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PENNY WISE BUT POUND FOOLISH

How Permanent Supportive Housing Can Prevent A World of Hurt

SEATTLE U
SCHOOL OF LAW

HOMELESS RIGHTS
ADVOCACY PROJECT

Penny Wise But Pound Foolish:

How Permanent Supportive Housing Can Prevent a World of Hurt

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EXECUTIVE SUMMARY

People experiencing chronic homelessness are trapped in a cycle of homelessness and trauma. Traditional approaches to homelessness attempt to address people's trauma first and use housing as a reward for complying with treatment; such approaches fail because people cannot improve physically or psychologically while they are actively experiencing the trauma of homelessness. Our current responses to chronic homelessness do not work, but cities often justify the status quo as the only fiscally responsible option. Instead, these approaches are among the most expensive and least effective.

Permanent Supportive Housing (PSH) flips the traditional order in which homelessness and trauma are addressed by providing non-time limited, low barrier housing, and offering—but not mandating—supportive services. Once housed, people formerly experiencing chronic homelessness can then improve their physical and mental health, address substance use, and seek education or employment. Research shows that PSH results in better housing stability than housing interventions that require sobriety or treatment compliance. Further, PSH is associated with better outcomes related to quality of life, emergency services, physical and psychiatric hospitalizations, and substance use.

Better outcomes for residents also save money, making PSH the most cost-effective, long-term solution to chronic homelessness. When people experiencing chronic homelessness receive PSH, they are less likely to use emergency departments, hospitals, detoxification facilities, and shelters. PSH residents are also less likely to interact with law enforcement, get arrested, and be incarcerated.

The decreased use of these expensive services is dramatic and results in savings. Often, cost savings equal or exceed the cost of PSH. PSH is a front-loaded investment that can replace ineffective traditional programming, show significant and persistent results, and save cities, states, and the federal government money over time. Key findings on PSH's cost effectiveness include:

- PSH residents stay housed: PSH residents show housing retention rates of up to 96 percent.[1]
- PSH increases residents' use of services: outpatient service use tends to increase with PSH, suggesting residents avail themselves of services and treatment at higher rates than if they are not housed.[2]
- PSH lowers public costs: It
    - decreases emergency room visits by up to 81 percent.[3]
    - lowers hospital admissions by up to 61 percent.[4]
    - shortens hospital stays by up to 80 percent.[5]
    - may decrease substance use; no evidence shows an increase.[6]

[1] *See infra* Section II.B.
[2] *Id*.
[3] *See infra* Section II.C.1.
[4] *Id*.
[5] *Id*.
[6] *Id*.

    - significantly increases engagement in substance use treatment and decreases use of detox services, saving nearly $9,000 per person over two years on that basis alone.[7]
    - reduces time spent incarcerated by up to 84.8 percent,[8] amounting to savings up to $1,800 per person per year, not accounting for substantial savings from avoiding police interaction, arrest, adjudication, or post-release probation or parole.[9]
    - better addresses the needs of an aging homeless population: one San Francisco study found providing PSH to just 51 elderly residents saved the public $500,000 per year.[10]
- PSH *always* results in gross savings when provided to people experiencing chronic homelessness.[11]
- PSH frequently results in net savings after factoring in the cost of housing and services.[12]
- When targeted to those who use the most services, PSH can generate gross savings of over $46,000 per person per year compared to leaving people on the streets.[13]

Although PSH is proven to be most cost-effective solution to chronic homelessness, existing studies radically underestimate the benefits. Most studies focus on just one or a few typical cost drivers associated with chronic homelessness, such as emergency services. No study accounts for the millions of dollars cities spend on sweeping encampments; the substantial costs for the entire criminal justice system process (from arrest through probation); the extraordinary demand for police and outreach services that do not result in issuing citations or criminal charges; the drag on each entity within the emergency response system (fire departments, EMTs, police, emergency rooms); the overtaxing of volunteers, members of the faith community, and community service providers; the clear economic impacts on local businesses, tourism, and travel; and the significant psychological and emotional tolls exacted from unsheltered people as well as the surrounding community. **Thus, even the already impressive evaluations of PSH's cost-effectiveness are vast underestimations of its impact**.

PSH is the most humane and cost-effective solution to chronic homelessness. Indeed, it is the most studied intervention in all of homelessness policy. Federal, state, and local governments must stop being pennywise but pound foolish, and instead take bold steps to bring PSH to scale to finally stem the crisis.

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[7] *Id*.
[8] *See infra* Section II.C.2.
[9] *Id*.
[10] *See infra* Section III.D.
[10] *See infra* Section III.A.
[11] Gross savings capture the costs saved by providing people PSH versus leaving them on the street. *See infra* Section III.A.
[12] Net savings refers to gross savings after the cost of PSH is subtracted. *Id*.
[13] *See infra* Section III.C.

INTRODUCTION

Homelessness is a growing crisis in cities along the West Coast.[14] Efforts to solve homelessness must target the most visible, vulnerable, and costly group: those experiencing chronic homelessness. Further, approaches must be cost-effective. PSH meets all these criteria.

PSH is a non-time-limited, low-barrier housing intervention that provides optional services to clients. It is also the most cost-effective solution to chronic homelessness. The Corporation for Supportive Housing, National Alliance to End Homelessness, and United States Interagency Council on Homelessness all acknowledge PSH as the solution to chronic homelessness.[15] PSH results in greater housing stability, which is central to preventing negative outcomes for chronically homeless individuals. PSH also benefits the entire community. Societally, PSH decreases costs in the medical and criminal justice systems, and it reduces visible blight; often, investments in PSH can create net savings for the public. Criticisms of the cost-effectiveness of PSH underestimate what homelessness costs the public, fail to reckon with a changing homeless population, or ignore the limitations of empirical research in the social sciences.

This report explains the problem of chronic homelessness and the promise of PSH as a solution. Next, it surveys studies of PSH's cost-effectiveness.[16] Finally, it summarizes recommendations for policymakers, non-profits, and businesses fighting chronic homelessness.

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[14] *See, e.g.,* U.S. DEPT. OF HOUS. & URB. DEV., THE 2018 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS 14 (2018), https://files.hudexchange.info/resources/documents/2018-AHAR-Part-1.pdf; Kathleen McCormick, *Housing the Homeless: Booming Cities Address the Growing Criss on their Streets*, in HOUSING THE HOMELESS, 19 (2018), https://www.lincolninst.edu/sites/default/files/pubfiles/housing-homeless-lla181004_0.pdf.

[15] Email Interview with Deborah Thiele, Managing Director, Western U.S., Corporation for Supportive Housing (Apr. 25, 2019).

[16] Hundreds—if not thousands—of studies consider the effectiveness of PSH. This report limited its assessment to studies found through the course of research with participant descriptions that closely matched the federal definition of "chronic homelessness" and focused on costs. *See infra* Section I.A. for complete definition of chronic homelessness.

I. THE PROBLEM OF CHRONIC HOMELESSNESS

In 2018, at least 550,000 people experienced homelessness in the United States.[17] But research suggests that the number could be 2.5 to 10.2 larger, meaning between 1.3 and 5.6 million people are experiencing homelessness in the United States.[18] Because the Point-in-Time Count is determined through volunteer efforts on a single night in January and is limited to observation within identified count areas, everyone sleeping outside designated areas is missed, making it a severe underestimation of the homelessness crisis.[19] People are considered homeless if they are sleeping in a place not meant for human habitation or if they are living in an emergency shelter.[20] Homelessness shortens people's lifespans by over two decades.[21]

U.S. Department of Housing and Urban Development, The 2018 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations (Nov. 13, 2018)

[17] U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, THE 2018 CONTINUUM OF CARE HOMELESS ASSISTANCE PROGRAMS HOMELESS POPULATIONS AND SUBPOPULATIONS (Nov. 13, 2018), https://files.hudexchange.info/reports/published/CoC_PopSub_NatlTerrDC_2018.pdf [hereinafter *2018 Point in Time*].

[18] *See* NATIONAL LAW CENTER ON HOMELESSNESS & POVERTY, DON'T COUNT ON IT: HOW THE HUD POINT-IN-TIME COUNT UNDERESTIMATES THE HOMELESSNESS CRISIS IN AMERICA, 8 (2016) https://nlchp.org/wp-content/uploads/2018/10/HUD-PIT-report2017.pdf (citing 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, 344 (2001), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497347/pdf/12037263.pdf).

[19] Sara K. Rankin, *The Influence of Exile*, 76 MD. L. REV. 4 (2016), http://digitalcommons.law.seattleu.edu/faculty/767 (noting critiques of homeless counts as underestimations). For example, compare two estimations of people experiencing chronic homelessness in Seattle in 2017: 4,300 per KING COUNTY AND SEATTLE HOMELESSNESS -SOME FACTS, COORDINATED ENTRY FOR ALL, MCKINSEY & COMPANY, at 19, http://www.seattleforgrowth.org/wp-content/uploads/2018/05/20181215-McKinsey-Homelessness-Final-Report-.pdf, and 3,500 per ALL HOME, SEATTLE/KING COUNTY POINT-IN-TIME COUNT OF PERSONS EXPERIENCING HOMELESSNESS 2018, at 4 (2018), http://allhomekc.org/wp-content/uploads/2018/05/FINALDRAFT-COUNTUSIN2018REPORT-5.25.18.pdf.

[20] ALL HOME, SEATTLE/KING COUNTY POINT-IN-TIME COUNT OF PERSONS EXPERIENCING HOMELESSNESS 2019, at 7 (2019), http://allhomekc.org/wp-content/uploads/2019/05/2019-Report_KingCounty_FINAL.pdf.

[21] Harry Murray, Homelessness as Death Sentence: Findings from the House of Mercy, at 2 (2017), http://www.saintjoeshouse.org/blog/wp-content/uploads/2017/11/Article.pdf.

People experiencing chronic homelessness are the most visible, vulnerable, and costly of the overall homeless population.[22] People experiencing homelessness are diverse and the consequences of leaving people homeless are dire but complex.[23] This section explores those consequences. First, it defines chronic homelessness, evaluates the scope of the problem, and surveys how the many vulnerabilities and traumas associated with homelessness cyclically reinforce homelessness. Second, it summarizes how leaving people homeless reinforces chronic homelessness within both the medical and legal systems.

A. Chronic Homelessness: Visibility and Vulnerability

People experiencing chronic homelessness are a specific subset of the general homeless population. In 2018, 96,913 individuals experiencing chronic homelessness lived in the United States, comprising less than 20 percent of the total homeless population.[24] To be considered chronically homeless, a person must (1) have a qualifying disabling condition and (2) remain homeless continuously for 12 months or have four or more homeless episodes within three years that total 12 months.[25] Such qualifying disabling conditions limit an individual's ability to work or perform at least one activity of daily living and include diagnosable substance use disorders, serious mental illnesses, developmental disabilities, chronic physical illnesses, and physical disabilities.[26] The necessary presence of a qualifying disabling condition is an important hallmark of chronic homelessness: it helps to explain the persistence of their homelessness.

Nearly two-thirds of people experiencing chronic homelessness are unsheltered, meaning they live in a place "not designed or ordinarily used as a regular sleeping accommodation for

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[22] U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, ENDING CHRONIC HOMELESSNESS IN 2017 (2016).
[23] *See* KAYA LURIE & BREANNE SCHUSTER, Seattle University Homeless Rights Advocacy Project, DISCRIMINATION AT THE MARGINS: THE INTERSECTIONALITY OF HOMELESSNESS & OTHER MARGINALIZED GROUPS (Sara Rankin ed., 2015).
[24] *2018 Point in Time*, *supra* note 17, at 2.
[25] Homeless Emergency Assistance and Rapid Transition to Housing, 24 C.F.R. § 91, 578 (2015).
[26] OFFICE OF COMMUNITY PLANNING AND DEVELOPMENT, DEP'T OF HOUSING AND URBAN DEVELOPMENT, QUESTIONS AND ANSWERS: A SUPPLEMENT TO THE 2008 CONTINUUM OF CARE HOMELESS ASSISTANCE NOFA AND APPLICATION 6 (2008), https://www.hudexchange.info/resources/documents/2008_CoC_NOFA_qa.pdf.

humans."[27] Unsheltered locations include cars, parks, abandoned buildings, bus stations, train stations, airports, and camping grounds.[28] The lack of shelter compounds the underlying challenges that are particularly pronounced in chronic homelessness.

Homelessness is *inherently* traumatic.[29] The trauma of homelessness can originate from three sources: (1) the sudden or gradual loss of one's home, (2) the conditions of shelter life or life on the street, and (3) the events triggering homelessness, which are frequently traumatic.[30] Trauma associated with homelessness contributes to negative emotional and physical wellbeing, including higher levels of psychiatric distress, substance use, premature mortality, and chronic health problems.[31] For example, homeless schoolchildren are significantly more likely than housed students to attempt suicide and suffer from depression.[32]

The necessary presence of a qualifying disabling condition is an important hallmark of chronic homelessness: it helps to explain the persistence of their homelessness.

Physical and psychological vulnerability and trauma result when society leaves people unsheltered for extended periods. First, exposure to the elements when sleeping outdoors is physically traumatic. People experiencing homelessness are most likely to die when outside in cold weather, even in only moderately cold conditions.[33] In New York City alone, cold-related illnesses bring nearly 420 people to the emergency department or hospital, and kill 15 people annually.[34] Although some New York residents were exposed to cold indoors due to lack of heat, people experiencing homelessness were disproportionately affected.[35] Nearly a quarter of those

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[27] U.S. DEPARTMENT OF HOUSING AND URBAN DEVELOPMENT, Point in Time Count Methodology Guide (Sept. 2014) 7, https://www.hudexchange.info/resources/documents/PIT-Count-Methodology-Guide.pdf.
[28] *Id*. at 18.
[29] Sara K. Rankin, *Punishing Homelessness*, 22 NEW CRIM. LAW REV. 99, 100 (2019).
[30] Lisa A. Goodman et al., *Homelessness as Psychological Trauma: Broadening Perspectives*, 46 AM. PSYCHOLOGIST 1219, 1219 (1991).
[31] *See, e.g.*, David S. Morrison, *Homelessness as an Independent Risk Factor for Mortality: Results from a Retrospective Cohort Study*, 38 INT'L J. EPIDEMIOLOGY 877, 880-82 (2009) (finding homelessness is an independent risk factor for deaths from specific causes); Adam M. Lippert et al., *Stress, Coping, and Mental Health Differences among Homeless People*, 85 SOC. INQUIRY 343, 364-65 (2015) (finding psychiatric disorders are most common among people who are chronically or episodically homeless); Rankin, *supra* note 29 (summarizing the consequences of chronic homelessness and trauma).
[32] INSTITUTE FOR CHILDREN, POVERTY, AND HOMELESSNESS, SUICIDE AND DEPRESSION AMONG HOMELESS HIGH SCHOOL STUDENTS 1 (2018).
[33] Jerzy Romaszko et al., *Mortality Among The Homeless: Causes And Meteorological Relationships*, PLOS ONE 1, 8 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5739436/pdf/pone.0189938.pdf.
[34] Kathryn Lane et al., *Burden and Risk Factors for Cold-Related Illness and Death in New York City*, 15 INT'L J. ENV'T RES. PUB. HEALTH 632, 633 (2018), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5923674/pdf/ijerph-15-00632.pdf.
[35] *Id*. at 632.

admitted to the hospital and a third of those who died in New York City were experiencing homelessness.[36]

Second, adverse sleeping conditions also cause sleep deprivation, which in turn causes cognitive impairment, memory lapses, irritability, impaired moral judgment, and increased risk of Type 2 Diabetes.[37] For people experiencing homelessness, poor sleep quantity or quality is associated with obesity, hypertension, cancer, and depression; poor sleep also contributes directly to the population's low life expectancy.[38] All the mental health disorders that disproportionately impact people with chronic homelessness are worsened by lack of sleep.[39]

Third, unsheltered people are vulnerable to physical assault and trauma because they are often in public and easily accessible to violent perpetrators.[40] People experiencing homelessness were the victims of reported hate crimes at least 1,657 times between 1999 and 2015.[41] A quarter of those attacks were lethal.[42] Even if it does not rise to the level of Post-Traumatic Stress Disorder, experiencing violence personally or witnessing extreme violence perpetrated against others results in trauma.[43]

Women without housing are especially at risk of both physical and sexual trauma. Between 22 and 57 percent of women experiencing homelessness cite domestic violence as the cause of their homelessness.[44] More than half of homeless women in the United States, the United Kingdom, and Australia report a history of sexual trauma.[45] Women experiencing homelessness who are victimized rarely report the abuse, and those who do are unsatisfied with responses they receive from authorities.[46]

Once a person becomes homeless, they enter a world of constant trauma and cannot begin to heal from that trauma until they are removed from it.

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[36] *Id*. at 638.
[37] Health Care for the Homeless Council, *Sufficient Sleep: A Necessity, Not A Luxury*, 18 HEALING HANDS 2, 1 (2014), https://www.nhchc.org/wp-content/uploads/2014/03/spring2014healinghands.pdf.
[38] Benjamin F. Henwood et al., *Longitudinal Effects of Permanent Supportive Housing on Insomnia for Homeless Adults*, SLEEP HEALTH, 2 (2019), https://www.sciencedirect.com/journal/sleep-health.
[39] Health Care for the Homeless Council, *supra* note 37, at 3.
[40] NAT'L COAL. FOR THE HOMELESS, NO SAFE PLACE: A SURVEY OF HATE CRIMES AND VIOLENCE COMMITTED AGAINST HOMELESS PEOPLE 2 (2016), https://nationalhomeless.org/wp-content/uploads/2016/07/HCR-2014-15.pdf.
[41] *Id*. at 3. These attacks are underreported. *Id*. at 1.
[42] *Id*. at 5.
[43] Anthony Feinstein et al., *Witnessing Images of Extreme Violence: A Psychological Study of Journalists in the Newsroom*, 5 J. ROYAL SOC'Y MED. 8, 6 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4100239/pdf/10.1177_2054270414533323.pdf.
[44] U.S. DEP'T OF HEALTH AND HUMAN SERVS., DOMESTIC VIOLENCE AND HOMELESSNESS: STATISTICS (2016), https://www.acf.hhs.gov/fysb/resource/dv-homelessness-stats-2016 (last visited Nov. 24, 2018).
[45] Sally Weinrich, *Assessing Sexual Trauma Histories in Homeless* Women, 17 J. TRAUMA DISSOCIATION 237, 237 (2015).
[46] Jana L. Jasinski et al., *The Experience of Violence in the Lives of Homeless Women: A Research Report* 96 (U.S. Dep't of Justice Grant Final Reports, Document No. 211976, 2005).

Lack of housing and the trauma of homelessness are cyclical because trauma puts people into survival mode, and their brains then prioritize tasks related to survival over all other goals. The minds of people experiencing chronic homelessness are so preoccupied with survival tasks that little energy remains for secondary goals such as finding employment, obtaining an education, improving mental health, and decreasing substance use.[47] Even the most ambitious, focused person experiencing homelessness is unlikely to succeed when they address substance use or seek an education: mental health and substance abuse treatment are ineffective for individuals experiencing an active trauma,[48] and students experiencing trauma learn slower than their peers.[49]

Most simply, the cycle of trauma for those experiencing chronic homelessness is demonstrated by the disabling condition required by the chronic homeless definition. That is, the disabling condition often causes homelessness and is worsened by a lack of housing.[50]

Once a person becomes homeless, they enter a world of constant trauma and cannot begin to heal from that trauma until they are removed from it.

B. Consequences for Individuals and Society

The visibility and vulnerability of the cycle of trauma and homelessness results in fiscal concerns as well as humanitarian ones. Individuals experiencing chronic homelessness can cost taxpayers around $83,000 or more per person per year in shelter, medical, and criminal justice expenses.[51] Individuals experiencing chronic homelessness are the most vulnerable, so services provided to that group can comprise 50 percent of society's homelessness costs although the group is only a small subset of the overall homeless population.[52]

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[47] Rankin, *supra* note 29, at 105.

[48] Lisa A. Goodman et al., *Homelessness as Psychological Trauma: Broadening Perspectives*, 46 AM. PSYCHOLOGIST 1219 at 1222 (1991), https://www.ncbi.nlm.nih.gov/pubmed/1772159.

[49] Salvatore Terrasi et al., *Trauma and Learning in America's Classrooms*, 98 PHI DELTA KAPPAN 35, 36 (2017), https://eric.ed.gov/?id=EJ1132636.

[50] CAROL WILKINS ET AL., A PRIMER ON USING MEDICAID FOR PEOPLE EXPERIENCING CHRONIC HOMELESSNESS AND TENANTS IN PERMANENT SUPPORTIVE HOUSING 3 (July 23, 2014), https://www.aspe.hhs.gov/sites/default/files/pdf/77121/PSHprimer.pdf.

[51] *See, e.g.,* Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 HOUSING POLICY DEBATE 107 (2002), https://shnny.org/uploads/The_Culhane_Report.pdf (finding people experiencing homelessness and a severe mental illness cost $40,451 per person per year in services); DANIEL FLAMING ET AL., HOME NOT FOUND: THE COST OF HOMELESSNESS IN SILICON VALLEY 2 (2015), https://economicrt.org/wp-content/uploads/2015/05/Home_Not_Found_2015.pdf (finding persistently homeless residents accrues average costs of $83,000 per person per year).

[52] *See, e.g.*, Culhane et al., *supra* note 51; Angela Ly & Eric Latimer, *Housing First Impact on Costs and Associated Cost Offsets: A Review of the Literature*, 60 CAN. J. PSYCH. 475, 475 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679128 (stating "service providers have observed that while chronically homeless people represent only 20% of shelter users, they consume the largest share of health, social, and justice services"); FLAMING ET AL., HOME NOT FOUND, *supra* note 51 at 2 (finding those experiencing "persistent homelessness" were responsible for almost half of homelessness spending).

This section considers how the traditional approach of leaving people homeless reinforces the cycle of chronic homelessness on a societal scale. This section first focuses on how the cycle operates: examining medical and psychological outcomes of the cycle on individual. Then, this section examines the consequences of the traditional approach on the legal system through the cycle of arrests, incarcerations, sweeps, and intergenerational consequences. Specific dollar amounts are addressed in later sections that review cost savings resulting from PSH.

1. Medical and Psychological Outcomes

Traditionally, society asks people experiencing homelessness to address their physical and psychological challenges while they are unhoused.[53] Traditional approaches may stress services or treatment but do not systemically connect these offers with housing. Unsurprisingly, this tactic does little to stop the cycle of chronic homelessness, as the ongoing trauma of homelessness reinforces these challenges and undermines treatment.

Maslow's Hierarchy of Needs (pictured below) visualizes the order in which human needs must be fulfilled, beginning with physiological and safety needs, such as housing, and building up to esteem and self-actualization, which play into mental health and employment.[54]

[55]

Traditional approaches conflict with human nature by forcing a start at the top of the hierarchy, expecting people to demonstrate success with service, treatment, or employment even with their basic physiological needs are not being met. Because traditional approaches fail to

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[53] DEBORAH PADGETT ET AL., HOUSING FIRST: ENDING HOMELESSNESS, TRANSFORMING SYSTEMS, AND CHANGING LIVES 7 (2015).
[54] INTRODUCTION TO HOUSING FIRST/PERMANENT SUPPORTIVE HOUSING, HOMELESS RIGHTS ADVOCACY PROJECT (2018), https://law.seattleu.edu/Documents/korematsu/Introduction%20to%20Housing%20First%20and%20Permanent%20Supportive%20Housing.pdf.
[55] *Id.*

address the disabling conditions associated with chronic homelessness, they are less effective and more expensive.

People experiencing chronic homelessness have disabling conditions and thus high rates of psychiatric disability, substance use, and chronic medical conditions.[56] These conditions often cause people to lose their housing through job loss.[57] Disabling conditions are also a direct consequence of homelessness, because living outside or in shelters exposes people to harsh weather, unsanitary conditions, and communicable diseases.[58] Conditions disproportionately affecting people experiencing chronic homeless include tuberculosis, HIV/AIDS, heart diseases, lung disease, hypertension, and hepatitis.[59]

By leaving people with disabling conditions homeless, society makes treatment less accessible and effective. First, homelessness is associated with past negative experiences with the health care system, and many people experiencing homelessness cite shame and low-self-esteem as reasons for avoiding medical services, even when diagnosed with terminal illnesses.[60] Second, the instability of homelessness makes it difficult for people to keep track of their medical records and what services are covered by their health insurance.[61] Third, many medical conditions cannot be properly managed on the street; for example, diabetics need their insulin to be refrigerated.[62]

Our current approach to treating people with disabling conditions living on the street is akin to treating burn victims who are still on fire.

Because of the barriers to medical treatment inherent in homelessness, people experiencing homelessness receive most of their medical care through costly emergency services, such as emergency room visits, inpatient hospital stays, and inpatient psychiatric stays. The emergency services cost more than preventative care *and* they often fail to solve the patient's concern: people experiencing homelessness admitted to the emergency room are more

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[56] *See, e.g.,* Carol L. M. Caton, *People Who Experience Long-Term Homelessness: Characteristics and Interventions, in* TOWARD UNDERSTANDING HOMELESSNESS: THE 2007 NATIONAL SYMPOSIUM ON HOMELESSNESS RESEARCH 4-1, 4-4 (Deborah Dennis et al. eds., 2007), https://www.huduser.gov/portal//publications/pdf/homeless_symp_07.pdf; Rankin, *supra* note 29, at 103.

[57] NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL, HOMELESSNESS AND HEALTH: WHAT'S THE CONNECTION? 1 (2011), https://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf

[58] *Id*.

[59] Rankin, *supra* note 29, at 106.

[60] Briony F. Hudson et al., *Challenges to Access and Provision of Palliative Care for People who are Homeless: A Systematic Review of Qualitative Research*, 15 BMC PALLIATIVE CARE 1, 4 (2016), https://bmcpalliatcare.biomedcentral.com/track/pdf/10.1186/s12904-016-0168-6.

[61] Terri LaCoursiere Zucchero, "*Walking In a Maze": Community Providers' Difficulties Coordinating Health Care for Homeless Patients*, 16 BMC PALLIATIVE CARE 1, 5 (2016), https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/s12913-016-1722-x.

[62] HCH CLINICIANS' NETWORK, ADAPTING YOUR PRACTICE: TREATMENT AND RECOMMENDATIONS FOR HOMELESS PATIENTS WITH DIABETES MELLITUS 6 (2007).

likely to leave against medical advice before their condition is resolved,[63] which leads to readmission and additional services that are more costly than preventative services or preliminary treatments.[64] Emergency services are expensive, do not create long-term solutions, and do not stop the cycle of chronic homelessness. Society's current approach to treating people with disabling conditions living on the street is akin to treating burn victims who are still on fire.

2. Arrests, Incarcerations, and Sweeps

The criminal justice system is another area in which leaving people homeless contributes to the cycle of chronic homelessness. Having a criminal record makes a person more likely to experience homelessness, and experiencing homelessness makes a person more likely to have a criminal record.[65]

First, every year, nearly 50,000 people leaving jail or prison go straight to shelters,[66] and re-offense rates are higher for people who lack housing upon release from jail or prison.[67] Also contributing to the causal link between criminal records and homelessness is a commonplace exclusion of people with criminal records from public housing, as nearly all local public housing authorities institute more severe bans than the federal government requires.[68] A poor person with a criminal record is more likely to become homeless than a poor person without one.

Second, by simply living exposed on the street, people experiencing homelessness interact with the criminal justice system more than the general population.[69] Cities across the country continue to criminalize homeless behaviors, such as sleeping in public and storing personal belongings in public; unsheltered people are virtually guaranteed to engage with the criminal justice system.[70]

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[63] Allen Kraut et al., *A Population-Based Analysis of Leaving the Hospital Against Medical Advice: Incidence and Associated Variables*, 13 BMC HEALTH SERV. RES. 1, 9 (2013), https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-415.

[64] Dima Saab et al., *Hospital Readmissions in a Community-Based Sample of Homeless Adults: A Matched-Cohort Study*, 31 J. GEN. INTERNAL MED. 1011, 1014-15 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4978672/pdf/11606_2016_Article_3680.pdf.

[65] Rankin, *Punishing Homelessness*, *supra* note 29, at 101.

[66] UNITED STATES INTERAGENCY COUNCIL ON HOMELESSNESS, CONNECTING PEOPLE RETURNING FROM INCARCERATION WITH HOUSING AND HOMELESSNESS ASSISTANCE 1 (2016), https://www.usich.gov/resources/uploads/asset_library/Reentry_Housing_Resource_Tipsheet_Final.pdf.

[67] TEXAS CRIMINAL JUSTICE COALITION, RETURN TO NOWHERE: THE REVOLVING DOOR BETWEEN INCARCERATION AND HOMELESSNESS 14 (2019), https://www.texascjc.org/one-size-fails-all.

[68] Marah A. Curtis et al., Alcohol, Drug, and Criminal History Restrictions in Public Housing, 15 CITYSCAPE: J. POL'Y DEV. AND RES. 37, 48 (2013), https://www.huduser.gov/portal/periodicals/cityscpe/vol15num3/ch2.pdf.

[69] TEXAS CRIMINAL JUSTICE COALITION, *supra* note 67, at 3.

[70] *See*, *e.g.*, Justin Olson & Scott MacDonald, Seattle University Homeless Rights Advocacy Project, WASHINGTON'S WAR ON THE VISIBLY POOR: A SURVEY OF CRIMINALIZING ORDINANCES & THEIR ENFORCEMENT (Sara Rankin ed., 2015).

Unsheltered people are virtually guaranteed to engage with the criminal justice system.

The criminal justice system reinforces homelessness when the police and other governmental authorities conduct clean-ups of encampments of people experiencing homelessness ("sweeps"). Sweeps involve the seizure and destruction or disposal of publicly-stored personal property belonging to people experiencing homelessness.[71] These sweeps often target entire homelessness encampments.[72] Despite frequently denying those affected by sweeps of constitutional protections of due process and equal protection,[73] sweeps are said to be for the good of the people living in unsanitary encampments.[74] However, no research supports this theory.[75] Instead, sweeps create huge setbacks, as they result in fines, personal property loss, physical stress, and psychological damage.[76] People impacted by sweeps can lose identification and medication; the loss of these items can have severe medical and practical consequences, and they are time-consuming and costly items to replace.[77] These setbacks further entrench people in their homelessness.

3. Inter-Generational Consequences

Chronic homelessness affects not only single adults, but that demographic is disproportionately represented in the data. Families are considered chronically homeless if any head of the household meets the federal definition;[78] however, this classification is rarely captured: only 8,273 of 96,913 people experiencing chronic homelessness in 2018 were in households with children.[79] One reason for this low number is the restrictive federal definition of homelessness, which does not capture the typical living arrangements of homeless families, such

[71] *See*, *e.g.*, Samir Junejo et al., Seattle University Homeless Rights Advocacy Project, NO REST FOR THE WEARY: WHY CITIES SHOULD EMBRACE HOMELESSNESS ENCAMPMENTS (Sara Rankin ed., 2016), https://ssrn.com/abstract=2776425; ACLU OF WASHINGTON, HOMELESS SWEEPS – IMPORTANT CASE LAW AND FREQUENTLY ASKED QUESTIONS 1 (2017), https://www.aclu-wa.org/file/101617/download?token=LGnmOLRk.
[72] TAI DUNSON-STRANE & SARAH SOAKAI, THE EFFECTS OF CITY SWEEPS AND SIT-LIE POLICIES ON HONOLULU'S HOUSELESS 6 (2015), http://blog.hawaii.edu/durp/files/2015/06/Houseless-Honolulu-Report.small_.pdf.
[73] *See, e.g.*, NAT'L L. CTR. ON HOMELESSNESS & POVERTY, HOUSING NOT HANDCUFFS: A LITIGATION MANUAL 11, https://www.nlchp.org/documents/Housing-Not-Handcuffs-Litigation-Manual (last visited Mar. 14, 2019).
[74] *See, e.g.,* Chris Daniels, *City Leaders to Council: Homeless Sweeps Must Continue*, KING 5 NEWS, Nov. 1, 2017, https://www.king5.com/article/news/local/city-leaders-to-council-homeless-sweeps-must-continue/281-488095121; Heidi Groover, *Seattle Releases New Rules for Clearing Homeless Encampments*, THE STRANGER, Jan. 31, 2017, https://www.thestranger.com/slog/2017/01/31/24836221/seattle-releases-new-rules-for-clearing-homeless-encampments.
[75] Junejo et al., NO REST FOR THE WEARY, *supra* note 71, at 15-16.
[76] STRANE & SOAKAI, *supra* note 72, at 4.
[77] Junejo et al., NO REST FOR THE WEARY, *supra* note 71, at 17-18.
[78] Homeless Emergency Assistance and Rapid Transition to Housing, *supra* note 25, at 792.
[79] *2018 Point in Time*, *supra* note 17, at 2.

as living in motels or "doubled-up" with other families in over-crowded living arrangements.[80] Frequently precarious and unsafe, such living arrangements put children in danger and increase the likelihood they will become homeless as adults.[81]

Such living arrangements go uncaptured by many definitions of homelessness, even though these conditions are frequently unintended for human habitation, precarious, and unsafe. Crowded living arrangements put children at an increased risk of physical injury, illness, developmental delays, and exposure to toxins.[82] Experiencing homelessness as a child increases the likelihood that a person will become homeless as an adult.[83] Thus one consequence of leaving families homeless is an inter-generational cycle of homelessness.

II. THE SOLUTION TO CHRONIC HOMELESSNESS

To solve chronic homelessness, the cycle must be stopped. Traditional approaches first address concerns related to trauma, such as counseling and substance abuse services. However, as explained in Section I of this report, trauma and medical conditions cannot be effectively addressed when people are actively experiencing homelessness. Effective interventions stop the cycle at its core by providing housing first, which is most successful in the form of PSH.[84]

This section considers the success of PSH in addressing chronic homelessness. It first defines PSH and explores its theoretical foundations. Second, it examines how PSH improves housing stability for its residents and why housing stability is important. Third, it explores how PSH results in better outcomes for individuals and cost savings for society.

A. Permanent Supportive Housing

Housing is a critical foundation for treatment and recovery, not a reward for it. But historically, housing was primarily made available to people experiencing homelessness in a Treatment First or "Staircase" fashion, where clients earned housing by complying with treatment regimens dictated by psychiatrists, social workers, and other professionals.[85] In this traditional approach, housing was a carrot on a stick: if a person experiencing homelessness attended programming, refrained from using drugs or alcohol, and stayed out of trouble, they were rewarded with a home of their own. Aside from housing's role as an incentive for treatment, providers feared that housing people actively using substances or avoiding mental health treatment would enable substance use or criminal behavior.[86]

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[80] INSTITUTE FOR CHILDREN, POVERTY, AND HOMELESSNESS, ARE WE CREATING CHRONIC HOMELESSNESS? THE PAST, PRESENT, AND FUTURE OF FEDERAL HOMELESSNESS POLICY 5 (2016), https://www.icphusa.org/reports/are-we-creating-chronic-homelessness-the-past-present-and-future-of-federal-homelessness-policy.
[81] *Id*. at 7.
[82] Kim T. Ferguson et al., *The Physical Environment and Child Development: An International Review*, 48 INT J PSYCHOL 437, 437 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4489931/pdf/nihms492361.pdf.
[83] INSTITUTE FOR CHILDREN, POVERTY, AND HOMELESSNESS, *supra* note 80, at 7.
[84] Rankin, *supra* note 29, at 115.
[85] PADGETT ET AL., *supra* note 53, at 7.
[86] *Id*. at 31.

Like the residents of adult family homes and nursing facilities, people experiencing chronic homelessness often need housing and supportive services to function.

Pathways to Housing First, a homelessness program in New York, deviated from this practice drastically in the 1990's, when it made housing immediately available to homeless clients with severe psychiatric disabilities, without requiring clients to stay sober or participate in treatment.[87] Clients lived in housing integrated in various communities ("scatter-site housing"), rather than condensed in one location ("single-site housing"). [88] The program also provided clients with services to help them reach goals related to areas such as mental health, physical health, substance use, and professional development.[89] The program innovated a Housing First approach to homelessness, and the results were impressive: after five years, 88 percent of program clients remained housed compared to 47 percent in traditional programs.[90] In other words, the Housing First approach was successfully ending chronic homelessness. These promising results persist in Housing First projects today.[91] Studies show that stable housing is a necessary precondition to effective treatment and recovery.

At its core, Housing First works because it corresponds with research on human behavior and needs and because it targets the central trauma of homelessness: a lack of housing. People experiencing the active trauma of homelessness cannot deal with secondary concerns such as long-term health. Housing First removes the active trauma of homelessness and provides the necessary stability so that people can address other issues.[92] The Housing First approach is especially successful for people experiencing chronic homelessness because people in that group have disabling conditions that are frequently worsened by a lack of housing.

Like the residents of adult family homes and nursing facilities, people experiencing chronic homelessness need housing and supportive services to function. Really, these two groups overlap substantially due to the disabling condition that impacts people experiencing chronic homelessness. Some people are chronically homeless in the first place because housing agencies face significant barriers in referring people experiencing homelessness to nursing and adult family homes.[93] PSH fills this gap in need.

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[87] Sam Tsemberis et al, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 PSYCHIATRIC SERV. 487, 487 (2000).
[88] PADGETT ET AL., *supra* note 53, at 3.
[89] *Id*.
[90] Sam Tsemberis et al, *supra* note 87, at 491.
[91] *See infra* Section II.C.
[92] PADGETT ET AL., *supra* note 53, at 67-68.
[93] HEALTH CARE FOR THE HOMELESS NETWORK, INTEGRATING HEALTH AND HOUSING SOLUTIONS FOR OLDER HOMELESS AND FORMERLY HOMELESS KING COUNTY RESIDENTS: A PROPOSED ROADMAP FOR AVERTING AN APPROACHING CRISIS 1 (2016), https://www.kingcounty.gov/depts/health/locations/homeless-health/healthcare-for-the-homeless/~/media/depts/health/homeless-health/healthcare-for-the-homeless/documents/Integrating-Health-and-Housing-Solutions-for-Older-Homeless.ashx.

Many housing models potentially fulfill the Housing First approach, but PSH is the most effective intervention.[94] PSH provides housing that is non-time-limited and low-barrier; further, it offers—but does not mandate—supportive services.[95] The housing is low-barrier because it does not require a person to maintain sobriety or participate in programming to keep their housing.[96] Staff assertively engages tenants in services, rather than coercing them.[97] Individual choice and self-agency in treatment are essential for successful recovery and stability.[98] Mandated substance abuse treatment is ineffective and conflicts with the rights of substance users.[99] In fact, compulsory treatment is likely harmful to those who receive it.[100]

PSH is not free. Residents commonly pay up to 30 percent of it in rent; such income often comes from disability or social security benefits.[101] It is also not bedlam: residents commonly sign leases with provisions like to those given to non-supportive housing tenants, such as prohibitions against violent conduct.[102] The remarkable retention rate for residents— as high as 96 percent[103]— shows that the overwhelming majority of PSH residents, given the opportunity, stay housed and do not return to homelessness.[104]

Over two decades of research shows that PSH delivered through a Housing First framework effectively reduces chronic homelessness. Notably, the federal government adopted PSH as its designated solution to chronic homelessness.[105] In the past two decades, PSH has been successfully implemented in cities throughout the United States, as well as Canada, Australia, and throughout Europe.[106]

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[94] 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*, 60 PSYCHIATRIC SERV. 473, 473 (2009), https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.4.473.
[95] PADGETT ET AL., *supra* note 53, at 3.
[96] *Fact Sheet: Housing First*, NAT'L ALLIANCE TO END HOMELESSNESS, http://endhomelessness.org/wp-content/uploads/2016/04/housing-first-fact-sheet.pdf (last visited April 25, 2019).
[97] Daniel Malone et al., *Single-Site Housing First for Chronically Homeless People*, 18 HOUSING, CARE AND SUPPORT 62, 63 (2015).
[98] *See, e.g.*, Richard Waters, *Jail Can't Fix Homelessness or Substance Use*, CROSSCUT (Apr. 26, 2019), https://crosscut.com/2019/04/jail-cant-fix-homelessness-or-substance-use.
[99] Karsten Lunze et al., *Mandatory Addiction Treatment for People Who Use Drugs: Global Health and Human Rights Analysis*, 353 BMJ 2943 (2016), https://doi.org/10.1136/bmj.i2943.
[100] Dan Werb et al., *The Effectiveness of Compulsory Drug Treatment: A Systematic Review*, 28 Int. J. Drug Policy 1, 2 (2016), https://doi.org/10.1016/j.drugpo.2015.12.005.
[101] PADGETT ET AL., *supra* note 53, at 43.
[102] *See*, *e.g.*, SUPPORTIVE HOUSING SCATTER-SITE LEASING, CORPORATION FOR SUPPORTIVE HOUSING 6 (2015), https://www.csh.org/wp-content/uploads/2015/12/IL_Toolkit_Model_Scattered-Site-Leasing.pdf.
[103] SARAH B. HUNTER ET AL., RAND CORPORATION, EVALUATION OF HOUSING FOR HEALTH PERMANENT SUPPORTIVE HOUSING PROGRAM 32 (2017), https://www.rand.org/pubs/research_reports/RR1694.html.
[104] Amanda Vail, *Plymouth Housing Announces $75 Million PROOF Campaign to Build 800 Homes for the Homeless*, CISION PR NEWSWIRE (June 11, 2019), https://www.prnewswire.com/news-releases/plymouth-housing-announces-75-million-proof-campaign-to-build-800-homes-for-the-homeless-300864852.html.
[105] U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, OPENING DOORS FEDERAL STRATEGIC PLAN TO PREVENT AND END HOMELESSNESS 9 (2010), http://dev2.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf.
[106] Cameron Parsell et al., *Cost Offsets of Supportive Housing: Evidence for Social Work*, 47 BRIT. J. SOC. WORK 1534, 1535 (2016), http://works.bepress.com/dennis_culhane/204.

B. Housing Stability

The primary goal of PSH is to improve housing stability.[107] Housing stability is the targeted result because the trauma, negative consequences, and high societal costs stemming from homelessness are only prevented when people are housed.[108] Also, housing stability is associated with a psychological concept called "ontological security," which refers to a sense of consistency in one's living arrangements that sets a foundation for identity development and self-actualization.[109] While identity and self-actualization are amorphous and intangible, they are essential in addressing issues such as psychiatric disabilities.[110]

PSH consistently improves housing stability for people experiencing chronic homelessness. The intervention's success is evident from the very beginning of the housing process, as it is more effective than traditional approaches at moving chronically homeless individuals off the streets and into housing.[111] PSH is better at providing housing stability, regardless of how it is measured: participants do better on measurements of length of time housed, percentage of days housed, and percentage of clients who never return to homelessness.[112] Up to 96 percent of people experiencing chronic homelessness provided PSH remain housed after one year.[113]

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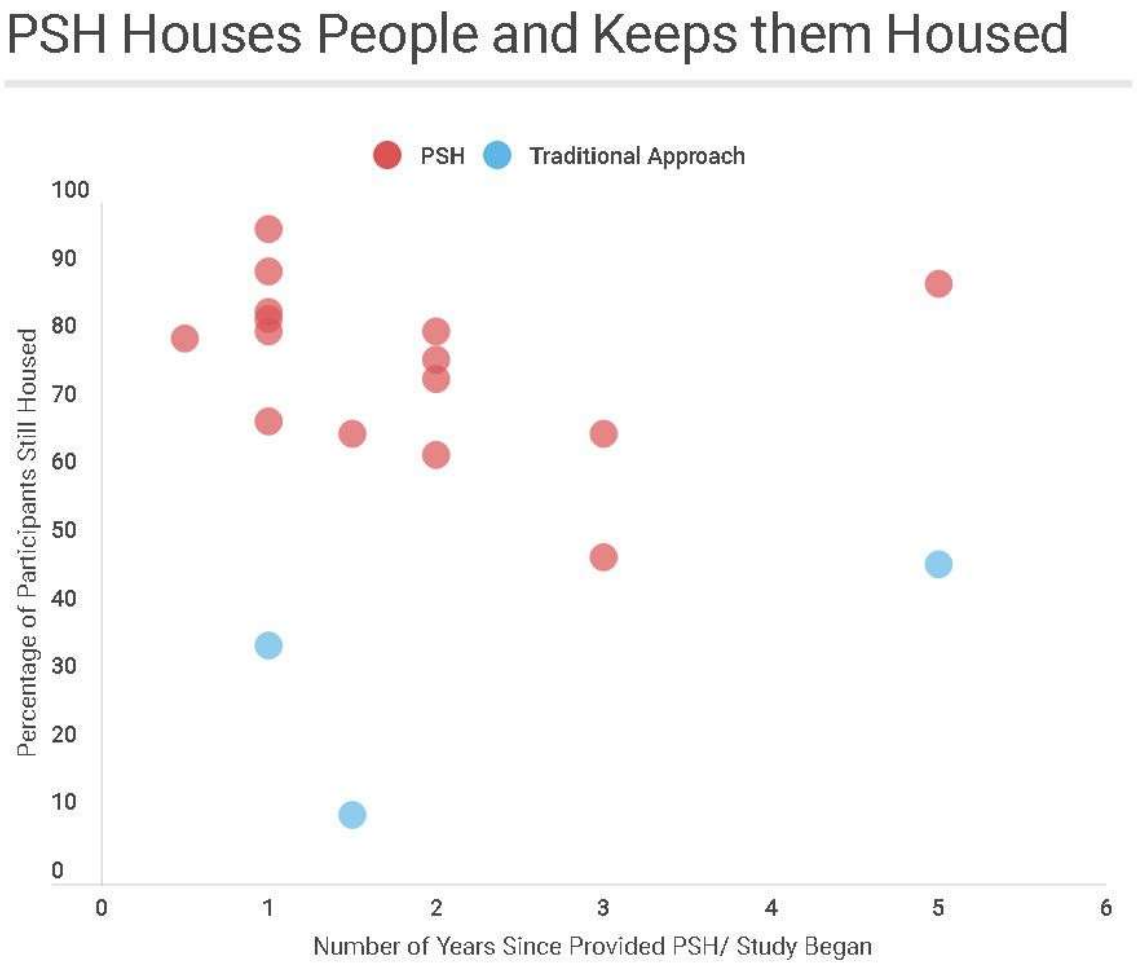
[107] PADGETT ET AL., *supra* note 53, at 54.
[108] THE NATIONAL ACADEMY OF SCIENCES, ENGINEERING, AND MEDICINE, PERMANENT SUPPORTIVE HOUSING: EVALUATING THE EVIDENCE FOR IMPROVING HEALTH OUTCOMES AMONG PEOPLE EXPERIENCING CHRONIC HOMELESSNESS 40 (2016) [hereinafter *NASE Report*], http://nap.edu/25133.
[109] PADGETT ET AL., *supra* note 53, at 68.
[110] Leyla Gulcur et al., *Community Integration of Adults with Psychiatric Disabilities and Histories of Homelessness*, 43 COMMUNITY MENTAL HEALTH J. 211, 211 (2007), https://pathwaystohousingpa.org/sites/pathwaystohousingpa.org/files/Pathways_Community_Integration_2007.pdf (finding self-actualization is required for community integration for adults with psychiatric disabilities).
[111] *See, e.g.,* Laura S. Sadowski et al., *Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults*, 301 JAMA 1771, 1774 (2009), https://jamanetwork.com/journals/jama/fullarticle/183842 (finding 66 percent of participants provided PSH reached stable housing compared to only 10 percent those in the control group); Tim Aubry et al., *A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness* 67 PSYCHIATRIC SERV. 275, 278 (2016), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400587 (finding the Housing First group was moved into housing within 72.9 days compared to 219.7 days for those in the control group).
[112] *See, e.g.*, Stergiopoulos et al., *Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness*, 313 JAMA 905, 909 (2015), https://jamanetwork.com/journals/jama/fullarticle/2174029 (finding 31.5 percent of the control group was never housed compared to only 5 percent of the PSH group after two years, and, in the second year of the study, only 39.9 percent of the control group was housed 50 percent of the time, compared to 78 percent of the PSH group); Tim Aubry et al., *Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the At Home-Chez Soi Demonstration Project*. 60 CAN. J. PSYCHIATRY 467, 471 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127 (finding 46 percent of the control group was not housed at all during the last 6 months of the two-year study compared to only 16 percent of the PSH group, and 62 percent of the PSH group was housed continuously for the last six months of the study, compared to only 31 percent of the control group); SUSAN BARROW ET AL., CORPORATION FOR SUPPORTIVE HOUSING, FINAL REPORT ON THE EVALUATION OF THE CLOSER TO HOME INITIATIVE 116 (2004), https://www.csh.org/wp-content/uploads/2011/12/Report_cth_final1.pdf (finding 77 percent of PSH participants were still housed after two years).
[113] HUNTER ET AL., *supra* note 103, at 32.

The high costs of homelessness are only prevented when people are housed.

First, PSH houses people and keeps them housed. The graph below compares PSH and the traditional approach on housing participants and keeping them housed over time. Red dots represent cohorts of participants provided PSH; blue dots represent cohorts of participants faced with the traditional approach.



[114]

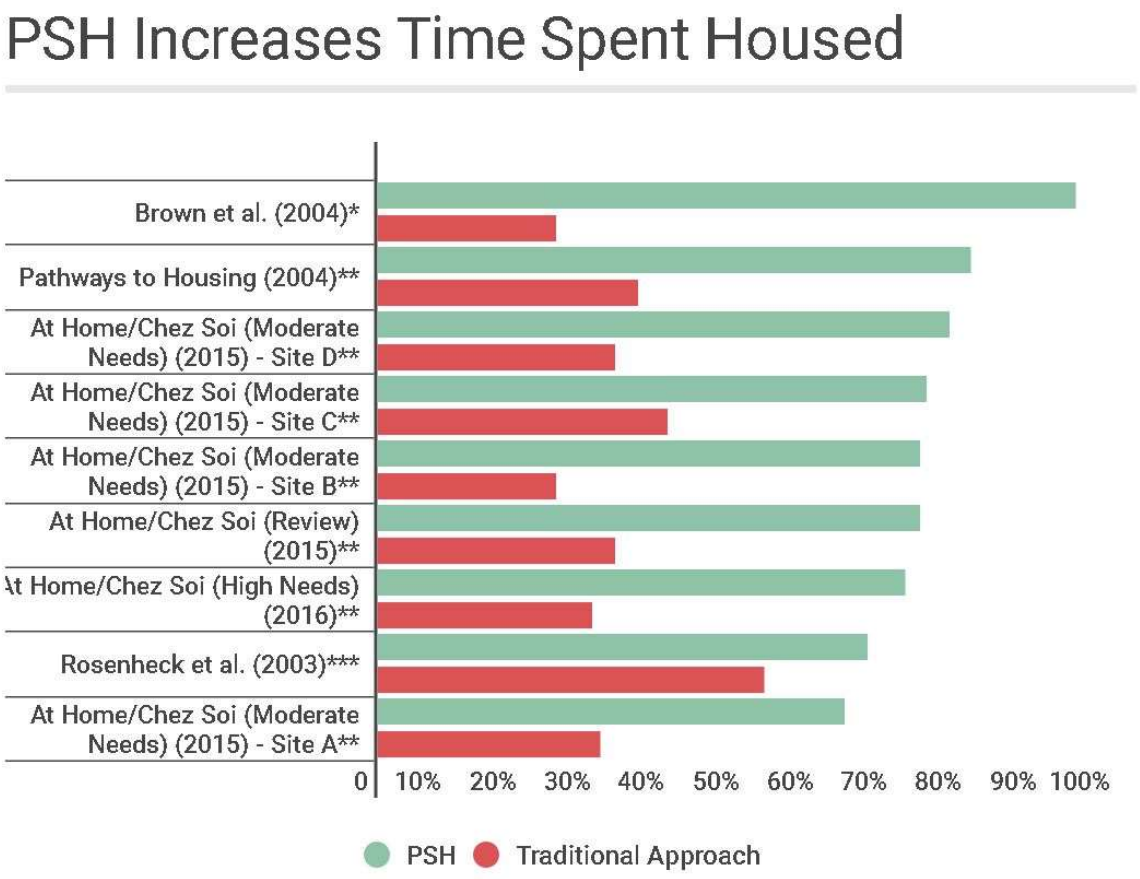
The graph above shows that PSH consistently keeps more people housed than the traditional approach.[115] Across multiple studies, a larger proportion of those provided PSH

[114] PSH consistently resulted in a greater percentage of housed participants over time. "Traditional Approach" refers to comparison groups not provided PSH. Traditional Approach participants may have been offered temporary housing, housing that requires compliance with treatment, abstinence-only housing, or no housing at all. *See infra* Appendix B for data and sources.

[115] *See infra* Appendix B for data and sources.

remained housed over time compared to those in traditional approach groups. Retention rates directly impact social service costs. Due to screening, temporary housing, and move-in costs for new PSH tenants, a participant's first year of PSH is likely to be the most expensive;[116] high retention rates suggest such costs are less likely to repeated for PSH than for higher-barrier housing.

Second, PSH ensures each person spends more time housed than traditional approaches. The following graph illustrates the percentage of time individuals provided PSH (green bars) spend housed compared to groups under the traditional approach (red bars). PSH consistently results in greater time spent housed.



* Study spanned 12 months.
** Study spanned 24 months.
*** Study spanned 36 months.

117

This graph shows that PSH effectively helps people maintain housing stability, as those provided PSH spend most of their time housed, while those who encounter the traditional approach typically spend less than a third of their time in housing. More time housed means less

[116] *See infra* Section III.A.
[117] *See infra* Appendix B for data and sources.

exposure to the traumas inherent in homelessness[118] and fewer social costs incurred from that trauma.

C. Better Outcomes for Individuals and Cost Savings for Society

The benefits of PSH for individuals are intertwined with the benefits for society, especially in terms of cost savings. When formerly chronically homeless individuals have a place to live, they use fewer taxpayer-funded medical and criminal justice resources. Also, because formerly chronically homeless individuals are no longer forced to occupy public spaces, cities are more visually appealing and welcoming.

No study accounts for all, or even most, of the costs associated with homelessness.

This section examines the individual and societal outcomes and cost savings associated with PSH. No study accounts for all, or even most, of the logical costs. But the isolated costs captured in existing studies are still impressive. This section first considers medical and psychological outcomes and costs. Second, it considers criminal justice outcomes and costs. Third, it considers the public effect and cost savings associated with decreased visible blight.

1. Medical and Psychological Outcomes

PSH improves medical and psychological outcomes because it eliminates physical and mental stressors inherent in living in shelters or in places not meant for human habitation. This section considers these medical and psychological outcomes. First, it examines medical and psychiatric hospitalizations. Second, it considers decreased use of emergency services. Third, it explores quality of life outcomes. Fourth, it touches on substance use.

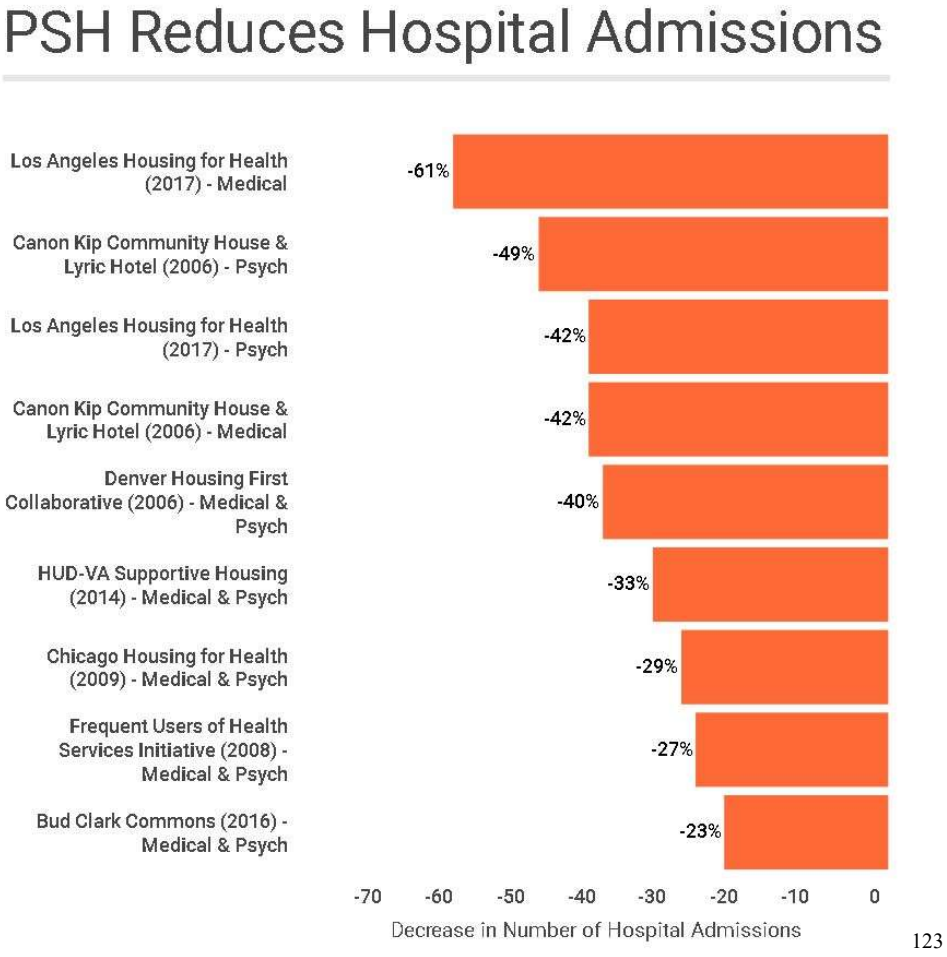
a. Medical and Psychiatric Hospitalizations

When PSH is provided to formerly chronically homeless individuals, the emergency department visits they make are less likely to result in inpatient admissions, and their visits are substantially shorter.

After two years in PSH, evidence shows that the likelihood that emergency department visits will result in inpatient admissions is cut nearly in half for formerly chronically homeless individuals, from 19 to 11 percent.[119] Other studies find reductions in similar rages: one year of

[118] *See infra* Section I.A.
[119] Tia E. Martinez & Martha R. Burt, *Impact of Permanent Supportive Housing on the Use of Acute Care Services by Homeless Adults*, 57 PSYCHIATRIC SERV. 992, 992 (2006), https://www.aidschicago.org/resources/legacy/pdf/2009/hhrpn/Martinez/martinez.pdf.

PSH reduced inpatient hospitalizations by 33 percent in one study[120] and by 29 percent in another.[121] Hospital admissions can be reduced by as much as 61 percent.[122] The graph below summarizes findings related to hospital admissions.



[123]

Decreased admission rates associated with PSH reflect that many people experiencing chronic homelessness are admitted to the hospital simply because they lack housing. PSH is a cheaper and more effective alternative to hospital stays for many concerns. Medical professionals can discharge housed people who present to the emergency room easier than those without housing.[124]

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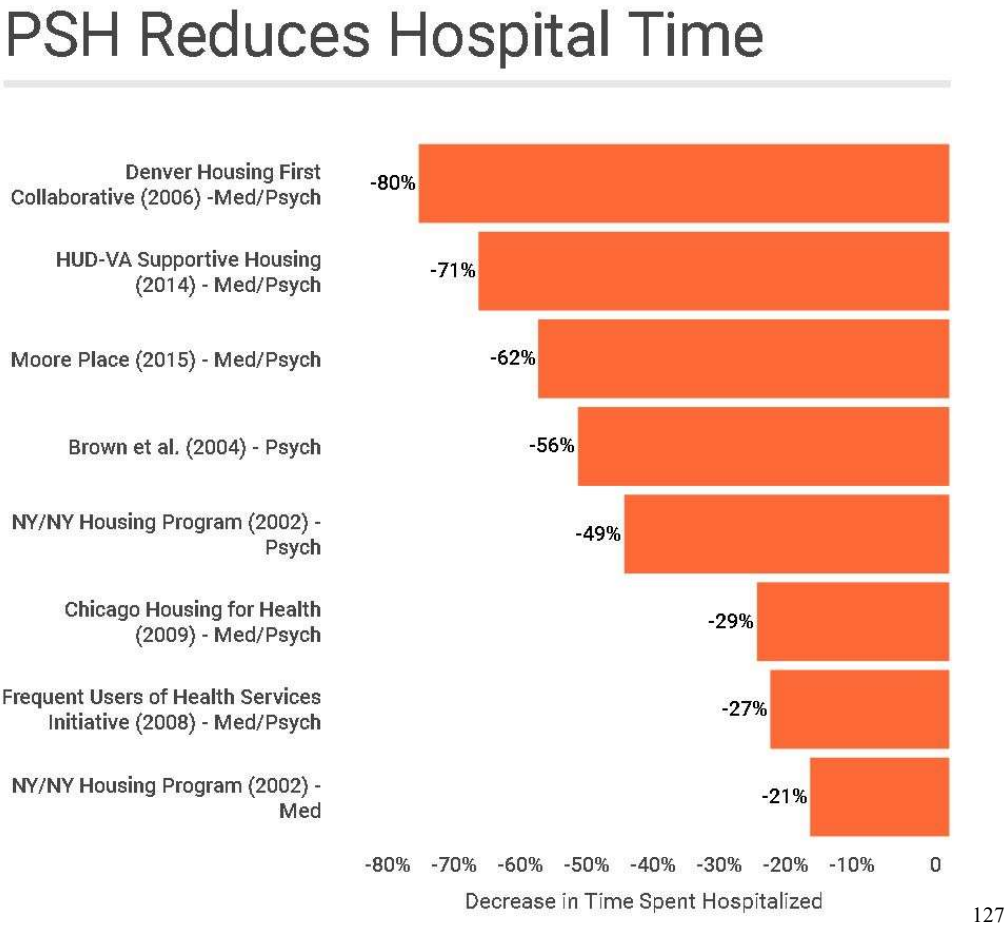
[120] ELIZABETH MONTGOMERY ET AL., VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS, HOUSING FIRST IMPLEMENTATION BRIEF 4 (2014), https://www.va.gov/homeless/nchav/docs/Housing-First-Implementation-brief.pdf.
[121] Sadowski et al., *supra* note 111, at 1771.
[122] HUNTER ET AL., *supra* note 113, at 38.
[123] *See infra* Appendix B for data and sources.
[124] DISCHARGE PLANNING, NATIONAL HEALTH CARE FOR THE HOMELESS COUNCIL (2019), https://www.nhchc.org/resources/clinical/tools-and-support/discharge-planning.

Of those admitted to the hospital, those in PSH have shorter stays. Studies have found hospital days reduced by anywhere from 21.2 percent, for a cohort of chronically homeless individuals with severe mental illness,[125] to 80 percent for a group of chronically homeless individuals with an average of eight years homeless.[126] The graph below summarizes these findings.



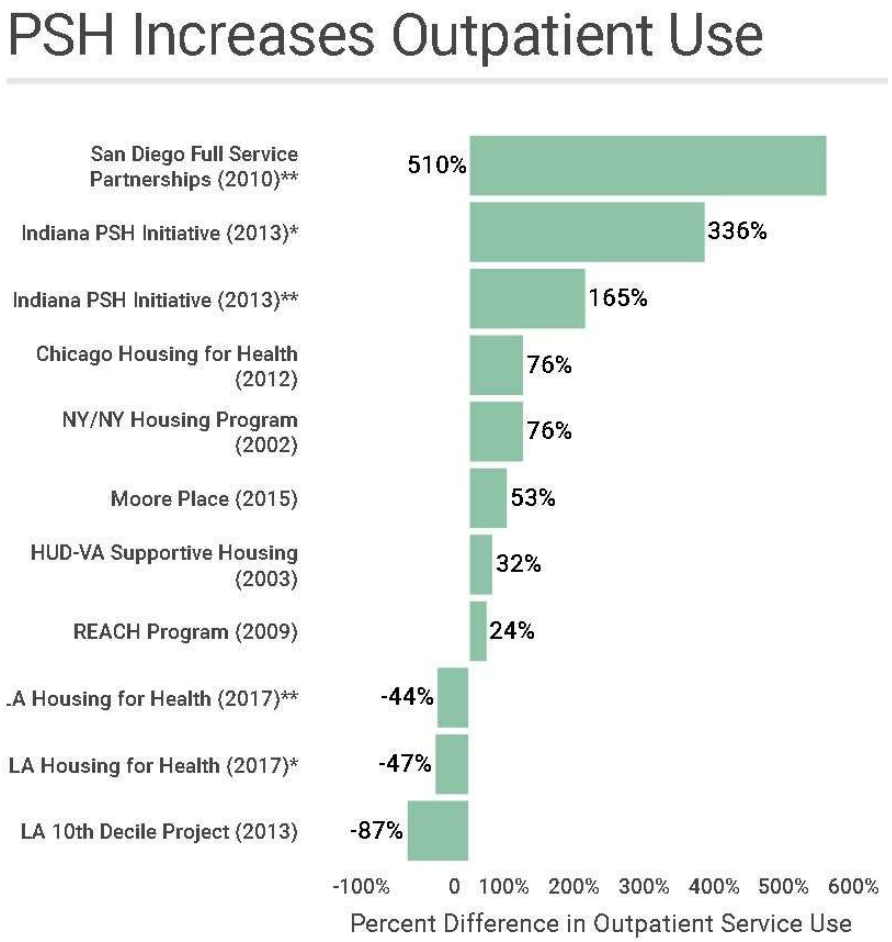
[127]

The graph above demonstrates that PSH reduces the need for inpatient psychiatric care as well.[128] Cost savings corresponding to reduced psychiatric service use are significant. For

[125] Dennis P. Culhane et al., *The Impact of Supportive Housing for Homeless People with Severe Mental Illness on the Utilization of the Public Health, Corrections, and Emergency Shelter Systems: The New York-New York Initiative*, 13 HOUSING POL'Y. DEBATE 107, 121 (2002), https://works.bepress.com/metraux/16.
[126] DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 5.
[127] *See infra* Appendix B for data and sources.
[128] *See, e.g.*, MELANIE MONDELLO ET AL., COST ANALYSIS OF PERMANENT SUPPORTIVE HOUSING: STATE OF MAINE-GREATER PORTLAND 9 (2007), https://shnny.org/uploads/Supportive_Housing_in_Maine.pdf (finding 38 percent decrease in psychiatric hospitalizations after PSH); Culhane et al., *supra* note 51, at 119 (finding PSH decreased psychiatric hospitalizations by 49.2 percent); MONDELLO ET AL., RURAL, *infra* note 154, at 11 (finding PSH decreased psychiatric hospitalizations by 58 percent).

example, in just six months, PSH reduced psychiatric hospitalization costs by 79 percent, or $356,159, for a group of 163 people previously experiencing chronic homelessness.[129]

A potential explanation for the decrease in inpatient care is an increase in outpatient service use.[130] One PSH tenant's explanation of life with secure housing sheds light on why outpatient visits tend to increase with PSH: "I found I am able to focus more on what is important; before, I was stressed out all the time and not able to focus much on stuff going on; I can breathe now; I can think."[131] PSH residents gain the ability to plan and think, so they transition from ineffective emergency department visits and inpatient stays to sustainable outpatient visits. The graph below shows changes in outpatient service use related to PSH.



132

[129] MONDELLO ET AL., RURAL, *supra* note 154, at 11.
[130] *Id*. at 2.
[131] *Indiana PSH Initiative*, *supra* note 153, at 29.
[132] *See infra* Appendix B for data and sources.

Outpatient services are more effective and efficient than inpatient, so an increase in outpatient use is beneficial to individuals and society. Research shows that integrating substance use and mental health treatment into people's lives is more effective than relocating people from their daily environments to inpatient facilities.[133] Outpatient visits are also much cheaper than inpatient stays.[134]

b. Emergency Service Use

People experiencing homelessness are some of the highest frequency users of emergency departments.[135] Although this higher use is partially accounted for by prevalent and severe medical, psychiatric, and substance use problems within the population,[136] being unhoused leads to greater emergency service use regardless of physical or mental health.[137] People experiencing homelessness report avoiding medical services until a crisis arises, largely because they feel labeled, stigmatized, and disrespected by health care providers. [138]

[139]

[133] *See, e.g.,* Gabrielle Glaser, *For Mark Willenbring, Substance Abuse Treatment Begins With Research*, N.Y. TIMES (Feb. 22, 2016), https://www.nytimes.com/2016/02/23/science/mark-willenbring-addiction-substance-abuse-treatment.html; ANNE M. FLETCHER, INSIDE REHAB: THE SURPRISING TRUTH ABOUT ADDICTION TREATMENT--AND HOW TO GET HELP THAT WORKS (2013).
[134] *Indiana PSH Initiative*, *supra* note 153, at 29.
[135] *See, e.g.,* Jack Tsai et al., *When Health Insurance Is Not a Factor: National Comparison of Homeless and Nonhomeless US Veterans who Use Veterans Affairs Emergency Department*, 103 AM. J. PUB. HEALTH 225, 225 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3969129/pdf/AJPH.2013.301307.pdf (finding homeless veterans were four times as likely to use emergency departments than non-homeless veterans); Brett J. Feldman et al., *Prevalence of Homelessness in the Emergency Department Setting*, 18 W. J. EMERGENCY MED. 366, 370 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5391885/ (finding between 7.5 to 18.8 percent of individuals visiting select emergency departments were experiencing homelessness or at risk of homelessness).
[136] Kinna Thakarar et al., *Predictors of Frequent Emergency Room Visits among a Homeless Population*, 10 PLOS ONE 1, 1-2 (2015), https://www.ncbi.nlm.nih.gov/pubmed/25906394.
[137] Molly M. Brown et al., *Housing First as an Effective Model for Community Stabilization Among Vulnerable Individuals with Chronic and Nonchronic Homelessness Histories*, 44 J. Community Psych. 376 (2016), https://onlinelibrary.wiley.com/doi/abs/10.1002/jcop.21763 (finding that housing reduced emergency department visits for older individuals experiencing homelessness, even when health status did not improve); Robert M. Rodriguez et al., *Food, Shelter and Safety Needs Motivating Homeless Persons' Visits to an Urban Emergency Department*, 53 ANNALS EMERGENCY MED. 598, 598 (2009), https://www.ncbi.nlm.nih.gov/pubmed/18838193 (finding people experiencing homelessness come to emergency departments for food, shelter, and safety, rather than medical care).
[138] Diane C. Martins, *Experiences of Homeless People in the Health Care Delivery System: A Descriptive Phenomenological Study*, 25 PUB. HEALTH NURSING 420, 426 (2008), https://www.ncbi.nlm.nih.gov/pubmed/18816359.
[139] *Infra* note 141.

A major issue with the high use of emergency services is the cost. High costs start with how people experiencing homelessness reach the emergency department: they are more likely to use emergency medical services and ambulances than housed individuals.[140] Once they reach the emergency department, a person experiencing homelessness is five times more likely to be admitted to the hospital than a housed person, and they stay four days longer on average.[141] This discrepancy exists because some minor conditions that can be managed while housed cannot be managed while on the street or in a shelter, so a patient experiencing homelessness requires greater inpatient recovery time than a housed individual.[142] Increased ambulance use and greater inpatient recovery time comes at a high cost.[143]

PSH significantly decreases the use of emergency medical services and ambulances.[144] One study found that every month of PSH resulted in three percent fewer emergency medical services contacts per person, suggesting PSH benefits accumulate over time.[145] Another study found an increase in transportation assistance accompanying decreased ambulance use, suggesting that the stability of PSH allows people to find more efficient means of transportation, rather than discouraging seeking treatment altogether.[146]

PSH also leads to significantly fewer and shorter emergency department visits for people experiencing homelessness.[147] PSH can decrease emergency room visits by up to 81 percent.[148] Fewer emergency department visits translates into lower costs, which can range between $1,800

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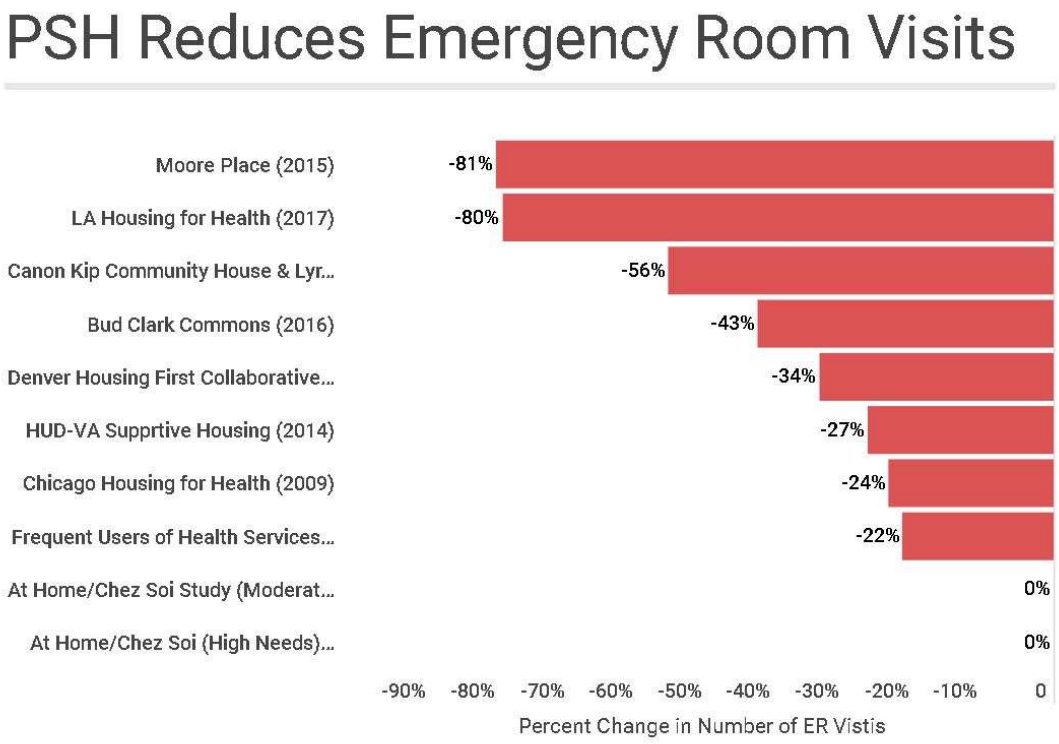
[140] Jessica L. Mackelprang et al., *Housing First Is Associated with Reduced Use of Emergency Medical Services*, 18 Prehospital Emergency Care 476, 477 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5102506.
[141] HEALTH RESEARCH & EDUCATIONAL TRUST, SOCIAL DETERMINANTS OF HEALTH SERIES: HOUSING AND THE ROLE OF HOSPITALS 6 (2017), http://www.hpoe.org/Reports-HPOE/2017/housing-role-of-hospitals.pdf.
[142] *Id*. at 9.
[143] *Id*.
[144] *See, e.g.*, Mackelprang et al., *supra* note 140, at 481 (finding chronically homeless adults with severe alcohol problems contacted ambulance services 54 percent less after 2 years in PSH); MONDELLO ET AL., RURAL, *supra* note 154, at 8 (finding PSH reduced ambulance transports by 45 percent, resulting in a 32 percent decrease in ambulance costs); MONDELLO ET AL., GREATER PORTLAND, *supra* note 128, at 6 (finding PSH reduced ambulance transports by 60 percent, resulting in a 66 percent decrease in ambulance costs).
[145] Mackelprang et al., *supra* note 140, at 481.
[146] MONDELLO ET AL., RURAL, *supra* note 154, at 9.
[147] *See, e.g.,* HUNTER ET AL., *supra* note 113, at 39; Martinez & Burt, *supra* note 119, at 992 (finding two years of PSH reduced emergency department visits by 56 percent); MONTGOMERY ET AL., *supra* note 120 (finding a 27 percent reduction in emergency department visits after one year of housing); Todd. P. Gilmer et al., *Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness*, 67 Archives Gen. Psychiatry 645, 649 (2010), https://www.ncbi.nlm.nih.gov/pubmed/20530014 (finding PSH reduced the use of emergency services by 32 percent); Debra Srebnik et al., *A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services*, 103 AM. J. PUB. HEALTH 316, 317 (2013), https://plymouthhousing.org/wp-content/uploads/2018/08/AJPH-Research-Pub-3-2013.pdf (finding emergency department use decreased by 74 percent after one year of PSH, compared to a 26 percent drop for those in the comparison group); Sadowski et al., *supra* note 111, at 1771 (finding a 24 percent reduction in emergency department visits after 18 months of PSH).
[148] M. Lori Thomas et al., MOORE PLACE PERMANENT SUPPORTIVE HOUSING EVALUATION STUDY FINAL REPORT (2015), https://www.urbanministrycenter.org/wp-content/uploads/2017/11/HFH_Moore-Place-Evaluation-Project_Final-Report_4-28-15.pdf.

per person per year[149] to almost $5,000 per person per year.[150] The graph below summarizes how PSH impacted emergency department visits in the research.



[151]

If cities provided PSH to people experiencing chronic homelessness, they would spend significantly less on emergency services *and* solve their homelessness. PSH is more effective and strategic in addressing chronic homelessness and health.

c. Quality of Life

Formerly chronically homeless individuals provided PSH experience an improved quality of life compared to homelessness as well as housing with strict treatment requirements.[152]

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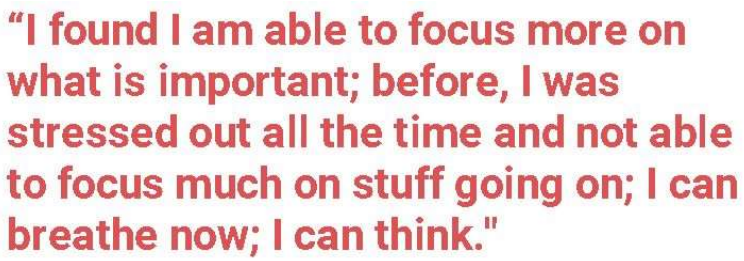
[149] DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 5 (finding $34,280 in savings for 19 participants).
[150] DANIEL FLAMING ET AL., GETTING HOME: OUTCOMES FROM HOUSING HIGH COST HOMELESS HOSPITAL PATIENTS 55 (2013), https://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf (finding $4,872 less spent on county and private emergency room visits when PSH is provided).
[151] *See infra* Appendix B for data and sources.
[152] *See, e.g.,* MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, PERMANENT SUPPORTIVE HOUSING: A SOLUTION-DRIVEN MODEL 8 (2015), https://www.mhsa.net/sites/default/files/January%202015%20HHG%20Report.pdf (finding 98 percent of PSH clients reported improved quality of life); JENNIFER PERLMAN & JOHN PARVENSKY, DENVER HOUSING FIRST COLLABORATIVE, COST BENEFIT ANALYSIS AND PROGRAM OUTCOME REPORT 2 (2006), https://shnny.org/uploads/Supportive_Housing_in_Denver.pdf (finding 64 percent of PSH clients reporting improved quality of life); Debra J. Rog et al., *Permanent Supportive Housing: Assessing the Evidence*, 65 PSYCHIATRIC SERV., 287, 287 (2014), https://www.coloradocoalition.org/sites/default/files/2017-01/287.pdf (finding consumers consistently rate PSH higher than other housing models); Leff, *supra* note 94, at 473 (finding PSH achieved the highest effect size for satisfaction).

Quality of life outcomes relate to day-to-day functioning and subjective experiences rather than service use. PSH improves quality of life by reducing exposure to domestic violence, increasing community involvement, and encouraging better relationships with family members.[153] Residents of PSH report feeling better able to work, learn, build relationships, and understand themselves.[154]



In explaining why PSH is better than shelter or street life, clients cite not having to worry about finding a place to sleep at night, being able to better prioritize tasks, and feeling less stressed, more stable, and better able to focus on life goals.[155] In comparing PSH to housing with strict rules and treatment requirements, clients point to increased autonomy inherent in PSH. One client described living in non-PSH housing: "I felt like I was in prison. I have more freedom in prison."[156] Housing with mandatory programming feels like prison because it interferes with individual choice and autonomy, which is harmful and undermines successful treatment.[157]

d. Substance Use and Detox Services

People experiencing chronic homelessness are disproportionately affected by substance use disorders.[158] Evidence overwhelmingly supports PSH as an intervention for people experiencing both homelessness and substance abuse disorders. Research shows that PSH decreases the use of detox services while it increases the use of substance abuse treatment.[159]

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[153] UNIVERSITY OF SOUTHERN INDIANA CENTER FOR APPLIED RESEARCH, IMPACT OF INDIANA PERMANENT SUPPORTIVE HOUSING INITIATIVE 2 (2013), https://www.in.gov/myihcda/files/IPSHI_Study.pdf [hereinafter *Indiana PSH Initiative*].

[154] MELANY MONDELLO ET AL., COST OF RURAL HOMELESSNESS: RURAL PERMANENT SUPPORTIVE HOUSING 14 (2009), https://www.mainehousing.org/docs/default-source/housing-reports/cost-of-rural-homelessness-5-2009.pdf?sfvrsn=af65d015_7.

[155] *Indiana PSH Initiative*, *supra* note 153, at 2.

[156] PADGETT ET AL., *supra* note 53, at 68.

[157] *See supra* note 100.

[158] David S. Morrison, *Homelessness as an Independent Risk Factor for Mortality: Results From a Retrospective Cohort Study*, 38 Int'l J. Epidemiology 877, 878 (2009), https://academic.oup.com/ije/article/38/3/877/686657.

[159] *See, e.g.*, DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 2 (finding PSH decreased detox visits by 82 percent); Srebnik et al., *supra* note 147, at 317 (finding that PSH decreased use of sobering center by 93 percent); MONDELLO ET AL., GREATER PORTLAND, *supra* note 128, at 9 (finding PSH increased substance abuse treatment by 22 percent).

There is no evidence that PSH increases substance use, although some studies show no change.[160] Some research suggests that PSH may decrease substance use.[161]

What is clear is that PSH significantly increases engagement in substance abuse treatment, while decreasing use of detoxification services, resulting in estimated cost savings of $8,732 per person over two years.[162]

2. Criminal Justice

People experiencing homelessness interact frequently with the criminal social justice system, largely because many cities are criminalizing homelessness to cope with growing unsheltered populations.[163] PSH's criminal justice benefits are two-fold: PSH (1) decreases costs accrued from costly criminalization ordinances and (2) reduces individual arrests and incarcerations.

Unsheltered people are disproportionately impacted by a range of laws that penalize the conduct of life-sustaining activities in public,[164] even when they have no reasonable alternative because they are homeless. Ordinances that prohibit loitering in public spaces, panhandling, camping in public places, residing in vehicles, storing personal property in public, and urinating in public effectively make homelessness illegal.[165] Police officers spend precious resources engaging with unsheltered people, asking them to move along, writing tickets, or arresting people for violating these ordinances.[166] Half of all 2017 arrests in Portland, Oregon, were of a

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[160] *See, e.g.*, Telephone Interview with Susan E. Collins, Director, The Harm Reduction Research and Treatment (HaRRT) Center (Nov. 5, 2018) (saying "we have never found evidence of an enabling effect from harm reduction"); Robert A. Rosenheck et al., *Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness*, 60 ARCHIVES OF GEN. PSYCHIATRY 940, 940 (2003), https://www.ncbi.nlm.nih.gov/pubmed/12963676 (finding PSH caused no change in substance abuse status); Aubry et al., *A Multiple-City RCT*, *supra* note 111, at 278 (finding no difference in substance use between PSH and control groups).

[161] *See, e.g.*, NATIONAL CENTER ON FAMILY HOMELESSNESS, THE MINNESOTA SUPPORTIVE HOUSING AND MANAGED CARE PILOT: EVALUATION SUMMARY 12 (2009) (finding that PSH decreased resident's average number of days drinking or using substances to intoxication by a third); Mary E. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 J. AM. MED. ASS'N 1349, 1354-55 (2009), https://www.ncbi.nlm.nih.gov/pubmed/19336710 (finding PSH decreased number of days residents spent intoxicated and average number of drinks residents had per day); DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 2 (finding 15 percent of PSH recipients decreased their substance use).

[162] DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 2.

[163] Josh Howard & David Tran, Seattle University Homeless Rights Advocacy Project, AT WHAT COST: THE MINIMUM COST OF CRIMINALIZING HOMELESSNESS IN SEATTLE & SPOKANE (Sara K. Rankin ed. 2015), http://ssrn.com/abstract=2602530.

[164] *See, e.g.,* Rankin, *The Influence of Exile*, *supra* note 19, at 40-41; Rankin, *Punishing Homelessness*, *supra* note 29, at 18.

[165] Justin Olson & Scott MacDonald, Seattle University Homeless Rights Advocacy Project, WASHINGTON'S WAR ON THE VISIBLY POOR: A SURVEY OF CRIMINALIZING ORDINANCES & THEIR ENFORCEMENT (Sara Rankin ed., 2015), https://ssrn.com/abstract=2602318.

[166] Howard & Tran, *supra* note 163, at 5.

person experiencing homelessness,[167] and one in five people booked into jail in Seattle, Washington, are experiencing homelessness.[168] Costs do not end with the police, however, as those citations carry with them adjudication costs required to resolve and handle violations.[169] No study has attempted to monetize the full range of costs generated as a result of police engagement with unsheltered people.

But criminalization ordinances are expensive. For example, in just five years the city of Seattle spent over $2.3 million enforcing only 16 percent of its criminalization statutes, while the city of Spokane, Washington, spent $1.3 million enforcing 75 percent of its criminalization statutes.[170] The other 84 and 25 percent of costs could not be measured due to limitations in data availability, so these costs are severely underreported.[171] Boulder, Colorado spends at least $1.8 million per year enforcing anti-homelessness ordinances.[172] If people received PSH rather than citations, millions of dollars would be saved. The precious and overtaxed resources of the criminal justice system could be reallocated to properly prioritize serious crimes.

No study has attempted to monetize the full range of costs generated as a result of police engagement with unsheltered people.

PSH also decreases the frequency at which formerly homeless people are arrested and reduces the time they spend in jail or prison.[173] Other research shows people provided PSH spend less time incarcerated than they would have without housing. For example, PSH reduces the number of days spent in jail by between 38[174] and 62 percent[175] and the number of days spent in prison by 84.8 percent.[176] Incarceration days generally declined by 76 percent.[177] One study found PSH increased time spent incarcerated, but that increase was potentially attributable to a

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[167] Rebecca Woolington & Melissa Lewis, *Portland Homeless Accounted for Majority of Police Arrests in 2017, Analysis Finds*, OREGONIAN, Jun. 27, 2018, https://www.oregonlive.com/portland/2018/06/portland_homeless_accounted_fo.html.
[168] David Kroman, *In Seattle, 1 in 5 People Booked into Jail are Homeless*, Crosscut (Feb. 19, 2019), https://crosscut.com/2019/02/seattle-1-5-people-booked-jail-are-homeless.
[169] Howard & Tran, *supra* note 163, at 4.
[170] *Id*. at iii.
[171] *Id*.
[172] Nantiya Ruan et al., Sturm College of Law Homeless Rights Advocacy Project, TOO HIGH A PRICE 2: MOVE ON TO WHERE? 12 (2018), https://ssrn.com/abstract=3174780.
[173] *See, e.g.*, Jocelyn Fontaine et al., Urban Institute, SUPPORTIVE HOUSING FOR RETURNING PRISONERS: OUTCOMES AND IMPACTS OF THE RETURNING HOME OHIO PILOT PROJECT (2012), https://www.csh.org/resources/supportive-housing-for-returning-prisoners-outcomes-and-impacts-of-the-returning-home-ohio-pilot-project/ (finding formerly incarcerated individuals provided PSH were 40 percent less likely to be rearrested and 61 percent less likely to be reincarcerated); Seema L. Clifasefi et al., *Exposure to Project-Based Housing First is Associated with Reduced Jail Time and Bookings*, 24 INT'L J. DRUG POL'Y 291, 291 (finding time spent in Housing predicted significant decreases in days in jail and jail bookings).
[174] Culhane et al., *supra* note 51, at 133.
[175] MONDELLO ET AL., GREATER PORTLAND, *supra* note 128, at 6.
[176] Culhane et al., *supra* note 51, at 130.
[177] DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 2.

change in local law.[178] Further, incarceration times were muted during the pre-housing year, as participants had to be living in the community, not jail or prison, to qualify for the program.[179] And because studies with encouraging results also did not recruit from jails or prisons, those studies may *underestimate* PSH's impact on time spent incarcerated.[180]

The cost of reduced incarcerations can translate into savings of between $1,400[181] and $1,800[182] per person per year. Even these estimations do not account for all the considerable costs associated with arrest, adjudication, or post-release probation or parole.

If people were given PSH rather than citations, millions of dollars would be saved.

Providing PSH would save millions in law enforcement costs and resources. And unlike the typical rotating door of the criminal justice system where people emerge more likely to remain homeless, PSH ends their homelessness. This result benefits not only unsheltered people, but society overall.

3. Visible Blight

Most individuals experiencing chronic homelessness are unsheltered, and thus disproportionately represented on the streets.[183] Unfortunately, visible homelessness near businesses can reduce consumer traffic and hurt local commerce.[184]

In response, cities spend significant funds to physically remove homeless individuals and their property from public spaces.[185] For example, in 2017, Seattle spent $10 million in sweeps, and the city was on track to *double* that spending in 2018.[186] Los Angeles is following a similar

[178] HUNTER ET AL., *supra* note 113, at 39 (stating a new local law made incarceration more likely for specific crimes).
[179] *Id*.
[180] *See, e.g.*, Culhane, *supra* note 51, at 109 ("to be eligible for this housing, tenants must have a diagnosis of SMI and have been recently homeless in shelters or on the streets"); DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 5.
[181] MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, *supra* note 152, at 11.
[182] N.Y.C. DEP'T HEALTH AND MENTAL HYGIENE, NEW YORK/NEW YORK III SUPPORTIVE HOUSING EVALUATION: INTERIM UTILIZATION AND COST ANALYSIS 1 (2013), https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf.
[183] *2018 Point in Time*, supra note 1, at 2.
[184] ROBERT EYLER, THE IMPORTANCE OF COTS TO PETALUMA'S BUSINESSES: AN ECONOMIC IMPACT STUDY OF LOCAL BUSINESSES AND THE HOMELESS (2012).
[185] Rankin, *supra* note 12, at 20.
[186] *Id*.

trend: the Los Angeles Bureau of Sanitation sought $17 million for homeless sweeps in 2018, double what it spent in 2017.[187] In 2019, Lost Angeles will spend $30 million on sweeps.[188]

Sweeps are temporary and ineffective responses to chronic homelessness because people affected by homeless sweeps have nowhere to go. After a sweep is conducted, people often return to the same spot to restart destroyed encampments.[189] Sweeps are shown to negatively impact unsheltered people,[190] who frequently lose vital items such as medication and identification, further entrenching their homelessness.[191] Thus, sweeps are a costly rotating door. PSH is a permanent solution that moves unsheltered individuals off the streets and into housing.

III. THE COST-EFFECTIVENESS OF PERMANENT SUPPORTIVE HOUSING

Inspired by PSH's effectiveness and potential cost savings, many cities across the country use PSH as an intervention for those experiencing chronic homelessness, including Seattle, Washington; Chicago, Illinois; and Los Angeles, California.[192] Through strategic and sufficient deployment of PSH, three cities have reached "functional zero" on chronic homelessness,[193] meaning the number of people experiencing chronic homelessness is less than or equal to the number of housing placements monthly.[194] While the success of these cities is promising, no city has yet to implement PSH to scale, leaving tens of thousands of people experiencing long-term homelessness with disabling conditions out in the cold.[195]

Research shows PSH costs the same or substantially less than leaving people homeless, and only PSH ends their homelessness. No studies found an increase in social service costs associated with PSH,[196] and the cost savings resulting from PSH often exceed the cost of providing PSH.[197] Moreover, no study assesses all or even most of the cost drivers associated

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[187] Dakota Smith, *LA Wants More Money for Homeless Encampment Sweeps*, L.A. TIMES (Feb. 21, 2018), http://www.latimes.com/local/lanow/la-me-ln-homeless-clean-backlog-20180221-story.html.
[188] Matt Tinoco, *LA Will Spend $30M This Year On Homeless Sweeps. Do They Even Work?*, LAIST (Apr. 10, 2019), https://laist.com/2019/04/10/homeless_sweeps_los_angeles_public_health.php.
[189] Chris Herring et al., *Persuasive Penalty: How the Criminalization of Poverty Perpetuates Homelessness*, SOC. PROBS., Mar. 2019, at 1, https://doi.org/10.1093/socpro/spz004.
[190] Junejo et al., NO REST FOR THE WEARY, *supra* note, at 18.
[191] *Id*. at 17; TENT CITY, USA: THE GROWTH OF AMERICA'S HOMELESS ENCAMPMENTS AND HOW COMMUNITIES ARE RESPONDING, NATIONAL LAW CENTER ON HOMELESSNESS & POVERTY 9 (2017), https://nlchp.org//wp-content/uploads/2018/10/Tent_City_USA_2017.pdf.
[192] PADGETT ET AL., *supra* note 53, at 1.
[193] These cities are Bergen County, NJ; Lancaster, PA; and Rockford, IL. COMMUNITY SOLUTIONS, BUILT FOR ZERO: SUCCESSES, https://www.community.solutions/what-we-do/built-for-zero (last visited July 6, 2019).
[194] COMMUNITY SOLUTIONS, COMMUNITY LEVEL METRICS ON ENDING HOMELESSNESS AMONG VETERANS (2016), https://www.community.solutions/sites/default/files/final_zero_2016_metrics.pdf.
[195] *See, e.g.,* SACRAMENTO REGIONAL COALITION TO END HOMELESSNESS, HOMELESSNESS & "FUNCTIONAL ZERO": A CRITIQUE (2015), http://nationalhomeless.org/wp-content/uploads/2016/10/Homelessness-and-Functional-Zero_A-Critique.pdf; INSTITUTE FOR CHILDREN, POVERTY & HOMELESSNESS, *supra* note 80.
[196] *See, infra* Appendix A.
[197] *See, e.g.*, Flaming, *Getting Home*, *supra* note 150, at 3 (finding net savings of $31,736 per person per year after accounting for program costs); Larimer et al., *supra* note 161, at 1353-54 (finding net savings of $2,449 per person per month after accounting for program costs, or $29,388 per person per year); Srebnik et al., supra note 147, at 316 (finding yearly gross savings of $36,579 per person per year, compared to yearly program costs of $18,600 per person per year, or net savings of $17,979); Joshua D. Bamberger & Sarah K. Dobbins, *A Research Note: Long-*

with leaving people unsheltered, including but not limited to sweeps, first responders, emergency room visits, hospital stays, psychiatric commitments, outreach workers, lost business, city services, environmental hazards, police time, courts, jail and prison time, probation, lost economic productivity, and the psychological and emotional tolls on homeless people and the surrounding community. So, while existing studies already establish PSH as the most cost-effective solution to chronic homelessness, these studies also vastly underestimate its impact.

PSH costs the same or substantially less than leaving people homeless.

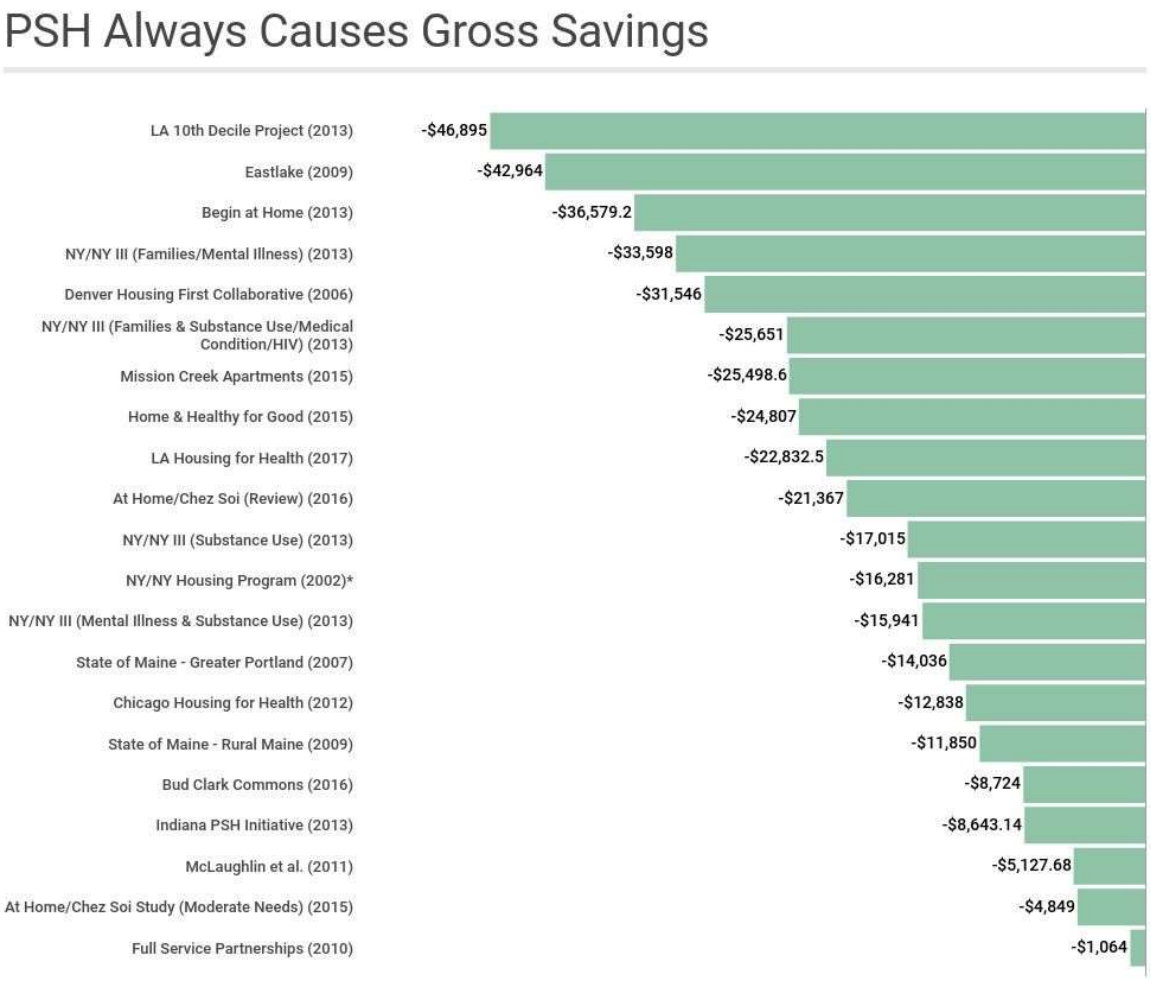
This section explores why PSH is cost-effective. First, it explains the gross and net cost savings that results from PSH. Second, it reiterates the variety of ways PSH saves the public money and explains how research both succeeds and fails to capture those savings. Third, it considers the high public service use of those experiencing chronic homelessness. Fourth, it explores the role of PSH in addressing the needs of a changing homeless population. Fifth, it addresses the need for diverse approaches to studying the cost-effectiveness of PSH. Last, it highlights the effectiveness of PSH as an intervention to chronic homelessness.

A. Gross and Net Savings

PSH causes gross and net savings when provided to people experiencing chronic homelessness. Gross savings capture the total costs saved by housing. Net savings subtract the cost of PSH from gross savings. For example, if a person experiencing chronic homelessness incurred $60,000 in medical and criminal justice costs the year before PSH and $30,000 the year after PSH, gross savings would be $30,000. If the cost of providing PSH for one year was $10,000, net savings would be $20,000.

Term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing, 17 CITYSCAPE 269, 273 (2015), https://www.jstor.org/stable/26326949 (finding approximately half a million dollars in annual savings for 51 PSH participants after accounting for program costs); Anirban Basu et al., *Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care*, 47 HEALTH SERV. RES. 523, 534 (2012), https://www.ncbi.nlm.nih.gov/pubmed/22098257 (finding net savings of $9,809 per person per year after accounting for program costs); MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, *supra* note 152, at 11 (finding net savings of $9,339 per person per year after accounting for program costs); HUNTER ET AL., *supra* note 113, at 41 (finding net savings of $7,688 per person per year after accounting for program costs); N.Y.C. Dep't Health and Mental Hygiene, *supra* note 182, at 13, 17 (finding net savings of $878 and $7,611 per person per year after accounting for program costs for two cohorts); DENVER HOUSING FIRST COLLABORATIVE, *supra* note 152, at 11 (finding net savings of $4,745 per person per year after accounting for program costs); MONDELLO ET AL., RURAL, supra note 154, at 2 (finding net savings of $1,348 per person per six months after accounting for program costs, or $2,696 per person per year); Thomas C. McLaughlin et al., *Using Common Themes: Cost-Effectiveness of Permanent Supported Housing for People With Mental Illness*, 21 RES. SOC. WORK PRACTICE 404, 408 (2011), https://journals.sagepub.com/doi/10.1177/1049731510387307 (finding net savings of $2,182 per person per year after accounting for program costs); *Indiana PSH Initiative*, *supra* note 153, at 1 (finding net savings of $1,149 per person per year after accounting for program costs); MONDELLO ET AL., GREATER PORTLAND, *supra* note 128, at 2 (finding net savings of $944 per person per year after accounting for program costs).

When provided to people experiencing chronic homelessness, PSH *always* results in gross savings.[198] Housing and supportive services reduce the amount of money spent on physical health, mental health, and criminal justice. Gross savings can exceed $46,000 per person per year.[199] The following graph summarizes gross savings found in the research.



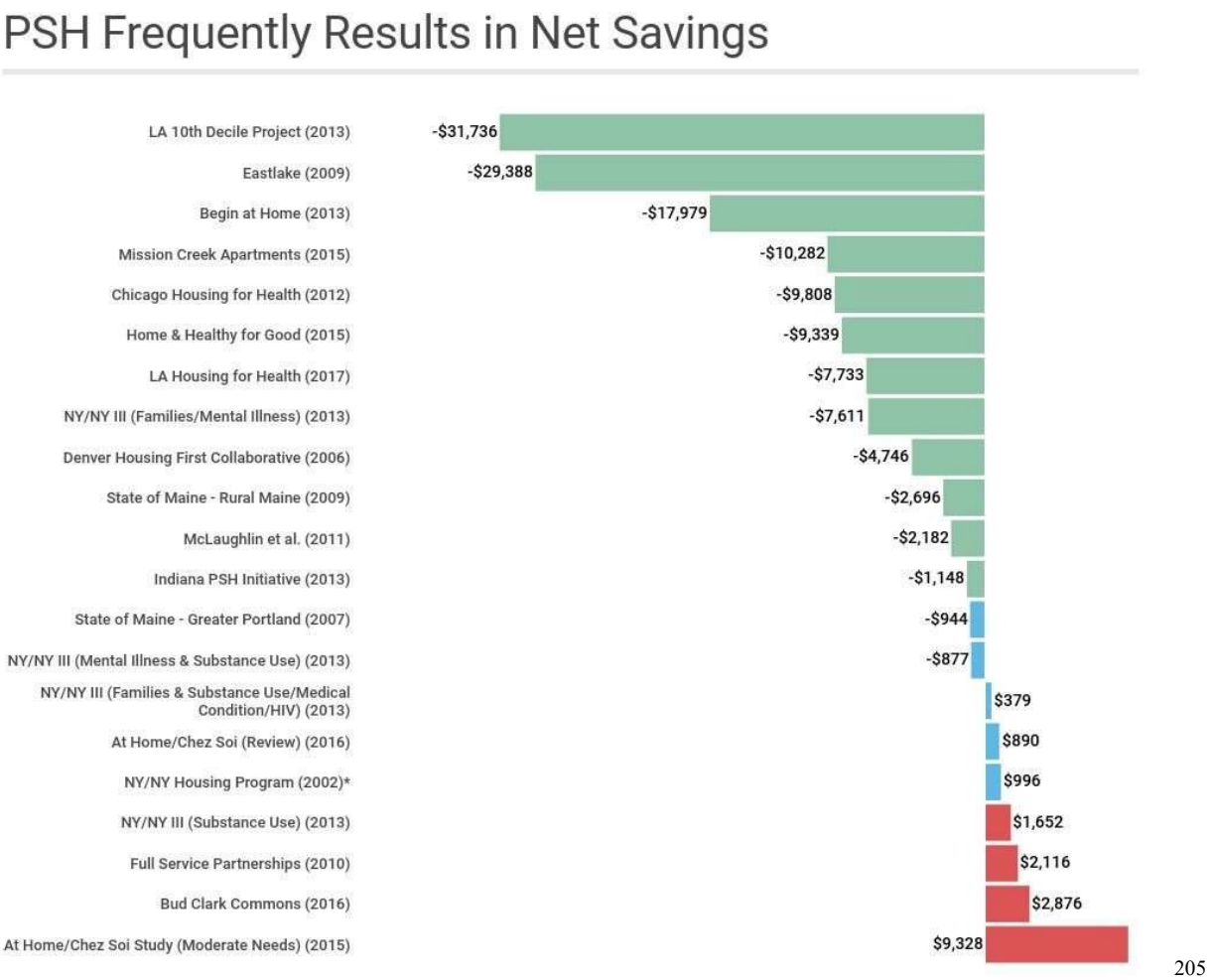
[200]

This graph demonstrates how much money society wastes every year by not housing people experiencing chronic homelessness. The above dollar amounts represent preventable emergency room visits, unnecessarily long hospital stays, wasted police time, coerced substance abuse treatment, and needless pain. Instead of spending thousands of dollars leaving people with disabling conditions to suffer on the streets and in shelters, cities should invest in PSH.

Many studies found that when we make such an investment, net savings result after factoring in the cost of housing and services.[201] This means that PSH saves society money

[198] *See infra* Appendix B.
[199] FLAMING, *supra* note 133, at 31.
[200] *See infra* Appendix B for data and sources.
[201] *See infra* Appendix B.

overall. For example, in the Los Angeles 10th Decile Project, gross savings of $46,895 per person per year far outweighed the $15,159 spent on housing and services during the first year:[202] net savings totaled $31,736 per person for the first year of housing.[203] Subsequent years of housing produce even greater savings, because one-time expenditures such as staff training and screenings are no longer required: net savings total $40,377 per person per year after the first year of housing.[204] The graph below summarizes findings related to net savings.



[205]

This graph shows that providing PSH to those experiencing chronic homelessness is a desirable economic policy because PSH savings so frequently offset its costs. Most studies found net savings of well over $1,000 per person per year, while only four found net increases of more than $1,000 per person per year. Indeed, the study with the largest cost increase was conducted

[202] *Id*. at 34; *See infra* Appendix B.
[203] *Id*.
[204] *Id*.
[205] *See infra* Appendix B for data and sources.

in Canada, where health care costs are cheaper than in the United States,[206] which may obscure cost savings as translated to the United States..

B. Sources of Cost Savings

Potential cost savings from PSH are numerous because homelessness impacts so many aspects of a person's life. The previous sections reviewed several potential sources of cost savings resulting from decreased inpatient medical hospitalizations, inpatient psychiatric hospitalizations, arrests, incarcerations, adjudications, post-release services, and sweeps. PSH also results in reduced use of shelters, emergency medical services, emergency departments, and detox services.

No study accounts for all or even most of these and other savings. Therefore, studies finding significant financial benefits from PSH underestimate the true savings.

C. Highest-Service Users

Targeting PSH to high-service users results in the most dramatic cost savings. Of those experiencing chronic homelessness, some have conditions that are disproportionately costly. The potential for savings is exemplified by the story of Million Dollar Murray, a Nevada man who suffered from alcohol addiction and used over $1 million in public services in a ten-year span before moving into PSH.[207] By prioritizing high-service users like Million Dollar Murray, non-profits and governmental agencies can maximize the impact of PSH.

A Seattle study found cost savings of $29,388 per person per year *after* accounting for the cost of housing and services.

On a wider scale, a Seattle study focused on people experiencing chronic homelessness "who incurred the highest total costs in 2004 for use of alcohol-related hospital emergency services, the sobering center, and King County jail" found net savings of $29,388 per person per year *after* accounting for the cost of housing and services.[208] Another study conducted in Seattle focused on high-service users found net savings of $17,979 per person per year.[209] The Seattle study findings are illustrated in the graph below.

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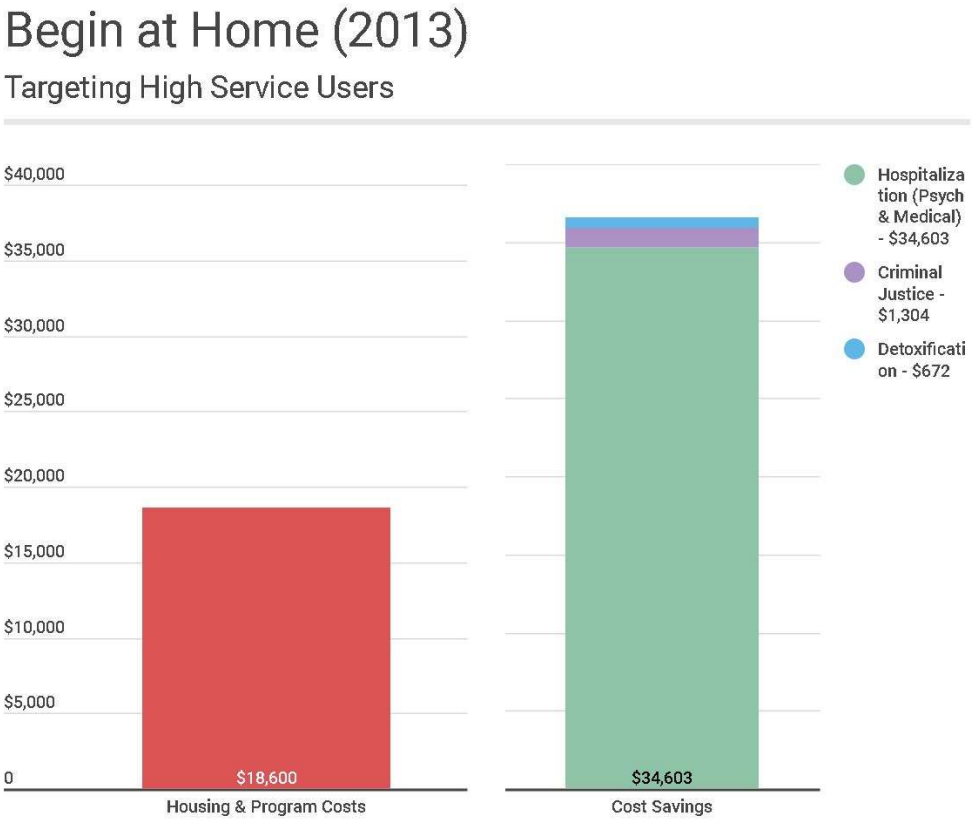
[206] RABAH KAMAL & CYNTHIA COX, KAISER FAMILY FOUNDATION, HOW DO HEALTHCARE PRICES AND USE IN THE U.S. COMPARE TO OTHER COUNTRIES? (2018), https://www.healthsystemtracker.org/chart-collection/how-do-healthcare-prices-and-use-in-the-u-s-compare-to-other-countries.
[207] Malcolm Gladwell, *Million Dollar Murray*, NEW YORKER, Feb. 5, 2006, https://www.newyorker.com/magazine/2006/02/13/million-dollar-murray.
[208] Larimer et al., *supra* note 161, at 1353-54.
[209] Srebnik et al., *supra* note 147, at 316.

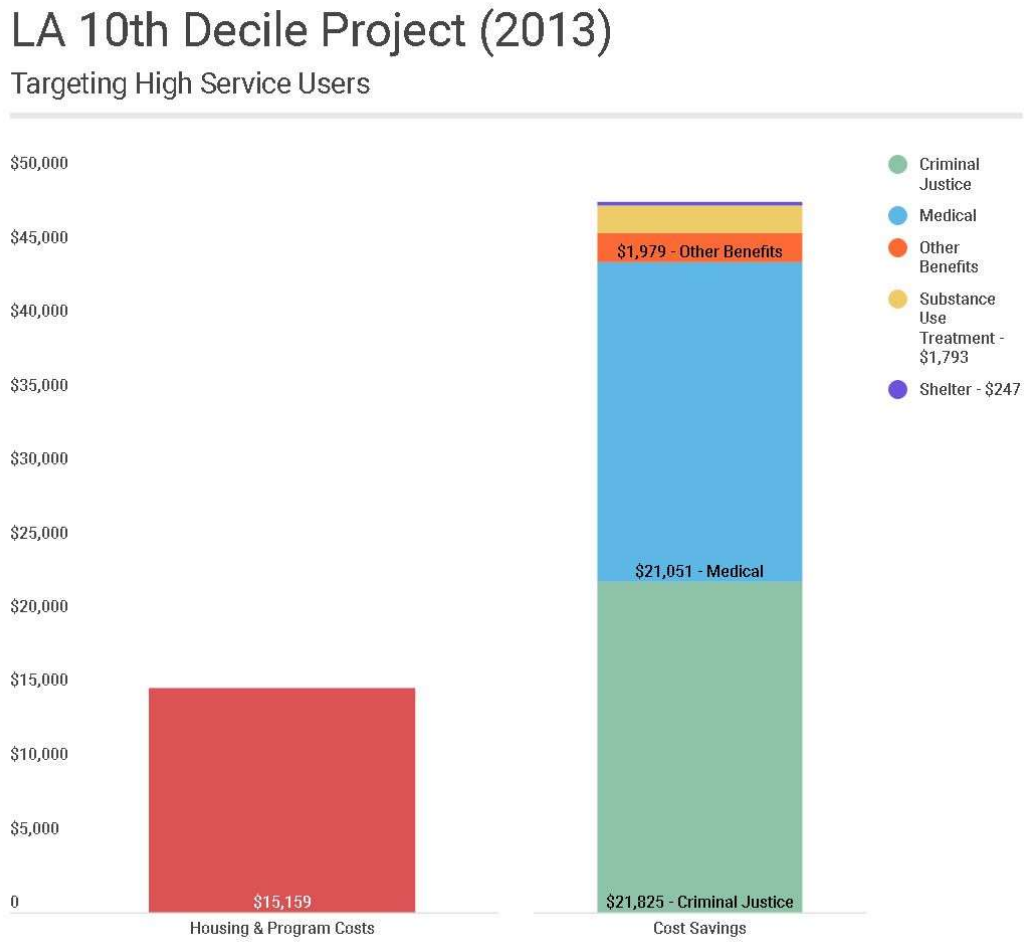


[210]

The graph above shows how savings from avoiding hospitalization, detoxification, and criminal justice engagement more than offset the costs of PSH.

Similarly, a Los Angeles study focused on the 10 percent of homeless hospital patients with the highest public and hospital costs found net savings of $31,736 per person per year.[211] Those net savings are visualized below.

[210] *See infra* Appendix B for data and sources.
[211] Flaming, *supra* note 133, at 34.



[212]

The graph above shows how gross savings from criminal justice, medical, substance use, shelter, and other benefits more than offset PSH programs and costs and housing, resulting in net savings. And because the first year of PSH involves one-time costs for temporary housing, training, screening, and move-in, those net savings increased to $40,377 for following years.[213]

By front-loading investments in PSH, cities can free up large sums of money for more effective investment in other social services.

D. A Changing Homeless Population

Two major trends in the composition of the homelessness population make PSH even more promising than current research can capture: the average age, and associated needs, of single adults experiencing homelessness increases,[214] while the growing number of children and families experiencing homelessness feeds a steady pipeline into chronic homelessness.[215]

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[212] *See infra* Appendix B for data and sources.
[213] *Id*. at 33-34.
[214] Dennis P. Culhane et al., *The Age Structure of Contemporary Homelessness: Evidence and Implications for Public Policy*, 13 Analyses Soc. Issues Pub. Pol'y 228, 228 (2013), https://doi.org/10.1111/asap.12004.
[215] While the Point in Time Count found a decrease in children experiencing homelessness, 2018 ANNUAL HOMELESS ASSESSMENT REPORT TO CONGRESS , *supra* note 14, at 34, the U.S. Department of Education has noted a

First, older people are a growing segment of the homeless population. Single adults most at risk for homelessness were born at the end of the Baby Boomer generation, so the average age of single adults within the homeless population has increased over time, from age 34-36 in 1990, to age 37-42 in 2000, and age 49-51 in 2010.[216] For people experiencing homelessness, the average age at death is 56 years old for men and 52 years old for women.[217] Nearly half of all elderly people experiencing homelessness became homeless after age 50.[218] As an increasing number of people approach the end of their lives while living on the street, medical needs and associated costs will increase.[219] Considering that medical costs are the largest component of expenses related to chronic homelessness and many costs avoided with PSH are medical,[220] an aging homeless population makes PSH even more promising.

One San Francisco study found providing PSH to just 51 elderly residents saved the public $500,000 per year.

Few PSH cost-effectiveness studies account for the growth of older people becoming homeless, but those that do find cost savings.[221] For example, a study conducted in San Francisco involving 51 elderly individuals who experienced chronic homelessness before entering PSH, found that PSH saved the public $500,000 per year, after accounting for housing costs.[222] Incredibly, researchers calculated these savings looking only at three sources of cost savings: emergency department visits, inpatient hospital stays, and skilled nursing facility use.[223] The study does not account for other savings, such as decreased mental health, shelter, detox, and criminal justice costs.

Second, the considerable number of children experiencing homelessness face an increased chance of becoming chronically homeless as adults. During the 2016-2017 school year, nearly 1.4 million schoolchildren were experiencing homelessness, a 7 percent increase from 2014-2015.[224] Children experiencing homelessness incur social costs during adulthood as well as

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steady increase: FEDERAL DATA SUMMARY SCHOOL YEARS 2014-15 TO 2016-17, NATIONAL CENTER FOR HOMELESS EDUCATION 9 (2019), https://nche.ed.gov/wp-content/uploads/2019/02/Federal-Data-Summary-SY-14.15-to-16.17-Final-Published-2.12.19.pdf; INSTITUTE FOR CHILDREN, POVERTY, AND HOMELESSNESS, *supra* note 80, at 1. The U.S. Department of Education is better able to measure student homelessness because its methodology is not limited to shelters, transitional housing, and people seen during counts, *The Pitfalls of HUD's Point-in-Time Count*, SCHOOL HOUSE CONNECTION (Jan. 11, 2019), https://www.schoolhouseconnection.org/the-pitfalls-of-huds-point-in-time-count.

[216] Culhane et al., *Age*, *supra* note 214, at 8-9.

[217] Romaszko et al., *supra* note 33, at 8.

[218] Rebecca T. Brown et al., *Pathways to Homelessness among Older Homeless Adults: Results from the HOPE HOME Study*, 11 PLoS One 1, 7 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4862628.

[219] Telephone Interview with Dennis P. Culhane, Professor, University of Pennsylvania (Oct. 16, 2018).

[220] PADGETT ET AL., *supra* note 53, at 112

[221] Dennis P. Culhane Interview, *supra* note 219.

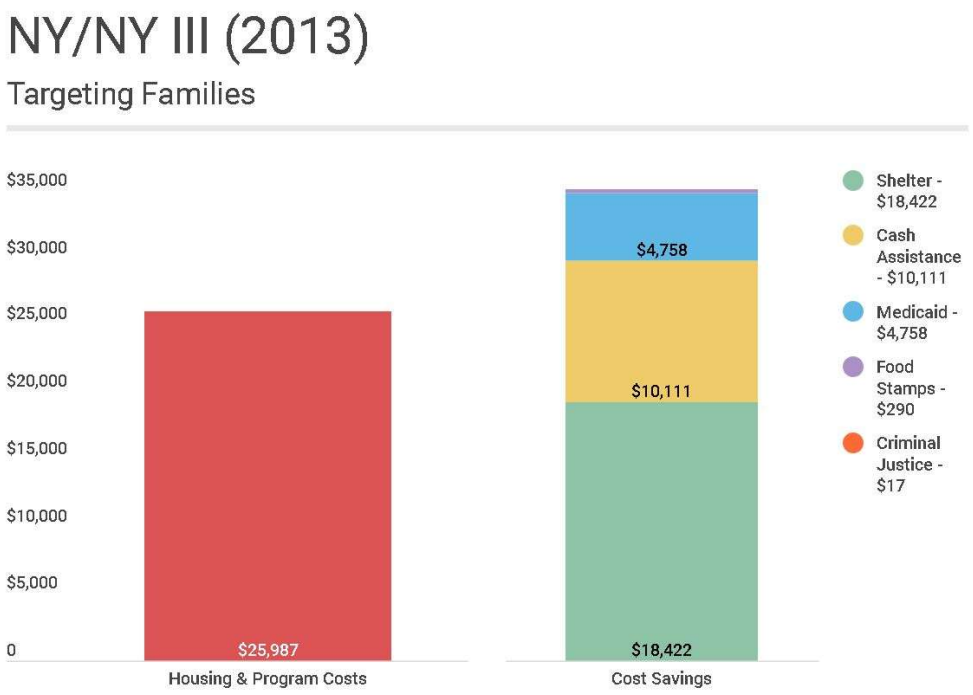
[222] Bamberger & Dobbins, *supra* note 197, at 273.

[223] *Id*. at 271.

[224] INSTITUTE FOR CHILDREN, POVERTY, AND HOMELESSNESS, *supra* note 80, at 1.

childhood. When homeless youth are not provided the support needed to become thriving adults, such as housing, they require more costly supportive services as adults and contribute less economic productivity.[225] Students experiencing homelessness are more likely to miss school, less likely to be proficient in academic subjects, and more likely to be subject to disciplinary action.[226] Poor educational outcomes translate into poor employment outcomes.[227] A group of 1,400 youth could cost almost $900 million dollars over their lifetime.[228]

Research on PSH for families experiencing homelessness is promising. Providing PSH to homeless families is less expensive than leaving them homeless, even when comparable groups of single adults result in increased costs.[229] Providing PSH to families can net up to $7,600 per family per year in savings compared to leaving families homeless;[230] these savings can be seen in the graph below. One study found a negligible net cost increase for families,[231] but it did not take into account the intergenerational costs that result from leaving children homeless and impoverished.[232]



[233]

[225] Steven S. Foldes & Andrea Lubov, YouthLink, THE ECONOMIC BURDEN OF YOUTH EXPERIENCING HOMELESSNESS AND THE FINANCIAL CASE FOR INVESTING IN INTERVENTIONS TO CHANGE PEOPLES' LIVES 6-7 (2015), https://www.youthlinkmn.org/the-cost-of-homelessness.
[226] FEDERAL DATA SUMMARY SCHOOL YEARS 2014-15 TO 2016-17, *supra* note 215, at 9.
[227] *Id*. at 6.
[228] Foldes & Lubov, *supra* note 225, at 45.
[229] NATIONAL CENTER ON FAMILY HOMELESSNESS, *supra* note 161, at 17.
[230] N.Y.C. DEP'T HEALTH AND MENTAL HYGIENE, *supra* note 182, at 17.
[231] *Id*. at 18.
[232] Foldes & Lubov, *supra* note 225, at 45.
[233] *See infra* Appendix B for data and sources.

The prior graph shows how gross savings from shelter, cash assistance, Medicaid, food stamps, and criminal justice exceeded the PSH costs, resulting in net savings. And because this figure does not consider intergenerational savings that accrue when families are housed, even these net savings are an under-estimation. When cities invest in housing families, they invest in cost savings that will benefit society for generations.

E. Diverse Research

Some criticisms of PSH argue that it is not truly cost-effective. Again, these criticisms are short-sighted. This brief already discussed two major responses. First, no study evaluates most or even all the logical costs associated with chronic homelessness, so the studies collectively underestimate the savings from PSH. Second, criticisms of PSH typically focus on net savings and may ignore the gross savings that are always present. Finally, these critiques are also problematic because they value randomized controlled trials over all other research.[234]

Randomized controlled trials concerning PSH are frequently inappropriate for several reasons.[235] First, randomized controlled trials randomly divide participants into separate groups, each receiving different interventions.[236] The success of each intervention is determined by comparing the groups' outcomes. Generally, randomized controlled trials are the "gold standard" in research because they are assumed to reduce bias and confounding factors through randomization, blinding, and clearly defined study populations.[237] Those assumptions can lead the scientific community to value randomized controlled trials over studies with pretest-posttest designs.[238]

While randomized controlled trials have strengths, they also suffer from significant limitations.[239] Notably, in the context of PSH, randomized controlled trials are often impractical or unethical to implement because the research involves complex, vulnerable humans.[240] Because homelessness is so damaging,[241] it is inhumane to deprive a person experiencing chronic homelessness of housing that is otherwise available to them for the sole purpose of creating a control group for a randomized controlled study. Additionally, many service providers lack the funds and capacity to design and implement highly complex randomized controlled trials.[242] As such, randomized controlled trials assessing the cost-effectiveness of PSH are sparse, and the results are mixed.[243]

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[234] *See, e.g.*, *NASE Report*, *supra* note 108, at 6-7.
[235] The three study designs most frequent in PSH research are randomized controlled trials, pretest-posttest with control, and pretest-posttest without control.
[236] Aubry et al., *A Multiple-City RCT*, *supra* note 111, at 276.
[237] Maria Kabisch et al., *Randomized Controlled Trials*, 108 DEUTSCHES ÄRZTEBLATT INT'L 663, 664 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196997.
[238] *Id*. at 666.
[239] *See, e.g.*, Interview with Daniel Malone, Executive Director, Downtown Emergency Service Center (Oct. 18, 2018); PADGETT ET AL., *supra* note 53, at 49.
[240] *See, e.g.*, Daniel Malone Interview, *supra* note 239; PADGETT ET AL., *supra* note 53, at 49.
[241] *See infra* Part I.
[242] Daniel Malone Interview, *supra* note 239.
[243] *See NASE Report*, *supra* note 108, at 73, which reports the net cost per person for the two randomized controlled trials it identified as -$6,875 and +$3,093 in 2015 dollars.

Second, better options, such as pretest-posttest studies exist. Pretest-posttest studies with control groups function like randomized controlled trials, except participants are divided non-randomly.[244] Pretest-posttest studies without control groups involve a single group receiving an intervention and a comparison of their outcomes before and after the intervention.[245] Non-random division of groups and single-group designs avoid the ethical issues that plague randomized controlled trials; they also better match work done by service providers because service providers do not randomly provide their services and often do research retroactively, which makes random division impossible.[246] Research on the cost-effectiveness of PSH is overwhelmingly done with pretest-posttest designs because they are flexible enough to test "natural experiments" on PSH happening across the country.[247] And the results are positive.[248]

Knowledge gained through research is cumulative, and each study should build upon the one before it.[249] To avoid becoming "wrapped up in the conceits of science," evidence should be considered collectively.[250] The overwhelming weight of the evidence proves that PSH is the most humane and cost-effective solution to chronic homelessness.

F. The Big Picture: Effectiveness

Cost-effectiveness is as much about "effectiveness" as it is about "cost." The cost savings resulting from PSH are powerful indicators of the value of PSH over traditional approaches but the economic value of PSH should not distract from its *effectiveness*. The real value of PSH should not be reduced to financial terms; instead, PSH is about prioritizing interventions that work.

Even the minority of studies that find net increases in costs after providing PSH are still glowing endorsements of PSH.[251] PSH improves the housing stability[252] and health[253] of those

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[244] Anthony D. Harris et al., *The Use and Interpretation of Quasi-Experimental Studies in Medical Informatics*, 13 J. AM. MED. INFO. ASS'N 16, 20 (2006), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1380192.
[245] Guido Alessandri et al., *Evaluating Intervention Programs with a Pretest-Posttest Design: A Structural Equation Modeling Approach*, 8 Frontiers Psych. 1, 1-2 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5332425.
[246] Daniel Malone Interview, *supra* note 239.
[247] *See, e.g.,* Daniel Malone; PADGETT ET AL., *supra* note 53, at 49.
[248] *NASE Report*, *supra* note 108, at 73, reports the net cost per person as -$33,502, -$19,777, -$2,575, +$250, and +$1,414 in 2015 dollars for studies with pretest-posttest designs.
[249] *See, e.g.,* David Faraoni & Simon Thomas Schaefer, *Randomized Controlled Trials vs. Observational Studies: Why Not Just Live Together?*, 16 BMC Anesthesiol 102 (2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5073487 (finding that assessing key elements of study design is as important as considering whether the study is a randomized control trial or observational study); Angus Deaton & Nancy Cartwright, *Understanding and Misunderstanding Randomized Controlled Trials*, 210 Soc. Sci. and Med. 2, 11 (2018), https://www.sciencedirect.com/science/article/pii/S0277953617307359 (finding randomized controlled trial results are "weak ground" for inferring what interventions are effective because the "best method depends on hypothesis tested, what's known, and cost of mistakes").
[250] Daniel Malone Interview, *supra* note 239.
[251] *See, e.g.*, Stergiopoulos, *supra* note 112, at 911-12 (finding improved housing stability, condition-specific quality of life, and improved social networks despite a lack of cost savings resulting from PSH);
[252] *See infra* Section II.B.
[253] *See infra* Section II.C.1.

experiencing chronic homelessness, and it can reduce incarceration[254] and substance use.[255] PSH also values the autonomy and humanity of those without shelter.[256] No other homelessness intervention has such potent potential.[257]

[254] *See infra* Section II.C.2.
[255] *See infra* Section II.C.1.d.
[256] *See, e.g.,* PADGETT ET AL., *supra* note 53; Rankin, *supra* note 29.
[257] *See infra* Section II.

CONCLUSIONS AND RECOMMENDATIONS

The cost-effectiveness of PSH in addressing chronic homelessness prompts key recommendations: (1) cities, states, and the federal government should increase investments in PSH as an evidence-based solution to chronic homelessness; (2) governments should prioritize PSH for those experiencing chronic homelessness with a focus on those needing the most services, those with the most complex medical or behavior needs, and families; (3) programs that benefit from the cost savings associated with PSH, such as Medicaid, should contribute funds to its implementation; and (4) new research should expand to collect data for broader, more inclusive categories of likely cost savings, such as those outlined in this report, so the real fiscal impact of PSH comes into better focus.

First, in trying to stem chronic homelessness, governments should pay attention to the strongest evidence: permanent supportive housing works. PSH is the most studied intervention in all of homelessness policy, and research proves it is the most humane and cost-effective solution. Traditional approaches are often expensive, inhumane, and even counterproductive.[258] PSH offers a win-win for people experiencing chronic homelessness and the communities in which they live. Cities should prioritize investments to bring PSH to scale.

Second, while cities build greater PSH capacity, they should target existing PSH to those within the chronically homeless population who use the most services, suffer from the most complex conditions, and families. PSH improves a vast array of physical, mental, and psychological outcomes. It also increases preventative service use, which is more effective and less expensive than emergency services. Although chronic homelessness is less common in families with young children, targeting PSH to such families promises not only to improve outcomes but also prevent intergenerational costs.

Third, programs that benefit from PSH should contribute to its implementation. As most cost savings stem from decreased medical costs and Medicaid covers most medical costs for people experiencing chronic homelessness, Medicaid dollars should be put towards PSH.[259] For example, Washington State developed Foundational Community Supports, a program that uses Medicaid funds to identify people in need, including those experiencing chronic homelessness, help them obtain appropriate housing, and provide support so they can maintain housing.[260] Medicaid funds currently cannot be used to pay for housing, however; they can be directed to the supportive services component of PSH.[261]

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[258] *See, e.g.,* Rankin, *Punishing Homelessness*, *supra* note 29.

[259] *See, e.g.*, DEBORAH THIELE, CREATING A MEDICAID SUPPORTIVE HOUSING SERVICES BENEFIT: A FRAMEWORK FOR WASHINGTON AND OTHER STATES 8 (2014), https://d155kunxf1aozz.cloudfront.net/wp-content/uploads/2014/08/Creating_Medicaid_Supportive_Housing_Servcies_Benefit_WashingtonState.pdf; Julia Paradise & Donna Cohen Ross, *Linking Medicaid and Supportive Housing: Opportunities and On-the-Ground Examples*, KAISER FAMILY FOUNDATION (Jan. 27, 2017), https://www.kff.org/report-section/linking-medicaid-and-supportive-housing-issue-brief.

[260] Washington State Health Care Authority, HEALTHIER WASHINGTON MEDICAID TRANSFORMATION: FOUNDATIONAL COMMUNITY SUPPORTS (2018), https://www.hca.wa.gov/assets/program/medicaid-demonstration-i3-factsheet.pdf.

[261] *Id*.

Last, future research on PSH should expand to capture as many sources of cost savings as possible. Cost savings may stem from sweeps, first responders, emergency room visits, hospital stays, psychiatric commitments, outreach workers, lost business, city services, environmental hazards, police time, courts, jail and prison time, probation, lost economic productivity, and the psychological and emotional tolls on homeless people and the surrounding community. Studies that cannot collect data on all sources of cost savings should provide rough estimations for unmeasurable sources, so as not to obscure their potential.

Chronic homelessness is a daunting crisis, but PSH is a clear solution. PSH is not only a humane approach affirming the basic human need for stable housing, it is the most cost-effective answer. Cities throughout the country often resist sufficient investments in PSH, believing it is cost prohibitive. Meanwhile, the same cities dump excessive funds into wasteful, counterproductive measures that make homelessness worse. It is time for American cities to stop being pennywise but pound foolish with respect to chronic homelessness. Our collective future depends on it.

APPENDIX A: LIST OF STUDIES

Short Name	Citation
At Home/Chez Soi (High Needs) (2016)	Tim Aubry et al., *A Multiple-City RCT of Housing First With Assertive Community Treatment for Homeless Canadians With Serious Mental Illness* 67 PSYCHIATRIC SERV. 275 (2016), https://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400587.
At Home/Chez Soi Study (Moderate Needs) (2015)	Stergiopoulos et al., *Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness*, 313 JAMA 905 (2015), https://jamanetwork.com/journals/jama/fullarticle/2174029.
At Home/Chez Soi Study (Review) (2015)	Tim Aubry et al., *Housing First for People with Severe Mental Illness Who are Homeless: A Review of the Research and Findings from the At Home-Chez Soi Demonstration Project*. 60 CAN. J. PSYCHIATRY 467 (2015), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4679127.
Begin at Home (2013)	Debra Srebnik et al., *A Pilot Study of the Impact of Housing First–Supported Housing for Intensive Users of Medical Hospitalization and Sobering Services*, 103 AM. J. PUB. HEALTH 316 (2013), https://plymouthhousing.org/wp-content/uploads/2018/08/AJPH-Research-Pub-3-2013.pdf.
Brown et al. (2016)	Molly M. Brown et al., *Housing First as an Effective Model for Community Stabilization Among Vulnerable Individuals with Chronic and Nonchronic Homelessness Histories*, 44 J. COMMUNITY PSYCH. 376 (2016), https://onlinelibrary.wiley.com/doi/abs/10.1002/jcop.21763
Bud Clark Commons (2016)	Wright et al., *Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing*, 35 HEALTH AFFAIRS 20 (2016), https://doi.org/10.1377/hlthaff.2015.0393.
Canon Kip Community House & Lyric Hotel (2006)	Tia E. Martinez & Martha R. Burt, *Impact of Permanent Supportive Housing on the Use of Acute Care Services by Homeless Adults*, 57 PSYCHIATRIC SERV. 992 (2006), https://www.aidschicago.org/resources/legacy/pdf/2009/hhrpn/Martinez/martinez.pdf.
Chicago Housing for Health (2009)	Laura S. Sadowski et al., *Effect of a Housing and Case Management Program on Emergency Department Visits and Hospitalizations Among Chronically Ill Homeless Adults*, 301 JAMA 1771 (2009), https://jamanetwork.com/journals/jama/fullarticle/183842
Chicago Housing for Health (2012)	Anirban Basu et al., *Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care*, 47 HEALTH SERV. RES. 523 (2012), https://www.ncbi.nlm.nih.gov/pubmed/22098257.
Closer to Home Initiative (2004)	SUSAN BARROW ET AL., CORPORATION FOR SUPPORTIVE HOUSING, FINAL REPORT ON THE EVALUATION OF THE CLOSER TO HOME INITIATIVE (2004), https://www.csh.org/wp-content/uploads/2011/12/Report_cth_final1.pdf

Denver Housing First Collaborative (2006)	DENVER HOUSING FIRST COLLABORATIVE, COST BENEFIT ANALYSIS AND PROGRAM OUTCOME REPORT (2006), https://shnny.org/uploads/Supportive_Housing_in_Denver.pdf.
Eastlake (2009)	Mary E. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems*, 301 J. AM. MED. ASS'N 1349 (2009), https://www.ncbi.nlm.nih.gov/pubmed/19336710.
Frequent Users of Health Services Initiative (2008)	KAREN W. LINKINS ET AL., FREQUENT USERS OF HEALTH SERVICES INITIATIVE: FINAL EVALUATION REPORT (2008), https://www.chcf.org/wp-content/uploads/2017/12/PDF-FUHSIEvaluationReport.pdf.
Full Service Partnerships (2010)	Todd. P. Gilmer et al., *Effect of Full-Service Partnerships on Homelessness, Use and Costs of Mental Health Services, and Quality of Life Among Adults With Serious Mental Illness*, 67 ARCHIVES GEN. PSYCHIATRY 645, 649 (2010), https://www.ncbi.nlm.nih.gov/pubmed/20530014.
Home & Healthy for Good (2015)	MASSACHUSETTS HOUSING AND SHELTER ALLIANCE, PERMANENT SUPPORTIVE HOUSING: A SOLUTION-DRIVEN MODEL (2015), https://www.mhsa.net/sites/default/files/January%202015%20HHG%20Report.pdf.
HUD-VA Supportive Housing (2003)/ Rosenheck (2003)	Robert A. Rosenheck et al., *Cost-Effectiveness of Supported Housing for Homeless Persons with Mental Illness*, 60 ARCHIVES OF GEN. PSYCHIATRY 940 (2003), https://www.ncbi.nlm.nih.gov/pubmed/12963676.
HUD-VA Supportive Housing (2014)	ELIZABETH MONTGOMERY ET AL., VA NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS, HOUSING FIRST IMPLEMENTATION BRIEF (2014), https://www.va.gov/homeless/nchav/docs/Housing-First-Implementation-brief.pdf.
Indiana PSH Initiative (2013)	UNIVERSITY OF SOUTHERN INDIANA CENTER FOR APPLIED RESEARCH, IMPACT OF INDIANA PERMANENT SUPPORTIVE HOUSING INITIATIVE (2013), https://www.in.gov/myihcda/files/IPSHI_Study.pdf.
LA 10th Decile Project (2013)	DANIEL FLAMING ET AL., GETTING HOME: OUTCOMES FROM HOUSING HIGH COST HOMELESS HOSPITAL PATIENTS (2013), https://www.csh.org/wp-content/uploads/2013/09/Getting_Home_2013.pdf.
LA Housing for Health (2017)	SARAH B. HUNTER ET AL., RAND CORPORATION, EVALUATION OF HOUSING FOR HEALTH PERMANENT SUPPORTIVE HOUSING PROGRAM (2017), https://www.rand.org/pubs/research_reports/RR1694.html.
McLaughlin et al. (2011)	Thomas C. McLaughlin et al., *Using Common Themes: Cost-Effectiveness of Permanent Supported Housing for People With Mental Illness*, 21 RES. SOC. WORK PRACTICE 404 (2011), https://journals.sagepub.com/doi/10.1177/1049731510387307.
Mission Creek Apartments (2015)	Joshua D. Bamberger & Sarah K. Dobbins, *A Research Note: Long-Term Cost Effectiveness of Placing Homeless Seniors in Permanent Supportive Housing*, 17 CITYSCAPE 269 (2015), https://www.jstor.org/stable/26326949.
Moore Place (2015)	M. Lori Thomas et al., MOORE PLACE PERMANENT SUPPORTIVE HOUSING EVALUATION STUDY FINAL REPORT (2015), https://www.urbanministrycenter.org/wp-content/uploads/2017/11/HFH_Moore-Place-Evaluation-Project_Final-Report_4-28-15.pdf.

NY/NY Housing Program (2002)	Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 HOUSING POLICY DEBATE 107 (2002), https://shnny.org/uploads/The_Culhane_Report.pdf.
NY/NY III (2013)	N.Y.C. DEP'T HEALTH AND MENTAL HYGIENE, NEW YORK/NEW YORK III SUPPORTIVE HOUSING EVALUATION: INTERIM UTILIZATION AND COST ANALYSIS (2013), https://shnny.org/images/uploads/NY-NY-III-Interim-Report.pdf.
Pathways to Housing (2000)	Sam Tsemberis et al, *Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 Psychiatric Serv. 487, 487 (2000).
Pathways to Housing (2004)	Sam Tsemberis et al., *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis*, 94 AM. J. PUB. HEALTH 651 (2004), https://www.ncbi.nlm.nih.gov/pubmed/15054020.
REACH Program (2009)	Todd. P. Gilmer et al., *A Cost Analysis of San Diego County's REACH Program*, 60 PSYCHIATRIC SERV. 445 (2009), https://www.ncbi.nlm.nih.gov/pubmed/19339318.
State of Maine - Greater Portland (2007)	MELANY MONDELLO ET AL., COST OF HOMELESSNESS: COST ANALYSIS OF PERMANENT SUPPORTIVE HOUSING (2007), https://shnny.org/uploads/Supportive_Housing_in_Maine.pdf.
State of Maine - Rural Maine (2009)	MELANY MONDELLO ET AL., COST OF RURAL HOMELESSNESS: RURAL PERMANENT SUPPORTIVE HOUSING (2009), https://www.mainehousing.org/docs/default-source/housing-reports/cost-of-rural-homelessness-5-2009.pdf?sfvrsn=af65d015.

APPENDIX B: GRAPH DATA AND SOURCES

PSH Houses People and Keeps them Housed

Study	Years	Percent Housed	PSH v. Traditional Approach
At Home/Chez Soi (High Needs) (2016)	2	74%	PSH
Brown et al. (2016)	1	90%	PSH
Brown et al. (2016)	1	35%	Traditional Approach
Closer to Home Initiative (2004)	2	77%	PSH
Closer to Home Initiative (2004)	1	83%	PSH
Canon Kip Community House & Lyric Hotel (2006)	1	81%	PSH
Canon Kip Community House & Lyric Hotel (2006)	2	63%	PSH
Canon Kip Community House & Lyric Hotel (2006)	3	48%	PSH
HUD-VA Supportive Housing (2014)	1	84%	PSH
HUD-VA Supportive Housing (2003)	3	66%	PSH
Chicago Housing for Health (2009)	1.5	66%	PSH
Chicago Housing for Health (2009)	1.5	10%	Traditional Approach
Moore Place (2015)	2	81%	PSH
Los Angeles Housing for Health (2017)	1	96%	PSH
Denver Housing First Collaborative (2006)	1	68%	PSH
Pathways to Housing (2000)	5	88%	PSH
Pathways to Housing (2000)	5	47%	Traditional Approach
Denver Housing First Collaborative (2006)	0.5	80%	PSH

PSH Increases Time Spent Housed

Study	PSH	Control
Brown et al. (2004)*	94%	24%
Pathways to Housing (2004)**	80%	35%
At Home/Chez Soi (Moderate Needs) (2015) - Site D**	77%	32%
At Home/Chez Soi (Moderate Needs) (2015) - Site C**	74%	39%
At Home/Chez Soi (Moderate Needs) (2015) - Site B**	73%	24%
At Home/Chez Soi (Review) (2015)**	73%	32%
At Home/Chez Soi (High Needs) (2016)**	71%	29%
Rosenheck et al. (2003)***	66%	52%
At Home/Chez Soi (Moderate Needs) (2015) - Site A**	63%	30%

* Study spanned 12 months.
** Study spanned 24 months.
*** Study spanned 36 months.

PSH Reduces Hospital Admissions

Study	Decrease
Los Angeles Housing for Health (2017) - Medical	-61%
Canon Kip Community House & Lyric Hotel (2006) - Psych	-49%
Los Angeles Housing for Health (2017) - Psych	-42%
Canon Kip Community House & Lyric Hotel (2006) - Medical	-42%
Denver Housing First Collaborative (2006) - Medical & Psych	-40%
HUD-VA Supportive Housing (2014) - Medical & Psych	-33%
Chicago Housing for Health (2009) - Medical & Psych	-29%
Frequent Users of Health Services Initiative (2008) - Medical & Psych	-27%
Bud Clark Commons (2016) - Medical & Psych	-23%

PSH Reduces Hospital Time

Study	Decrease
Denver Housing First Collaborative (2006) -Med/Psych	-80%
HUD-VA Supportive Housing (2014) - Med/Psych	-71%
Moore Place (2015) - Med/Psych	-62%
Brown et al. (2004) - Psych	-56%
NY/NY Housing Program (2002) - Psych	-49%
Chicago Housing for Health (2009) - Med/Psych	-29%
Frequent Users of Health Services Initiative (2008) - Med/Psych	-27%
NY/NY Housing Program (2002) - Med	-21%

PSH Increases Outpatient Service Use

Study	Percent Change
San Diego Full Service Partnerships (2010)**	510%
Indiana PSH Initiative (2013)*	336%
Indiana PSH Initiative (2013)**	165%
Chicago Housing for Health (2012)	76%
NY/NY Housing Program (2002)	76%
Moore Place (2015)	53%
HUD-VA Supportive Housing (2003)	32%
REACH Program (2009)	24%
LA Housing for Health (2017)**	-44%
LA Housing for Health (2017)*	-47%
LA 10th Decile Project (2013)	-87%

* Medical outpatient only
** Mental health outpatient only

PSH Reduces Emergency Room Visits

Study	Percent Change
Moore Place (2015)	-81%
LA Housing for Health (2017)	-80%
Canon Kip Community House & Lyric Hotel (2006)	-56%
Bud Clark Commons (2016)	-43%
Denver Housing First Collaborative (2006)	-34%
HUD-VA Supportive Housing (2014)	-27%
Chicago Housing for Health (2009)	-24%
Frequent Users of Health Services Initiative (2008)	-22%
At Home/Chez Soi Study (Moderate Needs) (2015)*	0%
At Home/Chez Soi (High Needs) (2016)*	0%

* The At Home/Chez Soi Studies found changes, but they were not statistically significant.

PSH Always Causes Gross Savings*

Study	Total Savings
LA 10th Decile Project (2013)	-$46,895
Eastlake (2009)	-$42,964
Begin at Home (2013)	-$36,579
NY/NY III (Families/Mental Illness) (2013)	-$33,598
Denver Housing First Collaborative (2006)	-$31,546
NY/NY III (Families & Substance Use/Medical Condition/HIV) (2013)	-$25,651
Mission Creek Apartments (2015)	-$25,499
Home & Healthy for Good (2015)	-$24,807
LA Housing for Health (2017)	-$22,833
At Home/Chez Soi (Review) (2016)	-$21,367
NY/NY III (Substance Use) (2013)	-$17,015
NY/NY Housing Program (2002)**	-$16,281
NY/NY III (Mental Illness & Substance Use) (2013)	-$15,941
State of Maine - Greater Portland (2007)	-$14,036
Chicago Housing for Health (2012)	-$12,838
State of Maine - Rural Maine (2009)	-$11,850
Bud Clark Commons (2016)	-$8,724
Indiana PSH Initiative (2013)	-$8,643
McLaughlin et al. (2011)	-$5,128
At Home/Chez Soi Study (Moderate Needs) (2015)	-$4,849
REACH Program (2010)	-$1,064

* Amount listed may differ slightly from what studies report due to author adjustments and rounding. Author adjusted all findings to be per person per year for comparison. Author also calculated total savings based on sub-group savings listed within each study.
** Considered per unit per year rather than per person per year.

PSH Frequently Results in Net Savings*

Study	Total Savings
LA 10th Decile Project (2013)	-$31,736
Eastlake (2009)	-$29,388
Begin at Home (2013)	-$17,979
Mission Creek Apartments (2015)	-$10,282
Chicago Housing for Health (2012)	-$9,808
Home & Healthy for Good (2015)	-$9,339
LA Housing for Health (2017)	-$7,733
NY/NY III (Families/Mental Illness) (2013)	-$7,611
Denver Housing First Collaborative (2006)	-$4,746
State of Maine - Rural Maine (2009)	-$2,696
McLaughlin et al. (2011)	-$2,182
Indiana PSH Initiative (2013)	-$1,148
State of Maine - Greater Portland (2007)	-$944
NY/NY III (Mental Illness & Substance Use) (2013)	-$877
NY/NY III (Families & Substance Use/Medical Condition/HIV) (2013)	$379
At Home/Chez Soi (Review) (2016)	$890
NY/NY Housing Program (2002)**	$996
NY/NY III (Substance Use) (2013)	$1,652
REACH Program (2010)	$2,116
Bud Clark Commons (2016)	$2,876
At Home/Chez Soi Study (Moderate Needs) (2015)	$9,328

* Amount listed may differ slightly from what studies report due to author adjustments and rounding. Author adjusted all findings to be per person per year for comparison. Author also calculated total savings based on sub-group savings listed within each study.
** Considered per unit per year rather than per person per year.

Targeting High Service Users/Begin at Home (2013)

Type	Savings/Cost
Hospitalization	$34,603
Criminal Justice	$1,304
Detoxification	$672
Housing & Program Costs	-$18,600

Targeting High Service Users/LA 10th Decile Project (2013)

Type	Savings/Cost
Criminal Justice	$21,825
Medical	$21,051
Other Benefits	$1,979
Substance Use Treatment	$1,793
Shelter	$247
Housing & Program Costs	-$15,159

Targeting Families/NY/NY III (2013)

Type	Savings/Cost
Shelter	$18,422
Cash Assistance	$10,111
Medicaid	$4,758
Food Stamps	$290
Criminal Justice	$17
Housing & Program Costs	-$25,987