

HEALING HANDS

NATIONAL
HEALTH CARE
for the
HOMELESS
COUNCIL

HCH | CN



Housing Solutions for People Experiencing Homelessness

Introduction

The relationship between health, housing, and homelessness is complex and multifaceted. Poor health, lack of access to health care, and overwhelming medical bills can catapult some people into homelessness. Living on the street, in shelters, or in substandard housing may exacerbate preexisting health conditions and expose people to risk factors for others. Because of this bidirectional relationship, research has shown that becoming housed is a form of health care that enables people to manage their health conditions, as well as to prevent new conditions from developing and existing conditions from worsening. As a social determinant of health, increasing access to housing has been recognized as a crucial part of caring for both the physical and mental health of individuals experiencing homelessness.

Despite the many documented benefits of housing, for individuals who are transitioning into housing, many challenges arise during the process. Newly housed individuals have to confront logistical difficulties such as paying rent and caring for a house, in some cases after many years without engaging in these activities. Moreover, it is common for newly housed individuals to report feeling lonely and isolated in their new homes and to lack social

support. They may also experience “housing guilt” around knowing that their friends remain unhoused, and run the risk of relapsing or leaving housing because of insufficient social support.

There are even reports of people entering housing and dying soon after, sometimes from medical conditions left untreated due to their isolation from care or from overdose or suicide related to the trauma of transitioning to housing. This unexplained phenomenon of early death occurring soon after one becomes housed has been called “re-housing syndrome” by clinicians who care for individuals without homes (it is important to note there may not be anything that can be done to prevent these deaths, and compassionate and appropriate end-of-life care is much easier to provide if a person is housed rather than on the streets). For care providers hoping to mitigate some of these challenges and risks, it is important to understand how complicated it may be for some individuals to enter housing, and to mobilize an array of supports designed to ease the transition.

In addition to managing the challenges faced by individuals transitioning into housing, programs that assist with housing placements face a number of logistical challenges of their own. Funding is always an issue. In cities, increasing

rent can make it difficult to access affordable housing. In rural areas, there may be a shortage of properties that are accessible and zoned appropriately. Because housing people experiencing homelessness can involve interfacing with various stakeholders—including clients, case managers, health care providers, landlords, property management companies, city officials, and so on—the process of developing effective housing programs demands tenacity.

This issue of *Healing Hands* will discuss some key housing approaches and models that may be utilized in housing programs, with a special focus on some of the challenges involved in housing families and a spotlight on lessons learned from care providers about how to create supportive structures and communities for people transitioning into housing.

Comparison of Housing Approaches

There are various strategies for obtaining housing for individuals without homes. The following are three key approaches, each with unique underlying philosophies:

- **Housing Readiness:** This linear approach to care requires that in order to enter housing, clients must first achieve behavioral stability and, in many cases, sobriety. Temporary housing resources ranging from emergency shelter to transitional housing may be utilized while offering treatment for substance use or other behavioral health issues, with the end goal of transitioning patients into permanent housing situations once behavioral stability has been achieved.
- **Housing First:** This philosophy posits that housing should be the first step in addressing homelessness. In many cases, there are no requirements around treatment, recovery, or behavioral stability prior to placement in housing; rather the housing placement is viewed as the first intervention. Additional health and social services may be provided to clients after they have been placed in permanent housing situations.
- **Permanent Supportive Housing (PSH):** PSH emphasizes a combination of permanent and affordable housing with the ongoing provision of services, which may be provided on-site or off-site, depending on the specific housing model being utilized. Ideally, interdisciplinary care teams can promote ongoing stability, mental and physical health, and recovery services for newly housed individuals.

The prioritization of different approaches can influence the types of housing models and service provision models, as well as funding priorities that are utilized by organizations seeking to provide access to housing resources for individuals experiencing homelessness.

Housing Models

Across the country, housing programs are working to respond to the housing needs of people experiencing homelessness with a variety of models. Single-site housing models involve residential buildings where all tenants live on-site; scattered-site housing models utilize tenant-based strategies to assist individuals accessing affordable housing in different buildings and areas. Often housing programs utilize novel and creative models tailored to their communities to increase access to housing for local populations of people experiencing homelessness.

SINGLE-SITE VS. SCATTERED-SITE HOUSING MODELS

The Colorado Coalition for the Homeless, located in Denver, Colorado, utilizes a Housing First model and Assertive Community Treatment (ACT) model to provide both single-site and scattered-site housing opportunities throughout the Denver area. **Carrie Craig**, Director of CCH's Housing First and ACT Services, explains that part of deciding whether single-site or scattered-site options would be more appropriate for an individual involves assessing

the level of need. Some consumers need a higher level of care and a high-intensity treatment team because of dual diagnosis or a mental health concern coupled with a substance use issue, etc. There are people who want or need more contact with staff or desire a more community-type living environment, whereas other clients might prefer to be on their own and not have staff involved in their day-to-day life. So for people who require more intensive services, it's easier to provide onsite case management and supportive services.

SUPPORTIVE SERVICES CHECKLIST FOR RECENTLY HOUSED INDIVIDUALS

- » Case management
- » Mental health services
- » Alcohol and substance use services
- » Independent living skills
- » Vocational services
- » Health/medical services
- » Peer support services

For more resources and toolkits on providing supportive services in conjunction with housing services, visit the Public Housing Agency's technical assistance resource at <http://www.csh.org/phatoolkit>.



because they may not have the training that our staff do, or the understanding of the population.

To this end, CCH meets biweekly with the property management company to discuss the needs of specific clients, behavioral issues, and how they can work together to discover what clients need to retain housing.

However, Ms. Craig emphasizes that development of these competencies is also a priority for CCH's tenancy-based scattered site housing placements:

Our housing intake team does a lot of intakes and placement as well as landlord recruitment. They spend time working closely with property owners to educate them about our population, including barriers and struggles that they face, so they understand the population that will be living in their property. Then, through case management support, landlords have ongoing contact with the agency so we can help address concerns that arise.

Because CCH has multiple community treatment teams that are able to provide wraparound services to clients, newly housed individuals in all forms of housing are provided with case management and access to services post-transition.

"We operate from a philosophy that emphasizes client self-determination and choice."

- CARRIE CRAIG, DIRECTOR OF HOUSING FIRST AND ACT SERVICES, COLORADO COALITION FOR THE HOMELESS, DENVER, COLORADO

Though it presents a different set of logistical challenges to continuous access to services for clients in scattered-site housing—particularly when the available scattered sites cover a broad geographic area, which can slow down response times when issues arise—there are also benefits to these models. Ms. Craig explains:

One benefit of scattered site is people have more housing choice—choosing the area they want to live in, possibly one that isn't as triggering as downtown Denver may be for some people, for example. It's an opportunity to facilitate housing choice, which is especially important since we operate from a philosophy that emphasizes client self-determination and choice.

When asked about the comparative challenges of the two housing models, Ms. Craig explains that onsite/single-site services can ease the process of staying in conversation with clients and maintaining access to services. CCH also has its own property management company, RPMC, so they are able to provide the property managers with training and information on trauma-informed care, cultural competence, harm reduction, and other key issues involved in providing appropriate supports. Ms. Craig explains,

This makes it easier for us to work closely with our property management on tenant orientations, maintenance problems, rent collection, behavioral issues, or housing retention strategies. Those things come up often and with landlords, it's more difficult

Different geographic locations and types of communities have differential access to housing resources, and must develop different strategies in response to these disparities. **Beth Keeney** is the Senior Vice President for Community Health Initiatives at LifeSpring Health Systems, a community mental health provider that has been providing public health safety net services for 54 years in Jeffersonville, Indiana, and surrounding areas. LifeSpring's permanent supportive housing program includes several supervised group living homes for people with serious mental illnesses, an apartment complex that functions as supervised independent living for people who are mentally ill or disabled due to substance use, and a permanent supportive housing program that is funded through the U.S. Department of Housing and Urban Development (HUD) and utilizes scattered sites.

As Ms. Keeney explains, "Resources are limited in our area and for our agency; there is a demonstrated shortage of affordable housing and not a lot of housing stock. Supply and demand is an issue... In our area there's no public housing with an open waiting list, and it's hard to find a landlord that takes Section 8 vouchers." Moreover, she explains that because LifeSpring's service area includes rural areas—"and it becomes rural quickly, so it can be difficult getting from one place to another"—issues like access to specialist care and transportation can make housing access and service maintenance particularly difficult. "Homelessness looks different in cities than in rural areas," explains Ms. Keeney. "In Austin, Indiana—part of

our service area—a few years ago [there] was a major HIV outbreak due to IV drug use. If you asked folks there if there was homelessness, they would say no. But by our definition [there is a huge homeless population in the area.]”

LifeSpring’s single-site housing projects take some of these pressures off, as services can be provided on-site and client needs can be responded to immediately. To respond to these challenges in the scattered-site housing project, LifeSpring has developed an array of responses. According to Ms. Keeney:

One thing we’ve done in Austin around transportation is to supply gas cards. This seems to help people access health care more reliably. In more metro areas, we give bus tokens. For specialist care, we establish relationships with specialists who want to serve in public health. Sometimes [we] can pay a copay if the situation is urgent... and we can assist with prescription drug costs. We run a bus to a local homeless shelter to eliminate transportation barriers. And because we know there is a lot of food insecurity in Austin, we have started stocking MREs. People come in looking for food and will get their blood pressure checked or be engaged in health care, check up on meds, etc.

“... clients experiencing a secure, safe, supportive shelter community leave to housing with a connection to their home base and feel less isolation when moved to independent housing.”

- ANNIE NICOL, DIRECTOR OF HOMELESS SERVICES AT PETALUMA HEALTH CENTER, PETALUMA, CALIFORNIA

As far as innovative solutions for expanding the housing projects, Ms. Keeney says, “That’s just difficult... We’ve been looking for new facilities and buildings for the last five years, and we’ve come up empty. Facilities that are zoned appropriately are not accessible. We still haven’t found a new complex or building that could accommodate multiple units.”

Annie Nicol, Director of Homeless Services at Petaluma Health Center in Petaluma, California, emphasizes that “housing is not one size fits all” and mentions a few considerations for care providers working to make the most effective housing arrangements for individual clients:

If your community has great transportation in proximity to food sources, medical care, social services, mental health and substance abuse, or inclusive existing services that can be delivered at home, [that is] great! However, if your scattered sites are not co-located near services, assistance is challenging to independence. If your shelter offers

abundant services on site i.e. medical, substance abuse, mental health and social services, three meals and a bed, the shelter can stabilize and engage the client prior to independent housing.

She goes on to note that “My experience is that clients experiencing a secure, safe, supportive shelter community leave to housing with a connection to their home base and feel less isolation when moved to independent housing.” Though single-site and scattered-site housing models differ in many fundamental ways, and since different sorts of challenges may emerge, there are also some common issues to consider regardless of the model being employed. These include how to build relationships with housing providers, how to prioritize the needs and goals of the clients, and how to ensure that clients are able to continue accessing necessary supportive services once they have transitioned into the new housing arrangement.

MIXED-POPULATION SOLUTIONS & OTHER NEW MODELS

Mixed-population buildings are market-rate properties with a few units designated for affordable housing. Housing advocates across the United States are also experimenting with other novel models, like tiny house villages, harm reduction housing projects, and managed alcohol programs that utilize assisted living models. Other

organizations utilize transitional housing, congregate housing, single-room occupancy strategies, and other approaches that are tailored to the communities being served. These models may also allow care providers to provide individuals experiencing homelessness with more choices about the kind of housing they access.

In addition to innovative models for providing access to housing resources, organizations are also developing models for maintaining access to services, including health care, after an individual or family has transitioned into housing. An example is Neighborcare’s Housing Health Outreach Team (HHOT), located in Seattle, Washington. Because the city of Seattle is committed to a Housing First model, HHOT is a team of nurses who are situated in buildings that are run by contractors that provide supportive housing. Through partnerships with multiple organizations, HHOT nurses welcome patients into their offices and provide health care outreach services, including reaching out to people who were previously inconsistent consumers of health care services. According

to **Heather Barr**, a HHOT Nurse and Clinical Practice Manager through Neighborcare, HHOT's mission is to both provide immediate nursing services and to connect recently-housed people to primary care services, dental care, mental health care, substance use treatment, and any other form of health care that they need. The nurses also do follow-up work and assist in management of chronic diseases and the development of self-management goals.

Ms. Barr explains that a trauma-informed approach is critical to the work of the HHOT nurses, since "housing doesn't assuage trauma problems; they persist in spite of having a roof over one's head." Based on this knowledge, the HHOT nurses are committed to incorporating what Ms. Barr calls

an understanding that all people we work with have come from places and situations and experiences that are marked by trauma. We try to model trauma-informed care to others who aren't necessarily exposed to that approach—moving through the lens of trauma to interpret people's behavior and have a deeper understanding of why people behave the way they do. This means moving away from punishment, and also requires a harm reduction approach, helping people make choices that are less dangerous than what they were doing.

The HHOT nurses seek to be "patient-centered, calm, and inventive," says Ms. Barr, and to use multiple strategies to engage with people. For example,

One nurse makes her office space very inviting for people to come in and get the feeling of the room and begin to engage with her by sitting with her for a while. People suffering with mental illness, or who have a lot of difficulty sitting still or engaging in the way you might expect people to, are sometimes drawn in by music, ambiance, or things on the wall for people to look at if they're not ready to look at her. So helping clients relate to the room is a way of building rapport.

Ms. Barr also notes that the HHOT nurses have discovered other "ways to work themselves into the fabric of the housing setting and become small beacons of comfort and trust," including motivational interviewing, relationship-building, and even the "magic of foot care and haircuts as a way of getting access to people and being perceived as a trustworthy entity." These are all ways of "letting people guide their journey with us rather than us trying to tell them what to do. We look at ourselves as guests in the homes of people we're working with and guests in the homes of organizations where we are able to be housed to work with clients. We have really good relationships with those partners."

Spotlight on Families

The number of families experiencing homelessness appears to be growing. According to **Ellen Bassuk, M.D.**, President and Founder of the Bassuk Center on Homeless and Vulnerable Children & Youth (www.Bassukcenter.org), a national nonprofit headquartered in Boston, Massachusetts, families now constitute approximately 37% of the overall homeless population. In certain cities, she notes, the numbers are even higher; in New York City, for example, there are an estimated 23,000 children without homes residing in shelters each night. There are also increasing numbers of young children experiencing homelessness; 51% of the estimated 2.5 children experiencing homelessness are under the age of six. As numbers rise, the average length of stay in shelters is also rising, and an increasing number of children are growing up in shelters, says Dr. Bassuk.

CORE PRINCIPLES OF A TRAUMA-INFORMED CULTURE

- » Safety: Ensuring physical & emotional safety; "do no harm"
- » Trustworthiness: Maximizing trustworthiness, making tasks clear, maintaining appropriate boundaries
- » Choice: Prioritizing consumer choice and control over recovery
- » Collaboration: Maximizing collaboration and sharing of power with consumers
- » Empowerment: Identifying what they are able to do for themselves; prioritizing building skills that promote recovery; helping consumers find inner strengths needed to heal

Source: Adapted from Beyer, L. L., & Blake, M. (2010). Trauma-informed care: Building partnerships and peer supports in supportive housing settings [PowerPoint slides]. Presentation at Services in Supportive Housing Annual Grantee Meeting. Washington DC. Retrieved from http://www.samhsa-ssh-meeting.net/assets/documents/trauma_informed_care.pdf

For more information on trauma-informed care for homeless populations, see: National Health Care for the Homeless Council. (2010, December). Delivering Trauma-Informed Services. *Healing Hands*, 14(6). Available at nhchc.org.

With their focus on family homelessness, the Bassuk Center “connects and supports communities across the nation serving families, youth, and children experiencing homelessness. Using research-based knowledge and evidence-based solutions, [they] advance policies and practices that ensure housing stability and promote the wellbeing of family members.” The Bassuk Center has a particular interest in trauma-informed care because of the compelling literature on Adverse Childhood Experiences (ACEs), “which clearly demonstrates that if you have a certain number of ACEs as a child, then your physical and mental health outcomes as an adult will be compromised,” explains Dr. Bassuk. “The hope is that as we identify the kids who have high numbers of ACEs, knowing that most likely their mothers will as well, we can create multifaceted approaches to their care.”

Though many housing programs focus on creating housing opportunities for single individuals, the process of re-housing families carries special difficulties. Uprooting families, and particularly children, from pre-existing support networks, including schools, daycare, and in some cases shelter programs, can be very stressful. The process of transferring schools while maintaining both educational and social support can create difficulties.

In some cases, establishing housing for families may involve collaboration with Child Services and other logistics related to family reunification. Moreover, there may be additional safety concerns to consider when placing families with children in housing, including neighborhood and home safety.

“What kinds of psychological supports are needed for kids to thrive when [they are uprooted]? We shouldn’t lose sight of that.”

- DEBBIAN FLETCHER-BLAKE, CHIEF OPERATIONS OFFICER OF VOCATIONAL INSTRUCTION PROJECT COMMUNITY SERVICES, NEW YORK CITY, NY

Debbian Fletcher-Blake, Chief Operations Officer of Vocational Instruction Project Community Services in Bronx, NY, explains that issues of trauma, support system disruptions, and the psychological health of children are often under-examined:

We uproot them and place them in other boroughs or far away from where their support system is and where their friendships are. That can have not only traumatic impacts on the kids, but is also so disruptive that often at their new schools, they sort of retreat to a lower level. What kind of psychological supports are needed for kids to thrive when this happens? We shouldn’t lose sight of that.

Some people may assume that housing is intrinsically less traumatic for children than living in a shelter, but Ms. Fletcher-Blake contests this idea, explaining,

There is trauma in shelters, but isolation from one’s social support is also extremely traumatic, especially for school age children who have finally assimilated in a school and now are uprooted.

The homeless experience for kids is so traumatic at so many levels, and living in a shelter may be traumatic, but so is moving out of the shelter. The shelter may have been a safe zone for children, so taking them out of that and putting them in areas where...they

don’t feel safe, where the support system isn’t there, they’re hearing gunshots, they don’t have a case manager, there are dark staircases, there’s no playground... all of these things are equally traumatic to children, and it takes a while for them to feel a sense of normalcy. As we know, people who have been living on the streets for a long time may be traumatized by being in housing! Moving them and not having the correct treatments and supports in place is equally traumatic. And probably more lasting.



When asked how clinicians can better support families and children by focusing on their emotional and psychological wellbeing through placement/displacement processes, Ms. Fletcher-Blake suggests always trying

to get attached to a mental health provider before the transition occurs—a psychologist or social worker, etc.—and that person will have the conversations with the mental health [providers] in schools [to ensure that] those basic needs are met for the kids. Then having the relationship with a therapist who they can call on and who can check on them from time to time. Teachers in schools need to have those conversations as well and be apprised of what's happening in order to make it as untraumatic as possible. You don't want kids in the classroom to start calling them names, and the teacher plays a pivotal role in that. Then, consider discussing the transition with a mental health provider who can go to their home to see them until they are fully transitioned into care at a new health center or...have been able to form a new community. I recommend constant contact after the transition. Within 6 months, do another ACE [assessment], and within a year see how they are thriving and how traumatic the experience has been for them.

Dr. Bassuk similarly emphasizes the importance of connecting families with community support and wraparound services:

We've done systematic reviews of the literature to look at longer-term outcomes of housing families. The bottom line is that many families don't stabilize unless there are adequate supports and services. Certainly affordable housing is at the heart of this, but the stock of affordable housing is inadequate; meanwhile families need support in shelters.... It is also important to ensure that when families are able to transition into the community, they are connected to supports in their new community.

Dr. Bassuk explains that all families, no matter their socioeconomic situation, "are interconnected and cannot live in isolation. Families require a variety of supports as children grow. These may include: transportation, health care, school services, tutoring, services for children with special needs—but these services are less accessible to extremely poor families even though the need for the services may be even more pressing." Moreover, maintaining access to services and supports is difficult for

families even after they have been housed; for example, if a child has a health condition for which he needs to stay home from school, and the mother does not have access to childcare or a supportive network, she may be at risk of losing her job. "Although housing is fundamental to ending homelessness, services and supports must also be part of this picture," explains Dr. Bassuk. "You can't live alone in this world. And if you're a single mother, as most homeless mothers are, it's hard to raise kids alone."

"The bottom line is that many families don't stabilize unless there are adequate supports and services. Certainly affordable housing is at the heart of this, but the stock of affordable housing is inadequate; meanwhile families need support in shelters..."

- DR. ELLEN BASSUK, PRESIDENT AND FOUNDER OF THE BASSUK CENTER ON HOMELESS AND VULNERABLE CHILDREN, BOSTON, MASSACHUSETTS

In addition to frequent contact and monitoring of the wellbeing of children and their families after a housing transition, Ms. Fletcher-Blake also notes the importance of information-sharing, training, and providing access to resources to families. In particular, families who have been living in shelters may need training on health and safety in order to transition smoothly into housing, since "in shelters, clinics have been doing certain kinds of follow-up work, but once they leave, they are on their own."

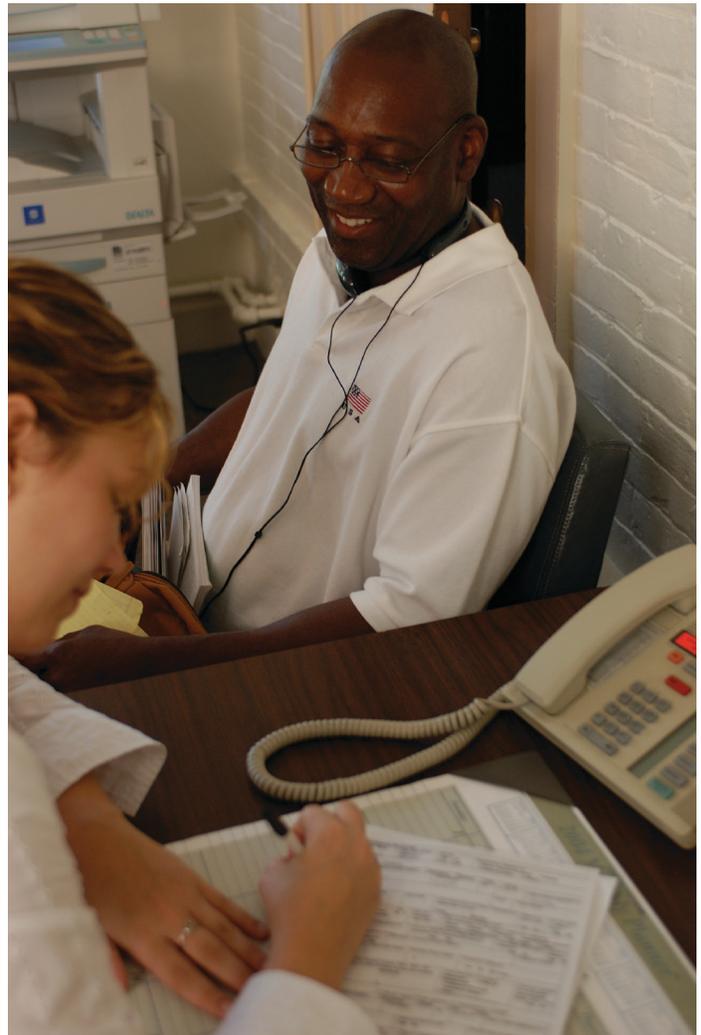
She notes that it is crucial to have safety assessments and safety education for families that are moving out of shelters into housing that includes information on "how to be safe in the neighborhood, how to protect yourself and your children when there is no curfew, and how to travel safely." Moreover, families may need information about issues such as providing nutritious food for children, accessing the full regimen of health care—including well child checks, oral health care, and immunizations.

Truly Supportive Housing: Lessons Learned on Providing Adequate Access to Services for Recently-Housed Individuals & Families

As care providers navigate the many challenges and opportunities intrinsic in building programs that supply people experiencing homelessness with housing resources, these tips may be useful:

- 1. Community relationships are the key to success.** As Ms. Keeney explains, "Relationships are key, whether it's with local housing authorities or other housing providers. Becoming part of local housing initiatives or housing continuums of care is critical. Calling and asking when they meet, sitting down with them, and asking to work together can lead to opportunities for collaboration."
- 2. Strong relationships with clients can be built at every stage of the process.** Ms. Craig notes, "Getting client feedback is essential. For example, empowering them to have their voices heard regarding what they need, ensuring their involvement in housing choice, treatment planning, goal development, and community activities, which needs to be client-driven to create buy-in for services."
- 3. Implement trauma-informed care.** Though the traumas of homelessness are well documented, being rapidly housed after years of experiencing homelessness on the streets can also be traumatic. As Ms. Fletcher-Blake emphasizes, trauma-informed care also means being attentive to the different sorts of impacts that homelessness has on children and families, and paying attention to the multi-faceted impacts that being housed can have on a child's development, sense of community, and experience of trauma. Developing a standard of trauma-informed care for everyone involved in the housing program—from clinicians to case managers to property managers—can increase the level of support that recently housed individuals experience.
- 4. Build community as quickly as possible.** Ms. Craig notes that the importance of

really providing an opportunity to build community right away—to provide opportunities for socialization immediately. Because when people are moved from the street into an apartment (and an apartment where often you can't have your whole community coming into your space because landlords and neighbors will complain about visitors, traffic, presumed drug use, etc.), clients who are coming straight off the street get lonely. They



used to be surrounded by people on the street and now are alone in an apartment. Being enclosed may feel difficult for clients who are not used to being indoors. So that community piece is really essential upfront.

Ms. Bassuk agrees that whether it is an individual or family being housed, it is crucial to "connect the individual or family with supports in the community and with whatever services they need so that they are networked in, not isolated. That's what matters: having contacts, networks, and support."

- 5. Provide a variety of concrete resources and assistance opportunities, early and often.** Ms. Craig says it is important to provide as many services as possible upfront:

Case management services may employ a tapering model, but it's better to provide the intensive services upfront. Are they struggling with socialization? With the fact that their street

family is still on the street? Do they know how to cook? Do they need to learn the basics of how to be safe, food storage safety, etc.? Really providing that intensive service upfront is helpful to identify what their needs are. If you ask, 'what do you need to work on?' they may not know yet. For someone who has been chronically homeless and on the street for decades, they may not know what they need to learn. [Organizations can] create resource guides upfront that respond to questions like how to pay rent, set up utilities, operate the internet: How do you settle in to the apartment? Stay safe? Get groceries, do laundry, keep the place clean, etc.? We try to always provide a move-in kit with cleaning supplies and other essentials.

Conclusion

Increasing access to housing for people experiencing homelessness is a form of health care. Though a range of philosophies and approaches exist for housing individuals experiencing homelessness, the most effective programs have at their core a respect for the plans and goals of individual clients, an attentiveness to the trauma histories and complex experiences of those clients, and a commitment to providing an increase in the quality of life for clients who have experienced the traumas and challenges of homelessness.

References

1. National Health Care for the Homeless Council. (n.d.) What is the Relationship Between Health, Housing, and Homelessness? *FAQs*. Available at <https://www.nhchc.org/faq/relationship-health-housing-homelessness/>.
2. Forchuk, K, Dickins, K & Corring, DJ. (2016). Social Determinants of Health: Housing and Income. *Healthcare Quarterly*, 18, 27-31.
3. National Health Care for the Homeless Council. (October 2011). *Policy & Practice Brief: Clinical Challenges in Permanent Supportive Housing*. [Author: Barbara DiPietro]. Nashville, TN. Available at <http://www.nhchc.org>.
4. Locke, G., Khadduri, J., & O'Hara, A. (2007). Housing Models. Paper presented at the 2007 National Symposium on Homelessness Research, Washington, DC. Retrieved from <http://aspe.hhs.gov/hsp/homelessness/symposium07>.
5. National Health Care for the Homeless Council. (August 2009). The Relationship Between Housing and Health Care. *Healing Hands*, 13(4). Available at <http://www.nhchc.org>.
6. The Bassuk Center on Homelessness and Vulnerable Children & Youth (n.d.) Website. Retrieved from <http://www.bassukcenter.org/>.

Disclaimer

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09746, a National Training and Technical Assistance Cooperative Agreement for \$1,625,741, with 0% match from nongovernmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

All material in this document is in the public domain and may be used and reprinted without special permission. Citation as to source, however, is appreciated.

Suggested citation: National Health Care for the Homeless Council. (April 2018). Housing Solutions for People Experiencing Homelessness. *Healing Hands*, 22:2. (Author: Melissa Jean, Writer). Nashville, TN. Available at: www.nhchc.org.

Healing Hands

Healing Hands is published by the National Health Care for the Homeless Council.

www.nhchc.org

Credits

Melissa Jean, PhD, writer | Rick Brown, MA, communications manager and designer | Lily Catalano, BA, project manager | Jule West, MD, CME activity director

HCH Clinicians' Network Steering Committee

Dana Basara, DNP, RN | Pooja Bhalla, DNP, RN | Brian Bickford, MA, LMHC | Carrie Craig, MSW, LCSW | Debbian Fletcher-Blake, APRN, FNP | Mark Fox, MPH, MD, PhD | Amy Grassette | Thomasine Mungo | Annie Nicol, FNP, PA | Eowyn Reike, MD, MPH | Mary Tomabene, APN, CNP | Pia Valvassori, PhD, ARNP | Lawanda Williams, MSW, LCSW-C

John the HCH Clinicians' Network Today

To learn more about clinical issues in homeless health care, [join the Clinicians' Network](#). Individual membership is free of charge.



© Mark Hines

Healing Hands received a **2013 APEX Award for Publication Excellence** based on excellence in editorial content, graphic design & the ability to achieve overall communications excellence.

