eighty percent of the youthful offenders they served had neither completed high school nor obtained a GED, and 41 percent had a history of substance use. Interestingly, 49 percent also had a history of out-of-home care placement. In some instances, their child welfare case had been closed when they were detained or incarcerated and they had nowhere else to go upon release. This is true even if they had not yet turned 18 years of age because child welfare agencies are reluctant to take these youth back into their custody, especially if they have frequently "gone AWOL" or exhibited violent behavior (Riley, 2003; Travis, 2002).

Although most studies of youthful offenders have not included homelessness as an outcome measure, at least some research suggests that they are more likely to be homeless or precariously housed than other youth. Specifically, Feldman and Patterson (2003) compared 209 court-involved youth who participated in Workforce Investment Act (WIA) programs in Seattle–King County, Washington to 419 non-involved youth who participated in the same programs between July 1, 2000 and June 30, 2002. At program entry, the court-involved youth were less likely to be living with their parents and more likely to have no permanent address. Research on homeless adults has also consistently found high rates of prior incarceration, including incarceration while the adults were juveniles (Toro, 1998).

Intervention Research

Much progress has been made in providing services to homeless youth and families since 1987 when the Stuart B. McKinney Homeless Assistance Act (Public Law 100-77) was signed into law. There now exist a vast array of shelters and other emergency services to address the diverse needs of homeless individuals and families, including homeless youth (Toro & Warren, 1999). Increased funding from the federal government as well as other sources has also led to the development of new interventions. Although many of these interventions are designed to help homeless youth become and remain housed, some include other components such as mental health services, alcohol and other drug treatment, or HIV/AIDS risk reduction.

Unfortunately, few of these new interventions have been formally evaluated, and when evaluations have been done, rigorous experimental or quasi-experimental designs have generally not been used. In fact, we are aware of only one rigorous evaluation of a program for homeless youth (Cauce et al., 1998). Below, we describe some of the interventions that have been evaluated, discuss the results of those evaluations, and suggest directions for future research on promising interventions, even if those interventions have yet to be tested among homeless youth.

Case management. Recognizing the multiple and diverse needs of homeless youth, Robertson and Toro (1999) advocated for a comprehensive and intensive case management approach that would address the unique needs of each homeless youth. Such an approach could be implemented in existing shelters and drop-in centers, and the relationship that developed between homeless youth and their case managers could become an important resource for the homeless youth and their families.

Intensive case management has been used successfully with homeless families and adults (Homan et al., 1993; James, Smith, & Mann, 1991; Toro et al., 1997). At least some research suggests that it might also be effective with homeless youth (Paradise et al., 2001). For example, Cauce et al. (1994) evaluated an intensive case management program for homeless youth in King County (Seattle), Washington. Youth were randomly assigned to either intensive or regular case management. Both groups experienced improved psychological well-being and a reduction in problem behaviors after the first three months of the intervention. However, youth who received intensive case management exhibited less aggression, fewer externalizing behaviors, and more satisfaction with their quality of life than youth who received "treatment as usual."

Another promising service model is Urban Peak Denver, which provides overnight shelter as well as a variety of other services to homeless youth between the ages of 15 and 21 years. A case manager conducts a needs assessment and develops a case plan that includes educational and employment goals. Youth can receive shelter for as long as they are moving forward on their case plans, and those who have been discharged are followed for six months. According to Urban Peak's Client Database, which tracks the housing outcomes of youth who receive services, the percentage who experienced a positive housing outcome (e.g., moving into their own apartment, obtaining permanent supportive housing, or returning to their family of origin) ranged from a low of 48 percent in 2000 to a high of 65 percent in 2003 (Burt, Pearson, & Montgomery, 2005).

Family-focused interventions. Although many programs work primarily, if not exclusively, with the youth who are homeless, others have targeted the family. This makes sense given that youth often cite family conflict as the cause of their homelessness (Whitbeck et al., 2002; Robertson & Toro, 1999) and they often end up returning to their families of origin anyway (Toro & Janisse, 2004). Moreover, at least one study found that youth who return home to live with their parents experience more positive outcomes than other youth (Thompson, Pollio, & Bitner, 2000). Of course, this could simply reflect the fact that the youth who are able to reunify are the youth with the fewest problems.

In any event, there is relatively little evidence as to the effectiveness of family-focused interventions. One example that is sometimes cited is a 1998 study by Coco and Courtney. They described a family systems approach for preventing recidivism among runaway females. Unfortunately, their evaluation of the intervention was weak, being based on a single-case design with a simple pre and post assessment of family satisfaction to assess the impact of the intervention.

It should be recognized that there are cases in which a family-focused intervention would not be in a homeless youth's best interest. The most obvious example is a youth who has been severely neglected or abused. Other examples would include youth who have irreconcilable differences with their families, youth who have lost contact with their families, and youth whose families are homeless or precariously housed. In these cases, efforts must be made to find alternatives such as placement in foster care or

independent living. Unfortunately, placement options may be limited, and may not represent an improvement in living situation (e.g., Benedict et al., 1994; Rosenthal, et al., 1991).

Social skills training. In addition to their various service needs, many homeless youth lack what might be considered basic life skills, including meal preparation, household cleaning, time management, and budgeting (Aviles & Helfrich, 2004). Such skills are essential if they are to successfully transition out of homelessness and into successful adult functioning. Teare, Authier, and Peterson (1994) evaluated an intervention that used role-playing and a token economy to teach social skills to homeless youth receiving emergency shelter services. The assumption was that youth with social skills would experience fewer conflicts both during and after their shelter stay. The researchers reported that youth satisfaction with the program was generally high, that only 13 percent of the youth engaged in or expressed an intention to engage in self-destructive behavior, and that 69 percent did not exhibit any behaviors that were considered "out of control" (e.g., verbal or physical aggression). However, the researchers did not examine whether these outcomes reflected a change in behavior and their design did not include a comparison group that would have allowed them to assess the relationship between outcomes and participation.

School-based interventions. School contexts provide an opportunity to assess and address the needs of homeless youth. Although there is some evidence that school-based interventions can benefit school age children who are homeless with their families, we are not aware of any school-based interventions that target unaccompanied homeless youth. However, we believe that such interventions could easily be adapted for homeless youth, most of whom do attend school (even if not consistently). For example, the Empowerment Zone provided a mental health treatment package for low-income and homeless elementary school age children during summer school (Nabors, Proescher, & DeSilva, 2001). Trained teachers and mental health providers administered classroom and small group interventions and individual counseling, and parents were offered parenting classes. Results showed that parents reported a significant decrease in child behavioral problems following the intervention. Another study found favorable results for a classroom behavioral management system in which trained teacher assistants used bracelets to reinforce positive behavior among homeless elementary school age children (Nabors, Hines, & Monnier, 2002). Although these initial findings are promising, the programs need to be expanded and more thoroughly evaluated.

Other intervention research. A number of other studies have also examined the outcomes of homeless youth who received shelter services. Several of these studies have analyzed data from the Runaway and Homeless Youth Management Information System (RHYMIS). RHYMIS includes information about all of the runaway and homeless youth served by the Family and Youth Services Bureau's (FYSB) Basic Center and Transitional Living and Street Outreach programs. RHYMIS includes demographic characteristics, services provided, and status at program exit (Family and Youth Services Bureau, 2006).

For example, Thompson et al. (2002) examined the outcomes of 261 runaway and homeless youth in four Midwestern states who received emergency shelter and crisis services, and compared their outcomes to the outcomes of 47 at-risk youth who received services from longer-term day treatment programs. Demographic information about the runaway and homeless youth was obtained from RHYMIS. Baseline data were collected from both groups at program intake. Follow-up data were collected six weeks post-discharge from the runaway or homeless youth and six weeks after intake from the comparison youth. Both the shelter youth and the day treatment youth experienced positive changes across six domains

(runaway behavior, family relationships, school behavior, employment, sexual behavior, and self-esteem) and there were no significant group differences in the amount of change they experienced. Whether these improved outcomes persisted beyond the six-week observation period was not addressed.

Prevention Research

In addition to research on how to best address the needs of youth who are already homeless, other studies have focused on preventive interventions. This interest in the prevention of homelessness among youth is a relatively recent development (e.g., Lindblom, 1996; Shinn & Baumohl, 1999; Toro, Lombardo, & Yapchai, 2002), and many interventions designed to prevent youth from ever becoming homeless (primary prevention) could just as easily be used to prevent youth who are currently homeless from becoming homeless again (secondary prevention; see Dalton, Elias, & Wandersman, 2007). Below, we discuss a number of issues regarding the prevention of homelessness. We focus on two groups of youth for whom the risk of becoming homeless appears to be particularly high: youth aging out of foster care and juvenile offenders.

Family-focused preventive programs. Given that the youth frequently cite family conflict as the main reason for their homelessness, it should not be surprising that some homelessness prevention programs have focused on family dynamics and their impact on youth development. These programs include support groups for parents, parenting skills classes, and teaching conflict resolution skills. The assumption is that these programs will lead to improved family relationships, and thus prevent youth from becoming homeless.

One example of this approach is Project SAFE, a program operated by Cocoon House in Snohomish County, Washington (National Alliance to End Homelessness, 2002). Project SAFE provides three services to parents and other caretakers who are concerned about a youth's behavior: phone consultation, groups or workshops, and a resource library. Parents or caretakers can call and speak with a master's level therapist who works with parents to develop a plan of action and decide what community resources will be needed to implement the plan. Plans can include steps to help parents deal with personal problems that may be contributing to the conflict with their youth. Parents receive a follow-up call, usually one week later, to check on their situation and provide any additional referrals. Parents can also participate in support groups that focus on cognitive behavioral skills or educational workshops that seek to raise awareness of parental risk factors that contribute to problem behaviors. In both cases, the goal is to promote healthier family functioning and to prevent teen homelessness. In FY 2005–2006, Project SAFE served 194 parents/caretakers. Outcome data showed a significant increase in parents' perceived ability to cope with their youth as well as a significant decrease in parental perception of the youth needing to leave the home (Gagliano, 2006).

Another family-focused intervention that has the potential to reduce youth homelessness is multisystemic therapy (MST). Families are provided with intensive, home-based services. Master's-level therapists empower parents to control their adolescent's behavior by enhancing supervisory and monitoring skills. They also coordinate service provision among parents, individual counselors, teachers, peers, and others with a stake in the youth's future.

Numerous randomized controlled trials have shown that MST can reduce antisocial behavior, even years following the treatment among chronic juvenile delinquents (Henggeler et al., 1997; Henggeler, Pickrel,

& Brondino, 1999). MST clients have significantly fewer out-of-home placements and decreased recidivism (Henggeler et al., 1997; Henggeler, Pickrel, & Brondino, 1999). MST has also been successfully adapted for a wide range of other target groups of youth, including those with mental disorders and chronic health problems (Henggeler, 2006).

Homeless youth and delinquent youth have many similarities, including an absence of adult supervision, a lack of consistent discipline, and association with deviant peers (Whitbeck & Hoyt, 1999). Thus, future research should examine ways to tailor such programs to directly address the needs of youth at risk for homelessness as well as evaluate the efficacy of such programs.

School-based preventive programs. School-based programs have the potential to prevent homelessness in adolescents at risk to run away by providing prosocial niches outside the home where they may be less vulnerable to influences of deviant peers (Johanson, Duffy, & Anthony, 1996). In addition, youth may have more opportunity to develop positive social bonds that discourage deviant behavior often associated with family conflict (Hirschi, 1969). However, programs that target youth at risk for homelessness have yet to be developed or evaluated. In-school and after-school prevention programs have shown to be effective in reducing the risk of youth delinquency and substance abuse (Crank, Crank, & Christensen, 2003; Pierce & Shields, 1998), and thus, may be extended to reductions of homelessness.

Preventing homelessness among youth aging out of foster care. Preventing homelessness among youth aging out of care has long been a goal of federal policy. In fact, it was partly in response to several studies indicating that young adults who had aged out of care were at high risk of becoming homeless that Congress created the Title IV-E Independent Living Program in 1986 (Citizens' Committee for Children of New York City, 1984; New York State Council on Children and Families, 1984; Shaffer & Caton, 1984). For more than a decade, this was the primary source of funding available to states to prepare their foster youth for the transition to young adulthood. States could use their Title IV-E funds to provide housing services such as helping youth find a place to live; however, the law prohibited those funds from being used for transitional housing or independent living subsidies (Allen, Bonner, & Greenan, 1988; Barth, 1990).

The Title IV-E program was replaced when Congress passed the Foster Care Independence Act of 1999 (FCIA). Title I of this legislation established the John H. Chafee Foster Care Independence Program and doubled the federal allotment for state independent living programs that prepare foster youth for the transition to adulthood. These funds can be used to provide youth with a wide range of services, including services to promote education and employment, life skills training, health education, case management, and mentoring (Ansell, 2001). Two provisions, in particular, are relevant to the prevention of homeless among youth aging out of foster care. One allows states to use up to 30 percent of their federal Chafee funds to pay for the room and board of former foster youth who are at least 18 years old but not yet 21. The other requires states to use at least some portion of their funds to provide follow-up services to foster youth after they age out. In the past, such services could be provided at state option, but seldom were.

States are currently using their Chafee funds as well as funding from other sources to assist foster youth with housing. For example, the Massachusetts Department of Social Services uses some of its Chafee money to fund its Discharge Support Program, which helps foster youth with their first month's rent, security deposits, and other assistance, but the youth must be employed and able to pay their own rent. Connecticut's Community Housing Assistance Program (CHAPS) provides foster youth, age 18 and older

who are working and enrolled in school, with a subsidy for rent and other living expenses. In fact, CHAPS is part of a continuum of housing options for Connecticut foster youth that also includes group homes for 14- to 16-year-olds and transitional living apartments for 16- and 17-year-olds. Illinois's Youth Housing Assistance Program targets youth who have aged out or will soon age out and are at risk of becoming homeless. The program provides housing advocacy services to help youth between the ages of 17.5 and 21 to secure and maintain stable housing as well as cash assistance to help with deposits, emergency rental assistance, temporary rental subsidies, and furniture and appliances.

Partnering is another strategy that states have implemented to address the housing needs of foster youth. Some states are taking advantage of federal legislation that made youth aging out of foster care eligible for housing assistance under the Department of Housing and Urban Development's Family Unification Program (FUP). In these states, child welfare agencies collaborate with housing authorities and/or community-based organizations to provide foster youth with time-limited housing vouchers over 18 months as well as other services. States with FUP programs for foster youth include New York, Colorado, Ohio, and California. In addition, some localities, including New York City, give foster youth priority access to Section 8 vouchers.

Most recently, Toro, et al. (2006) have proposed a comprehensive program that would both prevent homelessness and other negative outcomes among youth aging out of foster care and improve their emotional, behavioral, and socioeconomic well-being. The intervention would target foster youth transitioning to adulthood beginning at age 17. The program would be based on an intensive case management model and MST approaches and would involve the assessment of service needs across a number of domains, advocacy for the provision of services, coordination of service provision, and monitoring of service delivery. Small caseloads and frequent contact between case managers and youth would be important to keep youth who lack support from family members or other adults from falling through the cracks and because the quality of the client-case manager relationship is a key predictor of successful outcomes (Casey Family Programs, 2005; Thompson et al., 2006).

Youth would generally be referred to community resources, but program staff could provide services that are not available as well as direct funds to support independence (e.g., rent money to avoid eviction). In addition to service provision, the program would focus on empowering youth to make responsible life decisions. Toward this end, case managers would use a person-centered approach that emphasizes youth's strengths and preferences as well as motivational interviewing (Miller & Rollnick, 2002), a therapeutic technique that seems to be effective in promoting positive change behaviors even among multi-problem populations such as low-income, African American substance abusing mothers (Ondersma et a., 2005). Toro et al. (2006) have also recommended that the intervention be evaluated using random assignment within a longitudinal design, with data collected at baseline and then again at 6-month intervals for 18 months in total. It is hoped that this intervention will be implemented and evaluated starting in late 2007.

Although independent living programs have been described (e.g., Hoge & Idalski, 2001), there is very little in the way of empirical data regarding their effectiveness. Due to another provision in the FCIA, states will soon be required to track the outcomes of current and former foster youth at ages 17, 19, and 21 and report those outcomes to the National Youth in Transition Database. Homelessness is one of the six outcomes about which they will be required to report.

Several other issues related to research on the prevention of homelessness among youth aging out of care also merit attention. First, findings from the Midwest study indicate that some foster youth, including those who run away repeatedly, are at even greater risk. Targeting those youth for preventive interventions both before and after they leave care would seem to make sense, and the impacts of those interventions should be formally evaluated. Second, the Midwest study also found that feeling close to at least one family member reduced the likelihood of becoming homeless. This has important practice implications for child welfare agencies. Specifically, it suggests that more attention should be paid to maintaining relationships between foster youth and members of their biological family, including grandparents and siblings. Such attention may, perhaps, even be appropriate when the family is somewhat dysfunctional, because, if we wish to prevent homelessness, some (even imperfect) support from family may be better than no support at all. What is not yet clear, and merits further investigation, is why closeness to family has what appears to be a protective effect. One possibility is that family members are a resource to whom foster youth can turn if there is no other place for them to stay. Another is that strong family ties reflect underlying individual or environmental resources that function to protect youth. In any event, interventions aimed at promoting family ties, where doing so is in a youth's best interest, should be developed and their ability to reduce the risk of homelessness should be explored.

Third, one of the most striking findings to emerge from the Midwest study was that the foster youth who were still in care at age 19 seemed to be faring better than their peers who had left. There were statistically significant differences across a number of domains, including college enrollment, access to health care, and criminal justice system involvement, and they consistently favored the 19-year-olds who were still in care. It remains to be seen whether those differences will persist once the foster youth who were still in care at age 19 have also exited. A third wave of survey data being collected from the foster youth when they are 21 years old will begin to address this question. For now, at least, the results suggest that one way to reduce the percentage of youth who become homeless after aging out of care would be to extend their eligibility until age 21, as is already the case in a few states like Illinois.

Fourth, an often overlooked provision of the FCIA requires states to use some of their federal training funds to assist foster parents, group home workers, and case managers do a better job of preparing foster youth for the challenges they face during the transition to adulthood. With respect to preventing homelessness, this means educating foster parents, group home workers, and case managers about how to help their foster youth find housing and remain housed. To this end, Casey Family Programs (2005) has published *It's My Life*, a series of guides, including one focused on housing, that contain practical strategies and on-line resources for adults working with these youth. Researchers could examine whether educating foster parents, group home workers, or case managers about these or other strategies leads to more stable housing and lower rates of homelessness.

Finally, although the FCIA requires states to use a portion of their Chafee funds to provide supportive services to foster youth after they age out, at least some research suggests that young adults may not take advantage of such services even when they are available (Lindblom, 1996). Just why this is the case is not well understood. It may be that young adults are reluctant to participate in services that they associate with foster care or that they object to the conditions of participation. It is also possible that such services are perceived to be of little help.

Preventing homelessness among youthful offenders. As explained above, youthful offenders can become trapped in a cycle of homelessness and incarceration. If they return to the streets after their

release, there is a strong chance they will become involved in the same behaviors that initially led to their arrest (National Alliance to End Homelessness, 2001). Thus, programs that assist youthful offenders to find housing and stay housed have the potential not only to prevent homelessness but also to reduce recidivism in the criminal justice system.

Unfortunately, although a number of programs have been developed to help youthful offenders with the process of reentry, not much is known about their effects on homelessness prevention. One exception is the young adult component of the Going Home Reentry Grant in Polk County, Iowa. This program targets youthful offenders, aged 17.5 to 20 years, who are leaving state training schools. A Community Transition Team works with the youthful offender to create an individualized wrap-around plan that addresses housing and other service needs. In some cases, this plan involves reunification with parents or other family members. In other cases, housing is secured using project funds. Although there has been no formal evaluation of the program, there are outcome data for the 47 youthful offenders (32 males and 15 females) who were served during a three-year grant period. Seventy-nine percent of the females and 84 percent of the males were able to establish a stable residence.

The housing needs of youthful offenders have also been addressed by programs that target youth aging out of foster care. For example, Lighthouse Youth Services in Cincinnati, Ohio, runs an independent living program that focuses on foster youth between the ages of 16 and 19 as well as a transitional living program that targets homeless youth between the ages of 18 and 25 (Kroner, 2005). However, a number of youthful offenders are also served each year. Referrals come from child welfare agencies, homeless shelters, juvenile courts, and community-based organizations. Lighthouse's housing continuum includes several housing options for youth: scattered-site apartments, supervised apartments, shared homes (for four or five youth), host homes, and boarding homes. Youth move from more structured to less restrictive living arrangements, depending on the level of support and services they need. Unfortunately, no formal outcome data have been collected to date.

Employment programs as a prevention strategy. Although preventing homelessness is usually not a primary goal of employment programs, it stands to reason that youth and young adults are less likely to become homeless if they are self-sufficient and stably employed. From this perspective, several programs funded by the U.S. Department of Labor (DOL) could be considered preventive interventions. One example of this approach involves programs funded under the Workforce Investment Act (WIA). Low-income youth between the ages of 14 and 21 are eligible to receive WIA-funded services if they face one or more recognized barriers to completing school and attaining economic self-sufficiency. These services allow youth to continue their education and pursue employment. Youth aging out of foster care, homeless youth, and youth who have been involved with the juvenile justice system are among WIA's target populations.

In addition to these WIA services, DOL also funds a number of other workforce development and support services that can help prevent homelessness among at-risk youth. Job Corps is the largest and most comprehensive residential vocational training and education program for at-risk youth between the ages of 16 and 24. Youth aging out of foster care and runaway or homeless youth are among the target populations of Job Corps. In a multi-year evaluation of the program, eligible youth were randomly assigned to a treatment group that received Job Corps services or a control group that did not. They were interviewed at the time of enrollment and then again at 12, 30, and 48 months after random assignment. The researchers did not look specifically at homelessness. However, Job Corps participation was related

to independent living at the 48-month interview. A slightly smaller percentage of program group members were living with their parents, and a slightly larger percentage were living with a partner and reported being the head of the household (Burghart et al., 2001; Schochet, Burghardt, & Glazerman, 2001).

Likewise, DOL's Youth Offender Demonstration Program (YODP) is a labor-focused reentry program for youth ages 14 to 24 returning to their communities from detention or incarceration and who are already involved in the juvenile/criminal justice system, are gang members, or are at risk of gang or court involvement. Of particular relevance to homelessness prevention, some YODP sites are working with nonprofit housing programs. Unfortunately, no formal evaluation of the YODP has ever been completed.

Theoretical Developments

Haber and Toro (2004) provide a thorough review of various theories that have been applied in recent research on homeless children and youth. The theories most relevant to homeless youth include variants based on social learning theory (Bandura, 1977; Patterson, 1982). The Risk Amplification Model (RAM), one of the most widely applied of these variants, posits that noxious early environments, including poor parenting practices in the home, put youth at risk for homelessness and that being homeless further "amplifies" the risk for poor outcomes among such youth (Paradise et al., 2001; Whitbeck & Hoyt, 1999). The RAM suggests that risk is amplified by homelessness through victimization on the streets, engagement in subsistence strategies (e.g., stealing food, prostitution), association with deviant peers and adults, and other negative experiences.

Cross-sectional studies provide some empirical support for the RAM. For example, homeless youth tend to come from more deleterious home environments and experience higher rates of victimization compared to matched housed youth (Robertson & Toro, 1999). In a more direct test of the RAM, Whitbeck, Hoyt, and Yoder (1999) found that affiliation with deviant peers, deviant subsistence strategies, risky sexual behaviors, and substance use amplified the effects of a negative family environment on victimization and depressive symptoms among homeless female youth (but not among homeless males).

There is also some support from longitudinal studies. Using the Detroit-based dataset described earlier, Lombardo and Toro (2005) found that family conflict was related to heightened self-reported symptomatology and deviant peer associations, and that both of these were associated with risky sexual behaviors and substance abuse six months later. Analyses testing the RAM over longer periods of time (up to 6.5 years) are currently being conducted by Toro and colleagues.

Conclusion

Much has been learned since Robertson and Toro reviewed the literature on homeless youth for the 1998 National Symposium on Homelessness Research. Yet many important questions remain unanswered. Several areas, in particular, could be the focus of future research.

1. Many risk factors associated with youth homelessness have been identified. Examples include family conflict, aging out of foster care, and identifying as GLBT. What is not well understood is how these factors operate. That is, what are the pathways leading to homelessness among youth with these risk factors? Future research needs to explore these pathways and consider how other

factors (e.g., access to and quality of services received during childhood or early adolescence, growing up in a family that experienced homelessness) either aggravate or mitigate those risks.

2. Although many interventions have been developed to address the diverse needs of homeless youth, the vast majority have not been evaluated. As a result, we know relatively little about what works. Closing this gap will require methodologically sound studies that include control (or at least comparison) groups in experimental (or at least quasi-experimental) research designs.
3. Researchers should examine whether certain types of interventions are more effective with some homeless youth than others (e.g., runaway youth vs. throwaway youth vs. systems youth; street youth vs. shelter youth; rural youth vs. urban youth; youth homeless with their families vs. youth homeless on their own). Groups that are likely to have unique needs and hence for whom unique interventions may be merited include LGBT youth and youth who are pregnant or parenting.
4. Broadly speaking, there are two types of prevention strategies: universal approaches that seek to promote positive youth development, and more targeted approaches that focus on youth thought to be at greatest risk. Research is needed on both types of strategies to determine whether both can prevent homelessness and other negative outcomes among youth.
5. Because so many homeless youth cite family conflict as the reason for their homelessness, more attention should be paid to prevention and intervention strategies that focus on the family. Strategies might involve improving communication, developing conflict resolution skills, and increasing understanding of adolescent development. It is important for social workers and others assisting homeless youth and those at risk for homelessness (such as youth aging out of foster care) to help these youth connect with family members who might assist them in the future (often after the workers end their assistance). It is also important that "family" be broadly defined to include not only biological relatives but also others (e.g., fictive kin, close friends) who youth regard as part of their family.
6. Although interventions may benefit from tapping into familial resources, reunification may not be a good option for certain homeless youth. More research is needed to determine the individual and environmental circumstances that argue for and against familial reunification. Interventions should be developed using this information.
7. Not much is known about why so few homeless youth, whether in shelters or on the streets, use human services available to them (aside from short-term use of shelters for some). Similar to recent studies of homelessness among adults (e.g., Acosta & Toro, 2000), future research needs to ask the homeless youth themselves about their experiences and satisfaction with various services. Most likely, attention will be needed to alter approaches used by existing programs and services to make them more accessible and "user friendly."
8. Most existing research on homeless youth has focused on the "literally homeless," those who have spent at least some time in homeless shelters, on the streets, or living in other unconventional settings (Toro, 1998). Future research should also focus on youth who "couch surf" or who are otherwise precariously housed. This group may be larger than, and at equal risk as, those who are literally homeless.
9. Developing effective prevention and intervention strategies requires a clearer understanding of what youth experience before and after they become homeless. Toward that end, we need more quantitative and qualitative research to explore the outcomes of homeless youth, including the

pathways through which they exit, or fail to exit, homelessness. More longitudinal studies are also needed to examine how environmental, family, and individual factors affect both their short-term and long-term outcomes. Disentangling the effects of these different types of factors will also require multivariate data analytic techniques.

10. Preventive interventions with youth aging out of foster care and youthful offenders should be expanded. Although some programs exist, little firm empirical evidence exists on what works. Broader and better designed preventive interventions are needed.

11. It appears that few if any of the studies reviewed above directly involved homeless or other at-risk youth in the research process. We believe that such youth should, ideally, be consulted at every stage, including the design of the study, the development of survey instruments or interview protocols, the collection of data, the interpretation of results, and the dissemination of findings. Not only can involving homeless or other at-risk youth in the research process improve the quality of the research (Jason et al., 2004), but it may increase the likelihood that the research leads to better policy and practice. Similarly, there should be more collaboration between service providers and researchers, both to improve the quality of the research and the ability for the research to be applied to policy and intervention.

12. With regard to theoretical approaches, there is a need to move beyond the pervasive deficit orientation in much of the research toward more positive, resilience-based frameworks. There is also a need to more carefully consider the developmental contexts in which youth who are homeless or at risk for homelessness exist and to develop a better international understanding of homeless youth.

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Characteristics of Help-Seeking Street Youth and Non-Street Youth*

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Abstract

Alma Molino, a graduate student in Clinical Psychology at Rosalind Franklin University of Medicine and Science, was selected through a competitive process to prepare a paper on her research on runaway and homeless youth. The author used data collected from callers to the National Runaway Switchboard to describe the characteristics and issues facing a large national sample of youth who have run away or are in crisis, and to examine the associations between these issues and status as a street youth (runaway, throwaway or homeless) or non-street youth (considering running away or being in general crisis). The relationship between the type and number of issues and the frequency of running behavior is also assessed.

Introduction

Research overwhelmingly suggests that runaway, throwaway, and homeless youth are at higher than average risk of experiencing a wide range of deleterious outcomes. These outcomes result from exposure to stress and risk factors both before and after leaving home. Examples of stress and risk factors experienced by runaway, throwaway, and homeless youth prior to leaving home include physical, sexual, and emotional abuse; neglect; family conflict; disruptions in home life, including divorce or changes in the family structure; and substance abuse by both the youth and his or her family (Hyde, 2005; Martinez, 2006; Safyer, Thompson, Maccio, Zittel-Palamara, & Forehand, 2004; Whitbeck & Hoyt, 1999a).

The effects of early negative experiences can be exacerbated by the stressful experience of homelessness (MacLean, Embry & Cauce, 1999). Examples of stress and risk factors experienced by runaway, throwaway, and homeless youth after leaving home include poor nutrition, risk of criminal victimization, lack of supervision by caring and responsible adults, and exposure to sexually transmitted infections

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(Ennett et al., 1999; Hammer, Finkelhor, & Sedlak, 2002; Hoyt, Ryan & Cauce, 1999; Rew, Taylor-Seehafer, Thomas, & Yockey, 2001; Whitbeck & Hoyt, 1999a).

Because of the adversity experienced by runaway, throwaway, and homeless young people, there is a great need to develop effective prevention programs for at-risk housed adolescents and their families. Further, there is an equally important need for effective intervention programs to reduce the stress of being without a stable home. Research studies that identify and describe factors associated with street youth status can aid in the development of effective prevention and intervention programs. Other research needs include studies of runaway, throwaway, and homeless youth that utilize large representative samples, samples that include youth from both rural and urban areas, appropriate comparison groups, and assessment of strengths as well as problems of homeless youth (Robertson & Toro, 1999).

The present study addresses these research needs by utilizing data obtained from a large national sample of runaway, throwaway, homeless, and housed adolescents who contacted the National Runaway Switchboard (NRS) for assistance with crisis issues. This study aims to:

- provide descriptive demographic data on a large national sample of runaway, throwaway, and homeless youth as well as help-seeking youth who are currently housed,
- provide descriptive data on issues preceding or prompting help-seeking behavior by youth callers to NRS,
- examine the associations between these issues and status as a street youth (i.e., runaway, throwaway, or homeless) or non-street youth (i.e., contemplating running or being in general crisis),
- examine the relationship between the type and number of issues accompanying increases in frequency of running behavior.

To facilitate understanding of the research aims addressed by the current research project, the following section will provide background information on youth homelessness and an overview of pertinent areas of research published since 1998. A general overview of research on youth homelessness published prior to 1998 is provided by Robertson and Toro (1999). For a general review of research on the topic published since 1998, see Toro, Dworsky, and Fowler (2007) in this volume.

Background

Definitions of Street Youth

The definitions of runaway, throwaway, and homeless youth used by the National Runaway Switchboard are based on definitions from the first National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children, conducted by the Office of Juvenile Justice and Delinquency Prevention (NISMART-1; Finkelhor, Hotaling, & Sedlak, 1990), and the Runaway and Homeless Youth Act as amended by the Missing, Exploited, and Runaway Children Protection Act in 1999. The Runaway and Homeless Youth Act (42 U.S.C. 5701 note) defines the term “homeless youth” as referring to an individual, not more than 21 years of age and not less than 16 years of age, for whom it is not possible to live in a safe environment with a relative and who has no other safe alternative living arrangement. “Runaway” is defined as any youth who, without permission, leaves home and stays away overnight, or, if away from home, chooses not to come home when expected. Finally, children and youth who are

denied housing by their families or prevented from returning home by a parent or other household adult may be referred to as "throwaway" (U.S. Department of Education, 2004) or "thrownaway" children or youth (Hammer, Finkelhor, & Sedlak, 2002). The Runaway and Homeless Youth Act uses the term "street youth" to refer to both homeless youth and runaway youth. For clarity, in this study, the term "street youth" will be used as a general term to refer to runaway, homeless, and throwaway youth.[1]

Demographic Characteristics of Street Youth

In the United States, statistics for street youth who are runaways and throwaways are estimated by the National Incidence Studies of Missing, Abducted, Runaway, and Thrownaway Children (NISMART), conducted by the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice (Flores, 2002). The most recent of these studies, NISMART-2, was published in 2002, based on data collected in 1999 (Hammer, Finkelhor, & Sedlak, 2002). NISMART-2 researchers estimated that 1,682,900 youth nationwide were missing due to a runaway or throwaway episode, with 50 percent being male, 50 percent being female, and with the majority of these youth (68 percent) being 15 to 17 years of age (Hammer, Finkelhor, & Sedlak, 2002).

Two other large-scale research studies of street youth are the Midwest Homeless and Runaway Adolescent Project (MHRAP), which included 602 individuals in Missouri, Iowa, Nebraska, and Kansas (Whitbeck & Hoyt, 1999a), and the Seattle Homeless Adolescent Research Project (SHARP), which included 372 individuals (Whitbeck et al., 2001). MHRAP and SHARP participants ranged from 12 to 22 years of age. In each of these studies, the number of male and female participants was approximately equal (Whitbeck & Hoyt, 1999a; Whitbeck et al., 2001). The majority of the participants in both studies were of European-American, with African-Americans the next largest participant group (Whitbeck & Hoyt, 1999a; Whitbeck et al., 2001). Most of the MHRAP participants had run away from a metropolitan area or a suburb of a metropolitan area, and most participants had spent most of their time in the week prior to the interview at a shelter, with friends, or with their parents or another relative (Whitbeck & Hoyt, 1999a). The majority of the SHARP participants had spent at least part of the previous week in a shelter or on the streets (Whitbeck et al., 2001).

Both the MHRAP and SHARP studies included youth currently living on the street, in shelters or agencies, or with friends or relatives (Whitbeck & Hoyt, 1999a; Whitbeck et al., 2001). Statistics and demographic information on runaways that do derive from sampling these types of locations may not be fully representative of the street youth population. Additionally, depending on the sample used, gender composition of studies of street youth may vary, with males generally overrepresented in street samples, and females generally overrepresented in shelter samples (Yoder, Whitbeck, & Hoyt, 2001).

A brief summary of pertinent demographic data from these large-scale studies is found in Exhibit 1.

[1] For the purposes of this paper, the category of "street youth" includes runaway, homeless, and throwaway youth who are currently residing in alternate housing, such as a shelter or with friends or relatives, as well as those literally living on the street (also see Methods section).

Exhibit 1
Demographic Data from Large-Scale Studies of Street Youth

Sample site	Mean Age (years)	Percent Male	Percent Female	Percent White/ European American	Percent African American	References
Nationwide[a] (n=1,682,900)	15 - 17	50	50	57	15	Hammer et al., 2002
Midwestern U.S. (n=602)	16.24	40	60	61	~25	Whitbeck & Hoyt, 1999(a)
Seattle, WA (n=372)	17.15	55	45	53	18	Whitbeck et al., 2001

[a] Reflects runaway and throwaway youth sample combined.

Pathways to Street Youth Status

Running away and being "thrown out" of the home are among the pathways most commonly identified by public policy and research as leading to youth homelessness. Youth who have run away, perhaps only briefly, and youth who have been homeless on a long-term basis are often combined into one subgroup for research purposes (e.g., MacLean, Embry, & Cauce, 1999; Thompson, Safyer, & Pollio, 2001; Zide & Cherry, 1992). MacLean and colleagues (1999) suggest that youth who have been runaways or homeless on a long-term basis have made a choice to live on the streets rather than in their homes, and suggest that this choice likely indicates that runaway and long-term homeless youth have left a particularly aversive family environment and are confident in their ability to survive on the street. MacLean and colleagues (1999) contrast runaways and long-term homeless youth with throwaway youth, who are less instrumental in making the decision to leave home. In a throwaway situation, the parents or guardians have made the decision that the youth leave home, often because some aspect of the youth's behavior is considered unacceptable to the parents or guardians (MacLean et al., 1999). However, Hammer and colleagues (2002) caution against generally viewing runaways as having left home voluntarily, as this view may not fully encompass the problems faced by runaways. For example, children and young adults who leave due to family conflict or abuse may "leave to protect themselves or because they are no longer wanted in the home. The term 'voluntary' does not properly apply to such situations" (Hammer et al., 2002, p. 2).

Runaway youth comprise the largest subgroup included in the present study (approximately 38 percent). To provide a better understanding of the lives of these adolescents both before and after leaving home, the following sections provide an overview of issues pertaining to the runaway subgroup of homeless youth. Further information on homeless and throwaway youth can be found in the paper by Toro and colleagues (2007) in this volume.

Why Do Youth Run Away from Home?

The issues most often cited by youth as leading to runaway behavior are problems pertaining to family dynamics. In particular, runaway youth describe a family environment that is disorganized, dysfunctional, unpleasant, or dangerous (Hyde, 2005; Martinez, 2006; Safyer et al., 2004; Thompson & Pillai, 2006; Whitbeck & Hoyt, 1999a). Runaways may leave home environments characterized by physical, sexual, or emotional abuse or neglect; fighting or arguing between parents or between parents and the youth; drug or alcohol abuse; and frequent changes in family structure, including divorce, death, or the addition of new

members to the household (Hyde, 2005; Martinez, 2006; Thrane, Hoyt, Whitbeck & Yoder, 2006; Tyler, 2006; Tyler & Cauce, 2002; Whitbeck & Hoyt, 1999a). Among the MHRAP sample, it was found that increased changes in family structure and increased family disorganization were associated with increased rates of running away (Whitbeck & Hoyt, 1999a). Runaway participants in a qualitative study by Martinez (2006) also cited family dynamics as being among their reasons for having left home. For example, some participants stated that they left home in hopes of changing problematic family dynamics or finding out if their family truly cared about them (Martinez, 2006).

Both runaways and their parents acknowledge contributing to the dysfunction or disorganization of the family structure, either through their own individual actions or through dysfunctional interactions in the parent-child relationship (Hyde, 2005; Safyer et al., 2004; Whitbeck & Hoyt, 1999a). Reasons focusing on the youth as a direct agent of runaway behavior include not wanting to comply with household rules; behavior problems; alcohol abuse; truancy; a desire to live elsewhere; and a desire for independence, adventure, or excitement (de Man, 2000; Hyde, 2005; Martinez, 2006; Paradise & Cauce, 2003; Whitbeck & Hoyt, 1999a). Runaways may also see the act of leaving home as a way to assert or exert control over an intolerable situation at home, or they may leave home impulsively to gain immediate relief from their problems (Hyde, 2005; Martinez, 2006). However, Martinez (2006) notes that impulsivity is not unique to running away from home and marks many other teenage behaviors as well.

One perspective utilized by researchers to explain the connection between problematic family dynamics and runaway behavior is primary socialization theory (Thompson, Kost, & Pollio, 2003; Whitbeck, 1999). According to primary socialization theory, the family typically serves as a positive resource for the youth in that the family protects the youth from risks and promotes prosocial behaviors. When the family fails to fulfill this role, the youth may instead bond with deviant peers who encourage the youth to engage in negative behaviors such as running away (Thompson et al., 2003).

Chronic running away may signify a desire for early adulthood (Martinez, 2006), or an early or precocious entry into adulthood (Whitbeck & Hoyt, 1999a). As boundaries and ties within the family are weakened and the support of the family is reduced, adolescents become increasingly self-sufficient and/or dependent on options or allegiances with people outside of the family, which may lead to runaway behavior (Whitbeck & Hoyt, 1999a).

The risk amplification developmental model is a theory of risk behavior developed on the basis of the MHRAP data (Whitbeck & Hoyt, 1999b). This model holds that there is increased risk specific to the life situations and behaviors of street youth. Specifically, psychologically harmed children leave home and enter situations in which multiple and cumulative risks are present, with negative developmental trajectories gaining momentum over time. For example, Whitbeck & Hoyt (1999a) found that, among the adolescent females included in the MHRAP sample, physical or sexual abuse within the family led to consequences such as substance use, affiliation with deviant peers, and street victimization, and that these consequences in turn led to increased likelihood of further victimization and emotional distress. Other studies have found that problematic family dynamics predict negative outcomes on the street (Thrane et al., 2006; Tyler et al., 2001). Failure to address problematic issues within the family or through social institutions such as schools and mental health services can lead to repeated running behavior and exposure to risk (Clatts, Goldsamt, Yi, & Gwadz, 2005; Martinez, 2006; Safyer et al., 2004).

Because poverty is often part of the family backgrounds of runaway and homeless youth (e.g., Sanchez et al., 2006; Thompson et al., 2003), Robert and colleagues (2005) caution against misinterpreting risk

factors as solely related to homelessness when they might be more appropriately attributed to an impoverished family background. In a comparison between samples of homeless adolescents and non-homeless adolescents from an impoverished family, it was found that both groups had dysfunctional family backgrounds. However, a greater proportion of homeless participants cited family-related adversity, such as conflict and violence. In addition, the homeless sample had a greater number of behavioral disorder diagnoses (Robert et al., 2005).

Other risk factors associated with running away are found at the level of the individual or his or her environment. These include factors related to school, such as truancy and low academic achievement (Sullivan & Knutson, 2000); the presence of behavioral or psychological disorders (Kingree, Braithwaite & Woodring, 2001; Robert et al., 2005; Whitbeck, Johnson, Hoyt, & Cauce, 2004); long-term placement in foster care (Nesmith, 2006); and, to some extent, minority ethnic/racial background (Nesmith, 2006; Thompson et al., 2001; Kingree et al., 2001).

Exhibit 2 provides a brief summary of risk issues associated with runaway status among youth.

Exhibit 2
Risk Issues Associated with Status as a Runaway Youth

Risk Issue Category Leading to Decision to Leave Home	References
• *Family dynamics* (e.g., disorganized or dysfunctional household/family environment; fighting or arguing; substance use/abuse by family members; changes in family structure [e.g., divorce, deaths, extended family])	Whitbeck & Hoyt, 1999a; Martinez, 2006; Thompson & Pillai, 2006; Hyde, 2005; Safyer et al., 2004
• *Poverty*	Sanchez et al., 2006; Thompson et al., 2003
• *Abuse/neglect*	Thrane et al., 2006; Tyler, 2006; Tyler & Cauce, 2002; Hyde, 2005; Martinez, 2006
• *Factors relating to individual motivation* (e.g., unwillingness to comply with household rules; behavior problems; desire for independence, adventure or excitement; desire to assert or exert control over an intolerable home/family situation)	Whitbeck & Hoyt, 1999a; Hyde, 2005; Martinez, 2006; de Man, 2000
• *Substance use/abuse by youth*	Paradise & Cauce, 2003; van Leeuwen et al., 2004
• *Behavioral or psychological disorders*	Kingree et al., 2001; Robert et al., 2005; Whitbeck et al., 2004
• *Educational/academic difficulties* (e.g., truancy, low academic achievement)	Sullivan & Knutson, 2000
• *Long-term placement in foster care*	Nesmith, 2006
• *Minority or non-White/European-American ethnic or racial background*	Nesmith, 2006; Thompson et al., 2001; Kingree et al., 2001

Limitations of Research on Runaways

It is difficult to make generalizations about runaway youth as a population due to the difficulty of obtaining large random or representative samples of such individuals. Runaway adolescents may not be accessible to researchers for several reasons. First, the amount of time during which adolescents may be considered “runaways” may be as long as several months or years, or as brief as an overnight period

during which they are not supervised by a parent or guardian. For example, under federal guidelines, if a youth is 14 years of age or younger (or older and mentally incompetent), staying away from home one night defines him or her as a runaway; if the youth is 15 years or older, staying away from home two nights defines him or her as a runaway (Hammer et al., 2002). Those youth who spend only a brief time as runaways may be absent from research samples. Further, runaway adolescents may find shelter in places not readily available to researchers, such as abandoned buildings or the homes of friends or relatives, and may thus be absent from research samples. Adolescents who are living away from home but whose whereabouts are known to their parents or guardians may not always be reported as missing, and may therefore be excluded from statistics on street youth collected by law enforcement agencies or by agencies that assist in the location of missing children. Finally, runaways may, to an uninformed observer, be indistinguishable from housed adolescents who are spending recreational time outside of their homes; therefore, runaway adolescents who "blend in" may not be recruited for research. Follow-up data may be difficult or impossible to obtain from runaway youth who are transient. All of these factors can affect the size of research samples of runaway youth and the generalizability of research findings from such samples.

The current study utilizes data from the National Runaway Switchboard, addressing several limitations and needs in the field of youth homelessness research as identified by Robertson and Toro (1999). These include the use of a large representative sample; the assessment of strengths as well as problems of homeless youth; the inclusion of youth from both rural and urban areas; and the use of a comparison sample of housed youth similar to non-housed youth in terms of crisis issues and help-seeking behavior. The following sections provide background on the National Runaway Switchboard and the services it provides.

National Runaway Switchboard

The National Runaway Switchboard (NRS) is the federally designated national communication system serving runaway and homeless youth and their families, with the mission of ensuring the safety of runaway and at-risk youths and preventing runaway behavior. The hotline was established in 1971 as Metro-Help, a crisis hotline for runaway youth in the Chicago metropolitan area, and began providing services on a national level in 1974. NRS can be reached via a toll-free hotline from any state or territory, and is utilized by a number of different populations, including street youth; youth contemplating running away; youth in general crisis; and adult callers such as parents, relatives, teachers, law enforcement personnel, and social service agency staff. NRS provides prevention and intervention services through their hotline as well as through educational and outreach programs and web-based services, including a youth message board, a chat room for parents, and email communication with staff members trained in crisis intervention (NRS, 2004). Callers are referred to NRS in a variety of ways, including the phone book, social service agencies, word of mouth, television and radio public service announcements, promotional materials provided through schools or community agencies, and on the Internet through the official NRS Web site.

The major portion of direct services provided by NRS is administered to youth callers via telephone. A young adult may call the hotline seeking to utilize any of five services: crisis intervention, information and referral, message relay, conference calling, or the Home Free transportation program for runaway youth, which is administered by NRS in conjunction with Greyhound Lines, Inc. Crisis intervention is provided in a confidential, nonsectarian, nonjudgmental, and nondirective manner with the goal of empowering the youth to take control of his or her current situation and to make decisions with which he

or she feels comfortable (NRS, 2001). Hotline calls are handled by staff and supervised volunteers ("liners") who have, prior to taking calls independently, completed a minimum of 36.5 hours of training in active listening skills and classroom and experiential training in a solution-based crisis intervention model. The five components of this crisis intervention model are (1) establishing rapport; (2) exploring facts and feelings; (3) focusing on the main issues; (4) exploring options; and (5) establishing a plan of action.

A call log, including a checklist of issues relevant to the crisis situation, is filled out for each hotline call that involves crisis intervention. The information in this call log is based both on issues identified by the caller as contributing to the current crisis situation and issues identified by staff and liners based on the description of the situation as presented by the caller.

Many of the issues identified by research literature as correlated with or leading to runaway behavior, such as abuse and problematic family dynamics, are also identified by National Runaway Switchboard callers as prompting their help-seeking behavior. Studies of help-seeking youth who called NRS in 2004 identified issues that were mentioned with high frequency by runaways and by youth contemplating running away as well as issues that predicted status as street youth (runaway, throwaway, or homeless) or non-street youth (Molino, McBride, & Kekwaletswe, 2006a, 2006b). Issues frequently discussed by street youth included family dynamics, social issues or problems with peers, problems with youth service agencies, and school or education issues (Molino et al., 2006b). Issues frequently discussed by youth contemplating running away included family dynamics; social issues or problems with peers; problems with youth service agencies, school or education issues; and physical abuse (Molino et al., 2006b).

Further study of the NRS calls led Molino et al. (2006a) to identify issues predicting inclusion of callers in either the non-street youth or street youth category. Issues predicting status as a non-street youth caller included mental health issues of the youth, experience of emotional and verbal abuse, alcohol or drug use by the family, and suicidality of the youth. While these problematic issues were not exclusively identified by non-street youth, it appears that issues that were pressing or that led to help-seeking behavior were different for youth who were currently housed as opposed to issues identified by street youth, who were removed from the immediate household at the time of the call placed to the hotline.

Two issues were found to predict status as a street youth. One issue was family dynamics (Molino et al., 2006a). This result is consistent with current research on risk factors leading to street youth status, which suggests that the presence of disorganized or dysfunctional family dynamics is predictive of runaway behavior and homelessness among adolescents. The other predictive issue was judicial issues of the youth (Molino et al., 2006a). Judicial issues among street youth can occur for a number of reasons. For example, in the United States in 2005, an estimated 108,954 arrests were made for the offense of running away (U.S. Department of Justice, 2006). (However, the act of running away itself does not always result in an arrest. Criminal charges or consequences applied to runaways vary from state to state (National Law Center on Homelessness and Poverty, 2003); further, runaways are not always noticeable to police due to their staying with friends and relatives.)

Runaway adolescents may also be arrested or taken into police custody for other acts committed while away from the home, including violation of probation, burglary, or drug dealing. Researchers emphasize that criminal offenses or illegal acts committed by runaways frequently are motivated by basic survival needs, such as food and shelter; the presence of adverse situations, such as hunger and unemployment; and a lack of opportunities for legitimate self-support (Kaufman & Widom, 1999; McCarthy & Hagan,

2001; Whitbeck & Hoyt, 1999). Additionally, while running away can increase the odds of the youth engaging in delinquent or criminal behavior, it can also increase the odds of the youth being exposed to or becoming the victim of criminal or delinquent acts (Hammer et al., 2002; Hoyt, Ryan, & Cauce, 1999). For example, it was found by Hoyt and colleagues (1999) that the amount of time homeless adolescents spent living on the streets, as well as prior experience of personal assault, was associated with increased risk of criminal victimization.

The relationship between childhood victimization, running away, and delinquency was examined in a study by Kaufman and Widom (1999) that followed groups of youth forward in time and assessed each research domain. Participants who had experienced abuse and neglect were more likely to have run away, and a significant relationship was found between running away and being arrested as a juvenile. The relationship between running away and delinquency remained significant even after controlling for gender, race, ethnicity, and family social class, with victims of abuse and neglect being more than twice as likely to run away as participants in the control sample, and runaways being more than twice as likely to be arrested as juveniles in comparison to non-runaways. The authors concluded that both running away and being victimized as a child increased the risk of delinquent behavior, and that running away moderated the relationship between childhood victimization and delinquency. Because running away was indicative of high-risk outcomes, the point in time at which a youth ran away was concluded to be a "critical point for intervention" (Kaufman & Widom, 1999, p. 368).

Although family dynamics and judicial issues have been found to predict inclusion of callers in the street youth category, issues identified by youth callers as prompting or preceding a call to the National Runaway Switchboard generally fall into any of 25 categories. These include family dynamics, mental and physical health issues, involvement of the youth in the judicial system, and issues related to transportation. A complete listing of general problem domains and issues falling within these general domains can be found in Appendix A.

The current study goes beyond prior research on NRS callers by utilizing a large sample; combining data from multiple years; and by examining additional variables, such as caller location, caller's prior experience with homelessness or having run away, and variables predicting recidivism (i.e., repeated running away) and street youth status.

Method

Participants

Participants included youth callers, ranging from under 12 to 21 years of age, who contacted the National Runaway Switchboard from January 2000 to December 2005 for assistance with personal crisis issues (N=30,266). To avoid using duplicate information and maintain a sample of unique cases, we excluded data for youth who stated that they had previously contacted NRS for assistance (N=4,375). Included in the street youth category (n=14,865) were callers who were classified as *runaways* (n=11,299), *homeless youth* (n=1,968), or *throwaways* (n=1,598). Included in the non-street youth category were callers who were identified as *contemplating running away* (n=5,136) or who called in with a *general crisis* issue unrelated to street youth status (n=9,983).

Materials

Data were analyzed from call logs completed for each participant. These call logs consisted of five sections: 1) *caller profile*, including information such as demographic data and location; 2) *issues identified*, which is a checklist of common problems and risk factors cited by individuals as preceding or prompting their decision to call, 3) *resources*, which includes information on agencies to which the caller was referred, 4) *options discussed*, which is a checklist of common types of agencies and sources of help discussed with the caller, and 5) a *summary* of the call. Data analyzed in this project were limited to items from the caller profile and issues identified sections of the call logs.

The subgroup in which a caller to the hotline is classified (i.e., runaway, throwaway, homeless, contemplating running away, or youth in general crisis) is generally based on the caller's self-identification as a person belonging to one of those subgroups. Therefore, to some extent, the subgroup to which a caller belongs may reflect self-conceptualization in addition to their actual housed or non-housed circumstances. If no clear self-identification is made, hotline personnel use the information given by the caller regarding his or her situation to classify the youth.

Procedure and Methods of Analysis

A call log was completed by a trained hotline volunteer ("liner") or staff member for each call made to NRS that involved crisis intervention. Data from these call logs were compiled into a central electronic database, and all personal identifiers were stripped from the data prior to analysis. Research questions and methods of analysis are summarized below:

- *What are demographic characteristics of help-seeking youth callers to NRS?* Frequency analysis was used to describe the demographic characteristics of help-seeking youth callers. The resulting data described the number of occurrences for the following variables: age; gender; status of the individual as a runaway, throwaway, or homeless youth; location of the youth at the time of the call; whether the youth had crossed state lines, and if so, the state of origin; length of time away from home; and number of prior runaway or homeless experiences.
- *What risk issues are frequently identified by help-seeking youth callers to NRS?* Frequency analysis was used to describe problem issues or risk factors identified by youth callers as prompting or preceding their call to NRS.
- *Are certain problems associated with street youth or non-street youth status?* Based on the results of the frequency analysis utilized for Research Question 3, certain risk factors were identified that substantially differentiated between street youth and non-street youth groups. To examine the associations between these risk factors and street youth status, logistic regression analysis was used.
- *Does number/type of risk issues help predict repeat running?* Correlational[2] and logistic regression analyses were used to describe the relationships between increases in recidivism of running behavior and the type and number of issues identified by the youth as prompting help-seeking behavior.

[2] Because preliminary analysis of the data indicated that the recidivism variable was not normally distributed for this sample, a nonparametric test was used for correlational analysis (Spearman's rho).

Results

Demographic Data

The majority of callers to NRS were female and, on average, callers were in their mid-teens. Demographic and personal characteristics of the total sample of youth callers to NRS are found in Exhibits 3–6.[3] A summary table of key demographic data is provided in Exhibit 7.

NRS services are available to any youth in crisis, whether or not they have left home. Not surprisingly, given that NRS's name and marketing materials imply that runaway youth are the primary target group, most callers were either runaways (38 percent) or were considering running away (17 percent); at the same time, a substantial proportion of callers were youth in general crisis (33 percent; see Exhibit 3). Smaller numbers of callers identified themselves as throwaways (5 percent) or homeless (7 percent). On average, callers were 16.1 years old. Most callers were female (70 percent), with males making up just under 30 percent. A small number of callers (less than 1 percent) identified as transgender.[4] These findings are consistent with prior research, which suggests that females are generally overrepresented in samples of youth that are drawn from service agencies (Yoder, Whitbeck & Hoyt, 2001).

Callers classified as street youth included those who identified themselves as *runaways, homeless youth*, or *throwaways*. Like the sample overall, street youth callers in general tended to be female (66 percent) and in their mid-teens (16.3 years). Among street youth, those identifying themselves as homeless were older on average (18.2 years) while runaway youth were younger (16.0 years). It is possible that, in comparison to street youth approaching the age of majority, younger street youth are more inclined to view themselves as being able to return to their family homes, or as having parents or guardians responsible for their well-being. Another potential explanation is that older street youth may have been homeless for an extended period of time, and are therefore more likely to conceptualize themselves as being without any home at all, rather than simply being away from home.

Youth who were classified as non-street youth included those who were *contemplating running away* and those who called in with a *general crisis issue* unrelated to running away. The non-street youth were even more likely than street youth to be female (74 percent) and were slightly younger than the street youth (15.9 years, on average).

Callers contacted NRS from a variety of locations including friends' or relatives' homes, police stations, school, or bus stations, as shown in Exhibit 4. Most street youth (38 percent) were at a friend's home when they contacted NRS. About 10 percent of callers were at a shelter and a similar percent of callers were calling from a payphone. In November 2005, three new categories of general location were added to the NRS call log: the home of a recent acquaintance, a Greyhound station, and a location that the youth could not identify ("unknown to caller"). Because these locations were added to the call log relatively close to the end of the sampling period, there are few responses in these categories. Future research on call log data may reflect higher rates of calls made to NRS from these locations. Additional analyses of street youth caller location indicated that the states or territories from which the most calls were received were California (17 percent) and Texas (10 percent). It is likely that these statistics reflect the high populations of California and Texas relative to other states and territories (U.S. Census Bureau, 2006).

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[3] Information regarding the racial or ethnic background of callers is not collected during crisis calls.

[4] Information on transgender as a gender category was recorded only for calls received January 2005 or later.

Exhibit 3

Demographic Characteristics of Youth Callers to the National Runaway Switchboard, 2000–2005.

Characteristic	*n*	(Percent)	
Status of total sample[a]			
Runaway	11299	(37.7%)	
Throwaway	1598	(5.3%)	
Homeless	1968	(6.6%)	
Contemplating running away	5136	(17.1%)	
Youth in general crisis	9983	(33.3%)	
Gender of total sample[b]			
Male	9044	(29.9%)	
Female	21199	(70.1%)	
Transgender*	3	(Non-significant percentage of sample)	
Gender by status subgroup[c]			
Runaway			
Male	3642	(32.2%)	
Female	7652	(67.8%)	
Transgender*	1	(Non-significant percentage of sample)	
Throwaway			
Male	517	(32.4%)	
Female	1080	(67.6%)	
Homeless			
Male	906	(46.1%)	
Female	1058	(53.9%)	
Contemplating running away			
Male	1075	(20.9%)	
Female	4059	(79.1%)	
Youth in general crisis			
Male	2834	(28.4%)	
Female	7142	(71.6%)	
Transgender*	2	(Non-significant percentage of sample)	
	Mean	(SD)	Range
Age of total sample (years)[d]	16.14	(1.81)	12 – 21
Age by status subgroup (years)[e]			
Runaway	15.99	(1.46)	12 – 21
Throwaway	16.55	(1.42)	12 – 21
Homeless	18.23	(1.48)	12 – 21
Contemplating running away	15.27	(1.61)	12 – 21
Youth in general crisis	16.26	(1.99)	12 – 21

[a] Based on 29,984 valid responses.
[b] Based on 30,243 valid responses.
[c] Based on 29,968 valid responses.
[d] Based on 29,960 valid responses.
[e] Based on 29,713 valid responses.

** Information on transgender as a gender category was recorded only for calls received January 2005 or later.*

Exhibit 4

Location of Street Youth Callers to the National Runaway Switchboard, 2000–2005.

General location of street youth callers during call[a]

Location	*n*	(Percent)	Location	*n*	(Percent)
Detention/police	897	(6.8%)	School	62	(0.5%)
Friend	5011	(37.9%)	Shelter	1400	(10.6%)
Recent acquaintance*	8	(0.1%)	Street/payphone	1448	(10.9%)
Home	201	(1.5%)	Greyhound station*	15	(0.1%)
Other	574	(4.3%)	Unknown to hotline staff	2704	(20.4%)
Pimp/dealer	43	(0.3%)	Unknown to caller*	11	(0.1%)
Relative	838	(6.3%)	Work	26	(0.2%)

[a] Based on 13,238 valid responses.

** These locations recorded only for calls received November 2005 and later.*

Information pertaining to the extent of impact of current and past homelessness on street youth callers, in terms of time, distance, and prior experience as a street youth, is found in Exhibits 5 and 6. Most street youth callers had been away from home for one day (22 percent), and more than half of the street youth callers (58 percent) had been away from home for one week or less. The majority of callers (57 percent) had not crossed state or territory borders at time of the call. Among those who had crossed borders, most had left California (10 percent) and Texas (7 percent).

The majority of street youth callers (59 percent) had not run away prior to contacting NRS for assistance. Among the callers who had previously run away, the average number of prior runaway episodes was approximately 4. Similarly, the majority of callers (73 percent) had not been homeless prior to calling NRS. Among callers who had previously been homeless, the mean number of prior episodes of homelessness was approximately 3.[5]

Risk Issues

For the total sample of callers, the most frequently reported general category of risk issues was family dynamics (74 percent). This finding is consistent with existing literature that suggests that running away and youth homelessness are both associated with and predicted by problems in the family or household (Hyde, 2005; Martinez, 2006; Safyer et al., 2004; Sanchez et al., 2006; Thompson & Pillai, 2006; Whitbeck & Hoyt, 1999a). Within the domain of family dynamics, the subcategory of risk issues most frequently reported by the total sample were problems with parents or guardians and conflict with family or household rules.

Other frequently reported categories of issues among the total sample were peer or social problems (27 percent), problems related to youth or family service agencies (21 percent), physical abuse or assault (15

[5] Data on prior homelessness was available only for calls received in September 2001 and later.

Exhibit 5

Extent of Impact of Current Homelessness on the Street Youth Subgroup of Callers to the National Runaway Switchboard, in Terms of Time and Geographical Distance.

	Subgroup Status							
	Total Sample		Runaway		Throwaway		Homeless	
Time [a]	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
1 day	3169	(22.4%)	2128	(19.6%)	638	(42.6%)	403	(22.6%)
2 days	1334	(9.4%)	1000	(9.2%)	163	(10.9%)	171	(9.6%)
3 days	942	(6.7%)	744	(6.9%)	94	(6.3%)	104	(5.8%)
4 days	584	(4.1%)	506	(4.7%)	34	(2.3%)	44	(2.5%)
5 days	513	(3.6%)	420	(3.9%)	37	(2.5%)	56	(3.1%)
6 days	180	(1.3%)	168	(1.5%)	5	(0.3%)	7	(0.4%)
1 week	1535	(10.9%)	1273	(11.7%)	119	(7.9%)	143	(8.0%)
2 weeks	1153	(8.2%)	937	(8.6%)	88	(5.9%)	128	(7.2%)
3 weeks	676	(4.8%)	558	(5.1%)	40	(2.7%)	78	(4.4%)
1 month	1152	(8.2%)	924	(8.5%)	66	(4.4%)	162	(9.1%)
2 months	850	(6.0%)	689	(6.4%)	58	(3.9%)	103	(5.8%)
3 months	519	(3.7%)	398	(3.7%)	32	(2.1%)	89	(5.0%)
4 months	256	(1.8%)	209	(1.9%)	17	(1.1%)	30	(1.7%)
5 months	141	(1.0%)	118	(1.1%)	13	(0.9%)	10	(0.6%)
6 months	264	(1.9%)	195	(1.8%)	25	(1.7%)	44	(2.5%)
7 months	85	(0.6%)	68	(0.6%)	6	(0.4%)	11	(0.6%)
8 months	69	(0.5%)	59	(0.5%)	1	(0.1%)	9	(0.5%)
9 months	42	(0.3%)	31	(0.3%)	4	(0.3%)	7	(0.4%)
10 months	27	(0.2%)	25	(0.2%)	2	(0.1%)	0	(0.0%)
11 months	7	(Non-significant)	7	(0.1%)	0	(0.0%)	0	(0.0%)
1 year or more	624	(4.4%)	384	(3.5%)	56	(3.7%)	184	(10.3%)

	n	(Percent)
Had the youth crossed state or territory lines to get to his or her current location? [b]		
Yes	5606	(43.1%)
No	7408	(56.9%)

[a] Based on 14,122 total valid responses.

[b] Based on 13,014 total valid responses.

Exhibit 6

Past Experience of Homelessness by Street Youth Callers

	n	(Percent)		Mean	(SD)	Range
Had the youth ever run away from home before?[a]						
Yes	3786	(29.0%)	If "yes," how many times had youth run away before?[b]	4.31	10.57	1–99
No	7675	(58.9%)				
Unknown to hotline staff	1576	(12.1%)				
Had the youth ever been homeless before?[c]						
Yes	761	(8.0%)	If "yes," how many times had youth been homeless before?[d]	2.96	8.57	1–99
No	6936	(72.9%)				
Unknown to hotline staff	1813	(19.1%)				

[a] Based on 13,037 total valid responses.
[b] Based on 3,692 valid responses.
[c] Based on 9,510 valid responses.
[d] Based on 697 valid responses.

Exhibit 7

Key Demographic Data for Callers to the National Runaway Switchboard, 2000–2005

Total sample:	
Average age	16.1 years
Male	29.9 percent
Female	70.1 percent
Transgender*	Non-significant percentage of sample
Location at time of call to NRS:	
Friend's home	37.9 percent
Street / Payphone	10.9 percent
Shelter	10.6 percent
Duration of street youths' time away from home:	
One day	22.4 percent
> One day, less than 1 week	25.2 percent
1 week to < 1 month	23.8 percent
> 1 month	28.6 percent
Previous runs?[a]	
Yes	29.0 percent
No	58.9 percent
Previously homeless?[a]	
Yes	8.0 percent
No	72.9 percent

[a] Percentages sum to less than 100 percent because these numbers exclude "unknown" replies.

** Information on transgender as a gender category was recorded only for calls received January 2005 or later.*

percent), and problems related to school or education (14 percent). The most frequently reported peer or social problems for the total set of callers, as well as for the runaway and homeless subgroups, were a need for adventure or independence, and problems related to Internet relationships.

For throwaway callers, problems with friends or acquaintances and relationship problems were the most frequently reported peer or social issues. Issues related to protective service agencies most frequently pertained to county agencies (e.g., CPS, DCFS); residential, foster or group homes; and runaway shelters. Physical abuse or assault was frequently reported by the total sample and by runaway and throwaway callers relative to the reported rate of issues falling within other general domains of problems. Physical abuse or assault was most frequently perpetrated by a parent, and least frequently perpetrated by a non-relative. School/education issues most frequently reported by the total sample included problems with grades, dropping out, and truancy. For runaway and throwaway youth, the most frequently reported school/education issues were dropping out, truancy, and problems with grades. Problems with school or education were, in general, reported by relatively few long-term homeless youth (8 percent) as compared to the total sample (14 percent) and the runaway and throwaway samples (17 percent and 11 percent, respectively).

In general, the problems most frequently reported by street youth paralleled the problems most frequently reported by the sample as a whole. However, issues related to transportation were more frequently reported by runaways (18 percent) and homeless youth (19 percent) in comparison to the total sample (11 percent). This is likely related to homeless adolescents' general lack of access to resources, lack of contact with adults who might provide transportation, and inability to pay for transportation. Transportation issues may also be overrepresented among this sample in comparison to other research samples of street youth due to NRS's well-publicized Home Free program.

In addition, neglect was much more frequently reported by throwaways (25 percent) in comparison to the total sample (6 percent) and the runaway and homeless youth subgroups (5 percent and 4 percent, respectively). High rates of neglect among throwaways may be directly related to the manner in which these adolescents come to be away from their home, in that being thrown out or denied access to the home suggests that the parent or guardian is refusing responsibility for the youth's care.

It should be noted that any individual caller could potentially have indicated that he or she was experiencing problems in more than one general category as well as more than one than one specific problem or risk issue within each general category. A summary of the risk issue categories most frequently mentioned by callers is provided in Exhibit 8. A full listing of frequency analysis results for general categories and subcategories of risk issues is reported in Appendix B.

Risk Issues Predicting Street Youth or Non-Street Youth Status

Based on the frequency analyses of issues that prompted or preceded calls to NRS, risk issues were selected that substantially differentiated between street youth and non-street youth for further exploration (see Exhibits 9 and 10). Based on prior research involving NRS callers (Molino et al., 2006a, 2006b), it was expected that family dynamics and judicial issues of the youth would be among the issues found to predict street youth status, while mental health issues, emotional and verbal abuse, suicidality, and family substance use would be among the issues found to predict non-street youth status. Other risk issues examined during this analysis included problems with youth or family service agencies, neglect, issues pertaining to school or education, physical health issues of the youth and issues related to transportation. In contrast to earlier research involving NRS callers (Molino et al., 2006b), alcohol or drug use by the

family was found to be a non-significant predictor of both street youth and non-street youth status for the sample, and was thus removed from the final regression model.

Exhibit 8

Key Risk Issue Data: Issues Most Frequently Mentioned by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005[a]

Total Sample		Runaway Youth		Throwaway Youth		Homeless Youth	
Family dynamics	74%	Family dynamics	80%	Family dynamics	91%	Family dynamics	59%
Peer/social	28%	Peer/social	31%	Youth/family service agencies	32%	Peer/social	24%
Youth/family service agencies	21%	Youth/family service agencies	26%	Neglect	25%	Youth/family service agencies	22%
Physical abuse/assault	16%	Physical abuse/assault	19%	Physical abuse/assault	14%	Transportation	19%
School/education	14%	Transportation	18%	Peer/social	13%	Economic issues	11%

[a] Percentages sum to more than 100 percent because individual callers may have reported more than one category of risk issues.

Exhibit 9

Variables Predicting Status as a Street Youth for Youth Crisis Callers to the National Runaway Switchboard, 2000–2005

Variables	B	SE	Odds Ratio	95% CI	Significance
Involvement of the youth in the judicial system	0.70	0.06	2.02	1.78 – 2.29	$p < 0.01$
Problems with youth or family service agencies	0.60	0.03	1.83	1.72 – 1.94	$p < 0.01$
Neglect	0.39	0.06	1.47	1.32 – 1.64	$p < 0.01$
Family dynamics	0.35	0.03	1.42	1.34 – 1.50	$p < 0.01$
School or education issues	0.14	0.04	1.15	1.07 – 1.23	$p < 0.01$
Issues related to transportation	1.35	0.05	3.85	3.52 – 4.20	$p < 0.01$

Exhibit 10

Variables Predicting Status as a Non–Street Youth for Youth Crisis Callers to the National Runaway Switchboard, 2000–2005

Variables	B	SE	Odds Ratio	95% CI	Significance
Mental health issues of the youth	0.87	0.04	2.38	2.19 – 2.59	$p < 0.01$
Suicidality of the youth	0.79	0.08	2.20	1.89 – 2.57	$p < 0.01$
Emotional or verbal abuse	0.43	0.04	1.54	1.42 – 1.68	$p < 0.01$
Physical health issues of the youth	0.35	0.05	1.42	1.30 – 1.56	$p < 0.01$

Using a regression model,[6] issues related to transportation were the single best predictor of street youth status (odds ratio [OR] = 3.85), but these issues were likely to have been reported particularly frequently among our sample because NRS provides access to the Home Free program. The other general problem domains that best predicted inclusion in the street youth category were involvement of the youth in the judicial system, problems with youth or family service agencies, neglect, family dynamics and issues pertaining to school or education. The problem domains that best predicted non-street status were mental health issues, suicidality, emotional or verbal abuse and physical health issues. These findings were generally consistent with prior research on NRS callers (Molino et al., 2006b), and also call attention to additional issues that were not noted as significant in previous studies of NRS callers.

A summary of the risk issue categories predicting street youth and non-street youth status is provided in Exhibit 11.

Exhibit 11

Summary Table of Risk Issues Predicting Street and Non-Street Youth Status for Youth Crisis Callers to the National Runaway Switchboard, 2000–2005

Risk Issues Predicting Inclusion in Street Youth Category	Risk Issues Predicting Inclusion in Non-Street Youth Category
• Involvement of youth in judicial system	• Mental health issues of the youth
• Problems with youth/family service agencies	• Suicidality of the youth
• Neglect	• Emotional/verbal abuse
• Family dynamics	• Physical health issues of the youth
• School/education issues	
• Transportation issues	

Relationship Between Recidivism of Running Behavior and Risk/Problem Issues

Using correlative analyses,[7] we found a significant but relatively small relationship between recidivism of running behavior (repeated running away) and the number of problem domains reported by callers (Spearman's rho = 0.194, $p < 0.01$). Youth who, at the time of the call, reported two or more prior episodes of runaway behavior at the time of the call ("repeat runners," n = 3,022) comprised 25% of the sample.

Further analyses, exploratory in nature, were performed to examine the relationship between reported problem issues and recidivism of running behavior. Based on the results of frequency analysis of reported risk issues, we selected general domains of problematic issues that substantially differentiated between repeat runners and non-runners. These issues included family dynamics, alcohol or drug use by the youth, alcohol or drug use by the family, physical abuse or assault, involvement of the youth in the judicial system, problems with youth or family service agencies, peer or social issues, school or education issues, issues related to GLBTQ status, and issues related to transportation. To assess the relative importance of these variables to repeat runner or non-runner status, these variables were entered into a regression

[6] The technique used was stepwise multivariate logistic regression analysis.

[7] The technique used was a nonparametric correlative analysis (Spearman's rho) appropriate to variables that are not normally distributed.

model[8] (see Exhibits 12 and 13). Alcohol or drug use by the family was found to be a non-significant predictor of both repeat runner and non-runner status for our sample and was removed from the final regression model.

Exhibit 12

Variables Predicting Status as a "Repeat Runner" (Youth Reported Having Run Away from Home at Least Twice) for Youth Crisis Callers to the National Runaway Switchboard, 2000–2005

Variables	B	SE	Odds Ratio	95% CI	Sig.
Involvement of the youth in the judicial system	1.48	0.10	4.25	3.48 – 5.18	$p < 0.01$
Alcohol or drug use by the youth	0.88	0.09	2.42	2.02 – 2.90	$p < 0.01$
Family dynamics	0.60	0.07	1.82	1.60 – 2.07	$p < 0.01$
School or education issues	0.60	0.06	1.82	1.62 – 2.04	$p < 0.01$
Problems with youth or family service agencies	0.57	0.05	1.76	1.59 – 1.95	$p < 0.01$
Physical abuse or assault	0.32	0.06	1.38	1.22 – 1.55	$p < 0.01$
Peer or social issues	0.21	0.05	1.24	1.12 – 1.36	$p < 0.01$
Issues related to transportation	1.24	0.07	3.44	3.00 – 3.94	$p < 0.01$

Exhibit 13

Variables Predicting Status as a "Non-Prior Runner" (Youth Had Not Previously Run Away from Home) for Youth Crisis Callers to the National Runaway Switchboard, 2000–2005

Variables	B	SE	Odds Ratio	95% CI	Sig.
Issues related to GLBTQ status	0.88	0.18	2.41	1.69 – 3.43	$p < 0.01$

In general, status as a non-runner or repeat runner cannot be consistently predicted based on the types of problematic issues indicated, although repeat runners had experienced a wide variety of problematic issues. Experiencing problems in any of the problem domains included in the regression model significantly increased the probability of status as a repeat runner ($p < 0.01$), with the exception of the GLBTQ issue category, which was the only predictor reported more often by non-runners (3.7 percent) than by repeat runners (1.3 percent). Conversely, experiencing problems in any of the problem domains included in the regression model, with the exception of GLBTQ issues, significantly decreased the probability of being a non-runner ($p < 0.01$). Overall classification was inconsistent; on the basis of the nine significant predictors, correction classification rates were 96 percent for non-runners, but only 21 percent for repeat runners.

[8] The technique used was stepwise multivariate logistic regression analysis.

Discussion and Conclusions

Runaways comprised the largest of the five caller subgroups, which likely reflects the way in which NRS crisis intervention services are marketed. Although services are available to any youth who considers him or herself to be in a crisis situation (i.e., a situation that he or she considers to be intolerable or unmanageable), the name of the agency and the wording of promotional materials indicate that runaway youth are its target population.

Overall, callers were in their mid-teens, with the exception of the homeless subgroup, whose average age was around 18 years. It is possible that this reflects a tendency of older non-housed adolescents to think of themselves as being without a home, and of younger non-housed adolescents to think of themselves as being away from a primary home. However, this theme has not yet been directly examined in the literature.

For all five caller subgroups, the majority of callers were female. This finding is consistent with gender distributions found in other research studies on youth homelessness that utilize samples recruited through service agencies (Yoder et al., 2001). It is possible that gender distribution in this study reflects a larger theme of female street youth being more likely than males to seek assistance from formal sources of support, such as crisis hotlines. While some information was available on transgender youth, our statistics are limited because information in the transgender category was only recorded during the last year of available data. Further, because NRS provides crisis intervention to all callers regardless of gender, and because gender is, in many cases, largely unrelated to the process of providing crisis intervention, categorization of the youth as transgender is highly dependent on the caller directly disclosing such information to hotline personnel.

The crisis issues most frequently identified across caller subgroups were related to family dynamics, peer or social problems, and problems with youth or family service agencies. Problems related to family dynamics were mentioned by a majority of the total sample as well as by all three subgroups of street youth. Within the family dynamics category, problems with parents and conflict with family or household rules were identified by a majority of participants. These findings are consistent with literature on risk factors for runaway behavior (Hyde, 2005; Martinez, 2006; Safyer et al., 2004; Thompson & Pillai, 2006; Whitbeck & Hoyt, 1999a).

Since disorganized or dysfunctional family systems are frequently associated with runaway behavior, it follows that effective interventions can be implemented at the family level. Furthermore, youth who have ever experienced homelessness due to running away are frequently found in a housed situation. Results from NISMART-2 indicated that most runaways are gone for less than one week, with 99.6 percent having returned within a year (Hammer et al., 2002). Based on the NISMART-2 findings, Sanchez and colleagues (2006) concluded that most youth with runaway experiences are located in their family homes. Interventions targeting these youth will likely involve the family. Additionally, because the goal of federally funded shelters is reunification of families, it is necessary to address problematic family dynamics to ensure successful long-term placement in the home (Kidd, 2003; Thompson et al., 2003). Finally, in some cases, runaway and homeless youth cite family members as providing positive support and an impetus to succeed. In these cases, maintaining positive family relationships is beneficial for runaway youth (Kidd, 2003; Kurtz, Lindsey, Jarvis, & Nackerud, 2000; Robert et al., 2005). For all these reasons, it is important that family and household factors are considered in long-term intervention plans for runaway youth. Policy recommendations suggested by researchers include the focusing of primary

intervention efforts on the family, the inclusion of important family members in designing effective interventions, and the careful examination of the suitability of the home before reuniting a runaway youth with his or her family (Kidd, 2003; Riley, Greif, Caplan, & MacAulay, 2004; Robert et al., 2005; Thompson et al., 2003).

In general, street youth callers sought assistance relatively soon after leaving home. Over half of street youth callers contacted the hotline within one week of leaving home, and more than one-fifth of those callers (approximately 22 percent) contacted the hotline within one day of leaving home. In addition, for street youth callers whose general location at the time of the call was known, the majority were already receiving assistance to some extent from either a formal resource, such as police or a shelter, or a familiar resource, such as a friend or relative. Comparatively fewer callers contacted the hotline from a street area, a payphone, or the location of a pimp or dealer. This suggests that, while the participants in this study demonstrate help-seeking initiative by contacting NRS, they are also capable of locating and utilizing resources to handle their crisis situations even before receiving further aid or referrals through the hotline.

Predictors of status as a street youth included judicial issues of the youth, problems with youth or family service agencies, neglect, problematic family dynamics, and issues pertaining to school or education. The endorsing of these issues increased the odds of inclusion in the street youth category by factors of 2.02, 1.83, 1.47, 1.42 and 1.15 respectively. These results are consistent with current research suggesting that disorganized or dysfunctional households marked by high rates of verbal and physical conflict, as well as by escalating antisocial behavior on the part of the youth, are predictive of runaway behavior and homelessness among adolescents (Whitbeck & Hoyt, 1999a; Hyde, 2005; Martinez, 2006). Services for street youth that target these types of issues may alleviate the hardship and stress of being homeless.

Predictors of status as a non-street youth included mental health issues of the youth, suicidality of the youth, having experienced emotional or verbal abuse, and physical health issues of the youth. The endorsing of these problematic issues by callers increased the odds of inclusion in the non-street youth category by factors of 2.38, 2.20, 1.54 and 1.42 respectively. This suggests that crisis issues that are seen as particularly stressful, or that lead to help-seeking behavior, are different for youth who are currently housed as opposed to issues identified by street youth, who are removed from the immediate household at the time of the call placed to the hotline. These types of issues may be important to address in programs aimed at preventing homelessness and promoting the overall well-being of adolescents.

The majority of street youth callers had not run away or been homeless before. For those who had previously run away or been homeless, the number of prior episodes during which they had been non-housed varied widely. The number of prior runs and prior episodes of homelessness ranged from 1 to 99 (or more); the average number of runs was approximately 4 and the average number of prior episodes of homelessness was approximately 3. A significant but relatively small correlation was found between the average number of reported general problem domains and the number of prior runs (Spearman's rho = 0.194, $p < 0.01$).

Regression analyses found that predictors of youth having repeatedly run away from home included problematic family dynamics, substance use by the youth, the experience of physical abuse or assault, involvement of the youth in the judicial system, problems with youth or family service agencies, peer or social issues, school or education issues, and issues related to transportation. Issues related to GLBTQ status predicted youth having never run away before ("non-runner"). It should be noted that frequency analyses found that repeat runners were more likely than non-runners to have reported the majority of the

risk issue categories in the call log (17 out of 25 total categories). The results of the regression analyses are consistent with the results of these frequency analyses. It is likely that the lack of predictors for non-runners was affected by the tendency of repeat runners to more frequently report problems in any of the potential issue categories.

Despite the limitations of these analyses, the results provide information on the way in which the reporting of problematic issues by callers affected the odds of inclusion in the repeat runner versus the non-runner category. The risk issue categories that best predicted repeat runner status included judicial problems of the youth, issues related to transportation, and alcohol or drug use by the youth, which increased the odds of inclusion in the prior runner category by factors of 4.25, 3.44, and 2.42 respectively. While issues related to transportation predicted inclusion in the repeat runner category, they were likely to have been reported frequently among our sample due to NRS providing access to the Home Free program. The reporting of issues related to GLBTQ status increased the odds of inclusion in the non-runner category by a factor of 2.41. These results do not imply that repeat runners do not experience GLBTQ issues, nor do the results imply that non-runners do not experience the types of problems reported by repeat runners. Rather, different risk issues may be more important to or salient for youth who have repeatedly run away, as compared to youth who have not run away. It is also possible that the types of issues for which repeat runners are inclined to seek help are different from the types of issues for which non-runners are inclined to seek help.

While the analysis correctly classified a large majority of non-runners, it failed to classify a large majority of repeat runners. This suggests that, for this sample and the regression model used, we are limited in our ability to consistently predict runaway recidivism from the number or types of problem domains reported. Other factors may be more pertinent to whether or not a youth repeatedly runs away, such as prior runaway experience (Whitbeck & Hoyt, 1999), the severity of the problem issues, the extent to which a youth experiences stressors as problematic, and the ability of the youth to cope with such stressors. Runaway participants in this study experienced a wide variety of problem issues in different combinations, supporting the idea that there is no “typical” runaway youth (NRS, 2004). If the type and number of issues are idiosyncratic to each runaway, it may not be possible to reliably predict which individuals run away, or which individuals run away repeatedly. Efforts by runaway prevention and intervention programs to generally reduce risk and increase resilience will likely reduce overall rates of runaway behavior.

Limitations

The conclusions that can be drawn from the current study are limited in several ways. First, the data were collected to facilitate crisis intervention, rather than to answer specific research questions; therefore, the types of statistical analyses that could be applied to the data were limited. In addition, some call logs contained limited or incomplete data. For example, items may have gone unanswered if the caller declined to give particular pieces of information about him or herself or about the crisis situation. The data also consist of information from help-seeking individuals, who may differ from individuals who do not seek assistance in alleviating their crisis situations. For example, help-seeking individuals may have been more likely to disclose information about their problems or to have disclosed more serious issues such as physical abuse. The data were based on self-report and are thus potentially subject to biases such as social desirability or the selective underreporting of particular crisis issues. Underreported issues may have included experiences that involved some element of social stigma, such as having been sexually assaulted, or that involved the disclosure of criminal behavior perpetrated by the youth. Self-report biases

may also have contributed to the relatively low rates of reported sexual abuse or assault among this sample as compared to reported rates of neglect and of physical, verbal and emotional abuse. Callers who wished to receive confidential help for their crisis situations may also have been reluctant to disclose issues that they believed would result in the contacting of law enforcement or protective service agencies, such as suicidality, violation of probation or parole, or parental abuse.

It is also difficult to determine whether the problematic issues of street youth, as recorded in the call log, occurred before or after the adolescent came to be away from the home. Therefore, the extent to which one can interpret a reported problem as a risk factor for becoming homeless, as opposed to a consequence of homelessness, is limited for this research sample. In addition, because the data are cross-sectional, the extent to which conclusions can be drawn about causality is limited.

Finally, the information provided by callers is subject to interpretation by the staff and trained volunteers who provide crisis intervention services. While NRS hotline staff and volunteer liners receive the same type and number of hours of initial training before taking calls and follow the same model of crisis intervention, the interpretation of data may vary depending on level of skill or amount of experience.

Future Research Directions and Considerations

Our understanding of homeless youth and their needs will benefit from research studies that utilize large representative samples of both help-seeking and non-help seeking individuals who reside in a variety of locations, including shelters, friends' homes and street locations. In addition, prevention and intervention programs can be made more effective and appropriate when guided by findings from longitudinal research studies and other research efforts that identify a timeline of occurrence of problematic issues in the lives of homeless youth. The identification of problematic issues occurring before youths become homeless will assist prevention programs in better identifying risk factors contributing to street youth status, while the identification of problematic issues occurring after youths become homeless will help intervention and support programs for street youth to better meet the needs of their target population.

In making policy recommendations, researchers must take into consideration the potential differences in local laws that impact the lives and rights of homeless adolescent research participants. These include differences in the age of majority as defined by each state; local laws and regulations regarding loitering and squatting; and local laws and regulations regarding the potential penalties for runaway behavior, which can vary across states (National Law Center on Homelessness and Poverty, 2003).

Future research questions that may help to expand on the findings of the current study as well as address recent issues mentioned by callers to the hotline, include:

- What factors lead a youth to characterize him- or herself as runaway, homeless, or throwaway?
- What is the timeline of occurrence of problematic issues in the lives of homeless and runaway youth?
- Do youth who repeatedly run away report a difference in type, severity, or number of problematic issues that occur before their first run as compared to before subsequent runs?

APPENDIX A

General Categories and Subcategories of Crisis Issues Recorded in National Runaway Switchboard Call Logs for Youth Crisis Callers, 2000–2005.

General Category	Subcategories
Family dynamics	Problems with parents/guardians Conflict with family/household rules Blended/extended family Separation/divorce Custody Problem with siblings Teen parenting Death of friend / family member Move
Mental health issues of the youth	Depression Crime Victim/Witness Psychological/behavioral problem Eating disorder Self-injury
Mental health issues of friends or family members	Psychological/behavioral problem
Suicidality of the youth	Youth suicidal Youth prior suicide attempt
Suicidality of friends or family members	Friend/family member suicidal
Alcohol or drug use by the youth	Alcohol or drug use (general)
Alcohol or drug use by family members	Alcohol or drug use (general)
Alcohol or drug use by friends or peers	Alcohol or drug use (general)
Involvement of youth or family member in substance abuse treatment program	Youth or family member in S.A. treatment (general)
Physical health issues of the youth	HIV/AIDS Pregnancy Physically challenged Illness (general)
Physical health issues of family members	Illness (general)
Physical abuse or assault	By parent By parent's partner/stepparent By other family member Domestic violence By boyfriend/girlfriend By non-relative
Physical abuse or assault perpetrated by the youth	Youth physically assaulting others
Sexual abuse or assault	By parent By parent's partner/stepparent By other family member Rape By boyfriend/girlfriend By non-relative
Sexual abuse or assault perpetrated by the youth	Youth sexually assaulting others
Neglect	Neglect (general)
Emotional or verbal abuse	Emotional or verbal abuse (general)
Involvement of the youth in the judicial system	Probation/parole Crime involvement
Involvement of family members in the judicial system	Family member in jail

APPENDIX A

General Categories and Subcategories of Crisis Issues Recorded in National Runaway Switchboard Call Logs for Youth Crisis Callers, 2000–2005.

General Category	Subcategories
Economic issues	Poverty
	General employment issues
	Unemployed
	Underemployed
	Lost job due to housing issue
	Lack of affordable housing
Problems with youth or family services	Protective service agency (CPS, DYFS, etc.)
	Residential/foster/group home
	Runaway shelter
	Transitional/independent living
	Lack of available services
Peer or social issues	Problems involving friends or acquaintances
	Problems involving relationship
	Gang issues
	Cult involvement
	Adventure/independence
	Internet relationship
	Bullying
School or education issues	Grades
	Truancy (skipping school)
	Suspension/expulsion
	Dropping out
	Problems with teachers
	Problems with other students
	Home schooling
	Enrollment issues
Issues related to gay, lesbian, bisexual, transgender or questioning (GLBTQ) status	Verbal/physical abuse
	Harassment
	Coming out
	Sexual identity
	Questioning
Issues related to transportation	Lack of transportation
	Youth is stranded
	Youth is stranded by sales crew

APPENDIX B

Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Family dynamics	22508	(74.4%)	9016	(79.8%)	1459	(91.3%)	1165	(59.2%)
Problems with parents/guardians	17635	(58.3%)	7024	(62.2%)	1248	(78.1%)	825	(41.9%)
Conflict with family or household rules	9652	(31.9%)	4497	(39.8%)	572	(35.8%)	361	(18.3%)
Blended/extended family	3501	(11.6%)	1328	(11.8%)	214	(13.4%)	161	(8.2%)
Separation/divorce	3700	(12.2%)	1484	(13.1%)	179	(11.2%)	81	(4.1%)
Custody	2153	(7.1%)	902	(8.0%)	130	(8.1%)	63	(3.2%)
Problem with siblings	2261	(7.5%)	665	(5.9%)	98	(6.1%)	81	(4.1%)
Teen parenting	1566	(5.2%)	414	(3.7%)	125	(7.8%)	175	(8.9%)
Death of friend / family member	862	(2.8%)	291	(2.6%)	37	(2.3%)	78	(4.0%)
Move	1307	(4.3%)	367	(3.2%)	55	(3.4%)	132	(6.7%)
Mental health issues of the youth	3741	(12.4%)	940	(8.3%)	74	(4.6%)	105	(5.3%)
Depression	2763	(9.1%)	554	(4.9%)	53	(3.3%)	58	(2.9%)
Crime victim/witness	180	(0.6%)	65	(0.6%)	5	(0.3%)	11	(0.6%)

APPENDIX B

Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Psychological/behavioral problem	1281	(4.2%)	433	(3.8%)	27	(1.7%)	53	(2.7%)
Eating disorder	179	(0.6%)	16	(0.1%)	2	(0.1%)	2	(0.1%)
Self-injury	30	(0.1%)	4	(Non-significant)	1	(0.1%)	0	(0.0%)
Suicidality of the youth	1204	(4.0%)	232	(2.1%)	21	(1.3%)	16	(0.8%)
Youth suicidal	1194	(3.9%)	230	(2.0%)	21	(1.3%)	16	(0.8%)
Youth prior suicide attempt	1173	(3.9%)	226	(2.0%)	19	(1.2%)	16	(0.8%)
Mental health issues of friends/family	719	(2.4%)	244	(2.2%)	41	(2.6%)	25	(1.3%)
Psychological/behavioral problem		(same as above)		(same as above)		(same as above)		(same as above)
Suicidality of friends/family	152	(0.5%)	32	(0.3%)	1	(0.1%)	2	(0.1%)
Friend/family member suicidal		(same as above)		(same as above)		(same as above)		(same as above)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Peer or social issues	8459	(27.9%)	3508	(31.0%)	212	(13.3%)	474	(24.1%)
Friends/acquaintance problems	3316	(11.0%)	1224	(10.8%)	87	(5.4%)	160	(8.1%)
Relationship problems	3615	(11.9%)	1240	(11.0%)	84	(5.3%)	196	(10.0%)
Gang issues	195	(0.6%)	79	(0.7%)	9	(0.6%)	10	(0.5%)
Cult involvement	17	(0.1%)	3	(Non-significant)	0	(0.0%)	1	(0.1%)
Adventure/independence	3732	(12.3%)	2150	(19.0%)	81	(5.1%)	236	(12.0%)
Internet relationship	3649	(12.1%)	2115	(18.7%)	79	(4.9%)	234	(11.9%)
Bullying	9	(Non-significant)	1	(Non-significant)	0	(0.0%)	0	(0.0%)
School or education issues	4231	(14.0%)	1918	(17.0%)	177	(11.1%)	154	(7.8%)
Grades	1567	(5.2%)	500	(4.4%)	38	(2.4%)	9	(0.5%)
Truancy (skipping school)	1024	(3.4%)	622	(5.5%)	53	(3.3%)	8	(0.4%)
Suspension/expulsion	483	(1.6%)	212	(1.9%)	16	(1.0%)	9	(0.5%)

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	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Dropping out	1499	(5.0%)	836	(7.4%)	88	(5.5%)	130	(6.6%)
Problems with teachers	503	(1.7%)	140	(1.2%)	8	(0.5%)	5	(0.3%)
Problems with other students	26	(0.1%)	3	(Non-significant)	0	(0.0%)	1	(0.1%)
Home schooling	4	(Non-significant)	1	(Non-significant)	0	(0.0%)	0	(0.0%)
Enrollment issues	23	(0.1%)	8	(0.1%)	1	(0.1%)	1	(0.1%)
Economic issues	1022	(3.4%)	318	(2.8%)	63	(3.9%)	214	(10.9%)
Poverty	912	(3.0%)	294	(2.6%)	59	(3.7%)	185	(9.4%)
General employment issues	48	(0.2%)	11	(0.1%)	3	(0.2%)	3	(0.2%)
Unemployed	56	(0.2%)	16	(0.1%)	5	(0.3%)	14	(0.7%)
Underemployed	13	(Non-significant)	1	(Non-significant)	0	(0.0%)	1	(0.1%)
Lost job due to housing issue	6	(Non-significant)	1	(Non-significant)	1	(0.1%)	0	(0.0%)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth) (*N*=30,266)		Street Youth Subgroup Status					
			Runaways (*N*=11,299)		Throwaways (*N*=1,598)		Homeless (*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Lack of affordable housing	55	(0.2%)	7	(0.1%)	1	(0.1%)	26	(1.3%)
Physical health of the youth	2245	(7.4%)	678	(6.0%)	98	(6.1%)	164	(8.3%)
HIV/AIDS	133	(0.4%)	27	(0.2%)	3	(0.2%)	5	(0.3%)
Pregnancy	1620	(5.4%)	501	(4.4%)	80	(5.0%)	120	(6.1%)
Physically challenged	63	(0.2%)	17	(0.2%)	1	(0.1%)	6	(0.3%)
Illness (general)	498	(1.6%)	148	(1.3%)	16	(1.0%)	38	(1.9%)

APPENDIX B

Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Physical health of the family	493	(1.6%)	147	(1.3%)	16	(1.0%)	36	(1.8%)
Illness (general)	(same as above)		(same as above)		(same as above)		(same as above)	
Issues related to GLBTQ status	845	(2.8%)	178	(1.6%)	45	(2.8%)	50	(2.5%)
Verbal/physical abuse	(No data available)		(No data available)		(No data available)		(No data available)	
Harassment	222	(0.7%)	52	(0.5%)	9	(0.6%)	18	(0.9%)
Coming out	520	(1.7%)	120	(1.1%)	39	(2.4%)	24	(1.2%)
Sexual identity	487	(1.6%)	89	(0.8%)	21	(1.3%)	27	(1.4%)
Questioning	6	(Non-significant)	1	(Non-significant)	0	(0.0%)	0	(0.0%)
Alcohol/drug use by the youth (general)	1557	(5.1%)	756	(6.7%)	65	(4.1%)	75	(3.8%)
Alcohol/drug use by friends/peers (general)	362	(1.2%)	135	(1.2%)	16	(1.0%)	17	(0.9%)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Alcohol/drug use by family (general)	1752	(5.8%)	682	(6.0%)	96	(6.0%)	77	(3.9%)
Youth/family member in substance abuse treatment program (general)	119	(0.4%)	53	(0.5%)	7	(0.4%)	10	(0.5%)
Physical abuse/assault	4799	(15.9%)	2142	(19.0%)	221	(13.8%)	132	(6.7%)
By parent	3404	(11.2%)	1584	(14.0%)	185	(11.6%)	48	(2.4%)
By parent's partner/stepparent	827	(2.7%)	413	(3.7%)	31	(1.9%)	12	(0.6%)
By other family member	451	(1.5%)	172	(1.5%)	18	(1.1%)	8	(0.4%)
Domestic violence	528	(1.7%)	178	(1.6%)	9	(0.6%)	41	(2.1%)
By boyfriend/girlfriend	376	(1.2%)	126	(1.1%)	6	(0.4%)	43	(2.2%)
By non-relative	5	(Non-significant)	3	(Non-significant)	0	(0.0%)	0	(0.0%)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Physical abuse or assault perpetrated by the youth (general)	165	(0.5%)	59	(0.5%)	9	(0.6%)	7	(0.4%)
Sexual abuse or assault	1400	(4.6%)	560	(5.0%)	36	(2.3%)	38	(1.9%)
By parent	414	(1.4%)	182	(1.6%)	10	(0.6%)	3	(0.2%)
By parent's partner/stepparent	339	(1.1%)	155	(1.4%)	11	(0.7%)	5	(0.3%)
By other family member	239	(0.8%)	78	(0.7%)	5	(0.3%)	4	(0.2%)
By boyfriend/girlfriend	109	(0.4%)	35	(0.3%)	1	(0.1%)	5	(0.3%)
By non-relative	11	(Non-significant)	2	(Non-significant)	0	(0.0%)	1	(0.1%)
Rape	460	(1.5%)	170	(1.5%)	11	(0.7%)	22	(1.1%)
Sexual abuse or assault perpetrated by the youth (general)	26	(0.1%)	8	(0.1%)	2	(0.1%)	1	(0.1%)
Neglect (general)	1849	(6.1%)	571	(5.1%)	393	(24.6%)	86	(4.4%)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth)		Street Youth Subgroup Status					
			Runaways		Throwaways		Homeless	
	(*N*=30,266)		(*N*=11,299)		(*N*=1,598)		(*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Emotional or verbal abuse (general)	3228	(10.7%)	1151	(10.2%)	190	(11.9%)	60	(3.0%)
Involvement of the youth in judicial system	1374	(4.5%)	826	(7.3%)	50	(3.1%)	62	(3.2%)
Probation/parole	828	(2.7%)	528	(4.7%)	30	(1.9%)	20	(1.0%)
Crime involvement	746	(2.5%)	430	(3.8%)	28	(1.8%)	51	(2.6%)
Involvement of family in judicial system	392	(1.3%)	175	(1.5%)	18	(1.1%)	31	(1.6%)
Family member in jail		(same as above)		(same as above)		(same as above)		(same as above)
Problems with youth or family services	6359	(21.0%)	2927	(25.9%)	509	(31.9%)	438	(22.3%)
Protective service agency (CPS, DYFS, etc.)	2649	(8.8%)	1215	(10.8%)	236	(14.8%)	59	(3.0%)
Residential/foster/group home	2102	(6.9%)	971	(8.6%)	159	(9.9%)	130	(6.6%)
Runaway shelter	3707	(12.2%)	1729	(15.3%)	341	(21.3%)	345	(17.5%)
Transitional/independent living	5	(Non-significant)	1	(Non-significant)	1	(0.1%)	0	(0.0%)

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Frequency Analysis Results for General Categories and Subcategories of Risk Issues Reported by Youth Crisis Callers to the National Runaway Switchboard, 2000–2005.

	Total Sample (Street and Non-Street Youth) (*N*=30,266)		Street Youth Subgroup Status: Runaways (*N*=11,299)		Throwaways (*N*=1,598)		Homeless (*N* =1,968)	
General categories and subcategories	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)	*n*	(Percent)
Lack of available services	33	(0.1%)	15	(0.1%)	1	(0.1%)	4	(0.2%)
Issues related to transportation	3246	(10.7%)	2036	(18.0%)	95	(5.9%)	373	(19.0%)
Lack of transportation	3210	(10.6%)	2022	(17.9%)	94	(5.9%)	370	(18.8%)
Youth is stranded	47	(0.2%)	24	(0.2%)	2	(0.1%)	7	(0.4%)
Youth is stranded by sales crew	13	(Non-significant)	1	(Non-significant)	0	(0.0%)	1	(0.1%)

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Rural Homelessness

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Abstract

For the 1998 Symposium on Homelessness Research, rural homelessness was not assigned as a paper topic in its own right. Due to its increasing significance, the authors prepared a paper on rural homelessness for the 2007 Symposium. Given the somewhat limited formal research available, the authors supplemented their literature review with information from government documents and technical assistance materials as well as input from an expert panel of researchers and practitioners. The paper summarizes what is documented to date about the characteristics of people who are homeless in rural areas and examines whether rural homelessness and the service approaches to address it can be differentiated from urban homelessness. The authors identify gaps in current knowledge about rural homelessness and recommend new directions for research.

Introduction

Since the late 1970s when large numbers of homeless people began appearing on city streets, homelessness has been regarded by the public as primarily an urban phenomenon. Although advocates and providers in rural areas were also seeing increasing numbers of people without housing, prompting speculation about the existence of "the hidden homeless in rural communities" (Post, 2002), very few researchers addressed issues related to rural homelessness. This dearth of scholarly literature was deemed of sufficient concern to the Institute of Medicine (IOM) Committee on Health Care for Homeless People in preparing its comprehensive report on *Homelessness, Health, and Human Needs* (1988) that a special study of rural homelessness was commissioned (Patton, 1988). In 1991, the Housing Assistance Council

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(HAC) published *Rural Homelessness: A Review of the Literature*, summarizing the various studies documenting rural homelessness (Housing Assistance Council, 1991). By 1995, rural homelessness was a visible issue warranting focus from the U.S. Department of Agriculture's Rural Economic and Community Development (RECD) and the Federal Interagency Council on Homelessness (ICH), which held a series of regional conferences with providers and advocates (Burt, 1996). A decade following the IOM report, the federal government convened the 1998 National Symposium on Homelessness Research to present papers on the state of the art of homelessness research, published as *Practical Lessons* (Fosburg & Dennis, 1999). However, although Rosenheck, Bassuk, and Salomon (1999) identified rural homelessness as contributing to the diversity of American homelessness, they did not discuss the topic as a phenomenon needing specific enquiry or presenting unique characteristics and challenges for service providers. Since the 1998 Symposium, most of the additional research conducted to address homelessness policy and practice has continued to focus on urban settings, with the result that rural homelessness remains much less well understood.

There are three main reasons for examining what is known about rural homelessness. The first is to document the prevalence of the problem. The second is to examine whether rural homelessness can be differentiated from urban homelessness as well as to identify differences in how persons who are homeless are served in rural communities. The third is to identify the gaps in current knowledge and recommend areas critical to new research. This paper addresses these issues, synthesizing research conducted over the past 25 years. Because little research has been done on rural homelessness, the literature reviewed was expanded beyond peer-reviewed journals to include government publications, technical assistance documents, and program materials encompassing rural homelessness and related topics (i.e., sources covering homelessness in general, rural poverty, rural health, rural mental health and substance abuse, as well as various data sources). In a further effort to fill gaps in the literature, a number of telephone interviews were conducted with service providers to inform the services component of the paper. In addition, this paper draws on an expert panel comprising researchers, service providers, government officials, and advocates convened in October 2006 to discuss cutting-edge issues in rural homelessness and to identify areas for future enquiry.

Prevalence of Rural Homelessness

The Impact of Definitions on Rural Homelessness Research

The lack of consensus on how to define rurality has impeded research into rural homelessness by making it difficult to specify the population studied in a consistent manner (National Institute on Drug Abuse, 1997). To date, federal agencies and researchers have not settled on a single definition of "rural" but rather construct definitions specific to various uses. Moreover, the definitions have changed over the years to reflect demographic shifts as well as changing notions of urbanicity. While definitions adopted by various government agencies tend to overlap, there are important distinctions in the geographic areas delineated as rural, affecting population estimates, services eligibility, and the like.

Rurality is typically defined in contrast to urbanicity. The most commonly used definitions, such as those developed by the U.S. Bureau of the Census, the Office of Management and Budget (OMB), and the U.S. Department of Agriculture (USDA), are based on population density and proximity to metropolitan areas. For example, prior to 2003, OMB defined a "metropolitan community" as a population nucleus with a population of 50,000 or more and the economically tied surrounding area. Communities with more than

5,000 but fewer than 50,000 people were designated as "urban clusters." Subsequently, OMB added "micropolitan" communities with a population of up to 10,000 plus surrounding county areas where at least 25 percent of the population commutes to the micropolitan center. All other (or rural) communities are considered non-core. The U.S. Bureau of the Census definition of urban includes "urbanized" areas consisting of one or more central places and adjacent territory with a population density of at least 1,000 per square mile that together have a minimum residential population of at least 50,000 people, and "urban clusters" of densely settled areas having at least 2,500 but fewer than 50,000 people. Rural areas constitute all "territory, population and housing units not classified as urban" (Coburn, 2007). Because urban and rural classifications crosscut other geographic hierarchies, rural pockets can be located in both metropolitan and non-metropolitan areas.

Within the continuum of communities defined as rural, "frontier" areas represent the extreme. Although not a Census classification, frontier areas are usually defined as having a very low population density, typically fewer than seven persons per square mile (Popper, 1986). Most frontier counties are found in western states and are characterized by people's relative isolation and dispersion across large geographic areas. Frontier areas account for about 400 communities countrywide, which cover about 45 percent of the country's land mass. It is important to define frontier areas because of their distinctive characteristics relative to other rural areas; for example, economic downturns start earlier and snowball faster in frontier communities because they are less complex and often rely on a single industry (e.g., tourism, ranching, farming, logging, or mineral extraction) (Ciarlo et al., 1996).

Although these various agency definitions have been used, for example, to document differences in drug use and health across categories of population and geographic location, it is important to note that these definitions were developed to provide nationally consistent standards for collecting federal statistics for geographic areas and not for "inappropriate" uses such as determining program eligibility of individual applicants (Standards for defining Metropolitan and Micropolitan Statistical Areas, 2000). Nevertheless, these designations are frequently used to determine eligibility and distribute many types of federal funding—from homeland security to housing—in ways that exclude persons who are homeless in rural and frontier areas (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006).

Equally important is how homelessness itself is defined in rural areas and how the unique circumstances of rural living affect the enumeration of people who are homeless in rural settings. The most widely used definition of homelessness for determining policy comes from the McKinney-Vento Homeless Assistance Act (1987), which defines a "homeless person" as, "(1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is—(A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (B) an institution that provides a temporary residence for individuals intended to be institutionalized; or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." Structures commonly found in rural settings that the U.S. Department of Housing and Urban Development (HUD) calls "substandard but stable" housing do not meet criteria stipulated in Part C of the definition (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006). Although persons living in housing that has been condemned can be defined as homeless by HUD, a formal and consistent condemnation process does not exist in most rural communities. This means that a structure considered "not fit for human habitation" in Washington, D.C., would not be designated as such in Viper, Kentucky (Substance Abuse and Mental Health Services

Administration, Center for Mental Health Services, 2006). Consequently, undercounts of rural homeless people may result from exclusion of persons living in substandard structures—structures that in an urban setting would be condemned. To counteract this problem, some rural communities have worked with their local county governments to create a special designation for these properties in accord with the residence criteria stipulated in Part C of the homelessness definition. A few are now using the BOCA building code (Building Officials and Code Administrators International, 1996) definition of "not fit for human habitation" to distinguish persons who are homeless from those living in substandard housing.

The definition of a *chronic* homeless person as "any unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years," created by HUD, the U.S. Department of Health and Human Services (HHS), the U.S. Veteran's Administration (VA), and the U.S. Interagency Council on Homelessness (ICH) to determine eligibility under the consolidated plan (Consolidated Plan Revisions and Updates for Department of Housing and Urban Development, 2006), has been widely criticized for its exclusion of homeless families who have similar patterns of chronic homelessness (Child Welfare League of America et al., 2005). If families are a larger proportion of rural homeless populations than urban, use of this definition may also lead to disproportionate undercounts of chronic homelessness in rural relative to urban areas.

Enumeration of Rural Homeless People

Problems defining, locating, and sampling have made enumerating the homeless population virtually impossible (Cowan et al., 1988). In urban areas, estimates have commonly relied on counts of persons using services. However, by this measure, homeless persons in rural areas are likely substantially undercounted due to the lack of rural service sites, the difficulty capturing persons who do not use homeless services, the limited number of researchers working in rural communities, and the minimal incentive for rural providers to collect data on their clients (Burt et al., 1999). As a consequence, the number of homeless persons counted in a given area tends to correlate with how vigilant the surveyors are in finding them (Aron & Fitchen, 1996; Hudson, 1998). For example, when a man well-known by local providers to be chronically homeless was asked why he had not been included in a local HUD point-in-time count, he replied that he wasn't a dog that, when called, would come out to be counted (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006).

Most estimates of homelessness in rural areas have been extrapolated from rates reported in urban areas. For example, in 1987, as part of a study of eating patterns of homeless people in U.S. cities with populations of 100,000 or more, the Urban Institute collected data that researchers used to create one-day and one-week estimates of the numbers of homeless persons in central cities in the United States. Although no small city, suburban, or rural locations were included in the initial survey, these estimates were then extrapolated to the rest of the United States using assumptions about the ratio of homelessness rates in central cities compared to other areas of the country. This method produced a one-week estimate of 229,000 persons from shelters and meal programs in cities of over 100,000 and an extrapolation to the whole country of 500,000 to 600,000 people (Burt and Cohen, 1989).

The next national study of homelessness was mounted in 1996. The National Survey of Homeless Assistance Providers and Clients (NSHAPC) was a collaborative effort of 12 federal agencies, coordinated by the Interagency Council on Homelessness. Urban Institute researchers conducted an analysis of interviews with people sampled from shelters, meal programs, and other homeless service

agencies in communities as well as from some generic housing, community action, and welfare agencies in communities with few or no dedicated homeless services. Data from this study were used to estimate that 444,000 to 842,000 persons were homeless in the United States on any given night (Burt et al., 2001).

After weighting their data to be nationally representative of homeless assistance programs during an average week and to prevent double counting, NSHAPC estimated that about 9 percent of its homeless sample was drawn from rural areas in the U.S. (Burt et al., 1999). However, since people were only counted if they were clients in a broad array of targeted homeless service programs, the sample and findings of the study may have underrepresented the rural homeless population, because not all people who are homeless in rural areas use homeless service programs, and dedicated homeless assistance programs tend not to exist in smaller rural or frontier communities.

Another national one-day estimate of homelessness derives from the efforts of local communities to obtain counts of sheltered and unsheltered homeless people as part of their applications for funding under HUD's Supportive Housing Program and other related homeless assistance funding streams. Beginning in 2005, when HUD began requiring "methodologically defensible counts or no counts," HUD continuum-of-care applications included systematic counts, implemented with varied levels of rigorous methodology, from most communities in the country. The National Alliance to End Homelessness (NAEH) summed the reported counts from 2005 to create an updated base estimate of persons without housing in the U.S. From the 2005 counts from more than 450 communities, the National Alliance estimated that 744,313 Americans experienced homelessness on any given night in 2005 (National Alliance to End Homelessness, 2007). Applying the NSHAPC rate of 9 percent to this most recent national estimate by the National Alliance suggests that at least 67,000 adults may have been homeless in rural areas of the U.S. on any given night in 2005.

Unfortunately, using urban rates to estimate the extent of rural homelessness may not provide an accurate count due to differences in population density and other factors. Although rural areas represent 75 percent of the country's land mass, rural residents make up only 17 percent of the total population of the country (Johnson, 2006). While the absolute *number* of homeless persons in rural communities is smaller than that found in cities, the *prevalence* of homelessness (i.e., the number of homeless persons relative to the general population) has been estimated to be greater in some rural areas than in some major metropolitan areas (Kentucky Housing Corporation, 1994, 2002; Lawrence, 1995; Post, 2002). Furthermore, Burt (1999) cautioned that most studies that yield estimates of population size have methodological differences that make valid comparisons virtually impossible. One example of a survey that allows comparison, because it includes both rural and urban communities, is the statewide 1993 Kentucky Homeless survey, which found higher rates of homelessness in some rural communities compared to urban areas. The very rural Fleming and Lee counties had rates of 109 and 152 per 10,000 respectively while the most urban counties of Fayette and Jefferson had homeless rates of 32 and 17 per 10,000 (Kentucky Housing Corporation, 1994).

The numbers of homeless youth are not usually included in estimates of homeless populations in the United States. However, as part of the Youth Risk Behavior Survey sponsored by the Centers for Disease Control in 1992 and 1993, Ringwalt and colleagues analyzed data for a national representative household sample of 6,496 youth ages 12 through 17 (Ringwalt et al., 1998). Using a broad definition of homelessness, the researchers reported that overall, 7.6 percent of the national sample had experienced homelessness in the previous year. Contrary to findings reported for adults, the prevalence of homelessness among youth did not vary significantly by race, family poverty, family structure, or region

of the country. The annual rate of homelessness for youth in the previous 12 months was 8.4 percent in the rural (or non-metropolitan) areas compared to 8.3 percent in the Metropolitan Statistical Areas (MSAs) with central cities and 6.8 percent in MSAs without central cities. This finding suggests that homeless youth are a sizable and important subpopulation among homeless persons in both rural and urban areas. In contrast to homeless adults, whose homelessness is more often related to structural or economic factors, homeless youth in rural areas may become homeless due to conflict with parents or other household members, eviction, and other personal circumstances, as do homeless youth in urban areas (National Coalition for the Homeless, 2006a; Robertson & Toro, 1999; Wilder Research Center, 1998).

Rural Poverty in the United States

Demographic changes in rural communities since the 1970s have contributed to persistent poverty, institutions and infrastructures being stretched to their limits, and escalating housing costs (Johnson, 2006), all of which contribute to homelessness in rural areas. From the 1920s through the 1960s, rural counties grew slowly through natural increase (i.e., more births than deaths), even though millions of people moved from rural areas to cities. Subsequently, rural areas have experienced growth as a result of a reverse in earlier migration trends, with people, including immigrants, moving from cities into rural counties (except in the heartland of the Midwest), with about 17 percent (50 million) of the total U.S. population currently residing in rural areas (Johnson, 2006).

Homelessness has been characterized as the "extreme end of poverty" (Hopper & Hamburg, 1986). Poverty rates in the United States are highest in remote rural counties and central cities (Center for Family and Community Life, 2005; Mosley & Miller, 2004; National Coalition for the Homeless, 2006b). In 2005, 15.1 percent of rural populations were living in poverty compared to 12.5 percent of non-rural populations (Jensen, 2006). Among the 500 poorest counties, non-metropolitan (i.e., rural) counties outnumbered metropolitan counties by 11 to 1, and 48 of the 50 poorest counties were in rural areas (Aron, 2004). Recent research indicates that the odds of being poor are between 1.2 and 2.3 times higher for non-metropolitan residents than for metropolitan residents (National Coalition for the Homeless, 2006b). While the majority of rural low-income people are non-Hispanic whites, ethnic minorities in rural areas are particularly disadvantaged relative to both rural non-Hispanic whites and urban non-whites (Jensen, 2006; Mosley & Miller, 2004). For example, in non-metropolitan areas in 2001, almost one-third of African Americans and one-quarter of Hispanics lived in poverty compared to 11 percent of non-Hispanic whites (Jensen, 2006). American Indians in rural areas are also disadvantaged. In Montana, 38.4 percent of American Indians were living at or below poverty levels compared to 12.7 percent of all white persons in the state (Montana Council on Homelessness, 2007). O'Hare and Johnson (2004) point out that the highest poverty rates for children are also found in rural areas. Meanwhile, anti-poverty programs are often implemented less successfully in rural communities than in urban communities due to factors such as lack of transportation, physical and social isolation, stigma attached to seeking government assistance, and a dearth of health care providers and facilities (O'Hare & Johnson, 2004).

While rural communities have higher homeownership rates than most urban communities, 24 percent of rural households are renters. Because the rural housing stock is generally of lower quality, rural renters are twice as likely to live in substandard housing as their urban counterparts (12 percent of rural versus 6 percent of urban renters) (Housing Assistance Council, 2003b). Moreover, the cost burden is higher for rural renters than urban renters due to lower incomes (averaging $20,500 in rural versus $36,800 in urban areas in 2003). Lower incomes result in 36 percent of rural renter households paying more than 30 percent

of their adjusted income toward housing (Housing Assistance Council, 2003b). Meanwhile, federal funding for rural rental housing programs, including the U.S. Department of Agriculture (USDA) Rural Development Section 515 Program, has been drastically reduced, making it even more difficult to address this disparity. Under the Section 515 program, direct loans are made for terms of up to 50 years to for-profit developers, nonprofit corporations, and public bodies to construct, purchase, or rehabilitate rental housing in rural areas for low- and moderate-income families, elderly persons, and persons with disabilities; loans and grants also fund the development of housing for domestic farm laborers (Housing Assistance Council, 2007; National Rural Housing Coalition, 2004).

Additionally, unrealistically low fair market rents in rural communities do not create an incentive for housing development in rural areas. While there is a lack of affordable rental housing throughout the country (measured by the percentage of people paying over 30 percent of their income for housing) (Saulny, 2006), fair market rents continue to remain low in most rural communities. "Fair market rents (FMRs) serve as the payment standard used to calculate gross rent estimates (i.e., rent plus utilities) under the Rental Voucher program for 354 metropolitan areas and 2,350 non-metropolitan county FMR areas" (HUD Office of Policy Development and Research, 1995). As HUD is quick to point out, setting these standards means balancing between creating rent payments high enough to stimulate housing availability but low enough to serve as many persons as possible (U.S. Department of Housing & Urban Development, Office of Policy Development & Research, 1995).

In calculating FMRs, HUD works closely with the U.S. Bureau of the Census and takes into account both decennial census rent data and the Bureau's *American Housing Surveys.* This information is then supplemented with random telephone surveys. This process proves to be successful for most metropolitan communities in determining a base rent from what is being paid in the community. However, the process is less successful in rural communities because of the small populations and small stock of rental units in these communities. The *American Housing Surveys* are conducted only in the 44 largest U.S. metropolitan communities, and most rural communities do not have enough rental units available to make a reliable random telephone survey feasible. In order to address the issue of unreliable FMRs in rural communities, HUD has implemented minimum FMRs using the statewide average FMR of non-metropolitan counties. However, since these non-metropolitan county estimates are all considered to be low, the minimum FMRs actually affect very few communities and do not create high enough minimum rents to spur rental housing development in the country's poorest rural communities.

Meanwhile, minimum operational costs required to manage rental housing do not vary by community size or wealth. While rural developers are remarkably creative in developing housing, the average one-bedroom operating cost in rental housing development in communities less than 20,000 was between $3,749 and $4,064, similar to the average urban annual operating expense of $3,800 figured by the Federal Home Loan Bank. Therefore, the minimum break-even monthly FMR for most low-income rental housing in rural areas was about $333 per unit, not much different from the corresponding break-even monthly FMR for urban areas. Yet, the monthly one-bedroom FMR for high growth, urban communities, including Washington D.C. at $1,134, New York City at $1,069, Los Angeles at $1,016, and San Francisco at $1,239, was much higher than the FMR in rural areas. The minimum FMR for the poorest rural communities was as low as $335 per month (U.S. Department of Housing & Urban Development, Office of Policy Development & Research, 1995).

Causes of Rural Homelessness

Homelessness among adults and families is not evenly distributed across rural areas (Aron, 2004; Post, 2002), but rather is concentrated in communities that have histories of persistent poverty; are primarily agricultural or have economies based on declining mining, forestry, or fishing industries; have reduced employment opportunities due to changing economies (e.g., due to the replacement of family farms with mechanized or corporate farms); or are economic growth areas that attract both more job seekers than can be absorbed and relatively high-income residents whose presence increases housing costs and other living expenses. In his report for the Institute of Medicine on rural homelessness, Patton (1988) wrote that like urban homelessness in the United States, rural homelessness is fundamentally due to the interaction of structural and personal factors. However, some of the structural factors for current rural homelessness have different historic roots than those for urban homelessness, stemming from the rural economic restructuring of the early 1980s that included twin recessions, massive farm foreclosures, and loss of labor-intensive rural manufacturing to foreign competition. The impact of the rural economic crisis was uneven and had the most devastating impact on counties that lacked economic diversification (i.e., in which local economy was dominated by a single industry) and on counties where rural poverty has historically been entrenched, such as the southeastern states. Patton (1988) wrote that of 231 counties that ranked in the bottom fifth for income over the previous 30 years, all but 18 were in the southeastern United States. He emphasized the concept of "relative burden," by which he meant that relatively low numbers of homeless persons can easily overwhelm a rural community's resources.

Today, structural factors that continue to contribute to rural homelessness include inadequate housing quality, declines in homeownership, rising rent burdens, and insecure tenancy resulting from changes in local real estate markets. Related factors include lack of infrastructure to support employment, such as child care and public transportation, and long distances between low-cost housing and employment opportunities. Inadequate treatment opportunities for disabling medical and behavioral health problems, including serious mental health and substance use problems, also contribute to vulnerability to homelessness in rural areas (Center for Family and Community Life, 2005; National Coalition for the Homeless, 2006b). On occasion, natural disasters (such as Hurricane Katrina) contribute to homelessness in rural areas through displacement of formerly housed persons. In addition, local and statewide studies report domestic violence as a major contributor to homelessness of women (Intergovernmental Human Services Bureau, 2003; Kentucky Housing Corporation, 1994; Montana Council on Homelessness, 2007), and unaccompanied youth (Wilder Research Center, 1998).

Characteristics of Rural Homelessness

Status of Research on Rural Homelessness

Relatively little research has focused specifically on rural homelessness, with extant studies based mainly upon descriptive surveys of clients (demographic and social characteristics) or service providers. Interviews of service providers or clients typically used convenience samples, and anecdotal comments or informal observations were often reported as though they had the weight of more controlled empirical findings. Much of the research is dated, with the first statewide studies of rural homelessness conducted in the mid-1980s. The Ohio Mental Health Study (Roth et al., 1985; Roth & Bean, 1986) was an ambitious project that initiated survey data collection in 1983. Researchers conducted a representative survey with 790 urban and 189 non-urban homeless people statewide: the urban sample comprised 81 percent of the

respondents while the non-urban sample included respondents from both the mixed/urban (10 percent) and rural (9 percent) counties. Homelessness was defined broadly to include literally homeless adults (i.e., staying "on the streets" or in shelters) as well as residents of cheap hotels and motels and persons who were doubled up. In 1985, the Vermont Department of Social Welfare conducted a survey of district directors of state social welfare offices and other key informants to determine the number of homeless people in their areas, the dynamics of the problem, and service issues (Housing Assistance Council, 1991; Vermont Department of Social Welfare, 1985). A total of 2,800 persons were estimated to need shelter during 1984. In 1987, the California State Department of Mental Health conducted an enumeration and representative survey of homeless adults in three California counties, including one rural (Yolo) and two urban counties (Alameda and Orange) (Vernez et al., 1988). Using a more restrictive definition of homelessness, homeless adults were recruited from dedicated service sites (e.g., shelters or meal programs) and from "the streets" in an attempt to collect a more representative sample than from service sites alone.

Recent studies have expanded the scope and improved methods of studying homelessness in rural areas, going beyond mere population descriptions toward identifying ways to serve the rural homeless population and to intervene with at-risk populations in rural areas (Aron, 2004). For example, in 2006, a sample of 3,582 adults was interviewed in a one-night statewide survey of homeless adults and unaccompanied youth in Minnesota using a broad definition of homelessness. Selection criteria for the study included adults and youth in shelters (emergency shelters, domestic violence shelters, and transitional housing); non-sheltered adults and youth sampled from meal programs, drop-in centers, bridges, encampments, and other sites in more than 80 cities, towns, and surrounding areas; and other non-sheltered adults and youth who had stayed one night or longer in a shelter or been literally homeless (i.e., on the streets, in a car, in an abandoned building, or some other place not meant for habitation) any time within the previous seven days. This definition was broader than most by sampling from street sites and domestic violence shelters and by including anyone who had been "literally homeless" in the previous seven days. About one-third of homeless adults (30 percent) in the statewide Minnesota sample were sampled in non-metropolitan areas (i.e., outside of the seven-county metropolitan area that includes Minneapolis and St. Paul "Twin Cities") (Wilder Research Center, 2007a, b), and about half of homeless youth (ages 17 or younger) were sampled from non-metropolitan areas (Wilder Research Center, 1998). While this study collected a convenience sample that does not likely reflect the true distribution of homeless adults and youth throughout the state, it documented a large proportion of homeless adults in the non-metropolitan areas (Wilder Research Center, 2007a).

During February and March of 1993, Kentucky conducted a statewide survey of 2,484 adults in both rural and urban service facilities that met the HUD definition of homeless (Kentucky Housing Corporation, 1994). In 2006, a one-night statewide survey of 2,311 homeless persons in Montana was collected (Montana Council on Homelessness, 2007). A broad definition of homelessness was used that included people living doubled up with friends or family or in transitional housing facilities (including domestic violence shelters), foster care, jail, prison, or prerelease settings. Due to the dispersal of the state's population, the entire state was treated as rural for the purposes of this report and includes homeless persons from many frontier areas.

The most significant report among the recent literature is the *National Survey of Homeless Assistance Providers and Clients* (NSHAPC) (Burt et al., 1999), with results stratified by central city, urban and suburban fringe, and rural areas (See Exhibit 1.) This descriptive study was based on samples of individuals drawn from 16 types of homeless service sites, although authors note that because shelters,

Exhibit 1
Rural Homeless Clients in the U.S. in 1996 Compared with Central City and Suburban/Urban Clients (Based on National Survey of Homeless Assistance Providers and Clients [Burt et al., 1999])

Characteristic	Rural Clients	Rural Homeless Clients Compared with Homeless Clients in Central City and Suburban/Urban Areas
Gender	77% male, 23% female	Rural homeless clients included fewer women, compared to 29% in central cities and 45% in suburban/urban clients
Age (range 17+)	78% age 35 years or older	Rural homeless clients were somewhat older
Ethnicity[a,b]	41% white (non-Hispanic), 41% American Indian, 9% African American, 7% Hispanic	Rural homeless sample had fewer African Americans and Hispanics
Education	64% high school dropouts	Rural homeless clients had double the rate of high school dropouts versus urban homeless clients
Family status	Single-parent families: 17% of rural homeless sample were male or female parents with 1+ minor child	Rural homeless adults were similar to central city (16%) and suburban/urban (14%) homeless adults Most rural homeless women (74%) had one or more children with them Few homeless men had a child with them, whether rural (1%), central city (2%), or suburban/urban (7%)
	Single-mother families:16% of rural homeless sample were women with 1+ minor child	Rural homeless clients were similar to central city (12%) and suburban/urban(12%) homeless clients
	Single women:7% of the rural homeless sample were single women	Rural homeless clients included fewer single women than central city (12%) and suburban/urban samples (31%)
Homelessness	62% first episode, 44% for 6 months or less	Most rural homeless clients were experiencing their first episode of homelessness with most of these homeless less than 6 months; rates of "first homelessness" among rural homeless clients were very high compared to first homeless spells among central city (16%) and suburban/urban homeless clients (15%)
Habitation	On previous night, 49% in shelters or voucher hotels, 45% temporary private housing, 4% on street	Rural homeless clients less likely to be in shelter or on streets; more likely to be in county of birth
Employment	65% worked for pay past 30 days	More rural homeless clients working although underemployed and working in informal, part-time, short-term, or seasonal work without benefits
Income[c]	$475 median income past 30 days, 36% received income from parents/friends, 6% no income	Rural homeless clients had higher median income than more urban clients and less income from government programs; were more likely to receive cash support from parents or friends
Government entitlement	35% received support in past 30 days from AFDC, GA, SSI, food stamps, housing assistance	Rural homeless clients had less income from means-tested government programs
Childhood Victimization	12% reported physical or sexual abuse before age 18	Rural homeless clients much less likely to report abuse
Incarceration	67% were incarcerated at least one night in past 30 days	Rural homeless clients report higher rates of incarceration as minors and adults

[a] Generally, in rigorous studies of homeless adults in urban areas, racial and ethnic rates tend to represent the local areas, usually with an overrepresentation of non-Hispanic African Americans and American Indians in the sample. This pattern of racial/ethnic composition may or may not generalize to rural areas.

[b] Authors (Burt et al., 1999) caution (see footnote 10) interpretation of this finding since it represents only three American Indian clients at the same emergency shelter (1.3% of the actual unweighted rural client sample), but constitutes 34.4% of the sample after the data were weighted to account for the sample design.

[c] Post (2002), in her analysis of the NSHAPC data, noted that rural clients were more likely to report income assistance from friends and less from government assistance, except for VA benefits. Also, average reported income reported may over-represent actual average incomes of rural homeless people who may live in remote rural or frontier areas and far from homeless-specific assistance programs/services

meal programs, and dedicated homeless services sites are much scarcer in rural areas, homeless adults in rural areas may be underrepresented in their sample. Despite these limitations, the NSHAPC is the most authoritative and most often cited study of rural homeless persons. Not surprisingly, given the variation in their methodologies, locations, and goals, contradictions among findings of extant studies appear. Nevertheless, a profile of rural homeless persons in the United States can be constructed from a review of the existing literature.

Sociodemographic Characteristics

In most state and local studies, the majority of rural homeless adults are single males (Aron, 2004; Center for Family and Community Life, 2005; Montana Council on Homelessness, 2007; Patton, 1988; Vernez et al., 1988). More than three-quarters of the national NSHAPC rural sample were men (77 percent) (Burt et al., 1999). Similarly, males constituted a higher majority of rural homeless adults in California than of urban homeless adults (Vernez et al., 1988). Non-urban homeless adults in the Ohio study were also mostly male, although the non-urban counties had twice as many women as men (Roth et al., 1985; Roth & Bean, 1986). In Montana, virtually equivalent numbers of males and females were surveyed. In contrast, in the statewide survey in Kentucky the majority of rural homeless adults were women (62 percent) whereas urban homeless adults were mostly male (68 percent) (Kentucky Housing Corporation, 1994). In a follow-up to an earlier survey of key informants, which reported a preponderance of homeless men (Vermont Department of Social Welfare, 1985), the number of homeless women in Vermont was estimated to be increasing (Vermont Department of Social Welfare, 1987).

Most studies report that the majority of rural homeless adults are non-Hispanic whites (Aron, 2004; Center for Family and Community Life, 2005; Montana Council on Homelessness, 2007; Patton, 1988; Vernez et al., 1988). For example, homeless adults in the non-urban counties in Ohio were mostly white (Roth et al., 1985; Roth & Bean, 1986) as were homeless adults in rural California (Vernez et al., 1988). On a national level, NSHAPC (Burt et al., 1999) reported that persons without housing in rural areas compared to those in urban areas were more likely to be white. Among homeless youth in non-metropolitan Minnesota, however, racial and ethnic minorities were vastly overrepresented, with 53 percent being African American, American Indian, Hispanic, Asian, or mixed race compared to 18 percent of all Minnesota youth. However, racial and ethnic minorities were even higher among metropolitan homeless youth (80 percent) (Wilder Research Center, 2007a, b). Similarly, in Montana, American Indians were disproportionately represented among homeless persons surveyed, especially among women. American Indians represented 20 percent of all persons identified as homeless, which was 3.2 times higher than reported in the 2000 Montana Census of the general population. Two-thirds of all homeless women were American Indian, while less than 40 percent of homeless men were American Indians. Other minority groups were also overrepresented, constituting 4 percent of persons identified in the 2006 survey compared to 2 percent of the general Montana population (Montana Council on Homelessness, 2007).

Most reports indicate that people who are homeless in rural areas are somewhat younger than those in urban areas. For example, in Ohio, persons sampled in the non-urban counties were slightly younger (ages ranged from 16 to 83) (Roth et al., 1985; Roth & Bean, 1986) than in the urban areas. The estimated average age of homeless people in the Vermont statewide survey was in the early 30s; persons under 18 years of age were estimated to comprise 15 percent of the total, and 8 percent were over 60 (Vermont Department of Social Welfare, 1987). In California, rural homeless adults were more likely to be under age 35 than were those surveyed in urban counties (Vernez et al., 1988). However, in the NSHAPC, rural

homeless people were older than homeless adults in urban and suburban areas, with most between the ages of 35 to 44 (Burt et al., 1999).

Nationally, single adults represent the largest portion of the homeless population, and single women with children comprise the great majority of homeless families (Burt et al., 1999). The composition of rural homeless populations is similar: in the NSHAPC national survey, most *rural* respondents were single adults (84 percent), consisting of 77 percent single men and 7 percent single women (Burt et al., 1999). In rural Vermont, the homeless population was estimated to include 80 percent single adults, the majority of whom were male (70 percent), but with an increasing number of families (Vermont Department of Social Welfare, 1985; 1987). In contrast, in the statewide survey of 2,311 homeless persons in Montana (Montana Council on Homelessness, 2007), all of whom were considered to be rural for the purposes of this report, virtually equal numbers of males and females were identified, with 36 percent of the sample being families with children. Twenty-three percent of the NSHAPC rural sample were women, and most of these (74 percent, or 17 percent of sample) had one or more children with them (Burt et al., 1999). Among non-metro homeless adults in Minnesota, 26 percent were single women with children, 7 percent were couples with children, and 1 percent was single men with children; among metro homeless adults, 23 percent were single women with children, 3 percent were couples with children, and 1 percent was single men with children (Wilder Research Center, 2007a, b). In contrast, in California, none of the homeless adults sampled in non-urban counties had children with them (Vernez et al., 1988). Homeless people surveyed in Ohio non-urban counties were more likely to be married or living with a partner than in urban areas (Roth et al., 1985; Roth & Bean, 1986).

There is some evidence that rural homeless adults are less educated than their urban counterparts. For example, NSHAPC (Burt et al., 1999) reported that persons without housing in rural areas compared to those in urban areas were less likely to have completed high school. However, no differences by educational attainment between rural and urban samples were found in the Ohio study (Roth et al., 1985; Roth & Bean, 1986). In Montana, two-thirds of the rural sample had completed high school or better (66 percent) (Montana Council on Homelessness, 2007).

Studies indicate that rural homeless adults tend to have higher employment rates than their urban peers, but more of them are underemployed. For example, the NSHAPC rural sample was more likely to be working (65 percent)—although often underemployed and in the informal labor market—and less likely to be receiving any means-tested government benefits compared with the urban sample (Burt et al., 1999). Similarly, in the Ohio study, the non-urban sample had more resources and were more likely to be currently employed (35 percent vs. 22 percent urban), but they were less likely to receive welfare benefits or to use meal programs or shelters than the urban sample (Roth et al., 1985; Roth & Bean, 1986). In Montana, 28 percent of homeless adults with a high school education or less were working full- or part-time (Montana Council on Homelessness, 2007).

The experience and trajectory of homelessness among rural settings and rural subgroups is not well documented. For example, non-urban and urban adults in Ohio were equally likely to have been homeless less than one year (median 60-days homeless overall). In Montana, families with children tended to be homeless for shorter periods of time than others in the sample (i.e., 63 percent had been homeless less than 6 months compared to 52 percent of others) (Montana Council on Homelessness, 2007). Only about 5 percent of the sample had been chronically homeless (i.e., for 12 months or longer), and more than half of these had been homeless for more than two years. In the Minnesota study, non-metro homeless adults

were less likely to have histories of chronic homelessness (47 percent non-metro vs. 57 percent metro) (Wilder Research Center, 2007a, b).

In Ohio, non-urban respondents were only one-third as likely to have spent the previous night in a shelter as the urban sample; no one in the purely rural counties had stayed in a shelter. By contrast, the non-urban sample was more likely to have stayed with friends or family than the urban sample (Roth et al., 1985; Roth & Bean, 1986). Rural adults in California were more likely than urban adults to have been recruited from the streets than from a shelter (Vernez et al., 1988). In Montana, respondents spent the previous night with family or friends (22 percent), outside (20 percent), in an emergency shelter (18 percent), or in transitional housing such as domestic violence shelters (16 percent) (Montana Council on Homelessness, 2007). One fourth of families with children reported staying in transitional housing facilities. Chronically homeless persons most commonly spent the night outside, in emergency shelters, or in a motel.

In the NSHAPC study, non-urban adults were more likely to have ever been incarcerated than those in urban settings (Burt et al., 1999). In contrast, non-urban adults in Ohio included slightly fewer veterans and ex-offenders (Roth et al., 1985; Roth & Bean, 1986). The Montana study reported that most women in prison in Montana have committed drug-related offenses, usually involving methamphetamine, that range from possession or manufacturing of drugs to committing crimes to get money for drugs (Montana Council on Homelessness, 2007).

Physical Health Problems of Homeless Persons in Rural Areas

People who are homeless in rural areas have greater health problems but less access to health care (Center for Family and Community Life, 2005; National Coalition for the Homeless, 2006). For example, in Ohio, higher rates of health problems were found in the purely rural counties (41 percent versus 20 percent in mixed counties and 41 versus 31 percent in urban counties) (Roth et al., 1985; Roth & Bean, 1986). In Montana, diagnoses of hypertension (11 percent), asthma (11 percent) and hepatitis C (9 percent) were the most commonly reported diseases (Montana Council on Homelessness, 2007). In a series of qualitative interviews on the health of rural homeless persons, Post (2002) asked clinicians nationally to identify the medical conditions that seem to distinguish rural from other homeless clients and to identify obstacles that prevent clients from getting the health care and social support they need. Clinicians described the morbidity from chronic medical conditions such as hypertension or diabetes as being greater than in urban settings because rural clients remain untreated longer than their urban counterparts. Infectious diseases (including hepatitis C, which is associated with injection drug use) were reported to be a growing problem among rural homeless clients, as were sequelae of alcohol and drug problems. Tuberculosis was reported to be more prevalent among recent immigrants from Latin America and Southeast Asia who often work in rural areas. HIV is often diagnosed later in rural areas than in urban areas, after the illness has reached more advanced stages, making treatment more difficult. Traumatic injuries and musculoskeletal disabilities secondary to trauma or injuries from manual labor were also reported (Post, 2002). Several studies identified specific health problems such as HIV/AIDS as causes of homelessness in their samples (Montana Council on Homelessness, 2007; Post, 2002; Wilder Research Center, 2007a, b).

Behavioral Health Problems of Rural Homeless Persons

Sufficient standardized epidemiological studies have not yet been conducted to clarify the incidence, types, patterns, severity, and trajectories of mental health and substance use problems among rural

homeless persons. Nevertheless, growing evidence supports the prevalence of behavioral health problems among this population. In the national NSHAPC study, the great majority of homeless adults from all areas (rural, central city, and urban/suburban) reported at least one behavioral health problem (i.e., alcohol, drug, or mental health) in the previous 30 days (64–67 percent), during the past year (72–72 percent), and in their lifetimes (82 percent–87 percent) (Burt et al., 1999). However, significant differences in prevalence of specific disorders were found between rural and urban homeless samples. Rural homeless adults had more current problems with alcohol; however, they had fewer current problems with mental illness or drug use compared to more urban homeless clients (Burt et al., 1999). For example, compared to central city and suburban homeless adults, rural homeless adults consistently reported dramatically higher rates of alcohol use—50 percent of the rural homeless adults reported alcohol problems in the previous 30 days, and 66 percent reported alcohol use problems in their lifetimes. Rural homeless adults also reported generally high rates of mental health, drug use, or comorbid psychiatric and substance use problems; however, the rural rates were dramatically lower than rates reported by the more urban homeless adults.

In the California survey, homeless adults were screened for probable lifetime major mental disorders and lifetime substance use disorders with an instrument derived from the Diagnostic Interview Schedule (DIS-III) (Robins et al., 1981). Because the study used a short screener that identified people who have a high probability of having a lifetime disorder rather than the entire diagnostic interview, the rates of disorder are likely overestimated (Vernez et al., 1988). Nevertheless, homeless persons in the rural county screened higher for severe mental illness (SMI) (especially major affective disorder), substance use disorder (especially for alcohol), and for dual disorders (mental and substance use disorders). The rural county sample (Yolo County) screened positive for severe mental disorders, including high rates of major affective disorders (e.g., major recurring depression and bipolar disorders) and schizophrenia. The rural county had a higher rate of severe mental illness compared to the two more urban counties (Alameda and Orange Counties) (Vernez et al., 1988). Virtually all subjects who screened positive for severe mental disorder also screened positive for either alcohol or drug disorders or both, for a dual diagnosis rate of 37 percent of the total sample (Vernez et al., 1988).

In Montana, self-reported diagnosed conditions included mental illness (18 percent) and alcohol or drug abuse (15 percent) (Montana Council on Homelessness, 2007). About one-quarter of the total sample (26 percent) reported that chronic drug or alcohol abuse was a cause of their homelessness. Among these, 60 percent were male and 40 percent were female. About 17 percent of families with children identified drug or alcohol abuse as a cause of their homelessness.

Because proxy measures for mental health problems (such as psychiatric hospitalization) are often used in studies, the identification of specific mental health problems and their severity is impossible (Patton, 1988; Robertson & Greenblatt, 1992). For instance, in the Ohio study, non-urban and urban samples were about equally likely to have histories of psychiatric hospitalization, and they had similar rates of psychiatric symptoms and similar levels of perceived mental health status and life satisfaction (Roth et al., 1985). Vermont informants estimated that 30 percent of rural homeless adults were “deinstitutionalized”, that is, “people who in years past would have been sent to a state hospital,” before changes to the mental health commitment law (Agency Planning Division, 1986). In the Post (2002) study, clinicians serving rural homeless persons reported seeing a number of clients who were disabled with serious mental illnesses (e.g., schizophrenia and affective disorders such as depression or bipolar disorder) and other serious conditions (including personality disorders and posttraumatic stress disorder secondary to childhood abuse, domestic violence, or war-related injuries).

In the general U.S. adult population, substance use and abuse are less common in non-metropolitan areas compared to metropolitan areas, and within non-metropolitan areas, substance use is lowest in the most rural areas (Strong et al., 2005). The prevalence and distribution of substance use problems (alcohol or illicit drugs) reportedly varies by region and population (Post, 2002). In the California survey, the rural county had higher rates of any substance use disorders (alcohol or drugs) compared with the more urban counties. Specific findings on alcohol use and related problems among rural homeless adults are mixed. Some researchers have reported higher rates of alcohol problems among homeless persons in rural areas (Burt, 1996; New Freedom Commission on Mental Health, 2004; Office of Rural Mental Health Research, 2003; Vernez et al., 1988), while others report lower alcohol problems in rural areas (The Conservation Company, 1989, cited in Housing Assistance Council, 1991). In the NSHAPC national sample, rural clients had more current problems with alcohol compared to more urban clients (Burt et al., 1999). In the Ohio survey, few non-urban respondents identified alcoholism as a problem, although most had used alcohol in the previous 30 days and 20 percent had sought help for alcohol problems in their lifetimes (Roth et al., 1985; Roth & Bean, 1986).

Service providers report serious levels and severity of drug use across many rural areas (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006), yet empirical quantitative studies are limited so there is minimal assessment of the extent and specific nature of the drug problem among rural populations. For example, in her extensive interviews with health care providers, Post (2002) cites repeated anecdotes about extensive drug involvement of rural homeless persons, with the specific drugs used varying by geographic area. For example, prescription drugs such as OxyContin (also known as “synthetic heroin”) has become so widely used in places like Appalachia and rural Maine as to be called “hillbilly heroin” (National Institute on Drug Abuse & Community Epidemiology Work Group, 2001). Other more traditional street drugs, such as cocaine, heroin, or methamphetamine, are reportedly used in diverse rural areas. Anecdotal reports indicate that methamphetamine use in particular is increasing in rural areas (Strong, et al., 2005; Wilder Research Center, 2007a). Reportedly, methamphetamine use began in California and spread eastward as users started manufacturing the drug in home labs in rural areas in the South, Midwest, and other areas (Alligood, 2001, cited in Post, 2002). Empirical evidence of rural/urban differences in drug use is mixed. In the California study, the rural county had a high rate of drug abuse or dependence, which was similar to one urban county but lower than another urban county (Vernez, 1988). In the NSHAPC national sample, rural clients had fewer current problems with drug use compared to more urban clients (Burt et al., 1999). In the Ohio study, non-urban and urban counties reported similar rates of illicit drug use or problems with drugs (16 percent versus 15 percent urban) (Roth et al., 1985; Roth & Bean, 1986).

Access to Health and Behavioral Health Services

Although substantial rates of mental health and substance use problems have been documented among rural homeless persons, efficacy of treatment interventions for these problems in diverse rural populations has not been demonstrated. Many structural, sociocultural, and personal barriers reduce access to rural services generally and to health services in particular (Strong et al., 2005). Although some of these barriers exist in urban settings as well, their impact may be disproportionately greater in resource-poor rural areas, and their impact on homeless and other indigent rural populations is likely to be more severe. Primary structural barriers in rural areas include geographic dispersion and low population densities that increase the cost of services per capita compared to urban areas. Other structural barriers include scarce services, especially for mental health and behavioral health care; inappropriate service models (e.g., urban-based models not adapted to the needs of people living in particular rural areas); lack of outreach to

engage rural homeless persons in services; inaccessible health and other services (especially in small rural communities and frontier areas since service programs tend to concentrate in larger rural communities); fragmented systems of health care; lack of cultural competence on the part of program staff; lack of accessible transportation, with greatest impact on families with children and on disabled or older persons; insufficient numbers of health care professionals, particularly specialists; and lack of acceptance by program staff (Patton, 1988; Post, 2002; Strong et al., 2005).

In rural areas, primary care physicians are the main health care providers for persons with diverse health and behavioral health care problems, including comorbid medical, mental health, and substance use problems. These physicians may lack adequate training or experience to treat complex health problems in such a diverse patient population; further, healthcare settings may be understaffed. In many rural settings, recruitment of physicians may be limited to persons providing time-limited services as conditions of training programs, which may present cultural barriers and lack of continuity due to turnover of professional staff.

Sociocultural factors can reduce or delay help-seeking by rural families and individuals, especially for sensitive health and behavioral problems. Many rural communities are characterized by close social ties, reluctance to seek outside assistance, a desire for privacy (especially regarding sensitive problems such as domestic violence or alcohol, drug, or mental health problems), and a tradition of voluntary social support from the community (rather than from fee-based formal agencies) (Strong et al., 2005). Such structural, sociocultural, and personal barriers may result in less use of needed care due to delayed help-seeking. Such delays can lead to more severe symptoms and chronic health problems before the homeless person finally receives care (Post, 2002), which may then entail more intrusive or expensive treatment.

Major personal barriers to care have been reported by health care providers and others, including lack of financial resources and medical insurance; medical disabilities or behavioral health problems that reduce functional status or ability to navigate the available health care system; shame, hostility, or lack of trust, especially for mental health services; a tradition of dependence on self or family and friends; and cultural differences from service providers that may further limit the amount and quality of care available for medical and behavioral health problems (Patton, 1988; Post, 2002; Strong et al., 2005). For example, NSHAPC findings showed that homeless clients in rural areas nationally were less likely to have health insurance (including Medicaid) compared to clients in more urban areas. Furthermore, they were twice as likely as urban homeless clients to have missed getting medical care that they needed in the previous year (Burt et al., 1999). Many in the rural sample reported poor health and having histories of inpatient psychiatric treatment as well as residential treatment for substance use (Vernez et al., 1988). Despite higher apparent need for treatment, however, the rate of any mental health treatment was much lower in the rural county than in the more urban counties, including lifetime psychiatric hospitalization (in Yolo County, 14 percent among people with serious mental illnesses and 0 percent among others). Furthermore, none of the rural county homeless population with SMI had been hospitalized in the previous 12 months and few had received outpatient treatment (6 percent of SMI) or psychiatric medications (9 percent of SMI) in the previous 6 months (Vernez et al., 1988). In contrast, in the Ohio study, there were only minimal differences by county type in health status and utilization of emergency treatment and other health services, and of mental health problems (Roth et al., 1985; Roth & Bean, 1986). However, the urban adults were more likely to have been discharged with no arrangements for follow-up care (37 percent) compared to the non-urban group (24 percent) (Roth et al., 1985).

Reasons for Homelessness

While systemic factors, including lack of infrastructure (e.g., child care and public transportation) to support employment; long distances between low-cost housing and employment opportunities; and inadequate treatment opportunities for disabling medical and behavioral health problems, including serious mental health and substance use problems, are frequently cited as causes of rural homelessness (Center for Family and Community Life, 2005; National Coalition for the Homeless, 2006b), research studies report personal reasons as contributing to individuals' homelessness. For example, in the Vermont survey, key informants reported that homelessness was related to poverty, reduced housing options, and mental health and substance abuse problems. This contrasts with results of a follow-up study conducted in 1987, (Vermont Department of Social Welfare, 1987), which related homelessness to "federal cuts in housing, welfare, and services; high housing costs; low-paying jobs for unskilled workers; deinstitutionalization; and the increase in single-parent households." In addition, studies report domestic violence as a major contributor to homelessness of women (Kentucky Housing Corporation, 1994; Intergovernmental Human Services Bureau, 2003) and unaccompanied youth (Wilder Research Center, 1998). For example, in Ohio, although about half of both groups reported economic reasons for not having a home, the non-urban group reported more family-related reasons, with non-urban women less likely to have used domestic violence shelters (Roth et al., 1985; Roth & Bean, 1986). In addition, on occasion natural disasters (such as Hurricane Katrina) contribute to homelessness in rural areas through displacement of formerly housed persons.

Effective Service Models for Rural Homelessness

The research literature addressing rural homeless service models is very limited. Little research has evaluated rural programs, compared them to urban programs, or evaluated homeless service strategies unique to rural areas. Moreover, the available program evaluation and research tends to focus narrowly on one type of program, one particular program, or one location. Although valuable information concerning promising practices can be gleaned from providers and advocates, these service models have not been subjected to rigorous testing and have not been widely disseminated. An examination of state, regional, and city plans to end homelessness, completed in late 2006, indicates that only 1 percent of the 90 plans examined focuses on strategies to end homelessness in rural areas (National Alliance to End Homelessness, 2006). However, some states updated their plans since the NAEH study with the result that specific goals and strategies related to rural homelessness are beginning to emerge. The Montana plan, for example, calls for partnerships with tribes to learn more about homelessness in rural or reservation settings. South Dakota plans include capacity expansion in rural areas, including reservations, with a goal of developing housing and service models for rural areas. In response to a biannual study of homelessness in 2005, Iowa has revised its plan to end homelessness to include strategies for providing equitable access to health services to rural residents (Ditsler et al., 2007; Montana Council on Homelessness, 2007). In addition, 17 rural and Appalachian counties in southeastern Ohio have joined together to develop and implement plans to end homelessness. In 2007, the project, Rural Homeless Initiatives in Southeast and Central Ohio, will produce the first regional, county-driven plan to end homelessness in a rural area.

Two studies currently testing service models for homeless populations in both urban and rural areas include extensive evaluations. The Supportive Housing and Managed Care Pilot in Minnesota is a permanent supportive housing project operating since 2001 in Ramsey County (an urban county including

St. Paul and its suburbs) and Blue Earth County (a rural county including Mankato and the surrounding area). Blue Earth County has a population of approximately 58,000 residing in an area of 764 square miles, including the small town of Mankato (population 32,427). Early findings show that the families and single adults in Blue Earth County tend to enter the pilot with a higher level of functioning than their urban counterparts but have the same trajectory of progress (Jennifer Ho, personal communication, 2007). Trusting relationships with staff appear to hold promise for the development of long-term stability in the community (National Center on Family Homelessness, 2006). Stakeholder interviews indicate that individuals and families with long histories of homelessness, mental illness, substance use disorders, and HIV/AIDS are achieving housing stability. A cost study and an adult outcome study are scheduled for release in 2007.

The Sound Families Initiative, established by the Bill and Melinda Gates Foundation, has as its goal to create 1,500 service-enriched transitional housing units for homeless families in three counties in Washington, two urban (King County–Seattle and Pierce County–Tacoma) and one rural (Snohomish County), and to serve as a catalyst for a new level of cooperation on homelessness-related issues within the three counties. The mixed-method evaluation examines the impact of Sound Families on the families served, on transitional housing programs, as well as on the challenges the programs and their clients continue to face. The evaluation has nearly 200 families enrolled in a longitudinal interview process at 10 case study sites. Although the first reports do not compare the families living in the rural county with those in the two urban counties, families reported improvement in their overall quality of life, with 88 percent securing permanent housing at exit and 74 percent increasing their household income. In addition, the number of families with children who attended only one school during a school year increased from 49 percent at intake to 80 percent at exit and 86 percent one year after exit. Attendance improved for the children in stable housing, and parents reported their children were doing better in their schoolwork (Bodonyi et al., 2005).

Service Strategies

In 1999, Goodfellow began looking at the differences in rural and urban homeless service providers (Goodfellow, 1999). She discovered that there may be more differences among homeless service delivery systems in rural and urban areas than among the persons experiencing homelessness in the two areas. Through interviews with clinicians, Post (2002) identified rural service models that vary in size and distance from urbanized areas. In larger areas, strategies include community partnerships that link formal and informal support systems, multi-service centers, and hub-and-spoke models of outreach to and referrals from outlying rural and urban communities. In smaller rural or frontier areas, where there are only minimal services for people who are homeless, clinicians have two strategies: mobile outreach units and, as a last resort, “Greyhound referrals” or “Greyhound therapy,” that is, transport to urban areas that have the needed services (Post, 2002).

Clinicians have recommended strategies to overcome barriers to health care and to prevent rural homelessness. These include:

- integrating behavioral health care with primary care services to reduce or eliminate the powerful social stigma associated with mental illness in rural areas;
- providing transportation assistance to address the scarcity of public transportation in rural areas;

- expanding health coverage and facilitating access to covered services;
- expanding health care entitlement programs to cover low-income persons who are homeless or at risk of homelessness;
- developing a service delivery infrastructure in rural communities responsive to needs of people who are homeless (including temporary shelter services and basic health and social services);
- coordinating rural service delivery systems to maintain continuity of care;
- increasing outreach to hidden homeless people in remote rural areas;
- using community networks and indigenous workers to facilitate mobile outreach;
- promoting cultural competence of service staff to address communication and other cultural barriers;
- conducting early interventions for youth, families with children, and single adults who are newly homeless or at risk for homelessness; and
- focusing on prevention of homelessness by addressing structural causes of poverty (Post, 2002).

Best and Promising Practices

The literature on best practice models for services for people who are homeless focuses primarily on urban models, providing no comparative findings on the use of the same models in rural communities or on homeless service program models developed specifically for rural areas. Two reports produced by the HAC address related best practices for rural areas. *Continua of Care Best Practices: Comprehensive Homeless Planning in Rural America*, provides case studies of four rural communities "that have successfully created and maintained rural systems and homeless shelter and service projects" (Housing Assistance Council, 2002). Data were collected from site visits, interviews, and examination of the 1999 continuum of care applications. Based on analyses of these data, researchers identified four common themes across these successful programs: leadership, inclusive process, planning, and support networks.

Best Practices in Revolving Loan Funds for Rural Affordable Housing (Housing Assistance Council, 2003a), "analyzes four case studies of rural revolving loan funds, identifies similarities and differences, and provides specific advice for those seeking to establish such funds." Researchers sought to ascertain "which 'best practices' are most salient in different rural contexts." The study recognized that what works best in one rural community may not be appropriate in another, thus calling for careful examination of the impact of the social and economic context of community lending practices.

Despite scant research, there is some evidence pointing to models emerging as promising practices. These include regionalized services, development of community collaboration and coalitions, rural service teams, the housing-plus-services model, and employment initiatives. For example, a HUD continuum of care initiated by 50 service providers in a 23-county rural region of western Tennessee in 2004 brings in $1 million annually for services that help support 600 units of housing built using a combination of HUD and private funding (Rozann Downing, personal communication, 2007).

One of the greatest assets in rural communities is the ability—or necessity—to collaborate in the provision of housing and services due to limited resources. In fact, "the need to provide services to clients with complex needs drives the organization to create interconnections to a set of other service providers" (Goodfellow, 1999). This decreases cost, increases community building, and reduces duplication in service delivery. While limited resources in rural communities mean that proportionately more resources and funding sources are needed to create programs than in urban communities, once this is accomplished, the rural programs are more stable due to diversity of funding and other resources (Housing Assistance Council, 2006). This necessity also resulted in rural communities being the first to make full use of mainstream resources to serve homeless people (Burt, 1996). The work of Hazard Perry County Community Ministries in Southeastern Kentucky, in the Appalachian foothills, exemplifies some of the unique strengths found in rural communities attempting to address the issue of homelessness. The success of this agency's program models is attributed to using lay workers who know the community and understand the people they are serving, being creative in interpreting the regulations of mainstream programs so that people in need can be served, and maintaining an "organizational culture that doesn't give up on people" (Gerry Roll and Jennifer Weeber, personal communication, 2006). Rural citizens are more likely to have lifelong relationships with their service providers and other members of the community, creating strong community bonds, trust in service providers, and the desire to help one another. (Burt, 1996). This makes it possible to address the needs of persons in need more quickly and increases the likelihood of long-term success (Housing Assistance Council, 2006).

Rural service teams from across various agencies and organizations support the families and single adults in the previously mentioned Supportive Housing and Managed Care Pilot in Blue Earth County, Minnesota. A challenge faced by rural teams is having fewer disciplines represented, because teams are smaller on smaller-scale projects. This also means that cost efficiencies are fewer. An advantage for rural teams, however, is less bureaucracy to get in the way of linking people to the community services and supports they need (Jennifer Ho, personal communication, 2007). The pilot model, which demonstrated success in both rural and urban areas, was expanded in summer 2006 into the seven counties of rural northeastern Minnesota, including three Indian reservations, as well as into some southern Minnesota counties and the metropolitan area of Minneapolis–St. Paul.

Both the Tennessee and Minnesota initiatives described here are permanent supported housing models. Support services, whether offered by providers located on site or off site, are a critical component of the response to homelessness in both rural and urban areas. The smaller population in rural areas usually means fewer units in a project, with projects farther apart than their urban counterparts. The Millennium Center in Cuthbert, Georgia, consisting of 20 freestanding residences for homeless and near-homeless families with alcohol and/or drug addiction issues, offers a full spectrum of supports. There is a child care center and a satellite of Albany Technical College on site as well as treatment services for the whole family. About 60 percent of the 80 families who have lived at the Center since it opened in 2003 have adult family members who have gotten sober, secured educational services and a job, and moved on to permanent housing. Cuthbert is in the heart of a seven-county area of very rural Georgia with a total population of 38,000.

Employment demonstration projects in rural areas of Illinois, Nebraska, and Tennessee offer findings and lessons learned similar to other efforts that target rural poverty. Lack of transportation makes it difficult for low-income participants to access jobs and other services. Jobs are scarce and low paying, often providing less than full-time work. Partnering among local organizations is critical to client success, as is having program staff members who are familiar with the rural communities they serve and who can work

independently. Outreach services are essential in covering rural areas with large territories (Burwick, Jethwani, & Meckstroth, 2004). Employment opportunities are available to participants in a unique transitional living program operated by Good Works, Inc., in the Appalachian area of southern Ohio. Most residents are offered work in two agency-owned businesses, a gift shop and a bed and breakfast. Residents are linked with volunteer live-in mentors who are available for personal support, modeling the development of healthy relationships, and helping residents develop and carry out plans for future stability (Wasserman, 2006).

Directions for New Research

Gaps in Current Research

The literature that constitutes this first generation of research on rural homelessness has broken difficult ground and laid a foundation for the next generation of studies. Nevertheless, limitations of this generation's empirical work include problems with design, sampling, and instrumentation. Serious limitations of many studies in the existing literature include sampling from limited service sites; using idiosyncratic definitions of homelessness; collecting minimal information on smaller or more isolated rural or frontier areas; failing to collect data on household composition, which affects demand on social service systems; and lacking standardized instrumentation that would facilitate comparisons across studies and with normative populations.

Many of these studies relied on convenience samples collected from clients of homeless services in rural areas. These samples lacked comprehensive coverage of the target population by failing to include homeless persons who do not use services or who live in smaller or more remote rural or frontier areas where services are not available. The lack of comparison groups makes it difficult to identify factors that differentiate the rural homeless population from the rural low-income housed population. Simplistic divisions of samples into dichotomous rural/urban or trichotomous rural/urban/suburban categories potentially leave undiscovered important differences among these groups. Moreover, researchers often combined data from rural and mixed areas into a single category, potentially masking important differences by location and proximity to urban areas. Broad conclusions about rural homeless populations cannot be made without representative data (Strong et al., 2005).

In most studies, instrumentation did not adopt standardized questions about health status. Even the important study by Burt and colleagues (1999) used non-standardized assessments to measure alcohol, drug, and mental health problems. The lack of a core of common questions makes comparisons across studies difficult. There was minimal assessment of drug use in studies reviewed, despite reports by providers that drug use is an increasingly urgent concern for rural communities. The lack of longitudinal designs leaves many questions unanswered about the patterns of homelessness experienced by these rural populations and their utilization of services over time.

The limited research available leaves many questions unanswered about the rural homeless population. As was true in initial studies of urban homeless populations, variations in research methodologies, particularly sampling and instrumentation, provided contradictory findings concerning important population characteristics. Given the current state of the research on rural homelessness, it is not possible to determine with certainty whether rural homelessness is distinct from urban homelessness in terms of sociodemographic or behavioral health profiles. For example, some findings have suggested that persons

who are homeless in rural areas are more likely to be families, employed, and better educated than their urban counterparts. Studies as well as providers indicate that persons who are homeless in rural areas are more likely to be found in some type of substandard housing rather than to be literally homeless as is seen in urban settings. Nevertheless, whether or not future research identifies distinguishing characteristics between rural and urban homeless populations, it is abundantly apparent that the differences between rural and urban services infrastructures alone mandate that further research on the needs of rural homeless populations be pursued.

Methodological Challenges for Research with Rural Homeless Populations

More studies are needed that include rural areas, rural systems, and rural populations. Future research on people who are homeless in rural areas can build on the seminal first generation of work. The most relevant and rigorous methodologies developed for study of urban homeless populations and service systems, such as representative sampling, longitudinal designs, standardized instrumentation, and mixed qualitative and quantitative methodologies, can be adapted to explore the rural population that is still hidden to researchers. Some specific methodological challenges are outlined below.

Lack of common definitions. Development of a definition of the rural/urban continuum that captures the diversity across population densities and geographic locations is necessary for comparing findings across studies. Since rural populations in the United States are not homogenous, study results are often determined by how "rural" and "homelessness" are defined (National Institute on Drug Abuse, 1997). Whatever definitions are used must be carefully operationalized for each study and described to permit replication and comparison of findings (New Freedom Commission on Mental Health Subcommittee on Rural Issues, 2004; Rural Information Center, 2006; Strong et al., 2005). In addition, rural/urban typologies used in recent research on rural homelessness have been too crude to capture many true differences between rural and urban communities and between various types of rural communities. Given the apparent variation in medical and behavioral health problems by size and locations of rural communities, it will be necessary to study the epidemiology of health, mental health, and substance use disorders as a function of population density and geographic placement on a continuum rather than studying only dichotomous urban/rural or trichotomous urban/rural/suburban comparisons (National Institute on Drug Abuse & Community Epidemiology Work Group., 2001; Patton, 1988).

Sampling strategies. The most representative sampling strategy is desirable but often not considered feasible. A sampling strategy based on service sites must use a broad range of services across the range of rural areas (and not rely only on dedicated homeless services since they are frequently absent in smaller rural or frontier areas). Such sites might include, for example, welfare and other social service agencies, public and mental health departments, free clinics, employment centers, and other broad-based service programs (Aron, 2004). Many of the existing studies use such small numbers of rural subjects that characteristics of rural populations are masked by the usually larger urban sample. Also, variations in conditions between urban and rural populations or between varied types and sizes of rural communities are not possible to explore (e.g., differences in drugs used, psychiatric conditions experienced, or patterns of alcohol use) when insufficient rural sample sizes are used. Some aspects of research on rural communities may have limited generalizability, because rural communities exhibit unique regional character; for example, Appalachia and the western frontier have distinctive cultures that may affect homelessness through deeply held values such as importance of family structure, insularity, independence, and so forth. It is difficult to do cross-cutting research because of differences in the

character of a given rural area compared to other types of rural areas, and compared to non-rural areas. Conducting multisite studies may clarify aspects of homelessness in rural settings that are site-specific.

Standardized instrumentation for needs assessment and outcomes assessment. Epidemiological studies with standardized instrumentation are needed to clarify the prevalence and severity of medical, mental health, and substance use problems among rural homeless persons. Comparisons across studies for rural populations and comparisons with other groups will be facilitated by appropriate standardized instruments on health status, mental health and substance use disorders, and other domains (e.g., service outcomes and family violence). Also, use of common designations of demographic characteristics (e.g., racial or ethnic group using Census categories) will further facilitate comparisons across studies and with normative populations.

Data sources. A primary difficulty in conducting rural research is finding suitable data sources. It is rare that homelessness is measured in national, regional, or even local surveys and, rarer still, for data to be classified as rural and urban. However, related data sources on other aspects of rural research may indirectly illuminate rural homelessness. *Rural Research Needs and Data Sources for Selected Human Services Topics* (Strong et al., 2005) provides a thorough examination of data sources available for three human service focal topics. The detailed descriptions of these data sources include an assessment of their strengths and weaknesses for rural research as well as information on their availability and cost to researchers (Strong et al., 2005). For example, data collected as part of the required point-in-time counts for HUD continuum of care applications and other data reports required by various federal grants may provide a source of comparable information on rural homeless populations. However, it is important to be attentive to the quality of the methods used to collect such data, which varies broadly across sites. Data on children who are homeless are collected in every locality by the school board or other entity responsible for funding received through the No Child Left Behind Act of 2001 (U.S. Department of Education, 2004), which requires jurisdictions to locate and enroll homeless children. While the Act endorses the collection of longitudinal data by states and school districts, those entities are not required to incorporate collected data into a longitudinal database. Nevertheless, datasets such as these may be useful for researchers examining rural homelessness.

Recommendations for New Research

There are a number of gaps in current research on people who are homeless in rural areas. Gaps with regard to rural homelessness research are only one aspect of a much larger research gap with regard to rural human services knowledge. “In the absence of current empirical studies of rural human services conditions, needs, and programs, policymakers must either ignore rural differences or make assumptions about them. For all these reasons, rural human services research deserves a high priority” (Strong et al., 2005). Members of the Expert Panel on Rural Homelessness and others interviewed strongly agreed that rural homelessness research, informed by both available data and current work in the field, must be supported and undertaken in order to inform policy (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006). The following study areas are recommended.

Special populations. Persons without housing in rural areas are not homogeneous populations—their diversity cannot be overemphasized (Patton, 1988). Moreover, parts of the country, such as Appalachia, the Midwest, the western frontier, and the rural South, have distinctive cultures or regional characteristics informed by local factors such as geography, history, and economy that may have an impact upon the prevalence and trajectory of homelessness (Housing Assistance Council, 1991). Differences between rural

and urban populations are often masked by the characteristics of larger urban samples. In order to focus on rural communities, an overrepresentation of rural subjects and rural areas in future homelessness research may be necessary. More research is required to better document the special subpopulations, their sizes, distinctive characteristics, specific service or housing needs, cultural differences, and geographic characteristics of the areas that affect service provision. Both community size and proximity to urban areas have a profound impact on a community's ability to develop and maintain a formal social services network for the area's residents, including its homeless persons (Patton, 1988). Research is needed to identify the needs of these diverse populations and to develop effective housing and service interventions. However, the existing research is sparse and uneven. Specific next steps in research should include a staged series of studies on homelessness and near homelessness in rural and frontier environments (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006). The initial stage would include formative qualitative research to lay the foundation for subsequent research, including interviews with frontline service providers (social service program staff, housing authorities, social workers, treatment providers, outreach workers, school staff, and others living and working in rural and frontier areas). Additional efforts would include key-informant interviews and focus groups with people who are homeless or at risk for homelessness. This initial stage would lead to a second stage of carefully crafted survey research, including needs assessments and access to services for persons who are homeless (or at risk) and systematic assessment of systems of service programs. These two stages would inform the third stage, which is development of specific intervention strategies that would include program evaluations. The fourth stage would be dissemination of effective practices to other areas and evaluation of effectiveness in the new sites.

Longitudinal studies of rural homelessness. Rigorous studies of the course of homelessness can help identify precipitating events for a homeless episode in rural communities and pathways out of homelessness for an array of community types across the urban/rural continuum. More rigorous longitudinal research is needed on medical and behavioral health problems among rural homeless persons. Such research should include variations among different types of rural communities, between rural and frontier communities, and between homeless and non-homeless persons in rural areas.

Discharge planning and homelessness prevention. People in rural areas are at risk for homelessness (as in many urban areas) when discharged from public institutions including public hospitals, respite care, psychiatric wards, board and care homes, correctional facilities, foster placements, and other settings (Patton, 1988). Development and evaluation of strategies for discharge planning should avoid missed opportunities to make critical interventions that would follow the persons into the community to help support them against homelessness.

Services research. Research suggests that homeless persons in rural areas are underserved compared to homeless populations in more urban areas. Studies are needed that assess and monitor the availability, accessibility, quality, and outcomes of medical, mental health, alcohol, and drug abuse services for homeless and other indigent individuals in rural areas. Resources include information compiled from nontraditional sources to expedite compilation of good working models or practices from, for example, expert panels, regional meetings, and provider networks. Longitudinal research with large representative samples from across the rural/urban continuum is needed to measure the larger demand for and access to needed services in rural communities (whether broad or homeless-specific services) with consideration for stigma, confidentiality, perceived availability, true availability, and cultural sensitivity (Office of Rural Mental Health Research, 2003). Success for homeless persons is expected to be greater if people can be served early and in their own communities. Research is needed to determine how to make the best

use of limited service funds—whether to serve people in their own smaller or remote communities or to centralize services in larger communities. Some services may best be provided locally and others in centralized settings; if so, it is important to distinguish these services. Rural communities are becoming increasingly diverse, and research is needed to identify the impact of changes in population size and composition on the demand for services and housing in rural communities. Research is needed to help rural communities anticipate and plan for needed changes in the local service delivery systems (Office of Rural Mental Health Research, 2003).

Identify best practices for rural settings. There is a paucity of research about best practices for meeting the needs of homeless persons in rural areas, whether adults, families with children, or unaccompanied youth. Research is needed on the effectiveness of case management, supportive housing models, or other models for housing and service delivery for the array of rural and frontier populations. As outlined by the New Freedom Commission on Mental Health's Subcommittee on Rural Issues (2004), most rural advocates believe that because of scarce resources, specialized services are not practical and that service providers are obliged to provide the full range of services to the full spectrum of persons in need. Research is needed to determine which is more cost-effective: addressing homeless persons as a special separate population or together with the low-income housed rural population. Communities that have adequate infrastructure can test the relative efficacy of adapting local mainstream programs to serve homeless clients versus creating homeless-specific services. Studies are needed to assess access to care for both general and specialized health needs. Adaptation of evidence-based practices implemented in urban areas as well as development of models specifically designed for rural areas should be pursued. Developing best practice models should include examination of workforce issues needed to implement model programs and testing the cost-effectiveness of service and housing programs in rural areas generally, including remote rural and frontier communities.

Implications for Preventing and Ending Rural Homelessness

Once evidenced-based practices are established for rural areas, it is important to find ways to disseminate this information to rural communities. Generally, rural communities have much less access to resources for disseminating successful approaches or training providers on their implementation (Office of Rural Mental Health Research, 2003). This is part of what one rural expert called the "cycle of disparity" (Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2006). The lack of resources begins with funding. While an estimated 9 percent of the homeless population live in rural communities, only 5 percent of targeted homelessness assistance reaches these areas (Strong et al., 2005). A significant disparity in federal spending on rural community development has also been seen in recent years: two to five times more per capita is spent in urban areas versus rural (Johnson & Rathge, 2006). In addition, as described in *Evaluation of Continuums of Care for Homeless People* (Burt et al., 2002), a great deal of complexity is often added to service delivery in rural communities, because funds are distributed on a regional basis, requiring rural service providers to negotiate, plan, and compete for resources on a regional or statewide level. A prime example is the distribution of HUD continuum-of-care funding for persons who are homeless (Burt et al., 2002). While the continuum of care requires all applicants to compete for funding, other dollars for the provision of housing and services often are awarded directly to cities, when rural communities must compete at the state level for the same funds. Examples of this disparity include the Community Development Block Grant and the HOME Program.

The relative lack of funding going to rural communities also means that less is known about what is and is not working. The primary data sources for homelessness research are databases and reports made

available to federal funding sources. When these funds do not reach rural communities, the information is not collected and analyzed and program efficacy remains unevaluated. The lack of data and, therefore, research means that public policy responses continue to focus on urban poverty without regard to unique rural factors, including higher poverty rates among children and lack of transportation and specialized services (O'Hare et al., 2004). Only with a conscious effort to break this cycle can rural homelessness not only begin to be understood, but finally be addressed.

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Incarceration and Homelessness

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Abstract

This paper provides a synthesis of the emerging literature on the nexus between incarceration and homelessness. The authors explain how the increasing numbers of people leaving carceral institutions face an increased risk for homelessness and, conversely, how persons experiencing homelessness are vulnerable to incarceration. The authors review recent efforts to address reentry issues and review research results on studies of homelessness among prison and jail populations and research on incarceration among people who homeless. After reviewing common barriers to housing for people who have been incarcerated, the authors assess what is known about the effectiveness of services and housing interventions to address these barriers and outline needs for future research.

Introduction

Over the past 25 years the United States has seen large increases in both incarceration and homelessness. The jail and prison population went from approximately 500,000 in 1980 to 2.1 million in 2004 (Pastore & MacGuire, 2005), while the homeless population transformed from a small collection of individuals stereotyped as bums and winos to a diverse assortment of families and individuals that, according to best estimates, now include at least 2.3 million who are homeless at some point in a year (Burt et al., 1999). Little is known, however, about the relationship between these two concurrent phenomena. Although service providers have long pointed to anecdotal evidence about the overlap between these two populations, awareness of this nexus from a research perspective is relatively recent and in its nascent stages.

This paper presents evidence for evaluating two assumptions. The first assumption is that persons who are homeless are at increased risk for incarceration and, conversely, release from jail or prison leaves a person particularly vulnerable to an episode of homelessness. Much of the research on the homelessness-incarceration nexus is still documenting parameters. Specifically, this includes the rates at which people cross over from one to the other; the proximate factors associated with an increased probability of such crossovers; and more general explanations of why such a high degree of crossover exists.

The second assumption concerns the centrality of housing, coupled with supports (in whatever form they may take) that help to maintain this housing, in preventing both homelessness and incarceration among persons at risk for both. For those who lack the resources and supports to obtain secure housing upon release, providing such housing stands to mitigate the risks for both homelessness and reincarceration. Evaluating this assumption involves examining the more general experience faced by persons who reenter the community from jails and prisons, as well as examining empirical evidence on outcomes related to interventions that involve housing and supports. Service and housing providers have given limited attention and resources to addressing the needs presented by persons with histories of both incarceration and homelessness. When they have done so, the tendency has been to adapt other models rather than to develop specific interventions focusing on the specific problems presented by this population. Interventions that do exist, whether adapted from other housing models or designed specifically to address the needs of this population, typically are ahead of the research literature on best practices. This paper will review the range of housing approaches, featuring specific housing programs within this continuum, and what, in the absence of extensive evidence in this field, is considered to be best practice.

In describing what will be covered, it is also necessary to outline the limits as to what will be covered here. Community reentry (for persons released from incarceration) and homelessness are both broad topics that touch on a range of other topics. Focusing on the immediate nexus of these two topics necessarily steals attention from areas with a less direct bearing. For example, responses toward this problem do not, by and large, address more general policies regarding incarceration and housing, although this will ultimately be the solution to this problem. Similarly, more general topics such as employment, healthcare, education, and stigma figure into understanding this nexus, but are only touched on in this paper. And some related topics, such as how incarceration of an adult may lead to collateral homelessness for family members, are important but lack research and interventions that provide clearer understanding. This need for future research is addressed in the final section. Opportunities here abound, as knowledge of the nature of the problem and evidence to support current intervention practices still contain numerous gaps with respect to many key questions.

Policy and Institutional Context

This link between incarceration and homelessness can be viewed as a second wave of deinstitutionalization. Deinstitutionalization is a term traditionally used in reference to the exodus of persons treated for mental illness from psychiatric hospitals to the community (i.e., the “first wave”), and it has parallels to the more recent interactions between carceral institutions and homelessness. The problematic implementation of deinstitutionalization left many persons with mental illness to enter the community unprepared and unsupported, and has been widely thought to be the reason why, from the 1980s on, persons with mental illness figured prominently among the rolls of the homeless population. By comparison, rates of shelter use have been found to be higher among people exiting prison than among people exiting state psychiatric hospitals (Metraux & Culhane, 2004). The number of people exiting prisons and jails to the community was 650,000 and 9 million, respectively, in 2004 alone (Brown, 2006; Harrison & Beck, 2006); just the number of those released from prison alone dwarfs the number deinstitutionalized from psychiatric hospitals (Mechanic & Rochefort, 1990).

Actors involved in this current round of deinstitutionalization involving the criminal justice system can learn from some of the missteps of the previous round of deinstitutionalization involving the mental health system. One key lesson from deinstitutionalization of persons from psychiatric hospitals has been the importance of housing. For the deinstitutionalized mentally ill population, housing had been viewed

by community mental health services as a public welfare function, and was largely ignored until homelessness became linked with mental illness. Only as a result of this link did there emerge a consensus in the community mental health field that housing is, in fact, a mental health service and a prerequisite to effectively providing other forms of community-based services (Metraux, 2002). This is an example of where the criminal justice system appears to have learned little from the mistakes made in deinstitutionalizing persons who are mentally ill. The lack of jurisdictional clarity over the problem of post-incarceration homelessness means that people who are homeless at the point of their discharge from incarceration fall under the purview of neither the corrections system, which views its jurisdiction over inmates as ending at discharge, nor the homeless assistance system, as individuals leaving institutions are not considered presently homeless and are therefore ineligible for most forms of homeless assistance. Cho (2004) attributes this jurisdictional gap to a condition of "isolationist policymaking," in which sectors of government define their spheres of responsibility too narrowly thus leaving some individuals to become "institutional refugees." As Black and Cho (2004) explain, the result is ultimately a scarcity of public funding and resources that target persons who are homeless upon their release from incarceration. As a result, people leaving incarceration enter an uncertain transitional space between institution and community in which services are fragmented at the point where they are most vulnerable (Hopper & Baumohl, 1994).

What Has Changed Since 1998?

Criminal justice involvement among people who are homeless is hardly new: jails and detention facilities have historically served as de facto institutions for persons who were homeless when they were picked up either for violating vagrancy laws or as a benevolent means of quartering (Hopper, 2003). Likewise, shelter operators and other homeless housing providers have long reported seeing high rates of people with recent experiences in correctional settings among their clientele. Some providers of homeless shelters have anecdotally reported rates of formerly incarcerated people as high as 70 percent (Cho, 2004), while a national survey of providers of homeless services conducted in 1996 found that "[a]ltogether, 54 percent [of persons receiving homeless services] have some experience of incarceration" (Burt et al., 1999).

What is new is a growing level of concern. In terms of reentry, this concern has manifested itself in a changing political climate in which there is a greater receptiveness towards attending to problems related to reentry (Suellentrop, 2006). A recent analysis by Jacobson (2005) suggests that developments in the current political climate may further facilitate efforts to increase programming to address the needs of the formerly incarcerated. In this argument, the huge swell in the prison population, negative public opinions about crime and public safety, and interest in curbing or rethinking public spending practices all create a window of opportunity for policymakers and leaders to create and implement programs that hold the promise of slowing incarceration rates, reducing demand for emergency public services, and ultimately saving or making better use of public dollars. Jacobson argues that evaluation of existing practice—for its cost-effectiveness with respect to corrections and other public system utilization—is critical, thus furthering the case for supporting evaluation research.

Attending to the needs of persons with histories of incarceration has become a more bipartisan issue, with the Bush Administration first providing $100 million in funds towards reentry initiatives in 2001 under the Severe and Violent Offender Reentry Initiative, and then providing a major impetus for action with Bush's call, in what would become known as the Prisoner Reentry Initiative, for allocating $300 million in funding towards reentry initiatives in his 2004 State of the Union Address. This was followed by the

Second Chance Act, a bill that proposed allocating $100 million over two years to help states address reentry issues and that narrowly missed passage by Congress in 2006. This bill represents a start, as considerably more resources would be needed to match the magnitude of the reentry problem. But such beginnings encourage hope that the policy atmosphere will be more open to addressing the needs of those released from jails and prisons now than it has been during the decades-long growth in the incarcerated population.

In the last several years there has also been increased policy emphasis on ending (as opposed to managing) homelessness. More than 200 communities around the country have recently committed themselves to 10-year plans to end homelessness (Interagency Council on Homelessness, 2006; Cunningham et al., 2006). A particular target for many of these plans is the "chronic" elements of this homeless population. "Chronically homeless" refers to persons who have been homeless for extended periods, often have one or more disabilities, and disproportionately use other public services and institutions, including jails and prisons. These plans to end homelessness are increasingly seeking to bypass emergency shelters and transitional housing, instead placing persons who are homeless directly into permanent housing with support services, when needed. Insofar as these renewed efforts at addressing homelessness have the capacity and the will to specifically respond to incarceration, this policy focus also promises to be receptive to ameliorating the nexus between homelessness and incarceration.

Both from the reentry and homelessness perspectives, there are grounds to believe that increased attention will be focused on addressing the nexus of incarceration and homelessness. This is, however, still an issue in its infancy. As such, there is a particular need for research that outlines the parameters of this problem and provides evidence for what approaches can effectively address this problem. It is these areas that provide the foci for this paper.

Synthesis of Research Literature: Findings and Discussion

Empirical Basis for Defining the Issue

The basis of the link between incarceration and homelessness is the degree to which there is overlap among the populations—whether it is measured from the perspective of the prevalence of homelessness among an incarcerated population or prevalence of incarceration among a homeless population. That a substantial overlap exists should not be surprising given the similarities in profiles between the incarcerated population and the single adult homeless population, where incarceration is most prevalent. Both are both predominantly male, young, and minority (Langan & Levin, 2002; Burt et al., 1999; Mauer, 1999; Culhane & Metraux, 1999). People in both populations are typically poor and undereducated and possess few job skills (Western & Beckett, 1999; Lichtenstein & Kroll, 1996; Burt et al., 1999). Both populations are characterized by the research literature and the mainstream media as having high rates of disability, especially involving mental illness and substance abuse (Burt et al., 1999; Freudenburg, 2001; Conklin et al., 2000; Lamb, 1998; Peters et al., 1998).

Experience of Homelessness Among the Prison Population

Prisons are run by state or federal government entities. In contrast to jails, prisons incarcerate persons who are convicted of more serious offenses and who serve considerably longer sentences. Prisons are typically located at considerable distances from where incarcerated individuals lived prior to their

conviction. In 1999, the average time served for state prisoners was 34 months (Hughes, Wilson, & Beck, 2001), and in 2002 the average time served in federal prison (felony convictions) was 49 to 50 months (U.S. Sentencing Commission, 2004). Most persons are either released from prison on parole, meaning that the last part of their sentence is served while they are in the community and supervised by a parole board, or are released without supervision after serving their full sentence in prison.

Lengthy periods of incarceration in remote locations often attenuate the social and family ties that are crucial for successful reentry into the community. Regained economic and residential stability almost always requires that a person receive, upon release from prison, support from family, social service agencies, faith-based organizations, or other parties interested in facilitating a smooth transition for the released individual. In the absence of such supports (and in some instances the absence of any type of effective discharge plan), individuals released from prison are at high risk for homelessness as well as other undesirable outcomes.

Only a handful of studies examine the overlap of prison and homelessness, and the extant literature has limited comparability due to variation in the study populations and the time frames used. However, taken together, the research suggests that about a tenth of the population coming into prisons have recently been homeless, and at least the same percentage of those who leave prisons end up homeless, for at least some period of time.

These studies include a Bureau of Justice Statistics (BJS) study (Hughes, Wilson, & Beck, 2001), which found that, among a nationwide survey of state prisoners expecting to be released in 1999, 12 percent reported being homeless at the time of their arrest. Another nationwide BJS study (Ditton, 1999) found that in 1998, 9 percent of state prison inmates reported living on the street or in a shelter in the 12 months prior to arrest. A California study (California Department of Corrections, 1997) reported that in 1997, 10 percent of the state's parolees were homeless. This study also found that in urban areas such as San Francisco and Los Angeles, an estimated 30–50 percent of all parolees were homeless. A 1999 Urban Institute three-site study of 400 returning prisoners with histories of drug abuse found that 32 percent had been homeless for a month or more at least once in their lifetimes, and 18 percent reported they were homeless for at least a month in the year after they were released from prison (Rossman et al., 1999). The Massachusetts Housing and Shelter Alliance (Hombs, 2002) reported that 9.3 percent, 10.5 percent, and 6.3 percent of all people exiting state prisons in Massachusetts in 1997, 1998, and 1999, respectively, went directly to shelters after release. In The Urban Institute's four-site Returning Home study (Visher, 2006), anywhere from 2 percent (Maryland, Ohio, and Texas) to 5 percent (Illinois) of respondents slept at a shelter during their first night out of prison. Another 3 to 4 percent slept at a hotel, motel, or rooming house the first night out.

Research by Metraux and his colleagues used administrative data to not only assess shelter use among a cohort of persons released from state prisons, but also to assess factors associated with higher likelihoods of shelter use following release. Metraux and Culhane (2004), looking at people exiting the New York State prison system to New York City locations, found that, with incomplete pre-incarceration data, 6.6 percent had a history of shelter use in the two-year period prior to incarceration and, with more complete post-incarceration data, 11.4 percent had an episode of shelter use in the two-year period subsequent to release. Metraux (2007), looking at persons released from state prisons to Philadelphia locations, found the rate of shelter admissions within two years to be 4.3 percent. The later study found that a proxy measure for mental illness was associated with a substantial increase in the likelihood of a shelter stay. In both studies, an indicator of a history of shelter use prior to incarceration, although incomplete, was a

strong predictor of subsequent shelter stay in both studies. Increasing age was also significantly linked to higher likelihoods of post-release shelter use (and decreasing likelihood of reincarceration) in both studies, suggesting that as persons "age out" of criminal activity their risk for homelessness increases. Finally, the studies showed conflicting results on the effect of parole on homelessness, with the New York study showing release on parole to increase the likelihood of shelter stay, while the Philadelphia study showed a significant decrease in this likelihood.

These two studies, which merge data from multiple and large administrative datasets and use multivariate regression methods to assess various factors and their associations with the likelihood of shelter use, go beyond simply reporting rates and permit some insight into risk factors for homelessness among persons released from prison. For example, both studies confirm that shelter use prior to prison entry is the strongest predictor of post-release shelter use, a finding that lends itself well to being incorporated into a simple screening mechanism for targeting persons at-risk for homelessness. However, more studies of this type of sophistication, using other types of data, are needed to build a base of evidence for the role of such key factors as mental illness or parole supervision on the risk for homelessness after release from prison.

Experience of Homelessness Among the Jail Population

In contrast to prisons, most people are in jail for lesser offenses and only for a short time—the median stay is one day. Quick release commonly occurs when persons post bail or serve minimal time for minor offenses or charges are dropped. People will stay in jail longer when they are unable to post bail and remain in jail while awaiting trial or, following conviction, when persons convicted for lesser offenses serve their remaining time in jail. Some defendants are given split sentences, which involve a period of probation supervision after jail time is completed.

Persons serving longer jail sentences may have similar reentry issues as their imprisoned counterparts. However, even short-term incarcerations may disrupt lives and interfere with the ability to maintain employment and housing. Few jails have pre-release programs that provide case management services to link prisoners leaving jail to community services (Steadman & Veysey, 1997) and/or housing. Those on probation may have a number of court-ordered probationary conditions that make it difficult to return to live with family or friends or to find appropriate housing. Probation clients mandated to find employment right after release may be pressured to find a job regardless of how far the job is from their intended housing. While the housing options may be fewer given probation restrictions, being on probation may provide structured support to assist a released prisoner's search for housing.

The few studies on homelessness among jailed populations suggest that the rates of homelessness for those exiting jails are lower and more loosely coupled with the jail release than they are for those exiting prison. However, because the jail population is much larger that the prison population, the number of persons exiting jails who become homeless is much larger. Metraux and Culhane (2003) found that, among 76,111 persons released from New York City jails in 1997, 5.5 percent entered New York City shelters for single adults in the subsequent two-year period. A recent BJS survey of jail inmates (James & Glaze, 2006) found that for jail inmates without a mental heath problem, 9 percent reported homelessness in the year before jail entry, as compared to 17 percent of those who had a mental health problem. In a sample count of jail inmates in Salt Lake City in July 2005 and January 2006, nearly 10 percent identified themselves as homeless (Reentry Policy Council, 2006). One study of frequent jail users found that 82 percent of repeat users of jail in a metropolitan area in the South were transient or homeless at jail intake (Ford, 2005).

McNiel, Binder, and Robinson (2005) looked at homelessness and mental illness among a jailed population. The study found that for the almost 13,000 jail episodes that were examined, in 16 percent of the episodes the person in question was homeless at the point of arrest, and in 18 percent of the episodes the person in question was diagnosed with a mental disorder. This rate of mental disorder was 30 percent among the episodes involving homelessness. Furthermore, homelessness and a "dual diagnosis" of severe mental disorder and substance-related disorders were associated with longer jail episodes.

As with examining prison to homelessness, the literature here is sparse and offers only a sketch of the nexus between jail and homelessness. The extent and dynamics here need further exploration and need to incorporate other dynamics such as was done in the study by McNiel and colleagues. Furthermore, given that both homelessness and incarceration, especially in jails, disproportionately impact impoverished, minority males (Harrison & Beck, 2006; Culhane & Metraux, 1999), it is unclear how much more elevated the rates of homelessness are among persons released from jail when compared to a comparable group of persons who have not been jailed.

Experience of Incarceration Among the Homeless Population

Just as homelessness is a common experience among persons incarcerated in jails and prisons, having had an incarceration experience, be it jail or prison, is a common occurrence among single adults who are homeless. Conversely, the studies that examine incarceration histories among homeless populations are also difficult to compare, but judging from the results it appears that upwards of 20 percent of a single adult homeless population can be assumed to have been incarcerated at some point.

Examples of such studies include Metraux and Culhane's (2006) examination of a sheltered single adult population in New York City. In this study, 23.1 percent experienced at least one incarceration episode in the two-year period prior to the date examined. This included 7.7 percent with a prison stay and 17.0 percent with a jail stay. According to the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC), 49 percent of homeless adults reported at least one lifetime experience of having spent five or more days in a city or county jail, 4 percent had spent time in a military lock-up, and 18 percent had been incarcerated in a state or federal prison (Burt et al., 1999). A recent study of 1,426 community-based homeless and marginally housed adults found that 23.1 percent of study participants had a history of imprisonment (Kushel et al., 2005). Schlay and Rossi's (1992) summary of twenty studies conducted in the 1980s found that, depending on the study, 4 percent to 49 percent of the homeless population report serving time in prison. The mean across the studies was 18 percent.

When focusing on persons diagnosed with mental illness, the intersections between homelessness and incarceration appear to be intensified (Metraux & Culhane, 2004; Ditton, 1999). In contrast, however, Solomon and Draine (1999) found more tenuous links between criminal justice history and homelessness in a sample of 325 psychiatric probation and parole clients. Other studies examining homelessness and criminal justice-related risk factors among persons with mental illness focus primarily on arrests, without examining incarceration specifically. Several studies here have found housing instability to be associated with an increased likelihood of coming into contact with police and of being charged with a criminal offense (Brekke et al., 2001; Clark, Ricketts, & McHugo, 1999; Martell, Rosner & Harmon, 1995).

Metraux and Culhane (2006, 2004) also present evidence suggesting that the trajectories between homelessness and prison and homelessness and jail vary. The links between prison and homelessness are much more immediate, with an episode of homelessness being most likely to occur within 30 days of a prison release. This suggests that homelessness among persons released from prison is a reentry issue.

This is consistent with research that shows persons released from prison to be at greatest risk for a variety of undesirable outcomes during this time period (Nelson, Deess, & Allen, 1999; Travis, Solomon, & Waul, 2001). Furthermore, Metraux and Culhane (2004) find that shelter use increases, albeit modestly, the risk for a subsequent reincarceration. In contrast, Metraux and Culhane (2006) found that shelter and jail use tended to follow a more sequential pattern featuring multiple stays in each system and a more prolonged pattern of residential instability.

The Research Evidence: What Do We Know?

Evidence collected so far supports perceptions that there is a tangible link between incarceration and homelessness. However, most of the evidence linking incarceration and homelessness is correlational, and cannot demonstrate that incarceration causes increased risk for homelessness, or vice versa. While there is a need for studies that are capable of assessing causality in this relationship, the associations demonstrated here in the high rates of homelessness among incarcerated populations, and the high rates of incarceration among homeless populations, are consistent with other bodies of research that highlight factors which explain why such high rates would exist. The research reviewed here documents specific and multiple barriers to housing among persons recently released from carceral institutions, and increased vulnerability for arrest and incarceration among homeless persons. This research not only supplies explanations for the high rates just reported, it also implies that addressing these factors could ameliorate the connections between homelessness and incarceration.

Barriers to Housing for Persons Who Have Been Incarcerated

There are structural as well as individual barriers to housing for soon-to-be-released prisoners. These barriers start even before release. For example, one fundamental obstacle to effective discharge planning in prison is that prisons tend to be located in rural areas, whereas most persons released from prison will return to urban areas hundreds of miles from the prison where they were incarcerated. This geographic mismatch renders it difficult to connect returning prisoners to the available housing market or for discharge staff and social workers to even attempt to provide housing assistance, as they are unlikely to have sufficient knowledge of the housing landscape to aid returning prisoners.

Oftentimes, however there will not even be adequate discharge planning and other support services available to incarcerated persons prior to their release. Survey data for state prison inmates from 1997 reveal that only 13 percent of soon-to-be-released inmates reported participating in pre-release programs (Lynch & Sabol, 2001). Most likely, an even smaller percentage receives housing-related assistance (e.g., counseling, search assistance, referrals to local housing providers, vouchers for rent, renter education, etc.) within these programs. An Urban Institute study tracking released prisoners in Illinois found that of clients who responded that they “did not have a place to live lined up” upon release, only 21 percent participated in pre-release programs. Of those who did participate in pre-release programs, almost half (45 percent) reported that finding a place to live was not covered in the program. In addition, for those who discussed finding housing in their program, only 39 percent received housing referral information (LaVigne et al., 2003). These numbers were similar to the findings of reentry studies in Ohio and Texas (Visher 2006; Visher & Courtney, 2006). The findings suggest that discharge planning involving the provision of housing-related services is rarely a standard part of the pre-release suite of services.

Discharge planning in jails is also frequently inadequate, as exemplified by the case *Brad H. vs. City of New York.* In this case, the New York State Supreme Court ordered the New York City Department of Corrections to provide comprehensive discharge planning prior to release for discharged individuals

diagnosed with a mental illness. Prior to the Brad H. ruling, this class of persons released from jail was treated like other released inmates—they were dropped off in the city in the middle of the night with $1.50 and two subway tokens (Barr, 2003).

Upon release, financial instability can greatly reduce prospects for securing adequate housing. In a survey of housing providers that serve returning prisoners in the District of Columbia, respondents overwhelmingly reported that the inability of returning prisoners to secure jobs to provide income for rent was the greatest client barrier to housing (Roman, Kane, & Giridharadas, 2006). The majority of persons leaving prison have no savings, limited educational attainment and literacy skills, few or no job prospects, and no access to immediate unemployment benefits (Petersilia, 2000). Among those released from prison who are employed, the majority work in unskilled and low-wage jobs that are inadequate for meeting high housing costs, particularly in the urban areas where most prisoners live upon release (Western, 2002). Even among those exiting incarceration who do have skills and experience that would render them employable, having a criminal history poses a substantial barrier to employment, a barrier that is particularly daunting when accompanied by racial discrimination (Pager, 2003). Furthermore, employment opportunities become more restricted when criminal backgrounds, particularly a history of a felony conviction, bar people from being employed in a number of sectors.

After controlling for other factors, incarceration is associated with an earnings loss of anywhere from 10 to 30 percent (Grogger, 1995; Kling, 1999; Lott, 1990). However, economic disadvantages go beyond difficulties in securing employment. Benefits such as Supplemental Security Income, a key income support for persons with disabilities, are stopped while a person is incarcerated and application for reinstatement can only occur after release, often resulting in a wait in excess of several months before benefits resume (Blank, 2006). Persons with criminal histories can be restricted from receiving certain benefits (Legal Action Center, 2004). Many returning prisoners also face the added financial burden of supervision fees, child support, restitution, and other related costs, which often exceed average monthly income (Visher, La Vigne, & Travis, 2004).

Given these financial disadvantages, unsubsidized housing is often cost-prohibitive for persons who are released from incarceration (Scally & Newman, 2003). Many areas, especially urban areas, are witnessing increasingly tight rental markets, with limited numbers of units available for low-income households, particularly in neighborhoods accessible by public transportation. In such a market, individuals with criminal records are at a distinct disadvantage, having to compete with families and others who do not have criminal records and are thus deemed to be more desirable tenants.

These barriers to obtaining unsubsidized housing are coupled with restrictions on government subsidized housing that specifically deny ex-offenders access to public housing and the housing choice voucher program (Legal Action Center, 2004). This categorically puts the largest sources of affordable housing out of reach for many persons released from incarceration. These restrictions also limit the family support available to these persons if their families are living in subsidized housing, as their presence would put all household members at risk for eviction. Current policies pertaining to federal funding for specialized housing have provided little opportunity for housing to be developed to compensate for such restrictions. Ironically, even persons who were homeless prior to incarceration will have increased difficulty in accessing homeless services upon release. This is because persons released from incarceration, even if homeless prior to their incarceration, will not meet the standard criteria for being “homeless” and will have greater difficulty being eligible for programs targeting the homeless population.

Changes in sentencing structures also create barriers for returning prisoners looking for housing. As crime increased during the 1980s and early 1990s, many states adopted determinate sentencing and "truth-in-sentencing" laws. Determinate sentencing removed parole board discretion to determine when prisoners were deemed "ready to be released." The number of prison releases that were discretionary, meaning that a parole board decided release decisions, dropped from 65 percent in 1976 to 24 percent in 1999 (Travis & Lawrence, 2002). Truth-in-sentencing structures mean that inmates can no longer attain "good time" toward release for good behavior until they have served at least 85 percent of their sentence. These individuals—those who "max out"—are not placed on parole supervision, but return to the community unsupervised and absent the support a parole officer might be able to provide (Petersilia, 2003).

Community supervision, most commonly in the form of probation or parole, may facilitate or impede obtaining safe and affordable housing. On the positive side, parole supervision means that, in most states, persons about to be released are required to have an appropriate home plan that demonstrates viable housing arrangements upon release. Receiving community supervision represents a potential source of support, as the supervised person may have access to social services and transitional housing facilities upon release. Even without the mandate to transition through a halfway house or community-based facility, supervision may be particularly helpful if parole and probation officers are knowledgeable about local housing options or housing-related programming. On the other hand, community supervision often includes a variety of restrictions, financial obligations, and conditions that may make it more difficult to maintain housing or employment.

Community opposition creates a number of barriers. Laws restrict the residential options of persons with criminal records, such as barring them from publicly subsidized housing or, particularly in the case of persons convicted of sex crimes, keeping them from living in circumscribed areas. Neighborhoods are often resistant to the siting of any housing that targets persons who have had contact with the criminal justice system. Due to the stigma that accompanies incarceration, the proposals to expand funding and services for reentry programs fail to become a legislative priority.

Finally, indirect and often intangible obstacles arise from the fragmentation that exists across and within service systems that potentially could support the transition from prison or jail to the community. Despite the involvement of corrections and community corrections programs (e.g., probation and parole), housing and homeless assistance providers, and general social services agencies, no single agency or organization is responsible for ensuring that individuals exiting prison are able to find safe and affordable housing. Furthermore, there is little collaboration among systems and little consistency over time. What results is a prisoner reentry system that is disconnected from the housing and homeless assistance services system and from the neighborhoods where released prisoners live. Historically, corrections systems have not provided discharge planning focused on ensuring that releasees have sufficient funds to travel to their destination after release, proper identification, or up-to-date paperwork to apply for public assistance that may have been suspended during incarceration.

Taken together, the barriers reviewed here are legion, and, regardless of whether they involve systemic or individual shortcomings, they can, by themselves or in combination, create conditions that unintentionally facilitate a path toward homelessness or reincarceration for persons upon their reentry into the community.

Incarceration Risks Among the Homeless Population

There are also reasons why persons who are homeless would be at higher risk for incarceration. Homelessness occurs on the economic and social margins of society. In this context researchers have pointed to a related liability for persons who are homeless to incur more arrests and subsequent incarceration for misdemeanors and a range of minor crimes. This is attributed to the public nature of a homeless existence and to attempts at controlling a population that is perceived as unruly, threatening, and offensive (Barak & Bohm, 1989; Snow, Baker & Anderson, 1989). Many aspects of homeless life have become restricted and "criminalized," to where acts of subsistence and survival, especially in public places, are illegal and can lead to incarceration (Fischer, 1992; Foscarinis, 1996; Snow, Anderson, & Koegel, 1999, Eberle et al., 2000, Feldman, 2004). While these offenses are often minor, failure to pay fines or follow through with court appearances can lead to incarceration. Solomon and Draine (1995), show how arrest for "lifestyle" offenses such as trespassing among homeless persons with mental illness often lead to arrests for more serious charges such as burglary, which are likely to result in periods of incarceration.

Arrest rates have been high among homeless populations at least since the "Skid Row era" of the 1950s and 60s (Metraux, 1999), and there is a line of research that highlights the latent functions of this dynamic. Incarceration has been portrayed as a mechanism for exerting control and distance over the perceived threat to social order represented by the homeless population (e.g., Bittner, 1967; Spradley, 1970), a process Irwin (1985) describes as "rabble management." Fischer (1992) points out the role of carceral institutions as sources of, among other things, housing, substance abuse treatment, and mental health care. Taken a step further, shelters, jails, and prisons can be seen as interchangeable waystations on a longer "institutional circuit," where a series of institutions provide sequential stints of housing in place of a stable, community-based living situation (Hopper et al., 1997).

Reentry Programs and Housing Outcomes: What Do We Know?

The past decade has seen the development of new and innovative reintegration programs for returning prisoners, and funding for researchers and practitioners to examine the effectiveness of programs designed to facilitate community reintegration (and, as such, residential stability). Facilitating community reintegration often addresses the barriers to housing that were discussed in the previous subsection, but usually does not directly focus on preventing homelessness among persons reentering the community. New initiatives in this area are typically geared toward establishing comprehensive services. However, while these programs often include some type of housing assistance or housing referral, they rarely provide actual housing to returning prisoners. There has also been a body of research and evaluation that has followed this programming, but there is a paucity of research that examines homelessness related to reentry initiatives.

The existing research on these outcomes generally falls into three categories. First and most basic are needs assessments based on surveys and tracking of persons upon release from incarceration. A second category of this research tracks the use of services in homeless, criminal justice, and related public systems through matching administrative data. Finally, there are studies focusing on long-term outcomes measurement for persons in supportive housing and other housing/residential placements. These include a number of outcomes such as tenancy, homelessness, and recidivism. Each of these categories will now be briefly reviewed.

Needs Assessments/Surveys/Tracking

Most research relating homelessness to incarceration is based on cross-sectional studies or needs assessments that survey homeless individuals, individuals in prison, or those recently released from prison. A number of studies in this vein are also designed to track individuals over a period time. These studies, which typically do not contain comparison groups, are correlational in their examination of the relationship between homelessness and incarceration. The *Returning Home* study, conducted by the Urban Institute, provides a good example of how a large, multisite descriptive study of returning prisoners can shed light on important policy issues related to the needs of the formerly incarcerated. *Returning Home* documents the pathways of prisoner reintegration, examines what factors contribute to a successful or unsuccessful reentry experience, and identifies how those factors can inform policy. The *Returning Home* study has been implemented in four states, including a pilot study in Maryland (Visher, La Vigne & Travis, 2004) and full studies in Illinois (La Vigne et al., 2003), Ohio (La Vigne & Thomson, 2003), and Texas (Watson et al., 2003). The goal in each state was to collect information on individuals' life circumstances immediately prior to, during, and up to one year after their release. At each site, *Returning Home* grouped the challenges of reentry along five dimensions: individual, family, peer, community, and state (Urban Institute, 2005). *Returning Home* survey instruments include a number of questions related to housing and homelessness.

Use of Services and Corresponding Cost Offsets/Cost Effectiveness

This approach primarily uses administrative data, and links incarceration records, shelter records, and other program records through personal identifiers such as name and social security number. Such studies are retrospective, and use data contained in administrative databases collected by various service providers, often large public entities such as city and state corrections, welfare, and mental health systems, for purposes of recordkeeping and coordination of care. Research using this design can establish a sequential history of services use, typically prior and subsequent to a particular intervention such as housing. And while this method provides a practical means of gathering data on large numbers of subjects, data matching across systems can be cumbersome, time-intensive, and expensive (Culhane & Metraux, 1997).

Administrative data can provide more accurate and detailed information on services use than any other means of data collection, and cost figures can be attached to these records of services use to provide estimates of resources expended and financial impacts of particular interventions such as housing. Culhane, Metraux, and Hadley's (2002) study of the cost offsets associated with providing housing and support services for persons who had extensive histories of homelessness and who were diagnosed with severe mental illness is the best known of a small body of research that ties costs to outcomes for housing programs serving persons with mental illness. Among their findings is that, in the New York City program that they examined, a supportive housing placement is associated with an annualized reduction of $12,145 in shelter, health, mental health, and corrections services. Such a reduction in service-related costs would recoup 94 percent of the cost of the housing and services. This suggests that housing stability can lead to a reduction in service utilization among the homeless mentally ill population, mostly by saving public resources through collateral reductions in services consumed by the erstwhile homeless individuals in other services systems.

With groups that are heavy users of criminal justice and homeless services, or who receive an early release to community-based housing, the case for fiscal savings, to go along with other less tangible benefits, is a promising approach to evaluating the effectiveness of housing and other homelessness

prevention programs. The costs involved with maintaining people in prisons and jails have a median *per diem* cost of $60 and $70 (Lewin Group, 2004), respectively. These costs are high enough that an economic argument could be made for community-based interventions such as specialized reentry housing if such housing could be shown to reduce or avoid subsequent incarceration episodes. Culhane, Metraux and Hadley (2004) included jail and prison costs in their cost study and found reduced rates of incarceration after housing placement (as compared to a matched control group). However the overall levels of incarceration were low enough so that these reductions in incarceration made only a modest contribution to the overall cost savings associated with the supportive housing placements.

Long-Term Outcome Evaluation

One key limitation of the studies of services use and cost offsets using administrative data is that they rely on data already collected through other sources—data that are not collected for research purposes. In that context research is limited to examining, post hoc, questions that can be answered by the available data. An alternative to this is to build systematic and rigorous data collection procedures into housing programs. This permits data to be collected on an ongoing basis as part of providing services. Another, more expensive alternative is to incorporate larger, long-term evaluation components when developing new programming or when program outcomes seem promising. Long-term outcome or impact evaluations would involve examining the effects of programs in reducing recidivism and residential instability.

These studies usually track outcomes more than one year after release from incarceration. Although rigorous outcome or impact evaluations for reentry housing programs are scarce, a few jurisdictions have been building outcome data into their programs for a number of years. Maryland and California, for example, have developed statewide housing programs that serve persons with mental illness being released from prisons and jails.

Maryland's Shelter Plus Care program, operating in 21 counties, provides tenant and sponsor-based rental assistance to persons with serious mental illness coming from jails. Case management and supportive services are provided. Outcomes tracked by the State of Maryland demonstrate that recidivism to jails is less than 7 percent. Only 1 percent entered hospitals and only 1 percent were homeless during the evaluation period (SAMHSA, 2003).

In 1999, California passed Assembly Bill 34 (AB 34) that created pilot programs in three counties that provided a range of services, including housing support, for persons diagnosed with mental illness and who are either homeless or recently released from jail or prison. Based on positive early results of the pilot programs, in 2000 the state legislature expanded AB 34 services through Assembly Bill 2034 by providing $55 million for implementation of 40 programs in 31 additional counties across the state. Today, AB 2034 programs serve more than 4,500 individuals in California.

Evaluation findings based on AB34 and AB 2034 suggest that the provision of housing to persons who have mental illness and are justice-involved can enhance residential stability and increase successful community integration (Burt & Anderson, 2005; Mayberg, 2003). Research findings also indicate that programs that serve the most challenging clients—clients with longer histories of homelessness and incarceration—produce similar housing outcomes as those programs that serve less challenging clients (Burt & Anderson, 2005). Essentially, the evaluation demonstrates that people with serious mental illness and histories of arrest or incarceration can achieve housing stability with adequate support.

More specifically, in their analysis of housing outcomes for currently enrolled clients who had been enrolled in an AB 2034 program for 24 months, Burt and Anderson (2005) found that of those who were homeless at enrollment (43 percent of all consumers), 35 percent were in permanent housing at 3 months and 66 percent were in permanent housing at 24 months. Another 16 percent were in semi-dependent/structured living settings at 24 months. Overall, the findings also show that the most successful AB 2034 programs were utilizing multiple housing strategies, ranging from partnering with housing providers and landlords to securing housing units (Burt & Anderson, 2005).

As a result of both the recent implementation of most reentry programming and the limited direct focus on homelessness prevention as a specific goal for these programs, outcomes measures related to reducing homelessness is currently lagging. As more detailed databases emerge that focus on specific aspects of housing, services, and participant performance, research based on these long-term evaluation models can explore more nuanced questions that go beyond basic outcomes of recidivism and homelessness and offer a more complex picture of factors that are key to facilitating the reentry process.

Limitations of Research on and Evaluations of Reentry Programs

Numerous challenges encumber the extant research assessing the effectiveness of housing-related programs for the formerly incarcerated. Most basically, there are problems with logistics related to the research itself. Rigorous experimental designs—including the use of comparison groups (randomly assigned or otherwise)—are rare in this research literature. There are also temporal restrictions of the research, where few studies examine outcomes beyond one year. Next, there is substantial variability among the outcome variables examined across studies. The numerous combinations of variables unique to each study render any comparison of housing models difficult. For example, some studies focus on a reduction in recidivism to the exclusion of any reductions in homelessness and vice versa. In another example, studies comparing types of supervision or service structure rarely control for specific attributes of the housing setting, such as structure type and number of units, or criminal justice history of the consumer. There are also problems of fidelity in that a common housing approach may manifest itself in different ways under different programs and circumstances. Foremost among the challenges here is the lack of any housing model specific to providing housing to persons who have been incarcerated. Due to this and other issues related to specificity, there is often difficulty in generalizing research findings from one program to others.

Implications for Preventing and Ending Homelessness

To date, few attempts have been made to survey existing models of housing specifically targeted towards people released from incarceration. This section builds on the reviews of interventions that already exist (Hals, 2003; Black & Cho, 2004; Roman & Kane, 2007) by presenting different housing models and programs in the context of a continuum ranging from least to most restrictive and costly. Many of these programs have developed housing interventions that serve persons with incarceration histories and residential instability that is not based on, and in some cases are ahead of, the research in this area. Many are based on models targeting other populations, such as persons with mental illness, whose application to persons with incarceration records has been unexplored. Many of these practices are now considered state of the art, and are important to consider because they in some cases have become the *de facto* best practices and because research is needed to assess their effectiveness.

Continuum of Housing Options

Housing for the formerly incarcerated can best be viewed along a continuum of options from full self-sufficiency to institutionalization with high public costs. The continuum will vary both by the degree of structure and restrictions that are demanded of the resident, and by the cost of providing the housing. On one end of this continuum is *independent housing*, where an individual leaving incarceration reenters the community to live either independently, as a homeowner or renter, or as part of a larger family household. From a policy perspective, this is generally the most advantageous housing arrangement as direct public costs are minimal, and some form of independent housing is the preferred option for most persons. However, if there are difficulties in sustaining the living arrangement, due to economic or personal difficulties, then such an arrangement can also be a precursor to the consumption of costly public homeless, health care, and criminal justice services.

In many jurisdictions the market housing costs may be too high for many individuals released from carceral facilities given the preponderance of poor work histories, low educational achievement, and few marketable job skills in this population. *Subsidized housing*, available through a variety of publicly funded, project-based or voucher-based programs, when available, may be a viable, affordable option. However barriers exist to obtaining subsidized housing, as these programs usually have strict eligibility criteria and long waiting lists, and may proscribe occupancy by persons with a criminal history.

The next housing option, in terms of progressively increasing degrees of restrictiveness and cost, includes both *supportive housing* and *special needs housing*, which are permanent housing options coupled with support services. These types of housing are most often partially or wholly subsidized, and specifically designed to support disadvantaged populations. Not only are the rents in such housing subsidized based on tenant income, these subsidies also come with a range of services aside from housing, including counseling, life skills training, case management, and assistance brokering medical and mental health services. These services are designed to maximize independence, be flexible and responsive to individual needs, be available when needed, and be accessible (Corporation for Supportive Housing, 1996; Burt et al., 2004). Service configurations, as well as housing configurations, vary across programs. General examples of permanent supportive housing include the Shelter Plus Care Program, the Section 8 Moderate Rehabilitation Program for Single-Room Occupancy (SRO) Dwellings, and the Permanent Housing for the Handicapped Homeless Program administered by the U.S. Department of Housing and Urban Development (HUD) (Burt, et al., 1999).

"Special needs" programs often define eligibility for housing funding based upon the disability or health profile of individuals, rather than on the individual's homelessness status. People recently released from prisons or jails may be eligible for these programs due to factors such as a diagnosis of mental illness. As a result, some special needs programs serve returning prisoners simply because of the high rates of incarceration among populations who have disabilities related to substance abuse and mental health (Cho et al., 2002). For most programs, though, homelessness is a primary requirement for program eligibility (Burt et al., 1999, p. B-2). Many of these programs have eligibility criteria that may exclude persons returning directly from prison.

Moving along the housing options continuum, *transitional housing* falls after supportive housing and special needs housing but before full institutional care. Transitional housing is an umbrella term to capture any housing that is not permanent, and where housing is also integrated with at least some type of service that assists clients with personal rehabilitation and transitioning to a more permanent living situation in the community. Maintaining a transitional housing placement is often contingent on

participation in services, as compared to supportive housing where these two components are bundled much more loosely. Some housing experts make the distinction between short-term and long-term transitional housing. Short-term transitional housing programs have a finite length of stay, which may vary anywhere from one month to three months (or more depending on definitions). Long-term transitional housing programs generally have a time limit spanning from three months up to two years. These programs offer an extensive range of services that can include case management, mental health and medical services, counseling and general issues groups, life and social skills groups, anger management, vocational and educational training, advocacy, and assistance obtaining benefits and identification information. Configurations of transitional housing programs vary widely from barracks-type facilities, to shared living spaces, to individual apartments or houses. Programs most often will be site-specific, but programs exist that have their housing units in scattered sites.

Finally, *institutional settings* are the last housing option on the continuum. In the case of homeless shelters, providing housing may be their primary function. More often, however, institutions (e.g., prisons, hospitals) exist primarily for other functions, but provide these services in a residential setting. When looked upon as housing, institutional settings are the most restrictive and the most expensive form of housing. In New York City, for example, costs per bed in a psychiatric hospital run roughly $127,000 a year, and a prison cell costs over $50,000 annually (Culhane, Metraux, & Hadley, 2002). Even homeless shelters, often providing the most minimal of amenities, cost anywhere from $4,000 to $20,000 per person per year (Lewin Group, 2004). Institutional settings can be interchangeable; Park, Metraux, and Culhane (2006) found upwards of one-quarter of single adults entering a New York City homeless shelter for the first time in 1997 had a history of either hospitalization or incarceration in the 90-day period prior to shelter entry. And Hopper et al. (1997) documented how a group of persons diagnosed with severe mental illness made serial use, over an extended time period, of an "institutional circuit" comprising various types of facilities.

Housing Specific to Persons Released from Carceral Institutions

The housing models specific to persons released from carceral institutions documented in available surveys and reports appear to have few similarities, differing greatly in size, design, target population, and other characteristics. The physical designs include shared living in modified multi-bedroom houses, buildings with dorm-style multi-person units, buildings with single room occupancy (SRO) units with shared kitchens and/or baths, buildings with efficiency (studio) apartments, and multi-family apartment buildings. Target populations also vary greatly, largely an artifact of funding sources that drive eligibility. Most existing projects, however, serve a subset of formerly incarcerated people, whether by level of correctional involvement (prison or jail), disability (mental illness, HIV/AIDS, substance abuse), gender, or family status (singles or families).

The vast majority of this housing is either transitional or supportive. No documented non-service enhanced subsidized housing models or rental assistance programs exist that are specific for persons released from incarceration. This presumes that persons released from incarceration who have housing needs also have accompanying service needs, or that few housing providers are willing to develop subsidized housing models that do not also provide service supports. In either case, this means that housing services specifically for people leaving incarceration have a programmatic function (rehabilitation or reacclimatization). This drives up the cost of providing such housing substantially and may provide unnecessary services to some persons who are only in need of temporary housing support. Such housing, in addition to being programmatic, also remains limited to a small number of "boutique"

programs, implemented by community-based organizations and using resources originally intended for other purposes. Likewise, many of these interventions are modified or enhanced versions of interventions traditionally designed to serve other similar target populations such as homeless individuals or persons with serious mental illness (Black & Cho, 2004). For example, Burlington, Vermont's Dismas House is a modified version of the successful Oxford House model, adapted to the specific needs of persons leaving incarceration (Hals, 2003). Likewise, New York City's Iyana House and Chicago's St. Andrew's Court are enhanced or modified versions of permanent supportive housing (Roman, McBride, & Osborne, 2006).

Transitional Housing

Of the transitional housing models, several are notable for their uniqueness and lack of precedence. One in particular is New York City's Fortune Academy, operated by the Fortune Society. This project combines 19 beds of short-term and 41 units of long-term transitional housing to address a variety of housing needs among individuals discharged from state prisons and city jails. Lengths of residency are indeterminate and contingent upon individual needs. However, all residents are expected to move into private, unsubsidized housing at the end of their stays (Roman, McBride, & Osborne, 2006; Black & Cho, 2004; Hals, 2003). Another is the MIX Program operated by a New York City organization, Heritage Health and Housing. The MIX Program offers six units of long-term transitional housing for persons diagnosed with mental illness and released from state prison. Lengths of residency range from six months to two years. However, at the end of their tenures at the MIX Program, residents move into other permanent supportive housing operated by either the same organization or other organizations.

These two projects demonstrate the different functions of transitional housing for persons released from incarceration. On the one hand, stand-alone projects like the Fortune Academy fulfill a reintegration function, addressing a *temporary* housing need during the period of transition from incarceration to community. As such, the Fortune Academy prepares able-bodied and employable individuals to overcome barriers to independence—substance abuse, limited employment history or educational attainment, and/or lack of daily living skills—and eventually achieve self-sufficiency. On the other hand, transitional housing programs like the MIX Program or Project Renewal's Parole Support and Treatment Program work as part of a continuum of housing options, functioning as a bridge from incarceration to other forms of service-assisted housing (Roman, McBride, & Osborne, 2006). These continuum models are typically intended for residents who are lower functioning and who need indefinite service supports and housing assistance. Thus, an important consideration in understanding transitional housing models is whether the housing program is a stand-alone program or a part of a continuum of housing options. In the latter case, it may be more useful to consider the network of housing programs as a unit of analysis rather than any individual program.

Supportive Housing

Supportive housing specific to people leaving carceral institutions appears to be less common than transitional housing models. As with transitional housing, these supportive housing models vary in size, design, and characteristics. The range of models includes smaller, single-site supportive housing buildings with efficiency (studio) apartments and intensive on-site service supports (the Bridge's Iyana House); larger, single-site supportive housing projects with on-site supports (St. Leonard's Ministries' St. Andrew's Court); and scattered-site supportive housing with mobile case management supports (Maryland's Community Criminal Justice Program's Shelter Plus Care program) (Roman, McBride, & Osborne, 2006; Council of State Governments, 2002).

Like transitional housing models, supportive housing models specific to persons released from carceral institutions may function as stand-alone programs or as part of a continuum. An example of the former is St. Leonard's Ministries' St. Andrew's Court, which provides 42 units of "second-stage" supportive housing to homeless men with incarceration records. St. Andrew's Court is described as "second-stage" permanent housing because it serves individuals leaving St. Leonard's Ministries' transitional housing facilities (Roman & Travis, 2004). By contrast, the Bridge, Inc.'s Iyana House serves women with mental illness immediately upon their discharge from state prison. Tenants are engaged by the provider toward the end of their prison sentence and recruited to live at Iyana House, in some cases transferred directly by the parole agency to the housing site (Roman, McBride, & Osborne, 2006). The terms "housing ready" and "housing first" may be useful in distinguishing between these two approaches to providing supportive housing for formerly incarcerated individuals. In "housing ready" models, individuals are first placed into interim treatment or transitional housing settings before being placed into permanent housing. In the "housing first," individuals are placed directly from carceral institutions into housing without an intermediate stage or interim placement (Roman, McBride, & Osborne, 2006).

A common feature of the supportive housing programs specific to persons released from incarceration is that they target individuals who were homeless prior to incarceration and/or who have significant health and behavioral challenges. As such, these permanent supportive housing programs are willing to provide housing for those who are among the most challenging to serve among this population—those who are persistently and chronically caught in cycle of homelessness and incarceration to the extent that that they can be seen as being on the "institutional circuit." One example of this is a program in New York City that provides both scattered-site and single-site supportive housing with high intensity service supports to individuals with substance abuse and/or mental health issues who have a minimum of four jail admissions and four shelter admissions within the past five years (Anderson, 2006). Similarly, Central City Concern's Housing Rapid Response program in Portland, Oregon, targets frequent users of multiple public systems. These persons not only present the greatest levels of need, but are also among the most costly, in terms of services consumption, subsets of persons in the nexus of homelessness and incarceration.

What Can We Learn from Emerging or Promising Practices in the Field?

Given the tendency to re-adapt existing housing models and to use "patchwork" financing schemes to address post-incarceration homelessness, most practice in this arena remains ahead of, and therefore uninformed by, research that evaluates effectiveness. While many of these models are considered best practices or national models, empirical evidence that these models reduce homelessness and recidivism is often lacking. For example, studies have demonstrated that assertive community treatment (ACT), which is an intensive community-based case management regimen, targeted at criminal justice–involved persons with mental illness (often referred to as *Forensic* ACT or FACT) and other intensive case management models significantly reduce rates of recidivism and criminal justice involvement (Lurigio, Fallon, & Dincon, 2000; Ventura et. al, 1998; Hartwell & Orr, 1999; Lamberti, Weisman, & Faden, 2004). However, they have seldom been evaluated for their impact on homelessness and housing stability. An exception is a FACT program in Atlanta that showed substantial reductions in both criminal justice involvement and homelessness among its caseload of persons diagnosed with mental illness (Georgia Rehabilitation Outreach, 2005).

Only been recently have any programs made deliberate attempts to draw upon this limited body of research to shape their approaches. For example, Culhane and colleagues' (2002) evaluation of the New

York/New York housing initiative was a basis of the New York City Frequent Users of Jail and Shelter Initiative in their providing supportive housing to individuals identified as frequent recidivists to emergency shelters and city jails (Anderson, 2006). Moreover, New Jersey's Program to Return Offenders with Mental Illness Safely and Effectively (PROMISE) Initiative also draws upon the New York/New York study as well as research on the effectiveness of FACT at reducing recidivism in its combination of supportive housing and ACT-like intensive case management to parolees with mental illness who are found to be homeless at the time of their release. And in Philadelphia, the State of Pennsylvania and the Council of State Governments has funded a study to assess the impact of Gaudenzia FIR-St., a residential program for persons with mental illness leaving prison, upon community services use, homelessness, and reincarceration. While these studies show promise in providing insights into the performance of housing programs targeting persons released from incarceration, they are still too early in their implementation to provide evidence of program effectiveness.

Several trends are apparent among emerging practices. First and foremost, there is assumed to be an interaction effect between homelessness and incarceration. Just as incarceration, with its clinical and social consequences, leads individuals to homelessness, the lack of stable housing is considered to be a criminogenic factor. Therefore, assisting individuals to achieve housing stability can itself reduce returns to criminal justice involvement. Housing stability stands as a prerequisite to service delivery as well as a strategy for preventing returns to criminal justice involvement and incarceration. Promising programs tend to integrate services and treatment with either permanent or transitional housing rather than offer either services (e.g., case management) or affordable housing alone.

A second trend is the use of case management models for service delivery. ACT and intensive case management models are common, particularly for individuals with mental illness leaving incarceration, and these services are usually provided to this population at a higher intensity level than for other populations. This means that such case management regimens involve higher numbers of staff, often with more specialized expertise, and more frequent and intensive client contact. This case management is often supplemented with services from specialized personnel such as community supervision officers (as in FACT teams) or certified substance abuse counselors. Similarly, many housing projects targeted towards persons with histories of both homelessness and incarceration tend to use higher service worker-to-client staffing ratios (Hals, 2003). This larger and higher credentialed service staffing makes possible the incorporation of a range of clinical approaches such as cognitive or dialectical behavioral therapy, motivational interviewing, group counseling, and substance use counseling, as well as more frequent contact with tenants than is found in programs for non-justice involved homeless populations. Many programs make weekly or even daily contact with clients or tenants.

A third and related trend is the practice of "front-loading" services. Here a more intense level of services provision is utilized during a critical time period, usually defined as the first 30 to 90 days immediately following release from incarceration. During this period, persons are believed to be at particularly high risk for reincarceration and homelessness (Nelson, Deess, & Allen, 1999). Front-loaded service models attempt to assist individuals during this high-risk period by either first placing them into a housing setting with more intensive services and then transitioning them to another, less intensive setting, or by simply varying the number and type of staff assigned to each resident as he or she becomes acclimated to community living (Hals, 2003; Roman, McBride, & Osborne, 2006). In the latter approach, the resident agrees to participate in a formal "bonding" period, in which the resident is accompanied to most or all outside engagements by a service worker who assists the resident with navigating public systems,

evaluates the resident's cognitive patterns, and troubleshoots and mediates potential problems and conflicts.

Fourth, many interventions serving persons who are homeless leaving incarceration have working relationships with the criminal justice system, particularly those programs that serve people under community correctional or court supervision. This capacity may take the form of a formal agreement with a community supervision agency (Iyana House, Parole Support and Treatment Program), an informal arrangement with community supervision personnel (the Fortune Academy), or even dedicated community supervision personnel who serve as staff to the program (PROMISE Initiative). In programs that have incorporated this function, service personnel assist community supervision authorities to assess clients' progress in achieving service goals and lower the risk of reoffending. Because service personnel are able to interact with clients and observe their progress without a law enforcement obligation, they are able to assist supervising authorities to take into account individual service needs and issues in their monitoring. In doing so, they provide community supervision authorities with a means of distinguishing between behaviors that lead to true offenses and those that constitute a part of a process of recovery and stabilization.

A fifth critical trend emerging from promising programs for persons who are homeless upon release from incarceration is the emphasis on client engagement. Whereas many programs serving homeless individuals typically use a first-come first-serve approach to client intake and recruitment, many effective supportive and transitional housing programs serving persons who are homeless leaving the criminal justice system tend to be more proactive in their client recruitment. For example, programs will perform "in-reach" into correctional institutions to identify and engage potential clients, some even spending several months meeting with and preparing potential clients prior to their release. Even programs serving highly transient populations such as frequent jail users place a heavy emphasis on up-front client engagement, performing outreach in various settings where potential clients might be found in order to establish a relationship with clients prior to their housing placement. Such active and sometimes aggressive engagement helps to build trust with members of a target population who tend to be distrustful and avoidant of service providers (Hals, 2003).

Defining the Target Population

One promising emerging trend in practice is not a service delivery strategy but rather an approach that uses greater specificity in selecting a target population. In these emerging initiatives, data systems are used to identify and target housing and services to individuals who are frequent users of correctional institutions as well as other costly emergency public services such as homeless shelters, emergency rooms, and psychiatric hospitals. By targeting these frequent users of multiple systems, these programs not only seek to extend assistance to those corrections-involved individuals who represent the highest levels of housing instability, but also to achieve disproportionate reductions in the demand for public services, thus justifying continued public investment. For example, in the New York City Frequent Users of Jail and Shelter Initiative, individuals who cycle in and out of local corrections and homeless shelters are engaged and placed into permanent supportive housing with enhanced services with the intention of breaking their cycle of incarceration and homelessness (Anderson, 2006). Similarly, a Portland, Oregon program operated by Central City Concern called Housing Rapid Response provides permanent supportive housing to individuals who are identified as disproportionate users of both uncompensated healthcare and incarceration. Similar initiatives are being tried in Rhode Island, Chicago, and Atlantic County, New Jersey.

How Have Policy and Funding Affected the Population or Interventions Examined?

Initiatives like the New York City Frequent Users of Jail and Shelter Initiative and New Jersey's PROMISE Initiative are among the most recent and most ambitious attempts to address homelessness among people released from incarceration and redirect public resources from unproductive to cost-effective uses. These efforts hold promise in their attempts to link interventions for persons who are homeless leaving incarceration directly to potential cost savings. Yet these programs, through providing housing and intensive case management, are expensive in and of themselves. While such costs can be recouped by working with the most services-needy individuals, such an approach is more costly for the majority of persons who do not use public services extensively. This leads to two questions. First, should such services be based on the promise of cost savings when such cost savings are only likely to be realized among a small segment of the target population? Second, can less services-intensive approaches be developed to provide services at less expense to persons who do not need the high level of services that is typically provided through current supportive housing programs?

Like the majority of interventions for justice-involved homeless persons, these initiatives are ultimately "downstream" measures that serve individuals only after incarceration (and/or homelessness) has already been experienced. Few programs and interventions have been able to intervene with homeless individuals at the "front door" of the criminal justice system. While interventions such as mental health courts and jail diversion programs are growing in number and sophistication, these programs either fail to extend their reach to homeless persons or lack housing-related assistance. Furthermore, the homeless courts and diversion initiatives that do exist have a limited impact in that they primarily focus on homeless individuals who are arrested for "quality of life" offenses, and are not designed to provide alternative sentences to persons facing prison terms due to more serious offenses (e.g., felonies). Only one existing supportive housing effort, the Maryland Community Criminal Justice Treatment Program, offers permanent supportive housing to clients diverted from criminal justice custody (Council of State Governments, 2002). Thus, one area for needed programmatic exploration and expansion is the creation of combined housing and services interventions linked to alternatives to incarceration or jail diversion programs.

A resolution to the current jurisdictional controversy over individuals who are or become homeless upon leaving correctional institutions is a necessary prerequisite to any large-scale attempt to stem the growth in the number of persons entering homelessness after leaving incarceration. Indeed, it seems unlikely that any significant impact on rates of post-incarceration homelessness can be made by the current miniscule number of "boutique" projects funded through a patchwork of funding streams diverted from their original intent. While programming such as the Frequent Users of Jail and Shelter Initiative provide a promising prototype, there is currently no framework for the adoption of such a model on the scale necessary to make a substantial impact on reducing the overlap between incarceration and homelessness. And until this area is viewed as falling specifically under criminal justice, homeless services, or some other jurisdictional purview, programs such as are described here will continue to operate on a small scale.

Future Directions for Research and Policy

Much has been accomplished in past decade toward, first, gaining awareness and a basic knowledge of the dynamics between incarceration and homelessness, and then implementing programs to address this

nexus. However these developments represent a beginning; there remains significant ground to be covered in both understanding and addressing this area.

Looking at the research, the findings on incarceration among the single adult homeless population support the assumption that there are heightened rates of homelessness among incarcerated populations both before and after their incarceration episodes. Less conclusive evidence supports the plausible assumption that there exists a spiraling process in which involvement in one domain subsequently increases the risk for the other. More research is needed that goes deeper into this nexus than determining rates of overlap. Specifically, additional research should focus on three objectives.

The first is attaining a better understanding of the association between homelessness and incarceration. This includes research on specifics pertaining to the nature of this association; dynamics whereby people released from incarceration become homeless and people who are homeless become incarcerated; and risk factors and intervention points that exist among this population. There are also common, potentially mitigating factors that are prominent among the homeless and incarcerated populations whose role in this nexus is under-researched. The need for a better understanding of these factors, which include substance abuse, employment, and mental illness, and the roles they play in and of themselves and in interacting with each other, appears pre-requisite for outlining the nature of the homelessness-incarceration nexus. Such a gap in the research has practical implications as well, as empirically informed approaches to addressing these conditions are necessary for effective intervention models.

Second, additional research should assess the effectiveness of interventions that, either directly or indirectly, seek to prevent homelessness and incarceration among at risk populations. Currently, programmatic interventions are necessarily ahead of the available literature that documents best practices. Homelessness and reincarceration represent two basic, undesirable outcomes and should be used as measures by which to assess performance of such interventions. Having measures in place that can monitor the extent to which such outcomes occur would be a means to gauge program effectiveness, as well as the first step towards identifying specific features of the interventions that are effective in preventing these two outcomes.

Key here is evaluating the assumption that stable housing is necessary (though often not sufficient) to prevent both homelessness and incarceration among at-risk populations. The existing research suggests that housing is indeed a promising approach around which to focus intervention efforts, but beyond that many questions remain to be answered. Future studies will need to examine more detailed and nuanced outcomes than those typically reported in recent studies that focus on the blunt (though necessary) measures of occurrences of homelessness and incarceration, and would include outcomes that factor in issues such as community integration, employment, and quality of life. And, given a sufficient body of literature, at some point the research on incarceration and homelessness could go beyond examining and evaluating current practices and toward acting as a basis for designing models and interventions specific to reducing homelessness and incarceration among at-risk populations.

This begs the question about what is different with this population that is at heightened risk of incarceration and homelessness, and whether specific programming should address the needs of this population or if this population should instead be served under the auspices of existing programs. Indeed, demographically and in terms of disability and other characteristics, this subpopulation of persons who are homeless are very similar to the overall single adult homeless population. One difference, however, is jurisdictional. Many among this subpopulation who lapse into homelessness do so subsequent to release

from carceral facilities and *en route* to eventual reincarceration. Were the criminal justice system to extend its jurisdiction over this at-risk population to cover their immediate return back into the community, the end of involvement in the criminal justice system would not be marked by the completion of a sentence of incarceration, but by a reintegration into the community. The latter part of a person's sentence could be used for this, or the community housing and support services could extend beyond the sentence. This would extend reentry services and roll back the need for homeless services. It would also bring the resources of the criminal justice system to bear on reducing reincarceration and homelessness, and in this respect could take the housing expressly for this subpopulation beyond its current patchwork of "boutique" programs.

Extending the jurisdiction of the criminal justice system would not cover the entire subpopulation at risk for homelessness and incarceration. Even if the needs of those with proximate past histories of jail or prison were addressed through a separate reentry system, those who are homeless would still be at heightened risk for incarceration. The housing needs of those with identified conditions that are linked to homelessness and incarceration, most prominently mental illness, substance abuse and HIV/AIDS, should be addressed through interventions, with access to housing, in systems that target these specific populations. Those persons that remain, which should be a substantially reduced fraction of the at-risk population, would then be served through homeless services, with the view of housing as an outcome that would not only eliminate homelessness but also reduce the risk of incarceration.

In the absence of this partitioning of the subpopulation to different systems, homeless services will, by default, continue to act as a *de facto* reentry program. Homeless services have so far not responded sufficiently to this subpopulation. This, more generally, speaks to the need for flexibility in being able to establish programs that target new manifestations of homelessness, of which homelessness related to incarceration is one example. Currently, major federal homeless funding streams for new housing and services, primarily through HUD sources such as the McKinney-Vento program, are becoming less responsive to new initiatives as greater proportions of their resources become locked into continued funding of existing programs.

The third research objective is to explore dimensions of the relationship between homelessness and reincarceration that go beyond its current conception. An example of this is the extent to which family homelessness is linked to the incarceration of a parent or guardian. Incarceration is currently assumed to affect mostly homeless individuals, yet it may well manifest itself in family homelessness. Bringing families into this nexus is something that has heretofore largely been ignored, and research is needed to determine the extent to which such collateral impacts exist and the nature of their needs. Another example is the dynamic of this nexus in rural areas, which would explore and possibly challenge conventional thinking about both homelessness and incarceration as being urban problems. Finally, both homelessness and incarceration exact tolls on communities as well as on individuals and families. Research needs to look at the overlap of these two social phenomena from this perspective as well.

Conclusion

This paper has largely focused on presenting what is known about the nexus between homelessness and incarceration, and the approaches that have been developed to address these two interrelated phenomena. While awareness, knowledge, and response to this relationship have progressed substantially over the past decade, they are in many respects still in their initial stages. And while focusing on specifics, as is largely done in this paper, it is also important not to lose focus on the fact that incarceration and homelessness

interact in a context where, on one hand, millions of persons cycle through jails and prisons each year and face uncertain and tenuous prospects upon reentering the community and, on the other hand, the number of persons who experience homelessness each year also ranges into the millions. Ultimately, the answer to ameliorating the nexus described here is for conditions to change so that the overall rates of incarceration and homelessness decrease. In the absence of this, however, understanding and responding to the special challenges presented by this nexus is necessary for the benefits of both the people caught in its clutches as well as for the larger communities who ultimately must offer a means to reincorporate into its fabric those who have experienced homelessness and incarceration.

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Housing Models

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Abstract

This paper provides an overview of current housing and service models for programs serving people who are homeless and synthesizes the research on the efficacy of each model, what we know about which models work for whom, and the implications for preventing and ending homelessness. The authors begin with background on housing, poverty, and homelessness, including a discussion of changes in the policy and program context within which programs for homeless people operate that have affected housing models since the late 1990s. They then review the recent literature—both descriptions of program models and research on outcomes—focusing first on housing models for families and then on housing models for single individuals with disabilities. Finally, the authors suggest implications for preventing or ending homelessness and directions for future research.

Introduction

Housing is related to homelessness both as a cause and as a solution. Some families and individuals become homeless explicitly because of a housing crisis related to their extreme poverty and a lack of available housing at rents they can afford. For example, a family cannot pay the rent, is evicted, and can find no alternative housing or an individual is released from an institutional setting and cannot find affordable housing. Others are precariously housed with friends or relatives and lose their shelter in a crisis that involves issues such as mental or physical health or domestic violence. Still others have complex service needs and may spend years on the streets or cycling in and out of the shelter system for reasons that have little to do with their housing options.

Housing and Poverty

A well-documented shortage of affordable housing for the poorest American households—those with incomes below 30 percent of area median income, or roughly the poverty level—contributes to the flow of people into homelessness. The U.S. Department of Housing and Urban Development's (HUD) "worst case needs" reports show that there are millions of families and individuals homelessness who have low incomes, have no public subsidy to help them with their housing costs, and are paying more than half

their incomes for rent (HUD 2005).[1] Quigley and colleagues have shown that increases in over the past two decades are largely the result of increasing income inequality and a related increase in demand for low-cost housing (Quigley& Raphael, 2000; Mansur et al., 2002). Recent U.S. Census data cited by the Center on Budget and Policy Priorities indicate that more than 8 million households with incomes below 80 percent of the local median pay more than 50 percent of their incomes for rent. The number of such rent-burdened households has increased by 33 percent since 2000.[2] For some families and individuals, a severe rent burden is a temporary situation related to a short-term loss of income, but for many others it represents an untenable situation that can end in homelessness.

A recent Welfare-to-Work study evaluated the Housing Choice Voucher Program, the largest mainstream rental housing subsidy program, randomly assigning some welfare families[3] to receive housing assistance and others to a control group that did not receive assistance. Among those *not* using housing assistance, 12.5 percent reported that they had been literally homeless during the previous 12 months—that is, living on the streets or in a shelter—and 45 percent reported that they had at some point during the year been living temporarily with relatives or friends (Mills et al., 2006).

Regardless of the path taken to homelessness, the ultimate goal for every homeless individual and family is safe, affordable, and permanent housing. A system of housing and services for people experiencing homelessness has evolved to place people who become homeless into permanent supportive housing, to provide temporary emergency shelter to people who are homeless, and to provide time-limited housing to help people make the transition from homelessness to permanent housing. Services may include case management, mental health services, substance abuse treatment, or employment support to help them find and retain housing.

The topic of this paper is the various housing and service models that comprise programs for homeless people. At the same time, mainstream housing assistance programs have at least as important a role to play as the homeless service system in helping people to end their homelessness. Quigley and colleagues conclude that modest efforts to improve the availability and affordability of rental housing could substantially reduce homelessness in many communities (Quigley& Raphael, 2000; Mansur et al., 2002). Not surprisingly, in the Welfare to Work study cited above, using a housing choice voucher dramatically reduced both literal homelessness and the pattern of housing instability sometimes known as “couch surfing” (Mills et al., 2006).[4]

Almost 5 million units of federally subsidized rental housing reduce rent to 30 percent of a household’s income. These units can be used to help people exit homelessness, and sometimes they are, with documented success (Shinn et al., 2001). There is fierce competition for the limited subsidy slots from low-income people who are not homeless, however, as housing assistance is not an entitlement but instead is rationed through waiting lists (Khadduri & Kaul, 2005). The assisted housing stock has come

[1] Worst-case needs households are unassisted renters with incomes below 50 percent of area median income and paying more than 50 percent of their income for rent and utilities. The estimates produced periodically by HUD (and similar estimates published by the Joint Center for Housing Studies of Harvard University) are based on the American Housing Survey, conducted for HUD by the U.S. Census.

[2] See http://www.cbpp.org/2-1-07hous2.htm

[3] Families selected for the program were current TANF recipients, recent TANF recipients, and those eligible for TANF.

[4] See Quigley, Raphael, & Smolensky, 2001 for a similar conclusion based on econometric simulations.

under pressure in several ways over the past five years. First, the supply has been reduced because owners of roughly 300,000 privately owned, subsidized units have chosen to leave the subsidy program at the end of their contracts, have been subjected to foreclosure, or have come under enforcement action by HUD. In addition, there have been losses in the public housing stock because of deterioration or redevelopment. Finally, reductions in the number of households assisted by the voucher program has increased demand for public housing and project-based units from eligible households who might otherwise have received a tenant-based voucher.

Some formerly homeless families and individuals can rent mainstream housing without a subsidy because they are able to work and find jobs that lift them out of poverty, or because they live in communities where rental housing is relatively inexpensive, or both. However, many formerly homeless families and individuals do not gain the ability to pay for unsubsidized housing as part of their exit from homelessness. The shortfall of mainstream subsidized rental housing limits the ability of the homeless services system to achieve the goal of ending homelessness.

Housing Targeted to People Who Are Homeless

Within the homeless services system, three broad types of housing are targeted specifically to homeless families and individuals: emergency shelter, transitional housing, and permanent supportive housing. These three types—and specific models within each type—differ in their physical configuration, the expected tenure of the clients housed, and the degree of choice clients have in selecting where they will live. Each of these types also has its own set of funding streams. While a discussion of the financial models for developing and operating housing for homeless people is beyond the scope of this paper, it is important to note that the features of the different housing types may flow directly from the type of funding available.

Emergency shelters provide overnight shelter, often in a congregate setting. Some may be open during the day, as well. Services vary from minimal information and referral assistance to more intensive case management. Clients have little choice in the terms or conditions of a shelter stay, and the physical facilities may be less than ideal, especially for children. Transitional housing offers longer term but time-limited housing (typically 6 to 24 months), often in single household units or in smaller congregate settings with more intensive services. Clients may have some choice in where they live, depending on the scale of the program. Permanent supportive housing may be offered in these same physical configurations. It is targeted to persons with disabilities and offers intensive services on or off site, either by the same provider that operates the housing or through partnerships with community-based service providers. The level of choice about where to live depends on the program.

The approach to services varies among housing models. Services may be voluntary or required, on site or off site, intensive or limited—irrespective of the physical configuration, tenure conditions, or choice of location offered by the housing with which they are associated. The services offered may include housing search assistance, case management, support for finding and keeping a job, transportation assistance, mental health services, and substance abuse treatment.

Housing and service models for programs serving people who are homeless have become more diverse since the 1998 National Symposium on Homelessness Research. Three papers prepared for the 1998 Symposium addressed aspects of housing models. One paper described approaches to emergency shelter, while another reviewed transitional housing strategies (Feins & Fosburg, 1999; Barrow & Zimmer, 1999).

A third paper addressed the broader issue of reconnecting homeless individuals and families to the community, including approaches to fostering residential stability as well as employability and social connections (Rog & Holupka, 1999).

At the time, emergency shelter was viewed as an important first step in moving homeless people—especially families—to stable housing. At the same time, there was increasing recognition that not just shelter, but also services, were needed to help with that transition. The paper on transitional housing described the ambivalence of the policy and practitioner communities toward transitional housing. Its proponents argued that it was the best way to ensure homeless families and individuals received the services they needed to secure and maintain permanent housing. Detractors said it could be stigmatizing and ineffective if there was no next-step housing available at the end of the transitional program. The paper on reconnecting people who have been homeless with the community examined what was known about outcomes with respect to the different housing types and emphasized the importance of stable housing as a prerequisite to reconnecting to employment and social relationships. The paper also reviewed the substantial barriers to effective interventions.

As of the late 1990s, research on housing models and services was limited and inconclusive. Since then, housing and service strategies have evolved, and research and practice have delineated more sharply both the housing and the services components of housing models for homeless people. The key questions that have emerged are:

1. How quickly and how successfully do homeless families and individuals move to permanent housing?
2. Are supportive services voluntary or required, and does this make a difference in retention in the program and, ultimately, in housing success?
3. How independent is the permanent housing; that is, is it a private apartment or group setting? Are others who live there also program clients? Is there on-site or off-site support? What role do these features play in retention and success?

The rest of this section describes the changes in the policy and program context within which programs for homeless people operate and how these changes have affected housing models since the late 1990s.

Changes in Context Since 1998

Changes in the design and resources of mainstream programs that serve low-income people have had a substantial influence on the evolution of housing models for homeless people during the past decade. At the same time, priorities and program emphases for funding streams targeted specifically to preventing or ending homelessness, especially HUD's McKinney-Vento discretionary grants, have evolved along a number of dimensions. Finally, practices for serving homeless people have responded both to evidence and to changing philosophies and judicial decisions about how society treats its most vulnerable citizens.

Changes in income support and housing assistance. In some communities, the implementation of the welfare reform legislation enacted in 1996 had important effects both on patterns of homelessness among families with children and on the way in which providers think about serving families. Cash assistance is now temporary, and families reaching their TANF time limit or sanctioned for failing to comply with TANF rules are among those particularly vulnerable to housing instability (Mills et al., 2006). At the same time, providers helping families exit homelessness focus increasingly on stable

employment because of the temporary nature of assistance for those who do not work.[5] Some providers hope to see their clients leave homelessness with a wage high enough to pay for unsubsidized housing because of the increasing difficulty of gaining access to assisted housing.

The Housing Choice Voucher Program, the mainstream program best suited to providing permanent housing for homeless families, has become less available for that use over time due to budget cuts and shifting program priorities that reduce advantages that people leaving homelessness once had in competing for the limited number of subsidy slots. Access to HUD's assisted housing programs has become more difficult recently in many communities because "waiting priorities" for homeless families and individuals are no longer in effect. These priorities took two forms: (1) a "preference" on waiting lists for households experiencing homelessness that was equivalent to preferences for households with extreme rent burdens or living in substandard housing,[6] and (2) special allocations of vouchers reserved for clients of the homeless services system. In addition to the discontinuation of priorities for homeless people, admission policies have been tightened across assisted housing programs for people with criminal records or poor housing histories (whether previously homeless or not), making it more difficult to enter public housing and the voucher and project-based Section 8 programs (Khadduri & Kaul, 2005).

Furthermore, according to HUD data cited by the Center on Budget and Policy Priorities, the number of households assisted by housing choice vouchers fell by about 100,000 between 2004 and 2006.[7] Numbers of units in public housing and Section 8 projects declined starting in the mid-1990s. They were replaced by a comparable number of housing vouchers in the same communities, but more recently the number of vouchers has dropped as well, leading to an overall decline in the number of "slots" available in programs that permit people to pay no more than 30 percent of their income for housing.

For individuals, particularly people with disabilities, the picture is somewhat different. Supplemental Security Income (SSI) remains an entitlement, and providers have focused increasing attention on helping homeless people qualify for this important income source. Permanent supportive housing affordable to people who receive SSI continues to be produced by HUD's Section 811 program for people with disabilities; by the HUD McKinney-Vento grant programs; and by resources under the control of state and local governments, including funding from state mental health systems.

Some 4 million people receive SSI, yet housing that people with SSI can afford remains in short supply compared with the need. O'Hara and Cooper (2005) compared SSI income to the average cost nationwide of renting a one-bedroom apartment. In 2004, on average, a person receiving SSI needed to pay 109.6 percent of his or her monthly income to rent a modest one-bedroom unit. Like homeless families, individuals attempting to exit homelessness have been affected by the reduced availability of housing vouchers, public housing, and units in Section 8 projects that would help narrow the gap between incomes and housing costs.

The only federal housing program that has produced significant numbers of additional rental housing units since the 1998 Symposium, the Low Income Housing Tax Credit, has rents set at a fixed dollar

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[5] The Earned Income Tax Credit, available only for workers, has become an increasingly important income support for families with children.

[6] This preference was statutory and was repealed by the Quality Housing and Work Responsibility Act in 1998.

[7] See http://www.cbpp.org/3-13-06.htm

amount rather than as a percentage of a household's income, and those rents usually are not affordable for households with poverty incomes.[8] In addition, choosing to allocate tax credit resources to programs targeted to homeless people often means states must trade off using limited resources for people who are homeless against preserving or expanding housing for people who are low-income but not homeless.

Shifting priorities in HUD's homeless assistance programs. HUD funding for permanent and transitional housing for people leaving homelessness comes largely through two McKinney-Vento programs—the Supportive Housing Program (SHP) and the Shelter Plus Care (S+C) program.[9] As of the early 1990s, each program had its own Congressional funding authorization. The SHP funded transitional and permanent housing as well as services. S+C provided permanent housing for persons with disabilities. S+C program funds could be used only for rental assistance, while services had to be leveraged from other funding sources.

Beginning in the mid-1990s, HUD received lump sum McKinney-Vento appropriations instead of separate appropriation amounts for the SHP and S+C programs. Following that change, providers sought greater amounts of funding for eligible activities—specifically, transitional housing and supportive services programs—from the SHP program relative to the amount requested for permanent housing from both programs. For providers, SHP funding was one of a limited number of sources of services funding. Transitional housing was an attractive option because many providers did not have expertise in the development or management of permanent housing. As a result, the shift in the mix of transitional vs. permanent housing changed substantially. Whereas at one point more than roughly 60 percent of total funding was dedicated to permanent housing, by the late 1990s that percentage had declined to only 20 percent.

To renew emphasis on funding for permanent housing, Congress responded by mandating that at least 30 percent of McKinney-Vento funding (exclusive of S+C renewals) be used for this purpose. Concurrently, HUD began de-emphasizing the use of HUD McKinney-Vento funding for services by offering various incentives for applicants to use HUD funds for housing activities and mainstream sources for services. Recent HUD policies have also given continuums of care (CoCs) flexibility to "reprogram" existing McKinney-Vento funding during the renewal application process, which has prompted some CoCs to monitor more closely the effectiveness and outcomes of their housing and services programs. Given the scarcity of both mainstream and McKinney-Vento funding for permanent housing for homeless people, many CoCs are now working to redirect funding toward permanent housing.

There has also been an increasing emphasis on serving homeless people who are disabled. Since 2001, HUD's McKinney-Vento funding priorities have focused on addressing the needs of people who are chronically homeless. Through a federal interagency consultation process, chronically homeless people were defined as single individuals with a disabling condition who have been continuously homeless (on the street or in a shelter) for at least one year or have had at least four episodes of homelessness during the past three years. Many people meeting these criteria have histories of mental illness and co-occurring

[8] Some states have been able to put together the Low Income Housing Tax Credit and other funding sources to create permanent supportive housing for people with disabilities, but this is challenging because of the gap between the operating costs of housing and the rents that people with SSI income can afford. See Spellman et al. (2006).

[9] Emergency shelters are supported primarily by the formula-based Emergency Shelter Grants program. A third McKinney-Vento funded program is the Moderate Rehabilitation for Single Room Occupancy (SRO-MR) program, but this program has been little used in recent years.

substance use disorders. There are human and public benefits to having this population stably housed: safe, secure, affordable places to live for people who are chronically homeless and less strain on costly emergency services and institutional care systems.

Changing views on participation in services. At the same time that priorities were changing for public programs that serve low-income people in general and people who become homeless, so too were the models developed by practitioners for combining housing and services. Although not mandated by HUD, the model common in the 1990s in many communities emphasized providing services linked to a continuum of housing settings in which people moved from emergency shelter to transitional housing (typically for 6 to 24 months) and then to permanent housing. Requirements that residents participate in services to acquire and maintain housing were permitted, although not mandated, under HUD's Section 811, S+C, SHP, and Housing Opportunities for Persons with AIDS (HOPWA) programs.

During the 1980s and 1990s, the difficulty that people with mental illness had in accessing scarce mainstream affordable housing resources prompted a number of mental health systems (including those in California, Connecticut, Massachusetts, New York, Ohio, and Pennsylvania) and their service providers to fund their own housing programs. While these initiatives helped meet the need for housing, many of these programs came with "bundled" supports; residents were typically required to accept the services offered with the housing program, and the services often were co-located with the housing.

Some homeless people met the service participation requirements of this type of housing and moved successfully (not necessarily sequentially) through the continuum. Many, especially those with serious mental illness and/or substance abuse issues, were less successful. Some advocates said that housing and services should not be "bundled"; that is, participation in services should not be a condition of obtaining or maintaining housing, and housing should not be used to induce people to comply with services. This was a particular concern of advocates for people with mental illness, who saw this model as a continuation of coercive practices under which mental health systems "exercise enormous control over the lives and behavior of people with psychiatric disabilities" (Allen, 2003; see also Diamond, 1996; Carling, 1993).

Many providers of transitional housing would not agree that services should be voluntary. Most transitional programs mandate participation in services, considering it their mission to set goals that move the resident towards self-sufficiency and to use program services to reach the goals.

The Supreme Court's Olmstead decision. A landmark legal decision also figured into the evolution in housing and services models for people with disabilities. In 1999, the Supreme Court held in *Olmstead v L.C.* that segregating people with disabilities in state institutions may be discriminatory under the Americans with Disabilities Act and that states may be required to provide community-based services rather than institutional placements for persons with disabilities. Regulations promulgated by the Department of Justice to provide guidance on implementing the Court's decision clarified that: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities (28 CFR, Section 130(d))."

The Olmstead decision has had implications for both housing and services for people with disabilities, including those who are—or may become—homeless. On the housing side, states and the federal government have been encouraged to identify alternative housing for people in institutions who wish to live in the community. For example, HUD's ACCESS program provided voucher assistance to a set of

communities to test the concept of using vouchers to help non-elderly persons with disabilities move directly from nursing homes to permanent rental housing. The Olmstead decision is also credited with the creation of policies that promote the most integrated models of permanent housing for people with disabilities. For example, state policies encouraging sponsors of housing developed with Low Income Housing Tax Credits to set aside a percentage of units for people with disabilities have created integrated housing settings in California, New Jersey, North Carolina, Louisiana, and other states.[10]

On the services side, the Olmstead decision encouraged states to identify funding sources for community-based services. One source is Medicaid's Section 1915(c) Home and Community-Based Services Waiver program. This program gives HHS authority to waive Medicaid provisions in order to allow long-term care services to be delivered in permanent housing in the community instead of in institutional settings. Certain subpopulations of homeless people with disabilities may qualify for these services, depending on the state's Medicaid policies. Similarly, Medicaid's Medical Rehabilitation Option is used in some states to provide case management, health, mental health, and substance abuse treatment services.

Lessons from evidence-based behavioral health practices. In response to the perceived need for new models, policymakers and practitioners looked for housing and service approaches that had been tested and found effective, particularly for homeless people with mental illness and substance use disorders. The focus on evidence-based practices was particularly prevalent in the medical, mental health, and substance abuse treatment fields, in which the federal government, foundations, and researchers promoted clinical interventions that research studies had shown to be effective.[11] Within public mental health/behavioral health systems, the assertive community treatment (ACT) model gained credence as an effective way to engage homeless people with mental illness and substance abuse issues, a population that had been particularly challenging to serve in the emergency shelter and transitional housing programs of the 1990s.

In its pure form, the ACT approach uses multidisciplinary teams trained in mental health and substance abuse treatment, employability development, medical care, case management, and life skills training to reach out to homeless people on the street and in shelters to encourage them to enter more permanent housing. The service approach is client-focused and separates housing and other supportive services; that is, clients do not have to accept supportive services as a condition of entering or retaining housing. While not all communities have the resources to implement the ACT model in its pure form, aspects of the model, such as the emphasis on meeting clients "where they are," offering but not mandating services, and providing services *in-vivo* (either in the client's home or in the community), have been adopted in many communities even though it is not clear that piecemeal application of what is designed to be an integrated model would be as effective as full implementation.

Emergence of "housing first" models. The emphasis on permanent housing and on chronic homelessness, together with the success of approaches such as ACT to providing services to people with chronic mental illness and persistent substance abuse, encouraged a new paradigm for meeting the needs of this vulnerable population. In recent years, more providers have come to view the continuum of care not as a sequential series of placements but rather as a menu of options, any of which might be appropriate for any particular client. Among those options, housing first approaches are being tested that

[10] For further information on state LIHTC policies with respect to supportive housing, see Tassos (2006) and Spellman et al. (2006).

[11] For example, see http://www.mentalhealthpractices.org/index.html

emphasize rapid placement in permanent housing with no or minimal transitional placements or service requirements. Community-based support and treatment (some using the ACT team model or variations on it) help people maintain their housing.

The rapid housing placement aspect of the housing first approach is being used for both individuals with disabilities and families, although the service approaches differ somewhat. Programs serving single individuals with disabilities tend to focus heavily on housing placement and retention, with minimal service participation required either to enter housing or to retain it. Programs serving families also focus heavily on housing placement and retention up front, while typically also establishing service plans. Service plans are initially focused on the housing search process and short-term case management; once the family is in permanent housing, the plans focus on longer-term case management. Similar to housing first programs for single individuals with disabilities, service participation in programs serving families is typically voluntary. Engagement is a central component in working with both populations. Providers working with families must also take into account the needs and safety of children in determining how ”voluntary” service participation should be. The vulnerability of children to dangerous or abusive parental behavior makes the issue of voluntary services different for families who become homeless with their children than it is for people who become homeless without accompanying children. Further, when family reunification or preventing the loss of custody is a goal, the parent needs to show credible progress to the child welfare system.

Debate continues over the effectiveness of the housing and service approaches associated with housing first and which elements of the model are most important. More broadly, the evolution toward community-based housing and services approaches, driven by funding priorities and emerging evidence-based practices, has spurred increased interest in identifying which housing and services approaches work best for whom, but so far has not resulted in a commensurate level of rigorous research to provide answers to these questions. In the next section, we describe further the evolution of housing models and review recent research findings on the implementation of these approaches and what is known about their outcomes for clients.

Synthesis of Research Literature: Findings and Discussion

Research indicates that housing with services, especially for homeless single adults with serious mental illness, increases housing tenure, reduces hospital stays, and reduces homelessness (Rog, 2004). However, conducting rigorous research on how this comes about and which models are most effective is extremely challenging. Random assignment studies are rare, and even well-matched comparison studies are difficult to construct and implement. Further, measuring both the interventions and the outcomes across programs is very complicated. Developing reliable, replicable measures of the housing provided and the services received is problematic given the diversity of program approaches, housing market conditions, staff capacity, and other variables that are beyond researchers’ control.

These factors make it very difficult to answer the question foremost in the minds of policymakers and program administrators: what works best for whom? In this section, we attempt to shed light on this complex question by describing a broad range of program models for families and individuals, from those providing short-term or transitional housing and services interventions to those designed to provide permanent housing and long-term supports. We review the unfortunately quite limited research findings on the outcomes of those models.

Housing Models for Programs Serving Homeless Families

Advocates for homeless families are quick to point out that most Americans underestimate the extent to which homelessness affects families. About 600,000 families and 1.35 million children experience homelessness each year, and about half of the homeless population are part of a family. A homeless family typically comprises a woman in her late 20s who becomes homeless together with young children (Burt et al., 1999). In many ways, homeless families are similar to other low-income families that are not homeless. Their limited incomes make it difficult to find and keep housing that is safe and affordable, they face stagnant wages for workers with few skills, and they may be affected by welfare time limits or sanctions under Temporary Assistance for Needy Families (TANF).

HUD's Supportive Housing and Shelter Plus Care programs serve substantial numbers of homeless families.[12] However, given the greater emphasis in recent years on addressing the needs of homeless single individuals, the need to devote a major portion of McKinney-Vento grant funds to renewing funding for existing grants rather than placing additional units under subsidy, and the reduced availability of mainstream assisted housing, fewer new permanent housing resources are available for homeless families.

Programs serving homeless families range from short-term assistance to shorten or avert shelter stays for families experiencing a crisis to long-term permanent supportive housing for families with complex supportive service needs. In addition, non-residential service providers, such as housing resource centers, housing locator services, and housing counseling agencies, may play important roles in helping people who are homeless or at risk of losing their housing to locate and retain stable housing.

In the following sections, we describe a number of approaches to assisting homeless families and review the evidence, where available, on the efficacy of each. However, services provided by residential programs for families are so diverse in their nature and intensity that it is difficult to identify a model used in different communities that links housing to a particular set of services in a particular way. This points to the need for rigor in classifying the housing and support services provided according to exact type and range, frequency, and duration.

Short-term assistance. Modest levels of financial assistance to families who are precariously housed or newly homeless have been used to help families that are experiencing a short-term crisis. For example, Portland, Oregon's Transitions to Housing Program provides short-term emergency rent assistance to 400 individuals and families annually. The clients served may be homeless or at risk of homelessness; all have family-size adjusted incomes of no more than 20 percent of area median income. The average total assistance per household is $1,285. According to program data, this relatively small amount of assistance allows 70 percent of households to stabilize and remain in permanent housing for at least six months after intake (City of Portland, Oregon, 2004).

In the Minneapolis/St. Paul area, Hennepin County administers a state-funded Family Homeless Prevention and Assistance Program (FHPAP) through a network of providers. The legislation creating

[12] As noted elsewhere in this paper, Shelter Plus Care serves families only if the head of household meets the S+C program's disability criteria. Persons in families account for roughly 40 percent of persons served in the S+C program.

FHPAP established a set of intended outcomes, including preventing first-time shelter stays, reducing the length of shelter stays, and eliminating shelter reentry.

Prevention services are targeted to families that are threatened with housing loss because of nonpayment of rent, but for whom a resolution to the crisis is within reach. Case workers assess the amount of rent owed and the family's resources, credit history, rental history, and other circumstances to decide how much assistance the program will provide and what the family can contribute. Case workers also work with families for up to six months on budgeting, determining whether a move is necessary (e.g., to a smaller apartment), and other issues to ensure the family remains housed.

According to program data cited by Burt and Pearson (2005), FHPAP's screening system and prevention activities have reduced the average duration of shelter stays by one-half and reduced the daily census of families in shelter by 63 percent. The program's 2003 annual report (also cited in Burt & Pearson) shows that 95 percent of families in the prevention component did not use shelter within 12 months. The average cost to the county per family was $472.[13]

Illinois, the District of Columbia, and Massachusetts also have begun testing strategies that divert families from becoming homeless or use short-term assistance to help them exit homelessness. Illinois's Homeless Prevention Program, administered by the Department of Human Services (DHS), provides short-term rent and utility assistance and supportive services to families that are homeless or at imminent risk of homelessness. Program funds can be used for up to three months back rent to prevent eviction, up to two months rent or security deposit, and services such as housing location/inspection, job search, counseling, and case management. According to the DHS Web site, some 10,000 families were served by the program in 2004.

In the District of Columbia, all families entering the homeless services system go through a central intake center that focuses on resolving the crisis that is about to make the family homeless. Those who cannot be stabilized in their current housing but can stay there for at least 30 days are referred to a grant program that provides intensive case management, housing search assistance, and short-term assistance such as deposits and first month rents. Only families considered unlikely to succeed in a rapid housing placement are placed in emergency shelter. Factors considered in this assessment include current substance abuse, uncompensated mental illness, and whether the head of household has ever been employed and has ever been a leaseholder.[14]

In Massachusetts, the rising costs of emergency shelters and the need for additional space in even more costly motels had increased the annual cost of sheltering a homeless family to an average of $47,000 by 2004. In response, Massachusetts implemented several pilot projects to explore alternative approaches to helping families find or retain housing. According to state data, three pilot programs kept 1,119 families housed for the same cost as 63 shelter rooms. The Rental Assistance for Families in Transition (RAFT) program provided flexible funds for first/last month rents, security deposits, or utility payments. Some 436 families were assisted over a two-month period at an average cost per household of $1,365. Similar assistance was provided to families eligible for the state TANF agency's emergency assistance program,

[13] The study also notes that the county has an extensive data system that allows it to monitor provider performance to ensure that program contracts are awarded to providers that are achieving target outcomes.

[14] Source: interviews conducted by one of the authors as part of a HUD-sponsored study of the costs of homeless services.

helping another 476 families avoid homelessness or shorten a shelter stay, at an average cost of $3,080 per family. Finally, under the Shelter to Housing Pilot, 207 families were assisted with a one-time subsidy of $6,000 to cover rent and some stabilization services such as job search and household budget assistance. Two years later, 80 percent of the families were still housed (One Family, 2006).

None of these programs for using short-term assistance for prevention or rapid exit from homelessness has been studied using a rigorous evaluation methodology that controls for family characteristics and examines long-term outcomes. Therefore, we do not yet know how to distinguish families who can benefit from this approach from other types of families, nor can we assess the costs and benefits of short-term assistance compared with more expensive approaches to placing families in permanent housing. Nonetheless, preliminary evidence from program records suggests that short-term housing assistance can play an important role in reducing and ending family homelessness.

Transitional housing. Many communities continue to consider transitional housing to be an effective strategy for helping families secure and retain permanent housing. Since 2000, the Sound Families program sponsored by the Bill and Melinda Gates Foundation has supported the development of 1,100 units of service-enriched transitional housing for families that have experienced homelessness in Pierce, King, and Snohomish Counties in Washington. Several housing authorities in the region have allocated project-based housing voucher assistance to the Sound Families projects to make them affordable to homeless families and financially viable for project sponsors.[15]

Sound Families provides supportive services during the transitional housing stay and assistance in moving to permanent housing, which can be public housing or private rental housing supported by a tenant-based voucher subsidy. In some program sites, a "transition in place" option allows families to continue living in the same complex (if not the same unit) where their transitional housing unit is located.

Preliminary results from an evaluation of 10 sites participating in the Sound Families program (Bodonyi & Erwin-Stewart, 2005; see also www.gatesfoundation.org/AboutUs/OurWork/Learning/SoundFamilies/) show that, of 139 families interviewed at intake, 80 percent remained in transitional housing until they graduated from the program. The average length of stay was 12.7 months. The researchers found increases in employment, from 27 percent employed full- or part-time at baseline to 41 percent at exit. These outcomes compare favorably with other social programs. Receipt of TANF benefits declined from 62 percent at baseline to 46 percent at exit. Children benefited as well. Some 80 percent of parents said their oldest child was doing "very well" or "excellently" in school six months after exit compared to 52 percent who said so at intake. The proportion of children attending more than two schools in the previous year declined from 53 percent at intake to 5 percent at exit.

Some 86 percent of families secured permanent housing at exit from their transitional program, and 89 percent continued to reside in permanent housing six months after exit. Of the 14 percent who were evicted or asked to leave their transitional housing unit, most had mental health or chemical dependency issues the program was not designed to address. A pilot program to provide permanent supportive housing that does address these issues is under development.

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[15] Public housing authorities administering the voucher program may "project-base" a portion of their vouchers. Voucher assistance, whether tenant based or project based, typically can be used only for permanent housing. The PHAs providing project-based vouchers to the Sound Families program have additional flexibility in this regard under the demonstration authority known as Moving to Work.

Many transitional housing programs have a primary focus not on getting the highest-needs families ready for placement into permanent housing, but on other objectives, such as employment, income growth, and better life chances for children. Some transitional housing providers admit only families deemed able to take advantage of services the transitional housing program offers. They may screen out families with severe mental illness, current chemical dependency, or no employment history. Many transitional housing providers describe their programs in this way, and a recent analysis of patterns of use of emergency shelter and transitional housing in Philadelphia and Massachusetts suggests that such screening is common. The study found that the families with the longest stays in residential facilities within the homeless services system (most long stays were in transitional housing) were less likely to have histories of inpatient behavioral health treatment, had lower rates of disability, and had higher rates of employment than families with shorter stays (Culhane, 2006).

A recent survey of HUD-funded transitional housing programs for families shows that, although most programs screen out families with active substance abuse and about a third of programs would not accept families with severe and persistent mental illness, the families served have high needs. About one-quarter of parents take psychotropic medications for mental or emotional problems, and at least as many have histories of drug abuse. Addiction relapse is the primary reason for families being asked to leave transitional housing programs (Burt, 2006).

This study also collected information about housing outcomes for transitional program participants. On average across the 53 programs surveyed, 70 percent of families exited to permanent housing. More than one-third (36 percent) went to unsubsidized mainstream housing, while 22 percent left for housing with a rent subsidy, and 13 percent went to permanent supportive housing. A subsequent phase of the study will attempt to relate these and other outcomes to the different characteristics of transitional housing programs, such as whether the program provides scattered-site housing, whether it permits transition in place, and the program's staffing levels (Burt, 2006).

Permanent supportive housing. Permanent supportive housing for families may take several forms. The "transition in place" model mentioned above may offer security of tenure by allowing a family to stay in what is initially treated as a transitional placement while continuing with case management support and other linked services. HUD's Shelter Plus Care (S+C) program provides permanent supportive housing to families if the head of household is disabled. S+C may be used to provide tenant- or project-based rental assistance. Regardless of the form of the rental assistance, the organizations that receive Shelter Plus Care funding must provide services that, in the aggregate, are equal in value to the value of the S+C rental assistance. S+C rental assistance is often used to provide the housing component of programs created by mental health or substance abuse treatment providers for their clients.

A study of San Francisco's Family Permanent Supportive Housing Initiative (FPSH) offers lessons from permanent housing programs designed to serve families with the kinds of supportive services needs that the Sound Families transitional housing programs had difficulty addressing (Nolan et al., 2005). The seven programs studied offer access to affordable permanent housing and *voluntary* services to address mental health and addiction issues as well as a variety of health and social services for adults and their children. The housing situations varied across the seven programs and included scattered-site units; buildings dedicated to homeless families; and "mixed" buildings housing low-income people, only some of whom had been homeless. Residents reported high levels of satisfaction with their living environments as well as with the services they received. According to the researchers:

> No single program model appears to be significantly better than any other at helping tenants achieve the primary goal of housing stability, as long as the model succeeds in creating an atmosphere of respect and trust among tenants and staff and is able to provide the resources that tenants need.

According to program staff, services for children are an important component of permanent supportive housing for homeless families. Many mothers in these families have been separated from their children at some point in their lives, and housing stability with their children is an important objective for residents.

A 2006 study prepared by the National Center on Family Homelessness combined results from a number of studies of permanent supportive housing programs for families to identify client and program characteristics and client outcomes and to assess whether certain combinations of program characteristics are associated with improved client outcomes (Bassuk, 2006). The study examined 13 programs, all located in the San Francisco area or in Minnesota. The researchers assembled data on program context, housing arrangements, program control (that is, strictness of program rules for participation), the range of services available for adults and children, and the intensity of adult services (derived from the number of households per case manager and services per family per month). Participant outcomes in terms of residential stability, family reunification, and self-sufficiency were ranked as "high," "medium," or "low" for each program.

Although the authors caution that the analyses are limited by inconsistencies in the data collected across studies, the high control programs seem to have better reunification and self-sufficiency outcomes, but their attrition rates are high. By contrast, low control programs may have higher residential stability but are not as successful at helping families reunify or move to greater economic self-sufficiency.

Housing First for Families

Other lessons on serving homeless families may be drawn from the program operated by Beyond Shelter in the Los Angeles area. Beyond Shelter's "Housing First" Program for Homeless Families began in 1988 and has been widely cited as a model for serving families with extensive supportive services needs (www.beyondshelter.org/aaa_programs/housing_first.shtml). The housing first approach in this program, as in other programs that use that name, emphasizes rapid placement in permanent housing while minimizing or avoiding transitional stays. Beyond Shelter helps families move from emergency shelters to permanent affordable rental housing scattered throughout residential neighborhoods and provides 6 to12 months of follow-up case management and services. Most families receive voucher assistance through a local housing authority, and the program provides assistance with moving expenses.

According to program administrators, three-quarters of the families served would be considered multi-problem families with unstable living patterns. Families and their case managers develop Family Action Plans to guide services. Services are provided by agencies other than the housing authority and focus on helping families retain their housing. Beyond Shelter has some aspects of a transition-in-place model, because services continue for a defined period after the housing placement. However, the families have security of tenure in their housing placement, which contrasts with many transitional programs that can evict families who do not cooperate with their services plan.

A two-year evaluation of Beyond Shelter's "Housing First" Program was conducted by local researchers from the University of Southern California as part of a Pew Partnership initiative. Data on 185 families

were collected from April 1, 2000 to October 1, 2001, based on the Substance Abuse and Mental Health Administration (SAMHSA) Program Logic Model for Homeless Families.[16] Outcomes identified by the model include increased residential stability, improved mental health functioning, reduced drug and alcohol use, and increased trauma recovery. For children, outcomes include reduced emotional and behavioral problems and improved school attendance.

The study found that more than 90 percent of the mothers who graduated from the program at the end of six months in permanent housing had achieved the short, intermediate and long-term goals identified in the SAMHSA model, and more than 80 percent of the children's goals were achieved. More than 80 percent of adults were employed, and others were enrolled in job training programs. Only 2.3 percent of those who entered the program with reported substance abuse problems had relapsed, and less than 1 percent of domestic violence survivors had returned to a dangerous relationship. Some 80 percent of children were enrolled in school during the evaluation period and 77 percent attended regularly.

Hennepin County, MN, developed a shelter screening and admission system to limit access to shelters to the families that need the most help. Pregnant or parenting teens, families with more than two children or with infants, and families receiving SSI receive priority for shelter space. Within one to three days, shelter guests meet with the rapid exit coordinator for an in-depth screening that focuses on housing barriers. The family is then referred to a separate rapid exit program where a caseworker works with the family to develop a housing stabilization plan. Continued shelter stay is contingent on the family cooperating with the caseworker and the plan. The caseworker focuses on helping the family find housing and coordinates with other service providers to address other needs. Follow-up continues for six months after the family leaves shelter. Some 88 percent of families served in the rapid exit component did not return to shelter within 12 months; the average cost per family for this component was roughly $800.

Without a comparison group drawn from a similar emergency shelter population or a population placed into transitional housing with tenure dependent upon cooperation with services, it is difficult to place these outcomes in context. Nonetheless, both the Hennepin County and Beyond Shelter programs seem to demonstrate that rapid placement into permanent housing is feasible for high-needs families.

Housing Models for Programs Serving Single Individuals

Over time, homeless assistance programs have served single individuals who are homeless for various reasons—from people who are working but experiencing a short-term crisis to those who are experiencing long-term homelessness and have complex service needs. Given the recent emphasis on addressing chronic homelessness, permanent and transitional housing programs serving single individuals who are homeless usually focus on people with a disabling condition such as mental illness, physical or medical disability, substance use disorder, or HIV/AIDS. Permanent housing funded under the McKinney-Vento Shelter Plus Care program can only be used for people with disabilities.

Emergency shelters often do not have an explicit focus on people with disabilities in their admissions process, but people with disabilities are heavily represented among those who use shelters frequently or for long periods. Homeless individuals with disabling conditions are considered particularly difficult to serve, especially if they have been homeless for extended periods and the symptoms of their disabilities have gone untreated.

[16] http://www.endhomelessness.org/best/beyondshelter.html

Programs designed to serve these populations may take several forms. Because these are some of the most vulnerable people, some communities have emergency shelter programs specifically designed for them. Safe havens, which can be permanent or transitional housing, are designed to serve chronically mentally ill people who are homeless and who have been reluctant to enter the shelter system. Safe havens offer housing and make services available but in a low demand environment.

Transitional housing programs may provide "next step" housing to clients with substance use disorders after they have completed detoxification to prepare them for mainstream permanent housing without intensive supports. A permanent supportive housing program is sometimes used as a further "next step" for homeless individuals after a transitional program, but often is offered directly to homeless people coming from the streets or from emergency shelters under one or another variant of a housing first approach.

Research has shown that persons with severe mental illness who are offered the opportunity to live in permanent supportive housing experience reductions in shelter use, hospitalizations, length of stay per hospitalization, and time incarcerated (Culhane et al., 2002; Martinez & Burt 2006; Mayberg 2003). There has been some disagreement, however, on which model works best for this population: a model that requires clients to move through two or more housing placements before achieving permanent housing, or a housing first model that places clients directly in permanent housing with community-based supports.[17]

Safe havens. Safe havens may be the first step off the streets for some of the most severely mentally ill homeless people. The Ward Family Foundation (2005) surveyed safe haven programs to collect information on program characteristics and effectiveness in transitioning safe haven residents to permanent housing. Seventy-nine of the 118 programs identified (about 85 percent of which were HUD-funded) responded to the survey. The findings on program characteristics are consistent with what we expect safe havens to provide. The programs serve people who are extremely vulnerable—mentally ill and homeless—and rarely refuse admission to anyone who meets those criteria. Participation in services or activities is rarely imposed. Most programs (72 percent) have no limit on length of stay; with the average length of stay among programs surveyed 262 days.

The program administrators surveyed said that, overall, just over half their residents exit to some kind of permanent housing, while about 14 percent return to homelessness. The most common reasons cited for residents not moving to permanent housing are that the resident's condition is too unstable (64 percent), the community lacks housing with appropriate supports (63 percent), and the community does not have subsidies to make the housing affordable (59 percent).

The researchers identified the characteristics of programs that had a high rate of successful referrals to permanent housing based on results from 15 programs that achieved an average referral rate of 85.2 percent. This compares to an average referral rate of 41.6 percent for the remaining 64 programs. The programs with higher successful referral rates were smaller, more likely to offer private rooms, and more likely to operate at full capacity. These programs were more likely to require that clients come from the street and be severely mentally ill, but were also more likely to refuse admission to clients with felony or sexual violence convictions. The proportion of programs with a rich variety of services offered on site appears higher in the group with higher referral rates. The programs with higher referral rates had only a

[17] For a summary of this debate, see Brown (2004).

slightly higher average annual cost per bed ($43,089 compared to $41,534 for those with lower referral rates).

Transitional programs. The concept of transitional housing grew out of halfway houses for people released from prisons or mental institutions. HUD's transitional housing program began as separate from the permanent housing program. Both were later brought under the Supportive Housing Program component of the McKinney programs, although each with its own set of distinguishing rules (Burt, 2006). However, there was not a strong theoretical framework for applying this concept to homeless individuals. Only recently, with transitional housing challenged by shifting federal funding priorities and by the housing first model, have researchers begun to create a theory of transitional housing that goes beyond the simple McKinney-Vento programmatic rule that a transitional housing stay may not last more than two years.[18] Much of the research on outcomes for individuals participating in transitional programs focuses on comparisons of supportive housing programs serving homeless individuals with mental illness (who often also have co-occurring substance use disorders and other disabilities) with traditional mental health treatment without a housing component. There have been few studies of transitional programs that compare them to other housing models.

Analysis of data on transitional housing has emphasized the rate of placements in permanent housing. This is one of HUD's GPRA performance measures for the McKinney-Vento programs, with a current goal that 61 percent of those exiting HUD-supported transitional housing be placed in permanent housing.[19] An early study of the Supportive Housing Program, when it was funded as a demonstration, provided qualitative evidence that the housing and supportive services offered clients in transitional housing contributed to successful placement into permanent housing for 56 percent of clients studied (Matulef, et al. 1995).

Evaluations of local Supportive Housing Demonstration programs in Boston, Chicago, and Michigan also yielded promising findings on housing stability, although little change in the level of functioning of the clients served was observed. For example, as described in Brown (2004), in 1995, 114 undomiciled patients of a state psychiatric hospital in Chicago were randomly assigned to a supportive housing program (n=48) or to a controlled treatment (n=47) that provided links to whatever community service was available and no ongoing case management. According to data from case managers, experimental group participants were more than twice as likely to be housed. At six-month follow-up, none of the experimental group had returned to homelessness and 68 percent of the experimental group remained in supportive housing.

Permanent supportive housing. In contrast to the paucity of research on transitional housing programs for individuals with disabilities, a number of studies of permanent supportive housing have looked at both housing outcomes and service approaches.

A recent evaluation of the Connecticut Supportive Housing Demonstration Program examined the supportive housing concept in mid-sized cities such as New Haven and Hartford as well as in smaller communities such as New Britain and Middletown (Arthur Andersen, LLC and University of

[18] See Burt (2006). This study focuses on transitional housing for families, not individuals.

[19] This indicator applies to all "participants," including adult individuals, heads of families, and unaccompanied youth.

Pennsylvania, 2002). The Connecticut demonstration served people who were homeless or at-risk, many of whom also had mental illness, histories of addiction, or HIV/AIDS. The purpose of the study was to assess whether stable housing reduces the need for expensive social services over time, enhances residents' quality of life, and allows residents to attend to employment and vocational needs. Connecticut's supportive housing approach provides permanent housing in which participants hold their own leases in projects developed by the state with multiple state, federal, and private funding sources. Some services are offered on site, but participation is voluntary.

Findings on client outcomes from the 4.5 year study included that tenants decreased their use of costly acute care health services while increasing their use of necessary routine and preventive health care, compared to their use of those services before they were placed in permanent supportive housing. Tenants were satisfied with most aspects of the program, functioned at high levels, and were able to move toward greater independence. Employment increased modestly. Of some concern, however, was that about 39 percent of the tenants exited housing during the study period, and 36 percent of leavers (14 percent of all tenants) left under negative circumstances. The researchers found that the negative departures were associated with substance abuse, some aspects of functioning (e.g., self care, daily chores, using transportation), not working toward goals in life, unemployment, and social isolation, but cautioned that the small sample sizes did not permit conclusive analysis of reasons for leaving.[20]

The state of California has devoted substantial resources to serving vulnerable groups who had been inadequately served, including people who are seriously mentally ill and homeless, insufficiently housed, or returning from jails or prisons. The programs are known as AB2034 programs after the section of legislation that funded them. Mayberg (2003) found the programs resulted in reductions in homelessness, emergency room use, hospitalizations, and incarcerations. In a study prepared for the Corporation for Supportive Housing, Burt and Anderson (2005) found that clients with stable housing were more likely to stay enrolled in the program—that is, to stay engaged in mental health services. Housing approaches vary across the 53 programs operating in 34 counties; AB2034 funds can be used for housing development, securing dedicated voucher assistance from PHAs, or providing ongoing rental subsidies through Shelter Plus Care or state funds. The program has achieved promising outcomes in helping clients, including those deemed "hard to serve," obtain and retain housing, The researchers note that:

> Programs with a high proportion of consumers who are homeless, recently incarcerated, or diagnosed with a co-occurring substance use disorder have similar outcomes to other programs… [T]he data [also] show that those who disenroll from the AB2043 programs are no more likely than current enrollees to have lived on the streets, been incarcerated, or have a diagnosed substance abuse disorder.

An evaluation of the Closer to Home Initiative offers insights into the outcomes of six programs designed to engage and house people with disabilities, long histories of homelessness, and repeated use of emergency services (Barrow et al., 2004). The six programs are located in four cities: three in New York and one each in Chicago, San Francisco and Los Angeles. The purpose of the study was to describe the

[20] The study's analysis of the financial stability of the supportive housing developments indicated that the costs of departures to the projects in terms of lost rental income were not great enough to cause concern.

program models, document implementation over time, and assess outcomes for an initial cohort of participants.

The Closer to Home programs fell into two general program models. Three programs attempted to engage long-term residents of shelters or lodging houses to encourage them to move to permanent housing.[21] The results of the assertive engagement efforts at these shelter/lodging house programs were modest:

> The programs developed relationships with most residents, provided a range of direct services, and initiated housing referrals for a substantial proportion of the individuals at the sites. But engagement in complex services and housing remained low, and most residents still lived at the sites two years later. Moreover, the predictive analyses failed to confirm that building relationships with long-term residents would improve housing outcomes—a key premise of these programs—but did show better outcomes for residents who had entitlements and who became engaged around housing. . . . [T]hose who had been homeless longest were least likely to be housed, indicating a need to prevent long-term homelessness at earlier stages.

The other three programs provided housing to adults referred from various community service providers; the emphasis in the services provided by these programs was on housing retention. The housing settings included buildings housing only program clients and buildings with a mix of program clients and other residents. In all cases, the service approach was characterized as "low demand," although one of the three programs screened prospective residents for those willing to participate in services and accommodate its building's "clean and sober" environment.

In the three programs that provided housing directly, housing outcomes were more promising than the outcomes of programs that focused on engagement and referrals to permanent housing. After two years, more than half (55 percent) of the residents in the shelter/lodging house programs were still at their original location, and 18 percent had moved to other temporary settings. Only 25 percent had moved to longer-term settings, defined by the researchers to include permanent housing, transitional housing, adult homes, or nursing homes. By contrast, in the programs that provided housing, 77 percent of residents remained housed, and a large majority of tenants were engaged in clinical or social services. Mental health referrals significantly increased housing stability, according to the researchers, who further conclude: "Across diverse housing approaches for homeless individuals with long-term homelessness and other barriers, housing works."

Despite these promising findings, there have been concerns about the fact that departure rates from permanent housing are as high as they are. In 2004, according to data reported by HUD-funded permanent supportive housing providers, roughly one-quarter of residents in HUD-funded permanent housing that year left after stays of two years or less. A recent HUD-sponsored study explored the reasons residents may leave permanent supportive housing programs (Morris Davis and Company, 2006). The study focused on programs serving people with serious mental illness. The researchers examined patterns among participants in 28 permanent housing programs in Philadelphia. Based on patterns observed

[21] The lodging house selected for study was not a typical shelter, but rather a former flophouse that had been leased by a nonprofit service provider offering lodging to single men in small cubicles. When the study was getting underway, the service provider had plans to redevelop the property as a drop-in center, and thus needed the lodging house residents to relocate.

among a cohort of people who entered permanent housing in 2001, the authors estimate that only half of those entering permanent housing would maintain residency for three years or more. More than 10 percent of the 2001 cohort left within six months.

The researchers found that about one-third of leavers were "positive leavers" who went to stable alternative housing. The remaining two-thirds were non-positive leavers who went to congregate settings, institutional settings, homelessness, or other unspecified destinations. Some 61 percent left voluntarily, while the remaining 39 percent left involuntarily. Positive leavers tended to leave in order to improve their living situations. Negative leavers had more severe levels of mental illness, greater incidence of substance abuse, and higher supportive services needs. The study authors encourage initial and on-going monitoring of permanent housing residents to identify and address issues for those most at risk of leaving under negative circumstances.

Housing first. The recent interest in the housing first approach as applied to homeless individuals with disabilities has led to studies of programs that move the most vulnerable homeless people rapidly to permanent housing with limited or no transitional placements. A number of studies have been published on the Pathways to Housing program in New York City (Tsemberis & Eisenberg, 2000; Padgett, Gulcur & Tsemberis, 2006; Siegel et al., 2006). In the Pathways program, participants are offered scattered-site permanent apartments with limited or no transitional stays. Neighborhood-based, multidisciplinary support teams work with clients to maintain their housing and, if the client chooses, address other supportive services needs. A study comparing the outcomes of homeless persons with serious mental illness placed in community residential treatment facilities (where service participation and sobriety are typically required to obtain and retain housing) with those in the Pathways to Housing program found that the Pathways to Housing supportive housing approach resulted in greater housing stability. After five years, 88 percent of Pathways to Housing participants remained housed, whereas only 47 percent of the residents in the residential treatment system remained housed (Tsemberis & Eisenberg, 2000).

In a HUD-sponsored study, researchers examined outcomes in the Pathways to Housing program along with two other programs that have adopted the housing first approach—Downtown Emergency Services Center (DESC) in Seattle and Reaching Out and Engaging to Achieve Consumer Health (REACH) in San Diego (Pearson et al., in press). The three programs share some features: they serve clients with severe mental illness (including many with co-occurring substance use disorders) and long histories of homelessness; they offer permanent housing with access to a wide variety of services, but service participation is voluntary; and efforts to provide services continue even if the client leaves program housing for as long as 90 days. The housing types vary, however. While Pathways to Housing leases scattered-site units in privately owned buildings, DESC offers housing in several buildings the organization owns or controls. REACH (a program funded by California's AB2034 program discussed above) has access to (but neither owns nor controls) a variety of housing units funded by Shelter Plus Care subsidies, project-based Section 8, and state funds. Some units are clustered in a safe haven and several downtown SRO buildings, while others are scattered site-apartments in complexes throughout the county. While REACH does not require service participation, a number of the housing providers associated with the program do have occupancy rules regarding alcohol and drugs, curfews, noise, and other issues.

The researchers tracked 25 to 29 clients at each site for 12 months to examine housing tenure patterns, among other outcomes. Overall, the programs had similar outcomes, but the findings reveal that there are nuances to housing stability. While a large majority of clients (84 percent) were still housed at the end of

12 months, not all had stayed in program housing throughout the tracking period. Across all three programs, 43 percent of the clients stayed in housing for the full 12 months. Some 41 percent experienced at least one departure to another living environment, but returned to program housing. The remaining 16 percent left or died during the follow-up period. The researchers did not observe substantial changes in clients' mental health or substance use status, but this was not expected given the relatively short follow-up period. As has been seen in other studies, clients who entered housing from the streets and had more severe psychiatric impairment or co-occurring substance use disorders were more likely to leave.

The San Francisco Department of Public Health's Direct Access to Housing (DAH) program offers another housing first approach. DAH provides permanent housing with on-site supportive services for formerly homeless adults, most of whom have mental health, substance abuse, and chronic medical conditions. The program is targeted to "high users" of the city's public health system and describes itself as a "low threshold" program that accepts single adults into permanent housing without requiring service participation or abstinence from substance use. The housing consists of 876 units that include nine SRO hotels, three newly developed buildings, and one licensed residential care facility (or "board and care"). The program also secures blocks of units in several buildings owned by nonprofit providers. To access this large stock of housing, DAH has identified buildings that are vacant or nearly vacant and then negotiated with the owners to renovate the buildings in exchange for entering a long-term lease with DAH. When a building is ready for occupancy, DAH contracts with service providers to provide on-site services.

The DAH program pays particular attention to health outcomes, given that the program targets high users of emergency services. According to program data, emergency department use was reduced by 58 percent after program entry. In the two years after program entry, participants had 57 percent fewer inpatient episodes compared to the two years prior to program entry. Numbers of days of hospitalization also declined for participants with histories of mental illness and psychiatric hospitalization (Trotz, 2005).

Research comparing service approaches in permanent supportive housing. Researchers have attempted to tease out the roles of different housing and services models for permanent supportive housing in affecting tenure outcomes. One small-scale, New York City–based study conducted interviews with 224 residents from 10 developments financed by the Enterprise Foundation; the researchers also used case management data. Most residents in the study had their own apartments with kitchen and bathroom, and paid subsidized rents. On-site and off-site services were offered, but not mandatory. The study found positive outcomes in housing stability, as well as increased incomes and strong client satisfaction with services (Bayer & Barker, 2002).

In a larger study of homeless persons with severe mental illness served in the New York, New York Initiative,[22] Lipton and colleagues (2000) followed a total of nearly 3,000 persons placed in high-, moderate-, and low-intensity housing for a period of five years. Intensity levels were determined by the researchers and refer to the degree of structure in the program, including the level of scheduling, house rules, and requirements for program participation. The degree of clients' independence, including control

[22] The New York, New York Agreement was a response to the lack of housing for homeless persons with serious mental illness in New York City. Implemented in 1990, the agreement was to place 5,225 homeless persons with serious mental illness into housing and to develop 3,314 units of supportive housing. A third wave that will produce 9,000 units is just getting underway.

over decisions about the living environment, activities, income, medications, and privacy, was also factored into intensity.

Clients placed in housing with different levels of intensity had somewhat different characteristics. Clients placed in high-intensity settings (30 percent of the sample) tended to be younger, referred from hospitals, and to have a history or diagnosis of substance abuse. Clients placed in moderate-intensity housing (18 percent of the sample) were more likely to be female and were least likely to have substance abuse problems. Individuals in low-intensity settings (52 percent of the sample) were more likely to be referred from city shelters where they had lived for four or more months.

Lipton examined tenure outcomes, classified as follows: consumers who were "continuously housed" either stayed in their initial placement or moved to another stable setting. Those classified as "discontinuously housed" became homeless, moved to an unstable setting, or were imprisoned. Consumers who died, were hospitalized for medical reasons, or could not be located were not classified. The study found that, for the sample overall, 75 percent, 64 percent, and 50 percent of consumers were continuously housed for one, two and five years, respectively. The risk of being discontinuously housed was highest in the first four months following housing placement, and this risk was greatest for those in high-intensity housing. The researchers also found that older age was associated with longer tenure, while a history of substance abuse was associated with shorter tenure. In addition, consumers referred from psychiatric hospitals were more likely to have poor housing outcomes regardless of the type of housing. The authors conclude:

> Discussions about housing for this population have at times unnecessarily pitted the residential continuum model against the supported housing model. Although some individuals will initially benefit from normalized housing, others may require various degrees of structure, interpersonal intensity, and support. Varied types of housing are needed to meet the heterogeneous needs of a diverse consumer group.

Implications for Preventing and Ending Homelessness

Implications for Families

The National Alliance to End Homelessness recently developed a set of *Promising Practices to End Family Homelessness* (2006). The strategies identified include some of the themes reflected in the research cited here:

- prevention strategies such as landlord mediation, financial assistance to pay back rent or utility bills and emergency assistance;
- housing first approaches that focus on bypassing or limiting stays at emergency shelters in favor of placement in permanent housing accompanied by intensive but usually time-limited services;
- expanded tools to pay for housing such as using TANF funds or raising revenues or fees for housing trust funds; and
- services tailored to meet families' needs.

Prevention. The dilemma of prevention strategies is that it is hard to distinguish a person or family that will become homeless without an intervention from one who will not and, therefore, hard to target resources without the homeless services system taking on the whole burden of providing affordable housing for people with low-incomes. This is particularly the case for homeless families, who may be very difficult to distinguish from other low-income families with unstable housing and job histories and with some level of behavioral health problems. Burt and Pearson (2005) conclude that effective approaches include a single agency or system controlling the eligibility determination process, a community commitment to provide housing subsidies for a particular at-risk population (including funding that may come from a non-housing mainstream source such as the mental health or child welfare system), and having a system in place to provide feedback on success.

Short-term rental assistance mitigates the targeting dilemma for prevention strategies since people are not likely to create a housing crisis in order to get help with security deposits or one or two months rent. Increasing numbers of communities are likely to use this approach as part of their plans to end homelessness for this reason, because of its relatively low cost, and because of the limited availability of longer-term, mainstream rent subsidies.

Rapid placement into permanent housing. Clearly it is best, particularly for children, if a family can limit the duration of shelter placements or bypass shelters altogether. Given the need for a safe and supportive environment for children, there does not appear to be an analog to safe havens that can be applied to families.

Rapid placement into permanent housing is as promising an approach for families as it is for individuals. However, it is less clear which of the features of the housing first model are relevant to families; for example, whether services should be completely voluntary or whether the family should be expected to enter into a services plan and to follow it after the housing placement.

Transitional housing for families as a housing and services model may well have a role to play in a community's strategy to end homelessness. However, communities should be clear about the purpose and its precise role in their strategies. Is transitional housing to be targeted for those for whom rapid placement into permanent housing is not feasible—for example, because of active substance abuse or other issues on which progress must be made before public or private providers of mainstream housing will sign a lease? Or, is transitional housing a service-enriched living environment to be offered to those families most likely to use it to lift themselves out of poverty and to give their children better life chances—even though such families could go directly to mainstream permanent housing? Communities that make the latter choice should be aware that doing so can draw funds away from interventions more directly targeted to ending homelessness and should seek to fund this type of transitional housing through broader resources such as TANF or the child welfare system.

Mainstream housing opportunities and permanent supportive housing. Mainstream permanent housing has a crucial role to play in preventing and ending family homelessness. Findings from the Sound Families program indicate that families with limited supportive services needs can be served effectively in public housing and voucher-assisted units. From the findings on Beyond Shelter's programs and on the Family Permanent Supportive Housing Program, we can conclude that mainstream assisted housing can also be appropriate for multi-problem families when sufficient services support is provided. But is this mainstream housing or permanent supportive housing? For families, the line is blurred by the fact that

most families with children need intensive services only for a limited time after placement into permanent housing.

This implies that more funding for mainstream assisted housing programs is needed. The alternative is to redirect existing resources (in particular, housing vouchers and the Low Income Housing Tax Credit) to provide access to affordable housing for people leaving homelessness. Which families need long-term intensive services has been little studied. HUD's Shelter Plus Care program answers that question by making only families with a disabled head of household eligible for permanent supportive housing. However, lack of access to mainstream assisted housing may put pressure on communities to develop permanent supportive housing for families using the Supportive Housing Program or local and state resources.

Implications for Individuals with Disabilities

Prevention. Targeting prevention programs may be less difficult for individuals than for families, because of evidence that interventions that include housing reduce the use of expensive medical services by people with certain types of disabilities. Such "high users" can be targeted, as California's AB2034 program does, to avert their becoming homelessness. Other obvious targets, because they are at such high risk of becoming homeless, are people with disabilities leaving psychiatric hospitals and correctional institutions (Burt & Pearson, 2005).

Safe havens and housing first. For programs serving individual persons with disabilities who become homeless, housing models with low-demand services have shown positive outcomes, especially for those who have been reluctant to enter or stay in transitional programs. Yet those with the most severe mental illness and substance abuse issues are still the most likely to leave, even from low-demand housing settings. Identifying risk factors in the program population is important as are services focused explicitly on retaining housing.

For communities with a sizable population of service-resistant individuals, safe havens can be an important part of a strategy to end street homelessness. The research evidence suggests that this approach can be costly, however.

Evidence also suggests that approaches that combine a low-demand approach with available intensive services help some succeed in permanent housing who otherwise would be at substantial risk of failing (Tsemberis & Eisenberg, 2000, Padgett, Gulcur, & Tsemberis, 2006; Siegel et al., 2006). Housing configuration seems to be less important than the service approach, although more research is needed to confirm this. Researchers have found positive housing retention outcomes in programs with a wide variety of housing configurations, from buildings dedicated to formerly homeless people with disabilities to mixed-occupancy buildings to scattered-site models. Services need to be available and adapted to the housing configuration. On-site support may work well in buildings where all the residents are program clients. In programs with scattered-site and/or mixed housing configurations, low client-to-staff ratios and frequent contact with clients are important in ensuring clients have sufficient support to maintain their housing. Balancing consumer choice and access to subsidies poses a policy dilemma in addressing the housing needs of homeless people who prefer scattered-site housing in their communities. There are not enough mainstream subsidies to meet the overall demand from people who are homeless and others of low-income, and people with mental illness or other disabilities may face greater barriers accessing the limited available subsidies.

Recommendations for Future Research

The challenge facing researchers is that there are so many programs in the field, each influenced by its housing market, service delivery system, community funding, and institutional capacity. Authors of many of the multisite studies cited in the research findings above acknowledge that the researchers were not always comparing "apples to apples." While programs in a multisite study may have similar overall approaches, the intervention can easily be different enough from site to site that the findings are difficult to compare. For example, differing credentials for case managers, varying landlord receptivity to housing homeless people, mixed housing types, different administrative procedures, or other factors can influence outcomes in ways that are difficult to observe or measure.

Thorough and accurate descriptions of both the service and housing interventions are crucial to expanding our knowledge. We need greater rigor in classifying exactly what the services are, how they are delivered, and how service approaches are linked to housing: how is the housing setting structured, what is the nature of the housing and services provided, and over what period of time? In addition to substantially improved methods for documenting and measuring the types and intensity of housing and services interventions, use of more rigorous experimental or quasi-experimental design studies would strengthen our knowledge of what works for whom. Given the challenges such studies entail, it is important to focus research efforts on the most critical questions. We offer several suggestions:

- What are the impacts of housing characteristics such as scattered-site vs. project-based settings, shared vs. individual housing, tenant-held leases vs. provider-held leases, and housing-based services vs. community-based services on housing stability, housing satisfaction, short- and long-term self-sufficiency measures?
- Do structured programs, whether transitional or permanent, with curfews, rules requiring sobriety, and expectations around service participation have different outcomes from programs with fewer rules but still intensive support modeled on the ACT approach?
- What are the most effective strategies for dealing with substance use in permanent supportive housing? What factors (age, length of time homeless, etc.) most influence the appropriate service approach for people with substance use disorders? In programs using a low demand approach, how much do tenants reduce their level of substance use and abuse? How does this come about?
- Given the promise of housing first models for families and individuals, what role should transitional housing play? Do transitional housing programs for families achieve outcomes other than helping families find and retain permanent housing—for example, reunifying and stabilizing families, helping families to become financially self-sufficient, or improving the life chances of children? Is transitional housing cost-effective compared with other approaches to achieving these objectives?
- How should prevention programs identify precariously housed families and target limited prevention services to them? What family characteristics or immediate circumstances distinguish a family likely to become homeless from the large number of equally low-income families without severe disabilities who are doubled up or pay unsustainable portions of their income for housing?

- How effective is short-term rental assistance as a tool for prevention or for rapid exit from homelessness? Can families who have been homeless really sustain themselves in private market housing after the rent subsidy goes away? How does this differ by family characteristics and by type of housing market (the relationship between local housing costs and wage rates for low-wage workers)?
- What types of families in what types of housing markets need a housing subsidy over a longer period of time?
- What are the longer-term effects of permanent supportive housing on mental health status and substance use?
- What are the cost implications of different housing configurations and different models for combining housing and services? To what extent are mainstream benefit programs assisting people who are homeless?

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Employment and Income Supports for Homeless People

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Abstract

In this paper, the authors synthesize the findings of recent studies examining the role of mainstream programs such as Social Security Administration (SSA) disability programs, Temporary Assistance for Needy Families (TANF), and Workforce Investment Act (WIA) initiatives in enhancing employment and incomes for people who have experienced homelessness. They also describe the design and outcomes of targeted programs designed specifically to address employment and income support for people who are homeless. While some rigorous evaluations have been done on mainstream programs, the effects of the interventions on the subpopulation that has been homeless are often not addressed. Few rigorous studies have been done on targeted programs. The authors draw several conclusions from the available evidence and outline future research directions to fill important gaps in the research literature.

Introduction

Policymakers face many fundamental questions in deciding how government should respond to the immediate needs of homeless families and individuals—a place to live and the food, clothes, health care, and other items they require. Mainstream federal programs, such as disability assistance, welfare, Medicaid, and assisted housing, provide income and in-kind assistance to meet the needs of low-income people, including those who are homeless. For two reasons, these same programs also provide both incentives and a range of services to encourage employment. First, any assistance that is income conditioned can have the unintended consequence of discouraging work, because earnings reduce or eliminate the assistance for which people qualify. Second, programs that try to meet individuals' immediate needs also seek to respond to individuals' longer-term need and desire to pursue economic independence. As a result, employment and income supports are closely linked in the mainstream programs that provide the bulk of government assistance to people who are or have been homeless.

This paper synthesizes the findings of recent studies examining the efforts of mainstream programs to increase employment and also reduce immediate hardships among families and individuals who are

homeless. These findings indicate that mainstream programs—those serving large populations of which homeless individuals are a small segment—meet many of the basic needs of some groups of homeless people, but struggle to promote employment by these groups while continuing to provide income and other support. They also show that other groups of people who are homeless receive little income or employment support. This is partly due to the difficulty that some individuals and families have in accessing mainstream programs. More fundamentally, however, most mainstream programs do not serve adults unaccompanied by dependent children unless the former have severe and documented disabilities.

This paper also considers programs specifically targeted to homeless people. The homeless assistance programs funded by the U.S. Department of Housing and Urban Development include employment services as fundable activities. The Department of Health and Human Services funds a Transitional Living Program for homeless youth that provides an array of services, including job attainment skills. The Department of Labor funds a Homeless Veterans' Reintegration Program, emphasizing employment. In addition, mainstream federal employment programs and demonstrations have particular local grantees that target homeless people. However, the available research on such employment initiatives targeted to homeless people is limited to descriptive reviews and qualitative studies that do not provide hard evidence on the effectiveness of the employment services. We are not aware of experimental studies specifically focused on evaluating employment strategies for any homeless population. In contrast, several experimental investigations have addressed the mainstream programs that serve larger populations, including people who are or have been homeless, and we attempt to tease out of those evaluations implications for homeless people.

Our review of the research evidence is organized by federal agency.[1] While the federal government has undertaken efforts to coordinate policies for people who are homeless —through state Policy Academies funded by HHS, through HUD's continuum of care planning and application process, and through the Interagency Council on Homelessness—each agency responds to the segment of the overall homeless population for which it is responsible, providing (or funding state and local governments to provide) the types of income and in-kind support Congress has mandated. For example, the Social Security Administration serves people with disabilities;[2] the Department of Veterans Affairs serves veterans, particularly veterans with disabilities; the Department of Health and Human Services provides income support for families with children and, through the Substance Abuse and Mental Health Services Administration (SAMHSA), funds activities that support the resilience and recovery of people with mental illness and substance use disorders. HUD's mainstream housing assistance programs serve all types of low-income households, as does the Food Stamps program of the U.S. Department of Agriculture. The federal government's most powerful work support tool, the Earned Income Tax Credit (EITC), is targeted largely to families with children and administered by the Internal Revenue Service.

The Department of Labor is the lead federal agency for supporting employment across the population spectrum. However, because income support and in-kind benefits programs may create disincentives to working, each federal agency that serves low-income people has produced its own work-support strategy,

[1] The review covers several initiatives sponsored by private foundations. These initiatives are considered in the context of the federal agency with primary responsibility for the population segment served by a particular project. For example, the Next Step Jobs initiative, funded by the Rockefeller Foundation to serve supportive housing residents, is discussed in the "U.S. Department of Housing and Urban Development" section.

[2] The Social Security Administration also serves long-term workers who have reached retirement age, a population unlikely to experience homelessness.

leading to an array of federal programs that have employment as their objective. Those programs often focus on people who face barriers to work—as do many homeless individuals and families. Therefore, before turning to our agency-by-agency review of the research literature, we describe the barriers to employment that may challenge the capacity of mainstream programs to support the work efforts of homeless people.

Barriers to Work Faced by Homeless People

There are assertions and supporting evidence throughout the research literature that all segments of the homeless population—unaccompanied adults, heads of family households, and youth—face significant and multiple barriers to employment. These barriers are personal, programmatic, and systemic. People who are homeless often lack skills in stress management and social interaction, independent living skills, and skills for vocational engagement (Munoz, Reichenbach, & Hansen, 2005), as well as a place to live and financial resources. Barriers such as lack of transportation and educational credentials are prevalent among homeless people in both urban and rural areas (Taylor, 2001). In addition, homeless young adults and youth experience high levels of trauma and typically have poor educational and vocational preparation (Barber et al., 2005).

Mental health and physical health play central roles in the employment and program participation of people who are homeless or at risk for homelessness. Disabilities are well-documented barriers to employment, although the extent of the hindrance varies. For example, the employment of persons with schizophrenia is impeded by a range of specific clinical problems. People with schizophrenia who have greater cognitive impairment experience more difficulty in the labor market and require more vocational support than those with lesser impairment (McGurk et al., 2003).

Substance use disorders, alone or in combination with disabilities, substantially reduce the income people receive from work (Zuvekas & Hill, 2000). Competitive employment is further impeded by receipt of disability payments (and concomitant adverse work incentives) and by race (Rosenheck et al., 2006). Among homeless people with severe mental illness, those with a history of incarceration have more serious problems and show less improvement in community adjustment domains (McGuire & Rosenheck, 2004). Incarceration can decrease the types of employment available after release from jail or prison, and a history of incarceration has been shown to alter how homeless ex-offenders conduct job searches (Cooke, 2004).

The barriers faced by homeless families are generally similar to those of other low-income families, including families on welfare. The key issues are transportation, child care, educational limitations, and substance abuse (Burt & Anderson, 2005; Burt, Aron, & Lee, 1999; Taylor, 2001). Severe mental health problems and histories of incarceration are less common for homeless family heads than they are for homeless adults who are unaccompanied.

In addition to these barriers, the digital divide remains a deep chasm for homeless populations. Competing for jobs today requires some understanding of and comfort and competency with information technology. Miller and colleagues (2005) identified the lack of such facility among homeless men as an important barrier to employment. Because they lacked computer knowledge and feared failure, the majority of study participants had not sought to use computers available through public access.

These limitations help to produce poor labor market outcomes for homeless people. Unemployment among homeless populations is widespread, and the problem is especially great during economic downturns. For example, at the end of 2002, there were 3.2 unemployed workers for every job opening, compared to 1.3 at the end of 2000 (Bernstein & Chapman, 2003), and low-wage job seekers, including people experiencing homelessness, suffered as a result.[3] In addition, the jobs that homeless people and tenants of supportive housing most frequently secure are low paying—laborer positions, jobs in the services sector (including food service and hospitality), and clerical or office positions (Isaac, 2001; Rog et al., 1999; Trutko et al., 1998).

As formidable as these barriers may seem, there are consistent reports in the literature that homeless people rise above the barriers and find ways to earn income from employment (Sowell et al., 2004; Theodore, 2000). Indeed, mounting evidence counters the view that homeless people face insurmountable barriers or are simply work shirkers. Given the opportunity, training, and sustained support, even people who have been homeless for long periods or who have experienced frequent episodes of homelessness have succeeded at working. Evidence of homeless individuals' desire for jobs and tenacity in working has emerged from case studies and surveys of homeless people (Burt, Aron, & Lee, 1999; Weinberg & Kogel, 1995; Evans, 1998).

Personal characteristics and histories can indicate how well people, including homeless people, will fare in employment. Researchers continue to search for predictive indicators for successful job placement of people with complex problems (McGurk & Mueser, 2006; Hoffman et al., 2003; Macias et al., 2001). Bogard et al. (2001) found that poor single mothers who had experienced an episode of homelessness and had symptoms of depression, but had a work history of full-time employment, left shelters quickly and entered employment after a shelter episode. Identifying such indicators can assist program planners in designing services most likely to meet the needs of a variety of job seekers, so that job seekers and service providers can transcend barriers to employment and achieve vocational objectives.

Income Support and Employment Programs

For each federal agency, we describe mainstream income support and employment programs and their target populations, discussing the barriers to eligibility or participation faced by homeless individuals and families[4] and, in some cases, evidence that the inability to benefit from the program may contribute to homelessness. We describe relevant efforts that have been made to increase access to the mainstream program for people who are homeless and other hard-to-serve groups. Then we examine ways in which the mainstream program may create disincentives to employment and the agency's efforts to overcome these disincentives through program design or through employment and training initiatives. Finally, we examine the available research to determine what is known about the results of employment and training programs targeted to homeless people or used by homeless people who are part of the broader population group served by the agency.

[3] The U.S. was in recession from March through November 2001 (Business Cycle Dating Committee, 2001). For a discussion of the evidence of harm to disadvantaged populations, such as welfare recipients, see Holzer (1998).

[4] GAO (2000) provides a good summary of eligibility barriers to mainstream programs experienced by homeless people.

Social Security Administration

The Social Security Administration (SSA) focuses on a specific segment of the homeless population: people with serious physical and mental impairments. SSA's mission has always been to provide income support, initially to retired workers and their families and later also to workers with disabilities and their dependents. Most homeless people served by SSA receive Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI). When SSDI was established in 1956, policymakers expected that individuals who became disabled enough to qualify for benefits would not return to the labor force unless their medical condition significantly improved. Indeed, eligibility for SSDI and SSI has always been contingent on the inability of the applicant to work at any job in the national economy. Disability determination is binary; an applicant is found either "disabled" or "not disabled." As a result, SSA did not initially have a work-support strategy. A strategy modification has gradually evolved during the last 30 years, allowing beneficiaries to earn a limited amount through employment or, on a trial basis, to earn more. Employment-related assistance is offered to all beneficiaries. Earning more than the allowed amount, however, results in termination of benefits, and this has created widespread fear of attempting any work.

SSDI provides monthly benefits to qualifying adults with a significant work history. SSDI benefits vary based on the amount of time worked and the money earned from employment. Using the same disability standard,[5] SSI is the disability benefit program for low-income people who have never worked, have an insufficient work history to qualify for SSDI, or would receive less in SSDI than the maximum SSI cash grant. Individuals who are disabled are only eligible for SSI if they meet federal income and asset guidelines. Benefits are currently capped at $623 per month for an individual and $934 per month for a couple.[6] An individual who has been found disabled and eligible for SSDI or SSI will continue to receive benefits as long as SSA's disability standard is met and the individual does not receive more earnings than program rules allow.

SSA Programs and Homelessness

SSDI and SSI benefits are important both as income supports and as gateways to the receipt of other supports. SSDI receipt provides eligibility for Medicare after a waiting period, [7] and in most states SSI

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[5] SSDI and SSI have similar disability determination criteria—adults will be found disabled if they are unable to perform "substantial gainful activity" (SGA) for at least 12 months due to one or more medically determinable disabilities. To be found eligible for benefits, an applicant under either program must be unable to perform SGA in any former jobs as well as any job that exists in the national economy. This is a high standard, considerably more stringent than the standard used to determine eligibility for HUD's housing and homeless assistance programs, so many homeless individuals who qualify for HUD assistance based on a disability will not be eligible for SSDI or SSI. Inability to perform SGA is often equated with inability to work at all, which is inaccurate. SGA is actually defined as a certain threshold of work earnings, below which an individual is disabled under SSA standards and above which an individual—although he or she might have a disability—is not considered disabled under SSA rules. Whether a person is performing SGA is dependent on the amount of money earned, the number of hours worked, and the type of work being performed. This means that it is possible for people to work and still receive SSDI or SSI.

[6] 2007 Social Security changes are available at http://www.ssa.gov/pressoffice/factsheets/colafacts2007.htm. While some income and assets are excluded from being factored into basic eligibility determinations and determinations of monthly benefits, receipt of too much non-excluded income and assets can result in temporary ineligibility for monthly benefits or even removal from the program's rolls.

[7] SSDI beneficiaries do not begin receiving cash payments until 5 months after qualifying for benefits; Medicare coverage begins 24 months after benefits start.

recipients are immediately eligible for Medicaid. Medicare and Medicaid permit homeless persons to obtain primary and specialty health care as well as prescription drug coverage. These services can help to stabilize people with mental health disorders, and provide proper therapy and other treatment for people with physical disabilities. This care may help people return to work.

A major anti-poverty program targeted to disabled individuals and their families, SSI has been credited with lifting 2.4 million people out of poverty in 2003 (Sweeney & Fremstad, 2005). SSI recipients include many current and formerly homeless people. The National Survey of Homeless Assistance Providers and Clients (NSHAPC) found that 8 percent of homeless people surveyed were receiving SSDI, and 11 percent were receiving SSI.

Receipt of SSI or SSDI can be an important protective factor, preventing people with disabilities from becoming homeless, and may partly explain the finding that homeless people do not have higher rates of disability than other poor people (U.S. Department of Housing and Urban Development, 2007a). Furthermore, both SSDI and SSI are important sources of income for people who move from homelessness into permanent housing. Among *formerly* homeless people, NSHAPC found that 29 percent received SSI (Burt, Aron, & Lee, 1999).

Barriers to Receiving SSA Income Supports

A recent report found that many homeless persons who are eligible for disability benefits do not receive them. In 2000, the General Accounting Office (GAO, now the Government Accountability Office) estimated that 39 percent of homeless persons reported mental health problems and 46 percent of homeless persons had chronic physical disabilities, far more than the 11 percent receiving SSI. While not all persons with disabilities are eligible for SSDI or SSI, these disparities suggest that at least some eligible individuals who are homeless are not receiving benefits (GAO, 2000). One cause of this gap is a 1997 change in SSI eligibility criteria that prevents receipt of benefits by individuals whose drug or alcohol addiction "is a contributing factor material to the determination of disability" (Employees' Benefits, 2006). A 1999 survey revealed that homeless people losing benefits under the 1997 eligibility changes were more likely than other homeless persons to lose access to both housing and substance abuse treatment services (National Health Care for the Homeless Council and the National Law Center on Homelessness and Poverty, 1999).[8]

Another reason that many homeless individuals are unable to access disability benefits is that, at the beginning of the application process, they may have difficulty verifying identity or immigration status, because they do not have copies of the necessary documentation. Similarly, homeless persons are often unable to provide documentation of their work history or past medical treatment. Once an application is filed, homeless people are often without a mailing address to receive important communications such as decisions or hearing notices. As a result, their cases can be closed on procedural grounds (Rosen, Hoey, & Steed, 2001).

In recent years, federal agencies have begun programs designed to help homeless persons obtain SSDI and SSI benefits. In 2004, Congress gave SSA funding to operate the Homeless Outreach Projects and

[8] Seventy-six percent of survey respondents who were paying for their own housing lost that housing when their disability benefits were cut off; and 29 percent of respondents who were in a drug treatment program when their benefits were cut off were required to leave that program. In Cook County, Illinois, 74 percent of people surveyed who had lost their benefits also lost Medicare or Medicaid coverage.

Evaluation (HOPE) demonstration grant programs. Each HOPE grantee developed a collaborative relationship with its local SSA office to facilitate the claims of homeless clients. A year later, the Substance Abuse and Mental Health Services Administration (SAMHSA) began its SSI/SSDI Outreach, Access and Recovery (SOAR) technical assistance. The SOAR program provides state agency officials and service provider staff within SOAR states with training and technical assistance designed to improve the work of case managers or other program staff who are handling SSI/SSDI claims on behalf of homeless persons. Both the HOPE and SOAR programs appear to be adopting good practices, but neither initiative has yet been evaluated. However, some preliminary SOAR program data can be discussed.

As of November 2006, eight states had reported outcomes from the SOAR training. Prior to SOAR, only 10–15 percent of the homeless SSDI/SSI applicants being assisted by participating agencies were awarded benefits on their initial application. After SOAR, the percentage of successful initial applications increased dramatically. For example, service providers in Montana and the city of Nashville reported 100 percent success rates, while service providers in New York reported a 96 percent success rate. Several other participating states had success rates ranging from 64 percent to 91 percent. In Oklahoma, the success rate lagged at 33 percent, although this was still a notable improvement over prior performance. In addition to higher success rates, the states that documented case processing times all reported significant reductions. In Oregon, cases were approved in an average of 4.5 months, versus 8 months prior to training. In Oklahoma, approval took an average of 80 days, versus 120 days before the training (Policy Research Associates, Inc., 2006).

Rosenheck and colleagues (2000) evaluated outcomes among homeless, mentally ill veterans who applied for SSDI or SSI through a special outreach program. Veterans who were awarded benefits were compared with those who were denied benefits. Beneficiaries were more willing to delay gratification, as reflected in scores on a time preference measure. Three months after the initial decision, beneficiaries had significantly higher total incomes and reported a higher quality of life. They spent more on housing, food, clothing, transportation, and tobacco products, but not on alcohol or illegal drugs. The authors concluded that receipt of disability payments is associated with improved quality of life and is not associated with increased alcohol or drug use.

SSA Employment Supports

Once disabled people begin receiving SSI or SSDI, the probability of their becoming employed is greatly reduced (Rosenheck et al., 2006; Resnick et al., 2003). The work disincentives of SSI and SSDI are well documented (Stapleton & Burkhauser, 2003).[9] There also is widespread fear among recipients of both SSI and SSDI that, by becoming employed and earning too much money, they risk losing eligibility for continued benefits, including health insurance. In addition, severely disabled individuals face substantial barriers to employment.

A number of studies have shown, however, that disabled people who are homeless and receive vocational services can achieve promising employment outcomes (Shaheen, Williams, & Dennis, 2003; Zlotnick, Robertson, & Tam, 2002; Picket-Schenk et al., 2002; Cook et al., 2001; Quimby, Drake, & Becker, 2001;

[9] The incentive to work is also low at the time people apply for SSI and SSDI. Work at more than a minimal level calls the severity of the disability into question, potentially resulting in a denial of benefits. If too much income is earned, SSI eligibility criteria may not be met. As a result, applicants for disability benefits often avoid work while their applications are pending.

Rog et al., 1999; Becker et al., 1999; Trutko et al., 1998). The best research evidence on the effectiveness of employment services for SSI and SSDI recipients comes from Project NetWork, which was evaluated using a rigorous random assignment research design (Kornfeld et al., 1999). SSA implemented NetWork, beginning in 1991, to provide rehabilitation and employment services to SSI and SSDI applicants and recipients. Four program models were tested in eight sites around the country. NetWork significantly increased the earnings of both SSI and SSDI recipients, but these impacts declined in magnitude over time. The least intensive intervention tested—the referral manager model—also appeared to be the least effective in improving earnings and other outcomes. The evaluation did not isolate the impacts of NetWork on sample members who had experienced homelessness.

SSA's Ticket to Work (TTW) program has sought to make a wider range of employment and training services accessible to beneficiaries. TTW gives eligible beneficiaries tickets that may be used to obtain employment-related services from participating providers. The eligible providers are called Employment Networks (ENs). Beneficiaries may choose to work with any approved EN from a range of service providers in public and private sectors. The most common providers are state vocational rehabilitation agencies.[10] The TTW Program is designed to provide the specific services needed to meet a beneficiary's employment goals and ultimately move him or her off disability insurance. The maximum allowable payment to an EN for a SSDI beneficiary is approximately $20,000.

In addition, the Ticket to Work legislation improved work incentives in several respects, most notably by allowing people who work to maintain Medicare and/or Medicaid coverage even as their income rises. The legislation also funded counselors to provide reliable information to beneficiaries about pertinent SSA rules and opportunities. Finally, people who lose benefits altogether due to significant work can get those benefits reinstated in an expedited manner if their disability returns and they must reduce or stop their work activity as a result.

A large-scale, rigorous evaluation of TTW is currently underway (Thornton et al., 2004). The evaluation's most important interim finding is that the participation rates of SSI and SSDI beneficiaries in the Ticket program are extremely low. The cause of low participation is said to be the TTW payment system. ENs are paid for services they provide in two ways. One, the "outcome payment" system, provides higher payments, but only when a beneficiary leaves the rolls due to earnings. The other option provides smaller outcome payments, but allows up to four milestone payments for services while the beneficiary is still on the rolls. Recently proposed changes in the EN payment system allow for higher milestone payments.

U.S. Department of Health and Human Services

The U.S. Department of Health and Human Services (HHS) oversees a wide range of programs that target various populations, some including people who are homeless. Temporary Assistance to Needy Families

[10] State vocational rehabilitation agencies also receive substantial funding from the Rehabilitation Services Administration (RSA), U.S. Department of Education. The funding provided by RSA is authorized under the WIA legislation discussed in the section on U.S. Department of Labor programs. Most notably, the state vocational rehabilitation (VR) agency system has been the main provider of employment-related services to disabled individuals and, until 1996, the only option disability insurance recipients had for publicly financed rehabilitation services (the VR agencies are also by far the most widely used TTW providers as well). VR agencies typically assess disabled individuals, develop rehabilitation plans, and then purchase needed services for their clients or leverage resources at other agencies or service providers. VR staff also counsel clients about their potential eligibility for disability insurance and other program benefits.

(TANF) is extended to low-income families with dependent children, who automatically become eligible for Medicaid, one of the two largest federal health insurance programs, and several types of social services. Welfare reform efforts during the 1980s and 1990s have left TANF and related programs with a strong emphasis on employment and promoting family self-sufficiency. HHS's Administration on Children and Families also funds transitional living programs for homeless youth.

The programs managed by HHS's Substance Abuse and Mental Health Services Administration (SAMHSA) focus on people with mental illness and people with substance abuse disorders, including people who are homelessness. SAMSHA targets homeless people directly through the Projects for Assistance in Transition from Homelessness (PATH) formula grants and a number of current and past demonstration programs, including Access to Community Care and Effective Services and Supports (ACCESS). Many of SAMHSA's employment efforts are collaborative initiatives with other federal agencies (DOL, HUD, and VA).

Temporary Assistance for Needy Families

Ten years ago, Temporary Assistance for Needy Families (TANF) replaced Aid to Families with Dependent Children (AFDC) as the nation's welfare program. Federal funds are distributed to states, each of which operates its own TANF program under broad federal standards. In addition to cash assistance, TANF offers several types of support services to low-income families, including many homeless families. TANF benefits are paid monthly and are time-limited; while there are exceptions, the general rule is that no family may receive federally funded assistance for more than five years.

TANF and Homelessness. The NSHAPC indicated that 52 percent of homeless families were receiving welfare (it was still AFDC at the time the survey was done) (Burt, Aron, & Lee, 1999). No recent research has updated this percentage, but given the substantial declines in TANF caseloads, it seems likely that fewer homeless families are receiving these benefits. A recent study found that families reaching their TANF time limit or sanctioned for failing to comply with TANF rules are among those particularly vulnerable to housing instability and homelessness (Mills et al., 2006).

The TANF program requires that non-disabled adult recipients work or take part in job training or other educational programs as a condition of receiving benefits. Specific options vary by state; for example, some states have allowed TANF recipients to attend college while receiving benefits, while others do not allow it unless recipients are also working.

Research evidence shows that mandatory work participation programs, which sanction uncooperative TANF recipients by reducing or eliminating their monthly TANF grants, can increase homelessness. One study, based on a random assignment evaluation of a mandatory work program in Connecticut, found that 2.6 percent of the program group reported being homeless and living on the streets and 9.9 percent had to live with family or friends (doubling up). The rates were 1.5 percent and 6.4 percent respectively for the control group, both significantly lower than for the program group. Qualitative data led the evaluators to conclude that these impacts on homelessness were caused by these penalties and by TANF time limits (Bloom, Riccio, & Nandita, 2002).

TANF Employment Supports. States spend a significant portion of their TANF funds on work supports. Just over one-third of all TANF spending goes to cash benefits, while 18 percent is spent on childcare, 8 percent on work support or employment programs, 2 percent on transportation, and 24 percent on other services (Coven, 2005). When recipients go to work, they may have access to childcare, transportation,

and other resources needed to get to work and maintain employment. The benefit calculation process also provides an incentive for TANF recipients to work; benefits are reduced by less than one dollar for each dollar in earned income that a family receives.

However, availability of many work supports is dependent on sufficient funds to provide them. Since 1996, TANF payments to states have been provided in block grants at flat annual amounts. Due to inflation, these funds are not worth as much as they were 10 years ago. As a result, states have been forced to cut TANF spending, and many of the first cuts to be made came in work supports such as childcare and transportation (Coven, 2005).

The TANF disability rules are much less restrictive than the SSI standards. Typically, a doctor's letter attesting to an inability to work is sufficient to have an adult exempted from TANF work requirements. In most cases, states have not focused their employment support and job training efforts on households headed by persons with disabilities. Instead, those households have been exempted from time limits and allowed to continue receiving cash assistance. The impact of these policies has not been carefully studied.

Employment services provided by TANF are the subject of a vast evaluation research literature, which has been summarized by Blank (2007). Several studies suggest that employment, training, and support services provided to the most disadvantaged TANF recipients, including those who have been homeless, can produce positive results. One example is the evaluation of Welfare-to-Work Strategies, which rigorously evaluated the impacts of 20 programs on employment and other outcomes, and analyzed impacts for particularly disadvantaged recipients (Michalopoulos & Schwartz, 2000). This and other studies (Danziger & Seefeldt, 2002) have looked at the effectiveness of employment supports for very disadvantaged TANF families, although none have isolated the impacts of employment services on homeless families.

The Job Opportunities for Low-income Individuals (JOLI) program is a discretionary grant program administered by the, HHS Administration for Children and Families Office of Community Services.[11] Its purpose is to provide technical and financial assistance to create employment and business opportunities for individuals receiving TANF and for other low-income individuals, including homeless people, with incomes not exceeding 100 percent of the official federal poverty guidelines. Over a three-year period, grantees are expected to help low-income participants achieve self-sufficiency through business expansion, new business ventures, micro-enterprise development, or other non-traditional strategies. Among the 47 JOLI grants to communities across the country from 1998 to 2001, six projects included homeless people among their targeted populations, but no project specifically aimed at or tailored its services for homeless individuals. Largely qualitative evaluations have been conducted for individual JOLI grants, but generalizable research results are not available.

Other Efforts to Help Homeless Families Become Self-Sufficient. A number of initiatives have sought innovative strategies to stabilize homeless families, most of which are current or former TANF recipients, and help them move towards self-sufficiency. These initiatives typically utilize TANF funds together with resources from HUD, other agencies, and sometimes private sources.

[11] JOLI is authorized under Section 505 of the Family Support Act of 1988, Public Law 100-485, as amended by Section 112 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Public Law, 104-193.

One such initiative is Sound Families, a transitional housing venture in the Seattle area funded by the Gates Foundation, as well as government agencies. Reporting on the 292 families in Sound Families, of which nearly two-thirds were still TANF recipients at intake, Bodonyi et al. (2004) reported positive changes in the primary caregiver's resources between entry into transitional housing and exit. Employment increased from 27 percent at intake to 50 percent at exit; TANF reliance decreased from 64 percent at intake to 44 percent at exit. However, the average hourly wage earned at intake and exit did not significantly increase, holding steady at approximately $9.25, which is several dollars below the self-sufficiency wage needed to support a family with only one child in the Puget Sound region.

A follow-up report on the Sound Families initiative suggests a possible relationship between preentry employment and program completion. Data indicate that those unsuccessfully exiting the project were slightly more likely to be receiving TANF and less likely to have income from any level of employment. They were more likely to be receiving Medicaid and less likely to be receiving child support (Bodonyi et al., 2006).

Another initiative, Hearth Connection in Minnesota's Twin Cities, is using a network of service providers to test a "managed care" approach to ending homelessness for families and single adults. The pilot program tries to coordinate assistance to families and individuals from the Minnesota Family Investment Program (MFIP), which is Minnesota's TANF program, and the Social Security Administration while also providing supportive housing (see additional discussion of supportive housing under "U.S. Department of Housing and Urban Development"). Four years into the pilot, respondents in family programs reported support from food stamps, TANF, earned income, rent support, and child support, while singles were more likely to report receiving income from Social Security and SSDI (National Center on Family Homelessness, 2004). With many of their survival needs met, few participants worked. Those who did not have jobs noted that their daily activities were limited to walks, watching television, and occasionally talking with friends. Many participants wished they could find and keep a job, even a non-paying job. These feelings were echoed by service providers, who wanted more funds and resources for creating employment opportunities (National Center on Family Homelessness, 2006).

SAMSHA Demonstrations for Homeless People with Mental Illness. Among SAMHSA's demonstrations, the Access to Community Care and Effective Services and Supports (ACCESS) demonstration program, funded for five years beginning in 1993, produced the most noteworthy results (Randolph et al., 2002; Morrissey et al., 2002; Rosenheck et al., 2002; Pickett-Schenk et al., 2002; Goldman et al., 2002). The ACCESS initiative sought to improve performance and integration of services to reduce homelessness among persons with serious mental illness. More than 35 journal articles used client-level data from the 18 demonstration sites across nine states (Illinois, Connecticut, Missouri, North Carolina, Pennsylvania, Texas, Virginia, and Washington). Of particular interest for this paper are those investigations that addressed themselves to the employment status of the participants (Lam & Rosenheck, 2000; Cook et al., 2001; Pickett-Schenk et al., 2002; Min, Wong, & Rothbard, 2004).

The research design of the ACCESS project involved a comparison of two service delivery models and the results of these in reducing homelessness as well as making improvements in well-being, such as decreased hospitalizations, increased quality of life, and reduced service use. The first intervention was an effort to integrate services at a systems level in conjunction with outreach and case management. The second condition included an outreach and case management strategy absent a systems-level integration component. Researchers used client-level data and a systems-level evaluation to measure the impacts.

In an examination of nearly 5,000 demonstration participants, researchers found that despite receiving relatively few job-related services, modest but significant increases in employment occurred across 12 months of participation. Those employed at 12 months were more likely to have received job training and job placement services, suggesting a relationship between receipt of employment services and positive vocational outcomes (Cook et al., 2001).

A review of the work histories of 7,228 homeless individuals with mental illness in the ACCESS demonstration supports this conclusion. Earlier studies indicated that lengthy periods of homelessness posed a major barrier to employment for the mentally ill population (Lehman et al., 1995; Ratcliff, Shillito, & Poppe, 1996). However, in the ACCESS study, having been homeless for a long time was not a significant predictor of employment status.

Severe psychiatric illness, however, did emerge as a significant predictor of employment status. Clients with a mental health diagnosis but who appeared not to be hindered by this obstacle—those who had not used mental health services, had never been hospitalized, and did not have schizophrenia—were more likely to have worked for pay in the month prior to enrolling in ACCESS. Most interesting, however, is that, holding all other factors equal, clients who received job training assistance prior to enrollment into ACCESS were one and a half times more likely to be employed at the program's conclusion, while people who also received help in finding a job were two and a third times more likely to find employment. These results suggest that homeless people with serious mental illness can use vocational services, and that receipt of these services is significantly associated with an increased likelihood of being employed (Pickett-Schenk et al., 2002).

U.S. Department of Veterans Affairs

The Department of Veterans Affairs (VA) is one of the federal government's most important providers of employment services and income and in-kind assistance directed to the homeless population, especially unaccompanied adults. NSHAPC estimated that about one-quarter of the adult homeless population has served their country in the Armed Services (Burt, Aron, & Lee, 1999). The Department reports that, on any given day, as many as 200,000 veterans (male and female) are living on the streets or in shelters, and perhaps twice as many experience homelessness at some point during the course of a year (U.S. Department of Veterans Affairs 2006). The VA also provides cash assistance and health care coverage to veterans, including those who are or have been homeless, although NSHAPC estimated fairly low percentages of homeless veterans receiving veterans' disability payments or veterans' pensions (Burt, Aron, & Lee, 1999). Two VA programs support employment and training interventions for homeless veterans: the Capital Grant and Per Diem program and the Compensated Work Therapy program.

The Capital Grant and Per Diem program funds community-based agencies to provide transitional housing or service centers for homeless veterans. Under the Capital Grant Component, the VA may fund up to 65 percent of the project for the construction, acquisition, or renovation of facilities or to purchase vans to provide outreach and services to homeless veterans. The Per Diem Component is available to grantees to help offset operational expenses. Programs may apply for "Per Diem Only" funding. Per Diem funds can be used for a variety of services, including education and job training.

No specific evaluations have been done to determine whether stays in transitional housing programs funded by the Capital Grant and Per Diem program increase the likelihood that homeless veterans will become employed. However, many Grant and Per Diem residents are receiving job training assistance through the Homeless Veterans Reintegration Program (HVRP), which is operated by the Department of

Labor. HVRP has produced positive employment outcomes for program participants (see "U.S. Department of Labor" section below).

The VA also administers a Compensated Work Therapy (CWT) program for impaired, at-risk, and homeless veterans who have multiple challenges, including psychiatric and substance abuse issues, physical limitations, ex-offender status, and/or family relationship issues. Participants in CWT programs are referred by a primary-care clinical team that has assessed the veteran and determined that he or she could benefit from the program. Vocational rehabilitation specialists then work with the veteran to address barriers that stand in the way of achieving full-time gainful employment in the private sector.

Compensated Work Therapy has two components, Transitional Residence (CWT/TR) and Veterans Industries (CWT/VI). Transitional residences are community-based supervised group homes in which veterans live while working for pay in the Veterans Industries program. Veterans in the CWT/TR program work about 33 hours per week, with approximate earnings of $732 per month, and pay an average of $186 per month toward maintenance and upkeep of the residence. The average length of stay is about 174 days.

Veterans Industries is a vocational rehabilitation program that endeavors to place veterans in competitive jobs and to provide workplace supports as needed. VA contracts with private industry and the public sector for work done by these veterans. CWT/VI staff provide vocational rehabilitation services; employment supports and case management; work site analysis; and consultation with businesses regarding assistive technology, accommodation, and guidance in addressing Americans with Disabilities Act (ADA) regulations compliance. An evaluation of the program found that these services did not produce significantly greater improvement among participants than other clients on any of seven outcome measures, one of which was employment (Rosenheck, Stolar, & Fontana, 2000).[12]

U.S. Department of Housing and Urban Development

The U.S. Department of Housing and Urban Development (HUD) provides mainstream rental housing assistance to very low-income and low-income families and individuals. Housing assistance comes in three basic forms: tenant-based housing choice vouchers, public housing developments owned and operated by local housing authorities, and rental developments owned and operated by private landlords who have subsidy contracts with HUD under the project-based Section 8 program. HUD also administers McKinney-Vento grant programs targeted specifically to homeless people. HUD's homeless assistance programs include competitive funding for local providers of transitional housing for homeless people and permanent supportive housing for homeless people with disabilities, as well as a formula-based Emergency Shelter Grant program.

Mainstream Housing Assistance

HUD-funded housing assistance is a major source of in-kind income support, freeing up cash income for other needs by enabling assisted households to pay only 30 percent of their income for rent and utilities.

[12] In their analysis, Rosenheck, Stolar, and Fontana evaluated the interaction of participation in CWT and changes in outcomes over time using propensity scoring and hierarchical linear modeling. In addition to employment, the outcomes addressed by the analysis include two measures of clinical improvement in posttraumatic stress disorder (PTSD), violence, an alcohol problem index, a drug problem index, and a medical problem index. All sample members had PTSD; other impairments and characteristics varied within this sample.

A recent experimental design evaluation of the Housing Choice Voucher program found that families using vouchers were much less likely to live in unstable housing situations than families assigned to the control group and that having the availability of a voucher virtually eliminated homelessness among sample members (Mills et al., 2006). Housing assistance programs also are widely used by homeless families and individuals as a means to leaving homelessness for permanent housing.

The main barrier to the use of assisted housing by people at risk of homelessness or trying to leave homelessness is that housing assistance is not an entitlement. Altogether, it serves about 5 million households, while a similar number of renter households with incomes below 50 percent of local median income have severe or "worst case" housing needs and would likely use housing assistance if they could get it (US Department of Housing and Urban Development, 2007b). Thus, homeless people face stiff competition from other households on waiting lists for assisted housing. The housing authorities that administer the voucher and public housing programs may establish priorities for assisting homeless people, but such priorities are not common (Khadduri & Kaul, 2005.) One of the purposes of the Community of Care planning process required of HUD McKinney-Vento grantees is to bring local housing authorities into the effort to end or reduce homelessness by encouraging them to create such priorities and to find ways to address other barriers to program participation, such as histories of evictions from rental housing.

Employment Supports in Mainstream Housing Assistance Programs. When homeless people are able to use HUD mainstream programs to leave homelessness, does that help them work? Like other means-tested programs, housing assistance may discourage work. Receiving housing assistance reduces the need for income to buy housing, and tenants must pay 30 percent of most earnings as their contribution toward their subsidized housing, which amounts to a 30 percent tax on top of other taxes residents pay on their earnings (Olsen et al., 2005).

However, the work disincentive effect of public housing and housing vouchers is not as strong as is widely thought. Corcoran and Heflin (2003) studied current and former welfare recipients receiving housing assistance and how they differed from those not receiving assistance on various potential barriers to employment. They found that housing assistance is not associated with the probability of receiving welfare or being sanctioned for noncompliance with the work requirement. Additionally, they found that support for the relationship between housing assistance and work outcomes is weak. Housing assistance has no effect on the probability of being employed, the natural log of weekly earnings, the percentage of months observed working, or the percentage of months observed receiving welfare.

The recently completed Housing Choice Voucher Demonstration randomly assigned more than 9,000 current and former TANF families to program and control groups in six sites. The demonstration, which included many families that were unstably housed or homeless, found that the reduction in labor supply caused by housing vouchers was modest and temporary (Mills et al., 2006).

The Family Self-Sufficiency (FSS) program is HUD's program to help voucher families obtain employment that will lead to economic independence and self-sufficiency.[13] Housing authorities work with welfare agencies, schools, businesses, and other local partners to develop a comprehensive program that gives participating FSS family members the skills and experience to enable them to obtain

[13] FSS was established in 1990 by section 554 of the National Affordable Housing Act. There is a smaller FSS program for public housing residents.

employment that pays a living wage. FSS has not been rigorously evaluated, but both case studies and analyses of FSS participant outcomes have been encouraging (Sard, 2001; Ficke & Piesse, 2004). No one has studied the extent to which formerly homeless families who use vouchers participate in the FSS program.

A demonstration project, Jobs Plus, sought both to reduce public housing's role as a barrier to employment (by limiting increases in rent due to increased earnings) and increase its role as a bridge (by offering attractive, place-based services in public housing). The evaluation found statistically significant impacts on public housing residents' earnings, whether or not the residents lived in their homes for extended periods. The overall effects were determined primarily by large, sustained impacts in Dayton, Los Angeles, and St. Paul, where implementation of Jobs Plus was strongest (Bloom, Riccio, & Nandita, 2005; Riccio & Orenstein, 2003).

In addition to housing assistance programs without a specific target population, HUD also funds the development of housing dedicated for occupancy by elderly people through the Section 202 program and housing for people with disabilities through the Section 811 program. Section 811 housing can be one of the permanent housing options for people with disabilities. Another residential program, Housing Opportunities for People with AIDS, is among the programs often identified in particular communities as preventing homelessness or helping people leave homelessness.

McKinney-Vento Homeless Assistance Programs

Among HUD's programs explicitly targeted to homeless families and individuals, the McKinney-Vento Supportive Housing Program can be used for transitional housing; permanent housing; and for services, including employment supports, that are part of a particular residential program or that serve a broader homeless population. The McKinney Vento Shelter Plus Care program provides permanent housing for people with disabilities through a rent subsidy structured in the same way as mainstream assisted-housing programs (residents pay 30 percent of their income and the subsidy pays the balance of the housing cost). Grantees must match the Shelter Plus Care rent subsidy with funding for services that comes from other sources. Services usually include case management focused on working and increasing employment income.

Employment is an important objective for transitional housing programs, both as an aspect of self-reliance and because the limited availability of both mainstream assisted housing and supportive housing means that moving to permanent housing often means having enough income to pay for it. Employment is important for permanent supportive housing because of its importance for self-reliance and self-esteem and because residents of supportive housing often want to move on to mainstream housing.

HUD has established performance goals under the Government Performance Reporting Act (GPRA) for its McKinney-Vento programs that give employment gains the same importance as housing stability. Reviewed annually, the programs are expected to increase the percentage of clients working by 11 percent from entry to exit from the program. This is expected to change in 2007 to a performance measure that expects an additional 18 percent of exiting clients to be employed compared with the percentage employed at entry. Without a rigorous impact evaluation, we cannot judge the extent to which increased employment is attributable to the HUD-funded homeless assistance programs.

We also do not have systematic knowledge of the type of employment services and work supports that are provided to homeless people in connection with residential programs for homeless families and

individuals or to other homeless people (those in emergency shelters or unsheltered) as part of local continuums of care. Vocational training, job search assistance, and job placement all are used by particular providers and in particular communities, but no one has documented the patterns or assessed the quality and appropriateness of the services provided to particular groups of clients as part of local strategies to address homelessness.

Supportive Housing and Employment-Related Services. In Philadelphia, researchers tracked 96 leavers of permanent supportive housing and found that less than a quarter engaged in paid employment. The study examined the experience of some 943 residents of permanent supportive housing in the City during the period from 2001 to 2005 (Wong et al., 2006).

Many supportive housing organizations appear to recognize the important role employment can play—as a source of income from which tenants pay rent; as a viable platform from which to enter the workforce; and as an important occupying activity in the face of potential idleness. Employment services are frequently part of the supportive services linked to permanent supportive housing (Burt & Anderson, 2005). Supportive housing projects in New York, Chicago, San Francisco, and other cities combine housing with social services and employment and educational services (Rio et al., 1999). Supportive housing for homeless people, including single adults and heads of family households with complex needs, frequently offers job-retention supports to help residents maintain their attachment to the workforce.

Research evidence on the effectiveness of supportive housing generally does not focus on the separate effect of employment-related services (Martinez & Burt, 2006; Nelson et al., 2005; Rog, 2004; Tsemberis, Gulcur, & Nakae, 2004; Rosenheck et al., 2003; Rog & Randolph, 2002; Culhane, Metraux, & Hadley, 2001). However, Long and Amendolia (2003) evaluated the cost-effectiveness of employment and training supports provided as part of the Next Step: Jobs Demonstration, which introduced intensive new services to existing supportive housing programs operating in New York City, Chicago, and San Francisco. The demonstration was conducted between 1996 and 2000 with funding from the Rockefeller Foundation. Demonstration services included basic and life skills training, GED and ESL classes, vocational training, on-site employment (mostly in program-sponsored businesses), and job development and placement services. The net impacts of the services were estimated using a comparison group research design and regression adjustments for demographic and pre-enrollment experience differences between program and comparison groups. The study concluded that the benefits of the employment supports—resulting primarily from statistically significant increases in earnings and reductions in the use of transfer program—far exceeded their costs to the Foundation and government programs.

U.S. Department of Labor

The U.S. Department of Labor (DOL) concentrates on the employment and training needs of all Americans, including those who are homeless. Many of its mainstream programs operate under the Workforce Investment Act (WIA), which funds state and local workforce development systems.[14] These

[14] The Workforce Investment Act (WIA) of 1998, Public Law 105-220, replaced the Job Training Partnership Act (JTPA) that had been in place from 1982 to 2000. Title I of the legislation authorizes the Workforce Investment System and the dislocated worker programs described in this section; Title II reauthorizes adult education and family literacy programs; Title III amends the Wagner-Peyser Act mentioned in this section; Title IV reauthorizes Rehabilitation Act programs (operated by the Rehabilitation Services Administration in the U.S. Department of Education), such as rehabilitation services, projects with industry, and independent living centers; and Title V contains general provisions.

systems place great emphasis on universal access to services and local planning and control—principles that help determine the services that are provided—and not provided—to homeless people. WIA created a national infrastructure in which state workforce boards oversee the local Workforce Investment Boards (WIBs) that control the funding and employment services within their jurisdictions. At the heart of the system are some 3,500 One-Stop Career Centers operated by 600 WIBs.[15] States and localities are given broad discretion to design and operate their systems to meet state and local needs.[16]

One-Stop Employment Centers

WIA-funded programs are intended to provide access to employment-focused assistance to all individuals in need of help, including hard-to-serve people such as homeless families and individuals. A person needing employment assistance should be able to obtain, through WIA's One-Stop Centers, information and services from the various federal agencies that provide help finding jobs and advancing in the labor market. However, the WIA system is not designed to pay special attention or deliver specially tailored services to people who are homeless. Indeed, DOL does not currently count the number of homeless adults or homeless dislocated workers served by WIA and apparently has no plans to do so in the future (counting homeless clients is not mentioned in DOL's Strategic Plan for 2006–2011). Under WIA's predecessor, the Job Training Partnership Act (JTPA), about 2 percent of the 151,580 individuals served in 1998 by JTPA's adult programs were homeless; and 2.4 percent of JTPA participants in 1994 were homeless (GAO, 2000). A subsequent report estimated that 416,000 WIA participants received training in program year 2003 (GAO, 2005). If the estimated percentage of homeless participants in JTPA applies to WIA, then perhaps 8,000–10,000 people who are homeless are served annually under WIA. However, given WIA's demanding performance requirements (which discourage programs from working with hard-to-serve clients), the percentage of WIA participants who are homeless might be less than under JTPA.

Participants seeking assistance through One-Stop Centers are supposed to receive services designed to meet individual needs. However, evaluation research findings offer several reasons to think this may not be happening in the case of homeless individuals. First, while customer choice is promoted through Individual Training Accounts (ITAs), which allow individuals to choose the kind of training they want, resources for these accounts are limited.[17] GAO's assessment of ITAs (2000) concluded that (1) the dollar value of the ITAs may not be sufficient to meet the training needs of homeless individuals who require more intensive services, (2) the network of "qualified providers" may not include enough providers with expertise in meeting the needs of hard-to-serve populations, and (3) homeless people may find the vouchers difficult to use and may not be in a position to choose the training programs most suitable for their needs. A more recent study, which focused on persons seeking employment assistance

[15] Workforce investment areas are defined by the state boards, and are generally different from the regions used by other mainstream and targeted programs. For example, the geography of HUD's continuums of care frequently overlap, but rarely share the same boundaries.

[16] State and local Workforce Investment Boards develop strategic plans and set priorities to meet workforce needs. The majority of board members on both state and local boards are business people. Most WIA funding flows to the states and local areas by formula. The mainstream WIA program includes three funding streams: youth, adult, and dislocated workers.

[17] DOL, as part of its 2007 budget request, proposed creating "career advancement accounts," providing workers more ownership of their education and training. The proposal, based on Individual Training Accounts and experiences with community colleges, is intended to help meet the Administration's goal of achieving higher enrollment rates in training.

from One-Stop Centers in Chicago, found that most job seekers who were homeless did not receive the assistance they needed (Chicago Coalition for the Homeless, 2005).

Second, most One-Stop Centers are not able to provide special guidance to homeless individuals about how to use the available resources. Only a few centers have staff with suitable training to work with homeless clients. Selected WIBs in about half the states have received special funding for Disability Program Navigators (DPNs), staff who are specially trained to facilitate access to services and benefits for workers who are disabled.

DOL also funds the Comprehensive Employment Program (CEP) in eight sites (made up of WIBs or groups of WIBs) around the country. The CEPs provide employer-linked services, such as job "carving" and restructuring, to a small number of people with disabilities. It is unlikely that more than a fraction of the disabled people served by these special programs are homeless (no estimates are available), but a largely qualitative evaluation of these services (Holcomb & Barnow, 2004) offers hope that approaches like these would be successful if operated on a larger scale.

Third, the One-Stop Career Center system, as currently designed, discourages centers from serving homeless people. DOL's Office of Disability Employment Policy conducted an evaluation of pilot employment programs to identify policy and practices concerns that would improve employment outcomes for people with disabilities served by the centers. Project staff told the evaluators that the current indicators of performance for workforce investment activities under WIA are a disincentive to serving customers with disabilities, including people who are homeless. Several project sites noted that state and federal policies, such as WIA performance measures, impede the ability of One-Stop Centers to provide needed services to hard-to-serve clients.[18] Thus, the demonstration projects have tended to enroll participants they gauge will be successful in finding employment, helping the projects meet the performance measures. The One-Stop Centers were consequently reluctant to enroll participants with disabilities and other severe problems. Some members of the WIA system also said they were reluctant to participate in these pilot projects, because they feared they would be penalized as their staff members took on time-consuming responsibilities that negatively affected their WIA-defined performance (Elinson et al., 2005). Such observations are consistent with those reported elsewhere (GAO, 2000).

A number of individual WIBs and One-Stop Centers have sought to do more for the homeless population. Some have partnered with homeless assistance agencies or have developed employment and training services for job seekers who are homeless, often using McKinney Supportive Housing Program (SHP) dollars. Others have enrolled homeless job seekers in WIA services or have secured funding to enhance their core services to meet the needs of homeless populations. As part of a national evaluation of WIA implementation, cases studies focused on One-Stop Centers serving homeless job seekers in three areas: Tucson, Arizona, Portland, Oregon, and Portland, Maine. These sites were selected because of their

[18] WIA services are divided into three tiers: core, intensive, and training. Core services are available to all job seekers, including access to job listings, information about careers and the local labor market, and limited staff assistance with job search activities. Intensive services are only available after core service efforts are exhausted, and include life skills workshops, case management, and comprehensive assessments leading to the development of an individual employment plan. Training services, such as employer-linked programs and classroom-based skills training leading to a specific occupation, can only be accessed by individuals who have failed to obtain or maintain employment through core and intensive services. Operators of these programs are expected to meet certain performance outcomes established by the state and negotiated with the DOL. Failure to meet performance measures can result in decreased funding to the WIB.

experience and innovative strategies for working with people who are homeless. All were connected to community networks of homeless service providers, which appeared to increase their effectiveness. The three sites had service strategies that emphasized job placement over job training, but also provided supports (including assessment and case management services) intended to produce greater success for homeless individuals. Finally, the sites had local political support that helped promote effective partnership strategies and the linking of mainstream resources (Henderson-Frakes, 2004).

Alternatives to conventional job services have also been used as employment strategies for people who are homeless: day labor programs (now referred to as "contingent labor") and social purpose business ventures. In a review of 27 staffing services, including services that provide temporary jobs for homeless people, researchers suggest that these services can play a unique role in addressing the needs of disadvantaged job seekers in ways more conventional job services do not. They conclude that access to these jobs is less difficult for those with barriers to employment than jobs they are able to find at One-Stop Centers. The jobs offered do not require a long-term commitment; the brokering service agency has an investment in the jobs and acts as a protective buffer for those who would find it difficult to interact directly with employers. Community organizations provide temporary-job brokering specifically to disadvantaged workers, often in conjunction with career counseling, transportation assistance, and other supports; in some instances the brokering agency offers health care benefits to workers (Carre et al., 2003).

Other Mainstream DOL Employment Programs

In addition to One-Stop Centers, other Department of Labor programs that sometimes include homeless people within their service populations are the Adult and Dislocated Worker Program and the WIA Youth Program. The Adult and Dislocated Worker Program serves people who have been terminated or laid off, have received a notice of termination or layoff, or are eligible for or have exhausted unemployment insurance. The Youth Program provides services to low-income youth (age 14–21) with barriers to employment. Eligible youth are deficient in basic skills or are homeless, runaway, pregnant or parenting, offenders, school dropouts, or foster children.

Another DOL initiative that included homeless people among its service population was the Welfare-to-Work (WtW) Grants program, which was designed to help the most disadvantaged TANF recipients leave the rolls and become employed. The program was the subject of a large-scale evaluation (Mills et al., 2006). [19] The sites in the WtW Grants demonstration generally provided services, such as job search assistance, geared to moving welfare recipients rapidly into jobs in the labor market. The WtW enrollees generally had characteristics associated with disadvantages in the labor market—including being an unmarried parent with young children, having little education or work experience, and experiencing work-limiting health problems—although the enrollees in some sites appeared to be less disadvantaged than those in other sites. Two years after entering WtW programs, 4 in 10 enrollees were working—a much higher proportion than at program entry—and nearly two-thirds worked at some point in the second year. Receipt of TANF and poverty rates both declined substantially.

Three of the sites in this demonstration (in Chicago, Ft. Worth, and Nashville) funded organizations that specialized in serving homeless families and persons with mental or physical disabilities. In addition, enrollees in three other sites (Boston, Milwaukee, and Phoenix) exhibited high rates of homelessness

[19] The evaluation was originally intended to be a random assignment experiment, but, because of low local program enrollment, this research design became unfeasible.

shortly after program entry. The evaluation findings indicate that these rates fell significantly by the end of the second year in Boston and Phoenix, but not Milwaukee. A significant reduction in homelessness was also found for Yakima, Washington.

DOL Employment Programs for Homeless People

The Homeless Veterans' Reintegration Program (HVRP) awards funds on a competitive basis to eligible applicants such as state workforce boards and local WIBs; public agencies; commercial entities; and nonprofit organizations, including faith-based and community-based organizations. [20] Administered by DOL's Veterans Employment and Training Service, it is a modest program with an annual appropriation of about $25 million supporting 87 grantees in 2006. It funds services to assist in reintegrating veterans who are homeless into meaningful employment within the labor force and to stimulate the development of effective service delivery systems that address the complex problems facing homeless veterans. In the Department's last program report on HVRP, 13,725 homeless veterans were served, 61 percent of those seeking assistance entered employment, and 58 percent retained employment for six months. The key program-effectiveness metric used in the report, average wage at placement, was $10.11 (greater than both the average wage in previous years and DOL's goal for HVRP). In program year 2004, the HVRP's average cost per placement ($2,152) was less than the average cost per participant during the same year under other DOL programs for special population groups, the Dislocated Worker program ($3,318) and the Employment Opportunities for Youth and Adults with Disabilities program ($2,882).[21]

DOL, jointly with HUD, is sponsoring a federal five-year demonstration for Ending Chronic Homelessness through Employment and Housing, in partnership with Local Workforce Investment Boards in Boston, Indianapolis, Portland, Oregon, San Francisco, and Los Angeles.[22] Projects are expected to make use of evidenced-based and best practices to address mental health and addiction disorders and provide customized employment—a job placement service in which the service provider negotiates with the employer to "customize" a job to reflect the special needs of the client. Nearly all participants have been served with grant resources; few were enrolled in WIA-funded services. Housing retention rates for the comparable period are not available. However, at mid-course of this demonstration, 484 chronically homeless, mostly single, adult men had been served. Half were African American, and 63 percent reported a psychiatric or emotional disability at intake. In terms of income supports, 25 percent were receiving SSI, 21 percent were receiving food stamps, and 14 percent were working either full- or part-time at intake. After 33 months of grant awards, projects reported an entered-employment rate of 51 percent (competitive) and a 22 percent rate at which participants were placed in non-competitive employment activity. For participants for whom data were available, those in competitive employment worked an average of 28 hours per week and started at $9.06 per hour (Palan, Elinson, & Frey, 2006).

U.S. Department of Agriculture

The U.S. Department of Agriculture (USDA) administers the Food Stamps program, which enables low-income people, including those who are homeless, to buy food. At the local level, the program is often

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[20] HVRP was initially authorized under Section 738 of the Stewart B. McKinney Homeless Assistance Act in July 1987. It is currently authorized under Title 38 U.S.C. Section 2021, as added by Section 5 of Public Law 107-95, the Homeless Veterans Comprehensive Assistance Act of 2001.

[21] U.S. DOL, PART Review for FY 2008.

[22] For more information about this initiative go to http://www.dol.gov/dol/audience/aud-homeless.htm or www.csh.org/cheta

implemented in the same offices where people go to apply for TANF, Medicaid, and other public assistance benefits. A similar policy perspective is shared across the federal agencies that administer these programs. However, while TANF is targeted to families and Medicaid is directed to both families and to individuals with disabilities or high medical expenses, food stamps are, in principle, available to the entire homeless population.

Food Stamps

Homeless families are typically eligible for food stamps based on income alone, as are non-disabled single adults over 50. However, non-disabled adults between the ages of 18 and 50 face significant time limits in the receipt of food stamps. People in this category may only receive food stamps for 3 months out of a 36-month period, unless they are working at least 20 hours per week or enrolled in a job training program. As in the TANF program, the disability standard is not nearly as stringent as that used by the SSDI and SSI programs. A letter from a doctor, provided to the food stamp office, is typically sufficient proof of disability—meaning that work requirements will not apply.

Food stamps are a significant income support for individuals and families attempting to leave homelessness. Often most of a TANF grant or an SSI benefit goes to pay rent in permanent housing; receipt of food stamps may allow a household to reach a subsistence level. Food stamps also are an important source of income support for people who leave homelessness with a job. A household may earn up to 130 percent of the federal poverty line and still be eligible for food stamps. The food stamps benefit is reduced by no more than 36 cents for every dollar earned.

The NSHAPC indicated that 31 percent of homeless single adults were receiving food stamps, compared to 71 percent of people in homeless families (Burt, Aron, & Lee, 1999). No research has reviewed the reasons for this disparity. However, it can be inferred that program restrictions on the receipt of benefits by non-disabled adults between the ages of 18 and 50 are responsible for much of this disparity.

Homeless persons who are living on the street can find it difficult to interact with local food stamp offices. They typically do not have the documentation necessary to apply for benefits or a mailing address at which to receive important notices. In addition many applicants for food stamps are incorrectly told that they are ineligible for benefits if they are living in a homeless shelter, particularly if the shelter serves meals. However, this is incorrect. Residents of homeless shelters are exempted from the general rule that residents of institutions providing more than 50 percent of daily meals are ineligible for food stamps, and often persons who are homeless will want food stamps to supplement shelter meals for their children or to purchase food while they are away from a shelter at work (Rosen, Hoey, & Steed, 2001; GAO, 2000).

A recent study tested the effect of housing and substance use treatment histories on the receipt of food stamps. The study showed that people who were homeless or unstably housed were less likely to receive food stamps than people in stable housing. Conversely, people receiving current substance use treatment were more likely to receive food stamps (Nwakeze et al., 2003). This study indicates that people who are stably housed are more likely to obtain government benefits.

Many homeless families believe that food stamps are linked to the TANF program, particularly its time limits. As a result, they are reluctant to apply for food stamps, not wanting to have months of food stamp receipt count against their lifetime five-year TANF time limit.

There are a number of key recommendations for improving homeless persons' access to food stamps. The first, and perhaps most important, is outreach. States are advised to put caseworkers in hospitals, homeless shelters, food pantries, and soup kitchens. Another recommendation is for states to train workers at homeless shelters, so those workers can ensure that their eligible clients receive food stamps. Finally, agencies must exhibit flexibility in working with homeless persons. A homeless person should be able to pick up a letter at the local office instead of having it mailed, and if a homeless person needs help in obtaining documentation, agencies should fulfill their obligation to provide that assistance. These recommendations can be expected to increase homeless persons' access to food stamp benefits (K. Gale Consulting, 2003; Rosen, Hoey, & Steed, 2001; GAO, 2000).

Employment Programs Linked to Food Stamps. For single non-disabled adults who must register for work, USDA has a Food Stamps Employment and Training program (FSET). Funds are awarded in each state based on the number of work registrants in that state. In addition to these funds, states may draw additional FSET resources through the 50:50 matching program in which states use non-federal revenue to match federal dollars. In FY2005 total FSET funds expended were $466,599,435, including federal and state resources.

Delivering services through a variety of local entities, such as TANF offices, community-based service providers, or One-Stop Career Centers, FSET focuses on placing food stamp recipients who are able-bodied adults without dependents in employment and training slots to enhance their ability to gain unsubsidized private sector employment. About 30 percent of food stamp recipients are exempt from mandatory participation because of disability, taking care of a child under six, or being employed 30 or more hours a week, but they can voluntarily access employment and training services without the sanctions that may be applied to mandatory participants.

Several communities—including Seattle,[23] Houston, and Boston—have used FSET resources to help homeless job seekers who are food stamp recipients. Anecdotally, it seems that participants who participate in employment services voluntarily are more job-ready than participants mandated to participate and referred from the local food stamps office.

Reports about FSET focus on information about how states operate their programs (Botsko et al., 2001). There are no FSET evaluations or reports specifically evaluating the inputs and results of employment and training services for homeless job seekers who receive food stamps, or whether the program helps participants get a job. In preparing its report to Congress, the GAO surveyed 15 states and found the entered employment rate ranged from 15 percent of enrolled participants to 62 percent (GAO, 2003).

Internal Revenue Service

The Internal Revenue Service (IRS) has a very different mission from the other agencies: compliance with federal tax laws. One policy instrument contained in those laws, the Earned Income Tax Credit (EITC), is considered by many to be the country's most important anti-poverty tool. Essentially, the EITC pays a family with children 40 cents for every dollar of earned income up to $11,000. This is an important source of income, and a powerful work incentive, to heads of families.

[23] See Seattle Jobs Initiative report 8/18/06, Food Stamp Employment and Training—Lessons Learned from Community Partners Engaged in King County Third Party Match Pilot Providers.

Earned Income Tax Credit

The Earned Income Tax Credit (EITC) provides a refundable tax credit to qualifying low-wage workers. Individuals or families who do not work are ineligible for the EITC. Many people with low earned income find that when they claim the credit they do receive money back from the federal government (National Law Center on Homelessness & Poverty, 1998). Single individuals are eligible for a very small EITC—up to $380. The bulk of the credits are received by households with at least one dependent child; households with two dependent children will receive a credit that may reach the maximum of $4,400, depending on the family income level.

The credit is calculated by reviewing a household's annual income from work. It rises as work income grows from zero to approximately $11,000. The credit stays the same between $11,000 and $15,000. After $15,000 the credit gradually declines, until it is phased out at approximately $37,000.

There are two ways to apply for the EITC. Most commonly, a household will apply for the EITC as part of its annual federal tax return. If the household is found eligible for the EITC, the credit is applied to their tax liability, and any remaining amount is refunded to the household. It is also possible to apply for the EITC in advance. If a household's earnings for the year are predictable and within the range of EITC eligibility, IRS forms can be filled out so that a portion of the EITC is included in a worker's paycheck every two weeks. However, this can be tricky, as it requires workers to know their annual income at the beginning of the year. If the IRS determines that a household received advance EITC payments that it was not entitled to, those payments will be due on the next annual federal tax return.

EITC can be a strong work support for low-wage earners, including people who are homeless. EITC payments are not treated as income under federal programs such as public housing, the Housing Choice Voucher Program, Section 8 subsidies, TANF, food stamps, or Medicaid.

EITC refunds have allowed homeless persons to buy cars to provide reliable transportation to work, pay a security deposit and the first month's rent on apartments, and pay off student loans to reduce monthly expenses (National Law Center on Homelessness & Poverty, 1998). One housing policy expert has recommended that policymakers consider expanding the EITC and other tax provisions that benefit low-income workers to improve the ability of those workers to afford housing (Stegman et al., 2003).

Approximately 75 to 86 percent of eligible workers claim the EITC each year. NLCHP estimates that this includes between 44,000 and 79,000 homeless workers. At the same time, several significant factors prevent additional eligible homeless workers from claiming the EITC. First, homeless workers are often unaware of the EITC; second, homeless workers are frequently unable to document some or all of their earned income; and third, many homeless workers do not have a mailing address or bank account at which to receive a tax refund check (National Law Center on Homelessness & Poverty, 1998).

Although a significant portion of eligible workers do claim the EITC, NLCHP found that many homeless persons were simply unaware of it. A number of homeless workers do not earn enough to owe taxes, but would still qualify for the EITC. However, their lack of knowledge of the program prevents many from filing tax returns. This problem could be remedied by additional outreach, both directly from the IRS and by ensuring that the IRS educates employers about the credit, so that those employers can encourage their employees to apply (National Law Center on Homelessness & Poverty, 1998).

Homeless workers can often have significant problems in documenting their annual income—a requirement for filing taxes, including filing for the EITC. This can be a problem for several reasons. First, homeless persons often move frequently during the year, as they cycle in and out of homelessness or from one shelter to another. As a result, they may have multiple addresses and multiple jobs. When this occurs, employers may not know where to send a W2 form at the end of the year. Or, a W2 form is received by a homeless person but the paperwork is lost or stolen before that person files his or her taxes in the following year. And, in many cases, homeless persons have day labor jobs or perform other short-term work, employment that may go unreported to the IRS. Consequently, these workers do not file tax returns. Agencies can and should work with consumers to help surmount these barriers. For example, a case manager could help a worker obtain a replacement W2 form, or might be able to persuade a recalcitrant employer to provide a W2 and report earned income to the IRS (National Law Center on Homelessness & Poverty, 1998).

Even though the IRS has ruled that workers do not need a mailing address in order to claim the EITC, lack of an address remains a barrier—particularly if a homeless person is reluctant to file for the EITC because he lacks an address where a refund check can be mailed or a bank account in which to deposit funds. To remedy this problem, homeless service providers can allow consumers to use the agency address as a mailing address. In addition, case managers should explore the availability of low- or no-cost bank accounts where consumers can deposit their EITC refund as well as any additional income (National Law Center on Homelessness & Poverty, 1998).

Conclusions

We draw three general conclusions from our examination of the research evidence. First, both mainstream and targeted programs offer promise. Second, looking across the income support and employment programs of the various federal agencies, it is clear that specific groups within the homeless population receive much more assistance than other groups. Third, the research evidence about the effectiveness of programs in reaching the homeless population with income support and in encouraging employment and self-sufficiency while support is provided is plainly weak. In each case, steps could be taken to learn and accomplish more than we have so far.

Mainstream vs. Targeted Programs

Mainstream programs reach far more people than do programs specifically targeted to segments of the homeless population. They are available everywhere, their rules and benefits are relatively well understood by counselors and advocates, and all have grappled with the need to encourage employment and self-sufficiency. Their main drawback is that they are not tailored to the particular needs of homeless people. Several mainstream programs have demonstrated that this shortcoming can be addressed. In particular, the available evidence suggests that SOAR has reduced the barriers that people who are homeless face in accessing disability assistance. The efforts of selected One-Stop Career Centers appear to have increased involvement of homeless individuals in employment activities, although there is no evaluation evidence to gauge their effectiveness. Funding for such mainstream initiatives geared to the homeless, and for evaluating the effectiveness of these initiatives, would be a wise investment.

The rationale for targeted programs is clear: the programs can be tailored to the needs of people who are homeless, and program resources can be focused on the homeless population as opposed to other low-income groups. Targeted programs can also assemble resources for homeless families and individuals from multiple mainstream programs into an accessible package. Unfortunately, there is relatively little

evaluation evidence on the effectiveness of such efforts, particularly for employment outcomes. An exception, the evaluation of the Next Step Jobs employment and training services for supportive housing residents, provides reasons to be optimistic that targeted efforts would produce substantial effects. A more systematic, larger-scale evaluation of such services would be extremely valuable.

Employment and Income Support of Specific Groups

One group within the homeless population, severely disabled heads of families, includes people with mental disabilities (such as schizophrenia and mental retardation) and physical disabilities (such as blindness, musculoskeletal problems, and HIV/AIDS). A family in this category is eligible for income support from SSDI if its head has a sufficient earnings history, or for SSI if he or she does not (assuming that the family's income is not too high to qualify for SSI). Both of these mainstream programs provide monthly cash benefits and Medicare or Medicaid coverage. Regardless of whether they receive disability benefits, families may qualify for food stamps, TANF, assisted housing, veterans' benefits, unemployment insurance (UI), and other programs.

In some ways, the picture for family heads with disabilities who are homeless is encouraging. If they receive income support from SSI and/or SSDI, they are eligible for extensive employment, training, and rehabilitative services from the Ticket to Work program. Many have access to additional services through vocational rehabilitation, TANF, or other programs. The pertinent evidence on the effectiveness of these services is limited, but the results of research on hard-to-serve welfare recipients provide reason for optimism.

In other ways, the picture we see for this group is decidedly discouraging. One reason is that many people with severe disabilities do not receive SSI or SSDI and consequently may receive few services and little income support. The other reason is that, among SSI and SSDI beneficiaries, very few people currently use the employment-related services for which they are eligible.

A second group includes severely disabled single individuals. Individuals with documented disabilities can qualify for SSDI or SSI, which in turn gives them access to Medicaid or Medicare, Ticket to Work and other vocational rehabilitation services. Individuals may also qualify for VA aid and other forms of assistance. As with families, however, eligibility does not ensure program utilization. A small numbers of eligible individuals currently utilize these services. Findings from evaluations of employment services for SSDI and SSI beneficiaries suggest that, when services are used, improvement in employment outcomes can be achieved.

The third group, families whose heads are not severely disabled (according to the Social Security Administration's standards for disability assistance[24]) includes many families whose heads are not living with a spouse. The families are eligible for TANF and food stamps so long as they meet income eligibility requirements. Families on TANF automatically receive Medicaid and other assistance. However, TANF is time-limited, and families lose eligibility after five or fewer years. Indeed, since welfare time limits

[24] SSA evaluates disabilities on the basis of medically determinable impairments, the extent to which these impairments limit the individual's ability to work, and whether the limitations are expected to last at least a year. The severity of disabilities in each physical and mental diagnostic category is assessed in terms of two types of criteria: medical findings and impairment-related functional limitations.

were first imposed in 1996,[25] a steady stream of families has lost eligibility for welfare and, at least temporarily, has experienced homelessness.[26] Some of these heads have physical or mental impairments limiting their functioning. These families may qualify for exemptions from welfare time limits as well as assistance from other programs, including mainstream assisted housing when it is available.

While the income support provided to this group is not as generous as that available to severely disabled individuals and family heads, the evaluation research evidence on the effectiveness of employment services is more plentiful and promising. There is extensive evidence from research on services provided to welfare families, and these services generally appear to be as effective for hard-to-serve welfare recipients as for others. In addition, there is encouraging qualitative evidence from some initiatives targeted specifically to homeless families.

The last group, homeless individuals who are not severely disabled, is generally eligible for the fewest services and the least income support. They do not qualify for SSI, SSDI, TANF, or the employment services and public health insurance that accompany such assistance. This is also a heterogeneous and changeable group. Homelessness among this group more often consists of a single episode or is brief and often due to an event such as a job loss, medical emergency, house fire, or natural disaster.

Although challenged by a lack of permanent housing, these individuals apparently have employment prospects similar to those of housed individuals competing for employment in the labor market. However, there is very little hard evidence on the effectiveness of employment services in helping people who are homeless improve their labor market prospects. Numerous qualitative studies have highlighted promising program approaches to working with people who are homeless.

Limitations of the Available Research Evidence

A range of income support and employment programs is available to the homeless population. We know that many families and individuals who have experienced homelessness are served by these programs. We also know that some people who need assistance never gain access to the programs. We cannot assess the extent to which programs reach the homeless population. The best available evidence, the National Survey of Homeless Assistance Providers and Clients, is now more than a decade old. Changes in both the programs (program features, eligibility requirements, and outreach efforts) and the homeless population (due to immigration, the introduction of welfare time limits, and many other developments) leave the survey's findings clearly out of date.

There is research evidence, some of it very good, on the effectiveness of mainstream programs in encouraging employment and self-sufficiency in the people they serve. We have highlighted several rigorous evaluations of mainstream programs' employment interventions. Unfortunately, none of these evaluations has isolated the impacts of employment-related services on homeless people, who represent a small fraction of mainstream programs' clienteles. Identification of homelessness, including family and individual homelessness, should become a standard part of research that targets a broader population,. For

[25] The federal Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 enacted this and other changes in welfare. The time limits began to affect families in subsequent years.

[26] Based on a large survey of TANF-eligible families, 14 percent of involuntary TANF leavers and 8 percent of voluntary leavers report being evicted from their residences. Such families may live with friends and relatives, find other housing, or experience homelessness (living in emergency shelters or on the streets). See Fragile Families and Child Wellbeing Study (2003).

example, SSA and HHS could collect data on homelessness in their new research projects testing employment initiatives for SSI, SSDI, and TANF recipients. Similarly, while it may not be feasible to count the number of homeless job seekers served in the mainstream workforce investment system, a study using sampling techniques could provide insight into how well homeless people are being served by the system.

The evidence on programs specifically targeted to homeless people is limited. To date, none of these programs has evaluated its employment and training interventions rigorously.

The research we have examined suggests that now would be a good time to fill these gaps in our understanding of how to help the homeless population. A survey of the homeless population, measuring their use of income support and employment programs, would be enlightening. Substantial changes in eligibility requirements for and benefits of several mainstream programs, most notably welfare and disability assistance, have been fully implemented. New survey findings could provide a good picture of where we currently stand in meeting the immediate needs of the homeless population.

Finally, many of the studies we have cited have promising findings. The findings are, for the reasons we have given, far from conclusive. However, we now have a stronger basis for taking policy research related to homelessness to the next level—rigorous evaluation research. Rigorous studies of mainstream programs can and should isolate program impacts for the homeless population and assess ways to increase those effects. Rigorous studies of programs targeted specifically to homeless people can realistically be undertaken. Such research will build our policy knowledge base, enabling policymakers to do more for the families and individuals who encounter homelessness.

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Accountability, Cost-Effectiveness, and Program Performance: Progress Since 1998

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Abstract

The authors summarize the progress made in the past decade toward making homeless assistance programs more accountable to funders, consumers, and the public. They observe that research on the costs of homelessness and cost offsets associated with intervention programs has been limited to people who are homeless with severe mental illness. But this research has raised awareness of the value of this approach, such that dozens of new studies in this area are underway, mostly focused on "chronic homelessness." Less progress has been made in using cost and performance data to systematically assess interventions for families, youth, and transitionally homeless adults. The authors present case studies of promising practices from the State of Arizona and Columbus, Ohio, demonstrating innovative uses of client and program data to measure performance and improve program management toward state policy goals, such as increased housing placement rates, reduced lengths of homelessness, and improved housing stability.

Introduction

This paper summarizes the progress made in making homeless assistance programs more accountable to funders, consumers, and the public since the first national homelessness research symposium in 1998. Some published studies related to the costs and cost offsets of homeless assistance programs are reported, although the published literature on costs remains relatively modest. A recent spate of research on the costs of *chronic* homelessness has emerged, most of which has yet to make it into the published literature and some of which is not intended for an academic audience. These new studies are playing an instrumental role in local “10-year plans” to address chronic homelessness and are summarized here for the first time. The literature on cost, cost-effectiveness, and program outcomes for populations who are *not* experiencing chronic homelessness or who do *not* have a severe mental illness, has experienced even

more limited growth. Relatively little progress has been made in identifying systematically the types of interventions that work for families, youth, and transitionally homeless adults. However, some new or newly documented initiatives for families, including innovations in housing stabilization and relocation programs, may soon provide evidence on the cost-effectiveness of these interventions as compared to emergency shelter and transitional housing. The growing number of cities that have implemented management information systems to track the use of homelessness services has also begun to create a more general capacity for better data and more accountability of homeless assistance programs in many communities. Progress in this area is documented here and holds promise that an infrastructure can be established for the more standardized assessment of program performance and for improving local service systems in the near future. Two jurisdictions in particular, the State of Arizona and Columbus, Ohio, have made innovative use of client and program data to measure program performance and to improvement the management of their service systems toward explicit policy objectives. Those efforts are examined as best-practice case studies here.

Background

In their 1998 paper, *Making Homelessness Programs Accountable to Consumers, Funders and the Public* (Culhane et al., 1999), the authors provide a framework for assessing program outcomes that addresses the information needs of the various constituencies for homelessness services (consumers, funders, and the public). Consumers, it was argued, need data on services received and whether those services meet their perceived needs. Funders require program-level performance data both to demonstrate that programs are delivering the services they are funded to perform, and to compare providers on standardized performance benchmarks. The public needs system-wide performance measures that demonstrate whether the system as a whole is meeting its primary objectives of improving the lives of homeless people and reducing homelessness, and to demonstrate if it is doing so in as efficient and cost-effective a manner as practicable. A variety of studies were cited that illustrated different approaches to these areas and that demonstrated that the measurement of outcomes of interest to these respective audiences was indeed possible. Nevertheless, the empirical evidence on program accountability was quite limited at that time. Little systematic research was occurring on a national scale, aside from a few federally sponsored research demonstrations and the research based on the nationally standardized program data from the U.S. Department of Veterans Affairs. The research was also limited in its timeliness and utility, in that it was frequently geared toward academic audiences, appearing in professional journals years after the completion of the interventions studied. The authors recommended an expansion of standardized data collection tools, including more brief questionnaires that would have program-level and local service system utility. They also argued for a broader, more "systems-wide" view of homeless assistance programs that would examine the relationship of homeless assistance programs to other, mainstream social welfare systems. The authors encouraged the development of automated systems that could track clients longitudinally and that could be used to assess program effectiveness on a more routine basis. To accomplish this, the authors also urged closer collaboration between researchers and practitioners.

Since the publication of that paper, important advances have been made, although much remains to be done. In general, our sense is that the rate of published research on homelessness has slowed since 1998. For our purposes here, we have chosen to focus on the areas where there does seem to be a growing interest and/or literature: analyses of the costs of homelessness and the cost offsets associated with various interventions; and the use of standardized data collection tools and performance reporting in homeless assistance programs. Unfortunately, the literature has grown unevenly with respect to the

various subpopulations who experience homelessness. As has been the case for the last 25 years, since 1998 research on homelessness among people who have a severe mental illness (SMI) is more prevalent than research on other populations, perhaps owing to the funding priorities of federal research sponsors such as the National Institute of Mental Health (NIMH) or the Substance Abuse and Mental Health Services Administration (SAMHSA). The bulk of our literature review will, therefore, focus on services and housing for persons with severe mental illness, and the review is far less comprehensive for other persons who are homeless. Although there has been a recent increase in studies of *chronic* homelessness, beyond people with severe mental illness, this is a relatively new phenomenon; most prior research has not included people who do not have a severe mental illness, even among the chronically homeless—for example, people whose primarily disability is related to substance use—although people without severe mental illness are the majority of people who experience chronic homelessness. Hence, as a result of both the reduced rate of published research since 1998 and its continued focus on persons with mental illness, the available literature is frustratingly narrow in applicability to the homelessness problem overall.

That said, some research on families and youth has begun to inform interventions for these populations, as has literature on adults who are not chronically homeless but who are transitioning from institutional programs (prison, foster care, detoxification). Experimental tests of these interventions are not yet available, and neither are there many detailed cost and utilization studies associated with these subpopulations. Where limited data are available—for example, for families—they will be discussed here.

Despite the limited progress to be found in the research literature, policymakers have made substantial progress in increasing the accountability of homeless assistance programs since 1998. Most significantly, the requirement by Congress in 2000 that communities implement Homelessness Services Management Information Systems (HMIS) has been responsible for a broad and systematic expansion in data collection on both clients and programs. To date, actual research based on these data has been limited, as most communities have had to overcome various technical and human resource challenges during system implementation. However, a growing body of cities have successfully implemented HMIS, and as that pool grows, analyses based on these data will surely find their way into the published literature. The increasing interest in costs and the cost offsets associated with various interventions and subpopulations could also drive more research based on HMIS data. Absent information identifying emergency shelter users from HMIS, it is difficult for communities to track services use across other service systems, let alone within shelter and housing programs. One could argue that the literature on costs and utilization has not grown as quickly as one might have expected since 1998 because of the slow pace with which these information systems have been fully implemented. However, as implementations proceed, more data should yield more analysis and knowledge development, including for populations of homeless people who are not experiencing chronic homelessness.

Until the relatively recent adoption of HMIS, the lack of standardized data collection also restricted the growth of performance measurement and performance-based contracting in the field of homelessness. Performance measurement generally has been limited to fulfilling reporting requirements, such as HUD's Annual Performance Report (APR). While such performance reports enable HUD to conform to the Government Performance and Results Act of 1993 (GPRA), they have not generally served as practical tools for program improvement and management at a local level (with some exceptions, see the Columbus case study below). A few communities have set up other reporting systems that serve as the basis for performance-driven planning and contracting. Such reporting and feedback processes are necessary for guiding service systems toward a desired set of policy objectives. The HMIS infrastructure could be used

as the basis for such systems in the near future. Innovators in this area, such as Arizona and Columbus, Ohio, have shown how quality program-level information can be used for such purposes.

Culhane et al. (1999), in their "accountability" paper, established a framework for considering comprehensively how to measure the accountability of homeless assistance programs to funders, consumers, and the public. However, progress since then has been mixed, and only a subset of programs (mostly a particular type and intensity of supportive housing) and a subset of the homeless population (people with severe mental illness, and some people who are chronically homeless) have been studied to any significant degree since the last symposium. We still know very little about the accountability of other service interventions and the costs associated with homelessness among several important population groups. What follows here is an assessment of what we do know, how the field is working systematically to improve our knowledge base, and some examples of how communities can integrate accountability and management standards into their practices so that further advances can be made across a broader spectrum of programs and populations in the near future.

Literature Review: The Cost of Homelessness and Its Alternatives

Some advances in knowledge about the effectiveness of homeless assistance programs and the costs of intervening—or not—have been achieved since the publication of the Culhane et al. (1999) accountability paper. A growing interest in demonstrating the cost and cost offsets associated with programs targeting people who experience "chronic" homelessness has led to a recent growth of research in this area. Not all of this research has yet made it into academic journals; indeed, some of it has been intended foremost for a policy audience. Most commonly, cost and cost offset studies are based on aggregations of services utilization data, and costs are imputed based on unit costs derived from budget documents or reimbursement rates. More formal cost-effectiveness and cost-benefit studies have seldom been conducted.

Culhane et al. (1999) provide a framework for comparing and describing the differences among the various cost-based evaluation research methodologies, and readers are referred to that document for more complete descriptions of their approaches. In this paper, we focus on the lessons from the published research on the costs and cost offsets of homeless assistance programs, and we examine and discuss the implications of the rapidly emerging literature on chronic homelessness.

Studies of the Costs of Homelessness

Researchers and others have been interested in documenting the costs of homelessness because it is believed that demonstrating high costs will inspire investments in alternative housing and services. Indeed, as will be discussed in the next section, several investments in alternative housing and service models have included evaluations to examine the degree to which the costs of such interventions are offset by reducing the excess costs associated with homelessness. But is homelessness costly? Before reviewing the literature on interventions, we examine the assumption that *not* intervening carries some significant costs. Although the identification of such costs may not reflect on the accountability or effectiveness of homeless assistance programs *per se*, they may shed light on those social welfare systems that should be more accountable, or whose collective costs for accommodating homelessness might compel society to be more accountable.

Studies have found high rates of emergency room use and high rates of hospitalization for mental health and substance abuse problems among adults who are homeless, particularly in comparison to other low-income, but housed populations. Kushel et al. (2002) found that unstable housing and homelessness were associated with more emergency room use than was marginal housing. Kuno et al. (2000) also found that homelessness among a sample of people with severe mental illness was associated with greater inpatient admissions and longer hospital stays, as compared to a non-homeless comparison group. Salit et al. (1998) found that homeless adults in public hospitals in New York City stayed on average 36 percent longer than other patients, controlling for differences in demographics and diagnoses. While this study did not distinguish types of homeless persons or degrees of services use, it did highlight the nature of the health problems of persons who are homeless and hospitalized, with 80 percent of the primary or secondary diagnoses including substance abuse or mental illness.

In his review of the cost-effectiveness literature on homeless assistance programs, Rosenheck (2000) observes that, while service use may be greater among adults who are homeless than those who are not, heavy service use is relatively uncommon, even among people with severe mental illness. A lack of health insurance and a lack of access to primary care are typical for people who are homeless, so it is quite possible that many people either go untreated or avoid care altogether. Rosenheck cites data from two programs, the Homeless Chronically Mentally Ill Program (HCMIP) and the Access to Community Care and Effective Supportive Services Program (ACCESS), in which average annual inpatient costs for participants were $7,905 and $8,346 respectively (1996 dollars). However, at the 90th percentile, average costs reached $32,605 and $25,010, respectively, leading him to conclude that only the most costly 10 percent of the people who are homeless and have mental illness are likely to have such excess costs as to be able to demonstrate a sufficient offset for the costs of the interventions under study. It is worth noting that enrollees in these programs had to have a serious mental illness, which occurs in about 20–25 percent of the adult homeless population (Lehman & Cordray, 1993).

Other research has supported the conclusion that a costly subpopulation of homeless people does exist and appears to be quite distinct from the single adult homeless population in general. Cluster analyses based on shelter utilization data in New York City and Philadelphia has identified a “chronic homeless” population that stays in shelter for long periods of time but represents only 10 percent of adult shelter users overall (Kuhn & Culhane, 1998). Because of their heavy utilization, they account for 50 percent of the total number of shelter nights or of the total annual public expenditures for shelter. Nearly all of the chronic shelter users have a treatment history of severe mental illness or substance abuse, or a physical disability. The average shelter cost for the chronic shelter user population was $6,600 in Philadelphia and $20,400 in New York City (2006 dollars). In neither city was it possible at the time of the study to track episodes of street homelessness, nor street outreach contacts, so costs and total days and episodes of homelessness are underestimated. For the chronic shelter users, even ignoring their use of other service systems, annual shelter costs may equal or exceed the costs of providing rental assistance in many housing markets.

Part of the challenge in identifying costs associated with people who are homeless is obtaining sufficient data to document those costs. Consumer self-report poses reliability issues, so often researchers have relied on administrative data to measure service utilization and costs. As will be discussed later, administrative data come with their own challenges, especially limited accessibility. But when available, administrative data can provide detailed information on diagnoses or charges (in the case of criminal justice) and on admission and discharge dates, all of which can be used to infer costs. However, every study is limited by the administrative data it can include (or does not include). For example, a study that

includes only VA hospitalization data or Medicaid data will miss state psychiatric facility inpatient days, shelter days, jail and prison stays, or uncompensated care provided in public or private hospitals. The inclusion or exclusion of particular systems can have significant impacts on the assessment of overall costs.

A multi-system study of approximately 5,000 people with severe mental illness who were homeless in New York City found that the average annual service utilization costs were $40,500 per person (1999 dollars) (Culhane, Metraux & Hadley, 2002). This per person average is much higher than those reported from the HCMIP and ACCESS programs discussed above, which were closer to $8,000. Part of the difference may be attributable to the inclusion of data from more systems of care in the New York study. For example, had the authors added only Medicaid inpatient days, the cost would have been $11,500.

Even considering the inclusion of multiple systems, the inpatient mental health costs for the group studied in New York are still markedly higher than for the national sample, and are more in line with the heaviest service users (90^{th} percentile) identified by Rosenheck (2000). Because this study did not involve random selection but was based on enrollees in a housing program, it is possible that the sample was biased to include more costly service users or people who were engaged in intensive services prior to enrollment. Part of the difference may also reflect regional variations in access to care, in that New York has relatively generous public health and mental health systems compared to other regions in the US, as well as the nation's only court-enforced "right to shelter."

The possibility of regional factors is further suggested by results from a multi-system utilization study in Houston (Sullivan et al., n.d.). The Houston study found that homeless people with severe mental illness used an average of $3,700 per year (1996 dollars) in health, mental health and criminal justice services (police and courts, not jail/prison), and that people who were homeless and without SMI used an average of approximately $2,700. Neither estimate includes shelter or outreach costs. In stark contrast to the New York results, these utilization costs for people with SMI are less than half of the national average from the VA and ACCESS programs. Because of its sample design, the Houston sample is likely to be broadly representative of a cross-section of adults who are homeless, as in the VA and ACCESS programs, rather than of intensive service users as may have been the case in the New York study.

Moreover, regional factors in access to care also likely play a role, particularly limited access to mental health services for people who have a severe mental illness. Texas state mental health agency expenditures equaled $37 per capita in 1997, as compared to $116 per capita in New York State, a threefold difference (Lutterman & Hogan, 2000). Access to mental health services may be even more constrained for people who are homeless, as the study results show that the comparison sample of people with SMI who were housed used five times as many mental health services as the people with SMI who were homeless. Regardless, the results indicate that in some regions of the U.S., limited access to services for people who are homeless may result in underutilization of services, and therefore lower costs than for other low-income persons. (This would inherently limit the potential for demonstrating cost offsets associated with alternative program placement, as there are relatively few costs to reduce in the first place.)

Although research on the costs and cost-effectiveness of homeless assistance programs (and homelessness in general) appears to have slowed since the 1998 symposium, there has been a recent resurgence in interest in identifying the costs associated with homelessness, and, in particular, chronic homelessness. Since 2000, Congress has required that 30 percent of McKinney-Vento spending be reserved for

permanent housing, and HUD has further required that one third of this set-aside be used for projects that serve a population that includes at least 70 percent persons who are chronically homeless. The U.S. Interagency Council on Homelessness (ICH) has similarly focused local and state officials and planners on identifying people who are chronically homeless through local and state 10-year plans to end (chronic) homelessness. Many of these 10-year plans require communities to identify the resources to pay for alternative housing interventions, and this has led a number of them to conduct or sponsor "cost studies" as the basis for garnering political will for their cause.

The U.S. Interagency Council on Homelessness has recently identified 14 such unpublished "cost studies," including 11 that are complete and 3 that are ongoing. As shown in the ICH summary of these cost offset studies (see Appendix exhibit), the studies have taken a variety of forms, with some conducted by academic researchers and others by planners. Some were inspired by an article in the *New Yorker* by Malcolm Gladwell (2006) entitled "Million Dollar Murray," which summarized the results of the Reno study. Because most of these studies have not been published, many details about the sources of data and about the exact nature of the samples are not precisely known. Nearly all have involved tracking individuals through various administrative data sources, and a handful have involved only aggregations of costs attributed to homeless people by various systems of care.

A general observation about these projects is that they are mostly based on convenience samples, with a few exceptions: one study includes a data match between all HMIS records from Richmond, VA, and a statewide psychiatric inpatient database for the entire state of Virginia; another from Durham, NC, of "verified chronically homeless individuals" required that people be identified as chronically homeless by at least two independent service providers, and appears to include the universe of such persons served by the participating providers. Other projects that used convenience samples, especially those specifically intended to identify the high costs of certain people who are chronically homeless, cannot be generalized to the adult homeless or the chronic homeless population overall. Given a distribution of costs, some subset of persons will have very high costs.

The studies also have varying data sources and time frames for measuring costs, which limits their comparability. Consequently, the results are highly variable and include a broad range of costs per person, from $5,360 per person per year (incarcerated homeless only, and their jail costs only, in Louisville, KY) to $133,333 per person per year (public inebriates only from San Diego, based on EMS, hospitalizations, and police charges). The studies with aggregate results (not based on client-level tracking) indicate that homeless persons have a significant impact on hospitals and other emergency services in total, although we do not know the proportion of total expenditures in these institutions that they represent, nor the number of unique individuals to which these costs can be attributed.

While these studies have limitations and their findings may be regarded as primarily illustrative from a social science standard, they are playing an instrumental role in local policy discussions. In many cities, documentation of such high costs associated with a subset of homeless people, however unrepresentative, is a powerful means of demonstrating the impact of chronic homelessness on society and garnering political momentum around local plans to address it. On that measure, these studies may be even more effective than more polished academic research, having a local basis, involving the participation of local institutions, demonstrating the impact on those local institutions, and often involving known homeless persons in the community. The U.S. Interagency Council on Homelessness has also encouraged communities to identify the most expensive persons, because, regardless of their representativeness, they are real people who can be housed, and likely with significant reductions in costs because they are such

high service users. From this perspective, the issue of representativeness is moot until the pool from which to draw people who are likely high-cost service users dwindles appreciably. At that point, modeling costs and cost offsets for the larger population of persons would require a different sample definition.

Finally, it is worth noting that, while some of these projects include academic researchers, further participation by academic partners could bring more value to these efforts. This is an area where federal resources could help to bring some formalization and standards to the research, and, in so doing, could greatly expand the knowledge base.

Some Observations on the Cost of Homelessness Among Families

Homeless families are relatively understudied when it comes to research on the costs of homelessness. A recent study of family shelter utilization patterns and costs has identified a long-stay population that is roughly analogous to the "chronic" shelter stayers identified in the single adult literature (Culhane et al., in press). Most of these families do not have disabilities or other intensive service histories; however, as is the case for single adults without accompanying children, long-stay families represent a minority of the families sheltered (20 percent) but they account for half of the shelter system costs. And these shelter costs alone are quite remarkable. The study included four US jurisdictions, and found that the average cost for the long-stay families ranged from $27,000 to $55,000 per family. These resources are the equivalent of four or more years of a permanent housing subsidy, or they could provide four or more families with a rental subsidy for a year. The prospect of such cost-efficiencies and of supporting more normalized living environments for a larger population suggests that future research is needed on cost-effective alternatives to long shelter stays for families. Furthermore, unlike the research on adult individuals experiencing chronic homelessness, no research to date has looked at the collateral impact of homelessness among families on other service systems such as child welfare, health, mental health, or education. Other research has also shown that homelessness can be costly to the child welfare system. In particular, a recent study compared the cost of juvenile detention and residential treatment for youth to the costs of a housing subsidy, noting that stable housing costs nearly a tenth of institutional placement (Van Leeuwan, 2004). These are areas deserving further investigation, as are the costs and utilization patterns of other non-chronic or non-SMI populations, including transitionally homeless adults and adults with substance abuse problems.

Studies of Interventions

Studies of the costs of homelessness do not assess directly the accountability or effectiveness of homeless assistance programs. They have been reviewed because they are a means of assessing whether other social welfare systems, policymakers, or society at large, should be accountable for the fact that homelessness can have potentially negative impacts (costs) to society if insufficiently addressed. To assess further the effectiveness of interventions designed to ameliorate homelessness, the federal government and others have funded research demonstration projects and other experimental and quasi-experimental studies. Rosenheck (2000) and Dickey (2000) published separate reviews of this literature, with an emphasis on the cost-effectiveness of programs. In both cases, the authors distinguish studies of outreach programs, case management and other service interventions, and specialized housing programs. Their reviews will be summarized here by these categories. Although most of the studies reviewed were published before 1998 (e.g., five of the eight studies reviewed by Rosenheck), so little has been published overall that they are included again here, along with the handful of studies published subsequent to these reviews. The

growing interest in addressing chronic homelessness has also led to a spate of recent, but as yet unpublished efforts to assess the cost offsets of housing and other service programs; some preliminary results from these studies will be considered here as well.

Outreach

Very little has been published about outreach programs in general, so the literature on costs and cost-effectiveness is consequently slim. An experimental study in New York (Shern et al., 2000) evaluated an outreach program for people living on the streets that included engagement, low-demand shelter/drop-in services, respite housing, and community rehabilitation. The enrolled clients had better outcomes than the control group, including a 54 percent reduction in nights sleeping on the street. However, because the enrolled clients were engaged in more services through the program, and through this engagement were more likely to be hospitalized, Rosenheck concludes that the intervention resulted in increased costs.

Rosenheck also cites the experience of the ACCESS program with street outreach: clients contacted through street outreach had significantly improved housing and clinical outcomes. However, because of the high costs of engagement and enrollment, Rosenheck argues that the outreach likely increased program costs substantially. Only one in five screened candidates entered the program, and engagement took twice as long for the people recruited through street outreach as for those recruited from shelters or other programs. The review does not speculate on the potential costs of outreach per case, nor does it report on how service utilization patterns may have changed as a result of enrollment (such as inpatient or emergency room costs, police contacts, or emergency medical transport charges). However, a more recent evaluation study reported reduced inpatient stays associated with enrollment in the ACCESS program (Rothbard et al., 2004).

Finally, Rosenheck also cites a VA study that tracked outreach and health care costs for people who were homeless and had a severe mental illness. Results showed that costs increased by 35 percent in the year after entry, including an increase of $855 in health care costs and a total of $2,285 after combining case management and residential treatment costs. He concludes that outreach can be costly, when it is effective, but notes, “This is not surprising, since the very reason for conducting outreach is to enhance access to services for the underserved” (p. 1565).[1]

Case Management and Other Service Interventions

Two experimental studies from St. Louis (Wolff et al., 1997) and Baltimore (Lehman et al., 1999) examined the cost offsets associated with providing case management services to people who are homeless and have a severe mental illness. In the St. Louis study, the authors found comparable housing outcomes when comparing two assertive community treatment (ACT) models to a broker case management model (assessment and referral), but improved clinical outcomes for the ACT groups. The ACT models cost approximately $9,000 more than brokered case management, but those costs were offset by reductions in inpatient use, making them effectively cost-neutral. Similar results were found in the Baltimore study. People enrolled in the ACT model had improved clinical *and* housing outcomes

[1] While outreach as an intervention as such represents a cost of resolving homelessness, in some cases one might consider outreach a cost of homelessness, against which one could measure the associated decline in outreach costs for persons who are subsequently housed or placed in a program. Of course, because outreach is part of the interventions studied, it is appropriately considered as a cost of the interventions in comparison to doing *no* outreach. Where to show the costs of outreach will depend on the boundaries of the intervention studied.

compared to standard care. ACT services cost about $8,244 more, but those costs were again offset by reductions in inpatient service use.

In his review, Rosenheck (2000) questions the generalizability of these findings. As noted in the previous section, Rosenheck compared the average inpatient costs for large national samples of homeless people with mental illness from the VA Chronically Mentally Ill Homeless Assistance Program and the ACCESS program to the samples from the St. Louis and Baltimore studies. The comparison shows that average utilization in both the St. Louis and Baltimore studies is much greater than in the larger and, presumably, more representative national samples. Rosenheck concludes that, while the experimental nature of the local studies gives them high internal validity, they likely had a sample bias by selecting more costly users of services for participation in the study. Cost neutrality for such an intervention would presumably have been much more difficult to demonstrate in the national samples, as average inpatient costs are only approximately $8,000 to begin with. Rosenheck concludes that only in the higher cost groups would cost offsets likely be achieved.

The other service intervention that Rosenheck and Dickey reviewed for its potential cost-effectiveness is the Critical Time Intervention (CTI) experiment in New York City (Susser et al., 1997; Jones et al., 2003). The critical time intervention involved providing support services for a nine-month period to people who were homeless with a mental illness as they transitioned from shelter to housing. The support services involved strengthening ties to services, family, and friends, and providing people with practical and emotional support. The control condition was also transitioning from shelter to housing, and received "usual services" such as referrals to mental health and rehabilitation programs. The CTI group had better housing and clinical outcomes up to 18 months after enrollment in the program. However, the CTI group had more hospital days (3.8), emergency room visits (.3), outpatient visits (12.8), and day program visits (4.4) than the control group, leading Rosenheck to conclude that the intervention likely increased costs (a cost analysis was not part of the original study). This assessment does not include consideration of the shelter and outreach costs associated with increased homelessness (an additional 60 days on average) or related criminal justice system costs for the control group.

In a recent reanalysis of the data from the CTI study (Lennon et al., 2005), the authors were able to distinguish different subgroups within each condition and observed that the experimental condition likely prevented chronic homelessness from occurring and was an added, but as yet unobserved, benefit of the intervention. The experimental and control groups had three similar groups with regard to their pattern of recurrent homelessness, with the exception of a chronic homelessness pattern that emerged in only the control group. This group, while relatively small (8.3 percent), returned to homelessness quickly after their initial exit and remained homeless for the duration of the study. No such group was observed in the CTI group, leading the authors to conclude that CTI was associated with preventing chronic homelessness.

A recent study of an intervention for people with serial inebriation found significant reductions in emergency medical services use among adults, many of whom were homeless (Dunford et al., 2006). Judges offered residential treatment for the duration of custody as part of an experimental intervention to address "serial inebriates." Of the 156 people who accepted the residential treatment option (58 percent of those offered), costs declined by $5,642 one year after enrollment. The authors were not able to examine costs beyond EMT services and data from two participating hospitals, so the reductions are likely to be underestimates. The authors do not provide an estimate of the costs of the intervention, but given that the intervention included residential treatment, they are likely to be greater than the offsetting costs from the

service reductions. Because the study was part of a formal court-administered program, random assignment was not possible. The study data indicate that people who accepted residential treatment had higher costs prior to enrollment than the people who refused the treatment option, a selection bias in the treated sample that would favor greater cost offsets.

Supportive Housing

Published studies of various housing interventions have demonstrated that housing does indeed resolve homelessness, though to varying degrees depending on the nature of the intervention, and with varying cost offsets. An experimental study in Boston (Dickey et al., 1997) of people who were homeless with severe mental illness compared people who were placed in an "evolving consumer" group living arrangement with similar persons placed in independent subsidized housing. The group living model had staff supervision, which was expected to decline over time as consumers developed a mutually supportive community. Housing outcomes were positive in both conditions, with retention rates at 18 months of 83 percent in independent housing and 92 percent in the group settings. No changes in clinical or functional outcomes were associated with either type of placement. The cost of the group living condition was much greater than the cost of the independent living condition, mostly attributable to the staffing costs. There was not a "no housing" condition in the study, so it is not possible to estimate the degree to which housing placement in either condition was associated with reduced inpatient days or other services use. Rosenheck notes that inpatient services use at baseline in both conditions was modest, more in line with the national samples. This would suggest that the intervention included a broadly representative sample of people who were homeless with mental illness and did not target heavy service users. Thus, it is unlikely that an offsetting cost effect would have been found.

Several studies have included study designs that enable some inferences about the impact of housing on services utilization and costs. A quasi-experimental study (Culhane, Metraux, & Hadley, 2002) with a pre/post design and a matched control group evaluated the New York-New York Agreement, a joint state- and city-funded initiative to develop supportive housing for people who were homeless and had a severe mental illness in New York City. The study analyzed administrative records from seven service systems to estimate the impact of supportive housing placement on services utilization for two years post placement as compared to two years prior to placement. The study found that supportive housing placement was associated with declines in hospitalizations, incarcerations, and shelter stays. Ninety-five percent of the costs of the supportive housing were offset by service reductions ($17,200 per unit per year), resulting in an estimated net annual cost of the supportive housing programs of approximately $1,000 per unit per year. While an advantage of the study was its inclusion of multiple systems to measure impacts on services use and costs, it did not include all potential costs, including police and court costs, emergency medical transport, and emergency room costs. The primary limitation of the study is that it did not involve randomization. It is possible that there was sample selection bias, and that people were selected for housing only if they were sufficiently stable or had received sufficient treatment before program entry. Indeed, as noted in previously, the pre-intervention average cost of $40,500 per person per year suggests that a heavy service-using population was targeted for the intervention and that such high utilization made it possible to achieve such a high degree of offsetting costs.

Rosenheck, Kasprow, and Frisma (2003) conducted an experimental study of a housing intervention for veterans who were homeless and had a severe mental illness. The housing condition included a Section 8 housing voucher coupled with intensive case management. It was compared to a condition of intensive case management alone and a standard care condition. The results estimated potential cost offsets through

administrative data from the Veterans Administration that track health services use and through participant self-report in a quarterly interview for non-VA health and other services use (including shelter and jail stays). The results found generally positive housing outcomes regardless of the study condition, including standard care. The housing voucher and intensive case management condition was associated with greater cost offsets, and the intervention had a net annual cost of approximately $2,000 per unit per year. According to the authors, a limitation of the study is that attrition was high in the "standard care" condition. It is possible that persons with recurrent homelessness or in other unstable circumstances were differentially lost to follow-up, biasing the sample in the standard care condition to more favorable outcomes, and thereby lessening the observed differences with the experimental conditions. In any case, although the study was based in part on self-report and included randomization, the findings are roughly consistent with the $1,000 net cost found in the NY-NY evaluation.

A supportive housing intervention in San Francisco (Martinez & Burt, 2006) tracked people who were homeless and who had at least two qualifying conditions (an axis I or II mental disorder, a substance use disorder, or HIV/AIDS). A list of eligible persons was generated through a solicitation of applicants recruited at shelter and feeding programs. Just over 200 people were randomly selected from the list to enter one of two supportive housing programs. Their health service use at the San Francisco General Hospital for two years prior to program entry was compared with service use for two years following placement. A small control group from the waiting list was also selected for comparison purposes. The results show that housing placement is associated with declines in emergency room use, hospitalizations, and inpatient days. The authors estimate that the service reductions offset approximately $1,300 of the cost of the intervention, or 10 percent. The authors attribute the comparatively small cost offsets to their limited access to administrative records, having included only visits to the San Francisco General Hospital, and not including other health or social welfare systems.

Schumacher, et al. (2002) focused only on people with substance abuse disorders (particularly addiction to crack cocaine), rather than mental illness, and randomly assigned people to either abstinence- and work-contingent housing and treatment or day treatment alone. The results show that the enhanced services model (housing, work, and treatment) cost more per person (approximately $7,700 versus $3,300 per year). The authors did not investigate any potential cost offsets from other service systems that might be associated with the enrollment in the study, but it is possible that shelter, criminal justice, and other health system costs could have reduced the net cost of the intervention. Given the modest success of the program (abstinence was higher at 6 months in the enhanced condition but there was no significant difference at 12 months) and given the modest cost, the authors argue that investments in programs providing housing and treatment to adults who are homeless with addictions are comparable in net cost to other common social interventions of comparable value.

A quasi-experimental study by Clark and Rich (2003) compared people who were homeless with a severe mental illness and who were placed in a comprehensive housing program, including rental subsidies, support services, and case management, to similar people who were placed in a case management-only condition. The results again indicated that housing outcomes were positive irrespective of the study condition. However, persons who had high psychiatric symptom severity and high substance abuse had better outcomes in the comprehensive housing than in the case management alone condition. Although the authors did not include a cost component in their analysis, they conclude that "the effectiveness, and ultimately the cost, of homelessness services can be improved by matching the type of service to the consumer's level of psychiatric impairment and substance use, rather than by treating mentally ill homeless persons as a homogeneous group" (p. 78).

The fact that several of the studies reviewed here have found positive housing outcomes over time, irrespective of treatment conditions, reinforces the idea that narrower program targeting might be considered as a means of improving the efficiency and effectiveness of programs, as suggested by Clark and Rich (2003). As has been previously noted, most people who experience homelessness, including most people who have a severe mental illness, exit homelessness quickly and do not return within three years; most do so without formal exit support from the homelessness service system (Kuhn & Culhane, 1998). The subpopulation with histories of heavy services use, who experience chronic homelessness or who are otherwise unable to exit homelessness without added supports, should be considered the priority target of the more costly interventions. They not only are the people most likely to need them, but they also are the group for whom the opportunity for demonstrating cost-effectiveness is much greater.

Finally, as with "cost studies," there has been a recent surge in interest in cost offset studies, particularly for interventions targeting people who are chronically homeless. *Nineteen* such studies have recently been identified by the U.S. Interagency Council on Homelessness (ICH)—more than have been conducted in the entire period preceding 2003. The Appendix exhibit provides ICH's summary of 14 studies. The studies are being led by a variety of people, including consultants, academics, planners, and advocates. The interventions are primarily permanent supportive housing programs, some of which include an ACT component. The samples are typically enrollees in the various interventions. They do not appear to have been randomly assigned, so, the opportunity for selection bias exists. Because the people targeted by these projects have experienced chronic homelessness, they are likely to be relatively higher service users, as compared to the homeless population in general. Therefore, they are among the populations for whom significant cost offsets are likely to be achieved following a housing intervention. Most of the studies do not include comparison groups and appear to be pre-post designs. The studies vary in the degree to which they included multiple service systems and in the comprehensiveness of their data, but most have included at least some health services data and some criminal justice systems data. Of course, data coverage determines the ability to find costs as well as cost offsets, and variability in coverage and in other study design issues make the studies not truly comparable.

Results of the completed studies indicate substantial reductions in services use associated with both the ACT and supportive housing interventions (half of the studies are ongoing and do not yet have results). Perhaps not surprisingly, the largest study, based on nearly 5,000 formerly homeless people with mental illness in California, reports the most modest cost offset, at $5,614 in hospitalization, incarceration and emergency room costs. The size of the sample suggests that the intervention did not target people who were chronically homeless, but may have been more broadly representative of people with mental illness who experienced some type of homelessness. Several of the studies report annual cost reductions per person in the range of $13,000–$18,000, which would be roughly consistent with cost offset found in the NY-NY evaluation. Intervention costs are not shown in the Appendix exhibit summarizing the studies, so it is not possible to discern here the degree to which these service reductions offset the costs of the interventions. But such average reductions would appear to be fairly substantial, comparable to the costs of supportive housing in many jurisdictions.

The amount of interest and activity in this area suggests that there is a great appetite for research of this nature. The 10-year planning processes and the resulting housing efforts targeting people who are chronically homeless have no doubt inspired communities to evaluate their progress. But this is an area where federal leadership and support could make a valuable contribution, both by helping to establish standards and comparability in the research and by providing funding that would engage academic researchers as partners with local planners and implementers. The use of administrative records and the

lack of randomization would seem to preclude NIMH as a source of funding for these efforts. Many of these communities are seeking more timely feedback than is likely in most prospective, longitudinal studies based on primary data collection. While research of that nature continues to be needed, mechanisms are also needed for supporting qualified research based on administrative databases and research that is more evaluation than experimental in nature.

Prevention

In her review, Dickey (2000) also addresses the issue of homelessness prevention, and the need for cost-effectiveness and evaluation research in this area. She includes the Critical Time Intervention study from New York in that category, Otherwise, this is an area where little formal research or experimentation has been done. Lindblom (1991) and Shinn, Baumohl, and Hopper (2001) have written very thoughtful papers on the subject and helped to distinguish program types. Interventions that are based in the community and work with "at risk" households are probably the least likely to be able to demonstrate an impact, because it is not possible to know who would have become homeless had an intervention not been provided. An evaluation of a neighborhood-based homelessness prevention intervention in Philadelphia found that, while few of the people assisted became homeless, there was no net impact on rates of shelter admission from the areas served (Wong et al., 1999). It is likely that greater potential impact on shelter use can be achieved by targeting people who recently became homeless with interventions designed to prevent continuing or recurrent homelessness. By targeting newly homeless people the intervention can more directly assist households whose risk of homelessness is known (they are in shelter), and the effect on continued or repeat shelter stays is more immediately realizable. Moreover, if client assessments can carefully profile people and match them with the appropriate type and amount of the intervention(s), they may also be more likely to be able to demonstrate cost-effectiveness. Caton et al. (2005) suggest that the results of their study of long-term homelessness can be used to identify people at greatest risk of chronic homelessness early on in their homelessness experience, and that they can be targeted with various interventions to prevent chronic homelessness. Similar assessment tools and service matching strategies are needed for families.

Practice and research on homeless families may be beginning to show some promise in the area of prevention. The National Alliance to End Homelessness (2006) has recently documented the experiences of six jurisdictions that are systematically diverting families from shelter or providing relocation assistance as an alternative to shelter stays or unnecessarily long shelter stays. The anecdotal experience of these jurisdictions suggests that many families can be successfully prevented from having to stay in shelter for more than 30 days by providing modest relocation grants or time-limited rental subsidies. As noted previously, recent research on typologies of families' shelter stay patterns has suggested that long shelter stays are not associated with personal barriers of families, but with program and policy factors that promote long stays (Culhane et al., in press). The costliness of these stays suggests that resources currently being spent to provide long-term shelter[2] could be reallocated to a prevention and rapid relocation purpose and could serve families in more normalized environments and in a more cost efficient manner. Future research and demonstration projects could investigate the various packages of housing

[2] We use the term "long-term" shelters to more directly refer to their functional role in the shelter system. Distinctions between transitional housing and emergency shelters are not always clear or obvious in practice, and sometimes reflect funding sources more than programmatic differences. Alternatively, long shelter stays can occur in both "emergency" and "transitional" facilities, although some facilities are disproportionately used for long stays than others (Culhane, Metraux, Park, Schretzman, & Valente, in press).

assistance and services that can maximally achieve independent living among families and in the most cost-efficient manner. New initiatives under consideration in Massachusetts, New York, and Philadelphia may herald a new period of experimentation in an area that has been historically understudied.

Conclusion

Research on the cost and cost-effectiveness of homeless assistance programs indicates that costly interventions are not likely to be cost-effective, except for the most costly clients. Generally positive housing and homelessness outcomes frequently found in studies of people with severe mental illness, irrespective of their being in the intervention or control groups of various demonstration projects, further suggest the importance and value of targeting costly programs to people experiencing (or likely to experience) chronic homelessness, or to people who are heavy service users of non-homeless assistance programs. While some people who are chronically homeless may not be heavy users of non-homelessness services, it is likely that inclusion of heavy and modest service users together can still achieve average outcomes that demonstrate substantial cost offsets, if not cost neutrality for the more costly programs. This area deserves more careful study. Unfortunately, it must also be noted that establishing "cost offsets" doesn't actually mean that savings that accrue in one agency are then transferred to another agency for this purpose. Inter-agency transfers are the exception, and some communities that have sought to use the "cost offset" arguments to advance new program development have learned that demonstrating cost offsets doesn't mean that anticipated savings will be advanced for this purpose, particularly across agency boundaries.

Unfortunately, much of the published literature is limited almost exclusively to people who have severe mental illness. The absence of research on other important populations is striking. People with severe mental illness are a minority of the homeless, including a minority of the people who are chronically homeless, among whom they comprise approximately 30 percent (Kuhn & Culhane, 1998; Maguire et al., 2005). Because they may also be among the more expensive service users, given their high rates of hospitalization, studies of people with mental illness are likely to overstate the costs of homelessness for this population relative to people without mental illness. People with primary substance abuse problems, who account for a majority of the chronic homeless population, may use fewer services because they have less access to insurance (low-income people with substance abuse issues must have a co-occurring disabling condition in order to qualify for Supplemental Security Income (SSI), hence Medicaid eligibility), and because managed care has severely limited inpatient and residential treatment for substance abuse. This only highlights the importance of including emergency room use, police and jail records, and emergency medical transport data in cost and cost-effectiveness studies, as people with substance use disorders are more likely to use these services than the inpatient services typically tracked in mental health research.

Even after including these data, it may be the case that some of the people who are homeless and who do not have a severe mental illness (and even some who do have a severe mental illness) may not reach the level of costliness that would inspire major investments in new housing and service interventions. On the other hand, it is also likely to be the case that many of the people who are not severely mentally ill or who are not heavy service users are also likely to need less costly interventions. This is particularly noteworthy given that supportive services costs are typically the largest cost component in most supportive housing projects. Future research (including research demonstration projects) could focus on people who are homeless without a mental illness, including people who have substance use disorders and people who are not chronically homeless, as there has been so little research on the service histories of these very

important subpopulations. Moreover, most of the interventions which have been tested, and whose costs are known, are based on people with severe mental illness and have examined only fairly costly interventions. Future research could test interventions that are more modest in cost as well, and which address the issue of identifying the least costly interventions that are necessary to achieve positive housing outcomes.

As Rosenheck (2000) and Dickey (2000) both caution, one should not assume that cost-effectiveness can or should be demonstrated in all interventions intended to reduce or end homelessness, or for all people the programs may serve. Being able to demonstrate cost-effectiveness or offsetting cost reductions can certainly help make the case to policymakers and the public that effective interventions can and should be expanded. However, cost-offset and cost effectiveness studies can also be tricky, particularly with regard to determining how to allocate costs that precede the intervention or which may be part of the intervention. For example, is case management associated with street outreach a cost of homelessness, or part of the intervention that gets someone out of homelessness? Where to allocate such costs will significantly impact any results as to the "cost offsets" associated with the intervention. Aside from this and other methodological concerns, reducing homelessness has other less easily quantifiable benefits as well. Rosenheck and Dickey suggest that other methods be explored to assess both the less tangible benefits of reduced homelessness and the value that the public places on achievement of such an outcome. As Rosenheck also notes, arguments can be made that housing is a social necessity in an advanced society such as ours, and that we have a collective responsibility for making sure that resources are distributed in such a way as to assure everyone has access to housing. Such arguments deserve further consideration, irrespective of the cost-effectiveness of particular homeless assistance programs.

Opportunities for More Periodic and Systematic Use of Homeless Assistance Program Utilization and Effectiveness Data

Research and other evaluation projects are by necessity time-consuming. They are also intended to produce information that will be useful on a long-term basis for service system planning. By contrast, many of the information needs of public agencies are much more immediate. Managers and policymakers need timely data to forecast budgets, monitor their inventory of programs, guide programs toward intended policy and program objectives, and allocate resources in the most effective manner possible. Establishing accountability on the part of public agencies and the contractors with whom they work is also critical to garnering public confidence, and the willingness of legislators and the executive branches of government to continue to support these programs. Much progress has been made in the last eight years in creating means by which government agencies can track the utilization of homeless assistance programs and measure program performance. Innovations have also been achieved in the capacity and methods for measuring the impact of homelessness on other social service systems. In this section, we provide an update on advancements made since the publication of the accountability framework in 1998. We also consider some of the barriers that have been encountered in trying to implement accountability systems, and we examine two examples of jurisdictions (Arizona and Columbus, Ohio) that have been effective in using performance measures to shape their service systems to meet explicit policy objectives.

Utilization Monitoring and Reporting

When Congress created the permanent housing set-aside within HUD's McKiney-Vento programs in 2000, it also directed the Department of Housing and Urban Development to require that grantees

implement homelessness services management information systems, or HMIS. Congress asked that HUD fund implementation of such systems so that jurisdictions could establish unduplicated counts of clients served by their local homelessness services system, the characteristics of the people served, their patterns of service use and lengths of stay, and the outcomes of their services use. Congress also directed that such systems be used to identify how homelessness was associated with mainstream social welfare systems, both to assure access to mainstream services for people who are homeless and to assess whether mainstream service systems are shifting clients and responsibilities onto the homeless system. In 2000 and in subsequent appropriations, the Congress also asked HUD to compile the HMIS data into an annual report on the utilization of homeless assistance programs and their outcomes. These directives have helped the field to move toward realization of one of the primary recommendations from the Culhane et al. (1999) paper on accountability, namely, the widespread adoption of automated systems for tracking the use of homelessness services.

This effort has not been without obstacles. Most communities have still not fully implemented their systems, and many communities have struggled with technical, cultural, and human resource challenges. However, substantial progress has been made, and the HMIS initiative promises to provide much more comprehensive information for policymakers at all levels of government than has been possible before, and with it, a greater ability to plan and achieve policy goals.

As noted by Congress, one of the principle uses of these new data sources is to measure utilization and outcomes in the homeless system. At a local level, HMIS has enabled communities to create reports like the HUD Annual Progress Reports (APR) on a routine basis. It has also enabled some system managers to monitor utilization through live “dashboards” that show current trends in vacancies, length of stay, admission rates, etc. Agency planners have also been able to use data showing historic utilization patterns to forecast bed demand and as the basis for budget requests. These are but a few of the practical uses of HMIS data for performing the most elementary aspects of program administration.

HUD has also used the expanding HMIS infrastructure as a basis for creating the annual profile of homeless system utilization requested by Congress, through a project called the Annual Homeless Assessment Report (AHAR). The AHAR project has thus far involved several efforts intended to standardize information and reporting and to enable uniform assessments of homeless assistance program utilization nationally. A comprehensive set of federal data definitions and standards was published in the July 30, 2004 issue of the Federal Register. The data standards help ensure that all homeless shelters are collecting the same information on the clients they serve. Software vendors and other system developers use the federal standards to assure that their products are sufficient for meeting HUD’s expectation for privacy and data security, that common data elements are being collected and in standard formats, and to assure that key analysis and reporting features can be supported. The data elements distinguish between “universal data elements” (a short set of identifiers and characteristics to be tracked for all clients in all programs), and “program data elements” (a longer list of client characteristics and needs/progress updates that support collection of data required for HUD’s APR).

The primary goal of the AHAR project is to produce a national estimate of the number of homeless persons sheltered and a profile of the persons served. The report is based on a nationally representative sample of jurisdictions in the U.S. The 15 largest cities were all selected with certainty to be part of the national sample, as the largest jurisdictions contain a substantial proportion of the urban homeless population overall. The remaining sites were chosen randomly within strata defined by geographic region,

jurisdiction type, and population. In total, 80 communities were selected for inclusion in the AHAR project.

The first AHAR report had to be based on a partial year (February 1–April 30, 2005), as HMIS implementation had not progressed sufficiently and data standards had not been promulgated in time to include the entire government fiscal year as the reporting period. A longer, but still partial period has been selected for the second AHAR (January 1–June 30); the third AHAR (September 2006–October 2007) and subsequent AHARs will cover an entire year. The 2005 AHAR includes data from 64 jurisdictions, including 55 from the sample and 9 voluntary contributors. Only jurisdictions from the sample that had sufficient participation of providers were included (50 percent of a jurisdiction's beds had to be tracked). This "coverage" threshold was set to support reliable extrapolation for the untracked beds.

The results of the first AHAR have not yet been published as of January 2007, but initial indications are that the results show that the HMIS effort and the national sample are effective methods for estimating homelessness nationally, and that they will eventually enable the measurement of changes in utilization over time. As more cities are able to provide data, estimation will improve. Although initial AHARs are focused primarily on population estimates and demographic breakdowns, future reports will be able to provide more detailed analyses of stay patterns and outcomes for specific subpopulations and programs.

Although the HMIS is the largest and most ambitious homelessness-specific reporting system, other federally supported reporting systems also hold promise for providing data on service utilization trends, costs, and performance measurement. These include the Department of Veterans Affairs national reporting systems, which have served as the basis for many valuable research and evaluation projects; the Runaway and Homeless Youth Management Information System (RHYMIS); and the national reporting requirements for Programs for Assistance with the Transition to Housing (PATH) projects. Each of these efforts can help to shape public awareness and understanding of homeless people, and the programs that serve them, as well as serve as tools for improving program performance and outcomes.

Administrative Data Linkages

Perhaps the most valuable use of HMIS data beyond its reporting functions is the data capacity it creates for longitudinal, multisite, multisystem research. The Congressional directive authorizing the HMIS initiative refers to the need to use HMIS data to determine if people served in homeless assistance programs are accessing mainstream social welfare and to determine if mainstream systems are shifting people and costs onto the homeless assistance system. Indeed, this may prove to be the most powerful use of HMIS data if it can encourage larger service systems to dedicate additional resources to this vulnerable population. Administrative data integration projects, or "data linkage" efforts, are not without challenges. Yet, as the surge in cost and cost offset studies mentioned previously reveals, communities are getting increasingly savvy about how to access these data sources and have had some significant successes, even without full-scale HMIS data infrastructures. In this section, we briefly consider the potential opportunities for administrative data linkages and some of the challenges that have to be overcome.

A potential research agenda for advancing our understanding of homelessness based on data integration efforts has been summarized elsewhere (Culhane & Metraux, 1997). Among the most fundamental issues to address is the degree to which the homeless system and other social welfare institutions share common populations. From the perspective of the mainstream systems, particularly those that invest heavily in institutional care (hospitals, foster care, corrections), the rate at which people leaving their care become

homeless would presumably be of keen interest. From the perspective of homeless assistance systems, an important issue is the amount of shelter demand that is accounted for by people exiting mainstream systems. In both cases, researchers could use event history analysis to inform these issues and to identify risk factors that distinguish these subpopulations from their respective reference populations. Administrators could conduct periodic database merges to assess whether efforts intended to reduce discharges to homelessness are working.

A second general class of questions relates to the impact of homelessness on other service systems. The cost studies reviewed earlier are an example of these efforts. The cost offset studies are a related use, serving evaluative purposes associated with a given intervention. Evidence of a particular type of system use (e.g., inpatient mental health treatment) is also an indicator that can be used in various research projects, as a control variable, or as a moderating variable in models seeking to examine utilization dynamics or program effectiveness.

A cross-system utilization analysis could also be used to determine program eligibility—for example, for programs that target high service users. However, in most cases, uses of data integration are restricted by law to planning, auditing, and research functions and cannot be used for client contact or eligibility determination or any other means of identifying individuals, unless clients provide written consent.

The social welfare systems with data that could serve as valuable linkage include, but are not limited to: public assistance, various health service records, corrections, vital statistics, public and assisted housing, criminal justice, child welfare, public education, and earnings. Linkage with each of these data sources could form the basis of mainstream program targeting, program design, evaluation, and policy analysis across a wide variety of program areas.

Finally, address data can be used to study patterns of residential instability and moves among households that become homeless. Addresses provide a spatial distribution of the places people lived before they became homeless. This can be used as a means of studying underlying causal processes in neighborhoods or in the housing market more generally, and for geographic targeting of prevention programs. Through integration with other housing databases, researchers can also examine building- or unit-level risk factors or triggering events (e.g., utility terminations) that may present opportunities for intervention.

Research of this nature is not possible without the cooperation of the agencies that have responsibility for maintaining these data. Obtaining data access can be very complicated. However, the federal government could provide incentives or even requirements for routine data matches through its mainstream programs. For example, the federal mental health block grant program already requires states to report how many of the people with severe mental illness in their respective states are homeless and what mental health services are provided to them. It is possible that this could be answered more precisely and consistently through a database merge, perhaps on an annual basis. State Interagency Councils on Homelessness, formed in some states in response to the federally sponsored “Policy Academies,” could be the entities that use such data for their own planning and priority setting. The federal government could pilot data merge projects among willing state volunteers to demonstrate the feasibility and cost of requiring such reporting of all grantees. Similar approaches could be taken to improve state reporting regarding homeless children, prisoners re-entering society, and youth aging out of foster care.

Given their relatively low cost and temporal efficiency, administrative data linkage projects based on HMIS implementations could well be the basis for a rapid expansion of research on homelessness and on

the accountability and effectiveness of homeless assistance programs. Indeed, based on the recent experiences reported here with 10-year plans, such an expansion appears to be already underway. However, as has been observed in the growing number of cost and cost offset studies, many of these efforts could benefit from the participation of academic partners and from federal support. Organized and sponsored programs of research are necessary to bring needed cohesion and value to these and other projects like them.

Until now, we have focused on the literature and reporting tools that inform system design, policy, and program planning. Another area in which there has been some progress since 1998 is program assessment and performance measurement. While most communities are still working to implement their HMIS, some communities have gone further by using HMIS and other program data to assess how programs are doing relative to one another in terms of client outcomes. A few others have used such data to award performance incentives to programs that meet stated objectives, such as improved housing placement rates, or shortened lengths of stay ("performance-based contracting"). Such uses of HMIS and program performance data provide homeless assistance system administrators with systematic tools with which they can attempt to manage or shape provider behavior. Such tools can help to assure that programs are working to serve designated client populations, delivering the intended services and achieving the desired outcomes. While some promising practices have emerged in this area, fully operational models are still far and few between. Only a few of the larger and more sophisticated homelessness service systems are likely to include ongoing performance assessments, let alone performance-based contracting.

In a recent overview of outcome measurement in homeless assistance programs, Crook et al. (2005) characterize an outcome measurement system as "a comprehensive, systematic approach to identifying, tracking, and reporting data that reflect the extent to which program participants experience the intended benefits or changes as a result of service provision" (p. 379). However, the authors state that they were unable to locate a single comprehensive outcome measurement instrument that could be used for the homeless assistance system of care. Instead, at the client level, there are instruments that reflect the impact on a single domain, primarily mental illness or substance abuse. In this section, we review the efforts of a model program from Arizona, where an assessment and outcome system was created that is giving providers the ability to better measure whom they serve and how they perform in terms of client progress over time. A feedback system helps providers to benchmark their effectiveness relative to other providers, and to meet and discuss program strengths and weaknesses. Following that case study, we will also examine the experience of Columbus, Ohio, where regularly collected and analyzed program data has enabled that city to shape its service system to meet stated policy objectives.

Case Study: The Arizona Evaluation Project on Homelessness

The Arizona Evaluation Project on Homelessness was designed to address the need to improve the measurement of program impacts at the client level. The Project was designed to use aggregate impact measures to assess the effectiveness of particular agencies as well as the overall effectiveness of the various continuums of care in the state. The Project commenced in 2002 and included several stages, including an assessment of best practices in outcome measurement, psychometric testing of various instruments, the creation and deployment of a standardized instrument, establishment of a reporting and analysis system, and the creation of a feedback process with the providers.

The first stage brought together service providers to determine what, if any, evaluation tools were being employed by their agencies. Each agency that provided an instrument was also asked to provide raw data

on at least 150 homeless clients. The intent was to analyze the psychometric properties of the existing instruments to determine which, if any, met sufficient standards for reliability and validity. Approximately ten instruments were provided, half of which were called "Self-Sufficiency Matrix." Despite the common name and some obvious similarities across the instruments, the various self-sufficiency matrices had striking differences and appeared to reflect different evolutions at each agency of a long-lost progenitor tool.

Reliability is measured in many ways and is often narrowly defined as the extent to which two measurements yield consistent results in a short period of time (test-retest reliability). This is a specific type of reliability, but the concept of reliability is broader; it also refers to the amount of error in a given set of measurements. The type of reliability most often studied by psychometricians is *internal reliability*, which measures the level of error and hence the quality of a given instrument. The internal reliability of each assessment tool provided to the project team was assessed using the archived data set accompanying the tool.

While an instrument can be reliable, it may still not be useful. To help assess the potential utility of each of the assessment tools provided, construct validity was also examined. To examine the extent to which the instruments were capturing one or more underlying constructs, a factor analysis was also conducted for each instrument. A factor analysis is a multivariate statistical technique which determines the extent to which items on a test "clump" together to form subsets of questions that measure particular scales. Identifying the existence of such underlying scales can be used to establish client typologies for program targeting as well as program performance assessment.

Upon review of the ten instruments that were submitted along with archived data, only one instrument met acceptable reliability and validity standards. This tool was one of the versions of the "self-sufficiency matrix"; it was far superior not only to the other types of instruments but also to the other versions of the self-sufficiency matrix. Since this instrument showed some promise, it was further piloted by a number of local agencies for six months. The agencies submitted all of their data for further psychometric testing. One large agency used the tool as a client self-report measure, while the others used it as a case manager reporting tool. Results from the pilot indicated that it was an inappropriate tool to use for self-report with the homeless population, but it was much more reliable and valid as a case manager reporting tool. The factor analysis yielded two robust factors: the extent of client dysfunction/functioning and the extent of independent life skills. An overall combined score for self-sufficiency is the sum of these two factors. The two factors and the overall score all demonstrated good reliability (internal reliability of client dysfunction=.79, independent life skills=.78, and overall self-sufficiency = .81). The final instrument produced is provided in Exhibit 1.

The client assessment tool was then used for predictive mathematical modeling. The fear of the project staff was that building expectations and incentives for demonstrating client improvement alone could produce an unintended consequence, namely, that agencies would gravitate toward the "low hanging fruit," i.e., relatively easy clients who require less investment of staff time to produce results. An assessment system that included disincentives to serve a particular client group would be counterproductive. The predictive modeling was an attempt to avoid this dilemma. Using HMIS data fields including supplementary client history fields and baseline scores on the self-sufficiency matrix, equations are generated to determine the predictors of change while in homeless assistance programs for the varying level of dysfunction, independent skills, and overall self-sufficiency. These equations are then used to predict the amount of change that would be predicted in each individual client if randomly

Exhibit 1 Self-Sufficiency Matrix

DOMAIN	1	2	3	4	5
Income	No income.	Inadequate income and/or spontaneous or inappropriate spending.	Can meet basic needs with subsidy; appropriate spending.	Can meet basic needs and manage debt without assistance.	Income is sufficient, well managed; has discretionary income and is able to save.
Employment	No job.	Temporary, part-time or seasonal; inadequate pay, no benefits.	Employed full time; inadequate pay; few or no benefits.	Employed full time with adequate pay and benefits.	Maintains permanent employment with adequate income and benefits.
Housing	Homeless or threatened with eviction.	In transitional, temporary or substandard housing; and/or current rent/mortgage payment is unaffordable (over 30% of income).	In stable housing that is safe but only marginally adequate.	Household is in safe, adequate subsidized housing.	Household is safe, adequate, unsubsidized housing.
Food	No food or means to prepare it. Relies to a significant degree on other sources of free or low-cost food.	Household is on food stamps.	Can meet basic food needs, but requires occasional assistance.	Can meet basic food needs without assistance.	Can choose to purchase any food household desires.
Childcare	Needs childcare, but none is available/accessible and/or child is not eligible.	Childcare is unreliable or unaffordable, inadequate supervision is a problem for what childcare is available.	Affordable subsidized childcare is available, but limited.	Reliable, affordable childcare is available, no need for subsidies.	Able to select quality childcare of choice.
Children's Education	One or more school-aged children not enrolled in school.	One or more school-aged children enrolled in school, but not attending classes.	Enrolled in school, but one or more children only occasionally attending classes.	Enrolled in school and attending classes most of the time.	All school-aged children enrolled and attending on a regular basis.
Adult Education	Literacy problems and/or no high school diploma/GED are serious barriers to employment.	Enrolled in literacy and/or GED program and/or has sufficient command of English to where language is not a barrier to employment.	Has high school diploma/GED.	Needs additional education/training to improve employment situation and/or to resolve literacy problems to where they are able to function effectively in society.	Has completed education/training needed to become employable. No literacy problems.
Legal	Current outstanding tickets or warrants.	Current charges/trial pending, noncompliance with probation/parole.	Fully compliant with probation/parole terms.	Has successfully completed probation/parole within past 12 months, no new charges filed.	No active criminal justice involvement in more that 12 months and/or no felony criminal history.

Self-Sufficiency Matrix *continued*

DOMAIN	1	2	3	4	5
Health Care	No medical coverage with immediate need.	No medical coverage and great difficulty accessing medical care when needed. Some household members may be in poor health.	Some members (e.g. Children) on AHCCCS.	All members can get medical care when needed, but may strain budget.	All members are covered by affordable, adequate health insurance.
Life Skills	Unable to meet basic needs such as hygiene, food, activities of daily living.	Can meet a few but not all needs of daily living without assistance.	Can meet most but not all daily living needs without assistance.	Able to meet all basic needs of daily living without assistance.	Able to provide beyond basic needs of daily living for self and family.
Mental Health	Danger to self or others; recurring suicidal ideation; experiencing severe difficulty in day-to-day life due to psychological problems.	Recurrent mental health symptoms that may affect behavior, but not a danger to self/others; persistent problems with functioning due to mental health symptoms.	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health problems.	Minimal symptoms that are expectable responses to life stressors; only slight impairment in functioning.	Symptoms are absent or rare; good or superior functioning in wide range of activities; no more than every day problems or concerns.
Substance Abuse	Meets criteria for severe abuse/dependence; resulting problems so severe that institutional living or hospitalization may be necessary.	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol; withdrawal or withdrawal avoidance behaviors evident; use results in avoidance or neglect of essential life activities.	Use within last 6 months; evidence of persistent or recurrent social, occupational, emotional or physical problems related to use (such as disruptive behavior or housing problems); problems have persisted for at least one month.	Client has used during last 6 months, but no evidence of persistent or recurrent social, occupational, emotional, or physical problems related to use; no evidence of recurrent dangerous use.	No drug use/alcohol abuse in last 6 months.
Family Relations	Lack of necessary support form family or friends; abuse (DV, child) is present or there is child neglect.	Family/friends may be supportive, but lack ability or resources to help; family members do not relate well with one another; potential for abuse or neglect.	Some support from family/friends; family members acknowledge and seek to change negative behaviors; are learning to communicate and support.	Strong support from family or friends. Household members support each other's efforts.	Has healthy/expanding support network; household is stable and communication is consistently open.

Self-Sufficiency Matrix *continued*

DOMAIN	1	2	3	4	5
Mobility	No access to transportation, public or private; may have car that is inoperable.	Transportation is available, but unreliable, unpredictable, unaffordable; may have care but no insurance, license, etc.	Transportation is available and reliable, but limited and/or inconvenient; drivers are licensed and minimally insured.	Transportation is generally accessible to meet basic travel needs.	Transportation is readily available and affordable; car is adequately insured.
Community Involvement	Not applicable due to crisis situation; in "survival" mode.	Socially isolated and/or no social skills and/or lacks motivation to become involved.	Lacks knowledge of ways to become involved.	Some community involvement (advisory group, support group), but has barriers such as transportation, childcare issues.	Actively involved in community.
Safety	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement	Safety is threatened/temporary protection is available; level of lethality is high	Current level of safety is minimally adequate; ongoing safety planning is essential	Environment is safe, however, future of such is uncertain; safety planning is important	Environment is apparently safe and stable
Parenting Skills	There are safety concerns regarding parenting skills	Parenting skills are minimal	Parenting skills are apparent but not adequate	Parenting skills are adequate	Parenting skills are well developed

assigned to a homeless assistance program. Each individual's predicted change is uniquely determined based upon the client's individual characteristics. These predicted changes constitute the expected change for each client. The expected change is then compared to the actual change at the time of program exit. Agencies whose clients typically do better than expected are the most successful and those whose clients typically perform below expectations are in need of programmatic improvements (see sample feedback form, Exhibit 2).

No agency excels with all clients, and the predictive model allows each agency to objectively explore whether there are systematic differences between the types of clients with whom they experience the most success and those who are most challenging. Each agency receives a written feedback report on a quarterly basis detailing how, if at all, their clients differ from those served by other agencies, the extent to which agency outcomes differ from those expected from the predictive model, and the relative strengths and weaknesses of client successes within each agency. For example, one agency serving disabled and older homeless men and women was able to determine that it was far more effective with the older subpopulation than with people with disabilities. Further analyses showed that the frequency of "acting out" behavior among the people with disabilities was determinative of agency effectiveness, with a greater frequency of "acting out" associated with less successful client progress. This agency is now exploring what practices and techniques can increase its effectiveness with such clients. Another agency

was able to identify that despite stronger outcomes than expected overall, it was much less successful with Hispanic clients. As a result, the agency is working with agencies that are more successful with Hispanics to help identify what changes might increase its effectiveness with this subpopulation.

Such feedback systems can also allow agencies to rethink their target populations. If an agency learns that it is effective with people who have a mental illness or a substance use disorder, but is ineffective when these conditions are co-occurring, that knowledge is valuable both for the program and for the local continuum of care. For example, if another agency is highly effective with clients who have co-occurring disorders, the initial agency can either choose to learn from that agency and strengthen outcomes with this group, or it can decide to accept clients with whom it is likely to be effective and refer those clients with whom it is less likely to be successful to programs more likely to benefit them.

The initial expectation of the project was that agencies would naturally discuss and learn from each other in this feedback process. However, it became apparent that the various continuums of care (CoCs) could play a convening role by structuring activities that brought both leadership and line staff from the agencies together to learn from each other in "evaluative learning circles." These are regularly scheduled meetings of homeless agencies from similar locations with similar missions to learn from each other the relative strengths and weaknesses of each and how they can cooperate to produce better client outcomes.

Beyond aiding individual clients or individual agencies, the evaluation system has been helpful in identifying patterns that are valuable for policy considerations for the CoCs as a whole. One finding has been that the distinction between emergency and transitional programs in actual practice in Arizona appears to be an arbitrary one. There is no difference locally between the two types of programs in who they serve, the types and extent of problems their clients exhibit, or the expected change from each program. Another finding in data analyzed thus far suggests that, across all agencies, there is a window of between three and seven weeks when programs are likely to have their greatest impact. Shorter term stays are typically inadequate to effect change, and stays longer than seven weeks tend to cause individuals (but not families) to regress. This suggests that, for homeless individuals, a period of training and stabilization of three to seven weeks followed by placement in long-term housing is likely to maximize client impact. It is also hoped that the predictive model will assist in the rating and ranking process for the McKinney-Vento Assistance application by making quality assessments more objective and rigorous.

The findings related to duration of treatment and lack of distinction between emergency and transitional programming were included to demonstrate the types of findings the model is capable of yielding. However, these results should be regarded with some caution. They are accurate for the sample of homeless we have studied. The sample is not yet representative of the broader homeless community and a sizable number of clients in transitional housing are still in the pipeline without yet having an exit matrix. We are anxious to see if these findings persist when the dataset becomes more representative of the entire state homeless population.

This case study provides one example of how a jurisdiction is able to use program and outcomes data to develop benchmarking and performance standards, as well as to develop a process for engaging providers in discussions about strategies for improving their performance. The development of the self-sufficiency matrix was an important tool in that process, as was the creation of learning communities. Other potential approaches are also possible. In the next section, a case study from Columbus, Ohio, is presented, with particular attention to some of the challenges that community faced in bringing performance measurement to its system.

Exhibit 2 Arizona Homeless Evaluation Project Progress Report

(Based on clients who have exited the program; N=129)

I. PROGRAM: Demo Shelter

Type: Emergency Shelter

Continuum: MAG Continuum of Care Regional Committee on Homelessness

Date: June 19, 2006

We have compared characteristics of Demo Shelter clients to clients from other agencies with like program types within the Maricopa Continuum of Care who entered and exited programs during the same time period (October 2005 through March 2006). In terms of these demographic variables, Demo clients tend to be mildly older, mildly less likely to be female, and mildly more likely to serve black clients and mildly less likely to serve Hispanic clients. However, overall there are not great differences in the demographic characteristics.

DEMOGRAPHICS	Demo Shelter	Other Emergency Shelters
Typical age	38.5	33.6
Gender (% female) [1]	53 %	75 %
Primary race		
White	64 %	62 %
Black	24 %	16 %
Asian	1 %	2 %
Native American	11 %	11 %
Hispanic	14 %	21 %
Other	0 %	8 %
DV clients	26 %	26 %
Extent of homelessness		
First time	40 %	43 %
1-2 times in past	46 %	41 %
Long-term	6 %	6 %
Chronic	8 %	10 %

MATRIX SCORES UPON ENTRY

Dysfunction Score	Demo clients moderately less dysfunctional
Independent Life Skills Score	Demo clients mildly greater life skills
Total Self-Sufficiency Score	Demo clients mildly less challenging

DEMO CLIENT OUTCOMES	Expected	Actual	Difference
Dysfunction Scores	1.3	1.6	+0.3
Independent Life Skill Scores	6.9	7.3	+0.4
Overall Self-Sufficiency Scores	8.3	8.8	+0.5

The predictive model determines the most likely change each client would make if they were randomly assigned to a homeless assistance program. This expected change is then compared to the actual change clients make in the program. If the difference is positive this program is performing above expectations and if the difference is negative then the agency is performing below expectations.

Overall, Demo Shelter is mildly better than other programs in decreasing dysfunction and moderately better in increasing independent life skills and overall self-sufficiency. Demo Shelter has its greatest success with homeless individuals recently released from jail/prison. An area of challenge for Demo Shelter is the program's difficulty in having significant impact with its Hispanic clients.

[1] Arizona HMIS systems contain a high percentage of McKenny-Vento funded participants as well as those served under Arizona Department of Economic Security contracts. Other homeless clients are less well represented within HMIS. This produces a higher percentage of homeless clients than is believed to be represented in the general homeless population.

Case Study: The Community Columbus Shelter Board, Columbus, Ohio

Since 1997 the Community Shelter Board has conducted annual program evaluations for the Columbus and Franklin County Continuum of Care Steering Committee. The Steering Committee utilized evaluation of renewing projects as a means to make ranking decisions, adjust funding awards, and monitor program performance. The program evaluation has considered client characteristics, program utilization and outcomes, program design and implementation, and program costs. The evaluation compared planned results as described in the prior application with actual results obtained. The program was also assessed for compatibility with local priorities and overall community impact. The data were obtained from HUD APRs, interviews with providers, and on-site program visits. Over time, the Steering Committee began tracking and comparing housing outcomes for all programs, as well as comparing program costs (per household served and per housing unit provided). As the process is centered only on the HUD application and is not part of the HUD contracting process, it has more control than a purely voluntary process but less control than a performance-based contracting process. (See Exhibit 3.)

Over this 10-year period, the evaluation process has been modified to better address community needs, respond to best practices, and comport with HUD funding requirements. The impact of using data to inform community funding decisions has been profound:

1. Overall program performance has increased. Programs experience higher housing outcomes and improved program occupancy, and serve more challenging clientele.
2. The inventory of programs has shifted to 91 percent permanent supportive housing beds in 2006 vs. 69 percent in 1997.
3. Community confidence in program accountability and results has increased.

As a result of poor program performance, the Steering Committee ended funding for eight transitional housing and supportive services only programs. Additionally, three programs converted from transitional housing to permanent supportive housing. The latter occurred as the Steering Committee determined that HUD continuum-of-care resources could be allocated on a priority basis to programs that focus both on (1) high need clients (i.e., those with long histories of homelessness, severe disabling conditions, and limited income); and 2) improved housing outcomes for those clients. Clients with low needs (i.e., those with fewer barriers to housing placement, less disabling conditions, and/or better income stability) were diverted to housing placement services and community-based services that were both more effective at meeting their needs and less expensive to the community.

The Steering Committee established a priority for effective and innovative housing service delivery that is expressed as providing housing and services for those with the greatest needs and greatest difficulty accessing the current homelessness service system. Monitoring of program admission and client selection practices has been particularly important during evaluation to determine how programs serve persons with special needs, demonstrate proactive inclusion and non-restrictive housing admission requirements, and practice expedited admission processes. Thus programs that operate in a more selective manner, such as requiring multiple interviews, mandating pre-admission drug testing, and/or restricting admission by persons with criminal histories will disadvantage those with histories of chronic homelessness and multiple barriers. Such program would be rated lower in performance. Based on these provider ratings, HUD resources can be prioritized for the most difficult to house homeless persons.

The Steering Committee has defined program occupancy as one measure of cost-effectiveness. The average monthly occupancy over the 12-month review period should be at least 95 percent. Low occupancy can indicate many program problems, including offering a program that is not desired or needed by homeless persons, selective admission practices, and/or poor property management resulting in slow unit turnover. By evaluating occupancy, the Steering Committee pushed providers to adjust their practices to assure that the precious resource of housing was available to homeless persons on a timely basis.

As HUD has only recently defined housing stability measures (as opposed to allowing programs to self-define outcomes), it was necessary for the local Steering Committee to define the measurement and assign a performance target. The Steering Committee established that as all HUD funding programs were aimed at addressing the needs of homeless persons, it was imperative that housing stability be a primary outcome for each program. This shift is evident when comparing residential stability goals in the late 1990s to the most recent period.

For example, a Shelter Plus Care provider was operating under these agency-designed residential stability goals during 1998-99:

1. 50 percent of initial participants will maintain continuous sobriety and active participation in all program components for at least their first 12 months.
2. 50 percent of the single women clients who had children placed in foster care prior to entry into the program will regain custody within 12 months of program entry.
3. 100 percent of clients will develop quarterly goals for independent living skills.

In 2006, this same program was required by the Continuum of Care Steering Committee to meet the following residential stability goals:

1. There is evidence in the APR that at least 80 percent of persons served during the evaluation period remain in the permanent supportive housing project or exit and move into permanent housing, where the client has control of the housing.
2. The average length of stay for persons living in permanent supportive housing is at least 12 months.
3. The project has met its housing stability goals for the APR period being evaluated.

This example illustrates the shift from addressing homelessness as a personal condition in need of rehabilitation to addressing homelessness as a condition resolved by achieving housing stability. In 1998-99, this program would have considered clients to have been “successful” if they were sober but still homeless. In 2006, clients are only “successful” if they remained housed and are no longer homeless.

The full evaluation report includes all programs that were evaluated during the period and is provided to each agency for distribution to program and management staff. It is hoped that agency leadership not only shares the report but also uses the measures to communicate their vision for program and client outcomes. The ability to benchmark programs against other programs operating within the community is also helpful.

Program and financial data were readily available to the CoC Steering Committee due to the HUD requirements for submission of annual reports. Upon closer review, we did find that programs that experienced program and agency administrative problems were not able to produce reliable, accurate client and financial data. The lack of administrative capacity was also usually correlated with poor program performance.

Providers have resisted the use of standardized measures, citing concerns about differences in admission criteria, program design, and resources. Initially, some providers were more focused on service and treatment delivery, rather than housing stability, thus they were resistant to having their programs' performance evaluated on the basis of attainment of stable housing.

The conduct of annual program evaluations is also not without cost. The Steering Committee's process requires the services of an outside evaluator and two or three Steering Committee members who participate in the site visits. The evaluator is responsible for reviewing program documentation and reports, communicating with the provider, coordinating and participating in site visits, and summarizing findings. Providers also absorb staff costs related to preparing for the evaluation, participating in site visits, and responding to the reviewers' report.

As renewal grants are now required to be limited to one-year terms, rather than three- to five-year terms, the number of programs reviewed is increasing each year. The need for annual program evaluation is being questioned, as overall program performance has improved over time and nearly all programs consistently perform at high levels. The Steering Committee is considering the efficacy of conducting bi-annual reviews for high performing programs and reserving annual program evaluations for programs with sub-par performance.

Another challenge relates to the timing of the design of program evaluations. All too often programs are designed for implementation, with evaluation measures as an afterthought or treated only as a grantor-imposed requirement. Thus, program evaluation measures may be perceived as irrelevant to the program, not measurable based on data collection instruments, and/or too costly for implementation.

Another challenge is that programs change over time and their evaluation methods may not change. The Steering Committee observed the latter when a program shifted from an abstinence-based sobriety housing model to low-demand safe haven programming. Obviously, attainment and maintenance of sobriety was no longer relevant as a measure of self-sufficiency, but measuring reductions in substance use, while more relevant, was also more difficult. This particular provider was also reluctant to concurrently reduce admission barriers (be less selective in admission) and increase housing outcomes expectations as it believed that serving a more "difficult" population would mean that housing outcomes would decrease. Based on local experience and the national literature, however, the Steering Committee required that housing outcomes goals be greater than under the prior program design.

Recently, the Community Shelter Board has begun publication of quarterly program indicator reports from the HMIS. Most HUD SHP–supported programs submit data into the HMIS, and Shelter Plus Care programs will be added over the next year. The following measures are reported for each program:

1. Number served
2. Program occupancy (average number of units occupied)
3. Housing stability (average length of stay)

4. Housing outcomes (number remaining in supportive housing or moved to other permanent housing destination)

Results are compared to community or program standards (if higher than community) for compliance. CSB also aggregates data across programs to create a report on results for the systems as a whole (i.e., family shelter, adult shelter, and supportive housing). In the future, CSB intends to include clients' demographic and key characteristics (gender, age, race, household type, disability, education, homelessness history, etc.) to better understand program results. As the shelter and housing systems better refine their assessment processes, it will be possible to better define risk adjusted outcome targets and improve matching between programs and clients.

To provide accountability to the community and promote transparency, CSB posts all program evaluations and indicator reports to www.csb.org . This transparency has been very powerful in achieving greater program and system accountability for client results. While some providers have expressed concern about this practice, it is overwhelmingly supported by funders, providers, and others. Although there was concern about the potential for political fallout (e.g., loss of local government funding) if programs did not achieve planned results, this has not been the case. Continuously low-performing programs have improved program performance, changed the program model, or ended the program. The elimination of programs has been both voluntary and as result of funding withdrawal. The overall result is better-performing programs that address higher priority community needs.

Exhibit 3

Summary of program evaluations conducted by the Columbus and Franklin County Continuum of Care Steering Committee, 1997-2006

Year	# Programs Evaluated			Performance Rating			Not Funded
	Permanent Supportive Housing	Transitional Housing	Services Only	High	Medium	Low	
1997	4	9	1	7	6	1	1
1998		5		1	3	1	
1999	2	3	3	1	3	4	1
2000	6	4	1	3	6	2	
2001	0	7	0	1	4	2	2
2002	1	3	0	3	0	1	
2003	4	4	2	5	3	2	2
2004	1	2	0	0	1	2	2
2005	5	2	0	6	0	1	
2006	10	3	0	12	0	1	

By focusing on a limited number of indicators that are directly related to the overall community goal of ending homelessness, it is feasible to utilize the HMIS to report on the impact across programs and for the overall system of care. This approach could be feasible for communities across the country to implement. While providers may want to track and report on other measures, e.g., completion of treatment, job placements, etc., these measures would vary by program and thus be difficult to implement across all programs. By keeping the approach simple, communities will be more successful at implementation and will be more effective at communicating progress and challenges to the public and decision makers.

As the Columbus experience illustrates, creating accountability systems and performance measures is possible, but not without challenges. Including providers, funders, and other community leaders in the process can help to encourage change, and transparency can assure that problems and issues are confronted in an open and forthright manner. Most importantly, the Columbus experience shows how deliberate goal setting accompanied by consistent and clear performance measurement can be used to move both providers and the service system overall in a desired policy direction and, ultimately, change the configuration of the service system consistent with the goals of the local planning authority. Since most agencies have multiple funding streams, it is important that performance measures be constructed to allow the agencies to respond to a variety of grant reporting requirements. It is important to construct the measurement system so that the basic measures (stable housing, employment and/or income, linkage to needed services like mental health, and improvements in education/skills) be used to respond to multiple grants.

Summary and Conclusion

Since 1998, progress has made in our understanding of how homeless assistance programs could be more cost-effective and more responsive to consumer needs; however, much more remains to be done. Considerable research has been conducted that shows that various supportive housing models are effective for ending homelessness among most people with severe mental illness. For people with histories of heavy service utilization, these interventions are likely to achieve significant offsetting cost reductions, or at least cost neutrality. This literature also suggests that service matching and other program targeting strategies are also indicated. Most homeless people with mental illness, even those who are not the target of experimental interventions, have short-term homelessness and positive housing outcomes, suggesting that a smaller subsegment of this population needs the intensive (and more expensive) housing and service interventions that have been tested in the literature. Research on chronic homelessness likewise suggests that a small subsegment of the homeless population consumes most of the homeless system resources and is likely to be unable to exit without significant housing and service supports. Thus, while not all people who experience chronic homelessness have severe mental disorders nor are they all heavy service users (service use may vary as a function of regional and other accessibility factors), it is likely that many are costly users of public services, including homeless system resources, and therefore, they would be the appropriate targets of the more intensive supportive housing interventions.

People who experience non-chronic homelessness, including most families and the vast majority of homeless people overall, would seemingly require less intensive interventions. Unfortunately, this is an area where the literature is quite limited. Research is needed to identify the various costs associated with these subpopulations, in part to inform the potential cost efficiency of alternative program models. Relocation programs, transitional rental assistance, and various service support models may be effective

in reducing or preventing homelessness among these subpopulations, and future research could test such models. These can include programs specifically targeting people transitioning out of institutions, people with substance use disorders, and people with temporary economic or domestic crises. While cost-effectiveness or cost offsets may or may not be achieved, such research would identify if better outcomes can be achieved than from congregate shelters, and more efficiently.

Significant progress has been made in the area of standardized, automated information collection on homeless assistance program use. HUD's HMIS initiative has led to the adoption of client tracking technology in hundreds of jurisdictions, and with sufficient coverage for jurisdiction-wide reporting in several dozen cities to date. Future research could take advantage of these data for local studies of homelessness service utilization patterns, as well as for analyses of multi-system services use and costs. More than 30 studies have recently attempted to track costs and cost offsets associated with chronic homelessness through the analysis of multiple service system databases. These efforts could be further expanded and standardized with appropriate federal support, and should take advantage of the implementation of HMIS programs in communities around the country.

The expansion of HMIS capacity has also made possible more rigorous program performance assessments. In this paper, best-practice case studies from Arizona and Columbus, Ohio, were provided that illustrated how these communities were able to implement a client assessment and tracking system that also formed the basis for measuring provider performance. Providers can be measured with regard to a peer group, and their outcomes tracked and compared over time. In Arizona, a process has been established whereby the agencies can share successes and strategies for program improvement, based on their quarterly performance reports. And in Columbus, yearly reviews by the Continuum of Care Steering Committee set expectations and goals for providers, and monitor annual progress in meeting those goals. Such systems hold the promise of making programs more accountable to consumers by assuring that target populations are served (not underserved), that the intended services are delivered, and that they are having their expected outcome. In so doing, a feedback process can be created that will help providers to continually improve their programs. Creating accountability systems is not without challenges. Some providers will be resistant to program performance measurement and to changes that may be required based on feedback. But including relevant stakeholders and an open process can help to insure that provider interests are addressed, at the same time that the community's priorities can be achieved.

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Appendix: The U.S. Interagency Council on Homelessness Summary of Cost Offset Studies

Location	Funder/ Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Data Sources	Years	Costs	Status
Asheville, North Carolina	Ten Year Plan	Asheville TYP Committee	37	Convenience sample identified by police department as chronically homeless individuals with high levels of interaction.	County jail, EMS provider, county health center, area hospitals, mental health facility, homeless shelters.	2001-2002	$39,444 per person per year	Completed
Boston	Boston Health Care for the Homeless Program (BHCHP)	Jim O'Connell, Boston Health Care for the Homeless	119	Convenience sample of street dwellers living on the street at least six consecutive months and one or more identified risk factors.	Medicaid records.	1999-2003	$27,563 per person per year	Completed
Durham, North Carolina	Ten Year Plan	Liz Clasen, Duke University	147	Convenience sample of chronically homeless individuals collected through data of three local service agencies and verified “chronic” by at least two sources.	Duke Hospital System, public health department, VA, EMS, shelter, police, courts, sheriff’s department, corrections department, courts, social service department.	2004-2005	$10,334 per person per year	Completed
Indianapolis I	Coalition for Homeless Intervention and Prevention	Dr. Eric Wright, Indiana University-Purdue University	80-120	Convenience sample of homeless individuals identified and screened (standardized protocol) by outreach workers as high users of public services.	Regional medical records system, police department, jail, homeless services (HMIS).	2006	Not yet available.	Ongoing
Key West, Florida	Ten Year Plan	Office of former Mayor Jimmie Weekley	418	All individuals arrested in Monroe County in 2004 known to be homeless.	Jail (incarceration costs only).	2004	$5,360 per person per year	Completed

Location	Funder/ Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Data Sources	Years	Costs	Status
Louisville	Coalition for the Homeless, City of Louisville	Rod Barber, University of Louisville	NA	Individuals and families counted in annual census. (Future work will include more specific frames.)	Area hospitals, corrections, jail, mental health providers, substance abuse providers, TANF.	2004-2005	Not yet available.	Ongoing
Minneapolis	Hennepin County	Hennepin County Criminal Justice Coordinating Committee	33	Convenience sample of repeat offenders with police interaction during course of study (April-June 2005).	Jail, prison, county courts, county detox, county substance abuse, county mental health services, county hospital and clinics.	1985-2005	$112,967 per person	Completed
Reno	Reno Police Department	Officers Steve Johns, Patrick O'Bryan, Reno Police Department	3	Convenience sample of homeless chronic inebriates known to police officers.	Hospitalization costs reported by one area hospital.	2005	$50,000-$100,000 per person per year	Completed
Richmond, Virginia	Virginia Department of Mental Health	Michael Shank, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services	541	All homeless individuals enrolled in Greater Richmond HMIS who had used inpatient psychiatric care in 2002-2004.	HelpNet (HMIS), statewide hospital database.	2002-2004	$9,000 per person per year. A subset of high utilizers (3+ annual stays) accounted for $21,000 per person per year.	Ongoing
San Diego	University of California-San Diego, City and County of San Diego	Jim Dunford, City EMS Medical Director	15	Convenience sample of known chronic public inebriates who were frequent users of hospital emergency room.	USCD Medical Center (hospital admissions and paramedic runs), police.	1998	$133,333 per person per year.	Completed
Seattle	King County Mental Health	King County Mental Health, Chemical Abuse and Dependency Division	20	Sample included highest users of Sobering Center and Crisis Triage Center.	Jail, county hospital, detoxes, and sobering center.	2003	$54,542 per person per year	Completed

Location	Funder/ Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Data Sources	Years	Costs	Status
Waco, Texas	City of Waco	Baylor University, Business Excellence Scholarship Team	NA	Looked at aggregate costs to municipal, nonprofit, law enforcement and hospital services related to homelessness.	City expenditures, local business donations, nonprofit spending on direct care, jail, police emergency response records, area hospitals.	2001-2003	Aggregate costs related to homelessness were $7,607,349.	Completed
Santa Barbara, California	Santa Barbara County	Roger Heroux, Health Care Consultant	NA	Looked at aggregate costs to three municipalities, county, public safety, medical, and emergency services related to homelessness.	Police, public works, parks and recreation, library, fire department, shelters, county departments, jail, ambulance service, three area hospitals, emergency shelters.	2006	Aggregate municipal and county costs related to homelessness were $36,897,012.	Completed
Gainesville, Florida	Alachua County	Jon Decarmine, Alachua County Housing Authority	NA	Looked at aggregate costs to emergency, public safety and medical systems related to homelessness.	Fire department calls, jail, sheriff's department and police emergency response calls to homeless shelters, records from one area hospital. No client level data.	2002-2005	Aggregate law enforcement and emergency services costs related to homelessness were $3,844,156.	Completed

Intervention Studies

Location	Funder/Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Intervention	Data Sources	Years	Cost Reductions	Status
Atlanta	Georgia Rehabilitation Outreach	Georgia Rehabilitation Outreach	60	Convenience sample of mentally ill individuals referred from criminal justice, health care and homeless service agencies.	FACT team. (Some subjects received housing but this aspect was not included in study.)	Admissions records from one local psychiatric hospital, jail, FACT team budget.	2004-2005	$18,333 per person per year	Completed
Atlanta	United Way of Metropolitan Atlanta	Dr. James Emshoff, Georgia State University	30	Random sampling of dually-diagnosed chronically homeless individuals in Atlanta. Comparison group.	Education and Community Services Engagement Linkage (ECSEL) Housing First program.	Housing and utilities costs, homeless services, three area hospitals, vocational services, police, sheriff, jail, courts, prison, probation, parole, statewide databases of Medicaid, disability and SSI data.	2005-2006	Not yet available.	Ongoing
Broward County, Florida	Ten Year Planners	Camille Franzoni, HHOPE Project Director	44	All participants enrolled in HHOPE Housing First program for chronically homeless individuals.	Permanent supportive housing.	Inpatient hospital stays at one local hospital, jail, shelter.	2004-2005	$13,456 per person per year	Ongoing
California	State of California	Stephen Mayberg, California Department of Mental Health	4,881	All individuals enrolled AB 2034, a statewide, state-funded supportive housing program for homeless mentally ill individuals.	Permanent supportive housing.	Self-reported baseline data including psychiatric inpatient care, incarceration, emergency room visits.	1999-2003	$5,614 per person per year	Completed
Chicago	Housing and Health Partnership	Arturo Bendixen, AIDS Foundation of Chicago	436	Randomly assigned individuals who are homeless and have one chronic illness being discharged from one of three Chicago hospitals. Comparison group.	Permanent supportive housing.	Inpatient care and emergency room visits from the three major hospitals engaged in the Housing and Health Partnership.	2003-2007	Not yet available.	Ongoing

Location	Funder/Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Intervention	Data Sources	Years	Cost Reductions	Status
Dayton, Ohio	Ten Year Planners	Kathleen Shanahan, Shelter Policy Board	4	Convenience sample of dually-diagnosed chronically homeless individuals enrolled in Housing First.	Permanent supportive housing.	Self-reported hospitalizations, substance abuse treatment, emergency shelter.	2004-2005	$43,045 per person per year	Completed
Denver	Colorado Coalition for the Homeless	Jennifer Perlman, Colorado Coalition for the Homeless	19	Chronically homeless individuals in Federal Collaborative Initiative and 16th Street Housing First programs who had been enrolled for 24 or more months.	Permanent supportive housing.	Local hospitals, substance abuse treatment facilities, jails, state prisons and homeless shelters.	2002-2006	$15,772 per person per year	Completed
Hennepin County, Minnesota	Hennepin County	Kelby Grovender, Hennepin County	120	Chronic inebriates enrolled in one of two supportive housing programs.	Permanent supportive housing.	County medical center, housing program records of detox utilization.	2003	$6,659 per person per year	Completed
Indianapolis II	Coalition for Homeless Intervention and Prevention	Dr. Eric Wright, Indiana University-Purdue University	49	Individuals enrolled in Action Coalition to Ensure Stability (ACES) program between 1999 through September 2003.	Permanent supportive housing.	Hospitals included in regional medical information system and two unaffiliated hospitals.	1999-2004	$9,049 per person per year	Completed
Los Angeles	Los Angeles Homeless Services Authority	Los Angeles Homeless Services Authority	120	Chronically homeless individuals enrolled in Federal Collaborative Initiative Housing First program in Skid Row.	Permanent supportive housing.	County health, county mental health and county jail facilities.	2004-2007	Not yet available.	Ongoing
Minneapolis	Family Housing Fund	Ellen Hart-Shegos, consultant	1	Convenience sample of mother and children experiencing long-term homelessness.	Permanent supportive housing.	County children and family services, emergency shelters, halfway house, county jail, probation, county juvenile services, county medical center, county economic assistance department, county training and employment services, child care and special education providers.	1991-1999	$39,500 per family per year	Completed

Location	Funder/Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Intervention	Data Sources	Years	Cost Reductions	Status
Minnesota	Hearth Connection	Ellen L. Bassuk, National Center on Family Homelessness	616	Families and individuals having long histories of homelessness enrolled in state – funded Supportive Housing and Managed Care Pilot. Comparison group of those with similar use trajectory is being constructed.	Permanent supportive housing.	Minnesota Departments of Human Services, Medicaid, Social Services, corrections, education, county law enforcement.	2001-2006	Not yet available.	Ongoing
Oregon	Oregon Network of Independent Living Centers	Oregon Network of Independent Living Centers	266	Convenience sample representing 10 percent of all disabled individuals in Oregon independent living programs with an open Consumer Service Record.	Housing assistance, mental health services, independent living skills, employment services. This varied by subject.	Self- reported foster care, mental health, incarceration, nursing home, assisted living, opportunity, shelter and opportunity costs.	2004	$5,266 per person per year	Completed
Portland	Central City Concern	Thomas L. Moore, Consultant	35	Dually-diagnosed consumers previously enrolled in Community Engagement Program who volunteered to be part of study.	Housing and ACT team.	Self-reported physical and mental health care, incarceration, addiction services.	2005	$16,000 per person per year	Completed
Quincy, MA	The Boston Foundation, Father Bill's Place	Boston Health Care for the Homeless Program, UMass McCormick Institute	37	Convenience sample of chronically homeless individuals identified by homeless service providers and enrolled in Housing First program.	Permanent supportive housing.	One local hospital, case notes, shelter, jail.	2004-2007	$10,000 per person per year	Ongoing

Location	Funder/Sponsor	Researchers/ Contact	Number of Subjects	Sampling Frame	Intervention	Data Sources	Years	Cost Reductions	Status
Salt Lake City	Utah	James Wood, University of Utah	17	Convenience sample of chronically homeless individuals identified by area homeless providers. Comparison group.	Permanent supportive housing.	Shelter and outreach service providers, area medical clinic, nonprofit health care system, university hospital, detox, mental health service provider, housing authority, jail.	2004-2007	Not yet available.	Ongoing
San Francisco	San Francisco Department of Public Health	San Francisco Department of Public Health	71	Homeless individuals enrolled in Direct Access to Housing program between October 2002 and October 2003.	Permanent supportive housing.	San Francisco General Hospital.	2002-2003	$16,300 per year per person	Completed
San Diego II	Department of Emergency Medicine, University of California-San Diego	Jim Dunford, City EMS Medical Director	156	Homeless serial inebriates who had been transported to inebriate reception center five times in 30 days and who accepted treatment. Comparison group.	Serial Inebriate Program, a six-month outpatient substance abuse treatment program in lieu of custody.	City EMS provider, two regional hospitals.	2000-2003	$7,130 per person per year	Completed
Seattle	Robert Wood Johnson Foundation	Mary Larimer, University of Washington	75	Selected homeless chronic inebriates based on health and jail costs. Comparison group of those on waiting list.	1811 Eastlake harm reduction housing program for chronic public inebriates.	County hospital, county jail, county sobering center.	2006	Not yet available.	Ongoing

Appendix A

Symposium Agenda

U.S. Department of Health and Human Services

U.S. Department of Housing and Urban Development

National Symposium on Homelessness Research

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Hyatt Regency Washington on Capitol Hill
400 New Jersey Avenue, NW
Washington, DC
March 1-2, 2007

Agenda

Thursday, March 1

8:00 - 8:30 Registration

8:30 - 9:10 **Welcome**

Introductions: Paul Koegel, Rand, Santa Monica, CA

Speakers:

- Jerry Regier, Principal Deputy Assistant Secretary, Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC
- Darlene Williams, Assistant Secretary for Policy Development and Research, U.S. Department of Housing and Urban Development, Washington, DC
- Philip Mangano, Executive Director, United States Interagency Council on Homelessness, Washington, DC

9:10 – 10:15 **Accountability, Cost Effectiveness and Program Performance: Progress Since 1998**

Moderator: Paul Dornan, Office of Policy Development and Research, U.S Department of Housing and Urban Development, Washington, DC

Paper Presenter: Dennis Culhane, University of Pennsylvania, Philadelphia, PA

Discussants:

- Barbara Ritter, Michigan Coalition Against Homelessness, Lansing, MI
- Martha Burt, The Urban Institute, Washington, DC

10:15 – 10:45 BREAK

10:45 – 12:30 **Paper Presentations**

Moderator: Anne Fletcher, Office of the Secretary, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC

- **Historic and Contextual Influences on the U.S. Response to Contemporary Homelessness –** *Presented by:* Walter Leginski, Gaithersburg, MD
- **Consumer Integration and Self Determination in Homelessness Research, Policy, Planning, and Services** -- *Presented:* Susan Barrow, New York State Psychiatric Institute, New York, NY
- **Homeless Families and Children –** *Presented by:* Debra Rog, Westat, Rockville, MD
- **Rural Homelessness –** *Presented by:* Marjorie Robertson, Alcohol Research Group, Oakland, CA

12:30 - 1:30 LUNCH (on your own)

1:30 - 2:45 **Concurrent Discussion Sessions**

Session #1: **Historic and Contextual Influences on the U.S. Response to Contemporary Homelessness**

Moderator: Fran Randolph, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD

Discussants:

- Rosanne Haggerty, Common Ground, New York, NY
- Bill Breakey, Johns Hopkins University School of Medicine, Baltimore, MD
- Fred Karnas, Fannie Mae Foundation, Washington, DC

Session #2: **Consumer Integration and Self Determination in Homelessness Research, Policy, Planning, and Services**

Moderator: Lawrence Rickards, Homeless Programs Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD

Discussants:

- Michael Rowe, Yale University, New Haven, CT
- Meredith Deming, Bradenton County Coalition on Homelessness, Bradenton, FL
- Judith Klain, Project Homeless Connect, Community Programs, Department of Public Health, San Francisco, CA

Session #3: **Homeless Families and Children**

Moderator: Marsha Werner, Office of Community Services, Administration for Children and Families, Washington, DC

Discussants:

- Beth Shinn, New York University, New York, NY
- Karen Olson, Family Promise, Summit, NJ
- Tanya Tull, Beyond Shelter, Inc., Los Angeles, CA

Session #4: **Rural Homelessness**

Moderator: Pamela Fischer, Homeless Programs Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, Rockville, MD

Discussants:

- Greg Owen, Wilder Research, St. Paul, MN
- Sherrie Downing, Montana Council on Homelessness, Helena, MT
- Gerry Roll, Hazard-Perry County Community Ministries, Hazard, KY

2:45 – 3:15 BREAK

3:15 – 3:45 **Emerging Researcher Paper Presentation: Characteristics of Help-Seeking Street Youth and Non-Street Youth**

Introductions: Charlene LeFauve, Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, MD

Paper presenter: Alma Molino, Rosalind Franklin University, North Chicago, IL

3:45 – 4:55 **Characteristics and Interventions for People who Experience Long-Term Homelessness**

Moderator: Mary Ellen Hombs, U.S. Interagency Council on Homelessness, Washington, DC

Paper presenters:

- Carol Caton, Columbia University, New York, NY
- Carol Wilkins, Corporation for Supportive Housing, Oakland, CA

Discussants:

- Paul Koegel, Rand, Santa Monica, CA
- Katie Kitchin, City of Norfolk, Norfolk, VA

4:55 – 5:00 **Day One Wrap-Up**

Paul Koegel

Friday, March 2

8:30 – 10:15 **Paper Presentations**

Moderator: Marge Martin, Policy Development and Research, U.S. Department of Housing and Urban Development, Washington, DC

- **Housing Models –** *Presented by:* Gretchen Locke, Abt Associates, Cambridge, MA
- **Employment and Supports for Homeless People –** *Presented by:* John Rio, Advocates for Human Potential, White Plains, NY
- **Incarceration and Homelessness –** *Presented by:* Stephen Metraux, University of the Sciences, Philadelphia, PA
- **Homeless Youth in the United States: Recent Research Findings and Intervention Approaches** *Presented by:* Paul Toro, Wayne State University, Detroit, MI

10:15 – 10:45 BREAK

10:45 – 12:00 **Concurrent Discussion Sessions**

Session #1: **Housing Models**

Moderator: Julie Hovden, Office of Special Needs Assistance Programs, U.S. Department of Housing and Urban Development, Washington, DC

Discussants:
- Sandra Newman, Johns Hopkins University, Baltimore, MD
- Richard Harris, Central City Concern, Portland, OR
- Michael DeVos, Michigan Housing Development Authority, Lansing, MI

Session #2: **Employment and Income Supports for Homeless People**

Moderator: Ruth Samardick, U.S. Department of Labor, Washington, DC

Discussants:
- Norm Hursh, Boston University, Boston, MA
- Dan Buck, St. Patrick Center, St. Louis, MO
- Steve Nelson, Pima County Jackson Employment Center, Tuscon, AZ

Session #3: **Incarceration and Homelessness**

Moderator: Denise Juliano-Bult, National Institute of Mental Health, Rockville, MD

Discussants:

- Hank Steadman, Policy Research Associates, Delmar, NY
- Cynthia Belon, Homeless Program, Contra Costa County Health Services, Martinez, CA
- Martin Horn, New York City Corrections and Probation, New York, NY

Session #4: **Homeless Youth in the United States: Recent Research Findings and Intervention Approaches**

Moderator: Stan Chappell, Family and Youth Services Bureau, Administration for Children and Families, Washington, DC

Discussants:

- Norweeta Milburn, University of California at Los Angeles, Pasadena, CA
- Ann Masten, University of Minnesota, St. Paul, MN
- Judith Dobbins, Covenant House Washington, Washington, DC

12:00 – 1:00 LUNCH (on your own)

1:00 – 2:20 **Changing Homeless and Mainstream Service Systems: Essential Approaches to Ending Homelessness**

Moderator: Lynnette Araki, Office of Planning and Evaluation, Health Resources and Services Administration

Paper Presenter: Martha Burt, The Urban Institute, Washington, DC

Discussants:

- Martha Are, North Carolina Department of Health and Human Services, Raleigh, NC
- Martha Fleetwood, HomeBase, San Francisco, CA

2:20 - 2:35 BREAK

2:35 - 4:00 **Closing Reflections: Where Do We Go From Here?**

Moderator: Paul Koegel, Rand, Santa Monica, CA

Discussants:

- Janice Elliot, Corporation for Supportive Housing, New Haven, CT
- Laura Kadwell, Minnesota Housing Finance Agency, St. Paul, MN
- Sue Marshall, Community Partnership, Washington, DC
- Paige Perry, Oregon Health Sciences University, Portland, OR

- Nan Roman, National Alliance to End Homelessness, Washington, DC
- Jim Wright, University of Central Florida, Orlando, FL

4:00 – 4:15 **Closing Remarks & Adjourn**

Paul Dornan, Office of Policy Development and Research, U.S Department of Housing and Urban Development, Washington, DC

Anne Fletcher, Office of the Secretary, Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services, Washington, DC

The National Symposium on Homelessness Research

Is Co-Sponsored By:

U.S. Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation
Substance Abuse and Mental Health Services Administration

U.S. Department of Housing and Urban Development
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The U.S. Interagency Council on Homelessness

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Appendix B

Symposium Faculty Biographies

U.S. Department of Health and Human Services

U.S. Department of Housing and Urban Development

National Symposium on Homelessness Research

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Hyatt Regency Washington on Capitol Hill
400 New Jersey Avenue, NW
Washington, DC
March 1-2, 2007

Faculty Biographies

Jacquelyn Anderson is currently the senior program manager for policy research at the Corporation for Supportive Housing where she is responsible for managing research and evaluation for the organization. Jacquelyn has a decade of experience in social policy research and program evaluation. Prior to working for CSH, she was a research associate for MDRC, a nonprofit social policy research organization. There she evaluated a number of large-scale national initiatives targeted to low-income families and disabled individuals focused primarily on employment, job retention, and career advancement. She also worked for two years at Mathematica Policy Research in Washington, DC, where she studied anti-poverty programs and policies. Jacquelyn earned a master's degree in public policy from the University of Michigan.

Lynnette S. Araki is a senior health program analyst in the Office of Planning and Evaluation (OPE), Health Resources and Services Administration (HRSA) Office of the Administrator, and serves as the lead staff on several cross-cutting projects for HRSA, including the HHS/HUD/VA/DOL joint initiative to improve access to mainstream programs for people experiencing homelessness or who are at risk of homelessness. She is the lead staff for the HRSA Work Group on Homelessness, which is responsible for developing and monitoring implementation of the agency's work plan to address homelessness in HRSA programs in conjunction with the U.S. Department of Health and Human Services Plan for Ending Chronic Homelessness. She is a staff member of the Secretary's Working Group to End Chronic Homelessness. Other cross-cutting projects for which Ms. Araki is responsible include the HRSA Pacific Basin Initiative, National Forum for State and Territorial Chief Executives, and the agency's Continuing Operations Team to assure continuity of essential functions during a crisis or emergency.

Martha Are is North Carolina's first homeless policy specialist, employed by the Department of Health and Human Services. She provides policy staff to the NC Interagency Council for Coordinating Homeless Programs. Prior to her work with the state, Ms. Are had over 15 years of experience with homeless programs including direct service, advocacy, community organizing, and administration.

Susan Barrow is an anthropologist who works as a research scientist at the New York State Psychiatric Institute and is an associate director of the Center for Homelessness Prevention Studies at Columbia University. Dr. Barrow's work, which has combined qualitative and quantitative research methods, has focused on services and housing approaches that reduce homelessness among people with mental illness and additional conditions. Recent and current studies have examined how contrasting housing approaches construct social integration for people who have been homeless; the role of housing loss in the dispersal of homeless families; and the processes through which residential instability affects HIV risk among women who experience homelessness.

Cynthia Belon has served as the director of the Contra Costa County Health Services Homeless Program since 2000. She is responsible for the planning, organization and direction of all Homeless Program activities, including development and organization of program objectives; coordination of housing, social welfare, and health care for service integration; development and analysis of policies and procedures related to service delivery; and coordination and facilitation of continuum of care planning for ongoing enhancement of countywide homeless services. She has spearheaded the creation and implementation of Contra Costa County's Ten Year Plan to End Homelessness, securing grants from SAMHSA, HUD's Supportive Housing, Shelter Plus Care, and Emergency Shelter Programs. She also secured a federal Interagency Council on Homelessness Chronic Homeless Initiative grant. She began her career in the nonprofit sector, as a clinician and as an executive director, responsible for administration and management of homeless services and of alcohol and other drug treatment services.

William R. Breakey is emeritus professor of psychiatry at the Johns Hopkins Medical School. Dr. Breakey was director of community psychiatry at Johns Hopkins and in the 1980s and 1990s with Pamela Fischer conducted several studies of the epidemiology of mental illness in homeless people in Baltimore. He is a former chairman of the Mental Health Section of the American Public Health Association. He has been closely associated with Health Care for the Homeless in Baltimore since its inception, first as a service provider and then as a member of its board of directors. He is chairman of the board of the National Law Center on Homelessness and Poverty.

Dan Buck left a successful broadcasting career in 2003 to become the CEO of St. Patrick Center in St. Louis. St. Patrick Center is the largest Homeless Service Agency in the State of Missouri. In his 18 years of broadcasting, Mr. Buck received 13 prestigious media awards, including 18 Emmy nominations and 6 Emmy awards. Known best for his work with *Show Me St. Louis on KSDK,* Dan also spent two years as the morning show host on the BIG 550 KTRS. He was the founder and president of his own video production company that helped nonprofit organizations across America in their fundraising efforts. Dan

was also the creator and executive producer of *Cardinals Crew, a* children's TV show hosted by former Cardinals pitchers Andy Benes and Fred Bird on Fox Sports Net.

John C. Buckner is a clinical/community psychologist and assistant professor of psychology in the Department of Psychiatry at Children's Hospital-Boston, Harvard Medical School. Dr. Buckner has worked in the area of family homelessness and poverty for 18 years in both the federal government (National Institute of Mental Health) and as a researcher. Dr. Buckner was the director of research at the National Center on Family Homelessness from 1991–1998. He served as the principal methodologist and led the design and implementation of child assessments in the Worcester Family Research Project, a comprehensive longitudinal investigation of 436 homeless and low-income housed families. Dr. Buckner has also been very involved with the SAMSHA-funded Homeless Families Initiative and serves as the chairperson of the publications subcommittee. Dr. Buckner has been the principal investigator on two NIMH-funded grants and has authored/co-authored numerous empirical articles and reviews/book chapters pertaining to homeless and poor housed families and children.

Martha Burt is the director of the Social Services Research Program at the Urban Institute. Dr. Burt has conducted research and written about homelessness for more than 20 years. In 1987, she directed the first national survey of homeless individuals. She has directed numerous studies and reports for HUD, including *Strategies for Reducing Chronic Street Homelessness* (2004) and *Evaluating Continuums of Care for Homeless People* (2002), which was recently followed by a companion *Strategies for Preventing Homelessness* (2006). Her current work focuses on evaluations of transitional and permanent housing efforts in multiple communities, efforts to reduce homelessness among people who are seriously mentally ill, and the Massachusetts Department of Mental Health's Special Homelessness Initiative. Dr. Burt has authored many books on homelessness and continues to be involved in research and policy work on homelessness and residential instability.

Carol L.M. Caton is Professor of clinical sociomedical sciences at Columbia University with a joint affiliation with the New York State Psychiatric Institute and the Mailman School of Public Health. She is the recipient of NIH and foundation grants for studies of the socio-epidemiology of homelessness, schizophrenia and severe mental illness, and psychosis and substance use comorbidity. She is the author of *Homeless in America* (Oxford University Press) and numerous scientific articles and book chapters on the topic of homelessness. Dr. Caton is currently principal investigator and director of the Columbia Center for Homelessness Prevention Studies, the nation's only NIMH-funded research center for the development of new and more effective approaches to homelessness prevention. She participated in the development of the New York City ten-year plan and currently serves as a member of the Research Advisory Board for the New York City Department of Homeless Services. Dr. Caton is a member of the Research Council of the National Alliance to End Homelessness.

Stan Chappell supervises more than twenty ACF professional staff in ten regional offices whose primary responsibilities are administering the Runaway and Homeless Youth programs (RHY). He also oversees national research and evaluation, strategic planning, partnership development, data collection/analysis, and systems development both in RHY and in the Mentoring Children of Prisoners

program. He is currently directing several congressionally mandated national research projects. In 2003, he was senior advisor for the White House Task Force for Disadvantaged Youth, which released its report to the President in October, 2003. He directed the "from-the-ground-up" re-engineering of FYSB's national management information system for runaway and homeless youth programs and played a principal role in the creation of the interdepartmental statement of principles, *Toward a Blueprint for Youth: Making Positive Youth Development a National Priority* (2000).

Richard Cho, Associate director for the New York Office of the Corporation for Supportive Housing (CSH), oversees and manages CSH's New York program activities and supervises professional staff with primary responsibility for advancing innovative program design and service policies for CSH target populations. Mr. Cho also directly provides financial and technical assistance to nonprofit and public organizations around the creation and operation of supportive housing and provides assistance to government in shaping policies and programs to better serve the needs of new and emerging populations such as people reentering communities from institutions, substance users, youth aging out of institutional care, and families, especially those with chronic health and behavioral health challenges. He has co-authored several reports and publications discussing the housing needs of former prisoners, documenting promising models and practices that can prevent their homelessness and reduce their risk of recidivism, and analyzing policy approaches to integrating sectors and systems to end homelessness. Previously, Mr. Cho worked at AIDS Housing Corporation, a nonprofit that provides technical assistance to HIV/AIDS housing providers in New England.

Dennis Culhane's primary areas of research are homelessness, housing policy, and policy analysis research methods. His work includes studies of the impact of homelessness on the utilization of public health, corrections, and social services in New York City and Philadelphia. Dr. Culhane is leading an effort to produce an annual report for the U.S. Congress on the prevalence and dynamics of homelessness based on analyses of automated shelter records in a nationally representative sample of U.S. cities. He is also working with several jurisdictions to develop a typology of homelessness among families, and to test various interventions to prevent or reduce homeless spells among families.

Meredith Deming was born and raised in New York City and environs, and in 1988 relocated to Tampa, FL. Prior to entering a recovery program in 1991, she experienced 20 years of drug addiction and homelessness. As a recipient of numerous public health and government services, as well as 16 years in a 12-step fellowship, Meredith rebuilt her life. She holds master's degrees in social work and public health, and is currently pursuing a Ph.D. Meredith is an independent consultant and therapist, focusing on addiction/recovery and homelessness. She serves on the Board of Directors of the Community Coalition on Homelessness in Bradenton, FL., and is frequently invited to speak at national, state, and local conferences.

Deborah Dennis is vice president for technical assistance at Policy Research Associates in Delmar, New York. She has conducted research and provided technical assistance on federal, state, and local homelessness policy and practice for more than 20 years. Together with staff from Abt Associates, she is responsible for organizing the second National Symposium on Homelessness Research. She was an

author and co-editor of *Practical Lessons*, the compendium of commissioned papers produced from the first National Symposium on Homelessness Research in 1998. Ms. Dennis' current projects include providing technical assistance to the federal interagency Policy Academies on Chronic and Family Homelessness, the HUD McKinney Vento National Technical Assistance Program, and the SSI/SSDI Outreach, Access and Recovery (SOAR) Technical Assistance Initiative. She was also the project director for SAMHSA's National Resource Center on Homelessness and Mental Illness from 1988 to 2004 and currently manages HRSA's Health Care for the Homeless Information Resource Center. She is the author or co-author of numerous journal articles and federal policy reports related to homelessness. Prior to joining PRA in 1988, she was a research scientist in the New York State Office of Mental Health evaluating programs for homeless people with serious mental illnesses.

Michael R. DeVos is executive director of the Michigan State Housing Development Authority (MSHDA). MSHDA, a quasi-public agency, actively participates in Michigan's Campaign to End Homelessness and has invested more than $4 billion in housing for Michigan's low and moderate-income renters, homebuyers, and homeowners. From 1995 to 2005, Mr. DeVos served as the director of the Development Division at the Maine State Housing Authority. While in Maine, he was responsible for policy for affordable housing, supportive housing, and homeless initiatives. He wrote the country's first statewide plan to end homelessness in 2001. From 1991 to 1995, Mr. DeVos served as the executive director of Resources for Community Development, a housing corporation that developed multi-family and supportive housing throughout the San Francisco bay area. He currently serves on the boards of the Michigan Land Bank Fast Track Authority, the Michigan Interfaith Trust Fund, the statewide Local Initiative Support Corporation, and the advisory council of the Community Development Advocates of Detroit.

Judith Dobbins is executive director of Covenant House in Washington, DC, where she has worked since 1997. She has spent over 30 years in Washington DC in the design, development, and management of human services programs for children, youth and families in the metropolitan area. Ms. Dobbins began her career at the Children's National Medical Center as coordinator of a program designed to determine the impact of methadone treatment on pregnancies and the neonatal outcomes from mothers addicted to heroin. Following this, she served as director of Youth and Family Services with the Washington Urban League to develop and implement a city-wide program designed to divert pre-adjudicated youth from the juvenile justice system. In early 1990, she became executive director of the District's Coalition for the Homeless, which provides shelter and housing services to over 5,000 individuals annually in the District of Columbia. Ms. Dobbins' vision is to improve access to affordable housing for youth and young adults, and to seek increased vocational training opportunities that will prepare them to earn a living wage.

Paul B. Dornan is a social science analyst with the Office of Policy Development and Research (PD&R) in HUD, with a concentration in homeless policy. He has managed numerous research contracts, recent among them Abt Associates' *Effects of Housing Vouchers on Welfare Families* (2006) and M. Davis and Company and UPenn's *Predicting Staying In or Leaving Permanent Supportive Housing* (2006). He is currently monitoring research contracts concerning Housing First, Transitional Housing for Homeless Families, the Costs of Homelessness and the *Annual Homeless Assessment Report* (2007). Before joining PD&R, he served for a number of years as a Branch Chief in the Office of Special Needs

Assistance Programs, which administers the Department's homeless programs. He has taught political science at the University of Louisville, Wittenberg University, and Marquette University.

Sherrie Downing is the state team lead for Montana's Policy Academies on Homelessness, state team lead for Montana's SOAR (SSI/SSDI Outreach, Access and Recovery) Team, and coordinator of the Montana Council on Homelessness. She owns Sherrie Downing Consulting and has focused her career on issues and solutions related to poverty and homelessness. Sherrie is the author of numerous publications, including N*o Longer Homeless in Montana 2005-06.* She is also editor of the *Prevention Connection Newsletter*, a professional journal for prevention and treatment professionals.

Amy Dworsky is a senior researcher at the University of Chicago's Chapin Hall Center for Children. Her research interests include youth aging out of foster care, the educational trajectories of homeless children, pregnant and parenting foster youth, and the service needs of low-income families in Chicago. Dr. Dworsky is currently the project director for several studies at Chapin Hall, including a longitudinal study examining the young adult outcomes of more than 700 former foster youth who aged out of care and a project examining the experiences of pregnancy and parenting Illinois foster youth. She is also the principal investigator for a study examining the educational trajectories of homeless children in the Chicago Public Schools whose families received services from an umbrella organization that operates many of the city's homeless shelters.

Janice Elliott is the managing director for program support at the Corporation for Supportive Housing (CSH) where she coordinates CSH's four national programs: Policy and Research, Project Development and Finance, Resource Center, and Strategic Partnerships. These program support teams work with CSH service hubs and with project sponsors, government agencies, and other key partners to strengthen the supportive housing industry, reform public policy, and advance the production of high-quality supportive housing. Through her teams, Ms. Elliott leads several national programmatic and policy initiatives, including Taking Health Care Home, Returning Home, and CSH's national lending pool. Ms. Elliott is the former director of CSH's Southern New England program, where she provided overall direction for CSH's efforts to promote supportive housing production and industry growth. Through partnerships with government and philanthropy, she helped to design three statewide initiatives that have served as national models for state-led collaborations to finance supportive housing production.

Pamela J. Fischer is a medical anthropologist currently working as a social science analyst in the Homeless Programs Branch, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Prior to entering federal service, Dr. Fischer spent more than 20 years researching issues related to homelessness and authored numerous publications on topics such as epidemiology of health and behavioral health problems, criminal behavior, women and children, trauma, and services use.

Marty (Martha) Fleetwood is the founder and executive director of HomeBase, a nonprofit legal and technical services firm advancing solutions to homelessness. HomeBase's focus on addressing the health, mental health, and treatment needs of homeless people began with the groundbreaking report, spearheaded by Ms. Fleetwood, *Meeting the Health Care Needs of California's Homeless Population*, which detailed not only their needs but also the systemic barriers that impede homeless people's access to services. Ms. Fleetwood has worked with several California counties and cities to implement multidisciplinary mobile outreach teams to engage homeless people with mental illnesses and co-occurring disorders and link them with housing and services. This work resulted in the publication of two best practice manuals on outreach and service to homeless adults. She has been at the forefront of efforts to promote "mainstreaming" strategies that enhance homeless people's access to the range of public programs available for low income people. Toward this end, she designed a successful comprehensive technical assistance conference focusing on how to expand access to Medicaid and other benefit programs and to key services such as mental health.

Anne Fletcher is a social science analyst within the U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Office of Human Services Policy. ASPE conducts policy-relevant research and plays a policy coordination role across the many agencies in the Department, taking the lead on a range of the Departmental activities related to homelessness, such as the Secretary's Work Group on Ending Chronic Homelessness and serving as the liaison between the Department and the Interagency Council on Homelessness. Anne is the lead analyst within ASPE regarding policy and research issues related to homelessness.

Patrick J. Fowler is a graduate student in clinical psychology at Wayne State University. His research and clinical interests pertain to the emotional and behavioral development of at-risk children and adolescents living in poverty, particularly the marginalizing processes involved in exposure to violence and maltreatment among youth. His research and clinical experiences stress the importance of evaluating and intervening at multiple system levels to address the needs of marginalized youth. Recently, Patrick coordinated a study that followed-up 265 adolescents who "aged out" of the foster care system in the Detroit metropolitan area in 2002 and 2003. The study examined the mechanisms that led youth to experience homelessness after foster care and the impact of such experiences on mental health. Patrick also is involved in a federally funded longitudinal study of 251 homeless adolescents and a matched housed sample of 150 other youth. His analyses have been presented at several professional meetings and submitted for publication.

Nancy Fritz assumed the role of the first director of Homeless Initiatives in Maine in the summer of 2005 after being appointed to the post by Governor John Baldacci. She serves as the governor's primary liaison on homeless issues and is a member of his cabinet. Her position is funded by the Maine State Housing Authority, where she also serves as director of the Homeless Initiatives Department. For the past 20 years, Ms. Fritz held leadership positions with Maine nonprofit organizations including one that focused on domestic abuse, one that served young children with disabilities and their families, and a community action agency with a mission to help low-income individuals and their families build their assets. She was a founding member of the Maine Association of Nonprofits and the Maine Children's

Alliance, and she was a previous chair of the Maine Affordable Housing Network and the Maine Community Action Association. She currently serves on the Board of Directors for the Maine Center for Economic Policy.

Kennen S. Gross is a doctoral candidate, specializing in on policy research, evaluation and measurement, at the University of Pennsylvania Graduate School of Education. He previously served as a housing policy analyst for the New Jersey Housing and Mortgage Finance Agency and as an epidemiologist for the Philadelphia Department of Public Health.

Rosanne Haggerty is the president and founder of Common Ground Community H.D.F.C., Inc., a New York City-based nonprofit organization dedicated to finding innovative solutions to homelessness. Common Ground was founded in 1991 to rehabilitate the Times Square Hotel, the largest special needs single-room occupancy facility in the United States. Common Ground has similarly developed a range of housing facilities serving formerly homeless and low income households located in New York City, the Hudson Valley, and Connecticut. In addition, Common Ground operates programs designed to prevent homelessness among vulnerable individuals and groups and to assist long-term homeless adults in accessing housing. Under her supervision, Common Ground's innovative work has been recognized with many national and international awards. Ms. Haggerty was a Japan Society Public Policy Fellow, an Adelaide Thinker in Residence, and the recipient of a John D. and Catherine T. MacArthur Fellowship.

Natalie Harris joined Miami Valley Housing Opportunities, a nonprofit supportive housing provider in Dayton, Ohio, in August of 2005. MVHO manages almost 450 units of supportive housing through ownership and rental assistance administration. Natalie served for 12 years as director of the Specialized Housing Resources Department at Kentucky Housing Corporation. There, she was responsible for development, implementation, and coordination of policies and procedures relating to programs serving homeless and special needs populations. She was also responsible for developing new partnerships and housing solutions and for creating a pipeline to fund over 1,500 units of permanent, supportive housing for homeless people. She has served as a consultant to the U.S. Census Bureau, Corporation for Supportive Housing, U.S. Department of Housing and Urban Development, and the Urban Institute on issues related to rural homelessness and supportive housing. Before joining KHC, Natalie served as director of the statewide Homeless and Housing Coalition of Kentucky and the Appalachia Service Project home repair program.

Richard L. Harris is the executive director of Central City Concern, a private nonprofit agency creating solutions to homelessness and chemical dependency in the Portland, Oregon area since 1979. Central City Concern owns or manages 20 buildings with over 1,300 units of low-income housing and provides detoxification facilities, outreach programs to public inebriates, outpatient drug and alcohol treatment, job training, transitional housing, and residential treatment for homeless families. In 2006, Central City Concern served over 15,000 unduplicated individuals. Mr. Harris has 39 years experience in the field of social services, housing, and chemical dependency treatment. In that time, he has created programs that have since been duplicated nationally, such as alcohol and drug free communities in low income transitional and permanent housing; an outreach program for public inebriates; and a network of

those providing service to homeless, chemically dependent people in Portland to share information, reduce duplication and improve the services to individual clients.

Mary Ellen Hombs is deputy director of the U.S. Interagency Council on Homelessness. Prior to joining the Council in 2003, Ms. Hombs was executive director of the Massachusetts Housing and Shelter Alliance, a statewide coalition of 85 agencies that operate over 250 housing and emergency services programs for homeless people. At MHSA, she led initiatives on both prevention and intervention, served as the sole non-governmental member of the state's Policy Academy team, and participated in Governor Romney's Executive Commission for Homeless Services Coordination, the predecessor to the state's interagency council. She was responsible for several multi-year technical assistance initiatives focused on discharge planning and housing, working closely with state agencies and private sector partners responsible for mental health and substance abuse treatment, Medicaid, housing, and homeless programs. Ms. Hombs has more than 25 years of public policy, direct service, and technical assistance experience in homeless advocacy and programs at the local, state, and national level. She is the author of numerous books and articles on homelessness.

Martin F. Horn is the commissioner of New York City's Department of Correction and Department of Probation. Prior to assuming his NYC posts, he was secretary of administration for the State of Pennsylvania, reporting to Governor Tom Ridge, and served as Pennsylvania's secretary of corrections from 1995 to 2000. Commissioner Horn began his career as a New York State parole officer, and his record of public service includes several senior assignments in criminal justice. He was executive director and chief operating officer of the New York State Division of Parole, assistant commissioner of the state's Department of Correctional Services, and superintendent of the Hudson Correctional Facility.

Julie Hovden is a special needs assistance specialist in HUD's Office of Special Needs Assistance Programs (SNAPs). Her primary areas of responsibility are HMIS policy development, coordination of all homeless technical assistance activities, oversight of technical assistance contracts and grants related to HMIS, and participation in SNAPs team responsible for data collection and reporting related to continuum of care competitions and IDIS. Prior to joining HUD, she worked on the HMIS Technical Assistance Initiative at The QED Group for 18 months. During the six years prior to her work at The QED Group, she worked in the Bureau of Housing at the Department of Commerce in Madison, Wisconsin, the office responsible for all state and federally funded homeless and housing programs.

Norman Hursh is an associate professor in the Department of Rehabilitation Counseling of the Sargent College of Health and Rehabilitation Sciences at Boston University. He directs the graduate specialization in Industrial Rehabilitation and Disability Management and the graduate specialization in Vocational Evaluation. Dr. Hursh is the director of Vocational Rehabilitation Services of the Sargent Clinic at Boston University, a free standing rehabilitation clinic that provides evaluation, return-to-work planning, and rehabilitation services and consultation to workers and employers. He is a certified rehabilitation counselor, a certified vocational evaluator, a licensed rehabilitation psychologist, and a licensed rehabilitation counselor. Dr. Hursh has consulted and provided training to employers, unions, insurance companies, health care providers and governments across the United States, Canada, and New

Zealand. He has conducted research and published extensively in areas of vocational evaluation, job accommodation, and return-to-work for individuals with severe and multiple impairments. He serves on the editorial board of *Work* and *The Psychosocial Rehabilitation Journal*.

Mark Johnston was selected in October 2006 as the Deputy Assistant Secretary for Special Needs for the U.S. Department of Housing and Urban Development (HUD). As Deputy Assistant Secretary, he is responsible for administering the Department's $1.6 billion in assistance for persons who are homeless and those with AIDS. These funds are used to provide homeless prevention, emergency shelter, transitional housing, permanent housing and supportive services. Mr. Johnston has previously served in various capacities related to solving homelessness, including HUD's director of Homeless Programs, senior advisor on Homelessness, and the deputy director for the U.S. Interagency Council on Homelessness. He joined the federal service when selected as a presidential management intern in 1983. He has a bachelors degree in public policy from Brigham Young University and a master's in public affairs from Indiana University.

Denise Juliano-Bult is chief of the Systems Research Program in the Division of Services and Intervention Research at the National Institute of Mental Health (NIMH) Extramural Research Program. She is also an adjunct professor at the School of Social Service at the Catholic University of America. Her prior experience includes serving as supervisor of allied health professions in the NIMH Schizophrenia Research Program at St. Elizabeths Hospital, as well as working as a social worker at the House of Ruth shelter for homeless women in Washington, DC.

Laura Kadwell is the director for Ending Long-Term Homelessness in Minnesota, reporting to the commissioners of human services, corrections and housing. She leads implementation of Minnesota's business plan for ending long-term homelessness. Developed by a bi-partisan, public-private-nonprofit working group, the plan has as its primary strategy the creation of 4,000 additional permanent supportive housing opportunities by 2010. Prior to assuming her current position, Ms. Kadwell served as the state of Minnesota's child support director, counsel to the Minnesota House of Representatives' Health and Human Services Committee, and senior program associate for the Children's Defense Fund – Minnesota. Ms. Kadwell has practiced law and provided management consulting to the Department of Work and Pensions in the United Kingdom as well as to state and local child support agencies in the United States.

Fred Karnas, Jr. recently joined the Fannie Mae Foundation as senior director for homelessness initiatives where he provides strategic direction to financial and intellectual investments in efforts to end homelessness. For over two decades, Dr. Karnas has worked on homelessness as an advocate, housing and services provider, and policymaker. Before coming to the Fannie Mae Foundation, he served as a policy adviser on urban affairs and community development for Arizona Governor Janet Napolitano. Previous to that, Dr. Karnas served as a Deputy Assistant Secretary at HUD in the Clinton Administration, overseeing that department's $1.5 billion continuum of care and AIDS housing programs. He served concurrently as acting director of the federal Interagency Council on the Homeless. From 1991 to 1995, he served as executive director of the National Coalition for the Homeless.

Jill Khadduri's area of expertise is the use of data to answer policy questions. Her work on homelessness has focused on measuring the performance of programs that serve people with homelessness, evaluating program costs and benefits, and understanding the characteristics and dynamics of homelessness. Currently, Dr. Khadduri is directing a project to develop methodologies for measuring the costs of homelessness and the costs of interventions for people who become homeless. She is co-director, with Deborah Dennis of Policy Research Associates, of the effort that has supported this National Symposium on Homelessness Research. Dr. Khadduri is also supporting HUD's efforts to improve performance reporting for the HUD McKinney-Vento programs and is part of the team that uses Homeless Management Information Systems data to produce HUD's Annual Homeless Assessment Report. Dr. Khadduri joined Abt Associates, Inc., in 2000 after many years in HUD's Office of Policy Development and Research.

Katie Kitchin is the director of the City of Norfolk's Office to End Homelessness where she is tasked with developing and implementing the city's ten year plan to end homelessness, as well as coordinating and overseeing various initiatives in the city to prevent or reduce homelessness. Prior to this, Ms. Kitchin served as special assistant to the director of the Norfolk Department of Human Services where she led a variety of projects related to workforce development programs for families leaving welfare. She also served as a professional staff member of the U.S. House Ways and Means Committee, with responsibility for oversight and legislation related to the nation's Temporary Assistance for Needy Families (TANF) and child welfare programs. Her previous positions, include work as an analyst at the U.S. General Accounting Office, and as legislative director for Pennsylvania Governor Tom Ridge.

Judith Klain has worked for the City and County of San Francisco since 1983 in various positions in the health and human service areas. Since 1994, she has worked with the Department of Public Health in the areas of policy and planning, HIV/AIDS, disaster readiness, hospital planning, and most recently, community programs where she helps to implement "change" programs in the areas of primary care, mental health, substance abuse, and housing for indigent San Franciscans. In September 2004, she was asked by the mayor's office to develop a new initiative for improving access to services for hard-to-reach homeless San Franciscans. Thus, San Francisco's Project Homeless Connect (PHC) was born; Ms. Klain has been directing this project since its inception. Based on a one-stop-shop model, PHC is a collaboration between government, the private sector, and individual community members. PHC is now an international best practice model implemented in over 100 US cities as well as Canada, Puerto Rico and Australia.

Paul Koegel, a medical and urban anthropologist, has engaged in research on homelessness for over 20 years. He directed an NIMH-funded study of homelessness in the Skid Row area of Los Angeles that documented the demographic, social support, and life-style characteristics of the inner-city homeless population and determined the prevalence of mental illness among this population. This study has been called one of the most methodologically sound of NIMH's first generation studies of homelessness. Dr. Koegel was the principal investigator of a longitudinal ethnographic study of the adaptation of homeless mentally ill adults in Los Angeles' Skid Row. He was also the co-principal investigator of an NIMH-funded study that examined service use patterns and costs among homeless and domiciled SMI persons in

Houston, Texas. Dr. Koegel's research on homelessness has focused on evaluating innovative programs, including substance abuse services for homeless adults with co-occurring mental illness and substance dependence. He is currently associate director of RAND Health and manages the internal affairs of its $50-million research portfolio.

Charlene E. Le Fauve is the branch chief for the Co-occurring and Homeless Activities at the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA). Dr. LeFauve is a clinical psychologist who specialized in treating addictions and co-occurring disorders for many years before joining the federal workforce. Her federal career includes policy, legislative, and research experiences at the National Institute on Drug Abuse, the White House Office of National Drug Control Policy (ONDCP), and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). She came to SAMHSA in 2004 from NIAAA's Division of Treatment and Recovery Research, where she served as a program official for Pharmacotherapy and Behavioral Clinical Trials Research. Prior to her position at NIAAA, she served as a legislative analyst at ONDCP and scientific consultant to the director. Dr. Le Fauve has held numerous positions at Virginia Commonwealth University's Medical College, including posts as professor, program supervisor, and consultant. She has served on government-wide interagency task forces working with groups on alcohol and substance abuse research, policy, and legislative strategies.

Walter Leginski retired from a career in the Department of Health and Human Services in 2004. His last 13 years in HHS were focused on services to homeless individuals, both in the Substance Abuse and Mental Health Services Administration and in the Office of the Assistant Secretary for Planning and Evaluation. In retirement, he is affiliated with Manila Consulting, assisting with the legislatively required triennial evaluation of Projects for Assistance in Transition from Homelessness, consults independently with a small number of clients, and is learning the pleasures of leisure.

Gretchen Locke is a senior associate in Abt Associates' Housing and Community Revitalization area. She has 15 years of experience in program evaluation research and technical assistance consulting. Under subcontract to Walter R. McDonald & Associates, Ms. Locke was co-principal investigator on a recent three-site study of the housing first approach to permanent housing for homeless people with chronic mental illness. She has directed projects to develop resource and training modules for HUD's Shelter Plus Care program and Safe Havens. Ms. Locke has contributed to publications on continuums of care for states and involvement of veterans' organizations in homeless assistance networks. Ms. Locke has managed and contributed to projects on a variety of topics in affordable housing, public and assisted housing, and HUD's voucher program. She has also worked with staff from Abt, Policy Research Associates, HHS and HUD to organize this Symposium.

David Long is a senior associate at Abt Associates. He has spent more than 30 years evaluating a public policies and programs for disabled individuals, families on welfare, and other disadvantaged populations. During his career he has directed many large-scale, rigorous evaluations at Abt Associates, MDRC, and Mathematica Policy Research. His expertise in applying cost-benefit analysis to social programs is nationally recognized. Mr. Long currently is leading several program implementation and

research tasks in the Benefit Offset National Demonstration (BOND), the largest and most important study of changes in U.S. disability policy ever undertaken. BOND is systematically testing major changes in cash assistance, employment supports, and health insurance for SSDI beneficiaries. The evaluation will involve the random assignment of close to half a million beneficiaries in about one-fifth of all communities nationwide.

Philip F. Mangano is the executive director of the U.S. Interagency Council on Homelessness. Since coming to the Council in 2002, he has engaged every level of government and the private sector to constellate a national partnership to end homelessness. The priority of the Council has been to ensure that the President's commitment to ending chronic homelessness is realized. Mr. Mangano has been recognized for his leadership on the issue of homelessness and new results in ending homelessness being achieved in cities across the country through the National Partnership created by the Council. He began his work in homelessness in the 1980s, starting as a full-time volunteer on a Boston breadline, then working with African-American churches in responding to homelessness, and eventually serving as director of Homeless Services for the City of Cambridge. Prior to his appointment, Mr. Mangano was the founding executive director of a regional advocacy alliance which became the Massachusetts Housing and Shelter Alliance (MHSA), a statewide coalition of 80 agencies that operate more than 200 programs. During his 12-year tenure, MHSA developed statewide strategies to reduce and end homelessness in Massachusetts, which influenced the national dialogue in Washington and throughout the nation.

Sue Marshall is the founding executive director of The Community Partnership for the Prevention of Homelessness, a public/private partnership in the District of Columbia. The Community Partnership, which implemented the DC Initiative on Homelessness in partnership with the District government and HUD, fosters local neighborhood initiatives to resolve chronic community problems, including homelessness, and annually administers more than $30 million of publicly funded services to people who are homeless. Sue has provided technical assistance in the areas of continuum of care development and implementation, development of plans to end homelessness, and replication of the District of Columbia's model Community Care Grant Program. She has significant experience in the areas of capacity building, organizational development and management, and economic development. Sue also has an extensive history of public service, including eight years as the vice chair of the District of Columbia Housing Finance Agency. She has served as chief of staff of the DC Department of Human Services, mayor's homeless coordinator, staff economist to the DC Council Committee on Finance and Revenue, and urban policy analyst for HUD.

Marge Martin is currently director of the Policy Development Division in the Office of Policy Development and Research at HUD. Prior to her position as director, Ms. Martin served as a social science analyst in the division, working on a variety of issues, including the impact of rent and income on affordable housing, community and economic development, mixed income housing, and homelessness. Shortly after beginning her career at HUD in 1987, Ms. Martin helped established the Office of Special Needs Assistance, the part of HUD responsible for administering the Department's homeless programs. She has been involved in homeless issues and homeless research for the past two decades and continues to serve as one of the Department's leading experts in this area.

Ann S. Masten, a licensed psychologist and Distinguished McKnight University Professor in the Institute of Child Development at the University of Minnesota, has studied risk and resilience in development for many years, including studies of children in homeless families, refugees, and other highly mobile populations. Her work has been widely disseminated nationally and internationally among scientists, policymakers, and practitioners. In recent years, Dr. Masten has served as director of the Institute of Child Development at Minnesota, president of Division 7 (Developmental) of the American Psychological Association, and a member of the Governing Council of the Society for Research in Child Development.

Lorraine McMullin coordinates the Mental Health Association in New York State's (MHANYS) Parents with Psychiatric Disabilities Initiative promoting cross-systems collaborations, peer linkages, provider training, and dissemination of research and evidence-based practices. She provides research and evaluation services to government and nonprofit agencies through McMullin Consulting Services. Lorraine was Policy Research Associates' project coordinator for the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) Homeless Families Program multisite evaluation of homeless services for mothers with psychiatric and/or substance abuse issues. As part of her responsibilities, she facilitated the work of the Homeless Families Program's Consumer Panel. Lorraine worked for the CMHS GAINS TAPA Center where she developed training curriculum, a multimedia consumer exhibit, and coordinated a network of peer specialists involved in 32 jail diversion programs for adults with mental health and substance abuse issues. This year she is the coauthor of three articles: *Consumer Integration and Self-Determination in Homelessness Research, Policy, Planning, and Services*; *Establishing Consumer Integration in the Evaluation of the SAMHSA Homeless Families Program*; and *Continuing Trauma in the Lives of Homeless Mothers*. Lorraine has been a consumer of mental health, trauma, and homeless services.

Stephen Metraux is an assistant professor in the Department of Health Policy and Public Health at the University of the Sciences in Philadelphia. Dr. Metraux is also affiliated with Penn's Center for Mental Health Policy and Services Research. His research interests center around urban health, especially in the context of issues such as homelessness and housing, community mental health, and incarceration and prisoner reentry. His current research includes examining services use patterns by person diagnosed with mental illness following release from prison, using administrative data for evaluation of homeless services, and assessing residential segregation among persons with mental illness.

Norweeta G. Milburn is an associate research psychologist at UCLA's Center for Community Health. Prior to coming to UCLA, Dr. Milburn was an associate professor of psychology at Hofstra University and assistant director of the PsyD Program in School/Community Psychology. Her research interests include substance abuse and homelessness, and mental health among African Americans. She has been a principal investigator of National Institute on Drug Abuse research on homeless adults and a co-principal investigator of U.S. Department of Education research on coping and adaptation in older African Americans, and was a co-principal investigator of a NIMH investigation of anxiety and depression in older African Americans. As a principal investigator of NIMH studies of homeless youth, she has examined paths into and out of homelessness and risk for HIV among homeless youth. Dr.

Milburn is implementing a behavioral intervention for homeless adolescents at risk for HIV and their families.

Alma Molino is a PhD candidate in clinical psychology at Rosalind Franklin University of Medicine and Science, where her current research interests are risk and resilience in underserved adolescent populations. She has worked and volunteered with the National Runaway Switchboard since 2002. Other recent qualitative and quantitative research efforts include studies of sexual risk-taking and substance use among homeless African-American young adults and research on risk and health behaviors in relation to adolescent relationship skills.

Steven Nelson has served as director of employment services at the Pima County Jackson Employment Center for over 16 years. He has served four terms as chair of the Tucson Planning Council for the Homeless, the lead entity for the City of Tucson/Pima County continuum of care planning process. He developed an employment services model of collaborative networks working with HUD Supportive Housing Programs to provide both housing and employment services to homeless men, women, families, and youth in Pima County. This model prompted the HUD Supportive Housing Program "La Casita" that provides young adults with employment assistance, vocational training, and transitional housing assistance to fill the gap in services to youth. La Casita was awarded a HUD National Best Practice Award in August 2000. Mr. Nelson has played a lead role in developing collaborative networks within the Tucson Planning Council for the Homeless and in providing employment services to homeless populations within the One-Stop Career Center in Pima County.

Sandra J. Newman is professor of policy studies and director of the Institute for Policy Studies at Johns Hopkins University. She also holds joint appointments in the department of sociology and the department of health policy and management, the latter at the Bloomberg School of Public Health of Johns Hopkins. Dr. Newman was a Fulbright senior fellow at the Australian National University and a visiting scholar in the research office of the U.S. Department of Housing and Urban Development, for which she received a distinguished service award. Her research is interdisciplinary and focuses on the intersection of housing, employment, welfare and health. Her current research focuses on the effects of housing on the life outcomes of children and families. Her recent Baltimore research focused on the low end rental market and on abandoned properties. She is on the editorial board of the *Journal of Policy Analysis and Management* and *Housing Studies*, and is an associate editor of *Housing Policy Debate*.

Rebecca F. Noftsinger is a research associate at Westat with 25 years of experience in health care research and management. At Westat, she recently managed a SAMHSA project on rural homelessness. As part of that project, Westat convened an expert panel meeting of a representative group of homeless service providers, researchers and government officials. Ms. Noftsinger has extensive experience as the executive director of rural nonprofit free clinics serving uninsured low-income populations, including homeless persons. In this capacity, and as president of the Virginia Association of Free Clinics, she was responsible for advocacy; improving service delivery; and working with local, state, regional, and national organizations concerned with medically underserved populations and people who are homeless.

Ann O'Hara is co-founder and associate director of the Technical Assistance Collaborative, Inc., in Boston. Ms. O'Hara is a national expert on policies and practices to expand affordable housing opportunities for people with disabilities and in implementing supportive housing approaches for people who are homeless or at-risk of homelessness. She has over 25 years experience in the development and administration of the full range of subsidized rental and homeownership programs funded at the national, state, and local level. Ms. O'Hara provides consultation to the Washington, DC-based Consortium for Citizens with Disabilities Housing Task Force and has provided congressional testimony on their behalf on numerous occasions. She is also the author of many articles, monographs and studies related to expanding affordable and supportive housing opportunities for persons with disabilities.

Karen Olson is the founder and president of Family Promise, formerly National Interfaith Hospitality Network. She began the organization in 1986 in her home state of New Jersey, and it has expanded to 39 states and now involves more than 110,000 volunteers and 4,500 congregations of all religious faiths. It is recognized nationally for its innovative and effective work in mobilizing volunteers. Family Promise's core program is the Interfaith Hospitality Network, which provides shelter, meals and comprehensive services to homeless families. The goal of the program is to help families regain their independence, and approximately 80 percent of guests secure permanent or transitional housing. Under Karen's leadership, Family Promise has expanded its mission to include a family mentoring program, along with initiatives to address the underlying causes of homelessness.

Greg Owen is a consulting scientist at Wilder Research in St. Paul, Minnesota, with more than 30 years experience in applied social research. Dr. Owen has led a wide range of research projects including studies of welfare reform, economic self-sufficiency, and homelessness. His work on homelessness dates to 1984 when he led the first area effort to describe the homeless population in St. Paul. Since that time he has directed six statewide surveys of homeless adults and children and currently provides data to support the statewide plan for ending long-term homelessness. Dr. Owen participated in the 1998 National Symposium on Homelessness Research. Greg gives numerous presentations on homelessness each year, recently speaking at 2006 convention Homes for All!, the National Association for the Education of Homeless Children and Youth, and the Minnesota Supportive Housing Conference. Greg serves as an adjunct professor in the Health and Human Services graduate program at St. Mary's University.

Wayne D. Parker is a licensed psychologist as well as a certified teacher and certified counselor. In addition to teaching at the college level, he has taught at the secondary level in Austria, Mexico, and Venezuela. Dr. Parker was a senior researcher at Johns Hopkins University where he researched the personality and adjustment of gifted individuals as well as evaluating educational programs. He has been awarded the Mensa International Award for Excellence in research three times. Since 2000 he has been the director of Research and Evaluation for the Piper Trust, where he is responsible for evaluating the effectiveness of programs funded by the Trust.

Paige Perry has been working with people who are homeless, mentally ill, alcohol and drug impaired and people who are developmentally disabled for more than 16 years. She began her career as an advocate

for and subsequently as program manager for the Homes for Community Living, a nonprofit organization that pioneered the concept of providing the first permanent Intensive Tenant Support Housing in the de-institutionalization movement in Washington State. In 1997, Ms. Perry became program director for Old Town Clinic, located in downtown Portland, OR. In the late nineties, Old Town Clinic became a Federally Qualified Health Center. Working closely with the Medical Director, staff, and the community, Ms. Perry expanded services ensuring the needs of the uninsured and under insured were met. Ms. Perry continues to help in shaping the evolution of the primary health care and integrated continuum of care services for the expanding homeless and addiction impaired populations in Oregon. Ms. Perry now works with the Internal Medicine Practice with Oregon Health Sciences University, where she continues to be a strong advocate for ending homelessness.

Barbara Poppe has more than 20 years of nonprofit experience in homelessness and housing related organizations. She currently serves as executive director the Community Shelter Board (CSB), a nationally recognized nonprofit organization charged with funding, planning and coordinating prevention, shelter, and housing to end homelessness in Columbus and Franklin County, Ohio. Barbara provides visible leadership in achieving community wide homeless services and prevention objectives. She is responsible for strategic planning and collaborative efforts, private sector fundraising and resource development, effective governmental systems, and private sector relationships. CSB received the 2002 Non Profit Sector Achievement Award from the National Alliance to End Homelessness and, in 2004, Ms. Poppe received the Buddy Gray Award for homeless activism from the National Coalition for the Homeless. From June 1990 to October 1995, Barbara was the executive director of Friends of the Homeless, Inc. She has published and presented on various topics related to homelessness and is a frequent national and statewide speaker.

Fran Randolph, director of the Division of Services and Systems Improvement in the Center for Mental Health Services, SAMHSA, oversees the Community Support Programs Branch, the Children, Adolescence and Families Branch, and the Homeless Programs Branch. Specific areas of responsibility include directing the Mental Health Transformation State Incentive Grant Program, overseeing the implementation of a national plan for behavioral health workforce development, and facilitating the development of a federal strategy to address trauma. Prior to becoming the division director, Dr. Randolph was the chief of the Homeless Programs Branch where she was responsible for managing the ACCESS Program, a multisite, systems change initiative on homelessness. Dr. Randolph has also worked at the National Association for State Mental Health Program Directors, the Center for Psychiatric Rehabilitation at Boston University, and Hawaii's Department of Mental Health. Her research on housing and residential service needs for persons with mental illnesses, community-based service needs of elderly persons with mental illness, and outcome measures in services research has resulted in numerous reports and publications.

Jerry Regier is the principal Deputy Assistant Secretary for Planning and Evaluation (ASPE) in the U.S. Department of Health and Human Services, and functions with all the operational authority of the Assistant Secretary. He provides leadership to policy analysis and policy development and evaluation research for Secretary Leavitt. He was appointed by the Secretary as a member of the Medicaid Commission in 2006. Mr. Regier previously served as Secretary of the Florida Department of Children &

Families, where he oversaw a department of over 25,000 with a budget of $4 billion. In 2001 he was named the Administrator of the Year in Oklahoma by the American Society of Public Administration (Oklahoma Chapter). He previously served as acting administrator of the National Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice. Prior to that position, he served in the first Bush Administration as acting director of the Bureau of Justice Assistance for three years.

Lawrence Rickards is the chief of the Homeless Programs Branch, Center for Mental Health Services, in the Substance Abuse and Mental Health Services Administration of the U.S. Department of Health and Human Services. Dr. Rickards has more than forty years of experience in health and primary care, mental health and co-occurring disorders, child and adult services, policy and legislative affairs, and government service. His primary experience has been with older adults and with individuals experiencing homelessness and co-occurring mental and substance use disorders. He joined SAMHSA in 1992, and was previously the assistant director of the National Association of Area Agencies on Aging and legislative affairs officer in the Public Interest Directorate of the American Psychological Association.

John Rio is a senior program associate at Advocates for Human Potential and Co-Director of the Chronic Homelessness Employment Technical Assistance Center supported by the U.S. Department of Labor. With over 30 years of experience in rehabilitation and recovery services, supportive housing, and homeless assistance services, his work has focused on developing and delivering materials, strategies, training, and technical assistance to help increase the capacity of supportive housing and service organizations to offer employment services to formerly homeless people with disabilities and assist supportive housing and service providers on innovative programming. He has managed two special project grants to link the supportive housing industry and the vocational rehabilitation system in New York City and a career advancement initiative for homeless individuals in Chicago. Before joining AHP, he was a senior staff member of the Corporation for Supportive Housing where he directed national employment initiatives and worked on public policies related to employment and supportive services for homeless people with co-occurring mental health and substance use disabilities.

Barbara Ritter is a quality improvement and measurement specialist with over 25 years experience as a consultant and staff person in mental health, domestic violence, education, substance abuse, and homeless services environments. As the City of Spokane's Human Services Department program evaluator, Ms. Ritter has participated in the planning, development and operation of Spokane's eight-year-old "Best Practice" locally developed HMIS system. She is currently implementing Michigan's Statewide Outcomes Project involving over 300 diverse agencies participating with a single HMIS. The Outcomes Project is designed to identify appropriate outcomes and other measures for different kinds of programs and populations, identify knowledge-based performance targets, share best practices or strategies that result in improved care, and document contextual variables that impact performance. Quality programs designed by Ms. Ritter have won three commendations from the Joint Hospital Accreditation Board and, most recently, received the Board's Recognition for Innovation award.

Marjorie Robertson is a senior scientist with the Alcohol Research Group in the San Francisco Bay area. She is a research psychologist with a specialization in psychiatric epidemiology. Since 1983,

her research has focused primarily on homeless and other indigent populations, explored primarily through population-based surveys and studies of clients in public systems. Dr. Robertson's recent work includes a study to assess the course of homelessness among adults with alcohol, drug, or mental disorders and to test whether service use affects that course. She has also surveyed homeless "street" youth in San Francisco to identify barriers to services for this high-risk population. Dr. Robertson has recently studied the impact of a specialized residential treatment program on outcomes for dually diagnosed adults who had recently been discharged from a public inpatient psychiatric facility. Currently, her research addresses the epidemiology of HIV and tuberculosis, access to services, and treatment adherence among homeless and marginally housed adults in San Francisco. In a separate project, she is exploring the epidemiology of hepatitis B and C among homeless adults and strategies for viral screening and intervention with this high-risk population.

Debra Rog is an associate director and vice president of the Westat's Rockville Institute in Rockville, Maryland. She has more than 25 years experience in research and evaluation. Before joining the Westat staff in January 2007, Dr. Rog was director of the Washington office of Vanderbilt University's Center for Evaluation and Program Improvement, where she managed several multisite research and evaluation projects in the areas of poverty, homelessness, education, housing for vulnerable populations, mental health, and applied research methodology. Dr. Rog has provided project management and subject matter expertise for research funded by clients such as the Robert Wood Johnson Foundation, CMHS, NIMH, SAMSHA, the National Mental Health Association, and the Bill and Melinda Gates Foundation, among others. Between 1987 and 1989, she was associate director of the Office of Programs for the Homeless Mentally Ill, NIMH. She has published and presented widely on mental health treatment issues, program evaluation, and methodological topics and is a recognized expert in evaluation methodology, homelessness, and mental health. She is an editor for numerous books, series, and journals and is action in several professional associations.

Gerry Roll is the executive director of Hazard Perry County Community Ministries, Inc. (HPCCM), a nonprofit community development organization with a mission to lead the community in meeting basic human needs in rural eastern Kentucky. Under her direction, Community Ministries has opened three new child care centers, including after-school programs; a transitional housing program; a crisis intervention program and a family support center for families at risk of becoming homeless. In addition, HPCCM has led the City of Hazard in the creation of a state recognized Community Housing Development Organization serving the people of Perry County with good affordable housing and mortgage options. Most recently, HPCCM has undertaken a community-wide effort to provide health care to the most vulnerable population, rural homeless, uninsured and underinsured people in the rugged mountain communities of Appalachian Kentucky. Gerry is a 2002 recipient of the Ford Foundation's Leadership for a Changing World award.

Caterina Roman is a senior research associate in the Justice Policy Center at the Urban Institute where she has worked for the past 15 years. Dr. Roman's research interests include policy and programming related to prisoner reentry; the role of community organizations and institutions in crime prevention and neighborhood well being; the effectiveness of community justice partnerships; and the spatial and temporal relationship between neighborhood characteristics and violence. She is currently

involved in a number of projects evaluating housing models that support the community reintegration of returning prisoners. Her work on prisoner reentry has been published in the journals *Criminology and Public Policy, Justice Research and Policy*, and *Housing Policy Debate*. In addition, she recently authored two books, *Schools, Neighborhoods, and Violence: Crime within the Daily Routines of Youth* (2004) and *Illicit Drug Policies, Trafficking, and Use the World Over* (2005).

Nan Roman, president and CEO of the National Alliance to End Homelessness, is a leading national voice on the issue of homelessness. The Alliance is a public education, advocacy, and capacity-building organization with a network of over 5,000 nonprofit and public sector agencies and corporate partners around the country. Under her leadership, the Alliance has developed a pragmatic plan to end homelessness within ten years. To implement this plan, Ms. Roman works closely with members of Congress and the Administration, as well as with cities and states across the nation. She collaborates with Alliance partners to educate the public about the real nature of homelessness and successful solutions. She has researched and written on the issue, is frequently interviewed by the press, and regularly speaks at events around the country. Her unique perspective on homelessness and its solutions comes from over twenty years of local and national experience in the areas of poverty and community-based organizations.

Jeremy Rosen is the director for Homelessness and Mental Health at the national headquarters of Volunteers of America. Previously, Mr. Rosen served as a staff attorney with the National Law Center on Homelessness & Poverty, and co-directed the Homeless Legal Assistance Project at Legal Services of Greater Miami. At Volunteers of America, Mr. Rosen is responsible for federal public policy in the areas of homelessness, housing, mental health, and substance abuse. Mr. Rosen also manages Volunteers of America's homeless services network.

Michael Rowe is a medical sociologist in the Yale Department of Psychiatry. Dr. Rowe has studied and written about homelessness and mental illness, assertive mental health outreach to persons who are homeless and other innovative community-based interventions for persons with behavioral health disorders. He is the author of many articles and book chapters, three books, and is the lead editor of a forthcoming volume on classic texts in community psychiatry over the past fifty years.

Ruth M. Samardick is the Department of Labor's first director of Homeless Assistance Programs. She advises the Secretary of Labor and the Assistant Secretary for Veterans' Employment and Training Services on the employment of persons who are homeless. She also serves as the Department's senior policy liaison to the U.S. Interagency Council on Homelessness. Previously, she was the director of Programmatic Policy in DOL's Office of the Assistant Secretary for Policy.

Marybeth (Beth) Shinn is professor of applied psychology and public policy in the Steinhardt School of Culture, Education, and Human Development and the Wagner School of Public Service at New York University. Dr. Shinn studies how social contexts and social policies affect individual well-being. Much of her work concerns homelessness, including a longitudinal study of homeless and housed poor

families to understand the correlates of initial shelter entry and long-term stability, a study of causes of homelessness for older adults, evaluations of intervention programs for single individuals and for families, and an evaluation of New York's street count. She has written on prevention of homelessness and on what can be learned from international comparisons. She serves on research advisory panels for the NYC Department of Homeless Services, the National Alliance to End Homelessness, and the National Low Income Housing Coalition. She has served as president of the Society for the Psychological Study of Social Issues and the Society for Community Research and Action, and received the latter's award for Distinguished Contributions to Theory and Research.

Brooke Spellman, an associate with Abt, specializes in providing technical assistance to help communities plan and implement research-based strategies to effectively address homelessness. She has extensive experience in grants management, the continuum of care planning processes, and Homeless Management Information Systems (HMIS). Ms. Spellman is currently managing a federal research study on the costs of homelessness and is involved in two studies to evaluate the effectiveness of local homeless program strategies. She is also leading two technical assistance projects to help Indianapolis, IN, and Montgomery County, MD, implement plans to end homelessness. Performance measurement is a cross-cutting theme of her work, evident in recent federal and local efforts. Formerly the family support services director for the City of Chicago, Ms. Spellman was instrumental in the planning and writing of Chicago's plan to end homelessness, which sets ambitious goals for creating new permanent supportive housing units and transforming the existing shelter-based services into a housing first system. She has also been involved with other local government and nonprofit agencies working on community development issues.

Henry J. Steadman is the president of Policy Research Associates, Inc., which he founded in 1987. His work in mental health and criminal justice has resulted in eight books, over 130 journal articles in a wide range of professional journals, 20 chapters, and numerous reports. Dr. Steadman's current projects include: the National GAINS Center for Evidence-Based Practices in the Justice System; the John D. and Catherine T. MacArthur Foundation Mental Health Court Study; National Institute of Justice Women's Brief Jail Mental Health Screen Study; SAMHSA's Technical Assistance and Policy Analysis Center for Jail Diversion; and NIMH Adult Mental Health-Criminal Justice Cross-Training Curriculum Development Project. He has received many awards, including the American Public Health Association's Carl A. Taube Award for Outstanding Contributions in Mental Health Services Research in 2005. Before founding PRA, Dr. Steadman directed a nationally known research bureau at the New York State Office of Mental Health for 17 years.

Ezra Sykes is director of policy and advocacy for the Massachusetts Housing and Shelter Alliance (MHSA), a public policy advocacy group with the singular mission of ending homelessness in the Commonwealth of Massachusetts. Through strategic partnerships formed with government, private philanthropy, service providers, homeless individuals, and business, MHSA works to ensure that homelessness does not become a permanent part of the social landscape. Ezra is an MPA candidate at Suffolk University in Boston and holds a bachelors degree in journalism.

Paul Toro is a professor of psychology at Wayne State University in Detroit where he also directs the University's Research Group on Homelessness and Poverty. As a community/clinical psychologist and an applied researcher who studies poverty and homelessness, Dr. Toro has conducted many studies on homeless adults, families, and adolescents. He has developed and evaluated community-based services for persons with mental illnesses and substance use disorders. Dr. Toro has an interest in prevention programs for children and families. His work has been supported by public and private grants, including one from the National Institute on Alcohol Abuse and Alcoholism.

Julia Tripp is a consultant with Advocates for Human Potential (AHP), where she brings her understanding and special focus of how to engage and work with people who are chronically homeless and those struggling with mental illness and substance abuse. She is a creative, dynamic leader in the field of consumer-informed program development, and has impacted the way data is collected in the human service system by highlighting and defining the potential contributions of consumers to the development of the Homeless Management Information System (HMIS), an initiative of HUD. She developed the curriculum on Consumer Involvement in HMIS, and is an accomplished trainer and facilitator. She has served as moderator, presenter, and keynote speaker for numerous events. In addition to her work with AHP, Ms. Tripp serves as constituent coordinator for the Center for Social Policy in the John W. McCormack Graduate School of Policy Studies, University of Massachusetts (Boston) where she developed the foundation for her work involving consumers in HMIS and is involved in research related to homeless prevention.

Sam Tsemberis founded Pathways to Housing in 1992 and currently serves as the executive director. Pathways, an organization based on the belief that housing is a basic right for all people, developed the housing first approach that provides *immediate access* to permanent independent apartments to individuals who are homeless and who have psychiatric disabilities and substance use disorders. In October 2005, The American Psychiatric Association Institute on Psychiatric Services awarded Pathways to Housing its prestigious Gold Award in the area of community mental health. Dr. Tsemberis is on the faculty of the Department of Psychiatry of the New York University Medical Center and has served as principal investigator for several federally funded studies of homelessness, mental illness, and substance abuse. He is currently providing training and technical assistance to agencies across the country implementing the housing first model. In April 2006, the National Alliance to End Homelessness awarded Dr. Tsemberis its prestigious Macy Award for Individual Achievement in the battle to end homelessness.

Tanya Tull, president and CEO of Beyond Shelter, has spent 25 years developing innovative solutions to combat increasing poverty and homelessness among families with children, both in Los Angeles and nationwide. Dr. Tull founded Beyond Shelter in 1988 to address the need for a more comprehensive approach to serving increasing numbers of homeless families in Los Angeles. Beyond Shelter develops service-enriched, affordable housing in inner-city neighborhoods and is credited with developing and promoting housing first for families experiencing homelessness. Since 1988, her work has focused on the development of new methodologies to promote systemic change. Dr. Tull is a member of the Board of Trustees of the National Housing Conference and serves on advisory committees of the National Alliance to End Homelessness, the National Low Income Housing Coalition, and the National Law Center on

Homelessness and Poverty. In Los Angeles, she chaired the Working Group that developed the Strategies to End Family Homelessness in L.A. County for the county's Ten Year Plan. Currently, she is an assistant research professor at the University of Southern California's School of Social Work.

Marsha Werner is the federal project officer for the Policy Academies on Homeless Families with Children. She also is the lead specialist for the Social Services Block Grant program at the Office of Community Services at the HHS Administration for Children and Families. She has extensive experience as a program and management specialist.

Carol Wilkins is the director of Intergovernmental Policy with the Corporation for Supportive Housing (CSH) where she works to develop and support the implementation of policy solutions to end long-term homelessness for people who have complex health needs and multiple barriers to employment. She has more than 25 years of experience in public finance, human services and policy work, including work with the California Legislature's office of the Legislative Analyst, the State Assembly Ways and Means Committee, as deputy mayor of finance in San Francisco, and as finance director for the San Francisco Housing Authority. She manages CSH's national public policy and research activities, and works to increase the capacity of state and local governments and nonprofit agencies to create integrated systems to expand supportive housing opportunities for people with disabilities and those who are homeless.

Darlene F. Williams serves as HUD's Assistant Secretary for Policy Development and Research (PD&R). The Office of Policy Development and Research is responsible for the analysis, evaluation, collection, interpretation, and reporting of national housing, demographic and economic data used to develop complex, national housing and related economic development policies and programs affecting virtually every aspect of the U.S. economy. Dr. Williams is a principal advisor to the Secretary, regarding policy development, applied social science and economic research on housing policy as well as for evaluation and monitoring of the Department's programs. Prior to becoming Assistant Secretary, Dr. Williams served at HUD, first, as the General Deputy Assistant Secretary for Policy Development and Research, from 2003 to 2005, and most recently as the General Deputy Assistant Secretary for Administration. Dr. Williams also has 23-years of experience in the private sector, including management positions with two Fortune 500 companies.

James D. Wright is an author, educator, and the Provost's Distinguished Research Professor in the Department of Sociology at the University of Central Florida. Dr. Wright also serves as the director of the UCF Institute for Social and Behavioral Sciences and as editor-in-chief of the journal *Social Science Research*. He has published 17 books and more than 250 journal articles, book chapters, essays, reviews, and polemics on topics ranging from poverty to homelessness to guns to NASCAR to survey and evaluation research methods. He also serves on the Board of Directors of the Coalition for the Homeless of Central Florida and chairs the Board's Research and Evaluation Committee.

Appendix C

Symposium Participant List

U.S. Department of Health and Human Services

U.S. Department of Housing and Urban Development

National Symposium on Homelessness Research

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Hyatt Regency Washington on Capitol Hill
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March 1-2, 2007

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