CHAPTER 1

Ending Homelessness Now

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On January 5, 2015, Mayor Mitch Landrieu of New Orleans announced that his city had *ended* veteran homelessness. According to the press announcement, not a single veteran remained among the city's homeless population. A year earlier, the city and its federal and community partners had generated a list of the nearly 200 homeless veterans in New Orleans and laid out a plan to house them one by one through a variety of programs. The news of this success made headlines, as did the proclamations a year earlier by the mayors of Phoenix and Salt Lake City that they too had ended chronic homelessness among veterans in their communities. These successes, perhaps unprecedented in any recent social policy arena, have demonstrated that concerted efforts by communities, in partnership with the federal government, can make a real and lasting difference for what was once a seemingly intractable social problem. These achievements have proven that the United States is poised to make even more compelling and dramatic improvements in the lives of some of the most vulnerable Americans by ending homelessness—among veterans *and* nonveterans—once and for all.

Ending homelessness in the United States is possible and within reach. Over the last several years homelessness has been declining, including among veterans and people who experience chronic

homelessness. This decline is due to a change in long-standing practices among policy makers. The success of current homelessness policy can be attributed to greater reliance on evidence-based practices. Advocates, policy makers (including Congress and Presidents Barack Obama and George W. Bush), and practitioners in the field are to be credited with committing themselves to data-driven decision making rather developing policies based on stereotypes about homeless people. With further strategic investments, these policies can be *taken to scale*, and homelessness can become a thing of the past.

Longitudinal Research Establishes Scope and Dynamics of Homelessness

Research conducted in the early 1990s found that homelessness was more common than previously thought. Previous research had focused on single-night counts that, given the limited time frame, would be expected to yield a low count relative to most other methods. In 1994 two studies produced *longitudinal* estimates of homelessness for the first time, showing the cumulative impact of homelessness over a year or more rather than just on one given night. One study found that people responding to a household survey of the general U.S. population reported that 3.2% had stayed in an emergency shelter or slept in a place not meant for habitation for at least one night in the previous five years. A study of New York City's and Philadelphia's computerized shelter tracking systems yielded counts of the unique number of people to stay in a shelter in those cities, confirming that 3.2% had used those shelters in the previous five years, including 1% of each city's general population in 1992 alone. Adjusting for race and poverty, later studies established that as many as 25% of poor African American men in their 30s and 40s experienced homelessness in New York City in just 1995.

That homelessness could affect so many persons indicated that the problem was not only more widespread than previously thought but was also much more brief and episodic in nature. Such volumes of people could not be accommodated by these systems if there

wasn't substantial turnover—people exiting the condition as well as entering. Researchers have since looked at the dynamics of homelessness using shelter records and have consistently found that indeed, as many as 75–80% of adults and families who use shelters do so on a relatively short-term basis, less than 60 to 90 days, a condition that could be called "crisis homelessness." Others either move in and out of shelters frequently over time or get stuck in the homelessness system for years on end in a condition called "chronic homelessness." Having identified these distinct patterns, research has further indicated that compared to people experiencing crisis homelessness, adults who experience chronic homelessness and families who are repeatedly homeless have much higher rates of behavioral health problems and disabilities and much higher intensive social support needs, such as child protection interventions for families.

Together, this evidence has helped to establish that a two-pronged approach to homelessness is needed, with strategies differentially targeting those who experience crisis homelessness and those who experience chronic homelessness.

Evidence-Based Programs Match Housing and Services with Need

Chronic Homelessness

People with severe mental disorders were among the first to argue that they needed and wanted normalized housing—housing as housing—not residential treatment programs, group homes, shelters, or transitional housing. Their self-advocacy led to the development of a housing model called "supported housing." As initially conceived, the housing was to come from the standard rental market, with the psychosocial support services acting as the "wheel-chair ramp" to help people obtain a unit, move in, and maintain the unit. The housing would not be a treatment program; it would be housing. But as service professionals in the homelessness sector began to experiment with this approach, it gradually morphed into supportive housing.

It was often in congregate nonprofit buildings (not in the standard rental market), which sometimes included treatment requirements or even sobriety, and included on-site treatment staff—effectively transmuting into what can sometimes look and feel like a residential treatment program.

Yet the model still seems to work, and throughout the 1990s efforts to place people who were chronically homeless into supportive housing saw great successes. But the more programmed the housing, the harder it was to place people who were stubbornly homeless, whose active substance use or resistance to treatment made them "hard to house," at least in the view of the programmed housing sector. In response, the Housing First approach emerged. Early innovators, such as Pathways to Housing in New York City, returned to the roots of the *supported* housing movement by self-advocates arguing that housing should just be housing, without treatment or sobriety requirements and in normal, standard rental units, with treatment independent of the housing. They proved that such an approach worked to stabilize even the so-called hard to house.

Thus, by 2002 the homelessness practice and policy field had identified a set of housing solutions for virtually all of the people who experience chronic homelessness, whether in Housing First programs or in the treatment- or sobriety-required supportive housing units. Research finds that for many, placement in housing is associated with reduced use of acute hospital, shelter, and justice services. Indeed, for some populations, such as those with severe mental disorders, frequent jail users, and the aging, the reduced service use fully offsets the cost of the housing—a win for taxpayers and a win for our neighbors, who could now be called *formerly* chronically homeless.

With this new evidence in hand, the Bush administration made it a federal goal to "end chronic homelessness" in its 2003 budget and directed the Department of Housing and Urban Development (HUD) to prioritize new funding for more supported housing. In the ensuing decade, the number of permanent supportive housing units has grown dramatically, from just over 150,000 in 2003 to 300,000 in 2014 nationally. And the number of people who experience chronic homelessness on a given night has declined by half.

Crisis Homelessness

In 2009 as the dimensions of the economic crisis were being felt, President Obama and Congress passed emergency stimulus spending. Federal housing officials contemplated how they could use this opportunity to mitigate the impact of the economic crisis on homelessness. Innovators in homelessness at the time had been experimenting with promising models to address crisis homelessness, including programs in Los Angeles, Minneapolis, New York City, and Mercer County, New Jersey. The emerging model, dubbed Homelessness Prevention and Rapid Rehousing (HPRP), was enacted as a national demonstration program as part of the American Recovery and Reinvestment Act of 2009. Under the program and consistent with previous research, homelessness was presumed to primarily affect people experiencing a short-term social or economic crisis, and with temporary services (e.g., emergency cash assistance and housing supports) people could resolve their homelessness relatively quickly and perhaps avoid it entirely. Indeed, as a result of the program, nearly 1 million people were served between 2010 and 2012. Unlike most other economic indicators of the recession, homelessness did not increase, other than a relatively small increase in 2010 among suburban and rural families as the program was just getting under way.

The HPRP concept has now been established in federal law as part of the renewed McKinney-Vento Act. HUD has created a new program, the Emergency Solutions Grant program, to allocate rapid rehousing resources and has encouraged communities to prioritize rapid rehousing in their main homelessness assistance programs, including through the conversion of more costly transitional housing programs.

With these innovations in policy and practice and supported by evaluation research, the field now has two solutions—supported housing and rapid rehousing—for chronic homelessness and crisis homelessness, respectively. The new federal plan to end homelessness, Opening Doors, has affirmed this direction in policy and is guiding federal agency resources using these two jointly labeled Housing First approaches.

Congress and HUD Build National Data Capacity to Track Progress

Beginning in 2000, Congress called for all communities in the United States to develop computerized systems for tracking the use of homeless services and outcomes. The rationale was that through better data, communities would be able to more effectively target their resources and identify strategies that worked (and those that didn't) and that federal policy could also be better informed by this new system of information. The data collection process became known as Homelessness Services Management Information Systems (HMIS) and is governed by explicit federal data standards and security guidelines. While some communities are not fully using the data capacity created by HMIS, and indeed in some places it is viewed more as a data collection burden than benefit, others are recognizing that the HMIS data can form the core of a smarter and more strategic effort to end homelessness.

President Obama and Congress Invest to End Veteran Homelessness

Building on the success of the Bush administration's chronic homelessness initiatives, the Obama administration and Congress turned their attention to the problem of homelessness among veterans. In 2009, U.S. Department of Veterans Affairs (VA) secretary Eric Shinseki charged his agency with ending veteran homelessness by 2015 and, with congressional support, mounted a major expansion of housing and services targeting the problem.

The first major program expansion was to the HUD-VA Supported Housing (VASH) program. The program had been a relatively minor effort to that point, linking two federal agencies—HUD to administer the housing vouchers and VA medical centers to provide the case management. However, under the Obama administration, the program grew from just over 8,000 units in 2008 to over 70,000 today. This major expansion in housing enabled the VA to

reach tens of thousands of veterans on the streets and move them into permanent housing. Implementation was not without its challenges, and some communities have proved better at doing the outreach and making timely placements than others. But the VA has mounted a technical assistance and training effort to assist medical centers in the practice of Housing First and in the timely placement of people into housing. Perhaps no other program has contributed so much to the decline in veteran homelessness during the Obama administration, from an estimated 85,000 people at a given point in time in January 2009 to about 49,000 people five years later.

To address the problem of *crisis homelessness* among veterans, the VA launched a parallel program to HUD's HPRP program called Supported Services to Veteran Families (SSVF). Like the HPRP that preceded it, the SSVF offers both preventive interventions to households on the brink of homelessness and rapid rehousing to those who find themselves homeless in shelters or on the streets. The program provides assistance with debt reduction, rent arrears, and utility shutoffs as well as relocation assistance to households that have to move, including first and last months' rent and security deposits. The program also provides up to nine months of rental assistance based on need.

Like the HPRP program, the SSVF program has been a success and has contributed to the decline in veteran homelessness. Evaluations show that 85% of the households assisted do not return to homelessness up to one year after they have exited the program. Because most of the veteran households who are assisted consist of single adults, mostly men (mirroring the dominant population of adult homelessness more generally), the program has offered an important opportunity to test whether this rapid rehousing intervention model can work with single adults as well as families. Indeed, the evaluations show that the program, while slightly less effective for singles than families, is still associated with better than 80% retention in housing up to 12 months after exiting the program.

By relying on evidence-based practices and pairing up the prevention and rapid rehousing resources for veterans who experience crisis homelessness, these expanded VA programs are making a

significant dent in veteran homelessness. While zero veteran homelessness at any given time may be impossible to sustain, these programs hold the promise of reducing homelessness among veterans even more steeply in just the next couple of years. Access to these critical resources could mean that no veteran should be homeless for more than 30 days and that, indeed, we can end *every* veteran's homelessness quickly and effectively.

On the Horizon: Taking Supported Housing to Scale

The successes resulting from changes to homelessness policy and practice demonstrate that combining knowledge from research, innovations from the field, insights from the people who use these programs, and a data-driven policy environment can lead to public policy victories. Human lives can benefit, as can society, from a better and smarter approach to programs and services. But more remains to be done. Homelessness continues to persist, especially among nonveterans, and in some communities has even grown, as these programs remain discretionary and are not funded sufficiently to take them to scale. Indeed, it remains a striking fact that nearly half of the homeless adults in this country, about 250,000 persons on a given night, are living *unsheltered* on the streets, in cars, in parks, or in other places not meant for human habitation, facing daily threats to their health and safety.

Future sessions of Congress and the new president in 2017 will have the chance to make a major difference in the lives of the many people who suffer from homelessness or who are fated to become homeless in the face of stark housing affordability problems and the periodic crises that beset very poor people in our society. But proven successes have provided the framework for making further progress, and urgent action is needed.

First, the federal government should redouble its efforts to address chronic homelessness. Just as it has expanded vouchers and housing supports for veterans, it should commit itself to expanding

subsidies for supported housing to nonveterans. Approximately 80,000 people experience chronic homelessness on a given day, and an expansion in the number of vouchers targeting them by 20,000 a year for five years could effectively solve that problem. A focus on the aging homeless population also holds the promise of offsetting the costs of housing by reducing end-of-life health care costs. Nearly 50% of the chronic homeless population is over age 50. A program targeting people ages 55 and over, whose life expectancy is a mere 64 years, could help reduce hospitalizations and nursing home placements and fully offset the cost of their housing.

An expansion of rapid rehousing opportunities could also help to end homelessness, if not avert it, for the 135,000 families who experience homelessness annually. If the HPRP is a guide, the average household used approximately $3,500 in rent or cash supports to resolve its homelessness. Thus, a program of approximately $550 million could help to end family homelessness for all homeless families each year, possibly doing so in 30 days or less, as has been called for in the reauthorized McKinney Vento Act (also known as the HEARTH Act, for "Homeless Emergency Assistance and Rapid Transition to Housing"). Indeed, a revamping of the whole approach to addressing crisis homelessness, including for single adults, could build on the experiences of the HPRP and the SSVF and provide all people who become homeless with urgent crisis interventions, including emergency cash and supports, as an alternative to the neglect of long and repeated stays in barracks-style emergency shelters.

One emerging opportunity for expanding rapid rehousing for the single adult homeless as well as some families comes from the behavioral health field and the promise of newly expanded Medicaid eligibility. Under the Medicaid expansion of the Affordable Care Act, nearly all single adults who experience homelessness should now be eligible for Medicaid, at least in the states that adopt the expansion. Given that many of the single adults who experience crisis homelessness are also experiencing behavioral health issues, be they mental disorders or substance use disorders, and that many are also recently leaving institutions such as detoxification centers, inpatient psychiatric care, or jails, they may benefit from a Medicaid-funded

behavioral health intervention known as Critical Time Intervention (CTI). CTI was established as a program to effectively transition people with behavioral health problems out of institutions and back to the community so they do not end up being readmitted to hospitals or detox programs or return to jails or homelessness. With many of the adults experiencing crisis homelessness now eligible for Medicaid and with CTI an eligible service for reimbursement (as long as states include it in their Medicaid plans), a great number of the single adults who experience homelessness may be able to get the social and health supports they need to both avoid homelessness and access stable housing either with their families or on their own. This could prove to completely change the way crisis homelessness is addressed, bringing to nonveterans some of the rapid rehousing support services currently provided to veterans.

Finally, continuing expansion of funds targeting homeless veterans could effectively end veteran homelessness for every homeless veteran in 30 days or less, with only modest further investments. It is likely that 10,000–20,000 additional VASH vouchers and a total of $500 million in SSVF annually could sufficiently meet the demands of both those veterans who are homeless today and those who are at risk in the future.

Housing Now!

The year 1990 marked the peak of homelessness activism, when several hundred thousand marchers gathered before the U.S. Capitol with the call "Housing Now!" to end the homelessness crisis. Initially progress was discouragingly slow, and street-level activism waned. But as research has improved and federal agencies and communities systematically turned their attention to housing solutions, we now know that people who previously suffered on the streets can be housed. Millions more can be, including poor families and individuals who experience crisis homelessness each year. All people can be quickly and effectively restored to dignity and safety if we can continue to draw from the best of evidence-based practices,

organize our resources, convert our goodwill to political will, and convert our best of intentions into the best of practices.

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