

**U. S. APPROACHES TO ENDING LONG-TERM
HOMELESSNESS FOR PEOPLE WITH DISABILITIES**

Martha R. Burt, Ph.D.
Urban Institute, Washington, DC

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The past five years have witnessed a major shift in public commitment to end chronic homelessness. This article examines the phenomenon of chronic homelessness and its emergence as the focus of a significant policy transformation. It first sets the scene with a brief review of why homelessness remains a significant social problem after twenty years of public and private investment in homeless assistance networks. It then looks at definitions of homelessness in general, and chronic homelessness in particular. With respect to policy, it traces a story that starts with research. First came research proving that even the most chronic, disabled, street-dwelling homeless people will accept and remain in housing, given the right configuration and the right supportive services. Research on program effectiveness was followed by analyses showing near break-even public costs for providing the housing. The story continues with evidence that the numbers of chronically homeless people who would need housing are within a manageable range. The article concludes by examining what advocates have done and are still doing with the research evidence, and an overview of public commitments and the effort it will take to assure that they are fulfilled.

CAUSES OF HOMELESSNESS

Two types of factors are generally acknowledged as causing homelessness, in the sense that they create the conditions under which people are more or less likely to find themselves homeless. Factors of the first type are structural – they are larger societal trends and changes that affect broad segments of a population. These include changes in housing markets and land use, employment opportunities, the quality and relevance of public education, institutional supports

for people with disabilities, and discriminatory policies of several varieties. If housing prices go up, all other things being equal, fewer people can afford housing. If unemployment rises, or if pay levels of the most available jobs remain too low relative to the price of housing, fewer people can afford housing. If public education and other institutions do not prepare most people to obtain jobs that pay a living wage, more people will be at risk of homelessness. And so on. Structural factors determine why levels of homelessness rise or fall in *this* place, at *this* time, rather than in some other place or at some other time.

Factors of the second type are individual—they are the conditions and circumstances that make particular people particularly vulnerable to homelessness. These include various disabilities (e.g., mental illness, developmental disabilities, physical disabilities), illnesses, illiteracy, and addictions. They may also include personal circumstances such as domestic violence, having too many children for one's own income or one's family to support, having no family to rely on (e.g., because one has been in foster care, or because one's family is abusive), one's apartment building being condemned, or being in a fire, flood, hurricane, or war.

A third factor, public policies, may mitigate structural and individual factors to determine the ultimate level of literal homelessness in a particular time and place. Emergency relief often does this for victims of natural disasters or war. A guarantee of housing does it for citizens of several European countries. Income and other supports for people with disabilities severe enough to prevent their working might prevent their becoming homeless. There will always be some people without roofs, communities, or families. The sheer numbers of people experiencing literal homelessness in the United States during the past two decades, however, indicates a very unfortunate convergence of structural and individual factors that, to date, have not been countered with public policies adequate to reduce their ability to generate homelessness. The

campaign to end long-term homelessness during the coming decade arises from recognizing that public policy changes could make a big difference.

DEFINING HOMELESSNESS AND CHRONIC HOMELESSNESS

Homelessness has been defined in various ways in different eras, countries, and circumstances. Historically, ideas of homelessness have usually incorporated one or more of the concepts of being without place (not being “from here”), without family, or without housing (Burt, Aron and Lee, 2001; Hopper, 1991, 2002; Hopper and Baumohl, 1994, 1996). In the United States during the last two decades, federal policy has been governed by the definition articulated in the principal federal legislation related to homelessness—the Stewart B. McKinney Homeless Assistance Act of 1987 (P.L. 100-77) and subsequent reauthorizations and expansions. The Act defines¹ someone as homeless if he or she “...lacks a fixed, regular, and adequate nighttime residence.” People sleeping in “a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings,” as well as those staying in shelters for homeless people, are part of the definition.

To operationalize the *public policy* of the Act’s definition, at a very practical level it often gets translated into the narrowest of working definitions—having been without housing *last night*, or expecting to be without housing *tonight*. Thus people in very precarious circumstances who still manage to stay in conventional dwellings by moving every few days or weeks from one relative’s house to another would not be considered homeless until they reached the situation of having nowhere to go but the streets or a shelter.

¹ 42USC11302, Section 103 of the Act.

Likewise, someone whose pension or disability check provides enough money to afford a cheap hotel room for three weeks every month and who resorts to the streets until the next check arrives would only be considered homeless at the end of the month, even if this pattern has lasted for years. The consequence of this policy-driven working definition has been the development of an extensive network of homeless assistance programs that help to ameliorate the realities of homelessness for those already without housing. But most existing homeless-specific programs can do little to prevent homelessness or change the forces that continue to generate homelessness.

CHARACTERISTICS OF CHRONICALLY HOMELESS PEOPLE

Officially, the Department of Housing and Urban Development (HUD) defines chronic homelessness as (1) having a disability, and (2) being continuously homeless for one year or more or having been homeless four or more times in the past three years. Using this definition or any of several variations on spell length or frequency, long-term homeless people are largely male (79 to 86 percent), about 60 percent are middle-aged (between 35 and 54 years old), and most are very disabled. Between 83 and 87 percent, again depending on definitions of chronic, have mental health, alcohol, and/or drug problems.² Thus ending long-term homelessness means assisting people who have one or more severe disabilities, and often have a history of resisting efforts to help them address those disabilities.

² Previously unpublished analyses of data for single homeless adults from the National Survey of Homeless Assistance Providers and Clients (NSHAPC).

PROGRAM SUCCESS: EVIDENCE THAT SOMETHING WORKS

To make a new policy, one must know what will work and how much will be needed, after which advocacy focuses on getting authorities to act on this knowledge. In the 1980s there was no evidence of what would work to bring long-term homeless people into housing and induce them to stay there. An early contribution of public policy to the knowledge base of what works were research-demonstration programs authorized by the McKinney Act to see what would work to end homelessness among long-term homeless persons with severe mental illness and/or chronic substance abuse. Starting in the early 1990s with results appearing during the middle and end of that decade, these studies consistently found that services were not enough, but that *if housing was supplied* along with services, people would come in from the streets and remain stably housed. However, without the housing component, no amount of other services affected levels of homelessness (Oakley and Dennis, 1999; Shern et al., 1997; Shinn and Baumohl, 1999). The approach that worked was permanent supportive housing. The housing could take any of many configurations – apartments, houses, group houses, single room occupancy hotel rooms (SROs); the supports could be offered through many mechanisms – on site staff, drop-in, community-based teams. But the housing component was essential; services alone were not enough. On the other hand, *just* offering housing was often not enough either—long-term homeless people with major disabling conditions would lose the housing without the supports that helped them fulfill their obligations as tenants. Practitioners and advocates quickly got the message – this *can* be done, but it takes services *plus* housing!

NUMERIC ESTIMATES: EVIDENCE OF REASONABLE SCOPE

The next question for policy makers and advocates was: how much would be needed? Some local communities have estimates or counts of homeless populations, and even of chronically homeless or street-dwelling homeless people. Some of these communities have already used their estimates as the basis for local campaigns to end long-term homelessness (Columbus/Franklin County, Ohio and Philadelphia, Pennsylvania).³ But to stimulate national policy, national data are needed. For a long time, the only source for national estimates was the National Survey of Homeless Assistance Providers and Clients (NSHAPC), conducted in 1996 with point-in-time and annual estimates of the homeless population published in early 2000.⁴ The only more recent estimate was published just within the last few months (Kasindorf, 2005), being a compilation of hundreds of local counts conducted throughout much of the country in winter 2005.

Analyses of the NSHAPC data first published in 2003 (Burt, 2003), used combinations of spell length and number of times homeless to create different definitions of “chronic” homelessness, and then estimated how many single adults might fit each one (table 1). Using only information about the length of a person’s current homeless spell, a definition requiring two years of homelessness to qualify as chronic includes 28.8 percent of all single homeless adults. Reducing the required time to one year increases the proportion considered chronic to 42.7 percent. The pattern examined for multiple episodes (four or more within the past five years) captures the smallest proportion of single homeless adults (16.4 percent). Putting the two criteria

together (length of current spell and multiple episodes) increases the proportion of single homeless adults who would be defined as chronic, and also make clear that some people qualify under both criteria—they have had several homeless spells *and* their current spell has lasted at least one or two years.

Table 1: Estimates of the Number of Chronically Homeless Single Adults¹

Numbers and Characteristics	Alternative Definitions of “Chronic” Homelessness				
	1 year +	2 years +	4+ episodes in 5 years	1 year + OR 4+ episodes in 5 years	2 years + OR 4+ episodes in 5 years
Percent of all single homeless adults	42.7	28.8	16.4	50.7	40.2
Estimates of Numbers ¹					
Based on October 1996 estimate	126,000	85,000	48,000	149,000	118,000
Based on February 1996 estimate	228,000	154,000	87,000	270,000	214,000
Characteristics – Percentages:					
Male	82	79	87	82	81
Aged 35 to 54	64	63	67	63	63
Past year substance abuse problem	68	63	80	69	67
Past year mental health problem	54	58	45	54	55
Past year either substance abuse or mental health problem or both	84	82	87	84	83
Characteristics – Estimates of Numbers: ^{1,2}					
Past year substance abuse problem	86/166	53/96	38/70	104/188	79/144
Past year mental health problem	68/124	49/89	22/39	80/145	84/117
Past year either substance abuse or mental health problem or both	106/192	70/126	42/76	125/227	98/178

Source: Urban Institute analysis of weighted 1996 NSHAPC data for currently homeless single adults; n = 2473.

¹ Numerical estimates are for a single point in time, either October or February 1996. ² Estimates are in 1,000s; first and second numbers are based on October and February estimates, respectively.

In terms of numbers, estimates based on NSHAPC data for a single point in time range from a low of 48,000 (based on October estimates and a definition using multiple episodes—column 3) to a high of 270,000 (using February estimates and a definition of “at least one year *or* four or more episodes within the last five years”—column 4). Kasindorf’s figures for the nation

³ The National Alliance to End Homelessness provides links to the plans for 11 such states and localities on its website, <http://www.naeh.org/localplans>.

⁴ Burt, Martha. America’s Homeless II – Populations and Services. First released through the Urban Institute’s First Tuesdays series on February 1, 2000 and available at <http://www.urban.org/url.cfm?ID=900344>. Later published in greater detail in Burt, Aron, and Lee, 2001, chapter 2.

as a whole in early 2005 put the total point-in-time homeless population at around 730,000, and the chronically homeless population at around 115,000.

The in-and-out movement expected during a year's time for the homeless population as a whole involves up to six times as many people experiencing homelessness as would be true at a single point in time. Estimates based on NSHAPC data suggest 2.5 to 3.5 million people annually, including children, or about 1 percent of the total U.S. population and 9-10% of all poor people. For long-term homeless people, numbers for longer lengths of time such as a year might be as much as twice as large as point-in-time estimates but are not likely to be more, as people with past homeless episodes come back into homelessness or already homeless people's spells lengthen.

Roughly speaking, then, we could assume that over the course of a year between 150,000 and 250,000 single adults experience chronic homelessness. In the eyes of many people, providing housing and supportive services for a population of this size is manageable. And there is no denying that people who fit the chronic homeless definition need help—they are not likely to be able to solve their housing problems themselves, or they would already have done so.

Most chronically homeless people have significant personal vulnerabilities, such as severe mental illness, substance abuse, or both. These problems often lead the public and policy makers to believe that chronically homeless people will resist housing and services. But, as the evidence cited earlier shows, most will accept housing and services if they are structured appropriately, and most will stay in that housing rather than return to the streets.

MONEY: EVIDENCE OF REASONABLE COSTS

Providing housing and supportive services to chronically homeless people costs a lot of money, which is one reason why communities do not do more of it. However, chronically

homeless people also cost communities a lot of money when they are *not* housed, as well as reducing the quality of life for homeless and non-homeless people alike. Databases showing shelter use by individuals allow us to see that relatively few (about 10 to 15 percent) of the people homeless at any given time are continuously homeless, or return to homelessness regularly and never establish stable residence. Further, these few take up at least half of the resources available in the system of emergency response to homelessness – using 50 percent or more of the available shelter bed-nights, in quite a number of cities capable of providing this information. Culhane and colleagues (Culhane, et al., 1994) showed this for New York City and Philadelphia in 1994; numerous communities have subsequently observed the same patterns of homeless service use, with relatively few people using a disproportionately large share of system resources. So people are being housed (in shelters), just badly housed, and expensively housed. And in shelters they do not get much help to leave homelessness.

In addition to shelter and other resources of the homeless assistance system, chronically homeless people drain the resources of hospital emergency rooms and inpatient services, psychiatric outpatient and inpatient services, substance abuse services, jails and prisons, veterans services, and other public agencies. Recent work by Dennis Culhane and his colleagues at the University of Pennsylvania on supported housing programs in New York City (Culhane, Metraux, and Hadley, 2002), Connecticut (Corporation for Supportive Housing, 2000), and San Francisco (Proscio, 2000) documents the extensive public costs incurred by these systems in caring for chronically homeless adults. Results show that the costs of *not* offering housing and supportive services come close to equaling the costs of providing them. The evidence of near break-even costs was the final piece of the puzzle that has stimulated recent commitments to ending chronic homelessness.

DEVELOPING A PUBLIC POLICY

Research provided the first step toward developing today's emphasis on ending chronic homelessness. Early federally-funded demonstrations, showed that very long-term homeless people with many disabilities and problems will come directly into housing and stay there, with appropriate services and supports. Subsequent studies and evaluations have demonstrated the same thing. National survey data provided evidence that the chronically homeless population was of reasonable size—a calculation that Kasindorf's compilation of 2005 local counts substantiates. Finally, financial analyses showed that the public costs of *not* providing housing and supportive services for this population came very close to equaling the costs of making housing available.

Advocacy followed the research. Armed with evidence that chronically homeless people would move in off the streets, that the numbers were not that large, that the people affected have many vulnerabilities, and that it does not even cost very much extra, advocates prepared the case. Some organizations and communities had already been working to develop permanent supportive housing, including the Massachusetts Housing and Shelter Alliance in partnership with the Massachusetts Department of Mental Health; Columbus/ Franklin County, Ohio's Community Shelter Board in its Rebuilding Lives initiative; and the Corporation for Supportive Housing in projects in eight states. What advocates began to promote was *national* commitment.

An early step was advocacy to convince Congress to make permanent supportive housing a priority within federal homeless funding streams. Such housing is an essential element in any plan to end homelessness among chronically homeless individuals. For the first time in federal fiscal year 1999, the annual HUD appropriations bill carried the stipulation that 30 percent of HUD funding for the supportive housing program be set aside for permanent supportive housing.

Advocacy and bipartisan Congressional support has seen to it that the 30 percent set-aside has been maintained; additional funds have also been made available to assure renewals of permanent supportive housing programs whose initial grants were expiring.

The National Alliance to End Homelessness kicked off a campaign during its 2000 annual conference, unveiling its “Ten Year Plan to End Homelessness.”⁵ The part of the plan pertaining to ending chronic homelessness marshaled the evidence reviewed above, then laid out steps that would be necessary to achieve the goal, including the now oft-repeated phrases of:

- “opening the back door” (providing housing to help people leave homelessness),
- “closing the front door” (assuring that people leaving institutions such as mental hospitals, substance abuse treatment facilities, and the foster care system do not leave into homelessness), and
- “building infrastructure” (creating more housing, more earning capacity, and better preventive services).

The National Alliance worked to build partnerships and get commitments from federal agencies, and eventually also from the White House. Early in his tenure, National Alliance members visited then-HUD secretary Mel Martinez and convinced him that ending chronic homelessness was something that could be done, and should be done. The fact that there was strong Congressional backing for providing federal funds to the effort also helped move HUD toward a commitment to work on ending chronic homelessness. By the National Alliance’s 2001 annual conference the HUD Secretary was a featured speaker, discussing the need to end chronic homelessness in the United States.

By July 2002, the federal Interagency Council on the Homeless was revived (it had been moribund for six years), and a staunch advocate from Massachusetts was appointed as its

⁵ Available at www.naeh.org/pub/tenyear/index.htm, accessed January 13, 2003.

executive director. His portfolio includes working to end chronic homelessness and increasing cooperation and coordination among the major federal agencies to bring this about. In July 2002, the Council was able to announce a new federal strategy to end chronic homelessness, including a substantial commitment to work on prevention (closing the front door) as well as helping people once they become homeless. That commitment involved directives to three federal agencies (Health and Human Services, Housing and Urban Development, and the Department of Veteran Affairs) to develop working relationships around ending homelessness.⁶

As part of this rapid increase in emphasis on ending chronic homelessness (two years from announcement to federal commitment is very fast in the world of politics), national commitment grew. Editorials appeared in major newspapers (e.g., the New York Times⁷) calling for the end of chronic homelessness and declaring it possible to accomplish. A national conference in May 2002 sponsored by the Corporation for Supportive Housing began a national campaign to get state and local jurisdictions to agree to a “Compact” to end chronic homelessness by developing 150,000 units of permanent supportive housing in the next ten years. The momentum can be seen in the number of communities that have developed their own plans to end chronic homelessness (or all homelessness) in ten years—about 200 cities and counties, plus all but one state.

The question is, will the momentum of new policies and commitments carry through to actual changes in levels of chronic homelessness? Ending chronic homelessness will not be cheap, and although costs are near to break-even with current practices that leave vulnerable people on the streets, the costs come out of different agencies’ pockets. It will take political will

⁶ “White House Interagency Council Announces New Strategy to Combat Chronic Homelessness.” HUD press release, July 18, 2002. Accessed January 13, 2003 at www.ich.gov/library/pr02-078.html.

⁷ Ending Chronic Homelessness, March 13, 2002, p. A24, column 1.

in local communities and at the federal level to capture the savings from various departments and invest them in the activities and programs that will end chronic homelessness. Further, the effort must be sustained over a decade and beyond. Columbus, Ohio, for instance, began its Rebuilding Lives campaign and its commitment to create 800 units of permanent supportive housing for street homeless people almost eight years ago, and it is now about three-fourths of the way to its goal. In this effort, political will is everything, but political will is usually very hard to sustain as years go by and administrations change.

The larger question also, of course, remains—what will it take to end homelessness altogether. In a recent brief, Burt (2001) discussed several steps that are widely regarded as essential if we are to see the end of all types of homelessness in this country. These steps are quite similar to the “building infrastructure” component of the National Alliance’s plan to end homelessness. First, housing has to become more affordable. The simplest way to do this is to subsidize housing; research indicates that the public policy that would do the most to reduce the risk of homelessness is subsidizing housing (Quigley, Raphael, and Smolensky, 2001). This involves no need to build new units, no struggles with project siting or zoning or “not in my backyard” behavior. All it takes is giving people with the worst housing costs in relation to their income the financial resources to remain in place. In addition, new housing needs to be created that is affordable by people earning relatively little despite working regularly—renewed incentives for producing affordable rental housing would greatly help the current situation of inadequate housing supply. And it is also essential that people who are poor today, and their children, have the educational and training opportunities to assure that they are not poor tomorrow. That is, we have to increase the ability of the poorest people in this country to be able, in the future, to afford housing without requiring subsidies. The problem is, these steps are

not in political favor at this time, being seen as the old anti-poverty agenda. Instead, present federal budget proposals actually offer significant cuts in public and subsidized housing—actions that in the long run will work against the federal commitment to end chronic homelessness. Ultimately, the solution to chronic homelessness will rest on the solution to homelessness in general; the latter begets the former. Only a few communities so far have committed themselves to this larger goal.

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