March 18, 2020

Dr. Benjamin Carson
U.S. Secretary of Housing and Urban Development
451 7th Street, SW
Washington, DC 20410

Joe Grogan
Director of the Domestic Policy Council
The White House
Eisenhower Executive Office Building
1650 Pennsylvania Ave, NW
Washington, DC 20502

Robert Marbut
Executive Director
U.S. Interagency Council on Homelessness
301 7th Street, SW, Room 2080
Washington, DC 20407

Dear Secretary Carson, Mr. Grogan, and Mr. Marbut:

We, the undersigned researchers on homelessness, write to urge the use of evidence-based approaches in addressing America's homelessness crisis. This requires continued adherence to Housing First and the provision of adequate shelter wherever permanent housing is unavailable.

Over the last couple of decades, there have been efforts to increase and improve the federal government's use of evidence-based policies and practices. This goal has been bipartisan. Both the George W. Bush and Barack Obama Administrations shared it. Within Congress, members of both parties supported legislation creating the Commission on Evidence-Based Policymaking (which cited current efforts to provide chronically homeless individuals with permanent supportive housing as a best practice). And President Donald J. Trump signed the Foundations for Evidence-Based Policymaking Act of 2018.

We encourage a continued emphasis on evidence-based policymaking, which has particular implications in the field of homelessness.

Housing First

The weight of existing evidence favors the Housing First approach to ending chronic patterns of homelessness. The two-decades-old initial evaluations produced findings that have been repeatedly replicated since then. It has been shown that Housing First is associated with greater housing stability and better treatment outcomes than transitional housing (or stair approaches) approaches to homelessness.

Understanding this research requires understanding the model. "Housing First" does not mean "housing only." Rather, Housing First is housing plus voluntary services. Harm reduction is an aim—but services can take the form of sober living or other rule-based programs when participants believe such services match their needs and current stage of recovery. Housing is the priority. It stabilizes lives and allows individuals to participate more effectively in mental health, physical health, and substance abuse

services. It eliminates the challenges tied to maintaining treatment plans, keeping appointments, or being located by a provider when individuals are constantly moving from location to location.

The multiple evaluations of Housing First highlight a pattern of success that includes:

- *Housing Stability.* Housing First participants are more housing stable than those enrolled programs that condition housing on participation in services (transitional housing or residential treatment). This finding is consistent across all relevant evaluations, including those focused on individuals with severe mental illnesses, substance abuse disorders, and chronic patterns of homelessness.

  The research outcomes have been striking. For instance, an early evaluation of Pathways (the initial Housing First program) found that 88 percent of tenants remained housed five years later compared to only 47 percent of those in residential treatment. A subsequent Canadian study with a more significant number of subjects found 62 percent of Housing First participants still housed two years later compared to only 31 percent of those required to participate in treatment before being placed in housing.

  The Pathways and Canadian studies were among others included in a thorough literature review completed by the National Academies of Sciences, Engineering, and Medicine in 2018. The resulting publication concluded that Permanent Supportive Housing (PSH) following Housing First principles "effectively maintains housing stability for most people experiencing chronic homelessness."

  These findings partially reflect an important virtue of Housing First. It serves and shelters *everyone* right away—not just those who are ready to participate in treatment and who are good at following a list of rules.

- *Treatment.* Various services are available via Housing First programs. A 2015 evaluation found that, with their housing stabilized, Housing First participants with severe mental illness increased their participation in outpatient mental health services.

  Treatment outcomes have been neutral or positive. An early study compared Housing First participants to individuals with housing conditioned on sobriety and participation in treatment. There was no difference between the two groups on substance use or psychiatric symptoms. More recent evaluations indicate that Housing First participants are more likely than others to report reduced usage of alcohol, stimulants, and opiates.

- *Service Use.* Aside from the positive individual-level outcomes, Housing First reduces acute care services use for some populations. People with severe mental disorders, frequent jail users, and "superutilizers" have been found to reduce use of acute care systems once housed. The aging of the adult homeless population is also projected to increase services use and costs substantially over the next decade, so a housing first strategy targeting the aged homeless could help to avoid costs associated with excess hospital days and nursing home stays.

Adequate Shelter

We are aware that the Council of Economic Advisors' recent *The State of Homelessness in America* report suggests that the availability of shelter beds increases homelessness. We are not aware of any studies that confirm these conclusions (finding that people living in communities respond to the existence of shelters by choosing to become homeless).

Further, we are concerned about the health consequences of an insufficient number of shelter beds and unsheltered homelessness.

Various studies have shown that unsheltered individuals have far more health challenges than those in shelter. Most recently, the California Policy Lab examined multiple communities across the country, finding physical health conditions being reported by 84 percent of unsheltered individuals compared to 19 percent of those in shelter. Mental health challenges were reported by 78 percent of unsheltered individuals compared to 50 percent of those in shelter. These challenges extend to higher mortality rates. For instance, a Boston-based study found that unsheltered people had mortality rates that were nearly three times as high as those who spent significant amounts of time in shelter.

People experiencing unsheltered homelessness are exposed to the elements—snow, rain, and extreme cold and heat. This contributes to their health conditions. Living outside complicates one's ability to take care of their personal health needs. This includes routinely taking medication, attending regularly scheduled doctor's appointments, healing from infections and injuries, getting sufficient uninterrupted rest, and accessing healthy food and clean water. Living unsheltered is also associated with victimization, including violent crime.

Health concerns point towards the need for permanent housing with services (Housing First). Where that's unavailable, individuals should have access to low-barrier emergency shelters that are focused on getting people into permanent housing as quickly as possible.

Criminalization

We are unaware of any studies demonstrating that criminalization reduces homelessness.

Rather, a detailed review of community policies and practices concluded that criminalization disperses unsheltered homelessness into smaller areas. Away from larger groups and highly visible locations, individuals can be less safe and more vulnerable to victimization. Further, repeated stays in jail disrupt contemporaneous efforts to find and keep work and housing. A well-established body of research demonstrates that having a criminal record makes it more difficult to find employment and housing.

Providing permanent housing is a proven method of 1) reducing homelessness and 2) preventing unnecessary cycles of incarceration. For example, New York City's Frequent Users Service Enhancement (FUSE) Initiative offered PSH to chronically homeless individuals. Two years later, 86 percent of participants but only 42 percent of the comparison group were still permanently housed. PSH participants spent 40 percent less time in jail than the comparison group. And the city's shelter and jail costs were reduced by $8,372/person each year.

Investments in criminalization are costly and avoidable if permanent housing is made available.

Data Collection

The Council of Economic Advisers report alludes to imperfections within the Point-in-Time (PiT) Count. While HUD's data on sheltered homelessness offers useful and reliable insights into just how many people experience homelessness over the course of the year, the PiT is the best available snapshot of both *unsheltered* and *sheltered* homelessness in America. Recognizing its imperfections (it is not a funded activity, and so a post enumeration survey is not feasible), no other source offers nation-wide data of this type. And no other source offers such data over time, allowing for trend analyses. Importantly, over the years, there have been consistent improvements in PiT data collection process. Such efforts are ongoing, benefiting from the contributions of researchers, data experts, and local service providers.

More statistically robust approaches are available, including post-enumeration surveys. However, such elements require far greater government investments. Congress has yet to allot such funds. In the meantime, the best available information comes from the PiT, which should be read in conjunction with other available data.

Conclusion

High-quality information about what works will help the nation end homelessness. Thus, we welcome an ongoing dialogue about 1) available research and evidence, 2) potential new research aimed at addressing unanswered questions, and 3) methods for improving data collection efforts. We believe that great things can happen when we work together!

Sincerely,

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Resources

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