MAYOR'S COMMISSION
ON HOMELESSNESS

November 28, 2012
Proposed Agenda

I. Review Agenda
II. Public Comment
III. Approve minutes of last meeting
IV. Work Group reports
V. Review Draft
VI. Public Meeting, Dec. 13
VII. Public Comment
VIII. Next Steps

Attachments:
Minutes from 11/7/12 meeting
Draft

Meeting Schedule:
December 12, 3:00 pm– 5:00 pm, Phoenix Bldg, 101 E. Vine Street, 3rd Floor Conference Room
January 9, 3:00 pm– 5:00 pm, Phoenix Bldg, 101 E. Vine Street, 3rd Floor Conference Room

Commission Members:
Steve Kay, Councilmember at Large, Chair
Debra Hensley, Business Owner, Co-Chair, Chair, 1990 Mayor's Task Force on Homelessness
Mark Davis, Pastor, First Presbyterian Church
James P. "Ike" Adams, Dean, UK College of Social Work
Melody Flowers, Assistant Director for Strategic Planning, UK Healthcare
Lisa Adkins, Blue Grass Community Foundation, President/ CEO
Laura Babbage, Clergy Member, Community Volunteer
Michelle Beverly, FCPS Student Support Services, Associate Director
Claudia Blaylock, Central KY Housing and Homelessness Initiative, Chair
Rocky Burke, LexTran, General Manager
Linda Caroll, Business Owner, Downtown Resident
Rev. Dr. Alberto Carrillo, Bethel Hispanic Church
Catherine Deflorio, Legal Aid of the Bluegrass
Bill Embry, St. James Place
Kevin Fleming, Kentucky Department of Advocacy
Jessica Gies, Lexington-Fayette Urban County Government, 5th District Legislative Aide
Mary Hunter, Homeless Representative
Janice James, Hope Center, Deputy Director, Recovery Program for Women, Director
Laverne Laine, Lexington Housing Authority
Sherry Maddock, East End Resident
Randy Moler, VA Medical Clinic Homeless Program
Doug Pape, Lexington Division of Police
Don Ralph, Eastern State Hospital, Former Director
Harry Richart, Community Volunteer
Kate Savage, Community Volunteer
Mike Scanlon, Community Volunteer
Joe Shuman, Homeless Representative
Darlene Thomas, Bluegrass Domestic Violence Prevention Program, Director
Tanya Torp, United Way of the Bluegrass, Community Engagement Coordinator
Brian Varble, Calvary Baptist Church, Minister of Missions and Recreation
Ginny Vicini, New Beginnings Bluegrass, Inc., Executive Director
Kyle Whalen, Community Volunteer
Kathy Witt, Sheriff

Mayor's Commission on Homelessness Meeting
3rd floor conference room, Phoenix Building
Wednesday, November 7, 2012
3:00 to 5:00 pm

DRAFT Minutes

Commission Members Present:
Steve Kay (Chair), Debra Hensley (Co-chair), Melody Flowers, James "Ike" Lawrence, Darlene Thomas, Kathy Witt, Catherine DeFlorio, Claudia Blaylock, Linda Carroll, Jessica Gies, Kate Savage, Janis Durham, Joe Shuman, Harry Richart, Bill Embry, Janice James, Kyle Whalen, Doug Pape, and Don Ralph.

LFUCG Staff (members) present:
Shaye Rabold, Office of the Mayor
Leah Boggs, Legislative Aide to Steve Kay

Guests:
Connie Milligan, Billie Mallory, Ike Lawrence, and Sandra Zupan.

The meeting was called to order at 3:05 pm by Steve Kay, Chair of the Commission.

Agenda
The agenda was sounded and there were no changes.

Public Comment
There was no public comment.

Minutes
The minutes from the last meeting were approved as submitted.

Work Group Preliminary Reports

Survey – Don Ralph reported that the work group has prepared the survey as a structured interview and have asked questions that are not usually asked. They are conducting the survey at the New Life Day Center, Catholic Action Center/ Community Inn, Phoenix Park, the Salvation Army, the Hope Center, Bluegrass Domestic Violence, and MASH. They should have the data by the end of next week and their next steps are to determine how to analyze the data.

Shelter/Housing – Kyle Whalen reported that the work group believes that the focus should be on the lack of affordable housing, and housing certain populations such as youth, the mentally ill, and women and children. The Commission should not focus on building more emergency shelters.

Prevention – Debra Hensley reported that a significant portion of foster children aging out of the system become homeless due to a lack of structure and support. They may also have some untreated mental illness. The work group believes that this is an important area of prevention on which the Commission should focus by providing housing and advocating for legislative change to the foster care system.

The work group also believes there is a need for medical respite care for people being discharged from the hospital that need assistance in recuperating.

Kate Savage discussed mental illness and the revolving door of homelessness. There is a significant need for mental health advocacy, housing, treatment, and case management. Connie Milligan mentioned the loss of Medicaid or Medicare eligibility if you are in a hospital or jail. She also discussed the Mobile Outreach Team. It appears that there is a need for both assisted outpatient treatment and a mental health court. A mental health court is similar to veterans or drug courts where you have a hearing officer that specializes in the area and a team of persons working with the individual to solve the problem. The Commission should advocate for legislative change in these areas. There is also a definite for additional housing that includes case management.

Another important aspect of prevention is affordable housing. Claudia Blaylock explained that HUD considers you to be cost-burdened if you pay over 30% of your income for housing. In 2005, 18% of renters in Lexington were paying over 50% of their income for housing. In 2011, 24% are paying over 50% and 50% are paying over 30%. Many Lexington households are one paycheck away from homelessness so any emergency (car repair, job loss, medical treatment) can send them over the edge. Housing costs have risen, income hasn't risen, and federal money for subsidies has decreased.

Catherine DeFlorio discussed the barriers to housing for survivors of domestic violence including a security deposit, utility deposit, landlord refusing to let the abuser off the lease, bad credit, and criminal convictions. Some states have passed legislation giving survivors of domestic violence protection in these areas. Advocacy for this legislation could be a recommendation of this Commission. Sheriff Witt suggested partnering with the judiciary to educate them on these issues. The Commission should also encourage stronger relationships with the landlords so that we can educate them regarding these issues.

Resources – Shaye Rabold reported that the work group is working to identify innovative resources not currently being used in Fayette County. One solution is social impact bonds which are a way to leverage private equity into social issues. The private investor invests in a government program that it believes will be successful. If the program is successful, the investor is paid from the savings generated by the program. Therefore, the private investor is taking the risk on the failure of the program allowing governments to experiment and scale services. They are very recent. The United Kingdom first issued one in 2010 for lowering recidivism in jail. New York and Massachusetts have issued requests for proposals. However, there is a concern that it is not scalable to Lexington.

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There are 4 parties to the transaction: the government, the investor, the intermediary, and the bundler. The investors provide quality control. Harry Richart mentioned that there are a lot of investors looking for opportunities. Steve Kay asked to be provided a specific example of what's being done.

The group is also looking at social networking as an engagement tool. It is part of the Bloomberg Challenge proposal and Lexington has made it to the top 20. The Commission believed that bringing more human capital to the table was important.

The Committee also believed that a single point of entry and coordination was useful. It would help with the redundancy in the system and the competition for funds. It might also assist in involving the faith community involved.

Day Services – Doug Pape and Leah Boggs reported that the work group saw a need for a 24 hour facility for the hard to serve and extended hours for a day center including restrooms, laundry, storage, computer, telephone, and mail. They are also investigating the need for 24 hour day care.

Discussion

The Commission discussed that we will always need emergency shelter but it is a stop gap measure and should not be the focus of the Commission. The Commission should focus on the prevention of homeless and re-housing people rapidly. The discussion turned to affordable housing and the need for housing for individuals with no income and those that need case management.

Steve Kay noted that there was a fair amount of consensus regarding the nature of the problem and the needs including prevention, housing, and support services. The Commission is building toward drafting recommendations and then can discuss the priorities. Steve Kay also explained that the information from in the packet is information to use as you see fit. Please let Leah or Shaye know if you have any questions or corrections. Shaye Rabold explained that the recommendations from the 2008 Needs Assessment and the 2010 Ten Year Plan were included because part of the charge of the Commission is to reaffirm, change, or add to these recommendations. All of the previous reports will be referred in the Final Report.

Public Comment

Billie Mallory suggested that it might be helpful to have David Christiansen come and talk about affordable housing. She also announced that November is National Homeless Awareness Month.

Next Steps

The staff will start to integrate reports and formulate recommendations to be reviewed at the next meeting. Debra Hensley inquired if the Commission was missing anything and Shaye Rabold asked if we were headed down a wrong path.

Sandy Zupan said information regarding affordable housing trust funds in other locations would be helpful. Steve Kay mentioned that the Affordable Housing Trust Fund Task Force has made specific recommendations to the Council and the Commission has asked Council to delay acting on those recommendations until the Commission can finish its work. He anticipates that the Commission will recommend some mechanism for affordable housing whether either by adopting or modifying the current recommendation.

The meeting adjourned at 4:35 pm.

DRAFT 5 11/26/12

FOR DISCUSSION ONLY. ALL ELEMENTS TENTATIVE AND SUBJECT TO REVISION UNTIL FINAL APPROVAL BY THE COMMISSION

((Please follow these directions for drafting: Use Arial 12; use no formatting except for tab indents; use single spacing; forward all inserts or draft revisions to Leah, who will keep the master draft; enter any changes in the current draft in "track changes" format, so Leah can cut and paste the changes))

I. EXECUTIVE SUMMARY

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.

The homeless.

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 right before our eyes 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 the face of "Mary Francis", a single mother escaping from domestic violence.

Mary Francis had a bad boyfriend and a good dog. Getting rid of the boyfriend meant a ride to the emergency room and no place to return to when she was discharged. It was easier to find a home for the dog than for Mary Francis.

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

That homeless

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

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.

Read the 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 on 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

Recognizing the complex set of issues presented by people finding themselves without adequate shelter, Mayor Gray created the Commission on Homelessness in July, 2012. 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."

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 practices examples from other communities. The homeless are not a group, class, or category. Because the homeless are not one "thing", one "entity", there is no one size fits all solution. The implication is simple. Multiple problems require multiple solutions.

Because the primary encounter with homelessness for most citizens is with the chronic 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. We believe that hard working folks can find housing if they want. We believe that high school students can't really be on their own sleeping one week on this couch and the next week on that. We 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. We believe that hospitals would never release anyone out of an emergency room without someplace to recuperate from their injury or illness. We believe that a nation that honors its veterans must surely attend to their needs after service. We believe that mental illness and disability can surely be dealt with by a crisis line or a pharmacist. We believe that mothers with children can't really be without shelter or a roof over their heads. It is a long list of what we believe. And because we believe these things it is hard to see the truth. Of the approximately 2,000 homeless folks in Fayette County, only 125 at most fit the profile we have in mind when we hear the word homeless.

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

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 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.

IV. CATEGORIES

A. Domestic Violence

1. Description

Domestic violence is the immediate cause of homelessness for many women and children. A study by the National Law Center on Homelessness and Poverty ranks domestic violence as the leading cause of homelessness in the nation. Some studies have shown that between 90-100% of homeless women report that they have been victims of domestic violence.

2. Present Services

Bluegrass Domestic Violence Program, Inc. (BDVP) serves male and female survivors of intimate partner violence and their children from a 17 county region. 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 main office and emergency shelter is located in Lexington-Fayette County

The emergency shelter has 32 beds, but the shelter 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.

3. Gaps/needs

Most of the clients are currently served without providing them 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 transfer utilities into their name, 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 domestic violence often need to be released from a lease or utility contract.

90% of the clients who end up in shelter could be served without shelter if more money were available for housing and case management. Service providers have difficulty placing some clients with private landlords for a variety of reasons. Some clients have criminal histories, or poor credit, rental, and employment histories, or inability to pay security deposits, first and last month's rent, and utility deposits, or the have 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 domestic 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.

4. Recommendations

Seek additional funding to allow services to be provided without the need for emergency shelter.

Increase housing for those needing transitional housing and for those ready to leave transitional housing.

Legislative and policy change – Lobby for laws and policies which allow victims of domestic 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 trafficking.

Education and outreach to private landlords to facilitate housing for survivors of intimate partner violence.

a. Priority level (important, very important, extremely important, critical)

Very important

b. Prevention

If affordable housing 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.

c. Services

d. Resources needed: financial, volunteer, partnerships, other

Financial resources for housing and case management.

e. Timeline: short, medium, long

Short – Education and outreach to private landlords, courts, and utility companies.

Medium – Housing and funding to serve in place without moving to emergency shelter.
Long – Advocacy for legislative change and policy changes.

f. Agency/organization/person responsible

B. Mentally Ill

1. Description

Approximately 20% of the homeless population has some sort of mental illness: 15% have severe mental illness or co-occurring condition (dual diagnosis); and 5% have less serious mental illness.[i] However, they account for 62% of the multi-service system cost expended by a community for homelessness.[ii] This group includes men, women, and young adults. Their condition can range from independent with the correct medication to the need for permanent housing with case management. This population started to increase with the deinstitutionalizing of the mental ill by the federal government in the 1960's and has continued to increase as both federal and state governments withdraw funding in this area. As the population is aging, it is sometimes difficult to place mentally ill individuals in nursing homes.

In Lexington and the surrounding counties, initially most individuals with some level of mental illness are taken to Eastern State Hospital. However, only 25% of the individuals brought to Eastern State for evaluation meet the criteria for admission. The remainder is released. 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.

Little resources are provided for outpatient treatment. In fact, there are more mental health resources provided within the corrections system than outside of it. Because there has been no good alternative proposed to fill this gap, law enforcement has become the last resort, resulting in the increased criminalizing of mental illness.

2. Present Services

Currently, emergency shelter for men is provided by the Hope Center for Men and the Community Inn. The Salvation Army and Community Inn provide emergency shelter for women but they are not counted separately than the general population. Bluegrass Mental Health and Mental Retardation (Bluegrass MHMR) provides outpatient care, case management, and housing. New Beginnings provides case management and housing. Bluegrass MHMR provides 2 beds of emergency shelter, 28 beds of transitional housing, 4 personal care beds at Eastern State, and 29 in permanent supportive housing. New Beginnings provides permanent supportive housing for 38 people. The Catholic Action Center provides housing for 16 people while they are awaiting placement at the other facilities. 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 for the mentally ill and this number will increase if the state moves forward in closing personal care homes.

3. Gaps/needs

Given the federal and state policy changes, and that this part of the homeless population is the hardest to reach and the most difficult to serve, there are many critical needs. There is a need for: street outreach;[iii] a central intake/triage center[iv] where services can be provided for those not admitted to a psychiatric facility; mental health courts to divert criminal charges if the individual receives treatment; agreed outpatient treatment to require them to follow the case plan; assertive outpatient treatment; and at least 100 more beds of permanent supportive housing. The housing can be provided scattered site with case management according to the needs of the individual. Changes in state law regarding mental health courts and agreed outpatient treatment, and policies regarding Medicaid and managed care are also needed. There is also a need for community outreach and education regarding these issues.

4. Recommendations

Develop a program of "street outreach" to provide treatment to the mentally ill before they cycle through the jail and hospital system. Provide a Triage/Central Intake location to provide services to the individuals that are not admitted to Eastern State, to prevent them from ending up on the street.

Legislative Change - Lobby for the creation of a mental health court and changes to the agreed outpatient treatment law.

Policy Change - Lobby for changes to the state's Medicaid system regarding funding for assertive outpatient treatment.

Local government - Expand the payee program and provide more opportunities to assist this population with obtaining disability benefits.

Provide funding for housing and case management for 200 beds through both Assertive Outpatient Treatment and Housing First programs.

a. Priority level (important, very important, extremely important, critical)

Critical

b. Prevention

Outreach and treatment to this population will significantly reduce the homeless population and the costs of multi-system service.

c. Services

d. Resources needed: financial, volunteer, partnerships, other

The main resource needed is financial. Partnerships with the providers currently serving in this area would provide coordination and ensure that no one was falling through the cracks. There is also a volunteer opportunity for mentors.

e. Timeline: short, medium, long

Housing – short
Street outreach - short
Triage - short
Payee program - short
Legislative change for agreed outpatient treatment - long
Legislative change for mental health court - long
Policy change for Medicaid – long

f. Agency/organization/person responsible

C. SUBSTANCE ABUSE

1. Description

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

2. Present Services

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 women with children 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.

3. Gaps/needs

There is an unmet need for 28 recovery beds for men and 240 transitional housing beds. There is an unmet need of 115 recovery beds for women and 110 transitional housing beds. (would we need more transitional if we had more recovery?)

4. Recommendations

Provide an additional 115 recovery beds for women. Provide transitional affordable housing with case management for 240 men and 115 women.

a. Priority level (important, very important, extremely important, critical)

Recovery beds for women – critical
Transitional housing – critical

b. Prevention

There is currently a significant need for recovery beds for women, many of which probably have children. The children may be in the care of relatives or the state. Providing substance abuse treatment for these women will not only assist in preventing homelessness for these women but also their children later on in life. It will also decrease the total cost of homelessness if the children are in state care.

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.

c. Services

d. Resources needed: financial, volunteer, partnerships, other

The main resource needed is financial. Partnerships with the providers currently serving in this area would provide coordination and ensure that no one was falling through the cracks. There is also a volunteer opportunity for mentors and assistance to these men and women in transition.

e. Timeline: short, medium, long

Recovery beds - short
Housing – short

f. Agency/organization/person responsible

D. YOUTH AND YOUNG ADULTS (18-24 years old)

1. Description

The children in emergency shelter can be literally homeless (runaways and kicked out of the house), committed to the Cabinet but not yet placed, have parents in other homeless shelters, or have homes where it is not appropriate for them to stay at that time.

Upon turning 18 years old a youth who has been committed to the Cabinet for Families and Children (the Cabinet) and has not been adopted has 12 months to decide whether he or she wants to remain in the state's care.[v] 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.[vi] If the youth "opts-out", he or she receives no further assistance from the state.[vii] The youth are considered to have "aged-out" of foster care. Approximately 20% of the homeless population in Lexington are young adults (18-24 years old), most 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.

2. Present Services

Currently, Lexington-Fayette County has 10 emergency shelter beds for youth under 18 years of age and 80 transitional independent living beds.[viii] The present shelter services provided for youth under 18 years of age appears to meet the need.

Like other social workers in the nation, social workers in Kentucky are overworked and underpaid. Little attention is able to be paid to the youth that are aging out and opting out, 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.

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 4E 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.

3. Gaps/needs

There is significant unmet need of 80 more independent living beds for youth who age-out of the foster care system. 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.

4. Recommendations

Provide transitional living, including housing and case management, for eighty (80) youth between the ages of 18-24 years old.

Legislative and Policy Change

Lobby for: legislative changes to the foster care laws to allow more time for youth aging out to opt-in to the system; policy changes to the Chafee program to include housing and case management; changes to the Medicaid system to allow for coverage for these youths; and funding for housing and case management until the age of 25.

a. Priority level (important, very important, extremely important, critical)
Transitional independent living housing – critical
Legislative and policy change – very important

b. Prevention
Addressing the complex issues regarding youth aging out of foster care 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.

c. Services

d. Resources needed: financial, volunteer, partnerships, other
Currently, MASH of the Bluegrass, the Methodist Home, and Bellewood are all serving this population. It is important to partner with the current providers to most efficiently use the scarce financial resources and obtain other resources, including grants. There are grants available in this area.

e. Timeline: short, medium, long
Medium

f. Agency/organization/person responsible
Department of Social Services, Division of Youth Services

E. FINANCIAL CONSTRAINTS

1. Description
This group accounts for 68% of the homeless population. The main contributing cause of homelessness for this group is that ((since xxxx)) the cost of housing has risen 10% while wages have risen only 5.5%.[ix] Also, the federal government has significantly reduced funding for affordable housing.[x] 20% of the population of Fayette County lives in poverty even though most of them are working. This population is literally a paycheck away from homelessness and can fall into homelessness because of loss of job or through sickness of themselves or their child.

2. Present Services
Approximately 116 people are unsheltered, sleeping in parks and doorways, under bushes and awnings, and in other encampments. There are approximately 559 persons in an emergency shelter system designed to serve 419. 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. MASH of the Bluegrass Houses individuals under the age of 18 years of age.

The Hope Center serves only men and sleeps 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. MASH has space for 5 males and 5 females and currently has 5 in shelter.

Transitional housing is provided by the Catholic Action Center, the Lexington Rescue Mission, the Salvation Army, Community Action Council, One Parent Scholar, Volunteers of America, Rainbow House (HIV/Aides), and St. James II (veterans). There is a significant unmet need for these units of approximately 623.

3. Gaps/needs

It appears that there is capacity in the emergency shelter system if housing or emergency shelter are provided for young adults and the mentally ill and transitional and permanent housing are provided. The present need of affordable housing units is 623 but this does not include the persons sleeping on floors, couches, in cars, doubled-up, or in marginal housing.

Some of the barriers to employment include: criminal convictions, 24 hour day care, and transportation.

4. Recommendations

Rental assistance and affordable housing.

Felony bonding for employment.

24 hour day care.

Assistance with transportation.

5. Priority level (important, very important, extremely important, critical)

Rental assistance and affordable housing – Critical.

Felony bonding for employment – Important.

24 hour day care – Important.

Assistance with transportation – Important.

6. Prevention

This group is the largest segment of the homeless population. If they can be provided affordable housing and rental assistance to prevent them from becoming homeless it will have a large impact on reducing the number of chronic homeless and on the need for emergency shelter.

7. Services

8. Resources needed: financial, volunteer, partnerships, other

Financial resources are needed. There is a great opportunity for partnerships with private landlords and the faith community.

9. Timeline: short, medium, long

Rental assistance and affordable housing – Short.

Felony bonding for employment – Short.

24 hour day care – Short.

Assistance with transportation – Short.

10. Agency/organization/person responsible

V. SYSTEMIC RECOMMENDATIONS

A. Housing

1. Description

There are critical junctures at which having a modest level of support and decent housing alternatives will keep an individual or a family from becoming homeless. There are critical junctures at which having a decent place to live will lead to housing independence for those who find themselves temporarily homeless. This is true for people who presently emerge from transitional and support programs with no good options for next steps: people discharged from hospitals, people who age out of foster care, people who time-out of transitional housing programs. Housing with support services for chronically homeless people who often have mental health and substance abuse issues can lead to better lives for them and less dependence on emergency room services and mental health services, and less impact on the criminal justice system.

2. Present services

((Insert list of programs and what they do: LHA, Habitat, Faith Housing, etc.))

3. Gaps/needs

We presently do not have a sufficient supply of adequate housing to meet the needs of our community. ((Insert data on waiting lists))

4. Recommendations

There is a simple answer to the question of how to end homelessness: ensure adequate housing for all those in need. However, the simple answer is not also an easy answer, because the need is so great. 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.

We therefore propose creation of a Housing Trust Fund that builds on and modifies the recommendations submitted to Urban County Council by the Affordable Housing Task Force. We recommend an increase of 1% on all insurance premiums except for health care to create a reliable and consistent source of funding of roughly $3.9 million per year. We recommend that the funds be used to target those in danger of becoming homeless and to support a "housing first" approach to support those who are chronically homeless.

5. Priority level (important, very important, extremely important, critical)

6. Prevention

7. Services

8. Resources needed: financial, volunteer, partnerships, other

9. Timeline: short, medium, long

10. Agency/organization/person responsible

B. Hospital Discharges/Medical Respite

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 a ____basis, there are approximately _____ of individuals they serve who have no housing or safe and appropriate place to stay. Of these _____ are those who suffer from a physical disability, _____ from a SPMI, with or without a substance abuse disorder and _____who are terminally ill. (LIST OTHER CATEGORIES AS ADVISED BY THE SHELTERS)

2. Present Services

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 who contact the various shelters and organizations serving the homeless populations for possible placement. One hospital in particular, Eastern State Hospital, has 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.

3. Gaps

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 and inadequate supply of housing and support services to meet the demand.

In some instances, patients are discharged prematurely because of financial or legal constraints, making recovery more difficult and re-entry to the hospital more probable.

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.

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.

4. Recommendations

Based upon conversations and responses to questionnaires (see attachments) about a "safe discharge" for homeless individuals or for those who are at-risk of becoming homeless; local providers were in consensus that there is a need for additional:

Permanent and Transitional Housing with support services including, but not limited to, housing options for individuals with SPMI diagnosis or SPMI and dually diagnosed with a substance abuse disorder.

Respite Care – follow-up treatment respite care is 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. Unlike "respite" for caregivers, "medical respite" is short-term residential care that allows homeless individuals the opportunity to rest in a safe medical environment while accessing medical care and other supportive services

Shelter-based palliative care for the terminally ill

Availability of maintenance medications for no-income and no-insurance individuals

5. Priority level

6. Prevention

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 services a person with mental illness, substance abuse, and other vulnerabilities needs when leaving an institutional or custodial setting and returning 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.

Good discharge planning weaves together people and agencies who provide services for stable and permanent housing, integrated with ongoing psychiatric and psychosocial treatment/rehabilitation, as well as community services (e.g. transportation, money management, medication management, etc.) to support independent living.

There is a growing body of evidence that the cost of care with a collaborative approach with local hospitals can reduce costs and increase positive outcomes. In an ideal system, service programs are integrated through collaborations, joint ventures, and memoranda of agreement to provide a single point of accountability and service provision from a single location.

7. Services

8. Resources needed: financial, volunteer, partnerships, other

9. Timeline: short, medium, long

10. Agency/organization/person responsible

C. Single point of entry

1. Description

A system for centralized intake is intended to better assess clients early in the process so that assistance can be targeted in a way that is most effective to the client in need and gets them into stable housing as soon as possible. A central 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.

2. Present services

Except for data that is required to be entered into the HMIS database, Lexington does not have a centralized intake program or database. The HMIS data is primarily used to provide information to HUD. Individual agencies use their own intake forms, procedures and some utilize databases separately from HMIS.

3. Gaps/needs

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's story. Therefore,

thoughtful assessment of each individual's needs is an essential part of the process. There is not a one size fits all solution to homelessness. In Lexington, there are numerous resources available to help people in need. While the Commission has found no evidence to suggest that there is a systematic problem with people getting the help they need from the right providers, it is believed that a central intake program would allow clients to access these services quicker, while saving time and resources for both the client and the many providers.

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.

Currently, there is limited or no sharing of information among providers regarding client's needs. A centralized intake program would require providers to share information about their clients and programs.

There are numerous models for a centralized intake program throughout the country. Lexington must design a program that meets its specific needs. It is possible that the existing HMIS system can be enhanced to meet this need. While implementing a centralized intake process is important, Lexington should carefully examine lessons learned from communities around the nation and implement best practices so mistakes can be avoided.

A common assessment tool should be developed with a standard set of questions.

4. Recommendations

The 2008 Social Services Needs Assessment report recommended creation of a centralized intake program. We recommended that Lexington implement this strategy. We recommend that a committee be formed to fully explore how to design and implement a centralized intake program that is best for Lexington. It is imperative that providers be included in the design of the assessment tool, the process and expected outcomes.

5. Priority level (important, very important, extremely important, critical)
Very important

6. Prevention

7. Services

8. Resources needed: financial, volunteer, partnerships, other

Significant financial resources will likely be needed to develop, implement and manage an effective central intake program.

9. Timeline: short, medium, long

Medium

10. Agency/organization/person responsible

LFUCG in partnership with all providers.

D. Data management

1. Description

Accurate data is important to Lexington's effort to address homelessness for a variety of reasons. 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 centralized intake program). 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.

2. Present Services

The two primary sources of data relating to homelessness in Lexington is the annual Point In Time Count and any information generated collected through HMIS.

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 Point in Time Count of people experiencing homelessness. The primary purpose of this count is to determine how many people are homeless at that particular time. 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.

Agencies receiving federal funding are required to use HMIS.

3. Gaps/Needs

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. Information is not shared among providers or routinely used to inform decisions locally.

It takes a great deal of agency staff time to enter the data into the system. This time could be better used serving clients with support services and case management.

There is little buy-in among providers about the usefulness and efficacy of HMIS.

4. Recommendations

We recommend that Lexington 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.

We recommend that Lexington 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.

Data management is an essential part of an effective central intake program…

5. Priority level

Extremely important.

6. Prevention

7. Services

8. Resources needed:

9. Timeline: short, medium, long

Short

10. Agency/organization/person responsible

LFUCG lead, all

E. Coordination/collaboration

1. Description

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.

2. Present Services

Central Kentucky Housing and Homeless Initiative (CKHHI) serves as Lexington's Continuum of Care organization. CKHHI is responsible for Lexington's Continuum of Care application to HUD. CKHHI also advocates for the homeless, homeless service agencies and provides a forum for collaboration among providers.

3. Gaps/Needs

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 prevents 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, the continuum of care process has been codified as well as use of HMIS. As a result, the responsibilities of CoCs has increased and will likely continue to do so.

4. Recommendations

Create an agency (ideally inside government) that is tasked with focusing on housing and homeless issues every day as its principle function. It will provide planning, coordination and awareness about the changing needs and gaps of services within Lexington. The intention of this agency is not to control or direct providers, but rather to serve as an objective source of information and assist in problem solving for difficult situations that require multiple resources and organizations to work together.

Part of this agency would be a homeless ombudsman, which would serve as a resource to convene parties and work to find solutions to difficult situations or the unique needs of a homeless person or family. The ombudsman and the agency as a whole would also serve as advocates for issues relating to homelessness.

This agency could also play a lead role in prioritizing funding needs and monitoring progress.

This agency would also take the lead in the implementation of this plan.

This agency would be the likely home to manage the HMIS program.

5. Priority level: critical

6. Prevention

7. Services

8. Resources needed:

Significant financial resources would be required from both the local government and possibly a portion of federal allocations.

9. Timeline: short, medium, long

10. Agency/organization/person responsible

LFUCG

F. Case management and Support Services

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.

2. Present services

Case management is provided by a number of organizations 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.

3. Gaps/needs

According to the providers that responded to the Commission's questionnaire, more case management and supportive services were the most frequently cited needs.

4. Recommendations

Work to find ways to increase case management and supportive services available to people in need.

Encourage collaboration among providers and LFUCG to find innovative ways to deliver these services.

Work with providers to reduce or eliminate unnecessary paperwork and processes that take time away from literally helping those in need.

5. Priority level (important, very important, extremely important, critical)

Extremely important

6. Prevention
7. Services
8. Resources needed: financial, volunteer, partnerships, other
9. Timeline: short, medium, long
10. Agency/organization/person responsible

G. Supportive services (suggestion to combine this with case management)
1. Description
2. Present services
3. Gaps/needs
4. Recommendations
5. Priority level (important, very important, extremely important, critical)
6. Prevention

7. **Services**
8. **Resources needed: financial, volunteer, partnerships, other**
9. **Timeline: short, medium, long**
10. **Agency/organization/person responsible**

H. Individual Advocacy/ombudsman

1. **Description**
2. **Present services**
3. **Gaps/needs**
4. **Recommendations**
5. **Priority level (important, very important, extremely important, critical)**
6. **Prevention**
7. **Services**
8. **Resources needed: financial, volunteer, partnerships, other**
9. **Timeline: short, medium, long**
10. **Agency/organization/person responsible**

I. Overall funding needs

1. **Description**
2. **Present services**
3. **Gaps/needs**
4. **Recommendations**
5. **Priority level (important, very important, extremely important, critical)**
6. **Prevention**
7. **Services**
8. **Resources needed: financial, volunteer, partnerships, other**
9. **Timeline: short, medium, long**
10. **Agency/organization/person responsible**

J. Education and outreach

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 on danger of becoming homeless, to alert them to the full range of service and support offered in our community. This should be 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 and expand the rage if resources needed to address the issues raised by homelessness.

2. Present services

3. Gaps/needs

4. Recommendations
5. Priority level (important, very important, extremely important, critical)
6. Prevention
7. Services
8. Resources needed: financial, volunteer, partnerships, other
9. Timeline: short, medium, long
10. Agency/organization/person responsible

K. Day center with expanded hours
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.

2. Present services
There are currently 2 day centers that are operating.

3. Gaps/needs
It does not appear that there is a need for an additional day center, but expanded hours for at least one of the centers would be helpful. The goal would be to assist this center in expanding its hours with the recruitment and coordination of volunteers.

4. Recommendations
5. Priority level (important, very important, extremely important, critical)
6. Prevention
7. Services
8. Resources needed: financial, volunteer, partnerships, other
9. Timeline: short, medium, long
10. Agency/organization/person responsible

L. 24 hour shelter for hard to serve
1. Description
The chronic 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 those around them.

2. Present services
The Catholic Action is currently operating a night shelter at the Community Inn and a day center at the Catholic Action Center. It is their wish to combine their operations. This appears to be a good solution if an appropriate location can be found.

3. Gaps/needs
4. Recommendations

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5. **Priority level (important, very important, extremely important, critical)**
6. **Prevention**
7. **Services**
8. **Resources needed: financial, volunteer, partnerships, other**
9. **Timeline: short, medium, long**
10. **Agency/organization/person responsible**

VI. CRITERIA/BENCHMARKS (for monitoring progress, and mechanism for reporting; to be written last.)

VII. CONCLUSION (to be written last)

VIII. APPENDICES:

A. Mayor's Charge
B. Make-up of Commission
C. Definitions
D. Homeless Count Spreadsheet
E. Homeless Count Spreadsheet explanation
F. Homeless in Lexington narrative
G. Provider spreadsheet
H. Links to additional resources
I. Grid/matrix for recommendations

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[i] Louisville study
[ii] Louisville study
[iii] Alabama
[iv] Tucson, AZ
[v] State statute
[vi] State regulations
[vii] State regulations
[viii] MASH of the Bluegrass
[ix] Ten Year Plan to End Homelessness
[x] Ten Year Plan to End Homelessness