

Solving Street Homelessness in Louisville, KY: Improving the Climate of Care for Individuals Experiencing Homelessness

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“The way I feel about it is if someone could walk 10 miles in my shoes they wouldn't say nothing to me. But I hope that one day that they really do get help for us. I hope that they find people that do genuinely care about us because we do have hearts just as well as everyone else. We care about people.”

Louisvillian experiencing homelessness

Homelessness is on the rise nationally, and it is among the most vexing of social problems, one that touches on aspects of virtually every other social policy in a given community and nation. The United States (U.S.) Department of Housing and Urban Development (HUD) defines homelessness as “sleeping in a place not meant for human habitation OR living in a homeless emergency shelter.”¹⁶ Not only does homelessness severely impact the wellbeing of the individuals and families experiencing it, it is costly to society at local, state, and national levels.

Homelessness has long been seen as a complex, multidimensional “social phenomenon often associated with mental illness, poor health, unemployment, and severe poverty.”²² In the U.S. (and therefore in Louisville), all four of those correlates have in recent decades propelled an overall increase in homelessness, as well as some changes in its character. Deindustrialization and wider changes in the U.S. economy after the 1970s have resulted in greater concentrations of wealth, stagnation of wages at the economy’s lower levels, and corresponding declines in public funding for many wider social safety net programs. More recently, the Great Recession and the associated foreclosure crisis devastated many families, negatively affecting their employment, savings, and homes, with communities of color experiencing some of the worst outcomes. This series of events—the unraveling of that safety net, the 2008 recession and banking crisis, then the opioid and drug crises that have exploded in the last few years, means that the “bootstrap” ideology that suggests that anyone can lift themselves out of poverty with enough hard work and perseverance is simply not working out for many Americans.

As a result, today’s homeless residents in Louisville and more broadly still experience mental illness, poor health outcomes, and severe poverty. As of 2016, 16 percent of metro Louisvillians lived below the federal poverty line, and those percentages are much higher in parts of west and south-central Louisville—in some places as much as 90 percent.⁹ As is depicted in this report, many individuals experiencing homelessness claim these high-poverty communities as their last permanent residence. Local poverty is also extremely racialized, with black and Hispanic-Latinx poverty rates more than double that of whites.⁹

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Nationally and locally, the homeless population is an increasingly diverse one. Although poverty, often compounded by violence, poor health, and addiction, remains at the root of homelessness, what is new in recent years is that people experiencing homelessness are also now far more likely to be employed full time in low-wage jobs than ever before.²³ Furthermore, while about 50 percent of Louisville’s homeless residents come from the county’s 10 poorest zip codes, it is also the case that people come into homelessness from every one of the

Jefferson County zip codes (see Figure 13).²⁴ Aging single men constitute a smaller proportion today of the homeless population than they once did: there are now significant homeless subpopulations of women and youth, as well as of people who are elderly, disabled, and/or identify as LGBTQ. Strikingly, the numbers of homeless families have also risen significantly in recent years. The faces of the homeless population are changing, and there is no “one size fits all” solution to their problems.

Since 2014, there has been a steady rise in people made homeless by being victims of domestic violence, with a 17 percent increase among this group from 2017 to 2018 alone.¹

Because Kentucky ranks high nationally in homeless families with children, a lack of family shelters and affordable family housing units are among the most urgent dimensions of today’s local homelessness crisis.²⁵ Homelessness and housing instability have increased in school-aged children’s families and in English-as-a-second-language households.²⁶ Those experiencing homelessness because of domestic violence are an especially pressing aspect of this problem: since 2014, there has been a steady rise in people made homeless by being victims of domestic violence, with a 17 percent increase among this group from 2017 to 2018 alone.¹ The prevalence of these significant subpopulations of the homeless, many of whom have experienced trauma, underscores the increasing need for specialized care that is trauma-informed.

One result of these national social and economic changes is the dramatic increase of unsheltered homelessness, defined as living on the street, in a car, or other place not meant for human habitation. Over the last decade American cities have seen a rise in homeless encampments, to the point where such encampments are now an ongoing feature of urban life in Louisville, as elsewhere.²⁷ Locally, the overall homeless population declined by 27.6 percent from 2012 to 2016, but grew by 5.1 percent from 2016 to 2017. Recent growth in the unsheltered homeless population started in 2016, rising 22.2 percent from the previous year, followed by a 4.2 percent increase in 2017. If, in light of current shelter options, every homeless Louisvillian decided tomorrow to seek shelter, they could not feasibly do so: the number of shelter beds available locally can only accommodate 67 percent of the known people experiencing homelessness in Jefferson County. Additionally, available beds are not always aligned with the subpopulations in need of shelter. That capacity is even lower for families: in Louisville Metro, available family shelter beds can accommodate only 54 percent of the expressed need.

Encampments provide powerful evidence of the inadequacy of local shelters and affordable housing^a alternatives, both in the scarcity of housing and in the restrictions or limitations of shelters that prompt many people to choose not to stay in them. Larger, more visible encampments, such as the one recently cleared from Jefferson Street downtown under the I-65 overpass, have propelled communities such as ours to act to provide new solutions. Interventions made available in late 2018 with emergency funding from Louisville Metro

^a Terms italicized and underlined can be found in the Homeless Glossary of Terms on page 72.

Government, such as paid outreach workers, have saved lives. In addition, the opening of a large low-barrier shelter on December 24, 2018—though not without significant problems—offered accommodations during the coldest of conditions this year to people who would perhaps previously have been unsheltered and likely also barred from shelters in the area for a variety of reasons.

The report that follows originated from that same awareness that new solutions are needed, especially for unsheltered homelessness. Produced by a transdisciplinary team of University of Louisville scholars whose research encompasses multiple disciplines and perspectives, this report includes the following elements:

- 1) a summary and analysis of key aspects of homelessness and related solutions that have worked best in other cities facing similar problems of homelessness and inadequate affordable housing to reduce it;
- 2) a more detailed summary of the status of homelessness in Louisville Metro and an analysis of current services and opportunities designed to reduce homelessness locally and move more people into homes; and
- 3) a set of evidence-driven recommendations (some borrowed from best practices nationally and others already practiced locally and in need of expansion) to reduce homelessness by providing additional services and housing options and to improve support service provisions to Louisville's homeless residents.

The data reported and analyzed here are drawn from multiple sources, in particular an extensive review of both scholarly and popular writings on homelessness policies and practices internationally and locally. Qualitative interviews were then conducted with more than 30 local service providers, advocates, housing professionals, and downtown stakeholders, as well as with over two dozen people directly affected by homelessness, most of whom have elected not to stay in shelters. Included in the data are also the results of several sessions of participant observations of the work of outreach providers.

Across all sources, one salient finding recurred repeatedly: **the only permanent solution to homelessness is housing**. Housing instability and homelessness are intimately linked. People most often become homeless, both initially and repeatedly, because of the prohibitive cost of the housing that is available to them. More than 80 percent of renters and homeowners earning \$20,000 or less are housing cost burdened, or paying more than 30 percent of their income towards shelter.⁹ Louisville Metro has an eviction rate that is twice the national average, resulting in about 14 evictions every day of the year.⁹ Therefore, evaluating solutions to homelessness must involve evaluating options for affordable housing.

The research team approached this study with a belief in the dignity and worth of all human beings and a commitment to integrate the voices of those affected by homelessness. Accordingly, several foundational themes and principles recurred repeatedly across multiple data sources and are reflected in all sections of the report.

- 1) Pre-eminent among these is the significance of **respect**—i.e., recognizing the humanity of people experiencing homelessness, not simply viewing them as a number in line for a meal or as a problem to be solved. A model of *accompaniment*, for example, embodies this respect, as an approach that is distinct from and more mutual and egalitarian than mere charity.²⁸ This emphasis on a sense of unity with people who have been stigmatized is a key ingredient in the work of at least one local service provider with homeless and housing-distressed immigrants, and it represents an alternative model that bears wider recognition among homeless service providers, based on data gathered from interviews with Louisvillians who are experiencing homelessness. Virtually every one of those interviewees reported that sort of recognition and respect as a priority in equipping them to move toward improving their quality of life, whether it be dealing with service providers, police, or even passers-by.

- 2) From best practices and research on communities to anecdotal evidence and individual stories, the importance of recognizing the **resilience** of individuals experiencing homelessness is clear. Biology tells us that nature will find a way, and that organisms have the capacity for resilience – "the capability of a strained body to recover its size and shape after deformation especially caused by compressive stress; an ability to recover from or adjust easily to misfortune or change."²⁹ As human beings, we are hard-wired to fight or flee, and resilience is part of our being. The field of psychology views resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress."³⁰ It is our ability to bounce back and move forward, perhaps better than before. Transdisciplinary science and practice suggest we must appreciate resilience as something that is not uncommon – not a rare superpower – but rather as something all humans have, a kind of ordinary magic, that like a muscle can be strengthened or atrophy. The science of resilience and trauma and stress tells us that resilience is nurtured most by healthy, supportive relationships with individuals and communities. There is a need to train this muscle, as resilience provides a unique opportunity for growth and improvement that should not be missed.

- 3) Homelessness is an issue that affects all Louisvillians, and it will **take the participation of everyone** to ensure that our city lives up to its compassionate, welcoming standards while thriving as an economically competitive city. Too often, among social service providers and other stakeholders in the city, there is duplication, a lack of awareness of what others are doing, or inaccurate perceptions of a problem or a program. The literature reinforces that solving homelessness requires collaboration across sectors, among service providers—and with support from the wider public—to address not only homelessness, but also its root causes. Data from stakeholder interviews also reflect this need, and in many cases, pointed

"I can say that a lot of the women have a home. Some of them, without reading and writing. Some of them without speaking English. Some of them having four, five, six, seven kids. So we're talking about barriers that are huge. Some of them without transportation, and you bring in with that, most of them have been very successful because of that accompaniment..."

Homeless Service Provider

to where communication, coordination, and collaboration are lacking in Louisville’s system. Social network research suggests that network outcomes benefit from strong integration of diverse membership, and the sharing of resources, including knowledge and information.³¹ Louisville’s network of resources—from government, housing, health care, private businesses, media, and social services—needs to serve as the connective tissue of our community that supports all residents equitably, so each person has the opportunity to meet their potential. Given that the purpose of a coalition is to accomplish something that one entity cannot do alone, and the causes of homelessness are broad, strengthening the connectivity of the many entities working to tackle this issue makes sense.

What follows is the most complete synthesis possible within the short time frame of this study (just under six months). Because, as the data clearly showed, the problem of homelessness cannot be considered in a vacuum, solutions as modest as continuing a paid outreach team or as wide-ranging as raising the local minimum wage would produce an ameliorative impact and are among the ideas considered here. As the famed early-20th-century African American sociologist W. E. B. DuBois astutely observed, social science knowledge alone is not enough to repair the deepest social ills, which also require persistent effort and considerable collective political will. Yet, such knowledge is a necessary first step.

BEST PRACTICES

Homeless Services

In 2017, Mackie, Johnsen, and Wood completed an in-depth literature review to assess interventions for unsheltered homelessness.³² Their findings included a brief list of evidence-based practices:

1. adoption of the *Housing First* model;
2. person-centered supports that honor choices made by the individual in need of service;
3. swift action to prevent or end unsheltered homelessness, with a focus on short-term outcomes;
4. assertive outreach targeting individuals with complex needs and those who have experienced chronic unsheltered homelessness, with linkage to services and housing;
5. the provision of ongoing supports to individuals who have returned to permanent housing, to address non-housing needs that could interfere with maintaining permanent housing; and
6. effective collaborations among agencies and across sectors to provide optimal interventions.

The authors add that individuals often find emergency shelters intimidating or unpleasant, thus avoiding them, and that unsuitable or inadequate support—including over-intrusive support—is ineffective.³²

The list that Mackie, Johnsen, and Wood present speaks to the system of homeless services: because unsheltered homelessness occurs within the context of all homeless services, it is essential to understand evidence-based interventions throughout the spectrum of services offered. However, the overarching goal of any application of the system is to end homelessness. Recognized best practices in meeting this goal have shifted from models that couple treatment with housing, or require treatment prior to housing, to the Housing First model, which posits that people are more likely to succeed in achieving health and financial goals while in stable housing.³³⁻³⁶

As a community-level system orientation to ending homelessness, the model proposes removing housing entry barriers and prioritizing housing assistance for the most vulnerable and those with the highest need.^{37,38} Core principles of Housing First include the provision of immediate access to permanent housing without housing readiness requirements, and with consumer self-determination, individualized supports, a recovery orientation, and community integration.³⁶ Creating and sustaining Housing First at the local level requires strong, continued commitment from local government, community stakeholders, nonprofits, and academic institutions working in partnership to meet the goals of preventing and ending homelessness in the community.

Application of this community-wide approach has been demonstrated to make occurrences of homelessness rare and brief; help those individuals and families experiencing homelessness obtain permanent housing in a quick, cost-effective manner; and assist those most vulnerable in a community with accessing multiple forms of care and support needed to maintain housing and achieve a better quality of life.^{37,39-41}

HUD, as the oversight for federal funding of housing and homeless services, requires communities to organize a Continuum of Care (CoC). The CoC acts as the planning body to coordinate all local efforts around housing and services for individuals and families experiencing homelessness. Together with community partners, the CoC works to ensure that programs and services are cost efficient, effective, and offered immediately, if space is available, to individuals and families in the community needing and wanting access. Performance goals of the CoC include:

- Decreasing length of shelter stays;
- Increasing the number of individuals exiting to permanent housing;
- Decreasing returns to shelter; and
- Increasing the number of chronic unsheltered persons utilizing housing and related services.

Elements of an effective Continuum of Care^{37,40,42,43}

- An oversight organization to manage and direct resources to the most appropriate CoC partner for that specific service or program.
- Effective *coordinated entry process* (CEP) for overall management of response system resources, providing users with tools and processes needed to make consistent decisions from available information.
- Outreach, intake, and assessment services that identify service and housing needs of individuals and families experiencing homelessness.
- Quick and efficient connection of individuals and families to the most appropriate service and/or housing resources needed to end homelessness rapidly.
- Emergency shelter when appropriate as a safe alternative to living in a place unfit for human habitation.
- Availability of permanent housing/*permanent supportive housing* (PSH), paired with case management as appropriate, ensuring an individual can maintain housing and service needs over time.
- Effective homeless prevention services throughout the community.

Coordinated Entry Process (CEP)

All people in the CoC's geographic region must have fair and equal access to the CEP and to all services offered; individuals and families should easily be able to access the CEP in person, by phone, or by other methods, with the process for accessing help well known by all sub-populations. Regardless of operating hours for the CEP and assessment, a protocol is in place and followed which provides individuals and families access to needed emergency services if space is available, at any hour of the day, seven days a week.^{42,44,45} Additionally, as a first step in this process, staff connects people to community resources needed to avoid shelter stays, and consistently applies shelter diversion techniques in this triage to help households in self-resolving their housing crisis.^{39,42,44}

The CoC utilizes the CEP to ensure that individuals and families that are most vulnerable and with the greatest needs receive priority for any housing and homeless assistance available. All service providers within the CoC must be equipped to address effectively these needs if offering services utilized by the most vulnerable individuals. Complex needs often include cognitive difficulties, HIV status, co-occurring disorders, multiple chronic conditions, substance use disorders, and Post Traumatic Stress Disorder (PTSD).^{42,44}

Standardized assessment and referral system

The CEP must use a consistent assessment process to gather only information required to determine severity of need and eligibility for services. People must be given the choice to refuse to answer questions during the assessment without fear of losing access to services.^{41,42,46}

Emergency low-barrier services

Within the CoC, *low-barrier* refers to the accessibility of services. Low-barrier services do not turn people away or make access contingent upon meeting certain criteria or expectations. Emergency low-barrier shelters are appropriate as short-term intervention, but are ineffective in reducing long-term, chronic homelessness.⁴¹ When operated in isolation, these emergency services cannot provide a long-term comprehensive response for addressing and eliminating homelessness in a community. Utilizing the principles of Housing First, emergency services must provide immediate, easy access to housing, and then combine housing with supportive services, working to ensure those served rapidly exit emergency services/shelter into permanent housing.^{47,48}

The CoC works through its CEP to prioritize limited emergency services, including shelter beds, by assessing an individual or family's level of vulnerability through a vulnerability assessment tool.³⁹ After an assessment, the CoC prioritizes services for those most at risk from extended exposure to life on street due to:

- Physical and behavioral health conditions,
- Victimization,
- Self-harm, or
- Risks related to inability to take care of own basic needs.

Emergency services, including shelter as well as other supports, must be low-barrier because many individuals experiencing chronic homelessness also experience mental health issues and substance use disorders, or have co-occurring disorders.⁴⁹ This requires training all staff in working with people experiencing trauma, mental health disorders, and/or substance use disorders, among other conditions. Additionally, all staff are trained in supporting individuals and families fleeing domestic violence.⁵⁰ Initial and continued access to emergency services, including shelter, cannot be contingent on housing and/or service readiness, familial status, sobriety, willingness to engage in the practice of a certain religion or belief system, lack of mental health conditions, lack of identification, being unable to meet a minimum income requirement, lack of criminal record, and/or other unnecessary conditions.⁴⁷ People with disabilities are offered clear opportunities to request reasonable accommodations during the assessment process and shelter stay, and all buildings are designed to accommodate individuals with disabilities or who may otherwise need environmental modifications.

Any rules in place around emergency services should be minimal, so the rules themselves do not become barriers to a person's ability to receive and/or maintain services, including shelter. Rules are only in place around safety, health, and/or service consistency.³⁹ The only restrictions to services, including shelter, are related to recent violence done to others (including sexual violence), recent excessive damage to property including arson, and recent theft of property.⁴⁶ Utilizing a minimum rules response requires a shift in messaging from "rules" to "expectations."

Emergency Service Components⁴⁷

- Shelters are open 24/7, every day of the week, with no requirement for people to leave during the daytime hours.
- All emergency services are closely linked to outreach efforts. Through the CEP, the CoC accepts referrals directly from shelters, street outreach team members, drop-in centers, and other parts of the crisis response system frequented by vulnerable people experiencing homelessness.
- People must be allowed to keep pets and possessions with them at all times, with the exception of weapons and illegal substances. Organizations can provide secure storage of these barred items, returning all to clients upon leaving shelter services. If an individual will not relinquish one of these items, they can be asked to leave for that day/night only, invited to return the next day to continue receiving services.
- Access points and shelter offered should be tailored and appropriate for the population served. Specific populations who require separate facilities include:
 - Adults without children
 - Adults accompanied by children
 - Unaccompanied youth
 - Individuals and households fleeing domestic violence
- All staff work with the CoC and CEP to ensure individuals and families who arrive at a location can quickly access necessary services, including housing elsewhere, if their initial point of contact is not capable of serving their specific needs.

Ongoing support and housing

Once the immediate housing needs of an individual or family are met, a multidisciplinary support team works to address the more complex needs of a client through case management and linkage to community services. During this period, the individual or family continues to receive assistance in sustaining housing, with clients working at their own pace towards community integration. However, service engagement is not required to maintain housing.

Encampments

Although homeless encampments are not new to U.S. cities, the number, size, and visibility of them have increased sharply over the past decade due to a number of factors related to poverty, a chronic and severe lack of affordable housing, and other factors, as described earlier. In the eyes of many, homeless encampments are unacceptable in a nation as wealthy as the United States. Yet as one recent study of such encampments found, they are also the “predictable result of policy choices made by elected officials,”²⁷ beginning with major cuts to HUD in the late 1970s. These reductions in *public housing* supports (declining from nearly eight percent of the federal budget to less than one percent by the twenty-first century) were never

compensated for by state and local governments and have affected people most severely at the bottom rungs of the socioeconomic ladder.²⁷

Where such encampments grow and become more visible, the media often report on them, generating widespread alarm over their potential threat to both public health and safety and public image. The majority of U.S. cities have responded with punitive measures ranging from frequent loitering or trespassing citations to large-scale clearances to erecting fences and other barriers to prevent their re-establishment. Criminalizing and clearing encampments is expensive: Honolulu, for example, spent \$15,000 per week, three quarters of a million dollars total, on clearances in 2016, only to have more new encampments re-establish nearby.⁵¹ Moreover, courts are increasingly leaning toward protecting the rights of homeless people and their advocates who file suits based on the way they were treated during clearances, as evidenced in a case filed in Charleston, WV.²⁷

Indeed, encampments may threaten public health and safety, but more so for those who live in them than the community around them.⁵² Yet, camp clearances are typically not effective in getting people into shelter or into housing. Not only is shelter space—as in Louisville—inadequate to house all who live in encampments, but what shelters are available often have policies that prohibit certain subgroups of homeless people from using them (as discussed in more detail elsewhere in this report). Many camp residents are already on long wait lists for housing assistance. Most often, authorities break up one camp only to see many of its residents simply relocate elsewhere, sometimes only a few blocks away. For camp dwellers, such sweeps often mean the loss of their belongings and the destruction of what semblance of stability or community they have.

A few U.S. cities have responded to the growth of homeless encampments with more constructive measures. An increasing number impose clearance notification periods.^{53,54} Some communities have adopted complementary policies that offer protection or storage of displaced persons' possessions in the wake of a sweep. A smaller minority (but one that includes Indianapolis and Charleston WV, for example) have formalized procedures that allow clearances only when alternative housing is provided immediately for every camper cleared.

A handful of cities, mostly in the West (but including Milwaukee) have passed or are considering policies that sanction encampments, at least in limited ways and circumstances. The state of Washington, for example, permits religious organizations to host small groups of campers or car dwellers when certain safety and health conditions are met.²⁷ Sanctioning encampments, however, has its problems, including opposition from some homelessness advocates and service providers, who argue that it unconscionably accepts the inevitability and permanence of homelessness. Additionally, the evidence on the success of sanctioned encampments is limited, and cities do not agree on a single model. Reports offering information about encampment development list key elements of formal encampments, which include access to hygiene facilities and an ongoing relationship with service providers to move residents to permanent housing, such that an encampment is not seen as a permanent solution.^{27,55,56}

Sites are generally chosen because of the proximity to transit and other public services, and provisions range from simple land use to the offering of a village of insulated structures or tiny houses.^{56,57}

Cities who have implemented a sanctioned encampment model presented on their experiences at the National Alliance to End Homelessness conference in February 2019.^{58,59} Anecdotally, these cities reported that situations in which large numbers of people can congregate create chaos and liability to the city, and that the model does not work well for individuals with chronic and persistent mental illness or addiction.⁶⁰ Encampments that work well have remained small and monitored although the associated costs for security, hygiene facilities, and waste removal may be equal to that of a housing subsidy.⁶⁰ Ultimately, sanctioned encampments have not been productive in cost savings for a city.

Without actually sanctioning encampments, criminalization of them can be de-emphasized and support services provided as part of transitioning away from them, as in the case of Charleston, SC. In 2016, Charleston developed and enacted a ten-point plan to transition residents of a large encampment into permanent housing through an ambitious combination of engaging the private sector, enlisting law enforcement in non-traditional roles, and building an expansive branding and fundraising campaign. The resulting dispersal succeeded without destroying any property or making any arrests.²⁷

In any case, supporting or closing encampments initiated by individuals experiencing homelessness means balancing interests among the rights of the camp residents, safety and community health, and the interests of economic development of a city.²⁷ A major study of urban responses to encampments nationwide has found that “conducting outreach backed with resources for real alternatives. . . is the approach that has shown the best, evidence-based results.”²⁷ An important blueprint for doing so is a 2015 report issued by the U.S. Interagency Council on Homelessness, which lays out best practice guidelines that stress the following two principles when it comes to ending encampments.⁶¹ First, dismantling an encampment does little alone to solve the problems camp residents face, or even to reduce homeless encampments. Second, the dispersal of a homeless encampment should instead be prefaced by an action plan, consisting of (1) adequate preparation and planning; (2) multi-sector collaboration; (3) intensive and persistent outreach and engagement; and (4) provision of low-barrier pathways to permanent housing.⁶¹ Charleston, SC and Indianapolis are two communities that have employed this approach successfully to reduce encampments and provide homes for more of their residents.

Homelessness and Trauma

It is critical to understand the connection between homelessness and trauma. Early trauma – such as child abuse, neglect, and disrupted attachment – is often part of the pathway to homelessness,^{62,63} and violence in adulthood is a likely continuous theme, with domestic or intimate partner violence as a significant predictor of homelessness as well.⁶⁴ Exposure to other

kinds of trauma, such as that following combat, accidents, and disasters, is also an incredibly common history among the homeless. In addition, homelessness itself may be traumatic, as individuals face a myriad of challenges, including but not limited to the loss of their home, routine, community, stability, and social networks. Homelessness often involves adjusting to life in a shelter or on the street, along with issues of marginalization, isolation, prejudice, and discrimination. Individuals who are homeless, especially women and children, are at risk for victimization and violence, and for many reasons are often re-traumatized.^{65,66}

This vicious cycle makes coping incredibly difficult, as individuals who are homeless face innumerable obstacles, and trauma has likely compromised their sense of safety, self-regulation, sense of self, perception of control, self-efficacy, and interpersonal relationships.⁶⁷

Some people demonstrate resilience in the face of such challenges,⁶⁸ showing few symptoms or recovering quickly from trauma, while others suffer more severely. That is, stress and trauma affect each of us differently, and a number of variables contribute to this, including individual, family, and environmental risk, and protective factors.¹⁰

Protective factors are an opportunity in the trauma outcomes equation, as they mean that biology and stress can be mitigated and there is hope for survival and improvement.

Furthermore, trauma can affect an individual at any level—in terms of physical, behavioral, mental, or spiritual functioning—

yet trauma is often private or ignored, and its effects are infrequently assessed or treated.⁶⁹

Furthermore, the direct impacts of trauma can be serious, varied, long lasting, and costly, both personally and economically. Many homeless residents suffer from trauma reactions such as PTSD or complex trauma, and it is not surprising that depression, anxiety, substance abuse, and other mental illnesses are common among them as well. These issues further complicate an individual's service needs, as those who are homeless are often challenged in their ability to work or maintain social networks or social conventions. "These findings suggest that we will be unable to solve the issue of homelessness without addressing the underlying trauma that is so intricately interwoven with the experience of homelessness."⁶⁷

Homelessness and Trauma-Informed Care – Service Provider Training

The homeless service system provides a unique gateway to reaching trauma survivors who are often forgotten or underserved. Homeless services do well to address the immediate needs of food, clothing, and (often) shelter, but mainly miss the opportunity to effect long-term change by helping individuals and families develop sustained, supportive community connections and progress toward healing from stress and trauma. Organizations, programs, and staff (at every level) who interact with individuals experiencing homelessness have unique front-line access to trauma's impact, and as such, their ability to meet homeless community members with a trauma-informed disposition of safety, warmth, and appropriate structure should be seen as decisive in any effort at reducing or eliminating homelessness. That is, it is essential to promote and provide quality care for those who are homeless or at-risk of becoming homeless that is also trauma-informed.

The evidence-based practice of *trauma-informed care* engages service providers and organizations in learning about trauma and its effects, including vulnerabilities, risk factors, triggers, and vicarious trauma. The focus is on providing services and environments that avoid re-traumatizing individuals receiving care, while also recognizing that providers are not immune

As in medicine, the provision of services surrounding homelessness must *first do no harm*, and should aim to promote resilience, healing and improvement in individuals

to the effects of trauma, re-traumatization, or compassion fatigue. Trauma-informed service delivery recognizes that trauma is common and that it likely influences the effectiveness of any and all human services,⁷⁰ and is thus relevant for staff at all levels. Some examples of how trauma-informed systems may operate are in Table 1.

Table 1. Examples Regarding Trauma-Informed Care

Systems that are <i>insensitive to trauma</i> often...	Systems that are <i>trauma-informed</i> aim to...
<ul style="list-style-type: none"> • Focus on “what’s wrong with you?” • Misuse or overuse of displays of power— keys, security, requirements, etc. • Have higher rates of staff turnover; low staff and client morale • Disempower and devalue consumers • Expect engagement; offer generalized care that may miss individual needs • Label and pathologize consumers • Have a “deficits” approach; see weakness in individual, community, society 	<ul style="list-style-type: none"> • Focus on “what has happened to you?” • Recognize that coercive environments or interventions can cause trauma and re-traumatization • Maintain awareness and training regarding re-traumatization and vicarious trauma • Value consumer and individual voices in all aspects of care • Meet people “where they are;” recognize the importance of targeted individualized care • Take survivor’s perspective and have holistic recognition of person • Have an “assets” approach to individual, organizational and community strengths and resources

Clearly, the language that is used is critical, and working to modify procedures and rules to come across more often as guiding principles that are focused on safety and expectations is in line with this approach.

According to the National Coalition for the Homeless, trauma-informed care is “an overarching structure and treatment attitude that emphasizes understanding, compassion, and responding to the effects of all types of trauma. Trauma-informed care also addresses physical, psychological, and emotional safety for both clients and providers, and provides tools to empower folks on the pathway to stability.”⁷¹ Especially within the context of the delivery of homeless services, trauma-informed care involves creating a climate of safety, trust, and healing in programmatic settings where the goal is to achieve and sustain housing. In general, it

is important to recognize that becoming trauma-informed can involve an individual, a team or organization, a community, a system, or society.

The basic principles of trauma-informed care vary somewhat across workgroups, organizations, expert panels, and researchers. Rather than following a checklist of fixed procedures, a trauma-informed approach involves intentionality and practice surrounding key principles. These principles are meant to be applicable in a variety of settings (e.g., primary care, behavioral health, education, child welfare, criminal justice, first responders, etc.), but may involve language and practice that is more fine-tuned and context-relevant for a given sector.

The Substance Abuse and Mental Health Services Administration (SAMHSA) states that “a program, organization, or system that is trauma-informed:

- realizes the widespread impact of trauma and understands potential paths for recovery;
- recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- seeks to actively resist re-traumatization.”⁷¹

SAMHSA’s six key principles of a trauma-informed approach and trauma-specific interventions are described in Table 2.

At its best, the foundation of trauma-informed care is evidence-based and is an emerging best practice that includes engagement, empowerment, and collaboration on the part of individuals and their families. Its emphasis is on meeting individuals where they are, and recognizing its relevance to crisis intervention. The domains of trauma-informed care and intervention also variously include early screening and assessment, community outreach and building partnerships, and ongoing performance evaluation and improvement.⁶⁷ Systems and organizations for the homeless population should aim not only for training and information sharing of these trauma-informed best practices, but also for reflecting on compliance. That is, service providers should assure trauma-informed intentions are playing out in their day-to-day actions and operations. Again, a trauma-informed approach can be implemented in any type of service setting or organization, although it likely necessitates some specificity within different subpopulations and contexts.

Subpopulations of Homelessness, Best Practices, and Trauma-Informed Care

As noted, an effective CoC employs strong inter-agency collaboration in providing housing, health, education, and human services, as a comprehensive system of care and prevention for the homeless and unstably housed populations. Planning and delivering services for individuals and families experiencing homelessness require awareness, sensitivity, and intentionality surrounding the variety of subpopulations within the community. A service delivery model based on emerging best practices involves coordinated intake and comprehensive (i.e., not

“one-time”) assessment in order to provide timely service and intervention from those in the community’s CoC that match the individual’s needs. Furthermore, because homelessness intersects with multiple other social and health conditions, it is important to address these. However, the scope of this report is limited to solutions to homelessness, and solutions to other issues warrant their own in-depth research.

Table 2. Key Principles of Trauma-Informed Care

Key Principles of Trauma-Informed Care		
1	Safety	Staff and individuals in their care are meant to feel physically and psychologically safe.
2	Transparency and trustworthiness	Decisions and operations are carried out openly to create and sustain trust among staff, clients, and clients’ family members.
3	Peer support	Critical to the service delivery and organizational approach, peer support offers an avenue to establishing safety, trust, and empowerment.
4	Collaboration and mutuality	Interactions among staff and clients happen on a level playing field, in partnership, and power differentials are minimized (including among staff at all levels). Meaningful relationships and the sharing of power are seen as necessary for healing, and every individual in the equation has a role to play in this approach.
5	Empowerment, voice, and choice	A strengths-based effort where individuals are recognized as having capabilities that are validated and nurtured alongside new skill sets. The experiences of staff, clients and their family members are meant to be positive, to be individualized, and to involve choices. The emphasis is on resilience and the opportunity for individuals, organizations and communities to heal and recover from trauma; individual and community assets (rather than deficits) are part of this focus.
6	Respect for culture, history, and gender	There is intention to defy stigmas, biases, and negative stereotypes based on age, culture, race, ethnicity, sexual orientation, geography, etc. Services are sensitive to gender and historical trauma, and there is appreciation for traditions and culture as they are leveraged toward healing.

Homeless children and families

Between 2005 and 2018, The National Alliance to End Homelessness and the National Child Traumatic Stress Network have consistently reported that over one-third of our nation’s homeless population are families.⁷² On a single night in 2018, over 56,000 families, amounting to 180,413 individuals, were homeless. Of these, 16,390 were unsheltered. In one year alone, 478,718 individuals in 150,630 family households used an

“Adult homelessness appears to represent a circumstance through which past childhood adversities are brought forward and associated with contexts of developmental risk for subsequent generations of children.”¹³

emergency shelter or transitional housing space (data reported for Oct 2016-Sept 2017).^{14,73} The data on family homelessness are expected to strongly underestimate its prevalence, as many families and children who are homeless are missed by point-in-time counts and may be precariously housed, living doubled-up with others or couch surfing.

Homeless families are most often headed by a single mom with children who are under the age of six.^{66,74} While homelessness can be found in all geographic areas and among individuals of all ages, occupations, and ethnicities, people of color are disproportionately represented. Demographics aside, most homeless mothers and families have experienced physical or sexual violence. While homelessness is likely the result of many issues, for families, domestic violence is often implicated in why they are homeless. Indeed, adults who report more adverse childhood experiences (ACEs) are more likely to have experienced homelessness.^{13,75,76} Homeless families have thus often had prior experiences of trauma, homelessness itself can be (re)traumatizing, and the negative consequences of trauma and stress may continue to multiply.

Toxic stress can occur “when a child experiences adversity that is extreme, long-lasting, and severe (e.g., chronic neglect, domestic violence, severe economic hardship) without adequate support from a caregiving adult.”¹⁰

Studies of families in emergency shelters, transitional housing, PSH programs show that trauma, depression, and substance abuse often co-occur for homeless mothers, influencing their ability to form safe and trusting relationships, work consistently, and parent effectively.⁷⁷ As an example of the risk to children, one study found that depression in homeless mothers predicted educational and emotional problems in their children. Current research continues to reveal cross-generational transmission of trauma, as well as the influence of childhood toxic stress on cognitive, behavioral, psychological and medical disorders in its victims.⁷⁸

Of course, housing is the immediate solution to homelessness, and is what homeless families need most. However, housing alone may not be sufficient to secure long-term family stability.⁷⁹ Assistance in (re)gaining permanent housing and rapid re-housing are critical to this effort as are services in housing search, financial assistance, and case management. Homeless families require speedy movement out of shelters and into housing of their own. More intensive or long-term supportive or transitional housing may be necessary for a subset of homeless families. A 2014 report lists essential responses to (family and) child homelessness, which include education and employment opportunities, comprehensive needs assessments of all family members, and parenting supports.²⁵ Furthermore, employers can play a role in family stability and wellbeing, and even preventing homelessness, through supportive workplace policies, such as paid parental leave and flexible work hours that allow parents to engage and care for their children.⁸⁰

Following from the findings regarding the effects of stress and trauma, including the potential for toxic stress and especially for families and children experiencing homelessness, additional efforts that emphasize strengthening family interactions and outcomes are necessary. Recall

that the presence or absence of protective factors are among the variables that determine outcomes for individuals (i.e., any of us) in the face of stress and trauma, and these are crucial for children and families in any circumstance. The Strengthening Families Approach has identified five protective factors which, when cultivated, help families and children thrive: parental resilience, social connections, concrete support in times of need, knowledge of child parenting and development, and social and emotional competence of children.⁸¹

In general, homeless families also require access to other supports and programs designed to improve outcomes for children and families, such as positive parenting practices and early childhood services, childcare, behavioral health, and income support. Other cost-effective supportive practices for families working toward residential stability are those that involve trauma-informed care.⁸² Importantly, trauma-informed organizations and staff are more likely to avoid strategies that can trigger trauma symptoms in families (e.g., harsh disciplinary practices).

Elements of a trauma-informed child and family service system⁸³

Agencies, programs, and service providers:

- screen routinely for exposure to trauma
- use developmentally appropriate, culturally sensitive and evidence-based assessments, materials and procedures
- provide resources for families on trauma exposure, its impact and treatment
- strengthen resilience and protective factors in children and families impacted by or at-risk of trauma
- attend to parent and caregiver trauma and its impact on the family system
- emphasize continuity of care and collaboration across child-service systems
- promote a climate of wellness and care for staff and clients alike that minimizes and addresses (experienced or vicarious) trauma and stress

Providers engaged in these efforts should be well connected in the community and able to address a variety of short- and long-term family needs, such as those surrounding income, education, employment, and trauma history and health, mental health, and emotional challenges. Primary supports include helping parents get their children enrolled in school, providing secure transportation to school or work, accessing after school programs, and connecting to other community resources for families. Policies for trauma-informed family-focused spaces (shelters or otherwise) should reflect the specific needs of families and children, and those that do not should be eliminated to minimize triggers to trauma or stress (e.g., tolerating alcohol or drug use among residents may mean greater exposure to community violence or drug dealing). Programs, collaborations, and partnerships that offer parent supports and skills training should aim to promote behavioral and physical health, healthy attachment relations, and awareness of child development, all toward the goal of healthy life-span

development and improving family and child outcomes.⁸⁴ In sum, families need safe, sustained, supportive interactions and healthy relationships, and spaces that are free from perpetrators of violence.⁸⁵

Homeless children and youth

Data on children and youth who are homeless typically come from two sources: censuses of federally-funded homeless shelters and temporary housing programs which are conducted by HUD, and school districts, which are required to collect data and report on the number of students they serve who are homeless.³ In the 2016-17 school year, 1.4 million students nationally (ages 6 to 18) experienced homelessness.⁸⁶ This is well over twice the number of students who were homeless in school year 2004-05 (590,000). This increase may be due, in part, to improved reporting on the part of school districts,⁸⁶ but a good percentage of that increase likely signifies a real increase in student homelessness across the United States. Of those students who were homeless during the 2016-17 school year, 75 percent lived doubled up with other families, 15 percent in shelters, seven percent in hotels/motels, and four percent were unsheltered. The reported percentage of infants and young children in federally-funded shelters during school year 2016-17 is disproportionately high, and data for children and youth who were unaccompanied by an adult are likewise surprising.

Children in federally funded shelters during school year 2016-17:

- 10% infants
- 35% ages 1 to 5
- 34% ages 6 to 12
- 22% ages 13 to 17

Unaccompanied children in federally-funded shelters during school year 2016-17:³

- 2% under age 6
- 10% ages 6 to 12
- 87% ages 13 to 17

Like others in the homeless system, homeless youth share a history of abuse or neglect. Often, homeless youth have been involved in the child welfare or juvenile justice systems, and separation from family members and placement in the homes of strangers is common.⁸⁷ In fact, the number of foster care placements is positively associated with homelessness and victimization for youth and young adults.⁸⁸ Issues surrounding safety and trust are pervasive among homeless youth; they are likely to distrust those in authority, and are unlikely to disclose personal information.

The most pressing needs for youth and young adults who are homeless are stable housing, sustained, supportive connections to caring adults, and access to mainstream services that facilitate long-term stability and success. When safe and appropriate, reunification with family or a support system (and possibly family intervention) should be a priority.⁸⁹ Supports for education and employment are likely needed, along with options for low-barrier short- and long-term housing, including rapid re-housing.

Substantial investments must be made at the federal, state, and local level to prevent children and young adults from entering homelessness and living on the streets. A parallel effort is necessary that is focused on alternative models to house youth in crisis (including shelter

responses that are more flexible, the CoC transitional housing/rapid re-housing joint component,⁹⁰ or host homes), and on expanding the reach and effectiveness of existing housing programs for youth and young adults. PSH options may need to be reserved for homeless youth who are the most vulnerable and in need of intensive intervention to exit homelessness. Another major gap in most youth and young adult services centers on the systemic response: a single, coordinated community response that involves collaboration among local, state, and federal partners is needed.

Similarly to adults and families, best practices in efforts for youth and young adults who are homeless begin by meeting the individual's most immediate needs first. Next steps involve tailored, age-appropriate programs where institutional demands are minimal, services span a variety of topics (educational outreach, employment training and assistance, transitional living, health care)⁹¹ and individuals have options to choose from to help them regain stability. More generally speaking, efforts to fight poverty and homelessness for adults (e.g., improved wages, affordable housing, etc.) will benefit homeless youth down the road.

Trauma-informed support for homeless children and youth often mimics what is needed for families who are homeless. Building safety and trust are key, as are assessing readiness and prioritizing immediate needs through age-appropriate tools and programs. Youth experiencing homelessness need a youth-friendly environment, and developmentally appropriate options and skill development in the areas of communication, emotion regulation, decision-making, conflict management, problem solving, and self-care.⁹² Recognition of the need for safe, sustained, supportive interactions and healthy attachment relationships for children and youth is vital, and providing spaces that are free from perpetrators of violence is a necessary component.^{87,91}

Homelessness for victims of domestic violence

Perpetrators of domestic and intimate partner violence often work to damage their victim's economic stability, and issues with poor credit, eviction, unemployment, or medical debt (following from their abuse) make it especially difficult to secure rental properties. Studies indicate that 22 to 57 percent of all homeless women report domestic violence as the immediate cause of their homelessness.⁹³ On a single day in 2015, records indicate that over 31,500 adults and children fleeing domestic violence utilized a domestic violence emergency shelter or transitional housing program, and yet domestic violence programs left over 12,197 requests for services unmet due to lack of funding, staffing, or other resources. The majority of these of unmet requests (63 percent) were for housing. Emergency shelter and transitional housing are consistently the most urgent unmet needs for survivors of domestic violence. Studies exploring the causes of homelessness among mothers with children consistently reveal that more than 80 percent report previously experiencing domestic violence.⁹⁴

The immediate need of a survivor fleeing domestic violence is safety. Rental assistance may help some survivors who can safely stay in their own home. Other survivors may require an

emergency shelter or transitional housing program before regaining their own independent housing. Available short- or long-term rental assistance can be used to help survivors exit shelter and re-enter housing.⁹⁵ Affordable housing is a priority, as are preventing and reducing homelessness in this population, and minimizing the risk of continued experiences with violence. Research indicates that families that receive a housing subsidy after exiting homelessness are far less likely to experience interpersonal violence compared to those who do not.¹¹

As part of the prescribed CEP, staff must conduct mandatory screening for domestic violence in order to make the safest and most appropriate referrals for services. The CoC and CEP have standards in place around safe entry and assessment options for those fleeing domestic violence, and the CEP can immediately offer available secure shelter locations and/or other secure accommodations to these individuals and families in an emergency. Domestic violence providers partner with agencies in the emergency response and homeless assistance systems in order to ensure people can easily connect to housing and service resources, in cases of domestic violence. Staff are regularly trained in confidentiality and individual privacy rights, as well as HIPAA, the Violence Against Women Act, and other relevant state and federal laws that protect survivors.^{96,97} In accordance with these laws, the CoC partners with domestic violence programs to ensure the CEP safely addresses the needs of those fleeing domestic violence, including the provision of a safe location for conducting assessments, confidential referrals, and data collection that is consistent with the Violence Against Women Act. Clients must also have access to the appropriate services for domestic violence, as well as appropriate housing or homeless assistance services.

In addition to tackling their immediate safety and housing needs, survivors of domestic violence require supportive services that facilitate healing from the trauma of abuse and improving their economic security and well-being. A trauma-informed approach for homeless survivors of domestic violence operates similarly to that of trauma-informed care for families who are homeless. It is even more critical for domestic violence shelters, programs, and staff to operate in a trauma-informed manner, as an

“Having an affordable place to call home is crucial for this population, to both reduce their risk of homelessness as well as the possibility of future violence... survivors of domestic violence [also] require supportive services that can help them heal from the trauma of abuse and improve their economic security and well-being.”¹¹

awareness of potential triggers to trauma and threats to physical and emotional safety is vital. Trust in the organization and provider is key, as is an emphasis on transparency, clarity, and consistency. Survivors of domestic violence can benefit from efforts toward empowerment, shared power, collaboration, and choices. Interactions with providers should be sustained and supportive, and are bound by confidentiality protections for housing and homelessness services. For survivors of domestic violence facing homelessness, the theme of safe, sustained, supportive interactions and healthy relationships, and the provision of spaces that are free from perpetrators of violence is a necessary component.

More generally, it is important to address housing practices and policies, as these often have the unintended consequence of making it harder for women fleeing domestic violence to gain stable housing. Survivors facing homelessness continue to require national, state, and local government supports that include: (1) funding safe, affordable housing and homeless shelters for domestic violence, (2) solid protections against discrimination in housing, and (3) policies that promote transfers to safe housing.⁹⁸

Homelessness and human trafficking

Sex trafficking is “the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion” but for victims under the age of 18, this definition does *not* require being “induced by force, fraud, or coercion.”⁵

Human trafficking, including sex trafficking, is another kind of violence experienced by many who are homeless, especially those who are young. In 2017, findings were announced from the largest ever combined study of homeless youth in the United States and Canada.⁹⁹ This three-year study involved interviews with 911 homeless youth from 13 cities, where the vast majority of victims accessed services through Covenant House. Providing for over 46,000 youth each year in 30 cities within six countries, privately funded Covenant House offers the largest

network of residences and community service centers for homeless youth across the Americas. The 2017 report revealed that over 19 percent of homeless youth identified as victims of human trafficking, with 15 percent as victims of sex trafficking.⁹⁹

The Youth Experiences Survey (YES) was designed by Arizona State University’s Office of Sex Trafficking Intervention Research (STIR) to continue collecting more of this kind of data. The YES study provides data from 2014 to 2016 and indicates even higher percentages: across the three years, an average of 31.5 percent of homeless youth self-reported they experienced sex trafficking.¹⁰⁰

A more recent study of youth experiencing homelessness in Kentuckiana utilized a revised version of the YES and revealed even more startling findings: that over 41 percent of homeless youth in their study reported they had been sex trafficked. Forty-seven percent of female homeless youth and 32 percent of male homeless youth indicated they were victims of sex trafficking. Approximately 65 percent of heterosexual homeless youth, and 28 percent of LGBTQ homeless youth indicated they were sex trafficking victims. Reported ACE scores were significantly higher for sex trafficked youth than for non-sex trafficked youth; emotional abuse, sexual abuse, emotional neglect, physical neglect, and witnessing domestic violence were all significantly more common among the sex trafficked youth.⁶⁵ However, data also indicate that, as vulnerable individuals who are seeking to meet their basic needs, many victims of trafficking do not know they are being trafficked.¹⁰¹

Both the 2017 (Covenant House) and 2018 (Kentuckiana) studies report a greater percentage of women and a disproportionately high percentage of the LGBTQ population have been sex trafficked. According to the 2017 report, though they accounted for only 19.2 percent of the respondents interviewed, LGBTQ youth accounted for 33.8 percent of the sex trafficking victims, and 31.8 percent of those who engaged in the sex trade.

Regarding sex trafficked youth, a researcher from the 2017 Covenant House study describes “youth were seeking what we all seek — shelter, work, security — and the trafficker preyed on those very needs.”⁹⁹ Victims were asked what they needed to avoid or escape such violence and exploitation, and their responses frequently included the same resources that homeless shelters can and do provide them. As described above regarding other subpopulations of homeless, resources are needed, including spaces, programs, and staff that are trauma-informed and equipped to meet the needs of individuals with histories of trauma. “What we need is more resources to support those programs and additional training that help service providers identify and assist those who are most at risk.”⁸

“What does it take for a child to escape homelessness *for good*? Our Continuum of Care model means support for kids at every step of their journey off the streets... Every child’s experience *and life* is unique. That’s why our staff works with each kid individually to develop a case plan that is tailored to their specific needs and goals.”⁸

Stated simply, the CoC at Covenant House provides street and van outreach, crisis care, and long-term support.⁸ Crisis care offers shelter and programs where a homeless youth’s most immediate needs (including safe shelter, medical and mental assessment and care, a hot meal, etc.) are met first, and an individual can enter the shelter at any time, day or night, with no requirement for a referral through official channels. Shelter spaces are designed with the intention of building community, encouraging healthy relationships,

and inspiring individuals to pursue new opportunities. The Mental Health Department at Covenant House sees clients on a steady schedule of referral from either the medical clinic or residential social workers. Additional support strategies include such things as educational programs, job training and placement, medical services, mental health and substance abuse services and counseling, legal aid, and more. Covenant House helps “young people embrace the great promise of their lives, overcome barriers to independence, and strive to achieve their aspirations.”⁸

Models for trauma-informed care like those described for survivors of domestic violence apply equally here, as safety and trust are primary needs. It follows that interactions with providers must be sustained, supportive, and bound by confidentiality protections for housing and homelessness services. For survivors of human trafficking who are homeless, safe, sustained, and supportive interactions and the provision of spaces that are free from perpetrators of violence and stressors that stem from bias are necessary components.

Homelessness and LGBTQ

When asked why they are homeless, the top five responses given by LGBTQ individuals include running away because of family rejection, being forced out by parents, abuse at home, aging out of the foster care system, and financial or emotional neglect from family.⁶ LGBTQ individuals face a particular set of physical, psychological, and emotional challenges, both in becoming homeless and while trying to avoid homelessness. LGBTQ persons live with social stigma, discrimination, and often rejection by their families, which compound the physical and mental strains of homelessness.

According to 2012 data reported by the Williams Institute:⁶

- 40% of the homeless youth served by agencies identified as LGBT
- 43% of clients served by drop-in centers identified as LGBT
- 30% of street outreach clients identified as LGBT
- 30% of clients utilizing housing programs identified as LGBT

Additionally, LGBTQ individuals experiencing homelessness often face inordinate challenges in accessing homeless supports. Shelters frequently fail to demonstrate acceptance of or respect for LGBTQ people.¹⁰² Acceptance is even more limited for transgender people; indeed, some shelters even post signs barring transgender people, or if they do allow them, fail to respect rights as basic as bathroom preferences consistent with their gender identification. LGBTQ individuals experiencing homelessness are at even greater risk than their heterosexual peers for violence and abuse⁶ —as indicated previously, this often includes sex trafficking. In addition, because transgender individuals are turned away from shelters at a higher rate, they share a physical risk that is higher still.¹⁰²

The experience of multiple, interrelated risk factors is especially common among LGBTQ runaway and homeless youth, and outcomes are worse in terms of mental health, physical health, substance use, illegal activity, educational attainment, and employment.¹⁰³ Given the complex trauma that is exacerbated by homelessness, LGBTQ individuals in this subpopulation of homeless often demonstrate impairment that spans many levels of functioning (e.g., affective, cognitive, and behavioral).¹⁰³ It is for these reasons that a holistic, trauma-informed approach to treatment is recommended — “across all program sectors, from clinical to case management to employment to housing services.” Homeless services and programs for LGBTQ youth and adults are best designed to include peer supports, case management that offers attention to mental health needs, and opportunities for voice and choice. Models of care such as the SPARCS, the LGBTQ-affirming comprehensive services model, the IPS model of supported employment, and supportive housing integrated with clinical services are sound models of such trauma-informed, holistic treatment.¹⁰³

The needs of our LGBTQ homeless mirror many of those described for other subpopulations that have experienced substantial marginalization and trauma. Certainly, the foundations of trauma-informed care are relevant to such interactions and the organizations and systems in which they occur. For LGBTQ individuals who are homeless, provisions involving safe, sustained, supportive, and culturally-sensitive interactions that offer a feeling of acceptance (and appreciation), and spaces that are free from fear and stressors that stem from bias are

necessary. Policy advocacy must also be embedded in these strategies for homeless LGBTQ to help eliminate barriers faced when pursuing housing. For example, instead of requiring individuals to use their born-sex on legal documentation, city-level funding requirements could allow self-identification of gender.

Racial disparities in homelessness, and homelessness for people who are non-English-speaking

People of color in the United States are more likely to experience poverty than whites.¹⁰⁴ It follows then, that they also experience homelessness at higher rates than whites experience, and therefore make up an unbalanced share of the homeless population.

Individuals of Latinx ethnicity represent 30 percent of the population engaged by outreach programs, 24 percent of the homeless population placed in interim housing, and 21 percent of those placed in permanent housing.¹⁰⁵ Within homeless services, Spanish translators (not to mention those for other languages) are in short supply, meaning individuals who are non-English-speaking are prevented from understanding rental contracts, legal rights, and many homeless services. Latinx families are frequently altogether unaware of their rights, do not advocate for themselves (often due to fear surrounding their citizenship status), and are less likely to utilize homeless services for some of these same reasons.

Concerns surrounding fear, safety, awareness, and access to human services are relevant to individuals who are homeless and non-English-speaking. There is strong need for providers who cannot

only translate, but who bring cultural awareness and sensitivity (i.e., respect) to their interactions with homeless individuals in this subgroup. Additional needs often mirror those described for other homeless individuals and families. The foundations of trauma-informed care are relevant to such interactions and the organizations and systems in which they occur, and recognition of legal rights is critical. For individuals who are homeless and non-English-speaking, the themes of safe, sustained, and supportive culturally sensitive interactions, and the provision of spaces that are free from fear surrounding citizenship and legal issues or other stressors that stem from bias are repeated as necessary components.

The homeless population in the United States is comprised of:

- 35% African Americans, but this group represents just 13% of the general population.
- 22% Latinx, but this group makes up 18% of the general population.
- 11% (of each group) American Indians/Alaska Natives, Native Hawaiians and Pacific Islanders, and those of more than one race, but each of these groups make up less than 5% of the general population.
- 1.5% Native Hawaiians and Pacific Islanders, which is 7.5 times higher than their representation in the general population (0.2%).
- Both Whites and Asians are significantly *under-represented* among the homeless population.¹⁴

In the United States:

- People with disabilities who experience chronic homelessness make up 24% of adults experiencing homelessness and 5% of families⁷
- Approximately 50% of individuals experiencing homelessness are over 50²¹

Homelessness for medically involved individuals, individuals with disability, and aging adults

Homelessness is both a cause and a result of both physical and mental health problems,^{106,107} and lack of housing is linked to excess mortality.¹⁰⁸ A lack of housing affects nutrition, personal hygiene, first aid, and chronic stress.¹⁰⁹ Homelessness is a major risk factor for both acute and chronic health conditions, including respiratory disorders, cardiovascular disorders, liver disease, and traumatic injuries, and research estimates that the life expectancy of homeless individuals is substantially lower than that of the

general population at 42-52 years.¹⁰⁸ The prevalence rates for both intellectual disabilities and acquired brain injuries are both higher among people who are homeless than in the general population, resulting in a number of individuals with cognitive disabilities.^{110,111} Moreover, as the general population ages, so does the homeless population. Although aging is not itself a health condition, the likelihood of an older individual requiring environmental modifications or medications due to health conditions is higher. National trends have already seen an increase in older adults among those experiencing homelessness, which is associated with the rising burden on public services, including health care.¹¹² Again, evidence suggests that prevention, PSH, and rapid re-housing are best practices for intervention. Current studies are examining the role of both public and private sector entities in funding housing in an effort to prevent the excess health care costs associated with homelessness.¹¹²

However, given the need for emergency shelter, it is essential to ensure safety for the individuals served. In order to meet low-barrier standards, emergency shelters should be ready to serve the basic needs of all clients, including older adults and those with critical illnesses.⁵⁷ First, emergency shelters must be equipped to engage individuals who are experiencing chronic conditions or who need ongoing care. This includes ensuring a shelter environment is accessible for individuals with limited mobility, and that accommodations are available for those who need them. Additionally, strong partnerships between shelters and health care entities are required to provide continuity of care. Partnerships may vary from bi-directional information sharing, incorporating training for shelter staff or shelter tours for clinical staff, or offering a medical outreach team, shelter-based health services, or onsite clinics, which enable providers to physically meet individuals where they are and can assist clients with following through with recommended interventions.⁵⁸

Homeless services also must be prepared to serve people with mental illness, substance use disorders, and dual diagnosis of both conditions. These conditions are by nature chronic and difficult to treat, and the individuals who have these diagnoses may have difficulty establishing trusting relationships with providers.^{59,60} Clients may require repeated, consistent engagements with a familiar provider over time in order to accept treatment opportunities and strategies.⁵⁹ Both outreach and shelter staff require education about behavioral health conditions and training on how to respond, specifically in regards to anger management.¹⁰⁶ Not only should

providers use trauma-informed care for these encounters, they should feel empowered to quickly connect individuals to providers who specialize in treating behavioral health conditions.

One such mechanism for quick response and an evidence-based practice is assertive community treatment (ACT). [33-35] As an interdisciplinary team (including peer support specialists) with widespread availability to provide treatment in the community, ACT teams consist of behavioral health professionals who use assertive outreach to engage clients and address both symptoms of mental illness and substance use. [33, 36] ACT teams can also assist a client with linking to more intense treatment services, when necessary. Another opportunity for intervention is use of crisis diversion programs such as the Living Room model, which serves as a non-clinical space for crisis intervention specific to symptoms of mental illness or substance use.¹¹³ Using a recovery mindset, the Living Room employs peer support specialists to provide short-term assistance during the crisis and potentially link guests to opportunities for additional assistance beyond that moment, in hopes of deflecting the need for emergency room treatment or hospitalization.

In the United States:

- 45% of all individuals experiencing homelessness have any mental illness, and 25% have a diagnosis of serious mental illness²
- 68% of cities reported that substance abuse was the largest cause of homelessness for single adults and 12% of cities report it is one of the top three causes of family homelessness¹⁵

Although most cities now recognize the importance of homeless outreach teams and service providers to have naloxone available, some cities have experimented with innovative solutions around substance abuse and homelessness.¹¹⁴ For example, several cities nationally, including St. Paul, MN offer a “wet house,” in which residents receive supportive housing for persons addicted to or choosing to use alcohol, without the requirement of treatment.¹¹⁵ Although the outcomes for residents might not be optimal (i.e., sobriety and wellness), the intervention eliminates the risk of dying on the streets, as well as the consistent use of more expensive public services, like emergency care.^{114,116} Boston Health Care for the Homeless Program has implemented a harm-reduction program called Supportive Place for Observation and Treatment (SPOT), which has shown promising results in its goal to prevent overdose deaths.¹¹⁷ The drop-in facility offers engagement and medical monitoring to individuals who are over-sedated from substance use, and medical care is available if overdose occurs. Cities outside the U.S. have sanctioned supervised injection facilities, which have been found to improve public health outcomes and costs associated with substance use, while successfully referring participants to recovery opportunities.¹¹⁸ Similar to needle exchange programs, these harm-reduction strategies have not been associated with increases in substance use.^{118,119}

Homelessness for individuals who are sex offenders

Identifying housing options for all sex-offenders is challenging, but providing shelter for individuals listed on the sex offense registry is particularly burdensome. For many years now, laws have prohibited registered sex offenders (RSOs) from living within 500-2,500 feet from

where children tend to gather. While important for the safety of children, these restrictions have created barriers to permanent residence for RSOs within many communities. In reality, because of residency restriction laws, many sex offenders are homeless.

As reported in 2014, in New York City less than 6 percent of shelters allow access to individuals registered as sex offenders.¹²⁰ Of the 850,000 people listed on publicly accessible registries in the United States, 98 percent are men.¹⁰⁵ Adhering to their state's sex offender registration and notification (SORN) and residence restriction laws often leads to marginalization and additional (intended and unintended) consequences for sex offenders and their families, and society alike.¹²¹ Some sex offenders may qualify for public housing, but federal law prohibits lifetime registrants from utilizing this option.¹²² It is commonly recognized that public services in general are limited, regardless of an individual's criminal background, and homeless services (not just the shelter beds) are often altogether inaccessible to sex offenders.

In terms of registration requirements, sex offenders who do not have an address are required to check in with authorities once every 30 days, which differs from those who have a permanent address who must check in once a year.⁴

Across the nation, there is a need for access to homeless services and living space for individuals who are sex offenders and homeless. Best practices include ensuring that individuals with felony charges are assisted with successful reentry into the community following incarceration, with a thorough assessment, the provision of risk-need-responsivity interventions, change-promoting supervision, and stable housing.¹²³ Housing, in conjunction with wraparound services, has been found to decrease the likelihood of recidivism.¹²⁴ Although some states have implemented notification policies, most have established designated shelters for sex offenders, and have removed them from staying with the general population.¹²⁵ However, these policies limit options for these individuals, leaving them at higher risk of experiencing unsheltered homelessness. Ensuring safety through implementation of best practices within a shelter environment can limit instances of sexual violence.

Housing and Community Development

Homelessness intersects with housing and community development issues at a practical level because persons experiencing homelessness are presently without housing. As the sections above describe, housing is consistently put forth as the key solution to homelessness. From a policy perspective, much of the federal funding to address housing, community development, and homelessness flows through HUD. Housing and community development are critical contextual elements for understanding homelessness, and enacting policies that can prevent homelessness. Moreover, housing market characteristics, particularly rent levels, are strong predictors of homelessness. For example, a \$100 increase in median rent is associated with a 15 percent increase in homelessness within metropolitan areas.¹²⁶

The Fair Housing Act of 1968 and its subsequent amendments were designed to eliminate housing discrimination (by race/color, religion, sex, disability, familial status, and national origin) in both the public sector and private market. This legislation was part of the broader Civil Rights movements and intended to dismantle stark patterns of racial segregation perpetuated by racist government policies and actions with the private real estate market. However, progress has been slow at best in reducing housing discrimination and reversing neighborhood racial segregation, both of which are systems level factors contributing to homelessness.¹²⁷

The most recent advancements in federal fair housing policy include the Affirmatively Furthering Fair Housing (AFFH) Rule, issued in 2015. This rule offered guidance to local agencies receiving HUD funding for developing plans that would more directly address housing disparities among protected classes, including exclusionary zoning, lack of affordable housing, and other policies reinforcing racial segregation. Despite evidence that the AFFH Rule resulted in improved housing plans with stronger potential to mitigate fair housing problems, HUD suspended the rule in 2018.¹²⁸ Proactive measures to further fair housing opportunities are necessary to consider as a means of preventing homelessness. In other words, ensuring protected classes have fair access to available housing opportunities and are not prevented from renting or purchasing housing because of their race, familial status, or disability, etc. Further, at the local level, expanding protections by designating additional protected classes to such things as age, source of income, ancestry, domestic violence survivor, sexual orientation, and gender identity is one national best practice for advancing fair housing.¹²⁹ Including source of income as a protected class is one way to improve the utilization rates of Housing Choice Vouchers and prevent landlords from discriminating against persons using this housing subsidy to pay rent.¹³⁰ Criminal history is another potential barrier to housing that disproportionately affects persons of color, particularly African Americans and Latinx, and HUD recommends careful and limited use of criminal history in applications to minimize barriers and promote fair housing.¹³¹

Fair housing is also directly tied to affordable housing. While discrimination within the housing market clearly limits housing choice, it can also increase housing costs for the most vulnerable populations. People most commonly become homeless because they are too poor to pay the costs of housing that is available to them. Providing shelter to the homeless is costly to municipalities, but the only permanent solution to homelessness is permanent housing. Housing affordability is therefore a critical dimension of the broader conversation focused on homelessness and unsheltered populations. Housing is generally considered affordable when costs for rent/mortgage and utilities comprise 30 percent or less of a person's income. For a household earning \$25,000, this would represent a monthly payment at or below \$625. Households paying more than 30 percent of their income towards housing costs are considered cost burdened. Nationally and locally, there are substantial gaps in the supply of affordable housing for the poorest households, or those earning 30 percent or less than the area median income (AMI). There is currently a shortage of 7 million rental units for these households nationally.¹³²

In the context of declining federal government support coupled with stagnating wages, solutions from local and state government alongside nonprofit, for-profit, and philanthropic partners are necessary to meet the growing need for affordable housing. The primary means for funding the construction and rehabilitation of affordable housing is through the Low-Income Housing Tax Credit (LIHTC), and twice as many households reside in tax-credit supported units as compared to public housing.¹³³ While the LIHTC is a vital source of funding, research shows that this program is perpetuating the spatial concentration of poverty as well as racial and ethnic minority households, and many of the units produced with LIHTC are still not affordable to the poorest households, where needs are greatest.¹³⁴

Because of the high costs associated with developing affordable housing, a stable and consistent funding source is necessary for the effective operation of an affordable housing trust fund.¹²

Affordable housing trust funds are a common approach for establishing a dedicated source of financing to address affordable housing needs. As a tool for developers, affordable housing trust funds minimize the financial risk of building or preserving affordable units by providing grants and loans

towards the costs of construction. Because of the high costs associated with developing affordable housing, a stable and consistent funding source is necessary for the effective operation of an affordable housing trust fund.¹²

Inclusionary zoning is another tool localities deploy to bolster the development of affordable housing units. These programs add to the supply of affordable housing by requiring the inclusion of affordable units in market-rate developments or providing development incentives such as density bonuses or relaxed parking requirements to support the creation of affordable units. Research shows that the most important factor in creating affordable units through inclusionary zoning is the length of time the program has been in place.¹³⁵ Considering the current climate of federal retrenchment for funding affordable housing, inclusionary zoning offers another pathway for creating more affordable units with the public sector bearing administrative costs and the private sector fulfilling the financing needs.¹³⁶

Other types of zoning changes that more broadly increase density and permit smaller types of housing can also help grow the supply of affordable housing and promote economically and racially diverse neighborhoods. For instance, Minneapolis recently eliminated its single-family zoning classification, which is intended to both address its housing affordability challenges and entrenched racial segregation proliferated through zoning.¹³⁷ These changes will create denser neighborhoods by allowing the development of more multifamily units. The increase in supply coupled with the creation of comparatively smaller housing units can make housing more affordable. Single-family zoning – along with other racist housing policies (e.g. redlining, discriminatory mortgage lending) – has perpetuated the legacy of racially segregated neighborhoods and concentrated poverty, making this policy change one that can directly address fair *and* affordable housing needs. Furthermore, diverse neighborhoods are shown to improve the wellbeing of all residents, providing low-income families with opportunities to which they would otherwise not have access, and thus preventing instances of homelessness.¹³⁸

Community land trusts, cooperative ownership, and permanent affordability covenants are additional models for creating sustainable, long-term affordable housing. Within these shared equity approaches, permanent affordability is maintained through a stable, long-term subsidy and limited appreciation for homeowners.¹³⁹ Shared equity models offer promising strategies for building wealth through homeownership for low-income households.

Homeless Prevention

Obviously, homelessness is a dire condition in which one finds themselves, not something for which one plans. However, because poverty, discrimination, and other structural causes are likely to precipitate an episode of homelessness in addition to individual circumstances, there are opportunities to use policies, practices, and interventions that reduce the likelihood that someone will experience homelessness, and complement the Housing First model. In fact, there is substantial evidence that interventions to prevent homelessness are more cost effective than addressing issues after someone is already homeless.^{17,140-142} Successful prevention systems span across sectors, and demonstrate collaboration amongst funders and service providers.¹⁴² Prevention can address structural factors, with policies to increase wages, combat discrimination, and develop affordable housing.^{143,144} For instance, while rent control is limited to a handful of cities across the United States, recent evidence from San Francisco finds that these regulations support the retention of existing tenants in neighborhoods where rents are rising, particularly renter households that are older, long-term residents, and non-white.¹⁴⁵ Prevention might also include assessing system failures, by examining barriers to accessing public services, providing support services for transitions out of institutions, and enhancing cross-sector collaborations.^{143,144}

Because poverty, discrimination, and other structural causes are likely to precipitate an episode of homelessness in addition to individual circumstances, there are opportunities to use policies, practices, and interventions that reduce the likelihood that someone will experience homelessness.

Finally, eviction prevention may include direct services to aid individuals during times of crises or trauma, or address housing insecurity, with specific attention to at-risk subpopulations. A study of temporary financial assistance for rent, security deposits, or utility bills in the Chicago market area resulted in an 88 percent decrease in the probability that an individual or family would enter an emergency shelter within three months of the call, and a 76 percent decrease of the need for emergency shelter after six months.¹⁴⁰ There is additional evidence to support the role of legal support in eviction prevention,¹⁴⁴ as well as ongoing case management or diversion programs from which at-risk households may benefit, resulting in the ability to remain in safe housing rather than entering a shelter.^{146,147} A study of one such program in New York found that targeted case management to help families secure resources needed to maintain housing averted shelter entries by five to 11 percent, saving the city millions of dollars.¹⁴⁶

THE STATUS OF HOMELESSNESS AND ITS IMPACTS IN LOUISVILLE, KY

Demographics of People Experiencing Homelessness

Louisville conducted its annual Point in Time Count (PIT) on the morning of January 31, 2019. During this event, the Coalition for the Homeless led volunteers canvassing the city from 4:00-6:00am to identify individuals sleeping on the streets and in encampments,^b while emergency shelters reported their total number of shelter guests. Due to extreme cold, Operation White Flag beds were also available. A total of 1,071 individuals experiencing homelessness were identified on that one night, and 118 of those were unsheltered. It is reasonable to believe that this number is an underestimate—individuals who remain unsheltered are often difficult to locate, as are those who stay with friends and family, when possible. Over the course of 2018, 6,986 unique individuals were identified as experiencing homelessness and using services in Louisville, and 632 of them were recognized as unsheltered at one time.

Louisville Homeless Trends, 2012-2018

According to data from the Homeless Management Information System (HMIS), between 2012 and 2017, the overall homeless population in Louisville declined by 23.9 percent (see Figure 1). However, between 2016 and 2017, the overall homeless population began to rise, increasing by 5.1 percent. Similarly, the unsheltered homeless increased by 22.2 percent from 2015 to 2016 and by 4.2 percent from 2016 to 2017.

Although the data show declines in family homelessness, this also coincides with a sharp decrease in services available to families. The data may reflect fewer families seeking services and being identified. The qualitative interviews completed for this research point to fewer families seeking services, rather than an actual decline in families experiencing homelessness.

The number of young adults experiencing homelessness was down in 2017 from its highest point in 2014, most recently declining by 11.1 percent from 2016 to 2017. These trends are likely attributed to targeted community efforts to house and provide services for this population. However, this population increased by 13 percent in 2018. In 2018, the Coalition was awarded \$3.45 million from HUD to address youth homelessness, towards achieving functional zero, or housing young adults at the same rate that they become homeless.

Veterans experiencing homelessness steadily declined since its peak in 2013, with essentially no change from 2016 to 2017 (0.3 percent) and minimal change from 2017 to 2018 (3 percent). Again, these trends align with recent efforts in Louisville to house veterans as part of Mayor

^b Per HUD regulations, an individual must be observed as homeless on the night of the Point in Time Count. Individuals who are known to receive services but were not observed that night cannot be counted.

Fischer’s commitment to the national mayor’s challenge, in partnership with Robley Rex VA Hospital, Family Health Centers, Volunteers of American Mid-states, and the Louisville Metro Housing Authority (LMHA). Together, these organizations housed 838 homeless veterans, and were housing veterans at the rate they became homeless through 2018.

One of the most alarming trends within Louisville’s homeless population is the sharp rise of persons experiencing homelessness due to domestic violence, paralleling previously discussed national trends. This group has grown year-over-year since 2015, most recently increasing by 17 percent. Louisville Metro Police Department (LMPD) deploys the best practice of fatality reviews for Domestic Violence calls, which serves to protect victims at risk of death by moving the victim out of a dangerous home and into a shelter.

Figure 1: Snapshot of Louisville Homeless Trends, 2012-2018

Snapshot of Louisville Homeless Trends, 2012-2018

	Overall Homeless Numbers	Percent Change	Unsheltered*	Percent Change	Families	Percent Change	Young Adults	Percent Change	Veterans	Percent Change	Domestic Violence	Percent Change
2018	6986	4%	632	-18%	266	-21%	510	13%	726	3%	1584	17%
2017	6695	5.1%	774	4.2%	337	-6.9%	394	-11.1%	708	0.3%	1349	8.0%
2016	6373	-5.4%	743	22.2%	362	-15.6%	443	6.0%	706	-10.7%	1249	19.9%
2015	6737	-12.5%	608	-0.5%	429	-4.5%	418	-35.1%	791	-12.5%	1042	18.5%
2014	7697	-10.6%	611		449	-28.5%	644	22.7%	904	-1.3%	879	-33.5%
2013	8608	-2.2%	228		628	9.6%	525	-5.4%	916	34.5%	1321	85.0%
2012	8802		368		573		555		681		714	

Source: Homeless Management Information System (HMIS).
 *Between 2013 and 2014, there was a change in the way the unsheltered homeless are counted. We do not report percent change for these years due to this difference (Coalition for the Homeless, Annual Census of Homeless in Metro Louisville, <https://www.louhomeless.org/wp-content/uploads/2013/02/2014-Homeless-Census-Coalition-for-the-Homeless-final1.pdf>).

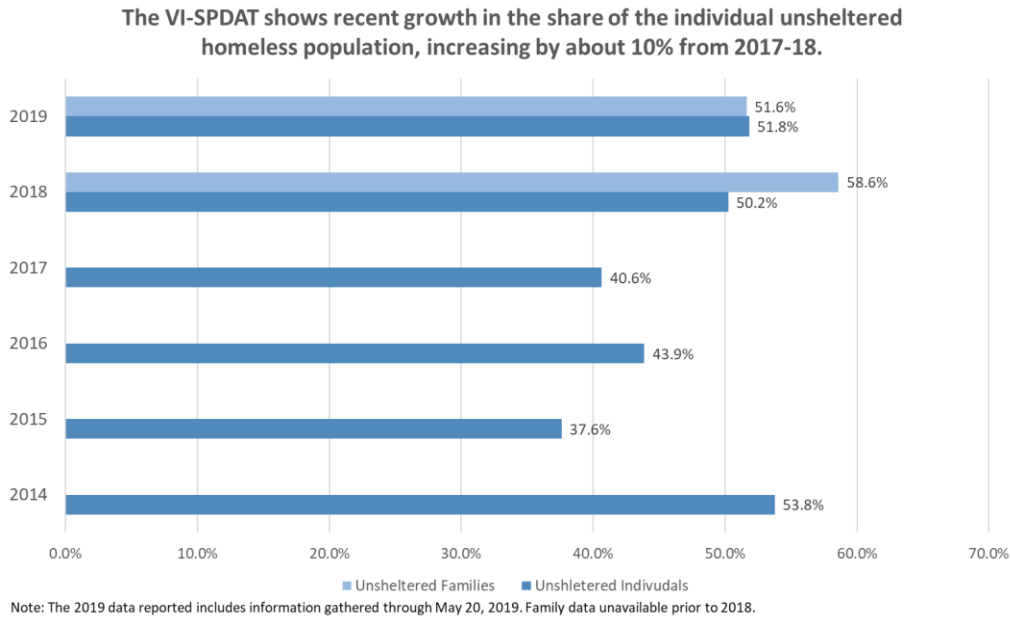
The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT): Examining a Subset of Louisville’s Homeless Population

Starting in 2014, the Common Assessment Team began administering the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) to individuals experiencing homelessness. Not all persons experiencing homelessness have been assessed with the VI-SPDAT tool, thus the data analyzed in this section represent a small subset of Louisville’s total homeless population. The total number of individuals completing the VI-SPDAT each year is much smaller than the number of individuals within HMIS, and an individual may only complete the assessment once, despite experiencing homelessness for multiple years. Although these data are not representative of the total homeless population, they are still useful to better

understand and describe persons experiencing homelessness in Louisville. The VI-SPDAT was updated in 2018, which included changes to the wording of some questions. Where possible, these data were aggregated across versions for individuals, and instances where questions were worded differently between the two versions are noted. Family data were only collected starting in 2018 with VI-SPDAT Version 2, thus there are no family data in any charts/tables prior to this year. The data points presented focus on (1) the total count of homeless individuals/families that have completed the VI-SPDAT and (2) unsheltered individuals that have completed the VI-SPDAT.^c The 2019 data reported below include information gathered through May 20, 2019. Most of the charts display data for homeless individuals since 2014. The VI-SPDAT began collecting family data separately in 2018, thus there is less to information report. Key points on unsheltered families are noted in the text.

Data collected through the VI-SPDAT indicates growth in the proportion of unsheltered homeless most recently between 2017 and 2018 (Figure 2). This sub-population accounts for about half of the VI-SPDAT observations through May 2019. In 2018, nearly 60 percent of families completing the VI-SPDAT identified as being unsheltered.

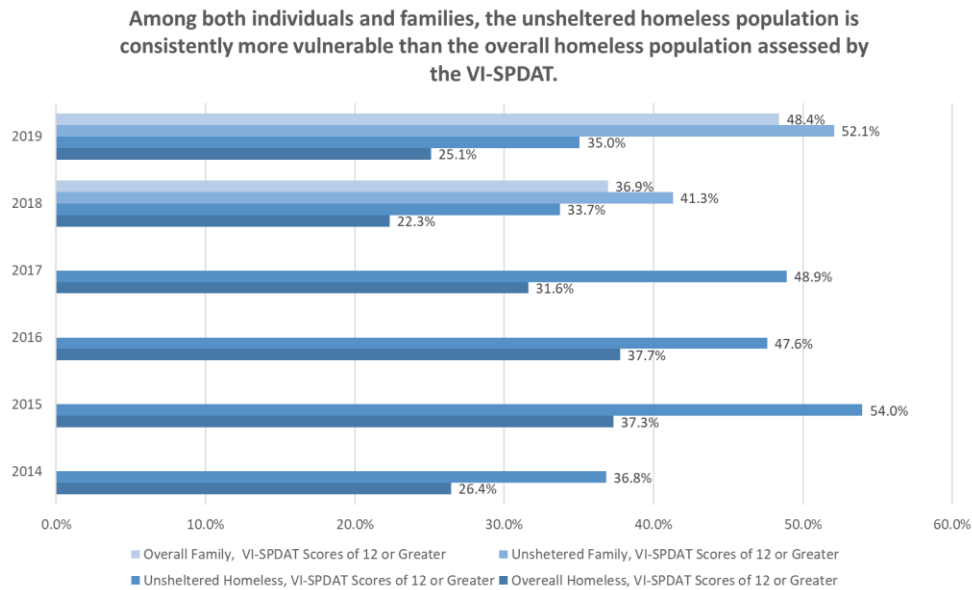
Figure 2: Unsheltered Individuals (2014-2019) and Families (2018-2019) Assessed by the VI-SPDAT



^c Unsheltered individuals are also included in the total VI-SPDAT counts. Family counts are separate from individual counts. In 2018, the VI-SPDAT developed a separate family assessment tool, for which the data are reported here ($n = 255$). Unsheltered individuals ($n = 1998$) are defined as those who did not select shelters, transitional housing, or safe haven as their sleeping location in response to VI-SPDAT Version 1 question 13 (“I am going to read types of places people sleep. Please tell me which one that you sleep at most often.”) and Version 2 question 1 (“Where do you sleep most frequently? [Choose one.]”). Unsheltered families are defined as those who did not select shelters, transitional housing, or safe haven in response to question 5 (“Where do you and your family sleep most frequently? [Choose one.]”).

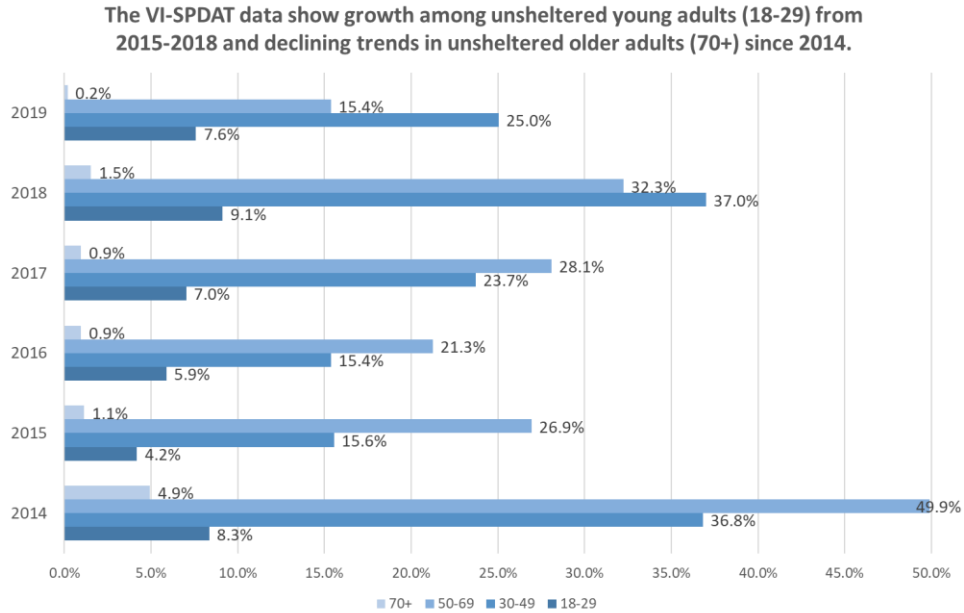
The vulnerability index is calculated based on responses to questions across four categories – (1) history of housing and homelessness, (2) risks, (3) socialization and daily functioning, and (4) wellness. Persons with scores higher than 12 are prioritized for services. Figure 3 shows that the unsheltered homeless consistently score 12 or higher on the VI-SPDAT, compared to the overall homeless population. From 2015 to 2017, approximately half of the unsheltered population scored 12 or higher. In 2018, only about one-third (33.7 percent) of unsheltered homeless scored 12 or higher. Part of the decline may be associated with the changes in survey instrument and wording of questions. Notably, almost 50 percent of all homeless families scored 12 or higher.

Figure 3: VI-SPDAT Scores of 12 or Greater, Individuals and Families



Turning to the demographic characteristics of the unsheltered individuals, Figure 4 shows age cohorts from 2014 to 2019. Among the most prominent trends is a continued increase in the share of unsheltered young adults (18-29), which grew from 4.2 percent in 2015 to 9.1 percent in 2018. The presence of older adults (70+) among the unsheltered has declined since 2014, which may be a result of increased PSH opportunities and targeted efforts to decrease chronic homelessness. In 2018, 38 percent of family heads of household were within the young adult (18-29) age cohort, a higher rate than among individuals of the same age.

Figure 4: Age Cohorts, Unsheltered Individuals



As displayed in Figure 5, the primary race of the unsheltered population identified through the VI-SPDAT tool is roughly split between Black/African American and White from 2014 to 2018. However, among unsheltered families, Black/African American are far more prevalent, representing the primary race of nearly 80 percent of this population in 2018 (Figure 6).

Figure 5: Primary Race/Ethnicity of Unsheltered Individuals

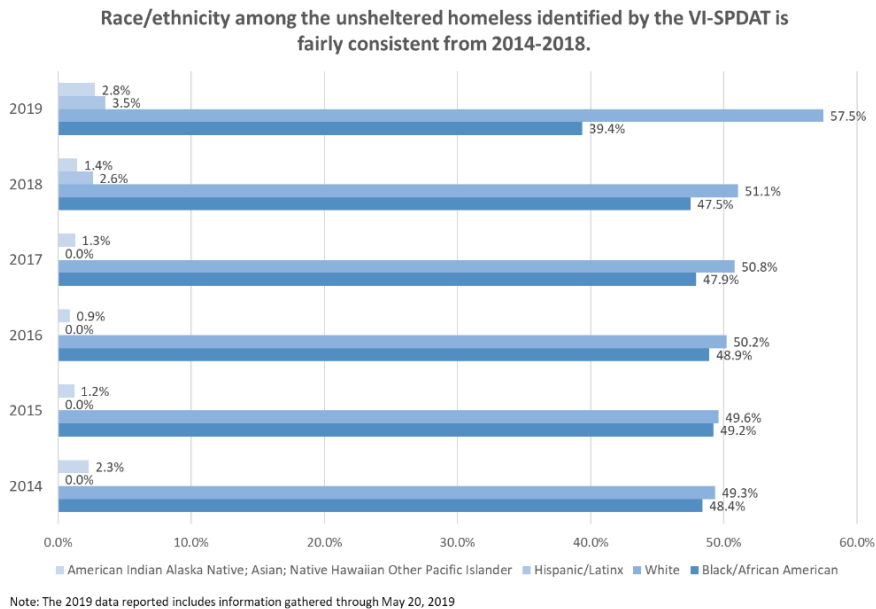
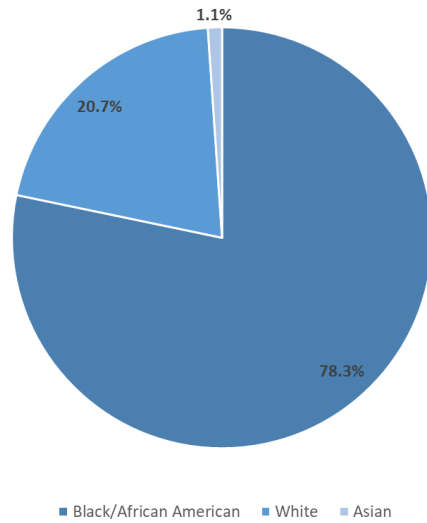


Figure 6: Primary Race of Unsheltered Families, 2018

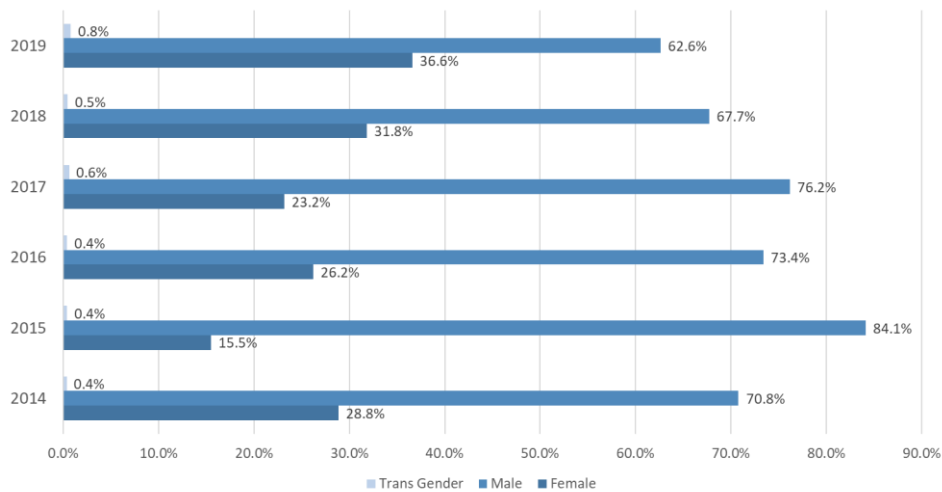
In 2018, unsheltered families were disproportionately Black/African American.



Males are more prominent among unsheltered individuals compared to females and persons identifying as transgender (Figure 7). However, the female unsheltered population assessed by the VI-SPDAT increased from 2017 to 2018 and remains higher than past trends through the first five months of 2019. Among unsheltered families, female heads of household comprise upwards of 90 percent of this group in 2018, with similar patterns through early 2019.

Figure 7: Gender Identity of Unsheltered Individuals

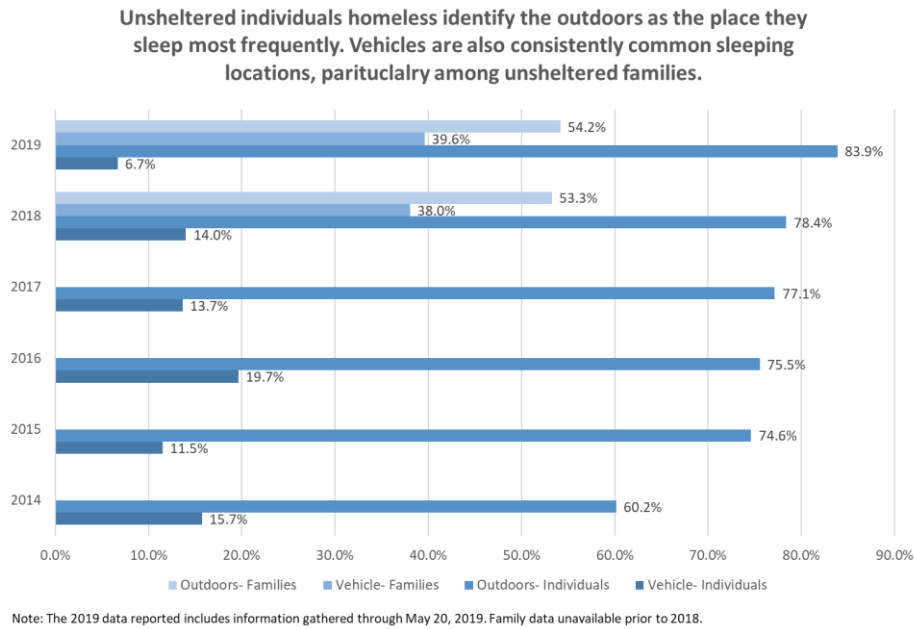
The female unsheltered population assessed by the VI-SPDAT increased from 2017 -18 and remains higher than past trends through the first five months of 2019.



Note: The 2019 data reported includes information gathered through May 20, 2019.

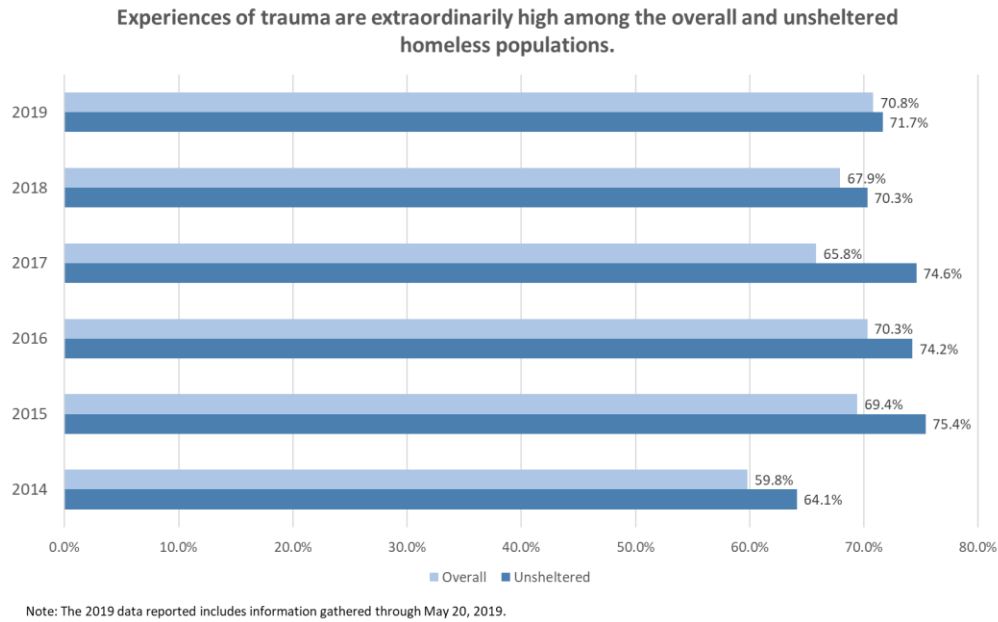
Figure 8 summarizes where unsheltered individuals and families report sleeping, with most unsheltered individuals sleeping outdoors. Vehicles are also common sleeping locations, particularly among unsheltered families.

Figure 8: Sleep Locations of Unsheltered Individuals



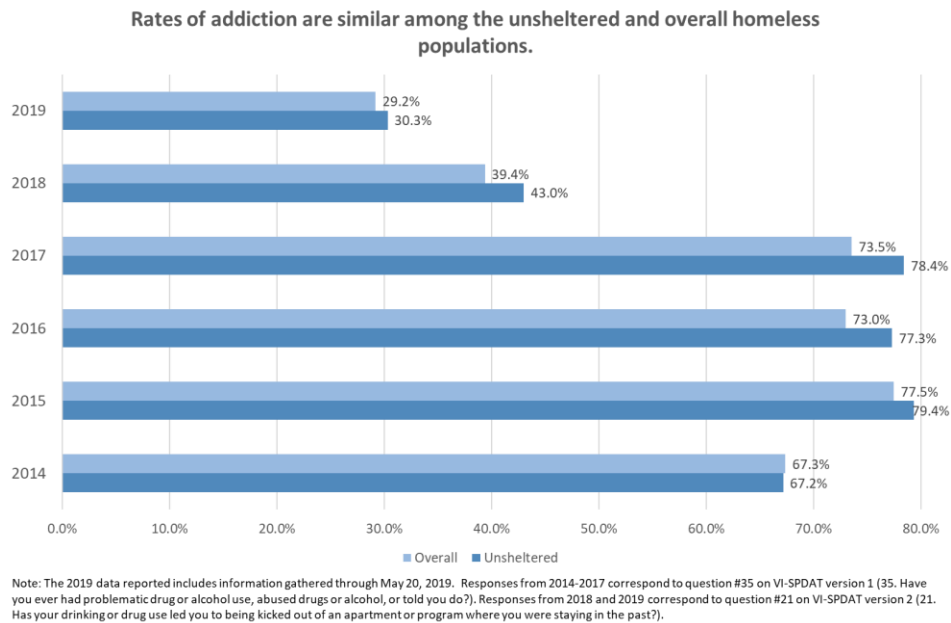
Instances of trauma are consistently very high among the overall individual homeless population and unsheltered individuals, with well over half of both groups attributing trauma as part of the cause of their current period of homelessness (Figure 9). These rates also hold for the entire population of families and subpopulation of unsheltered families.

Figure 9: Trauma among Unsheltered and Overall Homeless



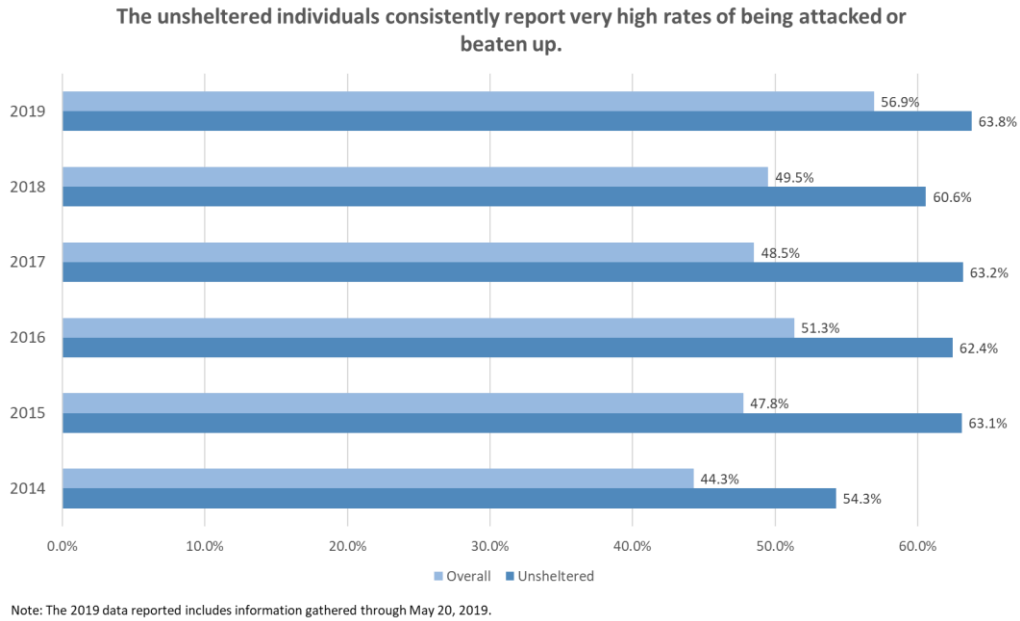
Rates of addiction are relatively similar between unsheltered individuals and the overall homeless population (Figure 10). Version 2 of the VI-SPDAT asked a slightly different question regarding addiction (21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?), which likely accounts for the difference in overall rates starting in 2018. Addiction appears to be less prevalent among unsheltered families and families overall, based on the 2018 VI-SPDAT data.

Figure 10: Addiction among Unsheltered and Overall Homeless Individuals



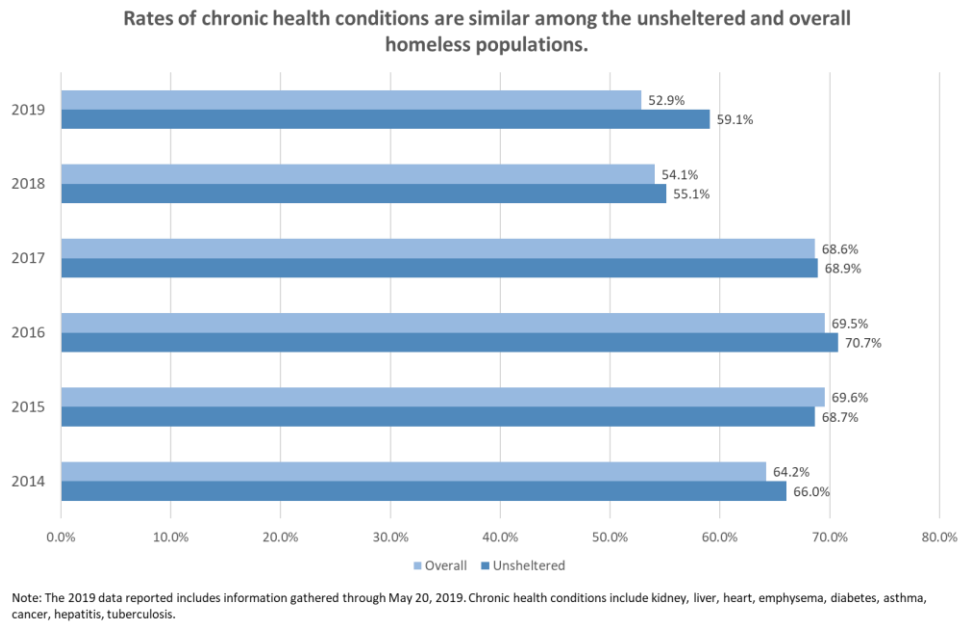
The VI-SPDAT asks whether people have been attacked or beaten up since becoming homeless, and Figure 9 shows the unsheltered are somewhat more likely to be attacked, compared to the overall homeless population. Unsheltered individuals are also somewhat less likely to report having planned activities, other than just surviving, that make you feel happy and fulfilled.

Figure 11: Rates of Violence against Unsheltered and Overall Homeless Individuals



Finally, chronic health conditions (e.g., kidney, liver, heart, emphysema, diabetes, asthma, cancer, hepatitis, tuberculosis) appear to occur at similar rates among unsheltered and overall homeless individuals. Of those who completed the VI-SPDAT, over half reported at least one chronic health condition.

Figure 12: Rates of Chronic Health Conditions against Unsheltered and Overall Homeless Individuals



Louisville’s Continuum of Care

In 2018, the Louisville CoC submitted 36 projects to HUD for a total application of \$10,342,443. The projects consist of PSH units, transitional housing units, and rapid re-housing units, managed by 12 different organizations (and offered with services by additional partner organizations). Additionally, the CoC includes the HMIS, mandated for tracking individuals experiencing homelessness in the community, and the Single Point of Entry System, both administered by the Coalition for the Homeless. As a service provider, each recipient of CoC funds is responsible for 25 percent of the total cost of the project; HUD provides funding up to 75 percent of any given project.

Emergency Shelters and other homelessness services are funded through the Louisville Metro Government budget, with allocations from federal funds through the Community Development Block Grant (CDGB), the Emergency Solutions Grant (ESG), Housing Opportunities for person with AIDS (HOPWA), the Area Community Ministries and Louisville Forward budgets, and the Office of Resilience and Community Services General Fund.

Aligned with best practices of a CEP, Louisville’s CoC transitioned to a Single Point of Entry system in 2014. Individuals facing a night of homelessness can contact the Client Care Staff at the Coalition for the Homeless office daily between 10:00am and 4:00pm, either by calling or via walk-in to their downtown location. Single Point of Entry Client Care Staff provide assistance to reserve a bed in an emergency shelter and connect to other social service agencies as needed. Louisville’s CoC also includes the use of VI-SPDAT, administered by the Common

Assessment Team, which serves as the common assessment referenced in best practices. This team provides outreach services beyond the assessment, and assists individuals and families to navigate community resources, including applications to housing. However, the processes in place currently do not provide individuals and families access to needed emergency services at any hour of the day, seven days a week, as is recommended in best practices.

Emergency Shelter

Tables 2 and 3 summarize the opportunities for emergency shelter and transitional housing. In total, Louisville offers 344 emergency shelter beds for single adults and youth, and 53 units for families nightly. During extreme temperatures, Operation White Flag provides for another 163 beds, and the new low-barrier options have added an additional 124 beds. Although the CoC approximates this to 67 percent capacity for single individuals given the 2019 PIT, the calculation does not align the demographics of the population with the number of available beds for subpopulations, which exacerbates the need for more emergency shelter. Louisville’s capacity for families is reported at 54 percent, but in January 2019, as many as 70 families were on the waiting list for emergency shelter.

Very few people really truly want to be out. They want to be in support, just finding a space that meets what they want and what they're going to be able to handle is not there. It may be really hard to ever find that match for them, but most people if they... had to they would take it.

Homeless Service Provider

Programs and Services

A good shelter should have a job placement program where they could help young men and women to find suitable employment ...and look into getting vouchers for vocational education. That would be real good cuz a lot of people just don't have the skills. Homeless but no skills and so you can't find good work. You can't find enough livable wage to elevate yourself out of the homeless situation.

Louisvillian Experiencing Homelessness

Some agencies in Louisville also offer short-term housing, beyond an emergency stay, that is contingent upon enrollment in a transitional housing program. Transitional housing programs offer supervision and stability while individuals gain skills for future employment or save money that would enable them to move successfully to permanent housing. This opportunity is available in Louisville for 143 individuals and 18 families.

All overnight emergency shelters also offer hygiene facilities, as do some day shelters. Twelve local organizations provide meals throughout the week (including Salvation Army, St. Vincent de Paul, and

Wayside Christian Mission, in conjunction with emergency shelter services) and seven organizations provide clothing donations. See the Coalition for the Homeless’ [Louisville Street Tips](#) for additional services, as well as days and times of availability.

Table 2. Louisville Emergency Shelters

Organization	Designation	Availability
<i>Overnight Emergency Shelter</i>		
Wayside Christian Mission	Single Men	56 beds: 4:00p.m.-7:00a.m.
Wayside Christian Mission	Single Women	18 beds: 4:00p.m.-7:00a.m.
Wayside Christian Mission	Phoenix Hospital Respite	15 beds: 4:00p.m.-7:00a.m.
Wayside Christian Mission	Veteran	8 beds: 4:00p.m.-7:00a.m.
Salvation Army Center of Hope	Single Men	69 beds: 4:45p.m.-6:45a.m.
Salvation Army Center of Hope	Single Women	26 beds: 4:45p.m.-6:45a.m.
Salvation Army Center of Hope	Men's Honor Dorm	8 beds: 4: 4:45p.m.-6:45a.m.
Salvation Army Center of Hope	Men with Limited Mobility	6 beds: 4:45p.m.-6:45a.m.
Salvation Army Center of Hope	Youth	6 beds: 4:45p.m.-6:45a.m.
St. Vincent de Paul Ozanam Inn	Single Men	58 beds: 4:00p.m.-7:00a.m.
YMCA Safe Place Services	Teens	24 beds
House of Ruth	Diagnosed with HIV	2 beds
Center for Women & Families	Victims of Domestic Violence	28 beds
Kristy Love Foundation	Victims of Domestic Violence	18 beds
Wellspring	Crisis Stabilization	2 beds
<i>Family Emergency Shelter</i>		
Volunteers of America	Families	16 units
Salvation Army Center of Hope	Families	6 units
Wayside Christian Mission	Families	12 units
Wayside Christian Mission	Veterans	1 units
Center for Women & Families	Domestic Violence	18 units
<i>Operation White Flag (Wind chill below 35° or heat index above 95°)</i>		
Salvation Army	Men, Women, Families	30 beds
St. Vincent de Paul	Single Men	51 beds
Wayside Christian Mission	Men, Women, Families	64 beds
Wayside Christian Mission	Families	13 beds
Family Life Center	Families	5 beds
<i>Low-Barrier Shelters</i>		
Wayside Christian Mission	Couples and Pets allowed, as well as families and singles	100 beds, Open 24-hours with designated cleaning time
Healing Place	Men	24 beds
<i>Emergency Day Shelters</i>		
St. John Center for Homeless Men	Single Men	M-T, Th-Su: 7:00a.m.-3:00p.m. W: 7:00a.m.-2:00p.m.
Uniting Partners for Women and Children (UP)	Women and Children	MWF: 9:00a.m.-1:00p.m.
Re: Center Ministries	Women and Children	M-F: 7:00a.m.-2:00p.m.
Jeff Street Baptist at Liberty	Men and Women	M-F: 7:00a.m.-10:00a.m.
Ekklesia Christian Life Ministries	Families	M-F: 9:00a.m.-1:00p.m.
YMCA Safe Place	Youth age 16-22	MThF: 9:00a.m.-1:00p.m. T: 5:00p.m.-9:00p.m.

Table 3. Transitional Housing Programs

Temporary/Transitional Housing		
Coalition for the Homeless	Young Adults	12 single beds and 10 family units
Rhonda's Another Chance	Women	4 beds
Salvation Army	Veterans	31 single beds and 7 family units
St. Vincent de Paul	Veterans	20
St. Vincent de Paul	Single Men	10
Volunteers of America	Veterans	10
Wayside Christian Mission	Work Therapy	24 beds
Wayside Christian Mission	Veterans	17 single beds and 1 family unit
Wayside Christian Mission	College and Career	15 beds

Permanent Supportive Housing (PSH) and Rapid Re-housing

In total, nine organizations host a total of 1,162 PSH units for single adults and 166 PSH units for families. Scattered throughout Metro Louisville, the majority of units provide residents with settings integrated in their local neighborhood rather than clustered together. Organizations that engage in PSH programming include Phoenix Health Care for the Homeless, St. John Center for Homeless Men, Wayside, St. Vincent de Paul, Louisville Metro, the Coalition for the Homeless, House of Ruth, Veterans Administration Supportive Housing (VASH), and Wellspring. Additionally, LMHA (at Robert's Hall and the YMCA), St. Vincent de Paul, and Wayside Christian Mission (through their Work Out program) offer onsite permanent housing units (either apartments or single room occupancies) totaling 79 beds, which provide clustered opportunities for permanent housing with Section 8 vouchers.

Louisville's rapid re-housing program, which provides short-term financial assistance to return individuals and families to housing as quickly as possible, accommodates 93 families, 27 individuals, 16 Veterans, and 4 single youth. These services are supported by the Home of the Innocents, Louisville Metro Office of Resilience and Community Services, and Volunteers of America. The CoC also collaborates with LMHA, so that if, after a few months, participants in the rapid re-housing programs are unlikely to maintain housing without financial subsidy, they are provided with a "move-up" Section 8 voucher. Similarly, if persons in PSH are no longer in need of the supportive services, LMHA will work to shift them to a regular voucher, freeing up additional PSH for those in need.

Outreach

The Coalition for the Homeless distinguishes between outreach and case management by defining a case manager as the person coordinating services for an individual, while the primary purpose of outreach is to ensure safety and serve as a connector to the use of services. This

spring, the new Outreach Team established by St. John Center and Uniting Partners for Women and Children (UP) through Metro Council funds allocated in January 2019, joined existing outreach provided by Centerstone and the Common Assessment Team from Phoenix Healthcare for the Homeless. Outreach providers not only establish relationships with individuals in encampments to introduce them to services, but also offer some of the functions associated with case management. Within three months of operation, the St. John Center/UP Outreach Team, which consists of both peer support specialists and experienced providers, had connected 161 encampment residents to shelter and assisted 56 individuals to access mental health care—demonstrating a substantial need for this additional service. More impressively, since January, St. John Center/UP Outreach Team, the outreach team from Centerstone, the Common Assessment Team from Phoenix, and representatives from emergency shelters convene monthly to communicate and coordinate services for individuals who remain without shelter. As a compassionate city, Louisville also has multiple volunteer outreach teams that provide food and items that help to meet the basic needs of the unsheltered homeless population.

I hate just handing out a Street Tips book and say, "Well here's where you can go for lunch, here's where you can go to get clothes, here's where you can go to the doctor." I like, "I'm going to give you this book, it's full of information, but come with me and I'll show you. We can go down and get this done right now." The soft hand-off makes the difference in everything... because when somebody's ready you need to respond immediately.
Homeless Service Provider

Louisville’s newest service to reduce barriers is St. John Center’s storage facility, also funded by Metro Council’s allocation in January 2019. This much needed service provides lockers in which individuals experiencing homelessness can keep their belongings, relieving the burden of carrying them everywhere they go throughout the day, and reducing the likelihood that valuables are lost or stolen.

Encampments

*They put a lot of teenage rules on adults in those shelters. They need to take us as adults even if we've made poor life choices that have put us in our spots. It doesn't mean this is our permanent thinking. We all know we've made mistakes, but it makes it really hard for us as grown adults to make better decisions when we're being treated like **** kids.*
Louisvillian Experiencing Homelessness

In December 2017, Louisville Mayor Greg Fischer commissioned the Homeless Encampment Task Force to address the growing number of urban homeless encampments and their reported health problems and unsightliness.¹⁴⁸ With the passage of Louisville Metro Council Ordinance 131.02 in early 2018, Louisville joined the growing number of cities that have formalized policies requiring notification periods before permitting camp clearances, in this case 21 days for camps on public lands. Still, inadequate storage provisions prior to and during subsequent clearances resulted in the loss of many campers’ belongings, and there is no basis for thinking that most from local camp clearances went into shelter or housing.¹⁴⁹

The use of the First Link grocery property on Liberty Street as a storage facility, operated by St. John Center, for people experiencing homelessness to secure safely their belongings was a positive step forward in this regard. Both individuals experiencing homelessness and providers confirmed that in 2019, some campers did on occasion (especially on coldest or White Flag nights) use the new Wayside low-barrier shelter, which remained full through the coldest weather. More importantly, perhaps, many benefited from the support services provided by the street outreach teams and from the storage lockers. Street outreach workers, for example, shared information in encampments about resources offering treatments, showers, or laundry. Collectively, these are steps in the right direction. Substantive difference has been made, even given the short time they have been in effect.

Yet, reducing local shelterlessness remains out of reach at present even with the new clearance notification policy and these additional innovations. In that context, the idea of sanctioning encampments locally remains a viable alternative from the perspective of some homeless residents and even their advocates, while it continues to be fiercely opposed by others, based on interviews conducted in the course of this research.

And there should be an onsite place for baggage to stay onsite if you have a permanent bed there because you cannot go to [a job] interview with a backpack, that's a red flag when you come through the door. So we need a place to store your bags if you're staying there.

Louisvillian Experiencing Homelessness

Policing

It's time for all of us to take a stand and actually fight for our rights because a lot of us homeless people, we don't get rights. We don't. People can come beat us up, take from us... When in reality some of us can't work. Some of us are mentally challenged and they still don't have a home. There's people walking around that's not always there and they're out on the streets where they shouldn't be.

Louisvillian Experiencing Homelessness

LMPD often serves as a frontline responder to problematic behavior and complaints about homeless encampments. LMPD has collaborated with local mental health providers to give crisis intervention training to every officer. Because someone sleeping on the street does not qualify as a formal encampment until 48 hours, LMPD officers attempt to respond to those exhibiting signs of camping or trespassing quickly, and refer those individuals to services. On occasion, officers perform formal outreach services, which include assuring the wellbeing of individuals who live in encampments and abandoned buildings, documenting the instance of homelessness, and

making referrals to the Common Assessment Team. LMPD has also agreed to participate in diversion programs, and partnered with Centerstone to bring individuals exhibiting symptoms of crisis to the Living Room, and with the Criminal Justice Commission to refer individuals assessed for opioid-related criminal activity to the Law Enforcement Assisted Diversion (LEAD) program.

Substance Abuse Treatment Programs

Note that, although some substance abuse programs serve individuals experiencing homelessness, and likely, those individuals are the largest portion of their clientele, recovery beds are not counted as emergency shelter beds. In fact, agencies whose primary designation is that of a provider for substance use disorders are not listed as participants in the CoC, as they may not provide housing services, even if a person has an expressed need for housing following treatment.

Panhandling

All panhandlers are not homeless, nor do all individuals experiencing homelessness solicit money. Studies estimate that between 65 and 82 percent of people panhandling are experiencing homelessness,^{150,151} although they may display signs that state otherwise. In Louisville, as in many cities, asking a fellow human for money while standing in a public space is a protected form of free speech. As with homelessness, this problem requires a community-wide response, and best practices cite beginning with an in-depth analysis of the local circumstances. Although participants in this study described panhandling as an issue Louisville might address, a thorough investigation of the problem and its potential solutions was beyond the scope of this report.

Identified Gaps in Louisville's Homeless Services

In addition to emergency shelter, agencies often provide case management services to their guests. However, mechanisms for this service vary across providers. Most programs offer the service at intake, but then may not approach the client again about needs, and often wait for the client to initiate a relationship. In fact, it is likely that case management staff are not available during most of the overnight shelter hours, when most guests are present. Instead of using the opportunity to extend assistance, fostering trust, and demonstrating evidence of accompaniment, the onus of the request for help is on the client.

Furthermore, case management services are generally unique to each shelter, meaning that the service does not extend beyond the time that a guest stays at that location. As a guest transitions to another shelter, spends the night with a friend, or camps out for a few nights, the relationship is likely disengaged. The lack of continuity of care from emergency shelter intake to the identification of a permanent housing option results in prolonged homelessness and potential isolation from other needed services. Instead of the system of supports providing a coordinated effort to navigate resources, remove barriers, and identify solutions, the individual experiencing the trauma of homelessness may repeatedly slip through the cracks, as multiple opportunities for developing relationships and supports are missed.

This consistency extends beyond the boundaries of homeless service providers across sectors. Individuals reported that they had become homeless and without secured shelter in a transition

out of another institution or care facility— jail or prison, hospitals, substance abuse treatment, and foster care. Most institutions report some form of discharge planning, but there is evidence that it may be poorly executed and in need of stronger ties between agencies to provide referrals and warm hand-offs.

Individuals experiencing unsheltered homelessness repeatedly reported that they did not feel welcome nor safe in all of Louisville’s emergency shelters, although their reasoning for this varied.^d Despite service providers asserting that their staff attend routine training in trauma-informed care, individuals experiencing homelessness did not perceive that all providers were able to hear them, respect them, or help them. They reported experiences of discrimination and unfair treatment. Individuals of subpopulations additionally expressed concerns about the cultural competency of providers, especially in serving transgender individuals and non-English speaking populations.

To date, only the low-barrier shelters have allowed couples and pets, as well as a place to leave belongings, although one overnight shelter shared plans to revise their existing shelter list to reduce the barriers to entry. As indicated in Table 2, which additionally lists the times emergency shelters serve guests, there are a number of gaps in service provision within shelter spaces. These gaps are likely contributing to the numbers of individuals who are seen loitering in other places downtown. Typically, family

Shelters have rules and expectations that can be difficult for people experiencing homelessness to follow or that impose the values of the agency on those it serves. These rules may include:

- Prohibition of the ability to stay with a partner, pet, or family group;
- Sobriety;
- Limitations on personal belongings due to space;
- Entry and exit at specific times;
- Dorm assignments limited to birth sex rather than based on gender identity; and
- Service or program participation.

Other reasons for remaining unsheltered include:

- Shelters are crowded, shared spaces exposing guests to the germs, noises, odors, and behaviors of strangers. Because it can be difficult to keep large, shared spaces clean, shelters are sometimes dirty or have bugs.
- Shelters are over-crowded, and there are not enough emergency beds within the CoC to accommodate the need.
- Being barred from services, or thinking that a past bar still holds.
- Fear of being found, either because of an outstanding warrant, or because of an abusive relationship.
- Shelters are not accessibly located. In Louisville, most emergency shelters are located downtown, and the public transportation system is not comprehensive enough to accommodate easy access to other areas of town.
- Language barriers or fears related to immigration status.
- Women and families experiencing homelessness are frequently victims of interpersonal violence. Having experienced trauma, they are more vulnerable to violence in and around shelter spaces.

^d Generally, the Coalition for the Homeless has received positive feedback about treatment by shelter staff in their annual survey.¹⁵²

shelters remain open throughout the day, allowing guests to come and go, as they need to. Some overnight shelters accommodate their guests' needs in the building during daytime business hours. But, Downtown stakeholders shared concerns about loitering and the impact it has on their businesses and perceptions of safety. One evident problem with the current shelter structure is that more day shelter availability is needed; without a designated place to call home—no “home base” to settle in—individuals experiencing homelessness congregate in public places downtown, near services.

A notable service that is scarce in Louisville's generous system is the offering of laundry services. Although a few agencies offer this service, designated hours are limited. Moreover, commercial laundromats are not prevalent in the few blocks in which many of the emergency shelters are located. Furthermore, for the most part, homeless residents reported they do not have their own means of transportation, and walk between services. Access to transportation—especially for those camping outside of downtown—is problematic.

One of the needs around having shelters and homes and programming, also for young people. We don't actually have that at all... And because we don't... they figure out a way they can stick them in detention because they think that's the safest place for them because at least their pimp can't get them, or at least it's a shelter... But it's absolutely re-traumatizing them.

Homeless Service Provider

As the next section describes in more detail, Louisville does not offer enough affordable housing. This also applies to affordable housing that accepts PSH vouchers and move-up vouchers that are designed to end an episode of homelessness. There are individuals who remain homeless despite having a voucher, because they cannot find landlord who will accept the voucher. Other individuals agree to move into less than ideal housing scenarios when discriminatory property owners do accept the voucher. The places where people with vouchers

can find housing that is affordable and landlords will accept a voucher are primarily within Louisville's most impoverished zip codes, further perpetuating existing patterns of racial and economic segregation.

I believe [the storage lockers is] one of the better ideas they've had... it keeps stuff off the streets. We need a place to wash clothes. That's one of the hardest things to do: keep clean clothes. I mean that's what people do. They get rid of it and get something new. Now I take my stuff to storage. That way I got it when I get my house... I have what I got cuz I just lost everything about two months ago. Everything. Apartment. Everything I owned... I have nothing left... it's brand new to me. But I'll tell you what I'm goin' to do. I'm gonna keep goin' forward. Ain't no fishin' backward.

Louisvillian Experiencing Homelessness

Although many PSH programs have outstanding retention, a common theme among those who return to the streets is difficulty managing finances to ensure rent and utilities are paid in a timely manner. These individuals could benefit from additional strategies to improve housing stability while in the PSH program, both through increased case management accompaniment and representative payee services to aid with financial management. However, representative payee services are rare for this population in Louisville.

Our clients also absorb that and internalize that... I had somebody tell me the other day, "Oh, you don't want to be around us?" or something like that, and they're internalizing what other people have said or the way they've been treated. And so, I'm like "What do you mean? I'm one of you too. We're all people." You know, you have to turn that around, but sometimes they don't get that, even in shelter, and that's the one place that you think they should be able, every time they go, they should be treated like humans with dignity and they don't get treated like that.

Homeless Service Provider

Individuals experiencing homelessness cited concerns about security within shelters. Security among the emergency shelters varies; each program utilized a different model and experienced different results. For example, St. John Center for Homeless Men employ security staff who are responsible for not only aiding to deescalate crises within the day shelter, but also for triaging guests' service needs. Security staff receive the same training as other social service providers within the Center, and contribute to collective problem solving within staff meetings. They do not wear uniforms that set them apart from other staff. St. Vincent de Paul contracts with off-duty LMPD Officers to provide security on campus overnight. Salvation Army contracts with a professional security company that provides services by uniformed security officers. Additionally, as guests check in for the evening, they

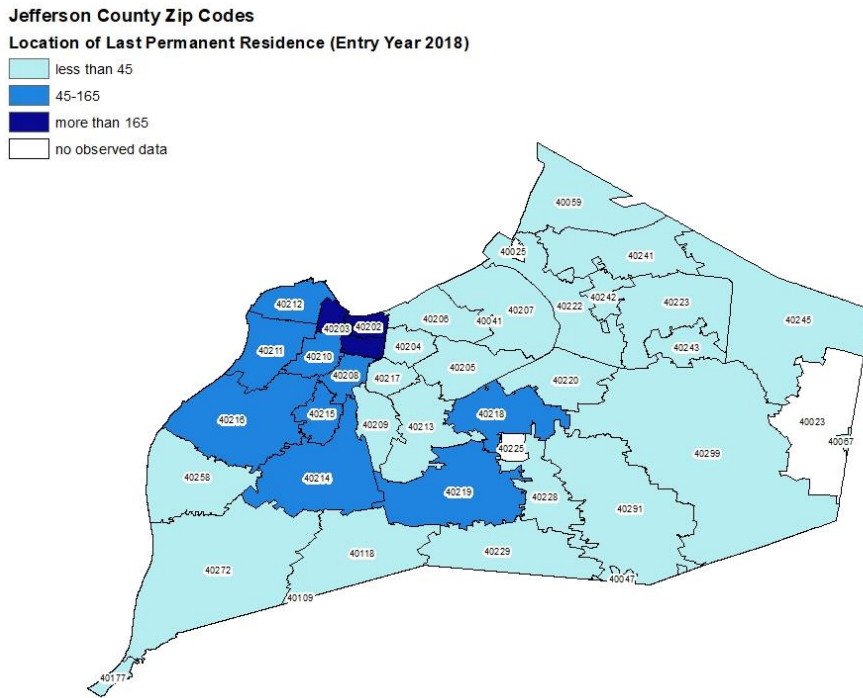
are asked to depart with all but a few possessions specific to overnight use. Their bags are secured for the night, and returned when they leave in the morning, in attempt to prevent weapons from entering the shelter. Guests participating in in the Work Therapy Program provide security at Wayside. Individuals checking in and out of Wayside enter through a metal detector. This inconsistency in facility security programs, responses to emergencies, and provider training contributes to the sentiments that individuals who use services may not always feel safe and respected in their times of crisis.

Finally, of Louisville's many programs to address addiction, none offers a safe space for using substances, whether the substance of choice is alcohol or an illegal drug. Homeless residents reported that police encounters are often around open containers, and other stakeholders spoke to the masses of used needles and syringes that litter streets and campsites. Although there is much debate around harm-reduction strategies within the realms of public health and recovery, individuals who are experiencing addiction will likely remain unsheltered while homeless; the illness of addiction is stronger than their ability to comply with shelter rules that prohibit active use during their stay.

Housing and Community Development

As previously discussed, the challenges of homelessness cannot be understood without considering the closely related challenges of affordable housing and poverty. Among people that entered the CoC in 2018, 11 zip codes in Jefferson County – shown in the darker blue shades in Figure 13 – account for over 35 percent ($n = 1,585$) of the last known permanent residences.

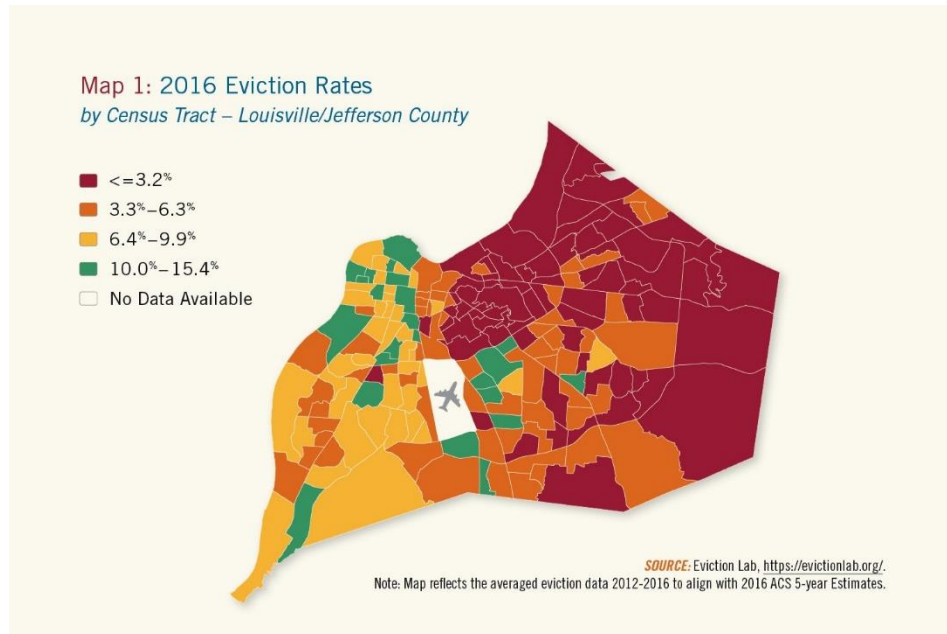
Figure 13. Location of Last Permanent Residence by Jefferson County Zip code



Source: HMIS

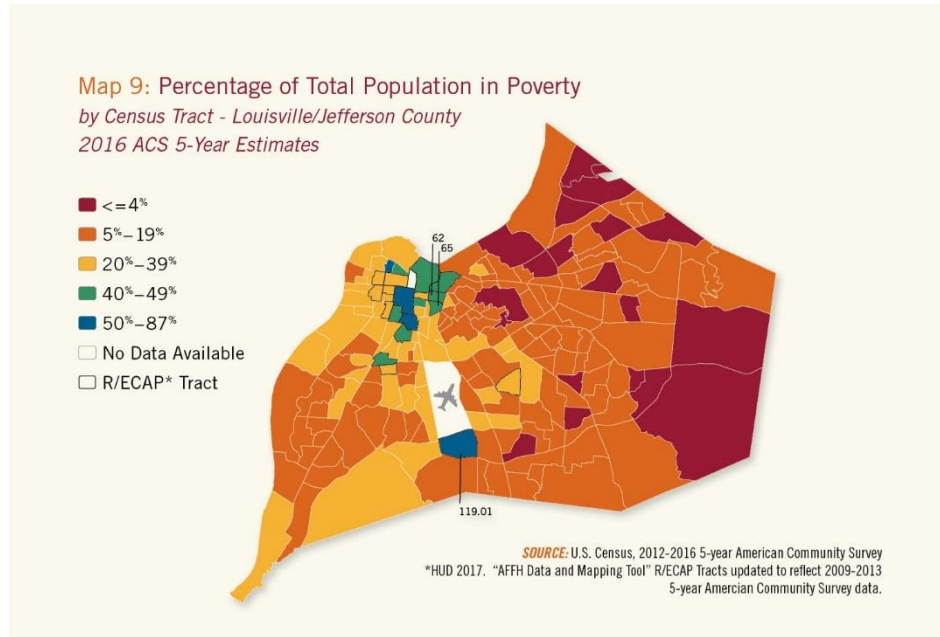
These locations are also closely aligned with the highest rates of eviction, poverty, and foreclosure sales in Louisville (Figures 14-16).⁹

Figure 14. Jefferson County 2016 Eviction Rates by Census Tract



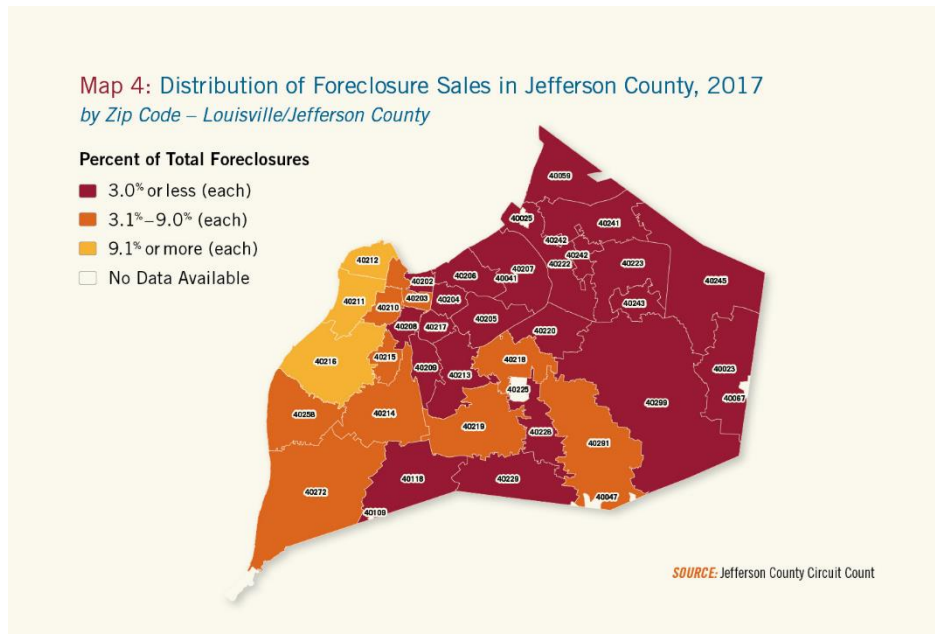
Source: MHC (2018) p. 6.

Figure 15. Jefferson County 2016 Percentage of Population in Poverty by Census Tract



Source: MHC (2018) p. 24.

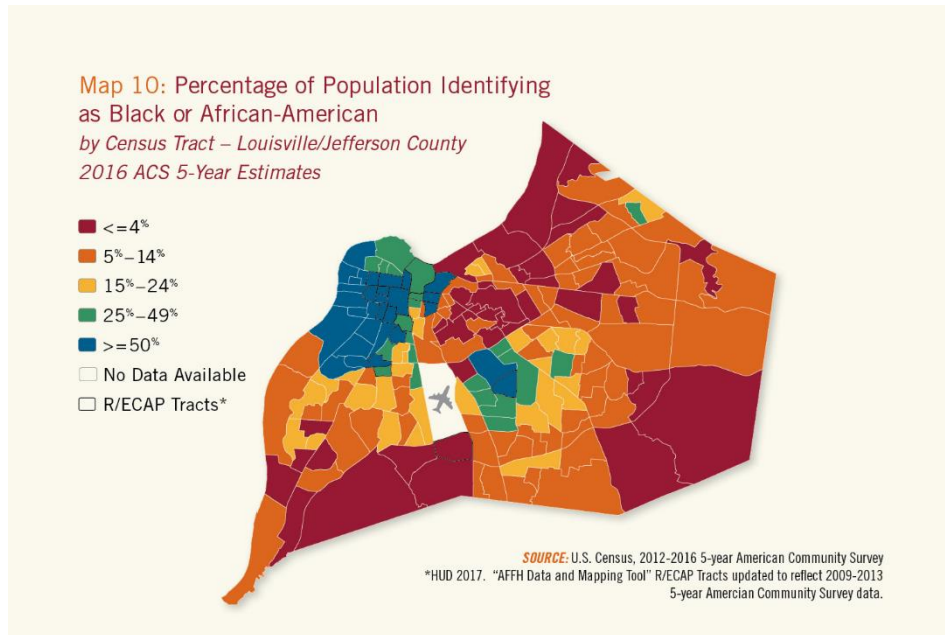
Figure 16. Jefferson County 2017 Distribution of Foreclosure Sales by Zip Code



Source: MHC (2018) p. 11.

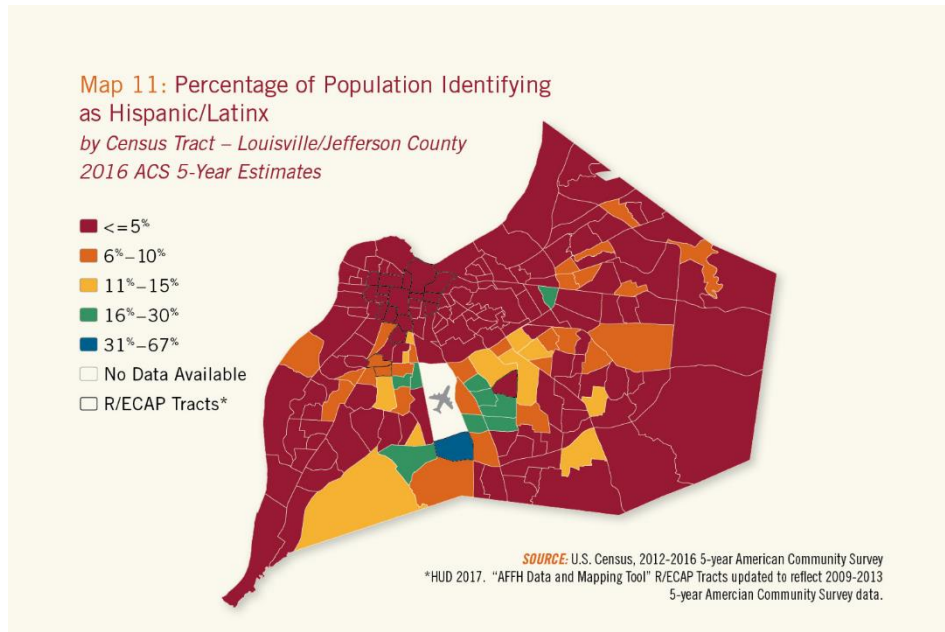
Additionally, these areas are home to large shares of Louisville’s non-white population, particularly Black and Latinx residents (Figures 17 and 18).

Figure 17. Jefferson County 2016 Percentage of Population Identifying as Black or African American by Census Tract



Source: MHC (2018) p. 26.

Figure 18. Jefferson County 2016 Percentage of Population Identifying as Hispanic/Latinx by Census Tract

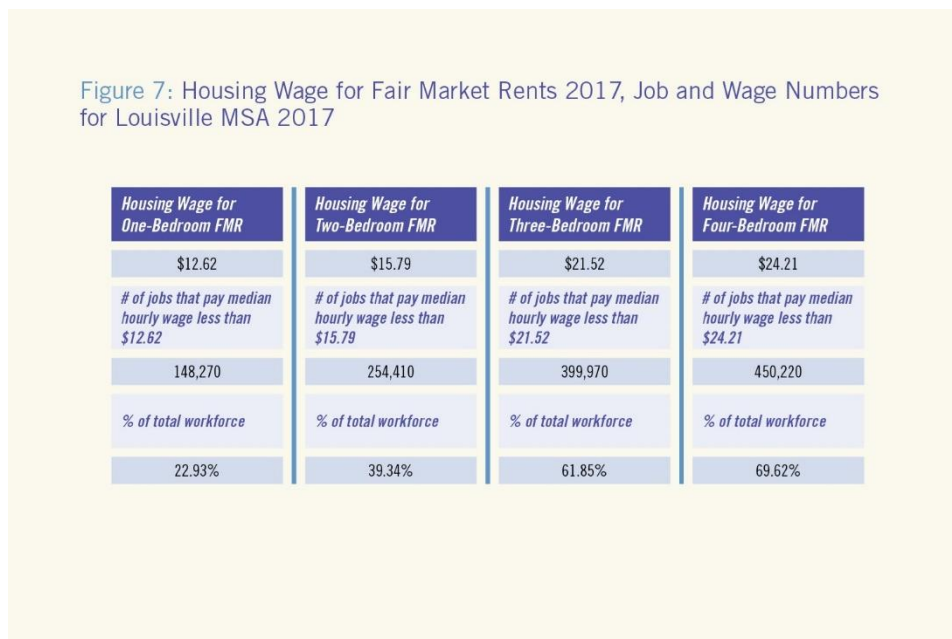


Source: MHC (2018) p. 26.

The ability to afford housing is directly tied to income. Following national trends, wages in Louisville have stagnated while housing costs continue to rise. Depressed wages are particularly

acute among non-white households. Median household income declined steadily in Louisville from 2008-2014, and despite recent increases, median income remains 3.1 percent below 2008 levels, adjusting for inflation.⁹ These trends affect both renters and homeowners, particularly those with lower incomes. For instance, from 2008-2018, *Fair Market Rent* for a two-bedroom unit increased by 5.4 percent from \$663 to \$821, adjusting for inflation.⁹ To afford a two-bedroom unit without being housing cost burdened (i.e., devoting more than 30 percent of income towards housing), a worker would need to earn an hourly wage of \$15.79, yet nearly 40 percent of jobs in the Louisville region pay median wages below this hourly rate (see Figure 19).⁹ According to recent Census data, over 97 percent of homeowners earning less than \$20,000 are cost burdened, as are 83 percent of owners earning \$20-\$35,000, and 46 percent of owners earning \$35-\$50,000.⁹

Figure 19. Housing Wage for Fair Market Rents 2017, Job and Wage for Louisville MSA



Source: MHC (2018) p. 29.

Stagnating wages and rising housing costs can easily lead to loss of shelter, particularly for low- and moderate-income households or those with limited savings. Specifically, eviction and foreclosure processes can potentially result in homelessness and/or unstable housing situations. Over 5,000 eviction judgments occurred in Louisville in 2016, resulting in an eviction rate of 4.82 percent. This is higher than coastal cities that are routinely recognized as having a high cost of living, such as New York (1.61 percent), Boston (1.3 percent), Seattle (less than 1 percent), or San Francisco (less than 1 percent).¹⁵³ One in 10 renter households faced an eviction filing, which initiates the formal process of eviction.⁹ After declining in the years immediately following the Great Recession (2013-2015), *foreclosure starts* have again begun to increase in Jefferson County, rising by 5.7 percent from 2016-2017.⁹

Kentucky's strategic plan to end homelessness includes the use of diversion and prevention strategies, such as assistance problem-solving and navigating resources and financial assistance to resolve immediate housing crises.¹⁵⁴ In 2018, the Coalition for the Homeless instituted the Family Prevention and Diversion program. Families who call the Single Point of Entry office are referred to a Prevention and Diversion Coordinator at the Coalition, who assesses the family's needs and help to problem-solve through barriers to housing and navigate the complex system of available services in Louisville.¹⁵⁵ Not only has the program diverted numerous families from entering an emergency shelter, instead staying somewhere safe or remaining home, it adds capacity to the limited family shelter system in place.

Other prevention services occur through the Office of Resilience and Community Services, which provides emergency rental and utility assistance through its Financial Assistance Program and Low-Income Home Energy Assistance Program, and through regional Community Ministries, which also provide emergency assistance for residents.¹⁵⁶ These programs are critical services that require ongoing funding streams to continue. In addition to government-coordinated services, some nonprofit housing developers are beginning to offer support services to help prevent eviction among residents. The Louisville CARES program considers whether developers applying for funding will provide training opportunities for renters (e.g. preparing a budget), which can also help minimize the potential for eviction.

The federal government retreat from building new public housing units and shift to policies rooted in the private market like LIHTC and the Section 8 voucher and project-based programs makes housing the lowest-income residents in many cities, including Louisville, an uphill battle. Many of Louisville's poorest households maintain housing with the support of different subsidized housing programs, including public housing and Section 8, which are managed by the LMHA. Collectively, these two programs account for over 19,000 housing units in Jefferson County.²⁶ However, there is substantial additional demand for both public housing and Section 8 units. As of October 2018, there were over 13,000 applicants on the Section 8 waiting lists and over 4,400 on the site-based list for public housing. LMHA maintains an open waiting list, meaning it continually adds persons in need of housing assistance to its lists. While this potentially improves access for people in need of housing assistance, it also results in stale list with very long wait times until units or vouchers are available. During this wait time, applicants must continue to update LMHA with their information, which can prove challenging over multiple years. Thus, when units/voucher become available, it can be difficult to locate the persons on the waiting lists.

LMHA uses the flexibility permitted within its Moving to Work status to support persons experiencing homelessness.⁵ This includes collaborating with service providers within the CoC to address directly the needs of various homeless sub-populations. For instance, LMHA works

⁵ Moving to Work is a designation from HUD that permits high-performing housing authorities to "design and test innovative, locally designed strategies that use Federal dollars more efficiently, help residents find employment and become self-sufficient, and increase housing choices for low-income families."157. U. S. Department of Housing and Urban Development. Moving to Work Demonstration Program. <https://www.hud.gov/mtw>.

with the Veterans Administration to house homeless veterans with Veteran Affairs Supportive Housing (VASH) vouchers. LMHA also works closely with the Common Assessment team to shift households receiving PSH, but no longer in need of the supportive services, to traditional housing choice vouchers. This supports efficiencies within the subsidized housing pipeline, freeing up PSH services for other households in need. LMHA partners with and provides vouchers for entities offering case management services to persons experiencing homelessness through its special referral programs, which often support extremely vulnerable populations including persons with HIV and those experiencing domestic violence. Similarly, LMHA modified its administrative plan for the Housing Choice Voucher program to reduce barriers to housing related to criminal history. However, private market landlords that are screening tenants can still impose more stringent background requirements. For public housing, LMHA does still impose stricter criminal background checks, but they are currently reviewing the application of these standards to minimize barriers to housing and ensure alignment with the Admissions and Continuing Occupancy Plan.

Affordable housing has long been a systemic problem. If we had adequate affordable housing, there'd be adequate shelter beds, but there are so many people stuck in shelters that are eligible for housing.

Homeless Service Provider

Recently, HUD allowed a handful of selected housing authorities to experiment with a different Fair Market Rent calculation, one that was based on zip codes rather than metropolitan areas, known as Small Area Fair Market Rents (SAFMR), as a means of providing greater access to neighborhoods with higher rents – and presumably better resources and opportunities – to housing choice voucher-holders. Evaluation of the

SAFMR demonstration found mixed results; voucher households accessed neighborhoods of greater opportunities in some cities, but not in others.¹⁵⁸ While LMHA continues to use traditional Fair Market Rent calculations for its voucher program, the flexibility within its Moving to Work status could allow it to implement an approach similar to SAFMR, which could have the benefit of improving access to a wider cross-section of neighborhoods in Jefferson County for voucher households. However, the SAFMR approach would concurrently decrease FMR in neighborhoods lower housing costs.

One of the key existing mechanisms to support the production of affordable housing is the federal Low-Income Housing Tax Credit (LIHTC), which was used to develop over 1,900 units in Jefferson County since 2008.⁹ This program is administered at the state level through the Kentucky Housing Corporation. Housing professionals note LIHTC scoring criteria often prioritizes funding for non-urban projects, further squeezing already limited resources to address

So we need more [housing]... [and to] take our resources and help people with transportation, child care, health, food scarcity, job training, work force development, living wages. All those things that keep people in a subsidized living environment. If we would focus our resources on people, one family at a time and move them out then you're really looking at vertical affordable housing... People are using it but they're not still getting stuck there. They're using it, they're stabilizing, and they're moving along, that's the ultimate goal.

Housing Developer

Louisville’s affordable housing needs. As previously noted, analysis of this program also finds it contributes to concentrating poverty and racial and ethnic minorities, while not addressing housing needs for the poorest households.¹³⁴

Louisville Metro Government has also recently created two additional local tools to support increased production of affordable housing: the Louisville Affordable Housing Trust Fund (LAHTF) and Louisville CARES: Creating Affordable Residences for Economic Success. The LAHTF provides grants, loans, and technical assistance to housing developers. The \$9.57 million allocated to the LAHTF in 2018 leveraged more than \$164 million in additional funds.¹⁵⁹ In fiscal year 2018, the trust fund allocated \$9.2 million for 22 projects that created 492 new units of affordable housing and preserved 814 existing units.¹⁵⁹ The LAHTF is aligned with the Housing First model, providing funding for several PSH projects in 2018 including a \$477,000 forgivable loan to the YMCA for maintenance of 41 PSH units.¹⁵⁹ In addition, the LAHTF allocated \$50,000 in 2018 specifically for supportive housing services.¹⁵⁹

By ordinance, the LAHTF is required to dedicate 50 percent of its publicly funded dollars to households at or below 50 percent AMI, which in 2018 for a Louisville family of four was approximately \$35,750.⁶

The remaining public funds can serve households earning up to 80 percent AMI, which in 2018 for a Louisville family of four was approximately \$57,200. In addition to public funding, the LAHTF is permitted to accept private gifts, grants, donations, and other contributions, which can support households earning up to 110 percent AMI, which in 2018 for a Louisville family of four was approximately \$78,650.

And that happens too often in city government. We write a policy to prevent something from happening, as opposed to encourage something to happen. And so we are reactive instead of proactive. And so part of what we're doing with the Housing Needs Assessment is trying to be proactive, by taking it, looking at the policies we have in place and trying to develop programs that fit better in alignment with the strategies we have available.

Louisville Downtown Stakeholder

CARES funding differs from the LAHTF in that all the funds have to be repaid within 15 years. The goal of this program is to establish a revolving loan fund and to provide funding for mixed-income projects offering both affordable and market rate units. The CARES program is intended to target affordable housing for low and moderate-income households earning 80 percent AMI or less (approximately \$57,200 in 2018).

Understanding the state of housing affordability in Louisville is imperative for developing policy solutions that will address overall homelessness and unsheltered populations as well prevent future homelessness. The recently released Housing Needs Assessment highlights the need for a substantial number of additional units that are affordable to households with the most limited means.¹⁶⁰ Specifically, the report cites an unmet need of over 30,000 units for households earning less than 30 percent AMI (approximately \$25,100) and over 20,000 units for household earning between 30 percent and 50 percent AMI (between \$25,100 and \$35,750).¹⁶⁰

⁶ In 2018, area median income for Louisville was \$71,500.

Notably, the unmet need for moderate-income groups (earning 80 percent to 100 percent AMI, or \$57,200-\$71,500) is far smaller and there is a surplus of housing for upper income households (earning over 100 percent AMI).¹⁶⁰ Thinking about these findings through a fair housing lens, the most recently available Census data from the American Community Survey (2017 five-year estimates) show that non-white households continue to disproportionately comprise the lowest income household in Louisville, with a median household income among Black households of \$32,456, \$45,412 for Latinx households, and \$59,372 for non-Hispanic White households. In other words, these unmet housing needs disproportionately affect Louisville's non-white households. Furthermore, these households are spatially concentrated in western and southern parts of Jefferson County, which is at least partially driven by the widespread single-family zoning classification that dominates the eastern and northern parts of Louisville. These single-family zoning patterns are a vestige of historic redlining processes and other public and privately sanctioned discriminatory housing practices. Dismantling single-family zoning has the potential to undo these injustices.

In short, the biggest gap in Louisville's existing housing infrastructure is providing affordable units for our lowest-income households. Rents that are affordable to the lowest income households do not cover the costs of construction and maintenance for private sector developers. For instance, the subsidy needed to develop a housing unit for households earning 30 percent of Louisville's AMI (approximately \$25,100 in 2018 for a family of four) can oftentimes exceed \$30,000. The challenge and expense associated with developing housing for extremely low-income households is a point echoed in the literature and among local housing professionals in the for-profit, nonprofit, and government sectors.¹³² The Housing Needs Assessment provides an opportunity to proactively pursue housing policy changes that will help address Louisville's most pressing housing needs, which the report clearly identifies are among our lowest income households. This includes policies such as Inclusionary Zoning, which can support the supply of affordable housing by either requiring these units within developments or allowing developers to make contributions to the LAHTF in-lieu of the physical units.

A focused effort to expand available and affordable housing opportunities to Louisville's poorest households is a necessary component for achieving a Housing First system orientation, and this effort will require substantial work and coordination with entities internal and external to the CoC. Addressing the challenges of homelessness should not be limited to the domain of social service providers and the CoC, but should be part of the broader collective vision of the city, and include those focused on economic development and within private sector businesses. Specifically, pursuing a policy that raise minimum wage levels to help reduce poverty rates is one way to address homelessness directly.

Public Awareness

The information presented above pertaining to homelessness, the services required to combat it, and its relationships to housing policies and practices, as well as to broader health and social services, is complex, to say the least. The research team reviewed local service and advocacy

literature as well as media coverage of these issues, and identified knowledge gaps in public awareness in these three regards: 1) individuals experiencing homelessness and in particular unsheltered local residents; 2) advocates and service providers for homeless and housing-distressed local residents; and 3) the general public.

Interviews with local advocates and service providers revealed a great deal of commitment and hard work. Nonetheless, information made available to unsheltered persons and those staying in shelters is in many cases spotty and/or not easily accessed, especially by comparison with best practices found in comparable cities such as Charleston, SC, or Columbus, OH. Some homeless service providers are not fully informed about the many facets of, and barriers to, obtaining and sustaining permanent housing. Considerable knowledge gaps exist between homelessness and housing service providers and case

I think it's a really basic thing... to treat people like human beings... you've got to make eye contact. You've got to say hello. Every once in a while if you initiate conversation, people will be shocked, because no one speaks to them. They don't act like they're even present. It's like they're invisible. I think that's really where it's so simple where it starts, because it's just like basic decency.

Louisville Downtown Stakeholder

managers, sometimes undermining the “warm handoff” that is optimal between these two constituencies. Likewise, interviews suggest that not all are sufficiently aware of or sensitive to the many forms of discrimination that some groups of the homeless population face. These groups correspond to protected classes under federal and local fair housing laws. The disadvantaged members of these protected classes face, as discussed earlier in this report, mirror systematic inequalities evident in the larger society (e.g., racism, homophobia, transphobia, gendered violence, linguistic barriers, immigration status, and the challenges of disabled persons, to name a few). Interviews with those experiencing homelessness and their advocates/service providers revealed particular levels of problems facing people with disabilities and those who identify as transgender.

Too often, the complex lived experiences of homeless and unsheltered residents are not made clear to the larger public even in news coverage of homelessness. Much of the local news reporting over the past nine months tends to respond to crises and does not fully reflect the complex dynamics that sustain homelessness or the myriad of strengths that Louisville demonstrates in solving it. Public awareness is also limited in the most effective ways other residents can be most helpful (information as basic as providing food, water bottles, or food-related gift cards to homeless people, for example, but not other items they cannot consume or carry), as well as in the associated need for affordable housing in their own neighborhoods.

RECOMMENDATIONS

In its recent strategic plan, the Kentucky Interagency Council on Homelessness proposed that Kentucky's primary goal is reflective of the federal plan, which is to "transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness into stable housing."¹⁵⁴ The recommendations in this report are made in alignment with this goal.

Mackie, Johnsen, and Wood's literature review on solutions to street homelessness also offers clues as to why communities are not successful in implementing best practices and resolving unsheltered homelessness, despite the understanding of mechanisms by which success might be met:³²

- Lack of affordable housing;
- Lack of funding for both short-term and sustained interventions;
- Lack of effective collaboration among disciplines and sectors, both in providing effective support services and in contributing funding to solutions;
- A lack of attention to addressing the needs of subgroups within the homeless population;
- Barriers to housing and public services, such as eligibility restrictions to housing subsidies;
- Bureaucracy that complicates processes; and
- Absence of political will to alter prevailing systems and invest in new systems.

The evidence-based recommendations that follow are powerfully important and were made with these difficulties in mind.

1. Expand and evolve homeless services. Although Louisville offers many valuable services that are meeting needs at many points both within the CoC and among other agencies, a few gaps that have become hurdles in meeting the goals of the Housing First model. Ultimately, too many Louisvillians have been homeless for too long and unsheltered homelessness presents as problematic for both residents of encampments and other stakeholders.

- An individual's first point of contact within the system, through outreach or CEP, should consistently screen for the immediate and pressing needs of every caller or visitor, in an effort to understand barriers to housing. These barriers should be documented within shared CoC records, perhaps in HMIS or United Community, to relieve the burden of repeating stories and reliving trauma. In addition to receiving a bed assignment for the night, this individual should also receive the name of a case manager who will initiate contact onsite upon their arrival to the facility.

- Another revision of this system entails the CoC facilitation of one care coordination team, with case management to aid individuals and families to identify permanent housing options and resolve existing barriers to housing, allowing them to move out of homelessness as quickly as possible. Because the goals of the CoC include decreasing length of shelter stays and increasing number of individuals exiting to permanent housing, a centralized case management team would follow the person or family from the CEP to permanent housing. Case managers would be associated with individual cases, and not specific locations or agencies. This centralized team would eliminate duplicative services across the CoC, as well as provide consistency for individuals, which improves accountability. The case management team would accept referrals from outreach and CEP, and provide the accompaniment needed to navigate a complex system, resolve barriers, and move home.
- Develop an intentional climate of caring and connection throughout services in the CoC. Ensure all staff providing services are competent in trauma-informed and culturally-sensitive care, by performing a compliance evaluation and responding when consumer satisfaction surveys indicate problem areas. Understand that training does not equate to competence, and no one training ensures cultural competency. Rather, provide intentional and ongoing training throughout the year by inviting participation of those with expertise on each specific subpopulation (and for staff with credentials, offer continuing education units). From the executive director, to case managers, to the maintenance and security staff, every interaction a client or guest experiences with a homeless service provider should be respectful and empathic. Clients should feel safe in care environments, know that their voices are valued, and have the opportunity to make their own choices as adults. Place high demand on staff, and low demand on clients; they come seeking assistance, and the first step through the front door may have been traumatizing enough. Employ the accompaniment model, and honor the concept that everyone is creative, resourceful, and whole.¹⁶¹
- Expand designated medical respite beds, and ensure emergency facilities are accessible per the standards set by Title III of the Americans with Disabilities Act.

We have completely changed the way ... we were doing this service. It was not, "You homeless people, I'm going to empower you." It was like, "I'm going to work with you until you are ready." When they're ready, we're ready. Whenever the time comes you will come... So it takes the value of our culture, the value of community, which I think that that's what's lacking in our mainstream community.

Homeless Service Provider

- Expand Assertive Community Treatment (ACT) services for individuals with mental illness, substance use disorders, and dual diagnoses. Centerstone offers one ACT team for individuals with chronic and persistent mental illness. While the specific parameters and outcomes of this team are unknown for this report, the service by only one team or one provider limits the ability to truly address the need of the Louisville community. It should be noted that ACT is most beneficial in producing positive outcomes when the fidelity of the ACT model is closely observed.¹⁶²
 - Increase transportation opportunities. Encourage clients to take advantage of nontraditional resources, such as Medicaid MCOs that offer transportation services to employment training and Medicaid non-emergency transportation for medical appointments. Request assistance from faith communities to donate the use of their vans and the time of a volunteer driver. Enhance the existing partnership with TARC that enables individuals experiencing homelessness to show their Coalition for the Homeless identification cards to provide transportation to locations and appointments other than emergency shelters.
 - Explore further the potential for implementing harm-reduction models for individuals with addiction who are not yet ready for treatment. Substance abuse remains a significant issue in our community, and interventions can take multiple attempts prior to success. Kentucky has received funding to address opioid addiction throughout the state in innovative ways.¹⁶³ But we can expect some Louisvillians to continually find themselves at the intersection of addiction and homelessness. Harm-reduction strategies, such as wet houses and other safe places to use, can reduce unsheltered homelessness by meeting people where they are.
 - Ensure access to safe spaces 24 hours a day, 365 days of the year. Invite partners from other sectors to offer availability that reduces the likelihood that individuals with nowhere else to go might congregate in unwelcomed places.
- 2. Encampment policies.** Sanctioning encampments remains a problematic concept, with no clearly established paths for success. Yet clearing these camps is equally problematic when some residents (especially families) have nowhere else to go except to a different freeway underpass or parking spot (in the case of those who live in their cars). There will always be those who insist on living outside rather than in shelters, several homeless service providers told us in interviews, but provision of meaningful alternatives would almost certainly reduce that number significantly.
- In determining solutions to encampments, which are now ongoing features of U.S. urban landscapes, the suggestions below need further refinement that can only come from listening to those living in encampments. In order to advance best practices and policies locally, it is imperative that policymakers develop mechanisms for listening to and engaging with those campers more fully to devise alternatives that better meet

their needs. This report reflects a few voices of encampment dwellers, but a full survey of them was beyond the capacity of this research project, and is a central recommendation for dealing with encampments more effectively.

This is my family here. [describing people also living in the encampment] These people, they've opened up to me, I've opened up to them.

Louisvillian Experiencing Homelessness

- Louisville Metro should provide, or authorize third parties to provide, hygiene and shower facilities that are made freely available to camp residents. Likewise, the storage facilities should be expanded promptly to provide additional lockers in multiple locations close to the most heavily camped areas of the city.

- Other alternatives should also be considered to better respond to the needs of those living in camps: these could include small, authorized camping spaces or small, safe, secure parking areas for families living in cars. Such alternatives might best be provided by nonprofits, as in the case of Washington, which allows faith communities to establish and maintain such spaces.
- Additional efforts that nonetheless stop short of sanctioning could and should be made toward further decriminalization of the encampments. The most pressing option is to extend the encampment ordinance, as other cities have done, to require storage of all belongings when a camp is dismantled instead of allowing the destruction of residents' property. As is the case in Indianapolis, the ordinance could also be expanded so that in addition to advance notice, another prerequisite to clearance is provision of alternative shelter arrangements for each member of the encampment, whether they take it or not. The response among local street outreach workers to such a policy was the reminder that we lack sufficient shelter beds for fulfilling such a commitment, yet such beds could be prioritized even within existing shelter space.

3. Create a system of low-barrier shelters. As noted in national best practices, low-barrier shelters are most successful when they are small and designated for subpopulations, and accessible throughout the geographic region. Rather than providing one large low-barrier shelter and multiple additional shelters, Louisville's CoC should transition to only low-barrier emergency shelters.

- Smaller shelters—ones that reach capacity at less than 50 beds—can offer increased safety and dignity while ensuring a staff to guest ratio that supports trauma-informed care and cultural competency. Emergency shelters should be open 24 hours.

Are consumers consulted on programs? Or are people who have houses and food security developing programs and telling people how great they are?

Homeless Service Provider

- Shelters should be specific to subpopulations of individuals experiencing homelessness, with the primary goal of ensuring safety. Subpopulations listed in recognized best practices include single and coupled adults, families with children, unaccompanied youth, and individuals and households fleeing domestic violence. Although the literature does not name LGBTQ people, they may feel more comfortable in a shelter specific to the population. Additional shelter opportunities are needed especially for families and victims of domestic violence due to notable shortages in Louisville.
- If an individual's first point of contact is at a shelter that does not meet their needs, shelter staff should link them directly to one that can.
- Current services are mostly located downtown, but people experiencing homelessness are all over Jefferson County. Specific needs are identified in South Central Louisville, Fern Creek, and South Dixie Highway, but there has been a rise in individuals who are staying in the eastern parts of the county as well.

4. Improve collaboration. As noted in the introduction of this report, resolving homelessness must be a community-wide effort.

- The newest addition of a full-time homeless outreach team has proven vital in connecting unsheltered individuals to needed services, including emergency shelter. Expanding the outreach team, in terms of membership, availability, and diversity, can increase the footprint of the team. Additional members should include officers from LMPD and clinicians who can provide onsite medical care. The role of this team is to ensure the basic wellbeing of campers, and connect them to services, including a housing case manager, with a warm-handoff if need be.

Government, business, nonprofit, faith, education, health care, and community at-large... every one of those sectors have a significant role to play and every one of those sectors has a lot of experience and resources that are different from the other sectors to bring to the table.

Louisville Downtown
Stakeholder

- Additionally, the monthly care coordination meeting among outreach and shelter providers has added organization around community-wide efforts. However, other entities are engaging in outreach, through both volunteerism and their official capacities. Include LMPD, staff from the Louisville Downtown Partnership, and others whose daily paths cross those of individuals experiencing homelessness, in monthly outreach coordination meetings. As noted, LMPD officers engage in outreach. They track encounters, and collaborating with them to understand their data can aid in verifying an episode of homelessness.

- Connect to the United Community platform. United Community, housed at Metro United Way, is the city's newest opportunity for improved communication among providers, making direct referrals, and enhancing information sharing. One key element of an individual's record within United Community should be the date of their most recent TB test; since homeless providers require TB testing for entry, a lost card has been a barrier to the receipt of timely services.
 - Improve discharge planning from institutions, such as the jail, hospitals, recovery centers, and foster care, to ensure no one in Louisville exits to unsheltered homelessness. If a client arrives at a facility reporting homelessness, connect them with housing counseling in advance of discharge. In the case of youth in foster care, ensure the receipt of life skills training and begin preparing for transition as early as age 15. Use the United Community referral system, the assistance of outreach teams, and develop new relationships across sectors that support transitions.
 - Train police officers of other jurisdictions on homelessness, trauma-informed care, crisis intervention, cultural competency, and racial disparities. Jefferson County is comprised of many smaller cities that provide their own public services in addition to those provided by LMPD. Recognizing that police officers are often an initial point of contact for an individual requiring assistance, all officers should be competent in directing someone to the right resources.
- 5. Housing and Community Development.** Amend existing affordable housing programs to address the most pressing housing needs, and enact policies for community development with affordable housing, fair housing, and equity in mind. This requires adjustment to planning and zoning regulations to meet affordable housing needs.
- As research suggests and as data from interviews confirmed, a dedicated funding source for the LAHTF and CARES are needed to solidify Louisville's commitment to funding affordable housing for its residents. Both LAHTF and CARES are relatively new programs. Research shows developers desire certainty around these types of incentive programs, including long-term stable funding so they can plan projects with funding sources and requirements known upfront, reducing risks and costs.
 - Redirect LAHTF and CARES funds to the affordable housing gaps identified by the Housing Needs Assessment – households earning less than 30 percent of AMI and households earning between 30 percent and 50 percent AMI. With limited public resources to support affordable housing development, it is imperative that these resources are directed to those households with the greatest need, even though these units are more expensive to build. Consider amending the LAHTF ordinance to include homeless persons specifically and increasing funding directed to PSH projects and services.

- In January 2019, Louisville Metro formally adopted Plan 2040 as the document guiding land development decisions and changes to the built environment for the next 20 years. As updates to the Land Development Code to align with the goals of Plan 2040 are considered, careful attention should be paid to approaches that can support the creation of more affordable housing and dismantle the racial and economic segregation that persists in Louisville. Specifically, Louisville Metro should consider increasing density within single family zoning districts as a means of encouraging more affordable housing, and racially and economically integrated neighborhoods to promote health and quality of life.
- As recommended in the Housing Needs Assessment, a formal inclusionary zoning policy should be created and adopted as an additional tool for closing the gap in Louisville's affordable housing needs. This policy should be aligned with the key findings from the Housing Needs Assessment and should target the inclusion of units for households earning 50 percent AMI or less.
- Promote fair housing by including source of income as a local protected class. Given the prevalence of local poverty, it acts as a systematic barrier to securing housing for those in this "class." Research shows this is one way to improve the utilization rates of Housing Choice Vouchers and prevent landlords from discriminating against persons using this housing subsidy to pay rent.¹³⁰
- LMHA should continue to foster relationships with landlords, in an effort to resolve barriers to their willingness to accept vouchers and residents who rely on them. LMHA should also investigate whether Small Area Fair Market Rent would be an appropriate tool for improving fair housing in Louisville.
- Prevent future homelessness. Continue and expand funding for eviction and foreclosure prevention services and utility assistance as a means of proactively preventing homelessness. Expand the availability of representative payee services for vulnerable individuals. As the Mayor and Louisville Metro Council develop the annual budget, note that preventive measures are costly up front, but there is evidence that they provide the needed help to keep a household from experiencing the trauma of homelessness, and are a cost-effective way in treating the issue of homelessness.
- Listen to and support advocates, activists, and residents working for community land trusts, cooperative ownership, permanent affordability covenants, rent control, and tenants unions as approaches to homelessness prevention. Many tools to address affordable housing needs are rooted in the market-based dynamics that shape our housing systems. However, we also know that many market-based mechanisms perpetuate systems of racial injustice and inequality. Thus, affordable housing solutions should not only be market-based, but these approaches can and should be balanced with support and funding for collective ownership models and community-based

strategies that are vital to preventing future homelessness. As neighborhoods in West Louisville experience unprecedented reinvestment, the low-income residents that currently reside in these neighborhoods are at great risk of being displaced from their homes due to rising rents and property values, which can potentially lead to homelessness. Thus, it is crucial to proactively address this displacement potential and have tools in place that will help renters and homeowners remain in their neighborhoods.

- Complete a feasibility study on billing Medicaid for housing and related services. Although becoming a Medicaid-enrolled provider and adding the organizational capacity to bill for services might be prohibitive to small, individual providers, joint among providers to recoup funds through Medicaid might provide operational efficiencies. See [Medicaid policy guidance](#) for more information.

6. Address root causes of homelessness beyond housing. Be conscious about the inequities and un-intended consequences that policy decisions create, especially when they are embedded in structural discrimination and perpetuate poverty.

- Create policies to raise the minimum wage and promote generational wealth. Beyond affordable housing development, consider policies and practices that promote home ownership rather than gentrification and displacement.
- Revise policies within the criminal justice system that create barriers to accessing employment and housing. Consider incentives to private employers who follow “ban the box” standards.

I think that's the thing is... to remember in the big picture, this is a systemic thing... that we can do all the outreach and shelter we want, but we have crises in our affordable housing and mental health treatment... So, we can do all these things to make the work we do better, and we should, but there are all these larger things in society that are always going to drive homelessness, and we're never going to end it unless we really look at those factors.

Homeless Service Provider

7. Community Education and Engagement. A key recommendation based on all of our findings is to develop a comprehensive public awareness campaign that is aimed at all three audiences discussed earlier (homeless Louisvillians, homelessness and housing service providers and advocates, and the general public). Community education will require everyone’s participation, not just those who serve the homeless: those experiencing homelessness, those who encounter someone affected by homelessness, the organizations and individuals combating this problem, the stakeholders affected by the growing homeless population, and finally local policymakers and their enforcers, who ultimately must lean toward or away from justice. A major campaign of unlearning and relearning the real and complex narratives behind homelessness will be necessary if Louisville is to succeed as a

community in making the city a home for all. To enact better community-wide solutions, larger-scale and more coordinated efforts to educate and involve more segments of the public on the issue of homelessness are needed, and Louisville possesses a vibrant and diverse arts, culture, and media community that could contribute significantly to that effort.

- The central local hotline for someone in need of shelter is a critical service, and LouieConnect has become an invaluable online asset by listing local agencies and resources. But, comprehensive supplemental information for homeless residents and their advocates should also be more widely available in printed form to all outreach workers and onsite at all local shelters, transitional housing facilities, treatment centers, social welfare organizations, sites of homeless concentration, places of worship, and informal encampments, for staff and volunteers alike. The existing Louisville Street Tips resource contains information relevant to obtaining both homelessness and housing assistance services, as well as all relevant services for unsheltered people in need (e.g., free meals, drop-in centers, free shower and storage options). It is positive that such a brochure exists, but it needs far greater printing and distribution than is currently the case. Distribution of such material is crucial, not just production of it. Louisville Metro and the Coalition for the Homeless should devote attention to ensuring the piece is widely reproduced and circulated, updated regularly both in print and online (i.e., not buried inside other pages or dated versions), translated into Spanish (and other languages as needed), and distributed among non-English speaking networks.
- From the findings of this report in regards to enhanced coordination of services, the Coalition for the Homeless and Louisville Metro Department of Resilience and Community Services should work with the research team to identify the best providers to produce a webinar or presentation. This training should be required of all service providers who deal with any aspect of homeless support, outreach, transitional housing, or low-income housing assistance applicable to those at 30 percent or less of AMI. The purposes of such a training are 1) to reinforce for all relevant service providers the inherent connection between reducing homelessness and providing permanent housing solutions for the lowest-income poor and the importance of a warm hand-off and follow-up monitoring in doing so; and 2) to ensure greater cultural competency in all who deal with that income group.
- Work with Metropolitan Housing Coalition to develop and distribute training materials to prevent discrimination among federal and local protected, and specify how such discriminations apply to those experiencing homeless. Such materials need reinforcement and should be part of ongoing cultural competency training, not simply a one-time program.

- Develop basic informational materials, workshops, or webinars that provide information about low-barrier shelters, the Housing First approach, and longer-term support services that reinforce housing security, which are open to the public and held in neighborhood locations. Some of this material should be particularly aimed at faith communities since they tend to provide homelessness and resettlement assistance.

You know, people always say, "Well, why don't they just go get a job?" It's not that easy. It's not that easy when you've got four kids, because you couldn't pay your bills or whatever, for whatever reason, you're homeless, who's going to watch the kids? ... This is going to take a village type of situation to fix this problem, and we've got to stop pouring money down rabbit holes that ain't solving anything.

Homeless Service Provider

- Leadership from Coalition for the Homeless and the CoC in development of a realizable, measurable, community-wide goal for reducing all homelessness in collaboration and in close communication with multiple sectors (government, industry, media, faith, health care/hospitals, nonprofits, schools, businesses). Part of this campaign should be devoted to marketing and messaging, including the development of a logo that is required for use by all agencies and groups that work to provide homeless support and advocacy. Such a logo should be eye-catching and convey a message about reducing homelessness, and its distribution should include TV public service announcements, billboards, and on digital media. Use of a common logo and messaging would signify a level of unity and coordination that would benefit, educate, and engage the local community.
- Since Thanksgiving and winter holidays and the Street Count in January represent “flashpoints,” as one homeless advocate reported, of greatest public awareness of the plight of homelessness, the launch of such a broad-based community awareness campaign should be timed to correlate with those occasions.
- As part of such a campaign, develop and distribute an “identification of good story” handout to homeless assistance providers that is incorporated into part of the material routinely collected on the cases each works on. This content could be housed either at Coalition for the Homeless or Louisville Metro Department of Resilience and Community Services, but it should also be shared. In this way, eloquent and willing voices of the homeless can be identified for possible media features, ranging from those who successfully found permanent housing to others who have made a rational choice to remain unsheltered given their alternatives.
- Coalition for the Homeless and Louisville Metro Department of Resilience and Community Services should collaborate through the auspices of the CoC to generate and distribute news releases more regularly and systematically that are then made readily apparent on their respective websites. News releases should emphasize transparency, and proactively feature positive steps as well as new challenges. In this manner, local residents can more easily follow the progress of homelessness policies and solutions.

- The Mayor’s Office should collaborate with the Louisville Free Public Libraries to host multiple screenings and discussions in various parts of the county of the recent Amazon Prime documentary film, “Under the Bridge,” which profiles the problem of encampments in Indianapolis and how an ordinance resulted that ties clearance to required housing provision.
 - Working with, and extending, materials such as Aaron Hutchings’ documentary interviews with homeless Louisvillians, pursue a partnership with local media to develop a radio or podcast series featuring experiences and voices of homeless Louisvillians. If possible, involve individuals who are homeless or formerly homeless in such a production. An excellent media partnership opportunity lies in Louisville Public Media’s “Next Louisville” series. This production could then be archived and made widely available on an ongoing basis, possibly through the Coalition for the Homeless website and other avenues.
 - Pursue a partnership with Actors’ Theatre of Louisville or another local theatre company (perhaps through a local call for partners promoted through social media) to develop a play on homelessness that includes the participation of homeless and formerly homeless people and is promoted broadly through all homelessness and housing-related service providers. A similar successful project was implemented in Billings, MT in 2013.¹⁶⁴
- 8. Evaluate the outcomes of new policies and programs.** Too often, new programs and policies are put into place, without consideration of evaluation from the onset. Not only is evaluation key to understanding the effectiveness of interventions locally and the productivity of associated costs, but it can offer awareness of actual practices within organizations and can promote continued improvement. Evaluation adds to the larger body of evidence that supports best practices. It is recommended that evaluation is planned from the initial conception of program design, and funding allocated to this element of system-level changes.

The above measures are not dependent on one another: implementing one or some of them would move the metro area in the direction of best practices even if implementing all were beyond the community's means at this time. Costs of each of measure vary depending on the partnerships involved in enacting each of them, and are therefore not attached to this recommendation.

It's our experience, again and again and again, that when someone's mental health is treated, that they want to be in a place where they are safe, that they can call their own, where they have community, where they have the dignity of having their own bathroom and making their own coffee in the morning. And for others, it's when their substance abuse is treated... and when people have enough invitations that they deserve housing and that we're gonna be there for them to help them maintain that housing, then they can say yes... So I don't buy it, that people want to be homeless. I think that people believe that's their best option today. And I think we never ever, ever, ever give up on offering an invitation to a better day.

Homeless Service Provider

HOMELESSNESS GLOSSARY OF TERMS

Adverse Childhood Experiences (ACEs): *The term used to describe all types of abuse, neglect, and other potentially traumatic experiences that occur to people under the age of 18; linked to a risk of negative behavioral outcomes such as alcoholism, drug use, and smoking, as well as increased physical and mental health issues*

Affordable Housing: *Housing for which the occupant(s) is/are paying no more than 30 percent of his or her income for gross housing costs, including utilities*

Area Median Income: *The household income for the median, or middle, household in a region*

Common Assessment Team: *The coordinated system for homeless client referrals in Louisville*

Continuum of Care: *A community's plan to organize and deliver shelter and services that meet the specific needs of homeless individuals and families as they move toward stable housing and maximum self-sufficiency. This plan should include:*

- *Outreach, intake, and assessment to identify an individual's and family's service and housing needs, and link them to appropriate housing or service resources.*
- *Emergency shelter and safe, decent alternatives to the streets.*
- *Longer term shelter with supportive services to allow people the time and support to eliminate barriers to permanent housing, such as utility debt.*
- *Permanent housing and permanent supportive housing*

Coordinated Entry Process (CEP): *The CEP serves as the first point of contact to individuals and families experiencing homelessness in the community, in which staff triage individual and family housing and service requests, including requests for emergency shelter*

Fair Market Rent: *The 40th percentile of gross rents for typical, non-substandard rental units occupied by recent movers in a local housing market*

Foreclosure Starts: *Legal actions filed in circuit courts*

Cost Burdened: *When a household is paying more than 30 percent of their income for housing costs*

Housing First: *An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements*

Low-Barrier Shelter: *A 24-hour facility that does not turn people away or make access contingent on sobriety, minimum income requirements, or lack of a criminal history; does not require family members, partners, and pets to separate from one another in order to access shelter; and ensures that policies and procedures promote dignity and respect for every person seeking or needing shelter*

Permanent Supportive Housing: *An intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services*

Public housing: *Provides decent and safe rental housing for eligible low-income families, the elderly, and persons with disabilities*

Rapid Re-housing: *An intervention, informed by a Housing First approach that is a critical part of a community's effective homeless crisis response system. Rapid re-housing rapidly connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services*

Resilience: *The ability to recover from adversity*

Section 8: *Includes the housing choice voucher program, which is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market, and project-based rent subsidies, which are tied to specific units*

Transitional Housing: *Housing and appropriate supportive services to homeless persons to facilitate movement to independent living. The housing is short-term, typically less than 24 months. In addition to providing safe housing for those in need, other services are available to help participants become self-sufficient*

Trauma-informed care: *An approach in the human service field that recognizes the presence of trauma symptoms and acknowledges the role trauma may play in an individual's life*

Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT): *A survey administered both to individuals and families to determine risk and prioritization when providing assistance to homeless and at-risk of homelessness persons*

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