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# "Housing First" for the Chronically Homeless: Challenges of a New Service Model

## *Nestor M. Davidson*

Recent efforts to combat homelessness have increasingly focused on the chronically homeless and, in particular, on people grappling wtih mental illness, substance abuse, or other conditions who have often proven most resistant to traditional models of service. With the federal government encouraging local governments to adopt Ten-Year Plans to End Chronic Homelessness,[1] one novel strategy—the "Housing First" approach—is gaining a central place in many local efforts.[2] Housing First, as its name suggests, offers homeless individuals the chance to move directly from the streets to independent housing. This approach reverses the long-standing paradigm of combining shelter with services predicated on individuals' readiness for housing. Traditionally, providers have required that individuals be stabilized through a gradual process of acculturation, with each step in a ladder of greater independence conditioned on meeting service requirements such as following a regime of medication or maintaining sobriety. In place of this approach, Housing First provides shelter without any predicate requirement of treatment or recovery, with intensive services available but not mandatory. The early evidence suggests that long-time homeless individuals with dual or multiple diagnoses find housing more rapidly and remain off the streets longer under this approach. Housing First also appears to reduce costs when compared to the the informal system of shelters, hospitals, mental hospitals, and incarceration that marks the cycle of life on the streets for many of the chronically homeless.

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The rapid proliferation of Housing-First-based programs represents a kind of Kuhnian paradigm shift in combating homelessness,[3] sharply over-turning long-held assumptions about how best to approach the hardest cases. Any change of this magnitude inevitably raises challenges in the process of transitioning from established models. This commentary ex-plores some of the challenges that this shift has engendered, focusing on implementation issues that can arise as service providers and policy mak-ers feel their ways toward a new approach. The author serves on the board of directors of a transitional housing program, and the experience that this organization is undergoing in the process of experimenting with Housing First illustrates some common hurdles facing service providers in this arena. Although there is no silver bullet for the problems of homelessness, chronic or otherwise, the federal government has articulated a serious com-mitment to ending chronic homelessness, and lessons that can be learned as service providers embrace novel approaches like Housing First can shed important light on obstacles to implementation of that goal.

### Chronic Homelessness and the Rise of Housing First

National, state, and local policy makers have focused on homelessness since the early 1980s; and, as with many areas of policy, broad shifts in emphasis have taken place in that time. The McKinney Act,[4] the first com-prehensive federal response to homelessness, initially concentrated on in-creasing shelter capacity with an emphasis on family homelessness and the structural economic predicates to homelessness.[5] Policy makers in the in-tervening decades, however, have grown increasingly aware of the diver-sity of subgroups within the homeless population. Since the revival of the Interagency Council on Homelessness (ICH) in 2002, the federal govern-ment has prioritized the goal of ending chronic homelessness in ten years, a goal first articulated by the National Alliance to End Homelessness in 2000.[6] This ambition—however hortatory—has been at the heart of efforts to promote state-level homelessness coordination and the rapid prolifera-tion of local ten-year plans.[7]

What separates the "chronically homeless" from other segments of those experiencing homelessness on any given night or over the course of the year? The federal government's definition[8] singles out individuals (rather than families) with a disabling condition and emphasizes the length or repeat nature of the homelessness.[9] In other words, for most people who experience episodes of homelessness over the course of a year, the expe-rience of being without a home tends to be a temporary dislocation instead of a repeated occurrence.[10] For a fraction of those on the streets, however, being homeless is anything but short-term or temporary.

Providing a clear picture of any segment of the homeless has always proven difficult, but broadly speaking the chronically homeless tend to be male, middle-aged, and experiencing substance abuse or mental illness, or often both.[11] The best estimates of the size of this population nationwide indicate a range, on a point-in-time basis, of roughly 150,000 to 250,000

individuals, but likely closer to the higher end depending on the definition of chronic homelessness used in the relevant study.[12] This represents approximately 10 percent to 20 percent of the roughly 1.4 million adults who are estimated to experience homelessness over the course of a year.[13]

Although the current focus on chronic homelessness is not without its critics,[14] the argument for focusing on this segment of the homeless population has gained many adherents. As Philip Mangano, ICH's executive director, has testified, chronically homeless individuals present unique and arguably the most severe needs.[15] If the homeless population shared roughly similar characteristics, singling out one segment of the population would make little sense. However, if the condition of homelessness actually represents significantly different challenges for different populations, a unique set of strategies is necessary to target resources toward people whose lack of a home hinges on mental illness and substance abuse. Thus, as the need to create shelter beds for those suffering from a temporary dislocation has arguably become a less pressing policy concern,[16] there is an increasing recognition that much more than emergency services is needed for the chronically homeless.

There is an additional fiscal dimension, also controversial, to the current emphasis on ending chronic homelessness. Prioritizing services for chronically homeless individuals recognizes that this population, particularly individuals with dual or multiple diagnoses, consumes a disproportionate allocation of public resources—by some estimates over half of all emergency shelter services.[17] This concentrated investment is arguably wasteful, given the costs of the services involved in the cycle of shelters, hospitals, mental hospitals, and incarceration[18]—all of which are often more expensive than supportive housing.[19] This is not to say that the vast majority of those experiencing homelessness on any given night or over the course of a year do not need assistance, but rather that they represent a population for whom the services that may best respond to their needs have more to do with basic housing, employment, and income supports.

Given the current prevailing emphasis on chronic homelessness, policy makers and service providers are now embracing an even more fundamental shift in how to respond to the most intractable aspects of chronic homelessness. Rather than providing shelter beds as the primary response to homelessness, an emphasis on permanent supportive housing, and especially Housing First as a service model, is rapidly gaining ground.[20]

As exemplified by its best-studied incarnation, New York's Pathways to Housing program, Housing First combines three basic elements.[21] First, as its name suggests, Housing First prioritizes independent living as the gateway to other supports, typically placing homeless individuals in scattered-site housing.[22] Traditional "continuum of care" approaches often structure the availability of housing along a hierarchy, beginning with outreach, and then moving to various transitional settings, and then, based on the client's perceived "readiness" for housing, ultimately permanent housing, often in a congregate or community-resident setting.[23] Second, and closely related

to this prioritization of housing, is a decoupling of required services—psychiatric, substance-abuse, or otherwise—from an entitlement to housing. In the traditional model, adherence to clinical regimes is often a prerequisite to eligibility for housing and a psychiatric crisis or substance-abuse relapse can be grounds for moving back down the hierarchy of independence or losing a placement altogether.[24] Instead, Housing First makes intensive services available, under a form of the assertive community treatment (ACT) model,[25] but does not make compliance with treatment plans or sobriety the predicate to housing.[26] Finally, Housing First provides services on a "harm-reduction," consumer-focused basis, allowing clients to guide their service plans or refuse services altogether.[27] Fundamentally, Housing First changes the definition of success for serving the homeless—rather than focus on independence and eventual transition, Housing First recognizes that for some clients there will be a permanent need for support and then provides those clients first with housing, then with other services.

The early evidence in favor of Housing First is impressive. One study of the Pathways program showed an 88 percent housing retention rate over a five-year period compared to 47 percent in more traditional programs.[28] Other studies have shown similarly positive housing outcomes.[29] The evidence of nonhousing outcomes, in terms of client satisfaction and mental-health and addiction outcomes, likewise supports Housing First.[30] Studies of supportive housing have shown clear reductions in the use of more cost-intensive interventions, such as hospitalization.[31]

Given this evidence, Housing First, as part of the larger shift in emphasis towards permanent supportive housing, is now regularly touted at the federal level.[32] The model has been explicitly embraced by programs across the country, including in New York, Denver, Seattle, Houston, San Francisco, and elsewhere.[33]

### Transforming Service Delivery and Housing

As Housing First increasingly becomes the predominant service model for responding to chronic homelessness, some local providers have experienced challenges in transforming their approaches. These challenges are by no means unique to Housing First, or to serving the homeless in general, but can raise object lessons.

As noted at the outset, the author serves on the board of directors of a nonprofit organization, Boulder County Advocates for Transitional Housing (BCATH). BCATH was founded as a coalition of local service providers, including the Boulder Shelter for the Homeless, the Mental Health Center of Boulder County, the Center for People with Disabilities, and others, to serve a niche in Boulder County that is perennially underserved.[34] Since its inception, BCATH has exclusively operated transitional housing, with member organizations providing case-management services and housing provided on the predicate requirement that clients follow treatment plans where applicable. Clients are limited to two years in BCATH with the explicit goal of independence following the period of transition. BCATH,

however, is now in the process of creating a new program attempting to incorporate the Housing First model.[35] The experiment is still an early work in progress, but the implementation questions BCATH has confronted, even at this initial stage, are illustrative.

To begin with, some of the funding that BCATH is using raises challenges of matching general funds to a targeted purpose. Although McKinney-Vento funds are now largely focused on permanent supportive housing,[36] providers like BCATH have had to utilize multiple funding sources and resources that are often not directly targeted at the kind of service model represented by Housing First.[37] Indeed, although HUD and the Department of Health and Human Services have advocated the use of "mainstream" funding,[38] doing so can require fitting a decidedly square peg into the round hole of a unique target population. This mismatch can raise practical problems, even though using such mainstream funding is technically proper under open-ended funding requirements.

BCATH's funding for the housing component of its Housing First program is coming from a new Colorado Division of Housing Tenant-Based Rental Assistance (TBRA) program. The TBRA, a pass-through of federal HOME funds and a required local government match, provides a two-year rental subsidy "coupon" similar to Section 8 Housing Choice Vouchers.[39] The TBRA program is designed to serve homeless families living in shelters, the homeless more generally, victims of violence, families currently working, and the elderly and disabled.[40] Nothing in the TBRA program guidance precludes a local provider from targeting the chronically homeless, and the Colorado Division of Housing lists the TBRA program as part of its efforts to end chronic homelessness.[41] However, BCATH is attempting to use funds for a narrow segment of the population that the TBRA program might serve, which requires care in ensuring that the appropriate client base is found—those clients who are hardest to serve in transitional housing and who represent the greatest commitment of public resources in their current status.[42] Using time-limited, general rental assistance to launch a program predicated on a commitment to *permanent* supportive housing requires a leap of faith that either the state will continue the TBRA program or other funds can be identified at the end of the two-year period to continue the Housing First approach.[43]

Moreover, because the TBRA is only a rental subsidy, the individual service providers that make up BCATH are each required to find other sources of funding for the case-management and treatment aspects of the program, a common problem for many service providers.[44] Thus, although a complete Housing First approach typically includes making intensive services available on an ACT model,[45] the BCATH experiment is taking its first steps in this direction without resources for full ACT teams.[46] BCATH is looking for creative ways, for example, to backstop existing case-management services to form more of the kind of safety net that Housing First promises.[47] In the end, however, BCATH is moving forward with an awareness that its model is incomplete.

BCATH, like other organizations moving to Housing First,[48] has had to work to convince stakeholders, including individual service providers and case managers, that the experiment is worth undertaking. Although BCATH lacks the resources to do any comprehensive analysis of service utilization by its clients before and after enrollment in its Housing First program,[49] BCATH is working to identify—at least in general terms—the profiles of its target population.

Moving from transitional housing to Housing First has raised questions from some agencies who work with BCATH about the conceptual merits of the harm-reduction approach, decoupling housing and services from treatment plans, and other requirements.[50] Member agencies have also raised practical questions about how their case managers are to manage a mix of clients, some of whom are working towards independence with the stick of losing eligibility and some of whom, not subject to the same constraints, are being promised essentially permanent help.[51] Operating under two models at the same time presents more logistical and practical flexibility than simply shifting over entirely to a new service model. BCATH is working towards pragmatic answers to all of these challenges, as all local providers must do, but the organization's experience illustrates that even the most potentially promising practices often cannot be successfully adopted over night.

## Conclusion

Housing First is by no means the only tool being employed in current efforts to combat homelessness and particularly chronic homelessness,[52] and one has to be careful about oversimplifying the complex mix of approaches, funding sources, and experiences of thousands of local providers. Moreover, as potentially successful as these tools might be, they are still serving only a fraction of the need.[53] With that in mind, however, it is important to recognize the rise of the Housing First service model and to highlight some of the challenges that transitioning to the model raises as illustrated by the experience of one service organization, BCATH.

As with any transition of this magnitude, there will inevitably be bumps in the road. It is not easy to use mainstream resources in creative ways to convince stakeholders to experiment, and to make changes with the pragmatic realization that it is often impossible to precisely replicate existing successes. But given the increasing emphasis by policy makers and funding sources on evidence-based practices, and the data supporting Housing First's success in helping the most challenging of the long-term homeless get off the streets and reconstruct their lives, it is well worth trying.

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1. *See, e.g., Good ... to Better ... to Great: Innovations in 10-Year Plans to End Chronic Homelessness in Your Community*, U.S. INTERAGENCY COUNCIL ON HOMELESSNESS, *available at* http://www.ich.gov/slocal/Innovations-in-10-Year-Plans.pdf (last visited Apr. 11, 2006).

2. *See generally* Brennen Jensen, *Program Pioneering 'Housing First' is Catching on Across the Country*, CHRON. OF PHILANTHROPY, Aug. 18, 2005, at 7–8; Colleen Fitzpatrick, *'Housing First' Becoming the Standard Model for Homeless Populations*, SPECIAL REPORT: INNOVATIONS IN BEHAVIORAL HEALTH, MENTAL HEALTH WKLY. & ALCOHOLISM & DRUG ABUSE WKLY., Oct. 2004, at 1–3, *available at* www. courtinfo.ca.gov/programs/collab/documents/innovationsissue1.pdf. Housing First has been appearing not only in service plans, but in popular discussions of homelessness as well. *See, e.g.*, Malcolm Gladwell, *Million-Dollar Murray*, NEW YORKER, Feb. 13 & 20, 2006, at 96; *Gimme a roof over my head*, THE ECONOMIST, Aug. 23, 2003, at 19.

3. *See, e.g.*, THOMAS S. KUHN, THE STRUCTURE OF SCIENTIFIC REVOLUTIONS 92–110 (3rd ed. 1996).

4. McKinney-Vento Homeless Assistance Act, 42 U.S.C. §11301–11408a (2004). *See* www.hud.gov/offices/cpd/homeless/rulesandregs/laws/index.cfm (history of law and hyperlinks to U.S.C. sections and related regulations).

5. *See* MARTHA BURT ET AL., HELPING AMERICA'S HOMELESS: EMERGENCY SHELTER OR AFFORDABLE HOUSING? 12, 93 (Urban Inst. Press 2001) [hereinafter, BURT, HELPING AMERICA'S HOMELESS].

6. *See* MARTHA BURT ET AL., STRATEGIES FOR REDUCING CHRONIC STREET HOMELESSNESS: FINAL REPORT xiii, (HUD 2004) [hereinafter BURT, STRATEGIES], *available at* www.huduser.org/Publications/PDF/ChronicStrtHomeless.pdf;*see generally* Martha R. Burt, *Chronic Homelessness: Emergence of a Public Policy*, 30 FORDHAM URB. L. J. 1267 (2003) (describing the recent and rapid emergence of chronic homelessness as a focus of policy) [hereinafter Burt, *Chronic Homelessness*].

7. At last count, 53 state and territorial governors have established or are in the process of creating State Interagency Councils on Homelessness, and 208 mayors and county executives are working on ten-year plans to end chronic homelessness. Interagency Council on Homelessness web page, www.ich.gov (last visited Mar. 24, 2006).

8. An "unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years." *See, e.g.*, Fiscal Year 2006 SuperNOFA for HUD's Discretionary Programs, Part II, 71 Fed. Reg. 11712, 11974 (Mar. 8, 2006). Under the McKinney-Vento Act, by contrast, people are considered homeless more generally if they lack "a fixed, regular, and adequate nighttime residence," 42 U.S.C. § 11302(a)(1), or if their "primary nighttime residence" is a shelter or "a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings." 42 U.S.C. § 11302(a)(2).

9. For these purposes, the federal government defines a disabling condition as "a diagnosable substance abuse disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." *See* 71 Fed. Reg. 3382, 3396 (Jan. 20, 2006).

10. *See* Dennis P. Culhane et al., *Public Shelter Admission Rates in Philadelphia and New York City: Implications of Turnover for Sheltered Population Counts*, 5 HOUS. POL'Y DEBATES 107 (1994), *also available at* www.knowledgeplex.org/showdoc.html?id = 1304; Gladwell, *supra* note 2, at 98.

11. Martha Burt estimates that between 77 percent and 86 percent are men and that approximately 60 percent are between the ages of 35 and 54. *See* Burt, *Chronic Homelessness, supra* note 6, at 1270.

12. *Id.* at 1273. Burt estimates point-in-time numbers of roughly between 48,000 (based on an October sample and a definition "using multiple episodes") and 270,000 (with February estimates and a definition much closer to the current federal definition, but not singling out individuals with a disabling condition). Given that the chronically homeless are less likely to cycle in and out of homelessness in a given year, the higher end estimates are justified. *Id.* Hard data on how many individuals nationwide at any given time are likely to meet the federal definition are not currently available.

13. *See* BURT, HELPING AMERICA'S HOMELESS, *supra* note 5, at 48 (citing the 1996 National Survey of Homeless Assistance Providers and Clients, the most recent national data). The ICH estimates that the chronically homeless represent roughly 10 percent to 20 percent of the adult homeless population. *See Looking at Our Homeless Veterans Programs: How Effective Are They?, Hearing Before the Senate Comm. on Veterans Affairs,* 81st Cong., Mar. 14, 2006 (statement of Philip Mangano, Exec. Dir., Interagency Council on Homelessness, at 2).

14. As advocates have noted, focusing on chronic homelessness raises a concern about pitting one group of potential recipients of assistance against another. *See* Nat'l Policy and Advocacy Council on Homelessness, Questions & Answers about the "Chronic Homelessness" Initiative, www.npach.org/chronicq.html (last visited Mar. 24, 2006). One answer is that there genuinely are two (and likely more) distinct public policy problems encompassed by the label "homelessness." Structural economic determinants and individual factors like mental illness and substance abuse interact in any given instance, *see* Burt, *Chronic Homelessness, supra* note 6, at 1267–68, but at base it is appropriate to distinguish the root causes of and appropriate interventions for "chronic homelessness."

15. *See* Mangano Testimony, *supra* note 13, at 2.

16. *See* BURT, HELPING AMERICA'S HOMELESS, *supra* note 5, at 12.

17. *See* Mangano Testimony, *supra* note 13, at 2.

18. *See* Kim Hopper et al., *Homelessness, Severe Mental Illness, and the Institutional Circuit,* 48 PSYCHIATRIC SERV. 659 (1997) (discussing the "institutional circuit" that many homeless individuals with severe mental illness traverse), *available at* http://ps.psychiatryonline.org/cgi/content/abstract/48/5/659; *see also* Gladwell, *supra* note 2, at 96–97 (describing the cycle of institutional responses for one homeless individual).

19. A recent study comparing the per-day-per-person cost of serving homeless individuals in nine sample cities showed that almost any intervention in the typical cycle of chronic homelessness was more expensive than supportive housing. *See generally* The Lewin Group, *Costs of Serving Homeless Individuals in Nine Cities: Chart Book,* prepared for the Corporation for Supportive Housing (2004), *available at* www.rwjf.org/files/newsroom/cshLewinPdf.pdf. For example, in New York, a day's stay in the hospital was estimated to cost roughly $1,185, mental hospital, $467; jail, $164; and supportive housing, $41.85. In Seattle, the comparable costs were $2,184, $555, $87.67, and only $25 for supportive housing. *Id.* To put this in perspective, the Colorado Coalition for the Homeless Housing First program in Denver reportedly spends about $15,000 per client

annually, a third of what that individual would cost in service utilization out-side the program. *See* Gladwell, *supra* note 2, at 103.

20. One trend fueling the shift toward Housing First and related programs is an emphasis on the federal level and from other funding sources on pro-moting "evidence-based" practices. *See, e.g.,* SUBSTANCE ABUSE & MENTAL HEALTH SERV. ADMIN., U.S. DEP'T OF HEALTH & HUMAN SERV., BLUEPRINT FOR CHANGE: ENDING CHRONIC HOMELESSNESS FOR PERSONS WITH SERIOUS MENTAL ILLNESSES AND/OR CO-OCCURRING SUBSTANCE ABUSE DISORDERS 59 (2003) (dis-cussing evidence-based and promising practices), *available at* www.mental health.samhsa.gov/publications/allpubs/sma04-3870/default.asp.

21. For an excellent description of the Pathways program in practice, *see* JAY NEUGEBOREN, TRANSFORMING MADNESS: NEW LIVES FOR PEOPLE LIVING WITH MENTAL ILLNESS 304–26 (1999). It should be noted that some service providers also apply the "Housing First" label to programs to respond to family home-lessness, although that is not the focus of this commentary.

22. *See* Ronni Michelle Greenwood et al., *Decreasing Psychiatric Symptoms by Increasing Choice in Services for Adults with Histories of Homelessness*, 36 AM. J. COMMUNITY PSYCHOL. 223, 224 (2005); Sam Tsemberis & Ronda Eisenberg, *Path-ways to Housing: Supported Housing for Street-Dwelling Homeless Individuals with Psychiatric Disabilities*, 51 PSYCHIATRIC SERV. 487, 488 (2000), *available at* www. shanj.org/Resources/pathways.pdf

23. *See* Tsemberis & Eisenberg, *supra* note 22, at 488.

24. *Id.*

25. The ACT model involves teams of service providers, such as case man-agers, nurses, social workers, mental-health and addiction counselors, benefits experts, and others, working together with individual clients. *See* Sam Tsem-beris et al., *Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program*, 32 AM. J. COMMUNITY PSYCHOL. 305, 310 (2004) [hereinafter Tsemberis et al., *Consumer Preference Programs*]; *see also* NEUGEBOREN, *supra* note 21, at 305 (de-scribing the Pathways ACT teams).

26. *See* Tsemberis & Eisenberg, *supra* note 22, at 488. Pathways also employs a significant number of fully salaried peer specialists—individuals who have experienced the kinds of mental illness, substance abuse, and homelessness that Pathways clients have. *See* NEUGEBOREN, *supra* note 21, at 308.

27. *See* Tsemberis & Eisenberg, *supra* note 22, at 489. Advocates of Housing First argue that the consumer-driven focus can respond to the dissatisfaction and frustration that many homeless individuals experience in accessing tradi-tional services. *See* Greenwood et al., *supra* note 22, at 224.

28. *See* Tsemberis & Eisenberg, *supra* note 22, at 491.

29. A 2003 study showed that a random sample of chronically homeless individuals with diagnoses of serious and persistent mental disorders and par-ticipants in the Pathways program had a 79 percent rate of stable housing at six months compared to the control group in a more traditional program rate of 24 percent. *See* Tsemberis et al., *Consumer Preference Programs, supra* note 25, at 313. In the same study, 52 percent of Housing First participants moved into housing within the first week, compared to 32 percent in the continuum of care group. *Id.* A 2004 study along the same lines showed an approximately 80 percent retention rate at twenty-four months compared to a roughly 30 percent rate in more traditional programs. *See* Sam Tsemberis et al., *Housing First, Con-*

*sumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis*, 94 AM. J. PUB. HEALTH 651, 654–55 (2004) [hereinafter Tsemberis et al., *Housing First*].

30. Client perceptions of choice have been shown to be stronger in Housing First compared to more traditional programs, which may have an effect on psychological impacts. *See* Greenwood et al., *supra* note 22, at 234–235. In general, it has been harder to show statistically significant differences on symptoms of mental illness, self-esteem, quality of life, substance use, or alcohol use. *Id.; see also* Tsemberis et al., *Housing First, supra* note 29, at 654; Greenwood et al., *supra*, note 22, at 234–35. For proponents of the Housing First approach, however, this lack of evidence of lower mental-health and substance-abuse outcomes is an argument in favor of Housing First.

31. Time hospitalized was shown to be significantly less for Housing First over continuum programs. *See* Leyla Gulcur et al., *Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes*, 13 J. COMMUNITY & APPLIED SOC. PSYCHOL. 171, 177–81 (2003). Likewise, a 2000 study for the Corporation for Supportive Housing showed for supportive housing generally a 12-month reduction in use of emergency services by 58 percent; hospital in-patient bed use declined by 57 percent. TONY PROSCIO, SUPPORTIVE HOUSING AND ITS IMPACT ON THE PUBLIC HEALTH CRISIS OF HOMELESSNESS 15–16 (Corp. for Supportive Hous. 2000).

32. *See* Mangano Testimony, *supra* note 13, at 2.

33. *See* Kevin Fagan, *Homes for the Homeless; Two New Supportive Housing Residences Open in Tenderloin*, S.F. CHRON., Feb. 15, 2006, at B10; David Scharfenberg, *Homelessness Halved*, N.Y. TIMES, Feb. 26, 2006, at 14WC, 1; Lynn Anderson, *City May Expand Housing Program; Officials Seek Funds; Plan Helps Homeless Find Apartments*, BALT. SUN, Feb. 27, 2006, at 1B; *Grand Plans on Homeless Front*, ROCKY MT. NEWS (Denver), May 28, 2005, at 14C; Mike Snyder, *Fifty Homeless People to Get Housing*, HOUSTON CHRON., Feb. 10, 2006, *available at* www.knowledgeplex.org/news/145329.html.

34. Some 1,577 individuals were counted as without a permanent home in Boulder County in the most recent point-in-time survey available. *See* HOMELESSNESS IN METROPOLITAN DENVER: SIXTH ANNUAL POINT-IN-TIME STUDY, 2005, at 18 (2005), *available at* http://mdhi.org/download/files/FULL%202005 %20Point-In-Time%20Study.pdf.

35. BCATH will place chronically homeless clients in scattered-site housing with supportive case management. Clients will not be required to be clean and sober or stay on psychotropic medications but must meet their lease obligations and pay 30 percent of their income in rent.

36. *See* Dept. of Hous. and Urb. Dev., Continuum of Care Homeless Assistance: Supportive Housing Program (SHP), Shelter Plus Care (S + C), Section 8 Moderate Rehabilitation Single Room Occupancy for Homeless Individuals (SRO), 71 Fed. Reg. 12054, 12055–12058 (Mar. 8, 2006) (discussing availability and priorities for the current round of HUD homelessness assistance).

37. Overall, the National Alliance to End Homelessness has estimated that total funding for homeless-assistance programs is roughly $2 billion annually, *see* BURT, STRATEGIES, *supra* note 6, at 19 (citing National Alliance to End Homelessness, *A Plan, Not a Dream: How to End Homelessness in Ten Years* (2000)), but

much of this funding has traditionally not been specifically targeted at chronic homelessness.

38. A HUD-commissioned study, *Strategies for Reducing Chronic Street Homelessness*, canvassed the number of sources other than core federal grants under the McKinney-Vento Act, noting that local programs across the country use a blend of federal, state, and local sources, as well as private-sector support. *See* STRATEGIES, *supra* note 6, at 63–76. Overall, however, the study argues that "reducing chronic street homelessness requires significant investment of mainstream public agencies," *id.* at 74, and creative blending of existing resources, *id.* at 70. Likewise, the HHS Blueprint for Change advocates using "mainstream resources" to serve the homeless. *See* BLUEPRINT, *supra* note 20, at 93–100.

39. *See* COLORADO DEPARTMENT OF LOCAL AFFAIRS, DIVISION OF HOUSING, PROGRAM GUIDELINES FOR TENANT BASED RENTAL ASSISTANCE 4 (2004).

40. *Id.* at 5–7.

41. *See* Colorado Division of Housing, PHA Plans 5-Year Plan for Fiscal Years 2005–2009, Annual Plan for Fiscal Year 2007, at 11 (2006), *available at* www.dola.state.co.us/DOH/Documents/co911.pdf.

42. Finding clients is not as simple as walking up to homeless people on the street and offering them apartments. An individual service provider commitment must be found for each client, and BCATH is relying on its constituent agencies to provide referrals. Because BCATH's transitional program has been more open-ended, a wider client base has been available.

43. BCATH's Housing First program is targeting chronically homeless individuals with dual or multiple diagnoses.

44. See BURT, STRATEGIES, *supra* note 6, at 70 ("One of the biggest problems for homeless assistance providers is assembling the funds to be able to offer all the various services that chronically street homeless people with disabilities are likely to need.").

45. *See supra* text accompanying notes 25–26.

46. BCATH is doing so in the hope that such resources can be identified as the program moves forward.

47. Some clients, for example, will be eligible for Medicaid Waiver Home and Community Based Services (HCBS), which can provide access to around-the-clock emergency services. *See generally* COLO. REV. STAT. 26–4-671 to 26–4-676, *as amended*; 42 C.F.R. 441.300 to 441.310, COLO. DEP'T OF HEALTH CARE POL'Y & FINANCING, STAFF MANUAL VOLUME 8, MEDICAL ASSISTANCE, SECTION 8.509, *available at* www.chcpf.state.co.us/HCPF/MedicaidEligibility/mefcc.asp.

48. For a fascinating case study of the institutional, cultural, and bureaucratic challenges that attended the introduction of a Housing First program on a county-wide basis in one instance, *see* Barbara J. Felton, *Innovation and Implementation in Mental Health Services for Homeless Adults: A Case Study*, 39 COMMUNITY MENTAL HEALTH J. 309 (2003). Felton describes initial opposition to the introduction of Housing First by providers and other stakeholders, although Felton reports that Housing First eventually took hold. *Id.* at 318.

49. A process that would, in any event, raise privacy concerns to the extent information is being gathered from agencies with whom potential clients have existing relationships.

50. The goals of Housing First fundamentally differ from transitional housing in that the primary desired outcome is that a client stay housed as long as possible. The primary outcome measure is thus how long a client stays in hous-

ing and out of shelters, hospitals, and jail. This differs from BCATH's transitional housing, where success means moving clients out of the program and into stable housing.

51. Another challenge in moving from the transitional model to a TBRA-based Housing First program is making the program work with vouchers. BCATH transitional housing uses units that the organization owns, whereas Housing First requires building relationships with private landlords and helping clients in their relationships with landlords.

52. *See* BURT, STRATEGIES, *supra* note 6, at 19.

53. Denver's Housing First program, for example, has had wait lists of six or seven times the one hundred clients that the program is designed to serve. *See* John Parvensky, *Letter from the President*, LASTING SOLUTIONS (Colorado Coalition for the Homeless, Denver, CO), Fall/Winter 2004 Issue, at 2 (reporting a wait list of seven hundred), *available at* http://www.coloradocoalition.org/images/advocacy_images/nl200410pit.pdf; Stuart Seers, *The 'Housing First' Revolution*, ROCKY MT. NEWS (Denver), May 24, 2005, at 5A (reporting a wait list of six hundred).