

Kentucky's Ten-Year Plan to End Chronic Homelessness

Kentucky Council on Homeless Policy
2005



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EXECUTIVE SUMMARY

Background

The Kentucky Council on Homeless Policy was created after Kentucky participated in two policy academies sponsored by the U.S. Departments of Health and Human Services and Housing and Urban Development. The two academies brought together state agencies and nonprofits to coordinate policy decisions. As a result of the academies, Governor Ernie Fletcher tasked the Kentucky Council on Homeless Policy to develop a ten-year plan to end chronic homelessness in Kentucky.

The development of the plan was coordinated with the cities of Louisville, Lexington and Bowling Green, as well as the Northern Kentucky Area Development District, in a process that included 12 community forums held across the state. The following summarizes key elements of the plan.

The Need

The 2005 preliminary data demonstrated there are approximately 19,141 homeless persons in Kentucky. Of that number, 2,470 are chronically homeless; however, they consume over 50 percent of the homeless resources. Studies of the chronically homeless reflect that many report occurrences of mental illness (22 percent), alcohol/chemical dependency (50 percent), major physical disability (15 percent) and domestic violence (46 percent).

Gaps and Barriers

In Kentucky, there is an insufficient supply of all types of safe, decent and affordable housing. Adequate funding for support services is critical to help find stable housing. There is a need for improved discharge planning for those aging out of foster care, persons exiting correctional institutions and persons with serious mental illness and/or substance abuse disorders leaving state facilities.

The Strategy

To address the gaps and barriers, the state must create more housing for the homeless (1,000 transitional units and 2,400 permanent supportive housing units) and locate additional sources of funding. Kentucky must work to provide more supportive services. Prevention strategies for discharge planning, alternatives to incarceration and emergency assistance, as well as the coordination of these services, must occur to prevent the ongoing issues of homelessness.

Progress to Date

In January 2005, Governor Ernie Fletcher unveiled an initiative called Recovery Kentucky that works toward ending chronic homelessness. Recovery Kentucky is an initiative to help Kentuckians recover from substance abuse, which often leads to chronic homelessness. The program accomplishes two goals: it reduces the state's drug problem and resolves some of the state's homeless issues.

The Corporation for Supportive Housing granted Kentucky Housing Corporation (KHC) \$454,280 to aid in integrating the state systems that finance and create supportive housing, establishing a supportive housing pipeline of 532 units and increasing investments directed toward supportive housing by \$3 million.

KHC provides \$300,000 a year matching funds from its Housing Assistance Fund for recipients of Supportive Housing and Shelter Plus Care.

KHC HOME Tenant-Based Rental Assistance provides up to two years of rental assistance until a Section 8 voucher is received or some other form of housing can be provided.

Most recently a Memorandum of Understanding (MOU) was signed by representatives of the Governor's Office, Cabinet for Health and Family Services, Department of Veterans Affairs, Education Cabinet, Governor's Office for Local Development (GOLD), Justice and Public Safety Cabinet and KHC to achieve systems integration or change that will better focus resources to prevent and end homelessness.

Governor Fletcher established an Office for Faith-Based and Community Nonprofit Social Services in the Office of the Governor. Kentucky plans to work with faith-based and community service groups to enhance the delivery of services to chronically homeless individuals.

The Financing Plan

The creation of 1,000 transitional housing units will be accomplished through Recovery Kentucky. Financing for this initiative includes a \$2.5 million annual allocation of Low Income Housing Tax Credits from KHC, which will generate a total equity investment of approximately \$20 million for construction costs. Operational funding includes approximately \$4 million from GOLD's Community Development Block Grant program and approximately \$3 million from the Department of Corrections.

Kentucky needs to create 2,400 units of permanent supportive housing. In conjunction with KHC's grant from the Corporation for Supportive Housing, all other available resources will be utilized to construct the units needed to provide permanent supportive housing. Funding will need to come from federal, state, local and philanthropic sources.

Vision and Goal

Kentucky joins President George W. Bush and the U.S. Interagency Council on Homelessness in the goal to end chronic homelessness in a ten-year period. Adequate affordable housing of all types for individuals experiencing homelessness is needed to provide a solution to chronic homelessness.

The Implementation Plan

To implement the plan, lead agencies participating in the MOU are identified to work on the housing, service and prevention strategies. They will also work within the six Continuum of Care regions in the state to execute the plan, coordinate the efforts of all agencies involved and use the provided performance indicators to annually report their progress.

I. Background

As part of the Bush administration's initiative to end chronic homelessness, Kentucky has participated in two policy academies sponsored by the U.S. Departments of Health and Human Services and Housing and Urban Development (HUD) that brought together state agencies and nonprofits to better coordinate policy decisions. The Kentucky Council on Homeless Policy (see Appendix A), which receives staff support from KHC, was formed as a result of these academies and was tasked by Governor Ernie Fletcher with the development of a ten-year plan to end chronic homelessness in Kentucky.

The development of the plan was coordinated with the cities of Louisville, Lexington and Bowling Green, as well as the Northern Kentucky Area Development District. Louisville developed its *Reducing Homelessness: A Blueprint for the Future* in 2002 and is using this opportunity to update the plan. Bowling Green and Lexington will have plans that are basically addenda to the state's plan, with goals that are specific to those communities. The process included 12 community forums held across the state from late August to mid-October 2004 and the work of four standing committees (discharge planning, substance abuse treatment, accessing mainstream services and mental health treatment). Input from the community forums and work committees formed the basis for discussions that were held at daylong regional meetings where participants organized the identified gaps and barriers with possible solutions to shape the structure of the ten-year plan.

II. Need

In Kentucky, a point-in-time survey conducted the last week of January 2005 reflects that there are currently 19,141 homeless individuals in the state. Of that number, there are 2,470 chronically homeless individuals.

The need to set a course to end chronic homelessness is compelling, but through a collaborative effort a plan can be successful. Dennis Culhane of the University of Pennsylvania provides clear data in his 2001 study that indicates there are a small number of individuals (approximately 20-25 percent of the adult homeless population) who are chronically homeless and unable to maintain stability and connections to their community. The chronically homeless population is likely to suffer from physical or mental illnesses, alcoholism, drug addiction and, more often than not, dual diagnoses. These individuals consume a disproportionate share of resources in homeless shelters, jails, mental health and substance abuse treatment facilities and public hospitals.

In a recently released report, the Lewin Group listed the costs of supportive housing, jail, prison, shelter, mental hospital and hospital for nine cities across the nation¹. On average, the cost per day to keep a person in supportive housing was roughly equal to the cost of a

Who does HUD consider to be chronically homeless?

A person who is "chronically homeless" is an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years. In order to be considered chronically homeless, a person must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency homeless shelter.

A disabling condition is defined as "a diagnosable substance use disorder, serious mental illness, developmental disability, or chronic physical illness or disability, including the co-occurrence of two or more of these conditions." A disabling condition limits an individual's ability to work or perform one or more activities of daily living.

An episode of homelessness is a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter. A chronically homeless person must be unaccompanied and disabled during each episode.

shelter per day and half the cost of jail or prison. The cost per day for a mental hospital was 18 times greater than the cost of supportive housing, and for a general hospital, 59 times greater. The cost to society of having a person remain homeless – being committed or recommitted to a state institution or accessing emergency room hospital care – far outweighs the cost of providing permanent, supportive housing. The costs to the individuals and to the community at large are very high, both in the loss of human potential and/or in taxing of local treatment resources or overextending the health care system.

Prevention must become part of the equation sooner than later. It can be much more cost effective to invest in keeping someone from becoming homeless rather, than trying to steer them back on a stable course after they are homeless.

An issue that cannot be overlooked is the importance of creating a supportive community around homeless individuals as they are housed. To live independently in the community is a measure of success in society. In reality, for people struggling with a mental illness and who are vulnerable to homelessness, it translates into isolation. The most significant need, along with having basic needs met, is **support**. Stability requires it. Government and social services alone cannot solve the issue of homelessness. Without a focus on development of supports (e.g., skills training, job placement, advocacy) and opportunities for inclusion in society, many chronically homeless will return to the streets. The plan to end homelessness will require the involvement of everyone investing in the community through creative partnerships, volunteers, mentors and much more.

Participants in the creation of this plan envision a Kentucky where chronic homelessness is eliminated and homelessness is a short-lived and rare occurrence. The goals and strategies articulated in the plan have specific outcomes that are based on state government providing guidance and resources for collaborative community efforts. In the end, the plan will only be successful if it brings about the systematic change necessary to effectively address issues of homelessness.

III. Gaps and Barriers

- Gaps – tools and resources that do not exist.
- Barriers – issues that prevent solving problems of homelessness.

The following sections outline the gaps and barriers to ending homelessness that were identified through the community forum process.

A. Affordable Housing

It is clear that there is an insufficient supply of all types of affordable housing – from that targeted to working families to service-enriched housing for special needs populations likely to experience chronic homelessness. For the purposes of this plan, affordable will be defined as a housing that costs no more than 30 percent of adjusted gross income. In most of the state, there exists a shortage of all housing stock, but in the larger metropolitan areas, the shortage is very specific to affordable housing. The demand for subsidized housing far outweighs the funds available. As a result, some Section 8 waiting lists, that were so long, closed because it could be ten plus years before assistance would be offered.

B. Services

Housing alone will not solve the problem of chronic homelessness. Without adequate support services to prevent and end homelessness, many of those who have experienced homelessness find themselves unable to remain in stable housing. The number one gap identified is the lack of funding for these supportive services. HUD and other government agencies stress that mainstream resources should be prioritized to meet the need for these supportive services. However, the inability to access mainstream services is cited by many as a clear barrier by those seeking to serve homeless populations. Consequently, inadequate funding has led to providers having limited staffs with a lack of cross training on the types of support services offered by other service providers. For certain special needs populations, the lack of funding for 24-hour per day support services is a critical gap.

With HUD's continuing emphasis on housing as opposed to services in awarding Continuum of Care grants for McKinney-Vento funds, the scramble for service funding has increased. While this has led to a more concerted effort to increase access to mainstream resources for the homeless, the availability of service funding remains a critical issue.

Results of the Kentucky 2001 Homeless Surveyⁱⁱ clearly demonstrate the special needs of the homeless population and the necessity of support services to allow them to be housed with the greatest degree of independence. The survey determined that 22 percent of the adult homeless population has a mental illness, a statistic supported by studies conducted by the Kentucky Department for Mental Health and Mental Retardation Services. Meanwhile, Kentucky's adult homeless survey reports that alcohol/chemical dependency has doubled over the past seven years to 50 percent. At least two-thirds of this population will need ongoing services to sustain permanent housing. Finally, 15 percent of the homeless adults surveyed had a major physical disability that would require long-term services. All three of these subpopulations need extensive services for at least a period of time in order to remain housed.

While there may be personal barriers for an individual to access treatment for mental illness and substance abuse (impaired thought process, denial of need, negative experiences), this plan will focus on breaking down systemic or structural barriers by developing and implementing a "no wrong door" policy that ensures homeless people seeking assistance from any source will be properly linked to appropriate resources and services.

In spite of the number of services that exist, the service delivery system still suffers from fragmentation in accessibility, availability and appropriateness of services delivered. Restrictive eligibility requirements often limit access. Medicaid waivers serve a small subset of the disability population as defined in the specific federal waiver applications. In Kentucky, these waivers serve the elderly and people with physical disabilities, mental retardation, developmental disabilities and brain injuries.

The ability of low- and no-income Kentuckians to access mental health or substance abuse treatment is a clear gap that exacerbates the homeless problem. If one is fortunate enough to receive treatment, they face the prospect of limited case management (if at all), which further keeps many mainstream services out of reach. Bureaucratic systems can effectively limit access to entitlements and other mainstream services, such as transportation, childcare, employment training, food stamps and Social Security. Often, frontline workers know very little about other programs that clients need to either prevent or help them out of homelessness.

C. Discharge Planning

Inadequate discharge planning contributes to homelessness among persons aging out of foster care, persons exiting correctional institutions and persons with serious mental illnesses and/or substance abuse disorders leaving state facilities.

In October 2003, Louisville's Coalition for the Homeless conducted an institutional discharge survey of homeless shelters in the two largest metropolitan areas of the state. Results showed that 52.8 percent of the shelter population aged 18-24 had foster care experience, while 46.8 percent of the total population had a prison record. It also revealed that during the period of the study, 26 percent of prison releases and 38 percent of those released from mental health facilities went directly to shelters.

During the 2004 session of the General Assembly, legislation (HB 376) was passed that created a homelessness prevention pilot project to be undertaken in both rural and urban locations. The bill directed the Cabinet for Health and Family Services and the Justice Cabinet to develop and implement a pilot project that offers institutional discharge planning to persons exiting from state-operated or supervised institutions involving corrections, mental health and foster care programs. Although implementation has been delayed, the fiscal year 2006 budget has an allocation of \$100,000 to fund the pilot.

Foster Care. One of the fastest growing segments of the adult homeless population is the number of young adults who are turning 18 and leaving the foster care system. Youth in foster care often have considerable health and mental health problems.ⁱⁱⁱ Nearly one-third have physical or emotional difficulties and are likely to have complex health needs resulting from past neglect or abuse. They are also likely to be behind academically, with high rates of special educational needs, as well as a high drop out rate.

Corrections (Adult). Since nearly all of those currently incarcerated will eventually be released, proper planning must ensure that the transition from jail to the community is safe and successful. However, people are released from jail with complex issues including substance abuse (75 percent), lack of high school diploma or GED (40 percent) and a physical or mental disability (30 percent).^{iv} A telling statistic is that approximately 30 percent of individuals entering jail were homeless during the year prior to incarceration.^v Once released and without sufficient support, they are likely to be homeless again. In addition to discharge there is a need for better management of relevant systems. Rehabilitation should begin while people are incarcerated creating a more effective use of relevant management systems.

Juvenile Justice. No experience may be more predictive of future problems for young adults than having been confined in a secure juvenile facility. Whether confined awaiting trial or sentenced for a crime, almost all youth entering juvenile custody are at significant risk of failure when they exit. Similar to adult offenders, they have complex issues including mental health disorders (50-75 percent), substance abuse (>50 percent) and learning disabilities (42 percent). Unfortunately, current statistics show that 50-75 percent will be re-incarcerated.^{vi}

Psychiatric Hospitals. Kentucky currently has four public psychiatric hospitals serving a mixture of short-term and long-term care patients. Kentucky is one of only two states in the nation that provides primarily short-term care (30 days or less). At the end of fiscal year 2001, more than 20 percent of adults in the hospital had been there for less than 7 days.^{vii} In addition, data from the Department for Mental Health and Mental Retardation Services shows that 50.8 percent of patients had a stay of less than 30 days. Last year, three of the psychiatric hospitals discharged 141 patients (2.6 percent of discharges) to a homeless shelter or mission, out of a total of 5,482 discharges.^{viii}

Some suggested initiatives do require increased funding. However, inadequate discharge planning can lead to an increased incidence of psychiatric symptoms and substance abuse, hospitalization, incarceration and homelessness, each costing society more than the expense of effective discharge planning.

D. Prevention and Coordination

A lack of coordination among programs that provide services to the homeless and those at-risk of becoming homeless hinders the ability to use resources in the most effective, efficient way possible. While the HUD Continuum of Care (COC) process is designed to be a comprehensive planning process for the delivery of services to the homeless, it is not as effective as it could be for several reasons. First, funding available through the COC is restricted to McKinney-Vento programs, Shelter Plus Care and Supportive Housing. Second, it is often viewed as a funding process, rather than a planning process, limiting participation to only those interested in seeking funds.

While adequate discharge planning is a critical component of homeless prevention, there are a number of other issues that, when properly addressed, can prevent those who are at-risk from becoming homeless. In 2003, the Council on Homeless Policy created a *Homeless Prevention Plan* for Kentucky; many of the preventative ideas discussed here can be found in that document.

Prevention Funds. In many cases, individuals and families who are at-risk become homeless because they cannot pay rent or utilities. For example, they lose their job because they cannot get the car repaired to get to work, then they cannot pay the rent and it spirals from there. Unfortunately, there are limited emergency funds to pay those bills and prevent homelessness. Nor are there sufficient funds available to pay for preventative care to avoid hospitalization or institutional care. The funds that exist for payment of rent and utility deposits are very limited.

Coordination. Blending varied funding streams for programs to serve the homeless presents many challenges, particularly with the inflexibility of many of these funding sources. The limited coordination of existing resources provides further challenges for providers.

The bureaucracy is viewed as a maze – not only by those trying to access services, but also by those frontline workers trying to serve the at-risk and homeless. With this inherent difficulty in navigating the system, a “no wrong door” strategy has been discussed as a viable coordination plan along with the development of the Homeless Management Information System (HMIS). HMIS tracks the homeless and the provision of services to homeless clients. However, extensive cross training of frontline personnel has not been accomplished.

Rules. From application requirements that are perceived as too stringent to processing delays, many current administrative procedures and rules are often viewed as barriers.

For example, people living in shared, overcrowded or doubled-up conditions are often not considered homeless and the potential impact on other families in the house can discourage individuals from applying for assistance. Earning one dollar above a qualifying income limit can stop services all together rather than reducing benefits on a sliding scale based on income.

Likewise, youths aging out of the foster care system have a very short time frame in which they can request additional assistance for their transition into adulthood and independent living. Often the deadline is long past when they realize that they could use additional assistance to make this transition.

Financial Literacy. Without “blaming the victim,” many who are at-risk become homeless in part because of limited financial management skills. A lack of understanding of credit, which can lead to overspending, combined with predatory lending practices that target those with low income, can create a situation that can lead to homelessness. Financial literacy is an integral part of support services for families who are homeless or at imminent risk of homelessness. For individuals who are required by the Social Security Administration to have a payee, there are limited resources for this service when there is no available/appropriate family or friend to fulfill this responsibility. On a more temporary basis, there is a need for direct management of finances for individuals or families while they learn the skills to do so for themselves.

E. Economic/Public Education

According to the U.S. Census Bureau, in 2000, over 621,000 Kentuckians (15.8 percent) were living below the poverty level. By 2003, this figure had increased by 75,000 (17.4 percent), rising at a rate significantly higher than the national rate. Additionally, nearly one-quarter of the population is disabled.

Out of Reach 2004, published by the National Low Income Housing Coalition, documents both the depth and the scope of the American housing crisis. According to the report, there is not a single jurisdiction in the country where a person working full time earning the prevailing minimum wage can afford a two-bedroom rental home. Moreover, there are only four counties in the country where a person or a household working 40 hours a week, 52 weeks a year, at the prevailing minimum wage can afford even a one-bedroom apartment.

Because of the general acceptance of poverty and the ability of many homeless Kentuckians to remain “hidden,” there is a lack of public awareness as to the depth of the problem. As the “face of homelessness” is more and more that of a young woman with children, there are more true costs of homelessness that are hidden. For

Paying the Rent in Kentucky

The “housing wage” in Kentucky is \$10.23 (up from \$9.60 in 2003). This is the amount a full-time worker must earn per hour in order to afford a two-bedroom unit at the area's fair market rent. The housing wage ranges from a high of \$13.58 in Boone, Kenton and Campbell Counties to a low of \$6.38 in Clay County.

A minimum wage earner can afford monthly rent of no more than \$268. In Kentucky, a worker earning the minimum wage must work 79 hours per week in order to afford a two-bedroom unit at the area's fair market rent.

An extremely low-income household (earning \$15,222 or 30 percent of the area median income of \$50,742) can afford monthly rent of no more than \$381, while the fair market rent for a two-bedroom unit is \$532.

example, the effect changing schools often and becoming further behind has on children or, not so hidden, the cost of emergency health care. Policy changes can have unintended consequences. While studies from other states have demonstrated the cost of homelessness, if Kentucky does not provide specific data, policy makers may remain unconvinced. However, studies are planned that will provide data for Kentucky.

Finally, NIMBYism remains an issue in many communities. Even the most well-meaning citizens may not understand and appreciate the benefits of affordable housing when it is planned in their community. Therefore, resistance to having affordable housing nearby remains high.

IV. Strategies

A primary component of providing housing and services to meet the needs of the chronically homeless is to ensure that programs and services have the flexibility to respond to a variety of individual needs. For each individual and family to obtain and keep a stable housing environment, their individual housing situation must be one that best meets their needs. As needs change, housing and service providers and programs must be flexible enough to adapt to continue meeting the needs of this population. Below are listed strategies for housing, services and prevention.

A. Housing Strategies

Key Elements of the Blueprint

Sufficient, adequate, safe units integrated into the community should be created to meet a range of emergency, transitional and permanent housing needs.

These housing developments must:

- Include units with supportive services and units without supportive services;
- Be located in a manner that meets need;
- Not contribute to concentration;
- Meet general community development guidelines of integration and access to transportation and other services; and
- Provide dedicated units for the homeless and marginally housed through subsidies, new construction and/or rehabilitation.

While demand for the full range of safe, decent, affordable housing is great, the following grid displays goals for unit production for the chronically homeless:

<u>Type</u>	<u>No. of Units</u>	<u>Notes</u>
Permanent	2,400	Based on 2,470
Transitional	1,000	chronic
*Emergency	0	homeless

* 0 is shown for emergency units because there is already a solid network of emergency housing providers. With the goal of eliminating chronic homelessness, there is not currently a need to create new emergency units.

An adequate supply of transitional or relatively short-term housing to meet local needs for individuals and families should be developed to provide temporary housing that assists individuals and families in regaining stability and independence.

Each year in Kentucky, approximately 19,141 people are homeless. Of that number, 2,470 remain homeless for extended periods of time due to chemical dependency and other special needs. While these chronically homeless only represent one-quarter of the homeless population, they consume over 50 percent of homeless resources. To focus on the needs of homeless with substance abuse issues, social model recovery programs should be developed in rural and urban areas that are based on the proven methods used by The Hope Center in Lexington and The Healing Place in Louisville.

The Recovery Kentucky initiative, initiated earlier this year, will create ten new housing recovery centers, providing 1,000 new slots for both the homeless and those coming out of the corrections system. These centers will assist individuals in ending their chemical dependency and be required to have plans for permanent supportive housing for individuals upon completion of their program. Each center will use a recovery program model that includes peer support, daily living skills training, job responsibilities and challenges to practice sober living. This type of supportive housing and recovery program is proven to help people who suffer from substance abuse and addiction. These individuals, who often cycle through shelters, public hospitals, psychiatric institutions and detoxification centers, are also more in need of a stable place to live. It is estimated that the Recovery Kentucky initiative will save Kentuckians millions in tax dollars that would have been spent on hospital emergency room visits and jail costs.

The goal of Recovery Kentucky is to have at least two housing recovery centers in each congressional district through a joint effort by the Governor's Office for Local Development (GOLD), the Department of Corrections and KHC. These agencies have developed a financial plan that provides construction and operational financing, including a \$2.5 million annual allocation of Low Income Housing Tax Credits from KHC, which will generate a total equity investment of approximately \$20 million for construction costs. Operational funding includes approximately \$4 million from GOLD's Community Development Block Grant program and approximately \$3 million from the Department of Corrections.

Permanent supportive housing options with 24-hour per day on-site and off-site supports should be available for individuals who no longer meet admission criteria for hospitalization but lack the skills needed to live independently.

The greatest demand exists for permanent supportive housing, both single- and multifamily. Housing, ranging from single-room occupancy (SRO) units to single-family homes, is considered permanent when there is a lease with the tenant and the stay is not time-limited. There must be a wide range, specifically in the size and type of development, of permanent housing choices for this population. From low-demand, residential options for individuals at an early stage in the recovery process (for example, Safe Havens, SROs using a harm reduction model) to housing for men and women who are in recovery and want to live in a safe and sober community, the key will be providing housing and services that meet the needs of the tenant. A benchmark model of success is the Oxford House model, a democratically run, self-supported and a drug-free recovery house for recovering alcoholics and drug addicts.

Combining permanent housing with coordinated, flexible supportive services is critical to ending chronic homelessness. However, while the service component is crucial, tenants must have a lease and the rights and responsibilities of a tenant, with support services available to them, but not required as a condition of residency.

Homeless shelter safe zones for youth should be developed to provide additional options.

The needs of youth who are in emergency situations differ from those of adults in emergency situations. Outreach and engagement options tailored to this group are a key to successful intervention. Likewise, placing youth in adult shelters can provide an environment that is detrimental to meeting their needs successfully. There are currently only fourteen shelters across the state dedicated solely to helping youth.

Vacant project-based rental units throughout the state will be used in coordination with planning and placement for permanent housing.

Currently, some project-based units throughout the state have vacancies. Increased coordination among agencies to use these federally subsidized units for placement of individuals and families will decrease the number of homeless and reduce the amount of funding needed to provide permanent housing.

Funding

A concerted effort will be made to identify a dedicated revenue source for Kentucky's Affordable Housing Trust Fund (AHTF).

KHC invests federal HOME funds, AHTF funds, as well as its own SMAL and Housing Assistance Funds to assist those who are at-risk or homeless achieve housing permanency. The AHTF, if funded at \$5 million per year, would leverage over 800 units.

As evidenced in the funding of Recovery Kentucky, a blending of sources is needed to provide housing for special needs populations. Low Income Housing Tax Credits (initial allocation of \$2.5 million will generate equity investment of over \$20 million), HOME and AHTF funds through KHC, as well as operating monies from the Department of Corrections (approximately \$3 million annually) and Community Development Block Grant (approximately \$4 million annually) funds through the Governor's Office of Local Development are required to make these projects work.

A state funding source for additional rental assistance, both project- and tenant-based, should be found to meet these housing goals.

In light of decreasing federal funding of the Section 8 housing program and the subsequent closing of many of the state's waiting lists, an alternative means of funding subsidy for these units should be investigated. HOME Tenant-Based Rental Assistance could be maximized since it is less restrictive than other housing programs, allowing those with criminal histories and poor credit to more readily participate.

Statewide incentives to support the production of affordable housing should be adopted and enforced.

Providing a 20 percent state match (potentially requiring some local match) to each federal Continuum of Care dollar received by local communities for services could substantially reduce the dependence on HUD for service dollars that continue to decrease. This will also improve coordination of the existing resources by strengthening existing Continuum of Care planning boards.

The state should encourage localities to offer more favorable zoning to include incentives to spur development of affordable housing.

Possible incentives to explore, include expanding the homestead exemption for low-income homeowners, abatement of property tax for a period of five years, and increased availability of zero percent loans for permanent supportive housing for special needs populations.

B. Service Strategies

To sustain permanent housing and maximize independence, much-needed flexible services should be established for all supportive housing units as they are built or come into utilization as supportive housing.

The ideal service array will be an overall system of care approach based on the principles of prevention and evidence-based practice that is consumer- and family-driven as well as culturally competent. The emphasis is on permanent housing and supports with continuity of care and accountability. This system of care should include assertive outreach, integrated treatment of mental illness with alcohol and drug abuse treatment and integrated case management strategies like assertive community treatment.

There are several additional strategies to enhance access to services. These include the co-location of services (for example, in shelters, in existing clinics or community centers); free standing facilities and clinics providing services to the homeless, including the expansion of healthcare for the homeless through existing community health centers; and special accommodations in program hours and eligibility requirements. There must be more of a focus on outreach, using mobile units for street outreach and assertive community treatment.

To increase services that target the homeless, an intergovernmental department by department review should be initiated and conducted in conjunction with community leaders.

This review should look for ways that mainstream programs can be better utilized by those who are at-risk or homeless, identify how programs respond to needs of the homeless and highlight best practice interventions that work.

Medicaid 1915c Community-Based Waiver services should be linked with supportive housing for eligible disabled persons who are homeless and/or marginally housed.

This could begin to fund services that maintain Medicaid eligible people in housing and could include case management, mental health treatment, medical health services and support for the client.

C. Prevention Strategies

The existing Homeless Prevention Plan, which includes many of the recommendations that are articulated in the following strategies, should be implemented as part of this plan.

The Kentucky Council on Homeless Policy having identified a lack of coordinated policy priorities to address homelessness has directed its efforts to facilitating partnerships among agencies that work to provide services to those who are homeless or at risk of becoming homeless. Their most recent work was to create a statewide prevention plan that identifies existing institutional barriers, which can contribute to exacerbating homelessness. The plan makes recommendations on specific problems or barriers identified within existing programs covering five broad areas: coordination, planning, procedural, training and funding.

Comprehensive discharge planning for all persons leaving certain state institutions or programs should be developed and implemented.

A comprehensive discharge planning protocol must be established to ensure permanent housing and employment solutions to avoid any increase in homelessness. Such planning must include assistance in applying or reapplying for disability benefits, coverage for health and mental health treatment through Medicaid for the transition period or until other insurance is obtained and a state identification card. Case management services and housing opportunities must be provided.

More specifically, plans to meet the needs of each discharging facility should be relevant to the needs of those being discharged. These include:

- *Mental Health.* As part of discharge procedures from state psychiatric hospitals, an adequate supply of medications should be provided to last until community services and appropriate outpatient services and treatment can be accessed. With funding now budgeted for HB 376, this homelessness prevention pilot project should guide the establishment of one-stop, up-to-date resource centers in all regions of the state to ensure that proper discharge plans are created for those exiting state institutions.
- *Foster Care.* Given the difficulties of any 18-year-old making the transition to adulthood, an important first step for youths aging out of foster care would be to extend their length of time to consider recommitment to the Cabinet for Health and Family Services for aftercare assistance and education. Similarly, the age limit for those in the Chafee Foster Care Independence Program should be extended to 24 instead of the current 21. Likewise, the initiation of a program to bring together the people and resources needed to help these youths meet their education, employment, health care and housing needs. Capacity expansion of private and public organizations along with community engagement could be a goal of this effort.
- *Corrections.* To prevent recidivism and homelessness, create a prisoner re-entry initiative that includes the following elements: assessment of clinical and social needs, delivery of appropriate treatment, planning for the treatment and services and identification of required community resources and correctional programs responsible for services. A formal agreement must be executed between the prisoner and the transition team detailing the preparations for release, terms and conditions of release, the level of supervision required and services needed in the community and when

discharge is appropriate. This transition plan must be coordinated to ensure implementation and avoid gaps in care. A critical component is access to housing assistance; policies prohibiting ex-felons from taking advantage of public housing must be changed. For example, ex-felons with addiction-related offenses can receive Section 8 assistance if they can document that they are in recovery (completion of treatment or drug tests) and will continue participation in recovery programs or supportive services from a substance abuse program (i.e., drug court).

Active system integration processes must be promoted among justice, mental health and substance abuse systems to avoid incarceration or institutionalization.

In Kentucky, “drug court” refers to a court-managed program with a strong treatment component, designed to provide an effective, efficient and cost-effective alternative to traditional criminal case processing and incarceration. The program targets nonviolent, substance abuse-related offenders and features intensive court supervision combined with a substance abuse treatment continuum. Participants must complete a three-phase program including aftercare that lasts an average of one to two years.

Continuing to build the drug court system statewide is key, the state must look at not only providing funding as federal grants expire, but look for resources to expand drug courts to each jurisdiction. The current mental health court pilot should be evaluated for expansion beyond Jefferson County.

A triage system for jailed persons suffering from mental illness was developed as a result of the work of the HB 843 Commission, named for the legislation which established the commission on mental illness, alcohol and other drug abuse disorders and dual diagnoses. This triage system should be taken to the next step and provide actual diversion from jail for non-violent offenders suffering from mental illness.

The Department of Juvenile Justice program that offers alternatives to detention should be expanded. A number of youths who have been committed to the juvenile justice system, particularly those with mental health problems and/or no appropriate relative resources, may face unique discharge problems. Such youths need concentrated assistance with job-specific training, transitional housing and access to mental health resources in the community. Without such supports, many of these youth are at risk of long-term homelessness and/or incarceration in the adult correctional system.

The state must promote crisis stabilization programs as an alternative to the state’s psychiatric hospitals. Increasing access to and utilization of the crisis units will result in better service for the patients as well as cost savings for the state.

The Commonwealth should fund a homeless prevention demonstration project using the existing administrative infrastructure for HUD’s Continuum of Care programs, coordinated by Louisville Metro, Lexington/Fayette Urban County Government and KHC (for the balance of the state).

An important component of the project would be the creation of a fund with some degree of flexibility to prevent at-risk individuals and families from becoming homeless and to be sustained in permanent housing. This homeless prevention emergency assistance fund could pay for such things as mortgage or rent, utility bills or deposits and other related expenses.

Demonstrated savings could be used as a basis for future funding requests and full implementation of the homeless prevention emergency assistance fund.

With a Memorandum of Understanding reinforcing the coordinating role of the Council on Homeless Policy among the cabinets in place, various state planning documents (Consolidated Plan, Community Services Block Grant State Plan, Continuum of Care Plan, Public Housing Authority Plan, cabinet-level strategic plans) should be aligned.

This would provide for a unified strategy to prevent homelessness and distribute additional resources to prevention activities. The importance of improving coordination between those entities – public and private – that serve homeless and at-risk Kentuckians cannot be over emphasized. While the Council on Homeless Policy has facilitated connections among agencies, enhancing capacity to work on homeless issues and improve service provision to at-risk families, much still can be done to increase cooperation and collaboration.

The council has provided some structure for coordination of homeless programs; however, existing statewide housing and homeless planning documents do not reflect a consistent homeless prevention strategy, creating a major impediment to addressing these issues. Plans should encourage and foster collaboration among community organizations, state agencies and federal programs to empower local communities to prevent homelessness.

As mentioned in the Service Strategies section of this document, strengthening existing Continuum of Care planning boards will improve coordination of existing resources. Where feasible, allocation of other existing homeless funding sources, such as Projects for Assistance in Transition from Homelessness funds from the U.S. Department of Health and Human Resources through the Continuum process, would greatly advance these efforts as would other federal agencies to make their funding available through the Continuum of Care. In addition, model Memorandum of Understanding documents among agencies should be developed to standardize cooperative efforts.

Training programs for staff working directly with individuals and families should be adapted to ensure that they are aware of all programs and services available for clients.

There must be a focus on training the frontline human service agency staff, with development of a core set of homeless prevention and homeless services, including incorporation of identification of at-risk or homeless persons, into assessment practices. To the extent possible, agencies must ensure that there is no “wrong door” for clients who should be able to be connected by intake workers to all programs that could be of benefit.

Awareness of the state’s online information directory for providers should be a focus of any information shared to increase use of the directory among agencies and individuals.

KyCARES (<http://kycares.ky.gov>), an online information directory and guide for federal, state and community providers, is perhaps one of the most underutilized resources in the homeless prevention arena. Currently, this Web site contains thousands of provider/service agency pages of detailed information as well as hundreds of subject matter specific “Tip Sheets.” It should serve as an invaluable tool for human service providers, giving them immediate access to information on basic services like housing, food, childcare, transportation and benefits. However, KyCARES can only be as good as the information it is given by providers. Public and

private providers must be encouraged to post – and regularly update – their services and information on KyCARES.

Likewise, a statewide Homeless Management Information System is being implemented that will improve coordination and compatibility among various computerized systems used to track homeless services funded by HUD. However, its effectiveness will be dramatically increased if other federal partners would require the same system to be used, further reducing inefficiencies caused by providers having to use multiple systems.

To increase job acquisition and retention for those able to work, job training and development programs should be more accessible to the homeless population.

Employer interventions such as waivers of employment requirements, jobs for special needs populations and support from the business community for homeless employability are all required to help insure sustained stable housing.

V. Progress to Date

A. Recovery Kentucky

Drug addiction is one of the leading causes of homelessness in this state. Recovery Kentucky is an initiative to help Kentuckians recover from substance abuse that often leads to chronic homelessness. The program accomplishes two goals: it reduces the state's drug problem and resolves some of the state's homeless issues. Once an individual has completed the program they will be given help to find permanent housing.

Implementing this program is the first step to ending chronic homelessness in the state. When all of the recovery centers are complete, they will serve 1,000 chronically homeless individuals and those on the verge of chronic homelessness. This accomplishes the goal of serving the current population and working to prevent more people from becoming chronically homeless. With an average length of stay from 12-18 months and a maximum stay of 24 months it could potentially take six years to get the current chronic homeless population off the streets through the program and into permanent supportive housing.

B. Corporation for Supportive Housing

In August 2003, the Corporation for Supportive Housing granted KHC \$454,280 to aid in integrating the state systems that finance and create supportive housing, establishing a supportive housing pipeline of 532 units and increasing investments directed toward supportive housing by \$3 million. To date, 468 units have already been built.

C. Housing Assistance Fund

KHC provides \$300,000 a year of matching funds from its Housing Assistance Fund for recipients of Supportive Housing and Shelter Plus Care funds.

D. KHC HOME Tenant-Based Rental Assistance (TBRA)

The objective of the HOME TBRA Program is to provide temporary (two years) rental assistance to eligible families affected by emergency events as determined by the governor and KHC management.

Eligible emergency events determined by the governor may include, but are not limited to:

- Natural disasters.
- Major layoff of workers.
- Other events that impact the ability of low-income Kentucky families to maintain affordable rental housing.

The program will also be used as an emergency program to meet individual family emergencies, such as:

- Fire.
- Flood.
- Emergency protective order.
- Domestic violence order.
- Shelters at capacity.
- Families in danger of losing their children through court action solely due to lack of suitable housing.
- Terminally-ill persons without housing.
- Eviction from military quarters due to divorce.
- Other—To be determined on a case-by-case basis.

Families receiving this temporary assistance are placed on the Section 8 waiting list and are issued a regular housing choice voucher once their name reaches the top.

This assistance provides approximately 250 units and \$1 million annually.

E. Memorandum of Understanding

In April 2005, a Memorandum of Understanding (MOU) was signed by representatives from the Governor's office, Cabinet for Health and Family Services, Department of Veterans Affairs, Education Cabinet, Governor's Office for Local Development, Justice and Public Safety Cabinet and KHC. The MOU reinforces the commitment of the Council on Homeless Policy state agency participants to facilitate interagency coordination, broaden collaborative efforts and set administrative policies to achieve the goal of ending chronic homelessness.

This MOU is a major step in ensuring the success of the ten-year plan. Without the cooperation of the agencies involved, there would not be a paradigm shift in the goals and approaches of the homeless assistance network.

F. Office for Faith-Based and Community Nonprofit Social Services in the Office of the Governor

Governor Fletcher has developed a new office for faith-based initiatives. MOU agencies will aggressively work with these faith-based groups to enhance the delivery of services to chronically homeless individuals.

VI. The Financing Plan

Recovery Kentucky is the solution to the first part of the equation to ending chronic homelessness. When the recovery centers are complete, Kentucky will have met the goal of creating 1,000 transitional units. The other part of the equation is the creation of 2,400 permanent supportive housing units.

Once an individual has successfully completed their stay at a recovery center, they will need to move into permanent supportive housing.

Funding for the permanent supportive housing units will need to come from federal, state, local and philanthropic sources.

VII. Vision and Goals

Kentucky joins in the federal goal adopted by President George W. Bush and the U.S. Interagency Council on Homelessness to end chronic homelessness in a ten-year period. Adequate affordable housing of all types for individuals experiencing homelessness is needed to provide a solution to chronic homelessness.

According to an U.S. HUD report, Strategies for Reducing Chronic Street Homelessness,^{ix} there are five essential elements needed to reach the goal of ending chronic homelessness.

1. There must be a paradigm shift in the goals and approaches of the homeless assistance network.
2. Set a clear goal of reducing chronic street homelessness.
3. Commit to a community-wide level of organization.
4. Have leadership and an effective organizational structure.
5. Have significant resources from mainstream public agencies that go well beyond the homeless-specific funding sources.

In order to sustain the vision and goal of this plan, Kentucky must:

- Gain significant involvement of the private sector.
- Obtain commitment and support from mayors, city and county councils and other local elected officials.
- Have a mechanism to track progress, provide feedback and support improvements.
- Be willing to try new approaches to services.
- Have a strategy to handle and minimize negative reactions to locating projects in neighborhoods.

VIII. Implementation

To implement the ten-year plan lead agencies as identified in the MOU, must be identified for each strategy.

- Housing Strategies – Governor’s Office for Local Development and KHC
- Service Strategies – Cabinet for Health and Family Services and the Department of Veterans Affairs
- Prevention Strategies – Governor’s Office, Education Cabinet and Justice, Public Safety Cabinet and Cabinet for Health and Family Services

These lead agencies will identify representatives to work within the six newly identified Continuum of Care regions to execute the plan, coordinate the efforts of all agencies involved and use the provided performance indicators to report their progress annually. These groups will meet monthly to share knowledge on the nature and availability of services and to discuss ideas to accomplish the goals of their assigned strategy.

The Council on Homeless Policy will provide oversight to these regions as they work on ending chronic homelessness. They will offer advice and expertise as needed.

IX. Measuring Progress

Each region should measure progress using certain performance indicators. Following are standard indicators:

- Number of chronically homeless
- Number of homeless
- Average length of stay
- Average time to link to services
- Average time to link to housing
- Average time to link to case management
- Average time to develop interdepartmental team case management plan for chronically homeless
- Number of housing units created for chronically homeless

Regions may track additional performance indicators; however, the six regions should agree on a common set of performance indicators that are the priority performance indicators.

Each region will prepare an annual progress report to present to the governor and the Council on Homeless Policy. The report will document the region’s success in implementing this plan and will include the following:

1. Data
2. Implementation efforts to date
3. Goals for coming year
4. Additional actions planned in upcoming year

Additionally, each region will make recommendations in four areas when they submit their annual progress report:

1. Proposed legislation
2. Resources
3. Recommended system changes
4. Proposed amendments to the Ten-Year Plan

Meetings with representatives from each region, the Council on Homeless Policy and HUD officials will occur annually to discuss progress to date, recommended actions for the next year, recommended system changes and any proposed legislation and resource requests.

The Council on Homeless Policy will measure the progress of each region to determine their success by reviewing:

1. Changes in the number of people found on the streets from year to year;
2. Increases in the number and percentage of chronically homeless people who have moved into permanent housing;
3. Reductions in costs of providing emergency health, mental health and shelter services;
4. Reductions in days homeless, hospitalized or incarcerated; and
5. Less recidivism in the homeless assistance system, as documented by street counts, program operations and outcome data, and interagency homeless management information systems data.

The council will devise an incentive program that rewards those who have fulfilled the goals as outlined in the strategy section using the given performance indicators.

The first meeting for each region will occur in the summer of 2005. Each region will be prepared to report their initial plans, progress and any recommendations by the end of September 2005. Updates will be provided each subsequent year in September.

X. Recommendation

The ultimate success of this plan will be to end chronic homelessness. However, ending chronic homelessness only provides a solution to just one part of the homeless problem. The needs of other homeless populations and those near homelessness must be met as we pursue this goal.

It is recommended that a plan for ending homelessness for other homeless populations be devised by the Council on Homeless Policy as well. Other populations would include singles that do not fall into the category of chronically homeless and families; including households headed by single mothers and single fathers and couples without children. It would be unfair to include all of the homeless populations under one plan because each segment has their own unique needs.

XI. Future Initiatives

Additional ideas to end homelessness that will be explored.

- Section 8 providers will look at setting aside temporary vouchers for homeless individuals. The temporary voucher will be provided until a housing choice voucher becomes available. The homeless individual receiving a temporary voucher will be given a preference so that once they are given a housing choice voucher the temporary voucher would be available to help the next homeless individual.
- Increase the utilization of family self-sufficiency and homeownership voucher programs across the state. Increased utilization of these programs will allow a participant to graduate from their Section 8 assistance freeing up more housing choice vouchers for those that are homeless.
- For populations that are more difficult to serve, vouchers will be set-aside for that population only (i.e., mental health / mental retardation).

XII. Appendix: Council on Homeless Policy Member Agencies

Cabinet for Health and Family Services

MH/MR

Substance Abuse

Community-Based Services

Medicaid

Cabinet for Public Protection & Regulation

The Coalition for the Homeless

Department of Veterans Affairs

Education Cabinet

Workforce Development

Homeless Education

Governor's Office

Governor's Office for Local Development Alternate

Hazard-Perry County Community Ministries

Homeless and Housing Coalition of Kentucky

Justice and Public Safety Cabinet

Juvenile Justice

Corrections

Probation and Parole

Kentucky Domestic Violence Association

Kentucky Housing Corporation

Kentucky Housing Policy Advisory Committee

Foothills Development Council Community Action Agencies

Kentucky State Legislature

Phoenix Health Center

UK Institute on Women and Substance Abuse

Volunteers of America of Kentucky

XIII. Endnotes

- ⁱ The Lewin Group, “Costs of Serving Homeless Individuals in Nine Cities,” November 2004
- ⁱⁱ Kentucky 2001 Homeless Survey
- ⁱⁱⁱ “Moving Youth from Risk to Opportunity,” KIDS COUNT 2004, Douglas W. Nelson, Annie E. Casey Foundation
- ^{iv} Report Preview, Re-Entry Policy Council, Coordinated by the Council of State Governments, 2004
- ^v “Working with People with Mental Illness Involved in the Criminal Justice System: What Mental Health Service Providers Need to Know,” Jackie Massaro, MSW, Revised Feb. 2004
- ^{vi} “Moving Youth from Risk to Opportunity,” KIDS COUNT 2004, Douglas W. Nelson, Annie E. Casey Foundation
- ^{vii} National Association of State Mental Health Program Directors Research Institute, Inc. – State Profile Highlights, July 2002
- ^{viii} Kentucky Department for Mental Health and Mental Retardation Services, 2004
- ^{ix} U.S. Department of Housing and Urban Development, Research Strategies for Reducing Chronic Street Homelessness, Final Report (Washington: Office of Policy Development, 2004)