Article

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Chronic homelessness: Disability diagnoses as prioritization

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Patterns of Chronicity

Chronic homelessness is the concept driving much of the policy directed at ending the perpetual homelessness crisis in America. Illicit substance and mental health disorders are closely associated with homelessness in the popular imagination. While there is a prevalence of both among the population experiencing homelessness, there is little evidence suggesting that the rate of illicit substance use among people "becoming homeless", entering the homeless response system, for the first time is significantly different than the rate of illicit substance use in the general population controlling for economic measures. In practice, to a large degree, increased illicit substance use and mental health disorders are symptoms of homelessness rather than causal (Hungaro, Anai Adario, et al. 2020). This means that the observed high rates of illicit substance use are more likely to be caused by the experience of homelessness. This is particularly true once poverty is controlled for suggesting illicit substance use is more a function of poverty, a coping mechanism, a punitive measure against the behaviors of the poor, or a combination of those. (Sheely 2021)

And so, much policy coming from the United States Department of Housing and Urban Development (HUD) is aimed at sorting out the people who are more likely to need minimal intervention before finding housing stability, exiting assistance, and never needing that assistance again, at least for the two-year lookback used in those measures. For much of the population experiencing homelessness, even if there are several system entries across the time span, the episode of homelessness is one time and finite ending in a system exit from which there is no return to homelessness. 80.3% of those who exit to permanent housing are not seen again in two years, nationally (U.S. Department of Housing and Urban Development 2021a) in 2021, and 74% in Polk County, Iowa, for the same period.

The remainder should be people who are unable to find a path to long term stability without further assistance. For that remainder there are two predominant interventions. Rapid re-housing is preferred for people who have the fundamental ability to maintain stability but need a time-limited assistance. The balance is people who need long term or permanent assistance and may need support for underlying permanent disabilities that interfere with their ability to maintain housing independently. And, aside from special populations like youth and military veterans, that should cover everyone.

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In 2012 HUD mandated the use of a triage tool to try to predict what sort of intervention will be most effective in each case. Permanent supportive housing solutions have been used as a matter of policy since the 1980s, but the rules implemented nationally in 2012 as part of the HEARTH act included direction from congress to HUD to establish preferences from 'chronically homeless' individuals through the amendment of the definition of 'chronically homeless'.

> "Chronically homeless. (1) An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability; (2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless."
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> (U.S. Department of Housing and Urban Development 2012)

The direction that the individual 'can be diagnosed' has been interpreted to mean that the individual 'has been diagnosed'. In practice, this means that a medical professional must be included in every decision whether to provide best practice housing interventions. However, the Americans with Disabilities Act (Americans With Disabilities Act, 1990; ADA Amendments Act, 2008) this includes people who have a record of such an impairment, even if they do not currently have a disability as well as individuals who do not have a disability but are regarded as having a disability. This clearly includes all people experiencing homelessness over an extended period.

If prioritization is necessary for funding purposes, then mental health symptom and illicit substance use are closely associated with homelessness. There is little to no evidence suggesting that the rate of illicit substance use among people "becoming homeless", entering the homeless response system, for the first time is significantly different than the rate of illicit substance use in the general population, however to a large degree increased illicit substance use is a symptom of homelessness rather than a cause (Hungaro, Anai Adario, et al. 2020). This means that the observed high rates of illicit substance use are more likely to be caused by homelessness than causal of homelessness. This is particularly true once poverty is controlled for suggesting illicit substance use is more a function of poverty, a coping mechanism, a punitive measure against the behaviors of the poor, or a combination of those. (Sheely 2021)

Furthermore, for the portion of the population experiencing homelessness where, even if there are several system entries across the time span, the episode of homelessness is one time and finite ending in a system exit from which there is no return to homelessness. 80.3% of those who exit to permanent housing are not seen again in two years, nationally (U.S. Department of Housing and Urban Development 2021) in 2021, and 74% in Polk County, Iowa, for the same period.

The population that fits the definition for chronically homeless, exhibiting patterns of chronicity in their experience of homelessness, is the population for which we have more theoretical interest in this investigation. "Individuals are considered to have chronic patterns of homelessness if they have a disability and have been homeless for a total of at least a year over the past three years." (United States 2021) Employing point-in-time data (PIT and HIC Data Since 2007) and cautioning that both the numerator and denominator contributing to the rate of chronicity could be affected by the COVID pandemic, nationally 16.8% of individuals experiencing homelessness sheltered in emergency or safe haven shelters exhibited patterns of chronicity. Family chronic homelessness is excluded in large part for lack of reliability. The percent of sheltered individuals exhibiting patterns of chronicity in their experience of homelessness had been trending upward since 2016, when a low value of 9.6% was reported. The average across the years 2007-2020 excluding 2021 shows 14.6%.

The 2021 Polk County (IA-502) point in time count was conducted on the night of 27 January 2021. It showed 353 persons in emergency shelters and an additional 13 persons in Safe Haven of whom 64 exhibited patterns of chronicity, for a 17.5% rate, slightly above the national average. Polk county had been at or below the national average from 2016-2019. Local and national l trends had both been moving upward.

In Polk County, Iowa, annualized 2,705 people were in emergency shelter in 2020 and 2,291 were in shelter in 2021. Of the 2,705 people in 2020, 402 (14.9%) exhibited patterns of chronicity in 2020. However, over the course of the available data through the end of June 2022, 703 (26%) of the population seen in 2020 would eventually qualify as exhibiting patterns of chronicity. In 2021, of the 2,291 people in emergency shelter 290 (12.7%) showed the patterns of chronicity. By the end of June 2022, 522 had developed such patterns (22.8%).

At any given time, a small percent of the population shows patterns of chronicity but because they stay in shelter longer, The annualized rates should be lower than the point in time rate, however the true rate of people exhibiting patterns of chronicity may be underreported, which we will explore more later in this analysis. While most people exit to stable housing and stay housed, this subsection of the population experiencing homelessness in patterns of chronicity hew more closely to the preconceived notions of homelessness in the popular imagination. For the balance of the population the existing response is quite effective, but for this sub-population there is merit in pursuing new perspectives and new solutions.

There is a strong correlation between exhibiting patterns of chronicity in homelessness and illicit substance use. However, as individual indicators, having children and anxiety disorders are much more significant related (Nilsson, Nordentoft, and Hjorthøj 2019). To some degree this is reductive, because chronicity requires a disability, so all people who exhibit patterns of chronicity have a disability. Many of those will be illicit substance related. But there is a matter of practice for which this is an important question.

Chronicity

Our data includes 8,791 (N) people who were served in street outreach, coordinated entry, or emergency shelter program types during 2020, 2021 and the first half of 2022, through the end of June. The data includes 7,159 people served through coordinated entry. 5,260 people were served in emergency shelter. 416 people were served in street outreach.

	Distinct count of People
Coordinated Entry, Emergency Shelter, and Street Outreach	159
Coordinated Entry and Emergency Shelter	3,588
Coordinated Entry and Street Outreach	103
Emergency Shelter and Street Outreach	35
Coordinated Entry	3,309
Emergency Shelter	1,478
Street Outreach	119
Total	**8,791**

Table 1. Distinct count of people by program type participation.

From that population (8,791), 836 (9.5%) fit the definition for chronic homelessness as described above at each and every entry they experienced across the data set. That is below the 17.5% rate from the 2021 Polk County the point in time, though 1,670 (19%) people fit the definition during at least one of their entries by the end of the analysis period. This means that 834 (9.5%) additional people qualified by the middle of 2022, double what was originally thought.

In practice determining whether an episode of homelessness exhibits patterns of chronicity is a complex calculation. The determining factors are the presence of a diagnosed disability and length of homeless episode, and whether the person stayed in a place not meant for human habitation on the night before entry.

The disability diagnosis is determined by medical professionals and must be communicated to and verified by the case manager. The disability must be of long duration and affect their ability to keep and maintain housing.

Length of homeless is complex as well. The process involves determining if the individual experienced homelessness for longer than a year, during which time they lived in a shelter, safe haven, or a place not meant for human habitation, or experienced homelessness four or more times in the last three years. This requires the determination of the approximate date the episode of homelessness began, which is a process involving variables like, if the person stayed in a hotel paid for by themselves that can constitute a break in the episode of homelessness, but if the hotel was paid for by a service provision agency or church then the stay does not constitute a break. If they slept in a place that was meant for habitation, for instance on a friend's couch, for seven days or more then that is a break in the episode. A stay in an institutional setting like a hospital, residential treatment facility, or jail does not count as a break if it was under 90 days. Then once the starting date of the episode of homelessness is determined, if that is a year or more from the date of entry, or if with those breaks there have been four or more episodes in the previous three years which together included dates that fell on 12 separate months, and so constate a year of homelessness, then the length of time is sufficient.

Additionally, each person is asked where they slept the night before entry. They must have slept in place not meant for human habitation, like a car or the street, including shelter or safe haven, on the night before entry.

If at any point the disability diagnosis is determined, the person may *become* qualified as exhibiting patterns of chronicity. That process is complex, but most of it is out of the control of homeless service agencies and the case managers employed in this work. Of the 834 people who did not qualify for the chronic measure at their initial entry but did qualify at a later entry, 290 (34.8%) people did not initially have a disability diagnosis recorded, but were later determined to have a disability of long duration that affects their ability to keep and maintain housing.

If over the course of staying in shelter or safe haven the person qualifies, and the disability diagnosis is present, then the person is included in counts of chronic homelessness. Of the 834 people who did not qualify for the chronic measure at their initial entry but did qualify at a later entry, 512 (61%) people did not initially have a sufficient length of time experiencing homeless. Also, 577 (69.2%) were not recorded as having spent the night prior to entry in a place not meant for human habitation.

Among those who never qualified as exhibiting patterns of chronic homelessness, 7,121 people, 3,793 (53.3%) had a diagnosed disability, 1,001 (14.1) had a qualifying length of homelessness and 2,976 (41.8%) came from a place not meant for human habitation, but never had all three line up in a way that qualified their episode as exhibiting patterns of chronicity.

In the population (8,791) included in this analysis there were 1,670 people (19%) in total who exhibited patterns of chronicity at some point throughout the period of data collection. Those 1,670 people will be considered as having patterns of chronic homelessness for analysis moving forward. From the subpopulation included for additional drug use preference questions, 495 people (45%) exhibited such patterns.

Exhibited Pattern of Chronicity	**Distinct count of People**	
Always exhibited patterns of chronicity during the period of the study.	836	9.5%
Began to exhibit patterns of chronicity during the period of the study.	834	9.5%
Never began to exhibit patterns of chronicity during the period of the study.	7,121	81%
Total	**8,791**	**100%**

Table 2. Patterns of chronicity between exhibited.

The argument could be made that any person experiencing so many episodes of homelessness would be expected to be, and could reasonably be assumed to be, experiencing a diagnosable disability, and the difficulty documenting the disabilities may be a result of homelessness, the disability itself, or some other outside factor for which the person experiencing homelessness should not be held responsible and for which they could not be expected to compensate.

Among those 1,670 people experiencing chronic patterns of homelessness, 799 (47.8%) had documented mental health disorders and 413 (24.7%) had drug use disorders. Among those 7,577 people not qualifying for chronic patterns of homelessness, 1,245 (17.5%) had documented mental health disorders and 487 (6.8%) had drug use disorders.

Triage

The assessment is conducted using a triage tool, the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) which provides a score that is interpreted to recommend a course of action between emergency shelter, rapid re-housing, and permanent supportive housing, to some extend based on the likelihood of the respondent dying on the street as a result of their homelessness. A set of questions about illicit substance use and preferences was added to the tirage process. The resulting data from the triage, the illicit substance use questions, along with the answers to the questions that constitute the minimum required data standards as entered into the Homeless Management Information System (HMIS), a federally required data system governed by the HUD data standards (https://www.hudexchange.info/ news/hud-releases-fy-2022-hmis-data-standards/), serve as the data set for this analysis.

A strong case can be made that chronicity as a concept is not a good indicator of those things that it is intended to indicate, most significantly whether the person is best suited for permanent supportive housing. To test that case, there is data available from the coordinated entry process. Beginning with the HEARTH Act (U.S. Department of Housing and Urban Development 2012) HUD has mandated the use of a coordinated entry system including a triage tool for prioritization of people seeking services to address and prevent homelessness, such that people are prioritized into the various responses available in a continuum of care (Berg 2013). Polk County adopted the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT), developed by OrgCode, which includes questions about disabilities, mental health and substance use. Across the span of this study, six tools were employed. The tool for unaccompanied adults (OrgCode Consulting Inc. and Community Solutions. 2016a) was originally used along with a tool for youth (OrgCode Consulting Inc. and Community Solutions. 2015b) and a tool for families (OrgCode Consulting Inc. and Community Solutions. 2016b). Another tool was used for people discharging from institutional settings (OrgCode Consulting Inc. and Community Solutions. 2015a).

The tool itself is somewhat controversial for introducing racial bias (Cronley 2022) and for serious questions about whether the tool, which proports to give recommendation about the best course of action to address homelessness in a way that reduces morbidity, validly and reliably measures morbidity (Brown et. al 2018), to the point where OrgCode announced in January 2022 that it planned to phase out the VI-SPDAT and would no longer be supporting its use. Version 3 of the tools for unaccompanied adults and families were adopted to address racial bias inherent in the tool (OrgCode Consulting Inc. and Community Solutions. 2020a and 2020b).

The tool(s) assigns scores in ranges which vary depending on whether the household is an adult-only household (25 and over), a family with children, or a youth-only household (under 25), and then makes recommendations around housing interventions are made based on total scores. In practice, triage is administered through the coordinated entry process, which can be administrated at the emergency shelter, but is most often administered at the primary healthcare office or by the primary healthcare outreach staff. Some people were administered the triage tool more than once and in those cases we used the highest score over the course of the study period, though that is rare and readministering the tool requires a significant change in circumstances. Over the course of the study there were 18 cases where a triage resulting in a no intervention recommendation was changed to recommending rapid re-housing and there were 58 cases where a triage recommending rapid re-housing was updated to recommend permanent supportive housing.

For the purposes of this study, we are interested in the questions pertaining to the presence of a disability that interferes with the person's acquisition and retention of housing, substance use disorders, and mental health disorders. In the VI-SPDAT currently being administered to unaccompanied adults (OrgCode Consulting Inc. and Community Solutions. 2020a), there is a broad question about disabilities; "Do you have any diagnosed, documented, disabling conditions?", which we will refer to as "Disability." There is also a question about mental health; "Do you have any physical or mental health issues or cognitive issues including a brain injury, that you would require assistance to access or keep housing?", which we will refer to as "Mental Health Disorder." Finally, there is a question about substance abuse; "Do you use alcohol or drugs in a way that it: impacts your life in a negative way most days, makes it hard to access housing, or would require assistance to maintain housing?", which we will refer to as "substance use disorder." Other versions of the triage tool have comparable and similarly worded questions.

We will use those recommendations and the points assigned for mental health and substance use as data points, though we will not look at the other non-disability related questions in-depth. Out of the 8,791 people served, 6,502 were heads of households. Triage is only captured for heads of households including households comprised of a single person. 3,812 people had scores.

The people for whom there was no triage score captured are primarily those cases where the person was only seen in emergency shelter (72% of null values) and if there was a coordinated entry assessment made it did not include the triage tool or were seen in coordinated entry and the triage tool was not begun or if it was begun it was not completed (21% of null values), or the person was seen through street outreach only and no triage assessment was made (4% of null values).

The population for whom the triage tool is administered is predominately in need of intervention, and the intervention is close to evenly divided between rapid re-housing and permanent supportive housing. Rapid re-housing is a much more cost-effective solution. In 2009 as a part of the American Recovery and Reinvestment Act, rapid re-housing was greatly expanded. At the time the expectation was that for many the mortgage crisis would result in homelessness, but that the economic fundamentals of many affected were stable, and so a limited time intervention would be a way to bridge a crisis. Guidance from HUD read, "While HUD will allow grantees the discretion to develop prevention and/or rapid re-housing programs that meet locally-defined needs, HUD also expects that these resources will be targeted and prioritized to serve households that are most in need of this temporary assistance and are most likely to achieve stable housing, whether subsidized or unsubsidized, outside of HPRP after the program concludes." (U.S. Department of Housing and Urban Development 2009) In the time since that crisis, the low-cost intervention has remained a favorite funding priority largely because of the time-limited nature of the intervention, though the portion of the population for whom it is affective has diminished. By contrast, permanent supportive housing is much more effective at ending homelessness but necessitates a long-term financial commitment on the part of the community.

The triage tool recommended 44% of respondents use rapid re-housing and 48.6% use permanent supportive housing. A diminishingly small portion were recommended for no intervention. This population for whom mental health and drug use are constant hinderances to maintaining stable housing are likely to benefit from the more intensive intervention.

Recommendation	**Point assigned**	**Average Triage Score**	**SD**	**Distinct count of People**	
No recommended intervention	None	2.58	0.65	262	93.6%
	Substance use	2.71	0.46	5	1.8%
	Mental health	2.98	0.15	13	4.6%
	Both			0	0%
Rapid Re-housing	None	5.56	1.13	1,228	73.2%
	Substance use	6.36	1.05	192	11.4%
	Mental health	6.11	0.82	236	14.1%
	Both	6.12	1.01	22	1.3%
Permanent Supportive Housing	None	9.43	1.49	727	39.2%
	Substance use	9.70	1.33	362	19.5%
	Mental health	10.19	1.75	456	24.6%
	Both	11.36	2.01	309	16.7%
Total		**8.18**	**2.90**	**3,812**	**100%**

Table 3. Triage derived service recommendation, points assigned for substance use and mental health and average triage score.

Discussion and Findings

It is a bit reductive to say that the higher the triage score, the more likely the person was to have received points for substance use and mental health disabilities. Assuming this is an accurate measure of the relative need of intervention at an individual level, if it mis-represents the absolute need it still accurately reflects the relative need, then we would expect the population in need of permanent supportive housing to have a high percent of the population demonstrating patterns of chronicity across the data including substance use and mental health disorders interfering with their ability to stay stably housed. We would expect very few in rapid re-housing should demonstrate such patterns because the expectation is that they will remain stably housed with minimal intervention, and that the population for whom no intervention is recommended, presumably having social supports in place sufficient to find stability, should have no, or nearly no, indications of chronicity or instability.

Recommendation	Received triage points for mental health or substance use disabilities	Distinct count of People Exhibited Pattern of Chronicity	
		No	Yes
No recommended intervention	No	233	29
	Yes	16	2
Rapid Re-housing	No	969	259
	Yes	339	111
Permanent Supportive Housing	No	532	195
	Yes	682	445
Total		**2,771**	**1,041**

Table 4. Triage points assigned for substance use or mental health, and patterns of chronicity by current standards.

We see that while only 7% of the people for whom no intervention was recommended had mental health or substance use disabilities that interfered with their housing stability, in the rapid re-housing recommendation category that was 27% and in permanent supportive housing it was 61%. And from the population for whom no intervention was recommended, 11% exhibited patterns of chronicity. 22% of the rapid re-housing recommendation category exhibited patterns of chronicity, and in the permanent supportive housing category 40% exhibited such patterns.

Race	Triage indicated chronicity		*Total*
	No	Yes	
NULL	18	3	*21*
American Indian, Alaska Native, or Indigenous	27	9	*36*
Asian or Asian American	28	8	*36*
Black, African American, or African	847	136	*983*
Native Hawaiian or Pacific Islander	6	1	*7*
Multi Racial	368	97	*465*
White	1,768	496	*2,264*
Total	**3,062**	**750**	***3,812***

Table 5a. Race category and patterns of chronicity by triage indicated standards (ignoring physician verified disability diagnosis).

Race	Current standard chronicity		*Total*
	No	Yes	
NULL	19	2	*21*
American Indian, Alaska Native, or Indigenous	25	11	*36*
Asian or Asian American	25	11	*36*
Black, African American, or African	778	205	*983*
Native Hawaiian or Pacific Islander	5	2	*7*
Multi Racial	335	130	*465*
White	1,584	680	*2,264*
Total	**2,771**	**1,041**	***3,812***

Table 5b. Race category and patterns of chronicity by current standards..

It emerges that, in practice, exhibiting the patterns of chronicity are important, but the ability to receive a disability diagnosis is an impediment to the affective value of that data point. If we take the triage tool assessment of a disability that interferes with the ability of the person to maintain housing, even if we only use mental health and substance use disabilities, acknowledging that there are other sorts of disabilities, then substitute that for the physician diagnosed disability in combination with the length of time measure, what emerges is likely a much more equitable, if still deeply flawed, measure of chronicity. Looking at the distribution of the HUD chronic measure across the population, we see a simple chi square significance of p=0.00001 however using the triage derived measure of disability we reduce the significance of disparity to p=0.00004, which is still awful considering the real-world implications of this statistic, and it would take a path analysis to figure out how much of the inequity is still coming

from the measure of disability as opposed to systemic racism from other dimensions like housing discrimination, policing, and other social factors, but this points to a promising direction for future research. Discarding the physician diagnosed and verified disability requirement would have reduced the measure of inequitable distribution by a factor of 4 in Polk County between 2020 and the first half (end of June) of 2022.

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