EDITORIALS

Homelessness Research: Shaping Policy and Practice, Now and Into the Future

As this special issue of the journal well reflects, much progress has been made in homelessness research. That progress has been matched with advances in homelessness policy and programming, nearly all of it informed by the contributions of the research community. While the imperatives of policy-making have required decisions to be made with imperfect knowledge, a substantial enough convergence of theory and evidence has enabled policymakers to shift homelessness policy and practice in important ways. Those shifts have also prefigured some of policymakers' needs from the research community in the future.

The US Interagency Council on Housing (USICH) has recently called for a "Housing First" approach across homeless programs,[1] meaning that they have urged federal agencies and their state and local partners to prioritize housing interventions to address homelessness, with the necessary services and supports to follow. While the "housing first" phrase is often associated with a specific model of permanent supported housing, such as the Pathways program in New York City, in this case the phrase is being applied more broadly to advocate for "housing led" policies across subpopulations, including youth, families and nonchronically homeless adults. Of course "housing first" doesn't mean "housing only," so there's much room for further knowledge about how health and social services can support the permanent housing goal, especially for populations with special needs.

US Veteran Larry Mainor recently ended three decades of homelessness through the efforts of "Unsheltered No More" in Atlanta, GA. Photograph by Jaime Henry-White. Printed with permission of AP Images.

The evidence base for this Housing First strategy comes from both the fairly robust research literature on the effectiveness of permanent supported housing, such as from the Collaborative Initiative to End Chronic Homelessness[2] and the Housing and Urban Development Veterans Affairs Supportive Housing (HUD-VASH) program,[3] but also from an emerging evidence base on the effectiveness of homelessness prevention and rapid rehousing (HPRP) programs.[4] The federal HUD HPRP program, funded with $1.5 billion through the American Recovery and Reinvestment Act, provided for a national demonstration of a program model that had strong theoretical support, but limited empirical evidence. Because of that program, and other initiatives like it, including the VA's new Supportive Services to Veterans and Their Families, the evidence base is growing and indicates that the vast majority of families and nonchronically homeless single adult households can resolve their homelessness with timely, intensive, but also relatively brief financial and social assistance.

But none of these programs is perfect, and no program model seems to work for everyone. Returns to homelessness, although relatively infrequent, occur in the fully rent-subsidized and case-managed permanent supported housing programs, as well as in the HPRPs. At least one major thrust of the future research agenda will need to focus on why these interventions don't always work for everyone, and what more needs to be done to make housing attainable (and sustainable) for all. And while conventional rental housing has been the primary approach to ending homelessness, it may well be that some housing models will need to look different, such as assisted living for aging populations, some group living for youth recently exiting foster care and juvenile justice, or safe havens for people unable to comply with conventional housing rules. What is clear,

however, is that federal homelessness policy, most notably through the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 and the VA's new initiatives to end veteran homelessness in 2015, has sharpened the focus onto the housing endgame, and a clear need is evident for research in support of that goal.

From a public health perspective, the emerging evidence also shows how housing serves as a powerful public health intervention. Especially in the realm of HIV prevention and treatment, the evidence base is convincing that stabilizing housing for people who are homeless is associated with improved treatment adherence, and reduced risk behavior, thus an important tool both for increasing survival and reducing infections.[5] Other populations with special needs, such as people with severe mental illness and people with addictions, also reduce their use of hospitals, shelters and jails, as housing functions to improve not only housing stability but also health behaviors and access to more regular forms of care.[6] Yet even considering significant changes in health services use and outcomes, such housing interventions cannot be cost effective for every subpopulation. Nevertheless, the public health and societal benefits of housing for people who were once homeless need to be better documented and understood to continue to inform policymakers and program design. Such evidence has proven to be key to mobilizing political support for expanded housing resources for these populations, and will continue to be important for making the case in the future.

The evidence is now clear that the single adult homeless population is aging.[7] Based on 3 decennial censuses (1990, 2000, 2010), single adult homelessness has been revealed to be part of an "Easterlin (cohort) effect,"[8] disproportionately impacting babyboomers, but especially the latter half of the cohort born between 1955 and 1965. By 1990, the latter half of the babyboom cohort would have averaged 30 years in age, and Census data reveals that they were already the predominant subpopulation among the adult homeless population; they have since remained so. The immediate, and perhaps urgent, implication is that with a substantially lower life expectancy than the general population, most of the adult homeless are facing premature aging-related morbidity, disability, and death, in the next fifteen years. This will have significant repercussions for health care delivery and costs, for housing and long-term care demand, and for the capacity of current supported housing programs to serve an aging and frailer population.

Of a longer-term concern is the etiology of this cohort effect. Easterlin's hypothesis is that such cohort effects result from population surges that produce excess labor supply, which in turn thwarts labor force attachment among young adults in the cohort at disproportionately high rates. The effect could be amplified if combined with an economic crisis (a period effect) that produces even greater rates of unemployment and labor force nonparticipation among young adults in the cohort. Indeed, such would have been the case when the latter half of the babyboom cohort came into young adulthood during the back-to-back and comparatively deep recessions of the late 1970s and early 1980s. Many who failed to make connections to the labor market during those periods may have been permanently dislocated economically and socially; some turned to illegal activities including drug sales to survive, along with the attendant risks for violence, addiction, incarceration and family and community disruption. Thus, one critical concern now is whether the most recent recession and its aftermath, combined with the coming of age of the so-called millennial generation, will produce its own permanent dislocations among yet another cohort of vulnerable young adults, including returning soldiers from Iraq and Afghanistan. And if it does, what will we do differently than we did in the 1980s to better improve and sustain the connections of young people to work, family, community, and housing? This is a pressing research and intervention agenda that calls for a reexamination of our emergency services approach that proved so limited in the face of the problem in the past. Will the new "housing first" approaches prove adequate to the task? Will they need to be supplemented with labor market-based strategies? How important could employment programs be to averting premature disability, social marginalization, substance dependence, and the related health problems that could otherwise result from another possible Easterlin effect in homelessness?

A final set of research concerns relates to the Affordable Care Act (ACA). Most people who experience homelessness, especially as adults unaccompanied by children, are uninsured (and male).[9] Without a Supplemental Security Income (SSI)–determined disability, and with many being relatively able-bodied, these adults have spent much of their lives without access to regular health care. Along with their often marginally housed contemporaries, they are going to be among the chief beneficiaries of the Medicaid expansion of the ACA. Yet this expansion will also raise many questions, including those about the adequacy of the health care delivery system to provide access to this population; those about how to integrate primary care and substance abuse treatment, given both the need for such treatment and the barriers to primary care for this group; and those about how improved access to health care can be used to identify housing needs and barriers—and interventions—that would mitigate homelessness. Given its experience in integrating behavioral health and primary care for indigent adults, the US Department of Veterans Affairs could be an important source of experience for the nonveteran health delivery system. The Home and Community-Based Services waiver option under the ACA raises the possibility that Medicaid could be used to fund the transition from homelessness to housing, such as through evidence-based practices like Critical Time Intervention. Defined benefits for particular subpopulations, like adults who are homeless or exiting homelessness, could likewise create eligibility for special housing support-related benefits and coordinated care models that could fund the supported services of supported housing—an otherwise difficult resource to obtain. The variability in states' adoption of Medicaid expansion will also create natural experiments of whether and how Medicaid can and is being used to reduce homelessness. The ACA promises to provide tremendous opportunities for research on services that

can enhance and support the federal goal of ending homelessness for everyone. ■

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Application of Implementation Science for Homeless Interventions

The Federal Strategic Plan to Prevent and End Homelessness, *Opening Doors*, developed by the US Interagency Council on Homelessness,[1] offers a national vision and direction to address homelessness at a federal level, building upon coalitions and partnerships and developing coordinated and cost-effective local service efforts. For managers implementing programs, the initiative requires an assessment of existing homeless services and exploration of systematic approaches to evaluate and develop new and enhanced models of care that respond to the unique characteristics of their local homeless populations. Both the immediacy and the importance of the initiative require systematic, effective approaches to ensure that *best* practices lead to *common* practices.

Through the years, interventions and practices that address the causes and effects of homelessness have been offered by a multitude of service providers such as churches, nonprofit entities, community groups, and city and county agencies. Programs have ranged from shelters and soup kitchens to transitional housing and rent and housing subsidies. Funding for these services has come through diversified, and at times mixed, sources including donations, community agency allocations, local and state authorities, or federal regulation or statute.

With limited resources and persistent need, it is imperative that we use evidence-based, cost-effective interventions to get people stably housed and that we disseminate these practices as widely as possible. Service providers should carefully consider implementation designs when operationalizing programs.

IMPLEMENTATION OF SERVICES

Implementation research is the scientific study of methods to promote the systematic uptake of research findings and other evidence-based practices into routine practice designed to improve the quality and effectiveness of health services and care.[2] Dissemination of new intervention models that researchers find promising and translating those models to practical applications for managers and practitioners of homeless services often proves challenging. Many models have been proposed and applied with modest empirical support.[3–5] Additionally, different model frameworks have more reasonable application for various settings or program designs.

Addressing homelessness is complex, and solutions are multifaceted. Research demonstrates that prevention initiatives—as well as those interventions that promote and lead to safe, stable, and permanent housing within the community—reduce homelessness and are cost-effective. The successful dissemination of these programs requires a deliberate method of development, implementation, monitoring, and evaluation. It is also imperative that