

National Academy of Sciences, Engineering and Medicine (2018)

Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes among People Experiencing Chronic Homelessness.

Washington, DC: The National Academies Press.

Permanent supportive housing (PSH) has risen quickly to become the gold standard approach for getting high need individuals off the streets and into stable, long-term housing. In the United States, the number of PSH units doubled between 2007 and 2018, and PSH has been adopted and expanded internationally as well, including in European countries. Defined broadly as ongoing subsidized housing paired with an array of supportive services, PSH embraces the once radical, but thankfully now commonplace idea that housing is the best solution to homelessness.

The rise of PSH is certainly warranted. Evidence that PSH is effective at improving housing stability is unequivocal. Yet, dig a little deeper beyond housing outcomes and the impact of PSH becomes less clear. Studies examining how PSH affects outcomes such as physical and mental health status, substance use, health care costs and criminal justice system involvement have been conducted in a variety of locations, with different populations, and with varying degrees of methodological rigor. In turn, these studies have yielded findings that are all over the map. Trying to make some sense of this map is the task of the National Academy of Sciences, Engineering and Medicine's report *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes among People Experiencing Chronic Homelessness*. Written by a committee of subject matter and technical experts, the report seeks to address a straightforward question: To what extent have permanent supportive housing programmes improved health outcomes and affected health care costs in people experiencing homelessness?

The committee's approach to answering this overarching question is to break it down into several smaller and more nuanced questions, such as: What is the evidence that PSH improves health-related utilization and outcomes in homeless persons with serious, chronic or disabling conditions? What characteristics of permanent supportive housing programmes, if any, result in improved health

outcomes? And what are the key policy barriers and research gaps associated with developing programmes to address the housing and health needs of homeless populations? In turn, the report is divided into chapters that address each of these sub-questions and offers recommendations related to each. The end result is a remarkably thorough document for which the members of the committee are to be commended. The report serves as indispensable reading about the state of the evidence on PSH.

Moreover, in addressing its various sub-questions, the report takes several interesting detours that provide ample food for thought for researchers, policymakers and practitioners alike. One of the most useful of these detours is the discussion of PSH programme characteristics. The report ticks through the evidence on whether variables such as housing configuration (i.e. single-site vs. scattered site) and housing quality have an impact on housing and health outcomes. These are important considerations that often get glossed over in research on PSH, and the inclusion of this section is most welcome in the report. On the other hand, while the report's discussion of the myriad barriers to scaling up PSH in the United States was highly informative for this American reader, it will be of less interest to European readers, who may be flummoxed at the fragmented and siloed state of social and health care spending in the United States.

So what, then, does the report find to be the answer to its central question? Does PSH improve health? The answer provided is less straightforward than the question itself. The report concludes that there is "no substantial evidence that PSH contributes to improved health outcomes, notwithstanding the intuitive logic that it should do so and limited data that it does so for persons with HIV/AIDS." The report goes on to note that "there are significant limitations to the current research and evidentiary base on this topic." In simpler terms: PSH has the *potential* to improve health outcomes, but we don't have a strong enough evidence base to definitively say that it does.

I do not dispute the conclusion that the committee reaches. Yet, one critique I have of the report is that it makes the exceptions it identifies to its overall conclusion seem more minor than I believe they are in reality. The evidence of the impact of PSH on HIV/AIDS is strong and HIV/AIDS is exactly the type of "housing-sensitive" condition that the report goes on to argue should be the focus of future research efforts examining the health impact of PSH. The report also describes evidence from experimental studies of the positive impact of PSH on general well-being, and concludes that, for people with high medical needs, PSH decreases emergency department use and hospital stays. Thus, an alternative framing of the report's conclusion might go something like this: There is some evidence that PSH has a positive impact on health, although the extent and magnitude of that impact may vary across groups and health conditions.

In finding that there is not enough evidence to say definitively that PSH impacts health, the report dutifully pivots to suggest more research to examine the issue in a more rigorous manner. But, in making this pivot, the committee avoids important questions that lie just below the surface of the report: What should be the reasonable expectation of a housing intervention like PSH on non-housing outcomes like health? Should improvements in health outcomes be an explicit goal of PSH programmes towards which services could be better tailored to achieve? Or should we see health improvements as simply a welcome collateral benefit—a bonus—from something works quite well at its main purpose of helping people get into and stay housed? Answers to these questions are more philosophical and political than they are scientific, and thus perhaps beyond the scope of the committee's charge. Nonetheless, these questions are important. In the context of growing interest in so-called social determinants of health, there is an implicit expectation that interventions that address social needs will lead to health improvements. But, we should be wary of using such logic as the basis for justifying social interventions. There is a simple and undeniable benefit in making sure people who are hungry have food to eat and that those who are homeless have a decent place to live. We would do well to not forget this uncomplicated way of thinking about the impact of PSH.

Thomas Byrne

Boston University, USA

