HOMELESSNESS AND HEALTH
Overview

The experience of homelessness is considered one of the most important social determinants of health. When people are forced to live without stable shelter, they are exposed to a number of risk factors for poor health and well-being, including harsh living environments, violence and unsafe conditions, drugs and alcohol, reduced access to health care, and existing or new physical and behavioral health issues. The daily struggles of being homeless - safety, food, shelter, clothing - limits or prevents individuals' capacity to focus on their physical and behavioral health care needs.

This paper reviews the current state of homelessness in Colorado, explores the connection between homelessness and health, and identifies promising strategies that Colorado communities are using or may use to end homelessness, improve the health of their communities, and promote health equity. It is important to recognize the cyclical nature of homelessness. In examining the relationship between homelessness and health, some health problems may cause or contribute to homelessness, while other health problems are a consequence of homelessness. In either case, homelessness often complicates existing health problems. This paper primarily focuses on how health problems result from homelessness and how homelessness may exacerbate health issues specific to mental health, Substance Use Disorder (SUD), chronic disease, and violence.

What is Homelessness?

The U.S. Department of Housing and Urban Development (HUD), guided by the McKinney-Vento Act and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act[1], provides a definition for homelessness that includes four broad categories:

1. "People who are living in a place not meant for human habitation, in emergency shelter, in transitional housing, or are exiting an institution where they temporarily resided.
2. People who are losing their primary nighttime residence, which may include a motel or hotel or a doubled-up situation, within 14 days and lack resources or support networks to remain in housing.
3. Families with children or unaccompanied youth who are unstably housed and likely to continue in that state.[2]
4. People who are fleeing or attempting to flee domestic violence, have no other residence, and lack the resources or support networks to obtain other permanent housing."[3]

Researchers also define the extent or severity of homelessness using chronic homelessness, intermittent homelessness, and crisis or transitional homelessness.

The causes of homelessness are complex and include factors that cross the social-ecological model and require an examination of interaction between the individual, relational, community, and societal levels. These include:

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[1] The HEARTH Act updates the McKinney-Vento Act by including people at imminent risk of becoming homeless and by providing a formal definition of chronic homelessness.

[2] This is a new category of homelessness, and it applies to families with children or unaccompanied youth who have not had a lease or ownership interest in a housing unit in the last 60 or more days, have had two or more moves in the last 60 days, and who are likely to continue to be unstably housed because of disability or multiple barriers to employment.

[3] "Homeless Emergency Assistance and Rapid Transition to Housing: Defining ''Homeless''", Office of the Assistant Secretary for Community Planning and Development, HUD. 24 CFR Parts 91, 582, and 583

- Poverty[4]
- Childhood adverse events[5]
- Mental health and substance use disorders[6,7]
- Criminal justice system interaction[8]
- Child welfare interaction[9,10,11]
- Lack of a safety net[12,13, 14]
- Victimization of violence[15]
- Lack of affordable housing[16] (See CDPHE research paper *Housing Stability: Lack of Affordable Housing* for a further discussion on this topic.)
- Lack of employment for low-skilled workers[17]
- Non-conforming gender and sexual identity[18]
- Income inequality[19]

The State of Homelessness in Colorado

In 2016, half of all people (549,926) experiencing homelessness in the U.S. lived in one of five states: California (22%, 118,142 people); New York (16%, 86,352 people); Florida (6%, 33,559 people); Texas (4%, 23,122 people); and Washington (4%, 20,827 people). In Colorado, 10,550 individuals experienced homelessness in 2016.[20] Colorado experienced the third largest percent increase in homelessness nationally - 13 percent between 2015 and 2016 (following Delaware at 25% and Rhode Island at 22%). Denver ranked 8th out of 48 major metropolitan areas in the U.S. with the greatest number of homeless

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[4] R. Thompson Jr et al, "Substance-use disorders and poverty as prospective predictors of first-time homelessness in the United States*", American Journal of Public Health* 103 (2013):S282–88.

[5] L. Roos et al., "Relationship between adverse childhood experiences and homelessness and the impact of axis I and II disorders*", American Journal of Public Health* 103 (2013):S275–81.

[6] Thompson et al., "Substance-use disorders and poverty", 2013

[7] Greenberg and Rosenheck, "Mental health correlates of past homelessness in the National Comorbidity Study Replication", *Journal Health Care Poor Underserved* 21 (2010):1234–49.

[8] Greenberg and Rosenheck, "Jail incarceration, homelessness, and mental health: a national study", *Psychiatric Services* 59 (2008):170–77.

[9] Dworsky, Napolitano, and Courtney, "Homelessness during the transition from foster care to adulthood", *American Journal of Public Health.*103 (2013):S318–23.

[10] Dworsky and Courtney, "Homelessness and the transition from foster care to adulthood", *Child Welfare* 88 (2009):23–56.

[11] Kushel et al., "Homelessness and health care access after emancipation: results from the Midwest Evaluation of Adult Functioning of Former Foster Youth", *Archives of Pediatrics and Adolescent Medicine* 161 (2007):986–93.

[12] Busch-Geertsema et al., "Homelessness and homeless policies in Europe: lessons from research; European consensus conference on homelessness" *FEANTSA*, Brussels, 2010.

[13] Burt, Aron, and Lee, "Helping America's homeless: emergency shelter or affordable housing?", *The Urban Institute Press*, Washington, 2001.

[14] N. Pleace, "The new consensus, the old consensus and the provision of services for people sleeping rough", *Housing Studies* 15 (2000):581–94.

[15] Greenberg and Rosenheck, "Mental health correlates of past homelessness', 2010

[16] Burt, Aron, Lee, "Helping America's homeless", 2001

[17] Ibid.

[18] Rosario and Schrimshaw, and Hunter, "Risk factors for homelessness among lesbian, gay, and bisexual youths: a developmental milestone approach", *Children and Youth Services Review* 34 (2012):186–93.

[19] M. Shinn, "International homelessness: Policy, socio-cultural, and individual perspectives", *Journal of Social Issues* 63 (2007):657–77

[20] The number of homeless individuals is measured by point-in-time counts, which are unduplicated one-night estimates of both sheltered and unsheltered homeless populations. The one-night counts are conducted by Continuums of Care nationwide and occur during the last week in January of each year. (Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations", *HUD,* 2016,)

families with children (2,147) and Colorado ranked 7th out of 40 statewide assessments.[21] However, a long-term national decline in homelessness also is reflected in Colorado. Between 2010 and 2016, there was a 31.9 percent decrease in homelessness, reducing the total to an estimated 10,550 homeless individuals in the State.[22] Among this number, 72.1 percent (7,611) were sheltered and 27.9 percent (2,939) were unsheltered. Compared to the national trend (68%), Colorado has a higher percentage of homeless individuals living in shelters. Of the homeless living in shelters in Colorado, some 4,100 were in families with children, 653 were unaccompanied youth, 1,181 were veterans, and 1,642 were chronically homeless individuals.[23]

People of color are disproportionately affected by homelessness in Colorado, as are men. A single point of time count for Colorado in 2016 showed that of the state's homeless population, 60 percent were male, almost 30 percent were Latino and some 20 percent of were black; this is despite the fact that Colorado's overall population is only about 20 percent Latino and 5 percent black.[24]

Despite an overall recent homeless population decline of about 11 percent from 2007 to 2015, numbers of homeless individuals have increased in cities with rising housing costs, such as Denver. [25] A 2016 study showed that renters in Colorado are now spending over 30% of their pre-tax income on housing costs, leaving less than $1,000 for other living expenses for those making minimum wage.[26,27] The growing disparity in minimum wage versus the cost to rent a home in metro Denver is one driver of a recent increase in homelessness in Colorado between 2015 and 2016.[28] (See CDPHE research paper *Housing Stability: Lack of Affordable Housing* for a further discussion on this topic.)

Homelessness and Health

Homeless individuals are at higher risk for illness and have higher death rates than the general population; the experience of being homeless has been found to be an independent risk factor for mortality.[29] Studies show that homeless persons report difficulty accessing health care and experience low rates of outpatient care.[30] Harsh living conditions - including the street and crowded shelters - are intensified by exposure to disease, violence, poor access to healthy foods, and inclement weather. These factors further limit an individual's ability to obtain and keep medications, preventing them from managing health issues that otherwise are relatively easy to control. If poor mental health or substance use did not cause an individual's homelessness, often the conditions of living on the street, a shelter or housing instability can result in the exacerbation or development of behavioral health issues. Therefore, stable housing is a protective factor for better health, both primary and behavioral health, which creates opportunities to

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[21] Ibid.

[22] Ibid.

[23] Ibid.

[24] Anna Boiko-Weyrauch, "Housing First Approach to Homelessness Continues to Grow in Denver", *Colorado Trust,* July 13, 2016.

[25] Koh, H.k. & O'Connell, J.J. (2016). Improving health care for homeless people. *JAMA.* 316 (24): 2586-2587.

[26] "Housing Roadmap to 2016: Denver," Zillow, March 2016, https://wp.zillowstatic.com/3/Denver_Roadmap-373913.pdf

[27] "Minimum Wage", Colorado Department of Labor and Employment, 2017, https://www.colorado.gov/pacific/cdle/minimumwage.

[28] "Employment and Homelessness Factsheet", National Coalition for the Homeless, 2009, http://www.nationalhomeless.org/factsheets/employment.html

[29] Morrison "Homelessness as an independent risk factor for mortality: results from a retrospective cohort study", *International Journal of Epidemiology,* 38 (2009): 877-883.

[30] Bushnell et al., "Factors Associated with the health care utilization of homeless person", *JAMA.* 285 (2001): 200-206.

better manage and recover from illness without the distraction of finding a place to sleep and be safe.

Each category of homelessness (noted above) has varying harmful effects on health. Although homelessness can negatively impact health outcomes regardless of duration, chronically homeless individuals have worse clinical outcomes than individuals who experience either intermittent or crisis homelessness.[31,32] Homelessness has been found to be an important predictor of being a high utilizer of the emergency department (ED). For example, one study found homelessness was associated with 115 percent increase in the odds of ever being classified as a high utilizer of the ED compared to those living independently or with family and others.[33]

Ways that Homelessness Impact Health
High exposure to both "structural" and "individual" risk factors to poor health that may occur after becoming homeless or are exacerbated by homelessness.
Risk factors for poor health outcomes while homeless are often a combination of both structural and individual risk factors that may result in both the initiation or the persistence of homelessness.[34] For example, mental health and substance misuse problems are not only individual risk factors for an individual to become homeless, but also are likely to come about or be worsened as a result of homelessness.[35] Structural factors include the absence of low-cost housing (see the CDPHE research paper *Affordable Housing* for more on the links to health outcomes), employment opportunities for low-skilled workers, and income support. Apart from contributing to the ability to meet daily needs (e.g., food, shelter, clothing), employment can bring about "social inclusion and recovery for people who are, or have recently been, homeless and have a mental illness."[36]

Limited access to health care services.
Common health issues, specifically chronic diseases such as diabetes and hypertension, are worsened as a result of homelessness and the instability that derives from homelessness. Homeless individuals have difficulty accessing medical care and adhering to medications because of the lack health care insurance, transportation to providers, and the daily conflicts of competing basic needs.[37,38] "Long waiting times in clinics and feelings of being stigmatized by health care professionals" are additional obstacles felt by homeless persons.[39] Due to these barriers, the lack of appropriate health care for homeless individuals often contributes to deterioration in their health status, prolonged homelessness, and even death.[40]

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[31] Edens, Mares, and Rosenheck, "Chronically homeless women report high rates of substance use problems equivalent to chronically homeless men*", Womens Health Issues* 21 (2011):383–89.

[32] Fazel, Geddes, and Kushel, "The health of homeless people in high-income countries: descriptive epidemiology, health consequences, and clinical and policy recommendations", *Lancet.* 384 (2014): 1529–1540.

[33] Lindamer et al., "Predisposing, enabling, and need factors associated with high service use in a public mental health system", *Administration and Policy in Mental Health* 39 (2012):200–09.

[34] Fazel, Geddes, and Kushel "The health of homeless people in high-income countries", 2014

[35] Patterson, Somers, and Moniruzzaman, "Prolonged and persistent homelessness: multivariable analyses in a cohort experiencing current homelessness and mental illness in Vancouver, British Columbia", *Ment Health Subst Use* 5 (2012):85–101.

[36] Shaheen and Rio, "Recognizing Work as a Priority in Preventing or Ending Homelessness", *Journal of Primary Prevention* 28 (2007):341-358.

[37] Lewis, Andersen and Gelberg, "Health care for homeless women: unmet needs and barriers to care", *J Gen Intern Med* 18 (2003):921–928.

[38] Gelberg et al., "Competing priorities as a barrier to medical care among homeless adults in Los Angeles", *Am J Public Health* 87 (2007):217–220.

[39] Wen, Hudak, and Hwang, "Homeless people's perceptions of welcomeness and unwelcomeness in healthcare encounters", *J Gen Intern Med* 22 (2007):1011–1017.

[40] Hwang et al., "Health care utilization among homeless adults prior to death", *Journal of Health Care for the Poor and*

Homelessness ages an individual

Homelessness expedites the aging process, by as much as 20 years, resulting in higher incidences of chronic diseases and medical conditions normally found in older populations.[41] Middle-age individuals (aged 50-64) who have experienced or are experiencing homelessness can have similar rates of chronic conditions and geriatric conditions often found in seniors ages 65 and older. Conditions typically seen include memory loss, falls, difficulty performing activities of daily living, and urinary incontinence. As a result, many of these middle-aged individuals are considered "elderly" at age 50, rather than at age 65.[42]

Accelerated aging is particularly prevalent among homeless veterans. A study of veterans found that those who are homeless are being treated for, and undergoing surgery for, conditions that are seen in veterans 10-15 years older who have not experienced homelessness.[43] Homeless veterans tend to "age" at an increased rate, which can result in younger homeless veterans needing more interventions. It also suggests, that for this group, public services available to individuals once they turn age 65 could be made available to younger homeless veterans.[44] Health policy implications for the homeless may need to adjust eligibility for the homeless population in contrast to the general population.

Common health conditions of being homeless are risk factors for violent criminal activity

Homelessness and incarceration for both violent and non-violent crimes appear to increase the risk of co-occurrence. Greenberg and Rosencheck conducted a study of jail inmates that found "recent homelessness was 7.5 to 11.3 times more common among jail inmates than in the general population."[45] And a 2015 report noted nearly 15 percent of the newly incarcerated population was homeless, suggesting this may be a growing issue.[46] Several studies show how the health conditions of homeless individuals, including mental health issues and SUD, are risk factors for involvement in criminal justice system for violent criminal activity.[47]

Homelessness is a risk factor for children's long-term health and well-being

Homelessness has a significant impact on children's health, and in turn, their education (see the CDPHE research paper *K-12 Education* for more on the links between education and health outcomes; in 2016, some 24,685 Colorado students were estimated to be homeless[48]. Homeless children have twice the rate of emotional and behavioral issues—including anxiety, depression, and withdrawal.[49] By the time homeless children are eight years old, one in three has a major mental disorder. Homeless children are sick at twice the rate of other children. They suffer twice as many ear infections, have four times the rate of asthma, and have five times more diarrhea and stomach problems.[50]

Underserved 12 (2001):50–58.

[41] Brown et al., "Geriatric syndromes in older homeless adults", *Journal of General Internal Medicine*, 27 (2012):16–22.

[42] Ibid.

[43] Adams et al., "Hospitalized younger: a comparison of a national sample of homeless and housed inpatient veterans", *Journal of Health Care for the Poor and Underserved* 18 (2007):173–84.

[44] Ibid.

[45] Greenberg and Rosenheck, "Jail Incarceration, Homelessness, and Mental Health", 2008.

[46] Richard Cho, "We Can Break the Cycle of Homelessness and Criminal Justice System Involvement", *United States Interagency Council on Homelessness*, 2015.

[47] Fischer and Shrout, "Homelessness, Mental Illness, and Criminal Activity: Examining Patterns Over Time", *American Journal of Community Psychology*, 42 (2008): 251-265.

[48] "2016 KIDS COUNT in Colorado!", *Colorado Children's Campaign*, Denver, 2016.

[49] Bassuk and Friendman, "Facts on Trauma and Homeless Children", *The National Child Traumatic Stress Network*, 2005.

[50] Ibid.

Strategies to Reduce Homelessness at Community and Societal Levels

There are several strategies to reduce homelessness and the associated negative health outcomes, falling into three primary categories: 1) health and healthcare strategies; 2) workforce strategies; and 3) housing strategies. Each of these types of strategies are discussed in more detail below.

Health and Health Care Strategies

As described above, homeless individuals often become ill or their existing illnesses are exacerbated because of being homeless. A strategy to improve the health outcomes of these individuals, including substance use disorders, chronic disease, and mental health outcomes, must include the delivery of health care services in a stable living environment. Additionally, health-care providers need to be aware and sensitive to the living conditions homeless individuals, and adapt chronic disease management accordingly.

Offering medical respite care services is one health care strategy starting to occur in communities throughout the United States. Medical respite care provides a transition for those exiting the hospital who have no permanent residence and are not well enough to return to the street. In addition to meeting the health care needs of these individuals, a respite care program also works to connect individuals to community based resources, including permanent housing. Successful medical respite care programs, including Yakima Neighborhood Health Services in Yakima, Washington and Circle the City, in Phoenix, Arizona coordinate with their communities' local continuum of care.[51] HUD defines the continuum of care as a local coalition that promotes community commitment to ending homelessness, funding for efforts to rehouse people without homes, and access to mainstream programs.[52]

National Case Study: Health Care for the Homeless – Respite Care

Barbara McInnis House (BMIH), Boston, Massachusetts, providing up to 104 beds, is the first and largest medical respite program for homeless people in the U.S. The multidisciplinary staff provides medical, recuperative, rehabilitative, palliative, and hospice care for 2,000 people annually. The program at BMIH is also the primary referral source for Boston hospitals when they discharge homeless people who need long-term care. The intended result will be fewer readmissions after staying at BMIH.

Colorado Case Study: Stout Street Health Center

The Colorado Coalition for the Homeless opened an integrated-care health center to serve Denver's homeless residents. The center deploys a single intake system to coordinate the provision of physical and mental health services in one location and during one visit. The center is located within a mixed-use building that also provides 60 units of permanent supportive housing for the chronically homeless, allowing for a homeless individual to be housed while receiving health care and other case management services. More than 13,000 patients were treated at the health center in 2015, resulting in approximately $1,263 in annual public sector health cost savings per health center patient.

Workforce Strategies

Being out of work is known to have negative impacts on health and well-being.[53] Waddell and Burton,

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[51] "Improving care for medically complex patients: medical respite and supportive housing", *The Source for Housing Solutions*, 2017.

[52] For more information about the Continuum of Care, visit https://www.hudexchange.info/programs/coc/

[53] Waddell and Burton, "Is work good for your health and well-being?", *Department for*

(2006) conducted a literature review of scientific evidence on the relationship between work, health, and well-being. They found unemployment to be harmful to health, including resulting in higher mortality, poor general health, long-standing illness, poorer mental health, and higher medical consultations, consumption, and hospital admission rates. They also found evidence that re-employment leads to improved self-esteem, improved general and mental health, and reduced psychological distress and minor psychiatric morbidity. Work has been shown to be therapeutic and rehabilitative for vulnerable populations, such as those who are sick or disabled, which leads to better health outcomes, reduces poverty, and improves quality of life and well-being. While there is limited research on the benefits of work to homeless individuals, applying research findings suggests that if homeless individuals are given the opportunity for long-term employment, they will receive similar benefits. The role that stable housing has in these outcomes is substantial though, and must be a significant factor in what other supports homeless individuals need to sustain their employment.

Thus, while employment and training programs targeting homeless individuals have proven to be effective connecting individuals to work, successful completion of an employment program by a homeless individual does not necessarily end their homelessness if they are not concurrently offered a place to live. Workforce strategies must be complimented by housing strategies. Therefore, transitional housing programs such as Sound Families in Seattle, are important models to consider as they work to connect homeless individuals and families to stable employment along with stable housing and other supportive services. In Colorado, the city of Denver is implementing a pilot program with the goal of getting homeless individuals to work for more than one day.

National Case Study: Sound Families in Seattle, Washington
The Sound Families Initiative, an eight-year, $40 million program supported by the Bill and Melinda Gates Foundation, is aimed at increasing the amount of transitional housing, while offering coordinated entry to services and identifying employment opportunities. The program helps build transitional housing and support services for homeless families in Pierce, King, and Snohomish Counties. The project emphasizes housing of mothers with children and working families earning $16,000 or less a year. The program is unique because funding also supports the coordination of services, such as child care and job training. In this program, employment upon entry into the transitional housing was 27 percent; when these people exited their employment rate was 50 percent showing that employment outcomes may be primarily effected by housing.[54]

Colorado Case Study: Work Programs for the Homeless, Denver
The Denver Day Works Pilot Program is an effort by the City of Denver to provide a work experience opportunity for people who are experiencing homelessness throughout the city. There is a specific focus toward engaging those not already connected to other supportive day services. The goal of the program is to have at least 70 participants engage in more than one day of work through the program, at least 49 participants gain permanent employment, and 30 of those participants stay employed for at least 90 days. The City of Denver also intends to have 20 of the permanent jobs to be with city agencies.[55] To date, the City of Denver reports that 109 people have been given work opportunities, 49 participants have found permanent employment, and five of these are with the City and County of Denver.[56]

Work and Pensions, 2016.
[54] Laura Orlando et al., "Breaking the Cycle: Serving Homeless Children in Supportive Housing Programs", *Bill & Melinda Gates Foundation*, 2007.
[55] "Denver Day Works FAQs", Bayaud Enterprises, 2016.
[56] "Denver Day Works, "City and County of Denver, 2017.

Colorado Case Study: Urban Peak, Denver and Colorado Springs

Homelessness for young people ages 15 to 24 can be particularly difficult. According to the 2015 homelessness point in time study, one in five youth in the Metro Denver area who are homeless were living on the streets, while the rest were living in shelters or other transitional housing programs.[57] Urban Peak was founded in 1988 and is the only non-profit organization in Denver offering a complete spectrum of services for youth who are experiencing homelessness or at imminent risk of becoming homeless. The organization, which operates today in both Denver and Colorado Springs, works to support young people through "real life challenges" to become self-sufficient adults. Services are provided at little or no cost (youth in housing do pay a minimal rent each month).

Of the youth served by Urban Peak in 2015, 49 reported past involvement with child welfare. Many of the youth served also engage in high-risk behaviors such as having unprotected sex, having multiple sex partners, and participating in intravenous drug use, making them much more likely to remain homeless and be more resistant to change. According to research conducted by Urban Peak, the costs to taxpayers of incarcerating a young person because of these behaviors would be approximately $8,629; conversely, through Urban Peak, this same young person can receive supports and services that may help them succeed at a cost of $972 to $2,200.

In addition to housing services, Urban Peak offers youth education and employment services, including individual and small group instruction to obtain a GED or re-enroll or engage in high school to complete remaining coursework needed to graduate, as well as assistance in applying for post-secondary educational courses. Employment services include a Job Readiness Training course. In 2016, Urban Peak served 1,814 unduplicated clients:

- Outreach – 564 youth
- Drop-In Center -1,132 youth
- Shelter – 381 youth
- Education & Employment – 418 youth
- Housing – 149 youth
- Obtained employment - 99 youth
- Obtained GED - 22 youth

Housing strategies

Supportive Housing- Housing First Model

Supportive housing strategies target the most vulnerable people who need housing and service supports to remain stably housed and live healthy lives. Supportive housing, also often referred to as service enriched housing, provides an essential platform for the delivery of services, including community-based social, mental health, substance abuse, and primary/specialty medical care services, that lead to improved health and stability.

Housing First is an evidence-based, permanent, supportive housing intervention for chronically homeless individuals that has the potential to improve health outcomes and reduce costs to health care and other public safety net programs. The model offers housing to individuals prior to any engagement or commitment to supportive and health services. Studies of the model found that it dramatically reduced

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[57] "About Urban Peak", Urban Peak, 2017 http://www.urbanpeak.org/denver/about-us/about-urban-peak/about-urban-peak/

levels of alcohol and drug addiction as well as shrank health related costs by half.[58] McCoy, 2015, found that "adults who have experienced chronic homelessness may be successfully housed and can maintain their housing." These analyses confirm similar findings from more than 30 studies nationwide that show how supportive housing, by addressing critical social determinants of health for the most vulnerable populations, can significantly reduce costs while simultaneously improving health and other quality of life outcomes.[59]

One specific Housing First model in Massachusetts - the Home and Healthy for Good (HHG) Program - is run by the Massachusetts Housing and Shelter Alliance and is funded by the Commonwealth of Massachusetts. The HHG has provided chronically homeless adults with housing and supportive services, in accordance with the Housing First model, since 2006. As of February 2017, HHG has served 960 homeless individuals. An evaluation of the program indicates that six months prior to housing, participants accumulated 1,812 emergency department visits, 3,163 overnight hospital stays, 847 ambulance rides and 2,494 detox stays.[60] The estimated total cost per person for measured services – including Medicaid ($26,124), shelter ($5,723) and incarceration ($1,343) - amounted to $33,190 per year. After one year in the program, the total per person costs for these same services fell to $8,603.[61]

Colorado Case Study: Homeward Pikes Peak, Colorado Springs

Homeward Pikes Peak (HPP), serving chronically homeless individuals in Colorado Springs, provides recovery and housing services to individuals who struggle with addiction and homelessness. There are three programs: Housing First, Harbor House Residential, and Harbor House Clinic.

- Housing First focuses on homeless individuals and their families by providing vouchers for apartments and case-management and substance abuse or mental health services for veterans and individuals with severe mental illness.
- Harbor House Residential is a "sober living" program for homeless individuals struggling with alcohol or drugs with enough space to house 30 individuals.
- Harbor House Clinic provides outpatient substance abuse treatment specializing in pregnant women and women with dependent children.

For individuals to qualify for services, they must be homeless at the time of application, have a history of chronic homelessness, and have a dual diagnosis of mental illness and substance abuse. Homeward Pikes Peak estimates to have "saved taxpayers over $2 million per year just in our housing programs by reducing ER visits, 911 calls, detox stays, and psychiatric hospitalizations."[62]

Colorado Case Study: Denver's Road Home and Denver Housing First Collaborative (DHFC)

The Colorado Coalition for the Homeless (CCH) created the Denver Housing First Collaborative (DHFC) program in 2003 and is now one of 11 programs funded nationally through HUD and the Ending Chronic Homeless Initiative program. In 2016, DHFC received $4.2 million across two grants to pay for housing and support costs for 400 homeless people, including disabled, youth, veterans, seniors, and people with severe mental illness. The city's human services agency administers the funds, which come from the U.S. HUD and support programs at five service providers: Colorado Coalition for the Homeless, Colorado

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[58] T. McCoy, "Meet the outsider who accidentally solved chronic homelessness", *The Washington Post,* May 2016.

[59] "Cost-Savings", Supportive Housing Network of NY", 2017, https://shnny.org/research-reports/research/cost-savings/

[60] "Permanent Supportive Housing: A Solution That Works", *Supportive Housing Network of New York*, May 2012, https://shnny.org/uploads/Home-Healthy-Good-2012.pdf

[61] Ibid.

[62] "Our Programs", Homeward Pikes Peak, 2017 https://www.homewardpp.org/

Health Network, the Empowerment Program, Mental Health Center of Denver and St. Francis Center. DHFC seeks to provide disabled, chronically homeless individuals with supportive housing, including services in integrated health, mental health, substance abuse and general support.

DHFC has been incorporated as a priority strategy into Denver's Road Home – Denver's Ten Year Plan to End Homelessness. In addition to saving taxpayers money, the local and national evaluations of the DHFC program document overall improvement in the health status and residential stability of program participants. For participating individuals, who averaged nearly eight years of homelessness each prior to entering the program, 77 percent continue to be housed in the program. More than 80 percent have maintained their housing for six months. Some 50 percent of participants have documented improvements in their health status, 43 percent have improved mental health status, 15 percent have decreased their substance use, and 64 percent have improved their overall quality of life. [63]

Colorado Case Study: Neighbor2Neighbor, Fort Collins

Neighbor to Neighbor (N2N) started in 1970 in a neighborhood in northeast Fort Collins when a large family was on the verge of becoming homeless.[64] Neighbors in the community banded together and raised enough money to keep the family in their home. The effort later morphed into a non-profit organization supporting families throughout Larimer County. N2N provides supports to help families find affordable housing and self-sufficiency programs, serving more than 5,000 individuals every year. They operate HUD-Certified Renter and Home Ownership programs, and an Affordable Housing program. N2N offers supports for housing stability to all Larimer County residents in three key service areas: renter and homelessness prevention, affordable housing apartments, and a homeownership program. The organization continues to receive significant support from the community, and successes include: preventing homelessness for 500 households in Larimer County each year; preventing foreclosure for 90 percent of their cases, educating 1000 individuals working toward homeownership annually; maintaining affordable apartments for more than 300 adults and children; and maintaining supportive programs for youth and residents.[65]

Colorado Case Study: Continuum of Care, Rural Colorado

A significant portion of Colorado is rural, and there are thousands of families and individuals in Colorado's small cities and towns affected by homelessness. Many of the factors that contribute to homelessness can be even more prominent in rural communities, such as low wages, seasonal jobs, limited transportation options, lack of affordable housing, higher rates of domestic violence, and fewer social service and charitable organizations who also are stretched thin with smaller budgets. To combat homelessness in rural areas of the State, the Colorado Coalition for the Homeless partnered with non-profit homeless service providers in rural areas to create the Rural Initiatives Program.[66] Known as the Continuum of Care, the partners jointly operate nine programs, including seven rapid rehousing programs, one transitional housing program, and one permanent supportive housing program. They also run several Emergency Solutions Grants (ESG) funded homeless prevention and rapid rehousing programs which offer rental assistance and supportive services to help families and individuals move from homelessness to housing stability and self-sufficiency. In 2016, Continuum of Care provided emergency shelter to over 3,400 Larimar county residents, and transitional housing to another 1,667 residents.[67]

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[63] Perlman and Parvensky, "Denver Housing First Collaborative Cost Benefit Analysis and Program Outcomes Report", *Supportive Housing Network of NY,* 2007 http://shnny.org/uploads/Supportive_Housing_in_Denver.pdf
[64] "About Us", Neighbor to Neighbor, 2014, http://www.n2n.org/Pages/AboutUs.php
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Conclusion

When people are forced to live without stable shelter, they are exposed to a number of risk factors for poor health and well-being. Homelessness has been found to not only exacerbate existing health issues, but also bring about new ones. Over the past 10 years, more and more evidence has been documented that, rather than focusing on strategies such as getting participants "clean and sober" prior to finding them stable housing, the key strategy to ending homelessness for individuals is to get them stable housing first. Once housing is stabilized, other supportive services and needs may be met and participants are much more likely to achieve health improvements, including reductions in SUD and better mental health. Key successes in Colorado include the Housing First programming in Denver and Colorado Springs, which has been shown to improve health outcomes for individuals upon receiving stable housing.