for the

GREATER GOOD

Report of the Mayor's Commission on Homelessness

JAN 2013 LEXINGTON, KY

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EXECUTIVE SUMMARY

The causes of homelessness are easy to identify: lack of affordable housing, lack of resources to pay market-rate rents, lack of ability to live independently, lack of support services for those who need them on a temporary or permanent basis.

Adequate shelter is a fundamental human right. Unfortunately, some people in our community do not experience that right. The causes of homelessness are easy to identify: lack of affordable housing, lack of resources to pay market-rate rents, lack of ability to live independently, lack of support services for those who need them on a temporary or permanent basis.

The trends affecting these causes have been going in the wrong direction: decreases in affordable housing, a growing gap between cost of housing and lower-income earning capacity, and reductions in funding for services.

The major single or combined routes by which a particular person or family comes to lack one or more of these essential aspects for remaining adequately housed is also relatively easy to identify: children who flee their homes; youth who "age out" of foster care; people who have difficulty finding or holding a job; people who work at jobs that do not pay well; people who have difficulty caring for themselves because they are mentally ill and/or have substance abuse issues; people with or without children who are forced to flee their homes or who lose critical financial support because they are victims of intimate partner violence. This report addresses both the general causes and specific roots of homelessness.

In Lexington, the current system is overwhelmed with people sleeping on the floor of emergency shelters, on waiting lists for transitional housing, and spending extended periods of time in transitional housing because there is no permanent housing, supportive or affordable, to which to exit. While we will always need emergency shelter, including transitional housing, to meet emergency needs, it appears that the current system has sufficient capacity, but only if certain subpopulations such as families, young adults, persons with mental illness, and the chronically homeless are provided housing. Creating more affordable housing units and expanding rapid rehousing programs will reduce the backlog in emergency shelters and transitional housing.

A nationwide body of research now documents the ways that homelessness costs the community. Emergency and other services for a homeless individual or family on the street or in the shelter system can cost the community up to five times as much as for those who are permanently housed. There is both a moral and an economic benefit gained by providing housing for these individuals and families.

We start with the firm belief that the overall goal of any effort to address homelessness should revolve around the prevention of becoming homeless in the first place and the reduction of the time a person or family is homeless. The recommendations included in this report are intended to reflect that goal.

Mayor Jim Gray created the Commission on Homelessness in July, 2012 in response to the complex set of issues that impact people finding themselves without adequate shelter and support services, and that impact the community as a whole. The Commission represents a diverse cross-section of the community, including homeless service providers, advocates, people who have experienced homelessness, community activists, education and business leaders, and government officials. Mayor Gray charged the Commission with reviewing the full range of materials and experiences related to homelessness and creating a report of findings and a set of recommendations to "meet unmet needs and areas identified for improvement."

This report contains 48 inter-related recommendations regarding 1) systemic factors affecting homelessness in Lexington: the housing and wage gap, collaboration and coordination, funding, data management, case management and supportive services, a unified system of entry, education and outreach, day centers, and 24-hour shelter service; and 2) subpopulations of homeless: families, persons with mental illness, the chronically homeless, youth and young adults, persons with substance abuse issues, survivors of intimate partner violence, hospital and jail discharges, the elderly, and veterans. Comprehensively, the recommendations include funding, structure, facilities, services, legislative and policy changes, and items for further study.

Three recommendations that received the Commission's highest priority ranking are comprehensive and foundational. They are:

1. **Increase from 5% to 6% the present fee assessed on insurance premiums, to create an Affordable Housing Trust Fund that will provide a consistent, reliable, dedicated funding stream to address the recommendations contained in this report (this recommendation is an increase of .5% above the recommendation of the Affordable Housing Task Force proposal presently being considered by Urban County Council and reflects the expanded scope of programs and services included in this report's recommendations which would be funded in part by the fee increase);**

2. **Create an Office within LFUCG, funded in part by the fee increase and tasked with overall coordination of the recommendations contained in this report;**

3 **Create more affordable housing units to meet the needs of the homeless and those at risk of homelessness.**

In addition, these specific recommendations, all of which address more effective ways to prevent and deal with chronic and episodic homelessness, received the next highest level priority ranking:

1 **Institute a "Housing First" model for the mentally ill and chronically homeless;**

2 **Support creation of a mental health court;**

3 **Develop a program of street outreach and intervention;**

4 **Provide employment support;**

5 **Encourage and support collaboration among providers to provide more case management.**

The report also contains a concise set of initial Key Indicators designed to provide a snapshot of progress on improving the quality, efficiency, and effectiveness of services for people who are homeless in our community. The Key Indicators will be the primary vehicle for reporting progress to the community. The Key Indicators are:

1 **Increase in the number of affordable housing units;**

2 **Reduction in the number of homeless included in the annual Point-In-Time Count;**

3 **Reduction in the number of people included in the Street Count in the Point-in-Time Count;**

4 **Reduction in the number of homeless requiring incarceration;**

5 **Reduction in the number of homeless requiring emergency medical care;**

6 **Reduction in the number of homeless requiring referral and evaluation by Eastern State Hospital;**

7 Reduction in the number of youth who age out of foster care who become homeless;

8 Reduction in the number and the amount of time spent in emergency shelter and in transitional housing.

II. PROLOGUE

The Faces of Homelessness

In the process of preparing this report Commission members learned—or had reinforced for them—that homelessness isn't a simple problem. Understanding homelessness is not just a matter of walking in someone else's shoes. It's that the feet of the homeless range from the shoes of infants and toddlers to the 14W work boots of veterans. The homeless wear sneakers to school, loafers to work, flats and slippers and sandals and sometimes have no shoes at all. The homeless wear the shoes that were on their feet when they finally fled domestic violence and those are the only shoes they will have until they find relief, respite, and recovery.

There are startling moments when we see right before our eyes homeless folks who have, in fact, been there all along. In an instant, with stinging clarity we see people that may frighten, trouble, or disturb us. The nagging truth that something is broken, something awry in our nation and our community when so many others live, every day, in a ragged, worn out state of mind and state of affairs wears us down and wears us out.

There is no single face to homelessness. It is the face of "Bill", who served in Iraq and returned unable to hold a job or function on his own.

It is "Jeff," "Mary," and their two kids. "Jeff" had just been hired into management of a store in town. When the company downsized and he lost his job, the family was thrown into the shelter system.

Mary Francis had a bad boyfriend, a small child, and a dog. Getting rid of the boyfriend meant a ride to the emergency room, putting her child in emergency foster care, and no place to return when she was discharged. It was easier to find a home for the dog than for Mary Francis and her child.

It is the face of "Mary Francis", a single mother escaping from domestic violence.

It is the face of "Harry" who lost his job as a carpenter's helper, was out of work for two months, could not pay his rent and utility bills, and was evicted from his apartment.

The homeless face is the face of "Joe", a 16 year old student who has finally run out of another new couch on which to sleep.

That homeless face is the face of "Roger", who sometimes fails to take the medication prescribed to keep the effects of his bipolar disorder in check. He is one of the many homeless people with mental health disabilities that range from modest and manageable to extraordinary and inconceivable.

In short, the homeless are not a problem to be solved. They are not a riddle for which an answer will provide a path forward. The homeless are people.

Joe came to live with us after 18 months of sleeping in parks, stairways and the floor of friends. He came with a tent, a stove, a sleeping bag and a 3.2 G.P.A. Is this the best we can do? I asked him how he made it. He said, "mom or dad is always in trouble, she's in jail and he's on probation. They can't look after me and I'm tired of foster care. But I know this much. My mother loves me and I have a good mind. I just have to get through this the best I can."

Because the primary encounter with homelessness for most citizens is with the chronically homeless who are often on our streets and in other public places, it is easy to confuse the reality of homelessness with the most common faces of the homeless. It turns out, contrary to the cliché, that actually believing is seeing. Many believe that hard working folks can find housing if they want. Many believe that high school students can't really be on their own sleeping one week on this couch and the next week on another couch. Many believe that law enforcement can deal with the victims of domestic violence and that once the violence is brought to light people can just get on with their lives. Many believe that hospitals would never release anyone out of an emergency room without someplace to recuperate from their injury or illness. Many believe that a nation that honors its veterans must surely attend to their needs after service. Many believe that mental illness and disability can surely be dealt with by a crisis line or a pharmacist. Many believe that mothers with children can't really be without shelter or a roof over their heads. It is a long list of misunderstanding and myth. And because we believe these things it is hard to see the truth. Of the approximately 1,500 homeless folks in Fayette County at any given time, only around 125 at most fit the profile of the person on the street we have in mind when we hear the word homeless.

Read the executive summary, read the details, read the recommendations, and consider the costs. The costs of inaction. The costs of trivial consideration. It is costing all of us too much to continue with business as usual. There is a cost to productivity, our revenue, and our conscience. Extraordinary action and unusual thinking can, however, create a legacy that will be a real gift to the next generation.

III. INTRODUCTION

Lexington is a caring community with a long history of working to reduce homelessness. Over the past several decades numerous organizations and individuals have worked diligently to meet the needs of individuals and families who experience homelessness. Lexington is also a community driven by continuous improvement even when things are going well.

The Commission has worked to be as comprehensive as possible, and as consistent as possible with the 2010 Federal Strategic Plan to End Homelessness. We have taken into consideration the many different paths into and out of homelessness, the many ways that the community now provides services and support, and best practice examples from other communities.

We have constructed our report and tailored our recommendations to reflect the specific needs of the differing individuals who at any one time experience homelessness. We have also included recommendations that are more systemic in scope and would affect all aspects of homelessness.

The homeless service providers have been very helpful throughout this process and have provided invaluable information. The Commission sought feedback from service providers and people who are experiencing homelessness through questionnaires and structured interviews. The feedback received in these surveys and conversations have been carefully considered in the development of the recommendations presented in this report.

In submitting this report we recognize that any reduction in the numbers of homeless, any improvement in the services available for people who are homeless, and any lessening of the negative impacts of homelessness on both the individual and the community depend on our working together as a community to understand the diverse needs and the best use of limited resources to address those needs.

We encourage your attention to this report and your support for the recommendations advanced in it.

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Following a section that provides an overview of homelessness, the main body of this report is organized into three major sections, each of which looks at homelessness from a different perspective and contains a description of the present status and one or more related recommendations. These sections are: Systemic Socio-Economic Factors; Systemic Service Provision Factors; and Specific Subpopulations within the Homeless Population.

The Systemic Socio-economic Factors section considers those major elements of the social and economic environment that are significant contributing factors to the creation and continuation of homelessness, regardless of the differences among those who are homeless or at risk of homelessness. These factors are: 1) the growing gap between wages earned and the cost of housing, and the resultant lack of sufficient affordable housing; 2) lack of job opportunities and/or skills that pay adequate wages.

The Systemic Service Provision Factors section presents information about present services and the ways that services could be provided more effectively in the effort to reduce both the numbers of homeless and the duration of episodes of homelessness. Specific opportunities for new or improved approaches identified in this section include:

1. Coordination and collaboration among service providers and community partners;
2. Increased financial and volunteer resources;
3. Case management and supportive services;
4. A unified system of entry for those in need of services;
5. More comprehensive and consistent data management;
6. Education and outreach to provide better information for the public about the nature and extent of the issue in order to increase understanding and support;
7. Education and outreach to provide more information about options for those in need of services;
8. The ways that day centers can meet some of the needs of the homeless population; and
9. The ways that night-time or 24-hour shelters can meet some of the needs of the homeless population.

The Specific Subpopulations section identifies the ways that differing segments of the homeless population present differing challenges and thus require differing strategies for effective intervention, whether prevention, transitional services, and/or ongoing support. The specific subpopulations are separated for description and analysis only, since many people do not fit easily within any one subpopulation, or may fit within multiple subpopulations.

1. Families;
2. Persons with Mental Illness;
3. Persons Who Are Chronically Homeless;
4. Youth and Young Adults;
5. Persons with Substance Abuse Issues;
6. Survivors of Intimate Partner Violence;
7. Persons Who Have Been Discharged From Hospitals;
8. Persons Who Have Been Discharged From Jail;
9. Elderly Persons; and
10. Veterans.

Major substantive Recommendations from these three sections are presented in summary in three ways:

1. A list of recommendations structured to reflect the order of organization within the report;
2. The same list organized by logical categories, with overlap and redundancy reduced;
3. A second list organized by weighted priority.

In addition, the report includes a set of procedural recommendations meant to ensure that an administrative structure is in place to provide coordination and assistance to primary service providers and to monitor and report back to the community on a regular basis about progress in the Key Indicators that provide a snapshot of the status of homelessness in our community.

The Appendix includes information about the charge to the Commission, its membership and structure, explanatory and supportive materials, and references to studies, reports, and successful programs in other communities.

IV. OVERVIEW OF HOMELESSNESS

FORMAL AND INFORMAL DEFINITIONS

It is important to understand just what is meant by the word "homeless." While the federal Department of Housing and Urban Development (HUD) has established legal definitions for who qualifies as homeless, for purposes of simplicity, when this report refers to homelessness, it means that a person or family is without a place to live of one's own that is meant for human habitation. Being homeless does not mean that a person has to be literally living on the street, under a bridge, or sleeping on a park bench. People who are staying in an emergency shelter are homeless, as are many who are in substance abuse recovery programs, or transitional housing provided by one of Lexington's non-profit organizations that are intended to help people get back on their feet.

BRIEF RECENT NATIONAL HISTORY

The deinstitutionalization of the mentally ill in the 1960's was a major contributing factor to homelessness in America because long-term psychiatric patients were released from state hospitals and sent to community-based treatment for follow up with no residential services provided. Homelessness grew in the 1980's as a result of significant cuts to low-income housing and a deterioration of the economy. As a result of the growth of homelessness, the McKinney-Vento Homeless Assistance Act was passed in 1987. Despite the focus on homelessness, the numbers remained high and it became apparent that treating the symptoms of homelessness was not helping the root causes.

In recent years, the focus has turned to "Housing First" models and rapid re-housing and homelessness among some populations has begun to decline. Great strides were made in improving the situation but a setback occurred in the economic downturn of 2008. It is a testament to the success of current programs that the percentages of homelessness for individuals in the nation remained flat during the economic downturn. Only homelessness among families increased slightly.

THE SHELTER SYSTEM

While most people who become homeless or are at risk of homelessness will likely need a range of support services in order to exit homelessness or stay out of it entirely, providing some level of shelter is the fundamental way Lexington, as well as the rest of the nation, has developed to address the issue.

In the traditional "Continuum of Care" model, there are three primary methods of housing the homeless: Emergency Shelter, Transitional Housing, and Permanent Supportive Housing. Most of the federal funding for homeless services is tied to these three types of housing programs, so each program must meet certain requirements in order to be eligible for this funding. In theory, the thought has been that people move through the system on a continuum, starting with emergency shelter, then transitional housing and so on. That is certainly the case for some, but many people enter the system at different points. If intervention is made early, people may avoid the shelter system entirely by being provided with the best support for their respective needs.

Emergency Shelter is intended to be temporary and is meant to meet the basic needs of an individual or family often after a crisis event. In Lexington, as well as many other communities, an emergency shelter serves as the entryway to more targeted assistance beyond just a place to stay overnight.

Transitional Housing is intended to facilitate the movement of homeless individuals and families to permanent housing. Individuals and families can stay in transitional housing for up to 24 months and supportive services are often provided to help people become better prepared to live independently. Recovery beds for substance abuse treatment are included in this category for the purposes of the Point-in-Time (PIT) Count.

Permanent Supportive Housing is typically for an indefinite timeframe and is paired with services to help homeless people with disabilities achieve housing stability. While federal funding is available for permanent housing as a component of homeless initiatives, the federal government no longer considers people in permanent housing to be homeless. Therefore, these numbers are not included in the official count of the homeless submitted to HUD each year for Lexington's PIT Count.

CHRONIC AND EPISODIC HOMELESSNESS

There is also a difference between Chronic and Episodic Homelessness. Most people who are homeless experience "episodes" of homelessness. This means they are either homeless for a finite amount of time that is less than a year or they go in and out of homelessness throughout their life. As defined by current federal policy, a person experiencing chronic homelessness is an "individual who has been continuously homeless for a year or more or has experienced at least four episodes of homelessness in the last three years and has a disability....HUD will begin to include estimates of chronically homeless families in 2013."

It is difficult to know just how many people are homeless at any given time in Lexington. It is even more difficult to know how many people experience homelessness throughout the span of a year. While people who are chronically homeless are the ones most people are familiar with, more people are actually homeless for shorter periods of time or go in and out of homelessness depending on circumstances. Furthermore, there are many people who are "marginally housed" or "precariously housed" that are not included in any dataset or report. These are people who may be sleeping on a friend or family member's couch or are just a paycheck away from not being able to pay rent.

Each year across the nation, communities attempt to count the number of people who are homeless in their towns. Lexington participates in this count known as the Point-in-Time (PIT) Count. The following chart indicates the number of people who were identified as homeless over the past six years in Fayette County. These numbers do not include the "hidden homeless" who are on floors, couches, in cars, doubled-up, or in marginal housing.

2007-2012 PIT COUNT

TYPE	2007	2008	2009	2010	2011	1/1/2012	11/1/2012
EMERGENCY	514	472	485	481	471	401	629
TRANSITIONAL	609	770	766	961	958	911	1575
STREET COUNT	96	96	68	116	116	116	116
TOTAL PSH	1219	1338	1319	1558	1545	1428	2320
PERMANANT SUPPORTIVE HOUSING	300	300	471	560	481	486	384
TOTAL WITH	1519	1638	1790	2118	2026	1914	2704

In 2011 the PIT Count included 947 single men, 406 single women, and 242 families with 357 children. In preparing this report, the Commission spoke with providers regarding the current number of clients served. This homeless count and the explanation is included in Appendices E, F, & G and in the last column above.

While the elimination of homelessness is a goal to which our community should aspire, it is important to recognize that Lexington will continue to have individuals and families who experience homelessness for the foreseeable future and we must continue to support efforts to serve these people in need.

In addition, we know that people come to Lexington because of the quality of life opportunities it offers. Besides economic opportunities, we are a regional hub for health care, including mental health services. It is likely that people will continue to come to Lexington for these services and other quality of life opportunities, including access to homeless resources.

COSTS OF HOMELESSNESS

Homelessness is not only a humanitarian concern but an economic concern as well. As we have discussed, there is a broad spectrum of persons suffering from homelessness and they can cost the community between $35,000 and $150,000 depending on the type of services needed. The cost to provide housing and services, however, is between $13,000 and $25,000 an individual. Therefore, a homeless person on the street or in the shelter system can cost up to five times as much as those who are permanently housed.

A landmark study in Los Angeles recognized the "nationwide body of research into the cost of homelessness and the savings that are achieved by housing homeless residents, particularly individuals who are chronically homeless and mentally ill." The study found "that practical, tangible public benefits result from providing supportive housing for vulnerable homeless individuals. The stabilizing effect of housing plus supportive care is demonstrated by a 79 percent reduction in public costs for these residents." The findings are mirrored in a study conducted in Louisville, KY.

Both studies also found that costs for homeless individuals vary widely depending on their demographics. Young men with no jail history, substance abuse or mental health problems, cost the system very little. Older adults, particularly ones with mental health problems, substance abuse, or co-occurring disorders are very costly. Not surprisingly, these costs increase as individuals get older.

Families, however, even without substance abuse or mental health issues, are very costly on the shelter system because they require a private room and transportation for the children. The economic cost, however, does not take into effect the emotional and physical toll homelessness takes on an individual, a family, a community, and a school system.

There are important junctures when intervention will minimize the effects on these individuals and families and the cost to the community. In order to take advantage of these opportunities it is important to match the range of solutions to the needs of the different groups in the homeless population and target the housing strategy to the high-cost users. Therefore, data management, coordination, and vision are important.

Nationally, the proven solutions are the prevention of homelessness in three ways; through the provision of affordable housing; through "rapid re-housing" which gets people back into housing as quickly as possible through rental assistance, case management, and vouchers; and through "Housing First" or permanent supportive housing for hard-to-serve populations including the mentally ill and chronically homeless. This report addresses all three and provides recommendations regarding their implementation in this community.

While this report focuses much of its attention on programs and services geared at either preventing homelessness or reducing its duration, it is important to note that the Commission understands the need for emergency shelter and encourages the continued support of our shelters. The emergency shelter system is overcapacity and taking resources away from them at this time for other solutions is not advised. Ideally, with time and the right interventions, we will not need to further expand our emergency shelters, but that will take long-term commitment, including financial support, from the community.

Finally, it is important to note that while improvements are needed, Lexington is very fortunate to have such a strong group of services providers and programs to address homelessness. The Commission expresses its thanks to all organizations and individuals who work each day to help the homeless. If not for their efforts, many more people would be homeless and the overall community would be negatively impacted.

There are important junctures when intervention will minimize the effects on these individuals and families and the cost to the community. In order to take advantage of these opportunities it is important to match the range of solutions to the needs of the different groups in the homeless population and target the housing strategy to the high-cost users.

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V. SYSTEMIC SOCIO-ECONOMIC FACTORS

The minimum wage needed to afford a two bedroom apartment in Lexington is $12.73. Since minimum wage is only $7.25, a minimum wage worker would have to work 65 hours a week or a household would have to have 1.8 wage-earners to afford it.

V. a. THE GAP BETWEEN THE COST OF HOUSING & EARNING CAPACITY

V. a.1. DESCRIPTION

One of the main causes of homelessness is the large and ever increasing gap between wages earned and the cost of housing. Nationally, wages have fallen 19% since 1970 and for those with only a high school diploma, wages have fallen 41%. In Lexington, from 2003 - 2005, the cost of housing rose 10% while wages only rose 5.5%. From 2005 - 2010, the cost of housing rose 7% while wages only rose 1%. Minimum wage workers are especially vulnerable to rising housing costs because their wages tend to stay stagnant. Individuals and families with extremely low incomes are at the most risk for homelessness. This population is literally a paycheck away from homelessness and can become homeless because of job loss, sickness of themselves or their child, or any other emergency.

It is difficult for persons working at or near minimum wage to afford decent housing. In Lexington, minimum wage is $7.25. A person working full-time at minimum wage makes $15,080 annually, which is below the federal poverty threshold of $15,130 for a two person household. It is no surprise then that 20% of the population of Fayette County lives in poverty, which is higher than the state average of 19% and the national average of 15%.

The minimum wage needed to afford a two bedroom apartment in Lexington is $12.73. Since minimum wage is only $7.25, a minimum wage worker would have to work 65 hours a week or a household would have to have 1.8 wage-earners to afford it. This has several damaging results: it causes families to be housed in marginal housing or to be homeless, it takes money from other sectors of the economy (food, clothing, services, etc.) because so much money is spent on housing, and it forces minimum wage laborers to move out of the county to afford housing, or tips them into homelessness when tragedy strikes. All are very costly to the community.

PUBLIC HOUSING AND RENTAL ASSISTANCE

Whether or not a household is classified as "low income" is determined by the federal government according to the area median income (AMI), which is the midpoint in household income for a certain geographic area. In order to qualify for public housing or rental assistance, a household can make no more than 80% of AMI. 80% AMI is considered "low income," 50% AMI is considered "very low income," and 30% AMI is considered "extremely low income." In Lexington, the AMI is $67,100. 30% AMI for an individual is $13,450 and for a two person household is $15,350 regardless of the number of wage earners. Once qualified for public housing, the household pays the landlord 30% of their actual monthly adjusted income.

In Lexington, public housing is provided by the Lexington Housing Authority (LHA) which manages 4,133 units. They provide both conventional public housing units and Housing Choice (Sec. 8) vouchers that assist the household in obtaining housing in the private rental market. In July of 2011, there were 1,543 households on the waiting list for a public housing unit and 339 households on the waiting list for a Sec. 8 voucher. The trend has only gotten worse. In November of 2012, there were 2,376 households on the waiting list for a public housing unit and 316 households on the waiting list for Sec. 8 voucher. Both waiting lists are closed. The number of households does not reflect the total number of persons living in the household including children. The average income of the persons on the waiting list is $11,000 which is under the poverty threshold for an individual of $11,170.

AFFORDABLE HOUSING

Affordable housing is "housing that requires families and individuals to pay no more than 30% of their income for housing and housing-related costs including taxes, insurance, and utilities." Households are considered "cost burdened" if they pay more than 30% of their income for housing and "extremely cost-burdened" if they pay more than 50% of their income.

In Lexington, the problem has only gotten worse as shown by the chart below:

HOUSEHOLDS PAYING MORE THAN 30% GROSS INCOME

DESCRIPTION	2005	2010
RENTER HOUSEHOLDS	48,357	49,910
# that pay between 30% and 50% gross income	17,312	21,710
% that pay between 30% and 50% gross income	36%	43%
# that pay more than 50% gross income	8,753	12,090
% that pay more than 50% gross income	18%	24%
Total # that pay more than 30%	25,966	33,800

This means that only 33% of the renter households in Lexington meet the criteria for having affordable housing.

Housing becomes affordable in two ways: construction of affordable housing units or rental subsidies paid to market rate landlords. Affordable housing stock in America has decreased significantly in the last decade. From 2001 to 2007, affordable rental housing stock decreased by 6.3% while high-rent rental housing stock increased by 94.3%. This translates into a loss of more than 1.2 million affordable housing units. While 15.8 million households are eligible for tenant based housing subsidies (Sec. 8) only one in 9 receives them. Programs dedicated to the provision of affordable housing are primarily funded under the HUD budget but it has been reduced by $50 billion in the last 30 years. While there are 6 million units of affordable housing accessible to households earning 30% of AMI, there are 7.7 million such households. There is no expectation that there will be more federal funding in this area. There is a significant affordable housing crisis in the country and in the community because we do not have a sufficient supply of adequate housing to meet the needs of those who are on the edge of homelessness, those who are temporarily housed, and those who are chronically homeless.

ADDRESSING SYSTEMIC FACTORS

There is a simple answer to the question of how to end homelessness: ensure adequate housing for all those in need. There is also a simple answer to the question of how to reduce homelessness: ensure adequate housing for those most in danger of becoming or remaining homeless. These simple answers, however, are not also easy answers because the need is so great and resources are limited. It is critical to have a dedicated funding stream, vision, resources, criteria for evaluation, and coordination.

There are critical moments when having a modest level of support combined with decent housing alternatives will keep those on the edge of homelessness from becoming homeless. These moments offer opportunities to minimize the effects on these individuals and families and to minimize the ultimate costs for our community.

There are similar critical moments when having a decent place to live will lead most quickly to full housing independence for those who find themselves temporarily homeless. This is true for people who presently emerge from one of the transitional and support programs in our community and find themselves with no good options for next steps. These people include those who age out of foster care, those people who time-out of transitional housing programs, and those with no resources who have been discharged from hospitals.

In a different way, housing, along with relevant support services, can lead to better lives, less dependence on emergency room services and mental health services, and less impact on the criminal justice system for the chronically homeless, which often have mental health and substance abuse issues.

V. a.2. RECOMMENDATIONS

V. a.2.a.

V. A. 2. a. We recommend creation of an Affordable Housing Trust Fund to begin to meet the need to increase the supply of affordable housing units in a systematic and reliable way, and to provide services necessary to ensure stability for those in housing. Providing housing, with support services where necessary, will prevent the greatest number of people from falling into homelessness and assist the greatest number in getting out of homelessness. This recommendation builds on and modifies the recommendations previously submitted to the Urban County Council by the Affordable Housing Task Force in the following ways.

V. a.2.b.

We recommend that the Lexington-Fayette Urban County Government (LFUCG) increase from 5% to 6% the fee presently levied by LFUCG on insurance premiums to create a source of funding of roughly $3.9 million per year. This recommendation is an increase of .5% above the recommendation of the Task Force, and reflects the expanded scope of programs and services included in this report's recommendations which would be funded by the fee increase, as enumerated below.

V. a.2.c.

We recommend that the allocation of funds be as follows: 1) 50% for the programs, approaches, priorities and targeted populations cited in the Affordable Housing Task Force recommendations; and 2) 50% for programs, approaches, priorities and targeted populations cited in the recommendations in this report.

V. a.2.d.

We recommend that the funds generated by the increased fee be used in the following ways:

V. a.2.d. I.

Provide support for the creation of more affordable housing units, to target low-income households, those at-risk of becoming homeless, and those already homeless. This is consistent with the Task Force recommendations, and is the main focus of the Affordable Housing Task Force recommendations.

V. a.2.d. II.

Fund administrative support. This is consistent with the Task Force recommendations.

V. a.2.d. III.

Initiate a "Housing First" program, a nationally recognized best practice that provides ongoing housing and support services for those who have been mentally ill and/or chronically homeless. This is an expansion in scope of programs and services.

V. a.2.d. IV.

Support a rapid rehousing program. This is an expansion in scope of programs and services.

V. a.2.d. V.

Target those transitioning out of support programs, and include support services as needed to help ensure that there will be a lasting transition to independent housing. This is an expansion in scope of programs and services.

V. a.2.e.

The Affordable Housing Task Force report includes an Appendix with a description of a recommended independent board and management structure for the Trust Fund. We support that recommendation with one modification: instead of an Administrative Agent hired by the board, we recommend that an Office of Homelessness Prevention and Intervention (described in detail in later sections) be created within Urban County Government. That office should be funded by the proceeds from the fee increase and be charged with day-to-day administration of the Affordable Housing Trust Fund, whose expanded scope would include coordination and/or implementation of the recommendations in this report.

V. b. EMPLOYMENT

V. b.1. DESCRIPTION

Lexington/Fayette County is currently experiencing an unemployment rate well below the national average. Therefore, we can conclude that the majority of the employment problems for the homeless are created by barriers that create unemployment, underemployment, and the lack of job readiness. The sources of these barriers include:

V. b.1.a. LACK OF TRANSPORTATION

Often this population does not own or have access to reliable private transportation or does not have the funds or access to public transportation. Both homeless provider input and the survey information from individuals that are homeless indicate a clear need for transportation assistance to medical appointments, jobs (both in and out-of-county), community resources such as Social Security, Food Stamp Office, and housing opportunities, and to surrounding counties when people have been transported to Lexington via ambulance and cannot get transportation back to their counties. Currently, most transportation assistance that is provided to individuals who are homeless is from the homeless services providers and is inadequate to meet the need.

V. b.2.b. LACK OF JOB READY TRAINING

Many members of the homeless population have not had necessary training in personal life skills to interview for a job or have formed the habits necessary to maintain a job. Other members of the population have the personal life skills to maintain a job but do not have the training to match their abilities. They are, therefore, under-employed, and earning less income than they could.

There are numerous organizations in Lexington that provide job training and/or placement services and people who are homeless are eligible for these services. The problem is generally not a lack of resources/services, but often a lack of awareness by the individual and the homeless service provider about how to access them. Some people are already employable, but the individual and the homeless service providers who are assisting them find jobs do not have relationships established with employers willing to hire these individuals or are not aware of the existing job placement services available. There are also individuals who need job training or skills building prior to seeking employment. It is important that these individuals be matched with training that is within their capabilities and that a linkage to a job is already established.

V. b.2.c. LACK OF OPPORTUNITY

In many cases employers are reluctant to hire members of this group because of a poor work history, criminal record, or reasons observed above. Solutions include the consideration of incentives by LFUCG to its vendors and contractors, as well as private sector employers, to remove the barriers to full employment; insurance or bonding that insure against the risk to employers who employ people with certain criminal records; and LFUCG taking a leadership position in hiring and training members of this population and incentives for vendors and contractors of LFUCG to include members of this population in their workforce.

One of the solutions to the problem of lack of opportunity is assistance with placing individuals with a criminal record. It is a common practice for employers to purchase insurance to indemnify them against employee dishonesty but insurance companies typically will not provide insurance for "at risk" employees or if they do so, it is cost prohibitive. At-risk or "non-bondable" job seekers include ex-offenders, recovering substance abusers, welfare recipients, and other people having poor financial credit, economically disadvantaged youth and adults who lack a work history, and individuals dishonorably discharged from the military.

The Federal Bonding Program is a tool to help "at-risk" job seekers gain employment. Through this program, Fidelity Bonding Insurance is provided as an incentive to employers to hire at-risk job seekers. This program is the only Fidelity Insurance program for at-risk job-seekers. However, these employees can become commercially bondable by demonstrating job honesty during the six month duration of the bond coverage. While these bonds have historically been exclusively provided by state employment agencies, now any organization can deliver these services, including non-profit organizations, private industry associations, and local government.

V. b.1.d. LACK OF CHILD CARE

Working parents often do not have access to reliable or affordable child care for their children or other dependents. This is especially true for single parent households, families with children who are ill or disabled, and families working 2nd and 3rd shift.

V.b.2 RECOMMENDATIONS

V. b.2.a. TRANSPORTATION

V. b.2.a. I.

We recommend that the Office of Homeless Intervention and Prevention investigate a procedure that provides transportation assistance to providers working with individuals and families who are homeless. This assistance could be given as an incentive for entering data into the Homeless Management Information System (HMIS) or providing sufficient data to LFUCG so it can be entered. Such assistance could include discounted and free bus passes, and funding for a limited amount of cab vouchers.

V. b.2.a. II.

We recommend that the Office explore the creation of partnerships with homeless providers to have access to iTNBluegrass and Wheels for scheduled medical appointments; with Lexington hospitals to establish funding and procedures for transporting individuals back to home counties, if individuals wanted to return; and partnerships with local non-profits including the faith-based community to assist with transportation needs including a discount or used bicycle program.

V. b.2.b. JOB TRAINING

V. b.2.b. I.

In order to increase awareness and utilization of existing resources, we recommend that the Office maintain a list of job training programs and placement agencies and cultivate a list of employers who are willing to hire employees who have been or are currently homeless.

V. b.2.b. II.

The Office would also serve as a reference for organizations looking to assist people who are homeless find employment. In order to ensure that there are jobs available for individuals coming out of these training programs, relationships must be built with employers to understand their specific needs so that the training can be appropriately tailored. Some people may not need training and can be referred to these employers quickly. We recommend that the Office help providers foster relationships with these employers and develop new partnerships as well.

V. b.2.c. OPPORTUNITY

V. b.2.c. I.

We recommend that LFUCG fund a Federal Bonding Program operated by the Office.

V. b.2.c. II.

We recommend that the Office study the barriers to opportunity and look for solutions.

V. b.2.d. CHILD CARE

It appears to be cost prohibitive to create a 24-hour child care service just to serve homeless individuals and families. It would be more effective to partner with a current 24-hour child care provider to place children that need these services with them. We recommend that the Office investigate this possibility.

VI. SYSTEMIC SERVICE PROVISION FACTORS

Identifying the right solutions and implementing these measures is much more complex and requires vision, consistent and deliberate planning, coordination and collaboration.

VI. a. COORDINATION/COLLABORATION

VI. a.1. DESCRIPTION

We have established in this report that the causes of homelessness are often simple to identify but because individuals and families are homeless for a variety of reasons, long-term solutions are not simple to implement. Identifying the right solutions and implementing these measures is much more complex and requires vision, consistent and deliberate planning, coordination and collaboration.

There are numerous organizations in Lexington that provide service or programming for people experiencing homelessness. These organizations rely on a mix of support from the public and private sectors. Various divisions within LFUCG also deal with certain aspects of homelessness on a limited basis, though no one person or office is responsible on a day to day basis for thinking about the issues surrounding homelessness and how our community can best address them in collaboration with appropriate partners. Without such a person or office, the ability for LFUCG and its leadership to proactively address homelessness is significantly reduced. The issues are complex and solutions require deliberate planning across governmental divisions and with community partners.

Central Kentucky Housing and Homeless Initiative (CKHHI) serves as Lexington's Continuum of Care organization and has taken the lead in collaboration efforts regarding homelessness. CKHHI is responsible for Lexington's Continuum of Care application to the Department of Housing and Urban Development (HUD), which brings in approximately $1.6 million in federal dollars annually. CKHHI also advocates for the homeless and homeless service agencies in addition to providing a forum for collaboration among providers. There is limited partnership and communication with LFUCG, however, because LFUCG does not have an Office that is responsible for the overall coordination and vision for a communitywide housing and homeless plan.

The HUD Continuum of Care grant requires coordination and collaboration among service providers. Many other granting agencies also emphasize its importance, and it is considered one of the key aspects of successful community-wide programs. At a minimum, some structure for regular communication and sharing of information is essential.

While a strong CoC organization is important, CKHHI does not have full-time professional staff or an operating budget. While it does an excellent job convening providers and advocates on a regular basis, its limited resources prevent it from providing the consistent level of coordination that a funded and staffed organization can provide. A decision was made when the Continuum of Care was originally formed that CKHHI would not take any money away from the allocations awarded to the individual agencies actually providing services. With the passage of the HEARTH Act (Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009), the continuum of care process has been codified as well as the use of the Homeless Management Information System (HMIS). As a result, the responsibilities of CoCs have increased.

It is nearly impossible to find a community who is successfully dealing with homelessness without broad community collaboration and innovative partnerships.

Collaboration and coordination will be essential if Lexington is to comply with these requirements. Furthermore, without proper resources and structure, Lexington will be at risk of losing vitally important federal support, which will only increase the burden on local government. It is important to note, however, that collaboration is not something Lexington should be doing simply to comply with HUD standards, but rather it is a fundamental component of any serious effort to address homelessness for our community. Resources are limited and rarely ever enough, which further demonstrates the need for strategic collaboration. It is nearly impossible to find a community who is successfully dealing with homelessness without broad community collaboration and innovative partnerships. Communities who are often cited as being on the leading edge of addressing homelessness share two common traits: strong local government leadership and commitment and meaningful collaboration among service providers and other community partners. To be successful, Lexington is no different.

VI. a.2. RECOMMENDATIONS

VI. a.2.a.

In order for LFUCG to take a more active role in addressing homelessness and the impact it has on our community, we recommend that the Office of Homelessness Intervention and Prevention's principle function be to focus on housing and homeless issues. It will provide planning, coordination, advocacy, and awareness about the changing needs and gaps of services within Lexington. This office would not provide direct support services, nor would it control or direct providers, but rather serve as an objective source of information and assist in problem solving for difficult situations that require multiple resources and organizations to work together.

The Office would work in conjunction with the Department of Social Services, CKHHI, and other providers to leverage private sector involvement including businesses, non-profits, the faith-based community, and private individuals both monetarily and as volunteers.

This Office, working with CKHHI, would also play a lead role in prioritizing funding needs and monitoring progress, applying for grants, recruiting volunteers, providing education and outreach, and keeping LFUCG more involved in services related to serving the homeless. The head of this Office would be the direct liaison with CKHHI and significantly improve LFUCG's coordination with Lexington's homeless service providers. This Office would also be charged with the implementation of this plan, manage the HMIS program, and a member of this Office will serve as Administrative Agent of the Housing Trust Fund.

The Office would also organize educational outreach and community campaigns such as the 100,000 Homes Campaigns which creates a community-wide focus on getting people housed and motivates coordination and leverages private resources.

We recognize that no one individual or individuals within this Office will be able to singlehandedly implement every recommendation within this report. However, the Office will provide consistent leadership in ensuring that the goals within this report and others that are developed in the coming years will have the attention and support they need to be realized. Nearly every recommendation within this report will require partnerships among organizations and this Office will work daily to ensure that innovative solutions through collaboration are developed.

VI. a.2.b.

Because of the expanded responsibilities and expectations of CoCs by HUD, we recommend that financial support be provided to Lexington's CoC via a contract to provide specific services for the community. Nationally, communities with both strong CoCs and local government collaboration and support are the most likely to have success in addressing homelessness.

VI. b. FUNDING

VI. b.1. DESCRIPTION

There are currently several avenues of funding for homelessness and prevention in Lexington-Fayette County, consisting of federal, state, and local governmental funding, private non-profit funding, grants, donations, and volunteer hours. Federal dollars flow to LFUCG directly through the Community Development Block Grant (CDBG), the HOME Investment Partnership Program, and the Emergency Solutions Grant (ESG). Federal dollars flow directly to the providers through the Continuum of Care.

CDBG is a flexible program allowing local government to address a wide range of community development needs. In 2012, LFUCG received approximately $2 million in CDBG funds. The bulk of the money was used to fund infrastructure needs (approximately $865,000), housing rehabilitation (approximately $752,000), and provided to partner agencies for services (approximately $364,000). The remainder of the money was used for administration.

HOME is the largest federal block grant to local governments to be used exclusively for creating affordable housing for low-income families. In 2012, LFUCG received approximately $1.3 million. The HOME Funds were provided to R.E.A.C.H., Inc., Lexington Habitat for Humanity, Fayette County Local Development Corporation, Parkside Development Group, Salem Village Apartments, Bluegrass.org, Community Action Council, and AIDS Volunteers Inc.

ESG is to be used exclusively for homelessness. In 2012, LFUCG received $154,919 which was used by the Salvation Army, the Hope Center, Bluegrass Domestic Violence, and LFUCG Adult and Tenant Services. Adult and Tenant Services received approximately $80,000 for homeless prevention services and uses the money for rent and utility deposits and payments to assist households to remain in permanent housing. In order to qualify a household has to be at 30% AMI, have income, and be homeless. Recipients are required to meet monthly with their case worker. In December of 2012 they had 39 on-going clients and 84 short-term case management clients.

Adult and Tenant Services also receives $200,000 in a general fund allocation to operate the emergency financial assistance program. The amount allocated is down from $300,000 in 1996 even though the need has not decreased.

This is a crisis response program that provides all types of emergency financial assistance including rent and utility deposits and payments, and burial expenses. A household can only receive assistance once every two years and they have to currently be without income but have pending income. There is no case management attached to the receipt of this money.

In addition, Adult and Tenant Services operate a payee program with 13 clients. There is an unmet need for 50 additional payee clients but it would require an additional social worker. Bluegrass.org also has a significant need for additional resources to expand their payee program.

Adult and Tenant Services was previously awarded $849,668 in federal Homeless Prevention and Rapid Re-housing Program funds as part of the American Recovery and Reinvestment Act of 2009 but this money is now expended and will not be renewed.

LFUCG also allocates in the budget approximately $1 million each year to partner agencies that provide services to the homeless including the Hope Center, the Salvation Army, Community Action, Arbor Youth Services, and the Chrysalis House.

Lexington-Fayette County receives approximately $1.6 million in federal dollars through the Continuum of Care. In 2011, this money was used by Chrysalis House, Hope Center, Volunteers of America, the Kentucky Housing Corporation, New Beginnings, Bluegrass.org, Community Action Council, and the LHA.

The majority of the funds provided by the federal government to Lexington are based on a standard formula used throughout the country by HUD. The formula is based on a number of demographic factors. It should be acknowledged that the $1.6 million from the CoC grant is not enough to meet the real needs of our community, especially since Lexington is a regional hub for mental health care needs. Therefore, to adequately address the issues as opposed to scraping by each year, it is critical that supplemental revenue streams be identified and actively pursued. Reliance on the federal government alone is not a good policy decision for Lexington.

There are, of course, funds outside of government expended to address this need but more funding is needed to more fully and comprehensively address the spectrum of need outlined in this report.

For instance, Atlanta has just recently received an approximately $1.5 million grant from Bloomberg Philanthropies to do research and develop a program for street outreach. Boise, ID has a program called "Project Catch" which partners with businesses and non-profits to sponsor a homeless family or individual for a year. Minneapolis raised $350,000 in private funding primarily from downtown businesses and interfaith congregations to hire 10 case managers to evaluate the needs of homeless individuals and connect them with appropriate services. In the first six months of the program, 150 chronically homeless individuals were housed. There are clearly options and ideas of which Lexington needs to take advantage. It will, however, take someone focused on this issue on a full-time basis.

VI. b.2. RECOMMENDATIONS

We recommend that the Office, in collaboration with appropriate partners, look for ways to increase the funds available through all sources including applying for grants and leveraging private, non-profit, and faith-based participation.

VI. c. CASE MANAGEMENT AND SUPPORT SERVICES

VI. c.1. DESCRIPTION

Case management is a system of comprehensive one-on-one support for the full range of needs for those who are homeless or in danger of becoming homeless. The type and duration of case management needed is dependent upon the needs of the individual. Case management is an essential component of the services needed to help most people exit homelessness or prevent them from becoming homeless in the first place. While case management can be a simple one-time intervention, it is an absolute requirement for programs like rapid re-housing and Housing First. Case management is provided by a number of organizations and LFUCG for the clients they serve. While there is some funding available for case management and support services at the federal level, it is very limited. According to Adult and Tenant Services and the providers that responded to the Commission's questionnaire, more case management and supportive services were the most frequently cited needs.

As noted in the previous section, other communities have found creative ways to fund case managers, including partnering with the private sector. Some communities have been successful in providing case workers at the public libraries where people who are experiencing homelessness often frequent.

VI. c.2. RECOMMENDATIONS

We recommend that the Office collaborate with appropriate partners to find innovative ways to increase case management and supportive services available to people in need including reducing or eliminating unnecessary paperwork and processes that take time away from helping those in need. The Office would also seek funding for additional case management throughout the system including within LFUCG.

VI. d. UNIFIED SYSTEM OF ENTRY

VI. d.1. DESCRIPTION

A unified system for entry is intended to better assess clients early in the process so that assistance can be targeted in a way that is most effective for the client in need and gets them into stable housing as soon as possible. A unified intake program can be a physical location or a process that is utilized by multiple organizations -- ideally all organizations -- involved in services to those who are homeless or on the verge of becoming homeless. A critical component of a successful intake system is to have a common assessment tool that is used by all organizations. Louisville is in the process of developing such a tool.

Except for data that is required to be entered into the HMIS (Homeless Information Management System) database managed by the Kentucky Housing Corporation (KHC), Lexington does not have a centralized intake program or database in which data is shared and accessible across providers. The HMIS data is primarily used to provide information to HUD. Individual agencies use their own intake forms and procedures, and some utilize databases separately from HMIS.

People become homeless for many reasons and the help they need to exit homelessness or to stay out of it entirely is unique to each individual. Therefore, thoughtful assessment of each individual's needs is an essential part of the process. Early and appropriate intervention is also critical to reducing the cost of homelessness to both the individual and community. While the Commission has found no evidence to suggest that people are not getting the help they need from the right providers, we believe that a unified system of entry would allow clients to access these services quicker and more efficiently, while saving time and resources for both the client and the many providers.

In addition, information about the makeup of Lexington's homeless population that is more consistent would enhance the coordination of prevention and homeless services and reduce fragmentation.

This is especially important as the demographic makeup of those in need changes and resources continue to be limited. Furthermore, if Lexington's goal is to rapidly rehouse individuals and families, linking them to appropriate services as quickly as possible is critical.

Such a system is a requirement of HUD but communities maintain some flexibility in what type of system it implements. There are numerous models for unified systems of entry throughout the country and if deemed appropriate, Lexington should design a program that meets its specific needs. It is also possible that the existing HMIS system can be enhanced to meet this need. Lexington should carefully examine lessons learned from communities around the nation and implement best practices so mistakes can be avoided. It is imperative that providers be included in the process and expected outcomes including the design of the assessment tool with a standard set of questions.

VI. d.2. RECOMMENDATIONS

We recommend that the Office, in partnership with CKHHI and other appropriate partners, fully explore whether a unified system of entry would be effective in Lexington and if so, how to design and implement such a system.

VI. e. DATA MANAGEMENT

VI. e.1. DESCRIPTION

Accurate data is important to Lexington's effort to address homelessness for a variety of reasons, including a unified system of entry. Decision makers utilize this information to make funding and policy decisions. It can also be used at a micro-level to better assist those in need (see unified system of entry). It is imperative that the data collected is the appropriate information needed to quickly assist an individual or family. The data collected should also provide useful information for providers and policy makers. Ideally, data can be used to evaluate the progress made of certain programs or the overall effort to reduce homelessness in Lexington. The two primary sources of data relating to homelessness in Lexington are the annual PIT Count and any information generated and collected through HMIS.

Participation in HMIS is a requirement of some HUD funded programs, and there are sanctions for the failure to enter the data, including loss of funding. Furthermore, when making funding decisions, HUD considers the extent to which a community is able to get service providers to participate in HMIS.

Not all providers participate in HMIS and information is not always entered accurately and in a timely manner. The information is used primarily to submit reports to the Kentucky Housing Corporation (KHC) and HUD and is not shared among providers or routinely used to inform decisions locally. It also takes a great deal of agency staff time to enter the data into the system which could be better used serving clients with support services and case management. While individual agencies maintain and utilize their own data, which is entirely appropriate, access to timely, reliable information for the whole system is difficult.

Each year, CKHHI coordinates a PIT Count of people experiencing homelessness and a Housing Inventory County (HIC). The primary purpose of this count is to determine how many people are homeless at that particular time and how many beds are available. To avoid duplication, the count is conducted on a single night. Providers are called and asked to provide the number of individuals staying in their program on that night as well as other demographic information. In addition, every other year a count of unsheltered individuals is conducted at the same time the shelter count takes place.

VI. e.2. RECOMMENDATIONS

VI. e.2.a.

We recommend that the Office, together with appropriate partners, implement a more coordinated data management system and utilize the information to identify gaps in service and find ways to continually improve the continuum of care.

VI. e.2.b.

We recommend that the Office, together with appropriate partners, improve usage of the existing HMIS and find ways to enhance the data collected in order to better meet the needs of Lexington's continuum of care for the homeless.

VI. e.2.c.

We recommend that the Office hire or fund via contract one or more HMIS data entry specialists to assist agencies with correctly entering HMIS data on a regular basis. The agencies could submit data to this specialist who could then enter the data into the HMIS system. This would allow agencies to direct staff time and financial resources towards other needs such as much needed case management. This position should be funded with new money and CKHHI could be contracted to provide this service.

VI. e.2.d.

We recommend that the Office work with service providers to develop incentives to encourage participation in HMIS, including by organizations that are not required to participate because they do not receive any federal dollars.

VI. f. EDUCATION & OUTREACH

VI. f.1. DESCRIPTION

Two kinds of education and outreach are essential components of a comprehensive approach to homelessness. The first kind is directed at the homeless and those in danger of becoming homeless, to alert them to the full range of service and support offered in our community. This is often integrated with efforts at coordination of services.

The second kind is education and outreach for the community, beginning with those who might provide resources and extending to the general community. The more people understand the many faces of homelessness the better able we will be as a community to focus present resources, expand the range of resources needed to address the issues raised by homelessness, and recruit volunteers and other public/private partnerships.

VI. f.2. RECOMMENDATIONS

We recommend that the Office, in collaboration with appropriate partners, develop and coordinate training for the community including landlords, judges, law enforcement, local business, non-profits, churches, and schools. Additionally, on-going training for volunteers and other staff in service provider agencies and programs should be provided.

VI. g. DAY CENTER WITH EXPANDED HOURS

VI. g.1. DESCRIPTION

Day centers provide a place for those who are homeless, whether in shelter at night or not, to get in out of the elements and receive some services during the day. The Catholic Action Center and the New Life Day Center are day centers operated by faith-based organizations which serve adults and Arbor Youth Services has a day center which serves youth 11-17 years of age.

While the Catholic Action Center is open from 6:00 am to 6:00 pm seven days a week, the New Life Day Center is only open from 8:30 am – 3:00 pm Monday through Friday. At the present time, it does not appear that there is a need for additional day centers but the number of the people using the current day centers continues to rise and should be monitored closely. It would, however, be helpful for both day centers for adults to operate from 6:00 am to 6:00 pm seven days a week.

VI. g.2. RECOMMENDATIONS

We recommend that the Office assist the New Life Day Center in expanding its hours and days of operation with the recruitment and coordination of volunteers and continue to ensure that it is operating in an appropriate location.

VI. h. 24-HOUR SHELTER FOR THE HARD-TO-SERVE POPULATION

VI. h.1. DESCRIPTION

The chronically homeless, often people with substance abuse and/or mental health issues, are both the most visible portion of the homeless population and the hardest to serve. Some resist any assistance, some resist enrollment in programs designed to help them cope or change behaviors, some behave in ways that present challenges to themselves and those around them. The Catholic Action Center is currently operating a night shelter at the Community Inn and a day center at the Catholic Action Center and wishes to combine these operations.

VI. h.2. RECOMMENDATION

We recommend that the Office work with the Catholic Action Center to find an appropriate location where these services will not negatively impact residential neighborhoods and where the services could be more conveniently and efficiently coordinated.

VII. SUBPOPULATIONS

The Commission clearly understands that homelessness involves people and therefore both the causes and solutions are multi-faceted. However, there are some subpopulations that are discussed separately. The order of the sections is not meant to indicate priority of importance.

The best alternative to prevent homelessness, or ensure that it does not reoccur, is to ensure that an adequate stock of affordable housing and rental subsidies are available.

VII. a. FAMILIES

VII. a.1. DESCRIPTION

Families now make up 38% of the homeless population and are the only segment of the homeless population that increased during the most recent economic downturn. The primary cause for most homelessness among families is the inability to find housing they can afford. Most families experiencing homelessness are headed by a single mother who has an average of two children, an extremely low income, less access to housing subsidies, and a weaker support system. Many families are broken apart in the homeless system, causing an increase in the rate of placement in foster care.

The cost to the taxpayer of family homelessness is greater than that for single adults. Not only does it include the cost of shelter or transitional housing but it also includes the cost of transporting children to schools and the impact of transiency on the education system. A study in Louisville, KY found that the availability of safe, decent, and affordable housing has a direct effect on student and school success. Those students who moved schools and homes more than once during the year scored an average of 10 academic index points lower on the Kentucky Core Content Reading Test than students who had only one school move. Multiple movers were 8% more likely to be rated as novice (below grade level) than single movers and 10% less likely to be rated as proficient.

There are also costs borne by the child welfare and the health care systems. As will be discussed below, it is important to do all that we can to prevent children from entering the child welfare system since a significant number of the homeless population are people who have aged out of that system. Providing families with affordable housing and rental assistance will prevent them from falling into homelessness and assist them in rapidly exiting homelessness. The best alternative to prevent homelessness, or ensure that it does not reoccur, is to ensure that an adequate stock of affordable housing and rental subsidies are available.

Rapid re-housing is the primary tool that communities currently use to reduce the number of families experiencing homelessness. Communities are quickly re-housing families at a minimal cost by providing assistance in locating new affordable housing, short-term rental assistance, and follow-up case management focused on employment. This approach has resulted in a decline in the need for emergency shelter and transitional housing, it dramatically reduces the time families remain homeless, it costs 50% less than emergency shelter and 75% less than transitional housing, it improves access to emergency shelter and long-term supportive housing for those who really need it, and it allows homeless service systems to serve all kinds of families. Shelter and transitional housing are ill-equipped to meet the needs of families including two-parent households, single fathers with young children, and multi-generational households.

VII. a.2. RECOMMENDATIONS

We recommend a rapid-rehousing approach be funded and rental assistance be expanded. In addition to its intrinsic value, it offers a great opportunity for partnerships with private landlords and the faith community.

VII. b. PERSONS WITH MENTAL ILLNESS

VII. b.1. DESCRIPTION

Approximately 20% of the homeless population has some mental illness: 15% have severe mental illness or co-occurring condition (dual diagnosis); and 5% have less serious mental illness. This group includes men, women, and young adults. Their condition can range from independent living skills with the correct medication to the need for supportive permanent housing with case management. This population started to increase with the deinstitutionalizing of persons with mental illness by the federal government in the 1960's and has continued to increase as both federal and state governments withdraw funding in this area. Approximately 44% of this subpopulation is also chronically homeless. They are often the most visible, sometimes scary, and always heart-breaking subpopulation of our homeless. This population is also aging and it is sometimes difficult to place mentally ill individuals in nursing homes.

In Lexington and the surrounding counties, most individuals with mental illness who need evaluation for hospitalization are taken to Eastern State Hospital.

Only 25%, however, meet the criteria for admission. While Eastern State does everything in its power to find a safe alternative for these individuals, often they wind up back on the street, in shelter, in the emergency room, or in jail. In some cases, the individual qualifies for assistance, but has never applied or does not have a payee to manage their money. Without resources and stable housing, it is almost impossible for these individuals to maintain their required medication and other outpatient treatment, so they cycle through the system.

While this subpopulation is only 20% of the homeless population, they account for 62% of the cost expended by a community for homelessness.

While this subpopulation is only 20% of the homeless population, they account for 62% of the cost expended by a community for homelessness. In Louisville, the average cost for persons with severe mental illness was just over $17,000 and the average cost for persons with less serious mental illness was just under $6,000 per person. However, this subpopulation contains 71% of the clients which cost the system over $50,000 per person a year. A study in Louisville found that in 2004-2005, there were 1,452 persons who were severely mentally ill or had a dual diagnosis that used homeless services: 626 were in emergency shelter, 792 were in transitional housing, and 34 were in permanent housing. Of the 626 in emergency shelter, 107 were considered "high-cost" with an average multi-system service cost of $53,596. Of the 792 in transitional housing, 167 were considered "high-cost" with an average multi-system service cost of $54,945. The average cost of providing permanent housing was $27,450. Therefore, the community could save $7.4 million a year by providing permanent housing to the high-cost clients.

In Lexington the service array currently includes emergency shelter, transitional housing, and permanent supportive housing, but there is a need for more permanent housing. Because of the permanent nature of the housing, the providers do not keep waiting lists. However, they believe that there is a need for at least 100 more beds of permanent supportive housing for the mentally ill and this number will increase if the state moves forward in closing personal care homes.

The Louisville study recommended two models which have demonstrated their cost effectiveness with these clients: Assertive Community Team or Assertive Community Treatment (ACT) and "Housing First."

The Louisville study found that "[c]ontrolled research studies showed that homeless clients participating in ACT had reduced psychiatric hospitalization and psychiatric symptoms, better housing stabilization, greater client satisfaction, and greater likelihood of obtaining independent housing….Assertive Community Team models are expensive and must be targeted to homeless clients with histories of heavy multi-service use." It costs approximately $27,450 per client per year. ACT will be discussed below. "Housing First" is discussed in the section on the chronically homeless.

VII. b. 1. A. ASSERTIVE COMMUNITY TREATMENT

"Assertive Community Treatment" or "Assertive Community Team" (ACT) is voluntary and provides support and treatment to individuals with serious and persistent mental illness utilizing a team of providers who offer services in the community, including the individuals' homes. The team typically provides case management, clinical treatment, psychiatric services, employment, housing assistance, family support, and education. The goal is to wrap services around the individual who has not successfully obtained mental health treatment within the traditional service delivery system and whose symptoms create cycles of dysfunction that include frequent hospitalizations, incarceration, homelessness, unemployment, and poor daily living skills.

The small client-to-staff ratio means services are more intensive and highly individualized. The 24-hour a day access to services means a crisis is averted as soon as it surfaces. Research has shown that this model is highly effective in stabilizing symptoms, increasing functionality, dramatically reducing rates of hospitalization, and consequently eliminating homelessness. ACT, even with its high cost of 24/7 treatment, has been demonstrated to be a highly effective and cost efficient model of service that produces excellent results.

In 2006, bluegrass.org implemented a modified ACT program called the Mobile Outreach Team (MOT) to serve individuals in Fayette County. The team consists of two full-time case managers along with a part-time clinician, prescriber, and peer support specialist. To date, the team has served 54 individuals with 25-30 people receiving services at any given time. 63% of individuals served by the MOT were homeless at entry but with these supportive services, 85% were transitioned to permanent housing. The MOT provides similar services as an ACT team for about half the cost, with the same excellent results.99

VII. b.1.b. MENTAL HEALTH COURTS

People with mental illness have had a dramatic over-representation in the jails and prisons of our country for several decades. Untreated mental illness is often the causal factor to criminal charges. While there are a broad range of outpatient mental health resources in Fayette County, offered by Bluegrass, there are limited resources for people who are homeless. In fact, mental health services provided by Corrections have expanded exponentially while community mental health service funding has been flat- lined for a decade or more. Due to this limitation of mental health services, many persons with mental illness become unstable and are arrested, resulting in increased criminalization of mental illness.

Mental Health Courts have been developed as a way for the Justice system to use the leverage of their authority to help people with mental illness follow through with treatment, thus diverting them from Corrections. This type of "problem solving court" is most effective when it works in collaboration with Community Mental Health services, with staff that actively engage people in treatment and other needed social services. A key component is the voluntary participation in treatment as a diversion from jail and the dismissal of judicial sanctions with follow through. The successful mental health courts show that active engagement in treatment programs and support services not only improves the quality of participants' lives, it also reduces public safety concerns, overcrowded jails and corrections costs. In Kentucky, there are several Mental Health Courts, most notably in Louisville and in Northern Kentucky. Both have impressive data that show the number of people who have been diverted from jail and frequent court involvement through increased engagement in mental health treatment. In Lexington, the establishment of a Mental Health Court is being explored.100

VII. b.1.c. FEDERAL BENEFIT ASSISTANCE

The Social Security Representative Payment Program (Payee program) provides financial management of benefits for people who are incapable of managing their payments on their own.

For most of us, this would most likely be a family member or friend but this is often not an option for the homeless. In that case, another qualified organization or individual can serve.101 While sometimes it is LFUCG, Bluegrass.org, other churches and non-profits, or individuals in town, it can also be a slumlord or corner liquor store. There is a great need for additional payees.

There is also a program to assist individuals in obtaining their disability benefits called "SOAR" which stands for "SSI/SSDl Outreach, Assistance, and Recovery." It is designed to increase access to the disability income benefit programs administered by the Social Security Administration for eligible adults who are homeless or at risk of homelessness and have a mental illness and/or a co-occurring disorder. This is very important for a number of reasons. The Louisville study found that 43% of this population was not receiving the disability benefits to which they were entitled which also made them eligible for Medicaid. Once they obtained their disability benefits, they had access to both benefits and health care which brought $4 million into the system to pay for their care.

VII. b.1.d. STREET OUTREACH & INTERVENTION

Street Outreach and intervention is also important for this population, as well as others, because it has been proven to significantly reduce the homeless population and the costs of multi-system service in other communities. People who are mostly unsheltered or not already in programming often have a number of challenges such as mental illnesses and/or substance abuse problems that make it difficult to seek appropriate help. These individuals are often chronically homeless and cycle in and out of jails, emergency rooms and hospitals, and mental health facilities. The cost to the community is significant and the problems only continue. Street outreach and intervention can identify these hard-to-serve individuals and through coordinated case management, individuals can receive the support they need. The Hope Mobile does provide a form of street outreach, but individuals must choose to go the Hope Mobile and case management is not necessarily provided. Historically, street outreach has been about providers trying to bring people on the street in to their programs. This should be continued, but a more aggressive approach is needed to target the hard-to-serve who likely need a number of interventions.

VII. b.1. e. TRIAGE/CRISIS CARE CENTER

As discussed above, currently patients are evaluated at Eastern State but very few meet the criteria for admission. If the person is homeless, the choices for shelter then become the jail (if they have committed an offense), the hospital (if they are ill), or a homeless shelter. Often persons will have some medical and mental issues but they are not sufficient to require admission to the hospital. They are then placed in the shelter system which does not have adequate facilities to care for them.

In response to this problem, some cities have developed a 24-hour Triage/Crisis Care Center which allows for around the clock assessment and triage. After evaluation, individuals can be admitted for in-patient treatment, but if they do not meet the criteria for admission, they can stay at the facility, be monitored, and receive case management until the proper placement is made. The facility also serves as a step-down facility from inpatient care if clients are not ready to return home which will be discussed later in the report in the "Hospital Discharge" section.

Some Crisis Care Centers also have a jail diversion service which provides alternatives to incarcerating individuals impacted by their mental health issues. The Crisis Care Center provides the community with less costly options than inpatient psychiatric care, emergency room visit, incarceration, or involuntary admission to detoxification services and places the individual on a road to recovery not homelessness.

VII. b.1.f. COURT-ORDERED OUTPATIENT TREATMENT

Some persons with severe mental illness do not accept that they are ill and will not take their medication or participate in treatment. Because the law protects individual civil liberties, it requires a court order to force people to do so. In Kentucky, court-ordered outpatient treatment is allowed under KRS 202A.081 in limited circumstances when symptoms are severe and long-term hospitalization appears to be the only option. Consequently, it is not used as often as it is needed.

There is a ground swell of support for changing the civil commitment legislation to broaden the ability to order an individual into outpatient treatment. Changes in the legislation would allow treatment to be ordered any time there is evidence that an individual has a significant history of problems that are directly related to not following treatment recommendations. A change in legislation will have a positive impact on reducing an individual's cycle from being on the street, to jail, to homelessness due to untreated mental illness.

VII. b.2. RECOMMENDATIONS

VII. b.2.a. PERMANENT SUPPORTIVE HOUSING

We recommend that housing and case management for 100 beds of permanent supportive housing be provided under the assertive community treatment model. The average cost per individual would be approximately $15,000 for a total annual outlay of $1.5 million.

VII. b.2.b. LEGISLATIVE LOBBYING

We recommend that the Office, in collaboration with appropriate partners, lobby for the creation of a mental health court and advocate for changes to the outpatient treatment laws and any other laws regarding mental health that will assist this population.

VII. b.2.c. FEDERAL BENEFIT ASSISTANCE

We recommend that the Office, in collaboration with appropriate partners, work to expand the Payee and SOAR programs.

VII. b.2.d. STREET OUTREACH & INTERVENTION

We recommend that the Office, in collaboration with appropriate partners, actively develop an aggressive program of street outreach and intervention.

VII. b.2.e. TRIAGE/CRISIS CARE CENTER

We recommend that the Office, in collaboration with appropriate partners, further study the cost and efficiency of a Triage/Crisis Care Center to provide services to the individuals that are not admitted to Eastern State, other area hospitals, or the jail, to prevent them from ending up on the street and cycling through the jail and hospital system. The study should include using this Center for respite and palliative care, discussed subsequently in this report, as a detox center, and as a jail diversion center to cut down on the system cost of the criminalization of homelessness.

VII. b.2.f. POLICY CHANGES

We recommend that the Office, in collaboration with appropriate partners, lobby for changes to the state's Medicaid system regarding funding for assertive community treatment and court-ordered outpatient treatment to ensure that these programs are covered by Medicaid.

VII. c. PERSONS WHO ARE CHRONICALLY HOMELESS

VII. c.1. DESCRIPTION

A person experiencing chronic homelessness is an "individual who has been continuously homeless for a year or more or has experienced at least four episodes of homelessness in the last three years and has a disability....HUD will begin to include estimates of chronically homeless families in 2013." Nationally, the chronically homeless account for 17% of the homeless population and 6 out of 10 are "unsheltered." In Lexington, they account for approximately 11% of the homeless population and 3 out of 10 are unsheltered. Therefore, they are most often the people you see "on the street" and are the most difficult to reach and serve. They are also the most costly using almost 50% of the services. The average cost of a chronically homeless person on the street is $42,000 a year for police, hospital, emergency rooms, and incarceration.

Like the mentally ill, members of this group will most often cycle through the system of hospitalizations and incarceration without receiving the help they need to break the cycle. Most are not enrolled in Medicaid or other health insurance programs which could cover part of their care.

They also have high rates of mental illness and/or substance abuse which prevent them from seeking the services available which often require them to be stable and sober before providing treatment. Often, the chronically homeless must be served "on the street" before they can either become stable or develop enough trust in the system to seek shelter and services.

Like the mentally ill, members of this group will most often cycle through the system of hospitalizations and incarceration without receiving the help they need to break the cycle.

As discussed in the Louisville study, one successful model for addressing the chronically homeless is "Housing First." As discussed in the introduction, the traditional approach to providing homeless services was a "continuum of care" including emergency shelter, transitional housing, and permanent supportive services. In order to obtain housing, an individual would have to be "housing ready" which included being clean and sober. However, it is now clear that the best practice for ending chronic homelessness is permanent supportive housing using a "Housing First" model. In this model, the homeless are moved from the streets directly into their own apartments without the condition of accepting mental health or substance abuse treatment.

However, it is now clear that the best practice for ending chronic homelessness is permanent supportive housing using a "Housing First" model.

The model was pioneered by Dr. Sam Tsemberis, Department of Psychiatry, Columbia University Medical Center, and the organization Pathways to Housing in New York City in the early 1990s. It is currently recognized as a "best practice" by the United States Interagency Council on Homelessness (USICH) and the Department of Housing and Urban Development. It has been implemented in at least 22 cities across the United States; 6 cities in Canada; Australia; Netherlands; and Japan. It has also been included in more than 300 cities' 10-year plans to end homelessness.

Case studies have shown that it is incredibly cost-effective. It saves the taxpayers nearly 50% of the money they would have spent if the individual remained on the street for emergency services, police, and corrections. It significantly reduces the number of chronically homeless. Nationally, there was a 7% drop in those experiencing chronic homelessness because of this model. The average cost of the "Housing First" program varies between $14,000 and $26,000 a participant.

Prevention policies, street outreach and appropriate discharge planning from hospitals, jails, foster care, and other institutions, is important to ending chronic homelessness. The City of Louisville has recently started a program targeting the top 50 revolving-door offenders who struggle with mental illness, substance abuse, homelessness and criminal recidivism finding that they incur millions of dollars in taxpayer costs at jails, courts, police, hospitals, and treatment centers. They are using an "assertive community treatment" model discussed above and they anticipate that it will cost between $16,000 and $20,000 a year per person in addition to the housing. The Louisville study found that the cost for such persons living in emergency shelters was $107,912 which was more than twice as much as for those in permanent supportive housing. It is also more effective in improving lives. It is anticipated that Medicaid will pay approximately $1.8 million of the $6 million tab.

Most people initially find the program counterintuitive and resist spending money on individuals that are not working and may have a substance abuse problem, mental health issues or both. The reality is that the taxpayers are already spending money on these individuals and this program is much cheaper with a better success rate.

In Lexington, most programs have beds set aside for the "chronically homeless." However, there is no intentional outreach or coordination regarding this group. This group needs intentional outreach (as discussed in the section "Street outreach"), coordination, housing, and case management.

VII. c.2. RECOMMENDATIONS

VII. c.2.a.

We recommend the creation of a "Housing First" program for at least 50 people. At last count, there were approximately 116 persons living on the street or chronically homeless. Not all, however, will agree to participate in the program. Based on information from local providers, the cost should average $15,000 a person for a total annual outlay of $750,000.

VII. c.2.b.

We recommend that the Office, in collaboration with appropriate partners, develop a street outreach and intervention program as discussed above.

VII. d. YOUTH AND YOUNG ADULTS (18-24 YEARS OLD)

VII. d.1. DESCRIPTION

It is troubling to learn that there are unaccompanied children under 18 years of age that are homeless. There is also a concern in the homeless community that the number of homeless youth is underreported. Homeless youth can be runaways, committed to the Cabinet for Health and Family Services (Cabinet) but not yet placed, have parents in other homeless shelters, or have homes where it is unsafe or undesirable for them to stay at that time because of severe family conflict, parental abuse or neglect that is not yet substantiated, parental mental health issues or substance abuse, or be in the juvenile justice system as status offenders (truants, runaways, or out of control).

Children must leave emergency shelter upon turning 18 years of age. If they have not been committed to the Cabinet prior to that time, they have no further support system. If they have been committed to the Cabinet and have not been adopted, they have 12 months from their 18th birthday to decide whether to remain in the state's care. If the youth "opts-in," he or she can stay in the state's care through age 21 and continue to receive housing and case management. The Cabinet does not have to accept every youth that wishes to opt-in. Also, the youth can be asked to leave the system for disobeying the rules. If the youth "opts-out", he or she receives no further assistance from the state. The youth are considered to have "aged-out" of foster care. Approximately 20% of the homeless population are young adults (18-24 years old), many of whom have aged out of foster care. The percentage of homeless who are older but were in the foster care system at some point is significantly higher.

VII. d.1.a. EMERGENCY SHELTER FOR YOUTH UNDER 18 YEARS OF AGE

Arbor Youth Services (AYS) currently operates a 10-bed shelter for 11-17 year olds, but the demand is greater than shelter capacity.

VII. d.1.b. EMERGENCY SHELTER FOR YOUTH 18-24 YEARS OLD

Little attention is paid to the youth that are aging out of the foster care and juvenile justice systems, many of whom are reluctant to listen or receive assistance. Like most 18 year-olds, youth in foster care are eager to "be free" and often opt-out of continued care. It is not until after the year has passed that they realize they need assistance. There is no designated emergency shelter for these youth. They are mixed with the general population at the Hope Center, the Salvation Army, and the Community Inn. In 2011, the Hope Center provided shelter for 185 18-24 year old men.

This population, however, has special needs because of their experiences in foster care and the juvenile justice system, and their developmental stage. Their situation is compounded by debt and lack of access to medical care. Youth who age out of foster care are eligible to receive Pell Grant tuition waivers for post-secondary education. If students with Pell Grants do poorly, which occurs often, and are unable to return to school by choice or because of grades, they have to pay back the tuition. Furthermore, they cannot return to school until the loan is repaid. This happens routinely and creates another obstacle for the youth to overcome, makes self-sufficiency less attainable, and many become homeless or marginally housed.

Youth with serious mental illness receive Title IV-E funding, which is federal dollars, in place of disability. These are the youth most likely to become homeless, but there is often no effort made to flag them for additional help. Also, after 19, foster care youth lose Medicaid coverage unless they are able to qualify on their own. Therefore, they lose access to medications and mental health treatment as well as other medical care. It is unclear if the Affordable Care Health Care Act will address this issue.

An emergency shelter designed specifically for this population would allow for a transitional setting with more accountability and less supervision than shelter for youth under 18 years of age but with more assistance and case management than offered by adult shelters in the community. AYS believes that approximately 15-20 beds would remain full if this service were offered in Lexington.

VII. d.1.c. TRANSITIONAL HOUSING FOR YOUTH 18-24 YEARS OF AGE

Currently, AYS is serving the population of youth who have not been committed to the Cabinet and the Methodist Home and Bellewood serve youth who have been committed to the Cabinet and have opted-in. AYS currently operates a Transitional Housing Program for youth that is funded by LFUCG. The program offers case management, rent subsidies, and other assistance to homeless youth ages 18-21 years old. 10 youth are served per year in this program, although the demand is much higher and the waiting list can be up to one year long. There is a great need for these services to be provided to youth up to 24 years of age but AYS has been unable to expand the program due to insufficient funding. AYS needs funding to provide service to an additional 60 young adults each year.

VII. d.2. RECOMMENDATIONS

Addressing the complex issues regarding youth homelessness is critical since these youth are a major component of the homeless population. If they do not obtain stability as young adults, they will battle the revolving door of homelessness for the rest of their lives. This is a crucial point of possible intervention, where an investment of resources would reduce the numbers of youth who end up homeless for a period of time or chronically homeless.

VII. d.2.a. HOUSING

VII. d.2.a. I.

We recommend that at least 10 additional beds of emergency shelter be provided for youth under 18 years of age. According to AYS, additional annual funding of $400,000 is needed in this area in addition to the capital cost to buy or rent housing.

VII. d.2.a. II.

We recommend that 20 beds of emergency shelter be provided to young adults between the ages of 18-24 years old. The cost to open a 20-bed shelter would be approximately $373,000 per year in addition to the cost of the construction or purchase cost of the facility.

VII. d.2.a. III.

We recommend that an additional 60 young adults be provided transitional housing each year. It costs approximately $3,500 a bed to provide transitional housing for young adults. Therefore, approximately $210,000 is needed annually.

VII. D.2.b LEGISLATIVE AND POLICY CHANGES

We recommend that the Office lobby for legislative changes to the foster care laws to allow more time for youth aging out to opt-in to the system and state policy changes to the Medicaid system to allow coverage for these youth and the Chafee program funding for housing and case management until the age of 25.

VII. e. PERSONS WITH SUBSTANCE ABUSE ISSUES

VII. e.1. DESCRIPTION

Persons suffering from substance abuse account for approximately 13% of the homeless population but 20% of the system costs. This group includes men, women, and young adults. In some ways it is one of the most noticeable groups of the homeless, and significant resources have been provided in the past to address this issue, particularly for men. Lexington has significant recovery resources but more is needed, particularly for women.

There is an unmet need for 143 recovery beds, particularly for women many of whom have children. Providing substance abuse treatment for these women will not only assist in preventing homelessness for these women but also their children later in life. Whether there is also a need for recovery beds for women with older children should be investigated.

Currently recovery programs are graduating individuals and sending them back into the systems from which they came. The possibility of recidivism is greatly increased if individuals do not have stable housing and case management during this period of transition. There is an unmet need for 350 beds in transitional housing. It is possible that more transitional beds will be required if more recovery beds are added, particularly for women.

VII. e.2. RECOMMENDATIONS

VII. e.2.a.

We recommend that an additional 115 recovery beds be provided. The cost of a recovery bed, not including the capital cost of acquiring the building, is approximately $15,000 per year.

VII. e.2.b.

We recommend that 350 beds in transitional housing be provided. The cost of a transitional bed for this population is primarily the capital cost of the building.

VII. f. SURVIVORS OF INTIMATE PARTNER VIOLENCE

VII. f.1. DESCRIPTION

A study by the National Law Center on Homelessness and Poverty ranks domestic violence as the leading cause of homelessness for women in the nation. Some studies have shown that between 90-100% of homeless women report that they have been victims of intimate partner violence. It is essential that any homeless assistance program include adequate training of assessment and case management staff on the basic dynamics of domestic violence, risk assessment, and adherence to federal laws in place to protect survivors of domestic violence, sexual assault, dating violence, and stalking.

Bluegrass Domestic Violence Program, Inc. (BDVP) serves male and female survivors of intimate partner violence and their children from a 17 county region. The main office and emergency shelter is located in Lexington-Fayette County. In 2011, they served 10,000 clients, including 300 in shelter. 98% of the clients served are female, 2% are male; 50% are adult, 50% children; and 50% come from Fayette County.

The emergency shelter has 32 beds, but sleeps an average of 20 additional people each night on couches, floors, or in motel rooms. They also serve 208 in transitional housing through the Lexington Housing Authority, but could serve an additional 150 if there were funding for housing and case management.

Most of the clients are currently served without the need for emergency shelter. They are assisted in obtaining a protective order, which orders their abuser to vacate their shared residence, or in changing the domicile locks, or in changing domicile, or through other forms of case management.

While many survivors of violence choose to remain in their homes after successfully obtaining an order of protection, they often find that they cannot maintain the property due to a lack of financial resources to pay the rent, pay the deposits to change names on the utility accounts, or pay for the necessary security measures to make their home safer, such as lock changes, window locks, trimming bushes, improving lighting, or obtaining a home security system. Survivors of intimate partner violence often need to be released from a lease or utility contract.

90% of the clients who end up in emergency shelter could be served without coming into emergency shelter if more resources were available for rental assistance and case management.

90% of the clients who end up in emergency shelter could be served without coming into emergency shelter if more resources were available for rental assistance and case management. Some clients have criminal histories, or poor credit, rental, and employment histories; inability to pay utility and security deposits and first and last month's rent; or past due utility bills that must be paid in order to get the service transferred.

Immigrant survivors of intimate partner violence have even fewer housing choices as they are often unable to work, are ineligible for public housing, face discrimination in private housing, and have language access barriers. While immigrant victims of intimate partner violence are eligible to seek emergency shelter regardless of their immigration status, they often do not seek protection through the courts due to fear of deportation and language access barriers.

VII. f.2. RECOMMENDATIONS

VII. f.2.a.

We recommend that the Office, in collaboration with appropriate partners, seek additional funding for rental assistance and case management to allow services to be provided without the need for emergency shelter. If rental assistance and funding for case management are made more available, then most clients could be served without the need for emergency shelter, which would be more beneficial for the family and the community, and would be more cost effective.

VII. f.2.b.

We recommend that an additional 150 beds in transitional housing be provided.

VII. f.2.c.

We recommend that the Office, in collaboration with appropriate partners, lobby for clarification or changes in the laws and policies which would allow victims of intimate partner violence to: terminate a lease; remove an abuser from their lease or utility contract; require the abuser to pay for enhanced safety measures for victims such as changing locks and improve lighting and any damage caused by the abuser; and increase ease of access to U Visas and T Visas for undocumented victims of intimate partner violence and human trafficking.

VII. g. PERSONS DISCHARGED FROM HOSPITALS

VII. g.1. DESCRIPTION

Most hospitals do not specifically track the number of homeless individuals they treat in a way that could be useful to the Commission. The agencies who provide shelter to the homeless indicate that on an annual basis, there are approximately 70 individuals they serve who are unable to live independently and/or are in need of referral to boarding homes, personal care homes, or nursing homes due to medical issues, or are in need of Hospice care. Although local shelters make every provision to help discharged patients, there is a lack of personnel and appropriate facilities to provide follow-up treatments, medical equipment needs and management of medications for the homeless discharged patient.

Hospitals in Lexington are staffed with professionals who are trained to address the unique challenges of discharging chronic homeless individuals into a safe environment. Each hospital has discharge personnel whose job it is to contact the various shelters and organizations serving the homeless populations for possible placement. One hospital in particular, Eastern State Hospital, has recently added a Transition and Outreach Coordinator who serves as the liaison between the hospital and the Hope Center. This collaboration has proven to be an effective technique to ensure continuity of care.

Discharging chronic homeless patients from the hospital is a complex process that is fraught with challenges. Often the individuals who are discharged into homelessness do not have insurance or an income.

Local hospitals often keep consenting patients well past discharge dates, while attempting to identify services and resources for a safe discharge all to find an inadequate supply of housing and support services to meet the demand.

Preventing avoidable re-hospitalizations has the potential to profoundly improve both the quality-of-life for patients and the financial well-being of healthcare systems.

Patients with co-occurring disorders, Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) pose an extremely difficult challenge for a safe discharge as do the homeless terminally ill, who have a heavy burden of disease, including physical illness, psychiatric conditions and addictions.

Effective discharge planning can contribute significantly to preventing homelessness. As part of a larger continuum of care, this process can help people reach goals of stable housing, recovery, and increased quality of life in the community. Discharge planning identifies and organizes the services a person with mental illness, substance abuse, and other vulnerabilities needs when leaving an institutional or custodial setting and returns to the community.

Preventing avoidable re-hospitalizations has the potential to profoundly improve both the quality-of-life for patients and the financial well-being of healthcare systems. There is national recognition of the importance of this issue. The Affordable Health Care Act is penalizing hospitals if there readmission rates are too high.

Many communities are now providing “medical respite” shelters which is short-term residential care that allows homeless individuals the opportunity to rest in a safe environment while accessing medical care and other supportive services. It might be possible to combine “medical respite” with a Crisis Care Center that was previously discussed.

There is a growing body of evidence that a collaborative approach with local hospitals can reduce costs and increase positive outcomes. Partnerships with hospitals will be critical in solving this problem.

VII. g.2. RECOMMENDATIONS

VII. g.2.a.

We recommend that the Office, in collaboration with appropriate partners, work with the local hospitals and homeless providers to develop a Respite Care facility to provide acute and post-acute medical care for homeless persons who are too ill or frail to recover from a physical illness or injury on the streets, but who are not ill enough to be in a hospital.

VII. g.2.b.

We recommend that the Office, in collaboration with appropriate partners, work with the local hospitals, homeless providers, and other non-profits to provide shelter-based palliative care for the terminally ill.

VII. g.2.c.

We recommend that the Office, in collaboration with appropriate partners, examine the availability of necessary medications for individuals with no income or insurance.

VII. h. PERSONS DISCHARGED FROM JAILS

VII. h.1. DESCRIPTION

Approximately 1 in 5 persons leaves prison and becomes homeless soon after. Former inmates tend to have limited or low incomes and have trouble obtaining jobs or housing because of their criminal history. Former inmates who are homeless are also more likely to return to prison. It is therefore critical to address this situation, including federal bonding for employment and working with private landlords to overcome some housing barriers. Some communities have had success with "re-entry housing" which is subsidized housing with associated intensive support services. In New York, it saved $20,000 to $24,000 relative to the cost of release to shelter and re-incarceration. Boston starts discharge planning while the inmates are still incarcerated and forms a Transition Accountability Plan with a re-entry support team which includes jail staff and mentors from the community. The inmate continues to work with the team 12-18 months after release. It has had a significant effect on recidivism rates.

VII. h.2. RECOMMENDATIONS

We recommend that the Office work with the Kentucky Department of Corrections and the local Division of Corrections to determine what, if any, re-entry programs are operating in Fayette County and find best practices to deal with the issue.

VII. i. ELDERLY PERSONS

VII. i.1. DESCRIPTION

According to the National Coalition for the Homeless, approximately 17% of the persons in shelters in 2008 were over 51 years old. The age group between 51-65 years old frequently falls between cracks because they are not old enough to qualify for Medicare but their physical health resembles that of a 70 year old. Elderly homelessness is increasing despite the fact that a lot of housing assistance is directed toward the elderly. It is difficult for them to survive in the shelter system because of the physical demands including climbing stairs and waiting in long lines. They often need additional medical care or assistance with daily living, have difficulty navigating the system, and may not be receiving all the benefits to which they are entitled.

One of the main causes for homelessness in this group is the lack of affordable housing. The current maximum monthly SSI benefit is $710 for an individual and remains well below the poverty line. A person receiving Supplemental Security Income (SSI) cannot afford housing at the fair market rate anywhere in the country and often the wait list for senior housing is very long. Economic growth will not solve the problem because it is unlikely they can return to work.

Because of the problems finding appropriate housing and the shelter system, they tend to stay in dangerous situations and there is a concern about elder abuse.

VII. i.2. RECOMMENDATIONS

We recommend that the Office, in collaboration with appropriate partners, determine and address the needs of the elderly homeless in Lexington.

VII. j. VETERANS

The Veterans Administration has made significant progress in reducing homelessness for veterans primarily using a “Housing First” model. We applaud their efforts and do not believe that this report can add to what is already being provided. We recommend that the Office work with the Veterans Administration in any way possible to support their success and learn best practices.

VIII. RECOMMENDATIONS

VIII. a. SUMMARY OF RECOMMENDATIONS BY SECTION

1. THE GAP BETWEEN THE COST OF HOUSING AND EARNING CAPACITY (V.A.2., P. 19)

A. Create an Affordable Housing Trust Fund;
B. Increase the present fee levied on insurance premiums from 5% to 6%;
C. Allocate 50% of funds for programs in the original AHTF proposal and 50% for recommendations in this report;
D. Use funds for affordable housing units, administrative support, "Housing First," rapid rehousing, and transitional housing;
E. Designate the Office of Homelessness Intervention and Prevention as the Administrative Agent.

2. EMPLOYMENT (V.B.2., P. 23)

A. Transportation:
- i. Provide transportation assistance to providers;
- ii. Explore partnerships with providers and local transportation networks and non-profits;

B. Job training:
- i. Maintain a list of job training programs and employers;
- ii. Help providers foster relationships with employers;

C. Opportunity:
  i. Fund a Federal Bonding program;
  ii. Study the other barriers to employment and seek solutions.

D. 24-hour child care.

3. COORDINATION AND COLLABORATION (VI.A.2., P. 26)

A. Create an Office of Homelessness Intervention and Prevention within LFUCG;
B. Fund CKHHI to provide CoC services.

4. FUNDING (VI.B.2., P. 30)

Increase funding through grant applications and leveraging private, non-profit, and faith-based participation;

5. CASE MANAGEMENT AND SUPPORTIVE SERVICES (VI.C.2., P. 31)

Encourage collaboration among providers to provide more case management and seek funding for additional case management;

6. UNIFIED SYSTEM OF ENTRY (VI.D.2., P. 32)

Office of Homelessness Intervention and Prevention to explore if system would be effective and how to implement such a system;

7. DATA MANAGEMENT (VI.E.2., P. 33)

A. Implement a more coordinated date management system;
B. Improve usage of existing HMIS;
C. Hire or fund a HMIS date entry specialist;
D. Create incentives to encourage participation in HMIS.

8. EDUCATION AND OUTREACH (VI.F.2., P. 34) - DEVELOP AND COORDINATE TRAINING.

9. DAY CENTER (VI.G.2., P. 35)

Assist center in expanding its hours and days of operation with the recruitment and coordination of volunteers and continue to ensure that it is operating in an appropriate location.

10. 24-HOUR SHELTER (VI.H.2., P. 35)

Work with the Catholic Action Center to find an appropriate location where these services will not negatively impact residential neighborhoods and where services could be more conveniently and efficiently coordinated.

11. FAMILIES (VI.A.2., P. 37)

Fund rapid rehousing and expand rental assistance.

12. PERSONS WITH MENTAL ILLNESS (VII.B.2., P. 43)

- **A.** Add 100 beds of permanent supportive housing;
- **B.** Lobby for creation of mental health court and changes to outpatient treatment laws;
- **C.** Expand Payee and SOAR programs;
- **D.** Create program of street outreach and intervention;
- **E.** Study cost and efficiency of Triage/Crisis Care Center;
- **F.** Lobby for changes to State's Medicaid system regarding assertive community treatment and court-ordered outpatient treatment.

13. PERSONS WHO ARE CHRONICALLY HOMELESS (VII.C.2., P. 46)

- **A.** Create "Housing First" program for 50 people;
- **B.** Create a program of street outreach and intervention.

14. YOUTH AND YOUNG ADULTS (VII.D.2., P. 49)

- **A.** Housing
  - i. Add 10 emergency shelter beds for youth under 18 years old;
  - ii. Add 20 emergency shelter beds for young adults 18-24 years old;
  - iii. Add 60 beds of transitional housing for young adults 18-24 years old.
- **B.** Lobby for changes to foster care laws, the Chafee program, and changes to the Medicaid system.

15. PERSONS WITH SUBSTANCE ABUSE (VII.E.2., P. 51)

- **A.** Add 115 recovery beds for women;
- **B.** Add 350 transitional beds for men and women.

16. INTIMATE PARTNER VIOLENCE (VII.F.2., P. 53)

A. Provide additional funding for rental assistance and case management;
B. Add 150 transitional beds;
C. Lobby for changes to landlord/tenant laws and increase ease of access to U Visa and T Visas for immigrant survi vors.

17. PERSONS DISCHARGED FROM HOSPITALS (VII.G.2., P. 56)

A. Work with local hospitals and homeless providers to develop a Respite Care facility;
B. Work with local hospitals and homeless providers to provide shelter based palliative care to the terminally ill;
C. Examine the availability of necessary medications for individuals with no income or insurance.

18. PERSONS DISCHARGED FROM JAIL (VII.H.2., P. 57)

work with the kentucky department of corrections and the local division of corrections to determine what, if any, re-entry programs are operating in fayette county and find best practices to deal with the issue.

19. ELDERLY (VII.I.2., P. 57)

Investigate needs of elderly population.

20. VETERANS (VII.J., P. 57)

Support the VA in its work.

VIII B. READILY AVAILABLE COST ESTIMATES

CATEGORY/SUBPOPULATION	RECOMMENDATION	PER UNIT COST	ANNUAL COST
FAMILIES	Additional funding for rapid re-housing, rental assistance, and case management		$250,000
YOUTH AND YOUNG ADULTS	60 transitional beds	$3,500	
CHRONICALLY HOMELESS	50 “Housing First” beds	$15,000	$750,000
PERSONS WITH MENTAL ILLNESS	100 permanent supportive housing beds for mentally ill	$15,000	1,500,000
SUBSTANCE ABUSE	115 recovery beds	$15,000	$1,700,000
YOUTH AND YOUNG ADULTS	20 beds for Emergency shelter		$280,000
YOUTH AND YOUNG ADULTS	10 beds for Emergency shelter		$380,000
TOTAL			$5,070,000

VIII. c. COMPREHENSIVE RECOMMENDATIONS

VIII. c.1. FUNDING

We recommend an increase from 5% to 6% in the present fee assessed by LFUCG on insurance premiums, to create an Affordable Housing Trust Fund that will ensure consistent and reliable funding to provide major support for the recommendations that follow. We also recommend that the Office look for ways to increase the funds available through all sources including applying for grants and leveraging private, non-profit, and faith-based participation.

VIII. c.2. STRUCTURE

We recommend that an Office of Homelessness Prevention and Intervention be created within LFUCG, guided by an Advisory Board appointed by the Mayor and approved by council, funded by the increased fee on insurance premiums, and tasked with overall coordination of the housing and housing-related issues cited in this report.

VIII. c.3. FACILITIES

We recommend the following, funded in part by the increased fee on insurance premiums and coordinated by the Office of Homelessness Prevention and Intervention:

- **A.** Create additional units of affordable housing;
- **B.** Create additional beds in transitional housing;
  - i. 60 additional beds of transitional housing for young adults 18-24 years old;
  - ii. 150 transitional beds for victims of intimate partner violence;
  - iii. 115 recovery beds for women;
  - iv. 350 transitional beds for men and women.
- **C.** Create a 24-hour emergency shelter for hard to serve;
- **D.** Create emergency shelter for youth and young adults;
  - i. 10 additional emergency shelter beds for youth under 18 years of age;
  - ii. 20 beds for young adults 18-24 years old.
- **E.** Expand present homeless day-center hours;

F. Adopt a "Housing First" model for the mentally ill and chronically homeless:
    i. 100 permanent supportive beds for persons with mental illness;
    ii. 50 permanent supportive beds for the chronically homeless.
G. Adopt a "rapid re-housing" approach for the temporarily homeless;
H. Expand the rental assistance program.

VIII. c.4. SERVICES

We recommend the following additional or enhanced services:

A. Create and support a system for a unified point of entry;
B. Create and support a system for data management;
C. Provide employment support including:
    i. Transportation;
    ii. 24-hour child care;
    iii. Job readiness training;
    iv. Federal bonding.
D. Expand Payee and SOAR program;
E. Develop a program of street outreach;
F. Support VA in work with veterans;
G. Encourage collaboration among providers to provide more case management and seek funding for additional case management.

VIII. c.5. POLICY CHANGES

We recommend advocacy at the state and/or federal level for the following:

A. Changes to the landlord/tenant laws;
B. Creation of a mental health court;
C. Improvements in the foster care laws regarding "aging out";
D. Increase ease of access to U Visas and T Visas for immigrants ;
E. Changes in community-based treatment laws;
F. Changes in Chafee program;
G. Changes in Medicaid system for person with mental illness and youth and young adults.

VIII. c.6. FURTHER STUDY

We recommend further study, with an eye to implementation, for the following issues:

A. Investigate a Triage/Central Intake center;
B. Work with homeless providers to determine how many beds of medical respite/palliative care are needed and work with hospitals to fund;
C. Examine the availability of necessary medications for individuals with no income or insurance;
D. Determine best practices regarding re-entry programs;
E. Assess needs of elderly homeless.

VIII. d. RECOMMENDATIONS BY PRIORITY

All of the recommendations are important and are integral to solving and reducing homelessness in Lexington. The Commission, however, understands that priorities must be set to guide the Office of Homelessness Prevention and Intervention in addressing these issues. The Commission also understands that the Office of Homelessness Prevention and Intervention may need to reorder these priorities given their expertise and information that may come to light after this report. With that in mind, the Commission made the following priority rankings among the recommendations:

The recommendations that received the Commission's highest priority ranking are:

1. Increase from 5% to 6% the present fee assessed on insurance premiums, to create an Affordable Housing Trust Fund to provide a consistent, reliable, dedicated funding stream to address the recommendations contained in this report;
2. Create an Office within LFUCG, funded by the fee increase and tasked with overall coordination of the recommendations contained in this report including finding ways to increase the funds available through all sources such as applying for grants and leveraging private, non-profit, and
3. faith-based participation;
   Create more affordable housing units to meet the needs of the homeless and those at risk of homelessness.

The recommendations that received the next highest level priority ranking are:

1. Institute a “Housing First” model for the mentally ill and chronically homeless;
2. Support creation of a mental health court;
3. Develop a program of street outreach;
4. Provide employment support;
5. Encourage and support collaboration among providers to provide more case management.

The recommendations that received the 3rd level of priority ranking are:

1. Adopt a "rapid re-housing" approach for the temporarily homeless;
2. Create a 24-hour emergency shelter for the hard-to-serve;
3. Lobby for changes to the foster care laws regarding "aging out;'
4. Create and support a system for data management;
5. Create emergency shelter for youth and young adults;
6. Work with homeless providers to determine how many beds of medical respite/palliative care are needed and work with hospitals to find funding;
7. Lobby for clarification of or changes to the landlord/tenant laws with special attention to assisting survivors of intimate partner violence.

The recommendations that received the 4th level of priority ranking are:

1. Support the Veterans Administration in their work with the veterans;
2. Increase ease of access to U Visas and T Visas for immigrants;
3. Expand the rental assistance program;
4. Expand present homeless day center hours;
5. Create and support a system for a unified point of entry;
6. Lobby for changes in the Medicaid system for person with mental illness and youth and young adults.

The recommendations that received the 5th level of priority ranking are:

1. Determine best practices regarding re-entry plans;
2. Lobby for changes in the community-based treatment laws;
3. Examine availability of medications for people with no income;
4. Investigate a Triage/Crisis Care center;
5. Create additional beds in transitional housing;
6. Expand the SOAR and Payee programs;
7. Lobby for changes in the Chafee program;
8. Assess the needs of the elderly homeless.

IX. IMPLEMENTATION PLAN

We recommend that the Office of Homelessness Prevention and Intervention and the related Advisory Board recommended in this report be charged with ongoing implementation, and with monitoring, assessment, and reporting of progress made towards increasing the supply of affordable housing and related appropriate services, reducing the incidence of homelessness, reducing the duration of homelessness, reducing the impact on those who become homeless, and reducing the impact of homelessness on the community. This progress should be reported annually to Council and the community.

We recommend that the Mayor's Commission on Homelessness not be disbanded until decisions have been made about recommended funding and structures, to ensure that there is a successful transition to an ongoing structure for carrying out the recommendations in the report.

X. KEY INDICATORS

These initial Key Indicators are designed to provide a snapshot of progress on improving the quality, efficiency, and effectiveness of services for people who are homeless in our community. The Key Indicators would be the primary vehicle for reporting progress to the community.

The Key Indicators are:

1. Increase in the number of affordable housing units;
2. Reduction in the number of homeless included in the annual Point-In-Time Count;
3. Reduction in the number of people included in the Street Count in the Point-in-Time Count;
4. Reduction in the number of homeless requiring incarceration;
5. Reduction in the number of homeless requiring emergency medical care;
6. Reduction in the number of homeless requiring referral and evaluation by Eastern State Hospital;
7. Reduction in the number of youth who age out of foster care who become homeless;
8. Reduction in the number and the amount of time spent in emergency shelter and in transitional housing.

XI. CONCLUSION

We know what a more humane, rational, effective system for reducing homelessness in Lexington looks like.

We know that we can keep some people out of emergency shelters if we intervene with minimal financial support when they are threatened with the loss of their home by short-term financial stress. We know that we can shorten the amount of time that some people spend in emergency shelters if we have more transitional housing available for them. We know that we can shorten the amount of time that some people spend in transitional housing if we have appropriate supportive services and more affordable housing units available for them.

We know that we can shorten the amount of time that some people spend in transitional housing if we have appropriate supportive services and more affordable housing units available for them. We know that we can keep more chronically homeless people off the streets if we have more affordable housing units with supportive services available for them.

We know, in short, the most effective ways to intervene to prevent some people who are most at risk from becoming homeless or remaining homeless. And we know that these interventions reduce the present costs of homelessness by reducing the frequency of emergency room services and incarceration, and by replacing costly services with less-costly services.

We know that to have a more humane, rational, effective system we need a reliable source of consistent funding, a single, professionally staffed coordinating body, increased volunteer effort, and greater cooperation and coordination among all those presently providing services and support aimed at the homeless population.

We know that we can have a more rational, effective system if we have the will to commit the necessary human and financial resources to bring it about. We look to our community to have that will and make that commitment.

XII. APPENDICES

A. Executive Order Establishing Mayor's Commission
B. Commission Members
C. Commission Work Plan
D. Meetings Held
E. Glossary of Frequently Used Terms
F. Homeless Count Spreadsheet
G. Homeless Count Spreadsheet Explanation
H. Homeless in Lexington Narrative
I. Provider Survey
J. Client Survey
K. Links to Additional Resources
L. References

EXECUTIVE ORDER NO. 2012-01

An Executive Order Relating to the Establishment of the Mayor's Commission on Homelessness

Whereas,
Lexington values all of its citizens and is a community committed to preventing and ending homelessness, and;

Whereas,
the United States Interagency Council on Homelessness is encouraging communities to reassess their Ten Year Plans to End Homelessness and align local efforts with the first-ever "Federal Strategic Plan to Prevent and End Homelessness," and;

Whereas,
a safe community where citizens have the opportunity to have their basic human needs met is essential for Building a Great American City.

NOW, THEREFORE, I, JIM GRAY, MAYOR OF LEXINGTON-FAYETTE URBAN COUNTY GOVERNMENT, ORDER AND DIRECT THE FOLLOWING:

1. The Mayor's Commission on Homelessness ("Commission") is hereby created to provide more direct focus on and attention to a set of issues many in the community are already working to address and recommend a course of action for the implementation of any needed changes or improvements in Lexington's effort to prevent and end homelessness.

2. The Commission shall:

A) Consider the Federal Strategic Plan to Prevent and End Homelessness developed in 2010 by the United States Interagency Council on Homelessness; and identify opportunities for Lexington to align its Plan with national efforts to end homelessness.

B) Identify resources—including funding, programming and organizations—currently committed to addressing the issues associated with homelessness and near homelessness in Lexington.

C) Examine prior local efforts—including Lexington's 2010 Ten Year Plan to End Homelessness, task force reports, needs assessments or similar efforts—and determine strengths and weaknesses of implementation efforts.

D) Determine what Lexington is currently doing well to address homelessness and near homelessness.

E) Determine where unmet needs and areas for improvement still exist in addressing homelessness and near homelessness.

F) Propose new or confirm previously identified goals and specific strategies to meet unmet needs and areas identified for improvement.

G) Identify best practices to address homelessness in benchmark cities or elsewhere.

H) Propose specific action steps required to achieve each strategy and goal.

I) Recommend community initiators, opportunities for collaboration among the local, state and federal governments, as well as public-private partnerships, and sources of funding, if needed, for proposed strategies.

J) Suggest practical time frames for the implementation of proposed strategies.

K) Prioritize areas of need and proposed strategies into short term, intermediate and long term areas requiring action.

3. The Commission shall be chaired by Steve Kay, at-large councilmember and co-chaired by Debra Hensley, business woman and Chair of the 1990 Mayor's Task Force on Homelessness. There shall be a five-member steering committee to direct the work of the commission and keep it on track. In addition to the Chair and Co-Chair, the steering committee shall be comprised of the following three people:

James P. "Ike" Adams, Dean, UK College of Social Work; Mark Davis, Pastor, First Presbyterian Church; and Melody Flowers, Assistant Director for Strategic Planning, UK Healthcare.

4. The Commission shall be comprised of the following additional members:

Lisa Adkins, President and CEO, Blue Grass Community Foundation; Laura Babbage, clergy member and community volunteer; Michelle Beverly, Student Support Services Director, Fayette County Public Schools; Rocky Burke, General Manager, Lextran; Claudia Blaylock, Chair, Central Kentucky Housing and Homeless Initiative;

Linda Carroll, business owner and downtown resident; Alberto Carrillo, Pastor, Bethel Hispanic Church; Catherine DeFlorio, Legal Aid of the Bluegrass; Bill Embry, St. James Place; Kevin Fleming, Kentucky Department of Advocacy; Jessica Gies, Aide to Councilmember Bill Farmer; Peggy Henson, 11th District councilmember; Mary Hunter, homeless representative; Janice James, Hope Center Deputy Director and Recovery Program for Women Director; Laverne Laine, Lexington Housing Authority; Sherry Maddock, East End resident; Randy Moler, Veterans Administration Medical Clinic; Douglas Pape, Division of Police; Don Ralph, former director, Eastern State Hospital; Harry Richart, community volunteer; Kate Savage, community volunteer; Mike Scanlon, community volunteer; Tanya Torp, Community Engagement Coordinator, United Way of the Bluegrass; Brian Varble, Minister of Missions and Recreation, Calvary Baptist Church; Ginny Vicini, Executive Director, New Beginnings Bluegrass, Inc.; Kyle Whalen, community volunteer; and Kathy Witt, Sheriff. Other members may be added, as needed.

5. The Chair shall have the authority to call meetings, appoint committees, develop meeting agendas and guide constructive debate in a civil manner towards consensus.

6. The Commission shall meet as often as necessary to complete its work and deliver its findings and recommendations to the Mayor and Council no later than January 15, 2013.

7. The Commission shall be provided administrative support by the Office of the Mayor and the Department of Social Services. All meetings shall be subject to the Kentucky Open Meetings Act and all documents pertaining to the Commission shall be subject to the Kentucky Open Records Act.

Signed this, the _13_ day of July, 2012

MAYOR

MAYOR'S COMMISSION ON HOMELESSNESS MEMBERSHIP

STEERING COMMITTEE

Steve Kay, Commission Chair
At-Large Councilmember

Debra Hensley, Commission Co-Chair
1990 Mayor's Task Force on Homelessness, Chair

Ike Adams
UK College of Social Work, Dean

Mark Davis
First Presbyterian Church, Pastor

Melody Flowers
UK Office of the Provost, Financial Model Implementation, Director

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Laura Babbage
Chaplain

Michelle Beverly
Fayette County Public Schools Student Support Services, Associate Director

Claudia Blaylock
Central Kentucky Housing and Homeless Initiative, Chair and Volunteers of America, Director of Regional and Outreach Services

Rocky Burke
LexTran, Manager

Alberto Carrillo
Bethel Hispanic Church

Linda Carroll
Business Owner and Downtown Resident

Catherine DeFlorio
Legal Aid of the Bluegrass

Janis Durham
VA Medical Center

Bill Embry
St. James Place

Kevin Fleming
KY Department of Advocacy

Jessica Gies
Legislative Aide to Councilmember Bill Farmer, 5th District

MAYOR'S COMMISSION ON HOMELESSNESS MEMBERSHIP

Mary Hunter
Homeless Representative

Janice James
Hope Center, Deputy Director and Hope Center Recovery Program for Women, Director

Laverne Laine
Lexington Housing Authority

Sherry Maddock
East End Resident

Doug Pape
Lexington Division of Police

Don Ralph
Former Director of Eastern State Hospital

Harry Richart
Community Volunteer

Kate Savage
Community Volunteer

Mike Scanlon
Community Volunteer

Joe Shuman
Homeless Representative

Darlene Thomas
Bluegrass Domestic Violence Program, Director

Tanya Torp
United Way of the Bluegrass, Community Outreach Coordinator

Brian Varble
Calvary Baptist Church, Minister of Missions and Recreation

Ginny Vicini
New Beginnings Bluegrass, Inc, Executive Director

Kyle Whalen
Community Volunteer and Lexington Public Library Board of Trustees, Chair

Kathy Witt
Sheriff

STAFF

Shaye Rabold
Office of the Mayor

Leah Boggs
Legislative Aide to Steve Kay

MAYOR'S COMMISSION ON HOMELESSNESS WORK PLAN OUTLINE

September 5, 2012

WHAT DO WE NEED TO KNOW?

1. Indentify categories of homeless, near-homeless and at risk of homelessness
Initial discussion, 9/5: start with Open Space list

2. Identify present services within each category and across categories
Initial draft by staff and volunteers, for discussion 9/26

3. Identify gaps: missing services, alternative approaches, improvements to present services
Initial discussion 9/5: start with Open Space list

WHAT DO WE NEED TO THINK ABOUT?

4. Identify options for filling gaps, including best practices in literature and in other communities

WHAT DO WE NEED TO DO?

5. Develop recommendations
- **A.** start with list from Open Space; further categorize and condense
- **B.** add possible items
- **C.** choose/prioritize
- **D.** fill in details for the chosen few (possibly work in subgroups, one to a recommendation)

SCHEDULE OF MEETINGS

AUGUST 15, 2012

AUGUST 25, 2012

SEPTEMBER 5, 2012

SEPTEMBER 26, 2012

OCTOBER 17, 2012

NOVEMBER 7, 2012

NOVEMBER 28, 2012

DECEMBER 12, 2012

JANUARY 9, 2013

JANUARY 16, 2013

GLOSSARY OF FREQUENTLY USED TERMS

CHRONICALLY HOMELESS: As defined by current federal policy, a person experiencing chronic homelessness is: Unaccompanied (single adult) and disabled and homeless continuously one year or more or four or more episodes in the past three years. With implementation of the HEARTH Act, in the future this definition will include families with children.

CONTINUUM OF CARE (COC): The CoC Program is designed to assist individuals (including unaccompanied youth) and families experiencing homelessness and to provide services needed to help such individuals move into transitional and permanent housing, with the goal of long-term stability. More broadly, the program is designed to promote community-wide planning and strategic use of resources to address homelessness; improve coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; improve data collection and performance measurement; and allow each community to tailor its program to the particular strengths and challenges within that community.

To accomplish CoC Program goals, funds may support activities under five primary program components: permanent housing (permanent supportive housing and rapid re-housing), transitional housing, supportive services only, HMIS and, for HUD-designated high-performing communities, homeless prevention.

CoC refers to both the group of stakeholder's making up the community's coordinated approach and the entity in charge of applying for CoC funding through HUD. Lexington's CoC is headed by the Central Kentucky Housing and Homeless Initiative (CKHHI).

DISABLED: (1) A person shall be considered to have a disability if he or she has a disability that: (i) Is expected to be long-continuing or of indefinite duration; (ii) Substantially impedes the individual's ability to live independently; (iii) Could be improved by the provision of more suitable housing conditions;

and (iv) Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, posttraumatic stress disorder, or brain injury. (2) A person will also be considered to have a disability if he or she has a developmental disability, as defined in this section. (3) A person will also be considered to have a disability if he or she has acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV). (4) Notwithstanding the preceding provisions of this definition, the term person with disabilities includes, except in the case of the SRO component, two or more persons with disabilities living together, one or more such persons living with another person who is determined to be important to their care or well-being, and the surviving member or members of any household described in the first sentence of this definition who were living, in a unit assisted under this part, with the deceased member of the household at the time of his or her death. (In any event, with respect to the surviving member or members of a household, the right to rental assistance under this part will terminate at the end of the grant period under which the deceased member was a participant.)

EMERGENCY SOLUTIONS GRANT (ESG): This program was formerly called the Emergency Shelter Grant. The change was made as part of the 2009 HEARTH Act. ESG funds may be used for five program components: street outreach, emergency shelter, homeless prevention, rapid re-housing assistance, and HMIS; as well as administrative activities.

HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) – Established by HUD to address the specific needs of persons living with HIV/AIDS and their families. HOPWA makes grants to local communities, States, and nonprofit organizations for projects that benefit low-income persons medically diagnosed with HIV/AIDS and their families.

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS): Computerized data collection tool designed to capture client-level information over time on the characteristics and service needs of men, women, and children experiencing homelessness. HMIS databases are operated at the state or local level and are required by the Department of Housing and Urban Development to receive funding for HUD homeless programs.

HOMELESS: The federal government has developed an official definition of homelessness and it is divided into four categories. An individual or family can be literally homeless, at imminent risk of being homeless, homeless under other federal statutes or fleeing/attempting to flee domestic violence.

Literally homeless: Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Imminent Risk of Homelessness: Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

Homeless under other Federal Statutes: Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who" (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing/Attempting to Flee Domestic Violence: Any individual or family who (i) Is fleeing, or attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing.

HOMELESS EMERGENCY ASSISTANCE AND RAPID TRANSITION TO HOUSING ACT OF 2009 (HEARTH): Federal legislation that amended the McKinney-Vento Homeless Assistance Act. Among other changes, the HEARTH Act consolidated the three separate McKinney-Vento homeless assistance programs (Supportive Housing program, Shelter Plus Care program, and Section 8 Moderate Rehabilitation SRO program) into a single grant program known as the Continuum of Care (CoC) Program.

HOUSING CHOICE VOUCHER: See Section 8 Housing Choice Program

HOUSING FIRST: A consumer driven program that provides people who are homeless and have mental health and addiction problems immediate access to permanent housing and support services and clients are not required to participate in psychiatric treatment or attain a period of sobriety in order to obtain housing. Housing First programs may be constructed in a number of ways, but share the following features: 1) Direct, or nearly direct, placement of targeted homeless people into permanent housing. 2) Supportive services that are offered and readily available, but not required to remain in housing. 3) Assertive outreach to engage and offer housing to homeless people. 4) Low demand approach that accommodates client alcohol, substance use and symptoms of mental illness. 5) Continued effort to provide case management

MCKINNEY-VENTO ACT - The McKinney-Vento Homeless Assistance Act was signed into law by President Ronald Reagan on July 22, 1987. The McKinney-Vento Act funds numerous programs providing a range of services to homeless people, including the Continuum of Care programs: the Supportive Housing Program, the Shelter Plus Care Program, and the Single Room Occupancy Program, as well as the Emergency Shelter Grant Program.

PERMANENT HOUSING (PH): Permanent Housing is defined as community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently as possible.

PERMANENT SUPPORTIVE HOUSING (PSH): Permanent housing with indefinite leasing or rental assistance paired with services to help homeless people with disabilities achieve housing stability.

POINT IN TIME (PIT) – A snapshot of the homeless population taken on a given day. Since 2005, HUD requires all CoC applicants to complete this count every other year in the last week of January. Every other year, this count includes a street count in addition to a count of all clients in emergency and transitional beds.

PRECARIOUSLY HOUSED: Persons living in substandard housing conditions, doubled-up
with family or friends, or expecting eviction within seven days who have no community support network to assist them.

Rapid Re-Housing (RRH): A model that emphasizes housing search and relocation services and short- and medium-term rental assistance to move homeless people as rapidly as possible into permanent housing.

SAFE HAVEN

The Safe Haven program component is no longer eligible under the CoC Program. No new Safe Haven projects will be funded, but the CoC Program interim rule explicitly states that all projects eligible under the McKinney-Vento Act before passage of the HEARTH Act, including Safe Havens, may be renewed in order to continue ongoing leasing, operations, supportive services, rental assistance, HMIS operation, and administrative functions beyond the initial funding period. The CoC Program NOFA will provide additional details.

SECTION 8 HOUSING CHOICE PROGRAM: Section 8 is a form of tenant-based rental assistance, which allows recipients to locate and rent a house, duplex, apartment or mobile home on their own using a Housing Choice Voucher, as long as the dwelling meets U.S. Department of Housing and Urban Development (HUD) guidelines. HUD pays a portion of the resident's monthly rent to their landlord and the resident pays the remainder, which is usually 30 to 40 percent of their income. In Fayette County, the Lexington Housing Authority administers the Section 8 program. There is a large waiting list for people needing rental assistance through this program.

SHELTERED HOMELESS: People who meet the definition of being homeless, but are living temporarily in an emergency shelter, transitional housing or permanent housing with supportive services. For purposes of the Point-in-Time Count, people residing in permanent housing with supportive services are not included in the total number.

SHELTER PLUS CARE PROGRAM (S+C):

The Shelter Plus Care (S+C) Program provides rental assistance in connection with supportive services. The program provides a variety of permanent housing choices, accompanied by a range of supportive services funded through other sources. S+C assists hard to serve homeless individuals with disabilities and their families. These individuals primarily include those with serious mental illness, chronic problems with alcohol and/or drugs, and HIV/AIDS or related diseases. S+C includes four separate components: Tenant-based Rental Assistance (TRA), Sponsor-based Rental Assistance (SRA), Project-based Rental Assistance (PRA), SRO-based Rental Assistance (SRO). These components are described below:

TENANT-BASED RENTAL ASSISTANCE (TRA) COMPONENT

Under the TRA component, an applicant may request funds to provide rental assistance on behalf of program participants who choose their own housing units. If a participant decides to move, he or she may take their rental assistance to the new housing unit.

Applicants may require participants to live in a particular structure for the first year of assistance and in a particular area for the remaining period of assistance, or may require participants to live in a particular area for the entire rental assistance period. Such a requirement may be implemented if it is necessary to facilitate the provision of supportive services.

SPONSOR-BASED RENTAL ASSISTANCE (SRA) COMPONENT

Under the SRA component, an applicant may request grant funds to provide rental assistance through a contract(s) with a nonprofit organization(s), called a sponsor. The nonprofit organization may be a private nonprofit organization or a community mental health center established as a public nonprofit organization. The units to be used must be owned or leased by the sponsor.

After a grant is awarded, the sponsor may change sites provided the sponsor continues to own or lease the property and the grantee continues to serve the overall number of persons indicated in its approved application. A site change may occur because the sponsor has found it necessary to change the type of housing provided (for example, to lease 6 one-bedroom units rather than one unit that accommodates 6 persons), changes in the availability of units, or other similar reasons.

PROJECT-BASED RENTAL ASSISTANCE (PRA) COMPONENT

Under the PRA component, an applicant may request grant funds to provide rental assistance through a contract with a building owner(s). An applicant must enter into a contract with the building owner(s) for the full five- or ten-year period of assistance. The building owner must agree to accept eligible S+C participants for this time period. Participants must live in an assisted unit in a particular property.

Under the component, applicants may assist units that will be rehabilitated or existing units that do not need to be rehabilitated. If the units are rehabilitated, and the rehabilitation meets the requirements specified on page 9, the applicant may request 10 years of rental assistance. Otherwise, assistance will be for a period of five years.

SRO-BASED RENTAL ASSISTANCE (SRO) COMPONENT

Under the SRO component, an applicant may request grant funds to provide rental assistance in an existing SRO setting. The units to be used must be in need of moderate rehabilitation. The rental assistance includes an allowance to pay for debt service to pay off the cost of the moderate rehabilitation over the ten-year grant period.

The component is designed to bring more standard SRO units into the local housing supply and to use those units to assist homeless persons with disabilities. The SRO units might be in a rundown hotel, a vacant motel, a Y, or even in a large, abandoned home. Applicants are encouraged to be creative in searching out suitable SRO dwelling units -- large or small structures.

A similar program, the Section 8 Moderate Rehabilitation SRO program, has been operating since 1987. The SRO component of the S+C program draws on that experience. Applicants interested in the SRO component should request the booklet titled, "Understanding the Section 8 Moderate Rehabilitation Single Room Occupancy Program". While leaving many of the technical features the same, the SRO component improves on the original model in the following ways:

To ensure the provision of supportive services, an element vital to the residential stability of homeless persons with disabilities, the S+C program requires that supportive services be available to participants. To ensure that the most needy segments of the homeless population are being served, the S+C program requires that participants be homeless persons with disabilities, particularly those with serious mental illness, substance abuse problems, and AIDS or related diseases.

SECTION 8 MODERATE REHABILITATION SRO PROGRAM:
The Section 8 Moderate Rehabilitation SRO program component is no longer eligible under the CoC Program. No new SRO projects will be funded. Current SRO projects will continue to be renewed under the Multifamily Assisted Housing Reform and Affordability Act of 1997.

SUPPORTIVE HOUSING PROGRAM (SHP): The Supportive Housing Program (SHP) helps develop housing and related supportive services for people moving from homelessness to independent living. Program funds help homeless people live in a stable place, increase their skills and their income, and gain more control over the decisions that affect their lives. The transitional housing component facilitates the movement of homeless individuals and families to permanent housing. Homeless persons may live in transitional housing for up to 24 months and receive supportive services such as childcare, job training, and home furnishings that help them live more independently.

SUPPORTIVE SERVICES - Services that may assist homeless participants in the transition from the streets or shelters into permanent or permanent supportive housing, and that assist persons with living successfully in housing.

SUPPORTIVE SERVICES ONLY (SSO): The supportive services only program component is limited to recipients and subrecipients providing services to individuals and families not residing in housing operated by the recipient. SSO recipients and subrecipients may use the funds to conduct outreach to sheltered and unsheltered homeless persons, link clients with housing or other necessary services, and provide ongoing support. SSO projects may be offered in a structure or structures at one central site, or in multiple buildings at scattered sites where services are delivered. Projects may also be operated independent of a building (e.g., street outreach) and in a variety of community-based settings, including in homeless programs operated by other agencies.

TRANSITIONAL HOUSING

Transitional housing is based on the definition of "transitional housing" in section 401 of the McKinney-Vento Act, as follows: "The term 'transitional housing' means housing, the purpose of which is to facilitate the movement of individuals and families experiencing homelessness to permanent housing within 24 months or such longer period as the Secretary determines necessary." The definition has been expanded to distinguish this type of housing from emergency shelter. This distinction is necessitated by the McKinney-Vento Act's explicit distinction between what activities can or cannot be funded under the Continuum of Care program. The regulatory definition clarifies that, to be transitional housing, program participants must have signed a lease or occupancy agreement that is for a term of at least one month and that ends in 24 months and cannot be extended.

UNACCOMPANIED YOUTH – Minors not in the physical custody of a parent or guardian, including those living in inadequate housing such as shelters, cars, or on the streets. Also includes those who have been denied housing by their families and school-age unwed mothers who have no housing of their own.

UNDUPLICATED COUNT – The number of people who are homeless within a specified location and time period. An unduplicated count ensures that individuals are counted only once regardless of the number of times they entered or exited the homeless system or the number of programs in which they participated. Congress directed HUD to develop a strategy for data collection on homelessness so that an unduplicated count of the homeless at the local level could be produced.

UNSHELTERED HOMELESS: Persons sleeping in a place not meant for human habitation—cars, parks, tents, sidewalks, abandoned buildings, etc.

EMERGENCY	Gen Beds	Gen Count	Gen Unmet need	DV Beds	DV Count	DV Unmet Need	Vet Beds	Vet Count	Vet Unmet Need
Single Men									
Community Inn	60	60							
Hope Center	76	137	61				30	68	38
Room in the Inn	24	24							
TOTAL	160	221	61				30	68	38
SINGLE WOMEN									
Bluegrass									
Domestic Violence				16	26	10			
Community Inn	32	32							
Salvation Army	66	79	13						
TOTAL	98	111	13	16	26	10			
WOMEN WITH HOUSEHOLDS									
Bluegrass Domestic Violence				16	26	10			
Salvation Army	66	79	13						
TOTAL	66	79	13	16	26	10			
COUPLES									
Community Inn	23	23							
YOUTH (MALE AND FEMALE)									
Arbor Youth Services	10	7							
TOTAL EMERGENCY ALL CATEGORIES	357	441	87	32	52	20	60	136	38
Total Beds	449								
Total Count	629								
TOTAL UNMET NEED	145								

TRANSITIONAL	Sub buse Bed	Sub Abuse Count	Sub Abuse Unmet Need	Vet Bed	Vet Count
SINGLE MEN					
Hope Center Jacob's House	132	132			
Hope Center Privett	137	137			
Lighthouse	12	12	13		
Shepherd's House	31	31	15		
VOA (veterans)				40	40
TOTAL	312	312	28	40	40
SINGLE WOMEN					
Chrysalis House	35	35	35		
Hope Ctr for Women	70	70	40		
TOTAL	105	105	75		
WOMEN WITH HOUSEHOLDS					
Chrysalis House	35	35	40		
TOTAL	35	35	40		
TOTAL ALL CATEGORIES TRANSITIONAL	4523	452	143	40	40
Total Beds	492				
Total Count	492				
TOTAL UNMET NEED	143				

TRANSITIONAL	Gen Bed	Gen Count	Gen Unmet Need	Mental Illness Bed	Mental Illness Count	Mental Illness Unmet Need	Sub Abuse Bed	Sub Abuse Count
Single Men								
Bluegrass MHMR				29	29			
CAC Divine Providence	24	24						
CAC Lex Homelss Vets								
CAC Scattered Housing	10	10		6	6	25		
Lexington Rescue Mission	14	14	8					
CAC From the Streets to a Home	31	31						
Rainbow House								
St. James II								
Hope Center Hillrise Apts.							40	40
Shepherd's House							10	10
TOTAL	79	79	8	35	35	25	50	50
SINGLE WOMEN								
Bluegrass Domestic Violence								
Bluegrass MHMR				29	29			
CAC From the Streets to a Home	30	30						
CAC Lex Homelss Vets								
CAC Scattered Housing	10	10		5	5	20		
CAC St. Anne			30	5	5	5		
Lexington Rescue Mission	12	12						
Rainbow House								
Salvation Army	10	10						
St. James II								
Chrysalis House							52	52
Hope Center Rouse House			30				44	44
TOTAL	62	62		24	24	25	96	96
MEN WITH HOUSEHOLDS								
CAC Scattered Housing	8	8						
Community Action Council (Project Independence)	6	6						
One Parent Scholar	4	4						
VOA - family housing	50	50	32					
TOTAL	68	68	32					
WOMEN WITH HOUSEHOLDS								
Bluegrass Domestic Violence								
CAC Scattered Housing	10	10						
Community Action Council (Project Independence)	7	7						
One Parent Scholar	196	196						
Salvation Army	10	10						
VOA - family housing	63	63	33					
Chrysalis House							53	53
TOTAL	2865	286	33				53	53

TRANSITIONAL CONT.	Gen Bed	Gen Count	Gen Unmet Need	Mental Illness Bed	Mental Illness Count	Mental Illness Unmet Need	Sub Abuse Bed	Sub Abuse Count
YOUTH MALE								
Bellewood	8	8	5					
Arbor Youth Services (formerly MASH)	5	5	40					
Methodist Home	10	10						
TOTAL	23	23	45					
YOUTH FEMALE								
Bellewood	8	8	5					
Arbor Youth Services (formerly MASH)	5	5	40					
Methodist Home	10	10						
Florence Crittendon	24	24						
TOTAL	47	47	45					
TOTAL ALL CATEGORIES	565	565	193	59	59	50	199	199
Total Beds	1083							
Total Count	1083							
TOTAL UNMET NEED	743							

TRANSITIONAL	Sub Abuse Unmet Need	DV Bed	DV Count	DV Unmet Need	Vet Bed	Vet Count	HIV/ Aids Bed	HIV/ Aids Count
Single Men								
Bluegrass MHMR								
CAC Divine Providence								
CAC Lex Homelss Vets					5	5		
CAC Scattered Housing								
Lexington Rescue Mission								
CAC From the Streets to a Home								
Rainbow House							3	3
St. James II					34	34		
Hope Center Hillrise Apts.	200							
Shepherd's House	40							
TOTAL	240				39	39	3	3
SINGLE WOMEN								
Bluegrass Domestic Violence		104	104	75				
Bluegrass MHMR								
CAC From the Streets to a Home								
CAC Lex Homelss Vets					3	3		
CAC Scattered Housing								
CAC St. Anne								
Lexington Rescue Mission								
Rainbow House							3	3
Salvation Army								
St. James II					4	4		
Chrysalis House	25							
Hope Center Rouse House	60							
TOTAL	85	104	104	75	7	7	3	3
MEN WITH HOUSEHOLDS								
CAC Scattered Housing								
Community Action Council (Project Independence)								
One Parent Scholar								
VOA - family housing								
TOTAL								
WOMEN WITH HOUSEHOLDS								
Bluegrass Domestic Violence		104	104	75				
CAC Scattered Housing								
Community Action Council (Project Independence)								
One Parent Scholar								
Salvation Army								
VOA - family housing								
Chrysalis House	25							
TOTAL	25	104	104	75				

TRANSITIONAL CONT.	Sub Abuse Unmet Need	DV Bed	DV Count	DV Unmet Need	Vet Bed	Vet Count	HIV/ Aids Bed	HIV/ Aids Count
YOUTH MALE								
Bellewood								
Arbor Youth Services (formerly MASH)								
Methodist Home								
TOTAL								
YOUTH FEMALE								
Bellewood								
Arbor Youth Services (formerly MASH)								
Methodist Home								
Florence Crittendon								
TOTAL								
TOTAL ALL CATEGORIES	350	208	208	150	46	46	6	6
Total Beds								
Total Count								
TOTAL UNMET NEED								

PERMANENT HOUSING WITH SUPPORTIVE SERVICES	Gen Bed	Gen Count	Mental Illness Bad	Mental Illness Count	Mental Illness Unmet Need	Vet Bed	Vet Count	HIV/ Aids Bed	HIV/ Aids Count
SINGLE MEN									
Bluegrass MHMR (LHA-SPC)			14	14					
Bluegrass MHMR (PCH)			2	2					
Bluegrass MHMR (Safe Haven)			1	1					
Bluegrass MHMR (SHP)			15	15					
Lexington Housing Authority	8	8							
Community Action Council (Lexington Samaritan Project)	4	4							
New Beginnings			16	16	20				
Solomon House								4	4
Veteran's Administration						98	98		
St. James	85	85							
TOTAL	97	97	48	48	20	98	98	4	4
SINGLE WOMEN									
St. James	15	15							
Bluegrass MHMR (LHA-SPC)			14	14					
Bluegrass MHMR (PCH)			2	2					
Bluegrass MHMR (Safe Haven)			1	1					
Bluegrass MHMR (SHP)			14	14	50				
Community Action Council (Lexington Samaritan Project)	4	4							
Lexington Housing Authority	9	9							
New Beginnings			22	22	30				
Solomon House								3	3
VOA (disability)	9	9	9	9					
TOTAL	37	37	62	62	80			3	3
MEN WITH HOUSEHOLDS									
Lexington Housing Authority	8	8							
TOTAL	8	8							
WOMEN WITH HOUSEHOLDS									
Lexington Housing Authority	9	9							
VOA (disability)	9	9	9	9					
TOTAL	18	18	9	9					
TOTAL ALL CATEGORIES PERMANENT WITH SUPPORTIVE	160	160	119	119	100	98	98	7	7
Total Beds	384								
Total Count	384								
Total Unmet Need	100								

HOMELESSNESS COUNT SPREADSHEET EXPLANATION

I. EMERGENCY SHELTER

A. SINGLE MEN

i. GENERAL

1. The Hope Center has 106 beds – 76 for "single men" and 30 for "veterans." Their nightly count averages 205 including 68 veterans. We assigned 61 slots of unmet need to "general" and 38 slots of unmet need to "veterans." They are currently constructing 70 more beds for a total of 176 beds after construction. However, they will still have an unmet need of 29 beds.

2. Room in the Inn has 24 beds – We assigned them all to "single men."

3. Catholic Action Center (Community Inn) has 115 beds – We assigned 60 to "single men," 32 to "single women," and 23 to "couples." Men and women sleep in separate quarters.

ii. VETERANS

1. The Hope Center has 106 beds – 76 for "single men" and 30 for "veterans." Their nightly count averages 205 including 68 veterans. We assigned 61 slots of unmet need to "general" and 38 slots of unmet need to "veterans." They are currently constructing 70 more beds for a total of 176 beds after construction. However, they will still have an unmet need of 29 beds.

B. Single Women

i. GENERAL

1. Catholic Action Center (Community Inn) has 115 beds – We assigned 60 to "single men," 32 to "single women," and 23 to "couples." Men and women sleep in separate quarters.

2. Salvation Army has 132 beds – We assigned 66 to "single women" and 66 to "women with households." On the average they have 26 people sleeping on mats. We assigned 13 each to the unmet need

ii. DOMESTIC VIOLENCE

1. Bluegrass Domestic Violence has 32 beds – We assigned 16 to "single women" and 16 to "women with households" classified as "domestic violence." On the average they sleep 52 people each night. We assigned 10 each to the unmet need category for "single women" and "women with households."

III. SUBSTANCE ABUSE

1. Hope Center Recovery for Women has 10 beds classified as "substance abuse." However, they are not for women coming off the street but coming out of jail and into the program so we have moved them to "transitional" beds.

C. YOUTH (MALE AND FEMALE)

i. Arbor Youth Services (formerly MASH) has 10 beds – They currently have an average of 7 in shelter.

D. WOMEN WITH HOUSEHOLDS

i. General

1. Salvation Army has 132 beds – We assigned 66 to "single women" and 66 to "women with households." On the average they have 26 people sleeping on mats. We assigned 13 each to the unmet need category for "single women" and "women with households."

ii. Domestic Violence

1. Bluegrass Domestic Violence has 32 beds – We assigned 16 to "single women" and 16 to "women with households" classified as "domestic violence." On the average they sleep 52 people each night. We assigned 10 each to the unmet need category for "single women" and "women with households."

E. COUPLES

i. General

1. Catholic Action Center (Community Inn) has 115 beds – We assigned 60 to "single men," 32 to "single women," and 23 to "couples." Men and women sleep in separate quarters.

II. TRANSITIONAL - RECOVERY

A. SINGLE MEN

1. The Hope Center Privett Center has 137 beds for "single men" classified as "substance abuse."

2. The Hope Center Jacob's House has 132 beds for "single men" classified as "substance abuse."
3. Volunteers of America (VOA) has 40 beds assigned to "single men" classified as "veterans."
4. The Lighthouse has 12 beds for "single men" classified as "substance abuse." They need an additional 13 beds.
5. The Shepherd's House has 31 beds for "single men" classified as "substance abuse." They need an additional 15 beds.

B. SINGLE WOMEN

1. Hope Center Recovery for Women has 60 beds for "single women" classified as "substance abuse." We included the 10 beds listed as emergency shelter for a total of 70. They have 40 people on their waiting list.
2. Chrysalis House has 70 beds – We assigned 35 to "single women" and 35 to "single women with households" classified as "substance abuse." They need an additional 75 beds. We assigned 35 of the unmet need to "single women" and 40 of the unmet need to "women with households."

C. WOMEN WITH HOUSEHOLDS

1. Chrysalis House has 70 beds – We assigned 35 to "single women" and 35 to "single women with households" classified as "substance abuse." They need an additional 75 beds. We assigned 35 of the unmet need to "single women" and 40 of the unmet need to "women with households."

III. TRANSITIONAL - OTHER

A. SINGLE MEN

i. General

1. Catholic Action Center (Divine Providence) has 24 beds which we assigned to "single men."
2. Catholic Action Center (Scattered Housing) has 29 beds – we assigned 6 to "single men" who are classified as "severe mental illness," 5 to "single women" who are classified as "severe mental illness," 10 to "single men," 10 to "single women," 8 to "men with households," and 10 to "women with households." They need an additional 50 beds classified as "severe mental illness." We assigned 25 of the unmet need to "single men" and 25 of the unmet need to "single women."
3. The Catholic Action Center (HUD) as 61 beds – We assigned 31 to "single men," and 30 to "single women."

4. Lexington Rescue Mission has 14 beds for "single men" with 8 on the waiting list.

ii. Substance Abuse

1. Hope Center (Hillrise Apts.) has 40 beds for "single men" classified as "substance abuse" and needs 200 additional units.

2. The Shepherd's House has 10 beds for "single men" classified as "substance abuse" and need 40 additional units.

iii. Mental

1. Bluegrass MHMR has 58 total beds – We assigned 29 to "single women" and 29 to "single men" classified as "severe mental illness."

iv. Veterans

1. Catholic Action Center (Lexington Homeless Vets Program) has 8 beds – We assigned 5 to "single men" and 3 to "single women" classified as "veterans."

2. St. James II has 38 beds – We assigned 34 to "single men" and 4 to "single women" classified as "veterans."

v. HIV/Aids

1. Rainbow House has 6 beds – We assigned 3 to "single men" and 3 to "single women" classified as "HIV/Aids."

B. Single Women

i. General

1. Catholic Action Center (Scattered Housing) has 29 beds – We assigned 6 to "single men" who are classified as "severe mental illness," 5 to "single women" who are classified as "severe mental illness," 10 to "single men," 10 to "single women," 8 to "men with households," and 10 to "women with households." They need an additional 50 beds classified as "severe mental illness." We assigned 25 of the unmet need to "single men" and 25 of the unmet need to "single women."

2. Catholic Action Center (St. Anne) has 5 beds – We assigned 5 to "single women" who are classified as "severe mental illness."

3. The Catholic Action Center (HUD) as 61 beds – We assigned 31 to "single men," and 30 to "single women."

4. Salvation Army has 20 beds – We assigned 10 beds to "single women" and 10 beds to "women with households."

5. Lexington Rescue Mission has 12 beds for "single women" with 30 on the waiting list.

ii. Domestic Violence

1. Bluegrass Domestic Violence has 208 beds – We assigned 104 to "single women" and 104 to "women with households" classified as "domestic violence." They have an unmet need of 150 beds. We assigned 75 to "single women" and 75 to "women with households."

iii. SUBSTANCE ABUSE

1. Chrysalis House has 105 beds – We assigned 52 to "single females" and 53 to "women with households" classified as "substance abuse." They need an additional 50 beds. We assigned 25 to "single women" and 25 to "women with households."
2. Hope Center (Rouse House) has 44 beds for "single female" classified as "substance abuse."

iv. VETERANS

1. Catholic Action Center (Lexington Homeless Vets Program) has 8 beds – We assigned 5 to "single men" and 3 to "single women" classified as "veterans."
2. St. James II has 38 beds – We assigned 34 to "single men" and 4 to "single women" classified as "veterans."

v. MENTAL

1. Bluegrass MHMR has 58 total beds – We assigned 29 to "single women" and 29 to "single men" classified as "severe mental illness."

vi. HIV/AIDS

1. Rainbow House has 6 beds – We assigned 3 to "single men" and 3 to "single women" classified as "HIV/Aids."

C. MEN WITH HOUSEHOLDS

i. GENERAL

1. Catholic Action Center (Scattered Housing) has 29 beds – We assigned 6 to "single men" who are classified as "severe mental illness," 5 to "single women" who are classified as "severe mental illness," 10 to "single men," 10 to "single women," 8 to "men with households," and 10 to "women with households."
2. Community Action Council (Project Independence) has 13 beds – We assigned 6 to "men with households" and 7 to "women with households."
3. One Parent Scholar House has 200 beds in 80 units – We assigned 196 to "women with households," and 4 to "men with households."
4. VOA (family housing) has 113 beds in 35 units – We assigned 50 to "men with households" and 63 to "women with households." They need an additional 65 units. We assigned 32 to men with households and 33 to women with households.

D. WOMEN WITH HOUSEHOLDS

i. GENERAL

1. Catholic Action Center (Scattered Housing) has 29 beds – We assigned 6 to "single men" who are classified as "severe mental illness," 5 to "single women" who are classified as "severe mental illness," 10 to "single men," 10 to "single women," 8 to "men with households," and 10 to "women with households."

2. Community Action Council (Project Independence) has 13 beds – We assigned 6 to "men with households" and 7 to "women with households."
3. One Parent Scholar House has 200 beds in 80 units – We assigned 196 to "women with households," and 4 to "men with households."
4. VOA (family housing) has 113 beds in 35 units – We assigned 50 to "men with households" and 63 to "women with households." They need an additional 65 units. We assigned 32 to men with households and 33 to women with households.
5. Salvation Army has 20 beds – We assigned 10 beds to "single women" and 10 beds to "women with households."

ii. Domestic Violence

1. Bluegrass Domestic Violence has 208 beds – We assigned 104 to "single women" and 104 to "women with households" classified as "domestic violence." They have an unmet need of 150 beds. We assigned 75 to "single women" and 75 to "women with households."

iii. Substance Abuse

1. Chrysalis House has 105 beds – We assigned 52 to "single females" and 53 to "women with households" classified as "substance abuse." They need an additional 50 beds. We assigned 25 to "single women" and 25 to "women with households."

E. MALE YOUTH

i. Bellewood has 16 beds – We assigned 8 to "youth male" and 8 to "female youth." None were given to "youth males with households" or "youth females with households."
ii. Methodist Home has 20 beds – We assigned 10 to "single men" and 10 to "single women."
iii. Arbor Youth Services (formerly MASH) has 10 beds – We assigned 5 to "youth male" and 5 to "youth female." They need an additional 80 beds. We assigned 40 to "youth male" and 40 to "youth female."

F. FEMALE YOUTH

i. Bellewood has 16 beds – We assigned 8 to "youth male" and 8 to "female youth." None were given to "youth males with households" or "youth females with households." Bellewood has 16 beds – We assigned 8 to "youth male" and 8 to "female youth."
ii. Florence Crittenden Home has 24 beds assigned to "youth female."
iii. Methodist Home has 24 beds – We assigned 12 to "single men" and 12 to "single women."
iv. Arbor Youth Services (formerly MASH) has 10 beds – We assigned 5 to "youth male" and 5 to "youth female." They need an additional 80 beds. We assigned 40 to "youth male" and 40 to "youth female."

IV. Permanent Housing
A. Single Male
i. General
1. Community Action Council (Lexington Samaritan Project) has 8 beds – We assigned 4 to "single men" and 4 to "single women."
2. Lexington Housing Authority has 34 beds – We assigned 8 to "single men," 8 to "men with households," 9 to "single women," and 9 to "women with households."
ii. Mental
1. Bluegrass MHMR (LHA-SPC) has 28 beds – We assigned 14 to "single male" and 14 to "single female" classified as "severe mental illness."
2. Bluegrass MHMR (PCH) has 4 beds – We assigned 2 to "single male" and 2 to "single female" classified as "severe mental illness."
3. Bluegrass MHMR (Safe Haven) has 2 beds – We assigned 1 to "single male" and 1 to "single female" classified as "severe mental illness."
4. Bluegrass MHMR (SHP) has 29 beds – We assigned 15 to "single male" and 14 to "single female" classified as "severe mental illness."
5. New Beginnings has 38 beds – We assigned 16 to "single male" and 22 to "single female" classified as "severe mental illness." They need 50 additional units.

iii. VETERANS

1. The Veteran's Administration has 98 beds which we assigned to "single men."
2. St. James has 100 beds – We assigned 85 to "single men" and 15 to "single women" classified as "veterans."

iv. HIV/Aids
1. Solomon House has 7 beds – We assigned 4 to "single men" and 3 to "single women" classified as "HIV/Aids."

B. SINGLE FEMALE

i. GENERAL

1. Community Action Council (Lexington Samaritan Project) has 8 beds – We assigned 4 to "single men" and 4 to "single women."
2. Lexington Housing Authority has 34 beds – We assigned 8 to "single men," 8 to "men with households," 9 to "single women," and 9 to "women with households."

ii. MENTAL

1. Bluegrass MHMR (LHA-SPC) has 28 beds – We assigned 14 to "single male" and 14 to "single female" classified as "severe mental illness."
2. Bluegrass MHMR (PCH) has 4 beds – We assigned 2 to "single male" and 2 to "single female" classified as "severe mental illness."

3. Bluegrass MHMR (Safe Haven) has 2 beds – We assigned 1 to "single male" and 1 to "single female" classified as "severe mental illness."
4. Bluegrass MHMR (SHP) has 29 beds – We assigned 15 to "single male" and 14 to "single female" classified as "severe mental illness."
5. New Beginnings has 38 beds – We assigned 16 to "single male" and 22 to "single female" classified as "severe mental illness." They need 50 additional units.
6. VOA has 36 beds in 22 scattered site units for "single women" with a documented disability.

iii. Veterans

1. St. James has 100 beds – We assigned 85 to "single men" and 15 to "single women" classified as "veterans."

iv. HIV/Aids

1. Solomon House has 7 beds – We assigned 4 to "single men" and 3 were assigned to "single women" classified as "HIV/Aids."

C. Male with households

i. General

1. Lexington Housing Authority has 34 beds – We assigned 8 to "single men," 8 to "men with households," 9 to "single women," and 9 to "women with households."

D. Female with households

i. General

1. Lexington Housing Authority has 34 beds – We assigned 8 to "single men," 8 to "men with households," 9 to "single women," and 9 to "women with households."

1 Homeless individuals and the providers and their services are not static but change according to many different variables including the need, the time of the year, and funding. Therefore, these numbers and descriptions are a snapshot at a point in time. They also do not reflect the total number of individuals who experience homelessness throughout the year.

HOMELESSNESS IN LEXINGTON

"Homeless" means without a fixed, regular, and adequate dwelling. On an average night in Lexington, there are approximately 2,600 persons that are considered "homeless." These numbers include those "on the street," in emergency shelter, in recovery, in post-recovery and other transitional housing, or in permanent housing with supportive services. They include single men, single women, couples, families, women with children, men with children, and unaccompanied youth. They are suffering from financial difficulties, health issues, domestic violence, substance abuse, and mental illness, among other things. The causes, needs, and solutions are as varied as the number of the people. There is no one size fits all category or solution. Homeless individuals and the providers and their services are not static but change according to many different variables including the need, the time of the year, and funding. Therefore, these numbers and descriptions are a snapshot at a point in time. They also do not reflect the total number of individuals who experience homelessness throughout the year.

UNSHELTERED - 116

Approximately 116 people are unsheltered sleeping in parks and doorways, under bushes and awnings, and other in other encampments.

SHELTERED

Emergency – 629; Unmet need - 145

There are approximately 629 persons in an emergency shelter system designed to serve 449. The additional persons are sleeping on couches, cots, and mats. The Hope Center for Men, the Salvation Army, and the Community Inn are the only emergency shelter providers in town except for Bluegrass Domestic Violence which only serves individuals fleeing domestic violence. Arbor Youth Services (formerly MASH) houses individuals under the age of 18 years of age.

The Hope Center serves only men and will sleep 205 in a shelter designed for 106. The Salvation Army serves primarily women and children but if space is available, they will house a family.

Otherwise, families are separated in the emergency shelter system. On an average night, the Salvation Army will sleep 158 in shelter space designed for 132.

Both men and women, including couples, can stay at the Community Inn which averages 115 a night. On the average, Bluegrass Domestic Violence serves 52 women and children a night in a shelter with 32 beds. Arbor Youth Services (formerly MASH) has space for 5 males and 5 females and currently has an average of 7 in shelter.

TRANSITIONAL (RECOVERY) – 492; UNMET NEED - 143

Chrysalis House provides substance abuse treatment for women with children and serves 70. The Hope Center for Women provides substance abuse treatment for single women and serves 70, 10 in pre-treatment and 60 in treatment. The Hope Center for Men, the Lighthouse, Shepherd's House, and Volunteers of America provide substance abuse treatment for men. The Hope Center serves 269, the Lighthouse serves 12, Shepherd's House serves 31, and Volunteers of America (VOA) serves 40.

TRANSITIONAL (OTHER) – 1083; UNMET NEED - 743

Bluegrass.org (formerly Bluegrass Mental Health and Mental Retardation), Catholic Action Center, Lexington Rescue Mission, St. James II, Volunteers of America, Community Action Council, Rainbow House, Hope Center Hillrise, Shepherd's House, Bluegrass Domestic Violence, Chrysalis House, Hope Center Rouse House, the Salvation Army, and One Parent Scholar provide transitional housing (including post-treatment) to both men and women. Bluegrass Mental Health and Mental Retardation serves 58, the Catholic Action Center serves 147, Lexington Rescue Mission serves 26, St. James II serves 34 veterans, Volunteers of America serves 113, Community Action Council serves 13, Rainbow House serves 6, Hope Center Hillrise serves 40, Shepherd's House serves 10, Bluegrass Domestic Violence serves 208, Chrysalis House serves 105, Hope Center Rouse House serves 40, and One Parent Scholar serves 200 in single parent households while going to school.

Arbor Youth Services (formerly MASH), Bellewood, Florence Crittendon Home, and the Methodist Home provide transitional housing to youth ages 18-24 years old. Arbor Youth Services serves 10, Bellewood serves 16, Florence Crittendon serves 24, and the Methodist Home serves 20.

Permanent with Supportive Services – 384; Unmet need - 100

Bluegrass.org (formerly Bluegrass Mental Health and Mental Retardation), Community Action Council, New Beginnings, Solomon House, St. James, the Veteran's Administration, Volunteers of America and the Lexington Housing Authority provide permanent housing with supportive services. Bluegrass MHMR serves 63, Community Action Council serves 8, New Beginnings serves 38, Solomon House serves 7, St. James serves 100, the Veteran's Administration serves 98, the Volunteers of America serves 36, and the Lexington Housing Authority serves 34.

MAYOR'S COMMISSION ON HOMELESSNES

Provider Survey

APPENDIX I

Name of agency:

Name of program(s):

Completed by: _____ Phone:

Email: _____ Website:

Please feel free to use as much space as you need to answer these questions. You may enter your responses directly into this document or you can use separate sheets. Please send your responses to Shaye Rabold by October 11th. Email: srabold@lexingtonky.gov; Fax: 859-258-3194; Mail: Office of the Mayor, 200 East Main Street, Lexington, KY 40507

1. If you were starting from scratch, how would you address the problem of homelessness in Lexington from prevention through shelter to permanent housing including services?

2. What gaps do you see in the system, if any, regarding shelter, services, programming, etc. (either lacking entirely or needing improvement)?

3. How many people could leave your program(s) if they had:
   a. Permanent housing without supportive services _____
   b. Permanent housing with supportive services _____

4. What does your program(s) need?

5. What type of client is the most challenging to serve and how do you serve them?

6. What changes, if any, have you seen in the clients you serve over the past few years (for example, are you seeing more families, younger/older, etc.)?

7. How many clients in your program(s) have come from outside of Fayette County in order to receive services?

8. Tell us what else we need to know that we may not have asked:

9. Attached is the 2012 Point in Time (PIT) Count. For your program(s), please let us know if anything has changed including beds, units, or target population.

MAYOR'S COMMISSION ON HOMELESSNESS SURVEY OF HOMELESS INDIVIDUALS

APPENDIX J

at New Life Day Center or Phoenix Park (2012)

1. What brought you to Lexington?

2. If you don't have housing now, do you want housing? ☐ Yes ☐ No

3. If you don't have housing now, why is that?

4. (a) If you are not staying in a shelter now, why is that?

(b) What kind of shelter would you be willing to stay in?

(c) What would it take for you to get off the street?

MAYOR'S COMMISSION ON HOMELESSNESS SURVEY OF HOMELESS INDIVIDUALS

at New Life Day Center or Phoenix Park (2012)

5. Do you have a job for pay? ☐ Yes (skip to question 8)
☐ No (continue to question 6)

6. If you don't have a job for pay, do you want one? ☐ Yes (continue to question 7)
☐ No (skip to question 8)

7. What do you need to get a job?

8. How do you generally spend your time?

9. What, on a daily basis, makes your life particularly difficult now, and what would make things better?

MAYOR'S COMMISSION ON HOMELESSNESS SURVEY OF HOMELESS INDIVIDUALS

Sheltered (2012)

1. What brought you to Lexington?

2. If you don't have housing now, do you want housing? ☐Yes ☐No

3. If you don't have housing now, why is that?

4. Do you have a job for pay? ☐Yes (skip to question 7) ☐No (continue to question 5)

5. If you don't have a job for pay, do you want one? ☐Yes (continue to question 6)
☐No (skip to question 7)

6. What do you need to get a job?

7. How do you generally spend your time?

8. What, on a daily basis, makes your life particularly difficult now, and what would make things better?

LINKS TO ADDITIONAL RESOURCES

Kentucky Housing Corporation - http://www.kyhousing.org/

Lexington-Fayette Urban County Housing Authority - http://www.lexha.org/

National Alliance to End Homelessness - http://www.naeh.org/

National Coalition for the Homeless – http://www.nationalhomeless.org/

National Low Income Housing Coalition - http://nlihc.org/

Substance Abuse and Mental Health Services Administration - http://www.samhsa.gov/

U.S. Department of Housing and Urban Development – http://portal.hud.gov/hudportal/HUD

U.S. Department of Health and Human Services – http://www.hhs.gov/

United States Interagency Council on Homelessness – http://www.usich.gov/

APPENDIX J FOOTNOTES

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128 There must be a finding of dependency or neglect for the child to be committed to the Cabinet and placed in foster care. Kentucky Revised Statutes (KRS) 620.140.

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135 AYS believes they would be able to maintain 20 emergency shelter beds if adequate funding were available. At a minimum, $20,000 in additional funding would allow AYS to regain the staff position lost this year so that they could provide adequate services to 10 youth on a daily basis. In order to add beds, a larger facility is needed. Their current annual budget includes $46,350 in fixed expenses and $335,085 in variable expenses for the shelter program. Adding an additional 10 beds, therefore, would roughly double the expense. The cost is greater for youth under 18 years of age because of the state required supervision ratios. Staff-to-youth ratios would need to be considered in determining the specific cost of incrementally increasing shelter beds between 10 and 20. For example, 11 beds would not be as cost-efficient as 16 beds due to required ratios.

136 Information provided by AYS.

137 The program currently has a budget of approximately $29,000 per year. To expand this program, a full-time staff member would be necessary. Even so, AYS approximates that they could serve 20 youth per year and hire a full-time case manager for the program for a total of $70,000 (an increase of $41,000 over the current budget).

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139 The following providers have recovery services for men: The Hope Center - 269 beds; The Lighthouse - 12 beds;

The following providers have recovery services for men: The Hope Center - 269 beds; The Lighthouse - 12 beds; Shepherd's House - 31 beds; and Volunteers of America serves 40 veterans. The Lighthouse has a waiting list of 13 and Shepherd's House has a waiting list of 15. The Hope Center, Shepherd's House, and the Lexington Rescue Mission provide transitional housing for individuals that have completed a program. Hope Center Hillrise Apartments houses 40 with an unmet need of 200; Shepherd's House houses 10 with an unmet need of 40; and Lexington Rescue Mission houses 14 with a waiting list of 8. Recovery beds for women are provided by The Hope Center and Chrysalis House. The Hope Center serves only women and has 70 beds with 40 on the waiting list. Chrysalis House serves single women and women with children less than two (2) years of age, and has 70 beds with 75 on the waiting list. The Hope Center, Chrysalis House, and the Lexington Rescue Mission also provide transitional housing for individuals that have completed a program. Hope Center Rouse House houses 40 with an unmet need of 60; Chrysalis House houses 105 with an unmet need for 50, and the Lexington Rescue Mission houses 12 with an unmet need of 30. The Schwartz Center, which serves both men and women, is operated by bluegrass.org, and has 20 beds for short term residential substance abuse treatment.

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155 The Commission understands that it is difficult to obtain a reliable street count because it can vary on a variety of factors including the weather. The Commission, however, does feel that it is important to include it in a set of indicators to be evaluated.