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MaryJo Schmidt Date

Return to Nowhere:
Chronic Homelessness in the Atlanta Continuum of Care

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Return to Nowhere:
Chronic Homelessness in the Atlanta Continuum of Care

By

MaryJo Schmidt
B.S.S Human Behavior: From Cells to Society
Cornell College
2020

Thesis Committee Chair: Eric J. Nehl, PhD

A thesis submitted to the Faculty of the
Rollins School of Public Health of Emory University
in partial fulfillment of the requirements for the degree of
Master of Public Health
in Behavioral, Social, and Health Education Sciences
2024

ABSTRACT

Return to Nowhere:
Chronic Homelessness in the Atlanta Continuum of Care

By MaryJo Schmidt

Introduction: As of January 2022, over half a million people are currently experiencing homelessness in the United States. The experience of homelessness has been associated with worsening health conditions and includes a disproportionate number of people with marginalized identities in the United States. To assist the unhoused population in gaining stable shelter, housing, and basic needs, an abundance of programming has been implemented in the past few decades. However, few studies have directly compared outcomes between programs to evaluate associations with sustained housing stability.

Methods: This study applied the Theory of Fundamental Causes and the Housing First Model to the participants of Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) programs through a secondary analysis of Homelessness Management Information System data from August 2020-July 2023 to determine statistically significant associations between demographic, programmatic, and structural factors and a return to homeless within two years of program exit. Sequential logic regressions produced adjusted odds ratios (AORs) for homelessness recidivism in the overall sample, among PSH participants, and among RRH participants.

Results: Statistically significant differences were found in homelessness recidivism between participants in Permanent Supportive Housing (PSH) and Rapid Rehousing programs (RRH). The participants in RRH program were less likely to experience homelessness following program exit when compared to participants enrolled in PSH programs (AOR=0.58, $p<.01$).

Discussion: This study found that structural and programmatic factors had statistically significant associations with homelessness recidivism. These significant associations revealed important differences in the ways programs, prior experiences with homelessness, and aftercare can play in homelessness recidivism. The causes and effects of homelessness recidivism, including the social, structural, and programmatic determinants must be considered in future research evaluation housing programs for people experiencing homelessness.

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TABLE OF CONTENTS

CHAPTER I: Introduction

Introduction

As of January 2022, over half a million people are currently experiencing homelessness in the United States (Lanham, White, & Gaffney, 2022). Some of the risk factors leading to homelessness include substance abuse, poverty, lack of social support, and adverse life events (Lanham, White, & Gaffney, 2022; Nilsson et al. 2019; Tucker et al., 2022). Each of these may lead a person to no longer be able to find stable shelter, though the specific causes vary for every person experiencing homelessness (Lanham, White, & Gaffney, 2022; Nilsson et al. 2019; Tucker et al., 2022). The experience of homelessness has been associated with worsening health conditions and includes a disproportionate number of people with marginalized identities in the United States (Downes, 2023; State of Homelessness, 2023;Vaclavik et al., 2018). To assist the unhoused population in gaining stable shelter, housing, and basic needs, an abundance of programming has been implemented in the past few decades (Benson, 2015; Kaltsidis et al., 2022; Lanham, White, & Gaffney, 2022; Quinn et al., 2018; O'Campo et al., 2022). These programs include outreach services, housing programs, and emergency shelters (Benson, 2015; Kaltsidis et al., 2022; Lanham, White, & Gaffney, 2022; O'Campo et al., 2022). Each of these are intended to meet the person experiencing homelessness where they are and give them support and guidance to build stability (Benson, 2015; Kaltsidis et al., 2022; Lanham, White, & Gaffney, 2022; Quinn et al., 2018).

The process to access these services works similarly across the United States with steps that take someone from homelessness to housing. However, the demand for these services and affordable housing is greater than what is presently available within communities (Balagot et al., 2019; Ecker et al., 2022). These factors along with increasing rent and housing prices and

stagnation of the minimum wage has led to a marked increase in chronic homelessness. In this project, persons without stable housing will be referred to as homeless or person(s) experiencing homeless due to the homeless community's preference to be labeled as such (Abrams, 2023; Blanchet House, 2022). In the United States, a person is considered chronically homeless when they are homeless four or more separate instances in a 12 month period, or they are homeless for a total of 12 months (Dickson-Gomez et al., 2020; Ecker et al., 2022; Miterko & Brauna, 2022). Persons who are chronically homeless often have significant poor health outcomes due to the near constant stress from living with unstable or short-term housing (Dickson-Gomez et al., 2020; Ecker et al., 2022; Miterko & Brauna, 2022). This population is also considered more difficult to house as they often have severe and persistent mental illness (SPMI), substance use disorders, and physical or mental disabilities (Dickson-Gomez et al., 2020; Miterko & Brauna, 2022; O'Campo et al., 2022).

To access housing, a majority of people experiencing homelessness must undergo a Coordinated Entry (CE) assessment and a Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) to be placed on a housing priority list in their area (Balagot et al., 2019). Through these assessments, the person experiencing homelessness shares their housing history, personal demographics, mental or physical issues, and their current income or benefits with a social services worker. Next, a vulnerability score is calculated and they are placed on the prioritization list in their area (Balagot et al., 2019; Ecker et al., 2022). Each area in the US has a Continuum of Care (CoC) that manages the prioritization list for a city, county, or group of counties. All CoCs are overseen by the United States Department of Housing and Urban Development (Blanchet House, 2022). After completing an assessment and being placed on the priority list, the person experiencing homelessness can be placed in a housing program vacancy

(Ecker et al., 2022). Depending on the housing program, the person may be housed within a week, in 90 days, or may have to wait months after the referral to move into the housing program (Balagot et al., 2019; Ecker et al., 2022).

Housing Program Type Description

There are many types of housing programs within the United States, but this study will be focused on two types: Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH). Both of these program types are derived from the Housing First Model, meaning those referred to these programs do not need to meet sobriety, religious, or health criteria before being referred to housing (Tsembaris, Gulcur, & Nakae, 2004). The wide implementation of PSH and RRH programs in the US have made them the most common programs homeless adults are referred to and enrolled in (Jacob et al., 2022; Taylor & Johnson, 2023). These program types have been studied and compared in regards to their ability to improve the mental health, substance use, and income of clients (Quinn et al., 2018; Sullivan et al., 2023; Tiderington et al., 2020). However, PSH and RRH programs are rarely directly compared to determine their ability to assist clients in achieving and sustaining stable housing (Rodriguez & Eidelman, 2017). Additionally, previous comparisons of these programs have not determined which factors may predict successful exits or sustained housing stability (Byrne et al., 2021; O'Campo et al, 2022; Rodriguez & Eidelman, 2017; Semborski er al., 2021).

Further research is required to determine how these programs improve access, and maintenance of, stable housing. The purpose of this study is to compare participants in RRH and PSH programs in the Atlanta Continuum of Care to determine which factors are associated with successful program exits and sustained stable housing following program exit. Informed by the Theory of Fundamental Causes, this study aims to fill a gap in the research by evaluating the

success of clients exiting both types of programs and determining factors associated with sustained stable housing.

Theoretical Framework

Public and social programs centered on human behavior change have utilized a number of different theories as the foundation for their interventions. For housing and rental assistance programs, their interventions are driven by policy and social work practice (Bezgrebelna, 2021). In the past few decades, housing programs shifted from using a Treatment First approach, where participants must adhere to behavior change or substance abuse treatment before accessing housing, to using a Housing First Approach (Woodhall-Melnik, 2016). This has been adapted into what is presently known as the Housing First Model.

The Housing First Model (HF), was created by Dr. Sam Tsemberis after his own program, Pathways to Housing, in New York City implemented the model in the recruitment and care of his clients (Gillis, Dickerson, & Hanson, 2010; Tsemberis, Gulcar, & Nakae, 2004). The Housing First Model is based on a human-rights approach which views housing as a human right (Aubry et al. 2020; Gillis, Dickerson, & Hanson, 2010; Tsemberis, Gulcar, & Nakae, 2004). The values of housing first were novel at the time as most housing programs followed a treatment first approach (Aubry et al. 2020; O'Campo et al., 2022). For the treatment first programs, clients had to be sober from substance use or already accessing mental health treatment before being permitted access to housing. In other words, clients had to be 'housing ready' before getting housing, an approach that rarely led to clients maintaining stable housing (Aubry et al. 2020; O'Campo et al., 2022; Tsemberis, Gulcar, & Nakae, 2004). The housing first approach had a much higher percentage of clients maintain permanent or stable housing (80%) and a larger

proportion of clients in housing first programs were shown to continue substance use or mental health treatment when compared to treatment first programs (50%) (Downes, 2023).

Following the success of a HF approach in the Pathways to Housing program, this approach was adopted by other agencies across the US and studied by the Department of Housing and Urban Development (HUD) (O'Campo et al., 2022; Abt Associates, 2023). The report on HF was released in 2007, and since then a Housing-First approach has been the recommended model for all housing programs (Abt Associates, 2023). Presently, approximately 67% of all housing programs across the United States and Canada utilize a HF approach (Tsemberis, Gulcar, & Nakae, 2004). As such, both PSH and RRH programs are designed to follow a HF approach by not requiring clients to undergo treatment or be sober prior to attaining housing (Byrne et al., 2021; Gillis, Dickerson, & Hanson, 2010). The differences in these programs lie in their structure and the resources available to clients (Rodrigues & Eidelman, 2017). These differences in program offerings and outcomes are closely related to the flexible resources constructed and presented in the Theory of Fundamental Causes.

The Theory of Fundamental Causes (TFC) has been used to study and describe the effect of social mechanisms on disease outcomes (Phelan, Link, & Tehranifar, 2010). The theory, developed by Phalen and Link in 1995, called attention to the 'risk factor' approach to public health (Link & Phelan, 1995). TFC asserts that health outcomes cannot only be attributed risk factor exposure and instead, disease risk involves multiple pathways that are influenced by 'fundamental causes' and 'flexible resources' (Phelan, Link, & Tehranifar, 2010). The flexible resources described in TFC include knowledge, money, power, prestige, and beneficial social connections (Phelan, Link, & Tehranifar, 2010). To be considered a fundamental cause of disease, the determinant must have four essential features: 1) Fundamental social causes

influence multiple disease outcomes, 2) The disease outcomes are affected through multiple risk factors, 3) Access to resources that can be used to avoid risks or minimize the consequences of a disease once it occurs, and 4) The association between health and a fundamental cause is reproduced over time via the replacement of intervening mechanisms (Link & Phelan, 1995).

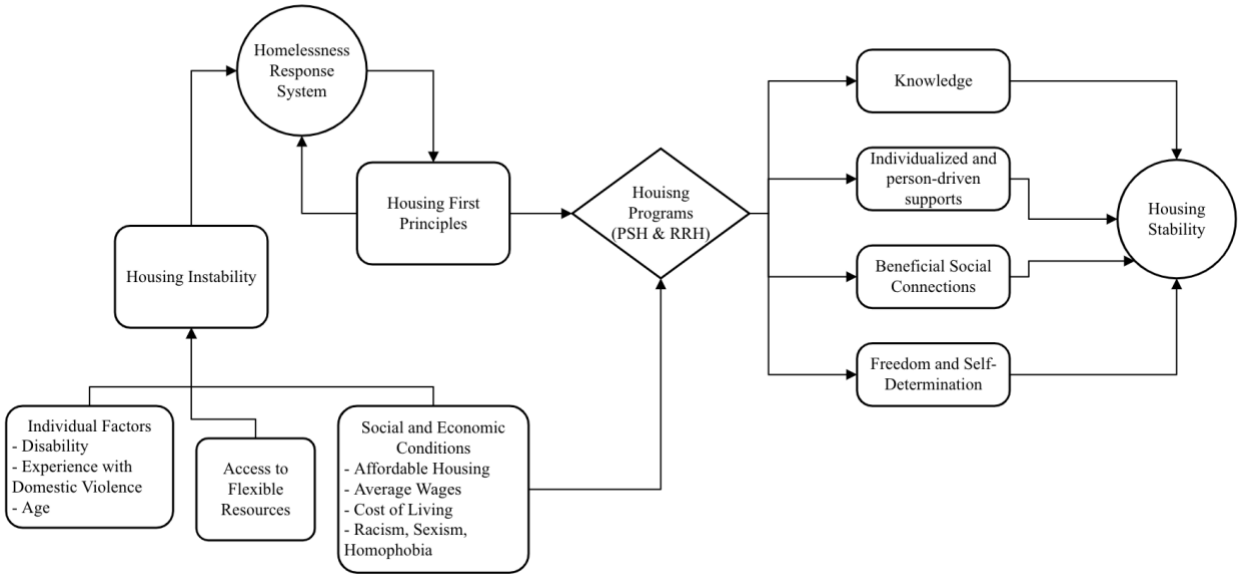
In their initial publication of TFC, Link and Phelan attribute socioeconomic status (SES) as a fundamental cause of disease. Since their initial publication of TFC, Racism has been recognized as a second fundamental cause due to the large and enduring connection between race and mortality in the US (Phelan & Link, 2015). Racism influences the use of and access to flexible resources through similar pathways as SES and affects access to flexible resources outside of the influences of SES (Phelan & Link, 2015). TFC demonstrates the mechanisms by which those with more flexible resources are better able to manage their health and social conditions.

The flexible resources described by TFC have been empirically measured and shown to make substantial difference in disease occurrence and mortality rates (Mackenback et al., 2017; Phelan & Link, 2005; Phelan et al., 2004). SES has remained a fundamental cause and demonstrated its persistent relationship with mortality rate. Since the development of the theory in 1995, new technology in medicine has been introduced to improve preventative and acute care, but the cost of using that technology perpetuates SES being a marker of health status. The only instance where the relationship has not been clear is with incurable diseases (Phelan, Link, & Tehranifar, 2010). Because these diseases cannot be prevented or predicted, those with a higher SES have indistinguishable outcomes from those with a lower SES as the flexible resources at their disposal are not useful in preventing the disease. The constructs and mechanisms of the TFC can be applied to the study and evaluation of housing programs.

There exists a large gap in the literature on the evaluation of housing programs and the comparisons of their success. Most of the research conducted on housing programs, people experiencing homelessness, and the housing system is atheoretical and does not consider the mechanisms or constructs of health behavior theory (Schutt & Goldfinger, 2009). The research that has been conducted to inform programs has typically focused on the individual level mechanisms influencing a homeless person's substance use, mental health, or social behaviors (Cummings et al., 2022; Shukla, Walsh, & Grande, 2023; Taylor & Johnson, 2023).

The gap in this evidence has led to a continued focus on the causes of chronic homelessness instead of investigations on necessary programmatic changes (Dickson-Gomez et al., 2020; Ecker et al., 2022; Jacob et al., 2022; Miterko & Bruna, 2022; Semborski et al., 2021). The flexible resources described in the Theory of Fundamental Causes offer a theoretical construct to apply to patterns of chronic homelessness. Both PSH and RRH programs are meant to house individuals and prepare them for permanent housing or transition them to stable housing. However, the way these programs work with clients to increase their power, prestige, knowledge, income/money, and beneficial social connections likely affects the client's ability to maintain stable housing following program exit. By examining the flexible resources of a person experiencing homeless as they enter, exit, and re-enter the housing system, areas for growth in program offerings or implementation will be shown. Figure 1 describes the theoretical framework for this study, an adaption of the Housing First Model and the Theory of Fundamental Causes to demonstrate the impact of housing programs on attaining housing stability.

Figure 1.



Research Question

This research aims to answer the following question: What structural, programmatic, and personal factors are associated with sustained housing stability between clients in Permanent Supportive Housing and Rapid Rehousing programs?

The study addresses the following aims:

1) To assess potential differences in client outcomes between housing programs
2) To examine the associations between program type, client characteristics, and sustained housing following program exit

Significance Statement

This project takes an innovative approach to the quantitative analysis of housing programs through the application of the Theory of Fundamental Causes. Though these programs

utilize a housing first approach, their mechanisms of improving client resources, connections, and education have not been compared. Previous evaluations of both PSH and RRH programs have not considered the influence of flexible resources on homelessness history or homeless recidivism. By taking flexible resources into account, this study presents new evidence for housing programs to take into consideration in their design and implementation.

Client circumstances prior to being enrolled in these programs has also not been explored. By utilizing quantitative analysis in the comparison of RRH and PSH programs, the Housing First Model and current housing system will be tested (Byrne et al., 2021; Tsemberis et al. 2004). The results of this study will provide the public health literature with evidence regarding the efficacy of current housing policy and programs.

To this end, the present study is intentional about understanding the specific interventions of each program and determining if the programs associated with homelessness recidivism differ significantly. This research takes a novel approach in utilizing a multivariable model to predict housing outcomes. By demonstrating the key differences between PSH and RRH programs within Atlanta, the Housing First Model will be tested. This research intents to add to the investigation of the implementation and effectiveness of current housing policy and homelessness interventions.

Definition of Key Terms

Department of Housing and Urban Development (HUD): The Federal agency responsible for national policy and programs that address America's housing needs, that improve and develop the Nation's communities, and enforce fair housing laws.

Homelessness Recidivism: In the present study it will refer to people experiencing homelessness who exited a housing program to stable housing but then lost stable housing again

Continuum of Care (CoC): Regional or local planning body that coordinates housing and services funding for homeless families and individuals

Chronically Homeless: Any person who has been unhoused for twelve consecutive months or had four occasions of homelessness in the last three years and is living with a disability

Permanent Supportive Housing (PSH): Permanent housing or housing with no pre-determined length of stay for chronically homeless individuals

Rapid Rehousing (RRH): Permanent housing that provides short term and medium term tenant based rental assistance and supportive services to households experiencing homelessness

Coordinated Entry Assessment (CES): Assessment developed by HUD and implemented in CoC's to ensure that all people having a housing crisis have fair and equal access and are quickly identified, referred, and connected to housing and assistance based on their strengths and needs.

CHAPTER II: Review of the Literature

Introduction

The following chapter provides an overview of the current research on housing maintenance after program exit among people experiencing homelessness in the United States. The chapter situates the current landscape within the Housing First Model and the Theory of Fundamental Causes (TFC). An overview of the scope of the problem of chronic homelessness is covered as well as the individual and structural causes of homelessness. This is followed by the structure, implementation, and evaluation of housing programs over the past thirty years. Current evidence for differences in program success are provided and explored within the TFC. Finally, evidence is presented for the relevance of applying the Theory of Fundamental Causes to housing program implementation and evaluation and a gap is identified.

The Scope of the Problem of Homelessness

The public health issue of homelessness has faced cities of all sizes and has been exacerbated over the past 30 years. Homelessness affects both the persons experiencing homelessness and the communities in which they live. The rates of homelessness have been increasing since the 1980s with rapid increases following major economic events such as the 2008 financial crisis and the COVID-19 pandemic (National Alliance to End Homelessness, 2023). To better understand the rise in rates of homelessness and the scope of this problem, a review of current and previous literature must be conducted.

Current perceptions and policies around housing and homelessness have been a direct result of shifts in economic policy and values from the Reagan era of 1981-1989 (Jones, 2015; Shinn & Weitzman, 1990). Prior to this era, there were unstably housed people living in central urban areas all across the US, but these groups of people were often able to find shelter outside of the streets and assistance from federal programs. Current research frameworks for homelessness came out of this time and homelessness began to be understood as an intersectional issue .

Historical Perceptions of Homelessness

The intersections of this issue include economic, social, and political causes (Dennis et al., 1991; Jones, 2015). In the 1980s, cuts to federal social and welfare programs led to numerous physically or mentally disabled individuals not being able to get the resources or support they had previous access to. This was compounded by an era of policies that deinstitutionalized mental hospitals in the late 1960s (Erickson, 2021; Segal, 1979). Though deinstitutionalization was absolutely necessary to maintain the civil rights of the residents of these facilities, the options for mental health supports were shifted to state and local programs. These programs did

not have necessary funding or resources to meet increasing community needs, leaving many without support.

The lack of support meant those with severe or persistent mental illness (SPMI) or mental disabilities began to be more prevalent within the homeless or severely poor population. Due to increases in those with SPMI within the homeless population, deinstitutionalization was cited as a potential cause of the rise in homelessness in the 1980s. Homeless populations began to be studied to determine the prevalence of SPMI and substance use or misuse. The disproportionate prevalence of these personal factors among homeless population fed into the idea or view that homelessness was a choice. This idea was promoted in multiple publications describing the experiences and history of unsheltered people living in areas such as Boston, Los Angeles, and New York City (Jones, 2015). These publications were then spread by the media of the time. The popularization of homelessness as a result of personal factors provided opportunities for federal and state entities to shift the blame of this problem to state hospitals, local programs, or the homeless individuals themselves.

Political Response to Homelessness

The academic community at the time pointed out the methodological flaws that led to some of these "victim blaming" findings in studies of homeless individuals. These publications and disputes led to increased pressure on the federal government to do something in response to the homelessness crisis. The Reagan Administration refused to intervene in this social issue and promoted the idea that homelessness was a problem of personal convictions or circumstance, not one with ties to structural causes. From this crisis, after much scrutiny in Reagan's second term, legislation was enacted to provide programs for homeless populations and promote research in this area (Jones, 2015; National Center for Homeless Education, 2023).

This legislation, the McKinney Act of 1987, is the foundation for much of the public programming being carried out today including funding for emergency shelters, expanded education and job training programs, and research through the National Institute of Mental Health on mental illness and substance use. The framing of homelessness as an issue related to mental illness and substance use has led to the majority of research on causes and problems related to homelessness being focused in these areas. There is a rich body of literature describing the feedback loop between trauma, homelessness, and substance use (Fisher & Breakey, 1985; Perry & Craig, 2015; Tsai et al., 2017). A discussion of this literature will be covered more extensively within the topic of individual, social, and structural causes of homelessness.

Summary of Immediate Health Impacts

Housing instability affects individuals in a multitude of ways and is considered a traumatic event (Brown et al., 2018; Mantell et al., 2023; O'Campo et al., 2022; Semborski et al., 2020). The lack of safety and stability in searching for shelter each night leads to chronic stress among persons experiencing homelessness. Additionally, the vulnerability of staying outdoors, in shelters, or in other places not meant for human habitation increases the likelihood of physical and sexual assault. The need to be hypervigilant of surroundings to maintain safety affects mental functioning and can lead to PTSD, depression, anxiety and other mental health disorders (Aldridge et al., 2018; Brown et al., 2018; Henkind et al., 2023). The persistence of negative life events among people experiencing homelessness has led to an increase in death by suicide and suicidal ideation among this population (Henkind et al., 2023; Gentil et al., 2021; Mantell et al., 2023; Rhoades et al., 2018). The repeated trauma of experiencing homelessness and traumatic events that may occur while experiencing homelessness has led to significant differences in life

expectancy, mortality, and accelerated aging among this population. These health effects demonstrate the need for experiences of homelessness to be considered a public health problem.

Accessibility of Affordable Housing

The problem of homelessness will likely worsen as the proportion affordable housing decreases and rent burden increases (Semarin & Sharma, 2023; Sharma & Semarin, 2022). Affordable housing is any housing that requires less than 30% of the monthly income of a renter. Units that are affordable are dwindling across the US, with housing becoming particularly unaffordable in coastal regions. To improve the availability of affordable housing and prevent homelessness, there have been a variety of affordable housing programs implemented in the US.

These affordable housing programs include Public Housing, the Housing Choice Voucher Program (Section 8), and Section 42 Housing or the Low Income Housing Tax Credit (Kalugina, 2016). These programs work via lottery system and either provides rent stabilized units at 30% of the tenants monthly income or provides vouchers to cover the remaining rent. These programs are meant to support those with extremely low incomes or assist in preventing eviction and homelessness.

However, the demand for these programs far exceeds their capacity and the units that could assist those with low incomes are usually unavailable (ABC News, 2023; Acosta & Gartland, 2021; Atlanta News First, 2023; Graves, 2016; King, 2023). This is in combination with increases in rent burdened households in the US, or households paying 30% or more of their income in rent. There have been increases in rent burden in both small and large cities, affecting the number of renters able to maintain housing (Sharma & Semarin, 2022; Semarin & Sharma, 2023; Seymour et al., 2020). Restrictions and regulations on rent increases does affect rent

burden, but due to pressures from building developers and landlords, there is seldom the political will to enact such policy.

Together, the factors around rent and housing affordability affect the problem of homelessness as those without housing are unable to access affordable housing for their income level. The lack of access to such housing prolongs the period of time a person is without stable housing. Prolonging this period of time increases their exposure to the mental health effects of being unhoused, increasing negative health outcomes. As we consider the scope of the problem of homelessness on the person experiencing homelessness and their community, we must next examine the individual and structural causes of homelessness.

Individual and Structural Causes of Homelessness

Determining the causes or risk factors of homelessness requires dissecting the connections across multiple levels of influence. Being unable to stay long-term in a place meant for human habitation is the cause of homelessness. However, the factors that affect the propensity for someone to become homeless are multi-level, interdependent systems and behaviors. These must be explored to gain a better understanding of how a person becomes homeless and why exiting homelessness presently is so difficult.

Individual Causes of Homelessness

Personal risk factors described in the literature include psychiatric or severe and persistent mental illness, substance use, lack of social support, history of foster care, and childhood household abuse (Batterham, 2017; Creech et al., 2015; Phillips, 2014). These behavioral and social conditions affect a person's ability to react to stressful situations, their resilience, and their ability to accurately perceive social situations. They have been identified as risk factors due to their disproportionate prevalence within homeless populations (Bassuk, Rubin L, & Lauriat, 1984; Patten, 2017; Winiarski et al., 2021). The most prevalent mental health disorders within homeless population include post-traumatic stress disorder (PTSD), anxiety, depression, and substance use disorder. These disorders are often the effect of stressful life circumstances and affect environmental perceptions and reactions. They influence a person's ability to find and maintain gainful employment or positive relationships. The loss of gainful employment or relationships causes a loss of housing either by eviction or through the end of the relationship with household members. When the person experiencing homelessness becomes unstably housed, these mental health disorders can make it harder to regain housing for similar reasons leading to a cycle or feedback loop of instability.

This feedback loop has been demonstrated in studies on homeless youth and homeless veterans (Creech et al., 2015; Fry et al., 2017; Liu et al., 2022; McQuinston et al., 2014; Wenzel et al., 1993; Winiarski et al., 2021). In both of these populations, a higher proportion of traumatic experiences has led to the development of severe psychiatric issues or other mental health disorders. Over 50% of homeless youth surveyed across multiple studies have reported experiencing a traumatic event or physical or sexual abuse prior to becoming homeless. Among veterans, this same disproportionate prevalence rate has been found time and again. The mental health issues prevalent within these populations draws attention to the lack of access to mental health services among the unhoused and, further, the barriers to accessing medical care generally. Lack of access leads to a high utilization of emergency rooms or emergency care within this population (Moore & Rosenheck, 2016; Willison et al., 2021). In reviewing emergency department use by persons experiencing homelessness, their disproportionate use of these services was mentioned in tandem with the factors that made emergency services one of the better options. These include lack of health insurance, lack of access to primary care or ambulatory services, and difficulty in transportation to medical appointments.

In addition to the mental health and well-being of persons experiencing homelessness, experiencing abuse in childhood, being involved in the foster care system, and adolescent traumatic experiences are considered personal risk factors for homelessness. These experiences are most often what those experiencing homelessness attribute their homelessness to (Mabhala et al., 2017). In interviews with homeless individuals, they describe the cause of their homelessness as connected to the lack of social support and limited resources available to these individuals in childhood.

These factors are prevalent within current foster youth and disproportionate numbers of youth have mental health disorders or have experienced homelessness (Cummings et al., 2022; Fowler et al., 2017). The experiences of foster youth greatly affect their cognition and mental function to make them significantly different from their peers (Fry et al., 2017). Then as these youth age out of the foster care system and lose social support, they become more likely to experience homelessness. Among youth who exit foster care, between 33%-50% experience homelessness before they turn 25 (Fowler et al., 2017). The lack of a support network outside of the foster care system in combination with difficulty in accessing social services is likely what creates the conditions for the high rates of homelessness within this population.

Limitations of Individual Causes

Although these personal factors have been consistently identified within the literature as characteristics that are associated with experiences of homelessness, their ability to be targeted by interventions and prevent homelessness is uncertain (Betterham, 2017; Rankin, 2019; Rent, 2023). These factors provide insight on the persons experiencing homelessness, but they do little to describe how support in these areas would prevent homelessness. Thus, there is a debate within the literature on the level of influence that should be targeted in homelessness prevention interventions. This discussion is in tandem with changing political perceptions of the homeless population as the people experiencing homelessness become more or less visible in urban and suburban areas (Betterham, 2017; Main, 1996). For instance, in the 1980s and 1990s, the interventions developed to prevent homelessness mostly focused on these personal factors, encouraging substance use treatment programs and mental health services. It was thought that if individuals were “housing ready,” it would be easier to find and maintain stable housing (Tsai,

2020). However, these interventions did not improve access to housing, meaning the population of people experiencing homelessness generally remained the same.

Structural Causes of Homelessness

The structural causes of homelessness are namely the policies and programs that affect access to housing, the cost of housing, and maintaining housing. These causes are economic, political, and social in nature. As with all the causes of homelessness, the status of one factor influences another making the specific mechanisms of causation difficult to discern. These structural mechanisms are demonstrated through labor market trends, the benefits cliff, affordable housing policy, and increasing rent burden. Together, these factors make the ability to regain stability in housing and income increasingly more difficult than losing housing stability.

Trends in the labor market and job prospects directly affect the ability for persons to find and maintain gainful employment. Since the 1980s there have been significant changes within the labor market affecting wage inequity and stagnation (Gravelle, 2020; Hill, 2023). The most notable change from this time to present day has been the growth of technology and technological changes. As the utilization of technology increased, the need or demand for skilled labor began to outpace the demand for unskilled labor. This was in combination with increasing globalization and the decrease in labor unions affecting the ability of unskilled laborers to advocate for fair wages. The federal minimum wage has not been increased since 2009, and though many states or municipalities have set their own minimum wage, this is often the rate available to persons experiencing homelessness in unskilled labor. Increases in the minimum wage have been proposed as an intervention to decrease rates of homelessness but due to the relationship between wages, housing prices, and rent, this intervention may have an inverse effect.

To supplement their income and maintain the ability to provide for basic needs, individuals with low or extremely low incomes can apply for and receive benefits through federal, state, or local programs (Dillard & Mers, 2023). These programs can include the Supplemental Nutrition Assistance Program (SNAP), Women, Infants and Children (WIC), Temporary Assistance for Needy Families (TANF), Medicaid, or Social Security Disability Insurance (SSDI/SSI). Each of these programs is designed to assist Americans living slightly above, at, or below the federal poverty line subsidize their basic needs (Anderson et al., 2022; Richardson & Blizard, 2022). However, as their income increases, they no longer meet the qualifications to receive these benefits and they lose monthly subsidies. The design of most of these programs is such that when a person no longer qualifies, they lose all of their benefits instead of their monthly benefit gradually being decreased.

The sudden loss of benefits is what is known as the 'benefits cliff' and affects many low income Americans, including people experiencing homelessness. The benefits cliff means that as a person living around the poverty line gains promotions or increases their wages, they lose their monthly income as the benefit subsidy covers more than their increased wages (Ballentine et al., 2022). The steepness of benefits cliff or drop-off in supportive subsidies varies by the benefit programs offered in each state and municipality. Overall, for those living around the poverty line to overcome this cliff (have a monthly income greater than their monthly benefits) they would have to receive wages 2 to 4 times the federal minimum wage (Anderson et al., 2022).

This benefits cliff works in tandem with the stagnation of wages for unskilled workers as earning higher wages decreases the amount available to people living in this income threshold. The cliff has been regarded as a disincentive for people living in extreme poverty to earn higher wages, a consideration that is reminiscent of the 'welfare queens' of the 1980s and a fear of

benefit programs for people in poverty (Dillard & Mers, 2023). Instead, the benefits cliff illustrates the age of these benefit programs and their inability to be flexible to economic changes. The benefits cliff also shows the widening gap in wealth inequality in the US and the difficulties in finding employment that pays a livable wage.

For those living close to the poverty line who are unable to work, they likely rely on a fixed income through SSI or SSDI and are unable to have additional outside income. Among persons experiencing homelessness, the SSI/SSDI Outreach, Access, and Recovery (SOAR) program has been implemented by the Substance Abuse and Mental Health Services Administration (SAMHSA) to improve access of homelessness persons to SSDI benefits (Lowder et al., 2017). However, the benefits and fixed income provided by these programs becomes a barrier to housing as average rent continues to increase in the US. The median rent in the US currently stands at $2,011 a month (Leckie, 2023). This is about two times the maximum monthly income of a person working 40 hours a week on the federal minimum wage.

These factors together demonstrate the effect of rising rents on both those working in unskilled labor and those living on a fixed income. Both of these populations are in need of affordable housing options to down their rent burden and prevent homelessness. However, as previously discussed, the options for affordable housing are limited with waitlists in most municipalities closed or taking years to process through (ABC News, 2023; Acosta & Gartland, 2021; Atlanta News First, 2023; Graves, 2016; King, 2023). The demand for affordable housing far exceeds supply, leading to many losing housing and experiencing one or more episodes of homelessness. These episodes repeat as people are unable to attain gainful employment, cannot make enough income to afford basic needs or rent, and lose their housing while waiting for affordable housing options.

Influence of COVID-19 Policy

The influence of economics and politics on homelessness were illuminated during the COVID-19 pandemic as many were unable to maintain their employment (Baggett & Gaeta, 2021; Cawley et al., 2022; Perri et al., 2020; Ralli et al., 2021; Wiessing et al., 2021). During this time, eviction moratoriums were passed to prevent those unable to work due to the pandemic from becoming homeless. Additionally, many of those working in unskilled labor began to be considered essential workers and wages for those working became scrutinized. Finally, this period demonstrated the power of policy to prevent homelessness as millions of dollars became available within communities to provide or extend rental assistance (Reina et al., 2021; Reina & Lee, 2023).

The pandemic illuminated the state of employment, wage stagnation, rent burden, and homelessness in areas across the US and demonstrated the power of policy to intervene in this issue. This time also spurred researchers to determine the effect of this increase in available funds on communities and programs (Reina & Lee, 2023). Since then, there has been cross-sector analysis of the intersections of these issues and how they each contribute to the current state of homelessness and housing systems with recommendations to policy makers.

Difficulty in Assigning Causes to Homelessness

Altogether, determining causes of homelessness requires an understanding of how each of these factors intersect with each other to make a person more vulnerable to experiencing homelessness. It is not just a person's mental health, traumatic history, or substance use that affects their likelihood to experience homelessness, it is also the jobs and wages available to them in their city, the cost of housing in their community, and the support available to them both politically and socially that can make someone more or less likely to experience homelessness.

Each of these factors also affects their ability to exit homelessness and maintain stable housing making it more difficult to become stably housed than to lose housing. Thus, the causes of homelessness together form a feedback loop or downward spiral where it can feel impossible to alter course. This is precisely why ‘solving’ or ‘ending’ homelessness is incredibly difficult.

The system that has been implemented to address homelessness reflects this complexity in an attempt to help people experiencing homelessness find and become stably housed. The homeless response system was built out of the programs implemented by religious institutions during the rapid rise in homelessness in the late 1980s. As the understanding of the homeless population improved, these programs became a part of a larger response system for people experiencing homelessness. An exploration of the history and current implementations of housing programs is needed to demonstrate how the present system is working to address some of the causes of homelessness.

Structure, Implementation, and Evaluation of Housing Programs in the US

A contemporary understanding of the homelessness response system requires an examination of the structure and implementation of housing programs over the last few decades. This will include an overview on the historical foundations of these programs, their funding mechanisms, target populations, and reasonings for specific programmatic components.

As previously discussed, much of the current homelessness response system infrastructure was not implemented until the late 1980s and early 1990s (van Hoffman, 2012; Nelson et al., 2021). The novelty of the structures and systems used to respond to people experiencing homelessness has also affected the frequency and quality of program evaluations. Additionally, determining the historical foundation of these programs is difficult due the overlap of housing with economic will and shifts in political power. Prior to the 1980s, much of the shelters and resources available to those experiencing homelessness were provided by religious organizations or small non-profits. These shelters were seen as sanctuaries for those without homes and served mostly as connection points to other services. During this time, housing policy was mostly focused on helping Americans purchase homes and ensuring equality in housing access.

The programs related to housing and homebuying at the time were all directly funded and managed by federal programs, there were not programs directly targeting the unhoused (van Hoffman, 2012; Listokin, 1991). These included the public housing projects passed under President Franklin Delano Roosevelt and the Housing Choice Voucher Program (Section 8) passed by President Nixon. This was also a period where low income housing was being built in cities to increase supply of housing. As Reagan entered office, building projects were rapidly cut, affecting the supply of available housing.

Though these programs remain active, changes in budget priorities and admission to these programs, as well as the rapid decline in available units in the early 1990s led to the implementation of new housing program models (van Hoffman, 2012; Locke & Khadduri, 2007). These models were primarily funded through the McKinney-Vento act and fall into two distinct categories: treatment-first and housing-first. These two program models differ in their dogmas of what people experiencing homelessness need to be successful or achieve housing stability (Locke & Khadduri, 2007; Owadally & Grundy, 2023; Tsai et al., 2010).

Treatment First Program Approaches

The first of these is the treatment first (TF) approach or Traditional housing program. The treatment-first approach is derived from the belief that personal factors such as mental health issues or substance use are the cause of a person's homelessness. Thus, by solving for these personal factors, the person experiencing homelessness will be able to find and maintain stable housing. In the programs derived from this model, participants are required to undergo residential mental health or substance use treatment as a part of the program (Henwood et al., 2011; Hsu et al., 2021; Latimer et al., 2019). These programs work by moving participants from temporary shelters to transitional housing or supervised residential settings, and then finally to permanent housing.

The program follows a staircase model such that as the person experiencing homelessness completes more mental health or substance use treatment, they gain more independence. At the end of their treatment, they have increased their "housing readiness" and are considered ready for full independence in a permanent housing placement (Henwood et al., 2011; Locke & Khadduri, 2007). However, if they fail to meet program rules or requirements at any time in the program, they are asked to leave and sacrifice their housing in the process. Though these

programs have many components, their emphasis on treatment as the first step in achieving housing stability is why they are considered “treatment-first” models.

Treatment-first programs were the standard of care for much of the 1990s. This is the reason treatment-first programs are often considered the “traditional” housing program (Henwood et al., 2011; Tiderington et al., 2020). Though they were the standard, these types of programs left many without housing, due to the staircase model, specifically those less able to maintain mental health or substance use treatment (Tsemberis et al,. 2004). The inability of these programs to keep participants from vulnerable populations housed led to the creation of a new model for housing: housing first.

Housing First Program Approaches

The Housing First (HF) Model was developed in direct contraction to TF as a way to provide housing for those unable to stay housed in the staircase model. In these programs, housing is considered the first step in transitioning a person experiencing homelessness to stable housing. These programs provide support and treatment to participants if they are in need of it, but their housing is not dependent on their participation (Pina & Priog, 2019; Souza et al., 2020; Tsemberis et al., 2004; Tsai et al., 2010). This model was implemented in the Pathways for Housing program in New York City with chronically homeless participants to great effect, showing better housing outcomes for those who were previously considered difficult to house. The outcomes associated with this model were met with enthusiasm and soon cities across the country began testing their own programs using a Housing First Model (Jacob et al., 2022; Loubiere et al., 2022).

Following improvements in the rates of stable housing in these cities, HUD published a report describing the applicability of HF models to homeless persons with severe and persistent

mental illness (Pearson et al., 2007). In this report, HUD described an evaluation of housing first programs across the country and provided recommendations for wider implementation. This report, along with increasing evidence in the effectiveness of the Housing First Model has made this model the most commonly used in the development and implementation of housing programs (Leclair et al., 2019; Ly & Latimer, 2015; McDonald et al., 2009). Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) have been adapted from the Housing First Model.

History of Program Funding and Program Differences

The history of housing programs stretches back to the 1980s, but the programs based on housing first were developed and implemented in the early 2000s. Two of these housing programs, Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) are the subject of this study. Permanent supportive housing was developed and implemented as a part of the McKinney-Vento funding shortly after the recommendations from HUD on the Housing First Model (Person et al., 2007; Locke & Khadduri, 2007). These programs primarily house people experiencing chronic homelessness, special populations, or those with severe and persistent mental illness. Special populations include homeless veterans and people living with HIV/AIDS. The programs for special populations are funded by additional federal agencies in collaboration with HUD such as the Department of Veteran Affairs. These programs include additional enrollment requirements and activities tailored to the population they are intended to serve.

Permanent Supportive Housing (PSH) began being rapidly implemented in communities in the early to mid-2000s. These programs are either scatter site or residential programs with wraparound services such as case management, life skills training, and mental health services (Hsu et al., 2021; Loubiere et al., 2022; Souza et al., 2020). PSH programs are designed and

intended to have the capacity to provide these additional services to people experiencing homelessness due to the populations they are intended to serve: the chronically homeless, those with severe and persistent mental illness, or those who are homeless and physically disabled.

Rapid Rehousing programs are different than permanent supportive housing as they target different populations and provide funding for prevention efforts – working in a different area of the homelessness response system. Rapid Rehousing (RRH) is structured to serve those who are not previously homeless and in some communities provides funding for rental assistance or the prevention of homelessness. RRH programs were funded through the Homeless Prevention and Rapid Rehousing Program in 2009 in response to the 2008 financial crisis (Gubits et al., 2018). The purpose of this funding was to keep individuals and families from experiencing long-term homelessness. The funding can be used in homeless prevention programs to provide rental assistance to those who may be evicted and lose housing and to pay for rental deposits for those seeking housing (Cunningham & Batko, 2018; Gurdak et al., 2022; Vaclavik et al., 2018; Youngbloom et al., 2022). The purpose of the program was to help individuals and families exit homelessness as quickly as possible. The intention of RRH was for it to be used by those who are experiencing homelessness for the first or second time. In this way, the program is considered an upstream intervention as it is working to prevent recurrent homelessness.

Historical Evaluation of Housing Programs

Evaluations of PSH and RRH programs are rarely conducted after the programs have been established by HUD and regulated by community Continuums of Care. The diversity in program implementation and definitions of success across these programs based on geography or standards given by the CoC adds nuance to evaluation processes and results (Burt et al., 2016; Byrne et al., 2023; Goering & Streiner, 2015). The evaluations of PSH and RRH programs stem

from HUD standards and mostly focus solely on outcome evaluation, namely how well both programs do at assisting their participants, people experiencing homelessness, in attaining and maintaining stable housing following program exit (King, 2018; Vaclavik et al., 2018). The lack of process evaluation within the literature demonstrates a gap in understanding how the enrollment of people experiencing homelessness into PSH and RRH programs affects their ability to achieve stable housing. Furthermore, by only evaluating one or two key outcomes of these programs, the health related effects of housing are not documented. To that end, the previous evaluations of PSH and RRH programs provide mixed evidence on which program produces better outcomes for participants.

Current Evidence for Differences in Program Success

Altogether, Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) programs are not equally able to help clients achieve housing stability. The differences in client outcomes are tied to program development, implementation, and activities, but the details of these programs are hard to discern (Winship, 2001; Finkel et al., 2016). The evidence for program success lack consistency due to missing evaluation frameworks, the lack of a theoretical foundation to these programs, the lack of fidelity to housing first principles, and the diversity in the implementation of housing programs (Burt et al., 2016; Finkel et al., 2016; Slesnick et al., 2023; Wallace et al., 2020). Essentially, the evidence that could be used to determine whether PSH or RRH programs are better suited to provide participants with the means to achieve housing stability were not considered in program development, and thus are not components of the program, and change based on geographic location (Fowler et al., 2019; Meschede & Chaganti, 2015; Slesnick et al., 2023). Furthermore, the referral system clients use within the homelessness response system to become enrolled in these programs may hamper their evaluation.

The Coordinated Entry System

The referral system used within the homelessness response system is the Coordinated Entry System (CES). This system has been implemented in Continuum's of Care (CoC) across the United States to improve access to housing programs. It is intended to ensure those who are most in need or most vulnerable, are more likely to be placed in a housing program. Each CoC structures their CES based off of the programs in their community. After completing an assessment for the CES, persons experiencing homelessness are placed on a priority list and may have to wait months for a referral (Selsnick et al., 2023; Srebnik et al., 2017). In the Atlanta

CoC, persons experiencing homelessness usually use that time to gather their vital documents as they cannot be referred to a housing program without all their vital documents (Rockwell Heard, 2023). These documents include their birth certificate, driver's license, and social security card. The piece of the CES assessment that is meant to assess the level of vulnerability of a person experiencing homelessness in the Atlanta CoC is the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI_SPDAT). A higher score on the VI-SPDAT indicates a person experiencing homelessness has higher vulnerability and should be referred quickly (Balagot et al., 2019; Ecker et al., 2022). Yet, due to the high demand of these programs and short supply of housing, even those with a high VI-SPDAT score often have to wait months before being referred.

In the Atlanta CoC, the waiting period between assessment and referral for PSH programs is around 6 months and is even longer for RRH programs (Rockwell Heard, 2023). This wait time can affect the assessment of chronic homelessness within the population as a person may not fit the definition at the time of their assessment, but after waiting for placement, be able to be considered chronically homeless, changing the number of programs they are eligible to be referred to. Additionally, the validity and reliability of the Vulnerability Index-Service Prioritization Decision Assistance Tool has been called into question as the scoring is done by a trained assessor and all the information is self-report (Brown et al., 2018; Hill et al., 2022; Osborne, 2019). The tool has led to increased disparities in who among the homeless population is referred to housing. The discretion of CES assessors in assessments often reinforce harmful stereotypes about who is 'fit for housing' meaning that those who are truly vulnerable are perhaps not always reflected as such in the Coordinated Entry System.

Program Implementation

An additional component that demonstrates why there may be differences in program success is the implementation of programs. In evaluations of RRH programs, HUD demonstrated that there is little consistency between RRH program components in the US (Burt et al., 2016; Finkel et al., 2016). All programs provide rental assistance and case management, but the programs are different beyond that. This may be positive in demonstrating the flexibility of RRH programs to adapt their resources to their community, but negative in that the program titles do not necessarily describe the same program components or activities between communities. This adds nuance to distinguishing between programs and evaluating their ability to keep participants stably housed.

This lack of consistency is reflected also in PSH programs, making the definition of these programs and their components increasingly variable dependent on geography (Ecker et al., 2022; Petry et al., 2021; Rice et al., 2018). Altogether this means that there may be differences between homelessness recidivism between PSH and RRH programs in some communities in the US, and no differences in others. This is an issue because these programs are intended to work with different populations, and a lack of difference demonstrates that these programs are not working as intended. The lack of consistency in implementation across these programs is likely due to a missing theoretical framework as the foundation for these programs. An exploration of the Theory of Fundamental Causes as a theoretical framework is necessary to fill this gap.

Theoretical Framework and Application

Both Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) programs are derived from the housing first model. However, the Housing First Model does not have any mechanisms of action or specific concepts tied to it (Osborne, 2019; Slesnick et al., 2023). The housing first model does have principles that may inform programs, but there are not any connections between these principles and specific concepts, constructs, or activities. Thus, being "housing-first" has become something of a buzzword, as all housing programs claim to be enacting these principles. Ultimately, there is consistently low fidelity to such principles in program implementation (Burt et al., 2016; Finkel et al., 2016). Furthermore, the lack of concepts and constructs tied housing program components leaves little area for process evaluation or innovation. The reasoning behind housing programs is left unanswered, and programs are without theory to describe how they are keeping people experiencing homelessness from experiencing homelessness again following program exit.

In this study, the Theory of Fundamental Causes (TFC) will be used to describe the how and why of housing programs, as well as discern why there may or may not be differences in housing success. As described in Figure 1, the Theory of Fundamental Causes provides a framework for understanding how these housing programs are affecting participants to improve their access to flexible resources. The TFC was developed by Link and Phelan to demonstrate how those with lower SES had consistent higher mortality rates throughout time and technological advances (Phelan et al., 2010).

The TFC describes how it is not only structural factors affecting mortality but also personal and social factors. The TFC posits that the gaining and use of flexible resources by an individual or community is what affects access to improved health and decreases mortality rates.

These flexible resources include knowledge, money, power, prestige, and beneficial social connections (Phelan et al., 2010; Riley, 2020). The authors describe the fundamental cause able to affect each of these resources at the time as SES, but have since also attributed Race and Gender as fundamental causes of disease or disparities in disease mortality (Clouston and Link, 2021; McCartney et al., 2021).

The Theory of Fundamental Causes has been tested repeatedly since its inception in 1995 and has emphasized the strong relationship between SES and mortality time and again (Clouston et al., 2020; Mackenbach et al., 2017; Masters et al., 2015). TFC has been used since to describe additional disparities in health and help healthcare providers improve their perceptions or programs targeting disease disparities (Boyd et al., 2021; Link et al., 2008; Reich et al., 2016; Riley, 2020; Zelner et al., 2023). The Theory of Fundamental Causes has not been used or implemented as a theoretical foundation to housing, but the flexible resources outlined in the theory may illuminate the mechanisms of action in housing programs, demonstrating the reasoning and processes of these programs in their work to prevent homelessness recidivism.

Specifically, the TFC demonstrates the importance of socioeconomic status in improving health (Nelson et al., 2012; Rice et al., 2018; Wallace et al., 2020). The way housing programs improve their SES and flexible resources is by providing a stable place to live and connections to additional support. Essentially, these programs should be focused on measuring and improving the knowledge, money, power, prestige, and beneficial social connections of participants to improve their resilience to disease or health challenges affecting their rates of mortality. Since both PSH and RRH programs provide participants with a case manager, they are improving participants knowledge and beneficial social connections (Brown et al., 2017; Slesnick et al., 2023). However, RRH programs provide rental assistance, also improving the participants access

to money (Burt et al., 2016). The different ways these programs affect the participants flexible resources is one of the reasons there may be differences in program success and the TFC provides a theoretical framework for understanding the mechanisms of action for these programs.

Summary of the Current Problem

A review of the present literature demonstrates the gap in understanding between housing implementation and outcomes. A history of programs in the US over the past three decades illustrated the change in the understandings of the causes of homelessness and the priorities of the homelessness response system to decrease rates of homelessness. Programs targeting people experiencing homelessness and the homelessness response system were developed in reaction to changes in policy and funding, they were not developed using program planning frameworks and lack theoretical foundations. Though present programs claim to be derived from a theoretical model, there is a marked lack of consistency in program structure and components. Furthermore, the current referral process to these housing programs has led many to be referred to programs misaligned with their needs, likely resulting in increases in homelessness recidivism. Utilizing the Theory of Fundamental Causes in the evaluation of these program outcomes will provide novel evidence supporting differences in program outcomes and illuminate areas of improvement in program implementation.

CHAPTER III: Methods

Introduction

Study Purpose

The purpose of this study was to investigate differences in successful housing outcomes between participants in either Permanent Supportive Housing and Rapid Rehousing programs in the Atlanta, Georgia Continuum of Care (CoC) from August 2020 to July 2023. This study aimed to fill a gap in the literature by determining the affect size of program components themselves or individual factors on the ability of participants to maintain stable housing following housing program exit. In addition, this study was able to shed light on the processes within the homeless response system in Atlanta, Georgia, and demonstrate gaps in providing services to persons experiencing homelessness in the Atlanta area.

This study was a secondary analysis of Homeless Management Information System (HMIS) data collected by case managers and homeless response system staff on participants in the homeless response system from 2020 to 2023. An agreement to use HMIS data was made between the primary investigator and the Atlanta Continuum of Care Collaborative Applicant, Partners for Home, prior to data dissemination. Though the data used for this study centers around participant experiences in the Atlanta CoC, the results of this study may be generalizable to other CoC's due to standards of the homelessness response system enforced by HUD. The study was theoretically grounded in the Theory of Fundamental Causes as described in Chapter One. This research sought to answer the following research question: What structural, programmatic, and personal factors are associated with sustained housing stability between clients in Permanent Supportive Housing and Rapid Rehousing programs?

Research Aims

The study was designed to address the following two research aims:

1) To assess the difference in client outcomes between housing programs
2) To examine the relationship between program type, client characteristics, and sustained housing following program exit

Human Subjects Approval

This thesis project is a secondary analysis of HMIS data on participants in Atlanta area housing programs from 2020-2023. All program participants agreed to the use and sharing of their data in HMIS during program enrollment, a copy of the agreement and notice visible to participants can be found in Appendix A. The form available to program enrollees to opt out of data sharing can be found in Appendix B. Due to the sensitive nature of this data, all identifiable information of participants from these programs was removed prior to data dissemination. Based upon the Non-Human Subjects Research Determination form made available by the Emory University IRB Emory University's Institutional Review Board deemed this project "non-human subjects research" (see Appendix C). Thus, no additional IRB approval was required for this study.

Population and Sample

The population used in this study is single adult heads of household who are participants of Permanent Supportive Housing (PSH) or Rapid Rehousing (RRH) programs in the Atlanta CoC who exited those programs from August 1st 2020 to July 31st 2021.

The sample was collected from data in the Homeless Management Information System detailing enrollments, exits, and coordinated entry assessment of all persons in the Atlanta Homelessness Response System from August 1st 2020 to July 31st 2023. This data was entered by case managers of the PSH and RRH programs operating during this time through the self-report of their participants/clients. Demographic data and housing history was collected as a part of every enrollment and assessment of participants. The sample includes those who were exited from either program between August 1st 2020 to July 31st 2021 to permanent housing. From this sample, two comparison groups were determined: those who re-entered the Atlanta Homelessness Response System within two years, and those who remained stably housed.

Measures

Homelessness Recidivism

The outcome variable addressed by this study is homelessness recidivism. Homelessness Recidivism was measured by comparing the Personal ID's of participants who exited either PSH or RRH programs with those who re-entered the Atlanta Homelessness Response System. The variable was dichotomous, with participants who re-entered coded 1 and those who did not coded 0.

Personal Demographic Characteristics

In this study the primary demographic variables of interest were racial identity, gender identity, persons with disability, experience of domestic violence, and age.

Racial Identity was measured categorically with a single question: "Race and Ethnicity: Select all that Apply," with response options "American Indian, Alaska Native, or Indigenous," "Asian or Asian American," "Black, African American, or African," "Native Hawaiian or Pacific Islander," "White," "Client doesn't know," "Client refused," or "Data not collected." This variable was recoded to consolidate response options to include 1= Black, African American, or African, 2=Other, 3=White.

Gender Identity was measured categorically with a single question: "Gender: Select all that Apply," with response options "Female," "Male," "A gender other than singularly female or male (e.g., non-binary, genderfluid, agender, culturally specific gender)," "Transgender," "Questioning," "Client doesn't know," "Client refused," or "Data not collected." This variable was recoded to consolidate response options to include 1=Female, 2=Male.

Persons with Disabilities was measured categorically with a single question: “Disabling Condition:” with response options “No ,” “Yes,” “Client doesn’t know,” “Client refused,” “Data not collected.” This variable was recoded to consolidate response options to include 0=No, 1=Yes.

Experience with Domestic Violence was measured categorically with a single question: “Is this Client a Survivor of Domestic Violence?:” with response options “No ,” “Yes,” “Client doesn’t know,” “Client refused,” “Data not collected.” This variable was recoded to consolidate response options to include 0=No, 1=Yes.

Age was captured by date of birth and computed to a numerical value in years according to their exit date. This variable was recoded categorically by quartiles of partipants in the population of interest with participants 18-32 years old=1, 33-45 years old=2, 46-58 years old=3, 59-80 years old=4.

Explanatory Factors

Program type was captured by the Project ID associated with participants enrollment. It was recoded to PSH=1 and RRH=2.

Previous Living Situation was measured categorically with a single question: “Prior Living Situation:” with response options “Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter,” “Transitional housing for homeless persons (including homeless youth),” “Permanent housing (other than RRH) for formerly homeless persons,” “Psychiatric hospital or other psychiatric facility,” “Substance abuse treatment facility or detox center,” “Hospital or other residential non-psychiatric medical facility,” “Jail, prison, or juvenile detention facility,” “Client doesn’t know,” “Client refused,”

"Rental by client, no ongoing housing subsidy," "Owned by client, no ongoing housing subsidy," "Hotel or motel paid for without emergency shelter voucher," "Foster care home or foster care group home," "Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)," "Safe Haven," "Rental by client, with VASH housing subsidy," "Rental by client, with other ongoing housing subsidy," "Owned by client, with ongoing housing subsidy," "Long-term care facility or nursing home," "Rental by client, with GPD TIP housing subsidy," "Residential project or halfway house with no homeless criteria," "Rental by client, with RRH or equivalent subsidy," "Host Home (non-crisis)," "Rental by client, with HCV voucher (tenant or project based)," "Rental by client in a public housing unit," "Staying or living in a family member's room, apartment, or house," "Staying or living in a friend's room, apartment, or house." The variable was recoded to consolidate response options and collapsed options into HUD Homelessness, Housing with Program/Subsidy, Institutional Setting, Stable Housing.

Length of Time Homeless was measured categorically through a single question: "Length of stay in the prior living situation:" with response options "One night or less," "Two to six nights," "One week or more, but less than one month," "One month or more, but less than 90 days," "90 days or more, but less than one year," "One year or longer," "Client doesn't know," "Client refused," "Data not collected." The variable was recoded to consolidate response options and collapsed options into Less Than One Week, Between One Week and 90 Days, 90 Days or More but Less Than One Year, One Year or Longer.

Days in Program was captured by entry date and computed to a numerical value according to their exit date. This variable was recoded categorically by quartiles of participants in the population of interest with days being 0-113, 114-272, 273-471, 472-4595.

Destination following Program Exit was measured categorically with a single question: "Exit Destination:" with response options "Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter," "Transitional housing for homeless persons (including homeless youth)," "Permanent housing (other than RRH) for formerly homeless persons," "Psychiatric hospital or other psychiatric facility," "Substance abuse treatment facility or detox center," "Hospital or other residential non-psychiatric medical facility," "Jail, prison, or juvenile detention facility," "Client doesn't know," "Client refused," "Rental by client, no ongoing housing subsidy," "Owned by client, no ongoing housing subsidy," "Hotel or motel paid for without emergency shelter voucher," "Foster care home or foster care group home," "Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)," "Safe Haven," "Rental by client, with VASH housing subsidy," "Rental by client, with other ongoing housing subsidy," "Owned by client, with ongoing housing subsidy," "Long-term care facility or nursing home," "Rental by client, with GPD TIP housing subsidy," "Residential project or halfway house with no homeless criteria," "Rental by client, with RRH or equivalent subsidy," "Host Home (non-crisis)," "Rental by client, with HCV voucher (tenant or project based)," "Rental by client in a public housing unit," "Staying or living in a family member's room, apartment, or house," "Staying or living in a friend's room, apartment, or house." The variable was recoded to consolidate response options and collapsed options into HUD Homelessness, Housing with Program/Subsidy, Institutional Setting, Stable Housing.

Data Analysis Methodology

Databases and Integration

Data was prepared and disseminated according to the Department of Housing and Urban Development (HUD) guidelines. Altogether, nine comma separated value datasets were shared to the primary investigator. These datasets included the Assessment, Client, Current Living Situation, Employment Education, Enrollment, Event, Export, HealthDV, Project, and Services reports. Of these nine reports, all but the Export and Services report was used in the preliminary and primary data analyses. The Export and Services reports do not describe clients or activities within the population of interest and are thus not relevant to the current investigation and excluded from analyses. New data sets with combinations of variables from these reports were created to reflect the experiences of persons experiencing homelessness in Permanent Supportive and Rapid Rehousing programs in the Atlanta Continuum of Care.

Preliminary Analyses

Data analyses were conducted using Statistical Analysis System (SAS) version 9.3. Guidance from the HUD FY 2024 Data Dictionary and FY 2024 HMIS CSV Format Specifications was used in determining variable definitions and preparing the data for analysis. All personal identifying information regarding housing program participants was removed before data dissemination to ensure privacy and confidentiality.

Following data dissemination into nine comma separated value files, further data separation was needed to find program participants that matched eligibility criteria. To discover this population, the Project dataset was split to only include PSH and RRH projects. The project ID’s from those projects was the referenced to split the Enrollment data set into all participants

who were enrolled in a PSH and RRH project, and exited between August 2020 and July 2021. New categorical variables were created to recode ProjectID into “PSH” and “RRH” for easier location and separation. The PersonalID variable was then used to locate participants in the Client, Employment Education, and Health and DV datasets. The demographic variables of interest were merged with the Enrollment dataset by PersonalID variable to create a new dataset with the demographics of the population of interest.

After determining the Personal ID’s of participants in PSH and RRH programs who exited between August 2020 and July 2021, these participants were searched again in the Enrollments Database to determine who returned to homelessness or re-entered the system following their exit. Then these participants were located in the Client, Employment Education, and Health and DV datasets from their second entrance into the system. These demographics were re-coded to indicate they were from the participants second entrance and added to a subset of the data. Altogether, this subset included only the measures described above and was used in the remaining analyses.

The first step in the preliminary data analysis was to produce frequency tables of all categorical variables to determine missing values and the distribution of characteristics among participants. The second step was to determine the distribution of the population in the two program types of interest, PSH and RRH programs as well as the population attributes among those who returned to homelessness. Demographic variables included Race, Gender, Ethnicity, Last Grade Completed, Veteran Status, Employment, and Domestic Violence Victim; outcome variables included Return to Homelessness, and Health Status. The outcome variables were cross tabulated with each of the demographic variables to determine whether any statistically significant crude associations existed between the primary variables of interest. Statistical

differences were examined using a Person Chi-Square test, significant differences were assessed at a value of α=0.05.

Next, bivariate logic regression analyses were run to asses crude associations with each study variable and the outcome variables of interest. This step was used to determine the statistical significance of the association of between variables and assist with the construction of the multivariable model. In the construction on the multivariable model, only variables that were theoretically relevant and statistically significant with the outcome of interest at the bivariate level were included. For each bivariate association, odds ratios (ORs), along with their 95% confidence intervals and associated p-values were recorded. Significance was assessed at a value of α=0.05.

Finally, a correlation matrix was produced to check for multicollinearity between study variables. The cut-off correlation value of 0.70 or above was used to assess whether any of the study variables were too highly correlated with each other to both be included in a multivariable model, because this would lead to redundancy in the analysis. The study variables highly correlated with each other were not included in the multivariable model in order to prevent multicollinearity in the final models.

Primary Analyses

After these initial data steps were completed, the primary study analyses of multivariable logistic regression models were carried out. Sequential logistic regression models were produced for each research aim. In the first step of the multivariable models, program type and disability for all participants were included to test the associations of demographic variables with the outcomes in multivariable logistic regression. In the second step of the model program type, disability, previous living situation, and destination following program exit were included as the

additional variables of interest that were statistically significantly associated at the bi-variate level. In the third step of the model, participants were separated by program type to determine differences in significant associations by program. The model included all variables of interest for each program that were statistically significant at a bivariate level. The Nagelkerke R^2 was reported for each model in order to determine the percentage of variance in the outcome variables that could be explained by the variables in the model. Finally, the adjusted odds ratios (AOR) with their 95% confidence intervals and accompanying p-values are reported. Significance was assessed at a value of α=0.05.

CHAPTER IV: Results

Introduction

Study Purpose

The purpose of this study was to investigate differences in successful housing outcomes between participants in either Permanent Supportive Housing and Rapid Rehousing programs in the Atlanta, Georgia Continuum of Care (CoC) from August 1st 2020 to July 31st 2023. This study aimed to fill a gap in the literature by determining the affect size of program components themselves or individual factors on the ability of participants to maintain stable housing following housing program exit. This study was a secondary analysis of Homeless Management Information System (HMIS) data collected by case managers and homeless response system staff on participants in the homeless response system from 2020 to 2023 to understand the impact of program type on homelessness recidivism. This chapter will discuss the findings from an analysis on homelessness recidivism based on the research questions and aims.

This research sought to answer the following research question: What structural, programmatic, and personal factors are associated with sustained housing stability between clients in Permanent Supportive Housing and Rapid Rehousing programs?

Research Aims

The study was designed to address the following two research aims:

1) To assess the difference in client outcomes between housing programs.
2) To examine the relationship between program type, client characteristics, and sustained housing following program exit.

Key Findings

Preliminary Analyses

Univariate Analyses

The personal demographic characteristics of the study sample are presented in Table 1. The total sample consisted of 880 individual who exited from either a Permanent Supportive Housing or Rapid Rehousing program in the Atlanta CoC between August 1st, 2020 and July 31st, 2021 (12 months). The sample reported being 43.8% Female, 55.7% Male, and 1.5% Non-binary or Transgender. The sample consisted of 68.3% of participants who reported a disability and 13% of participants being a person who experienced domestic violence. The ages of participants were evenly distributed between the following ranges: 18-32, 33-45, 46-58, and 59-80. The sample was 91.3% Black, African American, or African, 8.1% White, and 0.6% Other (Asian, or American Indian or Alaska Native).

Table 1.

Personal Demographic Characteristics of Study Sample	N=880
Variable	N(%)
Racial Identity	
Black, African American, or African	803 (91.3)
Other	5 (0.6)
White	72 (8.1)
Gender Identity	
Female	385 (43.8)
Male	481 (55.7)
Non-Binary or Transgender	14 (1.5)
Persons with Disabilities	
Yes	601 (68.3)
No	279 (31.7)
Experienced Domestic Violence	
Yes	151 (17.2)
No	729 (82.8)
Age at Exit	
18-32	246 (28.0)
33-45	208 (23.6)
46-58	246 (28.0)
59-80	180 (20.4)

Descriptive statistics summarizing of the remaining study variables are presented in Table 2. Across the sample, 31.6% of participants experienced homelessness again between July 31st, 2021 and July 31st, 2023. The sample was comprised of 31% Permanent Supportive Housing (PSH) enrollees/participants and 69% Rapid Rehousing (RRH) participants. Upon their enrollment into the respective programs, 69.9% reported previously living in a literal homeless situation, (living in an emergency shelter or a place not meant for human habitation (car, hotel, outside), or HUD homelessness), 18.5% reported living in Housing with a Program or Subsidy, 2.5% reported living in an institutional setting, and 9.1% were previously living in Stable Housing. The most reported length of time experiencing homelessness prior to program enrollment was between one week and 90 days which included 43.1% of participants, the second most common was 90 days or more but less than one year, which included 31% of participants. The days each participant spent the programs were evenly distributed among the following ranges: 0-113 days, 114-272 days, 273-471 days, and 472-4595 days. Of the destinations following program exit, 57% were reported as going to Stable Housing, 29.2% were reported as going to Housing with a Program/Subsidy, 10% were reported as returning to literal or HUD homelessness, and 3.8% were reported as going to an institutional setting.

Table 2.

Univariate Analysis of Explanatory and Outcome Variable	N=880
Variable	N(%)
Experienced Homelessness Again	
Yes	278 (31.6)
No	602 (68.4)
Project Enrolled	
Permanent Supportive Housing (PSH)	272 (31.0)
Rapid Rehousing (RRH)	608 (69.0)
Previous Living Situation	
HUD Homelessness	615 (69.9)
Housing with Program/Subsidy	163 (18.5)
Institutional Setting	22 (2.5)
Stable Housing	80 (9.1)
Length of Time Homeless	
Less Than One Week	55 (6.3)
Between One Week and 90 Days	379 (43.1)
90 Days or More but Less Than One Year	273 (31.0)
One Year or Longer	173 (19.6)
Days in Program	
0-113	207 (23.5)
114-272	206 (23.4)
273-471	240 (27.3)
472-4595	227 (25.8)
Destination Following Program Exit	
HUD Homelessness	88 (10.0)
Housing with Program/Subsidy	257 (29.2)
Institutional Setting	33 (3.8)
Stable Housing	502 (57.0)

Bivariate Analyses

Given the purpose of this study was to understand how enrollment in two different types of housing programs impacted the propensity of participants to experience homelessness again, the program type variable was selected to see if there were statistically significant differences in homelessness recidivism between program types. Results of a Chi-Square test of independence demonstrated that there was a statistically significant difference in homelessness recidivism between PSH and RRH program participants (χ^2 =7.12, p<0.001). As shown in Table 3, a higher

percentage of Permanent Supportive Housing participants (37.9%) experienced homelessness again when compared to Rapid Rehousing participants (28.8%).

Table 3.
Cross Tabulation of Homeless Recidivism by Program Type

Variable	Experienced Homelessness Again (Homelessness Recidivism)	
	Yes N(%)	No N(%)
Program Type		
Permanent Supportive	103 (37.9)	169 (62.1)
Housing	175 (28.8)	433 (71.2)
Rapid Rehousing		
Pearson Chi Square	*7.12 (p=0.0074)***	

*p<.05 **p<.01 ***p<.001

Additionally, the frequencies of experiencing homelessness again were cross-tabulated with the demographic variables of interest as shown in Table 4. Chi-square test indicated statistically significant differences by homelessness recidivisms. Of participants in Rapid Rehousing programs, statistically significant differences were observed in participants reporting disabilities (χ^2 =4.49, p<.05), and based on the age of participants at program exit (χ^2 =8.74, p<.05). People reporting a disability in RRH programs had a higher percentage of participants experiencing homelessness again (32.1%) compared to those who did not report a disability (24.2%). People in the 46-58 age group had a higher percentage of participants experiencing homelessness again (33.8%) compared to those 18-32 (28.7%), those 33-45 (19.7%), and those 59-80 (33.3%).

Table 4.

Frequency of Homelessness Recidivism by Demographic Variables Split by Program Type

Variable	Experienced Homelessness Again (Homelessness Recidivism)			
	PSH		RRH	
	Yes N(%)	No N(%)	Yes N(%)	No N(%)
Racial Identity				
Black, African American, or African	97 (38.7)	154 (61.4)	161 (29.2)	391 (70.8)
Other[a]	0 (0)	1 (100)	1 (25)	3 (75)
White	6 (30.0)	14 (70.0)	13 (25)	39 (75)
Pearson Chi Square	*1.20 (p=0.55)*		*0.43 (p=0.80)*	
Gender Identity				
Female	28 (30.8)	63 (69.2)	80 (27.2)	214 (72.8)
Male	71 (41.0)	102 (58.9)	93 (30.2)	215 (69.8)
Non-Binary or Transgender	5 (50.0)	4 (50.0)	2 (33.3)	4 (66.7)
Pearson Chi Square	*3.19 (p=0.20)*		*0.71 (p=0.70)*	
Persons with Disabilities				
Yes	90 (36.1)	159 (63.9)	113 (32.1)	239 (67.9)
No	13 (56.5)	10 (43.5)	62 (24.2)	194 (75.8)
Pearson Chi Square	*3.7 (p=0.05)*		*4.49 (p=0.03)**	
Experienced Domestic Violence				
Yes	10 (32.3)	21 (67.7)	36 (30.0)	84 (70.0)
No	93 (38.6)	148 (61.4)	139 (28.5)	349 (71.5)
Pearson Chi Square	*0.46 (p=0.49)*		*0.10 (p=0.74)*	
Age at Exit				
18-32	20 (39.2)	31 (60.8)	56 (28.7)	139 (71.3)
33-45	30 (45.5)	36 (54.6)	28 (19.7)	114 (80.3)
46-58	35 (35.7)	63 (64.3)	50 (33.8)	98 (66.2)
59-80	18 (31.6)	39 (68.4)	41 (33.3)	82 (66.7)
Pearson Chi Square	*2.89 (p=0.42)*		*8.74 (p=0.03)**	

*p<.05 **p<.01 ***p<.001

Note: PSH=Permanent Supportive Housing, RRH=Rapid Rehousing

[a]Analysis of Racial Identity without Other Category produced identical results, Other category was included to encompass all Racial Identities in the population of interest

Furthermore, the frequency of homelessness recidivism was cross tabulated with additional variables of interest, as shown in Table 5. Chi-square tests indicated statistically significant differences in homelessness recidivism between housing types. The reported destination of participants exiting both program types had a statistically significant relationships with homelessness recidivism (χ^2 =9.7, p<.05; χ^2 =23.2, p<.001). For those in PSH programs,

those exiting into HUD homelessness (62.5%) had a higher percentage experience homelessness again when compared to Housing with a Program/Subsidy (30.4%), Institutional Setting (47.6%), or Stable Housing (38.3%). For those in RRH programs, those exiting into Institutional Setting (66.7%), had a higher percentage experience homelessness again when compared to HUD homelessness (45.3%), Housing with a Program/Subsidy (19.3%), or Stable Housing (28.4%). Among participants in PSH programs, there were statistically significant differences by Previous Living Situation and Days in Program. Participants in PSH programs who were previously living in Institutional Settings (77.8%) has a higher percentage experience homelessness following program exit when compared to those previously living in HUD homelessness (42.6%), Housing with a Program/Subsidy (27.6%), or Stable Housing (28.1%). Participants enrolled in PSH programs between 273-471 days (51.6%) had a higher percentage experience homelessness following program exit when compared to those enrolled for 0-113 days (51.5%), 114-272 days (45.2%), and 472-4595 days (30.7%).

Table 5.

Frequency of Homelessness Recidivism by Explanatory Variables Split by Program Type

Variable	Experienced Homelessness Again (Homelessness Recidivism)			
	PSH		RRH	
	Yes N(%)	No N(%)	Yes N(%)	No (%)
Previous Living Situation				
HUD Homelessness	66 (42.6)	89 (57.4)	144 (31.3)	316 (68.7)
Housing with Program/Subsidy	21 (27.6)	55 (72.4)	20 (23.0	67 (77.0)
Institutional Setting	7 (77.8)	2 (22.2)	1 (7.7)	12 (92.3)
Stable Housing	9 (28.1)	23 (71.9)	10 (20.8)	38 (79.2)
Pearson Chi Square	*12.2 (p=0.0066)***		*7.15 (p=0.06)*	
Length of Time Homeless				
Less Than One Week	2 (40.0)	3 (60.0)	17 (34.0)	33 (66.0)
Between One Week and 90 Days	29 (43.3)	38 (56.7)	82 (26.3)	230 (73.7)
90 Days or More but Less Than One Year	30 (36.1)	53 (63.9)	53 (27.9)	137 (72.1)
One Year or Longer	42 (35.9)	75 (64.1)	23(41.1)	33 (58.9)
Pearson Chi Square	*1.14 (p=0.77)*		*5.81 (p=0.12)*	
Days in Program				
0-113	17 (51.5)	16 (48.5)	44 (25.3)	130 (74.7)
114-272	19 (45.2)	23 (54.8)	46 (28.1)	118 (71.9)
273-471	16 (51.6)	15 (48.4)	70 (33.5)	139 (66.5)
472-4595	51 (30.7)	115 (69.3)	15 (24.6)	46 (75.4)
Pearson Chi Square	*9.67 (p=0.021)**		*3.86 (p=0.28)*	
Destination Following Program Exit				
HUD Homelessness	15 (62.5)	9 (37.5)	29 (45.3)	35 (54.7)
Housing with Program/Subsidy	34 (30.4)	78 (69.6)	28 (19.3)	117 (80.7)
Institutional Setting	10 (47.6)	11 (52.4)	8 (66.7)	4 (33.3)
Stable Housing	44 (38.3)	71 (61.7)	110 (28.4)	277 (71.6)
Pearson Chi Square	*9.7 (p=0.021)**		*23.3 (p<0.0001)****	

*p<.05 **p<.01 ***p<.001

Note: PSH=Permanent Supportive Housing, RRH=Rapid Rehousing

The associations between each study variable and experiencing homelessness again or homelessness recidivism was then assessed using bivariate logistic regression models to determine the variables that would be included in the multivariable model are presented in Table 6. The variables were first assessed from all sample participants, and then split into groups of participants from the PSH and RRH programs. Program Type, Persons with Disability, Previous

Living Situation, and Destination Following Program Exit were all statistically significant with Homelessness Recidivism among the entire sample at the bivariate level. Participants in Rapid Rehousing Programs were less likely to experience homelessness again following program exit (OR=0.66, p<.01). Those with a disability were more likely to experience homelessness again (OR=1.39, p<.05), as were those who exited into homelessness (OR=2.26, p<.001) and those exited to an institutional setting (OR=2.71, p<.001). Living in housing with a program/subsidy was a protective factor for homelessness recidivism (OR=0.65, p<.05).

Between PSH and RRH programs, reporting a Disability, Previous Living Situation, Length of Time Homeless, Days in Program, and Destination Following Program Exit were found to exhibit statistically significant associations with homelessness recidivism. Among participants in PSH programs, previous living in housing with a program/subsidy (OR=0.52, p<.05) and being in the program for longer than 471 days (OR=0.42, p<.05) were less likely to experience homelessness following program exit. Among participants in RRH Programs those reporting a disability were more likely to experience homelessness after program exit (OR=1.96, p<.05). Those who reported a disability (OR=1.48, p<.05), or exited the program into institutional settings (OR=5.04, p<.05) were also more likely to experience homelessness following program exit.

Bivariate logistic regression results showed that the odds of experiencing homelessness following an exit from PSH or RRH programs differ based upon program type. The likelihood of return to homelessness was not statistically significant for all demographic variables besides the reporting of a disability, demonstrating the strength of structural factors affecting homelessness recidivism.

Table 6.

Bi-Variate Analysis between Homeless Recidivism and All Variables

Variable (Ref)	Experienced Homelessness Again (Homelessness Recidivism)		
	Overall OR (95% CI)	PSH OR(95% CI)	RRH OR (95% CI)
Program Type (PSH)			
Rapid Rehousing	0.66 (0.49-0.86)**		
Racial Identity (White)			
Black, African American, or African	1.32 (0.76-2.27)	1.47 (0.55-3.9)	1.24 (0.64-2.38)
Other	0.69 (0.07-6.64)	0.001 (0.001-99.9)	1.00 (0.09-10.47)
Gender Identity (Female)			
Male	1.33 (0.99-1.78)	1.56 (0.91-2.68)	1.16 (0.81-1.65)
Non-Binary or Transgender	1.92 (0.65-5.67)	2.25 (0.53-9.65)	1.34 (0.24-7.45)
Persons with Disabilities (No)			
Yes	1.39 (1.01-1.89)*	0.44 (0.18-1.03)	1.48 (1.03-2.13)*
Experienced Domestic Violence (No)			
Yes	0.94 (0.64-1.37)	0.76 (0.34-1.68)	1.08 (0.70-1.67)
Age at Exit (0-32)			
33-45	10.87 (0.58-1.30)	1.29 (0.62-2.71)	0.61 (0.36-1.02)
46-58	1.18 (0.81-1.72)	0.86 (0.43-1.73)	1.27 (0.80-2.00)
59-80	1.09 (0.72-1.65)	0.72 (0.32-1.58)	1.24 (0.76-2.02)
Previous Living Situation (HUD Homelessness)			
Housing with Program/Subsidy	0.65 (0.44-0.96)*	0.52 (0.29-0.93)*	0.65 (0.38-1.21)
Institutional Setting	1.10 (0.46-2.67)	4.720 (0.95-23.46))	0.18 (0.02-1.42)
Stable Housing	0.60 (0.35-1.03)	0.53 (0.23-1.22)	0.58 (0.28-1.19)
Length of Time Homeless (Between One Week and 90 Days)			
Less Than One Week	1.27 (0.70-2.32)	0.87 (0.14-5.57)	1.09 (0.72-1.63)
90 Days or More but Less Than One Year	1.06 (0.75-1.48)	0.74 (0.38-1.43)	1.45 (0.76-2.73)
One Year or Longer	1.45 (0.99-2.12)	0.73 (0.39-1.36)	1.96 (1.09-3.52)*
Days in Program (0-113)			
114-272	1.10 (0.73-1.68)	0.78 (0.31-1.94)	1.15 (0.71-1.87)
273-471	1.34 (0.89-1.99)	1.00 (0.38-2.68)	1.49 (0.95-2.33)
472-4595	0.98 (0.65-1.48)	0.42 (0.19-0.89)*	0.96 (0.49-1.89)
Destination Following Program Exit (Stable Housing)			
HUD Homelessness	2.26 (1.42-3.58)***	2.69 (1.09-6.67)*	2.09 (1.22-3.58)**
Housing with Program/Subsidy	0.72 (0.51-1.01)	0.70 (0.41-1.22)	0.69 (0.38-0.96)*
Institutional Setting	2.71 (1.33-5.52)***	1.47 (0.58-3.74)	5.04 (1.49-17.07)**

Note: Unadjusted odds ratios are reported from bivariate logistic regressions between each variable and Became Homeless Again

Ref=Reference Group; OR=Odds Ratio; 95% C.I.=95% Confidence Interval

*p<.05 **p<.01 ***p<.001

The final preliminary analysis step was to assess a correlation matrix of all study variables to assess multicollinearity among predictors that were to entered into the multivariable models. Correlations between to dichotomous variables were assessed using the Phi coefficient, while the correlations between categorical variables and dichotomous variables or categorical variables were assessed with Cramer's V. Additional details on how multicollinearity was assessed was described in Chapter 3. As shown in Table 7, a number of variables exhibited statistically significant correlations, but none of the values exceed the multicollinearity cut-off of 0.70. Based on these results and the results of all other bivariate analyses, the following variables were statistically significant at the bivariate level and therefore included in the multivariable models described in the next section: Program Type, Disabled, Previous Living Situation, Length of Stay, Days in Program, and Exit Destination.

Table 7.
Point-Biserial Correlation Matrix between All Study Variables

Variable	1	2	3	4	5	6	7	8	9	10	11
1. Homeless Recidivism	--										
2. Race	0.04	--									
3. Gender	0.07	0.09**	--								
4. Disabled	0.07[a]*	0.02	0.18***	--							
5. Domestic Violence	-0.01[a]	0.04	0.37***	0.03[a]	--						
6. Project Type	-0.09[a]*	0.02	0.15***	-0.33[a]***	0.10[a]**	--					
7. Previous Living Situation	0.09*	0.08	0.12**	0.17***	0.06	0.19***	--				
8. Length of Time Homeless	0.07	0.04	0.10**	0.17***	0.11*	0.42***	0.12***	--			
9. Destination Following Program Exit	0.18***	0.02	0.11**	0.22***	0.09	0.24***	0.14***	0.15***	--		
10. Days in Program	0.05	0.04	0.06	0.25***	0.09	0.54***	0.16***	0.10**	0.21***	--	
11. Age at Exit	0.05	0.08	0.31[a]***	0.22***	0.27***	0.16***	0.09**	0.09**	0.11**	0.07	--

Note. Cramer's V are reported unless otherwise denoted
[a]*Phi Coefficient*
*p<.05 **p<0.01 ***p<.0001

Primary Analyses by Study Aim

Research Aim 1

The first aim of the study was to evaluate potential differences in client outcomes between housing programs. This aim was assessed using sequential multivariable logistic regression models. The first step of the models included the main affects for the Program Type and Disability Status. The second step of the model included the main affects for the explanatory variables of interest including Program Type, Previous Living Situation, and Destination Following Program Exit.

Table 8. *Multivariable Model Step 1: Logistic Regression with Demographic Variables and Homelessness Recidivism Outcome*

Variable (Ref)	Experienced Homelessness Again (Homelessness Recidivism) AOR (95% CI)
Program Type (PSH)	
Rapid Rehousing	0.71 (0.52-0.98)*
Persons with Disabilities (No)	1.24 (0.89-1.73)
	R^2(0.01)

Ref=Reference Group; OR=Odds Ratio; 95% C.I.=95% Confidence Interval
*p<.05 **p<.01 ***p<.001

The result of the first step of the final model are presented in Table 8. The first step of the model revealed statistically significant associations between Program Type and Homelessness Recidivism (AOR=0.71, p<.05), and no statistically significant associations between reporting a disability and Homelessness Recidivism. Participants in Rapid Rehousing programs were less likely to experience homelessness recidivism when compared to participants in Permanent Supportive Housing programs. The results of the second step of the model are presented in Table 9. The second step of the model for Homelessness Recidivism reveals that Program Type remained statistically significant after all other explanatory variables were included in the model. Participants enrolled in a Rapid Rehousing Program (AOR=0.58, p<.01) were less likely to

experience homelessness following program exit when compared to participants enrolled in a Permanent Supportive Housing Program. Participants who were previously living in Housing with a Program/Subsidy (AOR=0.62, p<.05) or Stable Housing (AOR=0.57, p<.05) were less likely to experience homelessness following program exit when compared to participants previously living in HUD homeless situations. Participants exiting housing programs for HUD homeless situations (AOR=2.22, p<.01), or institutional settings (AOR=2.29,p<.05) were more likely to experience homelessness following program exit when compared to those exiting to stable housing where as those exiting to Housing with a Program/Subsidy (AOR=0.68, p<.05) were less likely to experience Homelessness Recidivism.

Table 9. *Multivariable Model Step 2:Logistic Regression with Explanatory Variables, and Homelessness Recidivism Outcome*

Variable (Ref)	Experienced Homelessness Again (Homelessness Recidivism) AOR (95% CI)
Program Type (PSH)	
Rapid Rehousing	0.58 (0.42-0.81)**
Persons with Disabilities (No)	1.24 (0.89-1.73)
Previous Living Situation (HUD Homelessness)	
Housing with Program/Subsidy	0.62 (0.41-0.93)*
Institutional Setting	0.94 (0.37-2.41)
Stable Housing	0.57 (0.33-0.99)*
Destination Following Program Exit (Stable Housing)	2.22 (1.39-3.53)***
HUD Homelessness	0.68 (0.47-0.97)*
Housing with Program/Subsidy	2.29 (1.09-4.77)*
Institutional Setting	
	R^2(0.07)

Ref=Reference Group; OR=Odds Ratio; 95% C.I.=95% Confidence Interval
*p<.05 **p<.01 ***p<.001

Research Aim 2

The second research aim of the study was to examine the relationship between program type, client characteristics, and sustained housing following program exit. This aim was assessed

with the third and fourth step of the multivariable logistic regression model. The results of the third and fourth step of the multivariable logistic regression model are in Table 10. The third step of the multivariable model included only participants enrolled in PSH programs and the explanatory variables of interest for the population. Among participants enrolled in PSH, those previously living in Housing with a Program/Subsidy were less likely to experience homelessness recidivism (AOR=0.46, $p<.05$). The fourth step of the multivariable logistic regression model included only participants enrolled within RRH programs and the explanatory variables of interest for the population. Among participants enrolled in RRH programs, those reporting a Disability (AOR=1.6, $p<.05$), exiting to a HUD homeless situation (AOR=1.9, $p<.05$), and exiting to an Institutional Setting (AOR=4.62, $p<.05$)were more likely to experience homelessness following program exit. Participants in RRH exiting to Housing with a Program/Subsidy (AOR=0.55, $p<.05$) were less likely to experience homelessness following program exit.

Table 10. *Multivariable Model Steps 3 and 4:Logistic Regression with Explanatory Variables by Program and Homelessness Recidivism Outcome for Participants in Each Program Type*

Variable (Ref)	Experienced Homelessness Again (Homelessness Recidivism)	
	PSH	RRH
	AOR (95% CI)	AOR (95% CI)
Days in Program (0-113)		
114-272	1.45 (0.52-4.02)	
273-471	1.34 (0.46-3.90)	
472-4595	0.63 (0.26-1.53)	
Previous Living Situation (HUD Homelessness)		
Housing with Program/Subsidy	0.46 (0.24-0.87)*	
Institutional Setting	3.49 (0.65-18.69)	
Stable Housing	0.67 (0.28-1.59)	
Destination Following Program Exit (Stable Housing)		
HUD Homelessness	1.77 (0.63-4.96)	1.91 (1.09-3.32)*
Housing with Program/Subsidy	0.75 (0.42-1.34)	0.55 (0.34-0.88)*
Institutional Setting	1.37 (0.49-3.82)	4.62 (1.33-16.1)*
Persons with Disabilities (No)		1.60 (1.09-2.34)*
Length of Time Homeless (Between One Week and 90 Days)		
Less Than One Week		1.23 (0.64-2.37)
90 Days or More but Less Than One Year		1.00 (0.66-1.52)
One Year or Longer		1.42 (0.76-2.66)
	R^2(0.12)	**R^2(0.07)**

Ref=Reference Group; OR=Odds Ratio; 95% C.I.=95% Confidence Interval
*p<.05 **p<.01 ***p<.001

Summary of Findings

Overall this study found statistically significant differences in homelessness recidivism between participants in Permanent Supportive Housing (PSH) and Rapid Rehousing programs (RRH). The participants in RRH program were less likely to experience homelessness following program exit when compared to participants enrolled in PSH programs. Participants entering both programs from housing with a program/subsidy or stable housing were less likely to experience homelessness following program exit when compared to participants entering programs from literal homelessness, such as living in an emergency shelter or a place not meant for human habitation (car, hotel, outside), or HUD homelessness. Participants exiting either PSH

or RRH programs into HUD homeless situations or institutional settings were more likely to experience homelessness following program exit when compared to participants exiting to stable housing. Though, participants exiting into housing with a program/subsidy were less likely to experience homelessness following program exit when compared to participants exiting into stable housing. These results revealed statistically significant differences in the odds of homelessness recidivism depending on the program type participants were enrolled in, previous living situation, and destination following program exit.

The second aim of the study was to examine statistically significant differences in likelihood of homelessness recidivism within programs to determine relationships between personal and structural factors. Among participants enrolled in PSH programs, those who had previously lived in housing with a program/subsidy were less likely to experience homelessness following program exit when compared to those who were previously living in HUD homelessness. Among participants enrolled in RRH programs, those who had reported a disability were more likely to experience homelessness following program exit when compared to those who did not. Additionally, those who exit to either HUD homelessness or an institutional setting were more likely to experience homelessness following program exit when compared to those exiting programs into stable housing. Those who exited RRH programs to housing with a program/subsidy were less likely to experience homelessness following program exit when compared to those exiting programs into stable housing. These overall findings support the research question which seeks to understand how personal and programmatic factors are associated with sustained housing stability between clients in both program types.

CHAPTER V: Discussion

Introduction

This study was informed by a conceptual model, homelessness recidivism through fundamental causes, to consider the impact of housing program participation on the experience of homelessness following housing program exit (see Figure 1). The conceptual model was adapted from the Theory of Fundamental Causes and the Housing First Model to address the gaps in understandings of Permanent Supportive Housing and Rapid Rehousing Programs and their effects on homelessness recidivism. The present study applied a multi-level lens to the homelessness response system by considering how the both structural (previous living situation, length of time homeless, destination following program exit), programmatic (program enrolled, days in program), and personal (age, race, gender, disability, experience with domestic violence) components affect the housing stability of participants following program exit. This study was intentional about considering the historical context of these programs, their operations in Atlanta, and the contemporary processes used in program placement.

Summary of Study

The purpose of this study was to determine the influence of program type on homelessness recidivism among participants in the Atlanta Continuum of Care (CoC). To the knowledge of the authors, this study was the first of its kind to apply the Theory of Fundamental Causes to the homelessness response system generally and to two specific housing program types: Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH). This study was a secondary analysis of enrollment data from the Homeless Management Information System (HMIS) between August 1st 2020 and July 31st 2023 from participants in PSH and RRH program types. This research was designed to answer the following research question: What structural,

programmatic, and personal factors are associated with sustained housing stability between clients in PSH and RRH programs?

Discussion of Key Results

Research Aim 1

The first aim of this study was:

1) To assess potential differences in client outcomes between housing programs

To date, there are few evaluations of housing programs with a focus on client outcomes. The evaluations that are present do not directly compare PSH and RRH programs to ascertain their impact on sustained stable housing for participants. Evaluations conducted by the Department of Housing and Urban Development (HUD) have provided mixed answers due to the diversity of housing program implementation in the United States (Finkel et. al, 2017). In an evaluation previously conducted in Georgia, only RRH, transitional housing (TH), and emergency shelter (ES) programs were included in the analysis. Within this evaluation, participants with children were found to be more likely to return to emergency shelter following program exit (Rodriguez & Eidelman, 2016).

This was one of only a few examples of housing program evaluations being conducted outside of HUD and with an emphasis on returns to experiencing homelessness or homelessness recidivism. Additionally, these studies rarely compare different programs types, limiting the understanding of the reach or impact of the homelessness response system (Brown et. al, 2017; Byrne et. al 2022; Finkel et. al, 2017; Winship, 2001). In the present study, statistically significant differences were found in the associations with homelessness recidivism between participants in PSH and RRH programs, demonstrating the importance of program type in investigating sustained housing stability.

While a majority of the literature is focused on housing programs within the context of the Housing First Model, examinations of the fidelity to Housing First principles within housing programs are few and far between (Finkel et. al, 2017; Osborne 2019; Rodriguez & Eidelman, 2016). The discrepancy between housing programs and the role of coordinated entry within the homelessness response system leads to questions regarding the implementation of programs. However, the literature that investigates the program implementation of housing programs is focused on their fidelity to the Housing First Model instead of program activities or standards. This leads to cyclical nature within the literature where questions about housing first fidelity are tied to implementation which is then tied to the utilization of housing first.

Additionally, there are few studies detailing and comparing the implementation of specific housing programs and their outcomes. This leads to a lack of consistency in understanding how programs operate generally across the US. Though the nature of these programs can and must reflect the diversity of the populations they are serving, the lack of consistency increases difficulty in evaluation (Burt et. al, 2016; Finkel et. al, 2017). Given the scarcity in original research directly comparing different program types within the same CoC, this study will contribute to closing a gap in the literature and provide a foundation for future research within the field.

Research Aim 2

The second aim of this study was:

2) To examine the associations between program type, client characteristics, and sustained housing stability following program exit

The relationship between client characteristics and sustained housing stability has historically focused on the demographic, behavioral, or health characteristics of clients (Gabrielian et. al,

2016; Leclair et. al, 2019; Loubiere et. al, 2022). These characteristics include age, experience with domestic violence, family size, military service, and mental health diagnoses (Byrne et. al, 2016; Gurdak et. al, 2022; Hsu et. al, 2021; Slesnick et. al, 2023; Tiderington et. al, 2020; Wood et. al, 2022; Younbloom et. al, 2021). These factors are all measured at an individual level likely due to the historical context and understandings of the causes of homelessness stemming from individual choices or actions. The inclusion of structural factors or historical context is often missing from analyses on housing sustainability by program type. Through the inclusion of additional factors in this study, a more robust understanding of the associations between client characteristics, programs, the homelessness response system, and homelessness recidivism was ascertained.

The relationship between program type and homelessness recidivism has previously been explored through the Housing First Model. This model is implemented in Permanent Supportive Housing and Rapid Rehousing programs. Since both programs are based in housing first, previous literature asserts that they should equally help people experiencing homelessness achieve housing stability. The results from this analysis demonstrate that this is not the case for individuals experiencing homelessness in the Atlanta CoC as the proportion of clients experiencing homelessness recidivism were statistically significantly different between program types. This difference demonstrates the lack of tangibility of HF principles in the implementation of housing programs. These findings emphasize the need for theory driven programming in housing programs and the gap between historical principles and practice.

Overall Findings

This study was the first of its kind to compare Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH) programs directly within an evaluation. This study sought to understand

the effect of the two most common program types on the housing stability of their participants, taking special care to note and understand the historical differences in the development of both of these programs. The conceptual model for this study was informed by the Theory of Fundamental Causes and the Housing First Model and the study findings are consistent with the proposed model. Overall, program type, having a disability, previous living situation, and destination following program exit were significantly associated with homelessness recidivism at the bi-variate level. However, only program type, previous living situation, and destination following program exit remained significant at the multivariable level.

For participants in PSH programs, previous living situation, days in program, and destination following program exit were significantly associated with homelessness recidivism at the bi-variate level. At the multivariable level, only previous living situation remained statistically significant. For participants in RRH programs, reporting a disability, length of time homeless, and destination following program exit were significantly associated with homelessness recidivism at the bi-variate level. At the multivariable level, reporting a disability and destination following program exit remained statistically significant. Given that disability was not significantly associated at the multivariable level, and that program type was significantly associated with homelessness recidivism, further research is needed to explore the relationship between enrollment in different program types and housing stability after exit.

Overall this study revealed more about the relationship between program enrollment and homelessness recidivism, it also demonstrated the strength of structural and programmatic factors in predicting health and housing outcomes. In particular, this study showed how program types have a statistically significant relationship with homelessness recidivism, which is consistent with some previous literature (Rodriguez & Eidelman, 2016). The significance of this

relationship demonstrates the need for additional research to determine the effect of specific programmatic components and the gap between design and implementation of programs for people experiencing homelessness. The study also demonstrated a lack of significant associations between demographic characteristics and homelessness recidivism, calling into question the treatment of individual level characteristics as a cause of homelessness.

Across the study's findings, the consistent association with homelessness recidivism with structural and programmatic factors demonstrated the difficulty in helping participants achieve housing stability within the present social and economic conditions. Although participants may stay in these program for years, where they go following program exit had a stronger association with homelessness recidivism than any other factor. This demonstrates the small amount of power or influence these programs may have on people experiencing homelessness when compared to present economic and social structures.

Strengths and Limitations

Strengths

A key strength of this study was its use of data from the Homeless Management Information System (HMIS). In using this data set, the study was able to use a source as close as possible to people experiencing homelessness in the Atlanta CoC. The information collected include demographic, programmatic, and systemic factors as well as provided context for the information collected by case managers and programs about their clients. In addition, the use of HMIS allowed the researcher to evaluate participants in the entire homelessness response system of Atlanta, instead of participants in only one or two programs. It also assisted with producing a more robust definition of homelessness recidivism as outreach and basic needs service

organizations were able to be used in the analysis. This design elucidated a more comprehensive understanding of the factors associated with homelessness recidivism in Atlanta.

Limitations

Despite its strengths, this study was constrained by several limitations. The primary limitation was also in the use of HMIS. This is due to the use of the Department of Housing and Urban Development (HUD) definitions and data elements within HMIS and the lack of flexibility CoC's have in collecting additional data. The HUD data standards work to capture information about clients and programs to be used in their own reporting but these data elements fall short in describing the health conditions, health history, and perceptions of the persons experiencing homelessness enrolled in these programs. The data elements do not describe program operations or components such as case management interactions, number of case managers, number of referrals, or type of assistance given by programs staff. This decreased the amount of available information that could be used to describe the programs.

The diversity of PSH and RRH programs themselves compounded this problem as their implementation varied greatly. The activities and provisions of each PSH or RRH program was dependent on the organization running the program and guidance on the program components was not provided due to time constraints. This was reflected in the literature as HUD evaluators mentioned the prolific diversification in the implementation of the housing programs (Finkel et al., 2017).

Additionally, HMIS data is collected and reported by case managers instead of participants themselves leading to potential bias in the interpretation between what is reported and what was said by the participant. The data elements themselves are self-reported, presenting additional limitations in data quality. Furthermore, the setting in which the data are collected and

power dynamics between case managers and their participants also likely affects data quality. In the same way, all data elements include options for case managers to report what information was not collected which led to a large percentage of missing data in elements related to client demographics and health history in the data used for this study.

Implications and Recommendations

The findings of this study have numerous implications for research on the experience of homelessness and the homelessness response system across public health and social work broadly. First, the homelessness response system must focus on the development of a working theory of change that affects the structure and implementation of housing programs. This theory must go beyond principles and describe the nature of the relationship between enrollment in housing programs and housing stability using evidence based in health behavior or social theory. In doing so, these programs will strengthen their mission, purpose, and activities to better align with current evidence on the needs of people experiencing homelessness.

The purpose of these program activities in communities has to move past historical precent and include innovations that center clients, not funders, in their development, implementation, and evaluation. To that end, Continuums of Care should strive to examine the standards of their programs and ensure that programs are doing distinct work. Additionally, CoC's should be feel empowered to be innovative in their use of HMIS and add measures that more accurately assess programmatic components to better ascertain the experience of these programs for participants. The use of HMIS varies by state and by CoC. In collaboration with community partners and researchers, CoC's should work to make the data more reflective of those who are experiencing homelessness in their community. The evaluations of programs

needs to move beyond the HUD reporting standards and provide communities with the evidence they need to make change.

Secondly, there needs to be more attention given to these systems by fields outside of social work including public health, public policy, urban development, and medicine. The housing crisis in the United States and economic conditions that affect rates of homelessness have been present for decades and are not ending anytime soon. Due to present economic conditions, this crisis will likely continue to affect hundreds of thousands of Americans. In addition, the effects of climate change in the coming decades will likely only create further disparities in the access and maintenance of affordable housing. The production of knowledge in this area needs to take an interdisciplinary approach and center those with lived experiences of homelessness.

Future Directions

Future studies of homelessness recidivism and it's associations with housing programs should be conducted using a mixed-method approach and include components with community based participatory research (CBPR) methods. Using a mixed-methods approach and community based design will help provide greater context to quantitative findings and provide qualitative descriptions of the experiences of participants enrolled in these programs. Despite the use of HMIS data, this study was unable to describe the nuances or intricacies of the homelessness response system in Atlanta from multiple perspectives. Using CBPR methods would ensure that communities are collaborated with and share in the knowledge production process with researchers. In research conducted with vulnerable populations, the product created or results of the study are rarely shared with the community or the community does not have shared power with the researchers. By using CBPR methods in the research of housing programs and the

homelessness response system broadly, researchers can ensure the voice of these vulnerable populations is heard and can shape studies to investigate the questions of concern from these communities. It also ensures the cessation of a power dynamic that excludes community members in aim of the creation of knowledge.

Future studies should work to develop a robust, contemporary understanding of the experience of homelessness in the United States. The communities of Americans experiencing homelessness are at the intersection of many fields and yet are not centered in studies of health access, health equity, and economic justice. Future research is required to improve understandings and center those with lived experience of homelessness.

Conclusion

This study applied the Theory of Fundamental Causes the Housing First Model to the participants of Permanent Supportive Housing and Rapid Rehousing programs to determine significant associations between demographic, programmatic, and structural factors and a return to homelessness within two years of program exit. The study found that structural and programmatic factors had statistically significant associations with homelessness recidivism. These significant associations revealed important differences in the ways that programs, prior experiences with homelessness, and aftercare can play in homelessness recidivism. The causes and effects of homelessness recidivism including the social, structural, and programmatic determinants must be considered in future research evaluating housing programs for people experiencing homelessness.

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Appendices

Appendix A: Notice Displayed in All HMIS user agencies in the Atlanta Continuum of Care

This notice is required of all Georgia HMIS Participating Agencies by the Georgia Department of Community Affairs

Privacy Posting

Georgia Homeless Management Information System

The U.S. Department of Housing and Urban Development (HUD) and other federal and state partners require that each jurisdiction that receives homeless funding have a Homeless Management Information System (HMIS) in place. Therefore, this Agency is required to participate in the GA Homeless Management Information System (GA HMIS), a computerized system that collects and stores basic information about the persons who receive services from this Agency. The goal of the GA HMIS is to assist us in determining your needs and to provide a record for evaluating the services we are providing to you.

We only collect information that is needed to provide you services, or that we consider relevant to helping us understand the scope and dimensions of homelessness in order to design effective service delivery. Information may be disclosed as required by funders or by law, or for specific administrative or research purposes outlined in our privacy policy. By requesting and accepting services from this project, you are giving consent for us to enter and share your personal information into the GA HMIS.

The collection and use of all personal information is guided by strict standards of confidentiality as outlined in our privacy policy. A copy of our agency's Privacy Policy and a copy of the Georgia HMIS Privacy Policy is available upon request for your review.

Appendix B: Georgia Homeless Management Information System Client Data Sharing Opt-Out Form

Client Data Sharing Opt-Out Form

Please select your preference:

- ☐ Opt-Out for Sharing Transactional Data (programs, enrollments, assessments, services and referrals)
- ☐ Opt-Out of all sharing (restrict to the organization)

I hereby revoke access for GA HMIS participating organizations to share the information entered in the GA HMIS about me and my family as indicated above. By signing this form, I understand that agencies will not be able to access and share my information unless I indicate otherwise in the future. I further understand that this opt-out option does not affect disclosures already made and will not result in the removal of historical information collected about me.

Client/ Legal Guardian Name (Please Print): _____ DOB: _____ Last 4 digits of SS_____

Minor Children (if any):

Client Name: _____ DOB: _____ Last 4 digits of SS_____
Client Name: _____ DOB: _____ Last 4 digits of SS_____
Client Name: _____ DOB: _____ Last 4 digits of SS_____

SIGNATURE AND ACKNOWLEDGEMENT

Your signature indicates that you have read (or been read) this form and have received answers to your questions.

Signature _____ Date _____

For Agency Personnel Use Only:

_____ _____

Print Name of Organization **Print Name of Organization Staff**

Appendix C: Emory University IRB Approval Memo and Form Responses

Memo from Emory University

To: Emory Research Community

From: Emory IRB Office

Date: July 11, 2019

RE: Documentation for projects that do not require IRB review

Starting on July 15, 2019, the Emory IRB will create a new form to help investigators to determine if a study requires IRB review. In order to document this determination, the research team is invited to use our Non-Human Subjects Research Determination Electronic Form. This form will indicate if the study needs IRB submission or not. If not, the study team is expected to keep a copy of the form responses as an attestation of the researchers 'intent for the project. The responses from the form and this memo can be provided to others as needed.

If you have any questions, please contact our office.

Responses from Form:

EMORY UNIVERSITY
Institutional Review Board

NON-HUMAN SUBJECTS RESEARCH DETERMINATION FORM

Emory does not require IRB review of studies that do not meet the definitions of "human subjects research" (DHHS) or "clinical investigation" (FDA). This tool is to help you define your project and to ensure proper review and regulatory requirements are met. If the tool results in an outcome of "no IRB review required," this form will serve as your documentation of that determination. Please keep the completed copy in your records. AUDIT: The IRB will periodically audit completed forms and your written proposal to ensure that the tool is providing accurate results. NOTE: this tool should only be used for projects completed by Emory/EHC affiliates doing work for Emory purposes. When answering the questions in this determination tool, consider only the project activities performed by Emory/EHC affiliates in the current proposed project (e.g. if your study is a secondary data analysis, do not include the primary data collection activities when considering your responses.) Emory/EHC affiliates who are completing a project for academic credit at a different institution should seek a determination from that institution's IRB.

1

Project Title *

Return to Nowhere: An Evaluation of Chronic Homelessness In Atlanta

2

PROJECT LEADER (not necessarily the person filling in this form) *

MaryJo Schmidt

3

FUNDING *

If this is externally-funded and Emory is prime, have you verified that the funder does not consider this project to be research with human subjects?

NOTE: If Emory is the prime recipient of a DHHS award and the funding application indicates that human subjects will be involved, IRB submission is required.

Also, if Emory is the prime recipient of a DHHS award, but contracting with another site to carry out all non-exempt human subjects research activities for that award, please contact the Emory IRB for guidance instead of using this form.

If Emory is the subrecipient, only the activities done by Emory should be considered for this form, even if other sites are performing human subjects research.

- ○ Yes
- ◉ No

4

SHARING DATA/SPECIMENS OUTSIDE OF EMORY *

Will you be sharing data or specimens (identified or de-identified) outside of Emory? If yes, you need to review the instructions on this webpage to what agreement might be necessary: https://ott.emory.edu/resources/forms.html.

- ○ Yes
- ◉ No

5

Does the project involve Veterans Affairs?
(e.g. study site, data source, researcher's affiliation) *

- ○ Yes
- ◉ No

6

RESEARCH DETERMINATION- Systematic Investigation *

Is the proposed project a "systematic investigation?" For example: are you conducting online or in-person surveys, focus group discussions, or data analysis?

A. RESEARCH DETERMINATION – Systematic Investigation

- The "Common Rule," generally used by the Emory IRB to evaluate all human subjects research, defines "**research**" as *a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.* (45 CFR 46.102(l))
- A *systematic investigation* involves a prospective plan that incorporates data collection (either quantitative or qualitative), and data analysis to answer a question. It may include: surveys, interviews, cognitive experiments, behavioral or biomedical interventions or procedures, or medical chart reviews. It may also include observation of public behavior (e.g. ethnography).

(●) Yes

( ) No

7

RESEARCH DETERMINATION- Generalizable Knowledge
Is the proposed project "designed to develop or contribute to generalizable knowledge?" *

Review this page, https://www.irb.emory.edu/guidance/getting-started/review.html, if your project may be a **case study/series**, **classroom activity**, **public health practice**, **program evaluation**, or **quality improvement**.

If you still have questions, you can call our office for clarification at (404) 712-0720.

B. RESEARCH DETERMINATION – Generalizable Knowledge

Is your project *designed to develop or contribute to generalizable knowledge*? (45 CFR 46.102(l))

Your project may have results that could be useful or interesting to others. But we ask if your project is *DESIGNED* to contribute to generalizable knowledge. Your project's results may be presented without being generalizable (for example, as a case study).

Hallmarks of generalizable projects:

- Can the knowledge be applied to populations/contexts outside of the specific scope of the project?
- Is the work designed to contribute to a theoretical framework, even if the details of the population studied are unique to that population?
- Are the primary beneficiaries of the research: other researchers, scholars, and practitioners in the field of study?
- Are the results intended to be replicated in other settings?

( ) Yes

(●) No

8

Confirm: NON-RESEARCH. This project is not research because it is: *

Select the option that best describes your non-research project

- ○ A Case Study, or Case Series of 5 or fewer subjects (Note that HIPAA authorization may still be required)
- ○ A Classroom Activity
- ○ Public Health Practice
- ◉ A Program Evaluation
- ○ Quality Improvement
- ○ Oral History/Journalistic Activities
- ○ Other

9

This project does not require IRB review because it is not "research" as defined in the federal regulations. This project should not be described as "exempt" but as "not human subjects research." Please use the Microsoft Print to PDF or Microsoft XPS Document Writer option to save a copy of your responses to this form. *

- ◉ There is no eIRB submission necessary. I will ensure any publications resulting from my project present results accordingly. I will protect the confidentiality of information accessed or obtained in this project. I have reviewed the available guidance when making my determination. I will keep a copy of my responses to this form for my records.