Toward a New Understanding

The California Statewide Study of People Experiencing Homelessness

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Benioff Homelessness and Housing Initiative

UCSF

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Executive Summary

IN CALIFORNIA, more than 171,000 people experience homelessness daily. California is home to 12% of the nation's population, 30% of the nation's homeless population, and half the nation's unsheltered population. While homelessness is a major issue for California, there are many conflicting ideas about what to do about it. To design effective programs and policies to address homelessness, we need to understand who is experiencing it, how they became homeless, what their experiences are, and what is preventing them from exiting homelessness.

To answer these questions, the University of California, San Francisco (UCSF) Benioff Homelessness and Housing Initiative conducted the California Statewide Study of People Experiencing Homelessness (CASPEH), the largest representative study of homelessness since the mid-1990s and the first large-scale representative study to use mixed methods (surveys and in-depth interviews). Guided by advisory boards composed of people with lived experience of homelessness and those who work on homelessness programs and policies, we selected eight counties that represent the state's diversity and recruited a representative sample of adults 18 and older experiencing homelessness throughout California. The investigators conducted the research between October 2021 and November 2022. We administered questionnaires to nearly 3,200 participants, selected intentionally to provide a representative sample, and weighted data to provide statewide estimates. To augment survey responses, we recruited 365 participants to participate in in-depth interviews. With this context, CASPEH provides evidence to shape programs and policy responses to the homelessness crisis.

WHO EXPERIENCES HOMELESSNESS IN CALIFORNIA

First, we explore the life experiences of study participants. Individuals with certain vulnerabilities, those with a history of trauma, and/or those from racially minoritized groups, are at higher risk of experiencing homelessness. People who experience homelessness have higher rates of mental health conditions and substance use than the general population. For many, these problems predated their first episode of homelessness.

- **The homeless population is aging, and minoritized groups are overrepresented.** The median age of participants was 47 (range 18-89). Participants who report a Black (26%) or Native American or Indigenous identity (12%) were overrepresented compared to the overall California population. Thirty-five percent of participants identified as Latino/x.

- **People experiencing homelessness in California are Californians.** Nine out of ten participants lost their last housing in California; 75% of participants lived in the same county as their last housing.

- **Participants have been homeless for prolonged periods.** Thirty-nine percent of participants were in their first episode of homelessness. The median length of homelessness was 22 months. More than one third (36%) met federal criteria for chronic homelessness.

- **Participants reported how stress and trauma over the life course preceded their experience with homelessness.** Participants reported experiences of discrimination, exposure to violence, incarceration, and other traumas prior to homelessness. These experiences interacted and compounded to increase vulnerability to homelessness.

- **Physical and sexual victimization throughout the life course was common.** Nearly three quarters (72%) experienced physical violence in their lifetime; 24% experienced sexual violence. Sexual violence was more common among ciswomen (43%) and transgender or nonbinary individuals (74%).

- **Participants reported high lifetime rates of mental health and substance use challenges.** The majority (82%) reported a period in their life where they experienced a serious mental health condition. More than one quarter (27%) had been hospitalized for a mental health condition; 56% of these hospitalizations occurred prior to the first instance of homelessness. Nearly two thirds (65%) reported having had a period in their life in which they regularly used illicit drugs. Almost two thirds (62%) reported having had a period in their life with heavy drinking (defined as drinking at least three times a week to get drunk, or heavy intermittent drinking). More than half (57%) who ever had regular use of illicit drugs or regular heavy alcohol use had ever received treatment.

PATHWAYS TO HOMELESSNESS

Second, we sought to understand the context of participants' lives prior to their most recent episode of homelessness. High housing costs and low income left participants vulnerable to homelessness.

In the six months prior to homelessness, the median monthly household income was $960. A high proportion had been rent burdened. Approximately one in five participants (19%) entered homelessness from an institution (such as a prison or prolonged jail stay); 49% from a housing situation in which participants didn't have their name on a lease or mortgage (non-leaseholder), and 32% from a housing situation where they had their name on a lease or mortgage (leaseholder).

Participants exiting housing to homelessness reported having minimal notice. Leaseholders reported a median of 10 days notice that they were going to lose their housing, while non-leaseholders reported a median of one day.

Non-leaseholders reported lower incomes and housing costs than leaseholders. In the six months prior to homelessness, the median monthly household income for non-leaseholders was $950. Of non-leaseholders, 43% were not paying any rent; among those who reported paying anything, the median monthly rent was $450. Among non-leaseholders who paid rent, 57% were rent burdened (paying more than 30% of household income for rent). Many non-leaseholders previously had been in leaseholding arrangements, but were able to forestall homelessness by moving in with family or friends. Not only did participants lack legal rights, but they often were living in substandard and overcrowded conditions. These arrangements tended to be highly stressful, leading to conflicts.

Leaseholders had higher incomes, but higher housing costs. The median monthly household income for leaseholders in the six months prior to homelessness was $1400. The median housing costs were $700. While 10% of participants whose names were on the lease didn't pay for housing, among those who paid rent, 66% met criteria for rent burden. Sixteen percent of leaseholders had received a rental subsidy in their last housing. Those who became homeless immediately after leaving a leaseholding situation were similar in many ways to the non-leaseholders but lacked options to move to after losing their housing.

The most common reason for leaving last housing was economic for leaseholders and social for non-leaseholders. Twenty-one percent of leaseholders cited a loss of income as the main reason that they lost their last housing. Among non-leaseholders, 13% noted a conflict within the household and 11% noted not wanting to impose. For leaseholders, economic considerations interacted frequently with social and health crises. For example, participants' (or household members) health crises led them to lose their job.

Participants who entered homelessness from institutional settings reported not having received transition services. Nineteen percent of participants entered homelessness from an institutional setting, such as prolonged jail and prison stays. Few reported having received services prior to having exited.

A low proportion of those who entered homelessness from housing situations had sought or received homelessness prevention services. Many participants were unaware of these services. Overall, 36% of participants had sought help to prevent homelessness, but most sought help from friends or family, rather than non-profits or government agencies.

Even if the cause of homelessness was multifactorial, participants believed financial support could have prevented it. Seventy percent believed that a monthly rental subsidy of $300-$500 would have prevented their homelessness for a sustained period; 82% believed receiving a one-time payment of $5,000-$10,000 would have prevented their homelessness; 90% believed that receiving a Housing Choice Voucher or similar option would have done so.

EXPERIENCES DURING HOMELESSNESS

Next, we examined participants' experiences of homelessness. Homelessness is devastating to health and well-being. Participants' experiences were difficult and marked by significant health challenges, high use of drugs and alcohol, frequent victimization, and interactions with the criminal justice system. For the most part, participants were disconnected from the job market and services.

- **Most participants were unsheltered.** More than three quarters (78%) noted that they had spent the most time while homeless in the prior six months in unsheltered settings (21% in a vehicle, 57% without a vehicle). Over the prior six months, 90% reported at least one night in an unsheltered setting. Participants who stayed in shelters reported general satisfaction with them; many who didn't expressed concerns about curfews, the need to vacate during the day, health risks, and rules. Forty-one percent of participants noted a time during this homelessness episode where they wanted shelter but were unable to access it.

- **Participants reported poor health and many health challenges.** Forty-five percent of all participants reported their health as poor or fair; 60% reported a chronic disease. More than one third of all participants (34%) reported a limitation in an activity of daily living, and 22% reported a mobility limitation.

- **Among women of reproductive age, pregnancy was common.** One quarter (26%) of those assigned female at birth age 18-44 years had been pregnant during this episode of homelessness; 8% reported a current pregnancy.

- **Despite these health challenges, participants had poor access to healthcare.** While 83% of participants reported having health insurance (primarily Medicaid); half (52%) reported a regular non-emergency department (ED) source of care. Half (49%) had seen a health care provider outside the ED in the prior six months. Almost one quarter (23%) reported an inability to get needed healthcare in the prior six months.

- **Participants had high rates of acute and emergent health service utilization.** In the prior six months, 38% reported an ED visit that didn't result in a hospitalization; 21% reported a hospitalization for a physical health concern and 5% for a mental health issue.

- **Many participants had symptoms of mental health conditions; few had access to treatment.** Participants noted how the stresses of homelessness exacerbated their mental health symptoms. Two thirds (66%) noted symptoms of mental health conditions currently, including serious depression (48%), anxiety (51%), trouble concentrating or remembering (37%), and hallucinations (12%). Only 18% had received non-emergent mental health treatment recently; 9% had received any mental health counseling and 14% any medications for mental health conditions.

Substance use, particularly methamphetamine use, was common; few received treatment. Many participants reported using drugs and alcohol to help them cope with the circumstances of homelessness. Almost one third (31%) reported regular use of methamphetamines, 3% cocaine, and 11% non-prescribed opioids. Sixteen percent reported heavy episodic drinking. Nearly one quarter (24%) noted that substance use currently caused them health, legal, or financial problems. Approximately equal proportions reported that their use of drugs had decreased, stayed the same, or increased during this homelessness episode. Six percent of participants reported receiving any current drug or alcohol treatment. Twenty percent of those who report current regular use of illicit drugs or heavy episodic alcohol use reported that they wanted treatment, but were unable to receive it.

Criminal justice involvement and experiences of violence were common. Nearly one third (30%) of participants reported a jail stay during this episode of homelessness. Participants reported that homelessness left them more vulnerable to violence. More than one third of all participants (38%) experienced either physical (36%) or sexual (10%) violence during this episode of homelessness. Ciswomen (16%) and transgender or non-binary individuals (35%) were more likely to experience sexual violence.

Participants noted substantial disconnection from labor markets, but many were looking for work. Some of the disconnection may have been related to the lack of job opportunities during the pandemic, although participants did report that their age, disability, lack of transportation, and lack of housing interfered with their ability to work. Only 18% reported income from jobs (8% reported any income from formal employment and 11% from informal employment). Seventy percent reported at least a two-year gap since working 20 hours or more weekly. Of all participants, 44% were looking for employment; among those younger than 62 and without a disability, 55% were.

BARRIERS AND FACILITATORS OF RETURNS TO HOUSING

Next, we examined what prevented participants from re-entering housing. While participants faced many barriers to returning to housing, the primary one was cost. Participants overwhelmingly wanted permanent housing, but they had conflicting feelings about emergency shelter.

Nearly all participants expressed an interest in obtaining housing, but faced barriers. Nearly 9 in 10 (89%) participants noted housing costs as a barrier to re-entering permanent housing. Other barriers included lack of necessary documentation, discrimination, prior evictions, poor credit history, challenges associated with physical or behavioral health conditions, and family considerations (such as having enough space for their children).

- **Participants were not receiving regular assistance, such as housing navigation, to help them exit homelessness.** Eighty-six percent thought that a monthly subsidy of $300-$500 a month would help them re-enter housing. Ninety-five percent thought a lump-sum payment of $5,000-$10,000 would help them. Ninety-six percent thought that a Housing Choice Voucher (or similar rental subsidy) would help them re-enter housing.

- **Participants believed that financial assistance would help them obtain housing and exit homelessness.** Eighty-six percent thought that a monthly subsidy of $300-$500 a month would help them re-enter housing. Ninety-five percent thought a lump-sum payment of $5,000-$10,000 would help them. Ninety-six percent thought that a Housing Choice Voucher (or similar rental subsidy) would help them re-enter housing.

POLICY RECOMMENDATIONS

Based on these findings, we offer policy recommendations. The full report presents more detailed recommendations; we list our top six here:

1 **Increase access to housing affordable to extremely low income households** (those making less than 30% of the Area Median Income) through (1) supporting production of housing (e.g., Low Income Housing Tax Credits, leveraging land use tools), (2) expanding availability of rental subsidies (e.g., Housing Choice Vouchers), and (3) supporting their use on the rental market (e.g., increase housing navigation services, create and enforce anti-discrimination laws).

2 **Expand targeted homelessness prevention** (e.g., financial support, legal assistance) at service settings (e.g., social service agencies, healthcare settings, domestic violence services, community organizations) for both leaseholders and non-lease holders. Expand prevention and transition services at institutional exits (jails, prisons). Expand and strengthen eviction protections.

3 **Provide robust supports to match the behavioral health needs of the population** by (1) increasing access to low barrier mental health, substance use, and harm reduction services during episodes of homelessness (including unsheltered settings) and (2) appropriately staffing permanent supportive housing with evidence-based models (e.g., pathways to housing, assertive community treatment, and intensive case management) that meet the needs of the population.

4 **Increase household incomes through evidence-based employment supports** (e.g., training, transportation) and affirmative outreach to support increasing receipt of benefits.

5 **Increase outreach and service delivery to people experiencing homelessness,** including a focus on unsheltered settings.

6 **Embed a racial equity approach in all aspects of homeless system service delivery.** Ensure that prevention activities and coordinated entry prioritization schemes address racial inequities; and that service delivery is conducted in a way that support racial equity.

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California is home to the largest population of people experiencing homelessness in the United States.

More than 171,000 people experience homelessness daily in California, two times more than the next highest state. While 12% of the overall United States population lives in California, 30% of the nation's homeless population and half the nation's unsheltered population (those living outside, in vehicles, or in places not meant for human habitation) reside here. There are many conflicting ideas about how homelessness became a crisis in California and what to do about it. To determine effective policies, we need to understand who is experiencing homelessness, how they came to be homeless, what their experiences are while homeless, and what is preventing them from returning to housing.

The University of California, San Francisco (UCSF) Benioff Homelessness and Housing Initiative (BHHI) conducted the California Statewide Study of People Experiencing Homelessness (CASPEH). The CASPEH is the largest representative study of homelessness conducted in California and the largest representative study of homelessness in the United States since the mid-1990s. The study examined the characteristics and experiences of adults experiencing homelessness, the precipitants of homelessness, the barriers and facilitators to exiting homelessness, the impact of the COVID-19 pandemic on homelessness, and the opportunities to better prevent and end homelessness in California. By recruiting a representative sample of all California adults experiencing homelessness and by using a combination of questionnaires and in-depth interviews, we provide an accurate picture of the homelessness crisis and its impact on the adults who experience it. We intend for this work to help the public understand the myriad causes and consequences of homelessness and to shape policy conversations about potential solutions.

STUDY OVERVIEW AND METHODS

The research team used best practices to recruit a representative sample of all adults experiencing homelessness in California, whether they be young or old, in family units with children or single, sheltered or unsheltered, and using services or not. Thus, the sample accurately represents all adults experiencing homelessness regardless of service use, living situation, family structure, or language spoken. The study used questionnaires to determine accurate data on the proportions of people who report certain experiences. In addition, the study used in-depth interviews to understand how and why participants experienced what they did.

To guide our work, we convened community advisory boards consisting of those with lived experiences of homelessness and those involved in policy and practice. These boards played a critical role at every stage of the process. Designed to be representative of all adults 18 years and older experiencing homelessness in California,[1] the study includes nearly 3,200 administered questionnaires and 365 in-depth interviews with adults experiencing homelessness in counties representing eight regions (Figure 1). In partnership with a wide array of community stakeholders, the UCSF BHHI team collected data between October 2021 and November 2022.

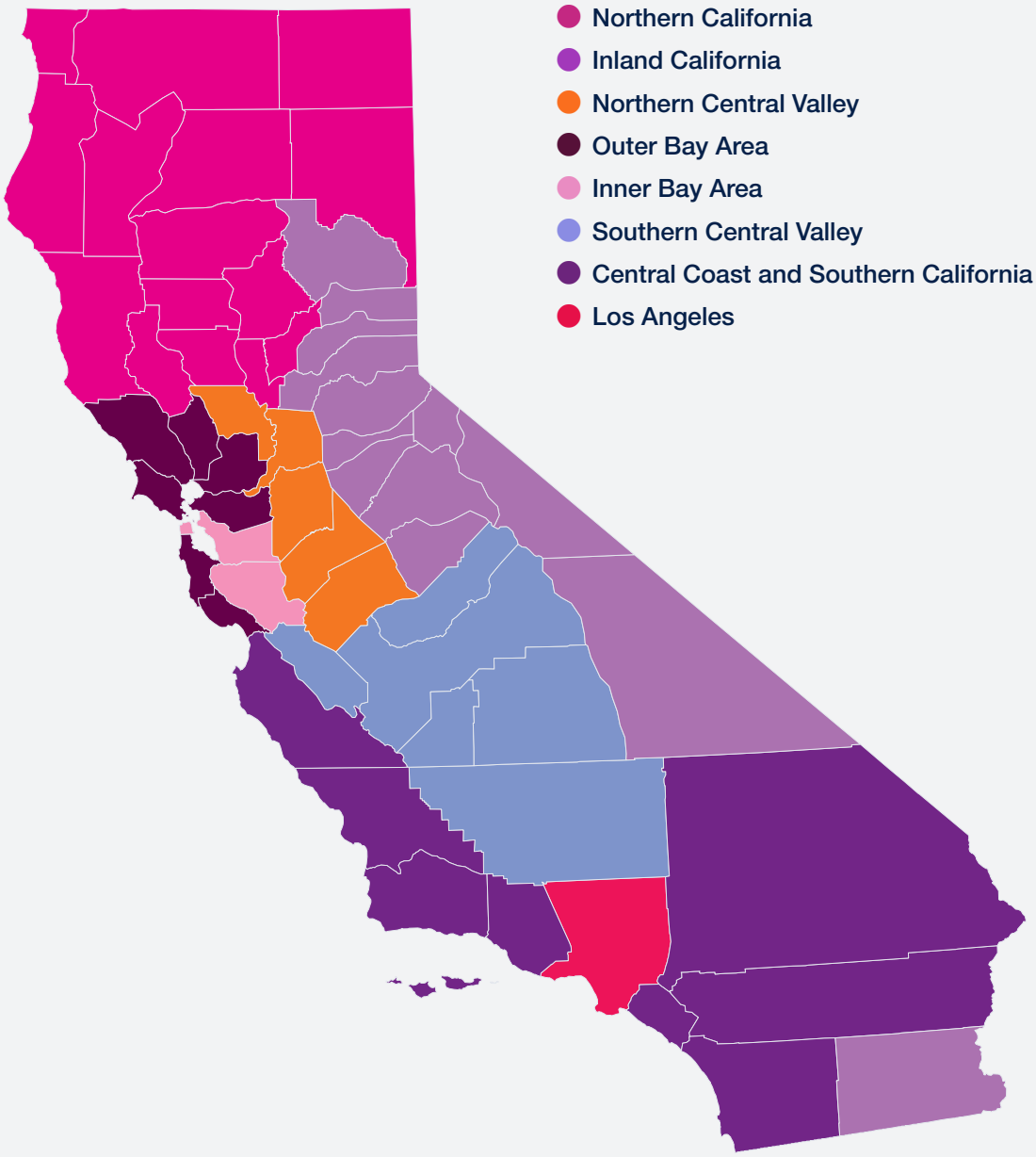
The study received approval from the UCSF Institutional Review Board. All study staff underwent extensive training in research methods and received certification in ethical conduct of research. The study was funded by the UCSF Benioff Homelessness and Housing Initiative, the California Healthcare Foundation (CHCF), and Blue Shield of California Foundation (BSCF). UCSF conducted the study at the request of the California Health and Human Services Agency Secretary Mark Ghaly. The study did not receive funding from the State of California. UCSF BHHI takes responsibility for the findings. Neither CHCF, BSCF, nor the State of California had a role in analyzing the data or interpreting the findings.

Study Population and Eligibility

The California Statewide Study sought to understand the experiences of all adults experiencing homelessness in California. Eligible participants were at least 18 years old and homeless, as defined by the Homeless Emergency Assistance and Rapid Transitions to Housing (HEARTH) Act.[2] All participants provided informed consent prior to study participation.

> Representative of all adults 18 years and older experiencing homelessness in California, the study includes nearly 3,200 administered questionnaires and 365 in-depth interviews with adults experiencing homelessness in eight counties representing eight distinct regions.

FIGURE 1 Map of the Eight Study Regions



Venue-Based and Respondent-Driven Sampling Methods

To provide a representative sample, we divided California into eight regions (Figure 1). Using a variety of data inputs to choose counties within a region that would allow us to draw conclusions about all adults experiencing homelessness in California, we chose one county in each region (Figure 1). With these methods, the counties together stand in for every county across California.

To ensure representativeness within each county, we used venue-based sampling supplemented by respondent-driven sampling (RDS) to recruit participants. In venue-based sampling, we developed a list of places where people experiencing homelessness may be found (encampments, shelters, free and low-cost food programs, showers, and community centers) and selected a random sample of these places. Within each venue, we selected a random sample of people to interview based on the number of people who were present at the time of our visit.[3]

Respondent-driven sampling seeks to recruit people from populations who are likely to be missed during venue-based sampling. Our Advisory Boards recommended we use RDS to find young adults, LGBTQ adults, farmworkers, and residents at domestic violence shelters. With the help of community members who have connections to these groups, we recruited study participants, administered the survey to them, and then asked them to help us recruit other people in their networks. This process continued with participants referring us to members of their communities who then referred us to others.

Using information on all who were eligible and all who participated, we weighted responses to generate statewide estimates.[4]

Photo: Barbara Ries

Administered Questionnaires

Trained research staff administered questionnaires to 3,198 participants, covering topics including demographics, prior and current living situation, employment, income, precipitants of homelessness, barriers to re-entering housing, physical and mental health, work, criminal justice involvement, experiences of violence, experiences of discrimination, and service utilization (e.g., health, mental health, homelessness, benefits, etc.) (Table 1). We designed the questionnaire to understand who was homeless, how participants came to be homeless, what happened to them when homeless, and what was preventing them from exiting homelessness.

Study staff administered questionnaires in person using internet-enabled tablets. For select participants staying in domestic violence shelters, staff conducted surveys via telephone to protect privacy. We conducted interviews in English (95%) and Spanish (5%). For a few interviews (<1%), staff conducted interviews with trained interpreters (American Sign Language and Russian). Interviews lasted 45-60 minutes.

We designed the questionnaire to understand who was homeless, how participants came to be homeless, what happened to them when homeless, and what was preventing them from exiting homelessness.

TABLE 1 Overview of Questionnaire Domains and Location(s) in Report

Questionnaire Domain	Content Summary	Chapter(s)
Demographics	Race, gender identity, sexual orientation, education, relationship status, place of birth, chronic homelessness, household status, size	1
Housing Trajectories	Qualities of last housing prior to homelessness, including where they lived, tenure, when they left, and institutional entries and exits	2
Precursors and Precipitants to Homelessness	Qualities of last housing: owned/rent, leaseholder status, housing costs, rental assistance, circumstances of exiting last housing (e.g., notice prior to leaving, reasons for leaving)	2
Homelessness Prevention	Help sought and/or received prior to homelessness, scenarios that might have prevented homelessness	2
History of Homelessness	Previous experiences of homelessness, age when first experienced homelessness	1
Returns to Housing	Barriers and resources that would help exit homelessness	4
Housing Services	Instrumental support during this episode of homelessness	4
Living Situation	Sheltered and unsheltered locations during this episode (limited to past six months)	3
Income, Employment, and Benefits	Income before and during homelessness, employment changes prior to homelessness, current employment and employment barriers, receipt of social safety net benefits	3
Healthcare Access and Utilization	Health insurance, regular place for healthcare, ambulatory care, emergency department use, hospitalization, unmet needs for healthcare	3
Physical Health	Health status, chronic disease, disability, functional status, COVID-19	3
Pregnancy and Children	Pregnancy history, minor children, custody	1, 2, 3
Carceral System	Involvement with the criminal justice system (lifetime, prior to homelessness, during homelessness), re-entry support, interactions with police	1, 2, 3
Mental Health	Mental health symptoms (lifetime, prior to homelessness, current). Receipt of mental health treatment (ambulatory and hospitalization) prior to and during episode	1, 2, 3
Substance Use	Substance use (tobacco, alcohol, cocaine, methamphetamine, opioids) before and during homelessness, unmet treatment needs, changes in use with homelessness, treatment	1, 2, 3
Interpersonal Violence	Physical, emotional, or sexual violence (lifetime, prior to, and during homelessness)	1, 2, 3
Discrimination	Discrimination before and during homelessness	1, 2, 3

TABLE 2 In-Depth Interview Sub-Studies, Objectives, and Number of Participants

In-Depth Interview Topic	Objective	Number of Participants
Barriers to Returns to Housing	To understand the challenges that participants face in returning to permanent housing	65
Behavioral Health Among People Experiencing Homelessness	To understand the impact of behavioral health issues on participants' experience of homelessness and the deleterious effects of homelessness on behavioral health	58
Precipitants of Homelessness	To understand the precursors of homelessness and identify opportunities for homelessness prevention	66
Black Experiences of Homelessness	To understand Black Californians' experiences of homelessness, with an emphasis on the effects of anti-Black racism	50
Latino/x[5] Experiences of Homelessness	To understand Latino/x populations' experiences of homelessness	35
Incarceration and Homelessness	To understand the interconnectedness between experiences of incarceration and/or other criminal legal contact and homelessness	41
Intimate Partner Violence (IPV) and Homelessness	To understand the relationship between intimate partner violence and homelessness	50

Photo: Barbara Ries

IN-DEPTH INTERVIEW SUB-STUDIES

To understand the full context of participants' experiences, we conducted 365 in-depth interviews in seven sub-studies. In these in-depth interviews, we asked a series of open-ended questions, which allowed participants to share their experiences. The research team selected participants for in-depth interviews based on their questionnaire responses and the researcher's assessment that the participant would be able to discuss the interview topic at length. Staff audio-recorded all in-depth interviews and trained transcriptionists created written transcripts. We coded and analyzed all of the in-depth interviews. See Table 2 for more details on the interviews.

COMMUNITY-ENGAGED PRACTICES

Our team committed to community-engaged practices throughout the study. We relied on the expertise of three advisory boards: the Lived Expertise Advisory Board (a group of individuals with lived experiences of homelessness); the Learning Collaborative Advisory Board (a group of leaders from each of the representative regions); and the Policy and Practice Advisory Board (a group of local, state, and national government partners, service providers, and members of advocacy groups). These boards provided feedback on questionnaires and qualitative interview guides, provided region-specific expertise during study implementation, interpreted findings, and partnered with us to disseminate findings.

To collect data, we partnered with community workers with lived experience of homelessness and knowledge of homelessness in their communities to help with study administration. Supporting outreach and recruitment efforts, they served as integral members of the study staff team.

We partnered with community workers with lived experience of homelessness and knowledge of homelessness in their communities to help with study administration. Supporting outreach and recruitment efforts, they served as integral members of the study staff team.

ABOUT THE REPORT

This report summarizes our main findings, organized by the pathways that lead to homelessness to highlight that homelessness is an experience people have—not an indicator of their character. Chapter 1 provides an overview of who experiences homelessness in California. Chapter 2 discusses our findings on how people became homeless, with a focus on what was happening prior to their current episode of homelessness and opportunities for prevention. Chapter 3 describes the experience of homelessness, with attention to the health and safety of those experiencing homelessness. Chapter 4 focuses on individuals' interactions with the homelessness system and the barriers they faced to regaining housing. Finally, in Chapter 5, we present policy recommendations.

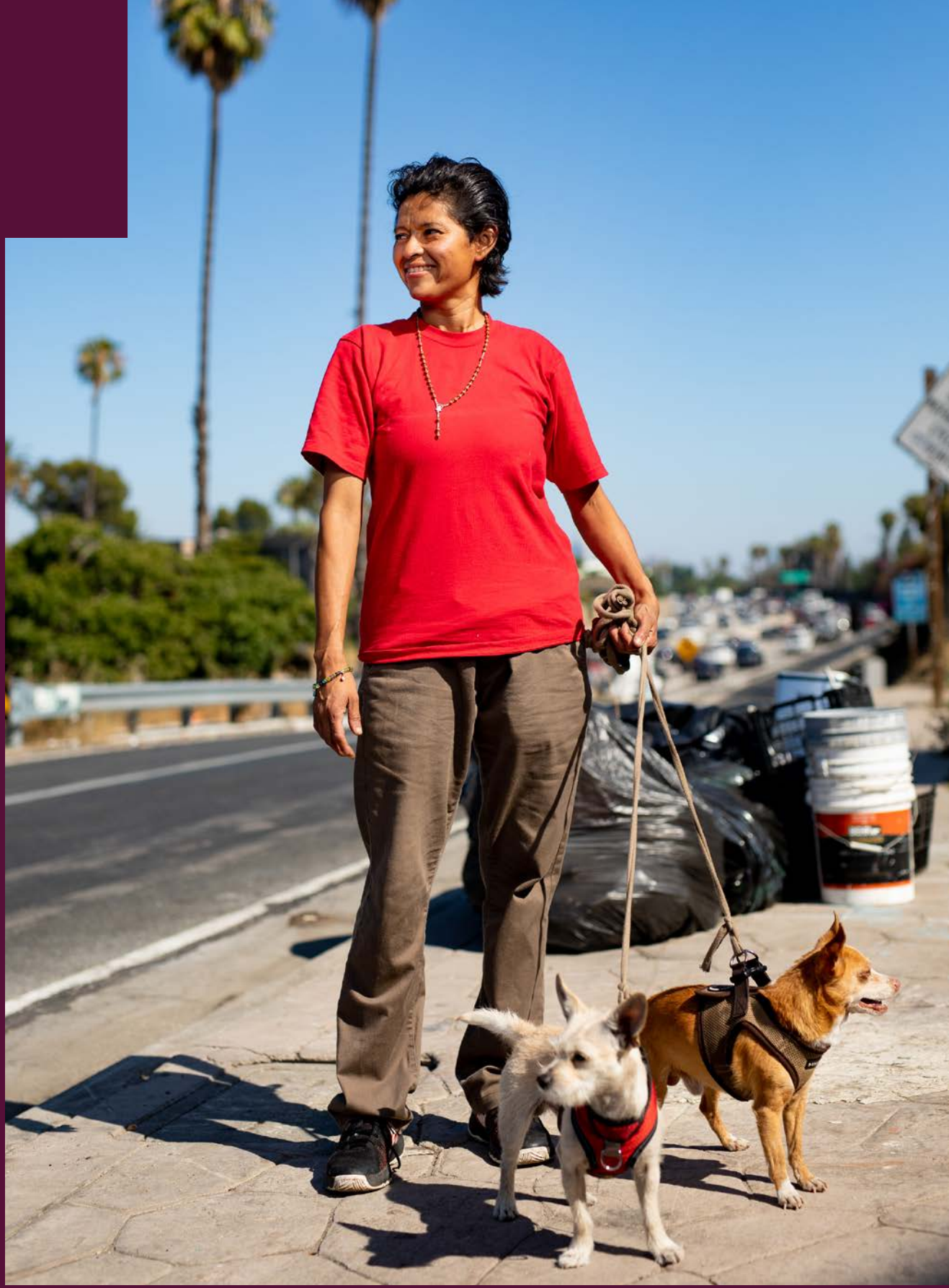
Throughout this report, we use vignettes, drawn from our in-depth interviews, to help readers understand the experience of study participants. A widely-used approach for illustrating themes in qualitative research, such vignettes draw on a composite of several participants' common experiences. We created composite experiences to protect privacy and to elucidate the range of experiences shared by multiple participants.

A NOTE ON TERMINOLOGY

We use several terms to describe our participants and their housing status. These terms include: people experiencing homelessness (or PEH), homeless, unhoused, and unsheltered.

We define these terms as follows:

- **People Experiencing Homelessness:** A human-centered alternative to the term homeless, people experiencing homelessness centers the person and their experience with housing.
- **Homeless:** Refers to the circumstances of not having a permanent indoor place to sleep.
- **Unhoused:** Refers to not having a permanent indoor place to sleep.
- **Unsheltered:** Refers to living in an area not meant for human habitation such as a sidewalk, a park, or a car.



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CHAPTER 1

WHO Experiences Homelessness in California?

Overview

In their book, *Helping America's Homeless: Emergency Shelter or Affordable Housing*,[6] Martha Burt and Laudan Aron note that homelessness arises because of an interaction between structural factors (such as the availability of affordable housing or income inequality), individual factors that increase a person's risk of becoming homeless (such as substance use, mental health challenges, or childhood adversity), and the presence or absence of a social safety net (unemployment income, publicly funded healthcare).

When structural conditions are favorable and there is a strong safety net, fewer people become homeless, and those that do tend to be only those with many individual risk factors. When structural conditions are unfavorable and there isn't a strong safety net, those with fewer individual vulnerabilities become homeless as well. In the United States, structural conditions are unfavorable. Income inequality is the widest it has been in decades.[7] There is an enormous wealth gap by race (the median white family had $184,000 in wealth in 2019 compared to just $38,000 and $23,000 for the median Hispanic and Black families, respectively).[8] Only 33 units of housing are affordable and available for every 100 extremely low-income households (those who make less than 30% of the area median income) in the United States; in California, there are only 24.[9] Our safety net is frayed, with only one in four households who qualify for rental housing subsidies nationwide receiving them, time-limited unemployment benefits, and other gaps. Thus, in the United States in 2023, many who become homeless do not have significant individual vulnerabilities, but those with individual vulnerabilities are at an even higher risk.

> *"I've met some really good people [out here]… Everybody out there in the real world is one paycheck away from being homeless.*
>
> — CASPEH participant

When someone asks "Who experiences homelessness?" it is easy to conflate two different questions. As they explain in their book, *In the Midst of Plenty: Homelessness and What to Do About It*,[10] Marybeth Shinn and Jill Khadduri note that you will get different answers depending on which question you ask: "Why do some people become homeless?" or "Why do so many people become homeless?" The former question will lead to answers about individual characteristics, and the latter will lead to answers about structural conditions. Sometimes, people confuse these and answer one (why are so many people homeless) with an answer better suited for the other. In their book, *Homelessness is a Housing Problem*,[11] Gregg Colburn and Clayton Page Aldern help us understand this distinction by using the analogy of musical chairs, reminding us that the game starts with an equal number of chairs and players who walk around those chairs. At some point, someone pulls away a chair and stops the music, and the players scramble for the remaining chairs. Imagine a game where one player had sprained their ankle the night before, and played walking with crutches they don't know how to use. In this analogy, players are people in an area, chairs are housing, and the player with the sprained ankle is someone with an

individual vulnerability. If you had to guess who would be standing when the music stops, you would guess it would be the person on crutches. That helps answer the question: Why is this person standing? But, if you ask a different question: Why is there someone standing? They are standing because there are only 9 chairs. If there had been 10 chairs, everyone would be sitting. If no one had sprained their ankle and yet you only had 9 chairs, either two people would be sitting on one another, or *someone* would be standing. As we will explain, the reason California has so much homelessness is that we don't have enough "chairs"—in this case, housing affordable to the lowest income households. But, when we ask who is homeless, we find that those with certain individual vulnerabilities to homelessness—either because of a health condition or exposure to structural racism—are at increased risk of homelessness.

In this chapter, to answer the question "Who is experiencing homelessness in California?" we examine the demographic characteristics of CASPEH participants including age, family structure, partner status, race and ethnicity, place of origin, gender, and sexual orientation. To set the stage for later chapters, we explore where study participants were living, for how long they had been homeless, and their experiences of trauma, mental health conditions, and substance use throughout their lives.

Due to the ongoing impact of structural racism, homelessness disproportionately impacts racially marginalized communities, including Black and Indigenous people. We report on the very high rates of prior trauma in those who experience homelessness. We describe the high proportion of people who have experienced mental health and substance use challenges. We recognize that many characteristics that increase one's risk for homelessness are intertwined. For example, experiencing trauma, such as sexual or physical violence, increases one's risk for having substance use and mental health problems. Those who face structural vulnerabilities, having less access to resources throughout their lives, are at higher risk of developing health problems. In calling out these issues, we point out how they interact with one another. In noting them, we are not saying that these experiences are responsible for someone becoming homeless, nor are we answering the question: "why are there so many people experiencing homelessness?" Rather, we are recognizing that in a state with far too few "chairs," it is important to know who has been left standing.

WHO EXPERIENCES HOMELESSNESS IN CALIFORNIA?

Family Structure

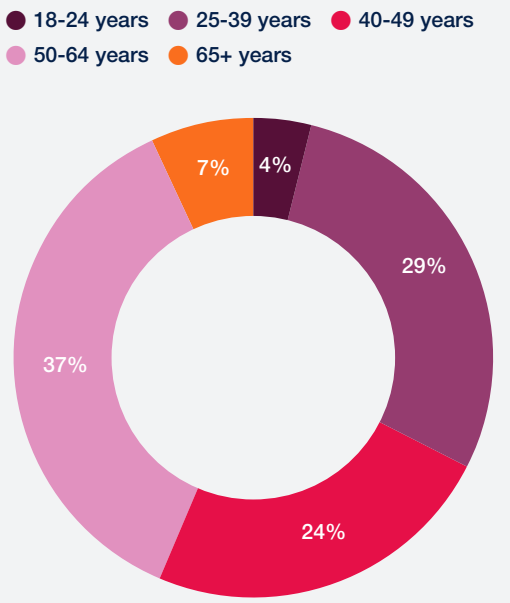
One way that policymakers and researchers categorize people experiencing homelessness is through family structure. In alignment with the federal definitions of homeless adults, we classified people as belonging to one of three family structures: single homeless adults (adults 25 and older who are not living with minor children); adults in homeless families (adults living with minor children); and transition age young adults (TAY; young adults aged 18-24 not living with minor children). Ninety percent of our sample were single adults, 7% were adults in families, and 3% were TAY. Throughout the report, when appropriate, we will present data by family structure, as these groups have different needs and experiences.

Children and youth younger than 18 are an important contingent of people experiencing homelessness. However, our study did not attempt to capture the experience of children and youth younger than 18. This leads to several key differences with the Point in Time Count (PIT), which presents data on "people in homeless families," including both adults and minor children. Because our study included adults only, it has a lower proportion of people in families than the PIT. Further, when the PIT and others discuss TAY, they typically include those 12-24 experiencing homelessness without a caregiving adult. For our purposes, we included only those aged 18-24 and call them transition age young adults. Prior research suggests that aging out of institutions (such as the child welfare system ["foster care"] and juvenile detention), complex family situations, and holding a gender or sexual minority identity increase risk for homelessness among TAY.

Older Adults

California's homeless population is aging, with the proportion of older adults (defined as adults older than 50) in the state's homeless population increasing. Among single homeless adults, 48% were 50 and older. Among single adults 50 and older, 41% became homeless for the first time at age 50 or older.

FIGURE 2 Age Distribution of CASPEH Participants



Cumulative percentage does not equal 100% due to rounding.

Age

The CASPEH sought to understand the experiences of homeless adults (18 years and older). Participants ranged from 18 to 89 years of age. The median age of participants was 47 years, with an interquartile range[12] (IQR) of 37 to 56 years. The median age of single adults was 49 (IQR 38 - 57), 36 (IQR 29-42) for adults in families, and 22 (IQR 21-23) for TAY. Overall, 4% of participants were between 18 and 24 and 44% were 50 and older. Figure 2 presents the age distribution of participants.

Adults with Minor Children

Seven percent of participants met the federal definition of being adults in homeless families. Adults living in homeless families had a median of 1 child living with them (range 1-6). The median age of children living in homeless families was 7 (IQR 2-12). Twenty-six percent of children living in homeless families were aged two or younger. In keeping with the federal definition, we included only adults with minor children (younger than 18) currently living with them as adults in homeless families.

Many adults experiencing homelessness have minor children, but those children aren't staying with them. We found that an additional 27% of participants had children (younger than18) who were not currently living with them (30% of single adults and 8% of TAY). There are many reasons why parents who experience homelessness may not be living with their children. Among all participants, 18% reported having ever lost custody of a child to Child Protective Services (CPS); 11% reported they currently did not have custody of a minor child due to their child being removed by CPS. Homelessness can increase the chance that CPS removes a child from a parent's custody. In addition, parents may make the difficult decision to temporarily give up custody of their children due to struggles with housing—either because they cannot find a place where both they and their children can stay, or because they have a place where their child can stay, but not themselves. Faced with the difficult decision to remain with one's child or have the child not be homeless, some parents make the decision to separate from their child. We found that 11% of all participants (24% of all women) had voluntarily given up primary caretaking responsibilities due to housing instability or homelessness at some point in their lives. Currently, 8% of all participants (10% of those younger than 60) reported that they had given up custody of their minor children temporarily because they were homeless. This was more common in women than men (19% of women younger than 60 and 6% of men younger than 60).

Although some participants had lost custody of their children to CPS, others asked relatives to care for their children so that they would not be exposed to the challenges of being homeless. For example, after describing how she had lost her housing due to a substantial rent increase, a participant added: "So, I wound up homeless. My son had to go stay with his dad. And it wasn't fair to my son." Many of these parents maintained contact with their children and put aside money to purchase small gifts for when they visited them. These parents expressed a determination to improve their housing situation so that they could live with their children.

Current Marital or Partner Status

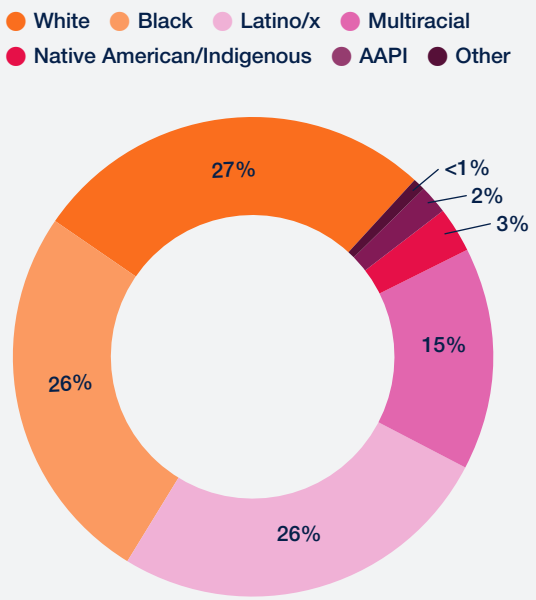
More than half of participants (57%) were currently single and never married, while 23% were either married or partnered. Twenty-one percent of participants were divorced, separated, or widowed (18% divorced or separated and 3% widowed).

Race

We asked participants to share their racial identities (Figure 3). Unlike the PIT, which asks one question about racial identity and a separate question about Hispanic origin, we constructed one race measure. Our race measure treats Latino/x participants as a racial group rather than an ethnicity and includes expanded racial categories. Along with allowing participants to choose all that apply, we include the category "multiracial." These differences mean that our race data cannot be compared to the PIT or general population estimates. For the purpose of description, in this section we provide a breakdown of racial groups in two ways: the percentage of our sample who identified a racial group as their sole racial identity and the percentage of our sample who identified a racial group as one of their racial identities. Separately, we constructed categories around those who chose: (1) white only, (2) Black only or Black and another racial group,[13] (3) Latino/x only, (4) more than one racial group or the multiracial category, (5) Native American/Indigenous or Indigenous to Mexico, Central or South America, (6) Asian American or Pacific Islander[14] (Figure 3).

Across our sample, 27% of participants identified as white and 26% as Black or African American (20% selected Black as their sole racial identity and 6% selected Black as one of their racial identities). Thirty-five percent of participants identified as Latino/x (26% identified Latino/x as their sole racial identity and 9% as one of their racial identities). Twelve percent of our study participants identified Native American, Alaskan Native, or Indigenous to Mexico, Central or South America as one of their racial identities (3% selected Native American/Alaskan Native only; 0.15% selected Indigenous to Mexico, Central or South America only; 8% selected Native American and some other racial group; 1% selected Indigenous to Mexico, Central or South America and some other racial group). Asian or Pacific Islanders made up 3% of our sample (2% selected Asian or Pacific Islander as their sole identity and 1% as one of their identities.). Twenty-two percent of all participants identified as either more than one race or multiracial. The most common answers for those who marked more than one racial group were: Native American/Indigenous and White; Latino/x and White; and Latino/x and Native American/Indigenous.

FIGURE 3 Racial Identities of CASPEH Participants



Twenty percent identified Black as their sole racial identity; 6% as one of their racial identities.

UNDERSTANDING RACE AND ETHNICITY IN THE CASPEH

In order to measure the lived experience of race for CASPEH participants, our team decided to include a race and ethnicity measure that differs from the race and ethnicity domains on the Point-in-Time Demographic Survey. The Point-In-Time Demographic Survey follows the United States Census in asking two separate questions about race and Hispanic origin: a five-category measure of race ([1] White, [2] Black or African American, [3] American Indian or Alaska Native, [4] Asian, and [5] Native Hawaiian or Other Pacific Islander) and a two-category measure of Hispanic origin ([1] Hispanic or [2] Non-Hispanic.) There is a debate about whether this is the best way to categorize race and ethnicity in the United States. Scholars point out that the socially constructed five-category measure of race is an imperfect reflection of the way that people live race in their daily lives, flattening and concealing in-group variation and inequality. With regard to the Hispanic origin measure, scholars note that Latino/Latina/Latinx, Hispanic, or Latin American are ways that people racially identify and differentiate themselves from other racial groups.[15]

In our quest to represent people's lived experiences of race as accurately as possible, our team made the decision to use a single nine-measure race domain that treats those who identify as Latino/x or Hispanic as a racial group and includes expanded racial categories. These categories are: Black, African-American, African; White, Caucasian, or European-American; Native American or Alaskan Native; Pacific Islander, Samoan, or Hawaiian; Asian or Asian-American; Latino/Latina/Latinx, Hispanic, or Latin American'; Indigenous from Mexico/Central/South America; 'Mixed/Multiracial'; or 'Other.'

While these changes make it difficult to compare our race data one-to-one with the Point-In-Time Count, we believe it reflects the daily lived experience of race in California and elsewhere more accurately.

Black Californians were overrepresented among older homeless adults compared to those in younger age brackets. One in three (31%) adults aged 50 and older identified as Black compared to 23% of participants younger than 50 years.

Birthplace and Where Participants Lived Prior to Homelessness

Despite conjecture that people move to California once homeless, our data did not support this. In fact, most participants did not move far from where they last were housed. Ninety percent of participants became homeless in California, having been last housed in the state. People who experience homelessness in California *are* Californians. Three-quarters (75%) of participants lived in the same county where they were last housed; 3% were homeless in a nearby county within the same census region. Eleven percent stayed within California, but lived in a different census region from where they lost their housing.

Most participants (87%) were born in the United States. One-quarter (28%) of Latino/x, 60% of AAPI, and 52% of "other" respondents were born outside of the United States. Two-thirds (66%) were born in California.

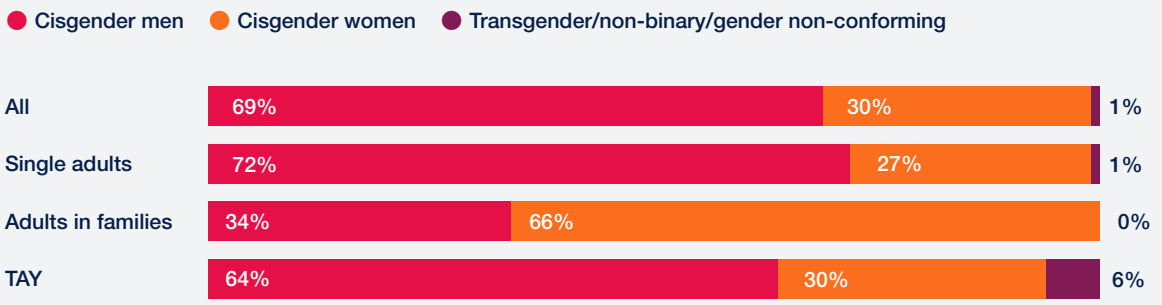
Gender

Sixty-nine percent of all participants identified as cisgender men; 30% identified as cisgender women; and 1% identified as non-binary, transgender, or gender non-conforming (Figure 4).[16] The proportion of non-binary, transgender, or gender non-conforming participants was higher among TAY (6%). While adults in homeless families are thought to be primarily women, we found that 34% of participants experiencing homelessness with their minor children were cisgender men.

Sexuality

Nine percent of participants identified as lesbian, gay, bisexual, pansexual, queer, or another non-heterosexual sexual identity. Transition age young adults were more likely to identify with these identities. While a similar proportion of single adults (9%) and adults in families (9%) did, one in five (19%) of TAY did.

FIGURE 4 Gender Identities of CASPEH Participants by Family Structure



Education

Two-thirds of all participants (63%) had at least a high school diploma or equivalent. Twenty-nine percent held a high school diploma or GED, 24% had some college-level education (but did not obtain a degree), and 10% held a college degree (Associates or Bachelors). Single adults reported education beyond high school (26% some college and 11% a college degree) more frequently than adults in homeless families or TAY.

Veteran Status

There has been substantial progress preventing and ending homelessness among United States Veterans in the last decade. Still, 6% of participants report having served in the military (active duty). An additional 0.4% reported serving in the reserves or National Guard (and not active duty).

Prior Experiences of Homelessness and Length of Current Episode

Participants reported recurrent and lengthy episodes of homelessness. Less than half of participants were in their first episode of homelessness. Thirty-nine percent of participants indicated their current episode of homelessness was their first episode. Adults in families (54%) were more likely to report that this is their first episode of homelessness than single adults (38%) and TAY (35%).

The median length of the current episode of homelessness was 22 months. Those in their first episode had been homeless longer than those with prior episodes. For those who experienced homelessness before, the median length of their current episode was 16 months, compared to 34 months for those in their first episode.

Participants first became homeless as an adult at the median age of 33 (IQR 21-45). Those who had a prior episode of homelessness reported first experiencing homelessness at the median age of 28 (IQR 18 - 39). For those in their first episode of homelessness, the median age when they first became homeless was 41 (IQR 33-52). Among single adults 50 and older, 41% had their first episode after age 50.

A small proportion (4%) reported having experienced childhood homelessness along with their caregivers (before the age of 18). This was more common among TAY (13%) than adults in homeless families (4%) and single homeless adults (4%).

Chronic Homelessness

Chronic homelessness is defined as both (1) experiencing homelessness for at least 12 months or having four or more episodes of homelessness in the prior three years that together total more than 12 months and (2) having a disabling condition. More than one third (36%) of participants met criteria for chronic homelessness. Single adults were more likely to experience chronic homelessness (37%) compared to adults in families (26%) and TAY (23%). Were chronic homelessness defined only based on the time period (rather than requiring having a disabling condition), more would qualify: 75% of single adults, 62% of adults in families, and 74% of TAY.

THE DISPROPORTIONATE BURDEN OF HOMELESSNESS

People who are members of populations marginalized by racism and colonization face economic and structural disadvantages. These structural disadvantages lower the threshold for people who face them to become homeless and prolong episodes by creating barriers to exiting homelessness. Racially marginalized populations are at higher risk for experiencing homelessness due to historical and ongoing structural racism and discrimination. We found that Black and Indigenous participants were overrepresented compared to their representation in the general population in California. Because there are different methodologies for measuring race, it is difficult to make direct comparisons between CASPEH participants and California's overall population. With that said, 26% of participants reported Black as one of their racial identities; among Californians of all ages, 7% did. Twelve percent of participants identified Native American/Alaskan Native as one of their racial identities; among Californians of all ages, 3% did.[17,18] The 2022 PIT count found that homelessness in the Latino/x community is increasing. We defined Latino/x differently than the Census or the PIT count, making comparisons difficult. In our study, 35% of study participants identified as Latino/x (26% as the sole identity and 9% as Latino/x and another identity).[19]

EXPERIENCES OVER THE LIFE COURSE

Homelessness does not happen in a vacuum. It occurs in conjunction with structural conditions that produce and reproduce inequalities. These conditions include high housing costs, low wages that do not keep pace with inflation, the steady disappearance of jobs from low-income neighborhoods, the consequences of mass incarceration on families, and the ongoing effects of classism, racism, sexism, homophobia, and transphobia on people's life chances. Individual vulnerabilities—like substance use and mental health conditions—interact with these structural conditions. At the beginning of the chapter, we reviewed how homelessness is an interaction between structural conditions, individual conditions, and the presence or absence of a safety net. When structural conditions are worse and there isn't a safety net, people with fewer individual vulnerabilities become susceptible to homelessness. However, the relationship between structural conditions, individual experiences, and homelessness is complex—as unequal structural conditions not only create the overall risk for homelessness, but they also increase the risk of having, and severity of, individual vulnerabilities. To understand CASPEH participants' experiences of homelessness, we have to understand their experiences of trauma, stress, mental health, substance use, and incarceration over the life course. In this section, we share some key common experiences that participants had over the life course, including exposure to trauma, incarceration, mental health challenges, and substance use. We reflect on how these experiences amplify and reinforce one another and leave participants at higher risk of experiencing homelessness.

Discrimination, Exposure to Violence, and Incarceration

In in-depth interviews, participants shared stories of discrimination and exploitation that impacted their daily lives and abilities to thrive throughout their lives. Participants faced repeated barriers to meeting their basic needs and bureaucratic hurdles to receiving help. Living in communities with few employment options, they reported experiencing exploitation and discrimination on the job market and in other aspects of their lives. Because of their constrained choices, they faced numerous impediments to thriving.

Our survey data revealed that participants experienced high rates of interpersonal violence (Figure 5). Nearly three quarters (72%) of participants reported a lifetime experience of physical violence; 24% reported experiencing sexual violence. Physical violence was common among both cisgender men (70%), cisgender women (75%), and transgender/non-binary individuals (87%). Experiences of sexual violence were more common among cisgender women (43%) and trans/non-binary (74%) participants than cisgender men. Nearly half (49%) of all participants experienced physical or sexual violence before age 18; 45% reported experiencing physical violence and 15% sexual violence.

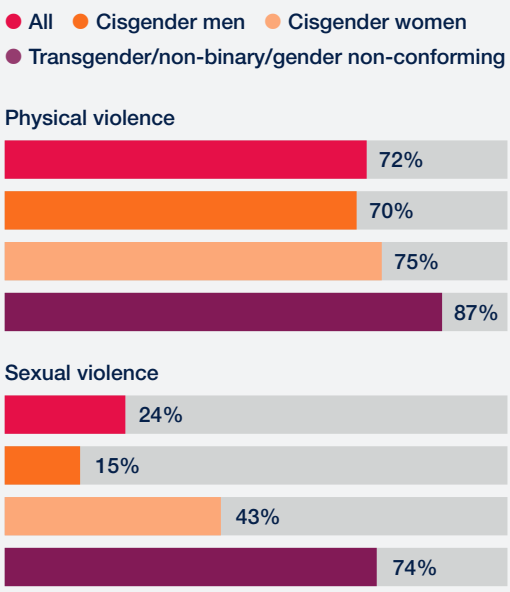
More than three quarters (79%) of participants had been incarcerated in jail or prison during their lifetime. More than one third (37%) spent time in prison, and 77% were incarcerated in jail.

Research shows that cumulative trauma exposure is linked to poor self-rated mental health as well as substance use disorders. It is not surprising that CASPEH participants had high levels of depression, anxiety, suicidal ideation, and substance use.

Mental Health Over the Life Course

Because one can only receive a mental health diagnosis if one had access to healthcare, we asked about experiences of mental health symptoms over the lifecourse; using standard language, we described the conditions we asked about in addition to naming them. Because we wanted to focus on conditions that led to impairments in function, we asked about "serious symptoms" that lasted over a "significant period of time." We asked whether participants had ever experienced a "significant period in your life where you experienced" serious depression (sadness, hopelessness, loss of interest, difficulty with daily functioning); serious anxiety (uptight, unreasonably worried, inability to feel relaxed); hallucinations (saw things, heard voices that others didn't hear or see); or trouble understanding, concentrating, or remembering (Figure 6).[20] Eighty-two percent of participants experienced one of these in their lifetime; depression (69%) and anxiety (69%) were the most common, but 23% reported having experienced hallucinations. Separately, we asked whether they had ever received a diagnosis of post traumatic stress disorder; one quarter (25%) said that they had.

FIGURE 5 Lifetime Experiences of Physical and Sexual Violence by Gender



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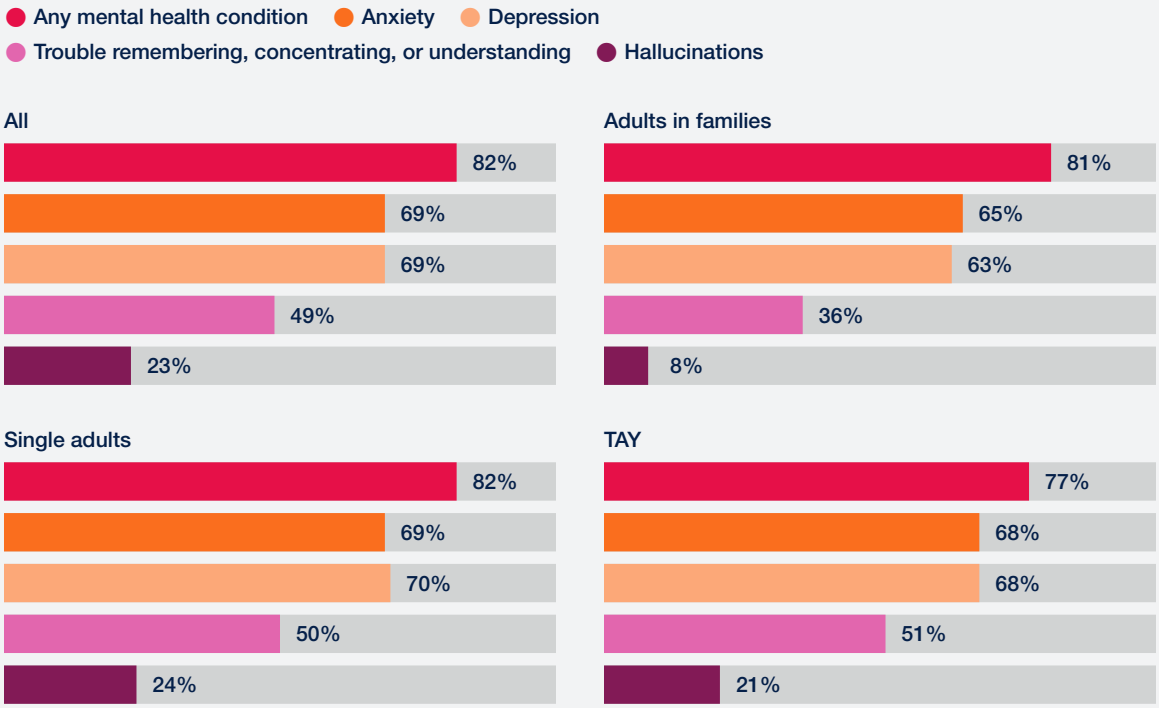
To assess whether participants ever had a severe enough mental health crisis to lead to a hospitalization, we asked whether they had ever experienced a hospitalization for a mental health problem; 27% had. More than half (56%) reported that their first hospitalization had occurred prior to their first episode of homelessness. Fifteen percent of adults in families reported a mental health-related hospitalization, while 28% of single adults and 32% of TAY did.

One in three participants (31%) attempted suicide at some point in their lifetime. Twenty-one percent of adults in families reported a suicide attempt, while 32% of single adults and 32% of TAY did. Many factors are associated with the risk of suicide attempts—including individual factors (e.g., prior trauma, mental health, and substance use challenges); criminal legal involvement; relationship factors (e.g., social isolation or loss of relationships); and community factors (discrimination and poor access to healthcare).[21] Many of these are heightened among people experiencing homelessness. The high rates of attempted suicide reflect the many overlapping traumas that people who are homeless have experienced.

FIGURE 6 Self-Reported Mental Health Conditions at Any Point in Participants' Lifetime by Family Structure



Substance Use Over the Life Course

People who have experienced trauma (including violence and childhood adversity) and those with mental health problems are at higher risk of having substance use disorders. We asked participants to report their lifetime use of three classes of drugs (non-prescribed amphetamines [like methamphetamine], cocaine, and non-prescribed opioids) and to describe patterns of use (Figure 7). We asked participants if they ever used any of these substances three times a week or more frequently. Nearly two-thirds (65%) of participants reported ever using either amphetamines, cocaine, or non-prescribed opioids regularly (at least three times a week). More than half (56%) reported having had a period where they used amphetamines regularly, one third (33%) reported lifetime regular cocaine use, and one in five (22%) reported regular non-prescribed opioid use in their life. Among those who reported ever using any of these substances regularly, 64% reported having started to do so prior to their first episode of homelessness. We asked participants if they had ever used injection drugs; 26% had.

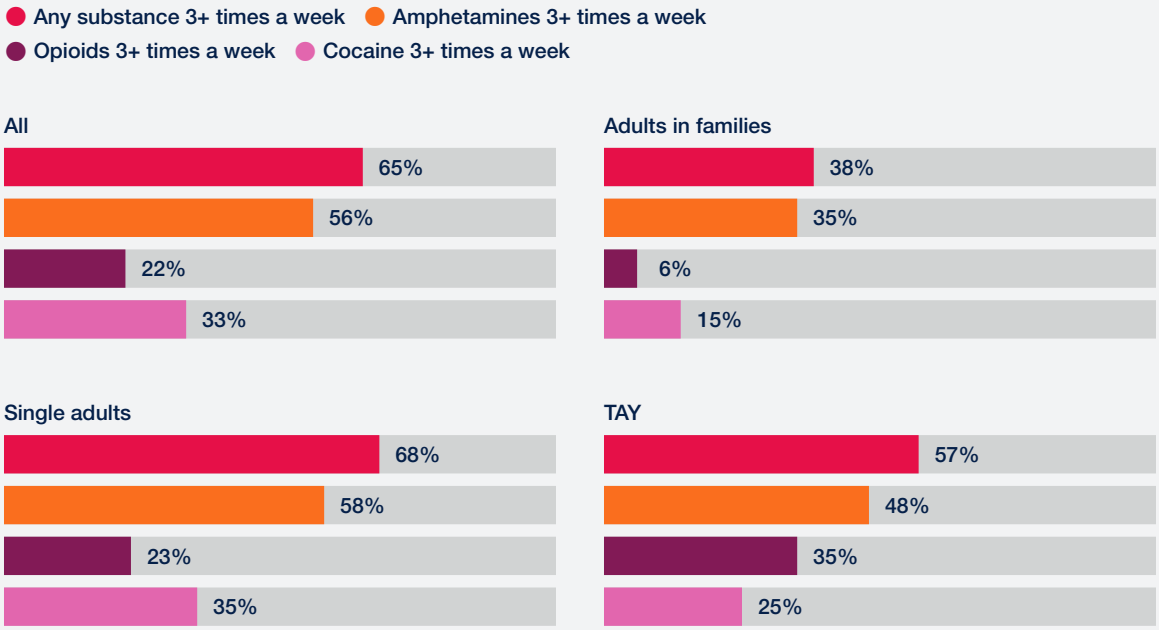
> Homelessness does not happen in a vacuum. It occurs in conjunction with structural conditions that produce and reproduce inequalities. Individual vulnerabilities—like substance use and mental health conditions—interact with these structural conditions.

To understand participants' experiences with alcohol, we asked participants if there was ever a time where they drank alcohol three or more times per week to the point where they felt buzzed or drunk, or drank less frequently but more heavily for short periods (like getting drunk on the weekends). By this measure, 62% reported this. Of these participants, 79% reported doing so prior to their first episode of homelessness.

We asked participants if they had ever had a non-fatal overdose, asking about episodes of overdose that required immediate medical attention, naloxone, or a visit to the emergency department. One in five (20%) participants indicated that they experienced an overdose during their lifetime. To assess whether drug or alcohol use had caused problems with function, we asked whether drug or alcohol use led to financial, health, social, or legal problems at some point in their lifetime. Half (47%) of participants indicated that it had.

To understand whether participants had ever received treatment for a drug or alcohol problem, we asked about receiving any type of treatment, including 12-step groups (such as Alcoholics Anonymous [AA] or Narcotics Anonymous [NA] groups), residential treatment, counseling, medications, or any other treatment to help with drug or alcohol problems. Among those who ever had regular use of any drugs or regular heavy alcohol use, 57% reported having ever received treatment. Finally, we asked whether they had ever wanted treatment but had been unable to access it, to understand whether they had encountered any barriers to treatment. Among those who ever had regular drug use or regular heavy alcohol use, 29% reported having ever wanted treatment for drugs or alcohol and had been unable to receive it.

FIGURE 7 Proportion of Participants Who Reported Regular Substance Use Ever in Their Lives by Family Structure



SUMMARY

In this chapter, we learned about who experiences homelessness in California. We found that the vast majority of adults who experience homelessness in California are single homeless adults, meaning those 25 and older living without minor children. However, we learned that many more had minor children but were living separately from them. The single adult homeless population in California is aging, with nearly half age 50 and older, 41% of whom had their first ever episode of homelessness after age 50. Adults in homeless families and TAY shared many similarities with single homeless adults, but had some key differences, including a much higher proportion of TAY young adults identifying as members of gender and sexual minority communities. Due to the ongoing impacts of structural racism, Black and Indigenous individuals are overrepresented in the adult homeless population. Due to different ways to assess racial and ethnic identity, we cannot make easy comparisons to census data for Latino/x adults.

Despite myths surrounding the homeless population, adults experiencing homelessness in California are Californian, with deep roots in the community. Most are experiencing homelessness in the same county as where they were last housed. Participants reported significant sources of trauma in their lives, much of it predating their homelessness, including experiences with physical and sexual violence and incarceration. Like many with these experiences, they reported high levels of both mental health distress and substance use. A high proportion reported episodes in their life with serious mental health symptoms, hospitalizations, and suicide attempts; a significant proportion reported periods of regular substance use and almost half reported that their substance use had caused them social, legal, or health problems. These findings give us a sense of who is experiencing homelessness in California.

KEY TAKEAWAYS

- Single homeless adults comprise the vast majority of adults experiencing homelessness in California.
- Single homeless adults are aging, with nearly half age 50 and older.
- People experiencing homelessness in California are Californians. Ninety percent of our sample last lost their housing in California. Seventy-five percent of participants lost their housing in the same county in which they experienced homelessness.
- Once homeless, adults remain homeless for extended times. The median length of homelessness was nearly two years.
- One-third of adults met criteria for chronic homelessness.
- Ongoing impacts of structural racism place communities of color at increased risk for homelessness. Black and Indigenous communities are disproportionately impacted.
- Participants' lives were marked by multiple forms of stress and trauma, including violence and incarceration. Nearly three in four experienced physical violence, one in four experienced sexual violence, and three in four were incarcerated at some point in their lifetime.
- Substance use and mental health conditions were common. Many of these predated homelessness. One in five reported a history of a non-fatal overdose. Almost one third reported a lifetime history of a suicide attempt, reflecting the deep vulnerability of this population.

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CHAPTER 2

PATHWAYS to Homelessness

Understanding the context of people's lives prior to becoming homeless is necessary for designing policies to prevent and end homelessness. Homelessness is an experience that people have, not a statement of who they are. In this chapter, we seek to understand how people came to be homeless.

In the survey, we asked participants to report on experiences during the six months prior to their becoming homeless. The months before people become homeless are marked by tremendous stress. Challenges with health, mental health, and substance use can contribute to the descent into homelessness, but can also be caused by the stress of housing instability. We present findings on these aspects of the participants' life in the six months prior to homelessness (including their health, mental health, and use of substances) recognizing the complex interactions between these experiences and the subsequent loss of housing. Through our in-depth interviews, we learned how these experiences acted—as a cause of housing loss or an effect of stress of losing housing, or both.

We asked where participants were living, whether they had tenancy rights or other legal protections, the costs of their housing, and their income immediately prior to this episode of homelessness. We asked about the last place they stayed for at least a month right before their current episode of homelessness. For this analysis, we considered the last place individuals lived as the last non-institutional setting where they stayed for one month or more, or the last institutional setting where they stayed for three months.[22] We determined whether the non-institutional settings were places where they held a lease or mortgage[23] ("leaseholders") or not, such as a doubled-up situation ("non-leaseholders").

> *The rent's so high in this town, it's unbelievable... If you had a minimum wage job you cannot pay your rent, and no one would let you in on a minimum wage job. You couldn't get a place. There's no way.*
>
> — CASPEH participant

We asked participants to report what they believed caused their most recent episode of homelessness, acknowledging that multiple precipitants are often intertwined. Thus, we allowed participants to name more than one cause. Then we asked participants to name which, among the causes they reported, contributed the most. We asked them to report on what assistance they sought and what they received. Finally, we asked participants to reflect on what could have prevented their homelessness.

We used in-depth interviews to untangle how multiple stressors interacted and the sequence in which they occurred. For example, job loss may lead participants to fall behind in rent, which may lead the household to be evicted. After eviction, household members may move in with family members without a lease. Overcrowded conditions can cause tempers to flare, leading to conflict. Understanding how these factors are connected can lead to a clearer and more actionable picture of how homelessness begins.

HOUSING COSTS AND HOUSEHOLD INCOME

High housing costs combined with low incomes left participants vulnerable to homelessness. The median monthly household income of participants' in the six months prior to homelessness was $960 (IQR $220-$2100) (Table 3). Overall, the median monthly housing costs were $375 (IQR $0–$800). However, this statistic obscures an important point. Many participants were already living with family or friends ("doubled up") or living in informal arrangements without leases; others entered from a leaseholder arrangement and still others entered homelessness from institutional settings where they didn't have housing costs. Overall, 49% entered homelessness from a non-leaseholder, non-institutional housing situation, [24] 32% entered from a leaseholder arrangement, and 19% entered from an institutional setting.

Participants entering from non-leaseholder arrangements tended to have relatively low housing costs, but were staying in suboptimal—and impermanent—places, without legal protections. Many, if not most, had left formal leaseholding arrangements at some point before doubling up, but had forestalled homelessness through one or more non-leaseholding arrangements. Earlier, they had faced experiences similar to those who had left leaseholding arrangements. After losing that housing, they experienced a more gradual descent into homelessness, exhausting other options before entering homelessness. Those who came from leaseholding situations had higher housing costs and when they lost that housing had no other options but homelessness. Next, we describe the experiences of those who entered homelessness from non-leaseholders situations, leaseholder arrangements, and institutional settings.

HOMELESSNESS ENTRANCES FROM A NON-LEASEHOLDING ARRANGEMENT

Among those who entered homelessness from a non-institutional setting, 60% were in non-leaseholder arrangements. Some contributed rent while others stayed for free. The median monthly housing costs for these non-leaseholders was $200, (IQR: $0 to $500). Almost half (43%) reported paying nothing for rent. Among non-leaseholders who reported paying anything for housing, the median monthly rent was $450.

The median monthly income for all non-leaseholders in the six months prior to homelessness was $950 (IQR: $221-$2000). For those who paid no rent, their median monthly household income was $500 (IQR: $0-$1200). For non-leaseholders who did pay rent, their median household income was $1200 (IQR: $500-$2400). Among non-leaseholders who paid rent, 57% were rent burdened (paying more than 30% of their income in rent) and 41% were severely rent burdened (paying more than 50% of their household income in rent).

TABLE 3 Median Monthly Income, Housing Costs, Housing Tenure, and Advance Notice Before Homelessness for Leaseholders and Non-Leaseholders

Participant Type	Monthly Income Prior to Homelessness (IQR)	Monthly Cost of Last Housing (IQR)	Housing Tenure	Warning Before Losing Housing
All Participants	$960 ($220-$2,100)	$375 ($0-$800)	1 year	5 days
Non-leaseholders	$950 ($221-$2,000)	$200 ($0-$500)	1 year	1 day
Leaseholders	$1,400 ($700-$2,600)	$700 ($350-$1,100)	3 years	10 days

CARLOS' STORY

Carlos experienced a spinal injury when he fell off a ladder at work. Unable to continue working and ineligible to receive workers' compensation since he was paid in cash, Carlos could no longer afford the rent for his apartment. As the leaseholder, he decided to vacate the apartment to avoid having an eviction on his record. He then rented a room in a two-bedroom apartment, but left after several months due to conflicts with his roommates. Carlos hoped that moving in with his sister's family would provide a long-term solution to his housing situation, but her family was facing COVID-related job loss and a shortage of space. Wanting to avoid being a burden to his family and without other options, Carlos became homeless, living in his truck. After receiving multiple parking tickets, his truck was towed. He now lives in an encampment in a park near City Hall.

Participants described using limited financial or social network resources to secure suboptimal housing, by living temporarily with friends or relatives. These arrangements were often strained by the hosts' financial stress and/or overcrowding. The conditions became untenable, sometimes falling apart due to interpersonal conflict brought on by difficult circumstances. Others reported losing their housing in non-leaseholding situations when the primary tenants faced eviction.

For those whose last housing was a non-leaseholding arrangement, the median warning time that they would lose their housing was one day, reflecting the volatility of these circumstances. Participants who entered homelessness from a non-leaseholding arrangement reported having spent a median of one year at their last (non-leaseholding) housing. Of non-leaseholders, 42% reported that this was their first episode of homelessness.

HOMELESSNESS ENTRANCES FROM A LEASEHOLDING ARRANGEMENT

Among all participants, 32% entered from a stable living situation in which they were on a lease, mortgage, or other written agreement, although most were on a lease (rather than a mortgage).[25] Among those who entered from a non-institutional setting, 40% entered directly from holding a lease (36%) or mortgage (4%). These individuals described rapid descents precipitated by discrete events, such as a threatened (or actual) eviction, domestic violence, a family health crisis that required immediate full time caretaking, an incarceration, or wildfire. By the time they became homeless, many had navigated through a series of less stable and lower quality housing. These included moving from being a primary leaseholder to renting a room in a shared house, having multiple roommates, or renting low-quality housing.

Those who left leaseholder situations described little forewarning prior to being forced to leave, with no chance to make alternative arrangements, or no alternatives remaining. Participants who left leaseholder arrangements reported having a median of 10 days of warning before losing their housing.

For those who had a lease agreement, the median monthly housing costs were $700, with an interquartile range of $350 to $1100. Leaseholders' median monthly income was $1400 (IQR: $700-$2600). Some (10%) of those on leases contributed nothing for rent; for instance, some participants were listed on a family member's lease but didn't contribute to the rent. Among those who paid rent in leaseholder arrangements, 66% met the criteria for rent burden (spending at least 30% of income on rent) and 42% met criteria for severe rent burden (spending at least 50% of income on rent). Across the eight counties, leaseholders' median income ranged from $1100 to $1800 and median housing costs from $500 to $800. Comparing median rent to median income, we found that median cost burdens ranged from 33% to 55%. A small proportion (6%) of participants reported receiving a rental subsidy in their last housing; 16% of all leaseholders did.

SPOTLIGHT ON EVICTION

An eviction occurs when someone is forcibly removed from their home, often (but not always) for falling behind on rent or mortgage payments. Those whose names appear on the lease receive a notice to vacate the property. Once a leaseholder is evicted, the eviction appears on their housing record making it more difficult to find a new place to live. It can also trigger a move into worse housing, housing with others, or directly into homelessness. For those living doubled up or in housing without a lease, we don't use the term eviction. However, a leaseholder may ask non-leaseholders to leave a property. While this doesn't leave a legal trail, it has similar effects in displacing the non-leaseholder—either to a different housing option (often less favorable) or into homelessness.

> *"We lost our home in January. Our landlord had received the full amount or some substantial amount of the emergency rent assistance…about $6,000.00, and two months later he pretty much nailed us with a 90-day notice to quit. We were paid up on rent and everything, and he didn't give us any option of helping us stay in a hotel or anything while he fixed the little crack that was in our bathroom that he said that was the whole foundation being unstable. But he moved two people in like two weeks after we got our stuff out in March… we've been homeless ever since."*

Participants who entered homelessness from a leaseholding situation reported having spent a median of three years in their last housing. Almost half (47%) reported that this was their first ever episode of homelessness.

Participants discussed their experience with eviction or threatened eviction.[26] Many reported evictions due to falling behind in rent. Participants reported a variety of reasons for being behind in rent including job loss, personal health crises, accumulation of financial struggles, and the loss of contributing household members due to ill-health, death, or other reasons. Those who lost their housing due to evictions for non-payment of rent reported receiving "pay or quit" orders. Unable to pay the rent and fearing the impact of an eviction on their credit record, they left their housing suddenly without adequate time to make alternative arrangements. Some participants reported other non-financial reasons for eviction, including lease violations, or conflict with property owners and other household members. Others reported receiving eviction notices due to the need for property repairs. Participants regarded these eviction notices as a response to their complaints about poor housing conditions. In some cases, participants faced eviction due to the owner or a family member moving in or the owners selling the property. Several survivors of interpersonal violence described facing eviction as a result of conflict-related property damage, noise disturbances, or "causing a scene" including 911 calls to the home. Others reported losing housing due to climate emergencies, such as wildfires.

Leaseholders in California have rights that grant either 3-, 30-, 60-, or 90-day notice prior to eviction. The 10 day median notice leaseholders reported may reflect a high proportion of people who were behind on their rent and received a 3-day notice to pay or quit. The three day warning is allowable only for non-payment of rent. The short notice participants reported may reflect that many evictions were for non-payment of rent or that tenants had limited access to legal protections to enforce eviction orders. The absence of adequate notice presents a challenge to homelessness prevention efforts, which depend on recognizing that someone is at risk of losing their housing in time to intervene.

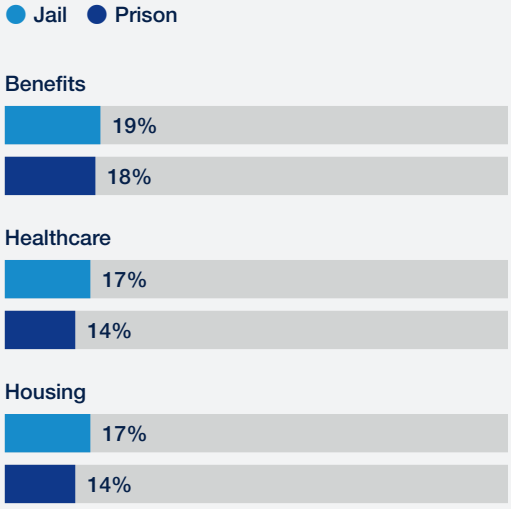
HOMELESSNESS ENTRANCES FROM INSTITUTIONAL SETTINGS

Nineteen percent of all participants entered homelessness directly from an institutional setting; 8% entered from a prolonged jail stay and 6% from a prison stay.[27] Of those who entered from institutional settings, 67% had been homeless when they entered that setting.

A larger proportion of participants had institutional stays in the six months prior to homelessness than entered directly from those institutions, suggesting that some who became homeless had short housing stays between their institutional stay and homelessness. In the six months prior to homelessness, 20% of participants spent time in jail, 9% spent time on probation, 10% were released from prison, and 4% served parole.

People leaving institutional stays reported facing different but related challenges compared with those who entered from housing. In addition to struggling to identify and pay for housing, their social networks had been depleted, they faced barriers to employment, and in many cases, they did not receive assistance from service providers. Participants who were incarcerated in a different county than they were living prior to conviction reported not having the resources to travel back to their home county post-release. Those under community supervision faced barriers to living with friends or relatives living in different parts of the state from where they were serving community supervision. Some who left drug treatment facilities noted that they left after relapsing and had limited options. Like those coming from non-institutional settings, they faced the prospect of finding new housing in high-cost housing markets with low incomes.

FIGURE 8 Proportion of Participants Exiting Jail or Prison Who Received Support Signing Up for Benefits, Health Care Services, or Finding Housing



Jail re-entry support is only reported for individuals who reported jail stays of 30 days or more.

In survey data, participants who had been incarcerated reported receiving minimal support upon exiting prisons or jails. In fact, most who exited the carceral system reported receiving no support at all (Figure 8).

In-depth interviews highlighted the dearth of integrated discharge support. When asked to describe what being released from jail was like, one participant shared: "[They said] 'Thank you,' cut your bracelet off, and off you go. There's nothing. They don't know if you're going to go out and going to be homeless, if you're going back to being homeless, they don't—they don't ask any of that."

> *"It's a rough road and then people treat you as though you're nothing because you have been incarcerated. Nevertheless, I feel like I've served my time… and if I'm striving to get jobs and find avenues and find housing, then those opportunities should be more readily available for me..."*

REASONS FOR LEAVING LAST HOUSING

We asked participants to report on the circumstances that led them to leave their last housing.[28] They could choose as many causes as they felt described their situation. We grouped these reasons into general categories (economic, social, health, and other) and stratified by leaseholder status, to see whether patterns differed between leaseholder and non-leaseholders. While the patterns are useful, within each category there are diverse reasons which call for different solutions. We present these data in broad categories (Figure 9), then separately by specific reason. Finally, we asked participants to name which reason was the most important. We detail specific economic, health, social, and other reasons in Table 4.

Separately, we asked participants to report on experiences that they may have had in the six months prior to becoming homeless—recognizing that these experiences may have contributed to their housing loss, or been a result of the stress or difficulty that they were under. Through in-depth interviews, we explored how these factors played out and interacted with one another.

TABLE 4 Economic, Social, Health, and Other Reasons for Leaving Last Housing

Economic	Social	Health	Other
Exchanged work for housing, and work ended	Breakup between residents	COVID-19 health and safety concerns	Left the area for a job, family, etc.
Lost or reduced income	An issue with the rules	Became sick or disabled	Went into an institution
Lost rental assistance	Conflict among residents	Participant or partner became pregnant	Poor housing conditions
Non-housing costs increased	Conflict with property owner	Participant's substance use	Program ended
Building sold or foreclosed; owner/primary leaseholder change	Conflict with your neighbors or concerns about neighborhood safety	Someone else became sick, disabled, or died	Fire or natural disaster
Housing costs were too high	Didn't want to impose/ wanted own space	Other health reason	
Housing costs increased	Discrimination (race or other identity)		
Someone else stopped paying rent	Others needed more space		
Stolen from or was victim of scam	Substance use by others in the household		
Other economic reason	Violence or abuse in the household		
	Other social reason		

ECONOMIC REASONS

We included anyone who reported any economic reason to have an economic reason for housing loss; participants could indicate multiple reasons (Figure 10) along with social, health, or other reasons. Participants whose last housing was as a leaseholder cited at least one economic reason (58%) more commonly than non-leaseholders (40%).

The most frequently reported economic reason was loss of income. Participants living on the economic margin, with high housing costs, low incomes, and little savings, had little margin for error. Loss of income or decrease in work propelled many living on the economic margins into homelessness. Twenty-two percent reported that lost or reduced income was a reason for losing their last housing. Leaseholders reported this reason more frequently than non-leaseholders (35% of leaseholders, 15% of non-leaseholders). Many participants reported other economic reasons related to low income and high housing costs. Twelve percent noted that while neither the cost of their housing nor their income had changed, they could not keep up with housing costs. One in ten (10%) noted that they had been stolen from or the victim of a scam, and 10% noted that non-housing costs (such as healthcare, food costs, and unexpected expenses) had increased, leaving them unable to pay their rent. Eight percent each noted that their rent had increased, someone else in their household stopped contributing to rent, or their building had been foreclosed on or the primary leaseholders lost their lease.

Leaseholders were more likely to report various economic reasons than non-leaseholders (Figure 11). The economic reasons all point to the fact that, for most, the rent was too high for their income.

In addition to asking about reasons for losing housing, we asked about life events in the six months prior to homelessness. During this time period, 28% of participants had a decrease in work-related income (through job loss, decrease in hours, or decrease in pay). Eleven percent reported having been laid off, 10% reported having had their income reduced, 8% reported having been furloughed or had hours reduced, 5% reported having been fired, and 1% reported having retired. In the months prior to becoming homeless, 2% reported losing a rental subsidy. Some (22%) reported loss of their own, or a member of their household's, income due to the COVID-19 pandemic, either through job loss or a decrease in hours.

Participants discussed experiences of job loss resulting from the COVID-19 pandemic, seasonal employment, and others. As one participant shared: "The virus (COVID) screwed everything up. If the virus, if that wouldn't have never happened, I'd still have my job. And a place. I would have both of them." In many cases, economic and health reasons were intertwined. Participants reported job loss due to injuries (both work and non-work related), illness (their own or family members), the need to provide caregiving to family members, or deaths of household members. Some participants described losing jobs after contracting COVID, due to not having job protections when they missed work due to prolonged illnesses or the need to isolate or quarantine.

FIGURE 9 Proportion of Participants Who Reported at Least One Economic, Social, or Health-Related Reason for Leaving Last Housing by Leaseholder Status

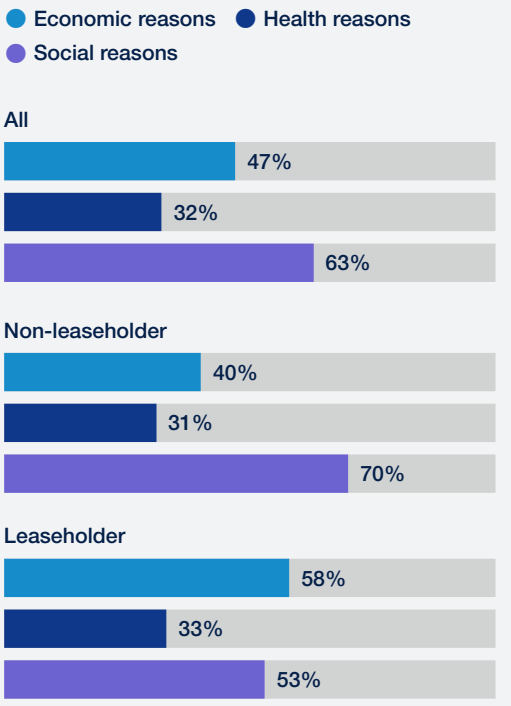


FIGURE 10 Economic Reasons for Leaving Last Housing, All Participants

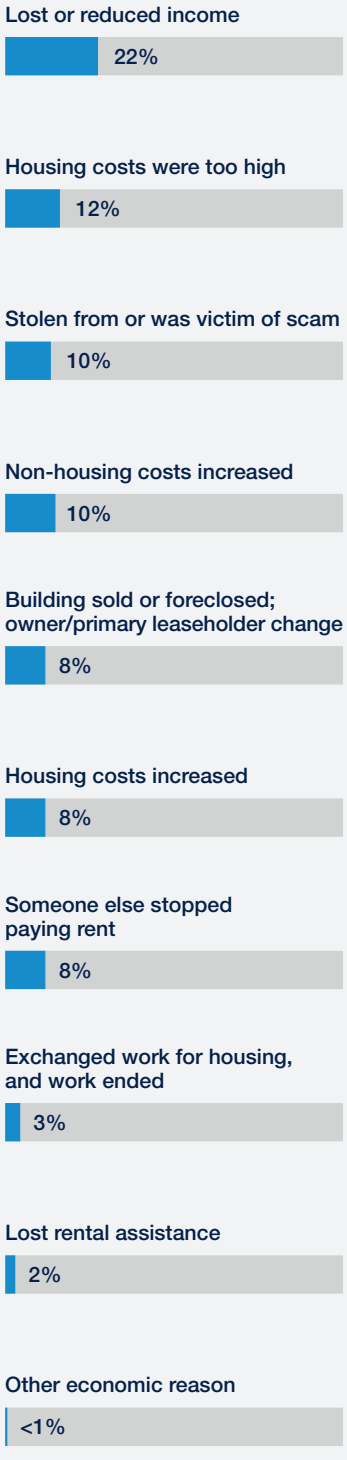
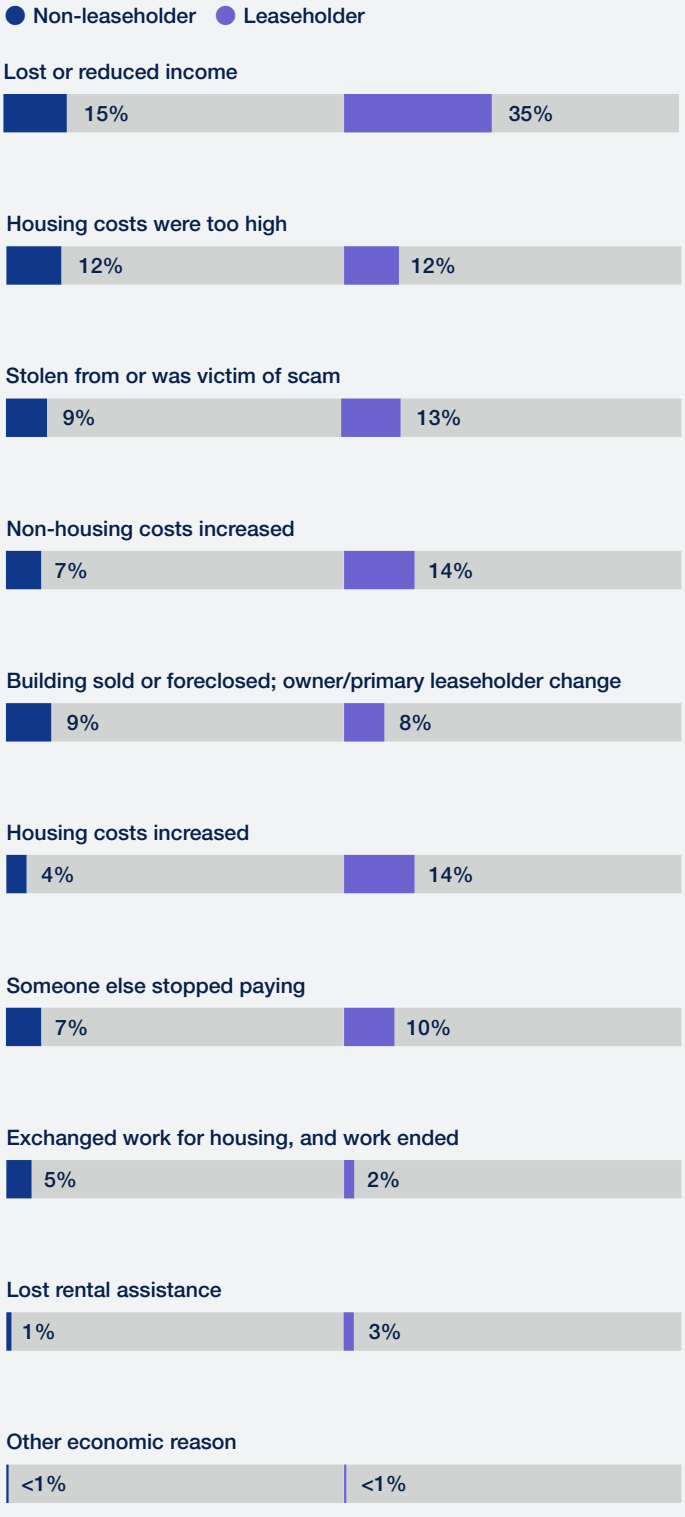


FIGURE 11 Economic Reasons for Leaving Last Housing by Leaseholder Status



Some participants experienced housing precarity and eventual homelessness due to macro-level economic crises. One interview participant shared the lasting impact of the last economic recession: "We applied for a mortgage and financed a condo. That was in 2006 and in 2010 we had to leave the place because of the lack of money when the entire country went through an economic crisis. We were not able to make the $3,500 to pay the mortgage, so we had to leave the place. Since then, we have been homeless. We got divorced, and since then I have lived in my car." Participants who worked as farm workers and day laborers described challenges finding or keeping work during the off-season, which was particularly challenging during the pandemic as farmers were hiring fewer farm workers than they had in previous seasons.

In talking with non-leaseholders, we found that many had experienced an economic shock earlier that led to their entering a non-leaseholder housing situation. Their non-leaseholding housing situations were stressful and overcrowded. When the stress of these situations became too much, the participants exited into homelessness. When we asked for causes, they noted social causes, such as conflict with their hosts. However, an earlier economic shock underlay their downward trajectory.

SOCIAL REASONS

Sixty-three percent of all participants noted at least one social reason for losing housing. As with economic and health reasons, there was substantial overlap between reasons. Due to the diversity of these experiences, we report them separately in Figure 12.

We know that people who have difficulty paying for housing costs—whether with or without leases—face overcrowded, suboptimal conditions. We see the impact of these throughout the social reasons for leaving. One third of participants noted that conflict between people staying in the house was a reason they left their last housing. When people struggle to make rent and housing is overcrowded, conflict may arise. In these situations, particularly for those without a lease, people can feel like they are imposing or in others' space. Almost a quarter noted that not wanting to impose and/or wanting their own space contributed to why they left. Similarly, 16% noted that others in the household wanted more space and thus asked or encouraged the participant to move. Almost one in five (19%) reported a conflict with a property owner, which could reflect economic considerations. Other factors contributing to the decision to leave included violence in the household (13%), an issue with rules (12%), and substance use of others in the household (9%). Experiences of discrimination due to their race or other aspect of their identity contributed to 9% of participants leaving their last household. A similar proportion (8%) reported concerns about neighborhood safety or conflict with neighbors.

Non-leaseholders more frequently reported a social reason than leaseholders (Figure 13). Non-leaseholders were much more likely to report that their not wanting to impose (or wanting their own space) drove them to leave than did leaseholders (33% vs. 10%). Non-leaseholders were more likely to report an issue with rules (15% vs. 7%), reflecting the lack of agency that non-leaseholders have.

Interpersonal Precursors

In in-depth interviews, participants discussed how interpersonal conflicts precipitated homelessness. As with other categories, there was overlap. For example, conflicts over money could lead to interpersonal conflict, as could disagreement about things like substance use. For people living under the constraints of poverty or struggling with health issues, tensions ran high. Conflicts could revolve around finances, rules, responsibilities, or expectations. Participants reported informal arrangements around splitting the cost of rent, utilities, and other household expenses with people they were living with, with resultant conflicts when their expectations were not met.

Violence

Regardless of whether people reported violence or abuse as a reason for leaving, violence was common in participants' lives. In the six months prior to homelessness, one quarter (25%) of all participants experienced physical violence (27% cis-women, 24% cis-men) and 6% (8% cis-women, 5% cis-men) experienced sexual violence. Violence or abuse was a reason for leaving their last housing for 13% of participants (20% of all cis-women, 9% of cis-men).

FIGURE 12 Social Reasons for Leaving Last Housing, All Participants

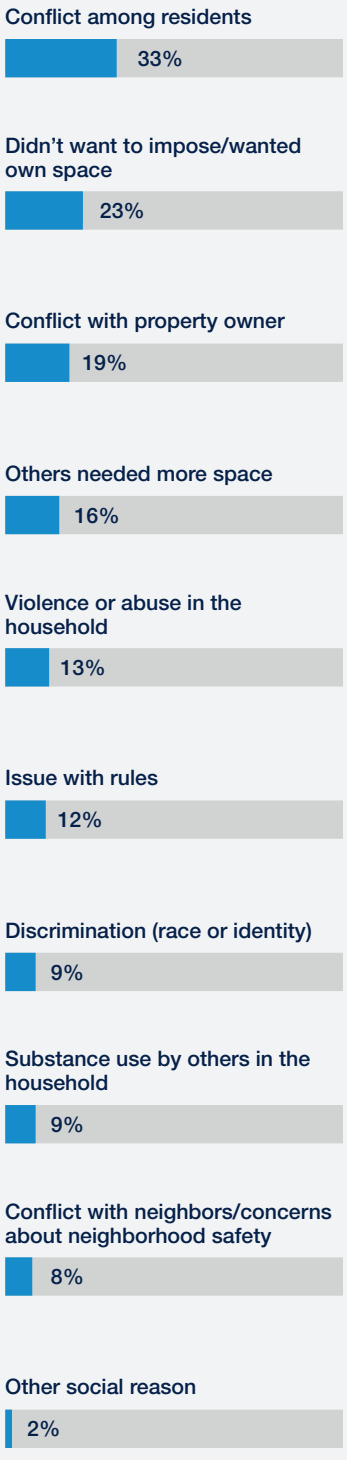
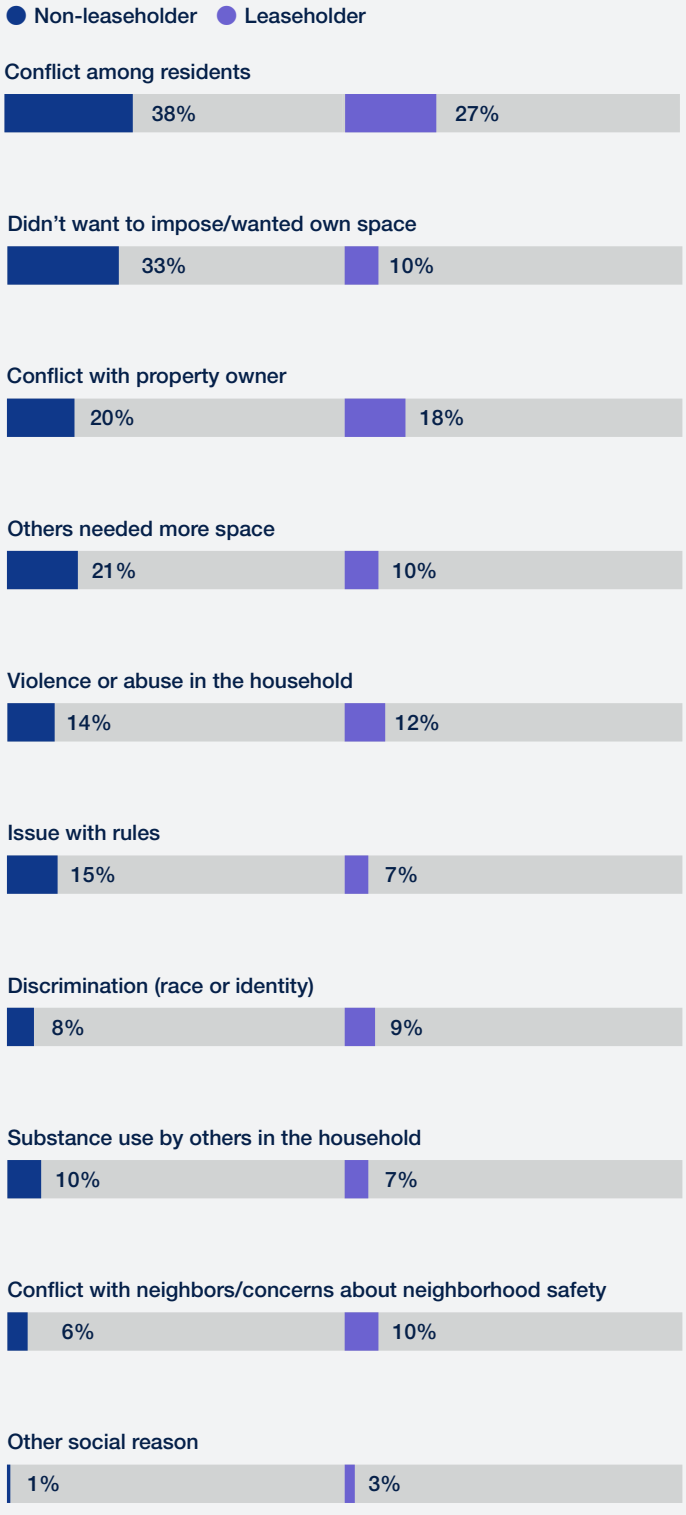


FIGURE 13 Social Reasons for Leaving Last Housing by Leaseholder Status



Participants who left due to violence spoke of leaving as a strategy to survive. Leaving due to interpersonal violence (IPV) affected those in both non-leaseholder and leaseholder housing, with a similar proportion reporting it as a reason for leaving. For some, IPV led to their leaving behind a housing subsidy. One participant stated: "I told my brother, 'Stay in the house, and don't let [my husband] come back... Because if he gets in the house, then he's not going to leave. And it's going to mess up my Section 8.'...my husband got out of jail and went there. And he wouldn't leave the house, and [my brother] couldn't get him out. Because it's his address, too. And so, they had an inspection, but I wasn't there to do the inspection. So, I lost my housing. If I came back there, he would've – he's almost killed me twice already." Some participants noted that pandemic-related conditions (including stay-at-home orders and related job loss) led to more time and stress (and thus more violence) with partners/perpetrators.

Discrimination

Participants shared stories of discrimination that led to their housing loss either directly or circuitously. They experienced discrimination in the labor market based on disability, race, immigration status, and language. People encountered discrimination when trying to find work and experienced discrimination at work that led to reduced hours, reduced wages, lower pay than promised, being targeted for harsher and more frequent evaluations, or exclusion from raises and promotions. This made it harder for participants to find any work or work that paid a living wage, and contributed to their inability to pay for housing. One participant who used a wheelchair told us: "[I] do feel discriminated [against] because of…race, because of the disability I walk in a store and say, 'Are you hiring?' 'No, we're not hiring. Apply online.' You know? I get that a lot. Everywhere I go, I ask. I mean I've been all over with employment. It's difficult, especially with the disability and wheelchair. You know, I can fix and dress myself up nice. But, once they see the [wheelchair]– you know?"

Discrimination on the housing market can lead to homelessness. A participant shared that he had been renting a room in an apartment with a friend, who was the primary leaseholder. Their landlord was "not friendly to Black people" and one day told him to "get out now,' instead of giving me my 30 days. He's like a violent type, so he'll go against the law and not give me my 30 days." With no savings and minimal notice, he had no option but to check into a shelter as he searched for another room to rent. He shared that he searched for housing online and on social media, but people did not want to rent to him once they knew he was Black. Reflecting on searching for housing on social media, he shared: "[Social media] is hard…cause you gotta show your face. I would get a lot of 'no's' or like, 'we're busy' or like 'we're not renting it yet', even though it says 'renting out now.' So, yeah. They didn't respond to me after I showed them a picture—after they asked for a picture of me, they didn't respond."

HEALTH-RELATED REASONS

In both survey data and in-depth interviews, participants reported health problems—theirs and their family members—as a reason for entering homelessness. There were myriad types of health problems—physical health, mental health, substance use, COVID-19, pregnancy, and the need to become a caregiver. Like with economic and social issues, these problems interacted with others to increase the risk for homelessness. Health problems could lead to economic issues (through job loss or excessive non-housing costs) or social issues (for instance, a participant's substance use could cause conflict with others). Pregnancy and the post-partum period are known risk periods for homelessness. Of participants who were assigned female at birth and 18 to 44 years old , 11% were pregnant during the six months prior to homelessness (representing 2% of all participants). Overall, nearly one third of participants indicated at least one health-related reason as a cause of their homelessness.

Thirteen percent of participants noted that their use of substances was a factor in their leaving their last housing (Figure 14). Nearly as many (11%) noted that someone else's illness or death contributed to their becoming homeless, and 9% noted that their own health crisis was a reason for their housing loss.

Concerns about their—or others—health or safety related to COVID contributed to 5% leaving. A small percentage noted pregnancy as a reason.

Unlike economic and social reasons, we did not find much variation between leaseholders and non-leaseholders for health-related reasons (Figure 15).

Physical Health

In many cases, physical health problems and housing loss were linked through employment. Participants reported that health crises (theirs or a household member's) led to job loss and then the loss of income caused them to lose housing. A participant described the impact of an injury and the COVID pandemic on his ability to work as a driver: "I got hurt…That's kind of making it bad for me because I really can't do too much. They have me as disabled because of my back and my leg, so I really can't do all the things I used to do...I got hurt at work just before COVID. And when COVID came, it just messed up everything. That's how I became homeless." Another participant described how her pregnancy led to job loss, which led to homelessness: "I lost my job because I got pregnant, I got fired after working there for one year. I was not feeling well one day, and the supervisor didn't let me go home, so I left. The next day he told me that there was no longer work for me. So, the owner of the house gave me one month while I found another job, but it is not easy since I was pregnant. I found work for one or two days, so I couldn't make the money to pay the rent."

FIGURE 14 Health-Related Reasons for Leaving Last Housing, All Participants

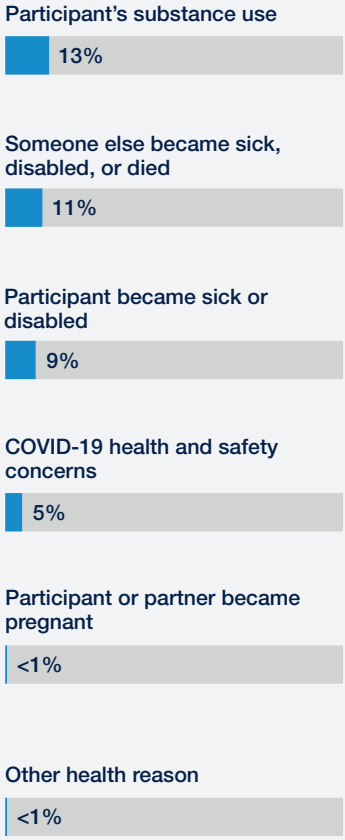
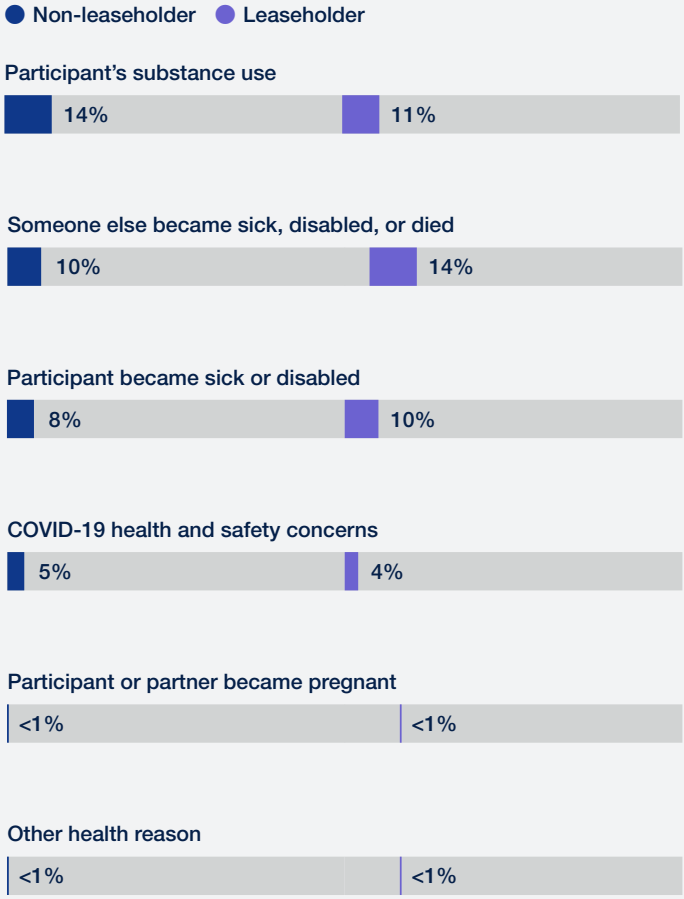


FIGURE 15 Health-Related Reasons for Leaving Last Housing by Leaseholder Status



Mental Health Conditions

The period prior to homelessness is frequently marked by multiple forms of stress. Decreased household income, difficulty paying for rent, physical health problems, conflict with others, and concerns about losing one's housing can precipitate or worsen mental health challenges. Similarly, having mental health challenges can make it difficult to maintain work and relationships and can contribute to housing loss. Mental health hospitalizations are known to be associated with future homelessness. In the six months prior to homelessness, 7% of all participants reported a mental health hospitalization. A higher proportion reported significant mental health challenges that did not require hospitalization: half of participants (50%) experienced significant depression, half experienced significant anxiety (51%), 13% experienced hallucinations, and a third (32%) experienced trouble understanding, concentrating, or remembering. Only a small proportion received formal help for these symptoms: 14% received outpatient treatment or counseling, and 20% were prescribed medication for mental health issues.

Substance Use

Substance use disorders can increase vulnerability to homelessness. Thirteen percent of participants noted that their substance use was a reason for leaving their last housing. In the six months before homelessness, 29% used amphetamines, cocaine, or non-prescribed opioids regularly (at least three times a week). Nearly one quarter (24%) reported heavy regular drinking. One quarter (25%) of all participants reported that their substance use led to health, social, or legal problems in the six months prior to homelessness. One in eight (12%) received treatment or counseling for alcohol or substance use; however, 9% indicated that they wanted treatment but could not access it during this period.

In some instances, employment challenges, substance use, and mental health problems worked in synchrony to increase risk for homelessness. Participants described how these three factors contributed to their becoming homeless: "I was laid off. Went to unemployment and then as things progressed my depression set in more. It was just almost like a relationship that I lost through depression and drugs... these are the cycles that I go through."

Substance use and incarceration can interact to increase risk for homelessness. One participant shared: "In a broader sense maybe it was more of the addiction that led to the homelessness, that also led to the arrest... But being homeless definitely did put you out in the public to where you can be arrested."

Substance use can increase the precarity of already fragile housing situations, as was the case for those actively using substances and those who were seeking support to reduce or stop their substance use. Participants discussed how their substance use was a source of conflict within their household and contributed to their loss of housing or inability to stay with friends or family. In in-depth interviews, participants reported how infractions while in residential treatment programs resulted in housing loss. One participant reported: "I went into residential rehab for six months... And then I moved into their sober living environment when I graduated from the program. And then I relapsed after a couple months and they kicked me out. And I've been homeless ever since." Residential programs may decide to terminate residents for these infractions, leaving individuals at risk of homelessness.

Caretaking and Health of Others

In addition to personal health crises, some reported that other's health crises contributed to their homelessness. Some participants described moving in with family members to serve as a caregiver (paid or unpaid) for a family member—and then losing their housing upon the hospitalization or death of their loved one. When participants were paid caregivers, they risked losing both their employment income and their housing when their family member died. In other cases, a household member's illness led to the household member's job loss and inability to contribute to housing costs, leading the entire household to be displaced. In other cases, the death of a household member led to housing loss—either because the decedent was the only one with their name on the lease, or because the loss of their income led to the household being unable to make rent. Still others spoke about complicated grief from the death of a loved one interfering with their ability to work.

Participants explained how the health or death of loved ones could lead them to homelessness. One participant noted: "I took care of my mom before that so—after she passed away, I had nothing. I became homeless after that, because there was no income for me, nothing after that. The job gets cut off, and she was on housing and the day she died is the day they closed the house and threw me out."

OTHER REASONS

Some participants discussed reasons for leaving their last housing that we did not classify as economic, social, or health-related. These reasons included leaving an area for a job, relationship, or for family, living in deteriorating housing conditions, having a program (such as a substance use treatment program) end, entering an institution, or being impacted by a fire or natural disaster (Figure 16). We found that 9% of people left the area for a job or relationship, 6% left because conditions were poor, and 6% left because a program they were in which supplied housing ended. Two percent each reported leaving to enter an institution (such as a jail, prison, or hospital) or due to a fire or other natural disaster.

A participant explained how a move to a new area could not work out: "My dad had been trying to talk me into moving with him [to Florida] anyway, so I decided to take him up on that offer… and it ended up being the worst thing I could have ever done for myself. And so we ended up moving back... it took everything we had… all of our money, took everything. And then when we got here we had nothing."

Climate-Related Housing Loss

Some participants discussed losing housing due to climate emergencies, such as wildfires. Overall, 1% of all participants noted this as a reason, but responses were concentrated in certain regions. A participant shared: "I was staying with my sister and my niece, and then their house went up in flames while I was in the hospital. Then I ended up in a care home for a little bit, and then [I had] no place to go."

FIGURE 16 Other Reasons for Leaving Last Housing

Housing Conditions

Sometimes people left housing because the conditions deteriorated to the point that the home was no longer habitable. Among all participants, 6% noted this as a reason for leaving their last housing. One participant share: "Nothing worked—the trash compactor and the disposal was clogged, my bathroom, this pipe was leaking—broken, the toilet kept overflowing. It's just very hard to live in that house."

PRIMARY REASON FOR LEAVING LAST HOUSING

In this section, we discuss the primary reason that participants identified as contributing to their housing loss.

Overall, participants reported that loss of income was the most important for them to leave their last housing: 12% of all participants did (Figure 17). Nine percent noted a conflict with residents of their household was the primary reason.

Figure 17 Primary Reasons for Leaving Last Housing, All Participants

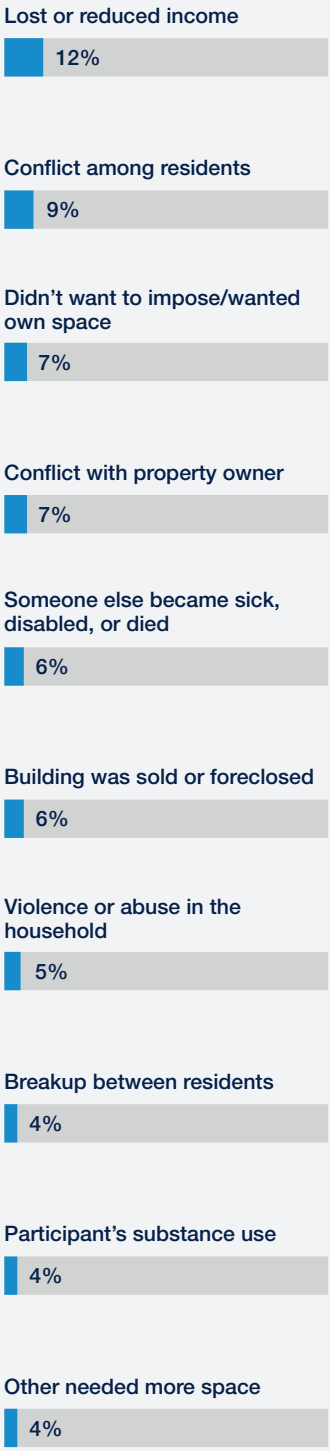


Figure 18 Primary Reasons for Leaving Last Housing, Non-leaseholders

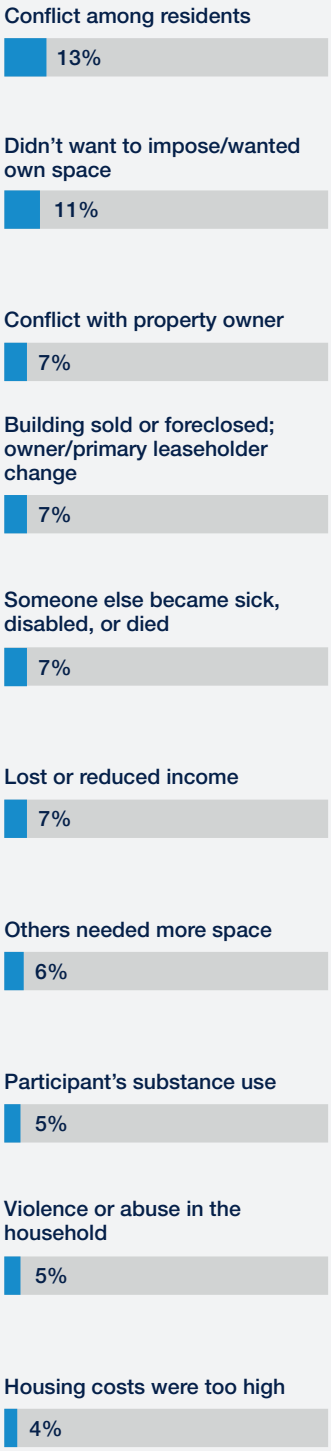
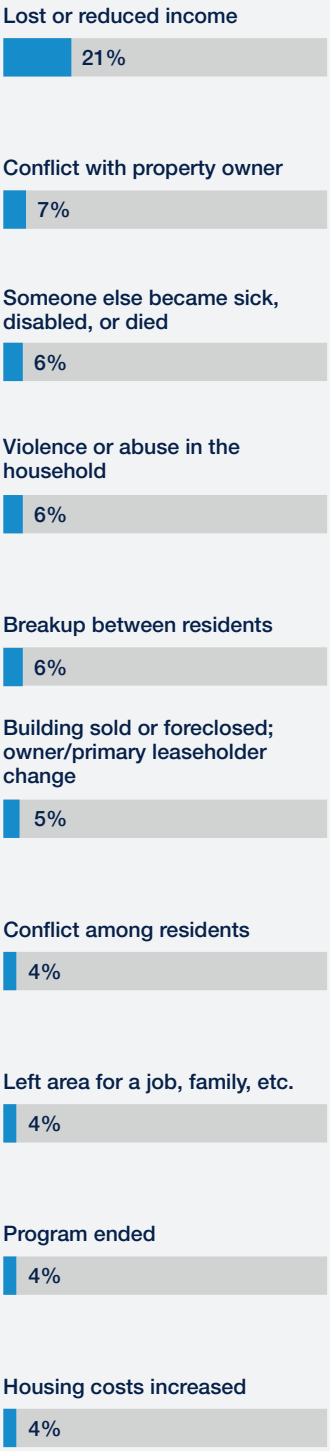


Figure 19 Primary Reasons for Leaving Last Housing, Leaseholders



However, when we look at reasons separately for non-leaseholders and leaseholders, a different pattern emerges: non-leaseholders were more likely to report social reasons and leaseholders economic ones. A similar proportion of all participants (5%), non-leaseholders (5%) and leaseholders (6%) left due to violence in the home.

In examining the most important reason for non-leaseholders to leave their last housing, the most common reasons were ones we classified as social: conflict between residents (13%) and not wanting to impose on others/wanting more space (11%) (Figure 18). These reasons reflect the stress of living with others, often in overcrowded situations, with limited money or space. After these two leading reasons, there were multiple others with similar proportions. Seven percent reported conflict with the property owner, which could reflect non-leaseholders not being allowed to stay in properties without their names on leases. A similar proportion (6%) reported that their building was sold or foreclosed upon, there was a change in ownership, or the primary leaseholder lost their housing (reflecting that when one is a non-leaseholder, if the leaseholder has to vacate, others living with them do as well). Others included a household member becoming sick, disabled, or dying, or a loss of household income.

Among leaseholders, economic reasons predominated. Figure 19 presents the 10 reasons leaseholders reported most frequently. One in five (21%) leaseholders noted reductions in income as the most important reason they entered homelessness. Leaseholders noted this as the primary reason at least three times more frequently than any other reason.

HOMELESSNESS PREVENTION

Limited Support Before Becoming Homeless

Homelessness prevention programs, when targeted appropriately, can prevent homelessness effectively at a reasonable cost. What complicates the design of prevention programs is that among a large group of people who seem to be at risk of becoming homeless, only a small proportion do. Because our study, by design, included only those who became homeless, it is possible that those who received effective homelessness prevention never entered our sample. Thus, perhaps it is not a surprise that few in our study received homelessness prevention services–because it is possible those who did never became homeless.

To understand the experiences of those who did become homeless, we asked participants whether they sought and received help from any source (e.g., family, friends, government agencies, community based organizations, legal services, etc.) prior to homelessness. We included a broad definition of what we considered support, including advice from friends and family who experienced a similar situation before, information about housing resources, and transportation support to search for alternate housing. Participants could choose more than one source of support if applicable.

In the survey, few reported seeking or receiving any support. One in three participants (36%) reported seeking help from any source before their homelessness began. Seeking support was more common for adults in homeless families, where 61% sought assistance. The most common sources of support sought across all participants were friends and family (22%); community-based organizations, religious organizations, or domestic violence services (16%); and government agencies (8%) (Figure 20). Adults in families sought help from any source more frequently than single adults and TAY.

Twenty-three percent of all participants received help. Adults in homeless families were more likely to receive help; nearly half (48%) of adults in families received help of any kind (compared to 21% of single adults and 24% of TAY). The most common reported types of support received were from friends and family, community-based organizations, and government agencies. Adults in families received help from any source more frequently than single adults and transition age young adults.

No matter the cause of the housing loss, in in-depth interviews, few reported awareness of eviction or homelessness prevention resources prior to their becoming homeless. As one participant said, “I didn’t know about services or organizations that were available at the time when I was searching that could help me.” With the minimal amount of warning that participants received prior to becoming homeless (i.e., median of 5 days among all participants), participants may have found seeking help to be unrealistic.

Financial Support Would Have Prevented Homelessness

To understand what participants believed may have prevented their homelessness, we asked them to engage in a thought experiment about the likelihood that their homelessness could have been prevented had they received financial intervention. We provided all participants with three different scenarios and asked them whether each intervention would have prevented their becoming homeless for at least two years.[29] The interventions were: (1) a monthly rental subsidy worth $300-$500; (2) a one-time payment of $5,000 to $10,000; or, (3) a voucher that limits rent contribution to 30% of their income (such as a Housing Choice Voucher).

We asked participants whether, with financial intervention, they would have been able to stay in the same housing or have to move to a different location.[30] Even with financial help, 72% of participants from non-institutional settings reported that they would have needed to move to a different housing situation (81% of non-leaseholders and 59% of leaseholders).

However, many of these participants believed the intervention would have allowed them to obtain alternate housing. Seventy percent of all participants believed that a shallow subsidy of $300-$500 a month would have allowed them to avoid homelessness for at least two years (Figure 21). Eighty-two percent of participants believed that a one-time lump sum payment between $5,000-$10,000 would have kept them housed for at least two years. The highest proportion of participants (90%) reported that an ongoing subsidy that capped their housing costs at 30% of their income (such as a Housing Choice Voucher) would have prevented their homelessness.

Among those who entered homelessness from an institutional setting, 71% believed a shallow monthly subsidy would have prevented their homelessness, 83% reported a lump-sum payment would have done so, and 93% believed that a permanent subsidy would have.

FIGURE 20 Sources of Homelessness Prevention Help Sought Prior to Homelessness by Family Structure

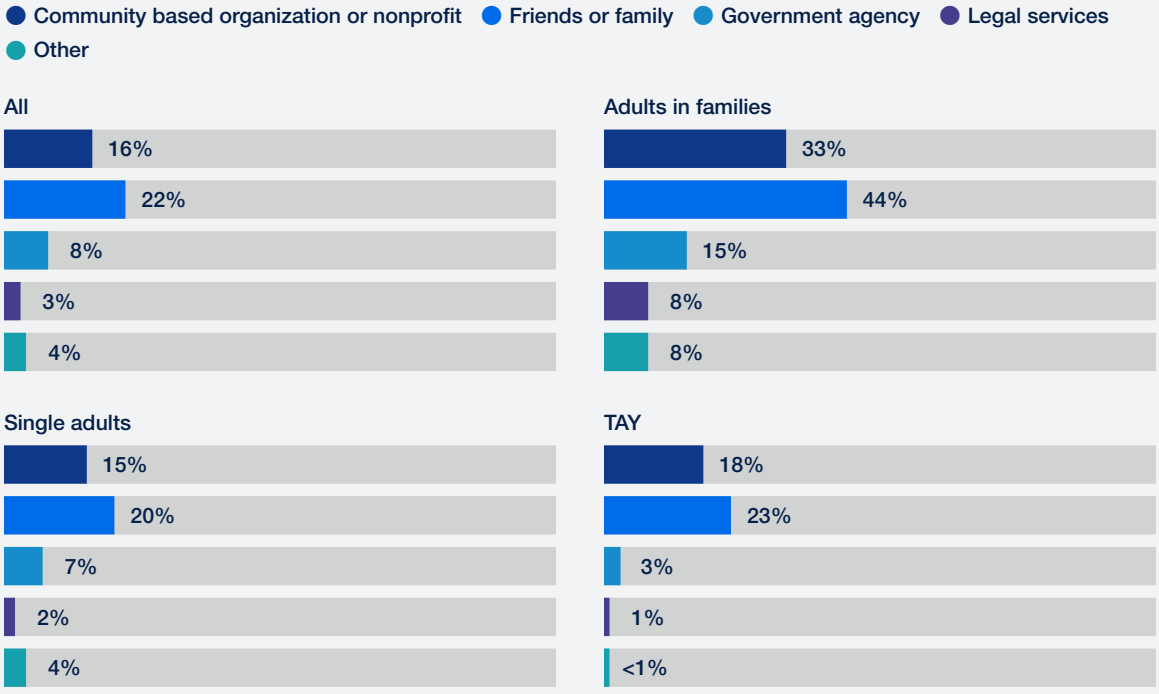
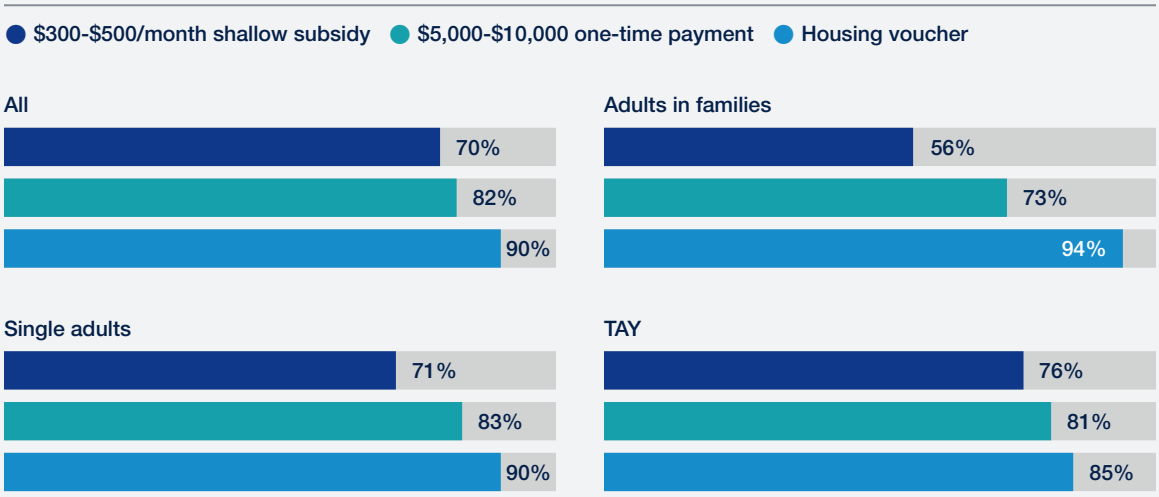


FIGURE 21 Participant Report of Effect of Hypothetical Homelessness Prevention Interventions by Family Structure



Participants may have been overly optimistic in their assessments. However, the high proportion of all participants who thought that these interventions could have prevented their homelessness highlights the role that high housing costs play in homelessness and may suggest an untapped potential for prevention. Even those who had substantial substance use or mental health conditions, had experienced an interpersonal conflict that immediately precipitated homelessness, or had exited institutional settings, believed that having financial resources to pay for housing would have meaningfully prevented their homelessness.

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The high proportion of all participants who thought that these interventions could have prevented their homelessness highlights the role that high housing costs play in homelessness and may suggest an untapped potential for prevention.

SUMMARY

In this chapter, we learned that those who became homeless did so after losing tenuous holds on housing. One in five came from institutional settings. Among those who came from housing situations, more than half came from non-leaseholder settings where they held few legal rights. Many had entered non-leaseholder situations after a series of losses; they entered suboptimal housing situations in a fruitless effort to stay out of homelessness. When the stress of living in overcrowded housing became too much, these housing options fell apart with little warning. Those who came from leaseholder arrangements lived in places they could barely afford and had no cushion to protect them if something went wrong. Despite legal protections, they had little warning before entering homelessness.

Few who lost housing had asked for help prior to exiting their housing, and even fewer received it. In-depth interviews revealed that many participants were not aware help existed and didn't know where to turn. Those who were aware did not receive the assistance they needed to prevent homelessness. Those who entered from institutional settings had little assistance before exiting into homelessness. It is possible that those who received this assistance never entered homelessness. Participants were able to tell us what they thought would have prevented their homelessness. The vast majority believed that receiving help paying the rent—either through shallow subsidies, deep subsidies (like Housing Choice Vouchers) or one-time payments—would have made an enormous difference.

KEY TAKEAWAYS

- Homelessness is inextricably linked to deep poverty. The median monthly household income preceding homelessness was $960 ($1400 for leaseholders and $950 for non-leaseholders).
- One in five participants entered homelessness from an institutional setting.
- Precarious living situations often precede homelessness; 60% of participants in non-institutional settings prior to homelessness were not on a lease agreement.
- Participants reported minimal notice before losing their housing. Leaseholders received a median of 10 days notice, while non-leaseholders reported a single day.
- Trajectories to homelessness differ. Some participants reported a rapid transition to homelessness, while others reported using limited financial resources and social networks to slow their descent into homelessness.
- Leaseholders reported that an economic reason contributed to their homelessness more often than non-leaseholders. Non-leaseholders were more likely to report a social reason. However, participants spoke to structural conditions (e.g., high housing costs, crowded housing, low-income, etc.) that preceded the social reasons.
- Most participants believed that interventions that provided financial assistance could have prevented their homelessness. Participants overwhelmingly believed that shallow monthly subsidies, a lump-sum payment, or rental assistance that reduced rental burdens would have been effective.

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CHAPTER 3

EXPERIENCES During Homelessness

In this chapter, we review the experiences of study participants during homelessness. We begin with an overview of where people stayed while homeless, recognizing that these environmental contexts shape the experience of homelessness. We then discuss participants' physical health, mental health, use of substances, experiences of violence, and interactions with the police.

> *Most of the time we're running around, trying to figure out where we're going to sleep at night or how we're going to be housed, or it's about to start raining soon. And we worry about that. We're not worried about going to the doctors or going to see somebody or going to get help with our mental state.*
>
> — CASPEH participant

We conducted interviews between October 2021 and November 2022, when the COVID pandemic altered many facets of life. Due to the public health emergency, there were many changes to services and benefits. During the pandemic, many congregate shelters decreased their capacity, or changed their rules. At the time of our data collection, many shelters were still operating on limited capacity, or closing new admissions due to outbreaks of COVID. Participants might have changed decision-making about whether to stay in shelters based on concerns about infection or may not have been able to access them due to limitations. Many communities were operating enhanced non-congregate shelters, such as those from Project RoomKey,[31] providing opportunities for non-congregate shelter that had not existed prior to the pandemic.

Where Did People Stay?

People experiencing homelessness stay in a variety of settings: in unsheltered settings (with or without vehicles), in emergency shelters, couch surfing with family and friends, and in short-term institutional settings (including jails and hospitals). Although people experiencing homelessness view staying in a vehicle as distinct from being unsheltered without a vehicle, the Federal Government considers both to count as unsheltered. Because those who experience homelessness view staying in vehicles differently than in unsheltered settings without one, we present these data separately. Experiences of homelessness are not static; people move between settings. Thus, we present the locations where people stayed in three ways: where they stayed the prior night; where they stayed most often in the last six months during this episode of homelessness; and every place they stayed while homeless (within the last six months). More than three-quarters of participants (76%) stayed in unsheltered settings the night prior to their interview; 20% stayed in a vehicle, and 56% without a vehicle. Nineteen percent stayed in an emergency shelter, 0.3% stayed in a domestic violence shelter, 2% stayed in a motel, hotel, or trailer paid for by the government or an organization (e.g., as part of a COVID program), 0.1% stayed in a motel or hotel paid for by self or family, 1% stayed with family or friends, and 0.5% stayed in institutional settings, such as hospitals or jails.

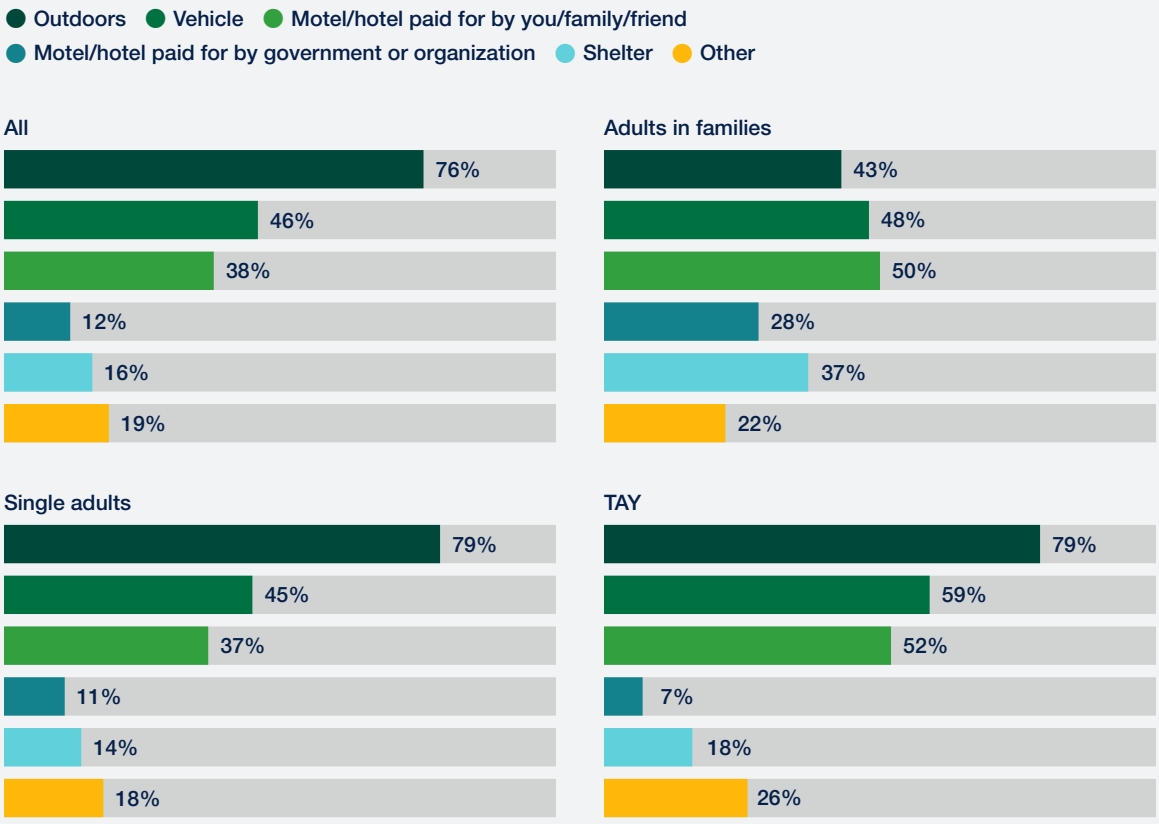
Among those who spent the prior night in a vehicle, 51% spent the night in a car, van or truck and 49% in an oversized vehicle (such as an RV or converted commercial vehicle). A minority (13%) of those who stayed in vehicles stayed in a safe parking site or authorized place for people who live in vehicles. The rest were either on a public street (77%), on private property (10%), or at a public rest stop (1%).

We asked where people spent the most time during the past six months of this episode of homelessness. If people had been homeless for less than six months, we asked where they had spent the most time during their episode of homelessness. The responses were similar to where participants had been the previous night: 78% were in unsheltered settings (21% in a vehicle, 57% unsheltered settings without a vehicle). Fifteen percent reported that they spent the most time in an emergency shelter, 0.3% in a domestic violence shelter, 2% in a motel, hotel, or trailer paid for by the government or organization, 2% in a motel or hotel paid for by self or family, 0.5% in a substance use treatment program, and 2% with friends and family.

Where people stayed differed by family structure. Adults in families were most likely to spend most of their nights homeless in a sheltered setting; 59% reported that they were primarily sheltered (compared to 19% of single adults and 26% of TAY). Adults in families and single adults reported living in vehicles more frequently than TAY (22% of adults in families, 21% of single adults, 12% of TAY).

Looking at every place participants spent time while homeless in the prior six months (or since they became homeless, if their current episode was less than 6 months) presents a different picture (Figure 22). By asking this way, we see that people have multiple experiences, although almost all had spent time unsheltered. Many more report staying with family

FIGURE 22 All Places Participants Slept For At Least One Night in the Last 6 Months, by Family Structure



or friends or institutional settings at least once than reported these as where they stayed the last night or the most. Ninety percent of participants spent at least one night in an unsheltered setting in the prior six months; almost half (46%) spent at least one night in a vehicle; and three-quarters (76%) at least one night unsheltered without a vehicle. Thirty percent stayed in an emergency shelter at least one night in the prior six months, 2% stayed in a domestic violence shelter, 12% in a motel, hotel or trailer paid for by the government or an organization. Thirty-eight percent stayed in a motel/hotel paid for by self or family, 31% spent at least one night staying temporarily with family or friends; and 7% spent at least one night in a substance use treatment program.

Shelter Access and Suitability

Forty-one percent of participants noted that, during this episode of homelessness, there was a time that they wanted shelter but could not access it, showing unmet need (and desire) for shelter. Those who didn't report this included both those who received shelter when they wanted it and those who did not want it.

Participants residing in congregate shelters reported being satisfied, generally, with their living arrangements. They appreciated having access to a place to bathe, hot food, and case management services. In contrast, some living in encampments held negative views of congregate shelters. They reported concerns about COVID and other health risks of sleeping in close quarters. They noted burdensome rules about securing a bed, curfews, and the need to vacate during the day as disincentives to shelter stays. Those living in unsheltered settings perceived the case management services offered in shelters to be ineffective for securing permanent housing.

Vehicular Homelessness

Many participants reported living in their vehicles when they first became homeless. Although some managed to reside in their vehicles for an extended period, many lost this option. They did not give up their vehicles by choice. Vehicle residents reported needing to be vigilant to avoid having their vehicles ticketed and towed. Instead, participants reported that their vehicle became inoperable or that, after multiple tickets, their vehicle was towed. Participants noted preferring their vehicles to other unsheltered settings or congregate shelters; having their own vehicle allowed them to secure their belongings and feel more safe than when they slept outside, while allowing them to live without the restrictions of congregate settings.

Use of Domestic Violence Shelters by Survivors of IPV

In in-depth interviews, some survivors of intimate partner violence discussed facing barriers to entering domestic violence shelters. They described being turned away because either all available beds were full or because there were beds available only for women with children. Others described difficulty accessing domestic violence shelters because they didn't know how to. Participants who entered domestic violence shelters mentioned varied experiences receiving adequate support and access to services; some described positive and helpful interactions and others reported limited support. A participant described the challenge of trying to access services while dealing with her own trauma: "It seems like you have to stay on top of the people that are supposed to be helping you to get the help that you're supposed to need, and like that's really hard. When you're going through trauma, it's hard to even get up sometimes, like you feel really low. I feel like your advocates that are supposed to be helping you, [they] should be reaching out to you to make sure that you're okay because you're already in a bad place."

PHYSICAL HEALTH AND USE OF HEALTHCARE SERVICES

Homelessness takes a toll on health. Health problems—including physical and mental health conditions and substance use—can increase the chance that someone becomes homeless. All can interfere with the ability to function— including interfering with work or social relationships—and make it harder to compete in a difficult housing market. People who become homeless are more likely than those who don't to have health problems. Being homeless has deleterious impacts on health, worsening these problems and furthering the disparities between those with and without housing. The experience of being homeless brings with it stress, exposure to violence and harsh environmental

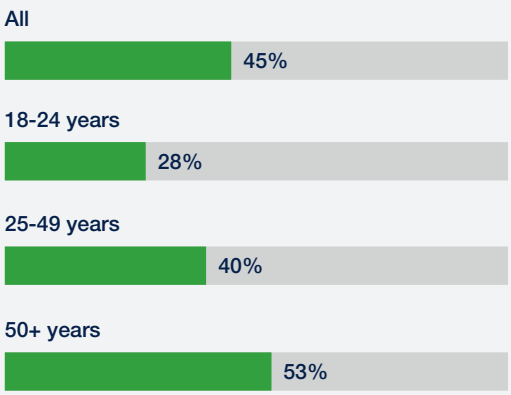
conditions, lack of access to food and ways to prepare it, inability to sleep and other challenges. The experience of homelessness can be all-consuming, leading people to engage in unhealthy behaviors such as using cigarettes, alcohol, or illicit drugs to stay awake (or go to sleep), lessen hunger pains, or manage untreated mental health conditions. These, in turn, worsen health.

People who are homeless lack money, transportation, telephones, and addresses to receive mail or access to the internet—all of which interfere with the ability to get preventive and longitudinal healthcare or to receive treatment for substance use. While homeless, people lack time, energy, and focus. The constant need to manage day-to-day issues that people with housing are protected from—threats of violence, exposure to cold (or heat, or rain), finding an electrical outlet, ensuring that belongings don't get stolen, and trying to find food and a place to sleep or just rest—is exhausting. In the face of this exhaustion, people who experience homelessness may find it difficult to think about addressing health problems, taking medications, or receiving treatment for, reducing or quitting smoking, alcohol, or substance use. As a result, people who become homeless are more likely to have health problems than people who don't become homeless, and once homeless, they are more likely to have their health problems worsen and less likely to be able to seek the care that would address these problems.

Physical Health Status

Nearly half (45%) of study participants reported having fair or poor health (as opposed to good, very good, or excellent) (Figure 23). Self-reported fair or poor health is a simple but important measure of health; those who report it have a higher likelihood of being hospitalized or dying in the coming years. In the general population, rates of fair or poor health are elevated in older adults. Our finding is significantly higher than would be expected in older adults in the general population. Among the general non-institutionalized population age 65 and older in the United States, 22% report fair or poor health. Despite the median age of 47, twice the proportion of participants in this study reported fair or poor health than those 65 and older in the general population. We found the highest reports of fair or poor health among the oldest participants. More than half (53%) of those 50 and older reported that their health was fair or poor (compared with 28% of those 18-24).

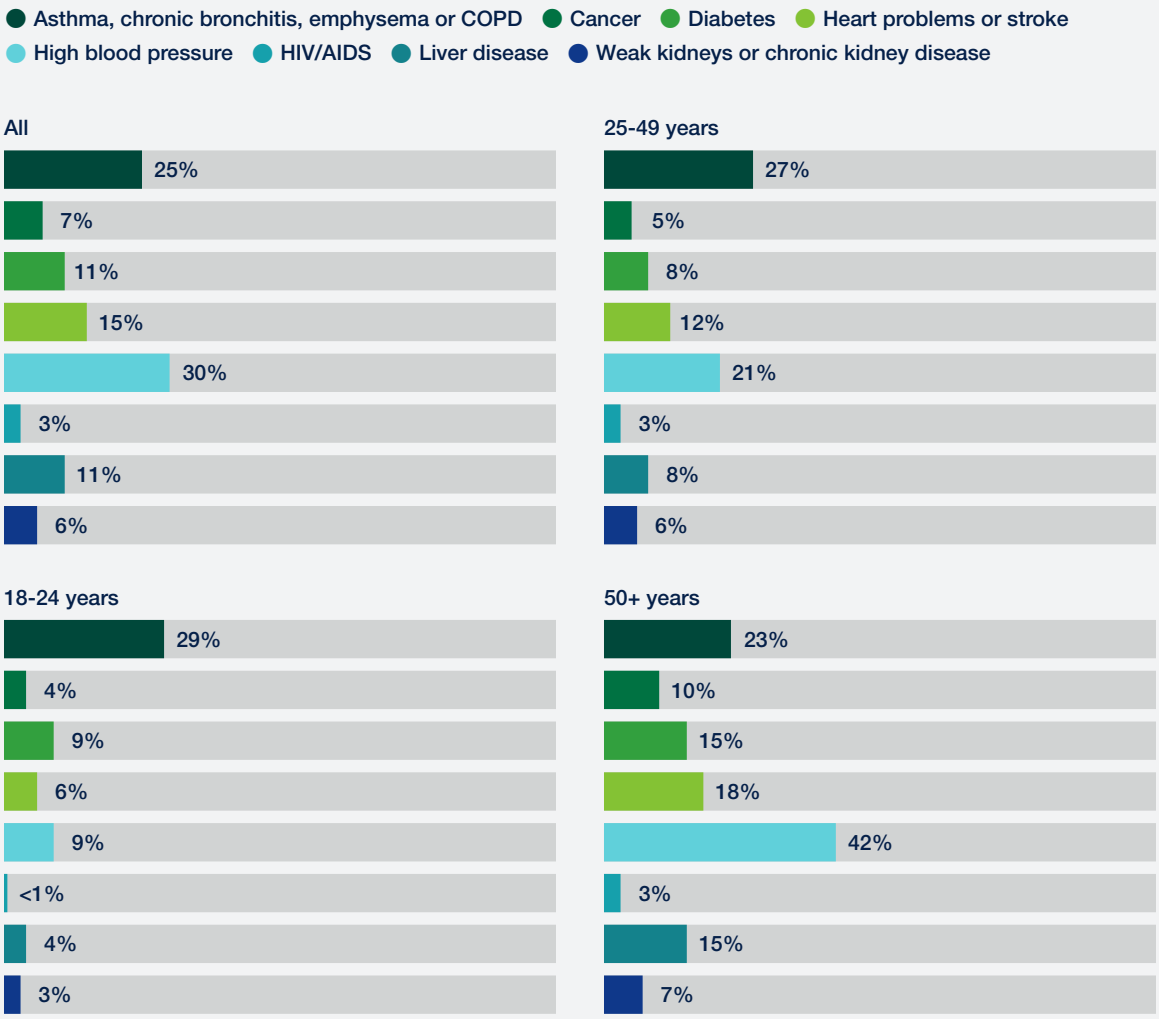
FIGURE 23 Self-Reported Fair or Poor Health Status by Age



People experiencing homelessness are more likely to underreport chronic health conditions, because they have poor access to healthcare. People who don't receive healthcare are less likely to know that they have chronic health problems such as diabetes or high blood pressure. Nevertheless, participants reported high prevalence of chronic diseases. Sixty percent of participants reported having at least one chronic health condition and 28% at least two.[32] Hypertension (30%) and asthma or chronic obstructive pulmonary disease (COPD) (25%) were the most prevalent conditions, while 15% of participants noted having a heart condition or having had a stroke, 11% had diabetes, and 11% liver disease. As in the general population, the likelihood of having a chronic health condition increased with age, but all age groups reported higher proportions than would be expected. Forty-one percent of young adults reported a chronic health condition, slightly over half (55%) of those 25-49, and almost two-thirds (68%) of adults 50 and older did. In Figure 24, we outline the prevalence of chronic diseases by age.

Function, meaning the ability to engage in activities of daily living (ADL: dressing, bathing, eating, transferring [out of a bed or chair], and toileting) is an important component of health. Having difficulty with any ADLs places people at risk of requiring

FIGURE 24 Self-Reported Chronic Health Conditions by Age



future nursing home placement, with the highest risk for those having difficulty with three or more ADLs. Thirty-four percent of participants indicated that they had difficulty performing at least one ADL; 23% reported difficulty with at least two. Among participants 50 and older, approximately 43% reported difficulty with at least one ADL, and 31% reported difficulty with at least two. Almost a quarter (22%) of participants reported difficulty with mobility, which was more common in those 50 and older (32%). One in five (20%) reported using a mobility aide, such as a cane, crutches, walker, or wheelchair; such use was more common in those 50 and older (33%).

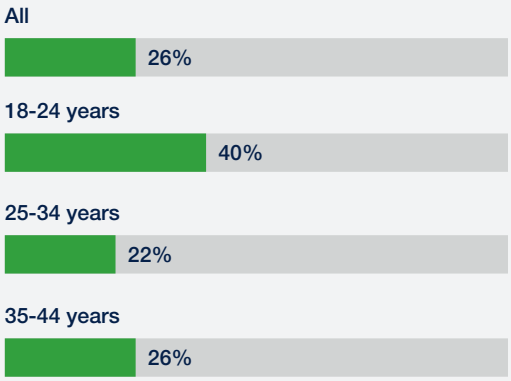
Participants reported that their mobility challenges negatively impacted their lives. Their mobility aids were in poor repair and their mobility challenges hindered visits to prospective housing units. They found that many congregate shelters and permanent housing were inaccessible. As one participant reported: "I was trying to rent a room; the doors are not wide enough for the wheelchair that I had. They're not wheelchair accessible. I'd have to put myself in a place that I really probably wouldn't like if I found one that specifically catered to wheelchairs."

Pregnancy

Pregnancy was common. Among those assigned female at birth aged 18-44, 26% reported having been pregnant at some point during this episode of homelessness. Among those aged 18-24, 40% reported a pregnancy during this episode of homelessness; among those 25-34, 22% did; 35-44, 26% did (Figure 25). We asked participants to report if they were currently pregnant. At the time of the interview, 8% of those aged 18-44 were pregnant.

Participants described the experience of pregnancy while homeless. As one participant said: "It's uncomfortable. Got to use the bathroom 2:00, 3:00 in the morning,... [my friend] has an apartment. I park in her parking lot so she [leaves] her door open, I use their bathroom and I come back out. But it's uncomfortable. My damn back hurt, and I'm four months pregnant."

FIGURE 25 Proportion of Adults Age 18-44 Assigned Female at Birth Who Were Pregnant at Any Time During Their Current Episode of Homelessness by Age



Access to Healthcare

To assess access to healthcare, we asked participants whether they had health insurance (and which kind), whether they had a regular source of healthcare other than the emergency department (ED), and if so, if they had an identified primary care provider. Having insurance is an important precursor for medical care, but obtaining insurance is not the only barrier that people experiencing homelessness face. Other barriers, including lacking phones, time, transportation, knowledge of where to go, concerns about leaving belongings unattended or of facing stigma in health settings may be more important. Having a non-ED regular place for care and a primary care provider suggests that one has some engagement with longitudinal healthcare and a place to call when they need care. However, it doesn't ensure one will receive care. To assess non-emergent care, another measure of access, we asked when was the last time participants saw a healthcare provider outside of the ED. The frequency with which one should see a healthcare provider (outside the ED) is related to several factors, including age and underlying health conditions. However, due to the high prevalence of health problems in this population, we considered not having seen a provider outside the ED in longer than a year a marker of poor access. To assess whether they had unmet need for healthcare, we asked (separately) whether they had a need for healthcare and had been unable to receive it, and whether they had been prescribed medication and unable to obtain it. Medicaid (known as Medi-Cal in California) relaxed rules on needing to re-enroll, due to the pandemic during the period of our study allowing more people to remain insured than otherwise might have. Some health services had switched to telehealth, providing both opportunities and barriers for people experiencing homelessness. People may have accessed care more, due to having COVID, or less, due to fears about acquiring COVID. Our results should be understood in the context of the disruptions of the pandemic.

With Medicaid expansion in California, at the time of the study most participants would have been eligible for Medicaid[33] based on their low incomes. Eighty-three percent of participants reported having health insurance, most frequently Medicaid (Figure 26).[34] Young adults were less likely to have coverage (65% of adults aged 18-24 compared to 82% of adults aged 25-49, and 86% of adults 50 and older).

Approximately half of participants (52%) reported having a regular source of healthcare other than the ED. Having a regular source of care was more common among those who were sheltered (64%) versus unsheltered (48%).[35] Fewer (39%) reported having a primary care provider. Six in ten (61%) reported

having seen a healthcare provider outside of the ED in the past year; 49% reported having done so in the prior six months (Figure 27). Almost one-quarter of participants (23%) reported having an unmet need for care in the past six months. The same proportion (23%) indicated an inability to get needed medication in the past six months.

Participants described challenges they faced trying to enroll in Medicaid. They noted that enrollment processes were time consuming and confusing. Even if insured, participants reported having difficulty finding healthcare providers who accepted Medicaid. Participants reported that their difficulty maintaining a phone—keeping one safe (from being lost or stolen), charged, and paid for—limited their ability to schedule and attend appointments and receive communications from their healthcare providers. Transportation was a significant barrier, particularly in areas where clinics were far away and public transportation was limited. When providers substituted telehealth appointments for in-person visits due to the pandemic, participants reported being unable to access care due to their not having access to a reliable smartphone and power source.

Participants described a range of experiences with healthcare. Some distrusted the healthcare system, resulting from prior negative experiences. Some noted that treatment had improved their quality of life or saved their lives. Others reported feeling that they received substandard treatment. Participants, particularly those who identified as Black and/or Latino/x, reported experiencing discrimination and stigma when they sought healthcare, creating additional barriers. These participants reported facing longer wait times for appointments than others, experiencing microaggressions from administrative staff regarding their names or the way they looked, and that their clinicians hadn't taken their medical concerns seriously. One participant explained: "When I went to the gastro doctor… From my name, they can't tell my race, okay? So, when I showed up with locks, dressed very eccentric for my race, you know; he's like, 'Oh, I didn't know.' I said, 'Didn't know what? What, did I scare you?' He's like, 'No, on the phone you sound so proper.' I said, 'Oh, you didn't know I was Black.'"

FIGURE 26 Health Insurance Coverage Type by Age

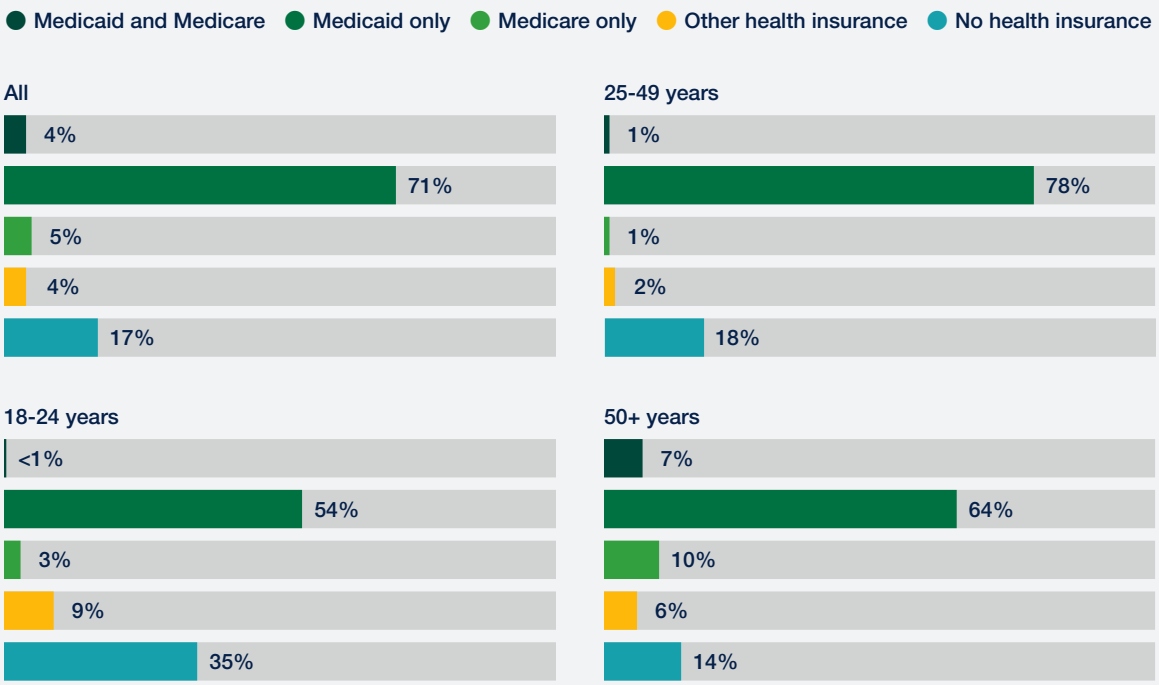
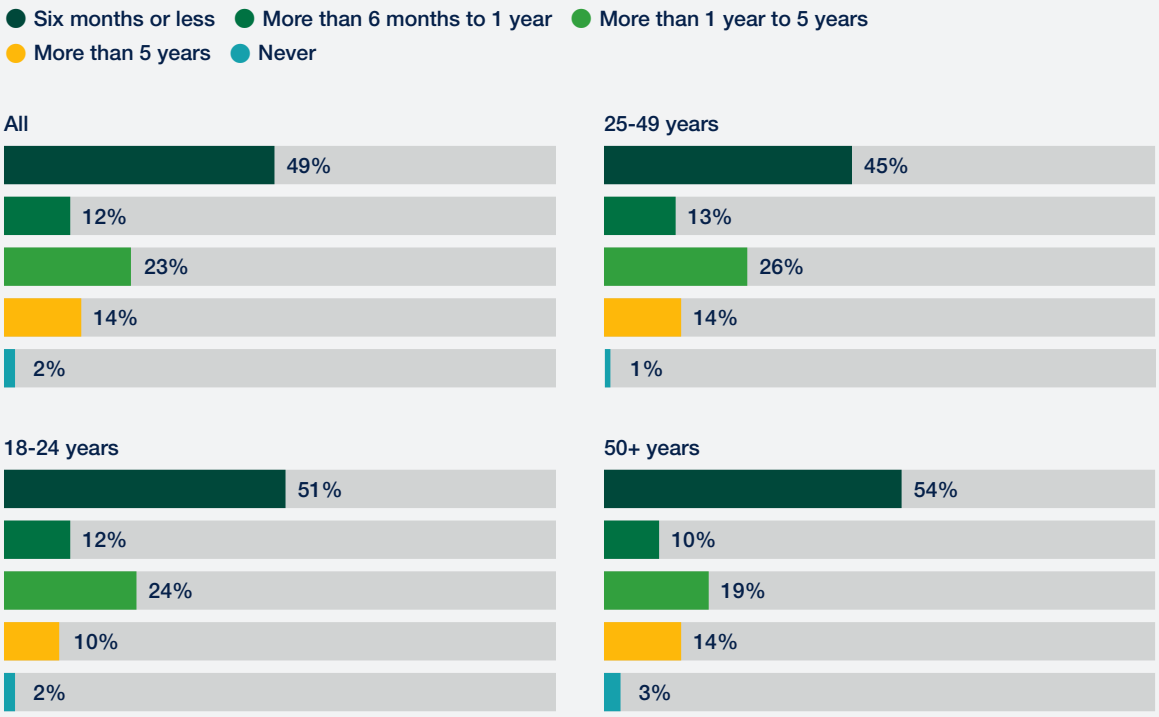


FIGURE 27 Time Since Last Visit with a Health Care Provider by Age



Participants connected their challenges accessing care to worsening of their health. Throughout the study, we heard a common theme: if participants were housed, they would be more able to prioritize their healthcare and face fewer barriers to care, leading to improved health. As one participant said: "(If I had housing) I would start hitting [AA/NA] meetings. I would go to an outpatient behavioral health drug treatment program. It's a volunteer basis. And I would do that. I would be working. Services I would be accessing, definitely behavioral health. I would get a primary doctor and get my health in order. I would probably join a club or two, like photography? You know? Something fun... It would change everything."

Acute Health Care Utilization

In the past six months, 38% of participants reported a visit to the ED that did not result in a hospitalization (Figure 28). For comparison, in 2019, approximately 22% of Americans aged 18 and older had visited the ED at least once in the prior *year*.[36] As in most reports, a small group of people made the majority of the visits by using the ED repeatedly. In our study, 9% visited the ED at least three times in the last six months.

In the prior six months, 21% reported an inpatient hospitalization for a physical health reason (Figure 29). Adults aged 50 and older (25%) and young adults aged 18-24 (29%) reported a higher rate of hospitalizations. These rates are substantially higher than similarly aged adults in the general population.

The high proportion of people reporting ED visits and inpatient hospitalizations reflect several factors, including the overall poor health of those who are homeless, the deleterious impacts of homelessness on health, the lack of access to non-emergency healthcare, and the limited options to treat people who are ill as outpatients (lowered admission thresholds).

Participants reported few options for places to recover from illnesses when they didn't feel well. They reported the inability to get adequate sleep or rest while in unsheltered settings and noted that

FIGURE 28 Emergency Department Visits in the Last Six Months by Age

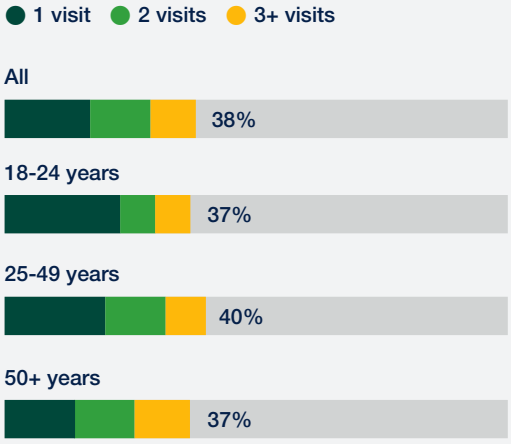
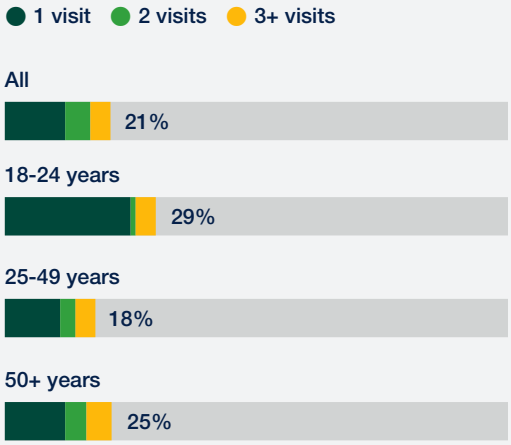


FIGURE 29 Physical Health Hospitalizations in the Last Six Months by Age



many shelters required guests to leave during the day. Those who were hospitalized noted the lack of adequate post-hospitalization care (e.g., recuperative care/medical respite). Participants described hardships they experienced when discharged from inpatient stays to unsheltered situations. Those who lived in vehicles noted that while they were hospitalized, they risked their vehicles being ticketed or towed. Some participants noted that they had access to recuperative care following hospitalizations: "It's a good thing and it's a bad thing being in this situation. It's a good thing, because of my medical condition…I have shelter. The bad thing is because I have a heart condition. That's a bad thing for me to get housing in this situation. I wish I didn't have my health condition and still have housing."

BEHAVIORAL HEALTH

Mental Health

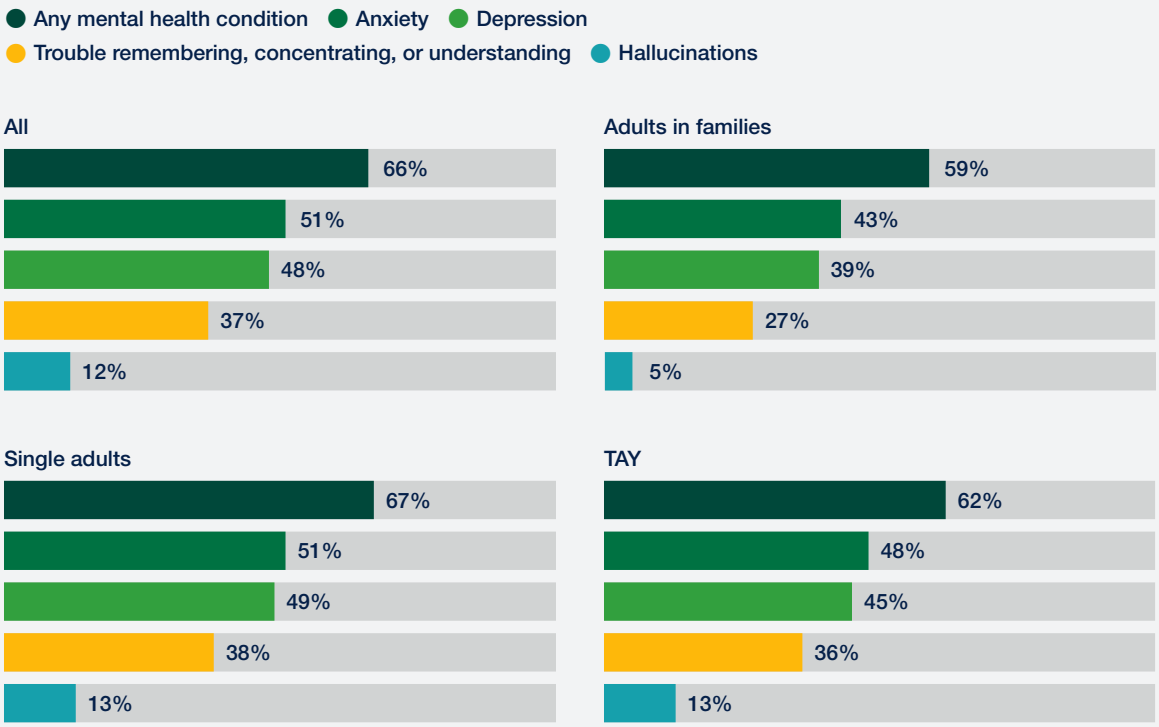
Many who experience homelessness have had past trauma. The experience of homelessness is highly stressful—exposing participants to worry, poor sleep, violence, and hopelessness. Mental health problems can increase one's risk for homelessness and be exacerbated by homelessness. It is not surprising that many participants reported mental health symptoms. To receive a diagnosis of a mental health condition, one needs to have accessed mental health treatment. Because access to treatment can be limited, we asked about specific symptoms rather than diagnoses.

To determine current symptomatology, we asked participants to report on mental health symptoms in the prior 30 days. We asked whether participants experienced serious depression (symptoms of sadness, hopelessness, loss of interest, difficulty with daily functioning) or serious anxiety (uptightness, unreasonably worried, unable to relax). We asked if they had ever experienced hallucinations (saw things or heard things that weren't there) or had difficulty concentrating or remembering things.

Current mental health symptoms were common (Figure 30). Two-thirds (66%) of participants reported experiencing symptoms of either depression, anxiety, trouble concentrating or remembering, or hallucinations in the past 30 days. Many experienced more than one type of symptom. Half (51%) experienced anxiety, half (48%) experienced depression, one-third (37%) reported trouble concentrating or remembering, and 12% reported hallucinations.

We asked participants about their access to and receipt of treatment for mental health concerns. We asked all participants if they had received outpatient mental health counseling or treatment in the prior 30 days. Similarly, we asked whether they had been

FIGURE 30 Current Self-Reported Mental Health Conditions by Family Structure



prescribed medication for a mental health concern as an outpatient in the prior 30 days. Finally, we asked about whether they had ever had a mental health hospitalization, and if so, if they had in the prior six months.

> *"I just want to get in a place. This pain that I'm feeling, emotional and physical pain, you know. If I can just get beyond that, most of it be solved by getting in a place. I'd be so happy to be in my own place."*

Despite two-thirds (66%) of participants reporting current mental health symptoms, only 18% of all participants had received either mental health counseling or medications in the prior 30 days; 9% had received mental health counseling and 14% medications for mental health conditions. Among those who reported current mental health conditions, 24% reported receiving either counseling or a prescription for a medication currently. Five percent reported a hospitalization for a mental health problem in the prior six months.

Participants discussed daily stress, anxiety, and feelings of hopelessness associated with homelessness, as well as symptoms of severe depression, mania, psychosis, and panic attacks that occurred while homeless. They described how homelessness worsened their mental health symptoms through a variety of mechanisms, including inability to maintain medications that had kept them stable, lack of sleep, experiences of violence, and experiences of shame and stigma associated with homelessness. Participants reported numerous barriers to accessing mental health treatment, such as the inability to obtain counseling due to challenges with navigating mental health services or not having a phone to make appointments. Without access to services, participants noted deploying other strategies to

manage symptoms, including self-segregating from other individuals to decrease exposure to loud noises or difficult interactions and self-medicating with drugs or alcohol. Participants discussed difficulty accessing medications or losing their existing medications. As one participant reported: "But day to day, I have social anxiety, physical anxiety, and hopelessness. Those are more to do with mental health. I haven't had my meds… a couple weeks ago when I had to leave a different place, all my things were taken. So, I haven't had meds in a couple weeks, and I'm on a few of them. So, definitely depression has been a lot worse, and it's a bad time to have all this because I'm trying to get into a new place, get a job, whatever."

Substance Use

Substance use patterns change over time; it is common for people to fluctuate between periods of heavy use and cessation. People increase and decrease their use of substances for a myriad of reasons (e.g., response to trauma, to self-medicate mental health challenges, concerns about health or legality). We asked about current use (including whether they used, what substances, and the frequency), including non-fatal overdose experiences during this episode of homelessness and availability of naloxone. We asked similar questions about alcohol use. We asked participants how their use changed during this episode of homelessness, whether they had sought and received help, whether they had had difficulty accessing treatment that they wanted, and whether they felt that their substance use was causing them social or legal problems. To help us understand why people used, didn't use, changed their use patterns, or engaged (or didn't engage) in treatment, and the consequences of those decisions, we used in-depth interviews.

We describe current regular use of cocaine, amphetamines, and non-prescribed opioids as use three times a week or more. By this definition, one third (35%) of participants reported currently using cocaine, amphetamines, or non-prescription opioids regularly (Figure 31). Thirty-one percent of participants report current regular use of methamphetamines; 3% cocaine, and 11% non-prescribed opioids. In the prior six months, 13% of all participants report using injection drugs. During this episode of homelessness, 11% of participants reported experiencing an overdose; one-quarter (26%) reported having access to naloxone.

FIGURE 31 Current, Regular Substance Use by Family Structure

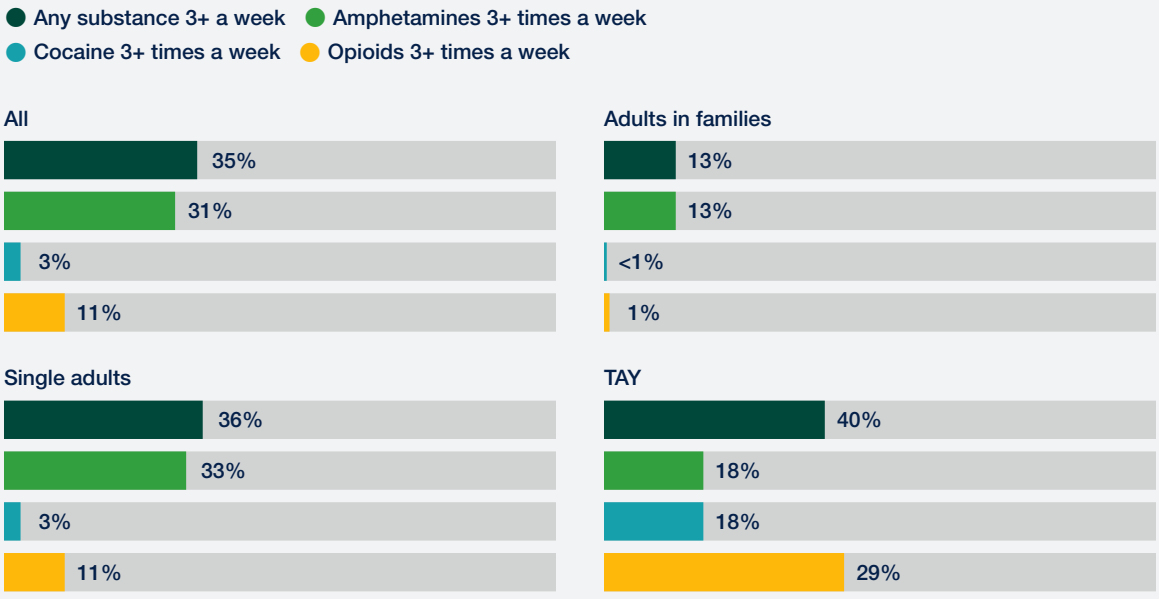
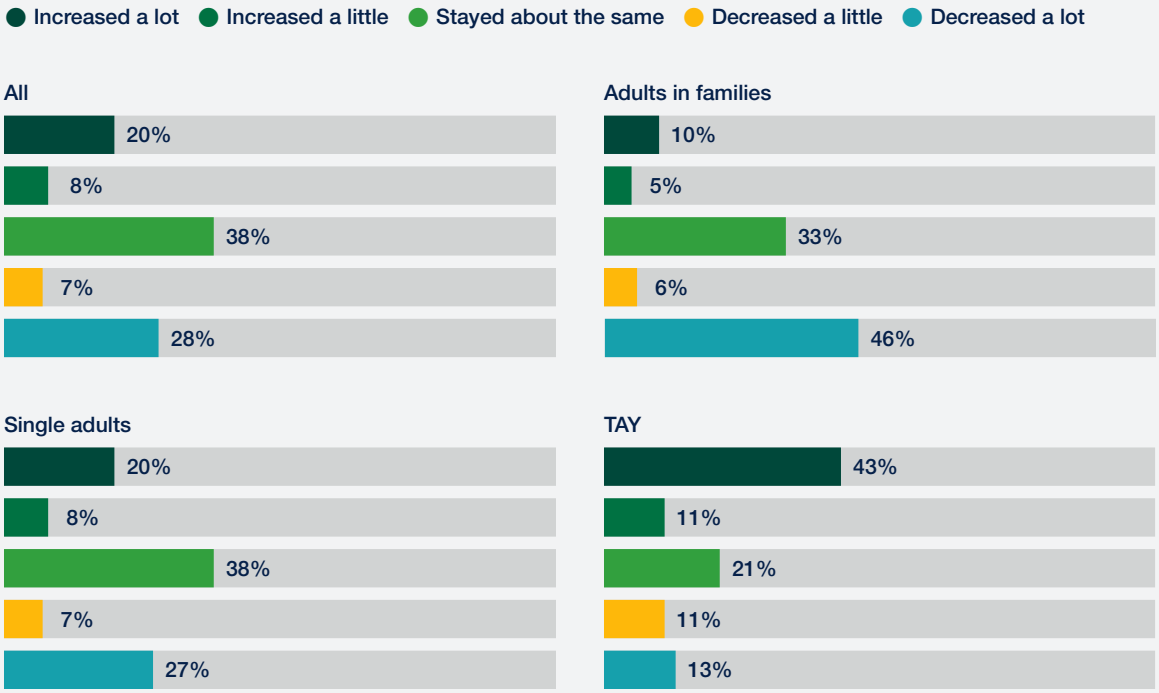


FIGURE 32 Self-reported Changes in Substance Use Since Homelessness (of Participants Who Ever Used Substances) by Family Structure



To assess current alcohol use, we asked standardized questions to assess regular drinking and heavy episodic drinking (drinking 6 or more drinks in one sitting). Using standard definitions, we defined regular drinking as drinking three or more times a week until buzzed or drunk or drinking less frequently but more heavily, like getting drunk regularly on weekends. We assessed current unhealthy alcohol use using commonly accepted definitions of heavy alcohol consumption.[37] We defined unhealthy alcohol use as either heavy use[38] or heavy episodic use (consuming 6 or more drinks in a single sitting monthly or more often). Sixteen percent reported heavy episodic drinking at least monthly and 9% report heavy episodic drinking at least weekly. Eleven percent of women and 21% of men reported either unhealthy drinking or heavy episodic drinking at least monthly.

One measure of substance use is the frequency and amount people use. Another is the consequences of that use. To assess that, we asked whether participants believed that their use was currently causing them health, legal, social, or financial problems; 24% reported that it did. Single adults were more likely (26%) than TAY (17%) or adults in families (9%) to report this. Looking only at those with current regular use of drugs or alcohol, 46% reported that it was currently leading to health, legal, social, or financial problems.

We were interested in knowing how participants' drug use changed during this episode of homelessness (Figure 32). Of those who reported substance use at some point in their lives, 28% noted that their drug use increased either a little (8%) or a lot (20%) during this episode of homelessness, 38% noted that it didn't change, and 35% reported that it decreased either a little (7%) or a lot (28%). These statistics differed by family category. Transition-aged young adults were much more likely to note an increase (a little or a lot) during this episode (54%); adults in families were more likely to note a decrease during this episode (52%); and single adults were equally as likely to report increases as decreases.

JOHN'S STORY

John is living in an encampment with about 20 other people on a riverbed—a spot that is well known to the local police. Early morning raids mean that he often must quickly gather his things and leave, or he might be searched and arrested. He has started using methamphetamine to stay up all night. He used to drink, but when he passed out in the encampment his things would get stolen and he would miss the others' signals that the police had arrived. Methamphetamine makes him feel antsy and wired. Sometimes he isn't able to sleep for several days in a row, which makes him feel worse. But right now, he doesn't see a way to be sober given where he is living.

Combining these measures gives us one indicator of drug or alcohol use severity. Of all participants, 45% currently used either methamphetamines, cocaine, or non-prescribed opioids three or more times weekly or engaged in heavy episodic drinking (6 drinks) at least once a month. Single adults (47%) and TAY (48%) were more likely than adults in families (16%) to report this.

Homelessness can limit access to substance use treatment. Currently, 6% of all participants (8% of those who reported ever using drugs or alcohol regularly) were receiving any substance use treatment. The most common forms of substance use treatment that participants received included 12-step programs (such as AA or NA), outpatient or one-on-one counseling, or opioid replacement therapy (such as buprenorphine or methadone). Eleven percent of all participants indicated that they currently wanted substance use treatment but were unable to receive it. Among those who report current regular use of methamphetamine, cocaine, opioids, or heavy episodic alcohol use, 20% indicated that they currently wanted substance use treatment but were unable to receive it; 4% of those who do not report current regular use reported that they did.

Participants who reported spending most of their time unsheltered were more likely to report current regular use of drugs or heavy episodic drinking than those who were primarily sheltered (52% vs. 19%). There are several explanations for this difference. Many shelters do not admit guests who are intoxicated or showing other signs of substance use. The rules may vary from allowing all, to allowing individuals so long as they don't use during the time that they are in shelter, to not allowing anyone who uses at all. Some shelters don't allow use on site but don't allow individuals to leave during their stay, making it difficult for those who use to stay there. Individuals who use may have had behaviors that led them to be asked to leave or may have found the rules difficult. Those who do not have access to shelter may have used to help cope with the challenges of being unsheltered.

Participants explained that their substance use had caused them problems (with their health, the law, relationships, work), but had also played important roles for them (helping them cope with trauma, pain or depression; helping keep them alert; or numbing them to their circumstances). In-depth interview participants who used drugs and alcohol discussed how drug use or heavy alcohol use contributed to losing their homes or custody of their children. They described how illicit substance use had exposed them to criminal charges, probation or parole violations, and produced negative impacts on their health and well-being. But, people who use drugs or alcohol tend to recognize ways in which this use benefits them (even if they recognize the overall pattern is detrimental). Participants who used drugs and alcohol described how substance use helped them form social relationships, which enhanced safety and security. Those using methamphetamine described the benefits of staying awake to protect themselves from assault or theft and having energy to engage in recycling and other ways to gain income. Participants reported using substances to cope with depression, anxiety, and the routine trauma of experiencing homelessness. In many cases, the same participant described the ways that substances not only caused them harm but also helped them cope. As one participant noted: "For the most part, the drugs that I do, I stay up, I stay focused, and it keeps

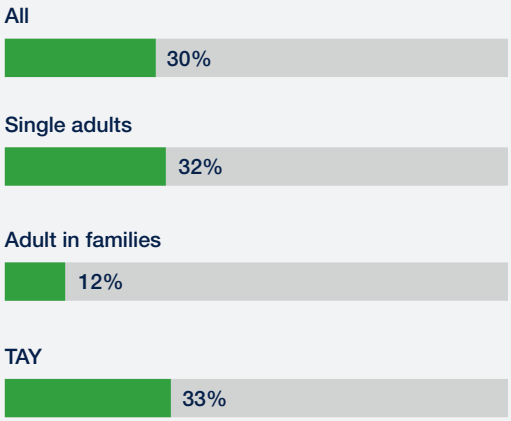
me with a numb attitude. It keeps me out of reality. And when you're sober, you come back to reality and that hurts. You feel it more when you're sober."

Participants reported engaging in efforts to decrease the harm that drugs and alcohol caused them. Some participants noted that they substituted alcohol for illicit drugs to reduce the risk of targeting by police. Others reported reducing alcohol use in order to stay more alert, or remaining abstinent from opioids to prevent overdose.

Participants described how homelessness complicated efforts to reduce their use or maintain sobriety. They discussed how using substances built a community that they were reluctant to leave—by stopping use, they would lose relationships they had developed. Participants reported that having few choices of where to stay limited their ability to avoid being around others who used substances, making it difficult to reduce or stop using. Without access to medications to manage withdrawal symptoms, participants found it difficult to stop use. Participants discussed numerous barriers to receiving treatment or other help to reduce use or enter recovery. They reported times where they were ready to engage with treatment services but they were unavailable, either because there weren't openings at local treatment facilities and wait times were long, or the staff were unresponsive to their needs, or the treatment was far away. Some participants discussed their concern that by seeking help for substance use, they could risk losing custody of their children.

Substance use, for many participants, was related to their homelessness. Some reported increased use as a way to cope with the challenges of homelessness. Others reported decreasing their use as a coping strategy, because they felt doing so would keep them safer or allow them to exit homelessness earlier. Some reported that obtaining housing would eliminate their need to use substances, noting that they would likely quit once they were housed. A participant shared: "Well, if I found housing, I'd probably wouldn't even get high at all... Like there's stuff that I do [that's] out of character, I probably wouldn't do it otherwise. But as long as I'm out here, I have to do it. It's like a survival tactic." Participants explained that if they were housed they would be better situated to address their substance use. For some, housing would make going through symptoms of withdrawal less challenging. Others noted that housing would allow them to access medication assisted treatment for their substance use more easily and safely. Others noted that housing would give them the sense of safety and security that they needed to reduce or stop their use.

FIGURE 33 Proportion of Participants Who Experienced a Jail Stay During Current Episode of Homelessness, by Family Structure



Tobacco Use

Compared to approximately 10% of adults in California, 70% of study participants smoked cigarettes currently. More than half, 54%, smoked daily. Daily smoking was less common among adults in families (33%) and TAY (47%) compared with single adults (56%).

Criminal Justice Involvement

In previous chapters, we described how many participants were incarcerated during their lifetime, how exiting prison or a prolonged jail stay led a large proportion to homelessness, and how few who had entered homelessness from carceral settings had received transition resources. Here, we examine a different issue—that of jail stays during the current episode of homelessness.[39] At the time of the interview, 13% of participants were under community

supervision, either parole (from prison) or probation (from jail). Nearly a third (30%) of participants reported a jail stay during their current episode of homelessness (Figure 33). In accordance with the federal definition of homelessness, we counted any jail stay that lasted more than three months as starting a new episode of homelessness (as opposed to the current episode), so this proportion underestimates the true toll of arrests and incarcerations. The frequency of short-term jail stays reflects the revolving door between jail and homelessness: jail stays increase the risk of homelessness and homelessness increases the risk of jail stays.

Incarceration wasn't the only interaction with the criminal justice system for participants. In in-depth interviews, participants noted frequent interactions with police—particularly in encampments, participants felt that they were being surveilled. They described interactions with police that included being checked for outstanding warrants, probation violations, and having themselves or their belongings searched to assess for possession of illicit substances. Participants noted that minor drug offenses propelled them back into the carceral system. One participant shared: "On probation [the police] would just show up and, man, there they are tapping on my shoulder, and they'd want to search me. And they'd find drugs on me or something, and off to jail we went."

> *"The numero uno is housing... [If I had housing I would] have to see people that use all the time, but I don't have to live with them. I can go home and shut my door and say, 'no.' Okay? You have to have some will power to do this. And I know how to do it. [While I am homeless] there's nowhere to hide here. There's nowhere to go."*

To quantify negative interactions with the police, we asked all participants whether they had been roughed up by the police or felt that the police were harassing them when they were experiencing homelessness.[40] Forty-seven percent said that they had.

Confiscations and Forced Displacements

Participants spoke about the impact of forced displacements on their lives. Forced displacements, or sweeps, occur when municipal officials (e.g., police officers, sanitation workers) resolve a homeless encampment by confiscating or disposing of all belongings that individuals living in the encampment do not, or cannot, remove themselves. Individuals are then requested or required to physically relocate from the area. Sometimes individuals targeted for sweeps are given referrals to services or access to temporary shelter beds, but often, services are not provided. Forced displacements occur with varied frequency. In the survey, we asked participants if they had their belongings taken away by authorities (such as police or other government workers) in the prior six months (if they had been homeless for shorter than six months, we asked about the time that they had been homeless). A significant proportion of participants had this experience: 36% noted that it had happened at least once in the prior six months. Among all participants, 11% had had this happen once, 10% 2-3 times, and 15% more than 3 times. Those who had spent most of their time unsheltered were more likely to have had this happen at least once (42%) than those who had spent most of their time in sheltered locations (15%).

Participants spoke about the impact of forced displacements and confiscation on their lives. Participants described how forced displacements resulted in their losing critical materials and supplies, including medications and cell phones. They discussed how displacement resulted in the loss or destruction of personal documents that they needed to apply for housing and other services, including birth certificates and state-issued IDs. Some expressed concern that they could lose their pets if the displacement occurred while they were away from their encampment.

Experiences of Violence

In previous chapters, we reviewed the prevalence of physical abuse or violence and examined how often violence contributed to or precipitated homelessness. In this chapter, we examine violence that occurred during the current episode of homelessness. We asked about both physical and sexual violence and asked participants to report on their relationships (or lack thereof) to perpetrators. In in-depth interviews, we explored the experience of violence and how it intersected with participants' homelessness. While past experiences of violence increase the risk of homelessness, homelessness increases the risk of violence.

More than a third (38%) experienced either physical or sexual violence during this episode of homelessness. Those who spent most of their time unsheltered without a vehicle reported similar rates of violence (42%) to those who were in vehicles (39%) but higher than those who spent most of their time in sheltered locations (26%).

More than one-third (36%) of all participants experienced physical violence during their current episode of homelessness. Of those who experienced physical violence, half (49%) reported that the violence was committed by a stranger and 21% by an intimate partner. Women were more likely than men to report that their perpetrator of physical violence was an intimate partner: 39% of cis-women did, versus 23% of non-binary, transgender, or participants with other gender identities and 13% of cis-men.

Ten percent of participants experienced sexual violence during their current episode of homelessness. Cis-women (16%) and non-binary, transgender, or other gender participants (35%) experienced sexual violence more frequently than cis-men (7%). As with physical violence experienced during homelessness, approximately half (54%) who experienced sexual violence reported the perpetrator was a stranger. One in five (22%) indicated that an intimate partner perpetrated this violence. Cis-women (21%) and cis-men (21%) reported similar proportions, but nearly half (46%) of non-binary, transgender, or participants with other gender identities who reported sexual violence reported that it was perpetrated by an intimate partner.

Participants explained that homelessness left them more vulnerable to violence. Without the protection of home, participants had less protection against violence perpetrated by strangers. Participants reported frequent harassment by members of the housed community, which they connected to the stigma of homelessness. Some participants experienced physical violence as a result of personal conflict with other encampment or shelter residents, acquaintances' gang involvement, or in the course of being robbed of their belongings. Others reported being physically harassed by law enforcement officers.

Participants noted that being homeless decreased their protection from intimate partner violence, as being homeless could facilitate the ability of perpetrators to locate them. Participants noted that, at times, they remained in abusive situations due to their need for shelter, stability, safety, and material resources. With choices constrained, they had less ability to exit abusive relationships. Alcohol and substance use could exacerbate experiences of intimate partner violence. Some described experiencing more physical abuse when their partner was under the influence, intoxicated, or going through withdrawal; others reported self-medicating to address the trauma of abuse.

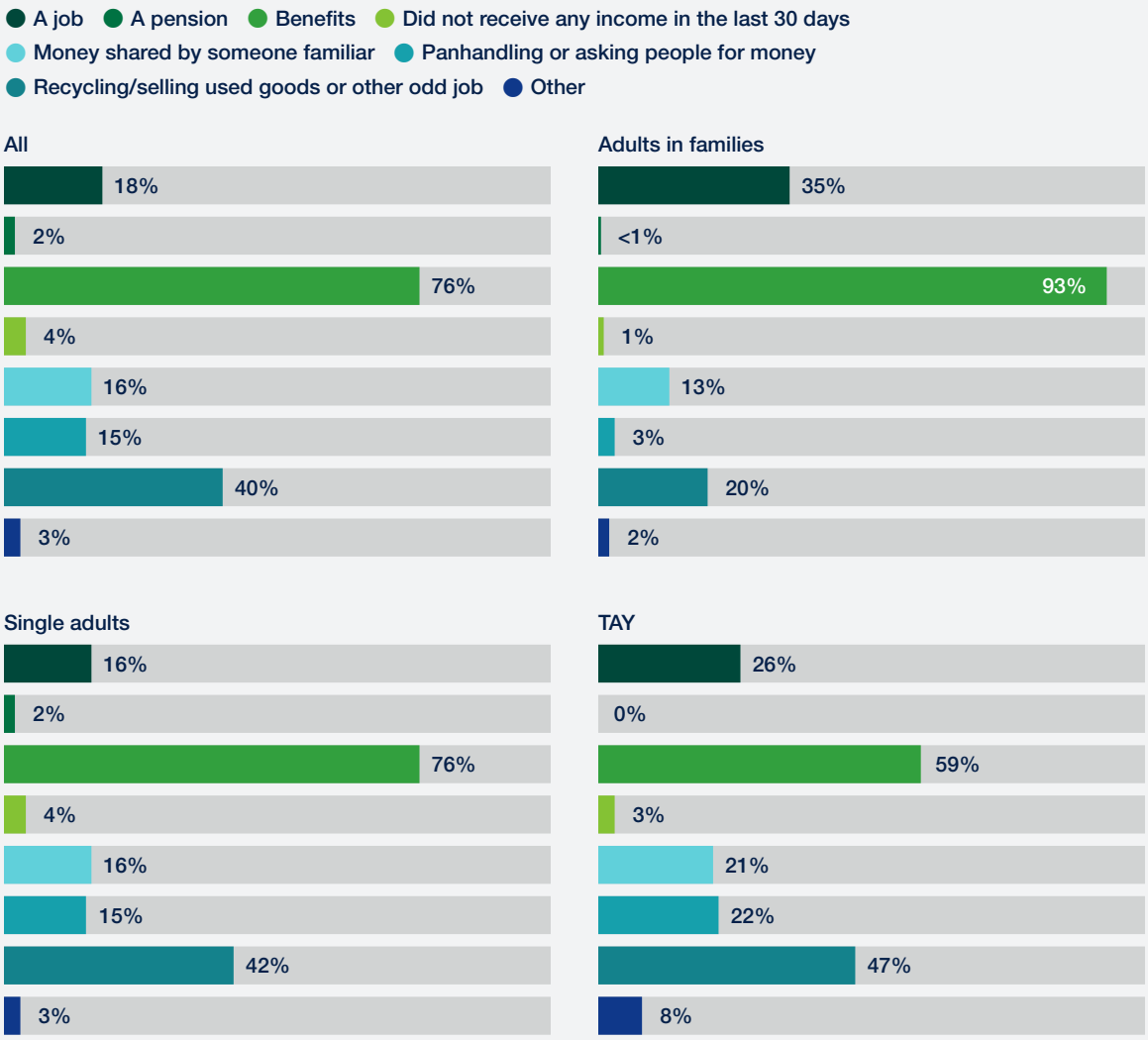
Income

Participants reported low total household incomes (including income from work (formal and informal) and income benefits). In the previous month, the median income in individuals' personal households (all those with whom they currently shared income and expenses) was $400 (IQR $100-1000).[41] Approximately 16% reported no current income; of those who reported any income, the median monthly income was $600 (IQR $221-1060).

Work and Employment

The pandemic may have changed employment patterns. For many, employment opportunities decreased due to pandemic-related economic disruptions. One quarter (24%) of participants reported COVID-related health and safety concerns as a barrier to work. Six percent of all participants (8% of those under 62 without a disability) reported working at least 20 hours for pay in the week prior

FIGURE 34 Sources of Income in the Last 30 Days by Family Structure



Participants could have reported more than one source of income.

to the interview. Overall, 18% reported income from a job in the month; 11% from informal employment or gig work and 8% from formal employment. More than a third (40%) reported income from recycling or odd jobs. Two percent of participants had income from a pension or retirement fund. When we restricted the data set to those younger than 62 and without a physical or mental health disability, 13% reported income from informal employment or gig work and 12% from formal employment. Figure 34 presents participants' income sources in the past month.

Participants faced extended disconnections from the formal labor market. Seventy percent reported that it had been longer than two years since they last worked a paying job for 20 hours a week or more. Sixty-two percent of those younger than 62 without a physical or mental disability reported the same. Nonetheless, participants were interested in finding a job. Of all participants, 44% reported they were looking for employment. Among those younger than 62 and without a disability, 55% were looking for work.

"Being homeless is a full time job."

Participants noted numerous barriers to engaging in paid work. The conditions of homelessness required time and energy that reduced participants' ability to earn income. Just as the lack of well-paid work had interfered with participants' ability to maintain housing, their homelessness restricted their ability to engage in paid work. While homeless, they reported spending their time accessing services, searching for housing, safeguarding belongings, and meeting basic needs. As one participant summarized it: "Being homeless is a full time job."

In the survey, we asked all participants to report what interfered with their ability to engage in paid work. Participants reported multiple barriers. Half (52%) of participants indicated that they were unable to work due to problems related to their older age, health, or disability. Half of participants (50%) indicated that transportation to or from the workplace hindered their ability to work. One in five (20%) participants reported that having a record of arrests or prior convictions, and being on community supervision following incarceration posed challenges to employment. Eight percent of all participants reported that caretaking responsibilities interfered with work, but 51% of adults in families did.

Participants described the complex interplay between their work, their homelessness, and their health, noting that health conditions interfered with work, and work could produce health problems. One participant described how staff at a shelter helped him secure a job, but he then got hurt on the job: "I got a job in [retail store] by staying at that shelter... I worked there for a long time till I fell down and got hurt there, and then I couldn't work for a year because my back and my hip." Participants recognized that their inability to work served as a major barrier to housing. As one participant said, in response to what was keeping him from regaining housing: "Being able to work. Right now, that is preventing me from paying rent. Because I can't move my arm…And the stroke I got."

Benefits

Benefits are a critical source of income for those experiencing homelessness. During the COVID-19 pandemic, many social safety net programs eased eligibility and certification requirements for benefits, reducing some administrative barriers to accessing income support. Since we conducted research during this period, our findings reflect the result of pandemic-related increased access.

Nutrition Benefits

CalFresh

CalFresh, California's Supplemental Nutrition Assistance Program (SNAP), is a federally-funded, county-administered benefits program that helps low-income individuals purchase groceries and other food items. At the start of the pandemic, CalFresh increased its monthly benefit amount to eligible individuals. California's Department of Social Services requested federal waivers to ease initial application and re-certification requirements (such as eliminating face-to-face interview requirements) for the program. These actions expanded the program's reach. Seventy percent of participants received CalFresh; 68% of single adults; 90% of adults in families; and half (52%) of TAY.[42]

Income Benefits

Social Security

A federally-funded entitlement program, Social Security provides income to retirement-aged individuals. Those who are at least 62 years of age and have paid Social Security taxes for a federally determined time period are eligible to receive benefits; surviving spouses of beneficiaries do as well. Overall, 8% of participants received social security benefits; 36% of participants age 62 or older did.

Supplemental Security Income

Supplemental Security Income (SSI) is a federal program which provides monthly payments to adults with limited income who are 65 or older, or individuals of any age who have a disabling condition. While administered by the Social Security Administration, SSI is distinct from Social Security benefits, and those who receive Social Security are not precluded from SSI receipt. Overall, 12% received SSI; 35% of participants age 65 and older; and 17% of participants with a disability did.

Social Security Disability Insurance
Social Security Disability Insurance (SSDI) provides monthly benefits to people with severe disabilities, as defined by the Social Security Administration, who are unable to work due to their disabling condition. In general, a recipient of SSDI must prove that they are unable to work due to their disability for at least a year; however, exemptions exist (for example, compassionate allowances for individuals with certain medical conditions). Overall, 8% of participants received SSDI; 11% of participants who reported having a disabling condition did. The criteria for SSDI eligibility determination is likely more strict than the one we used to determine having a disabling condition.

Veterans Administration Income Benefits
The Veterans Administration (VA) offers benefits to both active-duty veterans and National Guard and Reserves members; however, eligibility for some benefits may differ based on length of service and duty status. Overall, 2% received VA income benefits. Six percent of participants had completed military service (either active duty or served in the National Guard or Reserves). Of those participants, 19% reported receiving VA benefits.

CalWORKs
CalWORKs, California's Temporary Assistance for Needy Families (TANF) program, is a federally-funded, locally-administered program that provides monthly assistance to unemployed or underemployed families with minor children. Overall, 5% received CalWORKs; 36% of adults in families did.

General Relief and General Assistance
The General Assistance and General Relief (GA/GR) program is designed to provide financial assistance to adults who have not received other income benefits.[43] Thus, only those who did not receive Social Security, SSI, SSDI, VA income benefits, or CalWORKs would be eligible. In California, counties determine both eligibility criteria and the amount of aid offered through GA/GR. Many people who receive GA/GR are able to receive nutrition benefits, such as SNAP (CalFresh). One quarter (28%) of participants received GA or GR. Among those who did not receive any of the other income benefits, 34% received GA/GR.

Participants described their challenges obtaining benefits. They reported being frustrated by challenges completing online benefit forms without the aid of a case manager, because they found the online navigation and interface confusing. These participants used computer terminals in libraries and other public locales, which delete session-specific information once the user logs off. As a result, some participants reported being unable to retrieve passwords and other identifying information the next time they logged on. Participants noted the lack of mobile phones as a barrier to two-factor authentication. Additionally, participants described bureaucratic impediments that resulted in their being turned down for services or remaining on waiting lists for an extended period.

Discrimination

To assess experiences of discrimination,[44] we administered the Everyday Discrimination Scale (EDS).[45] The EDS is a widely used measure of subjective experiences of discrimination.[46] We asked participants to assess how often in their day-to-day life they were treated with less courtesy or respect than other people, they received poorer service than other people at restaurants or stores, they were treated as if they were not smart, people acted as if they were afraid of them, or they were threatened or harassed. We asked participants why they believe people discriminated against them from a list of 13 commonly marginalized statuses including housing/homelessness status.[47] Acknowledging that people experiencing homelessness often embody multiple marginalized statuses such as homelessness, race/ethnicity, gender, sexual orientation, and disabilities, participants could indicate multiple reasons. We then asked participants what they believed to be the main reason that people discriminated against them.

Discrimination has been linked to a wide range of adverse health outcomes. A stressor that negatively impacts physical, mental, and behavioral health, discrimination can trigger physiological and psychological responses, such as increased cortisol and adrenaline levels, as well as emotional distress. Most (83%) participants reported experiencing discrimination in their daily lives. Nearly half (47%) of participants indicated that they were treated with less courtesy or respect than other people almost

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every day or at least once a week. Forty percent of participants report being treated as if they are not smart almost every day or at least once a week. Of those who reported any discrimination, 32% of participants believed that their homelessness was the main reason people discriminated against them. Those who were unsheltered were more likely to report their homelessness as the main reason (35%) compared to those living in sheltered locations (20%). Participants specified physical appearance and race as main reasons as well. A smaller proportion 21% shared that their physical appearance was the main reason and 9% indicated that race was the main reason.

Participants described the stigma that they faced due to being unhoused. One participant shared: "Do you know how many people are so close to being homeless? Like one paycheck, and they're going to be homeless…There's some people that are homeless because they're mentally messed up or they're on drugs or whatever… But they just stereotype [everyone] and put them in that category."

Participants highlighted the intersectional nature of discrimination, emphasizing the importance of understanding the complex and interrelated reality of these experiences. Discrimination can occur based on more than one embodied status at a time. One participant shared his experience attempting to apply for an apartment as a Latino/x man with tattoos. He shared: "[Leasing agents are] discriminating because I've got tattoos everywhere. So, if I walk in, they'll give me an application, but that's not going to make it into the records or whatever. So, I just don't waste my time on it… [And] my race plays a big factor out here. They look and they see a brown guy with a bald head and tattoos. What are they going to say? 'He's out here stealing stuff.' It's stressful."

SUMMARY

The experience of homelessness is highly stressful: participants spent much of their time trying to survive and find shelter, food, safety. They reported that these efforts consumed much of their energy, leaving them less able to seek healthcare (including treatment for physical and mental health challenges and substance use) and employment. They reported frequent exposure to violence (often perpetuated by strangers), surveillance by the criminal justice system, and discrimination in multiple arenas. When they had the energy to seek help, they found many doors closed, encountering barriers wherever they turned. These barriers caused their health and economic conditions, which were already poor when they entered homelessness, to worsen. They reported that what they most needed—housing—remained elusive.

KEY TAKEAWAYS

- Most participants experienced unsheltered homelessness. Nine out of ten participants slept in an unsheltered location at least one night during their current episode of homelessness.
- Participants' health status is far worse than their housed, non-institutionalized counterparts. Nearly half of participants self-reported fair or poor health; 34% had difficulty performing at least one activity of daily living; nearly two-thirds had at least one chronic health condition. The high proportion of participants who were age 50 and over faced even greater health challenges.
- Homelessness presents barriers to physical and behavioral health treatment and care needs. Half reported having a regular place for care. A quarter of participants reported an inability to access prescription medications for physical health conditions; a quarter experienced a time where they needed health care, but were unable to get it. Of those who reported current regular substance use, one in five wanted treatment, but were unable to receive it.
- Pregnancy is common during homelessness. One in four of those assigned female at birth aged 18-44 experienced a pregnancy at some point during their current episode of homelessness. Eight percent were pregnant at the time of interview.
- Stress and feelings of hopelessness characterized many participants' experiences of homelessness.
- Two-thirds of participants reported current mental health symptoms, with serious depression and anxiety symptoms being reported most commonly. Approximately half reported symptoms of either depression or anxiety; 12% reported experiencing hallucinations.
- Participants noted frequent interactions with police. One in three were incarcerated for at least one night during their current episode of homelessness.
- Participants spoke about the adverse impact of forced displacements on their lives; over a third reported losing belongings to confiscations in the prior six months. Participants noted that important documents and medication had been confiscated.
- More than a third of participants experienced physical or sexual violence during this episode of homelessness. The perpetrators of this violence were commonly strangers.
- Although benefits were a key source of income, many who may have been eligible for income benefits didn't receive them.
- Eight out of ten participants reported experiencing discrimination in their daily lives. Housing or homelessness status was most frequently identified as the main reason for discrimination.

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CHAPTER 4

BARRIERS & FACILITATORS of Returns to Housing

After exploring who experiences homelessness, what life events led to homelessness, and what happens to people while they are homeless, we turn to a different question: what factors interfere with exits from homelessness.

We know that for individuals, housing solves homelessness; if people were housed, they would no longer be homeless. In this chapter, we ask what is getting in the way of people returning to housing, and what would help them do so. Through in-depth interviews, we asked participants about their experiences trying to return to housing: what hopes they had, what challenges they faced, what things would help them.

We heard time and again about participants' eagerness to return to permanent housing—and the seemingly insurmountable barriers they faced. While participants faced many barriers, the primary barrier for all was the high cost of housing.

INTEREST IN OBTAINING PERMANENT HOUSING

In in-depth interviews, participants expressed an eagerness to obtain permanent housing, because they felt permanent housing would offer needed stability to seek employment and address physical and behavioral health issues. They explained that permanent housing would provide personal safety, security for belongings, access to meal preparation, and protection from the elements. The few participants who expressed concern about permanent housing noted that mental health issues (including PTSD) could make living in housing feel constraining.

> *There's just not enough resources out there for people who want to get out of being unhoused... You kind of just seem like you're stuck there. Even if you're trying to get a job, like you have to have an address. And, if you don't have an address, you can't get a job. If you can't get a job, you can't stop being unhoused.*
>
> — CASPEH participant

CHALLENGES TO ACCESSING HOUSING

Despite the high level of interest in obtaining housing, study participants faced multiple challenges to doing so. Participants described barriers, including the scarcity and high cost of housing, the lack of rental subsidies, the absence of information about how to access housing services, the lack of assistance in identifying housing, and concerns about whether romantic partners, close friends, or pets would be eligible to stay with them.

In the survey, we sought to understand the barriers that participants faced obtaining housing. To do so, we asked participants about a number of potential barriers to housing and asked them to note how much each interfered with housing returns: not at

all, a little, a lot, or don't know. We asked questions about costs; formal assistance (housing navigators or case managers); logistical and technical difficulties; family structure and pets; health problems; past history (credit, criminal justice); and discrimination. Through in-depth interviews, participants helped us understand how these problems played out in their lives.

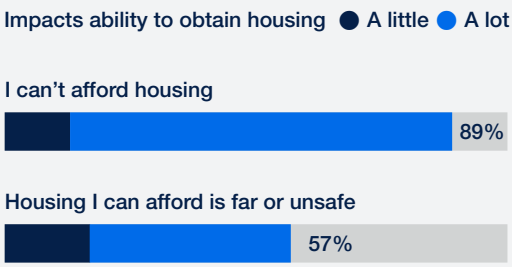
Housing Costs

Nearly 9 in 10 participants (89%) noted that housing costs negatively affected their ability to re-enter permanent housing; 76% noted that housing costs impacted their ability to re-enter housing a lot. Participants discussed the cost-related barriers to re-entering permanent housing, including their having insufficient income to cover monthly rental costs and lack of cash reserves to cover the security deposit, first and last months' rent. As one participant told us, "I've tried to look for apartments on my own, but I wanted to make sure that I could afford them. And most of them, they want three times the rent, you know. And just for, like, studios or one bedrooms out here, it's, like, $1100, $1200 just for that alone. I'm like, 'whoa', you know? So that means I'm going to have to make $3300, you know. And I wasn't making that. And I'm not going to be making that anytime soon."

Trade-offs to Make Housing Affordable

Affordability can be a tradeoff. In theory, there might have been housing that a participant could afford, but other barriers, such as being too far away interfered with it being a viable option. More than half (57%) of participants reported that housing they could afford was either too far away or unsafe: 40% noted that this barrier impacted them a lot (Figure 35). Participants discussed these trade-offs in interviews, noting the many challenges of moving elsewhere for lower cost housing. Those who were able to identify housing that fit their budget found the housing was located in neighborhoods the participant considered unsafe, not well-served by public transportation, or too far away from their place of employment or medical care. Participants discussed the need to find housing in the same city or town to remain in proximity of children, family, and others in their social network. As one participant described their reasoning for not considering moving to a lower cost area: "No, I wouldn't [move there], mainly because my doctors are here. And that's a big concern for me. You know, [to] have the same doctors, they know what's going on, they have all my records, and I know them, too."

FIGURE 35 Proportion of Participants Who Reported Affordability-Related Housing Barriers



In in-depth interviews, we presented participants with a set of hypothetical trade-offs for obtaining housing (e.g., you would need to double up with people you do not know, your place would be inaccessible to public transportation or in another town or city). While participants' responses varied, nearly all expressed being willing to compromise in order to obtain permanent housing. There were common themes to the criteria that participants had in order to accept a housing offer. Participants noted that they would accept a permanent place to live, provided that: (a) the unit was accessible to public transportation, employment, medical care, and/or their social networks; (b) the property owner would accept pets, romantic partners, and/or friends and family members as roommates; and (c) the regulations were no more restrictive than those found in the general housing market (i.e., they were not asked to accept restrictions that people who are not homeless agree to accept).

> *"There's not much out there for people with low income. I live below poverty. SSI, I get $900.00 a month. You can't live on that. You can't rent a place with that because you need first month's rent, security deposit, plus you need to make three times that amount of rent. I don't make that much. If I pay rent, even if I pay $500.00 a month rent and I have to have a storage unit, I have to pay for food. I can't do it."*

Because of interest in shared housing as a means to decrease housing costs, we asked interview participants about this possibility. Some participants stated that they would be willing to share housing with someone they did not know if (a) they would live with just one other person, (b) they would have their own separate bedroom, or (c) they had the opportunity to get to know the person they would be living with before moving in together.

Although participants were, for the most part, willing to accept housing with others (rather than by themselves or with members of their personal household), they were reluctant to accept housing with people they did not know and hadn't chosen. They expressed concern about being forced to live with someone who might be untrustworthy or irresponsible, unwilling to share the same standard for cleanliness, or would steal their belongings. Others explained that their reluctance to share housing with people unknown to them resulted from their past experiences of physical or sexual violence. The ongoing trauma of these experiences led them to be reluctant to accept housing with someone they didn't know. Some participants expressed reluctance to double up with someone with mental health issues or who is actively engaged in substance use. For some, this was because they felt that it would complicate their efforts to maintain their own sobriety or manage their own mental health issues.

The Role of Rental Subsidies

Rental subsidies, such as Housing Choice Vouchers, allow individuals to pay only 30% of their household income on housing, with the rest paid for by the subsidy. However, there are long wait lists for vouchers and most who qualify don't receive them. Nationally, only one in four households who meet the criteria for Housing Choice Vouchers receive them. In high cost regions with housing shortages like California, even those who receive vouchers may have difficulty using them. We asked participants about rental subsidies: whether they had heard of them, were on wait lists for them, or had one that they couldn't use. Since we interviewed only those who remained homeless, we did not speak to anyone who was currently using a voucher.

The availability of housing vouchers varied greatly by region. In some regions, we spoke to participants who had never heard of them or never heard of anyone having received them. Other participants described being on waiting lists for them. One described his situation this way: "Finding the help and actually believing that I'm not on a hamster wheel with the people I'm working with. I feel like that's what the Section 8 list is, for sure. I feel like that never goes through. It never goes anywhere. You just stay on that waiting list forever and ever and ever. I mean, I stayed on it one time. My ex was on it. We both were on it, but she actually ended up getting picked for the voucher, but they never told her. And then they couldn't find her on the list. After she got selected, she went to go meet with them, and they couldn't find her on the list anymore. You lose hope after a certain point in time." In one or two regions, we met participants who had vouchers or knew others that did. Participants described vouchers as highly valued and rare, with one participant referring to them as "a golden ticket." Those without vouchers described the voucher distribution process as opaque. The lack of transparency led some participants to suspect that favoritism played a role in voucher determinations. These participants speculated that case managers provided vouchers to clients who were members of their own racial or ethnic group.

Participants identified numerous obstacles to obtaining housing, even for those with a Housing Choice Voucher. Some participants with vouchers reported that available housing was outside of the allowable price range for the voucher and that their ability to use them was limited by discrimination against voucher holders by property owners.

Lack of Case Management and Housing Navigation Assistance

Participants expressed enthusiasm about receiving assistance to re-enter housing, but described substantial barriers to receiving it. Unsheltered participants, particularly in rural areas, discussed lack of knowledge about providers that could help participants regain permanent housing. When we asked what formal assistance they received to help them exit homelessness, some were unfamiliar that such services existed. It is possible that the disruptions of the pandemic decreased interactions with case managers and housing navigators.

When (in surveys) we asked about barriers to regaining housing, two-thirds (63%) of participants endorsed that not having someone from an agency to help them interfered with their finding housing; 46% said that this negatively impacted them a lot. When asked whether they had received formal assistance in finding housing, fewer than half (46%) reported receiving help from a case manager, housing navigator, or someone else from an agency or community organization during this episode of homelessness. Even among those who received help, almost half had not received help more than once or twice in the prior six months, if at all. Among the 46% who had received help, 15% reported monthly contact in the prior six months, 29% weekly, and 12% daily or almost daily. Thus, overall, only one quarter (26%) of all participants received help (from a provider) finding housing monthly or more frequently in the prior six months. Sheltered participants were more likely to have received help in the prior six months (44%) than unsheltered participants (20%).

In in-depth interviews, participants residing in shelters (congregate or non-congregate) reported more consistent case management service access, including housing navigation. Some noted that shelters required interaction with case managers. Unsheltered participants reported that outreach workers from social service agencies occasionally offered housing navigation assistance, but rarely returned to provide follow-up information. Participants reported difficulties remaining in contact with case managers/housing navigators, due to lack of access to a reliable telephone. Some participants reported missing out on housing opportunities due to the inability to stay connected. Participants remarked that their phones were either broken, misplaced, stolen, or confiscated during forced displacements, or "sweeps." Given sporadic access to electricity, unsheltered participants with working phones struggled to keep them charged. Participants explained how this led to hopelessness.

As one participant explained, "If you called the [resource hotline] or they give you all these resources and other numbers to call. There is none. They put you back in the link of calls and they send you here, they send you there. But nobody has the right information for the right guidance of where you need [to go] – who is the person you need to speak to and how can I get the help... It was ridiculous to a point you give up. You give up."

Whether sheltered or unsheltered, participants reported that housing navigation services varied in quality. Some participants praised their case managers for facilitating efforts to obtain permanent housing, assisting them with paperwork, helping them to collect the necessary documents, and offering other assistance. Others felt that the assistance they received was inadequate. Participants described receiving out-of-date lists, so when they called about a housing unit, it was no longer available. Participants reported that providers gave them information about housing that was market rate, and thus, outside their price range. Some participants believed these negative experiences could reflect service provider caseloads being too large, frequent staff turnover in service organizations due to low pay or labor shortages, and the lack of existing affordable housing to which case managers/housing navigators could refer.

Wait Times and Hopelessness

Almost half of participants (46%) reported that their having "given up or (not having) the time or energy" to look for housing options negatively impacted their ability to re-enter housing; 30% noted this impacted them a lot. Over half (52%) noted being negatively impacted by extended waits on waitlists; 42% noted this impacted them a lot.

As one participant said, "They tell us, "You're on the waiting list," and all this. It's been three years. How long can the waiting list be? We should be priority according to what the news says all the time. We should be priority to get us off the streets, and they don't. Some of these guys have been out here 20 years... I understand you get the elderly and those out of the way, health conditions. But they tell us the same thing all the time. "You're next. You're next."... It's just stressful."

> *"The most stressful thing I could think of is not having secure or stable housing… I know how to survive, but I don't really know how to live. And then the older I get, the higher [more expensive] stuff is starting to become. So once I think that I'm at a manageable level, I'm noticing that I have to make either three times more than I'm already making or four times more... Previously, I had two jobs, but even still having two jobs wasn't enough."*

Logistical and Technological Barriers to Receiving Housing

Participants described lacking necessary documentation to re-enter housing. During their homelessness, they had lost track of documents that they needed to regain housing. They discussed having lost birth certificates, government-issued IDs, and other documents due to theft and loss. A common theme was the role that forced displacements played in

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documents becoming damaged or misplaced. During these forced displacements, authorities would dispose of belongings or leave them unattended and thus exposed to theft or the elements. Participants reported that COVID-related government closures created an additional barrier to obtaining necessary documents, since government agencies responsible for providing this documentation remained closed for an extended time. Participants noted the toll of their recurring exposure to the elements, with documents destroyed due to rain or lost to wind. In the survey, more than half of participants (53%) noted a lack of documents as a barrier to finding permanent housing; 37% of all participants indicated this impacted them a lot.

FIGURE 36 Proportion of Participants Who Reported Family Status Housing Barriers by Family Structure

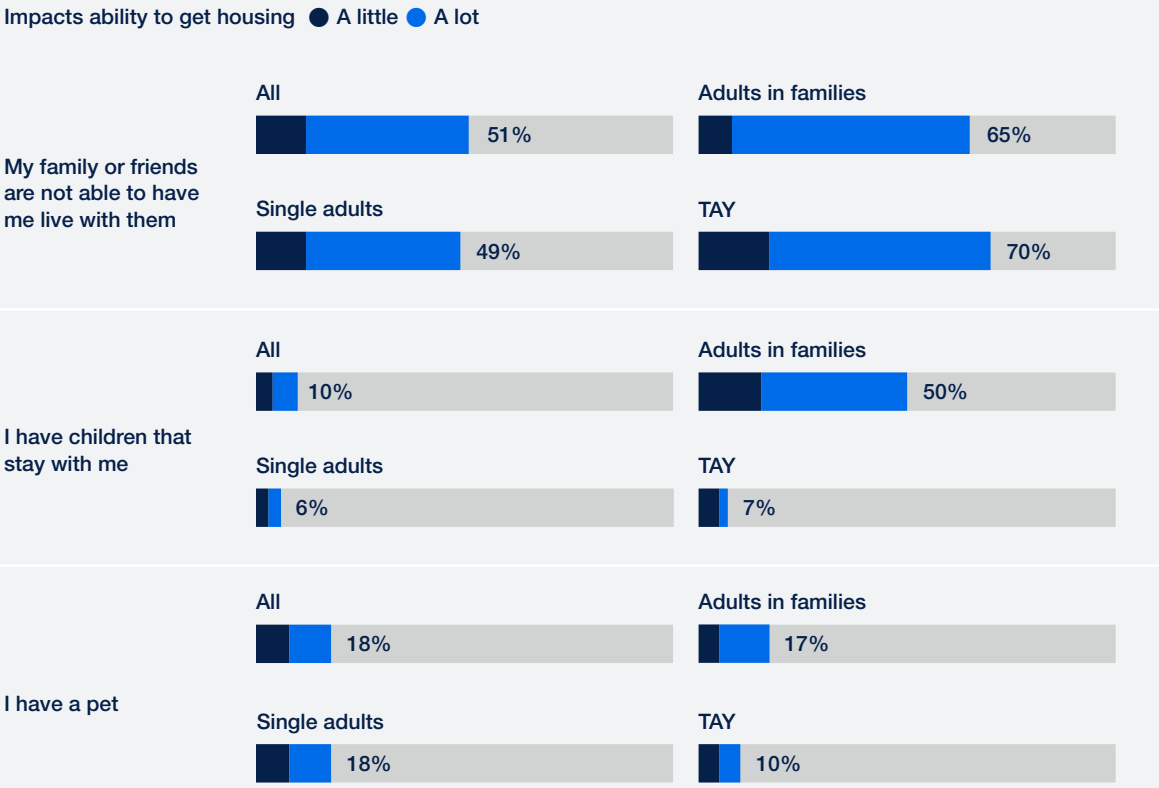
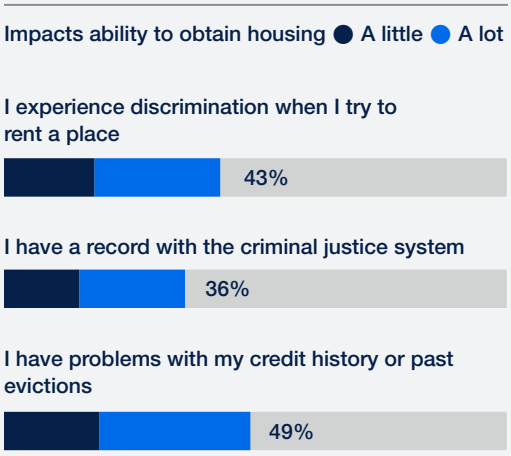


FIGURE 37 Proportion of Participants Who Report Discrimination and Prior History as a Barrier



Family Status

Families and friends can be a source of housing support for many individuals, providing places for individuals to live. But many participants noted that their family or friends were not able to provide a place to stay (Figure 36). Half (51%) of all participants noted that their family and friends were unable to accommodate them, with 39% noting it as a barrier that impacted them a lot. This issue was more frequently identified as a barrier among transition age young adults (70%, with 53% indicating it impacted them a lot) and adults in families (65%, with 57% indicating it impacted them a lot) than single adults (49%, with 37% indicating it impacted them a lot). This finding could be because family or friends do not have space or resources for the participant to live with them, or because rental agreements

for market-rate or subsidized housing may limit the number of residents permitted to reside in a unit, or the length of time a guest is allowed to stay there.

Among all participants, 10% noted that they were impeded in finding housing because they needed to find housing for themselves and their children; 6% noted that this impacted them a lot. This issue was more common among adults in homeless families, where half (50%) noted it; 35% reported that it impacted them a lot. While having children presented a barrier for housing (either because property owners discriminated against children or because participants could not find affordable spaces with room for their children), housing was critical for those with children to maintain or regain custody.

We asked participants whether having pets was an impediment to their finding housing. Eighteen percent of participants reported this served as a barrier, with 10% noting it impeded them a lot. Participants discussed the challenges of finding housing that allows pets. These participants considered their pets to be part of their family, and would not consider housing that wouldn't allow their pets, despite encountering barriers associated with having a pet.

Discrimination and Prior History as Barriers

We examined the role that identity-based discrimination and histories of eviction, poor credit history, or a criminal record played in creating barriers to reentering housing. We defined discrimination broadly to encompass any perceived disparate treatment based on participants' characteristics. Forty-three percent of participants reported that they had experienced discrimination when trying to rent, with one quarter (25%) indicating this barrier impacts them a lot (Figure 37). One in three (36%) participants indicated their carceral record as a barrier, with 21% of participants noting that this negatively impacted their ability to find housing a lot. Nearly half of participants (49%) noted that either problems with their credit history or prior evictions negatively impacted their ability to find housing, with 30% noting it did a lot.

Participants described instances where property owners discriminated against those with rental subsidies/vouchers, those with little or no rental history, and those with a history of incarceration. Participants discussed being discriminated against in the housing market on account of their race or ethnicity. Because of these challenges, participants reported needing to apply for several units, leading to cost-prohibitive application fees that stalled their housing search. One participant shared: "There's so many times of just applying and not even hearing a phone call back to even say that you're not even accepted... If they don't want to have me there, why have me fill out the application and all that? ... they were charging like $35.00 credit checks and stuff each time, each application... After so many times of trying, you just give up because that money is just going to them for nothing when they know their answer already."

Challenges Associated with Physical and Behavioral Health

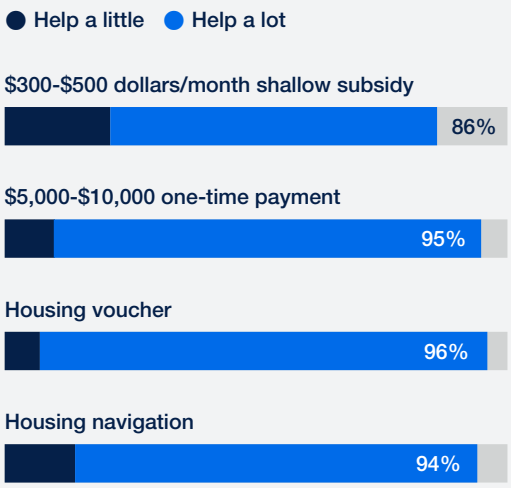
Some participants encountered challenges due to physical and behavioral health conditions. A quarter (24%) of participants noted they could not find housing that meets their needs due to a physical disability; 14% indicated that this impacted their ability to find housing a lot. More than a quarter (29%) of participants indicated that their mental health or substance use impeded their ability to obtain housing, with 19% noting it impacted their ability to find housing a lot.

Some participants discussed how behavioral health conditions caused them to feel overwhelmed by the bureaucratic hurdles necessary to secure housing. When asked how their mental health impacted their ability to find housing one participant shared: "My mental health, bipolar disorder, because of my mania I don't think more than a day ahead. It's day by day. I try to focus on the day. When I try to think about next week, I get too much anxiety and I freak out and I panic."

WHAT WOULD HELP INDIVIDUALS END THEIR HOMELESSNESS?

Similar to the prevention program thought experiment (Chapter 2), we asked all participants (in the survey) about several hypothetical interventions that could help them re-enter housing right now. We asked participants what they believed would help them obtain housing: (a) a monthly subsidy of $300-$500 dollars, (b) a lump-sum payment of $5,000-$10,000 dollars, (c) a subsidy or voucher that limited their rent to 30% of their income (similar to a Housing Choice Voucher), or (d) a housing navigator (Figure 38). We asked about each hypothetical intervention separately and asked, for each, for participants to rate whether the intervention would help them a lot, a little, not at all, or not sure. Eighty-six percent thought that a monthly subsidy of $300-$500 would help; 65% thought it would help a lot. Ninety-five percent indicated a lump-sum payment of $5,000 to $10,000 (that could help with security deposit, first, and last month's rent) would help, 85% indicated it would help a lot. Ninety-six percent of participants indicated a rental subsidy that would limit their rent to 30% of their income would help; 89% thought it would help a lot. Finally, 94% indicated that a housing navigator would help; 80% thought it would help a lot.

FIGURE 38 Participant Report of Effect of Hypothetical Interventions to Support Returns to Housing



> *"You be cold and freezing in the tent sometimes. You've got plenty blankets, gloves, hoodie, jackets. But it really makes you appreciate being inside. You can bathe when you want to. You can flush the toilet when you want to. I was going to flush the toilet when I get in my apartment, just so I can hear it. You don't realize how important it is to be inside… I know now that I would cut all my limbs off, if that's what it took to pay my rent for the rest of my life. And I would never have to be outside again. That's what I would do... Having a place, a stable place over your head, is the most honorable thing you can give yourself. Because you can eat, you can sleep, come and go. Yeah, see your grandkids. They come to see you because you have somewhere for them to come to. It's the most beautiful thing."*

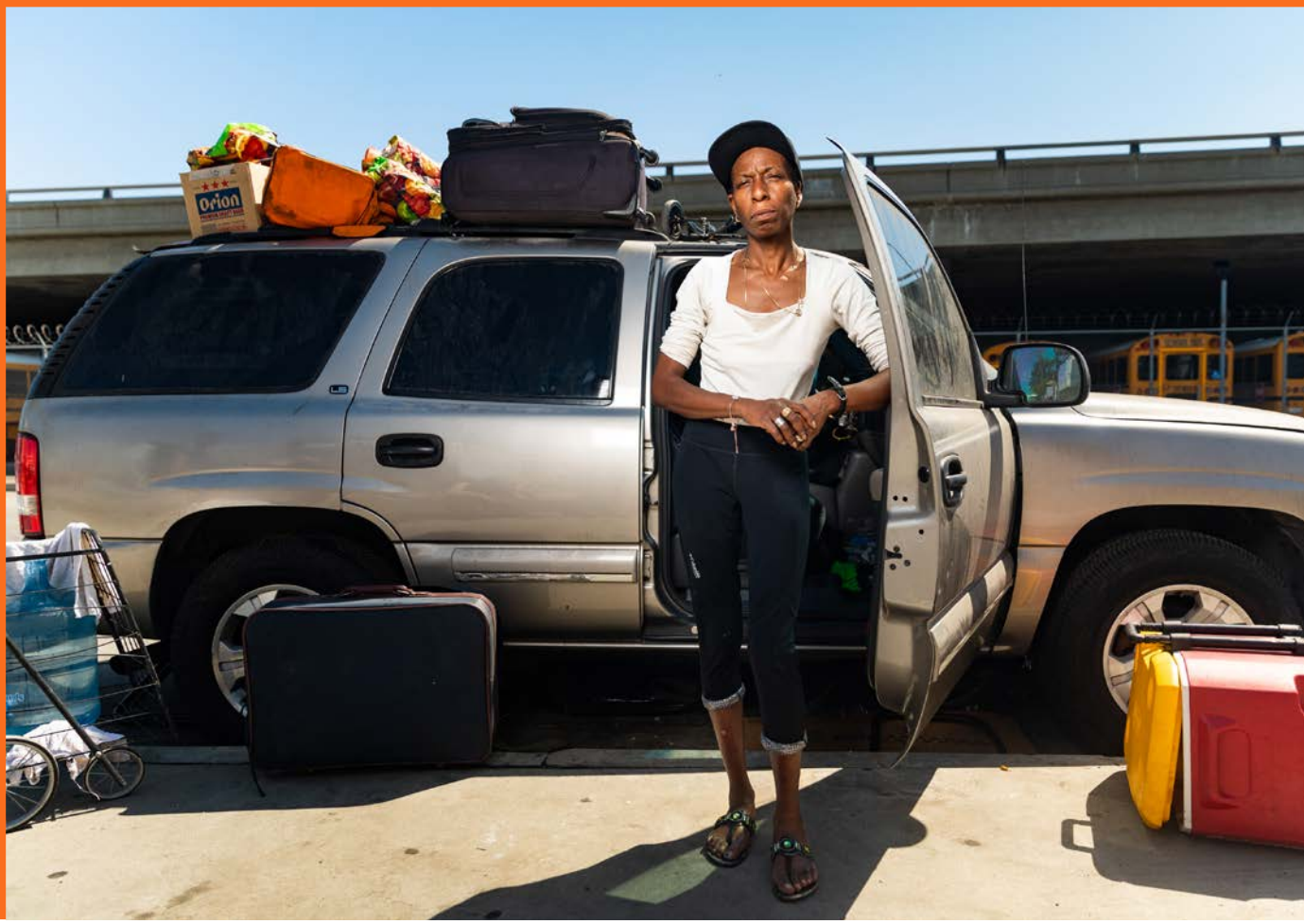
Participants wanted housing desperately. And while they suffered immensely, they held out hope for a better future–one in which they could, once more, know the safety and security of home.

PARTICIPANTS WANTED HOUSING, BUT FACED MANY BARRIERS.

Participants wanted to exit homelessness. They wanted to have a permanent home, knowing that it would provide them a pathway toward health, reunification with their children, employment, safety, and stability. While many had lost hope, they yearned for home. Everywhere they turned, they came up against barriers: they had poor credit, no savings, no phone to receive calls, no documents, transportation, or money for rental applications. Many did not have anyone to help find housing. Those who did considered themselves lucky, but their luck would run out when the person helping them left their job, or they lost their phone. If they were one of the few to get a rental subsidy, they still had to overcome a host of obstacles: discrimination against voucher holders, racial discrimination, no internet, no transportation. The biggest obstacle they faced was costs: they could not make enough money every month to pay the rent. Participants believed, overwhelmingly, that money—a monthly subsidy or one-time payment-- would help them end their homelessness. Participants wanted housing desperately. And while they suffered immensely, they held out hope for a better future–one in which they could, once more, know the safety and security of home.

KEY TAKEAWAYS

- Nearly all participants expressed interest in obtaining housing. However, significant barriers impacted their ability to do so.
- Housing costs posed the most significant barrier to regaining housing.
- Participants are willing to make trade-offs to access permanent housing.
- Participants noted additional obstacles, including logistical barriers (no phone, transportation, documents); lack of housing navigation support; family considerations; identity-based discrimination; and prior histories of criminal justice involvement, eviction, and poor credit.
- Fewer than half of participants received help from a case manager, housing navigator, or someone else from an agency. Only one quarter of participants received any help finding housing monthly or more frequently in the prior six months.
- Participants overwhelmingly believed that additional money would end their homelessness, whether through shallow subsidies, one-time lump-sum payments, or deep rental subsidies.



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CHAPTER 5

Policy Recommendations

In this chapter, we discuss policy recommendations for local, state, and federal policymakers. Our recommendations include increasing affordable housing, homelessness prevention, appropriate services and supports, and income, and centering racial equity. We highlight where programs or policymakers could leverage or expand existing funding mechanisms to implement these recommendations. For example, the California Advancing and Innovating Medi-Cal (CalAIM) program, California's transformation of their state Medicaid plan (known as Medi-Cal), offers several opportunities to bring key recommendations to scale. We intend for these recommendations to start a conversation, rather than to be comprehensive. Ending the homelessness crisis will take time and demand resources and coordination between local, state, and federal entities.

INCREASE AFFORDABLE HOUSING OPTIONS AVAILABLE TO EXTREMELY LOW-INCOME HOUSEHOLDS

The median monthly household income in the six months prior to homelessness across all CASPEH participants was $960. Almost all participants met criteria to be considered "extremely low-income" or making less than 30% of the Area Median Income. Participants' inability to afford housing was both the underlying cause of homelessness and the primary barrier to their returning to housing. This finding was true throughout California, not only in the high-cost coastal regions.

Any solution to homelessness must address the lack of affordable housing for extremely low-income households. In 2023, California had only 24 units of housing available and affordable for every 100 extremely low-income households.[48] Shrinking this housing deficit will require investments at every level of government. But, it is essential to end the homelessness crisis. We recommend the following:

Expand deep rental assistance programs (such as Housing Choice Vouchers). Funded by the federal government and administered by local housing authorities, Housing Choice Vouchers limit a household's rent to 30% of income. Only one in four households nationwide who qualify for Housing Choice Vouchers receive them. While most Housing Choice Vouchers are tenant-based, some housing authorities use project-based vouchers. Expanding rental assistance programs could provide housing stability for many extremely low-income households.

In addition to advocating for the federal government to support additional vouchers, local jurisdictions could expand locally operated rental subsidy programs with funding from local, state, and federal programs.

Support usability of existing subsidies. Expansion of Housing Choice Vouchers (or similar rental subsidies) is necessary, but not sufficient. In certain regions, participants reported having a voucher and not being able to use it. Providing increased housing navigation support, funding for non-rent housing costs (e.g., housing search, security deposits, and move-in costs), incentivizing property owners' acceptance of vouchers, and enforcing anti-discrimination laws could increase use of vouchers in tight rental markets.

Incentivize production of deeply affordable housing through existing mechanisms, such as the Low Income Housing Tax Credit (LIHTC) program. California is one million units short of available and affordable housing for extremely low income renters.[49] There is a need to leverage

land use tools to achieve affordability by removing local permitting barriers to affordable housing. By incentivizing public-private partnerships in support of development, LIHTC has helped finance nearly all affordable housing in California. Other examples include programs such as Homekey, which provided funding for local governments to purchase pre-existing housing or convert commercial properties to interim or permanent housing.

Pilot shared housing; to make them tenable, give clients agency in choosing with whom they live, privacy, and support. While there is a clear and critical need for housing production, closing the housing gap will take time. Shared housing (an option in which two or more unrelated people live together in a housing unit and share expenses) offers an opportunity to maximize use of limited existing housing. Previous Housing and Urban Development (HUD) programs allowed for shared housing (e.g., two households could split rent). In our in-depth interviews, we engaged participants in a thought experiment about trade-offs they would make in order to obtain permanent housing. While many participants expressed concerns about shared housing, some participants were open to the idea under the condition that they shared with only one other person, had their own bedroom, and had a chance to get to know any potential housemates prior to moving in together. Participants noted that they would not accept shared housing with a housemate whom they didn't have a choice in selecting.

Effective models of shared housing give agency to residents. Shared housing programs should allow for clients to choose whom they live with and provide private bedrooms within the space. Allowing individuals to live with whom they are most compatible with, while providing all residents in the unit their own space, could mitigate conflict among residents. Additionally, shared housing models should integrate mediation services to help residents navigate issues that may arise while living together. Piloting shared housing programs that promote client choice and provide support may be a strategy to increase use of existing housing units.

Pilot providing monetary support to facilitate shared housing with family members/friends. More people entered homelessness from non-leaseholder agreements than from traditional leases. One quarter of individuals in non-leaseholder agreements paid no rent. The second most common reason for leaving housing among non-leaseholders was "not wanting to impose." Pilot programs could explore the ability of rental stipends to facilitate extremely low-income individuals to remain with or move in with members of their social network (family or friends).

INCREASE HOMELESSNESS PREVENTION

Participants received minimal warning before losing their housing; few knew about or accessed prevention services. Leaseholders' median notice before losing housing was 10 days, while non-leaseholders had a single day. While few reported access to prevention services, many participants engaged with other mainstream systems. We recommend the following:

Pilot shallow monthly subsidy or lump-sum payment programs. Many CASPEH participants believed that a one-time payment of $5000-$10,000 or a shallow monthly subsidy of $300-$500 would have prevented their current episode of homelessness. These interventions can help renters catch up on late rent and avoid pay or quit eviction, help others pay security deposits and moving costs, or make up the difference between income and rent. This recommendation is in line with research on homelessness prevention, which shows that if targeted appropriately, homelessness prevention can reduce episodes of homelessness (and the attendant downstream consequences) at a reasonable cost.

Incentivize property owner and tenant mediation processes as a means for eviction diversion. Incentivizing property owner participation in mediation processes prior to eviction proceedings could allow tenants and property owners to come to a resolution that averts eviction. If they cannot reach agreement, the mediation process could offer tenants additional time to find alternate housing arrangements. Currently, property owner–tenant

mediation in California is voluntary. However, dedicated efforts to incentivize landlords to participate in the process could increase its reach.

Nearly half (47%) of participants indicated that eviction or credit history were key barriers to exiting homelessness. Mediation offers a critical pathway to housing stability and avoids a record of eviction. Mediation should be paired with legal support for tenants to navigate the process.

Increase homelessness prevention in institutional settings. One in five participants entered homelessness directly from an institutional setting (jail, prison); few had received prevention services. Embedding robust homelessness prevention in institutional settings (carceral settings, drug treatment, hospitals) could reduce inflows into homelessness.

Embed homelessness prevention in mainstream systems where low-income individuals receive services. Few participants had sought or received prevention services. Embedding screening and prevention services where at-risk individuals seek services (healthcare, social service, domestic violence services, educational settings) could increase awareness and use of prevention services.

FACILITATE SWIFT EXITS FROM HOMELESSNESS

The median duration of current homelessness episodes was 22 months. Participants spoke about numerous barriers that made re-entering permanent housing difficult. While almost 9 in 10 reported that the cost of housing was the main barrier to re-entering housing, they noted other barriers as well. Participants described the lack of support received for finding housing, difficulty identifying available affordable housing, and challenges with documents. To quicken exits from homelessness, we recommend:

Increase housing navigation, with targeted outreach to those in unsheltered settings. Housing navigation can help clients with searching for housing, negotiating with property owners, and gathering necessary documents. Implementing comprehensive housing navigation services could help people experiencing homelessness overcome barriers to returning to housing.

Ease barriers to identifying affordable housing options. Participants described challenges identifying available affordable housing, complicating their housing search. Tools that make the search for deeply affordable housing easier could ease barriers.

Lower barriers for accessing State-issued identification cards and other needed documentation. Half (52%) of participants noted a lack of documents, such as State-issued identification cards and birth certificates, as a barrier to finding housing. Participants could not afford to replace these, nor did they have access to transportation or other resources to start the replacement process. Improving outreach to assist with document replacement, waiving replacement fees, and providing safe storage would reduce barriers to employment and housing.

INCREASE ACCESS TO SERVICES TO MATCH CLIENTS' PHYSICAL AND BEHAVIORAL HEALTH NEEDS

Study participants had poor health and poor access to appropriate services. They reported barriers to receipt of routine healthcare, substance use services, and mental health treatment. The aging of the population, poor functional status, high prevalence of chronic illnesses, high rate of pregnancy, and high prevalence of behavioral health needs call for additional services and support—both while people experience homelessness and to support them in housing. Because of the extraordinarily high rate of trauma—before and during homelessness—these services must be offered in a way that adheres to trauma-informed principles.

Substance Use

Increase access to substance use treatment. Twenty percent of participants who reported current regular substance use indicated that they wanted treatment, but were unable to receive it. Evidence shows that substance use treatment is most effective among those who choose to engage with it. A higher proportion of individuals who used substances regularly live in unsheltered environments. There is a need for increased access for those who want it, particularly those in unsheltered settings. Promising models for low-barrier, outreach-focused services (including medication treatment) should be expanded.

Increase outreach with harm reduction services (naloxone, needles, drug testing). Participants report a high rate of substance use, injection drug use, and drug poisoning (overdose). There is a need to increase access to harm reduction services, including those aimed at preventing overdose (naloxone), skin and soft tissue infections, and infectious diseases, particularly in unsheltered settings.

Prioritize investments in promising treatments for stimulants. Participants report high rates of methamphetamine use. There is a need to invest in promising treatments, such as contingency management for those with stimulant use disorders.

Increase linkage to harm reduction and substance use treatment through emergency departments. As with other studies, we found high rates of emergency department (ED) use among those experiencing homelessness and low use of non-ED ambulatory care. To meet the needs of those with substance use disorders, increase ED's capacity to provide and link to substance use treatment and harm reduction services. This capacity could include initiation and linkage to medication treatment for opioid and alcohol use disorders, linkage to residential treatment and distribution of naloxone.

Provide Appropriate Services to Match Client Needs in Housing

Increase availability of permanent supportive housing for those with complex behavioral health needs. Permanent supportive housing should be aligned with Housing First principles and use evidence-based models of care (e.g., Assertive Community Treatment, Intensive Case Management, Pathways to Housing) that meet the needs of those who have significant behavioral health needs. There is a need for funding to pay for appropriate service provision. For those who are not able to thrive in permanent supportive housing with high levels of support, we recommend expanding availability of behavioral health focused residential care facilities.

Create permanent supportive housing responsive to the needs of older adults. Nearly half of adults experiencing homelessness are 50 or older. By the age of 50, people experiencing homelessness have health and function similar to adults in their 70s and 80s in the general community, with high prevalence of functional and cognitive impairments. Many have co-occurring behavioral health problems. To avoid preventable institutional care, there is a need for housing options that support independence for those with functional and cognitive impairments. Medicaid Home and Community Based Services can fund supports and services, but traditional consumer model in-home supportive services may not meet the needs of this population. There is a need for models of care for older adults that take into account the co-occurrence of behavioral health needs with significant functional and cognitive impairments, narrow social networks, and history of trauma. There is a need for expanded permanent supportive housing with robust services and supports for those with chronic illness and functional or cognitive impairments; using the Home and Community Based Alternatives Waiver offers a promising opportunity. Other potential models (such as integration of the Program of All-Inclusive Care for the Elderly [PACE]) programs with permanent supportive housing) and expanded use of the contract mode of in-home supportive services should be considered.

Physical and Mental Health Services

Increase street medicine outreach. *Street medicine* is the practice of providing critical health care services to those experiencing unsheltered homelessness. Despite relatively high levels of insurance coverage, only half (51%) of participants noted having a regular place for care. Meeting people where they are to provide care lowers barriers to care among a population with high need.

Increase access to full scope reproductive services, prevention, and housing resources for pregnant people. More than one quarter (26%) of participants assigned female at birth who were aged 18-44 experienced a pregnancy during their current episode of homelessness; 8% were currently pregnant. Increasing access to comprehensive reproductive health services and facilitating connections to housing resources is crucial to the health of pregnant people experiencing homelessness and children.

Increase access to mental health care in all settings. Despite a high prevalence of mental health needs, participants reported limited engagement with mental health services. Increasing access to mental health care in both unsheltered and sheltered settings offers a critical opportunity to increase parity between needs and availability of services.

Increase availability of recuperative care/ medical respite. More than one third (38%) of all participants visited the emergency department and one in five (21%) were hospitalized for a physical health condition in the prior six months. Participants spoke of their experiences being discharged from hospitalizations to unsheltered settings, or shelters that did not have the resources they needed for recovery. Recuperative care combines shelter with health services for people exiting hospitals who no longer meet criteria for the hospital but are too ill for sheltered or unsheltered settings. These programs may help decrease length of hospital stay and readmissions and improve health outcomes. With an aging homeless population, the need for recuperative care will increase.

ADDRESS THE CRIMINAL JUSTICE SYSTEM TO HOMELESSNESS CYCLE

Nearly one in five participants (19%) entered homelessness from an institutional setting, including jail and prison. Thirty-seven percent spent time in prison and 77% spent time in jail at some point in their lifetimes. While experiencing homelessness, 30% of all participants had a jail stay during their current episode.

Participants reported their prior criminal justice records were a barrier to employment and housing. They reported frequent interactions with law enforcement agencies while homeless. We recommend the following:

Lower housing barriers for those with criminal justice system records. Consider prohibiting consideration of criminal justice records in the tenant review processes and taking a more individualized approach to reviewing applicants with criminal justice records.

Improve re-entry support for those exiting carceral settings. Few participants exiting prison or prolonged jail stays reported that they had received re-entry support. Improving re-entry supports, including meaningful connections to permanent housing, healthcare, and employment could result in reductions in homelessness and returns to carceral settings.

Reduce carceral responses to homelessness. Criminal justice responses to survival behaviors, such as sleeping or living in public spaces are associated with increased rate of incarceration and prolongation of homelessness. Using non–law enforcement responses to behavioral health crises increases trust and supports connection to ongoing care. Ticketing and towing of vehicles leads to loss of a resource that can provide safety and security for individuals (as well as transportation to employment and healthcare). Following encampment resolution best practices, including supporting access to low barrier housing, can reduce trauma, loss of documents, and support better health outcomes.

INCREASE OPPORTUNITIES FOR EARNED INCOME AND BENEFITS UTILIZATION

One in five leaseholders cited reduced or lost income as the biggest reason for leaving their last housing. Many participants have extended disconnections from the labor market. While benefits are a critical source of income for people experiencing homelessness, we found relatively low rates of utilization of many benefits. We recommend the following:

Increase evidence-based employment supports. Given lengthy disconnections from the workforce and the relatively high rate of people actively looking for work, increasing evidence-based employment supports for people living in affordable or supportive housing, those with histories of homelessness, and with behavioral health needs could increase opportunities for earned income. Many participants reported transportation barriers to employment; this should be considered as part of employment support.

Increase enrollment in income-eligible benefits. We found low rates of utilization of income-eligible benefits, such as SSI/SSDI. Streamlining processes, removing recertification barriers, increasing affirmative outreach to those experiencing unsheltered homelessness, and connecting participants to benefits when participants interact with other systems could provide crucial income support.

SUPPORT THOSE IMPACTED BY DOMESTIC VIOLENCE

Fifteen percent of all participants noted that violence or abuse in the household was a reason for leaving their last housing arrangement. In the six months prior to homelessness, 25% of participants experienced physical violence and 6% experienced sexual violence. We recommend the following:

Increase availability of emergency shelters and permanent housing options for those impacted by domestic violence. Increased shelter availability could better meet the needs of those impacted by domestic violence. Expanded availability should be coupled with enhanced training of shelter staff to ensure consistent connection of those impacted by domestic violence with coordinated entry systems. While emergency shelters play an important role in allowing those impacted by domestic violence to exit situations swiftly, there is a need for permanent housing to promote exits from shelter settings.

INCREASE OUTREACH TO THOSE EXPERIENCING UNSHELTERED HOMELESSNESS

Nearly 8 in 10 participants (78%) reported that they spent most of their prior six months in unsheltered settings. Many who started in vehicles lost their vehicles. Those in unsheltered settings had less access to services and higher rates of behavioral health challenges. We recommend the following:

Invest in sustained outreach into unsheltered communities. We recommend increasing outreach related to physical health, behavioral health, benefits, and housing navigation services to those living in vehicles, encampments, and other unsheltered places. Increase opportunities for individuals to retain their vehicles, which provided a form of shelter and transportation. Some communities in California have safe parking programs, which often provide access to restrooms, running water, and secure parking to support those experiencing vehicular homelessness.

CENTER RACIAL EQUITY

Minoritized racial groups are disproportionately represented in homeless populations. Because they have experienced multiple forms of discrimination throughout their lives, services must be aligned with best practices to build trust and reduce harm. Participants experienced discrimination at multiple points across their life course.

Strengthen anti-discrimination policies and enforcement mechanisms. Given that participants experienced discrimination on the housing market, there is a need to strengthen anti-discrimination housing policies (such as HUD's Fair Housing Act and California's Fair Employment and Housing Act). These strengthened policies should be coupled with adequate enforcement mechanisms to ensure more equitable housing outcomes.

Prioritize equity in local coordinated entry systems. Some coordinated entry processes and assessment tools have perpetuated racial inequities. Coordinated entry should embed racial equity at all steps—from assessments and prioritization to ensuring non-discriminatory practices in housing placement. To accomplish this goal, coordinated entry systems should regularly review data to ensure equitable pathways to permanent housing.

Lower housing barriers for those with criminal justice system records. Given the disproportionate impact of incarceration on people of color, lowering barriers for justice-impacted individuals is critical to advancing racial equity.

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Margot Kushel, MD

Director, UCSF Benioff Homelessness and Housing Initiative

CASPEH Principal Investigator

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1 Our study focuses on adults only. We include all adults, including those in homeless families (those living with minor children while homeless) and transition age young adults (aged 18-24). The experience of children living in homeless families and homeless youth (under age 18) is outside the scope of this project.

2 The Homeless Emergency Assistance and Rapid Transition (HEARTH) to Housing Act of 2009 is the definition of homelessness used by the Federal Government. It defines homeless individuals and families as those who lack a fixed, regular, and adequate nighttime residence; those who will lose their primary nighttime residence imminently (i.e., within 14 days); or who are fleeing domestic violence, dating violence, stalking, or similar threatening situations.

3 Our random samples were determined based on the number of people at a given site and the number of people we needed to interview. Our staff kept track of which people we approached for an interview and who we skipped over so that we could accurately determine the percentage of people at each site that we interviewed.

4 Weighting is a statistical technique in which researchers adjust data to allow them to represent the population studied.

5 We use the term Latino/x to refer to our participants who indicated Latino/a/x, Hispanic, or Latin American on the CASPEH race measure. We use this term to recognize both those who prefer to use the terms Latino or Latina and those who prefer to use the term Latinx to describe their ethnic and/or racial identity.

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12 Interquartile range is a measure of the spread of numeric data. The lower value represents the 25th percentile of the data and the upper value represents the 75th percentile. These values provide context to how responses may have differed across participants.

13 In the United States, Blackness is treated as a racial category at the bottom of a racial hierarchy. This means that those who are perceived as Black, even if they are multiracial, are treated as Black. Scholarship in public health has shown that due to structural, institutional, and interpersonal racism, people with any Black racial identity have similar health outcomes to one another than to other racial groups. Therefore, in our report, we define the category 'Black' as those who identify Black as their sole racial identity and those who identify Black as one of their racial identities.

14 Race in the United States is extremely complex. We relied on current scholarship about race to inform how we reported race. We recognize that our categories may conceal unique experiences within groups and plan to conduct further analysis on race in the CASPEH at a later time.

15 For more on the history of racial measures on the census see Mora,G.C. (2014). *Making Hispanics: How Activists, Bureaucrats, and Media Constructed a New America*. Chicago, Illinois: University of Chicago Press.

16 While we aggregated participants who identified as transgender, gender non-conforming, or other gender identities into a single category because of the size of the sample, we recognize experiences differ across these identities. Our sample included transgender men, transgender women, non-binary, genderqueer, or gender non-conforming individuals, and individuals who indicated another or unknown gender identity.

17 We did not interview on tribal lands throughout California in order to match the PIT methodology, which, by mandate from HUD, does not count individuals on tribal lands. However, we consulted with Tribal partners throughout the course of the study to ensure that we surveyed Native Americans living in the counties surveyed.

18 To make these comparisons, we use the U.S. Census in two ways. First, California population estimates were taken from calculations on "Race alone or in combination with one or more other races" in the 2021 American Community Survey 1-Year Estimates (See U.S. Census Bureau. (2021). American Community Survey 1-Year Estimates. Retrieved from: https://data.census.gov/table?q=race+by+age&g=040XX00US06&y=2021&tid=ACSDP1Y2021.DP05). Additionally, in line with the guidelines provided by the U.S. Census and the U.S. Office of Management and Budget (OMB), we combined those who identified as Native American/Alaskan Native with those who identified as Indigenous to Mexico, Central or South America into one category. (See U.S. Census Bureau. (2022, March 1). About the Topic of Race. Retrieved from: https://www.census.gov/topics/population/race/about.html)

19 In the Census and PIT, individuals select a racial identity and separately mark whether their ethnicity is Hispanic/Latino/x. Because we asked the question differently, and asked people to mark a racial identity only (including Latino/x), our findings are not comparable to either the general population or the PIT.

20 Problems understanding or remembering can be a symptom of a variety of health conditions, including cognitive impairment, depression, anxiety, schizophrenia, or developmental delay.

21 Centers for Disease Control and Prevention. (2022, November 6). Suicide Prevention: Risk and Protective Factors. Retrieved from: https://www.cdc.gov/suicide/factors/index.html

22 If a person experiencing homelessness spends 3 or more months in an institutional setting, they are considered to start a new episode of homelessness if they are homeless upon release.

23 If a person was named on the lease or mortgage, we considered them leaseholders.

24 We include those whose personal household didn't include a leaseholder as non-leaseholders. This could include people doubled-up with family or friends, or staying in informal arrangements without the protection of a lease.

25 We will use the term "leaseholder" for those who either held a rental lease or a mortgage.

26 Many report leaving prior to a formal eviction to avoid having an eviction on their record. In this report, we will use the term eviction for either–formal eviction, or, more commonly–leaving under the threat of eviction.

27 While 19% entered homelessness directly from an institution, an additional 4% either had left their last stable housing arrangement to enter an institution for a short time or exited the institution for a short stay in housing. When we include these, jail stays increase to 10% and drug treatment to 3% of those entering homelessness.

28 We did not ask those exiting prisons, jails, or hospitals for these responses.

29 We chose two years because we were not interested in brief delays in homelessness, but also wanted to choose a duration for which participants could project.

30 For those entering from an institutional setting, we assumed that they would have needed to find new housing.

31 California Department of Social Services. Project Roomkey/Housing and Homelessness COVID Response. Retrieved from: https://www.cdss.ca.gov/inforesources/cdss-programs/housing-programs/project-roomkey

32 Self-reported chronic diseases included diabetes, cancer (excluding non-melanoma skin cancer), HIV/AIDS, chronic kidney disease, hypertension, heart problems or stroke, liver disease, asthma or COPD.

33 Most individuals who were undocumented or recent immigrants were not eligible during the study period.

34 Pandemic-related changes, including reductions in barriers to remaining enrolled, may have increased enrollment.

35 We used where participants reported spending the most time in the prior six months to determine shelter status and considered those in vehicles to be unsheltered, consistent with HUD definitions.

36 Clarke T.C., Schiller J.S. (2020). Early Release of Selected Estimates Based on Data From the January–June 2019 National Health Interview Survey. *National Center for Health Statistics*. https://www.cdc.gov/nchs/data/nhis/earlyrelease/earlyrelease_202009-508.pdf

37 Volpicelli, J.R., & Menzies, P. (2022). Rethinking Unhealthy Alcohol Use in the United States: A Structured Review. *Substance Abuse: Research and Treatment* 16, 1-12

38 We defined heavy alcohol use for women as consuming 5 or more drinks at a time, twice a week; 3 or more drinks at a time, 4 or more times a week; or 6 or more drinks at a time weekly or more often. For men, heavy use was defined as consuming 5 or more drinks at a time, two or more times a week; or 6 drinks at a time weekly or more often.

39 If an individual who is homeless enters an institutional setting and stays for more than three months–their homelessness episode is "reset"--meaning–when they exit, they are considered to be in a new episode of homelessness.

40 For this question, we asked about any episode of homelessness, not focused solely on this episode.

41 To calculate income, we asked participants to include income from work (formal or informal) and benefits. We asked participants to not include money from Supplemental Nutrition Assistance Program (SNAP)/CalFresh.

42 We did not count these towards participants' income.

43 California Department of Social Services. (n.d.). Benefits and Services. General Assistance. https://www.cdss.ca.gov/general-assistance

44 Discrimination is defined as the process in which members of a socially defined group are treated differently, often unfairly, due to their membership in that group.

45 Sternthal, M., Slopen, N., & Williams, D.R. (2011). Racial Disparities in Health: How Much Does Stress Really Matter? *Du Bois Review*, 8(1), 95-113.

46 We used the Everyday Discrimination Scale – Short version. We modified this scale by combining the first two questions for brevity and adding housing status to the list of identities that can be discriminated against.

47 Possible answers include: ancestry or national origin; gender; race; age; housing/homelessness status; religion; sexual orientation; criminal record; physical disability; physical appearance; the shade of your skin color; education or income level; other.

48 National Low Income Housing Coalition. (2023). The GAP: A Shortage of Affordable Housing. https://nlihc.org/sites/default/files/gap/Gap-Report_2023.pdf

49 Ibid.

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