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REFORMING THE SYSTEM OF CARE: A REVIEW OF THE LITERATURE ON HOUSING AND SERVICE ARRANGEMENTS FOR HOMELESS POPULATIONS

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Introduction

Reforming the system of care for homeless and precariously housed individuals and families is a central objective of Washtenaw County's *Blueprint to End Homelessness*. This objective recognizes that improved understanding of the relationship between housing, services, and housing stability for homeless people will help communities minimize entries into the housing assistance network and increase the number of successful transitions out of homelessness and into stable housing.

In collaboration with Washtenaw County, Michigan, the Washtenaw Housing Alliance, and local service providers, researchers at the Gerald R. Ford School of Public Policy at the University of Michigan have developed a series of evaluation tools and policy reports to help the community evaluate and reform the system of care for homeless persons in Washtenaw County. This report offers a review of recent academic and applied research on the relationship between housing and service arrangements and housing stability for homeless, formerly homeless, and precariously housed individuals and families.

The breadth and diversity of research on homelessness offers academics and policymakers the opportunity to understand multiple aspects of homelessness. In this report we focus exclusively on research that examines housing and service arrangements that have been found to facilitate stable housing outcomes for each of three subpopulations: (1) homeless persons with disabilities including mental illness, substance abuse, dual diagnosis, and HIV/AIDS; (2) adults in homeless families; and (3) survivors of domestic violence. These subpopulations were selected because each is represented in large proportion in Washtenaw County's homeless population (see Ebron, Haradon, and Phinney 2006), and existing research on each subpopulation is extensive. In addition to this analysis of subpopulations, we provide a brief discussion of homelessness prevention in the final section of the report.

By focusing on housing and service arrangements for disabled homeless individuals, adults in homeless families, and domestic violence survivors, and offering a brief review of research on prevention, we hope to contribute to the efforts of government actors, service providers, and funders to address homelessness in Washtenaw County.

CLOSUP

Housing, Service Arrangements, and Housing Stability

HOMELESS PEOPLE WITH DISABILITIES

Federal law defines a homeless person as someone who lacks a fixed nighttime residence and whose primary nighttime residence is a supervised temporary shelter, institution, or place not ordinarily used for sleeping (U.S. Code: Title 42, Chapter 119, Subchapter 1, § 11302). Although many federal agencies are involved in the administration of programs related to homelessness, the U.S. Department of Housing and Urban Development (HUD) is the primary agency responsible for administering homeless and housing programs for persons with disabilities. HUD defines homeless individuals with a disability as those who suffer from serious mental illness, chronic problems with alcohol and/or drugs, developmental disabilities, and/or chronic physical illness or disability including AIDS and related diseases. Programs such as HUD's Shelter Plus Care Program specifically target mental illness, substance abuse, and AIDS and related diseases, and most studies on disabled homeless people focus on these disabilities.

For homeless individuals who are disabled, the obstacles to securing stable housing are acute. In the absence of housing support, supportive services such as health care, substance abuse treatment, mental health services, job training, and case management are unlikely to yield positive outcomes. Conversely, providing housing in the absence of supportive services is unlikely to result in stable long-term housing, particularly for those with chronic disabilities (Burt 2005; Oakley and Dennis 1996; Shinn and Bauhmohl 1999).

Research on homelessness among disabled persons is extensive, and suggests that several housing and service arrangements are associated with housing stability for homeless persons with various types of disabilities. These arrangements include permanent supportive housing (PSH), "Housing First" models of housing provision, and the use of outreach services to connect disabled populations with needed services. We review each of these approaches to housing and service provision before discussing research specific to each subpopulation.

Permanent supportive housing (PSH) refers to permanent housing provided in conjunction with supportive services. This type of housing is affordable and permanent for people with extremely low incomes, and unbundled from but linked to services (Corporation for Supportive Housing 2006). In recent years, PSH has become the focus of government efforts to address chronic homelessness, or long-term homelessness among persons with a chronic disability. This emphasis on PSH "…is based on the assumption that permanent community-based housing, coupled with supportive services, would foster the greatest stability, independence and self-sufficiency possible among formerly homeless individuals who are chronically disabled" (Wong et al. 2006, p. 1). PSH models recognize that supportive services provided in emergency shelters or transitional housing are often insufficient for homeless persons with disabilities to transition into stable housing situations.

A substantial body of research underlies the belief that PSH helps to stabilize housing and reduce homelessness among formerly homeless individuals with disabilities, relative to other housing and service arrangements (Burt 2005; Culhane, Metraux, and Hadley 2002; Drake et al. 1997; Matulef et al. 1995; Ridgway and Rapp 1998; Shern et al. 1997). For example, an early evaluation of HUD's Supportive Housing Demonstration Program revealed that 70 percent of traditionally "hard-to-serve" clients remained stably housed in permanent housing for disabled individuals after one year in the program, and half of those who left the program exited to stable housing situations (Matulef et al. 1995). Similarly, a study by Shern and colleagues (1997) found that formerly homeless individuals participating in an experimental program that integrated supportive housing and case management achieved higher rates of stable housing over time, relative to individuals in standard treatment programs.

PSH has also proven successful at reducing the costs associated with medical care, incarceration, and emergency shelter for disabled homeless people who are not permanently housed (Culhane, Metraux, and Hadley 2002; Rosenheck 2000; Rosenheck et al. 2003). Culhane, Metraux, and Hadley (2002) found that prior to receiving permanent housing, homeless people with severe mental illness used an average of $40,449 per year in services related to shelter, emergency care, and incarceration. In this study, living in supportive housing was associated with a reduction of $16,292 in the cost of service use.

Physical configurations of PSH include scattered site arrangements where clients occupy a single apartment within a standard apartment complex, clustered scattered site arrangements with a small apartment building set aside for program tenants on a block with no other such buildings, and larger mixed-use buildings where a small portion of units are leased by a PSH provider with the understanding that a specific number of units will go to homeless clients. There is little evidence to suggest that certain configurations are linked to better client outcomes. Rather, configuration is often determined by the financial and political feasibility of a specific development (Burt et al. 2004).

As strategies for treating the homeless evolve, communities are increasingly adopting Housing First approaches. Housing First models place homeless

people directly from the streets into housing with access to voluntary supportive services. This approach recognizes that the instability associated with navigating multiple housing and service environments, as well as the requirement of participation in substance abuse treatment or sobriety as a condition of maintaining housing, can deter disabled individuals from entering traditional emergency or transitional shelters.

Many studies suggest that substance abuse treatment or mental health services should be coupled with services addressing tangible needs of homeless clients if they are to engage clients long enough to focus on intrapersonal issues related to addiction and mental illness (Acosta and Toro 2000; Benjamin 2003; Stahler and Stimmel 1996; Tsemberis, Gulcur, and Nakae 2004). In addition, some researchers suggest there is a benefit to linking clients and services in a single environment rather than transitioning clients across multiple service environments (Tsemberis et al. 2003; Padgett, Gulcur, and Tsemberis 2006).

Housing First approaches have been shown to reduce homelessness and increase housing stability among homeless persons with disabilities (Corporation for Supportive Housing 2005; Burt et al. 2004; Tsemberis et al. 2003; Tsemberis, Gulcur, and Nakae 2004). In a sample of 225 homeless individuals with mental illness and/or substance abuse problems, Tsemberis, Gulcur, and Nakae (2004) found that participants who received immediate housing without treatment prerequisites (experimental group) achieved higher housing retention rates over a period of two years relative to participants who received housing contingent on sobriety and/or participation in treatment programs (control group). Additionally, although participants in the control group were more likely to utilize treatment services, participants in the experimental group were not significantly more likely to have used alcohol or drugs after a period of four years (Padgett, Gulcur, and Tsemberis 2006).

Permanent supportive housing, Housing First approaches, and outreach are important components of connecting disabled homeless clients to needed housing and services.

Finally, outreach is an important component of connecting disabled homeless clients to needed housing and services. Homeless individuals confronting a disability face unique barriers that make them unlikely to access supportive services independently. For example, individuals with mental illness may be wary or distrustful of housing programs that mandate treatment; individuals suffering from addiction may not be able to maintain sobriety; and individuals with dual diagnosis (mental illness and substance abuse) may be discouraged from engaging in treatment that addresses one disability but not the other (Tsemberis, Gulcur, and Nakae 2004). Efforts to make initial contact with disabled homeless individuals on the street have proven successful in engaging a subpopulation that is otherwise difficult to reach in services associated with greater housing stability and better clinical outcomes (Burt et al. 2004; Burt 2005; Shern et al. 2000; Zerger 2002).

Additionally, service providers are often deterred from engaging in outreach because of the costs associated with outreach activities and the perception that services will be less successful for homeless individuals suffering from disability. However, Lam and Rosenheck (1999) found that although the symptoms of clients accessing services through outreach were generally more severe than other clients, most outcome measures for these clients were equal to the outcomes for those contacted through service agencies.

Permanent supportive housing, Housing First approaches, and outreach services are important components of programs targeting homeless persons with disabilities. While homeless individuals living with disabilities share many of the same housing and service needs, there are also important differences. The following sections highlight housing and service needs that are unique to homeless individuals with mental illness, substance abuse problems, and HIV/AIDS.

HOUSING AND SERVICES FOR HOMELESS PEOPLE WITH MENTAL ILLNESS

A significant percentage of the homeless population experience some form of mental illness. According to data from the National Survey of Homeless Assistance Providers and Clients (NSHAPC), 45 percent of homeless individuals indicated having a mental health problem during the past year, and more than half of the severely mentally ill population is precariously housed (Burt et al. 1999). In Washtenaw County, Michigan, over half of all homeless adults experience mental health problems (Ebron, Haradon, and Phinney 2006).

The provision of housing is critical in helping those with mental illness remain stably housed, and housing provided in conjunction with supportive services is consistently associated with better housing outcomes compared to supportive services alone (Clark and Rich 2003; Rosenheck et al. 2003). In a study of homeless adults with severe mental illness, Clark and Rich (2003) found that clients in a comprehensive housing program (including housing, housing support services, and case management) spent more time in stable housing (88 percent of the time compared to 56 percent of the time for the comparison

group), and less time literally homeless (0 percent of time compared to 8 percent of the time), relative to clients who received case management alone. Similarly, Rosenheck and colleagues (2003) found that the provision of a subsidy alongside case management led to higher rates of housing stability for mentally ill clients, although differences between subsidy and non-subsidy groups attenuated over time.

Studies also reveal an interaction between housing and service arrangements and severity of mental illness. For example, the comprehensive housing program cited above resulted in better housing outcomes *only* for those individuals with high-symptom severity. Individuals with low-symptom severity achieved comparable housing outcomes whether they were placed in the comprehensive housing program or received case management alone (Clark and Rich 2003). Although mentally ill homeless individuals with high symptom severity have a strong need for housing and housing services (in conjunction with case management or other supportive services), it is important to note that these individuals may be at greater risk of housing instability in high *intensity* housing and service settings (Lipton et al. 2000).

Homeless individuals diagnosed with mental illness are often required to participate in mental health treatment as a condition of maintaining housing, but many are unwilling or unable to participate in treatment. Safe havens have emerged in response to this barrier. A safe haven refers to a type of housing for homeless individuals with severe mental illness where shelter and voluntary services are provided for an unspecified duration (Burt et al. 2004; Bridgman 2002). These housing models have the professional capacity to address the needs of mentally ill clients that emergency shelters tend to lack. Because participation in services is voluntary, safe havens attract a subpopulation generally considered difficult to reach via traditional homelessness programs. Safe havens are intended to provide an effective link between homeless individuals living on the street and PSH. A recent evaluation of four safe havens in Philadelphia found that individuals stayed in safe havens for an average of 1.3 years, at which time residents tended to transition into PSH (Burt et al. 2004).

Some debate exists over the long-term effectiveness of voluntary or "low-demand" mental health treatment. However, voluntary treatment does not appear to be associated with adverse client outcomes. Tsemberis and colleagues (2003) examined the effectiveness of an experimental program emphasizing client choice for homeless persons suffering from mental illness, and found that removing requirements to participate in mental health treatment prior to receiving housing did not worsen overall participation in mental health treatment.

Together, these studies suggest that programs favoring immediate housing and voluntary participation in services do not necessarily reduce participation in mental health treatment. Nor do such programs appear to increase substance abuse among the dually diagnosed. Safe havens can thus be an effective tool for attracting homeless individuals affected by mental illness who would otherwise be deterred from entering the homeless assistance network.

Finally, one barrier to the development of PSH for persons with mental illness is the assumption that development and operation of housing for this subpopulation is difficult and more resource intensive than housing for other vulnerable populations. Harkness and colleagues (2004) examined the financial profiles of 153 properties developed for persons with serious mental illness between 1988 and 1992 and found that all of the properties continued to operate and serve individuals with severe mental illness after ten years. These findings suggest that communities can overcome many of the challenges associated with developing housing for homeless individuals suffering from mental illness, such as securing financing, hiring capable staff, and building effective partnerships.

HOUSING AND SERVICES FOR HOMELESS PEOPLE WITH SUBSTANCE ABUSE PROBLEMS

Although estimates of the prevalence of alcohol and drug abuse among the homeless vary, most studies conclude that between 20 and 35 percent of homeless people experience substance abuse disorders at any given point in time (Zerger 2002). More homeless people experience substance abuse problems over time: 62 percent of individuals surveyed in the NSHAPC study reported a problem with alcohol in their lifetime, and 58 percent reported a problem with drugs (Burt et al. 2001).

The relationship between substance abuse and homelessness is complex. Substance abuse does not necessarily cause homelessness, but housing problems can become more severe in the presence of substance abuse. Conversely, homelessness can exacerbate problems related to substance abuse. Although the relationship between the two problems is interactive, federal policy has primarily viewed substance abuse as a cause, rather than effect, of homelessness. Programs targeted to substance abusing homeless individuals typically focus on treating the drug or alcohol problem, rather than on problems related to housing markets or economic conditions (Zerger 2002).

While the focus of federal policy has been on substance abuse treatment, research indicates that housing is a critical component of treating homeless persons with substance abuse problems. A recent review of substance abuse and homelessness states: "The importance of housing … in successfully treating individuals cannot be understated; it comprises one of the most consistent themes in the literature" (Zerger 2002, p. 20). For those addicted to drugs or alcohol, lack of secure housing can exacerbate the health and social

problems associated with substance abuse. Housing placement is thus critical to sustaining positive outcomes associated with substance abuse treatment.

Equally important is the need to integrate permanent housing with substance abuse treatment. Interviews with homeless drug users reinforce the need for integration of housing and substance abuse treatment if users are to sustain stable housing and avoid relapse (Rowe 2005). Often times, provision of housing and substance abuse treatment is hindered by organizational constraints, whereby treatment is provided by an agency lacking access to housing resources and vice versa (Freund and Hawkins 2004). Additionally, most emergency shelters without specialized treatment and support staff weed out those individuals with serious addiction and alcohol conditions (Hoch 2000). There is considerable evidence to suggest that access to stable housing leads to better adherence to referrals, improved retention programs, and better outcomes (Zerger 2002). Similarly, some research suggests that efforts to transition homeless substance abusers into stable housing are likely to be more effective if emergency shelters can be bypassed (Burt 2005). Together, these findings suggest that substance abuse treatment may be more effective when linked with permanent housing.

A debated issue in the literature involves the requirement of sobriety and participation in substance abuse treatment as a condition of maintaining housing. Similar to those suffering from mental illness, many homeless individuals with a substance abuse disorder are resistant to housing programs that require participation in substance abuse treatment and/or sobriety. Some practitioners have argued that services that require participation in substance abuse treatment as a condition of service provision are more likely to lead to long-term housing stability. However, research does not always support this argument. A study conducted by Orwin (2005) found that individuals required to participate in substance abuse treatment were more likely to be stably housed six months following treatment, but less likely to remain stably housed after two years. This suggests that mandatory participation in substance abuse programs may not always lead to better long-term outcomes.

Optional substance abuse services may be more effective than mandatory programs for homeless individuals with substance abuse problems.

Some evidence indicates that low-demand services are more effective for homeless individuals with substance abuse problems. Low-demand services refer to conditions where housing is accompanied by optional supportive services. In this context, sobriety is preferred, but not required. A growing body of evidence indicates that low-demand services are more likely to lead to long-term housing stability compared to programs where participation in supportive services is required (Stahler and Stimmel 1996; Burt 2005). Zerger (2002) notes, "… there is therefore a need to develop flexible, low demand interventions which can accommodate clients who are not willing to initially commit to more extended care" (p. 44). In Columbus, Ohio, low-demand services have proven effective when provided in conjunction with Permanent Supportive Housing (Community Shelter Board 2003).

A substantial body of literature documents the importance of providing housing and substance abuse treatment in tandem. Yet, few studies examine the relationship between features of organizations and client outcomes. Stahler and colleagues (1995) evaluated outcomes associated with three types of service delivery: comprehensive residential services, intensive shelter-based case management with referrals to a network of service providers in the community, and basic shelter services with case management. They found no differential effects across the three types of service delivery with respect to client outcomes.

While the method of service delivery does not significantly affect client outcomes, organizational characteristics such as funding, complexity, size, and professionalism affect access to and utilization of supportive services by the homeless. A recent study found that organizations having diverse sources of funding and more professional staff showed greater likelihood of substance abuse service use by homeless clients (North et al. 2005). Increased service use may result from the capacity of organizations with diverse sources to free themselves of government funding constraints mandating strict participation in treatment programs (rather than low-demand services).

HOMELESSNESS AND HIV/AIDS

According to self-reported data, approximately 3 percent of homeless individuals have HIV/AIDS (Burt et al. 2001).However, the reliability of self-reports is limited and many individuals who are suffering from HIV/AIDS have not been diagnosed. As a result, the actual number of homeless individuals who have HIV/AIDS is likely to be significantly higher than this figure suggests. A large body of literature documents the prevalence of HIV/AIDS among vulnerable populations, yet findings specific to the homeless are limited. Research specific to this subpopulation suggests the social circumstances of homelessness exacerbate risk factors associated with transmission of HIV/AIDS, particularly a higher

prevalence of intravenous drug use and high-risk sexual practices (Goldfinger et al. 1999).

Although research examining the housing and service needs of homeless people suffering from HIV/AIDS is scarce, policymakers and service providers have responded significantly to the unique vulnerability of this subpopulation. In 1992, the U.S. Department of Housing and Urban Development created the Housing Opportunities for Persons with HIV/AIDS (HOPWA) program. Since 1992, HOPWA has provided more than $3.2 billion in funding for housing assistance and supportive services for individuals suffering from HIV/AIDS, who are at risk of becoming, or currently are, homeless. HOPWA funding is commonly used to build and operate Permanent Supportive Housing. Although this funding stream is not specific to individuals who are currently homeless, HOPWA funding places a unique emphasis on programs aimed to prevent those suffering from HIV/AIDS from becoming homeless.

HOUSING AND SERVICES FOR THE CHRONICALLY HOMELESS

In recent years, chronic homelessness has become an important focus of national homeless policy. According to the federal definition, a chronically homeless person is "an unaccompanied individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years" (U.S. Department of Labor 2003, p. 4019). The recent emphasis on the chronically homeless results from the fact that the chronically homeless place extraordinary demands on homeless assistance networks, in large part because emergency shelters and transitional shelters and services are not equipped to prevent repeat episodes of homelessness among this population.

Nationwide, approximately 10 percent of the homeless population is estimated to be chronically homeless. The proportion of homeless people who are chronically homeless in Washtenaw County, Michigan is significantly higher than national estimates: data from the 2005 Point-In-Time Survey in Washtenaw County indicate that at a single point in time, approximately 29 percent of homeless people not residing in permanent supportive housing are chronically homeless, and would likely benefit from additional permanent supportive housing arrangements.[1]

While many current research initiatives seek to understand the characteristics and needs of the chronically homeless, some attributes of the population are known. For example, it is clear that chronically homeless persons are heavy users of housing and support services in the homeless assistance system, exhibit patterns of being disconnected from community and family life, are likely to face multiple obstacles to housing stability, and are likely to require a range of services that are often dispersed across different service systems (U.S. Department of Health and Human Services 2003).

Because all chronically homeless individuals live with a disability of some kind, many findings from studies involving the mentally ill, substance abusers, and those with HIV/AIDS also apply to the population of individuals classified as "chronically homeless." As discussed in the previous sections, permanent supportive housing is critical in helping these individuals remain housed. Additionally, because the chronically homeless have service needs that span several service systems, case management may be a particularly important service for this population. A recent national evaluation notes the importance of developing dual competence and certification among service providers in order to serve those diagnosed with mental illness and substance abuse problems, as well as the importance of community-wide cooperation between homeless-specific and mainstream public agencies (Burt et al. 2004).

HOMELESS FAMILIES

Homeless families are typically defined as adult clients currently accompanied by minor children. Most research on homeless families focuses on adults in homeless families, rather than children. Consistent with the literature, we focus on the characteristics and housing and service needs of adults in homeless families, recognizing that children in homeless families also represent an important subpopulation with unique housing and service needs.[2]

There are several reasons to suspect that adults in homeless families differ from other homeless adults with respect to the housing and service arrangements that lead to housing stability. First, research indicates that homeless families differ demographically from other homeless subpopulations. Some of these demographic differences may lead to differences in housing and service needs. For instance, homeless families are considerably less likely to report having substance abuse problems and some types of mental illness. Data from the National Survey of Homeless Assistance Providers and Clients (NSHAPC) indicate that relative to all homeless clients, homeless families are less likely to report alcohol or drug problems in the past month, in the past year, and over the course of their lifetime (Burt et al. 2001).[3] Shinn and Weitzman (1996) write:

> *While there is evidence that problems such as substance abuse and mental illness are more prevalent among poor families who are homeless than among those who are housed, studies have repeatedly demonstrated that only a minority of homeless families have any of these problems; the proportion is far lower than among homeless single adults (p.112).*

Demographic differences may result in different housing and service needs. For example, relative to other homeless indi-

For families with multiple barriers to housing stability, housing subsidies may not be enough to prevent repeat episodes of homelessness.

viduals, homeless families are overwhelmingly headed by women: NSHAPC data indicate that while women constituted approximately 32.0 percent of the entire homeless population in 1996, 85.7 percent of all homeless families were headed by women. The percentage of homeless families headed by women in Washtenaw County, Michigan is even higher: in 2005, women constituted 90.0 percent of adults in homeless families (Ebron, Haradon, and Phinney 2006). This may have implications for the types of shelters that families seek out, and the types of housing and services they are likely to receive while in shelter. Homeless families are also more likely to report additional sources of income and benefits including AFDC and food stamps (Burt et al. 2001). Shinn and Weitzman (1996) note that similarities persist across cities with respect to the demographic profile of homeless families, suggesting that homeless families may be particularly vulnerable to national economic or housing market conditions.

Second, relative to the homeless population as a whole, families offer different explanations for their current homeless spell. When homeless respondents in the NSHAPC study were asked why they left their last regular place to stay, the four most prevalent responses for all homeless respondents were: (1) couldn't pay rent (15 percent); (2) a job was lost or ended (14 percent); (3) drug problems (7 percent); and (4) landlord made the client leave (6 percent). Larger percentages of homeless families attributed current homeless episodes to financial or housing problems: 33 percent of male-headed families and 20 percent of female-headed families said they couldn't pay rent; 28 percent of male-headed families and 8 percent of female-headed families said the landlord made the client leave; and 6 percent of male-headed and 8 percent of female-headed families said there was a problem with the residence or the area where the residence is located. Sixteen percent of families headed by women reported that domestic violence drove them from their last regular place to stay, compared to 4 percent for homeless respondents overall (Burt et al. 2001). These data provide evidence that the causes of homelessness for families differ substantially from those for other homeless subpopulations.

A consistent finding from research involving homeless families is that housing subsidies are critical in helping families achieve stable housing (Wong et al. 1997; Shinn et al. 1998; Zlotnick et al. 1999; Stojanovic et al. 1999; Metraux and Culhane 1999). Stojanovic and colleagues (1999) examined a sample of 233 families in New York City experiencing their first shelter stay, and found that families who received housing subsidies were considerably more likely to be stably housed during a 3 to 5 year follow-up period. Specifically, 73 percent of subsidized households were residing in their own apartment at follow-up, compared to 9.2 percent of families who exited shelter without subsidized housing. In this study, families with housing subsidies were also less likely to re-enter the emergency shelter system: 14.9 percent of subsidized households returned to emergency shelter during the follow-up period compared to 42.6 percent of unsubsidized households. Metraux and Culhane (1999) obtained similar findings in a sample of approximately 8,000 homeless women in family shelters in New York City. For women in this sample, exiting to subsidized housing substantially decreased the risk of having a repeat homeless episode, although the overall effect of subsidized housing decreased with time.

In many of these studies, the use of social services is not assessed. As a result, it is not possible to evaluate the extent, frequency, and type of service use, determine the relationship between service use and housing stability, or control for service use when evaluating the impact of subsidized housing on housing stability. It is quite likely that the use of particular services is associated with housing stability. There is some evidence to suggest that a positive relationship exists between the use of housing services and housing stability, either by acting through housing subsidies, or by increasing the ability of those with subsidies to locate housing (Shinn et al. 1998; Rog and Gutman 1997). For example, Shinn and colleagues (1998) found that assignment to a particular type of nonprofit shelter that provided extensive housing services was positively associated with receiving a housing subsidy and eventual housing stability. Some research suggests that the contribution of services such as case management to housing stability is minimal after subsidized housing and income support from welfare are taken into account (see Shinn and Weitzman 1996).

While housing subsidies lead many families to housing stability, some families face multiple barriers that increase episodes of homelessness or reduce the likelihood that housing subsidies will lead to stable housing. Rog and Gutman (1997) write: "… whereas some families are homeless for reasons that are primarily economic, others face more complex problems. For them, a lack of housing was not believed to be the sole cause of their homelessness, and housing alone was not the simple solution to it" (p. 213). Some factors that may impede housing stability for homeless families are mental illness, substance abuse, and domestic violence. Bassuk, Perloff, and Dawson (2001) compared families who

were homeless multiple times ("multiply homeless") to families who were homeless only once, and found that multiply homeless mothers were more likely to have a diagnosis of major depression in their lifetime (63.5 percent of multiply homeless compared to 39.2 percent of first-time homeless), substance abuse in their lifetime (65.4 percent compared to 34.1 percent), and one or more lifetime diagnoses of depression, post-traumatic stress disorder, substance abuse, and/or anxiety (65.4 percent reported 2 or more lifetime diagnoses compared to 38.5 percent of first-time homeless families). Families who had multiple experiences of homelessness were also much more likely to report experiencing violence by either a stranger or partner (Bassuk, Perloff, and Dawson 2001).

For families with multiple barriers to housing stability, housing subsidies may not be enough to prevent repeat episodes of homelessness. Research from the Homeless Families Program (HFP)—a national project aimed at improving the residential stability of families with multiple problems—provides some insight into the housing and service arrangements that may help these families achieve housing stability. Rog and Gutman (1997) found that prior to the implementation of the HFP in select sites nationwide, strong majorities of adults in homeless families suffered from mental illness and domestic violence, and the vast majority of these families were not being connected to needed services. Furthermore, although needed services existed at each site, many families were unable to access services due to constraints involving capacity and eligibility. In particular, many families were unable to access case management services and thus received little assistance in navigating the web of services—many of which were fragmented across different agencies and systems of care (Rog and Gutman 1997). This suggests that homeless families with multiple problems may require support in identifying and accessing needed services, particularly when these services span multiple service areas.

Some researchers have compared families who become homeless to those who are poor but remain housed, providing evidence of the predictors of homeless episodes for the precariously housed families. Shinn and colleagues (1998) looked at the predictors of shelter seeking among a sample of poor families in New York City and found that both demographic characteristics and housing variables were significant in predicting which families eventually became homeless. Being African American, having a pregnancy or recent birth, living in crowded housing, and moving frequently were predictors of becoming homeless; having subsidized housing or one's own apartment decreased the risk of becoming homeless. Weitzman, Knickman, and Shinn (1992) found that childhood sexual abuse and adult physical abuse were associated with becoming homeless; Bassuk and colleagues (1997) concluded that minority status, evictions and moves, substance use, and hospitalization for mental illness were related to increased risk of homelessness among families; Phinney and colleagues (2007) found that physical and mental health problems, criminal conviction, domestic violence, hard drug use, young age, and lack of a high school diploma were significantly associated with experiencing homelessness over a period of five years.

SURVIVORS OF DOMESTIC VIOLENCE

Many homeless individuals and families experience violence and victimization prior to or during episodes of homelessness (Browne and Bassuk 1997; Metreaux and Culhane 1999; Zorza 1991). The relationship between violence and homelessness is particularly strong for poor women, both because violence is a risk factor for poverty among women and because impoverished women are more likely to be victimized (Wenzel et al. 2006).

In a national sample of homeless clients, 16 percent of women in families and 10 percent of single female clients reported leaving their last residence because of violence in the household (Burt et al. 2001). In Washtenaw County, Michigan, nearly one-fourth (24.9 percent) of respondents from the 2005 Point-In-Time Count identified themselves as lifetime survivors of domestic violence (Ebron, Haradon, and Phinney 2006). Individuals and adults in families who experience domestic violence are overwhelmingly female (77.8 percent), and slightly younger than the general homeless population (37.2 years of age compared to 38.7 years of age). Nearly half of adults in homeless families have experienced domestic violence (46.7 percent), while slightly more than one-fifth of individual respondents have experienced domestic violence (20.5 percent) (Ebron, Haradon, and Phinney 2006).

Domestic violence is an important precursor to homelessness and housing instability for many reasons. Immediate experiences of violence may force women into emergency shelters or temporary living situations. Shortages of permanent affordable housing may lead victims to return to their abusers, and poor employment, credit, or rental histories resulting from battery can impact the ability of victims to obtain employment and independent housing.

Research on domestic violence highlights several services that help individuals in this subpopulation achieve stable housing after they have become homeless. These include case management services that connect individuals to mainstream services including cash assistance and access to affordable housing, services that focus on employment, and services that connect domestic violence survivors with continued medical services.

Domestic violence survivors need immediate access to safe, temporary shelter, and often to housing subsidies or other affordable housing options. Service providers report that many victims return

Services that focus on employment may be particularly important for victims of domestic violence.

to their batterers when temporary or permanent housing is unavailable (National Coalition against Domestic Violence 2003). Problems may be particularly acute given public housing laws that may hold battered women accountable for partners' criminal activity or abusive behavior towards landlord or other tenants (Renzetti 2001).

Furthermore, homeless women who are escaping violent situations seek shelter in both emergency shelters and domestic violence shelters. It is important to recognize that women in both types of shelters have similar service needs that may or may not be met depending on the type of shelter. Individuals in domestic violence shelters may need but are unable to obtain housing and general services to address tangible needs; survivors in emergency shelters may require services to address psychological ramifications of battery that are not readily available (Williams 1998).

Services that focus on employment may be particularly important for victims of domestic violence, as violence can hinder victims from finding and retaining employment (Moe and Bell 2004). Domestic violence can impact work directly if a batterer refuses to allow his/her partner to work or stalks his partner on the job, or indirectly by heightening the risk for mental and physical health problems that may interfere with work. Large sample studies of low-income women find that domestic violence is significantly associated with poorer work outcomes (Zink and Sill 2004; Tolman and Wang 2005).

Researchers also emphasize the importance of coordination between service providers and practitioners in the medical profession. Medical professionals are often the first to come into contact with people experiencing domestic violence and as a result, cooperation and coordination between service providers and medical professionals is important. Additionally, survivors of domestic violence may require medical attention even after the abuse has ended: in reviewing research on domestic violence and homelessness, Bassuk and colleagues (2001) find that people who experience violence exhibit higher rates of physical and mental health problems, particularly over the course of their lifetimes.

Relative to research on disabled homeless persons and adults in homeless families, research on homeless persons who experience domestic violence is less extensive (Williams 1998). In addition, research on this subpopulation often employs different methods of data collection and analysis. In contrast to the large sample studies that dominate research on other subpopulations, research on homelessness and domestic violence is often qualitative or ethnographic, involving small numbers of women residing in emergency or domestic violence shelters. Future research with larger samples may better identify the relationship between violence and homelessness and generate findings that are more generalizable. Studies examining violence and victimization among the general population (rather than homeless people specifically) often include larger samples, and can yield findings that are considerably more reliable. Finally, it is important to note that violence and victimization are pervasive in the lives of homeless persons, whether perpetrated by an intimate partner, a stranger, or during childhood (Wenzel, Koegel, and Gelberg 2000; Burt et al. 2001).

Research on Homelessness Prevention

Research on housing, services, and housing stability for homeless individuals and families is concerned with "opening the back door" out of homelessness and into stable housing. An equally important area of homelessness research focuses on "closing the front door" to homelessness. Research and policy point to a growing interest in homelessness prevention (Burt, Pearson, and Montgomery 2005; Benjamin 2003; Lezak and Edgar 1996; National Alliance to End Homelessness 2000).

Most prevalent prevention activities focus on moments of personal vulnerability to housing loss or homelessness. Examples of prevention activities include providing cash assistance to households facing eviction, and connecting people with housing and/or supportive services upon discharge from prison or release from a mental hospital.

In their study on national homeless prevention efforts, Burt, Pearson, and Montgomery (2005) distinguish between effective and efficient prevention strategies. Effective interventions directly affect a person's housing status, for example by preserving or supplying housing for vulnerable populations through housing subsidies, providing permanent housing and supportive services for persons with severe barriers to housing stability, engaging in mediation in housing courts to preserve tenancy, providing cash assistance to those facing eviction, and encouraging rapid exit from shelter into stable housing. Efficient interventions narrowly target those at greatest risk for homelessness. Efficient targeting is aided by information sharing across agencies and systems, and more significant control over eligibility

processes for prevention interventions (Burt, Pearson, and Montgomery 2005).

Additional research suggests that prevention strategies must address structural conditions that contribute to homelessness, particularly shifts in labor and housing markets that increase the vulnerability of those who are at the greatest risk of becoming homeless (Benjamin 2003; Burt et al. 2004). Benjamin (2003) states, "…prevention strategies alone will not end homelessness unless our definition of prevention is widened to include the provision of adequate affordable housing, decent wages and income supports, and assistance to low-income communities from which the majority of homeless people emerge" (p.32).

The literature thus suggests that meaningful efforts to prevent homelessness will include interventions that reduce individual risk factors, as well as broad strategies that respond to housing and labor market conditions that contribute to homelessness. The call to prevent homelessness presents a significant challenge for researchers, policymakers, and practitioners alike.

Discussion and Conclusion

This review of homelessness research has revealed several important findings. The first is that the provision of housing support, whether in the form of housing subsidies, housing support services, or permanent subsidized housing linked with services, is critical in helping homeless individuals and families achieve stable housing overtime. While other support services are important in helping people remain housed, services in the absence of housing support are generally not enough to prevent initial or repeat episodes of homelessness, particularly for individuals and families with more severe barriers to stable housing.

Second, there are important differences across subpopulations with respect to the housing and service arrangements that are associated with successful housing outcomes. Disabled homeless populations typically require housing linked with supportive services, and some research suggests that voluntary services are more effective than mandated treatment or sobriety. In addition, housing and services provided in the context of emergency or transitional shelter do not often lead to successful housing outcomes for this population. Homeless people with mental illness or substance abuse are best served by permanent supportive housing.

The housing and service needs of families are different. Housing subsidies help the majority of homeless families achieve stable housing, but housing subsidies in the absence of services do not lead to successful housing outcomes for homeless families with severe barriers to housing stability. Families with multiple barriers to housing stability may require case management services to help link them with services that span several service dimensions.

In addition, homeless subpopulations are not equally likely to enter the housing and service arrangements associated with the greatest likelihood of housing stability. Substance abusing and/or mentally ill people may be reluctant to enter housing arrangements that require sobriety or participation in treatment programs. In contrast, the research does not suggest that families are reluctant to enter the homeless assistance network or that they are averse to receiving housing subsidies or supportive services. This speaks to the need for outreach services to the disabled homeless population but not necessarily for homeless families.

Finally, recent scholarly and policy interest in homelessness prevention holds promise for reducing homelessness in the future. Preliminary research suggests that policymakers should focus on the efficiency and effectiveness of prevention efforts, and suggests that both structural factors and individual vulnerability factors influence experiences of homelessness.

More research is needed on the relationship between housing and services. In particular, more research is needed that isolates the role that housing support, housing services, and supportive services play in helping people stay stably housed. While some studies exist (see Rosenheck 2000; Rosenheck et al. 2003), research in this area typically focuses on the mentally ill or substance abusers, rather than all subpopulations of homeless people. In addition, few studies examine the relative contribution of different types of services to housing stability.

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ENDNOTES

1. Washtenaw County's definition of chronic homelessness closely approximates the HUD definition. In Washtenaw County, a chronically homeless person is defined as a person with any mental health problem or physical or cognitive disability, who has been homeless four or more times in the past three years or has been continually homeless for more than one year.

2. For discussions of issues pertaining to homeless children, please see Rosenheck et al. (1999) and Burt et al. (2001).

3. One exception is male heads of household in homeless families, who reported extremely high levels of drug abuse over the course of their lifetime (although not in the past month or year).

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