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ORIGINAL ARTICLE

Applying a prevention framework to address homelessness as a population health issue

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Abstract This paper presents a population health framework for homelessness prevention. Rooted in the Los Angeles County Homeless Initiative, the framework includes strategies that affect social determinants of health that influence a broad range of health outcomes prevalent among the homeless. For each prevention level, we consider the purpose of prevention, the sub-population of interest, and evidence of the effectiveness of interventions in addressing factors that affect health and health outcomes. Our review highlights the importance of cross-cutting strategies and the limits of our knowledge about more targeted preventive interventions. We note that a prevention orientation requires attention to the social and physical environments that affect homelessness plus connections between the homelessness services sector and mainstream systems of care and support.

Keywords Homelessness · Prevention · Population health · Conceptual framework

Introduction

In 2017, Los Angeles County (LAC) provided permanent housing to more than 16,000 people experiencing homelessness—a record number for a United States (U.S.) city or county. According to the January 2018 *point-in-time homeless count* (see Table 1, Glossary of U.S. Homeless Services Terminology), the homeless population is just over 53,000 individuals, including more than 9000 who became

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Table 1 Glossary of U.S. Homeless Services Terminology

Affordable Housing Housing at or below 30% of household income is considered to be affordable.

Chronic Homelessness The lived experience of someone with a physical or mental disability who has been homeless (i.e., living in a place not meant for human habitation or an emergency shelter) for at least one year, either consecutively or across for our more episodes of homelessness over a three-year period.

Coordinated Entry System (*CES*) A systematic approach to homelessness services with an electronic intake and referral process designed to connect homeless youth, adults, and families to the housing and supportive services that are most appropriate to their needs.

Housing Choice Voucher Program (*HCV*) The largest U.S. housing subsidy program. Vouchers are provided to beneficiaries and can be used with any participating landlords. HCV subsidies are not available for all those who are eligible, and not all landlords accept HCV.

Housing First An evidence-based approach to housing people experiencing chronic homelessness that places them in PSH without treatment or behavioral requirements.

Individual Placement and Support A type of supported employment program designed specifically for people with serious mental illness.

Local Homeless Services Authority A local organization that coordinates federal housing and supportive services funding for eligible homeless individuals and families within a designated local area, typically a city.

Medical Respite Care Short-term residential care for homeless individuals not ill enough to be in a hospital but too to ill to recover on the street or in an emergency shelter. This model of care can prevent expensive re-hospitalizations and help chronically homeless individuals transition to permanent supportive housing.

Permanent Housing Subsidy Government-funded cash assistance to help very low-income households afford rental housing. Payments go directly to participating landlords and are considered "permanent" because the payments continue as long as the enrollee remains eligible based on their income.

Permanent Supportive Housing (*PSH*) A housing intervention that combines affordable housing, health care, and supportive services to help chronically homeless individuals become stably housing while also addressing their health and social needs. In the US, most PSH programs are required to follow a housing-first approach.

Point-in-Time Homeless Count A visual count of a city or county's homeless population in January that is required by the federal government every other year (LAC conducts a count every year).

Rapid Re-Housing A housing intervention for families and individuals who have recently become homeless, which attempts to connect them with permanent housing as quickly as possible. The intervention consists of a tailored package of services that may include assistance locating affordable housing, temporary rental assistance, and targeted medical, legal, and/or social services.

Subsidized Employment A government-funded program that pays employers a portion of wage costs to encourage them to hire employees with significant barriers to employment (e.g., criminal justice systems involvement, recent homelessness, health problems, etc.).

Supplemental Security Income (*SSI*) A federal cash-assistance program for the elderly, blind, and disabled people with little or no income. Many people who are eligible are not enrolled due to administrative barriers.

Supported Employment A program for people with disabilities designed to help them integrate into the labor market by providing ongoing support services and accommodations.

SSI Outreach, Access, and Recovery Program (*SOAR*) A program designed to increase the proportion of those eligible for *SSI* who are actually enrolled by helping them navigate the complex application process.

Transitional Housing An approach to providing temporary housing to people experiencing homelessness so that they can achieve certain therapeutic milestones. A housing-first approach bypasses transitional housing.

Veterans Affairs Benefits Federal cash and health care assistance for disabled veterans of the US military, many of whom are homeless.

homeless for the first time in 2017 [1]. These data underscore the need to prevent people from becoming homeless in addition to addressing homelessness once it has occurred.

We provide a population health framework for homelessness prevention to guide the evaluation of local homeless initiatives. The framework is rooted in the strategies proposed in the Los Angeles County Homeless Initiative (LACHI). Launched in 2016, after a comprehensive planning process and funded in large part by a voter approved sales tax and a municipal bond measure to finance the construction of *permanent supportive housing* (PSH), LACHI aims to reduce homelessness by addressing the broad continuum of needs among people experiencing homelessness and those most at risk.

We build in three ways on the work of others who have applied a similar preventive lens to homelessness services [2–4]. First, we extend the evidence base to include more recent findings. Second, we treat housing stability as a determinant of good health, thereby capturing a longer-term social goal of homelessness reduction and contributing to public health's conceptualization of housing as a social determinant of health. Finally, we ground our framework in a well-funded and comprehensive local homeless initiative that, while not self-identified as prevention centered, has incorporated all the elements of such an approach into its planning documents. LACHI thus provides, as the initiative unfolds, an opportunity to test and further refine the elements of the framework.

Figure 1 groups core LACHI strategies according to level of prevention and links them to social determinants of health that they are designed to address. These social determinants, in turn, have been shown to influence a broad spectrum of health outcomes that are significantly more prevalent among the homeless [5, 6]. Although many LACHI strategies fall within a single level of prevention, others cut across multiple levels, thus increasing their flexibility and potential impact.

In the following sections, we further examine the levels of homelessness prevention presented in Fig. 1. For each level, we consider the purpose of prevention; the

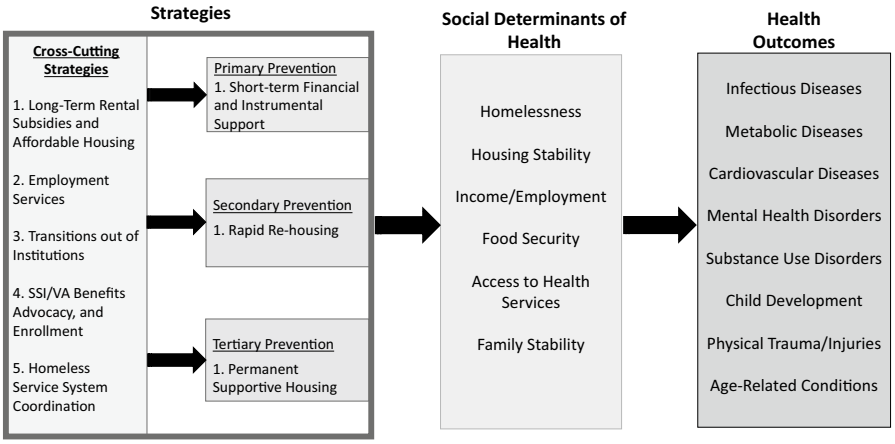

Fig. 1 Population health framework for homelessness prevention

sub-population of interest; targeted versus universal approaches; and evidence of the effectiveness of interventions to address social determinants of health and health outcomes. We begin with tertiary prevention, where the evidence is currently most robust.

Tertiary prevention

Described as mitigating the impacts of an ongoing illness through treatment and rehabilitation [7], tertiary prevention in the homelessness services field focuses on those who have experienced prolonged or *chronic homelessness*. The U.S. Department of Housing and Urban Development (HUD) defines chronically homeless individuals as those who have a disabling condition and have been homeless for more than a year or had at least four episodes of homelessness during the past 3 years. LACHI aims to provide to the chronically homeless permanent supportive housing (*PSH*) as a form of universal tertiary prevention, as this population is unlikely to exit homelessness without it. PSH with a *Housing First* approach—immediate provision of *affordable housing* with integrated support services—is now federally recognized as supported by evidence [8]. A recent systematic review found that this approach effectively reduced homelessness, increased housing tenure, reduced hospitalizations and emergency room use, and increased consumer satisfaction [9]. The longer-term health effects of PSH, however, have yet to be demonstrated [10]. Some initial findings suggest that PSH may not reduce premature mortality [11].

In 2018, over 14,000 people in LAC were considered to be chronically homeless—about one-third of the total homeless population—almost all of whom were single adults. Although a limited supply of PSH has required the creation of a waiting list with those in most severe need being housed first, as LACHI and other capital funds increase over the next 10 years, PSH may become a universal intervention for this population. Still some chronically homeless individuals transitioning out of hospitals and other acute care settings may require interim housing arrangements prior to placement in PSH. *Medical respite care* serves this bridging function by providing supervised, short-term housing in a variety of community-based settings. A recent review of medical respite care for homeless individuals found that it reduced hospital readmissions and inpatient days and improved housing outcomes [12]. The U.S. Interagency Council on Homelessness recommended medical respite care in its 2015 Federal Strategic Plan to Prevent and End Homelessness [13], and LACHI has made it as a key component of the continuum of care for people experiencing homelessness.

Secondary prevention

Secondary prevention is designed for those more recently homeless. According to the 2018 LAC point-in-time homeless count, almost 40,000 homeless individuals were not chronically homeless, and the majority of those had been homeless for less than 1 year. Individuals in families represented approximately one-fifth of the total

nonchronically homeless population. *Rapid re-housing*, an emerging secondary prevention strategy, consists of assistance locating affordable housing, temporary rental assistance, and connections to other services and supports to help recently homeless people regain housing stability. Rapid re-housing, although growing, is still a relatively new intervention. Implementation has been on a relatively small scale, mostly among homeless families with children. Early descriptive research showed that length of family participation in rapid re-housing ranged from 3 to 24 months; housing placements were high (82–84%); and rates of return to homelessness within 1 year were low (4–14%). Returns to homelessness were more common in tight housing markets with low vacancy rates, where residential instability remained high, with 76% of families moving at least once in the year after securing housing [14].

Alternatives to rapid re-housing that were evaluated as part of a recent randomized control trial with homeless families included *permanent housing subsidies*, *transitional housing*, and usual care [15]. After 3 years, the permanent housing subsidy group did significantly better than all other groups on housing-related outcomes. Those in the rapid re-housing group fared neither better nor worse on housing-related outcomes compared to the usual care and transitional housing groups. Thus, although rapid re-housing was not as effective as permanent housing subsidies at providing long-term housing stability, it was at least as effective as transitional housing and usual care and cost considerably less than any of the three alternatives. Importantly, this was the first controlled study of homelessness prevention to measure health outcomes. The most consistent health-related finding was that children in families receiving rapid-rehousing had fewer behavioral problems after 3 years than those receiving transitional housing or usual care. Also, adults receiving rapid re-housing had significantly fewer signs of psychological distress and alcohol or drug abuse compared to those in transitional housing. While rapid-rehousing has not been tested among homeless single adults, LACHI has explicitly included single adults in its prevention strategies.

When considering whether secondary prevention should be universal or targeted, it is important to note that most families experiencing homelessness are able to regain housing stability on their own [16, 17], so secondary prevention can be targeted to families who have been homeless repeatedly, or for a minimum number of weeks. Another potential target group for secondary prevention is recently homeless individuals transitioning out of institutional settings, such as jails and hospitals, who may benefit from either rapid re-housing services or a permanent housing subsidy as part of a discharge planning [18]. LACHI has identified the strengthening of discharge-planning guidelines for homeless populations as a key strategy, although more research is needed to determine who would respond better to less-expensive rapid re-housing versus more-expensive permanent housing subsidies. Finally, the fact that almost half of those defined as nonchronically homeless in 2018 had been homeless for more than a year begs the question of when a homeless person shifts from needing secondary to tertiary prevention.

Primary prevention

Primary prevention seeks to prevent people from becoming homeless in the first place. A universal approach would require addressing the upstream drivers of homelessness, including the absence of low-cost housing, living-wage jobs, and a strong social safety net as well as the experience of early childhood adverse events. Yet even more targeted approaches to primary prevention may be cost prohibitive. For example, targeting very low-income renter households with severe housing cost burdens—defined as those who earn below 30% of area median income and spend more than 50% of their income on rent [19]—would still mean serving more than 370,000 households in LAC, or 21% of all renter households [20]. A narrower target based on HUD's homelessness prevention service eligibility criteria, which include imminent eviction, recent and frequent moves, living in other people's homes, and living in overcrowded single-room occupancy units [21], might approximate the estimated 200,000 LAC households that have reported ever being homeless or not having their own place to live or sleep in the past 5 years [22].

In the homeless services field, targeted primary prevention typically consists of short-term financial and instrumental supports, including cash assistance for rental arrears, mediation in housing courts, and social service referrals [3]. This package of services has been shown to be effective but not necessarily efficient. In the U.S. city of Chicago, researchers designed a natural experiment based on their determination that the month-to-month volatility of funding availability through the Chicago Homelessness Prevention Call Center created variation in the allocation of primary prevention resources to those seeking assistance. Those calling when funding was available were 76% less likely to become homeless during a 6-month follow-up period. Program cost was approximately $10,300 per homelessness spell averted, although this could be reduced by 35% simply by targeting assistance to the lowest-income households who were otherwise eligible [23]. Similarly, a New York City primary prevention program called Homebase was part of a randomized controlled trial that found enrollees were half as likely to have spent at least one night in a homeless shelter during the 2-year follow-up period. However, only 14.5% of the control group became homeless, despite being at high risk and receiving no prevention services.

Despite evidence of primary prevention effectiveness, efficiency remains a critical challenge. To address this challenge, researchers developed a screening tool using 4 years of risk-factor data from Homebase applicants that, in an evaluative simulation, increased the rate of enrollment of clients who would have become homeless by 26% and reduced the rate of enrollment of those who would not have become homeless by two-thirds. Factors most predictive of future homelessness among applicants included 'currently receiving public assistance,' 'involvement with child protective services,' 'being served an eviction notice,' 'multiple moves,' 'ever having been in a shelter as an adult,' and 'number of adverse childhood experiences' [24].

Cross-cutting strategies

Some strategies can be flexibly tailored across levels of prevention. The provision of Federally funded permanent housing subsidies and construction of affordable housing would likely have the greatest impact. Recommended as 'evidence-based' by the U.S. Task Force on Community Preventive Services [25], tenant-based rental subsidy programs provide housing vouchers to low-income individuals and families, including those who have become homeless. A challenge with housing vouchers, however, is finding landlords willing to accept them from formerly homeless individuals. LACHI offers financial incentives (e.g., vacancy payments to hold units, funds to cover damage mitigation and compliance with HUD standards, and security deposit assistance) to encourage landlords to accept these tenants. Facilitated by the passage of a municipal bond measure to fund permanent supportive housing construction, the creation of affordable units for the chronically homeless is another key LACHI strategy.

Employment services can also address multiple levels of prevention. A recent review concluded that *subsidized employment* programs for people facing significant barriers to employment successfully raised earnings and employment and had other nonemployment benefits—including reduced dependence on public benefits, improved educational outcomes, and improved psychological well-being. Evaluations of programs specifically targeting formerly homeless individuals are currently underway, with results forthcoming [26]. LACHI has identified subsidized employment as a strategy for increasing income among homeless individuals. *Supported employment* for those with serious mental illness is also robustly evidence based [27]. A quasi-experimental study of *individual placement and support* among homeless veterans found that it improved employment and housing outcomes [28], and a randomized controlled trial involving formerly homeless PSH tenants found that it significantly improved employment outcomes [29].

Another versatile financial assistance strategy is ensuring that all those who are eligible for public benefits are receiving them. *Supplemental Security Income* (*SSI*) benefits, for example, improve housing outcomes among homeless veterans [30]. Despite their eligibility, the homeless have low SSI enrollment rates, largely because the conditions of homelessness (e.g., lack of a mailing address or a place to store important documents) make the lengthy eligibility determination process more challenging [31]. A recent evaluation of the *SSI Outreach, Access, and Recovery* (*SOAR*) program found that SOAR-assisted applications were two times more likely to be approved [32]. LACHI has established countywide SSI and *Veterans Affairs* (*VA*) *benefits* advocacy programs, and a targeted SSI advocacy program for homeless inmates, both based on SOAR.

Beyond connecting people to benefits for which they are eligible, there is a broader need to streamline the delivery of services and supports across all levels of prevention. A *coordinated entry system* (*CES*) that tailors and organizes assistance based on types and severity of need has been identified as critical to achieving this goal [13]. Although developing an effective CES can pose challenges to

local homeless services authorities, a recent evaluation of early CES implementation in LAC characterized the system as providing: low barriers to assistance; client choice; accessibility of entry points; standardized access and assessments; links to street outreach; and full coverage of the service area—all of which align with key elements in HUD's guidelines for coordinated entry [33].

Discussion

We have presented a population health framework for homelessness prevention. Our review of the evidence has shown that, despite the serious negative health consequences of homelessness, there is limited evidence of positive health effects of interventions to prevent or reduce homelessness. Nevertheless, emerging research on the effects of secondary and tertiary prevention suggests that both mental and physical health factors are important and measureable outcomes of these interventions. The framework also helps balance two key challenges for researchers and practitioners who pursue a preventive approach to homelessness.

First, a focus on prevention raises the challenge of reducing homelessness in the face of broader social and economic forces. While there is good evidence that homelessness can be prevented through targeted and temporary financial, legal, and social services, program effectiveness at the household level is no match for population-level social dynamics that produce flows of new entrants to homelessness. Likewise, rapid re-housing, with its narrower focus on those who have already become homeless, can be overwhelmed by inflows of newly homeless people. This reality is dictating a narrow approach in LAC and elsewhere, whereby scarce primary and secondary prevention resources are available to those deemed as most in need.

Second, even as those charged with reducing homelessness limit the scope and scale of their primary and secondary prevention strategies, they must contend with the limits of current knowledge on the effectiveness of those strategies. This requires building strategies based on limited evidence, while addressing remaining questions through applied research. Evidence from primary prevention, for example, suggests the cost efficiency of programs can be increased through better screening of clients, but local data required to develop effective screening tools may still be lacking. Meanwhile, given the challenges associated with targeting primary prevention, rapid re-housing appears to be more promising, given its focus on those already homeless and its cost efficiency relative to other interventions. More research is needed to understand rapid-rehousing program elements and the client characteristics that drive long-term positive outcomes in the absence of permanent housing subsidies.

The homelessness prevention framework described in this paper can help balance these two challenges. The cross-cutting strategies all involve links to mainstream housing, social and health service systems that, while not specifically designed or funded to address homelessness, can support targeted homelessness prevention programs at each level. With their independent funding streams and broader purview, these mainstream systems address upstream factors critical to a more universal approach to homelessness prevention and represent an essential complement to the targeted approaches reviewed above. The U.S. *Federal Housing Choice Voucher*

(*HCV*) program is the single largest source of HUD funding to low-income households, both nationally and in LAC, and plays a vital role in make housing affordable. In fact, the U.S. Congressional Budget Office recently found that the HCV program could cover virtually all eligible households if various housing-related tax expenditures were reduced and the savings redirected to the HCV program [34]. While it is unlikely that housing vouchers will become an entitlement in the near future, advocacy for their expansion is growing and should figure strongly into homelessness prevention efforts [35]. Likewise, income-generating programs like subsidized employment, SSI, and *VA benefits* play an important upstream role in stabilizing low-income households, beyond their targeted role in addressing homelessness.

The criminal justice and healthcare systems, in addition to their direct role in identifying and transitioning homeless inmates and patients to stable housing upon discharge, play an important role in helping to shape the conditions that allow individuals and families to thrive and remain stably housed. Diversion programs that provide young criminal offenders with rehabilitative services in lieu of criminal sentencing, for example, can help them avoid the negative economic consequences of a criminal record; and health insurance, coupled with quality preventive care and disease management, can help prevent and control incapacitating physical and mental health conditions that precipitate chronic homelessness. The active and strategic engagement of these mainstream systems enhances the prevention orientation of efforts to reduce homelessness.

Finally, the successful integration of primary, secondary, and tertiary homelessness prevention programs with mainstream social and health service systems is not possible without a broad coalition of engaged, cross-sector leaders and the commitment of significant local funds beyond those available from Federal sources. The LACHI coalition and dedicated local tax revenues are what make LACHI's comprehensive 10-year plan promising. We hope that the framework presented here can serve as way to communicate the conceptual power of that plan to other jurisdictions tackling this complex issue and that it can help guide researchers partnering with them to build the knowledge base for effective action.

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