

REIMAGINING THE RESPONSE

Treating Homelessness as a Public Health Crisis

A companion document to the US Homelessness Crisis Reference Guide

“How can we worship a homeless man on Sunday and ignore one on Monday?”

— Shane Claiborn

PART ONE: THE BIG REFRAME — HOMELESSNESS AS ILLNESS, NOT FAILURE

What if we stopped treating homelessness as a social services problem and started treating it the way medicine treats disease? Not as a reflection of individual failure, but as a condition caused by exposure, environment, and a compromised social immune system — one that can be predicted, intercepted, and prevented with the right tools.

This is not merely a metaphor. Epidemiologists, public health researchers, and a growing number of cities are beginning to apply the frameworks of disease prevention — surveillance, early warning systems, outbreak response, and environmental remediation — to the homelessness crisis. The results, where implemented seriously, are striking.

The Epidemiological Model Applied

In public health, every outbreak is understood through three lenses: the host (the individual and their vulnerabilities), the agent (the precipitating event that causes the condition), and the environment (the structural conditions that make people susceptible). This framework maps cleanly onto homelessness:

- The host is the individual — their financial reserves, family network, employment stability, physical health, and social connections. Some hosts are more susceptible than others, but susceptibility is not a moral failing. It is a condition of exposure and underlying vulnerability, just as being immunocompromised is not a character flaw.
- The agent is the precipitating event — a job loss, an eviction, a medical crisis, a domestic violence situation, a discharge from hospital, jail, or foster care with nowhere to go. These are the moments of transmission, the equivalent of exposure to a pathogen.
- The environment is everything structural — housing costs, zoning laws, wage levels, the strength of the safety net, the availability of mental health and addiction treatment. In public health, you never solve a disease outbreak by only treating individual patients. You must fix the environment that makes people susceptible in the first place.

Social Contagion: How Homelessness Spreads Through Networks

There is something genuinely contagion-like in how homelessness spreads through social networks — what researchers call the spillover effect. When one person in a doubled-up household loses income, the entire household becomes destabilized. When eviction sweeps through one part of a community, it increases competition for affordable units and raises rents for everyone nearby.

Public health addresses these dynamics through the concept of a syndemic — multiple intersecting epidemics that amplify each other. Homelessness, untreated mental illness, substance use disorder, and chronic physical illness form a classic syndemic. Each condition makes the others worse. You cannot treat one in isolation and expect resolution. The appropriate response is coordinated, multi-system intervention — precisely what the current fragmented homeless response system fails to provide.

Poverty is not a housing market failure. It is a housing market opportunity — for those on the right side of it. And like any public health threat, it will not recede until we treat its structural causes, not just its visible symptoms. — Matthew Desmond

The Symptom vs. Disease Distinction

This is perhaps the most powerful element of the public health reframe. Medicine distinguishes sharply between treating symptoms (fever suppression, pain management) and treating the underlying disease (antibiotics for the infection, surgery for the tumor). Most current homelessness policy is symptom treatment — emergency shelter, food provision, crisis beds. These are necessary, but they do not address the pathogen.

Using the public health model, the pathogens driving the homelessness epidemic are:

- The housing supply shortage: equivalent to a water supply contaminated at the source. No amount of individual treatment resolves a cholera outbreak if the contaminated water keeps flowing.
- The wage gap: incomes that structurally cannot cover housing costs in most American cities. This is a nutritional deficiency at the population level — creating universal susceptibility regardless of individual behavior.
- The credit and record system: eviction records, criminal records, and low credit scores that permanently compromise people's ability to access housing. Once exposed to one episode of homelessness, the individual's defenses against the next episode are dramatically weakened — like a compromised immune system.
- The absence of a safety net: no universal healthcare, no guaranteed income floor, no universal childcare. These are the equivalent of vaccination — they do not guarantee that no one ever gets sick, but they dramatically reduce both incidence and severity at the population level.

PART TWO: A DIAGNOSTIC FRAMEWORK — TRIAGE BEFORE TREATMENT

The epidemiological model suggests categorizing people experiencing or at risk of homelessness the way a hospital categorizes patients presenting in different stages of a condition. This framework points toward radically different interventions at each stage — and reveals where the current system is most misallocating resources.

STAGE	WHO THEY ARE	APPROPRIATE RESPONSE
ACUTE	Currently homeless — on the street, in shelter, or in a car	Emergency medicine: stabilization, safety, shelter, Housing First placement. Goal is survival and stability, not cure.
SUBACUTE	In a housing crisis — eviction filed, utilities shut off, doubled-up in must-leave situation — but not yet literally homeless	RAPID RESPONSE. This is the highest-value intervention window. Rental assistance, legal aid, mediation, utility assistance. Cheapest and most effective point of intervention.
PRE-SYMPTOMATIC	Income below housing cost threshold, weak social network, prior eviction record, recent job loss, recent release from incarceration — not yet in crisis but predictably at risk	PREVENTIVE INTERVENTION. Predictive analytics, proactive outreach, financial counseling, connection to benefits, relational support. Greatest long-term impact per dollar.
ENVIRONMENTAL / STRUCTURAL	Entire neighborhoods or demographic groups where systemic conditions — high rent burden, low wages, high eviction rates — create population-level susceptibility	POLICY INTERVENTION. Zoning reform, universal vouchers, wage policy, affordable housing construction. This is the public health infrastructure layer — the sewage system, not the antibiotics.

Most current homelessness spending is concentrated on the acute tier — emergency response after the crisis has already occurred. Almost nothing is spent on subacute intervention. Almost nothing on pre-symptomatic prevention. And

the structural tier is addressed only episodically, when political will briefly materializes. Inverting this pyramid — spending prevention dollars earlier — is the central insight of the public health model.

PART THREE: EARLY WARNING SYSTEMS — DETECTING THE OUTBREAK BEFORE IT HAPPENS

Public health surveillance systems detect disease before it becomes an outbreak. A coordinated early warning system for homelessness would aggregate data signals that reliably predict housing loss before it occurs. The research supports the following as strong predictive indicators:

The Key Warning Signals

- **Utility shutoff notices and past-due balances:** A 2023 peer-reviewed study published in PLOS One demonstrated that utility billing data is a statistically significant predictor of first-time homelessness within 12 months. Past-due balances and the total current balance amount were strong predictors; having a payment arrangement in place was protective. The researchers concluded that predictive models using utility data could act as an initial population-level screening tool — identifying people at risk who previous methods would have missed entirely.
- **Eviction filing — not the judgment:** Most evictions result in a negotiated outcome if someone intervenes at the filing stage with rental assistance or legal aid. Court-based early intervention programs have shown that intervention at filing is dramatically more effective and cheaper than shelter-based response after the eviction is completed. The filing is the early warning signal; the judgment is the onset of illness.
- **School absenteeism:** A well-documented predictor of family housing instability. The McKinney-Vento Act already requires schools to identify homeless children, but this identification is largely reactive — done after the family has lost housing — rather than prospective. Chronic absenteeism patterns are a leading indicator that precedes housing loss. In California, homeless youth have a chronic absenteeism rate of approximately 31%, versus 17% for the general student population.
- **Emergency room use for non-emergency conditions:** Repeated ER visits for conditions that should be managed in primary care are a documented signal of housing instability. Several health systems and Medicaid managed care organizations have begun screening for housing insecurity in clinical settings — but this data is almost never shared across systems to trigger coordinated response.
- **Lapsed benefits and missed appointments:** Gaps in prescription refills, missed mental health appointments, food stamp application spikes, and sudden enrollment in free school lunch programs all signal financial crisis. These data points exist in different systems — pharmacy, health, schools, social services — but are almost never synthesized because the silos do not communicate.
- **Criminal justice contact:** An arrest, a fine, or a probation violation that leads to a brief incarceration can be enough to cost someone their job and their housing. Contact with the criminal legal system is one of the strongest predictors of housing loss in the subsequent 12 months.

The key insight of the epidemiological model: you do not wait for patients to present in the emergency room with full-blown illness. You detect the exposure before symptoms emerge and intervene. Every day of delay is more expensive and more harmful.

PART FOUR: THE LOS ANGELES COUNTY HOMELESSNESS PREVENTION UNIT — A CASE STUDY

The most advanced real-world implementation of the public health prevention model in the United States is Los Angeles County's Homelessness Prevention Unit (HPU). Launched in 2021, it is the first program in the United States to use artificial intelligence and linked administrative data to proactively identify people at risk of homelessness and reach out to them before they lose their housing.

What It Is and Why It Is Different

Every other homelessness prevention program in the United States requires the person at risk to identify themselves, know the program exists, and seek help. The HPU flips this entirely. It uses predictive modeling to identify people at high risk who are not seeking help — often because they do not know they are about to lose their housing, or do not know resources exist, or have past experiences with the system that make them unwilling to come forward.

"This project is a testament to how a marriage of administrative data and advanced analytics can unlock new possibilities in public services. By harnessing predictive models, we're able to identify those at high risk of homelessness who might otherwise go unseen." — Max Stevens, Chief Analytics Officer, LA County Chief Information Office

How the Predictive Model Works

- The model was developed by the California Policy Lab at UCLA in partnership with the LA County Department of Health Services, the Department of Mental Health, and the County's Chief Information Office.
- It uses linked, anonymized administrative data from multiple county agencies — including the Department of Public Social Services, Department of Mental Health, Department of Health Services, criminal justice systems, and emergency services — pooled through an established data-sharing partnership.
- The model analyzes approximately 580 individual factors for each person in its eligible population, including emergency room visits, arrests, interactions with probation, recent applications for new benefits, mental health crisis holds, family size, income history, and housing stability indicators.
- It generates a risk score for each individual, identifying those who are most likely to experience homelessness within the next 12 months. People on the high-risk list experience homelessness at a rate nearly 3.5 times higher than the average county client.
- The model has been evaluated for equity across racial, ethnic, and gender groups. The evaluation found no evidence of systematic exclusion — and notably, the model was slightly better at predicting risk among Black individuals, who face historically higher rates of homelessness due to systemic racism. The county chose not to adjust the model to select fewer Black individuals, as doing so would have reduced the program's equity.

What Happens After Identification: The Intervention

- Once the risk model generates its list, a dedicated HPU outreach team proactively contacts individuals. This is one of the most challenging aspects of the program — during the pilot phase, only 21% of eligible individuals enrolled. After the outreach team was expanded and the contact process improved, enrollment rose to 35%, a 67% increase.
- HPU case managers carry low caseloads — a 15-to-1 ratio of participants to case managers — enabling genuinely personalized support over four to six months. This is far more intensive than typical prevention programs, which usually offer cash assistance with minimal ongoing contact.
- Participants receive an average of \$6,469 in flexible financial assistance. Critically, this money is not restricted to rent — it can be used for rent arrears, utility bills, vehicle repair (to maintain employment), debt resolution, appliances, laptops for job searching, or any other housing-stabilizing need.
- Case managers also connect participants to health and mental health services, substance use treatment, benefits advocacy, legal aid, employment assistance, job training, and education — addressing the full picture of what makes someone vulnerable to homelessness, not just the immediate financial crisis.

The Results

Reduction in shelter use or street outreach contact within 18 months	71% less likely than comparable non-enrolled individuals
Housing retention upon program completion	86% of participants retained housing
People served by the program to date	1,498 individuals (as of 2025 reporting)
Improvement in enrollment rate after operational changes	67% increase (from 21% to 35%)

Reduction in mental health crisis holds	Lower rates observed vs. non-enrolled group
Reduction in criminal justice involvement	Lower rates observed vs. non-enrolled group
Full randomized control trial results expected	2027
Average financial assistance per client	\$6,469

Note: The pilot-phase results comparing enrolled vs. non-enrolled individuals are promising, but researchers acknowledge the limitations of non-randomized comparison. The formal randomized control trial, currently underway, will provide more rigorous evidence. Results are expected in 2027.

The Key Challenge: Reaching People Who Do Not Seek Help

The HPU's fundamental insight — that the most vulnerable people are often the least connected to services — is also its primary operational challenge. People who are identified by the model as high-risk may have had negative experiences with county agencies, may distrust government systems, may not speak English, or may simply not know that help is available. The program has found that a dedicated outreach team with sufficient time and cultural competency is essential. This is not a problem that technology alone can solve. The algorithm identifies the person; a human being has to build the relationship.

PART FIVE: PROGRAMS THAT HAVE WORKED — VERIFIED RESULTS

The following programs have documented, verified results in reducing homelessness. They represent different approaches, different scales, and different focuses — but together they constitute a playbook of what is possible when resources are directed at the right problem at the right time.

The Way Home — Houston, Texas

Metropolitan area; 100+ partner organizations coordinated under one system

WHAT IT DOES: In 2012, Houston unified over 100 separate homeless service agencies, government entities, and nonprofits under a single coordinated system called The Way Home, managed by the Coalition for the Homeless. All funding — federal, state, county, city, and philanthropic — was brought under a shared steering committee. The system adopted Housing First principles, used shared data to drive decisions, and measured success by housing placements, not service outputs. When outreach workers visited encampments, housing was found for occupants before the encampment was ever cleared.

RESULTS: Since 2012, Houston has reduced homelessness by more than 63% — from approximately 8,500 people in 2011 to around 3,280 in 2024. The region ended veteran homelessness in 2015, achieved an 82% reduction in family homelessness, and a 69% reduction in chronic homelessness. More than 30,000 people have been housed, with 90% remaining housed for two or more years. The 2024 Point-in-Time count showed a 17% decrease in unsheltered homelessness since 2020, even as homelessness rose nationwide.

HUD-Veterans Affairs Supportive Housing (HUD-VASH)

National program; all 50 states

WHAT IT DOES: Launched in 2008 as a partnership between the Department of Housing and Urban Development and the Department of Veterans Affairs, HUD-VASH provides Housing Choice Vouchers (rental subsidies) specifically for homeless veterans, paired with intensive VA case management services. The program operates on strict Housing First principles — veterans are placed into permanent housing without preconditions of sobriety, employment, or treatment completion. The VA has offered approximately 10,000 new vouchers per year since 2008.

RESULTS: Since 2010, veteran homelessness has decreased by more than 52%. Each voucher awarded between 2008 and 2017 corresponded to a one-person decrease in veteran homelessness. A modeling study estimated that without the program, an additional 90,000 veterans would have become homeless by 2017. As of 2024, 83

communities and 3 states have officially ended veteran homelessness. This is the single most successful homelessness reduction program in US history, and the clearest proof that the problem is solvable with sustained political will and adequate resources.

Massachusetts RAFT (Residential Assistance for Families in Transition)

Statewide, Massachusetts — administered by regional housing agencies

WHAT IT DOES: RAFT is a state-funded homelessness prevention program that provides short-term financial assistance of up to \$7,000 per household per year to families and individuals facing eviction, foreclosure, utility shutoff, or other housing crises. Unlike most assistance programs, RAFT accepts utility shutoff notices and eviction notices as triggering eligibility — treating these as early warning signals rather than waiting for literal homelessness. The program is demand-driven (families apply) rather than proactive like the HPU, but it intervenes at the subacute stage before housing is lost.

RESULTS: Metro Housing Boston's annual RAFT reviews have shown consistent cost-effectiveness: in FY2018, the average cost per family assisted was \$3,130, compared to \$24,000 for an average eight-month emergency shelter stay — a ratio of roughly 8:1. The program saved Massachusetts an estimated \$26-31 million annually in avoided shelter costs. In FY2016, 95% of clients did not return for a second year of RAFT assistance, suggesting one-time intervention was sufficient for most households. During the COVID-19 pandemic, RAFT was scaled to serve over 18,000 households in a single year, tripling its normal annual output.

Denver's Housing First Initiative — Permanent Supportive Housing

City and County of Denver, Colorado

WHAT IT DOES: Denver implemented a comprehensive Housing First permanent supportive housing program combining rental assistance with voluntary wraparound services — mental health, substance use treatment, employment support — without requiring participants to achieve sobriety or treatment milestones before receiving housing. The Urban Institute conducted a rigorous three-year evaluation of the program's outcomes.

RESULTS: Urban Institute evaluation found that over three years, 77% of participants remained in stable housing. Participants experienced a 40% reduction in shelter visits, a 40% reduction in arrests, a 30% reduction in unique jail stays, and a 40% reduction in emergency department visits. Approximately half of the total program cost per person was offset by avoided costs in jail, emergency services, and shelters — making the program cost-neutral or better while dramatically improving human outcomes.

Philadelphia Eviction Prevention Project (PEPP) and Utility Grant Program

City of Philadelphia, Pennsylvania

WHAT IT DOES: Philadelphia operates two interconnected prevention programs. The Eviction Prevention Project provides tenants facing eviction with legal representation, financial counseling, a live hotline, and a tenant help center. The City's Utility Grant Program provides direct financial assistance to households facing utility shutoff — treating shutoff notices as a housing stability crisis, not merely a utility problem. Both programs are part of Philadelphia's Housing Action Plan, which also includes LIHEAP Crisis Assistance for households with active 10-day shutoff notices.

RESULTS: Tenants with legal representation in Philadelphia's eviction court have dramatically better outcomes than those without — a finding consistent with research across jurisdictions. The utility-focused assistance acknowledges the documented link between utility shutoffs and subsequent homelessness, though Philadelphia's programs remain largely demand-driven rather than proactively reaching households before they apply for help.

Finland's National Housing First Program (Y-Foundation)

National scale, Finland

WHAT IT DOES: Beginning in 2008, Finland implemented a national Housing First strategy through the Y-Foundation, converting homeless shelters into permanent supported housing units and providing residents with standard tenancy agreements and voluntary services. The government made an explicit political commitment to treat housing as a right, backed by consistent multi-year funding and cross-agency coordination at the national level. This is the most complete implementation of the public health model — addressing not just individual cases but the structural supply conditions simultaneously.

RESULTS: Finland has virtually eliminated street homelessness. Since 2008, overall homelessness has fallen by more than 35%. Finland is the only European Union country where homelessness has decreased consistently over

the past decade. The program is widely cited as the global evidence base for Housing First at scale, demonstrating that structural commitment combined with Housing First principles can achieve what US cities have only approached.

PART SIX: BOLD IDEAS WORTH PURSUING

The following ideas range from programs already piloted in early-stage form to concepts drawn from other fields that have not yet been seriously applied to homelessness. They are not presented as certainties, but as imaginative possibilities worth examining seriously.

IDEA 01 | A National Housing Crisis Surveillance System

The CDC's disease surveillance infrastructure monitors thousands of data points across jurisdictions in near real-time to detect outbreaks before they spread. The equivalent for housing would be a federal platform aggregating eviction filings, utility shutoff notices, school absenteeism rates, and emergency shelter entry data by zip code — enabling early detection of emerging housing crises before they become encampments.

- Seven LA County agencies already share data through the HPU's data partnership — this is proof the infrastructure is feasible at city scale; the question is whether to build it nationally
- The PLOS One utility data study demonstrated that billing records alone can predict first-time homelessness with meaningful accuracy — and utilities already collect this data monthly
- A national system could route federal prevention dollars to communities showing early-warning signals, rather than after the crisis has peaked
- Privacy protections, data governance, and community consent frameworks would need to be built in from the beginning — the HPU's equity analysis provides a model for how to approach this
- This is not science fiction: the Census Bureau already aggregates household economic data at roughly this level of granularity

IDEA 02 | Rapid Response Housing Teams — Modeled on Disaster Response

FEMA deploys teams within hours of a disaster declaration. Homelessness produces a slow-motion disaster for hundreds of thousands of people annually, but the response is fragmented and delayed by weeks or months of bureaucratic process. What if a jurisdiction maintained trained, deployable multi-disciplinary rapid response teams that could be activated when early warning signals exceeded a threshold?

- Teams would combine housing case managers, legal aid workers, behavioral health staff, and peer navigators with lived experience — not just outreach workers with lists of shelters
- Activation triggers could include eviction filing spikes, utility shutoff surges, school absenteeism increases, or encampment formation in new areas
- Houston's Way Home model already approximates this — when an encampment is identified, the system works to house all occupants before any clearance occurs, rather than displacing people with nowhere to go
- A rapid response fund — pre-authorized emergency resources that can be deployed within 72 hours — would dramatically reduce the gap between identification and intervention
- Cities could maintain small standing teams and scale up through mutual aid agreements with nonprofits, similar to how volunteer fire departments work

IDEA 03 | Contact Network Intervention — Treating the Social Web, Not Just the Individual

When an epidemiologist identifies an index case for a communicable disease, they do not only treat that person. They trace the exposure network — who else was in contact, who else is at risk. The homelessness equivalent: when a household enters crisis, who else in their social network is also destabilized?

→ When a grandmother is housing three adult children who can no longer afford rent, intervention focused only on the grandmother misses the larger vulnerability — and the three children are likely to need help within months

→ Miracle Messages already demonstrates the power of network-based thinking: reconnecting unhoused people with estranged family members changes the social immune system of the entire network, not just the individual

→ Contact network intervention would require case managers to assess not just the presenting household but their immediate social network — and offer preventive support to those at secondary risk

→ This approach is especially relevant for newly arrived immigrants and refugees, where tight family networks mean one household's crisis rapidly destabilizes multiple families

→ It reframes the unit of intervention from the individual to the social cluster — more complex, but more aligned with how vulnerability actually spreads

IDEA 04 | Discharge Planning as a Prevention Mandate

A substantial proportion of people who become homeless do so directly from institutions — hospitals, jails, prisons, psychiatric facilities, and the foster care system. These are predictable, preventable transition points. Every institutional discharge is an opportunity to prevent homelessness if housing is secured before the person walks out the door.

→ Currently, hospitals are legally required to plan for safe discharge but have no obligation to ensure the patient has housing — a gap that sends medically fragile people directly to the street

→ Some states and cities have begun requiring discharge planning to include housing verification — California's AB 1730 (2024) requires certain hospitals to screen for housing instability before discharge

→ The same logic applies to jails: a person leaving incarceration without housing is predictably at high risk; pre-release housing placement has shown strong results in the few programs that have tried it

→ Foster care aging-out is one of the clearest pipelines into homelessness — youth who age out of foster care without a stable home or support network are at extremely high risk. Extending support to age 25 (as some states have done) has shown meaningful reductions

→ The public health framing makes this obvious: you do not discharge a patient with an infectious disease to a crowded shelter. You plan for a safe environment before release. The same standard should apply to housing.

IDEA 05 | Relational Poverty Programs at Scale

The When We Walk By research found that approximately one in three unhoused Bay Area individuals cited relational breakdown — not job loss or addiction — as the primary cause of their homelessness. Miracle Messages has shown that reconnecting unhoused people with estranged family produces meaningful outcomes at very low cost. What if this model were scaled into a national relational infrastructure?

→ A national phone buddy program — connecting housed volunteers with unhoused individuals for regular, human, non-transactional contact — builds the relational capital that protects against chronic homelessness

→ Family reunification services, integrated into the homeless response system as a standard offering rather than a niche nonprofit function, could change outcomes for a substantial fraction of the chronic homeless population

→ Peer navigators — people with lived experience of homelessness who are now housed — are consistently more effective at building trust with unhoused individuals than credentialed professionals. Professionalizing and funding this workforce is a high-leverage investment

→ Social prescribing programs — where healthcare providers prescribe social connection, community participation, and relationship-building activities alongside medical treatment — have shown strong results in the UK for reducing loneliness-related illness and could be adapted for housing instability

→ The core idea: housing stability requires social stability. Building relational capital is not soft work — it is the social equivalent of building the immune system that prevents reinfection

IDEA 06 | **Community Land Trusts and Social Housing — Removing Land from the Speculative Market Permanently**

Affordable housing built with public subsidies eventually reverts to market rate — the subsidy runs out, the covenant expires, and the unit is lost from the affordable stock forever. Community land trusts and social housing models break this cycle by removing land from speculative markets permanently. The housing remains affordable forever, not just for the term of a subsidy.

→ The Champlain Housing Trust in Burlington, Vermont — the largest CLT in the US — has demonstrated that permanently affordable homeownership is operationally viable at meaningful scale

→ Vienna, Austria has maintained approximately 60% of its population in publicly owned or subsidized housing for decades — with per-unit construction costs that are a fraction of American affordable housing costs because the LIHTC financing overhead does not exist

→ A social housing model does not require eliminating the private market — it requires building a permanent affordable alternative that competes with the private market and keeps a floor under affordability

→ The public health parallel: just as public water systems removed water from the private market to ensure universal access to a basic human need, public housing systems can remove some portion of the housing stock from speculative cycles

→ This is a generational investment, not a quarterly one — which is why political will is the central constraint

PART SEVEN: THE STIGMA PARALLEL — WHAT HISTORY TEACHES

Every major public health advance has required overcoming stigma that located the cause of disease in the moral character of the people who got sick. Cholera was attributed to the filthiness and vice of the poor neighborhoods it struck. HIV/AIDS patients were told they deserved their illness. Tuberculosis patients were seen as morally weak. In each case, stigma delayed effective response, blocked resources, and caused immense preventable suffering.

The breakthrough always came when the disease was reframed: not as punishment for bad behavior, but as the predictable result of exposure to a pathogen in an environment with insufficient protective factors. Cholera ended when cities built sanitation infrastructure, not when they persuaded poor people to be more virtuous. HIV/AIDS outcomes improved dramatically when the virus was understood as a communicable disease requiring medical response, not moral judgment.

The person who is homeless is not a failed person. They are someone who was exposed to a pathogen — economic disruption, housing unaffordability, system failure — in an environment with insufficient protective factors, and their social immune system was not strong enough to resist. That is a public health problem. And it has public health solutions.

The public health reframe does something politically powerful: it shifts the unit of responsibility. In the current moral framework, homelessness is the failure of the individual — a consequence of bad choices, addiction, or laziness. In the public health framework, homelessness is the failure of the environment — inadequate housing supply, insufficient wages, a compromised safety net, and institutions that discharge people into the street with nowhere to go. Both framings have political implications. Only one points toward solutions.

WHAT THIS MEANS FOR PRACTITIONERS

If you work directly with people experiencing homelessness, the public health model validates something you already know from the ground: the causes of homelessness are structural, the solutions require systems thinking, and the most effective interventions happen before someone ends up on the street.

The HPU in Los Angeles is proof that predictive prevention is not a future idea — it is a present reality showing 71% reductions in shelter entry. Houston is proof that systemic coordination produces 63% reductions at city scale. HUD-VASH is proof that a 52% national reduction in a specific population's homelessness is achievable with sustained political will and adequate resources.

The policy and structural failures are real and stubborn. But the tools exist. The evidence exists. The question — as always — is the political will to use them.

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