

POLITICAL REMODEL · POLICY BRIEFING

A conservative response to the homeless crisis

Kitsap County and Bremerton

Starting conditions · Evidence of misrepresentations · Recommendations

August 2026

Start with agreements, then prove the case, then act

Three sections — less repetition, clearer path

01

Starting understandings

Shared goals, two populations, funding and enforcement conditions

02

Evidence of misrepresentations

Demographics, safety, exits, clinical data, spending, crime

03

Recommendations

Temporary displaced vs. chronic · five-step alternative

Start with these understandings and conditions

Shared goals before program design

1

Reduce the homeless population in Kitsap County — that is the overall goal.

2

Citizen groups and advocacy groups agree: homelessness risks health and death. A person who is homeless with untreated mental illness or addiction should be treated as posing danger to self and others. Current law often says homelessness alone is not enough for involuntary treatment — a barrier that has propped up low-barrier shelters that have not reduced the crisis.

3

Within existing law, government should design programs from the view that homelessness is unhealthy and unsafe for the individual and the community.

4

The goal is not primarily to cut spending. It is to find permanent solutions that reduce the population. Successful exits organically reduce demand — and then cost.

Two populations — two programs

You cannot combine these groups into one solution

5a · Temporary displaced

People and families who would normally be part of society, but lost housing because of abuse, an unhealthy environment, financial shock, or similar conditions.

Once those conditions are addressed, they can move into permanent housing.

Mostly women, children, elderly, and families.

5b · Chronic homeless

Individuals with mental conditions and/or drug or alcohol addiction that prevent integration into ordinary society.

They cannot achieve acceptable living conditions until the root cause is addressed.

Treatment first — not open-access shelter as the default.

Evidence, incentives, enforcement, and funding

Conditions 6–10

6

Do not combine temporary displaced people and the chronically homeless into one program. Different needs require different solutions.

7

There is substantial misinformation about homelessness that is not backed by evidence. Programs must be judged on results — not on protecting well-funded organizations that fail to deliver long-term exits but have effective marketing campaigns.

8

Government currently incentivizes organizations to grow the caseload: larger counts often mean more money. That rewards bad programs and does nothing to shrink the crisis.

9

Laws on loitering, extended camping, and related public-order rules should be strongly enforced — provided they include a real option to accept proper shelter or treatment.

10

There is sufficient funding. It needs to be reprioritized and redirected to better use.

For temporary displaced individuals and families

Priority housing — never low-barrier adult sites

- 1 Priority into permanent housing facilities that provide food, shelter, utilities, and basic needs (clothing, children’s supplies, etc.).
- 2 Facilities must have security and occupancy conditions: no drug use (with testing), healthy hygiene, proper conduct (limited police calls; respect for neighbors), limited access so dealers and criminals cannot use the property, access to services and counseling, and active work toward permanent housing, jobs, and supports.
- 3 Under no circumstances should these individuals or families be placed in temporary, low-barrier sites. (See evidence section.)

For chronic homeless — evaluate and treat

KMHS / DCR gate within 24 hours

1 • Rapid evaluation

Once identified by law enforcement or outreach, evaluate through KMHS / a Designated Crisis Responder as soon as possible — preferably within 24 hours.

2 • Talk to the condition

Engage the mental illness or the addiction — the person is trapped inside. Illness may say “don’t trust help.” Addiction may say “I don’t have a problem.” “Just leave me alone” is often not what they really need.

3 • Right facility

If mental condition, drug addiction, alcohol addiction, or a combination is found: process into an Evaluation & Treatment (E&T) facility for mental illness, or a Secure Withdrawal Management & Stabilization (SWMS) facility for substance use.

SECTION 02

Evidence of misrepresentations

Claims used to sell low-barrier campuses vs. what the data shows

Most people seeking help are single adults

2025 Kitsap Point-in-Time and related local picture

47%

Single men

Share of households seeking help who are single men or boys

36%

Single women

Single women or girls; about 8% are women with children

8%

Age 65+

Of unsheltered people — seniors are not the majority

63%

Unsheltered male

Of unsheltered heads of household identify as male

What the 2025 Kitsap PIT adds

- County total: 647 people (350 sheltered, 297 unsheltered). About half of unsheltered counted in Bremerton.
- Children under 18: 16% of sheltered, only 4% of unsheltered. Families already have priority in existing shelter.
- Working-age adults dominate: ages 25–44 are 47% of unsheltered; ages 45–64 another 37%.
- Mental health and substance use are the most commonly reported conditions among unsheltered heads of household.

Emergency campuses are not mainly a family-safety tool

Claim vs. local picture

THE CLAIM

Tent or rigid-structure emergency sites are needed to protect families — mostly women with small children fleeing abuse — and elderly people who lost homes on limited income.

THE LOCAL PICTURE

Kitsap's unsheltered population is concentrated among working-age single adults. Children are a small share of the street count. Seniors are underrepresented relative to the story used to site mixed, low-barrier campuses.

THE POLICY IMPLICATION

Family and elder emergencies need separate, safe, time-limited housing with casework. Mixing those cases into a low-barrier adult site built for chronic street homelessness is the wrong design.

Mixed-gender temporary shelter is not a safe default

About 40% of women who experience homelessness report sexual violence in their lifetime

Measure	Temporary shelter	Street / unsheltered	What it means
Physical assault	~28% in temporary shelter	~57% street / unsheltered	Street is worse; shelter is not low-risk
Sexual assault	~27% temporary shelter	~36% street	Gap is smaller — risk stays high inside
Robbery	Lower in shelter	Much higher on street	Privacy and lockable space matter
Women-only sites	Safer than mixed	Rare locally	Most emergency beds are co-ed

Some women leave mixed hostels and sleep outside because they feel less trapped. A low-barrier hybrid site serving mostly single men is not a family-safe or women-safe model.
Sources: Wenzel et al.; 2026 Journal of Urban Health meta-analysis; California statewide homelessness study.

Temporary programs usually do not end in a home

HUD 2024 national averages (Measure 7b1)

34%

Exit to permanent housing

From emergency shelter, transitional housing, or rapid rehousing

66%

Do not exit to housing

Unknown destinations, other shelters, institutions, or the street

17%

Return within 24 months

Of those who exit to housing, about 1 in 6 return

Read 34% correctly: that is the share who exit to housing — not the success rate of the whole system. Permanent supportive housing with rules retains about 95% of residents; temporary shelters do not.

Families and temporarily displaced people have higher housing-exit rates, which can mask weaker results for the chronically homeless.

Mental illness and addiction dominate the chronic caseload

Clinical reviews vs. HUD’s narrower “serious mental illness” snapshot

Any mental-health disorder	67% current / 77% lifetime	Psychotic disorder	~14%
Any substance-use disorder	~44%	Schizophrenia-spectrum	~7–12%
Alcohol-use disorder	~37%	Bipolar disorder	~8%
Drug-use disorder	~22%	Antisocial personality	~26%
Major depression	~19%	PTSD (recent studies)	~8–14%

HUD’s official SMI snapshot (~20–24%) is lower because it relies on self-report and observation, not full diagnosis.

You often cannot treat this as a housing-only problem

Root cause

The condition drives decisions

Addiction and untreated psychosis change judgment. People decline shelter, leave treatment, or return to the street even when a bed is offered. That is not the same as a rent shortfall.

Low-barrier sites do not interrupt it

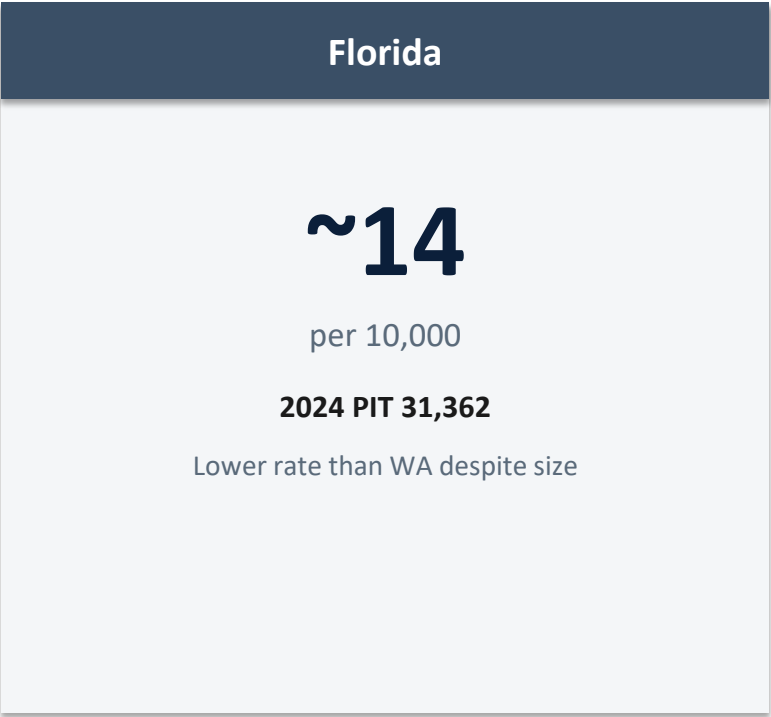
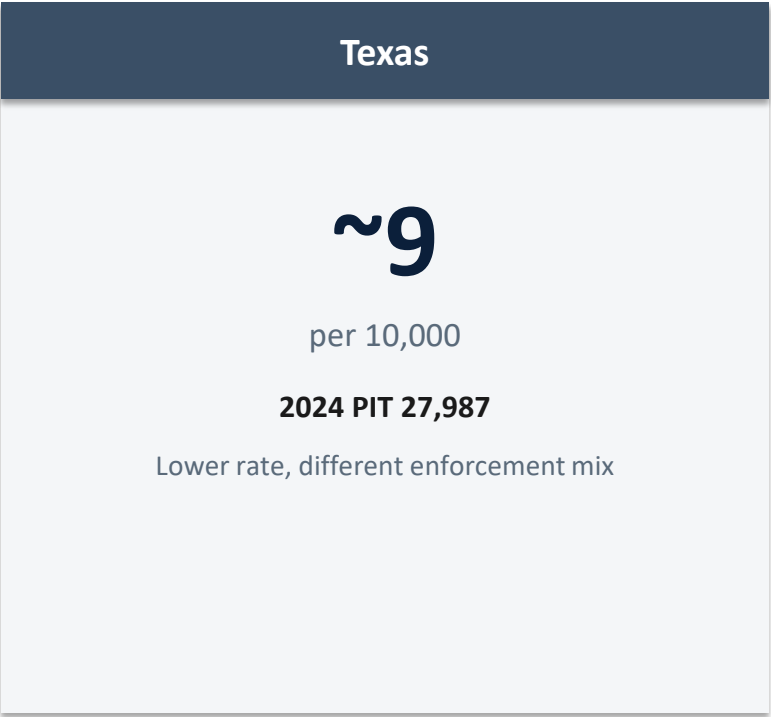
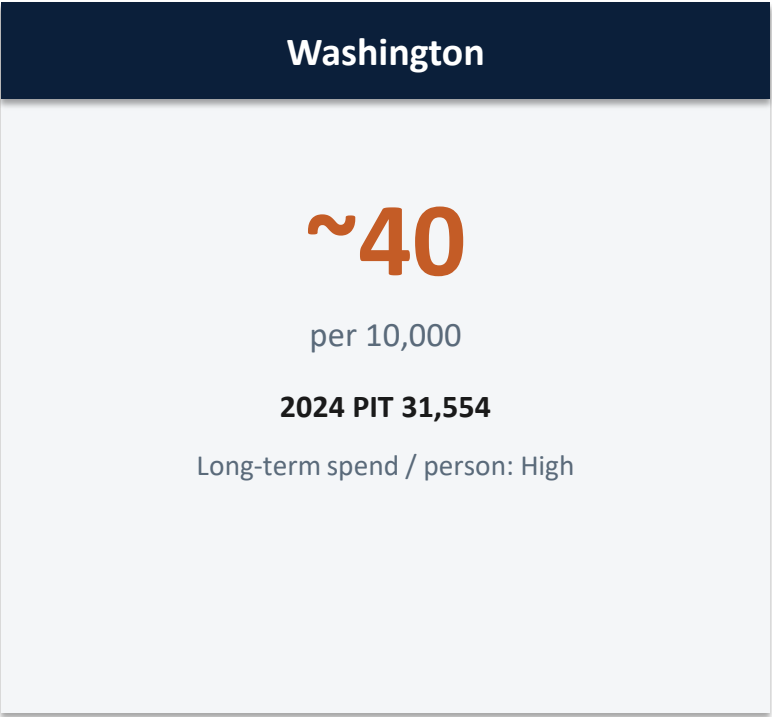
Open-access emergency shelter can keep someone alive for a night. It does not require treatment, and history shows most residents do not convert that stay into housing or recovery.

Separate the two populations

Economic displacement needs fast, safe housing and work supports. Chronic street homelessness with SMI or addiction needs treatment capacity, rules, and a legal path into care.

Washington spends more and still has a higher rate

2024 PIT comparisons



Higher spending has not produced a lower street rate. Kitsap’s local spend has also grown while unsheltered counts stayed stubborn.

Kitsap homelessness rose as emergency beds increased

Five-year local trend

Measure	2020	2021*	2022	2023	2024	2025
Total PIT	533	324	563	604	597	647
Unsheltered	199	—	183	245	255	297
Sheltered	334	324	380	359	342	350

+21% Total PIT, 2020 → 2025

533 → 647. 2026 preliminary total fell to 551.

+49% Unsheltered, 2020 → 2025

199 → 297. Beds and spending rose; the street count still grew.

*2021 unsheltered count was disrupted by COVID protocols.

Local police have described the shelter as an epicenter

Crime near gathering sites

+132%

Drug violations

117 in 2023 → 271 in 2024. Chief Wolfe: open-air dealing around the homeless shelter.

+32%

Aggravated assault

119 → 157. Wolfe: “A lot of the aggravated assaults center around our homeless shelter.”

97

Encampments cleared

Kitsap HEART reported 97 encampment clearances over two years.

What local law enforcement has described

- Bremerton’s 2024 crime ratio was 88.2 per 1,000 people — among the highest in the region.
- Chief Wolfe distinguished people trying to leave the street from “criminal vagrants” who prey on the homeless and on each other.
- Downtown encampments on MLK Way and Broadway required multi-agency clearances and 11 truckloads of debris in November 2023.
- Permanent supportive housing with 24/7 security, curfew, no-drug rules, and admission standards has a different crime profile than low-barrier emergency sites.

Temporary low-barrier shelter does not treat the cause

Policy conclusion from the evidence

It does not solve root causes

- Most users are single adults with mental illness and/or addiction.
- Nationally, only about 34% exit temporary programs to housing.
- Low-barrier models do not require treatment. Few volunteer for it.
- More beds without accountability can stabilize the street population without shrinking it.

It shifts risk onto neighbors

- Bremerton police tied assaults and open-air drug dealing to the shelter area.
- Women in mixed sites still face high sexual-assault risk.
- Concentrating high-need adults next to homes and retail raises calls for service.
- A neighborhood campus is the wrong geography for untreated addiction.

The funding model rewards growth, not exits

Spending has been large. Outcomes have not.

System incentives (illustrative ranges)

City homeless-services manager	\$120,000–\$170,000
Mid-size homeless NGO CEO	Up to about \$180,000
Large urban contractor CEO	\$250,000–\$400,000+
Typical housing/shelter nonprofit ED	About \$105,000 median

The bill so far

\$170–200B
Federal targeted homelessness programs over ~40 years (order-of-magnitude)
\$5.3B
WA housing/homelessness programs, 2013–2024 (OFM)
\$1.2B+
WA 2025–27 operating housing/homelessness package
\$17–23M
Kitsap system spend in recent years vs. PIT ~550–650

SECTION 03

Recommendations

Treat causes. Stop subsidizing the street. Split services by population.

Five steps: treat causes, stop subsidizing the street

Political Remodel alternative

1

Reset incentives

Pay for fewer unsheltered people and more treatment placements — not a larger caseload.

2

Fund treatment first

Hire mental-health and rehab capacity. Scholarships tied to service in treatment settings.

3

Use lawful pressure

Camping, trespass, and public-drug rules. Courts offer treatment instead of jail for eligible cases.

4

Triage by cause

Economic displacement gets housing and work supports. SMI/addiction gets treatment first.

5

Change the geography

Rural emergency sites with security and evaluation. Permanent, rule-based housing in town.

Pay for exits. Staff the treatment system.

Steps 1 and 2

STEP 1 • Remove bad incentives

- Tie contracts to treatment placements, housing exits, and a falling unsheltered count.
- Bonus for hitting placement goals.
- Reduce or stop program funding if unsheltered numbers grow after a defined period.
- If a program reaches 100% placement, transition staff into long-term housing and treatment roles — do not keep an empty emergency machine running.

STEP 2 • Invest in treatment

- Shift new dollars toward mental-health and drug-rehabilitation professionals, not another neighborhood campus.
- Scholarships for students who agree to serve three years in homeless treatment settings.
- Divert resources to staff KMHS/DCRs, judges, and related professionals so evaluations and placements happen quickly.
- Same bonus / reduction rules: pay for placements into care, not for occupancy of low-barrier beds.
- Use competition to find the best programs. Organizations like the OUT Coalition and the Other Side Academy have higher success rates than current homeless programs. Government should include these programs in their solutions and compare results.

Use law enforcement to create a path into treatment

Step 3

01 Enforce existing public-order laws

Camping, vagrancy where lawful, drug possession, trespass, and health-code violations. Bremerton Ordinance 5482 should mean unmanaged street living is not the default.

02 Offer a real alternative

Except for serious felonies, officers offer approved shelter or treatment instead of a charge. Courts use treatment as an alternative to jail time for eligible defendants.

03 Use civil commitment where the law already allows it

Washington already authorizes involuntary treatment when a person is a danger to self or others. Street living with untreated psychosis or addiction can meet that standard. The point is care with authority, not abandonment.

Split services by cause — stop one-size-fits-all shelter

Step 4 (ties to understandings 5a / 5b)

Economic displacement

Job loss, eviction, medical bills, or fleeing abuse with no cash reserve.

- Safe emergency housing immediately — not a mixed adult street campus.
- Women and children in women-only or family settings.
- Social-services plan with dates: work, benefits, independent housing.
- Goal is a short stay and an exit, not a new neighborhood institution.

Mental illness / addiction

Illness or addiction that blocks ordinary housing and work.

- Initial placement at a rural emergency site (Step 5), not next to schools and retail.
- Evaluation on arrival. Treatment is the first objective.
- Overdose or crime on site triggers a court path: treatment or prosecution.
- Move to permanent, rule-based housing only after stabilization starts.

Rural emergency sites + in-town permanent housing

Step 5 — and rules for any temporary chronic placements

Location

Place emergency capacity away from dense residential and commercial blocks. Do not site a low-barrier adult campus next to homes, schools, and retail.

Operations

24/7 security. Rigid sleeping structures, restrooms, food, and basic medical care. Transport into the city for appointments. Monitor for dealers and arrest them.

Clinical gate

Mental-health staff (KMHS/DCR) evaluate new residents immediately. If the person is a danger to self or others, start the treatment process (E&T or SWMS).

Time limit with a path

Overall goal: temporary placement until treated — or turned over to law enforcement if they commit crimes or threaten self/others. No site should keep anyone longer than 30 days. Stays beyond one week require treatment participation or an active housing plan.

The question is not whether we can afford a different model

It is whether we keep buying a model that grows the street population.

Enforce camping rules

so unmanaged street living is not the default.

Require treatment and accountability

instead of open access with no conditions.

Build permanent, service-rich housing

with security and rules — not another temporary campus in a neighborhood.

Pay providers for exits

not for a permanently larger emergency.

We are not opposed to helping people who are homeless.

We deeply care about their situation.

We are very concerned about their suffering and want to end it.

We disagree with a system that manages the crisis instead of ending it.

Doing the same things over and over again and expecting different results is insane.

Doing the same things over and over again and continuing to get worse results is planned failure.

End the crisis. Do not professionalize it.