THE HOMELESS ASSISTANCE MODEL
YOU KNEW IS HISTORY

BY ROSE PHILLIPS

INTRODUCTION

The past few years have seen a renewed fervor for addressing homelessness—and a new sense of confidence that we can successfully prevent and end it. We've also heard some new terms circling around, including Housing First, Rapid Re-Housing, and Permanent Supportive Housing. These new approaches to homeless assistance are described as "evidence-based" and "data-driven" . . . but what does that mean? What is the evidence exactly? And what roles do transitional housing and supportive services play? This article describes the history of homeless assistance policy in the U.S. and the emergence of the best practices that now dominate federal policy.

HELPING PEOPLE EXPERIENCING HOMELESSNESS: A BRIEF HISTORY

Homelessness emerged as a national social problem in the early 1980s, driven by the perfect storm of deinstitutionalization, rising housing costs, and stagnating wages. In 1987, Congress passed the Stuart B. McKinney Homeless Assistance Act, a landmark bill that created funding programs for emergency and transitional shelter, job training, health care, and other services for the homeless, and required that homeless children have access to public education. In 2001, it was renamed the McKinney-Vento Act [1,2].

By 1992, four major HUD programs had been established under the McKinney Act, all of which still exist in modified forms. The Emergency Shelter Grant (ESG)

provided funding to state and local governments on a formula basis for renovation of structures for emergency shelters, shelter operation, essential services, and limited prevention activities[3]. In addition, HUD offered three competitive grant programs. The Supportive Housing Program (SHP) was the most diverse, supporting development, operation, and service provision for Transitional Housing (TH), Permanent Supportive Housing (PSH) for people with disabilities, and safe havens[4]. Shelter Plus Care provided rental assistance for homeless persons with chronic disabilities; and the Section 8 Moderate Rehabilitation Single-Room Occupancy (SRO) Program helped finance rehabilitation and rental assistance for SRO units for formerly homeless persons[5].

HOMELESS ASSISTANCE AS WE KNEW IT: THE CONTINUUM OF CARE MODEL

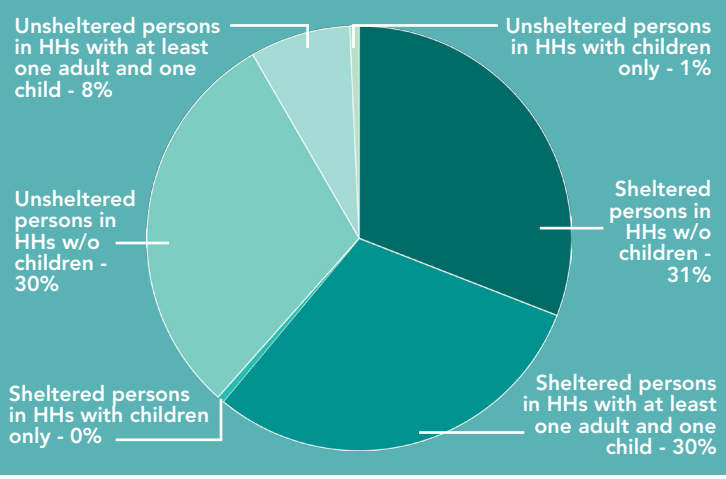
Initially, housing and service providers applied individually for HUD's competitive McKinney funds. In 1994, however, HUD introduced a process that is used to this day. Homeless service providers were required to organize themselves into geographically delineated "Continua of Care", or systems for planning, coordinating, and delivering services to people in all stages of homelessness. Within the CoC, individual project applications for all three competitive programs are pooled into a joint application submitted by a designated "lead agency". By collaborating on funding applications and year-round planning efforts, providers ideally avoid duplication of efforts, identify gaps, coordinate with mainstream services, and are able to seamlessly make client referrals.

The term "Continuum of Care" also refers to the linear model of homeless service provision that dominated through the 1990s and early 2000s. The archetypal client would enter emergency shelter for initial stabilization, be accepted into a Transitional Housing (TH) program after an initial period of sobriety, and "graduate" to permanent housing after completing the TH program and saving up enough money for relocation costs. McKinney-Vento-funded TH programs serve clients for up to 24 months, and many (though by no means all) are congregate facilities that require residents to accept mental health/substance abuse treatment, participate in life skills training classes, and abide by various house rules[6].

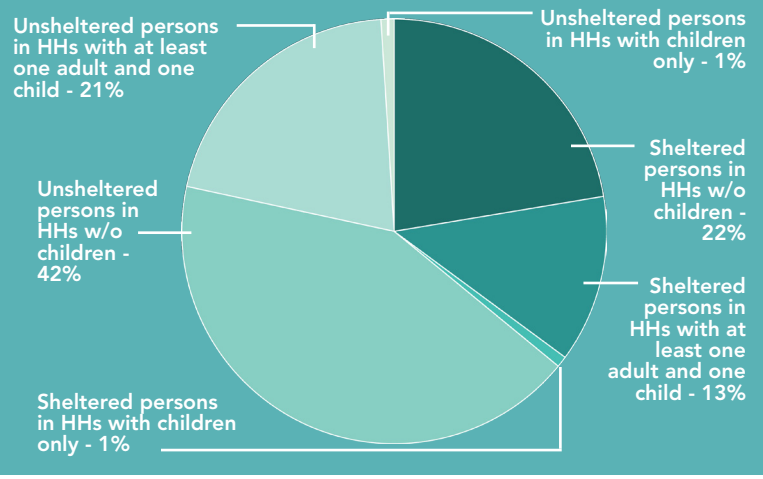
THE ASCENDANCY OF "HOUSING FIRST"

Although the CoC model dominated homeless assistance policy and practice until recently, it did not hold a monopoly. In the late 1980s, Permanent Supportive Housing (PSH) models were developed for homeless persons with disabling conditions, such as physical impairments, mental illness, and/or substance abuse. These individuals are often chronically homeless, a subgroup that comprises a minority of all those who experience homelessness in a given year, yet consumes a majority of homeless assistance resources. PSH providers offered these individuals full tenancy rights in "regular" units, and participation in supportive services was encouraged but not required as a condition of tenancy. Between the mid-1990s and early 2000s, several studies of PSH programs showed that large majorities of participants maintained housing stability for at least a year[7,8].

ALL HOMELESS PERSONS IN US 2012 POINT-IN-TIME COUNT (TOTAL = 633,782)



ALL HOMELESS PERSONS IN FLORIDA 2012 POINT-IN-TIME COUNT (TOTAL = 55,170)

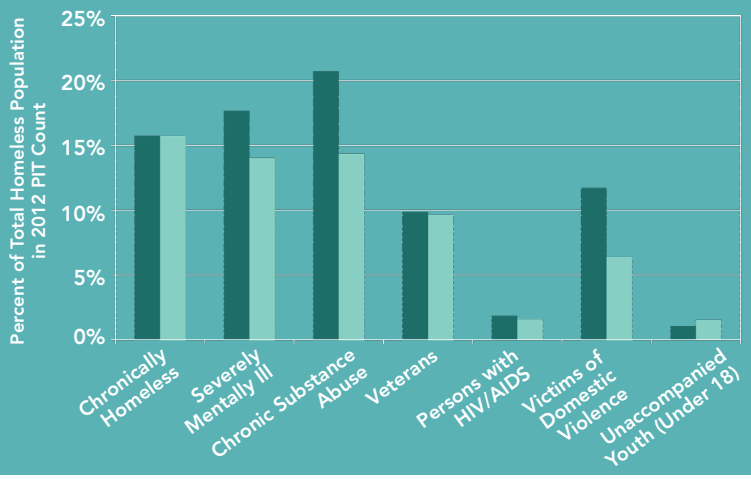


The term "Housing First" was probably coined in 1988 by Beyond Shelter, a nonprofit in Los Angeles, CA, that offered "rapid re-housing" services to homeless families[9]. The premise was that stable housing is a basic right and serves as a platform for other interventions to succeed. Much of the research on Housing First, though, addresses PSH programs for single adults with severe mental illness. The first such program—and the most heavily studied—was Pathways to Housing, founded in New York City in 1992. Homeless persons are referred to Pathways by outreach teams, shelters, drop-in centers, jails, and hospitals, and Pathways maintains relationships with a network of private landlords willing to lease to its clients. Each participant is linked with a staff team of professionals in fields such as medicine, psychiatry, and vocational rehabilitation. Program participants are required only to pay 30% of their income for rent and meet regularly with a case worker, although their staff teams strongly encourage them to use available services. Many Housing First programs around the country have developed variations of the same basic model that Pathways pioneered[10].

The spread in popularity of HF was driven by several lines of evidence, in addition to the success of PSH. First, most people who enter emergency shelters exit homelessness without formal assistance and do not return within the study horizons. As a result, a disproportionate share of homeless assistance resources are consumed by the minority of people who are chronically or episodically homeless. Second, the public costs incurred by the chronically homeless in hospitals, jails, shelters, and other institutions may be largely offset by providing PSH[11,12,13]. And third, surveys found that homeless people themselves prefer permanent housing to transitional housing[14]. In 2002, these findings motivated the Bush administration to set a national goal of ending chronic homelessness in ten years, largely by developing PSH. In the last half-decade, studies of HF programs other than Pathways proliferated, and most have found that participants have high rates of housing stability and reductions in use of costly public services. Not all studies have control groups (e.g. Transitional Housing participants), but those that do generally show better housing outcomes for HF participants. However, the evidence is mixed on whether HF reduces mental illness and substance abuse[15,16,17].

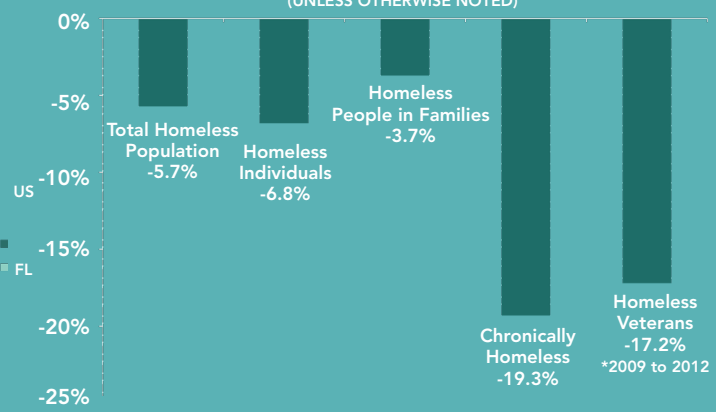
Research on Housing First approaches for homeless families is more limited, but several studies show that receipt of a housing subsidy is a major predictor of housing stability for families exiting homelessness[18]. Preliminary studies of family PSH programs have also found some successes[19]. One study in Upstate New York found that PSH programs for families are more expensive than TH, but have better outcomes[20]. Additionally, a landmark study in four cities found that families who stayed in emergency and transitional shelters the longest did not have higher social service needs than those who exited shelter and did not return[21]. As a result, many advocates have promoted a "Rapid Re-Housing" (RRH) model for families (as well as individuals) with relatively few barriers to housing stability. RRH programs provide

2012 POINT-IN-TIME COUNT: PERCENT OF HOMELESS PERSONS IN SELECTED SUBPOPULATIONS



CHANGES IN HOMELESS SUBPOPULATIONS IN US POINT-IN-TIME COUNTS 2007-2012

(UNLESS OTHERWISE NOTED)



just enough assistance to quickly stabilize these families in permanent housing—outreach to landlords, security and utility deposits, moving costs, temporary rental subsidies, and temporary case management addressing behaviors that directly affect a client's housing stability[22]. In early 2009, HUD created a Homelessness Prevention and Rapid Re-Housing Program (HPRP), a 3-year demonstration. In the second year, nearly 90% of the participants who exited the program went to permanent housing, and HUD classified about two-thirds of exit destinations as "stable" housing[23]. Several communities also report that RRH programs have lower costs, higher rates of exits to permanent housing, and lower rates of return to homelessness after 12 months than TH programs[24].

THE FEDERAL GOVERNMENT CATCHES UP: THE HEARTH ACT, OPENING DOORS, AND BEYOND

The growing emphasis on Housing First and prevention culminated in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, which reauthorized and updated the McKinney-Vento Act for the first time since 1992. The definition of homelessness was expanded to include households that will lose their housing in 2 weeks[25], as well as unaccompanied youth and families with children who are living unstably. The definition of "chronic homelessness" was expanded to include families as well as unaccompanied individuals[26]. The Emergency Shelter Grant, meanwhile, was renamed the "Emergency Solutions Grant", and its share of HUD's McKinney Vento funds doubled from 10% to 20%. Rapid Re-Housing (RRH) was added as an eligible component, and the 30% cap on homelessness prevention activities was removed and replaced with a 60% cap on street outreach and emergency shelter. The competitive grant programs were consolidated into a single, more flexible "Continuum of Care" program, and RRH was added as an eligible activity. The application and scoring process was revised to emphasize outcomes, including reductions in total homeless populations and in rates of return to homelessness. The HEARTH Act also created a new Rural Housing Stability Program (RHSP), in which rural communities can compete more effectively for funding. RHSP allows a broad array of activities (including repairs needed to make homes habitable) that reflect the unique nature of rural housing instability[27,28].

The Obama administration followed up in 2010 with Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, the first comprehensive planning document for federal homeless assistance policy. Chronic homelessness had declined by one-third in the preceding five years, and Opening Doors built on the momentum by pledging to end chronic and veteran homelessness by 2015, and family and youth homelessness by 2020. Similar to the HEARTH Act, Opening Doors embraced Housing First, and provided guidance for homeless assistance providers to coordinate more effectively with mainstream social services[29]. It drew on emerging federal programs, including HPRP and HUD-Veterans Affairs Supportive Housing (HUD-VASH). In the latter program, the VA provides social services to qualified veterans while HUD provides a Section 8 voucher[30]. Around the same time Opening Doors was released, Congress authorized the VA to create the Supportive Services for Veteran Families (SSVF) program, which provides homelessness prevention and rapid re-housing assistance to veteran families who might not qualify for other VA benefits[31].

The HEARTH Act, Opening Doors, and recently released HUD rules all promise to change the process of homeless assistance as well as the substance. In particular, HUD's interim Continuum of Care rule requires CoCs to implement "Coordinated Assessment" programs for intake and referral of homeless clients. In many communities, the homeless assistance network is fragmented, and homeless

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persons must approach multiple providers before finding one who will accept them. The services a client receives may be based more on which provider is able or willing to admit them than on their actual needs. With coordinated assessment, clients enter the homeless assistance system through well-defined entry points. Providers collectively assume responsibility for matching clients with the right programs, and agree on a set of intake questions and referral criteria[32,33].

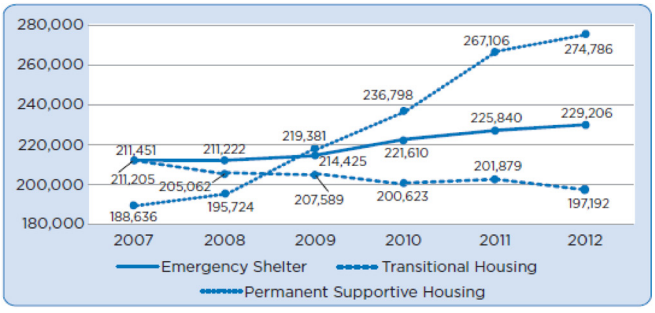
REMAINING CHALLENGES

With Housing First approaches and massive emphasis on system coordination, our generation's push to end homelessness might just be the one that works. As one example, the 100,000 Homes Campaign has already housed over 70,000 people. A national grassroots effort led by a New York-based nonprofit, 100,000 Homes targets the most vulnerable individuals experiencing chronic homelessness[34]. However, challenges remain at all levels, from federal policy to local implementation. As always, federal funding is stretched and uncertain. Although Congress has been relatively generous with McKinney-Vento funding in the past few years, the current funding is not enough to cover renewals for projects that have already been developed[35,36]. Some of the "mainstream" resources we need to create paths out of homelessness, such as public housing, CDBG, and community health centers, have seen significant cuts[37]. Others, such as Temporary Assistance for Needy Families (TANF) and Medicaid, receive non-discretionary federal funds and can grow with demand. However, the recently proposed cuts to the Supplemental Nutrition Assistance Program (SNAP, or "food stamps"), show that even these programs are vulnerable.

The new federal approach to homelessness is also pushing communities to diminish the role of Transitional Housing (TH). The downsides of TH have been somewhat exaggerated—the limited scholarly research finds that most TH clients who complete their programs are satisfied with their experience and find permanent housing, and programs do not generally "cream" the easiest-to-serve clients. However, "screening out" and attrition of the hardest-to-serve clients are common, especially for single adults[38,39]. And, as noted above, some communities have had better results with Rapid Re-Housing. TH providers can stay competitive and protect their investments by "retooling" their programs. Some providers may wish to tailor their programs to populations that need them most, such as domestic violence survivors and recovering addicts. Programs may increase retention and avoid having empty beds by easing admission standards, such as requirements for sobriety and treatment compliance[40]. Some programs are even shifting their service models toward emergency shelter, interim housing for people awaiting a PSH or RRH unit, or permanent supportive housing, depending on the physical structure of their units[41].

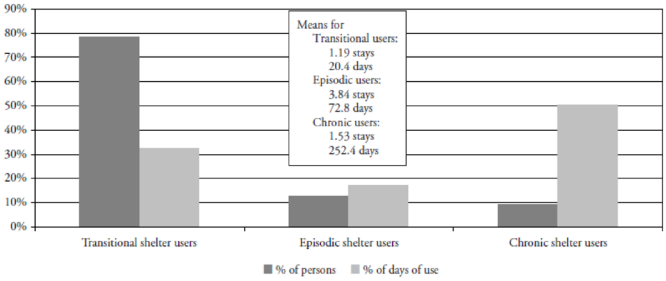
Advocates for the homeless have also struggled with the role of supportive services and how to pay for them. In Permanent Supportive Housing programs, McKinney-Vento grants are a critical funding source for support services. However, beginning in 1999, HUD established requirements and incentives for CoCs to shift spending from supportive services toward housing. The HEARTH Act shifts funding priorities even further toward housing. Medicaid is another vital funding source, but not all services are eligible for reimbursement, and not all people exiting homelessness would necessarily qualify for it.

INVENTORY OF BEDS FOR HOMELESS PEOPLE IN THE US



Source: National 2012 Point-In-Time Count

PUBLIC SHELTER USE AMONG SUBPOPULATIONS OF HOMELESS SINGLE ADULTS IN PHILADELPHIA DURING A 3-YEAR PERIOD



Source: Kuhn and Culhane 1998, in Culhane and Metraux 2008.***Note:** "Transitional shelter users" means users who had just one brief shelter stay within the study period. "Episodic users" cycled in and out of shelters repeatedly, and "chronic users" stayed for months or years at a time.

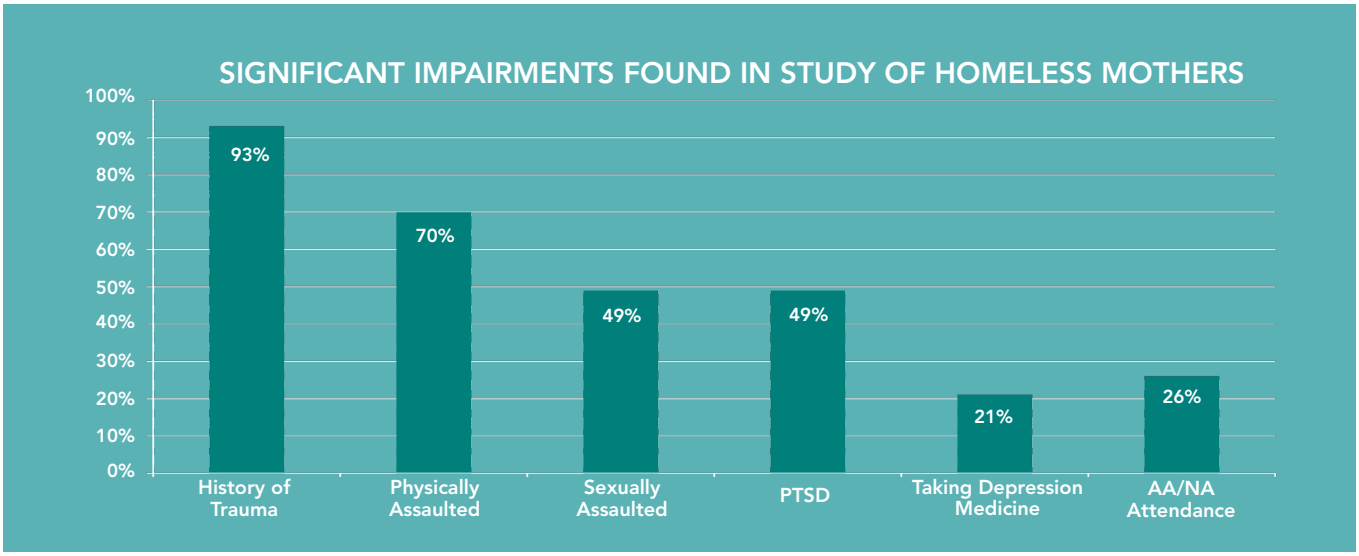
While other federal funds exist, particularly from the Department of Health and Human Services (HHS), none has been sufficient to fill the gap left by shifting McKinney funds[42].

The greatest risk, though, may be for families who need ongoing services that Rapid Re-Housing programs do not provide, yet may not have severe enough impairments to qualify for PSH. Some analysts accept the principles of Housing First, but worry that families will lose access to services as Transitional Housing programs decline[43,44]. Although previous research suggested that families with long shelter stays do not have higher service needs, some needs may have flown under the radar. For example, PTSD and depression are widespread among homeless mothers, and may be major predictors of long-term housing stability. However, they seldom require hospitalization and often remain undiagnosed[45,46].

Of course, internal issues of program design are just as important as external funding sources. The issue of serving higher-need families is closely tied to that of designing eligibility criteria for RRH programs. Even RRH's staunchest advocates recognize that a program with broad eligibility criteria may become much more expensive than anticipated, by drawing many unstably housed families out of the woodwork. Moreover, if RRH programs accept families who need longer-term support, they may have a high and politically damaging rate of return to homelessness[47,48]. Similarly, despite the documented success of PSH, a substantial minority of tenants leave within two years for less favorable living arrangements. It can be difficult to predict which tenants will "fail", so PSH programs should strive for constructive tenant-staff relationships, an ability to detect the early warning signs of a relapse, and attractive units in neighborhoods that tenants like[49].

CONCLUSION

In recent years, homeless assistance has received unprecedented political support, largely because of documented successes in housing the chronically homeless. Without a doubt, the supply of affordable housing may put an upper limit on our efforts to prevent and end homelessness. But if we can successfully help the populations targeted by the HEARTH Act to regain stable housing with the resources we do have, we can make a stronger case than ever that affordable housing prevents homelessness, saves taxpayer dollars, and helps people live more productive lives. With policy makers watching closely, we have to do it right. Providers of housing for the homeless should carefully define their target populations and help them connect to mainstream resources. Support service agencies who want to venture into housing development should recognize how it will change their capacity needs and organizational culture. And all players should communicate early and often, bringing new stakeholders to the table, educating themselves about best practices, and retooling local programs based on what works for their communities. HNN



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