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INTRODUCTION

Homelessness as a Public Mental Health and Social Problem: New Knowledge and Solutions

Jack Tsai
Veterans Affairs New England Mental Illness Research Education and Clinical Center, West Haven, Connecticut; Yale University School of Medicine; and National Center on Homelessness Among Veterans, Philadelphia, Pennsylvania

Thomas O'Toole
National Center on Homelessness Among Veterans, Philadelphia, Pennsylvania, and Warren Alpert Medical School of Brown University

Lisa K. Kearney
Veterans Affairs Center for Integrated Healthcare, San Antonio, Texas, and University of Texas Health San Antonio

Homelessness is a major public health problem that has received considerable attention from clinicians, researchers, administrators, and policymakers in recent years. In 2016, 550,000 individuals were homeless in the United States (U.S. Department of Housing and Urban Development, 2016) with 4.2% of individuals in the United States experiencing homelessness for over 1 month sometime in their lives and 1.5% experiencing homelessness in the last year (Tsai, 2017). Homelessness remains a recalcitrant problem and a ripe area for study, particularly in addressing needs of individuals at high risk for homelessness and those from understudied populations. New and innovative measurement approaches, interventions, and study methodologies are presented in this special issue to shed light on how psychology can help benefit and improve homeless services.

Keywords: homelessness, housing, public mental health

After deinstitutionalization in the 1960s when thousands of patients were moved out of mental institutions into community-based care, many became homeless and marginalized. As the problem grew, homelessness began to be recognized as a public health problem and one that could be addressed with mental health and social services (Bassuk, 1984; Rossi, 1990).

Beginning in the early 21st century under the Bush Administration, the federal government began to urge communities around the country to build infrastructure and make ambitious plans to end homelessness (National Alliance to End Homelessness, 2014). The government also began requiring communities to conduct and report annual point-in-time (PIT) counts of homeless people to track the scope of the problem, which has continued to today. The most recent PIT count in 2016 found that approximately 550,000 people were homeless on a given night, with 68% staying in sheltered locations and 32% in unsheltered locations (U.S. Department of Housing and Urban Development, 2016). The majority of homeless Americans are only homeless for a brief period of time, but about 22% are chronically homeless which is federally defined as being continuously homeless for at least 1 year, or being homeless more than four times in the past 3 years for a cumulative period of being homeless for at least 1 year. The reliability of PIT counts is uncertain so the prevalence of homelessness can also be ascertained from epidemiological studies. A recent epidemiological study found that 4.2% of Americans have experienced homelessness for over 1 month sometime in their lives and 1.5% experienced homelessness in the past year (Tsai, 2017). From both epidemiological studies and PIT counts, it is clear that homelessness remains a major problem in the country.

Homelessness is a complex, interdisciplinary issue and one that psychology can provide solutions for. Understanding the behavioral health needs of homeless populations and developing interventions to address their needs are instrumental to preventing and ending homelessness. A growing body of psychological research has already contributed to knowledge in this area. Reviews of risk

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Jack Tsai, Veterans Affairs New England Mental Illness Research Education and Clinical Center, West Haven, Connecticut; Department of Psychiatry, Yale University School of Medicine; and National Center on Homelessness Among Veterans, Philadelphia, Pennsylvania. Thomas O'Toole, National Center on Homelessness Among Veterans, and Department of Internal Medicine, Warren Alpert Medical School of Brown University. Lisa K. Kearney, Veterans Affairs Center for Integrated Healthcare, San Antonio, Texas, and Department of Psychiatry, University of Texas Health San Antonio.

Correspondence concerning this article should be addressed to Jack Tsai, Veterans Affairs New England Mental Illness Research Education and Clinical Center, 950 Campbell Avenue, 151D, West Haven, CT 06516. E-mail: Jack.Tsai@yale.edu

factors for homelessness have revealed that adverse childhood experiences, mental illness, and substance abuse are strongly associated with homelessness (Susser, Moore, & Link, 1993; Tsai & Rosenheck, 2015). Moreover, most research on homelessness has focused on the large number of homeless, single, middle-aged men, but there is increasing study on the growing number of homeless women and families who may have different needs.

In the past decade, there have been great advances in research and services to address homelessness. For example, the U.S. Interagency Council on Homelessness provided the nation's first comprehensive strategy to prevent and end homelessness in 2010 to spur coordinated, joint action among different federal agencies, local and state partners in the public, and private sectors. There has also been increased attention on veteran homelessness. In 2009, the Department of Veterans Affairs (VA) embarked on a multiyear federal initiative to prevent and end veteran homelessness and has invested billions of dollars toward that goal. Since that time, there has been a 47% decline in veteran homelessness as reported in PIT counts, and over 30 communities and three states have declared a functional end to veteran homelessness. Various new service models have also been developed and disseminated throughout the country. For example, the Housing First (HF) model has become the predominant model for supported housing and has been shown to be effective in reducing homelessness in several randomized controlled trials (Aubry et al., 2015; Tsemberis, Gulcur, & Nakae, 2004). Comprehensive primary care and behavioral health services have been integrated into many homeless clinics to address the complex needs of homeless populations (O'connell et al., 2010). The VA has also led numerous programmatic efforts to help homeless and-at risk veterans with housing, health care, employment, and criminal justice involvement.

However, homelessness remains a recalcitrant problem and there are still many challenges that are ripe for study, especially for behavioral health scientists. Many people who enter supported housing return to homelessness, and there have often been limited improvements in mental health, substance use, and community integration in supported housing (Kertesz, Crouch, Milby, Cusimano, & Schumacher, 2009; Tsai, Mares, & Rosenheck, 2012). New and innovative measurement approaches, interventions, and study methodologies are needed to continue to shed light on how psychology can be used to benefit and improve homeless services. Thus, this special issue is devoted to highlighting recent work and developments in these areas to address the needs of homeless populations.

Highlights From the Special Issue

Developments in Methods for Addressing Housing Needs

Kertesz and colleagues (2017) aimed to expand our understanding of the real world application of the highly successful HF model (Aubry et al., 2015; Tsemberis et al., 2004) through their review of the VA's implementation of the model nationwide. Kertesz and colleagues (2017) reviewed fidelity to the HF model across eight VA medical centers to identify each facility's fidelity to 20 key criteria of the model divided into five domains: no sobriety or treatment preconditions, rapid placement into permanent housing, prioritization of the most vulnerable homeless clients, sufficient supportive services available in a community context, and a modern recovery philosophy that guides all services. High fidelity was found in two of the domains, no preconditions and rapidly offering permanent housing, and low fidelity was found in two other domains, sufficient supportive services and modern recovery philosophy. This finding occurred despite VA's tremendous national effort in supporting implementation of the model through formalized guidance, conference training calls, and checklists to guide implementation. The authors concluded that implementation of randomized controlled studies of the successful HF program will require significant and potentially long-term technical support to obtain the results desired in decreasing homelessness long term.

Brown, Vaclavik, Watson, and Wilka (2017) extended understanding of outcomes for the Homelessness Prevention and Rapid Rehousing Program, which has shown excellent placement in permanent housing for individuals struggling with homelessness. Brown and colleagues (2017) reviewed whether this impact remained on a longer-term basis by looking at data from 2009 to 2015 for 370 permanently housed and 71 nonpermanently housed individuals. They found that only 9.5% of permanently housed and 16.9% of nonpermanently housed individuals returned to homeless services during the follow-up period. Individuals who were veterans and whose income did not increase during the program were at greatest risk for reentry into services. Reentry was also more likely to occur in the first 2 years following the program, suggesting that focused efforts in providing more follow-up during this critical time may be helpful. These findings are encouraging as they point to the maintenance of impressive outcomes for the Homelessness Prevention and Rapid Rehousing Program.

Crisanti et al. (2017) also worked to identify longitudinal impacts of housing initiatives, specifically reviewing the impact of the New Mexico Healthy Homes program, a peer-delivered permanent supportive housing (PSH) model using the HF approach with the majority of services provided by peers who had personal experience being homeless. In their study of 237 individuals enrolled in the program, the authors compared mental and overall health outcomes of those who were and were not housed. Longitudinal outcomes reveal a strong association with good to excellent health after 6 months for those receiving supportive housing. Additionally, improvement in psychological distress was noted for both groups. Future studies will be needed to assess outcomes for programs utilizing peer support services compared to those not having these services.

Gabrielian, Hamilton, Alexandrino, Hellemann, and Young (2017) also looked at long-term outcomes for VA Supported Housing (VASH), particularly focusing on the population of individuals who lose their housing over time in comparison to those who are able to retain their housing. Qualitative interviews were completed on 20 stayers and exiters who were identified as having previously participated in the VASH program 1 year prior. Additional interviews were completed with VASH staff and leadership from the same program. Findings indicated that several factors were associated with loss of supportive housing, including low intrinsic motivation, unmet mental health service needs, substance use disorder (SUD) treatment, poor engagement in primary care services, mental health hospitalization, and frequent emergency department utilization. The authors suggested that further identifying methods for increasing services with significant mental

health needs and enhancing individuals' engagement in primary care may help facilitate housing retention in the future.

Homelessness, Health Conditions, and Health Care Utilization

Expanding on the association between homelessness and primary care engagement, Johnson, Borgia, Rose, and O'Toole (2017) endeavored to assess whether engagement in primary care services was associated with improved housing outcomes. In their analysis of 142 homeless veterans, they found several strong associations between housing and utilization of primary care services. For those who received primary care services within 1 month of enrollment in housing service, the average length of time for moving from unstable to stable housing was nearly half the time for those not receiving primary care service (84.8 days vs. 165.9 days). Of those receiving primary care services within 1 month of being enrolled, 88.9% were in stable sheltering at 6-month follow-up. Early prioritization of primary care services appears to play a role in achieving stable housing.

Jones and colleagues (2017) also investigated primary care utilization and experience among homeless and nonhomeless veterans through a national survey of veterans with mental health or substance use disorders (MHSUDs) utilizing VA outpatient primary care services. Homeless veterans with MHSUDs in the sample reported more negative experiences in communication in primary care and reported more negative ratings of their primary care team providers compared to other veterans with MHSUDs. As primary care engagement appears to be associated with improved housing outcomes, the authors urged further study in identifying methods for improving primary care experience and engagement, particularly for those individuals struggling with MHSUDs in addition to homelessness.

Emergency department (ED) services are often highly utilized in the homeless population. Moore and Rosenheck (2017) reviewed data from the Collaborative Initiative to Help End Chronic Homelessness to compare ED utilization when assessing for engagement in case management, comprehensive housing, MHSUDs, and primary care services. Engagement in housing was found to be the key factor in reduced ED utilization, not involvement in these other services.

Mitchell, Leon, Byrne, Lin, and Bharel (2017) further assessed the cost of utilization of ED services and other health care services in the homeless population. Interestingly, even after adjusting for demographics and clinical diagnoses, frequent ED use was associated with higher non-ED costs. Those with trimorbid illness, older persons with chronic illness, those with disabilities and mental health concerns, and younger individuals with illicit drug use and co-occurring disorders were the costliest subgroups of homeless individuals with frequent ED use. Each of these unique groups may benefit from different targeted interventions to address their unique health care needs.

Tsai, Hoff, and Harpaz-Rotem (2017) studied over 300,000 veterans engaged in specialty mental health to identify 1-year incidence of homelessness with a focus on elucidating sociodemographic and clinical predictors of homelessness in this population. In this large scale sample, 5.6% of veterans became homeless within 1 year of referral to specialty mental health care. Sociodemographic factors which were identified as predictors of homelessness including being single, Black, between the ages of 46 and 55, or having an annual income less than $25,000, and clinical predictors for homelessness identified included alcohol use disorder or drug use disorder diagnosis. The authors called us to consider how expanding our screening for homelessness to include these factors may be helpful to increase early interventions to prevent homelessness.

In addition to specialty mental health care, Cox, Malte, and Saxon (2017) assessed for health care utilization patterns in homeless veterans engaged specifically in SUD treatment. This study of 181 veterans in a randomized trial of housing and SUD case management were identified as being newly, episodically, or chronically homeless. Those who were chronically homeless were higher utilizer of ED and inpatient services, but a majority in all groups has high attendance in primary care and mental health services, which the authors suggested may be related to the implementation of a homeless focused patient centered medical home at the facility. Findings suggested the critical nature of addressing homelessness in SUD treatment programs to improve overall health care outcomes, which will also lead to reduced health care costs.

As a high-risk population and high utilizer of ED services, it is critical for homeless individuals to have documented their treatment preferences should they become unable to participate in health care decision making. Dubbert, Garner, Lensing, Sullivan, and White (2017) reviewed program evaluation data from 288 homeless veterans who participated in psychoeducational groups related to advance health care planning. Only 26% of participants had an advance directive in their medical record while 70% reported that they had thought about care they desired and 50% reported they had talked with someone about making medical decisions on their behalf. The authors urged future efforts in improving advance health care planning including mental health advance directives with homeless individuals to assist in guiding care during times of crisis or at end of life.

Homeless individuals have higher rates of visual impairment than the general population (e.g., Maberley et al., 2007) and are at greater risk for not obtaining appropriate glycemic control when diabetic (Arnaud, Fagot-Campagna, Reach, Basin, & Laporte, 2010), which can lead to diabetic retinopathy and visual impairment. Davis and colleagues (2017) looked at data on over 20,000 veterans with Type 1 or Type 2 diabetes. Homeless veterans with diabetes were more likely to have had diabetic retinopathy eye screening than those veterans with housing. Surprisingly, in this study, having diabetic retinopathy was associated with being housed. The authors postulated that the intensive homeless program services available at the Greater Los Angeles VA may be a reason for these positive findings with homeless veterans at this facility receiving frequent medical care visits, care management, and receipt of diabetes self-management programming. This highlights how a strong housing program with services meeting a variety of biopsychosocial needs may have impact not only on housing but be related to improved health care outcomes for patients.

Special Populations and Special Issues in Homelessness

This special issue also advanced understanding of homelessness in special populations with unique needs which may warrant

individualized interventions. Metraux, Cusack, Byrne, Hunt-Johnson, and True (2017) provided an in-depth view into pathways from military discharge to homelessness in our newest era of veterans who served post-9/11. Through qualitative interviews with 17 homeless veterans of this era, the authors identified five themes that arise related to transitioning from military to civilian life: employment and relationships, mental and behavioral health, use of veteran-specific services, lifetime poverty, and adverse events. Yet these veterans found their homelessness primarily associated with nonmilitary factors, which included unemployment and relationship distress, despite our understanding of the connections between combat experience, homelessness, and posttraumatic stress disorder. They also provided a greater understanding of the potential challenges in accessing VA and community services for veterans in this era, leading to a call for increased measures to engage our newest veterans during a time of potential risk for homelessness.

Kaiser and colleagues (2017) also expand our understanding of newer generations of homeless individuals and unique technological methods of outreach for this population. Through a series of focus groups, the authors engaged 24 homeless youth to increase understanding of their use of technology, mental health needs and experiences, and openness to engage in technologically supported interventions for mental health concerns. Findings indicate a potential for development of technologically supported applications to reach this population who reported a history of poor mental health service experiences.

Dichter, Wagner, Borrero, Broyles, and Montgomery (2017) focused on the experiences of homeless women veterans, assessing the association between housing concerns and intimate partner violence (IPV), unhealthy alcohol use, and other psychosocial experiences. Experiences of IPV in the prior year were associated with increased risk of housing instability, but there was no association between unhealthy alcohol use and homelessness. These findings call upon clinicians to consider increased assessment for housing concerns when IPV is first reported, offering early interventions to address any housing needs identified, particularly as lack of housing has been reported as a barrier for women seeking to obtain independence from an abusive relationship (Clough, Draughon, Njie-Carr, Rollins, & Glass, 2014).

Homelessness and incarceration have shown a strong, bidirectional association. Cusack and Montgomery (2017) further explored this association by studying data from 1,060 male veterans enrolled in PSH. Risk factors for exiting PSH due to incarceration included a history of drug use disorder with decreased care frequency and prior history of incarceration. The authors call for greater coordination of homeless services and criminal justice system, integration of housing services with other community services, a focus on employment, and utilization of peer support in reentry programs.

A little over one quarter of homeless men are noted to be noncustodial fathers, yet little literature is dedicated to the needs and understanding of this population (Ferguson & Morley, 2011; Schindler & Coley, 2007). A final study by Rice and colleagues (2017) furthered understanding of homeless fathers' perceptions of masculinity and fatherhood through qualitative interviews with 11 men living in a homeless shelter. Common themes identified common perceptions of masculinity and fatherhood that were changed as a result of homelessness, expectations of homeless fathers, and physical and psychological challenges of being a homeless father. Homeless fathers reported decreased self-esteem related to perceptions of failing in the provider role for their family. Positive adaptations of fatherhood when experiencing homelessness were also noted by focusing on other roles outside of provider, such as role model, teacher, and guide. Clinicians are encouraged to consider methods of fostering these positive interactions between homeless fathers and their children in a way that bolsters self-efficacy related to fatherhood and masculinity, which may be critical ways to support individuals working to obtain permanent housing.

Conclusion

Our special issue has provided an opportunity to bring together studies of new approaches to addressing housing needs among various homeless populations, with attention to special populations and complex issues that require uniquely adapted methods to meet the full spectrum of needs. The scope and breadth of this research sheds further light on the complex picture of who is homeless and why, as well as how, they impact and interface within our communities and institutions. The research also highlights many new advances and approaches to how we can move forward in ending the homelessness by working better, smarter, and with greater insight. Finally, several of the articles in this issue speak to the bidirectional role and importance of good policy informing best practices. Collectively, the findings provided here call our readers to continue to strive for advancing methods to address this large-scale public mental health and social problem. The Bush and Obama Administrations supported great efforts to address this problem through calls for action, policies and legislation, and funding for research and services. Under the new Trump Administration, we hope these efforts will continue and advances will be made through research as well as implementation of successful programs through real-life applications in public sector settings.

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