WISCONSIN FAMILY IMPACT SEMINARS

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*Using research to build
better public policy for families*

A Place to Call Home:
Evidence-Based Strategies for Addressing
Homelessness across Wisconsin

Robert M. La Follette
School of Public Affairs
UNIVERSITY OF WISCONSIN–MADISON

A Place to Call Home:
Evidence-Based Strategies for
Addressing Homelessness across Wisconsin

Briefing Report for the 35th Wisconsin Family Impact Seminar

FIRST EDITION

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PURPOSE OF THE WISCONSIN FAMILY IMPACT SEMINARS

Since 1993, the Wisconsin Family Impact Seminars have provided objective, high-quality research on timely topics identified by state legislators. The seminars promote greater use of research evidence in policy decisions and encourage policymakers to view issues through the lens of family impact. The family impact lens highlights the consequences that an issue, policy, or program may have for families, so policymakers can make decisions that strengthen the contributions families make for the benefit of their members and the good of society.

The award-winning Family Impact Seminar model is a series of presentations, discussion sessions, and briefing reports for state policymakers, including legislators and their aides, the Governor and gubernatorial staff, legislative service agency analysts, and state agency officials. The seminars provide neutral, nonpartisan opportunities for legislators to engage in open dialogue, foster relationships, and find common ground.

"A Place to Call Home: Evidence-Based Strategies for Addressing Homelessness across Wisconsin" is the 35th Wisconsin Family Impact Seminar. For additional information and resources, visit our website at **www.wisfamilyimpact.org**.

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PREVIOUS SEMINAR TOPICS

Since 1993, the University of Wisconsin–Madison has conducted 35 Family Impact Seminars. Each Family Impact Seminar is accompanied by an in-depth briefing report that summarizes the latest research on the topic and draws implications for families and policy decisions. These reports along with audio and/or video of the seminar presentations are online at **www.wisfamilyimpact.org**. Legislators can request a complimentary copy of reports and/or audio CDs from recent seminars by contacting Heidi Normandin at 608-263-2353 or hjnorman@wisc.edu.

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EXECUTIVE SUMMARY

During the 2016 federal fiscal year in Wisconsin, 22,050 people experiencing homelessness received services and shelter from providers that use the state's tracking system. Homelessness is not just a Milwaukee or Madison concern, nor is it limited to single adults: 58% of Wisconsinites receiving homeless services lived outside Milwaukee and Dane counties, and 46% were members of a family with minor children. Approximately 9% of those receiving services were veterans. Homelessness not only causes poor outcomes for the families and individuals affected; it can be costly for taxpayers in terms of emergency shelter costs, medical expenses, criminal justice system intervention, and other public services. Children who experience homelessness are particularly vulnerable to negative outcomes and more likely to become homeless as adults. This briefing report provides an overview of the state of homelessness in Wisconsin, including information about who is homeless and the funding sources currently used to address the problem. In addition, the report highlights the work of researchers who have decades of experience studying evidence-based, cost-effective ways to reduce and prevent homelessness.

In the first chapter, Adam Smith, Director of Wisconsin's Homeless Management Information System (HMIS), explains *Who Is Homeless in Wisconsin? A Look at Statewide Data.* The annual Point-in-Time count in January 2016 revealed that 5,685 people in the state were counted as literally homeless that particular day. Of this population, 22% had a severe mental illness, 22% were victims of domestic violence, and 15% had chronic substance abuse. In recent years, the federal government, states, and communities have learned how to more effectively address and end homelessness. As such, programs and funding priorities are changing, providing policymakers with an opportunity to focus on ensuring that families and individuals experiencing homelessness have access to evidence-based services and shelter.

In the second chapter, Jill Khadduri, Principal Associate and Senior Fellow at Abt Associates, describes *What Interventions Work Best for Homeless Families? Impacts and Cost Estimates from the Family Options Study.* The Family Options Study, a rigorous three-year experiment sponsored by the U.S. Department of Housing and Urban Development (HUD), examined which housing and services interventions work best to improve the housing stability and well-being of families experiencing homelessness. Families were randomly assigned to receive priority access to one of three programs: long-term housing subsidies; community-based rapid re-housing assistance; service-intensive, project-based transitional housing; or access to "usual care" available within the community. By far, priority access to long-term housing subsidies led to the best outcomes for reducing family homelessness. Compared to usual care, priority access to long-term subsidies reduced by more than one-half the proportion of families who reported being homeless within the last six months. Families with priority access to long-term subsidies also reported improved measures of adult and child well-being and reduced food insecurity. Although providing priority access to such long-term subsidies cost 9% more than not giving families priority access to any particular program, the benefits suggest there is a return on investment for long-term subsidies. The other two interventions demonstrated few positive impacts in any of the domains, compared to usual care. The striking positive impacts of providing priority access to long-term subsidies suggest that for most families, homelessness is a housing affordability problem that can be remedied with long-term housing subsidies, without specialized services.

In the third chapter, Martha Burt, consultant and Affiliated Scholar with the Urban Institute, discusses *Ending Homelessness: What the Research Says It Will Take.* The homeless population is diverse, and multiple, interacting structural and individual factors may lead to homelessness. Rigorous research suggests that access to affordable housing is key to reducing homelessness and improving individual and family well-being, and simply providing services without housing will not be effective. Permanent supportive housing has been particularly effective in reducing chronic homelessness. States can do many things to make housing more affordable through policies and practices that increase the supply of affordable housing and make existing housing more affordable to individual households through rent subsidies. For example, New Jersey has built more affordable housing per capita in high-opportunity communities near good schools and jobs than any other state, using a wide range of local, state, and federal funding sources. Other successful state strategies for addressing homelessness include rental assistance, capital/construction assistance, bond financing, local taxes, cross-jurisdictional planning, inclusionary zoning, and programs to address specific household needs. Key to making many of these policy options work for individuals and families is having an integrated service system.

In the fourth chapter, fiscal analyst Rachel Janke from the Wisconsin Legislative Fiscal Bureau documents *State of Wisconsin Funding and Fund Sources for Homelessness.* This chapter provides information related to funding, including federal funds, provided by the State of Wisconsin for homelessness or prevention of homelessness and focuses on housing needs in particular. Some programs target specific populations [such as individuals with a disability, individuals living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), individuals with mental illness or a substance abuse disorder, and veterans], while others address homelessness and housing in general. Funded activities may include: rental assistance; housing vouchers; foreclosure prevention payments; utility bill assistance; supportive services and outreach to homeless individuals; operation of transitional housing, emergency shelters, or housing voucher programs; housing rehabilitation; renovation or capital improvements to emergency and transitional housing facilities; low-income housing tax credits for housing developments; multifamily housing development loans; Homeless Management Information System (HMIS) project costs; and administrative expenses. In addition to programs related to homelessness or prevention of homelessness, a summary of programs that provide other types of services relating to homelessness is included as an appendix to this chapter.

In sum, homelessness is a costly problem experienced by many families across Wisconsin; however, there are evidence-based, cost-effective ways to reduce homelessness and help more families succeed. Importantly, attaining stable housing sets up families to be more successful at work and school, and is key to providing a nurturing environment in which children can thrive. When families have safe, affordable housing, they also are better able to take care of their family members; thus, reducing the burden on the public safety net. States can play a key role in fostering this success.

Adam Smith

WHO IS HOMELESS IN WISCONSIN? A LOOK AT STATEWIDE DATA

By Adam Smith, Director, Wisconsin Homeless Management Information System
Institute for Community Alliances

*D*uring the 2016 federal fiscal year, 22,050 people experiencing
*homelesssness across Wisconsin were served by providers that use the
Homeless Management Information System (HMIS) database. The data
show that homelessness is both an urban and rural problem, and impacts many
Badger state families. Well over half (58%) of people who used services were
located outside of Dane and Milwaukee counties, 46% were members of families
with minor children, and 9% were veterans. The annual Point-in-Time count in
January 2016 revealed that of the 5,685 people who were counted as literally
homeless that particular day, 22% had a severe mental illness, 22% were victims
of domestic violence, and 15% had chronic substance abuse. In recent years, the
federal government, states, and communities have learned how to more effectively
address and end homelessness. As such, programs and funding priorities are
changing, providing policymakers with an opportunity to focus on ensuring
homeless families and individuals have access to evidence-based services and
shelter.*

HOW IS DATA ABOUT PEOPLE EXPERIENCING HOMELESSNESS COLLECTED?

In 2010, the U.S. Interagency Council on Homelessness released Opening Doors:
Federal Strategic Plan to Prevent and End Homelessness. Benchmarks were set to
prevent and end homelessness among veterans by 2015, to end chronic homelessness
by 2015 (later changed to 2017), to prevent and end homelessness for families, youth,
and children by 2020, and to set a path for ending all types of homelessness. To achieve
these goals, collecting quality data on who is homeless and definitions of homelessness
have become increasingly important.

In Wisconsin, as in other states, there are two primary types of data collected about
the homeless: the annual homeless Point-in-Time (PIT) count conducted in January
each year, and the data entered into the Wisconsin Homeless Management Information
System (HMIS) throughout the year. The HMIS is a secure statewide database that
collects real-time, unduplicated client-level data from the vast majority of homeless
service programs in the state. These programs include emergency shelters, transitional
housing, street outreach, permanent supportive housing, homeless case management,
and homelessness prevention. The database also is referred to as Wisconsin
ServicePoint, or WISP. The HMIS is administered by the Institute for Community
Alliances (ICA), a nonprofit organization specializing in HMIS database management.
ICA provides similar services in nine other states, primarily in the Midwest.

Unless otherwise specified, most of the information in this chapter is based on those
providers who enter their data into the HMIS. Although most (approximately 80%) of
all Wisconsin non-domestic violence emergency shelter and transitional housing beds
are included in the HMIS, individuals and families who are living with friends or family

*Two primary types
of data are collected
about homeless
people: the annual
Point-in-Time
count and the
real-time Homeless
Management
Information System.*

The federally recognized definition of homelessness includes four main categories, one of which is "literally homeless."

(also known as doubled up) or are not actively connected to homeless service providers are not included in this report. Point-in-Time data in this report include data for all programs regardless of HMIS participation, excluding people who are doubled up.

Definitions are important in homelessness policy because various federal agencies use different definitions to guide funding and programming. The U.S. Department of Housing and Urban Development (HUD) funds emergency shelter, transitional housing, and permanent supportive housing programs throughout the country to alleviate and end homelessness. The federally recognized definition of homelessness includes four main categories: 1) literally homeless, 2) at imminent risk of homelessness, 3) homeless under other federal statutes, and 4) fleeing/attempting to flee domestic violence. Unless otherwise noted, data in this chapter includes only those people meeting the "literally homeless" definition of homelessness.

It is important to emphasize that this most strict definition may not include children, families, and individuals who are experiencing housing instability (e.g., staying doubled up with friends or family, living temporarily in hotels, or being at imminent risk of losing housing). All of these situations are associated with decreased well-being. Broader definitions of homelessness may be used, for example, to provide services to students in public schools under the McKinney-Vento Education for Homeless Children and Youth program.

WHAT IS A CONTINUUM OF CARE (CoC)?

A Continuum of Care (CoC) is an important part of each state's efforts to reduce and end homelessness. Continua of Care are communities, counties, or regions in which homeless shelters and service providers collaborate on the goal to end homelessness. HUD defines a continuum of care as a system designed to "provide funding for efforts by nonprofit providers, and state and local governments, to quickly re-house homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness."

There are four HUD-defined Continua of Care in Wisconsin:

- City of Madison/Dane County
- Milwaukee City and County
- Racine City and County
- Balance of State – encompassing 69 counties excluding Dane, Milwaukee, and Racine

Due to the large geographic reach of the Balance of State Continuum of Care, for organizational, logistical, and reporting purposes, it is further broken down into local Continua of Care, as represented in Figure 1.

FIGURE 1
Wisconsin Local Continua of Care Map

46 percent of home-less people who sought services in Wisconsin were members of families with minor children.

HOW MANY PEOPLE WERE SERVED BY WISCONSIN'S HMIS PROVIDERS THIS YEAR?

Between October 2015 and September 2016, Wisconsin HMIS providers served 22,050 people in emergency shelters, transitional housing, and safe haven projects.

Of those people served:

- 46% were in families with minor children;
- 58% were in communities outside of Dane and Milwaukee counties;
- 9% were U.S. military veterans;
- 8% met the federal definition for chronic homelessness; and
- 2% were runaway homeless youth under the age of 18.

According to the U.S. Department of Housing and Urban Development, an individual is experiencing chronic homelessness if he or she:

- Resides in a place not meant for habitation, a safe haven, or emergency shelter.

- Has been homeless and residing in such a place for at least one year or at least four separate occasions in the last three years (the four episodes of homelessness must total at least 12 months).

- Has a diagnosable disability, such as substance abuse disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments, or chronic physical illness or disability.

Families are defined as experiencing chronic homelessness if at least one adult in the household meets the definition of chronic homelessness.

Following the national trend, urban areas in Wisconsin have the highest rate of homelessness. However, many people in rural areas facing extreme poverty will live doubled up with family or friends, or they may live in substandard housing. In other cases, they may leave rural areas for the promise of increased opportunities and social services in larger communities.

HOW MANY PEOPLE WERE SERVED IN EMERGENCY SHELTERS?

In 2016, 88% of homeless people who sought services stayed in an emergency shelter.

The majority of people experiencing homelessness in Wisconsin use emergency shelters. Of the 22,050 people served by HMIS providers, 88% (19,312) were served in emergency shelters. Figure 2 provides more information about who uses emergency shelters. These data show that the majority of people utilizing emergency shelters in Wisconsin are young. Approximately 28% (5,332) of those served were under the age of 18, and the average age of a person using an emergency shelter in Wisconsin was 30.4 years old. The median age was 30 years old.

FIGURE 2
Number of People Served in Wisconsin Emergency Shelters by Age
October 2015 – September 2016
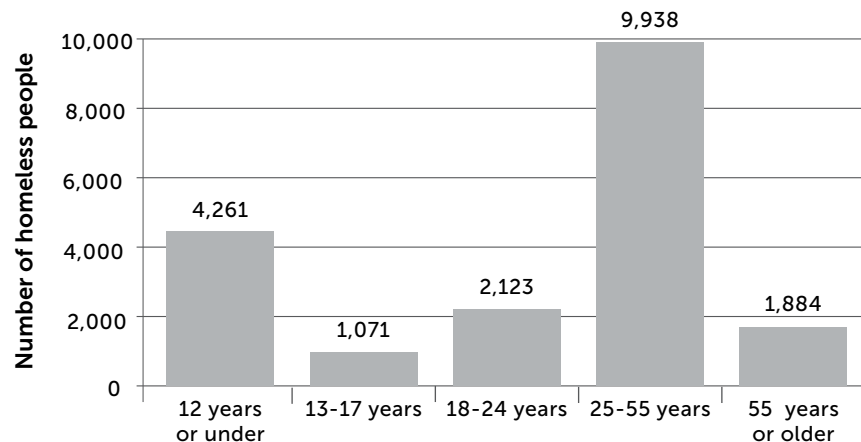
Note: The age of 35 clients was unknown.

Figure 3 shows the distribution of people who used an emergency shelter in the last federal fiscal year by county. It may appear that some counties, particularly in the northern part of the state, had no homeless individuals or families; however, this is likely more a reflection of service availability than people's actual housing situation. Counties reporting no emergency shelter clients either have no emergency shelter programs in operation or do not have emergency shelter programs reporting data in HMIS. When a county does not have an emergency shelter program in operation, people in need of assistance tend to travel to the closest community where a shelter program exists.

FIGURE 3
Number of People Served in Wisconsin Emergency Shelters by County
October 2015 — September 2016

When a county does not have an emergency shelter program, people who need assistance tend to travel to the closest community where a shelter program exits.

Note: Client counts represent total number of people served in each county. Counts are only unduplicated by county. It is possible and likely that some clients are served in more than one county during the time period.

HOW MANY PEOPLE WERE COUNTED AS HOMELESS IN THE POINT-IN-TIME COUNT IN THE LAST THREE YEARS?

The U.S. Department of Housing and Urban Development requires states to collect additional data through an annual Point-in-Time (PIT) count of sheltered and unsheltered people experiencing homelessness on a single night in late January. The count includes people in emergency shelters, in transitional housing, in safe havens, on the streets, or in places not meant for human habitation. The Point-in-Time count is the only official count that includes information from domestic violence shelters as well as a comprehensive count from all providers not using the HMIS.

The decrease in the Point-in-Time count between 2015 and 2016 is partly due to decreased funding for programs that are included in the count.

Table 1 shows the change in the number of people experiencing homelessness in Wisconsin over the last three years. While it shows the number of homeless people decreased from 2015 to 2016, it is partly a reflection of a federal systems change in the programs being funded. In many states, including Wisconsin, there has been a reduction of transitional housing programs and their beds over the past couple years. These programs have been replaced with rapid re-housing programs and beds, which are considered permanent housing programs and not included in the annual Point-in-Time count. For example, there were 290 beds in Dane County for transitional housing in January 2015 and only 205 beds at the beginning of 2016.

Rapid re-housing programs are replacing transitional housing programs in an ongoing effort to improve service delivery and effect systems change. Studies have shown that rapid re-housing programs are more cost-effective and produce better outcomes than transitional housing programs.

Looking at the Balance of State numbers, the total count decreased from 3,597 to 3,445 people between 2015 and 2016. However, the number of people using emergency shelters in the region was the highest ever in 2016: 1,939, up from 1,920 the year before and 1,924 in 2014.

TABLE 1
Total Number of People Experiencing Homelessness in Wisconsin Point-in-Time Count, 2014–2016

Regions	2014	2015	2016
Balance of State	3,569	3,597	3,445
Milwaukee County	1,499	1,521	1,415
Dane County	777	771	629
Racine County	210	168	196
Totals	**6,055**	**6,057**	**5,685**

Figure 4 breaks down the January 2016 Point-in-Time count by sub-population. Of the 5,685 homeless people counted that day:

- 22% had a severe mental illness;

- 22% were victims of domestic violence;

- 15% had chronic substance abuse;

- 7% were veterans;

- 6% were chronically homeless;

- 6% were unaccompanied youth under the age of 25; and

- 188 youth under the age of 25 were parents to 267 children.

FIGURE 4
Homeless Sub-Populations in Wisconsin
2016 Point-in-Time Count
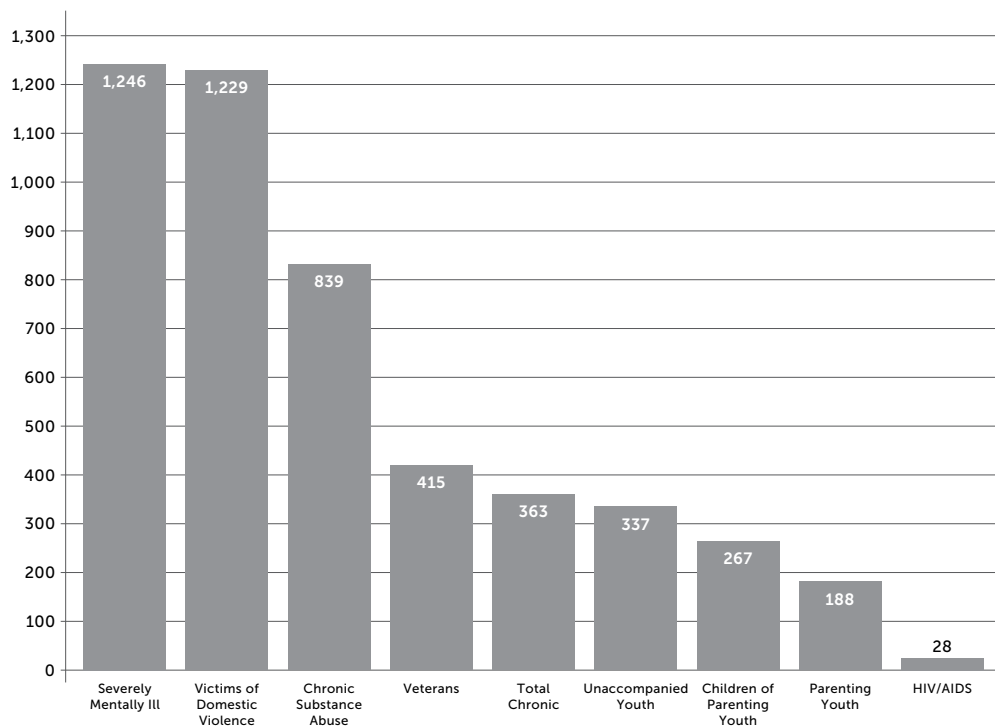
Of the homeless people counted on a single night in January 2016, 22% had severe mental illness and 15% had chronic substance abuse.

HOW MANY PEOPLE IN THE POINT-IN-TIME COUNT WERE IN FAMILIES?

As shown below in Table 2, the number of individuals and families experiencing homelessness in Wisconsin was about equal. Families for the Point-in-Time count are defined as a group with at least one adult and one youth under the age of 18 at time of count.

TABLE 2
Homelessness in Wisconsin by Household Type
2016 Point-in-Time Count

Household Type	Percent	Total People
Individuals	50.8%	2,886
Family	49.2%	2,799

HOW DOES HOMELESSNESS IN WISCONSIN COMPARE TO OTHER STATES?

Tables 3, 4, and 5 compare the January 2016 Point-in-Time data in Wisconsin to three other Midwestern states: Indiana, Minnesota, and Missouri. Figure 5 shows that while the number of people experiencing homelessness in the Wisconsin count has declined, it has not reached the 2007 level.

TABLE 3
Percentage of People Experiencing Homelessness in Midwestern States by Race
2016 Point-in-Time Count

State	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian or Other Pacific Islander	Multiple Races
Indiana	61.9%	33.0%	0.7%	0.4%	0.3%	3.8%
Minnesota	37.9%	45.0%	9.7%	1.1%	1.0%	5.3%
Missouri	55.8%	37.3%	1.7%	0.4%	0.3%	4.5%
Wisconsin	**53.3%**	**35.9%**	**3.6%**	**0.8%**	**0.2%**	**6.2%**
United States	48.3%	39.1%	2.8%	1.0%	1.6%	7.2%

TABLE 4
Percentage of People Experiencing Homelessness in Midwestern States by Gender
2016 Point-in-Time Count

State	Male	Female	Transgender
Indiana	58.2%	41.6%	0.2%
Minnesota	52.3%	47.4%	0.3%
Missouri	53.7%	46.2%	0.1%
Wisconsin	**54.2%**	**45.6%**	**0.2%**
United States	60.2%	39.5%	0.3%

TABLE 5
Percentage of People Experiencing Homelessness in Midwestern States
by Other Sub-Populations, 2016 Point-in-Time Count

State	Chronically Homeless	Severely Mentally Ill	Chronic Substance Abuse	Veterans	HIV/AIDS	Victims of Domestic Violence	Unaccompanied Youth	Parenting Youth	Children of Parenting Youth
Indiana	10.2%	18.2%	16.2%	11.4%	0.6%	18.8%	6.3%	1.5%	2.5%
Minnesota	11.9%	15.9%	10.7%	3.8%	0.6%	12.0%	10.0%	3.5%	5.1%
Missouri	18.3%	19.8%	20.3%	9.3%	0.8%	18.1%	10.3%	2.2%	3.3%
Wisconsin	**6.4%**	**22.0%**	**14.8%**	**7.3%**	**0.5%**	**21.6%**	**6.0%**	**3.3%**	**4.7%**
United States	15.7%	19.6%	7.2%	7.2%	1.7%	12.4%	6.5%	1.8%	2.4%

FIGURE 5
Change in Total Homeless Point-in-Time Count
in Midwestern States, 2007–2016
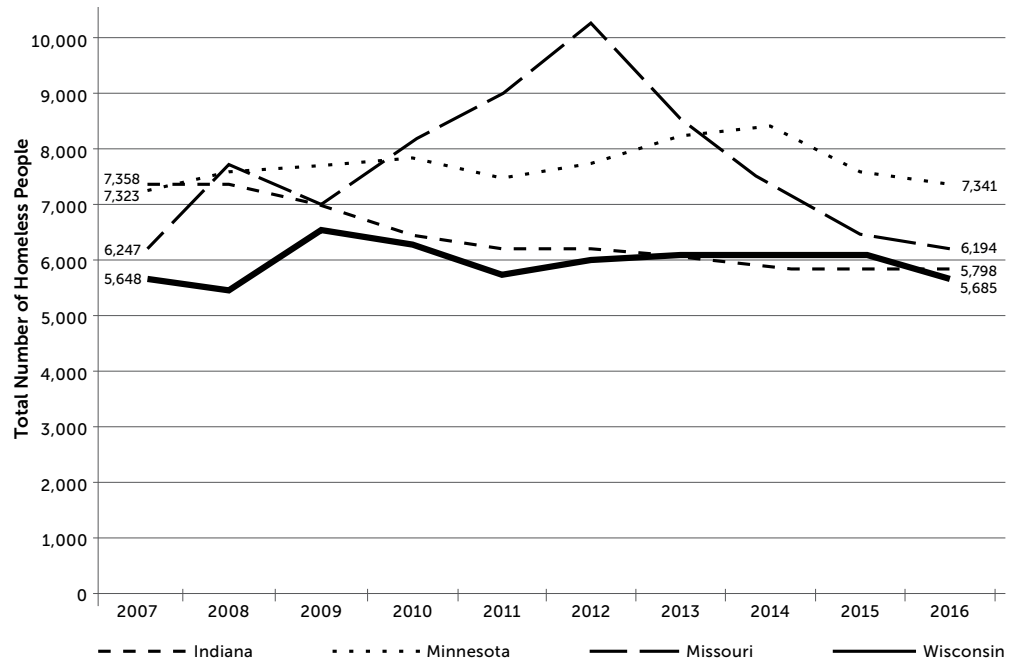
CONCLUSION

Homelessness in Wisconsin is a statewide concern. It affects both families and individuals, many of whom have substance abuse or mental health issues, or are victims of domestic violence. As the federal government, states, and communities understand more about effective ways to help people who are homeless, policies and program funding are changing.

Communities in Wisconsin are creating a coordinated entry system that is intended to prioritize housing beds based on need and divert people who may have other housing options at their disposal.

Like other states, Wisconsin is reducing temporary and transitional housing, which is designed to provide short-term shelter for up to 24 months, and increasing permanent housing or rapid re-housing. Furthermore, communities in Wisconsin and around the country are creating a coordinated entry system that is intended to prioritize housing beds based on need. The system also is operating, especially in Madison and Milwaukee, as a diversion system, keeping people out of the shelter system altogether. This has replaced the first-come, first-served model that would often result in beds in programs being used by people who may have had other housing options at their disposal.

Policymakers should take into consideration that as these system changes take place, the number of people experiencing homelessness by official definitions may fluctuate from year to year. Families and individuals who need services or shelter arrive at that need due to many different circumstances. In addition, the definition of "literally homeless" reflected in the data throughout this chapter does not reflect the extent to which individuals and families throughout the state experience housing instability more broadly, which impacts overall well-being.

Adam Smith is the Wisconsin, Vermont, and Rock River (Illinois) Homeless Coalition HMIS Director at the Institute for Community Alliances. He has overseen Wisconsin's statewide HMIS implementation since 2006 and previously worked for the Wisconsin Department of Administration. He has been involved in the implementation and oversight of Wisconsin's HMIS since 2001, including serving on the state's HMIS Advisory Board. In addition to overseeing the Wisconsin, Vermont, and Rock River HMIS implementations, he provides technical assistance to Alaska on its statewide implementation. Smith serves on the Wisconsin Interagency Council on Homelessness as well as the Rock River Homeless Coalition Board of Directors. He is a lifelong resident of Wisconsin and a graduate of the University of Wisconsin–Madison.

Because of space limitations, additional data from the January 2016 Point-in-Time count of homelessness in Wisconsin can be found online at: http://www.icalliances.org/wisfamilyimpact. The online data are presented in an interactive format with the ability to select specific data points on each chart. The reports may be downloaded to a PDF format. The data used in this report have been reviewed and monitored for accuracy and completeness. While some data errors are unavoidable, participating HMIS organizations strive to report timely and accurate information.

WHAT INTERVENTIONS WORK BEST FOR HOMELESS FAMILIES? IMPACTS AND COST ESTIMATES FROM THE FAMILY OPTIONS STUDY

By Jill Khadduri, Principal Associate and Abt Senior Fellow
Abt Associates

*T*he Family Options Study, a rigorous three-year experiment sponsored by the U.S. Department of Housing and Urban Development (HUD), examined which housing and services interventions work best to improve the housing stability and well-being of families experiencing homelessness. Families were randomly assigned to receive priority access to one of three programs: long-term housing subsidies; community-based rapid re-housing assistance; service-intensive, project-based transitional housing; or access to "usual care" available within the community. By far, priority access to long-term housing subsidies led to the best outcomes for reducing family homelessness. Compared to usual care, priority access to long-term subsidies reduced by more than one-half the proportion of families who reported being homeless within the last six months. Families with priority access to long-term subsidies also reported improved measures of adult and child well-being, and reduced food insecurity. Although providing priority access to such long-term subsidies cost 9% more than not giving families priority access to any particular program, the benefits suggest a return on investment for long-term subsidies. The other two interventions demonstrated few positive impacts across any of the domains, compared to usual care. The striking positive impacts of providing priority access to long-term subsidies suggest that for most families, homelessness is a housing affordability problem that can be remedied with long-term housing subsidies, without specialized services.*

WHAT IS THE FAMILY OPTIONS STUDY?

In 2008, the U.S. Department of Housing and Urban Development (HUD) launched the Family Options Study to learn which housing and services interventions work best to improve the housing stability and well-being of families and children experiencing homelessness. The study team followed families for three years and measured outcomes in five domains of family well-being: housing stability, family preservation, adult well-being, child well-being, and self-sufficiency.

The study used a rigorous, experimental methodology to best ensure that results reflect actual effects of each intervention rather than pre-existing differences in the families. Approximately 2,300 families from 12 communities across the country participated in the study (see Table 1).[1] Families included at least one child age 15 or younger, and had to have resided in an emergency shelter for seven or more days.

The Family Options Study measured impacts on housing stability, family preservation, adult well-being, child well-being, and self-sufficiency.

TABLE 1
Family Options Study Sites

Alameda County, CA	Honolulu, HI
Atlanta, GA	Kansas City, MO
Baltimore, MD	Louisville, KY
Bridgeport and New Haven, CT	Minneapolis, MN
Boston, MA	Phoenix, AZ
Denver, CO	Salt Lake City, UT

WHICH INTERVENTIONS WERE STUDIED?

After spending at least seven days in emergency shelter, families were randomly assigned to one of four groups. Each of the interventions is described below:

1. *Long-term housing subsidy:* Families were given priority access to a long-term housing subsidy, typically a Housing Choice Voucher, which might have included assistance to find housing but did not include other support services.

2. *Community-based rapid re-housing:* Families were given priority access to a temporary housing subsidy, lasting up to 18 months, paired with limited, housing-focused services to help families find and rent conventional, private-market housing.

3. *Project-based transitional housing:* Families were given priority access to a temporary stay, lasting up to 24 months, in agency-controlled buildings or apartment units, paired with intensive support services.

4. *Usual care:* Families had access to the usual care and services homeless people might access within the community, but were not given priority access to any particular program. This typically included some additional stay in the emergency shelter from which families were enrolled.

Families were randomly assigned to receive priority access to one of three housing interventions or usual care available in their community.

The interventions reflect different underlying theories about the nature of family homelessness and the best way to address the problem. **Long-term housing subsidies** and **community-based rapid re-housing** are based on the view that family homelessness is primarily a consequence of a mismatch between housing costs and the income of poor families. This is a problem subsidies can solve. As suggested by the names of the programs, long-term subsidies focus on long-term housing stability, while rapid re-housing programs seek to get families housed as quickly as possible. Proponents of rapid re-housing programs suggest that such an approach may encourage family economic self-sufficiency sooner, while proponents of long-term subsidies question whether such short-term assistance is sufficient. **Project-based transitional housing** focuses on the idea that many families who become homeless have other barriers besides poverty that make it difficult for them to secure and maintain stable housing. These programs are designed to address these barriers with an array of services in a supervised residential setting, theoretically, to build the best foundation for ongoing stability.[2]

Families who were randomly assigned to one of the three program interventions (not usual care) were given "priority access" to a program slot. They still needed to meet eligibility criteria of the program to which they were referred, complete required paperwork, and, in some cases, find an acceptable housing unit. Families were not prohibited from using other programs outside the study. Although families were most likely to use the program to which they were given priority access, not all families took up such services. The take-up rate for long-term subsidies was highest (83%); take-up rates for community-based rapid re-housing and project-based transitional housing were lower (59% and 53%, respectively). As a result, the Family Options Study evaluated the effect of priority access to a program, which might be of high interest to policymakers because it measures the impact of emphasizing a particular policy approach—i.e., providing more availability of a program in a community.[3]

Researchers measured impacts of the programs 20 months after random assignment; however, this time period was not long enough to evaluate priority access to temporary programs that could last up to two years. Therefore, researchers also measured impacts approximately three years (37 months) after random assignment. Some impacts detected at 20 months were not detected at 37 months, and other impacts detected at 37 months were not detected at the earlier follow-up point. Impacts found at either time point are important when considering the overall benefits and return on investment of the interventions.[4]

HOW DID THE IMPACTS OF LONG-TERM SUBSIDIES COMPARE TO USUAL CARE?

By far, priority access to a long-term housing subsidy led to the best outcomes for reducing family homelessness. As shown in Figure 1, three years after random assignment, priority access to long-term subsidies reduced by more than one-half the proportion of families who reported being homeless (i.e., having spent at least one night in a shelter or in places not meant for human habitation, or doubled up) in the past six months. The intervention also reduced the proportion of families with a stay in shelter by almost one-half at the 20-month follow-up point, and by more than three-fourths at the 37-month follow-up point.[5]

Priority access to long-term subsidies led to the best outcomes for reducing family homelessness.

FIGURE 1
Long-Term Housing Subsidy Versus
Usual Care at the 37-Month Follow-up

**Assignment to long-term subsidy results in large improvements
in average housing stability over usual care**
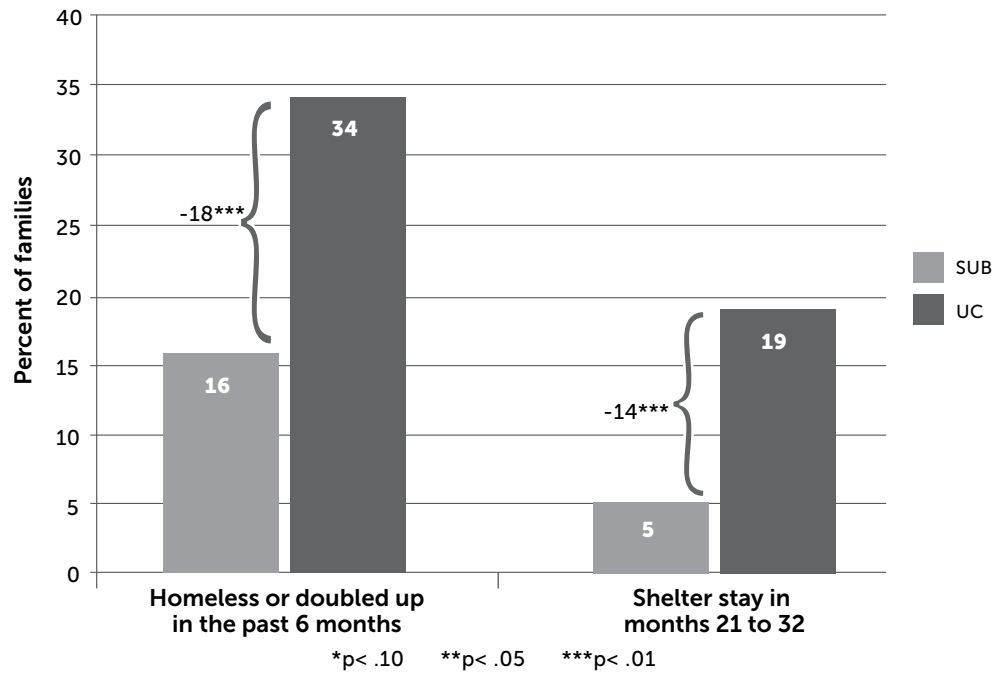
SUB = priority access to long-term housing subsidy. UC = usual care.

In addition, at both the 20- and 37-month follow-ups, the proportion of families living in their own place increased by 15 percentage points and the number of places lived in the past 6 months was reduced in the housing subsidy group, compared to the usual care group.

Assignment to the long-term subsidy intervention also produced beneficial effects in other areas of family well-being. Compared with usual care, long-term subsidies reduced:

Compared to usual care, long-term subsidies reduced psychological distress, intimate partner violence, the number of schools children attended, and food insecurity.

- the proportion of families separated from a child who had been present at baseline (at 20 months);
- psychological distress of the family head (at both time points);
- intimate partner violence (at both time points);
- evidence of alcohol and drug problems (at 20 months);
- the number of schools that children attended after random assignment (at both time points);
- the number of school or child care absences for children (at 20 months);
- behavior problems of children, as reported by parents (at 37 months); and
- the proportion of families who were food insecure (at both time points).

In contrast to these beneficial findings, assignment to long-term subsidies compared to usual care reduced the proportion of family heads who were working at 20 months (30% compared to 24%) and reduced the proportion of those who had worked between follow-up surveys (64% compared to 58%).[6]

An ambiguous finding was that at 37 months, a higher proportion of families in the long-term subsidy group (48%, compared to 34% of families in usual care) experienced separations from the spouse or partner present at baseline. Because of the high rate of intimate partner violence reported in the baseline survey, it is possible that subsidies actually enabled some respondents to escape violent relationships.[7]

HOW DID THE IMPACTS OF COMMUNITY-BASED RAPID RE-HOUSING COMPARE TO USUAL CARE?

At both follow-up points, almost no evidence suggests that assignment to the community-based rapid re-housing intervention improved outcomes for families, compared to assignment to usual care. Most strikingly, assignment to community-based rapid re-housing did not reduce stays in shelter or places not meant for human habitation, at either 37 months, as illustrated in Figure 2, or at 20 months.[8]

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FIGURE 2
Community-Based Rapid Re-Housing
Versus Usual Care at the 37-Month Follow-up

Assignment to rapid re-housing does not improve housing stability over usual care

*p< .10   **p< .05   ***p< .01
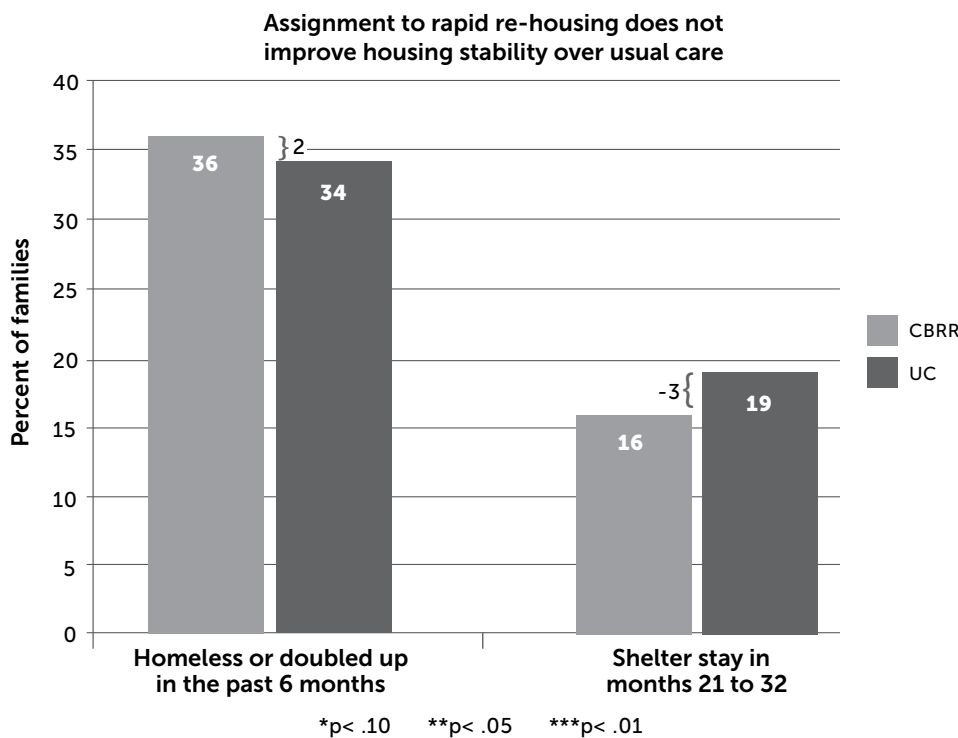
CBRR = priority access to community-based rapid re-housing. UC = usual care.

Almost no evidence suggests that assignment to community-based rapid re-housing improved outcomes for families, compared to usual care.

Only a few effects were found in other domains. Compared to usual care, community-based rapid re-housing appeared to reduce school or childcare absences (at 20 months) and behavior problems of children as reported by parents (at 37 months). At 20 months, the intervention also appeared to improve food security and family income, although neither of these effects were evident at the 37-month follow-up.[9]

HOW DID THE IMPACTS OF PROJECT-BASED TRANSITIONAL HOUSING COMPARE TO USUAL CARE?

As shown in Figure 3, relative to usual care, assignment to project-based transitional housing reduced stays in emergency shelter during the intervention period; however, it did not improve families' likelihood of living in their own place, or reduce the likelihood of being homeless or the number of places lived in the last six months.[10]

FIGURE 3
Project-Based Transitional Housing
Versus Usual Care at the 37-Month Follow-Up

Assignment to project-based transitional housing results in some improvements in housing stability over usual care

*p< .10   **p< .05   ***p< .01

PBTH = priority access to project-based transitional housing. UC = usual care.
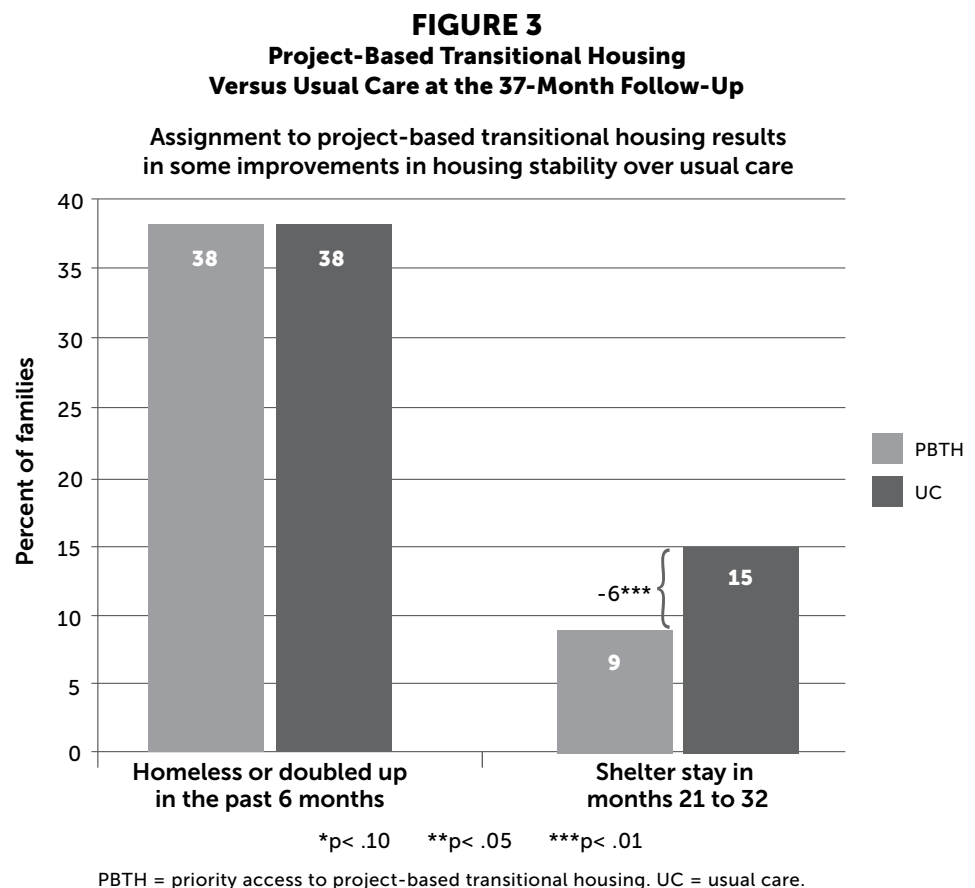
Despite the emphasis on service provision, project-based transitional housing had no positive effects on adult well-being or family sufficiency.

Perhaps most striking, given the intervention's emphasis on service provision, assignment to project-based transitional housing produced no positive effects on any of the other measures of adult well-being or family sufficiency. In other words, after three years, families participating in this intensive service-based intervention were no better off than those in the usual care group.[11]

WHAT WERE THE COSTS OF THE INTERVENTIONS?

The Family Options Study also analyzed the costs of emergency shelter and the three programs offered, including all resources used to provide shelter or housing with supportive services to a family during the course of one month. Figure 4 shows the average per-family monthly cost of shelter or housing, with supportive services, across program types.[12]

The analysis shows that on a per-month basis, emergency shelters are very expensive compared to all of the other interventions. Both emergency shelters and transitional housing are more expensive than the two rent subsidy programs, most likely due to the cost of providing supportive services. The community-based rapid re-housing monthly costs are smaller than the long-term subsidy costs, as these programs do not use the U.S. Housing and Urban Development Housing Choice Voucher formula, and provide a somewhat smaller monthly rental subsidy to families.

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FIGURE 4
Average Per-Family Monthly Cost of Shelter or Housing, With Supportive Services, Across Program Types
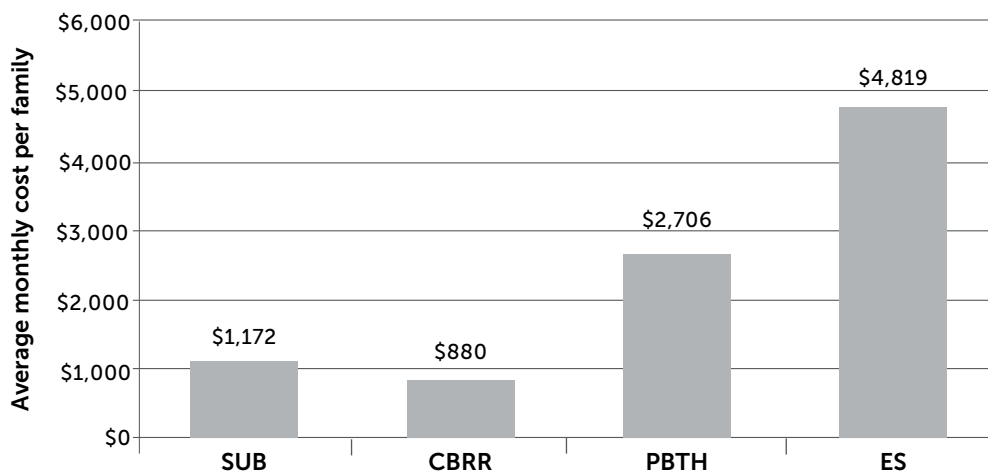
CBRR = rapid re-housing programs offered to the CBRR group. ES = emergency shelter. PBTH = transitional housing programs offered to the PBTH group. SUB = housing subsidies offered to the SUB group.

Sources: Family Options Study cost data (CBRR, PBTH, and ES);HUD Public and Indian Housing Information Center, Tenant Rental Assistance Certification System, and Financial Data Schedule records (SUB)

On a per-month basis, emergency shelters are very expensive compared to all of the other interventions.

The study also measured the costs of all the programs families used during the three-year follow-up period, accounting for both the programs they were offered in the study and those they found on their own. It is important to note that over time, families in the usual care group found their way to programs similar to the interventions. For example, by the 37-month follow-up, 37% of families in the usual care group had used some type of long-term housing subsidy, 30% had used transitional housing, and 20% had used rapid re-housing. Over time, their use of housing subsidies increased, and the use of temporary homeless assistance (e.g., emergency shelter, transitional housing, and rapid re-housing) decreased.

As stated in the beginning of this chapter, some interventions appear to have been more attractive to homeless families, and resulted in higher take-up rates than others. One contributing factor may be that community-based rapid re-housing and project-based transitional housing programs often had screening criteria that would exclude families with greater challenges.

The average cost of all programs used by families assigned to the usual care group was about $41,000 per family.

Figure 5 shows the costs of all programs used by families in the 37 months after random assignment to each intervention group, compared to the costs of services used by families assigned to usual care. In the three-year study period, the average cost of all programs used by families assigned to the usual care group was about $41,000 per family. Families in community-based rapid re-housing incurred the lowest average costs over three years; however, all of the costs illustrated in Figure 5 are best considered in the context of both the short- and long-term benefits associated with each intervention.

FIGURE 5
Costs of All Programs Used in the 37 Months Since Random Assignment for Intervention Comparisons With Usual Care
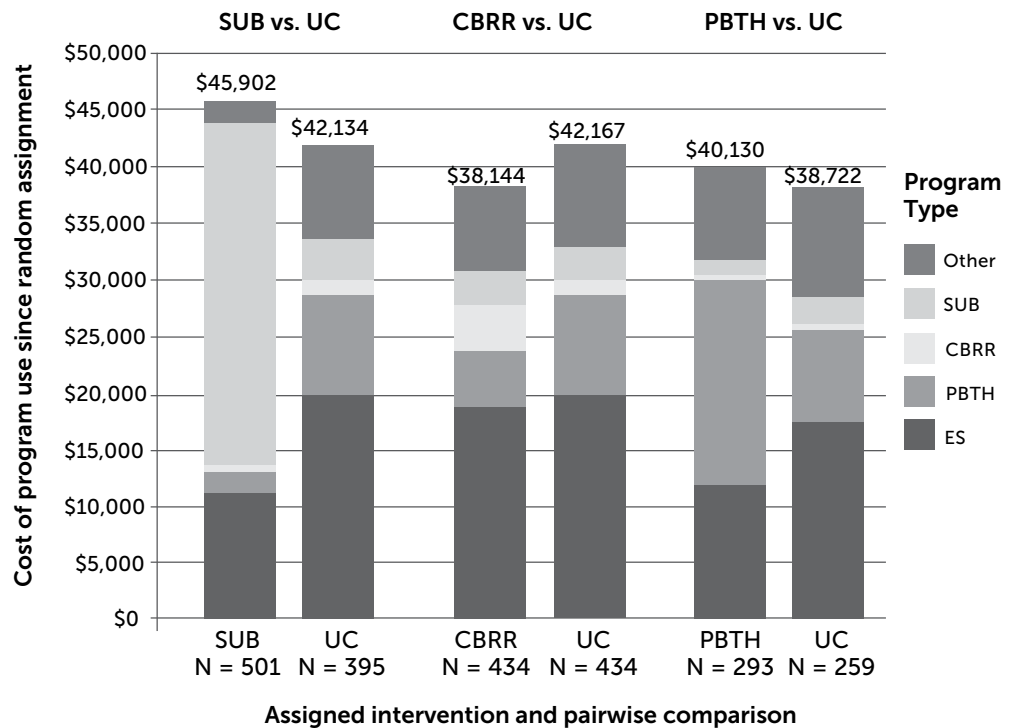
CBRR = priority access to community-based rapid re-housing. PBTH = priority access to project-based transitional housing. SUB = priority access to housing subsidy. UC = usual care

Notes: Averages are for all 37-month survey respondents in each arm of each pairwise comparison and are weighted for survey nonresponse to represent full comparison sample. Cost estimates assume a site-specific average cost per month based on the Family Options Study cost data and HUD administrative data. The *other* category refers to other long-term housing subsidies and includes permanent supportive housing, public housing, and project-based assistance (project-based vouchers or Section 8 projects).

Sources: Family Options Study cost data; HUD, Public and Indian Housing Information Center, Tenant Rental Assistance Certification system, and financial Data Schedule records (SUB); Family Options Study Program Usage Data

WHAT ARE THE POLICY IMPLICATIONS OF THE FAMILY OPTIONS STUDY?

The Family Options Study shows that homelessness is expensive for families and communities. Over three years, even families who were not assigned to receive priority access to services used housing and other programs that cost approximately $41,000. Yet, despite these substantial public (and sometimes private) investments, about one-third of families in the usual care group were recently homeless, nearly one-half were food insecure, and family incomes averaged less than two-thirds of the poverty threshold.[16]

The Family Options Study also points to some interventions that can make a difference in the lives of homeless families. In particular, access to long-term housing subsidies helped families find stable housing, improved multiple measures of adult and child well-being, and reduced food insecurity. Although providing priority access to long-term subsidies cost 9% more than not giving families priority access to any particular program (usual care), the substantial benefits suggest there may be a positive return on investment for long-term subsidies.[17]

Families given priority access to community-based rapid re-housing did about as well as families assigned to usual care, but at about 9% lower cost, primarily due to less use of expensive transitional housing programs. Families given priority access to project-based transitional housing programs saw few positive impacts compared to families in the usual care condition, at higher expense.

The study suggests that families who experience homelessness can successfully use and retain housing vouchers. The current homeless assistance system does not provide immediate access to such subsidies for most families in shelters, although more than one-third of families without priority access obtained some type of long-term housing subsidy during the three-year follow-up period.[18]

The striking positive impacts of providing priority access to long-term subsidies also suggest that for most families, homelessness is a housing affordability problem that can be remedied with long-term housing subsidies, without specialized services.

Jill Khadduri is Principal Associate and one of eight Senior Fellows at Abt Associates, where she is noted for her ability to translate the results of research into policy guidance. Dr. Khadduri specializes in conducting research about programs targeting vulnerable sub-populations, including individuals, youth, and families experiencing homelessness, and in research on the Low Income Housing Tax Credit and other rental housing subsidy programs such as housing vouchers and public housing. Prior to this position, she was the Director of the Division of Policy Development at the U.S. Department of Housing and Urban Development (HUD), where she worked for over two decades to apply the results of HUD's research program to discussions of budget and legislative proposals within HUD, the Office of Management and Budget (OMB), and Congress. She recently contributed a chapter documenting the history of the agency to the book, HUD at 50: Creating Pathways to Opportunity, published in 2015. Dr. Khadduri earned her PhD from The Johns Hopkins University.

Although providing priority access to long-term subsidies cost 9% more than offering usual care, benefits suggest subsidies may provide a return on investment.

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ENDING HOMELESSNESS: WHAT THE RESEARCH SAYS IT WILL TAKE

By Martha Burt, Affiliated Scholar, Urban Institute
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*H*omelessness not only causes poor outcomes for the families and individuals affected; it is costly to communities, states, and taxpayers. Children experiencing homelessness are particularly vulnerable to negative outcomes, and more likely to become homeless as adults. The homeless population is diverse, and multiple, interacting structural and individual factors may lead to homelessness. Rigorous research suggests that access to affordable housing is key to reducing homelessness and improving individual and family well-being, and simply providing services without housing will not be effective. Permanent supportive housing has been particularly effective in reducing chronic homelessness. States can do many things to make housing more affordable through policies and practices that increase the supply of affordable housing and make existing housing more affordable to individual households through rent subsidies. For example, New Jersey has built more affordable housing per capita in high-opportunity communities near good schools and jobs than any other state in the nation, and uses a wide range of local, state, and federal funding sources to generate this housing. Other successful state strategies for addressing homelessness include rental assistance, capital/construction assistance, bond financing, local taxes, cross-jurisdictional planning, inclusionary zoning, and programs to address specific household needs. Key to making many of these policy options work for individuals and families is having an integrated service system.

The lower a household's income, the more likely it is to be severely affected by the cost of housing.

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INTRODUCTION

At its core, homelessness happens when people's incomes are too low to allow them to pay for housing and have enough left over for other needs. The distance between the two sides of this equation—incomes versus housing costs—has grown increasingly wide since the early 1980s. Currently, there is no county in the United States where people working full time and earning the minimum wage can find rental housing that costs no more than 30% of their income.[1] Not surprisingly, the lower a household's income, the more likely it is to be severely affected by the cost of housing.

Since the 1980s, programs and services to address homelessness have expanded dramatically; yet, the number of people experiencing homelessness has not significantly diminished over time, except where concerted efforts have been made to provide housing and supportive services. A growing body of research suggests that there are effective strategies for moving individuals and families out of homelessness. This chapter illuminates ways in which policymakers can use this research to end homelessness in the future.

WHAT ARE THE COSTS AND IMPACTS OF HOMELESSNESS?

Homelessness not only causes poor outcomes for the families and individuals affected; it is costly to communities, states, and taxpayers. Research over the past decade has strengthened our grasp of these costs, which include programs for people experiencing homelessness (emergency shelters, transitional housing, permanent supportive housing, and supportive services) as well as public agency costs (for health care, police and ambulance services, jail and prison, veterans' services, hospitalizations, and behavioral health). A basic study found significant costs (paid by federal, state, and local governments) for even the simplest homeless situations.[2]

Health care costs, in particular, may escalate, as homelessness is a barrier to people in need of consistent care of pre-existing and chronic medical conditions. Compared to housed individuals with similar characteristics, people experiencing homelessness are more likely to use emergency department services and experience greater numbers and longer lengths of inpatient hospitalizations, and may also need alcohol and drug treatment and detoxification or mental health services.[3] These medical costs are often borne by public payers—especially by cities and counties for uncompensated care. Before the Affordable Care Act, very few homeless people had publicly funded health insurance, so city and county hospitals paid a larger share of these costs of care. Federal programs paying for some of this care include Medicare, Veterans Affairs, and Medicaid in states that opted to expand benefits under the Affordable Care Act.

Studies suggest that services for a chronically homeless person may cost taxpayers $30,000 to $50,000 per year.

Other studies have identified costs for various sub-groups of people experiencing homelessness. One study of chronically homeless people with severe alcohol problems estimated the median cost per person was $4,066 per month—nearly $49,000 per year—while people remained on the streets.[4] Another study of homeless veterans showed that they used $24,988 in health, mental health, and substance abuse treatment services alone in the year before they entered a housing program.[5] Ultimately, studies suggest that leaving a person chronically homeless may cost taxpayers as much as $30,000 to $50,000 per year.[6] A 2010 study looked at the costs associated with serving first-time homeless families, many who leave homelessness relatively quickly. Looking at the families who stayed for an extended length of time (8 to 18 months), the average cost per household ranged from $6,574 to $38,742 depending on the community.[7]

While homelessness undoubtedly affects the well-being of everyone who experiences it, it can have a particularly negative and lasting impact on children. Children experiencing homelessness suffer from high rates of hunger and malnourishment, mental and physical health problems, and increased risk of out-of-home placement in foster care.[8, 9, 10] Homeless children may also experience developmental delays and emotional and behavioral problems, which may be associated with their mother's emotional distress.[11] Homelessness also is associated with negative effects on academic achievement. Homeless or unstably housed students are more likely to miss school or change schools often, do poorly on standardized tests, and repeat grades or drop out.[12] Most notably, experiencing homelessness as a child translates into a greater risk of homelessness in adulthood.

HOW MANY PEOPLE ARE HOMELESS AND WHO ARE THEY?

The pervasiveness of homelessness may not be easily apparent given different ways of defining and counting the population. The Homeless Management Information System (HMIS), which provided some of the Wisconsin data for Adam Smith's chapter, is a database used by most shelters and homeless providers in each state to keep track of every individual who uses their services. The HMIS produces an accurate count of sheltered people and can provide information about the number of people who used a shelter or other homeless program during the course of a year. But any count from the HMIS will still undercount homeless people, because many people do not use homeless shelters, even for one night during a year.

The annual Point-in-Time count captures the number of people who were in a shelter, in transitional housing, or on the streets and counted by a worker or volunteer on a designated day. This count, conducted during a 24-hour period in January, captures significant numbers of people not in shelter on that night; however, an unknown number of additional people will not be seen, and therefore not counted, or will be seen but be incorrectly deemed not homeless by the people doing the counting. Thus, all counts include some measure of inaccuracy, almost always in the direction of an underestimate.

One group that is particularly difficult to count is unaccompanied youth—those not connected to their families. Typical counting methods that work for adults don't accurately capture the survival strategies youth use, such as being mobile, staying in groups, "couch surfing," or hiding in plain sight. Plus, many youth don't want to be found because they are fleeing abuse or fear being placed into foster care. In addition, many unaccompanied youth aren't connected to support services, because they aren't aware of or are avoiding them.[13] In recent years, HUD has emphasized the importance of including youth in the annual count, and communities are working on creative ways to make this happen.

Regardless of what definition or type of count is used, homelessness remains pervasive. My research over the last 30 years shows that the annual homeless count exceeds 1% of the U.S. population and may represent as much as 10% of all poor people.[14] Data from the National Survey of Homeless Assistance Providers and Clients reveals extensive diversity in the homeless population.[15] Other than extreme poverty, no other characteristic (such as marital status or race) is true for even half of the homeless population. The same can be seen in the Annual Homeless Assessment Reports that have been delivered to Congress annually since 2007.[16] These data challenge the idea that there is a stereotypical "homeless population" or simple solutions to homelessness.[17]

Another important concept to consider is the dynamic nature of people's homeless experiences. Some are homeless once and for only a short time. This is sometimes called "transitional" or crisis homelessness—most people fall into this group. Others experience "episodic" homelessness, where they have several short or medium-length spells before finally securing stable housing. Yet others live on the streets or in other places not intended for human habitation for many years, or keep flowing into and out of homelessness. This group of people experiencing "chronic" homelessness also often has serious mental illness, physical disabilities, or substance abuse disorders. Each type of homelessness is associated with poor outcomes for individuals and families, and understanding these patterns is critical for improving program design and developing effective public policies to address the problem.

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The annual homeless count may represent as much as 10% of all poor people.

WHY DO PEOPLE BECOME HOMELESS?

Understanding why people become homeless also is key to designing effective strategies to prevent and end the problem. Structural factors provide the underlying basis for homelessness; then, individual factors play out upon the stage set by structures. Public programs can introduce supports and services intended to ameliorate the effects of structural factors on people whose individual circumstances make them particularly vulnerable to losing their housing.[18]

Structural Factors
Structural factors are those aspects of society that affect everyone and contribute to the odds that we will have higher or lower levels of homelessness. They include:

The changing housing market has priced out many low-income families and single adults.

- ***The cost of housing***. Changing housing markets for extremely low-income families and single adults have priced many of them out of the market. Aspects of a changing housing market include gentrification (removal of low-cost housing from the market), extreme income inequality (very high earners bid up the price of housing), increasing production costs, and zoning and other regulatory frameworks.

- ***The capacity to earn enough money to live on***. There are declining employment opportunities for people with a high school education or less. Even those with a job often do not earn enough to raise their incomes above the poverty level.

Since 1989, the U.S. Department of Housing and Urban Development has tracked the housing needs of very low income households (incomes below 50% of area median, or about $31,000 in today's dollars) who pay more than 50% of their income for rent. In 1989, only 5% of all households paid more than 50% of their incomes for housing[19]; in 2001, it was 12.6%, rising to 16.2% in 2013, the most recent year for which data are available. Among renters, the situation is even worse. In 2013, 24% of very low income renters paid more than 50%, and another 23% paid between 30% and 50% of their income for rent.[20]

Evidence for the effects of the economy on levels of homelessness can be seen most clearly during recessions. Modern homelessness in the United States began as a public issue during the 1981-1982 recession, when women and families with children began appearing in soup kitchens and shelters for the first time.[21, 22] The recent recession beginning in 2008 strongly affected the number of families with children experiencing homelessness over a year's time, from about 131,000 in 2007 to about 170,000 in 2009—a 30% increase.[23] By 2013, those numbers had not returned to 2007 levels, reflecting slow economic recovery, especially for people at the bottom.

Structural factors help answer the question: "Why are there more homelessness people *now*?" However, during times when structural conditions worsen, even low-income people without vulnerabilities may experience a crisis that leads to a homeless episode.

Individual Factors
Individual factors make a difference when structural factors increase the difficulty of affording housing. They make individuals and families more vulnerable to housing loss because they are less able to cope with the changes. Personal circumstances that are more common among homeless people than among the general population include:

- adverse childhood experiences (e.g., physical or sexual abuse, removal from the home and placement in foster care or other institutions),

- disconnection from family, friends, and other sources of social and financial support,

- alcohol and/or drug abuse (current or historical),

- mental illness,

- chronic physical health problems,

- incarceration (for males),

- low levels of education or skills training,

- poor or no work history, and

- too-early childbearing.

Most people have a personal network of friends and family upon whom they rely for temporary assistance when they need help. Studies of homeless families (e.g., the Family Options Study) reveal that most families who eventually find their way to emergency shelters have used their networks to the extent that their networks are able to help. They have doubled up, stayed with family and friends, stayed in their cars, and used other approaches to avoid using emergency shelter for as long as possible.

People with few or no personal network resources are more at risk of homelessness when a crisis occurs. For example, children coming from the foster care system are more vulnerable to homelessness because they are less likely to have any network to fall back on once they leave care. They don't have their birth family, having been removed from it after experiencing neglect or abuse, and their foster family has no obligation to help them after they age out of care (age 18 in most states). Children aging out of the system are often also without the training, skills, or experience to sustain themselves independently.[24]

These individual factors help to identify the people who are most likely to lose their housing when the structural situation worsens. For virtually all homeless people, extreme poverty (less than half the federal poverty level) is also a reality, and the basis upon which all other individual factors influence potential homelessness. However, according to my research, considering all individual vulnerabilities that predict homelessness, plus extreme poverty, accounts for only 32 percent of the variance in whether a particular person does or does not experience homelessness.[25] Given circumstances caused by structural factors, sometimes it is as simple as bad luck.

Social Safety Net
The third part of the puzzle of homelessness is the social safety net. States vary in the level of funding for and number of programs available for poor individuals and families, which play a role in the number of people who experience homelessness. One striking example of the effect of a public intervention occurred when it was removed—the closure of institutions for people with mental disabilities starting in the 1960s.

For the first decade or so after deinstitutionalization began, many people with mental disabilities lived in small hotel rooms or boarding houses; however, during the 1970s and 1980s, more than one-third of this type of housing disappeared—in some cities

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Youth aging out of foster care are more vulnerable to home-lessness because they are less likely to have a network to fall back on once they leave care.

the loss was above 50%. As they were displaced, more and more people with mental disabilities became homeless.[26] The same thing happened on a smaller scale when the Social Security Administration eliminated the category of "drug and alcohol abuse" as the basis of eligibility for SSI. Many who lost benefits also became homeless.[27]

The fact that multiple interacting factors may lead to homelessness, as well as the diversity of the homeless population, point to the need for well-targeted interventions that address structural factors first, then individual ones. The following section discusses what the research suggests about how to reduce homelessness among different sub-populations and what it may take to end the problem.

WHAT WILL IT TAKE TO END HOMELESSNESS?

Ultimately, people experiencing homelessness need housing. In addition, people at high risk of homelessness need to have their current housing secured, and households that might be able to take in a struggling family member or friend need secure housing.

In the early years of homeless policy, policymakers and communities focused on temporary housing (e.g., emergency shelters, transitional housing, and motel vouchers) and service provision (e.g., meal programs, work training, alcohol and drug abuse treatment, medical care). Despite significant public and private investments, however, people continued to become or remain homeless. Providing more "services" without also providing affordable housing may paradoxically increase the homeless population. People become reliant on such services, which may help ameliorate the effects of homelessness but do not end it.[28]

In Wisconsin, about 16% of working households had a severe housing cost burden in 2014.

A recent briefing paper from the National Conference of State Legislatures summarized the research well: "... the quantity of safe and affordable housing has failed to keep pace with demand."[29] As discussed earlier, the poorest of the poor are increasingly unable to find housing that doesn't consume most of their income. In Wisconsin, about 16% of working households had a severe housing cost burden in 2014.[30]

Rigorous research supports the idea that the provision of housing leads to better outcomes for families and individuals. For example, as noted in Jill Khadduri's chapter, the Family Options Study found that housing subsidies are most effective for helping homeless families find stable housing and improving their well-being. Research on other subgroups of people experiencing homelessness is similarly instructive.

People Experiencing Chronic Homelessness, Including Veterans
People experiencing chronic homelessness have been the focus of much attention, for good reason. They are a finite, high-cost, high-need population. The federal government, and some states and communities, have set goals to eliminate chronic homelessness and have made good progress, using research to drive programmatic solutions. These include Utah, Denver, Los Angeles County, and others.

Research is clear that one effective solution for people experiencing chronic homelessness is permanent supportive housing. Permanent supportive housing has several key features: housing is kept affordable, it is permanent, and services such

as substance abuse treatment and health care are offered, along with supports to remain stably housed. Tenants' ability to stay in their housing is not dependent on their participation in services—i.e., permanent supportive housing is "housing," not "treatment." Retention rates are generally more than 80%.[31]

The most effective form of permanent supportive housing for people experiencing long-term homelessness is Housing First, which offers housing without strings to get people off the streets first, then works on helping them stabilize and reduce or eliminate behaviors and conditions that put them at risk of losing their housing. What distinguishes Housing First from other permanent supportive housing is that housing is not conditional on any particular tenant behavior. People do not have to be clean and sober; they do not have to be medications-compliant; they do not have to be "nice." They only have to pay their rent and comply with conditions of their lease, the same as any other tenant. The mantra of Housing First is "housing is health," meaning that it is virtually impossible to address a person's disabling conditions while they are still on the street. Housing is the platform from which all else flows—treatment for chronic and life-endangering health conditions, recovery from substance abuse, reconnection with family, and other outcomes.

Many research studies attest to the effectiveness of permanent supportive housing at moving people experiencing chronic homelessness into housing and keeping them there.[32] Such programs help explain recent reductions in chronic and veteran homelessness.[33]

Over the long term, providing permanent supportive housing is also cost-effective. It dramatically reduces shelter costs, expensive visits to the emergency room and hospitals, mental health costs, and involvement with the criminal justice system. One study showed a return on investment even for homeless people with the most severe disabilities.[34] In another study, 95% of the costs to provide permanently supportive housing were offset by reductions in acute services such as inpatient hospital visits, which saves money for cities, counties, and Medicaid.[35] Similar studies have been conducted in rural areas with similar results, even for communities that do not invest a lot in serving people while they are homeless.[36]

Youth Experiencing Homelessness
Compared to information available on what works for chronically homeless people and families experiencing homelessness, research on homeless youth is still trying to get a grasp on the size and nature of the population. Very few studies have looked at what works. What does exist tends to come through the silo of youth services rather than of homelessness. For instance, research from Chapin Hall at the University of Chicago (featured in the 33rd Wisconsin Family Impact Seminar) looked at policies that extend foster care beyond the age of 18, to see if longer supports lead to greater ability to maintain independence and avoid homelessness once care ends.[37] Preliminary results indicate that extending care may delay but not prevent homelessness. By age 23, about the same proportion of youth leaving foster care at age 18 or at age 21 has experienced at least one night of homelessness or unstable housing reflected in couch surfing.

Permanent supportive housing reduces chronic homelessness and saves taxpayer dollars spent on emergency shelter, medical, and criminal justice costs.

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WHAT ARE SOME POLICY OPTIONS FOR STATES?

States can do many things to make housing more affordable through policies and practices that increase the supply of affordable housing and make existing housing more affordable to individual households through rent subsidies. It is critically important to increase supply, because increased subsidies to households in the absence of more actual units, while helping individual households, will ultimately do little more than drive up the price of housing. Given that low-income households cannot pay enough rent to cover the costs of development and post-occupancy operating expenses of low-income housing, subsidies are needed.[38]

New Jersey has built more affordable housing per capita in high-opportunity communities near good schools and jobs than any other state.

Increasing the Supply of Affordable Housing: The Case Study of New Jersey
Spurred on by several landmark State Supreme Court decisions, New Jersey is probably the best example of a state committed to creating new affordable housing. "Mount Laurel I" ruled that zoning ordinances that make it physically and economically impossible to provide low- and moderate-income housing were unconstitutional. "Mount Laurel II" created a "fair share formula" to measure each municipality's obligation to provide affordable housing, as well as a "builder's remedy" to force municipalities to fulfill that obligation. As a result of the Mount Laurel decisions, New Jersey has built more affordable housing per capita in high-opportunity communities near good schools and jobs than any other state in the nation.[39]

New Jersey uses a wide range of local, state, and federal funding opportunities to generate this housing.[40] Local jurisdictions may use fee ordinances and payment-in-lieu fees. State-funded resources come from several sources.

- Under the jurisdiction of the New Jersey Department of Community Affairs: Urban Housing Assistance Fund, New Jersey Affordable Housing Trust Fund, Deep Subsidy Program, Municipal Land Acquisition Program, State Rental Assistance Program, and the Neighborhood Revitalization Tax Credit Program.

- Under the jurisdiction of the New Jersey Housing and Mortgage Finance Agency: home ownership incentives, a small rental project loan program, a housing preservation program, a special needs housing trust fund and revolving loan program, and a transitional and permanent housing loan program for youth aging out of foster care.

New Jersey's Neighborhood Preservation Balanced Housing program creates housing opportunities in viable neighborhoods for households of low and moderate income and is funded by the New Jersey Realty Transfer Tax. It uses the following practices and techniques:

- Housing trust funds;

- Rent subsidies to households, to reduce what the household must pay to what it can afford at 30% of its income;

- Production subsidies of various types, including land acquisition and costs of construction; and

- Establishment of a statewide allocation of affordable housing to assure that each municipality includes its "fair share" of housing affordable to very low-income households.

The net result of all these policies is the access of more than 60,000 households to affordable housing, distributed fairly within communities around the state—and still counting.

Other Affordable Housing Programs and Funding Sources

The National Low Income Housing Coalition has assembled a database of programs established with state or local resources that offer either **rental assistance** (157 active programs, 5 in Wisconsin) or **capital/construction assistance** (171 active programs, 1 in Wisconsin).[41] In addition to the practices noted for New Jersey, another source of funding used to support housing production is **bond financing**. The cities of Houston and Louisville, Los Angeles County, Seattle/King County, and the states of Alabama, Arizona, Hawaii, and Vermont sell bonds to support affordable housing production. Washington state law established the practice of adding a small percentage to real estate transfer taxes to give each county a funding source for programs addressing homelessness. A relatively rare option is a **local tax** such as Miami/Dade County's food and beverage tax, which is levied only on establishments doing a certain level of business and most likely to serve visitors to the area. Proceeds are dedicated to programs addressing homelessness and domestic violence.

In addition to these sources of funding, **cross-jurisdictional planning** to include affordable housing in all jurisdictions is essential; further, the plans must be enforceable. There are some localities that have attempted regional zoning or planning with an eye to creating more affordable housing, but none has gone as far as New Jersey, with its "fair share" applying to all municipalities in the state.

Quite a few jurisdictions address the need for affordable housing with policies described as **inclusionary zoning**, an affordable housing tool that links the production of affordable housing to the production of market-rate housing. Inclusionary zoning policies either require or encourage new residential developments to make a certain percentage of the housing units affordable to low- or moderate-income residents. Evidence is mixed as to how well these policies work to produce more affordable units.[42] A good deal depends on the terms of the policies and how well they are enforced. Some research has been done to identify factors that lead to more effective inclusionary zoning.[43]

Programs to Address Specific Needs

Other common practices address the specific needs of individuals and households. These include:

- Scattered-site approaches that negotiate with landlords in the private market and help currently homeless households find housing;

- Supportive services aimed at helping households keep their housing once they move in, including working with landlords as well as tenants;

- Services that address particular skill deficiencies such as personal and family financial management skills;

- Techniques that help households establish or re-establish credit and successful rental histories;

- Practices that help people re-connect with family members; and

- Practices that seek to reduce the harm people do to themselves and others through alcohol and drug abuse.

Inclusionary zoning policies require or encourage new residential developments to make a certain percentage of housing units affordable to low-or moderate-income residents.

Integrated Service Systems

Key to making many of these policy options work for individuals and families is having an integrated service system among state agencies that moves beyond coordination to collaboration.[44] This is particularly important for households with complex and interacting health and behavioral health conditions, because without it, they can fall through holes between siloed agencies. This work consists of joint analysis, planning, and the development of shared goals, all supported by agency leadership. A truly coordinated community response includes the following components:

- participation from *all* actors that provide services and support to the homeless;
- a mechanism for ensuring households receive the services they need, which results in improved client outcomes and more efficient and effective use of resources;
- a functioning, data-informed feedback mechanism; and
- an ongoing mechanism for thinking about next steps and how to accomplish them.

Best practice suggests that these elements are easiest to maintain if there is a paid coordinator to organize and staff interagency work groups and committees. Maine and Connecticut are good examples of states that have made a concerted effort to integrate their services. Local initiatives in Seattle/King County; Portland, Oregon; and Los Angeles County are other examples.

CONCLUSION

When homeless families and adults achieve stable housing, they are more able to support family members who have mental illnesses or are in stressful situations.

The research and policy options above have the potential to both reduce current and prevent future homelessness. They also work to strengthen families, ending the cycle of homelessness for children and providing a more stable platform for dealing with other barriers to well-being. For example, when homeless families and adults achieve stable housing, they are more able to support family members who have mental illnesses or are in stressful situations. Further, helping low-income families and individuals get and keep safe, affordable housing can be a simple way to sidestep complicated minimum income policies. This not only alleviates human suffering, but impacts the state budget by reducing expenditures on safety net programs and the justice system.

Martha Burt is a consultant and Affiliated Scholar with the Urban Institute, where she was the Director of the Social Services Research Program for nearly three decades. Dr. Burt has directed numerous research projects for the U.S. Department of Housing and Urban Development (HUD) and is currently part of a HUD research team conducting a demonstration study of housing and service options for homeless families. Over her distinguished career, Dr. Burt has been instrumental in developing ways to count and describe homeless children and adults; and in examining state policies, legislation, funding, and programs to serve homeless people and to prevent homelessness. She is the author of three books and dozens of articles and reports on homelessness, and has submitted testimony to or presented before Congressional committees numerous times. Dr. Burt's other areas of research include hunger, teen pregnancy and parenting, domestic violence, the impact of federal and state policy changes on the well-being of children and youth, and services integration projects for at-risk youth. In 2008, Dr. Burt received a Lifetime Achievement Award from the National Alliance to End Homelessness. She received her PhD in sociology from the University of Wisconsin–Madison.

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STATE OF WISCONSIN FUNDING AND FUND SOURCES FOR HOMELESSNESS

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*T*his chapter provides information relating to funding, including federal funds, provided by the State of Wisconsin for homelessness or prevention of homelessness and focuses on housing needs in particular. Some programs target specific populations [such as individuals with a disability, individuals living with human immunodeficiency virus (HIV) or acquired immunodeficiency syndrome (AIDS), individuals with mental illness or a substance abuse disorder, and veterans], while others address homelessness and housing in general. Funded activities may include: rental assistance; housing vouchers; foreclosure prevention payments; utility bill assistance; supportive services and outreach to homeless individuals; operation of transitional housing, emergency shelters, or housing voucher programs; housing rehabilitation; renovation or capital improvements to emergency and transitional housing facilities; low-income housing tax credits for housing developments; multifamily housing development loans; Homeless Management Information System project costs; and administrative expenses. In addition to programs related to homelessness or prevention of homelessness, a summary of programs that provide other types of services relating to homelessness is included as an appendix to this chapter.

DEPARTMENT OF ADMINISTRATION

Housing programs of the Department of Administration (DOA) are administered by the agency's Division of Energy, Housing and Community Resources. Funding for DOA programs that relate specifically to homelessness for 2014-15 through 2015-16 is summarized in Table 1. This information was provided by the administration. Depending on the program, budgeting may be done based on a state fiscal year, federal fiscal year (FFY), or program year. Therefore, funding listed for each program may be for different time periods for the year that is indicated in the table. Funding shown in Table 1 is from state general purpose revenues (GPR), state program revenues (PR), and federal revenues (FED). A description of each program follows Table 1.

TABLE 1
Department of Administration Funding for Homelessness
2014—15 and 2015—16

Program		Annual Funding	
		2014-15	2015-16
Homeless Prevention Program GPR	(1)	$1,503,700	$1,515,000
Critical Assistance Program GPR	(1)	$282,800	$282,800
Transitional Housing Grants GPR	(1)	$300,000	$297,500
State Shelter Subsidy Grant Program GPR	(1)	$1,113,600	$1,113,600
Tenant-Based Rental Assistance (TBRA) FED	(2)	$780,000	$1,064,019
Emergency Solutions Grants FED	(2)	$3,169,745	$3,453,944
Projects for Assistance in Transition from Homelessness (PATH) GPR FED All funds	(1) (2)	$58,400 $836,000 $894,400	$58,400 $836,000 $894,400
Housing Opportunities for Persons with AIDS FED	(2)	$466,613	$468,812
Shelter Plus Care FED	(2)	$254,548	$261,692
Interest-Bearing Real Estate Trust Account Receipts (IBRETA) PR	(3)	$19,213	$17,894

(1) For state-funded programs (GPR and PR), funding is for a state fiscal year, July 1 through June 30.
(2) Federal funding shown for PATH is for state fiscal years 2014-15 and 2015-16, associated with the program award period. For other federally funded programs, funding is associated with federal fiscal years (FFY) 2014 and 2015.
(3) Receipts of IBRETA program revenue are shown for calendar years 2015 and 2016 (through October 31, 2016). Several programs may be supplemented from IBRETA receipts as needed from the available revenue balance, including transitional housing grants, state shelter subsidy grants, emergency solutions grants, and funding for PATH.

Homeless Prevention Program. This program funds homeless prevention and is awarded in annual grant cycles in combination with state funding for Transitional Housing Grants and federal funding for Emergency Solutions Grants. Funded activities under the program may include: rental assistance to households in the form of security deposits, short-term rental subsidies, or utility costs; foreclosure prevention, including payment of principal and interest on a mortgage loan that is past due, property taxes, and utility payments, if the homeowner shows the ability to make future payments; and administrative funds to support the above activities.

Critical Assistance Program. The Critical Assistance program funds Homeless Prevention Program activities in parts of the state that are not served by federal Emergency Solutions Grants or other state funds. As with the homeless prevention program, funded activities under the program may include: rental assistance to households, foreclosure prevention, and administrative funds.

Transitional Housing Grants. The Transitional Housing Grants program provides grants to private, nonprofit organizations; community action agencies; and county or municipal governments for operating transitional housing and associated supportive services for the homeless. The purpose of the program is to facilitate the movement of homeless individuals to independent living.

State Shelter Subsidy Grant Program. The State Shelter Subsidy Grant program provides funding of up to 50% of the annual operating budget of an emergency shelter or housing voucher program. Funding is distributed to eligible applicants using a formula that is based on the number of shelter nights provided.

Tenant-Based Rental Assistance. The Tenant-Based Rental Assistance program, known as TBRA, funds rental assistance and supportive services to homeless individuals with a disability and households at risk of homelessness. Funding is provided from the federal Home Investment Partnerships program (HOME).

Emergency Solutions Grants. The federally funded Emergency Solutions Grants program, which was known as the Emergency Shelter Grant program prior to FFY 2011 when the U.S. Department of Housing and Urban Development focused more on providing funding for shelters, funds homelessness prevention, rapid re-housing, emergency shelter, street outreach, and Homeless Management Information System projects.

Projects for Assistance in Transition from Homelessness. The Projects for Assistance in Transition from Homelessness program, known as PATH, funds outreach and mental health services for homeless individuals with serious mental illness, including individuals with co-occurring substance abuse disorders. Funding is distributed to counties with populations over 150,000 through a competitive application process.

Housing Opportunities for Persons with AIDS. The Housing Opportunities for Persons with AIDS program, known as HOPWA, provides rental housing assistance and services to households with an individual who lives with HIV or AIDS. Funding may be provided for housing assistance, including: emergency housing; shared housing arrangements; and permanent housing placement in apartments, single-room occupancy units, and community residences. Non-housing support services may include: supportive services such as physical and mental health care and assessment; drug and alcohol abuse treatment

The Emergency Solutions Grants program funds homeless prevention, rapid re-housing, emergency shelter, street outreach, and HMIS projects.

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and counseling; day care services; intensive care; nutritional services; and assistance in gaining access to local, state, and federal government benefits and services.

Shelter Plus Care. The Shelter Plus Care program provides rental and utility assistance in combination with support services for homeless people with mental illness. The program is funded through the U.S. Department of Housing and Urban Development Continuum of Care application process.

Interest-Bearing Real Estate Trust Accounts. The source of funding for this program is generated from earnings on interest-bearing real estate common trust accounts established under state statute. The program, known as IBRETA, requires real estate brokers and salespeople in Wisconsin to deposit down payments, earnest money, and similar types of real estate payments in a pooled interest-bearing trust account at a depository institution. From the amounts credited to this PR appropriation, DOA provides grants to organizations that provide shelter or services to homeless individuals or families.

Other Housing Programs. The Department administers several other housing programs not listed in Table 1 that benefit low-income and moderate-income households in general. To the extent that availability of affordable housing prevents homelessness, these programs could be considered preventive. The following programs could potentially be considered related to homelessness prevention: (a) the Housing Cost Reduction Initiative Homebuyer program (funded at $2.6 million GPR over the 2015-17 biennium); (b) initiatives of the federally funded Home Investment Partnerships program (HOME) such as the Homebuyer and Rehabilitation program (allocated $3,306,700 FED in FFY 2016) and the Rental Housing Development program (allocated $2,803,500 FED in FFY 2016); and (c) federal funding for the Housing Rehabilitation program (allocated $5,490,500 FED for rehabilitation of owner-occupied housing and $59,700 FED for rehabilitation of rental housing in FFY 2016) and the Emergency Assistance program ($3,317,800 FED from a combination of FFY 2015 and FFY 2016 funds to Vernon County for September 2016 flooding) from the Small Cities Community Development Block Grants program. It should be noted that emergency assistance funds provided to Vernon County relating to flood damage were not limited to assistance for damage to housing, and included public infrastructure and business assistance. Additionally, funding awarded to Vernon County represents an approved budget for disaster expenses. Actual expenses could differ from the estimated budget.

In addition, DOA administers the Wisconsin Home Energy Assistance Program, which provides low-income energy assistance services, including crisis assistance services and benefits to households experiencing or at risk of experiencing an energy emergency (heating or non-heating electric emergency). The crisis assistance component of the program provides limited cash assistance and services including providing heating fuel, short-term housing assistance, or in-kind benefits such as blankets or space heaters. The program also offers proactive services designed to minimize the risk of heating emergencies during the winter months. Funding is provided from: (a) the federal Low-Income Home Energy Assistance Program (LIHEAP); and (b) the state segregated utility public benefits fund. In 2015-16, about $16.3 million ($12.4 million FED and $3.9 million SEG) was provided for crisis assistance benefits. In June 2016, DOA announced that it would allocate a portion of federal LIHEAP funds for crisis assistance targeted to homeless veterans, to assist with payments to energy providers, payment for one month of rent, and a security deposit (if needed). Through September 30, 2016, $208,400 FED was expended for the initiative.

The Department of Administration administers several programs that increase the availability of affordable housing and could prevent homelessness.

DEPARTMENT OF CORRECTIONS

The Division of Community Corrections within the Department of Corrections administers two programs that relate to housing and homelessness.

Emergency and Supplemental Housing. The Department provides state funds for offenders to stay up to 30 days in a hotel, motel, or small furnished apartment on a temporary basis in cases of emergency (with an option to apply for 30-day extensions). Emergency housing assistance is provided when an offender under community supervision does not have an appropriate residence and may be waiting for a residential program opening. Supplemental housing consists of temporary support of offender-leased housing for which the Division pays part or all of a few months' rent. Payment is made directly to the landlord on behalf of the offender. Purchase of offender goods and services funding is allocated to eight Division of Community Corrections regions. Subsequent to regional allocation, funding is provided on a needs-based prioritization. The Department expended $851,371 GPR in 2015-16 for this purpose.

Transitional Housing (Transitional Living Program). Transitional housing is provided in the form of one to two bedroom apartment(s) or a facility with multiple single- or double-occupancy bedrooms with access to a congregate living area and shared kitchen. The housing program contractor supplies all bedding, household supplies (items such as dishes, cooking utensils, and alarm clocks), a food supply for one week, and supervision by staff through random on-site inspections. Offenders must follow rules, participate in program services as determined by their agent, and comply with employment requirements. The program is used to transition offenders from prison to the community when other housing options are unavailable. Housing may be provided for up to 90 days based on availability and may be extended. Funding targets offenders under supervision who do not have housing. As with emergency and supplemental housing (described above), purchase of offender goods and services funding is allocated to eight Division of Community Corrections regions, where regional chiefs allocate funding according to a needs-based prioritization. The Department expended $3,615,675 GPR in 2015-16 for this purpose.

The Transitional Living Program is used to transition offenders from prison to the community when other housing options are unavailable.

It should be noted that for the Corrections programs described above, the agency expends the funds to perform its statutory duties to place offenders in the community in a manner that protects public safety and provides for secure supervision of individual offenders.

DEPARTMENT OF HEALTH SERVICES

Ryan White Part B. The Department of Health Services receives Ryan White Part B funds from the U.S. Health Resources and Services Administration to support both medical and support services for persons living with HIV. For the 2016 project year (April 1, 2016, to March 31, 2017), $82,800 FED is provided under a contract with the AIDS Resource Center of Wisconsin to provide security deposits and housing assistance not to exceed seven days to low-income people living with HIV.

DEPARTMENT OF VETERANS AFFAIRS

Veterans Assistance Program. The Veterans Assistance Program (VAP), also known as the Veterans Housing and Recovery program, provides transitional housing and support services to homeless veterans and veterans who are at risk of becoming homeless. By rule, a veteran is eligible for the program if the veteran's need for services is based on any of the following circumstances: (a) homelessness or conditions that indicate that the veteran is at risk of becoming homeless; (b) incarceration; (c) unemployment or underemployment that significantly limits the veteran's ability to be self-supporting; (d) an affliction with acute or chronic physical or mental health problems that significantly limits the veteran's ability to be self-supporting; or (e) insufficient monthly income and resources to pay for the cost of care provided at an assisted living facility operated at a state veterans home. The Department funds VAP residential services on the campuses of the three state veterans homes.

Services provided in the VAP include: (a) transitional housing; (b) referrals to service providers; (c) financial assistance to veterans who are eligible for residency at a veterans home but lack financial resources; (d) assistance in seeking vocational opportunities; and (e) single-occupancy rooms at reduced rent for working veterans. Veterans who receive transitional housing or single-occupancy housing assistance may be charged a program fee, which is generally capped at 30% of monthly income.

The Veterans Assistance Program provides services such as housing assistance, financial assistance, vocational assistance, and other service referrals.

The Veterans Assistance Program is funded primarily with federal per diem payments, but it is also supported with other funding sources. In 2015-16, program expenditures totaled $1,841,500, including federal per diem payments ($1,120,100 FED), an appropriation from the veterans trust fund ($364,300 SEG), an appropriation from the general fund ($178,200 GPR), and revenue contributed by veterans who received VAP housing services ($178,900 PR). Federal funds received for the Veterans Assistance Program must be used for supportive housing or supportive services for veterans. Program revenue funds represent rent payments received from certain program participants, and the use of those funds is subject to federal rules. The general fund appropriation is used to support the cost of assisted living services at the state veterans home at Union Grove for veterans who have insufficient income and assets to pay for those services.

WISCONSIN HOUSING AND ECONOMIC DEVELOPMENT AUTHORITY

WHEDA Foundation Grants. The Wisconsin Housing and Economic Development Authority (WHEDA) annually awards grants for entities or facilities offering emergency and transitional housing to alleviate or prevent homelessness in Wisconsin. Grants typically support smaller-scale renovations or capital improvements to facilities. Table 2 shows grants for 2011 through 2016. Awards are funded by annual surpluses in WHEDA's general reserves. The WHEDA Foundation, a nonstock corporation indirectly controlled by WHEDA, administers grants after the Authority annually transfers funds for the program.

TABLE 2
WHEDA Foundation Emergency and Transitional Housing Grants

Year	Amount
2011	$250,300
2012	$279,000
2013	$257,100
2014	$177,500
2015	$174,900
2016	$227,200

Source: WHEDA

Other Housing Programs. To the extent affordable housing programs can prevent homelessness for low-income households, other programs could be considered as addressing or preventing homelessness. The following paragraphs describe additional programs administered by WHEDA for affordable housing.

The federal Low-Income Housing Tax Credit (LIHTC) program is administered for Wisconsin by WHEDA. LIHTC competitively awards proposed developments an amount of future federal tax credits, the claims to which are typically sold at a discount to investors. The program therefore utilizes tax credits to encourage up-front private investment in the development and rehabilitation of low-income rental housing. For a period of 30 years, an LIHTC property must ensure either: (a) 20% or more of the units in a project are available to individuals with incomes at or below 50% of the county median income; or (b) 40% of the units are available to persons with incomes at or below 60% of the county median income. Rent paid by families in qualifying units typically is not to exceed 30% of income. Initial LIHTC awards in 2016 are $14,271,600, although the credits are claimable each year for 10 years, making the total nominal value of the credits approximately $142.7 million.

Under LIHTC, WHEDA in recent years has routinely allocated a supportive housing set-aside of 10% for developments intending to provide supportive services in at least 50% of the units for individuals or families who are chronically homeless or prone to homelessness and who require access to supportive services to maintain housing. The Department of Administration reports that funding allocated to this purpose totals $1,428,700 in 2016.

The federal Section 8 program provides low-income households with rental assistance in the form of either: (a) tenant-based housing choice vouchers; or (b) subsidies paid to property managers for units continually participating in the program, so long as eligible tenants occupy available units. This latter type of subsidy is typically known as project-based assistance. Participants must make a minimum monthly contribution toward rent, which typically is 30% of adjusted monthly income. Section 8 assistance is limited to households at no more than 80% of county median family income (MFI), although some portions of the program require a limit of 50% of MFI, and program provisions commonly

The Low-Income Housing Tax Credit program utilizes tax credits to encourage up-front private investment in the development and rehabilitation of low-income rental housing.

target available assistance to households at or below 30% of MFI. WHEDA administers project-based assistance and a portion of voucher assistance available to Wisconsin. WHEDA reports it administered $165.1 million in Section 8 project-based assistance in 2015-16. In the 2016 calendar year, WHEDA has budget authority to administer $7.8 million in housing vouchers, plus up to $2 million in contingent reserves held by HUD. Other local public housing authorities (PHAs) in Wisconsin also administer Housing Choice Vouchers, for a total of $152,326,000 in FFY 2015 for all of Wisconsin.

Section 8 rental assistance is administered by both WHEDA and local public housing authorities.

WHEDA provides financing for multifamily housing developments through: (a) issuance of bonds, the interest on which may be tax-exempt; and (b) its general reserves. As under the LIHTC, WHEDA multifamily housing financing programs generally require properties to set aside: (a) 20% or more of the units in a project for persons with incomes at or below 50% of the county median; or (b) 40% of the units for persons with incomes at or below 60% of the county median. Rent paid by families in qualifying units typically is not to exceed 30% of income. Table 3 shows annual multifamily housing loans issued by WHEDA since 2010-11.

TABLE 3
WHEDA Multifamily Lending Activity

Fiscal Year	Amount
2010–11	$42,468,600
2011–12	$216,147,000
2012–13	$74,840,300
2013–14	$50,736,500
2014–15	$30,143,500
2015–16	$97,358,100

Source: WHEDA

The federal Section 811 program provides project-based assistance for housing for disabled adults under age 62 and with income no more than 30% of area median. As under other programs listed above, tenant contributions to rent are to be 30% of monthly income. Target populations for the program include those seeking to live in the community, but who are at risk of institutionalization due to substandard housing or the loss of adequate housing. WHEDA reports it has up to $2,532,100 in funding available to award through 2020.

Finally, it should be noted that WHEDA is not a state agency. Its operating budget and authorized positions are not included in the state budget and are not subject to direct legislative control. Revenues to finance its operating budget primarily come from interest earnings on loans it makes, investments of its assets, and administrative fees it assesses.

APPENDIX

Programs Administered by the State for Homelessness Services Other than Housing Services

DEPARTMENT OF ADMINISTRATION

SSI/SSDI Outreach, Access, and Recovery. This program, known as SOAR, is designed to increase access to Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI), which are disability income benefit programs administered by the Social Security Administration for people who are homeless and have a mental illness or a co-occurring substance use disorder. The Department provides funding to SOAR programs in the state, where people are trained to facilitate the expediting of SSI and SSDI applications for this population. The program is funded $382,500 FED in 2015-16 from the mental health block grant program ($74,000) and community development block grant program ($308,500).

DEPARTMENT OF CHILDREN AND FAMILIES

The Department of Children and Families (DCF) administers many programs to ensure the safety, well-being, and stability of children and their families. This includes several programs aimed in part toward alleviating and reducing homelessness.

Emergency Assistance. The Emergency Assistance program provides assistance to needy people with children in cases of fire, flood, natural disaster, energy crisis, homelessness, or impending homelessness. Emergency Assistance may be provided once in a 12-month period. Wisconsin Works agencies administer the Emergency Assistance program at the local level via contract with DCF.

Benefits are in the form of cash, voucher, or vendor payment and are funded under the federal Temporary Assistance for Needy Families block grant. Emergency Assistance payments totaled approximately $6.9 million in 2015-16 and are budgeted at $8.4 million in 2016-17.

Runaway and Homeless Youth Services. Twenty-three programs across the state provide residential, counseling, and other services designed to protect and reunite runaway and homeless youth with their families, such as the basic center and street outreach programs. These services are federally funded with $700,000 annually under the Social Security Act, Title IV-B, Subpart 1. Most of these programs are also supported through other grants and funding sources, such as federal Family and Youth Services Bureau Runaway and Homeless Youth grants.

Independent Living Services. In FFY 2015, the state received $2.1 million in federal funding under the Chafee Independent Living program to assist eligible youth and young adults who age out of the out-of-home care system to transition to self-sufficiency. The Department allocated $1.6 million of these funds to regional service agencies, counties, and tribes, most of which is used for direct services for youth. No more than 25% may be used for room and board expenses.

The state receives federal funding under the Chafee Independent Living program to assist youth who age out of the out-of-home care system to transition to self-sufficiency.

DEPARTMENT OF HEALTH SERVICES

State Partnership Initiative to Address Health Disparities. The Department of Health Services provided a one-time grant to Pathfinder, Inc., for the period of August 15, 2015, to August 1, 2016, to promote HIV prevention practices among youth who are homeless, runaway, gay, bisexual, transgender, or minorities otherwise at risk for HIV. Through street outreach and a drop-in center, youth were provided access to condoms, HIV prevention education, regular HIV testing, referral to pre-exposure prophylaxis for appropriate clients, and supportive services addressing alcohol and drug abuse, mental health, and other social determinants that contribute to HIV disparities impacting minority communities. Support for clinical services was provided through formal collaboration with the Greater Milwaukee Center for Health and Wellness. The grant was funded $16,000 FED from the U.S. Department of Health and Human Services Office of Minority Health.

DEPARTMENTS OF HEALTH SERVICES AND VETERANS AFFAIRS

Veterans Outreach and Recovery Program. The Department of Health Services and the Department of Veterans Affairs jointly operate the Veterans Outreach and Recovery Program (VORP) to connect homeless veterans in northern Wisconsin who have been diagnosed with a behavioral health condition with existing services related to housing, employment, and mental health and substance abuse treatment. The program combines funds received from two federal grants, which run through FFY 2017. The departments plan to spend $1 million on the program in both FFY 2016 and 2017, funding that will be used primarily to hire outreach specialists. These funds were received based on a specific program description in the grant applications and must be used for those purposes.

DEPARTMENT OF PUBLIC INSTRUCTION

Wisconsin receives federal funding under the McKinney-Vento Education of Homeless Children and Youth Assistance program to serve homeless students.

Under the McKinney-Vento Education of Homeless Children and Youth Assistance program, federal funding is provided to states to support school district programs that serve homeless students. Funding can be used to provide homeless students with tutoring and other educational support, school supplies, referral for medical or mental health services, and other support. Three-year grants are awarded to school districts on a competitive basis. Wisconsin school districts received approximately $696,400 in federal funding under the McKinney-Vento Act in 2014-15, and $700,200 under the act in 2015–16.

DEPARTMENT OF WORKFORCE DEVELOPMENT

The Department of Workforce Development's Office of Veterans Services provides employment services to veterans and other eligible applicants with significant barriers to employment. Disabled Veterans Outreach Program (DVOP) specialists provide employment services and training for veterans and other eligible applicants, with maximum emphasis on serving those who are economically or educationally disadvantaged, including homeless veterans, and veterans with barriers to employment. DVOP specialists assist veterans in coordination with partner agency programs within Job Centers, Workforce Development Centers, and community-based organizations. Funding levels for the DVOP are $1,975,000 FED in FFY15 and $1,756,000 FED in FFY16.

GLOSSARY

Chronic Homelessness: defined by HUD as a type of homelessness experienced by an adult with a physical, mental, emotional, or developmental disability or diagnosable substance abuse disorder who has experienced either one consecutive year of homelessness on the streets or in an emergency shelter, or four distinct episodes totaling at least 12 months over a three-year period while living on the streets or in an emergency shelter.[1] Families with at least one adult and one minor child are considered chronically homeless if at least one adult meets the requirements.

Continuum of Care (CoC): a regional or local planning body that may include nonprofit organizations, state and local governments, public housing agencies, and other stakeholders that coordinates housing and services funding for homeless families and individuals.[2] Wisconsin has four CoCs: Milwaukee County/City, Dane County/City of Madison, Racine County/City, Balance of State (69 remaining counties).

Continuum of Care Program: the grant program through which HUD provides funding to Continuums of Care to coordinate and provide services with the goal of ending homelessness. Program funds can be used for five program components: permanent housing (including permanent supportive housing and rapid re-housing), traditional housing, supportive services only, Homeless Management Information Systems (HMIS), and, in some cases, homelessness prevention.[3]

Cost-Burdened Household: a household that pays more than 30 percent of its income on housing and may have difficulties affording necessities such as food, clothing, transportation, and medical care.[4]

Emergency Shelter: a facility with the primary purpose to provide a temporary shelter for people experiencing homelessness in general or for specific populations of the homeless and that does not require occupants to sign leases or occupancy agreements.[5] In 2016 in Wisconsin, there were 3,614 emergency shelter beds available year-round from providers participating in the Homeless Management Information System (HMIS).[6]

Episodic Homelessness: type of homelessness experienced by people who have short- or medium-length spells of homelessness.

Extremely Low-Income Household: a household with an income 30 percent or less of the area median income (AMI).

Federal Fiscal Year (FFY): October 1 through September 30. The HMIS data used in Adam Smith's chapter are from FFY 2016.

Homeless: HUD defines four categories of homelessness: (1) *Literally Homeless*-individuals and families who live in a place not meant for human habitation (including the streets or in their car), emergency shelter, transitional housing, and hotels paid for by a government or charitable organization; (2) *Imminent Risk of Homelessness*-individuals or families who will lose their primary nighttime residence within 14 days and have no other resources or support networks to obtain other permanent housing; (3) *Homeless under Other Statutes*-unaccompanied youth under 25 years of age, or families with children and youth, who do not meet any of the other categories but are homeless under other federal statutes, have not had a lease and have moved two or more times in the past 60 days, and are likely to remain unstable because of special needs or barriers; and (4) *Fleeing Domestic Violence*-individuals or families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking, and who lack resources and support networks to obtain other permanent housing.[7]

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009: reauthorized the McKinney-Vento Act's homeless assistance programs and included an expanded focus on homelessness prevention and rapid re-housing. It also modified HUD's definition of homelessness to include people at imminent risk of homelessness and unstably housed families or unaccompanied youth.[8]

Homeless Management Information System (HMIS): an information system designated by each Continuum of Care to collect and manage client-level data of people experiencing homelessness or at risk of homelessness. All projects funded through the CoC Program (except those federally prohibited from entering data such as domestic violence service providers) are required to use the locally approved HMIS to report client demographics and outcomes to HUD. Approximately 80 percent of homeless service programs in the state participate in Wisconsin's HMIS.

Housing First: an approach to quickly connect individuals and families experiencing homelessness to permanent housing without preconditions, such as sobriety or requirements to participate in the treatment programs or supportive services that are offered.[9]

Housing Subsidy: assistance for very low-income families, the elderly, or people with disabilities that allows them to afford safe and sanitary rental housing. The Section 8 Housing Choice Voucher program allows tenants to choose a suitable home in the private market as long as it meets guidelines. Project-based Section 8 programs provide housing in privately owned rental units where the subsidy stays with the building and does not follow the person. Public housing is managed by local housing authorities and provides affordable apartments and single-family houses.

HUD: *See U.S. Department of Housing and Urban Development*

Institute for Community Alliances (ICA): a nonprofit organization that provides HMIS training and support for 10 states, including Wisconsin.

Length of Time Homeless: a performance indicator that measures the amount of time a person was homeless in total days or average days (e.g., length of time a person was homeless before placement in permanent housing).

McKinney-Vento Homeless Assistance Act: created in 1987 as the first federal response to homelessness, the Act authorizes a variety of programs that are administered by several U.S agencies including the Departments of Housing and Urban Development (HUD) and Education (DOE). The Act established the U.S. Interagency Council on Homelessness.[10]

Permanent Housing: community-based housing, including both permanent supportive housing and rapid re-housing.[11]

Permanent Supportive Housing: community-based housing without a designated length of stay.

Permanent Housing Destinations: a classification used by HMIS providers to document where clients go when they leave the program or shelter. These destinations include housing owned or rented by the client with or without subsidy, permanent residence with friends or family, and permanent housing projects.

Point-in-Time (PIT) Count: an annual count of sheltered and unsheltered people experiencing homelessness on a single night in January, as required by HUD. The count includes people in emergency shelters, transitional housing, safe havens, and on the streets or places not meant for human habitation. The PIT count is the only official count that includes information from domestic violence shelters as well as a comprehensive count from all providers not using HMIS.

Projects for Assistance in Transition from Homelessness (PATH): a federal grant program managed by the U.S. Department of Health and Human Services (HHS) that provides assistance to individuals who are homeless and have serious mental illnesses. PATH funds are distributed to states/territories that, in turn, contract with local public or nonprofit organizations to fund a variety of services to homeless individuals.[12]

Rapid Re-Housing: a housing model designed to provide temporary assistance to help individuals or families who are homeless move into permanent housing as quickly as possible, and achieve stability through a combination of rental assistance and tailored supportive services.[13]

Safe Haven: a form of long-term supportive shelter that serves hard-to-reach homeless people with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services.[14]

Severely Cost-Burdened Household: a household that spends more than half of its income on housing costs.

Street Outreach: a method used to engage unsheltered individuals and families experiencing homelessness and connect them with shelter, housing, and critical services. It may include case management, emergency health and mental services, transportation, and other services for special populations. Most street outreach is funded by the PATH program (see definition above).[15]

Temporary and Some Institutional Destinations: a classification used by HMIS providers to document where clients go when they leave the program or shelter. These destinations include emergency shelter, foster care, hotel/motel paid for without an emergency shelter voucher, transitional housing, psychiatric hospitals, temporary residences with friends or family, substance abuse treatment facilities/ detox centers, long-term care facilities, and nursing homes.

Transitional Homelessness: type of homelessness experienced by individuals or families who enter the shelter system once and often for a short period.

Transitional Housing: housing with the purpose to facilitate the movement of individuals and families experiencing homelessness to permanent housing within 24 months or a longer period if deemed necessary by the U.S. Department of Housing and Urban Development.[16]

Unaccompanied Youth: homeless people up to age 24 who are unaccompanied by a parent, guardian, or spouse, or who are with their own children. Reasons for youth homelessness include family problems, economic circumstances, racial disparities, mental health issues, substance abuse, and involvement with public systems such as child welfare and juvenile justice.[17]

U.S. Department of Housing and Urban Development (HUD): federal agency responsible for the administration of the CoC Program. It became a Cabinet-level agency in 1965 and in the late 1980s was designated the lead federal agency for addressing homelessness.

U.S. Interagency Council on Homelessness (USICH): an independent organization within the Executive Branch of the federal government established by the Stewart B. McKinney Homeless Assistance Act of 1987 to coordinate the federal response to homelessness. The current membership includes the heads of 19 federal departments and agencies. Each state and territory can establish its own Interagency Council on Homelessness through executive order or legislative action.[18]

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THE FAMILY IMPACT GUIDE FOR POLICYMAKERS
Viewing Policies Through the Family Impact Lens

- Most policymakers would not think of passing a bill without asking, **"What's the economic impact?"**
- This guide encourages policymakers to ask, **"What is the impact of this policy on families?" "Would involving families result in more effective and efficient policies?"**

When economic questions arise, economists are routinely consulted for economic data and forecasts. When family questions arise, policymakers can turn to family scientists for data and forecasts to make evidence-informed decisions. The Family Impact Seminars developed this guide to highlight the importance of family impact and to bring the family impact lens to policy decisions.

WHY FAMILY IMPACT IS IMPORTANT TO POLICYMAKERS

Families are the most humane and economical way known for raising the next generation. Families financially support their members, and care for those who cannot always care for themselves—the elderly, frail, ill, and disabled. Yet families can be harmed by stressful conditions—the inability to find a job, afford health insurance, secure quality child care, and send their kids to good schools. Innovative policymakers use research evidence to invest in family policies and programs that work, and to cut those that don't. Keeping the family foundation strong today pays off tomorrow. Families are a cornerstone for raising responsible children who become caring, committed contributors in a strong democracy, and competent workers in a sound economy.[1]

In polls, state legislative leaders endorsed families as a sure-fire vote winner.[2] Except for two weeks, family-oriented words appeared every week Congress was in session for over a decade; these mentions of *family* cut across gender and political party.[3] The symbol of *family* appeals to common values that rise above politics and hold the potential to provide common ground. However, family considerations are not systematically addressed in the normal routines of policymaking.

HOW THE FAMILY IMPACT LENS HAS BENEFITED POLICY DECISIONS

- In one Midwestern state, using the family impact lens revealed differences in program eligibility depending upon marital status. For example, seniors were less apt to be eligible for the state's prescription drug program if they were married than if they were unmarried but living together.

- In a rigorous cost-benefit analysis of 571 criminal justice programs, those most cost-beneficial in reducing future crime were targeted at juveniles. Of these, the five most cost-beneficial rehabilitation programs and the single most cost-beneficial prevention program were family-focused approaches.[4]

- For youth substance use prevention, programs that changed family dynamics were found to be, on average, over nine times more effective than programs that focused only on youth.[5]

QUESTIONS POLICYMAKERS CAN ASK TO BRING THE FAMILY IMPACT LENS TO POLICY DECISIONS:

- How are families affected by the issue?
- In what ways, if any, do families contribute to the issue?
- Would involving families result in more effective policies and programs?

HOW POLICYMAKERS CAN EXAMINE FAMILY IMPACTS OF POLICY DECISIONS

Nearly all policy decisions have some effect on family life. Some decisions affect families directly (e.g., child support or long-term care), and some indirectly (e.g., corrections or jobs). The family impact discussion starters below can help policymakers figure out what those family impacts are and how family considerations can be taken into account, particularly as policies are being developed.

FAMILY IMPACT DISCUSSION STARTERS

How will the policy, program, or practice:

- support rather than substitute for family members' responsibilities to one another?

- reinforce family members' commitment to each other and to the stability of the family unit?

- recognize the power and persistence of family ties, and promote healthy couple, marital, and parental relationships?

- acknowledge and respect the diversity of family life (e.g., different cultural, ethnic, racial, and religious backgrounds; various geographic locations and socioeconomic statuses; families with members who have special needs; and families at different stages of the life cycle)?

- engage and work in partnership with families?

ASK FOR A FULL FAMILY IMPACT ANALYSIS

Some issues warrant a full family impact analysis to more deeply examine the intended and unintended consequences of policies on family well-being. To conduct an analysis, use the expertise of (1) family scientists who understand families and (2) policy analysts who understand the specifics of the issue.

- Family scientists in your state can be found at http://www.familyimpactseminars.org
- Policy analysts can be found on your staff, in the legislature's nonpartisan service agencies, at university policy schools, etc.

APPLY THE RESULTS

Viewing issues through the family impact lens rarely results in overwhelming support for or opposition to a policy or program. Instead, it can identify how specific family types and particular family functions are affected. These results raise considerations that policymakers can use to make policy decisions that strengthen the many contributions families make for the benefit of their members and the good of society.

Additional Resources

Several family impact tools and procedures are available on the Wisconsin Family Impact Seminars website at http://www.wisfamilyimpact.org.

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