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The Economics of Homelessness:
An Analysis of the Facts, Theories, Policies, and Emerging Programs

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Abstract

This thesis seeks to examine the multifaceted aspects of homelessness and its causes. It will begin with an examination of many different literature sources drawing from economics, sociology, and psychology for a foundation for the thesis. It then examines the facts on homelessness including definitions, methods of examination, statistics, and demographic of the homeless. The thesis continues with an examination of some of the major causes, and some other contributing factors. Then looking towards laws and policies that are being passed regarding homelessness, and looks at several cases where cities went too far in trying to regulate the homeless. Lastly it looks at many programs that have been developing across the United States that offer large areas of effective holistic approaches to treating and reintegrating homeless. The thesis finds that there is no single cause or cure for homelessness, and that many approaches must be cultivated to best help these individuals, and coordination between different programs is needed to have a long lasting effect.

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Introduction

Because there are varied reasons why people become homeless, there is no simple answer to the question of how to best help the homeless reintegrate into society. There is no single program or law that will solve the problem. Funding programs, shelters, and services can become substantial expenses for governments at all levels. Providing cost effective programs is a focus of many nonprofit organizations. The degree to which addressing homelessness also has implications for how an area is perceived and its ability to attract and sustain business. The complexity of the homelessness issue makes it worth studying.

This thesis provides a relatively comprehensive examination of homelessness, and review of the research literature. From this literature, key facts about homelessness are presented, along with varying theories offered to explain why homelessness occurs. Policy recommendations found in the literature are also presented, along with descriptions of some programs that have demonstrated some success. A goal is to inform the decision makers about what programs should include, what laws are most effective, what ethics should guide the development of programs, how programs should be funded, and how long programs should last. The goal here is not to identify a single way to address the homelessness issue, but rather the goal is to help the reader identify the numerous aspects that should be weighed and balanced with each other when examining homelessness.

This thesis unfolds as follows. First, an overview of the literature is provided which focuses on the findings of different researchers. Second, key facts on

homelessness are provided. Third, various theories will be presented that have been offered to explain how people become homeless. Fourth, varying policies being established to address homelessness are presented. Fifth, emerging programs that address homelessness are examined. Finally, the paper concludes with some summary observations.

Part 1: Literature Review

This section reviews research on homelessness from the literature in the economics, sociology, and psychology fields. This broad spectrum of information will then form the foundation of the rest of the paper.

Hill and Stamey (1990) took a broad look at the possessions and consumption behaviors of the homeless in America. Using an ethnographic approach, they examined the types of possessions consumed and how they are acquired. They examined what was purchased versus what was obtained by scavenging. They examined the methods used to search, acquire, store, and consume everyday items. They looked at the importance of community in terms of obtaining self-protection, acquiring possessions, and influencing consumption.

Hill and Stamey (1990) found that homeless take an active role in determining their life choices. Activities include nontraditional employment and scavenging instead of purchasing daily consumables and items like clothes. Additionally, many encounter alternative methods of vending for goods in the form of drug dealers and nontraditional outlets. Other methods of acquisition include bartering or sharing with other homeless.

They confront their challenging environments and engage in endeavors designed to improve the quality of their lives.

Quigley, Rapheal, and Smolensky (2001) examined the extent to which homelessness arises from changing housing markets. The assembled information on the homelessness in U.S. urban areas. They find that that variations in the availability, pricing, and demand for the lowest quality housing explains a large amount of the variation in homelessness. Consequently, their research indicates improvements in the affordability and availability of housing can reduce the incidence of homelessness. Their results show that a twenty-five percent reduction in the homeless rate could be achieved nationally by a one percent increase in the vacancy rate, and a decrease in the monthly national rent to income ratios from 17.5 percent to 16.8 percent. The vacancy rate is the percentage of empty housing units.

Moulton (2013) examined whether increased funding for homelessness programs reduced chronic homelessness. He analyzed data from the Department of Housing and Urban Development (HUD) for 130 U.S. communities from 2005 to 2007. He estimated that it costs $55,600 for the first year to move one chronically homeless person into permanent supportive housing. This cost includes fixed upfront costs of building new housing units, so this cost would not be as high in future years as the fixed costs of the new units are spread over many years.

Continuing to examine the chronically homeless, Greene (2014) examined how to provide better training models to reduce provider stigmas about the homeless. The focus is on research-based methods of engagement between providers and homeless. The

recommendation is an anti-stigma training program for providers, designed to cause a longer-term engagement of homeless in treatment services.

Russolillo, Patterson, McCandless, Moniruzzaman, and Somers (2014) examined the emergency department utilization of formerly homeless adults with mental health disorders after one year of a housing intervention had been conducted. The sample included 297 people enrolled in the Vancouver At Home Study, with these people being randomly allocated into one of three treatment groups. One group received treatment as usual, where individuals continued to use existing services available to homeless adults with mental illness. Another group participated in the Housing First Initiative, which provides housing with minimal prerequisite requirements like sobriety or employment. A third group participated in a scattered site apartment program in the private rental market that spread the participants out across an area instead of consolidating them in one area. Data from six urban emergency departments was also gathered from a regional database. They found that the Housing First Initiative produced significantly lower hospital emergency department utilization among homeless adults with a mental disorder, while the Scattered Site Apartment Initiative had no significant impact.

Culhane, Dejowski, Needham, and Macchia (1994) looked at public shelter admission rates in large U.S. metropolitan areas. They focused on the turnover of the sheltered population. Philadelphia and New York City record identifiers for all people admitted to shelters, so those cities might provide more accurate homeless counts. They found that approximately 1 percent of the population of each city was admitted to a shelter during a year. Findings of this study show that the annual number of people using shelters are three times what are shown in PIT counts.

Mental illness and homelessness often co-occur. Zerger, Pridham, Jeyaratnam, Connelly, Hwang, O'Campo, and Steriopoulos (2014) looked at the role and meaning of intern housing in housing first programs for people experiencing homelessness and mental illness. Compared with traditional housing programs requiring individuals to meet requirements like sobriety or employment before enrollment in housing first programs do not require individuals to meet housing readiness by meeting prerequisites. It is commonly seen as an alternative to traditional programs that is supported by a growing body of evidence and literature in its effectiveness. The study revealed a growing need for safe and flexible intern housing options and shows how they are a factor in consumer recovery, continuous service engagement, and housing stability.

Brown, Vaclavik, Watson, and Wilka (2017) looked at predictors of homeless services re-entry. The examined 370 permanently housed and 71 non-permanently housed single adults participating in the Homelessness Prevention and Rapid Re-Housing Program (HPRP) participants in Indianapolis, Indiana. Using Homeless Management Information System data from 2009 to 2015, this study constructed Kaplan-Meier survival curves to analyze time to service re-entry for the full sample, and the HPRP participants separately. After exiting HPRP 9.5% of those in the permanently housed program and 16.9% of those in the non-permanently housed program returned to services for the homeless within 4.5 years of leaving. Veterans, individuals receiving rapid rehousing services, and people with a stagnant income at significantly greater risk of returning to homeless services.

Lucas (2017) critiques federal homelessness policies, seeking to shed light on the unobserved costs of the new housing programs. He argues the new Housing First

approach generates resource misallocation, exacerbates the Samaritan's dilemma, and invites rent seeking. Resource misallocation arises in this case since there is a chance that resources will be used before reaching the individuals who need it most. This is because many of the assistance decisions are based on unreliable data. Samaritan's dilemma is when a program offers a charity an individual will either use it to improve their situation or come to rely on the charity. Rent seeking would occur as the huge costs of these programs are passed onto the tax payer and continually expanded with no results. The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act cost $5.4 billion dollars in 2014 adjusted to 2011 dollars. Passed in 2009 the HEARTH Act changed how grants were allocated, rural housing programs were funded, and simplified requirements for enrollment. He stresses that many of the resources targeted for the homeless in the typical program get absorbed before they reach those who need it and there is usually no way of gauging patient needs.

Metraux, Causack, Byrne, and Hunt-Johnson (2017) looked at pathways into homelessness taken by post 9/11 era veterans. Qualitative semi-structured interviews were conducted with 17 post 9/11 era veterans who were then tracked as they transitioned into a post-military life. Data was gathered on relationships and employment, mental and behavioral health, lifetime poverty and adverse events, and use of veteran specific services. They found veterans do not see their homelessness as rooted in military experiences, but instead attribute it to one of the following; relationships and employment, mental and behavioral health, lifetime poverty and adverse events. Additionally, veterans recounted difficulties in accessing the assistance provided by the U.S. Department of Veterans Affairs and community based organizations.

Tsai, Hoff, and Harpaz-Rotem (2017) to look at one-year incidence and predictors of homelessness among 300,000 U.S. veterans seen in specialty mental health care. Investigation of these factors identified demographics and clinical predictors of homelessness. They obtained data on 306,351 veterans that were referred to the VA for anxiety and post-traumatic stress disorder at clinics across 130 VA facilities from 2008 to 2012. They were followed for 1 year after their first referral. The researchers found 5.6% of men and 7.8% of women experienced homelessness after being referred to a VA specialty clinic. Those who were unmarried or diagnosed with a drug use disorder were two times more likely to become homeless. Those with an income of less than $25,000 or who were black were more than one and a half times more likely.

The bidirectional association between veteran homelessness and incarceration within the context of permanent supportive housing was examined by Cusack and Montgomery (2017). They found individuals experiencing homelessness are more likely to become incarcerated, and former inmates are more likely to become homeless. To break this cycle, programs like Permanent Supportive Housing (PSH) have been proven effective for participants with criminal histories. This study uses data on veterans participating in a PSH program at 4 locations from 2011 to 2014. They found that exiting a PSH program due to incarceration was rare. They found that veterans with drug use disorders had increased risks of incarceration increasing the risks of homelessness.

Part 2: Facts About Homelessness

This section looks at some of the known facts of homelessness including definitions, methods of study, statistics, and demographics of the homeless.

Homelessness has been defined as "a lack of shelter that meets minimal health and safety standards including those living squatter style in vacant housing, stores, cars, vans and buses, and makeshift structures, or living on the streets." (HILL & STAMEY, 1990, p. 305).

Methods for counting the number of homeless have varied, but the current method in the United States is Point in Time (PIT) method. As Moulton (2013) describes, PIT estimates are a count of sheltered and unsheltered homeless individuals conducted in 456 communities. On a specified night, usually in early January, local service providers, past and current homeless people, volunteers, and police count the number of people living in places not meant for human habitation. Moulton (2013, p. 607) claims, "These homeless PIT counts are the best estimates available of the number of homeless people in each community in the United States and are comparable from year to year due to the consistent late-January timing of the counts." PIT estimates have been used in the United States since 2007 to evaluate the success of homelessness policy and to inform grant allocations (Lucas, 2017, p. 282). Without these estimates, it is difficult for a community to get federal grant funding.

According to the report *Current Statistics on the Prevalence and Characteristics of People Experiencing Homelessness in the United States* produced by the Substance Abuse and Mental Health Services Administration (SAMHSA), approximately 1,593,150 individuals experienced homelessness at some point during the year in 2011. Of these, 62 percent were male and 85 percent single: 21.8 percent were under age 18, 23.5 percent were 18-30, 37.0 percent were 31-50, 14.9 percent were 51-61, and 2.8 percent were 62 or older. By race or ethnicity, 41.6% were White (Non-Hispanic), 37% were

Black/African-American, 9.7% were White (Hispanic), 7.2% were multi-racial, and 4.5% were other races. By condition, 26.2 percent had experienced a severe mental illness, and 34.7 percent had experienced drug or alcohol use issues. (SAMHSA, 2011, p. 2-3).

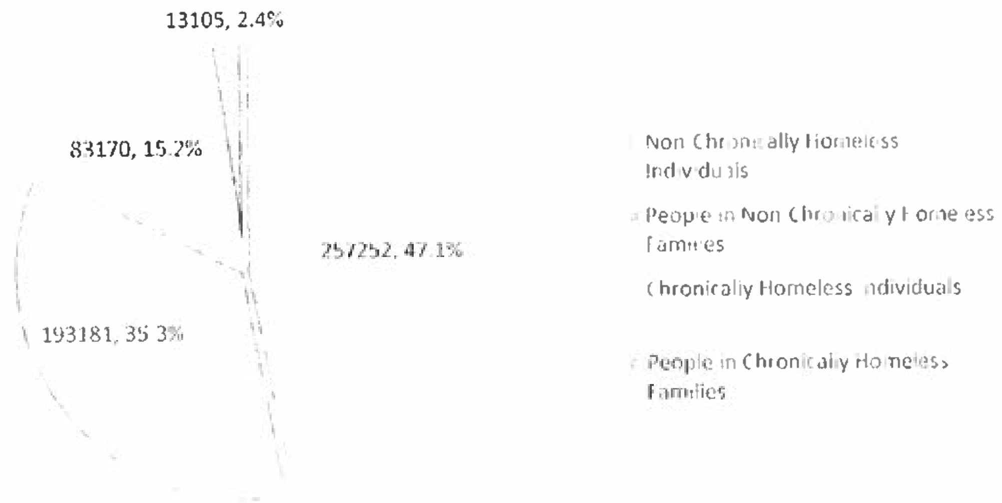
HUD has distinguished chronic homelessness from homelessness more specifically. Their definition of a chronically homeless person is "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years" (Moulton, 2013, p. 600). When the chronic homeless population is considered separately, the substance use and mental illness issues are more significant. Among the chronically homeless, 80 percent have experienced drug or alcohol problems and 60 percent have experienced mental health issues (SAMHSA, 2011, p. 2).

Chronically Homeless individuals are harder to move out of homelessness, implying higher costs, greater resource requirements, and longer time horizons. Of 754,000 homeless individuals in 2005, Moulton estimates 23% were chronically homeless. He estimates the first-year cost of moving one person out of chronic homelessness is $55,600, with continued treatment in subsequent years being delivered at lower costs due to initial costs of program development being high. (Moulton, 2013).

A report by the National Alliance to End Homelessness (National Alliance to End Homelessness, 2016) divides the homeless population into four major groups. The first and largest group is Non-Chronically Homeless, which included 275,252 individuals in 2015 and accounted for 48.7 percent of homeless. The next largest group are people in Non-Chronically Homeless Families, 193,181 individuals making up 34.2 percent of homeless. A third group is Chronically Homeless Individuals, 83,170 individuals

accounting for 14.7 percent of the homeless. The fourth group is Chronically Homeless Families, 13,105 individuals accounting for 2.3% of the homeless. This subpopulation breakdown is presented visually in Figure 1.

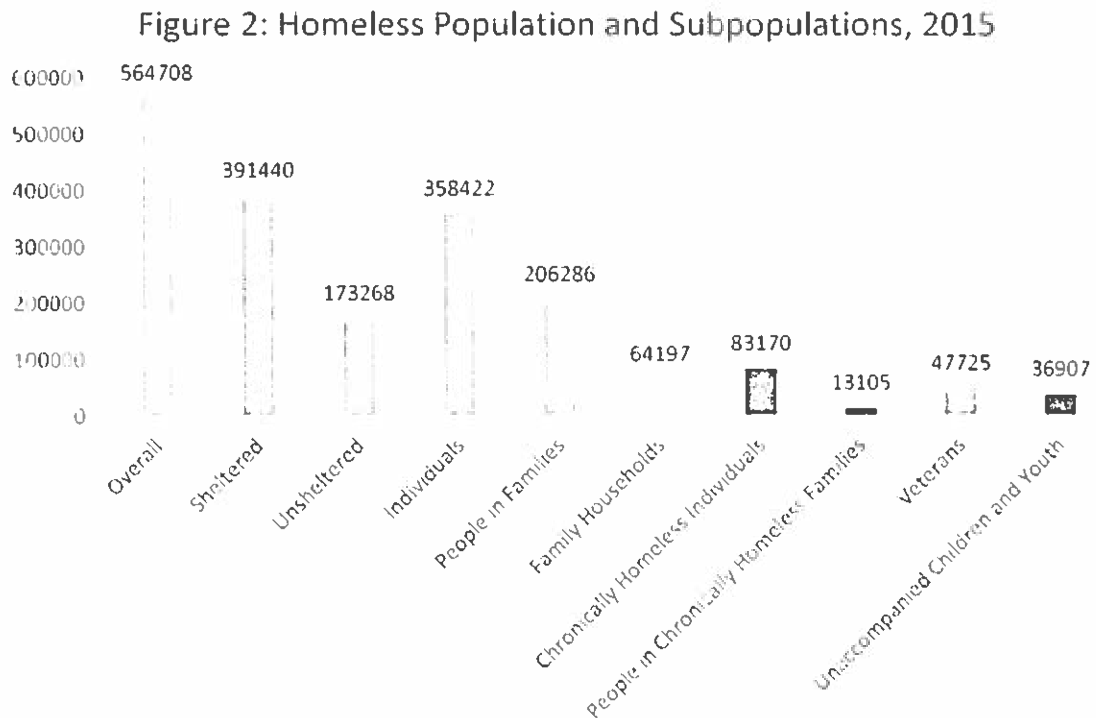
Figure 1



(National Alliance to End Homelessness, 2016, p. 8)

The homeless population can be further categorized. The whole population can be split into sheltered and unsheltered: the numbers for 2015 were 391,440 and 173,268 respectively. The whole population can also be split into individuals (358,422) and people in families (206,286). Other subpopulations that have been separately counted include Family Households (64,197), Chronically Homeless Individuals (83,170), People in Chronically Homeless Families (13,105), Veterans (47,725), and Unaccompanied Children and Youth (36,907). All these point in time estimates for year 2015 are shown in Figure 2.

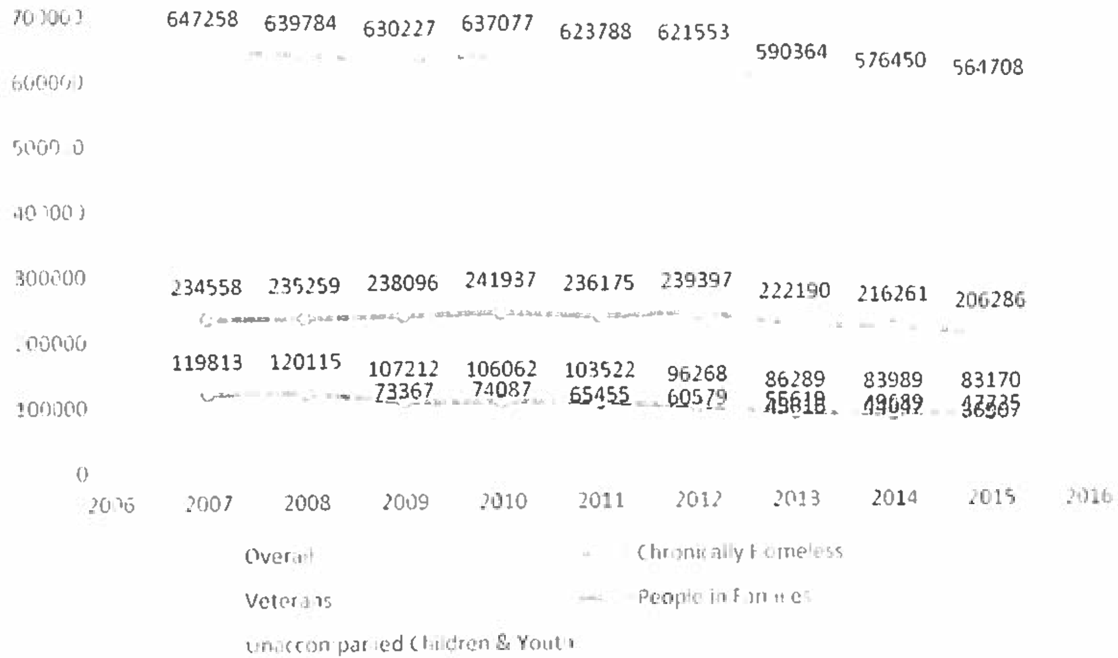
Figure 2



(National Alliance to End Homelessness, 2016, p. 7)

Figure 3 presents selected subpopulations over time from 2007 to 2015. Overall, the homeless population is decreasing from 647,258 in 2007 to 564,708 in 2015. The number of unsheltered homeless people has decreased significantly, falling from 255,857 in 2007 to 173,268 in 2015. People in families increased slightly from 2007 to 2012, rising from 234,558 to 239,397. However, from 2012 to 2015, the number of people in families has decreased to a low of 206,286.

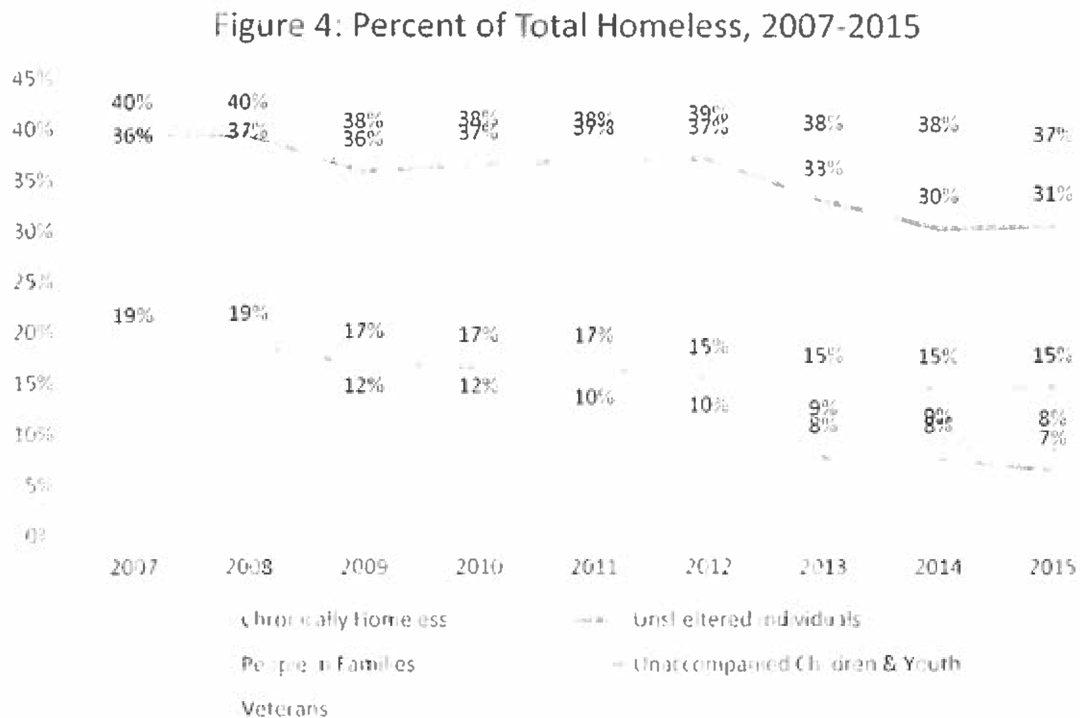
Figure 3



(National Alliance to End Homelessness, 2016, p. 9)

To further examine the trends of the subpopulations, Figure 4 shows the subpopulations as a percent of the total homeless population from 2007 to 2015. Subpopulations of note are Unsheltered Individuals that have decreased from 40 percent to 31 percent over the specified time period. Also of note is the nearly constant level of People in Families. This subpopulation has remained between 36 and 38 percent of the population total over the course of the time period. This could point to one area where more resources are required, or a new approach to assisting these families. The trend for all other populations in Figure 4 is downward.

Figure 4



The National Alliance to End Homelessness (2016, p. 3) reports a decrease in homelessness from 2014 to 2016. The number of unsheltered persons decreased by 1.2 percent, families by 4.6 percent, chronically homeless by 1 percent, and veterans by 4 percent. A decrease in the homeless has occurred nationwide. However, when broken down by state, the District of Columbia and 33 states reported decreases, but 16 states reported increases. The states with decreases in homelessness were concentrated in the South and Midwest.

Homeless tend to gather in larger cities with four cities that have a homeless population exceeding 0.40 percent of the population. These are Seattle at 0.44 percent, San Francisco at 0.57 percent, Atlanta at 0.62 percent, and Washington D.C. at 0.78

percent. The estimated total homeless population for urban and rural is between 230,000 to 600,000 (Culhane, Dejowski, Needham, & Macchia, 1994). The total homeless population in January 2015 at 564,708 individuals, as shown in Figure 3. It should be noted that this is not the same as the 1,593,150 people who experienced homelessness in 2011 cited earlier. This is because a PIT count is conducted once a year, and the number of people who experience homelessness over the course of a year is much higher.

The federal government spends considerable funds supporting different programs to assist the homeless. Lucas (2017, p 277) reports that "federal targeted homelessness assistance hovered around $2.5 billion until the HEARTH Act of 2009; by 2014, spending exceeded $5.4 billion adjusted to 2011 dollars. One of the largest recipients of this funding is HUD's Homelessness Prevention and Rapid Re-Housing Program (HPRP). This $1.5 billion program was implemented between 2009 and 2012 and aimed to reduce the negative social and health outcomes associated with prolonged homelessness (Brown, Vaclavik, Watson, & Wilka, 2017, p. 129). The Continuum of Care (C of C) system receives $1.8 billion, distributed to the Supportive Housing Program (SHP) (73%), the Shelter Plus Care (SPC) Program (25.7%), and the Section 8 Single Room Occupancy (SRO) Program (1.3%) (Moulton, 2013, p. 604) .

Part 3: Theories Explaining Why People are Homeless

This section looks at the co-occurring nature of homelessness, substance use, mental health, and incarceration, and how there is often a cyclical nature between these

factors for what is the cause of the other. It also looks at veterans, climate, and shifts in housing prices as other factors that can contribute to homelessness.

Substance use and homelessness are strongly co-occurring. Quigley, Rapheal, & Smolensky (2001, p. 38) report that approximately one-half of those who are homeless abuse drugs or alcohol. Metraux, Causack, Byrne, Hunt-Johnson, & True, (2017, p. 230) similarly identify substance use as being associated with homelessness. "Substance Use Disorders" are defined as "the recurrent use of alcohol and/or drugs causing clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home" (Substance Abuse and Mental Health Services Administration, 2018). High rates of substance use make it difficult to treat homelessness without also treating the substance use simultaneously.

Mental health illness also contributes to homelessness. Quigley, Rapheal, & Smolensky (2001, P. 38) report that "nearly one-third of the homeless suffer from mental illness." Therefore, treating homelessness is difficult without also treating mental illness.

The change in the laws regarding of mental health patients in the 1980s has contributed to an increase in homeless. Goldman & Morrissey (1985, p. 728) report that the resident population of state mental hospitals decreased from 560,000 to less than 140,000 between 1950 and 1980. Quigley, Rapheal, & Smolensky (2001, p. 38) report that the number of people housed in mental hospitals per 100,000 dropped by almost 80% from 148 to 30 between 1971 and 1993. Goldman & Morrissey (1985, p. 728) note that "mental health centers failed to meet the needs of acute and chronic patients discharged in increasing numbers from public hospitals. Homelessness and indecency were predictable outcomes for many."

Incarceration is correlated with homelessness. Cusack & Montgomery (2017, p. 250) find there is "a bidirectional association" between both homelessness and incarceration: they share risk factors such that "each increases the risk of the other." Belcher (1988, p. 93) discusses how homeless individuals become involved with the criminal justice system "because of a combination of severe mental illness, a tendency to decompensate in non-structured environments, an unwillingness or inability to participate in voluntary aftercare arrangements, and an unwillingness to take prescribed medications." (Belcher, 1988, p. 193).

It is common for homeless people to experience "short hospital stays" and "frequent incarceration in jails" (Belcher, 1988, p. 186). Because homeless with co-occurring mental health problems often end up on the streets "wandering aimlessly in the community, psychotic much of the time, and unable to manage their internal control systems, these people found the criminal justice system was an asylum of last resort" (Belcher, 1988, p. 193). The short-term hospital stays and unsupervised treatments are typically not transformational. Consequently, many mentally ill homeless people do not obtain supervised mental health care until they commit a crime. That is, the prison system has at least partially replaced mental health institutions as treatment centers for seriously ill mental health patients.

Veterans have a high representation in the homeless community. According to Metraux, Causack, Byrne, Hunt-Johnson, and True (2017, p. 230-232) approximately two-thirds of combat veterans become homeless within two years of leaving the military. This was approximately 31,412 to 33,376 of veterans in 2015 who had been deployed in Operation Enduring Freedom or Operation Iraqi Freedom. They conclude that

"understanding the risks for homelessness for these veterans requires delineating (a) general links between military service and homelessness and (b) the particular circumstances affecting this group" (Metraux, Causack, Byrne, Hunt-Johnson, & True, 2017, p. 230).

Tsai, Hoff, & Harpaz-Rotem (2017, p. 204) provide information on the age demographics of homelessness among veterans. They find that veterans aged 46 55 years were at highest risk for homelessness. The majority of homeless veterans are aged 26 55.

Posttraumatic stress disorder (PTSD) has been linked to homelessness. Cusack & Montgomery (2017, pp. 250-251) find an interaction between PTSD and incarceration, reporting that "twice as many incarcerated veterans as nonveterans have a diagnosis of posttraumatic stress disorder." This is important given the bidirectional nature of homelessness and incarceration. Veterans are especially challenging given the additional layers of experiences of the group that are very specific, difficult to relate to, and difficult to convey.

Quigley, Rapheal, & Smolensky (2001, p. 50) note a consistent effect of weather conditions on the incidence of homelessness: colder weather yields lower rates. Hawaii and California have more temperate climates, and have rates of homlessness that are among the highest. Hawaii has 53.7 homeless per 10,000, while California has 29.8 per 10,000 (National Alliance to End Homelessness, 2016, p. 12). Colburn (2017, p. 81) identifies weather among a number of factors, reporting that changes in "labor markets, weather patterns, the school calendar, evictions and utility shutoffs contribute to homelessness with varied intensity throughout the course of a specific year."

Quigley, Rapheal, & Smolensky (2001, p. 50) find that tighter housing markets are positively associated with higher levels of homelessness. Their results show that a twenty-five percent reduction in the homeless rate could be achieved nationally by a one percent increase in the vacancy rate, and a decrease in the monthly national rent to income ratios from 17.5 percent to 16.8 percent. The vacancy rate is the percentage of empty housing units. Consequently, they argue that one of the most efficient ways to combat homelessness is to implement policies that increase the housing supply and housing assistance programs that are focused on individuals and families for whom housing costs require a large share of their incomes.

Part 4: Policies to Reduce Homelessness

Municipalities across the country are addressing homelessness. The primary tool is to change laws and local codes. Each of these areas is working to remove what they call blight, vagrancies, panhandling, or pennilessness from their streets to make their cities more appealing.

Broder (2015) summarizes the activities common among the homeless that have become targeted by laws: (1) standing, sitting, and resting in public places; (2) sleeping, camping, and lodging in public places, including in vehicles; (3) begging and panhandling; and (4) food sharing. As an example, more than 7,000 Californians were picked up for vagrancy in 2013, (Boden & Selbin, 2015).

Panhandling is soliciting in the form of a request of an immediate donation of money or other thing of value from another person without regard for the intended use of

the money or thing of value (Manager, 2010). A number of court cases have refined the law regarding who is allowed to solicit, when, and where. The legal tension involves balancing the right of a community to construct a desired environment against the right of an individual to freely speak to and assemble with others.

In McCullen v. Coakley (2014), overturned a Massachusetts law that established a 35 foot buffer zone around abortion clinics. While the case does not directly involve the homeless is establishes a framework that has been used in other cases that do. The law prohibited people from remaining in the buffer zone during business hours. The Court decide the law burdened free speech more than necessary to further the government's legitimate interests. It deprived the abortion objectors of their primary methods of communicating: close, personal conversations and distribution of literature. Also, the Court found Massachusetts had another option for accomplishing its interest. It could also enact legislation similar to the Freedom of Access to Clinic Entrances Act, which imposes sanctions for obstructing, intimidating, or interfering with persons obtaining or providing reproductive health services.

Although the McCullen v. Coakley case was not focused on panhandling or the homeless, it has repercussions because the Court decided that restrictions on speech of this type would be consider under "intermediate scrutiny." Intermediate scrutiny requires that a government restriction on speech satisfy three requirements: a) the restriction must be content neutral; b) the restriction must be narrowly tailored to serve a significant government interest; and c) the restriction must provide ample alternative channels of

communication (Blair, 2015). These requirements shape the restrictions on local governments can place on the speech of the homeless.

In Clatterbuck v. City of Charlottesville (2013), the Fourth District Court examined a Charlottesville, Virginia ordinance that prohibited individuals from soliciting immediate donations near two streets that run through the Downtown Mall in Charlottesville. Clatterbuck challenged the ordinance "as a content-based regulation that criminalizes speech based on the content of the communication" designed "to restrict the right of the impoverished to solicit funds for their own well-being." In its opinion, the Fourth District notes that the Supreme Court has held that the solicitation of "charitable contributions" is protected speech in Riley v National Federation of the Blind of N.C. (1988). Further, the opinion notes that the Supreme Court has repeatedly referred to public streets and sidewalks as "the archetype of a traditional public forum," where speech should especially be protected. The opinion recognizes the right of government to "impose reasonable content-neutral time, place, and manner restrictions that are narrowly tailored to serve a significant government interest. However, they note that if the law restricts the content of speech, then strict scrutiny, not just intermediate scrutiny must be applied. Under strict scrutiny, a restriction on speech can only be allowed if "it is the least restrictive means available to further a compelling government interest." The opinion indicated that the City did not clearly identify its purpose in creating the legislation, which prevented the Court from being able to decide whether the ordinance was the least restrictive means and prevented the court from deciding whether the speech was content neutral. The decision to deem the ordinance unconstitutional was based upon the view that it specifically targeted the speech of

beggars, rather than restricting solicitation in general, and based upon the view that less restrictive alternatives existed which could accomplish the interests of the government.

In Reynolds v. Middleton (2015), a homeless man named Robert Reynolds brought an action against an ordinance that prohibited solicitation near road ways. Fourth Circuit U.S. Court of Appeals found that, while solicitation has protection under the First Amendment, it can be generally restricted under the intermediate scrutiny standard if government presents evidence that there is a compelling state interest. The court found that public safety and the unobstructed use of roadways and sidewalks is a legitimate government interest. In this case, the police chief testified about the increasing number of people soliciting contributions from intersections, and he described potential dangers associated with that activity. However, the ordinance applied to all public roadways, even those where there was not significant traffic. In sending the case back to the District Court for consideration, the Circuit Court indicated speech in the form of solicitation can be limited when there is evidence that it presents a public safety concern but not when evidence cannot be presented.

The take away from these cases is that restrictions on solicitation speech must be content neutral, and they must outlaw all acts of solicitation not just the acts of the homeless. For example, a city cannot remove homeless solicitors while allowing other charity groups to solicit donations. The laws cannot narrowly target the homeless. More narrowly tailored laws targeting panhandling are more likely to be upheld if reasonable alternatives are presented that will allow the homeless to accomplish their objectives. To

summarize, because of the importance of the protection of free speech, the homeless cannot be legislated out of an area as may be desire by passing a few laws.

California has one of the highest concentrations of homelessness. With 12 percent of the U.S. population, Broder (2015) reports that California has more than 20% of the nation's homeless. In 2016, the rate of homelessness in Californian was 29.8 homeless persons per 10,000 people (National Alliance to End Homelessness, 2016, p. 12). With such a heavy concentration of homeless, California is a state worth examining with regard to policy.

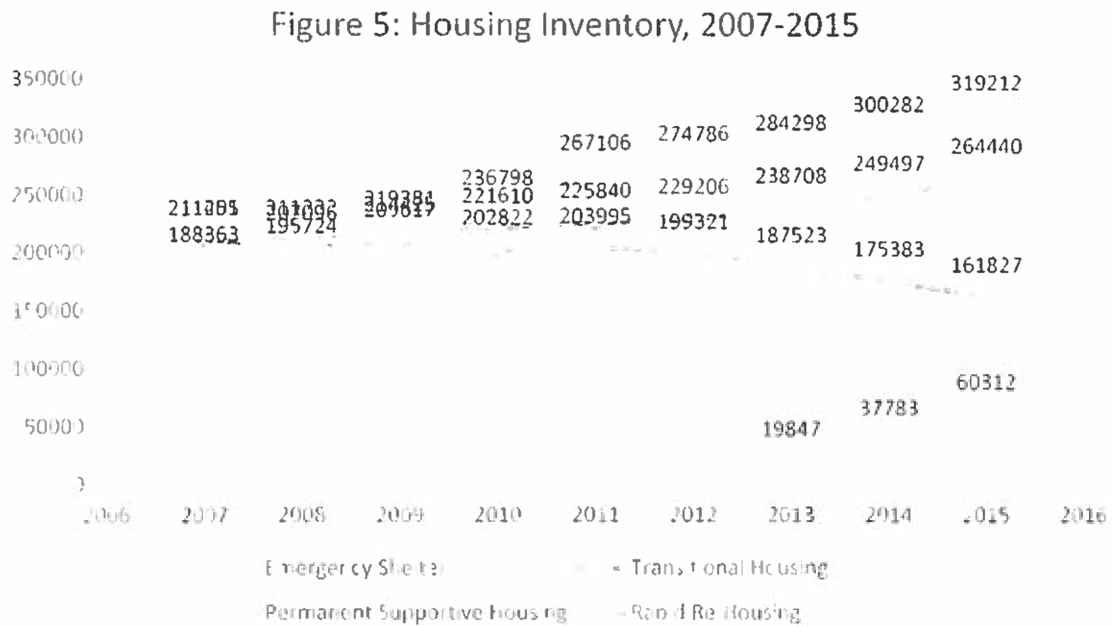
The National Coalition for the Homeless (2016) has recognized the California city Santa Monica for its laws related to homelessness. It is illegal in Santa Monica to lie or sit on any sidewalk in the city. It is illegal to shave, bathe, or wash clothing items in any public restroom. It is illegal to sleep anywhere in a vehicle. Santa Monica even has laws that make it difficult or illegal for groups who help the homeless to serve meals outdoors to the city's homeless.

Similar to what has been happening in Santa Monica, cities across the nation are outlawing actions typically undertaken by homeless including living in vehicles, camping in public, and panhandling (Bussewitz & Slevin, 2016). Bussewitz and Slevin (2016) note that Denver, Colorado and Honolulu, Hawaii have been criticized by homeless advocates for their actions. Denver forcibly dismantled camps where homeless were congregating. Honolulu enforced a sit-lie ban. A positive side of these laws in Hawaii is there is evidence the laws have moved many homeless off the streets and plugged them into programs meant to help them. Specifically, Bussewitz and Slevin (2016) report that

the result of the actions in Hawaii moved 1,000 homeless into housing, and 860 of these were veterans.

At the national level, there have been significant efforts to address homelessness through housing programs. Figure 5 shows housing inventories for four different types of housing systems developed to help the homeless. These types include (1) emergency shelters, (2) transitional housing, (3) permanent supportive housing, and (4) rapid re-housing.

Figure 5



(National Alliance to End Homelessness, 2016, p. 56)

Emergency Shelters are defined by HUD as "any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless" (HUD USER, 2018). From 2008 to 2015, the inventory of emergency shelters increased by 25.1 percent.

Transitional Housing is defined by HUD as "a project that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months)" (HUD USER, 2018). The inventory of Transitional Housing decreased 23.4 percent from 2007 and 2015.

According to HUD, permanent supportive housing is designed to assist homeless persons in transitioning from homelessness so they can live as independently as possible (HUD.GOV, 2018). Permanent supportive housing increased 69.2 from 2007 to 2015.

Rapid re-housing is a more recent program, with data available only from 2013 to 2015. According to the United States Interagency Council on Homelessness, rapid re-housing is designed to help individuals and families quickly exit homelessness and return to permanent housing. The program has no preconditions like employment, income, criminal record, nor sobriety, and the resources and services provided are tailored to the unique needs of the household (United States Interagency Council on Homelessness, 2018). This program shows promise because of its flexibility and its ability to be tailored to the individual. From 2013 to 2015, rapid re-housing has increased a staggering 203.9 percent.

In addition to housing, medical care is another major factor in the lives of the homeless. Using 1980 data, researchers identified 1,800 community hospitals approximately 30 percent of the nation's total that provide 70 percent of the hospital care to the poor, including those covered by Medicaid and those for whom hospitals receive no reimbursement at all (Committee on Health Care for Homeless People, 1988, p. 90). Altogether, the nation's hospitals provide over $6 billion a year in bad debt and

charity care, primarily to low-income people, in addition to roughly $16 billion in services to Medicaid recipients (American Hospital Association, 1986). States are required to provide additional payments to hospitals treating a disproportionate share of low-income patients (Health Care Financing Administration, 2000, p. 9).

The City of Reno, Nevada area is currently in the process of constituting a Community Homeless Advisory Board (CHAB). The board will include six members, all of whom will be elected officials. Kristopher Dahir, Sparks' city councilman, will be a member of the board, and he provided some additional information on the CHAB.

During the interview, councilman Dahir described the purpose of CHAB is to be the center of a wagon wheel where other local resources that help the homeless are the spokes. CHAB should "connect the dots," so there will be better coordination. CHAB also aims to help the almost homeless in addition to helping the homeless. By helping individuals on the border of becoming homeless, it is hoped that the total level of homelessness can be lessened, benefitting the individuals and the community as a whole.

CHAB has yet to meet, but it has been successful at securing a federal grant for fact finding. The fact finding study will provide a "bird's eye view" of what Reno has to offer and where resources would be best utilized. Demographic data on the homeless in the Reno area will be gathered, and information on the resources that can help homelessness will also be gathered.

Nevada has a high rate of homelessness relative to the average state. The Nevada rate is 30.8 per 10,000, while the national average is 17.7 per 10,000, (National Alliance to End Homelessness, 2016, p. 13). The creation of CHAB should reduce Nevada's rate.

In a 2006 article from the New Yorker entitled "*Million-Dollar Murray*," the costs of homelessness are discussed. Mr. Murray Barr was a homeless person in Reno, whose homelessness was estimated to have cost almost $1millions over a 10 year period. The article presented statistics on the costs generated by homelessness for a number of cities.

In Boston, 119 chronically homeless people accounted for 18,834 emergency-room visits costing a thousand dollars a visit on average. (Gladwell, 2006). This means that these 119 chronically homeless cost 18,834,000 over a five year period.

Another example is from the University of California, San Diego Medical Center. In this case, fifteen chronically homeless were followed over eighteen months where these individuals were treated at the hospital's emergency room four hundred and seventeen times. Average cost was a hundred thousand dollars a visit. This would be a cost of approximately $41,700,000 in a year and a half, (Gladwell, 2006).

Within Reno, Nevada there were 869 homeless in the city, (Deines, 2018). If following Moulton's assumption of approximately 23 percent being chronically homeless that would mean there are just under 200 chronically homeless in Reno. Assuming that they also average a thousand dollar per emergency room visit, and that they have accounted for 20,000 emergency room visits in the last 5 years similar to the Boston case discussed earlier. This would mean that these individuals accounted for $20,000,000 in five years of emergency room visits a cost of $4,000,000 a year for just 200 chronically homeless. These costs would be reoccurring every year making treatment options for more appealing.

According to the U.S. Inter-Agency Council on Homelessness it costs a community $30,000 to $50,000 per year in emergency room visits, shelters, and jails to support one homeless, and only costs $20,000 to provide supportive housing. (Olivares, 2015). This means that the costs of the chronically homeless population in Reno would be approximately $10,000,000 a year assuming they cost $50,000 and there are 200. The costs of the other 669 homeless would be another $20,070,000 assuming they only cost the city $20,000 per individual. The total approximate cost would be over 30 million dollars to the city. The cost of providing housing would be $17,380,000 total for all 869 homeless. A saving of $12,690,000 per year.

The ability to save on the costs of homlessness makes the costs of a program like Haven for Hope look more appealing. Additionally, the city would have an increased workforce that would allow for more taxes. Another benefit would be local businesses would lose fewer customers from a high concentration of homeless in the area. Also, the city would appear more beautiful and people would be more likely to use amenities like the river walk.

Part 5: Descriptions of Some Current Programs

Treating homelessness with its varied causes is difficult. This section describes several programs that have been effective at treating homelessness. The section is organized by starting with larger national level programs. It then shifts the focus to state and local programs, including several in the Reno, Nevada area.

Housing First

Housing First (HF) is a federally funded program that provides barrier-free access to housing and other supports for the homeless, regardless of compliance with treatment, symptom improvement, or abstinence (Tsemberis, 1999). According to Russolillo, Patterson, McCandless, Moniruzzaman, & Somers (2014, p. 80), the goal of HF is to provide clients with access to permanent market housing along with services and supports as needed to promote recovery.

While those examining HF has reported down sides, the program also has demonstrated effectiveness. Lucas (2017) expressed concern that large federal programs like HF can crowding out other programs that are less costly and more effective. Despite some detractors, HF has shown potential to help on a large national scale.

HUD-VASH

HUD-VASH is a program that helps homeless veterans and their families obtain and sustain permanent housing. It is a collaboration between the Veterans Administration (VA) and HUD. HUD provides rental assistance, and the VA provides supportive services to veterans and their families. The housing involved in the program is privately owned.

The HUD-VASH program is the largest single help for veterans who experience long term homelessness or repeated homelessness. As of September 30, 2015, HUD had allocated more than 78,000 vouchers to help house Veterans across the country (U.S. Department of Veterans Affairs, 2018). While a vet is in the program, a VA case

manager may connect the vet with health care, mental health treatment, or substance use counseling to help them in their recovery process.

Outcomes for the program have been overall positive. Cusack and Montgomery (2017, p.252) report on a study of 1060 male veterans who were admitted to HUD-VASH and then exited the program did so for the following reasons: accomplished goals/no longer needed program (43.7%), evicted (11.3%), chose other housing (8.9%), no longer interested (8.7%), financially ineligible (5.2%), unable to be located (3.8%), noncompliant with case management (3.0%), too ill (1.8%:), transferred to another program (1.4%), unhappy with housing (0.5%), and other reasons (11.6%) (2017, p. 252). This study shows the program is successful and does help veterans get out of homelessness.

Delancey Street

Delancey Street is considered one of the leading residential self-help organizations for substance abusers, ex-convicts, homeless, and others who have hit rock bottom. Located in San Francisco, their average resident is an addict with 16 year history of addiction, abused alcohol and multiple drugs, and has dropped out of school by the seventh grade. Many have been institutionalized, been in gangs, or have lived in family that has faced poverty for several generations. Their facility is run with no experts or staff, and alumni help residents develop strengths and help each other. By taking ex-convicts and ex-addicts and educating them to be teachers, general contractors, and truck drivers the facility looks to be changing lives in a way that is "against all odds."

The program began when 250 people who had no skills, and who had never worked before, built a 400,000-square foot facility. They then began to partner with colleges to take people from illiteracy to the ability to achieve B.A. degrees. An additional important step was to include practical entrepreneurship. Delancey Street residents go on to run successful restaurants, moving companies, furniture making companies, cafes, and bookstores without professional help.

Delancey Street is a model that has endured. It now has forty years of developing social entrepreneurship, education, rehabilitation, and change.

Habilitat

Habilitat is a program in Hawaii which has been proven successful at treating substance abuse over the long-term. It boasts a perfect success rate for people who voluntarily make it through the two-year program, and Habilitat is entirely self-funded. Given the prevalence of drug abuse among the homeless, Habilitat provides a model that could be applied across the country to help homeless.

Habilitat implements three phases of recovery: (1) Treatment, is highly structured focusing on assessing individual's inclinations, strengths and weaknesses; (2) Re-Entry, focuses on the development of self-reliance through gathering life skills; and (3) Post, the rigor of the program begins to relax for a transition into normal life.

The program seeks to alleviate the culture shock of returning to a normal life. It does this through a gradual transition to increase chances of success. The Habilitat program stands out for the self-reliance individuals possess after the program. The struggle that is faced in a structured environment leads to increased independence and maturity. This makes it more likely that those helped will be able to "find their own

job." The Habilitat process of treatment, education, and gradual integration is replicable, a model for addressing the multiple issues that are invariably associated with homelessness.

Haven for Hope

Haven for hope differs from the other programs in the paper as it is specifically targeted to homelessness. The facility is in San Antonio, TX and is a 22-acre campus with over 30 agencies present on campus. Available services range from medical, to legal, and even kennels for the pets of clients. Boasting 2700 clients moved into permanent housing and another 4600 moved into temporary housing. The facility has been a major part of the 15% reduction in homelessness in San Antonio since 2010.

Another service offered by Haven for Hope is 'the courtyard.' This is an area where homeless can congregate that is patrolled by security, close to treatment facilities, and shaded against the heat of the city. It allows the homeless to become adjusted to the Haven for Hope staff and programs if they should choose to enter the program.

Costs for the campus were approximately $101 million with much of the funding coming from donors and $20 million donated by Bill Greehey who began the program. Haven for Hope has seen such high success rates that 250 other cites from across the country have looked at duplicating the program or parts of it.

Northern Nevada Community Housing

Northern Nevada Community Housing (NNCH) recently completed construction of Hillside Meadows Apartments. This complex features 44 apartments and many

amenities all focused to helping veterans. The complex is a partnership with Veterans Resource Center of American. The complex was constructed so veteran households and veterans with special needs can be immediately referred to Hillside Meadows when housing needs arise.

Hillside Meadows aims to be more than a housing complex. It also provides financial literacy and budgeting classes, a food pantry, and a hygiene center. The aim is "ensure tenant success and maximize partner resources" (Northern Nevada Community Housing, 2018).

Veterans Resource Centers exist all across the country. The centers are part of a 40-year program with a history of serving veterans. Hillside Meadows will have a positive impact on the Reno, Nevada area for years to come.

Volunteers of America

Volunteers of America (VOA) is a national non-profit, which includes approximately 16,000 professionals helping people rebuild lives and reach maximum potential. VOA helps approximately 1.4 million people annually including homeless people, veterans, and the disabled. In the Reno area they offer Affordable Housing Communities, ReStart, a Resource Center, and Shelters.

In Northern Nevada, VOA affordable housing communities focus on seniors age 62 and older. ReStart offers clinical and non-clinical services for individuals and families who are homeless, or at risk of homelessness, or have a mental illness." (Volunteers of America, 2018). Resources centers help homeless work toward greater self-sufficiency by offering computers, telephones, and mail delivery. Emergency shelters are available

for families, men, and women. In total, the VOA provide a vital part of the community support system in the Reno area.

Crossroads

A program specific to the Reno, Nevada area, Crossroads offers housing and programs to help with a successful transition from substance abuse and homelessness to a more normal lifestyle. With established connections with the Washoe County Sheriff's Department, Human Services Agency, and Catholic Charities of Northern Nevada, the program is helping community members reintegrate.

The Washoe County Sheriff's Department provides direct referrals upon release from jail, and it provides two full-time deputies who are on site with funds provided by The Human Services Agency. Between the 241 clients that have been helped they have spent a total of 12,590 days in jail or 35 years in jail. (Crossroads, 2018).

The Human Services Agency commits social workers and specialists to the program. These positions are out-stationed at the Crossroads facility to provide a more complete service connection. (Crossroads, 2018).

Catholic Charities of Northern Nevada (CCNN) operates and owns the property upon which Crossroads is built. Additionally, CCNN provides for housing services and basic needs in addition to providing donations to the program, thrift store, and food pantry.

Other community agencies that collaborate with Crossroads include Alta Vista Mental Health, the Veterans Resource Center and Smile Restore, Washoe County Alternative Sentencing Department, Reno Justice Court, Reno Municipal Court, Second Judicial District Court, WestCare and Northern Nevada Adult Mental Health Services.

(Crossroads, 2018). With all of these programs, services, and resources operating together, Crossroads is an effective program at treating homelessness and all of the causes that were discussed earlier.

Ridge House

Another program local to the Reno, Nevada area is The Ridge House. It is a recovery-oriented program providing comprehensive residential and out-patient services for individuals struggling with addiction. Accomplished through strategic programming their clients can succeed in their recovery and reintegrate into society (The Ridge House, Inc., 2018).

The program focuses on recovery through developing skills for independent living. By offering financial education, counseling, and communication courses individuals learn to manage life skills, credit, and even voting. Many clients also receive assistance with substance abuse and mental health illness. Counseling is offered for behavioral health, substance abuse, and mental health on both one on one and group environments.

Another area the program focuses on is employment. The program recognizes that to truly be independent clients will need to be employed. That is why the program helps with job placement and career development programs including resume and job skill courses, education, vocational training, and interviewing skills.

Ridge House reports helping 327 individuals in 2013, with a 25 percent recidivism rate. They also report to have saved the community $15,000 per individual

helped (The Ridge House, Inc., 2018). Because the program treats multiple causes of homelessness, it is well positioned to make a major impact in the Reno community.

Eddy House

The Eddy house is aiming to end youth homelessness in the Reno, Nevada area. They plan to do this through promoting self-sufficiency in youth age 18 to 24. This is being done by providing individualized programs that are relationship based, a trusting and safe environment, basic needs, and access to resources from the Reno community.

The Eddy House was founded in 2011 by Lynette Eddy at a residence purchased for former foster youth who found themselves aging out of the foster system (Eddy House, 2018). Over the next 5 years and with an initiative from the Community Foundation of Western Nevada Eddy House has become a drop in center for homeless youth. Managers provide light case management and referrals to community agencies.

Of the roughly 53,000 youth who are homeless in the United States over a given year, there are an estimated 3,500 in Reno. (Eddy House, 2018). These young people are often coming from backgrounds of neglect and abuse, homes with substance abuse or mental illness, and area aging out of foster care. Eddy House offers youths a safe place to connect with resources, develop skills, and found their futures.

Conclusion

After presenting insight from reviewing literature on homelessness, this thesis presented key facts about homelessness. Nationwide, roughly one half of one percent of

the U.S. population is homeless in a given year. The majority are between the ages of eighteen and fifty, one-third are mentally ill, and about one-half have drug or alcohol use issues. Approximately one fifth of the homeless are chronically homeless and the cost to rehabilitate a chronically homeless person is an estimated $55,600.

Since PIT counts began in 2007, the homeless population has been declining. Homelessness is not on the decline in every state, but 33 states and Washington DC show declines. The costs of programs designed to serve the homeless are significant, but likely explaining some of the decline in the homeless population.

This thesis summarizes the reasons why people become homeless that researchers have identified. A key finding is homelessness, substance abuse, mental health, and incarceration are co-occurring. Again, approximately one-half of homeless abuse drugs or alcohol, and one third have mental health issues. Resulting in the criminal justice system becoming a replacement for mental health institutions when it comes to treating the mentally ill.

One of the greatest limiters on success for treating any of these disorders is the co-occurrence between homelessness and one or many of these other factors. Meaning to effectively treat one of the conditions the other must be treated simultaneously. If this is not done the patient will end up bouncing between treatment programs, homelessness, or jail.

Other contributors of homelessness are veteran status, warmer climate, and increasing housing prices. Approximately two-thirds of combat veterans experience homelessness within two years of leaving the military. There are higher populations of

homelessness in larger cities with milder climates. There is evidence that increasing the housing supply can help alleviate this issue.

Localities have sought to use changes in the law to address homelessness, but the success is limited by the fact that a balance must be struck between trying to reduce the negative externalities of homelessness and protecting the civil rights of individuals. Many laws have the appearance of harassing the homeless, but courts for the most part have ruled against laws that too specifically target the homeless. A law that prevents all solicitation, not just solicitation by the homeless, near busy roadways has been upheld in court based upon a government legitimate interest for public safety. However, courts have upheld the rights of the homeless to solicit in public when localities have not been able to provide evidence of significant harm. Consequently, it appears that localities will not be able to effectively use laws alone to remove homeless people from areas as they may desire.

On a national level, programs are becoming more prevalent, and funds are also being reallocated as more effective programs are identified. For example, traditional transitional housing programs experienced a 23.4 percent decrease in funding from 2007 to 2015, but Rapid Re-housing saw a 203.9 percent increase from 2013 to 2015. Overall, it appears funds are getting to programs that are more effective.

Many private programs that help the homeless are self-funded. Haven for Hope is an important example, funded by the local community. Community programs complement the government programs. A mix of programs seems to be required so a community has the ability to offer holistic help to homeless. To be effective, a

community must have the ability to treat not just one issue, but rather multiple co-occurring disorders must be addressed at once.

To conclude, I will provide my impressions about how to effectively treat homelessness. First, we should not expect that homelessness can be cured by a single program, a single law, or a single organization. Multiple treatments must be available to treat the multiple causes. Treatments that are not holistic will most likely only provide temporary relief rather than a long-term solution.

A single organization is often not capable of providing a holistic approach for treating the co-occurring nature of homelessness. Instead, coordination of existing programs is needed. An effective program will be tailored to the needs of the patient, with each existing program bringing its relevant help to the situation. A government organization might facilitate especially on larger scales. CHAB being organized in Northern Nevada is promising in this regard.

When a program specializes in a specific area of treatment, it is essential that the program refer patients to other programs when co-occurring problems are evident. A common problem is that homeless individuals go through detox and are then sent 'home,' but the inability to maintain a home leads many back the streets where the drug addiction may have begun. That is, many cycle through detox and homelessness. If this cycle is to end the treatment of multiple problems must become the norm. Movement to a stable income and stable housing must be part of the goal.

There are a few programs that recognize the importance of holistic treatment. Haven for Hope, Habilitat, Delancy Street, Crossroads, and Ridge House are all examples. Focusing on drug and alcohol treatment, housing, mental health, and

education these programs makes employability and stability a reality. The high success rates of these programs illustrates the promise of the holistic approach.

It is evident that society could more effectively allocate the resources currently allocated to helping the homeless, but finding specific improvements is challenging because incentives are misaligned. The costs incurred for emergency room visits, which have been estimated at an average of $1000 per visit, would decrease if a locality were able to reduce the number of people who are chronically homeless. However, a city does not have a direct incentive to fund initiatives to help the homeless when the medical costs are born by the hospital and its funding sources. While hospitals might improve their finances by shifting efforts toward reducing homelessness, but they are not designed for this purpose.

The efforts of localities to address homelessness seem to be primarily motivated by a combination of compassion, and a concern for the impact of homelessness on local businesses and on the reputation of the city. A concern for the direct impact on police resources and public safety have also provided motivation. More progress toward reducing homelessness would be made if changes in laws or changes in institutional structures could better align incentives, so the costs of homelessness are not shifted to hospitals, jails and prisons, or to a few local businesses, but rather are born more broadly by the community, giving the community more incentive to act through their local governments.

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Appendix A

Homeless Supports

Crossroads:
A partnership with Washoe County Social Services and the Washoe County Sheriff's Office that provides housing and supportive living arrangements for men and women battling addiction and transitioning out of homelessness. Drug and alcohol counseling is offered to all residents.
Main Campus: (775) 785-4006
River House: (775) 229-5847
Park House: (775) 785-4006
https://ccsnn.org/pages/crossroads-housing-program

Ridge House:
Ridge House is the only statewide organization providing a comprehensive recovery-oriented system of care that includes behavioral health treatment to individuals in recovery from addiction. Through compassionate services and strategic programming, we help our clients become productive community members. Since 1982, our work continues to save our community over $7 million per year.
(775) 322-8941
https://www.ridgehouse.org/about/

Community Assistance Center:
Provides services to assist individuals who are homeless with resources and case management. Offering a 30-day emergency placement program that can be extended depending on the person's circumstances, and a Triage Center is a short-term detox and stabilization center.
Men's Shelter (775) 329-4141
Women's Shelter (775) 329-4145
Family Shelter (775) 722-2296
www.voa-ncnn.org/family-shelter-reno

Reno-Sparks Gospel Mission – Men's Emergency Shelter:
The Reno-Sparks Gospel Mission offers both emergency and long-term services for men and women in need.
(775) 329-0485
www.rsgm.com

Family Promise of Reno Sparks:
Through the Interfaith Hospitality Network program Family Promise of Reno/Sparks provides a safe place from which families can transition into permanent housing.
(775) 284-5566

https://www.shelterlistings.org/details/20606/

Food Bank of Northern Nevada:
Over 140 partners that provided 14,135,466 meals last year and served 95,000 people each month.
550 Italy Drive Reno, NV.
(775) 331-3663
https://fbnn.org/

Catholic Charities of Northern Nevada:
Offering adoption services, case management, food pantry, dining room, senior nutrition, immigration assistance, crossroads (housing), children's learning center, plates to ease poverty, operation stocking stuffer, operation Easter basket, project homeless connect, food drives, and heartfelt haircuts there are tons of program and ways to engage in the community.
(775) 322-7073
www.ccsn.org

Community Services Agency:
The Agency has initiated and developed numerous programs in human services, economic development, education and affordable housing.
(775) 786-6023
www.csareno.org

Division of Welfare and Supportive Services:
Their mission is to engage clients, staff, and the community to provide public assistance benefits to all who qualify and reasonable support for children with absentee parents to help Nevadans achieve safe, stable, and healthy lives.
Reno: (775) 684-7200
Sparks: (775) 824-7400
https://dwss.nv.gov/

Family Resource Center:
Providing information, referrals, and case management to residents in each Service Area, defined by residential zip code. FRCs collaborate with local and state agencies and organizations to help individuals and families access needed services and support.
Northwest Reno: (775) 337-9979
Sun Valley Office: (775) 674-4411
Sparks Office (775) 353-5733
http://dhhs.nv.gov/Programs/Grants/Programs/FRC/Family_Resource_Center/

Eddy House:

The central intake and assessment for homeless and at-risk youth. Works with homeless and at-risk youth to develop life and job skills necessary for sustainable independence.
(775) 316-8969
http://eddyhouse.org/

Nevada Youth Empowerment Project:
A unique, community-based youth service provider founded in 2007, develops, implements and evaluates programming targeting homeless, aged-out, unprepared, parent less youth (ages 18-24), designed to produce the outcomes desired for older youth and emerging adults: high school graduation, employment, college education, independent housing, good citizenry, and avoidance of welfare.
(775) 747-2073
http://nyep.org

Children's Cabinet:
Community's stand to ensure that every child and family has the services and resources to meet fundamental development, care and learning needs.
(775) 856-6200
http://www.childrenscabinet.org/