THIRTEEN

# Ending the Persistence of Homelessness

*R. Neil Greene and Wayne Centrone*

## The Problem

Homelessness has been with us for generations and the problem shows no real sign of ending. Despite rapid innovation in homelessness services and indicators of success over the last few decades, hundreds of thousands of people can still be counted on the streets and in shelters in the United States on any given night. Homelessness is also increasingly criminalized. In this chapter, we argue that despite being in an era in which we have a lot of information about homelessness, making a difference will require shifts in thinking and practice. These include broadly viewing homelessness as a social symptom that can be treated, respecting common humanity, prioritizing social equity, coordinating efforts across services and sectors, and improving prevention and coordinated response efforts. Such changes can facilitate better access to and quality within housing, employment, and health and social services. After briefly reviewing the history of homelessness in the United States and describing our current state of knowledge, we further elaborate on our recommendations.

Numerous scholars have described the history of homelessness in the United States alongside changing social factors—industrialization, the great depression, the New Deal, and nuanced contemporary times. Attention has ebbed and flowed, with varied concern and relationships between public and private sectors. The tail end of the era of deinstitutionalization—a period of time in which people were transferred out of the confined spaces of asylums and into community oriented care—is often associated with increased homelessness, but deinstitutionalization as a primary cause is disputed and, importantly, this period coincided with a confluence of additional factors such as reductions to welfare (including the dismantling of social sector housing), wage stagnation, declining union strength, growing

income inequality, and rising housing costs. In any event, greater public exposure to extreme poverty and homelessness during this period precipitated a movement of sorts. Organizations such as the Community for Creative Non-Violence, led by the likes of charismatic leaders like Mitch Snyder, conducted hunger strikes, tent-city protests, and housing marches to advocate for housing as a basic human right.

The passage of the McKinney–Vento Homelessness Assistance Act of 1987 was a legislative success. McKinney–Vento funds transitional housing, job training, primary care, education, and permanent housing. Private and public sector funding converged at this time as well. Healthcare for the Homeless (HCH) programs began as demonstration projects in the early 1980s, with programs in 19 cities funded by the Robert Wood Johnson Foundation, Pew Charitable Trust, and the U.S. Conference of Mayors. Later, HCH was federally authorized under McKinney–Vento. The program is now situated under the Consolidated Health Center Program. Illustrating the influence and growth of such programs, The National Association of Community Health Centers reports that 299 health centers received federal funding under the Health Care for the Homeless program in 2017. Increased funding and infrastructure led to greater attention to inclusion and exclusion criteria for services. Defining and categorizing people experiencing homelessness has not been easy, though.

At present, The United States Department of Housing and Urban Development (HUD) defines homelessness as inclusive of the following abbreviated criteria: 1) People who are living in places not meant for human habitation; 2) People who are losing their primary nighttime residence within 14 days; 3) Unaccompanied youth; and, 4) People attempting to flee domestic violence. In comparison, The Health Resources and Services Administration (HRSA) defines homelessness as follows: Individuals who lack housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and individuals who are resident in transitional housing.

Despite formal definitions, and predating them, people without permanent homes (or families to live with) have been disparagingly called "bums," "vagrants," and "hobos" over various time periods. Moreover, homelessness is perhaps most accurately described as an *experience* and one that is different for each person caught in it. This is generally broken down into three experiential groupings often used to describe subgroups: transient, episodic, and chronic. The majority of people experiencing homelessness face transient homelessness – they

lose a domicile situation, find their way into unstable housing (e.g., shelters, cars, sofa surfing, or camps) and then rebuild their resources to leverage a more stable if not permanent situation.

Contemporary scholars have argued that we are now in the "new homelessness" era, one in which we know a lot about the problem and there is focus on prevention. And yet, shortages of affordable housing and emergency shelter are well documented and cities across the country continue to prohibit camping in public, sleeping in vehicles, asking for money, and food sharing. People experiencing homelessness are also targets of violence. Reports suggest that the criminalization of homelessness is increasing while more people and families are experiencing homelessness.

## The Research Evidence

Point-in-time counts found that 552,830 people were experiencing homelessness on a single night in 2018. In 2019 counts found 568,000 people, an increase of roughly 3 percent. But this number is only a fraction of those experiencing homelessness over the course of a year. The National Association of Community Health Centers reported serving 1.4 million people experiencing homelessness in 2018. The most recent estimates from the National Center for Homeless Education (2017) reported 1.36 million homeless students.

Homelessness data sources include Annual Homelessness Assessment Reports (AHAR), which have been submitted to Congress since 2005 and include publicly available raw data files from the point-in-time counts. Much can also be learned from administrative datasets within homelessness services organizations. At a more aggregate level, continuum of care (CoC) integrates common data elements using electronic health records and homelessness management information systems (HMIS). Linking datasets can be particularly insightful. For example, homelessness services administrative data can be linked with mortality data from the offices of medical investigators and/or national death indices, and can be used to study trends in mortality rates and causes of death over time.

Systematic reviews on homelessness abound. A recent PubMed search for "homeless" and "systematic review" yielded 134 citations including reviews on LGBTQ+ youth homelessness, health interventions for communicable diseases, and palliative care. According to the current state of knowledge on homelessness, it is a complex and nuanced social problem with myriad macro and micro factors. It is related to poverty, racism, affordable housing, domestic violence, and access to resources

and opportunity. It is also related to alcohol and drug use. People experiencing homelessness have an accelerated age-adjusted mortality rate up to 3 to 4 times that of the general population. Studies show the average age of death for a person experiencing homelessness is roughly 40–50 years. Although housing and acute care are important, researchers have found that increased and improved services provision is not necessarily related to changes in the number of people dying without a stable place to live. Rather, studies have found shifting medically determined causes of death across time. Whereas HIV/AIDS deaths were more common in the 1980s and 1990s, opioid-related deaths are more common at present. We might better understand the health needs of people experiencing homelessness by acknowledging the impact of trauma and toxic stress on the life course as well as strongly looking at fundamental causes of health disparities. We know a lot about homelessness, but have not ended it.

## Recommendations and Solutions

Given the history of homelessness and its complexity, policy and social action suggestions risk pushback and failure. It should be noted that many leaders and advocacy organizations have proposed good ideas related to housing, services, income, health care, and social connectedness. This chapter builds on this foundation using a multi-disciplinary and intersectional lens. As such, the following include a blend of large-scale societal worldview changes and more concrete suggestions for policy and social action. To begin, we need leadership and a body politic that respects our common humanity and encourages a collective willingness to help our poorest neighbors. A gestalt switch is needed, from blame and anger to concern for the most vulnerable among us. This is a prerequisite for the following recommendations: 1) Recognize homelessness as a social symptom that can be treated; 2) Respect common humanity by decriminalizing homelessness; 3) Improve social equity through affordable housing and universal health care; 4) Build a safety-net across civil-sector, non-governmental, and faith-based coalitions; and 5) Improve tracking of homelessness and poverty indicators and coordinated responses.

### *1. Recognize Homelessness as a Social Symptom that can be Treated*

We can create conditions (e.g., economic inequality and diminished support for people in need) in which the experience of homelessness

is more likely. In this view, homelessness is a sign or symptom of larger social factors. Changing our social prognosis will require citizens and leaders to recognize the connection between our individual lives and experiences and structural factors. We must elect and support policymakers that seek to end conditions that increase homelessness and support collaborative efforts to end it. We must do this because the experience of homelessness is about us, as a society, not them as others within it. Solving this problem can't just be about money, although that will undoubtedly be of concern. Rather, our framing has to be about the quality of our society—and ourselves as participants within it.

### *2. Respect Common Humanity by Decriminalizing Homelessness*

At present, the signs and symptoms of homelessness are often punished. Tent cities are broken up and removed along with personal possessions by law enforcement; panhandling and even the act of giving food or money is made illegal. Quality of life ordinances make public activity and hygiene open to police intervention. Such policies are primarily aimed at keeping homelessness out of sight—for the benefit of those who are better off—not at ending homelessness or addressing its causes. Criminalizing homelessness paints it as inherently bad and encourages othering the poorest among us. This encourages blind eyes to social problems and people in need. We must move beyond blaming individuals for problems, and toward transcending difference and seeing people as people. The National Law Center of Homelessness and Poverty is at the forefront of documenting and challenging homelessness criminalization.

### *3. Improve Social Equity through Affordable Housing and Universal Health Care*

The historical and lifetime accumulation of advantage and disadvantage by different groups influences resources for everyone. True equity means that those who need more may receive more. Equitable approaches to housing and health care would eliminate many of the causes of homelessness and would allow people who become homeless to quickly escape those conditions.

Making housing a right would return us to the origins of the homeless and unhoused advocacy movement. Housing First models have moved us in this direction by removing barriers to housing. This momentum is helpful, but there is not enough affordable housing. Policies should aim to improve the number of affordable

housing units available, ensure mixed-income housing (so as to not segregate low-income people and families), and strengthen existing fair housing and anti-discrimination policies. The National Low Income Housing Coalition is at the forefront of this work. In addition, universal health care access and coverage would ensure that people do not become homeless because of medical bills and that people do not have exacerbated health outcomes because of inability to pay for preventative care for early-stage health conditions. We should push for parity-driven health care remuneration that qualifies mental, physical, and substance use disorders and diseases in a similar way. These policies would minimize causes of homelessness, value our shared humanity, and benefit a wide range of social and economic groups.

### *4. Build a Safety-Net across Civil-Sector, Non-Governmental, and Faith-Based Coalitions*

Policies that encourage collaboration across services and sectors are also needed. This might best be illustrated through an example that connects early interventions for mothers living in poverty. Cross-services collaboration might work to improve access to quality daycare, increase training, and pay for daycare workers who provide trauma-informed care, and include funding and resources to help families stay in housing rather than face eviction. Additional collaborative efforts might include making substance use treatment more accessible while recognizing the role of peer providers in preventing relapse. Alongside these efforts, we could advocate vocational training programs that incorporate life skills enhancement and coaching services after entering a new job. We can begin collaborative work like this by supporting a more integrated model of services delivery.

### *5. Improve Tracking of Homelessness and Poverty Indicators and Coordinated Responses*

We currently rely on once a year point-in-time counts for annual homelessness assessments, but conditions can change quickly and much can be missed in between counting efforts. Pairing these counts with additional metrics and indicators can help. Many cities and communities are conducting death reviews and have created systems that involve public health, hospitals, service organizations, and other advocacy groups in the process of assessing numbers, causes, and locations of deaths of people without homes in their jurisdictions. Homeless death review teams have been formalized in Philadelphia,

New York, Sacramento, and San Francisco among other cities and more cities are developing such teams. Annual death counts show steady numbers of people dying without a place to live and many are not involved with local homelessness services. Tracking deaths raises attention to the most severe health outcome and can precipitate quicker community action. This work requires coordination between organizations, facilitates the sharing of best practices, and can help improve access to and quality of services. Further, such work has moved communities toward inclusive and standardized definitions of homelessness, and strengthened arguments for affordable housing and housing-first programing. Tracking housing status as a "vital sign" is another key opportunity. Linking health status and housing status would allow providers to identify at-risk or vulnerable populations and focus services delivery.

In summary, there is a long history of homelessness in the United States and a strong body of research about it. Despite knowing a lot about homelessness, we have not ended it. Resistance to change among the machineries of the status quo has always been strong, but reshaping the social world is possible. We must view homelessness as a societal problem—that can be treated—and we must work together, across formal and informal groups and organizations. We can move in this direction by advocating recovery, being inclusive, and fostering belonging. We must come to see that caring for the poorest and most vulnerable among us is good and is something that everyone can do. Homelessness has persisted for generations, but it is a problem that can be solved. Our worldview matters.

**Key Resources**

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