

**Testimony of  
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**for the**

**House Veterans' Affairs Subcommittee on Economic Opportunity**

**"Making HUD-VASH Work for all Veteran Communities"**

**Hearing: January 14, 2020**

**Introduction**

Chairman Levin, Ranking Member Bilirakis, and other distinguished members of the House Veterans' Affairs Subcommittee on Economic Opportunity, thank you for inviting the National Alliance to End Homelessness (hereinafter referred to as "the Alliance") to testify at this January 14<sup>th</sup> hearing entitled "Making HUD-VASH Work for all Veteran Communities". I am Steve Berg, and I am the Alliance's Vice President for Programs and Policy. The Alliance is a nonpartisan, evidence-based, and mission-driven organization committed to preventing and ending homelessness in the United States.

Because of our mission, the Alliance views the veteran homelessness programs as a vital part of a larger national effort to eliminate homelessness. The Department of Housing and Urban Development (HUD) is responsible for the administration of the Continuum of Care (CoC) and Emergency Solutions Grant (ESG) programs, the two federal programs that attempt to address the needs of homeless Americans generally. In FY20, more than \$2.8 billion will be awarded by HUD through the CoC and ESG programs to state and local governments as well as nonprofit organizations. The CoC program, which is the larger of the two, funds rapid re-housing (RRH), permanent supportive housing (PSH), and transitional housing (TH); the coordinated entry system; and initiatives to improve systems, including the Youth Homelessness Demonstration Program. These programs balance local control with an insistence on evidence-based practices and results. HUD uses research and data to establish criteria for the CoC competition based on cost-effectiveness and performance, while states and localities determine which evidence-based interventions are most needed, and which entities in the community should be funded to carry them out. Approximately \$290 million will be awarded by HUD in FY20 through formula grants to state and local governments for the ESG program, which funds shelters, RRH, and homelessness prevention (HP).

The Department of Veterans Affairs (VA) is responsible for three different housing programs designed to assist veterans and their families with ending their homelessness. The Homeless Providers Grant and Per Diem (GPD) program will provide \$250 million in FY20 in funding for community-based TH and supportive services. The Supportive Services for Veterans Families

(SSVF) program, which provides both RRH and HP services, will receive \$380 million in funding for FY20. The three components of RRH, a Housing First program, are identifying housing, providing short-term rent and move-in financial assistance, and offering case management and employment services. The historically well-funded HUD-VASH program, an interdepartmental collaboration which will receive an additional \$40 million from HUD for FY20, provides homeless veterans with PSH through HUD vouchers as well as VA services to help enrollees find and sustain permanent housing. PSH, another Housing First program, combines housing subsidies and support services that are designed to build independent living and tenancy skills and connect people with community-based health care, treatment, and employment services. HUD-VASH is reserved for chronically homeless and highly vulnerable veterans who have a high level of housing and service needs, such as those with barriers to employment and self-sufficiency. A demonstration project to provide HUD vouchers and VA supportive services to homeless American Indian veterans (Tribal HUD-VASH) will receive an additional \$1 million for FY20.

The Alliance asks members of the Subcommittee to keep two important points in mind during their efforts to oversee and improve the veteran homelessness programs:

1. The veteran homelessness programs are widely considered by providers and academics to be the gold standard in preventing homelessness and housing people experiencing homelessness. These programs, which are designed and implemented with proven, evidence-based practices, are significantly better-resourced than programs which serve the general homeless population. The amount of money available for each newly homeless veteran each year is as much as six times that for each homeless non-veteran. Moreover, homeless veterans also benefit from their access to VA's world-class health care system. Finally, because VA is an integrated health care system, the department can continuously disseminate and implement best practices across its far-flung network of medical centers.

This doesn't mean that VA's homelessness programs are above criticism. Certainly not. If anything, we should hold VA's dedicated, conscientious, and hard-working managers, health care professionals, and caseworkers to even higher standards. But it does mean that non-veteran homelessness services providers look to VA for inspiration and innovation. Non-VA providers follow the department's homelessness initiatives—including newer initiatives like Rapid Resolution and Shallow Subsidy—with as much interest as the Department's authorizers and appropriators on Capitol Hill. Consequently, please understand that what you do and don't do as lawmakers on this Subcommittee with respect to veteran homelessness programs has broader implications for homelessness programs generally and establishes precedents for your Congressional colleagues who set the rules and funding levels for non-veteran homelessness programs.

2. The veteran homelessness programs are strong because they enjoy bipartisan support. That's not to say there aren't reasonable differences of opinion between the two parties, but there is a bipartisan consensus in support of an evidence-based approach towards the reduction and even the elimination of homelessness among veterans, the programs used to achieve those goals, and adequately resourcing those programs. No lawmaker blames homeless veterans for their plight, advocates for criminalization of the conduct of homeless veterans, or insists we can't adequately resource veteran homelessness programs until states and localities have reformed their zoning and housing regulations. Unfortunately, even though non-veteran homelessness programs are pursuing the same policies and approaches, albeit with less funding, they do not enjoy the same level of support. The Alliance commends this Subcommittee for its bipartisan approach towards veteran homelessness, putting principle before party, and urges other lawmakers to learn from the example set by Chairman Levin and Ranking Member Bilirakis.

I attach to the end of my testimony a chart which illustrates re-housing capabilities for individuals, families, and veterans. The Alliance calculates that we could re-house more than three-fifths of veterans who entered a shelter in 2017, one out of every three families (which is a significant improvement from one out of every eight families several years earlier), and less than one-tenth of individuals. I would be happy to discuss the conservative assumptions used in the creation of the chart as well as provide the Subcommittee with an updated version when more recent information becomes available.

### **Housing First**

Integral to the success of the veteran homelessness programs has been the use of Housing First, an approach which prioritizes quickly providing permanent housing to people experiencing homelessness, thus ending their homelessness and serving as a platform from which they can improve their quality of life. The provision of wrap-around services—to support housing stability, promote employment, and recovery – is an integral part of Housing First, and the effectiveness of all these services depends on the recipients living in stable housing. Housing First starts with housing, with no preconditions, including those related to religion, employment, income, absence of criminal record, and sobriety.

Why should housing (with services) come first? People who experience homelessness may have a myriad of other challenges, including a mental health or substance use disorder, limited education or work skills, scant credit history, or a history of domestic violence and trauma. Would people experiencing homelessness be better off if we helped them to deal with other problems they are struggling with *first* and only addressed their housing needs later? Housing First, some have argued, allows people to avoid addressing severe challenges, such as a substance use disorder, so that people will quickly return to homelessness.

But this argument is based on a false premise. In fact, services are part of Housing First interventions. Under Housing First, people are offered or connected to services that are tailored to the needs of their households. But those services are not mandated: and people are not coerced into accepting them because client choice is a fundamental tenet of Housing First.

Housing First-informed interventions such as PSH and RRH demonstrate again and again that when people who have experienced homelessness have help paying for their housing, and when they receive services tailored to their individual needs, they will escape homelessness and they will stay housed. Not only are Housing First interventions effective in ending homelessness, but many and sometimes all of their cost is offset by reductions in the public spending that inevitably results from allowing people to remain homeless and reliant on shelters and other services.

Practitioners experienced with serving long-term homeless adults know that withholding housing help until people “get better” or change in some way can perversely result in people spending years on the streets as their health declines. People with severe mental illnesses cycle frequently between jails, hospitals, shelters, and streets without ever achieving stable homes. Those that have seen this heartbreaking cycle, unfortunately still too common given inadequate resources, understand this fundamental truth: withholding housing assistance doesn’t help people, it hurts them.

Instead of requiring people to stabilize before receiving housing, Housing First interventions focus on helping people to achieve stability in housing. This is often a prerequisite to other improvements in their lives. People with the foundation of a home are in better positions to take advantage of supportive services. They have the stability with which to engage in a job search. They have the platform they need to provide care and continuity for their young children. The safety housing affords allows those who want to address traumatic experiences with a skilled practitioner to do so at a pace that is unthreatening and makes sense to them. They have a safe place to store medication and address their physical and mental health needs. The absence of housing, on the other hand, makes attaining those personal goals so much more difficult.

Housing First focuses on providing the housing assistance and the supportive services that people require to sustain housing and avoid future homelessness. Study after study demonstrates that housing has many curative benefits for people experiencing homelessness. It is true that Housing First does not fulfill every need; people still require additional supports to attain personal goals and continue to thrive. But there is one thing that housing clearly does solve: homelessness.

One criticism of Housing First is that it has led to a loss of temporary beds for people experiencing homelessness. There has been an increase in the number of emergency shelter beds in the period from 2007 to 2018. Long-term TH beds have declined but they have been replaced by a much larger increase in permanent housing opportunities for people who are

homeless, based on greater cost-effectiveness and greater demand, thus leading to long-term decreases in the number of people homeless, including dramatic decreases for veterans. TH continues to be available for homeless veterans through the GPD program in appropriate cases.

During two field hearings, the Chairman and the Ranking Member of this Subcommittee listened carefully to the concerns of many groups and individuals who care deeply about veteran homelessness programs, and I am pleased that their testimonies included much praise of Housing First and reaffirmed its importance in the success of those programs. Housing First has enjoyed strong bipartisan support since the Administration of President George W. Bush—and if the approach is judged on the merits that should not change. The Alliance urges the Subcommittee to continue to support Housing First—and, if necessary, aggressively reaffirm its importance for the veteran homelessness programs.

The Appendix at the end of my testimony summarizes research on the effectiveness of Housing First.

### **Point-in-Time Counts**

HUD's annual point-in-time (PiT) count is what it is—a snapshot in time of the sheltered and unsheltered homeless populations based on one or several days of diligent searching by small armies of experts and volunteers across the length and breadth of a CoC. A PiT count does not include everyone who experiences homelessness in a particular year. The count of the sheltered homeless population is obviously more accurate than the count of the unsheltered population. A CoC that is sufficiently-funded to employ an aggressive outreach effort throughout the year is more likely to know where more of the unsheltered population is during a count. The Alliance believes that for the last several years communities across the nation have worked hard to ensure greater accuracy in the documentation of homelessness. I understand there are fears that the integrity of the count might be undermined by schemes to over-count or under-count. However, it is our impression that too many conscientious people from too many different entities are involved, many of them governmental, to prevent such conspiracies.

There are concerns about who is to be counted—a family which spends the night in a car would be counted, while a family which sleeps in a relative's house (doubled-up) would not. There are other sources of data, including the Bureau of the Census, to make estimates about the doubled-up population. However, the PiT count is the only comprehensive source of data about people sleeping in places not intended for human habitation.

Conducted over time and in a consistent manner, the counts can be helpful tools to identify trends, both generally and with respect to specific subpopulations, and allocate very finite resources, particularly when used in conjunction with Housing Inventory Counts (HIC) and other helpful data tracked by HUD's CoC Homeless Management Information Systems (HMIS).

The nation's affordable housing crisis has created three distinct populations: the rent-burdened, those several million low-income households paying a large and unsustainable

percentage of their income towards housing; the unstably-housed, often referred to as the doubled-up, who, according to the Alliance's analysis of the census are more than 4.4 million people; and the more than one half-million people who experience homelessness on a particular day. Thanks to the PiT and HIC counts as well as HUD's HMIS systems, we know far more about the homeless population than the much larger rent-burdened and doubled-up populations.

In our view, the biggest flaw of a PiT count is that it doesn't account for the productivity of homelessness programs. For example, casual readers might have read HUD's November 12 press release on the 2019 veterans PiT count ("Trump Administration Announces Continued Decline in Veterans Homelessness—Since last year, 793 more veterans now have a roof over their heads") and failed to appreciate how hard the veterans homelessness programs had to work in order to achieve that increase. Because of the constant churn—veterans continuing to become homeless due to the lack of affordable housing or for their own personal reasons-- those programs managed to house tens of thousands of homeless veterans in 2019, in addition to the 793 for which they were accorded public credit. In FY18, for example, I understand the total number of homeless veterans permanently housed by veteran homelessness programs was in excess of 50,000—which does not include family members and dependent children, let alone veterans prevented from becoming homeless.

There is a similar churn in the non-veteran homelessness programs. The increase in homelessness in California is much discussed. However, it is easy to lose sight of the productivity of homelessness programs in the Golden State. Los Angeles County manages to house 133 homeless persons per day, a remarkable accomplishment; unfortunately, 150 persons become homeless in Los Angeles County every day. In San Francisco, for every homeless person housed, three more become homeless. We should be wary of judging the success or failure of anti-homelessness efforts entirely on PiT counts. In most instances with bad PiT counts, if we dig a little deeper, we'll learn that it is not that the programs aren't working, it is that the programs aren't adequately resourced to meet extraordinary demands for services, which are largely caused by the nation's affordable housing crisis.

The Alliance supports both the effort led by the United States Interagency Council on Homelessness (USICH) to identify communities making progress towards ending veteran homelessness through the establishment of benchmarks developed by USICH, HUD, and VA, as well as another interagency initiative known as the Mayor's Challenge to End Veteran Homelessness. Public recognition is a cheap but powerful incentive for our leaders to show us their best selves and for their staffs to overcome parochial concerns that might otherwise divide them and work together to achieve this goal.

Most importantly, both efforts remind us that ending homelessness is possible, that we do have the right programs in place, and that we just need to work better together to fund and implement them. When one looks at the list of the states and localities that have been determined, consistent with the USICH benchmarks, to have "ended" veteran homelessness, it

is difficult to generalize about them—because it’s happening in cities, suburbs, and the countryside; it’s happening in all regions—north, south, east, and west; it’s happening in red states and blue states; it’s happening in areas with lots of people as well as less populated areas; and it’s happening in wealthy localities as well as more modest localities. Ultimately, the list shows we can end homelessness, veteran and otherwise, in all areas of the United States if our federal, state, and local leaders make that objective a higher priority—and in doing so, it is clear from the experiences of these three states and 78 communities that we won’t break the bank.

## **Prevention**

The best way to keep the number of homeless veterans low is to prevent veterans from becoming homeless in the first place. The Alliance appreciates the leadership shown by this Subcommittee in ensuring a successful transition for military personnel to civilian life, particularly as shown by H.R. 2326, the Mulder Transition Improvement Act, by enhancing job prospects.

The VA has been justifiably lauded for devising a set of questions to ask veterans which can help to identify which ones are at risk of becoming homeless. It would be helpful if a version of those questions were asked by the Department of Defense of departing personnel prior to discharge as well as part of a proactive follow up by VA soon after discharge, rather than wait until a medical center’s initial interaction, in order to identify potential referrals to the veteran homelessness programs. The Alliance commends the House and Senate Appropriations Committees for the inclusion of a report requirement in the FY20 funding measure for VA that will help us to understand how much more needs to be done to ensure “servicemembers identified through the Transition Assistance program process” develop viable post-transition housing plans.

Similarly, it would be helpful if more military personnel received instruction in basic life lessons prior to discharge. Military service requires many sacrifices, including a significant loss of personal autonomy. Financial responsibility, including buying a home or leasing an apartment, can be daunting and difficult for anyone, let alone someone for whom housing was largely determined by her or his employer.

The potentially problematic transition out of controlled environments is also a challenge for non-veteran homelessness programs. People emerging from incarceration and hospitalization are disproportionately vulnerable to homelessness for several reasons, including diminished job prospects, skeptical landlords, inadequate health care, and lack of family support, in addition to being unprepared to make basic life decisions.

## **HUD-VASH: Case Management**

The single biggest complaint the Alliance hears about the HUD-VASH program is the difficulty the VA has in recruiting and retaining caseworkers. Apparently, caseworkers can find jobs with

comparable work but better pay outside of VA. Too often, we hear, vouchers that might be used to house chronically homeless veterans are sitting idle because of a shortage of caseworkers. This is not a problem everywhere, but it is enough of a problem that it is important to address.

Why should helping chronically homeless veterans be less attractive than other casework? We need to change this culture so that HUD-VASH casework is sought after by the very best caseworkers because of the challenge of the work and the prestige of the clients. Perhaps the VA, in consultation with its own caseworkers and their union representatives as well as recognized leaders in social work, should devise a new pay scale that more adequately compensates this workforce, endows it with a higher status, and invests it with more prestige. Other VA positions can receive additional pay if it can be shown there are recruitment and retention problems—but has the necessary pay survey been conducted for caseworkers? Are hiring or performance bonuses appropriate? Should VA caseworkers be made eligible for performance pay? Does VA's personnel staff need to be specially trained to expedite at least for caseworkers the infamously lengthy federal hiring process? The Alliance commends the House and Senate Appropriations Committees for the report language included in the FY20 funding measure for VA on the department's staffing for HUD-VASH and the program's management of vouchers.

Until a more robust in-house casework capability can be established, medical centers should be directed to at least consider outsourcing HUD-VASH casework and be required to publicly explain why they failed to do so if vouchers are not being used because of an absence of federal caseworkers. Perhaps a little transparency is all that is needed to induce medical centers to staff up their caseworker positions.

Finally, HUD-VASH casework should be limited to supporting a veteran's recoveries from physical and mental illnesses and substance use disorders in order to allow her or him to live independently in the affordable permanent housing of her or his choosing. Identifying landlords who will accept HUD-VASH vouchers, negotiating with those landlords, and then cultivating them so that they will remain receptive to the program's enrollees are functions which should be performed by experienced housing navigators, who are usually locally grown and need not be federal employees. Congress and VA should work together to make housing navigation a regular part of the HUD-VASH program. Allowing VA caseworkers to focus exclusively on recovery, rather than real estate, may ultimately allow them to take on more cases and make their work more rewarding.

### **HUD-VASH: Cooperative Landlords**

Another complaint the Alliance hears about the HUD-VASH program is the difficulty in getting landlords to accept vouchers. Although there are obviously outliers, the Alliance believes that landlords are just as appreciative of the service of our veterans as other Americans and that they genuinely want to do right by veterans enrolled in HUD-VASH. Consequently, we favor the

use of the carrot, rather than the stick. Experienced housing navigators who actively seek out and cultivate cooperative landlords can open up a lot of doors for veterans enrolled in HUD-VASH. Should VA reward every landlord who houses, say, fifty HUD-VASH veterans with a commemorative coin? Why not? Such landlords are private actors doing their part in the promotion of a cherished public interest. Should Congressional lawmakers single out for praise every year in one of their town hall meetings landlords who consistently serve HUD-VASH veterans? Why not? Landlords are almost as much a part of the recovery process for HUD-VASH veterans as VA caseworkers and HUD vouchers. There are no doubt other ways to earn goodwill from landlords at minimum expense. Similarly, if landlords know that the HUD-VASH veterans they are asked to house are being served by effective caseworkers the more likely they will be to honor the program.

This could be an area where Members of Congress can play a leadership role in their local communities. Members of Congress could work with local Mayors and VA leadership to invite landlords to participate in the program and thus be accorded public recognition.

If there continues to be problems generating support from landlords in a particular area, we may need to look more closely at the payment standard established by the local Public Housing Authority.

### **Additional Improvements VA Homelessness Programs**

**Allow HUD-VASH to serve more chronically homeless veterans:** The Alliance thanks the House Veterans Affairs Committee—no doubt because of the bipartisan leadership shown by the Economic Opportunity Subcommittee—for being the first Congressional panel to mark-up H.R. 2398, legislation introduced by Representative Scott Peters (D-CA) to allow military personnel who are discharged under the category of “other-than-honorable” (OTH) to be eligible for HUD-VASH benefits. We continue to hear concerns from providers that there are homeless veterans in their communities who need the more intense treatment provided by HUD-VASH but who are denied access to that program because of the status of their discharge. Given that OTH veterans are already eligible for the GPD and SSVF homelessness programs, H.R. 2398 breaks no precedents, and the legislation commands the strong support of homelessness and veteran groups. Enactment of this legislation will allow a small group of veterans, but one that is disproportionately vulnerable to chronic homelessness, to enroll in a program that can actually help them.

**Rebuild confidence in HUD-VASH through greater transparency:** HUD-VASH is immensely popular, but it seems just about every Congressional office with whom we consult has its own administrative concerns about the program, particularly how many vouchers are actually available in their states and districts. The Alliance does not necessarily share all of those concerns, but we believe that H.R. 2399, another bill introduced by Representative Peters, would help to rebuild trust in the program. HUD-VASH is a fine program, a shining example of how the federal government can help deserving Americans. We have nothing to fear from

learning more about how HUD-VASH works. The Alliance thanks this Subcommittee for its bipartisan leadership on H.R. 2399.

**Target HUD-VASH to chronically homeless veterans:** The Alliance understands that there are homeless veterans enrolled in the program who aren't actually chronically homeless, and that these veterans might be more efficiently served by the less expensive SSVF program. In the non-veteran context, the Alliance encourages providers of services to those experiencing homelessness to employ "Moving On" strategies for clients in PSH who may no longer need or want the intensive services offered but continue to need help to maintain their housing. Any savings generated can be used to serve more homeless veterans.

If a community has housed all or nearly all of the veterans experiencing chronic homelessness, then additional vouchers should be targeted at homeless veterans with severe medical conditions that require intensive treatment (including behavioral health treatment) and which make employment an unrealistic, short-term goal.

The Alliance does hear concerns about HUD-VASH not covering important incidental costs, e.g., repair of a car needed for transport to health care. Co-enrollment in SSVF and HUD-VASH should address most of those concerns, assuming the former program is sufficiently funded.

**Better serve veterans in high-cost areas:** The VA is to be commended for its ambitious Shallow Subsidy pilot program to serve homeless veterans enrolled in SSVF who live in high cost areas through the provision of longer housing subsidies. We are concerned about the adequacy of funding in the program's second year. However, the Alliance is convinced that this program enjoys strong, bipartisan support, and that any financing concerns will be satisfactorily addressed by Congress. Shallow Subsidy is a promising initiative—it's success would be a very favorable precedent for non-veteran homelessness programs.

**Continue to make the veterans homeless programs accessible to different groups of veterans:** This Subcommittee is playing a leading role in attempting to ensure that the SSVF program continues to serve the needs of women veterans and their families. Native Americans have served in the Armed Forces in greater numbers per capita than any other ethnic group. The Alliance strongly supports Tribal HUD-VASH, particularly because this program can help to build new housing stock on reservations with project-based vouchers. Veterans are becoming older as a group and thus facing greater medical expenses. The Alliance supports efforts to allow veterans to age in place, which should reduce costs to VA and promote autonomy for veterans. And under the appropriate supervision of Congressional authorizers and appropriators, the VA should be encouraged to experiment with its homelessness programs in order to devise new and better ways to help more veterans. As mentioned earlier, the advances achieved and the innovations embraced by VA managers will ultimately redound to the benefit of homelessness programs generally.

## Leadership and Accountability

Finally, I will emphasize the importance of VAMC management in the exercise of strong leadership in the fight against veteran homelessness and holding that VAMC management accountable when it fails to exert such leadership. Notwithstanding variations in the housing market, it is the Alliance's view that an important factor in making substantial progress towards a reduction in veteran homelessness in a particular area is whether the relevant VAMC management has made veteran homelessness a priority and insisted on allocating finite resources accordingly. And it is incumbent upon public officials—at the local, state, and federal levels of government—as well as veteran and homelessness groups to hold that VAMC leadership accountable. VAMC's have immense workloads and limited resources, so it can be all too easy for local management to give homelessness short shrift. The field hearings conducted earlier this year by this Subcommittee in the districts of the Chairman and Ranking Member were master classes in how to put management in the relevant VAMC's on notice that ending veteran homelessness must continue to be a top priority.

The Alliance thanks the Subcommittee for consideration of its views as well as its bipartisan determination to end veteran homelessness.

### Appendix: Housing First is a Demonstrated Best Practice

The *Pathways to Housing* program, one of the early versions of Housing First, has greatly informed the field of homeless services. Sam Tsemberis (its founder) first evaluated *Pathways* in 2000 and continued to examine its results in subsequent years. The published findings include:

- [\*Pathways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities\* \(2000\)](#)
- [\*Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program\* \(2003\)](#)
- [\*Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis\* \(2004\)](#)

*Pathways* participants in New York City, many of whom had mental health and/or substance abuse challenges, largely experienced positive housing outcomes. In the five-year longitudinal study, 88 percent remained housed compared to 47 percent of those in the system that required treatment prior to housing placements.

Encouraged by these results, Canada implemented the housing first model. It conducted a [massive evaluation](#), encompassing five cities (Vancouver, Winnipeg, Toronto, Montreal, and Moncton) and over two thousand participants. After two years, 62 percent of the housing first participants were housed the whole time compared to 31 percent of those who were required to participate in treatment prior to the receipt of housing.

In recent years, additional evaluations of housing first were completed in multiple locations including California and New York City. These studies have consistently found greater housing stability among housing first participants:

- [Association of Housing First Implementation and Key Outcomes Among Persons with Problematic Substance Use](#) (2014)
- [Fidelity to the Housing First Model and Variation in Health Service Use Within Permanent Supportive Housing](#) (2015)

Materials prepared by two relevant executive branch agencies support these findings.

The United States Interagency Council on Homelessness (USICH), in a memorandum for local officials, describes Housing First as

*“a proven method of ending all types of homelessness and (it) is the most effective approach to ending chronic homelessness. Housing First offers individuals and families experiencing homelessness immediate access to permanent, affordable or supportive housing. Without clinical prerequisites like completion of a course of treatment or evidence of sobriety and with a low-threshold for entry, Housing First yields higher housing retention rates, lower returns to homelessness, and significant reductions in the use of crisis service and institutions...Housing First should be adopted across your community’s entire homelessness response system, including outreach and emergency shelter, short-term interventions like rapid re-housing, and longer-term interventions like supportive housing.”*

USICH, Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation, Updated September 2016, pages 1-2.  
[https://www.usich.gov/resources/uploads/asset\\_library/Housing\\_First\\_Checklist\\_FINAL.pdf](https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf)

The Department of Housing and Urban Development (HUD) emphasizes the success of Housing First in treating the most difficult category of homelessness:

*“While the principles of Housing First can be applied to many interventions and as an overall community approach to addressing homelessness, permanent supportive housing models that use a Housing First approach have been proven to be highly effective for ending homelessness, particularly for people experiencing chronic homelessness who have higher service needs. Studies such as HUD’s The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness have shown that Housing First permanent supportive housing models result in long-term housing stability, improved physical and behavioral health outcomes, and reduced use of crisis services such as emergency departments, hospitals, and jails.”*

HUD, Housing First in Permanent Supportive Housing Brief, Published July 2014, pages 1-2.  
<https://files.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf>

USICH explains the evidence-based rationale behind quickly connecting those experiencing homelessness with housing and services, i.e., Housing First:

*“Housing stability is essential for people to address their challenges and pursue their goals. Housing and income are core social determinants of personal health, along with the circumstances under which people are born, grow up, live, work, age, and access health care. Substantial evidence indicates that when people—both adults and children alike—experience homelessness, their prospects for future educational attainment, employment growth, health stability, and family preservation are significantly reduced. The lack of a safe and stable home also results, for some people, in increased use of crisis services, like shelter, emergency departments, detox programs, and psychiatric institutions, and greater engagement with other systems, like child welfare and criminal and juvenile justice, creating significant, preventable costs for public programs. To reduce these impacts and end homelessness as quickly and efficiently as possible, communities are increasingly focused on using evidence-based practices to streamline connections to housing opportunities and to provide people with the appropriate level of services to support their long-term housing stability. This shift in focus to permanent housing outcomes, driven by research on effective practices, has helped reduce homelessness nationwide by 13% between 2010 and 2017, according to annual Point-in-Time counts.*

*“Shifting to Housing First: To improve housing outcomes, communities are making a fundamental shift to Housing First, removing as many obstacles and unnecessary requirements as possible that stand in the way of people’s access to permanent housing...”*

USICH, The Evidence Behind Approaches that Drive an End to Homelessness, Published December 2017, page 1.  
[https://www.usich.gov/resources/uploads/asset\\_library/evidence-behind-approaches-that-end-homelessness.pdf](https://www.usich.gov/resources/uploads/asset_library/evidence-behind-approaches-that-end-homelessness.pdf)