The Social Determinants Of Health And Their Role In Rising Homelessness

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Introduction

Homelessness is both a housing crisis and a major social determinant of health. The original article review correctly identifies unaffordable housing, poverty, unemployment, healthcare barriers, racism, domestic violence, disability, family conflict, legal-system involvement, and illness as connected factors. It also describes mental illness and substance use in a circular way that can imply that people remain homeless mainly because of individual pathology. Current evidence shows a more complex relationship. Severe rent burdens, low vacancy rates, inadequate income, eviction, institutional discharge, discrimination, and shortages of supportive housing create the conditions in which a personal crisis becomes homelessness. Homelessness then worsens physical and mental health and makes treatment, employment, family stability, and recovery more difficult. This revised review uses the 2019 PBS article as a historical starting point and connects it with the U.S. Department of Housing and Urban Development's 2024 national assessment. It evaluates definitions, measurement, health pathways, structural causes, prevention, Housing First, medical respite, and coordinated policy. (U.S. Department of Housing and Urban Development, 2024)

The Article's Central Argument

The PBS article "Chronic Homelessness Is at an All-Time High. Here's Why It Continues to Climb" argues that rising chronic homelessness cannot be explained by one decision or diagnosis. It directs attention to the shortage of affordable housing, limited services, poverty, and failures across systems. Its strength is an upstream perspective: people are more likely to lose housing when rent rises faster than income, benefits are inadequate, and healthcare or social support arrives only after crisis. The article was published in 2019, so its figures should not be treated as current. The 2024 HUD assessment documented a substantial national increase in homelessness and reinforced the continuing relevance of housing supply, affordability, and service capacity.

Defining Homelessness

Homelessness includes several situations that are measured differently. Sheltered homelessness refers to people staying in emergency shelters, transitional housing, or safe havens. Unsheltered homelessness includes living in streets, vehicles, abandoned buildings, or places not designed for habitation. Some education and social-service definitions also include families doubled up with others

because they lost housing. Housing instability is broader and includes difficulty paying rent, repeated moves, overcrowding, eviction risk, unsafe conditions, and spending an unsustainable share of income on housing. These categories matter because official point-in-time counts do not capture every person facing severe insecurity.

Chronic Homelessness

HUD uses a specific definition of chronic homelessness involving a qualifying disability and a long or repeated history of homelessness under federal program rules. The term does not mean that a person is permanently incapable of housing. It identifies people who have experienced extended instability and may need permanent supportive housing rather than a brief shelter stay. Chronic homelessness can become self-reinforcing because documents are lost, health deteriorates, criminalization increases, relationships weaken, and ordinary rental screening becomes harder. The label should guide service intensity, not become a fixed identity.

Limits of the Point-in-Time Count

The national point-in-time count estimates sheltered and unsheltered homelessness on one night. It provides a consistent annual snapshot but inevitably misses people who avoid enumerators, move frequently, stay temporarily with others, enter homelessness later in the year, or live in hidden rural locations. Weather, local counting capacity, shelter availability, and methodology affect results. Annualized administrative data usually show more people experiencing homelessness over a year than the one-night count. Policy should use several sources—school data, shelter records, healthcare encounters, eviction filings, and community surveys—while protecting privacy.

Housing as a Social Determinant of Health

Stable housing influences exposure, sleep, nutrition, medication storage, hygiene, safety, social connection, and access to care. A person managing diabetes needs refrigeration, food, supplies, and regular routines. A person recovering from surgery needs a clean place to rest. A family in an overcrowded or unsafe unit may experience mold, injury, stress, and infectious disease exposure even before literal homelessness occurs. Housing is therefore not merely a background variable. It is part of the practical infrastructure through which health treatment succeeds or fails.

The Affordability Gap

One of the strongest structural drivers is the gap between rent and income. Low-wage work, disability benefits, and fixed retirement income often do not cover market housing. A household may remain stable until a rent increase, job interruption, medical bill, vehicle repair, or family separation removes

the remaining margin. Housing vouchers can help, but funding and landlord participation may be insufficient, and recipients may search unsuccessfully in tight markets. Building and preserving deeply affordable housing is essential because services cannot compensate for the absence of units people can afford. (National Health Care for the Homeless Council, 2025)

Eviction and Displacement

Eviction can be both a cause and consequence of poverty. Formal eviction records may make future rental applications difficult, while informal displacement may occur through pressure, unsafe conditions, utility shutoff, or unaffordable renewal. Families facing eviction can lose possessions, school continuity, employment access, and social networks. Prevention may include legal representation, emergency rental assistance, mediation, flexible cash support, and rapid rehousing. These interventions work best before a household enters shelter, when the cost and disruption of stabilization may be lower.

Racial Inequality

Black and Indigenous people are overrepresented among people experiencing homelessness in many U.S. communities. This pattern reflects histories of segregation, redlining, land dispossession, discrimination in rental and mortgage markets, unequal wealth, criminal justice exposure, and labor-market inequality. It should not be explained through cultural deficiency. Communities should analyze entry, service, placement, and return-to-homelessness data by race and ethnicity and involve affected groups in program design. Equity requires changing institutional pathways, not merely offering identical services after unequal harm has occurred.

Domestic Violence

Domestic violence can force adults and children to choose between danger and homelessness. Survivors may lack independent income, documents, credit, or safe family support. An abusive partner may sabotage employment, damage rental history, monitor technology, or threaten children and pets. Shelter and housing programs need confidentiality, flexible eligibility, trauma-informed advocacy, legal support, and rapid access to safe units. A survivor should not be required to prove danger through a police report when reporting itself may increase risk. Housing is a central safety intervention.

Disability and Health Crisis

Disability can reduce income and increase housing costs, while inaccessible units limit options. A serious illness may produce job loss, medical debt, and inability to manage rent. Conversely,

homelessness can worsen disability through exposure, interrupted treatment, violence, and exhaustion. The relationship is bidirectional. Health systems should screen for housing instability and respond with navigation, medical-legal partnership, benefits assistance, and discharge planning. Screening without available help can frustrate patients and clinicians, so organizations should establish referral pathways before collecting sensitive information.

Mental Health

Some people experiencing homelessness live with serious mental illness, but mental illness is neither necessary nor sufficient to explain homelessness. Symptoms may interfere with work, relationships, or lease compliance, particularly when care is inaccessible. Homelessness itself can cause or intensify anxiety, depression, trauma, paranoia, and sleep disturbance. People living outside need constant vigilance, and shelter environments may also feel unsafe. Effective response includes voluntary treatment, supportive housing, crisis services, peer support, and continuity rather than assuming that psychiatric stabilization must occur before housing is deserved.

Substance Use

Substance use can contribute to housing loss for some people through health effects, spending, conflict, or discrimination. Others begin or increase use while homeless to cope with trauma, pain, cold, or wakefulness. The original essay refers to “substance violence,” which is inaccurate and stigmatizing. Substance-use disorder is a health condition influenced by biology, environment, and experience. Harm reduction, medication treatment, overdose prevention, and recovery support can be offered without making abstinence a universal precondition for housing. Housing stability often creates better conditions for treatment engagement. (National Health Care for the Homeless Council, 2025)

Institutional Exits

People can enter homelessness after leaving foster care, jail, prison, hospitals, psychiatric facilities, the military, or residential treatment. Discharge plans fail when identification, benefits, medication, transportation, and a confirmed housing destination are absent. A referral to a shelter is not a complete transition plan, especially for someone with medical or behavioral needs. Institutions should begin planning early, share information lawfully, and fund bridge housing or case management. Preventing discharge into homelessness is an accountable system responsibility.

Families, Youth, and Older Adults

Homelessness affects different groups in different ways. Families may stay hidden in cars, motels, or doubled-up arrangements to avoid separation. Youth may leave unsafe homes or age out of care without support. Older adults may become homeless after rent increases, bereavement, disability, or fixed-income pressure and can experience rapid health decline outdoors. Programs should not assume that one shelter or service model fits everyone. Schools, aging services, child welfare, healthcare, and housing agencies need tailored pathways that protect family unity, education, accessibility, and safety.

Maslow’s Hierarchy and Its Limits

The original review uses Maslow’s hierarchy to explain why people need food, water, and safety before pursuing belonging or self-actualization. The framework can illustrate how housing insecurity consumes attention, but human needs do not always occur in a rigid sequence. People maintain love, spirituality, creativity, political action, and dignity while homeless. The theory can become paternalistic if professionals assume that people cannot make complex decisions until basic needs are solved. A better application recognizes that stable housing supports many domains while respecting the agency and relationships people already possess.

Housing First

Housing First provides permanent housing without requiring prior sobriety, treatment completion, or proof of “housing readiness,” then offers voluntary supportive services. Evidence shows strong housing-retention benefits for people with long histories of homelessness and complex needs. Housing First does not mean housing only. Effective programs need adequate rent support, responsive case management, healthcare, behavioral health, tenancy assistance, and meaningful choice. Weak implementations may use the label while offering poor-quality units or insufficient support. The principle is that housing is a foundation for recovery rather than a reward delivered after recovery.

Permanent Supportive Housing

Permanent supportive housing combines long-term rental assistance with services for people who need continuing support. Services may include care coordination, mental-health and substance-use care, benefits enrollment, transportation, and help sustaining a lease. Participation in services is generally voluntary, but staff remain available when crises arise. Communities need enough units and operating funds; otherwise, people qualify but remain on waiting lists. Quality should be assessed through housing stability, tenant choice, health, community integration, and returns to

homelessness—not only placement counts. (Rolfe, 2020)

Rapid Rehousing and Prevention

Rapid rehousing provides time-limited rental assistance and services intended to shorten homelessness. It may be effective for households whose main barrier is an immediate financial crisis rather than a need for permanent intensive support. Prevention programs assist people at imminent risk before entry. Targeting is difficult because many households facing eviction will avoid literal homelessness through informal arrangements, while others have less visible risk. Flexible assistance and coordinated assessment can help match duration and intensity to need. Programs should avoid creating artificial cliffs in which support ends before income or benefits stabilize.

Medical Respite and Street Medicine

Medical respite gives people without safe housing a place to recover after hospitalization. It can support wound care, medication, follow-up, and connection with housing services. Street-medicine teams bring care to encampments and other locations, building trust and treating conditions that would otherwise worsen. These programs reduce suffering and improve continuity but do not replace housing. A person should not cycle indefinitely between street outreach, emergency departments, and temporary recovery because no permanent unit exists.

Shelters and Encampments

Emergency shelters can save lives, especially during extreme weather, but barriers include crowding, theft, curfews, separation from partners or pets, lack of accessibility, and safety concerns. Unsheltered encampments may provide community and mutual protection while exposing residents to sanitation problems, weather, violence, and forced displacement. Clearing encampments without accessible housing often moves people and destroys documents, medication, and relationships. Communities need safe interim options, sanitation, outreach, and a real pathway to permanent housing rather than enforcement presented as resolution.

The Role of Healthcare Systems

Hospitals and clinics frequently treat the consequences of homelessness. They can also participate in prevention through housing screening, legal partnerships, care management, medical respite, supportive-housing investment, and coordination with Medicaid and community organizations. Data sharing must follow privacy law and should not create surveillance or exclusion. Health systems should measure whether patients are discharged to stable destinations and whether care plans are feasible without refrigeration, transportation, or privacy. Clinical advice that cannot be followed in the

patient’s environment is not fully effective care.

Policy Priorities

A comprehensive response requires expansion of deeply affordable housing, rental assistance, supportive housing, eviction prevention, income supports, accessible healthcare, and protections against discrimination. Land-use reform and construction can increase supply, but units must be affordable to people with very low incomes. Policy should also strengthen discharge planning, domestic-violence housing, youth transitions, and disability access. Private investment can contribute, but public funding and regulation remain necessary because the households at greatest risk cannot generate high market returns. Coordination must be paired with adequate resources; meetings alone do not create housing.

Conclusion

The rise in homelessness is not best understood as the accumulated failure of individuals to manage mental illness or substance use. It reflects the interaction of unaffordable housing, inadequate income, eviction, discrimination, violence, disability, health crises, and institutional failure. Homelessness then damages health through exposure, interrupted treatment, stress, violence, and the loss of ordinary routines. The 2019 PBS article correctly directed attention upstream, and the 2024 HUD assessment shows that the national challenge has intensified. Effective action includes prevention, deeply affordable housing, Housing First, permanent supportive housing, rapid rehousing, medical respite, street medicine, and accountable transitions from institutions. Stable housing is not the final answer to every health or social need, but it is an essential platform from which people can pursue safety, treatment, family life, and self-determined goals. (U.S. Department of Housing and Urban Development, 2024)

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