HOMELESSNESS IN PORTLAND:

A Meta-analysis and Recommendations for Success

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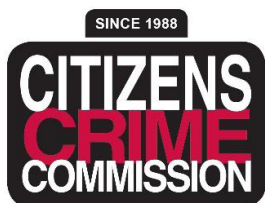
SINCE 1988

CITIZENS CRIME COMMISSION

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ACKNOWLEDGEMENTS

Portland has the fourth highest per capita rate of homelessness in the United States. Our homelessness crisis affects all of us, at work and at home, in the downtown core and throughout the 95 neighborhoods of our city. Listening in to conversations at any of Portland's ubiquitous bistros, the topic of homelessness arises continuously. Everyone has a story. Indeed, though Portland faces any number of issues, homelessness crowds out the other issues to the point where it often feels like it is the only issue we face as a community.

- At the time of the most recent Point-in-Time count (2/17/18), there were 4,177 unhoused individuals in Portland, of whom nearly 2,000 were unsheltered. It is widely acknowledged that this is a significant undercount.
- In 2017, police arrested 10,229 homeless people, 52% of all arrests.
- The Joint Office of Homeless Services will spend more than $71 million in FY 2019.

Finding No. 1: Portland's homelessness crisis is the predictable result of fifty years of policy on housing, economics and crime, and of decisions on how and where we treat our mentally ill. It is not the fault of local government. The crisis of homelessness is our community's crisis and not the crisis of the Mayor's Office or the Joint Office of Homeless Services.

Recommendation No. 1: Government agencies addressing the complex issue of homelessness in our community should embrace input gracefully and with an open mind.

Finding No. 2: The City and the County, through the Joint Office of Homeless Services, largely follow best practice in their efforts to address homelessness in our community. They focus on prevention, shelter-bed creation, and development of permanent supportive housing.

Recommendation No. 2: The City and County, through the Joint Office, should continue their programmatic focus on homelessness prevention through housing retention, additional shelter resources and growing the stock of permanent supportive housing, the most cost-effective solution to housing the chronically homeless. The City of Portland should instruct the Parks Department to ***immediately*** open park bathrooms 24/7/365.

Finding No. 3: Much of the public's criticism of government efforts to address the crisis arises within a vacuum of information. The current communications strategy leaves the public uninformed, creating conditions that are ripe for rumors and finger-pointing.

Recommendation No. 3: A more robust data- and outcomes-rich communications strategy is needed to keep us informed, to encourage engagement and to track progress.

Finding No. 4: The Joint Office has recently seen significant improvements to outcomes reporting. Comparative outcomes data reflecting program and system efficacy is essential to ensuring progress and maintaining public confidence.

Recommendation No. 4: Maintain and enhance existing efforts to capture, analyze and report data. Contract with the recently formed Portland State University Homelessness Research & Action Center to assess current outcomes measures and "own" an ongoing, transparent data set for use in establishing cost-effectiveness. Quarterly progress reports should be published widely.

Finding No. 5: This is our community's crisis and not simply a crisis to be shouldered by government. Through our support for two separate bond initiatives and through the Joint Office of Homeless Services, we, the citizens of our community, have committed to spending as much as $2 billion or even more over the next ten years to provide long-term solutions to our broader housing shortage for low- and no-income individuals. More could be done by

businesses, faith entities, foundations and individuals to address our crisis in the near-term as our government implements long-term strategies to address the crisis.

Recommendation No. 5: Businesses, foundations, faith congregations and individuals interested in improving the quality of life for all Portlanders should invest in addressing conditions on the street today while long-term solutions are developed and implemented.

Finding No. 6: Organized villages of the homeless have proven to be a cost-effective interim solution to the crisis of homelessness in our community with numerous benefits including, but not limited to, reduced crime.

Recommendation No. 6: Encourage the expansion of the houseless village concept as a largely private sector and faith community endeavor. Fees should be waived, permits should be fast-tracked, and public utilities should be provided. For its part, government should engage the neighborhoods, including businesses, churches and not-for-profit organizations, to make land and funding available for the houseless.

Finding No. 7: Expenditures on behavioral health – mental health and substance abuse – remain miserly. This has resulted in a system, however well-intentioned, with nowhere near the resources to address current demand and woefully inadequate to meet the need for services to individuals living in the projected 2,000 new permanent supportive housing units currently in the public pipeline. Permanent Supportive Housing (PSH) has been shown, repeatedly, to be the most cost-effective solution for the chronically homeless. Other states, including Washington Arizona and Hawaii, have pursued Medicaid waivers to allow Medicaid to support PSH.

Recommendation No. 7: Housing is healthcare. The Oregon Health Authority (OHA), through CCO 2.0, must make significant investments into behavioral health. OHA should pursue a Medicaid waiver to support PSH.

Our community will not resolve the homelessness crisis overnight. But we can resolve this crisis: through careful investments and a realignment of resources; through best practice; with transparency and humility; and above all through a willingness to recognize the humanity of the other.

FINDING #1:

Portland's homelessness crisis is the predictable result of fifty years of policy on housing, economics and crime, and of decisions on how and where we treat our mentally ill. It is not the fault of local government. The crisis of homelessness is our community's crisis and not the crisis of the Mayor's Office or the Joint Office of Homeless Services.

DEINSTITUTIONALIZATION

America's historic response to extreme poverty and mental illness has been to lock the problem up: in jails and prisons, so-called lunatic asylums, and poor [alms] houses:

> *Custodial institutions emerged and evolved to meet the demands of society (prisons, asylums and almshouses) emerged and grew together as part of a response to the social problems (crime, insanity and poverty) brought by industrialization and urbanization… The institutional solution played an important role in restoring social norms and cohesion by casting our marginalized groups and confirming the goodness of mainstream society.[1]*

Between 1880 and 1920, the population living in poor houses plummeted, while the number of patients in asylums grew from 40,000 to some 263,000 in 1923[2]. It continued to rise until the mid-1950s when the number of individuals residing in state psychiatric hospitals peaked at nearly 560,000[3]. During this time, important societal perceptions and subsequent policy changes altered the landscape in our nation leading to dramatic shifts in how society addressed these issues. In 1950, thorazine (chlorpromazine), the world's first anti-psychotic drug, was discovered and approved for use in patients with schizophrenia. During this period, journalistic exposure to the horrendous conditions under which the hundreds of thousands of individuals in state psychiatric hospitals were living, and in response to the promise of being able to treat people with mental illness, President John F. Kennedy signed into law the 1963 Community Mental Health Act which called for the construction of community mental health centers that would allow for the release into the community of patients who had been "warehoused" in public psychiatric hospitals. The Act provided funding for four and a half years, at which time states were expected to pick up the cost of caring for these individuals. But adequate state funding never fully materialized. As a result, individuals were increasingly deinstitutionalized onto the streets, initiating the homelessness crisis that has been a visible feature of our urban landscape since the late 1970s.

By 1994, the number of people living in state psychiatric hospitals had fallen to 71,619, 18% of the peak population. [4] The number of such individuals has continued to fall such that by 2015, that number was estimated to be 35,000[5], which, given population growth, represents roughly 5% of the 1955 peak population. Here in Oregon, there were 4,886 patients in public psychiatric hospitals in 1955.[6] With population growth, the equivalent number in

1   Kim, Dae Young. Psychiatric Deinstitutionalization and Prison Growth: A Critical Literature Review and Its Implications. Criminal Justice Policy Review. 2016, Vol. 27, page 4.

2   Ibid, page. 5.

3   Torrey, Fuller, M.D. Out of the Shadows: Confronting America's Mental Illness Crisis. New York: John Wiley & Sons, 1997.

4   Frontline, Deinstitutionalization: A Psychiatric Titanic. https://www.pbs.org/wgbh/pages/frontline/shows/asylums/special/excerpt.html

5   Swanson, Ana. A Shocking Number of Mentally Ill Americans End Up in Prison Instead of Treatment. Washington Post, 4/30/2015.

6   Frontline. Desinstitutionalization: A Psychiatric Titanic

2014 would have been 11,666.

While the decline in the number of patients in Oregon has not been as dramatic as it has been nationally, *Oregon State Hospital and Blue Mountain Recovery Center cared for only 1,386 people in 2014, roughly 10% of the 1955 per capita rate.*[7]
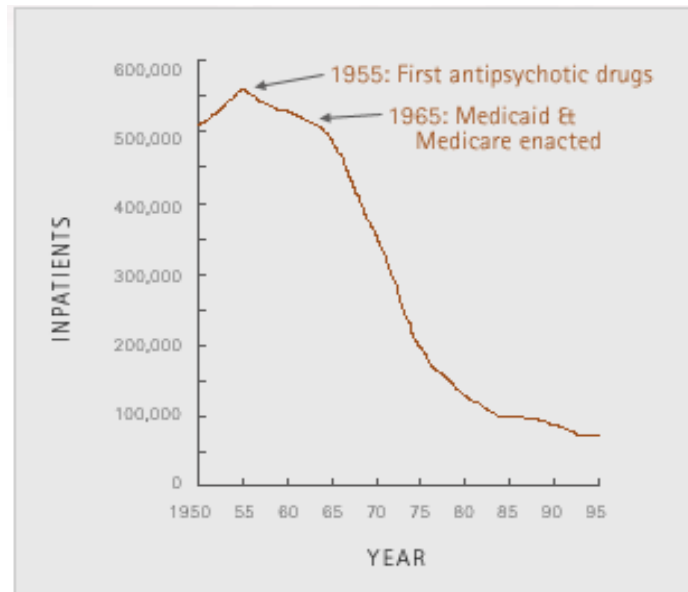
U.S. Psychiatric Hospital Population, 1950-1995[8]

INCARCERATION

Nearly simultaneous with deinstitutionalization, in 1971, President Nixon declared a war on drugs that led to a rapid rise in the U.S. prison population. The consequences of the War on Drugs have been undeniable in terms of lives ruined and treasure lost: more than 5% of all Americans have spent time in prison, including more than 16% of all African-Americans and nearly 10% of Hispanics. Between 1971 and 2010, more than $1 trillion was spent on the War on Drugs.[9]

In 1971, the rate of imprisonment in the United States was 161 per 100,000. Then it began a steady rise, peaking in 2007 at 767 per 100,000, the highest incarceration rate in the world.[10] As of 2016, there were approximately 1.5 million Americans in state and federal prisons across the country, up from approximately 200,000 in 1971.[11] In addition to prisons, jails hold an additional 1,000,000 Americans. Oregon's 2017 incarceration rate of 355 per 100,000 is roughly half the national rate.[12]

7   Saxton, Lynne, et al. Addictions and Health: Oregon State Hospital 2015-17 Governor's Budget. 3/23/2015.
8   Frontline, Deinstitutionalization.
9   Branson, Richard. War on Drugs a Trillion-Dollar Failure. CNN, 12/7/2012.
10   National Research Council. The Growth of Incarcertation in the United States: Exploring Causes and Consequences. Washington, DC: The National Academies Press, 2014.
11   The Sentencing Project. Trends in U.S. Corrections.
12   Whitworth, Whitney. Report: Oregon Incarceration Rate Expected to Fall 11% Over Next Decade. Statesman Journal, 10/9/2017.

U.S. State and Federal Prison Population, 1925-2016
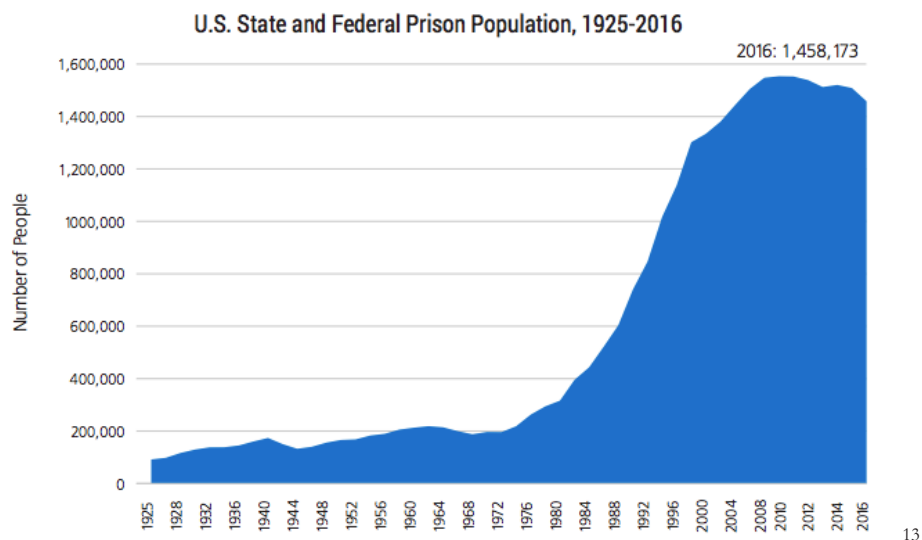
Just as the depopulation of the almshouses in the latter part of the 19th century led to a commensurate increase in the number of asylum patients, deinstitutionalization led to a statistically significant increase in the "number and percentage of prisoners with a history of mental hospitalization."[14]

The U.S. prison population is largely drawn from the most disadvantaged part of the nation's population: mostly men under age 40, disproportionately minority, and poorly educated. Prisoners often carry additional deficits of drug and alcohol addictions, mental and physical illnesses, and lack of work preparation or experience.[15]

FOSTER CARE

Any analysis of the increase in homelessness, particularly youth homelessness, must also consider our broken foster care system. Eighty percent of state and federal prisoners have spent some time in the nation's foster care system[16]. Similarly, it is well known that **40-50% of individuals who matriculate out of the foster care system become homeless within 18 months.**[17] According to Foster Focus, the nation's only monthly magazine devoted to foster care, 50% of the homeless population has spent time in the foster care system.[18]

Moreover, while it is notoriously difficult to "rank" foster care systems, such as they exist, Oregon's foster care system typically ranks among the worst systems in the nation. One such ranking places Oregon 42nd out of 51 systems.[19] The Annie E. Casey Foundation ranked Oregon 35th of 50 states and Washington, DC for underprivileged children.[20] The 2015 Children's Bureau of the Administration for Children and Families annual report on maltreatment within state foster care systems ranked Oregon 49th of 51 systems for recurrence of maltreatment within six months of a prior episode.[21]

A failing foster care system, deinstitutionalization and re-institutionalization within the prison system have led to a situation in which millions are in need of behavioral health services. And yet, the Substance Abuse and

13   The Sentencing Project, Fact Sheet: Trends in U.S. Corrections. June, 2018.
14   Kim, Dae Young, Psychiatric Deinstitutionalization.
15   National Research Council. Growth.
16   http://www.fostercare2.org/ask-the-pros-2/
17   Ibid.
18   O'Neile, Shalita. Foster Care and Homelessness. Foster Focus. Volume 5, Issue 3.
19   Richie Bernardo, 2017's States with the Most Underprivileged Children, Wallet Hub, 8/19/2017
20   Klein, Rebecca, These States Are the Worst States for Underprivileged Children. 8/11/2014.
21   Children's Bureau of the Administration for Children and Families, Children's Maltreatment Data: Outcomes 1 & 2: Safety. https://cwoutcomes.acf.hhs.gov/cwodatasite/recurrence/index.

Mental Health Services Administration points out that,

> *"Last year alone approximately 20 million people who needed substance abuse treatment did not receive it and an estimated 10.6 million adults reported an unmet need for mental healthcare. As a result,* **the health and wellness of the individual is jeopardized and the unnecessary costs to society ripple across America's communities, schools, businesses, prisons and jails, and healthcare delivery systems."** [22]

While the advent of Obamacare and 'mental health parity' regulations are ameliorating this situation to a modest degree, society's failure to adequately meet the behavioral health needs of a significant proportion of our population contributes significantly to the crises of incarceration and homelessness.

LOW-INCOME HOUSING POLICY

Added to this mix of deinstitutionalization, the War on Drugs, and our broken foster care system has been a sharp drop in the federal commitment to low-income housing. According to a study conducted by the Center on Budget and Policy Priorities, a Washington, D.C. think tank, "since 1995, federal spending on low-income housing assistance has fallen by well over 20% both as a share of all non-defense discretionary spending and as a share of the gross domestic product."[23]

Federal Spending on Low-Income Housing Has Fallen by More than 20% as Share of Budget, GDP

Spending on Low-Income Housing as Share of Total Spending on Non-Defense, Discretionary Programs

Spending on Low-Income Housing as Share of GDP
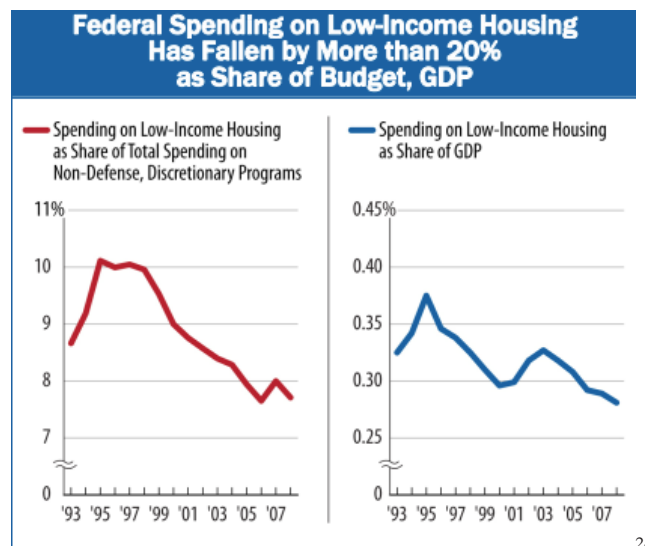
[24]

According to the National Law Center on Homelessness and Poverty, *since its peak in the early 1970s, federal spending on housing has shrunk from nearly eight percent of the budget to barely over one percent,*[25] a gap that, much like the gap in providing services for the mentally ill, has never been filled by states or localities.

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22 Substance Abuse & Mental Health Services Administration. Agency overview. Updated August 13, 2010. www.samhsa.gov/about/background.aspx Accessed January 5, 2011.

23 Sard, Barbara and Rice, Douglas. Decade of Neglect Has Weakened Low Income Housing Programs, 2/25/2009.

24 Rice, Douglas and Sand, Barbara. USA, Decade of Neglect has Weakened Federal Housing Programs. Center on Budget and Policy Priorities. 2/24/09

25 National Law Center on Homelessness and Poverty. Tent City, USA: The Growth of America's Homeless Encampments and How Communities are Responding. 2017.
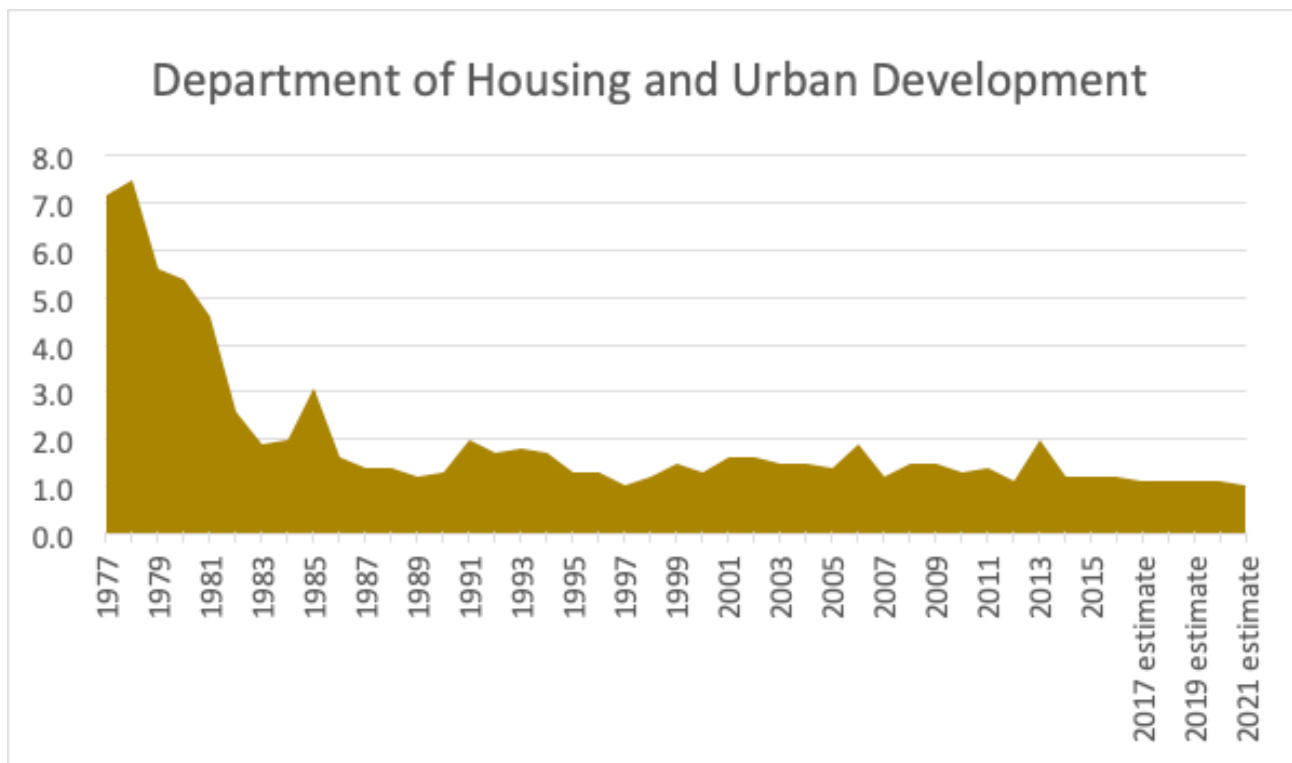
Distribution of Budget Authority by Agency: Housing and Urban Development, 1977-2021[26]

Finally, the United States continues to experience increasing urbanization, a reality that been felt most acutely in the West which has the highest urbanization rate in the United States.
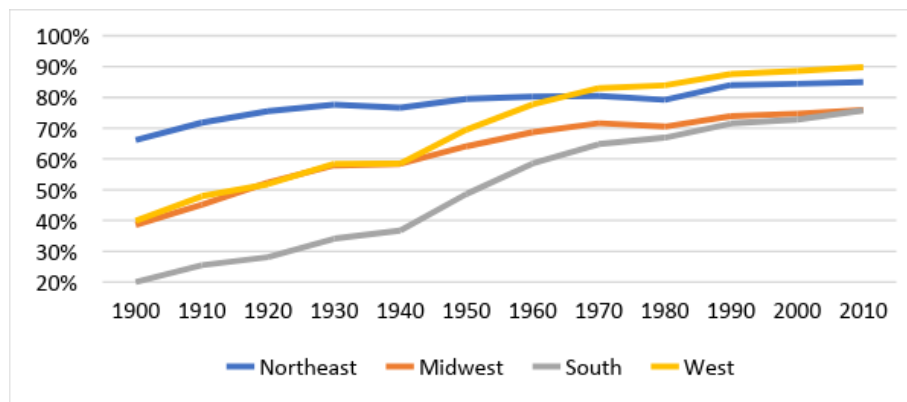
Urbanization in America by Region, 1900-2010[27]

As more people have migrated to urban centers, housing costs have skyrocketed. A recent study conducted by Zillow Realty of conditions in New York, Los Angeles, Seattle and Washington, D.C. illustrates the relationship between rising rents and homelessness.

26   U.S. Government Publishing Office, https://www.gpo.gov/fdsys/search/pagedetails.action?collectionCode=BUDGET&granuleId=BUDGET-2017-TAB-6-3&packageId=BUDGET-2017-TAB&fromBrowse=true
27   Wikipedia, Urbanization in the United States https://en.wikipedia.org/wiki/Urbanization_in_the_United_States.

The Effect of Rising Rents on Homeless Populations

How many more people will experience homelessness if rents rise 1 to 10 percent?   (Estimates are the expected increase in both the homeless counts and total populations.)

Region
Portland ▾

■ Homeless Population Count
■ Total Homeless Population
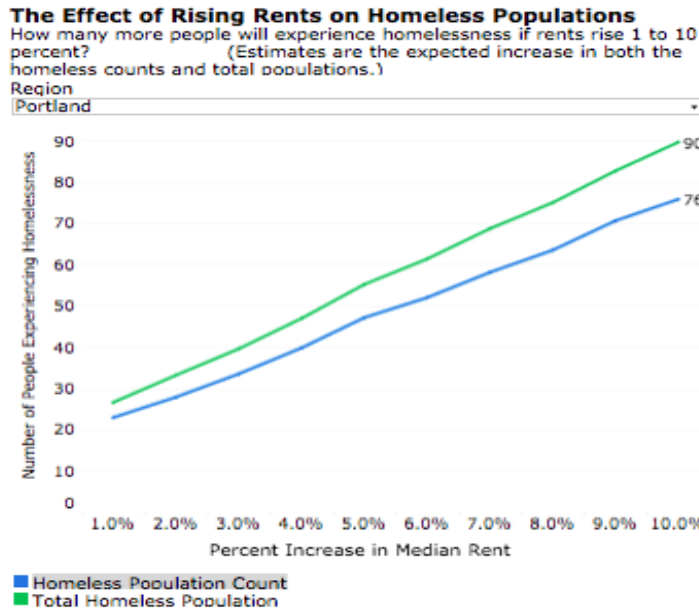
[28]

Is there a direct, causal relationship between gentrification and homelessness, or is it merely displacement? Studies in New York City characterize high levels of homelessness amid gentrification as "poverty destabilization," a ripple effect in which the poor are forced to compete with the poorest of the poor, who are subsequently forced into homelessness.

Although unstudied, this is likely true of Portland as well, which has been described as the **"most gentrified city in America,"** in which 58% of census tracts have been gentrified, more than any other major city in the country. [29]

While rents have skyrocketed, wages for the bottom quintile of Americans have stagnated, creating a perfect storm of homelessness in major cities across our nation.

Household Segment	2015 Mean Income	2016 Mean Income	YoY Change
Top 5%	$350,870	$375,088	6.9%
Top Quintile	$202,366	$213,941	5.7%
2nd Quintile	$92,031	$95,178	3.4%
Middle Quintile	$56,832	$59,149	4.1%
4th Quintile	$32,631	$34,504	5.7%
Bottom Quintile	$12,457	$12,943	3.9%
Source: Census Bureau			
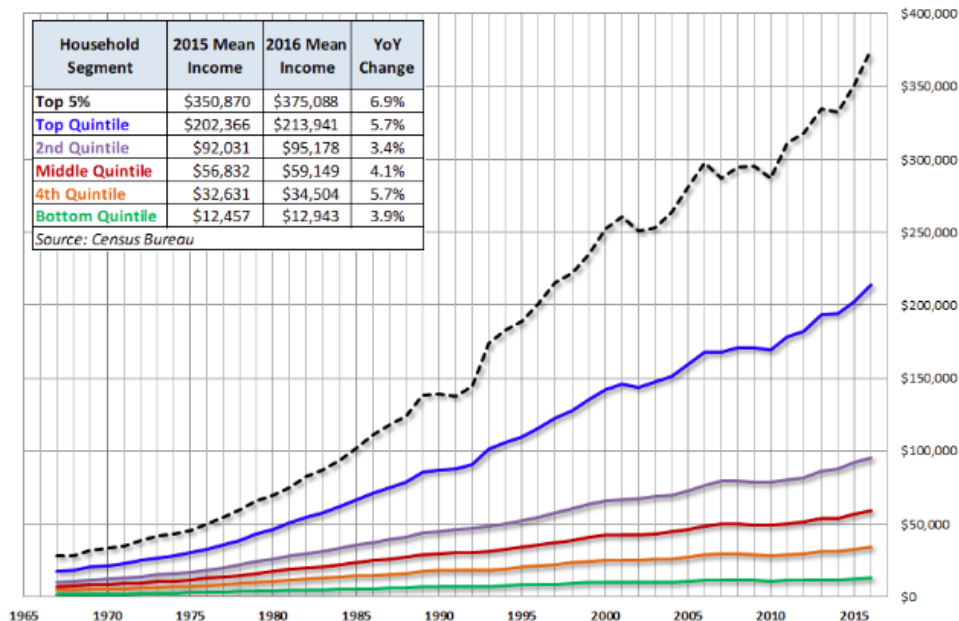
Real (Inflation-Adjusted) Average Household Income by Quintiles and Top 5 Percent[30]

28   Glynn, Chris and Atherton, Melissa. Rising Rents Mean Larger Homeless Population. Zillow Research, 8/3/17. https://www.zillow.com/research/rents-larger-homeless-population-16124/
29   Maciag, Mike. Gentrification in America Report. Governing. February, 2015.
30   Mislinkski, Jill. U.S. Household Incomes: A 50 Year Perspective. Advisor Perspective. 9/19/17.

Despite a rapidly rising minimum wage in Portland, rents have outstripped those gains as the chart below shows.
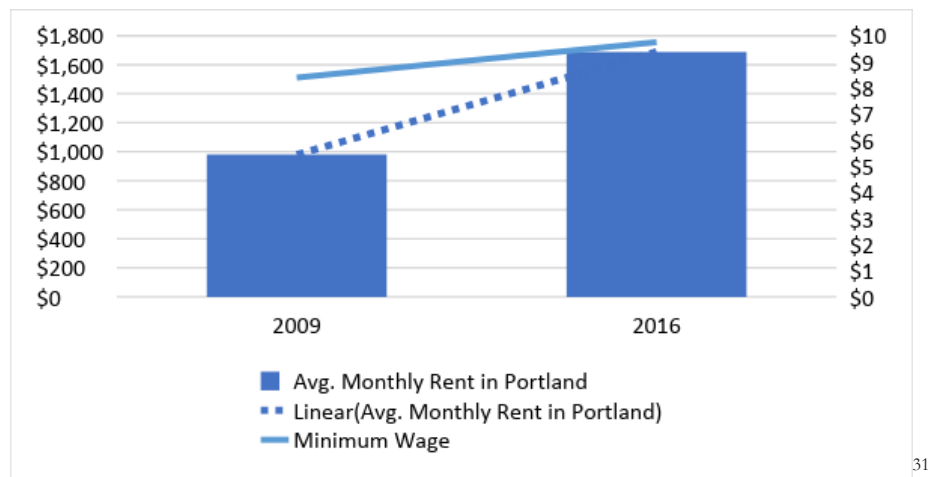
Average Monthly Rents – Portland, 2009 and 2016

Deinstitutionalization of people with mental health challenges and re-institutionalization within the criminal justice system and the withdrawal of the federal government from the low-income housing marketplace has given rise to a population vulnerable to homelessness. ECONorthwest's recent local study makes abundantly clear, however, that *mass homelessness occurs only where rising housing costs outstrip the ability of the poorest of us to afford housing.*[32] Just as there is ample "blame" to be shared, it is equally our shared responsibility, and not simply the responsibility of local government, to resolve this crisis. Again, this is **our** crisis.

R E C O M M E N D A T I O N   # 1 :

Government agencies addressing the complex issue of homelessness in our community should embrace input gracefully and with an open mind.

31   https://www.deptofnumbers.com/rent/oregon/portland/
32   EcoNorthwest. Homelessness in the Portland Region: A Review of Trends, Causes and the Outlook Ahead. 10/10/2018.

FINDING #2:

The City and the County, through the Joint Office of Homeless Services, largely follow best practice in their efforts to address homelessness in our community. They focus on prevention, shelter-bed creation, and development of permanent supportive housing.

The law, in its majestic equality, forbids rich and poor alike to sleep under bridges, to beg in the streets, and to steal their bread. ~ Anatole France

WHO ARE THE HOMELESS?

The U.S. Department of Housing and Urban Development defines the homeless as:

1. An individual who lacks a fixed, regular, and adequate nighttime residence: [or]
2. An individual who has a primary nighttime residence that is—
- a supervised or publicly operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill);
- an institution that provides a temporary residence for individuals intended to be institutionalized; or
- a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

While there is no such thing as a 'typical' homeless person, there is some truth to the notion that there are two distinct homeless populations: one population consists of those who, but for deinstitutionalization, might today live in state psychiatric hospitals or treatment facilities. These are the individuals experiencing addiction and/or mental illness who can be seen panhandling, living in tents and in doorways. These are the visibly homeless.

And then there are those who have become homeless as a result of poverty and the growing shortage of affordable rental housing. These are "economic refugees" who experience homelessness as a direct consequence of economic misfortune and/or rising rents. Again, however, to be clear, in a more affordable housing marketplace, the chronically or visibly homeless are often housed. The scale and scope of Portland's homelessness crisis is a function of a dysfunctional housing marketplace.

According to the most recent Housing and Urban Development report to Congress, nearly 9,000 out of a total Oregon state homeless population of more than 14,000 are "living "unsheltered," i.e. on the streets, in vehicles, parks or other places "not designated for humans to sleep."[33] According to that same report, homelessness has increased by nearly 13% over the past decade.[34] According to this report, *Oregon has the 4th highest rate in the nation of unsheltered, chronically homeless persons in America.*[35]

33   Jaquiss, Nigel. Oregon Has the Second Highest Rate of Unsheltered Homeless People, According to New Federal Report. Willamette Week, 12/18/2018.
34   U.S. Department of Housing and Urban Development. The 2018 Annual Homeless Assessment Report to Congress. 12/2018.
35   Ibid.

2018

Highest Rates				
HAWAII	**CALIFORNIA**	**MISSISSIPPI**	**OREGON**	**GEORGIA**
86.8%	**85.1%**	**84.3%**	**78.5%**	**76.0%**
1,529 Homeless 1,327 Unsheltered	32,668 Homeless 27,811 Unsheltered	255 Homeless 215 Unsheltered	4,013 Homeless 3,151 Unsheltered	992 Homeless 754 Unsheltered

Lowest Rates				
NORTH DAKOTA	**WYOMING**	**MAINE**	**RHODE ISLAND**	**INDIANA**
0.0%	**0.0%**	**0.5%**	**7.3%**	**11.0%**
69 Homeless 0 Unsheltered	42 Homeless 0 Unsheltered	198 Homeless 1 Unsheltered	233 Homeless 17 Unsheltered	428 Homeless 47 Unsheltered

Every two years, cities receiving funding the U.S. Department of Housing and Urban Development under its Continuum of Care (CoC) program must conduct a Point-in-Time (PIT) count. The PIT count is a count of sheltered and unsheltered homeless persons on a single night in January. The most recent Point-in-Time Survey in Portland, conducted in February of 2017, identified 4,117 individuals as homeless, a rate of 63.5 per 10,000, up 5% from the previous Point-in-Time survey conducted in January of 2015. Of these individuals, 1,688 were sleeping unsheltered; an additional 1,752 were sleeping in emergency shelter while the balance of 757 were sleeping in transitional housing.

Point-in-Time Count, 2011-2017
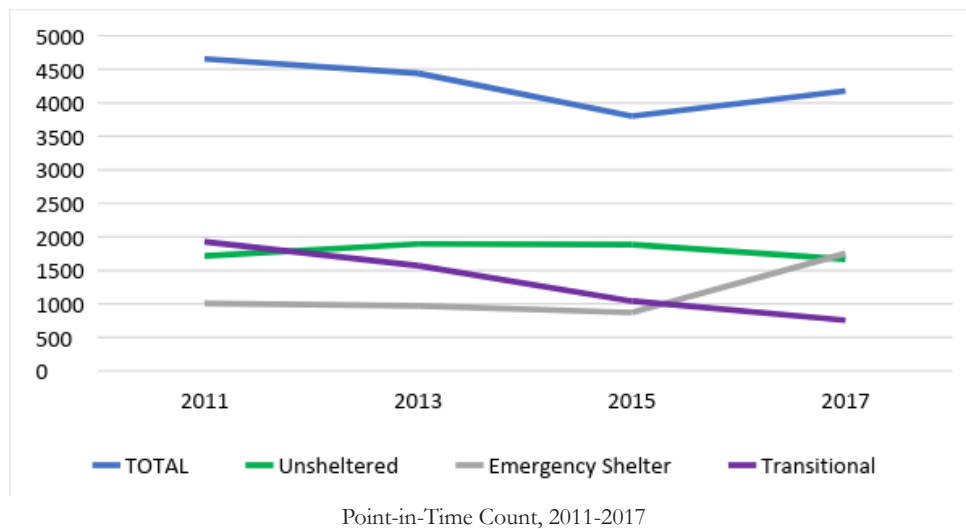
Of the 4,117 homeless individuals identified in the 2017 Point-in-Time survey, 1,290 met the definition of 'chronically homeless,' which the U.S. Department of Housing and Urban Development defines as having been homeless continuously for at least one year or on four separate occasions during the previous three years, where the combined length of time homeless on those occasions was at least 12 months, and have a disability. Of these 1,290 individuals, the vast majority (937) were unsheltered at the time of the Point-in-Time survey.

A significant majority, 2,527 (~61%) of the surveyed population, identify as having a disabling condition, defined as physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; a developmental disability; or the disease of acquired immunodeficiency syndrome (AIDS). Of the 2,527 individuals who identify as having a disabling condition, 1,195 were unsheltered on the night of the point-in-time survey, a rate of 47% vs. an overall unsheltered rate of 41% and an unsheltered rate among those without disability of 23%. In other words, *one is more than twice as likely to be unsheltered if one has a disabling condition.*
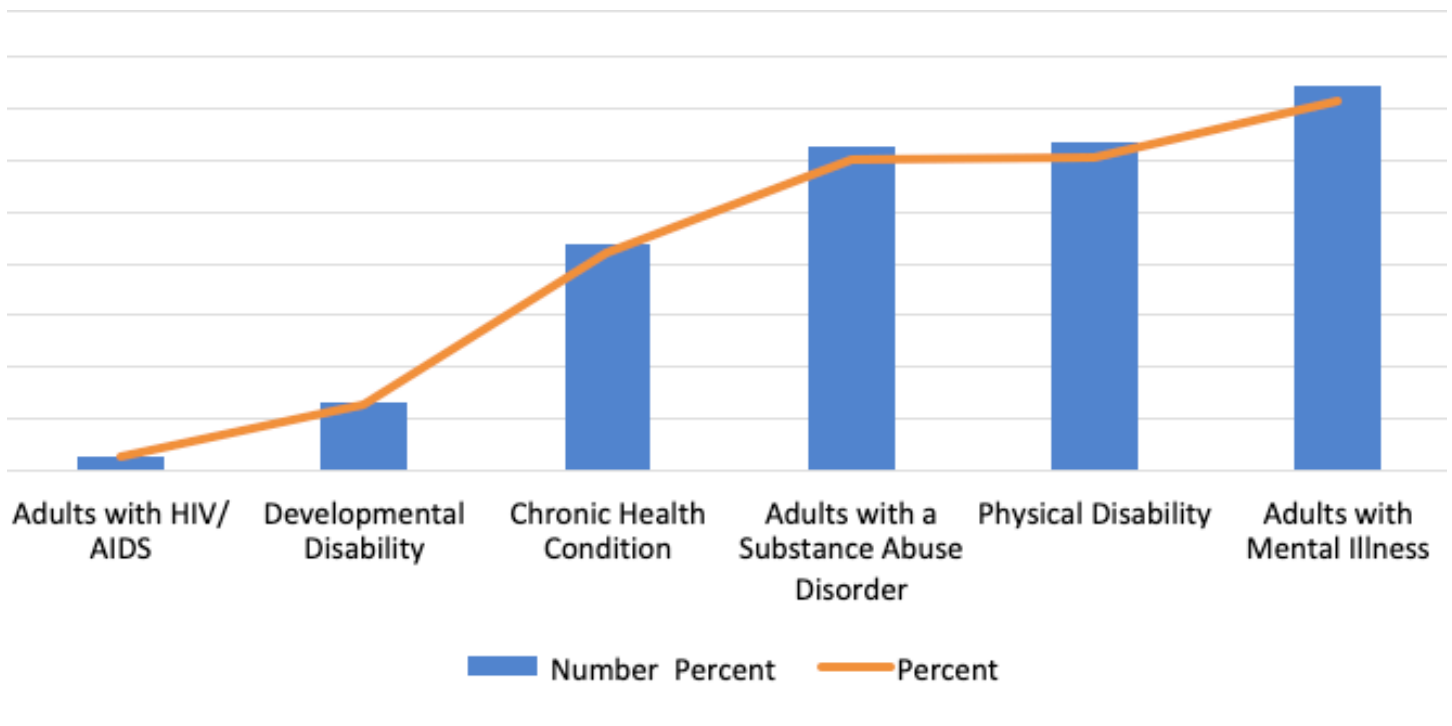
Unsheltered Adults with Disabling Condition, 2017 Point-in-Time*

*exceeds 100% as some individuals may have one or more disabling condition

Children and youth comprised nearly 17% of the homeless, the largest cohort of which were children under age 5 (156), 14 of whom were sleeping unsheltered. Despite the tremendous strides made towards addressing youth homelessness, the Point-in-Time survey identified 130 youths (under age 25) and children unsheltered and unaccompanied. Approximately half of homeless children and youth are people of color; that has been consistent over the years. However, the age of homeless youth (anyone under 25 is considered youth) has been rising over the past five to ten years: the average age of youth served by p:ear, a downtown youth drop-in center, and New Avenues for Youth, one of four providers in the homeless youth services continuum, has risen from the late teens to the early 20s while the average length of stay at the crisis center has risen from 32 nights to 44 nights.

People of color are disproportionately represented among the homeless. In particular, Native Americans are more than four times as likely to be homeless as the overall population; African Americans are more than twice as likely. Significantly, populations of color, but Native Americans in particular, and secondarily African Americans, suffer disproportionately from trauma. According to the Point-in-Time survey, *the prevalence of a disabling condition among homeless Native Americans was nearly 73%, significantly higher than in any other population.*

The popular image of the typical homeless person is male. And roughly 60% of the homeless population is male, including nearly 67% of the unsheltered population. However, certain populations, including Asians and Hawaiians/Pacific Islanders are majority female. Surprisingly, the percentage of the homeless population that identifies as transgender does not appear to be disproportionate although significant underreporting may affect the reliability of this number.

One third of homeless adults surveyed indicated that they had experienced domestic violence. Across all populations in the United States, it is estimated that one third of all women and one fourth of all men have experienced domestic violence. Significantly, 21% of the adult unsheltered population is in flight from domestic violence. Children and youth were not surveyed about domestic violence.

The homeless are increasingly elderly. According to the Point-in-Time count, 20% of the homeless are 55 and older while 43% are 45 and older. Using extrapolated data, we can estimate that roughly 80 people in the Portland metro area turn 65 each day[36], while 46% of seniors have $10,000 or less in assets[37], dependent almost entirely on social security. Without assets, and within the context of rapidly rising rents, these individuals are increasingly vulnerable to homelessness.

WHAT IS BEING DONE?

According to Mayor Ted Wheeler, at any moment in time, there are between 500 and 700 encampments across the City of Portland. [A weekly campsite report is posted on the City's website which may be found at www.portlandoregon.gov/toolkit/71771). In response to the housing crisis, in October 7, 2015, the City of Portland declared a housing emergency that:

> *"...allows the City to expedite permitting and siting for shelters and for building more affordable housing units — a both costly and time-consuming processes [sic]. The declaration allows for waiving certain procurement processes and, on a case-by-case basis, portions of the zoning and building codes.*
>
> *Additionally, the declaration gives the City the ability to closely examine existing barriers to moving people from the street into permanent housing and begin the process of making permanent code changes to increase investment in addressing homelessness after the State of Emergency is lifted." [38]*

The housing emergency led, in June 2016, to the formation of the Joint Office of Homeless Services, a collaboration between Multnomah County and the City of Portland to address the crisis of homelessness within our community. Since that time, the City and County have made significant investments in three primary housing programs described below.

Safety Off the Streets is the Joint Office name for Portland's emergency shelter program. At $17.3 million in 2018,

36   U.S. Census. American Fact Finder. https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=CF
37   Dzikes, Peter. Study: Many Americans Die with Virtually No Assets, MT News. 8/3/2012.
38   City of Portland, FAQ: State of Emergency. https://www.portlandoregon.gov/toolkit/article/563493

it is Portland's second-largest homelessness program. It provides funding for a total of 1,500 year-round emergency shelter beds, including 650 recently added beds, and an additional 400 seasonal winter beds. It also includes funding to make up for cuts in state and federal funding for domestic violence/women's shelter capacity. Shelters provide "light" counseling services to individuals, including referral, and have the capacity to do internal transfers when a higher level of care is needed. During severe weather, when certain thresholds are met, pop-up shelters become available to minimize the risk to life. Nevertheless, 79 homeless died on Portland's streets last year. The shelter system offers various other safety-net activities, including a mobile medical response team and Medical Reserve Corps that is activated during extreme weather. Janus Youth operates Harry's Mother, a shelter for youth ages 9-17. As Marc Jolin, Homeless Services Director with the Joint Office for Homeless Services, notes however: "Every dollar spent on a shelter bed is a dollar not spent on permanent housing. Every dollar not spent on homelessness prevention is another person living on the streets."

Homeless Placement and Retention – At $19.2 million, the largest program offered by the Joint Office, this program provided nearly 6,000 permanent housing placements in FY 2018 while maintaining ongoing services to existing households. More than 8,000 were served by homelessness prevention services.

Supportive Housing provided new and ongoing assistance to some 2,335 individuals in 2018 at a cost of $9.9 million. Supportive Housing targets the chronically homeless, and in particular those individuals with significant and often multiple disabilities including mental illness and substance abuse, those who have been identified earlier in this report as the visibly homeless. Unfortunately, the Joint Office does not separate out new from ongoing; nor is it possible to parse the percentage of units of permanent supportive housing provided from the 5,924 permanent housing slots created in FY 2018. Separate numbers suggest the number of supportive housing units created in FY 2018 was 162, including 35 created through new construction/acquisition and another 127 that were leased within existing units. Three hundred fifty new units should be available by 2020.

With funding from Meyer Memorial Trust, the Joint Office for Homeless Services is partnering with the Corporation for Supportive Housing and Providence's Center for Outcomes Research and Education to implement locally a system called FUSE – frequent user system engagement – to identify so-called frequent flyers, individuals with complex medical and behavioral health challenges who are the highest users of emergency rooms, jails, shelters, and other costly crisis services. In total, the Joint Office reports that approximately 3,700 units of supportive housing are currently operating in Portland/Multnomah County. Of these, 3,582 are permanent supportive housing in the Housing Inventory Count (HIC) required by the U.S. Department of Housing and Urban Development (HUD). (The remainder of the units are transitional recovery housing.) These units achieve an annual utilization rate of 91.7%, and experience approximately a 10% annual turnover rate. These permanent supportive housing units supported the following populations:
- 2,995 individuals without children.
- 587 families with children.
- 1,290 households experiencing chronic homelessness.

These three programs – Safety off the Streets, Homeless Placement and Retention and Supportive Housing - constituted 80% of the $58 million budget for the 2018 Joint Office for Homeless Services. Additional programs include administration, system support and coordination, diversion, employment and a one-time Tax Title Affordable Housing program that provided $4.7 million in funding that was restricted to youth and families with children

and included housing placement and retention services, flexible rent assistance, and the development of housing for those at 30% or less of the median family income.
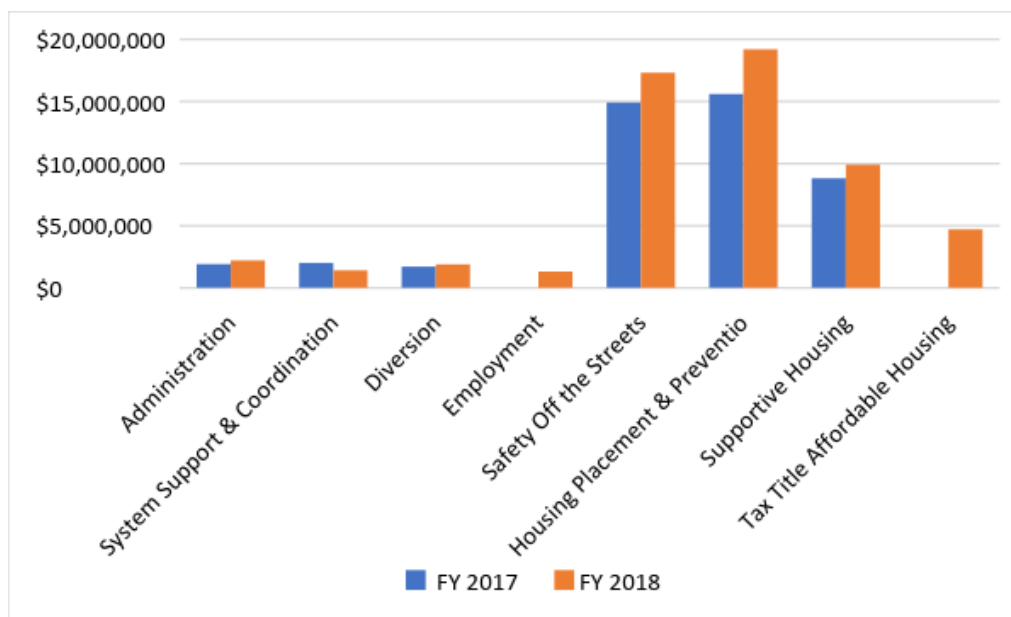
Joint Office Budget by Program, FY '17 and '18

In addition to the distinct programs outlined briefly above, in November of 2016, the City of Portland passed a $258.4 million general obligation bond for affordable housing with the goal of creating 1,300 "newly affordable homes." Of those 1,300 new homes, 600 must be dedicated to homeless families. Three hundred of these units will be devoted to permanent supportive housing, generally designed to serve the needs of the chronically homeless or those with co-occurring disorders.

According to Cupid Alexander, Senior Policy Advisor to Mayor Ted Wheeler, "we have currently permitted/or are in construction of nearly 600 of the 1300 units ahead of schedule." While the 600 units in the pipeline include purchased lands including a site at 30th and SE Powell that will eventually host up to 180 housing units, and another site at 50th and Cully that could host up to 75 units, it also includes the purchase of the Ellington, a 51-unit apartment building at 105th and East Burnside and the Westwinds, a 50-unit site at 6th and NW Flanders. While these purchased units are dilapidated and arguably not fit for human habitation, their purchase under the bond measure does not necessarily increase Portland's total stock of available housing. Indeed, because they will require temporary or permanent relocation of current tenants, their purchase and rehabilitation may exacerbate near-term housing challenges.

This past November, voters approved a $650 million bond measure to develop low-income housing across the three-county area. Additionally, statewide, voters approved Measure 102 which changed Oregon's constitution to allow local governments to leverage governmental funds with private funds for the purpose of housing development. As a result, the $650 million bond measure, which would have allowed for up to 2,400 units housing 7,500 people, will now allow for the creation of 4,000 units housing 12,500 people. While the distribution of those units between family units and supportive housing has not been determined, it will likely follow a pattern similar to that established through Portland's bond process.

While these are important contributions to addressing the housing crisis in our midst, 30,000 individuals moved to the Portland metro region in 2017 and the private sector continues to underdeliver housing to meet the

needs of our growing population. If the estimate made by ECONorthwest in its recent report – that the private sector is building seven units for every ten needed – held through 2017, it suggests that the effect of the bond measure could be wiped out with two years of continued in-migration. Indeed, according to data provided to the Citizens Crime Commission by Commissioner Kafoury's office, *nearly 9,000 individuals experienced homelessness for the first time* in 2018. In any event, as Cupid Alexander notes, to a large extent the problem is not housing per se but rather the type of housing being built. According to Mr. Alexander, there are 17,000 Type A (i.e., luxury) units vacant while 29,000 people are paying more than 30% of their income on housing, i.e., paying too much and thus vulnerable to becoming homeless. Ironically, Portland is currently experiencing price compression in the rental marketplace as the cost of luxury apartments falls while low-to-moderate-income housing continues its inexorable rise. [Note: *ECONorthwest places the number of individuals vulnerable to homelessness at 56,000*[39].]

As the Mayor stated, "We know what works; it's not at the scale it needs to be." *211 Info received 350,000 calls last year, of which more than 100,000 were related to housing.* The result is an inefficient and wasteful band-aid approach. For example, one of the leading substance abuse providers in the City discharges 25 people each week to homelessness, invariably leading to readmission. When sweeps of homeless camps occur, individuals are referred in for services. But capacity is inadequate across the system. Our community is overwhelmed by the sheer volume of homelessness, and we lack the resources to address it.

According to Sheriff Reese, even jails are at capacity. Except for serious crimes, the arrested are released on their own recognizance. Those who don't appear for court become criminals, compounding their trauma and making re-entry into society even more difficult.

New initiatives are in the works or being considered. They include developing a new dual diagnosis center while expanding navigation teams like San Francisco's successful model. The number of sanctioned encampments, or villages, may be expanded. The villages currently house nearly 10% of the unsheltered population. A committee of Home for Everyone, Safety Off the Streets, is currently conducting a policy analysis of sanctioned camping.

Hygiene is a significant concern both because of its public health ramifications and because of the concerns it raises regarding livability in our community. Each of us, no matter our status or circumstance, has at one time or another experienced the challenge of needing to use the facilities when facilities were not readily available. The homeless experience this multiple times on a daily basis.

A proposal has been made to open park toilets year-round, a proposal so far rejected by the Parks Department out of cost concerns. Parks Department bathrooms are not winterized and the cost to do so has been deemed prohibitive. However, the Parks Department closes the toilets at the beginning of October, months before a deep freeze that might threaten pipes might occur, and doesn't open them until April, long past when a deep freeze might occur. PHLUSH (Public Hygiene Lets Us Stay Human) has been actively promoting downtown public toilets for years. Portland Loo has opened seven downtown public toilets. Sisters of the Road, a local non-profit, is focused on hygiene. Several downtown Starbucks have opened toilets to the homeless. Unfortunately, portable toilet providers will no longer rent to the City because their toilets have been used as shooting galleries for intravenous drugs. San Francisco has created The Loo, staffed with attendants, to get around this problem. There is also a need for showers and laundry facilities for the houseless.

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39   ECONorthwest. Homelessness in Portland.

The City and County, through the Joint Office, should continue their programmatic focus on homelessness prevention through housing retention, additional shelter resources and growing the stock of permanent supportive housing, the most cost-effective solution to housing the chronically homeless. **The City of Portland should instruct the Parks Department to *immediately* open park bathrooms 24/7/365.**

Much of the public's criticism of government efforts to address the crisis arises within a vacuum of information. The current communications strategy leaves the public uninformed, creating conditions that are ripe for rumors and finger-pointing.

To the extent that this is **our** crisis and not a crisis of city/county government, there must be better communication to our community about the efforts being made to address the crisis. There is no regular, unified communication to our community about what is being done by whom, to what effect and at what cost. The result is frustration, misinformation and a rumor mill that separates rather than unites our community.

By way of example, a 2017 survey conducted by KGW on the homelessness crisis found that 41% thought Portland was headed in the right direction while 44% believed it was headed in the wrong direction. Similarly, 66% of respondents believed homelessness was worse in Portland than other cities along the I5 Corridor. It is not; it is roughly the same. Fifty-nine percent of respondents believe the situation has worsened over the past six months. Again, there is no evidence to support this. Seventy-eight percent believe the situation has worsened over the past five years. [40] The Point-In-Time survey, which is the only data tool available to compare homelessness across time, suggests that the population of homeless has been relatively stable over time and is, in fact, lower today than it was in 2011. [41],[42] Remarkably, fully *26% of survey respondents felt people were homeless as a personal choice; and for those making $75,000 or more a year, that number rose to 37%.*[43] While the law forbids rich and poor alike from sleeping under bridges, only the poor *elect* to do so: homelessness is not a choice.

As with any "good" crisis, there is controversy about how best to approach it. While the housing emergency has reduced the number and scope of encampment "sweeps," such sweeps continue to occur with or without advance notice, depending upon whether one is speaking with the Mayor's office or homeless advocates.

The tension between those who just want the problem to "go away" and those who empathize with the homeless was laid bare when Portland City Council, in successive October 2018 weeks, heard from petitioners advocating for a more compassionate response to homelessness and from a group calling itself "Enough is Enough," effectively calling for more sweeps.

Once again, the City/County, through the Joint Office, is pursuing best practice in its effort to address the crisis. This is good news. If we are to tackle this issue as a community challenge rather than a strictly governmental response, the strategies, tactics, failings and successes must be communicated to our community on a regular basis in known and reliable venues. This is not strictly a government problem; it is our problem. The community needs to know how it is doing.

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40   DHM Research. KGW News Portland Homeless Survey. 9/24-10/4/2017.

41   Smock, Kristina. 2011 Point-in-Time: Count of Homelessness in Portland/Multnomah County, Oregon. June 2011

42   Population Research Center at Portland State University. 2017 Point-In-Time: Count of Homelessness in Portland/Gresham/ Multnomah County, Oregon

43   DHM Research. KGW News: Portland Homeless Survey.

Significantly, the one audit that has been conducted on the Joint Office of Homeless Services also recommended improvements in the area of communication [and data]:

Regularly reporting performance on the HUD (Housing and Urban Development) measures alongside the output data may help decision-makers and the public see the progress of the system. For instance, the HEARTH Act set a national goal that no one will be homeless longer than 30 days. For our community in 2016, the average time homeless was 92 days. Setting targets toward the goal would be a data-driven practice.

Data-driven communities rely heavily on performance measurement and performance reporting. The National Alliance to End Homelessness cites the Community Shelter Board (CBS) in Columbus, Ohio as a model for data driven homelessness prevention systems. **The CSB reports publicly and transparently each quarter and annually on program and project goals and measurements, including performance targets for individual providers, which helps hold providers and the system accountable.** [44]

For example, the County reported to the Crime Commission that in 2017, more than 10,000 individuals experienced homelessness for the first time. Widely sharing that data would help the public begin to understand the sheer scale of the challenge we face as a community. In 2018, that number dropped more than 12% to less than 9,000 which indicates that the efforts of the Joint Office to prevent homelessness are having some effect.

For starters, we recommend a weekly column to appear in the Oregonian, the Willamette Week, the Portland Tribune and the Business Journal. While we suspect these papers may be willing to publish this for free, given the importance of the topic, it would be well worth the money to pay for these columns, to begin to reduce the rumors and underinformed commentary that hamper understanding of the issue. Similar efforts could and should be made to reach community members through tv and radio. Regular communication through relevant social media such as Next Door, coupled with general informational presentations at neighborhood association meetings would also contribute to more positive community response and engagement. While we can disagree about how to resolve our housing/homelessness crisis, operating from a shared set of facts will be critical to our success. This will lead to a healthier dialogue and an atmosphere more conducive to resolving the crisis. It would also diminish the NIMBYism that has characterized much of the community's response.

The Joint Office hired a communications "coordinator" more than a year ago. A former editor with the Oregonian, Denis Theriault is well-qualified, but doesn't appear to have the authority or resources needed to keep our community adequately informed.

R E C O M M E N D A T I O N   # 3 :
A more robust data- and outcomes-rich communications strategy is needed to keep us informed, to encourage engagement and to track progress.

44   Multnomah County Auditor, Joint Office of Homeless Services Audit: Report Highlights. https://multco.us/auditor/joint-office-homeless-services-audit

FINDING #4:

The Joint Office has recently seen significant improvements to outcomes reporting. Comparative outcomes data reflecting program and system efficacy is essential to ensuring progress and maintaining public confidence.

The Joint Office of Homeless Services captures a significant amount of data, data that is analyzed and shared among those who are working to address the crisis, and, on the occasion of public forums, such as the Mayor's Breakfast on Homelessness and Health, with the public. There is a frank and healthy acknowledgement of the shortcomings of the data and the fact that it almost certainly represents a significant undercount of the number of homeless within our community. At the end of December, 2018, the Joint Office released a report produced by the Multnomah County Department of County Management Evaluation and Research Unit (ERU), in partnership with the AHFE Data, Outcomes, and Evaluation Committee to analyze outcomes by spending between 2014 and 2017. While it is not perfect, e.g., it does not allow for comparative outcomes data amongst providers, it is nevertheless an excellent report that goes some distance towards addressing the need for outcomes data. While the report is a significant move in the right direction, neither the Mayor's office nor the Joint Office, appears to have anyone tasked with thinking strategically about data or about systematically pursuing answers to data questions that bedevil our community's efforts to address the crisis.

As indicated, it is widely acknowledged that the Point-in-Time survey significantly undercounts the homeless. By way of example, in 2017, *Portland Public Schools reported that 1,509 students were homeless, a 5% increase over 2016.*[45] Notably, the number of 1,509 homeless youth exceeds by a factor of eleven the number of homeless youth (130) reported in the Point-in-Time survey. While the PIT count and Portland Public Schools use different but both valid federal definitions of homelessness, it is difficult to manage a problem with such radically different definitions. As Peter Drucker famously noted, "you cannot manage what you cannot measure."

According to the Joint Office, permanent housing was found for nearly 6,000 individuals in FY 2018. However the perception by many is that the situation has deteriorated, not improved, over the past 12 months. Inexplicably, the Joint Office bundles the number served from two distinct programs serving two distinct populations: permanent supportive beds, designed to serve those with co-occurring disorders, and rapid rehousing, which largely serves those who have been priced out of the marketplace. By bundling "rapid rehousing" with "permanent supportive housing," we, the public, are left to form our own opinion as to the relative success or failure of the Joint Office's efforts to address the homeless crisis.

Significantly, no one is able to definitively describe the pipeline into homelessness. In his Mayor's Breakfast address, Mayor Wheeler alluded to this when he noted "The fact that the people on the street this year are different than the people who were on the street last year is small consolation to anyone." The Citizens Crime Commission was told by Jeremiah Stromberg, Assistant Director of Community Corrections for the State of Oregon, that *between 400 and 450 prisoners are released each month, and national data suggests that up to 50% of released prisoners will experience homelessness at some point during their first year after release.* One assumes that these former inmates naturally gravitate to Portland, the largest, most

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45   Harbarger, Molly. Homeless Students Jump Over 5 Percent in Oregon, Set New Record High, The Oregonian, 11/16/2017.

economically vibrant and most diverse corner of the state. Without counter-factual evidence, it is difficult to believe that the formerly incarcerated are not contributing to our homelessness crisis. Understanding where the homeless are coming from is important because upstream interventions are more effective, cost effective and, frankly, humane. To its credit, homelessness prevention is arguably the Joint Office's most successful program. Identifying more precisely where the 9,000 individuals came from who experienced homelessness for the first time in 2018 would create opportunities for more cost effective, upstream interventions.

The Joint Office for Homeless Services tracks retention in two of its three major programs: placement into permanent housing and homelessness prevention (it doesn't track shelter system retention because this is intended as a temporary intervention - retention is not the goal). Overall, retention appears to run between 80% and 90% with some fall off in the last couple of years. The implication, however, is significant. If retention is 90%, and 12,000 are being served through homelessness prevention and permanent housing placement, that suggests that 1,200 individuals are re-entering homelessness every year. If it is 80%, that means 2,400 are re-entering homelessness annually.

Many of these individuals likely seek housing in the remaining SROs (single resident occupancies) located in Portland. Oxford House, perhaps the country's largest SRO provider, reported to the Citizens Crime Commission an average length of stay of 18 months and an annual turnover rate of nearly 50%. Oxford House requires sobriety and charges market rates of between $650 and $750 per month. Oxford House does not, however, capture data on what happens to its tenants when they leave. While the number of people living in SROs in Portland today is unknown – the last count of 2,100[46], was registered in 2008 – their success or failure potentially has a significant impact on recidivism to the streets. Are tenants leaving Oxford House because they are failing sobriety, because they can no longer afford the rent or because they have moved on to better housing? This has significant implications for policy. Oxford House suggested a willingness to capture tenant departure data for a small fee.

Cities that have successfully addressed homelessness – a few have achieved what has been described as "functional zero" – have done so by counting down - by getting the chronically homeless on a list and working the list in a case-conference format. In fact, this is precisely what the Joint Office did to address the crisis of homelessness within the veterans community. The City/County achieved functional zero among veterans in December of 2015. (Despite achieving functional zero, the 2017 PIT Count still named 400 veterans as homeless – 10% of the total. As Erin Pidot of the Joint Office of Homeless Services noted of achieving functional zero, "It doesn't feel very satisfying.")

Merely creating a names list won't cause the Joint Office to achieve functional zero. As the Mayor noted in his November, 2018 address on Healthcare and Homelessness, the maximum monthly social security disability income (SSDI) payment is about $750 per month and the average monthly payment for veterans is $1,500. Portland's average rental listing as of October, 2018 was $1,428[47]. Homelessness is, ultimately, a market failure and we do not currently have the capacity to provide housing for everyone who needs it, whether or not they are on a list. But placing everyone on a list has been shown to be effective in driving down homelessness.

Each of the above-described scenarios – individuals leaving prison, individuals who have graduated from homelessness to SROs, veterans – potentially lend themselves to significantly more cost-effective upstream interventions **_if_** we better understood the data.

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46   Durning, Alan. Emancipating the Rooming House. December 3, 2012.
47   Rent Café, https://www.rentcafe.com/average-rent-market-trends/us/or/portland/.

As an example of the type of data that is currently collected and might be put to good effect, *the Citizens Crime Commission was able to utilize existing data to determine the cost per shelter bed night, i.e., what it costs to shelter one homeless person for one night: $83.20 in 2017 and $75.91 in 2018. Incidentally, that represents a 9% year over year improvement in efficiency,* a fact that, if shared with the public, would presumably be greeted favorably. With by provider/by shelter detail, it would be relatively easy to calculate cost effectiveness of shelter bed nights by provider/by shelter. While such objective data points fail to address what may be significant subjective data points, they do present opportunities for learning and sharing and with that the promise of refining practice to ensure the most effective and cost effective outcomes.

It has been said that data is merely narrative in numerical form. Data collection is a critical first step in understanding the crisis and measuring our progress. The Joint Office for Homeless Services' data collection efforts suffer from a lack of analysis that will allow us to track progress, to improve current practice and to identify upstream opportunities for intervention that may reduce redundancy and increase cost effectiveness.

RECOMMENDATION #4:
Maintain and enhance existing efforts to capture, analyze and report data. Contract with the recently formed Portland State University Homelessness Research & Action Collaborative to assess current outcomes measures and "own" an ongoing, transparent data set for use in establishing cost-effectiveness. Quarterly progress reports should be published widely.

Tenting near the Bud Clark Commons in Old Town.

FINDING #5:

This is our community's crisis and not simply a crisis to be shouldered by government. Through our support for two separate bond initiatives and through the Joint Office of Homeless Services, we, the citizens of our community, have committed to spending as much as $2 billion or even more over the next ten years to provide long-term solutions to our broader housing shortage for low- and no-income individuals. More could be done by businesses, faith entities, foundations and individuals to address our crisis in the near-term as our government implements long-term strategies to address the crisis

 In keeping with the idea that the homelessness crisis was not caused by local government but is the logical outgrowth of 50 years of public policy, and that it must be solved as a community, the Citizens Crime Commission recommends that the Joint Office of Homeless Services and the Office of Neighborhood Involvement encourage business and neighborhood involvement in addressing conditions on the street that will begin to alleviate the harsher aspects of the homelessness crisis – as government works to put into place the long-term solutions that will help resolve the homelessness crisis over time. There are many things that businesses – and non-profits and churches –

can do today to alleviate conditions on the street while improving Portland's day-to-day livability.

Above all, the homeless need our compassion and our empathy. Toward that end, hygiene is critical. Businesses, non-profits and churches can build or open up their existing facilities for the homeless to go to the bathroom and even to take showers.

Similarly, while possessions of the homeless often seem meager to those of us who do not experience the ravages of homelessness, that they are so meager makes them even more precious. It is one of the main reasons the act of "sweeping" encampments can be so traumatizing, because the homeless frequently lose their few possessions in the process. The streets of downtown Portland have recently begun to sport numerous bicycle storage lockers. While the Crime Commission has not explored security and sanitary concerns, bicycle lockers are also potentially ideal for the homeless to safely store their belongings. Businesses could purchase and host these lockers on behalf of the homeless outside their places of business.

Our economy runs on money and like everyone else, the homeless need money to purchase food and other necessities. Many of the homeless work. While there are a number of day shelters that allow the homeless to shower and change, many have difficulty finding employment because they lack a permanent address and a place to clean up and get ready for work. Many of our chronically homeless cannot work full-time but are perfectly capable of working part-time. The pride and self-confidence of holding a job can be important contributors on the path to healing. Providing a homeless person employment can contribute in a meaningful way to addressing the homelessness crisis.

The cleanliness of our streets is important to everyone, including our local businesses. In our experience, the homeless do not want to litter but there are simply not enough garbage cans in our city. Hosting a garbage can outside of one's business, or simply providing trash bags to the homeless is a simple way to become involved in helping to address current conditions on the streets. Likewise, businesses, churches and non-profits could maintain sanitizing stations, provide water, or host a "donation station" for customers to leave socks, hygiene items, etc.

As we noted in our second recommendation, our government, through the Joint Office of Homeless Services, has in place a long-term plan to address the crisis that appears to be working. In the interim, the rest of us can contribute in a meaningful way to alleviating the harshest aspects of our crisis.

RECOMMENDATION #5:
Businesses, foundations, faith congregations and individuals interested in improving the quality of life for all Portlanders should invest in addressing conditions on the street today while long-term solutions are developed and implemented.

Houseless villages have proven a cost-effective interim solution to the crisis of homelessness in our community with numerous benefits, including reduced crime.

In October, 2016, the City adopted an ordinance to allow churches and businesses to host up to four temporary shelters on their property. In coordination with the Office of Neighborhood Involvement and some of the non-profits that are promoting the villages such as the Village Coalition and Cascadia Clusters, businesses, churches and non-profits could open their property to host a village thereby providing clean and safe housing for a significant percentage of the homeless while removing hundreds of people from the streets. But there has been little uptake on this opportunity. For this reason the Citizens Crime Commission believes that support for the villages – as an interim solution to the homeless crisis – deserves its own separate recommendation.

The mayor's office seems to recognize that this effort is best led by the private sector. As Mayor Ted Wheeler's Senior Advisor Berk Nelson noted: "If you want bureaucracy involved, you're going to get it." Certainly the cost seems to rise as the City gets involved. Kenton Women's Village, a city-led effort the City considers a "great

success," cost Portland roughly $400,000 last year. The other villages, which house considerably more people, cost the City under $50,000 apiece annually. In its first 18 months, Kenton Women's Village graduated 22 individuals to permanent housing; over the past three years, Hazelnut Grove has graduated about 20 such individuals.

Unfortunately, there don't appear to be many options for villages on City lands. Of Portland's ~480 city-owned properties, only five have been identified as possible village sites. Hazelnut Grove, which will be relocated to St. John's at the insistence of the head of the Overlook Neighborhood Association in the spring of 2019, is taking one of those sites, and Kenton Women's Village has been relocated to another of those sites to make way for low-income housing. Nonetheless, A Home for Everyone/Joint Office for Homeless Services Shelter off the Streets program has formed a committee conduct a policy analysis of sanctioned camping. While supportive of private sector efforts to develop villages, Marc Jolin, Homeless Services Director with the Joint Office for Homeless Services, expressed a note of caution:

If we begin to call the pods housing, where does it stop? Does that become the new floor for housing and if so, what does that say about us as a society?

As the description of the villages that forms a pull-out to this report makes clear, the Citizens Crime Commission believes that the villages could house a significant percentage of the chronically homeless in the near-term (2-5 years) as the City/County/Joint Office implement long-term plans to end the homelessness crisis. We believe the model developed by Cascadia Clusters has the extraordinary potential of not only providing homes but providing employment, dignity and even capital to our homeless. Indeed, carried to its logical conclusion, Portland's many homeless could eventually become the workforce that helps build our way out of the crisis.

A group of private businessmen and women has recently put forth a proposal to convert 40' shipping containers into four comfortable 80 sq. ft. housing units at a cost of no more than $5,000 per unit, considerably less than is being spent on other forms of housing currently.

How can the City/County/Joint Office help without erecting bureaucratic obstacles that would impede development? The major impediments to the village concept are money and land. The City can help with both. The City could grant funds to a housing organization to provide modified individual development accounts [IDAs] so the homeless could purchase their pods over time. This eliminates any potential bureaucratic obstacles while still providing much-needed capital for pod construction.

The City has already adopted an ordinance allowing the private sector to host small villages. To date, there has been virtually no uptake from this. Portland's Office of Neighborhood Involvement could hire two or more individuals to conduct outreach to neighborhoods for the purpose of securing commitments to host villages on private lands. In this manner, the City could provide much-needed land and funds to support village development without creating bureaucratic barriers.

R E C O M M E N D A T I O N # 6 :
Encourage the expansion of the houseless village concept as a largely private sector, faith community endeavor. Fees should be waived, permits should be fast-tracked, and public utilities should be provided. For its part, government should engage the neighborhoods, including businesses, churches and not-for-profit organizations, to make land and funding available for the houseless.

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The Joint Office of Homeless Services has embarked on a long-term (10-year) effort to address the crisis of homelessness in our community. As housing units are built, many thousands will remain homeless, including the roughly 2,000 individuals who find themselves sleeping on the streets on any given night. This reality has invariably led to discussions regarding cost-effective interim solutions that may begin the path forward for the thousands of traumatized, dispossessed individuals who comprise Portland's houseless. Many have advocated for radically expanding shelter capacity. This includes Homer Williams who, in addition to his notable efforts to develop the navigation center, Harbor of Hope, has been a fierce advocate for converting Wapato Jail into a shelter.

An alternative, cost-effective interim solution has emerged around the nation from within the homeless community itself: the village concept. There have been a number of studies of these villages. One national study indicated rapid growth in the number of such villages from 19 in 2000 to nearly 300[48] today including four here in Portland:

1. Dignity Village, Portland's first homeless village. In existence since 2000 and sanctioned by the City, it provides housing to approximately 60 individuals.
2. Right To Dream Too. Located in the Lloyd District and sanctioned by the City, R2D2 provides temporary shelter to about 30 individuals.
3. Hazelnut Grove, an unsanctioned village in the Overlook Neighborhood, provides housing to approximately 30 individuals. It began in 2015, and is in the process of being relocated to St. John's; and,
4. Kenton Women's Village. A City-sponsored village located in the Kenton neighborhood, on Prosper Portland land, it provides shelter to approximately 15 women.

While public opinion about the houseless ranges from pity and shame to anger, one of the most commonly expressed concerns is health and safety. But the homeless are more likely to be victimized by crime than to commit crime. Indeed, the homeless band together in encampments not only because humans are social creatures but also because banding together is safer. And there are well-documented decreases in crime in neighborhoods that host organized, homeless villages. Such villages are self-governed entities with rules that are often strictly adhered to. And while some allow limited drug use, others expel drug users and are entirely drug-free.

A recent investigation conducted by British newspaper <u>The Guardian</u> found that crime decreased significantly near all three of the Portland villages that were studied: Kenton Women's Village, R2D2 and Hazelnut Grove. When R2D2 relocated from downtown to the Lloyd District, crime dropped 10% even as city-wide crime rose by 11%.[49]

Cities have struggled with these villages: to sweep or sanction. Here in Portland, that struggle has been most visible in the battle over Hazelnut Grove, a self-governed village in the Overlook neighborhood. This village, on a plot of city-owned land approximately 100 feet below the Overlook Neighborhood, has been severely criticized by the president of the Overlook Neighborhood Association. The village has, by all reports, been a model citizen, but relentless pressure from the neighborhood association is forcing the village to relocate to the St. John's neighbor-

48   National Law Center on Homelessness and Poverty, Tent City, USA: The Growth of America's Homelessness Encampments and How Communities Are Responding. 2017
49   Lynes, Abby. Homelessness. The Oregonian. 6/14/2018.

Agape Village rising on the property of Central Nazarene Church in SE Portland.

hood where a process of community engagement has created a more welcoming environment.

Others are concerned that these encampments will become a permanent solution to the homeless. Marc Jolin, executive director of the Joint Office for Homeless Services, has expressed his concern that if we encourage the development of villages, we, as a society, will consider the problem solved and release ourselves from responsibility for meaningful solutions to the crisis of homelessness.

As an interim solution, however, they hold potential. When Hazelnut Grove was being built in 2016 – 2017 with largely volunteer labor, the ReBuilding Center, Portland's iconic salvage materials non-profit, estimated that it could build a pod for roughly $2,000 in materials.

In addition to Portland's four villages, Clackamas County hosts a veterans village that provides transitional housing for up to thirty veterans on county land. Together these villages provide housing to nearly 200 individuals, a not insignificant percentage of the 4,000-odd individuals counted in the most recent Point-in-Time survey – 5% of the homeless population and nearly 10% of the unsheltered homeless population. Significantly, with the exception of Kenton Women's Village, they have been built with very little governmental help.

Most of these villages have seen significant upgrades in the past two years because of the efforts of one individual and his cohort of volunteers who has worked tirelessly to address Portland's homeless. He helped build out Hazelnut Grove in 2016 – 2017 and led efforts to refurbish housing at Dignity Village and R2D2. In 2017, a

group of Caitlin Gable students developed solar units for the pods. The solar units are now in place in nearly all the pods in Portland's four villages, providing power to charge phones and laptops, lighting, and heated sleeping pads, transforming the village experience during Portland's long winters.

Today, much of this work has been folded into a new not-for-profit, Cascadia Clusters, which is building a village at Central Nazarene Church in East Portland. This effort includes a pre-apprenticeship training program that may provide pathways to employment for the seven individuals who are building out what has been christened Agape Village. While it will take ten or more years for Portland to build its way out of its homelessness crisis, the Cascadia Clusters model demonstrates that our homeless neighbors could form the workforce that builds our way out of the homelessness crisis.

The cost of one Cascadia Clusters pod, in labor and materials, is roughly $18,000, significantly more than the $2,000 in materials cited by the ReBuilding Center but far less than a housing unit, and competitive with the cost of a shelter bed. Labor constitutes half the cost. Another possibility is shipping containers. A 40' shipping container can be rapidly remodeled into a comfortable, warm and dry four-pod housing unit for under $20,000.

Many homeless individuals have expressed interest in the village concept. In the Agape Village buildout, five homeless individuals living near Central Nazarene Church have joined two more experienced builders from Hazelnut Grove to build the village, and 42 homeless individuals living in the surrounding area have signed up to join the village.

The villages are not a permanent solution to our homelessness crisis. But they represent a reasonable, cost-effective interim solution that provide benefits beyond housing, e.g. income, skill-building, pride and self-efficacy.

Heather and Jessie are building their future home at Agape Village under the guidance of Cascadia Clusters.

FINDING #7:

Expenditures on behavioral health – mental health and substance abuse – remain miserly. This has resulted in a system, however well-intentioned, with nowhere near the resources to address current demand and woefully inadequate to meet the need for services to individuals living in the projected 2,000 new permanent supportive housing units currently in the public pipeline. Permanent Supportive Housing (PSH) has been shown, repeatedly, to be the most cost-effective solution for the chronically homeless. Other states, including Washington Arizona and Hawaii, have pursued Medicaid waivers to allow Medicaid to support PSH.

No discussion of Portland's homelessness crisis would be complete without reference to behavioral health services. At more than 71%, the chronically homeless (roughly defined as individuals with a disability who have been homeless for a year) are disproportionately represented among the unsheltered. Of the chronically homeless, 45% self-identify as having a serious mental illness. And while Multnomah County experienced a 10% increase in the Point-in-Time count between 2015 and 2017, the chronically homeless population increased 25% during the same time period[50], contributing significantly to the perception that homelessness is deteriorating, not improving.

Healthcare reform has heightened awareness of the extraordinary costs of substance abuse and mental health conditions. While numbers are difficult to pin down, in 2010 the *World Health Organization estimated behavioral health's global impact at $2.5 trillion annually, out of a global healthcare budget of $5.1 trillion.*[51] It has been widely reported that individuals experiencing serious mental illness are dying, on average, 25 years before the general population. [52] This is unsurprising: *40% to 70% of individuals with serious mental illness experience alcohol or other substance-abuse disorders.*[53] Seventy-five percent of people with serious mental illness smoke, versus 25% of the general population. [54] Individuals with serious mental illness disproportionately utilize expensive emergency department care while underutilizing preventative care.[55]

Despite their outsized impact, behavioral health services have been notoriously underfunded. *In 2016, $194.4 billion was spent nationally on mental illness – less than 6% of total healthcare expenditures of more than $3.3 trillion.* When substance abuse treatment is added, the total rises to about 7% of healthcare spending. Long term trends, however, are not encouraging: a recent study by the Substance Abuse and Mental Health Services Administration (SAMHSA) projected that behavioral health expenditures nationally were dropping from a high of 9.4% in 1986 to a projected 6.5% in 2020.[56] Conditions in Oregon are no better. A 2013 study of 35 behavioral health agencies in the tri-county (Clackamas, Multnomah, Washington) area revealed that 13 of 35 agencies had 30 days' or less cash on hand while only 13 of 35 had 120 days' or more cash on hand.[57]

50   Ibid.
51   Insel, Thomas. The Global Costs of Mental Illness. The National Institute of Mental Health, September 28, 2011.
52   Behavioral Health/Primary Care Integration and the Person Centered Primary Care Home, 2009, National Council for Community Behavioral Health Care
53   Parks, Joe, MD; Svendsen,Dale, MD; Singer, Patricia, MD; Foti, Mary Ellen, MD; Morbidity and Mortality in People with Serious Mental Illness. NASMHPD, October, 2006
54   Reardon, Christina. Integrating Behavioral Health and Primary Care – The Person-Centered Healthcare Home. Social Work Today, Vol. 10, No. 1.
55   Parks. Ibid.
56   SAMHSA, Projections of National Expenditures for Treatment of Mental Illness and Substance Abuse Disorders, 2010-2020. Washington, D.C. 2014.
57   Wassell, Tamsen and Reichard, Stephen. Assessing the Readiness of Portland, OR's Behavioral Health Sector to Engage Health Care Reform. May, 2013.

In the summer of 2018, Portland-based Human Services Research Institute conducted an exhaustive study of Multnomah County's mental health care system. The study found a system that by many measures meets SAMHSA's definition for a "good and modern system"[58] and included:

- An array of evidence-based services to support social determinants of health
- Peer-based systems that are widely embraced
- Care that is trauma-informed and culturally responsive
- Wherever possible, care that is delivered in community, in a non-restrictive setting; and,
- An abundance of dedicated professionals.

Specific programs cited positively in the report included:

- Portland Police Bureau's three county-funded Behavioral Health Response Teams (BHRTs) that pair officers with Cascadia Project Respond clinicians to conduct outreach to individuals who have had multiple police contacts. However the BHRTs, which receive more than 1,000 calls per year, only operate four days per week.
- A Service Coordination Team, run by Central City Concern but paid for by the City, is focused on individuals with drug and alcohol addiction but includes capacity to work with six individuals with co-occurring identified mental health concerns. This program has been associated with reduced arrests.
- Between 2004 and 2011, Multnomah County nearly doubled the number of individuals in the corrections system provided with mental health services.
- Community Court Program and Mental Health Court are successfully addressing people's needs before they get more serious.
- The Unity Center offers Peer Bridging services for individuals who have had three or more visits to Unity. Eligible individuals receive 45-90 days of peer support to help them connect to community-based services. While the program is effective, several stakeholders noted that peer bridging services lacked capacity.
- A Forensic Assertive Community Treatment Team, and its jail diversion services, works with incarcerated individuals and in the community to establish connections to treatment and meet court requirements for conditional release.
- County crisis response services are available all day every day and include a crisis hotline, mobile crisis outreach through Project Respond; an Urgent Walk-In Clinic operated by Cascadia; psychiatric emergency services at the Unity Center for Behavioral Health; and the Crisis Assessment and Treatment Center (CATC), a 16-bed, short-term secure alternative to hospitalization operated by MHASD.

Despite those positive highlights, the report portrays a system severely under-resourced, lacking in care coordination, with inadequate and underpaid staff. Indeed, the system's shortfalls are too lengthy to summarize in this report. Given the criticality of behavioral health system performance to the success of any effort to address homelessness, the report is must reading for anyone interested in tackling the issue of homelessness. A list of system issues would include:

- Systemic Weaknesses
- System Design Challenges
- Capacity Issues
- Access Challenges
- Culture/Diversity Issues
- Data Challenges
- Workforce Challenges

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58   HSRI, Multnomah County Mental Health System Analysis, June, 2018.

A partial list of more specific challenges may be found in Appendix 2.

Ultimately, HSRI's report describes a system that is relatively capable of "stabilizing people" but lacks the resources to "keep people stable," resulting in an expensive and ultimately unproductive revolving-door system.

There appears to be little disagreement within the regional behavioral health care system over the report's conclusions. For example, while not as exhaustive as the HSRI study described above, a 2016 Oregon Behavioral Health Collaborative report drew many of the same conclusions/recommendations. The primary author of this study met with a senior director for one of Portland's largest behavioral health services providers, who confirmed virtually all of the report's findings.

The director made the following points:

1. Much more integration with physical medicine is needed. "Patients come in for behavioral health therapy; they have sores, infections. [But] They need to make an entirely new appointment to be seen for those problems."
2. When a patient calls for a behavioral health appointment and has to wait two months for an appointment, it feels like no one cares, deepening their mental health issues. "By the time I say 'I need help,' I need help right now. So you need to be able to say, 'That's great. Come in today.' That sends the message that we want to see you. For someone who feels alone, that's an important message to send."
3. There's not enough Assertive Community Treatment or Dialectical Behavioral Therapy (DBT). There is currently a one-year wait for DBT.
4. Behavioral health providers must submit Measures and Outcomes Tracking data to the State but they get nothing in return. There is no correlation with other data that might tell them what's working and what's not.
5. Ninety percent of our clients have co-occurring disorders but few of our staff are trained to deal with them. "You can't bill unless you're certified. So you have to be certified in both substance abuse and mental health in order to bill. So patients are seen for their behavioral health, and then need to schedule another appointment for their substance abuse."

The bottom line: "We are set up to be in the business of brief interventions, not long-term stability." Underfunded, the system becomes more expensive as patients are discharged to the street to become retraumatized over and over again. Underpaid, habitually short of resources, dealing with the most difficult patients, providers become exhausted, rapidly losing compassion for their clients. As the primary report author was told: "Diabetics don't throw chairs at you." And yet many patients have diabetes and other stress-related chronic conditions, as a recent study in *Gerontologist*, makes clear:

Geriatric conditions were common among older homeless adults living in diverse environments, and the prevalence of these conditions was higher than that seen in housed adults 20 years older.[59]

The bottom line appears to be just that: the bottom line. Funding for behavioral health is inadequate to the challenges we face. About 50% of healthcare expenditures have roots in behavioral health factors. As the chart below suggests, there has not been a noticeable shift in the expenditure of health care dollars toward behavioral health since the 2012 advent of Coordinated Care Organizations in Oregon. Indeed, although spending on behavioral health in Oregon appears to be significantly higher than the national average as computed by the Oregon Health Authority, *as a percentage of total health care expenditures, spending on behavioral health has actually declined since the advent of health care reform.*

59   Brown, RT, et a. Geriatric Conditions in a Population-Based Sample of Older Homeless Adults. Gerontologist. 8/2017. 57(4)

	2013-2015	2015-2017	2017-2019
Total Behavioral Health Spending	$2,278,288,489	$2,514,026,280	$ 2,811,601,916
Total Health Spending	$12,055,899,647	$14,427,251,539	$16,333,548,663
Behavioral Health as a % of Total	18.90%	17.43%	17.21%

Oregon Health Care Authority Expenditures, 2013-2019[60]
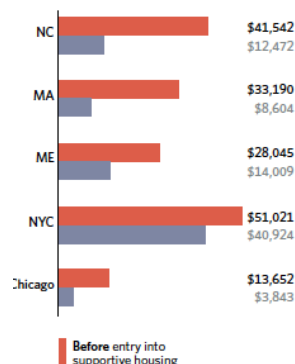
THE PROMISE OF HEALTH CARE REFORM

In 2012, the primary author of this report served as Director of Clinical and Business Operations for the precursor to HealthShare, the Tri-County Collaborative, that has become the largest Coordinated Care Organization in the State of Oregon. In those early days, the vision for these new entities was to realign incentives and spending within the healthcare system with the goal of realizing the so-called Triple Aim of improved outcomes, reduced costs and enhanced patient experience. Reduced costs, or "bending the cost curve," was to be achieved through the realignment of spending from downstream medical expenses toward the upstream so-called social determinants of health that account for 55% - 75% of health care costs.

Former Governor John Kitzhaber frequently told the story of a 90-year-old woman suffering from congestive heart failure who repeatedly checked into the hospital for want of a $200 air conditioner, costing the health care system some $50,000 per year. Similarly, investments in permanent supportive housing have been amply demonstrated as the most cost-effective solution to chronic homelessness. For example, a study in Seattle found that:

> *The use and cost of services for participants placed in permanent supportive housing—including jail bookings, shelter and sobering center use, hospital-based medical services, publicly-funded detoxification and treatment, and emergency medical services—fell from a median of $4,066 per person per month in the year prior to the study to $1,492 after 6 months and $958 after 12 months, a 76 percent reduction. At the 6-month follow-up, total cost offsets for the treatment group, accounting for the cost of housing, averaged $2,449 per person per month relative to the control group.*[61]

After 18 months of housing and case management services, a group of formerly chronically homeless persons in Chicago experienced 29% fewer hospitalizations; 29% fewer days in the hospital and a 24% decrease in emergency room visits.

A national study of five permanent supportive housing projects across the nation showed stunning decreases in costs:

	Before entry into supportive housing	
NC	$41,542	$12,472
MA	$33,190	$8,604
ME	$28,045	$14,009
NYC	$51,021	$40,924
Chicago	$13,652	$3,843

Reductions in Utilization of Major Services Before and After Entry into Supportive Housing[62]

60   Oregon Health Authority Data Request
61   Larimer, E. Mary, Ph.D., et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons with Severe Alcohol Problems. JAMA. 4/1/2009. 301(13)
62   The United States Interagency Council on Homelessness. Opening Doors: Federal Strategic Plan to Prevent and End

Locally, a study of residents at Portland's Bud Clark Commons (BCC) showed modest cost savings against medical expenses alone. Residents with Medicaid coverage saw significant reductions in medical costs after moving into BCC. The average resident saw a reduction of over $13,000 in annual claims, an amount greater than the estimated $11,600 it costs annually to house a resident at BCC.[63] According to the Center for Supportive Housing, the cost of an inpatient hospital stay is $888 per night; an ER visit is $500; a trip to county jail is $210 while supportive housing costs between $59 and $64 per night.[64]

Permanent supportive housing provides a path forward for chronic homelessness, but funding presents significant obstacles. The solution to chronic homelessness must include access to truly affordable housing and in many cases a range of support services. The lack of supportive housing is consistently identified as the major barrier to ending chronic homelessness.

FUNDING THE SUPPORTIVE COMPONENT OF PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing represents best practice for addressing the needs of the chronically homeless. It has repeatedly been proven to save money. Our community, through our approval of nearly $1 billion in bond financing for low-income housing, is investing in housing the houseless. The United States healthcare system represents roughly 20% of the U.S. economy. That's where the money is. The health care system, through the Oregon Health Plan, must realign its spending priorities to invest heavily in behavioral health, including the supportive component of permanent supportive housing. There is no other source of funding.

States are entitled to petition the Office of Medicaid and Medicare Services for what is known as a 1115 waiver to support "experimental, pilot, or demonstration projects that are found by the Secretary [of Health and Human Services] to be likely to assist in promoting the objectives of the Medicaid program." Oregon has had a waiver in place since 1994. Its initial waiver allowed it to ration health care services by prioritizing health care interventions. In 2012, Oregon received a new waiver, renewed in 2017, with the following principal goals:

1. Enhance Oregon's Medicaid delivery system transformation with a stronger focus on integration of physical, behavioral, and oral health care through a performance-driven system aimed at improving health outcomes and continuing to bend the cost curve;
2. Increase the state's focus on addressing the social determinants of health and improving health equity for all low-income, vulnerable Oregonians to improve health outcomes;
3. Commit to a sustainable growth rate and advance the use of value-based payments;
4. Expand the coordinated care model by implementing strategies for providing cost-effective, person-centered health care for Medicaid and Medicare dual eligible members.

To its credit, Oregon has implemented many of these reforms, establishing Coordinated Care Organizations [CCOs] which have been reimbursed from the Oregon Health Plan through value-based and performance-based payment models. In the early, heady days of healthcare reform, CCOs promised to introduce payment reform models to drive risk down to the provider level, thereby incentivizing the development of continuums of care that reward upstream interventions, thus curtailing ineffectual and expensive downstream expenditures such as emergen-

Homelessness. February, 2015.

63   Center for Outcomes Research and Education. Integrating Housing and Health: A Health Focused Evaluation-The Apartments at Bud Clark Commons.

64   Center for Supportive Housing. Portland and Multnomah County: Creating 2,000 Units of Supportive Housing through Systems Change. Slide presentation, 10/17/2018.

cy room visits. Emergency room visits have in fact dropped, as have hospitalizations, saving the state money while presumably improving care by relocating care to more appropriate, upstream settings. However, access to behavioral health care has not improved, according to the most recent comprehensive evaluation of Oregon's Medicaid Waiver program.[65]

Significantly, CCOs have engaged in so-called flexible spending, from gym memberships to bathroom scales in an effort to assist patients in maintaining or improving health. CCOs have even invested in housing, including hotel rooms for recovery to prevent discharge to homelessness, rental assistance and temporary housing.

While Oregon has begun the shift in payment to value- and performance-based systems at the payer level, CCOs have not shifted risk down to the provider level to stimulate shifts in investment upstream that might serve to reduce downstream risk. CCO 2.0, a series of recommendations for improving Oregon's coordinated care organizations, has recently been issued. It includes four primary recommendations:

1. Improve the behavioral health system
2. Increase value and pay for performance
3. Focus on social determinants of health and health equity
4. Maintain sustainable cost growth.

These are important recommendations and move Oregon in the right direction. However, absent a shift in global risk to the provider level that will give rise to a fundamental upstream realignment of health care spending, or a simple, but significant, reallocation of dollars to the behavioral health sector, the resources to address the behavioral health crisis that gives rise to a significant component of our homelessness crisis will not be there. The City of Portland and Metro government can, through bond financing and other measures, house our houseless. Without significant investment – arising from a reformed health care system – the supportive component of permanent supportive housing will not materialize and our community's homelessness crisis will likely continue.

As a downtown developer noted in his interview for this report, "We can buy our way out of this [the homelessness crisis]." And the citizens of the Portland metro region have indicated their willingness to do so through their support for nearly $1 billion in bond financing for low-income housing. The Oregon Health Authority must now indicate its willingness to do so as well through its meaningful efforts to fundamentally realign spending towards behavioral health.

RECOMMENDATION #7:
Housing is healthcare. The Oregon Health Authority, through CCO 2.0, must make significant investments into behavioral health. OHA should pursue a Medicaid waiver to support PSH.

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65   Kushner, Jonah, M.P., et al. Evaluation of Oregon's 2012-2017 Medicaid Waiver. Oregon Health Sciences University, 12/29/2017.

1. Individual Meetings:
   - Keith Jones – Portland Together
   - Erin Pidot – AFHE, Veterans Coalition
   - Anonymous, Director at major Portland mental health services provider
   - Liam Frost, Housing Policy Advisor, Multnomah County
   - Marc Jolin, Director, Joint Office of Homeless Services
   - Nick Fish, Portland City Council Commissioner
   - Marshall Runkel, Chief of Staff, Chloe Eudaly's Office
   - Chloe Eudaly, Portland City Council Commissioner
   - Berk Nelson and Seraphie Allen, Mayor Ted Wheeler's Office
   - Paul Udell, Outreach Manager, Oxford House
   - Stan Herman and Devon, Shared Recovery Homes
   - Cupid Alexander, Sr. Advisor, Mayor Ted Wheeler
   - Ashley Henry, Ex. Director, Business for a Better Portland
   - Don Mazziotti, Harbor of Hope
   - Sean Suib, New Avenues for Youth
   - Bill Sinnott, Portland Business Alliance
   - Beth Burns, p:ear
   - Tom Kelly, Neil Kelly
   - Sam Chase, Metro
   - Jeanine Smart, HealthShare of Oregon
   - Lyndon Tuck Wilson, member, Homelessness Research Project
   - Robert Stoll, Stoll Berne
   - Daniel Dean, former CIO for HealthShare
   - Vahid Brown, Clackamas County, Housing Policy Coordinator
   - Todd Ferry, Co-Director, PSU Homelessness Research & Action Center
   - Michelle Comer, Tamara Kennedy-Hill – Travel Portland
   - Heather Lyons, Corporation for Supportive Housing
   - Mitch Hornecker, Board member, Meyer Memorial Trust

   Regular Attending at A Home for Everyone Committee Meetings from 9/2018-12/2018
   - Coordinating Committee
   - Health Workgroup
   - Equity Workgroup
   - Safety Off the Streets Workgroup
   - Homeless Youth Oversight Committee
   - Community Advisory Workgroup
   - Housing Workgroup, AFHE
   - Workforce and Economic Opportunity Workgroup, AFHE
   - Safety Off the Streets: Camping Pilot Project Workgroup, AFHE
   - Mayor's Breakfast on Homelessness, Healthcare and Housing

ECONORTHWEST, Homelessness in the Portland Region: A Review of Trends, Causes, and the Outlook Ahead. October 10, 2018.

1. Expand and add analytic rigor to the effort to end chronic homelessness. The region has long sought to end chronic homelessness, and trends would suggest it lost ground in recent years. The manageable scale of the problem offers hope that this crisis is solvable. The effort begins with creating new PSH units, and the region has shown recent progress on that front. But new units—and their associated services—are only part of the answer. The region will also need to invest in better analytic capabilities and build rigorous evaluations into its programming.

2. Identify populations—in addition to chronically homeless single adults—that supportive housing models could serve cost effectively. Public and nonprofit agencies in a number of regions are testing the costs and benefits of extending supportive housing interventions to families with children. Some of the collaborations are organized under "pay for success" frameworks, in which investors commit funding upfront in return for calculable, downstream savings. These demonstrations may yield insights into specific populations (e.g., families involved in the child welfare system) that could be cost effectively targeted for PSH interventions.

3. Recognize that shallow, temporary subsidies require additional evidence, and enter into partnerships to identify next-generation, low-cost alternatives to the HCV. The federal government's HCV program is a proven homelessness prevention tool, but it covers only a quarter of eligible households. To spread limited resources to unserved HCV-eligible populations, Portland and many other communities have experimented with shallow and temporary rent subsidies. Shallow, temporary subsidies remain promising but unproven. Here, the region would be well-served by recognizing the policy unknowns, partnering with think thanks and communities from across the country, and continuing the investigation for effective, lower-cost alternatives to the HCV.

4. Increase the supply of affordable housing units. Rent-restricted units, regardless of what income bracket they target, provide stable housing for people who need it. They are also an important component of any comprehensive approach to addressing homelessness. Rent vouchers stretch further when they are used to buy down rent from 60% median family income (MFI) to 30% MFI, than when they are buying down market rate rent. In the past, rent-restricted units were primarily federally funded, but those resources are insufficient to meet the regional need. Local revenue-raising efforts are important steps. To ensure that those resources go as far as they can, local governments should evaluate opportunities for additional incentives, such as state-enabled tax abatement programs, fee waivers or reductions, and land write-downs for affordable units. They should also identify and remove regulatory barriers that drive development costs or unintentionally reduce the number of units possible on a site.

5. Expand the scope of plans to end homelessness to include goals for regional housing production and accelerate housing supply at all price points. Existing plans are developed by public and nonprofit agencies that work most directly with homeless populations. At that level, they have been generally well-designed and executed. But given that narrow scope, they are silent about goals and policies that will largely determine the future of homelessness in the region: the production of housing of all kinds and at all price points.

Future homelessness reduction strategies would be appropriately scoped if they articulated broad housing production goals. The region would need to hold itself accountable to the goals; prune land-use regulations that don't serve a clear health, safety, or environmental protection purpose; accelerate permit process timetables; cede regulatory power to the state for some zoning decisions; and explore little-used but promising policies such as land-value or split-rate taxes.

6. Leverage the newly created Homeless Research and Action Collaborative (HRAC) to elevate the public debate

and strengthen policy responses. This report has outlined the public's disagreement around the causes of homelessness, as well as the need for more evidence on policy responses. The hope is for this report to advance the policy discussion in a productive direction. Meaningful progress will require sustained effort and focus on the homelessness issue. On that front, the region recently received good news. Portland State University (PSU) announced the creation of the HRAC—a center that will provide research on why homelessness exists, evaluate the effectiveness of policy interventions, and uncover innovative approaches to supporting people experiencing homelessness. The center will tap expertise across multiple domains—urban planning, public health, social work, psychology, economics, business—and

work in close collaboration with city and county agencies in the region. Activities will include elevating the public debate on homelessness, implementing rigorous evaluations of local programming, and advancing the university's innovative work with temporary villages, hygiene centers, and more. The HRAC is perfectly positioned to address numerous challenges discussed in this report: inconsistent homeless counts, imperfect resource targeting, and promising-but-not-proven programming.

Portland State University. An Analysis of Homelessness and Affordable Housing: Multnomah County, 2018. July 31, 2018.

1. Reduce Barriers to Affordable Housing Development

a. For-profit developers focus more on 60-80% AMI

Based on the unique challenges of building affordable housing and the profit motive of private developers, it makes sense they primarily target households earning 60% to 80% AMI. This does not address the most pressing needs of households earning 50% AMI and below; however, it could take some of the pressure off the rental market in general by providing more options for households earning closer to the median wage.

b. Nonprofit and government developers focus more on 30% to 50% AMI

Nonprofit and government developers of affordable housing have greater access to resources such as land banking and government funds and may be able to better tolerate risks such as time delays. Focusing on households at 50% AMI and below will help address the 29,000 unit shortfall and ensure those who are most vulnerable have more housing options.

To incentivize more affordable housing development, the government could provide the following support:

- Simplify application procedures to reduce costs associated with applying for public funds.
- Balance project selection criteria to emphasize cost-efficiency along with non-housing social goals. The current process generates competition that may add costs, potentially limiting the number of units produced.
- Support for land purchases: Since land is one of the biggest cost drivers, selling land at a discount or creating additional resources for financing could help build more units.

2. Improve Accuracy of Homeless Count and Include Future Projections
The Point-In-Time count is the main source of information used by governments, nonprofits, and other organizations to assess the numbers of homeless people, their demographic characteristics, and living situations. The PIT Report could be more helpful if it was used as a supplement to other, more rigorous methods that provided a more accurate count on a regular basis.

Benefits of a more accurate count:

- Quantifying how many people experience homelessness on a regular basis.
- A more accurate demographic profile of who is experiencing homelessness and why.
- More targeted allocations of limited resources.
- More equitable and efficient service delivery.
- Better information about the types of approaches that are working.
- Forecasting how many people may become homeless, allowing for better planning.

Target: Joint Office of Homeless Services and the new Homeless Center for Excellence at Portland State University. JOHS would manage data gathered from new information sources. The Homeless Center for Excellence could help develop the methodology and assist with data collection efforts by tapping into the vast knowledge and resources available through local colleges and universities.

Customers: The main customers would be governments at all levels, homeless service providers, academic institutions, businesses, media, affordable housing developers, the public.

3. Develop a Model to Estimate the Full Cost of Homelessness

Quantifying homelessness in dollars allows community leaders and the public to better understand the full costs of homelessness and efficacy of different approaches. Developing a model for homelessness in Multnomah County could provide the following benefits:

- Analyzing the cost savings of prevention efforts.
- More conscious choices about how limited dollars are spent.
- Identifying who among the homeless population is costing the most and why.
- Understanding which organizations are carrying the largest financial burden.
- Examining how much is spent on services such as health care and law enforcement.
- Forecasting future expenses.

Target: Local governments, Joint Office of Homeless Services, and Homeless Center for Excellence. A private-public partnership could provide an opportunity to create a system that accounts for the full costs of homelessness and tracks them over time.

Customers: Governments, service providers, business community, academic institutions, media, the public.

4. Promote Home-Sharing among Baby Boomers and Retirees

Many baby boomers and retirees prefer to age in place, staying in their homes as long as possible. Additionally, there are a growing number of older people with few assets and limited incomes who need an affordable place to live. Home-sharing services can connect these two groups.

In 2017, Trulia conducted an analysis of major metropolitan areas to discover how many spare bedrooms were available for home sharing.113 The analysis focused on multi-generational living (baby boomers and millennials); however, this information could be used to connect baby boomers and retirees with each other. The Trulia analysis revealed 42,511 spare bedrooms in the Portland Metro area potentially available for rent. Monthly rent was estimated at $664/month, providing a more affordable option than a market rate studio and an additional $7,568 in annual income for older homeowners.

Home-sharing provides the following benefits:

- Helps people who want to age in place remain in their homes.

- Gives low-income baby boomers and retirees additional options for affordable housing.
- Reduces isolation among older people who are living alone.
- Supports local government density priorities.

There are several local examples of home-sharing services (i.e., Let's Share Homes114 and Metro HomeShare115); however, they do not appear to be well-known. Home-sharing services could be better promoted to raise awareness among target populations and technological support could be enhanced for recruitment, matching, and screening.

HSRI, Multnomah County Mental Health System Analysis. June, 2018.

Priority Recommendations

Engage in ongoing dialogue with service users and their families and other stakeholders to ensure a shared and actionable vision for the mental health system.

Our stakeholder engagement process reflected widespread views that Multnomah County lacks a vision – shared across all major system stakeholders – that can be translated into action. It also highlighted disconnects between system aims and service user experience.

1.1 Identify factors that contribute to the information gap between available resources and community awareness of those resources.
1.2 Work with local, regional, and state stakeholders—including the OHA, Health Share, and service users and providers—to identify and adopt a set of common metrics that align with this shared vision to support a system driven by person-centered outcomes including health and wellbeing and quality of life.
1.3 Develop a process for ensuring all services are experienced as trauma-informed, drawing from national best practice in trauma-informed approaches.
1.4 Convene provider agencies to assess their unique strengths and map current programs and service offerings. Develop a strategy to align agency strengths and organizational capacity with community need to maximize resources and reduce duplication. Consider adopting an alternative business model for contracting services based on a shared vision for a mental health system that capitalizes on unique strengths and expertise of local providers.

2. Establish a director-level lived experience leadership position.

Based on stakeholder interviews and best practice for state and county mental health systems around the country, Multnomah County would benefit from having a person who represents the perspective of lived experience at a leadership level. This position might be Director of the Office of Consumer Engagement at MHASD. Establishing a county-level leadership position demonstrates a fundamental belief in the power of personal experience in effecting change and would be one concrete step the current leadership could take to address stakeholder concerns about its commitment to a person-centered system.

2.1 Responsibilities could involve:

- Spearheading efforts to adopt a shared vision and enhancements to peer support services, including aligning local efforts with national best practice

- Working with advisory bodies and councils to craft recommendations and set priorities that can be translated to action

- Collaborating with local advocacy groups (including groups representing children, youth, and families and substance use recovery groups) to promote greater cohesion and identify shared goals and common ground

- Ensuring local advocates have needed tools to understand the complex system and identify levers for change

- Promoting positive relationships between the advocacy community, provider agencies, and County administrators

- Identifying and promoting additional opportunities for increasing the lived experience voice throughout the mental health system

- Liaising with other systems (housing, criminal justice, child welfare, education, and others) to support them to incorporate lived experience perspectives in their efforts

2.2 In the spirit of integration, work with Health Share to explore establishing a similar leadership position, or arrange for peer leadership within MHASD to work closely with Health Share on issues that impact individuals receiving mental health services in physical health care settings.

3. Integrate and analyze data on funding and services to support system improvements.

Conduct future analyses to better understand how funding flows through the mental health system and related systems, identify opportunities for expanding capacity, provide clarity for stakeholders, and otherwise inform system planning and improvements.

3.1 Develop a process for streamlining existing data across mental health and related systems to allow for rapid access, querying, and visualization of information about services, programs, funding streams, and capacity.

3.2 Conduct a comprehensive assessment of data and services across the County to identify service and financing gaps and areas of potential duplication and inefficiency.

3.3 On an ongoing basis, visualize data, generate simple reports, and respond to queries as needed to ensure all stakeholders have a common understanding of complex systems that influence population health in the region.

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