October 13, 2026

Ms. Claudette Fernandez
General Deputy Assistant Secretary for Office of Community Planning and Development
U.S. Department of Housing and Urban Development
451 7th Street SW
Washington, D.C. 20410

Submitted via regulations.gov

Re: Docket No. FR-6628-N-01, "Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness"

Dear General Deputy Assistant Secretary Fernandez:

The undersigned members and allies of the Consortium for Constituents with Disabilities Rights and Housing Task Forces submit these comments in response to the Notice, "Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness," Docket No. FR-6628-N-01.[1] CCD is the largest coalition of national organizations advocating for federal public policy that ensures the self-determination, independence, empowerment, integration, and inclusion of children and adults with disabilities in all aspects of society.

HUD relies largely on questionable evidence and incorrect assumptions in claiming that the activities it plans to incentivize are "proven to be effective at reducing homelessness generally, reducing homelessness for a specific subpopulation, or achieving homeless prevention and independent living goals."[2] Further, HUD ignores extensive evidence that the activities it is moving away from and claims are failures–Housing First and permanent supportive housing–are extremely effective.

---

[1] Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness, 91 Fed. Reg. 57901 (September 11, 2026) (Docket No. FR-6628-N-01), https://www.govinfo.gov/content/pkg/FR-2026-09-11/pdf/2026-18555.pdf (hereinafter "Notice").
[2] 42 U.S.C. § 11386b(d)(1).

HUD's proposed pivot to "Treatment First" housing and its characterization of "Housing First" as a failure flouts decades of robust research supporting the effectiveness of this approach, which has long enjoyed bipartisan support due to its success. Indeed, it was the Administration of President George W. Bush that first promoted this approach on a broad scale. Rather than providing affirmative evidence for its proposed shift away from Housing First, the Department simply points to the persistence of homelessness and Congress's 2009 findings that "the causes of homelessness are complex" and that "there is no single, simple solution"[3] to justify pursuing a "new approach."[4] These points neither establish that Housing First is ineffective nor that the proposed alternatives are more effective.

Further, HUD's proposed pivot away from permanent supportive housing (PSH) toward incentivizing transitional housing mischaracterizes the evidence in support of transitional housing and entirely ignores the needs of the largest group of people served by supported housing–people with mental health disabilities and/or substance use disorders. Decades of research have rejected the premise that people experiencing homelessness must first become "housing ready" or pass through an intermediate stage before obtaining permanent housing. The Department ignores the substantial peer-reviewed evidence supporting PSH and the lack of comparable evidence supporting its conclusions regarding Transitional Housing.

[3] *Id*. § 11301(a)(3), (4).
[4] Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness, *supra* note 1, at 57905.

The Department's proposed shifts would reverse years of federal policy across administrations[5] and agencies[6] while disregarding more than two decades of research supporting Housing First and permanent supportive housing and raising serious concerns about the alternative approaches HUD now seeks to incentivize.

I. HUD Should Not Pivot to Incentivizing Treatment-First Housing Over Housing First

[5] *See, e.g.,* President's New Freedom Comm'n on Mental Health, SMA-03-3832, Achieving the Promise: Transforming Mental Health Care in America (2003), https://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf (recommending that HUD develop and implement a plan to facilitate access to 150,000 units of permanent supportive housing for chronically homeless families); U.S. Dept. of Health and Human Services, HHS Pub. No. 4173, Transforming Housing for People with Psychiatric Disabilities: Report (2006), https://www.relmanlaw.com/media/publication/1871_SAMHSA%20Disability%20Report.pdf (explaining evidence demonstrating that even those with the most severe mental disabilities can live successfully in supportive housing); Pathways' Housing First Program, *SAMHSA's National Registry of Evidence-based Programs and Practices* (November 2007), https://web.archive.org/web/20120417022534/http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155 (identifying Pathways to Housing's Housing First program as an evidence-based practice); SAMHSA, Best Practices: Housing First (2017), https://web.archive.org/web/20160402171542/http://homeless.samhsa.gov/channel/housing-first-447.aspx ("Housing First is an evidence-based practice that looks at housing as a tool, rather than a reward, for recovery."); ; SAMHSA, Best Practices: Housing First (July 25, 2012), http://homeless.samhsa.gov/channel/housing-first-447.aspx (same); Pathways' Housing First Program, *SAMHSA's National Registry of Evidence-based Programs and Practices* (2012), http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=155 (identifying Pathways to Housing's Housing First program as an evidence-based practice); Nat'l Council on Disability, Inclusive Livable Communities for People with Psychiatric Disabilities (2008), http://www.ncd.gov/newsroom/publications/index.htm; Cmrt. Preventive Servs. Task Force, Social Determinants of Health: Permanent Supportive Housing with Housing First (2019), https://doi.org/10.15620/cdc/168591 (recommending permanent supportive housing and Housing First); Nat'l Council on Disability, The State of Housing in America in the 21st Century: A Disability Perspective (2010), https://www.ncd.gov/report/the-state-of-housing-in-america-in-the-21st-century-a-disability-perspective/ (recommending redirection of government housing and treatment funds away from board and care homes and towards housing first programs).

[6] *See, e.g.,* Carol L. Pearson et al., HH 14.2:H 75/4, The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness, at 102-03 (2007), https://www.govinfo.gov/content/pkg/GOVPUB-HH14-PURL-LPS121503/pdf/GOVPUB-HH14-PURL-LPS121503.pdf (Department of Housing and Urban Development); U.S. Surgeon General. Mental Health: A Report of the Surgeon General (1999), at 221-330, http://www.surgeongeneral.gov/library/mentalhealth/chapter4/sec6.html#human_services (Surgeon General); U.S. Interagency Council on Homelessness, Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation (2016), https://web.archive.org/web/20231028224301/https:/www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf (members of 19 Departments and agencies).

Housing First is an evidence-based approach to addressing homelessness. It provides people experiencing homelessness with immediate access to permanent housing and voluntary supportive services without requiring sobriety or compliance with psychiatric treatment as a prerequisite to obtaining or retaining housing.

For decades, the prevailing approach to homelessness was a linear residential treatment model, variously called the "linear," "continuum-of-care," "Treatment First," or "stair-step" model. Under this approach, individuals were required to progress through increasingly independent forms of housing while complying with treatment requirements and maintaining sobriety (i.e., "Treatment First;" or treatment before housing). Housing First emerged in response to the well-documented shortcomings of this model–including the difficulty of engaging people in treatment while they remain unhoused, the difficulty of teaching people skills outside of the environment in which those skills will ultimately be used, the lengthy process of attaining permanent housing, and the denial of housing to those with the greatest needs.[7]

Housing First is Highly Effective in Addressing Homelessness

Early studies found that 84 percent of Housing First tenants remained housed after three years, compared with 59 percent of the comparison group after two years;[8] after five years, 88 percent of participants remained housed, compared with 47 percent of those receiving linear residential treatment.[9] Subsequent randomized controlled trials (RCTs) and other studies likewise found that Housing First participants spent less time homeless and experienced greater housing stability than those receiving non-Housing First interventions.[10]

That evidence has only grown stronger. More than thirty years after Housing First's development, numerous RCTs and systematic reviews in the United States and abroad continue

---

[7] *See* Sam Tsemberis & Ronda F. Eisenberg, *Pathways to housing: Supported Housing for Street-Dwelling Homeless Individuals With Psychiatric Disabilities* (2000), 51 Psychiatric Servs. 487, https://doi.org/10.1176/appi.ps.51.4.487; Henry Korman et al., *Housing as a Tool of Coercion*, *in* Coercion and Aggressive Cmty. Treatment 95 (1996), https://doi.org/10.1007/978-1-4757-9727-5_7.

[8] Sam Tsemberis, *From streets to homes: An innovative approach to supported housing for homeless adults with psychiatric disabilities*, 27 J. Cmty. Psych. 225 (1999), https://doi.org/10.1002/(SICI)1520-6629(199903)27:2%3C225::AID-JCOP9%3E3.0.CO;2-Y.

[9] Tsemberis & Eisenberg, *supra* note 7, at 491.

[10] *See, e.g.,* Ana Stefancic & Sam Tsemberis, *Housing First for Long-Term Shelter Dwellers with Psychiatric Disabilities in a Suburban County: A Four-Year Study of Housing Access and Retention*, 28 J. Primary Psych. 265 (2007), https://doi.org/10.1007/s10935-007-0093-9; Leyla Gulcur et al., *Housing, hospitalization, and cost outcomes for homeless individuals with psychiatric disabilities participating in continuum of care and housing first programmes*, 13 J. Cmty. & Applied Soc. Psych. 171 (2003), https://doi.org/10.1002/casp.723; Sam Tsemberis et al., *Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis*, 94 Am. J. Pub. Health 655, (2004), https://pmc.ncbi.nlm.nih.gov/articles/PMC1448313/.

to find that Housing First is effective at achieving and maintaining housing stability.[11] A 2020 systematic review found that Housing First "results in greater improvements in housing outcomes for homeless adults in North America,"[12] while another found that, compared with Treatment First, Housing First reduced homelessness by 88 percent and improved housing stability by 41 percent.[13] A 2025 review similarly found strong evidence that Housing First increases housing stability, including up to six years after initial placement.[14]

While HUD points to the increase in homelessness since 2013 to contend that Housing First has failed, it presents no evidence–and indeed no evidence supports–that the numbers of unhoused people increased due to Housing First's alleged failure. Instead, the raise simply reflects that increasing numbers of unhoused people were offered nothing because insufficient resources were allocated. It is well-documented that the number of housing subsidies has been insufficient to serve the number of people in need of them.[15] Similarly, the reasons for increased homelessness are well-documented and they relate not to Housing First but to the COVID-19 pandemic, the expiration of certain emergency housing protections and funding, rising housing costs, changes in data collection following *City of Grants Pass v. Johnson*, and other policy and economic conditions.[16]

---

[11] *See, e.g.,* Jack Tsai, *Is the Housing First Model Effective? Different Evidence for Different Outcomes*, 110 Am. J. Pub. Health 1376 (2020), https://doi.org/10.2105/AJPH.2020.305835; U.S. Dep't of Housing and Urban Dev., Housing First: A Review of the Evidence (2023). https://journalistsresource.org/wp-content/uploads/2025/09/Housing-First_-A-Review-of-the-Evidence-_-HUDU-SER.pdf; Paula Goering et al., At Home/Chez Soi Final Report, (2014,.http://www.mentalhealthcommission.ca; Anirban Basu et al., *Comparative Cost Analysis of Housing and Case Management Program for Chronically Ill Homeless Adults Compared to Usual Care*, 47 Health Servs. Rsch. 523 (2011), https://doi.org/10.1111/j.1475-6773.2011.01350.x; Juha Kaakinen & Saija Turunen, *Finnish but not yet Finished – Successes and Challenges of Housing First in Finland*, 15 Eur. J. Homelessness 45 (2021) https://www.feantsa.org/files/Observatory/Journals/Volume-15/V15-3/EJH_15-3_A2.pdf; Pearson et al., *supra* note 6; Maria C. Raven et al., *A randomized trial of permanent supportive housing for chronically homeless persons with high use of publicly funded services* 55 Health Servs. Rsch. 797 (2020), https://doi.org/10.1111/1475-6773.13553; Yinan Peng et al., *Permanent Supportive Housing with Housing First to Reduce Homelessness and Promote Health among Homeless Populations with Disability: A Community Guide Systematic Review*, 26 J. Pub. Health Mgmt. & Prac.404 (2020), https://pmc.ncbi.nlm.nih.gov/articles/PMC8513528/.

[12] Tsai, *supra* note 11, at 1377.

[13] Peng et al., *supra* note 11, at 2, 5.

[14] Susan Collins, Housing First: Overview of the Evidence Base (2005), https://depts.washington.edu/harrtlab/wordpress/wp-content/uploads/2025/09/Housing-First-state-of-the-science-8.30.2025-1.pdf.

[15] National Low Income Housing Coalition, The Gap: A Shortage of Affordable Homes 24 (Mar. 2025), https://nlihc.org/sites/default/files/gap/2025/gap-report_2025_english.pdf ("[O]nly one in four renters who qualify receive federal housing assistance").

[16] *See* Laura Hausman et al., Homelessness, Housing Markets, and Federal Policy: Local Lessons and Policy Implications (2026), https://bipartisanpolicy.org/report/homelessness-housing-markets-and-federal-policy-local-lessons-and-policy-implications-1/#9f44e307-7a2a-4018-ba21-cdde5f13d553-link.

Housing First Is More Effective than Treatment-First Housing Because it Enables Providers to Engage Individuals

Service providers face difficulty maintaining consistent treatment and services when individuals lack a stable place to live. When individuals remain homeless because they are not considered "housing-ready" or because they have lost Treatment-First housing due to an inability to meet its requirements, it is far more difficult to serve them for multiple reasons–including that it is often difficult to locate them and that engaging in treatment is harder when individuals are focused on securing food and shelter on a daily basis. Housing First directly addresses this barrier by providing a consistent place where providers can maintain contact, deliver services, and respond to emergencies. By contrast, when individuals lose housing for failing to meet restrictive conditions under a Treatment First approach, or when time-limited Transitional Housing ends, they may also lose contact with providers, interrupt treatment, and become disconnected from community supports.

HUD's Notice recognizes that homelessness is associated with poor health outcomes. But that makes stable, unconditioned housing a critical foundation for addressing those outcomes. Housing First provides that foundation by ensuring that individuals remain housed and accessible to the services and supports they need.

Housing First is Cost-Effective

Housing First is not only effective at keeping people housed; it can also reduce the substantial public costs associated with homelessness. Stable housing reduces reliance on costly crisis systems and interventions, including emergency shelters, hospitals, jails, and other emergency services.[17]

The economic stakes are substantial. A 2022 systematic review estimated that chronic homelessness cost the U.S. approximately $3.4 billion in 2019, based on an estimated 96,000 chronically homeless individuals. By 2025, that population had increased approximately 62 percent, to 155,750. While cost should not be the sole measure of sound public policy, it is difficult to justify replacing an effective intervention with more expensive alternatives that produce worse housing outcomes.

[17] Kathy Dobbins et al., *Cost-Savings Associated with Reductions in Public Service Utilization with Provision of Permanent Supported Housing in Midsized City in the United States*, 92 Psych. Q. 833 (2021), https://doi.org/10.1007/s11126-020-09716-7.

The evidence for Housing First's cost-effectiveness spans more than two decades. Studies in Seattle,[18] New York City, Philadelphia, Delaware, and other cities have found that supportive housing with voluntary services can reduce shelter use, hospitalization, incarceration, and other costly interventions.[19] A 2015 review of 34 studies likewise found that Housing First interventions for homeless adults with mental illness were associated with cost offsets across shelter, emergency department, inpatient,[20] and justice-system costs.[21]

More recent evidence reinforces these findings. A 2022 systematic review of 17 U.S. studies found a median annual benefit of $18,247 per person and a benefit-to-cost ratio of 1.80:1. In other words, for every $1 invested in Housing First, the median estimated benefit was $1.80. Among higher-quality U.S. studies that found decreased costs, the median benefit rose to $33,637 per person. The review also found substantial reductions in healthcare, judicial, housing, welfare, mental health, and substance use disorder-related costs.[22]

Multisite research found that individuals placed directly into independent housing spent more days housed and fewer days incarcerated, without worse clinical outcomes, than those first

---

[18] Mary E. Larimer et al., *Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems*, 301 J. Am. Med. Assoc. 1349 (2009) https://jamanetwork.com/journals/jama/fullarticle/183666.

[19] *See, e.g.,* Dennis P. Culhane et al., *Public Service Reductions Associated with Placement of Homeless Persons with Severe Mental Illness in Supportive Housing*, 13 Hous. Pol'y Debate 107 (2002), https://doi.org/10.1080/10511482.2002.9521437 (finding that supportive housing participants used an average of $16,281 less in services per year and that the cost of providing supportive housing was approximately the same as the cost of having individuals remain homeless); Fairmount Ventures, Inc., Evaluation of Pathways to Housing PA (2011), https://pathwaystohousingpa.org/sites/default/files/attachments/2022-04/Fairmount%20Ventures%20evaluation%202011.pdf (finding that supported housing reduced participants' shelter, hospitalization, crisis response center, and prison system episodes and cost, compared to programs housing chronically homeless people and residential drug and alcohol programs for homeless people with mental illnesses); Corrected Fourth Report of the Court Monitor on Progress Toward Compliance With the Agreement: U.S. v. State of Delaware, U.S. v. Delaware, No. 1:11-cv-00591-LPS (D. Del. 2013); (finding per-person savings between $96,000 to $276,000 and low hospital readmission rate when state psychiatric hospital residents moved to supported housing).

[20] It's important to note certain limitations of the research. Some studies found increases in inpatient costs because Housing First "could also lead to people receiving needed care that had been neglected when they were living on the street." The literature review also invited future research on the possibility that decreased inpatient costs could be associated with increased community treatment costs. A similar invitation was offered to examine increased utilization of social assistance and income supplements. Nonetheless, these increased costs are reflective of individuals connecting to services and supports they otherwise may not have received and may not exceed the cost of Housing First itself.

[21] Angela Ly & Eric Latimer, *Housing First Impacts on Costs and Associated Cost Offsets: A Review of the Literature*, 60 Canadian J. Psych. 475 (2015), 10.1177/070674371506001103.

[22] Jacob Verughese et al., *Permanent Supportive Housing With Housing First: Findings From a Community Guide Systematic Economic Review*, 62 Am. J. Prev. Med. e188, (2021), https://www.thecommunityguide.org/media/pdf/he-ajpm-ecrev-housing-first.pdf ("The evidence from this review shows that economic benefits exceed the cost of Housing First Programs in the U.S.") at 1, 7.

placed in residential treatment or Transitional Housing.[23] The latter group incurred higher substance use service costs without a corresponding clinical benefit. State-level analyses have reached similar conclusions. Pathways Vermont, for example, found Housing First less costly than Transitional Housing, residential treatment, and incarceration,[24] while a 2025 analysis in Hawaii found that a Housing First program generated nearly $39 million more in net present value than a Treatment First program.[25]

Housing First is Not "Housing Only"

The Notice fundamentally mischaracterizes Housing First as "Housing Only." Housing First does not mean housing without services; making supportive services available and engaging people in services is an essential part of Housing First. HUD's Notice claims that because recent NOFOs did not fund new Transitional Housing or Supportive Services Only (SSO) projects, "Housing First very quickly became Housing Only."[26] But that conclusion does not follow and is simply inaccurate.

HUD itself has defined Housing First as providing supportive services that are "offered and made readily available" without requiring participation as a condition of remaining housed.[27] A 2010 Housing First Manual, authored by the creator of Housing First, similarly described the model as "provid[ing] housing first, and then combin[ing] that housing with supportive services and treatment services."[28]

The Notice's own cited source further undermines its mischaracterization. The source emphasizes that Transitional Housing with a Housing First approach does not require preconditions for entry, and that such programs provide or facilitate access to supportive services.[29] More importantly, HUD's selective presentation obscures the central distinction:

---

[23] Jack Tsai et al., *A multi-site comparison of supported housing for chronically homeless adults: "Housing first" versus "residential treatment first"*, 7 Psych. Servs. 219 (2010), https://psycnet.apa.org/doiLanding?doi=10.1037/a0020460.

[24] Pathways Vermont, Pathways Vermont Overview (2015), https://legislature.vermont.gov/Documents/2016/WorkGroups/House%20General/Housing/Homelessness/W~Hilary%20Melton~Pathways%20Vermont%20Overview~1-6-2016.pdf.

[25] Scioto Analysis, Homelessness in Hawaii A Cost-Benefit Analysis (2026), https://static1.squarespace.com/static/5bdb6f642714e55b84ebe507/t/69e57aaa8d22c8104ba1a800/1776646826039/Homelessness+in+Hawaii_+A+Cost-Benefit+Analysis.pdf.

[26] Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness, *supra* note 1, at 57906

[27] Pearson et al., *supra* note 11, at xv.

[28] Sam Tsemberis, *Housing First: The Pathways Model to End Homelessness for People with Mental Illness and Addiction*. Hazelden, 2010. https://books.google.com/books?id=MgCzcQAACAAJ, at 4.

[29] Off. of Cmty. Planning & Dev., U.S. Dep't of Hous. & Urb. Dev., Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2024 and FY 2025 Continuum of Care Competition and Renewal or

Housing First does not reject supportive services; it rejects making those services a condition of housing.

HUD-VASH Reflects the Success of Housing First

Far from undermining Housing First, the success of HUD-VASH provides further evidence of its effectiveness. The Notice attempts to distinguish HUD-VASH from Housing First by pointing to its requirement that participating veterans engage in case management services, provided such services are deemed necessary in each case. But this distinction overlooks the program's fundamental structure: HUD-VASH provides housing immediately, without requiring treatment, sobriety, or housing-readiness services as conditions of entry.[30] Indeed, the VA's own website stated that Housing First was built into HUD-VASH programs across the country since 2012, and this statement disappeared only after being highlighted by the New York Times.[31]

HUD-VASH's success is particularly notable following its transition to Housing First. HUD adopted Housing First as the HUD-VASH's official policy in 2012, following a transition that began in 2010. Veteran homelessness increased slightly between 2009 and 2010, from 75,609 to 76,329 individuals.[32] Since 2010, however, veteran homelessness has declined by approximately 56 percent, reaching 32,495 in 2025.[33] Thus, the success of HUD-VASH seems to be largely attributable to its Housing First approach.

II. HUD Should Continue to Prioritize PSH Over Transitional Housing

HUD's proposal to shift resources away from PSH towards transitional housing rests on similarly unfounded characterizations of the cited evidence and ignores overwhelming evidence of PSH's effectiveness.

PSH Is Effective in Addressing Homelessness

Replacement of Youth Homeless Demonstration Program Grants 86 (2024), https://www.hud.gov/sites/dfiles/CPD/documents/CoC/Foa_Content_of_FR-6800-N-25_1-9-download.pdf, at 17.

[30] Ann Elizabeth Montgomery et al, *Housing Chronically Homeless Veterans: Evaluating the Efficacy of a Housing First Approach to HUD-V* (Mar. 2 2013), https://dennisculhane.com/article/housing-chronically-homeless-veterans-evaluating-the-efficacy-of-a-housing-first.

[31] Ellen Barry, T*rump's Get-Tough Approach on Homelessness May Sweep Up Veterans*, N.Y. Times, Aug. 19, 2025, https://www.nytimes.com/2025/08/19/health/homeless-veterans-hud-vash-trump.html.

[32] U.S. Dep't of Hous. & Urb. Dev. & U.S. Dep't of Vet. Aff., Veteran Homelessness: A Supplemental Report to the 2010 Annual Homeless Assessment Report to Congress (2011), https://shnny.org/uploads/2010_Vet_Report.pdf.

[33] Shawn Liu, *Veteran homelessness continues downward trend: 56% since 2010*, VA news, June 25, 2026, https://department.va.gov/homeless/veteran-homelessness-continues-downward-trend-56-since-2010/.

A 2020 systematic review of 74 peer-reviewed studies concluded that participants who received PSH spent significantly more days stably housed over the following years than those receiving services as usual.[34]

These results are consistent for individuals with specific barriers to housing stability, as well as the broader homeless population. One study of chronically homeless individuals selected for their high use of publicly funded medical services or time spent incarcerated found that 86 percent of those participants offered PSH became housed during the follow-up period.[35] Similarly, a 2015 study of homeless adults with mental illness found that those offered PSH spent dramatically more days stably housed than those without the intervention—in one city, the difference was as high as nearly 50 percent.[36]

PSH also keeps people housed. Multiple studies have demonstrated high retention rates among individuals receiving PSH. One Seattle study of individuals with severe alcohol problems found that only 23 percent returned to homelessness during the follow-up period, and a quarter of those who did eventually returned to the housing project they had left.[37] A study by HUD itself in 2006 similarly found that, of 943 residents of PSH, 675 either remained in PSH or exited under positive circumstances, generally indicating that they were moving into other stable housing.[38]

Taken together, these findings demonstrate that PSH is effective at achieving the central goal of homelessness policy: helping people exit homelessness and remain stably housed.

PSH likewise produces important benefits beyond housing stability. Housing itself can reduce health risks associated with homelessness, including risk for respiratory infections, threats to safety, limited access to safe use supplies, social interaction, or refrigeration (for food or medicines), and lack of access to supports and services.[39] PSH is also associated with reduced

---

[34] Tim Aubry et al., *Effectiveness of permanent supportive housing and income assistance interventions for homeless individuals in high-income countries: a systematic review*, 5 The Lancet Pub. Health E342 (2020), https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667%2820%2930055-4/fulltext.
[35] Raven et al., *supra* note 11.
[36] Vicky Stergiopoulos et al., *Effect of Scattered-Site Housing Using Rent Supplements and Intensive Case Management on Housing Stability Among Homeless Adults With Mental Illness: A Randomized Trial*, 313 J. Am. Med. Assoc. 905 (2015) https://jamanetwork.com/journals/jama/fullarticle/2174029.
[37] Susan E. Collins et al., *Housing Retention in Single-Site Housing First for Chronically Homeless Individuals With Severe Alcohol Problems*, 103 Am. J. Pub. Health S269 (2013), https://doi.org/10.2105/AJPH.2013.301312.
[38] Dep't. Hous. & Urb. Dev., Predicting Staying In or Leaving Permanent Supportive Housing That Services Homeless People with Serious Mental Illness (2018), https://shnny.org/uploads/Staying_in_or_Leaving.pdf.
[39] Nat'l. Acad. Scis. Eng'g. & Med., Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness (2018), https://pubmed.ncbi.nlm.nih.gov/30148580/.

emergency department visits and spending,[40] as well as psychiatric emergency department and shelter use.[41] Further, PSH can reduce involvement in the criminal legal system. One 2014 study found that participants receiving PSH had fewer jail admissions and spent 40 percent fewer days incarcerated over the 24-month follow-up period.[42]

Transitional Housing, and the Related Concept of Housing Readiness, Are Less Effective Methods of Keeping People Housed

Contrary to HUD's assertions, Transitional Housing is measurably less effective than PSH at helping people achieve and maintain stable housing.

This was demonstrated by HUD's own Family Options Study, which tracked over 2,200 families receiving a variety of forms of intervention.[43] At both the 20-month and three-year follow-up dates, families who had received permanent housing subsidies were more likely to be living in their own houses or apartments and to be satisfied with their housing conditions than those who had received temporary supportive housing. They were also less likely to have spent any nights homeless during the preceding six months or to have been separated from at least one child.[44] Notably, the permanent housing option provided housing subsidies without additional supportive services. PSH, which combines permanent housing with supportive services, would therefore be expected to provide potentially greater benefits.

The preference for Transitional Housing over PSH is based largely on the concept of "housing readiness:" the misguided notion that individuals experiencing homelessness must first complete a period of treatment, acquire certain skills, or otherwise demonstrate that they are prepared for permanent housing. This premise is difficult to reconcile with the evidence.

---

[40]Derek DeLia et al., *Effects of Permanent Supportive Housing on Health Care Utilization and Spending Among New Jersey Medicaid Enrollees Experiencing Homelessness*, 59 Med. Care S199 (2021), https://www.ovid.com/jnls/lww-medicalcare/abstract/10.1097/mlr.0000000000001443~effects-of-permanent-supportive-housing-on-health-care?redirectionsource=fulltextview.

[41] Raven et al., *supra* note 11.

[42] Angela A. Aidala et al., Frequent Users Service Enhancement 'FUSE' Initiative: New York City FUSE II Evaluation Report (2013), https://shnny.org/uploads/CSH-FUSE-Evaluation.pdf.

[43] U.S. Dep't of Hous. & Urb. Dev., The Family Options Study Overview https://www.huduser.gov/portal/family_options_study.html.

[44] U.S. Dep't of Hous. & Urb. Dev., Short-Term Impacts of Housing and Services Interventions for Homeless Families (2015) https://www.huduser.gov/portal/sites/default/files/pdf/FamilyOptionsStudy_final.pdf.

Experience demonstrates that people need not become "housing ready" before they can successfully maintain permanent housing. PSH consistently produces strong housing-retention outcomes among people facing significant barriers to housing stability, demonstrating that individuals can successfully enter and remain in permanent housing without first passing through Transitional Housing. In the same vein, a Washington, D.C.-based housing and support nonprofit based has reported a retention rate exceeding 91 percent among people not traditionally considered as "housing ready."[45] These outcomes suggest that "housing readiness" is a poor measure of whether someone is actually capable of succeeding in permanent housing.

Transitional Housing Does Not Lead to Greater Self-Sufficiency than PSH

Throughout the Notice, HUD repeatedly invokes self-sufficiency as a reason to pursue Transitional Housing. But the data presented by HUD does not show that Transitional Housing is more effective than PSH at achieving this goal.

HUD wrongly assumes that "self-sufficiency" means not relying on any form of public assistance, which is entirely unsupported by the purpose and goals of the McKinney Vento Act. Even if this interpretation were correct, which it is not, exiting Transitional Housing does not mean that people stop relying on public assistance. A HUD study of families who exited within the previous three to twelve months found significant continued reliance on government assistance.[46] More than half of the surveyed families relied on housing subsidies, which covered between 27 and 38 percent of contract rent depending on the families' city of residence.[47] Further, 80 percent had received temporary assistance to help them locate and secure housing after leaving Transitional Housing.[48] Families exiting Transitional Housing continued to rely heavily on other forms of public assistance as well: 67 percent received food stamps, 63 percent received Medicaid, and 34 percent received assistance from local health programs.[49] These forms of assistance provided needed services and stability and undeniably helped families avoid a return to homelessness. However, they also demonstrate why an exit from Transitional Housing cannot be equated with self-sufficiency.

HUD's Identified Subpopulations Are Not Better Served by Transitional Housing than PSH and HUD Ignores the Needs of the Majority of People Served by the Continuum of Care Program

---

[45] Pathways to Housing DC, What We Do, https://pathwaystohousingdc.org/what-we-do/.
[46] U.S. Dep't of Hous. & Urb. Dev., Life After Transitional Housing for Homeless Families (2010), at xvi, https://www.huduser.gov/portal/publications/pdf/LifeAfterTransition.pdf.
[47] *Id*. at 60.
[48] *Id.* at 55-6.
[49] *Id.* at 78.

The Notice's assertions that particular subpopulations are especially well-served by Transitional Housing are belied by the evidence. In each case, the Department either relies on evidence showing that it is better than no intervention or cites research that does not compare Transitional Housing with PSH.

Further, HUD's focus on these subpopulations ignores the needs of the majority of people actually served by the Continuum of Care program. Many people with significant mental health disabilities and/or substance use disorders have long-term needs for services that assist them in maintaining stable housing. These needs are quite different from, for example, the housing assistance needs of domestic violence survivors or youth.

Youth

While youth, like other populations, may benefit from Transitional Housing compared with no housing whatsoever, the Notice offers no evidence that Transitional Housing is preferable to PSH for homeless youth. Notably, its only source for demonstrating positive outcomes of Transitional Housing compares it to no intervention, rather than to PSH.[50]

Another source cited by the Notice further demonstrates the problems with drawing a direct comparison between Transitional Housing and PSH. It notes that "permanent" housing means something different for youth, since "young people are in a phase of their life where it is appropriate to move into time-limited living situations," such as college dorms.[51] Thus, even if youth leave Transitional Housing at higher rates than PSH, that does not demonstrate that Transitional Housing is more effective. Young people may simply be more likely to move out from any form of supportive housing before the time limit ends. Nothing in the evidence establishes that a time-limited housing model is affirmatively preferable to PSH.

Survivors of domestic violence

The Notice's subsection on the subpopulation survivors of domestic violence is particularly weak. It cites only two sources, neither of which supports a preference for Transitional Housing. Both instead describe the dire need for housing in general for this subpopulation, including one source that explicitly identifies "long-term affordable housing,"

---

[50] Jing Zhang et al., Housing Stability, Employment, and Survival Behaviors Among Young Mothers Experiencing Homelessness: A Randomized Controlled Trial of a Housing Intervention, 366 Soc. Sci. Med. 117658 (2025), https://doi.org/10.1016/j.socscimed.2024.117658.

[51] Covenant House Int'l, National Network for Youth & School House Connection, ''To Become the Best Version of Myself'': Youth-Supportive Transitional Housing Programs as An Essential Resource for Addressing Youth Homelessness 23 (2021), https://www.covenanthouse.org/sites/default/files/2023-08/Transitional-Housing.pdf.

such as PSH, as a needed resource.[52] As with other subpopulations, evidence that survivors need housing does not establish that people are better served by Transitional Housing than PSH.

Families

HUD's own sources belie its claim that Transitional Housing is an effective intervention for families with children. HUD largely relies on the Family Options Study to support this contention. However, that very study provides greater support for permanent housing as a solution to family homelessness. As discussed above, families provided with Transitional Housing fared better than those receiving services as usual, but those who received permanent housing subsidies had the most positive outcomes of all studied groups.[53] Thus HUD's primary source–its own report–demonstrates that Transitional Housing performs worse than permanent housing.

HUD cites two additional sources concerning families with children, but neither compares Transitional Housing to permanent housing. Instead, both conclude that providing support services in addition to housing produces better outcomes for homeless mothers than providing housing alone.[54] These findings are entirely consistent with PSH interventions, which combine permanent housing with supportive services. They therefore provide no basis for shifting resources away from PSH and toward Transitional Housing.

Transitional Housing is More Costly than PSH

The Notice itself acknowledges concerns about the cost of Transitional Housing, citing a 2010 report that described it as an expensive model: "The report noted that 'transitional housing is the most expensive model [compared to shelter and Permanent Supportive Housing],' but also recognized that it frequently offered "more privacy and a comprehensive range of on-site services.'"[55] But the Notice's bracketed insertion of "[compared to shelter and Permanent Supportive Housing]" is misleading. The quoted passage itself compares Transitional Housing with emergency shelter, noting that shelter is less expensive but offers fewer services and less

[52] U.S. Dep't of Just. Off. on Violence Against Women, 30 Years of the Violence Against Women Act: A Legacy and Future of Safety and Justice (2025), https://www.justice.gov/ovw/media/1385701/dl?inline; Nat'l Network to End Domestic Violence, 20th Annual Domestic Violence Counts Report: National Summary (2026), https://nnedv.org/wp-content/uploads/2026/03/20th-Annual-DV-Counts-Report-National-Summary-FINAL-EN.pdf.
[53] U.S. Dep't of Hous. & Urb. Dev, *supra* note 43.
[54] Zhang et al., *supra* note 50; Natasha Slesnick et al., *Housing and supportive services for substance use and self-efficacy among young mothers experiencing homelessness: A randomized controlled trial*, 144 J. Substance Use & Addiction Treatment 108917 (2023) https://www.jsatjournal.com/article/S0740-5472(22)00199-4/abstract.
[55] Notice of Research Justifying Additional Incentives for Certain Activities To Reduce Homelessness, *supra* note 1, at 57908.

privacy. The report does not characterize PSH as part of that comparison, but does separately compare Transitional Housing with PSH, merely noting that PSH is less expensive.[56] More importantly, the broader research shows that PSH can provide these benefits while producing greater housing stability and cost savings.[57]

III. HUD Should Not Pivot to Supportive Services Only

HUD's proposal to incentivize supportive services that are not paired with housing is also unsupported. While HUD is undoubtedly correct that services are important, it fails to show why providing only services and not housing is more effective than providing housing *and* services. As described above, there is overwhelming evidence supporting that the most effective approach to addressing homelessness is to "provide housing first, and then combine that housing with supportive services and treatment services."[58] Providing services to people who are unhoused is far less effective than providing them to people who are housed, for the reasons identified above.

Further, the Notice fails to acknowledge that the supportive services used by people in supportive housing are typically provided through other programs such as the Medicaid program. HUD's focus in recent years on housing rather than on "supportive services only" was not accidental; it took into account the need to focus on the core activity of providing housing resources, while also leveraging other available resources that finance supportive services. HUD should continue to encourage PSH programs to identify existing resources to pay for services and collaborate with local service providers to strengthen supports.

IV. HUD Should Not Incentivize Partnerships with Law Enforcement

HUD's proposal to incentivize partnerships with law enforcement has the potential to bring deadly consequences. HUD acknowledges that a significant proportion of homeless people have disabilities, but ignores that police encounters are particularly deadly for individuals with disabilities, who account for 30-50% of incidents of police use of force.[59] Further, as many as half of police killings involve people with mental health disabilities.[60]

---

[56] U.S. Dep't of Hous. & Urb. Dev., Bridging the Gap: Homelessness Policy 5-6 (2011), https://www.huduser.gov/portal/periodicals/insight/insight_1.pdf.
[57] *See, e.g.,* Jacob et al., *supra* note 22; Pearson et al., *supra* note 11, at 32, 34.
[58] Tsemberis, *supra* note 28, at 4.
[59] David M. Perry & Lawrence Carter-Long, The Ruderman White Paper on Media Coverage of Law Enforcement Use of Force and Disability (2016), https://rudermanfoundation.org/wp-content/uploads/2017/08/MediaStudyPoliceDisability_final-final.pdf.
[60] *Id.*; Kimberly Kindy et al., *Fatal police shootings of mentally ill people are 39 percent more likely to take place in small and midsized areas*, Wash. Post, Oct. 17, 2020, https://www.washingtonpost.com/national/policementally-ill-deaths/2020/10/17/8dd5bcf6-0245-11eb-b7ed-141dd88560ea_story.html.

While HUD cites SAMHSA guidelines on behavioral health crisis to state that police officers are among those who "play an important role in engaging individuals in the midst of a mental health or substance use disorder crisis," it entirely misapprehends those guidelines. Rather than promoting police as playing an important role in engaging people during a mental health or SUD crisis, the guidelines aim to *reduce* and *prevent* law enforcement responses to people experiencing such crises, recognizing that police officers are not trained to address such crises and that their presence often *escalates* rather than resolving such crises.[61] Guidance from the Department of Justice and Department of Health and Human Services recognizes the risk that law enforcement involvement poses to individuals with mental health disabilities and instead recommends diversion to behavioral health crisis response services.[62] HUD should incentivize partnership with crisis response services rather than with law enforcement.

We appreciate the opportunity to comment on this important Notice.

Sincerely,

Access Ready, Inc.

Alliance for Rights and Recovery

American Association on Health and Disability

The Arc of the United States

Autistic Self Advocacy Network

Autistic Women & Nonbinary Network

Bazelon Center for Mental Health Law

Center for Public Representation

CommunicationFIRST

---

[61] U.S. Dep't of Health & Hum. Servs. Substance Abuse and Mental Health Servs. Admin, 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care (2025), https://library.samhsa.gov/sites/default/files/national-guidelines-crisis-care-pep24-01-037.pdf.

[62] U.S. Dep't of Just. & U.S. Dep't of Health & Hum. Servs., Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities (2023), https://www.justice.gov/archives/media/1295571/dl?inline.

Disability Rights Education and Defense Fund

Easterseals, Inc.

Epilepsy Foundation

Justice in Aging

The Kelsey

Lakeshore Foundation

National Association of Rights Protection and Advocacy

National Disability Rights Network

National Down Syndrome Congress

Paralyzed Veterans of America

TDIforAccess