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TOUCHPOINTS *of* HOMELESSNESS

Institutional Discharge as a Window of
Opportunity for Hawai'i's Homeless

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EXECUTIVE SUMMARY

Despite downward national trends in homelessness since 2007,¹ Hawai‘i has struggled with its persistent homeless population. The state has earned the dubious distinction of the highest per capita rate of homelessness in the country, a reality that stands in stark contrast with the idyllic perceptions of Hawai‘i as a land of paradise.²

With the goal of better understanding critical junctures that influence whether one may become or remain homeless, we examine in this report three subpopulations of homeless within Hawai‘i—specifically, youth emancipated from foster care, individuals discharged from medical care, and individuals released from incarceration. A growing body of research indicates that institutional discharge may offer a “window of opportunity” for intervention, potentially preventing or reducing the likelihood of subsequent homelessness. Our hope is that by illuminating the people, processes, and institutions engaged in and affected by institutional discharge in Hawai‘i, we as a community can more effectively capitalize on the opportunities for intervention that discharge presents.

SUBPOPULATION RECOMMENDATIONS

Our recommendations for each subpopulation are divided into near-term action items that would require modest investments of time and resources and long-term action items that may take longer to implement and/or require a significant investment of resources. Expanded considerations of the recommendations below are detailed in the respective sections of the report.



HAWAI‘I’S RATE OF
487 HOMELESS PEOPLE
PER 100,000 IS THE

**HIGHEST
IN THE
NATION**

YOUTH EMANCIPATED FROM FOSTER CARE

Near-Term Recommendations

- Ensure permanency planning for all foster youth begins early and gives youth a voice in determining their future.
- Increase investments in the Imua Kakou program and related efforts to increase supports for foster youth beyond age 18.
- Create a universal intake tool and data system for homeless youth to be used by all agencies.
- Create virtual or mobile course-taking that leads to a high school diploma or other credential.

Long-Term Recommendations

- Increase investments in street outreach and drop-in centers to engage recently emancipated young adults.
- Ensure a stable supply of housing for young adults age 18-24 that meets a spectrum of needs.
- Enable staff to focus on building trusting relationships with youth.
- Infuse rules, policies, and procedures with the flexibility needed by young adults.



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PATIENTS DISCHARGED FROM HOSPITALS AND EMERGENCY ROOMS

Near-Term Recommendations

- Ensure care coordination spans pre- and post-discharge.
- Increase availability of mobile medical clinics, community paramedics, and/or community-based drop-in centers.
- Create a shared homeless patient database, and support data sharing among hospitals.
- Expand medical respite programs.

Long-Term Recommendations

- Reframe housing as health care.

INMATES RELEASED FROM INCARCERATION

Near-Term Recommendations

- Provide more comprehensive pre-release assistance from jail/prison.
- Provide predictability and basic necessities as part of jail/prison release process.
- Provide and encourage jail/prison access for social service providers to work with inmates pre-release.
- Create mobile legal teams and expand community courts to bring legal services where homeless people are.

Better understanding institutional discharge can help our community capitalize on opportunities for homelessness intervention.

Homelessness is a symptom of an economic crisis affecting us all.

Long-Term Recommendations

- Shift correctional system culture from punitive to supportive/rehabilitative.
- Create a shared correctional systems database and improve data sharing among facilities.
- Further expand existing diversion programs to keep people out of the criminal justice system.
- Create additional housing options for releasing inmates.

Our research into three processes affecting homeless people uncovered broad findings and recommendations (below) that we believe inform efforts across the state to end homelessness. Consideration of these themes is detailed in the “Big Picture Findings and Recommendations” sections of the report.

BIG PICTURE FINDINGS

- Homelessness is merely a symptom of an economic crisis affecting all of us.
- “Compassionate disruption” on O’ahu can be counterproductive.
- Many homeless people will avoid emergency shelters, even after a “sweep.”
- Criminalizing homeless-related behaviors deepens homelessness and poverty.
- Current conditions make it difficult to build the trusting relationships required for success.
- Many services operate under the false assumption that “if we build it, they will come.”

BIG PICTURE RECOMMENDATIONS

- If camps or groups can meet certain criteria, designate them as partner sites or community partners.
- Use feedback and ideas from homeless individuals to inform solutions.
- Redesign services to meet people where they are.
- Build the capacity of homelessness service providers to make relationships the top priority.
- End policies that criminalize poverty and addiction. They only deepen homelessness.
- Relax building rules to allow for affordable tiny homes as permanent housing for homeless.
- Consider restrictions aimed at protecting local housing supply for Hawai’i residents who need it.
- Integrate data systems on homelessness to enable local analysis of costs and benefits.
- Reframe homelessness as the most severe symptom of an economic crisis affecting us all.

We recognize the enormity and complexity of addressing the issue of homelessness in our community. We hope that through this report, we contribute to a deeper understanding of institutional discharge, seen through multiple lenses, on the journey toward homelessness reduction and prevention. Most importantly, we hope the report sparks dialogue among and between the many stakeholders seeking to fulfill Hawai’i’s potential as a place that people of all means and circumstances can call “home.”

I. INTRODUCTION

Hawai'i currently stands at a critical crossroads regarding the issue of homelessness. While much of the rest of the country's homeless population has been decreasing over the past decade, Hawai'i has been battling rising homelessness rates year after year. In 2017, Hawai'i finally saw a slight reduction in its homelessness rate, but it still remains the highest in the nation.³

Although homelessness appears intractable locally, the downward trend of homelessness nationally suggests that inroads are not only possible, but well within reach. U.S. municipalities are finding success in addressing homelessness using a variety of approaches

The downward trend of homelessness nationally suggests that inroads in Hawai'i are well within reach.



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that resonate within their specific communities, often by focusing on subpopulations of homeless to target their efforts (e.g., chronically homeless in Utah;⁴ homeless youth in Austin, Cleveland, and Los Angeles;⁵ and “super-utilizers” of crisis services in San Diego).⁶

It is with this sense of possibility, as well as the promise of deeper understanding that can result from a tightened focus, that our attention in this study rests on three key subpopulations within Hawai‘i’s homeless community: youth emancipated from foster care, individuals discharged from medical care, and individuals released from incarceration. In particular, we consider the discharge points of these subpopulations as opportunities for intervention, potentially preventing or arresting movement along the path of recurrent and/or long-term homelessness.

We also recognize that these subpopulations and their respective discharge processes exist within a context of other forces impacting homelessness. Our analysis would be neither complete nor responsible if these larger systemic forces went unconsidered. We therefore offer findings and recommendations on systemic and contextual issues that emerged in our research, in addition to recommendations related specifically to discharge procedures. We believe that long-term strategies and programmatic solutions for addressing homelessness—whether among the defined subpopulations or among homeless persons more generally—cannot be meaningfully outlined without due consideration of public policy, as well as community and organizational culture and norms.

INSTITUTIONAL DISCHARGE AS A WINDOW OF OPPORTUNITY

A growing body of research identifies discharge from foster care, hospitals, and incarceration as critical moments affecting the likelihood that an individual will become or remain homeless. This report seeks to define the number of homeless individuals impacted by these processes and to explore ways that discharge might be modified to prevent or reduce the likelihood of homelessness.

Of course, discharge processes do not, by themselves, “cause” homelessness, nor are they necessarily gateways to first-time homelessness. Rather than thinking of discharge as an “entry point” to homelessness, it is more useful to think of it as a “touchpoint”—a moment that affects many homeless and at-risk individuals, and an opportunity for intervention that might decrease the chances of a person ending up or remaining on the street.

Where possible, we attempt to estimate the costs of inaction and identify parties who may have reason to invest in solutions. Based on data from 65 U.S. cities, the estimated cost to society of a homeless person remaining on the streets is between \$35,000 and \$150,000 per person per year, including the cost of hospital and ER visits, incarceration, and lost productivity due to interrupted education.⁷ In contrast, the cost of keeping formerly homeless people housed through permanent supportive housing programs ranges from \$13,000 to \$25,000 per year,⁸ yielding conservative savings estimates of \$10,000 per person per year and generous estimates of up to \$137,000 per person per year.

II. METHODS

This report combines findings from literature review, interviews, and data gathering and analyses.

The literature review examined national and local research on each of the three areas of study (the foster care system, hospitals, and prisons) to provide context and comparative models regarding discharge into homelessness among the target subpopulations. Information obtained through the literature review also informed estimates of the magnitude of homelessness with respect to each subpopulation.

We sought to conduct personal interviews with key community stakeholders to understand existing discharge processes and to identify challenges to and opportunities for better addressing the needs of those at risk for homelessness through institutional discharge. During August 2016, the research team identified over 80 programs, agencies, and organizations across the state for potential interviews; at least two attempts were made to reach identified contacts at each entity. Between August 2016 and June 2017, we completed either in-person or telephone interviews with 43 individuals representing those entities. The agencies and organizations interviewed include the Departments of Public Safety, Human Services (DHS), and Education; the State Homelessness Coordinator; offices of the prosecutor and public defender for Honolulu; hospitals and community health centers; homelessness service providers; foster care agencies; and other organizations and individuals familiar with the three subject institutions.

In addition, we conducted 52 “street interviews”—interviews with homeless individuals from each identified subpopulation—to understand discharge systems from their perspectives. Street interviews were concentrated in urban Honolulu, with roughly half conducted in the region from Ala Moana to Kapalama. Remaining interviews were with individuals from other regions of

O‘ahu, including Waimanalo and Wai‘anae, and a few from the neighbor islands. A majority were born and raised in Hawai‘i, and only 4 indicated that they lived in Hawai‘i less than 10 years. They ranged in age from late teens to sixties. Thirty-eight had visited a hospital during the past year, 32 had been incarcerated, and 4 were young adults who were former foster youth.

Finally, we gathered and analyzed data from a variety of sources to define and quantify the magnitude of the problem impacting each subpopulation. These data sources include the Homeless Management Information System (HMIS), Department of Public Safety databases, and judiciary databases. In addition, data was requested from numerous other agencies and organizations to identify, where possible, patterns or trends among the homeless or those at risk for homelessness being served by those entities.

At various places in this report, we use Point-in-Time (PIT) count data to support our findings. We recognize that the PIT count data has limitations. For example, it likely undercounts unsheltered homeless and marginally sheltered homeless (e.g., people living out of their cars), and there are particular challenges when counting young adults, which we touch on below. We therefore use PIT count data primarily to examine overall trends and changes in the homeless population over time, bearing in mind any changes in PIT count methodology that may have affected results from year to year.

An initial draft of the report was completed in April 2017, and relevant subsections of the report were shared with people interviewed from agencies and organizations, as well as additional stakeholders. The people with whom the draft report was shared were asked to provide content-specific feedback, including fact-checking the report, identifying omissions, and responding to initial findings and recommendations. Comments received were discussed by the research



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team, and report content was amended or corrected as appropriate.

A key limitation to our study is that, despite our best efforts to achieve statewide representation in our interviews, the perspectives of O‘ahu entities and individuals are more readily reflected in the report. This resulted from uneven levels of response from neighbor island entities, as well as the concentration of state agencies on O‘ahu. Likewise, the greater ease of logistics and access to homeless individuals on O‘ahu resulted in their experiences dominating the Street Perspectives sections of the report. This overrepresentation of O‘ahu’s homeless stakeholder viewpoints is not intended to diminish the importance of neighbor island agencies, organizations, or homeless communities. We recognize that the challenges around institutional discharge and homelessness are unique for each island, and we hope that this report uncovers common threads of both concern and opportunity across the state.

III. FINDINGS AND RECOMMENDATIONS: DISCHARGE PROCESSES

EMANCIPATION FROM FOSTER CARE

In an expensive housing market like Hawai'i, even young people who have grown up with every advantage find it difficult to be self-sufficient by the age of 18. Across the islands, 34 percent of people ages 18-34 live with their parents,⁹ and those who do not are often economically dependent on family in some way. In similarly expensive Los Angeles, a 2017 survey found that one in five community college students experienced homelessness within the past year,¹⁰ and across the country it is now normative for young people to remain economically dependent on their families well into adulthood.¹¹

For a child who has been separated from family and placed in foster care, the transition to adulthood is especially fraught. Moving between homes can interrupt academic progress and social-emotional learning. Research has found that childhood emotional trauma can cause delays in brain development, which means

a young person may be developmentally younger than their physical age suggests. At the same time, research has also found that the adolescent brain has a unique ability to heal and rebound if proper supports are provided, offering a critical window of opportunity for intervention.

The adolescent brain has a unique ability to heal and rebound if proper supports are provided.



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Many foster youth have had negative experiences with their parents, foster parents, and/or adult case managers, and have difficulty forming trusting relationships with adults. Even under the best circumstances, these young people have had to comply with oversight by adult strangers, and they have experienced considerable loss of choice and control in their lives. By the time they turn 18, many are hungry to be free of adult supervision and reluctant to maintain a relationship with a case worker, even if that option is available to them. The situation is even more difficult for some former foster youth who have their own children by the time they reach 18. And, youth who were abused or rejected by family and/or faith communities due to their sexual orientation can have even fewer supports to draw upon.

As a result of these factors, too many foster youth leave the system without supportive relationships, experience making important decisions for themselves, and the educational credentials needed to survive.

SCALE AND SEVERITY

As of 2015, there were 1,360 foster youth in Hawai'i.¹² Each year, about 1,000 youth leave foster care.¹³ Many reunite with parents, are adopted, or are placed with a guardian. A significant portion—between 60 and 120 annually¹⁴—age out of foster care and enter the adult world entirely on their own. These “emancipated” foster youth, along with runaway and formerly incarcerated youth, are at the highest risk of homelessness, human trafficking, teen pregnancy, and incarceration.

National and regional studies find that 11 percent to 37 percent of all former foster youth experience homelessness by age 26.¹⁵ Local youth services experts place the Hawai'i figure within the same range, estimating that 25 percent to 40 percent of former foster youth will experience homelessness by age 21 in the islands.

According to HMIS data, 12.5 percent of the people who sought homelessness services in Hawai'i from 2012

25–40%
**OF FORMER FOSTER
YOUTH IN HAWAII
WILL EXPERIENCE
HOMELESSNESS BY
AGE 21**



to 2016 indicated that they had been in foster care at some point during their lives—2,107 people out of the 16,879 entered into HMIS during that time. While less than 1 percent of people entered into the HMIS database indicated a foster care home as their most recent residence prior to seeking homelessness services, the data reinforces the conclusion that involvement in the foster care system has a strong connection to homelessness.

The number of homeless youth involved in or recently discharged from the foster care system is difficult to assess. Homeless youth are especially difficult to count, as they are more prone than other homeless individuals to move around, stay temporarily with family or kin, couch surf with friends, or “shack up” with an older adult for temporary shelter. Neighbor island service providers report that homeless youth stay in locations away from where homeless individuals typically congregate and are therefore hard to find and certify as homeless.¹⁶ The 2017 PIT count found 319 unaccompanied homeless youth (age 24 or younger) statewide, plus an additional 71 “youth parents” who were accompanied only by their own minor children.¹⁷

A recent survey of homeless young adults ages 18 to 24 by Hale Kipa and the University of Hawai‘i Center on the Family found that 58 percent had been in foster care or juvenile detention prior to becoming homeless. Applying this percentage to the estimated 390 unaccompanied youth and parenting youth yields an estimated 226 former foster youth or formerly incarcerated youth on the streets of Hawai‘i at any given time.

Again, due to the difficulties with precisely counting homeless youth, this likely understates the number of actual unsheltered youth.

HOW FOSTER CARE EMANCIPATION WORKS

A child is placed into foster care due to abuse, neglect, or abandonment that prompts the state to become the child’s legal guardian. While in the foster system, it is the state’s duty to ensure the child has adequate shelter, food, clothing, health care, and education. However, when foster children reach legal adulthood at age 18, they are “emancipated” from foster care and state guardianship. Some foster youth successfully reunify with family, live with kin, are adopted, or secure a transitional living residence. But for too many, entry into adulthood is also an initiation into housing instability and homelessness.

The federal Preventing Sex Trafficking and Strengthening Families Act of 2014 required states to have transition plans in place for all foster youth at least 90 days prior to discharge. The plan is intended to outline where the young person will live, work or attend school, and when and how assistance will be rendered with medical insurance, vital records, and other requirements of life as an independent adult.

At its most basic, a transition or “permanency plan” is prepared by the Child Welfare Services (CWS) social worker assigned to the foster youth’s case. Ideally, the social worker will work closely with the child to develop the plan. The social worker may also refer cases to contracted community agencies that specialize in permanency planning. Many such providers offer a permanency planning process that begins much earlier than the 90 days required by law and is more comprehensive than the legal standard (see “Bright Spots,” below).

In cases where a contracted provider is not involved, youth work with their CWS social worker to develop a permanency plan ahead of the 90-day requirement. In such cases, a successful transition depends heavily on the abilities of the CWS social worker, the willingness and abilities of the youth, and the quality of the relationship between the two. With large caseloads, limited resources, and a host of stresses for both CWS staff and youth entering adulthood, successful planning does not always

STREET PERSPECTIVES

Two stories of young adults illustrate the challenges former foster youth face in finding stable housing and the importance of cultivating at least one trusting relationship with a caring adult to improve outcomes for those aging out of the system.

Makana

As a self-described “ward of the state,” Makana had to turn her life around before it spiraled out of control. But with a profound mistrust of adults, it was difficult to find a path. “From my foster experience, I was very confused about what was even normal,” she said. “I remember staying in shelter for six months thinking, ‘This is normal.’ Shelter is not normal.”

Makana knew she was going down the wrong route and hanging with the wrong crowd. She was arrested for a felony at age 18 and pled guilty; she received probation. Makana’s social worker introduced her to Sheena Galutira of Hale Kipa and the Imua Kakou program. Sheena gradually earned Makana’s trust as they worked together to come up with a plan for the future. “At first I was very standoffish. I snapped at her. But she was consistent. She stuck it out and proved to me that she really wants to help,” said Makana.

Sheena knew that the plan they worked out would require significant initiative from her client. But she also knew Makana was up to the challenge. “Makana is determined, resourceful, independent, and advocates for herself,” Sheena observed. “She has consistently set goals for herself and makes good use of all the resources given to her.”

Makana also had the support of a loving hanai family who has accepted her as their own. “Before that,” she recalled, “I never had a structured existence. I did my own thing. They helped me be a part of a family. I came to believe I could do anything as long as I worked for it.”

Makana has since earned multiple scholarships, making it possible for her to focus on school without worrying about making a living. Today, Makana is working toward an associate’s degree in business at Leeward Community College. She plans to transfer to University of Hawai‘i West O‘ahu for her business management degree.¹⁸

Kim

Kim is 22 years old and has been homeless off and on for almost three years. Her mom, a single parent, struggled with depression and addiction for as long as Kim can remember. By the time she was 12, Kim was living with her Auntie, and her mom was on the street. Kim ran away repeatedly to be with her mom, which frustrated her Auntie. She got in trouble in school and was picked up repeatedly for truancy. Eventually, her Auntie had enough and Kim was placed in foster care. Before she was 18, Kim went through two different foster homes.

Each move meant starting over. Kim said, “The worst part was a new school every time. In the middle of the year, new everything: new teachers, new counselor, new students. Making up reasons for how come I was there all of a sudden.” Kim didn’t want people to know she was a foster kid. At some point, Kim said, “I gave up trying. I didn’t have no friends from school.” She dropped out before graduating.

Asked how she felt about the adults in her life while growing up, Kim said, “[They] just couldn’t deal with me” and “I couldn’t count on no one,” including one foster parent

“At first I was very standoffish, but... [my case manager] proved to me that she really wants to help.”

— MAKANA, FORMER FOSTER YOUTH

who, according to Kim, was abusive. Pressed on if there was any adult she felt she could trust, Kim said, “My mom will always love me,” and “I had one counselor at my old school who I trusted.” But when she moved schools, that connection was lost. In general, Kim was anxious to escape a cycle where she felt indifferent adults controlled her life. “I was *so* ready to turn 18. You have no idea.”

Upon emancipation, Kim went to live with her mom on the street. Her mom was incarcerated shortly thereafter. Kim met Jason and moved into his tent. They were together for almost a year when, during an argument, Jason hit her and knocked her unconscious. Then, Jason left her. Kim attempted suicide, trying to overdose on painkillers. Kim survived the attempt, but was back on the street shortly after her hospitalization.¹⁹



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happen. In particular, youth engagement in the process can vary case to case. Family Court reviews whatever plan is in place upon the child’s 18th birthday and typically closes the case at that time, though it can order extended state oversight under certain circumstances.

Ideally, a permanency plan helps a youth choose from a range of housing options that are developmentally appropriate and align with a young person’s own goals. Residential facilities, group homes, clusters of apartments, and “scattered site” apartments are operated by social service providers under state contracts, with varying levels of supervision and support for young adults. However, capacity is extremely limited, with each program able to house only a handful of young adults at a time. And, on neighbor islands, there are often no supervised, supportive housing options available for youth, meaning placement into an adult facility not equipped to adequately serve youth may be their only option, assuming space exists.

If a foster youth has been receiving intensive substance abuse or mental health services through the state’s Child and Adolescent Mental Health Division, the mental health care coordinator plays a crucial role in determining whether and how services continue after the age of 18. In these cases, therapeutic residential programs are an option, but again, space is limited. The availability of mental health and substance abuse ser-

vices beyond the age of 18 often determines whether a young adult is able to sustain housing and employment upon aging out.

High-functioning young adults may choose to seek housing through the Hale Kipa Step-Up Housing Program, which provides Section 8 rental housing assistance for former foster youth ages 18–21. Up to 100 Section 8 vouchers are set aside for the program. However, the overall supply of federal vouchers is so limited, and the waiting list to receive them so long, that freezes across all of Section 8 are common, impacting Step-Up. As of July 2017, the entire Section 8 voucher program was frozen, meaning no vouchers could be distributed—the third such freeze in six years.

Finally, youth have the option to extend their involvement with the foster care system through Imua Kakou, a program that offers certain foster care benefits and supports up to age 21. Imua Kakou gives former foster youth a monthly cash payment equal to what foster parents receive to support them, as well as ongoing case management. To be eligible, the young adult must be enrolled in school, working, or in vocational training at least 20 hours per week, or have a qualifying medical disability.

BRIGHT SPOTS

Both the research literature and local interviews indicate that successful transition to independence depends heavily on three factors:

- 1 Timely and comprehensive permanency planning that gives youth a meaningful role in deciding their future**
- 2 The availability of a continuum of housing options and supportive services that extend beyond age 18**
- 3 Access to at least one caring adult who is equipped to build and maintain a relationship with a young person, including “drop-in” availability and “light-touch” interactions (e.g., informal visits instead of, or in addition to, formal compliance reviews)**

Below are several local bright spots that incorporate one or more of these best practices.²⁰

EPIC ‘Ohana’s Youth Circle Program

Though federal law requires a transition plan for foster youth 90 days prior to a child’s 18th birthday, EPIC ‘Ohana begins their permanency planning process at least a year prior to aging out, convening a “Youth Circle” (YC) that includes all supportive adults in a young person’s life: birth family (if appropriate), foster family or other care givers, service providers, and social worker. Discussion focuses on the young person’s strengths and sets goals in areas of housing, health, school, career, and more. The youth is urged to take a leading role in the group to shape their own plan. The entire process culminates in a celebration of the youth entering adulthood, which the young person helps plan—setting the agenda, choosing the food, and crafting the invitation list. EPIC ‘Ohana gives former foster youth access to their YC up to the age of 27.

Imua Kakou Program

As noted, Imua Kakou is a voluntary program that allows a youth to remain in DHS care from the ages of 18 to 21. Young adults who opt in to Imua Kakou are paired with a case worker who can help them secure housing, medical and dental coverage, and education or job training. The youth also receives a monthly Foster Board maintenance payment equal to the

amount received by foster parents. To qualify, youth must be pursuing their GED or be enrolled in secondary or post-secondary education, have a job or be enrolled in a job preparation or training program, or be unable to meet these requirements due to disability. Importantly, Imua Kakou allows for “in-and-out” participation—that is, youth may come in and out of the program as often as they like, provided they meet eligibility requirements. There is mounting evidence from other states that have implemented programs similar to Imua Kakou that extending foster care produces measurable gains in education, employment, and housing stability for participating young adults.²¹

Youth Outreach (YO!)

For youth who age out of foster care and end up on the street, the best hope of a stable future lies in keeping in touch or getting connected with a caring adult and supportive services. Located in Waikiki, YO! is a drop-in center for street youth and young adults operated by Hale Kipa and Waikiki Health Center. It serves as a safe haven for homeless youth, offering medical care, social services, and non-judgmental support, as well as storage lockers, showers, and access to a computer lab. YO! staff engage in regular outreach to street youth, meeting them at times and places on the street where homeless youth congregate. The combination of proactive street outreach and a drop-in center is often the only way to get unaccompanied youth to reconnect with caring adults who can help get them on the path to a stable, independent, productive future.

RECOMMENDATIONS

Near-Term Recommendations

Action items that require relatively modest investments of time and resources include the following:

1 Ensure permanency planning for all foster youth begins early and gives youth a voice in determining their future. Building upon bright spots like the Youth Circle program, the state and community-based providers can work together to offer permanency planning that begins well in advance of the 90-day requirement. The process should place top priority on giving the youth choice and a voice in decisions about providers to work with and the types of housing, education, and employment opportunities they wish to pursue. As one interviewee who works with youth put it, “If a young person hasn’t had to make any consequential choices before they confront “Do I do drugs?” and “Do I have sex?” it’s

too late.” A permanency planning process, started early, can give young people practice at looking ahead and making decisions that will impact the course of their lives, with the support of caring adults.

2 Increase investments in the Imua Kakou program and related efforts to extend supports for foster youth beyond age 18. Extending contact with a case manager and other supports to at least age 21 is needed to give young people the chance to develop the skills and experience they need to be independent. A solid body of research finds that extending foster care yields multiple benefits for young people and society. Those required to leave care at age 18 are 2.7 times more likely to be homeless in their twenties. Remaining in care more than doubles the odds that a young person will be working or in school at age 19 and doubles the percentage who earn a college degree from 10.2 to 20.4, thereby increasing their earnings potential. Research also finds that extending foster care is associated with lower rates of incarceration, early pregnancy, and other risk factors.²²



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3

Create a universal intake tool and data system for homeless youth to be used by all agencies,

including the police, Child Welfare Services, the judiciary, and the Department of Education (DOE), along with homeless agencies. Once a young person is on the street, the top priority is to get them identified and connected to supportive services. Outreach workers report that the current VI-SPDAT (identification and intake form for all homeless) has questions that are irrelevant to youth and a lengthy format that can be off-putting when trying to connect with a skeptical, unaccompanied youth. At the time of this study, a Youth VI-SPDAT Form was being tested, but it was still viewed as in need of further streamlining.²³ Interviewees also noted that the DOE is ideally suited to help identify homeless youth. Aligning the criteria and definitions of “homeless” used by the DOE and homeless agencies, enabling DOE staff to issue homeless verification letters, and allowing DOE access to existing homeless databases were all suggested as potential improvements.²⁴

4

Create virtual or mobile course-taking that leads to a high school diploma or other credential.

Earning credentials through online coursework available at libraries, drop-in centers, or mobile computer labs would make it possible for homeless youth to maintain academic progress, even when they are displaced. In addition, basing credentials upon demonstrated competency rather than required attendance would allow for self-directed learning and give students the chance to earn credentials that enhance job prospects. Such efforts could build upon and align with the content of existing competency-based, credit recovery, work-study, and vocational education programs.²⁵

Long-Term Recommendations

Recommendations that may take longer to implement or require a significant investment of resources include the following:

5

Increase investments in street outreach and drop-in centers to engage recently emancipated young adults.

Young adults who opt out of continued contact with the system and their permanency plan are in an extremely vulnerable situation. Street outreach and drop-in centers are often the only ways to reach young adults during this critical

window. It can take multiple encounters over extended periods to build the trust required to re-engage emancipated youth with case management and other supports. Shelters should be advised to use a “low barrier to entry” approach for youth and young adults. Greater investment in street outreach, drop-in centers, and low-barrier shelters is critical, particularly in rural O‘ahu and on neighbor islands.

6

Ensure a stable supply of housing for young adults age 18-24 that meets a spectrum of needs.

Young people who have been involved with the foster/child welfare, juvenile justice, and/or mental health systems have varied needs and strengths. Some will thrive in a group setting, others in standalone supervised apartments, and some are ready for truly independent living. Still others will need therapeutic homes or housing tailored for young parents. There must be a spectrum of housing options for youth, even if only a small number of units in each category. The availability of transitional housing for youth on O‘ahu and Hawai‘i Island is far too limited for those exiting foster care and former foster youth who are already homeless. The supply on neighbor islands is even scarcer, with no transitional housing for youth in Maui County and Kaua‘i.

7

Enable staff to focus on building trusting relationships with youth.

National research and local interviews make it clear that the key to successful transitions from youth to independent adulthood (or getting them back on course, if transition falters) is having a trusting relationship with at least one adult. However, short staffing, swelling caseloads, limited professional development opportunities, and difficult working conditions in human service agencies can hamper the development of such relationships. Everyone, from the front-line staffer to the chief administrator, must seek to incorporate more patience and flexibility into work with youth. Staff who find ways to approach the work with patience, empathy, and professionalism—in spite of the challenges—should be celebrated and their knowledge tapped.

8

Infuse rules, policies, and procedures with the flexibility needed by young adults.

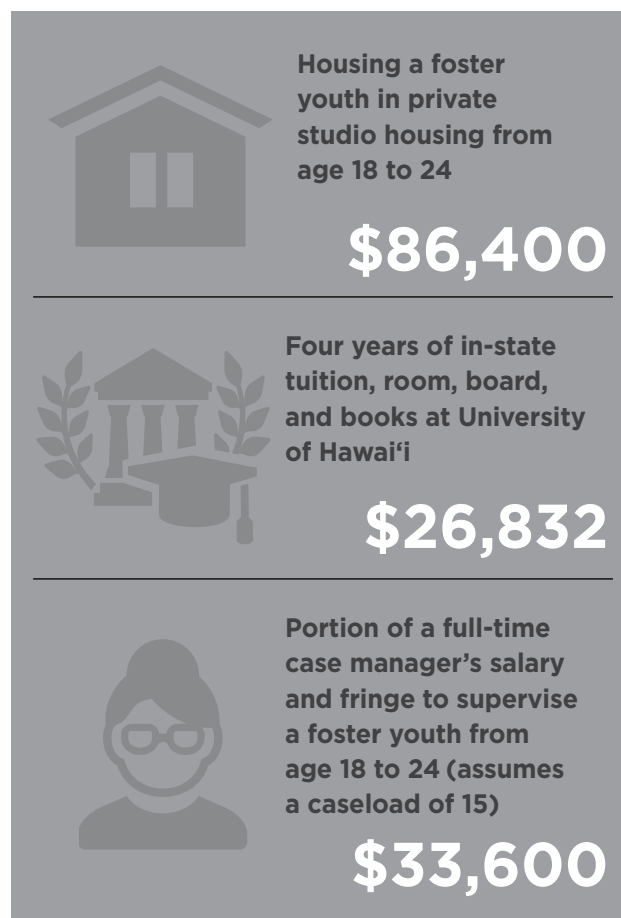
Along with investments to build capacity among youth-serving staff, policies and procedures must also change. For instance, evaluating youth transition programs under the same measures as all

Housing First programs places priority on accelerated placement into permanent housing. But for youth, such a focus can undermine the step-wise progression necessary for skill-building and sustainable independence (e.g., moving from group home to supervised apartment to independent living). Similarly, applying housing rules designed for adults to these young people can be counterproductive. Per Section 8 rules, missing a utility bill can result in a lifetime ban from the program—a weighty consequence for young adults in the Step-Up Program who are still acquiring life skills and experience. Often, creative and compassionate supervisors or front-line staff have found ways to follow rules but build in the flexibility and variability that serve youth best. Such staff and their creative solutions are assets to build upon.

The Investment: Who and How Much?

Given the currently poor outcomes for many foster youth, taxpayers pay a hefty price for society's failure to invest in these young people. For every child who ages out of foster care, taxpayers and communities will pay, on average, \$300,000 in social costs over that person's lifetime for taxpayer-funded public assistance, incarceration, and wages lost as a result of incomplete education.²⁶ Focusing exclusively on the 60-120 foster youth who age out with minimal supports (instead of the total universe of 1,000 who age out each year), the bill of future costs amounts to \$18-\$36 million each year.

The figure of \$300,000 represents a theoretical "break even" amount that we, as a community, should be willing to invest, per foster youth, to improve post-emancipation outcomes. By comparison, here are some of the per-youth costs of some of the recommendations at the right.



DISCHARGE FROM HOSPITALS AND EMERGENCY ROOMS

SCALE AND SEVERITY

Homeless persons are significantly overrepresented in their use of hospitals and emergency departments compared to the general population. Homeless individuals' reliance on ERs and high rates of hospitalization for often preventable conditions are well documented in the literature, as are their more frequent rates of hospitalization generally.²⁷ Indeed, homeless patients represent nearly 30 percent of urban ERs' annual adult census nationwide though they make up a tiny fraction of the overall population,²⁸ and more than 70 percent of inpatient hospitalizations of homeless individuals begin in the ER.²⁹ Once hospitalized, homeless patients have longer stays and cost, on average, \$2,500 more per hospitalization than do housed patients.³⁰

Post-discharge complications and readmission are common for homeless individuals, no doubt in part due to the lack of physical stability that being unhoused creates. Nationally, 67 percent of homeless patients spent their first night after hospital discharge in a shelter; 11 percent spent their first night after discharge on the streets.³¹ The nationwide, 30-day inpatient hospital readmission rate is 51 percent among homeless patients (versus 15.6 percent for the population at large³²), with nearly three-fourths of readmissions occurring within two weeks of discharge.³³

According to Hawai'i's HMIS database, from 2012 to 2016, 7.4 percent of people accessing homelessness services listed their last residence address as a hospital—1,255 out of 16,879 people accessing services during that period. HMIS data shows that people whose last residence is a hospital are especially likely to end up on the street after receiving homeless services. The “exit destination” of 41 percent of those who identified their last residence as a hospital often was a “Place not meant for habitation,” versus 24 percent for those whose last residence was not a hospital. Additionally,

HOMELESS PATIENTS
REPRESENT NEARLY

30%

OF URBAN ERS'
ANNUAL ADULT
CENSUS NATIONWIDE



Photo © MichaelDalyArtist.com

people who came from the hospital are four times more likely to return to the hospital after receiving homelessness services. Nearly 6 percent of people whose last residence was a hospital at the time they accessed homeless services had an exit destination of a hospital versus 1.5 percent of those that had a non-hospital prior residence.

The number of homeless encounters in hospital systems is increasing statewide, often with corresponding increases in unreimbursed health care costs. In 2015, Hawai'i hospitals treated homeless patients 15,900 times, a 6.7 percent increase from the 2014 figure of 14,900.³⁴ Data provided by the Queen's Medical Center, the largest hospital system in Hawai'i and the only system in the state for which counts of homeless encounters and corresponding gross charges are available,

shows a growth trend in both numbers of homeless served and related costs over the past several years:

Queen's estimates it has absorbed approximately \$40 million in unreimbursed medical costs from 2013 to 2016 caring for high-needs homeless patients.³⁶

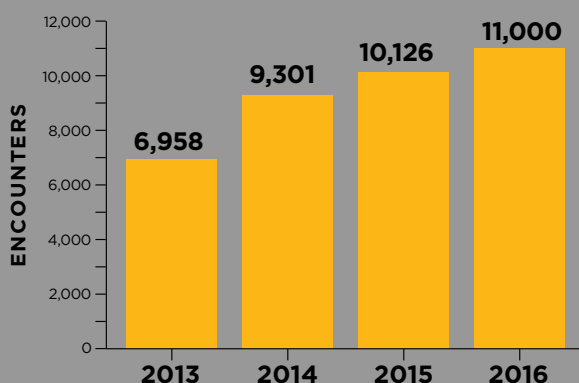
Super-Utilizers and Overutilization

While not all homeless are "super-utilizers" of health care, homeless individuals are nonetheless overrepresented among the heaviest utilizers of emergency departments, hospitals, and emergency medical services, such as ambulances. Homeless and marginally housed super-utilizers account for more than half of all ER visits in the United States.³⁷ Nationally, rates of ER visits and hospitalization are 9-12 times higher among homeless individuals than low-income housed patients.³⁸

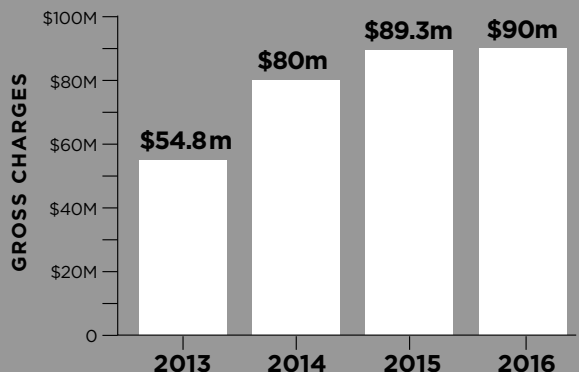
Queen's Medical Center provides an illustrative example of super-utilizers on a local level. In 2015, the top 25 super-utilizers at Queen's came to the hospital 1,514 times (with each individual averaging more than one visit per week), with gross billings for hospital and physician costs totaling approximately \$12 million.³⁹ During a 90-day period in 2016, 39 homeless individuals accounted for more than 730 ER visits. One individual went to the Queen's ER 60 times during that period.⁴⁰

Many homeless individuals are brought to the hospital by ambulance or police, at a cost of roughly \$1,000 per transport, often for non-emergent issues such as prescription refills, food, and minor ailments.⁴¹ An analysis by the Honolulu Emergency Services Department of 911 calls made in 2011 found that eight of the top 10 users of 911 services were homeless. As a group, they averaged 52 ambulance trips per year; the most frequent 911 caller used an ambulance 142 times in a single year.⁴² In addition to the public costs generated by such transports, the use of emergency medical services (EMS) for preventive or minor health care needs diverts personnel and resources away from genuine emergencies. A plan for a community paramedic program to reduce overutilization of EMS by homeless persons was shelved in 2013 due to lack of funding. It would have established two community paramedics to visit the top 50 utilizers of EMS services for redirection to more appropriate care.

Queen's Hospital Homeless Patient Encounters Rapidly Increasing



Queen's Hospital Homeless Patient Gross Charges Reach \$90 Million



HOW MEDICAL DISCHARGE WORKS

Hospitals in Hawai‘i typically attempt to determine if a patient is homeless because whether a person is sheltered will impact decisions regarding appropriate care. However, homelessness status is often determined by self-identification, so there may be instances where a homeless patient is not identified.

Although many hospitals in Hawai‘i have concrete plans in place for the discharge of homeless patients, in practice discharge is often informal and changes on a case-by-case basis. Homeless patients often have conditions that require intensive inpatient care and follow-up upon release, making discharge arrangements challenging. Ensuring adequate follow-up or outpatient care is difficult for patients who are unsheltered, further complicating decision-making regarding discharge plans. Often, hospitals in Hawai‘i try to maintain a continuum of care by setting follow-up appointments with a primary care physician or at a local clinic to ensure homeless patients’ medical needs are met. However, medical staff

report that homeless patients often miss follow-up appointments, and resources (such as transportation) typically are not in place to provide assistance that would ensure patients make their appointments.

At some hospitals, if the staff knows that a patient is unsheltered, the staff will provide resources to the person that will assist them in obtaining shelter and social services, though there is no statewide system in place to ensure that this occurs consistently. Some hospitals partner with local nonprofits and shelters that have staff specifically trained in providing social and support services to the homeless. However, these resources are often first come, first served, and shelter and nonprofit staff can be difficult to reach due to busy schedules and/or overtaxed resources. Since hospital patients cannot be connected with these services until they are discharged or about to be discharged, they have little to no time to wait for resources to become available, and they are often discharged without connecting with social services. Furthermore, hospital staff report that paperwork and other bureaucratic barriers to accessing social services limit the number of homeless patients who use them.

Adult foster care and/or nursing homes provide another option for shelter and care. As part of the discharge process, some hospitals help patients enroll in adult foster care and/or nursing homes. However, hospital staff report that few nursing homes accept homeless patients because of concerns about substance abuse issues or erratic behavior. While homeless patients who receive Social Security may be able to pay the costs of a nursing home with their Social Security payments, hospital staff report that many choose to remain on the streets rather than give up most or all of their payments.

If securing shelter is not a viable option, and a patient seems “healthy enough” to be on the street, hospital staff will generally discharge the patient back into homelessness. Although hospitals are less likely to allow a patient to leave without a support system in place, the patient may still be discharged, particularly if the hospital lacks resources to care for such patients long term. Hospital staff are generally unable to check up on patients once they have been discharged, but in some cases and at some hospitals, staff occasionally drive by areas where they know that patients reside to check up on them and provide them with transportation for medical appointments. In general, though, little interaction with patients occurs after they have been discharged due to time and resource constraints of hospital staff.

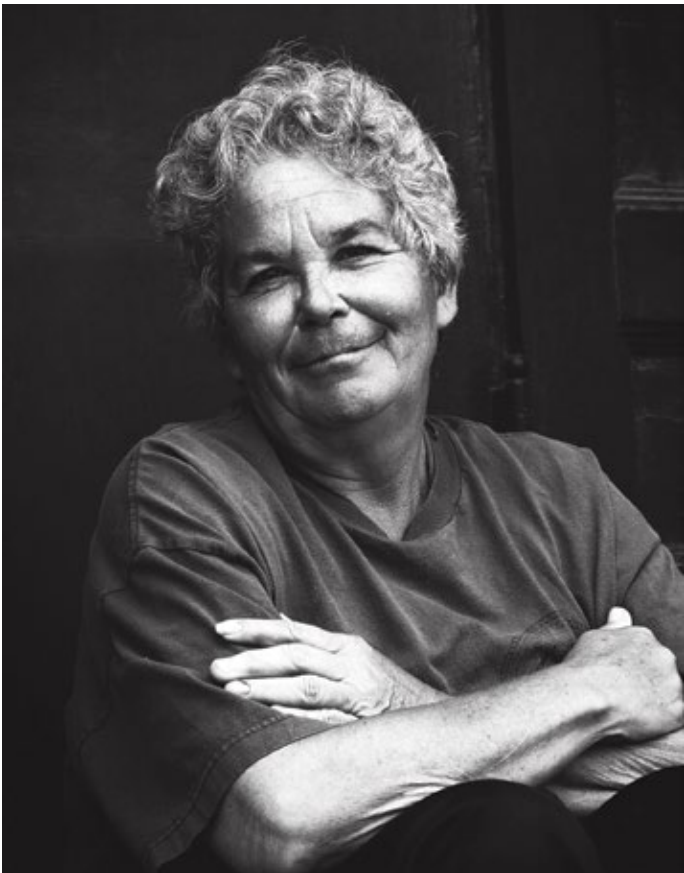


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STREET PERSPECTIVES

Street interviews painted a more mixed picture of hospital discharge procedures than what hospitals report as their standard practices for dealing with care and discharge of homeless patients.

There is an impression among many homeless individuals that some hospitals rush to discharge them, and that they treat persons differently if they are perceived to be homeless and/or have substance abuse issues. One interviewee recounted, “When you’re an addict, they just want you out...They do UA [urine analysis] and if there’s anything in there, they treat you different. I got bit by a dog and it got infected. At first, they were nice, but after the UA, their whole attitude changed.”

At the same time, some homeless interviewees reported positive experiences at other hospitals, suggesting that the culture and practices of each hospital make a considerable difference in the service homeless individuals receive. One interviewee said, “[They] went out of their way to help me. They treated me like a human being.” Another recalled, “I went to the...ER for an injury. I told them I was using. They followed me out the door to the street to try to encourage me to get [substance abuse] treatment.” Another interviewee said, “I asked the doctor to call...the housing office for me. [W]hen the doctor calls they pay attention. The doctor called...and I got temporary housing.”

All interviewees acknowledged there are homeless “super users” who visit the hospital regularly, but none of the interviewees fit that profile. Their sense was that a few “super users” create a bad impression of homeless patients generally. “Hospitals think I’m just there to sleep, and crash,” said one interviewee. “They treat me nice until they find out I’m homeless, then they treat me different.”

Only two interviewees out of 38 who had been to a hospital in the past year recalled an attempt by the hospital to coordinate post-discharge care with homeless agencies, housing, and social services.

Street interviews also revealed that getting outpatient therapy (e.g., physical therapy that would normally be provided in-home) is impossible if on the street, and virtually impossible in many shelters due to privacy issues and rules that require some shelters to be emptied during daytime hours. They also revealed that sweeps—

clearing people who are homeless out of a particular area where they have been sleeping and storing their property—and the instability they cause can contribute to readmissions by preventing unsheltered homeless from attending follow-up visits to physicians, keeping medications secure or refilling prescriptions, and having enough stability to rest and recover (see Big Picture Findings for more on this point).

The reported experiences of homeless individuals at hospitals help to illustrate some of these points.

“B” is a 34-year-old mother who worked as a mental health counselor:

I was brought to the hospital unconscious. Someone carried me there. Yes, the people at the hospital knew I was homeless. I had no place to go. When I woke up, I was in a ward where you needed to be crazy [in psychiatric crisis] to be there.

“I’ve been treated really badly—disrespectfully—at the hospital. The nurse and the doctor in the ER, it was clear they wanted to get me out as fast as they could.”

— S, PATIENT IN HER 30S WHO
PREVIOUSLY WORKED IN HEALTH CARE

They woke me up, did an observation, and they told me I was out. I told them my head was killing me and that I felt nauseous. But, they said, we can see that you're not crazy so you can't stay here. Security walked me out to the sidewalk at 3:20 a.m. That was Saturday night [early Sunday morning]. I couldn't get my property until the Monday. I had no phone, nobody's number. Nothing I came in with. I went straight to the park to see if I could find someone I knew. I had no idea what else to do.

“S” is a woman in her thirties who worked in health care:

I've been treated really badly—disrespectfully—at the hospital. The nurse and the doctor in the ER, it was clear they wanted to get me out as fast as they could. No caring. It could be just those individuals and not the hospital as a whole. But the two times I went to the ER it was the same. The thing is, I used to work in a doctor's office. I know about the Hippocratic Oath—do no harm. People

in a hospital, in helping professions, should have patience and empathy, not look down. Otherwise they are doing more harm than good.

“V” is a 56-year-old woman and former small business owner:

I went to the ER with a sore on my arm that was oozing pus. It was infected and it hurt a lot. They stuck a needle in, drained it, cleaned it, and put some medicine on it that made it burn like hell. It was so painful. They discharged me with some gauze and wipes and I was back to my tent. There was a sweep right after that. We got swept to an area where there was no water, no showers. We used to be near the park where there was at least a shower and bathroom. I lost a bunch of my stuff and it was impossible to keep my arm clean. Anyway, my arm got bad again. I went back to the hospital. This time they admitted me. It was MRSA. I was in for 10 days.

BRIGHT SPOTS

*Tutu Bert's House*⁴⁴

A private eight-bed medical respite administered by the Institute for Human Services in partnership with Queen's and HomeAid Hawaii, Tutu Bert's goal is to serve 60 individuals per year, with estimated annual taxpayer savings of \$2.68 million in unneeded health care costs.

*Housing First and the Hawai'i Pathways Project*⁴⁵

The Housing First model focuses on providing permanent housing to chronically homeless individuals, and then implementing wrap-around treatment and life skill services necessary to help these individuals stabilize, improve quality of life, and maintain housing. The Hawai'i Pathways Project (HPP), run by Helping Hands Hawai'i in partnership with Catholic Charities Hawai'i, is one of the Housing First programs. HPP specifically focuses on providing permanent supportive housing to chronically homeless individuals struggling with substance use

or substance use with mental illness. After obtaining stable housing through HPP, the estimated health care costs of an average client dropped from \$10,570 per month to \$5,980. With the combined cost of rent subsidies and supportive services for the program averaging \$2,220 per month, net savings from the program are estimated to be \$2,370 per client per month.⁴⁷ Although this is just a preliminary analysis based on clients' self-reported data on services utilization, these findings echo research on other Housing First programs around the nation, making Housing First and the HPP a promising program.

*Hawaii H.O.M.E. Project*⁴⁶

A John A. Burns School of Medicine student-run clinic staffed by volunteers that provides free medical, social, and vision care services to homeless on O'ahu. There are currently seven clinic locations: five in Honolulu, one in Wai'anae, and one in Kapolei. They also bring medical services via mobile health van to homeless encampments with the goal of treating ailments before they require hospitalization.



Photo © Kyle Durigan/Creative Commons

For patients with conditions that require follow-up care, the lack of a stable living situation can lead to repeated hospital admissions as their condition, which is stabilized during their hospital visits, deteriorates after each discharge. Hospital staff highlighted this issue for patients with substance abuse problems and patients with mental illness. For both situations, and for mental illness especially, community resources are insufficient to care for such patients, and they end up returning to hospitals for treatment again and again.

Another barrier to obtaining follow-up care is a lack of insurance. According to Queen's, nearly 80 percent of homeless patients treated at their hospital have insurance.⁴³ However, a sizable number of homeless patients are underinsured or do not have any insurance. While uninsured patients are able to access hospital care, they may be turned away by physicians who do not admit patients without insurance and will thus be unable to obtain adequate follow-up care.

In addition to these barriers, Limited English Proficiency (LEP) patients face another problem—discharge instructions are almost universally written in English and interpreters are often not provided. Thus, LEP patients may not even know what follow-up care is necessary, let alone how it can be accessed.

RECOMMENDATIONS

Near-Term Recommendations

Action items that require relatively modest investments of time and resources include the following:

- 1 Ensure care coordination spans pre- and post-discharge.** Pre- and post-discharge care coordination could take various forms: It could include implementing a partnership between hospital social workers and social workers in community-based agencies, involving case workers from community agencies with a patient prior to discharge, or coordinating among nurse case managers, hospital staff, and shelter providers. Care transition is a subcomponent of care coordination that focuses on the understanding and use of health information, as well as smooth movement of patients from one health setting to another. While few care transition models currently focus on homeless populations, several that target seniors and Medicare recipients may serve as useful models for homeless individuals transitioning into permanent supportive housing.⁴⁸

2

Increase availability of mobile medical clinics, community paramedics, and/or community-based drop-in centers.

Homeless patients benefit significantly when services are made available to them in the communities and locations where they live and congregate. Mobile medical clinics,^{49, 50, 51} community paramedics,^{52, 53} and community-based drop-in centers provide homeless people access to care for non-urgent/sub-clinical issues in a welcoming and/or familiar environment (e.g., less intimidating than a hospital) and can circumvent transportation or access issues. (Note: During the 2017 session, Hawai‘i’s legislators considered but did not pass a bill to fund two mobile medical clinics to be operated by the Institute for Human Services at a cost of \$1.4 million per year. Two existing “Care-A-Vans” previously operated by Waikiki Health Center are now idle due to the state contract for their funding not being renewed.⁵⁴)

3

Create a shared homeless patient database and support data sharing among hospitals.

Creating a shared database of homeless patients and treatment history, with appropriate patient permission, would likely improve clinical outcomes by providing better care coordination and continuity of treatment across medical facilities. Because HMIS is already in use by social service agencies to collect information regarding homeless individuals, it offers a natural shared repository for homeless patient data. By providing hospitals with access to HMIS, cross-institution data could also be consolidated, and statewide estimates of costs of care of homeless across hospitals and health care providers could be centrally generated. Capturing housing status through Medicaid plan application/eligibility forms (e.g., through a simple question such as, “Are you currently homeless?”) would allow filtering of data for the subpopulation of homeless within HMIS data.

4

Expand medical respite programs.

Investing in medical respite has the potential to save health care systems millions of dollars in unnecessary emergent and hospital-based medical care costs. This “medical respite” model is used in other jurisdictions (e.g., the San Francisco Medical Respite Program⁵⁵ and the Nightingale Program from Catholic Charities of the Diocese of Santa Rosa in California⁵⁶) and has been found to effectively reduce hospital utilization, both in readmission rates and in duration of hospital stay.⁵⁷

Long-Term Recommendations

Recommendations that may take longer to implement or require a significant investment of resources include the following:

5

Reframe housing as health care.⁵⁸

Embracing a framework that recognizes housing is a social determinant of health is critical to creating long-term, systemic, and sustainable solutions to homelessness. Particularly for already vulnerable populations such as individuals living in poverty, struggling with mental illness or substance abuse, or recovering from trauma—all of whom are overrepresented among the homeless—housing is a critical precursor to securing good health. Supportive housing approaches that combine housing and service supports have been shown to improve the stability and health outcomes of their participants by (a) providing physical safety and security that prevents new injury and illness, (b) improving access to coordinated health care and social support services, and (c) promoting lifestyle changes that support good health.⁵⁹ As a result, these at-risk populations benefit from decreased rates of morbidity, mortality, and chronic disease burden. During the 2017 session, state legislators considered but did not pass a bill that would classify chronic homelessness as a medical condition with the purpose of utilizing some of the \$2 billion Hawai‘i receives in Medicaid funds for housing.⁶⁰

The Investment: Who and How Much?

Beyond improving patient health outcomes, supportive housing approaches create significant returns on financial investment, particularly when aimed at high-cost utilizers of medical systems. Dozens of studies have found that supportive housing programs reduce taxpayer costs—often by more than 40 percent, sometimes by more than 70 percent—while improving health outcomes and patient well-being.^{61, 62, 63} Studies have found that providing permanent supportive housing saves public funds by (a) decreasing health care costs by 59 percent, (b) reducing emergency department costs by 61 percent, and (c) decreasing the number of general inpatient hospitalizations by 77 percent.⁶⁴

In our local context, the University of Hawai‘i report on the Housing First approach of the Hawai‘i Pathways Project is promising, suggesting a 43 percent drop in health care costs for formerly chronically homeless in-

SUPPORTIVE HOUSING
PROGRAMS REDUCE
TAXPAYER COSTS—
OFTEN BY MORE THAN

40%



dividuals when they had decent housing for an uninterrupted six-month period. Revisiting the legislation considered during 2017, which would have allowed the state to classify housing as health care (and/or classify homelessness as a medical condition), could make it possible to use Medicaid and other health-related funding to cover the cost of housing for homeless patients.⁶⁵



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RELEASE FROM INCARCERATION

Incarceration and homelessness are mutual risk factors for each other, meaning that homelessness may increase the likelihood of incarceration, and incarceration may increase the likelihood of homelessness. Although estimates range widely in the research regarding the percentage of the homeless population with a history of incarceration, researchers generally peg the figure to be between 25 percent and 50 percent. Recent homelessness was 7.5 to 11.3 times more common among jail inmates than in the general population.⁶⁶

The difficult barriers facing individuals trying to escape homelessness are multiplied for those with criminal records, and even more so for those who have recently released from a period of incarceration. Obtaining employment and stable housing are particularly important to staving off homelessness over the long term—both are especially difficult to obtain given the prevalence of

AN ESTIMATED
25-50%
OF HOMELESS
HAVE A HISTORY OF
INCARCERATION

policies that seek to exclude housing and employment applicants with criminal histories. Publicly subsidized housing, for example, has strict requirements regarding admission for people with criminal records. In light of these barriers, previously incarcerated individuals will sometimes engage in criminal activities to meet their basic needs, perpetuating a cycle of homelessness and incarceration.⁶⁷

SCALE AND SEVERITY

Prison Inmates Releasing Into Homelessness

In Hawai'i in 2015, 841 inmates were released from prison. Of those, 52 were listed as "homeless," "no permanent address," or something similar. An additional 184 inmates had no address entered. According to an official at the Department of Public Safety (PSD), it is safe to assume that most of these 236 individuals (28 percent of all those who were released) were homeless.⁶⁸

Jail Inmates Arriving From Homelessness: Homeless In, Homeless Out

The percentage of inmates releasing from prison into homelessness nearly matches the percentage of inmates who are homeless at the time they arrive at jail at



Photo © Leroy_Skalstad, Pixabay

the Oahu Community Correctional Center (OCCC). Close to 30 percent of inmates at OCCC were homeless immediately prior to entry.⁶⁹ According to PSD officials, the percentage of OCCC inmates who are homeless has increased in recent years, which is part of a statewide trend.⁷⁰

PSD officials have expressed concerns that the influx of homeless people, many with mental health issues and in need of special housing, is creating challenges for OCCC, which has a population of over 1,200 inmates in a space designed with a capacity of 628.⁷¹

Percentage of Homelessness Services Consumers Releasing Directly From Incarceration

According to a 2010 report by the U.S. Department of Housing and Urban Development, on a nationwide basis, 4.4 percent of adults entering emergency shelters or transitional living facilities had been in a jail, prison, or juvenile detention facility the night before entering the shelter (compared to 6.4 percent who had been in a psychiatric facility, substance abuse center, or hospital the night before, and 0.2 percent who had been in a foster home the night before).⁷²

Hawai'i HMIS data reveals that from 2012 to 2016, 5.1 percent of people entered into the HMIS system listed jail or prison as their last address. Thirty-two percent of people entered into HMIS indicated involvement with the criminal justice system at some point in their past, responding that they fit within one of the following categories: “probation,” “parole,” “drug court,” “supervised release,” “formerly in system, completed requirements,” or a last residence of prison or jail.

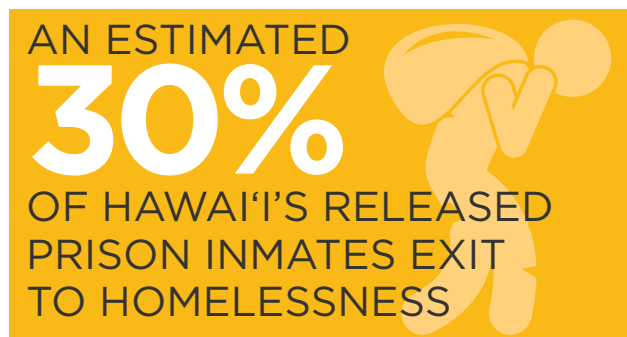
People with past involvement in the criminal justice system were over five times more likely to have jail or prison for an exit destination than were those without

such a history. Four and a half percent of those who indicated past involvement with the criminal justice system had an exit destination of prison or jail—a percentage that represents only those that exit from services directly to jail or prison, which is likely much smaller than the percentage who ultimately end up back in jail or prison.

According to national data, individuals releasing directly from a period of incarceration are much less likely to enter into permanent supportive housing (PSH). PSH is long-term, subsidized housing with supportive services to enable formerly homeless people to live as independently as possible in a permanent setting. This is possibly because people who have stayed in an institutional setting for 90 days or more do not qualify as homeless and would not be eligible to move directly into a PSH program. Only 0.6 percent of adults in PSH released directly from jail, prison, or juvenile detention (compared to 5 percent who had been in a psychiatric facility, substance abuse center, or hospital the night before entering a PSH program, and 0.3 percent who had been in a foster home the night before).⁷³ Similarly, only 0.4 percent of individuals releasing from incarceration directly entered a Homelessness Prevention and Rapid Re-Housing Program (compared to 0.5 percent who had been in a psychiatric facility, substance abuse center, or hospital the night before entering a PSH program, and 0.1 percent who had been in a foster home the night before).⁷⁴

Frequent Flyers

As with hospitals, super-utilizers are a concern in the context of the criminal justice system. PSD has identified 200-300 “frequent flyers”—people who in the last 3 to 5 years have been in OCCC more than 10 times.⁷⁵ However, this data may be unreliable and no analysis has been conducted regarding the homelessness status of this frequent flyer group.



HOW RELEASE FROM INCARCERATION WORKS

Jails and prisons in Hawai‘i are operated and overseen by PSD. Jails are used to detain criminal defendants awaiting trial and to incarcerate people with short sentences—typically less than a year. Hawai‘i’s jails also serve to transition people who have nearly completed their prison sentences and are returning to the community. Prisons are used to incarcerate people who have been convicted of a crime and issued a sentence of more than a year. The average length of stay for prisoners is seven years.

Pre-release assistance for ID, banking, and public benefits would help inmates meet basic needs upon release.

Intake

People enter the PSD system through the jail intake process at one of Hawai‘i’s four Community Correctional Centers. The intake protocol also includes questions that can be used to help identify whether an inmate is homeless, and which PSD has used to generate data on the number of inmates entering from and exiting to homelessness. PSD has concerns about the reliability of this data because it is based on self-reports and the relevant data fields are not consistently used by staff, but multiple sources reported that PSD is in the midst of a large data infrastructure project that may provide an opportunity to better track homelessness. Regardless of these concerns, the data could, in theory, be used to develop plans to prepare for the inmate’s release, though currently this is not done.

During the intake process, PSD will also conduct a bail evaluation, which uses an assessment tool to determine whether a pre-trial detainee is a low, medium, or high risk for “pre-trial failure,” i.e., whether a detainee is likely to be arrested for a new crime or fail to appear in court while on pre-trial release.⁷⁶ According to PSD officials and others, detainees will not be released pre-trial if they do not have a permanent residence address, meaning that criminal defendants who are homeless will remain jailed while awaiting trial, even if they may have otherwise met the qualifications for pre-trial release. The justification for this is that those without a permanent address have a greater likelihood of not returning for later court appearances. However, according to the opinion of one interviewee, many people who are held in jail should not be if they have somewhere to stay, “even if it is only a tent,” and especially if the person is employed.

Release From Jail

Once someone is incarcerated, little support is offered in terms of preparing for their release, especially from jails. Unlike prison inmates, jail inmates are offered little, if anything, in the way of programming during their time of incarceration. There is no release planning of substance. Whether inmates are jailed for a day or a year, when it is time for their release they are simply provided with their belongings when they leave.

In some cases, they do not even get their belongings. The property room at OCCC is open to releasing inmates Monday to Friday from 8 a.m. to 4 p.m. If inmates are released during a time when the property room is closed, they will need to come back to the jail when the property room is open. This presents an especially difficult problem for inmates who are released after the property room closes for the weekend on Friday.

According to one interviewee, OCCC inmates may be released directly from court in a paper suit with none of their belongings, left to find their own way back to the jail in order to get their things, which can be difficult because they do not have anything—a phone, money, or anything else they might use to get where they need to go. This portrayal of release was disputed by other interviewees who said that inmates will typically be transported to court with their belongings in case they are released. Additionally, the court will often need to issue a written order prior to the inmate’s release, so in most cases, the inmates will be returned to OCCC before release, where they will have access to their belongings.

Written PSD policy on the matter suggests that either could be true. Official policy states that inmates releasing from the courthouse will be offered “street clothes or paper suits to change into,” and that it is “the *option* [emphasis added] of the facility Warden to have the inmates’ property taken to court” so that the inmate will not need to return to the facility to obtain their property. However, “[i]f the property is not sent to court with the inmate, it is up to the court-released inmate to pick up their property from the facility at a later time.”⁷⁷

Release From Prison

Unlike jail inmates, prison inmates have access to at least some resources that might help them prepare for reentry, perhaps due to the greater ease and necessity of providing programming to those with relatively long stays—an average of seven years for Hawai‘i prisons. Although the programming options available in prisons have the potential to help inmates reintegrate into the community upon release, it was widely reported that programming was sparse and inadequate. Data regarding the prevalence and efficacy of these programs was not identified.

As with bail decisions, where jail detainees may be denied bail solely on the basis of the lack of a residence address, prison inmates may be denied parole based on the lack of a place to live upon release. The Hawai‘i Paroling Authority may deny parole in a number of circumstances, including finding that “the inmate does not have a viable parole plan.”⁷⁸ The parole plan includes information on the inmate’s plans for life after release, such as work plans and “where and with whom the inmate will reside.”⁷⁹ The necessity of a residence to release to was supported by multiple interviewees who stated that inmates will not be released into homelessness, and those without an address to release to will “max out” their sentence.

As an inmate’s release from prison draws near, they receive individualized written discharge plans. Housing is one of the issues covered by the discharge plan, but most inmates do not receive any significant assistance in finding housing. Upon release, people will receive civilian clothing and, according to PSD rules, *may* receive a small amount of gate money (e.g., \$200). However, interviewees suggested that gate money is rarely, if ever, provided.

Interviewees reported that prior to release, inmates do not receive assistance obtaining an ID, setting up a bank account, securing public benefits, or other as-

sistance that will help them meet basic needs upon release. While many people interviewed felt that it would be helpful to provide this additional pre-release support and assistance, one interviewee felt that it would be counterproductive for at least some services, and that people are better off with a “guide” to walk them through the steps of doing what they will need to do to reintegrate into the community—tasks that they may need to repeat at a later time (e.g., obtain a bus pass, set up a bank account, etc.). A small but significant improvement to this situation is coming. During the 2017 legislative session, a bill passed that will help to ensure that inmates have access to an ID prior to exiting prison.⁸⁰

Some interviewees expressed concern that inmates housed on the mainland faced special reentry challenges because their distance would cause them to lose their local ties and relationships. However, others suggested that prisoners preferred the mainland prison, which is perceived to have better facilities, increased safety, and more programming options.

General Issues Relating to Release From Jail and Prison

A successful process of reentry back into the community after a term of incarceration starts long before the day of release. A focus on reentry and a future in the community should start as soon as a person has contact with the criminal justice system, perhaps even before (see further discussion of “criminalization of homelessness” below). People who are arrested and have to go to court or spend time in jail run the risk of losing their jobs if they do not have paid time off. During a period of incarceration, inmates provided with certain types of programming, such as substance abuse treatment, are more likely to fare better in the community and avoid recidivating than those who are not given access to such services. Prior to release, assistance with obtaining housing, employment, and other resources can increase the likelihood that after release, a person will not revert to criminal behavior to satisfy their basic needs. Post-release, continued monitoring, support, and assistance can also help to improve the likelihood of success in the community.

To best address homelessness, and reduce the impact that incarceration may have on those who are at risk of homelessness, the entire system should be examined, including:

- passage and enforcement of laws that criminalize behavior associated with homelessness, such as illegal camping;
- opportunities to divert people from the criminal justice system toward services that may, in some cases, better address the root causes of their behavior;
- processes regarding granting of bail for defendants awaiting trial;
- programming opportunities (e.g., education, substance abuse treatment, etc.) provided to inmates in jails and prisons, and opportunities for them to stay connected to community;
- pre-release discharge planning; and
- post-discharge monitoring (e.g., parole), services, and support provided to those returning to the community. Thus, this section takes a broad view of “release” processes for jails in prisons.

In addition to examining the above components of the system, multiple interviewees indicated that special attention needs to be paid to the culture of PSD, access to mental health treatment, and creation of housing options for people releasing from incarceration.

Culture

The motivations of correctional workers are a factor in the outcomes of inmates who release. According to many of those interviewed, the culture of PSD focuses more on punishment rather than rehabilitation, which may hinder efforts to address recidivism.

Mental Health Treatment

According to a number of interviewees, people may often end up in jail or prison as a result of mental health issues and stabilize during their period of incarceration when they have access to treatment and medication, only to lose such access upon release—decompensating and returning to jail or prison to repeat the cycle over and over again. In fact, according to one interviewee, when cuts are made to mental health care—across the country, not just in Hawai‘i—the state jail population with mental issues goes up significantly. This claim is supported by research that has found a strong inverse correlation between the amount of money a state spends on mental health services and the size of jail and prison populations.⁸¹

The amount of money a state spends on mental health services and the size of jail and prison populations are inversely correlated.

According to PSD officials, PSD is working on improvements in connecting inmates with health care upon release, but it is unclear what systems are currently in place to ensure these health needs are consistently addressed.

Housing Options for People Releasing From Incarceration

For inmates who do not have family to take them in after release, housing options are limited.

According to one interviewee, the Housing First program has also not been helpful for people releasing from a period of incarceration. Housing First has attained significant success in housing the chronically homeless by providing them with housing without first requiring them to attain sobriety or follow the types of rules typically required to obtain housing under the traditional homelessness services model. Once housed, providers can more easily and effectively provide the services necessary to ensure long-term stability of the individual being assisted. However, for those releasing from jail or prison, Housing First is often not a viable option because of their criminal records and because timing may be an issue—vacancies in the Housing First program are not necessarily available at the moment an individual is released, and units cannot be held open and unoccupied to await someone’s release due to cost and efficiency concerns.

In rare cases, inmates are released to homeless shelters. There is no formal process for release to homeless shelters or for working with homeless shelters to secure housing for inmates who are up for consideration of

STREET PERSPECTIVES

Street interviews identified common perceived shortcomings of release from incarceration. In general, the lack of pre-release connection to basic services and benefits was the top concern among interviewees.

“P” is part-Hawaiian and a former welder and mechanic in his forties:

Yeah, they let you out with zero. I had the clothes on my back. Everything else was still locked in the property crate. My phone, little bit [of] money I had, even the shoes I came in with. I tried to get my stuff back, but it was after 3 [p.m.], and they said the office was closed so I had to wait until the next day. I hear if they let you out on a Friday [after 3 p.m.], you got to wait 'til Monday. I walked barefoot back toward town. A bus driver let me on with my [OCCC] bracelet [proof that I'd just been released]. I tried to find someone I knew back in the area where I was camped before. But it was all different. My tent was gone. This one guy Steve I knew from before let me stay with him.

“A” worked in building trades and moved to Hawai'i 20 years ago:

*I maxed out [served full sentence and released without supervision]. Before I got out, I got no counseling. I think I got the phone number of a place in 'Aiea where I could get a bus pass and a phone. And I got the number to call to sign up for health insurance. My question is, why couldn't I at least do the paperwork for ID, health insurance, welfare, Blue Jay phone, job training, and temporary housing before release? Why couldn't I get hooked up with a case manager who I could stay in touch with after I got out? You try getting all this lined up after you're released with nothing, nowhere to go. If you got no family—my family wanted nothing to do with me—you're fu***d.*

“N” is a former leader of a local community organization in her fifties:

I violated my probation because [I tested positive for alcohol], and I got picked up. I couldn't



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“You try getting all this lined up after you're released with nothing, nowhere to go. If you got no family...you're fu***d.”

— A, BUILDING TRADE WORKER WHO MOVED TO HAWAI'I 20 YEARS AGO

make bail, but I had some money coming to me from a contract job I'd picked up. I was going to use that money to help me get off the street—first month's rent and deposit. That was my plan. But I couldn't sit in jail. I needed to get out of there. So, I used it all for bail and went back to the street.

BRIGHT SPOTS

Pu‘uhonua Program

Pu‘uhonua is a collaboration between the Waikiki Health Center, First L.A.P. (Life After Prison), the Pu‘a Foundation, the Lili‘uokalani Children’s Center, and the O‘ahu Going Home Consortium—a network of public, private, and faith-based organizations—that works with prisoners inside WCCC, Oahu Community Correctional Center, Waiawa Correctional Facility, and the Federal Detention Center. A cadre of staff has been certified to enter correctional facilities and work with inmates prior to release, providing a range of social services including connections to programs for identification, employment, health insurance, public assistance, drug treatment, and shelter. Other community-based providers operated similar programs in the past, including Kokua Kalihi Valley, which sent clinicians into the Halawa Correctional Facility to identify medical needs that would require care or transitional support after release.

Jail Diversion Program

The Jail Diversion Program is a pre-trial diversionary program for defendants with mental health diagnosis run by the state Department of Health (DOH). Program participants are supervised in the community by PSD and provided mental health treatment and case management through the DOH. Program participants who remain stable in their treatment regimen are eligible for dismissal of their charges after six months of treatment and supervision.⁸²

United Self-Help

PSD provides funding to the University of Hawai‘i Social Science Research Institute, which contracts with United Self-Help to provide reentry services to prison inmates who are both maxing out and have severe mental illness. The people it services are not necessarily homeless, but most likely are.

The project provides post-release assistance in obtaining a bus pass, ID, public benefits, bank accounts, and other services individuals may need. The project also includes a “forensic peer specialist program” in which those who have been through the criminal justice system and succeeded on the outside mentor others who are releasing from prison. Program participants can continue to receive assistance for up to a year after release. No evaluation of the program had been published at the time of writing this report, but it is believed that the program is reducing recidivism among participants (relative to those not receiving services). Between 75 and 100 people receive assistance from the program each year.

Law Enforcement Assisted Diversion (LEAD)

This community-based pre-booking or pre-arrest diversion program is geared toward low-level offenders with behavioral health issues and connects them to individualized case management services. During the 2017 legislative session, funding was appropriated for a pilot LEAD that will be implemented in the near future.

Community Courts

Similar in concept to LEAD, though further downstream in the system, the idea behind community courts is to connect defendants to services that address the underlying causes of the relatively minor offenses for which they have been charged. Hawai‘i started a new unfunded pilot Community Outreach Court in January 2017, based in District Court in downtown O‘ahu. The court aims to resolve a backlog of pending “minor” or “nuisance” cases while providing defendants with needed services.⁸³ As of May 2017, 21 defendants, accounting for a backlog of 268 cases, had appeared before the court. The court has already found housing for four homeless defendants, including finding permanent housing for one of the defendants.⁸⁴ During the 2017 legislative session, a bill was passed and funding was appropriated to expand the pilot program.⁸⁵

parole. Instead, informal relationships with one or two PSD staff and homelessness service providers dictate whether release to a shelter will be arranged. It is uncertain whether it would be beneficial to increase the availability of homeless shelters as a post-release housing option; some studies suggest that releasing to a homeless shelter increases the risk of recidivism.

Many interviewees identified creation of more housing for people as a potential solution for getting those who remain in prison solely because of a lack of residence address out of the prison system and transitioning back into the community. Therapeutic living communities (TLCs) are one example of a type of housing that may be helpful. Geared toward people with addiction issues, in addition to housing, TLCs also provide services on site. Similar to Housing First, TLCs have the potential to generate significant cost savings. For inmates who are detained in prison solely because they do not have a residence to release to, the high costs of housing an inmate in prison could be traded for the lower costs of housing a person in the community.

RECOMMENDATIONS

Near-Term Recommendations

Action items that require relatively modest investments of time and resources include the following:

1 Provide more comprehensive pre-release assistance from jail/prison. This should include providing inmates with assistance obtaining an ID, public assistance, health insurance, job placement, temporary housing (including referral to shelters and a pre-issued homeless verification letter), and referral to substance abuse treatment (and/or case management for the above). This type of work is being done in the Pu‘uhonua program, but it is being conducted on a small scale that is grossly insufficient to meet the extent of the need.

2 Provide predictability and basic necessities as part of jail/prison release process. Providing more predictable windows for release time and access to the property cage, even after hours (or releases only when the property cage is

open) can help people get on their feet after release. Providing other necessities upon release, such as a set of clean clothes, bus pass, Blue Jay cell phone, shoes or slippers, and gate money, would give people a better chance of connecting with support and securing employment and housing.

3 Provide and encourage jail/prison access for social service providers to work with inmates pre-release. Provider experiences suggest reduced recidivism would result. From increased access to social service providers. One provider who plays a leading role in the Pu‘uhonua program reports serving nearly 1,000 inmates over the course of five months. This same provider observed that recidivism seemed low, as she did not recall servicing the same inmate a second time after release.

4 Create mobile legal teams and expand community courts to bring legal services where homeless people are—on the streets and in specific neighborhoods with a high density of homeless. This work has already begun with the creation of a pilot community courts program, with funding appropriated by the 2017 legislature.⁸⁶

Long-Term Recommendations

Recommendations that may take longer to implement or require a significant investment of resources include the following:

5 Shift correctional system culture from punitive to supportive/rehabilitative. Such a cultural shift will need to be consistent and shared by leadership, as well as front-line workers.

6 Create a shared correctional systems database and improve data sharing between facilities. Including a shared corrections database could aid in the identification of formerly homeless inmates, allowing for targeted interventions, intensive support services, and more integrated efforts across correctional institutions, e.g., between youth and adult correctional facilities.

7 Further expand diversion program to keep people out of the criminal justice system. Use LEAD and community courts as

**\$3,810/MONTH
TO INCARCERATE**

VS

**\$2,220/MONTH
TO HOUSE AND
SUPPORT**

an initial test, and examine additional ways that resources devoted to prosecution and incarceration can be redirected to services that address the underlying causes of the behaviors leading to involvement with the criminal justice system.

8

Create additional housing options for releasing inmates.

To ensure stability and reduce the likelihood of a return to the criminal justice system, create additional housing options for releasing inmates. Using these housing options as an alternative to denying bail or parole carries the potential of cost savings (reduced costs of housing in the community versus in jails and prisons) and, more importantly, is more ethical and humane than keeping people confined simply because they are unable to afford housing.

The Investment: Who and How Much?

State elected officials (legislature and governor), community justice groups (e.g., the Community Alliance on Prisons), taxpayer advocacy/watchdog groups (e.g., Tax Foundation of Hawaii), and PSD may have incentives to invest in pre-release interventions and post-release programs (e.g., transitional housing) that reduce recidivism if a direct connection can be made to a reduction in overcrowding. Provider interviews suggest that it is overcrowding, and not just budget savings, that may be effective motivation for PSD/corrections participation.

Where it is possible to shift from housing people in jails and prisons to housing them in the community (e.g., where they are denied bail or parole solely due to a lack of residence), the state has the opportunity to realize significant savings. In 2014, officials estimated that it cost an average of over \$3,810 per month to incarcerate someone, including medical, food, and security expenses.⁸⁷ Compared to the \$2,220 monthly cost of the Hawai'i Pathways Project's Housing First program,



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which provides housing and wrap-around supportive services, the potentials savings are tremendous.

IV. BIG PICTURE FINDINGS AND RECOMMENDATIONS

Our research into three institutional discharge processes uncovered broader findings and recommendations that we believe are relevant to efforts to end homelessness. Some are cross-cutting themes that are touched upon in more than one of the previous sections; others are alluded to in previous sections but not addressed specifically.

FINDINGS

Homelessness is merely a symptom of an economic crisis affecting all of us.

Over the past 15 years, the gap between wages and the cost of housing has grown dramatically in Hawai'i.⁸⁸

Street interviews revealed the ways this widening gap causes homelessness. Financial stress often leads to family conflict or dissolution, strains community relationships, drives people toward drugs or alcohol as coping mechanisms, exacerbates existing mental health issues, and encourages illicit activity to boost income. People who were once able to maintain stable housing—even with a disability, an addiction, or a mental health issue—could no longer do so as the gap grew wider. Street interviews identified financial strain as a key factor that led many to become homeless.⁸⁹ And, though our interviews focused on foster care, hospitalization, and incarceration, common refrains during our interviews included, “Where is the affordable housing?” and “We just can’t afford it here anymore.” If we do not take creative steps to close the wage-price gap, the chances of ending homelessness in Hawai'i are slim.⁹⁰

What Two Local Wage Earners Can Afford vs. State Median Home Price

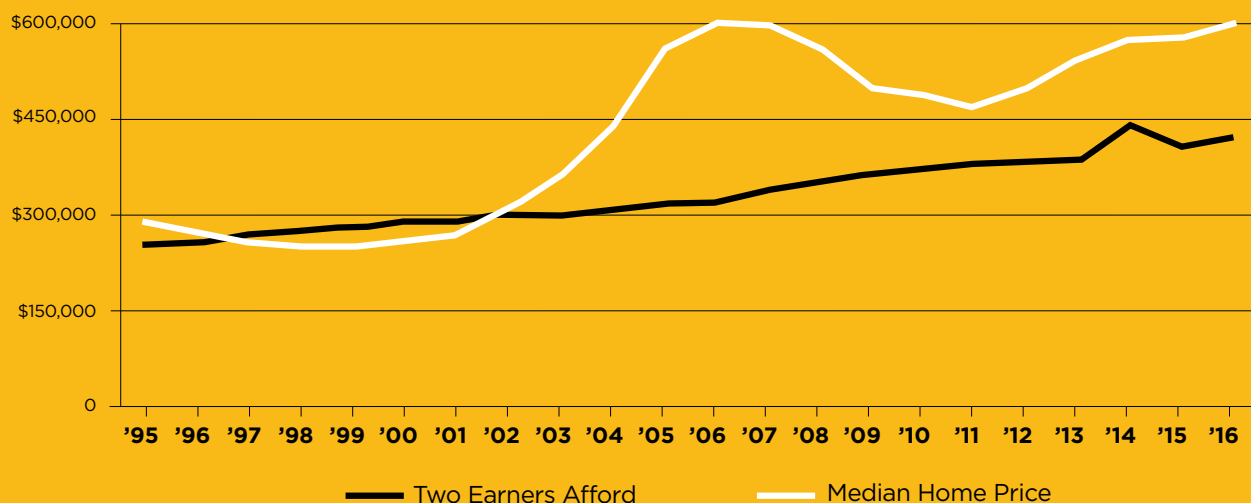




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“Compassionate disruption” on O‘ahu can be counterproductive.

On O‘ahu, government’s approach to homelessness has included “compassionate disruption.” The City and County of Honolulu has passed sidewalk “sit-lie” bans and other ordinances that criminalize aspects of living on the street and that are enforced via police citations and “sweeps” of homeless encampments. In 2017, the state legislature and governor passed a new law extending criminal trespass penalties to state-owned agricultural lands, under state highways, and around boat harbors.⁹¹

The stated intent of “compassionate disruption” is to make life on the street unpleasant enough to discourage people from becoming homeless and to encourage those who are already homeless to utilize shelters where they can secure services that will help them out of homelessness.⁹² Proponents of this approach represent a variety of perspectives and interests, including government officials, businesses, citizens, and nonprofits, including those that serve the homeless population. In carrying out this strategy, concerted efforts have been made to try to ensure that sweeps are accompa-

nied with outreach so that those that are displaced by the sweeps are given an opportunity to access services that will help to alleviate homelessness. Proponents are also concerned about the consequences of allowing encampments to proliferate. These concerns include the following:

- Impacts on tourism and businesses;
- Limiting access to parks for other residents, proliferation of garbage, etc., which may lead to an increasing lack of sympathy among the community and policies that are based on emotion rather than evidence, both of which can exacerbate homelessness; and
- Safety for those residing in the encampments, which are perceived to have higher crime rates and other dangers, from stray or unconfined dogs to other environmental conditions.

There is no doubt that in some cases, compassionate disruption has effectively connected individuals with useful or needed services, and that it has helped to address some of the concerns above. One shelter reported that it took in a third of the population of a large homeless encampment in Kaka‘ako when it was swept in the fall of 2015. It is reasonable to assume that the people

Data suggests that criminalizing and “sweeping” homeless people have not resulted in greater numbers moving into shelters.

who went to the shelter would not have done so without the intervention of the sweeps.

Despite these benefits, strong evidence points to the strategy of compassionate disruption being costly and counterproductive in many instances. Recent PIT count data suggests that shelter usage on O‘ahu has been declining. As sit-lie bans have extended into new areas and sweeps have intensified over the past five years, the number of “sheltered” homeless has gone down on O‘ahu by 15 percent, despite the fact that excess shelter capacity often exists, and that the overall homeless population has grown.⁹³

The neighbor islands, where “compassionate disruption” is not the norm, have had greater success at moving people into shelters. PIT count data shows that “sheltered” homelessness there has increased by 20 percent, while sheltered numbers on O‘ahu fell (though both saw overall growth in homelessness). Neighbor island providers noted there are parks and public spaces that are “accepted areas” for homeless people to congregate, making outreach easier.⁹⁴ Others pointed to a collaborative environment among agencies, which contrasted with their perception of O‘ahu as having “cut-throat” competition. One neighbor island interviewee also posited, “It may be harder for decision-makers and executives to connect with the front line and people served on O‘ahu,”⁹⁵ adding, “Our agencies are small and relationships drive. Everyone’s connected.”

Sweeps are fiscally counterproductive, using taxpayer funds to move homeless from one area to another, often without addressing the problem. Continuous and aggressive sweeps eventually push some people into re-

mote areas, diminishing providers’ ability to count “unsheltered” homeless accurately and provide them with services. As people are pushed further into isolation and marginalization, their physical and mental health can decline, addictions can deepen, and harmful or violent behaviors can increase.

Street interviews also revealed how sweeps of well-organized camps can be counterproductive, disrupting the relationships and safety that are building blocks for a better life. In at least one organized camp we visited, Pu‘uhonua O Wai‘anae, people trusted each other enough to leave their tents regularly to engage in productive activities like connecting with family, going to work, getting preventive or follow-up health care, and sending their children to school. The camp community helped look after keiki, the elderly, and other vulnerable people. Camp leaders enforced rules about cleanliness and safety, and they served as liaisons with law enforcement and service providers. We heard reports of similarly functioning homeless communities in Waimanalo and in sections of the Kaka‘ako camp before it was swept in the fall of 2015. When organized communities are swept, these building blocks are destroyed and are difficult to rebuild.

Many homeless people will avoid emergency shelters, even after a sweep.

Emergency shelters are often presented as a first step toward permanent housing, but many people we spoke to on O‘ahu streets viewed this as an empty promise. Shelters have time limits of a few weeks or months, and the shortage of permanent, affordable units means that in reality, many clients will either reach the time limit or be discharged for violating rules and find themselves homeless again. Most people interviewed on O‘ahu had been through a shelter at least once and now avoid going back, even after a sweep.

Often, entering a shelter means giving up the support network you may have built on the street—the people you trust to look after you and your belongings. Due to shelter privacy rules, it can be hard to keep in touch with people outside. There is no telling where your friends will be when you exit, especially if sweeps have occurred in the meantime. Similarly, if you have a pet that served as a guardian and friend, it must be left behind, as most shelters do not accept animals. When you exit a shelter and reenter street life, you may have none of the relationships that previously kept you safe.⁹⁶

Instead of relying on friends you trust, interviewees said entering a shelter means putting your fate in the hands of strangers who work within the shelter system. Several homeless individuals in urban Honolulu reported negative experiences with shelter staff or outreach workers. The reports ranged from demeaning treatment by staff to workers who played favorites by selectively enforcing rules or charging extra nightly fees for some clients (many shelters charge a standard nightly fee for all clients).⁹⁷

It's important to emphasize that these reports did not apply to all shelters. Indeed, some shelters received positive reviews, and one person we spoke to did get permanent housing through the work of the shelter he entered.⁹⁸ And we recognize that, because the experiences of individuals who have transitioned from shelters to permanent housing are by definition largely absent from street interviews, our understanding of their motivations is limited. These caveats notwithstanding, a clear theme emerged from the homeless people we spoke to: negative stories about particular facilities spread quickly on the street, eroding faith in shelters generally as a step toward a better life and preventing many from entering or reentering the shelter system.

Criminalizing homeless-related behaviors deepens homelessness and poverty.

Beyond the sit-lie ordinances central to compassionate disruption on O'ahu, homeless people are also frequently cited for offenses such as criminal trespass, illegal camping, smoking in public parks, carrying non-factory-sealed alcohol containers, and youth status offenses like truancy. From 2015 to 2016, citations for sit-lie violations increased 33 percent and arrests doubled, according to Honolulu Star-Advertiser reports. The available data suggests that homeless individuals on O'ahu are repeatedly cited for homeless-related offenses, making it questionable as to whether they are having the desired deterrent effect. For example, in a 261-day period starting in June 2016, over 5,300 new court cases were opened in the state for sit-lie, illegal camping, park closure, park rules, and shopping cart violations. Of the people who had cases opened against them, during that 261-day period:

- around 25 percent had more than one case opened against them;

- more than five percent of people had five or more cases opened against them;
- at least 12 people had more than 20 cases opened against them; and
- one person had 77 cases opened—an average of one new case every 3.4 days.

Unable or unwilling to leave their tent behind, people with opened cases often miss their court dates, which can result in bench warrants, arrests, and jail time. Furthermore, assessing fines that most cannot pay puts the hope of a stable life further out of reach. Finally, the sheer volume of these cases undoubtedly places severe burdens on the courts and criminal justice system—resources that could be more effectively spent elsewhere.

Current conditions make it difficult to build the trusting relationships required for success.

The effectiveness of homeless services depends heavily upon the ability of service providers on the front line to build trusting relationships with the people they serve. Yet, current conditions—including the lack of permanent housing—are not conducive to such trust-building. One provider with front-line experience described it as “operating with your hands tied.” Another described it as being “trapped in a bubble of things you cannot change...advocating for clients, trying to motivate [them], representing that you can take them somewhere and then being unable to deliver. That erodes trust. What ends up happening is they stay where they are [and] develop their own support system on the street.”⁹⁹

People working in homeless-serving organizations are often overworked, underpaid, and have limited opportunities for professional development. Decades-old cuts to human services and mental health funding have left many demoralized. Workers may be under financial strain themselves, and they can experience vicarious trauma through their clients. Many are frustrated, discouraged, or burnt out. When a frustrated worker with their “hands tied” meets a homeless person who is suspicious, traumatized, and in crisis, the interaction can do more harm than good, convincing a homeless person that providers are unable or unwilling to help, and preventing the person from seeking services in the future.¹⁰⁰



Photo © Tony Hisgett/Creative Commons

Many services operate under the false assumption that “if we build it, they will come.”

For the most part, services available to homeless individuals require them to leave their tent or camp, travel to the point of service, and remain there for extended periods of time. Our homeless-serving institutions—from emergency shelters and housing assistance to court houses and public benefits processing centers—operate under the assumption that the homeless can and will seek out help and endure time-consuming processes if their need is great enough. This may have been a safe assumption 20 years ago, when most homeless were isolated individuals on the street with no possessions or support networks. Today, many homeless people have moved all of their household possessions into their tents, including vital records, IDs, treasured personal items, and/or medications. Safeguarding these items often means missing a doctor’s visit, court date, welfare eligibility hearing, or meeting with a probation officer. And, with so many on the street, support networks have developed that are often a preferred alternative to agency-based sources of help.¹⁰¹

RECOMMENDATIONS

1

If camps or groups can meet certain criteria, designate them as partner sites or community partners.

If we acknowledge “compassionate disruption” can be counterproductive in some cases, and that many homeless people are actively avoiding emergency shelters, then we must consider investments in alternatives. Some of the self-organized, self-governing encampments offer one possibility. As noted above, communities like Pu‘uhonua O Wai‘anae have leadership, rules, and stability that improve the lives of people who live there. If homeless people form a community that can meet certain standards, then allowing them to stay in place and taking services to them may offer a more promising path forward than sweeping people and hoping they enter shelters.

2

Use feedback and ideas from homeless individuals to inform solutions.

It makes little sense to invest in solutions to homelessness without consulting with homeless people themselves. Whether building a new emergency shelter or rolling out a new social services program, feedback from homeless individuals can help ensure that programs are more effective and resources are spent more efficiently. We can take simple steps to gather feedback on proposals from homeless individuals, such as by adding a question to intake forms or asking for opinions about current policy proposals during outreach. If safe zones like Pu‘uhonua exist, and as leaders emerge there, we can begin to engage them as representatives in formal decision-making processes.

3

Redesign services to meet people where they are.

We must abandon the assumption that hardship and isolation will drive homeless people toward services. Instead, we must take services out to meet homeless

people where they are to the maximum feasible extent. ID replacement, public assistance benefits processing, sub-clinical health care, substance abuse and mental health counseling, education and training—all of these are services that would reach more people and be more effective if they could be made mobile, e.g., via vans equipped for health services, computer access, or pop-up, drop-in centers.

4

Build the capacity of homelessness service providers to make relationships the top priority.

We must build the capacity of all of our homeless-serving people and agencies to approach the work with durable patience and compassion. We should consider increasing pay and respite (vacation, paid sabbaticals) for front-line homeless services staff and including “customer satisfaction” measures as part of evaluation systems for individuals and organizations. We can form supportive “communities of practice” for front-line workers within and among agencies; recognize and reward staff (e.g., with bonuses) who have empathy and high rates of customer satisfaction, despite challenging conditions; and give outstanding staff the opportunity to train others. We must review each of the rules governing interactions between service providers and clients, and make every effort to build in flexibility and a long-term view of outcomes, recognizing that trust- and relationship-building are crucial elements of success that do not conform to artificial timelines.

5

End policies that criminalize poverty and addiction. They only deepen homelessness.

We must put an end to the criminalization of homelessness-related behaviors. Criminal trespass, smoking or drinking in public parks, youth status offenses—these types of offenses, if committed by a homeless person, should be diverted to case management, as described in LEAD recommendations earlier in this report. The requirement of bail for low-level offenses should also be eliminated, as it prolongs incarceration for those who cannot afford it and creates an incentive for an impoverished individual to spend everything they have in order to get out of jail.

6

Relax building rules to allow for affordable tiny homes as permanent housing for homeless.

We must aggressively pursue waivers of zoning and permitting rules that prevent us from building truly affordable homes that have a smaller footprint and are built with more affordable materials and labor. We should explore building tiny homes on un- or under-used land, streamline permitting for accessory dwelling units, and legalize alternative “shelter” structures made with materials like bamboo, wood pallets, and recycled materials, as many other cities have across the country. We should reexamine requirements for minimum lot size, minimum covered square footage, and minimum parking requirements that drive up the cost of homes.

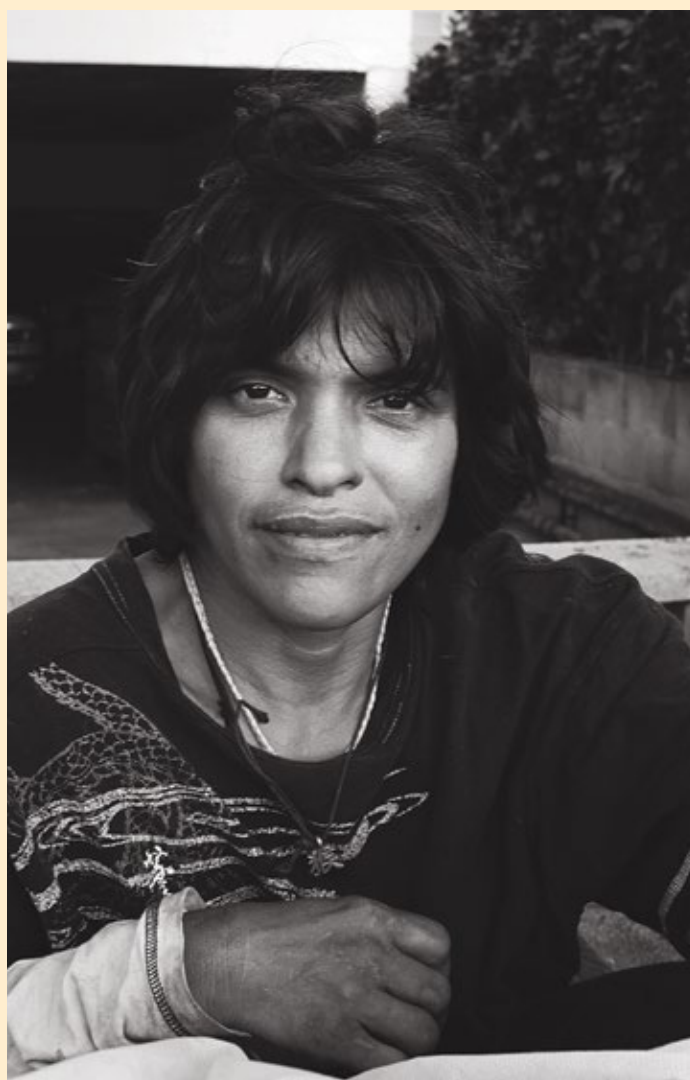


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7

Consider restrictions aimed at protecting local housing supply for Hawai'i residents who need it.

If we are to dramatically expand the definition of housing in order to create a wider menu of affordable options, we must also consider steps to curb excessive demand that drives prices up. We might consider, for instance, far steeper taxes on vacant second homes and vacation homes and steep taxes on purchases by out-of-state buyers—under the rationale that, during a housing crisis, owning more than you need should cost more, as we cannot afford to leave homes underutilized.

8

Integrate data systems on homelessness to enable local analysis of costs and benefits.

Consistent identification of homeless individuals as homeless when they utilize hospitals, interact with the criminal justice system (courts, public defenders, jails, prisons), or are former foster youth would allow for local cost estimates. Such cost estimates could then be compared to the cost of preventive interventions, like those recommended above (law enforcement assisted diversion, extended foster care, medical respite housing, and building affordable tiny homes, as a few examples). This type of data, and the analysis it enables, is essential to building the understanding and political will to invest in proven, preventive solutions that have the potential to reduce or eliminate homelessness in Hawai'i.

9

Reframe homelessness as the most severe symptom of an economic crisis affecting us all.

As a community, we must confront the direct relationship between homelessness and the growing gap between housing costs and what local wages can afford. We must also acknowledge that many of the social ills we think of as “causing” homelessness (addiction, crime, mental health issues) are, in fact, byproducts of or exacerbated by the wage-price gap. Along with tracking the number of homeless, we

should track the gap between housing costs and what average wages can afford, making that graph a key indicator of the challenge and our progress over time.

Those of us who work with homeless people must do a better job of listening for the stories of how people become homeless and retelling these stories to illustrate the humanity and diversity of people experiencing homelessness. We should also be attentive to the needs and stories of people who are struggling to make ends meet today, shedding the shame of poverty and struggle and speaking frankly about the stresses of living in Hawai'i today. And finally, those of us who have experienced or are currently experiencing homelessness ourselves must have the courage to tell our own stories. Only in this way will the dividing line between homeless and housed be blurred enough so that our entire community can clearly see the economic challenge confronting us all.

V. CONCLUSION: CULTURE AND RELATIONSHIPS

One of the undercurrents we discovered in our interviews and research was the critical role of personal relationships. Certainly, social policies lay the groundwork for systemic change regarding homelessness, but these policies live and die on the ground, at the intersection of the lived experience of individuals at risk for homelessness and the various people who work to navigate them in and among the foster care, public safety, and medical care systems and through the broad array of housing, homeless, and human service agencies. Personal relationships anchor individuals in bureaucracies that can be fraught with indifference. Those relationships can ultimately determine whether homeless persons receive the care, support, and services they need, and prevent them from becoming unmoored in a sea of bureaucratic machinery.

This should come as little surprise, however, when those of us who are housed consider our own lives and the role that relationships play in identifying mentors, finding a job, or locating housing. We rely on those whom we trust—the fundamental component of relationships—when we find ourselves in need of help. Likewise, we encountered numerous examples of homeless individuals being successfully connected to housing or services through the efforts of someone they knew and trusted—a persistent street worker, a caring discharge nurse, a dedicated youth mentor.

What would it take to create systems in which relationships, rather than processes, were at the core of organizations' efforts to address homelessness? In our experience, organizations that cultivate an ethos of compassion—not simply in name, but in action—achieve far greater success establishing the requisite trust to foster relationships. These relationships in turn create conditions under which homeless individuals are more receptive to services, more open to follow-up care, more willing to break adverse behavioral cycles—in short, more willing to take a leap of faith to improve their lives. On the other hand, when organizations seek

What would it take to create systems in which relationships, rather than processes, were at the core of efforts to address homelessness?

punitive approaches to “correct” the perceived moral failings of homeless individuals, we often observe little more than revolving-door interactions with those institutions at tremendous financial and societal costs.

We have, at both personal and institutional levels, the capacity to treat homeless individuals with care and compassion, and doing so is in keeping with our community values. In Hawai‘i, we often speak of viewing our neighbors and community members as part of our ‘ohana, our family, and of sharing our aloha, our love and compassion, with others. These values are integral to our community identity, and yet we are often unwilling to extend these concepts to the most vulnerable among us. Creating institutions and systems that truly recognize homeless individuals as part of our extended family—who are as deserving of compassionate care and support as our own parents, children, and siblings are—is fundamental to aligning our actions with our community values.

GLOSSARY OF KEY TERMS

Affordable housing: Housing, either ownership or rental, for which a household will pay no more than 30 percent of its gross annual income.¹⁰²

Case management: The process of arranging for provision of an array of services and supports for an individual or family that is based on assessment of their unique needs and designed to address the specific identified needs.¹⁰³

Chronically homeless: Federally defined as “either (1) an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR (2) an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.”¹⁰⁴

Continuum of Care: Organization of service providers established by the U.S. Department of Housing and Urban Development to oversee community planning around homelessness. Continuum work together to define needs, plan strategies, and prioritize funding for supportive housing services.¹⁰⁵

Dual diagnosis: A term describing someone experiencing a mental illness and a substance abuse problem simultaneously.¹⁰⁶

Emergency housing: Temporary housing provided on an emergency basis. Stays at emergency shelters are limited in time, and the amount of time varies among shelters. For some programs, emergency shelters are the first step in a series of steps as homeless adults and youth move from emergency to transitional to permanent housing.¹⁰⁷

Homeless: Federally defined as “a person sleeping in a place not meant for human habitation (e.g. living on the streets) OR living in a homeless emergency shelter.”¹⁰⁸

Homeless Management Information System (HMIS): A community-wide database that is congressionally mandated for all programs funded through the U.S. Department of Housing and Urban Development homeless assistance grants. The system collects demographic data on consumers as well as information on service needs and usage.¹⁰⁹

Homeless sweep: See “Sweep.”

Housing first: A term that has come to mean providing a chronically homeless person with direct and immediate access to housing. It reverses the traditional concept of “treatment first and then housing” to “housing first and then appropriate treatment.” Housing first is a consumer-driven model. It is producing successful outcomes for keeping people from returning to the streets.¹¹⁰

Medical respite: Medical respite care is acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets but not ill enough to stay in a hospital; it is usually delivered as short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services.¹¹¹

Permanent supportive housing: A housing approach that integrates permanent, affordable rental housing with wraparound supportive services needed to help people who are homeless and/or have serious and long-term disabilities (such as mental illness, developmental disabilities, physical disabilities, substance abuse disorders, and chronic health conditions) access and maintain stable housing in the community.¹¹²

Rapid re-housing: A housing approach that focuses on moving individuals and families who are homeless into appropriate housing as quickly as possible.¹¹³

Reentry housing: Transitional and supportive housing options for people coming out of prison and jail.¹¹⁴

Scattered site housing: A model of supportive housing in which dwellings are identified and secured in buildings across a neighborhood or community,¹¹⁵ allowing for the integration of supportive housing while maximizing available housing stock to achieve a range of housing types and unit sizes.¹¹⁶

Supportive housing: Subsidized housing directly tied to specific supportive services for homeless individuals or families who have come from emergency shelters or the streets. Supportive housing may be categorized as transitional (people may stay for up to two years) or permanent (no limit on the length of stay and clients abide by a lease).¹¹⁷

Sweep: Forced disbanding of a homeless encampment and the removal of both homeless individuals and their property from that area.¹¹⁸

Transitional housing: Housing that is more stable than emergency housing and that can be for a longer period of time, such as one to two years. Once homeless youth and adults have been stabilized in emergency housing, they may move to transitional housing as a next step.¹¹⁹

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