"…the evidence shows that homelessness is largely the result of failed policies" 7(p15)

BACKGROUND

Homelessness represents one of the most intractable social, health and policy failures. Despite decades of policy efforts, progress has been piecemeal, limited and often temporary. People experiencing homelessness represent one of the most persistently underserved, at risk and undervalued populations in the country, face myriad health burdens, lack access to healthcare and health-related social needs (HRSN) such as housing, hygiene, food, social support, and basic safety. People experiencing homelessness face numerous health inequities and systemic barriers to health and safety.[1]

CHWs serving the unhoused population* include many with lived experience of homelessness or related challenges. As trusted partners, CHWs work to break down barriers to health and belonging by serving as connective tissue within the fractured public health ecosystem. Although the importance of CHWs as trusted messengers is well-established, the specific work of CHWs serving the unhoused population remains under explored.

THE CURRENT STATE OF HOMELESSNESS IN THE U.S.

Over a million individuals and families experience homelessness annually, and many more are at risk of homelessness. Increasing numbers of the homeless population are unsheltered homeless (lack a "fixed, regular and adequate nighttime residence.")[3,4]

- Homelessness affects people and communities across age, race and ethnicity, gender, health status, geography, veteran status, citizenship and immigration status.
- Some groups experience disproportionate rates of homelessness: Native Americans and Alaska Natives, Native Hawaiians and Pacific Islanders, Black individuals, Latino/a individuals, LGBTQIA+ individuals, people with disabilities, people with HIV/AIDS, young adults leaving foster care, domestic violence survivors, and people in re-entry from incarceration [5,6]
- In addition to a lack of affordable permanent housing and long waitlists, there is a lack of safe, accessible shelter or interim housing options for people on waitlists. Often, shelters are full or deny entry to people most at risk, including those who are struggling with a mental health condition and/ or who have a substance use disorder (MH/SUD), have criminal records, live with a disability or chronic health condition, or identify as LGBTQAI+, despite anti-discrimination laws.[6]
- Building an efficient and effective homeless services system will require partners at all levels to understand and address these racial and health disparities.[6]

** Unhoused and homelessness are used interchangeably in this toolkit to reflect varied preferences of people with lived experience. The term unsheltered reflects an official government definition.*

HEALTH EQUITY: SOCIAL DETERMINANTS OF HEALTH AND HEALTH-RELATED SOCIAL NEEDS

People experiencing homelessness face high rates of chronic health conditions (including physical, mental and substance use, vision and dental), and face multiple barriers to accessing healthcare.[5,7,8] The social determinants of health (SDoH) and health-related social needs (HRSN) experienced by people experiencing homelessness are multilayered and cumulative.

Common health barriers and HRSN reported by CHW respondents and documented in public health literature include:

- **Immediate basic needs:** Basic needs such as food and shelter often must be prioritized over accessing healthcare and needed social services.[9] CHWs described how this prioritization requires urgent responses and limits their ability to focus on longer-term needs.
- **Health-related social needs:** Transportation, access to hygiene (showers and laundry), phone and internet, social support, language and literacy, medication storage, security and safety, privacy, employment, and access to mail, identification and documents are common.[9]
- **Chronic health conditions:** Higher rates of and increased risk of chronic conditions including physical, mental health, and substance use conditions including HIV/AIDS, asthma, diabetes, and tuberculosis, which require ongoing care and management.[10]
- **Access to healthcare:** Despite high rates of unmet health needs, 60% of people experiencing homelessness lack health insurance and preventative care. This results in high rates of Emergency Department use,[6,11,12] a "costly revolving door between homelessness and the hospital healthcare system."[12]
- **Poor quality healthcare, bias, and discrimination:** Poor quality healthcare and adverse experiences include bias, discrimination, lack of care, paternalism, humiliation, dehumanization, and not being listened to.[9,11,13] Mistrust of healthcare providers or systems is not surprising given these experiences.
  - CHWs described experience witnessing firsthand or hearing about the dangerous and one CHW described lethal impacts of poor treatment on their homeless client population, including failing to provide necessary services and discriminatory care of people experiencing homelessness in healthcare systems and emergency rooms.
- **Mental health and substance use (MH/SUD):** Higher than average rates of MH/SUD include severe or serious mental illness (SMI) (21% of unhoused individuals), substance use disorder (SUD), (16%), suicide, and trauma prior to and/or as a result of the stresses of homelessness.[11] MH/SUD emerged as the most frequently reported health concerns among CHW respondents serving unhoused clients.

  "untreated conditions, particularly mental health disorders and substance use problems, can propel people into homelessness by dismantling their financial stability, and these conditions can be made worse through periods of homelessness."[10]
- **Violence and trauma:** Routine safety threats include exposure to unsafe sleeping conditions, environmental dangers, extreme weather, and interpersonal violence (domestic violence and sexual assault (DV/SA)). Homelessness is often traumatic, and personal histories of violence and trauma can increase risk for homelessness.[6,11]
- CHWs reported additional barriers and challenges facing their unhoused clients who are elders, people with disabilities or chronic health conditions, and people with low technology access.

POLICY SPOTLIGHT

The ALL IN: Federal Strategic Plan to Prevent and End Homelessness was launched in 2022, leading to several local, state and federal policy initiatives nationwide aimed at tackling homelessness.[3] ALL IN highlighted homelessness as a public health issue, humanitarian crisis, and traumatic

experience with lasting impact. Notably, ALL IN emphasized the importance of centering people with lived experience (PwLE) in housing policy and initiatives and included PwLE in development of the plan.

The U.S. federal government first enacted policies targeting homelessness following the Great Depression as part of the New Deal. The 1980s is often considered the start of the modern era of homelessness in the U.S. due to social changes and crises including the HIV/AIDS epidemic, inadequate supply of affordable housing, economic recession, budget cuts, high unemployment and inadequately implemented deinstitutionalization. Since then, the country has seen increasing rents and stagnating wages.[2]

Recent federal policies included strategies for addressing homelessness, the American Rescue Plan (ARPA) and Coronavirus Aid, Relief and Economic Security (CARES), provided billions of dollars to move people into permanent housing and increase availability of housing and subsidies, along with other strategies. The Housing Supply Action Plan further sought to remedy policy failures,[14] and several Executive Orders addressed housing, structural racism, discrimination, climate crisis related housing needs, and many more related areas of focus.[6]

> *It is critical that people who have experienced or who are experiencing homelessness and housing instability lead and participate in the development and implementation of policies and programs. This includes…people of color …[and] other historically marginalized groups that are overrepresented in homeless populations, especially people identifying as LGBTQAI+ and people with disabilities."* [6(p29)]

Despite these accomplishments, anti-homelessness policies continue to criminalize homelessness, implement hostile architecture, and perpetuate barriers to accessing shelters and interim housing for people with disabilities, MH/SUD, communicable diseases, and criminal records, and/or who are LGBTQIA+.[6]

The federal homelessness strategy described in ALL IN centers on three priorities:

1. Availability of and access to safe housing;
2. Addressing immediate health and social needs of people experiencing homelessness; and
3. Prevention of new homelessness.

While ALL IN represents a time-limited political initiative, these core areas are representative of public health imperatives for prevention, intervention, and addressing SDoH. CHWs actively work within each of these housing priority areas.

CHW ROLES SERVING PEOPLE EXPERIENCING HOMELESSNESS

CHWs serve both unsheltered and sheltered individuals experiencing homelessness, as well as chronic and episodic homelessness, elders, youth, families, people with immigration barriers, people with English as a second language or limited English fluency, and people with chronic health conditions including MH/SUD.

Common CHW roles serving people experiencing homelessness include street outreach/medicine, patient advocacy and navigation, community-clinical coordination, and case management.[1]

Street medicine and outreach partnerships reflect a core role of CHWs in serving people experiencing homelessness. Some programs, such as the HOPICS-Akido Labs partnership in California, integrate clinical care providers in community-based street outreach to connect unhoused people with needed physical, behavioral, and social needs care.[15] A case example of a CHW-led street medicine and outreach program is included below.