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Closing the Door to Homelessness: How Clinicians Can Help

The rise of modern homelessness in America that began in the 1980s remains unresolved, despite a significant body of research documenting its causes and consequences, and 20 years of targeted programs designed to address the most devastating effects of residential instability. This issue of Healing Hands *explores strategies to prevent and end homelessness currently touted by researchers, policy analysts, and direct service providers, and specifies how HCH projects are participating in these efforts.*

Homelessness has become an enduring presence in America, 25 years after its reemergence as a mass phenomenon for the first time since the Great Depression. A recent point-in-time count of people living on the streets in 460 localities revealed that 727,304 individuals (about one in 400 Americans) were living without shelter, and 25 percent of them were deemed "chronically homeless" (disabled and homeless continuously for a year or more or at least 4 times in the past 3 years), surpassing previous estimates of 10–15 percent. Family members including children comprised 42 percent of those counted.[1] Requests for emergency shelter continue to increase and, on average, 1 in 4 requests for shelter was unmet in 2003-2004.[2]

The link between homelessness and poor health remains unbroken, despite the valiant and often successful efforts of HCH providers to stabilize individual patients. People without stable housing—particularly those considered chronically homeless—suffer multiple and complex health problems and have significantly higher risks of premature death than do people of comparable age in the general population. Homeless people experience illnesses at 3 to 6 times the rates experienced by poor housed people.[3]

A recent study of 119 high-risk and chronically homeless "rough sleepers" in Boston found that 28 percent of participants died before the 5-year study ended, at an average age of 51.[4] Cancer, AIDS, end-stage liver disease, and chronic pulmonary disease were the most frequent causes of death, notes Boston HCH Program Director James J. O'Connell, MD.

"Homelessness in America is a 'revolving-door' crisis," writes sociologist and Urban Institute researcher Martha R. Burt, PhD. "Many people exit homelessness quickly, but many more individuals become homeless every day."[5] Indeed, focusing exclusively on individuals after they become homeless does little to arrest this trend. Increasingly, policy makers are coming to agree with advocates that ending homelessness will require a more systemic and proactive approach that addresses its root causes as well as its devastating effects.

STRUCTURAL REMEDIES The bottom line is that homeless people need a place to live. "Homelessness stems from desperate poverty combined with unaffordable housing in communities too strapped to support their most troubled members," writes Burt. "Personal difficulties, such as mental disabilities or job loss, may increase vulnerability to homelessness, but they cannot explain the high number of people who fall into homelessness every year."[5]

Affordable housing If we are serious about ending homelessness, increasing the availability of affordable housing is of primary importance. Research over the past 20 years has demonstrated the cost-effectiveness of *supportive housing*—permanent housing with attendant social services—for formerly homeless people (see the December 2003 *Healing Hands* for more information: *www.nhchc.org/healinghands.html*). However, research also indicates that *housing subsidies*, with or without supportive services, have ended homelessness for many families and even for people with serious mental illnesses.[6]

Many States and communities, including more than 200 that are developing or implementing 10-years plans to end homelessness,[7] are putting this knowledge into practice by adopting the Housing First model, which places individuals living in shelters or on the streets

directly into permanent housing and provides services as needed to help them maintain their homes. Housing First approaches have reduced the numbers of people living on the streets of San Francisco, New York, and Philadelphia.[1]

This approach is the primary strategy employed to end homelessness in Baltimore City, according to Laura Gillis, RN, MS, President and CEO of Baltimore Homeless Services and former Clinical Director at HCH, Baltimore. "When you place the emphasis on permanent housing rather than temporary shelter for homeless people, you must work to increase the supply of housing in your community that people with very low incomes can afford," says Gillis. She oversees a pilot project with 20 housing units from Baltimore Housing, two city-funded case managers, and a contract with HCH for the services of case manager Lauren Siegel, MSW, LCSW-C. The model works well in principle, Siegel agrees. In practice, she says, "It takes more resources and staff than anyone realized."

Lack of furniture and basic supplies has been a problem, and individuals without IDs struggle to get benefits to which they are entitled. "We write letters verifying their identity so they can get a bus pass, which they use to apply for a Social Security card, which is necessary to get other benefits," Siegel explains. Moreover, adjustment to apartment living takes time and may require some assistance. "Formerly homeless residents often need help getting to appointments and the grocery store, opening a checking account, and learning how to cook," explains Gillis. These are the basics that help people retain their housing.

Livable income Low-cost housing is only part of the equation. People need sufficient income from employment and/or public assistance to pay for basic necessities. However, in no US jurisdiction can a full-time worker earning minimum wage afford a 2-bedroom rental unit at fair market rates (requiring less than 30 percent of income).[8] Five million extremely poor households pay over 50 percent of income for housing or live in severely substandard housing. In 2002, a Supplemental Security Income (SSI) check was not sufficient to pay for housing in any of the nation's 2,702 housing markets.[9]

Access to health care Poor health and inadequate access to health care are among the factors that precipitate and prolong homelessness among impoverished people. Lack of health insurance is an important reason why more homeless people do not receive the comprehensive care they need. More than half of surveyed homeless people nationwide have no health insurance[10] and 71 percent of HCH clients were uninsured in 2004.

Safety net programs, including HCH projects, are creating access to health care for some uninsured people who are homeless or at risk of homelessness, but resources are insufficient to meet the growing need. While the targeted homeless programs do alleviate homelessness for hundreds of thousands of people each year—still just a portion of those in need—and are crucial to homeless persons' very survival, they do not prevent homelessness, and do not put an end to homelessness itself.[11] To address these broader issues, HCH providers advocate for structural remedies, including improvements in mainstream

The Collaborative Initiative to Help End Chronic Homelessness (CHI)

This unique collaboration among the departments of Health & Human Services, Housing & Urban Development, Veterans Affairs, and Labor, launched in 2003, funds permanent housing and supportive services for individuals with disabilities who have been chronically homeless. The Interagency Council on Homelessness is coordinating this 3-year effort.

HCH project staff are playing a pivotal role in the 11 communities that received CHI grants (Chattanooga, Chicago, Columbus, Contra Costa County (CA), Denver, Ft. Lauderdale, Los Angeles, New York, Philadelphia, Portland, and San Francisco). Some of them shared key interventions and lessons learned from their participation in this national effort to prevent and end chronic homelessness:

Fortwood Mental Health Center, the lead CHI agency in **Chattanooga, TN,** fields an Assertive Community Treatment (ACT) team to enroll people who are chronically homeless into the program. The Homeless Health Care Center provides health care to program participants at its fixed-site clinic. But once homeless patients are housed, it is not always convenient for them to return to the homeless health center, notes Program Manager **Karen Guinn, RN-C.** To preserve continuity of care, health center staff work closely with a nurse hired by Fortwood Center who makes regular home visits to CHI clients. Guinn says this has convinced her of the need for HCH providers to collaborate with other agencies serving newly housed patients.

CHI funds the Rebuilding Lives Program of Assertive Community Treatment (PACT) team in **Columbus, OH,** that engages chronically homeless people. The Columbus Neighborhood Health Center provides a primary care nurse and two benefits case managers. "Our program uses a multidisciplinary team approach," explains HCH Program Director **Pearline Byrd, RN, MSA.** "Behavioral health care providers and benefits case managers support clients' transition to community living. The nurse makes regular home visits to monitor clients' progress and check on their medications." Byrd believes intensive case management is the glue that holds the program together. "Our clients need one-on-one support with activities of daily living," she says. Byrd credits HCH with providing the type of services individuals need to move forward.

Central City Concern's Old Town Clinic Community Engagement Program in **Portland, OR,** fields three multidisciplinary teams, funded by CHI, DOL, and the HCH project. All three teams use the Housing First model and a Stages of Change approach.[13] Clinical Director **Sonja Ervin** believes that residential stability has made a positive difference in her clients' willingness and capacity to pursue treatment. As a result, their overall health improves dramatically, observes **Paige Perry,** Director of Operations. Still, there have been challenges. "You almost see a collapse when people are first housed," remarks **Morganna Wolf,** the DOL team lead. "New residents need time to acculturate to having four walls and a locked door." The use of mentors (people who have experienced mental illness, addiction, and homelessness) has been critical to the teams' success, Ervin believes, helping them to engage and connect with clients.

and safety net programs. They also devote resources to helping homeless people obtain available benefits (see next article).

PREVENTION STRATEGIES "When assistance is restricted to those who are homeless tonight, not much can be done to prevent homelessness tomorrow," Burt writes.[5] Although research findings on homelessness prevention are mixed, several promising strategies are emerging. A forthcoming report on prevention strategies finds evidence to suggest that combinations of supportive housing and community-based services, including Assertive Community Treatment, "clubhouses," employment, and peer support, can reduce rates of homelessness at admission and discharge from psychiatric hospitals.[12]

Communities around the country that have committed resources to preventing homelessness have developed a variety of programs that encourage the creation of affordable housing, provide rental assistance and funds to meet short-term financial problems, help people establish or reestablish good credit and rental histories, and negotiate with landlords to resolve housing disputes.[5]

Indicated prevention programs[13] One targeted intervention that has helped people with disabilities at risk of eviction to remain housed is the Tenancy Preservation Program (TPP), begun in Springfield, MA, in 1998 and now operational around the State. The program is funded by the Massachusetts Housing Finance Agency (MassHousing) in collaboration with other State agencies, municipalities, and local programs. "The goal of TPP is to preserve current tenancy or provide reasonable accommodations for individuals with disabilities," says Francine Harrison, LCSW, LADC1, CISM, TPP Clinician in Worcester.

In Worcester, the Tenancy Preservation Program is part of Community Healthlink's Homeless Outreach and Advocacy Program (HOAP), an HCH grantee. Harrison attends Worcester Housing Court to screen individuals who are facing eviction, often for failure to pay rent due to impairments. She determines disability and makes referrals to local resources for assessment and linkage to housing and treatment. Harrison says there is often a service gap that occurs after the shift to independent living. Since Worcester TPP began a year ago, 90 percent of their clients have remained in their own homes or have been referred to housing with more intensive services, Harrison says.

A broader approach "Indicated" or targeted prevention strategies may reach only a small number of people who would otherwise become homeless. New York University psychologist Marybeth Shinn, PhD, and her colleagues worry that in resource-poor communities, prevention programs that offer scarce goods risk reallocating homelessness.[6] Thus, a program that prevents homelessness for some individuals or families—for example, by putting them at the head of the line for housing subsidies—may not reduce net homelessness for a locality. Instead, Shinn recommends increasing the supply of affordable housing and sustainable sources of livelihood nationwide or in targeted communities. "Such broad programs would affect the many rather than the few and lift vagrant boats on the flood tide," she concludes. Such an analysis also underlies support for universal health insurance.

INTERGOVERNMENTAL INITIATIVES The 10-year plans that many States and communities are adopting to end homelessness are "extremely ambitious, requiring major changes to a variety of famously intractable social welfare and other systems, not to mention significant allocation or reallocation of resources," writes University of Pennsylvania sociologist Dennis P. Culhane, PhD.[14] But it remains to be seen whether mainstream safety-net providers will take responsibility for clients who are homeless, and whether sufficient resources will be provided to fund the housing and supportive services that are essential to end homelessness.

Disability Benefits Help to Avert Homelessness

Disability often plays a central role in precipitating and prolonging homelessness, and people with disabilities constitute the "chronically homeless" population in America. Many homeless people thought to be eligible for federal disability benefits—Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI)—do not receive them.

Timely receipt of SSI or SSDI benefits dramatically improves access to food, stable housing, and health care, which can mitigate health risks associated with homelessness, facilitate recovery, and help resolve homelessness.[16] Clinicians have an important role to play in ensuring that clients with severe medical impairments get the assistance they need in a timely manner, contend the authors of the HCH Clinicians' Network's *Documenting Disability: Simple Strategies for Medical Providers (www.nhchc.org/DocumentingDisability.pdf)*.[17]

WHY HOMELESS CLAIMANTS DON'T QUALIFY A national study of homeless assistance providers and their clients found that only 11 percent of service users received SSI and 9 percent received SSDI in 1996.[10] HCH providers who responded to a survey conducted by the National Health Care for the Homeless Council estimated that as many as 31–84 percent of their uninsured homeless clients served in FY 2000 had mental or physical impairments that should have qualified them for SSI and Medicaid.[18]

Insufficient medical evidence and failure to keep consultative examinations are important reasons why many disability claims filed by homeless individuals are rejected on initial application, accounting for as many as one-third of denials. Nationally, the average initial allowance rate for decisions on applications for SSI/SSDI benefits in FY 2003 was 37 percent, but the rate for homeless people is often lower. A review of disability claims submitted to the Disability Determination Services (DDS) in Boston from July 2002 to September 2004 revealed that SSI/SSDI denials were 2.3 times more common than

approvals for homeless individuals, while denials for housed claimants were only 1.5 times more common than approvals.[17]

Other barriers for homeless people likely to be eligible for benefits include lack of access to health services, the lengthy and complex disability determination process, and limited access to legal assistance with appeals.[17] Such barriers are often intensified by factors related to disability, such as denial of mental illness.

HOW CLINICIANS CAN HELP

The authors of the *Documenting Disability* manual believe that facilitating applications for disability benefits is "perhaps the single most important intervention that clinicians can offer to minimize the health risks associated with poverty."[17] Here are some concrete and efficient ways that clinicians can help:

Engage the patient in ongoing care "An application for disability benefits can be an incentive to establish relationships with health care providers," co-author Paul Quick, MD, physician with the Tom Waddell Health Center Homeless Program in San Francisco, points out.

Become familiar with disability criteria Clinicians need to understand exactly what information the State DDS needs to make a decision. "Your job is to document the patient's level of impairment and how it impacts his or her functioning, not to determine disability," Quick explains. "That's an administrative and legal decision made by DDS or the courts." *Disability Evaluation under Social Security* ("the Blue Book"), published by the Social Security Administration, explains the criteria that DDS uses to determine whether or not a person is disabled according to the statutory definition *(www.socialsecurity.gov/disability/professionals/bluebook)*.

Avoid the need for a consultative examination When DDS adjudicators don't have enough medical information to determine disability, they may order a consultative examination (CE) by a physician of their choice. Frequently, these clinicians spend little time with patients claiming a disability, have a limited understanding of the needs of homeless people, and may miss mental illnesses that a claimant denies or tries to hide. Dan Reardon, JD, Benefits Acquisition and Retention Team (BART) Coordinator at the Colorado Coalition for the Homeless, encourages his team to gather enough medical evidence to avoid the need for a CE.

Document functional impairments To expedite letter writing in support of disability claims, routinely document impairments in clinic notes. Patients without limitations to perform activities that require physical exertion may qualify for benefits based on a mental impairment they have not claimed due to denial or fear of stigma. "Primary care providers are well qualified to document impairments that result from mental illness and should do so," urges Quick.

Don't ignore impairments related to substance use disorders In 1996, Congress rescinded SSI eligibility for people whose drug or alcohol use is "material" to the determination of their disability (who would not meet eligibility criteria if they were clean and sober). However, chronic and irreversible medical impairments and fixed functional deficits resulting from substance use—such as cirrhosis, organic brain syndrome secondary to alcohol use, and loss of limb function from infections related to IV drug use—may meet disability criteria.

Take an occupational history Because disability hinges on inability to work, it is important to document why patients have failed in work or school. An occupational history should be a routine part of medical history taking. You may find the individual has never engaged in substantial gainful activity.

Create a medical summary report Medical records alone may not be enough to convince a DDS adjudicator of a homeless person's disability. Physicians supporting a disability claim should compose or co-sign a medical summary report that documents the individual's impairments and how they limit functioning related to work and life-sustaining skills. Specify all medical Listings the patient meets (see Blue Book). "Some homeless patients don't eat because they can't interact with the people providing food, and they sleep outside because they can't tolerate shelters. It's important to document these limitations," Quick says. Examples of medical summary reports can be found in *Documenting Disability* (pp.33–40).

Work closely with SSA and DDS Programs that meet or exceed the national average in favorable disability determinations for homeless people have close working relationships with SSA field offices and DDS. The BART team, for example, has a 75 percent success rate on initial applications. BART cases are flagged at DDS and assigned to special adjudicators.

Since 1985, the Boston DDS has referred all disability determinations for homeless claimants to a special unit. "This increases the likelihood that claims will be approved, because DDS staff become familiar with how to develop a claim for a homeless person," explains Sarah Anderson, JD, of Greater Boston Legal Services. The Boston DDS and the HCH Program cross-train their staff.

Educate the community HCH providers have a key role to play in educating other homeless assistance providers about the importance of disability benefits. "A lot of people who see your clients—for example, food stamp workers—could refer them for assessment of medical impairments," notes Ginny Lilly, Homeless Outreach Coordinator at Phoenix Health Center in Louisville, Kentucky.

Consult available resources In addition to the *Documenting Disability* manual cited in this article, SAMHSA has recently completed a case manager training curriculum, as part of its *Stepping Stones to Recovery* series *(www.pathprogram.samhsa.gov/SOAR)*, designed to enhance access to SSI/SSDI for people who are homeless.

Provide the best medical evidence you can SSI/SSDI benefits can mean the difference between continued homelessness and a life of dignity in the community. "Documenting disability has become our passion because it's a life changing resource for our clients," Lilly says.

Preventing Chronic Homelessness among Youth

Trauma is a common denominator in the lives of homeless youth, who often leave home to escape family conflict, abuse, or neglect. The realities of street life—violence, use of addictive substances, survival sex, poor nutrition, and limited access to health care—place these youth at especially high risk for negative health consequences.[19] They have disproportionately high rates of suicide, substance use, and sexually transmitted diseases, including HIV.[20] Sexual, racial, and ethnic minorities are overrepresented among displaced youth, for whom stigma and victimization go hand-in-hand with homelessness.

Homelessness is surprisingly widespread among adolescents and young adults. As many as 1.6 million youth are estimated to be homeless each year in the United States.[21] Adolescents are at greater risk of unsheltered homelessness than adults.[22] "We have the perception that there aren't as many homeless youth because they are more successful at blending in," says **Josephine Ensign, FNP, DrPH,** Associate Professor in the School of Nursing at the University of Washington and a clinician at the 45th Street Homeless Youth Clinic in Seattle. Many youth "couch surf" with friends before ending up in shelters or on the streets.

Those who leave or age out of foster care or other institutional placements without transitional services are at significant risk of becoming homeless. Placement in foster care is one of two childhood risk factors that predict homelessness (maternal substance abuse is the second predictor).[23] One study found that nearly one quarter of emancipated youth were homeless within 2 to 4 years after leaving foster care.[24] Once homeless, these young people struggle to meet basic needs. Distrustful of adults, they may be reluctant to access mainstream services, including health care.

Many young adults are uninsured (during calendar year 2002, 45 percent of young adults ages 19–23 were uninsured for at least some time during the year[24]), which severely limits their access to health care. Youth under 18 living on their own frequently are denied health care without parental consent, whether they are insured or not.[22]

RECOMMENDATIONS HCH clinician advocates suggest the following ways to help reduce homelessness among America's youth:

Tailor services to the needs of homeless youth For example, the 45th Street Homeless Youth Clinic in Seattle has separate hours, paperwork, and expectations of young clients. Based on patient requests, they added naturopathic care and acupuncture. Providers address patients by their street names and avoid the use of medical jargon. Peer outreach workers who've experienced homelessness engage and connect them to services. "The most effective prevention strategies...are based on developmental stage rather than chronological age," note HCH providers.[24]

Maintain a posture of "nonjudgmental, positive regard" [24] Too often "preached to and preyed upon,"[19] homeless youth resent being judged for choices that they are frequently forced to make. "Judgmentalism slams the door on service accessibility," warns **Curren Warf, MD, FAAP, FSAM,** Medical Director of the High-Risk Youth Program at Children's Hospital Los Angeles. Providers need to acknowledge and respect the strengths of homeless youth and "allow them to experiment and reinvent themselves without being labeled," Warf advises.

Use health care as a conduit to comprehensive services Homeless youth feel especially vulnerable when ill, and some return home to recuperate.[22] Even minor health problems may be the entrée to more comprehensive services. Be knowledgeable about community resources. Providing emergency financial assistance, rent subsidies, move-in money, and life skills training are successful strategies to help young adults access and maintain stable housing.[24] Education is especially important to ensure self-sufficiency (see box).

Advocate for systems change Warf and Ensign recommend advocating for increased system capacity to meet the needs of homeless youth and stronger emphasis on family preservation programs that address the treatment and service needs of at-risk families and youth. "Early investment in preventive services is cheaper in the long run," Warf says.

Educational Resources for Homeless Youth

"Homeless youth have a clear set of rights to enroll in school and get services," says **Barbara Duffield,** Policy Director of the National Association for the Education of Homeless Children and Youth. Two Federal programs support the rights of homeless children to educational access, achievement, and stability:

- **The Education for Homeless Children and Youth program** (subtitle VII-B of the McKinney-Vento Homeless Assistance Act) requires school districts to identify, enroll, and provide transportation for homeless children. Each of the country's 15,000 school districts is required to provide a liaison for homeless children.
- **Title I, Part A of the Elementary and Secondary Education Act** is designed to close the achievement gap for disadvantaged students. 80–90 percent of school districts get Title I money, which can be used to support the work of homeless liaisons, offer supplemental instruction, buy supplies, and make referrals.

Duffield urges clinicians to contact their school district's homeless liaison or Title I director, to confirm that the provisions of both statutes are being implemented fully and to inform school districts where to refer students for health care. For more information, see *www.naehcy.org*.

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