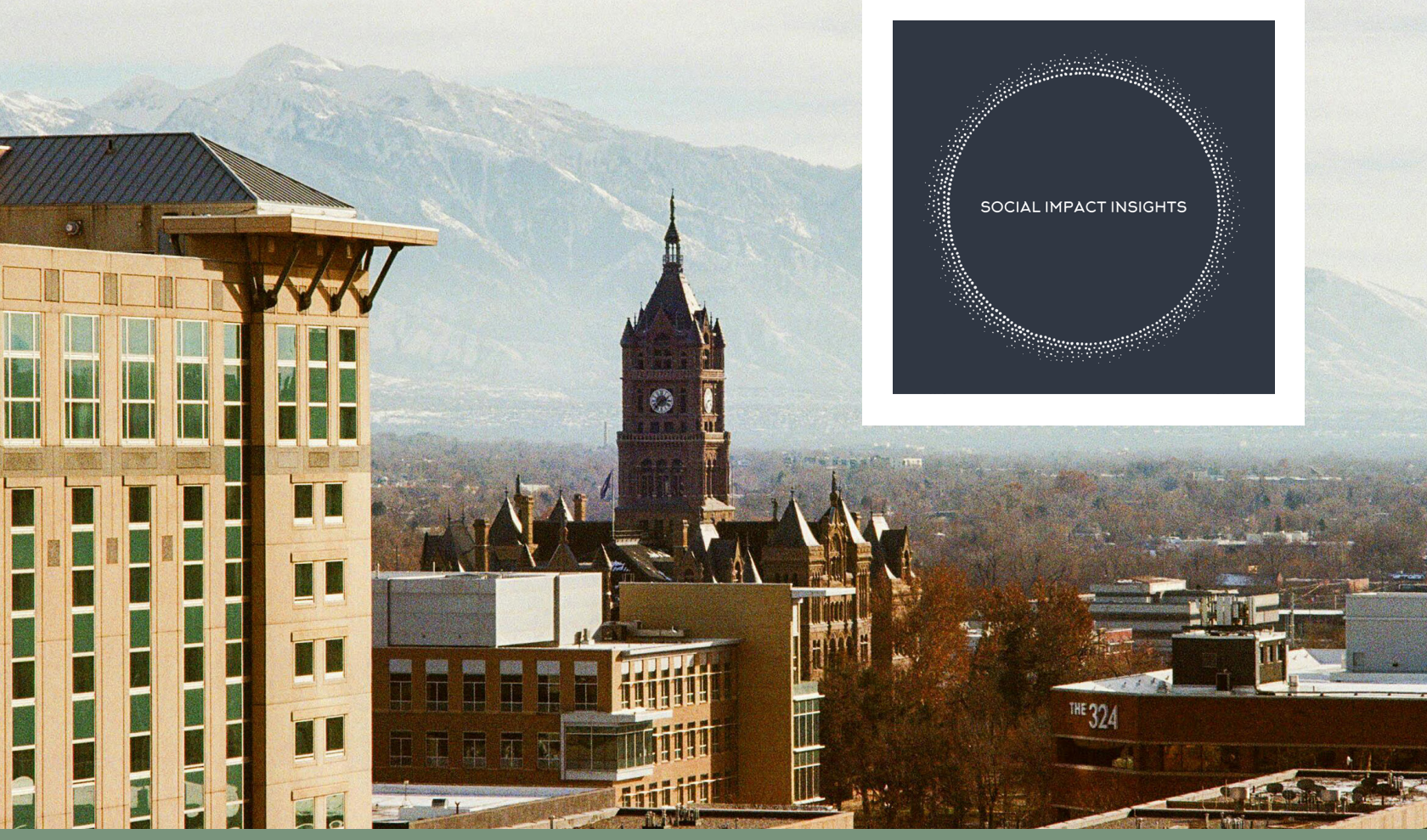

Homelessness in Salt Lake County and the Proposed Utah Campus

An Evidence-Based Assessment

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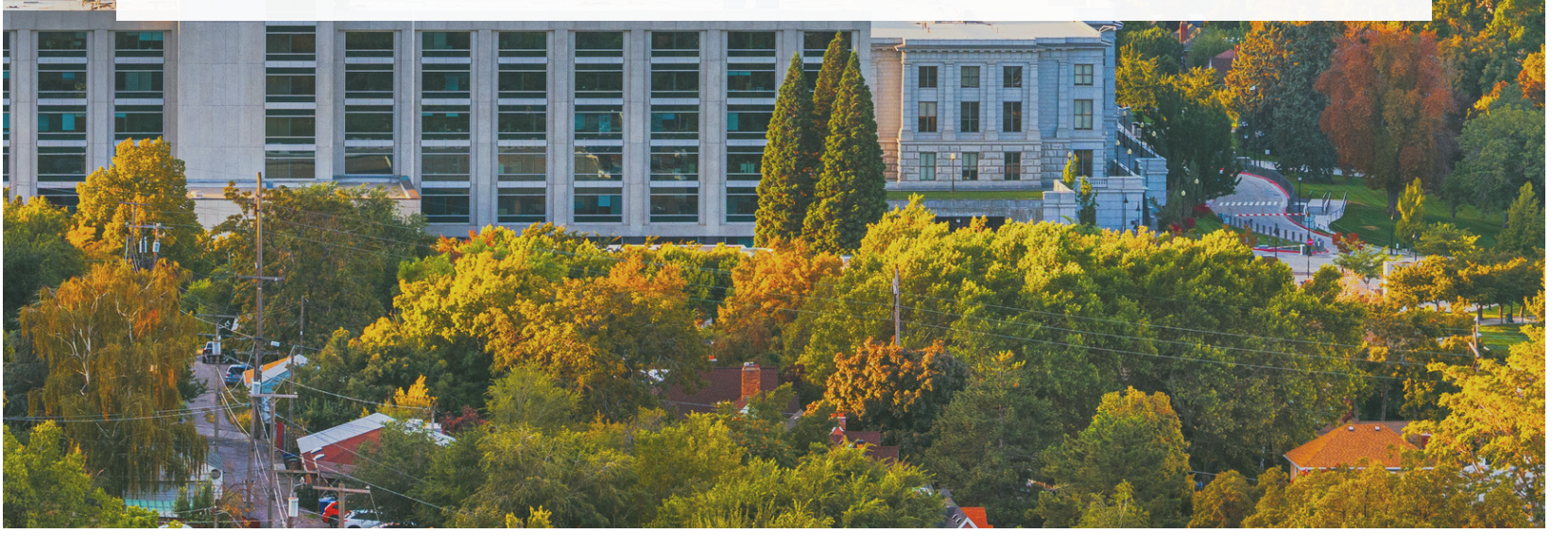
Prepared by Social Impact Insights

Contents



Executive summary

Salt Lake City is confronting a visible and increasingly urgent rise in homelessness, particularly among people experiencing unsheltered and chronic homelessness. Utah's proposed response includes a large "transformative campus." A site has been selected for a roughly 1,300-bed residential facility in a largely undeveloped area of the Northpoint neighborhood of Salt Lake City about seven miles from downtown.

Several features have been proposed for the campus:

- **Accountability Center:** A secure residential placement facility with treatment for substance use disorders (SUD) as an alternative to jail, with involuntary entry and exit.
- **Behavioral health services:** A Certified Community Behavioral Health Clinic (CCBHC) and at least 300 beds for civil commitment.
- **Emergency shelter:** More than 700 beds.
- **Wrap-around supportive services:** Including intensive case management.

The campus is framed as part of a policy shift toward greater "accountability," especially for "high utilizers" with repeated criminal justice system contacts, but also as a "path to thrive" for those experiencing homelessness.

State budget pressures and uncertainty about federal funding have delayed construction, but state leadership remains committed to the concept. Given the scale of capital and operating commitments involved, and the inclusion of unprecedented involuntary components, this proposal represents the most consequential homelessness policy decision in Utah in decades.

This report assesses the likelihood that the proposed campus would reduce chronic homelessness and improve outcomes for individuals experiencing homelessness. It also identifies key risks and uncertainties that could affect outcomes and costs. The analysis draws on Utah and national data, stakeholder interviews, cost and system performance data, research literature, and experiences in other cities.

Several additional key findings emerge. Together, they highlight both the primary drivers of rising homelessness in Salt Lake County and the potential risks associated with the proposed campus model.

Picture from Utah Office of Homeless Services

KEY FINDING #1

A growing share of people experiencing homelessness in Salt Lake County is unsheltered or chronically homeless

Concerns about rising homelessness are not unfounded. Homelessness has increased in Salt Lake County since the pre-pandemic period (2017–2019), with especially rapid growth in chronic and unsheltered homelessness. While increases in overall homelessness mirror trends in similarly sized cities, growth in chronic and unsheltered homelessness has been unusually steep. Chronic and unsheltered homelessness is highly concentrated among individuals and is rare among families with children.

The current upward trend began in 2020 during the COVID-19 pandemic. Evidence suggests the primary driver is rising housing costs and housing instability, compounded by additional factors. Regardless, it remains the case that most people experiencing homelessness in Salt Lake County are first-time homeless and will not become chronically homeless.

Trends in homelessness in Salt Lake County appear to be driven by several converging factors.

Housing instability

Research consistently finds that homelessness rates are closely linked to housing market conditions. Salt Lake County's housing market tightened considerably from 2019 to 2024: median rents rose about 16 percent, rents for the lowest-cost units increased about 13 percent, and home prices increased 59 percent. Meanwhile, incomes for the poorest households declined slightly. As a result, the number of renter households paying more than 50 percent of income toward rent—a strong indicator of housing instability—increased by about 11,000.

Behavioral health needs and treatment capacity

Individual vulnerabilities are less strongly associated with homelessness rates than housing costs, but behavioral health challenges remain important individual risk factors. Rates of severe mental illness in Utah are unusually high and may be increasing. At the same time, Utah has fewer behavioral health providers per capita than the national average.

The nationwide opioid epidemic has also affected Utah. Although trends in the overall population are mixed, self-reported chronic substance abuse among people experiencing homelessness in Salt Lake County is higher than in similarly sized cities.

Homeless services system capacity

Some system components have lost capacity, including emergency shelter beds and rapid rehousing, while others have expanded but not fast enough to keep up with need. In particular, growth in permanent housing has lagged increases in chronic homelessness.

The strain on the system is reflected in the increasing average length of time people remain homeless, which nearly doubled from 2019 to 2024. Poor health can contribute to homelessness, and homelessness in turn worsens health conditions, especially as episodes lengthen.

Among people placed in permanent housing in Salt Lake County, the likelihood of remaining housed is very high and improved from 2019-2024. Returns from permanent housing therefore do not appear to be contributing to the increase in homelessness.

Accountability standards

Utah policymakers have pointed to a need for greater accountability to address homelessness. However, we did not find evidence of a change in accountability standards or practices that would explain recent trends. Salt Lake County adopted a Housing First approach in 2005, so it cannot account for increases during the last five years, and we also do not believe the 2019 shift from a centralized downtown shelter to Homeless Resource Centers is the explanation.

Overall, the evidence points most strongly to population growth, rising housing costs, stagnant incomes among lower-income households, and systems struggling to keep pace with increasing needs.

KEY FINDING #2

High utilizers eligible for involuntary inpatient commitment may be fewer than projected

Utah policymakers have emphasized accountability for "high utilizers," defined currently as individuals arrested or cited four or more times in a year. Approximately 1,020 individuals meet this threshold in Salt Lake City.

However, several factors suggest that the number of individuals who would qualify for inpatient civil commitment may be far smaller, potentially in the dozens rather than hundreds. A key consideration is that individuals who meet the definition of chronic homelessness must have a qualifying disability, which means the Americans with Disability Act's "integration mandate" applies. This mandate limits unnecessary institutionalization when community-based alternatives are available.

Salt Lake City has reported early success with a community-based program that develops individualized solutions for its highest utilizers, including housing placements. The city reports the program requires staff time, but no additional funding.

Miami-Dade County offers a different model focused on jail diversion and supportive housing rather than a centralized campus. Its pre-arrest and post-booking diversion programs have reduced jail populations and recidivism among individuals with severe mental illness, in part by connecting individuals with supportive housing.

KEY FINDING #3

Evidence on centralized campuses is mixed

This report examines large campuses in San Antonio, Reno, Dallas, Phoenix, and Atlanta.

Experience from these cities indicates that:

- Claims that centralized campuses dramatically reduce homelessness do not match reality.
- Cities with campuses have experienced mixed homelessness trends.
- Among cities with a centralized campus, those that have the best outcomes in chronic homelessness have made investments in permanent housing.

Location appears to be an important structural factor rather than a logistical detail. Proximity to transit and downtown institutions affects service participation, client mobility, access to employment, and reintegration into community housing.

Salt Lake County's previous policy shifts suggest that a geographically isolated campus could reduce use of services and increase isolation. People experiencing homelessness may also be reluctant to travel to the campus, potentially increasing unsheltered homelessness.

Haven for Hope in San Antonio initially adopted a "tough love" approach. Campus leadership found that this approach was ineffective and sometimes resulted in making "people homeless when they didn't need to be homeless," and pivoted to a trauma-informed care and recovery approach. San Antonio has seen modest declines in overall and chronic homelessness since Haven for Hope opened, but these are most closely related to significant and sustained investments in permanent housing.

Publicly cited return on investment estimates for Haven for Hope contain methodological problems, including incomplete cost accounting and unrealistic assumptions about economic spillovers and causal impacts. These methodological concerns suggest that Utah policymakers should interpret estimated benefits from Haven for Hope with caution.

KEY FINDING #4

Evidence for several proposed treatment approaches is lacking

Key treatment components proposed for the campus have limited supporting evidence:

- Involuntary substance use disorder treatment increases treatment entry, but evidence on long-term outcomes is inconclusive.
- Treatment-first approaches can lengthen the time people spend experiencing homelessness compared with housing-first approaches.
- Risk mixing, or placing low-risk individuals in high-risk environments, may worsen outcomes for some residents.
- CCBHC integration within a large homelessness campus has not been tested.

Funding the campus could redirect resources from existing homeless services and other evidence-based investments such as voluntary behavioral health and substance abuse treatment, permanent supportive housing, rental assistance, jail diversion, or other strategies.

KEY FINDING #5

Costs are likely substantially higher than current estimates

The campus's official construction estimate of $75 million appears understated when benchmarked against peer campuses and Utah's Homeless Resource Centers. Peer comparisons suggest a likely cost closer to $142 million.

Operating costs may also be underestimated. Based on peer campuses, basic operations could cost about $46 million annually rather than the currently cited $34 million. These estimates exclude any services provided by partners.

They also exclude costs unique to the proposed Utah campus, including infrastructure, transportation, public safety, and additional expenses associated with involuntary treatment. Total construction and operating costs are likely to be materially higher than peer-based estimates. Factoring these in increases construction cost estimates to $165 million and operating costs to $53 million. Indirect costs for transportation and added public safety total $13 million annually.

Costs could rise higher at the civil commitment facility. Depending on the severity of patients, it could operate at a cost structure closer to a psychiatric hospital than a shelter. Operating costs at other such facilities suggest costs of at least $485 per bed per day (including treatment).

Long-term ongoing operational commitments would therefore represent a substantial fiscal obligation. Funding the campus could redirect resources from existing homeless services and other evidence-based investments such as voluntary behavioral health and substance abuse treatment, permanent supportive housing, rental assistance, jail diversion, or other strategies.

KEY FINDING #6

Key risks and unresolved policy questions

Given the scale of investment and the inclusion of involuntary components, the proposed campus presents several risks, in addition to those highlighted above.

Legal and civil rights risks.

As the first state to incorporate large-scale involuntary components into a homelessness campus model, Utah could face legal challenges. Litigation costs and court-ordered modifications could affect the design and long-term operation of the campus.

Behavioral health expertise.

The Utah State Homeless Board, which bears much of the responsibility for the campus, does not currently have a behavioral health professional among its members. Sustained input from qualified behavioral health professionals during campus design and implementation could reduce the risk that the facility fails to achieve its intended outcomes.

Capacity alignment with the target population.

Policymakers cannot currently determine how many individuals would meet legal and clinical eligibility criteria for involuntary treatment. If eligibility is far lower than planned capacity, as some evidence suggests, the campus could face low utilization rates or be repurposed to serve other populations.

Operational complexity.

The proposed campus would combine several functions not previously integrated into a single facility, requiring complex governance across state, county, and local systems.

Conclusion

The proposed homeless campus represents a significant shift in Utah's approach to homelessness. It reflects frustration with rising homelessness, particularly visible chronic and unsheltered homelessness, and seeks to address real challenges facing the state.

The proposed campus is also a major policy gamble. Several core components, including involuntary substance use treatment and civil commitment as a strategy for reducing chronic homelessness, have limited precedent or evidence of effectiveness. The treatment-first orientation of the campus also contrasts with evidence showing stronger outcomes from housing focused approaches. The campus would also require a very large public investment and commit the state to decades of operating costs.

If policymakers decide to proceed, several safeguards could reduce risks. These include clear legal standards and protections for involuntary placements, transparent cost estimates and long-term funding plans, and independent evaluation of outcomes. Most importantly, any campus-based strategy would need to be accompanied by sustained investment in permanent supportive housing and other affordable housing options.

INTRODUCTION

What is the proposed campus in Salt Lake City — and why now?

Homelessness is rising across much of the United States, including in Utah and in Salt Lake City.[1] In response, communities across the country are reconsidering how homelessness services should be organized, who they should prioritize, and what outcomes they should seek to achieve.

Utah's proposed response includes a large, "transformative campus." This report examines the proposal using evidence from Utah's recent policy history, experiences from cities with large, centralized homelessness campuses, and local and national data.

Because the proposed campus has also been discussed nationally as a potential model for a different approach to homelessness policy,[2] this report is also intended to contribute to the broader conversation about the future of federal, state, and local homelessness strategies.

What is the proposed campus?

The campus is a roughly 1,300-bed residential facility planned for a site in a largely undeveloped area of the Northpoint neighborhood of Salt Lake City, approximately seven miles from downtown.

The campus appears to have multiple, perhaps competing goals. The stated mission of the proposed campus is "To help those experiencing homelessness to receive the help and services to move from needing help to begin a new path to thrive."[3] Features of the campus and statements from Utah policy leaders, however, suggest that it is planned primarily to serve "high utilizers," defined as people with frequent arrests or citations whether they are experiencing homelessness or not.[4]

Plans for the campus are not finalized, but several features have been proposed:

- **Accountability Center:** A secure residential placement facility with beds for treatment for substance use disorders as an alternative to jail and where entry and exit are not voluntary.[5]
- **Mental and behavioral health care:** A Certified Community Behavioral Health Clinic (CCBHC) and at least 300 beds for civil commitment.
- **Emergency shelter:** 700+ beds.
- **Wrap-around supportive services** including intensive case management.[6]

Budget pressures during the 2026 legislative session and uncertainty in federal funding have postponed plans for the campus but state leadership remains committed to the project.[7] In the meantime, Utah's state homeless services coordinator plans to provide proof of concept by implementing programs targeting high utilizers.[8]

Accountability for high utilizers is central to both the proposed campus and the state's recent approach to homelessness, which also includes aggressive enforcement of no camping ordinances. In Utah, the policy shift toward involuntary measures reflects criticism of the Housing First model that provides housing with case management and voluntary services, a feature that some argue lacks sufficient accountability.[9]

There is some agreement about needs in the state—both critics and proponents agree that Utah lacks sufficient shelter space and mental health treatment capacity[10] —but much disagreement. Critics raise concerns about involuntary treatment and its potential for infringement on civil liberties. They also question the effectiveness of the approach and its costs.

Why now?

Several developments appear to be driving the proposal. First, unsheltered homelessness (per population) in Salt Lake County increased sharply—by 163 percent on a population-adjusted basis from 2017-2019 (baseline) to 2025[11] —and has become more visible in public spaces, leading to public concern.

Second, rising homelessness nationally has prompted debate about the effectiveness of the Housing First approach as a strategy to address chronic homelessness. This approach has been embraced by many homeless service providers beginning in the early 2000s, including widespread adoption in Utah, after research demonstrated it produced better housing retention than previous approaches requiring housing readiness prior to placement in housing (treatment first).[12]

Third, the White House has signaled a shift in federal homelessness response policy with a July 2025 Executive Order, "Ending Crime and Disorder on America's Streets."[13] Utah leadership directed Utah's State Homelessness Services Board to align with that policy direction.[14] (For a timeline of campus proposal development, see Appendix A.)

Overview of this report

This report evaluates the likelihood that proposed campus will reduce chronic homelessness using evidence from Utah and comparable cities. It addresses:

Who is experiencing homelessness and why?
Trends in homelessness and causes.

Who are high utilizers, and what interventions are effective?
Estimates of high utilizers in Salt Lake City and insights from programs targeting high utilizers in other places.

What can Utah learn from centralized campuses in other cities?
Experiences in Reno, San Antonio, and other cities, including implications of locating a campus far from downtown services.

How effective are proposed campus approaches likely to be?
Research on involuntary SUD treatment, treatment-first approaches, risk-mixing in a large congregate campus, and likelihood of long-term housing stability.

What are the likely costs of the campus?
Analysis of the proposed campus based on costs of other centralized campuses; opportunity costs of the campus.

What are the key risks and unanswered questions?
Areas of uncertainty that could affect the campus, its impact on homelessness, and its costs.

The analysis is based on interviews with Utah stakeholders, national experts, and staff at centralized campuses in other cities, analysis of housing market, homelessness, population, demographic, and system performance data, and review of public documents and prior research.

This report focuses primarily on Salt Lake City and County, which is the area served by the local Continuum of Care (CoC), for two reasons. Although policymakers describe the campus as serving Utah, homelessness service providers report that it is most likely to be used by people nearby. The Salt Lake County CoC includes both the city and the county. In the rest of the report, references to Salt Lake County cover both. A glossary of key terms is in Appendix B.

What is a Continuum of Care?

A Continuum of Care (CoC) is a group of organizations that receive federal funding to coordinate housing and services for people experiencing homelessness in a geographic area.

SECTION 1

Who is experiencing homelessness and why?

Characterizations of people experiencing homelessness often focus on the visible signs of homelessness such as camping in public spaces. This experience of homelessness is not typical. People experiencing homelessness come from a range of backgrounds and have unique histories and needs. There is no “one size fits all” solution, but rather a continuum of solutions that are tailored to meet individual needs. Effectively achieving Utah’s goals requires a clear understanding of who is homeless and why.

Utah policymakers have cited a need to increase accountability to counteract the rise in homelessness, but we did not find a change in accountability standards or practices that would account for the increase or the change in composition. For example, Salt Lake County adopted the Housing First model in 2005, so this strategy cannot account for increases in overall or chronic homelessness during the last five years.

We did find:

- Homelessness in Salt Lake County has become more unsheltered and more chronic in recent years, and this is unusual among similar-sized cities (peer cities).
- Economic and population growth led to significantly higher rents and housing instability.
- Rates of substance use disorder (SUD) may be rising, related to the nationwide opioid crisis and other factors; severe SUD is a risk factor for experiencing homelessness.
- High rates of severe mental illness statewide and long-standing shortages of behavioral health treatment capacity; severe mental illness is also a risk factor for homelessness.
- A homeless services system that, while well-performing on several measures, did not expand quickly enough to keep up with rising pressures.

This section explores these trends in homelessness and their causes.

1. Utah policymakers have good reasons to be concerned about homelessness

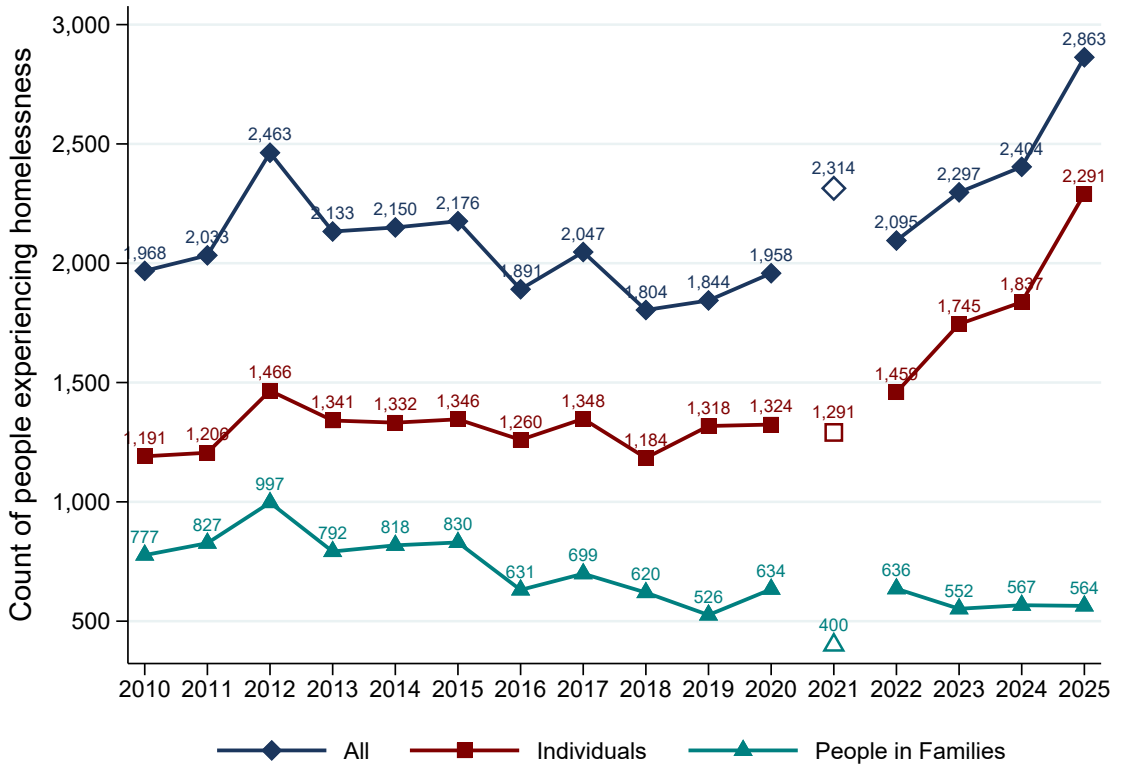
Concerns about rising homelessness are not unfounded. This section briefly reviews data documenting that:

- The number of people experiencing homelessness pre-pandemic through 2025 has increased.
- The categories of homelessness most likely to be related to visible signs of homelessness, chronic and unsheltered homelessness, have increased even faster, and these trends are unusual compared with peer cities.
- Sizeable minorities of people experiencing homelessness struggle with severe mental illness (SMI) and/or chronic substance abuse conditions.
- In good news, family homelessness declined on a per capita basis and is relatively rare.

Overall homelessness increased from the pre-pandemic baseline through 2025.

Between 2017–2019 (the baseline) and 2025, overall homelessness increased 41 percent in the Salt Lake City and County CoC (Salt Lake County) on a population-adjusted basis (Exhibit 1 plots homelessness counts by year). Homelessness increased across all categories of homelessness except among people in families with children, which fell by 14 percent. Chronic homelessness rose much faster, by 264 percent.

Exhibit 1: Salt Lake County saw large increases in overall and individual homelessness in recent years



Note: 2021 shown as disconnected point due to pandemic-related count disruptions. Source: HUD Point in Time count data.

Salt Lake County's growth in overall homelessness mirrors the experience of a group of 50 peer cities, but the composition differs sharply.

From baseline to 2024, on a per capita basis:

- Overall homelessness increased 20 percent in both Salt Lake County and peer cities.[15]
- Chronic homelessness increased much faster in Salt Lake County, by 147 percent.
- Unsheltered homelessness also increased much faster, by 139 percent, and this occurred almost entirely among individuals.

On the positive side, homelessness among people in families with children declined in Salt Lake County. In comparison, it rose by 13 percent in peer cities. For families, Salt Lake County appears to be near its goal of making homelessness "rare, brief, and non-recurring."

Exhibit 2: Salt Lake County's increase in overall homelessness mirrors peer cities, but the rate of increase in chronic and unsheltered homelessness is unusual (baseline-2024, per capita)

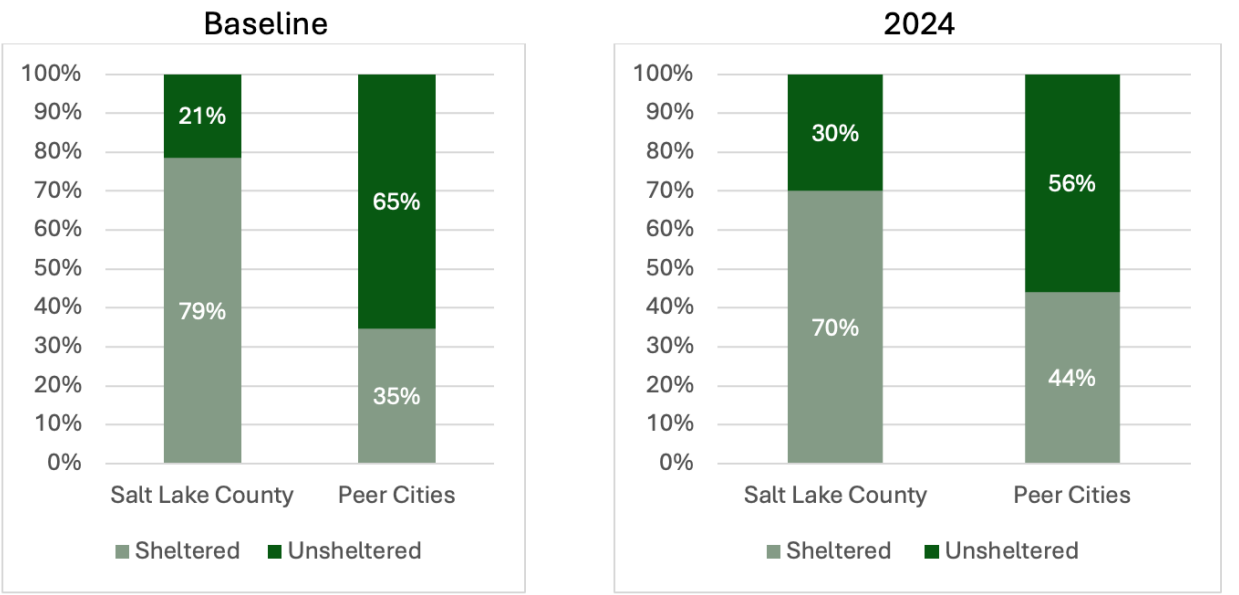
	Salt Lake County *% Change*	***Peer Cities*** *% Change*	***United States*** *% Change*
All people experiencing homelessness	20%	20%	33%
Individuals	35%	19%	30%
People in families with children	-13%	24%	40%
Unaccompanied youth	7%	-21%	6%
Chronic homeless	147%	57%	63%
Unsheltered homelessness among all people experiencing homelessness	139%	29%	33%

Note: Percent change is calculated using population-adjusted PIT counts relative to a 2017-2019 baseline.
Source: HUD Point in Time count data, American Community Survey.

Among those experiencing chronic homelessness in Salt Lake County, the large majority are sheltered.

Salt Lake County is an outlier in the share of people experiencing chronic homelessness who are sheltered (70 percent in 2024 compared with 44 percent in peer cities); however, the system is showing signs of strain. The share that was sheltered declined 9 percentage points from the baseline to 2024, from 79 percent to 70 percent (Exhibit 3).

Exhibit 3: People experiencing chronic homelessness in Salt Lake County are more likely to be sheltered than in peer cities



Source: HUD Point in Time count data.

Increasing chronic homelessness is a concern, but it remains the case that most people who are experiencing homelessness have never been homeless before.

In 2024, 70 percent of people in Salt Lake County who experienced homelessness did so for the first time. This was up from 60 percent in 2015.

Among those experiencing first-time homelessness, the large majority will not return to homelessness once their current episode is resolved. Among those entering emergency shelter, 79 percent exited and did not return within 12 months.[16] Although most people experiencing first-time homelessness will not become chronically homeless, the increasing numbers are cause for concern, because some of them eventually will.

In comparison to Salt Lake County, in peer cities, the share of people experiencing first-time homelessness was relatively flat over the past decade, starting at 77 percent in 2015 and ending at 79 percent in 2024.

2. Increasing homelessness is most closely related to rising housing costs, but behavioral health and other conditions are also a factor

Understanding root causes of homelessness is critical for the proposed campus and for homelessness policy in general. These causes fall into two primary categories:

Structural factors include broader societal conditions such as housing costs and availability, labor market conditions, and the overall economy.[17]

Individual risk factors include vulnerabilities that increase the likelihood that a person will lose or be unable to maintain housing such as poor physical health, disability, substance use disorders, SMI, and histories of incarceration.

Structural factors are more closely linked with community-level homelessness than individual risk factors.

A large body of research establishes that homelessness rates across U.S. cities are more strongly associated with structural factors such as housing market conditions, and especially high rents and low vacancy rates, than personal characteristics such as individual behavioral health conditions.[18] For example, a U.S. Government Accountability Office study found that a $100 increase in median rent is associated with roughly a 9 percent increase in homelessness.[19]

Salt Lake City's housing market tightened considerably from 2019 to 2024:

- Median contract rents (the amount specified in a lease) adjusted for inflation are up about 16 percent.
- Rents for the lowest cost apartments, defined as those in the bottom 25th percentile of rents, have increased by about 13 percent.[20]
- House prices increased 59 percent.[21]
- After adjusting for inflation, incomes for the poorest households, measured as the 20th percentile of household income, fell slightly.[22]

These indicators mean that rising housing costs have outstripped income increases since 2019. This is reflected in the rising share of renters with a severe cost burden (paying more than 50 percent of household income for rent), a strong indicator of housing instability. The number of renter households with a severe cost burden increased 46 percent—by nearly 11,000 households—compared with 16 percent growth in peer cities and 15 percent nationally (Exhibit 4).

Homelessness related to rising rents is most cost effectively addressed with prevention efforts such as emergency rent/utility assistance, renter protections and legal services, and increasing the supply of housing, especially low-cost housing. Rising first-time homelessness in Salt Lake County indicates that homelessness prevention efforts may need to be expanded.

Exhibit 4: Increasing numbers of renter households have severe housing cost burdens

Share of renters with a severe housing cost burden			
	2019	2024	% change
Salt Lake City	20%	23%	46%
Peer cities	24%	26%	16%
United States	24%	26%	15%

Source: American Community Survey

Individual vulnerabilities also increase the risk of homelessness, and the prevalence of these factors may also be increasing.

While individual characteristics do not predict community-level changes in homelessness rates, people who experience homelessness have different characteristics and life experiences on average compared with the population at large.[23] People experiencing homelessness are disproportionately also experiencing poverty, family problems, and mental health and substance abuse challenges.[24]

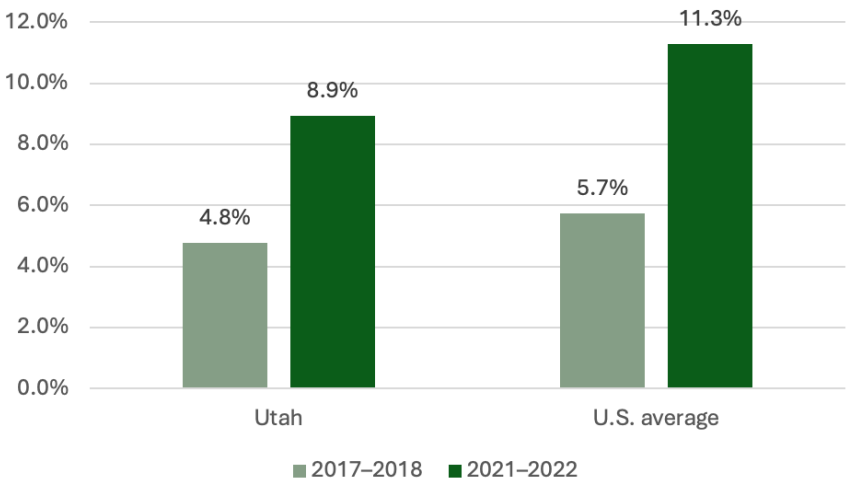
Recent years have seen increases in the prevalence of SUD in Utah and nationwide, attributed to the COVID-19 pandemic, among other factors. As one example, estimates of alcohol use disorder in Utah and nationwide increased sharply between 2017-2018 and 2021-2022 (the most recent data available) (Exhibit 5).[25] Utah's rate of increase was below the national average (85 percent compared with 98 percent), but is nevertheless concerning.

Trends in overdose deaths in Utah show some signs of promise: this number declined from 2023-2024 to 2024-2025. It remains to be seen whether this is the beginning of a longer-term trend of improvement in substance use prevalence.[26]

Note: Alcohol Use Disorder is defined as meeting criteria for alcohol dependence or abuse based on definitions found in the 4th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV).

Source: SAMHSA National Survey on Drug Use and Health, Model-Based Prevalence Estimates.

Exhibit 5: Prevalence of alcohol use disorder among those 18+ increased in Utah and nationwide



Serious mental illness is higher in Utah than nationally, but behavioral health treatment capacity is below average.

More than 8 percent of Utahns over the age of 18 are estimated to have experienced a serious mental illness during the last year—meaning one that results in serious functional impairment—and this is the highest of any state in the country. This compares with 5.7 percent nationally.[27]

At the same time, Utah has below-average behavioral health treatment capacity. The state has about two-thirds as many behavioral health providers per capita as the nation overall at approximately 222 providers per 100,000 residents compared with 334 per 100,000 nationally.[28]

Severe mental illness is more common than chronic substance abuse among people experiencing homelessness in Salt Lake County.

Both conditions are more common in Salt Lake County than in peer cities or nationwide (Exhibit 6). (Note that chronic substance use and severe mental illness often co-occur, so these rates are not mutually exclusive.) This share has increased over the last several years, faster in Salt Lake County than in peer cities (Exhibit 7).

Exhibit 6: Self-reported severe mental illness and chronic substance abuse among people experiencing homelessness are more common in Salt Lake County than elsewhere, 2024

Source: HUD Point in Time count data, 2024

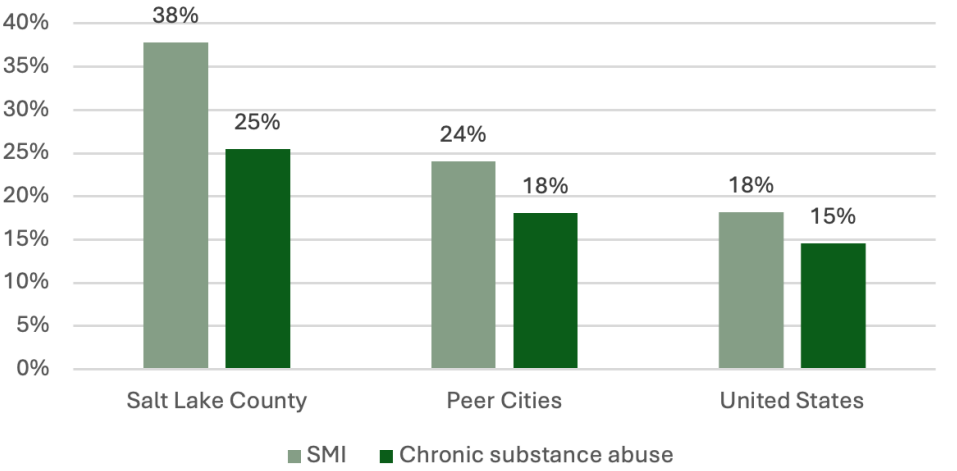
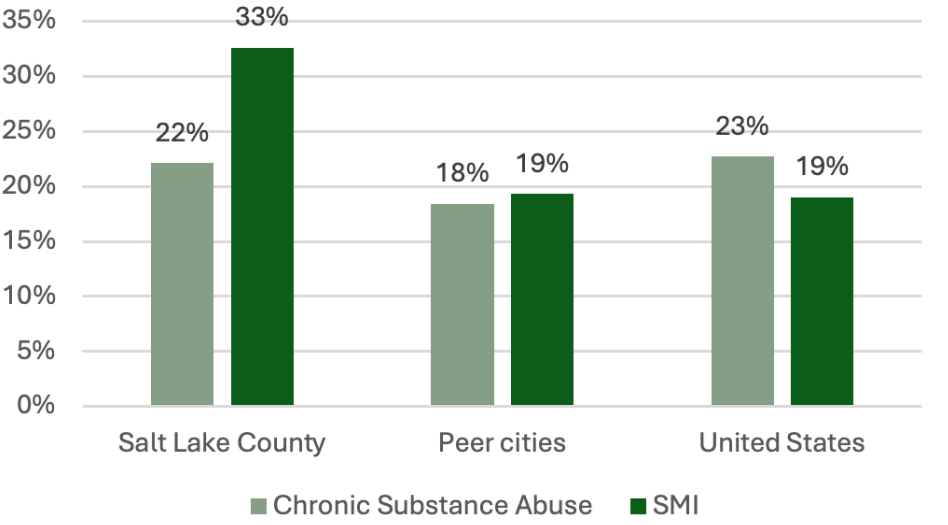


Exhibit 7: Increase in share of people experiencing homelessness reporting chronic substance abuse and severe mental illness, baseline-2024

Source: HUD Point in Time count data.



The rationale for including a significant involuntary treatment component at the proposed campus appears to be that expanding involuntary treatment capacity would address chronic substance use and severe mental illness, stabilize individuals before housing, and ultimately reduce chronic homelessness.

This rationale implicitly assumes that many individuals experiencing homelessness could access treatment services but must be compelled to do so. However, the extent to which this applies to the chronically homeless population versus the possibility that treatment services are simply not readily available is unclear. Section 4 examines the likelihood that involuntary treatment would meaningfully reduce chronic homelessness in Salt Lake County.

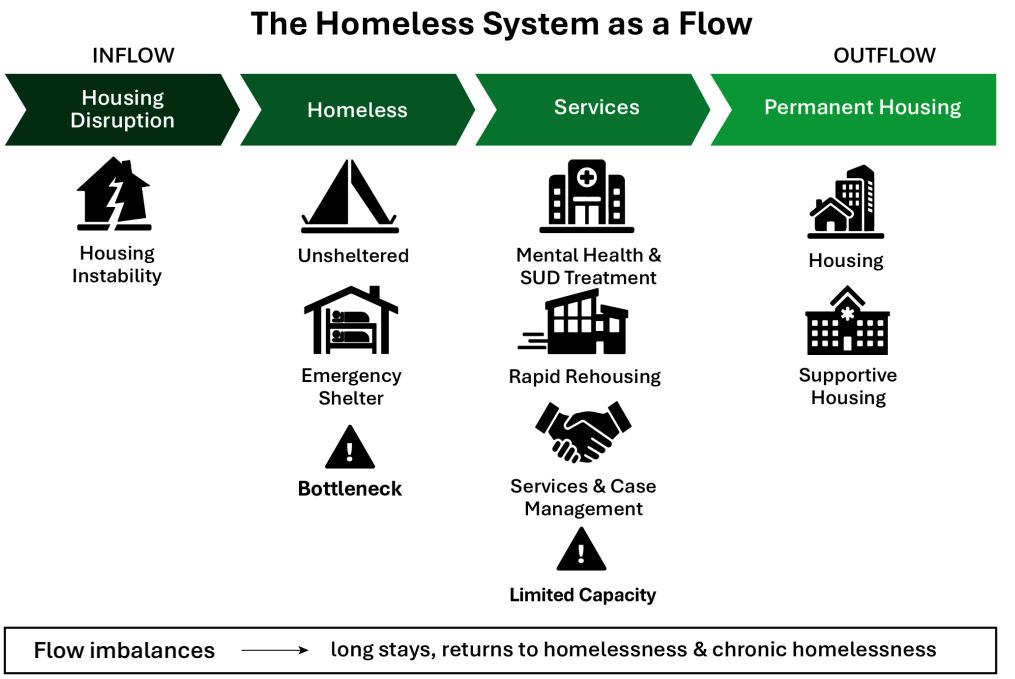
The data in this section supports the consensus that Utah has a shortage of mental health providers and inpatient mental health treatment capacity,[29] but opinions on the path forward diverge.

3. Salt Lake County's homeless services system has not kept up with rising needs

The evidence points to rising rents and housing instability as the most recent notable change in root causes of homelessness, and this is one side of the homelessness equation. The other side is the homeless services system.

Pressure on the homeless services system is increasing.

The system can be understood as a flow, with people entering, moving through, and exiting at different rates (see graphic). Salt Lake County's population growth and rising housing instability are clearly increasing pressure on the "front door" of the system (emergency shelters). Rising unsheltered and chronic homelessness points to system capacity that has not kept up with need.



The homeless services system has lost capacity by some measures and increased in others, but not enough to keep up with need.

Between 2019-2024, on a per capita basis:

- The number of emergency shelter beds for individuals declined (compared with an increase in peer cities) (Exhibit 8).
- Rapid rehousing capacity fell sharply (compared with an increase in peer cities).
- PSH and other permanent housing (OPH) increased (compared with smaller increases in peer cities).[30]
- PSH dedicated to chronically homeless individuals fell 15 percent.
- The rate of increase in people experiencing chronic homelessness outpaced the rate of increase in permanent housing.

The homeless services system has lost capacity by some measures and increased in others, but not enough to keep up with need. (cont.)

In addition:

- The median length of stays in emergency shelters nearly doubled, from 21 days in 2019 to 41 days in 2024 (Exhibit 9).

The increasing pressure on the "front door" of the homeless services system (increasing first-time homelessness, increasing overall homelessness) was worsened by increasing lengths of stay in shelters and was only partially offset by increases in permanent housing capacity. By 2024 there were 403 more people experiencing chronic homelessness than there were at baseline, but it is likely that number would have been higher without the additional permanent housing.

Exhibit 8: Salt Lake County has seen declines in emergency shelter beds and rapid rehousing for individuals experiencing homelessness but increases in permanent housing (per 10,000 population)

	Salt Lake County		Peer Cities	
	Total 2024	% change	Total 2024	% change
Emergency shelter	7.9	-8%	7.2	26%
Rapid rehousing	1.1	-63%	1.7	54%
PSH	13.6	26%	9.7	-3%
Other permanent housing	1.7	-*	2.9	288%

Note: Change is measured from 2019 to 2024. Source: HUD Housing Inventory Count data

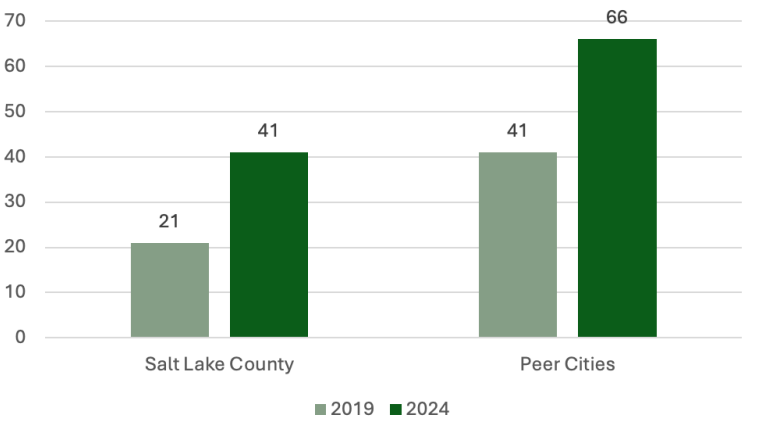
**The percentage increase is not meaningful because Salt Lake County had little other permanent housing in 2019.*

Longer stays in shelter indicate that it is becoming more challenging for people experiencing homelessness to resolve their situation, either because they are not successful in finding their own housing or because there are not enough permanent housing units to help those with more acute needs to leave shelters. Longer stays worsen the bottleneck of available emergency shelter created by increasing overall homelessness.

Lengthening episodes of homelessness are a concern for a variety of reasons, but a key concern is related to health.

Exhibit 9: Median length of homelessness nearly doubled from 2019 and 2024 in Salt Lake County (measured by stays in shelter)

Poor health is a major cause of homelessness, and experiencing homelessness can make existing conditions worse, and living on the street or in crowded shelters can create new problems.[31] People experiencing homelessness have a much higher mortality rate than the general population.[32]



Source: HUD Service Performance Measures

Although it is taking longer to find permanent housing, once obtained, success in retaining permanent housing is high.

Among people in permanent housing in the Salt Lake County (either PSH or OPH), almost all—95 percent—either left to another permanent housing situation or retained their permanent housing. Success rates were similar in peer cities.

The high rate of success in retaining permanent housing, which in Salt Lake City is almost entirely PSH, is consistent with several decades of research. The most consistent, high-quality evidence shows that PSH, typically delivered using a Housing First model, substantially improves housing stability and reduces time spent homeless for people with chronic homelessness compared with treatment-first and other approaches.[33] Importantly, there is also no difference in substance use between Housing First approaches with PSH and treatment-first approaches although treatment is voluntary, not required.[34]

Among the small group of people who leave permanent housing, fewer are eventually returning to the homeless system. In 2019, 31.4 percent of people who left permanent housing returned within 12 months; in 2024, that share was down by more than half, to 12.7 percent. In peer cities, returns to permanent housing within 12 months after exit were just slightly lower in 2024 than in 2019. Clearly, cycling out of permanent housing is not a factor contributing to the rise in homelessness.

The improved housing stability among those placed in permanent housing may reflect more engagement with case managers prior to placement in permanent housing, stronger targeting, and/or more stable placement practices.

Salt Lake County's homeless system works well by several measures but is showing signs of strain.

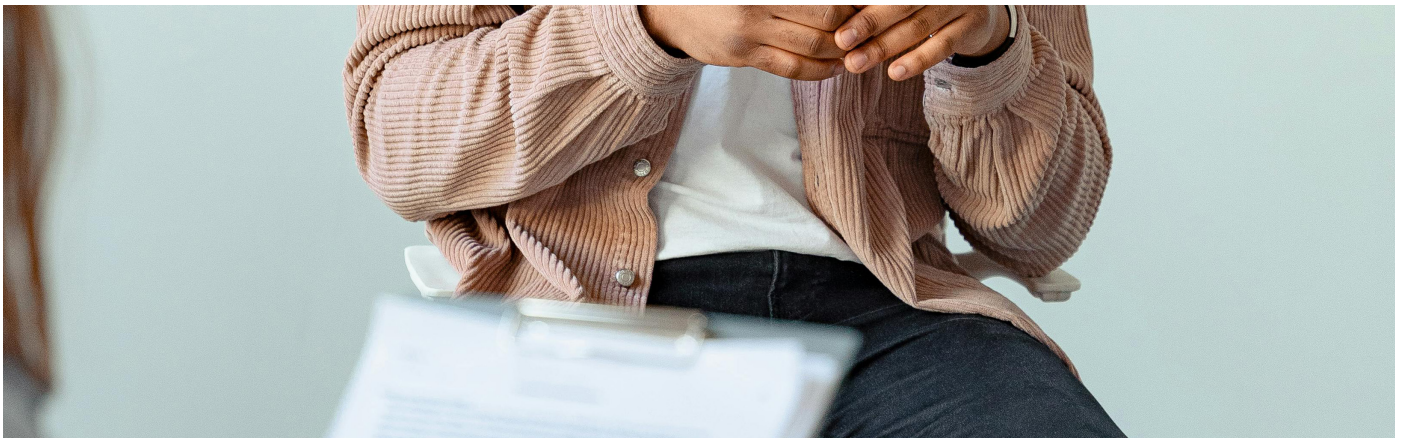
At baseline, Salt Lake County's homeless system was working well by several measures:

- Unsheltered homelessness was *much* lower than in peer cities
- Chronic homelessness was about two-thirds the rate of peer cities
- Unsheltered family homelessness was rare (and lower than in peer cities)
- Length of stay in emergency shelter was lower than in peer cities

By 2024, the system was still performing well, but comparisons with peer cities showed signs of strain:

- Unsheltered homelessness was still much lower, but the difference was narrowing
- Chronic homelessness was slightly higher
- Unsheltered family homelessness was still rare, and still lower
- Length of stay in emergency shelter was still much lower, but had almost doubled
- Success rates for permanent housing were high—95 percent
- Rates of return to homelessness after leaving permanent housing were much lower than in 2019

The evidence points to the conclusion that a homeless services system that was performing better than comparison cities at baseline has not scaled up in size to meet the need created by population and economic growth, rising rents, and rising acuities. Declines in emergency shelter beds increased unsheltered homelessness, and growth in permanent housing inventory did not keep pace with rising numbers of people experiencing chronic homelessness, contributing to longer shelter stays and unsheltered pressure.



SECTION 2

Who are high utilizers and what interventions are effective?

The proposed campus and Utah's broader homelessness policy reflect a shift toward focusing on "high utilizers," currently defined as individuals with frequent interactions with the criminal justice system. In fact, one of the three pillars of the state's strategy to address homelessness is "accountability for high utilizers."[35]

Policymakers have articulated that "accountability" includes:

- Involuntary substance use disorder (SUD) treatment at the proposed campus with jail as the alternative[36]
- Involuntary inpatient civil commitment at the proposed campus[37]
- Longer jail sentences for repeat offenders[38]
- Aggressive enforcement of public order offenses[39]
- Coordinated intervention (including support) for an identified list of high utilizers[40]

Utah and Salt Lake County are not unique in struggling with individuals who have repeated contacts with public systems. Cities around the country have recognized that small numbers of people can impose disproportionate costs, and that targeted strategies can improve outcomes for both individuals and public budgets.

In reviewing local data and approaches from other places we found that:

- Utah cannot yet determine how many high utilizers might be most effectively and cost-efficiently served with inpatient involuntary treatment.
- The number who might legally qualify for civil commitment may be closer to dozens than hundreds.
- Salt Lake City is seeing early success in a program that creates individualized solutions for high utilizers, including housing placements.
- Evidence from Miami-Dade County and other places suggests diversion from jail is more effective and cost-efficient than increasing arrests for minor repeated offenses.

Taken together, these examples suggest that targeted, individualized interventions combined with housing and behavioral health services may be more effective for high utilizers than broad reliance on incarceration or large-scale involuntary treatment.

1. Utah cannot yet determine how many high utilizers might benefit from inpatient involuntary commitment

Despite recent efforts to improve cross-agency data sharing, Utah lacks integrated data systems linking homelessness, health care, and criminal justice records.[41] As a result, policymakers cannot yet determine how many individuals might qualify for involuntary treatment or other intensive interventions.

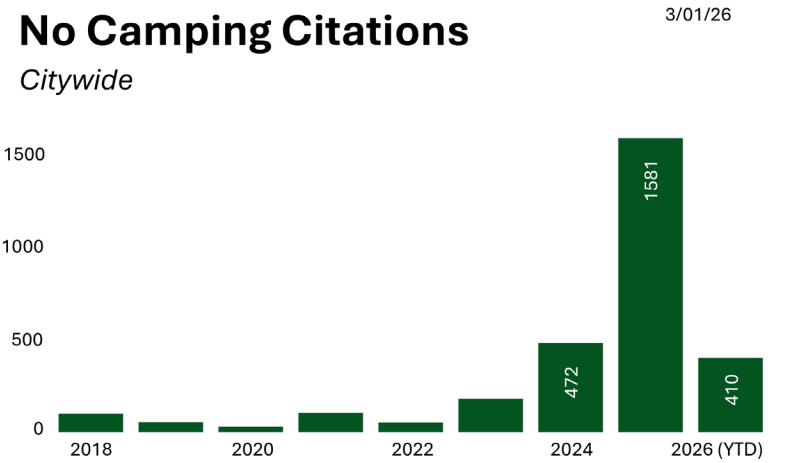
In practice, Utah is using an operational definition of high utilizers as individuals arrested or cited four or more times in a calendar year.[42]

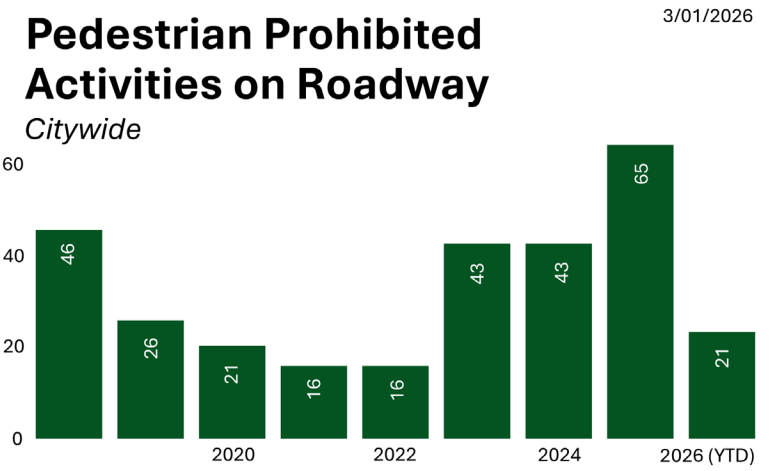
Salt Lake City has identified a total of about 1,020 of these individuals.[43] The city currently lacks the information needed to distinguish citations from arrests, which is another key data limitation. Citations, typically issued for low-level offenses, represent very different levels of public safety risk and behavioral health needs than arrests.

There were 1,654 citations for public camping and pedestrian-prohibited activity in 2025 (Exhibit 10); if even a fraction were issued to individuals in this group, they could account for a large share of the four-plus justice system contact threshold.

Exhibit 10: No camping citations and citations for pedestrian-prohibited activities on roadway increased sharply in 2025 in Salt Lake City

Source: Salt Lake City public safety dashboard, retrieved March 9, 2026





2. Few high utilizers might qualify for inpatient involuntary commitment

Even among people who have frequently been arrested in the past year, high utilizers are a diverse group with varying needs and risk levels. More than half were at the low end of the range, with four or five arrests or citations; the 5 percent with the highest utilization had 14 or more arrests or citations. None appear to have committed an offense serious enough to result in extended incarceration.[44] (Discussion of the Salt Lake County Jail dashboard and highlights of differences between housed and unhoused inmates is in Appendix C.)

If the proposed campus were operational today, how many of the roughly 1,020 high utilizers might be candidates for intensive intervention at the proposed campus, with jail as the alternative? Legal, clinical, and practical filters suggest this number may be small.

The most significant factor is that under Utah law, involuntary inpatient civil commitment generally requires mental illness *plus* dangerousness to self or others or inability to meet basic needs, and courts must order the least restrictive appropriate setting for treatment. This rules out involuntary inpatient treatment for most high utilizers.[45]

A second factor is the share of people experiencing homelessness in Salt Lake County who report chronic substance abuse—about 25 percent in 2024. Some fraction of high utilizers might be deemed to qualify for involuntary SUD treatment. As will be discussed in Section 4, long-term recovery from chronic substance abuse is improved with stable housing, so SUD treatment should be paired with permanent housing with support. Without additional investments in PSH, SUD treatment could continue system cycling rather than ending it.

A third consideration is that much less intensive—and costly—intervention could achieve similar or better outcomes without raising concerns about civil liberties. Salt Lake City's current Project CONNECT approach may be an example of such an approach.

Based on these factors, the number of candidates for the type of civil commitment described for the proposed campus may be closer to dozens than hundreds, indicating that the campus is not aligned with the scale of the problem.

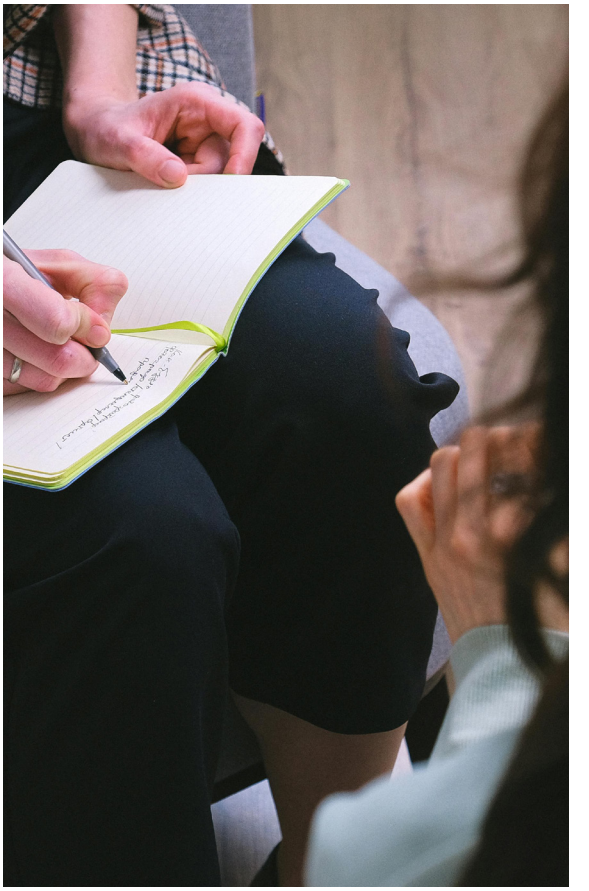
3. Salt Lake City is seeing success in reducing recidivism among high utilizers with individualized approaches

Of the roughly 1,020 people identified as having had four or more arrests or citations in the last calendar year, Salt Lake City is focusing on the 50 people with the most arrests or citations through Project CONNECT, most of whom have experienced homelessness. The effort connects frequent arrestees with social workers who develop individualized solutions using coordinated state, county, and city resources.[46]

When an individual on the Project CONNECT list is taken into custody, social workers connect them with needed resources such as medical care, mental health services, housing, or other services.[47]

Police spokesperson Michael Ruff was quoted in the Salt Lake Tribune as saying, "When someone is arrested and incarcerated, the team works with the individual to create a plan for exit from the jail that ideally includes housing and behavioral health support."[48]

Although it is too early to draw conclusions, the city reports that there were fewer arrests among people on the city's Project CONNECT list in the 250 days after project launch than before.[49]



4. Miami-Dade County's approach is effective for high utilizers

Other cities have also implemented programs aimed at diverting people from jail who would be better served with case management, treatment for SMI and/or SUD, and permanent supportive housing.

One of these programs, in Miami-Dade County, has seen particularly notable success. Like Utah's proposed strategy, the Miami model focuses on justice-involved individuals with serious mental illness. Participation in post-booking diversion is voluntary in the sense that defendants agree to treatment, but jail remains the alternative if they decline. Rather than being inpatient, treatment is community-based except for crisis stabilization.

Structure of the Miami Model

Jail diversion can take several forms. The Criminal Mental Health Project (CMHP), or Miami Model, which has documented effectiveness and is being considered for Salt Lake City, has two primary components:

Pre-arrest jail diversion by officers trained in CIT (Crisis Intervention Training) methods, who are equipped to de-escalate encounters involving individuals experiencing mental health crises and, when appropriate, connect them to behavioral health services instead of initiating arrest and jail booking.

Post-booking misdemeanor and felony jail diversion, which transfers qualified people with SMI from jail to a community-based stabilization unit. Once stabilized, charges may be dismissed for defendants who agree to services that may include community-based treatment, support, assistance accessing entitlement benefits, and housing.

CMHP also includes a forensic hospital diversion program that operates in a 10-bed facility, and a mental health diversion facility has been constructed but is not yet open.

CMHP's long-term goals include reducing chronic homelessness and decreasing reliance on jails, emergency rooms, and crisis settings. Supportive housing is tied to these goals as a structural solution and defined as a core element of the post-booking jail diversion programs. Supportive housing is used as:

- A stabilizing intervention for people with SMI
- A driver of reduced recidivism and jail costs
- A necessary response to the high rates of homelessness among justice-involved individuals with mental illness.

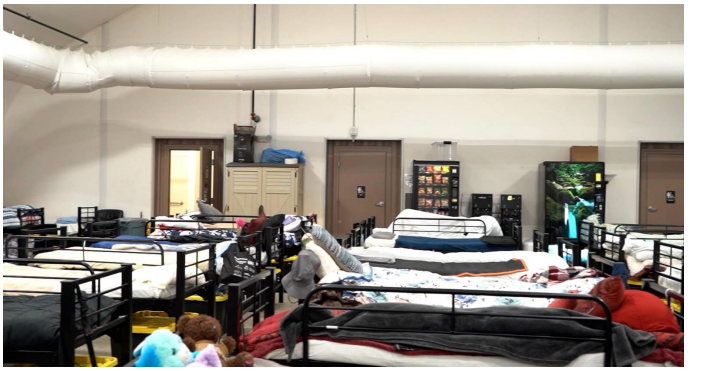
In Miami-Dade County, jail diversion was primarily designed to address large numbers of people with severe mental illness in the county jail and system cycling.[50] When the program began in 2000, the Dade County jail was described as the largest de facto psychiatric facility in Florida. Nationally, almost 20 percent of jail detainees experience severe mental illness. They are more costly to incarcerate (per-day costs can nearly double, related to special treatment, medications, and additional supervision), and are incarcerated four to eight times longer than those without mental illness for the same charges.[51]

The Miami Model has demonstrated success in reducing recidivism.

Among participants who complete the felony diversion program (about 200 referrals per year), jail bookings declined by 82% and jail days by 90% within one year. Since the program's implementation, the average daily jail population has declined by almost 40 percent, allowing the closure of one jail facility.[52]

Participants in the misdemeanor diversion program (about 300 referrals per year), tend to be those who suffer from the most severe mental illness and to have co-occurring SUDs. Among the program's participants, 75 to 80 percent are homeless at the time of arrest. Recidivism rates among participants in this program have declined from about 75 percent to about 20 percent annually.[53]

Permanent housing is a central component of jail diversion. Architects of the Miami Model stress the importance of expanding housing resources in the community across the continuum (ranging from high support and wraparound services to more independence) to the success of jail diversion. They emphasize that without stable housing, cycling through public systems among people with SMI is likely to continue.[54]



SECTION 3

What can Utah learn from centralized campuses in other cities?

Large, centralized homeless service campuses have been developed in several cities over the past two decades, including Haven for Hope (San Antonio), Nevada Cares Campus (Reno), The Bridge (Dallas), Keys to Change (Phoenix), and Gateway Center (Atlanta).

The experience of these campuses indicates that:

- Claims about large declines in homelessness related to a centralized campus do not match reality.
- The presence of a centralized campus does not reduce homelessness.
- Among cities with a centralized campus, those that have seen the best outcomes in chronic homelessness have made investments in permanent housing.
- Salt Lake County's past policy shifts suggest that a campus that is not close to downtown could reduce use of services and increase isolation. Further, people experiencing homelessness may be reluctant to travel to the campus, which could increase unsheltered homelessness.
- Haven for Hope, the centralized campus that opened with a "tough love" approach, found that this approach resulted in making "people homeless when they didn't need to be homeless," and pivoted away from it to a housing-focused approach.

This section documents trends in homelessness among cities with a centralized campus, factors in the capacity of the homeless services system, documents the impact of location, and includes a case study of Haven for Hope.

1. The presence of a centralized campus does not predict trends in homelessness

The campuses are summarized in Exhibit 11 and compared with the proposed campus in Salt Lake City. Notably, all except Salt Lake City:

- Are located within one to two miles of their downtown cores
- Are embedded in existing service networks
- Offer a broad array of services
- Operate through partnerships with dozens of nonprofit and public agencies.

None incorporates involuntary components.

Individual homelessness trends vary widely across cities with centralized campuses. On a population-adjusted basis, between the baseline of 2017-2019 and 2024:

- Dallas and Atlanta have seen overall declines in homelessness.
- San Antonio's increase in homelessness was relatively small.
- Reno and Phoenix have experienced significant increases.
- Reno had the largest increases in chronic and unsheltered homelessness, followed on both scores by Atlanta.
- San Antonio saw declines in chronic homelessness.

Exhibit 11: Overview of large congregate campuses around the country

Site	Distance from Downtown	Capacity (beds)	Core Services and Population Served	Funding	Date Opened
Proposed Utah campus	~7 miles	1,300	Shelter, SUD treatment, inpatient involuntary treatment, CCBHC, medical, employment, diversion, accountability center.	State GF, Medicaid, federal grants, TBD	TBD
Haven for Hope (San Antonio)	~1 mile	South campus: ~700 (adults) North campus: ~900 (adults and children)	Transformative (North) campus: TH, PSH, serves adults and families South campus: Low-barrier shelter, serves adults Both campuses: medical, counseling, navigation, case management, recovery, workforce, legal aid	City, county, philanthropy, HUD, Medicaid	2010
Nevada Cares Campus (Reno)	~1 mile	599 (549 ES, 50 PSH)	Low-barrier shelter in a tent structure, meals, case management, supportive housing, and medical services.	City, county, ARPA, state grants, philanthropy	2021: ES 2022: PSH
Keys to Change Campus (Phoenix)	~1.5 miles	~600	Shelter, bridge housing, coordinated entry, navigation, health care, employment, legal	City, county, HUD, philanthropy	2005
The Bridge (Dallas)	~1 mile	Day: 800 Night: 249	Shelter, recovery, case management, healthcare	City, philanthropy, foundations	2008
Gateway Center (Atlanta)	~2 miles	~350	Intake, shelter, workforce, health/behavioral health	City, state, philanthropy, HUD	Mid 2005

Despite the presence of a centralized campus model, trajectories diverge substantially. The presence of a campus does not predict whether overall homelessness, chronic homelessness, or unsheltered homelessness rises or falls.

2. Campuses have more impact when combined with investments in permanent housing

Across cities with a centralized campus, changes in chronic homelessness track more closely with changes in permanent housing inventory than with the presence of a campus or changes in emergency shelter capacity (Exhibit 12). Cities with stronger growth in PSH and other permanent housing (OPH) show better containment of chronic homelessness. For example:

- **San Antonio** has consistently expanded permanent housing since Haven for Hope opened in 2010. Since 2017-2019, it has seen decreases in chronic homelessness.
- **Dallas** expanded PSH and rapid rehousing and experienced the smallest increase in chronic rates among comparison cities (except San Antonio).
- **Reno** saw large increases in chronic homelessness alongside decreases in permanent housing.

Exhibit 12: San Antonio and Dallas expanded permanent housing and outperformed other CoCs with a centralized campus in chronic homelessness (baseline to 2024, per capita)

Change in housing inventory in the homelessness services system

	Emergency (ES + TH + SH)	Rapid rehousing	Permanent housing	Change in chronic homelessness
Atlanta	-10%	175%	-3%	127%
Dallas	10%	948%	45%	12%
Miami-Dade	5%	23%	19%	182%
Phoenix	87%	47%	15%	102%
Reno	55%	130%	-12%	366%
San Antonio	42%	108%	54%	-17%

Source: HUD Housing Inventory Count data. Percent change in chronic homelessness is calculated using population-adjusted PIT counts relative to a 2017-2019 baseline.

These patterns align with a large body of research indicating that permanent supportive housing is the intervention most consistently associated with durable reductions in chronic homelessness. Shelter expansion, even when service-rich, does not appear to substitute for permanent housing supply.

In comparison with peer cities, Salt Lake City's distinction is both rising unsheltered and high-acuity homelessness (higher chronic substance use and severe mental illness). Centralized campuses are typically designed to provide:

- High-volume shelter access
- On-site case management
- Housing navigation
- Linkages to behavioral health and stabilization services

The evidence from peer cities and research literature suggests that without simultaneous expansion of permanent housing, campuses alone do not reliably reverse chronic or unsheltered growth over the long term.

3. Location and integration into existing services is critical

All comparison campuses are located within one to two miles of downtown cores and embedded in existing service networks:

- Haven for Hope is adjacent to downtown San Antonio
- Nevada Cares Campus is approximately one mile from downtown Reno
- The Bridge is in central Dallas
- Keys to Change is near downtown Phoenix
- Gateway Center is within two miles of central Atlanta

In each case, campuses are integrated with transit, employment centers, medical providers, courts, and partner organizations.

Staff at comparison campuses emphasize that even the most comprehensive facilities rely heavily on off-site medical, housing, employment, and behavioral health resources. As one Nevada staff member noted, "To have everything you need on campus is a tall hill to climb."[55]

Location appears to be a structural variable, not a minor logistical detail. Proximity to transit and downtown institutions likely affects:

- Partner participation
- Client mobility
- Access to employment
- Successful reintegration into community-based housing

One homelessness services provider interviewed expressed concern about the proposed location of the Salt Lake City campus. She said, "If we're trying to help pull [people] up by their bootstraps, why would you do that in a way where they can't work?"[56]

A more geographically isolated campus would need to overcome these structural disadvantages through extensive transportation investments and sustained coordination.

Salt Lake City's own experience is that access to transit significantly affects mobility and the use of services.

Until 2019, Salt Lake City had a centralized shelter downtown, near a range of services and institutions used by the city's homeless population and within the TRAX Free Fare Zone.

Concerns about the shelter led to its replacement with three Homeless Resource Centers (HRCs) distributed around the county. Although the HRCs were safer in many respects than the original shelter and offered more on-site services, access to transportation declined, which reduced willingness and ability to travel to off-site services. Overall, there was a decline in access to services such as visits to churches, friends and family, and schools.[57]

There was also a reported increase in the number of people experiencing homelessness who were camping unsheltered. People interviewed believed there was a reluctance to travel to the farthest HRC, and that people wanted to be closer to downtown services.

One of the study's authors concluded about the location of shelters and their proximity to transportation, "The geography really does matter."

The research has implications for the proposed campus, strongly suggesting that transportation or proximity to services should be carefully considered in campus design. It also suggests that a campus located outside transit networks could increase isolation, especially for people with mobility, cognitive, or health limitations.

4. Haven for Hope pivoted away from the "tough love" approach Utah is considering

Haven for Hope in San Antonio has been cited as a model for Utah's proposed campus.[58] Public materials often attribute large reductions in homelessness and strong public returns to the project. This case study documents a more complicated story: Haven for Hope provides shelter and centralized services, but its impacts are overstated. Further, several years after opening the campus pivoted from a "tough love" approach to a housing-focused approach. This change in approach (that some describe as lacking accountability) has not been followed by an increase in homelessness in San Antonio.

Haven for Hope transitioned from behavioral modification to a housing-focused approach.

Opened in 2010 adjacent to downtown San Antonio, Haven for Hope has about 1,600 beds available and offers comprehensive services including case management, health care, employment services, childcare, and pet care. It is located near services and institutions including a crisis mental health facility, detox and recovery beds, a jail diversion program, and the county detention center. Additional details are in text boxes.[59]

The campus is organized into two primary components: a low-barrier shelter (South Campus) and the Transformational (or North) Campus with transitional housing and access to centralized services.

Originally, admission to the North Campus required passing a drug test; ongoing participation required strict engagement with classes and behavioral rules including continued sobriety. Failure could result in expulsion. One Haven for Hope staff member said, "In some cases, we were making people homeless when they didn't need to be homeless."[60]

Starting in 2014, the North Campus shifted to a more flexible, person-centered housing first approach.[61] The primary requirement is to engage in a personalized housing and income plan. Residents are encouraged to maintain sobriety, but infractions do not necessarily result in expulsion.[62]

Likewise, early operations at the shelter relied on a behavior-modification approach in which people began by sleeping outside, exposed to the elements, with minimal amenities intended to encourage participants to meet requirements to be admitted to the other side of campus. By 2020, Haven for Hope had pivoted from a behavioral modification approach at the South Campus as well.[63] The South Campus now provides shelter and voluntary comprehensive services to all clients.[64]

> **"In some cases, we were making people homeless when they didn't need to be homeless."**
>
> *-Haven for Hope Staff Member*

Haven for Hope Pivot Timeline

2010-2014

Behavioral modification approach with no access to housing funding.

Shelter clients sleep outdoors.

2014

Joins Healthy Community Collaborative grant program in Texas.

Receives funding to support transition to housing in the community using housing first principles.

Hires staff with lived experience.

Transformational campus transitions to trauma-informed care and recovery-oriented approach.

2020

All shelter clients sleep indoors and are counted as sheltered.

Changes in homelessness credited to Haven for Hope have been overstated.

Haven for Hope is often credited with reducing downtown homelessness by up to 80 percent.[65] This is not apparent in homelessness counts for the broader CoC, suggesting that the campus shifted the location of homelessness rather than reducing it.

Over the five years after the campus opened (2010-2015), homelessness declined but more modestly than claimed. Overall homelessness declined 20 percent on a population adjusted basis, individual homelessness dropped 22 percent, and family homelessness fell by 14 percent. The long-term trend (2010-2024) also indicates improvement but not a silver bullet. Overall homelessness decreased 16 percent; individuals saw a 19 percent decline, and family homelessness fell 8 percent (see Exhibit 13).

Costs of Haven for Hope

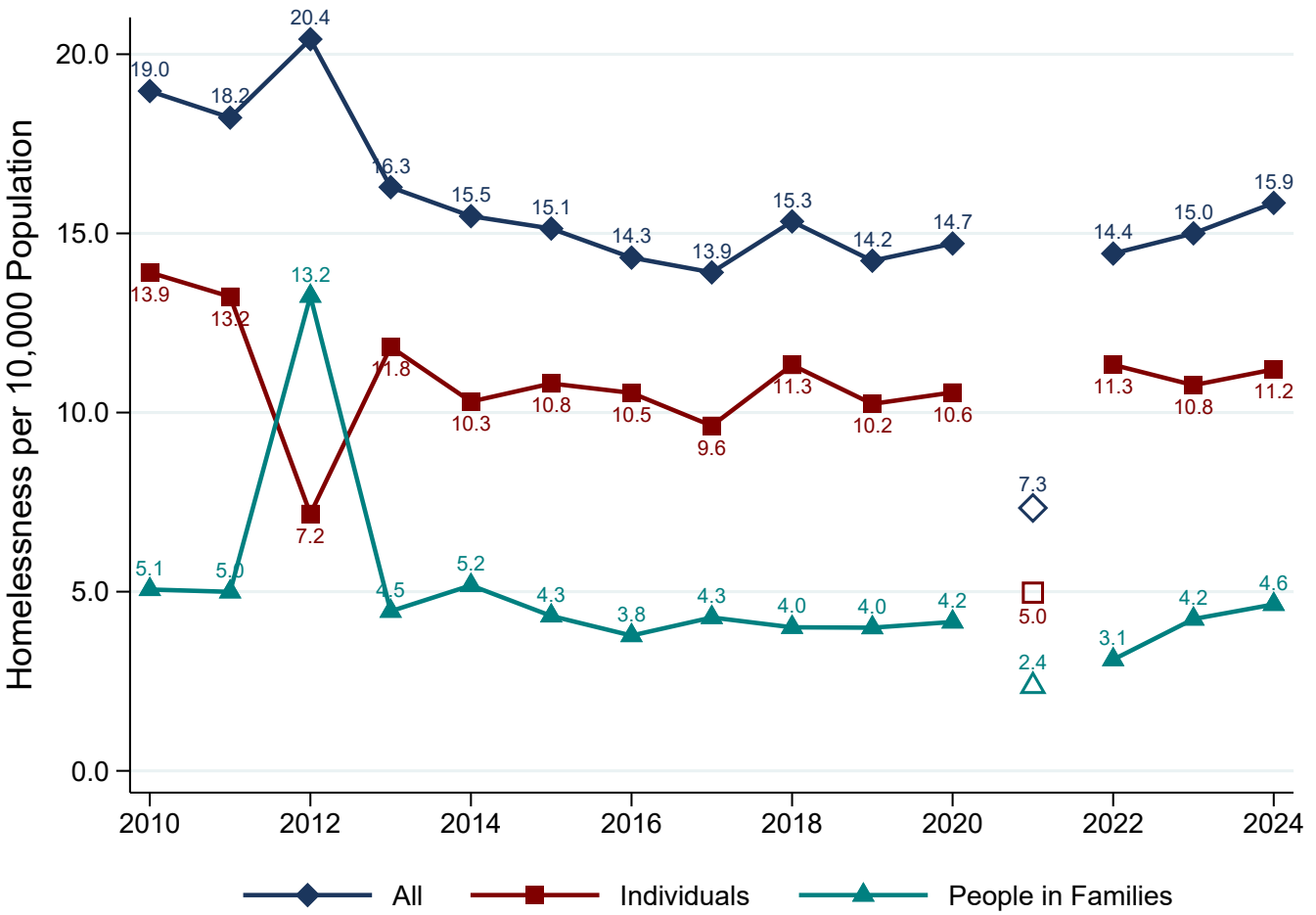
Construction

- $100.5 million in 2010
- $148.8 million adjusted for inflation
- $93,000 per bed

Operating

- $62 per bed per day

Exhibit 13: Homelessness has declined since Haven for Hope opened, but more modestly than often reported (per capita, 2010-2024)



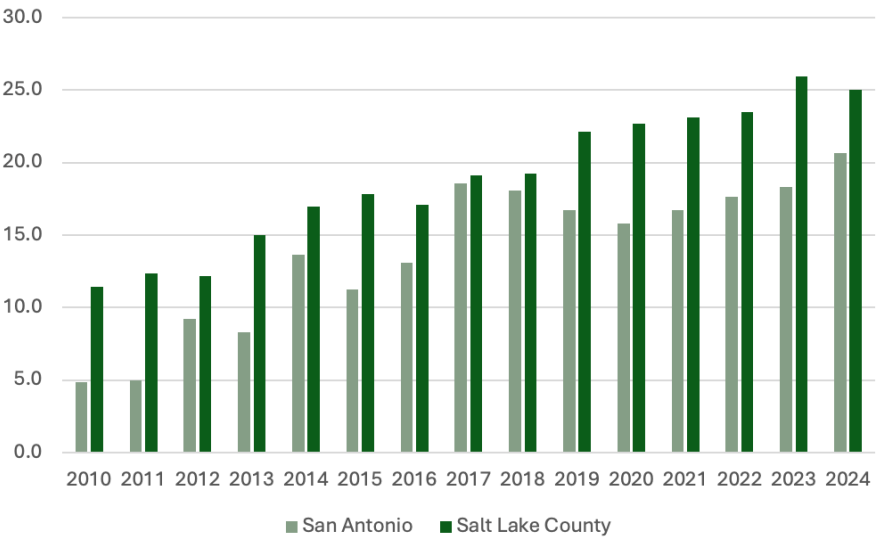
Note: 2021 shown as disconnected point due to pandemic-related count disruptions.
Source: HUD PIT Counts, ACS population

Crucially, San Antonio simultaneously expanded permanent housing.

From 2010 to 2012, permanent housing nearly doubled on a population-adjusted basis, and by 2024 had grown 424 percent. This exceeded Salt Lake City's 158 percent over the same period (Exhibit 14).[66]

Exhibit 14. San Antonio CoC created more permanent housing than Salt Lake County per capita, 2010-2024

Improvements cannot be attributed to the campus alone; expansion of permanent housing likely played a key role.



Source: HUD Housing Inventory Count data

Policymakers should interpret estimated economic benefits of Haven for Hope with caution.

A cost-benefit analysis of Haven for Hope completed in 2025 concluded that the campus produces large net economic benefits.[67] Proponents have cited estimates like this one to suggest the proposed campus might produce cost savings.[68]

Our review of the methods and assumptions used in the analysis raised several concerns; we highlight three here (additional details are in Appendix D). These concerns suggest that Utah policymakers should interpret estimated benefits from Haven for Hope with caution.

- **Direct costs appear to be understated.** Independent sources suggest the direct costs used in the analysis are almost certainly significantly understated.

- **The analysis includes a broad range of benefits but excludes costs used to provide services that result in those benefits.** For example, the analysis attributes 15 years of benefits to clients becoming housed but not the costs of providing that housing. More broadly, the analysis does not include the operating or program costs incurred by Haven for Hope's partner organizations, despite attributing downstream benefits from the services they provide to Haven for Hope.

- **Most benefits accrue to participants, may not translate into cost savings for governments, and are based on a central unrealistic assumption.** The majority (89 percent) of benefits counted accrue to participants through increases in "quality-adjusted life years" from improved housing and access to medical care. The impacts attributed to Haven for Hope are unrealistically large; they also do not generate cost savings that governments can use to offset costs of a large campus, which is often the framing applied to interpreting the large economic return.

The central unrealistic assumption is that Haven for Hope's role is causal, and that all of those who moved to a higher level of care would have remained homeless for an extended period (15 years). This is unlikely. Without a comparison group, it is impossible to say what outcomes were attributable to Haven for Hope and incorrect to claim a large return on investment.

SECTION 4

How effective are proposed campus approaches likely to be?

The proposed campus relies on several interventions designed to reduce chronic homelessness. Two of these are involuntary substance use disorder (SUD) treatment and treatment-first housing models. This section reviews the evidence on these approaches and compares them with voluntary treatment paired with permanent supportive housing (PSH). It also considers other key elements: the Certified Community Behavioral Health Clinic (CCBHC) for involuntary mental health treatment and the size of the campus.

In our review of the evidence, we found that:

- Involuntary treatment and treatment-first housing approaches do not reliably produce better long-term outcomes than voluntary treatment combined with permanent housing.
- If implemented without substantial housing expansion and long-term behavioral health capacity, these approaches risk increasing cycling through public systems rather than reducing homelessness.
- Locating a CCBHC on a campus designed to serve people experiencing homelessness is untested and may prove challenging.
- The size of the campus introduces the possibility of “risk-mixing.” If not carefully mitigated, this could harm low-risk individuals.

1. Evidence is lacking that involuntary SUD treatment will improve outcomes

By definition, involuntary treatment increases treatment entry.[69] Beyond that, however, the evidence that involuntary treatment improves outcomes for severe SUD is limited. Because harm to participants has occurred in some involuntary treatment settings, particular care is required.

Research on involuntary treatment remains limited and inconclusive.

A recent comprehensive review identified 42 studies evaluating involuntary treatment programs. Among studies comparing involuntary to voluntary treatment, findings were mixed: some showed worse outcomes (including higher substance use or recidivism), some showed improvements, and several found no significant differences. Only two randomized control trials have been conducted, with conflicting results.[70]

Additional research highlights several considerations and potential risks:

- Involuntary treatment may be necessary in limited circumstances but should generally be used only as a last resort and "Ought not to be used as a strategy to mainly remove difficult human beings from social life in the guise of care."[71]
- Some involuntary programs have involved human rights abuse, underscoring the need for strong safeguards.[72]
- The effectiveness of treatment depends heavily on whether the services are evidence-based.[73]
- Without stabilization support after detoxification, relapse rates are high.[74]

Taken together, the research suggests that involuntary treatment increases treatment entry but does not reliably improve long-term substance use or criminal justice outcomes compared with voluntary treatment.

2. Treatment-first approaches are likely to lengthen time spent homeless

High-quality evidence consistently shows that PSH, typically delivered using a Housing First approach, reduces time spent homeless compared with treatment-first models.[75] Programs that require sobriety or treatment participation before housing placement tend to have lower placement rates and higher returns to unsheltered homelessness.

That does not mean individuals cannot succeed in treatment-first programs. Rather, the probability of becoming and remaining housed is lower. Treatment-first programs, including therapeutic communities, can have good long-term outcomes for those who complete the program, but drop-out rates are often high.[76]

As Shinn and Khadduri observe, treatment-first programs often function less by changing individuals than by selecting who is allowed to enter housing. Those who meet program requirements move indoors, while others are "relegated to the streets."[77]

Interestingly, requiring treatment participation before housing does not appear to reduce substance use compared with Housing First approaches. Research on the original PSH model found no meaningful difference in substance use between the two approaches.[78]

One peer campus pivoted from a strictly treatment-first approach to a more flexible model.

Haven for Hope in San Antonio, the campus highlighted in Section 3, initially used a behavior-modification model requiring sobriety and service participation prior to housing access. Staff later concluded that this approach did not align well with client needs and shifted toward trauma-informed, voluntary engagement. Leadership reported that motivation and stabilization required time and trust-building rather than coercion.[79]

A Haven for Hope staff member emphasized that no single model works for everyone. The campus now offers multiple pathways including low-barrier shelter and more structured transitional programming, allowing clients to engage at different levels depending on their needs.[80]

3. Long-term success is unlikely without supportive housing after exit from campus

A common theme from practitioners and researchers is that severe mental illness and chronic substance abuse are typically chronic conditions that are managed rather than cured. Long-term supports, including supportive and other permanent housing, are therefore critical to preventing relapse, returns to homelessness, and continued cycling through public systems.

Among practitioners:

- Dallas and San Antonio, two cities with a centralized campus, have paired this with significant increases in permanent housing and subsequently saw declines in chronic homelessness.
- The Miami Model cites supportive housing as key to the success of the model in Miami-Dade County, and as a principal component of effective diversion strategies.
- Architects of the Utah campus similarly emphasize that additional housing, particularly permanent supportive housing and traditional affordable housing, is necessary for individuals to successfully transition out of the campus.

Efforts are currently underway in Salt Lake County to improve responses to behavioral health crises, homelessness, and justice system involvement. Local leaders are collaborating with Judge Steve Leifman, architect of the Miami Model, whose recent recommendations include expanding housing resources across the continuum. The action plan developed with the Leifman Group states, “A lack of deeply affordable, transitional, supportive, and permanent housing undermines diversion, treatment, and supervision.”[81]

This recommendation is reinforced by research indicating that housing instability worsens outcomes for remission in substance use and mental health disorders. Housing with treatment and other services is shown to improve outcomes and reduce relapse and recidivism.[82]

The campus does not appear to reduce the need for additional affordable and permanent supportive housing. A key concern raised by critics is that funding for the proposed campus could crowd out investments in Salt Lake County’s existing homeless response system, including homeless response centers, permanent supportive housing, rapid rehousing, and other services for individuals and families experiencing homelessness.

4. Risk-mixing in a large congregate model can cause harm

Large facilities inevitably serve individuals with a wide range of needs and risk levels. Research from correctional and diversion settings shows that placing low-risk individuals in intensive settings with high-risk individuals can worsen outcomes, a phenomenon called "risk mixing." [83]

This idea is grounded in the well-established "risk principle," which holds that interventions should match an individual's risk level. Research consistently finds that:

- Intensive interventions reduce recidivism among high-risk individuals
- The same interventions can increase recidivism among low-risk individuals
- Providing high-intensity services to low-risk individuals is both counterproductive and resource-inefficient[84]

The proposed Utah campus would significantly expand shelter capacity while also incorporating an accountability-focused component for high utilizers. However, most people experiencing homelessness do not pose a danger to themselves or others, and many individuals classified as high utilizers may have committed primarily low-level offenses.

Of the 1,300 beds, at least 700 are not designed for involuntary placement. As a result, the campus would serve multiple distinct populations:

- Individuals experiencing short-term, first-time homelessness
- High utilizers who do not meet civil commitment standards
- A smaller group who may qualify for involuntary treatment or present public safety risks.

Without careful structure, this creates potential for risk mixing. Best practices in diversion and correctional programming emphasize avoiding placement of low-risk individuals in intensive settings with higher-risk populations. Exposure to higher-risk peers can increase negative outcomes.[85]

Mitigating these risks would require safeguards that might include:

- Careful assessment and triage
- Physical separation by acuity level
- Distinct program tracks
- Strong staffing ratios and supervision

Without such safeguards, the campus could unintentionally worsen outcomes for lower-risk individuals.

5. Locating a Certified Community Behavioral Health Clinic (CCBHC) at a homeless campus is untested

CCBHCs, one of which is intended for the proposed campus, are intended to bridge gaps between behavioral health and general health and reliance on hospital emergency departments for mental health crises. CCBHCs:

- Provide comprehensive, integrated mental health and SUD services.
- Must offer nine required services, including crisis care, screening, assessment, diagnosis, patient-centered treatment planning, outpatient services, and care coordination.
- Must serve anyone who requests care, regardless of age, diagnosis, or insurance.[86]

Under some circumstances, CCBHCs can qualify for Medicaid funding, but Utah does not yet have a Medicaid-funded CCBHC.

While CCBHCs are encouraged to work with homeless service providers, the requirement to serve all individuals who request care raises implementation challenges. It is unclear whether the model can be structured to operate at a centralized campus primarily serving people experiencing homelessness.

SECTION 5

What are the likely costs of the campus?

This section estimates likely construction and operating costs of the proposed campus using 1) benchmarks from other campuses and 2) adjustments reflecting features unique to Utah's proposal. It then considers opportunity costs, or alternative investments that could be funded with comparable resources.

1. Estimated campus costs based on a survey of peer campuses

When benchmarked against comparable campuses, the official construction and operating cost estimates are lower than observed costs elsewhere. Using the average construction and operating costs of peer campuses (adjusted to 2025 dollars), estimated capital costs are approximately $142 million rather than $75 million, and annual operating costs are closer to $47 million rather than $34 million. This implies a per-bed daily operating cost of $100 (Exhibit 15).

Exhibit 15. Peer campus construction and operating cost comparisons

		Construction costs			Operating costs				
	Beds	Original cost	Cost adjusted to 2025 $	Cost per bed	Total (2025 $)	Cost per bed	Cost per bed per day	Total served (day use and overnight)	Cost per person per day
Proposed Campus - official estimate	1,300	$75 M	$75 M	$58,000	$34 M	$26,000	$72	1,300	$72
Peer-based Cost Estimate			*$141.6 M*	$109,000	*$47.4 M*	$36,000	$100	1,300	$100
Peer Comparisons									
Haven for Hope San Antonio	1,600	$100.5 M	$148.8 M	$93,000	$36.1 M	$23,000	$62	1,135	$87
Nevada Cares Campus Reno	604	$87.0 M	$96.0 M	$159,000	$19.2 M	$32,000	$87	650	$81
Keys to Change Campus Phoenix	695	$26.6 M	$41.3 M	$59,000	$21.0 M	$35,000	$97	1,100	$61
The Bridge Dallas	249	$19.5 M	$29.3 M	$118,000	$14.0 M	$56,000	$154	700	$55
Homeless Resource Centers (SLC)	700	$64.0 M	$80.8 M	$115,000					
Average of Peers				**$109,000**		**$36,000**	**$100**		

Sources: Tax filings, annual reports, media reports, interviews.

2. Adjustments to peer-based campus cost estimates

Peer campuses represent a range of buildings, amenities, services, and supports, and therefore costs. Nevada Cares Campus is the most basic version, a tent structure with additional tiny homes; the most complex is Haven for Hope. The proposed campus would offer a much higher level of services than any comparison site, with correspondingly higher costs. It also differs in other important respects from comparison sites in ways that are likely to increase costs from the peer-based estimate (Exhibit 16).

Exhibit 16. Likely additional costs relative to peer-based campus cost estimate

Additional Cost	Description	Estimate
Infrastructure	Comparison campuses are in locations with existing infrastructure; the proposed site lacks infrastructure.	Highly variable; assume at least $6 million for utilities, roads, stormwater, and environmental mitigation
Transportation	The site lacks access to transportation. We assume the need for a new bus route with frequent service between the campus and downtown/other locations.	$3.1 million annually Based on UTA cost per platform hour[87]; assume three trips per hour from campus to downtown, 16 hrs/day, 7 days/week
Police and Fire	Salt Lake City police and fire departments have identified additional FTEs and supply and equipment costs to serving the proposed campus	$10.3 million annually Estimates from Salt Lake City police and fire departments[88]
Involuntary SUD treatment beds; inpatient commitment beds	Higher construction standards, higher O&M costs to comply with health and safety standards, and higher security and other staffing costs. Percentage adjustments are conservative assumptions. Actual costs could vary depending on final design specifications and regulatory requirements	20% higher up-front construction costs; 25% more security FTEs; 35% higher O&M.
Certified Community Behavioral Health Clinic	A SAMHSA planning grant may cover most up-front costs of establishing the needed infrastructure, but the state may need to designate funding for start-up costs.[89]	$1 million Based on 2025-2026 general fund appropriation from Nebraska to streamline licensing and set standards

2. Adjustments to peer-based campus cost estimates (cont.)

In addition to direct operating costs, the campus would generate indirect costs for transportation, police, and fire services. Based on estimates from local agencies, these costs total approximately $13 million annually. These expenditures are not reflected in official operating estimates but represent real fiscal commitments.

Factoring in these costs increases total construction costs to $165 million. Indirect annual costs (for transportation, fire, and police) total $13 million. Added staffing, operations, and maintenance costs bring annual operating costs to $53 million.

Costs could rise higher.

Operating costs for an inpatient mental health treatment bed at Utah State Hospital, the state's primary inpatient mental health treatment facility, are about $485 per day, or $53 million per year for 300 beds.[90] Costs for inpatient involuntary commitment beds at the proposed campus could be similar. If the beds are included in a Medicaid-approved CCBHC, some of these costs could be shared with the federal government, although these clinics are designed to provide short-term stabilization rather than long-term treatment.

3. Opportunity costs

The proposed campus represents a significant investment of public resources. Although there is agreement among many in Utah that the state lacks behavioral health treatment and shelter capacity, every investment of public money requires a tradeoff. This section considers the opportunity costs—other services that could be funded using resources that might otherwise be used to fund the campus (Exhibit 17).

With capital resources equivalent to the campus ($165 million), approximately 691 PSH units could be created. The annual operating cost to sustain those units would be approximately $23.4 million. Using the remaining annual operating and indirect funds, an additional 1,182 households could be served annually through rapid rehousing.
(See Appendix E for details.)

These comparisons are illustrative and do not suggest that behavioral health treatment capacity is unnecessary. Rather, they highlight the scale of resources involved and the tradeoffs in allocating funds to one large facility versus distributed housing and service investments.

Exhibit 17. Opportunity costs of proposed campus using adjusted cost estimates

Adjusted campus cost estimates	
Capital budget (total campus capital cost)	$165 million
Equivalent annual capital cost (annualized)	$9.5 million
Campus annual operating cost	$54.8 million
Campus annual indirect costs	$13.4 million
Total annual fiscal commitment	**$77.7 million**
PSH illustration	
PSH capital cost per unit	$238,700
PSH annual operating and case management per unit	$33,900
Units that could be developed with same capital budget	691
Annual PSH operating cost for those units	$23.4 million
Rapid rehousing (RRH) illustration	
RRH cost per household episode	$26,550
Additional households that could be served with remaining annual operating cost after funding PSH	1,182
Total estimated spending on RRH	$31.4 million

SECTION 6

What are the key risks and unresolved policy questions?

Although some elements of the proposed campus have been defined (a site, selection of an architect), many key elements remain unresolved. Several legal, fiscal, operational, and implementation questions introduce uncertainty that could affect the campus's effectiveness, costs, and long-term sustainability.

Legal and civil rights risks

The proposal includes at least 300 beds for civil commitment. It remains unclear whether existing civil commitment standards under Utah law would support the scale of involuntary placements contemplated.[91] In addition, observers have raised questions about compliance with federal disability law, including the Americans with Disabilities Act's "integration mandate." This mandate requires services to be delivered in the "most integrated setting" appropriate to the needs of individuals with disabilities.[92]

As the first state to incorporate large-scale involuntary components into a homelessness campus model, Utah could face legal challenges. Litigation costs and potential court-ordered modifications could affect the design and long-term operation of the campus.

Fiscal sustainability

Official capital and operating estimates are not fully documented, and long-term operating funding sources have not been identified. Federal funding that appeared possible in mid-2025 remains uncertain. If recurring funding does not materialize, the state may face difficult tradeoffs between maintaining service quality at the campus and preserving funding for existing housing and homelessness programs. Given the scale of the investment, long-term financial sustainability represents a significant risk.

Integration of behavioral health expertise

The campus is intended to serve people with complex, often co-occurring mental health and substance use disorders. The Utah State Homeless Board, which bears much of the responsibility for the campus, does not currently have a behavioral health professional among its members. Designing effective treatment environments for individuals with severe behavioral health needs requires specialized clinical expertise. Incorporating sustained input from qualified behavioral health professionals into the campus's design and treatment approaches could reduce the risk that the facility fails to achieve its intended outcomes.

Location and systems integration

The proposed campus site is located outside existing service networks, employment centers, and major transit infrastructure. Research on Salt Lake County's previous decentralization of shelters found that reduced transit access can limit mobility and reduce service use among people experiencing homelessness. In contrast, all peer campuses examined in this report are located near downtown areas near existing service ecosystems. A more geographically isolated campus would require sustained transportation investment and coordination to maintain connections to employment, courts, healthcare, and transition into permanent housing.

Capacity alignment with the target population

The proposed campus includes hundreds of beds for involuntary treatment and intensive intervention, yet Utah currently lacks integrated data linking homelessness, behavioral health, and criminal justice systems. As a result, policymakers cannot yet determine how many individuals would actually meet legal and clinical eligibility criteria for involuntary treatment or civil commitment. If the number of eligible individuals is substantially smaller than planned capacity, the campus could face low utilization rates.

Housing pathways after stabilization and treatment

Evidence reviewed in this report suggests that long-term recovery from behavioral health challenges and durable reductions in chronic homelessness depend heavily on access to stable housing. If sufficient permanent supportive housing and other affordable housing options are not available for individuals exiting the campus, the facility may primarily stabilize individuals temporarily rather than end their cycle of homelessness. Without parallel expansion of housing resources, individuals may cycle back into shelters, unsheltered homelessness, or the criminal justice system.

Operational complexity

The proposed campus would combine several functions never before integrated into a single facility, including emergency shelter, involuntary treatment, civil commitment, behavioral health services, and justice-system diversion. Coordinating these elements will require complex governance arrangements among state, county, and local agencies as well as healthcare and housing providers. Implementation challenges could affect program effectiveness, costs, and accountability.

Taken together, these unresolved issues suggest that the campus represents a complex policy intervention with significant uncertainties. Careful planning, performance benchmarks, transparent reporting, and sustained coordination across housing, behavioral health, and criminal justice systems will be necessary to reduce these risks and improve the likelihood that the campus achieves its intended goals.

Conclusion

Utah's proposed homeless campus, which features involuntary substance use disorder and mental health treatment as key strategies, represents a significant shift in the state's approach to homelessness. It reflects frustration with rising homelessness, particularly visible chronic and unsheltered homelessness.

These trends appear to be driven by several converging factors: rapid population growth, rising housing costs, unusually high rates of serious mental illness, and increasing substance use disorders against a backdrop of a longstanding shortage of behavioral health capacity in the state. At the same time, Salt Lake County's homelessness response system, which performed well by several measures in the past, has not expanded quickly enough to keep pace with these pressures.

The proposed campus is therefore an attempt to respond to real and urgent challenges, but it is also a major policy gamble. The campus would require a very large public investment—likely larger than current estimates indicate—and commit the state to decades of operating costs. Federal funding may offset some costs, but much of the long-term financial responsibility would likely fall on Utah taxpayers.

By the same token, the proposed model has limited precedent. Utah clearly faces a shortage of inpatient mental health treatment capacity, and the proposed civil commitment beds could help address gaps in the behavioral health system. It is not clear, however, that all these beds are needed by people currently experiencing chronic homelessness.

Large-scale involuntary substance use disorder treatment as a central strategy for addressing homelessness is also untested. Involuntary approaches can increase entry into treatment, but it has not demonstrated better long-term outcomes than voluntary treatment combined with stable housing and support services.

Finally, long-term recovery from mental illness and substance use disorders depends on stable housing and support after treatment. Individuals who receive treatment but leave the campus without stable housing may simply continue cycling through shelters, emergency departments, and the criminal justice system. The proposed campus does not reduce the need for additional housing investments; in many cases, it would increase that need.

If Utah policymakers decide to proceed with the campus, several safeguards could reduce the risks identified in this report. These include clear legal standards and protections for involuntary placements, transparent cost estimates and long-term funding plans, and rigorous independent evaluation of outcomes. Most importantly, any campus-based strategy would need to be combined with investment in permanent supportive housing and other affordable housing options.

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Appendix A

Utah "Transformative Campus" proposal timeline

February 2024
Utah Legislature allocates $23.8 million (one-time) for the acquisition and development of a low-barrier (800+ bed) shelter site.

July 2024
Know-By-Name (coordinated case management approach using a Pathways to Human Thriving assessment tool) pilot launch in Weber County.

October 2024
Utah Homeless Services Board (UHSB) accelerates transformative campus project.
- Motion calling for a centralized, transformative campus with 1,200 low-barrier, year-round beds passes
- "Utah's Guiding Principles to Overcome Homelessness" that emphasize comprehensive wrap-around services and accountability adopted

July 24, 2025
Federal Executive Order, "Ending Crime and Disorder on America's Streets" issued. Includes calls for:
- Expanding civil commitment and institutional/step-down treatment
- Encouraging data-sharing (including with law enforcement where permitted)
- Shifting federal posture toward public order / enforcement

July 29, 2025
Utah leadership writes to UHSB directing action by September 30, 2025.
- Letter directs that the UHSB take action to fulfill the Executive Order, stating Utah's leaders do not support "Housing First" policies that "lack accountability."
- Priorities include accelerating the transformative, services-based homeless campus and identifying system gaps

September 3, 2025
Site acquisition agreement announced (15.85 acres)

September 30, 2025
UHSB issues recommendations for the 2026 General Legislative Session that formalize Executive Order-aligned policy concepts.
Recommendations are similar to those in "Utah's Action Plan to Address Homelessness: Aligning with the 'Ending Crime and Disorder Executive Order,'" presented to legislative committee on September 16, 2025.
Campus plans include:
- An Accountability Center described as a secure substance use disorder residential treatment alternative to jail where entry/exit are not voluntary
- A Certified Community Behavioral Health Clinic (CCBHC) using Medicaid PPS funding
- 300+ beds tied to civil commitment processes
- Additional beds described as medium barrier

November 20, 2025
Stakeholder input at UHSB Meeting

December 8, 2025
Governor Cox's 2026 budget calls for $30M one-time and $20M ongoing to target "high utilizers"

January-February 2026
Legislative session, Office of Homeless Services budget presentation highlights priorities other than the campus

Appendix B

Glossary of Key Terms

Definitions are drawn from official sources including the U.S. Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Alliance to End Homelessness (NAEH), and the Corporation for Supportive Housing (CSH). Sources are noted in brackets after each definition.

Accountability Center
As used in the Utah proposal, a secure residential placement facility providing treatment for substance use disorders as an alternative to jail, where entry and exit are not voluntary. This is not a standard term in HUD or federal homelessness policy; it is specific to Utah's proposed transformative campus. [Utah Homeless Services Board, 2025 Legislative Session Recommendations]

Annual Homeless Assessment Report (AHAR)
A report by HUD to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of people experiencing homelessness, service use patterns, and the capacity to house homeless persons. The AHAR uses aggregate data from Homeless Management Information Systems (HMIS) and Continuum of Care program applications. [HUD]

Certified Community Behavioral Health Clinic (CCBHC)
A designation for community-based behavioral health organizations that meet federal criteria established by SAMHSA. CCBHCs must provide nine types of services, including 24-hour crisis care, outpatient mental health and substance use services, screening and assessment, and care coordination. They are reimbursed through a Medicaid Prospective Payment System (PPS) intended to cover the actual cost of providing comprehensive services. More than 500 CCBHCs operate in 46 states. [SAMHSA; The National Council for Mental Wellbeing]

Chronic Homelessness
As defined by HUD, a homeless individual with a disabling condition who has been living in a place not meant for human habitation, a safe haven, or an emergency shelter continuously for at least 12 months, or on at least four separate occasions in the last three years where the combined length of time homeless totals at least 12 months. [HUD, 24 CFR 578.3]

Civil Commitment (Involuntary Commitment)
A legal process by which a judge or someone acting in a judicial capacity may order that a person with symptoms of a serious mental disorder, meeting specified criteria, be confined in a psychiatric facility or receive supervised outpatient treatment for some period of time. Thirty-seven states and the District of Columbia have statutes allowing involuntary commitment for individuals with substance use disorders. Standards typically require a finding that the individual poses a danger to themselves or others or is gravely disabled. [SAMHSA, Civil Commitment and the Mental Health Care Continuum]

Co-Occurring Disorders (Dual Diagnosis)
The coexistence of both a mental health disorder and a substance use disorder in a single individual. SAMHSA recommends integrated treatment in which both conditions are treated concurrently. [SAMHSA, TIP 42: Substance Use Disorder Treatment for People with Co-Occurring Disorders]

Congregate Shelter
A facility that provides temporary sleeping accommodations in a shared setting, typically with beds arranged in a common area or dormitory-style rooms. Distinguished from non-congregate shelter, which provides individual rooms or units. [HUD]

Continuum of Care (CoC)
A HUD-designated regional or local planning body responsible for coordinating housing and services funding for people experiencing homelessness. CoCs conduct the annual Point-in-Time count, submit applications for federal funding, and manage the Homeless Management Information System. There are approximately 400 CoCs nationwide. [HUD, 24 CFR 578]

Appendix B (cont.)

Glossary of Key Terms

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Coordinated Entry
A process designed to quickly identify, assess, refer, and connect people in crisis to housing and assistance no matter where they seek help. Coordinated entry uses standardized assessment tools to prioritize individuals and families based on vulnerability and severity of need. All HUD-funded CoCs are required to have a coordinated entry process. [HUD; National Alliance to End Homelessness]

Disabling Condition
As defined by HUD, a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug use, post-traumatic stress disorder, or brain injury, that is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently. A disabling condition is required to meet the definition of chronic homelessness. [HUD, 24 CFR 578.3]

Diversion
A strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion differs from prevention in that it targets people at the point of entry into the homeless services system. [National Alliance to End Homelessness]

Emergency Shelter
Any facility with the primary purpose of providing temporary shelter for people experiencing homelessness. Emergency shelters may have varying lengths of stay and levels of service. Under HUD's definition, individuals staying in emergency shelters are considered "sheltered homeless." [HUD]

Harm Reduction
A set of evidence-based strategies and interventions aimed at reducing the negative consequences of substance use without necessarily requiring abstinence. Harm reduction approaches may include naloxone (Narcan) distribution, fentanyl test strips, syringe services programs, and medication-assisted treatment. [SAMHSA]

High Utilizer
As used in the Utah proposal, an individual who has been arrested or cited four or more times in a calendar year. This is not a standard federal term; definitions vary by jurisdiction and context. In healthcare settings, the term typically refers to individuals with frequent emergency department visits or hospitalizations. [Utah Office of Homeless Services]

Homeless Management Information System (HMIS)
A locally administered electronic data system used to record and analyze client-level information on the characteristics and service needs of people experiencing homelessness. HMIS is designated by each Continuum of Care and required by HUD for all CoC- and ESG-funded programs. Aggregate HMIS data are used to produce the Annual Homeless Assessment Report. [HUD, 24 CFR 578]

Homeless Resource Center (HRC)
A term used in Salt Lake City for emergency shelters that replaced the larger Road Home shelter in 2019. Three HRCs were established in dispersed locations around the city with a combined capacity of approximately 700 beds, compared with 1,100 beds at The Road Home. [Salt Lake City]

Appendix B (cont.)

Glossary of Key Terms

Definitions are drawn from official sources including the U.S. Department of Housing and Urban Development (HUD), the Substance Abuse and Mental Health Services Administration (SAMHSA), the National Alliance to End Homelessness (NAEH), and the Corporation for Supportive Housing (CSH). Sources are noted in brackets after each definition.

Housing First
An approach to homeless assistance that prioritizes providing permanent housing to people experiencing homelessness as quickly as possible, without preconditions such as sobriety, treatment compliance, or participation in services. Supportive services are offered but not required as a condition of housing. Research consistently shows that Housing First approaches lead to higher housing retention rates compared to treatment-first models. [National Alliance to End Homelessness; HUD]

Housing Inventory Count (HIC)
An annual inventory of beds and units dedicated to people experiencing homelessness within a Continuum of Care, including emergency shelter, transitional housing, rapid rehousing, safe haven, and permanent supportive housing. The HIC is conducted on the same night as the Point-in-Time count. [HUD]

Jail Diversion
Programs that redirect individuals with mental illness or substance use disorders away from the criminal justice system and into community-based treatment and services. Pre-booking diversion occurs at or before the point of arrest; post-booking diversion occurs after arrest but before adjudication. The Miami-Dade County Criminal Mental Health Project is a prominent example. [SAMHSA]

Low-Barrier Shelter
An emergency shelter that minimizes requirements for entry. Low-barrier shelters do not require criminal background checks, sobriety, income verification, identification, or mandatory participation in programs or services as a condition of receiving shelter. Supports and referrals are available but voluntary. [HUD; USICH]

Median Length of Stay
In the context of homeless services, the midpoint duration of time individuals or families spend in emergency shelter or transitional housing before exiting to permanent housing or other destinations. Increasing median length of stay can indicate system bottlenecks or insufficient permanent housing capacity. [HUD System Performance Measures]

Microshelter
A small, individual sleeping unit, typically a prefabricated structure, used as a low-cost alternative to congregate shelter. Microshelter villages provide individual units with shared facilities and are typically paired with case management and supportive services. [Various; no standard HUD definition]

Opportunity Cost
The value of the next-best alternative that must be forgone when a particular investment or policy decision is made. In this report, opportunity cost analysis compares the resources required for the proposed campus with alternative investments such as permanent supportive housing or rapid rehousing. [Standard economic term]

Other Permanent Housing (OPH)
A HUD program category for permanent housing that serves people experiencing homelessness but does not require participants to have a disability. OPH includes subsidized housing placements that provide long-term stability without the intensive supportive services associated with PSH. [HUD]

Appendix B (cont.)

Glossary of Key Terms

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Permanent Supportive Housing (PSH)
Long-term housing combined with supportive services for people experiencing homelessness who have a disabling condition. PSH has no time limit on tenancy and provides access to voluntary, flexible services such as healthcare, mental health care, substance use treatment, and case management. PSH is the primary evidence-based intervention for ending chronic homelessness. In Salt Lake City, 95 percent of PSH residents retain their housing or exit to another permanent housing situation annually. [HUD; Corporation for Supportive Housing]

Point-in-Time (PIT) Count
An unduplicated count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires CoCs to conduct an annual count of sheltered individuals and a count of unsheltered individuals at least every other year (in odd-numbered years). PIT data are a primary source for the Annual Homeless Assessment Report. [HUD]

Prospective Payment System (PPS)
A Medicaid reimbursement methodology used by Certified Community Behavioral Health Clinics that bases payment on the anticipated cost of providing comprehensive services rather than billing for individual services rendered. PPS is intended to ensure CCBHCs can cover the full cost of care. [Centers for Medicare & Medicaid Services]

Rapid Rehousing (RRH)
A housing intervention that provides short- to medium-term rental assistance (typically 4 to 24 months) combined with housing search assistance and targeted supportive services to help people experiencing homelessness obtain and maintain permanent housing quickly. Rapid rehousing is appropriate for a wide range of individuals and families and is designed to increase self-sufficiency. [National Alliance to End Homelessness; HUD]

Recovery-Oriented Services
Treatment and support approaches that recognize recovery from mental illness and substance use disorders as an ongoing, individualized process. Recovery-oriented services emphasize person-centered care, self-determination, peer support, and community integration rather than symptom elimination alone. [SAMHSA]

Returns to Homelessness
A HUD system performance measure tracking the percentage of individuals who access services from homeless service providers in the reporting jurisdiction within a specified period (6, 12 or 24 months) after exiting to permanent housing. Lower return rates indicate more effective and durable housing placements. [HUD System Performance Measures]

Scattered-Site Housing
Permanent supportive housing in which units are located in private-market apartment buildings distributed throughout a community, rather than concentrated in a single building or project. Tenants hold individual leases and receive mobile supportive services. [Corporation for Supportive Housing]

Severe Rent Burden
A household spending more than 50 percent of its gross income on rent and utilities. Severe rent burden is a key risk factor for homelessness. [HUD]

Substance Use Disorder (SUD)
A medical condition in which the use of one or more substances leads to clinically significant impairment or distress, affecting the brain and behavior and causing difficulties in controlling use despite harmful consequences. Substance use disorders range in severity and are diagnosed based on criteria in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). [SAMHSA; National Institute on Drug Abuse]

Appendix B (cont.)

Glossary of Key Terms

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Therapeutic Community
A structured residential treatment program, typically for substance use disorders, that uses the community itself as the primary therapeutic tool. Therapeutic communities require abstinence and active participation in treatment programming. While completion can yield positive long-term outcomes, dropout rates are often high. [National Institute on Drug Abuse]

Transformative Campus
The term used by Utah policymakers to describe the proposed 1,300-bed centralized facility in Salt Lake City's Northpoint neighborhood. The campus is planned to include emergency shelter, involuntary civil commitment beds, a CCBHC, and wrap-around services. This is not a standard term in federal homelessness policy. [Utah Homeless Services Board]

Transitional Housing
A HUD-funded program that provides temporary housing (up to 24 months) combined with supportive services to facilitate the movement of individuals and families experiencing homelessness to permanent housing. [HUD]

Trauma-Informed Care
A framework for service delivery that recognizes the prevalence and effects of trauma on health and behavior, integrates knowledge about trauma into policies and practices, and seeks to avoid re-traumatization. Trauma-informed care approaches patients and clients with non-judgmental support. [SAMHSA]

Treatment-First Model
An approach that requires individuals to complete or comply with mental health or substance use treatment as a precondition for receiving permanent housing. Research shows that treatment-first programs have lower housing placement rates and higher returns to homelessness compared with Housing First approaches, though individuals who do complete treatment-first programs can achieve positive outcomes. [National Alliance to End Homelessness; research literature]

Unsheltered Homelessness
Individuals and families sleeping in places not designed for or ordinarily used as regular sleeping accommodations, such as vehicles, parks, sidewalks, abandoned buildings, or encampments. For HUD's Point-in-Time count, a person is unsheltered if they are not staying in an emergency shelter, transitional housing, or safe haven. [HUD]

Wrap-Around Services
A comprehensive, individualized set of supportive services designed to address the multiple needs of people experiencing homelessness, which may include case management, healthcare, behavioral health treatment, employment assistance, benefits enrollment, legal services, and life skills training. [HUD; Corporation for Supportive Housing]

Appendix B (cont.)

Glossary of Key Terms

Sources

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Appendix C

Salt Lake County Jail Dashboard

The Salt Lake County Jail gathers self-reported data on housing status of people in custody, a demonstration of Salt Lake County's commitment to understand and address system-wide interactions between homelessness and public safety that is uncommon among jurisdictions. The dashboard provides a daily count of inmates as of about 2:00 a.m. on the current day.

Snapshot of Salt Lake County Jail inmates, February 19, 2026

This figure reflects jail custody, not arrests. It likely overrepresents the number of unhoused individuals arrested (as a share of all arrests) because they are:

- Less likely to be able to pay cash bail
- Likely to be considered to have fewer community ties (such as a permanent address)
- More likely to have frequent repeat offenses (such as for prior failure to appear)
- More likely to have practical difficulties meeting pretrial release conditions (such as electronic monitoring and regular access to a phone)

With these caveats, the dashboard recently reported that 32 percent of inmates were unhoused. Most were unemployed (87 percent), single (72 percent), and male (80 percent), with ages 35-44 most common. The leading charge category was drug-related (29 percent), primarily possession. Unhoused people were more likely to be held on misdemeanor charges (44 percent) than housed individuals (23 percent), who were more often being held for felonies.

Appendix D

Haven for Hope Return on Investment

State officials have pointed to cost-benefit analysis of Haven for Hope such as the one conducted by Nivin, 2025, as evidence of large positive returns to a homeless campus. Our review indicates that these findings should be interpreted with caution.

Category	Description	Est Value	Concerns	Est of Error
Costs	Total expenses (2007–2024)	$313 M	Not inclusive of all costs, either direct or to partners	Large underestimate of costs
Economic Impacts of Operations	Measured by total output generated by operations (primarily multiplier effects)	$649 M	Economic impact multiplier assumptions not articulated. Campus is not intended to generate economic output (beyond benefits already measured to participants), unlike a factory or private-sector firm.	Large overestimate of benefit
Volunteer Contributions	Economic value of volunteer labor and induced economic activity	$6 M	Volunteer labor incorrectly included as a benefit; this is a cost. Induced economic activity multiplier assumptions not articulated, and volunteer contributions do not generate economic output beyond benefits already measured to participants.	No benefit; underestimate of cost
Reduced Crime	Savings to criminal justice system plus reduced social costs of crime (victimization, productivity loss, pain, and suffering)	$165 M	Inadequate evidence that Haven for Hope is a Substance Abuse Treatment facility or that clients receive adequate treatment; costs are not included	Large overestimate of benefit
School Stability	Increased lifetime earnings and induced economic activity from children remaining in their schools of origin	$583 M	Estimate of additional school persistence due to Haven for Hope is implausibly large; costs of bussing and related services for children experiencing homelessness are not included	Unlikely that substantial benefit is attributable to Haven for Hope
Medical, Housing & Other Care Services	Monetized value of improved health, housing stability, and reduced mortality using Quality-Adjusted Live Years (QALYs)	$11.6 B	Intensity of services provided is unlikely to create this degree of benefit; most costs of additional services like healthcare and future housing are not included	Large overestimate of benefit
Total Benefits		$13.0 B		

Appendix E

Opportunity Cost Assumptions

- The equivalent annual capital cost of the campus assumes a useful life of 30 years and a discount rate of 4 percent.
- The cost of creating PSH units is a weighted average of the cost of PSH unit types (new, acquisition/rehab, scattered site, and hotel/motel conversion) from Housing Now 2025.[93]
- Assumptions for the cost of rapid rehousing costs are from Housing Now 2025 and include rent subsidy for units in the market rental market for 4-24 months and targeted supportive services.

Assumptions for case management costs in PSH units are a weighted average of cost estimates of integrated case management, ACT, and tenancy support services from the Corporation for Supportive Housing.

Endnotes

1. De Sousa and Henry, 2024
2. Barry et al., 2025
3. Homelesscampusutah.gov
4. N. Coleman personal communication, February 10, 2026 and Coleman and Misner, 2026
5. Utah Homeless Services Board, September 2025
6. Utah Homeless Services Board, September 2025; Utah Homeless Services Board, November 2025
7. Tomco, March 2026
8. Tomco, February 2026
9. Cox et al., July 2025
10. Utah Homeless Services Board meeting minutes, November 2025, see also McKellar, 2024, and Earnshaw, 2024.
11. Authors' analysis of HUD Point in Time count data, including 2025 data for Utah published by the Utah Office of Homeless Services, 2026.
12. Tsemberis et al., 2003, Tsemberis et al., 2004
13. Trump, 2025
14. Cox et al., July 2025
15. U.S. data and data for peer cities for 2025 are not available as of this writing.
16. Authors' analysis of HUD System Performance Measures data.
17. Shinn and Khadduri, 2020.
18. See, for example, Quigley and Raphael, 2001; Byrne et al., 2013; Colburn and Aldern, 2022, GAO, 2022, Nisar, et al., 2019
19. GAO, 2020
20. Author's analysis of American Community Survey data
21. FHFA all transactions house price index for Salt Lake City
22. Author's analysis of American Community Survey data
23. O'Flaherty, 2023
24. Fazel, Geddes, Hushel, 2014
25. Rates of increase in other drugs are less comparable over time because of changes in survey methodology that expanded how prescription drug abuse and disorders were measured. https://www.samhsa.gov/data/data-we-collect/nsduh-national-survey-drug-use-and-health/national-releases/2021
26. Utah Department of Health and Human Services, 2025.
27. This survey, from the National Survey on Drug Use and Health, was conducted in 2021 and 2022 and measures serious mental illness during the past year.
28. Gardner Institute and Leavitt Partners, 2024
29. McKellar, 2024a and 2024b
30. OPH is housing that is part of the homeless services system but, unlike PSH, does not make disability a condition for admission or provide intensive services.
31. National Health Care for the Homeless Council, 2025
32. Riedesel, Nole, and Smith, 2024
33. Shinn and Khadduri, 2020
34. Shinn and Khadduri, 2020
35. Utah Office of Homeless Services, 2026
36. Utah Homeless Services Board, September 2025
37. Utah Homeless Services Board, September 2025
38. Salt Lake City, 2025
39. Salt Lake City, 2025
40. Salt Lake City, 2025
41. Personal communication, January 2026
42. Utah is making efforts to improve cross-agency data sharing, but this is a work in progress. Personal communication, January 2026.
43. Office of Homeless Services, 2026
44. Office of Homeless Services, 2026
45. Utah Disability Law Center, 2025
46. Davila J., 2026, see also Salt Lake City, 2025
47. Davila J., 2026
48. Davila J., 2026
49. Davila J., 2026
50. Boatwright, 2019
51. Boatwright, 2019
52. Boatwright, 2019
53. Boatwright, 2019
54. Salt Lake County, 2025
55. Personal communication, February 18. 2026
56. Personal communication, February 2026
57. Canham, et al., 2022
58. See https://homelesscampus.utah.gov/case-studies/haven-for-hope/, accessed February 5, 2026
59. Sources for text boxes are Tsai et al., 2025, tax filings, and annual reports.
60. Personal communication, February 13, 2026
61. Personal communication, February 13, 2026
62. Tsai et al., 2025
63. Bloomberg CityLab, 2019
64. Tsai et al., 2025
65. e.g., ULI, 2023
66. PIT data show a sharp one-year decline in homelessness among individuals in 2012 and a sharp increase in family homelessness. Both counts then returned to the previous trend. These anomalies are more likely related to the PIT count that year than actual numbers of homeless individuals and families.
67. Nivin, 2025
68. Utah Office of Homeless Services, 2024
69. Volkow, 2018
70. Werb et al., 2016 and Bahji et al., 2023
71. Fischer, et al., 2025
72. Werb et al., 2016 and Bahji et al., 2023
73. Werb, et al., 2016
74. Kertesz, et al. 2003
75. Tsemberis et al., 2003, Tsemberis et al., 2004
76. Andersson, 2018
77. Shinn and Khadduri, 2020
78. Aubrey 2015, 2016, Stergiopoulos 2015
79. Personal communication, February 6, 2026
80. Personal communication, February 6, 2026
81. Salt Lake County, 12/15/2025
82. Kertesz, Horton, Friedmann, Saitz, & Samet, 2003; Milby et al., 2008; Sosin, Bruni, & Reidy, 1995
83. Bonta, Wallace-Capretta and Rooney, 2000; see also Lowenkamp and Latessa, 2004
84. Andrews, Bonta, and Hoge, 1990 and Lowenkamp and Latessa, 2004
85. Lowenkamp et al., 2006
86. https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics
87. Utah Transit Authority, 2025
88. Utah Homeless Services Board, November 2025
89. A share of the costs of the CCBHC could eventually be covered by federal funding (e.g., SAMHSA grants, the Medicaid demonstration program, or a state-specific Medicaid waiver).
90. Knight, et al., 2023; adjusted to 2025 dollars
91. Utah Homeless Services Board, September 2025
92. U.S. Department of Justice, 2011
93. Housing Now 2025

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