

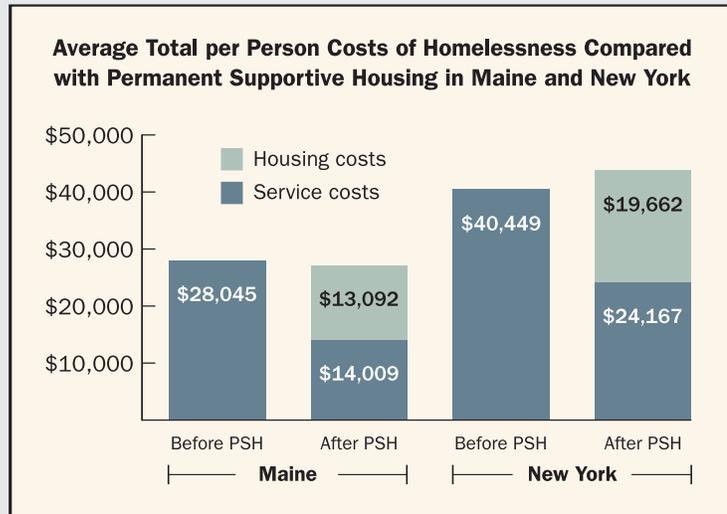


# **The Costs and Benefits of Assisting Vermont's Chronically Homeless**

*May 2008*

## Executive summary

Evidence is clear that ignoring the long-term needs of people with persistent homelessness and serious disabilities is costly and ineffective. Caring for this population (often referred to as the “chronically homeless”) in emergency settings, such as hospitals, and then releasing them back to a life of homelessness with its inherent health risks creates a short-sighted, costly cycle. Each year, additional studies show that providing permanent supportive housing — permanent, affordable housing coupled with a comprehensive array of services tailored to individual needs, such as preventative health care and substance abuse counseling — vastly improves the effectiveness of public dollars spent for the chronically homeless. Studies show that:



Data source: Mondello, Gass, McLaughlin, and Shore, *Costs of Homelessness: Cost Analysis of Permanent Supportive Housing, State of Maine, Greater Portland, 2007* and Houghton, T., *The New York/New York Agreement Cost Study: The Impact of Supportive Housing on Services Use for Homeless Mentally Ill Individuals, 2001*.

- Providing supportive housing to people with chronic homelessness cuts their average health care, police and prison costs in half by encouraging preventive health care rather than emergency medical treatment and drastically reducing the frequency of incarceration.<sup>1</sup> For example, movers into permanent supportive housing in Connecticut reduced their Medicaid usage for inpatient services by 71%. (Arthur Andersen LLP, 2002)
- Since the cost of the services they need decreases so dramatically when a chronically homeless person becomes housed, public funds formerly spent on costly emergency services can be used instead to pay for permanent housing. Consequently, the total monetary cost of providing a comprehensive package of permanent supportive housing is less or not much more than the costs of the emergency interventions required for people who remain chronically homeless.<sup>2</sup>
- Public dollars spent to move a chronically homeless person to permanent supportive housing achieve far more desirable long-term outcomes than serving them through emergency services. The vast majority of chronically homeless individuals who enter permanent supportive housing remain in their homes, leading more healthy and stable lives, freeing up much-needed beds in emergency shelters, and reducing overall homelessness in the community.<sup>3</sup>
- People with chronic homelessness are unlikely to extricate themselves from homelessness without help. It is extremely difficult for chronically homeless people to

1 Supporting studies include Mondello, Gass, McLaughlin, and Shore, 2007; Moore, 2006; and Culhane, Metraux, and Hadley, 2002.

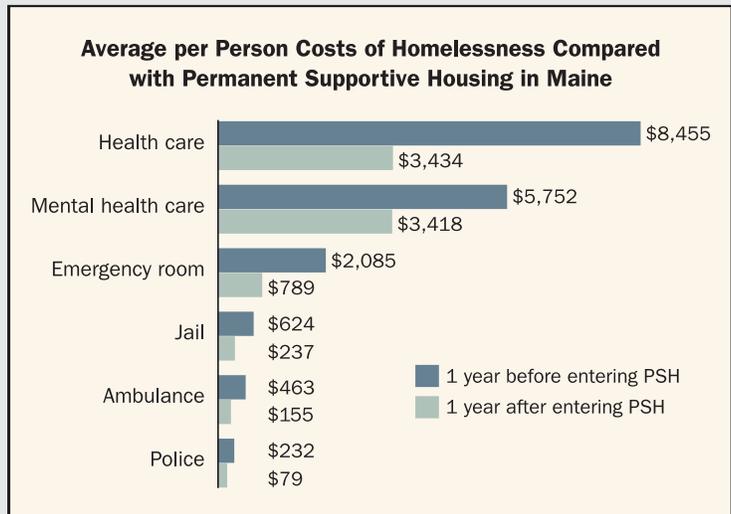
2 See note 1.

3 Supporting studies include Mondello, Gass, McLaughlin, and Shore, 2007; Tsemberis and Eisenberg, 2000; Trotz, 2005; and Arthur Andersen LLP 2002.

recover from an illness or obtain the treatment they need without a permanent home or support services. They are likely to need services in a variety of areas, such as primary and mental health care, substance abuse treatment, income and employment, and life skills, delivered through an extremely well-integrated system. (U.S. Substance Abuse and Mental Health Services Administration, 2003)

A growing body of evidence of cost offsets and improved outcomes has prompted many states and communities to increase their stock of permanent supportive housing. As of March 2008, reports documenting the costs offset by permanent supportive housing have been published in at least 20 different U.S. locations.<sup>4</sup> Studies in other locations are still in progress or had results that were incorporated in local planning documents and not separately published.

Addressing the diverse needs of the chronically homeless requires that policy makers, housing managers, and service providers invest time and effort into forging new partnerships. However, as shown by existing studies, this investment is well worth the individual and community benefits of providing healthier, stable lives for people who would otherwise spend their lives on the streets. Increasing the supply of permanent supportive housing is a way for society to accept its collective responsibility for distributing resources so that everyone, including those with the most complex needs, has access to housing.



Data source: Mondello, Gass, McLaughlin, and Shore, *Costs of Homelessness: Cost Analysis of Permanent Supportive Housing, State of Maine, Greater Portland, 2007*.

	Supportive housing	Jail	Prison	Shelter	MH Hospital	Hospital
Atlanta	\$33	\$53	\$47	\$11	\$335	\$1,637
Boston	\$33	\$92	\$117	\$40	\$541	\$1,770
Chicago	\$21	\$60	\$62	\$22	\$437	\$1,201
Columbus	\$30	\$70	\$59	\$25	\$451	\$1,590
Los Angeles	\$30	\$64	\$85	\$38	\$607	\$1,474
New York	\$42	\$165	\$74	\$54	\$467	\$1,185
Phoenix	\$21	\$46	\$87	\$22	\$280	\$1,671
San Francisco	\$42	\$94	\$85	\$28	\$1,278	\$2,031
Seattle	\$26	\$88	\$96	\$17	\$555	\$2,184
<b>Median</b>	<b>\$30</b>	<b>\$70</b>	<b>\$85</b>	<b>\$25</b>	<b>\$467</b>	<b>\$1,637</b>

Median costs per day

Data source: The Lewin Group, "Costs of Serving Homeless Individuals in Nine Cities," 2004

<sup>4</sup> Links to these studies are available in this report's bibliography and the "Evaluation and Research Resources – Chronic Homelessness" section of the Corporation for Supportive Housing's on-line library at <http://www.csh.org/index.cfm?fuseaction=document.selectSubTopics&parentTopicID=42>.

## Introduction

Although homelessness is not acceptable on any level, the extent to which different people experience homelessness in Vermont varies greatly. At one end of the spectrum, unexpected events leave some of us struggling to make ends meet and at risk of losing our homes. Further along the spectrum, some neighbors lose the struggle and face temporary periods of homelessness. Vermonters at the other end of the spectrum face a life of persistent homelessness, many of whom have debilitating illnesses or addictions. Chronically homeless people may have severe mental illness, substance abuse problems, other disabling medical conditions, or an all too common combination of these conditions.

Chronically homeless people may have severe mental illness, substance abuse problems, other disabling medical or an all too common combination of these conditions

The term “permanent” housing is important because it differs from other types of housing for the homeless, such as emergency overnight shelters, or transitional housing which is often available for a limited amount of time, such as 6 months to 2 years. Both emergency shelters and transitional housing usually have some level of supportive services, or at least can connect people with available community resources. Permanent supportive housing typically provides:

- Individually tailored and flexible supportive services that are voluntary and easily accessed and not a condition of ongoing tenancy;
- Leases that are held by the tenants without limits on the length of stay; and
- Ongoing collaboration between service providers, property managers, and tenants to preserve tenancy and resolve crisis situations that may arise (Caton, Wilkins, and Anderson, 2007).

Vermont has the highest rate of overall homelessness in New England

Vermont has the highest rate of overall homelessness in New England, according to the latest comparison of homeless count results for the region (Univ. of Mass.-Boston, 2007). Vermonters who are chronically homeless outnumber the permanent supportive housing units dedicated to them by more than 2 to 1 (VT Continuums of Care, 2007). This leaves many chronically homeless people on the streets or cycling in and out of shelters, hospitals, and jails. A desire to shift public money spent on emergency services for the homeless to an approach with better long-term outcomes prompted a coalition of organizations to explore the likely effects of increasing the availability of permanent supportive housing in Vermont. Commissioned by these organizations, this paper identifies potential costs and benefits of providing chronically homeless Vermonters with permanent supportive housing, based on research in other areas of the country.

The information presented in this paper is primarily from studies on the costs of homelessness compared to the costs of providing permanent supportive housing to people who were chronically homeless in areas outside Vermont. Due to its timeliness and the similarities that

Facts and figures on Vermont homelessness, 2007	
Homelessness rate per thousand residents	3.4%
Total number of people served annually in Vermont shelters	3,463
Percentage single adults	63%
Percentage in families	37%
Percentage adults	72%
Percentage children	28%
Estimated chronically homeless	191
Households in permanent supportive housing	184

Data sources: VT Office of Economic Opportunity, Emergency Shelter Grants Program Fiscal Year 2007 Report; University of Massachusetts-Boston, "Homelessness In New England"; and VT Continuums of Care 2007 applications for Chittenden County and the Balance of State.

exist between Vermont and Maine such as location, population, and rural environment, a recent report on permanent supportive housing in the greater Portland, Maine area is most often cited. In addition to information from existing studies, this paper also includes selected information on costs associated with chronically homeless Vermonters.

### The chronically homeless have complex needs

HUD defines chronic homelessness as an unaccompanied homeless individual with a disabling condition who: (1) has been continuously homeless for a year or more; or (2) has had at least four episodes of homelessness in the past three years. A disabling condition is defined as "a diagnosable substance abuse disorder, a serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." (U.S. Dept. of Housing and Urban Development, Sept. 2007)

The chronically homeless consume most of the social services targeted for the homeless population, and are unlikely to find homes without significant housing and service supports. (U.S. Substance Abuse and Mental Health Services Administration, March/April 2005) Living in an emergency shelter or on the streets with disabling conditions is extremely difficult when stressful living conditions exacerbate symptoms and make it difficult to follow through with treatment and receive preventive care.

According to the U.S. Substance Abuse and Mental Health Services Administration, a fundamental tenet underlying assistance to the chronically homeless must be that people with serious mental illness and/or substance use disorders can and do recover, despite widespread beliefs that these conditions are permanent (U.S. Substance Abuse and Mental Health Services Administration, 2003). Offering safe and affordable housing can go a long way in achieving that goal, however, recovery also requires coordinated multiple services including:

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## Chronically homeless families

Since HUD introduced its definition of chronic homelessness, some service providers have suggested that although individuals represent the vast majority of the chronically homeless, families (the fastest growing segment of the homeless population) may also experience long term and/or frequent homelessness (National Center on Family Homelessness, 2007). However, few studies have focused on the likely costs and benefits of casting the net of permanent supportive housing wider to include homeless families. Compared to single adults, families are likely to utilize services from an even wider variety of systems, making a comprehensive cost study more challenging. For example, homeless children may present unique costs for school districts, such as transportation from shelters outside of the district and increased guidance counseling.

Despite the administrative challenges of conducting costs studies pertaining to homeless families, providing the permanent housing and support service solutions these families need is no less urgent. Members of families with chronic homelessness may have some of the same characteristics and needs as single adults. The record number of homeless families seeking emergency shelter combined with evidence of the dramatic effect of homelessness on children illustrates the seriousness of the need among this segment of the population:

- Homeless children are sick at twice the rate of other children.
- Homeless children have twice the rate of learning disabilities and three times the rate of emotional and behavioral problems of non-homeless children.
- Half of school-age homeless children experience anxiety, depression, or withdrawal compared to 18 percent of non-homeless children (National Center on Family Homelessness, 2007).

- Health care
- Mental health services
- Substance abuse treatment
- Income supports and entitlements
- Life skills training
- Education
- Employment

These services are most effective if provided through a comprehensive, integrated system of care that is seamless to the recipient (U.S. Substance Abuse and Mental Health Services Administration, March/April 2005).

Most of Vermont's existing stock of 175 permanent supportive housing units for the chronically homeless consists of apartments owned by private landlords, with rental assistance provided through HUD tenant-based housing vouchers called Shelter Plus Care. Supportive services are delivered through one of ten local mental health centers, Community Action Programs, and other service partners across the state. Funding for services comes from HUD's Supportive Housing Program for the homeless, the federal Community Services Block Grant, Medicaid and other sources. Because these funds are usually provided for a year at a time, they do not provide long-term stability for involved agencies and housing managers. Also, much of the service funding created for people who are homeless has strict rules limiting the time people can continue receiving services after they are housed. Some formerly homeless people may live in permanent housing for as little as six months before services they need to stabilize their lives, such as treatment for mental illness, are stripped away, potentially launching them back into a cycle of street homelessness.

## Costs and Benefits of Addressing Chronic Homelessness

Due to the instability created by their combined homelessness and disabilities, most chronically homeless people are heavy users of public resources, such as emergency rooms and jails. For this reason, a number of states and communities have completed studies comparing these costs with the costs of providing the chronically homeless with permanent supportive housing.

Most of these studies show that not intervening on behalf of the chronically homeless carries high public monetary costs, without improving the long-term stability of their lives. The publicly funded institutions and facilities that primarily serve the chronically homeless fall into three categories: primary and mental health care providers, police departments and jails, and emergency shelters.

### *Primary and Mental Health Care Providers*

People who are chronically homeless have at least one disabling condition that jeopardizes their health. Those with serious mental illnesses and/or substance use disorders often have additional significant medical conditions, including malnutrition, diabetes, liver disease, neurological impairments, and pulmonary and heart disease (U.S. Substance Abuse and Mental Health Services Administration, 2003). Communicable diseases, including HIV/AIDS, Hepatitis B and C, tuberculosis and a wide variety of other infections ravage the homeless population and can quickly escalate from individual problems to costly and deadly public health emergencies. Furthermore, trauma resulting from violence and exposure to the elements is common. In addition to the many health problems that are particularly prevalent among the homeless, they also have all the same health problems as people with homes, but at rates three to six times greater (National Health Care for the Homeless Council, 2007).

### **Characteristics associated with chronic homelessness**

- Disabling conditions that almost universally involve serious health conditions, substance abuse, and psychiatric illnesses.
- The frequent use of the homeless assistance system and other health and social services which are costly and limited public resources.
- Frequent disconnection from their communities, including limited support systems, and disengagement from traditional treatment systems.
- Multiple problems such as frail elders with complex medical conditions or HIV patients with psychiatric and substance abuse issues.
- Fragmented service systems that are unable to meet their multiple needs in a comprehensive manner.

*Source: Adapted from U.S. Dept. of Health and Human Services. Ending Chronic Homelessness: Strategies for Action, 2003. <http://aspe.hhs.gov/hsp/homelessness/strategies03/>*

## Homelessness in Vermont: Health Care

“Our Housing First program is having similar results as permanent supportive housing programs in other parts of the country. We placed in stable housing units ten chronically homeless people who had extremely high levels of needs, including both severe mental illness and substance abuse. We then created the package of wrap-around social services that each client needed. Most have stayed in their units, with a substantial drop in their use of emergency room and other urgent services.”

— Tom Cimock, Homeless Health Care Program Director, Community Health Center of Burlington



Costs of providing emergency medical services in Vermont are on the rise, as operating expenses, gas and oil costs increase faster than inflation. The average cost of an admission to one of Vermont’s 14 hospitals was \$9,128 in 2007 (VT Dept. of Banking, Insurance, Securities and Health Care, May 2007).

Most Vermont hospitals have seen an increase during recent years in the relative amount of free care they provide to Vermonters living in poverty. Vermont’s 14 hospitals provided \$18.9 million of free care in 2007. Free care in hospitals is paid for through “cost shift,” and absorbed principally by payers of private health insurance, according to the Vermont Department of Banking, Insurance, Securities and Health Care (VT Dept. of Banking, Insurance, Securities and Health Care, Jan. 2007). Several community-based clinics, such as the Community Health Center of Burlington, also serve Vermont’s homeless population. In 2006, the Community Health Center of Burlington served 1,164 homeless adults, adolescents, and children.

Without health insurance, a connection to low-cost preventative health care, or a home in which to recuperate, some of the chronically homeless ignore health problems and avoid seeking medical treatment until problems become urgent medical emergencies. Ultimately, most people who are homeless do get treated, but it is often treatment of the most expensive sort, delivered in hospital emergency rooms and acute care wards. In addition, people who are homeless served in hospitals or nursing homes may require prolonged, more costly, inpatient stays since they have no home in which to complete their recovery. Through taxpayer support of public institutions and through the cost shifting inherent in the current health insurance system, we all pay the high costs of deferred care (National Health Care for the Homeless Council, 2007).

Not surprisingly, many studies have shown an overall decrease in the cost of providing health care to people who are chronically homeless after they enter permanent supportive housing, due to a reduced use of ambulances, emergency rooms, and inpatient hospitalizations. However, these studies also show that participants’ use of non-emergency health care services often increases initially after entering permanent supportive housing programs because they become more connected to the network of services they need to address their disabilities. In this way, the permanent supportive housing shifts the health care services used by participants from acute, emergency care to proactive, outpatient treatment.

A recent study of 99 people who had a long history of homelessness and were disabled in the Portland, Maine area compared the public costs of services during the year after they entered permanent supportive housing to the year before

(when they were homeless). Emergency room use among this study group decreased by 52% and associated emergency medical costs decreased by 62% after participants entered permanent supportive housing. In addition, ambulance use decreased by 60% and ambulance costs decreased by 66%. Furthermore, inpatient hospitalizations decreased by 77% after clients were placed in permanent supportive housing. Prescription drug costs among the Portland participants increased by 31%, suggesting that they were taking advantage of less expensive outpatient treatment (Mondello, Gass, McLaughlin, and Shore, 2007).

Studies in other locations have had similar results. Participants in the Connecticut Supportive Housing Demonstration Program experienced a significant decrease in the use of acute health services and increasing use of less expensive ongoing preventive health services such as home health care, outpatient mental health and substance abuse services, medical and dental services. For Medicaid eligible tenants whose service utilization records were examined during the two years prior and three years following entry into permanent supportive housing, there was a 71% decrease in the average Medicaid reimbursement per tenant using medical inpatient services (Arthur Andersen LLP, 2002). Homeless adults in public hospitals in New York City stayed on average 36 percent longer than other (housed) patients, controlling for differences in demographics and diagnoses (Culhane, Parker, Poppe, Gross, and Sykes, 2007).

Homeless adults in public hospitals in New York City stayed on average 36 percent longer than other (housed) patients

In addition to reducing their use of expensive health care services, participants show substantial health improvements after moving to permanent supportive housing including mental health and substance abuse recovery, according to existing studies. However, these improvements may take several years to occur. According to HUD's recent report on the early results from three recently initiated permanent supportive housing programs, "substantial progress toward recovery and self-sufficiency often takes years and is not a linear process, rather it's a series of ups and downs." (U.S. Dept. of Housing and Urban Development, July 2007).

### *Police Departments and Jails*

Some people with chronic homelessness frequently find themselves in handcuffs or jail, especially if their mental illness or addictions prompt disruptive or vio-

## Homelessness in Vermont: Corrections

Some of Vermont's chronically homeless cycle between jails and homelessness, while the jail costs alone quickly mount. Scott is a homeless Vermonter with alcoholism who lives just such a life. "When I reviewed his records, I realized how many times Scott was picked up and released. For example, this happened 19 times during March 2007. This means that in a single month, Scott went through intake procedures (including being searched and showered) 19 times. He also received 19 medical screenings and 19 mental health / substance abuse screenings, was held for 24 hours of observation 19 times, and went through release procedures 19 times, all in a single month. Scott's crimes are petty and non-violent. During this month, 18 of his jail stays were due entirely to incapacitation. The 19th time was an arrest for unlawful trespassing into a garage for shelter."

— John Perry, Vermont Department of Corrections



The average annual cost of incarceration in Vermont has grown steadily during the decade to the current level of \$46,000, or \$126 per day (VT Dept. of Corrections, 2007). Using the example described above, Scott's jail time alone cost nearly \$2,400 in a single month. According to the Vermont Department of Corrections, there are a number of reasons for the escalating incarceration price tag, including the lack of supportive housing for offenders re-entering the community. A significant number (179) of the current inmates in Vermont are being held past their minimum release dates, primarily due to lack of housing. It is not uncommon for offenders who are released to return to prison because they fail to make rent payments, violating their release conditions. Other inmates are considered "hard-to-house" and need services at the ready to help them make rent payments, for crisis intervention, and to provide referrals for other services. Although several housing retention specialists currently provide these services, more case management is needed to fully serve these re-entering individuals, according to the Department of Corrections (VT Dept. of Corrections, 2007).

lent behavior. A number of studies have found that the public costs to police departments and jails are significantly higher for people who are chronically homeless than for those who have entered permanent supportive housing.

Police had 68% fewer contacts with formerly homeless individuals after they moved into permanent supportive housing in the Portland, Maine area. In addition, there was a 62% reduction in the number of days spent in jail and in the cost of incarceration after entering permanent housing (Mondello, Gass, McLaughlin, and Shore, 2007). Similar improvements occurred for dually diagnosed chronically homeless adults in Portland, Oregon. Enrollment in the Community Engagement program resulted in a 75% decline both in the number of jail stays and in the estimated cost of incarceration for program participants (Moore, 2006).

### Emergency Shelters

Permanent supportive housing appears to be highly successful in ending the cycle of homelessness. Most participants stay in their units and avoid returning to emergency shelters. Participants' shelter use in Portland, Maine plummeted 98% during the year after they moved to permanent supportive housing. Of those who did use a shelter after starting the permanent supportive housing program, most used a partner shelter expressly for people with substance abuse problems during their transition to more independent living (Mondello, Gass, McLaughlin, and Shore, 2007).

Other studies found that 75% to 88% of permanent supportive housing participants remained in their units during the first 1 to 5 years after initial place-

ment. After five years, a permanent supportive housing program in New York City had an 88 percent housing retention rate compared to 47 percent for programs in which participants lived in congregate, residential treatment settings, such as group homes (Tsemberis and Eisenberg, 2000). A permanent supportive housing program that started in San Francisco in 1988 reported recently that 67% of the program's original residents are still in their original units (Trotz, 2005). Connecticut's evaluation in 2002 of nine PSH projects found that 61% of the participants remained in their original units after four and a half years and another 25% moved successfully to other permanent housing (Arthur Andersen LLP, 2002).

## Barriers to Creating More Permanent Supportive Housing

Despite direct benefits for the chronically homeless and their communities, creating permanent supportive housing challenges the ways in which systems with different funding streams, philosophies, and missions typically operate. For example, creating permanent supportive housing typically involves combining traditional affordable housing development with supportive service programs that have different timetables and linkages. Housing developers often take out 30-year mortgages and make long-term legal commitments to provide affordable housing in exchange for public resources or tax credits needed to fund housing construction. For a new supportive housing project, housing funders want to ensure that necessary services will be in place for the long run, to ensure both tenants and the housing developer success in their endeavors.

### Homelessness in Vermont: Shelters

"I am deeply troubled when we have to turn someone away because we are full. Although we work with folks to find other alternatives, it is morally wrong to have to turn anyone away because we are full."

— Linda Ryan, Executive Director, Samaritan House,  
St. Albans, Vermont



When people enter permanent supportive housing, they free up much needed emergency shelter space. Vermont shelters housed about 40 percent of the Vermonters who were homeless during an average night in 2007 (VT Continuums of Care, 2007). Others resorted to sleeping in cars, doubling up with friends or family, or seeking other types of refuge. Emergency shelters are targeted to people with unanticipated, temporary shelter needs. Beds taken by people with chronic homelessness create a shortage that has dire consequences when people who find themselves temporarily homeless are turned away. Although shelter directors report an increasing number of homeless Vermonters since 2000, the number of people the state's shelters are able to serve has decreased because the average client is staying longer (VT Office of Economic Opportunity). Almost all Vermont shelters have waiting lists on a regular basis.

The costs of running emergency shelters vary widely, depending on their location, the level of services they offer, and the extent to which donated facilities, materials, and volunteer staff offset regular operating costs. At Committee on Temporary Shelter family and adult shelters in Burlington, the cost of each stay averaged approximately \$939 for each single adult and about \$6,946 per family in 2007. At the Upper Valley Haven family shelter in White River Junction, the cost of each stay averaged approximately \$2,700 per person.

Unfortunately, traditional supportive service funding comes through 1-year state or federal government commitments. Therefore, the long-range commitment that housing funders look for is often impossible. Additionally, service funding is designed to follow a person with a specific diagnosis or level of need, and is rarely tied to a building or housing development. Consequently, if a person with services available to him/her moves out, funding for services may leave with them, creating uncertainty for the next tenant and for the property manager or landlord.

An added challenge is that each system (housing and services) has different public expenditure timing. A substantial portion of the public dollars spent on a permanent supportive housing resident may occur at once — when the housing is acquired, built, or renovated. Conversely, public expenditures for someone who is homeless are likely to be spread out as the person cycles in and out of emergency health care and corrections systems. Their extremely low incomes present further challenges for moving chronically homeless people to permanent supportive housing. People who are chronically homeless often qualify for federal disability benefits, or Supplemental Security Income (SSI). In Vermont, this means an income of only \$689 per person per month, as of 2008 (U.S. Social Security Administration, 2008). The rent for a 1-bedroom apartment at HUD’s fair market rate of \$682 would consume virtually all of a Vermonter’s monthly SSI check.<sup>5</sup> In addition, coordinating the expectations of private landlords and property managers with the behavior of people with significant disabilities and a history of chronic homelessness may be challenging. Landlords may want more involvement from service providers than they are willing or able to commit to a particular tenant.

## Conclusions

Permanent supportive housing addresses the dual needs of the chronically homeless for both housing and services with far superior outcomes to the traditional system of piecemeal emergency interventions

For about the same level of investment, permanent supportive housing addresses the dual needs of the chronically homeless for both housing and services with far superior outcomes to the traditional system of piecemeal emergency interventions. The monetary investment needed to provide a more stable life for people who are chronically homeless is less or not much more than these individuals are already costing through emergency interventions, according to most existing studies.<sup>6</sup> Furthermore, the quality of life for individuals provided with stable

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<sup>5</sup> Fair Market Rents (FMRs) are rent estimates calculated annually by the U.S. Dept. of Housing and Urban Development. FMRs are 40th percentile rents, the dollar amount below which 40 percent of standard quality rental housing units rent, including the cost of utilities. The statewide average FMR is an average of each county’s FMR weighted by the county’s renter population.

<sup>6</sup> These studies include Mondello, Gass, McLaughlin, and Shore, 2007; Moore, 2006; Culhane, Metraux, and Hadley, 2002; and Culhane, Parker, Poppe, Gross, and Sykes, 2006 — a literature review of the many studies reviewed during the 2007 National Symposium on Homelessness Research.

housing sky rockets when compared to the despair and constraints intrinsic in life in shelters or on the streets.

Vermont has an opportunity to eliminate chronic homelessness by capitalizing on evidence from other locations and setting its own stage for action. Existing studies document the potential benefits of serving our chronically homeless individuals through permanent supportive housing rather than through emergency interventions. In addition, policy makers and practitioners have the benefit of the lessons learned by many states and communities who have already forged the administrative and funding partnerships required for permanent supportive housing.

Vermont has an opportunity to eliminate chronic homelessness by capitalizing on evidence from other locations and setting its own stage for action

Creating more permanent supportive housing will undoubtedly involve an in-depth plan identifying the funding and partnerships that will work for Vermont's unique housing and service delivery systems. Shifting Vermont's system of caring for the chronically homeless away from emergency services and toward permanent, supportive housing will require initial capital investments from government agencies and private partners. This investment will be recouped through reduction in the costs of emergency services, mostly in mental and primary health care costs, and the longer term individual and community benefits of reduced homelessness. More creative approaches will also be needed to link long-term commitments of affordable housing funding with adequate supportive services.

Further research could help clarify the specific costs and benefits of addressing chronic homelessness that would be likely here in Vermont, particularly for an expanded target population such as individuals and families. This research might examine the experiences of the residents of the state's current permanent supportive housing units, perhaps assessing the longer term costs, benefits, and outcomes of their tenure in the program.

By taking steps to improve the supply of permanent supportive housing for Vermonters with chronic homelessness, policy makers move Vermont closer to the goal of ensuring that everyone, including those with the most complex needs, has access to housing. In addition to the individual benefits of stable housing, Vermont communities benefit from reduced homelessness by knowing that the needs of its disadvantaged, vulnerable, seriously ill members are being addressed. ■

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**Writing** **Leslie Black-Plumeau**  
*Vermont Housing Finance Agency*

**Maura Collins**  
*Vermont Housing Finance Agency*

**Editing** **Polly Nichol**  
*Vermont Housing & Conservation Board*

**Cynthia Reid**  
*Vermont Housing Finance Agency*

**Gustave Seelig**  
*Vermont Housing & Conservation Board*

**Brian Smith**  
*Vermont Agency of Human Services*

**Cathy Voyer**  
*Vermont Agency of Human Services*

**Review** **The Carsey Institute**  
*University of New Hampshire*

**Design** **Craig Bailey**  
*Vermont Housing Finance Agency*