THE CRIMINALIZATION OF HOMELESSNESS

Spring 2024

PROFESSOR STEPHEN J. SCHNABLY
http://osaka.law.miami.edu/~schnably/HomelessnessSeminarSyllabus.html
E-mail: *schnably@law.miami.edu*

Office: G472
Tel.: 305-284-4817

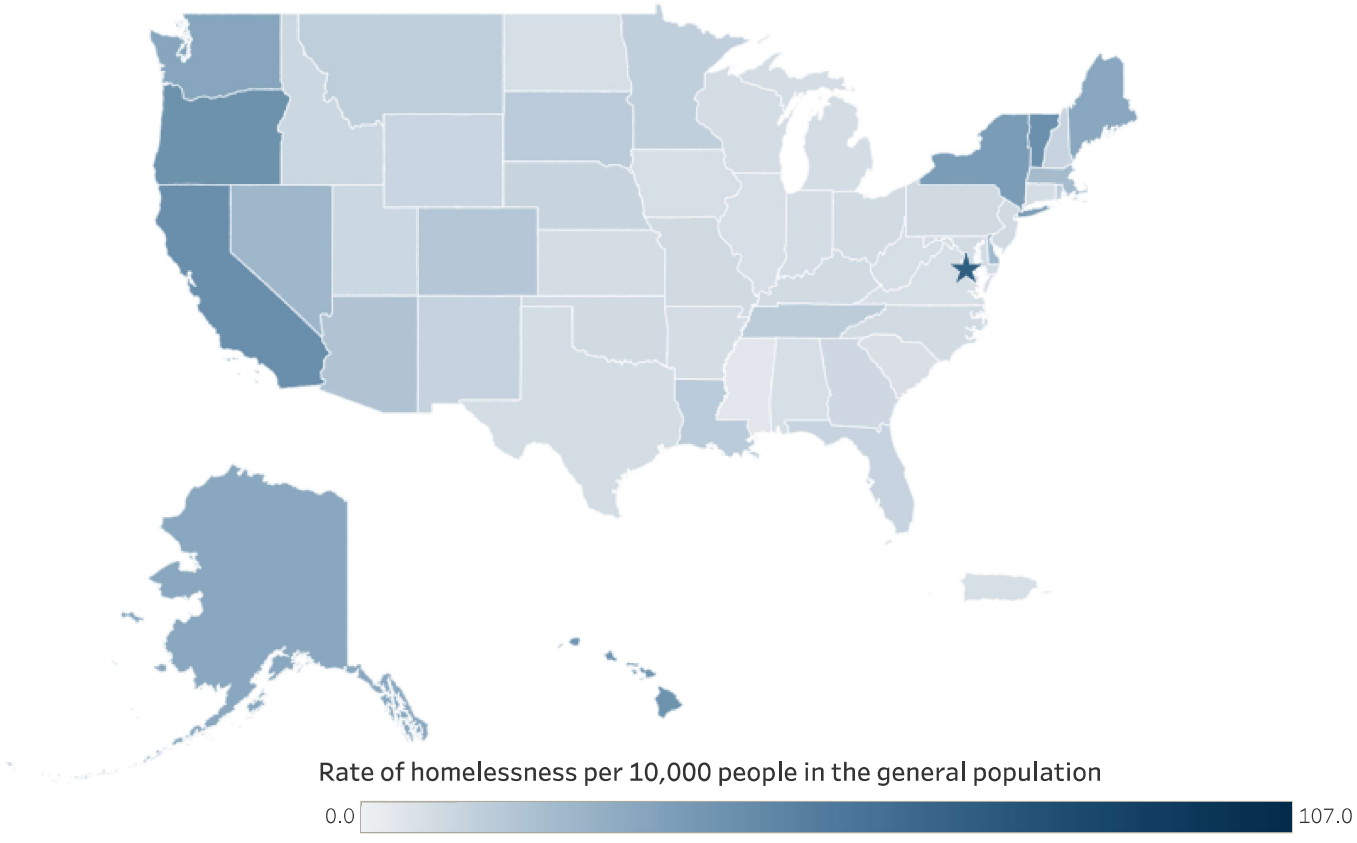
READINGS, Parts I, II & III

Part I

Part II

State of Homelessness: 2023 Edition

Click on your state to view detailed information on homeless statistics, bed inventory, and system capacity



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates.

Contents

KEY FACTS

The current edition of this report analyzes available data on homelessness for 2022 and over time. Key facts and data points include:

- Homelessness has been on the rise since 2017, experiencing an overall increase of 6 percent.
- In 2022, counts of individuals (421,392 people) and chronically homeless individuals (127,768) reached record highs in the history of data collection.
- Unsheltered rates are also trending upward, impacting most racial, ethnic, and gender subgroups.
- Homeless services systems continued to expand the availability of both temporary and permanent beds in 2022, but these resources still fall short of reaching everyone in need.

- Homelessness rose by a modest 0.3 percent from 2020 to 2022, a period marked by both pandemic-related economic disruptions and robust investments of federal resources into human services.

The State of Homelessness: 2023 Edition uses data from the U.S. Department of Housing and Urban Development (HUD) to provide an overview of the scope of homelessness in the U.S. on a given night in 2022, and illustrate emerging trends. Data in this report is pulled from HUD's 2022 Point-in-Time (PIT) Count data, as well as Housing Inventory Count data. Each section features interactive charts to display this data, with highlights discussed in the text of this report.

HOMELESSNESS IN 2022

According to the January 2022 PIT Count, **582,462 people** were experiencing homelessness across America. This amounts to roughly **18 out of every 10,000 people**[1]. The vast majority (72 percent) were individual adults, but a notable share (28 percent) were people living in families with children.

However, there is more to the story of homelessness in 2022. This section will delve deeper into questions of 1) who is experiencing homelessness, 2) where they are experiencing it, and 3) the degree to which people are living unsheltered.

Who is Experiencing Homelessness in 2022: Special Populations

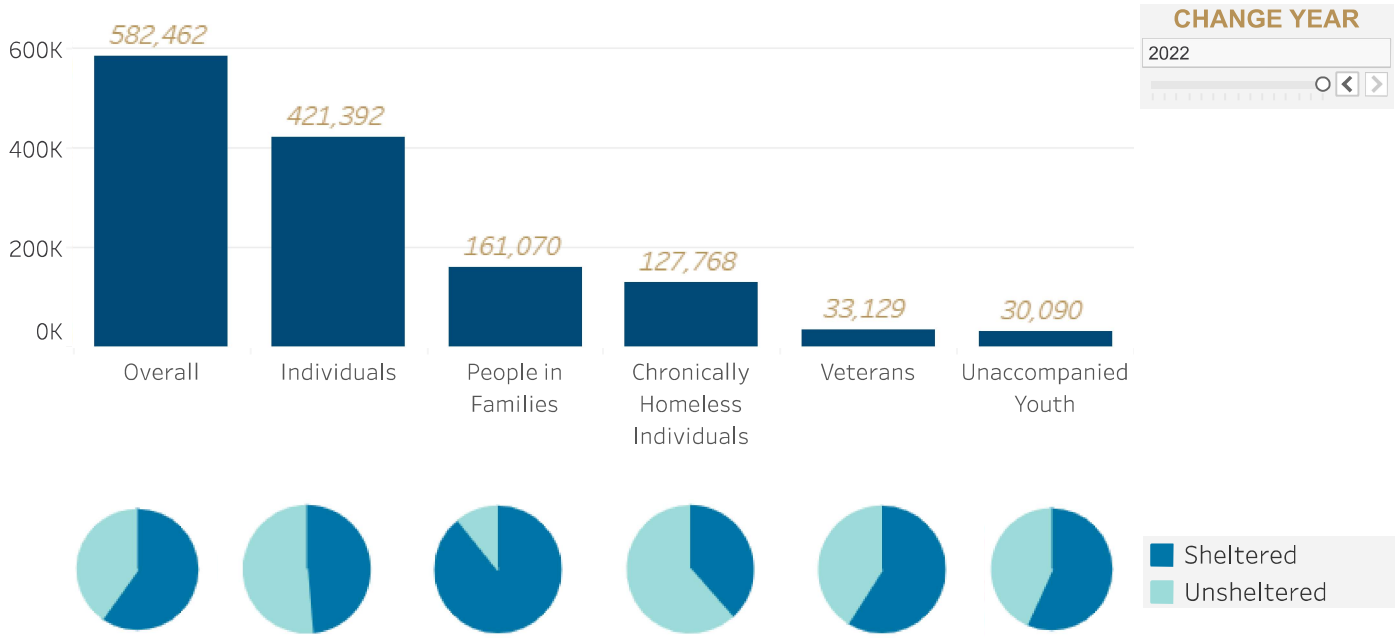
For reasons rooted in practice and policy, the homeless services world focuses on specific special populations. Of people experiencing homeless:

22 percent are **chronically homeless individuals** (or people with disabilities who have experienced long-term or repeated incidents of homelessness)

6 percent are **veterans** (distinguished due to their service to the country), and

5 percent are **unaccompanied youth** under 25 (considered vulnerable due to their age)

Total Number of People Experiencing Homelessness per Year by Type, 2007–2022

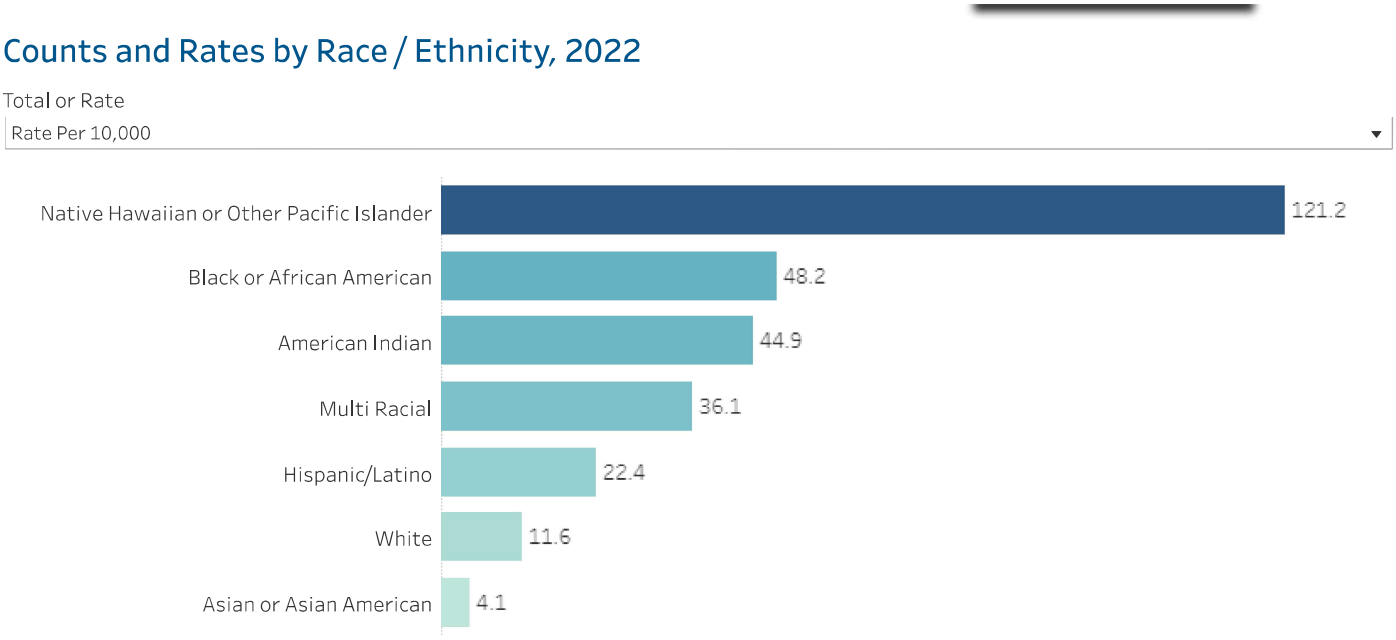


Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR). Note: The Covid-19 pandemic interrupted data collection in 2021 so data for that year is unavailable.

Who is Experiencing Homelessness in 2022: By Race/Ethnicity

Available data demonstrates that race and ethnicity are key determinants[2] that impact 1) who will become homeless and 2) the type and depth of rehousing barriers people will experience.

Within the 2022 PIT Count data, White people are numerically the largest racial group. They represent half (50 percent) of all people experiencing homelessness. However, issues of representation are more complicated than that data point would suggest.



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates.

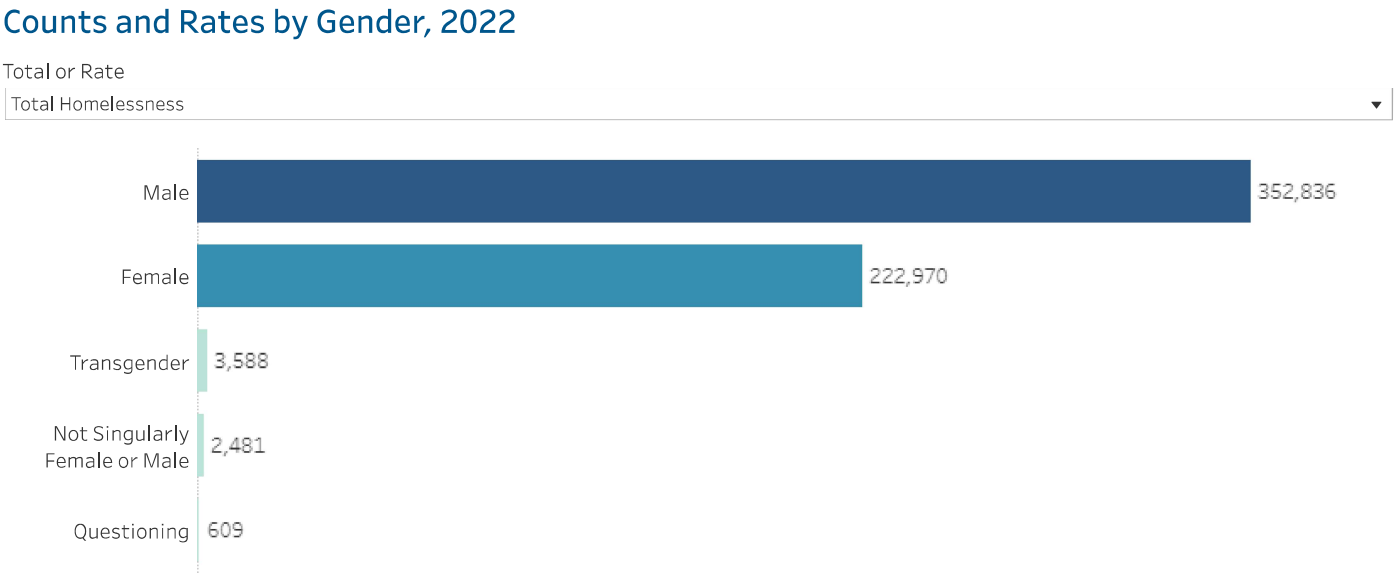
Most groups of color have higher rates of homelessness than their White counterparts—and, in some cases, far higher. Within the White group, 11 out of every 10,000 people experience homelessness. For Black people, that number is more than four times as large—48 out of every 10,000 people. Native Hawaiian or Pacific Islanders particularly stand out as having the highest rates, with 121 out of every 10,000 people experiencing homelessness.[3]

The racial and ethnic groups with the highest incidences of homelessness have extensive histories of experiencing oppression, including displacements from land and property and exclusions from housing opportunities. Effectively addressing homelessness will likely require invested partners to account for America's history, and that history's influence on current culture, policy, and practice.

Who is Experiencing Homelessness in 2022: By Gender

Gender also matters. Within the overall homeless population (which includes both adults and children), men, who are 68 percent of the individuals population, far outnumber women and are far more likely to experience homelessness. Serious systemic failures are occurring in relation to some of America's men, implicating holes in the social safety net, challenges within feeder systems, and barriers to rehousing.

Meanwhile, women (both those living as individuals and in families with children) and people who identify as transgender, nonbinary ("not singularly female or male," per HUD), and questioning are also notably represented within homelessness (see visualization below). They have unique barriers and needs that must also be addressed.



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates. Note: Rate information is unavailable for people who are Transgender, Not Singularly Female or Male, or Questioning.

Who is Unsheltered in 2022

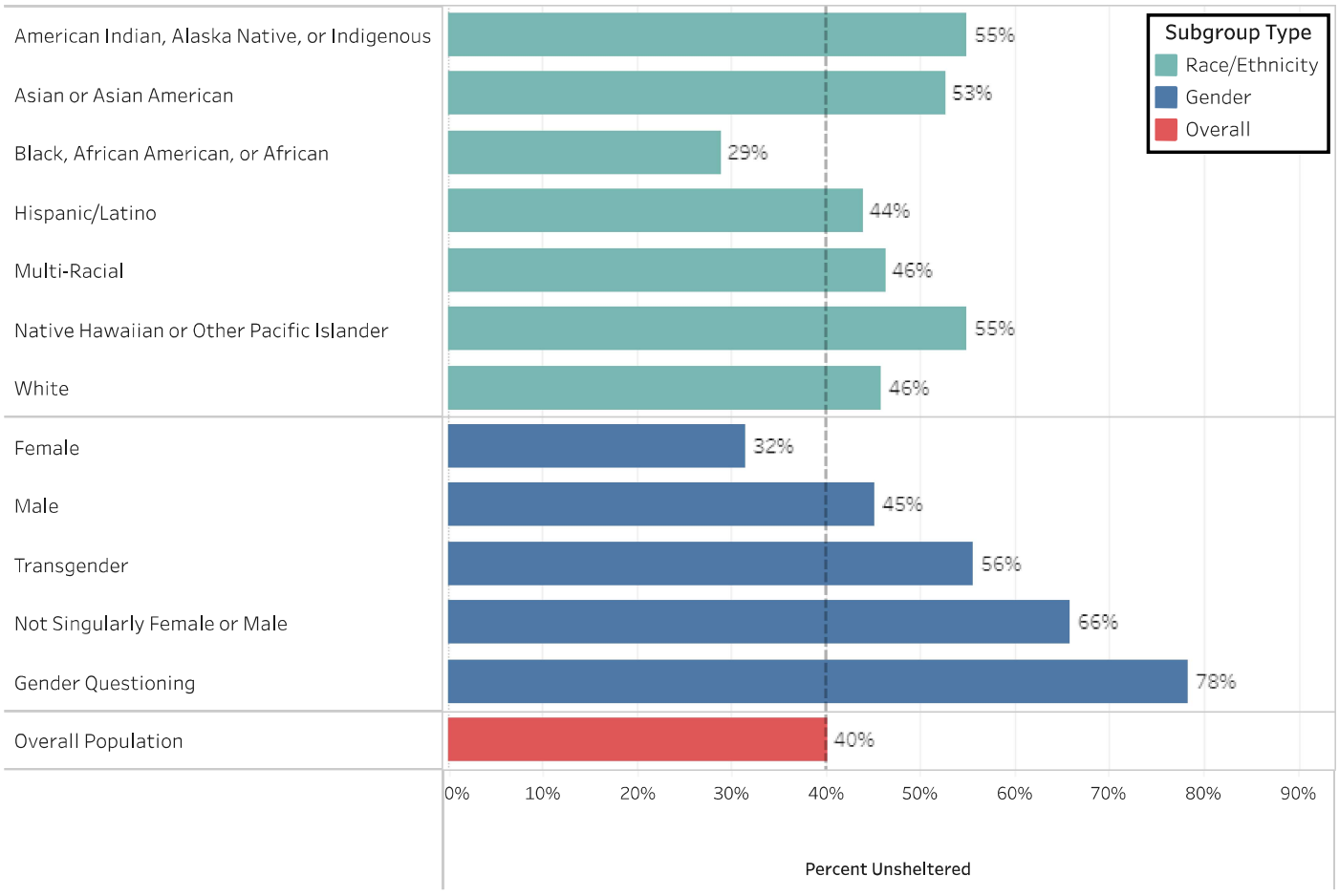
Throughout America, numerous dedicated workers use limited available resources to serve people experiencing homelessness. On a given night, the homeless services system provides shelter for 348,630 people. Despite these significant efforts, 40 percent of people experiencing homelessness live unsheltered, which means their primary nighttime residence is a place not suitable for human habitation (for example, a city sidewalk, vehicle, abandoned building, or park). Significantly, living unsheltered can impact a person's health and safety.

Individuals are particularly likely to be unsheltered. The majority of the group (51 percent) are sleeping in these settings. For the subset of individuals who are chronically homeless, the status quo is particularly dire—62 percent are unsheltered. Families with children, who are often prioritized for services, are least likely to live unsheltered—11 percent live in such ıations.

Race- and gender-based inequalities are readily evident in unsheltered homelessness (see visualization below). When subgroups are not accessing or utilizing shelter, it suggests they may not be equally benefitting from government investments in solutions to homelessness.

Members of the LGBTQ community accounted for in current data collection (i.e., people who identified on HUD surveys within the categories of transgender, gender questioning, or nonbinary), have particularly high rates of unsheltered homelessness. Many other populations also stand out, having levels of unsheltered homelessness that surpass those of the overall population. This includes **every racial, ethnic, and gender group** except women and Black people, whose levels of unsheltered homelessness are less than the overall population. The reasons for these disparities are worthy of further research and analysis.

Share of Subgroup Living Unsheltered, 2022



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

Locating Population Hot Spots in 2022

State and community stories of homelessness vary. Some are managing populations that are simply large; others have numbers that are larger than what would be expected given the size of their jurisdiction. Identifying locations with a disproportionately large homeless population is useful for at least two reasons: 1) it helps target resources to the places most in need of assistance, and 2) examining population variations across jurisdictions helps refine the field's understanding of homelessness causes and solutions. For example, jurisdictions with smaller-than-expected homeless populations may be implementing solutions worthy of replication in other parts of the country.

By Population Size. Among the states, homeless population sizes range from approximately 600 people to more than 170,000. Similar variations exist at the local level. For example, during the 2022 PIT Count, Salem County, New Jersey reported only 20 people experiencing homelessness, compared to more than 65,000 people identified in Los Angeles. Resource needs and system challenges can vary significantly according to these different homeless population sizes.

Homelessness is largely concentrated in certain areas of the country. Solving challenges in a few jurisdictions (those with the largest unhoused populations) would significantly advance the goal of ending homelessness. Just five states (California, New York, Florida, Washington, and Texas) account for 55 percent of people experiencing homelessness. And a mere 25 Continuums of Care (CoCs) account for 47 percent of all homelessness.

Many of these states and communities simply have a lot of residents and are generally populous. Thus, it is unsurprising that their subpopulations (including people experiencing homelessness) are also relatively large. To understand whether challenges exist beyond this dynamic, it is necessary to examine per capita experiences of homelessness.

Ranking by Rate and Total, 2022

Click the dropdown menu to select either Total Homeless or Rate of Homelessness Per 10,000. Click on the state abbreviation to filter the CoC List down to just the CoCs in that state or territory.

Total Homeless or Rate of Homelessness

Rate of Homelessness

States, Washington D.C., and U.S. Territories

Rank	Name	
1	DC	66
2	CA	44
3	VT	43
4	OR	42
5	HI	41
6	NY	37
7	WA	33
8	ME	32
9	AK	32
10	NV	24
11	DE	24
12	MA	22
13	AZ	19
14	CO	18
15	LA	16

CoCs

Rank	Name	
61	MN-501	31.5
62	CA-520	29.8
63	CA-511	29.4
64	PA-500	28.5
65	MN-509	27.9
66	MD-501	27.7
67	TN-504	27.2
68	CA-611	26.8
69	MI-501	26.7
70	GA-504	26.7
71	CA-505	26.6
72	CA-525	26.4
73	CA-518	26.1
74	CA-601	25.6
75	FL-517	25.4

Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR); U.S. Census Bureau, 2022 Population Estimates.

By Per Capita Experiences of Homelessness. Population size is important. But another critical question is: how common is it to experience homelessness within a jurisdiction? Per capita data answers this question by highlighting the share of the general population falling into the group.

Per capita experiences of homelessness vary greatly. For example, at the state level, Mississippi represents a low rate of homelessness, with only 4 people out of every 10,000 experiencing homelessness. Californians have the highest likelihood of being unhoused, however—44 out of every 10,000 residents. Similar variation exists at the local level, with Humboldt County, California reporting the highest per capita experiences of homelessness (121 out of every 10,000 people) and the CoC serving Dearborn, Michigan having the lowest (2 out of every 10,000 people).

Several major cities with high housing costs top the list of CoCs with the highest likelihood of homelessness, including San Francisco, New York City, Los Angeles

Boston, Washington, D.C., Portland, and Seattle. Implementing solutions to the housing affordability crisis in those areas would tremendously advance the goal of ending homelessness.

While housing costs and population size play into per capita experiences of homelessness, there are likely other factors contributing to high per capita rates. Researchers, data experts, and others should continue efforts to identify and unpack them.

HOMELESSNESS TRENDS OVER TIME

Homelessness in 21st century America has largely been defined by steady but modest progress since data collection began in 2007. Between 2007 and 2016, the population of people experiencing homelessness shrank most years. However, the overall reduction was only 15 percent during that nearly decade-long period.

This report was updated on January 5th, 2024 to correct an error in citing a 17% decrease in homelessness between 2007 and 2016. The accurate figure is 15%.

Prior to the COVID-19 pandemic, a new trend emerged: consistent annual increases in homelessness. And the unprecedented health crisis had the potential to further complicate matters. For people who were already unhoused, how would their health and economic security improvement efforts be impacted? And as businesses closed and unemployment rates rose, would new people seek help from shelters?

Tracking COVID-related population changes proved difficult. The pandemic disrupted data collection in 2021. By 2022, the full PIT Count resumed, and data showed that the homeless population had once again increased—but by only 0.3 percent. Given the unprecedented circumstances facing the nation, the shift could be characterized as being unexpectedly small. Federal policy likely impacted outcomes: COVID-19-related government interventions benefitted many people. Eviction moratoria and the federal Emergency Rental Assistance (ERA)

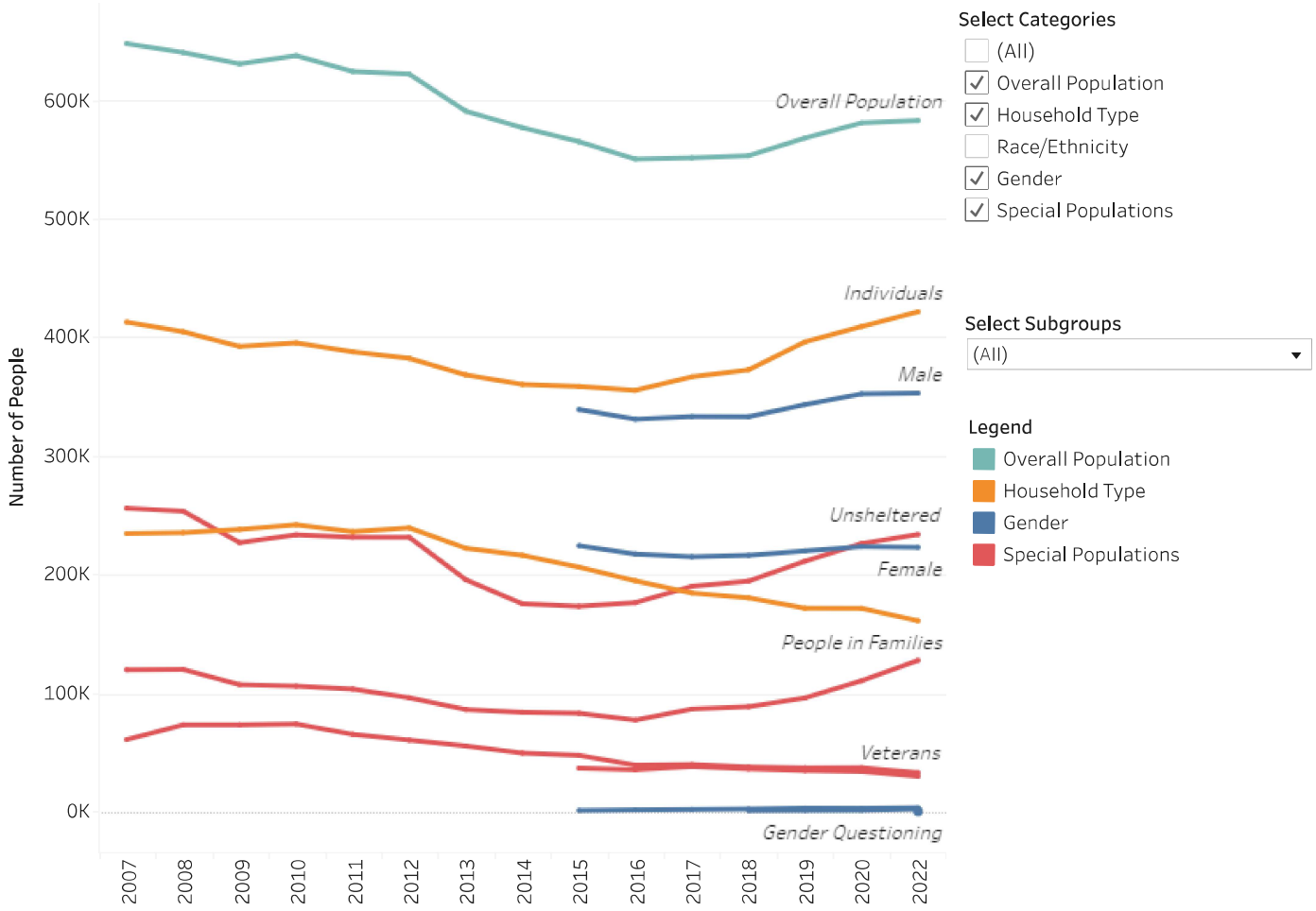
program kept (and are still keeping) many people housed. Additional investments were made in homeless assistance and housing vouchers targeted to people impacted by homelessness.

Homelessness Trends: Household Types and Special Populations

Progress in ending homelessness has been uneven across subgroups since data collection began in 2007. And although the overall homeless population increased slightly between 2020 and 2022, the same was not true for all subgroups. Some actually got smaller over that time period—1) families with children, 2) youth, and 3) veterans (see visualization below).

Subgroup Trends, 2007-2022

** Hover mouse over lines to see subgroup names and population size data.*

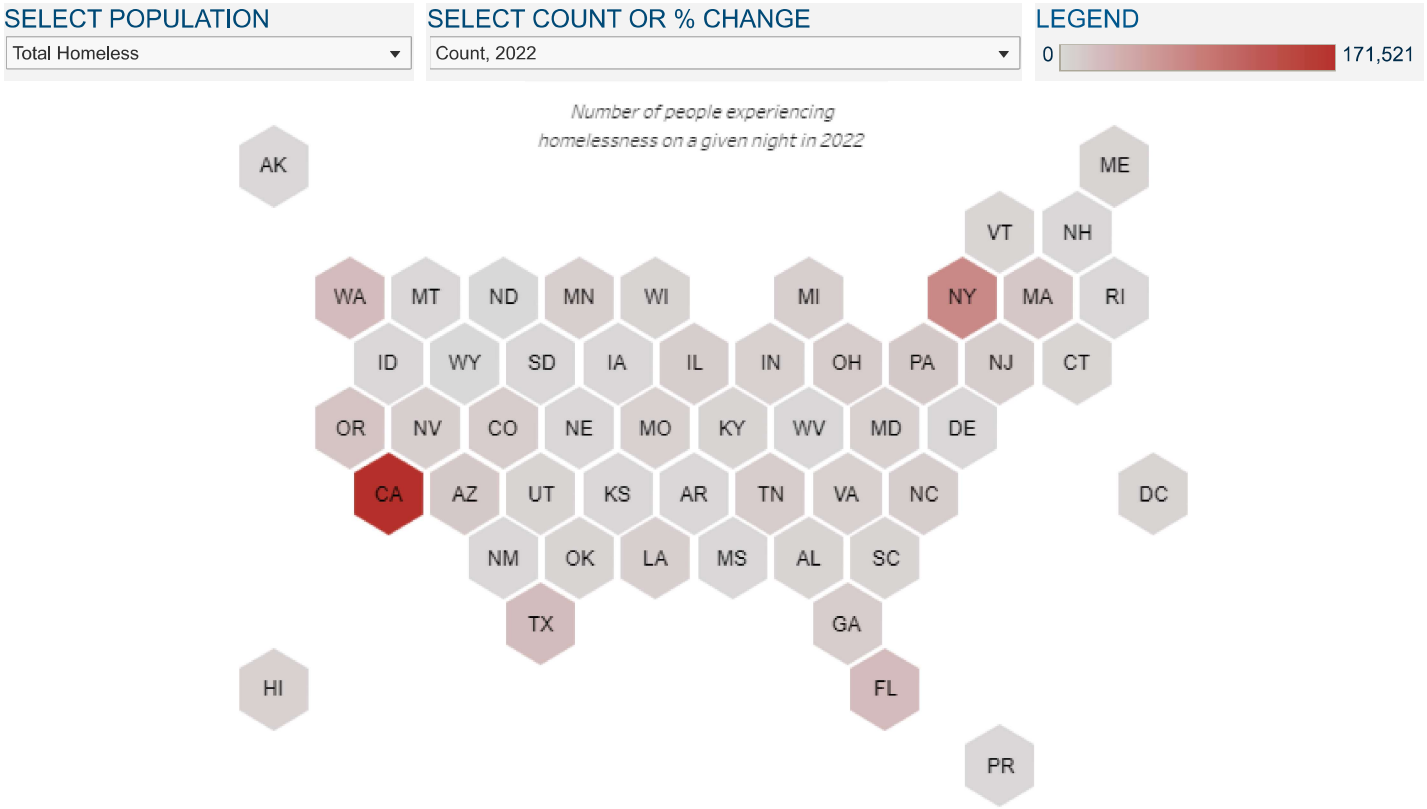


Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR). Note: The Covid-19 pandemic interrupted data collection in 2021 so data for that year is unavailable.

Due to factors such as vulnerability and history of military service, these groups are often targeted by both government and non-governmental interventions. Notably, the nation's progress on veteran homelessness has been particularly robust. The size of the group was cut in half over a decade-long period (2010-2020), decreasing by 50 percent. A total of 83 communities and 3 states have functionally ended veteran homelessness. Veterans have been the focus of concerted strategies and efforts (including governmental investments) that have been successful. Similar attention and resources could be extended to other subgroups in an effort to attain similar success.

The trends related to individuals experiencing homelessness are alarming. The 2022 Point-in-Time Count reflected record highs in the history data collection. The overall subpopulation of individuals reached 421,392 people, surpassing the previous record that existed in 2007. The count of chronically homeless individuals also surpassed all previous years. These trends reflect a notable shift after a period of population declines.

Count and Percent Change in Homelessness by State and Type, 2007-2022



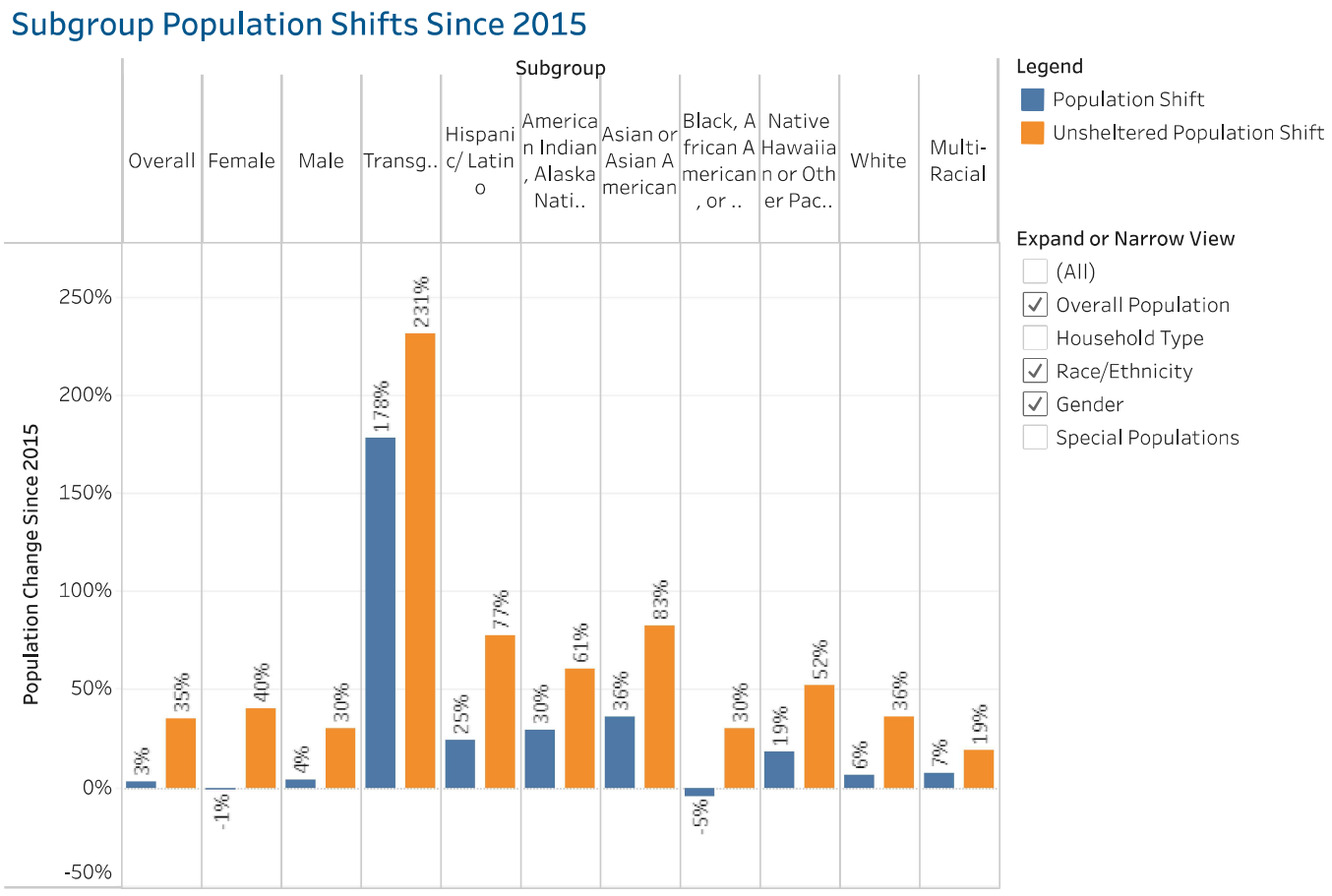
Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR). Note: Veteran data is unavailable before 2011. Youth data is unavailable before 2017.

Homelessness Trends: Race, Ethnicity, and Gender

In 2015, HUD began publishing homelessness data disaggregated by race, ethnicity, and certain gender categories. Although this isn't a long history of data reporting, it overlaps with the recent period of rising homelessness.

Uneven progress is evident between 2015 and 2022 among various identity groups. The above chart (Subgroup Trends, 2007-2022) illustrates that some subgroups have increased in size, while others have simply stagnated or gotten smaller. For example, the trend lines for White people and Hispanics/Latinos have been moving upward.

Digging a little deeper, the below chart (Subgroup Population Shifts Since 2015) highlights the extent of the changes occurring within each subgroup. It is clear that increases in homelessness have been particularly pronounced among people who are transgender (178 percent increase), Asian (36 percent increase), American Indian (30 percent increase), and Latino (25 percent increase).



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

Homelessness Trends: Shelter Utilization

Shelters are key components of America's response to homelessness. Since the beginning of the COVID-19 pandemic, certain trends have emerged in relation to this form of temporary housing:

Unsheltered Homelessness is On the Rise. The number of people living unsheltered decreased most years between 2007 and 2015. However, mirroring the pattern for individuals experiencing homelessness, that trend has recently made an about-face turn. The unsheltered population has grown yearly since 2015, amounting to a 35 percent increase over a seven-year span.

The impacts are not equal across groups. Since 2015, some populations have experienced growths in unsheltered homelessness that far surpass 35 percent. Of specific concern are people who are transgender (231 percent increase), Asian (83 percent increase), Latino (77 percent increase), and American Indian (61 percent increase). Challenges appear to be tied to western states (California, Oregon, Washington, and Hawaii) that are both diverse and highly immersed in affordable housing crises. Significant majorities of these homeless subgroup members live in these states.

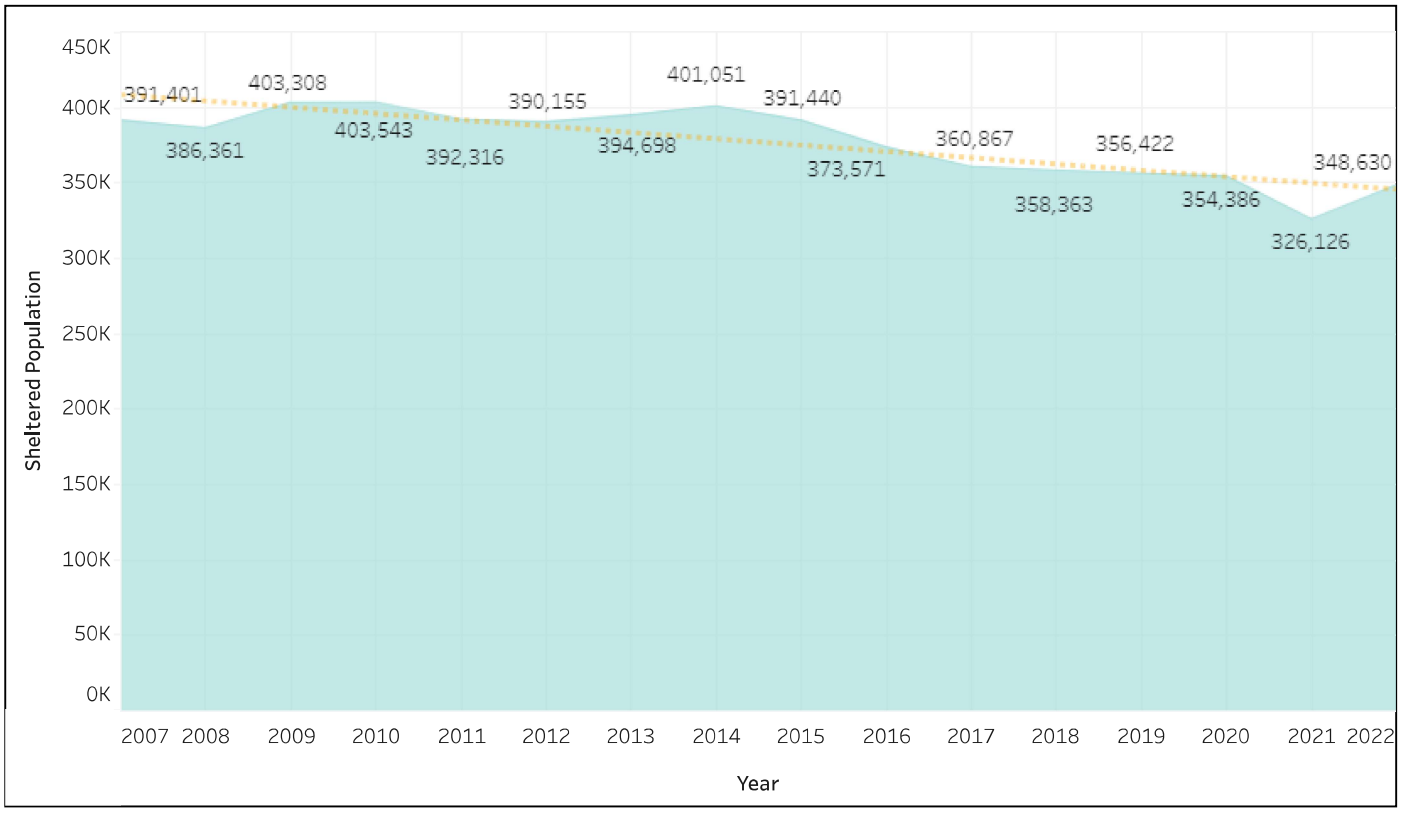
Systems Add More Shelter Beds in Response. As illustrated in the visualization below, the nation's shelter bed numbers have increased by 7 percent since 2019, indicating a slight increase in system capacity. Potential explanations include systems responding to increases in unsheltered homelessness, and/or the availability of pandemic relief dollars to create additional shelter beds.

Prior to this momentum, shelter bed numbers had been slowly trending downward as the number of permanent housing beds was greatly expanding. Such movements reflect fidelity to Housing First, a strategy that emphasizes stabilizing people in permanent housing as quickly possible.

Despite More Beds, Fewer People Are In Shelter. Even with the addition of more shelter beds, fewer people are staying in these facilities. The sh

been trending downward for several years, including 2021 (a year uniquely impacted by the COVID-19 pandemic, which necessitated a reduced congregate shelter capacity and consequent reduced inflow into shelter).

Overall Sheltered Trends, 2007 - 2022

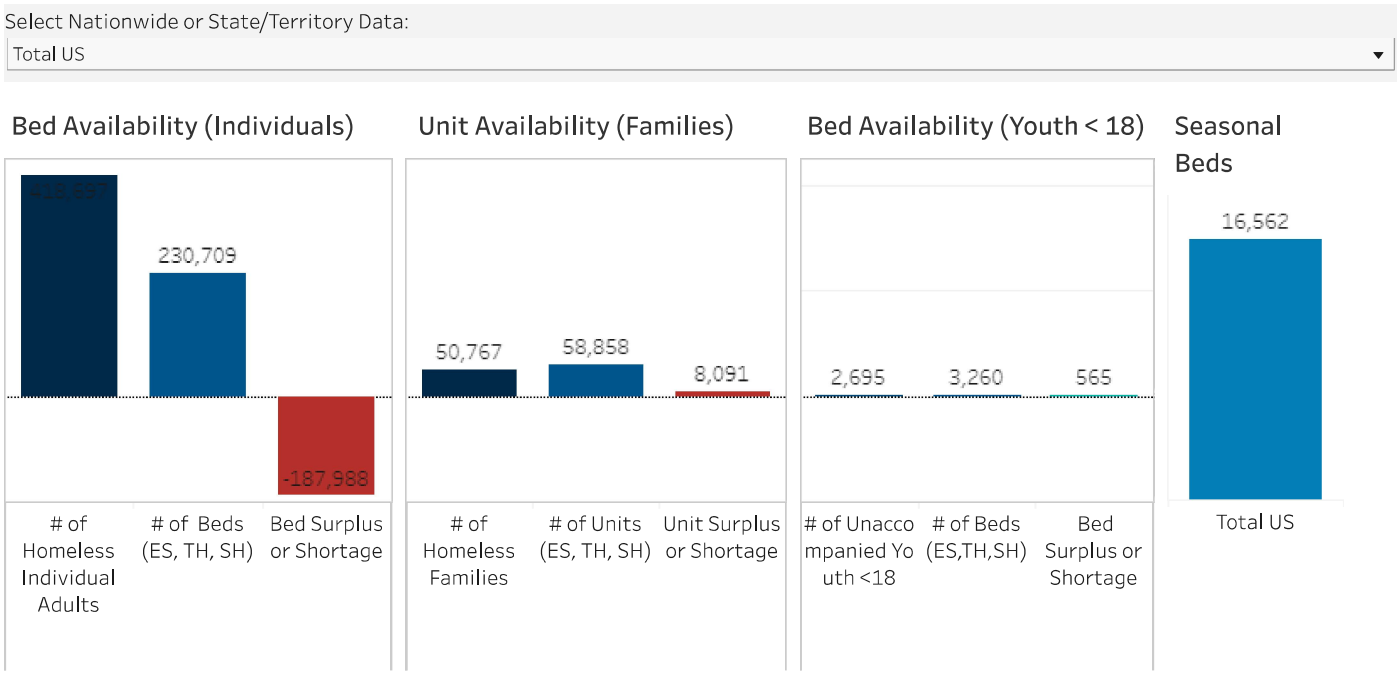


Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

HOMELESS ASSISTANCE IN AMERICA: USE OF RESOURCES AND CAPACITY

Homeless services systems often don't have the resources to house everyone in need. Thus, they make a host of difficult decisions related to 1) who to help and 2) how to budget available funds among temporary shelter and permanent housing options. This section provides a window into how homeless service systems are currently making limited government investments work for a growing population of people experiencing h

Availability of Temporary Shelter (Nationwide and By State/Territory), 2022



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

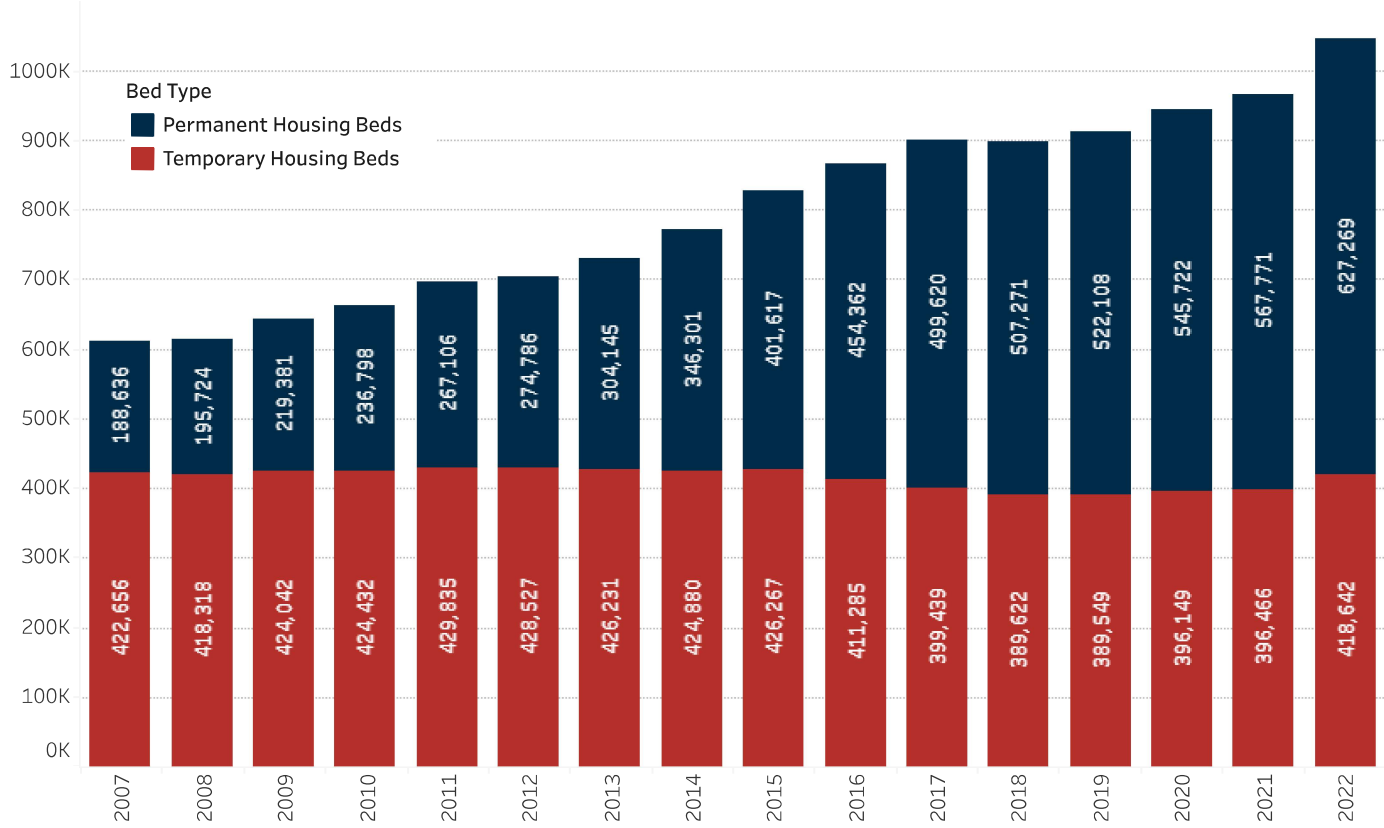
Shelter Beds

As noted in the section above, the number of people living unsheltered has been on the rise since 2015. Systems may be responding to this trend by expanding shelter capacity: after a few years of decreasing the availability of shelter beds, they expanded the total number by 7 percent over the last four years.

Importantly, a major contributor to unsheltered homelessness has been consistent and overwhelming shelter bed shortages since data collection began in 2007. At the high-water mark, there were 225,000 more people experiencing homelessness in America than existing shelter beds. Today, the gap has narrowed but remains vast, largely impacting individual adults.

In 2022, an examination of national-level data reveals a shortage of a little less than 188,00 year-round shelter beds for individual adults. There are only enough to reach 55 percent of the population. National-level data points to a surplus of available accommodations for families with children and unaccompanied youth.[4]

Permanent vs. Temporary Bed Inventory Trends, 2007-2022



Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

However, individual community circumstances vary. Thus, a specific town could have a shortage of available shelter units for families or a surplus of beds for individual adults.

Further, many communities set up temporary shelters during the winter months to prevent weather-related deaths. Thus, more people have spaces available to them than what is reflected by the year-round bed numbers.

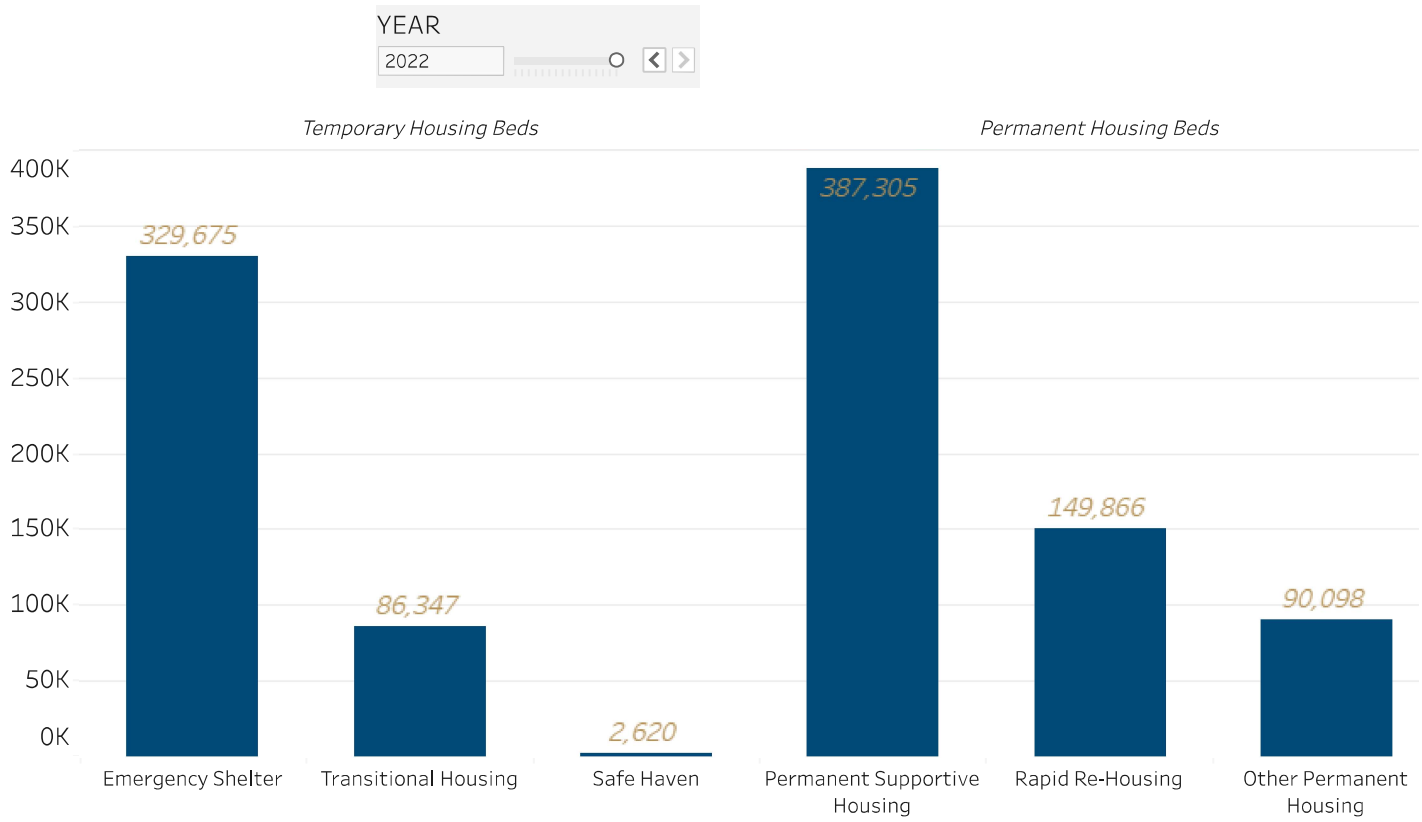
Permanent Housing Beds

Homeless services system investments suggest a prioritization of permanent housing options over temporary shelter. This is in line with Housing First, an approach to ending homelessness that emphasizes stabilizing people in permanent housing as quickly as possible while also making services available.

Permanent housing makes up 60 percent of all beds connected to homeless services systems. The number of such slots has consistently trended upwards since da , with a

26 percent growth over just the last five years. Despite these investments, homelessness (including unsheltered homelessness) is still on the rise. Available resources are simply not enough to ensure permanent housing for everyone who needs it.

Homeless Assistance Bed Inventory Trends, 2007-2022



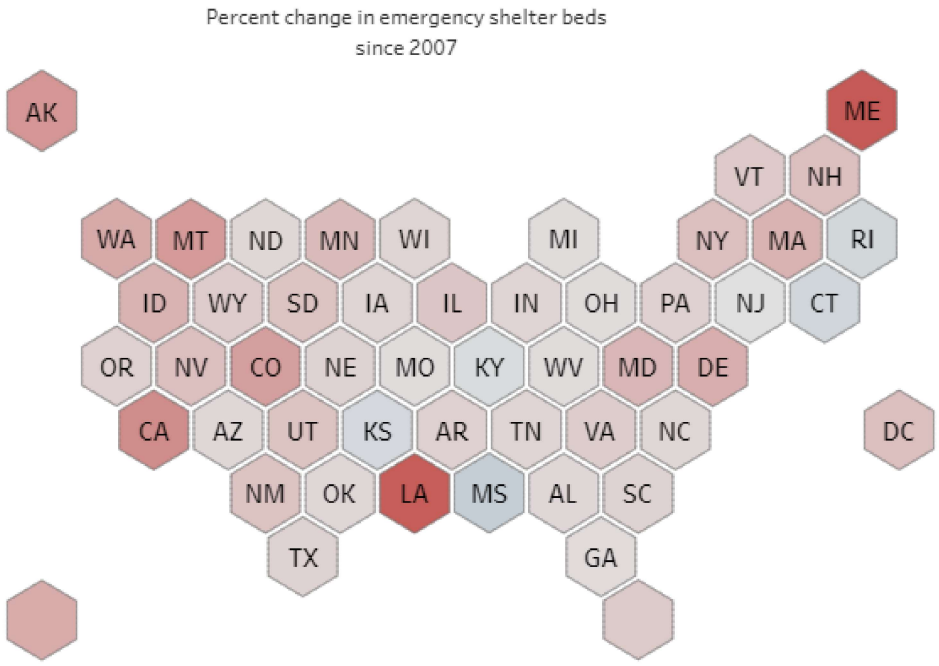
Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

Common Forms of Assistance

The top two forms of housing assistance are permanent supportive housing (37 percent of system beds) and emergency shelter (32 percent of system beds). The third most popular form of assistance (Rapid Re-Housing) is also the fastest growing: the number of beds in this category has grown by 60 percent over the last five years. Transitional housing is the only category on the decline. This model requires people to meet certain benchmarks before being awarded with permanent housing, and has fallen out of favor given growing adherence to the Housing First strategy, which is backed by research evidence.

State-by-State Trends in Homeless Assistance, 2007-2022

Category: Emergency Shelter | SELECT COUNT OR % CHANGE: Percent Change since 2007 | LEGEND: -55 to 274

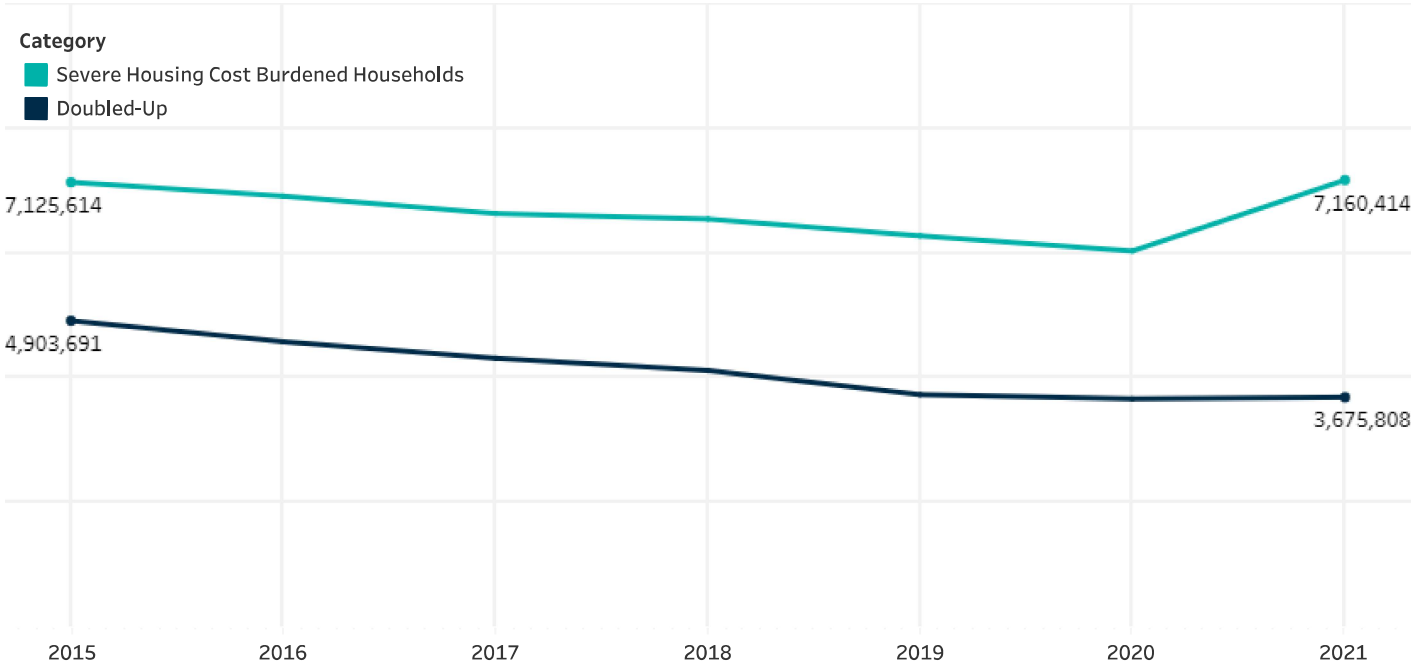


Source: U.S. Department of Housing and Urban Development, 2022 Annual Homeless Assessment Report to Congress (AHAR).

INDICATORS OF RISK

In the lead up to the pandemic, the nationwide poverty rate had decreased for five consecutive years. In 2020, that streak ended and the number of people living in poverty increased by approximately 3.3 million people. This trend continued into 2021 when nearly 41.4 million people, or 12.8 percent of the U.S. population, were counted in this group. Certain racial groups have even higher rates of poverty, including Black people (21.8 percent), American Indian and Alaska Native people (21.4 percent), and Hispanics/Latinos (17.5 percent). People living in poverty struggle to afford necessities such as housing, food, and medical care.

Populations at Risk of Homelessness over Time, 2015 - 2021

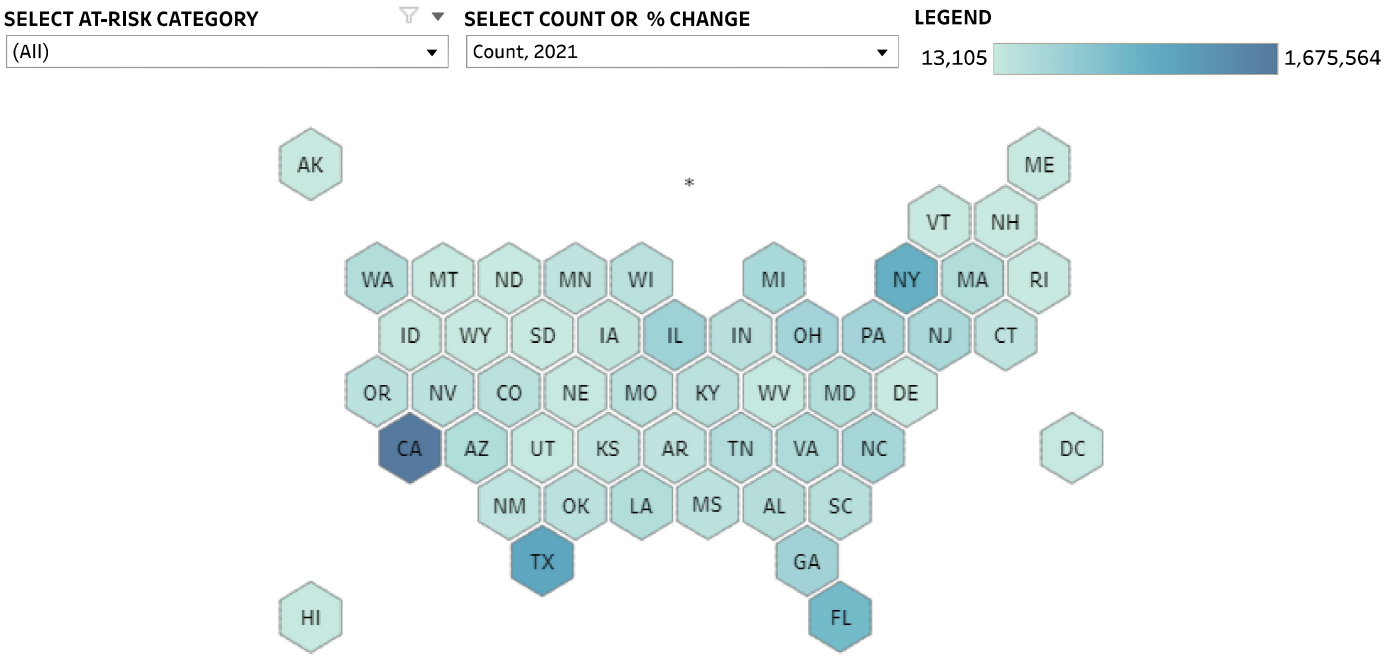


Source: 2007-2021 PUMS 1-Year, Accessed February 1, 2023 (Severe Housing Cost Burdened Households); Steven Ruggles, Sarah Flood, Matthew Sobek, Danika Brockman, Grace Cooper, Stephanie Richards, and Megan Schouweiler. IPUMS USA: Version 13.0 2015-2021 ACS PUMS 1-Year. Minneapolis, MN: IPUMS, 2023. https://doi.org/10.18128/D010.V13.0. Molly K. Richard, Julie Dworkin, Katherine Grace Rule, Suniya Farooqui, Zachary Glendening & Sam Carlson (2022): Quantifying Doubled-Up Homelessness: Presenting a New Measure Using U.S. Census Microdata, Housing Policy Debate, DOI: 10.1080/10511482.2021.1981976 (Doubled Up Population). Note: Doubled up data is not available before 2015.

In 2021, an estimated 7.1 million American households experienced severe housing cost burden, which means that they spent more than 50 percent of their income on housing. The overall size of this group had been gradually decreasing since 2014, but rose again in 2021. The number of severely cost-burdened American households is now 25 percent higher than it was in 2007, the year the nation began monitoring homelessness data. And more troublesome patterns may exist for notable subpopulations, including people with the lowest incomes and female-headed households.

"Doubling up" (or sharing the housing of others for economic reasons) is another measure of housing hardship and risk of homelessness. Approximately 3.7 million people across the country were in these situations in 2021. Some doubled up individuals and families have fragile relationships with their hosts or face other challenges in the home, putting them at risk of literal homelessness. Similar to severely housing cost burdened households, the number of people living doubled up had been decreasing but ticked upwards again in 2021. Currently, the doubled up population is 25 percent smaller than it was in 2015, the year in which utilized data came available.[5]

State-by-State Trends in Populations at Risk of Homelessness, 2007-2021



Source: 2007-2021 PUMS 1-Year, Accessed February 1, 2023 (Severe Housing Cost Burdened Households); Steven Ruggles, Sarah Flood, Matthew Sobek, Danika Brockman, Grace Cooper, Stephanie Richards, and Megan Schouweiler. IPUMS USA: Version 13.0 2015-2021 ACS PUMS 1-Year. Minneapolis, MN: IPUMS, 2023. https://doi.org/10.18128/D010.V13.0. Molly K. Richard, Julie Dworkin, Katherine Grace Rule, Suniya Farooqui, Zachary Glendening & Sam Carlson (2022): Quantifying Doubled-Up Homelessness: Presenting a New Measure Using U.S. Census Microdata, Housing Policy Debate, DOI: 10.1080/10511482.2021.1981976 (Doubled Up Population). Note: Doubled up data is not available before 2015.

National data on households who are housing cost burdened and doubled up do not tell the whole story, as certain regions across the country face more dire challenges than can be seen for the U.S. as a whole. Severe housing cost burdened households grew at higher rates than the national average in several states and the District of Columbia. For example, since 2007, severe housing cost burdened households grew by 155 percent in Wyoming, 87 percent in Nevada, 72 percent in Maryland, and 65 percent in Hawaii. Similarly, from 2015 to 2021, the number of people doubled up increased by 59 percent in South Dakota and 36 percent in Maine.

For over a decade, the nation has not made any real progress in reducing the number of Americans at risk of literal homelessness. Despite decreasing trends in people living doubled up overall, the rise in severe housing cost numbers are concerning. Even more troubling are the risks that inflation rising to a 40-year high in 2022, expiring eviction moratoria, and fading Emergency Rental Assistance dollars pose to those at risk of experiencing homelessness.

Data on **homelessness** are based on annual Point-in-Time (PIT) Counts conducted by Continuums of Care (CoCs) to estimate the number of people experiencing homelessness on a given night. The latest full counts (sheltered and unsheltered) are from January 2022. Point-in-Time data from 2007 to 2022 are available on HUD Exchange.

Rates of homelessness compare Point-in-Time Counts to state, county, and city population data from the Census Bureau's Population Estimates Program (Population and Housing Unit Estimates data tables, 2021 version). Rates for racial, ethnic, and gender demographic groups are drawn from the same source.

Data on **homeless assistance**, or bed capacity of homeless services programs on a given night, are reported annually by CoCs along with Point-in-Time Counts. These data are compiled in the Housing Inventory Count (HIC), which is also available on HUD Exchange for 2007 through 2022.

Estimates of **at-risk populations** are from analyses by the National Alliance to End Homelessness using the Census Bureau's 2021 American Community Survey 1-year microdata. Poor renter households with a severe housing cost burden are households whose total income falls under the applicable poverty threshold and who are paying 50 percent or more of total household income to housing rent. For people living doubled up, the Alliance has adopted the methodology developed by Molly K. Richard, Julie Dworkin, Katherine Grace Rule, Suniya Farooqui, Zachary Glendening, and Sam Carlson (Molly K. Richard, Julie Dworkin, Katherine Grace Rule, Suniya Farooqui, Zachary Glendening & Sam Carlson (2022): Quantifying Doubled-Up Homelessness: Presenting a New Measure Using U.S. Census M

Policy Debate, DOI: 10.1080/10511482.2021.1981976, Accessed from: https://nlihc.org/sites/default/files/Quantifying-Doubled-Up-Homelessness.pdf). Poverty is based on the composition and income of the entire household as compared to the poverty thresholds. A person is considered to be living doubled up based on their relationship to the household head and include: relatives for whom the household head does not take responsibility (based on their age and relationship) and nonrelatives who are not partners and not formally sharing responsibility for household costs (not roomers or roommates). Single adult children and relatives over 65 may be considered to be the householder's responsibility so they are included as doubling up only if the household is overcrowded. For more information, please consult the authors' study and methodology.

National Alliance to End Homelessness
1518 K Street NW, 2nd Floor, Washington, DC 20005 Privacy Policy
T: 202.638.1526 | F: 202.638.4664

Registered 501 (c)(3). EIN: 52-1299641

Alex F. Schwartz, Housing Policy in the United States (2014)

Homelessness

No housing problem is as profound as homelessness. Being homeless puts one at the mercy of the elements, charity, the kindness of family and friends, and the machinations of myriad social welfare agencies. Without a home, it is extremely difficult to find a job or to keep one. For children, it makes it difficult to attend school regularly and perhaps even more difficult to study and learn. Homelessness puts people at high risk of illness, mental health problems, substance abuse, and crime (Bratt 2000; Hoch 1998; Hopper 1997).

Although a portion of the U.S. population has perhaps always been homeless, the character and size of the homeless population began to change by the early 1980s. Until then, homelessness was chiefly associated with older, often alcoholic, single male denizens of a city's proverbial "skid row." Afterwards, the homeless population became much larger and more diverse, including an increasing number of women and families (Hopper 1997). Although many homeless, as before, struggle with alcoholism, drug addiction, or mental illness, many more homeless do not have these problems.

The Magnitude and Causes of Homelessness

Unlike other housing problems, homelessness is by its nature extremely difficult to quantify. Until recently, the homeless were not counted in the decennial census, the American Community Survey, the Current Population Survey, the American Housing Survey, or other studies of housing and households. National estimates of the homeless population only became regularly available in 2007 when HUD released its first annual homeless assessment report to Congress (HUD 2008). The data are based on counts and estimates of the sheltered and unsheltered homeless population provided by local and state agencies as part of their applications for federal funding for homeless services. To improve the quality of local estimates of homeless populations, HUD, in 2005, required these agencies to count the number

of sheltered and unsheltered homeless people on a single night in January at least every other year (HUD 2008). Since the 1980s, many localities had been tracking the number of beds available in homeless shelters and transitional housing facilities and estimating the number of unsheltered homeless living on the streets, in abandoned buildings, and other places not intended for human habitation, but now this information is collected more systematically across the nation. For example, the New York City government has mounted an annual "Homeless Outreach Population Estimate" since 2002. Staffed by hundreds of volunteers who spend an entire night searching randomly selected areas (groups of blocks and park areas as well as subway stations) for homeless individuals, the initiative attempts to estimate the total number of "street" (unsheltered) homeless (New York City Department of Homeless Services 2013). The results of this survey complement the city's homeless shelter intake statistics to gauge the city's overall homeless population.

Homelessness can be quantified in two ways. One is to count the number of people who are homeless at a single point in time. The other is to estimate the number of people who have been homeless one or more times during a specified time period, such as the preceding year. Both methods are difficult to carry out and are subject to different types of error and biases.

Point-in-time homeless counts have frequently been criticized for failing to provide a complete picture of the homeless. Using improved sampling techniques, methods of counting the homeless at a single point in time have undoubtedly become more sophisticated; however, the approach has inherent limitations. Most fundamentally, it fails to account for the fact that people differ in the length of time they are homeless. Homelessness is a long-term if not chronic condition for some people, but it is much more transitory for many more.

This difference has two consequences. First, point-in-time estimates will indicate that the extent of homelessness is much smaller than the size suggested by studies that look at the number of people who have experienced homelessness within a specified period of time. Second, point-in-time studies may not provide an accurate picture of the characteristics of the homeless. In other words, the longer someone is homeless, the more likely he or she will be covered in a point-in-time survey of the homeless. If people who are homeless for varying durations differ in other respects, such as mental health, substance abuse, education, or household status, point-in-time studies will overemphasize the characteristics of the more chronically homeless.

The limitations of this approach are illustrated by Phelan and Link (1998: 1334):

> Imagine a survey conducted in a shelter on a given night in December. If residents come and go during the month, the number on the night of the survey will be smaller than the number of residents over the month. If, in addition, length of stay varies, longer term residents will be oversampled (e.g., a person who stays all month is certain to be sampled while a person who stays one night has a 1 in 31 chance of being sampled). Finally,

if persons with certain characteristics (e.g., mental illness) stay longer than others, the prevalence of those characteristics will be overestimated.

The second approach for quantifying the homeless is to estimate the number of people who have been homeless over a specified period of time. Link and his colleagues (1994), for example, conducted a national telephone survey of 1,507 randomly selected adults in the 20 largest metropolitan areas to estimate the percentage who had ever experienced homelessness and who had been homeless at some point during the previous five years (1985 to 1990). The study concluded that 7.4% of the population had been homeless at some point in their lives and that 3.1% had been homeless at least once during the previous five years.

A still larger segment of the population had experienced homelessness when the definition was extended to include periods in which people had been doubled up with other households. Not surprisingly, low-income people reported the highest incidence of homelessness. Nearly one in five households that have ever received public assistance reported having been homeless at least once during their lifetimes.

Culhane and colleagues arrived at similar findings in their analysis of homeless shelter admission data in New York City and Philadelphia. They found that more than 1% of New York's population and nearly 1% of Philadelphia's had stayed in a public homeless shelter at least once in a single year (1992). Moreover, more than 2% of New York's and nearly 3% of Philadelphia's population had received shelter at least once during the previous three years (1990 to 1992). The incidence of homelessness was especially high among African Americans. For example, African Americans in New York City were more than 20 times more likely than Whites to spend one or more nights in a homeless shelter during a three-year period (Culhane, Dejowski, Ibanes, Needham, & Macchia 1999).

The most recent national estimates of the homeless population include figures for a single point in time and for people who had spent one or more nights within a homeless shelter during the previous 12 months. According to the 2012 Annual Homeless Assessment Report to Congress (HUD 2012a), a total of 633,782 people were homeless on a single night in January 2012 (see Table 2.16). In 2011, the latest year for which longitudinal data are available, more than twice as many people, 1.5 million, were in a homeless shelter or transitional housing facility for one or more nights during the year than were homeless on a single night in January. This figure does not include people who were homeless but did not enter the shelter system or people who stayed in shelters for victims of domestic violence (HUD 2012b). About one in every 201 persons in the United States stayed in a homeless shelter or transitional housing facility at some point between October 1, 2010 and September 30, 2011; however, a much larger proportion of the minority population experienced homelessness during the year—one in every 128 persons. The odds of a member of a minority group becoming homeless during the year are nearly double the risk of being diagnosed with cancer (HUD 2012b: 22).

Table 2.16 summarizes key trends in the homeless population. Most importantly, from 2005 to 2012 there was a decline of nearly 15% in the number of homeless persons. The decrease was largest among the chronically homeless (–42%), the unsheltered homeless (–24%), and individuals in families (–21%). From a longitudinal perspective, the magnitude of homelessness has also declined, but to a lesser degree. Table 2.16 shows that the number of people who stayed one or more nights in the shelter systems from October 1, 2010 to September 30, 2011 decreased by more than 5% compared to the number who utilized the shelter system for one or more nights from October 1, 2006 to September 30, 2007. However, this statistic masks a 13% increase in the number of people in families who were sheltered during the course of a year. (Fortunately, the figures for 2011 show a decrease in the number of homeless people in families from the previous year).

Some of the decrease in homelessness counts may stem from methodological improvements in how the homeless are counted, especially the unsheltered homeless (HUD 2008), but it probably also reflects increased resources allocated to permanent supportive housing and to a concerted effort by several hundred communities to reduce if not eliminate homelessness (see Chapter 10). It is remarkable

Table 2.16 Homelessness in the United States: Point-in-Time and Longitudinal Estimates of the Homeless Population

THE HOMELESS POPULATION ON A SINGLE NIGHT IN JANUARY							
	2005	2008	2011	2012	% DISTRIBUTION, 2012	CHANGE 2005–12	
						TOTAL	%
Total Homeless	744,313	664,414	636,017	633,782		–110,531	–14.9
Individuals	437,710	415,202	399,836	394,379	62	–43,331	–9.9
Persons in Familes	303,524	249,212	236,181	239,403	38	–64,121	–21.1
Chronically Homeless	171,192	124,135	107,148	99,894	16	–71,298	–41.6
Unsheltered	322,082	278,053	243,701	243,627	38	–78,455	–24.4
Sheltered	407,813	386,361	392,316	390,155	62	–17,658	–4.3
ESTIMATE OF SHELTERED HOMELESSNESS DURING A ONE-YEAR PERIOD							
	2007	2008	2009	2010	2011	CHANGE 2007–11	
						TOTAL	%
Total Homeless	1,588,595	1,593,794	1,558,917	1,593,150	1,502,196	–86,399	–5.4
Individuals	1,115,054	1,092,612	1,034,659	1,043,242	984,469	130,585	–11.7
Persons in Familes	473,541	516,724	535,447	567,334	537,414	63,873	13.49

Source: Sermons & Henry 2009: Table 1; HUD 2012a & 2012b.

that the incidence of homelessness continued to decrease after 2008 in the face of the Great Recession and the extremely slow recovery. While the number of households with severe housing affordability problems has increased sharply during this period, homelessness has declined.[5]

The causes of and remedies for homelessness have been subject to intense debate ever since homelessness emerged as a national issue in the 1980s (Burt 1991). Virtually all experts agree that homelessness is associated with extreme poverty, but there is much less consensus regarding the influence of mental illness, substance abuse, and social isolation as additional determinants of homelessness. Similarly, although some experts argue that stable, affordable housing is the best cure for homelessness, others claim that housing by itself is not sufficient and must be combined with case management and other supportive services (Cunningham 2009, Hoch 1998; Hopper 1997; Shinn, Baumohl, & Hopper 2001; Shinn, Weitzman et al. 1998; Wright & Rubin 1991). However, as discussed in Chapter 11, the dominant emphasis in homeless policy is shifting from policies and programs that emphasize transitional housing and supportive services as an intermediate step before placing them in permanent housing, to one that seeks to place the homeless in permanent housing as quickly as possible, and provide services afterwards if necessary. In part, disagreements over the causes and solutions for homelessness reflect the previously noted differences between point-in-time and longitudinal perspectives. Because individuals with mental illness, substance abuse histories, and other problems tend to be homeless for longer durations than other populations are, they are overrepresented in point-in-time surveys and have come to define the public face of homelessness. Disagreements over the causes and treatment of homelessness may also reflect the differences in the disciplinary backgrounds among researchers, advocates, and service providers. As Charles Hoch observes in his essay on homelessness for *The Encyclopedia of Housing* (1998: 234), "inquiry into the causes, conditions and prospects of the homeless follow different disciplinary pathways and so end up with different conclusions."

The Old Homeless and the New Homelessness in Historical Perspective

Peter H. Rossi

Department of Sociology and Social and Demographic Research Institute, University of Massachusetts/ Amherst

ABSTRACT: In the 1950s and 1960s homelessness declined to the point that researchers were predicting its virtual disappearance in the 1970s. Instead, in the 1980s, homelessness increased rapidly and drastically changed in composition. The "old homeless" of the 1950s were mainly old men living in cheap hotels on skid rows. The new homeless were much younger, more likely to be minority group members, suffering from greater poverty, and with access to poorer sleeping quarters. In addition, homeless women and families appeared in significant numbers. However, there were also points of similarity, especially high levels of mental illness and substance abuse.

Over the past decade, homelessness has received a great deal of popular attention and sympathy. The reasons for both appear to be obvious: Homelessness is clearly increasing, and its victims easily garner sympathetic concern. Our ideas about what constitutes a minimally decent existence are bound up inextricably with the concept of home. The Oxford Unabridged Dictionary devotes three pages to definitions of the word *home* and its derivatives; almost all of them stress one or more of the themes of safety, family, love, shelter, comfort, rest, sleep, warmth, affection, food, and sociability.

Homelessness has always existed in the United States, increasing in times of economic stress and declining in periods of prosperity (Monkkonen, 1984). Yet the problem has not received as much attention and sympathy in the past. Our current high level of concern reflects at least in part the fact that today's homeless are different and intrude more pointedly into everyday existence.

Before the 1980s the last great surge of homelessness occurred during the Great Depression in the 1930s. As in the present day, there were no definitive counts of the numbers of Depression-era homeless; estimates ranged from 200,000 to 1.5 million homeless persons in the worst years of the Depression.

As described in the social research of the time (Schubert, 1935), the Depression transient homeless consisted mainly of young men (and a small proportion of women) moving from place to place in search of employment. Many left their parental homes because they no longer wanted to be burdens on impoverished households and because they saw no employment opportunities in their depressed hometowns. Others were urged to leave by parents struggling to feed and house their younger siblings.

Homelessness After World War II

The entry of the United States into World War II drastically reduced the homeless population in this country, absorbing them into the armed forces and the burgeoning war industries (Hopper & Hamburg, 1984). The permanently unemployed that so worried social commentators who wrote in the early 1930s virtually disappeared within months. When the war ended, employment rates remained relatively high. Accordingly, homelessness and skid row areas shrank to a fraction of the 1930s experience. But neither phenomenon disappeared entirely.

In the first two postwar decades, the skid rows remained as collections of cheap hotels, inexpensive restaurants and bars, casual employment agencies, and religious missions dedicated to the moral redemption of skid row residents, who were increasingly an older population. Typically, skid row was located close to the railroad freight yards and the trucking terminals that provided casual employment for its inhabitants.

In the 1950s, as urban elites turned to the renovation of the central cities, what to do about the collection of unsightly buildings, low-quality land use, and unkempt people in the skid rows sparked a revival of social science research on skid row and its denizens. Especially influential were studies of New York's Bowery by Bahr and Caplow (1974), of Philadelphia by Blumberg and associates (Blumberg, Shipley, & Shandler, 1973), and of Chicago's skid row by Donald Bogue (1963).

All the studies of the era reported similar findings, with only slight local variations. The title of Bahr and Caplow's (1974) monograph, *Old Men: Drunk and Sober,* succinctly summarizes much of what was learned—that skid row was populated largely by alcoholic old men.

By actual count, Bogue (1963) enumerated 12,000

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homeless persons in Chicago in 1958, almost all of them men. In 1964, Bahr and Caplow (1974) estimated that there were about 8,000 homeless men living in New York's Bowery. In 1960, Blumberg et al. (1973) found about 2,000 homeless persons living in the skid row of Philadelphia. Clearly, despite the postwar economic expansion, homelessness persisted.

The meaning of homelessness as used by Bahr (1970), Blumberg et al. (1973), Bogue (1963), and other analysts of the era was somewhat different from current usage. In those studies, homelessness mostly meant living outside family units, whereas today's meaning of the term is more directly tied to the absolute lack of housing or to living in shelters and related temporary quarters. In fact, almost all of the homeless men studied by Bogue (1963) in 1958 had stable shelter of some sort. Four out of five rented cubicles in flophouse hotels. Renting for from $0.50 to $0.90 a night, a cubicle room would hardly qualify as a home, at least not by contemporary standards. Most of those not living in the cubicles lived in private rooms in inexpensive single-room occupancy (SRO) hotels or in the mission dormitories. Bogue reported that only a few homeless men, about 100, lived out on the streets, sleeping in doorways, under bridges, and in other "sheltered" places. Searching the streets, hotels and boarding houses of Philadelphia's skid row area in 1960, Blumberg et al. found only 64 persons sleeping in the streets.

As described by Bogue (1963), the median age of Chicago's homeless in the late 1950s was about 50 years old, and more than 90% were White. One fourth were Social Security pensioners, making their monthly $30–$50 minimum social security payments last through the month by renting the cheapest accommodations possible. Another fourth were chronic alcoholics. The remaining one half was composed of persons suffering from physical disability (20%), chronic mental illness (20%), and what Bogue called *social maladjustment* (10%).

Aside from those who lived on their pension checks, most skid row inhabitants earned their living through menial, low-paid employment, much of which was of an intermittent variety. The mission dormitories and municipal shelters provided food and beds for those who were out of work or who could not work.

All of the social scientists who studied the skid rows in the postwar period remarked on the social isolation of the homeless (Bahr, 1970). Bogue (1963) found that virtually all homeless men were unmarried, and a majority had never married. Although many had family, kinship ties were of the most tenuous quality, with few of the homeless maintaining ongoing contacts with their kin. Most had no one they considered to be good friends.

Much the same portrait emerged from other skid row studies throughout the country. All of the studies painted a similar picture in the same three pigments: (a) extreme poverty arising from unemployment or sporadic employment, chronically low earnings, and low benefit levels (such as were characteristic of Social Security pensions at the time); (b) disability arising from advanced age, alcoholism, and physical or mental illness; and (c) social disaffiliation, tenuous or absent ties to family and kin, with few or no friends.

Most of the social scientists studying skid rows expressed the opinion that they were declining in size and would soon disappear. Bahr and Caplow (1974) claimed that the population of the Bowery had dropped from 14,000 in 1949 to 8,000 in 1964, a trend that would end with the disappearance of skid row by the middle 1970s. Bogue (1963) cited high vacancy rates in the cubicle hotels as evidence that Chicago's skid row was also on the decline. In addition, Bogue claimed that the economic function of skid row was fast disappearing. With the mechanization of many low-skilled tasks, the casual labor market was shrinking, and with no economic function to perform, the skid row social system would also disappear.

Evidence through the early 1970s indeed suggested that the forecasted decline was correct; skid row was on the way out. Lee (1980) studied skid row areas of 41 cities and found that the skid row populations had declined by 50% between 1950 and 1970. Furthermore, in cities in which the market for unskilled labor had declined most precipitously, the loss of the skid row population was correspondingly larger.

By the end of the 1970s, striking changes had taken place in city after city. The flophouse and cubicle hotels had, for the most part, been demolished, and were replaced eventually by office buildings, luxury condominiums, and apartments. The stock of cheap SRO hotels, in which the more prosperous of the old homeless had lived, had also been seriously diminished (U.S. Senate, 1978). Skid row did not disappear altogether; in most cities, the missions still remained and smaller skid rows sprouted up in several places throughout the cities, where the remaining SRO hotels and rooming houses still stood.

The New Homelessness of the 1980s

The "old" homeless of the 1950s, 1960s, and 1970s—so ably described by many social scientists—may have blighted some sections of the central cities but, from the perspective of most urbanites, they had the virtue of being concentrated in skid row, a neighborhood one could avoid and hence ignore. Most of the old homeless on skid row had some shelter, although it was inadequate by any standards; very few were literally sleeping on the streets. Indeed, in those early years, if any had tried to bed down on the steam vents or in doorways and vestibules of any

Editor's Note. This article is an early version of Chapter 2 of Peter H. Rossi's book *Down and Out in America: The Origins of Homelessness,* published by the University of Chicago Press and copyrighted by Dr. Rossi in 1989.

The author is Stuart A. Rice Professor of Sociology and Acting Director of the Social and Demographic Research Institute at the University of Massachusetts Amherst.

Correspondence concerning this article should be addressed to Peter H. Rossi, Social and Demographic Research Institute, University of Massachusetts, Amherst, MA 01003.

downtown business area, the police would have quickly trundled them off to jail.

The demise or displacement of skid row, however, and the many other trends and developments of the 1960s and 1970s, did *not* put an end to homelessness in American cities. Quite to the contrary: By the end of the 1970s, and certainly by the early 1980s, a new type of homelessness had begun to appear.

The "new" homeless could be seen sleeping in doorways, in cardboard boxes, in abandoned cars, or resting in railroad or bus stations or in other public places, indications of a resurgent homelessness of which hardly anyone could remain oblivious. The immediate evidence of the senses was that there were persons in our society who had no shelter and who therefore lived, literally, in the streets. This change reflected partially corresponding changes in local police practices following the decriminalization of public inebriation and other court-ordered changes in the treatment of "loitering" and vagrancy. The police no longer herded the homeless into their ghettos.

Even more striking was the appearance of homeless women in significant numbers. The skid rows of the 1950s and 1960s were male enclaves; very few women appeared in any of the pertinent studies. And thus, homelessness had come to be defined (or perhaps, stereotyped) as largely a male problem. Indifference to the plight of derelicts and bums is one thing; indifference to the existence and problems of homeless women is quite another.

Soon, entire families began showing up among the homeless, and public attention grew even stronger and sharper. Women and their children began to arrive at the doors of public welfare departments asking for aid in finding shelter, arousing immediate sympathy. Stories began to appear in the newspapers about families migrating from the Rustbelt cities to cities in the Sunbelt in old cars loaded with their meager belongings, seeking employment, starkly and distressingly reminiscent of the Okies of the 1930s.

There is useful contrast between Bogue's, 1958, Chicago study (Bogue, 1963) and the situation in Chicago today. Data on the contemporary Chicago homeless was obtained in a study conducted by my colleagues and myself in 1985 and 1986 (Rossi, 1989; Rossi, Fisher, & Willis, 1986; Rossi & Wright, 1987). In 1958, there were four or five mission shelters in the city, providing 975 beds. In our studies in 1985 and 1986, there were 45 shelters providing a total of 2,000 beds, primarily for adult homeless persons.

New types of sheltering arrangements have come into being to accommodate the rising number of homeless families. Some shelters now specialize in providing quasi-private quarters for family groups, usually in one or two rooms per family, with shared bathrooms and cooking facilities. In many cities, welfare departments have provided temporary housing for family groups by renting rooms in hotels and motels.

In some cities, the use of hotel and motel rooms rented by public welfare agencies to shelter homeless families is very widespread. For example, in 1986, New York City's welfare department put up an average of 3,500 families in so-called *welfare hotels* each month (Bach & Steinhagen, 1987; Struening, 1987).

Funds for the new homeless are now being allocated out of local, state, and federal coffers on a scale that would have been inconceivable two decades ago. Private charity has also been generous, with most of the emergency shelters and food outlets for the homeless being organized and run by private groups. Foundations have given generous grants. For example, the Robert Wood Johnson Foundation, in association with the Pew Charitable Trust, supports health care clinics for the homeless in 19 large cities, a $25 million venture. The states have provided funds through existing programs and special appropriations. And in spring 1987, Congress passed the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), appropriating $442 million for the homeless in fiscal 1987 and $616 million in 1988, to be channeled through a group of agencies.

There can be little doubt that homelessness has increased over the past decade and that the composition of the homeless has changed dramatically. There are ample signs of that increase. For example, in New York City, shelter capacity has increased from 3,000 to 6,000 over the last five years, and the number of families in the welfare hotels has increased from a few hundred to more than 3,000 in any given month (Bach & Steinhagen, 1987; Struening, 1987). Studies reviewed by the U.S. General Accounting Office ([GAO]; 1985, 1988) suggest an annual growth rate of the homeless population somewhere between 10% and 38%.

The GAO figures and other estimates, to be sure, are not much more than reasoned guesses. No one knows for sure how many homeless people there are in the United States today or even how many there are in any specific city, let alone the rate of growth in those numbers over the past decade.

The many difficulties notwithstanding, several estimates have been made of the size of the nation's homeless population. The National Coalition for the Homeless, an advocacy group, puts the figure somewhere between 1.5 and 3 million (GAO, 1988). A much maligned report by the U.S. Department of Housing and Urban Development (1984), partially based on cumulating the estimates of presumably knowledgeable local experts, and partially on a survey of emergency shelters, put the national figure at somewhere between 250,000 and 300,000. A more recent national estimate by The Urban Institute (Burt & Cohen, 1988), based on direct counts in shelters and food kitchens leads to a current estimate of about 500,000 homeless persons.

No available study suggests a national total number of homeless on any given night of less than several hundred thousand, and perhaps it is enough to know that the nation's homeless are at least numerous enough to populate a medium-sized city. Although the "numbers" issue has been quite contentious, in a very real sense, it does not matter much which estimate is closest to the

truth. By any standard, all estimates point to a national disgrace.

Who Are the New Homeless?

Since 1983, 40 empirical studies of the homeless have been undertaken that were conducted by competent social researchers; the results provide a detailed and remarkably consistent portrait of today's homeless population. As in the 1950s and 1960s, the driving purpose behind the funding and conduct of these studies is to provide the information necessary to design policies and programs that show promise to alleviate the pitiful condition of the homeless. The cities covered in these studies range across all regions of the country and include all the major metropolitan areas as well as more than a score of smaller cities.

The cumulative knowledge about the new homeless provided through these studies is quite impressive, and the principal findings are largely undisputed. Despite wide differences in definitions of homelessness, research methods and approaches, cities studied, professional and ideological interests of the investigators, and technical sophistication, the findings from all studies tend to converge on a common portrait. It would not be fair to say that all of the important questions have been answered, but a reasonably clear understanding is now emerging of who the new homeless are, how they contrast with the general population, and how they differ from the old homeless of the 1950s.

Some of the important differences between the new homeless and the old have already been mentioned. Few of the old homeless slept in the streets. In stark contrast, the Chicago Homeless Study (Rossi, 1989; Rossi, Fisher, & Willis, 1986; Rossi & Wright, 1987) found close to 1,400 homeless persons out on the streets in the fall of 1985 and more than 500 in that condition in the dead of winter (early 1986). Comparably large numbers of street homeless, proportionate to community size, have been found over the last five years in studies of Los Angeles (Farr, Koegel, & Burnam, 1986); New York (New York State Department of Social Services, 1984); Nashville, Tennessee (Wiegand, 1985); Austin, Texas (Baumann, Grigsby, Beauvais, & Schultz, not dated); Phoenix, Arizona (Brown, McFarlane, Parades, & Stark, 1983); Detroit, Michigan (Mowbray, Solarz, Johnson, Phillips-Smith, & Combs, 1986); Baltimore (Maryland Department of Human Resources, 1986); and Washington, DC (Robinson, 1985), among others.

One major difference between the old homeless and the new is thus that nearly all of the old homeless managed, somehow, to find nightly shelter indoors, whereas large fractions of the new homeless sleep in the streets or in public places, such as building lobbies and bus stations. In regard to shelter, the new homeless are clearly worse off. *Homelessness today is a more severe condition of housing deprivation* than in decades past. Furthermore, the new homeless, whether sheltered or living on the streets, are no longer concentrated in a single skid row area. They are, rather, scattered more widely throughout downtown areas.

A second major difference is the presence of sizable numbers of women among the new homeless. In the 1950s and 1960s women constituted less than 3% of the homeless. In contrast, we found that women constituted 25% of the 1985–1986 Chicago homeless (Rossi et al., 1986), a proportion similar to that reported in virtually all recent studies (Hope & Young, 1986; Lam, 1987; Sullivan & Damrosch, 1987). Thus, all 1980s-era studies found that women compose a much larger proportion of the homeless than did studies of the old homeless undertaken before 1970.

A third contrast between the old homeless and the new is in age composition. There are very few elderly persons among today's homeless and virtually no Social Security pensioners. In the Chicago Homeless Study (Rossi et al., 1986), the median age was 37, sharply contrasting the median age of 50 found in Bogue's (1963) earlier study of that city. Indeed, today's homeless are surprisingly young; virtually all recent studies of the homeless report median ages in the low to middle 30s. Trend data over a 15-year period (1969–1984) from the Men's Shelter in New York's Bowery suggest that the median age of the homeless has dropped by about one half-year per year for the last decade (Rossi & Wright, 1987; Wright & Weber, 1987).

A fourth contrast is provided by employment patterns and income levels. In Bogue's (1963) 1958 study, excepting the aged pensioners, over one half of the homeless were employed in any given week, either full time (28%) or on an intermittent, part-time basis (25%), and almost all were employed at least for some period during a year. In contrast, among today's Chicago homeless, only 3% reported having a steady job and only 39% worked for some period during the previous month. Correspondingly, the new homeless have less income. Bogue estimated that the median annual income of the 1958 homeless was $1,058. Our Chicago finding (Rossi et al., 1986) was a median annual income of $1,198. Correcting for the intervening inflation, the current average annual income of the Chicago homeless (Rossi et al., 1986) is equivalent to only $383 in 1958 dollars, less than one third of the actual 1958 median. Thus, *the new homeless suffer a much more profound degree of economic destitution,* often surviving on 40% or less of a poverty-level income.

A final contrast is presented by the ethnic composition of the new and old homeless. The old homeless were predominantly White—70% on the Bowery (Bahr & Caplow, 1974) and 82% on Chicago's skid row (Rossi et al., 1986). Among the new homeless, racial and ethnic minorities are heavily overrepresented. In the Chicago study, 54% were Black, and in the New York men's shelter, more than 75% were Black, a proportion that has been increasing since the early 1980s (Wright & Weber, 1987). In most cities, other ethnic minorities, principally Hispanics and American Indians, are also found disproportionately among the homeless, although the precise ethnic mix is apparently determined by the ethnic composition

of the local poverty population. In short, minorities are consistently over-represented among the new homeless, compared with times past.

There are also some obvious continuities from the old homeless to the new. First, both groups share the condition of extreme poverty. Although the new homeless are poorer (in constant dollars), neither they nor the old homeless have (or had) incomes that would support a reasonable standard of living, whatever one takes *reasonable* to mean. The median income of today's Chicago homeless works out to less than $100 a month, or about $3 a day, with a large proportion (18%) with essential zero income (Rossi et al., 1986). Comparably low incomes have been reported in other studies.

At these income levels, even trivial expenditures loom as major expenses. For example, a single round trip on Chicago's bus system costs $1.80, or more than one half a day's median income. A night's lodging at even the cheapest flophouse hotel costs more than $5, which exceeds the average daily income (Hoch, 1985). And, of course, the median simply marks the income received by persons right at the midpoint of the income distribution; by definition, one half of the homeless live on less than the median and, in fact, nearly one fifth (18%) reported *no income at all.*

Given these income levels, it is certainly no mystery why the homeless are without shelter. Their incomes simply do not allow them to compete effectively in the housing market, even on the lowest end. Indeed, the only way most homeless people can survive at all is to use the shelters for a free place to sleep, the food kitchens and soup lines for free meals, the free community health clinics and emergency rooms for medical care, and the clothing distribution depots for something to put on their backs. That the homeless survive at all is a tribute to the many charitable organizations that provide these and other essential commodities and services.

The new homeless and the old also apparently share similar levels of disability. The one unmistakable change from the 1950s to the 1980s is the declining proportion of elderly, and thus a decline in the disabilities associated with advanced age. But today's homeless appear to suffer from much the same levels of mental illness, alcoholism, and physical disability as the old homeless did.

More has been written about the homeless mentally ill than about any other aspect of the problem. Estimates of the rate of mental illness among the homeless vary widely, from about 10% to more than 85%, but most studies report a figure on the order of 33⅓% (Bassuk, 1984; Snow, Baker, & Anderson, 1986). This is somewhat larger than the estimates, clustering between 15% and 25%, appearing in the literature of the 1950s and 1960s.

Physical disabilities also are widespread among the new homeless and the old. Some of the best current evidence on this score comes from the medical records of clients seen in the Johnson Foundation Health Care for the Homeless (HCH) clinics. Chronic physical disorders, such as hypertension, diabetes, heart and circulatory disease, peripheral vascular disease, and the like, are observed in 40% (compared with a rate of only 25% among urban ambulatory patients in general).

> In all, poor physical health plays some direct role in the homelessness of 21% of the HCH clients, and is a major (or single most important) factor in the homelessness of about 13%. Thus, approximately one homeless adult in eight is homeless at least in major part as a result of chronically poor physical health. (Wright & Weber, 1987, p. 113; see also Brickner, Scharar, Conanan, Elvy, & Savarese, 1985; Robertson & Cousineau, 1986)

Analysis of the deaths occurring among these clients showed that the average age at death (or in other words, the average life expectancy) of the homeless is only a bit more than 50 years.

All studies of the old homeless stress the widespread prevalence of chronic alcoholism, and here too, the new homeless are little different. Bogue (1963) found that 30% of his sample were heavy drinkers, defined as persons spending 25% or more of their income on alcohol and drinking the equivalent of six or more pints of whiskey a week.

A final point of comparability is that both the old homeless and the new are socially isolated. The new homeless report few friends and intimates, and depressed levels of contact with relatives and family. There are also signs of friction between the homeless and their relatives. Similar patterns of isolation were found among the old homeless.

Summary and Conclusions

The major changes in homelessness since the 1950s and 1960s involve an increase in the numbers of homeless persons, striking changes in the composition of the homeless, and a marked deterioration in their condition. The old homeless were older men living on incomes either from intermittent casual employment or from inadequate retirement pensions. However inadequate their incomes may have been, the old homeless had three times the income (in constant dollars) of the current homeless. The new homeless include an increasing proportion of women, often accompanied by their children, persons who are, on average, several decades younger. The old homeless were housed inadequately, but high proportions of the new homeless are shelterless.

Like the old homeless, the new have high levels of disabilities, including chronic mental illness (33%), acute alcoholism (33%), serious criminal records (20%), and serious physical disabilities (25%). Seventy-five percent have one or more of the disabilities mentioned.

REFERENCES

Bach, V., & Steinhagen, R. (1987). *Alternatives to the welfare hotel.* New York: Community Service Society.

Bahr, H. (1970). *Disaffiliated man.* Toronto, Canada: University of Toronto Press.

Bahr, H., & Caplow, T. (1974). *Old men drunk and sober.* New York: New York University Press.

Bassuk, E. (1984, July). The homeless problem. *Scientific American, 251,* 40–45.

Baumann, D., Grigsby, C., Beauvais, C., & Schultz, D. F. (not dated). *The Austin homeless* (Final report to the Hogg Foundation for Mental Health). Austin: University of Texas.

Blumberg, L., Shipley, T., & Shandler, I. (1973). *Skid row and its alternatives.* Philadelphia, PA: Temple University Press.

Bogue, D. (1963). *Skid row in American cities.* Chicago: University of Chicago.

Brickner, P. W., Scharar, L. K., Conanan, B., Elvy, A., & Savarese, M. (Eds.). (1985). *Health care of homeless people.* New York: Springer.

Brown, C., MacFarlane, S., Parades, R., & Stark, L. (1983, June). *The homeless of Phoenix: Who are they and what should be done?* Phoenix, AZ: South Community Mental Health Center.

Burt, M. R., & Cohen, B. E. (1988). *Feeding the homeless: Does the prepared meals provision help?* Washington, DC: The Urban Institute.

Farr, R., Koegel, P., & Burnham, A. (1986). *A study of homelessness and mental illness in the skid row area of Los Angeles.* Los Angeles: Los Angeles County Department of Mental Health.

Hoch, C. (1985, December). *SROs: An endangered species.* Chicago: Community Emergency Shelter Organization and Jewish Council on Urban Affairs.

Hope, M., & Young, J. (1986). *The faces of homelessness.* Lexington, MA: Heath.

Hopper, K., & Hamburg, J. (1984). *The making of America's homeless: From skid row to new poor, 1945–1984.* New York: Community Service Society.

Lam, J. (1987). *Homeless women in America.* Unpublished doctoral dissertation, University of Massachusetts, Amherst.

Lee, B. A. (1980, September). The disappearance of skid row: Some ecological evidence. *Urban Affairs Quarterly, 16,* 81–107.

Maryland Department of Human Resources. (1986, August). *Where do you go from nowhere?* Baltimore: Health and Welfare Council of Central Maryland.

Monkkonen, E. H. (Ed.). (1984). *Walking to work: Tramps in America, 1790–1935,* Lincoln: University of Nebraska Press.

Mowbray, C., Solarz, A., Johnson, V. S., Phillips-Smith, E., & Combs, C. J. (1986). *Mental health and homelessness in Detroit: A research study* (NIMH Grant No. 5H84-MH35823-04S1). Lansing: Michigan Department of Mental Health.

New York State Department of Social Services. (1984, October). *Homelessness in New York state: A report to the governor and legislature.* New York: Author.

Robertson, M., & Cousineau, M. R. (1986, May). Health status and access to health services among the urban homeless. *American Journal of Public Health, 76,* 561–563.

Robinson, F. (1985, November). *Homeless people in the nation's capital.* Washington, DC: University of the District of Columbia.

Rossi, P. H. (1989). *Down and out in America: The origins of homelessness.* Chicago: University of Chicago Press.

Rossi, P. H., Fisher, G. A., & Willis, G. (1986). *The condition of the homeless of Chicago.* Amherst: University of Massachusetts.

Rossi, P. H., & Wright, J. D. (1987, Spring). The determinents of homelessness. *Health Affairs, 6,* 19–32.

Schubert, H. J. P. (1935). *Twenty thousand transients: A year's sample of those who apply for aid in a northern city.* Buffalo, NY: Emergency Relief Bureau.

Snow, D., Baker, S. G., & Anderson, L. (1986, June). The myth of pervasive mental illness among the homeless. *Social Problems, 33,* 407–423.

Struening, E. L. (1987). *A study of residents of the New York City shelter system.* New York: New York State Psychiatric Institute.

Sullivan, P., & Damrosch, S. (1987). Homeless women and children. In R. Bingham, R. Green, & S. White (Eds.), *The homeless in contemporary society* (pp. 82–98). Newbury Park, CA: Sage.

U.S. Department of Housing and Urban Development. (1984). *A report to the Secretary on the homeless and emergency shelters.* Washington, DC: Author.

U.S. General Accounting Office. (1985, April). *Homelessness: A complex problem and the federal response* (GAO/HRD Publication No. 85-40). Washington, DC: Author.

U.S. General Accounting Office. (1988, August). *Homeless mentally ill: Problems and options in estimating numbers and trends* (GAO/PEMD Publication No. 88-24). Washington, DC: Author.

U.S. Senate, Special Committee on Aging. (1978). *Single room occupancy: A need for national concern.* Washington, DC: U.S. Government Printing Office.

Wiegand, R. B. (1985). Counting the homeless. *American Demographics, 7,* 34–37.

Wright, J. D., & Weber, E. (1987). Homelessness and health. New York: McGraw Hill.

Deborah K. Padgett, Benjamin Henwood, and Sam J. Tsemberis, Housing First: Ending Homelessness,Transforming Systems, and Changing Lives (Oxford, 2015)

Ch. 2 Homelessness in America: Truths and Consequences

Growing Inequality in America: Race, Poverty and Polarization

The story of Housing First (HF) must be set within the larger historical context of homelessness, and homelessness exists within a larger context of growing inequality and housing insecurity. The two major eras of homelessness—during the Great Depression and the 1980s and continuing today—represent key milestones along an historic upward trajectory in income inequality in the United States (Quigley & Raphael, 2004). The usual suspects—outsourcing of jobs overseas, economic recessions, low service-economy wages—intensified after the 1970s. The post-World War II middle-class flight to the suburbs began to reverse itself with the return of young professionals to colonize and gentrify neighborhoods once a haven for singles and working class families. Unable to pay rising taxes and rents, the latter were funneled toward low-income neighborhoods and the inner city (Wilson, 2012). Thus, "concentrated disadvantage" intensified in American cities (Sampson, Raudenbush, & Earls, 1997, p. 918).

For down-on-their-luck residents facing eviction and homelessness, old standbys were getting harder to find. Public housing units had years-long waiting lists. In New York City, single-room occupancies (SROs) declined by 60% between 1975 and 1981 (Wright, 1989), a turning point in the availability of affordable housing repeated in cities around the country. The usual restoration of jobs at the tail end of the 1970s recession did little to benefit those most in need (Burt & Aron, 2000).

It would be an understatement to say that African Americans fared less well amidst shrinking economic opportunities. The undertow of racism is evident in segregation and discrimination at each juncture, from the initial requirement that public housing developments be segregated to the fierceness of white resistance to integration (Wilkerson, 2011). Related events contributed to racial polarization. For example, draconian drug laws led to widespread incarcerations for low-level offenses and harsher penalties for crack (as opposed to powder) cocaine. A prime example of the effects of intersectionality, race and gender converged to produce a "feminization of poverty" in which women, especially single mothers, bore a disproportionate burden of income deprivation (Brenner, 1987).

Rarely benign in its effects, race consciousness was a not-so-subtle subtext to how the homelessness problem was framed in the 1980s and beyond (Hopper, 2003). The downward and blocked mobility adversely affecting people of color was reproduced and intensified among the homeless. Members of racial and ethnic minorities constitute about one third of the U.S. population, one half of the poor, and almost two thirds of the homeless. African Americans constitute 12% of the U.S. population, about one half of the homeless, and up to 85% of the long-term or chronically homeless (U.S. Department of Housing and Urban Development, 2010). African American women are underrepresented in the homeless adult shelter system but overrepresented in shelters for families.

Sociologists William J. Wilson, Robert Sampson, and their colleagues described inner city neighborhoods of the 1990s as beset by a shrinking job market, high crime, rising rents, and a growing availability of drugs (Sampson et al., 1997; Wilson, 1997). Childhood was lacking in

security and stability—with one or both parents unable to support their families. Turbulent family life meant being on the move, living with relatives, foster parents, or friends. There have always been hardworking, law-abiding citizens living this way. But it was undeniable that more of these citizens were losing their grip on financial stability after the economic recessions of the 1970s.

What happened to make homelessness such a problem in the late 1980s? People have been evicted, succumbed to addiction, and run out of money for a long time without becoming homeless. Demographic changes in the U.S. population after World War II may have amplified the effects of increasing economic disparity (Culhane, Metraux, Byrne, Stino, & Bainbridge, 2013). The adult homeless of the 1980s were born at the tail end of the Baby Boom—one of the largest increases in birth rates in U.S. history. As economic opportunities shrank along with the usual safety net protections, the number of adults vulnerable to homelessness expanded.

Affordable Housing as Federal Government Responsibility

Federal government involvement in building and providing affordable housing began with the New Deal Public Works Administration and the Wagner-Stegall Housing Act of 1937. Cities took over vacant lands and built low-rise apartment complexes for poor and working class families—50,000 new units were built in 1939 alone. In New York City, the first public housing units—known as First Houses—opened in December 1935 in a ceremony presided over by Mayor Fiorello LaGuardia and First Lady Eleanor Roosevelt. Towering housing projects opened in large cities around the United States beginning in the 1940s, their height made possible by the invention of the elevator and architectural designs featuring steel frames and reinforced concrete rather than masonry and stone.

Although the New Deal was steeped in idealism about public works, the post-World War II era ushered in a contraction in government spending on housing. The return of military veterans and the Baby Boom gave rise to unprecedented demand for single-family homes and private developers obliged in meeting this demand as the suburbs spread farther from the city center. Meanwhile, the rising value of urban real estate ran up against growing concentrations of poor and near-poor in inner city areas, especially in the North where thousands of African Americans migrated to escape the Jim Crow South (Wilkerson, 2011).

By the 1950s, cities like Chicago, Milwaukee, Detroit, and Philadelphia were transformed, their European immigrant neighborhoods in demographic transition prompted by Southern migration and race-baited “white flight” to the suburbs. Earlier civic reforms bent on slum removal gave way to urban renewal as these same neighborhoods were targeted for demolition and population displacement. However, a civic duty to replace blight with livable neighborhoods was rarely in evidence; only a fraction of razed homes were replaced by new ones. Public housing developments were built on some of the cleared lands but the open space was more often used for new office buildings and highways linking suburbs and cities (Kusmer, 2003).

President Johnson’s War on Poverty breathed new life into the Federal government’s role in housing and community development—starting the cabinet-level Department of Housing and Urban Development (HUD) in 1965 was a key part of Johnson’s Great Society initiatives. Meanwhile, the endurance of Section 8 of the Housing Act of 1937, a Federal rental assistance

program, kept untold millions from becoming homeless.[1] This voucher program allowed tenants who qualified (had low income) to pay no more than 30% of their income toward rent assessed at fair market value. For some landlords, a Federal guarantee that rent would be paid was attractive but for others, visits from HUD housing inspectors, a cap on fair market rents, and resistance to poor families living in their properties were sufficient grounds for rejection.

Nixon's retrenchment policies and the economic recession of the 1970s put an effective halt to new public housing developments, and the Reagan years added an ideological hardening to this economic rationale. As neo-liberal policies[2] of the late 1970s and early 1980s gained traction, local and federal governments backed away from financing for public welfare—from income supports to affordable housing to health care. This ushered in an era of private market-driven federal housing and tax policies that contributed to homelessness then and up to the present day. Essentially, there was a sharp turn away from supporting public housing to supporting home ownership. Homeowners got deductions for mortgage interest, property taxes, exempted or deferred tax on capital gains from the sale of a home and other perquisites. In addition, real estate investors received deductions for tax-exempt housing bonds, depreciation, and other expenses. Simultaneously, there was a significant reduction in federal housing assistance expenditures such as development of low-income housing or rental assistance.

From 1976 to 2002, housing outlays rose from $7.2 billion to $32.1 billion and the housing assistance budget dropped from $55.6 billion to $27.6 billion (Dolbeare & Crowley, 2007). One of the few exceptions in the general decline of federal benefits has been the availability of disability income such as SSI (Supplemental Security Income) where growth in the number of recipients has been steady over the past four decades.

Disillusionment with urban renewal and high-rise public housing also hastened the decline in Federal investment. The infamous Pruitt-Igoe housing project in St. Louis, Missouri epitomized this. A 33-building complex built in 1954, Pruitt-Igoe became marred by crime, violence, and extreme segregation, its grand demolition televised in 1972 to international audiences. The equation of high-rise living with vandalism and crime was viewed as rendering public housing unsafe for children and families. The solution—to abandon public housing rather than invest to improve it—reaped profits for private developers. The net result was that working class families, the working poor, and individuals on fixed incomes were steadily displaced by upwardly mobile urbanites.

Notwithstanding long waiting lists, deteriorating conditions, and general neglect, public housing keeps many families from the streets and shelters where they might otherwise find themselves. Currently, there are about 1.2 million households in public housing overseen by 3,300 housing authorities (www.hud.gov). There has been no significant increase in public housing units in decades.

[1] The Section 8 program (now called Housing Choice) was a rare instance of government involvement in rental assistance for use in the private housing market. Though funded at levels far below need, such vouchers help millions of Americans to stay housed. For proponents of Housing First, the Section 8 program is a natural fit as it fosters scatter-site living in the private rental market.

[2] The word "neoliberal" is a term of reference for conservative governments of the Reagan–Thatcher era and their policies of market-driven capitalist expansion, deregulation, reduced social programs, and privatization. As non-Western governments adopt such policies, the impact of globalization and rising poverty is attributed to neoliberalism.

Homelessness as a Federal Government Responsibility

The reductions in affordable housing and rising rents permanently "priced out" of the rental market those living on fixed incomes such as disability payments, given that they would need almost 150% of their total income to simply afford a month's rent (O'Hara, 2007). Individuals working at full-time minimum wage jobs would have to hold 3.1 full-time jobs in order for the rent to comprise 30% of their income (Frazier, 2013). One need not be a mathematician to know that eviction is a real possibility for those living on fixed and low incomes—even homeowners without a mortgage must pay taxes, utilities, and insurance.

A pivotal event in Federal Government actions to address homelessness occurred in 1987 with the passage of the Stewart B. McKinney Homeless Assistance Act (renamed the McKinney–Vento Act by President Clinton in 2000 to honor Minnesota Senator Bruce Vento's work on behalf of the poor). The McKinney Act offered 350 million dollars in funds in its first year to enable states, along with public and private organizations, to open and operate emergency food and shelter programs for homeless persons.

Provisions of the Act included support for education of homeless adults and children, job training, demonstration projects in mental health and substance abuse for homeless persons, and sustainable funding for the pilot Health Care for the Homeless (HCH) program. This represented a fraction of what was needed to address the problem—and the bulk of funding was targeted to the needs of homeless families rather than single adults—but it was a start.

Last but not least, the Act included the creation of the United States Interagency Council on Homelessness (USICH), a consortium of 20 Federal agencies including HUD. The USICH was left unfunded and remained without staff under President Clinton and then HUD Secretary Andrew Cuomo; it was essentially dormant from 1988 until 2002. Then, in 2002, President G. W. Bush appointed Philip Mangano to head USICH. Mangano, a Massachusetts Republican and former director of the Massachusetts Housing and Shelter Alliance, had long advocated for the abolition of homelessness.

There were plenty of other distractions for the Bush administration, including the aftermath of the September 11 attacks and the war in Iraq, but this appointment reverberated widely among homeless advocates as an unusual sign of attention from the President. The Wall Street Journal referred to it as a "Nixon-goes-to-China" reversal of policy in which $4 billion annually was pledged to HUD and the effort to address homelessness (Vitullo–Martin, 2007). Ever the entrepreneur, Mangano used his bully pulpit for homeless advocacy and gave it a Federal imprimatur.

From Single-Room Occupancy to Emergency Shelters to Transitional Housing

In larger American cities, single-room occupancy buildings (SROs) were one of the few viable options for those living on the margins. An SRO is typically a large building consisting of dozens of small rooms containing a bed, a dresser, and a hot plate; the shared bathroom is down the hall. SROs afforded a place to keep one's possessions, stay warm in the winter, and have a bit of security and privacy at a low cost. The deterioration of SROs may have seemed inevitable given rising real estate prices and urban renewal, but their tarnished reputations and inadequate upkeep by their owners did little to endear them to city authorities. Moreover, as elderly SRO residents died off and some SROs became vacant, the buildings decayed further.

Without the SRO safety net (however tattered and shrunk in size by the 1980s), cities and communities grew desperate to address a problem that was no longer hidden from sight. Most cities set up temporary shelters and specialty programs such as outreach teams, drop-in centers, and safe havens to engage those among the homeless with psychiatric disabilities. In New York City, massive fortresses like the Fort Washington Armory—with a peak count of 1,000 men each night—were repurposed with cots lined up 18 inches apart on the vast open drill room floor. Such crowded conditions violated United Nations standards for refugee camps. Box 2.1describes the early days of the homelessness crisis in New York City.

Box 2.1 The New York City Experience in the 1980s

Land-scarce and surrounded by rivers and oceanfront, New York City has long endured shortages of housing and near-record occupancy rates. But the city in the 1970s suffered an acute case of urban decay, increasing crime and middle-class abandonment. Movies like Midnight Cowboy, Needle Park, Fort Apache, the Bronx, and The French Connection captured this gritty reality Hollywood-style. Graffiti-covered subways rumbled over- and underground, drug markets thrived on street corners, and the South Bronx looked like a postapocalyptic movie set. Along with San Francisco, New York was the epicenter of the AIDS epidemic of the 1980s, a plague that spread through the gay community and on to poor neighborhoods.

When drug dealers, faced with a glut of cocaine, developed a solid smokable form in the early 1980s, crack cocaine became one of the greatest successes in the history of drug marketing. Delivering an intense high at a low price (as little as $5 for a small “rock”) meant that cocaine now ceased being a drug solely for the affluent, who continued to buy it in powder form. Starting in Los Angeles and Miami, crack spread quickly to the populous cities of the North. Crack addiction was devastating to poor minority communities, contributing to a rise in violent crimes, thefts, and burglaries. Although oversold as a cause of urban problems of the 1980s, there is little doubt that crack addiction sent many poor Latinos and African Americans over the edge into homelessness (Bourjois, 1996).

Complementing public shelter provision was a network of churches and synagogues that organized volunteers to serve an evening meal and accommodate about a dozen homeless guests on any given night. The guests would sleep on cots in the vestibule or basement of the building and as in city shelters they were required to leave the premises by dawn. This private voluntary network offered smaller, less dangerous venues for women and the elderly, but these were few and far between and “guests” were carefully screened.

Visitors to the public shelters were also immediately struck by the clearly intended message of enforced transience. Cots were lined up in rows, there was no storage space for personal belongings, meals consisted of little more than hot coffee and a cold sandwich, and clean bathrooms were in short supply. Possessions had to be closely guarded under the cot or pillow and residents had to leave the shelter early each morning and were permitted to return only at night. Shelter staff and security guards had little training; reports of theft, sale of contraband, or violence were common.

With crowded, unsanitary, and dangerous conditions, frustrations rose and fights often broke out. Weaker residents were preyed upon. AIDS, hepatitis, and tuberculosis (TB) were common along with the usual respiratory problems, injuries, and skin infections. This was the environment

where a strain of treatment-resistant TB first appeared, alarming residents, staff, and the general public. These conditions led to a seemingly irrational but entirely reasonable choice to stay away from the city shelters except under dire circumstances, like a freezing-cold winter night.

However unpleasant they might have been, the shelters were filled to overflowing in the 1990s, a reflection of the numbers of new homeless, given that the majority of shelter residents stayed only a few days then found some place else to go. Those unable or unwilling to enter shelters sought help in other ways, visiting soup kitchens and crowded drop-in centers where they might take a shower, store some of their belongings, and nap on a chair.

Stability in funding for the shelter system was made possible by McKinney funds and dollars from state and local governments. A profound shift took place, however, in homeless services that allowed providers to go beyond emergency accommodations—not abandoning these altogether but supplementing them with longer-term housing combined with services. A stay in such a shelter was expected to last 30 days, more or less. Transitional housing could be offered for one or two years, sometimes longer (Ellen & O'Flaherty, 2010).

New York City and New York State led the way in making available new sources of funding for nonemergency supportive housing, but this came with a price. The historic 1990 New York–New York (NY/NY) Agreement called for 3,615 units of permanent and transitional housing for homeless mentally ill people in New York City. After delays prompted by disagreements over jurisdiction and funding, Mayor David Dinkins and Governor Mario Cuomo signed the agreement, an unprecedented collaboration between city and state. The price of such an agreement lay in its narrowing of eligibility to persons who are mentally ill among the homeless.

This was a politically strategic decision for a couple of reasons. First, the visibility of psychotic individuals on city streets, though hardly representative of all homeless persons, fueled public demands for more concerted action. Second, New York State's Office of Mental Health had a multibillion-dollar budget that was being reconfigured as state psychiatric hospitals were closed or being closed by the late 1980s. Although community mental health centers remained underfunded (and a few expensive upstate hospitals stayed open due to political pressure), there were state and city mental health dollars available when the political will was forthcoming.

The NY/NY agreement channeled state and city mental health funds to nonprofit organizations that won successful bids to build or renovate congregate residences with some additional scatter-site independent apartment units covered by rental subsidies. Prior to NY/NY, the State had mostly funded group homes, adult homes, and in some instances nursing homes for residents discharged from state psychiatric hospitals. Providing permanent housing with supports represented a new philosophical and practice approach for the state's outdated mental health services. The use of these state funds for capital improvement and the city's issuance of municipal bonds to build or renovate housing also marked a new era in government resourcefulness and cooperation in providing for the homeless.

Steeped in New York's traditional liberalism in public assistance, the NY/NY agreement met with little overt opposition. But public generosity did not always extend to the neighborhoods where these projects were slated to be developed, as local groups protested "not in my back yard" (NIMBY) and expressed concerns about safety and lower property values. The politically influential, wealthier neighborhoods were able to resist these programs; new projects were typically placed in mixed-use areas or low-income neighborhoods.

It is worth noting that the construction and occupancy of the NY/NY-funded units did not reduce the number of people who were homeless according to annual street counts. As soon as some left homelessness, there were new entrants to take their places—and more. Less obvious was the fact that these new supportive housing programs used admissions criteria that were very demanding. Initially, applicants were required only to have a history of homelessness and a serious mental illness. Because these criteria applied to a very large pool of applicants, however, providers saw a need to narrow the admissions criteria. Most were new operators of supportive housing but they fully understood that their program's survival depended on maintaining a full census.

Ensuring that applicants would be reliable tenants meant screening for those who would not create a nuisance, need to be evicted, or disturb others in the building. Thus the successful applicant was one who was in treatment, medication compliant, did not use substances, and was willing to abide by the program rules. This screening for well-behaved tenants increased the proportion of more troubled and addicted men and women remaining on the street. Housing providers had plenty of terms for these people: "not-housing-ready," "hard-to-house," "housing resistant," and "treatment resistant" among others. Eventually, such persons also came to be known as the "chronically homeless."

Box 2.2 New York City in the 1990s: Crime, Squeegee Men and Giuliani

By the mid-1990s, rising crime rates were equated with homelessness (despite the absence of data to support this notion) and patience in some quarters was wearing thin. New York City's Rudolf Giuliani staked his successful 1994 mayoral campaign on law and order, in particular promising to rid the city of "squeegee men," the mostly African American men who frequented the city's busy traffic intersections, performing unsolicited windshield washings and expecting cash in return. Newspapers inflamed public hostility with stories of aggressive panhandling and public attitudes toward the homeless were souring.

Guiliani's police crackdown focused on lifestyle offenses—fare beating, public intoxication and trespassing—based upon the famous "broken windows" theory of criminology (Kelling & Wilson, 1982). Research has since called this into question (Harcourt & Ludwig, 2006) but the perception that police crackdowns for small offenses also tamped down serious crimes has stuck around. For the homeless, this was less about crime-fighting than criminalization.

Criminalizing the Homeless

New York City Mayor Guiliani's law and order rhetoric and "broken windows" policing became popular in many cities in the United States in the 1990s (see Box 2.2 for more on this subject). Yet most of the crimes committed by the homeless were minor offenses necessitated by their condition: theft of service (e.g., jumping the turnstile to ride the subway); theft of goods (e.g., stealing groceries); indecent exposure (e.g., urinating in public); or trespassing (e.g., sleeping in a public space). Once homeless men or women are charged with one of these offenses, the criminal justice system sets up a cascade of events that do not bode well for them (O'Sullivan, 2012). First, the fine goes unpaid. With no fixed address, the defendant never receives the notice to appear in court and misses the hearing date. Next, a bench warrant is issued and on the next encounter with the police the person is arrested and jailed. Without the cash for bail (sometimes as little as $10) homeless persons spend weeks and months in jail (at a cost to taxpayers of several hundred dollars a day).

The criminalization of homelessness in combination with woefully inadequate mental health care transformed many city jails into de facto mental institutions for the homeless. Seeing erratic behavior on the street and having little to do besides make an arrest, police officers treat a jail stay as the least problematic response to local complaints. In contrast, the crimes to which the homeless were subjected—physical and sexual assault, theft, confiscation and destruction of their belongings—were of less public concern.

Cities found creatively punitive ways to discourage people from sleeping rough and an urban phenomenon of "hostile architecture" flourished in the United States and abroad (Quinn, 2014). Benches were redesigned with armrests or uneven surfaces to prevent reclining; low border walls had fencing or planters along their surfaces to prevent sitting. Use of security fencing, razor wire, and "no trespassing" signs went up as did security cameras and guard services. A social media storm erupted in June 2014 when a luxury apartment building and nearby grocery chain in London installed metal spikes on the surfaces of doorways and entrances to discourage "anti-social behavior." After petitions and online protests, the spikes were removed.

Under stricter antivagrancy laws, libraries and other public buildings forbade lingering too long or sleeping on the premises (although more tolerant communities resisted this). Public-access toilets became harder to find as shops and restaurants restricted use to paying customers. Abandoned buildings, attractive to squatters and the homeless, were sometimes violently vacated by fire departments or city officials.

Box 2.3 The Los Angeles Experience: Skid Row

Los Angeles's Skid Row, for over 100 years a destination for the poor, homeless, and addicted, was home to faith-based missions that provided charity as well as personal redemption. Located not far from the downtown business district, the area was largely left alone until the 1980s when the growing numbers of homeless led city officials to order police crackdowns and destruction of the camps. The rights-based litigation and advocacy that ensued kept Skid Row intact and the missions empowered as advocates and service providers.

This policy of containment and segregation continued as downtown LA began to gentrify and attract businesses and affluent residents in the 1990s. A few blocks from the vast canyons of sleek office buildings and luxury condominiums, Skid Row is unique. There is no greater concentration of homeless adults in America, about 5,000 give or take. Visitors—mostly social service workers and a few curious tourists—enter 50 square blocks of shopping carts and tents filled with personal belongings and hoardings, of people sitting or sleeping, intoxicated or sober, waiting in lines at the missions for food or services. Skid Row is predominantly African American even though African Americans comprise only 9.8% of the city's population.

Los Angeles's policy of segregating and corralling the homeless in Skid Row (see Box 2.3) represents a scaled-up version of 19th-century practices—tolerating a Bowery or run-down district where vagrancy and sleeping rough were allowed as long as these practices did not spread to other parts of the city. The more common response by cities was to disperse their homeless shelters and use assertive outreach teams to convince or cajole street homeless to go to these shelters. Of course, "dispersing" was not random—zoning ordinances and NIMBY-ism ensured that shelters were located in lower-income (or more tolerant) neighborhoods. Some communities complained of becoming service ghettos, hosting a disproportionate number of half-way houses, congregate residences, or mental health and methadone clinics.

Box 2.4 An American Way of Changing Policy: Litigation as Advocacy

A lesser-known benefit of the litigious bent in American society is the rapidity with which social change can be mandated by a court order. The U.S. Supreme Court's 1972 Roe v. Wade decision swept away most restrictions on abortion in the United States and its Brown v. Board of Education in 1954 mandated school desegregation. The 1979 Callahan v. Carey court decision was a defining moment for New York City's homeless, binding the city to a legal right to shelter that continues at this writing. This legacy of bringing about change via litigation has been a prime tactic of legal advocates such as the American Civil Liberties Union (ACLU).

A recent case in point is Miami, Florida and its strategy of using arrests as a means of evicting homeless men and women from its revitalizing downtown business district. Beginning in mid-2013, attorneys for the local ACLU challenged the city, citing a previous court decision designed to protect the rights of the homeless. This 1998 settlement (Pottinger et al. v. City of Miami) was the culmination of a class action lawsuit and a decade of litigation involving two trials, two appeals, and almost two years of mediation in which a federal court found intentional and systematic violations of the constitutional rights of homeless persons in Miami. The agreement afforded protection in carrying out "life-sustaining misdemeanors" such as sleeping, erecting a tent in a park, and urinating in public if a toilet was not available.

By 2013, the city's downtown business leaders were urging a clampdown on the hundreds of homeless men and women living in parks and on sidewalks. Miami police stepped up arrests for minor infractions—all violations of the Pottinger agreement—and seized and demolished campsites and belongings.[3] Negotiations between the ACLU and the city bogged down as the city proposed to bus homeless persons to a shelter miles away. Measuring the distance to a public toilet, a trash receptacle, or a shelter was the metric for determining whether an arrest could be made.

Ascertaining what constituted "available shelter" was a major sticking point. The city sought to expand the definition to include shelters that imposed mandatory mental health and drug addiction treatment (prohibited under the Pottinger agreement). Helping to support the city's case, a local religious shelter offered open-air mats for sleeping as appropriate for shelter referrals (along with treatment mandates).

The ACLU attorneys countered with "Housing First" as the evidence-based standard against which the city was falling short. The case drew to a close when a judge-mediated agreement was reached in November 2013. With some minor concessions, the Pottinger protections remain in place until 2016. For the longer-term, the Miami-Dade County Homeless Trust embarked on a major shift in strategy focusing on Housing First with the goal of ending chronic homelessness by the end of 2015.

A Homeless Services Institutional Complex (or a Homeless Service "Industry") is Born

The homelessness crisis of the 1980s and subsequent governmental response set the stage for explosive growth in outreach, shelters, transitional housing, and support services in American cities. Such largesse did not extend to the general population of the poor—Reagan-era cuts in entitlements were followed by Clinton-era welfare reform (known as "workfare") in the mid-1990s. In this context, it is remarkable that the homeless received a measure of public

[3] Information on the ACLU-Miami legal standoff—all public documents—was available through the first author's preparation as an expert witness.

sympathy and financial support, though conditionally given and temporary in nature. As described in Box 2.4, policy changes were not always prompted by legislative mandates. Indeed, the successful use of litigation on behalf of homeless persons could produce sweeping mandates.

The era of local responses to homelessness gave way to large-scale efforts and a vast industry of homeless services came into being. This was not a matter of planning or coordination; it was willy-nilly in its evolution but coalescent nonetheless. Closely resembling Willse's (2010) "non-profit industrial complex" and Stid's (2012) "social services industrial complex," this "homeless services institutional complex" comprised a self-perpetuating system (the term "institutional" used to indicate that levels of government and governmental organizations worked together with nonprofits in cross-institutional collaboration). Providing services to and for the homeless becomes an end in itself, sustaining thousands of jobs for those working in the "industry."

What began as service silos for various needs (e.g., mental illness, substance abuse, the lack of food and shelter) were joined together by a common thread of first temporary then stable streams of funding. State mental hospitals, public hospitals, community mental health clinics, and rehabilitation centers were joined by a burgeoning number of shelters, drop-in centers, soup kitchens, and food pantries. Along with jails and hospital emergency rooms, these became stopovers on an "institutional circuit" (Hopper, Jost, Hay, Welber, & Haugland, 1997) traversed by homeless men and women.

As the number of homeless adults increased, government agencies responded by aggregating temporary housing with services and supervision under (often literally) the same roof. New programs sprang up and existing ones grew to meet demand by building and renovating properties, while hiring more staff to secure grants and service contracts. This growth—in needs, in services, in jobs—was especially evident in large cities (U.S. Department of Housing and Urban Development, 2010). In the smaller cities and towns of America affected by homelessness, the "industry" emerged in the form of shelters, rescue missions, and soup kitchens.

Conclusion

The homeless services institutional complex had a cultural logic as well as norms and taken-for-granted behaviors. Owing much to institutional entrepreneurs with divergent motivations and constituencies, the complex evolved into an unwieldy yet curiously unified service system. The complex was fragmented enough to allow an innovative upstart such as Pathways to emerge but cohered sufficiently to present resistance to the changes wrought by the HF approach. Neo-institutional theory renders both action and reaction understandable but offers little in the way of predicting the course of change once the process is underway. . .

CHAPTER 5: CONTEMPORARY HOMELESSNESS IN MIAMI

After decades of research on the characteristics of persons who are homeless, one of the most common findings is the heterogeneity of the overall population (Burt et al. 1999; Burt et al. 1999; Rosenheck, Bassuk, and Salomon 1998). While persons who are homeless share the common traits of poverty, poor access to affordable housing, and personal difficulty, they are incredibly varied when it comes to demographics, backgrounds, and characteristics. The nationwide heterogeneity of the homeless population holds true in Miami as well, with the homeless population comprised of a diverse mix of race, ethnicity, gender, age, family status, and personal characteristics including traumatic backgrounds and substance abuse, mental health, and medical problems. Of course, one would probably expect Miami's homeless population to be particularly diverse, given that the Miami-Dade County area is one of the most racially and ethnically diverse counties in the country, with a majority minority population that is now 65% Hispanic, 15% black, and 19% white non-Hispanic. The majority (52%) of residents were born in a foreign country, with 94% of those from Latin America (Cruz and Hesler 2011). Yet, the homeless population is diverse in a different way, and is not reflective of the racial/ethnic breakdown of the overall county. Blacks are significantly overrepresented in this subpopulation, as are single males. This chapter examines the overall demographics and characteristics of the homeless population, focusing on single, adult males. It seeks to answer Research Question 1: In Miami-Dade County, do black and Hispanic men who are homeless or at risk of homelessness have different personal characteristics and different experiences in avoiding and/or exiting homelessness? Specific hypotheses to be tested address differences between blacks and Hispanics

regarding risk of becoming literally homeless; characteristics and needs, including disabilities; destination upon exiting programs; expressed needs; spatial distribution; and outcomes upon completing programs.

5.1 Overview of Miami-Dade Homeless Population

In 2011, more than 15,000 individuals were homeless in Miami-Dade County at some point during the year (Miami-Dade County Homeless Trust 2012b). This number represents the 15,077 unduplicated individuals who have records in the County's Homelessness Management Information System (HMIS), which means they were served at least one time by an agency providing emergency, transitional, or permanent supported housing. There are 27 agencies that receive some type of funding through the Miami-Dade County Homeless Trust and are required to enter data on clients served into this HMIS system. Thus, the 15,077 figure represents the number of persons served in Trust-funded agencies, but does not include those served by other provider agencies external to the continuum of care network, or individuals who have had no contact with the homelessness system at all. So, it can be assumed that the real number is actually higher. On the other hand, it is also possible that some of the HMIS client records are actually duplicates, as some providers may have failed to follow procedures for sharing records between agencies and may have created a second record when an individual changed programs. Nonetheless, this figure provides a good starting point for analysis.

Amongst those individuals served in 2011, 11,808 were male or female adults. For purposes here, the time frame for analysis was expanded to cover the time period from June 2010 through December 2011, limited to all single males who were served in an emergency, transitional, or permanent housing program. This 18-month period

includes everyone who was in a program for any period during that timeframe, whether they entered, exited, or simply remained in the program throughout the duration of those 18 months. The total number of duplicated subjects for the 18-month period was 8,940, which included 7,605 unduplicated subjects. A total of 88 records for individuals who did not fall into any of the targeted racial/ethnic groups represented less than 1% of the population and were removed rather than listed as "other."

Table 2 below shows the racial/ethnic breakdown of persons who are duplicated in the system because they entered a homeless program more than one time. This includes persons who entered the same program more than once (i.e., they moved in and out of emergency shelters over time).

Table 2: Repeat entries into homeless system for homeless males in Miami-Dade

Repeat Entries into System				
Entries into System	**Black**	**Hispanic**	**White**	**Total**
One entry	3580	1949	1037	6566
% within race/ethnicity	73.5%	72.1%	76.1%	73.4%
Two or more entries in programs*	571	323	145	1039
% within race/ethnicity	11.7%	11.9%	10.6%	11.6%
TOTAL	**54.6%**	**29.9%**	**15.5%**	**7605**

*Denotes that columns are significant with Chi-Square test $p<.05$
Source: Miami-Dade County HMIS Records, Homeless Males 2010-2011

Hispanics are more likely than blacks or whites to have entered the system more than once (with a Pearson Chi-Square significance $p<.01$), although the actual percentage difference is relatively small, at 11.9% versus 11.7% for blacks. Amongst persons who were entering the system for the second time, more than 80% were entering an emergency housing program, suggesting that the majority of these were not persons who

were moving up in the system, but rather were re-entering after having failed the first time.

Throughout this analysis, data regarding *individual* characteristics is drawn from the unduplicated count to provide an accurate depiction of the population served. Data relating to *program* participation and outcomes is drawn from the duplicated set, so that differences in program experience are captured. Thus, an individual who was served in an emergency program and then later in a treatment program would be counted once in the overall demographic analysis, but two times or more (once for each program) when reviewing program-level data.

In most cases, the national data utilized for comparison purposes are drawn from HUD's report (ABT Associates 2011) on the 2009-2010 nationwide HMIS data provided from every continuum, which includes the exact data set used for the Miami information. Thus, it provides an excellent means of comparison. In general, the demographics of the average homeless individual in Miami correlate with demographics of the homeless population at the national level, although in aggregate Miami's racial/ethnic disparities far exceed national rates.

5.2 Race and Ethnicity

Individuals were grouped into three racial/ethnic categories, by combining the separate variables for race and ethnicity. The three combined categories were: *Black* (includes all Black/African-Americans, including Hispanic); *Hispanic* (includes all Hispanic racial groups except for black); and *White* (non-Hispanic only). A small percentage of individuals (less than 1%) who did not fit into any of these categories, including those who refused to answer, were not included.

The racial/ethnic breakdown of single, homeless males was 54.6% black, 29.9% Hispanic, and 15.5% white. As shown by Table 3 below, this is extremely disproportionate from the overall racial/ethnic breakdown of the general population in Miami-Dade County, even when controlling for extreme poverty. It is also disproportionate from the nationwide population of single homeless adults, which is 34.5% black, 8.5% Hispanic, and 47.2% white (HUD ABT Associates 2011).

Miami provides a particularly extreme example of the steady increase in the over-representation of blacks as poverty increases. Blacks constitute 17.6% of the county's overall population and 29.7% of the population living in extreme poverty, yet constitute 54.6% of the homeless population. On the other hand, Hispanics comprise nearly 60% of the county's overall population and 50.6% of those living in extreme poverty, but only 30% of the homeless population. Whites are 21% of the county population but only 15% of the homeless population. Thus, it is clear that the safety net for blacks in Miami is not functioning as well as it does for other racial and ethnic groups.

Table 3: Racial/Ethnic Make Up of Miami-Dade Population Compared to Local and National Homeless Population

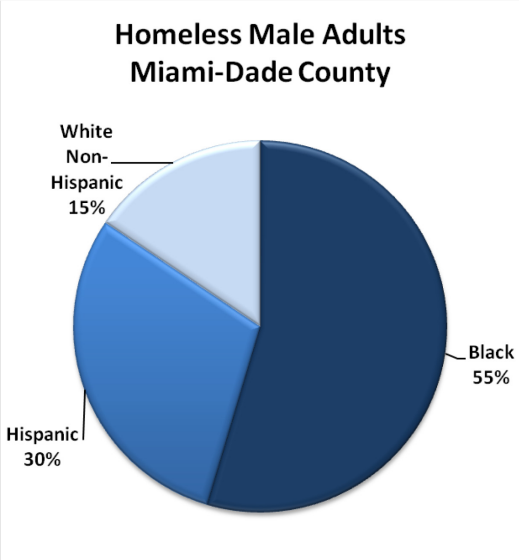
	White	Black	Hispanic (all races)	Other Minority	Total	Estimated Population
Miami-Dade County gen[1]	15%	17.2%	65%	2.8%	100%	2,434,465
Countywide Poverty (at/below 100%)[2]	13.7%	26.5%	58%	1.8%	100%	325,514 (13.7% pop)
Countywide Extreme Poverty (at/below 50%) [2]	17.7%	29.7%	50.6%	2.1%	100%	166,321 (7% of pop)
Miami-Dade Homeless Males [3]	15.5%	54.6%	29.9%	N/A	100%	7605 (18-mos)
Homeless Single Adults (national) [4]	47.2%	34.5%	8.5%	9.9%	100%	1,043,042 63% of homeless
National Poverty[4]	45.5%	22%	16%	16.6%	100%	

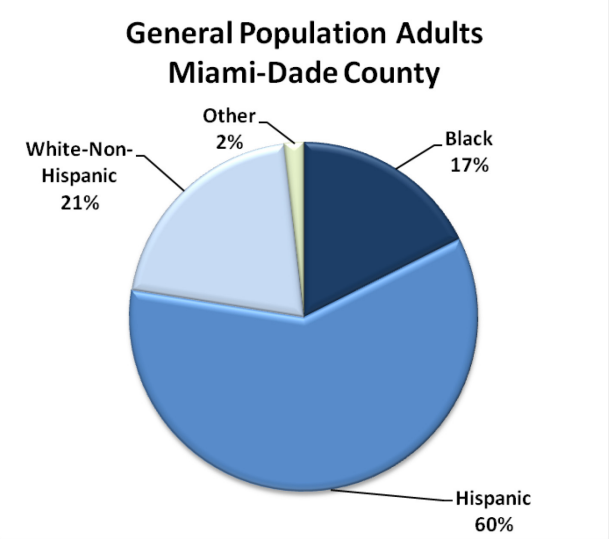
[1]US Census/American Community Survey 2010 – Miami-Dade County Summary (Cruz and Hesler 2011)
[2] US Census/ American Community Surveys 2005 (Ruggles et al. 2007)
[3] Miami-Dade County HMIS June 2010-December 2011. ("Other minority" < 1% so not included).
[4] US HUD Annual Assessment Report Oct 2009-Sep-2010. Figure includes male and female adults.

Disparities at the national level appear in a different manner. The proportion of whites within the poverty population is nearly identical to proportion in the homeless population. While the overall minority population is the same for poverty and homelessness, it diverges when separating blacks and Hispanics. In that case, as in Miami, blacks are overrepresented in the homeless population and Hispanics are underrepresented, compared to the poverty population. However, the disparity is at a much lower level than seen in Miami.

Figure 3 provides a visual illustration of the significant disproportion between the percentage of male and female adults in Miami-Dade County who are black or Hispanic, versus the percentage who become homeless.

Figure 3: Racial/Ethnic Make-Up of Miami-Dade Homeless Population Compared to General Population





[1] Source: Miami-Dade County HMIS 2010-2011

[2] Source: ACS 2010 Miami-Dade County

This disproves the null hypothesis (1A): Blacks are at greater risk of becoming literally homeless than are Hispanics, even when controlling for income level prior to homelessness. In fact, amongst the general population, blacks are 6.2 times more likely to become homeless than Hispanics. Amongst the population of persons living in extreme poverty, they are *3.1 times more likely to become homeless* than Hispanics. These figures regarding the disparity in likelihood of becoming homeless suggests that factors beyond poverty and income play a role in determining why blacks become homeless at a greater rate than Hispanics.

5.3 Characteristics and Disabilities

Age

The average age of a homeless male in Miami is 46. Ages range from 18 to 92. Two-thirds fall between the ages of 25-54, with more than a quarter (26%) being over 55. Hispanics are older than their black and white counterparts, with a mean age of 47.8, and over-representation amongst the elderly group over 55 (31.7%) (chi-square pearson test significant at $p<.001$). Miami's homeless population is clearly not a young population, having an average age of 46, with nearly a quarter being age 55 or older and only 6.8% under age 25. Miami's homeless population is also older than the national homeless population, which has only 17.1% over age 50 (ABT Associates 2011). The implications are that Miami may expect to see greater health needs and a higher level of disabilities that come with an aging population.

Table 4: Age Distribution of Homeless Men in Miami-Dade

	Black		Hispanic		White		Total	
Mean Age	45.5		47.8		46.8		46.4	
Range	18 - 86		18 - 92		18 - 85		18 - 92	
Age Groups	#	% within race	#	% within race	#	% within race	#	
18-25	311	7.5%	127	5.6%	76	6.4%	514	6.8%
26-54	2851	68.7%	1425	62.7%	788	66.7%	5604	66.6%
55-64	857	20.6%	523	23.0%	271	22.9%	1651	21.7%
65+	132	3.2%	197	8.7%	47	4.0%	376	4.9%
Total	4151	100%	2272	100%	1182	100%	7605	100%

Source: Miami-Dade County HMIS, Homeless Males 2010-2011

Veteran Status

The percentage of males who are veterans within Miami-Dade's homeless population (11.2%) is nearly the same as it is nationwide (11%) (National Alliance to End Homelessness 2012). Within the 7,605 HMIS cases, 119 were missing data; of the

remaining, 11.2% had marked that they were veterans. It is possible that in some of the records where "No" was answered, the question was not actually asked but the field still filled in.

Table 5: Veteran Status amongst Homeless Males in Miami-Dade, by Race/Ethnicity

Veteran Status	Black	Hispanic	White	Total
# Yes (frequency)	516	115	207	838
# No (frequency)	3572	2133	943	6648
Total Population	4088	2248	1150	7486
% YES within race/ethnicity*	12.6%	5.1%	18%	11.2%

*Denotes difference is significant at Pearson Chi-Square p<.001
Source: Miami-Dade County HMIS, Homeless Males, 2010-2011

The percentage of individuals who are veterans varies between all the racial/ethnic groups at a significance level of .001, with 18% of whites, 12.6% of blacks, and only 5.1% of Hispanics being veterans. The difference in veteran status is relevant to this study, as it affects an individual's access to veterans' benefits, including both cash and non-cash benefits. Whites are much more likely to be veterans than other racial groups within the homeless population, with nearly 1 in 5 white homeless persons being a veteran.

Disabilities

Single males who are homeless in Miami-Dade County suffer from serious disabilities in large proportions. More than three quarters (78%) have at least one serious disability. Data regarding prevalence of disabilities is drawn from the number of men who have at least one disability recorded in their HMIS record, with the disability being one of several that meet HUD's criteria: alcohol abuse, drug abuse, mental health disorder, medical/health problems (including HIV/AIDS), and/or other disabilities including developmental disabilities, vision, and hearing impairments.

When examining presence of disabilities, it is useful to separate out persons who are "sheltered" in an emergency, transitional, or institutional setting, compared to those who are living in a permanent supported housing program (See Table 6), because the way HUD categories persons in permanent housing is correlated with disability status. We would expect the number of persons with disabilities in permanent programs to be higher, as HUD requires the presence of a qualifying serious disability in order to live in many of its permanent programs. Typically, individuals who are ready to move into permanent housing but who lack a qualifying disabling condition would move into market-rate housing or housing subsidized by a non-homeless program, including HUD's Section 8 program, tax-credit funded affordable housing projects, or temporary rent-assistance programs. However, individuals who enter any of those program types are no longer tracked in the HMIS system and thus do not appear in this data set. Note that for the one-on-one interviews conducted for this study, discussed later in this chapter, formerly homeless individuals living in these non-homeless programs were included.

Table 6: Prevalence of Disabilities Amongst Miami-Dade Homeless Males, by Race/Ethnicity

	Black	Hispanic	White	Total
Sheltered in Emergency/Transitional (Non-Permanent)				
Any Disability	67.0%	64.3%	67.0%	66.2%
Alcohol Abuse*	26.0%	20.7%	32.5%	25.5%
Substance Abuse*	44.4%	29.7%	28.6%	37.6%
Mental Health*	29.5%	35.2%	31.4%	31.5%
Medical Problem	27.0%	27.5%	27.3%	27.2%
Living in Permanent Housing Program				
Any Disability	90.8%	93.0%	92.8%	91.8%
Alcohol Abuse*	31.7%	16.5%	27.6%	26.0%
Substance Abuse*	49.4%	23.0%	32.2%	38.3%
Mental Health*	54.2%	75.9%	74.3%	64.0%
Medical Problem	38.1%	32.8%	25.7%	34.9%

*Denotes difference is significant with Pearson Chi-Square P<.01
Source: Miami-Dade County HMIS, Homeless Males, 2010-2011

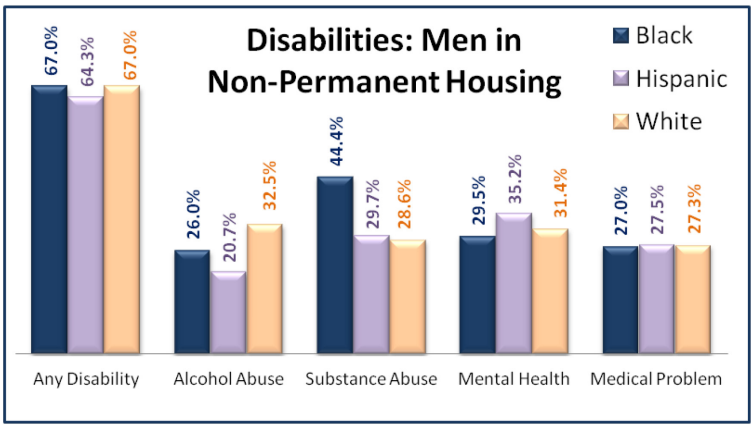
Nationwide, only 36.8% of homeless adults in shelters or non-permanent housing programs have a serious disabling condition (HUD ABT Associates 2011) compared to 66.2% in Miami. Homeless men in Miami are almost twice as likely as homeless individuals nationwide to have a disabling condition recorded in their HMIS record. For those in permanent housing programs, Miami has 91.8% compared to 78.8% nationwide.

While there is no significant difference between racial/ethnic groups regarding the likelihood that at least one disability will be present, we do see significant disparities in the disability *types* between racial/ethnic groups. For persons in emergency or transitional programs (i.e. non-permanent) each of the following test significant with Pearson Chi-Tests at p<.001 (See : Figure 4 and Figure 5)

- White are more likely to have an alcohol abuse problem than Hispanics or blacks, and Hispanics are less likely to abuse alcohol than blacks;

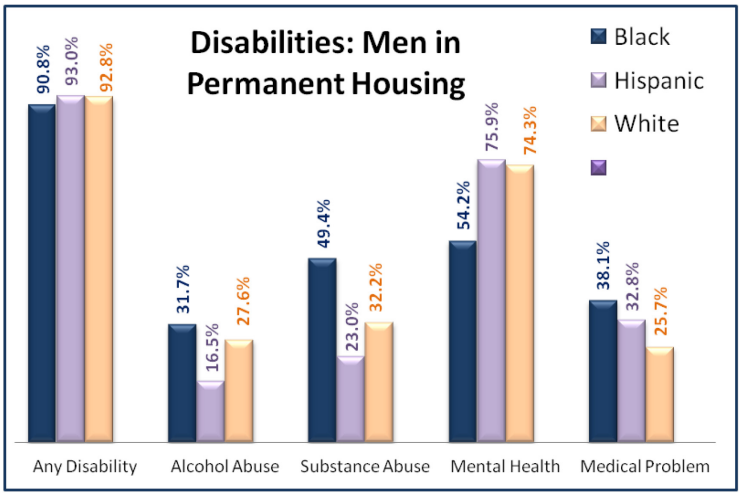
- Blacks are more like to have a substance abuse problem than Hispanics or whites;
- Hispanics are more likely to have a mental health disorder than are blacks or whites;
- There are no significant differences between those with medical or other disabilities.

Figure 4: Disabilities Amongst Men in Non-Permanent Housing Programs



Source: Miami-Dade County HMIS, Homeless Males, 2010-2011

Figure 5: Disabilities Amongst Men in Permanent Housing Programs



Source: Miami-Dade County HMIS, Homeless Males, 2010-2011

5.6 Program and Housing Outcomes

Considering that homeless men living in shelters, transitional, and permanent housing programs present with different demographics, disabilities, and needs, it is reasonable to ask whether they experience different outcomes. Table 9 describes where individuals went upon discharge from emergency shelters. The choices available in the HMIS system were condensed into seven categories: Street/Unknown; Emergency or Transitional Programs; Permanent Subsidized Housing (including supported homeless programs, Section 8 vouchers, or other subsidized options); Independent Housing (rental or ownership without a subsidy); Family; Treatment (substance abuse and

mental health treatment facilities); or Other (including hospitals, jails, or other). This table focuses on individuals leaving emergency shelters, as that is the first step in leaving the streets, and the destination upon leaving the shelter is vital to determining whether they will succeed in attaining permanent housing.

Table 9: Homeless Men's Destination Upon Exiting Emergency Shelter in Miami-Dade

	Black	Hispanic	White	TOTAL
	Count (% within race/ethnicity)			
Street/Unknown	1564 (47.5%)	877 (47.5%)	486 (51.0%)	2927 (48.1%)
Emerg/Trans Program	368 (11.2%)	202 (10.9%)	103 (10.8%)	673 (11.1%)
Permanent Subsidized	155 (4.7%)	89 (4.8%)	33 (3.5%)	277 (4.5%)
Independent*	**265 (8.1%)**	**189 (10.2%)**	**59 (6.2%)**	**513 (8.4%)**
Family*	**260 (7.9%)**	**195 (10.6)**	**91 (9.5%)**	**546 (9.0%)**
Other	387 (11.8%)	219 (11.9%)	137 (14.4%)	743 (12.2%)
Treatment*	**291 (8.8%)**	**74 (4.0%)**	**44 (4.6%)**	**409 (6.7%)**
TOTAL	3290	1845	953	6088
	100.0%	100.0%	100.0%	100.0%

*Denotes differences are significant with Chi-Square P<.01
Data Source: Miami-Dade County Homeless Trust HMIS records 2010-2011

Approximately half of men leaving shelters return to the streets, with no significant disparity amongst racial/ethnic groups. Significant differences do appear, however, in the group of men who transition into independent living or go to live with family, with Hispanics being more likely to access those options than blacks. Additionally, blacks are more than twice as likely as Hispanics (8.8% versus 4.0%) to enter a substance abuse treatment program.

These data disprove the null hypothesis, that single men exiting homeless programs in Miami-Dade County go to similar destinations when broken down race/ethnicity. Rather, it appears that Hispanics are more likely to go to independent living or to live with family, while blacks are more likely to go to a treatment program.

Given that blacks suffer from addiction at greater rates than Hispanics, the fact that more go to treatment programs is not surprising. However, it still suggests that further research may provide more detail regarding how the different resources of independent living and family are made available to Hispanics.

Reasons for Leaving Programs

The reason given when an individual leaves a program is also an opportunity for examining differences in the reasons minority males exit programs in Miami-Dade. The choices available for reason for leaving were condensed into five categories: Completed Program; Left On Own (for another housing opportunity); Discharged for Violation (breaking rules, criminal activity, failure to comply with case plan); Other; or Unknown/Disappeared (left without completing discharge interview, went AWOL overnight, etc.). Data was examined for those leaving emergency shelters, as well as for those leaving all other types of programs.

Table 10 below shows that there are actually very few major differences in reasons for leaving programs. However, the small differences do test as significant with Pearson Chi-Square values of $p<.05$. Whites are slightly more likely than blacks and Hispanics to leave an emergency shelter before completing the program, and blacks are the least likely to be discharged for a program violation. Within all non-emergency shelter programs, there are no significant differences in reasons for leaving a program.

Table 10: Homeless Men's Reasons for Leaving Programs in Miami-Dade

REASON FOR LEAVING	Black	Hispanic	White	Total
EMERGENCY HOUSING PROGRAM				
Completed Program*	**2108 (64.2%)**	**1147 (62.2%)**	**571 (60%)**	**3826 (62.9%)**
Left on Own*	**50 (1.5%)**	**35 (1.9%)**	**26 (2.7%)**	**111 (1.8%)**
Discharged for Violation*	**316 (9.6%)**	**211 (11.4%)**	**107 (11.2%)**	**634 (10.4%)**
Other*	**160 (4.9%)**	**104 (5.6%)**	**64 (6.7%)**	**328 (5.4%)**
Unknown/ Disappeared	652 (19.8%)	347 (18.8%)	184 (19.3%)	1183 (19.5%)
TOTAL	3286	1844	952	6082
	100.0%	100.0%	100.0%	100.0%
TRANSITIONAL AND PERMANENT HOUSING PROGRAMS				
Completed Program	(61.5%)	287 (60.4%)	190 (66.9%)	1066 (62.1%)
Left on Own	134 (14%)	76 (16%)	42 (14.8%)	252 (14.7%)
Discharged for Violation	132 (13.8%)	56 (11.8%)	37 (13%)	225 (13.1%)
Other*	**33 (3.4%)**	**33 (6.9%)**	**3 (1.1%)**	**69 (4%)**
Unknown/ Disappeared	69 (7.2%)	23 (4.8%)	12 (4.2%)	104 (6.1%)
TOTAL	957	475	284	1716
	100.0%	100.0%	100.0%	100.0%

*Difference is significant at Pearson Chi-Square $p<.05$
Source: Miami-Dade County HMIS 2010-2011

These data do not support the null hypotheses, although the variation is not large: Single men exiting homeless program in Miami-Dade County have slightly different outcomes regarding successful or non-successful program completion when broken down by race/ethnicity. The difference in outcomes is only true for men exiting emergency shelter programs; there is no significant difference when leaving transitional or permanent housing programs. The variations in reasons for leaving emergency shelter are fairly small in nature, but they do test significant (Pearson Chi-Square $p<.001$) given the large data set. Blacks are more likely than Hispanics or whites to complete a program (64.2% versus 62.2% and 60% respectively). Whites and Hispanics, on the other hand, are more likely to leave on their own or be discharged for a program violation. In this

area, there is room for further research to determine why blacks seem to be more program compliant than Hispanics or whites. It is possible that Hispanics and whites have other options and therefore do not have as much to lose in leaving a program early, or in being discharged for a violation. Have access to other resources could also explain why the difference disappears for transitional and permanent programs, as by the time an individual enters one of those longer-term programs, they likely do not have as many outside resources.

Nonetheless, in spite of the differences in backgrounds, disabilities, and program destinations, the final outcomes for men of different races and ethnicities are similar when exiting transitional or permanent programs. The similarity in outcomes is particularly true when looked at within a broader framework regarding whether the program was completed or not. While the details on where they go still varies slightly, there is almost no variation between rates of program completion and non-completion.

Defining Homelessness: Who Is Served

There is no single federal definition of what it means to be homeless, and definitions among federal programs that serve homeless individuals may vary to some degree. As a result, the populations served through the federal programs described in this report may differ depending on the program. The definition of "homeless individual" that was originally enacted in the McKinney-Vento Act is used by a majority of programs to define what it means to be homeless. The McKinney-Vento Act defined the term "homeless individual" for purposes of the programs that were authorized through the law (see Section 103 of McKinney-Vento), though some programs that were originally authorized through McKinney-Vento use their own, less restrictive definitions.[9] In 2009, the McKinney-Vento Act definition of homelessness was amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, enacted as part of the Helping Families Save Their Homes Act (P.L. 111-22).

Programs that use the definition in Section 103 of the McKinney-Vento Act are HUD's Homeless Assistance Grants, FEMA's Emergency Food and Shelter program, the VA homeless veterans programs, and DOL's Homeless Veterans Reintegration Program.[10] (Throughout this section of the report, the term "Section 103 definition" is used to refer to the original McKinney-Vento Act definition of homelessness.)

This section describes the original McKinney-Vento Act Section 103 definition of homeless individual, how the definition compares to those used in other programs, and how it has changed under the HEARTH Act and HUD's implementing regulations.

Original McKinney-Vento Act Definition of Homelessness

The definition of "homeless individual" in Section 103 of McKinney-Vento remained the same for years:

> [a]n individual who lacks a fixed, regular, and adequate nighttime residence; and a person who has a nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

This definition was sometimes described as requiring one to be literally homeless in order to meet its requirements[11]—either living in emergency accommodations or having no place to stay. This contrasts with definitions used in some other federal programs, where a person may currently

[9] These include the Education for Homeless Children and Youths program and Health Care for the Homeless.

[10] The definition of *homeless veteran* is a veteran who is homeless as defined by Section 103(a) of McKinney-Vento. 38 U.S.C. §2002(1). This definition applies to VA programs for homeless veterans as well as the Homeless Veterans Reintegration Program.

[11] See, for example, the Department of Housing and Urban Development, *The Third Annual Homeless Assessment Report to Congress*, July 2008, p. 2, footnote 5, http://www.hudhre.info/documents/3rdHomelessAssessmentReport.pdf.

have a place to live but is still considered homeless because the accommodation is precarious or temporary.

Definitions Under Other Federal Programs

Education for Homeless Children and Youths: The Department of Education program defines homeless children and youth in part by reference to the Section 103 definition of homeless individuals as those lacking a fixed, regular, and adequate nighttime residence.[12] In addition, the ED program defines children and youth who are eligible for services to include those who are (1) sharing housing with other persons due to loss of housing or economic hardship; (2) living in hotels or motels, trailer parks, or campgrounds due to lack of alternative arrangements; (3) awaiting foster care placement; (4) living in substandard housing; and (5) children of migrant workers.[13]

Transitional Housing Assistance for Victims of Domestic Violence, Stalking, or Sexual Assault: The Violence Against Women Act definition of homelessness is similar to the ED definition.[14]

Runaway and Homeless Youth: The statute defines a homeless youth as either ages 16 to 22 (for transitional living projects) or ages 18 and younger (for short-term shelter) and for whom it is not possible to live in a safe environment with a relative or for whom there is no other safe alternative living arrangement.[15]

Health Care for the Homeless: Under the Health Care for the Homeless program, a homeless individual is one who "lacks housing," and the definition includes those living in a private or publicly operated temporary living facility or in transitional housing.[16]

Projects for Assistance in Transition from Homelessness: In the PATH program, an "eligible homeless individual" is described as one suffering from serious mental illness, which may also be accompanied by a substance use disorder, and who is "homeless or at imminent risk of becoming homeless." The statute does not further define what constitutes being homeless or at imminent risk of homelessness.

HEARTH Act Changes to the McKinney-Vento Act Section 103 Definition

The Section 103 definition of "homeless individual" was changed in 2009 as part of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act, enacted as part of the Helping Families Save Their Homes Act (P.L. 111-22). The HEARTH Act broadened the McKinney-Vento Section 103 definition and moved the definition away from the requirement for literal homelessness. On December 5, 2011, HUD released regulations that clarify some of the changes.[17] The changes are as follows:

- **Amendments to Original McKinney-Vento Act Language:** The HEARTH Act made minor changes to the existing language in the McKinney-Vento Act. The

[12] 42 U.S.C. §11434a.

[13] Migratory children are defined at 20 U.S.C. §6399.

[14] 34 U.S.C. §12291(a)(12), referring to 34 U.S.C. §12473(6).

[15] 34 U.S.C. §11279(3). The statute specifies that short-term shelters can serve youth older than age 18 if the center is located in a state or locality that permits this higher age.

[16] 42 U.S.C. §254b(h)(5)(A).

[17] U.S. Department of Housing and Urban Development, "Homeless Emergency Assistance and Rapid Transition to Housing: Defining 'Homeless'," 76 *Federal Register* 75994-76019, December 5, 2011.

law continues to provide that a person is homeless if they lack "a fixed, regular, and adequate nighttime residence," and if their nighttime residence is a place not meant for human habitation, if they live in a shelter, or if they are a person leaving an institution who had been homeless prior to being institutionalized. The HEARTH Act added that those living in hotels or motels paid for by a government entity or charitable organization are considered homeless, and it included all those persons living in transitional housing, not just those residing in transitional housing for the mentally ill as in prior law. The amended law also added circumstances that are not considered suitable places for people to sleep, including cars, parks, abandoned buildings, bus or train stations, airports, and campgrounds. When HUD issued its final regulation in 2011, it clarified that a person exiting an institution cannot have been residing there for more than 90 days and be considered homeless.[18] In addition, where the law states that a person "who resided in a shelter or place not meant for human habitation" prior to institutionalization, the "shelter" means emergency shelter and does not include transitional housing.[19]

- **Imminent Loss of Housing:** P.L. 111-22 added to the Section 103 definition those individuals and families who meet all of the following criteria:
    - They will "imminently lose their housing," whether it be their own housing, housing they are sharing with others, or a hotel or motel not paid for by a government or charitable entity. Imminent loss of housing is evidenced by an eviction requiring an individual or family to leave their housing within 14 days; a lack of resources that would allow an individual or family to remain in a hotel or motel for more than 14 days; or credible evidence that an individual or family would not be able to stay with another homeowner or renter for more than 14 days.
    - They have no subsequent residence identified.
    - They lack the resources or support networks needed to obtain other permanent housing.

  HUD practice prior to passage of the HEARTH Act was to consider those individuals and families who would imminently lose housing within seven days to be homeless.
- **Other Federal Definitions:** P.L. 111-22 added to the definition of "homeless individual" unaccompanied youth and homeless families with children who are defined as homeless under other federal statutes. The law did not define the term youth, so in its final regulations HUD defined a youth as someone under the age of 25.[20] In addition, the HEARTH Act did not specify which other federal statutes would be included in defining homeless families with children and unaccompanied youth. So in its regulations, HUD listed seven federal programs as those under which youth or families with children can be defined as homeless: the Runaway and Homeless Youth program; Head Start; the Violence Against Women Act; the Health Care for the Homeless program; the Supplemental Nutrition Assistance Program (SNAP); the Women, Infants, and Children

[18] Ibid., p. 76000.

[19] Ibid.

[20] Ibid., p. 75996.

nutrition program; and the McKinney-Vento Education for Children and Youths program.[21] Five of these seven programs (all but Runaway and Homeless Youth and Health Care for the Homeless programs) either share the Education for Homeless Children and Youths definition, or use a similar definition. Youth and families who are defined as homeless under another federal program must meet each of the following criteria:

- They have experienced a long-term period without living independently in permanent housing. In its final regulation, HUD defined "long-term period" to mean at least 60 days.
- They have experienced instability as evidenced by frequent moves during this long-term period, defined by HUD to mean at least two moves during the 60 days prior to applying for assistance.[22]
- The youth or families with children can be expected to continue in unstable housing due to factors such as chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment. Under the final regulation, barriers to employment may include the lack of a high school degree, illiteracy, lack of English proficiency, a history of incarceration, or a history of unstable employment.[23]

Communities are limited to using not more than 10% of Continuum of Care (CoC) program funds to serve families with children and youth defined as homeless under other federal statutes. The 10% limitation does not apply if the community has a rate of homelessness less than one-tenth of 1% of the total population.[24]

- **Domestic Violence:** Another change to the definition of homeless individual is that the HEARTH Act amendment considers homeless anyone who is fleeing a situation of "domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized."[25] The law also provides that an individual must lack the resources or support network to find another housing situation. HUD's 2011 final regulation specified that the conditions either must have occurred at the primary nighttime residence or made the individual or family afraid to return to their residence.[26]

[21] Ibid.

[22] Ibid., p. 76017.

[23] Ibid.

[24] 42 U.S.C. §11382(j).

[25] 42 U.S.C. §11302(b).

[26] 76 *Federal Register,* p. 76014.

(a) In general

For purposes of this chapter, the terms "homeless", "homeless individual", and "homeless person" means--[1]

(1) an individual or family who lacks a fixed, regular, and adequate nighttime residence;

(2) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(3) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

(4) an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided;

(5) an individual or family who--

(A) will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by--

(i) a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;

(ii) the individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

(iii) credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause;

(B) has no subsequent residence identified; and

(C) lacks the resources or support networks needed to obtain other permanent housing; and

(6) unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who--

(A) have experienced a long term period without living independently in permanent housing,

(B) have experienced persistent instability as measured by frequent moves over such period, and

(C) can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

(b) Domestic violence and other dangerous or life-threatening conditions

Notwithstanding any other provision of this section, the Secretary shall consider to be homeless any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

(c) Income eligibility

(1) In general

A homeless individual shall be eligible for assistance under any program provided by this chapter, only if the individual complies with the income eligibility requirements otherwise applicable to such program.

(2) Exception

Notwithstanding paragraph (1), a homeless individual shall be eligible for assistance under title I of the Workforce Innovation and Opportunity Act[2].

(d) Exclusion

For purposes of this chapter, the term "homeless" or "homeless individual" does not include any individual imprisoned or otherwise detained pursuant to an Act of the Congress or a State law.

(e) Persons experiencing homelessness

Any references in this chapter to homeless individuals (including homeless persons) or homeless groups (including homeless persons) shall be considered to include, and to refer to, individuals experiencing homelessness or groups experiencing homelessness, respectively.

[1] So in original. Probably should be "mean--".

[2] 29 U.S.C.A. § 3111 et seq.

Subtitle VII-B of the McKinney-Vento Homeless Assistance Act (per Title IX, Part A of the Elementary and Secondary Education Act, as amended by the Every Student Succeeds Act), 42 U.S.C. § 11434a

For purposes of this part:

(1) The terms “enroll” and “enrollment” include attending classes and participating fully in school activities.

(2) The term “homeless children and youths”—

(A) means individuals who lack a fixed, regular, and adequate nighttime residence (within the meaning of section 11302(a)(1) of this title); and

(B) includes—

(i) children and youths who are sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason; are living in motels, hotels, trailer parks, or camping grounds due to the lack of alternative adequate accommodations; are living in emergency or transitional shelters; or are abandoned in hospitals;

(ii) children and youths who have a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings (within the meaning of section 11302(a)(2)(C) [1] of this title);

(iii) children and youths who are living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations, or similar settings; and

(iv) migratory children (as such term is defined in section 6399 of title 20) who qualify as homeless for the purposes of this part because the children are living in circumstances described in clauses (i) through (iii).

(3) The terms “local educational agency” and “State educational agency” have the meanings given such terms in section 7801 of title 20.

(4) The term “Secretary” means the Secretary of Education.

(5) The term “State” means each of the 50 States, the District of Columbia, and the Commonwealth of Puerto Rico.

(6) The term “unaccompanied youth” includes a homeless child or youth not in the physical custody of a parent or guardian.

HOMELESS TRUST CENSUS RESULTS & COMPARISON: JANUARY 27, 2022 to JANUARY 26, 2023

UNSHELTERED HOMELESS COUNT	# ON 1/27/22	# ON 1/26/23	Difference +/-	%
City of Miami-City of Miami, City Limits	591	608	17	**3%**
City of Miami Beach- Miami Beach	171	235	64	**37%**
Miami-Dade County-South Dade, South of Kendall Drive to Monroe County Line	62	49	-13	**-21%**
Miami-Dade County-Unincorporated Miami-Dade County, North of Kendall Drive to Broward County Line	146	166	20	**14%**
Subtotal- # of UNSHELTERED Homeless:	**970**	**1058**	**88**	**9%**

SHELTERED HOMELESS COUNT	# ON 1/27/22	# ON 1/26/23	Difference +/-	%
Total Homeless in Emergency Shelter	1,766	2,037	271	**15%**
Emergency Weather Placements	0	0	0	**0%**
Hotel/Motel	142	246	104	**73%**
Total Homeless in Transitional Housing	382	303	-79	**-21%**
Safe Haven	16	13	-3	**-19%**
Subtotal-SHELTERED Homeless:	**2306**	**2,599**	**293**	**13%**

TOTAL - SHELTERED AND UNSHELTERED HOMELESS:				
	3276	**3657**	**381**	**12%**

There was a 12% (n=381) overall increase in homelessness countywide when comparing the 2022 and 2023 PIT counts. The unsheltered count increased 9% (n=88), and the sheltered count increased 13% (n=293).

SUB-POPULATION COUNT	# ON 1/27/22	# ON 1/26/23	Difference +/-	%
Chronic Homeless Persons	762	939	177	**23%**
Family Households	328	381	53	**16%**
Veteran Households	131	93	-38	**-29%**
Unaccomapanied Youth Households (18-24 year old)	117	116	-1	**-1%**
Parenting Youth Households (18-24 year old)	52	53	1	**2%**
Senior Persons (55-64 year old)	N/A	612	N/A	N/A
Senior Households (65 and older)	N/A	501	N/A	N/A

MIAMI-DADE COUNTY HOMELESS TRUST

	# ON 1/27/22	# ON 1/26/23
Weather Conditions:	Partly Cloudy, High in the upper 60's	Partly Cloudy, High in the upper 60's

HOMELESS TRUST CENSUS RESULTS & COMPARISON: August 18, 2022 to August 24, 2023

UNSHELTERED HOMELESS COUNT	# ON 8/18/22	# ON 8/24/23	Difference +/-	%
City of Miami-City of Miami, City Limits	640	534	-106	**-17%**
City of Miami Beach- Miami Beach	167	152	-15	**-9%**
Miami-Dade County-South Dade, South of Kendall Drive to Monroe County Line	93	67	-26	**-28%**
Miami-Dade County-Unincorporated Miami-Dade County, North of Kendall Drive to Broward County Line	240	227	-13	**-5%**
Subtotal- # of UNSHELTERED Homeless:	**1140**	**980**	**-160**	**-14%**

SHELTERED HOMELESS COUNT	# ON 8/19/21	# ON 8/24/23	Difference +/-	%
Total Homeless in Emergency Shelter	1,876	2,053	177	**9%**
Emergency Weather Placements	0	0	0	**0%**
Hotel/Motel	128	302	174	**136%**
Total Homeless in Transitional Housing	411	368	-43	**-10%**
Safe Haven	11	17	6	**55%**
Subtotal-SHELTERED Homeless:	**2426**	**2,740**	**314**	**13%**

TOTAL - SHELTERED AND UNSHELTERED HOMELESS:				
	3566	**3720**	**154**	**4%**

There was a 4% (n=154) overall increase in homelessness countywide when comparing the 2022 and 2023 PIT counts. The unsheltered count decreased 14% (n=-160), and the sheltered count increased 13% (n=314).

MIAMI-DADE COUNTY HOMELESS TRUST

	# ON 8/18/22	# ON 8/24/23
Weather Conditions:	Partly Cloudy with Scatter Thunderstorms, High in the low 80s.	Partly Cloudy with a shower in spots, High in the upper 70s.

HOMELESS CENSUS RESULTS

Summary - Life - To - Date Census

	Actual Street Count	Multiplied By (2)*	Total Sheltered	Total Census Results
Feb-96				8000
Apr,97	2161	4322		4322
Oct,97	2138	4276		4276
Feb,98	2403	4806		4806
Oct,98	2490	4980	2220	7200
Apr,00	1737	3474	2093	5567
Nov,00	2141	4282	2708	6990
Jun,01	2604	5208	3050	8258
Nov,01	2001	4002	2873	6875
Apr,02	2094	4188	2912	7100
Nov,02	1960	3920	2969	6889
Apr,03	2211	4422	2998	7420
Dec,03	2231	4462	3165	7627
Apr,04	1982	3964	3093	7057
Jan-05	1989		3171	5160
Sep-05	2297		2759	5056
Jan-06	2182		2833	5015
Jul-06	1754		2955	4709
Jan-07	1380		3012	4392
Jul-07	1683		3151	4834
Jan-08	1347		3227	4574
Jan-09	994		3339	4333
Aug-09	1089		3067	4156
Jan-10	759		3120	3879
Sep-10	847		3083	3930
Jan-11	789		2988	3777
Jun-11	898		3011	3909
Jan-12	868		3108	3976
Aug-12	894		2769	3663
Jan-13	839		2963	3802
Aug-13	848		3103	3951
Jan-14	840		3316	4156
Aug-14	792		3349	4141
Jan-15	1007		3145	4152
Aug-15	1067		3000	4067
Jan-16	982		3253	4235
Aug-16	1126		2927	4053
Jan-17	1011		2836	3847
Aug-17	1133		2605	3738
Jan-18	1030		2486	3516
Aug-18	1105		2738	3843
Jan-19	1008		2620	3628
Aug-19	1148		2550	3698
Jan-20	1020		2540	3560
Aug-20	Census was cancelled due to COVID-19 pandemic			
Jan-21	892		2332	3224
Aug-21	929		2426	3355
Jan-22	970		2470	3440
Aug-22	1140		2598	3738
Jan-23	1058		2599	3657
Aug-23	980		2740	3720

Please note that there was no data collected for April 1997, October 1997 and February 1998.
The 1999 count was not used due to discrepancies in counting methodologies.
***The Multiplier was eliminated in 2005 per HUD guidance**

MIAMI-DADE COUNTY
HOMELESS TRUST

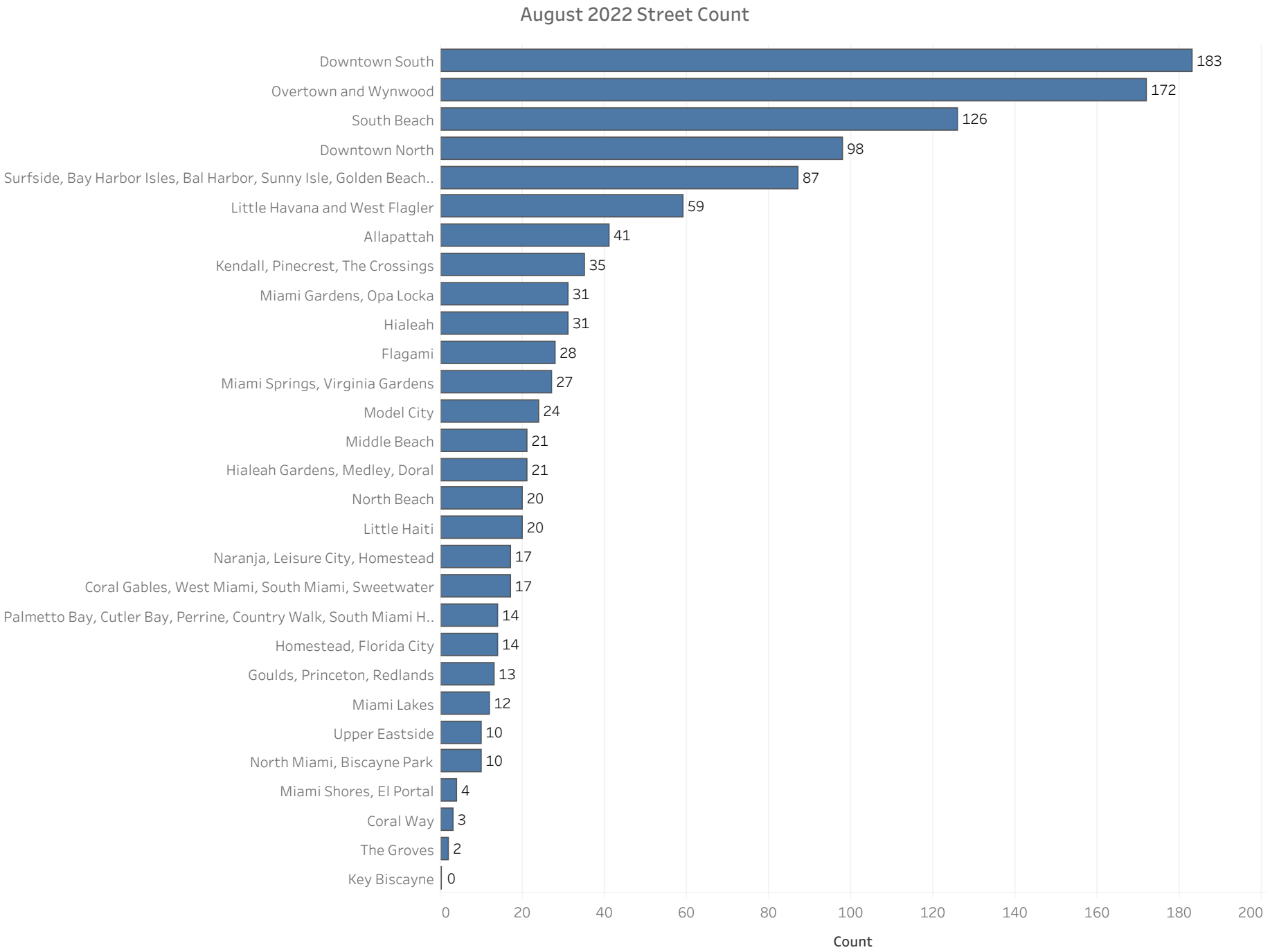
SUMMARY -ALL STREET COUNTS LIFE-TO-DATE

Outreach Providers	Miami Homeless Assistance Programs (City of Miami)	Formerly Douglas Gardens 4/03 City of Miami Beach (Miami Beach)	Formerly Metatherapy Institute Outreach-Camillus (South of Kendall Dr.) 12/05 (DHS Homeless Assistance Programs) 8/09 (City of Miami)	Formerly DHS Homeless Assistance Programs (balance of County)8/09 (City of Miami)	Subtotal	Total w/Multiplier of 2
1992*					6000	8000
Apr. 1997/Count # 1	1013	152	735	261	2161	4322
Number of Teams	7	2	5	4	18	
Oct. 1997/Count # 2	874	116	795	353	2138	4276
Number of Teams	8	2	5	5	20	
Feb. 1998/Count # 3	623	159	809	812	2403	4806
Number of Teams	9	2	5	8	24	
Oct. 1998/Count # 4	737	111	819	823	2490	4980
Number of Teams	6	1	5	8	20	
Apr. 2000/Count # 7	838	132	324	443	1737	3474
Number of Teams	8	2	4	9	23	
Nov. 2000/Count # 8	822	314	378	627	2141	4282
Number of Teams	8	2	4	9	23	
Jun. 2001/Count # 9	1157	277	353	817	2604	5208
Number of Teams	8	3	3	9	23	
Nov. 2001/Count # 10	867	281	432	421	2001	4002
Number of Teams	9	3	3	10	25	
Apr. 2002/Count # 11	926	255	209	704	2094	4188
Number of Teams	9	3	3	10	25	
Nov. 2002/Count # 12	980	310	173	497	1960	3920
Number of Teams	9	3	3	10	25	
Apr. 2003/Count # 13	1152	301	283	478	2214	4428
Number of Teams	9	3	3	10	25	
Dec. 2003/Count # 14	945	304	308	674	2231	4462
Number of Teams	10	4	3	10	27	
Apr. 2004/Count # 15	827	259	169	727	1982	3964
Number of Teams	10	4	3	10	27	
Jan. 2005/ Count #16	759	239	106	885	1989	
Number of Teams	10	4	4	11	29	
Sept. 2005/ Count #17	738	336	228	995	2297	
Number of Teams	10	5	3	11	29	
Jan. 2006/ Count #17	748	218	176	612	1754	
Number of Teams	10	4	4	10	28	
July. 2006/ Count #18	849	270	433	630	2182	
Number of Teams	10	4	4	9	27	
Jan. 2007/ Count #19	447	173	246	514	1380	
Number of Teams	10	3	4	9	26	
July. 2007/ Count #20	613	254	261	555	1683	
Number of Teams	10	4	4	9	27	
Jan. 2008/ Count #21	514	98	193	542	1347	
Number of Teams	9	4	4	9	26	
Jan. 2009/ Count #22	411	141	112	330	994	
Number of Teams	9	4	3	7	23	
Aug. 2009/ Count #23	674	232	85	98	1089	
Number of Teams	9	4	3	7	23	
Jan. 2010/ Count #24	512	149	65	33	759	
Number of Teams	9	4	3	7	23	
Sept. 2010/ Count #25	499	196	81	71	847	
Number of Teams	9	4	5	8	26	
Jan. 2011/ Count #26	487	177	58	67	789	
Number of Teams	9	5	5	10	29	
June. 2011/ Count #27	534	218	51	95	898	
Number of Teams	9	6	5	10	30	
Jan. 2012/ Count #28	535	173	72	88	868	
Number of Teams	9	5	5	10	29	
Aug. 2012/ Count #29	514	186	56	138	894	
Number of Teams	9	5	5	10	29	
Jan. 2013/ Count #30	511	138	66	124	839	
Number of Teams	9	7	5	10	31	
Aug. 2013/ Count #31	582	106	64	96	848	
Number of Teams	9	4	5	10	28	
Jan. 2014/ Count #32	577	122	71	70	840	
Number of Teams	9	4	5	10	28	
Aug. 2014/ Count #33	487	156	43	106	792	
Number of Teams	9	4	5	10	28	
Jan. 2015/ Count #34	616	193	61	137	1007	
Number of Teams	9	4	5	10	28	
Aug. 2015/ Count #35	667	196	75	129	1067	
Number of Teams	9	4	5	10	28	
Jan. 2016/ Count #36	640	156	68	118	982	
Number of Teams	9	4	5	10	28	
Aug. 2016/ Count #37	669	208	68	181	1126	

MIAMI-DADE COUNTY
HOMELESS TRUST

SUMMARY -ALL STREET COUNTS LIFE-TO-DATE

MIAMI-DADE COUNTY Outreach Providers	Miami Homeless Assistance Programs (City of Miami)	Formerly Douglas Gardens 4/03 City of Miami Beach (Miami Beach)	Formerly Metatherapy Institute Outreach-Camillus (South of Kendall Dr.) 12/05 (DHS Homeless Assistance Programs) 8/09 (City of Miami)	Formerly DHS Homeless Assistance Programs (balance of County)8/09 (City of Miami)	Subtotal	Total w/Multiplier of 2
Number of Teams	9	4	5	10	28	
Jan. 2017/ Count #38	**609**	**133**	**119**	**150**	**1011**	
Number of Teams	9	4	5	10	28	
Aug. 2017 / Count 39	**706**	**143**	**85**	**199**	**1133**	
Number of Teams	9	4	5	10	28	
Jan. 2018 / Count 40	**665**	**124**	**85**	**156**	**1030**	
Number of Teams	9	4	5	10	28	
Aug. 2018 / Count 41	**631**	**183**	**75**	**216**	**1105**	
Number of Teams	9	4	5	10	28	
Jan. 2019 / Count 42	**638**	**153**	**84**	**133**	**1008**	
Number of Teams	9	7	5	10	31	
Aug. 2019 / Count 43	**710**	**169**	**87**	**182**	**1148**	
Number of Teams	9	4	5	10	28	
Jan. 2020 / Count 44	**654**	**123**	**94**	**149**	**1020**	
Number of Teams	9	7	5	10	31	
Jan. 2021 / Count 45	**555**	**101**	**66**	**170**	**892**	
Number of Teams	9	3	3	10	25	
Aug. 2021 / Count 46	**510**	**183**	**64**	**172**	**929**	
Number of Teams	9	3	3	10	25	
Jan. 2022 / Count 47	**591**	**171**	**62**	**146**	**970**	
Number of Teams	9	3	3	10	25	
Aug. 2022 / Count 48	**640**	**167**	**93**	**240**	**1140**	
Number of Teams	9	3	3	10	25	
Jan. 2023 / Count 49	**608**	**235**	**49**	**166**	**1058**	
Number of Teams	9	3	3	10	25	
Aug. 2023 / Count 50	**534**	**152**	**67**	**227**	**980**	
Number of Teams	9	3	3	10	25	


August 2022 Street Count
Downtown South 183
Overtown and Wynwood 172
South Beach 126
Downtown North 98
Surfside, Bay Harbor Isles, Bal Harbor, Sunny Isle, Golden Beach.. 87
Little Havana and West Flagler 59
Allapattah 41
Kendall, Pinecrest, The Crossings 35
Miami Gardens, Opa Locka 31
Hialeah 31
Flagami 28
Miami Springs, Virginia Gardens 27
Model City 24
Middle Beach 21
Hialeah Gardens, Medley, Doral 21
North Beach 20
Little Haiti 20
Naranja, Leisure City, Homestead 17
Coral Gables, West Miami, South Miami, Sweetwater 17
Palmetto Bay, Cutler Bay, Perrine, Country Walk, South Miami H.. 14
Homestead, Florida City 14
Goulds, Princeton, Redlands 13
Miami Lakes 12
Upper Eastside 10
North Miami, Biscayne Park 10
Miami Shores, El Portal 4
Coral Way 3
The Groves 2
Key Biscayne 0
0 20 40 60 80 100 120 140 160 180 200
Count

EXECUTIVE SUMMARY

Crisis of homelessness and the PIT Count

Homelessness remains a national crisis, as stagnated wages, rising housing costs, and a grossly insufficient social safety net have left millions of people homeless or at-risk of homelessness.[1] It is important to have an accurate estimate of the number of people experiencing homelessness in this country if we want to enact effective laws and policies to address the homeless crisis. Each year the Department of Housing and Urban Development (HUD) releases an annual Point in Time (PIT) count of the homeless population in this country. This report is used throughout the country to measure progress on homelessness, to assess the efficacy of different policies, and to allocate federal funds, amongst other uses. This count includes a shelter count and a street count of unsheltered homeless individuals. In 2016 HUD reported that 549,928 people were homeless on a single night in January with 32% of those unsheltered.[2]

Flaws in the PIT Count

The annual PIT counts often mobilize large numbers of volunteers and serve to educate communities about homelessness. However, despite all the community effort and goodwill that goes into them, and due to no fault of the professionals and volunteers who carry them out, the counts are severely flawed.

Unfortunately, the methods used by HUD to conduct the PIT counts produce a significant undercount of the homeless population at a given point in time. In addition, regardless of their methodology or execution, point in time counts fail to account for the transitory nature of homelessness and thus present a misleading picture of the crisis. Annual data, which better account for the movement of people in and out of homelessness over time, are significantly larger: A 2001 study using administrative data collected from homeless service providers estimated that the annual number of homeless individuals is 2.5 to 10.2 times greater than can be obtained using a point in time count.[3]

Inconsistent Methodology: Varies by COC and over time, making trends difficult to interpret or inaccurate

HUD issues guidelines for the Continuum of Care (COC) programs across the country to follow when conducting the PIT count. However, these guidelines change from year to year and are not applied in the exact same manner by each COC. This inconsistency results in trends that are difficult to interpret and often do not reflect the true underlying data. For instance, in 2013 homeless people in Rapid Rehousing (RRH) were separated from the Transitional Housing (TH) classification and were no longer included in the homeless count.[4] Therefore the reported number of homeless people declined from 2012 to 2013 even where there was no actual change in homeless population.

Most methodologies miss unsheltered homeless people

Individual COCs determine their own counting procedures using guidelines issued by HUD. Generally, the counts are conducted over a single night using volunteers, homeless service provider staff, advocates, and occasionally members of law enforcement. These types of visual street counts are problematic for several reasons. The first is that the people need to be seen in order to be counted, however, a study of shelter users in New York found that 31% slept in places classified as "Not-Visible" the night of the count.[5] This problem is exacerbated by the increase in laws that criminalize homelessness. As documented in *Housing Not Handcuffs*, the Law Center's 2016 report that reviewed the laws in 187 cities around the country, laws that criminalize necessary human activities performed in public places such as sitting, lying, sleeping, loitering, and living in vehicles are prevalent and increasing.[6]

Only some kinds of homelessness are counted

The definition of homelessness that HUD uses is narrow and does not measure the real crisis. It does not permit the inclusion of people that are "doubled up", meaning that they are staying with friends or family due to economic hardship. The PIT counts also exclude people in some institutions such as hospitals and jails; this may result in a disproportionate undercounting of racial and ethnic minorities, who are overrepresented in incarcerated populations. For example, separate from its HUD submission, the Houston COC also reports an "Expanded" count which includes individuals in county jails that reported they were homeless before arrest. This "Expanded" count increased the total number of homeless individuals in 2017 by 57% from 3605 to 5651.[7] This indicates that there is a significant homeless population that is incarcerated that is not being included in the HUD PIT count.

1 National Law Center on Homelessness and Poverty, *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities* (2016).

2 Off. of Community Plan. & Dev., Dep't of Housing and Urban Development, The 2016 Annual Homeless Assessment Report to Congress (2016).

3 Stephen Metraux et al., *Assessing Homeless Population Size Through the Use of Emergency and Transitional Shelter Services in 1998: Results from the Analysis of Administrative Data from Nine US Jurisdictions*, 116 Pub. Health Rep. 344, (2001).

4 Kevin C. Corinth, *On Utah's 91 Percent Decrease in Chronic Homelessness*, Am. Enterprise Inst. (2016).

5 Kim Hopper et al., *Estimating Numbers of Unsheltered Homeless People Through Plant-Capture and Postcount Survey Methods*, 98 Am. J. Pub. Health 1438 (2008).

6 National Law Center on Homelessness and Poverty, *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities* (2016).

7 Catherine Troisi et al., *Houston/Harris County/Fort Bend County/Montgomery County 2017 Point-in-Time Count Report,* The Way Home and Coalition for the Homeless (2017).

There are better methodologies

Several other independent studies have been dedicated to counting the homeless population. A 2001 study by Burt *et al.* used the 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC) to produce one-day, one-month, and one-year estimates of the homeless population.[8] Their methods involved making evidence based adjustments to the data using the assumptions that a certain number of homeless individuals do not visit available homeless assistance providers, some areas do not even have homeless assistance providers, and that people tend to move in and out of homelessness over time. It was also recognized that some individuals may use more than one homeless assistance service and therefore the data was also de-duplicated. The final estimate from their study was 2.3 to 3.5 million adults and children in the U.S. were homeless at some point during the year in 1996.[9]

Recommendations

This report highlights many of the issues associated with the accuracy of the HUD PIT counts and how they produce a significant undercount of the homeless crisis in this country. The results of the PIT counts—and even the trend data—are not necessarily accurate indicators of the success or failure of programs or policies that address homelessness.

Conduct a better count nationally. HUD's count should:

- Be nationally coordinated with a more consistent and more rigorous methodology. This and requires appropriate funding levels in order to get more useful data.
- Include estimation techniques designed and overseen by experts in order to quantify the number of homeless individuals that were missed during the count.
- Include all people experiencing homelessness, including individuals that are institutionalized in hospitals and jails or prisons
- Include a separate estimate of people who are doubled up due to economic hardship.
- Ensure that all data, from all subpopulations, is disaggregated by race and ethnicity.

Conduct a better count locally. Even without change from HUD COCs can:

- Include estimation techniques designed and overseen by experts in order to quantify the number of homeless individuals that were missed during the count.
- Include all people experiencing homelessness, including individuals that are institutionalized in hospitals and jails or prisons
- Separately estimate individuals who are doubled up with friends or family due to economic hardship.

How and when to use current PIT count data:

- Current PIT count data must always be used with the explicit recognition that the data represent significant undercounts.
- Usage of year-to-year trends must include scrutiny of any methodology or classification changes that may have also occurred over the time period.

8 Martha Burt et al., *Helping America's Homeless: Emergency Shelter or Affordable Housing, 24-53* (1st Ed. 2001).

9 *Id*.

INTRODUCTION

Crisis of homelessness

Homelessness remains a national crisis, as stagnated wages, rising housing costs, and a grossly insufficient social safety net have left millions of people homeless or at-risk of homelessness.[10] The U.S. Department of Housing and Urban Development (HUD) released its Annual Homeless Assessment Report to Congress (AHAR) in 2016, including the results of the HUD Point in Time (PIT) count and the Housing Inventory Count (HIC). A key finding for 2016 was that homelessness decreased nationally by 2.6% over the previous year and the unsheltered population fell by 10.2%.[11] Some individual states, however, saw dramatic increases over the same time period, including Colorado (6.0%), Washington (7.3%), Oklahoma (8.7%), and the District of Columbia (14.4%).[12]

In 2016, HUD reported that 549,928 people were homeless on a single night in January with 32% of those unsheltered.[13] These numbers may seem high, but the point in time count methods used by HUD are often argued to be significant undercounts.[14] A recent study of the Los Angeles County PIT count concluded that the current methods are insufficient to accurately identify year to year changes in the homeless population.[15] The PIT counts rely on HUD's narrow definition of homelessness that only includes people in emergency shelters, transitional housing, and in certain public locations. Excluded from their counts are people that are in the hospital, incarcerated, living "doubled up", or simply not visible to the people conducting the counts on the particular night of the survey.

In addition, regardless of their methodology or execution, point in time counts fail to account for the transitory nature of homelessness and thus present a misleading picture of the crisis. Annual data, which better account for the movement of people in and out of homelessness over time, are significantly larger: A 2001 study using administrative data collected from homeless service providers estimated that the annual number of homeless individuals is 2.5 to 10.2 times greater than can be obtained using a point in time count.[16]

10 *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities, supra note 1.*
11 *The 2016 Annual Homeless Assessment Report to Congress, supra note 2.*
12 *Id*.
13 *Id.*
14 *See, e.g.*, Maria Foscarinis, *Homeless Problem Bigger Than Our Leaders Think*, USA Today, Jan. 16, 2014, https://www.usatoday.com/story/opinion/2014/01/16/homeless-problem-obama-america-recession-column/4539917/; Patrick Markee, *Undercounting the Homeless 2010*, Coalition for the Homeless, January 2010; Daniel Flaming & Patrick Burns, *Who Counts? Assessing Accuracy of the Homeless Count*, Economic Roundtable, (Nov. 2017).
15 *Id*.
16 Stephen Metraux et al., *Assessing Homeless Population Size Through the Use of Emergency and Transitional Shelter Services in 1998: Results from the Analysis of Administrative Data from Nine US Jurisdictions*, 116 Pub. Health Rep. 344, _(2001).
17 Metraux, *supra note 3*.
18 HUD is authorized to require COCs to conduct PIT counts through the McKinney-Vento Homeless Assistance Act Sec. 427 (b)(3).
19 Applied Survey Research, San Francisco Homeless Count & Survey 2017 Comprehensive Report (2017).

The results of a 2001 study using data collected from administrative records of homeless services providers estimated that the actual number of homeless individuals is 2.5 to 10.2 times greater than those obtained using a point in time count, which translates to an equivalent annual number of 1,374,820 to 5,609,265 homeless individuals for 2016.[17]

This report is in no way a criticism of the professionals and volunteers that conduct the PIT counts. Through the counts, they are able to increase public awareness of the homeless crisis and connect homeless individuals to services. The PIT counts are a valuable community engagement opportunity for volunteers and helps expose them to the work that service providers do and to homeless individuals themselves. Nonetheless, the PIT counts result in a significant undercount of the real homeless population in this country and should be improved in order to better guide policy and practice.

What is the PIT count and why is this important?

HUD administers the Point-in-Time (PIT) count of sheltered and unsheltered homeless individuals, as well as the Housing Inventory Count (HIC) of beds provided to serve the homeless population, through its Continuum of Care (COC) program. [18] COCs receive funds from HUD under the McKinney-Vento Homeless Assistance Act to provide direct services to homeless people in their communities. They are collaboratives typically composed of nonprofit service providers, state, and local governments agencies. HUD requires each of the COCs across the country to conduct a PIT count of sheltered and unsheltered homeless people and a HIC of shelter beds. HUD publishes guidelines and tools for the COC to utilize; however, these guidelines vary from year to year and provide a degree of latitude regarding the counting methodologies.

COCs are required to submit PIT count data with their Homeless Assistance Program applications. The first COC Homeless Populations and Subpopulations Report was produced in 2005, and 2007 is the first year for which national PIT count data are available. In 2016 there were 402 COCs spanning a range of population sizes in urban, suburban, and rural areas. The COCs rely heavily on volunteers to conduct their counts, many of whom receive as little as one hour of training.[19]

It is important to have an accurate estimate of the number of people experiencing homelessness in this country in order to have

an understanding of the scope and nature of the problem and, especially, the policy responses and funds needed to address it. These numbers are also used to determine funding allocations, the dividing up total funds among communities depending on population size. The size of the homeless population also contributes to the overall populations of states and local jurisdictions, affecting their political representation.

HUD refers to the data from the counts to inform Congress about the rates of homelessness in the U.S. and to measure the effectiveness of its programs and policies aimed at decreasing homelessness, and legislators frequently rely on the results of the counts to determine whether public policies are reducing homelessness. Rather than understanding that the PIT count represents only a portion of the homeless population, many interpret the count as a comprehensive depiction of the crisis and rely on it to inform policy design and implementation decisions. This can lead to policies that fail to address the homelessness crisis or may even exacerbate it.

FLAWS IN THE PIT COUNT

Methodology varies by COC & over time

HUD issues PIT count guidelines to be followed for each count, but specific procedures are determined by individual COC. The COCs vary widely from large urban cities to small rural towns. Even urban COCs can be quite different; for instance, the San Francisco COC is 47 square miles in area while the COC that contains Houston in 3,711 square miles.

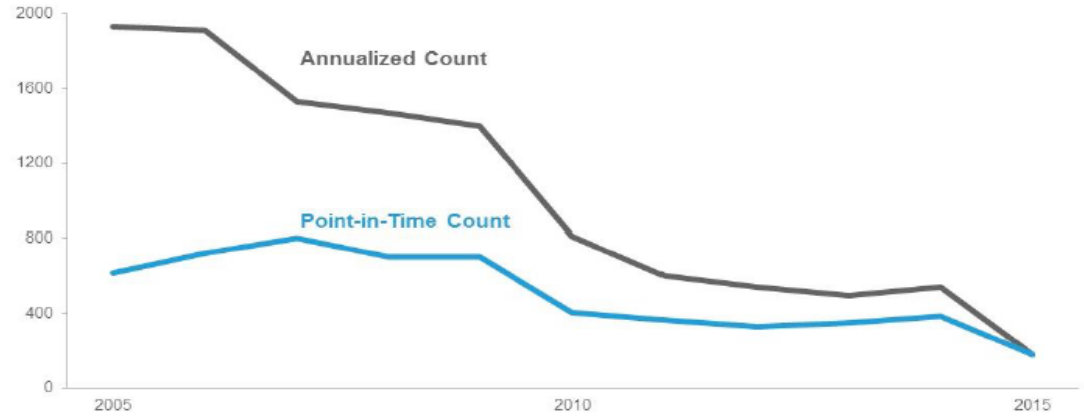
One difference in count procedures used by COCs includes the length of the count; most COCs conduct the count in a single night, however, some conduct it over several. For example, the San Francisco count is done on a single night, the Houston area count is done is over three consecutive nights, and the Greater Los Angeles COC conducts a three day street count followed by a 3-day youth count.[20] There also basic methodological differences, such as some COCs, while others Also, some COCs conduct annual counts, while other do them on odd years only.

Methods to upscale or annualize PIT counts can be used to more accurately portray homeless populations; however, they are not always applied consistently from year to year. One such example is in the reported 91 percent decrease in Chronic Homelessness in Utah from 2005 to 2015.[21] A 2016 review of the data and counting procedures by Kevin Corinth at the American Enterprise Institute revealed that changes to the way the homeless counts had been annualized accounted for at least a portion of the decrease in the number of chronically homeless people reported from 2005 to 2015. He showed that the 2009 annualized count is almost double the PIT count, while in 2015 the annualized count is identical to the PIT count (Figure 1). This indicates that there was likely a change in the methodology used to annualize the data from 2012 to 2015 and that the actual decline in chronically homeless people is most likely lower than reported.[22]

HUD counting and reporting guidelines change over the years, having an impact on the PIT counts and its interpretation of year to year trends. One example is the reclassification of Rapid Rehousing (RRH) in 2013. From 2011-2012, RRH was included in the Transitional Housing (TH) category and therefore classified as Sheltered Homeless. However, in 2013, RRH was separated from TH and was reclassified as Permanent Housing and no longer included in the homeless population count.[23] Therefore at least a portion in any decline in the homeless population count from 2012 to 2013 could be attributed to this change in classification.

Similarly, Utah reported a decline in chronically homeless people in 2010; however, at least a portion of this decline can be attributed to a change in classification. In 2009 Utah was including individuals in transitional housing in their chronic homeless totals, but this methodology was changed in 2010 when the count no longer included this population. Therefore the reported number of

Figure 2. Number of Chronically Homeless Individuals, Annualized and Point-in-Time, Utah 2005–15



Sources: Utah Department of Workforce Services, "Comprehensive Report on Homelessness: State of Utah 2014," https://jobs.utah.gov/housing/scso/documents/homelessness2014.pdf; Utah Department of Workforce Services, "Comprehensive Report on Homelessness: State of Utah 2015," October 2015, https://jobs.utah.gov/housing/scso/documents/homelessness2015.pdf; and US Department of Housing and Urban Development, Point-in-Time Counts of Homeless Persons.

Figure 1. Number of Chronically Homeless Individuals, Annualized and Point-in-Time, Utah 2005–15 (From Corinth, K., On Utah's 91 Percent Decrease in Chronic Homelessness, American Enterprise Institute, March 2016)

20 *See id.*; Markee, *supra* note 14.

21 Corinth, *supra* note 4.

22 *Id*.

23 *Id*.

chronically homeless people was reduced from 2009 to 2010 simply by removing those in transitional housing from the count.[24]

The changes in counting procedures can produce misleading conclusions. For example, nationally, the number of homeless people in families that were unsheltered decreased significantly from 2012 to 2013, but this may have been due to changes in the methods used to conduct their counts. In fact, HUD's 2013 report to Congress contained a warning regarding the validity of the results, stating:

"*The number of homeless people in families that were unsheltered has declined considerably in all three geographic categories between 2012 and 2013 ... However, in recent years many BoS or statewide CoCs have changed their enumeration methods to better account for the large geographic region, which could have affected the numbers considerably*."[25]

Finally, shifts in large cities—whether valid or not—can affect overall numbers and suggest national trends that may be misleading or inaccurate. For example, the 2009 PIT count showed a large decline in homelessness nationwide, primarily driven by the City of Los Angeles, in which the total count of homeless people dropped from 68,608 to 42,694 in a two year period. In fact, if the cities with the top three largest declines in the count of total homeless people are excluded, there was a 2.1 percent increase in the rest of the county from 2008 to 2009.[26] In its report to Congress, HUD stated:

"*The removal of these large cities from the PIT counts and the resulting shift in trends illustrates the need to interpret changes in one-night PIT counts carefully … one-night PIT counts are particularly sensitive to dramatic changes within the nation's largest cities and to evolving enumeration strategies*."[27]

These examples show that changes to the way that data is collected and classified can create the impression that there is a change in the number homeless individuals, even if there is no such trend in the underlying data.

Counting procedures systemically undercount unsheltered adults and youth

While actual counting procedures vary by COC, it is difficult to imagine that it would be possible to count every homeless individual in a given area in a single night. Typical counts are completed using volunteers supported by city staff, advocates, service providers, and occasionally local police enforcement. Volunteers are typically required to undergo 1 hour of training before they can participate in the count.[28] Some COC's must cover a large area with a relatively small number of volunteers. For instance, in 2017, the COC that contains Houston is 3,711 square miles in area and used 60 teams of volunteers and 150 people from the homeless service provider community, outreach teams, and VA staff to conduct the count over three nights.[29]

Volunteers are generally dispatched to predetermined areas in teams to conduct their counts. This requires knowledge of where homeless individuals are likely to be living on the night of the count, which may be obtained through consultation with homeless advocates, service providers, and previously homeless individuals.[30] This counting approach relies on homeless individuals residing in visual locations, an assumption that can be problematic; one study in New York found that 31% of the interviewed homeless people who slept outside on the night of the PIT count were in places classified as "Not-Visible".[31]

As documented in *Housing Not Handcuffs*, the Law Center's 2016 report that reviewed the laws in 187 cities around the country, laws that criminalize necessary human activities performed in public places are prevalent and increasing.[32] Laws prohibiting camping in public, sleeping in public, sitting or lying in public, loitering, and living in vehicles all potentially contribute to the undercount of homeless individuals as many would seek to avoid contact with those trying to count them. This would be especially true in the cases when city workers or police are involved in the counting procedure.

HUD training materials instruct volunteers to avoid areas that are deemed too dangerous to visit at night, such as abandoned buildings, large parks, and alleys, the very places where unsheltered homeless people are likely to be, especially if they are trying to protect themselves from the elements, crime, or police enforcing criminalization laws.

Some counts include a follow up interview with individuals counted in order to gain additional demographic information and to avoid double counting, while other counts are visual only. COCs that rely on visual only methods require the enumerators to make a judgment call on whether an individual is actually homeless or not. Volunteers are also sometimes instructed not to disturb homeless people residing inside of tents or vehicles. In such cases, they will have to make an educated guess at the number and description of

24 *Id.*
25 Off. of Community Plan. & Dev., Dep't of Housing and Urban Development, The 2013 Annual Homeless Assessment Report to Congress (2014).
26 Off. of Community Plan. & Dev., Dep't of Housing and Urban Development, The 2009 Annual Homeless Assessment Report to Congress (2010).
27 *Id.*
28 *See, e.g.*, *San Francisco Homeless Count & Survey 2017 Comprehensive Report supra* note 19; *2017 Greater Los Angeles Homeless Count Results, Los Angeles County and Continuum of Care, supra* note 20; Metro Denver Homeless Initiative, 2017 Point-In-Time Report: Seven-County Metro Denver Region (2017)..
29 Troisi, *supra* note 7.
30 *San Francisco Homeless Count & Survey 2017 Comprehensive Report, supra* note 19.
31 Hopper, *supra* note 5, 1440.
32 Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities, *supra* note 1.

people inside.[33]

HUD recognizes that accurately counting the unaccompanied homeless youth population is problematic because they often gather in different locations than adult populations, generally do not want to be found or even come in contact with adults, may not consider themselves to be homeless, and may be difficult to identify as homeless by an adult.[34]

Definition of homelessness is narrow and doesn't measure the real crisis

Doesn't include "doubled up"

HUD's definition of unsheltered homeless people for the PIT count includes individuals and families, "with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground." The sheltered count includes individuals and families, "living in a supervised publicly or privately operated shelter designated to provide temporary living arrangement (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low-income individuals)".[35] Neither of these definitions include individuals or families that are homeless but living "doubled up" meaning that they are staying with friends or extended family members due to economic hardship. This is particularly significant because the count is conducted each year on a night in January when the temperatures are typically cold. The intention of this is to maximize the participation in shelters where homeless individuals are easier to count, however, if the shelters are full (which is commonly the case),[36] individuals may temporarily "double up" with friends or family and will not be counted.

Doesn't include certain institutions, such as jail/prison

A 2008 national survey of 6953 jail inmates found that 15.3% were homeless at some point in the year before incarceration.[37] Another study found that 10 percent of people entering state and federal prison had recently been homeless and that 10 percent of those leaving prison go on to be homeless at some point.[38] Current and past HUD guidelines have no provisions for counting individuals that are in prison or jail regardless of the potential size of this population. Attempts to quantify this population are left up to individual COCs.

The Houston COC does not include incarcerated individuals in their homeless individual count submitted to HUD; however, they do separately report an "Expanded" count which includes individuals in county jails the night of the count if they stated they were homeless before arrest. The "Expanded" count increases the total number of homeless individual in the Houston COC in 2017 by 57% from 3,605 to 5,651.[39]

The San Francisco COC also conducts a count of the individuals that are in hospitals, residential rehabilitation facilities, and jails in their sheltered counts; however, they also exclude these individuals from the numbers they submit to HUD. This population amounts to 26% (641 people) of the sheltered count in 2017.[40] They also state that 5% of individuals surveyed reported being in jail/prison immediately prior to becoming homeless, and 20% had been in jail the previous 12 months.[41]

The Butte County 2017 Homeless Point in Time Count Report states that 21 individuals interviewed spent the night of the survey in jail. Furthermore, the County Sheriff's department reported that 26% of the jail population was homeless inmates, with 84% of the charges for felonies and 24% for misdemeanors.[42] 206 of the 1983 of the survey respondents cited incarceration as their cause of homelessness, and 265 said a criminal history was a primary barrier to ending their homelessness.[43] Additionally, their survey revealed that ordinances about sitting, lying, and storing property in public places led 181 people to be ticketed, 80 to be arrested, and nearly 50 to be incarcerated in the previous year.[44]

33 Focus Strategies, Orange County Continuum of Care 2017 Homeless Count & Survey Report (2017).

34 *Promising Practices for Counting Youth Experiencing Homelessness in the Point-in-Time Counts,* U.S. Department of Housing and Urban Development, November 2016.

35 Dep't of Housing & Urban Dev., Notice CPD-16-060 Notice for Housing Inventory Count (HIC) and Point-in-Time (PIT) Data Collection for Continuum of Care (CoC) Program and the Emergency Solutions Grants (ESG) Program (2016).

36 *See, e.g.* Brandon Marshall, *Nashville Homeless Shelters At Capacity*, News Channel 5, Jan. 6, 2017, http://www.newschannel5.com/news/nashville-homeless-shelters-at-capacity; Alasyn Zimmerman, *Homeless shelters at capacity as temperatures drop*, KOAA News 5, Sep. 20, 2017; http://www.koaa.com/story/36416084/homeless-shelters-at-capacity-as-temperatures-drop; Jake Zuckerman, *Front Royal homeless shelter at capacity*, Northern Virginia Daily, Dec. 2, 2016, http://www.nvdaily.com/news/2016/12/front-royal-homeless-shelter-at-capacity/; Esmi Careaga, Homeless shelters at full capacity, Local News 8, Dec. 15, 2016, http://www.localnews8.com/news/homeless-shelters-at-full-capacity/215333225; Dennis Hoey, *Portland homeless shelters reach capacity because of bitter weather*, Press Herald, Dec. 5, 2016, http://www.pressherald.com/2016/12/15/portland-homeless-shelters-reach-capacity-because-of-bitter-weather/.

37 Greg A. Greenberg & Robert A. Rosenheck, *Jail Incarceration, Homelessness, and Mental Health: A National Study*, 59 Psychiatric Serv. 170 (2008)

38 Caterina G. Roman & Jeremy Travis, *Where Will I Sleep Tomorrow? Housing, homelessness, and the returning prisoner*, 17 Housing Pol'y Debate 389, 395 (2006).

39 Troisi, *supra* note 7.

40 *San Francisco Homeless Count & Survey 2017 Comprehensive Report, supra* note 7.

41 *Id*.

42 Housing Tools, 2017 Homeless Point in Time Census & Survey Report: Butte Countywide Homeless Continuum of Care (2017).

43 *Id*.

44 *Id*.

These examples show that it is entirely possible to quantify the number of homeless individuals that are incarcerated during the night of the PIT count and that these populations are significant in numbers. Moreover, if the criminalization of homelessness continues—or increases—they will become even larger.

Current data indicate that homelessness disproportionately affects certain racial and ethnic minorities, the 2016 Annual Homeless Assessment Report to Congress states that 39% are African-Americans (despite being only 13% of the population overall); 22% Hispanic (19% overall); and 3% Native American (1% overall).[45] But because such minorities are also over-represented in the criminal justice system, in particular for the low-level "quality of life" violations typically used to criminalize homelessness,[46] by not counting homeless persons who are in jail or prison on the night of the count, the PIT count likely systemically *under*-counts the *over*-representation of homeless persons of color.

Within criminalized homeless populations, persons of color are disproportionately targeted by law enforcement. The United Nations Special Rapporteur on Racism specifically cited the example of Los Angeles' Skid Row during his 2008 visit to the United States.[47] 69% of the 4,500 homeless individuals in Skid Row are African American.[48] Beginning in September 2006, the City announced its "Safer City Initiative," bringing 50 new police officers to the area supposedly to target violent crime.[49] However, in the first year of the SCI program, the police confiscated only three handguns, while issuing an average of 1,000 citations per month, primarily for jaywalking violations by African Americans - 48 to 69 times the number of citations in the city at large.[50] Officers also enforce an ordinance which prohibits sitting, lying and sleeping on the sidewalk--one older African American woman, Annie, has been arrested more than 100 times for these violations since the beginning of the Initiative.[51]

Once arrested, unaffordable bail means that homeless persons are nearly always incarcerated until their trials occur – or until they agree to waive their trial rights in exchange for convictions. In a survey of homeless persons, 57% stated that bench warrants had been issued, leading to their arrest.[52] 49% of homeless people report having spent five or more days in a city or county jail.[53] In 87% of cases with bail of $1000 or less in New York City in 2008, defendants were not able to pay and were incarcerated pending trial.[54] The average length of pretrial detention was 15.7 days – more than two weeks, often for minor offenses.[55] This means significant numbers of homeless persons are spending significant amounts of time in jail, but they are homeless again as soon as they are released.

Indeed, because the rate of criminalization is increasing,[56] this disproportionate undercounting of incarcerated homeless persons of color may also be increasing. Thus, it is important not only to count the homeless individuals in jail, but also to ensure this data is disaggregated so we can continue to measure these impacts.

Department of Education counts appear to show different results

The U.S. Department of Education (ED) collects data on the number of homeless children and youth enrolled in our nation's public schools, in order ensure success of the Education for Homeless Children and Youth (EHCY) program, authorized under the McKinney-Vento Homeless Assistance Act.[57] This data provides an additional indicator of the scale of the homeless crisis. In the 2015-2016 school year, there were over 1.36 million homeless children counted in our public schools—a 70% increase since the inception of the housing foreclosure crisis in 2007 and more than double the number first identified in 2003 (602,000).[58] This is in part due to greatly improved identification, but is nonetheless significant. The other point is that except for a slight (less than 3%) decline from 2013-2014 to 2014-2015 school years, the ED numbers have gone up every single year since data was first collected in 2003. Contrast this with the PIT count which has decreased in recent years. This is significant because reliance on the HUD numbers would lead us to believe that things are getting better, when the trend from ED clearly shows things are getting worse and continue to get worse (despite the so-called end of the recession).

ED counts children that are homeless at any point during the school year, including those living "doubled up", staying in hotels/

45 *The 2016 Annual Homeless Assessment Report to Congress, supra* note 2.
46 *See, e.g.* Gary Blasi et.al, Policing Our Way Out of Homelessness? The First Year of the Safer Cities Initiative on Skid Row, (Sept. 2007).
47 U.N. Human Rights Council, Report of the Special Rapporteur on Contemporary Forms of Racism, Racial Discrimination, Xenophobia and Related Intoler-ance, Doudou Diéne, Mission to the United States of America, U.N. Doc. A/HRC/11/36/Add.3 (2009).
48 Inter-University Consortium Against Homelessness, Ending Homelessness in Los Angeles, (2007).
49 Testimony of Gary Blasi , UCLA Professor of Law, University of California, Los Angeles, to State Legislators in Sacramento, CA (July 18, 2007).
50 Blasi, supra note 46.
51 Email from Becky Dennison, Los Angeles Community Action Network, Mar. 28, 2014, on file with authors.
52 Paul Boden, *Criminalizing the Homeless Costs Us All* (Mar. 1, 2012).
53 Picture the Homeless, *Homelessness and Incarceration: Common Issues in Voting Disenfranchisement, Housing and Employment.*
54 Human Rights Watch, *The Price of Freedom: Bail and Pretrial Detention of Low Income Nonfelony Defendants in New York City*, at 2 (Dec. 3, 2010)
55 *Id*.
56 National Law Center on Homelessness & Poverty, *Housing Not Handcuffs: Ending the Criminalization of Homelessness in U.S. Cities* (2016).
57 EDFacts Data Documentation, Homeless Student Enrollment Data by Local Educational Agency - School Year 2015-16 (2017).
58 *Number of Homeless Students Grows More than 70% since 2007-2008*, Nat'l Low Income Housing Alliance (Sept. 21, 2015), http://nlihc.org/article/number-homeless-students-grows-more-70-2007-2008; *Education for Homeless Children and Youth Program, Analysis of 2005-2006 Federal Data Collection and Three-Year Comparison,* National Center for Homeless Education, June 2007..

motels, abandoned in hospitals, or awaiting foster care placement. Figure 2 contains a comparison of the National, California, and San Francisco ED counts with the HUD PIT counts for 2016. While direct comparisons are not valid due to differing methodologies, it is noteworthy that the National ED count for homeless children is almost 2.5 times as large as HUD's PIT count of the entire homeless population (1,364,369 vs. 549,928) and 7 times as large as the HUD's PIT count of homeless people in families (1,364,369 vs. 194,716). And while a large portion of the ED numbers consist of children living doubled up, their national unsheltered homeless count is still more than double the HUD count of unsheltered homeless people in families (41,725 vs. 19,153). Similar relationships can be seen in the state of California and the city of San Francisco with ED counts being much larger than the HUD PIT counts. Again, these number cannot be compared directly due to differing methodologies, most notably the fact that the ED numbers are annual. However, the much larger ED totals compared to the HUD PIT counts illustrate the impact that counting methods and classifications have on the resulting counts.

	National	California	San Francisco
Ed – Total	1,364,369	251,155	2,368
Ed – Unsheltered	41,725	7,407	48
Ed - Doubled Up	987,702	212,275	1,348
HUD - Total Homeless	549,928	118,142	6,996
HUD - Unsheltered Homeless	176,357	78,390	4,358
HUD - Homeless People in Families	194,716	20,482	687
HUD - Unsheltered Homeless People in Families	19,153	4,450	33
HUD - Homeless Unaccompanied Children (Under 18)	3,824	847	131
HUD - Unsheltered Homeless Unaccompanied Children (Under 18)	1,606	634	119

Figure 2. Comparison of National, California, and San Francisco Homeless data from the Department of Education vs the Department of Housing and Urban Development for the year 2016. (Source: Homeless Student Enrollment Data by Local Educational Agency, School Year 2015-16, https://www2.ed.gov/about/inits/ed/edfacts/data-files/lea-homeless-enrolled-sy2015-16.csv and PIT and HIC Data Since 2007, https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/)

Count of sheltered population measures supply not demand

In some ways, the sheltered population count of the PIT count is the most accurate. But what that count tells us is limited. Most shelters in the United States are at capacity. The count of sheltered homeless individuals indicates a city's supply of shelter beds rather than the demand for shelter or housing, and therefore cannot be used by itself to assess the homeless crisis. This can be seen in the plot of Homeless Count and Housing Inventory Count for San Francisco, which has a high unsheltered to sheltered ratio for its homeless population (Figure 3). The trend of Sheltered Homeless from 2007 to 2016 generally tracks the trend of Total Year Round Beds, while the Total Homeless number can be seen to move sharply upwards in 2013 and then downward in 2014. One might see the large drop in Total Homeless count in 2014 as a positive indicator of the state of homelessness in the city; however, it is due entirely to a drop in the Housing Inventory Count and an accompanying drop in count of sheltered individuals as no unsheltered street count was conducted that year. This shows that a count of sheltered individuals alone does not give an accurate view of the state of homelessness in a city. Furthermore, where shelters are continually full, the count of sheltered individuals can only be viewed as a measure of a city's supply and not its demand.

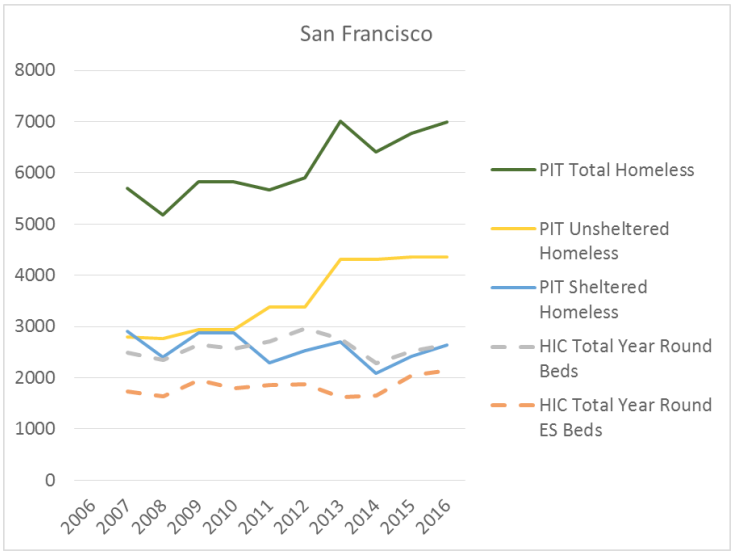


Figure 3. HUD PIT and HIC data for San Francisco (CA 501) from 2007 to 2016. (https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/)

ALTERNATIVE COUNTS

Survey at service providers sites over multiple days 1987, 1996

In 1989, Martha Burt and Barbara Cohen published the results of an Urban Institute survey in U.S. cities with populations above 100,000 over a month-long period in 1987.[59] This study did not include a street count and instead involved interviews at soup kitchens, meal distribution sites, and shelters. This methodology avoided many of the pitfalls that have been previously mentioned regarding counting an unsheltered population. The study produced a one-day estimate of 136,000 and a one-week estimate of 229,000 homeless individuals.[60] While the study likely did not capture everyone who is doubled up, the researchers were able to significantly improve the unsheltered count, finding that most unsheltered people were using at least one service center at least once a week. Furthermore, it illustrates the importance of conducting a study over a longer time period than one-day.

The 1996 National Survey of Homeless Assistance Providers and Clients (NSHAPC) was a comprehensive national survey of homeless service providers using methods similar to the 1987 Urban Institute study. The data was collected in two phases, the first phase was conducted from October 1995 to October 1996 and involved telephone surveys with staff at service providers such as soup kitchens and shelters. The second phase was conducted in October and November of 1996 and involved interviews with clients using services in the same types of locations as in phase one.[61] The interview questions used were designed to gather information regarding the frequency and length of time that individuals experienced homelessness. A 2001 study by Burt et al., used this NSHAPC data to create one-day, one-month, and one-year estimates of homeless individuals for the entire country.[62] Their methods involved making evidence-based adjustments using the assumptions that a certain number of homeless individuals do not visit available homeless assistance providers, some areas do not even have homeless assistance providers, and that people tend to move in and out of homelessness over time. It was also recognized that some individuals may use more than one homeless assistance service and therefore the data was also de-duplicated. The final estimate from their study was 2.3 to 3.5 million adults and children in the U.S. were homeless at some point during the year in 1996.[63] Once again, this study illustrates the importance of conducting a survey over a longer time period than a single point in time, and to recognition that people tend to move in and out of homelessness over time.

Measure and adjust for undercount of unsheltered

In an effort to increase the accuracy of the New York City estimate of its homeless population, researchers Kim Hopper et al. used two methods in conjunction with the annual PIT count.[64] One approach involved the Plant-Capture method where they "planted" decoys among the homeless population in various locations across the 5 boroughs to see if they were counted by enumerators during the PIT count. Plants at 17 of the 58 (29%) sites reported that they were missed during the count.[65]

The second approach the study used was to conduct interviews with individuals living in shelters following the PIT Count. They interviewed 1,171 people from 23 different sites and asked where they were residing the night of the count. They found that of the 314 respondents that reported being unsheltered, 31% said that they had slept in locations considered "Not-Visible."[66]

This study illustrates two flaws in the PIT count methodology, first that the enumerators cannot possibly be expected to cover the entirety of their areas of responsibilities as evidenced by the 29% of plants that reported to not being counted. Secondly, that many unsheltered homeless individuals were in "Not-Visible" locations, and thus were most likely missed by enumerators.

Expand the definition

Wilder Research conducts a study of the homeless population in Minnesota every three years, independently of the HUD PIT count. The study includes counts and estimates of the number of people who are homeless and a survey of homeless people. The count takes place every three years on the last Thursday in October in emergency shelters, domestic violence shelters, transitional housing programs, social service agencies, encampments, and abandoned buildings. As many as 1000 volunteers are used to conduct interviews in approximately 400 locations across the state. They also work with homeless service providers to obtain counts of the sheltered homeless population.[67]

The Wilder method uses an expanded definition of homelessness to include people who will imminently lose their housing (with eviction notices), people staying in hotels who lack the resources

59 Burt, *supra* note 8.
60 *Id*.
61 Steven Tourkin & David Hubble, *National Survey of Homeless Assistance Providers and Clients: Data Collection Methods, U.S. Census Bureau (1997).*
62 Burt, *supra* note 8.
63 Id.
64 Hopper, *supra note 5.*
65 *Id*.
66 *Id*.
67 *Frequently Asked Quest ons*, Wilder Research, http://mnhomeless.org/about/frequently-asked-questions.php (last visited 11, 1, 2017).

to remain for more than 14 days, or persons doubled up where there is evidence that they may have to leave within 14 days.[68] The definition is also expanded for youth who are not staying with their parents but are living with a friend or relative.[69]

A comparison of the count conducted by Wilder Research and the HUD PIT count for Hennepin Co. can be seen in Figure 4. The Wilder counts follow the same trend as the HUD PIT data in general, but are consistently higher, by as much as 24% in 2012. A portion of this difference is most likely due to the expanded definition of homelessness used by Wilder.

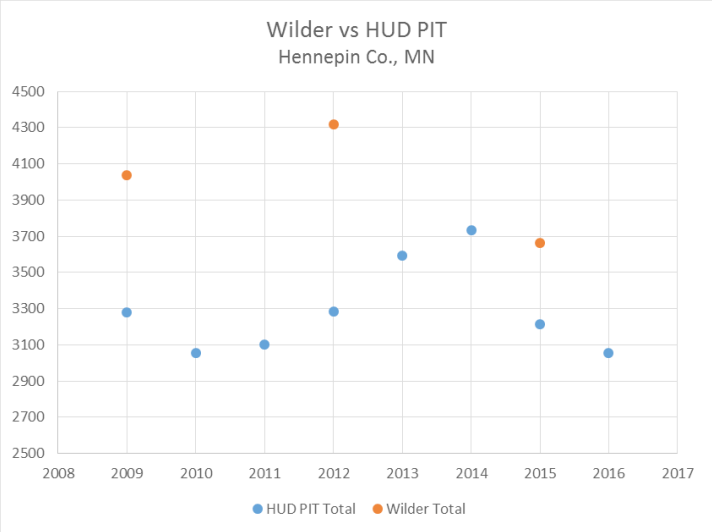


Figure 4. A comparison of the total homeless population count Hennepin Co., MN conducted by Wilder Research with the HUD PIT. (Source: Wilder Research, Homeless Study Detailed Data – Counts http://mnhomeless.org/minnesota-homeless-study/detailed-data-counts.php, https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/)

The Wilder study also includes an estimated number of homeless people in addition to the actual count. Their methods included weighting data collected from shelters using a one-night estimate based on findings from the U.S. General Accountability Office (GAO), a 1998 national study by the Research Triangle Institute, and a 2012 report from U.S. Department of Housing and Urban Development (HUD).[70] The U.S. GAO study found that for every child and youth in a shelter, 2.7 were doubled-up. The Research Triangle study found that 2.6 percent of all minors age 12 to 17 had been homeless for at least one night and had not used a shelter over the course of a year.[71] These two findings were averaged and then used to weight the sheltered youth count to produce an estimated total youth count. The HUD report stated that for every 100 single adults in shelters, there were 60 not in shelters, and for every 100 persons in families in shelters, there were 25 not in shelters. These findings were used to weight the sheltered count to provide an estimate of the total homeless adult population.[72]

They also produced an annual estimate based on a method in a 2001 report on homelessness by the Urban Institute.[73] This method assumes that people move in and out of homelessness and those that are homeless during the night of the survey are representative of others who may be homeless at any different night of the year. While the total count of homeless individuals at a given time might remain the same, specific individuals might change, making the total number of people experiencing homelessness in a year larger than the number counted.[74]

Figure 5 shows the Wilder count and its annual estimate of persons experiencing homelessness for the state of Minnesota by year from 1991 to 2015. The Wilder estimate in 2015 is more than 60% higher than their count.[75] Once again, this shows that the way that data is collected, classified, and processed can have a large impact on the reported estimates of homelessness and that the HUD PIT counts are a significant undercount.

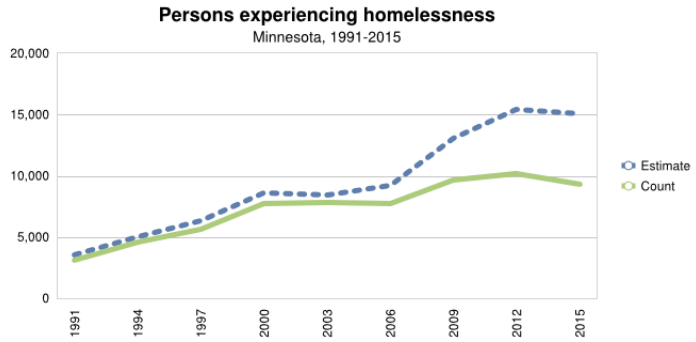


Figure 5. Count and Estimate of the Homeless persons in the state of Minnesota by Wilder Research. "Counts" of the number of people experiencing homelessness come from a census of all people staying in emergency shelters and other programs serving those experiencing homelessness, as well as a head count of those identified as homeless in non-shelter locations on the night of the survey. "Estimates" of the number of people experiencing homelessness are calculated by factoring in study-based estimates of those who are unsheltered, living temporarily with friends or family, and in detoxification centers. (Source: Wilder Research, Homelessness in Minnesota, http://mnhomeless.org/minnesota-homeless-study/homelessness-in-minnesota.php#1-3457-g)

68 Wilder Research, Homelessness in Minnesota - Findings from the 2015 Minnesota Homeless Study (2016).
69 *Id*.
70 *Id*.
71 *Id*.
72 *Id*.
73 *Id*.
74 *Id*.
75 *Id*.

CONCLUSIONS AND RECOMMENDATIONS

This report has highlighted many of the issues associated with the accuracy of the HUD PIT counts and how they produce a significant undercount of the homeless crisis in this country. We feel that the results of the PIT counts are not the best indicators of the success or failure of programs and policies that address homeless issues; therefore, the PIT counts as currently conducted should not be used to advise policy decisions.

Once again, this report does not intend to criticize the many professionals and volunteers that conduct the PIT counts but instead hopes to illuminate the shortcomings of the techniques and procedures required by HUD and their effect on the resulting counts.

Recommendations for the national count

Nationally coordinated, methodologically consistent count

Rather than depending on a single point-in-time count conducted by separate COC's across the country, we recommend a program that is nationally coordinated and consistent including input from service providers such as shelters and soup kitchens, the Department of Education, and correctional departments. This effort should be designed and its execution overseen by experts in such counting techniques.

The national program can learn from some of the more accurate studies that have been done. For example, it could include:

Periodic street counts which are conducted over longer periods than a single point in time.

Techniques such as plant and capture along with follow-up surveys to estimate and adjust for the number of individuals that are missed during the counts.

Annualized data and a more inclusive definition to show the true scope of the problem.

The Department of Education currently produces an annual count of homeless students and this data could be incorporated into a national count of all individuals. There is also a significant number of homeless individuals that are currently incarcerated in prisons and jails and any count of homeless individuals should include this population. This could be accomplished through coordination with correctional departments, as is currently done in COCs such as that in Butte.[76]

Ultimately, this would be the most effective long-term solution to addressing the flaws of the current point in time count system. This, however, would require commitment from government at all levels, service providers, and the public to work together. Of course, the real, and most important solution is to end homelessness.

Recommendations for the local counts

Even without change from HUD COCs can:

Include estimation techniques designed and overseen by experts in order to quantify the number of homeless individuals that were missed during the count.

Include all people experiencing homelessness, including individuals that are institutionalized in hospitals and jails or prisons

Separately estimate individuals who are doubled up with friends or family due to economic hardship.

Recommendations for using the PIT count data

Acknowledge it is an undercount

As shown above, the PIT count is a significant undercount of the homeless population, especially of those that are unsheltered, institutionalized, or doubled up. The data should never be used without the explicit acknowledgment of that fact, along with any available data that accounts for the scale of the undercount.

Acknowledge changes in methodology or classification

Particularly, year to year trends should include scrutiny of any methodological or classification changes that may have also occurred over the time period.

Use other data sources as comparison

It can be helpful to use both the HUD figures and the Department of Education (ED) report of homeless students. While the ED report is also an undercount and has its own challenges, it can show some indication of the broader problem because it uses a wider definition of homeless than HUD and produces annual estimates.

76 *2017 Homeless Point in Time Census & Survey Report: Butte Countywide Homeless Continuum of Care, supra* note

News

Even the mayor felt confused when San Francisco tried to count its homeless population

Mayor London Breed, right, passes a man in a wheelchair during the Department of Homelessness and Supportive Housing's Point-in-Time Count on Tuesday night. | Jason Henry for The Standard

Share

By **David Sjostedt**
Published Feb. 01, 2024 • 1:00pm

Volunteers and nonprofit workers fanned out across San Francisco on Tuesday night to count the number of homeless people on the streets, as the city does every other year. But hardly anyone, even Mayor London Breed, thinks they got an accurate number.

"How are we supposed to tell whether or not they're really unhoused?" Breed told The Standard after she spent several hours trawling the Tenderloin with the nonprofit Code Tenderloin as part of the Point-in-

Time Count. “You’ve got a lot of folks out here who are unfortunately suffering from mental illness and addiction, and that’s a big difference from being homeless.”

The one-night count, conducted by every major city across the country, is required by the federal government to determine how much homelessness funding to allocate. Two years ago, 4,397 people were counted as living on the streets of San Francisco.

Funding—and political futures—are on the line. A significant jump in the number of people counted could mean not only more money for San Francisco’s shelter and housing efforts but also political baggage for Breed and other incumbents facing reelection in November.

As the night began, Code Tenderloin founder Del Seymour went so far as to tell canvassers not to worry if they couldn’t tally every single homeless person.

“If you see you’re irritating someone, walk back and leave them alone. We ain’t got to count every single person,” said Seymour, who is locally known as the unofficial mayor of the Tenderloin.

Seymour later told The Standard he suspects the count underestimates the number of homeless people because many “double up” in the city’s supportive housing units.

A community ambassador hands Narcan to a man on Mission Street during Tuesday night's Point-in-Time Count of unhoused city residents. | Jason Henry for The Standard

Process Confusion?

Confusion was rife among various groups of counters as some deployed different tactics than others.

Breed said her group canvassing the Tenderloin was told not to engage with homeless people. Another group of five counters, which The Standard accompanied around the South of Market neighborhood, started a conversation with most of the homeless people they spotted.

The SoMa group was successful in engaging with people on the streets. But they weren't as good at counting them.

Around 9:40 p.m. on the corner of Eighth and Howard streets, the five fumbled around with their maps, trying to figure out which way to go, as a homeless person walked right past them, unnoticed.

Code Tenderloin community ambassadors try to figure out their maps during the Point-in-Time Count of homeless people in the city on Tuesday. | Jason Henry for The Standard

Just down the block, the group might have missed another homeless man who was tucked away in a corner if it hadn't been for The Standard's photographer pointing him out.

One of the volunteers told The Standard he lives in his car, but he didn't appear to count himself as homeless.

“There’s no process for how we’re supposed to do this,” Code Tenderloin employee Tyree Leslie said in frustration.

As the group navigated SoMa’s alleyways, one of the men asked where all the homeless people had gone. The surrounding streets were clean, and aside from a few scattered people using drugs, they were mostly empty.

“So they really cleaned it up?” asked Code Tenderloin employee Chuck Stubblefield.

“They moved it somewhere else. They didn’t clean it up,” said his co-worker, Brian Hudson.

That much was evident as the group turned a corner onto Eighth and Market streets, where the sidewalks were littered with trash and filled with dozens of people using drugs.

The block was outside Hudson and Stubblefield’s assigned zone, but some of the group’s members still stopped to offer people water, snacks and information about their nonprofit.

As the group of counters approached Seventh and Market streets, they saw hundreds of people buying and selling drugs and what appeared to be stolen goods in an illicit night market.

“There ain’t no counting that,” said Hudson, pointing at the crowd.

People sell items in front of the Proper Hotel on Market Street on Tuesday night. | Jason Henry for The Standard

Hudson estimated there were more than 120 homeless people in the crowd. However, the gathering was just outside the zone he was assigned to count.

“They’re not standing over there holding fellowship,” he said.

Breed told The Standard that during the daytime, the Tenderloin is “really, really clean.” However, she said increased drug activity at night is undermining the city’s efforts.

"It gives the impression that we're not out here working hard trying to clean up the streets and help people," Breed said.

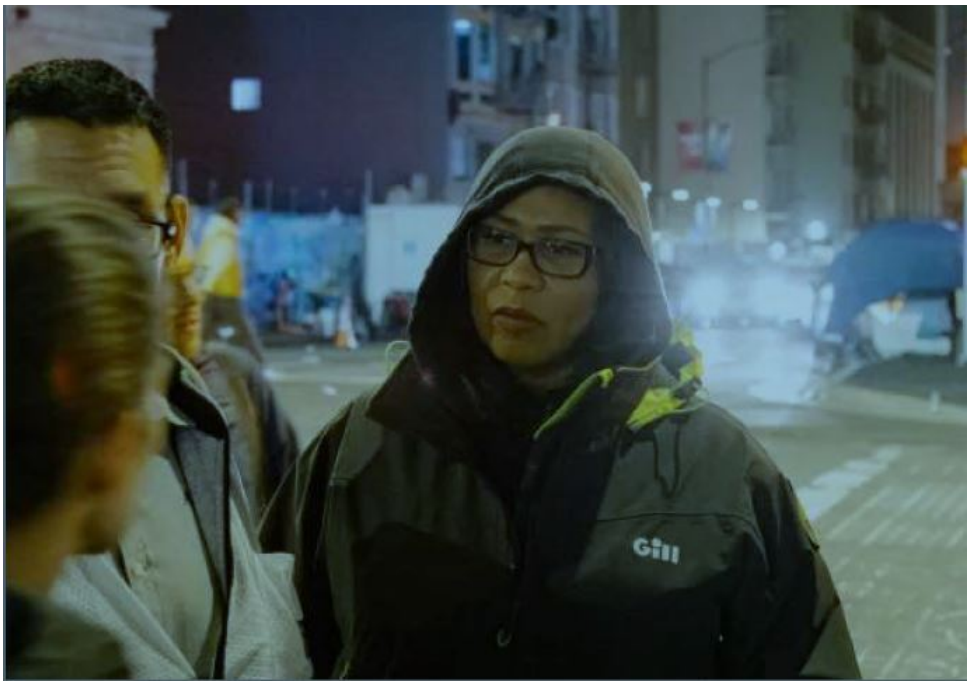
An Imperfect Count

Despite its shortcomings, the count provides a relatively consistent data point for the city, according to Emily Cohen, a spokesperson for the Department of Homelessness and Supportive Housing.

“While the count itself may be imperfect, it is relatively consistent and a good indicator of trends,” Cohen said.

However, many experts argue there are better methods of quantifying the crisis.

“The data wouldn’t get past an eighth-grade biology teacher,” said Paul Boden, executive director of the homelessness nonprofit Western Regional Advocacy Project. “The numbers are never used for anything except for public relations.”



San Francisco Mayor London Breed admitted she was confused about the process for counting the city's homeless residents.

Boden said the government would be better off measuring the demand for services in every city. In San Francisco, there were 77 people on a waitlist for shelter this week-though the list reached nearly 500 people long in August. There were 3,633 people in the city's homeless shelters this week.

In December, there were 238 homeless families-including 363 children-on a waitlist for shelter as Christmas approached.

An audit of the ci!J.'s street homelessness teams in November found that outreach workers encountered 3,641 unique clients on the street during fiscal year 2022.

Cohen said the homelessness department uses many data sets, not just the one-night count, to tabulate the number of homeless people in the city.

The department estimated in 2022 that as many as 20,000 people engage with the city's homelessness services over a year. Many are only temporarily homeless.

"It's an exercise in futility," Boden said. "We do all these plans, and we never, ever have seen a plan from the government that actually addresses what created this shit in the first place-wiping out affordable housing."

Cohen said the department will release the Point-in-Time Count data in the summer, and outreach workers are heading out again in the coming weeks to obtain demographic data on the city's homeless population.

David Sjostedt can be reached at david@sfstandard.com

CAMILLUS HOUSE, CAUSES OF HOMELESSNESS (www.camillus.org)

HOMELESSNESS BEGINS WITH A LACK OF RESOURCES: POVERTY

Homelessness and poverty are inextricably linked. People who are poor are frequently unable to pay for housing, food, child care, health care, and education.

Difficult choices must be made when limited resources cover only some of these necessities. Often it is housing, which absorbs a high proportion of income, that must be dropped. Being poor means being an illness, an accident, or a paycheck away from living on the streets.

In 2000, 11.3% of the U.S. population, or 31.1 million people, lived in poverty. *(US Bureau of the Census, 2001)* While the number of poor people has decreased a bit in recent years, the number of people living in extreme poverty has increased. In 2000, 39% of all people living in poverty had incomes of less than half the poverty level. This statistic remains unchanged from the 1999 level.

Forty percent of persons living in poverty are children; in fact, the 2000 poverty rate of 16.2% for children is significantly higher than the poverty rate for any other age group.

SHRINKING OPPORTUNITIES: ERODING WORK OPPORTUNITIES AND HOUSING

Declining wages have put housing out of reach for many workers: in every state, more than the minimum wage is required to afford a one- or two-bedroom apartment at Fair Market Rent. In Miami-Dade County a family needs to work 126 hours a week at minimum wage in order to afford a moderately priced two bedroom apartment.

In 1970 there were 300,000 more affordable housing units available, nationally, than there were low-income households who needed to rent them. By 1995, there were 4.4 million fewer available units than low-income households who needed to rent them.

DECLINE IN PUBLIC ASSISTANCE

The declining value and availability of public assistance is another source of increasing poverty and homelessness.

Welfare caseloads have dropped sharply since the passage and implementation of welfare reform legislation. However, declining welfare rolls simply mean that fewer people are receiving benefits — not that they are employed or doing better financially. Early findings suggest that although more families are moving from welfare to work, many of them are faring poorly due to low wages and inadequate work supports. Only a small fraction of welfare recipients' new jobs pay above-poverty wages; most of the new jobs pay far below the poverty line. (Children's Defense Fund and the National Coalition for the Homeless, 1998)

An illness or accident can change everything

For families and individuals struggling to pay the rent, a serious illness or disability can start a downward spiral into homelessness, beginning with a lost job, depletion of savings to pay for care, and eventual eviction. Nearly a third of persons living in poverty had no health insurance of any kind.

Homelessness severely impacts health and well-being. The rates of acute health problems are extremely high among people experiencing homelessness. With the exception of obesity, strokes and cancer, people experiencing homelessness are far more likely to suffer from every category of severe health problem.

Children without a home are in fair or poor health twice as often as other children, and have higher rates of asthma, ear infections, stomach problems, and speech problems. *(Better Homes Fund/1999)* They also experience more mental health problems, such as anxiety, depression, and withdrawal. They are twice as likely to experience hunger, and four times as likely to have delayed development. These illnesses have potentially deadly consequences if not treated early.

Total Number of Homeless Persons on the Street in Miami-Dade County on an average night: 1,347

DOMESTIC VIOLENCE

Domestic violence is the second leading cause of homelessness among women. Battered women who live in poverty are often forced to choose between abusive relationships and homelessness. Nationally, approximately half of all women and children experiencing homelessness are fleeing domestic violence.

MENTAL ILLNESS

Approximately 22% of the single adult homeless population suffers from some form of severe and persistent mental illness. (U.S. Conference of Mayors, 2001)

Despite the disproportionate number of severely mentally ill people among the homeless population, increases in homelessness are not attributable to the release of severely mentally ill people from institutions. Most patients were released from mental hospitals in the 1950s and 1960s, yet vast increases in homelessness did not occur until the 1980s, when incomes and housing options for those living on the margins began to diminish rapidly.

According to the Federal Task Force on Homelessness and Severe Mental Illness, only 5–7% of homeless persons with mental illness need to be institutionalized; most can live in the community with the appropriate supportive housing options. (Federal Task Force on Homelessness and Severe Mental Illness, 1992) However, many mentally ill homeless people are unable to obtain access to supportive housing and/or other treatment services. The mental health support services most needed include case management, housing, and treatment.

ADDICTION DISORDERS

The relationship between addiction and homelessness is complex and controversial. While rates of alcohol and drug abuse are disproportionately high among the homeless population, the increase in homelessness over the past two decades cannot be explained by addiction alone. Many people who are addicted to alcohol and drugs never become homeless, but people who are poor and addicted are clearly at increased risk of homelessness.

In the absence of appropriate treatment, addiction may doom one's chances of getting housing once on the streets. Homeless people often face insurmountable barriers to obtaining health care, including addictive disorder treatment services and recovery supports.

The following are among the obstacles to treatment for homeless persons: lack of health insurance; lack of documentation; waiting lists; scheduling difficulties; daily contact

requirements; lack of transportation; ineffective treatment methods; lack of supportive services; and cultural insensitivity. An in-depth study of 13 communities across the nation revealed service gaps in every community in at least one stage of the treatment and recovery continuum for homeless people. Source: National Coalition for the Homeless

WHO IS HOMELESS IN MIAMI-DADE COUNTY?

Most people who experience homelessness (83%) are homeless for a short period of time, and usually need help finding housing or a rent subsidy. A small portion (17%) is homeless for long periods of time or cycle in and out of homelessness. They need permanent supportive housing.

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Homelessness and Substance Abuse: Which Comes First?

Guy Johnson & Chris Chamberlain
RMIT University, Victoria, Australia

Abstract
The present paper uses a social selection and social adaptation framework to investigate whether problematic substance use normally precedes or follows homelessness. Clarifying temporal order is important for policy and program design. The paper uses information from a large dataset (N = 4,291) gathered at two services in Melbourne, supplemented by 65 indepth interviews. We found that 43% of the sample had substance abuse problems. Of these people, one-third had substance abuse problems before they became homeless and two-thirds developed these problems after they became homeless. We also found that young people were more at risk of developing substance abuse problems after becoming homeless than older people and that most people with substance abuse issues remain homeless for 12 months or longer. The paper concludes with three policy recommendations.

Keywords: Homelessness; Substance Abuse; Housing And Support

There is a common perception that substance abuse and homelessness are linked, but there is considerable contention about the direction of the relationship (Kemp, Neale, & Robertson, 2006; Mallett, Rosenthal, & Keys, 2005; Neale, 2001; Snow & Anderson, 1993). Does substance abuse typically precede or follow homelessness?

Correspondence to: Dr Guy Johnson, Australian Housing and Urban Research Institute, RMIT University, GPO Box 2476V, Melbourne, Vic. 3000, Australia. E-mail: guy.johnson@mit.edu.au

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Prevalence of Substance Abuse

The first task was to establish how many people in the sample had substance abuse problems. Studies that focus on the number of people with substance abuse problems are referred to as prevalence studies. A common finding is that homeless people have higher rates of problematic substance use than people in the general community (Teesson, Hodder, & Buhrich, 2003). In their recent study of 210 homeless people in Sydney, Teesson et al. (2003, p. 467) found that "homeless people were six times more likely to have a drug use disorder and 33 times more likely to have an opiate use disorder than the Australian general population". One welfare service in Melbourne reported that the prevalence rate of heroin use among its clients was "10 times greater than in the general community" (Horn, 2001, p. 8).

Although the empirical link between substance abuse and homelessness is well established, reported rates of problematic drug use among the homeless vary, with estimates ranging from 25% to 70% (Hirst, 1989; Jordon, 1995; Victorian Homelessness Strategy, 2002). Estimates vary because of different sampling procedures, as well as different definitions of problematic drug use and homelessness.

We found that 43% of our sample had substance abuse problems. The most common drug was heroin, but a minority identified alcohol or prescription drugs. Our findings are consistent with recent studies indicating that drugs have displaced alcohol as the most abused substance among the homeless, particularly among the young (Glasser & Zywiak, 2003; Johnson et al., 1997).

Substance Abuse as a Precursor to Homelessness

The first model we examine is the social selection approach. We start by identifying how many people in our sample had substance abuse issues prior to becoming homeless. Then, we identify three typical stages leading to homelessness for those with problematic drug use.

We found that 15% of the sample had substance abuse problems prior to becoming homeless for the first time. In the public domain, substance abuse is regularly seen as the main cause of homelessness, yet for most people in our sample other factors resulted in them becoming homeless. This finding is important for two reasons. First, when attributions of cause are incorrect, it can lead to inappropriate policy and program design. Second, by focusing on substance abuse as a causal factor, individuals are commonly blamed for the situation, diverting attention away from the structural factors that contribute to homelessness.

Many people in Australia use drugs for recreational purposes (Marks 1989; McAllister & Makkai, 2001), but here we describe the substance abuse pathway into homelessness. Studies of homeless pathways commonly point to a series of ruptures with mainstream life (Hartwell, 2003; Johnson et al., 2008; Keys, Mallett, & Rosenthal, 2006). We identify three stages in the substance abuse pathway. First, there is a break with the mainstream labour market; second, there is the loss of support from family and friends; and, finally, there is the acquisition of new social networks.

Substance Abuse as an Adaptation to Homelessness

Recently, more researchers have focused on substance abuse as adaptation. When people are homeless, they adapt in order to survive. Although responses may vary from person to person, using drugs is a common form of adaptation.

In the present study, 43% of the sample had substance abuse issues. Table 1 shows that two-thirds (66%) developed problematic substance use after they became homeless. Our data confirm that substance abuse is common among the homeless population, but, for many people, substance abuse follows homelessness. Drug use is an adaptive response to an unpleasant and stressful environment and drug use creates new problems for many people.

Table 1 Substance Abuse Identified Before or After Homelessness

	N	*%*
Substance abuse before homelessness	656	34
Substance abuse after homelessness	1,284	66
Total	1,940	100

There are two common explanations as to why people become involved in problematic substance use after they become homeless. First, some people take drugs as a way to cope with or escape the harsh, oppressive environment that confronts them (Neale, 2001). Toby said: "The only way I could deal with that place (a run down boarding house) was to use drugs and I did use them". David said that using heroin helped him to forget about his troubles: "Using smack was a way for me to hide . . . You just hide away from everything . . . You take your mind off everything else because the one thing you've got to do each day is make sure you get your hit."

For Cameron, the situation was similar. Cameron had tried a range of drugs before he became homeless, describing himself as an "on and off again" user. However, once homeless, Cameron's drug use worsened considerably as he tried to deal with his new circumstances. It soon got to the point where substance abuse was a major issue in Cameron's life: "I didn't realise how bad my drug use had got . . . my habit was climbing and climbing. Everything was pretty much out of control at that point."

The second reason for problematic substance use stems from increasing involvement in the homeless subculture, where drug use is a common and accepted social practice. Drug use is commonly a form of initiation into the homeless subculture (Auerswald & Eyre, 2002; Fitzpatrick, 2000). Tess said she started to use heroin "because everybody around me was using smack". Joan was more explicit about the influence of her homeless peers: "Just peer pressure, I suppose. People around me were doing it and I wanted to fit in."

Many homeless people strive for a sense of "belonging somewhere", particularly those who experience homelessness when they are young. As Goffman (1961, p. 280) noted, "Without something to belong to, we have no stable self . . . Our sense of being a person can come from being drawn into a wider social unit."

Regardless of whether substance abuse precedes or follows homelessness, it typically locks people into the homeless population. Table 3 uses three temporal classifications (short-term, medium-term, and long-term homelessness) to demonstrate that homeless people with substance abuse issues are more likely to get stuck in the homeless population. Table 3 shows that 82% of people who had substance abuse issues had been homeless for 12 months or longer. In contrast, only 50% of those who had no substance abuse issues had been homeless for that long. When people have substance abuse problems they become marginalised from mainstream institutions and getting out of homelessness becomes more difficult.

Not only do people with substance abuse problems face barriers to getting out of homelessness, but they also have difficulties remaining housed.

The Council of Economic Advisers, The State of Homelessness in America (Sept. 2019)

Executive Summary
September 2019

Due to decades of misguided and faulty policies, homelessness is a serious problem. Over half a million people go homeless on a single night in the United States. Approximately 65 percent are found in homeless shelters, and the other 35 percent—just under 200,000—are found unsheltered on our streets (in places not intended for human habitation, such as sidewalks, parks, cars, or abandoned buildings). Homelessness almost always involves people facing desperate situations and extreme hardship. They must make choices among very limited options, often in the context of extreme duress, substance abuse disorders, untreated mental illness, or unintended consequences from well-intentioned policies. Improved policies that address the underlying causes of the problem and more effectively serve some of the most vulnerable members of society are needed.

This report (i) describes how homelessness varies across States and communities in the United States; (ii) analyzes the major factors that drive this variation; (iii) discusses the shortcomings of previous Federal policies to reduce homeless populations; and (iv) describes how the Trump Administration is improving Federal efforts to reduce homelessness.

We first document how homelessness varies across the United States. Homelessness is concentrated in major cities on the West Coast and the Northeast. Almost half (47 percent) of all unsheltered homeless people are found in the State of California, about four times as high as California's share of the overall U.S. population. Rates of sheltered homelessness are highest in Boston, New York City, and Washington, D.C., with New York City alone containing over one-fifth of all sheltered homeless people in the United States.

In the context of a simple supply and demand framework, we analyze the major causes of this variation in homelessness across communities: (i) the higher price of housing resulting from overregulation of housing markets; (ii) the conditions for sleeping on the street (outside of shelter or housing); (iii) the supply of homeless shelters; and (iv) the characteristics of individuals in a community that make homelessness more likely.

The first cause we consider is the overregulation of housing markets, which raises homelessness by increasing the price of a home. Using external estimates of the effect of regulation on home prices and of home prices on homelessness, we simulate the impact of deregulation on homeless populations in individual metropolitan areas. We estimate that if the 11 metropolitan areas with significantly supply-constrained housing markets were deregulated, overall homelessness in the United States would fall by 13 percent. Homelessness

would fall by much larger amounts in these 11 large metropolitan areas, for example by 54 percent in San Francisco, by 40 percent in Los Angeles, and by 23 percent in New York City. On average, homelessness would fall by 31 percent in these 11 metropolitan areas, which currently make up 42 percent of the United States homeless population.

Second, more tolerable conditions for sleeping on the streets (outside of shelter or housing) increases homelessness. We show that warmer places are more likely to have higher rates of unsheltered homelessness, but rates are nonetheless low in some warm places. For example, Florida and Arizona have unsheltered homeless populations lower than what would be expected given the temperatures, home prices and poverty rates in their communities. Meanwhile, the unsheltered homeless population is over twice as large as expected—given the temperatures, home prices and poverty rates in their communities—in States including Hawaii, California, Nevada, Oregon, and Washington State. Policies such as the extent of policing of street activities may play a role in these differences.

A larger supply of substitutes to permanent housing through shelter provision also increases homelessness. Boston, New York City, and Washington, D.C. are each subject to right-to-shelter laws that guarantee shelter availability of a given quality. These places each have rates of sheltered homelessness at least 2.7 times as high as the rate in every other city, and this difference cannot be explained by their weather, home prices, and poverty rates. Boston, New York City, and Washington, D.C. also have substantially higher rates of overall homelessness than almost every other city, suggesting that most people being sheltered would not otherwise sleep on the street. While shelter is an absolutely necessary safety net of last resort for some people, right-to-shelter policies may not be a cost-effective approach to ensuring people are housed.

The final cause we consider is the prevalence of individual-level demand factors in the population. Severe mental illness, substance abuse problems, histories of incarceration, low incomes, and weak social connections each increase an individual's risk of homelessness, and higher prevalence in the population of these factors may increase total homelessness.

Drivers of Variation in Homelessness Across the United States

This section uses the model of supply and demand described in figure 1 to analyze the factors that explain why some places have higher rates of homelessness than others: (i) the higher price of housing resulting from overregulation of housing markets; (ii) the tolerability of sleeping on the street (outside of shelter or housing); (iii) the supply of homeless shelters; and (iv) the characteristics of individuals in a community that make homelessness more likely.

The Price of Housing

When housing prices rise, economic theory predicts that more people will have difficulty paying rent and in some cases end up homeless.

A central driver of higher home prices in some communities is the heavy regulation of housing markets by localities. For example, as stated in President Trump's Executive Order Establishing a White House Council on Eliminating Regulatory Barriers to Affordable Housing, such regulations include: "overly restrictive zoning and growth management controls; rent controls; cumbersome building and rehabilitation codes; excessive energy and water efficiency mandates; unreasonable maximum-density allowances; historic preservation requirements; overly burdensome wetland or environmental regulations; outdated manufactured-housing regulations and restrictions; undue parking requirements; cumbersome and time-consuming permitting and review procedures; tax policies that discourage investment or reinvestment; overly complex labor requirements; and inordinate impact or developer fees." These regulations reduce the supply of housing and as a result drive up home prices (e.g., Quigley and Raphael 2005; Quigley and Rosenthal 2005; Glaeser and Ward 2009; Saiz 2010; Gyourko and Molloy 2015).

Given that housing market regulations increase home prices and higher home prices are associated with higher rates of homelessness, areas with more regulated housing markets would be predicted to have higher rates of homelessness.

The Tolerability of Sleeping on the Street

Just as increasing the price of being housed increases homelessness, increasing the tolerability of sleeping on the streets (outside of housing or shelter) increases homelessness as well. Increasing the tolerability of living on the streets shifts the demand for homes inward, and so the number of people living on the streets increases.

One important factor that helps determine the tolerability of sleeping unsheltered on the streets is climate. Sleeping on the streets is always harmful to one's health, and can be associated with higher rates of mortality (Roncarati et al. 2018). However, sleeping unsheltered is even more harmful when it is cold. Research consistently finds that colder climates are associated with lower rates of unsheltered homelessness (Byrne et al. 2013).

As Corinth and Lucas (2018) point out, rates of unsheltered homelessness are uniformly low in cold places. In other words, the difficulty of sleeping on the streets is so high during the winter in places like Minneapolis that unsheltered homelessness is extremely rare. However, there is wide variation in rates of unsheltered homelessness in warmer places. For example, Orlando, Las Vegas, and San Francisco all have average January temperatures of between 50 and 60 degrees Fahrenheit. But their rates of unsheltered homelessness are 2, 19 and 60 per 10,000 people respectively. In general, CoCs in California have higher rates of unsheltered homelessness than CoCs in Florida, despite similar January temperatures. It is clear that warm climates enable, but do not guarantee, high rates of unsheltered homelessness. Thus, factors beyond climate help determine rates of unsheltered homelessness in warm places.

A number of potential factors could help explain the remaining variation in rates of unsheltered homelessness. One potential factor is differences in city ordinances and policing practices, as these policies would directly affect the tolerability of living on the street and predict the aggregate number of unsheltered homeless people. Some States more than others engage in more stringent enforcement of quality of life issues like restrictions on the use of tents and encampments, loitering, and other related activities. Others have noted that policing may help determine rates of unsheltered homelessness as well. Of course, policies intended solely to arrest or jail homeless people simply because they are homeless are inhumane and wrong. At the same time, when paired with effective services, policing may be an important tool to help move people off the street and into shelter or housing where they can get the services they need, as well as to ensure the health and safety of homeless and non-homeless people alike. More research is needed to understand how different policing policies affect the outcomes of homeless people—including their ultimate destinations, mental health, drug use, employment and other dimensions of wellbeing—as well as outcomes for non-homeless people.

The Supply of Homeless Shelters

The third factor that explains variation in homelessness is the supply of substitutes to housing through homeless shelters. Expanding the supply of homeless shelters shifts the demand for homes inward and increases homelessness. A larger supply of shelter entails a higher shelter quality (i.e., characteristics of a shelter that make it more desirable for people who sleep there) at any given level of beds in the market. While shelter plays an extremely important role in bringing some people off the streets, it also brings in people who would otherwise be housed, thus increasing total homelessness.

Individual-Level Factors

Finally, a higher prevalence of individual-level risk factors for homelessness within the population reduces the demand for homes and thus increases homelessness in a community.

This is especially the case when the supply of homes is lower, and the supply of shelter and the tolerability of the streets is higher (see O'Flaherty 2004 for a discussion of the interaction between individual and community-level factors in determining homeless populations). A number of individual-level factors have been studied, including mental health, substance abuse, incarceration, poverty, and social ties.

According to the 2018 homeless point-in-time count, 111,122 homeless people (20 percent) had a severe mental illness and 86,647 homeless people (16 percent) suffered from chronic substance abuse (HUD 2018b). Among all adults who used shelter at some point in 2017, 44 percent had a disability (HUD 2018a). The extent to which these estimates accurately reflect the true proportion of the homeless population with these issues is unclear, given the varying methodologies used by CoCs to count and survey their homeless populations. However, other studies similarly suggest a high prevalence of mental illness and substance abuse in the homeless population. A national survey of homeless individuals conducted in 1996 found that among single adults, 39 percent experienced mental health problems, 26 percent experienced drug use problems, and 38 percent experienced alcohol use problems in the past month (Burt et al. 1999). A history of incarceration is also relatively common among homeless individuals. Among those adults entering a homeless shelter in 2017 from a non-homeless situation, 9 percent were identified as previously staying in a correctional facility (HUD 2018). Metraux and Culhane (2006) find that 17 percent of single adults in New York City shelters spent time in jail over the previous two years, and 8 percent had spent time in prison.

People experiencing homelessness generally have low incomes and relatively weaker social ties. According to a 1996 national survey of the homeless, mean incomes were around half of the poverty line both for single adults and for families (Burt et al. 1999). Corinth and Rossi-de Vries (2018) find that the lifetime incidence of homelessness is reduced by 60 percent for individuals with strong ties to family, religious communities, and friends. Among people who entered shelter in 2017 who were not already homeless, 51 percent had previously been staying with family or friends (HUD 2018a). This suggests that homelessness may result when these social ties are exhausted.

Although mental illness, substance abuse disorders, former incarceration, poverty, and weak social ties place individuals at a higher risk of homelessness, the vast majority of people with any of these issues is not homeless (even if all half a million homeless people faced all of these problems, there are millions of non-homeless Americans who face each problem as well). Thus, other factors are important as well in determining who becomes homeless. Among those with higher risk factors, homelessness is often a case of bad luck (O'Flaherty 2010). Still, addressing these individual-level factors could in part help reduce homeless populations, especially when pursued in conjunction with polices that address community level determinants of homelessness.

CHAPTER ONE

Baseline

Homelessness occupies a prominent place in American political life. Although less than one-fifth of 1 percent of the U.S. population experiences homelessness on a given night in the country, the issue receives considerable attention from policy makers and the general public. This spotlight is striking given the scale of the homelessness crisis when compared to other prominent social problems. That fifth-of-a-percent figure translates to about five hundred sixty-eight thousand people. To be sure, this number should feel large and unacceptable. But on an absolute basis, for example, homelessness pales in comparison to the nation's poverty crisis: Over thirty-four million Americans were living below the federal poverty line in 2019. Meanwhile, abundant evidence highlights the political preoccupation with homelessness. In 2020, a poll in Washington State revealed that voters ranked homelessness as the top priority for the state legislature—far above other common public concerns like transportation, the economy, the environment, and health care.[1] We observe a similar focus at the national level. As depicted in

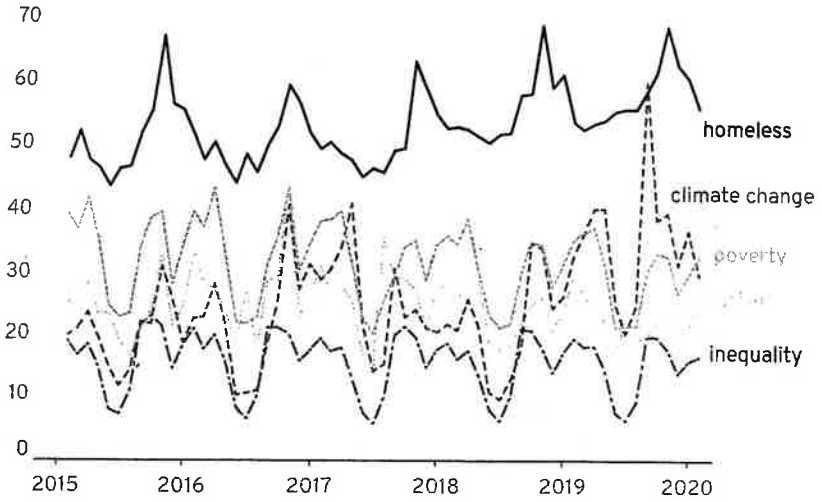

Figure 1. Public interest over time for five search terms. Data source: Google Trends

Figure 1, from January 2015 to January 2020, more people in the United States searched for the term *homeless* via Google than for *inequality*, *racism*, *poverty*, and *climate change*.[2]

How might we explain this seemingly disproportionate interest in the issue of homelessness? Two potential explanations come immediately to mind. First, maybe this interest isn't as disproportionate as it might initially appear. That is, maybe the numbers are wrong. Among astute observers, it is well understood that official point-in-time census estimates of homelessness underestimate the true size of the population experiencing homelessness on any given night.[3] For example, the federal definition excludes many precariously housed individuals and families who might be living with a friend or temporarily living in a motel room. The more expansive definition of homelessness used by the U.S. Department of Education suggests a population

of 1.35 million homeless students *without* counting their parents.[4] Furthermore, across greater spans of time—say, lifetimes—roughly 5 percent of the population experiences homelessness at least once.[5] In light of these figures, it is more accurate to consider homelessness as a problem that affects millions, rather than hundreds of thousands. But even the larger figure highlights the fact that only a small fraction of people living in poverty actually lose their housing.

More fundamentally, though, a second explanation for the intense interest in the topic may stem from the simple incongruity of a half million people living in shelters and on the street in the wealthiest country in the world. Reactions to this apparent paradox are diverse. For some, homelessness is a moral and political outrage indicting the capitalist system on which U.S. society is based; for others, homelessness is a scourge ruining the nation's largest and most dynamic cities. Other observers reside somewhere in the middle of this spectrum. What is uncontroversial is that homelessness elicits strong and emotional responses from all corners of society. From the perspective of the public, the intense focus on homelessness requires—and demands—an explanation. There is a strong desire to understand the causes of homelessness and where to assign blame. This book is in part concerned with the question of blame.

In January 2020, just weeks before the outbreak of the coronavirus pandemic in the United States, a long-simmering debate about the origins of and responsibility for the homelessness crisis erupted in public. Members of the federal government, including President Trump, argued vocally that the high rates of homelessness in many U.S. cities were a function of the local failings of Democratic leadership and policies. Referencing Democratic House Speaker Nancy Pelosi, the president said,

"She ought to go home and take care of her District, where the homeless is all over the place, and the tents and the filth and the garbage is eroding right into the Pacific Ocean and into their beaches."[6] In response to this finger-pointing, state and local policy makers—most notably California's governor, Gavin Newsom, a Democrat—argued that a lack of federal assistance had starved local communities of sorely needed resources, and housing instability and homelessness had flourished in turn.

Certainly, some of this political jostling is a product of the polarized nature of U.S. politics in the 2020s. From voting rights to climate change—issues that would appear at face value to be resoundingly nonpartisan but which often provoke party-line votes—policy responses to (and public perception of) the issues of our time are characterized by tribalism. Tailored media narratives and the so-called filter bubbles of social media add fuel to the flame of confirmation bias. It's harder than it should be to find fact-checked information, and it's even harder to internalize narratives that run counter to our beliefs. In this respect, homelessness is no different: It tends to provoke hyper-partisan diagnoses and prescriptions. And as with most cases of hyper-partisanship, neither argument above—Trump's nor Newsom's—sufficiently explains the state of homelessness in the country. If inadequate federal support alone accounts for the crisis, why does the rate of homelessness vary so substantially across cities? Presumably, all cities would be equally starved of resources if federal retrenchment were the cause. Yet while some cities have seen rates of homelessness rise over the last ten years, many others have seen rates fall. And if Democratic mayors and governors are the problem, how can we account for the many cities and states with both Democratic leadership and policies and relatively low rates of homelessness? Unsurprisingly,

the polarized plotlines are too simple, but they draw attention to essential questions about the nature and causes of the homelessness crisis.

As Ezra Klein writes in his recent book *Why We're Polarized*, one of the other phenomena driving polarization in the country is a grafting of our political identities onto national (as opposed to local) politics.[7] National politics, by definition, require a flattening of local variation—and in our de facto two-party system, with this flattening often comes a false dichotomization of many complex issues. This complicates the effort to respond to local issues that vary by geography—homelessness among them. In the United States, one of the most pressing and vexing questions about homelessness concerns the substantial *variation* in per capita rates of homelessness in cities across the country. Seattle and San Francisco, for example, have roughly four to five times the per capita homeless population of Chicago.[8] The stark differences between seemingly vibrant and healthy cities invite us (and many others) to ask: Why is homelessness so bad in cities like Seattle and San Francisco? Is this a failure of individuals, politicians, markets, or other structural forces? An understanding of variation might help us unlock the drivers of this crisis.

Many of us have, for good reason, struggled to identify a credible explanation for this variation. Accounts of and references to homelessness on television, online, in newspapers, and in scholarly sources offer a long list of potential causes of the issue; among them addiction, mental illness, poverty, domestic violence, eviction, high housing costs, racial discrimination, unemployment, and many others. Reports based on interviews with people experiencing homelessness highlight a wide range of potential causes, as well. A recent report from Seattle/King County for example, noted the following self-reported causes

of homelessness among respondents to the annual point-in-time homelessness census: job loss (24 percent of respondents), alcohol or drug use (16 percent), eviction (15 percent), divorce or separation (9 percent), rent increase (8 percent), argument with family or friend (7 percent), incarceration (6 percent), and family/domestic violence (6 percent).[9] Confronted with the question of why some cities have far greater per capita rates of homelessness than others, a reasonable, logical reaction might be to assume that higher levels of homelessness stem from higher incidences of these self-reported causal factors in these cities. In this book, we examine this logic.

While perusing any list of potential causes of homelessness, one can generally break the ostensible explanations down into two overarching categories. Some causes are individual in nature, and some are structural. The bifurcation is consistent with decades of research on poverty and homelessness. On one side of the debate are those who argue that poverty and homelessness are the result of individual factors, that vulnerabilities related to housing instability are fueled by illness, mental condition, laziness, or poor decision-making, including—for these observers—excessive drug and alcohol use. And in the central downtowns of cities like Los Angeles, San Francisco, or Seattle, thousands of unsheltered people experiencing homelessness may indeed be suffering from a substance use disorder, mentally ill, and/or unemployed. Following this logic, it is the disproportionate presence of people with these vulnerabilities in certain cities that explains the substantial variation in per capita homelessness rates around the country. Whether born in or attracted to these cities, *people* comprise the homelessness crisis, and so homelessness is an individual problem. (It is not uncommon for some to argue that homelessness is exclusively an individual choice.) On

the other side of the debate are those who argue that larger, structural forces, such as market conditions, housing costs, racism, discrimination, and inequality, causally explain the prevalence of homelessness. Under the structural explanation, homelessness is a consequence of broader and deeper societal factors driving people at the margins of society out of their housing.

Perhaps there is a middle road. The individual explanation is alluring—it's individual people who lose their housing, after all. Surely there must be systematic factors at play, though; otherwise, how could we possibly account for the dramatically different rates of homelessness around the country? Even if you were entirely convinced of the individual explanation, you would have to acknowledge that some kind of systemic variation—some combination of environmental, political, economic, and demographic trends—characterizes different places. In 2019, less than 1 in 1,000 residents were unhoused in Alabama and Mississippi, while California and Oregon had over five times that rate. Why? Existing research provides a helpful roadmap to navigate the seemingly complex and, at times, contradictory evidence about the causal drivers of homelessness. Homelessness researcher Brendan O'Flaherty, for example, suggests that to generate causal explanations of homelessness, one must consider the interaction between individual characteristics and the context in which that person resides. Either explanation alone is insufficient to explain or predict individual homelessness. By extension, he argues that people who lose their housing are effectively the wrong people in the wrong place.[10] This frame helps to provide a vantage point from which to consider the central question of this book: What explains the substantial regional variation in per capita homelessness rates in the United States?

To cut to the chase, the answer is on the cover of this book: *Homelessness Is a Housing Problem.* Regional variation in rates of homelessness can be explained by the costs and availability of housing. Housing market conditions explain why Seattle has four times the per capita homelessness of Cincinnati. Housing market conditions explain why high-poverty cities like Detroit and Cleveland have low rates of homelessness. Housing market conditions also explain why some growing cities, like Charlotte, North Carolina, are not characterized by the levels of homelessness that coastal boomtowns like Boston, Seattle, Portland, and San Francisco are. Variation in rates of homelessness is not driven by more of "those people" residing in one city than another. People with a variety of health and economic vulnerabilities live in every city and county in our sample; the difference is the local context in which they live. High rental costs and low vacancy rates create a challenging market for many residents in a city, and those challenges are compounded for people with low incomes and/or physical or mental health concerns.

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According to estimates from the U.S. Department of Housing and Urban Development (HUD), at least 567,715 people experienced homelessness on a single night in 2019.[11] But this aggregate figure masks significant geographic variation in the distribution of per capita homelessness across the country. The metropolitan areas of New York, Los Angeles, Washington, D.C., San Francisco, Seattle, and Boston alone account for over 29 percent of the homeless population in the country, despite being home to only about 7 percent of the general population. Regardless of one's view of the problem—and the political lens through which one considers homelessness—it is reasonable to wonder what

it is about these cities that produces (or, according to some, attracts) such large and disproportionate populations of people experiencing homelessness. To explore this phenomenon, we shift the unit of analysis away from the individual and turn our attention to the metropolitan area. From this perspective, we are not interested in predicting whether a given person will experience homelessness or why someone lost their housing in the past; we are interested in understanding why, for example, the crisis is so much more extreme in Boston than in Cleveland. This analytic pivot does not preclude individual explanations for homelessness; instead, it clarifies the object in which we are interested: the city-to-city variation itself.

Understanding this variance is critical to formulating an appropriate policy response. In cities with substantial unhoused populations, it is common for rival political factions to blame one another for the crisis—a microcosm of the Trump–Newsom sparring cited above—and for the issue to devolve into a political hot potato. Often caught in the middle of this dispute are municipal leaders who are tasked with "solving" the problem (with resources that many consider to be inadequate). Societal cleavages emerge in which compassionate responses to homelessness—those that stress social service provision and respect for the dignity and rights of people experiencing homelessness—are criticized by community members who advocate a tougher response to the crisis. Proponents of the latter approach argue that overly permissive local policies have incubated an underlying problem, all while individual desperation facilitates property crime, threatens public health, and abets a deterioration of a city's overall quality of life. The severity and polarization of homelessness is evident in public polling that identifies the problem as the highest-ranked public concern. In

the 2020 State of Washington poll of eligible voters mentioned earlier, 31 percent of voters ranked homelessness as Washington's top issue: an increase of ten percentage points over 2019.[12]

Accordingly, it is worth considering the relationship between perceptions of homelessness and its reality, not least because personal experience and anecdote play formidable roles in shaping opinions and perceptions about the issue. For housed city dwellers in Seattle, San Francisco, and Los Angeles, seeing and interacting with people experiencing homelessness is a daily occurrence. Tents dot the urban landscape; large encampments move (either voluntarily or forcibly) from neighborhood to neighborhood. There is a profound chasm in human experience in these cities, between new million-dollar condos and the tents and tarps that the unhoused use to protect themselves from the elements. And while large unsheltered populations in many coastal cities raise legitimate concerns about public safety and health—for the housed and unhoused alike—these visible reminders do not accurately reflect the homelessness problem as a whole. In most cities, the majority of people experiencing homelessness are not visible to the general population, because most people without housing sleep in shelters or other supportive housing facilities. On any given night in this country, the chronically unsheltered constitute only about one-tenth of the population experiencing homelessness. Yet the visibility—the literal conspicuousness—of the chronic, unsheltered population in many cities helps to cement a belief that people experiencing homelessness are mentally ill and/or addicted to a substance, as these conditions are disproportionately represented in the unsheltered population. Accordingly, the narrative about homelessness is often dominated by a focus on drugs and mental health, which may obscure other (often structural) explanations for the crisis.

In this book, we make an important distinction when considering the causal drivers of homelessness. First, we note *precipitating events* that can lead to a bout of homelessness. For example, in the survey of people experiencing homelessness in Seattle/King County, self-reported "primary reasons" for homelessness include divorce, domestic violence, and arguments with family or friends.[13] As they are identified in interviews with people then-without housing, we can indeed consider these events to have produced a spell of homelessness. But we can't consider each reason a *root cause* of a given housing crisis. If divorce is a cause of homelessness, for example, why don't far more people lose their housing after leaving a spouse? A key point to which we return in this book is that *under certain conditions*, a range of precipitating events (like divorce) can result in homelessness—but these events ought not be considered root causes of housing instability and loss. Underlying vulnerabilities matter.

Consider the following vignette about musical chairs, often deployed by homelessness researchers, to think through causality and homelessness. We use this example to highlight the difference between a precipitating event and a root cause:

> Ten friends decide to play a game of musical chairs and arrange ten chairs in a circle. A leader begins the game by turning on the music, and everyone begins to walk in a circle inside the chairs. The leader removes one chair, stops the music, and the ten friends scramble to find a spot to sit—leaving one person without a chair. The loser, Mike, was on crutches after spraining his ankle. Given his condition, he was unable to move quickly to find a chair during the scramble that ensued.

In other words, when housing is scarce, vulnerabilities and barriers to housing are magnified. Limited financial resources, mental illness, addiction, or interpersonal strife, under

a specific set of circumstances, could each precipitate a bout of homelessness—just as a sprained ankle might prevent one from finding a chair in musical chairs. But the fundamental question remains: Would we say that Mike's ankle injury *caused* him to lose the game? Under the specific conditions of the game (say, nine chairs and ten people), Mike's impairment prevented him from finding a chair. But under different conditions—ten chairs and ten people—Mike would have easily found one. One could argue, and we will in this book, that the fundamental *cause* of Mike's chairlessness—was a lack of chairs, not his ankle injury. The rules of the game meant that someone had to lose.

Over the course of this book, we illustrate that personal vulnerabilities may explain *who* becomes homeless within a given community under a specific set of circumstances—but that, in aggregate, these vulnerabilities do not adequately explain regional variation in homelessness. This finding suggests that broader structural explanations of homelessness—especially those that shape housing markets—may have more explanatory power than the precipitating events frequently cited in local surveys as the "primary causes" of homelessness. Policy responses ought to be tailored accordingly. This foundation guides this project as a whole. Our central argument—that the prevalence of homelessness is driven by structural forces—is not unique in its own right. Much research has identified a causal link between housing-market conditions and homelessness. But there is little evidence that these findings have altered and shaped public perceptions about the nature of the crisis; hence our desire to package a comprehensive analysis in a single volume.

Social science research frequently relies on complex statistical methods and expansive data sources to relay a credible causal

narrative about social phenomena for the subset of readers who are trained in these methods and have access to this content (usually via university journal subscriptions). For people outside of the academy, access to this information may be limited, both with respect to the specialized nature of academic social science and the expensive paywalls of academic journals. Understanding, then, is more frequently shaped by media narratives, experience, and anecdote. Cognitive dissonance is real, too. New findings from the academy may challenge deeply held ideology, and evidence doesn't always make a difference. Accordingly, in this book, we seek to present our research by means of intuitive appeals to first principles. We use geographic variation in rates of homelessness as the foundation from which to test a wide range of potential explanations for the crisis, using an accessible analytical methodology appropriate for a broad audience. In this manner, we address many of the common narratives about homelessness in a single work with relatively simple statistical methods. Basic causal reasoning allows us to dismiss several common explanations for higher rates of homelessness: If there is no fixed statistical evidence of a positive relationship between a potential cause and our outcome of interest (i.e., rates of urban homelessness), we have to conclude it does not bear on variation in this outcome in any straightforward manner. For example, if poverty rates are low in cities with high rates of homelessness, it is impossible to attribute regional variation in homelessness to differences in the relative presence of low-income households. Applied to all potential explanations in this book, this structure provides the basis from which we ultimately attribute varying rates of homelessness to the structure of housing markets—a finding corroborated by other research leveraging different data sources and methods.

HOMELESSNESS COUNTS AND TRENDS

To study variation in rates of homelessness, we shift the unit of analysis from individuals experiencing homelessness to metropolitan areas. This is a book about cities, not individual people. We seek to explain why certain geographic locations produce (or otherwise report) disproportionately high rates of homelessness. Because homelessness is largely an urban phenomenon, we focus our attention on the largest urban areas in the United States.

The first step in understanding variation in rates of homelessness is to understand the manners in which communities measure homelessness and deliver programming. In 1987, the U.S. Congress passed the McKinney-Vento Homeless Assistance Act, which created the contemporary administrative machinery behind the federal response to homelessness. A critical component of McKinney-Vento was the stipulation that federal money was to be distributed directly to jurisdictions to fund local service delivery. To facilitate the flow of funds from the federal government to local communities, HUD required states and municipalities to self-organize into units of geographic aggregation called Continuums of Care (CoC). Today, CoCs are the main administrative entities that manage homelessness programming, allocate federal funding to local service providers, and conduct the Congressionally mandated one-night census of homelessness. Virtually every locality in the country is covered by a CoC, but the construction and distribution of CoCs varies from state to state.[14] Most urban areas are covered by a single CoC, while smaller cities and rural areas might bundle together in a CoC that covers a large geographic area.

Ohio, for example, is divided into nine different CoCs (see Figure 2). Eight of the CoCs cover the most populous counties

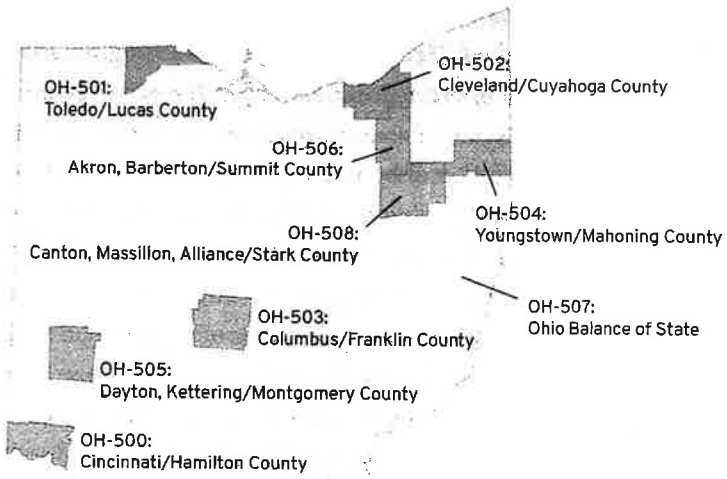

Figure 2. Ohio Continuum of Care map. The state is home to nine HUD CoCs: eight counties and the balance of state. Data source: HUD

in the state, including Cuyahoga County (Cleveland), Lucas County (Toledo), Franklin County (Columbus), and Hamilton County (Cincinnati). The largest CoC (in a geographic sense) is OH-507, which encompasses the entire balance of the state that is not covered by one of the other eight county-based CoCs. As CoCs administer their own one-night count of people experiencing homelessness—often conducted the last week of January and known as the Point-In-Time (PIT) count—the estimated unhoused population in Ohio, in the eyes of HUD, is the sum of Ohio's nine distinct CoC counts.

Relationships between CoC boundaries and other state and local boundaries can be messy. If we are interested in measuring homelessness in Cleveland, for example, the only geographic

unit available for analysis is the Cuyahoga County CoC, which includes both the city of Cleveland and its surrounding suburbs. Therefore, for those interested exclusively in the urban homelessness, Cleveland's homelessness rates as estimated by the Cuyahoga County CoC will be imprecise. Homelessness tends to be less prevalent in the suburbs.[15] Therefore, the rate of homelessness in county CoCs is, on average, lower than it is for CoCs that cover a single city. For example, the rate of homelessness in Cook County, Illinois (including the city of Chicago) in 2019 was 1.20 per 1,000 population. In the city of Chicago alone, the per capita rate was 1.96. Because major metropolitan areas correspond to a mix of city- and county-based CoCs, in this book we compare county-based CoCs to other county-based CoCs and city-based CoCs to other city-based CoCs.

To create our study sample, we began with a list of the thirty-five largest Metropolitan Statistical Areas (MSAs) in the United States. MSAs are geographic units of at least fifty thousand people that cover a major urban center plus its surrounding areas. For each MSA on the list, we identified the primary CoC in that MSA. We then excluded six MSAs because the primary CoC in question covered too large a geographic area. (For example, the CoC that includes Houston, Texas, encompasses five different counties—and won't be useful for understanding homelessness in the Houston metropolitan area alone.) Five other MSAs were excluded using similar criteria, including Riverside, California; Denver, Colorado; Orlando, Florida; Pittsburgh, Pennsylvania; and Kansas City, Missouri. After these exclusions, our sample covers twenty-nine of the thirty-five largest MSAs in the county. We ultimately include thirty CoCs, however, because of the unique case of Cook County, Illinois—which is divided into two CoCs, one for the city of Chicago, and one for the remainder of Cook County. Chicago is the only city in our sample with this structure. Accordingly, we include the Chicago CoC in the list of city-based CoCs, but we also separately aggregate the two CoCs to get a picture of homelessness for Cook County as a whole. We include Cook County in our list of county CoCs as well, leaving a final sample of nineteen county-based CoCs and eleven city-based CoCs. In 2019, the collection of thirty CoCs in our sample accounted for roughly 45 percent of all homelessness in the United States. We compare these regions every year from 2007 to 2019.

Returning to the regional differences that motivated this book, the following graphs offer a visual explanation of the variation in per capita rates of U.S. homelessness in the country over this time period.[16] Figures 3 and 4 show the per capita rates of homelessness in the city and county CoCs in 2007 and 2019—the beginning and ending years for our sample period.

As the figures illustrate, variation in rates of homelessness is not a new phenomenon: The 2007 figures show similarly wide-ranging dynamics as those from 2019. In our sample, we see single-night rates of homelessness anywhere between about 1 and 10 unhoused people per 1,000 population. The second key takeaway from these figures is that, generally speaking, high per capita locations in 2007 also saw high rates in 2019. Washington, D.C., New York City, Boston, San Francisco, King County (Seattle), Multnomah County (Portland), Los Angeles County, and Santa Clara County (San Jose) have persistently seen the highest rates of per capita homelessness over the thirteen years covered in this book. We are interested in what differentiates these cities from others. To the extent that policy choices, macroeconomic trends, or local cultural factors may drive variation in rates of homelessness, we want to know what differentiates Multnomah County, Oregon, from Maricopa County, Arizona.

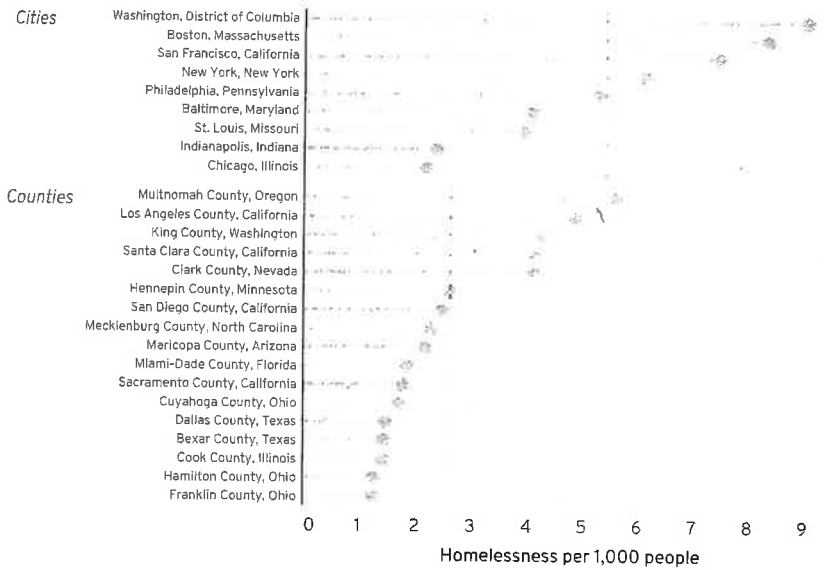

Figure 3. Per capita rates of homelessness in select U.S. regions, 2007. Dashed lines indicate city and country averages of per capita PIT counts. Data source: HUD

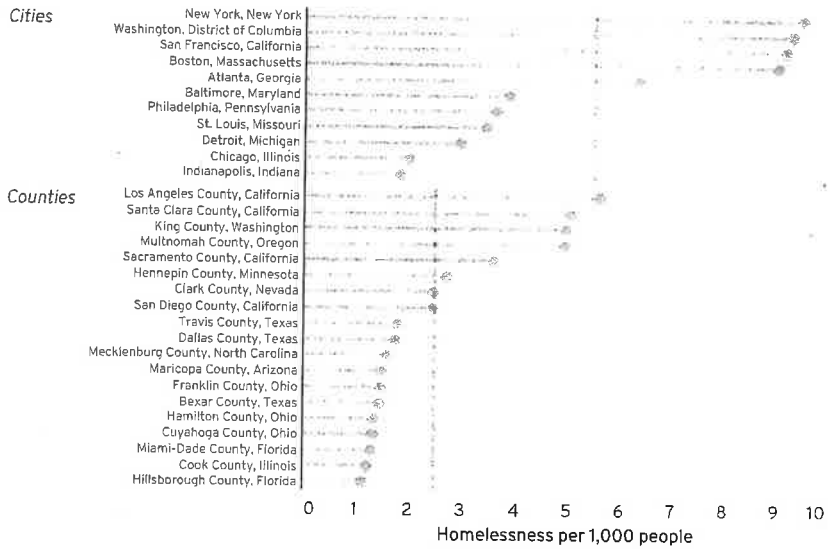

Figure 4. Per capita rates of homelessness in select U.S. regions, 2019. Dashed lines indicate city and country averages of per capita PIT counts. Data source: HUD

Throughout this book, to supplement our analyses of per capita homelessness in cities and counties, on occasion, we also deploy a simple indexing approach that allows us to compare city and county CoCs directly. To create an indexed value of homelessness intensity, we divide each measurement of city per capita homelessness by the largest observed city rate across the years in our sample (2007–2019), divide each measurement of county per capita homelessness by the largest observed county rate, and then combine the transformed values into a single measure. Doing so allows us to get a sense of how the severity of a given city's or county's homelessness crisis evolves over time, relative to other cities and counties. The indexing approach is a kind of ranking function. It's not superior to our bifurcated approach to presenting city and county rates; it complements it.

Using indexed values, Figure 5 below provides a comparison of the relative ranks of indexed rates of homelessness in each CoC in 2007 compared to 2019. (The CoCs with observations excluded in 2007 are removed from the analysis.) We observe some modest movement in the rank ordering of cities, but generally speaking, regions with high per capita homelessness in 2019 also had high rates a decade earlier.

Over the course of the book, we also make use of some core concepts from statistics to illustrate key points. The first of these is the *median*, a summary statistic that indicates the midpoint in a distribution of values. The median may differ meaningfully from

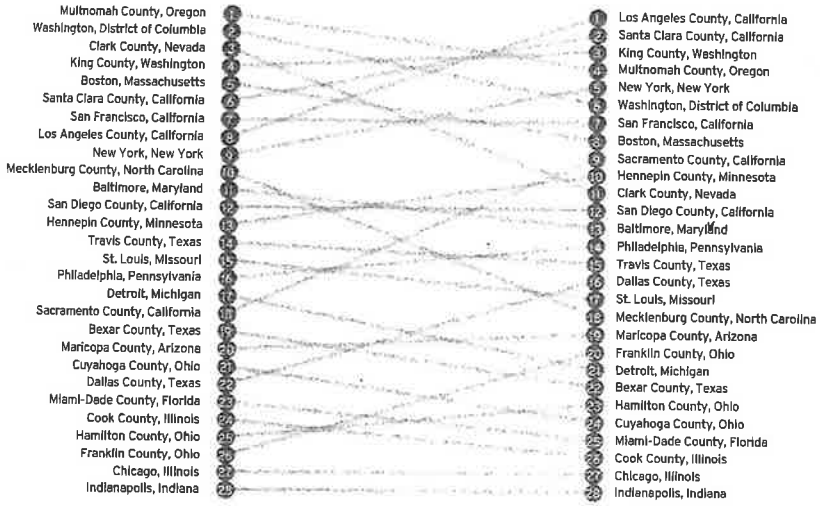

Figure 5. Rank of indexed rates of homelessness, 2010 v. 2019. Vertical position indicates rank of indexed per capita PIT counts for select U.S. regions. Data source: HUD

the average or *mean* of this distribution. Accordingly, we can understand the median as helping us understand the shape of a distribution in a manner that is less sensitive to large outliers—which drag up or down the mean. To further understand the shape of these distributions, we also measure a quantity known as the *variance*. The variance of a distribution measures how dispersed a set of values are around their mean. Mathematically, variance corresponds to the squared *standard deviation* of a distribution, a similar measure assessing dispersion. Small values for standard deviations and variance correspond to narrow distributions, while large values correspond to wide distributions. In this book, we use the word *variation* to mean "differences between measurements," while we use *variance* to indicate the mathematical quantity just described. Generally, the book attempts to

account for variation between regions by examining simple statistical models and evaluating the degree to which they explain the variance of the distributions in question.

Consider an example in which we analyze the relationship between age and height among children aged eighteen and under. The vertical axis on our chart measures height and the horizontal axis measures age. We can quantify this relationship using a scatterplot of dots, in which each dot represents one person and illustrates their height and age. After placing all dots in our data set on the scatterplot, we can assess what kind of relationship exists between the variables and how much of the variation in height can be explained by age. Because children become taller as they age, we might expect to see an upward sloping cloud of dots, but we probably wouldn't expect all the dots to fall along a perfectly straight line. Instead, we'd observe some variation. Some people are short, some are tall, some grow early, and some grow later. We can use statistics to measure the amount of variation in one variable (height) that's captured by variation in the other (age).

To do so, in several graphics throughout the book, we deploy a statistic known as the coefficient of determination, which for unfortunate mathematical reasons goes by the abbreviation R^2. This quantity (pronounced "R-squared") offers an estimate of the amount of variance that we might consider to be captured—that is, explained—by a line drawn through the scatterplot of points. In particular, we'll draw a line through the points that minimizes the total vertical distance between all the points on the plot and the line itself. That exercise represents a *linear regression*—a statement about one variable in terms of another, as characterized by that best-fit line. (The formula for calculating R^2 subtracts the proportion of variance *unexplained* by

this best-fit line from the number 1—leaving the proportion of *explained* variance.) R^2 tends to vary between 0 and 1, with values closer to 1 indicating a greater proportion of explained variance. There's no hard rule governing which values of R^2 imply small or large amounts of explained variance, but generally we might say that values of R^2 below 0.1 indicate very little explanation, while values above 0.3 indicate much stronger explanatory relationships. That is, it's important to note that R^2 doesn't tell us everything about these relationships. For example, on its own, it won't help us separate correlation from causality, it won't tell us if we're missing any important variables in our statistical model, and it won't tell us if we have enough data to draw solid conclusions. Nonetheless, it's a useful indicator of the coupling between two variables. Returning to our example of the relationship between age and height, it is likely that the R^2 would be high—age is a strong predictor of height among children—but it wouldn't be 1.0. There still exists plenty of variation in height among children that cannot be explained by age.

While the story about homelessness in major metropolitan areas has been generally consistent since 2007, some critical trends have emerged—see Figure 6. First, at a national level, overall levels of homelessness have fallen over this period—and this trend is apparent in the thirty CoCs in our sample.[17] While overall homelessness has fallen, the variance between different cities' rates of homelessness has increased. In practice, that means that while falling at a national level, homelessness has become increasingly concentrated in a few cities over this time period. Given the uneven progress toward reducing levels of homelessness, the task of understanding the drivers of regional variation is cast in an important light. If people and cities experience homelessness at increasingly different rates, it's worth asking why.

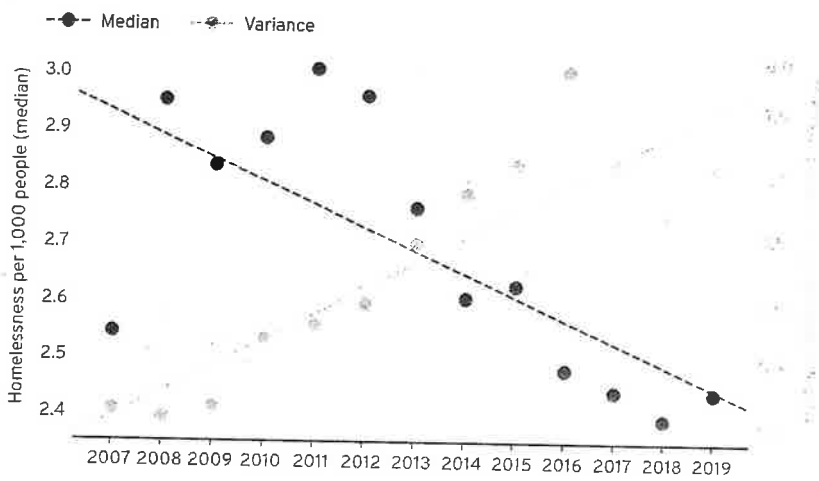

Figure 6. While median per capita homelessness has decreased over the last decade, its variance has increased. Dashed lines indicate linear regressions of year and median per capita PIT counts (and their variance) between 2007 and 2019 for a sample of U.S. regions. Data source: HUD

Over the course of writing this book, two major social events occurred with direct implications for understanding the issue of homelessness in the country. First, in March 2020, as the COVID-19 outbreak swept across the United States and residents went into lockdown, businesses and schools closed in the most immediate cessation of economic and social activity on record. The virus represented a particular concern for the most vulnerable in society, including elders, those with underlying health conditions, and people without permanent housing. Accordingly, many jurisdictions took extraordinary steps to protect the health of people experiencing homelessness—and limit community spread of the virus—by moving portions of their homeless population to hotels and motels.

In summer and autumn 2020, I (Gregg) partnered with colleagues from King County and the University of Washington to

evaluate the region's COVID-19 homelessness response. In the early days of the pandemic, the City of Seattle, King County, and their partner agencies moved over seven hundred people from congregate shelter settings into hotel rooms throughout the county—with the primary aim of adhering to public health guidelines and keeping a highly susceptible population safe. Our research—which included an analysis of quantitative data on infection rates, housing stability, exits to permanent housing, and 911 dispatch calls; as well as qualitative data from interviews with shelter residents who moved to hotels and agency staff—showed that the intervention wasn't just successful at limiting the spread of COVID-19, but also in producing other benefits on various measures of well-being, including improved health, better sleep, feelings of safety and security, less interpersonal conflict, and greater and more optimistic focus on the future (including education, employment, and permanent housing).[18] These results, in part, prompted King County Executive Dow Constantine to propose an additional sales tax to fund the purchase of hotels as supplementary housing for people experiencing homelessness.[19] In other words, in the Puget Sound region, out of crisis has come a major public investment in housing solutions for people experiencing homelessness.

The economic consequences of COVID-19 have also increased the risks of falling into homelessness for many precariously housed people around the country. Early estimates suggest that tens of millions of households could lose their housing as they struggle to make monthly rental payments due to loss of income.[20] In the early months of the crisis, many states and local jurisdictions enacted eviction moratoria to prevent people from losing their housing due to an inability to pay. In September 2020, the Centers for Disease Control and Prevention (CDC)

announced a national eviction moratorium, leveraging its broad authority to control the spread of the pandemic. As these eviction restrictions lapse, however, housing researchers and advocates offer dire predictions of a sharp rise in homelessness, since even under the CDC rules, renters are expected to pay any rent deferred under the moratorium.[21] Beyond the obvious public health consequences of COVID-19, this crisis highlighted the natural interconnectedness of larger, structural forces and the dynamics of homelessness.

In the midst of the country's early grappling with the novel coronavirus, the May 2020 killing of George Floyd in Minneapolis at the hands of the police ignited global protests of police violence and racial inequality. In the United States, these protests brought structural and systemic racism to the forefront of public and political discourse—and created the newest opportunity for substantive movement toward dismantling structural racism in the country. Racism is central to discussions that aim to reveal the causes and consequences of homelessness. Given their representation in the general U.S. population, Black, Native, and Hispanic/Latino individuals and families are disproportionately represented in the homeless population.[22] While Black people, for example, make up about 13 percent of the U.S. population, HUD reported to Congress in 2019 that almost 40 percent of the population experiencing homelessness was Black.[23] This fact alone ought to be unsurprising: A knot of conspicuous, racialized structural disadvantages—in housing, banking and lending practices, education, health care, employment, and policing and incarceration—readily amplify homelessness risk.

What's essential in these two extraordinarily salient crises —the coronavirus pandemic and the latest reckoning with structural and systemic racism—is the manner in which they

highlight whom we're talking about when we talk about homelessness risk. To the extent that this is a book about regional variation in homelessness, it is also a book about deck-stacking. Place is where it happens. If we want to understand the factors that cause people to lose their housing, we need to understand why and how those forces vary from city to city. For many, the pandemic and the Black Lives Matter movement have driven home the interconnectedness of U.S. society, not least because the health of one's neighbor is directly related to the health of oneself. But just as racism is not a monolith, homelessness is multifaceted, and households' experiences with housing vary with identity and geography. Here, we argue that an effective policy response to homelessness will only come from acknowledging and responding to these differences.

APPROACH

This book is split into three brief sections. We conclude the first section in the next chapter, in which we lay out the current state of knowledge about homelessness in the country. We provide an overview of existing academic social-science research on the topic and offer descriptive statistics about homelessness. The purpose of the second chapter is to place the reader in a position to engage critically with the specific causal arguments presented in the second section of the book.

In part 2, we consider the various potential explanations for the substantial variation in per capita homeless populations around the country. In chapter 3, we analyze a range of individual and household vulnerabilities and attributes and ask whether these common narratives explain regional variation. These data and analyses provide compelling evidence that the answer to that

question, most simply, is no. The homelessness crisis in coastal cities cannot be explained by disproportionate levels of drug use, mental illness, or poverty. In chapter 4, we then consider local culture and context, analyzing how variations in weather, local political climate, the mobility of low-income households, and the generosity of local welfare provision may influence rates of homelessness. Similarly, we find that these common explanations do not account for observed regional variation. Finally, we consider a third category of potential explanations: housing market conditions. In chapter 5, we consider housing costs, housing cost burdens, and housing availability as candidate explanations for intercity variation. In this analysis, two explanations emerge as credible factors: absolute rent levels and rental market vacancy rates. We argue that after eliminating a wide range of potential explanations for the variation in question, the descriptive and correlative findings in chapter 5 together offer the most compelling explanation of regional variation in rates of homelessness.

In part 3 of the book, we synthesize our findings in two policy-oriented chapters. In chapter 6, we propose a typology of cities to explain why certain cities—certain types of cities—experience elevated rates of homelessness; while other cities, relatively speaking, do not. Combining our data with principles from the field of urban economics, we construct a framework that, importantly, helps us understand why high-growth boomtowns don't always see significant rates of homelessness. Charlotte, for example, has grown as fast as San Francisco and Seattle, but because of a relatively robust housing supply response, the city has not faced the housing shortages that plague many coastal cities. The typology also demonstrates how population declines help to explain why a large, vibrant city like Chicago has relatively low rates of homelessness: A falling population

in Chicago has created higher rental market vacancy rates and lower prices, which produces a more accommodating housing market (relatively speaking) for vulnerable households.

In chapter 7, we conclude by presenting a broad proposal to end homelessness in the United States. Ultimately, in the long run, the prescription is simple: Policymakers must increase the number of affordable housing units and provide subsidies and rental assistance to households to ensure they can access housing. In the short run, competing demands and a lack of resources makes decision-making more challenging. Local jurisdictions must balance the needs for a more robust crisis response (i.e., greater emergency shelter capacity) with the desire to increase the supply of affordable housing. In reality, cities must devote resources to both of these responses.

To create a sustainable, robust response to homelessness, we argue that three interrelated steps are required. First, public perception of homelessness must change. As long as we continue to frame homelessness as an individual problem, we will struggle to make the structural investments needed to end it. Second, this crisis requires far greater resources from all levels of government. Existing investments, while substantial, are insufficient given the scale of the problem. Last, we encourage a broader systems approach to addressing homelessness. Focusing on three stages of the system—inflow, crisis response, and outflow—are necessary to move people out of homelessness and into stable, permanent housing. A lack of focus on any one of these stages will produce a system out of balance—and high levels of homelessness will persist.

Finally, a word on the motivation for this book. Both Gregg and Clayton are engaged in the study of and response to homelessness in the Puget Sound region. As one of the areas of the

country most affected by this crisis, understanding what drives homelessness in our region is a topic of great civic importance. In the years leading up to writing this book, we have been amazed that—despite our community wrestling with homelessness for many years—there is a lack of general understanding about the nature and causes of homelessness. Numerous narratives compete for the public's attention and, as a result, there is no consensus about the root causes of this crisis. Without a common understanding, it is impossible for elected leaders and the community at large to marshal the resources needed to end homelessness in our community. Much of the money spent on homelessness today constitutes a *response* to the crisis rather than an *alternative* to it. In the concluding chapter we share our vision—informed by thought leaders from around the country—for community-wide approaches that are required to prevent and limit homelessness. According to the United States Interagency Council on Homelessness, "An end to homelessness means that every community will have a comprehensive response in place that ensures homelessness is prevented wherever possible, or if it can't be prevented, it is a rare, brief, and one-time experience."[24] Fair enough. But without wrapping our head around the root of the crisis—its beginning—it'll be difficult to find its end.

SPARC

Supporting Partnerships for Anti-Racist Communities

Phase One Study Findings

MARCH 2018

Center for Social Innovation

Executive Summary

People of color are dramatically more likely than White people to experience homelessness in the United States. This is no accident; it is the result of centuries of structural racism that have excluded historically oppressed people—particularly Black and Native Americans—from equal access to housing, community supports, and opportunities for economic mobility.

In September 2016, the Center for Social Innovation launched SPARC (Supporting Partnerships for Anti-Racist Communities) to understand and respond to racial inequities in homelessness. Through research and action in six communities, SPARC has begun a national conversation about racial equity in the homelessness sector.

Through an ambitious mixed-methods (quantitative and qualitative) study, the SPARC team documented high rates of homelessness among people of color and began to map their pathways into and barriers to exit from homelessness. The team analyzed 111,563 individual records of people from HMIS (homeless management information systems) in SPARC partner communities (representing data aggregated across years 2013-2015); administered a provider workforce demographic survey; collected 148 oral histories of people of color experiencing homelessness; and conducted 18 focus groups in six communities across the United States.

Key findings include:

Demographics

The SPARC team analyzed HMIS data for each SPARC community as well as general population numbers and poverty population numbers in the United States and in each SPARC community. The results were astounding:

- Approximately two-thirds of people experiencing homelessness in SPARC communities were Black (64.7%), while 28.0% were White. 6.9% identified as Hispanic/Latinx*. In total 78.3% of people experiencing homelessness were people of color.
- By comparison, the general population of the U.S. was 73.8% White, 12.4% Black, and 17.2% Hispanic/Latinx.
- Black people were the most overrepresented among individuals ages 18-24 experiencing homelessness, accounting for 78.0% of this group. This group also had the highest over representation of people of color broadly with 89.1% of 18-24 year olds identifying as people of color.
- More than two-thirds (67.6%) of individuals over the age of 25 experiencing homelessness were Black, and 56.3% of individuals presenting as family members were Black.
- Rates of Native American homelessness were also disproportionately high. In SPARC communities, homelessness among American Indian/Alaskan Natives was three to eight times higher than their proportion of the general population.
- Poverty alone does not explain the inequity. The proportion of Black and American Indian and Alaska Native individuals experiencing homelessness exceeds their proportion of those living in deep poverty.

* Latinx is a gender-neutral form used in lieu of Latino and Latina.

Homeless Services Workforce

The homeless services workforce is not representative of the people it serves:

- Those working in senior management positions were 65.8% White, 12.6% Black, and 10.1% Hispanic/Latinx.
- Staff in all other jobs were 52.3% White, 22.1% Black, and 14.8% Hispanic/Latinx.

Key Domains Influencing Homelessness for People of Color

The oral histories revealed five major areas of focus regarding racial inequity and homelessness:

1. **Economic Mobility**. Lack of economic capital within social networks precipitates homelessness for many people of color.
2. **Housing**. The unavailability of safe and affordable housing options presents both risk of homelessness and barriers to permanently exiting homelessness.
3. **Criminal Justice**. Involvement in the criminal justice system, especially when such involvement results in a felony, can create ongoing challenges in obtaining jobs and housing.
4. **Behavioral Health**. People of color experience high rates of traumatic stress, mental health issues, and substance use. Behavioral health care systems are not responsive to the specific needs of people of color.
5. **Family Stabilization**. Multi-generational involvement in the child welfare and foster care systems often occur prior to and during experiences of homelessness, and people of color are often exposed to individual and community level violence.

Implications

This study is grounded in the lived experience of people of color experiencing homelessness, and it offers numerous insights for policy makers, researchers, organizational leaders, and community members as they work to address homelessness in ways that are comprehensive and racially equitable.

The demographics alone are shocking—the vast and disproportionate number of people in the homeless population in communities across the United States is a testament to the historic and persistent structural racism that exists in this country. Collective responses to homelessness must take such inequity into account.

Equitable strategies to address homelessness must include programmatic and systems level changes, and they must begin seriously to address homelessness prevention. It is not enough to move people of color out of homelessness if the systems are simply setting people up for a revolving door of substandard housing and housing instability. Efforts must begin to go upstream into other systems—criminal justice, child welfare, foster care, education, and healthcare—and implement solutions that stem the tide of homelessness at the point of inflow.

This brief report aims to present quantitative and qualitative findings from the SPARC study, examine what can be learned from these data, and begin crafting strategies to create a response to the homelessness crisis that is grounded in racial equity. Additional articles, reports, and other publications are forthcoming that will delve more deeply into specific insights gleaned from this project.

iCount Miami 2022

HIGHLIGHTS

About the iCount Miami:

- Each year Miami Homes For All, the University of Miami, The Homeless Trust, and The HOMY Collective: Helping Our Miami-Dade Youth partner to do the iCount Miami. This is our community's youth point-in-time census. The iCount Miami is directly after the general Point-In-Time count and lasts until the end of January. In 2022, it was from January 24 to January 31.
- The iCount Miami 2022 numbers are less compared to previous years due to the COVID-19 pandemic. In 2022, we surveyed over 329 youth experiencing homelessness. In 2022, engagement was lower and all strategies were implemented differently.
- The iCount is conducted all over the county through various magnet site partners (housing providers, service providers, libraries, parks, etc.) and youth leaders. All surveys were conducted over the phone, virtually, or in person.
- We raised awareness about the iCount through the leadership of our Youth Voice Action Council, partner agencies, social media, and news outlets. The following are some highlights. With these results, HOMY develops strategies to address youth homelessness in Miami-Dade County.

329 youth were counted as experiencing homelessness in Miami-Dade County!

We estimate that there may be 3,290 youth experiencing homelessness* under all definitions of youth homelessness**.

How old were they?

- **Unsheltered** youth are those living in places not meant for human habitation. This includes the street, sidewalks, or in a vehicle.
- **Sheltered** includes emergency shelter, transitional housing program, or were couch-surfing
- **Unstable** refers to youth experiencing housing insecurity but not involved in the systems involved. This includes couch surfing, group homes, and staying with a relative, etc.

Where did they sleep?

- 61% identified as Black or African-American
- 41% identified as Hispanic or Latinx

25% identified as LGBTQIA+

Their biggest barriers:

- Lack of transportation (40%)
- Did not know where to go for help (36%)
- Did not qualify for service (13%)

Regarding education + employment

- 38% were not in school
- 48% were unemployed

What is the main reason that they were on their own + experiencing housing struggles?

- Disagreement with parent(s)/legal guardian(s)
- They turned 18 and were asked to leave
- They left home to go to college or university
- They wanted to leave

Regarding foster care and families:

- 31% were placed in foster care
  - Of those, 68% said they left foster care and did not receive housing assistance
- 15% were pregnant/parenting
  - Of those, 56% have custody of their children

*This estimate is based on various reports describing the under count problem, including: Fleming, D. and P. Burns, Who Counts? Assessing Accuracy of the Homeless Count. 2017, Economic Roundtable: Los Angeles CA.

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iCount Miami 2021

HIGHLIGHTS

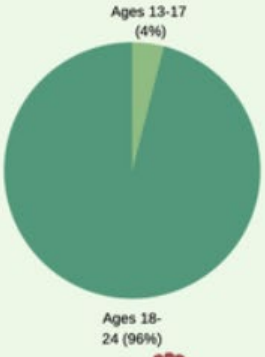
About the iCount Miami:

- Each year Miami Homes For All, the University of Miami, M-DCPS Project UP-START, The Homeless Trust, and The HOMY Collective: Helping Our Miami-Dade Youth partner to do the iCount Miami. This is our community's youth point-in-time census. The iCount Miami is directly after the general Point-In-Time count and lasts until the end of January. In 2021, it was from January 24 to January 31.
- The iCount Miami 2021 numbers are significantly less compared to previous years due to the COVID-19 pandemic. In 2020, we surveyed over 300 youth experiencing homelessness. In 2021, engagement was lower and all strategies were implemented differently.
- The iCount is conducted all over the county through various magnet site partners (housing providers, service providers, libraries, parks, etc.) and youth leaders. However, due to the pandemic, many of our partner agencies were closed. All surveys were conducted over the phone or virtually.
- We raised awareness about the iCount through the leadership of our Youth Voice Action Council, partner agencies, social media, and news outlets. The following are some highlights. With these results, HOMY develops strategies to address youth homelessness in Miami-Dade County.

206 youth were counted as experiencing homelessness in Miami-Dade County!

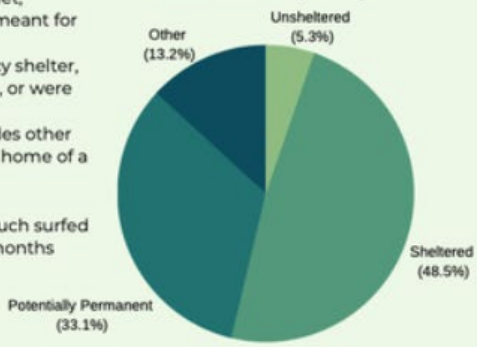
We estimate that there may be 2,000 youth experiencing homelessness* under all definitions of youth homelessness.**

How old were they?



- **Unsheltered** includes the street, sidewalk, or somewhere not meant for human habitation
- **Sheltered** includes emergency shelter, transitional housing program, or were couch-surfing
- **Potentially permanent** includes other relatives' home, group home, home of a significant other, or a dorm
- **44% (117)** of all youth survey participants said that they couch surfed at some point in the past 12 months

Where did they sleep?



25.8% identified as LGBTQIA+

- 65.2% identified as Black or African-American
- 35.4% identified as Hispanic or Latinx

Their biggest barriers:

- Did not know where to go for help
- Lack of transportation
- Did not have ID/personal documents

Regarding education + employment

- 51% were not in school
- 56.2% were unemployed

What is the main reason that they were on their own + experiencing housing struggles?

- Disagreement with parent(s)/legal guardian(s)
- There was physical, sexual, or mental abuse at home
- They turned 18 and were asked to leave
- They wanted to leave
- They left foster care/group home and had no place to go

Regarding foster care and families:

- 28.7% were placed in foster care
  - Of those, 70.7% said they left foster care and did not receive housing assistance
- 24.2% were pregnant/parenting
  - Of those, 65% have custody of their children

*This estimate is based on various reports describing the under count problem, including: Fleming, D. and P. Burns, Who Counts? Assessing Accuracy of the Homeless Count. 2017, Economic Roundtable: Los Angeles CA.

**There are various definitions of youth homelessness. As of January 2020, the Miami-Dade Continuum of Care adopted the Department of Housing & Urban Development's Category 3 definition. This means, they also recognize youth experiencing homelessness as per the Department of Education definition of youth homelessness.

Thank you to our sponsors!

iCount Miami 2020

HIGHLIGHTS

About the iCount Miami

Each year Miami Homes For All, the University of Miami, The Homeless Trust, and The HOMY Collective: Helping Our Miami-Dade Youth partner to do the iCount Miami. This is our community's youth point-in-time census. The iCount Miami is directly after the general Point-In-Time count and lasts until the end of January. In 2020, it was from January 24 to January 31.

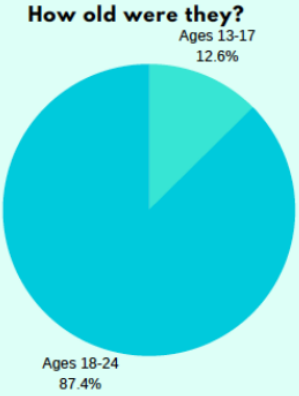
The iCount is conducted all over the county through various magnet site partners (housing providers, service providers, libraries, parks, etc.), youth leaders, and events. We raised awareness about the iCount through the leadership of our Youth Voice Action Council, partner agencies, social media, and news outlets. The following are some highlights. With these results HOMY develops strategies to address youth homelessness in Miami-Dade County.

336 young people are experiencing homelessness

We estimate that there may be 10x more -- up to 3,360 youth experiencing homelessness in Miami-Dade County!*

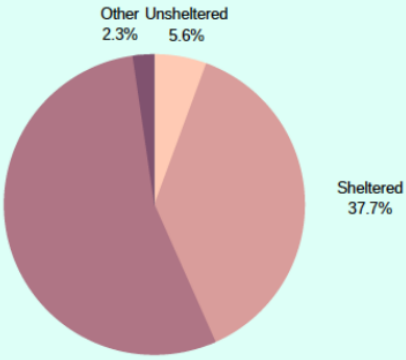
under all definitions of youth homelessness**

How old were they?



- **Unsheltered** includes the street, sidewalk, or somewhere not meant for human habitation
- **Sheltered** includes emergency shelter, transitional housing program, or were couch-surfing
- **Potentially permanent** includes other relatives' home, group home, home of a significant other, or a dorm
  - 32% youth said that they couch surfed at some point in the past 12 months

Where did they sleep?



15% identified as LGBTQIA+

- 50% identified as Black or African-American
- 42% identified as Hispanic or Latinx

Their biggest barriers:

- Lack of transportation
- Did not know where to go for help
- Did not have ID/personal documents

What is the main reason that they were on their own + experiencing housing struggles?

- Disagreement with parent(s)/legal guardian(s)
- Left home for college/university
- They wanted to leave
- They left foster care/group home and had no place to go
- There was physical, sexual, or mental abuse at home
- They turned 18 and were asked to leave

Regarding education + employment

- 21% were not in school
- 51% were unemployed

Regarding foster care and families:

- 15% were in foster care
  - 53% said they left foster care and did not receive housing assistance
- 14% were pregnant/parenting
  - 93% have custody of their children

*This estimate comes from various reports describing the under count problem, including: Fleming, D. and P. Burns, Who Counts? Assessing Accuracy of the Homeless Count. 2017, Economic Roundtable: Los Angeles CA.

**There are various definitions of youth homelessness. As of January 2020, the Miami-Dade Continuum of Care adopted the Department of Housing & Urban Development's Category 3 definition. This means, they also recognize youth experiencing homelessness as per the Department of Education definition of youth homelessness.

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Miami Homes For All · University of Miami Engagement, Power, & Social Action Research Team EPSA · Miami-Dade County Homeless Trust · The Children's Trust · United Way of Miami-Dade · Educate Tomorrow · Winn-Dixie

JAN 25 - 31, 2019

iCOUNT MIAMI

MIAMI-DADE COUNTY'S YOUTH POINT-IN-TIME COUNT: CENSUS OF YOUTH EXPERIENCING HOMELESSNESS

WANT MORE INFO?
Miami Homes For All
(786) 584 - 6338
Homeless Trust
(305) 375 - 1490

Join the 2019 iCount team
audrey@miamihomesforall.org
www.icountmiami.com

714 SURVEYS

iCount Miami is a survey administered throughout the community by Youth Ambassadors, volunteers, and staff at locations that youth frequent.

287 were in shelters or on the street

390 were alone without a parent or legal guardian

323 were couch-surfing or doubling up

310 were unemployed and 227 were not in school

DIFFERENT DEFINITIONS

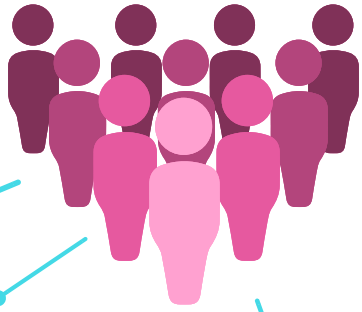
Youth experience housing instability in different ways:

- Living somewhere not meant for human habitation, like, parks, cars, or the street
- Fleeing from domestic violence
- At imminent risk of losing their residence
- Couch-surfing or doubling up, temporarily staying with multiple families

170 youth were in foster care or stayed in a group home

103 were pregnant and/or parenting youth.

462 youth were youth of color, of which, 245 were Hispanic or Latinx youth



44 youth were minors experiencing housing instability

227 youth were not in school

ALSO OF NOTE:

27% OF YOUTH EXPERIENCING HOUSING INSTABILITY IN MIAMI-DADE COUNTY ARE LGBTQ+

- **12 youth were told to leave home due to their sexual orientation or gender identity**
- **6 youth identified as transgender**
- **13 youth identified as genderqueer**
- **141 youth are queer, lesbian, or gay**

292

Youth cited the lack of transportation was a barrier in accessing resources and services.

209

Youth said they did not know where to go for help.

629

216

Youth shared that they have mental health issues; developmental disabilities; medical problems other than HIV/AIDS; or, drug or alcohol addiction issues.

Student Homelessness in America

School Years 2019-20 to 2021-22

Student Homelessness in America: School Years 2019-20 to 2021-22

National Center for Homeless Education
UNIVERSITY OF NORTH CAROLINA AT GREENSBORO

With funding from the U.S. Department of Education, the National Center for Homeless Education (NCHE) at the University of North Carolina at Greensboro provides critical information to those who seek to remove educational barriers and improve educational opportunities and outcomes for children and youth experiencing homelessness.

National Center for Homeless Education
5900 Summit Ave., #201
Browns Summit, NC 27214
NCHE Website: https://nche.ed.gov/

Student Homelessness in America

Overview

The purpose of Subtitle VII-B of the McKinney-Vento Homeless Assistance Act (McKinney-Vento Act) and funding provided by the American Rescue Plan (ARP-HCY)[1] is to ensure that students who experience homelessness have access to the education and other services they need to succeed academically. Each year, states submit information regarding the education of students who experienced homelessness to the U.S. Department of Education (ED) as a part of the ED*Facts* Initiative. Using the most recently available data, this brief examines the number of students who experienced homelessness, the type of housing they used when first identified by school districts, and subgroups of students who experienced homelessness. Additional information is provided on chronic absenteeism and the adjusted cohort graduation rates of students.[2] While the primary audiences for this report are state coordinators and local school district liaisons, the information in this report may be of interest to other administrators, policymakers, educators, and service providers.

Key findings in this brief include the following:

Enrollment Totals and Trends for Students Who Experienced Homelessness

- During School Year (SY) 2021-22, public schools identified 1,205,292 students who experienced homelessness. This represents 2.4% of all students enrolled in public schools (NCES, 2023).
- The total number of students who experienced homelessness in SY 2021-22 represents a 10% increase from SY 2020-21 and a 6% decrease from SY 2019-20. The impact of the COVID-19 pandemic may account for some of the variation, particularly for SYs 2019-20 and 2020-21.
- Between SYs 2004-05 and 2021-22, the number of students who experienced homelessness increased by 79%. The number of students identified as homeless increased by an average of 4% annually during that same period.
- The number of students who experienced homelessness was relatively evenly distributed across the grades, with 7% to 8% of homeless students enrolled in each grade starting with kindergarten. Grade 11 students and students who were aged three to five years old but not enrolled in kindergarten are exceptions at 6% and 3%, respectively. The split of students across grades has remained stable since SY 2013-14 (NCHE, 2017-2022).

[1] School Year (SY) 2021-22 was the first year of implementation of ARP-HCY for many LEAs.
[2] Additional data, including academic assessment data, are available at https://eddataexpress.ed.gov/.

Primary Nighttime Residence of Homeless Children and Youth at the Point of Identification

- The percentage of homeless students living in a particular type of housing remained relatively stable between SYs 2019-20 and 2021-22.
- In SY 2021-22, 76% of students who experienced homelessness lived in doubled-up situations, 11% lived in shelters/transitional housing, 9% stayed in hotels/motels, and 4% lived in unsheltered locations.

Demographic Subgroups of Students Who Experienced Homelessness

- Students with disabilities and English learners accounted for the largest two reported subgroups of students who experienced homelessness. These subgroups of students are also disproportionately represented among students who experienced homelessness. In the general population, the percentage of students with disabilities is 15%, whereas 20% of students who experienced homelessness were students with disabilities. Similarly, English learners make up 10% of the general population (Irwin et al., 2023), but 20% of students who experienced homelessness were English learners in SY 2021-22.[3]

Race and Ethnicity of Students Who Experienced Homelessness

- The largest subgroups of students by race and ethnicity included Hispanic or Latino students at 39%, followed by Black or African American students and White students at 25% each. Data for other racial and ethnic subgroups showed students with two or more races at 5%, Asian students at 2%, American Indian or Native Alaskan students at almost 2%, and Native Hawaiian or Pacific Islander students at less than 1%. With the exception of students who identified as Asian, students who experienced homelessness were disproportionately students of color compared to the overall student body.

Student Outcomes

- The four-year adjusted cohort graduation rate (ACGR) for students who experienced homelessness increased in nine states between SYs 2019-20 and 2020-21.
- The national four-year ACGR was 68.3% in SY 2021-22 for students who experienced homelessness.

[3] U.S. Department of Education, ED*Facts* file specification 118 (2023), SEA level.

Students Experiencing Homelessness and Educational Rights

The McKinney-Vento Act defines a student experiencing homelessness as one who lacks a fixed, regular, and adequate nighttime residence (42 U.S.C. Section 11434a(2), 2015). The McKinney-Vento Act requires public school districts to appoint a liaison to ensure the identification of students experiencing homelessness in coordination with other school personnel and community agencies (42 U.S.C. § 11432(g)(6)(A)(i)). It also outlines circumstances that fall under the definition of homelessness. While the list of circumstances described in the McKinney-Vento Act is not exhaustive, it helps liaisons determine which students are eligible for services under the law. Circumstances which meet the criteria of lacking fixed, regular, and adequate nighttime residence include:

- shared housing with others due to loss of housing, economic hardship, or a similar reason;
- hotels, motels, trailer parks, or camping grounds due to a lack of alternative, adequate housing;
- emergency or transitional shelters;
- public or private places not designed for humans to live; and
- cars, parks, bus or train stations, abandoned buildings, or substandard housing.

The definition also includes migratory students who are living in a situation that meets the homeless definition criteria (42 U.S.C. § 11434a(2)). Children and youth who are not in the physical custody of a parent or guardian are also eligible for services under the McKinney-Vento Act as unaccompanied youth if their housing meets the criteria for homelessness (42 U.S.C. § 11434a(6)).

Once identified, students have the right to remain in their school of origin or enroll in the local school where they are staying based on the student's best interest, receive transportation to the school of origin, receive free school meals, and receive educational and related supports under Title I, Part A of the Elementary and Secondary Education Act of 1965 (ESEA, 2015). The McKinney-Vento Act provides grants to state educational agencies, which make competitive subgrants to school districts to provide educationally related support services to students experiencing homelessness.[4]

Student Enrollment by State

States identified 1,205,292 students who experienced homelessness during SY 2021-22. Compared to the overall number of students enrolled in public schools, students who experienced homelessness accounted for 2.4% of enrolled students (NCES, 2023). The District of Columbia, the Bureau of Indian Education, and New York had the

[4] NCHE offers a number of resources and tools on implementing the McKinney-Vento Act, including webinars and issue briefs: https://nche.ed.gov/resources/.

highest rates of students who experienced homelessness at nearly 7% for the District of Columbia, and 5% for the Bureau of Indian Education and New York.

Table 1. Number of enrolled students who experienced homelessness by state with percent of all students, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12

State	Students experiencing homelessness SY 2019-20	Percent of all students SY 2019-20	Students experiencing homelessness SY 2020-21	Percent of all students SY 2020-21	Students experiencing homelessness SY 2021-22	Percent of all students SY 2021-22
United States[1]	**1,280,268**	2.5	**1,099,269**	**2.2**	**1,205,292**	2.4
Alabama	11,578	1.6	9,365	1.3	9,050	1.2
Alaska	3,126	2.4	2,578	2.0	3,092	2.4
Arizona[2]	17,386	1.5	13,920	1.3	18,040	1.6
Arkansas	13,336	2.7	11,871	2.4	13,718	2.8
Bureau of Indian Education	2,373	6.2	2,202	6.3	1,757	5.4
California	246,350	4.0	227,612	3.8	225,747	3.8
Colorado	20,821	2.3	15,176	1.7	16,540	1.9
Connecticut	4,183	0.8	3,310	0.7	3,979	0.8
Delaware	2,709	1.9	2,576	1.9	3,434	2.5
District of Columbia	6,332	7.0	5,026	5.6	5,871	6.6
Florida	79,357	2.8	62,971	2.3	77,203	2.7
Georgia	35,538	2.0	31,161	1.8	35,516	2.0
Hawaii	3,586	2.0	3,089	1.8	3,251	1.9
Idaho	7,835	2.5	7,358	2.4	8,428	2.7
Illinois	46,786	2.4	36,898	2.0	48,395	2.6
Indiana	17,324	1.6	15,373	1.5	16,334	1.6
Iowa	6,042	1.2	6,057	1.2	6,517	1.3
Kansas	7,650	1.5	5,632	1.2	6,688	1.4
Kentucky	21,620	3.1	18,697	2.8	21,034	3.2
Louisiana	15,533	2.2	11,771	1.7	17,375	2.5
Maine	2,302	1.3	2,142	1.2	3,087	1.8
Maryland	15,548	1.7	11,760	1.3	16,529	1.9
Massachusetts	22,648	2.4	19,954	2.2	21,388	2.3
Michigan	32,935	2.2	26,867	1.9	28,724	2.0
Minnesota	13,295	1.5	10,588	1.2	14,587	1.7
Mississippi[3]	7,973	1.7	7,754	1.8	5,556	1.3
Missouri	34,942	3.8	32,674	3.7	32,969	3.7
Montana	4,265	2.8	4,670	3.2	4,607	3.1
Nebraska	4,084	1.2	2,549	0.8	3,103	0.9
Nevada	18,277	3.7	15,119	3.1	16,476	3.4
New Hampshire	3,519	2.0	3,109	1.8	3,323	2.0
New Jersey	12,741	0.9	10,539	0.8	11,104	0.8
New Mexico	9,033	2.7	8,135	2.6	9,834	3.1
New York	143,329	5.3	126,343	4.8	133,578	5.2
North Carolina	27,073	1.7	22,682	1.5	28,631	1.9

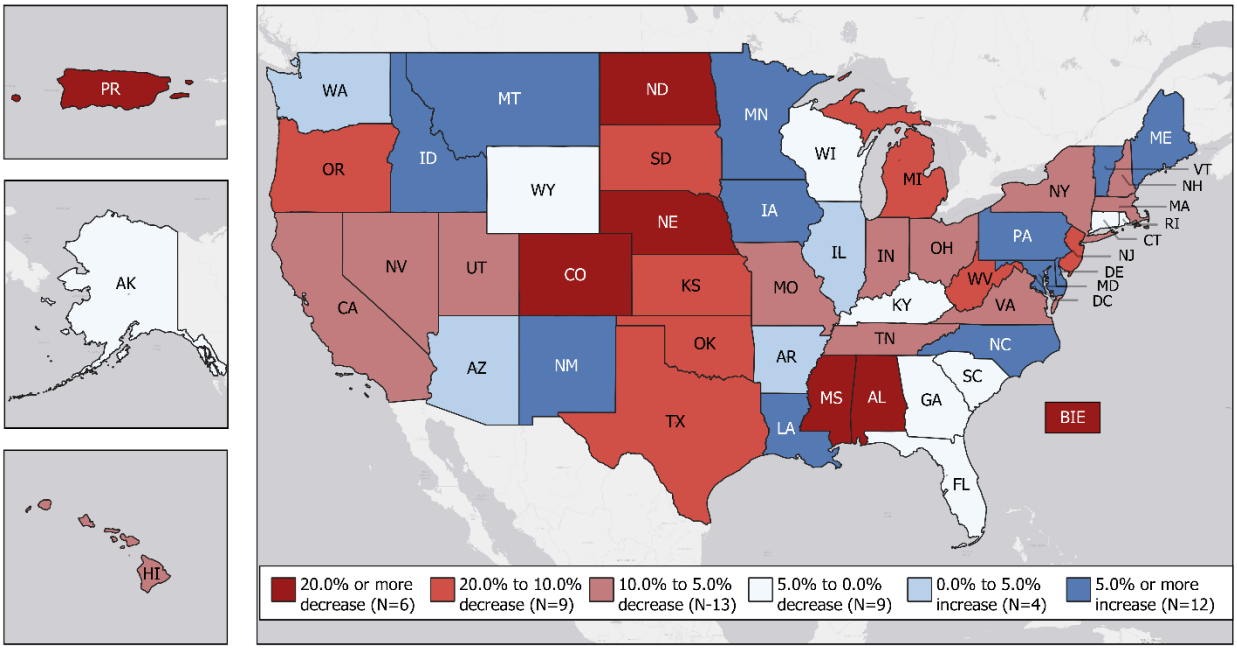
Table 1. Number of enrolled students who experienced homelessness by state with percent of all students, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12, continued

State	Students experiencing homelessness SY 2019-20	Percent of all students SY 2019-20	Students experiencing homelessness SY 2020-21	Percent of all students SY 2020-21	Students experiencing homelessness SY 2021-22	Percent of all students SY 2021-22
North Dakota	2,675	2.3	1,775	1.5	2,000	1.7
Ohio	30,060	1.8	24,699	1.5	27,333	1.6
Oklahoma	25,010	3.6	22,438	3.2	21,145	3.0
Oregon	22,336	3.7	18,485	3.3	18,475	3.3
Pennsylvania	31,876	1.8	27,235	1.6	34,043	2.0
Puerto Rico	4,058	1.4	2,424	0.9	2,661	1.0
Rhode Island	1,531	1.1	1,109	0.8	1,461	1.1
South Carolina	11,736	1.5	11,986	1.6	11,543	1.5
South Dakota	2,015	1.4	1,561	1.1	1,728	1.2
Tennessee	18,482	1.8	14,386	1.5	17,512	1.8
Texas	111,411	2.0	93,096	1.7	97,279	1.8
Utah	13,223	1.9	10,295	1.5	11,897	1.7
Vermont	883	1.0	1,006	1.2	1,312	1.6
Virginia	17,496	1.3	13,752	1.1	16,416	1.3
Washington	36,685	3.2	32,931	3.0	37,614	3.5
West Virginia	10,394	3.9	9,452	3.7	9,154	3.6
Wisconsin	17,221	2.0	13,450	1.6	16,487	2.0
Wyoming	1,747	1.8	1,661	1.8	1,734	1.9

[1] Enrolled students include those who were aged 3 through 5 but not in kindergarten, those enrolled in kindergarten through Grade 12, and those who are Ungraded. From SY 21-22, this table aligns with SEA education unit totals (EUT) reported via EDFacts and posted on ED Data Express (EDE). Please note that for past reporting years, previous NCHE reports may display somewhat different SEA totals because EUTs were not submitted, so NCHE aggregated age/grade totals for students experiencing homelessness.
[2] Arizona allowed LEAs to include students in more than one grade, resulting in duplicate counts during SY 2019-20.
[3] Mississippi does not include data on students who were identified as homeless but declined assistance from the schools (SYs 2018-19 and 2019-20).
NOTE: Any variation of state counts with ED Data Express (EDE) is because EDE uses SEA Education Unit Totals for homeless student enrollment. However, NCHE may use age/grade aggregate counts if they are higher, which occurs in subsequent report tables.
SOURCE: U.S. Department of Education, ED*Facts* file specification 118, SEA Level (2020, 2021, 2022); National Center for Education Statistics, Common Core of Data, *State nonfiscal public elementary/secondary education survey* (2020-21 v. 1a), SEA level.

Figure 1 displays the change in the number of students who experienced homelessness between SYs 2019-20 and 2021-22. Overall, 37 states showed a decrease in the number of students identified as homeless during this three-year period. By comparison, 49 states showed a decline during the previous three-year period (i.e., SYs 2018-19 to 2020-21), so fewer states are showing a decrease. Sixteen states identified more students in SY 2021-22 than SY 2019-20. In contrast, during the previous three-year period, only the Bureau of Indian Education, Mississippi, and Montana showed an increase in the number of students who experienced homelessness.

Figure 1. Percent change in enrolled students who experienced homelessness by state, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12

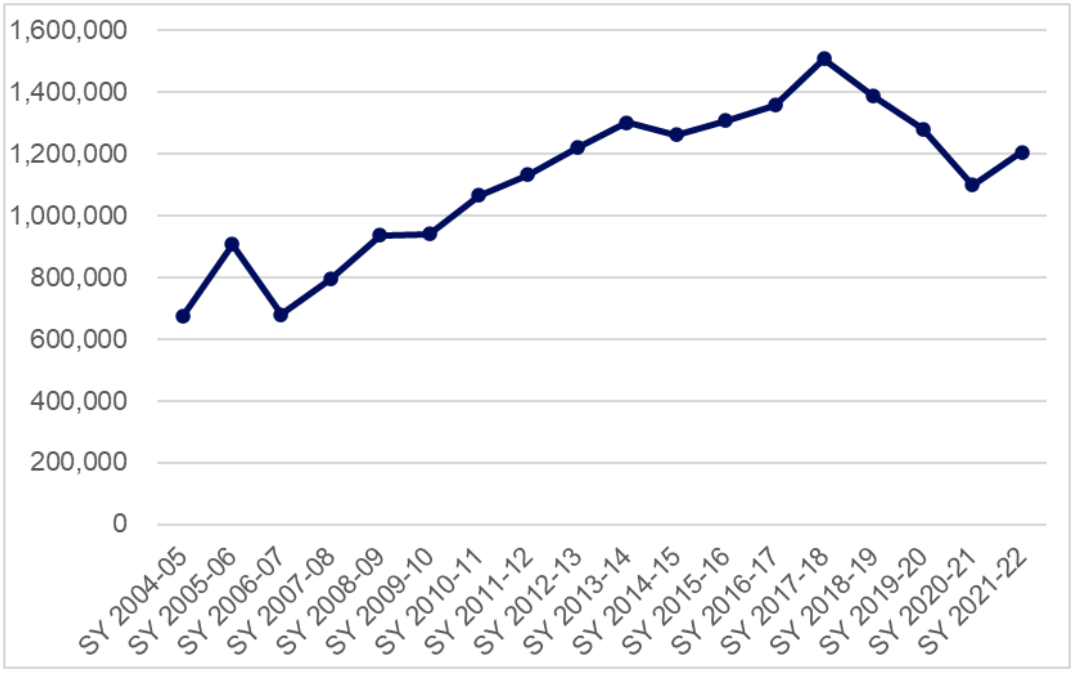


SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2023), SEA level.

Overall student enrollment decreased from 51,041,158 students in SY 2019-20 to 49,668,082 students in SY 2021-22 (NCES, 2022). This nearly 3% decrease in the overall number of students enrolled in public schools represents the largest single-year decline in school enrollment since 1943 (Irwin et al., 2022). Overall student enrollment dropped again in SY 2021-22 to 49,634,110 students (Irwin et al., 2023). Even as overall student enrollment has decreased, the percentage of students who experienced homelessness among all enrolled students remained relatively steady at 2.5% of all students in SY 2019-20 and 2.4% of all students in SY 2021-22.

Furthermore, during the 18 years in which these data have been collected, counts of students who experienced homelessness have increased steadily regardless of the overall well-being of the economy and other social impacts. Between SYs 2004-05 and 2021-22, the number of students who experienced homelessness increased by 79% overall or an average of 4% annually, as shown in Figure 2.

Figure 2. Enrolled students who experienced homelessness by state, SYs 2004-05 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12



SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2006-2023), SEA level.

Student Enrollment by Grade

The percentage of homeless students who were enrolled in each grade remained stable even as the number of students who experienced homelessness in a particular grade decreased. The number of students who experienced homelessness was relatively evenly distributed across the grades, with 7% to 8% of students who experienced homelessness enrolled in each grade starting with kindergarten. Grade 11 students and students who were aged three to five years old but not enrolled in kindergarten are exceptions at 6% and 3%, respectively. The split of students across grades has remained stable since at least SY 2013-14 (NCHE, 2017-2022).

Table 2. Number and percent change in enrolled students who experienced homelessness by grade, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12

Grade	SY 2019-20	SY 2020-21	SY 2021-22	Percent change SYs 2019-20 to 2021-22
Total[1]	**1,280,886**	**1,099,221**	**1,205,292**	**-5.9**
Age 3 through 5	51,170	30,241	38,879	-24.0
Kindergarten	98,673	79,227	93,439	-5.3
1st	101,289	86,564	88,093	-13.0
2nd	100,695	87,070	91,831	-8.8
3rd	100,548	86,694	92,394	-8.1

Table 2. Number and percent change in enrolled students who experienced homelessness by grade, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 12, continued

Grade	SY 2019-20	SY 2020-21	SY 2021-22	Percent change SYs 2019-20 to 2021-22
4th	99,151	85,670	91,563	-7.7
5th	98,709	84,969	90,425	-8.4
6th	97,076	82,582	88,239	-9.1
7th	91,151	80,542	86,497	-5.1
8th	87,402	79,089	87,528	0.1
9th	97,277	81,935	100,912	3.7
10th	83,289	77,106	82,844	-0.5
11th	75,762	69,979	76,969	1.6
12th	95,580	85,001	93,039	-2.7
Ungraded	3,114	2,552	2,640	-15.2

[1] The national totals in SY 2019-20 and SY 2020-21 differ slightly from those in Table 1 because the aggregation method is different. Rather than using EUTs, the totals reflect the SEA totals for each grade-level category.

NOTE: ED Data Express (EDE) contains data for 19 students in 13th grade across four states. Due to the inconsistent nature of reporting for 13th grade students, they are omitted from a separate line in this table.

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2022, 2023), SEA level.

Student Counts by Primary Nighttime Residence

States report data for the type of primary nighttime residence used by students at the point of identification by the school district liaison based on four categories: doubled-up, shelters and transitional housing, hotels or motels, and unsheltered. The *doubled-up* category includes students who are sharing housing with others due to loss of housing, economic hardship, or a similar reason. The *shelters and transitional housing* category includes all types of emergency and transitional shelters. The *hotels or motels* category includes students residing in hotels or motels due to a lack of alternative, adequate housing. The *unsheltered* category includes students who are staying in substandard housing, cars, parks, abandoned buildings, or other places not meant for humans to live. It also includes students staying in temporary trailers and campgrounds due to a lack of adequate, alternative housing. The percentage of homeless students living in a particular type of housing remained stable between SYs 2019-20 and 2021-22 despite changes in the number of students residing in each type of housing at the time they were identified. Seventy-six percent of students who experienced homelessness lived in doubled-up situations, 11% lived in shelters/transitional housing, 9% stayed in hotels/motels, and 4% lived in unsheltered locations.

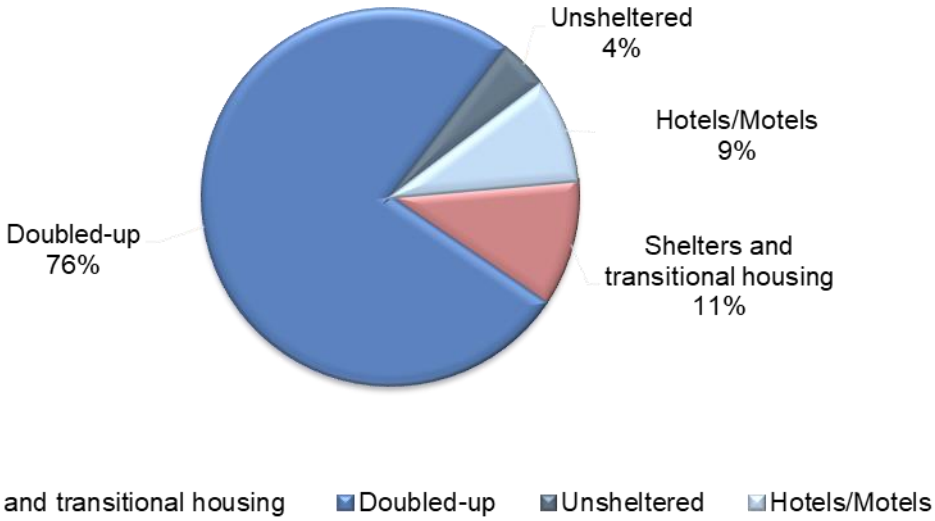
Table 3. Number of enrolled students who experienced homelessness and percent change by primary nighttime residence, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

Residence	SY 2019-20	SY 2020-21	SY 2021-22	Percent change SYs 2019-20 to 2021-22
Total[1]	**1,280,886**	**1,099,221**	**1,205,292**	**-5.8**
Doubled-up	991,300	844,245	915,578	-7.6
Shelters & transitional housing	146,769	119,934	131,051	-10.7
Hotels/Motels	88,663	85,422	106,621	20.3
Unsheltered	52,307	49,475	51,483	-1.6
Not Reported	1,847	145	559	-69.7

[1] Enrolled students include those aged 3 through 5 not in kindergarten, those enrolled in kindergarten through Grade 13, and those who were Ungraded. Grade 13 includes students who have successfully completed Grade 12 but stay in high school to participate in a bridge to higher education program.

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2022, 2023), SEA level.

Figure 3. Percentage of enrolled students who experienced homelessness by primary nighttime residence, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13



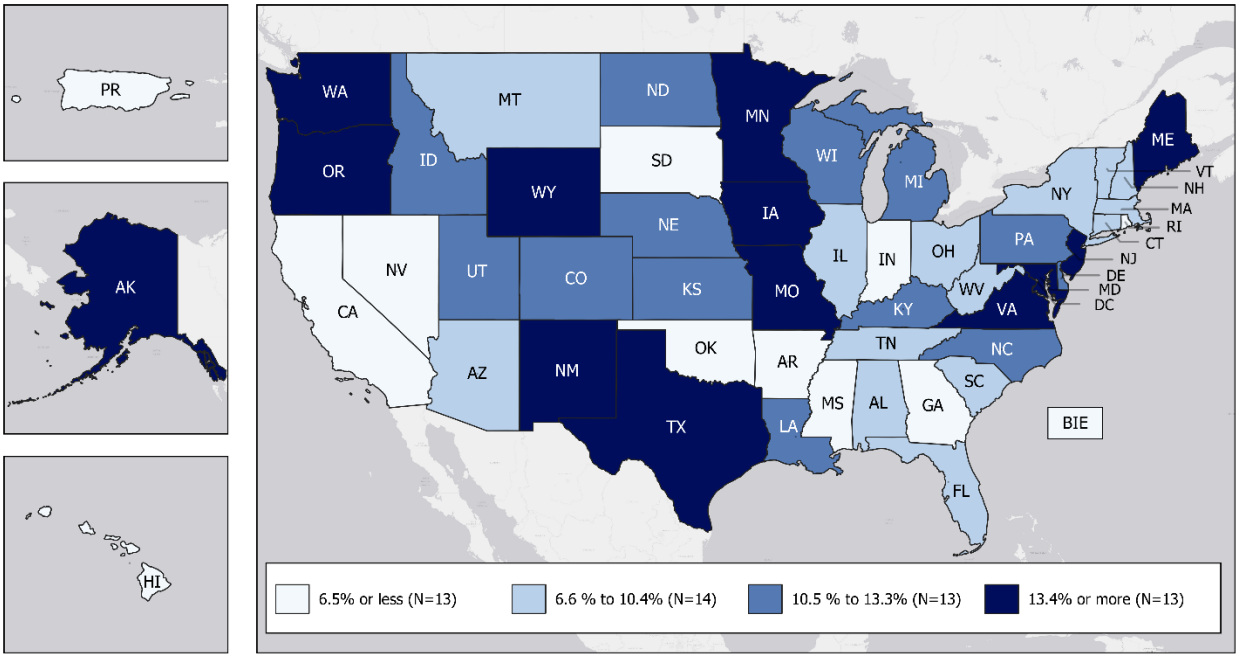
NOTE: Chart includes rounding to the nearest whole number. Grade 13 includes students who have successfully completed Grade 12 but stay in high school to participate in a bridge to higher education program.

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2022, 2023), SEA level.

Unaccompanied Homeless Youth

Unaccompanied homeless youth (UHY) are youth who are not in the physical custody of a parent or guardian and who meet the definition of homeless in the McKinney-Vento Act (42 U.S.C. § 11434a(6)). Students who are UHY can be of any age or grade. During all three school years included in this report, 9% of all students who experienced homelessness were unaccompanied. Ten states reported that 15% or more of the students who experienced homelessness were identified as UHY, while nine states reported less than 5% of its students were UHY.

Figure 4. Percent of children and youth experiencing homelessness who were unaccompanied, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13



NOTE: Grade 13 includes students who have successfully completed Grade 12 but stay in high school to participate in a bridge to higher education program.
SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2023), SEA level.

A lower percentage of UHY resided in shelters, transitional housing, and hotels or motels compared to the overall population of students who experienced homelessness. While 11% of students who experienced homelessness overall resided in shelters and transitional housing, 9% of UHY resided in shelters. Additionally, while 9% of students who experienced homelessness overall resided in hotels or motels, only 2% of UHY resided in hotels or motels. Four percent of both students who experienced homelessness overall and UHY lived in unsheltered situations. Finally, while 76% of students who experienced homelessness overall resided in doubled-up situations, 85% of UHY resided in doubled-up situations.

Table 4. Number and percent of enrolled UHY by primary nighttime residence, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

Residence	SY 2019-20	Percent of UHY	SY 2020-21	Percent of UHY	SY 2021-22	Percent of UHY	Percent change SYs 2019-20 to 2021-22
Total[1]	**112,822**	**100.0**	**94,363**	**100.0**	**110,664**	**100.0**	**-1.9**
Doubled-up	95,516	84.7	79,247	83.9	94,291	85.2	-1.3
Shelters & transitional housing	11,212	9.9	9,485	10.1	9,819	8.9	-12.4
Hotels/motels	1,578	1.4	1,711	1.8	2,035	1.8	29.0
Unsheltered	4,350	3.9	3,984	4.2	4,507	4.1	3.6
Not Reported	166	0.1	64	0.0	12	0.0	-92.8

[1] Enrolled students include those who were aged 3 through 5 but not enrolled in kindergarten, kindergarten through Grade 13, and Ungraded. Grade 13 includes students who have successfully completed Grade 12 but stay in high school to participate in a bridge to higher education program. The national totals in SY 2019-20 and SY 2020-21 differ slightly from those in Table 1 because the aggregation method is different. Rather than using EUTs, the totals reflect the SEA totals for each primary nighttime residence category.

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2022, 2023), SEA level.

Additional Subgroups of Enrolled Students Who Experienced Homelessness

In addition to reporting information about UHY, states report data on three additional subgroups of students who experienced homelessness, including students:

- who had disabilities;[5]
- who were English learners;[6] and
- who were migratory.[7]

Subgroups of students who experienced homelessness may belong to some, all, or none of the subgroups based on whether or not they meet the criteria for each subgroup. Between SYs 2019-20 and 2021-22, the percentage of students who were migratory and experienced homelessness remained stable at approximately 1% of all students who experienced homelessness. While the number of students with disabilities decreased by about 8,800, the percentage of students who experienced homelessness and also had a disability increased from 19% to 20%, indicating that the number of identified students decreased more than the number of students with disabilities who experienced homelessness. In contrast to other subgroups, English learners who experienced homelessness increased in both number and percentage. The increase of more than 18,000 students resulted in the percentage of students who were English learners and experienced homelessness changing from 17% in SY 2019-20 to 20% in SY 2021-22.

[5] As defined by the Individuals with Disabilities Education Act of 1975 (2004).
[6] As defined by the Elementary and Secondary Education Act of 1965 (2015).
[7] As defined by the Elementary and Secondary Education Act of 1965 (2015).

Students with disabilities and English learners not only accounted for the two largest subgroups of students who experienced homelessness, but the percentage of students who experienced homelessness and belonged to those subgroups was larger than the percentages of students in the general student body. Fifteen percent of students overall received special education services under the Individuals with Disabilities Education Act (IDEA) in SY 2020-21 versus 20% of students who experienced homelessness and were students with disabilities (Irwin et al., 2023). Similarly, while 10% of students overall were English learners, 18% of students who experienced homelessness were also English learners in SY 2020-21 (Irwin et al., 2022).

Table 5. Number and percent of students who experienced homelessness (SEH), by subgroup, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

Subgroup	Enrolled SEH[1] SY 2019-20	Percent of SEH SY 2019-20	Enrolled SEH SY 2020-21	Percent of SEH SY 2020-21	Enrolled SEH SY 2021-22	Percent of SEH SY 2021-22
Total[2]	**1,280,886**	**100.0**	**1,099,221**	**100.0**	**1,205,292**	**100.0**
Unaccompanied homeless youth	112,822	8.8	94,363	8.6	110,664	9.2
Migratory children/youth[3]	15,667	1.2	15,124	1.4	15,831	1.3
English learners	217,067	16.9	193,559	17.6	235,702	19.6
Children with disabilities (IDEA)	244,737	19.1	220,599	20.3	235,915	19.6

[1] SEH abbreviates "students who experienced homelessness."
[2] Counts include students aged 3 through 5 not in kindergarten, enrolled in kindergarten through Grade 13, and Ungraded. Grade 13 includes students who have successfully completed Grade 12 but stay in high school to participate in a bridge to higher education program. The national totals in SY 2019-20 and SY 2020-21 differ slightly from those in Table 1 because the aggregation method is different. Rather than using EUTs, the totals reflect the SEA totals for each subgroup.
[3] Connecticut, the District of Columbia, Puerto Rico, Rhode Island, and West Virginia do not operate migrant programs.
SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2021, 2022, 2023), SEA level.

Race and Ethnicity

Starting with SY 2019-20, states reported information to ED on the race and ethnicity of students who experienced homelessness. Although not all states could provide complete data that year, all states reported race and ethnicity data for SYs 2020-21 and 2021-22.

In SY 2021-22, Hispanic or Latino students made up the largest subgroup of students by race or ethnicity, at 39% of students who experienced homelessness. Both Black or African American and White students accounted for 25% of students who experienced homelessness. These same three subgroups were the largest based on race and ethnicity in SY 2019-20, but fewer Hispanic or Latino, Black or African American, and White students were identified in SY 2021-22 than in SY 2019-20 (NCHE, 2021).

Data for other race and ethnicity subgroups showed students with two or more races at 5%, Asian students at 2%, American Indian or Native Alaskan at 2%, and Native Hawaiian or Pacific Islander students at less than 1% of students who experienced homelessness. The number of students who experienced homelessness and were

identified as two or more races, American Indian or Alaskan Native, or Asian, increased in SY 2021-22 from SY 2019-20.

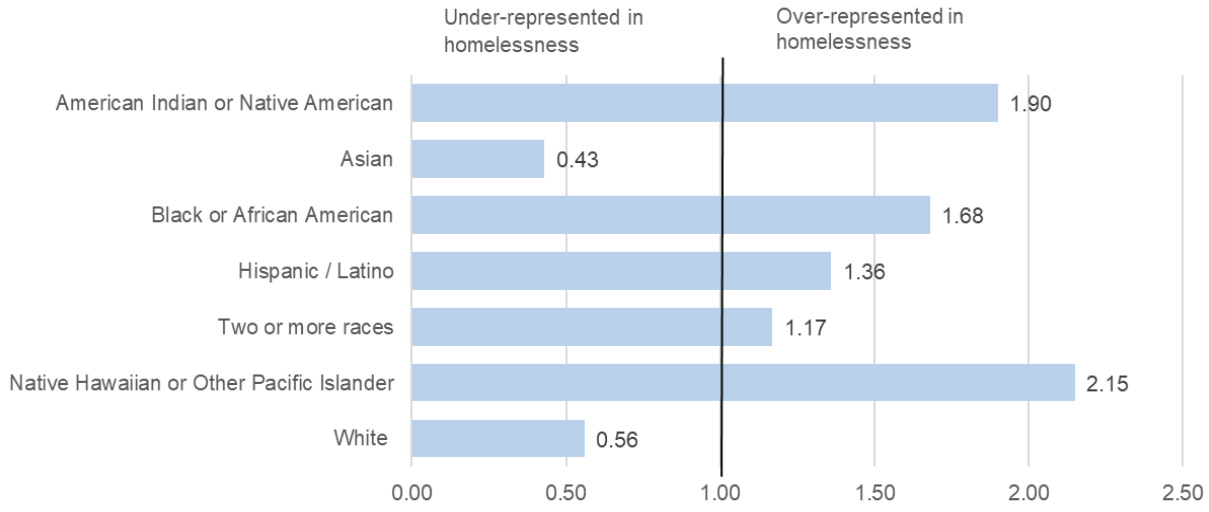
Table 6. Number of enrolled students by race, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

Race/ethnicity	Homeless students	Percent of homeless students	All students	Percent of all students
Total	**1,205,292**	**100.0**	**49,634,110**	**100.0**
Hispanic or Latino	473,309	39.3	14,262,450	28.7
Black or African American	306,381	25.4	7,381,626	14.9
White	300,830	25.0	22,325,966	45.0
Two or more races	64,967	5.4	2,328,808	4.7
Asian	27,640	2.3	2,657,629	5.4
American Indian or Alaskan Native	22,357	1.9	485,020	1.0
Native Hawaiian or other Pacific Islander	8,914	0.7	181,129	0.4
Not reported	894	0.1	11,482	0.0

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2023), SEA level; National Center for Education Statistics, Common Core of Data, *State nonfiscal public elementary/secondary education survey* (2021-22 v. 1a), SEA level.

Both Asian and White students were underrepresented among students who experienced homelessness. While White students accounted for 45% of all students enrolled in public schools, they represented 25% of students who experienced homelessness. Asian students accounted for 5% of students overall, but only 2% of students who experienced homelessness.

Figure 5. Ratio of students who experienced homelessness to total students by race, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13



SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2023), SEA level; National Center for Education Statistics, Common Core of Data, *State Nonfiscal Public Elementary/Secondary Education Survey* (2022-23 v.1a), SEA level.

Table 7. Number of enrolled students who experienced homelessness by race, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

State	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Two or more races	White
United States	**22,357**	**27,640**	**306,381**	**473,309**	**8,914**	**64,967**	**300,830**
Alabama	100	41	4,053	1,387	19	353	3,097
Alaska	904	55	160	251	360	569	793
Arizona	1,774	243	2,416	9,032	92	799	3,684
Arkansas	118	110	2,733	1,619	511	664	7,963
Bureau of Indian Education	1,757	—	—	—	—	—	—
California	1,788	8,986	17,811	165,064	1,271	8,788	22,039
Colorado	277	380	1,251	8,151	143	829	5,509
Connecticut	9	43	926	2,005	--	237	759
Delaware	19	16	1,870	491	5	283	750
District of Columbia	14	8	4,871	859	4	80	35
Florida	233	472	27,166	25,699	150	4,008	19,475
Georgia	88	182	19,061	4,714	39	2,153	9,279
Hawaii	4	314	21	614	1,807	381	110
Idaho	196	67	206	2,518	74	361	5,006
Illinois	140	414	22,287	10,310	35	2,135	13,074
Indiana	46	283	4,737	2,482	30	1,271	7,485
Iowa	92	108	1,598	1,391	196	537	2,595
Kansas	63	146	1,254	1,776	52	638	2,759
Kentucky	46	133	3,380	2,629	55	1,148	13,643
Louisiana	235	78	9,505	1,572	9	785	5,191
Maine	110	171	676	301	4	137	1,688
Maryland	53	129	7,938	4,627	15	1,071	2,696
Massachusetts	69	795	3,441	11,753	17	867	4,446
Michigan	388	183	8,009	3,365	45	2,196	14,538
Minnesota	1,202	471	5,151	2,079	23	2,515	3,146
Mississippi	16	24	3,250	422	5	299	1,540
Missouri	181	299	13,108	3,083	259	2,109	13,930
Montana	1,855	12	48	455	15	308	1,914
Nebraska	108	48	581	1,285	27	241	813
Nevada	188	263	4,734	6,346	362	1,455	3,128
New Hampshire	12	41	197	584	0	173	2,316
New Jersey	21	178	3,957	4,512	17	392	2,027
New Mexico	1,350	31	254	6,641	6	209	1,343
New York	1,258	8,104	38,627	69,153	384	2,666	13,386
North Carolina	235	166	14,721	5,250	53	1,985	6,221
North Dakota	554	14	283	298	20	167	664

Table 7. Number of enrolled students who experienced homelessness by race, SY 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13, continued

State	American Indian or Alaska Native	Asian	Black or African American	Hispanic or Latino	Native Hawaiian or Other Pacific Islander	Two or more races	White
Ohio	56	118	10,803	2,810	57	2,569	10,920
Oklahoma	2,541	387	3,214	4,833	126	3,076	6,968
Oregon	377	253	720	6,259	321	1,421	9,124
Pennsylvania	98	502	10,567	8,264	30	2,289	11,432
Puerto Rico	4	0	6	2,632	0	0	19
Rhode Island	32	11	226	423	3	143	623
South Carolina	17	44	4,385	1,938	8	848	4,303
South Dakota	760	6	118	307	5	181	351
Tennessee	35	100	5,303	3,069	40	963	8,002
Texas	336	1,247	24,381	52,772	194	3,293	15,056
Utah	754	177	330	4,594	511	562	4,969
Vermont	7	7	64	93	4	56	1,081
Virginia	52	518	6,371	4,608	21	1,175	3,671
Washington	995	838	3,400	13,806	1,456	3,598	13,521
West Virginia	4	30	508	382	4	448	7,778
Wisconsin	563	390	5,651	3,413	26	1,455	4,989
Wyoming	223	4	53	388	4	81	981

SOURCE: U.S. Department of Education, ED*Facts* file specification 118 (2023), SEA level.

Young Children Served by McKinney-Vento Subgrants

While most of this report focuses on students enrolled in public schools, states report additional information on the number of young children served by McKinney-Vento subgrants. These children may or may not be enrolled in public school as the ages of the students range from birth to five years old, but not yet enrolled in kindergarten. Data on school-aged children and youth served by the McKinney-Vento subgrants are not submitted to ED.

Table 8. Number of children from birth to age 5 but not enrolled in kindergarten served by McKinney-Vento subgrants: School Years 2019-20 through 2021-22

State	Served by subgrants SY 2019-20	Served by subgrants SY 2020-21	Served by subgrants SY 2021-22	Percentage change SYs 2017-18 to 2019-20
United States[1]	**64,788**	**48,694**	**58,433**	**-9.8**
Alabama	93	114	93	0.0
Alaska	52	16	26	-50.0
Arizona	129	86	99	-23.3
Arkansas	651	642	406	-37.6
Bureau of Indian Education	—	—	—	—
California	17,062	14,707	15,678	-8.1
Colorado	828	609	772	-6.8
Connecticut	78	52	93	19.2
Delaware	162	362	43	-73.5
District of Columbia	630	470	679	7.8
Florida	2,063	1,593	1,894	-8.2
Georgia	468	390	481	2.8
Hawaii	58	52	41	-29.3
Idaho	485	471	517	6.6
Illinois	2,985	1,610	2,580	-13.6
Indiana	109	107	115	5.5
Iowa	60	82	124	106.7
Kansas	650	329	504	-22.5
Kentucky	381	218	298	-21.8
Louisiana	666	331	734	10.2
Maine	19	32	22	15.8
Maryland	661	271	483	-26.9
Massachusetts	670	517	461	-31.2
Michigan	2,274	1,541	1,380	-39.3
Minnesota	440	380	395	-10.2
Mississippi	152	18	39	-74.3
Missouri	300	140	190	-36.7
Montana	436	337	359	-17.7
Nebraska	118	96	85	-28.0
Nevada	820	374	374	-54.4
New Hampshire	26	34	58	123.1
New Jersey	556	313	455	-18.2
New Mexico	194	583	762	292.8
New York	7,981	4,304	7,574	-5.1
North Carolina	824	468	911	10.6
North Dakota	136	177	74	-45.6
Ohio	2,430	1,946	1,946	-19.9
Oklahoma	423	308	281	33.6

Table 8. Number of children from birth to age 5 but not enrolled in kindergarten served by McKinney-Vento subgrants: School Years 2019-20 through 2021-22, continued

State	Served by subgrants SY 2019-20	Served by subgrants SY 2020-21	Served by subgrants SY 2021-22	Percentage change SYs 2017-18 to 2019-20
Oregon	896	622	271	-69.8
Pennsylvania	6,870	6,039	6,760	-1.6
Puerto Rico	34	11	34	0.0
Rhode Island	23	22	29	26.1
South Carolina	853	585	430	-49.6
South Dakota	305	251	308	-17.7
Tennessee	247	168	264	6.9
Texas	6,494	4,802	6,517	0.4
Utah	—	—	—	—
Vermont	26	20	30	15.4
Virginia	446	498	529	18.6
Washington	914	921	1,160	26.9
West Virginia	479	228	228	-52.4
Wisconsin	1,016	367	716	-29.5
Wyoming	115	80	131	13.9

[1] The United States total includes the Bureau of Indian Education, the District of Columbia, and Puerto Rico.
— Not available.
SOURCE: U.S. Department of Education, ED*Facts* file specification 194, SEA Level (2020, 2021, 2022).

Chronic Absenteeism

Research correlates chronic absenteeism with lower standardized test scores and grade point averages. Chronic absenteeism also correlates with higher rates of grade retention and dropping out (UEPC, 2012). Being present in school is a necessary precondition to receiving instruction and the needed supports to help master lessons. As a result, many states now use a measure of chronic absenteeism as a component in the accountability system to evaluate public schools each year. Additionally, states submit chronic absenteeism data annually through the ED*Facts* Initiative for students enrolled in kindergarten through Grade 12 and comparable ungraded students.

ED*Facts* data include students who miss 10% or more of the days in which they are expected to attend school, regardless of the reason the student missed school. Students who were enrolled in a school for at least 10 days are included in the count of students, while students enrolled in a state institution are included if they have been in attendance for 60 days.[8] Students also must participate in instruction or instruction-related activities for at least half of the school day to be considered in attendance. By basing the definition of chronic absenteeism on a percentage of the days a student is enrolled in school and the amount of time that a student participated in a school day, schools are able to consistently apply a standard for attendance that naturally accounts for students who attend more than one school during the year, intentionally planned half-days of school, and part-time.

[8] Examples of state institutions include department of health services schools and juvenile justice schools.

The first year for which the data are available using these criteria is SY 2016-17. Before this, the Office of Civil Rights (OCR) gathered data on chronic absenteeism using a different definition.[9] This report does not address the chronic absenteeism data collected previously by OCR and instead focuses on the newly available data.

Approximately 52%, or 632,129, of students who experienced homelessness were chronically absent during SY 2021-22. COVID-19 and its impact on school operations in SY 2019-20 and SY 2020-21 likely make it difficult to make comparisons over time. Idaho (21%), Missouri (34%), Tennessee (35%), Louisiana (36%), and Washington (36%) had the lowest rates of chronic absenteeism among students who experienced homelessness. The average state rate of students who were homeless and chronically absent was 55% in SY 2021-22. By comparison, the national average of chronically absent students for all students in public schools was 31%.

Table 9. Number and percent of students who experienced homelessness and chronic absenteeism, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13

	Students experiencing homelessness who were chronically absent					
	Number SY 2019-20	Percent SY 2019-20	Number SY 2020-21	Percent SY 2020-21	Number SY 2021-22	Percent SY 2021-22
United States	**351,702**	**33.1**	**459,972**	**41.9**	**632,129**	**51.7**
Alabama	2,643	22.8	2,542	27.1	4,085	44.8
Alaska	1,285	40.5	1,418	55.0	2,248	72.1
Arizona	6,777	37.8	8,144	58.5	11,015	59.5
Arkansas	4,895	36.7	3,304	27.8	5,534	40.3
Bureau of Indian Education	675	28.5	—	—	1,172	66.7
California	—	—	64,922	28.5	102,193	44.5
Colorado	10,132	47.3	8,787	57.9	9,723	54.1
Connecticut	1,439	33.5	1,716	51.8	2,042	50.5
Delaware	1,266	46.6	1,711	66.4	2,154	62.7
District of Columbia	2,462	37.8	2,330	46.4	3,622	59.1
Florida	35,645	44.6	38,689	61.4	49,841	63.5
Georgia	9,173	25	14,079	45.2	18,395	50.3
Hawaii	1,677	46.8	1,759	56.9	2,090	64.3
Idaho	1,582	19.5	1,983	27.0	1,839	20.9
Illinois	12,753	26.6	11,257	30.5	29,620	60.3
Indiana	5,205	29.6	8,073	52.5	9,691	58.3
Iowa	1,977	32.1	3,383	55.9	3,877	58.6
Kansas	2,697	32.8	2,339	41.5	3,531	49.7
Kentucky	5,345	24.1	9,682	51.8	8,802	41.0
Louisiana	3,487	22.1	5,050	42.9	6,164	35.5
Maine	971	41	1,149	48.8	1,590	50.6

[9] Information about data collected by OCR can be found at https://www2.ed.gov/about/offices/list/ocr/data.html. Furthermore, the 2015 CRDC data on chronic absenteeism is featured in a 2016 ED Data Story on *Chronic Absenteeism in the Nation's Schools*, available at https://www2.ed.gov/datastory/chronicabsenteeism.html.

Table 9. Number and percent of students who experienced homelessness and chronic absenteeism, SYs 2019-20 through 2021-22: Ungraded, 3- to 5-year-olds, and kindergarten to Grade 13, continued

	Students experiencing homelessness who were chronically absent					
State	Number SY 2019-20	Percent SY 2019-20	Number SY 2020-21	Percent SY 2020-21	Number SY 2021-22	Percent SY 2021-22
Maryland	7,775	49.2	6,866	58.4	11,291	67.4
Massachusetts[2]	7,361	30.7	9,025	45.2	11,552	52.1
Michigan	17,749	51.2	13,252	49.3	22,001	73.1
Minnesota	10,425	78.4	8,644	81.6	12,354	84.7
Mississippi	1,833	21	3,500	45.1	2,598	44.6
Missouri	7,697	22	6,561	20.1	11,432	33.8
Montana	1,570	36.3	2,514	53.8	3,092	65.4
Nebraska	1,735	42.2	1,332	52.3	1,762	56.3
Nevada	8,448	46.2	8,635	57.1	11,400	68.2
New Hampshire	1,549	44	1,918	61.7	2,331	69.0
New Jersey	2,753	21.6	3,660	34.7	4,342	38.2
New Mexico	2,934	32.5	3,691	46.5	4,683	47.6
New York	53,379	34.1	57,600	45.6	73,652	48.8
North Carolina	8,074	29.3	13,987	61.7	18,521	63.1
North Dakota	1,020	37.8	865	48.7	1,049	51.9
Ohio	11,488	38.4	14,124	57.2	16,783	61.6
Oklahoma	6,241	25	7,975	35.5	8,368	38.7
Oregon[2]	9,231	40.4	11,000	59.5	13,192	70.2
Pennsylvania	9,407	31.7	9,927	36.4	13,138	41.5
Puerto Rico	2,048	50.5	905	37.3	1,308	49.2
Rhode Island	849	54.8	728	65.6	1,016	69.0
South Carolina	3,008	25.3	5,109	47.9	5,946	50.6
South Dakota	803	39	1,034	66.2	1,184	68.0
Tennessee	4,108	21.4	5,091	35.4	6,540	35.4
Texas	23,812	20.8	32,783	35.2	48,540	48.7
Utah	3,066	23.2	4,084	39.7	6,031	50.7
Vermont	410	44.7	566	56.3	897	65.0
Virginia	4,917	27.7	4,627	33.6	6,422	38.6
Washington	12,380	32.8	16,583	50.4	13,880	35.8
West Virginia	3,596	34.6	2,431	25.7	4,345	47.5
Wisconsin	9,702	54.5	8,366	62.2	12,270	71.8
Wyoming	248	13.9	272	16.4	981	56.2

[1] From SY 21-22, the SEA counts in this table align with the counts posted on ED Data Express. Please note that in NCHE's previous report on chronic absenteeism, different national and SEA totals may be displayed because ED Data Express did not display SEA counts then, and NCHE aggregated SEA counts from school-level data. ED Data Express SEA counts reported through SY 21-22 are aggregated from privacy-protected school and LEA counts.
[2] Massachusetts and Oregon allow for non-binary gender, resulting in missing chronic absenteeism data.
-- Not available

NOTE: Due to altered school operations as a result of COVID-19, absenteeism data may be impacted by variability in school districts' capacity to track attendance accurately. This data may not accurately represent the actual chronic absenteeism numbers in SY 2019-20 and SY 2020-21.

SOURCE: U.S. Department of Education, ED Data Express SEA counts for file specification 195 (2023).

The percentage of students who experienced homelessness and chronic absenteeism represents an estimate; the actual percentage of students is likely lower. This is because chronic absenteeism data are only submitted at the school level, while enrollment data are submitted at the school district and state levels. As a result, a student who attended multiple schools may be included multiple times as a chronically absent student but only once as an enrolled student who was homeless. Starting with SY 2022-23, chronic absenteeism data will also be collected at the school district and state level, eliminating this issue.

In addition, the size of the population of students who experience homelessness is less stable than other groups of students. The number of students experiencing homelessness often increases or decreases more than other groups each year due to various economic, social, and environmental factors, while other groups of students remain relatively unchanged. For example, as a result of Hurricane Harvey in SY 2017-18, the number of students who experienced homelessness in Texas doubled compared to the previous year. During SY 2018-19, the number dropped to nearly the same level as in SY 2016-17. In contrast, the number of students enrolled in Texas public schools overall remained stable at 5.4 million in the fall of 2017 and the fall of 2018 (ED, 2021a and 2021b).

Adjusted Cohort Graduation Rate

Each state calculates an ACGR based on the number of students who graduate with a high school diploma within four years of when they first start high school.[10] A state may also adopt an extended-year ACGR (e.g., the number of students who graduate within five or six years of when they first start high school). Students who drop out of school or receive a GED/HiSET or other lesser credential may not be removed from a cohort (i.e., they are not counted as graduates but remain in the cohort). States may adjust their cohorts when a student has transferred out (and enrolls in a new school from which the student is expected to graduate), emigrated to another country, transferred to a prison or juvenile facility, or is deceased. To make the changes, the school must have written documentation that the student meets one of these criteria. The number of times a student has transferred and the time of year in which a student enrolls in school does not impact the student's status in the cohort. Even if a student is not on track to graduate on time, the student must be added to a cohort based on when the student enrolled in Grade 9 for the first time when they enroll in a new school.

All states must provide data on the number of students who graduated within four years for all students and each required subgroup, including students who experienced homelessness. Creating a cohort of students is straightforward for the general student population; all students are assigned to a cohort when they enroll in Grade 9 for the first time. When students transfer to a new school, they are still assigned to a cohort in the new school based on when they enrolled in Grade 9 for the first time. However, a student's status as homeless can change over time. In fact, it is common for students to experience multiple episodes of homelessness and to stay in

[10] Note that the ACGR includes students who receive a regular high school diploma or higher within four years or a student receiving an alternate diploma. It does not include a GED, certificate or completion or attendance, or similar lesser credential.

different nighttime living situations (Morton, Dworsky, and Samuels, 2017).[11] As a result, states must develop procedures to determine when a student will be included in the graduation rate cohorts for students who experience homelessness. For example, a common method used by states is to assign all students who experienced homelessness at any point during high school to the cohort. Another method used by some states is to include only those students who experienced homelessness during Grade 9 in the cohort.

As a result of differences across states in the definition of a high school diploma and how students are assigned to the cohort for students who experienced homelessness, caution should be used when comparing ACGRs across states.

The ACGR increased for students who were homeless in nine states (18%) between SYs 2019-20 and 2020-21. Overall, the ACGR for students who experienced homelessness decreased from 70% to 68% between SY 2019-20 and SY 2020-21. In nearly all states, the four-year ACGRs for all students are higher than those for economically disadvantaged students, which are higher than the four-year ACGR of students who experienced homelessness. This is true despite the fact that students experiencing homelessness most likely also meet the criteria for consideration as economically disadvantaged students and are included in the economically disadvantaged student ACGR. The four-year ACGR for students who experienced homelessness is higher than the four-year ACGR for students who were in foster care in all but four states.

[11] In the comprehensive prevalence survey completed by Morton, Dworsky, and Samuels (2017), half of youth experiencing homelessness within a year had experienced homelessness before.

Table 10. Four-year ACGR of students who experienced homelessness, were in foster care, were economically disadvantaged, and all students: School Years 2019-20 and 2020-21

State	Students who experienced homelessness		Students who were in foster care		Students who were economically disadvantaged		All students	
	SY 2019-20	SY 2020-21	SY 2019-20	SY 2020-21	SY 2019-20	SY 2020-21	SY 2019-20	SY 2020-21
Alabama	74	77	67	69	85.5	86.6	90.6	90.7
Alaska	58	51	54	45	72.3	69.9	79.1	78.2
Arizona	48.6	41.6	45	41	73.6	72.3	77.3	76.4
Arkansas	78	76	65	64	86.2	86.5	88.8	88.4
Bureau of Indian Education	73	—	—	—	65	—	65	—
California	69.6	67.8	58.2	55.7	81.2	80.4	84.3	83.6
Colorado	56.7	54	31	31	72.3	70.6	81.8	81.7
Connecticut	65	66	47	55	80.6	82.2	88.2	89.6
Delaware	73	57	74	45	82	70.8	89.0	80.5
District of Columbia	55	55	53	44	62	64	72.9	74.8
Florida	80.0	78.4	57	62	87.1	87.2	90.2	90.2
Georgia	65.8	63.6	—	45	79.6	80.6	83.8	83.7
Hawaii	69	69	69	67	81.5	81.1	86.2	86.0
Idaho	61	54	40	39	73.8	70.1	82.2	80.1
Illinois	—	—	—	—	—	—	—	—
Indiana	88	78	67	59	89.8	84.8	91.0	88.2
Iowa	76	65	64	62	85.6	82.3	91.9	90.2
Kansas	68	69	62	63	81.3	81.1	88.1	87.9
Kentucky	85	80	—	—	88.1	86.9	91.1	90.2
Louisiana	67	64	54	56	78.4	77.3	82.9	82.1
Maine	62	56	53	59	78.9	76.6	87.5	86.1
Maryland	66	65	50	57	79.2	79.0	86.8	87.2
Massachusetts	64	77	58	65	80.5	81.7	89.0	89.8
Michigan	60.0	54	40	40	71.6	68.8	82.1	80.5
Minnesota	50	45	—	37	71.6	70.3	83.8	83.3
Mississippi	75	71	65	60	85.9	90.0	87.7	88.4
Missouri	78	75	69	70	82.5	81.3	89.5	89.2
Montana	63	62	71	81	76.8	76.6	85.9	86.1
Nebraska	63	64	55	43	79.6	79.9	87.6	87.6
Nevada	75	73	50	43	79.1	79.0	82.6	81.3
New Hampshire[1]	58	58	43	45	74.9	72.2	88.1	87.1
New Jersey	74	68	55	47	85.0	82.1	91.0	88.5
New Mexico	59	62	39	37	71.7	72.3	76.9	76.6
New York	60.9	64.3	57	49	77.2	79.7	83.5	84.9
North Carolina	72.3	69.3	57	57	82.3	80.1	87.7	87.0
North Dakota	65	61	73	45	77	73	89.0	87.0
Ohio	58.6	57.4	57	59.4	74.4	75.4	84.4	85.3
Oklahoma	66	62	58	65	87.2	82.6	80.7	80.0

Table 10. Four-year ACGR of students who experienced homelessness, were in foster care, were economically disadvantaged, and all students: School Years 2019-20 and 2020-21, continued

State	Students experiencing homelessness SY 2019-20	Students experiencing homelessness SY 2020-21	Students in foster care SY 2019-20	Students in foster care SY 2020-21	Students who are economically disadvantaged SY 2019-20	Students who are economically disadvantaged SY 2020-21	All students SY 2019-20	All students SY 2020-21
Oregon	60.5	55.4	—	48	77.6	77.0	82.6	80.6
Pennsylvania	70	69	56	53	79.6	79.5	87.3	86.7
Puerto Rico	75	63	S	—	77.0	74.9	78.1	75.7
Rhode Island	57	61	57	49	75.9	76.3	83.6	83.7
South Carolina	64	62	44	38	76.2	75.5	82.2	83.3
South Dakota	53	40	43	38	69	69	84.3	82.9
Tennessee	78	73	60	54	84.4	82.1	90.4	89.3
Texas	—	79.2	—	61	—	86.7	—	90.0
Utah	—	—	—	—	78.3	77.8	88.2	88.1
Vermont	55	57	—	48	75	74	83.1	83.2
Virginia	62	65	54	55	82.5	83.3	88.8	89.8
Washington	69.4	—	50	—	75.2	—	83.1	—
West Virginia	82	77	—	63	87.1	85.4	92.1	91.1
Wisconsin	67	64	60	52	81.5	78.4	90.4	89.6
Wyoming	64	61	—	55	71.6	70.1	82.3	82.5

[1] New Hampshire counts only include those students who experienced homelessness by October 1.
— Not available.
S: Data suppressed to protect student privacy.
NOTE: Due to small student counts for graduating students in each group, many values in the table are rounded to the nearest whole number rather than the nearest tenth. The ACGR for groups with sufficiently large student counts is displayed rounded to the nearest tenth.
SOURCE: U.S. Department of Education, ED*Facts* file specification 118, SEA level (2022, 2023).

References

Irwin, V., Wang, K., Tezil, T., Zhang, J., Filbey, A., Jung, J., Bullock Mann, F., Dilig, R., Parker, S., Nachazel, T., Barnett, M., & Purcell, S. (2023). *The condition of education 2023.* U.S. Department of Education. Washington, DC: National Center for Education Statistics. https://nces.ed.gov/programs/coe.

Irwin, V., De La Rosa, J., Wang, K., Hein, S., Zhang, J., Burr, R., Roberts, A., Barmer, C., Bullock Mann, F., Dilig, R., Parker, S., Nachazel, T., Barnett, M., & Purcell, S. (2022). *The condition of education 2022.* U.S. Department of Education. Washington, DC: National Center for Education Statistics. https://nces.ed.gov/programs/coe.

Morton, M. H., Dworsky, A., & Samuels, G. M. (2017). *Missed opportunities: Youth homelessness in America, national estimates*. Chicago, IL: Chapin Hall at the University of Chicago. https://voicesofyouthcount.org/brief/national-estimates-of-youth-homelessness/

National Center for Education Statistics (NCES). (2023). *State nonfiscal public elementary/secondary education survey, 2019-20 v.1a, 2020-21 v.1a, 2021-22 v.1a* [Data set]. Common Core of Data. https://nces.ed.gov/ccd/files.asp.

National Center for Homeless Education (NCHE). (2022). *Student homelessness in America, School Years 2018-19 through 2020-21.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/.

National Center for Homeless Education (NCHE). (2021). *Student homelessness in America, School Years 2017-18 through 2019-20.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/.

National Center for Homeless Education. (2020). *Federal data summary School Years 2016-17 to 2018-19.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/.

National Center for Homeless Education. (2019). *Federal data summary School Years 2015-16 to 2017-18.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/.

National Center for Homeless Education. (2018). *Federal data summary School Years 2014-15 to 2016-17.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/

National Center for Homeless Education. (2017). *Federal data summary School Years 2013-14 to 2015-16.* University of North Carolina. Greensboro, NC. https://nche.ed.gov/data-and-stats/.

U.S. Department of Education (ED). (2021a). *C52: Membership file specifications, SY 2018-19.* https://www2.ed.gov/about/inits/ed/edfacts/archived-file-specifications.html

U.S. Department of Education (ED). (2021b). *C52: Membership file specifications, SY 2017-18.* https://www2.ed.gov/about/inits/ed/edfacts/archived-file-specifications.html

Utah Education Policy Center. (2012). *UEPC research brief: Chronic absenteeism.* https://daqy2hvnfszx3.cloudfront.net/wp-content/uploads/sites/2/2017/01/11134053/chronic-absenteeism-research-brief.pdf

Unhoused and Undercounted lead illustration. | *(Matt Manley for the Center for Public Integrity)*

DIVERSITY & EQUITY COMMUNITY & WRAPAROUND PROGRAMS FEDERAL POLICY AND REFORM

Hidden toll: Thousands of schools fail to count homeless students

Federal law promises homeless children an equal shot at education. Many fall through the cracks.

By Amy DiPierro, Center for Public Integrity and Corey Mitchell, Center for Public Integrity | November 15, 2022, 5:00am EST

REPUBLISH

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For months, Beth Petersen paid acquaintances to take her son to school — money she sorely needed.

They'd lost their apartment, her son bouncing between relatives and friends while she hotel-hopped. As hard as she tried to keep the 13-year-old at his school, they finally had to switch districts.

Under federal law, Petersen's son had a right to free transportation — and to remain in the school he attended at the time he lost permanent housing.

But no one told Petersen that.

"They should have been sending a bus for him. … He's missed so much school I can't believe it," Petersen said. "And school is stability."

Petersen was unaware of a federal law that would've allowed her son to remain in his district while they experienced houselessness. | (Zoë Meyers for the Center for Public Integrity)

A Center for Public Integrity analysis of district-level federal education data suggests roughly 300,000 students entitled to essential rights reserved for homeless students have slipped through the cracks, unidentified by the school districts mandated to help them.

Some 2,400 districts — from regions synonymous with economic hardship to big cities and prosperous suburbs — did not report having even one homeless student despite levels of financial need that make those figures improbable.

And many more districts are likely undercounting the number of homeless students they do identify. In nearly half of states, tallies of student homelessness bear no relationship with poverty, a sign of just how inconsistent the identification of kids with unstable housing can be.

The reasons include a federal law so little-known that people charged with implementing it often fail to follow the rules; nearly non-existent enforcement of the law by federal and state governments; and funding so meager that districts have little incentive to survey whether students have stable housing.

“It’s a largely invisible population,” said Barbara Duffield, executive director of SchoolHouse Connection, a Washington, D.C.-based nonprofit focused on homeless education. “The national conversation on homelessness is focused on single adults who are very visible in large urban areas. It is not focused on children, youth and families. It is not focused on education.”

Losing a home can be a critical turning point in a child’s life. That’s why schools are required to provide extra support.

Nationwide, homeless students graduate at lower rates than average, blunting their opportunities for stable jobs and increasing the risk of continued housing insecurity in adulthood.

The gap is often stark: In 18 states, graduation rates for students who experienced homelessness lagged more than 20 percentage points behind the overall rate in both 2017 and 2018.

The academic cost is not equally shared. Black and Latino children experience homelessness at disproportionate rates, Public Integrity’s analysis showed. Nationally, American Indian or Alaska Native students were also over-represented, as were students with disabilities.

Until recently, it was not clear from federal records which students were hit hardest by housing instability. Data disclosed in U.S. Department of Education reports revealed nothing about the race or ethnicity of students recognized by their school districts as homeless.

That changed in the 2019-20 school year when the federal government for the first time made public the race and ethnicity breakdowns for individual school districts. The pattern that emerged is a story of the country's sharp inequities, which put some families at far higher risk of homelessness than others.

The McKinney-Vento Homeless Assistance Act, first enacted in 1987 and expanded in 2001, requires that districts take specific actions to help unstably housed students complete school. Districts must waive enrollment requirements, such as immunization forms, that could keep kids out of the classroom. They must refer families to health care and housing services. And they must provide transportation so children can remain in the school they attended before they became homeless, even if they're now outside the attendance boundaries.

Earl Edwards, an assistant professor at Boston College's School of Education and Human Development, argues that McKinney-Vento was premised on an idea still pervasive in the policy debate on homelessness: Like a tornado that levels towns at random, housing misfortune has an equal chance of afflicting anyone, regardless of who they are.

In the 1980s, that rhetoric was a potent argument in favor of expanded federal support for homeless services. It was also wrong.

The McKinney-Vento Act started as an inadequate policy

The McKinney Act — later renamed — took shape at a time when the Reagan administration, if it acknowledged homeless people at all, regarded them as having chosen a life on urban skid rows, said Maria Foscarinis, who helped write the law.

Foscarinis, the founder of the National Homelessness Law Center, reframed homelessness as a broader structural problem impacting families, people of all races, even suburbanites. The outcome was a race-neutral solution, despite data at the time that went counter to that theory.

Foscarinis said the law's architects knew it was inadequate and planned to follow it with homeless prevention programs and housing. But they faced stiff resistance. It would have been better to include race-conscious language tracking the demographics of homeless children, she added, but doing so could have jeopardized the entire effort.

"Had we done that, it would have torpedoed the whole thing, which would have hurt Black communities even more," she said. "Then, we would have nothing at all."

Figures now available down to the school district show the consequences of homelessness policy that doesn't address race directly.

Nationally, Black students were 15% of public school enrollment but 27% of homeless students in 2019-20. In 36 states and Washington, D.C., the rate of homelessness among Black students was at least twice the rate of all other students that year.

Boston College's Edwards said the disconnect lies between the reality of housing inequality and the policies intended to address it.

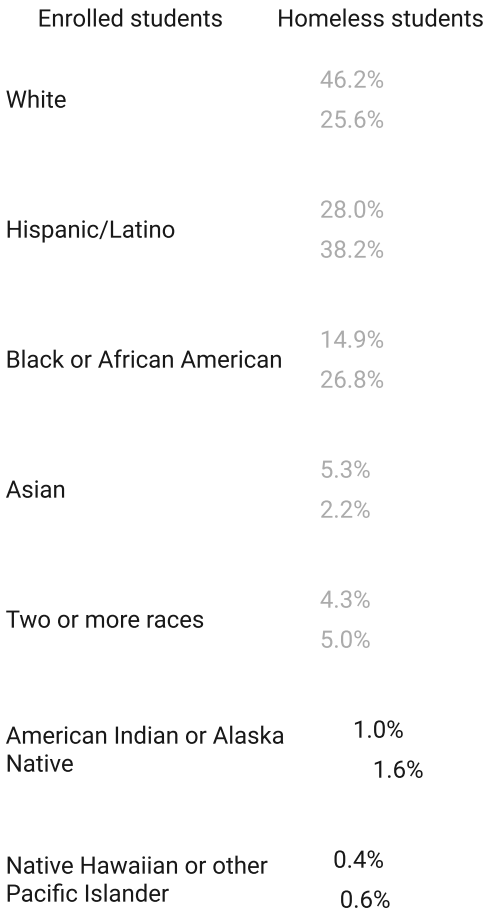
"If you don't recognize that Black people, during the time when you were establishing the actual policy, were disproportionately experiencing homelessness" — and that housing discrimination, urban renewal, blockbusting and other systemic factors pushing Black people out of housing were key drivers — "then you make a policy, and the policy doesn't have anything in place to prevent those things from persisting," Edwards said.

And under-identification of homelessness could impact Black students more than peers of other races.

In interviews with Black students who experienced homelessness while enrolled in Los Angeles County public school districts, Edwards found that many distrusted school personnel, who underestimated their academic ability, sent them to the principal's office for the smallest perceived slights, and threatened to call child protective services.

Race and homelessness in public schools

Black and Latino children were particularly over-represented among students identified as homeless nationwide in the 2019-20 school year, a reflection of the country's longstanding economic inequality.



Note: Data collection in 2019-20 was impacted by the Covid-19 pandemic. Includes the Bureau of Indian Education, the District of Columbia, and Puerto Rico. Some states did not provide complete data or provided counts that appeared to be in error.

Chart: Amy DiPierro, Center for Public Integrity • Source: National Center for Homeless Education analysis of Department of Education

As a result, Edwards found, many students went unidentified under McKinney-Vento because they feared that sharing their situation would only make things worse. They paid for transit passes out of pocket. They were forced out of their home districts. They navigated college admissions alone. If they were lucky, they found mentors outside of the school system.

Those experiences aren't an accident, Edwards argues, but the product of historical patterns. For example: "Calling child protective services would not be a severe threat to Black students if racial disparities within the institution itself were less pronounced."

Beneath the race-neutral veneer of McKinney-Vento, American Indian or Alaska Native students and Latino students also experience housing instability at higher rates than their peers in the majority of states.

In Capistrano Unified, a 44,000-student school district in southern California, the rate of homelessness among Latino students was roughly 24% in recent school years compared to about 2% among the rest of the student body.

"It's not anything that we've really done research on, so I wouldn't even be able to speculate" as to why, said Stacy Yogi, executive director of state and federal programs for the district.

Across California, Latino students are 56% of public school enrollment but 74% of homeless students.

A 2020 report from the University of California, Los Angeles, found that Black and Latino students who experience homelessness in the state are more than one and a half times as likely to be suspended from school as their non-homeless peers. They also miss more school days and are less prepared for college.

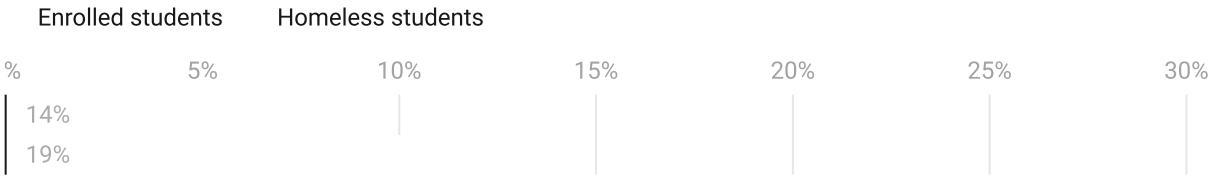
Public Integrity's analysis also found that students with disabilities have higher rates of homelessness than the rest of their peers in every state except Mississippi, suggesting that a significant share of students who already require additional support attend school uncertain of where they will sleep that night.

"They're experiencing trauma, and trauma has a pretty significant impact," said Darla Bardine, executive director of the National Network for Youth, a policy and advocacy group focused on youth homelessness. "You have to navigate an overly complicated system, and it's this competition for limited

resources where young people and children and families are just inherently disadvantaged."

Students with disabilities facing homelessness

Children with disabilities made up a greater share of homeless students in the 2019-20 school year than among the total student population.



Note: Data collection in 2019-20 was impacted by the Covid-19 pandemic.

EJ Valez, who has limited vision and requires large-print materials for reading and braille instruction, was among them.

Valez experienced housing instability for most of his youth, bouncing between homes and schools in the Bronx and Reading, Pennsylvania.

"I'm surprised I made it out of school," he said.

As a teenager, he said, he couch-surfed with friends and acquaintances after he became estranged from his family.

"Somehow I could retain information, but at no point in my childhood before full-on adulthood was there ever actual stability," said Valez, now a student at Albright College in Pennsylvania and a member of the National Network for Youth's National Youth Advisory Council. "No one cares about classes if we don't know where we're going to put our heads at night."

That, he said, is why extra help from schools is so critical.

Hidden homelessness in America

It might seem like common sense to assume that where more children experience poverty, more will experience homelessness, too.

But that's not what the data from school districts show. One of the most surprising patterns we found is that reported homelessness among students didn't mirror poverty in 24 states.

The finding runs counter to a growing body of empirical evidence supporting the connection between poverty and housing instability. Children born below 50% of the poverty line had a higher probability of eviction than higher-income peers, lower-income households are more likely to experience forced mobility, and renters who are forced to move end up in higher-poverty neighborhoods than renters who move voluntarily.

"There should be a stronger relationship between homelessness and poverty," said Jennifer Erb-Downward, director of housing stability programs and policy initiatives at the University of Michigan's Poverty Solutions, "and the fact that there's not supports that there's under-identification taking place."

Districts can tell teachers and staff to look for common signs of housing instability among students — fatigue, unmet health needs, marked changes in behavior. But those aren't always apparent.

If they're following the law, districts will survey families so they can self-identify as homeless. But some parents fear that acknowledging their housing struggles could prompt the government to take their kids away.

And then there's the gulf between what people commonly think of as homeless and the more expansive definition Congress uses for students. Living in a shelter, on the streets, in a vehicle or in a motel paid for by the government or a charitable organization are included, but that's not all.

More than 70% of children eligible for services were forced by economic need to move out of their homes — with or without their family — and in with relatives or friends, a practice that the U.S. Department of Education defines as "doubled up."

Research on doubled-up students shows there's good reason to provide them with help: They earned lower grades, for example, and were less likely to

graduate on time.

In Riverside County, California, Beth Petersen's son met the definition of doubled up for months, having lived temporarily with her sister and with friends.

Only Petersen didn't know it at the time.

Eventually, the two found housing outside the Temecula Valley Unified School District her son had attended for years. He switched districts, keeping up with the schoolwork but struggling to make friends.

Then a friend of Petersen's who works at a charter school told her that her son had the right to re-enroll in the Temecula Valley schools because the

McKinney-Vento law allows students to stay in the same school they attended before becoming homeless.

In early September, Petersen moved with her son into a two-bedroom apartment — still outside the district boundaries — paid for by a homeless prevention organization and shared with another family. Under federal law, her son is considered homeless because they live in transitional housing.

Petersen re-enrolled her son in Temecula Valley Unified but problems persisted. She said she pleaded with the district for weeks, trying to secure bus rides for the teenager. The district never responded to her emails, she said. He ultimately missed a month of classes, Petersen estimated, because she could not afford to continue paying acquaintances to transport her son every day.

The California Department of Education intervened in late September to ensure her son received transportation.

“This has been a teachable moment for the district and there are protocols and … barriers that have been removed to ensure the law is met,” an employee at the state agency wrote Petersen in an email.

A statement provided by Temecula Valley Unified in response to detailed questions regarding the Petersens said the district “does everything in its power to support our McKinney-Vento families experiencing homelessness” and has “highly responsive site and district teams,” but declined to comment further.

Experts think students like Petersen’s son are among those most likely to go unidentified and unassisted because their families don’t realize they qualify for help and schools too often fail to fill the information gap.

Petersen's son missed over a month of classes due to transportation issues with Temecula Valley Unified. | (Zoë Meyers for the Center for Public Integrity)

When that happens, "we're not even including most of our kids who are experiencing homelessness in the definition of who's homeless," said Charlotte Kinzley, supervisor of homeless and highly mobile services for the Minneapolis Public Schools. "So we haven't even named the problem."

In Minneapolis, the reported graduation rate for homeless students is at least 26 percentage points below the rate for all students. The district introduced programs in the last few years to help schools find more students experiencing housing instability and connect them with assistance. Lesson plans for teachers help high school students understand if they qualify.

Across Minnesota, districts generally reported homeless rates that loosely mirrored trends in free- or reduced-price lunch eligibility, suggesting some consistency in identification.

“It’s not a matter of getting the right count or getting the numbers,” said Melissa Winship, a Minneapolis schools counselor who works with students experiencing homelessness. “It’s a matter of those students and families having those supports and resources that they deserve.”

Data on student homelessness is collected by districts and funneled to the federal government by states, which can choose to leave out any districts that did not report having any homeless students. Our data adds those excluded districts back. We assume they identified no homeless students, since they’re not in federal data.

Our analysis focused on non-charter districts in the 2018-19 and 2019-20 school years. In addition to comparing poverty and reported homelessness, we applied a common benchmark used by education researchers and some public education officials — that one of every 20 students eligible for free- or reduced-price lunches experience homelessness under the federal definition.

In each school year we analyzed, more than 8,000 districts did not meet the one-in-20 guideline.

DeSoto County, Mississippi, for instance, identified fewer than 300 homeless students, according to state records Public Integrity reviewed. Its share of students eligible for free- or reduced-price lunches suggests the district has three times the number it reported.

That’s not the only reason to suspect an undercount. In 2018, local landlords filed more than 4,000 eviction cases, according to an estimate from Princeton University’s Eviction Lab.

By comparison, Mississippi’s Vicksburg Warren School District identified about as many homeless students as DeSoto despite having less than half as many children eligible for free- or reduced-price lunches.

The DeSoto County schools did not respond to requests for comment.

It's possible that some school districts genuinely have fewer homeless students than this benchmark predicts. But multiple researchers told us that they see the one-in-20 threshold as a conservative estimate.

J.J. Cutuli, a senior research scientist at Nemours Children's Health System, said the analysis bolsters the anecdotal experiences of school district staff, shelter personnel, and people who've lived through periods of homelessness.

"You're giving us a clue as to the magnitude of this problem. And that's really the important part here," he said.

The University of Michigan's Erb-Downward said the reason numbers are critical is because "we, somehow, as a society, have agreed that it is OK for the level of poverty and instability that children experience, from a housing perspective, to exist."

"If we don't actively track that, and have a conversation about what the level [of homelessness] really is, I don't think we're being forced to actually look at that decision that we've made societally," she said. "And we're not really being forced to say, 'Is this actually what makes sense? Is this actually what we want?'"

Why tracking homeless children in America is an 'uphill battle'

The federal government, state education departments, and families have few options to hold districts accountable if they fail to properly identify or provide assistance for students experiencing homelessness.

The U.S. Department of Education delegates enforcement to states. States where school districts fail to follow the law are subject to increased monitoring, but the federal agency would not say how often that happens. A spokesman said only that the agency "engages in monitoring and compliance activities that can include investigating alleged non-compliance."

Public Integrity reviewed dozens of lawsuits in which families and advocacy groups alleged that school districts denied students rights that are guaranteed

under the federal McKinney-Vento law.

Families experiencing homelessness have sometimes prevailed in their standoffs with education agencies, winning reforms like agreements to train school personnel in the law and, in one case, a toll-free number for parents and children to contact with questions about their rights.

“There’s not really a ton of capacity for actually investigating and dealing with these complaints,” said Katie Meyer Scott, senior youth attorney at the National Homelessness Law Center. “We have a problem where there’s not necessarily an investment in enforcement at either the federal or state level.”

As an extreme last resort, the U.S. Department of Education can cut funding — a step officials are loath to take because that would ultimately harm the very students the agency wanted to help. The agency said it has never penalized a state in this manner.

A 2014 investigation by the Government Accountability Office found that eight of the 20 school districts its staff interviewed acknowledged they had problems identifying homeless students. The watchdog agency found that the U.S. Department of Education had “no plan to ensure adequate oversight of all states,” with similar gaps in state monitoring of school districts.

State audits in California, Washington, and New York have also made the case that many school districts fail to identify a significant number of students who qualify for the rights guaranteed under federal law. Advocacy groups and researchers, too, have surfaced examples.

In Michigan, state Department of Education guidelines call for an investigation if school districts identify fewer than 10% of low-income students as homeless. Erb-Downward found that all but a handful of Detroit schools fell below this threshold in the 2017-18 school year.

Public Integrity’s analysis points to similar problems. Detroit’s public school district, the largest district in the state, identified 255 fewer homeless students

than the Kalamazoo Public Schools in 2018-19, despite having four times as many students and a much higher poverty rate.

Detroit school superintendent Nikolai Vitti said in a statement that the district's efforts to improve in recent years include adding full-time staff to its homeless student office, a residency questionnaire with its student enrollment form, referral systems, and public information about available services.

Homeless student numbers have tripled in the past several years, Vitti said. But, he added, "We are aware there is still an undercount."

Detroit's public school district, under Superintendent Vitti, have sought to improve its count of students experiencing homelessness. | (Nic Antaya for Chalkbeat)

A statewide review this year identified 120 Michigan school districts, roughly 20%, in need of additional monitoring, department spokesman Martin Ackley said. The state is asking those districts to provide evidence that they are in compliance with federal law.

The state expects to finish the reviews this winter and will provide technical support to districts struggling to meet federal requirements.

Districts in other parts of the country willing to explain likely undercounts offer a variety of reasons.

In the Chester-Upland School District outside of Philadelphia, interim homeless liaison Dana Bowser said many families consult district staff as a last resort when they can't find a solution to their housing troubles on their own. Language barriers make some parents reluctant to come forward, she added.

Florida's Broward County Public Schools described struggles to overcome limited funding, stigma, and fear of immigration services as "skyrocketing home prices and lack of regulation around rental fees have created an unfortunate climate in which more individuals and families are facing homelessness, including middle-class income families."

And in the Yuma Union High School District along Arizona's borders with both California and Mexico, where our benchmark predicted more than five times the number of homeless students than was reported in the 2019-20 school year, school officials said they do not report a child as homeless if they do not apply for and receive services under McKinney-Vento. The National Center for Homeless Education advises officials to count enrolled homeless children and youth even if they decline services available to them.

In Oklahoma, hundreds of districts report that no students experience homelessness. Tammy Smith, who oversees the state's homeless student programs, hears a common refrain from school leaders when she asks why.

"They tell me, 'We're going to take care of all of our students, whether we identify them as homeless or not,'" Smith said. "I remind them it's federal law, but it's kind of [an] uphill battle."

Leaving homeless children out of official records is a problem even if a district does manage to support them without properly counting them, said Amanda

Peterson, the director of educational improvement and support at the North Dakota Department of Public Instruction.

“If we are not able to tell the story, we’re not able to show that there’s discrepancies in the graduation rate, then what ends up happening is that it’s easy for legislators, community members, others to just close their eyes to the issue and just say, ‘Well, if it’s not reported, it doesn’t exist, and therefore we don’t need to worry about it,’” she said. “There’s harm if we just sort of push it under the rug.”

Yuma Union High School District does not count students as homeless if their family doesn’t apply for services under McKinney-Vento. | (David McNew / Getty Images)

‘Not enough money’ to support homeless students

Federal programs provide school districts little financial incentive to survey students’ housing situations more thoroughly. Money to serve these vulnerable children is limited and does not increase automatically as districts identify more of them, Public Integrity found.

Instead, the U.S. Department of Education awards funds to states using a formula that factors in poverty rates. States use their share to award competitive grants to districts.

Calling them paltry is an understatement.

The funding amounted to about $60 per identified homeless student nationwide before the pandemic. One state received less than $30 per student.

That's a fraction of what school districts actually spend to support homeless students, according to a recent study by the Learning Policy Institute, a nonpartisan research group. The four districts profiled by LPI spent between $128 and $556 per homeless student identified. In two of those districts, McKinney-Vento subgrants accounted for less than 14 cents on every dollar the district spent on homeless education programs.

Big need, little federal money

Nationally, federal funding for schools to assist homeless students as required by law amounted to just $60.12 per homeless student identified in the 2018-19 school year. Some states received far less.

Search in table

Page 1 of 6 >

State	Funding per homeless student
Washington	$29.44
Utah	$30.48
Oregon	$32.14
Missouri	$37.47
Nevada	$37.47
Colorado	$37.84
California	$38.90
Idaho	$39.93
District of Columbia	$40.03
Oklahoma	$42.94

Alabama's homeless count includes only students who were homeless on the last day of school. New Hampshire's homeless count includes only students identified by October 1, 2018.

And that's the districts awarded federal grants. Most get nothing.

Until a temporary funding influx during the pandemic, only one in four districts nationwide received dedicated funding. Washington state, which got the lowest amount in the 2018 fiscal year at $29 per identified student, passed a law in 2016 to provide additional support and resources.

“I would argue that a state like Washington has better identification, but it’s not reflected in how the feds dole out the money from McKinney-Vento,” said Duffield of SchoolHouse Connection.

Even in states that receive hundreds of dollars per student, the money does not stretch far, experts said. And it’s definitely not enough to provide long-term assistance for students without stable housing.

One sign of its inadequacy: Many districts don’t even bother applying for the federal money. In Oklahoma, just 25 of the state’s 509 districts requested funds.

Smith, who oversees the state’s homeless student programs, urges districts to apply. She said superintendents tell her, “There’s not a monetary benefit for us to identify them. So that’s not where we’re spending our time.”

In 2021, the American Rescue Plan made $800 million available to states and districts to identify and support homeless students, some of whom became disconnected from schools after the COVID-19 closures of 2020. The historic funding influx was seven times the annual budget awarded to schools to support their homeless students in 2022, making federal funds available to districts that had not previously received money.

In Wayne County, Michigan, where Detroit is located, the additional funding was sorely needed, said Steven Ezikian, the deputy superintendent of the Wayne County Regional Educational Service Agency, which helps train local districts to identify and support students experiencing homelessness.

“McKinney-Vento does not provide nearly enough funding,” he said. “Frankly, there’s just not enough money for them to do all the work for the amount of kids that we have.”

The traditional level of funding to support homelessness has left many districts struggling to fulfill the law's requirements.

"There [are] more and more students in crisis and the districts are not really getting more and more resources to help," said Scott, the senior youth attorney with the National Homelessness Law Center. "It comes down to resources rather than any kind of bad intent. The lack of investment in our schools over time is obviously hitting homeless students even harder."

In April, 92 members of the U.S. House of Representatives signed a "Dear Colleague" letter, urging the chairwoman and ranking member of the House Education Committee to renew the $800 million in funding, which represents 1% of the federal education budget, for the fiscal year that started Oct. 1. It would be money well spent, they argued.

"Investing in a young person's life will enable them to avoid chronic homelessness, intergenerational cycles of poverty, and pervasive instances of trauma," the letter read.

Budget bills from both chambers of Congress requested boosts in the program budget that are far short of what the House members requested. Federal budget negotiations will likely resume in December.

Temecula Valley Unified, the district Beth Petersen's son attends, received $56,000 to serve homeless students through the American Rescue Plan — about $470 per homeless student identified. District staff did not respond to questions regarding funding for homeless education programs. State financial records for the several years before the American Rescue Plan show the district received nothing.

Petersen watches from her apartment steps as her son leaves for the school bus. | (Zoë Meyers for the Center for Public Integrity)

Early on a Monday morning in October, Petersen sat at the kitchen table in her shared apartment, applying makeup under the glare of a bowl-shaped ceiling light. Her son emerged from the bathroom, barefoot but otherwise dressed for school. Petersen peered around the corner. Did he want anything for breakfast? He shrugged. No, he was fine.

But then he remembered an assignment that was due: a photo with his mom clearing him to attend a sexual education course. He stooped beside her and angled his laptop for a selfie. Beth could hardly remember the last time she needed to review any of his assignments. He was always a diligent student, even these last few months.

“Do not miss the bus coming home or we will be up a creek,” she said as the pair walked outside, the air crisp as morning haze yielded to blue sky.

At 7:02 a.m., a yellow school bus turned the corner. It slowed to a stop before them, the fruits of Petersen's long struggle to make the promise of the McKinney-Vento law a reality.

The doors opened, and her son was on his way.

Chalkbeat journalist Lori Higgins contributed to this article.

Amy DiPierro and Corey Mitchell are journalists with the Center for Public Integrity, a nonprofit newsroom that investigates inequality.

About our analysis

Public Integrity used a statistical modeling technique called simple linear regression to measure the strength of the association between the percent of students identified as homeless and, separately, three measures used to approximate the incidence of economic disadvantage or poverty:

- the percent of students eligible for free- or reduced-price meals
- the percent of school-age children under the poverty line
- the percent of school-age children in households that are under 50% of the poverty line.

We used federal data aggregated to the level of school districts and similar educational agencies, composing separate models by school year and state. We fit models for each state and the District of Columbia where there was sufficient data in the 2018-19 and 2019-20 school years.

We considered that a model showed a link between a variable we tested and homelessness if the model accounted for at least 20% of the variation in rates of homelessness and if the probability of coincidence driving results at least as extreme was relatively small. Twenty-four states failed this test on each of the three measures of economic disadvantage.

We assumed districts not included in federal data identified no homeless students. Districts may occasionally be left out in error. But we think our count is conservative in another way. That's because there are additional districts that

specifically told the Department of Education they have no homeless students, but the agency categorized them with districts reporting a low number of students and suppressed those figures.

SERVING OUR YOUTH 2015:

The Needs and Experiences of Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Experiencing Homelessness

Soon Kyu Choi
Bianca D.M. Wilson
Jama Shelton
Gary Gates

June 2015

The Palette Fund
TRUE COLORS FUND
the Williams INSTITUTE

EXECUTIVE SUMMARY

This report summarizes findings from the 2014 LGBTQ Homeless Youth Provider Survey, a survey of 138 youth homelessness human service agency providers conducted from March 2014 through June 2014 designed to better understand homelessness among LGBTQ youth. This report updates a similar report based on a survey conducted in 2011 (Durso & Gates, 2012). This new survey was designed to obtain greater detail on the similar and distinct experiences of sexual minority (lesbian, gay, bisexual, and questioning) and gender minority (transgender) youth experiencing homelessness. Recruitment was focused on agencies whose primary purpose is the provision of services to youth experiencing homelessness.

Similar to findings from the previous survey, a majority of providers of homeless youth services reported working with LGBTQ youth.

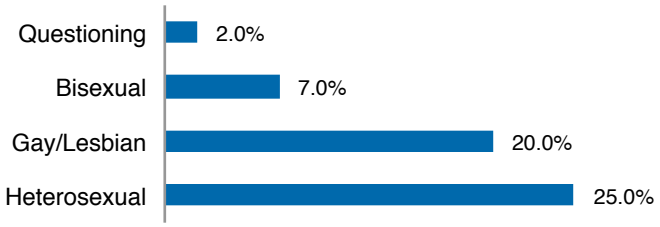
- Estimates of the percent of LGBTQ youth accessing their services indicate overrepresentation of sexual and gender minority youth among those experiencing homelessness. Of youth accessing their services, providers reported a median of 20% identify as gay or lesbian, 7% identify as bisexual, and 2% identify as questioning their sexuality. In terms of gender identity, 2% identify as transgender female, 1% identify as transgender male, and 1% identify as gender queer.[1]

- Youth of color were also reported to be disproportionately overrepresented among their LGBTQ clients accessing homelessness services. Respondents reported a median 31% of their LGBTQ clients identifying as African American/Black, 14% Latino(a)/Hispanic, 1% Native American, and 1% Asian/Pacific Islander.

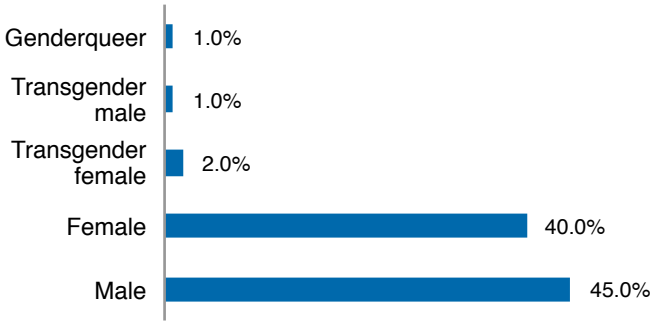
- Agency staff reported average increases in the proportion of LGBTQ youth they served over the past 10 years, and this change is higher for transgender youth.

- LGBTQ youth accessing these homelessness services were reported to have been homeless longer and have more mental and physical health problems than non-LGBTQ youth.

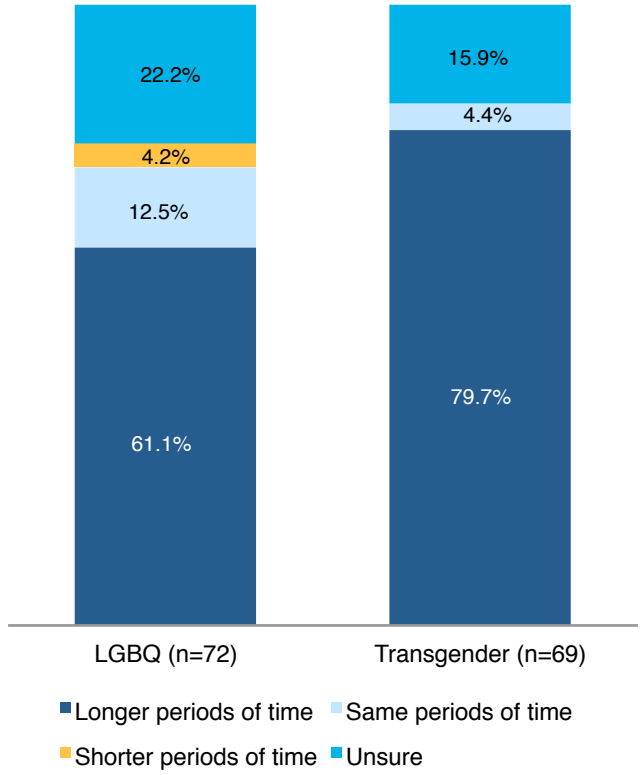
MEDIAN % OF YOUTH EXPERIENCING HOMELESSNESS BY SEXUAL ORIENTATION AS REPORTED BY PROVIDERS (N=83)



MEDIAN % OF YOUTH EXPERIENCING HOMELESSNESS BY GENDER IDENTITY AS REPORTED BY PROVIDERS (N=83)



DURATION OF HOMELESSNESS OF LGBTQ YOUTH COMPARED TO NON-LGBTQ YOUTH AS REPORTED BY PROVIDERS

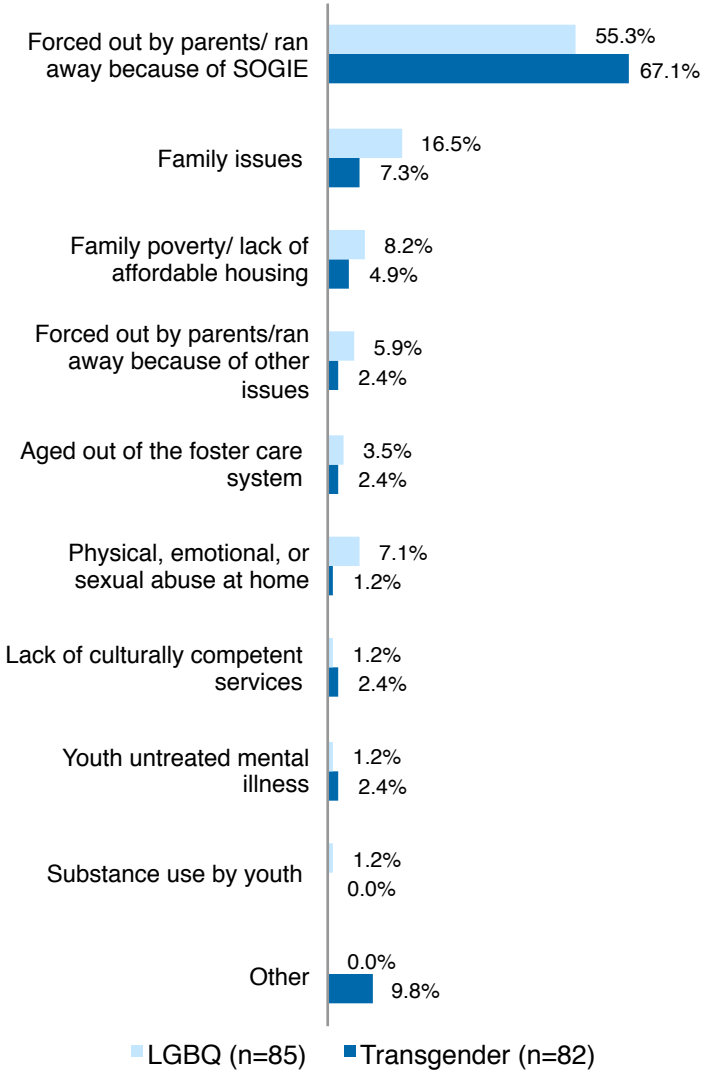


1 The median percent is reported to account for the wide range of responses and any outliers, therefore the sum will not equal 100%.

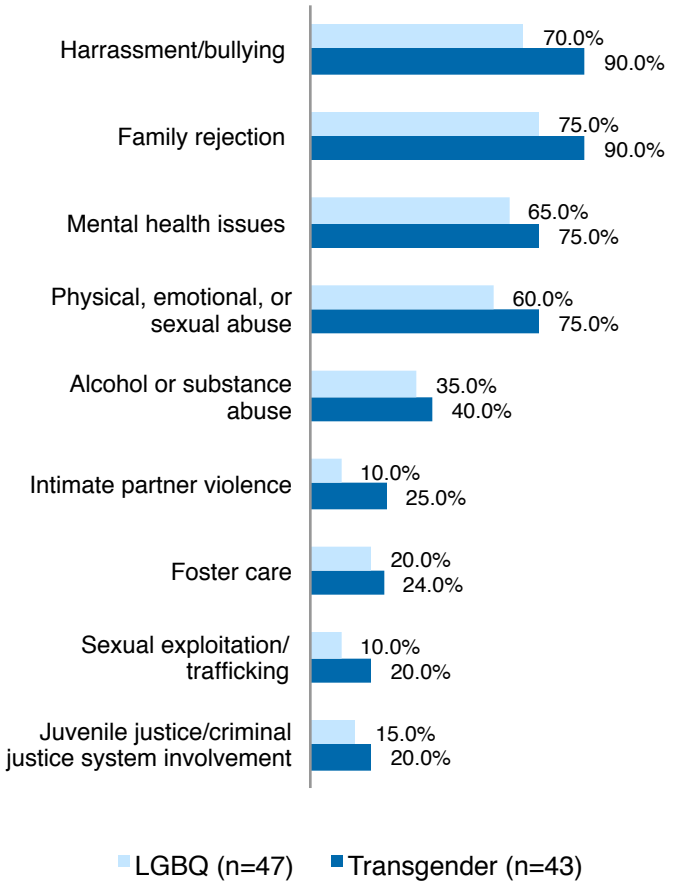
LGBQ and transgender youth were described as experiencing many similar issues leading to homelessness, but some of these issues were estimated by agency staff to be exaggerated for transgender youth.

- The most prevalent reason for homelessness among LGBTQ youth was being forced out of home or running away from home because of their sexual orientation or gender identity/expression.
- Transgender youth were estimated to have experienced bullying, family rejection, and physical and sexual abuse at higher rates than LGBQ youth.
- Both LGBTQ-specific and non-LGBTQ issues were cited as primary reasons for homelessness among LGBTQ youth.

PRIMARY REASON FOR HOMELESSNESS FOR LGBQ AND TRANSGENDER YOUTH AS REPORTED BY PROVIDERS



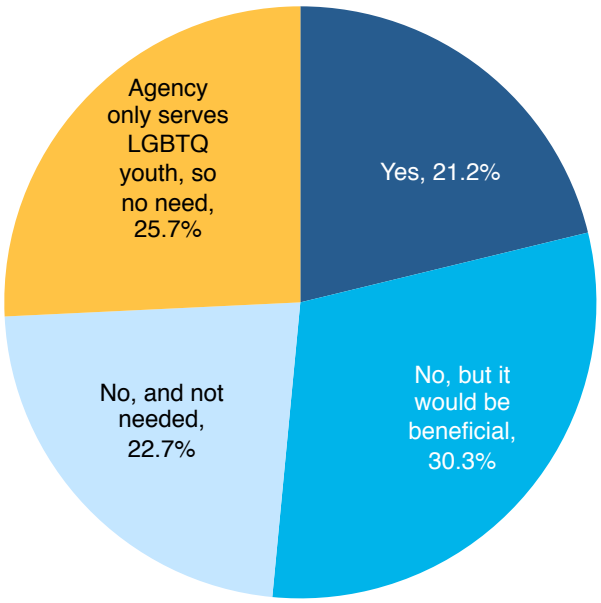
PROVIDER REPORTED MEDIAN % OF LGBTQ YOUTH EXPERIENCING HOMELESSNESS, BY REPORTED HISTORY



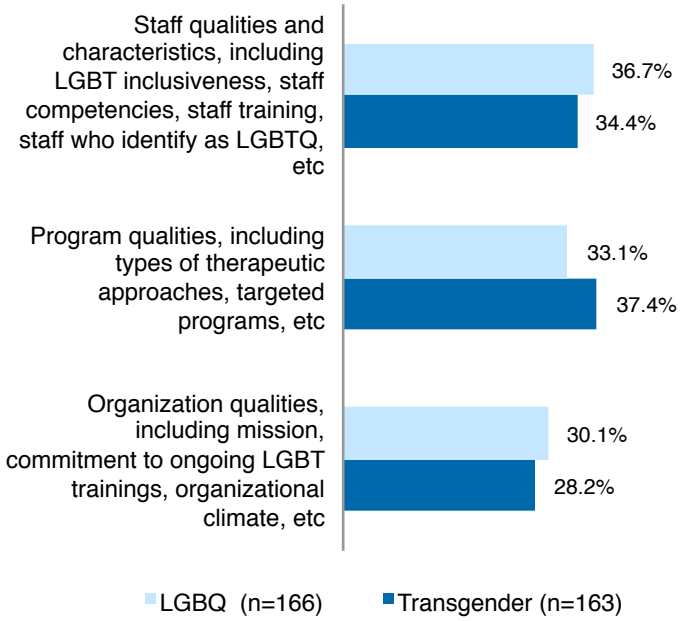
Several factors that continue to help or hurt existing efforts to address homelessness among LGBTQ youth were identified.

- After housing needs, acceptance of sexual identity and emotional support was the second most cited need for LGBQ youth experiencing homelessness. Whereas, transition services (access to healthcare specific to transgender youth, access to hormones, emotional support during transition, and legal support) was the second most cited need for transgender youth experiencing homelessness.
- Most survey respondents believed their agency staff was representative of the youth they served in terms of sexual orientation, race, and gender identity and expression. When asked if their agency employed a dedicated LGBTQ staff, 26% of the respondents reported that they worked exclusively with LGBTQ youth and 21% worked at agencies with dedicated LGBTQ staff. Less than a quarter reported they did not have dedicated LGBTQ staff and did not need one.

DOES YOUR AGENCY EMPLOY A DEDICATED LGBTQ STAFF? (N=66)



PROPORTION OF REASONS CITED BY PROVIDERS FOR SUCCESS IN SERVING LGBTQ YOUTH BY TOTAL NUMBER OF RESPONSES



- Similar to findings from the 2011 survey, lack of funding was identified as the biggest barrier to serving LGBTQ youth experiencing homelessness. This was followed by lack of non-financial resources such as lack of community support and lack of access to others doing similar work as barriers to serving youth experiencing homelessness. Between 26-37% of respondents also cited lack of training to address LGBTQ needs and difficulty identifying LGBTQ youth as a barrier.

- On the other hand, service providers attributed their successes in serving LGBTQ youth to their staff members, their programmatic approach, and their organizations' commitments to serving this population of young people.

    - About 7% of respondents cited the role of out LGBT staff as contributing to their success working with LGBTQ youth.

This study highlights the need to further understand not only the differences in experiences between LGBTQ youth and non-LGBTQ youth, but also differences between cisgender LGBQ and transgender youth. Further, the findings also indicate that a number of agencies are employing various strategies to address the unique needs of LGBTQ youth experiencing homelessness. Yet there are also many agencies that either do not see this population as a needed focus or reported the need for more help on how best to work with LGBTQ youth, including through training and organizational policies. The combination of findings that show many staff acknowledge that they received LGBT-related trainings and are aware of some existing policies with the results indicating a call for additional trainings and policies indicate that future research also needs to assess the actual effectiveness of current training and policy initiatives. Evaluations of the effects of what currently exists may help the field better understand how to fill in the gaps highlighted by this report.

DOMESTIC VIOLENCE HOUSING FIRST

The Intersection of Domestic Violence and Homelessness*

June 2013

Linda Olsen, MA, MSW
Chiquita Rollins, PhD
Kris Billhardt, MEd, EdS

*This is the first of a series of papers published by the Washington State Coalition Against Domestic Violence and the Volunteers of America Home Free Program in Portland, OR. These papers are designed to help organizations think about their role in providing housing stability services to DV survivors. Future papers will address the critical links between safe, stable housing and improved outcomes for survivors and their children, different approaches to permanent housing programs for DV survivors, organizational change information for those interested in these strategies, and developing and strengthening community partnerships.

Introduction

Battered women have long been among the hidden homeless in the United States. Efforts to find protection in safe and confidential locations have resulted in limited visibility for this population in the burgeoning numbers of homeless people. Because domestic violence (DV) survivors are affected by many of the same social forces that affect anyone struggling to find and keep housing, the battered women's movement and the homeless movement have followed parallel paths. Federal cuts in subsidized housing have greatly limited access to affordable housing for low-income people, among them millions of DV survivors and their children struggling with housing instability and compromised safety. The intent of this paper is to outline *briefly* the parallel paths of these movements and highlight where they intersect.

homelessness has affected a wide range of people throughout the history of the United States.

Homelessness

Homelessness, the condition of people without a regular dwelling, has long been associated with single men such as the hobos traveling across the country by train during and after the Civil War. But in reality, homelessness has affected a wide range of people throughout the history of the United States. During the Great Depression of the 1930s, millions of homeless people migrated across the country trying to find a way out of poverty, hunger, and homelessness. Decades later, in 1963, the Community Health Act set the stage for a new wave of homelessness as psychiatric patients were released from state hospitals into communities with the expectation that treatment and follow-up would be provided by community mental health centers. This plan was never fully funded, and without any sustainable support system, these former patients soon appeared on city streets and became the visible face of the homeless population.

Battered Women's Shelters

Prior to the women's movement of the 1960s, battered women had few options for seeking safety. They suffered silently for years, often watching the impacts of physical and mental abuse on their growing children. There were no laws to protect them and no reliably safe places for them to get away from abusive husbands. A battered woman was unlikely to bring her children to a community shelter or a soup kitchen and even less likely to camp out or live on the streets. In addition, divorce was difficult to obtain and divorced women were stigmatized in many communities. Employment opportunities and affordable, reliable childcare were often unavailable.

the climate of the times engendered a new response: the creation of "safe homes" and underground networks for escape.

Sisterhood is Powerful

EQUALITY

The women's movement created an opportunity for women to acknowledge and speak out about the abuse that existed in many of their homes. While the extent of abuse was not necessarily new information to those familiar with stories of a spouse's violence and cruelty passed down through generations of women or to those with memories of witnessing violence in their homes as children, the climate of the times engendered a new response: the creation of "safe homes" and underground networks for escape. Battered women and their allies set aside rooms in their homes to harbor women and children fleeing violence. The "safe homes" birthed the shelter movement, in which homes—usually in residential communities—were dedicated to the safety and healing of domestic violence victims. The first shelters were open by 1973. Family shelters operated by faith communities, such as Volunteers of America and the Salvation Army, slowly began to recognize that many if not most of the homeless women and children arriving at their doorsteps were fleeing abusive homes.

By 1979, more than 250 shelters for battered women existed in the United States.

The battered women's shelter movement spread. By 1979, more than 250 shelters for battered women existed in the United States. Domestic violence victims found a refuge where they were able to share their stories of abuse and hear that they were not alone and that the abuse was not their fault. Shelters typically afforded only a short-term stay—just enough to heal a little bit. Many women returned to their homes because there were no other realistic options, though some women were able to put together enough resources to start a new life.

As a testament to the growing recognition of the widespread incidence of abuse in homes across the country, the shelter movement gathered further momentum. By 1983, more than 700 battered women's shelters were operating

across the United States. Funding was scarce and the work to sustain these new supports required herculean grassroots efforts, with strategies that varied from community to community. Some of the logical funding sources were closed off to shelter organizers. Since most battered women technically had homes, these women and children were not perceived as homeless. Consequently, the shelters were not able to qualify for emergency assistance that other homeless shelters had access to through the Federal Emergency Management Act (FEMA) as it was established in 1979 to administer disaster relief and emergency assistance.

Survivors and allies started organizing to advocate for the public and private funding needed to support shelters and their services. These efforts resulted in the passage of legislation in many states to fund domestic violence programs through marriage license fees. In 1984, Congress passed the Family Violence Prevention and Services Act (FVPSA), which has since become a vital funding source for the more than 2,000 DV shelters and safe houses that currently exist. Many states also committed additional funds for battered women's shelters—often from their FEMA or Victims of Crime Act (VOCA) allocation.

In 1978, HUD's budget was over $83 billion. In 1983, draconian cuts reduced the budget to only $18 billion

Federal Housing Cutbacks Lead to Massive Homelessness

In the meantime, during the early 1980s, the U.S. Department of Housing and Urban Development (HUD) budget, which included funding for low-rent public housing and for affordable housing in rural areas, was severely cut. In 1978, HUD's budget was over $83 billion. In 1983, draconian cuts reduced the budget to only $18 billion: a *$65 billion reduction* in support for housing. Affordable housing stock shrank dramatically. For example, from 1976 to 1985 a yearly average of almost 31,000 new rural affordable housing units were built, but from 1986 to 1995 average yearly production fell to less than half that of the previous decade. This trend strongly suggests that the extensive homelessness we have seen in the United States since the 1980s is inextricably tied to these cutbacks and to the near elimination of the federal government's commitment to building, maintaining, and subsidizing affordable housing. Community perception also underwent a dramatic shift over the same time period. Recognition faded of the systemic problems historically viewed as the causes of homelessness, such as inadequate wage standards and inadequate affordable housing, and the blame was increasingly laid on the personal deficiencies of those struggling with poverty.

The McKinney Act increased the stock of emergency shelters and poured new life into transitional housing

Emergency Shelters and the Stewart B. McKinney Act of 1987

During the period of HUD cutbacks to affordable housing development and subsidy in the 1980s, family homelessness continued to rise. Meanwhile, a new funding stream emerged to support many new homeless shelters when Congress created the Emergency Food and Shelter National Board Program in 1983. Then, in 1987, Congress passed the Stewart B. McKinney Homeless Assistance Act (now McKinney-Vento), which provided $880 million in homeless assistance funding, presumably in an attempt to partially fill the $65 billion gap in subsidized housing. The McKinney Act increased the stock of emergency shelters and poured new life into transitional housing, a model developed for those leaving institutions such as mental institutions, drug/alcohol treatment programs (recovery houses), and prisons (halfway houses). The rationale for transitional housing was that these populations needed supportive services in order to learn how to handle financial and tenancy obligations. Some also saw the offer of permanent housing at the end of a transitional housing stay as the "carrot" needed to encourage residents to follow treatment programs, maintain sobriety, and secure employment. Shelters and transitional housing came to be viewed as the most appropriate response to the many people who were forced into homelessness due to poverty.

Domestic Violence Agencies as Homeless/Housing Service Providers

The battered women's shelter movement faced several new challenges in the 1990s. The rise in homelessness and the continuing lack of shelter and housing for an increasing population affected by mental health issues increased the number of women accessing domestic violence emergency shelters, often changing the mix of residents to include more impoverished women and many more with mental illness. Additionally, the impacts of trauma often resulted in drug and alcohol use by survivors. Battered women's shelter advocates were often not equipped to address chemical dependency, and drug/alcohol program counselors were not equipped to address the safety needs of survivors.

Both the increasingly complex needs of survivors and the general lack of community resources for mentally ill homeless women required additional training and a push for "professionalization" among those working in shelters. Many programs established educational requirements for their direct service employees and shifted toward a less grassroots and more clinical approach. While trying to better equip programs to effectively respond to the complex issues that accompanied survivors to shelter, the movement steadily resisted adopting a cause-and-effect analysis that identified domestic violence victimization as a mental health issue and refrained from mandatory mental health services as part of its response to victims. Recognizing that domestic violence services were made necessary because of systemic oppression based on gender, not because of women's mental health issues, leaders in the movement continued to support staff qualifications that valued life experience at the same level as higher education and certification programs.

Advocates started to make the case that battered women were indeed homeless if their residence was not a safe place for them

As the population coming to shelters changed, advocates began to see that homelessness and poverty were issues as significant for many survivors as was domestic violence. Advocates started to make the case that battered women were indeed homeless if their residence was not a safe place for them to be and argued that federal emergency shelter dollars (through FEMA and HUD) should join federal FVPSA and state and local funding as a critical part of domestic violence program budgets. With new public funding came new requirements and regulation, including service standards, administrative codes, reporting, and data collection. Running programs now involved more administrative effort, new responsibilities that competed with service delivery, and further intrusion into the privacy survivors could expect when entering a program for help.

On the social change front, as a result of the advocacy and education efforts of the movement, domestic violence began to be framed less as a private family matter and more as a public safety issue: a crime. Some funding sources required domestic violence programs to collaborate with the criminal legal system. These collaborations provided new tools to help keep some survivors safer, but they also narrowed the analysis of a complex issue and changed the flavor of domestic violence advocacy to fit within the criminal legal system. Additionally, federal and local grants that supported what came to be called a "coordinated community response" to domestic violence further deepened funder expectations and reporting requirements even as they provided more resources for survivors.

Yet advocates were keenly aware that survivors leaving shelters needed more options.

Throughout this time, emergency shelters remained the core service that most programs across the country provided to DV victims. Yet advocates were keenly aware that survivors leaving shelters needed more options. Those already impoverished or teetering on the brink of poverty due to the loss of an abuser's income and those with minimal education or vocational training and little or no employment history became stuck on long waiting lists for the shrinking stock of subsidized housing. Since emergency shelter stays were time-limited, many survivors returned to an abusive home, traveled from shelter to shelter, or relied on unstable housing with friends or relatives. The newly available HUD-McKinney funding for transitional housing programs seemed to be a perfect solution for the next housing step while survivors worked on job skills, financial management, and myriad other issues that were barriers to housing stability. Taking the lead from domestic violence agencies operating McKinney-funded transitional housing programs, Congress included in the 1994 Violence Against Women Act (VAWA) funding authorization to augment the transitional housing dedicated to domestic violence survivors.

Even as domestic violence agencies were embracing transitional housing as the next step after emergency shelter, organizations serving the chronically homeless population and homeless families were experimenting with "housing first" models. This approach supported access to permanent housing as soon as possible upon entry into homelessness, followed by wrap-around services, such as education, job training, mental health counseling, drug and alcohol treatment, and parenting support, to help with housing retention. Countering the prevailing notions of the time, the "housing first" movement asserted that housing is a right and not a reward for program completion.

Overlap of Domestic Violence and Homelessness

Domestic violence is one of the leading causes of homelessness for women and children. Among U.S. city mayors surveyed in 2005, 50% identified intimate partner violence as a primary cause of homelessness in their city. In the HUD 2012 Continuum of Care Homeless Assistance Program Point-in-Time Count, the largest subpopulation of homeless persons in Washington State was victims of domestic violence. (Each jurisdiction's housing and homelessness services that are funded by McKinney-Vento make up a Continuum of Care. Larger counties have their own Continuum of Care; smaller counties are usually included in a "balance of state" (or statewide) Continuum of Care.)

Domestic violence and homelessness are likely to occur together and can increase the need for resources and services, especially housing. The 2010 Federal Strategic Plan to Prevent and End Homelessness includes a citation from the National Center for Children in Poverty that indicates that "among

mothers with children experiencing homelessness, more than 80 percent had previously experienced domestic violence." According to a 1997 study by Browne and Bassuk, 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives. The same study indicated that 63% of homeless women have been victims of domestic violence as adults. Strikingly similar results can be found in the 2004–2009 Washington Families Fund Five-Year Report: In the Moderate-Needs Family Profile for families served, 66% of women had experienced domestic violence. In the High-Needs Family Profile for families served, 93% of women had experienced physical or sexual violence. Data from the SHARE study, conducted by Rollins, Glass, Niolon, Perrin, and Billhardt, indicates that while only 26% of women accessing a wide range of DV services would be defined as homeless according to the federal definition at the time of the study, all were experiencing varying degrees of housing instability. Survivors participating in the study cited help with housing as the most helpful service they had received. (More details about the SHARE study are available in the second paper in this series.)

By the early 1990s, domestic violence shelters were at capacity, and many urban shelters had high turn-away rates. This situation continued into the new century, until the economic recession in 2008 exacerbated the crisis of limited bed space. DV agencies were forced to develop triage systems to ensure that women in the greatest danger were prioritized for shelter space. Women who had not recently fled their abusers and did not appear to have immediate safety needs were often seen as simply homeless—even if the homelessness was a result of domestic violence. For many of these survivors, poverty and trauma combined to create a downward spiral of homelessness, too frequently accompanied by mental health and chemical dependency issues.

For many of these survivors, poverty and trauma combined to create a downward spiral of homelessness, too frequently accompanied by mental health and chemical dependency issues.

Many survivors who fell through the cracks of the DV system's eligibility triage ended up in homeless shelters. Survivors also turned to homeless shelters when DV shelters were full. Homeless shelter providers were often uncomfortable sheltering domestic violence victims due to their complex safety needs and the potential violence of abusive partners. In many communities, a schism formed between DV shelters and homeless shelters as women, often with their children, were sent back and forth between the two systems. Resources tended to be aligned to address only one realm of a survivor's circumstances, with DV shelters focusing on safety planning, legal issues, and advocacy and homeless service providers focusing on improved financial stability and permanent housing.

Women learned to redefine their experiences and needs in order to qualify for program admission. With the advent of more research documenting the high degree of intersection between domestic violence and homelessness and housing instability, both systems have become increasingly aware of the need to work together.

Domestic violence programs and homeless/housing organizations in many communities have forged relationships as a part of local planning efforts to end homelessness.

Where Are We Now?

Domestic violence agencies have successfully secured HUD grants for shelter, transitional housing, and rapid re-housing programs and have utilized VAWA funds for transitional housing. Domestic violence advocates were successful with legislative efforts on the national level to protect survivors' privacy by exempting victim services providers from HUD's requirements to enter personally identifying information of domestic violence survivors in shared Homeless Management Information System (HMIS) databases. Domestic violence programs and homeless/housing organizations in many communities have forged relationships as a part of local planning efforts to end homelessness.

During the last decade, with HUD's strong encouragement and with growing local will to better respond to homelessness, communities across the country have been developing their own 10-Year Plans to End Homelessness. HUD has invested in program evaluations and research to determine the degree to which McKinney-Vento Act programs for transitional and permanent housing have been successful in decreasing homelessness. Domestic violence advocates' involvement in 10-Year Plans and McKinney-Vento Continuum of Care plans varies from community to community, as do housing programs' awareness of and engagement with domestic violence victim services providers.

Evolving "housing first" approaches ... have been very successful in many communities.

During the course of these planning processes, advocates for the homeless brought the consistent message that it was the housing system that needed fixing, not those who were homeless. Many homeless advocates across the country developed and implemented pilot projects testing strategies to

Analysis has also shown that providing transitional housing costs more than providing rental assistance ... along with tailored support service

help homeless individuals access and retain housing. Evolving "housing first" approaches that expedited the move of homeless people into permanent housing and then provided tailored services to support housing retention have been very successful in many communities. Program evaluations have suggested that transitional housing program expectations are onerous and overly rule-based and are implicated in repeat episodes of homelessness rather than fostering the desired outcome of stability in permanent housing. Analysis has also shown that providing transitional housing costs more than providing rental assistance based on individual need along with tailored support services. Increasingly working within a social justice framework that emphasizes voluntary rather than mandatory services, advocates for the homeless have been successfully placing homeless people into permanent housing. Good outcomes—especially with a particularly high-barrier, chronically homeless population (primarily single men with long periods of living on the streets, often with chemical dependency and/or mental health issues)—have lent credibility to the "housing first" approach.

Positive outcomes and participant feedback in both HUD-funded research and pilot program evaluations caught the attention of policymakers. The reauthorization of the McKinney-Vento Act shifted the goal and funding authorization of the act toward supporting long-term housing, homelessness prevention, and brief homeless intervention services rather than facility-based transitional housing. This reauthorization, known as the Homeless Emergency and Rapid Transition to Housing (HEARTH) Act, became law on May 20, 2009. Implementation of the new provisions is gradually rolling out, with domestic violence programs left to determine what the impact will be on their emergency shelter and transitional housing programs. Continuums of Care are reviewing their housing inventory and analyzing housing programs to determine how they might be more cost effective and more responsive to the permanent housing needs of homeless individuals. Many jurisdictions are actively shifting funds from emergency shelters and transitional housing facilities to homelessness prevention, rapid re-housing, and permanent supportive housing programs.

Where Do We Go from Here?

Domestic violence programs that receive public housing money... will also need to participate in their community's 10-Year Plan to End Homelessness and/or their local Continuum of Care planning process.

Where Do We Go from Here?

The once-parallel paths of the homelessness prevention field and the domestic violence advocacy field have come to many points of intersection through the past decades. The recognition of the interrelatedness of these two social problems has introduced new funding streams, new approaches, and new challenges. At this juncture, it will be important for domestic violence programs that have historically provided emergency shelter and transitional housing as core service components to review their agency mission, the needs of survivors, and the resources necessary to meet those needs. Domestic violence programs that receive public housing money, especially funds that originate with HUD, will also need to participate in their community's 10-Year Plan to End Homelessness and/or their local Continuum of Care planning process. Advocacy to ensure agency viability and relevancy in the changing climate—and to ensure meaningful response is available to domestic violence survivors—is extremely important right now within both systems.

References

1. Western Regional Advocacy Project. 2006. *Without Housing: Decades of Federal Housing Cutbacks, Massive Homelessness, and Policy Failures.*
2. U.S. Conference of Mayors—Sedexho. 2005. Hunger and homelessness survey: A status report on hunger and homelessness in America's cities, a 24-city survey. Washington, D.C: Sodexho, Inc.
3. U.S. Department of Housing and Urban Development. *HUD's Continuum of Care Homeless Assistance Programs: Homeless Populations and Subpopulations, State Name: Washington.* http://www.hudhre.info/CoC_Reports/2012_wa_pops_sub.pdf.
4. United States Interagency Council on Homelessness. 2010. *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.*
5. Browne, A., and Bassuk, S. S. 1997. Intimate violence in the lives of homeless and poor housed women: Prevalence and patterns in an ethnically diverse sample. American Journal of Orthopsychiatry 67:261–278.
6. *Washington Families Fund Five-Year Report, 2004–2009*. Seattle: Building Changes.

7. Niolon, P. H., Rollins, C. M., Glass, N., et al. 2009. An innovative approach to serving the needs of IPV survivors: Description of a CDC-funded study examining the Volunteers of America Home Free Rent Assistance Program, *Journal of Women's Health* 18(6):775–778.
8. Rollins, C., Glass, N. E., Perrin, N. A., Billhardt, K. A., et al. 2012. Housing instability is as strong a predictor of poor health outcomes as level of danger in an abusive relationship: Findings from the SHARE Study. *Journal of Interpersonal Violence* 27:623–643.
9. For more in-depth history on current homelessness in the United States, please see: Leginski, Walter. *Historical and Contextual Influences on the U.S. Response to Contemporary Homelessness*. This paper was developed for the 2007 National Symposium on Homelessness Research and is available online at http://aspe.hhs.gov/hsp/homelessness/symposium07/leginski/.

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Volunteers of America OREGON
HOME Free

Camillus House

Our History and Mission

Camillus House has provided humanitarian services to the indigent and homeless populations of Miami-Dade County, Florida for more than 50 years.

Established by the Little Brothers of the Good Shepherd in 1960, Camillus House has grown steadily over the years from a small overnight shelter into a full service center offering a "system of care" for persons who are poor and homeless.

Every service offered at Camillus is carried out with the deeply held belief that every human being is precious in the eyes of the Lord and deserves love, respect and a chance to live a dignified life.

What We Do

Camillus House has grown steadily over the years from a small soup kitchen into a full-service center offering what we call a comprehensive "system of care" for the poor and homeless — a seamless, step-by-step process designed to bring persons from a life on the streets all the way to permanent housing.

- Fully integrated services are provided through multiple program areas.
- Compassionate Healing (substance abuse and mental health treatment)
- Continuum of Housing (emergency, transitional, and permanent housing)
- Compassionate Hospitality (food, clothing, showers, outreach, case management, rent assistance)
- Camillus Health Concern (sister organization providing health care services including adult primary care, pediatrics and a number of specialties)

Organization Profile:

- 501(c) 3 Non-Profit Agency serving the Poor and Homeless.
- Founded in 1960 to initially help Cuban exiles.
- Established by the Little Brothers of the Good Shepherd.
- Provides a broad range of social and health services to over 12,000 men, women and children on annual basis.
- Camillus House employs 135 staff members.

Mission, Vision & Values

Mission Statement: Rooted in the compassionate Hospitality of St. John of God, we improve the quality of life of those who are vulnerable and homeless in South Florida through the provision of a continuum of housing and supportive services.

Vision Statement: Camillus House envisions its service to the poor and homeless as a continuum of care which empowers clients towards personal rehabilitation and proactive integration as productive members of the general population.

Our vision for tomorrow is always built on the ideals of our founding mission which aims to provide every client with opportunities to combine personal and community resources in order to affect physical, mental and spiritual well-being.

Camillus House programs include development initiatives that will enhance client efforts to re-shape their ability for self-enrichment.

These initiatives include:

- Emergency assistance with food, clothing and shelter.
- Job training and placement.
- Residential substance abuse treatment and aftercare.
- Behavioral health and maintenance.
- Health care access and disease prevention.
- Transitional and permanent housing.

We commit ourselves eagerly to the adaptation of our mission in order to meet the new challenges facing the homeless in our contemporary society. The spirit of God moves us to action with reverence for the quality of life for all we serve and the elimination of the causes of homelessness in our times.

Our Values: Camillus House integrates the following values in every aspect of service:

- Hospitality
- Respect
- Quality
- Spirituality
- Responsibility

Camillus House, Services

HOSPITALITY SERVICES is the oldest and probably most well known of the services offered at Camillus House. Its primary purpose is to ensure that each client's basic human need for food, clothing and overnight shelter are met.

Since people who are hungry, or cold, or sleeping on the street cannot begin to address the larger issues that prevent them from leading a fulfilling life, Hospitality Services focuses on providing the immediate care they need.

Hospitality encompasses two primary program areas:

DIRECT CARE MINISTRY, which includes overnight shelter, showers, clothing exchange, mail services, telephone usage, public restrooms, and basic referrals and information.

Hospitality serves as an essential entry point into the full continuum of care services offered by Camillus, as many clients who initially visit in search of basic services decide to access the other programs available.

A Client Services Specialist serves as the first primary contact for most homeless persons who come to the Day Center for services. The Services Specialist assists clients in obtaining immediate needs, such as food, showers or clothing; provides information regarding services available; and provides hygiene items, such as soap, toothpaste and combs. Other types of assistance immediately available include bus tokens, water, foot lotion and other small items. Public restrooms and water fountains also are available.

Camillus offers free mail service, whereby persons who are homeless can use Camillus as a mailing address in order to send and receive mail. Incoming mail is sorted on a daily basis, and the names of all persons with mail pending are posted so that individuals know when to pick up their mail. Clients can make free local phone calls, or long distance calls with approval.

Homeless persons may obtain a free, “Camillus House” picture ID, which often serves as their only form of ID. Camillus also recently entered into a partnership with the 11th Judicial Circuit Court Criminal Mental Health Project, and Partners in Crisis, to begin producing special ID cards for clients with mental illness. Participation for clients is strictly voluntary.

The ID cards serve three purposes: 1) they provide clients with some sort of identification; 2) they alert police who may encounter the client on minor incidents that the client should be taken to a mental health facility rather than to jail; and 3) identify clients as registered with Camillus House and eligible for services, such as mail, phone, meals and showers.

In addition, Camillus assists clients who have lost all of their ID in re-establishing their identity by obtaining birth certificates, social security cards and other forms of ID vital to helping them obtain housing and employment.

Camillus offers free, hot showers for men three days per week, and for women three days per week. Clients may obtain a free exchange of clean clothing, in conjunction with the shower program, or via special referral.

The meal program at Camillus House offers free, nutritious meals to the hungry of Miami-Dade County. Five days a week, individuals registered as Camillus Day Center clients are provided with a hot, complete meal. The meal program also provides meals for clients of other Camillus House programs, including three (3) meals per day for the clients of the ISPA treatment program and breakfast for clients who have stayed in the emergency overnight shelter.

The Food Services program puts together bagged lunches and food boxes for distribution to individuals and families on a daily basis. Bagged lunches are provided through the Day Center program, to clients who are unable to attend the afternoon meal or who need immediate food to take with medication. Food boxes are provided to individuals or families on a case-by-case basis, and typically help those whose food stamps have run out by the end of the month.

Camillus provides large amounts of food, as well as other donations, to other nonprofit organizations, including many local faith-based organizations. Since Camillus sometimes cannot use all of the food donations it receives before some of the food spoils or exceeds its expiration date, Camillus distributes the food to other organizations that don't have the same capacity as Camillus to receive and store food. Organizations requesting food must complete a simple application. Camillus then works with that organization to determine their needs and to establish a specific pick-up schedule.

Camillus Health Concern: We offer a full complement of healthcare services to persons who are homeless by a caring team of healthcare practitioners

The Continuum of Housing

Camillus Housing Services addresses the most obvious aspect of homelessness — to provide individuals and families with a place to live.

A range of housing options include Emergency, Transitional and Permanent Housing, depending upon the stage in which each client is during their recovery from homelessness.

All housing programs are linked to Camillus' other programs so that clients receive the comprehensive health care and social services they require during their participation in the program. On an average night, some 1,000 men, women and children of South Florida will spend the night at Camillus House.

EMERGENCY HOUSING is temporary housing provided for a period of up to 90 days, depending upon the program and the needs of the client.

This type of housing provides persons who are homeless with an immediate place to get off the streets, and also serves as an entry point into the countywide "continuum of care." It is here that clients' needs are assessed, including the need for substance abuse treatment, mental health services, employment assistance and other help. Depending upon the individual needs and motivation of the client, he/she may then be placed into transitional housing or treatment program.

TRANSITIONAL HOUSING is generally provided for a period of 6–18 months, during which residents are able to gain some stability in their lives.

Clients receive a great deal of support while they adjust to living off the streets and learn to live independently. Residents are not given a free ride, though, as they must hold a job and pay monthly program fees.

Special emphasis is placed on teaching clients how to manage a personal budget. One third of clients' income is utilized for monthly program fees; one third is theirs to spend on bills and personal items; and one third is saved in a bank account for use when they exit the program.

Once ready for the next step, clients transition into permanent housing.

Camillus House provides transitional housing through multiple facilities located throughout Miami-Dade County.

Camillus House opened **Emmaus Place** in April 2011 for young men be-tween the ages of 18 and 23 who have aged out of the foster care system. Participants of Emmaus must be registered in Florida's Road to Independence program – a state funded initiative which provides a 2-3 year stipend to offset living expenses while attending college or university.

A recent study found that 25 per-cent of youth transitioning out of foster care in Miami become homeless within the first five years. By targeting this particular population, Camillus House is launching a dramatic new initiative

aimed at not just ending homelessness in Miami, but preventing it before it starts.
The seven-unit housing program provides residents the support and services they need to become self-sufficient, independent adults.
Located in the Lummus Park Historic District of Miami, Emmaus Place is a short distance away from employment centers (offices, retail and industrial), houses of worship, parks, stores, hos-pitals, fire station, library and other community services.
Camillus House partnered with Our Kids of Miami-Dade and Monroe, Inc., Casa Valentina and Biscayne Housing Group to create Emmaus Place.
Males, transitioning out of foster care, ages 18–23; attending school or working with Case Manager to develop plan.
Residents pay 30% of adjusted gross income as part of their client contribution.

The Good Shepherd Villas (GSV) provides 14 beds of Safe Haven housing for individuals who are homeless and suffering from persistent and severe mental illness.

The program includes eight one-bedroom apartments in four duplex buildings, along with two stand-alone units used as common areas and staff offices.
Safe Haven is a 24-hour/7 days-a-week community-based early recovery model of supportive housing that serves hard to reach, hard to engage individuals who are homeless with severe mental illness.
GSV offers a low demand setting where persons who are severely mentally ill can initiate the slow process of stabilization and recovery from pro-longed periods on the streets.
The integration of secure, stable housing with comprehensive social services including case management, benefit assistance, and transportation to and from health services appointments is critical in meeting the needs of the individuals who reside at GSV.
Individuals are housed in pairs and share a kitchen and bathroom but have their own enclosed sleeping area for privacy. A picnic and garden area create a serene space for rest, meditation and additional interaction.
Clients must be chronically homeless; have severe mental illness; meet a threshold level on the Instrumental Activities of Daily Living scale; not actively abusing drugs or alcohol; functional ability to participate in development of and work toward their Transition plan.
Residents pay 30% of adjusted gross income as part of their client contribution.

Mother Seton Village was opened in November 2000 as a transitional housing program for families with children who are homeless.
The facility is located on the former Homestead Air Reserve Base, and en-compasses a total of thirty-nine (39) one, two, and four-bedroom apartments with approximately 162 Beds.
The location offers residents easy access to community amenities such as Miami-Dade Transit's Metro Bus system with access to Dadeland South Metro Rail station; local grocery stores; health care facilities; restaurants and local shopping centers.

Camillus House provides a full array of supportive services, including case management, job development, basic life skills training, educational opportunities, child care, and much more.

Clients must be homeless with referral by walk-in or from an emergency shelter; ability to live independently; drug and alcohol free; compliance with program participation, including attaining employment/income.

Residents pay 30% of adjusted gross income as part of their client contribution.

St. Michael's Residences was opened in November 2000 as a transitional housing program for 30 single adults who are homeless, with a special emphasis on serving veterans who are homeless.

The housing facility offers a dignified, secure living environment where veterans facing similar circumstances can interact and support each other as they strive to transition to permanent housing.

The location offers residents easy access to community amenities such as Miami-Dade Transit's Metro Bus system with access to Dadeland South Metro Rail station; local grocery stores; health care facilities; restaurants and local shopping centers.

The primary goal of St. Michael's Residences is to transition veterans who are homeless into permanent housing. This housing program is also designed to guide participants in obtaining employment from the moment they enter the program.

Camillus House provides ongoing case management, life skills training, assistance in accessing benefits, and job skills training to ensure veterans achieve adequate income and skills needed to achieve a higher level of self-sufficiency before moving on to permanent housing.

Client must be a homeless veteran referred by the Veterans Administration, and drug and alcohol free.

Residents pay 30% of adjusted gross income as part of their client contribution.

PERMANENT HOUSING offers a supported living environment to persons who are formerly homeless and have transitioned out of transitional housing, but still require some sort of support in order to maintain their stability.

Although called "permanent housing," most residents eventually move out into unsupported housing after they have increased their income and become more comfortable with their independence, sometimes taking several years.

As with Camillus' transitional housing programs, residents contribute 30% of their income toward program fees and must participate in the programs' supportive services.

Brother Mathias Place provides permanent housing for single parent and intact families with children who are experiencing homelessness and who have a disabling condition in south Miami-Dade.

While it is a non-treatment pro-gram, heads of households must be either disabled or in recovery from substance abuse. The 10 available units are leased from a private owner with families contributing up to 30% of their adjusted gross income.

The program is structured with supportive services offering employment and job training, life skills training, and referrals to primary and out-patient health facilities as needed. The integration of secure, stable housing with comprehensive social services including case management, benefits assistance, and transportation is critical in meeting the needs of program participants.

Homelessness; disability such as mental illness, addiction, or health/physical; referred via walk-in, or from an emergency shelter, transitional housing, or treatment facility; ability to live independently; drug and alcohol free; compliance with program requirements; proof of income. Residents pay 30% of adjusted gross income as part of their client contribution.

Brownsville Christian Housing Center (BCHC) is a 74-unit housing pro-gram located in the renovated former “Christian Hospital” facility in the historic area of Brownsville.

The old Christian Hospital was the first hospital serving the African-American population in the community and is a historically significant building.

Each unit is an efficiency apartment with its own kitchen, bathroom, a twin bed, and individual air conditioning unit.

BCHC serves adult men and women who have come through Miami-Dade County’s Continuum of Care, and who are now ready to live on their own in a permanent housing setting but cannot afford unsubsidized housing.

Camillus House provides residents a range of services in a safe and supportive environment, allowing them to live productive and dignified lives.

Chronic homelessness; disability such as addiction, mental health or physical/health; referral via walk-in, or from an emergency shelter or transitional housing; ability to live independently; drug and alcohol free.

Residents must pay 30% of adjusted gross income as part of their client contribution.

Applicants with no income must show support in the amount of $50 per month and how they plan to eat and take care of basic needs.

Camillus House opened **Labre Place** in early 2012. The nine-story high-rise building is made up of 90 one-bedroom apartments. Fifty of the units are set aside for persons who were formerly homeless and are placed by Camillus House. The remaining 40 tenants will be persons who qualify as low income residents under federal guide-lines.

The new residential building is very close to local public transportation and to Interstate Highway 95. In addition, residents have easy access to Camillus Health, which provides primary health care services to persons who are homeless in Miami-Dade County.

Located in the Lummus Park Historic District of Miami, Labre is a short distance away from employment centers (offices, retail and industrial), houses of worship, parks, stores, hospitals, fire station, library and other community services. To enhance residents' quality of life, special programs and activities are available at no cost to them.

Camillus House provides supportive services to the formerly homeless residents to ensure their stability and quality of life. These services include medical care, behavioral health treatment and employment assistance.

Income eligibility: $8,000–$15,000 per year. 30% of adjusted gross income client contribution; flat rate of $674 per month. Managed by Royal America, an external company.

Camillus opened **Somerville Residence** in April 2001. The campus-style facility includes 48 units of one-, two-, and three-bedroom apartments and efficiencies.

The facility, which has provided permanent, affordable housing to single parent families and single women over age 40, is currently being re-purposed to support the emerging needs of other vulnerable populations within our community.

Updates on this facility and the future programs it will support will be posted on this page later this year.

CAMILLUS HOUSE, WHAT IS THE HOMELESS TRUST, AND HOW DOES CAMILLUS HOUSE RELATE TO IT? (www.camillus.org)

The Miami-Dade County Homeless Trust was created in 1993 by the Board of County Commissioners to:

• To administer the proceeds of a one-percent food and beverage tax.
• To implement the Miami-Dade County Community Homeless Plan, the local continuum of care plan.
• To serve in an advisory capacity to the Board of County Commissioners on issues involving homelessness.

The Trust is not a direct service provider. Instead, it is responsible for the implementation of policy initiatives developed by the 27-member Miami-Dade County Homeless Trust Board, and the monitoring of contract compliance by agencies contracted with the County, through the Trust, for the provision of housing and services for homeless persons. Camillus House is one of these agencies.

Through its policies and procedures, the Trust also oversees the utilization of the food and beverage tax proceeds dedicated for homeless purposes, as well as other funding sources, to ensure the implementation of the goals of the plan. Additionally, the Trust has served as lead applicant on behalf of the County for federal and state funding opportunities, and developing and implementing the annual process to identify gaps and needs of the homeless continuum.

The Trust's annual budget is approximately $37 million, comprised of local food and beverage proceeds, as well as Department of Housing and Urban Develop (HUD) and state funding. Approximately $20 million per year comes through a competitive process via HUD, $11 million via the Food and Beverage tax, and the remainder through State funding and private sector contributions.

The Trust is a proprietary department and receives no general fund dollars from the County. The Miami-Dade County Homeless Trust Board is comprised of a 27-member, broad-based membership representing numerous sectors of our community.

Camillus House is an active participant in Homeless Trust activities, with Camillus staff holding a seat on the Trust’s Board of Directors and participating in the Trust’s planning and advocacy efforts. Camillus currently maintains 14 contracts with the Homeless Trust.

About Us

The Miami-Dade County Homeless Trust serves as the lead agency for Miami-Dade County's homeless Continuum of Care (CoC), responsible for the oversight, planning and operations of the entire CoC including:

- Administering proceeds of a one-percent (1%) Food and Beverage Tax. Miami-Dade had the first dedicated funding source for homelessness in the United States – a unique 1% Food and Beverage Tax which is foundational to the funding of the Homeless Trust today.
- Implementing the Miami-Dade County Community Homeless Plan: Priority Home which provides a framework for preventing and ending homelessness in Miami-Dade County.
- Serving as the collaborative applicant for federal and state funding opportunities.
- Administering grants and overseeing operations and fiscal activities for over 120 housing and services programs operated by more than 20 competitively selected non-profit providers and government entities.
- Managing Miami-Dade County's Homeless Management Information System (HMIS), the local technology system used to collect client-level data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.
- Developing policy and serving in an advisory capacity to the Board of County Commissioners on issues involving homelessness.

History

In the early 1990s, more than 8,000 people were camping on the streets, sidewalks and underpasses of Miami-Dade County. Independent non-profits were overwhelmed and there was little coordination between agencies serving homeless households. In 1992, then Governor Lawton Chiles appointed leaders to a Governor's Commission on Homelessness. The commission was led by former Knight Ridder chairman, *Miami Herald* publisher, and longtime Miami resident, Alvah Chapman. Mr. Chapman, along with many other influential thought-leaders, businessmen and elected officials, came together and recommended three (3) key activities be pursued to address the community's needs:

- Pursue a dedicated source of funding/private sector funding
- Create a body with diverse representation to implement plan
- Research best practices to address homelessness and develop goals for implementation

Food & Beverage Tax

The Governor's Task Force pursued and secured a one-percent Food & Beverage Tax (F&B Tax). Approved in 1992, the enabling legislation for the Homeless and Domestic Violence F&B Tax became the first dedicated source of funding for homelessness through a tax in the country. Eighty-five (85%) of funds go toward preventing and ending homelessness; 15% is allocated to the construction and operation of domestic violence centers and overseen by the Domestic Violence Oversight Board.

This tax is collected on all food and beverage sales in restaurants which gross more than $400,000 a year and are licensed by the State of Florida to sell alcoholic beverages for consumption on the premises, except for hotels and motels. The tax is collected throughout Miami-Dade County with the exception of facilities in Miami Beach, Surfside and Bal Harbour. The levying of the tax required the creation of a community plan. The Homeless Trust Board created by county ordinance is responsible for the implementation of the Miami-Dade County Community Homeless Plan: Priority Home.
Chapman Partnership serves as the private sector partner to the Miami-Dade County Homeless Trust and is commissioned by the Homeless Trust to operate two Homeless Assistance Centers which have assisted more than 100,000 individuals and families during its 20+ year history.

As a result of the CoC's work, under the leadership of the Homeless Trust, unsheltered homelessness in Miami-Dade has gone from more than 8,000 people fewer than 1,100 persons. In 2019, the Homeless Trust recorded record low homeless totals. Currently, the Homeless Trust has more than 8,000 beds/units in its Housing Inventory Count dedicated to serving persons who are homeless and formerly homeless

Homeless Trust

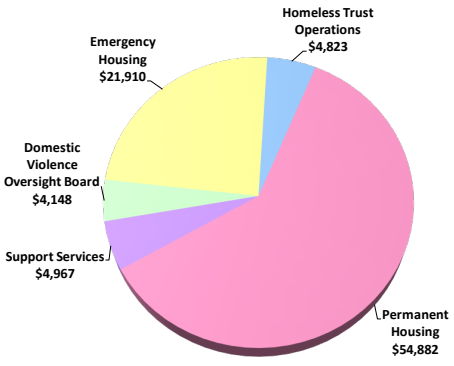
The Miami-Dade County Homeless Trust (Homeless Trust) serves as the coordinating entity for the provision of housing and services to individuals and families experiencing homelessness throughout Miami-Dade County. The Homeless Trust advises the Board of County Commissioners (BCC) on issues related to homelessness and serves as the identified "Collaborative Applicant" for the United States Department of Housing and Urban Development's (U.S. HUD) Continuum of Care Program and the Florida Department of Children and Families Office on Homelessness. The Homeless Trust implements Miami-Dade County's Community Homeless Plan: Priority Home and the one percent Food and Beverage Tax proceeds in furtherance of the plan. Eighty-five percent (85%) of Food and Beverage Tax proceeds are dedicated to homeless housing and services and leveraged with federal, state, local and other resources dedicated to providing housing and services for the homeless, including survivors of domestic violence. The Homeless Trust also provides administrative, contractual and policy formulation assistance related to homeless and domestic violence housing and services. The Homeless Trust also assists in coordinating and monitoring the construction and operations of domestic violence centers in Miami-Dade County, which are funded through the remaining 15 percent of the Food and Beverage Tax.

As part of the Health and Society strategic area, the Homeless Trust funds and monitors homeless prevention services, temporary and permanent housing, and supportive services for the homeless, including homeless outreach. Each area is specifically designed to meet the unique needs of homeless individuals and families when they first enter the system and as their needs develop and evolve over time. This blend of housing and services comprises what is known as the homeless continuum of care. Over 9,000 emergency, transitional and permanent housing beds have been developed by or through the Homeless Trust since its inception in 1993. A Board of Trustees, comprised of 27 members, governs the Homeless Trust. Membership consists of appointed leadership, including County and City commissioners, representatives from the Judiciary, the Superintendent of Schools, the Florida Department of Children and Families Regional Administrator and the City of Miami Manager. The Board also includes representation from Miami Homes for All; business, civic and faith-based community groups; homeless service providers; homeless individuals; and formerly homeless individuals. To fulfill its mission of assisting homeless individuals and families, the Homeless Trust relies on the services offered by provider agencies within the community, including its private sector partner, Chapman Partnership.

FY 2023-24 Adopted Operating Budget

Expenditures by Activity

(dollars in thousands)



Revenues by Source

(dollars in thousands)

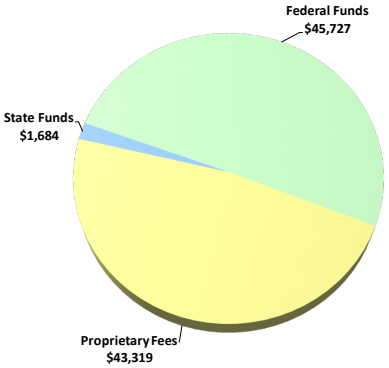
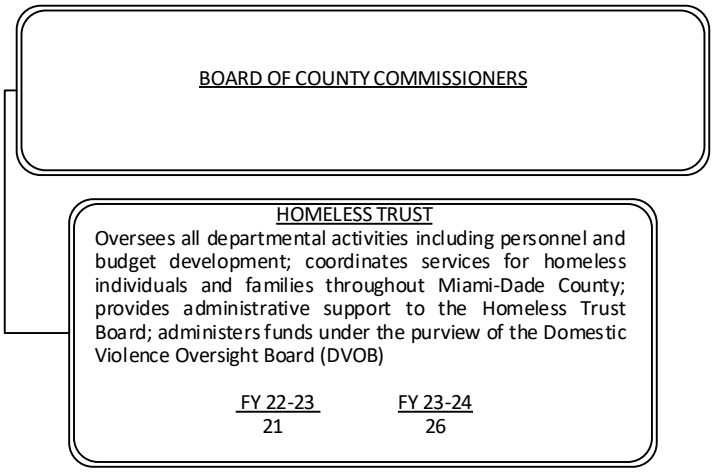


TABLE OF ORGANIZATION



The FY 2023-24 total number of full-time equivalent positions is 26

DIVISION: HOMELESS TRUST OPERATIONS

The Homeless Trust Division oversees all departmental activities, including personnel and budget development, and coordinates housing and services for homeless and formerly homeless individuals and families throughout Miami-Dade County.

- Administers more than 100 individual grant-funded programs with more than 20 organizations to provide essential housing and services for people experiencing homelessness in Miami-Dade County
- Administers 85 percent of the one percent Food and Beverage Tax proceeds
- Conducts two countywide homeless census counts each year to assess the type and number of homeless individuals in Miami-Dade County and surveys and analyzes system data to improve utilization and performance
- Coordinates Homeless Trust activities and recommends, defines and monitors operating goals, objectives and procedures for the Homeless Trust
- Coordinates referrals of homeless individuals and families to permanent supportive housing
- Implements policies developed by the Homeless Trust Board and Committees
- Manages the local Homeless Management Information System to track system utilization, needs, gaps and trends
- Provides a continuum of housing and support services for targeted homeless populations, including services related to sexual assault and domestic violence, mental health and substance abuse
- Provides culturally sensitive prevention, outreach and intervention services for homeless and formerly homeless individuals and families, including veterans, chronically homeless, youth and families
- Serves as staff to the Board of the Homeless Trust and liaison to the Office of the Mayor and the BCC
- Utilizes local, state and federal funds to assist the homeless and formerly homeless
- Administers 15 percent of the one percent Food and Beverage Tax proceeds; these funds are under the purview of the DVOB

Strategic Objectives - Measures

- HS1-1: Reduce homelessness throughout Miami-Dade County

Objectives	Measures			FY 20-21 Actual	FY 21-22 Actual	FY 22-23 Budget	FY 22-23 Projection	FY 23-24 Target
Eliminate homelessness in Miami-Dade County	Total number of homeless persons*	OC	↓	3,245	3,276	3,300	3,350	3,300
	Number of persons entering the system for the first time	OC	↓	4,703	5,101	4,650	4,700	4,600
	Average number of days persons remain homeless	OC	↓	141	145	138	140	137
	Percentage of persons who access permanent housing upon exiting a homeless program	OC	↑	45%	55%	58%	57%	59%
	Percentage of persons who achieve an increase in income upon exiting a homeless program	OC	↑	35%	35%	36%	35%	36%
	Percentage of individuals who return to homelessness within two years	OC	↓	24%	19%	24%	25%	23%

*Measure refers to the total number of sheltered and unsheltered homeless persons at a single point in time. FY 2022-23 Projection increased in part because of first time homelessness, but also, because of increased shelter capacity due to the loosening of COVID restrictions

DIVISION COMMENTS

- **During FY 2022-23 a Business Analyst overage position was added to analyze and measure systemwide and project-level performance for the homeless Continuum of Care, interpret data related to homeless sub-populations, identify provider characteristics and client pathways that contribute to performance and recommend changes to improve performance outcomes ($68,000)**
- **The FY 2023-24 Adopted Budget includes funding for the addition of two Contract Officers to process current and new provider reimbursements ($193,000), one Quality Assurance Coordinator to monitor the special NOFO project providers ($104,000), and one Accountant 2 to assist with the accounting and processing of payments for current and new providers ($100,000)**

The United States Department of Housing and Urban Development (USHUD) released a special Notice of Funding Opportunity (NOFO) to address unsheltered homelessness with an emphasis on serving people with severe service needs. Homeless Trust is receiving additional funds totaling $21,214,204 for three years commencing in FY 2023-24; the Homeless Trust will contract with five providers to provide the services (Camilus House, Educate Tomorrow, New Hope Corps, City of Miami Beach and Miami Recovery Project)

- The Homeless Trust continues to feel the impacts of Miami-Dade County's affordable housing crisis and the lack of housing options, particularly for persons at or below 30% of the Area Median Income, many of whom are disabled; continuing fallout from the COVID-19 pandemic, the closing of unsafe structures following the Surfside collapse and increased migrant inflow have further strained available resources; homeless prevention services also remain in demand as renters and property owners face hardships

The Homeless Trust continues to partner with and leverage the resources of area public housing agencies, including Miami-Dade, Miami Beach, Hialeah and Homestead, to provide housing to homeless households, including 770 Emergency Housing Vouchers made available through the American Rescue Plan Act

The Homeless Trust continues to work with Participating Jurisdictions, including Miami-Dade, Miami, Hialeah, Miami Beach and North Miami to target HOME Investment Partnerships American Rescue Plan Program (HOME-ARP) resources to add new units to the development pipeline targeted to people experiencing homelessness and rehouse persons experiencing homelessness

- Efforts continue to pursue full participation in the Local Option 1% Food and Beverage Tax in Miami-Dade as three municipalities (Miami Beach, Surfside and Bal Harbour) remain exempt from the penny program
- Food and Beverage Tax funded investments in homeless prevention, rapid rehousing and specialized outreach programs have been enhanced in the FY 2022-23 Adopted Budget to offset the phase out of Emergency Solutions Grant-Coronavirus (ESG-CV) resources made available through the Coronavirus Aid, Relief, and Economic Security Act (CARES Act); ESG-CV resources have largely returned to pre-pandemic levels

During the 2023 State Legislative Session, the Homeless Trust secured a special appropriation of $562,000 for low barrier, single-site permanent supportive housing allowing for quick placement of individuals coming directly from the street who would likely not do well in a congregate facility, such as an emergency shelter; this new housing serves as a bridge to other permanent housing

The Homeless Trust continues to pursue strategies to eliminate race as a social determinant of homelessness and is working to ensure black persons and persons with lived experience are part of CoC planning and decision making; the Homeless Trust continues to perform an annual racial disparity quantitative assessment, review its coordinated entry system to ensure people of color have equal access to permanent housing, and facilitate trainings on racial bias and equity

- In FY 2023-24 Adopted Budget, the Homeless Trust Capital and Tax Equalization Reserves for future infrastructure acquisition and renovations are $6.349 million; Tax Equalization Reserves, which are essential to maintaining service levels and adding needed capacity, are $2.002 million

ADDITIONAL INFORMATION

The FY 2023-24 Adopted Budget includes allocations to the Sundari Foundation, Inc., operators of the Lotus House Women's Shelter, for emergency shelter to provide evidence-based, trauma-informed housing and services for homeless women, youth, and children with special needs in the Health and Society Community-Based Organizations allocation for $578,900

CAPITAL BUDGET HIGHLIGHTS AND OPERATIONAL IMPACTS

The Department's FY 2023-24 Adopted Budget and Multi-Year Capital Plan includes funding to address long-term infrastructure needs at Chapman Partnership North; improvements include interior and exterior renovations, replacement of aging equipment, commercial kitchen upgrades and HVAC replacement; these projects are funded with Homeless Trust Capital Reserve funds; as part of the Mayor's resiliency initiative, where applicable, equipment will be energy efficient; these facilities, through a private -public partnership offer homeless assistance to men, women and children as well as provide a variety of support services (total program cost $2.4 million; $465,000 in FY 2023-24; capital program #2000002458)

The Department's FY 2023-24 Adopted Budget and Multi-Year Capital Plan includes funding to address long-term infrastructure needs at Chapman Partnership South; improvements include installation of security cameras, HVAC replacement, kitchen upgrades, and new generators; these projects are funded with Homeless Trust Capital Reserve funds; as part of the Mayor's resiliency initiative, where applicable, equipment will be energy efficient; these facilities, through a private -public partnership offer homeless assistance to men, women and children as well as provide a variety of support services (total program cost $1.785 million; $430,000 in FY 2023-24; capital program #2000002355)

In order to meet the increasing demand to provide shelter and support services to the homeless population in Miami-Dade County, the Department purchased the KROME facility in January 2023 for $4.594 million, funded with Miami-Dade Rescue Plan funds; in FY 2023-24, the Department's Adopted Budget and Multi-Year Capital Plan includes funding for the renovation of the facility in order to provide specialized housing and services for unsheltered single adult men with special needs; the project is funded with the HOMES Plan ($2.1 million), City of Miami Beach contribution ($1 million), and the Miami-Dade Rescue Plan ($6 million); the annual estimated operating cost is $1.5 million (total program cost $9.1 million; $4.506 million in FY 2023-24; capital program #2000002975)

The Department's FY 2023-24 Adopted Budget and Multi-Year Capital Plan includes funding to purchase and renovate the La Quinta Hotel in Cutler Bay; the project is funded with the HOMES Plan ($7.9 million) and the City of Miami's HOMES Plan ($8 million); this facility, through a private-public partnership will offer homeless assistance to chronically homeless individuals as well as provide a variety of support services to include case management and life skills training; the hotel has 107 rooms including 6 to 7 large suites; the annual estimated operating cost is $1.64 million (total program cost $15.9 million; $5.35 million in FY 2023-24; capital program #2000003116)

The Department's FY 2023-24 Adopted Budget and Multi-Year Capital Plan includes funding to address the aging infrastructure at Verde Gardens; improvements include, but not limited to interior and exterior renovations, replacement of aging of equipment, commercial kitchen upgrades, HVAC replacement, and the installation of security cameras; as part of the Mayor's resiliency initiative, where applicable, equipment will be energy efficient; the facility provides supportive housing and services to families experiencing homelessness; the project is funded with Homeless Trust Capital Reserve funds (total program cost $4.459 million; $641,000 in FY 2023-24; capital program #2000002356)

SELECTED ITEM HIGHLIGHTS AND DETAILS

Line-Item Highlights	(dollars in thousands) Actual FY 20-21	Actual FY 21-22	Budget FY 22-23	Projection FY 22-23	Adopted FY 23-24
Advertising	6	6	10	5	7
Fuel	0	0	0	0	0
Overtime	0	0	0	0	0
Rent	101	98	113	100	120
Security Services	0	0	0	0	0
Temporary Services	0	0	0	0	0
Travel and Registration	1	6	7	12	14
Utilities	9	10	8	8	8

OPERATING FINANCIAL SUMMARY

(dollars in thousands)	Actual FY 20-21	Actual FY 21-22	Budget FY 22-23	Adopted FY 23-24
Revenue Summary				
Carryover	24,902	27,770	38,070	37,008
Food and Beverage Tax	31,209	40,488	40,030	42,227
Interest Earnings	60	167	59	150
Miscellaneous Revenues	200	200	0	0
Other Revenues	62	116	301	175
State Grants	3,522	7,175	2,674	1,684
Federal Grants	28,769	30,857	33,850	45,727
Total Revenues	88,724	106,773	114,984	126,971
Operating Expenditures Summary				
Salary	2,341	2,044	2,043	2,545
Fringe Benefits	21	837	837	1,070
Contractual Services	65	98	126	101
Other Operating	697	969	559	653
Charges for County Services	572	562	569	624
Grants to Outside Organizations	51,593	59,386	85,539	85,729
Capital	5,431	382	30	8
Total Operating Expenditures	60,720	64,278	89,703	90,730
Non-Operating Expenditures Summary				
Transfers	0	0	5,074	1,568
Distribution of Funds In Trust	0	0	0	0
Debt Service	0	0	0	0
Depreciation, Amortizations and Depletion	0	0	0	0
Reserve	0	0	20,207	34,673
Total Non-Operating Expenditures	0	0	25,281	36,241

(dollars in thousands) Expenditure By Program	Total Funding Budget FY 22-23	Total Funding Adopted FY 23-24	Total Positions Budget FY 22-23	Total Positions Adopted FY 23-24
Strategic Area: Health and Society				
Homeless Trust Operations	4,002	4,823	21	26
Domestic Violence Oversight Board	4,601	4,148	0	0
Emergency Housing	19,796	21,910	0	0
Permanent Housing	57,855	54,882	0	0
Support Services	3,449	4,967	0	0
Total Operating Expenditures	89,703	90,730	21	26

CAPITAL BUDGET SUMMARY

(dollars in thousands)	PRIOR	FY 23-24	FY 24-25	FY 25-26	FY 26-27	FY 27-28	FY 28-29	FUTURE	TOTAL
Revenue									
City of Miami Beach Contribution	0	1,000	0	0	0	0	0	0	1,000
HOMES Plan	7,900	2,100	0	0	0	0	0	0	10,000
HOMES Plan - City of Miami	8,000	0	0	0	0	0	0	0	8,000
Homeless Trust Capital Reserves	4,826	1,568	730	780	580	160	0	0	8,644
Miami-Dade Rescue Plan	4,594	1,406	0	0	0	0	0	0	6,000
Total:	25,320	6,074	730	780	580	160	0	0	33,644
Expenditures									
Strategic Area: HS									
Homeless Facilities	17,341	11,392	1,877	1,899	975	160	0	0	33,644
Total:	17,341	11,392	1,877	1,899	975	160	0	0	33,644

FUNDED CAPITAL PROGRAMS

(dollars in thousands)

CHAPMAN PARTNERSHIP NORTH - FACILITY IMPROVEMENTS **PROGRAM #: 2000002458**

DESCRIPTION: Provide facility improvements to address long-term facility needs to include interior and exterior renovations, replacement of aging equipment, commercial kitchen upgrades, and HVAC replacement

LOCATION: 1550 North Miami Ave
North Miami

District Located: 3
District(s) Served: Countywide

REVENUE SCHEDULE:	PRIOR	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	FUTURE	TOTAL
Homeless Trust Capital Reserves	440	465	475	545	375	100	0	0	2,400
TOTAL REVENUES:	**440**	**465**	**475**	**545**	**375**	**100**	**0**	**0**	**2,400**
EXPENDITURE SCHEDULE:	**PRIOR**	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**FUTURE**	**TOTAL**
Furniture Fixtures and Equipment	55	5	15	455	5	0	0	0	535
Infrastructure Improvements	335	410	410	40	320	100	0	0	1,615
Major Machinery and Equipment	50	50	50	50	50	0	0	0	250
TOTAL EXPENDITURES:	**440**	**465**	**475**	**545**	**375**	**100**	**0**	**0**	**2,400**

CHAPMAN PARTNERSHIP SOUTH - FACILITY RENOVATION **PROGRAM #: 2000002355**

DESCRIPTION: Provide facility improvements to address long-term facility needs include the installation of security cameras, HVAC replacement, kitchen upgrades, and new generators

LOCATION: 28205 SW 124 Ct
Homestead

District Located: 9
District(s) Served: Countywide

REVENUE SCHEDULE:	PRIOR	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	FUTURE	TOTAL
Homeless Trust Capital Reserves	910	430	100	80	205	60	0	0	1,785
TOTAL REVENUES:	**910**	**430**	**100**	**80**	**205**	**60**	**0**	**0**	**1,785**
EXPENDITURE SCHEDULE:	**PRIOR**	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**FUTURE**	**TOTAL**
Infrastructure Improvements	485	380	50	30	100	60	0	0	1,105
Major Machinery and Equipment	30	50	50	50	500	0	0	0	680
TOTAL EXPENDITURES:	**515**	**430**	**100**	**80**	**600**	**60**	**0**	**0**	**1,785**

HOMELESS FACILITIES **PROGRAM #: 2000003116**

DESCRIPTION: Purchase, renovate and/or construct facilities to provide housing for chronically homeless individuals and families

LOCATION: Various Sites
Throughout Miami-Dade County

District Located: 8
District(s) Served: Countywide

REVENUE SCHEDULE:	PRIOR	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	FUTURE	TOTAL
HOMES Plan	7,900	0	0	0	0	0	0	0	7,900
HOMES Plan - City of Miami	8,000	0	0	0	0	0	0	0	8,000
TOTAL REVENUES:	**15,900**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**15,900**
EXPENDITURE SCHEDULE:	**PRIOR**	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**FUTURE**	**TOTAL**
Building Acquisition/Improvements	10,550	5,350	0	0	0	0	0	0	15,900
TOTAL EXPENDITURES:	**10,550**	**5,350**	**0**	**0**	**0**	**0**	**0**	**0**	**15,900**

KROME FACILITY - PURCHASE/RENOVATE **PROGRAM #: 2000002975**

DESCRIPTION: Purchase and repurpose the existing KROME facility to provide specialized housing and services for unsheltered single adult men with special needs

LOCATION: 18055 SW 12 St
Unincorporated Miami-Dade County

District Located: 11
District(s) Served: Countywide

REVENUE SCHEDULE:	PRIOR	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	FUTURE	TOTAL
City of Miami Beach Contribution	0	1,000	0	0	0	0	0	0	1,000
HOMES Plan	0	2,100	0	0	0	0	0	0	2,100
Miami-Dade Rescue Plan	4,594	1,406	0	0	0	0	0	0	6,000
TOTAL REVENUES:	**4,594**	**4,506**	**0**	**0**	**0**	**0**	**0**	**0**	**9,100**
EXPENDITURE SCHEDULE:	**PRIOR**	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**FUTURE**	**TOTAL**
Building Acquisition/Improvements	4,594	4,506	0	0	0	0	0	0	9,100
TOTAL EXPENDITURES:	**4,594**	**4,506**	**0**	**0**	**0**	**0**	**0**	**0**	**9,100**

Estimated Annual Operating Impact will begin in FY 2023-24 in the amount of $1,500,000 and includes 0 FTE(s)

VERDE GARDENS - FACILITY RENOVATIONS **PROGRAM #: 2000002356**

DESCRIPTION: Provide facility improvements to include interior and exterior renovations, replacement of aging equipment, commercial kitchen upgrades, HVAC replacement, and the installation of security equipment

LOCATION: Various Sites
Homestead

District Located: 9
District(s) Served: Countywide

REVENUE SCHEDULE:	PRIOR	2023-24	2024-25	2025-26	2026-27	2027-28	2028-29	FUTURE	TOTAL
Homeless Trust Capital Reserves	3,476	673	155	155	0	0	0	0	4,459
TOTAL REVENUES:	**3,476**	**673**	**155**	**155**	**0**	**0**	**0**	**0**	**4,459**
EXPENDITURE SCHEDULE:	**PRIOR**	**2023-24**	**2024-25**	**2025-26**	**2026-27**	**2027-28**	**2028-29**	**FUTURE**	**TOTAL**
Furniture Fixtures and Equipment	93	50	50	50	0	0	0	0	243
Infrastructure Improvements	1,149	591	1,252	1,224	0	0	0	0	4,216
TOTAL EXPENDITURES:	**1,242**	**641**	**1,302**	**1,274**	**0**	**0**	**0**	**0**	**4,459**

UNFUNDED CAPITAL PROGRAMS

PROGRAM NAME	LOCATION	(dollars in thousands) ESTIMATED PROGRAM COST
THIRD DOMESTIC VIOLENCE SHELTER - NEW	Undisclosed	16,500
	UNFUNDED TOTAL	**16,500**

The shelter movement began in earnest in the 1970s, as a response to the growing homelessness rate spurred by high unemployment, rising housing costs, and deinstitu-tionalization of people with severe mental illness (Arrighi, 1997; Dordick, 1996). At the time, homelessness was seen as a temporary problem on both an individual and societal level. However, as homelessness rates continued to rise through the late 1980s (represented increasingly by women and families), shelters became permanent community fixtures. With this de-velopment came heightened shelter bureaucratization and in-stitutionalization, perceived as a way to facilitate communal living (Gounis, 1992; Morgan, 2002; Stark, 1994).

Such bureaucratization and institutionalization have become so salient within contemporary homeless shelters that some argue they embody many of the tenets of a total insti-tution (Bogard, 1998; Dordick, 1996; Snow & Anderson, 1993; Stark, 1994) as originally conceptualized by Goffman (1961). In its most general definition, a total institution is "a place of resi-dence ... where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed formally administered round of life" (Goffman, 1961, p. xiii). While Goffman did not classify home-less shelters as total institutions at the time of his writing (pre- 1970s shelter movement), research on various types of shelters (e.g., homeless, domestic violence) has examined the ways in which they may be classified as such (Bogard, 1998; Moe, 2009; Snow & Anderson, 1993; Stark, 1994). As Stark (1994) attests, shelters become a type of total institution "when the role that the individual assumes as shelter resident blocks his or her ability to pursue the most basic human roles-those of friend, lover, husband, wife, parent, and so forth" (p. 557).

The goal[s] of this paper are twofold. First, we examine the ways in which an urban Midwestern shelter, referred here as The Refuge (pseudonym), operates as a total institution. Second, we explore the ways in which female residents ne-gotiated the bureaucracy and institutionalization within this shelter, presenting our findings within a typology of survival strategies: submission, adaptation, and resistance. Data come from field observations within the shelter and semi-structured interviews conducted with twenty female residents.

The Refuge as a Total Institution

In an effort to run efficiently and, presumably, fairly, a bureaucratic structure was employed at The Refuge, which encompassed many rules and illustrated a clear demarcation between staff and residents. For discipline, The Refuge uti-lized a point system. A staff member could issue a point to any resident for any rule infraction or disobedience. Once issued, the point could not be reversed, unless formally erased by the issuing staff member. Residents were terminated from the shelter after receiving three points.

Characteristic of total institutions, shelter staff enjoyed a wide degree of discretion in terms of issuing points, as well as enforcing other rules, administering services, and providing access to resources (Marvasti, 2002; Mulder, 2004). Through observation, it was clear that staff at The Refuge were encour-aged to use their discretion in such matters as distributing per-sonal items, as well as permitting entrance and exit of residents from the shelter. Likewise, education and access to community resources were subject to the approval and assistance of each resident's caseworker. The wide margin of staff discretion, and their potential misuse of authority, created a deep power dif-ferential from the residents' perspectives. As Becky comment-ed, "I think some of the staff treat

them [residents] okay, but overall, I think they treat them kind of harsh .... I think they on a power trip." Moreover, this discretion allowed staff to rein-force their own version of hierarchy, favoring some residents over others (see Holden, 1997).

Because total institutions emphasize conformity to rules, there is little respect for autonomy or individuality (Goffman, 1961). Residents are viewed as dependents, reduced to virtual child-like status, in that they are fully reliant on the institution for all of their basic necessities (e.g., food, shelter, clothing, per-sonal items) [Snow & Anderson, 1993]. In this way, residing at the shelter seemed to carry with it the presumption that one is incapable of regulating one's own affairs. Such a supposition is closely related to the original conceptualization of the total institution, in that such facilities have traditionally been asso-ciated with persons who, due to either illness or poor decision making, are seen as incapable of functioning in the larger com-munity (e.g., people with mental illness, criminal offenses or contagious diseases) [Stark, 1994].

Accordingly, The Refuge relied upon an age-graded system (Goffman, 1961) aimed at subjecting previously independent adults to rules and tasks that were infantalizing and demoral-izing. For instance, rules dictated when and where activities, mealtime, recreation, and bedtime took place. Residents re-sented such measures. As Nicole commented, "If they want respect, they should talk to you with respect and not talk to us like we kids, 'cause we are all adults here."

Mothers, in particular, recognized the institutionally imposed role conflict between autonomous adult and dependent. Prior to entering shelter, many women who were mothers were considered the sole heads of their families. Upon entering the shelter, however, their familial leadership roles were usurped by staff authority. Subsequently, both mothers and their children were subjected to the rules and discipline of the shelter.

Surviving the Shelter as a Total Institution

Submission: Embracing the Total Institution

Based on their responses to the interview questions and field observations, we categorized seven of the interviewees as "submitters" to the shelter institution because of their com-plete deference to the organization, its power hierarchy, and its disciplinary system. Such women fit the categories of "good," "deserving" or "appropriate" clientele (Ferraro 1981; Lindsey, 1998; Marvasti 2002), in that they obeyed the rules, did not question the authority of the staff, stayed out of others' busi-ness, and appeared grateful for what they received. The shelter organization thrived with these residents, who due to their compliance, reinforced the structure and created a reciprocal codependence between themselves and the organization. In other words, the shelter, whose stated purpose is to help resi-dents become independent, actually reinforced dependence on the system through its support of submissive residents (Stark 1994).

An example of such dependence and submission to the institution can be found in Mary and her two children, who had resided in The Refuge for six months at the time of her interview. The Refuge policy dictates a maximum shelter stay of thirty days, so substantial exceptions were made on her behalf. Instead of pursuing outside work, Mary applied for and was hired as a staff person in the women's dormitory -the same dormitory in which she was living. She lamented the lack of enforcement of shelter rules during the interview, which she had to both enforce upon others and follow herself. When asked if there were any rules that she would change, Mary replied, "No, definitely not. I would make sure they are enforced." Mary stated that she had no future plans of leaving the shelter, and she was indeed still living and working at The Refuge

when data collection was completed (comprising a nine-month stay).

Adaptation: Reframing the Total Institution

Seven women adjusted to shelter institutionalization through adaptation. The adaptive strategies assumed two primary strategies: (1) emphasizing spirituality; or (2) recre-ation of hierarchy. This group was characterized by their ac-knowledgement of their subjugated role within the shelter hierarchy. However, unlike the unquestioned acceptance il-lustrated by those who submitted to their status, "adapters" reframed their identities in ways that allowed them to define for themselves where they fit within the hierarchy.

Adaptation through emphasizing the spiritual self Adaptation through one's spiritual identity was a powerful element to shelter survival. Unlike the submitters, spiritual adapters were able to articulate the reasons for their homelessness, accept re-sponsibility for their situation, and view their faith as central to their efforts to regain economic independence. Indeed, what was distinct about this group of women was their heightened sense of personal responsibility. They viewed their homeless-ness as a result of their "sins," and believed that only through a genuine focus on their spirituality would they have any hope of escaping their plight. In contrast to submitters, spiritual adapters did not appear to embrace the bureaucratic and insti-tutionalized nature of the shelter. They seemed relatively un-interested in condoning the shelter's practices and the efforts of its staff. Instead they turned inward, embracing their faith as an instructional guide in accepting and resolving their situ-ations.

Iyayeiya expressed similar sentiments with regard to her "sin" of being "promiscuous" and having relationships with abusive men, "I get my strength from God through prayer ev-eryday. You know, He gets me up in the morning. He provides shelter. .. this is like God's hotel to me. I don't see this as, 'Uh, I stay at the shelter.'" As a result of her belief in God's care, Iyayeiya had resolved to keep men and "fornication" out of her life as she worked to move out of homelessness.

Adaptation through recreating hierarchies. In the second adaptive strategy, women reframed the shelter experience in ways that allowed them to see themselves as better positioned than other residents. Distinct from the spiritual adapters who focused on personal responsibility and spiritual growth, hier-archical adapters focused more on the distinct circumstances of shelter residents, differentiating between those considered "homeless" and those considered "houseless." Homelessness referred to those who entered shelter because of an incapaci-tation, perceived lack of judgment or poor decision-making, such as mental illness or alcoholism. Alternatively, house-less referred to those who entered shelter due to "bad luck" (e.g., losing a job, going though a difficult divorce). A home-less person was in a long-term predicament and deserved some amount of personal blame. A houseless person was in a temporary situation that could be rectified given some time and assistance. In this way, a hierarchy between residents was created.

Tasha illustrated the distinction well, "This is my third time being here. I might have been homeless, well houseless three times. Each time, I feel it wasn't my fault." She indicated that she had become houseless due to being laid off, suffering poor credit, and forced evictions.

Resistance: Rejecting the Total Institution

A third group of women actively resisted the bureaucracy and structure of the shelter, which they viewed as contributing to their marginalization. Comprised of six women, this group opposed the subordination of the shelter experience, doing so most often by verbally expressing their opinions and thoughts to staff and other residents. Nee-Nee exemplified the "resist-ers" when she blatantly responded that the shelter's services were "full of shit." This

group was characterized by consci-entious efforts at retaining a sense of themselves within the shelter. Their voices and actions expressed their desire for au-tonomy and respect as individuals. As Kelly described:

> I let them [staff] know they ain't gonna use none of that [rules and use of discretion] against me, 'cause I know that I have street smarts and educational smarts, and I'm not gonna let you judge me off that and break me down like I can't be on the same level as you ... That's how they do. They'll try to demean you, the staff do here ... They wanna just brainwash you ... But that's not gonna help you get an apartment.

This group of women aptly articulated the contradictory nature of the shelter institution, and were unique from the other groups in their ability to place their critiques within a larger social context. For example, Alice compared the shelter system to a correctional system:

> I think shelters should be like a shelter, not like a treatment center. If you come into a shelter, you need it not to feel like a correctional center. Like a prison! You got people right back out there on the streets because they don't want to be closed in all the time.

Conclusion

The results of this analysis point to several recommendations for homeless shelters, beginning with a thorough reevaluation of shelter goals and practices. A contradiction exists between the operation of such agencies, and their reaction to and dismissal of those who reject their structures. Indeed, the women in our study who resisted the shelter's rules and its staff, and subsequently risked being denied the safety and security the shelter could provide, were in a way the very type of individual social service-based agen-cies claim to want to create. Given the appropriate resources, these women exhibited the drive and tenacity to survive in an autonomous state. Indeed, if agencies that served marginalized populations, like homeless women, were truly concerned with and committed to fostering self-sufficiency, it would be these clientele who would be seen as at least somewhat desirable.

This adversarial relationship is inherently counter-produc-tive to the goal of self-sufficiency of shelter residents. Homeless shelter workers should operate as advocates for shelter resi-dents, providing individualized case management to aid in securing employment and stable housing. Staff should be educated about inequality (Abramovitz, 2005), urban neigh-borhood issues (Kissane, 2004), and poverty policies (such as welfare reform) to aid their advocacy for clients (Kissane, 2006). With this knowledge, staff should be able to display greater empathy for residents, holding more positive regard for clients rather than judgment. Appropriate strengths-based assistance may thus become possible (Saleebey, 2005).

Every night people in Santa Clara County, USA board 24-hour public transportation routes for shelter. While this social phenomenon exists in urban centres around the world, research or data about those who use buses or trains as shelter are limited. This is not surprising given that most research about people who are homeless takes place in shelters (Cunningham and Henry, 2008). Not only do we not know much about those who use this type of shelter strategy, the practice raises questions similar to those being asked about the rights of people without homes to access and use public space (such as libraries, public parks or plazas) as an alternative or in addition to separate services designed specifically to serve the unhoused.1 While laws are not being broken, policies and services are often being utilised by those who are unhoused in unintended ways, conflicting with how service providers, businesses and the housed envision or desire the space to be used.

Background

In most communities in the US, there exists a complicated maze of separate public and non-profit services and benefits available for people without permanent housing. While the UK, for example, has a framework of statutory responsibilities towards those who are homeless, the US response is typically piecemeal and differs significantly by locality (Minnery and Greenhalgh, 2007). Some cities and counties devote significant resources to build local shelters and affordable housing, as well as augment the work of independent non-profit shelters and private developers, but there is no federal or state mandate for such an approach (Shin, 2007). Therefore, as long as the US (and countries like it) approach homelessness as an individual problem of welfare, rather than a structural lack of affordable housing, the issue and problem are never adequately addressed (Daly, 1996). Relatedly, in most, if not all, communities in the United States there is not enough shelter space to meet the need.

While providing shelter has been the most common response to homelessness, this approach has been temporary and an inadequate stopgap. Emergency shelters typically follow similar rules about maximum nights of stay allowed. For example, single men are usually given shelter on a day-to-day basis, and families are allowed a longer time frame (30–90 days) (Feltey and Nichols, 2008). Many communities have also begun to open large shelter spaces during the winters only. In addition, because of the need to house large numbers of people, with a variety of needs and situations, rules tend to dominate lives in the shelters (Loseke, 1992; Spencer and McKinney, 1997). People must be in and out of the shelters at specific times. Shelter residents also worry about exposure to sickness and criminal activity (Donley and Wright, 2008).

This combination of uncoordinated structural and individual responses to homelessness in the US has meant that there are vastly larger proportions of people sleeping rough in the US compared to Europe. As a result, people often cannot access emergency shelters and try to find alternatives. Popular substitutes include sleeping in vehicles, on the streets, and in encampments. Riding public transportation for shelter has also been identified by the press as a creative way to stay warm throughout the night (Brown, 2005;Peterson, 2007;Royale, 2007; Samuels, 2006).

While riders legitimately pay to ride the bus, transportation authorities and housed riders make complaints similar to those often raised about the use of libraries by the unhoused, specifically pointing out odour and unruly behaviour as problems. In addition, public agencies and employees in non-homeless service fields are confronted with a range of

mental health, family and public health needs for which they are not prepared. Various cities have attempted to ask people who are homeless to leave libraries under a public nuisance clause. The removals have been challenged in the courts with mixed outcomes, and raise larger questions about who really has access to and control over public space and the functions of such spaces (Hodgetts et al., 2008; Wright, 1997). Homelessness becomes more visible as a public issue, and communities often struggle to figure out how to respond.

Context

These dilemmas were being actively discussed in the community where this study took place. Transportation officials said that the buses should not be used as shelters, and other entities should be responsible for unhoused riders. At the same time, shelter and other service providers said they were fulfilling their mandates and had no responsibility (or resources) for addressing the issue. Cities could not act because the bus route crossed through many different jurisdictions. And no entity was quite sure exactly what, if anything, should be done. We decided to conduct a study with unhoused riders in the hope this would move the conversation forward and better inform any policy decisions that might be considered.

Santa Clara County is in Silicon Valley in Northern California, and has an estimated 1.8 million residents (US Census, 2008) with one of the costliest housing markets in the United States (Center for Housing Policy, 2009). A recent street count puts the number of homeless individuals in the county at 7,086 unduplicated persons, 2,270 of whom are defined as chronically homeless (Fernandez, 2009). The county has approximately 26 emergency shelters that provide space for up to 1,000 persons each night. In the winter months (November through March), additional shelter is provided for 300 more persons (Santa Clara County, 2009).

At the systems level, shelter is not provided based on the numbers of unhoused persons or even known needs, but rather based on limited resources for existing services, funded usually on a year-to-year basis. As a result, non-profit shelters and social service organisations often compete with one another for funding, and while government entities support such organisations in their work, no entity is charged with monitoring needs and resources (Fogel et al., 2008). The lack of funding stability is even more pronounced when localities are struggling economically. In 2009, a large shelter provider in the county had plans to cut the number of emergency shelter beds available until two wealthy couples donated funds to keep the shelter open at full capacity.

This uncertainty and gap between needs and resources results in many persons living on the streets, in encampments, in abandoned buildings, and any other configuration that can be utilised for shelter. The bus is one such repurposing of space. While there are a number of questions and issues that could be understood and explored from the perspectives of people who ride public transportation for shelter, this study provides a preliminary look at how often people say they ride the bus for shelter, who they are, why they say they ride the bus for shelter, and the services they say they would like to utilise.

The 24-hour bus route

The route in question is 42 kilometers long and passes through six cities. At the southern most end, the route travels through some of the most impoverished areas of San Jos´e and ends in one of the most affluent cities in the county, Palo Alto, home to Stanford University. It is the only all-night full-service route and, according to the transportation authority, carries 20,000 riders a day, 20 per cent of the total ridership in the county (VTA, 2009).

Because of its centrality and popularity, the bus runs frequently, every ten minutes or so during the day, reducing to every hour after 12:30 a.m.

In the evening, the route takes approximately one hour and thirty minutes from end to end. At night, the layover times at the end of each line are at least an hour, and operators are required to empty the bus of passengers and lock up the bus until the bus leaves at the next scheduled time.

The bus on this route is often referred to by people who are homeless as 'hotel 22', in reference to the large numbers of people who ride this numbered route for shelter. Although there has never been an official count, an unofficial survey of bus operators puts the number at 50–60 persons a night who ride the route for shelter.

Findings

The bus as shelter

Like many experiences of being homeless, riding the bus for shelter requires timing and waiting. One rider said that she started her ride early, at 7:30 p.m., because that allowed her the longest stint to sleep: two hours before she had to deboard. After that the most she could sleep at a time was an hour and a half. Once boarded, most riders went to the front or back of the bus and quickly fell asleep. Although surveyors saw some people laying across the bench in the back of the bus or taking up two seats, most sat up and slept. Manuel noted how difficult it is to ride the bus:

It's been tough sleeping on the bus. Actually it's really hard to sleep on the bus because it moves a lot and makes a lot of noise. I have bruises on my body and wake up with pain. A human isn't meant to sleep on the bus, or to sleep sitting down. I know that this is only a phase in my life. I'm conscious of whom I am and I don't drink or do drugs like some of the other people on here. I know I'm going to be better and that things will work out.

Most unhoused riders did not leave the bus before the end of the line. At the end of the route, one operator would walk up and down the aisle of the bus hitting the metal rails with a cane to wake people up. During the layovers the data collection teams noted how deserted the bus terminals were, especially during the long layovers when the operators would drive the buses to a garage. Riders waited quietly, some sleeping on benches, a few huddled with other riders, but most stayed awake and alone with their belongings.

Both terminals at each end of the line are in isolated locations. One is essentially in the parking lot of a large shopping mall that is closed all night, and the other is near a train terminal and tucked behind a closed catering business. During short layovers, the operators empty the buses and drive them away from the loading area, but still in view of riders. Sometimes the operators stay on the buses with the lights on, other times they stand outside, smoking, reading and/or talking on their cell phones. The buses generally leave on time, with buses pulling up to the terminal and passengers responding by quietly lining up for the ride back to the end of the line.

Frequency of riding for shelter

To get a sense of how often riders use the bus for shelter and other shelter options that riders used, we asked respondents to name all the places they usually stayed for shelter. Almost two-thirds of those surveyed said that the bus was their only or one of their usual sources of shelter. Of the 29 persons who said they usually stayed in only one place, 14 named the bus as that one place. The next most usual place to stay was outdoors (see Figure 1). Eleven respondents combined both the bus and one to three other places. Hotels/motels, shelters and bus/train stations were the most popular combinations with the bus.

When asked how respondents usually paid for their bus fare, for 19 respondents the most common response was a monthly pass. Just over a third paid for a day pass and nine paid cash for a single ride. No one used an annual pass. However, even though a large proportion of unhoused riders said that they usually paid

with a monthly pass, half of those riders said they had paid cash for the particular trip they were on when surveyed (either for a single ride or a day pass).7 Overall, when asked how they had paid for their current trip, a third of riders said they paid cash for a single ride ($1.75), just under a quarter said they used a day pass ($5.25), and eight persons said they used a monthly flash pass. It should be noted that the day pass expires at midnight so riders who stay on the bus overnight must buy two day passes. One rider said that he paid $10 a night to ride the bus, far cheaper than any motel he could find.

Those surveyed ranged in age from 20 to 71 years, with a mean age of 47 years. More men (n = 35) than women (n = 13) rode the bus for shelter. Almost half were African American, ten were white, and similar proportions identified as Latino, Asian or of more than one race/ethnicity.

In Table 1 we compare the demographics of bus riders surveyed for our project with data from a survey conducted in March of 2007 as part of the homeless street count and census that takes place in the county every two years.8 The most interesting difference between those who usually stay in shelters or outdoors compared to bus riders is the large proportion of bus riders who self-identify as African American. This is even more striking given that less than 3 per cent of the population of the county is African American (American Community Survey, 2005)and 20 per cent of the homeless population in the county has been identified as African American (Fernandez, 2009).

When questioned about why they were unhoused, almost all respondents said they were not able to afford rent or did not have enough money in general.

Why ride the bus?

There were different reasons given by gender for riding the bus overnight. Thirty-two of the 35 men surveyed said that they rode the bus to sleep or because they did not have a permanent home. Over half of the women surveyed said that they rode the bus overnight for safety, while only a quarter of the men surveyed said that they rode the bus for that reason. Only five people in the full sample said that they rode the bus because they had been turned away from a shelter.

In informal conversations with riders, there was one person who said that he was unaware of local shelters, but most had stayed at shelters at some point and chose the bus over the shelters. The main reasons mentioned were concerns for safety and dissatisfaction with shelter rules.

The mixed attitudes of bus operators

Although interviewing bus operators was not part of the study, a number of the operators talked to the surveyors, as well as the instructor and peer educator on the ground. There were a variety of opinions among the operators about the presence of unhoused riders on their routes during the night. For example, although all operators were instructed to empty the bus at the end of the line, even when they were continuing back on the route, one did not, saying that he saw no need to empty the bus as long as he did not need to leave the bus himself and could stay awake.

During a layover, one of the riders told a surveyor that the operators were ‘being nice tonight because you guys [the surveyors] are on’. She commented that often the operators would not turn on the heat, but did this night she presumed because of the presence of the surveyors. Turning on the heat and dimming the lights in the bus during the ride were indicators to unhoused riders of a compassionate bus operator. Unhoused riders who had been riding for a number of years made sure to ride on the buses driven by those operators. As a result, some of the buses were quite crowded throughout the night, while others were virtually empty.

Discussion and Conclusion

Taken together, the perspectives of unhoused riders profiled in this study provide insight into the larger function of the bus and public space as shelter. Riding the bus, and using public space, is one way to attempt to escape the stigma and label that goes with homelessness. While libraries often function as day centres for those without housing, in the absence of other options public transportation serves as an overnight alternative to the shelter system. These options also allow people who are unhoused to potentially escape the label of being homeless and use spaces that are presumed to be accessible to all (Hodgetts et al., 2008;Johnsen et al., 2005). We saw riders distancing themselves from the label of homeless as well as acknowledging how bad it was to be homeless.

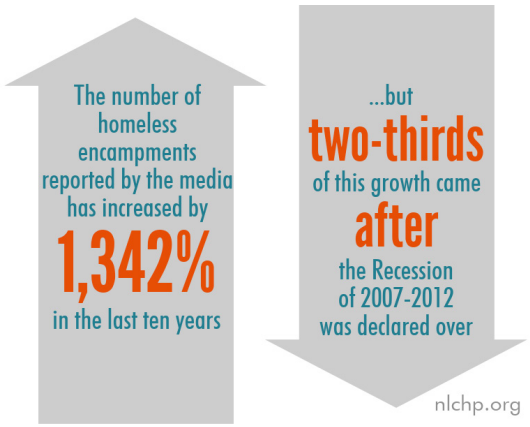
At the same time, the bus also provides a form of freedom that shelters do not. While most riders did not deboard the bus before the end of the line, theoretically they could at any time. This is different from most shelters that require checking in by a certain time and an inability to leave until the shelter opens its doors early the next morning. At the same time that the bus allows for a measure of freedom, it also provides a feeling of safety.

The practice of actively choosing forms of shelter outside the social service system also points to inadequacies in how homelessness is addressed in communities in the US. In the past, shelter has been the primary focus and assumed need.

While the use of public transportation as a form of shelter is viewed by some as a public nuisance, it can also be seen as an innovative way that individuals who are unhoused respond to the inadequate and often piecemeal way that homelessness has been addressed. At the same time, the practice also raises policy questions about how public services for all can be provided within the context of a large homeless population. As long as there is homelessness, people who are unhoused will use public space, sometimes in unintended ways. The magnitude of the use will likely depend on the availability, knowledge and perception of the utility of other possible options.

EXECUTIVE SUMMARY

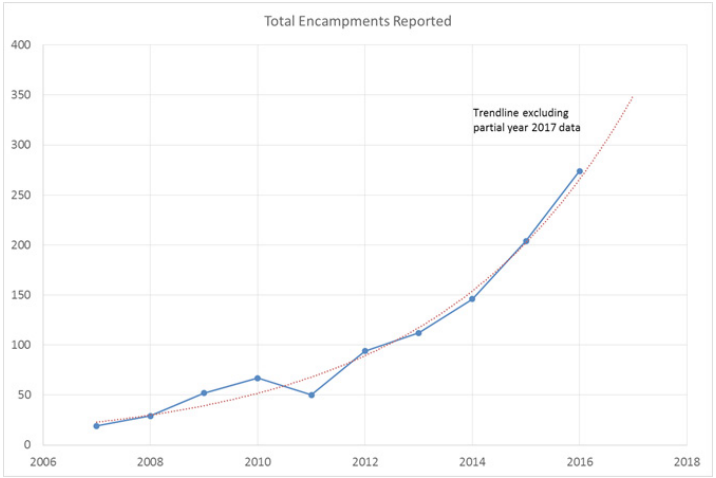
This report by the National Law Center on Homelessness & Poverty ("the Law Center") documents the apparent rapid growth of encampments of people experiencing homelessness or "tent cities" across the United States and the legal and policy responses to that growth. (This report uses the term "encampments" but recognizes that there are multiple ways to refer to the living situation of self-sheltering homeless persons).



The number of documented homeless encampments has increased sharply

This report finds that in the past decade, documented homeless encampments have dramatically increased across the country. Many encampments are designed to be hidden to avoid legal problems or evictions. While some encampments last for years, others are forced to move frequently. These factors make documenting their existence a challenge. As a proxy, this report counts only those encampments reported by the media, and of those, using only media reports that reference the state in which the encampment occurred. Only one report was counted for each encampment. While this is an imperfect proxy, the trends within that limited data set are useful and confirm anecdotal reports from across the country. Between 2007 and 2017:

- **The number of encampments reported grew rapidly**: Our research showed a 1,342 percent increase in the number of unique homeless encampments reported in the media, from 19 reported encampments in 2007 to a high of 274 reported encampments in 2016 (the last full year for data), and with 255 already reported by mid-2017, the trend appears to be continuing upward. Two-thirds of this growth comes *after* the Great Recession of 2007-2012 was declared over, suggesting that many are still feeling the long-term effects.
- **Encampments are everywhere:** Unique homeless encampments were reported in every state and the District of Columbia. California had the highest number of reported encampments by far, but states as diverse as Iowa, Indiana, Louisiana, Michigan, Oregon, and Virginia each tallied significant numbers of reported encampments.
- **Many encampments are medium to large**: Half the reports that recorded the size of the encampments showed a size of 11-50 residents, and 17 percent of encampments had more than 100 residents. Larger encampments are obviously likely to garner more coverage, but these figures suggest that there are high numbers of both medium and large encampments across the country.
- **Encampments are becoming semi-permanent features of cities:** Close to two-thirds of reports which recorded the time in existence of the encampments showed they had been there for more than one year, and more than one-quarter had been there for more than five years.
- **But most are not sanctioned and are under constant threat of eviction:** Three-quarters of reports which recorded the legal status of the encampments showed they were illegal; 4 percent were reported to be legal, 20 percent were reported to be semi-legal (tacitly sanctioned).

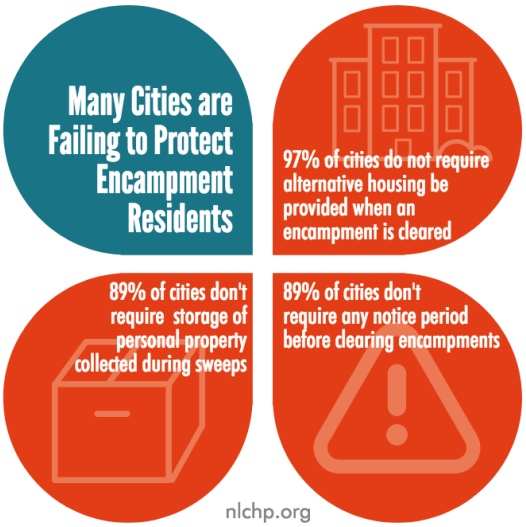


This increase in encampments reflects the growth in homelessness overall, and provides evidence of the inadequacy (and sometimes inaccessibility) of the U.S. shelter system. The growth of homelessness is largely explained by rising housing costs and stagnant wages. A new report by Freddie Mac documents a 60 percent drop in market-rate apartments affordable to very low-income families over just the past six years. Zillow recently documented a strong relationship between rising rents and the growth of homelessness, particularly in high-growth cities like Los Angeles, where a 5 percent rent increase equates to 2,000 additional homeless persons on the streets.

> "There are … reasons to say no when officers offer to bring you to shelter. Agreeing to go to a shelter in that moment means losing many of your possessions. You have to pack what you can into a bag and leave the rest behind, to be stolen or thrown away by City workers. For me, I would have lost my bulky winter clothes, my tent, my nonperishable food, and the bike parts I used to make repairs for money. You give up all this property just for the guarantee—if you trust the police—of a spot on the floor *for one night*. It's not really a "choice" for me to give up all those resources. I needed to make smart survival decisions.
>
> –Eugene Stroman, homeless in Houston, TX

The growth of encampments is a predictable result of policy choices made by elected officials. California, where the most homeless encampments were reported in our study, has acknowledged for a decade that it needs to be building approximately 180,000 units of new housing a year—but has been building less than half of that. Consequently, the *majority* of California renters now pay more than 30 percent of their income on rent, and nearly one third pay more than 50 percent, putting them just one missed paycheck or medical emergency away from eviction and possible homelessness. A recent Florida study found the majority of homeless persons surveyed named medical debt as the primary cause of their homelessness. Because the growth of encampments is primarily due to these other factors than individual character flaws or choices, the most effective responses will be systemic in nature and avoid involving individuals in the criminal justice system unnecessarily.

In the United States, the wealthiest country on earth, encampments of homeless people are unacceptable. But how cities respond to encampments varies widely.



Many communities are responding with punitive law enforcement approaches

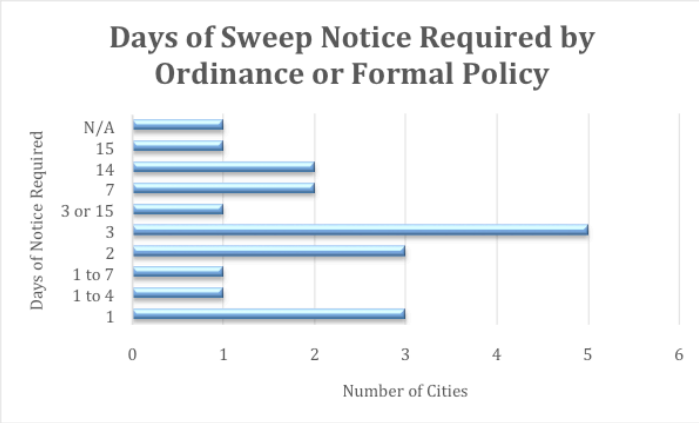
Municipalities often face pressure to "do something" about the problem of visible homelessness. For many cities, the response has been an increase in laws prohibiting encampments and an increase in enforcement. When a city evicts residents of an encampment and clears their belongings, it is often called a "sweep." We surveyed the laws and policies in place in 187 cities across the country (the first attempt at a national survey of formal and informal policies on encampments) and found:

- 33 percent of cities prohibit camping city-wide, and 50 percent prohibit camping in particular public places, increases of 69 percent and 48 percent from 2006-16, respectively.
- 50 percent have either a formal or informal procedure for clearing or allowing encampments. (Many more use trespass or disorderly conduct statutes in order to evict residents of encampments).
- Only five cities (2.7 percent) have some requirement that alternative housing or shelter be offered when a sweep of an encampment is conducted.
- Only 20 (11 percent) had ordinances or formal policies requiring notice prior to clearing encampments. Of those, five can require as little as 24 hours' notice before encampments are evicted, though five require at least a week, and three provide for two weeks or more. An additional 26 cities provided some notice informally, including two providing more than a month.
- Only 20 cities (11 percent) require storage be provided

for possessions of persons residing in encampments if the encampment is evicted. The length of storage required is typically between 30 and 90 days, but ranged from 14 to 120 days.

- Regional analysis found western cities have more formal policies than any other region of the country, and are more likely to provide notice and storage.

While a large and growing number of cities have formal or informal procedures for addressing encampments, relatively few affirmatively provide for the housing and storage needs of the persons living in the encampments.



"I honestly believe that people need to sleep and that people are healthier when they get sleep, they can make better decisions when they get sleep. If at some point in the future, we can have a place where people can go and sleep lawfully, I think that makes great sense. At the same time, [our decision not to enforce the anti-camping ordinance] gives us the opportunity to say, we can't enforce this [ordinance] rigorously when there aren't enough beds or even close to it for people to sleep."

–Andy Mills, Santa Cruz Police Chief

Encampment Evictions are Expensive

Using the criminal justice system and other municipal resources to move people who have nowhere else to go is costly and counter-productive, for both communities and individuals. Honolulu, HI spends $15,000 per week—3/4 of a million dollars a year—sweeping people living in homeless encampments, many of whom simply move around the corner during the sweep and then return a day later. Washington, D.C. spent more than $172,000 in just three months on sweeps. Research shows that housing is the most effective approach to end homelessness with a larger return on investment. Beyond this misuse of resources, sweeping encampments too often harms individuals by destroying their belongings, including their shelter, ID and other important documents, medications, and mementos. More often than not, this leaves the homeless person in a worse position than before, with a more difficult path to exit homelessness. Moreover, sweeps frequently destroy the relationships that outreach workers have built with residents, and that residents have built with each other, again, putting further barriers between residents and permanent housing.

"Did I get arrested? Sure. I had nowhere else to go. They took me to jail, and took away my stuff…I was chased and cited by the city, but I was determined to sleep somewhere...Arrests delayed me getting stabilized for six months."

-Milton Harris, formerly homeless in Sacramento, CA

Other cities spend thousands of dollars on fences, bars, rocks, spikes, and other "hostile" or "aggressive" architecture, deliberately making certain areas of their community inaccessible to homeless persons without shelter. San Diego, CA, recently spent $57,000 to install jagged rocks set in concrete underneath an overpass in advance of the Major League Baseball All-Star game. Other cities, like Chicago, IL, simply fence off areas under bridges to prevent homeless persons from sheltering there. In either case, the money did not reduce the need for people to find shelter but potentially put people at greater vulnerability to exposure and hazards.

To illustrate what criminalization of encampments is like on the ground, we invited some of our local partners to offer examples of punitive, non-constructive approaches.

- **Denver**, **CO**: Law enforcement removed blankets from sleeping people in the middle of the night while the

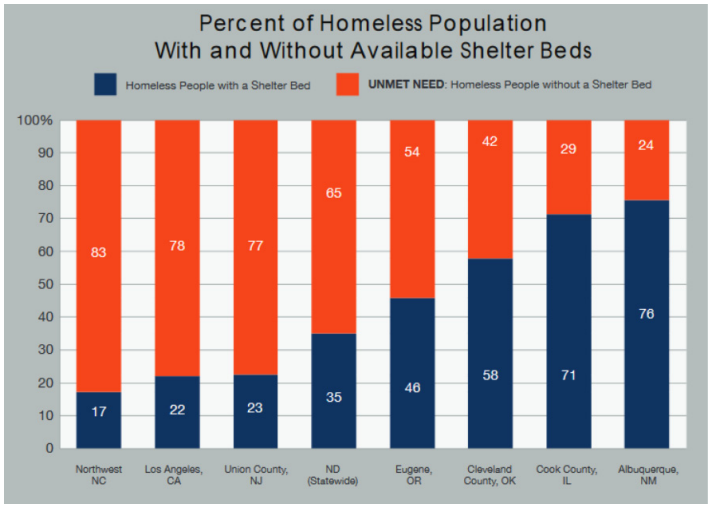
Photo credit: Ben Burgess//Street Sense Media

temperatures were below freezing.

- **San Diego, CA**: The city uses a law intended to keep trash cans off the sidewalk to arrest and jail people who are living outside.
- **Olympia, WA:** The city uses trespass laws to charge people who are sleeping in the woods, despite the fact that there are only 250 shelter beds for at least 800 homeless people.
- **Titusville, FL:** The city dismantled an encampment in 2011 that was home to mostly veterans, destroying irreplaceable items including the ashes of one man's father and the WWII flag that another man's father earned for service in the military.

Law Enforcement Threats Do Not Decrease the Number of People on the Streets

Many communities state they need criminalization ordinances to provide law enforcement with a "tool" to push people to accept services, such as shelter. Conducting outreach backed with resources for real alternatives, however, is the approach that has shown the best, evidence-based results. The 100,000 Homes Campaign found permanent housing for more than 100,000 of the most "service-resistant" chronically homeless individuals across America by listening to their needs and providing appropriate alternatives that actually meet their needs.



Most cities in the United States have insufficient shelter beds for the number of people experiencing homelessness; in some cities, the shortage is stark. So when law enforcement tells residents of encampments to go to a shelter, they risk finding the shelter full. Even where shelter beds are open, they are not always appropriate, or even adequate, for all people. Many shelters are available only to men or only to women; some require children, others do not allow children. Some do not ensure more than one night's stay, requiring daily long waits in line- sometimes far from other alternatives. Other shelters do not allow people to bring in personal belongings, much less store belongings during the day. These restrictions can make it very difficult to hold a job, whether day shift or night shift. Because of nighttime employment or physical disabilities, some people need a place to lie down undisturbed during the day. Congregant settings are not appropriate for all people, providing exposure to germs and noise and lacking privacy. And some shelters require residents to participate in religious activities, while others have time limits, charge money, or have other rules or restrictions that bar groups of people. Very few shelters allow pets. All of these factors may mean that even though a shelter may technically have a bed empty, it may not be actually accessible to an individual living in an encampment.

"I learned from other homeless people that the shelters were usually full, and it wasn't worth the effort to constantly wait in line…Going and seeking out shelter would have meant losing many of my things. I would have to pack a bag and leave everything else behind, trying to hide it in the bushes. I'd be risking a lot of my property just to try to get a shelter space for one night. Plus, with my cancer diagnosis, it felt like it was a health risk for me to go inside. It was cleaner on the street than it was in any of those shelters. In a tent, I could keep my area as clean as I wanted.… Rather than sacrificing my health and my dignity, I focused on moving on and making do with what was stable: a tent.

–Tammy Kohr, formerly homeless in Houston, TX

Encampment Evictions are Not the Best Way to Protect Health & Safety

City officials frequently cite concerns for public health and safety as reasons for sweeps of encampments, but again the cost is high and the impact is either minor or counterproductive. At the extreme are cities like Denver, where law enforcement officers were caught on video pulling blankets off homeless persons in sub-zero temperatures. The Denver Mayor claimed his concern was for the homeless persons: "Urban camping—especially during cold, wet weather—is dangerous and we don't want to see any lives lost on the streets when there are safe, warm places available for people to sleep at night." But Denver has far fewer available shelter beds than homeless people, meaning that the city increased exposure and health risks for vulnerable people instead of decreasing them.

City officials will often highlight the health and safety hazards of open fires, public urination and defecation, and rodent infestation encouraged by litter. While these concerns are valid, sweeps rarely result in improved health or safety. What works is providing access to sanitation facilities and water, regular trash removal, and safe cooking facilities—all things that a city can do that improve the health and safety of all its residents.

Case studies of non-enforcement approaches show promising lessons

This report explores experiments by a number of cities that have adopted approaches other than arbitrary evictions or criminalization, or at least approaches to lessen the number and negative consequences of encampment evictions. These are not all of the possible alternatives, nor do we cover every city that is using a non-enforcement approach. All of the cities highlighted need further improvements in their policies, some even more than others. But each case study seeks to inspire communities by sharing how other cities are addressing concerns about homeless encampments more effectively, more humanely, and at lower cost.

Cities Ending Encampments Through Housing

In 2015, the U.S. Interagency Council on Homelessness published guidance for cities entitled *Ending Homelessness for People Living in Encampments.* As the title implies, it emphasizes that the best approach to ending encampments is to end homelessness for the people living in them. It sets out four basic principles for effectively dealing with encampments:

1. Preparation and Adequate Time for Planning and Implementation
2. Collaboration across Sectors and Systems
3. Performance of Intensive and Persistent Outreach and Engagement
4. Provision of Low-Barrier Pathways to Permanent Housing

"The forced dispersal of people from encampment settings is not an appropriate solution or strategy, accomplishes nothing toward the goal of linking people to permanent housing opportunities, and can make it more difficult to provide such lasting solutions to people who have been sleeping and living in the encampment."

U.S. Interagency Council on Homelessness, *Ending Homelessness for People Living in Encampments* (2015)

This report looks at cities implementing this approach, at least in part:

- **Charleston, SC**, ensured adequate time for planning, outreach, housing and services to close a 100-person encampment through housing most of its residents, without a single arrest.
- **Indianapolis, IN**, adopted an ordinance requiring residents be provided with adequate alternative housing before an encampment can be evicted, and mandates at least 15 days' notice of planned evictions to encampment residents and service providers.
- **Charleston, WV**, settled litigation by adopting an ordinance requiring that encampment evictions cannot proceed unless residents are provided with adequate

alternative housing or shelter, and providing 14 days' notice to encampment residents and service providers of planned evictions, and that storage facilities will be made available for homeless individuals.

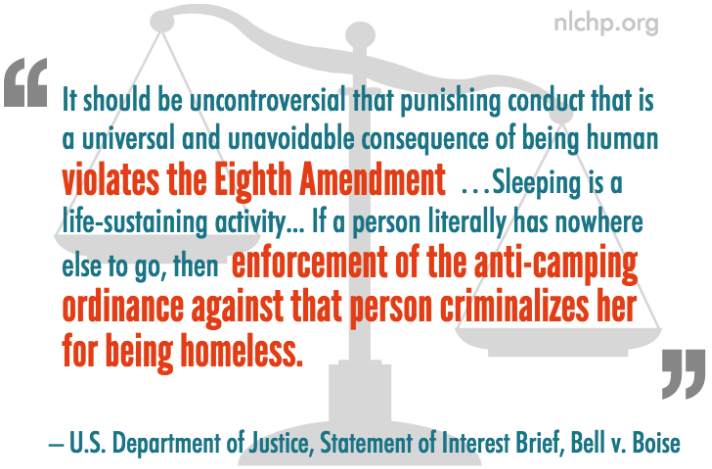
- **Seattle, WA and San Francisco, CA**, both cities proposed, but have not yet passed, ordinances that would improve upon Indianapolis, IN's and Charleston, WV's by ensuring adequate provision for sanitation and hygiene needs in existing encampments, as well as clear notice and provision of adequate housing alternatives and storage in the event of displacement. In 2016, the U.S. Department of Justice analyzed the Seattle proposal and found it to be a constitutional approach that is consistent with federal policy against criminalization.

Putting into law the commitment to closing encampments through housing the individuals living there encourages these communities to take an approach that will permanently end the need for the encampments.

> I know the City is also saying they need to ban tents because our encampment is so dirty. The only reason it's dirty is that people are getting overwhelmed and they don't know what to do with their trash. If the City would give them a solution, they'd use it…. It's not like we can pay for a trash man. The tents themselves are clean. People have their own areas that they generally keep tidy. It's the areas where we leave trash to be picked up that are not clean. It's where we have to go to the bathroom that is not clean. Those problems have nothing to do with the tents, and they can be fixed with solutions other than jail.
>
> –Tammy Kohr, formerly homeless in Houston, TX.

Cities Integrating Encampments as a Step toward Addressing Homelessness

Our survey of 187 cities found only ten of these cities have explicitly permitted some form of legalized camping. Encampments are not an appropriate long term solution to homelessness or the nation's affordable housing crisis. However, in the absence of such solutions—and while we advocate for them—homeless people need a place to sleep, shelter themselves, and store belongings. In order to be successful, legalized encampments require a tremendous amount of planning, consultation, and collaboration with all stakeholders, most especially the homeless residents of the



encampment. In many cases, this time and effort may be better spent developing other interim or permanent housing solutions. However, the following cities, which allow some forms of temporary encampments, may have lessons for others on how to effectively use them to get people closer to adequate housing and avoid subjecting them unnecessarily to the criminal justice system:

- **Las Cruces, NM**, hosts a permanent encampment with a co-located service center.
- **Washington State** permits religious organizations to temporarily host encampments on their property.
- **Vancouver, WA**, permits limited overnight self-sheltering encampments on city property.

In each of the above case studies, we examine, to the extent possible, both the substance of the approach and the means by which each community came to adopt that approach, to assist other communities in implementing similar reforms.

Other Approaches

Although outside the scope of our research for this report, we also mention some approaches that may merit further study. Some cities permit limited safe parking options for those who are living in vehicles, including **Eugene, OR; Los Angeles, CA; San Luis Obispo, CA; Santa Barbara, CA; and San Diego, CA.** Pilot programs in **Seattle, WA and Multnomah County, OR**, have that permit, or even pay for, residents to host tiny homes in back yards to house persons experiencing homelessness.

Courts are increasingly affirming the rights of homeless persons living in encampments

This report reviews relevant case law related to encampments. At the federal level, an increasing number

of courts are applying the First, Fourth, Fifth, Eighth, and Fourteenth Amendments to protect the rights of homeless individuals to perform survival activities in public spaces where adequate alternatives do not exist; the rights of homeless individuals not to be deprived of their liberty or property without due process of law; the due process rights of homeless individuals to travel; and their rights to be free from cruel and unusual punishment. At the state level, the record is more mixed, but lawyers have created some important precedents using principles of estoppel, unclean hands, and necessity. Settlements in cases have generally resulted in minimum notice periods before evictions can take place and requirements for cities to store belongs that are seized, in addition to compensation for the victims of the sweeps and their attorneys. At least one settlement, in Charleston, WV, led to a requirement of providing alternative housing for encampment residents before they can be evicted.

Additionally, we review recent international human rights law developments on the right to adequate housing and prohibitions on criminalization of homelessness, which can provide useful lessons for governments struggling to deal with growing homelessness and encampments.

Successful approaches to encampments all follow certain principles

Based on the case studies and our research to date, as well as relevant domestic and international laws and federal guidance that are reviewed in this report, we found certain key principles and corresponding practices appear to be important for successful interventions to end encampments in our communities—see the chart on the next page.

Beyond these specific recommendations, in order to create the long-term housing solutions communities needed to permanently end encampments, we also encourage individuals and organizations to look at the model policies of the **Housing Not Handcuffs Campaign**. The Campaign, launched in 2016 by the Law Center together with a number of other organizations and now endorsed by over 600 organizations and individuals, provides models for local, state, and federal legislation to shorten homelessness by stopping its criminalization, prevent people from becoming homeless through increased renter protections, and end homelessness through increasing access to deeply affordable housing.

View these policies and endorse the Housing Not Handcuffs Campaign at housingnothandcuffs.org.

Encampment Principles and Practices	
Principle 1: All people need safe, accessible, legal place to be, both at night and during the day, and a place to securely store belongings—until permanent housing is found.	1. Determine the community's full need for housing and services, and then create a binding plan to ensure full access to supportive services and housing affordable for all community members so encampments are not a permanent feature of the community. 2. Repeal or stop enforcing counterproductive municipal ordinances and state laws that criminalize sleeping, camping, and storage of belongings. 3. Provide safe, accessible, and legal places to sleep and shelter, both day and night. Provide clear guidance on how to access these locations. 4. Create storage facilities for persons experiencing homelessness, ensuring they are accessible–close to other services and transportation, do not require ID, and open beyond business hours.
Principle 2: Delivery of services must respect the experience, human dignity, and human rights of those receiving them.	1. Be guided by frequent and meaningful consultation with the people living in encampments. Homeless people are the experts of their own condition. 2. Respect autonomy and self-governance for encampment residents. 3. Offer services in a way that is sensitive and appropriate with regard to race, ethnicity, culture, disability, gender identity, sexual orientation, and other characteristics. Use a trauma-informed approach.
Principle 3: Any move or removal of an encampment must follow clear procedures that protect residents.	Create clear procedures for ending homelessness for people living in pre-existing encampments, including: 1. Make a commitment that encampments will not be removed unless all residents are first consulted and provided access to adequate alternative housing or—in emergency situations—another adequate place to stay. 2. If there are pilot periods or required rotations of sanctioned encampments, ensure that residents have a clear legal place to go and assistance with the transition. Pilot periods or requiring rotation of legal encampments/parking areas on a periodic basis (e.g., annually or semi-annually) can help reduce local "not-in-my-back-yard" opposition, but shorter time periods hinder success. 3. Provide sufficient notice to residents and healthcare/social service workers to be able to determine housing needs and meet them (recommended minimum 30 days, but longer if needed). 4. Assist with moving and storage to enable residents to retain their possessions as they transfer either to housing, shelter, or alternative encampments.
Principle 4: Where new temporary legalized encampments are used as part of a continuum of shelter and housing, ensure it is as close to possible to fully adequate housing.	**1.** Establish clear end dates by which point adequate low-barrier housing or appropriate shelter will be available for all living in the legal encampments. **2.** Protect public health by providing access to water, personal hygiene (including bathrooms with hand washing capability), sanitation, and cooking services or access to SNAPS hot meals benefits. **3.** Provide easy access to convenient 24-hour transportation, particularly if services are not co-located. **4.** Statutes and ordinances facilitating partnerships with local businesses, religious organizations, or non-profits to sponsor, support or host encampments or safe overnight parking lots for persons living in their vehicles can help engage new resources and improve the success of encampments. **5.** Do not require other unsheltered people experiencing homelessness to reside in the encampments if the facilities do not meet their needs.

Principle 5: Adequate alternative housing must be a decent alternative.	1. Ensure that emergency shelters are low-barrier, temporary respites for a few nights while homeless individuals are matched with appropriate permanent housing; they are not long-term alternatives to affordable housing and not appropriate in the short term for everyone. Low-barrier shelter includes the "3 P's"—pets, possessions, and partners, as well as accessible to persons with disabilities or substance abuse problems. 2. Adequate housing must be: a. Safe, stable, and secure: a safe and private place to sleep and store belongings without fear of harassment or unplanned eviction; b. Habitable: with services (electricity, hygiene, sanitation), protection from the elements and environmental hazards, and not overcrowded; c. Affordable: housing costs should not force people to choose between paying rent and paying for other basic needs (food, health, etc.); d. Accessible: physically (appropriate for residents' physical and mental disabilities, close to/transport to services and other opportunities) and practically (no discriminatory barriers, no compelling participation in or subjection to religion).
Principle 6: Law enforcement should serve and protect all members of the community.	1. Law and policies criminalizing homelessness, including those criminalizing public sleeping, camping, sheltering, storing belongings, sitting, lying, vehicle dwelling, and panhandling should be repealed or stop being enforced. 2. Law enforcement should serve and protect encampment residents at their request. 3. Law enforcement officers—including dispatchers, police, sheriffs, park rangers, and private business improvement district security—should receive crisis intervention training and ideally be paired with fully-trained multi-disciplinary social service teams when interacting with homeless populations.

Deborah K. Padgett, Benjamin Henwood, and Sam J. Tsemberis, Housing First: Ending Homelessness,Transforming Systems, and Changing Lives (Oxford, 2015)

Ch. 3 Three Lineages of Homeless Services

Ending homelessness in the 1990s did not happen, but not for lack of trying. The civic response to the crisis was an unprecedented outpouring of public and private funds. The strictures attached to these funds steered efforts in certain directions (and away from others), but they also allowed institutional entrepreneurs and organizations sufficient latitude to address homelessness in differing ways.

In this chapter, we describe three broad forms this service response took, which we call: *extending the mission, advocacy with action,* and *business model* approaches. Each of these approaches is rooted in different but overlapping philosophies of service and each has its own institutional logic. The first is rooted in traditional faith-based charity and philanthropic giving, the second in a manifestation of human rights activism, and the third in representing public–private partnerships infused with business practices. The examples described in this chapter are archetypal, and there are many organizations that draw on elements of more than one approach. Not surprisingly, the presence of multiple logics can introduce volatility and seed change, especially if they are competing or contradictory.

Lineage 1: Extending the Mission

Charitable giving has taken many forms in the United States; religious doctrine has always been a powerful motivator, seeking to reform the destitute and shape their destinies toward becoming productive God-fearing citizens. Among the more visible and impenitent were the men who drank in excess, stumbling on the streets or passed out in doorways. The rescue missions run by religious charities were places to dry out, get a meal, and hear a sermon.

Long-term presence in the skid rows of American cities meant faith-based organizations were among the first to step up in the 1980s, already equipped to operate soup kitchens, food pantries, and small shelters. Many Christian missions and their volunteers were driven by compassion as well as an evangelical impulse. Well-meaning but morality-driven, these religious missions have been small-scale but determined stakeholders in the "homeless industry."

Included in this lineage are the much larger but still charity-driven philanthropic organizations. Generally secular and more broadly defined in purpose, wealthy foundations extend assistance through program development and evaluation, spending private endowments for public welfare. …

Lineage 2: Advocacy with Action

Although missions and foundations did not eschew advocacy, it was not their primary goal. This second lineage represents putting advocacy first. Raising public consciousness and arguing for the human right to housing was no small effort.

Organizations and movements protesting homelessness.

Protest tactics of social activists were well honed by the time of the homelessness crisis, drawing inspiration from a variety of causes from civil rights to feminism to opposition to the Vietnam War. In October 1989, over 250,000 homeless men and women and their supporters marched in Washington, DC at a Housing Now! rally. Newspaper accounts of homeless protests were reported in over 60 U.S. cities during the 1980s with more than 500 protest events in 17 of those cities.

With the prominent exception of the AIDs response, no social movement at the time had as much draw as homeless advocacy.[2]

Movements by or on behalf of the poor are inherently under-resourced—the primary stakeholders have to expend precious energy on top of struggling to survive. Moreover, unlike other social movements such as AIDS advocacy, they rarely attract wealthy benefactors. Thus, it is all the more remarkable that hundreds of thousands turned out to protest homelessness, many of whom were drawn from the ranks of homeless men and women.

Lineage 3: The Advent of the Business Model

As homeless organizations expanded in size and scale, and as private donors and businesses became more influential, business practices were introduced and promoted as important to maintaining solvency. Although profits were not the goal, homeless organizations could presumably benefit from business practices such as monitoring productivity, maintaining quality assurance, and focusing on results. This also made public–private partnerships go more smoothly because both "sides" shared the same language.

The Corporation for Supportive Housing.

The Corporation for Supportive Housing (CSH) began in 1991 as a "middleman" organization extending financial and technical assistance to nonprofits seeking funding to house homeless families and individuals with special needs, including mental illness, HIV/AIDS, and substance abuse. Its founder, Julie Sandorf, was an advocate for the homeless who became inspired by priests at Manhattan's St. Francis Residence who had managed to transform SRO services into full-scale programs including housing for mentally ill parishioners.

Sandorf's admiration for this "extending the mission" approach, combined with her strong ties to foundations, led to the founding of CSH. With grants from the Pew Charitable Trusts, Robert Wood Johnson Foundation and the Ford Foundation, CSH benefited from the surge in availability of funds—and from the need for technical assistance to obtain those funds. CSH filled a niche, acting as a broker to help nonprofits get their share of the pie.

Another entrepreneurial force behind CSH's growth was Carla Javits, daughter of the late U.S. Senator Jacob Javits. Spearheading the West Coast operations of CSH, Javits later became its national President and Chief Executive Officer (CEO), overseeing CSH offices in 10 states. Under Javits, CSH made its mark by targeting the shortage of affordable housing for people with special needs and by developing complex public–private financial packages to build supportive housing for them. Negotiating low-interest loans and managing budgets and project costs were skills CSH offered.

Blurring the Boundaries between Non-profit and For-Profit: The Rise of Social Enterprise in Homeless Services

One variant of the business model approach brought a blending of nonprofit and for-profit within the same organization. The most common version of this involves starting a small business venture within a homeless services program to generate revenue and provide jobs for clients. Common Ground, for example, took advantage of its prime location to invite an ice cream franchise onto its ground floor, stipulating that the owners must hire tenants as workers. Denver's CCH opened pizza parlors where program residents found jobs. Coffee shops and copy centers are also favorite small business start-ups, run and staffed by nonprofits.

Embedding small businesses within a nonprofit organization is a minimalist version of boundary blurring, given that it does not change the essential function or daily operations of the parent organization. At the opposite end of the spectrum are the rare businesses (e.g., Paul Newman's line of salad dressings and food products) whose primary goal is turning over profits to charity. In the middle realm are organizations whose mission is charitable (not-for-profit) but whose operations follow business principles.

The term *social enterprise* is used to refer to this harnessing of business practices for social good as well as profits for shareholders. By drawing wealthy donors deeper into solving fundamental problems like poverty and food insecurity, social enterprises have become a favorite of business leaders seeking social and ethical relevance. Seen as filling gaps left by the heavily bureaucratic public sector and underfunded nonprofit sector, social enterprises are posited as smaller and more responsive to local problems. Initial funds and technical assistance come from wealthy investors; organizational recipients are expected to help the needy and thereby reap "profits" that benefit society. These organizations abide by (and succeed according to) business practices such as accountability and cost–benefit calculations.

Corporate social responsibility has become de rigueur at Harvard's and other business schools where a "double bottom line" is promoted. The rise of social enterprise supplies a more sophisticated and monetized version of the traditional philanthropic giving to charitable causes (recall Lineage #1).

Growing Convergence among the Lineages Over Time

The three lineages set forth in this chapter rested on different logics and philosophies, the oldest of these rooted in traditions of charitable giving, the second arriving on the heels of the protest movements of the 1960s, and the third a response to the surge in public funding as well as the corporatization of the nonprofit world. The lines became blurred, however, as homeless service organizations adapted to changing times and funding streams.

One prime mover of convergence arose from decisions on eligibility for funding. The emphasis on serious mental illness opened the door to state mental health dollars targeted to housing and services. Single adults constituted the most visible group of homeless people. Families—rarely seen living on the streets—were typically placed in temporary hotels or shared apartments. Adolescents were referred to nonprofit organizations that specialized in youth services—specific needs beyond shelter included determining guardianship, ensuring school enrollment, and seeking family reunification.

Single homeless adults were more likely to be male and had a significantly higher incidence of mental illness and addiction than homeless families or youths. In most large U.S. cities, single adult homeless were primarily African American. These demographic characteristics did not inspire a groundswell of sympathy compared with the response to other disabled and impoverished groups (Hopper, 2003). Of three types of disability—developmental, physical, and psychiatric—the first two were given special status in housing and service provision dating back to the early 20th century. Relatively few individuals who were blind, physically handicapped, or had developmental disabilities became homeless given the safety net services available for them. This was far from true for the third group. Persons with a psychiatric disability had (and still have) to prove their eligibility to a psychiatrist–gatekeeper—with varying degrees of accommodation given a lack of diagnostic clarity. Those with addictions are at the bottom of the pecking order of sympathy and disability entitlements.

However, the sight of homeless people visibly suffering from mental illness prompted action at several levels. In New York State, funding for mental health—largely a state responsibility—was supplemented by Federal dollars channeled through SSI, McKinney funds, and rental subsidies from the Department of Housing and Urban Development (HUD). The rationale for seeking funds for housing was simple: a sizeable minority (about one third) of the homeless had a serious mental illness and their mental problems were unlikely to improve while homeless. Rather than "treat and retreat," mental health providers entered the housing business (Houghton, 2001).

And thus a "disability ethos" became one of the bonds reaching across the disparate array of homeless services, along the way cleaving family homelessness from single adult homelessness and adjudicated disability from nonadjudicated disability. By comparison, homeless families were not subject to the same demands for treatment and other demonstrations of housing worthiness, but they faced different obstacles in not having the same access to disability income and housing-plus-services programs.

At the same time, the disability ethos created a labeled class for whom access to services meant accepting a psychiatric diagnosis that held lifelong consequences. The decision to accept disability income and related entitlements along with the potential for stigma and social exclusion was one made with few other options.

National Campaigns to End Homelessness

In 2000, the National Alliance to End Homelessness (NAEH) announced a bold national campaign challenging communities to develop "ten-year plans" to end homelessness. By this point, the so-called epidemic was entering its third decade, and few would disagree that a new approach was needed. NAEH was prepared to lead the way and it had a key ally in Philip Mangano, President Bush's appointee to the U.S. Inter-Agency Council on Homelessness (USICH). A self-described homelessness abolitionist, Mangano arrived in Washington just as the research findings on Pathways Housing First (PHF) were becoming widely known. The Ten Year Plan and its successor (the 100,000 Homes Campaign) were valiant attempts to inject national advocacy and energy into the lumbering bureaucracy surrounding homeless services. In a sign of the times, the 1980s protests and hunger strikes had morphed into sophisticated media-driven campaigns.

The 100,000 (100K) Homes campaign was an ambitious project that galvanized local communities throughout the United States. Ending in July 2014, 100K was featured on national television (the CBS news show "60 Minutes") and garnered international attention. Organized by Community Solutions, Inc. (founded by Rosanne Haggerty), the campaign depended on sophisticated media outreach, coordinated assistance, and buy-in by local homeless providers (many of whom were eager to try something new to jump-start flagging programs and morale).

Growing Convergence: Charity, Advocacy, and Business under One Roof

By the late 1990s, the converging of the three lineages had evolved such that the first two became small players in the larger industry. Rescue missions and soup kitchens continued to exist, but their assistance was stopgap and temporary. Similarly, advocacy groups continued to push for more funding and services, but the heavy lifting at the policy level was taken up by national organizations such as the NAEH and the National Coalition for the Homeless. Advocacy-only groups, dependent on private donations, also faced shortfalls in times of compassion fatigue. Many began to find a place as providers of services, taking advantage of public funds to offer direct services.

Between 1987 and 1993, Congress appropriated 4.2 billion dollars in McKinney-Vento funds for emergency food, shelter, and transitional housing programs as well as demonstration projects in mental health and job training (U.S. Government Accounting Office, 1994). In this climate of expansion, large multipurpose organizations were far more capable of securing grants and contracts for services and remaining self-sustaining via a mix of contracts, grants, donations, tax benefits, and low-interest loans. Enjoying the advantages of scale and diversification, they could produce sophisticated proposals for funding, oversee quality assurance, and assure donors large and small that the money would be responsibly spent.

What did such organizations look like? The bigger ones might have the staircase fully represented: drop-in center, emergency shelter, community residence (an entire building or portion of a building dedicated to congregate living for clients), scattered apartments where clients live two or three per unit, and single occupancy apartments (the ultimate step). Clients might enter at the bottom and work their way up or, if deemed higher functioning at the time of referral, enter at a higher step (only HF gave access to the highest step right away).

A more common approach for the larger-scale organization would be to stay with the middle steps, leaving the lowest to city authorities and private shelters and the highest to the individual's initiative.[3] Larger cities spawned several such organizations. In New York City, Project Renewal, The Bridge, Goddard-Riverside Community Center, Bowery Residents Committee, Common Ground, and Center for Urban Community Services (CUCS) coexisted and competed for city and state contracts. The primary advocacy organization in the city—the Coalition for the Homeless—continued to pursue litigation and produce policy briefs and press releases, but it also added service components such as scatter-site housing for persons with HIV/AIDS, summer camps and after-school programs for homeless children, and emergency rental assistance.

Conclusion: Lineages, Logics, and Paradigm Shifts

Despite diverse beginnings, homeless organizations serving single adults shared an institutional logic invested in the continuum or mainstream model and dependent on funding tied to disability. Homeless families with young children were given more immediate entrée to housing, typically short-term transitional housing that offered few support services.

The three lineages thus evolved. Charities that started out offering free meals or a bed for the night grew into multipurpose operations. Their much larger counterparts—philanthropic foundations—channeled private wealth toward public services. Advocacy groups shifted from protest marches to lawsuits and media campaigns; many also turned to government service contracts to stay solvent. The third lineage, the business model approach, came to subsume but not submerge the other two. Much of this evolution was a response to increases in funding for homeless services and the bureaucratization that accompanied growth and complexity. Close ties to the business community ensured greater access to wealthy donors as well as to expertise in management and accounting.[4]

Program founders and advocates were successful institutional entrepreneurs, garnering support for their organizations and drawing attention to the cause of ending homelessness. All of these individuals and organizations depended upon public funds and private partnerships and all were severely constrained by a level of demand that far exceeded the supply. To the extent that service providers were wedded to the mainstream model, a significant portion of the "demand" was unhappy with the "supply."

Homelessness: Targeted Federal Programs

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Libby Perl, Coordinator
Specialist in Housing Policy
eperl@crs.loc.gov

Eugene Boyd
Analyst in Federalism and Economic Development Policy
eboyd@crs.loc.gov

Johnathan H. Duff
Analyst in Health Policy
jduff@crs.loc.gov

Adrienne L. Fernandes-Alcantara
Specialist in Social Policy
afernandes@crs.loc.gov

Boris Granovskiy
Analyst in Education Policy
bgranovskiy@crs.loc.gov

Elayne J. Heisler
Specialist in Health Services
eheisler@crs.loc.gov

Lisa N. Sacco
Analyst in Illicit Drugs and Crime Policy
lsacco@crs.loc.gov

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The federal government administers a number of programs, through multiple federal agencies, that are targeted to assisting people who are experiencing homelessness by providing housing, services, and supports. Some programs target specific populations, such as veterans and youth, while others serve all people who are homeless. Available assistance may also depend on how programs define "homelessness."

There is no single federal definition of homelessness. A number of programs, including those overseen by the Departments of Housing and Urban Development (HUD), Veterans Affairs (VA), Homeland Security (DHS), and Labor (DOL), use the definition enacted as part of the McKinney-Vento Homeless Assistance Act (P.L. 100-77), as amended. The McKinney-Vento definition largely considers someone to be homeless if they are living in a shelter, are sleeping in a place not meant to be used as a sleeping accommodation (such as on the street or in an abandoned building), or will imminently lose their housing. Definitions for several other programs, such as the Department of Education (ED), are broader, and may consider someone living in a precarious or temporary housing situation to be homeless.

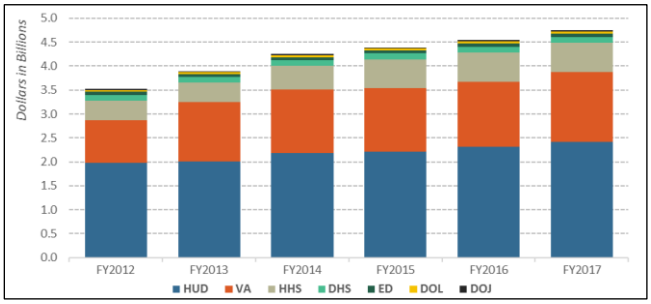
Programs that serve people experiencing homelessness include the Education for Homeless Children and Youths program administered by ED and the Emergency Food and Shelter program, a Federal Emergency Management Agency (FEMA) program run by DHS. The Department of Health and Human Services (HHS) administers several programs that serve homeless individuals, including Health Care for the Homeless, Projects for Assistance in Transition from Homelessness, and the Runaway and Homeless Youth program. The Department of Justice administers a transitional housing program for victims of domestic violence.

HUD administers the Homeless Assistance Grants, made up of grant programs that provide housing and services for homeless individuals ranging from emergency shelter to permanent housing. The VA operates numerous programs that serve homeless veterans. These include Health Care for Homeless Veterans, Supportive Services for Veteran Families, and the Homeless Providers Grant and Per Diem program, as well as a collaborative program with HUD called HUD-VASH, through which homeless veterans receive Section 8 vouchers from HUD and supportive services through the VA. The Department of Labor also operates a program for homeless veterans, the Homeless Veterans Reintegration Program.

The federal government, through the U.S. Interagency Council on Homelessness, has established a goal of ending homelessness among various populations, including families, youth, chronically homeless individuals, and veterans (the VA also has its own goal of ending veteran homelessness). Point-in-time counts of those experiencing homelessness in 2017 show overall reductions among homeless people, as well as reductions among chronically homeless individuals, people in families, and veterans compared to recent years. At the same time, however, homelessness in some parts of the country, particularly areas with high housing costs, has increased.

The chart to the right shows trends in targeted federal homelessness funding, broken down by federal agency, from FY2012-FY2017.

Funding for Select Targeted Federal Homeless Programs



Source: Federal appropriations laws and agency budget justifications.

Contents

Tables

Introduction

Federal assistance targeted to homeless individuals and families was largely nonexistent prior to the mid-1980s. Although the Runaway and Homeless Youth program was enacted in 1974 as part of the Juvenile Justice and Delinquency Prevention Act (P.L. 93-415), the first federal program focused on assisting all homeless people, no matter their age, was the Emergency Food and Shelter (EFS) program, established in 1983 through an emergency jobs appropriation bill (P.L. 98-8). The EFS program was and continues to be administered by the Federal Emergency Management Agency (FEMA) in the Department of Homeland Security (DHS) to provide emergency food and shelter to needy individuals.

In 1987, Congress enacted the Stewart B. McKinney Homeless Assistance Act (P.L. 100-77), which created a number of new programs to comprehensively address the needs of homeless people, including food, shelter, health care, and education. The act was later renamed the McKinney-Vento Homeless Assistance Act (P.L. 106-400) after its two prominent proponents—Representatives Stewart B. McKinney and Bruce F. Vento. The programs authorized in McKinney-Vento include the Department of Housing and Urban Development (HUD) Homeless Assistance Grants, the Department of Labor (DOL) Homeless Veterans Reintegration Program, the Department of Health and Human Services (HHS) Grants for the Benefit of Homeless Individuals and Health Care for the Homeless, and the Department of Education (ED) Education for Homeless Children and Youths program.

The way homelessness is defined largely determines who is served by a particular federal program. This report discusses the definitions of homelessness used by targeted federal homeless programs. In addition, the report describes the current federal programs that provide targeted assistance to homeless individuals and families (other federal programs may provide assistance to homeless individuals but are not specifically designed to assist homeless persons). These include those programs listed above, as well as others that Congress has created since the enactment of McKinney-Vento. In addition, this report discusses federal efforts to end homelessness. Finally, **Table 2** at the end of this report shows funding levels for each of the ED, DHS, HHS, HUD, DOL, and Department of Justice (DOJ) programs that assist homeless individuals. **Table 3** shows funding levels for VA programs.

The Federal Response to Homelessness

Homelessness in the United States has always existed, but it did not come to the public's attention as a national issue until the 1970s and 1980s, when the characteristics of the homeless population and their living arrangements began to change. Throughout the early and middle part of the 20th century, homelessness was typified by "skid rows": areas with hotels and single-room occupancy dwellings where transient single men lived.[1] Skid rows were usually removed from the more populated areas of cities, and it was uncommon for individuals to actually live on the streets.[2] Beginning in the 1970s, however, the homeless population began to grow and become more visible to the general public. According to studies from the time, homeless persons were no longer almost exclusively single men, but included women with children; their median age was younger; they were more racially diverse (in previous decades, the observed homeless population

[1] Peter H. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: The University of Chicago Press, 1989), pp. 20-21, 27-28.

[2] Ibid., p. 34.

was largely white); they were less likely to be employed (and therefore had lower incomes); they were mentally ill in higher proportions than previously; and individuals who were abusing or had abused drugs began to become more prevalent in the population.[3]

A number of reasons have been offered for the growth in the number of homeless persons and their increasing visibility. Many cities demolished skid rows to make way for urban development, leaving some residents without affordable housing options.[4] Other possible factors contributing to homelessness include the decreased availability of affordable housing generally, the reduced need for seasonal unskilled labor, the reduced likelihood that relatives will accommodate homeless family members, the decreased value of public benefits, and changed admissions standards at mental hospitals.[5] The increased visibility of homeless people was due, in part, to the decriminalization of actions such as public drunkenness, loitering, and vagrancy.[6]

In the 1980s, Congress first responded to the growing prevalence of homelessness with several separate grant programs designed to address the food and shelter needs of homeless individuals. These programs included the Emergency Food and Shelter Program (P.L. 98-8), the Emergency Shelter Grants Program (P.L. 99-591), and the Transitional Housing Demonstration Program (P.L. 99-591).[7] In 1983, a Federal Interagency Task Force on Food and Shelter for the Homeless was created to coordinate the federal response to homelessness. Among its activities was making vacant federal properties available as shelters.[8]

Congress began to consider comprehensive legislation to address homelessness in 1986. On June 26, 1986, H.R. 5140 and S. 2608 were introduced as the Homeless Persons' Survival Act to provide an aid package for homeless persons. No further action was taken on either measure, however. Later that same year, legislation containing Title I of the Homeless Persons' Survival Act—emergency relief provisions for shelter, food, mobile health care, and transitional housing—was introduced as the Urgent Relief for the Homeless Act (H.R. 5710). The legislation passed both houses of Congress in 1987 with large bipartisan majorities. The act was renamed the Stewart B. McKinney Homeless Assistance Act after the death of its chief sponsor, Stewart B. McKinney of Connecticut; it was renamed again on October 30, 2000, as the McKinney-Vento Homeless Assistance Act after the death of another prominent sponsor, Bruce F. Vento of Minnesota. In 1987, President Ronald Reagan signed the act into law (P.L. 100-77).

The original version of the McKinney-Vento Act consisted of 15 programs either created or reauthorized by the act, providing an array of services for homeless persons and administered by various federal agencies. The act also established the United States Interagency Council on Homelessness, which is designed to provide guidance on the federal response to homelessness through the coordination of the efforts of multiple federal agencies covered under the McKinney-Vento Act. Since the enactment of the McKinney-Vento Homeless Assistance Act, there have been some legislative changes to programs and services provided under the act and new programs that target homeless individuals have been created. Specific programs covered under the McKinney-Vento Act, as well as other federal programs responding to homelessness, are discussed in this report.

[3] Ibid., pp. 39-44.

[4] Ibid., p. 33.

[5] Ibid., pp. 181-194, 41. See also Martha Burt, *Over the Edge: The Growth of Homelessness in the 1980s* (New York: Russell Sage Foundation, 1992), pp. 31-126.

[6] Down and Out in America, p. 34; Over the Edge, p. 123.

[7] All three programs were incorporated into the McKinney-Vento Homeless Assistance Act in 1987. (The Transitional Housing Demonstration Program was renamed the Supportive Housing Demonstration Program.)

[8] See U.S. Congress, House Committee on Government Operations, Subcommittee on Intergovernmental Relations and Human Resources, *The Federal Response to the Homeless Crisis*, hearing, 98th Cong., 2nd sess., October 3, 1984, p. 205.

Efforts to End Homelessness

For nearly 10 years, since 2009, agencies within the federal government have focused on ending homelessness among all people experiencing it by focusing on specific populations, including veterans, families with children, youth, and people considered chronically homeless. However, efforts to bring about an end to homelessness began almost 20 years ago, when the concept was

[53] See U.S. Department of Veterans Affairs, *VHA Directive 1162.06, Veterans Justice Programs,* September 27, 2017, https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=5473.

[54] 38 U.S.C. §2062.

[55] 38 U.S.C. §8161 et seq.

introduced in a report from the National Alliance to End Homelessness (NAEH), which outlined a strategy to end homelessness in 10 years.[56] The plan included four recommendations: developing local, data-driven plans to address homelessness; using mainstream programs (such as Temporary Assistance for Needy Families, Section 8, and Supplemental Security Income) to prevent homelessness; employing a housing first strategy to assist most people who find themselves homeless; and developing a national infrastructure of housing, income, and service supports for low-income families and individuals.

While the idea of ending homelessness for all people was embraced by many groups, the George W. Bush Administration and federal government focused on ending homelessness among chronically homeless individuals specifically. Initially, the term "chronically homeless" only included single, unaccompanied individuals. The term was defined as "an unaccompanied homeless individual with a disabling condition who has been continually homeless for a year or more, or has had at least four episodes of homelessness in the past three years."[57] The HEARTH Act updated the definition to include families with a head of household who has a disability.[58]

In the year following the release of the NAEH report, then-HUD Secretary Martinez announced HUD's commitment to ending chronic homelessness at the NAEH annual conference. In 2002, as a part of his FY2003 budget, President Bush made "ending chronic homelessness in the next decade a top objective." The bipartisan, congressionally mandated Millennial Housing Commission, in its Report to Congress in 2002, included ending chronic homelessness in 10 years among its principal recommendations.[59] And, by 2003, the United States Interagency Council on Homelessness (USICH) had been re-engaged after six years of inactivity and was charged with pursuing the President's 10-year plan.[60] For the balance of the decade, multiple federal initiatives focused funding and efforts on this goal.

However, the initiative to end chronic homelessness raised some concerns among advocates for homeless people that allocating resources largely to chronically homeless individuals is done at the expense of families with children who are homeless, homeless youth, and other vulnerable populations.[61] When it was enacted in 2009, the HEARTH Act mandated that the USICH draft a Federal Strategic Plan to End Homelessness among all groups (families with children, unaccompanied youth, veterans, and chronically homeless individuals) within a year of the law's enactment, and to update the plan annually. In addition to the USICH plan, in November 2009 the VA announced a plan to end homelessness among veterans within five years. These plans—to end chronic homelessness, to end homelessness generally, and to end veterans' homelessness—are described below. Further, **Table 1**, following the descriptions of plans to end homelessness, presents numbers of homeless people, including people in families, veterans, and those experiencing chronic homelessness.

[56] National Alliance to End Homelessness, *A Plan: Not a Dream. How to End Homelessness in Ten Years*, June 1, 2000, http://www.endhomelessness.org/files/585_file_TYP_pdf.pdf.

[57] 24 C.F.R. §91.5.

[58] 42 U.S.C. §11360(2).

[59] The report is available at http://govinfo.library.unt.edu/mhc/MHCReport.pdf. See pp. 54-56.

[60] The Interagency Council on Homelessness (ICH) was created in 1987 in the Stewart B. McKinney Homeless Assistance Act, P.L. 100-77. Its mission is to coordinate the national response to homelessness. The ICH is composed of the directors of 19 federal departments and agencies whose policies and programs have some responsibility for homeless services, including HUD, HHS, DOL, and the VA.

[61] See, for example, the House Financial Services Committee, Subcommittee on Housing and Community Opportunity, *Hearing on Reauthorization of the McKinney-Vento Homeless Assistance Act, Part II*, 110th Cong., 2nd sess., October 16, 2007, http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:39908.pdf.

The Chronic Homelessness Initiative

In 2002, the George W. Bush Administration established a national goal of ending chronic homelessness within 10 years, by 2012. An impetus behind the initiative to end chronic homelessness is that chronically homeless individuals were estimated to account for about 10% of all users of the homeless shelter system, but are estimated to use nearly 50% of the total days of shelter provided.[62] (For more information about research surrounding chronic homelessness and permanent supportive housing, see CRS Report R44302, *Chronic Homelessness: Background, Research, and Outcomes*.)

Permanent supportive housing is generally seen as a solution to ending chronic homelessness. It consists of housing, paired with social services, available to low-income and/or homeless households. Services can include case management, substance abuse counseling, mental health services, income management and support, and life skills services. A model of permanent supportive housing called "housing first" offers homeless individuals with addictions and mental health issues immediate access to housing even if they have not participated in treatment. Instead, the housing first model offers counseling and treatment services to clients on a voluntary basis rather than requiring sobriety or adherence to psychiatric medication treatment. It also stresses the importance of resident choice about where to live and the type and intensity of services, with services structured to fit individual resident needs. In the late 1990s, research began to show that finding housing for homeless individuals with severe mental illnesses meant that they were less likely to be housed temporarily in public accommodations, such as hospitals, jails, or prisons.[63] Based on the research, service providers and HUD began to devote resources to housing first initiatives.

The Administration undertook several projects to reach its goal of ending chronic homelessness within 10 years, each of which took place during the mid-2000s. These included (1) a collaboration among HUD, HHS, and VA (the *Collaborative Initiative to Help End Chronic Homelessness*) that funded housing and treatment for chronically homeless individuals; (2) a HUD and DOL project called *Ending Chronic Homelessness through Employment and Housing*, through which HUD funded permanent supportive housing and DOL offered employment assistance; and (3) a HUD pilot program called *Housing for People Who Are Homeless and Addicted to Alcohol* that provided supportive housing for chronically homeless persons.

In addition, since FY2005, HUD has encouraged the development of housing for chronically homeless individuals in the way that it distributes the Homeless Assistance Grants to applicants through its annual grant competition. For example, HUD has set aside additional funding for projects that serve those experiencing chronic homelessness. In addition, HUD's Continuum of Care program requires that at least 30% of funds (not including those for permanent housing renewal contracts) are to be used to provide permanent supportive housing to individuals with disabilities or families with an adult head of household (or youth in the absence of an adult) who has a disability. While homeless people with disabilities need not have been homeless for the duration required for chronic homelessness, there is overlap in the populations. The requirement for permanent supportive housing is to be reduced proportionately as communities increase permanent housing units for those individuals and families, and it will end when HUD determines

[62] Randall Kuhn and Dennis Culhane, "Applying Cluster Analysis to Test a Typology of Homelessness by Pattern of Shelter Utilization: Results from the Analysis of Administrative Data," *American Journal of Community Psychology*, vol. 26, no. 2 (April 1998), p. 219.

[63] See Dennis Culhane, Stephen Metraux, and Trevor Hadley, "Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing," *Housing Policy Debate*, vol. 13, no. 1 (2002): 107-163.

that a total of 150,000 permanent housing units have been provided for homeless persons with disabilities since 2001.

The U.S. Interagency Council on Homelessness Federal Strategic Plan to Prevent and End Homelessness

The HEARTH Act, enacted on May 20, 2009 as part of the Helping Families Save Their Homes Act (P.L. 111-22), charged the U.S. Interagency Council on Homelessness (USICH) with developing a National Strategic Plan to End Homelessness. The HEARTH Act specified that the plan should be made available for public comment and submitted to Congress and the President within one year of the law's enactment.

The USICH released its report, entitled *Opening Doors*, in 2010. The plan set out goals of ending chronic homelessness as well as homelessness among veterans within the next five years and ending homelessness for families, youth, and children within the next 10 years. USICH updated the plan several times in subsequent years. The 2015 version expanded on what it means to end homelessness. It does not mean that homelessness will never occur, but rather that it should be "rare, brief, and non-recurring."[64] Specifically, communities should

- be able to identify people experiencing and at risk of homelessness;
- prevent and divert people from homelessness;
- provide immediate access to shelter and services while working to obtain permanent housing; and
- quickly connect people to housing and services when homelessness occurs.

The 2018 update to the USICH plan was retitled *Home, Together*.[65] The plan continues the goals of ending homelessness among specific populations, but it does not include time limits. The report includes six areas of increased focus—affordable housing, homelessness prevention and diversion, unsheltered homelessness, rural communities, employment, and learning from people who have experienced homelessness.[66]

The Department of Veterans Affairs Plan to End Homelessness

On November 3, 2009, the VA announced a plan to end homelessness among veterans within five years, by the end of 2015.[67] While the VA did not reach its goal to end homelessness within the time period, it has continued to work toward reducing veteran homelessness, acknowledging in 2017 that ending veteran homelessness may still be a "multi-year process."[68] Similar to the USICH plan, an end to veteran homelessness, according to the VA, means that communities will identify all veterans experiencing homelessness, be able to provide shelter immediately for

[64] U.S. Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness, As Amended In 2015,* June 2015, https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.

[65] U.S. Interagency Council on Homelessness, *Home, Together: The Federal Strategic Plan to Prevent and End Homelessness,* July 19, 2018, https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.

[66] Ibid., p. 4.

[67] See U.S. Department of Veterans Affairs, "Secretary Shinseki Details Plan to End Homelessness for Veterans," press release, November 3, 2009, http://www1.va.gov/OPA/pressrel/pressrelease.cfm?id=1807.

[68] Jennifer McDermott, "New VA head: It'll take longer to end veteran homelessness," *Associated Press,* May 11, 2017.

veterans who want it, be able to help veterans move quickly into permanent housing, and have the capacity to help veterans who fall into homelessness in the future.[69]

The VA has not released a formal written plan to end homelessness. Instead, beginning with the FY2011 budget, VA budget documents have outlined ways in which it will pursue the goal of ending homelessness.[70]

Numbers of People Experiencing Homelessness

In the years since USICH and the VA announced efforts to end homelessness, there have been reductions in the overall number of people experiencing homelessness according to HUD's point-in-time counts, as well as in specific populations—people in families with children, veterans, and chronically homeless individuals. However, some communities, particularly in urban areas with growing housing costs, have seen an increase in the number of people experiencing homelessness over the same time period. Among those that have drawn attention for rising numbers of homeless people are Los Angeles City and County, which saw homelessness increase by 66% between 2010 and 2017, Seattle and King County (29%), New York (44%), and Honolulu (69%).[71]

See **Table 1** for point-in-time counts of people experiencing homelessness since 2007. For more information on HUD counts and estimates, see CRS In Focus IF10312, *How Many People Experience Homelessness?*

Table 1. Point-in-Time Counts of People Experiencing Homelessness

(Total and select subpopulations)

				Chronically Homeless	
Year	All Homeless People	People in Families with Children[a]	Veterans	Individuals	People in Families[b]
2007	647,258	234,558	—	119,813	—
2008	639,784	235,259	—	120,115	—
2009	630,227	238,096	73,367	107,212	—
2010	637,077	241,937	74,087	106,062	—
2011	623,788	236,175	65,455	103,522	—
2012	621,553	239,397	60,579	96,268	—
2013	590,364	222,190	55,619	86,289	16,539

[69] U.S. Department of Veterans Affairs, *FY2018 Budget Justifications, Volume II, Medical Programs and Information Technology Programs*, pp. VHA-152 to VHA-153, https://www.va.gov/budget/docs/summary/fy2019VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[70] See, for example, *FY2019 VA Budget Justifications, Volume 2 Medical Programs and Information Technology Programs*, p. VHA-158, https://www.va.gov/budget/docs/summary/fy2019VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[71] See HUD point-in-time count data by Continuum of Care, available at https://www.hudexchange.info/resource/5639/2017-ahar-part-1-pit-estimates-of-homelessness-in-the-us/. Various news reports have noted the growing numbers of homeless people in these communities. See, for example, Gale Holland, "L.A.'s homelessness surged 75% in six years. Here's why the crisis has been decades in the making," *Los Angeles Times*, February 1, 2018; Vernal Coleman, "Annual homeless count reveals more people sleeping outside than ever before ," *Seattle Times*, May 31, 2018; Mara Gay, "NYC Rise in Homeless is One of the Biggest in the U.S.," *Wall Street Journal*, December 6, 2017; and Dan Nakaso, "Most see homeless problem getting worse," *Honolulu Star Advisor*, March 26, 2018.

Year	All Homeless People	People in Families with Children[a]	Veterans	Chronically Homeless	
				Individuals	People in Families[b]
2014	576,450	216,261	49,689	83,989	15,143
2015	564,708	206,286	47,725	83,170	13,105
2016	549,928	194,716	39,471	77,486	8,646
2017	553,742	184,661	40,056	86,962	8,457

Source: Data from 2007 through 2015 are taken from the HUD Annual Homeless Assessment Report, https://www.hudexchange.info/resources/documents/2015-AHAR-Part-1.pdf. Data from 2016 thereafter are taken from subsequent Annual Homeless Assessment Reports, available at https://www.hudexchange.info/programs/hdx/guides/ahar/#reports.

Notes: Point-in-time counts are conducted by local communities and are to take place during one day in January each year. Therefore, the counts are a snapshot of the number of people who are homeless on a given day. They do not represent the total number of people who experience homelessness over the course of a year.

a. Families with children are households with at least one adult and one child.

b. HUD began reporting chronically homeless people in families as part of the 2013 point-in-time count.

RAPID RE-HOUSING
RRH

FACT SHEET: HOUSING FIRST

APRIL 2016

National Alliance to End Homelessness

WHAT IS HOUSING FIRST?

Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life. This approach is guided by the belief that people need basic necessities like food and a place to live before attending to anything less critical, such as getting a job, budgeting properly, or attending to substance use issues. Additionally, Housing First is based on the theory that client choice is valuable in housing selection and supportive service participation, and that exercising that choice is likely to make a client more successful in remaining housed and improving their life.[i]

HOW IS HOUSING FIRST DIFFERENT FROM OTHER APPROACHES?

Housing First does not require people experiencing homelessness to address the all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. Housing First does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage.[ii] Other approaches do make such requirements in order for a person to obtain and retain housing.

WHO CAN BE HELPED BY HOUSING FIRST?

A Housing First approach can benefit both homeless families and individuals with any degree of service needs. The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. As such, a Housing First approach can be applied to help end homelessness for a household who became homeless due to a temporary personal or financial crisis and has limited service needs, only needing help accessing and securing permanent housing. At the same time, Housing First has been found to be particularly effective approach to end homelessness for high need populations, such as chronically homeless individuals.[iii]

WHAT ARE THE ELEMENTS OF A HOUSING FIRST PROGRAM?

Housing First programs often provide rental assistance that varies in duration depending on the household's needs. Consumers sign a standard lease and are able to access supports as necessary to help them do so. A variety of voluntary services may be used to promote housing stability and well-being during and following housing placement.

Two common program models follow the Housing First approach but differ in implementation. Permanent supportive housing (PSH) is targeted to individuals and families with chronic illnesses, disabilities, mental health issues, or substance use disorders who have experienced long-term or repeated homelessness. It provides longterm rental assistance and supportive services.

A second program model, rapid re-housing, is employed for a wide variety of individuals and

families. It provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and remain housed. The Core Components of rapid re-housing—housing identification, rent and move-in assistance, and case management and services—operationalize Housing First principals.

DOES HOUSING FIRST WORK?

There is a large and growing evidence base demonstrating that Housing First is an effective solution to homelessness. Consumers in a Housing First model access housing faster[iv] and are more likely to remain stably housed.[v] This is true for both PSH and rapid re-housing programs. PSH has a long-term housing retention rate of up to 98 percent.[vi] Studies have shown that rapid re-housing helps people exit homelessness quickly—in one study, an average of two months[vii]—and remain housed. A variety of studies have shown that between 75 percent and 91 percent of households remain housed a year after being rapidly re-housed.[viii]

More extensive studies have been completed on PSH finding that clients report an increase in perceived levels of autonomy, choice, and control in Housing First programs. A majority of clients are found to participate in the optional supportive services provided,[ix] often resulting in greater housing stability. Clients using supportive services are more likely to participate in job training programs, attend school, discontinue substance use, have fewer instances of domestic violence,[x] and spend fewer days hospitalized than those not participating.[xi]

Finally, permanent supportive housing has been found to be cost efficient. Providing access to housing generally results in cost savings for communities because housed people are less likely to use emergency services, including hospitals, jails, and emergency shelter, than those who are homeless. One study found an average cost savings on emergency services of $31,545 per person housed in a Housing First program over the course of two years.xii Another study showed that a Housing First program could cost up to $23,000 less per consumer per year than a shelter program.[xiii]

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[i]Tsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000.
[ii]Einbinder, S. & Tull, T. The Housing First Program for Homeless Families: Empirical Evidence of Long-term Efficacy to End and Prevent Family Homelessness. 2007.
[iii]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes. 2003.
[iv]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First programs. 2003.
vTsemberis, S. & Eisenberg, R. Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities. 2000.
[vi]Montgomery, A.E., Hill, L., Kane, V., & Culhane, D. Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-VASH. 2013.
[vii]U.S. Department of Housing and Urban Development. Family Options Study: Short-Term Impacts. 2015.
[viii]Byrne, T., Treglia, D., Culhane, D., Kuhn, J., & Kane, V. Predictors of Homelessness Among Families and Single Adults After Exit from Homelessness Prevention and Rapid Re-Housing Programs: Evidence from the Department of Veterans Affairs Supportive Services for Veterans Program. 2015.
[ix]Tsemberis, S., Gulcur, L., & Nakae, M. Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis. 2004.
[x]Einbinder, S. & Tull, T. The Housing First Program for Homeless Families: Empirical Evidence of Long-term Efficacy to End and Prevent Family Homelessness. 2007.
[xi]Gulcur, L., Stefancic, A., Shinn, M., Tsemberis, S., & Fishcer, S. Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First programs. 2003.
[xii]Perlman, J. & Parvensky, J. Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report. 2006.
[xiii]Tsemberis, S. & Stefancic, A. Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention. 2007.

Nicholas Pleace, Housing First Guide: Europe (2016)

1.1. Introducing Housing First

Housing First is probably the **single most important innovation in homelessness service design** in the last 30 years. Developed by **Dr. Sam Tsemberis** in New York, the Housing First model has proven very **successful in ending homelessness among people with high support needs** in the USA and Canada and in several European countries.

Housing First is designed for people who need *significant* levels of help to enable them to leave homelessness. Among the groups who Housing First services can help are people who are homeless with severe mental illnesses or mental health problems, homeless people with problematic drug and alcohol use, and homeless people with poor physical health, limiting illness and disabilities. Housing First services have also proven effective with people who are experiencing long-term or repeated homelessness who, in addition to other support needs, often lack social supports, i.e. help from friends or family and are not part of a community. In the United States and Canada, Housing First programmes are also used with homeless families and young people.

Housing First uses housing as a *starting point* rather than an *end goal*. Providing housing is what a Housing First service does before it does anything else, which is why it is called *'Housing First'*. A Housing First service is able to focus immediately on enabling someone to successfully live in their own home as part of a community. Housing First is also focused on improving the health, well-being and social support networks of the homeless people it works with. This is very different from homelessness services that try make homeless people with high support needs 'housing ready' *before* they are rehoused. Some existing models of homelessness services require someone to show sobriety and, engagement with treatment and to be trained in living independently before housing is provided for them. In these types of homelessness service, housing happens ***'last'***.

Housing First is designed to ensure homeless people have a high degree of choice and control. Housing First service users are *actively encouraged* to minimise harm from drugs and alcohol and to use treatment; they are *not required* to do so. Other homelessness services, such as staircase services, often *require* homeless people to use treatment and to abstain from drugs and alcohol, before they are allowed access to housing and may also remove someone from housing if they do not comply with treatment or do not show abstinence from drugs and alcohol.

In the USA, Canada and in Europe, **research shows that Housing First generally ends homelessness for at least eight out of every ten people.** Success has also been reported with diverse groups of homeless people. Housing First has worked very well for people who are not well integrated in society after long-term or repeated homelessness, homeless people with severe mental illness and/or problematic drug and alcohol use and homeless people with poor physical health.

Housing First in Europe can be described as following eight core principles. These core principles are very closely based on those developed by Dr. Sam Tsemberis, who created the first Housing First service in New York in the early 1990s. These principles were defined in consultation with Dr. Tsemberis and the advisory board for this Guide.

Eight core principles:

Housing is a human right

Choice and control for service users

Separation of housing and treatment

Recovery orientation

Harm reduction

Active engagement without coercion

Person-centred planning

Flexible Support for as Long as is Required

Operating within these core principles, Housing First pursues a range of service priorities, which include offering help with sustaining a suitable home and with improving health, well-being and social integration. Housing First is designed to provide opportunities to access treatment and help with integration into a community. There is also the option to get help with strengthening social supports and with pursuing rewarding opportunities, such as arts-based activities, education, training and paid work.

1.2. The History of Housing First

Housing First was developed by Dr. Sam Tsemberis, at Pathways to Housing in New York, in the early 1990s. **Housing First was originally developed to help people with mental health problems who were living on the streets;** many of whom experienced frequent stays in psychiatric hospitals. The target populations entering Housing First later grew to include people making long stays in homelessness shelters and those at risk of homelessness who were discharged from psychiatric hospitals, or released from prison. With some modification to the support services, Housing First services are now also used with families and young people who are homeless in North America.

Before Housing First, permanent housing with support was only offered to homeless people in North America after they had graduated from a series of steps that began with treatment and sobriety. Each step on this 'staircase' was designed to prepare someone for living independently in their own home. When all the steps were complete, a formerly homeless person with mental health problems was meant to be 'housing ready' because they had been 'trained' to live independently. These types of services are sometimes called 'staircase', 'linear residential treatment' or 'treatment-led approaches'.

These 'staircase' services and the 'housing readiness' culture had originally arisen from practice in North American psychiatric hospitals, where individuals with a diagnosis of severe mental illness were initially considered incapable of functioning in all areas of life and needed around-the-clock supervision and support. By the 1980s, North American mental health professionals were raising serious questions about

the effectiveness of services based on these assumptions about severe mental illness. However, a staircase approach became firmly established as the model for helping homeless people with high needs in North America.

The staircase approach for homeless people had three goals:

- Training people to live in their own homes after being on the streets or in and out of hospitals.
- Making sure someone was receiving treatment and medication for any ongoing mental health problems.
- Making sure someone was not involved in behaviour that might put their health, well-being and housing stability at risk, particularly that they were not making use of drugs and alcohol (sobriety).

During the 1990s, it started to become clear that staircase services for individuals with psychiatric diagnoses, especially those with co-occurring addiction problems, were not always working very effectively. There were three main problems:

- Service users became 'stuck' in staircase services, because they could not always manage to complete all the tasks necessary to move between one step and the next.
- Service users were often evicted from temporary and permanent housing because of strict rules, such as requirements for total abstinence from drugs and alcohol and being required to participate in psychiatric treatment.
- There were worries about whether staircase services were setting unattainable standards in the requirements they placed on people, i.e. service users were expected to behave more correctly than other people; they were required to be a 'perfect' citizen, rather than an ordinary citizen.

North American 'supported housing' services, developed as an alternative to staircase services, had a different approach. Former psychiatric patients were immediately, or very quickly, given ordinary housing in ordinary communities and received flexible help and treatment from mobile support teams, within a framework where the service user had a lot of choice and control. Support was provided for as long as was needed.

'Supported housing' services in North America did not require abstinence from drugs or alcohol, and they did not expect full engagement with treatment as a condition for being housed. Giving former psychiatric patients far more choice about how they lived their lives, while encouraging positive changes and providing help when it was asked for, was found to be more effective than a staircase approach. **This supported housing model was the basis for Housing First.**

However, as homelessness began to increase, services for homeless people often continued to use the stairway model, because that was still consistent with the predominant mental health services model in the USA. As most of those who were on the streets - the visibly homeless - were thought to have very high rates of severe mental illness, it seemed reasonable to use the traditional mental health services approach that had often been used by psychiatric hospitals. Most homelessness services therefore followed the staircase model. In Europe too, homelessness services had been designed according to a staircase approach, which saw housing as the end goal rather than as the first step in ending homelessness.

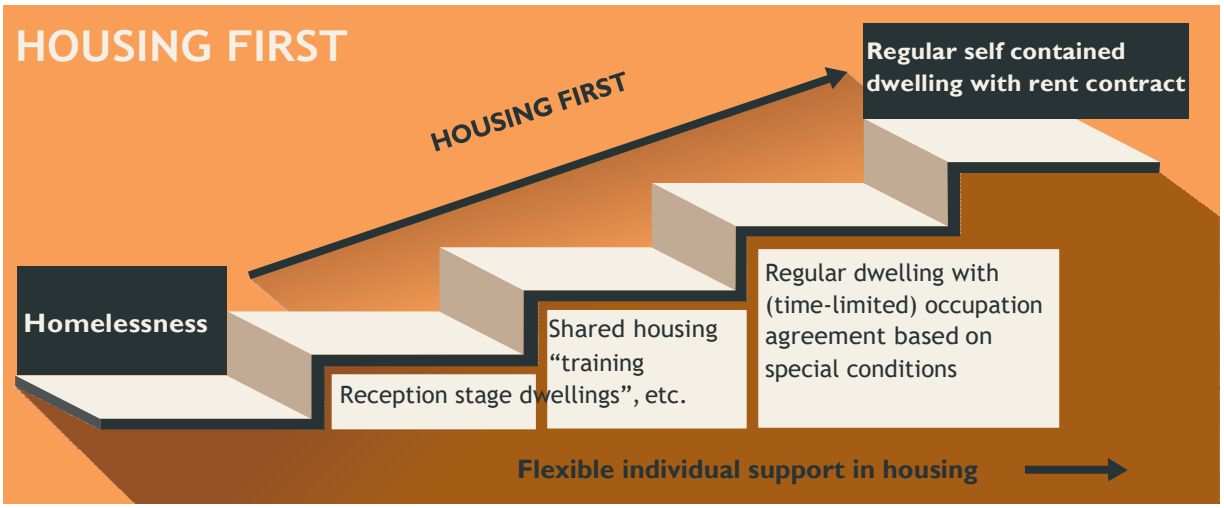
Research on staircase homelessness services reported similar problems to those identified in staircase mental health services. In particular:

- Homeless people became 'stuck', unable to complete the steps that they were expected to follow to be rehoused.
- Staircase services were abandoned by homeless people who did not like or could not follow the strict rules.

- There were concerns about the ethics of some staircase services - particularly a tendency to view homelessness as the result of someone's character flaws - with homeless people being blamed for causing their own homelessness.
- Staircase services could be harsh environments for homeless people.
- Costs were high, but the effectiveness of staircase services was often limited.

Building on the supported housing model, Housing First, as developed by Dr. Sam Tsemberis in New York, was focused on homeless people with a severe mental illness. Housing was provided *'first'* rather than, as in the staircase model, *'last'*. **Housing First offered rapid access to a settled home in the community, combined with mobile support services that visited people in their own homes.** There was **no requirement to stop drinking or using drugs and no requirement to accept treatment in return for housing.** Housing was not removed from someone if their drug or alcohol use did not stop, or if they refused to comply with treatment. If a person's behaviour or support needs resulted in a loss of housing, Housing First would help them find another place to live and then continue to support them for as long as was needed.

Rather than being required to accept treatment or complete a series of 'steps' to access housing, someone in a Housing First service leaps *over* the steps and goes *straight* into housing. Mobile support is then provided to help Housing First service users to sustain their housing and promote their health and well-being and social integration, within a framework that gives service users a high degree of choice and control (Figure 1).



In the late 1990s, pioneering American social research by Dennis P. Culhane and colleagues showed there was **a small group of people with very high needs, who made long-term and repeated use of homelessness services, yet whose homelessness was never resolved.** Staircase services were found not to be performing well in ending this long-term ("chronic" and "episodic") homelessness, which was being found to be very damaging to the health and well-being of the people experiencing it. Housing First, which research showed had been successful in New York, could, in contrast, end long-term homelessness at a much higher rate than staircase services. **The systematic use of comparative research, demonstrating Housing First in comparison with other homelessness services, encouraged wider use of Housing First throughout the USA and attracted attention from the Federal government.**

Importantly, **there was also an economic case for Housing First. This case centred on the relatively high cost of frequent hospitalisation and incarceration associated with long-term homelessness,** i.e. long-term homeless people often made frequent use of emergency medical services, had high rates of contact with mental health services and could often have contact with the criminal justice system. As they did not resolve long-term homelessness in many cases, staircase programmes started to be seen as not cost-efficient, especially because the staircase services themselves were also relatively expensive.

Research was showing that Housing First could potentially deliver significantly better results, for a lower level of spending, than staircase services. Comparatively, Housing First cost significantly less than other services. Figures from Pathways to Housing show programme costs of $57 per night, compared to $77 for a place in a shelter (approximately €52 compared €70, 2012 figures). In London, in 2013, one Housing First service was found to cost approximately £9,600 (€13,500) per person per year (excluding rent). This was compared to between £1,000 per year *more* for a shelter, or nearly £8,000 *more* for a place in a high-intensity staircase service (excluding rent). This represented an annual saving approximately equivalent to between €1,400 and €11,250 (2013 figures).

It was also seen that by ending homelessness among people with very high support needs, Housing First could potentially save money for other services, such as psychiatric services, emergency medical services and the criminal justice system. This was because homeless people with very high support needs, if they were housed with the proper support, would not encounter these services as often as when they were homeless and could stop using them altogether. Homeless people with high support needs could now be offered Housing First, which, as well as being very likely to end their homelessness, could be more cost effective than alternative homelessness services.

1.3. Housing First in Europe

European use of Housing First has been encouraged by the North American research results. Initially, the inspiration came from the original service developed in New York, then from other US Housing First services. More recently, some very successful results from the Canadian At Home/ Chez Soi Housing First programme, a randomised control trial (RCT) involving 2,200 homeless people comparing Housing First with existing homelessness services, have become influential in European debates (see Chapter 5).

Within Europe, the results of the **Housing First Europe research project,** led byVolker Busch-Geertsema, were among the first to confirm that Housing First could be successful in European countries. A large-scale randomised control trial as part of the French Un Chez-Soi d'abord Housing First programme, being conducted by DIHAL, will provide systematic data on Housing First effectiveness across four cities in France, in 2016. A number of observational studies, that look at Housing First but do not compare it with other homelessness services, have also reported very positive results from Denmark, Finland, the Netherlands, Portugal, Spain and the UK. Collectively, these findings show that:

- In Europe, Housing First is generally more effective than staircase services in ending homelessness among people with high support needs, including people experiencing long-term or repeated homelessness.
- Housing First can be more cost-effective than staircase services because it is able to end homelessness more efficiently. Housing First may also generate cost offsets for (reduce the costly use of) other services. For example, Housing First may reduce frequent use of emergency medical and psychiatric services, prevent long and unproductive stays in other forms of homelessness service and lessen rates of contact with the criminal justicesystem.
- Housing First addresses the ethical and humanitarian concerns raised about the operation of some staircase services.

In 2016, Housing First was becoming increasingly important in Europe. In some cases, Housing First was integral to comprehensive homelessness strategies, in others, experiments were still underway. The countries where Housing First was being used include:

Austria	Belgium
Denmark	Finland
France	Ireland
Italy	The Netherlands
Norway	Portugal
Spain	Sweden
The United Kingdom	

Housing First has been successfully piloted in Vienna. Nine Housing First projects were tested in Belgium in 2015, with 150 homeless people with high support needs receiving Housing First. The programme is being evaluated with a view to testing whether Housing First could be more widely used (see Appendix).

The first stage of the Danish Homelessness Strategy from 2009-2013 was one of the first large-scale Housing First programmes in Europe and housed more than 1,000 people. A summary of the Danish programme is included in the Appendix.

Finland has made extensive use of Housing First within its national strategy to reduce and prevent homelessness. Absolute and relative reductions in long-term homelessness have been achieved by using a mix of Housing First service models, including both congregate and scattered housing models (see Chapter 3 and Chapter 4). An example of a Finnish Housing First service is described in the Appendix. Initial results from the French Un Chez Soi d'abord Housing First pilot programme are positive, with the existing work to continue through 2017 before use of Housing First is expanded from 2018 onwards (see Appendix).

In Italy in 2015, homelessness service providers and academics cooperated to form the Housing First Italian Network, a confederation of organisations providing, or with an interest in, Housing First. Housing First Italia had 51 members in 10 Italian regions, of which 35 had operational projects in 2015. Two Italian examples of Housing First services are summarised in the Appendix.

In 2014 17, Housing First services were operating across the Netherlands. In Amsterdam, the Discus Housing First project had been operating successfully since 2006. In Portugal, the Casas Primeiro service in Lisbon has pioneered the use of Housing First. A summary of Casas Primeiro is presented in the Appendix. In Spain, the first Housing First service, HÁBITAT, began operations in May 2014, working in Madrid, Barcelona and Málaga. The HÁBITAT project was evaluated throughout and Housing First has now become part of wider Spanish homelessness strategy (see Appendix).

Norwegian use of Housing First has expanded quite rapidly from 12 Housing First services with 135 service users in December 2014 to 16 Housing First services with a total of 237 service users in July 2015. In Norway, Housing First is one of a range of services used within an integrated homelessness strategy (see Appendix).

In Poland, a practitioner conference on Housing First was held in Warsaw in February 2016. Promotion of Housing First is being pursued by an evidence-based advocacy project.

In Sweden, the University of Lund has been actively promoting the idea of Housing First with homelessness service providers and policy makers. In 2009, the University hosted a national conference on Housing First. Two municipalities, Stockholm and Helsingborg, began to operate Housing First services soon afterwards, as a direct result of this conference. Since that time, another 11 municipalities have started up Housing First services. It seems that Housing First has spread even more widely in Sweden, since 94 municipalities state that they provide Housing First services to their citizens (according to one of the 'Open Comparisons' conducted by the National Board of Health and Welfare). These on-going initiatives have been developed at local level rather than as a result of national policy (see Appendix).

In the UK, the first successful experiment with Housing First was run by Turning Point in Scotland in 2010. An observational evaluation conducted over the course of 2014-2015 also showed that early experiments with Housing First in England were also proving successful, although as in Sweden, development was often at local level. In England, there was not yet a national Housing First policy as of early 2016, but the English federation of homelessness organisations (Homeless Link) had launched a Housing First England initiative to promote the use of Housing First in the country. Additionally, the Welsh Government recommended the use of Housing First models in its guidance for its recently revised homelessness laws in 2015 (see Appendix).

In some countries in Central and Eastern Europe, Housing First was still in the process of being developed in 2015/16. Experiments with Housing First have taken place in the Czech Republic and Hungary.

1.4. The Evidence for Housing First

1.4.1. Ending Homelessness for People with High Support Needs

Housing First services are very successful at ending homelessness for homeless people with high support needs. In most cases, European Housing First services end homelessness for at *least* eight out of every ten people.

- In 2013, the Housing First Europe project reported that **97%** of the high-need homeless people using the Discus Housing First service in Amsterdam were still in their housing after 12 months in the service. In Copenhagen, the rate was **94%** overall, with a similarly impressive level reported by the Turning Point Housing First service in Glasgow (**92%**). The Casas Primeiro Housing First service in Lisbon reported a rate of **79%**.
- The French Un Chez-Soi d'abord Housing First programme reported interim results in late 2013, showing **80%** of the 172 homeless people using Housing First services in the four city pilot sites had retained their housing for 13 months.
- Initial results from the Spanish HÁBITAT Housing First programme indicated extremely high levels of housing sustainment in late 2015.
- Finland has reported a fall in the absolute numbers of long-term homeless people following the adoption of a national strategy centred on using Housing First to end long-term homelessness. In 2008, 2,931 people were long-term homeless in the ten biggest cities. This number had dropped to 2,192 in late 2013, a reduction of **25%**. Numbers of long-term homeless people fell from **45%** to **36%** of the total homeless population during the same period.
- In 2015, an observational evaluation of Housing First in England reported that, across five Housing First services, **74%** of homeless people had retained their housing for at least 12 months.
- In 2015, the Housing First service in Vienna reported that, among all the service users worked with over a two-year period, **98%** were still in their apartments.

Success rates in Europe parallel or exceed the results achieved in North America. US studies have reported rates of housing sustainment between 80% and 88%. The recent evaluation of the Canadian At Home/Chez Soi programme reported that Housing First service users spent 73% of their time stably housed over two years, compared to 32% of those receiving other homelessness services.

An international evidence review conducted in 2008 reported that between 40% and 60% of homeless people with high support needs were leaving or being ejected from staircase services before they were rehoused. This was in sharp contrast to Housing First services that were typically keeping 80% or more of their service users housed for at least one year.

As previously stated, Housing First is very successful at ending homelessness among homeless people with high support needs. However, there are some people, typically between 5-20% of service users, for whom Housing First is not able to provide a sustained exit from homelessness.

1.4.2. Health and Well-Being

Housing First can make a positive difference to the health and well-being of homeless people with high support needs:

- In 2013, the Housing First Europe research project reported that 70% of Housing First service users in Amsterdam had reduced their drug use, with 89% reporting improvements in their quality of life and 70% reporting improvements in their mental health. Positive results were also produced by the Turning Point service in Glasgow, where drug/alcohol use was reported to have stabilised or reduced in most cases. In the Casas Primeiro service in Lisbon, 80% reported a lower level of stress. Danish Housing First services reported a more mixed picture, but 32% reported improvements in alcohol use, 25% an improvement in mental health and 28% in physical health.

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- In 2015, interim results reported from the French Un Chez-Soi d'abord Housing First programme showed that, in the six months prior to inclusion in Housing First, homeless people had spent an average of 18.3 nights in hospital. When they had been using Housing First for 12 months, the time spent in hospital in the last six months had fallen to 8.8 nights on average. Contacts with hospitals and the frequency of stays in hospital had fallen significantly.
- The 2015 evaluation of Housing First in England found that 63% of service users self-reported improvements in physical health and 66% self-reported gains in mental health, with some smaller improvements around drug and alcohol use.

Housing First, both in Europe and North America, has been shown to deliver improvements in health and well-being. Results can be variable - not all Housing First service users benefit from better health and well-being - but Housing First is able to deliver positive changes for many of the people using it.

1.4.3. Social Integration

Social integration has three main elements:

- *Social support*, which centres on someone feeling that they are valued by others, called *esteem support*; help in understanding and coping with life, called *informational support*; *social companionship* (spending time with others) and practical or *instrumental support*.
- *Community integration*, which can be tricky to define precisely, but which generally refers to positive, mutually beneficial relationships between Housing First service users and their neighbours. In a broader sense, community integration also refers to a homeless person not being *stigmatised* by the community. Housing First can help someone to adjust to new community roles, i.e. being a good neighbour.
- *Economic integration*, which can mean paid work, but also socially productive or rewarding activities, ranging from participating in arts-based activities through to informal and formal education, training and job-seeking.

A key goal of Housing First (see Chapter 3 and Chapter 4) is to promote social integration in the community. Housing functions as the basis, or foundation, from which Housing First seeks to help a service user develop the social supports, community integration and economic integration that can improve their quality of life. Good quality social supports, living a life that involves positive engagement with the surrounding community and having a structured, purposeful existence, can all demonstrably enhance health and well-being.

- The Casas Primeiro Housing First service in Lisbon reported that almost half the Housing First service users had started to meet people in cafés to socialise, with 71% reporting they felt 'at home' in their neighbourhood and 56% reporting feeling part of a community.
- A recent evaluation of Housing First in England found that of 60 users of Housing First services, 25% had reported regular contact with their family prior to working with Housing First, rising to 50% once they were receiving Housing First support. Prior to working with Housing First, 78% of people were involved in nuisance behaviour, such as drinking alcohol on the street. This fell to 53% after they began working with Housing First.
- There is qualitative research from both Europe and North America that shows that people using Housing First can have a greater sense of security and belonging in their lives than was the case before homelessness. This has been described as Housing First enhancing someone's sense of security in their day-to-day life, or *ontological security*.

Evidence that Housing First has the capacity to help homeless people with high support needs into paid work is not extensive in Europe or North America, but it must be noted that the people using Housing First often face multiple barriers to employment. Housing First is designed to deliver improvements in health, well-being and social integration. Housing First is not presented, nor expected to be seen, as a 'miracle cure' or panacea that will rapidly end all the negative consequences of homelessness. Housing First successfully ends homelessness and that, in itself, creates a situation in marked contrast to the multiple risks to health, well-being and social integration that are associated with homelessness.

The Core Principles of Housing First

All Housing First services are based on the Pathways model, developed by Dr. Sam Tsemberis, in New York in the early 1990s. **The core principles of Housing First in Europe are drawn directly from the Pathways model.** However, there are significant differences between some European countries and North America and between European countries themselves.. This means that the core principles for Housing First in Europe do not exactly mirror those of the original Pathways model. **The eight core principles of Housing First in Europe, developed in consultation with the advisory board for this Guide,** of which Dr. Tsemberis was a member, are:

Eight core principles:

Housing is a human right

Choice and control for service users

Separation of housing and treatment

Recovery orientation

Harm reduction

Active engagement without coercion

Person-centred planning

Flexible Support for as Long as is Required

Support in Housing First

Support in Housing First centres on delivering **housing sustainment, the promotion and support of good health and well-being, developing social supports and community integration and extending participation in meaningful activity.** Housing First delivers these services using **multidisciplinary teams** and/or various forms of **high intensity case-management** services. **Mobile teams** of workers provide these services to the people using Housing First services by visiting them **at home**, or sometimes at **another mutually agreed location**, such as a café.

Delivering Housing

4.1. Housing and Neighbourhood in Housing First

There is an important distinction between being provided with accommodation and having a real home. To be a home, housing must offer:

- Legally enforceable **security of tenure**, i.e. someone using Housing First should not be in a position where they have no housing rights and can be evicted immediately without any warning and/or with the use of force.
- **Privacy.** Housing must be a private space where someone can choose to be alone without interference and can conduct personal relationships with family, friends and/or their partner.
- A space that the person living within it has **control** over, in terms of who can enter their home and when they can do so and also in terms of being able to live in the way they wish, within the usual constraints of a standard tenancy or lease agreement.
- A place in which someone feels physically **safe and secure.**
- **Affordability,** in that rent payments are not so high as to undermine the person's ability to meet other living costs, such as food and utility bills.
- **All the amenities** that an ordinary home possesses, sufficient furniture, a working kitchen and bathroom and working lighting, heating and plumbing.
- A **fit standard** for occupation, i.e. not overcrowded or in poor repair.
- **Their own place** that they can decorate and furnish as they wish and where they can live their life in the way they choose. Housing must not be subject to the kind of rules and regulations that can exist in an institution, determining how a space is decorated, furnished and lived in.

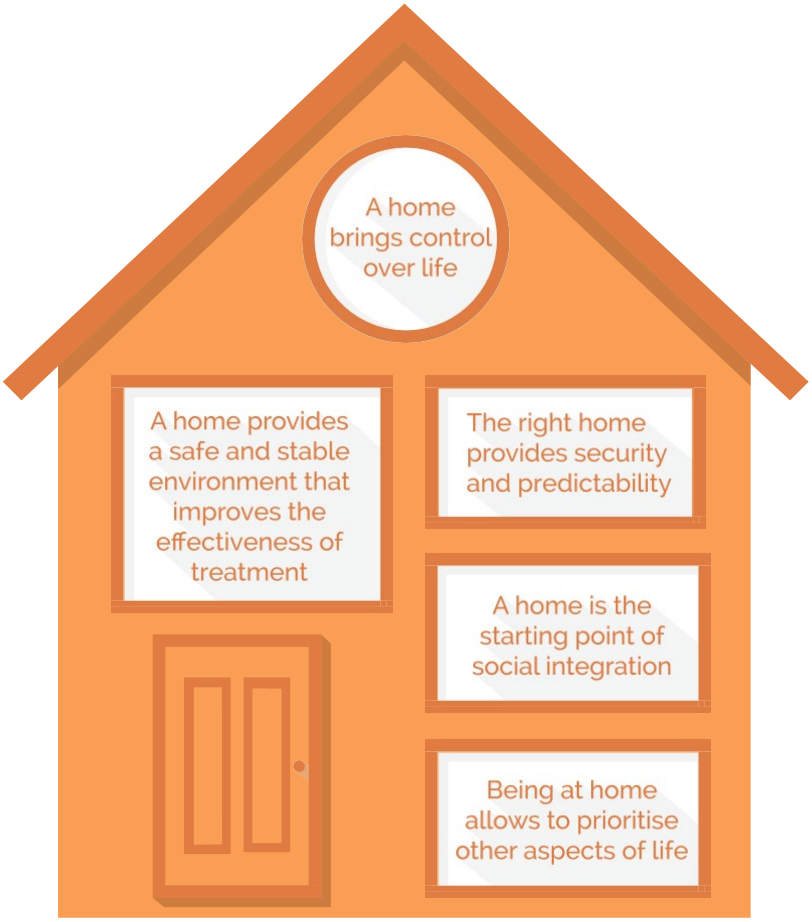
The European typology of homelessness (ETHOS) identifies physical, social and legal domains in defining what is meant by a home. The physical domain centres on having one's own living space, i.e. someone has their own front door to their own home, under their exclusive control. The social domain means having the space and the privacy to be 'at home'. The legal domain echoes the international definition of a right to housing, i.e. security of residence with legal protections (see Chapter 2).

The location of housing is important. However, Housing First services will not have the resources to simply pick anywhere in a city or municipality. In some locations, such as major European cities, there will very often be a need for compromise between what is affordable for Housing First service users and what would be an 'ideal' home.

Where possible, it is important to avoid areas characterised by high crime rates, nuisance behaviour and low social cohesion/weak social capital, where there is little or no 'community' in a positive sense and a Housing First service user might be subject to bullying or persecution or be at continual risk of being a victim of crime. There is clear evidence that the wrong location can inhibit or undermine the recovery that Housing First services seek to promote. More generally, it is desirable to avoid physically unpleasant locations and those without access to necessary and desirable amenities, e.g. an affordable local shop, public transport links and pleasant green space. The right kind of neighbourhood can be a determinant of health, well-being and social integration, positively influencing outcomes for Housing First service users.

Some Housing First service users may wish to move away from the locations in which they experienced homelessness. The reasons for this may include wanting to avoid negative peer pressure from their former life. For some Housing First service users, including women who have experienced gender-based/domestic violence, there may be a need to avoid living in certain areas for reasons of personal safety and to improve their health and well-being. Ideally, housing should not be located in an area that a Housing First service user wishes to avoid.

Adequate homes must be located in an adequate neighbourhood. Avoiding areas characterised by social problems and poor facilities will help increase the chances that housing can be sustained.



4.2. Providing Housing

Housing First service users are able to exercise choice in using treatment (see Chapter 2 and Chapter 3) and should also be able to exercise choice about where and how they will live. Obviously, housing options will be subject to what is available and what can be afforded by Housing First service users, but generally speaking:

Housing First service users should expect:

- To be able to **see housing before they agree to move into it.**
- To be offered **more than once choice of housing**, i.e. they should be able to refuse offered housing if they wish without there being any negative consequence for them. In practice, a Housing First service may face challenges in finding ideal housing. This will need to be made clear to each Housing First service user, but there should be no expectation that being offered only one or two choices is sufficient. Housing First should never withdraw an offer of housing and support on the basis that someone has refused one or more offers of housing.
- To have the **financial consequences of having their own home clearly explained to them** and to have the opportunity to discuss this. Before moving into their home, Housing First service users should understand what their financial obligations will be and how much money they will have. In some European countries, which pay a basic income to anyone who is unemployed, someone may have less *disposable* income when housed than when living in emergency or temporary accommodation for homeless people (because they have additional living costs).
- To have **some choice with respect to the location** of the housing that they are offered.
- To be offered some **flexibility around how they choose to live**, i.e. someone may wish to live with a partner, friends or with other people, rather than on their own in an apartment. Some Italian Housing First services, for example, will support families and some English services will support couples (see Appendix).

There are three main mechanisms by which a Housing First service can deliver housing:

- Use of the private rented sector
- Use of the social rented sector (where social rented housing exists)
- Direct provision of housing, by buying housing, developing new housing or using existing housing stock.

The challenges faced by a Housing First service may include:

- **Finding enough affordable, adequate housing** in acceptable locations in high-pressure housing markets (where housing demand is very high). Any area with high economic growth is likely to be a challenging place to find sufficient housing of the right sort. The type of housing available in some rural areas (a relative absence of smaller apartments) may also present a challenge.
- Where **social housing** is available, it may be **targeted on groups other than people who are homeless**, or it may be subject to high demand.
- There may be problems with the **availability, affordability and quality of housing in the private rented sector.**
- Both social and private sector **landlords may be reluctant to house formerly homeless people** with high support needs. There are concerns that people who have been homeless will present management problems, such as getting into disputes with neighbours, or failing to pay their rent.
- **Housing First service users sometimes cannot access sufficient welfare benefits to pay the rent.** This is more of an issue in European countries that have limited welfare systems than in those with extensive welfare systems, where various forms of housing benefit or minimum income benefit pay all or most of the rent for very low income/vulnerable groups. In countries with more limited welfare systems, Housing First services may need to find income streams to help pay the rent for their service users.
- It is possible to create new housing specifically for Housing First but **the costs of development (building new housing) or renovating/converting** existing housing are considerable. Buying housing is also an option, but while this *may* be cheaper than building or renovating, again, the costs may be too high for this to be a realistic option.
- **NIMBY (not in my back yard) attitudes** linked to the stigmatisation of homeless people which may lead neighbourhoods to try to stop Housing First services from operating in their area. Housing

First services may need to work with neighbouring households, providing information, reassurance and if necessary intervening if a Housing First service user has caused a problem (also intervening if a neighbour is behaving unreasonably towards a Housing First service user).

- Housing First can work flexibly and imaginatively, but it **cannot fix underlying problems with affordable and adequate housing supply** and may encounter operational difficulties in any context where there is just not enough affordable or adequate housing for the entire population.

Housing First is meant for homeless people with high support needs. The need that Housing First services have in terms of numbers of housing units will often be *relatively* small. Although data on European homelessness are incomplete, it appears that, even in a major city, a Housing First service would probably *not* require hundreds of homes.

REPORT | April 2020

HOUSING FIRST AND HOMELESSNESS: THE RHETORIC AND THE REALITY

Stephen Eide
Senior Fellow

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About the Author

Stephen Eide is a senior fellow at the Manhattan Institute and a contributing editor of *City Journal*. He researches state and local finance and social policy questions such as homelessness and mental illness. Eide has written for many publications, including *National Review*, the *New York Daily News*, the *New York Post*, the *New York Times*, Politico, and the *Wall Street Journal*. He was previously a senior research associate at the Worcester Regional Research Bureau. He holds a B.A. from St. John's College in Santa Fe, New Mexico, and a Ph.D. in political philosophy from Boston College.

Contents

Executive Summary

Over the past two decades, a policy known as "Housing First" has come to dominate the government response to homelessness. Housing First has two chief tenets: (1) the most effective solution to homelessness is permanent housing; and (2) all housing for the homeless should be provided immediately, without any preconditions, such as sobriety requirements. The movement to "end homelessness," in which hundreds of communities have participated, is centered on the implementation of Housing First.

More recently, the Trump administration has begun modifying the federal government's commitment to Housing First. These changes have been prompted, in part, by the fact that, in California and elsewhere, community efforts to end homelessness have failed even to arrest its increase. Though the changes thus far have been modest, they have been strenuously criticized by advocates who sense a weakening in the Housing First consensus.

This report contributes to the debate over homelessness policy by assessing Housing First's rhetoric—the claims made by proponents—in light of the available evidence. It argues that proponents overstate the ability of Housing First to end homelessness, the policy's cost-effectiveness, and its ability to improve the lives of the homeless.

Key Findings

- Housing First has not been shown to be effective in ending homelessness at the community level, but rather, only for individuals.
- A Housing First intervention for a small segment of "high utilizer" homeless people may save taxpayers money. But making Housing First the organizing principle of homeless services systems, as urged by many advocates, will not save taxpayers money.
- Housing is not the same as treatment. Housing First's record at addressing behavioral health disorders, such as untreated serious mental illness and drug addiction, is far weaker than its record at promoting residential stability.
- Housing First's record at promoting employment and addressing social isolation for the homeless is also weaker than its record at promoting residential stability.

Recommendations

- The U.S. Department of Housing and Urban Development should allow more flexibility from Housing First requirements for communities pursuing homelessness assistance grants through the "Continuum of Care" (CoC) program.
- State and local Housing First mandates should be reassessed.
- The homelessness debate should be reintegrated into the safety-net debate.

HOUSING FIRST AND HOMELESSNESS: THE RHETORIC AND THE REALITY

I. History of Housing First

In response to the emergence of "modern" homelessness in the early 1980s, cities first focused on developing emergency shelter programs. Shelter was emphasized in those years because the rise in homelessness was assumed to be a temporary crisis created by the 1980–82 recession, and, going back to the 19th century, temporary housing had always been part of the response to housing instability challenges.[1] Throughout the 1980s and 1990s, however, the economy improved but homelessness did not decline; in some cities, it increased. Policymakers thus began to reason that a new response was required to meet this new, and apparently structural, socioeconomic challenge.

The first proper homeless services system—as distinct from the preexisting array of safety-net programs and services—is often described as having had a "linear" character.[2] Housing programs for the homeless would be arranged in a continuum of emergency, transitional, and permanent options. Linear-style systems would guide clients out of homelessness gradually, first from the streets to shelter, then to a service-enhanced transitional housing program, and then to permanent housing, either publicly subsidized or private.[3] It was always understood that at least some of the homeless population would need permanent housing benefits—meaning a rental subsidy not subject to any time limits. But the most troubling cases, such as individuals who were mentally ill or had drug addictions, would need services in addition to housing benefits, both for their sake and to ensure the success of the housing intervention.[4]

The linear system was developed during the lead-up to the 1996 welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act. The same concerns about changing public assistance programs to promote self-sufficiency and minimize dependency also shaped the debate over the early 1990s homeless services system. A 1994 strategic plan by the United States Interagency Council on Homelessness (USICH) to "break the cycle of homelessness" began with an epigraph by President Bill Clinton about how "work organizes life"[5] and, in detailing the purpose of housing programs for the homeless, placed high emphasis on "mak[ing] housing work again."[6] With so many people cycling between the streets, shelter, and unstable housing arrangements, a welfare reform–style emphasis on work would overcome homelessness recidivism.[7]

Policymakers in the early 1990s were also concerned about the flaws of deinstitutionalization. Transitioning the public mental-health-care system from an inpatient to a mainly outpatient model began in the 1950s, and it proceeded at an especially rapid pace during the 1970s. Deinstitutionalization's promise of "better care in the community"[8] had been undermined by the spectacle of mentally ill individuals living on the streets who were either former patients in mental hospitals or people who would have been committed to long-term psychiatric care in earlier times. The homeless mentally ill needed not only housing but "structured care and residential support" similar to what had existed in the state hospitals.[9] To correct the mistakes of the past, the homeless mentally ill would need a variety of levels of support, depending on what stage they were at in their psychiatric rehabilitation.

The "linear" character also applied to programs designed to help homeless populations that faced substance abuse, unemployment, and other challenges that had contributed to their homelessness. Heavy focus was placed on the transitional housing model. Transitional housing provides temporary housing, like shelter, but for a longer

duration—up to 24 months—and in a more service-enhanced environment.[10] Housing was considered part of an overall effort to repair broken lives and address the problems that caused or strongly contributed to clients' homelessness.[11]

Press reports and advocates of Housing First often use the phrase "housing readiness" to describe the aim of linear programs. But housing readiness, while certainly used by some participants in the 1990s debate,[12] was not, in every case, how linear-style service providers themselves characterized their ultimate aims. Whereas Housing First providers hold themselves, most of all, to the standard of residential stability—keeping the most clients housed for the longest period—linear-style programs often viewed residential stability as secondary to larger goals of independence or health. Much like how residential treatment programs use temporary housing as a means toward the goal of sobriety, transitional housing providers always aimed at goals beyond mere residential stability.[13] This is why some have described the debate between the two approaches as one of different "paradigms"—the dispute concerns not just the best way to achieve a mutually agreed-upon goal but a dispute over which goals to pursue.[14]

The groundwork for Housing First was laid in the late 1970s, when advocates began promoting the term "homelessness," a term that previously had never been widely in use, to pressure governments to develop more subsidized housing.[15] The belief in housing as a human right—meaning that government is obliged to provide it for anyone who cannot find housing on his own—had many adherents in advocacy circles but was antithetical to the notion of preconditions for housing benefits.[16] Housing First advocates were influenced by the "recovery model," an approach to mental health that stresses the importance of letting mentally ill people choose their care and treatment regimens.[17] Criticisms that, decades earlier, had been leveled at the traditional asylums by Erving Goffman and others were revived and directed at the linear homeless services system.[18] Housing First advocates believed that linear programs did more to undermine independence than promote it, by placing the homeless in what they viewed as a quasi-institutional living environment. Theories of "community integration" called for decoupling housing benefits and social services for mentally ill clients.[19] Instead of transitional housing, they called for "supported" or "supportive" housing, which generally meant subsidized housing that made services available to tenants but did not require participation or have any other requirements.[20]

These concepts—housing as a human right, the imperative of personal autonomy, even for those with untreated serious mental illness, and community integration—were developed in academic articles in the 1990s and formed the theoretical basis for Housing First.

The empirical basis was developed by Sam Tsemberis, a New York–based clinician who founded Pathways to Housing in 1992. Pathways placed its mentally ill clients, all formerly homeless or at serious risk of homelessness, in scattered-site supported housing units without any preconditions. Tsemberis then did studies, including a rigorous randomized-controlled trial, on their rates of residential stability. He found that, of a pool of individuals suffering from serious mental-health disorders, clients placed in Pathways units stayed stably housed at higher rates than those placed in linear-style programs.[21]

In 2000, the National Alliance to End Homelessness launched the campaign to end the problem in 10 years. "People should be helped to exit homelessness as quickly as possible through a housing first approach," the organization proclaimed. "For the chronically homeless, this means permanent supportive housing (housing with services)—a solution that will save money as it reduces the use of other public systems. For families and less disabled single adults, it means getting people very quickly into permanent housing and linking them with services. People should not spend years in homeless systems, either in a shelter or in transitional housing."[22]

This campaign quickly found an ally in the George W. Bush administration, whose secretary of the Department of Housing and Urban Development, Mel Martinez, was the keynote speaker at the 2001 annual meeting of the National Alliance to end homelessness.[23] Under the leadership of USICH executive director Philip Mangano, the Bush administration began the "Chronic Homelessness Initiative," which encouraged states and localities to create 10-year plans to end chronic homelessness.[24] (Though the formal requirements for "chronic" homeless status have changed over time, the term generally means someone whose experience of homelessness is long-term and who suffers from a disability.) It has been estimated that more than 350 states and localities endorsed, in some fashion, the goal of ending homelessness through a Housing First approach.[25] California, host to the largest homeless population of any state, made Housing First a requirement for state-funded homelessness programs in 2016.[26]

The Obama administration put out a strategic plan to end homelessness in 2010 (updated in 2015).[27] USICH assumed responsibility for defining what it would mean to "end" homelessness and for validating claims made

FIGURE 1.

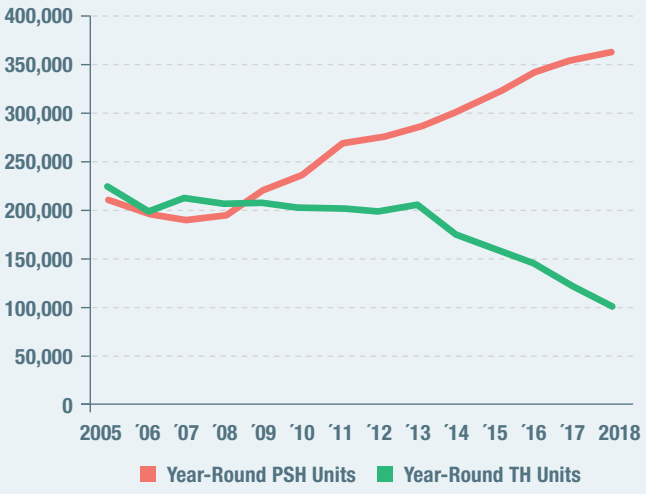
HUD's Homeless Assistance Grant Program, 2005–18

	Permanent Supportive Housing Award	Share of Total Grant	Transitional Housing Award	Share of Total Grant
2005	$595,483,232	50%	$417,439,417	35%
2006	$617,611,791	51%	$415,335,530	34%
2007	$727,119,842	55%	$435,684,534	33%
2008	$782,671,147	55%	$435,501,349	31%
2009	$926,779,901	59%	$428,789,845	28%
2010	$996,554,318	61%	$430,421,319	26%
2011	$1,040,824,807	62%	$430,229,366	26%
2012	$1,027,500,308	61%	$417,457,781	25%
2013	$1,132,624,508	67%	$371,494,431	22%
2014	$1,240,437,375	69%	$325,548,173	18%
2015	$1,407,021,020	72%	$172,252,643	9%
2016	$1,434,271,450	73%	$108,067,486	6%
2017	$1,496,858,863	74%	$80,669,446	4%
2018	$1,542,451,024	71%	$66,342,036	3%

Source: HUD, Continuum of Care Program. Numbers do not add up to 100% because permanent supportive housing and transitional housing are not the exclusive uses of these funds.

FIGURE 2.

Permanent Supportive Housing (PSH) vs. Transitional Housing (TH) Units, 2005–18



Source: HUD, CoC Housing Inventory Count Reports

by communities that they had "ended" homelessness for some cohort, such as the chronic or veterans' population. Targeting resources toward specific homeless cohorts was seen as beneficial in itself and, if successful, a source of proof that ending homelessness, broadly speaking, was achievable.[28]

HUD is the most important agency in federal homelessness policy because of its responsibility to disburse billions in funds for homelessness programs to states and localities. Over time, the federal government has tightened adherence requirements to Housing First for local agencies pursuing homeless assistance funds from HUD. **Figures 1** and **2** show how this has led to a dramatic shift in support from transitional housing programs—closely associated with the linear approach—to the permanent supportive housing programs favored by Housing First–oriented systems.

The Trump administration, despite departing from the Obama administration on several safety-net and poverty-policy questions, remained focused on Housing First for its first two and a half years in office. Six months into the new administration, 23 Republican congressmen sent a letter to HUD secretary Ben Carson, asking him to review his agency's "current procedures" that follow Housing First principles and to "end the recommended scoring guidelines that currently punish programs that prioritize work, education, and sobriety."[29] Much federal funding for homeless services flows through the Continuum of Care (CoC) grant competition, which is structured around a points system and set of criteria laid out by HUD.[30] In its response letter, HUD asserted that Housing First was an "evidence-based" practice and argued that its current approach was not unduly burdensome on local autonomy.[31] Carson and other prominent administration officials have made many public statements in favor of Housing First.[32] Most critically, HUD's Notice of Funding Availability (NOFA), the annual document that lays out requirements for access to billions in CoC program funds, kept in the Obama-era language regarding Housing First.

In summer 2019, the Trump administration began to signal a shift. The first notable change came in the 2019 NOFA, which "Provid[ed] Flexibility for Housing First with Service Participation Requirements."[33] In the section "CoC Coordination and Engagement" (VII.B.1 in the FY18 NOFA, VII.B.6 in the FY19 NOFA), the seven points allocated for embracing "Housing First" were, in FY19, dedicated to "Low Barriers to Entry" (**Figure 3**). The intention of the change was for localities to discourage service providers from attaching sobriety requirements or other preconditions to clients' initial entry into a federally funded housing program but allow for their usage in clients' ongoing participa-

FIGURE 3.

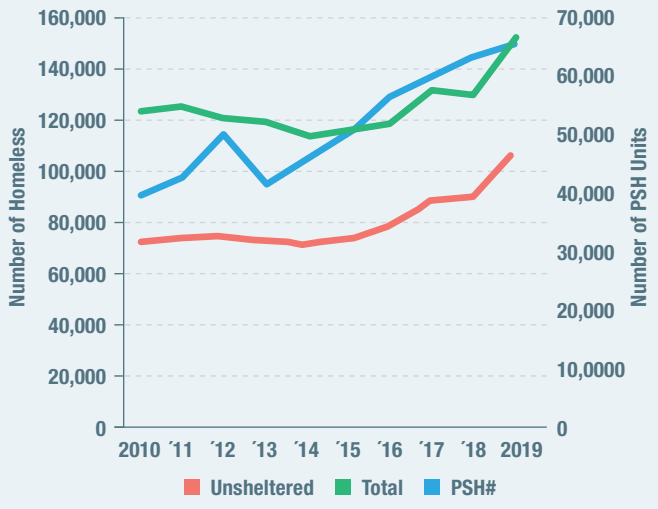
Housing First–Relevant Language in the FY18 and FY19 NOFAs

FY18 (7 Points)	g. Housing First. Uses a Housing First approach. Any housing project application that indicates it will use a Housing First approach, that is awarded FY 2018 CoC Program funds will be required to operate as a Housing First project.	At least 75 percent of all project applications that include housing activities (i.e., permanent housing, transitional housing, and safe haven) submitted under this NOFA are using the Housing First approach by providing low barrier projects that do not have service participation requirements or preconditions to entry and prioritize rapid placement and stabilization in permanent housing. This means the projects allow entry to program participants regardless of their income, current or past substance use, history of victimization (e.g., domestic violence, sexual assault, childhood abuse), and criminal record–except restrictions imposed by federal, state or local law or ordinance (e.g., restrictions on serving people who are listed on sex offender registries).
FY19 (7 Points)	g. Low Barriers to Entry. CoC Program-funded projects in the geographic area have low barriers to entry and prioritize rapid placement and stabilization in housing.	CoCs must demonstrate at least 75 percent of all project applications that include housing activities (i.e., permanent housing, transitional housing, and safe haven) submitted under this NOFA use the following practices: • provide low barriers to entry without preconditions and regardless of their income, current or past substance use, history of victimization (e.g., domestic violence, sexual assault, childhood abuse), and criminal record—except restrictions imposed by federal, state, or local law or ordinance (e.g., restrictions on serving people who are listed on sex offender registries), and • prioritizes rapid placement and stabilization in permanent housing The use of service participation requirements after people have stabilized in permanent housing will not affect the score on this rating factor.

Source: HUD, "Notice of Funding Availability (NOFA) for the Fiscal Year (FY) 2018 Continuum of Care Program Competition," June 20, 2018, p. 53; "Notice of Funding Availability (NOFA) for the Fiscal Year (FY) 2019 Continuum of Care Program Competition," July 3, 2019, pp. 63–64

FIGURE 4.

Trends in Investment in PSH Units and Homelessness in California, 2010–19



Source: Source: HUD, Continuum of Care Program

tion in programs.

In late 2019, prompted by advocates,[34] Congress required HUD to return to the FY18 language for the 2020 NOFA.[35] In the meantime, the Trump administration has been active in questioning Housing First on other fronts. In September 2019, the Council of Economic Advisers (CEA) released a comprehensive report on homelessness policy in America that included a critical discussion of Housing First's limitations.[36] In December, a new USICH executive director was appointed, Robert Marbut, an adherent of the older, linear approach ("I believe in Housing Fourth").[37]

The Trump administration has pursued these changes partly because of philosophical objections to the Housing First philosophy but also because so many communities that participated in the campaign to end homelessness, such as Los Angeles and San Francisco, are now dealing with crises of unprecedented magnitudes. The failures of California jurisdictions' 10-year plans to end homelessness in some form have been covered in a number of press outlets.[38]

California is host to approximately one-fourth of the nation's total homeless population and half of the nation's total unsheltered population. Since 2010, California has added more than 25,000 PSH (permanent supportive housing) units, an increase of about two-thirds (**Figure 4**)—yet the state's unsheltered homeless population, over the same span, increased by half. The public has registered support

for investing in homeless services, through successful initiative campaigns, but continues to voice concern over the direction of policy in opinion surveys.[39] This has inevitably raised questions about the Housing First approach that has been in place through this recent rise in homelessness. Therefore, now is a good time to take stock of Housing First. How effective has Housing First been? Does it deserve the wide acclaim it has received from advocates?

II. "We Know How to End Homelessness"

Housing First has evolved somewhat.[40] Originally, it was associated with providing permanent supportive housing for the chronically homeless. That remains a core priority of Housing First–oriented homeless services systems, but, more recently, USICH and advocates have encouraged governments to view Housing First as a "whole system orientation."[41] All homeless services, for all homeless populations, temporary and permanent housing alike, are expected to conform with the Housing First philosophy. In addition to expanding permanent supportive housing, the top priority of any Housing First system, emergency shelter should also be provided without any barriers (see, for example, San Francisco's Navigation Centers, Los Angeles's Bridge program, and New York City's Safe Haven shelters).[42] "Rapid Rehousing"—short-term rental assistance to be used for a private apartment—is also seen as part of a Housing First–oriented homeless services system, though it is a temporary benefit.[43] So, too, is providing standard affordable housing—understood as subsidized housing without any time limits—to non-chronic homeless clients, such as families, as long as it is provided without any barriers.[44] Housing First systems work to "align" or "integrate" existing affordable housing programs with homeless services, meaning, for instance, preferential access for the homeless for Section 8 vouchers or newly developed affordable housing units.[45]

Proponents argue for organizing homeless services systems around the principle of Housing First based on scientific evidence, not only, or even mainly, because it is founded on more just or humane principles. In their view, Housing First has been "proven" or "demonstrated" to be superior to alternatives and to be able to end homelessness.[46] In most instances, when a policymaker is making some claim about how "we know how to end homelessness,"[47] they are referring to the social science evidence base behind Housing First.

At their core, these claims are based on studies that have registered high rates of residential stability when homeless individuals, or people at serious risk of homelessness, have been placed in permanent supportive housing units under a Housing First policy. Residential stability may be measured in terms of how many days someone spends in his unit over a particular period, or whether he still occupies his unit at a certain time benchmark.[48]

The "gold standard" in social science research is the randomized-control trial (RCT). In an RCT, researchers examine the effect of some intervention on two different cohorts who are similar in every important respect. Though the literature on Housing First is significant, the number of truly rigorous RCT studies of the approach is relatively small. One 2015 review credits only four, with several more studies having a "quasi-experimental" design.[49] A 2014 survey identified seven RCTs and five "quasi-experimental" studies.[50] A 2017 survey of the literature credits 14 RCTs, based on 12 trials.[51] The best-known RCTs are the Pathways studies discussed earlier and the more recent At Home / Chez Soi, which encompassed five Canadian cities and more than 1,000 participants. One common criticism of the literature on Housing First is that studies often relate few details about the programs under examination (a significant concern for a policy that advocates are trying to scale up and expand nationwide).[52]

Still, despite certain limitations, the Housing First literature has demonstrated that Housing First interventions tend to yield high rates of residential stability.[53] The rates of residential stability are often in the 70%–80% range, for the length of the trial, which typically lasts a couple of years. "Usual care" or "treatment first" comparison groups, by contrast, often register rates below 50%. And, to reemphasize, these studies typically involved "chronic" homeless cases suffering from serious mental illness or some other behavioral health disorder. Whether looking at how many days housed as the measure of residential stability, or how many participants remained in housing at the end of the study, Housing First–style interventions have demonstrated real strength at addressing homelessness.

While it may have been the case 30 years ago that homeless policymakers doubted whether people with untreated serious mental illness and other social challenges could hold on to their housing if those challenges were not addressed first, there is less doubt about that point now. This is the thinking behind claims about how the Housing First literature "proves" how to "end homelessness."

The ability of Housing First programs to keep the homeless housed at a higher rate than linear-style programs has been acknowledged by, among others, the Trump administration's CEA.[54] The Trump administration also acknowledges that homelessness is, in large measure, a housing problem.[55] Any community that experiences a shortage of rental units affordable to low-income households will, all other factors being equal, experience higher levels of homelessness than communities with a larger store of such units.[56] Nor is there serious dispute that some of the homeless population, such as those with serious mental illness, will need rental subsidies for the rest of their lives.

But claims that Housing First has been shown to end homelessness elide the distinction between evidence at the individual level and the community level. Housing First advocates' rhetoric that investing in permanent supportive housing will end homelessness raises hopes of ending homelessness at the community or national level. For example, Los Angeles County's Measure HHH,[57] which authorized $1.2 billion in bonds to build thousands of permanent supportive housing units, had the working title "Housing and Hope to End Homelessness." However, as noted above (Figure 4), California's experience has been increased investment in permanent supportive housing and increased homelessness. Given that, according to advocates, hundreds of localities have adopted Housing First, one might have expected at least a handful of examples of communities where Housing First has eliminated or drastically reduced homelessness in a manner noticeable to the broader public. That has not been the case.

Scholars who have studied the community-level effects of increased investment in permanent supportive housing have found that: (1) governments may need to create as many as 10 units of permanent supportive housing in order to reduce the local homeless population by one person;[58] and (2) a certain "fade-out" effect is observed whereby the reduction is only temporary. There is no scholarly consensus as to the weakness of Housing First on community-level rates of homelessness. But it does show that scholarship conforms to people's experiences: more investment in PSH does not necessarily lead to less homelessness.

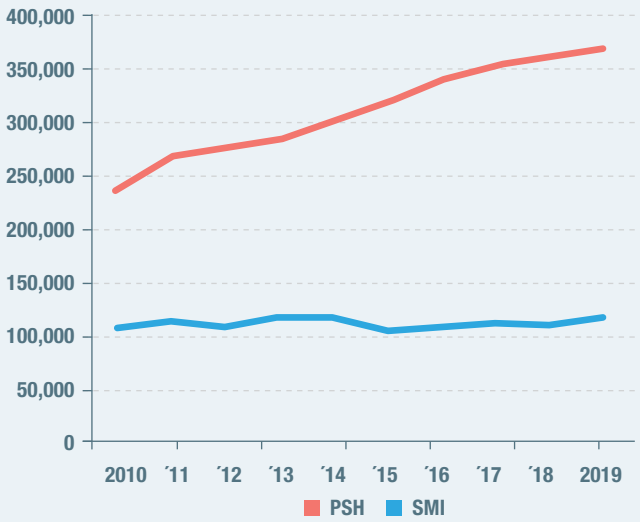
As noted, many participant communities in the campaign to end homelessness have targeted a specific cohort, such as the chronic homeless or veterans. Utah[59] is perhaps the most touted success story from the campaign to end homelessness. But in a 2015 study, economist Kevin Corinth showed how claims about Utah's "ending" homelessness can mostly be ascribed to methodological changes and shifting definitions of "chronic" status.[60] In 2009, Utah adjusted its "point-in-time" homeless numbers to reflect only the homeless who were counted on a certain day in January, instead of an "annualized" estimate to reflect all homeless throughout the year, and abruptly ceased including transitional housing clients in its count of sheltered "chronic" homeless. Nonetheless, media and public officials continue to tout Utah as a case study in how to end homelessness via Housing First.[61] (USICH does not currently list Utah or any of its localities among the communities that have "ended" chronic homelessness.)[62] Even when the definition of "chronic" homelessness is settled, the number of chronic homeless will always face the challenge of counting the unsheltered population. Counting the unsheltered and documenting their challenges, such as what disabilities they suffer from and how long they have been on the streets, are tasks that continue to be plagued by a range of methodological difficulties that quite possibly will never be resolved.

Problems with data and definitions are one reason for giving pause to claims about the success of the campaign to end homelessness. Another is that, even if homelessness has been "ended" or reduced for one specific cohort, that does not necessarily imply progress toward ending homelessness more generally. Just as many factors cause homelessness, many factors may also be at work in reducing it, such as an improving economy or demographic changes. Many sources have claimed that a recent investment in permanent supportive housing for veterans has reduced veterans' homelessness, and even ended it in some communities.[63] But a recent study by economist Brendan O'Flaherty demonstrated that the decline in veterans' homelessness can largely be attributed to the decline in the veteran population of the age at greatest risk of homelessness and the nationwide decline as the nation has emerged from the last recession, not to government policy.[64]

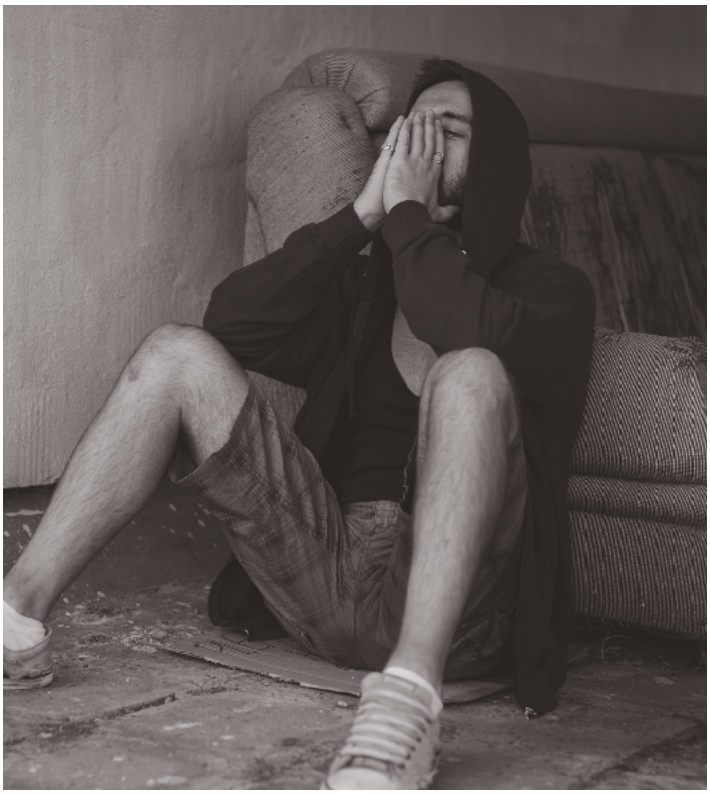
The case of the seriously mentally ill, though less of a priority for USICH (no criteria for "ending" homelessness for this population have been issued),[65] should also be discussed. Housing First supportive housing programs target the seriously mentally ill partly because of a commitment to helping the hardest or chronic cases, but partly because seriously mentally ill individuals qualify for disability benefits. For its influential 2004 study, Pathways to Housing recruited some participants directly from a mental hospital. Indeed, requiring, or strongly urging, supportive housing clients to participate in a money-management program is one of the few infringements on personal liberty that Housing First providers countenance.[66] The number of seriously mentally ill homeless has been virtually

FIGURE 5.

PSH Units, Seriously Mentally Ill Homeless, 2010–19



Source: HUD, Continuum of Care Program



flat since 2010, even as the number of permanent supportive housing units nationwide has increased by more than 50% (**Figure 5**).

USICH defines what it means to "end homelessness" and also evaluates communities' claims for having done so. The council has published criteria and benchmarks for ending homelessness for four cohorts: veterans, chronic, unaccompanied youth, and families with children and, at present, has recognized about 80 communities for having "ended" homelessness for one of these cohorts.[67]

However, the official language and criteria regarding "ending" homelessness are not uncontroversial. Some have criticized it as "Orwellian."[68] To give a community credit for having made homeless "rare, brief and one-time," USICH performs an assessment of that the community's services system. USICH examines system capacity, relative to need (number of homeless) but also whether that system conforms to Housing First. In other words, if the community's capacity to house the homeless—as assessed by the government—matches the number of homeless, the government says that the community has ended homelessness. But that does not mean that there are zero homeless people in the community. Ending homelessness in a community does not need to mean zero homeless people.[69]

Figure 6 lists a cohort of communities that USICH currently credits for having "ended" veterans' homelessness. These communities are, according to the most recent HUD figures, host to more than 2,000 homeless veterans. Communities with modest homelessness challenges more generally are host to as few as one homeless veteran, but others estimate that hundreds of veterans are included in their homeless populations. Most of the communities recognized for having "ended" veterans' homelessness have at least seen a reduction in veterans' homelessness since 2011 (the first year that CoC-level veteran data are available), though not all. In 2019, Portland/Gresham/Multnomah County Continuum of Care, the Northwest Minnesota Continuum of Care, and Norman/Cleveland County, OK all reported higher numbers of homeless veterans than in 2011, before they "ended" veterans' homelessness.

Officials in New York and Los Angeles continue to embrace the goal of ending homelessness, as did some candidates for the 2020 Democratic presidential nomination.[70] But no community has truly ended homelessness using Housing First, and certainly not any community facing crisis-level homelessness. We would not say that a community has ended murder based upon a qualitative analysis of its police department, but rather the absence of murder. If ending homelessness must remain the goal of homelessness policy, governments should define success in a way that can be independently verified by the public. The public

can observe homelessness. It cannot easily observe and analyze service systems' capacity and competence. Thus, ending homelessness should mean the absence of homelessness, as observable to members of the public.

Brendan O'Flaherty is an economist at Columbia University and has been, for decades, one of the leading scholars of homelessness. He is known for his analysis of how housing-market dynamics account for much of modern homelessness[71] and for refuting the "Dinkins Deluge" thesis that, when New York City provided housing to shelter clients around 1990, it led, through moral hazard, to a significant increase in sheltered homelessness.[72] In a recent review of the literature, including on Housing First, O'Flaherty came to the conclusion that "we don't know how to end homelessness. Not in the aggregate, anyway."[73]

FIGURE 6.

Number of Homeless Veterans in Communities Recognized as Having "Ended" Veterans' Homelessness, 2019

Community	# homeless veterans in 2019
Portland/Gresham/Multnomah County Continuum of Care	473
Atlanta, GA	349
Philadelphia, PA	250
Miami-Dade County, FL	169
Long Island, NY	128
Kansas City, KS/Kansas City, MO, and Independence/Lee's Summit/Jackson, Wyandotte Counties Continuum of Care	116
Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC	100
Western Pennsylvania Continuum of Care	88
Lowell, MA	45
Punta Gorda/Charlotte County, FL	43
Massachusetts Balance of State Continuum of Care	42
Cumberland County/Fayetteville, NC	38
Nebraska Balance of State Continuum of Care	31
Scranton/Lackawanna County, PA	30
Lansing, East Lansing, Ingham County, MI, Continuum of Care	26
Lancaster City & County, PA	21
Lincoln, NE	21

Community	# homeless veterans in 2019
Mississippi Balance of State Continuum of Care	20
DeKalb County, GA	17
Norman/Cleveland County, OK	14
Montgomery County, MD	13
Reading/Berks County, PA	13
Bergen County, NJ	13
Saint Joseph/Andrew, Buchanan, DeKalb Counties, MO, Continuum of Care	13
Northwest Minnesota Continuum of Care	9
Moorhead/West Central Minnesota Continuum of Care	9
Rochester/Southeast Minnesota Continuum of Care	9
Mississippi Gulfport/Gulf Coast Regional Continuum of Care	8
Jackson/West Tennessee Continuum of Care	8
Lynn, MA	2
Southwest Minnesota Continuum of Care	2
Northeast Minnesota Continuum of Care	2
Waukegan, North Chicago/Lake County, IL, Continuum of Care	1
Total	2,123

Source: USICH, "Communities That Have Ended Homelessness"; HUD, Continuum of Care Program

Note: This table includes every community that, as of March 2020, USICH has credited with "ending veterans' homelessness" for which HUD has homeless population data. HUD relates homelessness data on a CoC basis, and USICH has recognized, for ending homelessness, localities that are part of a larger CoC.

III. Cost-Effectiveness

One of the most famous statements in defense of Housing First came in Malcolm Gladwell's 2006 *New Yorker* article "Million-Dollar Murray."[74] This article, which the Bush administration had a hand in setting up,[75] detailed the struggles of a "high utilizer": a man in Reno, Nevada, whose homelessness and alcoholism placed a costly burden on the local health-care and criminal-justice systems. The central claim of Gladwell's article was that homelessness was "easier to solve than to manage" because placing people in permanent housing will lead to less usage of other service systems—most notably, hospitals and jails, thus saving money. Similar cost-savings claims have been central to the rhetoric over ending homelessness.[76]

But in the academic literature, the cost-savings argument for Housing First is treated with more skepticism. Here is an area where RCT-level rigor truly matters. Studies that have a "pre-post" design look at the reduction in costs of hospitals, jails, and so on, that result when a cohort is moved from the streets to stable housing. Homeless people who are put into permanent supportive housing programs often have extraordinarily high health costs immediately before their placement. But someone who costs the health-care system $100,000 in a given year is not necessarily going to cost the health-care system $100,000 every year of his adult life.[77] The reduction in costs, following a high utilizer's housing placement, may have as much to do simply with a "regression to the mean" than the virtue of the Housing First /PSH intervention.[78]

Moreover, high utilizers such as Million-Dollar Murray and people with untreated schizophrenia who have lived for years on the street are unrepresentative of the homeless population as a whole. Not only a minority, they are a minority of the chronic homeless.[79] They are certainly unrepresentative of the "working poor" or "down on their luck" homeless often cited in the media. The 2015 Family Options Study, prepared for HUD, examined various housing interventions among a pool of more than 2,000 homeless families with moderate social needs, over a three-year period. The permanent housing intervention was more successful in achieving housing stability than temporary housing interventions, but it was also more expensive.[80]

Governments can't save costs from people who don't make much use of expensive service systems, to begin with. Some homeless may have low service costs because they're "service-resistant," a particularly significant problem for the mentally ill. Another reason that many of the homeless may be low utilizers is that they live in a jurisdiction with limited mental-health and substance-abuse services[81] (states vary dramatically in their investment in behavioral health).[82] "Usual care," the control with which some studies compare Housing First interventions, can vary widely between jurisdictions. "Usual care," in the case of New York City, means a $2 billion shelter system. But, in other communities, to build a Housing First–oriented homeless services system might mean building the first homeless services system that they ever had.[83]

This is not to say that homeless services systems shouldn't focus on "high utilizers," or that, in some cases, they may yield short-term savings on jails and hospitals for certain individuals. But Housing First's success with different homeless populations has been cited as evidence of its merit as a systemwide organizing principle, applicable for the entire homeless population.[84] The evidence is weak that a systemwide application of Housing First—for the benefit of the many different types of homeless people—would generate net savings for taxpayers.

Physical Health-Care Systems. Homeless people are generally in bad health, due to rare diseases and illnesses associated with living in conditions not meant for human habitation, high rates of substance abuse, and inadequate treatment for ordinary illnesses.[85] They also make heavy use of emergency rooms and other expensive crisis services. Once they are stably housed, the homeless will be better positioned to avoid the need for costly triage treatment and instead use ordinary outpatient forms of care to prevent their health problems from becoming crises. Housing First programs will thus supposedly achieve better health at lower costs.

Evidence of the health effects of Housing First and permanent supportive housing is far less robust than many suggest. It is fair to argue that no policymaker who wants better health for the homeless can be indifferent as to whether they stay on the streets. But even assuming that Housing First improves people's physical health, it is not clear that that would mean it saved money. People who live long healthy lives have high health-care costs.[86] Cost-efficiency arguments for smoking-cessation campaigns have been criticized for failing to take into account the fact that nonsmokers live longer than smokers.[87] Perhaps the most reasonable view was expressed in a 2018 survey of the literature by the National Academies of Sciences, Engineering, and Medicine. While still defending the view that "housing in general improves health," this study came to the overall conclusion that "there is no substantial published evidence as yet to demonstrate that PSH improves health outcomes or reduces health care costs."[88]

Mental-Health-Care Systems. Arguments that the mental-health-care system, which has always been expensive, holds great potential for cost savings, go back a very long time.[89] Deinstitutionalization promised better care and at a lower cost. On an annual basis, inpatient psychiatric commitment at a state-run facility can run close to $250,000.[90] But civil commitment doesn't apply to the entire seriously mentally ill homeless population, which is itself a minority of the total homeless population (116,179 out of 567,715).[91] (Million-Dollar Murray was an alcoholic, not a schizophrenic.) Psychiatric hospitals have fixed costs that are difficult to reduce even if a few people avoided being committed as a result of receiving housing benefits.

Criminal-Justice Systems. Jails also have significant fixed costs. Over the last decade, New York City's jail population has declined by 40% while the Department of Correction budget has increased by one-third.[92] The argument that Housing First saves money on jails dovetails with the critique of the so-called criminalization of homelessness.[93]

There is no question that enforcing quality-of-life ordinances, which are often violated by the homeless,[94] places a fiscal burden on public safety agencies. However, it does not follow that investing massively in permanent supportive housing and drastically scaling back on law enforcement would be fiscally prudent.

First, as discussed above, academic studies and the experience of jurisdictions in California have demonstrated the weakness of permanent supportive housing programs to reduce homelessness and thus presumably reduce public complaints about disorder. Second, less law enforcement carries costs, including public spaces increasingly occupied by encampments (and their attendant crime and public-health burdens) and attracting more street homeless from neighboring jurisdictions, thus increasing the demand for public services.

In any event, total law-enforcement cost savings would be very difficult to calculate, since jail is a small part of the "use" that homeless make of the criminal-justice system (very few misdemeanor offenses result in incarceration).[95] If 20 men are removed from Los Angeles's Skid Row by being put in permanent supportive housing, how many cops would the LAPD redeploy? Quite possibly, there would be no savings.

Shelter Systems. San Francisco's "Navigation Center" costs $100 per bed per night.[96] In New York City, shelter beds for families with children average $201.60 (an 89% increase since FY15) and for single adult shelter beds, the average is $124.38 (a 58% increase since FY15).[97] Shelter costs are high to ensure a certain level of quality, particularly security and on-site social services. For decades, and long before Housing First and its attendant social science literature, advocates claimed that affordable housing is cheaper than shelter.[98] A leading topic of housing policy debate in New York state government concerns "Home Stability Support." This program would increase the "shelter allowance," a permanent housing benefit to which public assistance clients are entitled. Proponents of Home Stability Support estimate that a more generous shelter allowance would cost New York City taxpayers about $27,000 less than shelter on an annual basis.[99]

But comparing temporary and permanent housing costs raises "apples to oranges" difficulties. It is complicated to compare a housing benefit that someone may well receive for decades with one that he would receive for only weeks or months. People who receive subsidized housing in tight rental markets are apt to continue using that benefit for a long time.[100] In New York City, the average length of stay for a public housing resident is 23 years.[101] In 2017, the most recent year for which there are data, only about 16% of permanent supportive housing residents moved out, and the share of long-stayers in permanent supportive housing has been steadily increasing over the years.[102] It is extremely expensive to provide a lifetime rental subsidy to someone, which is how permanent housing benefits function in the high-cost jurisdictions that now face the most serious homelessness challenges. It would be extraordinarily expensive to provide such subsidies to everyone, every year, who claims to be homeless in such jurisdictions. It would be much cheaper to provide temporary assistance to the vast majority of the homeless.

Governments that invest heavily in Housing First programs should expect the overall cost of government to rise. For some individuals, or some service systems, there may be cost offsets, but cost offsets are different from savings. A $1 investment in Housing First may be offset by 30 cents in savings on other service systems, but that still means that the government is 70 cents larger. Certainly, cost-effectiveness arguments should not lead anyone to think that Housing First investments will lead to tax reductions or somehow free up money that may be devoted to other purposes. Service systems' costs are split between various governments and agencies and even nonprofit organizations. (This has been referred to as the "wrong pockets" problem.)[103]

Dennis Culhane, a leading homelessness researcher who was featured in "Million-Dollar Murray," has subsequently cautioned against the risk of "overstating" the cost-savings argument. In 2008, he criticized

the design quality of more than 40 cost studies based upon their small size and selectivity in populations examined, noting that "in general, the larger the sample (and presumably the more representative of adults who are homeless), the lower the average annual costs of services use." But such studies are beneficial, he says, for showing the efficiency and accountability of homeless services systems and thus "mobiliz[ing] political will."[104]

It is certainly the case that, in many jurisdictions where homelessness is at crisis levels, the public has shown a marked willingness to raise taxes for homeless services. Some recent, successful ballot initiative campaigns in California, such as Measure HHH (Los Angeles County, 2016), made use of cost-savings rhetoric. Whether those arguments were, ultimately, more important for the voting public than humanitarian considerations is unclear. Some scholars have questioned the benefit of distracting from the humanitarian case for investing in homeless services.[105] Certainly, for those with poor physical or mental health, it is not obvious why reducing health-care expenditures should be a standard of policy effectiveness.

In sum, the truly "evidence-based" view of Housing First, when it comes to cost savings, bears a certain parallel with residential stability. The evidence supports the view that a Housing First intervention may, for certain individuals, reduce costs, at least in the short term. But the evidence does not support any thesis about systemwide cost savings. Housing First has not been demonstrated to be capable of saving costs for entire systems any more than it has been demonstrated to be capable of ending homelessness for entire communities.

IV. The Record on Behavioral Health

HUD estimates that 16% of the homeless population exhibits "Chronic Substance Abuse" and that "Severe Mental Illness" afflicts 20%.[106] Drug addiction and mental illness drive much of the "chronic homelessness" challenge. Permanent housing is seen as a condition of recovery for this cohort.[107] One of the main recommendations that USICH made in its 2017 brief, "Strategies to Address the Intersection of the Opioid Crisis and Homelessness," was to "Remove Barriers to Housing" by implementing Housing First.[108] But the research is ambiguous as to how much permanent housing, on its own, stimulates recovery.

In a 2019 law review article, Sara Rankin, of Seattle University School of Law, argued in favor of Housing First based on "the reality that people need basic necessities like food, sleep, and a stable place to live before attending to any secondary issues, such as getting a job, budgeting properly, or attending to substance use issues." She wrote that the "Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter."[109]

However, a 2017 survey of the literature by researchers Stefan G. Kertesz and Guy Johnson judged Housing First to have demonstrated, at best, modestly beneficial clinical impacts.[110] The Trump administration's CEA acknowledged the research on Housing First residential stability but argued: "For outcomes such as impacts on substance abuse and mental illness, Housing First in general performs no better than other approaches."[111] The 2018 study published by the National Academies of Sciences, Engineering, and Medicine found no strong evidence of Housing First and improvement of mental disorders, as have other surveys.[112]

Stated otherwise, the evidence for Housing First and behavioral health is far weaker than for residential stability. Some Housing First proponents, committed to the harm-reduction philosophy of recovery as a choice, are forthright about Housing First's modest ability to address behavioral health disorders.[113] Harm-reduction policy calls for prioritizing the remediation of symptoms and the harmful effects of disorders such as opioid addiction over trying to root out or overcome the underlying disorder. More commonly, though, advocates display a rhetorical suggestiveness about the link between permanent housing and behavioral health that seems intended to convince the public of evidence that does not exist.[114]

V. Self-Sufficiency and Social Isolation

Originally, Housing First was mainly associated with the chronic homeless population who had disabilities—most notably, serious mental illness. Hence, employment outcomes were not of leading interest. But as the theory of Housing First has evolved to take on a "systemwide orientation," applicable to the entire homeless population, it has come to be applied for cohorts that might be considered potential members of the working class. Permanent housing benefits are often likened to a "platform" from which, after having secured stable

housing, people can go to pursue various other goals, such as health and employment.[115] "Optimize self-sufficiency" is an official goal of HUD's NOFA.[116]

As noted, the large-scale Family Options Study (2015) showed robust rates of residential stability for the families receiving a permanent housing intervention. Accordingly, the study has been seen as supportive of Housing First, particularly as regards the "whole systems" orientation. But it also found evidence that housing subsidies, instead of granting recipients the freedom to focus more on employment and less on their housing instability challenges (à la the "platform" theory), actually led to diminished work effort.[117] In sum, housing subsidies increased rates of housing stability (and, as noted, at a greater cost than other interventions) but not self-sufficiency.[118] This was a troubling finding, since lack of work was one of the major social challenges faced by homeless families that participated in the study.[119] A 2012 article about Housing First cautioned that "subsidized housing may create disincentives for employment … and for independent housing … much in the way that disability benefits and public income support have been found to be associated with less employment."[120]

Another outcome worth evaluating is social isolation, a significant cause of homelessness. HUD has noted that while, nationwide, about 13% of the U.S. population is a member of a single-person household, 65% of the sheltered homeless population is.[121] "Community integration" was one of the original goals of Housing First, which criticized the quasi-institutional character of the linear homeless services system.[122]

ProPublica's "Right to Fail" report in late 2018, and the accompanying documentary released by Frontline in February 2019,[123] suggested that Housing First may serve more to increase social isolation than address it.[124] The report profiled a few seriously mentally ill clients of a supported housing program in New York, and how an excess of independence led to decompensation and even death. These individuals were, in some cases, stably housed, but living in apartments strewn with waste, swarming with bugs, and living with untreated infections and other health problems, and extremely isolated. "Right to Fail" did not specifically target Housing First—these were former residents of adult homes who had been placed in independent living under court order. Still, the report demonstrates that many mentally ill adults are, on the one hand, not eligible for institutionalization but, on the other, plainly not prepared for independent living.

The ProPublica study cannot be dismissed as simply anecdotal.[125] Several peer-reviewed articles and studies have questioned whether Housing First has lived up to its initial promise of "community integration."[126] Others, to be sure, have defended it.[127] But the least that can be said is that whatever some Housing First program may have managed to achieve with respect to community integration, the evidence is far weaker with respect to that outcome than has been measured with respect to residential stability.

VI. Conclusion

The claim that Housing First is "proven" is an attempt to take homelessness policy out of the realm of ordinary policy debate. "Evidence-based" rhetoric means to suggest that homelessness policy is simply different: alternatives to Housing First are illegitimate because they are not grounded in science in the way that Housing First is. This is not accurate. Homelessness policy questions should not be considered more settled than questions of mental health, public safety, or any other element of poverty or social policy.

It is crucial to parse claims about what is evidence-based about Housing First and what is founded on humanitarian concerns, intuition, ideology, or some other factor. There is no evidence-based proof of Housing First's ability to treat serious mental illness effectively, or drug or alcohol addiction. Housing First is not a reliable solution to social isolation, a very significant cause and effect of homelessness. Claims made on behalf of the campaign to end homelessness—that Housing First has ended veterans' homelessness, chronic homelessness, or homelessness at the community level—are not based in "evidence," as that term is normally understood, and they rely on a highly technical (and dubious) definition of "ending" homelessness.

A common refrain among advocates is that " 'Housing First' does not mean 'Housing Only.' "[128] This is not an evidence-based claim. The claim could be verified only through a broad and thorough analysis of Housing First's implementation across scores of programs across the nation. Surely, some programs are far more inventive in getting service-resistant clients to accept treatment and services than are others. A supportive housing program that systematically fails to engage any of its clients is, practically speaking, a "Housing Only" program. The literature about how Housing First programs function is far too sparse to validate that " 'Housing First' does not mean 'Housing Only.' "

There is, however, reasonable evidence to suggest that Housing First–style interventions will promote

residential stability, and quite likely at a higher rate than programs that provide housing on a time-limited basis and/or rely on "barriers," at least over a one- to two-year horizon. But an intervention is different from a policy or service system. An intervention could be one program among many. The evidence does not support the idea that Housing First should be made an organizing principle of homeless services systems. Arguments for Housing First on a systemwide basis may be defended based on intuition or humanitarian concerns, but they are not evidence-based.

The result of governments adopting Housing First as a "whole-system orientation" has been to discredit, or at least drastically de-emphasize, approaches to homelessness other than permanent housing. Less than one-fifth of the homeless population is "chronic"[129]—the population for whom Housing First was initially developed. The more that the homeless problem is described as people "down on their luck," the less logical is the claim that permanent housing is the solution. Housing First is an entirely inappropriate intervention for the working poor, examples of which include participants in "Safe Parking" programs[130] (which is to say that, in addition to reckoning with the limitations of Housing First for the chronically homeless, permanent housing is not always an appropriate solution to street homelessness).

What kind of homeless services system do we want? That is ultimately what the Housing First debate is about. As noted, the reduction in transitional housing units is a striking example of the influence of Housing First. But it is impractical to try to design a homeless services system without programs that have features similar to transitional housing. The homeless population has many problems other than housing instability. As such, there is a certain logic to trying to address these problems along with housing instability and give them equal emphasis while doing so. That logic, though, runs contrary to the logic of Housing First, which, particularly in its original articulation, insisted on the separation of housing and social services.

In the criminal-justice world, "problem-solving courts" such as drug and mental-health courts are not simply concerned with adjudicating charges. They also deal with the addiction and untreated serious mental illness of people involved in the criminal-justice system.[131] Similarly, the linear approach to homelessness had much more of a problem-solving orientation than the current Housing First system—focused, as it is, on keeping the most people housed for the longest period of time.

But if homeless services systems don't work on problems other than housing instability, other systems will. Indeed, the line between emergency shelter and transitional housing can get blurry. New York City's family shelter system, for instance, in many ways resembles transitional housing more than traditional notions of emergency shelter.

Before Housing First, the homeless population was offered a robust variety of housing and service options that reflected their diverse needs. This so-called linear system viewed permanent supportive housing and other low-barrier housing programs for the homeless as valuable to a continuum of service options.[132] But when too much emphasis is placed on low-barrier options, governments must ask whether they are designing a truly inclusive homeless services system.

Clearly, some clients will be best served by providers that emphasize sobriety and work. In the world of addiction services, many providers use social pressure to encourage sobriety. Is it illegitimate or not "evidence-based" for residential treatment programs to offer temporary housing coupled with sobriety requirements?[133] What's more important—achieving a year of sobriety or a year of housing stability? A program that sets no goals other than "residential stability," and that specifically does not require sobriety, will not be able to use social pressure to encourage sobriety. The same issue arises for programs that try to turn their clients into responsible fathers and economically independent members of their communities. As an example: Joe Biden's presidential campaign has called for reinvesting in transitional housing programs to facilitate prisoner reentry.[134]

Housing First is the dominant policy framework for homeless services. Yet, after years of implementation, communities are not close to ending homelessness. If homeless services systems can't focus as much on substance abuse, unemployment, and other social ills as they do on residential stability, those challenges will simply be left to other social-services systems. In light of these facts, a certain reorientation is justified.

Recommendations

1. HUD should allow more flexibility from Housing First requirements for communities pursuing homelessness assistance grants through the "Continuum of Care" program.

There are about 400 CoC agencies across the nation. HUD directs billions in Homelessness Assistance

Grants through these agencies to on-the-ground service providers. Federal homeless services funding was structured in this manner in deference to localism.[135]

When the CoC program was set up in the 1990s, it was "designed to meet the multi-faceted needs of homeless persons in the nation's communities."[136] In many communities, the local "CoC" is the lead policymaking organization on homelessness. As Housing First requirements have tightened, however, the CoC program has been criticized for departing from its original spirit and adopting a "one-size-fits-all" approach to homeless services.[137] Many criticisms of HUD's application of Housing First principles have come from religious organizations, which have, for more a century, played a significant role in addressing homelessness.[138] The federally directed restructuring of homeless services has had a significant impact at the community level. Examples of highly regarded service providers that have experienced cuts include Community Housing Innovations, the largest provider of homeless services on Long Island,[139] and the New York City–based Doe Fund.[140] Other providers have ceased pursuing HUD funding or been pressured—by the federal government, ultimately—to make programmatic changes contrary to their priorities.

2. State and local Housing First mandates should be reassessed.

Homelessness is highly concentrated in certain urban areas, as are major homeless services systems. California and New York are hosts to about one-third of the total permanent and temporary year-round beds for the homeless.[141] Thus, state and local policies may, in some cases, matter even more than federal funding requirements. State Housing First mandates, such as California's SB 1380,[142] should be reassessed in light of the need to develop homeless services systems reflective of the needs of the entire homeless population.

3. The homelessness debate should be reintegrated into the safety-net debate.

Housing First has separated the debates over homelessness and the safety net more broadly. In its approach to poverty, the Trump administration has tried to promote the expanded use of work requirements for safety-net programs.[143] While there is a serious debate over the appropriateness and effectiveness of work requirements for noncash programs such as Medicaid and the Supplemental Nutrition Assistance Program, there is a broad acceptance of their legitimacy in the case of public assistance. In homeless policy circles, by contrast, there is broad opposition to the use of work requirements, as well as drug testing, program-participation requirements, and adherence to treatment regimens.

As a result of Housing First's influence, the question of upward mobility for the homeless is discussed far less often than it is for the poor. Policymakers speak with modesty about such grandiose goals as ending poverty. But with respect to ending homelessness, they are expected to accept not only the nobility of that goal but its practicality. As a result, Housing First has come to function as a harm-reduction approach not only for behavioral health but also for poverty. Someone placed in permanent supportive housing may have ended his homelessness, but he is only managing his poverty.

Endnotes

[1] On the history of shelter programs, see Kim Hopper, *Reckoning with Homelessness* (Ithaca, NY: Cornell University Press, 2003); Charles Hoch and Robert A. Slayton, *New Homeless and Old: Community and the Skid Row Hotel* (Philadelphia: Temple University Press, 1989); Kenneth L. Kusmer, *Down and Out, on the Road: The Homeless in American History* (New York: Oxford University Press, 2001).

[2] Stefan G. Kertesz et al., "Housing First for Homeless Persons with Active Addiction: Are We Overreaching?" *Milbank Quarterly* 87, no. 2 (June 2009): 495–534.

[3] U.S. Department of Housing and Urban Development (HUD), United States Interagency Council on Homelessness (USICH), "Priority: Home! The Federal Plan to Break the Cycle of Homelessness," 1994, pp. 73–75; HUD, "Notice of Funding Availability for Continuum of Care Homeless Assistance: Funding Availability," *Federal Register* 61, no. 52 (Mar. 15, 1996): 10866–77.

[4] New York City Commission on the Homeless, "The Way Home: A New Direction in Social Policy," February 1992, pp. 13, 32, 39–41, 55, 59; Rob Teir, "Restoring Order in Urban Public Spaces," *Texas Review of Law & Politics* 2, no. 2 (Spring 1998): 255–92; Alice S. Baum and Donald W. Burnes, *A Nation in Denial: The Truth About Homelessness* (Boulder, CO: Westview, 1993), chap. 8; Thomas J. Main, *Homelessness in New York City: Policymaking from Koch to de Blasio* (New York: New York University Press, 2017), chap. 3; HUD, "Priority: Home!" pp. 20–21, 37, 55–56, 94–96, 111–13.

[5] HUD, "Priority: Home!" p. iii: "I do not believe we can repair the basic fabric of society until people who are willing to work have work. Work organizes life. It gives structure and discipline to life. It gives a role model to children. We cannot repair the American community and restore the American family until we provide the structure, the value, the discipline and reward that work gives."

[6] Ibid., p. 34.

[7] Shannon E. Couzens, "*Priority: Home!* A True Priority? An Analysis of the Federal Plan to Break the Cycle of Homelessness," *Journal of Social Distress and the Homeless* 6, no. 4 (1997): 275–82.

[8] President John F. Kennedy, "Special Message to the Congress on Mental Illness and Mental Retardation," Feb. 5, 1963: "When carried out, reliance on the cold mercy of custodial isolation will be supplanted by the open warmth of community concern and capability. Emphasis on prevention, treatment, and rehabilitation will be substituted for a desultory interest in confining patients in an institution to wither away."

[9] Jack Tsai, Alvin S. Mares, and Robert A. Rosenheck, "A Multi-Site Comparison of Supported Housing for Chronically Homeless Adults: 'Housing First' Versus 'Residential Treatment First,' " *Psychological Services* 7, no. 4 (November 2010): 220.

[10] HUD, "The 2017 Annual Homeless Assessment Report (AHAR) to Congress, Part 2: Estimates of Homelessness in the United States," October 2018, p. v.

[11] See, e.g., Sam Tsemberis, "From Streets to Homes: An Innovative Approach to Supported Housing for Homeless Adults with Psychiatric Disabilities," *Journal of Community Psychology* 27, no. 2 (1991): 227: "Most [linear residential treatment] housing providers regard themselves as treatment providers rather than as landlords"; Priscilla Ridgway and Anthony M. Zipple, "The Paradigm Shift in Residential Services: From the Linear Continuum to Supported Housing Approaches," *Psychosocial Rehabilitation Journal* 13, no. 4 (April 1990): 17: "The residential program is seen as primarily a clinical modality designed to treat mentally ill individuals rather than a home for those who live there"; Daniel Gubits et al., "Family Options Study: Short-Term Impacts of Housing and Services Interventions for Homeless Families," HUD, Office of Policy Development and Research, July 2015, p. xxi: "Practitioners' goals for project-based transitional housing … extend beyond housing stability to adult well-being and aspects of family self-sufficiency."

[12] Sue Barrow and Rita Zimmer, "Transitional Housing and Services: A Synthesis," in *Practical Lessons: The 1998 National Symposium on Homelessness Research*, ed. Linda B. Fosburg and Deborah L. Dennis, HUD and U.S. Department of Health and Human Services (HHS), 1999, p. 315.

[13] Ibid., p. 313; H. Stephen Leff et al., "Does One Size Fit All? What We Can and Can't Learn from a Meta-Analysis of Housing Models for Persons with Mental Illness," *Psychiatric Services* 60, no. 4 (April 2009): 473–82.

[14] Ridgway and Zipple, "The Paradigm Shift in Residential Services"; Kertesz, "Housing First for Homeless Persons with Active Addiction"; Victoria Stanhope and Kerry Dunn, "The Curious Case of Housing First: The Limits of Evidence-Based Policy," *International Journal of Law and Psychiatry* 34, no. 4 (July/August 2011): 275–82.

[15] The role played by advocates in the popular adoption of the term "homeless" has been discussed in many sources. See, e.g., Robert C. Ellickson, "Controlling Chronic Misconduct in City Spaces: Of Panhandlers, Skid Rows, and Public-Space Zoning," *Yale Law Journal* 105, no. 5 (January 1996): 1192–93, 1214; Richard W. White, Jr., *Rude Awakenings: What the Homeless Crisis Tells Us* (San Francisco: ICS, 1992), chap. 9; Brendan O'Flaherty, *Making Room* (Cambridge, MA: Harvard University Press, 1996), pp. 9–11; Forrest Stuart, *Down, Out, and Under Arrest* (Chicago: University of Chicago Press, 2018), p. 49; Hopper, *Reckoning with Homelessness*, p. 7; HUD, "Priority: Home!" p. 22.

[16] Sam Tsemberis and Sara Asmussen, "From Streets to Homes: The Pathways to Housing Consumer Preference Supported Housing Model," *Alcoholism Treatment Quarterly* 17, nos. 1–2 (1999): 113–14, 127.

[17] Leff, "Does One Size Fit All?"; Deborah K. Padgett et al., "Substance Use Outcomes Among Homeless Clients with Serious Mental Illness: Comparing Housing First with Treatment First Programs," *Community Mental Health Journal* 47, no. 2 (April 2011): 227–32; DJ Jaffe, *Insane Consequences: How the Mental Health Industry Fails the Mentally Ill* (Buffalo, NY: Prometheus, 2017), pp. 100–102.

[18] Ridgway and Zipple, "The Paradigm Shift in Residential Services," p. 20: "The tendency to cluster or congregate persons with a history of mental illness tends to replicate historical institutional responses that were designed to segregate and contain deviants"; Kim Hopper et al., "Homelessness, Severe Mental Illness, and the Institutional Circuit," *Psychiatric Services* 48, no. 5 (May 1997): 659–65.

[19] Paul Carling, "Major Mental Illness, Housing, and Supports: The Promise of Community Integration," *American Psychologist* 45, no. 8 (August 1990): 969–75.

[20] Housing programs are more difficult to categorize than is typically acknowledged in the literature. Traditionally, "supported housing" meant ordinary rental apartments leased from a private landlord via a service provider. The term meant "tenant-based" or "scatter-sited" housing for the homeless, with services made available 24/7 but based out of a separate location. "Supportive housing," by contrast, was understood to mean congregate- or project-based—custom-built affordable housing for the homeless that offers 24/7 services on-site. However, the terms have become blurred, and "supportive housing," by far the more common term, now refers to both project-based and tenant-based programs. Support for "supportive housing" and "permanent supportive housing" programs has also become generally indistinguishable from support for Housing First, even though some older supportive housing programs were not designed in accord with Housing First principles. It is possible that the blurring of these concepts in advocates' rhetoric has been deliberate (see Richard Cho, "Four Clarifications About Housing First," USICH, June 18, 2014: "I see it as a sign of progress that permanent supportive housing and Housing First are being conflated").

[21] Though Pathways to Housing continues to operate in other jurisdictions, its New York program was forced to close because of bankruptcy proceedings, as Tsemberis's efforts to expand the program nationally jeopardized contracts with the state Office of Mental Health and even risked eviction for more than 100 Pathways clients. See Greg B. Smith, "Homeless Group in $25M Bankruptcy Fight Failed to Pay Rent for Mentally Ill," *New York Daily News,*

Feb. 13, 2018; "Motion to Approve Settlement, Deborah J. Piazza, as Chapter 7 Trustee of Pathways to Housing NY, Inc., Plaintiff, – v – Sam Tsemberis and Pathways to Housing National, Inc. a/k/a Pathways to Housing, Inc.," United States Bankruptcy Court, Southern District of New York, Mar. 2, 2018.

[22] National Alliance to End Homelessness, "A Plan, Not a Dream: How to End Homelessness in Ten Years," 2000.

[23] HUD, "Taking on the Problem That 'Cannot Be Solved,' " Secretary [Mel] Martinez's Speeches and Testimony, July 20, 2001.

[24] Douglas McGray, "The Abolitionist," *The Atlantic*, June 2004; Libby Perl et al., "Homelessness: Targeted Federal Programs," Congressional Research Service (CRS), Oct. 18, 2018; USICH, "U.S. Interagency Council on Homelessness Historical Overview," December 2016.

[25] Kertesz, "Housing First for Homeless Persons with Active Addiction," p. 497.

[26] California Senate Bill No. 1380, chap. 847, Sept. 29, 2016.

[27] HUD, "2017 Annual Homeless Assessment Report (AHAR)," pp. xii–xiii; USICH, "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness," 2010, and "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness as Amended in 2015," June 2015.

[28] USICH, "Home, Together: The Federal Strategic Plan to Prevent and End Homelessness," July 2018, p. 6.

[29] For the text of the letter, see Mitch Perry, "Ted Yoho Urges Ben Carson to Reverse Obama-Era 'Housing First,' Reinstate Homeless Shelter Funds," floridapolitics.com, June 19, 2017.

[30] See discussion in Libby Perl, "The HUD Homeless Assistance Grants: Programs Authorized by the HEARTH Act," CRS, Aug. 30, 2017.

[31] "Letter to the Honorable Darrell Issa," HUD, Aug. 9, 2017 (letter not posted online; available on request from the author).

[32] Jillian Kay Melchior, "Meet the Woman Rashida Tlaib Called a 'Prop,' " *Wall Street Journal*, Mar. 29, 2019; and see the series of HUD press releases: "HUD Makes $2 Billion Available to Local Homeless Programs: Funding Notice Encourages Local Applicants to Use Housing First Approach," July 14, 2017; "HUD Awards Record $2 Billion to Thousands of Local Homeless Assistance Programs Across U.S.," Jan. 11, 2018; "HUD Awards over $202 Million to Help End Homelessness," Feb. 8, 2019; "HUD Renews Funding to Thousands of Local Homeless Programs," Jan. 26, 2019.

[33] USICH, "CoC NOFA FY 2019: What's New and How to Build upon Your Work to End Homelessness," July 16, 2019, p. 13.

[34] National Alliance to End Homelessness et al., "Letter to Reps. Collins, Price, Reed, and Diaz-Balart," Dec. 3, 2019; Kriston Capps, "Trump's Plan to Criminalize Homelessness Is Taking Shape," CityLab, Dec. 17, 2019.

[35] 116th Congress of the United States, "Further Consolidated Appropriations Act, 2020" (HR 1865), p. 458: "when awarding funds under the Continuum of Care program, the Secretary shall not deviate from the FY 2018 Notice of Funding Availability with respect to the tier 2 funding process, the Continuum of Care application scoring, and for new projects, the project quality threshold requirements, except as otherwise provided under this Act or as necessary to award all available funds or consider the most recent data from each Continuum of Care."

[36] Council of Economic Advisers (CEA), "The State of Homelessness in America," September 2019, pp. 23–26.

[37] Arthur Delaney, "How a Traveling Consultant Helps America Hide the Homeless," HuffPost, Mar. 9, 2015. See also Western Regional Advocacy Project, "Criminalization Hitting the Fan at National Level Under Trump: Appointment of Robert Marbut to USIACH [sic]," Dec. 4, 2019; Kriston Capps, "The Consultant Leading the White House Push Against Homelessness," CityLab, Dec. 12, 2019; Capps, "Trump's Plan to Criminalize Homelessness"; Ben Kesling, "New Homelessness Czar Takes Aim at Long-Standing Policy," *Wall Street Journal,* Feb. 1, 2020.

[38] Heather Knight, "A Decade of Homelessness: Thousands in S.F. Remain in Crisis," *San Francisco Chronicle*, June 30, 2014; San Francisco Ten-Year Planning Council, "The San Francisco Plan to Abolish Homelessness," 2014; Robert Greene, "Tell Us Why This Homelessness Plan Will Work When the Others Failed," *Los Angeles Times*, Jan. 27, 2016; Bring L.A. Home Blue Ribbon Panel, "Bring Los Angeles Home: The Campaign to End Homelessness," 2006.

[39] Mark Baldassare et al., "Californians & Their Government," Public Policy Institute of California, January 2020; San Francisco Controller, "2019 San Francisco City Survey: A Biennial Survey of San Francisco Residents," May 13, 2019, pp. 7, 10; San Francisco Chamber of Commerce, "Public Safety, Homelessness and Affordability Are Biggest Issues in 2018 SF Chamber Poll, Feb. 2, 2018; Benjamin Oreskes, Doug Smith, and David Lauter, "95% of Voters Say Homelessness Is L.A.'s Biggest Problem, Times Poll Finds. 'You Can't Escape It,' " *Los Angeles Times,* Nov. 14, 2019; Emily Alpert Reyes, Benjamin Oreskes, and Doug Smith, "L.A. Is Swamped with 311 Complaints over Homeless Camps. But Are the Cleanups Pointless?" *Los Angeles Times,* June 7, 2019.

[40] National Academies of Sciences, Engineering, and Medicine, *Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness* (Washington, DC: National Academies Press, 2018), pp. 31–32.

[41] Richard Cho, "Four Clarifications About Housing First," usich.gov, June 18, 2014: "Housing First is not a 'program.' It is a whole-system orientation and response." See also USICH, "Home, Together" and "Deploy Housing First Systemwide," Aug. 15, 2018; Deborah Padgett, Benjamin Henwood, and Sam Tsemberis, *Housing First: Ending Homelessness, Transforming Systems, and Changing Lives* (New York: Oxford University Press, 2015); USICH, "The Evidence Behind Approaches That Drive an End to Homelessness," September 2019, p. 4.

[42] USICH, "Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation," September 2016, and "Tools That Support the Implementation of Home, Together," December 2019.

[43] USICH, "Tools That Support the Implementation of Home," p. 7.

[44] Patrick J. Fowler, "U.S. Commentary: Implications from the Family Options Study for Homeless and Child Welfare Services," *Cityscape: A Journal of Policy Development and Research* 19, no. 3 (Winter 2017): 255–64; HUD, "SNAPS in Focus: The Family Options Study," July 8, 2015.

[45] See New York City Council, "Our Homelessness Crisis: The Case for Change," January 2020, pp. 129–30; USICH, "The Evidence Behind Approaches," p. 4.

[46] McGray, "The Abolitionist"; Scott Carrier, "The Shockingly Simple, Surprisingly Cost-Effective Way to End Homelessness," *Mother Jones*, Feb. 17, 2015; USICH, "The Evidence Behind Approaches"; Coalition for the Homeless, "Proven Solutions."

[47] Ben Carson, "We Know How to End Homelessness and Housing Shortages," *USA Today*, Dec. 15, 2017: "For years, there has been a growing mountain of data showing that a Housing First approach works to reduce not only costs to taxpayers but the human toll as well. The evidence is clear: Doing something is better and less expensive than doing nothing. That something is prioritizing housing. Once we give people a stable place to live, it becomes much easier to provide mental and physical health treatment, education and job training—essential rungs on the ladder out of homelessness. As we prepare to turn the calendar on another year, we can say without hesitation that we know how to end homelessness."

[48] Sam Tsemberis, Douglas Kent, and Christy Respress, "Housing Stability and Recovery Among Chronically Homeless Persons with Co-Occurring Disorders in Washington, D.C.," *American Journal of Public Health* 102, no. 1 (January 2012): 13–16, is an example of a study that looks at the number of people still housed at the end of the study; Robert Rosenheck et al., "Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness," *Archives of General Psychiatry* 60, no. 9 (September 2003): 940–51, is an example of a study that uses the "days housed" measure; see also National Academies, *Permanent Supportive Housing*, pp. 40, 41, 49, 68, 84–85.

[49] Angela Ly and Eric Latimer, "Housing First Impact on Costs and Associated Costs Offsets: A Review of the Literature," *Canadian Journal of Psychiatry* 60, no. 11 (November 2015): 475–87.

[50] Debra J. Rog et al., "Permanent Supportive Housing: Assessing the Evidence," *Psychiatric Services* 65, no. 3 (March 2014): 287–94.

[51] Stefan G. Kertesz and Guy Johnson, "Housing First: Lessons from the United States and Challenges for Australia," *Australian Economic Review* 50, no. 2 (May 2017): 220–28.

[52] National Academies, *Permanent Supportive Housing*, pp. 3, 17, and chap. 8 on "Research Gaps"; Rog, "Permanent Supportive Housing," pp. 289, 293; Elizabeth A. Benston, "Housing Programs for Homeless Individuals with Mental Illness: Effects on Housing and Mental Health Outcomes," *Psychiatric Services* 66, no. 8 (August 2015): 811–13; Stefan Kertesz et al., "Housing First on a Large Scale: Fidelity Strengths and Challenges in the VA's HUD–VASH Program," *Psychological Services* 14, no. 2 (May 2017): 118–28; Kertesz and Johnson, "Housing First: Lessons from the United States," p. 223; Ana Stefancic et al., "The Pathways Housing First Fidelity Scale for Individuals with Psychiatric Disabilities," *American Journal of Psychiatric Rehabilitation* 16, no. 4 (October 2013): 242: "unwelcome model drift."

[53] Surveys of this literature may be found in Padgett, Henwood, and Tsemberis, *Housing First*; Brendan O'Flaherty, "Homelessness Research: A Guide for Economists (and Friends)," *Journal of Housing Economics* 44, issue C (2019): 1–25; Kertesz and Johnson, "Housing First: Lessons from the United States."

[54] CEA, "State of Homelessness," pp. 24–25.

[55] Ibid., p. 11.

[56] Steven Raphael, "Housing Market Regulation and Homelessness," in *How to House the Homeless*, ed. Ingrid Gould Ellen and Brendan O'Flaherty (New York: Russell Sage, 2010).

[57] BallotPedia, "Los Angeles, California, Homelessness Reduction and Prevention Housing, and Facilities Bond Issue, Measure HHH (November 2016)."

[58] Thomas Byrne et al., "The Relationship Between Community Investment in Permanent Supportive Housing and Chronic Homelessness," *Social Service Review* 88, no. 2 (June 2014): 234–63; Kevin Corinth, "The Impact of Permanent Supportive Housing on Homeless Populations," *Journal of Housing Economics* 35 (March 2017): 69–84; Kevin Corinth, "Ending Homelessness: More Housing or Fewer Shelters?" American Enterprise Institute, November 2015; O'Flaherty, "Homelessness Research," pp. 12–14.

[59] Michael Hobbes, "Why America Can't Solve Homelessness," Huffpost.com, May 15, 2019.

[60] Kevin C. Corinth, "On Utah's 91% Decrease in Chronic Homelessness," American Enterprise Institute, March 2016; idem, "Think Utah Solved Homelessness? Think Again," HuffPost, March 4, 2016.

[61] Matthew Doherty, "What I Learned About Housing First from Lloyd Pendleton," endhomelessness.org, May 6, 2019; Laurel Wamsley, "White House Names Controversial Pick to Head Homelessness Office," npr.org, Dec. 5, 2019.

[62] USICH, "Communities That Have Ended Homelessness."

[63] Tom Albanese, "Veterans," Center for Evidence-Based Solutions to Homelessness, December 2017; New York City Council, "Our Homelessness Crisis: The Case for Change," January 2020, p. 49; HUD, "2017 Annual Homeless Assessment Report (AHAR)," p. iii; Harvard Kennedy School, Joint Center for Housing Studies of Harvard University, "The State of the Nation's Housing 2018," p. 34; Shaun Donovan and Eric K. Shinseki, "Homelessness Is a Public Health Issue," *American Journal of Public Health* 103, no. S2 (December 2013): S180; USICH, "Home, Together," p. 4.

[64] O'Flaherty, "Homelessness Research," p. 21.

[65] USICH, "What Does Ending Homelessness Mean?" June 4, 2018.

[66] Kertesz, "Housing First for Homeless Persons with Active Addiction," p. 503.

[67] USICH, "Communities That Have Ended Homelessness."

[68] Barbara Duffield, "Are We Creating Chronic Homelessness? The Past, Present, and Future of Federal Homelessness Policy," Institute for Children, Poverty & Homelessness, October 2016.

[69] USICH, "What Does Ending Homelessness Mean?"

[70] U.S. Committee on Financial Services, "Chairwoman Waters Introduces Bill to End Homelessness in America," Mar. 26, 2019; Office of the Mayor of Los Angeles, "Mayor Garcetti Leads Coalition of Mayors Calling for Federal Action to Confront Homelessness Crisis," July 1, 2019; New York City, Office of the Mayor, "Transcript: Mayor de Blasio Presents 2020 State of the City," Feb. 6, 2020: "We have to end homelessness as we know it in New York City"; Protecting and Empowering Renters," elizabethwarren.com; "Housing for All," berniesanders.com; "Coming Home: An Agenda for Housing Justice in America," peteforamerica.com.

[71] O'Flaherty, *Making Room*.

[72] Discussed in Main, *Homelessness in New York City*, chap. 3.

[73] Kertesz, "Housing First for Homeless Persons with Active Addiction"; CEA, "State of Homelessness in America"; O'Flaherty, "Homelessness Research."

[74] Malcolm Gladwell, "Million-Dollar Murray," *The New Yorker*, Feb. 5, 2006.

[75] Dennis P. Culhane, "The Costs of Homelessness: A Perspective from the United States," *European Journal of Homelessness* 2, no. 1 (December 2008): 105.

[76] Ibid.: "Among advocates for the homeless in the US, a truism has long held that homelessness is more expensive to society than the costs of solving the problem." Philip Mangano, quoted in Erik Eckholm, "New Campaign Shows Progress for Homeless," *New York Times*, June 7, 2006: "Cost-benefit analysis may be the new compassion in our communities."

[77] Tracy L. Johnson et al., "For Many Patients Who Use Large Amounts of Health Care Services, the Need Is Intense Yet Temporary," *Health Affairs*, 34, no. 8 (August 2015): 1312–19; National Academies, *Permanent Supportive Housing*, pp. 4, 17, notes very large differences between what RCTs have found vs. what pre-post studies have found in terms of both cost savings and health.

[78] Ly, "Housing First Impact on Costs," p. 482; Stefan G. Kertesz et al., "Permanent Supportive Housing for Homeless People—Reframing the Debate," *New England Journal of Medicine* (Dec. 1, 2016): 2116.

[79] Kertesz and Johnson, "Housing First: Lessons from the United States," 224: "Housing First can almost 'pay for itself,' but only when it targets a costly clientele who represent only a very small portion of the chronically homeless."

[80] Daniel Gubits et al., "Family Options Study: 3-Year Impacts of Housing and Services Interventions for Homeless Families," HUD, Office of Policy Development and Research, October 2016, exhibit 9-5, p. 114.

[81] Culhane, "Costs of Homelessness," pp. 103–4.

[82] HHS, Substance Abuse and Mental Health Services Administration, "National Mental Health Services Survey (N-MHSS): 2017 Data on Mental Health Treatment Facilities," August 2018; DJ Jaffe and E. Fuller Torrey, "Funds for Treating Individuals with Mental Illness: Is Your State Generous or Stingy?" mentalillnesspolicy.org, Dec. 12, 2017.

[83] Culhane, "Costs of Homelessness," 103: "Areas with more limited public services overall may well have fewer costly service users among the people who are homeless, meaning that there are few costs to offset as a result of an intervention."

[84] See "Letter to the Honorable Darrell Issa," HUD, Aug. 9, 2017, pp. 3–4.

[85] Travis P. Baggett et al., "Mortality Among Homeless Adults in Boston: Shifts in Causes of Death over a 15–Year Period," *JAMA Internal Medicine* 173, no. 3 (February 2013): 189–95.

[86] Wei Sun, Anthony Webb, and Natalia Zhivan, "Does Staying Healthy Reduce Your Lifetime Health-Care Costs?" Center for Retirement Research at Boston College, May 2010.

[87] Jan J. Barendregt, Luc Bonneux, and Paul J. van der Maas, "The Health-Care Costs of Smoking," *New England Journal of Medicine* (Oct. 9, 1997): 2052–57; Wayne Hall and Chris Doran, "How Much Can the USA Reduce Health-Care Costs by Reducing Smoking?" *PLOS Medicine* 13, no. 5 (May 2016): 1–3.

[88] National Academies, *Permanent Supportive Housing*; Kertesz and Johnson, "Housing First: Lessons from the United States," 223: "Randomised trials have typically found no or minimal benefit for standard health measures."

[89] Samuel R. Bagenstos, "The Past and Future of Deinstitutionalization Litigation," Law & Economics Working Papers, article 46, 2012; Howard H. Goldman, "Perspective: Justifying Mental Health Care Costs," *Health Affairs* 18, no. 2 (March/April 1999): 94–95; Roland Sturm, "The Myth of Medical Cost Offset," *Psychiatric Services* 52, no. 6 (June 2001): 738–40; Burton A. Weisbrod, "Benefit-Cost Analysis of a Controlled Experiment: Treating the Mentally Ill," *Journal of Human Resources* 16, no. 4 (Autumn 1981): 523–48.

[90] National Association of State Mental Health Program Directors, "Trend in Psychiatric Inpatient Capacity, United States and Each State, 1970 to 2014," August 2017, p. 11.

[91] HUD, "HUD 2019 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations," Sept. 20, 2019.

[92] New York City Comptroller, "NYC Department of Correction FYs 2009–19 Operating Expenditures, Jail Population, Cost per Incarcerated Person, Staffing Ratios, Performance Measure Outcomes, and Overtime," Dec. 6, 2019.

[93] Sara K. Rankin, "Punishing Homelessness," *New Criminal Law Review: An International and Interdisciplinary Journal* 22 no. 1 (Winter 2019): 99–135; Joseph W. Mead and Sara Rankin, "Criminalizing Homelessness Doesn't Work," CityLab, June 20, 2018.

[94] Gale Holland and Christine Zhang, "Huge Increase in Arrests of Homeless in L.A.—but Mostly for Minor Offenses," *Los Angeles Times,* Feb. 4, 2018.

[95] Issa Kohler-Hausmann, *Misdemeanorland* (Princeton, NJ: Princeton University Press, 2018); Stuart, *Down, Out, and Under Arrest*; Rankin, "Punishing Homelessness."

[96] Kevin Fagan, "Bay Area Homelessness: 89 Answers to Your Questions," *San Francisco Chronicle*, July 28, 2019.

[97] City of New York, Mayor's Office of Operations, "Mayor's Management Report," September 2019, p. 197.

[98] Robert Hayes, "Litigating on Behalf of Shelter for the Poor," *Harvard Civil Rights–Civil Liberties Law Review* 22, no. 1 (Winter 1987): 79–93.

[99] New York State Senate, Office of State Senator Liz Krueger, "Home Stability Support Bill Moves Out of Senate Social Services Committee," Mar. 5, 2019.

[100] HUD, "Length of Stay in Assisted Housing," October 2017.

[101] New York City Housing Authority, "NYCHA 2019 Fact Sheet," March 2019.

[102] Of the PSH population, 38.8% are over 50, and the share has been steadily rising. See HUD, "2017 Annual Homeless Assessment Report (AHAR)," pp. xxi, 7-3, 7-4, 7-5, and 7-11: "The share of long-term stayers living in PSH during the reporting year has increased every year between 2010 and 2017." The share of "more than five years" is up to 28.6%.

[103] National Academies, *Permanent Supportive Housing*, p. 111.

[104] Culhane, "The Costs of Homelessness"; Culhane et al., "Accountability, Cost-Effectiveness, and Program Performance: Progress Since 1998," 2007 National Symposium on Homelessness Research, February 2008.

[105] Kertesz et al., "Permanent Supportive Housing for Homeless People."

[106] HUD, "HUD 2018 Continuum of Care Homeless Assistance Programs," Nov. 13, 2018.

[107] "Letter to the Honorable Darrell Issa," HUD, Aug. 9, 2017, p. 2: "Housing First models help people move quickly from homelessness to permanent housing, and then leverage the housing to serve as a platform for meeting other goals such as education, employment, and recovery. The combination of housing stability and a robust set of consumer driven services help people improve their self-sufficiency and well-being. The services can include employment, education and career development, mental health, and substance abuse treatment and recovery supports."

[108] USICH, "Strategies to Address the Intersection of the Opioid Crisis and Homelessness," February 2017.

[109] Rankin, "Punishing Homelessness."

[110] Kertesz and Johnson, "Housing First: Lessons from the United States."

[111] CEA, "State of Homelessness," p. 24.

[112] National Academies, *Permanent Supportive Housing*: "[E]ven though supportive housing models have been found to decrease the number of days spent homeless … for individuals with serious mental illness and/or substance use, this has not translated to significant improvements in mental health status in most studies," p. 48, and chap. 9 generally; Rog, "Permanent Supporting Housing," p. 292: "[The] majority of studies … found no effect of permanent supportive housing on psychological symptoms or alcohol or drug use"; Tsai, Mares, and Rosenheck, "A Multi-Site Comparison of Supported Housing," p. 20: "[N]o differences were found on psychiatric, substance abuse, or community adjustment outcomes"; Jack Tsai and Robert A. Rosenheck, "Considering Alternatives to the Housing First Model," *European Journal of Homelessness* 6, no. 2 (December 2012): 203: "Housing First, along with less clearly defined permanent supported housing programmes, have primarily shown success in housing outcomes, with minor or no improvements observed in clinical, social, and quality of life outcomes."

[113] Padgett, Henwood, and Tsemberis, *Housing First*, chap. 4.

[114] Sam Tsemberis, Leyla Gulcur, and Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis," *American Journal of Public Health* 94, no. 4 (May 2004): 652: "The program posits that providing a person with housing first creates a foundation on which the process of recovery can begin. Having a place of one's own may—in and of itself—serve as a motivator for consumers to refrain from drug and alcohol abuse"; and 655: "Providing housing first may motivate consumers to address their addictions to keep their housing, so that providing housing before treatment, may better initiate and sustain the recovery process"; National Alliance to End Homelessness, Fact Sheet,

April 2016: "Housing First is a homeless assistance approach that prioritizes providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can pursue personal goals and improve their quality of life."

115 Gubits, "Family Options Study: 3-Year Impacts," p. xx; USICH, "The Evidence Behind Approaches," p. 4, and "Home, Together," p. 23; National Academies, *Permanent Supportive Housing*, pp. 4, 13, 41, 50.

116 HUD, "FY 2019 CoC Program NOFA," July 2019, p. 1.

117 Gubits, "Family Options Study: 3-Year Impacts," exhibit 3-12, pp. 41–44.

118 Ibid.; Kevin C. Corinth, "What Should We Do About Homeless Families? Comments on the Family Options Study," American Enterprise Institute, August 2015.

119 Gubits, "Family Options Study: 3-Year Impacts," p. xxii: "Most family heads were not working at the time of random assignment (83 percent), and more than one-half had not worked for pay in the previous 6 months. The median annual household income of all families in the study at baseline was $7,410."

120 Tsai and Rosenheck, "Considering Alternatives to the Housing First Model."

121 HUD, "2017 Annual Homeless Assessment Report," October 2018, p. 1-11: "People experiencing sheltered homelessness were 5.1 times more likely to be by themselves than people in the total U.S. population (64.9% versus 12.8% have a household size of one person)."

122 Ridgway and Zipple, "The Paradigm Shift in Residential Services," p. 20: "a total environment made up of persons who have the status of deviants often results in social isolation. Even when such a setting is physically located in the community, residents may spend their time primarily in relation with their peers and lack interaction with the broader community."

123 ProPublica, Right to Fail, "New Documentary Chronicles the Challenges of New York's Supported Housing Program for People with Mental Illness," Feb. 20, 2019.

124 See ProPublica, "Right to Fail: For New Yorkers with Mental Illness, a Broken Promise."

125 Julia Solomons, "Written Testimony of the Bronx Defenders: Re: Oversight-Preventing Recidivism for Individuals with Mental Illness and Int 0903-In Relation to Funds Remaining in Inmate Accounts When Inmates Are Released," New York City Council, Joint Hearing: Committee on the Justice System and Committee on Health, Disabilities and Addiction, June 17, 2019, p. 6: "Not only are the barriers to successfully being placed in supportive housing significant, but once housed in one of the buildings run by a supportive housing agency, the conditions for this extremely vulnerable population are often not structured to result in long-term stability. We hear countless reports from our clients in supportive housing that they do not have regular, reliable access to the case management support that they are supposed to receive. Additionally, when they are struggling with issues directly related to their housing and safety, such as problems with another resident, they find it very difficult to get any assistance. The case management staff are often overworked and overburdened, and the bureaucracy that clients have to navigate in order to make any necessary changes to their housing is nearly impossible to achieve without extremely persistent advocacy. For example, we have had clients report that when they have a neighbor who is not on their medication and may be actively symptomatic and threatening to harm them, they receive little to no response on the part of the agency managing their housing. Requests to move units are in large part ignored but those that are not take far too long to happen, especially if a situation is acutely dangerous for that client and a threat to their stability. We also see this in situations where clients in recovery from substance use are placed in a housing site that, meaning they might have completed drug treatment and be in recovery but their neighbor is actively using drugs—a direct threat to their sobriety and therefore stability."

126 Jack Tsai, Alvin S. Mares, and Robert A. Rosenheck, "Does Housing Chronically Homeless Adults Lead to Social Integration?" *Psychiatric Services* 63, no. 5 (May 2012): 427–34; Deborah Quilgars and Nicholas Pleace, "Housing First and Social Integration: A Realistic Aim?" *Social Inclusion* 4, no. 4 (2016): 5–15; Tom Baker and Joshua Evans, " 'Housing First' and the Changing Terrains of Homeless Governance," *Geography Compass* 10, no. 1 (2016): 25–41; Tsai and Rosenheck, "Considering Alternatives to the Housing First Model"; Kim Hopper, "The Counter-Reformation That Failed? A Commentary on the Mixed Legacy of Supported Housing," *Psychiatric Services* 63, no. 5 (May 2012): 461–63; Russell K. Schutt and Stephen M. Goldfinger, *Homelessness, Housing, and Mental Illness* (Cambridge, MA: Harvard University Press, 2011).

127 Leyla Gulcur et al., "Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness," *Community Mental Health Journal*, 43, no. 3 (June 2007): 211–28; National Academies, *Permanent Supportive Housing*, pp. 51–53.

128 Samantha Batko et al., "Open Letter to Secretary Ben Carson, Joe Grogan and Robert Marbut," endhomelessness.org, Mar. 18, 2020.

129 HUD, "HUD 2018 Continuum of Care Homeless Assistance Programs," Nov. 13, 2018.

130 Sonja Sharp, "16,000 People in L.A. Now Live in Cars, Vans and RVs. But Safe Parking Remains Elusive," *Los Angeles Times*, June 10, 2019.

131 Greg Berman and John Feinblatt, *Good Courts: The Case for Problem-Solving Justice* (New York: New Press, 2005). There are problem-solving courts designed specifically for the homeless: see California Association of Collaborative Courts (CCAC), Types of Collaborative Justice Courts.

132 Barrow and Zimmer, "Transitional Housing Services"; HUD, "Priority: Home!"

133 About 3,500 residential treatment facilities are in the U.S., almost 2,800 of which offer long-term treatment of more than 30 days' duration. See HHS, Substance Abuse and Mental Health Administration, "National Survey of Substance Abuse Treatment Services (N-SSATS): 2018 Data on Substance Abuse Treatment Facilities," table 2.3: All Facilities and Facilities with Opioid Treatment Programs (OTPs), by Type of Care Offered: Number and Percent, 2008–2018, September 2019.

134 "Justice," Joe Biden.com.

135 Ester Fuchs and William McAllister, "The Continuum of Care: A Report on the New Federal Policy to Address Homelessness," HUD, December 1996, pp. 4, 5, 9, 45, 49.

136 HUD, Office of the Assistant Secretary for Community Planning and Development, "Notice of Funding Availability for Continuum of Care Homeless Assistance; Supportive Housing Program (SHP); Shelter Plus Care (S+C); Sec. 8 Moderate Rehabilitation Single Room Occupancy Program for Homeless Individuals (SRO)," *Federal Register* 61, no. 52 (Mar. 15, 1996): 10867.

137 "Letter to the Honorable Darrell Issa," HUD, Aug. 9, 2017.

138 See discussion in Byron Johnson, William H. Wubbenhorst, and Alfreda Alvarez, "Assessing the Faith-Based Response to Homelessness in America: Findings from Eleven Cities," Program on Prosocial Behavior, Baylor Institute for Studies of Religion, Feb. 1, 2017.

139 Community Housing Innovations, 2017–2018 Annual Report, Executive Director's Message.

140 "New Priority Means Fewer Beds in City Shelters," editorial, *New York Times*, May 17, 2016; Laura Nahimas, "HUD Slashes Funding for Some New York City Homeless Shelters," Politico, May 9, 2016.

141 HUD, "PIT and HIC Data Since 2007," January 2020.

142 California Senate Bill No. 1380, Chapter 847, Sept. 29, 2016.

143 Office of the White House, "President Donald J. Trump's Economic Mobility Reforms Will Restore Independence and Dignity to Millions of Americans," and "Executive Order Reducing Poverty in America by Promoting Opportunity and Economic Mobility," Apr. 10, 2018.

FIVE

The Invention of Chronic Homelessness

In 2007, a coalition of los angeles government offices and nonprofit organizations launched Project 50, a social service and housing program targeting what researchers, politicians, and journalists have recently begun calling the "chronically homeless." As defined by the United States Interagency Council on Homelessness, "A chronically homeless person is . . . an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more *or* has had at least four episodes of homelessness in the past three years."[1] Unlike individuals or families for whom living without shelter is a temporary episode, the chronically homeless are understood to exhibit long-term patterns of cycling in and out of shelters, hospitals, and jails, interspersed with periods of living unhoused and on the streets.

Following a model tested first in New York City, Project 50's team of outreach workers set out to identify chronically homeless individuals concentrated in downtown Los Angeles in a neighborhood still called Skid Row. Mortality rates are so high in Skid Row—three times that of the surrounding county—that in the 1970s, one group of researchers referred to the neighborhood as a "death zone."[2] In recent years, Skid Row has been undergoing a dramatic revanchist turn as it is reterritorialized by luxury housing developments and consumer amenities.[3] As described by Neil Smith, "revanchism" names a model of gentrification that seeks revenge on poor populations who occupy spaces that capital now wishes to reclaim for investment.[4] An expanding and increasingly hostile police presence has accompanied this real-estate push-out. After a pilot launch in 2005, the so-called Safer City Initiative targeted unsheltered individuals in Skid Row for criminal punishment from 2006 to 2007; it represented one of the greatest concentrations of police force in the United States.[5]

Armed with outreach questionnaires, Project 50 workers initiated face-to-face conversations with Skid Row residents. In these conversations,

they gathered targeted information about the lives of their interview subjects, including how much time they had spent in hospitals, shelters, and living on the street, their medical backgrounds and histories of substance use, as well as any current health conditions. For each Skid Row resident interviewed, the information obtained was measured against what is known as a "vulnerability index." The index used by Project 50 identifies eight conditions linked to increased mortality among street populations:

> more than three hospitalizations or emergency room visits in a year
> more than three emergency room visits in the previous three months
> aged 60 or older
> cirrhosis of the liver
> end-stage renal disease
> history of frostbite, immersion foot, or hypothermia
> HIV+/AIDS
> tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition.[6]

The index is based on medical research demonstrating that possessing any one of these indicators significantly decreases an individual's lifespan. The "50" in Project 50 refers to the goal of the outreach efforts: to use the index to identify the fifty people in Skid Row most likely to die in the coming year. These individuals were offered immediate placement into a housing program, with none of the typical case management requirements regarding social services or sobriety. One radio program described Project 50 residents as those "fortunate enough to be determined the most unfortunate."[7]

Project 50 is just one among hundreds of chronic homelessness programs launched in municipalities across the United States in recent years. Chronic homelessness programs depart from long-held assumptions about people living in poverty and long-established technologies for managing those populations, and thus their emergence and rapid spread defies easy explanation. As chapter 3 argued, popular conceptions of poverty in the United States have maintained that individuals living in poverty produce their impoverished conditions, not social or governmental institutions. Such discourse of personal responsibility has been accompanied by intensive networks of social welfare technologies that

seek to regulate the poor by intervening in individual behavior. As chapter 3 also demonstrated, persons living without shelter have been understood as being especially incapable of self-management and in need of invasive social assistance. Many decades of formal and informal policy have made treatment for substance abuse and psychiatric disabilities a mandatory condition for entering and remaining in housing programs. Such earlier policy argued that drug/alcohol and psychiatric treatment, as well as social services focused on money management, job training, and a wide range of other so-called life skills, make formerly "shelter-resistant" individuals "housing-ready."

Thus, chronic homelessness initiatives are quite surprising, as they facilitate immediate access to housing with no social service or work requirements, bypassing the coercive social control technologies associated with the contemporary workfare state and the war on the poor.[8] This departure in policy is even more surprising considering that those categorized as chronically homeless are disproportionately men of color who actively consume drugs and alcohol and lack close family ties.[9] Far from finding themselves the privileged targets of housing programs, members of this population, typically demonized as the "undeserving poor," are more commonly barred from social service agencies and housed in prisons and jails.[10]

Long before the advent of chronic homelessness initiatives, advocates and activists organized against mandatory health and social services in housing programs. Socially progressive service organizations, convinced that mandatory services actually kept people out of shelters, experimented with making services optional.[11] This model, known as "Housing First," remained marginal within the homeless services industry until its adoption by the federal government for chronic homelessness initiatives. How did this unexpected moment arrive, and through the efforts of the neoconservative administration of George W. Bush?[12] Should this be taken as a compassionate turn in social policy and administration? Does it represent a reversal of social abandonment, as vilified populations deemed most likely to die became targeted for life-saving housing interventions rather than displaced to zones of exclusion?

In my use, "chronically homeless" should always be read as if in scare quotes. As will become clear, I want to foreground the provisional and constructed nature of the term, even as I investigate its deployment.

Due to its very real material consequences, we must take the term seriously while nonetheless understanding it to mean populations *targeted* as "chronically homeless." How those quotes fall away and this subpopulation achieves a taken-for-granted status are investigated in the chapter that follows. The rise of chronic homelessness as a concern results from the convergence of two historical forces. The first is a counterdiscourse in homeless social services that challenges medical models and technologies of homeless management. This is the early Housing First movement and a related discourse of public health. The second is the production of an economic analysis of homelessness that emphasizes the financial cost of leaving populations housing deprived. This economic analysis is produced first by social scientists and then picked up and circulated by government offices and mass media. Uncovering the intersection of these historical forces makes the arrival of chronic homelessness initiatives less surprising, and points toward the limits of these initiatives as well. Despite the promise of chronic homelessness programs—namely, the lifting of barriers to access and the immediate provision of housing—I propose a cautious interrogation of the relationships between the technical calculation of death chances and the securing of health and life resources. This is to take seriously the tension expressed by a social worker with an activist background who told me:

> I mean the good thing is that we're really making an impact. We're really housing people. At times I'm like, oh my god, I'm just so "the Man" right now, selling out big time. But then at other times, you know, I see the folks that we're able to get inside. And they're the people that nobody else has ever been able to really talk to, or have wanted to talk to. You know, the quote-unquote "resistant to services" people. And we spend time with them, and we don't give up on them.

This social worker communicates some dismay at working within the government—"I'm just so 'the Man' right now"—while also asserting the incontrovertible fact that the program is housing exactly the people who have been most blocked from social welfare benefits. Ultimately, the contradictions that statement points to, and the surprise of finding a progressive housing agenda picked up and promoted by the U.S. federal government, arise from the ways in which managing vulnerable populations enables neoliberal economic expansion.

"Housing First" and the Demedicalization of Homelessness

As discussed in the previous two chapters, the primary mode for managing homelessness within the dominant medical model has been through case management technologies. In contemporary social work practice, the medical logics embedded in case management technologies comprise an inherited culture that has made case management seem obvious and necessary. This has been formalized by the Department of Housing and Urban Development (HUD) in the Continuum of Care (CoC) model, which mandates progression through stages of housing, from emergency shelter, to transitional housing, and ultimately in either private marketplace or supportive permanent housing. Thus, the old Progressive-era work test has survived in a new form. Rather than cutting stone or lumber, modern shelter aspirants demonstrate worth through commitment to working on themselves and making it through the Continuum. As a former caseworker and current director of a housing program told me, "I think there's just this really old-fashioned treatment approach to things, where you have to earn your way to housing. I can't really say that I've ever seen any kind of formal funding requirement of sobriety or anything like that. You basically worked your way up the Continuum." As the statement suggests, notions of deserving versus undeserving poor are embedded in practices that withhold housing and other services from those who have not "earned" it. As it also suggests, associations of homelessness with alcohol abuse and drug addiction have especially called forth the presumed necessity of professional intervention in the form of social work technologies. That informant continued, "People thought that they needed to have folks that were clean and sober. It was sort of just a requirement that was handed down but never really written anywhere." A staff therapist of another organization explained that mandatory treatment draws legitimacy from the popular conception that "addicts" require shaming and direct intervention. But it is also produced by the professionalization of social work, and the organizational status of the case manager over the client.

> I think to some degree it's a thing we're conditioned to about substance use generally. But I think it's sort of a natural extension of being in the social services world as well. Because just the logic of social services is

> that we're being paid to make life better for these people. Therefore, our judgment is paramount. And they ought to be following that. And so going into a setting where we don't just impose our judgment on things I think doesn't feel right to some people. And then you complicate it further with our conventional view of addiction stuff, where it's all about, you know, shaming someone until they come around and start making better decisions for themselves. . . . The whole thing just becomes a big mess I think.

Thus, moral, medical, and popular conceptions of selfhood and homelessness naturalize the compulsory deployment of case management technologies. As a result, the provision of housing services has almost always been conjoined to coercive attempts at fixing problem individuals.

In contrast to compulsory case management technologies of social and health services, Housing First represents a potentially radical break from medicalized models by separating shelter provision from social and health services. Housing First programs make available traditional social and health services, but as the designation suggests, housing is the first thing provided, and services are not required for admittance. Housing First represents a social commitment to the principle that all people deserve housing at all times, and an organizational commitment to putting resources into supporting all residents. The Downtown Emergency Services Center (DESC), which is based in Seattle and has become a model for agencies around the country, outlines the following core components of a Housing First approach:

> Move people into housing directly from streets and shelters without preconditions of treatment acceptance or compliance.
> The provider is obligated to bring robust support services to the housing. These services are predicated on assertive engagement, not coercion.
> Continued tenancy is not dependent on participation in services.
> Units targeted to most disabled and vulnerable homeless members of the community.
> Embraces harm reduction approach to addictions rather than mandating abstinence. At the same time, the provider must be prepared to support resident commitments to recovery.
> Residents must have leases and tenant protections under the law.
> Can be implemented as either a project-based or scattered site model.[13]

Before being named as such, Housing First practices were being put in place by a small number of nonprofit agencies targeting unsheltered populations. These organizations, each of which was attempting to reach what one informant called "the hardest to house" and another "the worst of the worst," came to a reverse logic about the relationship of services and housing. Compulsory psychiatric and drug treatment, rather than enabling people to stay housed, came to be seen as barriers that kept people on the streets. Compulsory requirements set up residents to fail (at sobriety, for example), and thus to be evicted and deprived of housing once more. A self-fulfilling prophecy was put in place: residents in fact appeared not to be ready for housing. Speaking of this process that leads to eviction, one caseworker told me, "It deepens people's impressions that these clients are impossible to house. Every time that happens, then they feel more strongly about that."

As suggested in the DESC principles cited above, proto–Housing First programs evolved out of contemporaneous harm reduction movements in AIDS activism. In the realm of HIV/AIDS prevention, harm reduction argues that abstinence models do not keep people safe and that education efforts should rather be aimed toward developing safer practices. Services must meet clients "where they're at" and provide tools for making healthier choices in how to have sex or use drugs.[14] Translated to the realm of housing, harm reduction suggested that rather than coercing residents to accept an organization's concept of housing readiness, organizations should simply provide housing; housing is a safer option than living unhoused, and once housed, clients can be supported in making informed choices about their needs and interests regarding services. Since many housing organizations were already working with populations targeted by harm reduction HIV/AIDS prevention, they were already prepped for Housing First. "It wasn't some huge internal dialogue we had to go through to get comfortable with Housing First as an idea. There was some pushback from some of the staff. But those values were pretty much in all of our seminal documents, part of orientation, part of ongoing supervision, part of service training. It wasn't a huge thing for us; it just felt like a very natural evolution."

The early adoption of Housing First did not occur all at once. Rather, it was a piecemeal effort that required reevaluating long-held

assumptions rooted in the disciplinary case management model. Service providers describe a kind of organic process of trial and error that led their respective agencies to develop "low-demand" environments that would eventually be named and organized as Housing First. The director of one such agency describes the shift at that agency from "housing readiness"—the notion that only some people were prepared to accept and stay in housing, and that others must first go through mandatory treatment.

> We employed a readiness concept. "So-and-so" is not ready for this housing because he's not keeping his appointments with their case manager. Or "so-and-so" is not ready because he's a crack addict and he's not doing anything. And yet, because of who we are . . . we were sort of known in the community as the organization of last resort. If you were so crazy, or so into drug and alcohol use, and the Y[MCA] didn't want to serve you anymore, they would refer you to [us]. Social workers and emergency departments, police officers—if they encountered someone who was very disorganized, very dysfunctional, they would take them here. So we had all that experience. But we were right out of the box with a housing project and we sort of, to a certain degree, followed this readiness thing. But because we had all this experience, we also stretched that a little bit, and took some risks with people.

As the statement indicates, an organizational commitment to finding ways to house those populations who were most neglected by compulsory services drove these early experiments in Housing First.

Of course, the medical model and its technologies of compliance proved quite sticky. Even as agencies experimented with low-demand environments with optional treatment services, pathologizing assumptions about homeless populations were not automatically or easily abandoned.

> When we developed [our first permanent low-demand housing,] we sort of had this naïve assumption that this group was gonna trash the building. And so we built in this humongous line item into the budget for repairing things. Because our thought was, "We're not gonna kick them out, we're just gonna fix the things that they break." And it turned out, that didn't happen. And I think that was part of the change in our thinking to "these people are really not any more difficult to house than anybody else."

> Even though we were close to these people, I think we bought into the same stereotypes. That they're a bunch of animals who are gonna rip the place to shreds. It's embarrassing to think about it now.

Despite some of these reservations, organizations that experimented with low-demand or Housing First approaches quickly saw that freeing clients from mandatory services did not render them incapable of staying housed.

> And over the first few years of operation we discovered that the people that we were taking risks with were just as likely to succeed in housing as those people that we predicted were housing ready. About the time we were coming to that realization, the Safe Haven idea was introduced at the federal level. And the next housing project . . . we decided that we wanted to build this housing project, and we wanted to use it as an engagement tool. So we set our caps to recruit residents that we knew to be crazy and homeless and not connected to anybody's [services] program, including our own. [15]

As the experiments bore results, the idea that some populations possess an untamed desire to live on the street came undone. Along with it, the notions of "service resistant" and "housing ready" seemed increasingly implausible.

> There was all sorts of mythology out there about, this is the one group of homeless people that is just not gonna come inside. They would prefer to be outside and just drink themselves to death. It turned out that was not the case. We had to make seventy-nine offers of housing to get seventy-five people to accept housing.
>
> I think we're experiencing evidence that homeless people want housing, and can maintain it. When I started . . . what they told me was, homeless people won't talk to you, they don't want housing. They would be labeled as "service resistant," which is just meaningless. It's just a meaningless thing to call a person, it doesn't mean anything. It's not rooted in behavioral science, it's just a cop out.

As the director of one program pointed out to me, these early experiments succeeded because agencies were offering permanent housing, as opposed to temporary placement in an emergency shelter while clients got clean and sober. An organizational recognition was emerging that clients respond to the conditions of housing opportunities, as

anyone would. Rejection of heavy service requirements or the lack of privacy and comfort in emergency shelters was being recognized as a reasonable reaction that agencies must take seriously. "Everybody knows that shelter is not a place anybody wants to be. So quote-unquote 'shelter resistant,' I never believed a word about it. If you give somebody housing, they're gonna go in. So why even tag somebody with that description? I'm resistant to shelter, anybody would be."

Slowly a new logic developed: clients who refused compulsory services would accept no-strings-attached housing. This led to new outreach approaches, as Housing First principles got structured into every stage of work.

> So we focused on going out to the folks on the street. They started to ask people, "Will you work with us toward permanent housing?" They didn't talk to them about, like, you need to get clean, you need to go into [emergency] shelter, you need to get mental health services. The first question was, "Will you work with us toward permanent housing? Your own apartment—your own place with a door that locks. And if you're willing to work with us, we will stick with you until it happens." And that's how they were able to reduce [street] homelessness.

As the bind between housing and compliance technologies loosened, pathological conceptions of homeless populations lost their logical force. Housing First technologies edged out disciplinary logics that individuals must be reformed to be housing ready. Rather than a war on the poor mentality that assigns individuals personal responsibility for conditions of poverty, a new view of institutional responsibility emerged. From this view, government and nonprofit organizations, not individuals living without shelter, bore responsibility for housing failures.

> If this person goes back on the streets, then you the housing provider need to realize that you failed the individual. It's not the individual that has failed himself, but we have failed to figure out how to work with him. And you need to be confident that you have exhausted the possibilities. I think too much still we just give up on people and say, "Well, they didn't jump through all the hoops we wanted them to, so they clearly don't want this housing." Well, that's nonsense, nobody wants to go to sleep back on the street.
>
> I think we should be held accountable for outcomes that are really difficult to achieve. . . . For a long time, we as a sector put the onus on

> the individual to figure out how to work with us. And now I think the shift is . . . [that] it's our job to figure out how to work with that individual, and it's not ok just to say, "They don't wanna come inside." We have to figure out how to get that person inside and how to negotiate with them and serve them.

For organizations to accept and understand the ways that technologies of compliance perpetuate housing deprivation requires fundamentally reconceptualizing the role of nonprofit organizations within the nonprofit industrial complex. It requires understanding the provision of housing—rather than the reforming of the individual—as the appropriate goal. This means, as many described it, that "housing is an outcome" rather than a tool for enforcing compliance in self-help regimes.

> A lot of people can't seem to accept the idea that being housed is an outcome for homeless people. They want to know, "So, what's happening to their mental health symptoms? And are they getting jobs, and are they abstinent from substance use?" and all that kind of stuff. Which for some people, certainly it's the route they end up taking and it helps and all that. But the point of housing is housing. It's an outcome for all of us. It isn't to facilitate something else for us. It's to have a home base. Why can't it be for them as well?

Housing First principles demand a rejection of the polarizing pathologization embedded in disciplinary social work regimes. Rather than marking out "the homeless" as a special category of individual, Housing First insists that housing-deprived populations deserve the same access to housing as any of us who are able to pay for that privilege.

Thus, throughout the 1990s, before being named as such, Housing First approaches developed organically through organizational experiments with housing under-served populations. When Pathways to Housing, an early advocate of this approach, published research indicating that mandatory services do not impact ability to find and maintain housing, Housing First was organized as a named concept, and began to formally travel around social service networks.[16] Thus, the leader of an effort to convert service-heavy supportive housing to Housing First describes recognizing the new common sense of Housing First. That manager, charged with dramatically reducing the street population of a tourist urban core, described hearing about Housing First

and recognizing almost immediately that it would be the most "efficient and effective way" of getting that population housed.

In challenging pathological conceptions of homelessness and attempting to address the needs of underserved populations, Housing First advocates enacted a demedicalization of homelessness. In other words, in this approach, the idea of homelessness as an incarnation of a failed selfhood is undermined, and along with it, the compulsory use of case management technologies is undermined as well. Accompanying this demedicalization has been a new discourse that reframes homelessness as a public health issue. This discourse also concerns medical issues, but does not treat housing deprivation as a pathology that must be cured. Rather, this new discourse draws attention to the health consequences of living without shelter, such as those outlined in chapter 1, including greater exposure to tuberculosis and HIV and much higher mortality rates than housed populations. Through this discourse, advocates emphasize that living without shelter dramatically harms health and shortens life—hence Project 50's goal of locating those most likely to die in the coming year. Insisting on the health needs of unsheltered populations has been an attempt to undo the stigmas attached to cultural conceptions of the homeless:

> The health piece is less stigmatized. We're able to use it as a more powerful advocacy tool. If you scratch an alcoholic you're gonna get liver disease. If you scratch, unfortunately, someone with severe and persistent mental illness, you're gonna find diabetes and heart disease from the secondary [effects] of taking the psych meds. So you can find a way to less stigmatized manifestations of all the things we see on the streets and use that.

This counter-discourse of public health also seeks to mobilize political sympathy against demonizing portraits of the undeserving poor. Advocates describe it as a means of redirecting attention and garnering support. Referencing an agency's work doing public presentations on the health consequences of housing deprivation, one staff member told me:

> Almost always . . . it's common for one of [the government officials] to start weeping. And then publicly, because it's framed as a life or death issue, not as a behavioral health issue, they have the clearance to take bold decisive action. They're like, "Oh my god, they're gonna die." And

> they have this little mini freak-out on Thursday, and then on Friday, they step up.

Another worker, describing efforts in the local community, echoed this sentiment:

> The number one most vulnerable guy we found . . . was in the middle of going through chemotherapy on the street when we found him. How can you as a public official not act? I mean, that's just ridiculous, there's no reason that man should be on the street. And so it takes away, I think, a lot of the "people are drug users, or they're crazy, or they're undeserving of our services." And brings it down to a level which everyone can relate to, about being how awful it is to be sick, and especially sick on the street.

While there is no doubt that for advocates, the public health discourse is a powerful mobilizing tool, it is not clear how much credit the discourse deserves for changing the political landscape of homeless social services. As it turns out, economics is playing at least as important a role as empathy.

The Costs of Chronic Homelessness

Looking at how public health concerns get rolled out suggests that we must attend to an economic dimension of those health concerns. This economic dimension follows from what I would call the "invention of chronic homelessness." By "invention," of course, I do not mean to deny that some people endure much of their lives deprived of housing. Nor do I mean to downplay the incredible risks to health and life posed by housing insecurity and deprivation. Rather, I want to draw attention to how a certain conception of a subcategory of homelessness—the chronically homeless—becomes the condition of possibility for the mobilization of public health discourses and Housing First practices. And in turn, I want to attend to how that condition of possibility sets limits on what becomes of those discourses and practices.

The terms "chronic homelessness" and "chronically homeless" start appearing in media discourse as early as the 1980s. The usage at that time, and up until the mid-1990s, was fairly loose.[17] The terms were used to describe a state any person might be in. So, for example,

a newspaper article might describe someone by saying, "Throughout his 20s and 30s, John was chronically homeless"—as in, John was frequently without a home. Beginning in the mid-1990s, however, the meaning of these terms began to congeal, and they came to refer to a specific *subset* of homeless people, rather than a state any person might be in. This solidification of the concept happened as a result of research conducted out of the University of Pennsylvania by Dennis Culhane and Randall Kuhn. In a series of studies published in 1998, Culhane and Kuhn argue that people who stay in emergency homeless shelters can be organized into three categories: the transitionally homeless, the episodically homeless, and the chronically homeless. In the first study, Culhane and Kuhn explain: "The *chronically homeless* population could be characterized as those persons most like the stereotypical profile of the skid-row homeless. These are people who are likely to be entrenched in the shelter system, and for whom shelters are more like long-term housing than an emergency arrangement."[18] Thus, the chronically homeless are one part of all those who use shelters. Culhane and Kuhn described them as "over-utilizers"—their shelter stays last the longest, and they are most likely to return. In the second study, Culhane and Kuhn argue that the chronically homeless tend to share a number of characteristics and that "in general, being older, of black race, having a substance abuse or mental health problem, or having a physical disability, significantly reduces the likelihood of exiting shelter."[19]

Culhane and Kuhn's research not only solidified the concept of chronic homelessness. It also introduced an economic dimension to the category. The extended stays and high rates of recidivism attributed to the chronically homeless are understood to be most significant in terms of their drain on the shelter systems; Culhane and Kuhn argue that chronically homeless individuals use a "disproportionate amount of resources" in the homeless service industry. In other words, with their long and frequent shelter stays, they are the most costly. Subsequent research by Culhane, Kuhn, and others went further, correlating shelter stay statistics with data from hospitals and jails to show that the chronically homeless in fact brought high costs to these other institutional sites as well.[20]

The concept that there exists a distinct subset of chronically homeless people has turned out to be quite compelling, and since the publica-

tion of Culhane and Kuhn's study, it has circulated widely through mass media. In the years just around the publication of their study, newspapers began to consistently use the term "chronically homeless" to refer to a specific set of people. In this circulation, the concept has brought the economic analysis along with it. Media accounts frequently refer back to the idea that chronically homeless populations are expensive. Malcolm Gladwell's widely read 2006 article for the *New Yorker,* "Million Dollar Murray," follows one of the chronically homeless as he moves about draining institutions of money. In the piece, Gladwell summarizes further research that tracks the impact of the chronically homeless on hospital systems:

> Boston Health Care for the Homeless Program, a leading service group for the homeless in Boston, recently tracked the medical expenses of a hundred and nineteen chronically homeless people. In the course of five years, thirty-three people died and seven more were sent to nursing homes, and the group still accounted for 18,834 emergency-room visits—at a minimum cost of a thousand dollars a visit. The University of California, San Diego Medical Center followed fifteen chronically homeless inebriates and found that over eighteen months those fifteen people were treated at the hospital's emergency room four hundred and seventeen times, and ran up bills that averaged a hundred thousand dollars each.[21]

Many social service agencies have produced their own studies, making note of some of the same costs. As a program manager told me, "We had someone run the Medicaid numbers on about one hundred clients, and they were costing $24,000 a year pre-housing. It was costing us $24,000 a year to do nothing."

In 2001, HUD named ending chronic homelessness one of its programming priorities. By 2003, the Bush administration included this goal in the fiscal year budget; it was followed by an endorsement of such efforts by the U.S. Council of Mayors.[22] Chronic homelessness programs have been a central feature of what are known as 10-Year Plans, or municipal initiatives to end street homelessness in a decade. Currently, at least 243 communities in the United States have established 10-Year Plans.[23] As partnerships among municipal governments, nonprofit organizations, and business leaders, the 10-Year Plans are typical arrangements of neoliberal governance. Like the destruction of skid rows that

began in the 1960s, 10-Year Plans today aim to clear space in city centers to improve opportunities for capital investment and growth.

Social service models that require psychiatric and drug/alcohol treatment have been considered an obstacle to 10-Year Plans, insofar as they keep the chronically homeless out of housing programs and on the streets, in the way of business ventures, wealthy residents, and tourists. Thus, the federal Interagency Council on Homelessness and HUD have called for a "paradigm shift" in social services and housing. As stated by *Strategies for Reducing Chronic Street Homelessness,* a report prepared for HUD, "The people on whom this project focuses are, by definition, those for whom these programs and services have not produced long-term solutions to homelessness. Their resistance to standard approaches has been a challenge to communities committed to ending chronic street homelessness."[24] While the statement still emphasizes individual-level resistance, rather than the institutional barriers indicated by my informants, its suggestion that mandatory requirements be lifted gels with what housing program residents and advocates have long argued—namely, that there is a mismatch between organizational requirements and clients' needs. This, rather than an untamed desire to live on the streets, explains resistance to shelter.[25] The paradigm shift called for in *Strategies for Reducing Chronic Street Homelessness* would remove barriers to access by delinking "housing and service use/acceptance, so that to keep housing, a tenant need only adhere to conditions of the lease (pay rent, don't destroy property, no violence), and is not required to participate in treatment or activities."[26] HUD's programs also call for harm-reduction, rather than zero-tolerance, approaches, "where sobriety is 'preferred but not required,' which often translate into a 'no use on the premises' rule for projects that use HUD funds."[27]

The federal government understands that chronic homelessness programs may be a difficult transition for housing providers, who have traditionally relied on more directly coercive measures for controlling resident populations, as well as the funds attached to such approaches. One director of a program, who formerly managed a housing program as it underwent a transition to Housing First, recounted feelings of resistance when first confronted with "hard to house" clients. "I'd say—he's not ready for our housing. You gotta send him to the shelter, you gotta send him to transitional housing, and then he can apply from there. With

us doing this project there was a real tension in our organization, with one part of our organization trying to house people, and the other part saying they're not housing ready." HUD has recognized the organizational challenges, and the organizational resistance they are likely to bring:

> For mental health and social service providers, low-demand environments mean they cannot require tenants to use services, and they have to deal with both mental health and substance abuse issues, and do so simultaneously. In addition, tenants may not use their services consistently, thus reducing reimbursements on which the providers may rely. For housing providers, a low-demand residence means that tenants may not act as predictably as the property managers might wish. For both, the challenges are as much philosophical as financial, in that the new model demands that they conduct business in ways that had formerly been considered not just impractical but wrong.[28]

Despite these obstacles, HUD has made programs that incorporate chronic homelessness initiatives a strong priority of its Homeless Assistance grants. This includes funding allocated through the Samaritan Housing Initiative to develop permanent housing exclusively for populations designated chronically homeless.[29]

Thus, as a result of its attachment to chronic homelessness initiatives and 10-Year Plans, Housing First has become not only prioritized but even a mandated approach. In a sense, the target of "the compulsory" has shifted from individual clients to organizations. And this compulsory has the force of the financial behind it. Many leaders of a loosely conceived Housing First movement argue that the traditional funding structure of the homeless services industry encouraged leaving populations unhoused.

> You know, to get the provider community . . . rethinking the way that they've been doing business for 20 years has been enormously challenging. Because what's the incentive for doing that? If the money you're getting isn't changing, if no one is paying you to do anything different than what you've been doing? If there's no consequence . . . then it's kind of understandable, why would you change what you're doing?

The reorganization of federal funding now provides this financial incentive for taking on Housing First approaches. Organizations that

previously received government contracts based on outreach (or what is described as "contact") are now being required to document placements and placement duration. "In the past, the contracts were really only based on contacts. So you could be constantly contacting people on the street and not housing anybody, and it wouldn't make a difference." The shift has required a willingness to work with and for demonized populations. One municipal program director remarked that many organizations that saw their work as providing health and treatment services rather than housing were unable to make this shift, "So we put them out of business." The change in federal funding priorities has been reproduced at all levels of government, including city contracts. City funding often provides the bulk of money for an organization, along with private foundation grants. Federal funding, though underwriting only a small portion of the work, functions as something like a "seal of approval": agencies must secure federal funding to qualify for other kinds of funding. In that way, federal funding requirements often "trickle down" to lower levels of government.

> And so when we demonstrated that there were results from this program, the city ended up withdrawing all of its outreach contracts and reissuing an RFP [request for proposals]. So they reissued that money. What they've now started paying outreach workers to do is to house people. And since they've done that, they've housed 1,100 people. So there's just been a huge shift . . . in part because of this shift from an approach which is about making contact to one which is about a census reduction in street homeless people, and therefore [about] requiring housing providers, and especially providers who were supposed to be serving this population, to take the hardest to house, and figure out how to keep them in housing.

Thus, the reinterpretation of housing deprivation as an economic burden on city resources has forced an economic overhaul of housing services as well. It is not surprising, then, that in taking up chronic homelessness as an object of knowledge and intervention, the federal government has translated the economic dimensions of the category into business plans for its management. An Interagency Council on Homelessness presentation on 10-Year Plans offers the following reasons to focus on chronic homelessness:

> This group consumes a disproportionate amount of costly resources.
> Addressing the needs of this group will free up resources for other homeless groups, including youth/families.
> Chronic homelessness has a visible impact on your community's safety and attractiveness.
> It is a finite problem that can be solved.
> Effective new technologies exist to engage and house this population.
> This group is in great need of assistance and special services.[30]

The presentation is a textbook example of neoliberal post-social thinking in action. The first two points make explicitly economic arguments. The third point makes an implicit economic argument, evoking the cost to urban economies posed by perceived danger and dirt. The fourth and fifth points make pragmatic arguments—it can be done—and only the last point makes something like a social welfare argument about the needs of the population itself. The presentation elaborates on only the first point, regarding the disproportionate consumption of resources, positing that the chronically homeless represent only 10 percent of the overall homeless population, but consume 50 percent of resources.[31] This data is also not correct. The 50 percent figure is rounded up from the 46.9 percent established by Culhane and Kuhn's research, which applies only to number of shelter days "consumed" by chronically homeless residents in the shelter systems they studied.[32]

That chronic homelessness demands savvy economic responses is made even more explicit in a second presentation entitled *Good . . . to Better . . . to Great: Innovations in 10-Year Plans to End Chronic Homelessness in Your Community.*[33] The presentation draws from *Good to Great,* a study by Jim Collins, which identifies the attributes of corporations that sustain long-term competitive edges over other corporations and perform "above market." The Interagency Council presentation applies the principles of Collins's study to analyze chronic homelessness programs and identify how "great" programs employ the same principles found by Collins as key to corporate success—"disciplined people, disciplined thought, disciplined action." The presentation not only encourages partnerships between government offices, nonprofit agencies, and private sector business leaders, but also suggests that 10-Year-Plan leadership be placed in someone "of high standing in the community who is *not* primarily

associated with homelessness." This is meant to lend credibility to the efforts, providing a sheen of respectability and distancing them from touchy-feely social programs.

According to the presentation, a key element of "disciplined thought" is the implementation of a business plan to combat chronic homelessness. Great plans include the following elements of disciplined thought:

> Business Principles—familiar concepts, such as investment vs. return, that bring a business orientation to the strategy
> Baselines—documented numbers that quantify the extent of homelessness in the local community
> Benchmarks—incremental reductions planned in the number of people experiencing chronic homelessness
> Best Practices—proven methods and approaches that directly support ending chronic homelessness
> Budget—the potential costs and savings associated with plan implementation.[34]

Thus, the invention of chronic homelessness becomes an opportunity for a thorough reimagining of social services as economic ventures. The problem of chronic homelessness becomes a problem of inefficient use of resources. The solution becomes better management of social welfare administration through the application of business principles.

Thus, the federal government's interest in Housing First is not so surprising after all. As one advocate told me, "From a conservative's perspective, it saves money. It saves taxpayers money. Research has even shown it's even cheaper in the long run to fund Housing First programs because it reduces recidivism rates. And it's really expensive to go from shelter to street to psych hospital to jail to community courts, through all these revolving doors." Recognizing the limits of political empathy, advocates have been able to leverage the economizing of health to advance their social agenda. "Asserting the cost savings offers an apparently irrefutable logic. So that's what I use sometimes when I'm talking to a government type. I'll talk about how it's really beneficial for people, but then if I'm really trying to sell somebody on it who hates homeless people, that's what I'll tell them about it. So that's why they're interested."

While advocates argue that the economic costs of housing deprivation become a way to translate across political divides, connecting advocates and politicians, it represents instead a new political constitution of housing needs. In this context, the economizing of life, health, illness, and death may provoke unexpected investments in vilified and long-abandoned populations. As a part of biopolitical governance, these programs serve to shore up and extend neoliberal economic industries that produce housing insecurity in the first place.

Economizing Race and Death

While many agencies and advocates are enthusiastic about this move to Housing First models, some have critiqued the language of chronic homelessness discourse. A report issued by the National Coalition for the Homeless states, "The term 'chronic homeless' treats homelessness with the same language, and in the same fashion, as a medical condition or disease, rather than an experience caused fundamentally by poverty and lack of affordable housing."[35] Of course chronic homelessness programs have a complicated relationship to medicalization. On the one hand, although the concept of "chronic homelessness" does carry a pathologizing taint, in practice the programs actually leave behind many of the disciplinary techniques of pathologization. If "chronically homeless" codes shelter needs as medical problems, as if some people are addicted to being homeless, we must nonetheless note that it is exactly the technologies of medicalization that chronic homelessness programs undo, insofar as they allow for immediate access to housing without service and treatment requirements. Policy reports on chronic homelessness initiatives continue to stress the responsibility of the individual, evoking some of that old moral argument. But rather than the individual's self-work being a necessary first step toward housing provision, the current model provides housing regardless of an individual's willingness to submit to medicalizing, disciplinary regimes.

On the other hand, in its adoption of Housing First through chronic homelessness programs, the federal government does not offer a critique of pathologization. While federal chronic homeless programs suppress the compulsory use of case management technologies, they do so through the argument that requiring services is not cost effective, insofar

as that requirement acts as a barrier keeping people on the street where they cost cities money. Pathological conceptions of homeless populations did not disappear with the rising validity of Housing First approaches. In fact, some argue that the persistence of these pathological conceptions provides a stumbling block for the adoption of Housing First in anything more than name. "If these providers feel like there's some kind of a gravy train for working with high utilizers and they don't know how long it's gonna last, and they want in on it, they're gonna say they're doing Housing First but they're afraid to do it. What I've seen at [our Housing First project] is people come to visit and they have all sorts of fears about what it would really be like to house this group of people in our community or wherever." The persistence of pathological conceptions opens a space for the rearticulation of medicalized notions and the reassertion of disciplinary technologies of compliance. Chronic homelessness programs allow for two ideas to exist side by side: that there is something wrong with these people, but nonetheless we need to house them. In the context of medicalized social problems, sympathy and disdain peacefully coexist.

Not only do federal chronic homelessness programs leave the pathologization of housing deprivation in place. These programs also expand housing opportunities only for people designated chronically homeless. So, as much as chronic homelessness initiatives function to bring people into permanent housing, they also serve a population-sorting function that excludes other people from housing. As Foucault wrote, "Knowledge is not made for understanding; it is made for cutting."[36] Those that chronic homelessness cuts from housing are populations whose costs are not directly carried by city institutions, but whose health and housing are nonetheless quite precarious. Keeping in mind that the federal government defines the chronically homeless as "unaccompanied adults," we can see that if you have a family that can absorb the work of the welfare state, you are considered a bad investment and unworthy of housing; only those with absolutely no familial safety net are brought into housing.

The earlier history of the concept of chronic homelessness indicates something about this cutting function. "Chronically homeless" as a category was introduced prior to Culhane and Kuhn in New York City by

Rudolph Giuliani. During his first mayoral campaign in 1993, Giuliani released a position paper in which he promised as mayor to limit shelter stays to ninety days for all shelter users except what he called the "chronically homeless." So the category has always served a sorting function, cutting out those who deserve investment from those who do not. While the public reacted with confusion to Giuliani's term, and some with hostility to his plan, soon enough Giuliani's suggestion that there was a chronic subset of shelter-stayers would be accepted as commonsense, and Culhane and Kuhn would provide the economic justification for what has in effect been a national policy that instates what Giuliani called for: the privileging of one part of the unsheltered population and the exclusion of the rest. As a population-sorting mechanism, chronic homelessness preserves the idea that some deserve housing and some do not. But if an a previous era, you proved you were among the deserving poor through a willingness to submit to mandatory case management technologies, today, the determination of who deserves housing moves from a moral calculation to an economic one.

Further, even within those targeted for chronic homelessness programs, distinctions continue to be made. Agency managers describe a process of "creaming" for chronic homeless housing—as in picking the cream of the crop among clients they already know. This is especially the case for "scatter-site housing," when programs rent apartments in buildings that also house private tenants with no program affiliation. The push for scatter-site responds to the pressure of white and wealthier residents to keep concentrated housing forms like shelters out of their neighborhoods, a sentiment described as "NIMBYism" (for "not in my backyard"). In cases of scatter-site housing, questions of sobriety, and even stratification of kinds of substance use, arise.

> The big thing now in Philly, and also in New York, in some scatter-site programs . . . is that they won't take people that are active crack users. Heroin is fine, schizophrenia is fine, but crack—no. Because they say that it attracts more criminal activity, more groups of people that are taking over apartments, and more dangerous behavior, sex work, and all of this. And that, you know, one lonely heroin addict is easier to deal with when you have to deal with landlords and an apartment building with other people in it that aren't in a Housing First program.

The stratification of need points to the lack of a structural critique in the rush to Housing First. The National Coalition for the Homeless report cited above goes on to point out that in addition to reproducing homelessness as a pathology or addiction, chronic homelessness programs will do nothing to alter the structural conditions that produce housing insecurity and deprivation. And at the same time, the adoption of Housing First by federal, state, and municipal governments runs the risk of emptying Housing First of its disrupting potential, instrumentalizing it as financial incentive rather than as a social or political commitment that directs agencies to adopt (or claim to adopt) Housing First approaches. "Now, because it is ensconced in policy, and it's everybody's priority—federal as well as state and local government—everybody's doing it. And the reality is, a bunch that are saying they're doing it, aren't."

Finally, while there is an immediate benefit in getting people housed, the successes of chronic homelessness programs are short-term and not sustainable. As one advocate commented, "And so people start throwing up units and developers are like, 'Great, the money's out there, the capital's out there.' But there's no operating [funds] to sustain that." The case of chronic homelessness programs in one city attests to the limits of this strategy. In this city, agency advocates were able to obtain records from public hospitals and calculate the seventy-five "most expensive homeless people" in the area—specifically, those with the most frequent or longest visits to public hospitals. Program managers then conducted targeted outreach to locate these individuals and place them into housing. However, as a staff member of that program noted, as beds open up (as residents move on, or die) and "less expensive" people are brought in, the savings to the city will decrease. In other words, the relative cost of housing versus hospitalization will *increase,* perhaps until the chronic homelessness program actually becomes more expensive than leaving people unhoused and reliant on hospital systems. As business ventures, chronic homelessness programs have no loyalty to an ethic of housing people, despite the commitment of individuals working within those programs to just such an ethic.

Nonetheless, most advocates remain enthusiastic about the rise of Housing First as federal policy. They suggest that the economic argument—"it is more expensive to leave people unhoused"—is ultimately a politically efficacious means to reach a socially desirable end.

While it is hard to argue against the immediate provision of housing for vulnerable populations—or, for that matter, the provision of housing for all people at all times—I would suggest that the economic here is more than simply an argument. Rather than a contradiction in politics that results in a surprising socially desirable end, this can be understood as a reconstitution of the political in the form of a neoliberal biopolitics. The genius of Culhane, Kuhn, and their colleagues' research is that they were able to mobilize neoliberal discourse of cost and efficiency to successfully advocate what humanist or ethical discourses have failed to do—namely, that people in need of shelter should be housed as quickly as possible. In recasting housing insecurity in terms of financial cost, their research provides an economic justification for permanent, long-term housing. The danger of the research is of course the same thing—its synchronicity with a neoliberal reshaping of social justice imaginations. While others have pointed out the rise in neoliberal governance of managerial strategies derived from private business sectors, the strategies are not simply an external logic applied to a stable social field, but rather a transformative force reshaping the very conception of something like housing deprivation. The invention of chronic homelessness retrofits a social problem as an economic problem. Thus, while at a discursive level, chronic homelessness evokes addiction and hence individual behavior and personal attributes, in practice, it functions as a statistical model for assessing the economic costs of a subpopulation; chronic homelessness is at its heart an economic category.

Culhane and Kuhn's stratification of shelter use effected an important shift in how individual-level behaviors can be linked to the organization of shelter services. The focus of Culhane and Kuhn's argument is not on what is wrong with the chronically homeless and how to fix them. The characteristics they attribute to the chronically homeless—"being older, of black race, having a substance abuse or mental health problem, or having a physical disability"—remain at the aggregate level to identify a subpopulation.[37] The research acknowledges that inadequate "'safety net' programs" force individuals to rely on emergency shelter systems.[38] It does not go as far as advocating structural changes that might slow or end the reproduction of housing insecurity—for example, challenging discriminatory renting practices or the racial wealth divide. But neither do the authors argue that service providers need to end

drug and alcohol use among their clients. In fact, as noted above, the application of their research has deemphasized the importance of sobriety and other individual-level interventions. For Culhane and Kuhn and the federal policies that followed their research, the most important changes that must be made are in the allocation of resources at organizational levels. Thus, while the role of nonprofits in governance changes and nonprofit agencies again become renewed targets of governance, the existence of a nonprofit industrial complex that is free of accountability to social movements persists.

Given the shift to biopolitical concerns provoked by the invention of chronic homelessness, the end of mandatory social and psychiatric services is not so surprising after all. The biopoliticization of housing insecurity moves away from targeting individual behaviors as the point of intervention, as the population instead is taken up as the proper object of governance. In putting forth a biopolitical model that abstracts attributes and behaviors of individuals and organizes them as a statistical population, the invention of chronic homelessness undercuts the disciplinary technologies of the case management system. In other words, disciplinary mechanisms of individuated control, considered inadequate or ineffective, are being suppressed by population management techniques. In matching the profile of the chronically homeless, subjects are in effect biopoliticized, or absorbed into a governance that regulates a population's costs by economizing and securing its health and life chances. Concern with the apparently limited resources of municipalities, rather than with individual well-being, motivates this biopoliticization. The invention of chronic homelessness deemphasizes individual compliance with service requirements in favor of economic containment of population costs—in a move that unexpectedly benefits an abandoned and usually despised and degraded population. The shift to population level concerns legitimated the Housing First model not because the federal government accepted that mandatory services are paternalistic or offensive, but because it saw mandatory services as a deterrent it could no longer afford.

Thus, the invention of chronic homelessness points to the reconfiguration of disciplinary sites through biopolitical projects. As the persistence of pathologization attests, this is not an end to discipline. Chronic homelessness programs, like the HMIS database program discussed in

the previous chapter, represent a rerouting of disciplinary technologies in a context of the biopoliticization of homelessness. If HMIS generates a homeless population as a mechanism for regulating service agencies, chronic homelessness initiatives form the population as a target of governance itself. Disciplinary case management puts in place the intersubjective relationships that advocates use in outreach efforts to make contact with people on the street and engage them toward learning their health histories. Nonetheless, while the vulnerability index used by programs such as Project 50 engage at the individual level, its use is not toward developing a full, deep understanding of the individual as an individual. Rather, the index is used to glean specific points of data that connect that individual to a population defined in terms of health patterns and economic costs. That individual then becomes understood not so much as a case, but as a data match with a statistical profile. In this sense, the index translates between the individual and the population across a ground of economized health concerns.[39] As I argued in the case of HMIS, like any technology, the vulnerability index is not simply a tool, but must be recognized for its productive capacities. In translating back from the population, the index reproduces the homeless individual, not as pathological subject in need of mandatory case management, but rather, as a component part of a population that must be collectively managed through forms of housing that contain its economic impact.

Patricia Ticineto Clough helps characterize such "post-disciplinary" social programs, which she understands as indicating

> the increasing abandonment of support for socialization and education of the individual subject through interpellation to and through national and familial ideological apparatuses. The production of normalization is not only, or even primarily, a matter of socializing the subject; increasingly, it is a matter of directly bringing bodies and bodily affective capacities under an expanded grid of control, especially through the marketization of affective capacity.[40]

For sure, the discourse of chronic homelessness continues to perform the disciplinary work of pathologizing residents of housing programs. In so doing, it may hold in place the imperative of reforming the individual, even if such an imperative is not mobilized as strongly in the present moment.[41] But in the meantime, a biopolitical model that addresses

individuals as component parts of a population whose death and life chances are correlated with economics and managed through economic means, or what Clough refers to as "marketization," overrides the imperatives of socializing into responsible selves. Within this model, the immediate provision of housing becomes the most economically efficient means of managing this population. The biopoliticization of homelessness signals and produces the transformation of social programs into economic programs, a transformation that characterizes Jacques Donzelot's description of the transition from the social welfare state to the social investment state.[42] The economics do not end with the analysis that produces the category "chronic homelessness," but extend into and transform the programs to which that category gives rise.

The greatest danger in chronic homelessness programs is that they are part of neoliberal economies, and thus they enable and extend, rather than challenge, the very economic conditions that produce housing insecurity and deprivation in the first place. In our conversations, some advocates suggested to me that the fact that their programs benefit businesses by "cleaning up" city neighborhoods is not an irresolvable conflict. A staff person at one such program told me:

> I think we have the same interests. The business community in downtown, some of the leaders are a little bit . . . hard to swallow. But we have the same interests, right? I mean, I don't think they give a crap about homeless people, but they wanna see no one sleep on the street and we wanna see no one sleep on the street.

But we must ask if the interests of the neoliberal economy and populations living without shelter can ever be the same. As proponents of the programs note, 10-Year Plans come into being through the support of police and local business organizations, both of which eagerly support the effort to remove unsheltered individuals from public view. In this way, 10-Year Plans function as the second phase of a spatial-capital reorganization of the city that began with the destruction of skid rows. 10-Year Plans attempt to clean up the mess made by the evaporation of SROs and other forms of low-cost housing by removing the individuals left behind. 10-Year Plans do nothing to alter the structural conditions that reproduce and distribute housing insecurity and deprivation. In this sense, the plans preserve an earlier assumption of housing insecurity,

as if removing "problem individuals" from "the streets" is an adequate solution. The fact remains that "the streets"—here we can substitute the racisms of labor markets, privatized housing, police/prison systems, and inadequate public assistance programs—will continue to produce unsheltered populations.[43]

Chronic homelessness initiatives are economic programs in that they (attempt to) remove obstructions to the smooth functioning of neoliberal consumer/tourist economies in urban centers, benefiting in the short term a small handful of clients who fit the profile of the chronically homeless. Chronic homelessness programs are furthermore economic in a second sense: the *management* of housing insecurity is itself an economic enterprise. The proliferation of chronic homelessness programs, the circulation of funding, the commissioning of studies and reports—all of this forms part of the nonprofit industrial complex, where the post-social state meets postindustrial service and knowledge industries. Contrary to rhetoric that associates "the homeless" with waste and cost, housing insecurity and deprivation prove to be sites of economic productivity in which individuals organized as "chronically homeless" become the raw material out of which studies and services are produced. While consumer/tourist economies may be served by removing unsightly reminders of poverty from view, the social service and knowledge industries that manage this removal are at odds with an end to housing insecurity. An actual elimination of housing insecurity and deprivation would also mean an end to the service and knowledge industries proliferating around managing and studying populations living without shelter. Hence, the complex of agencies and organizations produce new forms of industry that do not fundamentally challenge the social, political, and economic reproduction of housing insecurity and deprivation, even if they do reduce their immediate effects.

While some advocates argue that chronic homelessness initiatives contain something of an inherent contradiction in that they serve both the economic needs of neoliberal cities and the needs of a vulnerable population, there is no contradiction. Chronic homelessness programs serve the economy twice over: first by removing an economic obstacle and then by investing in a growing nonprofit industry of population management. The invention of chronic homelessness enacts the economizing of the social that characterizes neoliberalism, not simply by

subjecting social programs to economic logics, but by transforming social programs into economic industries. The classic or Keynesian social welfare state organized the national population by stratifying it in terms of labor. Populations organized as potential or former workers, or as vital to the reproduction of labor, would be invested in through social programs; those subject to extraction but organized as outside labor would be socially abandoned. Under neoliberal biopolitics, the targets of social programs need not be addressed as labor. Rather, the clients of such programs are labored on by social service and knowledge industries—industries that sustain rather than challenge the neoliberal economies that produce housing insecurity and deprivation.

Loïc Wacquant, Punishing the Poor: The Neoliberal Government of Social Insecurity (2009)

[C]ontemporary societies have at their disposal at least three main strategies to treat the conditions and conducts that they deem undesirable, offensive, or threatening.[12] The first consists in *socializing* them, that is, acting at the level of the collective structures and mechanisms that produce and reproduce them—for instance, as concerns the continual increase in the number of the visible homeless who "stain" the urban landscape, by building or subsidizing housing, or by guaranteeing them a job or an income that would enable them to acquire shelter on the rental market. This path entails (re)asserting the responsibility and (re)building the capacities of the social state to deal with continuing or emerging urban dislocations. The second strategy is *medicalization*: it is to consider that a person is living out on the street because she suffers from alcohol dependency, drug addiction, or mental deficiencies, and thus to search for a medical remedy to a problem that is defined from the outset as an individual pathology liable to be treated by health professionals.

The third state strategy is *penalization*: under this scenario, it is not a matter of either understanding a situation of individual distress or a question of thwarting social cogs; the urban nomad is labeled a delinquent (through a municipal ordinance outlawing panhandling or lying down on the sidewalk, for instance) and finds himself treated as such; and he ceases to pertain to homelessness as soon as he is put behind bars. The "legal construction of the homeless as bare life" abridges his

or her rights, effectively reduces him to a noncitizen, and facilitates criminal processing.[13] Here penalization serves as a *technique for the invisibilization of the social "problems"* that the state, as the bureaucratic lever of collective will, no longer can or cares to treat at its roots, and the prison operates as a judicial garbage disposal into which the human refuse of the market society are thrown.

Inasmuch as they have developed the necessary organizational and ideological capacity, advanced countries can implement these three strategies in diverse combinations and for diverse conditions. There is, moreover, a dynamic interrelationship between these three modalities of state treatment of deplorable states of affairs, with medicalization often serving as a conduit to criminalization at the bottom of the class structure as it introduces a logic of individual treatment.* What matters here is that the weighing and targeting of these manners of governing indocile populations and territories is *doubly political.* First, they are political in that they result from ongoing power struggles between the agents and institutions which contend, in and around the bureaucratic field, to shape and eventually direct the management of "troubled persons" and troubling collective states. Second, the shifting dosage and aim of socialization, medicalization, and penalization are political in that they result from choices that engage the conception that we have of life in common.

It is crucial that these choices be made with full knowledge of the causes and consequences, in the middle and long run, of the options offered. The most portentous scientific and civic mistake here consists in believing and making people believe, as the hypersecuritarist discourse that saturates the political and journalistic fields today asserts, that police and carceral management is the optimal remedy, the royal road to the restoration of sociomoral order in the city, if not the only means of ensuring public "safety," and that we have no alternative to

*In American history, the adoption of the medical model to deal with a variety of disquieting activities (opiate use and addiction, homosexuality, abortion, child abuse and madness) has repeatedly led to their penalization. Peter Conrad and Joseph W. Schneider, *Deviance and Medicalization: From Badness to Sickness* (Philadelphia: Temple University Press, 1992). An instructive case study of how medicalization worked to divert attention from the socioeconomic roots of the rising presence of homeless people on the streets of New York City in the 1980s (namely, the steep decline in stable jobs and severe penury of affordable housing) and to justify a policy of physical removal of social discards from public space is Arline Mathieu, "The Medicalization of Homelessness and the Theater of Repression," *Medical Anthropology Quarterly*, n.s. 7, no. 2. (June 1993): 170–84. For a germane analysis in the French case, see Patrick Gaboriau and Daniel Terrolle, eds., *Ethnologie des sans-logis. Etude d'une forme de domination sociale* (Paris: L'Harmattan, 1998).

contain the social and mental turbulence induced by the fragmentation of wage work and the polarization of urban space. The sociological analysis of the stupendous ascent of the penal state in the United States after the peaking of the Civil Rights movement demonstrates that such is not the case. Entering into the living laboratory of the neoliberal revolution also has the virtue of revealing in quasi-experimental fashion the colossal social cost and the irreversible debasement of the ideals of freedom and equality implied by the criminalization of social insecurity.

2

The Criminalization of Poverty in the Post–Civil Rights Era

In his lecture course on socialism, Émile Durkheim contends that the state is "not an enormous coercive power, but a vast and conscious organization" capable "of an action at once unified and varied, supple and extensive."* Historical experience shows that these two aspects are by no means incompatible, and that a state apparatus can very well be both at the same time. Such is the case at the dawn of the twenty-first century with the United States, where, notwithstanding the virulently antistatist ambient discourse, public force understood *in the strict sense* plays an increasingly decisive role in the patterning and conduct of national life.

Over the past three decades, that is, since the race riots that shook the ghettos of its big cities and marked the closing of the Civil Rights revolution, America has launched into a social and political experiment without precedent or equivalent in the societies of the postwar West: the gradual replacement of a (semi-) welfare state by a police and penal state for which the criminalization of marginality and the punitive containment of dispossessed categories serve as social policy at the lower end of the class and ethnic order. To be sure, this welfare state was, as we shall note shortly, notably underdeveloped compared to its European counterparts. For a number of well-known historical reasons, the sphere of citizenship is particularly constricted in the United States, and the ability of subordinate categories to make themselves heard, severely circumscribed.** Rather than of a welfare state, one should

speak here of a *charitable state* inasmuch as the programs aimed at vulnerable populations have at all times been limited, fragmentary, and isolated from other state activities, informed as they are by a moralistic and moralizing conception of poverty as a product of the individual failings of the poor.[1] The guiding principle of public action in this domain is not solidarity but *compassion*; its goal is not to reinforce social bonds, and still less to reduce inequalities, but at best to relieve the most glaring destitution and to demonstrate society's moral sympathy for its deprived yet deserving members.

Moreover, the hypertrophied penal state that is bit by bit replacing the rump social-welfare state at the bottom of the class structure—or supplementing it according to a gendered division of labor—is itself incomplete, incoherent, and often incompetent, so that it can fulfill neither the unrealistic expectations that have given birth to it nor the social functions that it has as its mission to shore up. And it is hard to see how its development could go unchecked indefinitely, since in the medium run it threatens to bankrupt the large states that lead the pack in the frantic race to hyperincarceration, such as California, New York, Texas, and Florida.[2] Lastly, notwithstanding the thundering proclamations of politicians from all sides about the necessity to "end the era of Big government"—the cheery chorus of Clinton's State of the Union address in 1996—the US government continues to provide many kinds of guarantees and support to corporations as well as to the middle and upper classes, starting, for example, with homeownership assistance: almost half of the $64 billion in fiscal deductions for mortgage interest payments and real estate taxes granted in 1994 by Washington (amounting to nearly three times the budget for public housing) went to the 5 percent of American households earning more than $100,000 that year; and 16 percent of that sum went to the top 1 percent of taxpayers with incomes exceeding $200,000. Over seven in ten families in the top 1 percent received mortgage subsidies (averaging $8,457) as against fewer than 3 percent of the families below the $30,000 mark (for a paltry $486 each).[3] This fiscal subsidy of $64 billion to wealthy home owners dwarfed the national outlay for welfare ($17 billion), food stamps ($25 million), and child nutrition assistance ($7.5 billion).

It is the thesis of this book that the United States is groping its way

toward a new kind of hybrid state, neither a "protector" state, in the Old World sense of the term, nor a "minimalist" and noninterventionist state, conforming to the ideological tale spun by zealots of the market. Its social side and the benefits it dispenses are increasingly secured by the privileged, especially through the "fiscalization" of public support (for education, health insurance, and housing),* while its disciplinary vocation is upheld mainly in its relation to the lower class and subordinate ethnic categories. This *centaur state*, guided by a liberal head mounted upon an authoritarian body, applies the doctrine of "laissez-faire et laissez passer" upstream, when it comes to social inequalities and the mechanisms that generate them (the free play of capital, dereliction of labor law and deregulation of employment, retraction or removal of collective protections), but it turns out to be brutally paternalistic and punitive downstream, when it comes to coping with their consequences on a daily level.

This chapter provides a preliminary sketch of the twofold shift that has *tipped the balance of the US bureaucratic field from its protective to its punitive pole* when it comes to managing poor populations and territories.[4] It argues that the downsizing of the social-welfare sector of the state and the concurrent upsizing of its penal arm are functionally linked, forming, as it were, the two sides of the same coin of state restructuring in the nether regions of social and urban space in the age of ascending neoliberalism. The gradual rolling back of the social safety net commenced in the early 1970s as part of the backlash against the progressive movements of the previous decade and culminated in 1996 with the conversion of the right to "welfare" into the obligation of "workfare," designed to dramatize and enforce the work ethic at the bottom of employment ladder. We shall show in the next chapter that the new punitive organization of welfare programs operates in the manner of a labor parole program designed to push its "beneficiaries" into the subpoverty jobs that have proliferated after the discarding of the Fordist-Keynesian compromise. The diffusing social insecurity and escalating life disorders caused by the desocialization of wage labor and

*In *The Hidden Welfare State: Tax Expenditures and Social Policy in the United States* (Princeton, N.J.: Princeton University Press, 1997), Christopher Howard shows that the social spending of the federal government is increasingly effected in a concealed manner, by way of fiscal arrangements that systematically favor business and wealthier households and effectively bypass the poor. In 1995, tax expenditures with social welfare objectives (such as deductions for home mortgage interest and employer-provided pensions) exceeded $450 billion, more than ten times the budget for AFDC and food stamps put together. Nine-tenths of these expenditures benefited the middle and upper classes (compared with two-thirds for official social spending).

the correlative curtailment of social protection, in turn, were curbed by the stupendous expansion of the penal apparatus that has propelled the United States to the rank of world leader in incarceration. This abrupt rolling out of the penal state will be mapped out in detail in the second part of the book.

Some Distinctive Properties of the American State

To grasp the nature and means of this political mutation, it is indispensable first to identify the distinctive structural and functional properties of what political scientist Alan Wolfe nicely calls America's "franchise state."[5] Here I will briefly emphasize five.

1. *A "society without a state," a society against the state*

The first distinctive trait of the state in America has to do with the representation it is given in the national *doxa*. Just as France has, until recently, thought of itself as a "nation without immigrants," even as its industrial, urban, and cultural history has been decisively stamped by the influx of foreign populations since the end of the nineteenth century, the reigning civic ideology of the United States has it that it is "a society without a state."[6]

From the Pilgrim fathers to the Bush dynasty, Americans have always viewed themselves as an autonomous people fundamentally rebellious to any suprasocial authority—save for that of God. This is attested by the many articles in the Constitution that disperse and curb public powers, regarded *ex hypothesi* as potentially tyrannical, and the venomous antistatism of the national political culture. The 1996 campaign for the presidential nomination offered a translucent illustration of this streak: all the candidates claimed that they wanted to "clean up Washington" and the federal government was characteristically presented as a foreign force, if not as the enemy of the people, by those who were its very servants. During the 2000 campaign, Albert Gore Jr., the sitting vice president for eight years, insisted on locating his campaign headquarters in Tennessee in order to stage his alleged closeness to the "people" and distance from "government elites," even though, as the son of a senator, he had spent his entire life and career in the corridors of power in Washington. Another indicator: Americans were likelier to blame the federal government (79 percent), and then "American workers themselves" (75 percent) and their fast-flagging unions

(62 percent), than they were Wall Street (50 percent) for the massive destruction of jobs that marked the beginning of the 1990s.[7]

2. *Bureaucratic fragmentation and dysfunctions*

The American state is a decentralized network of loosely coordinated agencies whose powers are limited by the very fragmentation of the bureaucratic field and the disproportionate power the latter grants to local authorities. The sharing of budgetary responsibilities and attributions among the various levels of government (federal, state, county, and municipal) is a source of constant dissension and distortion. The result is that there is often an abyss between the policies promulgated "on paper" in Washington and in state legislatures and the services actually delivered on the ground by street-level bureaucracies.[8]

The related absence of a tradition of public service and of stable channels for the recruitment and oversight of civil servants, especially in higher offices, means that the administrative apparatus is directly subjected to the forces of money, on the one hand, and to the brute demands of "electoral patrimonialism," on the other. Thence the bureaucratic incoherence and ineptitude that often preside over the design and implementation of national and local policies.[9] It also helps account for the extreme porosity of the public-private divide: according to a century-old tradition, updated by the "War on poverty" during the 1960s, a large share of social programs aimed at the lower class (such as the "Head Start" preschool plan or support for orphans and child protective services) is subcontracted to private and nonprofit agencies, which distribute and administer them in the name of the national collectivity. The historically entrenched pattern of reliance on the commercial and third sectors for carrying out many welfare duties of the state has created a vast and intricate mesh of organizations and interest groups "dedicated to preserving the private tilt of US social policy,"[10] which further complicates the landscape of large-scale public provision and creates an institutional terrain very propitious to efforts at further privatization of its activities.

3. *A dual state, or the great institutional-cum-ideological bifurcation*

Since the foundational era of the New Deal, the social action of the US state has been split into two hermetically sealed domains that are sharply distinguished by the composition and political weight of their respective "clienteles" as well as by their ideological charge.[11] The first

strand, under the heading of "social insurance," is responsible for the collective management of the life-risks of wage earners—unemployment, sickness, and retirement. In principle, everyone with a stable job is entitled to participate in these programs and enjoys benefits construed as the just counterpart to their contributions (but we shall see shortly that this principle is in practice routinely violated in the lower tiers of the job market). The second plank, designated by the loathsome idiom of "welfare,"[12] concerns only assistance to dependent and distressed individuals and households. Its recipients are submitted to draconian conditions (of income, assets, marital and familial status, residence, etc.) and are placed under a harsh tutelage that clearly demarcates them from the rest of society and effectively makes them second-class citizens, on grounds that the support they receive is granted without an offsetting contribution on their part, and thus threatens to undermine their "work ethic."

Historically, the main beneficiaries of the "social insurance" side of the US social state, such as the Social Security retirement fund, have been men (as full-time workers and heads of households), whites (who have long cornered the lion's share of stable jobs in the industrial and service sectors), and the families of the labor aristocracy and the middle and upper classes. Although public assistance programs such as Aid to Families with Dependent Children (AFDC, income and in-kind grants to destitute single mothers with young children) reach a broad public that is majority white—more than one American household in four was on the "welfare" rolls at some point during the 1980s[13]—in the popular imagination their clientele is essentially made up of urban minorities and dissolute women living off the nation in the manner of social parasites.

4. *A residual welfare state*

The American state is the prototype of the "residual welfare state"[14] to the extent that it offers support only in response to the cumulative failures of the labor market and the family, by intervening on a case-by-case basis through programs strictly reserved for vulnerable categories that are deemed "worthy": ex-workers temporarily pushed out of the wage-labor market, the handicapped and severely disabled, and, subject to varying restrictive conditions, destitute mothers of young children.[15] Its official clientele is thus composed of "dependents" from working-class backgrounds, low-pay workers, the unemployed, and families of color, who have no influence upon the political system and, by the same token, no means of protecting their meager prerogatives.

The United States thus presents the paradox of a nation that venerates children but has no family support or education policy, so that one child in four (one black child in two) lives under the official "poverty line"; a country that spends vastly more than any of its competitors on healthcare as a percentage of its GDP, yet leaves some 45 million people (including 12 million children) without medical coverage at any one time; a society that sacralizes work, yet has no national framework for training or supporting employment worthy of the name. All because "state charity" has for its primary objective bolstering the mechanisms of the market and especially imposing the tough discipline of deskilled wage labor upon marginal populations.[16]

5. *A racial state*

Finally, the United States sports the highly distinctive property of being endowed with a *racial state* in the sense that, much like Nazi Germany and South Africa until the abolition of apartheid, the structure and functioning of the bureaucratic field are thoroughly traversed by the imperious necessity of expressing and preserving the impassable social and symbolic border between "whites" and "blacks," incubated during the age of slavery and subsequently perpetuated by the segregationist system of the agrarian South and the ghetto of the Northern industrial metropolis.* The pervasiveness and potency of this denegated form of ethnicity called "race" as a principle of social vision and division that effaces, ideologically and practically, the insuperable contradiction between the democratic ideal founded on the doctrine of the natural

rights of the individual and the persistence of a caste regime, is essential to understanding the initial atrophy and accelerating decay of the American social state in the recent period on the one hand, and the stupefying ease and speed with which the penal state arose on its ruins on the other.

Indeed, the originary caesura of the national social space into two communities perceived as congenitally disjoint and inherently unequal, between which the other components of the US ethnic mosaic are inserted (Latinos, Asians, and Native Americans, according to the official taxonomy), overdetermines the design and implementation of public policy in all domains. The white-black cleavage infects the national political culture and distorts the electoral and legislative game at the local as well as the federal level, from campaign fund-raising to the drawing of districts, the rhetoric of candidates for office, the formation of legislative factions and alliances, to the manufacturing of legislation.[17] From its origins, this rigid partition has also thwarted the unification and organization of the working class. Together with the strong integration of the capitalist class at the onset of industrialization, it accounts for the absence of union mobilization of an oppositional kind and, by the same token, for the feeble political oversight of the markets for labor, capital, and public goods.[18]

Lastly, through the intercession of regional cleavages, racial division anchors the teratological development of a welfare state split into two blocs, one turned toward whites and the middle and upper classes, the other aimed at blacks and the unskilled working class during the foundational era of the New Deal no less than during the expansionary period of the 1960s; and it underpins the tilting, over the ensuing two decades, from the assistantial to the penal management of poverty, misperceived as a problem affecting blacks first and foremost.[19] The ethnic division of the proletariat and the structural dualism of the semiwelfare state contribute to perpetuating the racialization of politics, which in turn feeds the retreat from civic participation, facilitating the stranglehold of corporations and wealthy funders on the electoral system.

Rolling Back the Charitable State

These distinctive characteristics explain why, although social inequality and economic insecurity increased sharply during the closing three decades of the twentieth century,[20] the American charitable state has steadfastly reduced its perimeter of operation and squeezed its modest budgets so as to allow for the explosive increase in military spending

Table 1. Decrease in welfare payments to poor single mothers (AFDC)*, 1975–95

	1970	1975	1980	1985	1990	1995
Current dollars	221	264	350	399	432	435
Constant dollars	221	190	165	144	128	119
Change	100	86	75	65	58	49.8

*Median payment for a family of four

SOURCE: Committee on Ways and Means, US House of Representatives, *1996 Green Book* (Washington, D.C.: U.S. Government Printing Office, 1997), 443–45, 449.

and the extensive redistribution of income from wage earners toward firms and the affluent fractions of the upper class. So much so that the "War on poverty" has given way to a simile *war against the poor*, made into the scapegoats of all the major ills of the country[21] and now summoned to care for themselves lest they be hit by a volley of punitive and humiliating measures intended, if not to put them back onto the narrow path of precarious employment, then at least to minimize their social demands and thus their fiscal burden.

Impaired by the administrative and ideological split between "welfare" and "social insurance," stigmatized by their close association with the demands of the black political movement, and tarnished by the notorious inefficiency of the agencies responsible for implementing them, programs targeted at the poor were the first victims of the sociopolitical reaction that carried Reagan to power in 1980 and then fostered the success of Clinton's "New Democrats."[22] Although the cost of AFDC never reached 1 percent of the federal budget, every government since Jimmy Carter has promoted its reduction as a top priority. And they have very largely succeeded at the level of recipients (see table 1): in 1970, the median AFDC payment for a family of four without any other source of income was $221 per month; in 1990, this sum reached $432 in current dollars, or $128 adjusting for inflation, corresponding to a net decline in purchasing power of 42 percent. By 1995, on the eve of its elimination, the AFDC package came to a paltry $435, or $110 in 1970 dollars, representing a real drop of more than one-half.

Moreover, these nationwide statistics conceal sharp regional disparities (see table 2). Social assistance was always significantly higher in the urban and industrial Midwest and Northeast, the historic cradle of both the working class and the black ghetto, than in the South, where poverty is more prevalent still and the social safety net virtually nonexistent. Thus, in 1996 the maximum monthly allowance for a family of three came to $577 in New York and $565 in Boston, as against a

Table 2. Maximum AFDC payment for a family of three in selected states, 1970–96*

	1970	1980	1990	1996	% change in real value, 1970–96
New York (City)	279	394	577	577	–48
Michigan (Detroit)	219	425	516	459	–48
Pennsylvania	265	332	421	421	–60
Illinois	232	288	367	377	–59
Texas	148	116	184	188	–68
Mississippi	56	96	120	120	–46

*In dollars per month

SOURCE: Committee on Ways and Means, U.S. House of Representatives, *1996 Green Book* (Washington, D.C.: US Government Printing Office, 1997), 459, 861, 921.

mere $120 in Mississippi, $185 in Albert Gore's Tennessee, and $188 in George W. Bush's Texas. But the decline in real terms was catastrophic everywhere, ranging from one-half in Michigan to two-thirds in Texas. In 1970, the AFDC package covered a national average of 84 percent of the "minimal needs" officially entitling one to public assistance; by 1996, this figure had fallen to 68 percent; in Texas, this ratio had plummeted to 25 percent (compared to 75 percent a quarter-century earlier).

Yet impoverished families must first succeed in receiving the meager assistance to which they are legally entitled. The second technique for shrinking the charitable state is not budgetary but administrative: it consists in multiplying the bureaucratic obstacles and requirements imposed on applicants with the aim of discouraging them or striking them off the recipient rolls (be it only temporarily). Under the cover of ferreting out abuses and turning up the heat on "welfare cheats," public aid offices have multiplied forms to be filled out, the number of documents to be supplied, the frequency of checks, and the criteria for periodically reviewing files. Between 1972 and 1984, the number of "administrative denials" on "procedural grounds" increased by almost one million, two-thirds of them directed against families who were fully within their rights.[23] This practice of bureaucratic harassment has even acquired a name well known among specialists, "churning," and it has given rise to elaborate statistics tracking the number of eligible claimants on assistance whose demands were unduly rejected for each program category. Thus, whereas 81 percent of poor children were covered by AFDC in 1973, over 40 percent did not receive the financial aid to which they were entitled fifteen years later. In 1996, at welfare's burial, it was estimated that every other poor household in America did not receive benefits for which it was eligible.

Finally, there remains the third and most brutal technique, which consists of simply eliminating public aid programs, on grounds that their recipients must be snatched from their culpable torpor by the sting of necessity. To hear the chief ideologues of American sociopolitical reaction, Charles Murray, Lawrence Mead, and Daniel Patrick Moynihan, the pathological "dependency" of the poor stems from their moral dereliction. Absent an urgent and muscular intervention by the state to check it, the growth of "nonworking poverty" threatens to bring about nothing less than "the end of Western civilization."[24] At the start of the 1990s, several formerly industrial states with high unemployment and urban poverty rates, such as Pennsylvania, Ohio, Illinois, and Michigan, unilaterally put an end to General Assistance, a locally funded program of last resort for the indigent—overnight in Michigan, after a brief transition period in Pennsylvania. This resulted in the dumping of one million aid recipients nationwide.

The downsizing of America's charitable state has proceeded across a broad front and has not spared the privileged domain of social protection. In 1975, the unemployment insurance scheme established by the Social Security Act of 1935 covered 76 percent of wage earners who lost their jobs. By 1980 that figure had fallen to one in two due to state-mandated administrative restrictions and the proliferation of "contingent" jobs; and in 1995 it approached one worker in three. While coverage shrank, for twenty years the real average value of unemployment benefits stagnated at $185 per week (in constant dollars of 1995), disbursed for a meager fifteen weeks, giving most jobless people "on the dole" incomes putting them far below the poverty line.[28]

The same trend applies to occupational disability, for which the rate of coverage dropped from 7.1 workers per thousand in 1975 to 4.5 per thousand in 1991. Likewise for housing: in 1991, according to official figures, one in three American families was "housing poor," that is, unable to cover both basic needs and housing costs, while the homeless population numbered between 600,000 and 4 million. Meanwhile, the federal budget for social housing plummeted from $32 billion in 1978 to less than $10 billion a decade later in current dollars, amounting to a cut of 80 percent in real dollars.[29] At the same time, Washington eliminated funding for general revenue sharing, local public works, and urban development grants, as well as drastically pared most programs aimed at reintegrating the unemployed. When the Comprehensive Education and Training Act (CETA) program was terminated in 1984, over 400,000 public jobs for unskilled people disappeared. In 1975, the federal government devoted $3 billion to providing job training to 1.1 million poor Americans; by 1996, this figure had fallen to $800 million

(in constant dollars), barely enough to cover 329,000 trainees. Meantime, budgets allocated to financing "summer jobs" for underprivileged youth were cut by one-third and the number of their beneficiaries by one-half.[30]

But it is at the municipal level that the concerted attack on urban and social policy was most ferocious. Using the pretext of the fiscal crisis triggered by the exodus of white families, middle-class revolts against taxation, and the drying up of federal subsidies, American cities sacrificed public services essential to poor neighborhoods and their inhabitants—housing, sanitation, transportation, and fire protection, as well as social assistance, health, and education. They diverted a growing share of public monies toward the support of private commercial and residential projects that promised to attract the new service-based corporations and the affluent classes.[31] This shift was justified by invocation of the alleged efficiency of market mechanisms in the allocation of city resources and federal funds. And it was greatly facilitated by the rigid racial segregation of the American metropolis, which sapped the collective capacity of poor residents by fracturing them along the color line. A single example suffices to indicate the devastating effects of this turnaround: while the costs and profits of free-market medicine soared, in Chicago the number of community hospitals (i.e., those accessible to people without private medical coverage) slumped from 90 in 1972 to 67 in 1981 to 42 in 1991. By that year, outside of the dilapidated and overcrowded Cook County Hospital, no health center in the entire city provided prenatal support to mothers without private insurance. In 1990, the director of Chicago's hospitals announced that the public health system was a "non-system on the brink of collapse," fundamentally incapable of fulfilling its mandate. That this declaration elicited no response from city and state officials and administrators speaks volumes about the indifference with which the rights and well-being of the urban poor are regarded.[32] The fact that the dispossessed families of Chicago are disproportionately black and Latino (from Mexican and Puerto Rican parentage) is key to explaining their civic invisibility.

The consequences of the withdrawal of the charitable state are not hard to guess. At the end of 1994, despite two years of solid economic growth, the Census Bureau announced that the official number of poor people in the United States had surpassed forty million, or 15 percent of the country's population—the highest rate in a decade. In total, one white family in ten and one African-American household in three lived below the federal "poverty line." This figure conceals the depth and intensity of their dereliction inasmuch as this threshold, calculated according to an arbitrary bureaucratic formula dating from 1963 (based

on family consumption data from 1955), does not take into account the actual cost of living and the changing mix of essential goods, and it has been drawn ever lower over the years: in 1965 the poverty line stood at about one-half of the national median family income; thirty years later it did not reach one-third.* Comparative analysis reveals that, despite a notably lower official unemployment rate, "poverty in the United States is not only more widespread and more persistent, but also more severe than in the countries of continental Europe."[33] In 1991, 14 percent of American households received less than 40 percent of the median national income, as against 6 percent in France and 3 percent in Germany. These gaps were considerably more pronounced among families with children (18 percent in the United States versus 5 percent in France and 3 percent for its neighbor across the Rhine), not to mention single-parent families (45 percent in the United States, 11 percent in France, and 13 percent in Germany). This is hardly surprising when the minimum hourly wage is set so low that an employee working full-time year-round earned $700 per month in 1995, putting him 20 percent below the poverty line for a household of three, and when public aid is calculated to fall well below that wage rate in order to avoid creating "disincentives" to work:[34] the maximum AFDC cash payment in the median state in 1994 came barely to 38 percent of the poverty line and reached only 69 percent when combined with the value of food stamps and other in-kind support.

The degradation of employment conditions, shortening of job tenures, drop in real wages, and shrinking of collective protections for the US working class over the past quarter-century have been brought about and accompanied by a surge in precarious wage work. The numbers of on-call staff and day laborers, "guest" workers (brought in through state-sponsored programs of seasonal importation of agricultural laborers from Mexico or the Caribbean, for instance), office- or service-workers operating as subcontractors, compulsory part-timers, and casual staff hired through specialized "temp" agencies have all increased much more quickly than other occupational categories since the mid-1970s—with temporary help leading the pack at a yearly clip of 11 percent. Today *one in three Americans in the labor force is a non-standard wage earner*: such insecure work must clearly be understood as a perennial form of subemployment solidly rooted in the new socio-economic landscape of the country and destined to grow.[35]

During the 1980s and 1990s, mass layoffs became a privileged instrument for the short-term financial management of US firms,[41] so that the country's middle and managerial classes made the bitter discovery of job insecurity during a period of sturdy growth. The return of economic prosperity to the United States was thus built on a spectacular degradation of the terms and conditions of employment: between 1980 and 1995, 41 percent of "downsized" employees were not covered by unemployment insurance and two-thirds of those who managed to find new work had to accept a position with lower wages. In 1996, 82 percent of Americans said that they were prepared to work longer hours to save their jobs; 71 percent would consent to fewer holidays, 53 percent to reduced benefits, and 44 percent to a cut in pay.[42] The absence of collective action in the face of stock-market-driven layoffs is explained by the congenital weakness of unions, the lock that corporate financiers have placed on the electoral system, and the power of the ethos of meritocratic individualism, according to which each wage earner is responsible for his or her own fate.

Failing a language that could gather the dispersed fragments of personal experiences into a meaningful collective configuration, the diffuse frustration and anxiety generated by the disorganization of the established reproduction strategies of the American middle classes have been redirected *against the state*, on the one side, which was accused of weighing on the social body like a yoke as stifling as it is useless, and, on the other, *against categories held to be "undeserving,"* or suspected of benefiting from programs of affirmative action, henceforth perceived as handouts violating the very principle of equity they claim to advance. The former tendency expressed itself in the pseudo-populist tone of electoral campaigns during the closing decade of the century, in which politicians near-unanimously directed a denunciatory and revanchist discourse against Washington's technocrats and other bureaucratic "elites"—of which they are typically full-fledged members—and public services—whose personnel and budgets they promised to "trim." The second tendency is evident in the fact that 62 percent of Americans are opposed to affirmative action for blacks and 66 percent are against affirmative action for women, even in those cases where it is proven that those helped were targets of discrimination, while two Americans in three wish to curtail immigration, even as 55 percent concede that immigrants take jobs nationals do not want (precisely because they are overexploitative).[43] This is the logic according to which in 1996, confirming its historic role as the nation's bellwether, California abolished the promotion of "minorities" in higher education and excluded so-

called illegal immigrants from all public services, including schools and hospitals.

Whence, finally, the national hysteria around the problem of "welfare" that led to the public aid "reform" of 1996, which we shall analyze in some detail in the next chapter. Hypocritically entitled the "Personal Responsibility and Work Opportunity Act," it amounted to abolishing the right to assistance and instituted forced deskilled wage labor as the sole means of support on the pretext of setting the indigent back onto the road to "independence." Sacrificing the poor—and especially the black urban subproletariat, incarnation and scapegoat of all the country's ills—to exorcise the worries of the middle and working classes over their future is once again to ask those who are the living negation of the "American dream" to suffer for their alleged alterity so that, in spite of everything, the country may uphold its faith in the national myth of prosperity available to all.

Rolling Out the Penal State

How to stem the mounting tide of dispossessed families, street derelicts, alienated jobless youth, and the despair and violence that intensify and accumulate in the neighborhoods of relegation of the big cities? At all three levels of the bureaucratic field, county, state, and federal, the American authorities have responded to the rise of urban dislocations—for which, paradoxically, they are largely responsible—by developing their penal functions to the point of hypertrophy. As the social safety net of the charitable state unraveled, the dragnet of the punitive state was called upon to replace it. Its disciplinary mesh was flung throughout the nether regions of US social space so as to contain the disarray and turmoil spawned by the intensification of social insecurity and marginality. A causal chain and functional interlock was thus set into motion, whereby economic deregulation required and begat social welfare retrenchment, and the gradual makeover of welfare into workfare, in turn, called for and fed the expansion of the penal apparatus.

The deployment of this *state policy of criminalization of the consequences of state-sponsored poverty* operates according to two main modalities. The first and least visible one—except to those directly affected by it—consists in *reorganizing social services into an instrument of surveillance* and control of the categories indocile to the new economic and moral order. Witness the wave of reforms adopted between 1988 and 1995 in the wake of the Family Support Act by some three dozen states that have restricted access to public aid and made it conditional upon upholding certain behavioral norms (economic, sexual, familial, educational, etc.) and upon performing onerous and humiliating bureaucratic obligations. The most common of these requirements stipulate that the recipient must accept any job or assimilated activity offered to her, whatever the pay and working conditions, on pain of forsaking the right to assistance ("workfare"). Others index the amount of assistance received by the families to the school attendance record of their children or teenage recipient ("learnfare"), or peg them on enrollment in pseudo-training programs that offer few if any skills and job prospects.[44] Yet others establish a ceiling on the cash value of aid or set a maximum duration after which no support will be accorded. In New Jersey in the mid-1990s, for instance, AFDC benefits were terminated if an unmarried teen mother did not reside with her parents (even in cases where the latter had thrown her out), and the amount she received was capped if she begat additional children.

The insufficiency and inefficiency of forced-work programs are as glaring as their punitive character. While such programs are periodically vaunted as the miracle cure for the epidemic of "dependency" said to afflict the American poor, none of them has ever allowed more than a handful of participants to escape destitution. The reasons for their failure are several: the jobs proposed or imposed are too precarious and ill paid to offer a platform for economic autonomy; they do not provide medical coverage or child care assistance, making employment both risky and prohibitively costly for mothers with young offspring; the workplaces are physically and emotionally degrading; and a majority of "welfare mothers" already work while receiving aid in the first place.[45] At best, such programs replace "dependency" on means-tested state programs with "dependency" on superexploitative employers at the margins of the labor market, supplemented by fragile family networks, and illegal street commerce where accessible, a combination that nearly guarantees continued poverty. But precisely: it will be shown in the next chapter that workfare policy does not aim to reduce *poverty* but seeks only to diminish the *visibility of the poor in the civic landscape* and to "dramatize" the imperative of wage labor by issuing "a warning to all Americans who were working more and earning less, if they were working at all. There is a fate worse, and a status lower, than hard and unrewarding work."[46]

The long train of welfare reform measures also extols and embodies the new paternalist conception of the role of the state in respect to the poor, according to which the conduct of dispossessed and dependent citizens must be closely supervised and, whenever necessary, corrected through rigorous protocols of surveillance, deterrence, and sanction,

Table 3. Number of inmates in federal and state prisons, 1970–95 (in thousands)

	1970	1980	1990	1995	change 1970–95 (%)
Total	199	320	743	1078	442
Annual growth in preceding decade (%)	*–1.2*	*6.1*	*13.2*	*9*	
Blacks	81	168	366	542	569
Annual growth for blacks (%)	*–0.7*	*10.8*	*17.9*	*9.7*	

SOURCE: Bureau of Justice Statistics, *Historical Corrections Statistics in the United States, 1850–1984* (Washington, D.C.: Government Printing Office, 1986); idem., *Prisoners in 1996* (Washington, D.C.: Government Printing Office, 1997).

very much like those routinely applied to offenders under criminal justice supervision. The shift "from carrots to sticks," from voluntary programs supplying resources to mandatory programs enforcing compliance with behavioral rules by means of fines, reductions of benefits, and termination of recipiency irrespective of need, that is, programs treating the poor as *cultural similes of criminals* who have violated the civic law of wage work, is meant to both dissuade the lower fractions of the working class from making claims on state resources and to forcibly instill conventional morality into their members.* And it is instrumental in embellishing the statistics of public aid offices by "dressing up" recipients as workers while trapping the assisted population in the urban wastelands set aside for them.

The second component of the policy of punitive containment of the poor is *massive and systematic recourse to incarceration* (see table 3). Confinement is the other technique through which the nagging problem of persistent marginality rooted in unemployment, subemployment, and precarious work is made to shrink on—if not disappear from—the public scene. After decreasing by 12 percent during the

*This moral agenda is frankly laid out by the ideologues of state paternalism: "The social problems associated with long-term welfare dependency cannot be addressed without first putting the brakes on the downward spirals of dysfunctional behavior common among so many recipients. . . . Character is built by the constant repetition of diverse good acts. These new behavior-related welfare rules are an attempt, long overdue in the minds of many, to build habits of responsible behavior among long-term recipients; that is, to legislate virtue." Douglas J. Besharov and Karen N. Gardiner, "Paternalism and Welfare Reform," *The Public Interest* 122 (winter 1996): 70–84, citation p. 84.

1960s, the population condemned to serve time in state prisons and federal penitentiaries (excluding detainees held in city and county jails, awaiting judgment or sanctioned with short custodial sentences) exploded after the mid-seventies, jumping from under 200,000 in 1970 to nearly one million in 1995—an increase of 442 percent in a quarter-century never before witnessed in a democratic society. Like the social disengagement of the state, imprisonment has hit urban blacks especially hard: the number of African-American convicts increased sevenfold between 1970 and 1995, after falling 7 percent during the previous decade (even though crime rose rapidly during the 1960s). In each period, the growth rate of the black convict population far exceeded that of their white compatriots. In the 1980s, the United States added an average of 20,000 African Americans to its total prisoner stock *every year* (over one-third the total carceral stock of France). And, for the first time in the twentieth century, the country's penitentiaries held more blacks than whites: African Americans made up 12 percent of the national population but supplied 53 percent of the prison inmates in 1995, as against 38 percent a quarter-century earlier. The rate of incarceration for blacks *tripled in only a dozen years* to reach 1,895 per 100,000 in 1993—amounting to nearly seven times the rate for whites (293 per 100,000) and twenty times the rates recorded in the main European countries at that time.[47]

We will track down the sources and modalities of this astronomical increase in the prison population in detail in chapter 4 and demonstrate in particular that it is utterly disconnected from crime trends. In chapter 6, we will moreover show how the sudden growth of the prison relates to the crumbling of the urban ghetto as physical container for undesirable dark bodies. Here we want simply to note that a major engine behind carceral growth in the United States has been the "War on drugs"—an ill-named policy since it refers in reality to a guerilla campaign of penal harassment of low-level street dealers and poor consumers, aimed primarily at young men in the collapsing inner city for whom the retail trade of narcotics has provided the most accessible and reliable source of gainful employment in the wake of the twofold retrenchment of the labor market and the welfare state.[48] It is a "war" that the authorities had no reason to declare in 1983, considering that marijuana and cocaine use had been declining steadily since 1977–79 and that the supply-reduction approach to drug consumption has a long and distinguished history of failure in America.* And it was fully

predictable that this policy would disproportionately strike lower-class African Americans insofar as it was directly targeted on dispossessed neighborhoods in the decaying urban core.

The rationale for this narrow spatial aiming of a nationwide penal drive is easy to disclose: the dark ghetto is the stigmatized territory where the fearsome "underclass," mired in immorality and welfare dependency, was said to have coalesced under the press of deindustrialization and social isolation to become one of the country's most urgent topics of public worry. But it is also the area where police presence is particularly dense, illegal trafficking is easy to spot, high concentrations of young men saddled with criminal justice records offer easy judicial prey, and the powerlessness of the residents gives broad latitude to repressive action. It is not the War on drugs per se, but the timing and selective deployment of that policy in a restricted quadrant located at the very bottom of social and urban space that has contributed to filling America's cells to bursting and has quickly "darkened" their occupants.

Yet, the doubling of the carceral population in ten years, and its tripling in twenty years after the mid-197os, seriously underestimates the real weight of penal authority in the new apparatus for treating urban poverty and its correlates. For those held behind bars represent only a quarter of the population under criminal justice supervision. If one takes account of individuals placed on probation on parole, more than five million Americans, amounting to 2.5 percent of the country's adult population, fell under penal oversight by 1995. In many cities and regions, the correctional administration and its extensions are the main if not the sole point of contact between the state and young black men from the deskilled lower class: as early as 1990, 40 percent of African American males age 18 to 35 in California were behind bars or on probation and parole; this rate reached 42 percent in Washington, D.C., and topped 56 percent in Baltimore.51 Thus, during the same period when the US state was withdrawing the protective net of welfare programs and fostering th generalization of subpoverty jobs at the bottom of the employment lad der, the authorities were extending a reinforced carceral mesh reaching deep into lower-class communities of color.

The financial transla.tion of this "great confinement" of marginality is not hard to imagine. As will be documented fully in chapter s, to implement its policy of penalization of social insecurity at the bottom of the socioracial structure, the United States massively enlarged the budget and personnel devoted to confinement, in effect ushering in the era of "carceral big government" just as it was decreasing its com mitment to the social support of the poor. While the share of national expenditures allocated to public

assistance declined steeply relati ve to need, federal funds for criminal justice multiplied by 5.4 between 1972 and 1990, jumping from less than $2 billion to more than $10 billion, while monies allotted to corrections proper increased elevenfold. The financial voracity of the penal state was even more unbridled at the state level. Taken together, the fifty states and the District of Colum-bia spent $28 billion on criminal justice in 1990, 8.4 times more than in 1972; during this stretch, their budgets for corrections increased twelvefold, while the cost of criminal defense for the indigent (who make up a rising share of those charged in court) grew by a factor of 24. To enforce the Violent Crime Control and Law Enforcement Act of 1994, which envisaged boosting the national carceral population from 925,000 to some 2.26 million over a decade, the US Congress forecast expenditures of $351 billion, including $100 billion just for building new custodial facilities—nearly twenty times the AFDC budget that year.[52] We shall see in chapter 4 that these predictions turned out to be rather accurate: a decade later the country had doubled its popula-tion under lock, and budgets for corrections were pushing counties and states deep into debt.

Incarceration in America thus expanded to reach an industrial scale heretofore unknown in a democratic society, and, in so doing, it spawned a fast-growing commercial sector for operators helping the state enlarge its capacity to confine, by supplying food and cleaning services, medical goods and care, transportation, or the gamut of activities needed to run a penal facility day-to-day. The policy of hyperincarceration even stimulated the resurgence and exponential expansion of *jails and prisons constructed and/or managed by private operators*, to which public authorities perpetually strapped for cells turned to extract a better yield out of their correctional budgets. Incarceration for profit concerned 1,345 inmates in 1985; ten years later, it covered 49,154 beds, equal to the entire confined population of France. The firms that house these inmates receive public monies against the promise of miser's savings, on the order of a few cents per capita per day, but multiplied by hundreds of thousands of bodies, these savings are put forth as justification for the partial privatization of one of the state's core regalian functions.[53] By the late 1990s, an import-export trade in inmates was flourishing among different members of the Union: every year Texas brings in several thousands convicts from neighboring states but also from jurisdictions as far away as the District of Columbia, Indiana, and Hawaii, in utter disregard of family visiting rights, and later returns them to their county of origin where they will be consigned on parole at the end of their sentence.

Returning Home . . . to Homelessness:

San Diego's Homeless Court Program Models Ways to Help

By Steve Binder and Amy Horton-Newell

Editor's Note: *The ABA Commission on Homelessness and Poverty is dedicated to establishing homeless courts and legal services at Stand Down events for homeless veterans. It offers free technical assistance. For more information, e-mail Commission Director Amy Horton-Newell at amy.hortonnewll@americanbar.org. or call her at (202) 662-1693.*

Image: Getty Images

Steve Binder

Amy Horton-Newell

Steve Binder (steve.binder@sdcounty.ca.gov) *is a deputy public defender with the San Diego Office of the Primary Public Defender. He cofounded San Diego's Homeless Court Program in 1989 and Veterans Treatment Review Calendar (now Veterans Court) in 2011. He is a special advisor and former chair to the ABA Commission on Homelessness and Poverty.*

Amy Horton-Newell (amy.hortonnewell@americanbar.org) *is director of the ABA Commission on Homelessness and Poverty and the Coordinating Committee on Veterans Benefits and Services.*

In 1989, it was not unusual for a homeless person in San Diego to carry a pocketful of 20 or more citations. One could also find a handful of people on the streets with 50 to 100 warrants for "disturbing the peace." The citations issued by police came to be seen as an indirect invitation to get out of town. In practice, the police and the homeless were engaged in a game of cat and mouse. The police would conduct a sweep of the streets in downtown San Diego, issue citations, and force the homeless into Balboa Park. In an effort to clear out the park, police would issue a new round of citations. And another round-robin of citations and movement would ensue.

The Regional Task Force on the Homeless for San Diego County estimates the City of San Diego is residence to more than 9,600 homeless people, fewer than half of whom are sheltered. And the Department of Housing and Urban Development (HUD) and the Department of Veterans Affairs (VA) estimate that nearly 42 percent of our nation's homeless veterans are located in the San Diego area. The cost of housing people in an emergency shelter bed is $5 a night for an average transitional shelter bed, while support services cost $40 a day. The cost of incarceration in the county jail is an estimated $90 a night. If mental health services are required, the cost of incarceration exceeds $400 a day.

By the late eighties, the police complained that the people they arrested were released after serving a few days in custody. Judges were frustrated with the backlog of cases and warrants that accumulated when defendants failed to appear for court. These same judges realized the futility of handing out sentences and issuing orders that would not be obeyed.

Homeless defendants often fail to appear in court, not because of a disregard for the court system, but because of their status and condition. They struggle daily for food, clothing, and shelter. They are not in a position to adhere to short-term guidelines. Not only does the daily struggle to survive inhibit participation in court, but the participants are also scared. The court orders and sentences result in fines they cannot pay and custody that ends with their release back to the streets in the same condition in which they started. Custody leaves them, society, and the court no better off than before they went in.

When homeless people did appear in court, they tried to explain to the judge the sorry set of circumstances that had taken them from families, homes, and jobs to sleeping in the dirty bedrolls that lay beside them in court. Some were articulate and educated and some were even working. Yet they still were unable to afford a rent deposit or a room. They would come before the court and walk away with a sentence that required them to pay a fine, perform public service work, or spend time in custody. They picked up their court orders at the clerk's office and walked back to the streets, adding legal burdens on top of their other troubles.

Not only did this approach affect the people experiencing homelessness, but the prosecutors, judges, and even the police were uncomfortable and frustrated with the futility of this revolving-door approach. A person who cannot afford a room to rent cannot afford a fine for being homeless. At the time, there were no alternatives. The criminal justice system had an established routine that unfortunately did not adequately meet the needs of this population with special issues.

All Rise: The First Homeless Court Session for Veterans

Early one Saturday morning in July 1989, three gray, concrete handball court walls housed justice. They were located on San Diego High School's athletic field. Desert military camouflage netting sheltered the court from the sun. The United States flag was anchored in one corner, the State of California's in the other. The defendants appearing before this outdoor court were veterans living on the streets of San Diego, but for three days they were sheltered in tents (each a community unto itself), and they received employment counseling, housing referrals, medical care, and other social services.

These services were supplied under the auspices of Stand Down, San Diego's annual three-day tent city designed to relieve the isolation of homeless veterans

while assisting their reentry into society. "Stand down" as a military term signifies the process of pulling exhausted soldiers from the field of battle and moving them to a place of relative safety to rest and recover before returning to fight. The yearly event provides comprehensive services for homeless veterans, including those related to employment, housing, medical needs, legal services needs (civil and criminal), physical and mental health treatment, and numerous other matters. But the event is more than a collection of services. Stand Down, founded by Vietnam veterans Jon Nachison and Robert Vankeuren and sponsored by Veterans Village of San Diego, concentrates on building community and developing the strengths of the participants as members of that community. The Stand Down slogan reads, "A Hand Up, Not a Handout."

At the conclusion of the first Stand Down in 1988, 116 of 500 homeless veterans (one in five) said their greatest need was to resolve outstanding criminal cases. The Homeless Court Program (HCP) evolved in response. It is a special session of the San Diego Superior Court held at Stand Down events for homeless veterans and in community rooms at local homeless service agencies to resolve criminal cases of participants already engaged in program rehabilitative activities. Initial referrals of participants to homeless court originate from homeless service agencies. The prosecution and defense review the cases before the court hearing. The court order for sentencing substitutes participation in agency programs for fines and custody. The HCP is designed for efficiency: the majority of cases are heard and resolved, and people are sentenced, in one hearing. The HCP combines a progressive plea bargain system, alternative sentencing structure, assurance of "no custody," and proof of program activities to address a full range of misdemeanor offenses and bring the individuals back into society.

In 1989, at the first HCP session on that warm Saturday in July, a lone man and his attorney stood before the judge. Together, they presented his cases and an advocacy packet of his accomplishments. The judge reviewed the packet. He asked a few questions of the participant. The judge resolved all his cases, reconciling his offenses with his accomplishments, ruling that the defendant had fulfilled all requirements of the court. At that moment, an audible gasp emanated from the assembled crowd filled with fellow participants, service providers, and the founders of Stand Down. Free to go, the veteran returned to the community.

The audible gasp was a collective recognition that the court had, not only the power to bring order to the streets, but also the power to affirm hard-fought accomplishments in treatment services that reclaim lives. After the first group of HCP participants returned to the larger encampment, a deluge of homeless veterans rushed the court to seek resolution of their cases. Before, they had feared the police arresting them and believed the hearing was staged for a sweep. Now, they approached the HCP voluntarily, seeking redemption from their past and their criminal cases.

Following this first homeless court, the San Diego court reported 130 defendants with 451 cases adjudicated through Stand Down. In the next 20 years, the HCP served an average of 196 veterans annually with 832 cases adjudicated each year. Those totals—3,920 veterans and 16,640 cases—speak to the power of the court to affect change, as well as to the deep-rooted desire and commitment of homeless veterans to fully participate in our communities.

Because of participants' increased demand, the HCP expanded beyond Stand Down. In 1990, it began to serve battered and homeless women; in 1994, it included residents at the city-sponsored cold-weather shelter; and by 1995, it encompassed the general homeless population served at local San Diego shelters. It went from a court that convened once a year at Stand Down to meeting quarterly, and since 1999, it has held monthly sessions. In addition to the session held at the annual Stand Down event for homeless veterans, the court alternates between two shelters (St. Vincent de Paul and Veterans Village of San Diego) in order to resolve outstanding misdemeanor criminal cases.

Currently, the HCP has been replicated across the United States at annual Stand

Down events, as well as monthly calendars in communities across the nation, including Ann Arbor and Detroit, Michigan; Albuquerque and Santa Fe, New Mexico; Houston, Texas; New Orleans, Louisiana; Phoenix and Tucson, Arizona; and one-third of the California courts.

Coordinating Homeless Court at Stand Down

Practically speaking, the HCP process at Stand Down is relatively straightforward. In the weeks leading up to the event, homeless service providers encourage homeless veterans to sign up for participation. The court clerks research and pull each participant's misdemeanor cases for review by the prosecution and ready the docket for resolution of these cases on site during the Stand Down event.

On the day before the actual court session at Stand Down, the prosecution and defense attorneys commence the disposition of cases at 8:30 a.m. When the participants arrive on the handball court to address their misdemeanor case or cases, the court clerks check them in, pull their cases, and deliver the court file to the defense. Due to budget constraints, participants are not able to sign up for court on site. However, defense attorneys counsel Stand Down participants to dispose of their case or cases and to sign an alternative sentencing agreement, directing them to the next day's HCP calendar. The court clerks generate court calendars to ensure a smooth court session the following day.

The defense attorneys review cases with participating veterans, formalize plea bargains, suggest or recommend terms and conditions of probation, and set matters for trial as appropriate. Problem cases (e.g., felonies, threat of custody, domestic violence) are counseled for a court date in the downtown courthouse. Those who may participate sign up for on-site programs designated for alternative sentencing, which facilitates compliance with the disposition of cases.

The participants who will have all of their cases dismissed and are not entering a plea to any charge or case move to the on-site "bail office" to receive a court minute order. On the day of the court session, the on-site proceedings are held from 9 a.m. until noon. The disposition of cases continues while court is in session. The court clerks prepare cases (negotiated pleas and further proceedings) for court and walk the participants into the handball court while the homeless court is in session. The court clerks set a future hearing/follow-up calendar in the courthouse for complicated cases and cases not heard during this Saturday session.

Why a Specialized Court for the Homeless?

To effect real change, we must meet people where they are. When you step outside the traditional judicial boundaries, you have more tools, greater access, and stronger responses from treatment providers, clients, and the community at large. When you reach out to the community, the community responds. There is great power in accentuating the positive.

The HCP is a positive antidote to the overall frustration and despair in our justice system and the sense that it is not working. For people who experience homelessness in particular, the sense is amplified that the system most certainly does not work for them and that it is not in place to help them improve their lives; rather, the sense is that it pushes them further outside of society. The HCP recognizes that homelessness is a deplorable condition and that it is the condition that is deplorable, not the person. A person participates voluntarily in reclaiming his or her life via job training, learning computer skills, or attending AA or NA meetings. He or she actively works to rejoin society. We may find it hard to change the world, but we can change one person's world in the course of HCP proceedings. Opening the door of justice and returning people to our communities promotes the individual and public safety.

HCP sessions have been held for 25 years. It is apparent that, when participants work with agency representatives to identify and overcome the causes of their homelessness, they are in a stronger position to successfully comply with court orders. The quality, not the quantity, of the participant's time spent in furtherance of the program is of paramount importance for the participant, the court, and society in general. Reliance on convictions and incarceration to solve social problems overlooks our collective

ability to overcome trauma through treatment, which is an HCP endeavor that ultimately enhances public safety by conducting review hearings and monitoring to ensure people respond to the challenges in their program activities.

The HCP challenges criminal justice practitioners, treatment providers, and participants to view their roles and behaviors in a different light. Stepping outside the adversarial system of the traditional court, these collaborative partners understand the value of working together as equal partners to address the underlying problems homelessness represents. The realities underlying any given criminal offense challenge us to grasp the complexities that led an individual to this act. The court order creates a nexus to an offense. The homeless service agency can reach beyond the offense, conduct assessments of the individual's social history, develop an action plan, and challenge each person to resolve the underlying problems that lead to interaction with the criminal justice system. And so, the initial criminal charge is actually a headline to a greater story.

Conclusion

While the ongoing problems homelessness represents are discouraging and frustrating, it is important to remember that it is the condition of homelessness that is undesirable, not the people who are homeless. Homeless participants who successfully complete the HCP are living examples that people can overcome hardship and challenges, address problems that led to homelessness, and reclaim their lives. The HCP strengthens community and brings law to the streets, the court to providers, and homeless people back into society. ◆

Distinctions between a Traditional Court and Homeless Court

In San Diego, the traditional court sentence for a public nuisance offense is a fine of $300. A defendant receives a $50 "credit" against a fine for every day spent in custody. The defendant who spends two days in custody receives credit for a $100 fine. To satisfy a fine of $300, the court requires that a defendant spend six days in custody. Thirty days in custody is the equivalent of a $1,500 fine. The court might convert this fine to six days of public service work or the equivalent time in custody.

The traditional punishment for a petty theft is one day in custody (for book and release), $400 in fines, victim restitution, and an eight-hour shoplifter course. A defendant convicted of being under the influence of a controlled substance for the first time faces a mandatory 90 days in custody or the option of completing a diversion program. The diversion program includes an enrollment orientation, 20 hours of education (two hours a week for 10 weeks), individual sessions (biweekly for three months, 15 minutes each), drug testing, weekly self-help meetings, and an exit conference.

By the time typical participants stand before an HCP judge, they have already been in a homeless service program for at least 30 days (from the initial point of registration to the hearing date). By this point, their level of activities in the program or a service agency exceeds the requirements of the traditional court order. While the program activities vary from one agency to another, they usually involve a greater time commitment than traditional court orders and greater introspection on the part of their participants. Program staff ensure that the homeless participants are already successful in their efforts to leave the streets before they enter the courtroom. These individuals are on the right track before they meet the judge at the HCP.

Karen Garcia, CARE Court will change how California addresses serious, untreated mental illness. Here's how, LA Times, Sept. 15, 2022

California has a new statewide approach to treatment for people struggling with serious mental illness: the CARE Court.

The program connects people in crisis with a court-ordered treatment plan for up to two years, while diverting them from possible incarceration, homelessness or restrictive court-ordered conservatorship.

Gov. Gavin Newsom signed the measure (Senate Bill 1338) into law Wednesday. Because it does not go into effect immediately, however, most California counties will not see the program's implementation until 2024.

The law takes a phased-in approach, with Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne and San Francisco counties implementing the program by October 2023. The remaining counties are required to start the program no later than December of the following year.

How will CARE Court work?

To initiate a treatment plan, a family member, behavioral health provider or first responder petitions a judge to order an evaluation of an adult with an untreated psychotic disorder (such as schizophrenia) who is in severe need of treatment and, in some cases, housing. A court may also start the program by referring a person from assisted outpatient treatment, conservatorship proceedings or misdemeanor proceedings to a CARE treatment plan.

The judge then orders a clinical evaluation and appoints legal counsel and a volunteer CARE supporter. The supporter would help a CARE recipient understand the options available in the program so the recipient can make decisions with as much autonomy as possible.

If the person meets the criteria, the judge then orders a series of hearings and the development of an individualized CARE plan that's appropriate culturally and linguistically.

The plan — developed by county behavioral health professionals, the individual and the volunteer supporter — can include behavioral health treatment, medication, substance abuse treatment, social services and housing specific to the individual's needs.

If needed the court may issue orders necessary to support the CARE recipient in accessing housing and services, including imposing sanctions on providers and local government agencies if they fail to provide court-ordered services or treatment.

Throughout this process, the court will hold status hearings as needed to check in with the recipient and review the progress made, the services provided, any issues the person might be experiencing with the program and recommendations for making the plan more successful.

People who graduate from the program will remain eligible for ongoing treatment, supportive services, and housing in the community to support long-term recovery.

Who is eligible for this program?

The CARE Court program is for individuals diagnosed with schizophrenia spectrum disorder or other psychotic ailments in that class, as defined by the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

A person struggling with these mental health challenges must also be 18 years old or older and not currently stabilized by treatment. In addition, the person must be deteriorating substantially and "unlikely to survive safely in the community without supervision," or at risk of a relapse or deterioration that would result in "grave disability or serious harm to the person or others."

This program may be an appropriate step for someone who has experienced a short-term involuntary hospital hold (either 72 hours or 14 days) or who can be safely diverted from certain criminal proceedings.

Is this program voluntary?

Although participation in CARE plans is voluntary, a court can draw up a plan for a qualified individual without that person's consent, and a judge can order housing and other services for that person. Some critics of the program, including the ACLU and Human Rights Watch, argue that it's coercive to force people into court proceedings as a way to provide treatment.

February 11, 2024 | Miami Herald, The (FL) | Brittany Wallman, Miami Herald

This could be the year Miami-Dade County makes history, opening a center for treating and helping — instead of incarcerating — people with mental illness. It is thought to be the first of its kind in the nation.

But delay upon delay upon delay — so much bureaucracy it's hard to blame any one thing — mean that the planned Miami Center for Mental Health and Recovery is slated to open some 20 years after it first was promised.

Many of those who will be helped are chronically **homeless**. Most have been diagnosed with schizophrenia, or bipolar disorder. Many abuse drugs or alcohol. All of them find themselves in and out of jail, at great cost to taxpayers, after being accused of committing non-violent crimes. They're largely invisible to society, except when they cause problems.

An alternative to jail, the center will be a place judges can send non-violent defendants accused of misdemeanors or low-level felonies instead of locking them up. Police could take potential arrestees there instead of booking them in to the jail.

Offering the gamut of services a person might need to turn their life around, the center represents a starkly more humane approach than the neglectful, abusive treatment federal authorities documented in Miami-Dade jails as recently as 2011.

If it opens this year, the center will be the crowning achievement of Judge Steven Leifman's career. The 65-year-old Miami-Dade associate administrative judge retires from the county bench next January. Leifman has worked since his earliest days as a judge to reverse what he saw as an illogical, inhumane approach to handling arrestees with mental illness.

Screen Shot 2024-02-08 at 4.12.40 PM (1).pngThe Herald's reporting from the early 2000s gave an apocalyptic view of life on the ninth floor of the county jail.

It's a predicament no jurisdiction has solved, and mistakes can be deadly. On any given day in America, jails are filled with suspects with mental illness. Because of their chronic condition, they may not be safely mixed with the general jail population.

And simply cycling them in and out of jail is a waste of public money — and of human lives, Leifman said.

"No one's getting better. They don't get better in jail," Leifman said. "You have a chance to break that horrible cycle. ... You have a chance to help people recover."

Decades of plodding

Some 20 years ago, Miami-Dade voters approved a $2.9 billion "Building Better Communities" bond program for, among many other things, the center that still hasn't opened. It's at 2200 NW Seventh Ave. in Miami, a renovation of the building formerly housing a state lockup for restoring mental competency to accused felons awaiting trial.

A county list of projects said the center would free up jail space and provide a more effective way to "house the mentally ill as they await a trial date."

While progress stalled on the center, the underlying practices championed by Judge Leifman have taken root since then: non-violent suspects with mental illness or substance use disorders can be diverted from jails and connected with support services in the community. A national expert in decriminalizing mental illness, Leifman travels the country sharing "the Miami model."

MIA_109MIAMIMENTAL00NEWPPPConsultant John W. Dow, far left, and Judge Steve Leifman, center, lead a tour of the not-yet-opened Miami Center for Mental Health and Recovery at 2200 NW Seventh Ave..

But the new, 208-bed center will offer everything under one roof. Clients will get help accessing benefits they qualify for, receive optical, dental, medical and psychiatric care, appear in the facility's courtroom when necessary, detox from substances, quit smoking, have unfortunate tattoos removed, work with dogs in an on-site kennel, learn culinary job skills and receive help getting permanently stabilized. All in a seven-story, renovated state building near west Wynwood that will serve an estimated 9,000 clients a year.

A 2020 documentary entitled The Definition of Insanity about Leifman and the mental health project, narrated by director/actor Rob Reiner, premiered at the Miami Film Festival and was aired nationally on PBS.

"It's a humane, science-based concept," said retired Circuit Judge Jeri Beth Cohen, president of the board for the Miami Foundation for Mental Health.

A shameful past

Though Miami-Dade is now seen as progressive in diverting some mentally arrestees with mental illness away from jail cells, the county's past is dark.

A 1984 headline in the Miami Herald blared "Study: Dade fails with insane criminals."

The story, by legendary cops beat writer Edna Buchanan, led with a mentally sick robber and killer who had "18 arrests, 918 days in jail, 112 court appearances, 20 psychiatric evaluations and 1,033 days of treatment in state hospitals."

He was, according to the report, "a perfect example of the failure of Dade County's justice system to deal with incompetent and insane criminals."

Screen Shot 2024-02-08 at 4.07.31 PM.pngA Miami Herald story from 1984 about the county's failure to treat inmates with mental illnesses.

A citizen-led investigation, by activist Renee Turolla, had exposed the failures in a 400-page report that was followed by heavy news coverage.

A Dade grand jury picked up on it, peering into what it described as "the trail of the mentally ill from the street, to the jail, to court, to state hospitals, back to court and then back onto the street, only to retrace these steps again."

The grand jury in 1985 concluded that with proper care, these arrestees "would have a real chance for success," and the costs would be lower than repeatedly jailing or hospitalizing them.

Among the recommendations was a residential treatment facility.

Twenty-three years later, in 2008, conditions in Miami-Dade County jails were still so dismal for people with mental illness, the federal Department of Justice launched a three-year investigation.

Jail guards routinely physically abused inmates, the report said. Suicidal inmates were treated with such disregard that they did indeed die in their cells. Detainees were "routinely subject to discipline" for behavior that was symptomatic of their illness.

"[Miami-Dade Corrections and Rehabilitation's] deliberate indifference to protecting the Jail's prisoners from harm is a systemic failure," the report said.

In 2013, the county agreed to a slew of corrective actions, under a federal DOJ consent decree, including a renewed promise to build the mental health facility.

Judge Leifman, who'd been pressing for the facility for years by then, was quoted: "It's time that we change

the way we've been dealing with this problem. This is an excellent step in the right direction."

Last fall, the DOJ announced that Miami-Dade's jail system is mostly in compliance with the consent decree, and can be removed from federal oversight next year if the reforms are maintained.

MIA_20240124AD2469STATEOFTH'We might not be saving money just yet, but we're saving lives,' Miami-Dade Mayor Daniella Levine Cava said.

Neighboring Broward County, whose jail system also has been subject to consent decree monitoring, is facing similar issues, struggling with how to properly care for inmates with mental illness. On Jan. 29, the president of the national NAACP asked for a federal investigation into a reported 21 deaths in Broward jails since 2021, many of them committing suicide.

'It's going to cost'

Initially, there will be no savings, Leifman and Miami-Dade County Mayor Daniella Levine Cava conceded.

To the contrary, there will be startup costs — amounts Leifman, Levine Cava and others said were still in discussion and can't be revealed.

"We might not be saving money just yet, but we're saving lives," the mayor said.

She said the Miami-Dade County Commission will vote in February or March on a budget to operate the center, and on contracts with Jackson Health System and the Advocate Program, which is now slated to operate the facility.

Plans for Thriving Mind South Florida to operate the center collapsed when Thriving Mind withdrew, citing the lack of plans or a budget, CEO Dr. John W. Newcomer said in a written response to the Miami Herald.

Thriving Mind did agree to complete the building's $51.1 million renovation — paid for by Miami-Dade County and Jackson Health System. A temporary certificate of occupancy was granted Dec. 22, Newcomer said. The building was turned over to the county on Jan. 26.

But when?

Whether the Miami Center for Mental Health and Recovery will open its doors in 2024 is an unsettled question.

A published report in July 2019 quoted Leifman predicting an opening in 18 months. A county report in July 2020 put the project completion at June 2023. In a grant application in 2021, the county said it would be "opening in early 2022." News coverage last year had it opening in six months.

Levine Cava now predicts an opening "within the year." Leifman said it would likely be November. CEO Isabel Perez-Moriña of the Advocate Program said it would likely open by year's end.

One thing is agreed upon, though.

Each client, upon admission to the center, will have his or her feet washed, said Leifman, who borrowed the idea from a program for the **homeless** in Boston.

The gesture, an act of humanity and, for the foot-washer, humility, will set the tone, Leifman said.

"We want people to know they're welcome here," Leifman said. "Many of them have learned helplessness. They've given up because the system is so bad. Half of them don't care if they breathe, anyway. That's why the feet washing is so important."

At the labyrinthine mid-rise a bit north of Jackson Memorial Hospital, Leifman led his umpteenth tour on a recent Monday, asking criminal justice and social work faculty from Florida Atlantic University how they might collaborate.

"You have to be persistent," he said to the group. "Everyone talks about change, but no one wants to do it. It's hard. It takes time. But trust me, this is well worth it."

Staff writer Douglas Hanks contributed to this report.

CalHHS
California Health & Human Services Agency

Community Assistance, Recovery, and Empowerment (CARE) Act

The CARE Act ensures mental health and substance use disorder services are provided to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

CARE IS A NEW APPROACH AND A PARADIGM SHIFT

CARE is an upstream diversion that prevents more restrictive conservatorships or incarceration for people with schizophrenia spectrum or other psychotic disorders, and is based on evidence which demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing supports, CARE works to help individuals who are experiencing a mental health crisis before they get arrested and committed to a State Hospital or placed in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship.

CARE PROCESS

The CARE process begins with a petition to the Court from family members, behavioral health providers, or other parties specified in the CARE Act that have a relationship to the individual with untreated schizophrenia spectrum or other psychotic disorders. The Court reviews this petition and appoints a legal counsel to the individual, as well as a voluntary supporter chosen by the individual, if desired, to help the participant understand, consider, and communicate decisions throughout the CARE process.

If the individual is determined by the Court to meet the CARE criteria (as specified in Section 5972) and refuses to voluntarily engage in services, the Court orders development of a CARE plan. The CARE plan is developed by the county behavioral health agency together with the participant and their legal counsel and voluntary supporter, and focuses on the specific needs of the individual by ensuring access to a coordinated set of clinically appropriate, community-based services and supports that are culturally and linguistically

(rev 10/17)

competent. CARE plans may include provision of short-term stabilization medication, wellness and recovery supports, and connection to social services such as housing that are often not provided to this vulnerable population. The Court reviews and adopts the CARE plan with both the participant and county behavioral health as party to the Court order for up to 12 months.

Once the CARE plan is adopted, the county behavioral health agency and other providers begin treatment to support the recovery and stability of the participant. Progress on these treatments is regularly monitored by the Court, and the CARE plan may be revised or extended by up to 12 months.

Once an individual completes the requirements of the CARE plan, they remain eligible for ongoing treatment, supportive services, and housing in the community to support a successful transition and long-term recovery. The individual may also elect to execute a Psychiatric Advance Directive at this time, allowing them to document their preferences for treatment in advance of potential future mental health crisis.

ACCOUNTABILITY IN CARE GOES BOTH WAYS

If a participant cannot successfully complete a CARE plan, the Court may utilize existing authority under the LPS Act to ensure the participants safety.

However, the CARE Act also holds local governments accountable for using the variety of robust funding streams available to counties today to provide care to the people who need it. These funding sources include nearly $10 billion annually for behavioral health care and over $14 billion in state funding that has been made available over the last two years to address homelessness. Participants must also be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program, which provides $1.5 billion in funding for transition housing and housing support services. If local governments do not meet their specified responsibilities under the Court-ordered CARE plans, the Court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

CARE REQUIRES COMMUNITY ENGAGEMENT AND INPUT

Successful implementation of the CARE Act requires deep engagement with the community to ensure that it is built with Californians and not for them. In the coming months, we will engage a broad set of stakeholders to help shape implementation and ensure that CARE delivers meaningful results for some of our most vulnerable neighbors.

> We call on organizations and individuals alike to engage with us as CARE is implemented. Make sure to sign up for our listserv to receive information and notifications by e-mailing **CAREAct@chhs.ca.gov**.

CalHHS
California Health & Human Services Agency

CARE FAQ

Community Assistance, Recovery, and Empowerment (CARE) Act

Updated based on the enacted law SB 1338

What is CARE?

The CARE Act will ensure mental health services are provided to the most severely impaired Californians who too often languish without the treatment they desperately need.

CARE goes upstream to divert and prevent more restrictive conservatorships or incarceration. It connects a person in crisis with a court-ordered CARE plan or agreement for up to 12 months, with the possibility to extend for an additional 12 months.

A new approach is needed to act earlier and to provide support and accountability for individuals with severe untreated mental illnesses as well as for local governments responsible for providing behavioral health services. Through California's civil courts earlier action, support, and accountability is provided through the CARE process.

CARE provides individuals with clinically appropriate community-based services and supports that are trauma-informed and culturally and linguistically competent, including stabilization medications, wellness and recovery supports, and connection to social services and housing.

Advances in treatment models such as new longer acting antipsychotic treatments, along with the right clinical team and housing plan, can successfully stabilize and support individuals in the community who have historically suffered tremendously on the streets or during avoidable incarceration.

What are the Criteria for Participation in CARE?

CARE is NOT for everyone experiencing homelessness or mental illness; CARE focuses on people with schizophrenia spectrum or other psychotic disorders who meet specific criteria described below. The CARE process is intended to be the least restrictive alternative to help these individuals before they are committed to a State Hospital or become so impaired that they end up in an involuntary Lanterman-Petris Short (LPS) Mental Health Conservatorship.

To be eligible, a person must meet the following criteria:

- Is 18 years of age or older.
- Is currently experiencing a severe mental illness, as defined in paragraph (2) of subdivision (b) of Section 5600.3, and has a diagnosis identified in the disorder class: schizophrenia spectrum and other psychotic disorders, as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders. This section does not

establish respondent eligibility based upon a psychotic disorder that is due to a medical condition or is not primarily psychiatric in nature, including, but not limited to, physical health conditions such as traumatic brain injury, autism, dementia, or neurologic conditions. A person who has a current diagnosis of substance use disorder as defined in paragraph (2) of subdivision (a) of Section 1374.72 of the Health and Safety Code, but who does not meet the required criteria in this section shall not qualify for the CARE process.

- Is not clinically stabilized in on-going voluntary treatment.
- At least one of the following is true:

  (1) The person is unlikely to survive safely in the community without supervision and the person's condition is substantially deteriorating.

  (2) The person is in need of services and supports in order to prevent a relapse or deterioration that would be likely to result in grave disability or serious harm to the person or others, as defined in Section 5150.

- Participation in a CARE plan or CARE agreement would be the least restrictive alternative necessary to ensure the person's recovery and stability.
- It is likely that the person will benefit from participation in a CARE plan or CARE agreement.

How do the CARE Proceedings Work?

Referral/ Petition Process

CARE proceedings begin with a petition filed by a family member, roommate, first responder, provider/clinician, public guardian, authorized representative of the county behavioral health services, adult protective services, Indian health services/ tribal courts, or the respondent. The petition is a presentation of facts supporting the petitioner's assertion that the individual meets the criteria described above.

The court may also refer respondents to CARE proceedings from assisted outpatient treatment, conservatorship proceedings, or misdemeanor proceedings pursuant to Section 1370.01 of the Penal Code.

CARE Proceedings

Once a petition is filed, the court promptly reviews the petition to determine if a respondent meets, or may meet, the criteria for CARE. If not, the matter is dismissed.

If the petition is not dismissed, the court orders the county to investigate and submit a written report within 14 days with a determination as to whether the respondent meets, or is likely to meet, CARE criteria. The written report must also include conclusions and recommendations regarding the respondent's ability to voluntarily engage in treatment and services. Counties may be granted an additional 30 days to submit this report if they are making progress to engage the respondent.

If the respondent voluntarily agrees to receive services, or if there is insufficient evidence that the respondent meets the CARE criteria, the case is dismissed. If the respondent is likely to meet the CARE criteria and does not engage in services voluntarily, the court will set an initial appearance on the petition within 14 days.

Before the initial appearance, the court appoints counsel for the respondent and orders the county to provide notice of the hearing to the petitioner, respondent, counsel, and county behavioral health.

The petitioner as well as a representative from the county behavioral health agency must be present at the initial appearance, but the respondent may waive personal appearance and appear through counsel.
A tribal representative may also be present if applicable.

If the petitioner is not the county behavioral health agency, the court will relieve the petitioner and appoint the county behavioral health agency as the substitute petitioner. A petitioner who is relieved can make a statement at the hearing on the merits of the petition. If the petitioner is a family member or roommate and the respondent consents, the court may assign ongoing rights of notice and allow for continued participation and engagement in the respondent's CARE proceedings.

A hearing on the merits of the petition is scheduled within 14 days of the initial appearance, at which time the court will determine if the respondent meets CARE criteria. If the court finds that the respondent meets the CARE criteria, the court will order the county behavioral health agency to work with the respondent, respondent's counsel, and the voluntary supporter to engage in behavioral health treatment and enter into a CARE agreement, which is a voluntary settlement agreement entered into by the parties.

Within 14 days, a case management hearing will determine if the parties have entered, or are likely to enter, into a CARE agreement. If so, the court will approve or modify the terms of the agreement and set a progress hearing for 60 days.

If not, the court will order the county behavioral health agency, through a licensed behavioral health professional, to conduct a clinical evaluation of the respondent, unless there is an existing clinical evaluation of the respondent completed within the last 30 days and the parties stipulate to the use of that evaluation.

During the clinical evaluation hearing, the county will present its findings from the clinical evaluation, and the respondent will have an opportunity to address the court in response to the evaluation. If the court finds that the respondent meets the CARE criteria, the court will order the county behavioral health agency, the respondent, and the respondent's counsel to jointly develop and submit to the court a CARE plan within 14 days.

During the CARE plan review hearing, the court reviews the proposed CARE plan and listens to all parties involved and will adopt the elements of the CARE plan that support the recovery and stability of the respondent. The court may issue any orders necessary to support the respondent in accessing appropriate services and supports, including prioritization for those services and supports, subject to applicable laws and available funding. The evaluation and all reports, documents, and filings submitted to the court shall be confidential.

Once the court approves the CARE plan, the CARE timeline begins for up to one year. The court will have status review hearings not less frequently than 60-day intervals throughout the implementation of the CARE plan. Status review hearings will provide the following information:

- Progress the respondent has made on the CARE plan.
- What services and supports in the CARE plan were provided, and what services and supports were not provided.
- Any issues the respondent expressed or exhibited in adhering to the CARE plan.
- Recommendations for changes to the services and supports to make the CARE plan more successful.

Graduation

The court will hold a one-year status hearing in the 11th month of the CARE

process to determine whether to graduate the respondent from CARE or reappoint the respondent to the program for one more year.

The respondent may elect to continue to in the program or to be graduated from the program. If they respondent elects to be graduated, the court orders the creation of a graduation plan and schedules a graduation hearing in the 12th month. Upon successful completion and graduation by the court, the participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery.

If a respondent elects to remain in CARE, the respondent may request any amount of time, up to and including one additional year. The court may permit the ongoing voluntary participation of the respondent if the court finds both of the following:

- The respondent did not successfully complete the CARE plan.
- The respondent would benefit from continuation of the CARE plan.

The court will issue an order permitting the respondent to continue in the CARE plan or deny the respondent's request to remain in the CARE plan, and state its reasons on the record.

A respondent may be involuntarily reappointed to CARE only if the court finds that the individual did not successfully complete the CARE process, all services and supports required through CARE process were provided, the respondent will benefit from continuation in CARE, and the respondent currently meets criteria. Reappointment to CARE can only be once and up to one additional year.

How is Self-Determination Supported in CARE?

Supporting a self-determined path to recovery and self-sufficiency is core to CARE. Each respondent is offered legal counsel and may choose a volunteer supporter in addition to their full clinical team. The role of the supporter is to help the respondent understand, consider, and communicate decisions to ensure the respondent is able to make self-directed choices to the greatest extent possible.

The Department of Health Care Services, in consultation with disability rights groups, county behavioral health and aging agencies, individuals with lived expertise, families, racial justice experts, and other appropriate stakeholders shall provide optional training and technical resources for volunteer supporters on the CARE process, community services and supports, supported decision-making, people with behavioral health conditions, trauma-informed care, and psychiatric advance directives.

The CARE plan ensures that supports and services are coordinated and focused on the individual needs of the respondent. A Psychiatric Advance Directive provides further direction on how to address potential future episodes of a mental health crisis that are as consistent as possible with the expressed interest of the respondent.

Why doesn't CARE include all Behavioral Health Conditions?

CARE is meant for people with a focused diagnosis that is both severely impairing and highly responsive to treatment, including stabilizing medications. Broader behavioral health redesign is being led by the Administration, so all Californians have easy access to high quality and culturally responsive behavioral health care. This includes expansion of behavioral health

capacity through treatment and workforce infrastructure improvements and reducing fragmentation in the behavioral health system.

What does a Respondent in CARE Receive?

CARE provides respondents with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services and housing. Respondents will also be provided with legal representation for court proceedings.

What Housing is Available to a Respondent in CARE?

Housing is an important component to CARE, since finding stability and staying connected to treatment is next to impossible while living outdoors, in a tent or a vehicle. Respondents served by CARE will need a diverse range of housing, including clinically enhanced interim or bridge housing, licensed adult and senior care facilities, supportive housing, or housing with family and friends. The court may issue orders necessary to support the respondent in accessing housing, including prioritization for these services and supports.

In the 2021 Budget Act, the state made a historic $12 billion investment to prevent and end homelessness, included funding for new community based residential settings and long-term stable housing for people with severe behavioral health conditions. Additionally, the 2022- 2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which will fund clinically enhanced bridge housing settings that are well suited to serving CARE respondents. CARE respondents will be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program.

What is meant by Court-ordered Stabilization Medications?

Stabilization medications may be included in the CARE plan. Court-ordered stabilization medications cannot be forcibly administered. Seeking an involuntary medication order for a respondent would be outside the proceedings and subject to existing law.

Stabilization medications would be prescribed by the treating licensed behavioral health care provider, and medication management supports will be offered by the care team. The treating behavioral health care provider will work with the respondent to address medication concerns and make changes to the treatment plan as necessary.

Stabilizing medications will primarily consist of antipsychotic medications, which are evidence-based treatments to reduce the symptoms of hallucinations, delusions, and disorganization that cause impaired insight and judgment in individuals living with schizophrenia spectrum and other psychotic disorders. Medications may be provided as long-acting injections which reduce the day-to-day adherence challenges many people experience with daily medications.

What if a Respondent does not Participate in the Court-ordered CARE plan?

A respondent who does not participate in the court-ordered CARE plan may be subject to additional court hearing(s). If a respondent cannot successfully complete a CARE plan, the respondent may be

terminated from the CARE proceedings. They will still be entitled to all services and supports for which they are eligible. The Court may utilize existing authority under the LPS Act to ensure the respondents safety. The court will notify the county behavioral health agency and the Office of the Public Conservator and Guardian if the court utilizes that authority.

If the respondent was provided all the services and supports in the CARE plan, the respondents failure to participate in the CARE process will be considered in any subsequent hearings under the LPS Act that occur within 6 months, and shall create a presumption at that hearing that the respondent needs additional intervention beyond the supports and services provided by the CARE plan.

What if a Local Government does not Provide the Court-ordered CARE plan?

If the court finds that the county or other local government entity is not complying with court orders, the court will report that finding to the presiding judge of the superior court. If the presiding judge finds that the local government entity has substantially failed to comply, the presiding judge may issue an order imposing a fine up to one thousand dollars ($1,000) per day, not to exceed $25,000 for each individual violation.

Fines collected will be deposited in the CARE Act Accountability Fund and will be used to support the efforts of the local government entity that paid the fines to serve individuals who have schizophrenia spectrum or other psychotic disorders and who are experiencing, or are at risk of, homelessness, criminal justice involvement, hospitalization, or conservatorship.

If the court finds that the local government entity is persistently noncompliant, the presiding judge may appoint a receiver to secure court-ordered care for the respondent at the local government entity's cost. The court will consider whether there are any mitigating circumstances impairing the ability of the local government entity to fully comply with court orders, and whether they are making a good faith effort to comply.

How is CARE funded?

County behavioral health agencies are responsible for Medi-Cal Specialty Mental Health Services, substance use disorder treatment, and community mental health services.

Most respondents in CARE will be Medi-Cal beneficiaries or eligible for Medi-Cal.

For a respondent who has commercial insurance, CARE requires that a health plan reimburse the county for eligible behavioral health care costs.

Existing funding sources for CARE-related services and supports include nearly $10 billion annually for behavioral health care, including the Mental Health Services Act and behavioral health realignment funds. Additionally, various housing and clinical residential placements are also available to cities and counties, including over $14 billion in state funding that has been made available over the last two years to address homelessness. CARE process participants will be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program which provides $1.5 billion in funding for housing and housing support services.

In addition, the state will provide funding for technical assistance, data and evaluation, legal representation for the respondent, and funding to support court and county administration.

How will CARE be Evaluated?

The Department of Health Care Services (DHCS) will produce an annual CARE Act report which will include information on the effectiveness of CARE in improving outcomes and reducing disparities, homelessness, criminal justice involvement, conservatorships, and other outcomes as specified by law. The annual report will include measures to examine the impact and monitor the performance of CARE implementation. Data in the report will be stratified by age, sex, race, ethnicity, languages spoken, disability, sexual orientation, gender identity, health coverage source, and county, to the extent statistically relevant data is available.

DHCS will also contract with an independent, research-based entity to conduct an evaluation of the effectiveness of CARE. The independent evaluation shall highlight racial, ethnic, and other demographic disparities, and include causal inference or descriptive analyses regarding the impact of CARE on disparity reduction efforts.

DHCS will provide a preliminary report to the Legislature three years after the implementation date of the CARE Act and a final report to the Legislature five years after the implementation date of the CARE Act.

How will the State support Implementation?

CalHHS will convene a working group to provide coordination and on-going engagement with, and support collaboration among, relevant state and local partners and other stakeholders during implementation of CARE. The working group shall meet no more than quarterly and end no later than December 2026.

Will CARE be Available Statewide and When?

Yes—all counties will participate in CARE through a phased-in approach. The first cohort of counties to implement the CARE Act include the counties of Glenn, Orange, Riverside, San Diego, Stanislaus, Tuolumne, and San Francisco. This cohort will be required to implement the CARE Act by October 1, 2023, with all remaining counties to begin implementation by October 1, 2024, unless the county is granted additional time by DHCS. Counties will not have an option to opt-out.

Plans will include housing. Individuals who are served by CARE will have diverse housing needs on a continuum ranging from clinically enhanced interim or bridge housing, licensed adult and senior care settings, supportive housing, to housing with family and friends.

Various housing and clinical residential placements are also available to cities and counties, including over $14 billion in state funding that has been made available over the last two years to address homelessness. CARE process participants will also be prioritized for any appropriate bridge housing funded by the Behavioral Health Bridge Housing program, which provides $1.5 billion in funding for housing and housing support services.

CalHHS
California Health & Human Services Agency

CARE Court FAQ

A New Framework for Community Assistance, Recovery, and Empowerment

1. What is CARE Court?

CARE Court is a proposed framework to deliver mental health and substance use disorder services to the most severely impaired Californians who too often languish – suffering in homelessness or incarceration – without the treatment they desperately need.

It connects a person in crisis with a court-ordered CARE Plan for up to 12 months, with the possibility to extend for an additional 12 months. The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes court-ordered stabilization medications, wellness and recovery supports, and connection to social services and housing.

2. How is self-determination supported in the CARE Court model?

Supporting a self-determined path to recovery and self-sufficiency is core to CARE Court, with a Public Defender and a newly established CARE Supporter for each participant in addition to their full clinical team.

The role of the CARE Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible. The CARE Plan ensures that supports and services are coordinated and focused on the individual needs of the person it is designed to serve.

The creation of a Psychiatric Advance Directive further provides direction on how to address potential future episodes of impairing illness that are consistent with the expressed interest of the participant and protect against negatives outcomes such as involuntary hospitalization.

3. What are the criteria for participation in CARE Court?

CARE Court is NOT for everyone experiencing homelessness or mental illness; rather it focuses on people with schizophrenia spectrum or other psychotic disorders who meet specific criteria – before they get arrested and committed to a State Hospital or become so impaired that they end up in a Lanterman-Petris-Short (LPS) Mental Health Conservatorship. Although homelessness has many faces in California, among the most tragic is the face of the sickest who suffer from treatable mental health conditions—this proposal aims connect these individuals to effective treatment and support, mapping a path to long-term recovery.

(rev 6/22)

4. What is the purpose of CARE Court?

CARE Court aims to deliver behavioral health services to the most severely ill and vulnerable individuals, while preserving self-determination and community living.

CARE Court is an upstream diversion to prevent more restrictive conservatorships or incarceration; this is based on evidence which demonstrates that many people can stabilize, begin healing, and exit homelessness in less restrictive, community-based care settings. With advances in treatment models, new longer acting antipsychotic treatments, and the right clinical team and housing plan, individuals who have historically suffered tremendously on the streets or during avoidable incarceration can be successfully stabilized and supported in the community.

CARE Court may be an appropriate next step after a short-term involuntary hospital hold (either 72 hours/5150 or 14 days/5250), an arrest, or for those who can be safely diverted from a criminal proceeding. Remote or virtual proceedings may be especially effective for CARE Court participants.

5. Is CARE Court a conservatorship?

No, it seeks to prevent the need for conservatorship by intervening prior to the need for such restrictive services and providing shorter-term court ordered, community-based care with Supportive Decision Making.

Current Lanterman-Petris-Short (LPS) Act Mental Health conservatorship is rarely timely, difficult to have granted, establishes a substitute decision maker for the person, and typically relies on locked placements as a first line intervention.

6. What does a participant in CARE Court receive?

The framework provides individuals with a clinically appropriate, community-based set of services and supports that are culturally and linguistically competent. This includes short-term stabilization medications, wellness and recovery supports, and connection to social services and housing. Housing is an important component—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle.

Each participant will also be provided a new, designated CARE Supporter to assist with Supported Decision Making for the CARE Plan, the creation of a Psychiatric Advance Directive, and a "graduation" plan for recovery and wellness post-CARE Court. The role of the CARE Supporter is to help the participant understand, consider, and communicate decisions, giving the participant the tools to make self-directed choices to the greatest extent possible. Participants will also have a designated court appointed attorney, for court proceedings.

7. How does CARE Court work?

Referral: The first step is a petition to the Court, by a family member, behavioral health provider, first responder, or other approved party to provide care and prevent institutionalization.

Clinical Evaluation: The civil court orders a clinical evaluation after a reasonable likelihood of meeting the criteria is found. Court appoints a public defender and CARE Supporter. The court reviews the clinical evaluation and, if the individual meets the criteria, the court orders the development of a CARE Plan.

CARE Plan: The CARE Plan is developed by county behavioral health, participant and CARE Supporter including behavioral health treatment, stabilization medication, and a housing plan. The court reviews and adopts the CARE Plan with both the individual and county behavioral health as party to the court order for up to 12 months.

Support: The county behavioral health care team, with the participant and CARE Supporter, begin treatment and regularly review and update the CARE Plan, as needed, as well as a Psychiatric Advance Directive for any future crises. The court provides accountability with status hearings, for up to a second 12 months, as needed.

Success: Upon successful completion and graduation by the Court, the participant remains eligible for ongoing treatment, supportive services, and housing in the community to support long term recovery. The Psychiatric Advance Directive remains in place for any future crises.

8. What is meant by court-ordered stabilization medications?

Stabilization medications may be included in the court ordered CARE Plan.

Court ordered stabilization medications are distinct from an involuntary medication order in that they cannot be forcibly administered. Seeking an involuntary medication order for a participant would be outside the proceedings and subject to existing law. Failure to participate in any component of the CARE Plan may result in additional actions, consistent with existing law, including possible referral for conservatorship with a new presumption that no suitable alternatives exist.

Stabilization medications would be prescribed by the treating licensed behavioral healthcare provider/prescriber and medication management supports will be offered by the care team. As a participant in the development and on-going maintenance of the CARE Plan, the participant will work with their behavioral healthcare provider and their CARE Supporter to address medication concerns and make changes to the treatment plan.

Stabilizing medications will primarily consist of antipsychotic medications, which are evidence-based treatments to reduce the symptoms of hallucinations, delusions, and disorganization—these are the symptoms that cause impaired insight and judgment in individuals living with Schizophrenia spectrum and other psychotic disorders. Medications may be provided as long-acting injections which reduce the day-to-day –adherence challenges many people experience with daily medications.

9. What if an individual does not participate in the Court-ordered CARE Plan?

An individual who does not participate in the court-ordered CARE Plan may be subject to additional court hearing(s). If a participant cannot successfully complete a CARE Plan, the individual may be referred by the Court for a conservatorship, consistent with current law. For individuals whose prior conservatorship proceedings were diverted, those proceedings will resume under a new presumption that no suitable alternatives to conservatorship are available.

10. Will CARE Court be available statewide?

Yes—all counties will participate in Care Court. There is not an option to opt-out.

11. What if a local government does not provide the court-ordered CARE Plan?

If local governments do not meet their specified responsibilities under the court-ordered CARE Plans, the Court will have the ability to order sanctions and, in extreme cases, appoint an agent to ensure services are provided.

12. How is CARE Court different from current approaches in California - namely Mental Health (or LPS) Conservatorship and the more recent Laura's Law (Assisted Outpatient Treatment)?

CARE Court applies only to a small and distinct group of adults with under or untreated Schizophrenia spectrum and other psychotic disorders who meet certain criteria.

CARE Court differs fundamentally from Mental Health/LPS Conservatorship. It does not include custodial settings or long-term involuntary medications. CARE Court provides a new CARE Supporter role, to empower the individual in directing their care as much as possible. Lastly, the court ordered CARE Plan is no longer than 12 or, if extended, 24 months.

CARE Court is different from both Mental Health/LPS Conservatorship and Laura's Law approaches in that it may be initiated on a petition to the Court by family members, service providers, and other authorized parties, in addition to County Behavioral Health. Local government is also part of the court order, along with the participant, to ensure accountability to the provision of treatment and care.

CARE Court is also separate from Probate Conservatorship where a court may appoint a conservator for people determined to be incapacitated to manage their financial or personal care decisions.

13. How is CARE Court funded?

Existing funding sources for the CARE Plan services and supports include nearly $10 billion annually for behavioral healthcare (including Mental Health Services Act, mental health realignment, federal funds) and the proposed $1.5 billion for behavioral health bridge housing, as well as various housing and clinical residential placements available to cities and counties under the Governor's $12 billion homelessness investments which began in 2021. County behavioral health is responsible for Medi-Cal Specialty Mental Health Services and Substance Use Disorder (SUD) treatment and community mental health services.

Costs for the Court, the Public Defender, the new CARE Supporter program, and state oversight will require new funding. The state will provide technical assistance to the Counties and will be responsible for data collection, evaluation, and reporting.

14. What housing is available to an individual in CARE Court?

Housing is an important component of CARE Court—finding stability and staying connected to treatment, even with the proper supports, is next to impossible while living outdoors, in a tent or a vehicle. CARE Plans will include housing. Individuals who are served by CARE Court will have diverse housing needs on a continuum ranging from clinically enhanced interim or bridge housing, licensed adult and senior care settings, supportive housing, to housing with family and friends.

In the 2021 Budget Act, the state made a historic $12 billion investment to prevent and end homelessness which included unprecedented new funding to create new community based residential settings and long-term stable housing for people with severe behavioral health conditions. Additionally, the Governor's proposed 2022-2023 budget includes $1.5 billion to support Behavioral Health Bridge Housing, which will fund clinically enhanced bridge housing settings that are well suited to serving CARE Court participants.

350 Fifth Avenue, 34th Floor
New York, NY 10118-3299
Tel: +1-212-290-4700
Fax: +1-212-736-1300; 917-591-3452

April 12, 2022

Assembly Member Mark Stone
Chair, Judiciary Committee
California State Assembly
1021 O Street, Suite 5740
Sacramento, CA 94249

HUMAN RIGHTS WATCH

HRW.org

Re: Human Rights Watch's Opposition to CARE Court (AB 2830)

Dear Assembly Member Stone:

Human Rights Watch has carefully reviewed AB 2830[1] and the proposed framework for the Community Assistance, Recovery and Empowerment (CARE) Court created by CalHHS,[2] and must respectfully voice our strong opposition. CARE Court promotes a system of involuntary, coerced treatment, enforced by an expanded judicial infrastructure, that will, in practice, simply remove unhoused people with perceived mental health conditions from the public eye without effectively addressing those mental health conditions and without meeting the urgent need for housing. We urge you to reject this bill and instead to take a more holistic, rights-respecting approach to address the lack of resources for autonomy-affirming treatment options and affordable housing.

CARE Court proponents claim it will increase up-stream diversion from the criminal legal and conservatorship systems by allowing a wide range of actors to refer people with schizophrenia and other psychotic disorders to the jurisdiction of the courts without an arrest or hospitalization. In fact, the bill creates a new pathway for government officials and family members to place people under state control and take away their autonomy and liberty.[3] It applies generally to those the bill describes as having a "schizophrenia spectrum or other psychotic disorder" and specifically targets unhoused people.[4] It seems aimed at facilitating removing unhoused people from public view without actually providing housing and services that will help to resolve homelessness. Given the racial

[1] California AB 2830, "Community Assistance, Recovery, and Empowerment (CARE) Court Program (Bloom)," 2022, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2830 (accessed April 12, 2022).
[2] California Health & Human Services Agency, "CARE Court: A New Framework for Community Assistance, Recovery & Empowerment," March 2022, https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Framework_web.pdf (accessed April 12, 2022).
[3] California AB 2830, "Community Assistance, Recovery, and Empowerment (CARE) Court Program (Bloom)," 2022, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB2830.
[4] Marisa Lagos, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts'," *KQED*, March 16, 2022, https://www.kqed.org/forum/2010101888316/gov-newsom-on-his-new-plan-to-tackle-mental-health-homelessness-with-care-courts (accessed April 12, 2022).

demographics of California's homeless population[5], and the historic over-diagnosing of Black and Latino people with schizophrenia,[6] this plan is likely to place many, disproportionately Black and brown, people under state control.

CARE Court is Coerced Treatment

Proponents of the plan describe CARE Court in misleading ways as "preserving self-determination" and "self-sufficiency," and "empower[ing]."[7] But CARE Court creates a state-imposed system of coerced, involuntary treatment. The proposed legislation authorizes judges to order a person to submit to treatment under a CARE plan.[8] That treatment may include an order to take a given medication, including long-acting injections, and a housing plan.[9] That housing plan could include a variety of interim housing or shelter options that may be unacceptable to an individual and unsuited to their unique needs.[10]

A person who fails to obey court orders for treatment, medication, and housing may be referred to conservatorship, which would potentially strip that person of their legal capacity and personal autonomy, subjecting them to forcible medical treatment and medication, loss of personal liberty, and removal of power to make decisions over the conduct of their own lives.[11] Indeed, the court may use failure to comply with their court-ordered treatment, "as a factual presumption that no suitable community alternatives are available to treat the individual," paving the way for detention and conservatorship.[12] In practical effect, the mandatory care plans are simply pathways to the even stricter system of control through conservatorship.

This approach not only robs individuals of dignity and autonomy but is also coercive and likely ineffective.[13] Studies of coercive mental health treatment have generally not shown

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[5] Los Angeles Homeless Services Authority, "Report and Recommendations of the Ad Hoc Committee on Black People Experiencing Homelessness," December 2018, https://www.lahsa.org/documents?id=2823-report-and-recommendations-of-the-ad-hoc-committee-on-black-people-experiencing-homelessness (accessed April 12, 2022).

[6] Charles M. Olbert, Arundati Nagendra, and Benjamin Buck, "Meta-analysis of Black vs. White racial disparity in schizophrenia diagnosis in the United States: Do structured assessments attenuate racial disparities?" *Journal of Abnormal Psychology* 127(1) (2018): 104-115, accessed April 12, 2022, doi: 10.1037/abn0000309; Robert C. Schwartz and David M. Blankenship, "Racial disparities in psychotic disorder diagnosis: A review of empirical literature," *World Journal of Psyciatry* 4 (2014): 133-140, accessed April 12, 20220, doi: 10.5498/wjp.v4.i4.133.

[7] "CARE (Community Assistance, Recovery and Empowerment) Court," California Health & Human Services Agency, March 14, 2022, Slides 5, 10 and 20, https://www.chhs.ca.gov/wp-content/uploads/2022/03/CARE-Court-Stakeholder-Slides-20220314.pdf (accessed April 12, 2022); Marisa Lagos, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts'," *KQED*, March 16, 2022, https://www.kqed.org/forum/2010101888316/gov-newsom-on-his-new-plan-to-tackle-mental-health-homelessness-with-care-courts (accessed April 12, 2022).

[8] AB 2830, Section 59–82 (a)-(b).

[9] AB 2830, Section, 5982.

[10] AB 2830, Section 5982(c); "CARE (Community Assistance, Recovery and Empowerment) Court." The DHHS presentation discusses a range of housing possibilities including "interim or bridge housing," which in common usage means temporary shelter.

[11] AB 2830, Section 5979(a); California Welfare and Institutions Code Section 5350—5372, https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=WIC&sectionNum=5357 (accessed April 12, 2022).

[12] AB 2830, Section 5979(a).

[13] Sashidharan, S. P., Mezzina, R., & Puras, D., "Reducing coercion in mental healthcare," *Epidemiology and psychiatric sciences*, 28(6) (2019): 605–612, accessed April 12, 2022, https://doi.org/10.1017/S2045796019000350 ("Available research does not suggest that coercive intervention in mental health care "are clinically effective, improve patient safety or result in better clinical or social outcomes.").

positive outcomes.[14] Evidence does not support the conclusion that involuntary outpatient treatment is more effective than intensive voluntary outpatient treatment and, indeed, shows that involuntary, coercive treatment is harmful.[15]

Coerced Treatment Violates Human Rights

Under international human rights law, all people have the right to "the highest attainable standard of physical and mental health."[16] Free and informed consent, including the right to refuse treatment, is a core element of that right to health.[17] Having a "substitute" decision-maker, including a judge, or even a "supporter," make orders for health care can deny a person with disabilities their right to legal capacity and infringe on their personal autonomy.[18]

The Convention on the Rights of Persons with Disabilities establishes the obligation to "holistically examine all areas of law to ensure that the right of persons with disabilities to legal capacity is not restricted on an unequal basis with others. Historically, persons with disabilities have been denied their right to legal capacity in many areas in a discriminatory manner under substitute decision-making regimes such as guardianship, conservatorship and mental health laws that permit forced treatment."[19] The US has signed but not yet ratified this treaty, which means it is obligated to refrain from establishing policies and legislation that will undermine the purpose and object of the treaty, like creating provisions that mandate long-term substitute decision-making schemes like conservatorship or court-ordered treatment plans.

The World Health Organization has developed a new model that harmonizes mental health services and practices with international human rights law and has criticized practices promoting involuntary mental health treatments as leading to violence and abuse, rather than recovery, which should be the core basis of mental health services.[20] Recovery means

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[14] Sashidharan, S. P., Mezzina, R., & Puras, D., "Reducing coercion in mental healthcare," *Epidemiology and psychiatric sciences*, *28*(6) (2019): 605–612, https://doi.org/10.1017/S2045796019000350 (accessed April 12, 2022); Richard M. Ryan, Martin F. Lynch, Maarten Vansteenkiste, Edward L. Deci, "Motivation and Autonomy in Counseling, Psychotherapy, and Behavior Change: A Look at Theory and Practice," *Invited Integrative Review* (2011), https://www.apa.org/education/ce/motivation-autonomy.pdf (accessed April 12, 2022); McLaughlin, P., Giacco, D., & Priebe, S., 2016, "Use of Coercive Measures during Involuntary Psychiatric Admission and Treatment Outcomes: Data from a Prospective Study across 10 European Countries," *PloS one*, *11*(12), https://doi.org/10.1371/journal.pone.0168720 ("All coercive measures are associated with patients staying longer in hospital, and seclusion significantly so, and this association is not fully explained by coerced patients being more unwell at admission.").

[15] Joseph P. Morrissey, Ph.D., *et al.*, "*Outpatient Commitment and Its Alternatives: Questions Yet to Be Answered*," Psychiatric Services (2014): 812 at 814 (2014); S.P. Sashidharan, Ph.D., *et al.*, "Reducing Coercion in Mental Healthcare," *Epidemiology and Psychiatric Sciences* 28 (2019): 605-612.

[16] International Covenant on Economic, Social and Cultural Rights, ("ICESCR"), adopted December 16, 1966, entered into force January 3, 1976, Art. 12(1), https://www.ohchr.org/en/professionalinterest/pages/cescr.aspx.

[17] Human Rights Council; United Nations, General Assembly, "Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," March 28, 2017, https://undocs.org/en/A/HRC/35/21, para. 63. See also Convention on the Rights of Persons with Disabilities, art. 12 read in conjunction with art. 25; Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, https://documents-dds-ny.un.org/doc/UNDOC/GEN/G14/031/20/PDF/G1403120.pdf?OpenElement, para. 31, 41.

[18] Convention on the Rights of Persons with Disabilities, art. 12; Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, para. 7.

[19] Committee on the Rights of Persons with Disabilities: General comment No. 1 (2014), May 19, 2014, para. 7.

[20] Freedom from coercion, violence, and abuse. WHO Quality Rights core training: mental health and social services, 2019, https://apps.who.int/iris/bitstream/handle/10665/329582/9789241516730-eng.pdf?sequence=5&isAllowed=y, p. 2, 8, 22.

different things for different people but one of its key elements is having control over one´s own mental health treatment, including the possibility of refusing treatment.

To comport with human rights, treatment should be based on the will and preferences of the person concerned, and not defined by some other entity's conception of their best interest. Housing or disability status does not rob a person of their right to legal capacity or their personal autonomy, including the right to refuse treatment. In very narrow, exceptional circumstances, where a person poses a serious and imminent risk to themselves or a third party and a qualified healthcare professional has determined they lack capacity to give informed consent to treatment, a brief, temporary period of mandatory treatment may be permissible if strictly clinically necessary for the purpose of returning the person to a place of autonomy in which they can make decisions about their own welfare—and for no longer than that. The process envisioned by the CARE Court plan is far more expansive; by definition, involuntary; and, as discussed below, runs the risk of being abused by self-interested actors. This coerced process leading to "treatment" undermines any healing aim of the proposal.

CARE Court Denies Due Process

The CARE Court proposal authorizes family members, first responders, including police officers or outreach workers, the public guardian, service providers, and the director of the county behavioral health agency, to initiate the process of imposing involuntary treatment by filing a petition with the court.[21] These expansive categories of people with the power to embroil another person in court processes and potential loss of autonomy, many of whom lack any expertise in recognition and treatment of mental health conditions, reveals the extreme danger of abuse inherent in this proposal. For example, interpersonal conflicts between family members could result in abusive parents, children, spouses, and siblings using the referral process to expose their relatives to court hearings and potential coerced treatment, housing, and medication.

Law enforcement and outreach workers would have a new tool to threaten unhoused people with referral to the court to pressure them to move from a given area. These state actors could place those who disobeyed their commands into the CARE Court process and under the control of courts. Given the long history of law enforcement using its authority to drive unhoused people from public spaces, a practice that re-traumatizes those people and does nothing to solve homelessness, it is dangerous to provide them with additional powers to do so.[22]

The legislation does not set meaningful standards to guide judicial discretion and does not delineate procedures for those decisions.[23] It establishes a contradictory and unworkable procedure by which a petition may be made on an allegation that a person "lacks medical decision making capacity"[24] On a mere showing of "prima facie" evidence that the petition is

[21] AB 2830, Section 5974.
[22] Chris Herring, "Complaint-Oriented Policing: Regulating Homelessness in Public Space," *American Sociological Review* 1-32, (2019), https://static1.squarespace.com/static/5b391e9cda02bc79baffebb9/t/5d73e7609b56e748f432e358/1567876975179/complaint-oriented+policing_ASR.pdf.
[23] AB 2830, Section, 5972-5978
[24] AB 2830, Section 5972.

true, the person is then required to enter into settlement discussions with the county behavioral health agency.[25] If someone lacks decision-making capacity, they would not be able to enter a settlement agreement voluntarily. Unless the parties stipulate otherwise, failure to enter a settlement agreement results in an evaluation by that same behavioral health agency, which is used to impose a mandatory, court-ordered course of treatment.[26] This process is entirely involuntary and coercive. The role of the behavioral health agency poses a great potential for conflicts of interest, as they will presumably be funded to carry out the Care Plans that result from their negotiations and their evaluations.

The CARE Court plan threatens to create a separate legal track for people perceived to have mental health conditions, without adequate process, negatively implicating basic rights.[27] Even with stronger judicial procedures and required clinical diagnoses by mental health professionals, this program would remain objectionable because it expands the ability of the state to coerce people into involuntary treatment beyond the limited and temporary circumstances provided for under human rights law.

CARE Court will harm Black, brown, and Unhoused people

The CARE Court directly targets unhoused people to be placed under court-ordered treatment, thus denying their rights and self-determination. Governor Newsom, in pitching this plan, called it a response to seeing homeless encampments throughout the state of California.[28] CARE Court will empower police and homeless outreach workers to refer people to the courts and allow judges to order them into treatment against their will, including medication plans. Despite allusions to "housing plans," CARE Court does not increase access to permanent supportive housing and indeed, the bill prohibits the court from requiring the county to provide actual housing.[29]

Due to a long history of racial discrimination in housing, employment, access to health care, policing and the criminal legal system, Black and brown people have much higher rates of homelessness than their overall share of the population.[30] The CARE Court plan in no way addresses the conditions that have led to these high rates of homelessness in Black and brown communities. Instead, it proposes a system of state control over individuals that will compound the harms of homelessness.

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[25] AB 2830, Section 5977.
[26] AB 2830, Section 5977.
[27] Committee on the Rights of Persons with Disabilities, "Guidelines on article 14 of the Convention on the Rights of Person with Disabilities: The right to liberty and security of persons with disabilities," (September 2015), para. 14 https://www.google.com/search?q=Guidelines+on+CRPD+article+14%2C+paragraph+21&rlz=1C1PRFI_enUS936US936&oq=Guidelines+on+CRPD+article+14%2C+paragraph+21&aqs=chrome..69i57j33i160.3045j0j7&sourceid=chrome&ie=UTF-8, para. 14.
[28] KQED, "Gov. Newsom on His Plan to Tackle Mental Health, Homelessness with 'CARE Courts.'"

[30] Kate Cimini, "Black people disproportionately homeless in California," *CalMatters*, February 27, 2021, https://calmatters.org/california-divide/2019/10/black-people-disproportionately-homeless-in-california/ ("about 6.5% of Californians identify as black or African American, but they account for nearly 40% of the state's homeless population"); Esmeralda Bermudez and Ruben Vives, "Surge in Latino homeless population 'a whole new phenomenon; for Los Angeles," *LA Times*, June 18, 2017, https://www.latimes.com/local/california/la-me-latino-homeless-20170618-story.html; Los Angeles Homeless Services Authority, "Report and Recommendations of the Ad Hoc Committee on Black People Experiencing Homelessness," December 2018, https://www.lahsa.org/documents?id=2823-report-and-recommendations-of-the-ad-hoc-committee-on-black-people-experiencing-homelessness.

Further, much research shows that mental health professionals diagnose Black and Latino populations at much higher rates than they do white people.[31] One meta-analysis of over 50 separate studies found that Black people are diagnosed with schizophrenia at a rate nearly 2.5 times greater than white people.[32] A 2014 review of empirical literature on the subject found that Black people were diagnosed with psychotic disorders three to four times more frequently than white people.[33] This review found large disparities for Latino people as well. CARE Court may place a disproportionate number of Black and Latino people under involuntary court control.

CARE Court Does Not Increase Access to Mental Health Care

The CARE plan would establish a new judicial infrastructure focused on identifying people with mental health conditions and placing them under state control for up to twenty-four months. While touted as an unprecedented investment in support and treatment for people with mental health conditions, in reality, the program provides no new funding for behavioral health care, instead re-directing money already in the budget for treatment to programs required by CARE Court.[34] According to the DHHS presentation on the proposal, the only new money allocated for the program will go to the courts themselves to administer this system of control.[35]

The court-ordered plans will include a "housing plan," but not a guarantee of, or funding for, permanent supportive housing.[36] The court may not order housing or require the county to provide housing.[37] The proposal seems to anticipate allowing shelter and interim housing to suffice if available, without recognizing the vast shortage of affordable housing, especially supportive housing, throughout most of California.[38] To the extent the proposal relies on state investment in housing already in existence, it will prioritize availability of that housing for people under this program, meaning others in need would have less access to that housing.

California Should Invest in Voluntary Treatment and Supportive Services

CARE Court shifts the blame for homelessness onto individuals and their vulnerabilities, rather than recognizing and addressing the root causes of homelessness such as poverty, affordable housing shortages, barriers to access to voluntary mental health care, and racial discrimination. CARE Courts are designed to force unhoused people with mental health conditions into coerced treatment that will not comprehensively and compassionately address their needs.

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[31] https://pubmed.ncbi.nlm.nih.gov/29094963/; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/
[32] https://pubmed.ncbi.nlm.nih.gov/29094963/
[33] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4274585/
[34] "CARE (Community Assistance, Recovery and Empowerment) Court," California Health & Human Services Agency.
[35] Ibid.
[36] Ibid.
[37] AB 2830, Section 5982(c).
[38] Ibid.; National Low Income Housing Coalition, "The Gap: A Shortage of Affordable Homes," March 2020, https://reports.nlihc.org/sites/default/files/gap/Gap-Report_2021.pdf, p. 2, 9; California Housing Partnership, "California Affordable Housing Needs Report," March 2020, https://1p08d91kdoc03rlxhmhtydpr-wpengine.netdna-ssl.com/wp-content/uploads/2020/03/CHPC_HousingNeedsReportCA_2020_Final-.pdf.

Californians lack adequate access to supportive mental health care and treatment.[39] However, this program does not increase that access. Instead, it depends on money already earmarked for behavioral health initiatives and layers harmful court involvement onto an already inadequate system. Similarly, the "Care plans" mandated by the CARE Courts do not address the shortage of housing.

Investing in involuntary treatment ties up resources that could otherwise be invested in voluntary treatment and the services necessary to make that treatment effective.[40] California should provide well-resourced holistic community-based voluntary options and remove barriers to evidence-based treatment to support people with mental health conditions who might be facing other forms of social exclusion. Such options should be coupled with investment in other social supports and especially housing, not tied to court-supervision.

Rather than co-opting the language used by movements supporting housing and disability rights and cynically parading the trauma of family members let down by the state mental health system, as proponents of CARE Courts have done, we instead ask that you reject the CARE Court proposal entirely and direct resources towards making voluntary treatment and other necessary services accessible to all who need it.

Sincerely,

Olivia Ensign
Senior Advocate, US Program
Human Rights Watch

John Raphling
Senior Researcher, US Program
Human Rights Watch

[39] Liz Hamel, Lunna Lopes, Bryan Wu, Mollyann Brodie, Lisa Aliferis, Kristof Stremikis and Eric Antebi, "Low-Income Californians and Health Care," *KFF*, June 7, 2019, https://www.kff.org/report-section/low-income-californians-and-health-care-findings/#:~:text=About%20half%20of%20Californians%20with%20low%20incomes%20%2852,not%20able%20to%20get%20needed%20services%20%28Figure%208%29. ("A majority of low-income Californians (56 percent) say their community does not have enough mental health care providers to serve the needs of local residents.")

[40] Physicians for Human Rights, *Neither Justice nor Treatment: Drug Courts in the United States*, June 2017, phr_drugcourts_report_singlepages.pdf, p. 3.

Emma G. Fitzsimmons and Andy Newman, New York's Plan to Address Crisis of Mentally Ill Faces High Hurdles, N.Y. Times, Nov. 30, 2022

Many New Yorkers agree that the city must do more to help people with severe mental illness who can be seen wandering the streets and subways.

But on Wednesday, a day after Mayor Eric Adams announced an aggressive plan to involuntarily hospitalize people deemed too ill to care for themselves, experts in mental illness, homelessness and policing expressed skepticism that the plan could effectively solve a crisis that has confounded city leaders for decades.

Mr. Adams said he was instructing police officers and other city workers to take people to hospitals who were a danger to themselves, even if they posed no risk of harm to others, putting the city at the center of a national debate over how to care for people with severe mental illness.

Mental health experts and elected officials applauded the mayor's attention to the issue, but also raised questions about how his plan would be implemented, how many people might be affected and whether police officers should be involved.

Steven Banks, the former social services commissioner under Mr. Adams's predecessor, Bill de Blasio, suggested that the solutions to the current crisis lay beyond Mr. Adams's plan.

"Homelessness is driven by the gap between rents and income and the lack of affordable housing, and mental health challenges for both housed and unhoused people are driven by the lack of enough community-based mental health services," he said in a statement.

He added that the city, state and federal governments all "need to do more to address these interrelated crises in order for New Yorkers to see a difference on the streets, on public transportation, and in the shelter census."

The mayor's plan comes at the end of a year in which random attacks in the subways and streets, many of them attributed to homeless people with mental illness, have put many New Yorkers on edge. Mr. Adams and Gov. Kathy Hochul have both rolled out numerous programs to address the issue, including adding outreach teams and clearing encampments, to try to convince people to move to shelters.

Mr. Adams has said that people with mental illness were largely responsible for an increase in crime in the subway, though most crimes overall are not committed by people who are unhoused or mentally ill, and most mentally ill or homeless people are not violent.

Jody Rudin, a former deputy city commissioner of homeless services who is now C.E.O. of the Institute for Community Living, which runs housing and mental-health programs under contract with the city, applauded the mayor for "leaning into and talking about this issue."

"There seems to be an appreciation for the need for trauma-informed and community-based services, not just lip service, and to some extent he's putting his money where his mouth is," she said.

But Ms. Rudin said that most of the people in greatest need of help are already well known to clinicians who do street outreach. And she said that she was concerned that those people would be consulted by neither police officers, emergency services workers, nor hospital personnel who the mayor said would staff a new hotline, in deciding whether to bring someone to a hospital against their will.

"If it's done in a coordinated way, it could be really helpful to people's ability to live healthy and fulfilling lives," she said. "If it's done in a messy and uncoordinated way, we have real concerns."

William J. Bratton, the former New York City police commissioner, said that Mr. Adams was trying to do the right thing, but that his plan would be very difficult to carry out.

“There’s no place to put a lot of these poor souls,” he said. “It’s a well-intended measure and long overdue to try to deal in a more humane way with this seemingly intractable problem.”

Mr. Adams has acknowledged that New York did not have enough psychiatric beds to accommodate everyone, and said the city would start training police officers about responding with compassion.

After a decades-long deinstitutionalization push that closed thousands of psychiatric hospital beds, and the loss of more beds during the pandemic, the city finds itself with a chronic bed shortage. Hospitals are under constant pressure to make room for new psychiatric emergency patients.

Even if enough hospital capacity can be created to admit many more people, it is unclear what will happen when the hospital discharges someone.

Some people would be discharged to specialized shelters for people with mental illness. Some of those shelters have difficulty keeping their residents out of trouble.

Experts say the best place to put someone with severe mental illness after they leave a hospital is usually in supportive housing, which comes with on-site social services, and has the best track record for keeping people stable over the long haul. But though the city and state are accelerating plans to create more supportive housing, it is in such short supply that four of five qualified applicants are turned away.

Simply finding providers of outpatient psychiatric care, essential to breaking the cycle of hospitalization and jail that so many people with mental illness wind up in, is difficult.

“Outpatient clinics are booked for months out, if they even are taking referrals,” said Bridgette Callaghan, who runs teams of field clinicians that treat the most severely mentally ill people in streets and shelters for the Institute for Community Living under a city program called Intensive Mobile Treatment.

Mr. Bratton, who served as police commissioner under Mayor Rudolph W. Giuliani and Mr. de Blasio, said the plan was risky for Mr. Adams and that leaders across the nation would be watching New York’s approach. It will take months to properly train police officers about how to conduct psychological evaluations and how to handle people who resist being transported to hospitals, he noted.

“The cops are going to see this as another burden being placed on them,” he said.

New Yorkers should not expect to see dramatic changes overnight. The city started training doctors who work with patients about the new guidance on Tuesday. It will begin training police officers and Emergency Medical Services staff in the coming weeks, city officials said.

Mr. Adams acknowledged on Tuesday that the city would need many more psychiatric beds at hospitals for his plan to be successful, and he said that he would work with state lawmakers in Albany to add beds. Ms. Hochul, who has said she supports the mayor’s efforts, recently announced that the state was setting up two new units at psychiatric centers, including 50 inpatient beds.

Alanna Shea, 38, has dealt with homelessness, addiction and mental illness, and said she is currently a “drop in” at a shelter. She said she was alarmed by the new policy because of her own experiences in hospitals.

“It scares me,” she said, speaking near a subway entrance on 125th Street in Harlem. “I want to be safe here but I also want to be safe if I’m in a facility.”

Mental health advocates have said the plan infringes on people's rights. They argue that police officers should not be responsible for deciding who should be transported to hospitals.

"Instead of using the least restrictive approach, we are defaulting to an extreme that takes away basic human rights," said Matt Kudish, chief executive of the National Alliance on Mental Illness of New York City.

Jumaane Williams, the city's public advocate, and some other Democratic elected officials have raised concerns about police officers evaluating people on the streets and the lack of details on what care people will receive once they are removed.

"That's a major red flag right there," Mr. Williams said.

Mr. Williams said that while he was glad that Mr. Adams was committed to helping people with severe mental illness, he worried that Black men would be disproportionately affected by the new policy and that people would be turned away from overburdened hospitals. He said that the city should focus on funding less intrusive programs like homeless drop-in centers, where people can get a hot meal and a shower, and mental health urgent care centers.

"You have to put the funding into the programs that are needed so you don't have to do this," he said.

Ron Kim, a left-leaning state assemblyman from Queens, said he was supportive of the plan because he believes that Mr. Adams wants to rebuild government to help the public.

"He's saying the buck stops here — he's saying we're going to activate city workers to intervene," Mr. Kim said.

Mr. Kim said he was moved by a recent dinner with the father of Michelle Go, who was killed in January when she was shoved in front of a subway train by a homeless and mentally ill man.

"I was shocked to hear that from the pain he's been going through, he wasn't focused on punishing the attacker," Mr. Kim said. "He was really furious about how we didn't see the signs, and we failed to intervene."

Elizabeth Kim, New NYC policy to address mental illness will force more people to hospitals. Here's what to know, Gothamist, Nov. 30, 2022

Mayor Eric Adams is dramatically ramping up his strategy to address New York City's homelessness and mental health crisis by directing police and emergency medical responders to force individuals deemed unable to meet "basic human needs" into hospitals.

Adams, a moderate Democrat who has prioritized public safety, described the plan as the "next phase" of an approach to homelessness that has included increased policing on the subways and the removal of homeless encampments.

An estimated 3,400 New Yorkers live on the streets and subways according to an annual city survey, but experts say the figure is a severe undercount. Although that number is down slightly from the pre-pandemic era, a string of high-profile deadly crimes committed by homeless people with reported histories of mental illness has rattled many New Yorkers.

But the city's new plan is already facing a legal challenge and likely some logistical hurdles. Homeless and civil liberty advocates as well as some city lawmakers have already voiced their opposition to the policy.

Here's what New Yorkers need to know about the new directive and the obstacles that lie ahead.

How is this policy different from the previous way the city handled mentally ill New Yorkers?

The mayor's new directive essentially expands the definition of who qualifies for involuntary removal from public places for the sake of potential hospitalization. New York state's Mental Hygiene Law outlines that a person can be taken to a hospital or psychiatric facility for an evaluation "if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others."

But City Hall officials are relying on a state health department memorandum issued in February that interprets the law as allowing "for the removal of a person who appears to be mentally ill and also displays an inability to meet basic living needs, even when no recent dangerous act has been observed."

The memorandum also states that these guidelines are "intended to help clinicians and other community providers make thoughtful, clinically appropriate determinations relating to involuntary and emergency assessments."

Speaking to reporters on Tuesday, Adams described behaviors that he said New Yorkers have become accustomed to seeing but warrant greater city intervention.

"You're watching people standing there on the street talking to themselves, don't have shoes on, shadowboxing, unkempt — and we are walking by them," he said. "We are pretending as though we don't see them."

The mayor said he is refusing to "punt" the issue.

Who will be assessing whether an individual meets the criteria for involuntary hospitalization?

According to state law, a police officer, peace officer, physician or mental health professional can each make the assessment of whether to order someone to be involuntarily brought to a hospital.

On Tuesday, the mayor said that police and first responders have been reluctant to use their authority under the law "because there has not been any real clarity."

Deputy Mayor for Health and Human Services Anne Williams-Isom on Tuesday told reporters that

the decisions would be made on a “case-by-case” basis, but she outlined some of the process.

“You ask them questions, you ask them where have they been. You ask them do they have a place to go?” she said.

She added that an evaluation could take into account their physical well-being and whether they are “not based in reality.”

If police or first responders are unsure, she said they would be able to call on specialized teams that include mental health professionals. However, she could not immediately say how many city workers are currently dedicated to this helpline.

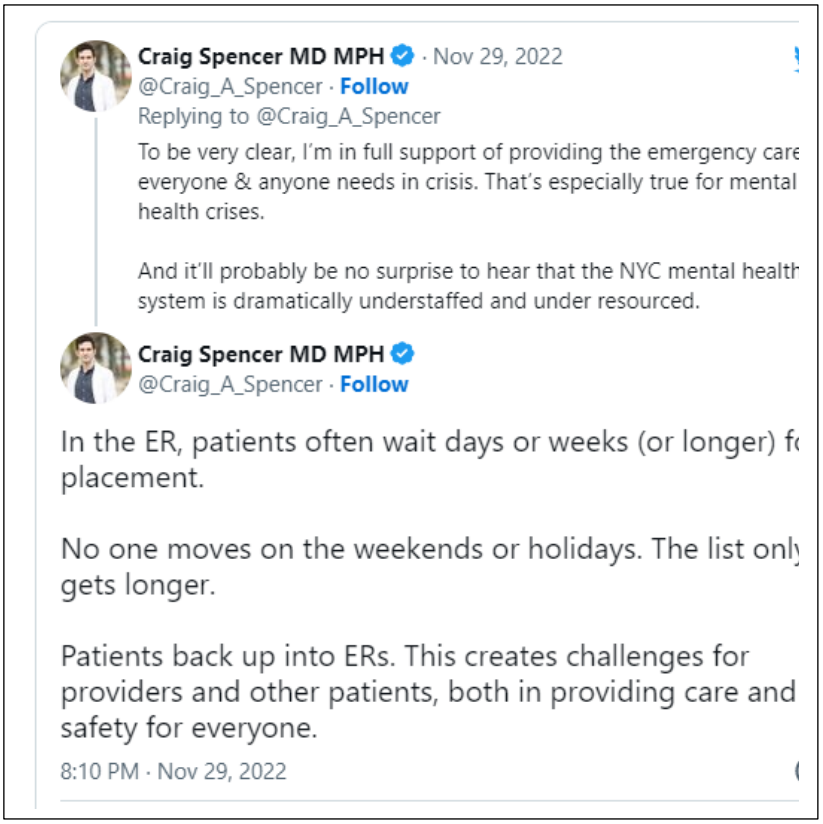
Once an individual is brought to a hospital, a medical doctor will determine whether they meet the criteria allowing them to be involuntarily committed, according to Brendan McGuire, the mayor’s chief legal counsel.

Does the city have enough beds and programs to treat the mentally ill?

No. Emergency room doctors have frequently complained about a shortage of so-called “psych beds.”

Following the mayor’s announcement on Tuesday, Dr. Craig Spencer, the former director of global health in emergency medicine at New York-Presbyterian/Columbia University Medical Center, was among those in the medical community who expressed their concerns. Spencer now works for the Brown University School of Public Health.

In a tweet, he described the city’s mental health system as “dramatically understaffed and under-resourced,” with patients often waiting days or weeks for placement in the emergency room.



Other mental health facilities and programs have also been strained, according to Public Advocate Jumaane Williams, who recently issued an update to a 2019 report on the city's response to the crisis. The public advocate also found that since 2019 the number of respite care centers — mental health facilities that offer an alternative to hospitalization — fell by half. Meanwhile, the number of mobile crisis units — teams made up of social workers, nurses and psychiatrists — dropped from 24 to 19.

How have lawmakers and advocates responded to the plan?

Reception has been mixed. On Wednesday, City Council Speaker Adrienne Adams issued a statement saying that she and her colleagues had "many questions" about the new policy and how it will be carried out.

"The vague and broad definitions surrounding mental illness, and the delegated authority to non-mental health professionals for involuntary removal and admission raise serious concerns," she said. "The way this new policy will be implemented and the agencies and individuals being tasked with this response need to be more carefully considered, and the Council will continue playing a strong oversight role." She cautioned against "unduly relying on involuntary commitment and short-term responses that can be counterproductive."

Tiffany Cabán, a left-leaning Queens councilmember and a former public defender, similarly criticized the use of involuntary hospitalization." Consent is key," she tweeted.

But at least two other Queens councilmembers have publicly expressed support for the mayor's directive.

The mayor has received key support from Gov. Kathy Hochul as well as a handful of state lawmakers. He will need the state Legislature's backing for an 11-point series of reforms in state law that seek to provide clearer guidance on when involuntary hospitalizations can be ordered.

Hazel Crampton-Hays, a spokesperson for Hochul, issued a statement praising the mayor's plan as one that "builds on our ongoing efforts together" around mental illness, including outreach teams in the subways and increasing bed capacity at psychiatric hospitals.

Among homeless advocates, Jacqueline Simone, policy director for Coalition for the Homeless, accused the mayor of having "continually scapegoated homeless people and others with mental illness as violent."

Simone argued that instead of leaning on involuntary hospitalizations the mayor should instead focus his efforts on "expanding access to voluntary inpatient and outpatient psychiatric care."

But the Legal Aid Society, which also represents the homeless, praised the mayor for taking a "step in the right" direction by addressing the city's mental health crisis.

At the same time, Tina Luongo, Legal Aid's chief attorney, told WNYC that "involuntary confinement, whether it's in a hospital or a jail or prison, is not the answer that we need."

The group is urging Adams to to support legislation that would allow New Yorkers who are charged with crimes and also have substance use disorders or mental health conditions to be placed in treatment programs as opposed to jail.

The stiffest criticism has come from civil liberty defenders.

Donna Lieberman, the executive director of the New York Civil Liberties Union, also decried the plan as "playing fast and loose with the legal rights of New Yorkers."

She also cautioned about legal challenges that the new policy will prompt. "The federal and state constitutions impose strict limits on the government's ability to detain people experiencing mental illness – limits that the mayor's proposed expansion is likely to violate," she said.

Similarly, Norman Siegel, a noted civil rights attorney and longtime adviser to the mayor, also said the plan was misguided and that the city was skating on thin legal ground.

Is there a legal challenge yet?

Yes, on Dec. 8, a coalition of civil rights groups and advocates for people experiencing mental illness filed a lawsuit — lumping it into an existing class-action lawsuit against the NYPD — claiming the policy "discriminates against individuals by treating them differently simply because of their actual or perceived mental disability."

Attorneys for the plaintiffs are asking a Manhattan federal judge for a temporary restraining order against the policy. They, along with attorneys representing the city, were in court on Dec. 12. It's unclear when a judge is expected to grant or deny a temporary restraining order.

Is this the first time the city has ever enacted such a policy?

No. In 1987, then-Mayor Ed Koch introduced a program that placed severely mentally ill people found on Manhattan streets into a psychiatric ward at Bellevue Hospital. But the policy was undermined by court battles, overcrowding and bureaucratic problems. It gave way to a landmark lawsuit involving a woman named Joyce Brown who was confined for 12 weeks. A state judge ruled that she should be freed because the city failed to prove she was mentally ill or unable to care for herself. But the decision was reversed by a state appeals court. Ultimately, psychiatrists decided to release her after Brown successfully convinced the court that she should not be forced

to take medication.

Brown later became famous, speaking at Harvard University and being interviewed on “60 Minutes.” She eventually moved into a long-term residence for people with mental illness.

She died at age 58 on Nov. 29, 2005.

Greg B. Smith, Judge Delays Ruling on Adams' Mental Health 'Involuntary Removal' Plan, The City, Dec. 12, 2022

A federal judge Monday reserved judgment on a request to halt Mayor Eric Adams' plan to expand the use of involuntary commitment for people having mental health crises.

Manhattan Federal Judge Paul Crotty postponed deciding on a request by lawyers and advocates for the mentally ill for a temporary restraining order that would have put the brakes on the mayor's "Involuntary Removal Directive," which went into effect Nov. 29.

But the judge had also questioned whether anybody has been directly affected by the new initiative — and thus whether the request to stop enforcement was premature.

City Hall lawyer Alan Scheiner stated flatly that the answer was no, asserting that there is "not a single example of someone taken into custody because of this initiative."

The judge referenced a plaintiff in the case, Steven Greene, a 26-year-old diagnosed with post-traumatic stress disorder (PTSD) and attention deficit disorder (ADD) who says he's been involuntarily detained three times by police responding to mental health calls in the last few years — all before the new expansion.

"What about Mr. Greene's statement that he's afraid to go out on the street?" Crotty asked.

Greene's most recent detention in 2020 happened before Adams even ran for office, but in an affidavit filed in the request to halt the plan, Greene asserted the new initiative has left him in fear.

"As a result of the mayor's announcement, I am afraid to leave my apartment," he stated. "I am now constantly fearful that my mental disability will cause an NYPD officer to forcibly and violently detain me and hospitalize me against my will."

"My PTSD has been exacerbated by this announcement," he added.

New vs. Old

During an hour-long court hearing, plaintiff attorneys from New York Lawyers for the Public Interest insisted that the mayor's announcement was clearly a new initiative, while the city attorney described it as merely an effort to educate police about a tool they already had.

Prior to Adams' announcement last month, city policy had been to involuntarily detain a person experiencing a mental health crisis only if they were deemed to be an immediate risk to themselves or others. Typically that meant evidence or an observation that they had actually threatened to harm others or themselves.

Adams' said that he was expanding that to say anyone who appeared to be mentally ill and unable to take care of their own basic needs would be eligible — "even when no recent dangerous act has been observed."

The new protocol listed three examples that could initiate involuntary removal: "serious untreated physical injuries, unawareness or delusional misapprehension of surroundings, or unawareness or misapprehension of physical condition or health."

Advocates for those with mental disabilities, including Community Access, National Alliance on Mental Illness of New York, and Correct Crisis Intervention Today, argue that this language is so broad it could result in people being forcibly detained against their will merely for mumbling to themselves or appearing to be homeless on a cold night.

"Police officers are now going to be policing mental health," said a lawyer for the groups, Luna Droubi of the firm Beldock Levine and Hoffman. "This is policing someone for being homeless. This is policing someone for being mentally ill."

The city's lawyer, Scheiner, questioned the

motivation of the groups in moving to halt the new effort, arguing that the mayor's intent was to provide more help — not less — to those with mental disabilities who are unable to provide for themselves.

"What the plaintiffs appear to want, and I find this a bit perverse, is for mentally ill people to starve to death, bleed to death in the street, walk into traffic," he said.

'Triggering' Tactics

The request for the temporary stay was filed as part of an ongoing lawsuit filed last year on behalf of Greene and others who've been detained against their will by police in the last few years for psychiatric reasons.

That includes the case of Peggy Herrera, highlighted Monday by THE CITY. Herrera called 911 seeking help when her 21-year-old son, Justin Baerga, was having a mental health crisis, specifically asking them to send EMTs — not police. Several cops showed up anyway and Herrera wound up handcuffed and arrested while Baerga was beaten, handcuffed and brought to a nearby hospital psychiatric ward.

In requesting a temporary stay on Adams' new directive, lawyers suing the city in the ongoing case warned about "police officers with little to no expertise in dealing with individuals with mental disabilities who will be required to determine whether an individual should be forcefully — often violently — detained against their will."

In Greene's case, regular police officers, Emergency Service Unit (ESU) cops and EMTs showed up at his Bronx apartment in May 2020. Unbeknownst to Greene, the cops were responding to a 911 call that came in as "EDP [emotionally disturbed person] with a gun," according to the lawsuit.

When Greene answered the door and stepped into the hallway, an ESU cop asked him if he was suicidal, and another cop told him his social worker had called 911 to ask police to check on him. An EMT at the scene then said he'd need to go to the hospital because of the call from the social worker, whom he did not identify.

Greene denied being suicidal and refused to go to the hospital. When he turned and re-entered his apartment, the cops followed and eventually handcuffed him.

On the street, he was forcibly strapped to a gurney and placed in an ambulance. On the way to North Central Bronx Hospital, he told the EMTs that "they should not barge into the apartment of someone who has PTSD because it is triggering," the lawsuit states.

Greene was released from the hospital a few hours after he arrived, and his lawyers say this was not a new experience for him. He had been detained against his will on two prior occasions, according to the suit.

The judge did not say when he would make a decision in the case.

Memorandum

To: NYS Public Mental Health Providers

From: Ann Marie T. Sullivan, MD, Commissioner, NYSOMH
Thomas Smith, MD, Chief Medical Officer, NYSOMH

Date: February 18, 2022

RE: Interpretative Guidance for the Involuntary and Custodial Transportation of Individuals for Emergency Assessments and for Emergency and Involuntary Inpatient Psychiatric Admissions

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This guidance is intended to help clinicians, and other community providers, make thoughtful, clinically appropriate determinations relating to involuntary and emergency assessments, while respecting an individual's due process and civil rights.

Summary

There is often a misconception amongst both police as well as front-line mental health crisis intervention workers that a person with mental illness must present as "imminently dangerous" in order to be removed from the community to a hospital or CPEP setting for evaluation, admission and treatment, meaning that they need to present an immediate overt risk of violence to others or an immediate overt risk of physical harm to themselves in order for removal to be implemented. This is not the case.

The Mental Hygiene Law provides authority for peace officers and law enforcement officers to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is likely to result in serious harm to self or others, which includes ***persons who appear to be mentally ill and who display an inability to meet basic living needs, even when there is no recent dangerous act***.

Likewise, Directors of Community Services, as well as physicians or qualified mental health professional who are members of an approved mobile crisis outreach team, have the power to remove or to direct the removal of any person to a hospital for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others, which includes ***persons with a mental illness who displays an inability to meet basic living needs, even when there is no recent dangerous act***.

Limiting the application of the Mental Hygiene Law's (MHL) removal and admission provisions to only those who present as "imminently dangerous" leaves vulnerable persons at risk in the community without an opportunity for assessment, care and treatment, and can also impact the public safety. The New York State Office of Mental Health (OMH) therefore wishes to clarify both removal and involuntary psychiatric admission criteria for individuals who are suspected of

having a mental illness who may not be considered imminently dangerous. Article 9 of the Mental Hygiene Law provides the statutory framework for these provisions, and relevant statutes are summarized within this guidance. For additional clarification, OMH has provided caselaw summaries to provide examples of the practical application of these statutes. [1]

Background

Homelessness in New York City has reached the highest levels since the Great Depression; in October 2021, there were over 48,000 homeless individuals in NYC homeless shelters.[2] One third of homeless individuals suffer from a serious mental illness; the numbers are even higher for homeless single adults.[3] Chronically homeless individuals with serious mental illness often have symptoms and cognitive difficulties that further contribute to difficulties accessing treatment and housing resources, placing them at higher risk for poor outcomes including harm to themselves or others.

Involuntary and emergency admissions are governed by New York State laws, regulations issued by OMH, and judicial decisions issued by courts in NYS that interpret those laws and regulations.

- The primary body of laws that govern Involuntary and Emergency Admissions is Article 9 of the Mental Hygiene Law.
- OMH's regulations are set forth in Title 14 of New York Codes, Rules and Regulations.
- There have been a number of important judicial decisions that help define criteria for admission; citations to some of these decisions are included below.

I. *Serious Harm to Self or Others*

Under the authority of MHL §§9.37, 9.41 & 9.45, and current case law, police and peace officers have the ability, and with respect to §§9.37 & 9.45 the duty, to take into custody for the purpose of a psychiatric evaluation those individuals who appear to be mentally ill and are conducting themselves in a manner which is likely to result in serious harm to self or others. MHL §9.59 confers statutory immunity from liability to police officers, peace officers, and EMTs, for non-motor vehicle related injuries and death allegedly incurred in the course of such removal, absent gross negligence.

In *Matter of Scopes*, the Appellate Division's Third Department ruled that in order to satisfy substantive due process requirements, "the continued confinement of an individual must be based upon a finding that the person to be committed poses a real and present threat of substantial harm to himself or others," but that such a finding does not require proof of a recent overtly dangerous act.[4]

[1] This guidance is intended to provide a synopsis of relevant caselaw and statutory authority and is not meant to constitute legal advice. This guidance memorandum should therefore not be construed as OMH providing legal advice or be relied on as legal authority. All providers should consult their own legal counsel as appropriate.
[2] Coalition for the Homeless. Basic Facts About Homelessness. January 2022. Accessed January 21, 2022 https://www.coalitionforthehomeless.org/basic-facts-about-homelessness-new-york-city/
[3] Shan LA and Sandler M. (2019). Addressing the Homelessness Crisis in New York City: Increasing Accessibility for Persons with Severe and Persistent Mental Illness. Columbia Social Work Review, 14(1), 50–58. https://doi.org/10.7916/cswr.v14i1.1856
[4] *Matter of Scopes v. Shah,* 59 A.D.2d 203, 398 N.Y.S.2d 911 (N.Y. App. Div. 1977).

The Appellate Division's First Department, in *Boggs v. Health Hospitals Corp.*, held that a person's inability to meet their basic living needs was sufficient to establish dangerousness to self, thereby meeting the involuntary admission standard that the person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. In that case, Ms. Brown, aka Billy Boggs, was homeless and was allegedly living on a sidewalk grate in winter, running into traffic, making verbal threats to passersby, tearing up and urinating on money that passersby gave her, and covering herself in her own excrement. On January 15, 1988, a state supreme court justice ruled that Bellevue Hospital could not forcibly medicate Ms. Brown and ordered her released from hospitalization, in part because although she was mentally ill, her behavior was not deemed by the court to be obviously and immediately dangerous to anyone. The case was appealed, and the appellate court ruled that Ms. Boggs' behavior met the standard for involuntary admission as she was unable to meet her needs for food, clothing, and shelter, which was deemed sufficient to establish dangerousness to oneself.[5]

Further cases followed and applied the same standard as found in *Boggs* and it is now well settled law[6] that an inability to meet one's need for food, clothing or shelter is sufficient to establish dangerousness to self for purposes of removal from the community for assessment and involuntary admission.

II. *Mechanisms for Removal from the Community*

MHL §§9.37, 9.41, 9.45 and 9.58, combined with the established *Boggs* standard in case law, provide the authority to remove and hospitalize people who appear to have mental illness and present a danger to themselves due to substantial self-neglect, with evidence of a recent overt dangerous act not being necessary.

MHL Section 9.37

Subsection (d) of MHL §9.37 provides that upon the written request of a director of community service or their designee, it shall be the duty of peace officers, when acting pursuant to their special duties, or police officers who are members of the state police or an authorized police department or sheriff's department, to take into custody and transport any such person (for whom there is an application for involuntary admission pursuant to this section) as requested and directed by such director or designee. Ambulance services are also authorized to transport such individuals.

MHL Section 9.41

Any law enforcement officer may take into custody for an evaluation any person who appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others. Likelihood of serious harm includes: attempts/threats of suicide or self-injury; threats of physical harm to others; or other conduct demonstrating that the person is dangerous to him or herself, including a person's refusal or inability to meet his or her essential need for food, shelter, clothing or health care, provided that such refusal or inability is likely to result in serious harm if there is no immediate hospitalization.

[5] *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).
[6] *In re Application of Consilvio v. Diane W.,* 269 A.D.2d 310, 703 N.Y.S.2d 144 (N.Y. App. Div. 2000), *In re Carl C.*, 126 A.D.2d 640, 511 N.Y.S.2d 144 (N.Y. App. Div. 1987).

MHL Section 9.45

A director of community services or their designee has the power to direct the removal of any person for an evaluation if any authorized individual reports that such a person has a mental illness for which immediate care and treatment in a hospital is appropriate and which is likely to result in serious harm to himself or herself or others. Authorized reporters include the following: licensed physician, licensed psychologist, registered nurse, or licensed social worker providing treatment, police/peace officer, spouse, child, parent, adult sibling, legal guardian, and supportive or intensive case manager. Peace officers, when acting pursuant to their special duties, or police officers must assist in taking into custody and transporting any such person.

MHL Section 9.58

A physician or qualified mental health professional who is a member of an approved mobile crisis outreach team shall have the power to remove or to direct the removal of any person to a hospital approved by the Commissioner for the purpose of evaluation for admission if such person appears to be mentally ill and is conducting himself or herself in a manner which is likely to result in serious harm to the person or others.

III. *Involuntary and Emergency Admissions*

Admission Standards:

- ***A person with a mental illness who displays an inability to meet basic living needs meets the involuntary admission standard for dangerousness to self.*** The individual is conducting himself or herself in a manner which is likely to result in serious harm to the individual or others.

- ***A person with a mental illness can meet criteria for involuntary admission even when there is no recent dangerous act.*** Courts have found that evaluating psychiatrists may consider an individual's entire history when determining if an individual needs involuntary admission.

The following provisions of the MHL are applicable to involuntary and emergency admissions and are subject to the *Boggs* and *Scopes* standards previously discussed.

Involuntary Admissions on Medical Certification ("2PC")

MHL §9.27 sets the standard for involuntary admissions by medical certification (also called a "9.27" or a "2PC") which may be utilized in psychiatric hospital settings, psychiatric emergency rooms and comprehensive psychiatric emergency programs at the point of admission. Under this statute, individuals can potentially be held for up to 60 days, although the patient, a friend or relative, or the Mental Hygiene Legal Service may request a court hearing to contest the involuntary retention at any time during such period.

As per statute, to be involuntarily hospitalized, an individual must have:

- "a mental illness[7] for which care and treatment as a patient in a hospital is essential to such

[7] The term "Mental Illness" is defined in MHL§ 1.03 as "an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking, or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation."

person's welfare and whose judgment is so impaired that he is unable to understand the need for such care and treatment." (MHL §9.01 and §9.27)

Court decisions have further clarified these requirements. For instance, the Appellate Division's Second Department held in the *Matter of Harry M* that involuntary admissions must be based on a finding that the individual is dangerous, but also that dangerousness is not solely determined based upon whether an individual is expressing suicidal or homicidal ideation.[8] The Court was clear that involuntary admissions were permissible for individuals "whose mental condition manifests itself in a neglect or refusal to care for themselves which presents a real threat of substantial harm to their well-being." ***Patients can meet criteria for involuntary admission even when there is no recent dangerous act.*** Courts have found that evaluating psychiatrists may consider an individual's whole history when determining if an individual needs involuntary admission.[9,10]

The following are examples of individuals who would meet criteria for involuntary admission on medical certification[11]:

- Patient A, who has a history of bipolar disorder and four prior psychiatric admissions, was brought to a medical emergency department (ED) where she was found to be acutely agitated by the consulting psychiatrist. She removed all her clothes, required several rounds of emergent intramuscular medications, and four-point restraints for agitated behavior. The consulting psychiatrist documented that Patient A had paranoia, poor impulse control, was unable to care for her basic needs, and was therefore a potential danger to herself.[12]

- Patient B is a 43-year-old woman with schizoaffective disorder. When unmedicated, she walks onto busy roads and preaches to the passing cars. She has had numerous prior admissions where the religious preoccupations improve, but she always discontinues treatment upon discharge and resumes this activity, which places her in serious danger of being hit by a car. Patient B consistently denies suicidal ideation. Patient B also refuses to engage in planning on how to obtain food and shelter and is insistent on being discharged to a shelter.[13]

- Patient C is a 40-year-old woman who is street homeless and has lived outside a restaurant in Manhattan for the last year. A homeless outreach team has observed her steadily deteriorate and become increasingly disheveled, malodorous, and malnourished. The outreach social worker observed Patient C urinate and defecate on the street, tear up money given to her by people walking by, and become increasingly verbally aggressive, including shouting racial slurs and other obscenities at pedestrians and delivery workers. The mobile crisis team staff are worried she will be assaulted because of her behavior.[5]

- Patient D is a 23-year-old with a prior diagnosis of anorexia nervosa. She was admitted with a weight of 52 lbs (normal for her height would be 100 lbs). Patient D continued to restrict caloric intake and intermittently became hyponatremic from polydipsia in an effort to show weight increase without eating. Patient D showed extreme difficulty gaining insight into the

[8] *Matter of Harry M*, 96 A.D.2d 201, 468 N.Y.S.2d 359 (N.Y. App. Div. 1983).
[9] *Boggs v. Health Hosps. Corp.*, 132 A.D.2d 340, 523 N.Y.S.2d 71 (N.Y. App. Div. 1987).
[10] *Matter of Seltzer v. Hogue*, 187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993).
[11] While these examples are derived from the cited published caselaw, some of the facts may have been altered in this guidance for narrative purposes.
[12] *Rueda v. Charmaine D.*, 17 N.Y.3d 522, 958 NE 2d 106, 934 N.Y.S.2d 72 (2011).
[13] *Matter of Yvette S.*, 163 Misc.2d 902, 622 N.Y.S.2d 879 (Sup. Ct, Queens Cnty. 1995).

dangerousness of her behavior and remained resistant to psychotherapeutic or pharmacologic treatment, even though she gained weight and was placed on fluid restriction in the structured unit milieu. Her treating psychiatrist was concerned that without a controlled environment that could impose fluid restrictions and further treatment, Patient D could experience cerebral edema and die.[14]

- Patient E is a 48-year-old man with bipolar disorder and several prior psychiatric admissions who was brought to the ED for treatment of severe hand injuries that required amputation of his left hand and three fingers on his right hand. Five days prior, he had allowed a large firecracker to explode in his hands and did not seek treatment until a family member found him and called 911. The need to amputate resulted from the patient's delay in seeking medical treatment. Two days after the surgery, he eloped from the hospital and was later brought back by police. He was transferred to the hospital's psychiatric unit where he remained irritable, labile, easily agitated, pressured, intrusive, and had disorganized speech. No suicidal ideation or intent was present. [15]

- Patient F is a veteran with a history of traumatic brain injury, schizophrenia, and substance use disorder (cocaine, heroin, PCP, cannabinoids, alcohol, and LSD) who was brought to a CPEP by the police with threatening behavior. Patient F has a 30-year history of extensive prior involuntary admissions and incarcerations for threatening and destructive behavior and shows no insight into having any mental illness or substance use disorders. He previously improved on treatment with lithium and chlorpromazine, but today is not on any medications. He also has a history of immediately discontinuing treatment and relapsing on substances upon discharge from psychiatric hospitals. While currently Patient F denies any suicidal and homicidal ideation, he has a history of masturbating in public, crouching between parked cars and jumping into traffic, siphoning gasoline from cars and using it to light newspapers on fire under other cars, and a history of assaulting and injuring an older woman. He has a prior admission for when Patient F threw a 150lb bench through a neighbor's windshield, bending the frame and breaking the steering system of the car.[16]

Emergency Admission for Immediate Observation, Care, and Treatment

MHL §9.39 sets the standard for emergency psychiatric hospitalization (also called a "9.39" or a "1PC"). Individuals alleged to have a mental illness can be held for up to 14 days under this statute for observation, care and treatment. An emergency admission under MHL §9.39 requires that the individual alleged to have a mental illness has engaged in a recent overt dangerous act or behavior and the individual must present either:

- A "substantial risk of physical harm to himself as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that he is dangerous to himself," OR

- A "substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm." (MHL §9.39)

[14] *Matter of Paulina D.*, 104 A.D.3d 883, 961 N.Y.S2d 320 (N.Y. App. Div. 2013).
[15] *New York City Health & Hosps. Corp. v. Brian H.*, 51 A.D.3d 412, 857 N.Y.S.2d 530 (N.Y. App. Div. 2008).
[16] *Seltzer v. Hogue*,187 A.D.2d 230, 594 N.Y.S.2d 781 (N.Y. App. Div. 1993)

However, a substantial inability to provide for one's basic needs because of a mental illness can be considered conduct demonstrating that a person is dangerous to themselves.

Examples of individuals who may meet criteria for an emergency psychiatric admission include:

- Patient W is a 19-year-old brought to the ED by police after yelling and shaking their fists at several customers in a supermarket. Patient W also pushed over a shopping cart, damaged products, and tried to break a display case.

- Patient X is an 87-year-old who was brought to the ED by his son after the son found a suicide note. Patient X recently gave away his money to charity and bought a gun.

- Patient Y is a 40-year-old with schizophrenia who has disengaged from care. Patient Y was brought to the ED by EMS with hypothermia because he was grossly disorganized and unable to locate shelter despite the freezing cold weather.

- Patient Z is 38-year-old with schizoaffective disorder. She is convinced N, an acquaintance, is a spy from the devil and Patient Z plans to "exorcise N from the earth." Patient Z has purchased a gun and has been carrying it in the event she runs into N.

Emergency Admission to a Comprehensive Psychiatric Emergency Program

MHL §9.40 provides for emergency admission to a comprehensive psychiatric emergency program (CPEP). Emergency admission to a CPEP uses the same standard as a MHL §9.39 emergency admission but differs in that individuals may only be held for observation, care and treatment for up to a maximum of 72 hours under this statute and upon the expiration of such time the individual must be discharged or else converted to MHL §§9.27 or 9.39.

The following is a hypothetical based upon caselaw of an individual who would meet criteria for an emergency admission:

- An individual was brought to a CPEP by EMS after a series of provoked verbal and physical altercations with another tenant in their housing development. The individual was interviewed by a medical student and subsequently by a doctor with the medical student present. Based upon the second interview, the doctor determined that the individual had demonstrated poor judgment and that this judgment combined with grandiosity could be a sign of ***hypomania***, which the doctor believed was a potentially dangerous condition if untreated that interfered with the ability to engage in the community in a safe way. The attending psychiatrist then interviewed the individual and reviewed the medical chart and collateral sources. The attending psychiatrist concluded that the individual exhibited poor judgment and potentially aggressive and violent verbal and physical behavior and as such, should be held for further observation under MHL § 9.40. Upon further interviews and observations, the individual was converted to a MHL § 9.39 status. The court found that the doctors' diagnoses, actions, and subsequent determinations under ***MHL §§ 9.40*** and ***9.39*** did not fall substantially below accepted medical standards.[17]

[17] *Kraft v. City of NY*, 696 F.Supp.2d 403 (2010).

Resources

Office of Mental Health; Mental Hygiene Law – Admissions Process
OMH Form 471 – Application for Involuntary Admission on Medical Certification
OMH Form 471a – Certificate of Examining Physician
OMH Form 471b – Request by Examining Physician to Transport A Mentally Ill Person
OMH Form 474 – Emergency Admission

This guidance is intended to provide information about NYS statutes related to involuntary inpatient mental health treatment. Clinicians should feel comfortable contacting their local NYS OMH Field Office to discuss specific cases and circumstances in which questions arise regarding involuntary care.