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Statewide Collaboration for Change:

Utah's Plan to Address Homelessness

NOVEMBER 2022

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Letter from the Utah Homelessness Council

Homelessness affects the entire state of Utah. All the large municipalities and many small ones have community members who, for a wide variety of reasons, find themselves unhoused and at risk. It is almost impossible for an individual or family to thrive when living in such adverse conditions. The personal implications of homelessness are broad and can affect multiple generations. Its impact on neighborhoods, public safety, and commerce can be deep and difficult to address.

Signs of homelessness are sometimes easy to see, such as camping on sidewalks and in public parks. These visible manifestations of homelessness draw much attention. Unfortunately, all too often homelessness is far less obvious to the public when community members live in their cars, shelters, or other temporary situations. Despite years of focused effort and spending millions of dollars to solve problems, Utah's experience with homelessness has proved to be perpetual and challenging.

Utah Code § 35A-16-203 charges the Utah Homelessness Council and the Coordinator of the Utah Office of Homeless Services with creating "a statewide strategic plan to minimize homelessness in the state." Pursuant to these provisions, the Utah Homelessness Council conducted a nationwide search for a consulting group to perform a careful study of homelessness in Utah and to help draft a strategic plan to "minimize it." The goal was to find an organization with wide experience in helping states and communities address homelessness. That search led to contracting with Homebase, a San Francisco based non-profit "dedicated to building community capacity to prevent and end homelessness."

Beginning early in 2022 and working under the direction of the Utah Homelessness Council and Coordinator of Homeless Services, Homebase undertook a comprehensive review of homelessness throughout Utah. Homebase reviewed multiple survey reports, interviewed community leaders, Office of Homeless Services employees, homeless and social service providers, persons with lived experience with homelessness, and other stakeholders and reported their findings to the Homelessness Council. Homebase's experience with successful practices from other jurisdictions and familiarity with Utah's homelessness situation provided a foundation for its team to draft a proposed strategic plan, consulting regularly during the process with a group appointed from the Homelessness Council, the Coordinator of Homeless Services, and the Utah State Office of Homeless Services. Over time, the plan set forth in this booklet was developed and then approved by the Council and Coordinator.

The Shared Vision Statement of the Utah Homelessness Council and Office of Homeless Services in this Strategic Plan states:

"Our vision for the homeless response system in Utah is to make homelessness rare, brief, and non-recurring; that all people experiencing homelessness can thrive to their fullest potential; and that our communities are stable and safe for everyone."

We recommend the Strategic Plan to everyone in Utah and invite the coordinated investment of community members, elected leaders, public employees, and stake holders in studying, applying, and working together to achieve this vision.

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Letter from Wayne Niederhauser

The Office of Homeless Services is excited to implement this new state homelessness strategic plan with the Utah Homelessness Council and the Utah Homelessness Network.

Statewide Collaboration for Change: Utah's Plan to Address Homelessness outlines specific goals and measurable benchmarks for minimizing homelessness and for coordinating much-needed wraparound services.

The plan identifies best practices and areas for improvement, ensuring all services are provided in a safe, cost-effective and efficient manner. It outlines gaps and recommends solutions for ensuring homelessness is rare, brief and non-recurring for Utahns.

While we have made real progress in some areas of homeless services, there is still much to do. We look forward to working with all stakeholders statewide to make significant and impactful advancements. Coordination is a key principle of success. The Office of Homeless Services is committed to collaborating with all stakeholders.

There is much more we can accomplish if we do it together.

Wayne Niederhauser
Wayne Niederhauser

Shared Vision Statement of the

Utah Homelessness Council & Office of Homeless Services

Our vision for the homeless response system in Utah is to make homelessness rare, brief and non-recurring; that all people experiencing homelessness can thrive to their fullest potential; and that our communities are stable and safe for everyone.

— Utah Homelessness Council

Overview of Strategic Plan and Outcomes

Homelessness affects everyone. This includes people experiencing homelessness, people who are unstably housed, their housed neighbors, local businesses, first responders, hospital systems, community leaders and organizations, and other stakeholders. The purpose of a statewide strategic plan is to define effective goals and strategies to address homelessness at the state level that also support local partners in preventing and ending homelessness. The Utah Homelessness Council, supported by the Office of Homeless Services and stakeholders across the state, has performed an extensive needs assessment to identify what resources and interventions are needed to effectively address homelessness. Based on the needs assessment findings, state level target outcomes were identified to reduce and prevent homelessness in Utah, and goals and strategies have been identified to achieve these target outcomes, as detailed below.

TARGET OUTCOMES BY 2027[1]

Based on the needs assessment as described in detail below, several target outcomes have been identified to address the key issues of a lack of permanent housing (especially for vulnerable subpopulations with high service needs), supportive/recovery services, and homeless prevention.

Create or identify **574 housing opportunities** for people experiencing homelessness

Increase supportive service interactions **by 20%**

Reduce number of people becoming homeless each year **by 20%**

Reduction of vulnerable subpopulations of chronically homeless, veterans, survivors of domestic violence, youth, and people with disabilities **by 7%**

GOALS AND STRATEGIES

In order to achieve these targets, the following goals and strategies are recommended for implementation. Success or progress towards these goals will be assessed using the measurable outcomes detailed below.

For additional information on each goal, including recommended **next steps to take for each strategy and nationally recognized innovative solutions to addressing homelessness**, see **Strategic Plan Implementation Recommendations.**

[1] State level aggregated HMIS data from the calendar year 2022 will be used as baseline data to assess progress towards target outcomes.

GOAL 1

Increase accessible and affordable permanent housing opportunities for people experiencing homelessness across the state

STRATEGIES TO ACHIEVE GOAL

1. Support localities to increase investment in permanent housing options at the state and local level, using private and public funds to meet the current housing need[2] across the state.
2. Support localities to increase development of permanent supportive housing programs.
3. Support localities to increase development of transitional/interim housing[3] for vulnerable subpopulations of people experiencing homelessness (e.g., those with mental health and substance use disorders, survivors of domestic violence, people experiencing chronic homelessness, people exiting criminal justice system, youth, and others) and create strong pathways for these populations to obtain and retain permanent housing.
4. Explore policy-level changes at the state and local level to preserve existing affordable housing.
5. Build community support for development of new permanent housing for people experiencing homelessness.
6. Support localities to employ innovative solutions for placing people equitably into permanent housing and design ongoing evaluation protocols that assess equity in housing outcomes.
7. Support local efforts across the state to perform housing needs assessments for vulnerable subpopulations experiencing homelessness and target resources and support to housing these populations.

MEASURABLE OUTCOMES FOR GOAL 1

- **By 2023, the state of Utah will implement an annual demographic analysis** of housing placements of people experiencing homelessness across the state to ensure equity in housing assistance, placement, and retention.
- **By 2024, the state of Utah will establish cross-agency partnerships** to develop a plan for identifying and funding permanent housing opportunities, including but not limited to permanent supportive housing, for people experiencing homelessness. The plan will examine how state agencies can work collaboratively to address the affordable housing deficit and current unmet housing needs for people experiencing homelessness across the state. This plan will also include housing needs assessments of vulnerable subpopulations experiencing homelessness (e.g., youth and survivors of domestic violence).
- **By 2024, the state of Utah will establish a coordinated plan** to help support localities in development and implementation of transitional/interim housing options for vulnerable subpopulations experiencing homelessness with strong pathways to permanent housing.
- **By 2024, the state of Utah will launch a statewide social marketing campaign** to change perceptions around homelessness and to lessen community resistance to development of new permanent housing for people experiencing homelessness.
- **By 2025, the state of Utah will establish at least two cross-agency partnerships** with the stated goal of advocating for and implementing policy changes to preserve affordable housing and support housing affordability.

[2] There is currently a deficit of approximately 40,000 units of affordable housing across the state (i.e. 20,240 affordable and available rental homes to meet the needs of 61,221 extremely low income renter households). According to the National Low Income Housing Coalition (NLIHC), Utah has a shortage of 40,981 affordable and available rental units. The deficit for units affordable for people who or at or below 50% AMI (area median income) is 43,253 units (https://nlihc.org/gap/state/ut). These data are based on the Housing Cost Burden by Income, which assess the degree to which individuals across income groups are cost burdened by housing (e.g., extremely low income = 0-30% of AMI; renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened). Current housing needs of people experiencing homelessness was identified as 574 permanent housing opportunities per year based on HMIS data demonstrating the current system inflow across the state.

[3] Transitional or interim housing refers to temporary housing often providing a bridge from shelter to permanent housing.

GOAL 2

Increase access to and availability of supportive services and case management for people experiencing and at risk of homelessness

STRATEGIES TO ACHIEVE GOAL

1. Develop a state-level supportive services working group to assess gaps and coordinate supportive services (e.g., behavioral health/addiction recovery, mental health services, and case management) across the state and identify strategies for increasing staff retention, capacity for client engagement, outreach, and general support.
2. Support localities to increase access to and availability of wrap-around mental and physical health services for people experiencing and at risk of homelessness across the state, with additional supports for people placed directly into housing from the street or emergency shelter.
3. Support localities to increase access to and availability of substance abuse services (including detox facilities and residential treatment) for people experiencing and at risk of homelessness across the state.
4. Support localities to increase housing navigation and location services to connect those in emergency shelter and on the streets with housing-focused case management.
5. Ensure that the delivery of supportive services is inclusive, culturally competent, and accessible to all people.

MEASURABLE OUTCOMES FOR GOAL 2

- **By 2023, the Utah Homeless Network will establish a working group** to coordinate supportive service efforts across the state.
- **By 2023, the state of Utah will implement an annual demographic analysis** of service administration across the state to ensure equity in the provision and delivery of services.
- **By 2024, the Utah Homeless Network will perform a gaps analysis** of supportive services and behavioral health services targeted to people experiencing and at risk of homelessness and identify strategies for increasing staff retention and capacity among supportive service providers.
- **By 2024, the Utah Homeless Network will convene an advisory group** of healthcare funders and providers, managed care plans, and stakeholders to evaluate and fund best practices in delivering healthcare to people experiencing homelessness in urban, suburban, and rural communities.
- **By 2024, the state of Utah will identify a identify a state liaison** to collaborate with Utah CoCs to create connections between localities and substance abuse services providers and assist with identification of funding opportunities for sober living/substance abuse services projects.
- **By 2025, the state of Utah will increase supportive service interactions** with people experiencing and at risk of homelessness by 20% as demonstrated by homeless management information system data.

GOAL 3

Expand homeless prevention efforts by increasing coordination, resources, and affordable housing opportunities

STRATEGIES TO ACHIEVE GOAL

1. Develop a subcommittee to coordinate homeless prevention efforts and expand data tracking of homeless prevention service interactions.
2. Lead and support coordination of discharge efforts across the state to ensure that people exiting adjacent systems: (e.g. criminal justice, healthcare, foster care, and domestic violence shelters) are not discharged directly to homelessness and receive housing, behavioral health/healthcare, and other complementary services to assist with obtaining and retaining permanent housing opportunities.
3. Support localities to identify funding and build infrastructure to increase homeless prevention support for people at risk of homelessness.

MEASURABLE OUTCOMES FOR GOAL 3

- **By 2023, the state of Utah will establish a subcommittee** to coordinate homeless prevention efforts statewide and expand data tracking of homeless prevention service interactions.
- **By 2025, the homeless prevention subcommittee will work to coordinate discharge efforts** from medical and criminal justice systems and decrease exits to homelessness from these systems by 5%.
- **By 2025, the state of Utah will increase homeless prevention assistance service interactions** to people at risk of homelessness by 10%, as tracked by HMIS.
- **By 2025, the state of Utah will decrease the number of returns** to homelessness from permanent housing projects by 5% overall, as tracked by HMIS.
- **By 2025, the state of Utah will decrease the number of returns** to the system of care after exiting homeless prevention assistance projects to permanent housing by 5%, as tracked by HMIS.

GOAL 4

Target housing resources and supportive services to people experiencing unsheltered homelessness

STRATEGIES TO ACHIEVE GOAL

1. Support localities to identify resources and infrastructure to increase availability of permanent housing and permanent supportive housing for people experiencing unsheltered homelessness with priority for people experiencing chronic unsheltered homelessness.
2. Assist localities in increasing supportive service and case management capacity to provide housing location, navigation, and stability services to provide the supports needed for unsheltered individuals to obtain and retain permanent housing.
3. Assist CoCs and LHCs to coordinate and target resources toward vulnerable unsheltered subpopulations by using by-name lists and other subpopulation targeting tools (e.g., chronically homeless, survivors of domestic violence, people with disabilities and/or substance use disorders, youth, etc.)
4. Support LHCs to identify specific needs, resources, and strategies to address unsheltered homelessness in their communities.

MEASURABLE OUTCOMES FOR GOAL 4

- **By 2023, the state of Utah will work with all local CoCs and LHCs** to ensure that people experiencing unsheltered homelessness are targeted for permanent housing opportunities, with priority for people experiencing chronic unsheltered homelessness.
- **By 2025, the state of Utah will identify public land** to develop safe parking, structured sanctioned encampments, and high access shelter in locations across Utah where there are elevated numbers of people experiencing unsheltered homelessness as demonstrated by Point-in-Time Count data.
- **By 2025, the state of Utah will decrease the population of people experiencing unsheltered homelessness** by 5% as demonstrated by aggregated state-level Point-in-Time Count data.
- **By 2025, the state of Utah will support localities** to develop by-name list tracking processes to target housing and services to vulnerable unsheltered subpopulations.
- **By 2027, the state of Utah will decrease the number of people experiencing homelessness** in the following subpopulations by 7%, as demonstrated by Point-in-Time Count count data: chronically homeless, veterans, survivors of domestic violence, youth, people with disabilities (including SUDs).

GOAL 5

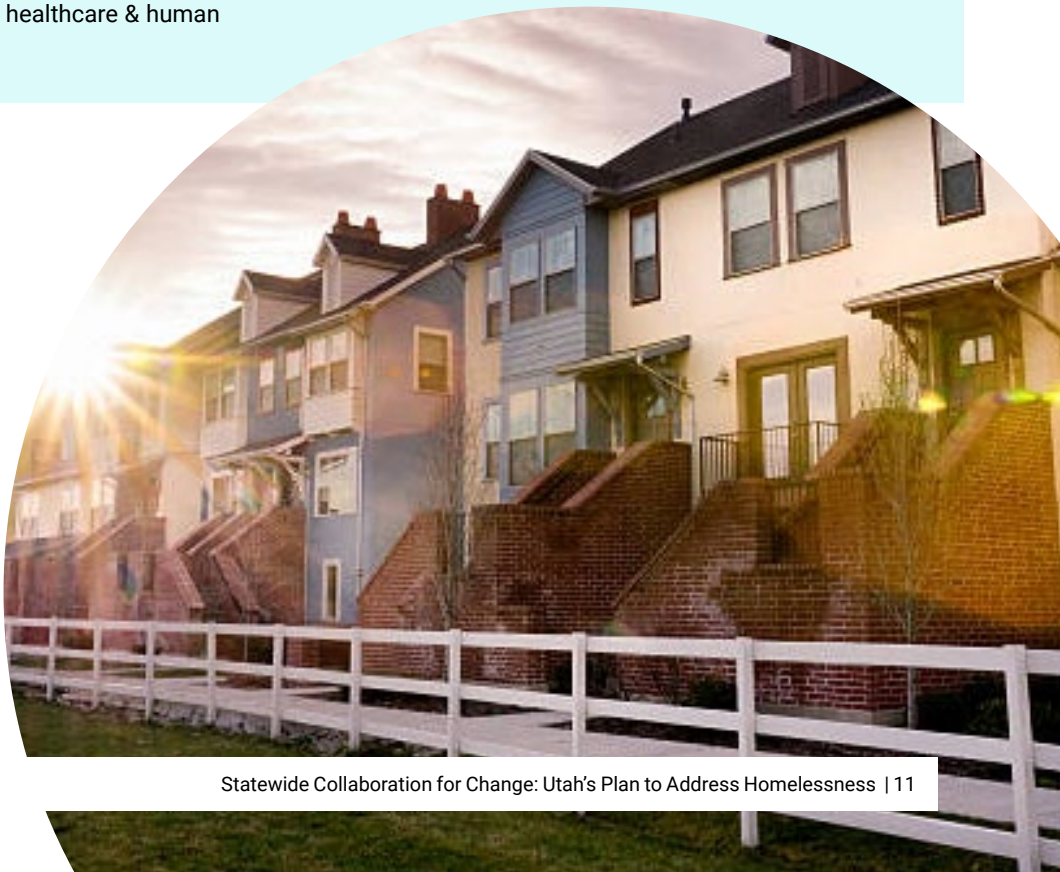
Promote alignment and coordination across multiple systems of care to support people experiencing and at risk of homelessness

STRATEGIES TO ACHIEVE GOAL

1. Develop cross-system partnerships with criminal justice, healthcare, human services, workforce development, foster care system, and education system stakeholders and state agencies.
2. Create a model case-conferencing practice guide to assist CoCs and local jurisdictions with cross-agency/system in-person collaboration.
3. Work with privacy law experts to craft data sharing framework and create data sharing platform accessible across multiple systems.
4. Leverage data sharing to create a generalized protocol for organizational and project performance evaluation.

MEASURABLE OUTCOMES FOR GOAL 5

- **By 2023, the state of Utah will establish a subcommittee** to take leadership on cross-system initiatives, projects, and data sharing.
- **By 2024, the state of Utah will create and disseminate a cross-system case conferencing practice guide** to all CoCs.
- **By 2024, the state of Utah will establish data sharing agreements** with at least three systems external to the homeless system of care (e.g., criminal justice, healthcare & human services, workforce, and education).
- **By 2026, the state of Utah will have a data sharing platform** accessible to providers who enter into HMIS that provides access to and visibility of system partner data.
- **By 2030, the state of Utah will develop a generalized protocol** for organizational and project performance evaluation across multiple systems that work with people experiencing homelessness.



Needs Assessment Data Collection and Methodology

The target outcomes, goals, and strategies are based on the findings of a state-level needs assessment of resources for and needs of people experiencing homelessness across the state of Utah, as directed by the Utah Homelessness Council, supported by the Office of Homeless Services. This assessment included these key components:[4]

A review of current research, reports, and efforts to address homelessness

This plan incorporates information, recommendations, and best practices derived from existing studies and reports focused on homelessness in the state, as well as studies of best practices from around the country.

Quantitative data analysis

This plan provides and analyzes data from Utah's local communities about people who are experiencing homelessness. Data are drawn from the federally mandated Homeless Management Information System (HMIS), which tracks people accessing certain types of housing and services for people experiencing homelessness, as well as annual Point-in-Time (PIT) counts, an annual snapshot which includes people who may not be accessing homelessness services, and other data provided by partners.

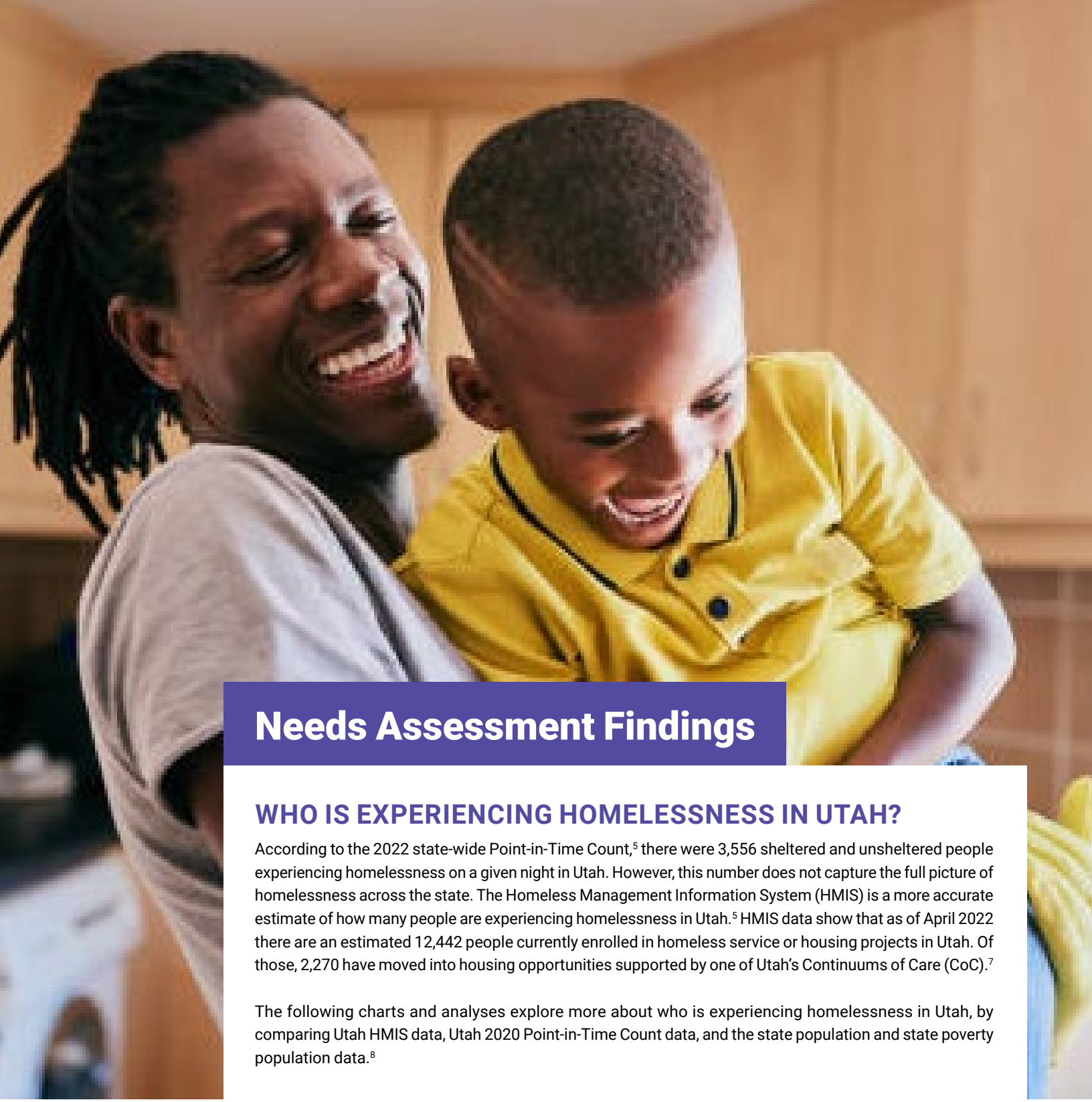
Stakeholder and community feedback survey

More than 600 people from a wide cross-section of the state responded to an online survey distributed by the Utah Office of Homeless Services, the Utah Homelessness Council's Strategic Plan Advisory Group, the Utah Homeless Network, homeless service providers, and other stakeholders across the state. The survey was designed to gather feedback and perspectives from community members, providers, and other stakeholders about needed resources and strategies for addressing homelessness.

Interviews and focus groups

This plan incorporates feedback from more than 20 groups of diverse community stakeholders, including people experiencing homelessness, funding organizations, business leaders, law enforcement and health care agencies, state and local leadership, and housing and services providers.

[4] The Appendix contains in-depth summaries of methodology and findings from these data- and feedback-gathering strategies.



Needs Assessment Findings

WHO IS EXPERIENCING HOMELESSNESS IN UTAH?

According to the 2022 state-wide Point-in-Time Count,[5] there were 3,556 sheltered and unsheltered people experiencing homelessness on a given night in Utah. However, this number does not capture the full picture of homelessness across the state. The Homeless Management Information System (HMIS) is a more accurate estimate of how many people are experiencing homelessness in Utah.[5] HMIS data show that as of April 2022 there are an estimated 12,442 people currently enrolled in homeless service or housing projects in Utah. Of those, 2,270 have moved into housing opportunities supported by one of Utah's Continuums of Care (CoC).[7]

The following charts and analyses explore more about who is experiencing homelessness in Utah, by comparing Utah HMIS data, Utah 2020 Point-in-Time Count data, and the state population and state poverty population data.[8]

[5] The Point-in-Time (PIT) Count is a physical count of all people experiencing homelessness within a Continuum of Care, including those who are unsheltered and may not have accessed the homeless system of care. It provides a snapshot of people experiencing homelessness at a specific point in time.

[6] Each Utah Continuum of Care (Balance of State, Mountainland, Salt Lake) is required to have homeless service and housing programs enter data about people experiencing homelessness into HMIS. Data fields conform to standards published by the Department of Housing and Urban Development (HUD), which requires that each CoC administer an HMIS.

[7] 2,270 people have moved into rapid rehousing or permanent supportive housing, as tracked in HMIS at the state leve, and thus are maintaining an active enrollment.

[8] American Community Survey [ACS] 2020 Five-Year-Estimates.

Race, Ethnicity and Sex

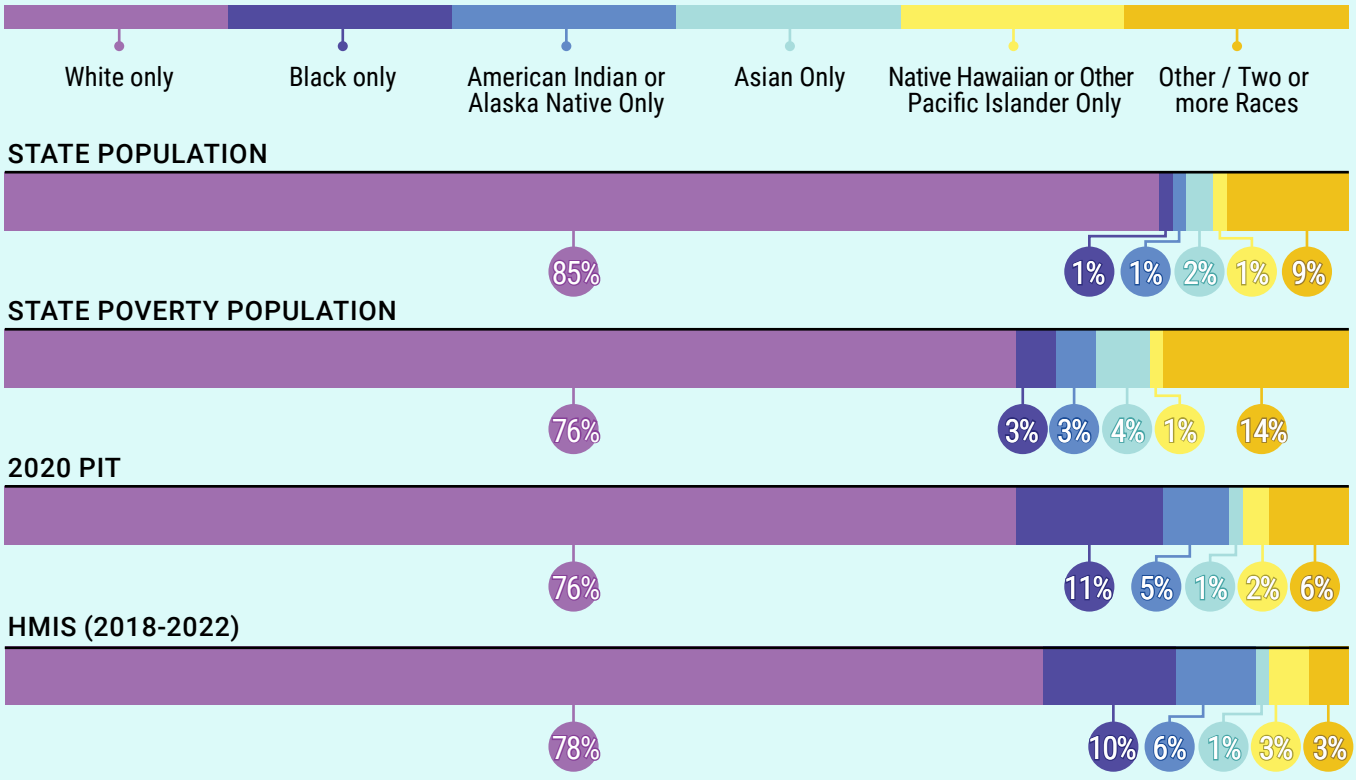
Examining the racial and ethnic makeup of people experiencing homelessness shows that while Utah is predominately white, Black, Indigenous, and People of Color experience homelessness at disproportionately higher rates across the state. When compared to state-level population data, Black, American Indian / Alaskan Native, and Native Hawaiian / Pacific Islander groups are overrepresented in the homeless population in Utah. For example: Black individuals are only 1% of the state population and 3% of the state population in poverty, but they represent over 10% of those in the homeless system of care. Similarly, those who are Hispanic / Latino are only 14% of the state population but make up 23% of the state population in poverty and over 23% of those experiencing homelessness.

Further, feedback from homeless service providers and people with lived experience emphasized the need for housing and services to be accessible and inclusive for everyone, especially vulnerable subpopulations including People of Color.

Demographic data from HMIS also demonstrated that, similarly to many states and localities, males represent a majority of the homeless population in Utah (57%).[9]

> **People of Color and low-income communities have been more impacted but it is not addressed […]. When we think about our homeless response, we are often thinking about white people who speak English. We don't meet the needs of People of Color, immigrants, people who speak other languages.**
>
> – Utah Housing Corporation Representative

Homelessness by Race Compared to State Population Data



[9] According to HMIS data from 2018-2022: 57% of the population is male, 42% female, and 1% who identified as a gender identity other than only male or female.

What household types are experiencing homelessness?

The majority of people and households experiencing homelessness in Utah are single adults (adult-only households), making up about 48% of the people experiencing homelessness and 76% of all households.[10] Families (adults with children) make up 30% of the people experiencing homelessness and 13% of the households.

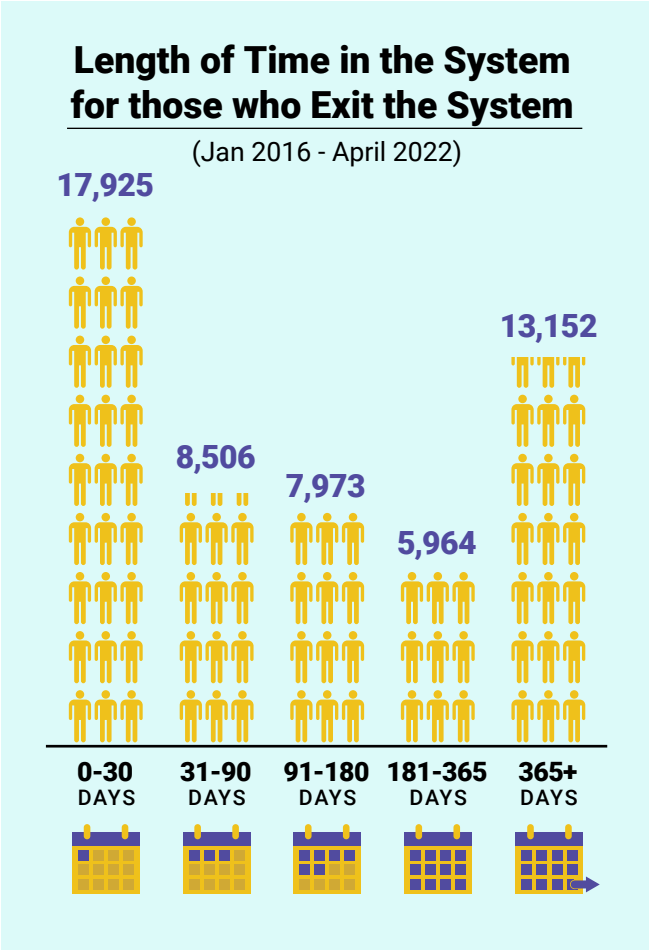
Stakeholder and survey feedback identified both families with children and transition age youth as a high-priority populations for housing and services across the state. Of the adult-only households experiencing homelessness in Utah, approximately 8% are transition age youth (ages 18-24). Stakeholder feedback noted the need for services and housing opportunities for transition age youth, who cannot access many of the programs designed for adults experiencing homelessness because they do not meet the eligibility requirements or do not feel comfortable in accessing these programs. Further, stakeholders emphasized that chronically homeless households, predominately single adults, are another priority population for assistance.

[10] The Department of Housing and Urban Development defines "household" as all the people who occupy a housing unit. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household.

LENGTH OF TIME HOMELESS

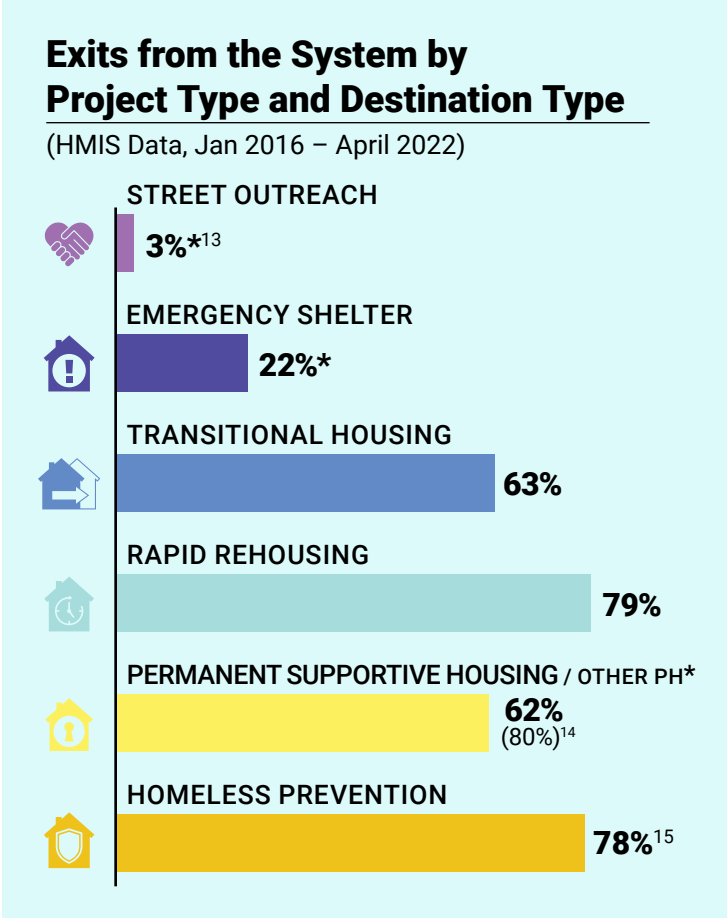
How long does it take for people to exit homelessness?

While some people experiencing homelessness in Utah are able to resolve their housing crisis and locate housing either on their own or with assistance through coordinated entry in their CoC, others struggle to find permanent housing and remain homeless for many days or sometimes years. The median time from system of care entry to exit (meaning placement in permanent housing[11]) is 92 days.[12]



What types of projects or services get people into housing?

Certain types of homeless assistance programs in Utah are shown to have high rates of moving people into permanent housing and keeping them housed, while others struggle to connect clients with permanent housing opportunities. The chart below shows how many people end up in permanent housing after they exit from certain types of homeless assistance projects.



Similarly, permanent supportive housing (PSH), transitional housing (TH), and rapid rehousing (RRH) have lower rates of returns to homelessness[16] once someone has become housed as compared to emergency shelter (30% of people return to homelessness from permanent destinations). Emergency shelter provides a vital service across the state, but providers face unique challenges in finding stable affordable and permanent housing opportunities for clients. Providers noted that, in many cases, they do not have enough resources to connect people, especially those who are highly vulnerable, to the services or housing opportunities they need to remain stably housed.

[11] Exit = if the person has moved into rapid rehousing or permanent supportive housing, if they have been exited for a year and have not returned (regardless of exit type), or if they exited to a permanent destination. Individuals in RRH and PSH are often still "enrolled" in the system and receiving other services.

[12] According to HMIS data from 2017-2022 for length of time in the system for those who exit the system.

[13] * = excluding retention

[14] ( ) = including retention

[15] Unknown Destination >10%,

[16] (PSH: 15% returns to homelessness from permanent housing; TH: 19% returns to homelessness from permanent housing; RRH: 24% returns to homelessness from permanent housing).

SUBPOPULATIONS EXPERIENCING HOMELESSNESS

How many people experiencing homelessness in Utah have disabilities?

Permanent affordable housing is out of reach for many Utah residents, but people experiencing homelessness with a disabling condition may face additional challenges to obtaining and retaining housing. Many adults experiencing homelessness across Utah have a disability or significant impairment, including chronic physical impairments, mental illness, substance use disorder, or combinations of multiple conditions. While many had a disability prior to losing their housing, many others acquired a disability resulting from living on the streets or being without stable housing. To return to housing successfully and for the long-term, people experiencing homelessness often require ongoing supports and services, including after housing placement.

According to HMIS data, about 48% of people who have experienced homelessness within the last five years in Utah had a disabling condition. Around 36% of them had a mental health or substance use disorder.

Stakeholders also strongly emphasized the need for additional supports and resources for people experiencing homelessness with disabling conditions, including substance use disorders and mental health needs. Approximately 51% of stakeholders that completed the survey stated that people with mental illnesses needs the most focus in the homelessness response system.

Disabling Condition Category[17]	Number (77,409)	Percent of Total Ever Enrolled in the Homeless System (Jan 2016 – April 2022)
Any Disabling Condition	37,925	48.99%
MHD OR SUD	27,904	36.23%
Mental Health Disorder (MHD)	20,959	27.33%
Substance Use Disorder (SUD)	15,302	19.92%
Alcohol Use Disorder (AUD)	6,899	8.99%
Drug Use Disorder (DUD)	12,447	16.24%
MHD AND SUD	8,357	10.80%
Chronic Health Condition	14,972	19.48%
Physical Disability	11,757	15.30%
Development Disability	7,376	9.61%
HIV/AIDS	659	0.90%

[17] 7.5% (6,274) missing data was not included in this table; CE not included due to poor data quality. Data are from Jan 2016 – April 2022 time period. Please note this chart reflects a number of people who may have multiple disabilities or health conditions.

How many people in the state are experiencing unsheltered homelessness?

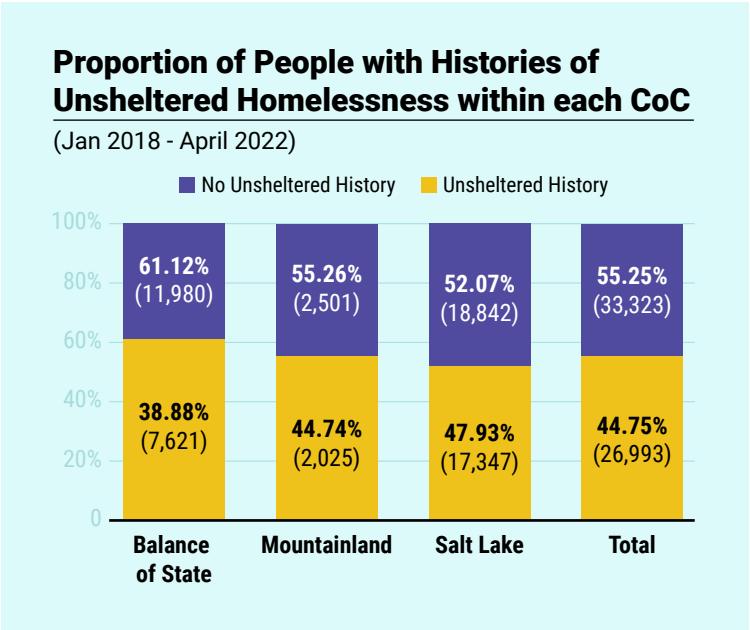
Experiencing unsheltered homelessness similarly creates challenges and barriers for people in obtaining permanent housing. People experiencing unsheltered homelessness are also uniquely vulnerable and, according to stakeholders, need housing and additional supports to exit homelessness and maintain permanent housing. Reducing unsheltered homelessness was identified by stakeholders as essential to addressing homelessness across the state.

Of all of the individuals in Utah who have experienced homelessness **since 2018[18] and enrolled in the system of care**, over 55% had a history of unsheltered homelessness.

Further, an estimated 39% of people **newly entering the system each year** will have experienced or will experience unsheltered homelessness.

Certain subpopulations experience unsheltered homelessness at a higher rate. For example, those who are considered chronically homeless have experienced unsheltered homelessness at higher rates (87.5%) than those who are not considered chronically homeless (38%), and adult-only households make up 61% of the total homeless population but 89% of those who are unsheltered.

> **Everyone should have a home. Those with children should take precedence. Those with a disability or having been a victim of DV and those marginalized communities need extra support.**
> – Survey Respondent

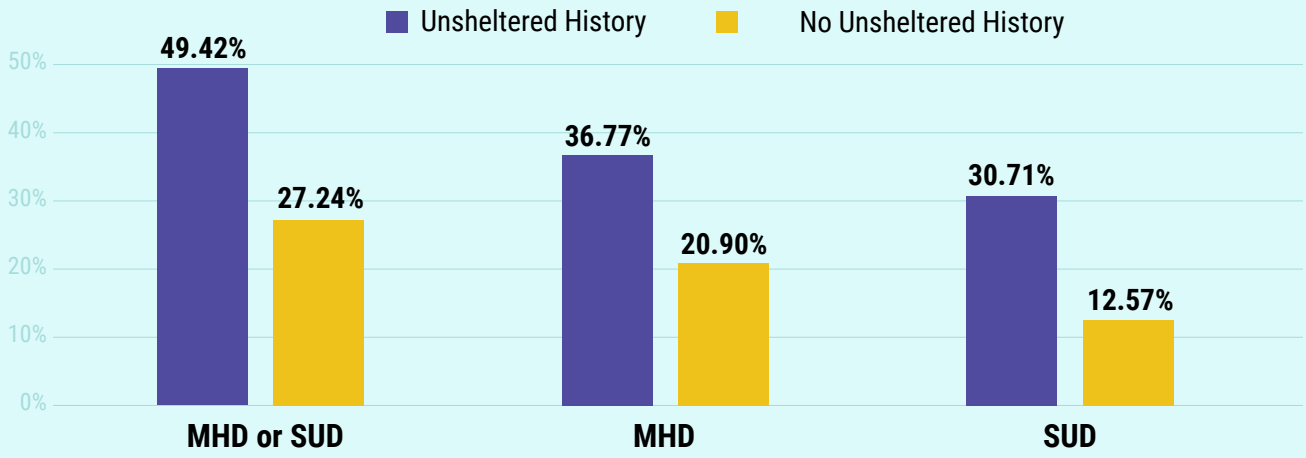


[18] Due to poor data quality for unsheltered homelessness prior to 2018, these data are for Jan 2018 – April 2022.

According to the HMIS data, approximately 49% of people with unsheltered histories (of those enrolled in the system of care in the last five years) also had records of mental health disorders (MHD) and/or substance use disorders (SUDs). The chart below shows how many people with unsheltered and sheltered histories are reported has having a mental health and/or substance use disorder across the state.

Mental Health Disorders (MHD) and Substance Use Disorders (SUD) by Unsheltered Histories

(HMIS Data, Jan 2016 - April 2022)



A wide range of stakeholders emphasized the need to prioritize people who are living unsheltered for services and housing and that people living outside is an not acceptable solution and creates harm and trauma to people experiencing homelessness and the larger community.

Stakeholders identified the top solutions to unsheltered homelessness as permanent supportive housing, affordable permanent housing, and hotel/motel conversions to permanent housing or shelter. Survey respondents identified the need to resolve encampments, but overwhelmingly objected to sweeps or camp cleanups – only 8-10% of respondents selected these as potential solutions to unsheltered homelessness.

How many unhoused people in Utah are experiencing chronic homelessness?

Like people experiencing unsheltered homelessness, people experiencing chronic homeless have vulnerabilities that may require expanded assistance and supports to connect them with permanent housing. Chronic homelessness[19] is used to describe individuals who have experienced homelessness for at least a year — or on repeated occasions over the course of several years — while struggling with a disabling condition such as a serious mental illness, substance use disorder, or physical disability.[20] Of the people currently enrolled in homeless assistance projects that enter data into HMIS, approximately 20% are considered chronically homeless.

- Balance of State CoC: 11.5% (284 people) are currently chronically homeless.
- Mountainland CoC: 20.6% (178 people) are currently chronically homeless.
- Salt Lake City CoC: 22.7% (1,783 people) are currently chronically homeless.

Each year, about 10% of those newly entering the system will be chronically homeless. Stakeholders also emphasized that people who are chronically homeless typically need a higher level of support paired with housing (e.g., permanent supportive housing solutions).

HOUSING AND SERVICES: WHAT IS NEEDED IN UTAH

In addition to providing a picture of who is experiencing homelessness in Utah, including the needs and characteristics of vulnerable subpopulations, the state needs assessment sought to identify what housing and service resources are required to meet the needs of Utah's homeless population.

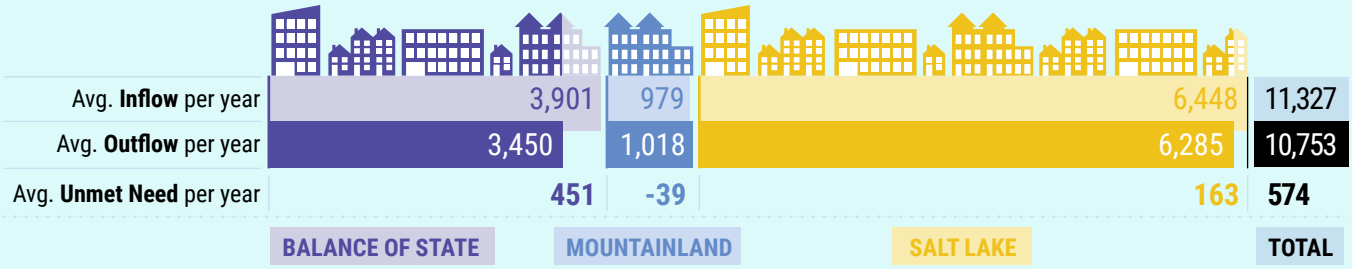
Unmet Housing Need Across the State

Permanent housing brings security and safety, allowing individuals and families to focus their efforts on maintaining a job, getting their kids to school or childcare, and improving or preserving their health and well-being. Stakeholders in all areas of Utah emphasized that there is a severe shortage of affordable housing for people experiencing homelessness and that meeting the current unmet permanent housing need was the most important solution to ending homelessness. To assess how much housing is required in Utah to serve the needs of all people who are currently experiencing homelessness, HMIS data was analyzed to determine (1) how many people come into the system of care (inflow), (2) how many people exit the system of care (outflow), and (3) the difference between those two (unmet housing need).

The following table shows the average unmet housing need is housing opportunities for 574 people **per year** by CoC (Continuum of Care). These three CoCs cover the entire state of Utah. The average was based on years 2017 through 2021, as those were the years with full data available for the analysis.

> **There's a less than 2% vacancy rate for housing in Salt Lake. So even if someone has a voucher, many people have trouble finding a unit within their voucher standards before it expires. Many people think vouchers are the solution to all, but searching for a unit, especially when someone has barriers (evictions, criminal background, poor credit, etc.), they still may not even get into housing.**
> – Survey Respondent

Average Unmet Need by CoC (2017-2021)



A majority of survey respondents stated that a key piece of solving homelessness was housing initiatives, including financial assistance and more units. Further, respondents also ranked deeply affordable housing units as the most effective strategy to addressing homelessness.

Similarly, broader data examining how many affordable housing units are needed to house low-income households across the state show significant deficits. According to the National Low Income Housing Coalition (NLIHC), there is currently a deficit of approximately 40,000 units of affordable housing across the state (specifically, there are 20,240 affordable and available rental homes to meet the needs of 61,221 extremely low-income renter households). The deficit for units at or below 50% of AMI (area median income) is 43,253 units (https://nlihc.org/gap/state/ut).[21]

[21] Data are based on the Housing Cost Burden by Income, which assess the degree to which individuals across income groups are cost burdened by housing (e.g., extremely low income = 0-30% of AMI; renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened).

What Types of Housing are Needed in Utah?

While the data clearly show the need for additional permanent housing of all types, stakeholders specifically emphasized both the success of and the need for permanent supportive housing. Shelter providers noted that while their supportive services are comprehensive there are not enough housing opportunities for people exiting the shelter, especially those who have a high level of physical or mental health needs. Providers also noted that permanent supportive housing projects provide the best outcomes for people with a high level of mental health or other service needs. Survey respondents further noted that permanent supportive housing and affordable permanent housing are the top two solutions for unsheltered homelessness.

To determine what percentage of different types of housing are needed across the state, this assessment looked at level of acuity of people experiencing homelessness throughout the state. Acuity is the level of vulnerability or need someone has. People with higher levels of acuity typically require more supportive services and longer-term housing support.

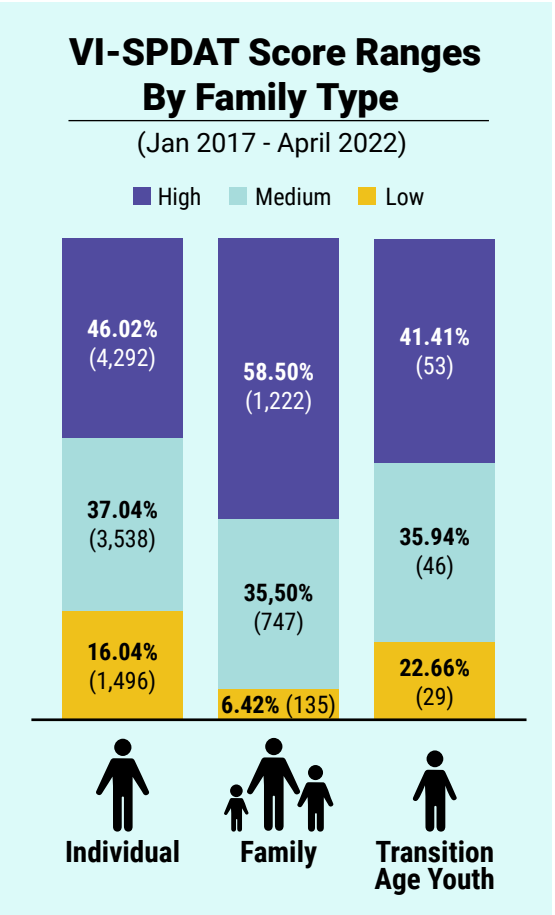
One way to determine acuity, or severity of need, is through examining VI-SPDAT scores (a vulnerability assessment tool which generates a number to represent a person's level of vulnerability) to examine how many people have low, medium, and high levels of acuity. Communities, including the Utah CoCs, use the VI-SPDAT in their coordinated entry systems to determine which people may need a high level of support such as permanent supportive housing.[22]

More than 50% of the people coming into the system are scoring in the low to medium range, below what is typically considered a range that is recommended for permanent supportive housing placement. This indicates that a significant number of people experiencing homelessness will not require permanent supportive housing.

The following chart shows the VI-SPDAT score ranges by family type (individual, family, and transition age youth)[23]. A "high" score range is 8+/9+ and indicates a need for permanent supportive housing. A "medium" score range is 4-7 and indicates a need for transitional housing or rapid rehousing. A "low" level is 3 or less and indicates a lower priority for permanent housing through coordinated entry, but services and housing assistance outside of coordinated entry are typically provided.

While 46% of adults, 41% of transition age youth, and 58% of families may be best served by permanent supportive housing, a much smaller percentage of these households are actually accessing permanent housing projects. Of people scoring in permanent supportive housing range,[24] only 11% ever access PSH or Other Permanent Housing (OPH) project types.[25]

> **A huge barrier is housing. If you are homeless that means you have no home. The prices of housing in the state make it much more difficult to house people. In this type of economy, it is hard to get people into something they can call home that is safe and stable. We don't have enough truly deeply affordable housing in the state.**
>
> – County Representative



[22] "High" acuity is 8+ for individual households or 9+ for family households, which qualifies that household for Permanent Supportive Housing (PSH).

[23] These data are from HMIS for January 2017 through April of 2022. There were not enough assessments in the dataset for 2016 to be included in analysis.

[24] Of those who are exiting "coordinated entry" project types in HMIS.

[25] Adults: 14% accessed permanent supportive housing or other permanent housing project types; Families: 3% accessed permanent supportive housing or other permanent housing project types; TAY: 9% accessed permanent supportive housing or other permanent housing project types.

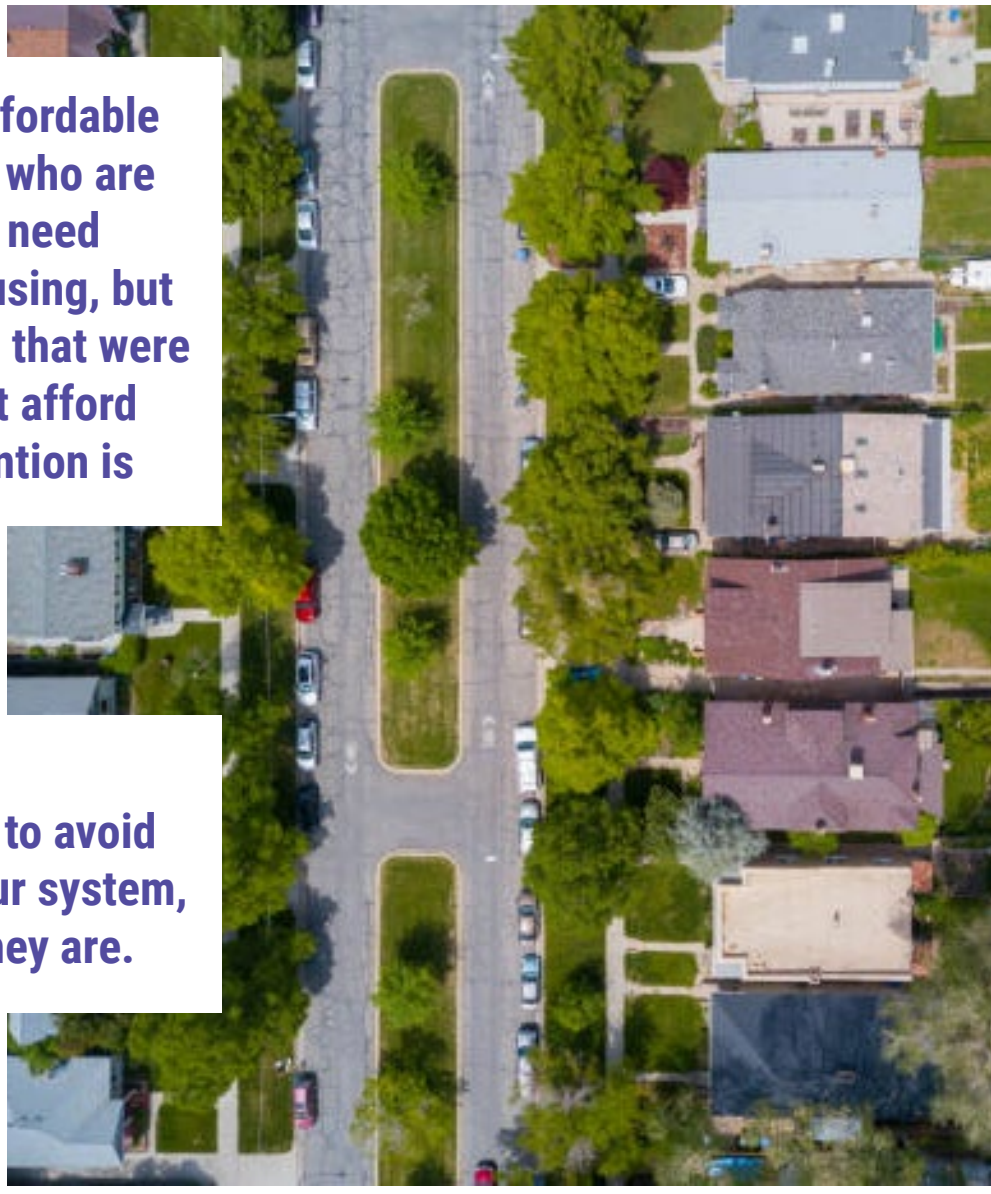
Homeless Prevention

As the lack of permanent affordable housing spreads to additional rural areas of the state, more people are just one paycheck or financial crisis away from losing their housing. Often it only requires a small intervention to prevent them from becoming homeless — whether it is one-time financial resources to provide a security deposit, legal assistance to prevent eviction, or help learning to balance a budget. Homelessness prevention can be a low-cost strategy that can be implemented immediately at any agency serving homeless clients, and stakeholders across Utah identified homeless prevention as a key measure to addressing homelessness. Survey respondents noted that homeless prevention financial assistance is the most needed type of assistance and other stakeholders emphasized that stronger partnerships between homeless service providers and other systems that may discharge clients into homelessness, such as hospitals, the foster care system, and the criminal legal system, are needed to prevent homelessness for those exiting these institutions.

Further, HMIS data shows that 78% of people who do receive homeless prevention assistance remain housed, supporting the efficacy of this cost-effective intervention.

> **We don't have available affordable housing. You have people who are chronically homeless that need permanent supportive housing, but then you also have people that were evicted because they can't afford their rent anymore. Prevention is housing.**
>
> – UHC Member

> **We need to focus more on preventing homelessness to avoid people from falling into our system, help keep people where they are.**
>
> – Homeless Provider



Unmet Service Needs

Housing is a solution to homelessness, however, it is often very difficultfor everyone experiencing homelessness to obtain and retain housing without the proper social services and supports. Nonprofits, community groups, county, and state agencies provide a variety of services that can help people to exit homelessness and stay housed for the long-term. Programs such as mental health treatment, employment and job training, health care, substance use recovery, and transportation are needed to help people attain greater stability. Case management is a crucial supportive service for people experiencing, exiting, and at risk of homelessness because they help assess the individual needs and make the connection to the right services. For people who are currently homeless, housing-focused case management is a best practice that focuses on the specific challenges and barriers preventing people from regaining stable housing.

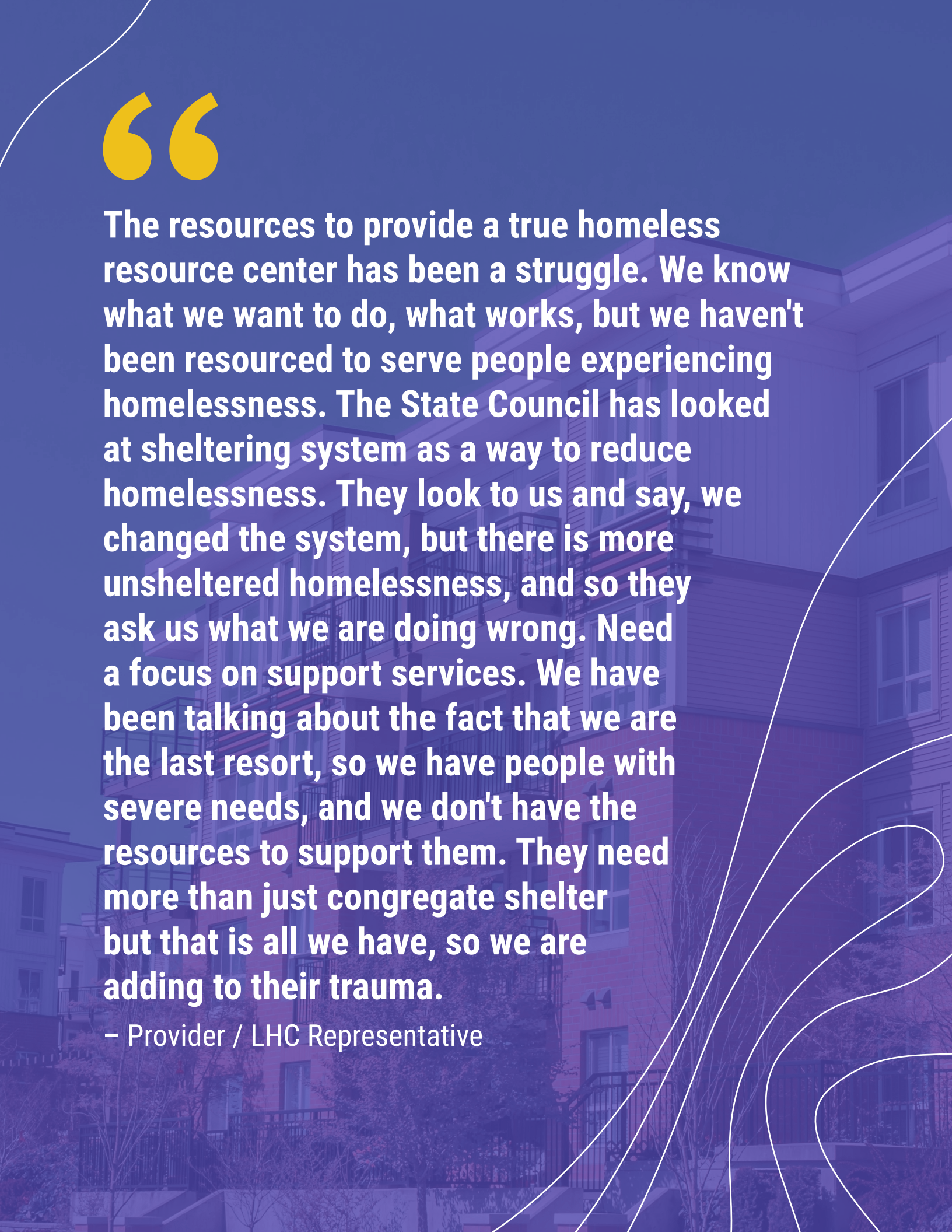
Data from across the state show that about half of people experiencing homelessness have disabling conditions that may require a high level of service needs, including mental health and substance abuse treatment. Feedback from survey respondents and other stakeholders also emphasized the need for more funding and state support for service providers.

Next to housing, supportive services was the second highest priority for addressing homelessness for a majority of survey respondents and stakeholders, and many stakeholders across Utah emphasized the need for SUD treatment and better linkages between homeless service providers and drug treatment programs.

Over 90% and 88% of survey respondents, stated that behavioral health and mental health treatment were the top health care priorities for people experiencing homelessness. A majority of survey respondents also stated that wrap-around supportive services and case management were the top two types of supportive services most needed. Stakeholders further emphasized that without adequate transportation to access supportive services and case management, people cannot be effectively connected to these services.

Finally, survey takers said that that some services are currently underutilized, primarily due to lack of staff resources. Providers and shelter staff similarly emphasized that low pay and high job turnover created significant challenges in running existing programs.

> **We need more permanent supportive housing with an emphasis on structured wrap-around services. Case management is critical for those who lack housing right now.**
>
> – LHC Representative



The resources to provide a true homeless resource center has been a struggle. We know what we want to do, what works, but we haven't been resourced to serve people experiencing homelessness. The State Council has looked at sheltering system as a way to reduce homelessness. They look to us and say, we changed the system, but there is more unsheltered homelessness, and so they ask us what we are doing wrong. Need a focus on support services. We have been talking about the fact that we are the last resort, so we have people with severe needs, and we don't have the resources to support them. They need more than just congregate shelter but that is all we have, so we are adding to their trauma.

– Provider / LHC Representative

Statewide Collaboration for Change:

Utah's Plan to Address Homelessness

Strategic Plan Implementation Recommendations

NOVEMBER 2022

During the plan implementation process the Utah Office of Homeless Services (OHS) will work with stakeholders, including a diverse group of adults and youth[1] with lived experience of homelessness, to identify plan priorities for implementation and define concrete next steps towards achieving the plan goals. The following recommendations and action steps are meant to assist with this process.

Recommended First Implementation Steps

1. Create a Joint Strategic Plan Implementation Committee which includes adults and youth with lived experience of homelessness, to take ownership and leadership of and accountability for, the strategic plan implementation.
2. Collaboratively prioritize strategies into short-, medium-, and long-term timeframes, considering available resources, impact, and support for each.
3. Select initial strategies for implementation, based on capacity, and assign responsibility to a lead entity or smaller task force.
4. Convene annual plan update session to report on progress of goals to allow for accountability and create ongoing opportunities for stakeholder feedback.

Implementation Strategies

- Adults and youth with lived experience of homelessness should be involved at every stage of the planning and implementation process.
- Equity, including racial equity, should be assessed at every stage of the planning and implementation processes for each goal. Please find further recommendations for implementing measures and practices that ensure racial equity here.
- The Utah Homeless Services Officer, in partnership with, the UHC, the UHN, and people with lived experience, should engage state and local entities to participate in innovative planning and budgeting process[2] for all recommendations related to increasing investments & resources.
- OHS and other stakeholders should support CoCs and LHCs across the state in efforts to increase funding, infrastructure, and reach for their HMIS and coordinated entry systems and partners who use them. This will assist with furthering both robust data tracking as well as rapid placement into permanent housing for the most vulnerable populations of people experiencing homelessness in Utah.

Roadmap to Implementation

Implementation of the strategic plan goals requires continued planning and assessment from regional and local partners, as well as leadership and support from state agencies. The following potential next steps to implementation create a roadmap for beginning the implementation process and represent specific and targeted ideas for the Joint Strategic Plan Implementation Committee to consider as they prioritize and plan for implementation of the following goals. The roadmap was drawn from data gathered, state and nationally recognized innovative strategies to addressing homelessness as well as suggestions from Utah leaders and system stakeholders. These are **not** required steps but meant to be used as a source of information and practices for consideration.

[1] Youth refers to transition age youth (TAY) defined as individuals aged 18 to 24 years old.
[2] Including processes recommended by the Gardner Policy Institute.

GOAL 1

Increase accessible and affordable permanent housing opportunities for people experiencing homelessness across the state

STRATEGIES WITH POTENTIAL NEXT STEPS

1 Support localities to increase investment in permanent housing options at the state and local level, using private and public funds to meet the current housing need[3] across the state.

- Develop a pre-development loan or lending fund (e.g., a housing trust fund) to create additional affordable housing building opportunities, particularly for rural communities.
- Identify underutilized land across the state to be used for dense affordable housing development.
- Identify ways to work with localities at the state level to foster developer connections, provide developer incentives, and support measures that increase development opportunities.
- Increase state support for local landlord engagement by providing training resources and targeted recommendations for CoCs and LHCs (e.g. a comprehensive list of funding sources that allow landlord incentive costs, training on sales techniques to increase landlord engagement, training on use of mitigation funds).
- Create resource guide to help support cities and counties to develop innovative housing strategies (e.g. shared housing, tiny homes, single room occupancy and micro-units).
- Assist CoCs and LHCs in developing partnerships with private funding sources, (e.g. The Utah Housing Preservation Fund (existing), The Rocky Mountain Homes Fund (existing) and The Utah Perpetual Housing Fund (being established) to coordinate efforts related to the development and preservation of permanent housing for people experiencing homelessness.

2 Support localities to increase development of permanent supportive housing programs.

- Create a pre-development loan or lending fund (e.g., a housing trust fund from public/private funders) to create additional permanent supportive housing building opportunities.
- Invest in site-based permanent supportive housing with intensive on-site wraparound services and supports for highly vulnerable persons experiencing homelessness, including those who have experienced extended periods of chronic and unsheltered homelessness and those with significant behavioral health needs.
- Work with Housing Authorities across the state to create "Moving On" initiatives that will free up space in current supportive housing projects and transition people who have stabilized onto permanent housing vouchers.
- Work with CoCs and LHCs to ensure that coordinated entry is working efficiently and effectively to place the most vulnerable people in a community into permanent supportive housing opportunities as quickly as possible.

[3] There is currently a deficit of approximately 40,000 units of affordable housing across the state (i.e. 20,240 affordable and available rental homes to meet the needs of 61,221 extremely low income renter households). See more information here. According to the National Low Income Housing Coalition (NLIHC), Utah has a shortage of 40,981 affordable and available rental units. The deficit for units affordable for people who or at or below 50% AMI (area median income) is 43,253 units (https://nlihc.org/gap/state/ut). These data are based on the Housing Cost Burden by Income, which assess the degree to which individuals across income groups are cost burdened by housing (e.g., extremely low income = 0-30% of AMI; renter households spending more than 30% of their income on housing costs and utilities are cost burdened; those spending more than half of their income are severely cost burdened). Current housing needs of people experiencing homelessness was identified as 574 permanent housing opportunities per year based on HMIS data demonstrating the current system flow across the state.

3 Support localities to increase development of transitional/interim housing[4] for vulnerable subpopulations of people experiencing homelessness (e.g., those with mental health and substance use disorders, survivors of domestic violence, people experiencing chronic homelessness, people exiting criminal justice system, youth, and others) and create strong pathways for these populations to obtain and retain permanent housing.

- Facilitate developer partnerships between providers and property developers interested in creating low-barrier transitional housing across the state that have direct pathways to permanent housing.
- Develop effective practices and facilitate meetings to assist CoCs in collaborating with other system of care (criminal justice system, healthcare, youth care systems) to coordinate resources and discharges planning efforts to ensure vulnerable populations receive the transitional housing and support services they need to stabilize in permanent housing.
- Support innovative solutions for transitional housing care which includes prioritizing exits to permanent housing.

4 Explore policy-level changes at the state and local level to preserve existing affordable housing.

- Establish cross-agency partnerships at the state and local level to engage interest and facilitate advocacy in preserving affordable housing.
- Explore legislative options to promote measures that preserve affordable housing.

5 Build community support for development of new permanent housing for people experiencing homelessness.

- Develop social marketing campaigns to help spread information on the impact of housing for people experiencing homelessness on neighborhoods and communities.
- Develop and support effective community engagement efforts that may be leveraged across the state.
- Set up systems to track engagement and evaluate public perceptions across the state.

6 Support localities to employ innovative solutions for placing people equitably into permanent housing and design ongoing evaluation protocols that assess equity in housing outcomes.

- Leverage 211 to improve connections to coordinated entry in all CoCs and quickly connect the most vulnerable people across the state with permanent housing.
- Collect ongoing and meaningful feedback from people with lived experience of homelessness about their experiences with homeless systems of care and their assessment of how to make these systems as inclusive and equitable as possible.
- Provide at least annual training on racial equity, cultural competency, and equal access and encourage CoCs to require this training for all staff and recipients of funding.
- Create equity toolkit for localities that addresses the following:
  - How localities can use a racial equity framework that allows for utilization of common definitions and understanding of core concepts necessary for racial equity work.[5]
  - Guidance for localities on how to develop equity experts and local champions throughout agencies, departments, and in each jurisdiction.
  - Guidance for localities on how to measure the success of specific programmatic and policy changes from an equity perspective and develop baselines, performance metrics, and measures towards community success.

[4] Transitional or interim housing refers to temporary housing often providing a bridge from shelter to permanent housing.

[5] Use GARE Racial Equity Toolkit as a guide for this process.

INNOVATIVE SOLUTIONS HIGHLIGHT:

Social Marketing & Public Awareness Campaigns

Raising awareness of homelessness itself, as well as the successes of the homeless response system, is a necessary activity to challenge misconceptions, build political support, and expand the scope of resources available to people experiencing homelessness. Well-designed and effective public awareness campaigns should consider:

1. **What is the primary purpose of the campaign?**
   Public awareness campaigns can focus on presenting accurate information to the community at large; increasing awareness of available resources to people experiencing homelessness; advertising opportunities to volunteer and contribute to the public; applying political pressure to elected officials; or securing additional funding through donations, philanthropy, or public funds. Public awareness campaigns are intended to address a number of these purposes.

2. **What are the specific needs of the community?**
   While commonalities exist, every community has its own localized needs pertaining to homelessness and the provision of housing and services. By identifying those needs in advance, your public awareness campaigns can generate a specific "ask" of those it encounters. In particular, setting a concrete goal that organizers can publicly track progress towards is often especially helpful both in generating support and advertising progress.

3. **What misconceptions exist in the community about homelessness and the homeless response system?**
   Coordinated public awareness campaigns are often necessary to combat misconceptions about homelessness and the activities of the homeless response system. Communities should attempt to identify misconceptions that may exist in their local area and address them head on through a combination of educational materials, one-on-one engagement, videos, workshops, and research. Where possible, tell personalized stories through effective means, such as video, rather than relying on statistics or data.

4. **What other campaigns and resources already exist?**
   Identify the campaigns and resources that already exist in the community and determine how they can be leveraged to support the efforts of a public awareness campaign. For instance, if meetings or mailing lists already exist that have previously demonstrated success and fit well within the goals of the public awareness campaign, there is no need to reinvent the wheel. Leveraging those resources can maximize benefits while minimizing costs. For example, Hunger and Homelessness Awareness Week is an annual event hosted by more than 700 colleges, high schools, and community groups across the country to raise awareness of the challenges of hunger, homelessness, and poverty. It is designed to educate the public, draw attention to the problem of poverty, and build up the base of volunteers for local anti-poverty agencies. Sponsored nationally by the National Coalition for the Homeless and the National Student Campaign Against Hunger & Homelessness, local actors are empowered to adapt the event to local needs and goals, while supported by manuals containing practices for organizing and advertising the event. While results vary from community-to-community, depending on their goals, its 50+ year longevity and growing number of participants are testament to its enduring success at drawing attention to hunger and homelessness. See https://hhweek.org/ for more information, as well as organizing resources.

5. **What is successful in your community?**
   Public awareness campaigns should always be targeted at the specific community that the campaign is designed to address. This means considering the unique attributes of the community and presenting information specifically about the local population experiencing homelessness and the local response to homelessness where possible. Try to connect community members to one another, either through in-person meetings or social media and create materials tailored to the community. Involve the strongest elements of the community (religious establishments, social service agencies, etc.) in the organization of the campaign.

7 Support local efforts across the state to perform housing needs assessments for vulnerable subpopulations experiencing homelessness and target resources and support to housing these populations.

- Support local and statewide efforts to identify housing needs of specific subpopulations, including but not limited to youth and survivors of domestic violence.
- Leverage existing partnerships with providers that serve these vulnerable subpopulations to carry out needs assessments.

MEASURABLE OUTCOMES FOR GOAL 1

- **By 2023, the state of Utah will implement an annual demographic analysis** of housing placements of people experiencing homelessness across the state to ensure equity in housing assistance, placement, and retention.
- **By 2024, the state of Utah will establish cross-agency partnerships** to develop a plan for identifying and funding permanent housing opportunities, including but not limited to permanent supportive housing, for people experiencing homelessness. The plan will examine how state agencies can work collaboratively to address the affordable housing deficit and current unmet housing needs for people experiencing homelessness across the state. This plan will also include housing needs assessments of vulnerable subpopulations experiencing homelessness (e.g., youth and survivors of domestic violence).
- **By 2024, the state of Utah will establish a coordinated plan** to help support localities in development and implementation of transitional/interim housing options for vulnerable subpopulations experiencing homelessness with strong pathways to permanent housing.
- **By 2024, the state of Utah will launch a statewide social marketing campaign** to change perceptions around homelessness and to lessen community resistance to development of new permanent housing for people experiencing homelessness.
- **By 2025, the state of Utah will establish at least two cross-agency partnerships** with the stated goal of advocating for and implementing policy changes to preserve affordable housing and support housing affordability.

GOAL 2

Increase access to and availability of supportive services and case management for people experiencing and at risk of homelessness

STRATEGIES WITH POTENTIAL NEXT STEPS

1 Develop a state-level supportive services working group to assess gaps and coordinate supportive services (e.g., behavioral health/addiction recovery, mental health services, and case management) across the state and identify strategies for increasing staff retention, capacity for client engagement, outreach, and general support.

- Identify innovative partnerships, strategies, and frameworks at the state level that can support the efforts of providers at the local level (e.g., partnerships between the state and local universities to recruit and leverage social work department graduate skills).
- Identify strategies to facilitate coordination of services and collaborations at the local level and disseminate this information to localities.
- Work to identify barriers to staff retention and payment of living wages for supportive services providers and support localities in securing funding to overcome these barriers.

2 Support localities to increase access to and availability of wrap-around mental and physical health services for people experiencing and at risk of homelessness across the state, with additional supports for people placed directly into housing from the street or emergency shelter.

- Provide tools to localities to identify funding sources and partnerships to fill gaps in mental and physical health care. (e.g., state Medicaid providers, county behavioral health, local health clinics).
- Support development of board and care and skilled nursing facilities to serve clients with high level of mental and/or physical health needs.
- Increase the number of free public transit passes and other transportation options for people who are unhoused to access services.
- Provide opportunities for people who have lived experience of homelessness to provide paid peer-to-peer support at a living wage level.

3 Support localities to increase access to and availability of substance abuse treatment (including detox facilities and residential services) for people experiencing and at risk of homelessness across the state.

- Identify state liaison to CoCs and LHCs to assist with creating connections between localities and substance abuse treatment providers and identifying funding opportunities for sober living/substance abuse treatment projects.
- Increase connections and pathways between shelters, interim housing, outreach staff and substance abuse treatment providers.

4 Support localities to increase housing navigation and location services to connect those in emergency shelter and on the streets with housing-focused case management.

- Disseminate evidenced-based practices on housing-focused case management to providers and homeless systems of care across the state.
- Work with CoCs and LHCs to develop strong connections between housing-focused supportive services and emergency shelters.

5 Ensure that the delivery of supportive services is inclusive, culturally competent, and accessible to all people.

- Advocate and provide resources for CoCs to carry out annual monitoring efforts to assess whether supportive services are accessible to all through quantitative and qualitative data analysis, including collecting feedback from people with lived experience of homelessness.
- Provide at least annual trainings on racial equity, cultural competency, and equal access and encourage CoCs to require this training for all staff and recipients of funding.
- Work across the state supporting and providing best practice resources to communities to help increase outreach, engagement, and culturally attuned services to vulnerable and historically underserved populations.

MEASURABLE OUTCOMES FOR GOAL 2

- **By 2023, the Utah Homeless Network will establish a working group** to coordinate supportive service efforts across the state.
- **By 2023, the state of Utah will implement an annual demographic analysis** of service administration across the state to ensure equity in the provision and delivery of services.
- **By 2024, the Utah Homeless Network will perform a gaps analysis** of supportive services and behavioral health services targeted to people experiencing and at risk of homelessness and identify strategies for increasing staff retention and capacity among supportive service providers.
- **By 2024, the Utah Homeless Network will convene an advisory group** of healthcare funders and providers, managed care plans, and stakeholders to evaluate and fund best practices in delivering healthcare to people experiencing homelessness in urban, suburban, and rural communities.
- **By 2024, the state of Utah will identify a identify a state liaison** to collaborate with Utah CoCs to create connections between localities and substance abuse services providers and assist with identification of funding opportunities for sober living/substance abuse services projects.
- **By 2025, the state of Utah will increase supportive service interactions** with people experiencing and at risk of homelessness by 20% as demonstrated by homeless management information system data.

INNOVATIVE SOLUTIONS HIGHLIGHT:
Coordination of Supportive Services

Coordinated, interagency case management and delivery of supportive services is an effective response to homelessness that can take three forms, depending on the unique characteristics and community strengths:

1. **Agency model:** Under the agency model, a single provider of services is responsible for coordinating the care of individual clients. Case managers are employed directly by and accountable solely to the individual agency, which often controls a single niche in the social service field (based on either population or service type). Interagency coordination of case management is thus based on informal relationships between agencies and staff. This model is relatively simple to implement and operate and is thus particularly well suited to rapid crisis response. However, it may limit the resources available to clients and does not allow for community input.
2. **Partnership model:** Case management is provided through informal coordination efforts between agencies or networks serving multiple populations is called the partnership model. Case management staff from disparate agencies meet informally in case conferencing meetings to discuss client cases and do not have formal contractual obligations to one another. Staffing decisions are made by the individual participating agencies. This model has the advantage of being relatively flexible, meeting and providing access to a broad array of services as needed. However, individual agencies may come into conflict with one another, resulting in service delivery delays or disruptions.

3. **Consortium model:** Under the consortium model, providers offering complementary services are connected to one another by formal contractual agreements covering the common purpose for which the consortium is established. The agreement usually identifies a lead agency which employs the case manager, though the case manager is often accountable to the entire consortium. Since it takes time, effort, and resources to create the consortium, the entity responsible for its creation, such as a funder, typically imposes conditions on the case management process. The consortium typically provides access to more resources and more coordination of care across agencies, but specialization can pose bureaucratic barriers or make access time consuming for participants if not well-designed.

In addition to the models of case management coordination, communities should also consider adopting innovative services designed to improve access to resources and increase efficiency within the homeless response system, as seen in the following examples:

- **ID Recovery Program (San Antonio, TX):** San Antonio's ID Recovery Program helps ensure that people experiencing homelessness are ready for housing as it becomes available by helping obtain driver's licenses, birth certificates, Social Security cards, proof of residency, or other forms of identification needed to access housing and services. It is staffed by officers and volunteers from the San Antonio Police Department's Homeless Outreach Positive Encounters (HOPE) team and civic organizations such as Corazon Ministries (homeless housing and service provider) and the South Alamo Regional Alliance for the Homeless (SARAH, the CoC Lead Agency). The volunteer program operates a weekly clinic serving roughly 1,000 people per year and helps to ensure that people experiencing homelessness are ready and able to access to housing and services for which they are eligible. This reduces the burden on providers and allows them to focus resources on providing services, improving the overall efficiency and performance of the homeless response system.
- **"There's a Better Way" Program (Albuquerque, NM):** Albuquerque's "There's a Better Way" Program provides people experiencing homelessness a pathway to earn an opportunity for employment and an equitable daily wage while providing connections to supportive services based on individual needs. It is funded by the City of Albuquerque's Family and Community Services Department and operated by the city's Solid Waste Management Department. The program organizes and employs paid teams of people experiencing homelessness to help beautify the city by picking up litter and pulling weeds. Because local shelters and service providers are active partners, participants are automatically connected with case managers who assess individual needs and help connect participants to needed services, in addition to providing a daily paycheck. The program operates five days per week, providing roughly 500 people with work each year and cleaning ~300 city blocks and collecting 75,000 pounds of waste during the same period.
- **Community First! Village (Austin, TX):** Mobile Loaves & Fishes' Community First! Village is a tiny home community providing 350 formerly chronic homeless individuals with affordable permanent housing on a 51-acre tract of land outside Austin, TX. In addition to manufactured tiny homes, the community features several services and resident-operated businesses, including a health clinic, food store, art studio, tiny home hotel, an auto shop, and outdoor amphitheater for film screening. Eligibility is based on chronic homeless status and residency in Travis County, after which residents tour the neighborhood to determine if they want to live there and complete an application to be put on a waiting list for a new, customized tiny home costing approximately $400 per month, including utilities. In addition to homes, residents have access to outdoor communal areas, including kitchens, bathrooms, showers, and entertainment spaces. Volunteers and professional service providers regularly come on site to attend to resident needs.
- **Community Resource Directory (SACRD) Program (San Antonio):** The San Antonio Community Resource Directory (SACRD) is a free, online directory of resources that allows San Antonio residents to proactively find help in their local community for their emergency or crisis needs. SACRD captures a wide range of services and resources offered by congregations, nonprofit organizations, government agencies, and compassionate groups in and around San Antonio. The website lists over 3,000 resources that can be searched by zip code, with approximately 100 additional resources being added every month. The directory can be used directly by an individual in need or by case workers and navigators to help connect an individual in need to appropriate resources.

GOAL 3

Expand homeless prevention efforts by increasing coordination, resources, and affordable housing opportunities

STRATEGIES WITH POTENTIAL NEXT STEPS

1 Develop a subcommittee to coordinate homeless prevention efforts and expand data tracking of homeless prevention service interactions.

- Arrange for providers and stakeholders across the homeless prevention continuum (fair housing, legal aid, eviction prevention resource, family resource centers) to participate in subcommittee and/or provide ongoing feedback.
- Develop state-level resources to target prevention services to communities with highest need, based on factors that increase risk of homelessness.
- Provide resources so that localities can leverage available homeless prevention funds to keep vulnerable populations housed (e.g. aging adults on fixed incomes).
- Encourage leveraging flexible funds to pay for expenses that either preserve or immediately re-direct someone at risk of homelessness to permanent housing.
- Support CoCs to build out HMIS capacity to expand tracking prevention efforts.

2 Lead and support coordination of discharge efforts across the state to ensure that people exiting adjacent systems: (e.g. criminal justice, healthcare, foster care, and domestic violence shelters) are not discharged directly to homelessness and receive housing, behavioral health/healthcare, and other complementary services to assist with obtaining and retaining permanent housing opportunities.

- Support localities to ensure that they are building ongoing partnerships with criminal justice, healthcare and mental health systems to ensure discharge coordination.
- Facilitate coordination between homeless system of care and law enforcement, judicial, foster care system, and probation programs to provide safe housing/shelter and transportation for individuals released from custody.
- Explore policy changes to require discharge protocols for people exiting health and criminal justice institutions.
- Increase links to legal services to help those experiencing homelessness with legal issues resolve these issues to increase housing opportunities.

3 Support localities to identify funding and build infrastructure to increase homeless prevention support for people at risk of homelessness.

- Identify and develop flexible cash assistance grants/short-term subsidies to pay for rental and utility arrears, security deposits, move-in expenses, reunification, relocation, and transportation.
- Partner with corporations to create living wage job opportunities to help increase income to support rent payments after temporary subsidy programs end.
- Leverage 211 to make quick connections for prevention assistance to address time sensitive cases.
- Provide resources on available state and federal funding for homeless prevention and resources for localities to effectively disseminate this information across their continuums.
- Provide resources on successful models for homeless prevention CoC/LHC infrastructure including data tracking practices.

MEASURABLE OUTCOMES FOR GOAL 3

- **By 2023, the state of Utah will establish a subcommittee** to coordinate homeless prevention efforts statewide and expand data tracking of homeless prevention service interactions.
- **By 2025, the homeless prevention subcommittee will work to coordinate discharge efforts** from medical and criminal justice systems and decrease exits to homelessness from these systems by 5%.
- **By 2025, the state of Utah will increase homeless prevention assistance service interactions** to people at risk of homelessness by 10%, as tracked by HMIS.
- **By 2025, the state of Utah will decrease the number of returns** to homelessness from permanent housing projects by 5% overall, as tracked by HMIS.
- **By 2025, the state of Utah will decrease the number of returns** to the system of care after exiting homeless prevention assistance projects to permanent housing by 5%, as tracked by HMIS.

GOAL 4

Target housing resources and supportive services to people experiencing unsheltered homelessness

STRATEGIES WITH POTENTIAL NEXT STEPS

1 Support localities to identify resources and infrastructure to increase availability of permanent housing and permanent supportive housing for people experiencing unsheltered homelessness with priority for people experiencing chronic unsheltered homelessness.

- Set state priorities to encourage localities to create permanent and transitional housing set-asides for unsheltered people experiencing homelessness and to prioritize those with a history of chronic homelessness.
- Ensure subsidized housing opportunities have robustly funded supportive services that are necessary to help people newly exiting unsheltered and chronic homelessness stabilize and maintain tenancy.

2 Assist localities in increasing supportive service and case management capacity to provide housing location, navigation, and stability services to provide the supports needed for unsheltered individuals to obtain and retain permanent housing.

- Ensure that CoCs are connected to substance use disorder (SUD) recovery and mental health resources and complementary services that are specifically designed to serve unsheltered populations and ensure people get into housing and are able to stay there.
- Facilitate and strengthen partnerships (e.g., holding regular meetings, hosting resource fairs) between mainstream agencies, such as legal aid, credit repair services, public benefits advocacy and appeals (Medicaid, SNAP, TANF, SSI/SSDI), workforce development, other housing and services providers, and the CoCs and LHCs to increase income and supports for unsheltered people.

3 Assist CoCs and LHCs to coordinate and target resources toward vulnerable unsheltered subpopulations by using by-name lists and other subpopulation targeting tools (e.g., chronically homeless, survivors of domestic violence, people with disabilities and/or substance use disorders, youth, etc.)

- Provide information and linkages to models for 100-day housing challenges and how to create a "by name list"[6] of people experiencing homelessness. These time bound pushes seek to house a certain number of people in a given subpopulation within 100 days.

[6] A by-name list is a comprehensive list of every person in a community experiencing homelessness, updated in real time. Using information collected and shared with their consent, each person on the list has a file that includes their name, homeless history, health, and housing needs. This data is updated monthly, at minimum.

4 Support LHCs to identify specific needs, resources, and strategies to address unsheltered homelessness in their communities.

- Identify locations to develop safe parking, structured sanctioned encampments, and high access shelter in areas where there are elevated numbers of people experiencing unsheltered homelessness.
- Develop operational guidelines and standard notices/intervention plans for all LHCs and agencies involved in responding to encampments, that combines and coordinates: intensive outreach and engagement; housing, shelter, safe parking or sanctioned encampment placement; clearance, and closure.[7]
- Develop and implement common standards for participation of outreach teams in winding down encampments and engaging people in diversion or housing, shelter, safe parking or sanctioned encampment placement.
- Design and implement a framework for advanced coordination with shelter providers to ensure shelter availability and equal access for all persons in the community to access shelter beds/services modeled on United States Interagency Council on Homelessness (USICH) principles.
- Provide strong community messaging and engagement on innovative solutions for encampment resolution and interventions for people experiencing unsheltered homelessness.

MEASURABLE OUTCOMES FOR GOAL 4

- **By 2023, the state of Utah will work with all local CoCs and LHCs** to ensure that people experiencing unsheltered homelessness are targeted for permanent housing opportunities, with priority for people experiencing chronic unsheltered homelessness.
- **By 2025, the state of Utah will identify public land** to develop safe parking, structured sanctioned encampments, and high access shelter in locations across Utah where there are elevated numbers of people experiencing unsheltered homelessness as demonstrated by Point-in-Time Count data.
- **By 2025, the state of Utah will decrease the population of people experiencing unsheltered homelessness** by 5% as demonstrated by aggregated state-level Point-in-Time Count data.
- **By 2025, the state of Utah will support localities** to develop by-name list tracking processes to target housing and services to vulnerable unsheltered subpopulations.
- **By 2027, the state of Utah will decrease the number of people experiencing homelessness** in the following subpopulations by 7%, as demonstrated by Point-in-Time Count count data: chronically homeless, veterans, survivors of domestic violence, youth, people with disabilities (including SUDs).

INNOVATIVE SOLUTIONS HIGHLIGHT:
Encampment Resolution

Communities around the United States are addressing the challenges of serving people experiencing unsheltered homelessness.[8] In 2020, for the first time, unsheltered homelessness exceeded sheltered homelessness in the United States. In Utah, 53% of people in the homeless data system (HMIS) at the time of this plan have experienced unsheltered homelessness, with more than half of those located in Salt Lake City CoC.

Encampments – or groups of people living in public places outside – represent the most visible segment of the population of people experiencing homelessness. In the face of this challenge, communities are beginning to develop practices to address this issue in a manner that leads to housing people, rather than temporarily relocating them.

The United States Interagency Council on Homelessness (USICH) has issued a toolkit for communities to address encampments[9] to help communities address groups of people living together in public or other visible outdoor spaces (like transit corridors, sidewalks, parks). The toolkit lays out seven principles for effective encampment resolution:

[7] Potential model to emulate is Houston, TX's "Homeless Encampment Response Strategy"
[8] HUD defines someone as unsheltered if they have a primary nighttime residence that is a public or private place, not meant for human habitation
[9] https://www.usich.gov/tools-for-action/7-principles-for-addressing-encampments

Principles for Addressing Encampments

PRINCIPLE 1 Establish a Cross-Agency Multi-Sector Response

PRINCIPLE 2 Engage Encampment Residents to Develop Solutions

PRINCIPLE 3 Conduct Comprehensive and Coordinated Outreach

PRINCIPLE 4 Address Basic Needs and Provide Storage

PRINCIPLE 5 Ensure Access to Shelter or Housing Options

PRINCIPLE 6 Develop Pathways to Permanent Housing and Supports

PRINCIPLE 7 Create a Plan for What Will Happen to Encampment Sites After Closure

These principles emphasize the need for coordination across multiple systems in order to provide low-barrier, service-intensive alternatives to people residing in encampments or other unsheltered areas. Service providers, government agencies (including public health, law enforcement, and other partners) and other partners must collaborate with neighbors and people who are living in the encampments to create plans for moving people out of unsheltered situations and into housing. Without such planning and collaboration, communities' efforts have only short-term effects: they may remove an encampment from view, but they will reappear in another area or return; and the people living in these encampments experience exacerbated traumatic stress, loss of possessions and social connections, adverse health outcomes, and the loss of trust in the system of care.

Using a similar approach to that endorsed by USICH, the greater Houston metropolitan addressed encampment clearance in 2021. Houston's strategy – defined as "clearance and closure with supports" -- uses intensive outreach and engagement strategies along with a housing surge in order to identify housing opportunities (that include either immediate housing placement or interim housing plus an identified pathway to permanent housing) for all people residing at targeted encampments. Using CARES Act and other funding, in the first half of 2021 Houston closed five encampments, and housed all 53 inhabitants.
The effort involved multiple partners and agencies who endorsed a common set of guiding principles, including:

1. All people can be housed, with the right housing model and service supports.
2. To the greatest extent practicable, individual choices about where and how to live should be honored.
3. Addressing encampments requires collaboration from multiple sectors and systems; no single entity can or should have exclusive responsibility.
4. Non-punitive, engagement-focused approaches are more preferable than enforcement, clearance, and criminalization. Houston should strategically combine enforcement approaches with housing offers to address broader community health and safety interests.
5. Intensive and persistent outreach and engagement is the key to building trust among persons living in encampments.
6. Persons in encampments do best with clear, low-barrier pathways to permanent housing.
7. Permanent housing placements must be followed by support services to ensure individuals are successful in maintaining their housing.

Despite the early success of this program, Houston noted the need for ongoing influx of resources to sustain and scale efforts in the future. Among the resources cited were investments in "specialized services, treatment beds, outreach staff expansion, and, most importantly, the supply of a variety of safe, accessible, and supportive housing options that people residing in encampments will need in the future."[10]

[10] https://www.homelesshouston.org/homeless-encampment-response-strategy-released

GOAL 5

Promote alignment and coordination across multiple systems of care to support people experiencing and at risk of homelessness.

STRATEGIES WITH POTENTIAL NEXT STEPS

1 Develop cross-system partnerships with criminal justice, healthcare, human services, workforce development, foster care system, and education system stakeholders and state agencies.

- Provide educational opportunities and materials to promote understanding of unfamiliar overlapping systems and increase fluency in partner-system languages.
- Develop 211 infrastructure to provide better linkages and referral structures between these systems.
- Encourage cross-system connections at the state and local level to ensure that people with disabilities receive case-management and advocacy from the appropriate agencies at every stage of a housing crisis.

2 Create a model case-conferencing practice guide to assist CoCs and local jurisdictions with cross-agency/system in person collaboration.

- Work with CoCs to develop case conferencing guidelines for inter-system/agency collaboration.

3 Work with privacy law experts to craft data sharing framework and create data sharing platform accessible across multiple systems.

- Draft a feasibility report on the current data tracking systems in place, governing privacy law, and the required agreements and releases of information required for shared identifiable data.
- Begin securing necessary agreements and rolling out new release of information frameworks.

4 Leverage data sharing to create a generalized protocol for organizational and project performance evaluation.

- Provide support for localities who wish to evaluate local projects for performance by designing an evaluation system based on the expanded data sharing capacity across the state.

MEASURABLE OUTCOMES FOR GOAL 5

- **By 2023, the state of Utah will establish a subcommittee** to take leadership on cross-system initiatives, projects, and data sharing.
- **By 2024, the state of Utah will create and disseminate a cross-system case conferencing practice guide** to all CoCs.
- **By 2024, the state of Utah will establish data sharing agreements** with at least 3 systems external to the homeless system of care (e.g., criminal justice, healthcare & human services, workforce, and education).
- **By 2026, the state of Utah will have a data sharing platform** accessible to providers who enter into HMIS that provides access to and visibility of system partner data.
- **By 2030, the state of Utah will develop a generalized protocol** for organizational and project performance evaluation across multiple systems that work with people experiencing homelessness.

INNOVATIVE SOLUTIONS HIGHLIGHT:
Cross System Data Sharing

Frequent User Systems Engagement (FUSE) initiatives offer a promising best practice for cross-systems data sharing to target limited housing resources to the people experiencing homelessness who, in the absence of such support, heavily utilize resources in other systems such as emergency services. By reducing frequent utilization of criminal justice and healthcare systems, effective deployment of housing resources can conserve funding that can then be reinvested into additional housing to maximize impact. Research indicates that provision of permanent housing and associated supportive resources are demonstrated to reduce negative, expensive outcomes in both the criminal justice and healthcare systems by reducing jail bookings, emergency room visits, and behavioral health interventions. The process is dependent on matching Homeless Management Information System (HMIS) data with Medicaid, jail booking, and other criminal justice and healthcare data to identify people experiencing homelessness that frequent other systems. Once identified, those persons are prioritized for access to permanent supportive housing through the community's coordinated entry system.

- **Connecticut:** Connecticut's initial statewide FUSE implementation focused on targeting housing resources to frequent users of the criminal justice system in order to reduce criminal justice recidivism, reduce public sector costs, and improve outcomes. Permanent housing resources were targeted to the 80 individuals in the 75th percentile of both jail and emergency shelter usage. In the 12 months after provision of permanent supportive housing, emergency shelter use was reduced by 99% while jail use was reduced by 73%. Later targeting to frequent users of the healthcare system via Medicaid data found $7,800 per person annual savings from reduced emergency room visits and hospitalizations.
- **Portland (OR):** Portland's FUSE implementation combined HMIS, Medicaid, and jail data to compare outcomes for people experiencing chronic homelessness who were able to access permanent supportive housing with a pool of 862 people who were chronically homeless and awaiting placement. The data indicated that housing those 862 chronically homeless individuals would save Medicaid $3.6 million per year (more than $4,000 per person annually, or $345 per month). In addition, it would translate into 400 fewer jail bookings, 17,000 fewer emergency room visits, 200 fewer hospitalizations. Preventing chronic homelessness altogether would've resulted in $10 million in Medicaid savings (approximately $9,000 per person annually, or $758 per month).

Statewide Collaboration for Change:

Utah's Plan to Address Homelessness

Appendices

NOVEMBER 2022

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Appendix 1: Glossary of Terms

Acronym or Key Word	Definition
ACS	American Community Survey
AMI	Area Median Income, the midpoint of a region's income distribution, meaning that half of households in a region earn more than the median and half earn less than the median
APR	Annual Performance Report (for Department of Housing and Urban Development homeless programs)
Board & Care	Licensed residential care facilities for people with special needs that provide intensive support and assistance with daily living
CES	Coordinated Entry System, a system that prioritizes the most vulnerable people experiencing homelessness in the community for certain types of housing and connects people at risk of or experiencing homelessness with needed resources
CH	Chronically Homeless
CoC	Continuum of Care, a group organized to carry out the responsibilities prescribed by the Department of Housing and Urban Development in the CoC Program Interim Rule for a defined geographic area. Typically, CoCs act as decision-making bodies for a community's homeless assistance activities and funding
COVID	Coronavirus or COVID-19
Case Manager	Provides client support to develop and implement a plan to address barriers to housing stability (e.g. mental health, income, drug addiction, lack of supports). Case managers assesses and monitor client needs, supports coordination of care and connection to community resources, public resources, and other service providers. If certified (e.g., QMHP, QMHA, LCSW, etc.,), may also conduct assessments, develop and implement individual service and support plans and behavioral support strategies, and ensure required documentation is collected. Education required is typically a Bachelor's degree in a behavioral sciences field.
Diversity	Diversity includes all the ways in which people differ, and it encompasses all the different characteristics that make one individual or group different from another. It is all-inclusive and recognizes everyone and every group as part of the diversity that should be valued. A broad definition includes not only race, ethnicity, and gender—the groups that most often come to mind when the term "diversity" is used—but also age, national origin, religion, disability, sexual orientation, socioeconomic status, education, marital status, language, and physical appearance. It also involves different ideas, perspectives, and values
DV	Domestic Violence, which includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual/family member that make them afraid to return to their primary nighttime residence
ES	Emergency Shelter
ELI	Extremely Low Income
FMR	Fair Market Rent (maximum rent for many Department of Housing and Urban Development housing programs)
FY	Fiscal Year
HCV	Housing Choice Voucher Rental Assistance, a type of rental subsidy administered by the public housing authority and formerly referred to as Section 8
HIC	Housing Inventory Count, inventory of housing for the homeless conducted annually in January for same night as the Point-In-Time Count
HMIS	Homeless Management Information System, a data system used by many homeless service and housing providers to track participants and outcomes and meet federal and state reporting requirements
Homeless System of Care	The homeless system of care refers to the network of resources, supports, services and governance structures in communities that support addressing homelessness

HUD	U.S. Department of Housing and Urban Development, a federal agency that administers many housing and homeless assistance programs
Inclusion	Authentically bringing traditionally excluded individuals and/or groups into processes, activities, and decision/policy making in a way that shares power
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual and/or Ally and others
Literally Homeless	Individuals and families who lack a fixed, regular, and adequate nighttime residence, which includes one of the following: • Place not meant for human habitation • Living in a shelter (Emergency shelter, hotel/motel paid by government or charitable organization) • Exiting an institution (where they resided for 90 days or less AND were residing in emergency shelter or place not meant for human habitation immediately before entering institution)
Lived Experience	Having a personal experience of homelessness
Local Homeless Councils	13 regional bodies supporting the coordination of homeless response efforts. The two largest CoCs (Mountainland and Salt Lake) are each their own CoC. The rest of the LHCs (11 total) are split up across the Balance of State CoC.
LSA	Longitudinal Systems Analysis, a report produced from the CoC's Homelessness Management Information System (HMIS) and submitted annually to HUD
MHSA	Mental Health Services Act
MOU	Memorandum of Understanding
NAEH	National Alliance to End Homelessness
PHA/ HA	Public Housing Authority
PIT Count	Point-In-Time Homeless Count, a yearly count of all people experiencing homelessness on a single night in January.
PSH	Permanent Supportive Housing, permanent housing with intensive supports for residents with a high level of service needs
Racial Equity	A condition that would be achieved if one's racial identity no longer predicted, in a statistical sense, outcomes and experiences. When the term is used in this strategic plan, it refers to racial equity as one part of racial justice, and thus the term also refers to addressing root causes of inequities, not just their manifestation. This includes elimination of policies, practices, attitudes, and cultural messages that reinforce differential outcomes by race or that fail to eliminate them
Rapid Rehousing	Short term (up to three months) or medium term (3 to 24 months) tenant based rental assistance and accompanying supportive services as necessary to help a homeless individual or family with or without disability move as quickly as possible into permanent housing and achieve stability.
RRH	Rapid Re-Housing, a temporary rental subsidy for housing with some supports
SAMHSA	Substance Abuse & Mental Health Services Administration, a federal agency
Sheltered homelessness	Those experiencing sheltered homeless are generally adults, children, and unaccompanied children who are living in shelters for the homeless, transitional housing, safe havens, or in a motel/hotel using publicly funded assistance/vouchers
SMI	Serious Mental Illness or Seriously Mentally Ill, defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities
SNAPS	Special Needs Assistance Program, a HUD division that deals with homelessness and homeless assistance
SOAR	SSI/SSDI Outreach, Access, and Recovery (SSI/SSDI Application program)
SRO	Single-Room Occupancy housing units
SSA	Social Security Administration
SSDI	Social Security Disability Income
SSI	Supplemental Security Income
SSO	Supportive Services Only, a type of homeless assistance grant that provides services only
STELLA	Household-level data from HMIS that is displayed through HUD's data visualization program
Street outreach worker	Conducts street outreach activities and provides support to people experiencing homelessness in the community. Supports community events and relief efforts to assist clients with their needs, providing them resources, and facilitating connection to housing and services programs.

SUD	Substance Use Disorder, Substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home
TA	Technical Assistance, often refers to an organization or agency that provides help or guidance to a homeless system of care on administration of funds and system design
TAY	Transition Age Youth, youth ages 18 to 24 years old
TH	Transitional Housing, temporary housing often providing a bridge from shelter to permanent housing
Unsheltered homelessness	An individual/family whose primary nighttime residence is public/private place not designed for or ordinarily used as a regular sleeping accommodation for human beings. These are typically households living on the street or in makeshift shelters (tents, boxes), encampments, as well as cars
Utah Homeless Network	A membership of individuals and organizations working to address homelessness across the state of Utah. Has a leadership group that meets at least quarterly. https://endutahhomelessness.org/utah-homeless-network/.
VI-SPDAT	Vulnerability Index–Service Prioritization Decision Assistance Tool, an assessment tool that assigns a numerical score to a person's level of vulnerability for the community's coordinated entry system
211	211 is an easy-to-remember, three-digit number that connects people to the services they need, such as housing and utility assistance, food resources, legal aid, and more. Find more information here: https://211utah.org/.

Appendix 2: HMIS Data Analysis

DATA BACKGROUND

Homelessness Management Information System (HMIS)

- State of Utah's data from each Continuum of Care (CoC) (Balance of State, Mountainland, Salt Lake).
- Programs that participate in their CoC and/or receive certain types of funding are required to enter data into the HMIS, while other service providers chose to do so voluntarily.
- Data fields conform to standards published by the Department of Housing and Urban Development (HUD), which requires that each CoC administer an HMIS.

Where does the data come from?

- Data is typically collected by case workers and program staff of homeless service and housing provider organizations.
- Data is primarily based on self-reports from those experiencing homelessness; some is also generated automatically from existing records.

Who is included?

- Includes a majority of people who have touched or contacted some aspect of the homeless system of care (everything from street outreach to permanent supportive housing). There are aspects of the system of care that do not enter into HMIS (DVSPs, non-participating agencies).
- Time span: 1/1/2016 to 4/29/2022 (some analyses used 1/1/2017 depending on the data, as some data was not available in full before 2017); demographics are 1/1/2018 onward due to dataset changes

Point in Time (PIT) Count

- Count conducted on one night during winter.
- Includes unsheltered and sheltered homelessness (e.g., those in emergency shelter or transitional housing).

Estimate of homelessness:

- Serves as an estimate of how many people are experiencing homelessness across the state at a given time.
- Counts people even if they have not engaged in services.

How is data collected?

- Details about individuals / households gathered through self-report and observation by counters.

TERMS AND NOTES

General Terms

- CoC = Continuum of Care (there are three in the State of Utah)

HMIS program types:

- CE = Coordinated Entry
- HP = Homelessness Prevention
- DS = Day Shelter
- SO = Street Outreach
- SSO = Supportive Services Only
- ES/SH = Emergency Shelter / Safe Haven
- TH = Transitional Housing
- RRH = Rapid Rehousing
- PSH/OPH = Permanent Supportive Housing / Other Permanent Housing

Household Types[1]:

- AO = adult-only
- TAY = transition age youth (18-24)
- AC = adult and child (family)
- CO = child-only

Highlights:

- Blue highlights = significantly disproportionate *over*-access compared to overall representation in HMIS.
- Yellow highlights = significantly disproportionate *under*-access compared to overall representation in HMIS.

Race / ethnicity (this is how the American Community Survey categorizes and labels race and ethnicity):

- White race (any) = if they person has ever identified as White (regardless of any other race).
  - Example: if they identified as White and Black, they are *also* included in the BIPOC category.
  - Example: if they identified as White and Latinx, they are *also* included in the Latinx category.
- No White race = has never indicated they are White.
- Latinx = if the person ever identified as Latinx (regardless of any other race).
- BIPOC = any indication of person of color (Black, Latinx, etc., but cannot be "White only").
- White only = the only racial or ethnic category indicated is White.

Other terms:

- Average number of enrollments = the average number of enrollments a household has *for that project type*.
- "More than M/F" = any other gender identity than *only* male or female. This category could be multiple gender identities that also include male or female; could be gender identities such as transgender, gender non-conforming, etc. Often the sample sizes were too small to statistically assess these categories individually, so we grouped them together for the sake of understanding whether there are disparities for individuals who hold marginalized gender identities.

[1] Expanded definitions available in the HMIS data dictionary.

OVERALL SYSTEM INFORMATION FROM HMIS/CES DATASETS

Overall Enrollment Summary

There were 319,506 deduplicated active enrollments across the state during the sample time period. There were 85,686 deduplicated people who accessed the system (any project type) across the state active during the sample period (2016-2022).

Percentage of Enrollments by CoC, Total 2016-2022		
	Percentage of Total Enrollments (of 319,506)	**Percentage of Total People (of 85,686)**
Balance of State CoC	27%	31%
Mountainland CoC	6%	9%
Salt Lake CoC	67%	59%

At the time of this analysis (April 2022), an estimated 12,442 people enrolled in the homeless system of care. Of those, 2,270 were moved into housing (Rapid Rehousing or Permanent Supportive Housing through a CoC-funded program, and thus maintaining an active enrollment).

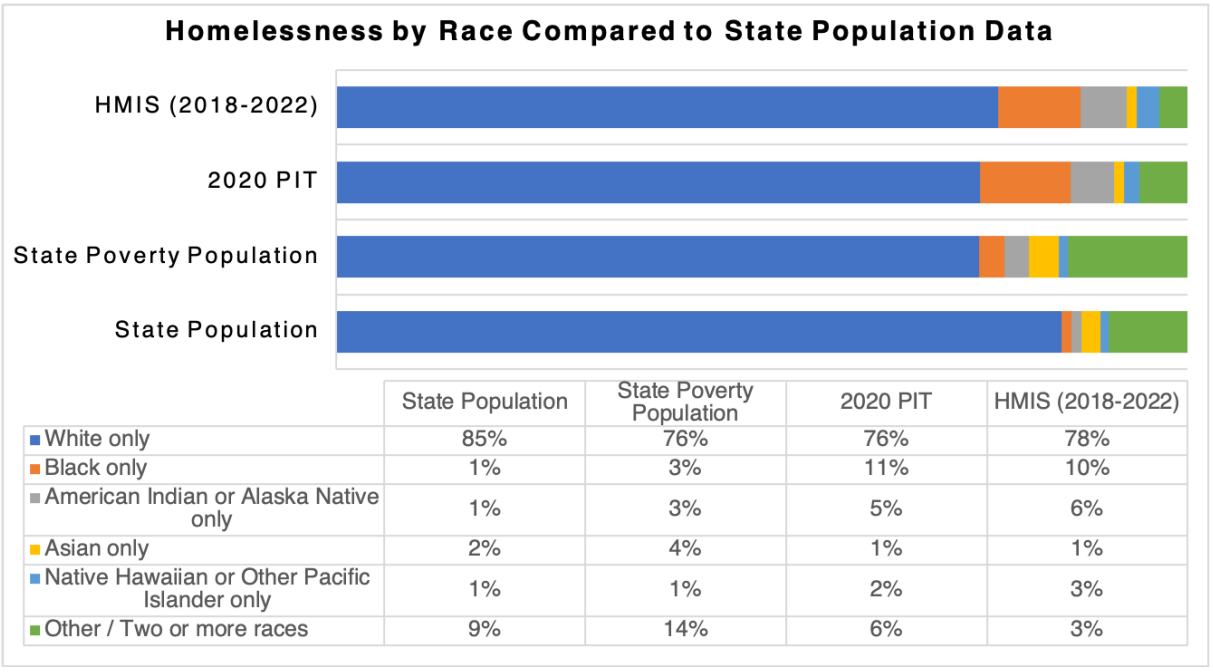
Continuum of Care Analysis

- At final enrollment: There is a disproportionate number of people in Child-Only households in Mountainland and BoS CoCs.
- **Balance of State enrollments summary**:
  - BoS has zero (0) Day Shelter enrollments.
  - BoS CoC has proportionally less PSH enrollments compared to other CoCs.
- **Mountainland enrollments summary**:
  - SSO, TH, and PSH projects in Mountainland have disproportionally more enrollments than other CoCs.
  - 41% of Child-Only households are in Mountainland, but only 9% of the people experiencing homelessness are in the Mountainland CoC.
  - There is proportionally less Day Shelter access in Mountainland CoC than Salt Lake CoC.
  - SSO projects make up 37% of all enrollments in Mountainland and marks a significantly different strategy when compared to the BoS and Salt Lake CoCs.
- **Salt Lake enrollments summary**:
  - There are overall more resources in Salt Lake CoC as evident by the disproportionate enrollment records for DS, PSH, RRH, SO, and TH as compared to the other CoCs.
  - 98% of Day Shelter enrollments are in Salt Lake CoC.
  - Only 48%of SSO enrollments are in Salt Lake CoC.
  - Only Salt Lake has “Other” project type enrollments.

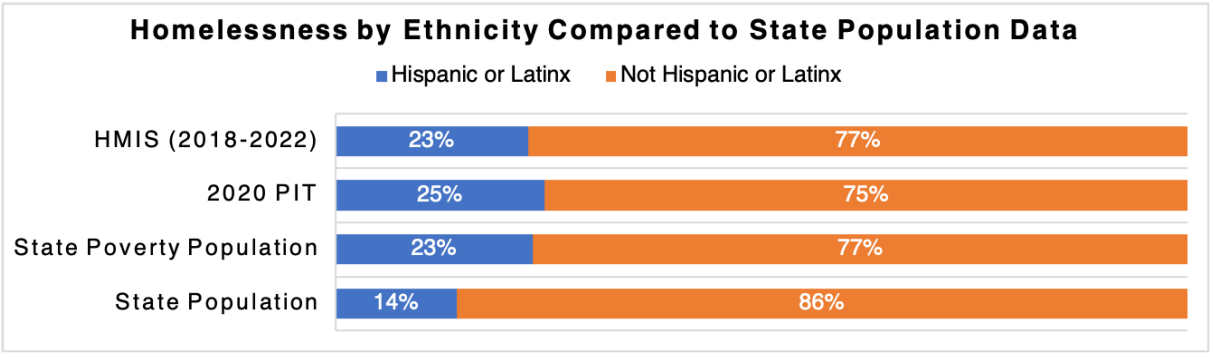
The following charts compare the Utah HMIS data, Utah 2020 Point-in-Time Count Data, and the State Population and State Poverty Population data (which come from the American Community Survey [ACS] 2020 Five-Year-Estimates.)

Race and Ethnicity

Examining the racial and ethnic makeup of people experiencing homelessness shows that Black, Indigenous, and People of Color experience homelessness at disproportionately higher rates across the state. When compared to State-level population data, Black, American Indian / Alaskan Native, and Native Hawaiian / Pacific Islander groups are overrepresented in the homeless population in Utah. For example: Black individuals are only 1% of the State population and 3% of the State population in poverty, but they represent over 10% of those in the homeless system of care. Similarly, those who are Hispanic / Latino are only 14% of the State population but make up 23% of the State population in poverty and over 23% of those experiencing homelessness.

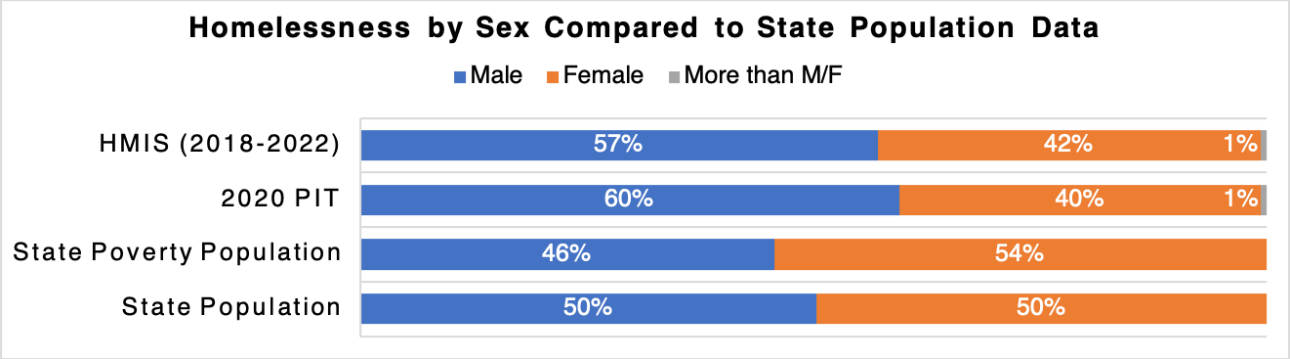


	State Population	State Poverty Population	2020 PIT	HMIS (2018-2022)
White only	85%	76%	76%	78%
Black only	1%	3%	11%	10%
American Indian or Alaska Native only	1%	3%	5%	6%
Asian only	2%	4%	1%	1%
Native Hawaiian or Other Pacific Islander only	1%	1%	2%	3%
Other / Two or more races	9%	14%	6%	3%



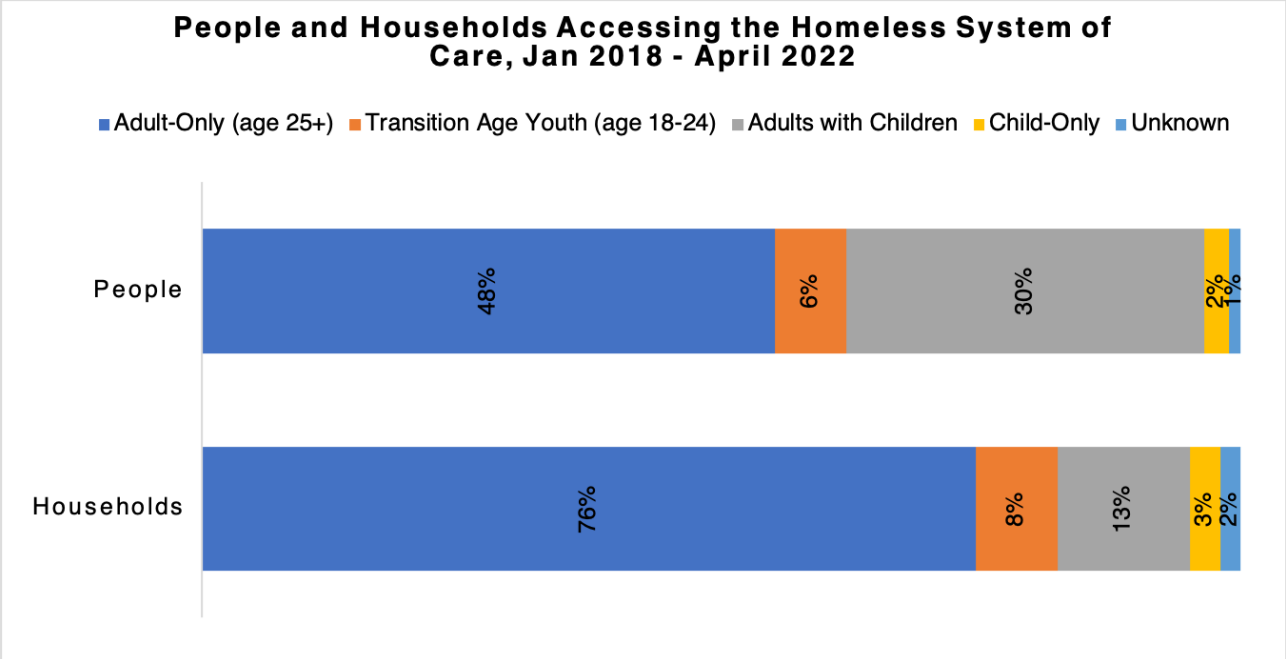
Sex

Demographic data also demonstrates that males are overrepresented in the homeless population in Utah compared to females.



What household types are experiencing homelessness?

The majority of people and households experiencing homelessness in Utah are adult-only households, making up about 53% of the people experiencing homelessness but 82% of the households. Families (adults with children) make up 30% of the people experiencing homelessness and 13% of the households.



People and households by household type (1/1/2018 to 4/29/2022)

	Adult Only	Transition Age Youth	Adults with Children	Child Only	Unknown	Total
People	33,150	3,814	20,847	1,683	822	69,316
	(48%)	(6%)	(30%)	(2%)	(1%)	(100%)
Households	31,877	3,313	5,383	1,445	768	42,186
	(76%)	(8%)	(13%)	(3%)	(2%)	(100%)

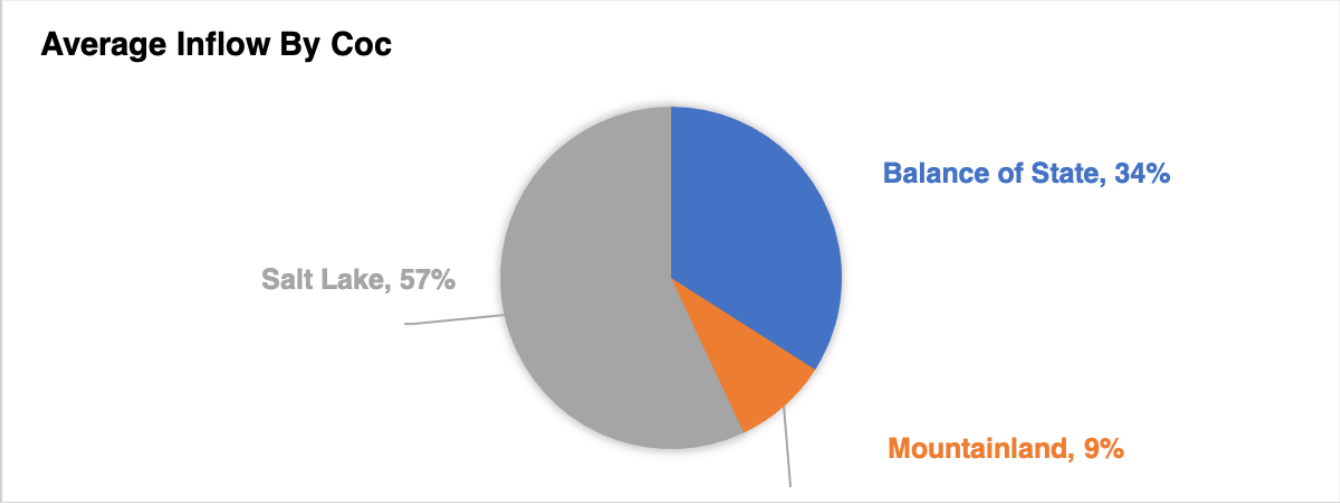
INFLOW AND OUTFLOW

System Inflow

This section attempts to address the questions: When are people coming to the system? What is the inflow by CoC?
Inflow into the system includes anyone who touches the homeless systems of care across the state and whose information is put into the HMIS. Average inflow was calculated using the 2017 through 2021 inflow numbers for each CoC.[2]

Inflow Over Time, 2016-2022, by CoC				
	Balance of State	**Mountainland**	**Salt Lake**	**Total**
Active or started in 2016	6,275	2,579	16,889	25,743
2017	4,200	1,432	7,789	13,421
2018	3,699	1,135	6,781	11,615
2019	3,586	775	6,329	10,690
2020	3,634	699	5,007	9,340
2021	4,385	852	6,332	11,569
2022[3]	1,350	237	1,721	3,308
Total	27,129	7,709	50,848	85,686
2017-2021 Average	3,901 (34%)	979 (9%)	6,448 (57%)	11,327

Fewer people seem to be coming into the Homeless System of Care from the Mountainland CoC each year. The BoS CoC and Salt Lake CoC show modest decreases, but 2021 totals are very close to average.



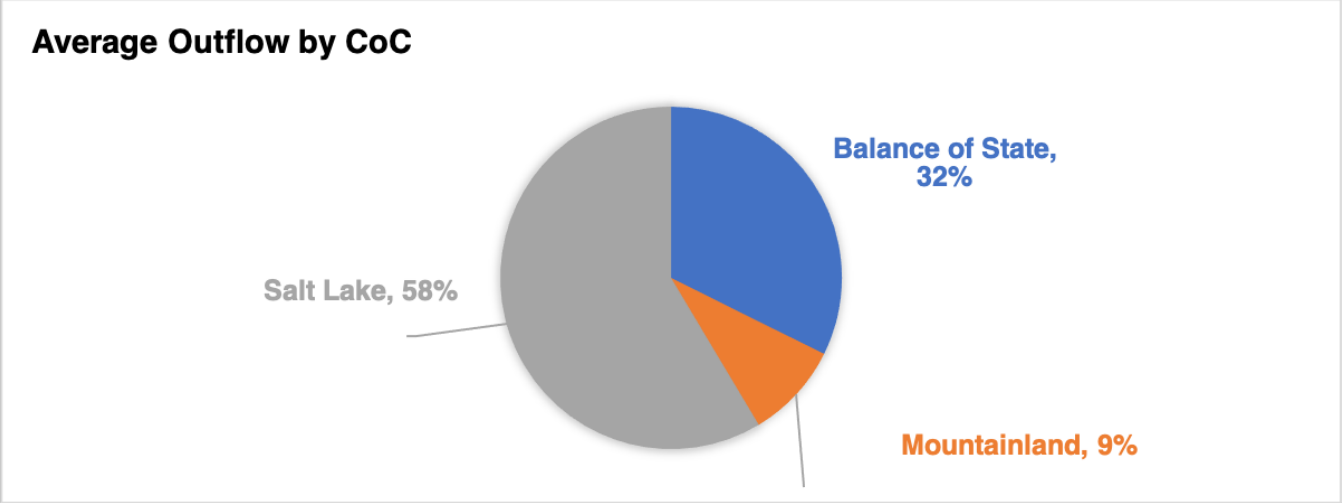
[2] 2022 data only included four months of data and thus was excluded; numbers for 2016 include all people who were in the system at that time, which includes inflow from years prior to 2016, and thus was excluded).

[3] Note: 2022 was not a complete year of data, as this analysis was completed in April 2022.

Exits from the System (Outflow)

Outflow from the system includes: those who have exited to permanent destinations, those with move-in dates for permanent housing, and anyone who has not touched the system for 12+ months (regardless of what their exit was).

Outflow Over Time, 2016-2022, by CoC				
	Balance of State	**Mountainland**	**Salt Lake**	**Total**
Active or started in 2016	3,266	1,496	6,761	11,523
2017	3,391	1,356	6,475	11,222
2018	3,496	1,197	6,567	11,260
2019	3,558	1,023	7,321	11,902
2020	3,921	869	6,308	11,098
2021	2,884	646	4,753	8,283
2022[4]	652	103	898	1,653
Total	21,168	6,690	39,083	66,941
2017-2021 Average	3,450 (32%)	1,018 (9%)	6,285 (58%)	10,753

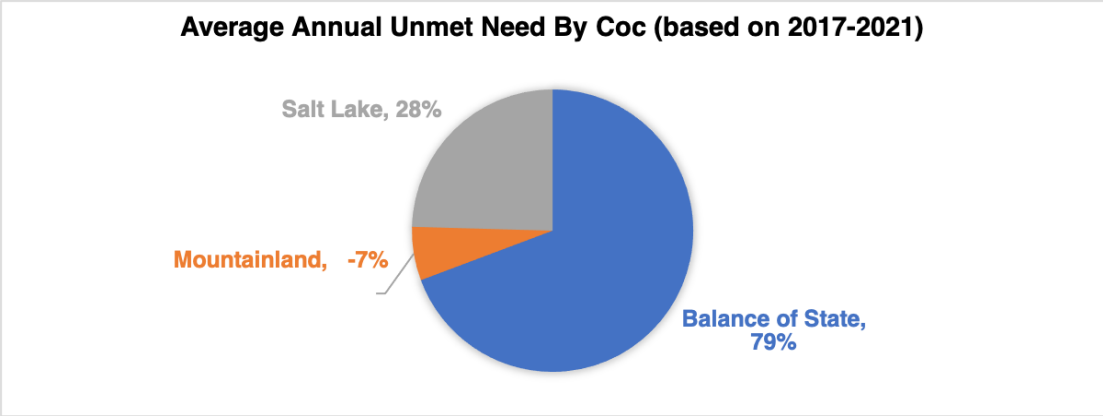


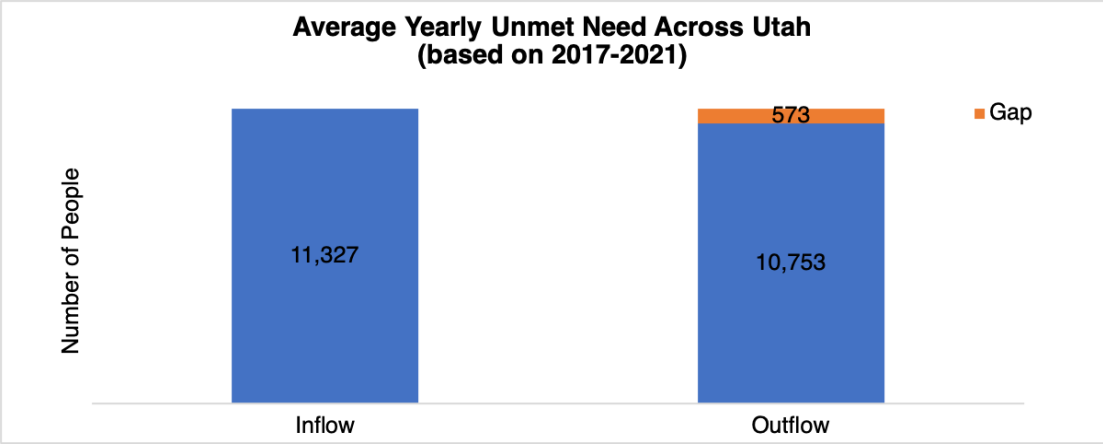
Unmet Need

Unmet need per year is the average inflow (1/1/2017 – 12/31/2021) minus the average outflow (1/1/2017 – 12/31/2021) (based on averages from 2017-2021, as 2022 was not complete at the time of analysis).

Average Unmet Need by CoC (based on averages from 2017-2021)				
	Balance of State	**Mountainland**	**Salt Lake**	**Total**
Average Inflow per year	3,901	979	6,448	11,327
Average Outflow per year	3,450	1,018	6,285	10,753
Average Unmet Need per year	451 (79%)	-39 (-7%)	163 (28%)	574

[4] Note: 2022 was not a complete year of data, as this analysis was completed in April 2022.





Level of Acuity

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as **a pre-screening tool for communities to conduct an assessment for clients**. It is one way communities measure acuity, or the level of vulnerability or need someone has for their housing program type.

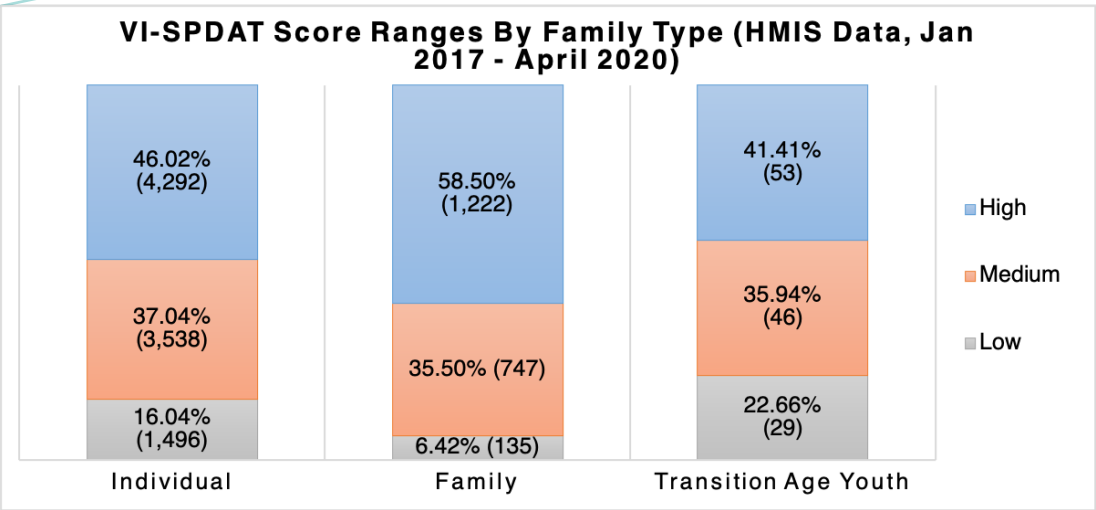
To assess acuity, or severity of need, we examined scores on the VI-SPDAT to examine how many people have low, medium, and high levels of acuity, which helps to estimate how many people need a high level of support such as permanent supportive housing. The following chart shows the VI-SPDAT score ranges by family type (individual, family, and transition age youth)[5]. A "high" score range is 8+/9+ and indicates a need for permanent supportive housing. A "medium" score range is 4-7 and indicates a need for transitional housing or rapid rehousing. A "low" level is 3 or less and indicates a lower priority for permanent housing through coordinated entry, but services and housing assistance outside of coordinated entry are typically provided.

"High" acuity is 8+ for individual households or 9+ for family households, which may indicate a need of that household for Permanent Supportive Housing (PSH).

More than 50% of the people coming into the system are scoring in the low to medium range (below PSH range). The percentages of individual adults, transition aged youth (TAY), and families that have scores indicating a need for PSH are as follows:

- Adults: 46% of individual adults (4,292) may need PSH.
- TAY: 41% of TAY (53 individuals) may need PSH.
- Families: 58% of families (1,222 households) may need PSH.

[5] These data are from HMIS for January 2017 through April of 2022. There were not enough assessments in the dataset for 2016 to be included in analysis.



What proportion need PSH?

- The proportion of those scoring in PSH range (above 8) is shrinking over time.
  - People with higher scores tend to stay in the system longer. This could also mean that their score is increasing the longer they are homelessness.
- Of people scoring in PSH range and exiting Coordinated Entry, only 43% access CES housing projects (which includes housing programs at lower levels than PSH, such as Transitional Housing).
  - Adults: 37% accessed an HMIS housing project
  - Families: 61% accessed an HMIS housing project
  - TAY: 42% accessed an HMIS housing project
- Of people scoring in PSH range and exiting Coordinated Entry, only 11% access PSH or Other Permanent Housing (OPH) project types
  - Adults: 14% accessed PSH or OPH project types
  - Families: 3% accessed PSH or OPH project types
  - TAY: 9% accessed PSH or OPH project types

FLOW THROUGH THE SYSTEM

How many project types do people touch during their time enrolled?

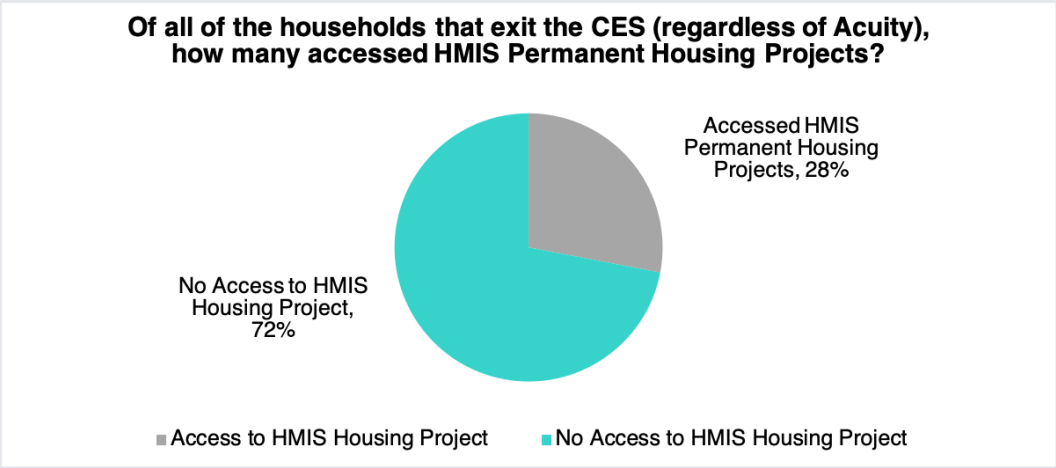
For all households starting their first enrollment in the system between 1/1/2017 and 4/28/2022, they tend to access 1 to 2 project types during the lifetime of their enrollments.

Access to HMIS/CoC Housing Projects

What proportion of all clients who exit the system accessed HMIS/CoC Permanent Housing projects?

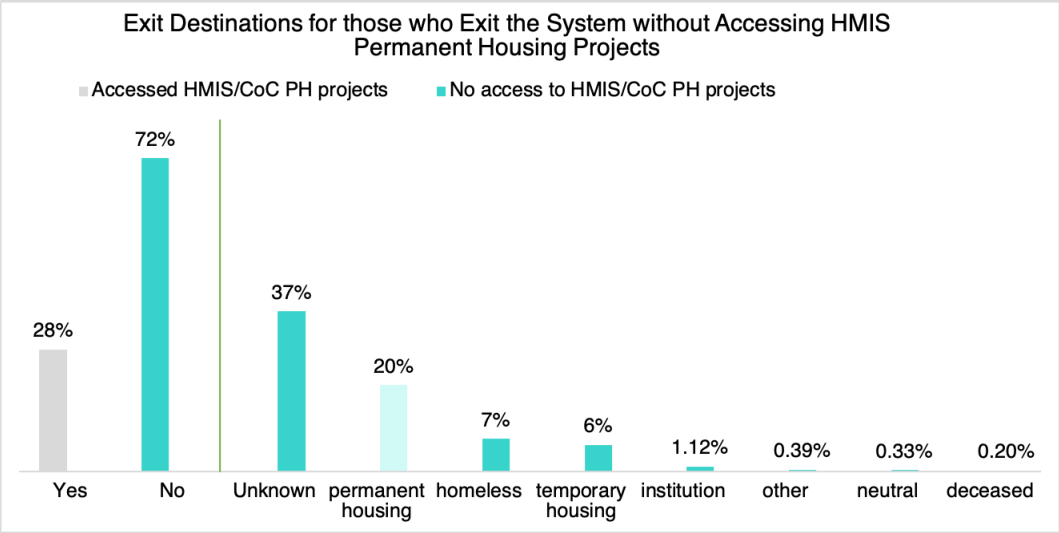
Of all clients entering and exiting the system (with and without VI-SPDAT scores), 72.35% of those exiting the system never access an HMIS Permanent Housing project (which includes Permanent Supportive Housing and Rapid Rehousing [PSH/RRH]).

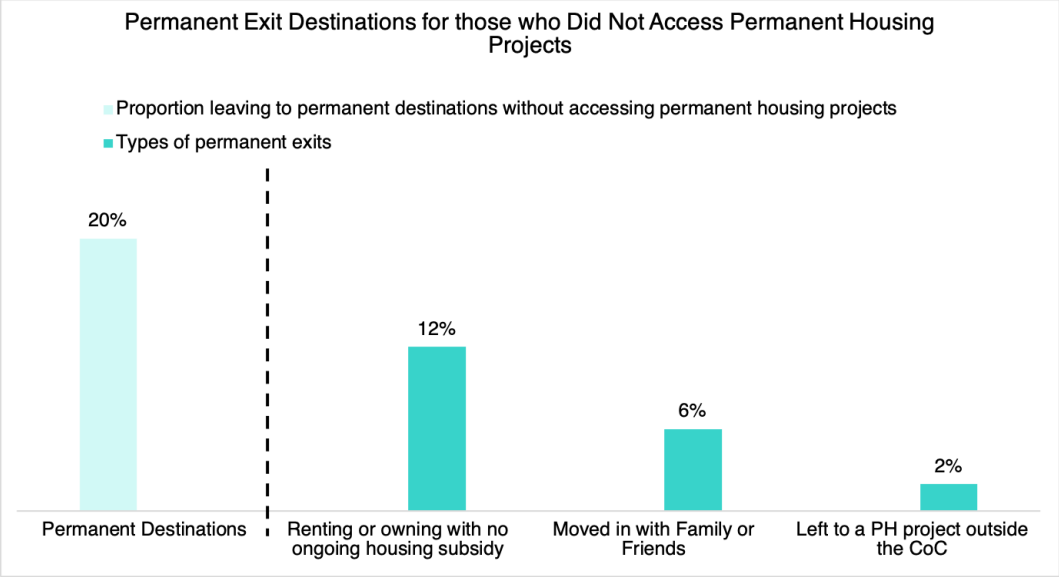
- Only 27.65% of those exiting have accessed an HMIS Permanent Housing project (PSH/RRH).
  - Individuals: 16.09% accessed PSH/RRH
    - Adults: 16.94% accessed PSH/RRH
    - TAY: 9.12% accessed PSH/RRH
  - Family: 45.78% accessed PSH/RRH



What are the exit destinations for people leaving the system without access to HMIS/CoC housing projects?

The following chart looks at the exit destinations for those who exit the system without accessing HMIS permanent housing projects. While 20% exited to permanent housing destinations (outside of the HMIS permanent housing projects), 37% exited to unknown destinations, 7% exited to homeless destination, and 6% exited to temporary housing destinations.





Those who exited the system had the following final exit destinations:

- 20.8% of people leaving the system left to a permanent destination without accessing HMIS housing projects.
    - 11.63% self-resolved in housing units without subsidy
    - 6.04% left to family and friends without subsidy
    - 2.41% left to a housing project outside of the CoC
- 7.49% left to homelessness without accessing HMIS housing projects
- 6.08% left to a temporary destination without accessing HMIS housing projects
- 1.12% left to a psychiatric or incarceration institution without accessing HMIS housing projects
- 36.66% left to "other" or "unknown" destinations without accessing HMIS housing projects
- .39 exited to "other" non-permanent destinations
- .33% left to a nursing home or medical rehabilitation facility without accessing HMIS housing projects
- 0.20% died without accessing HMIS housing projects
- 27.65% accessed a housing project with various outcomes.

What are the rates at which people who access the system through Emergency Shelter end up getting into another project type (e.g., TH, RRH, PSH)?

Those accessing emergency shelter have the lowest rate of connectivity (besides Homelessness Prevention).

- This means people are not moving from ES to other housing programs.
- Homelessness Prevention (HP) projects also have low rates of connectivity, but this may be because people in HP prevent their homelessness and thus do not touch other projects.

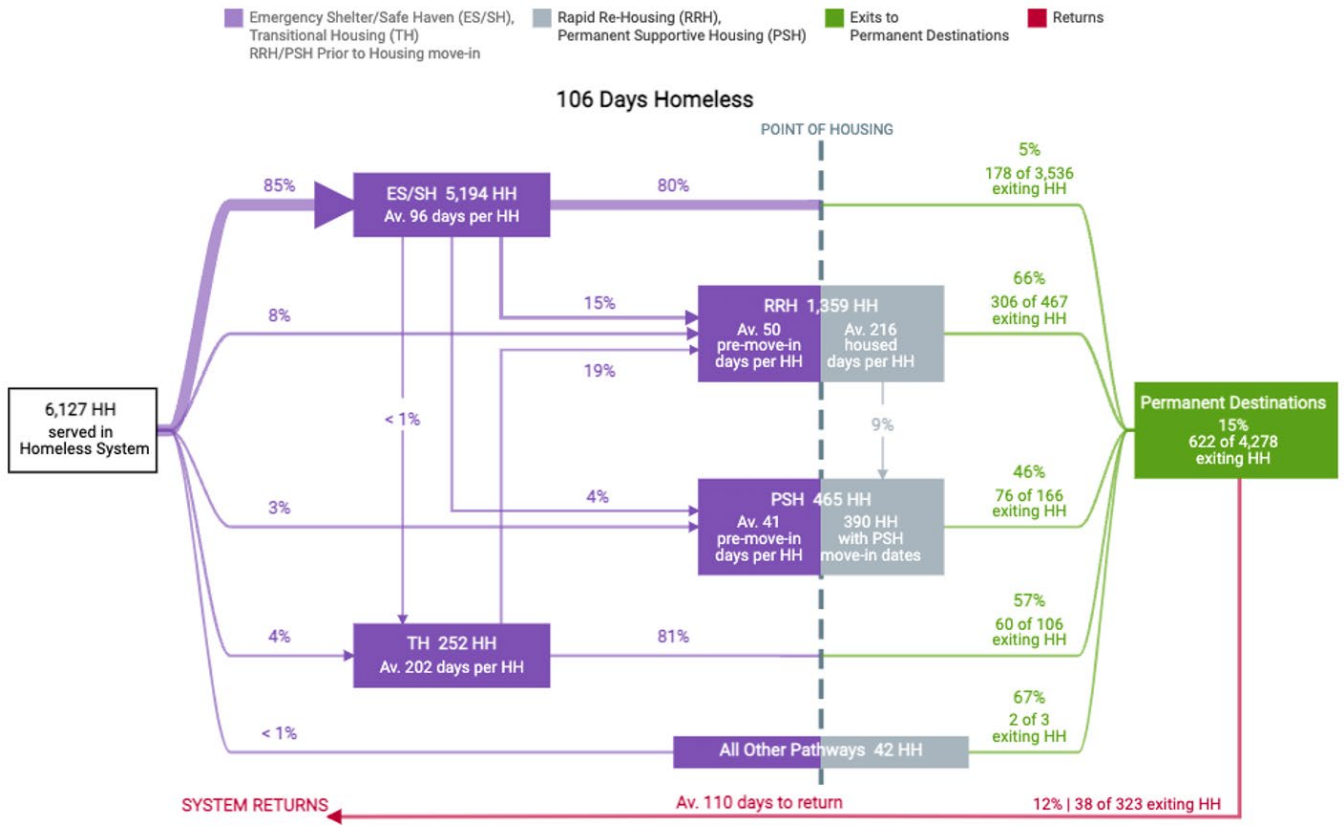
Stella System Maps

- Note: Stella excludes DS, SO, SSO, HP, CE and OPH
- Note: Stella system map is a household level analysis rather than the individual level above.

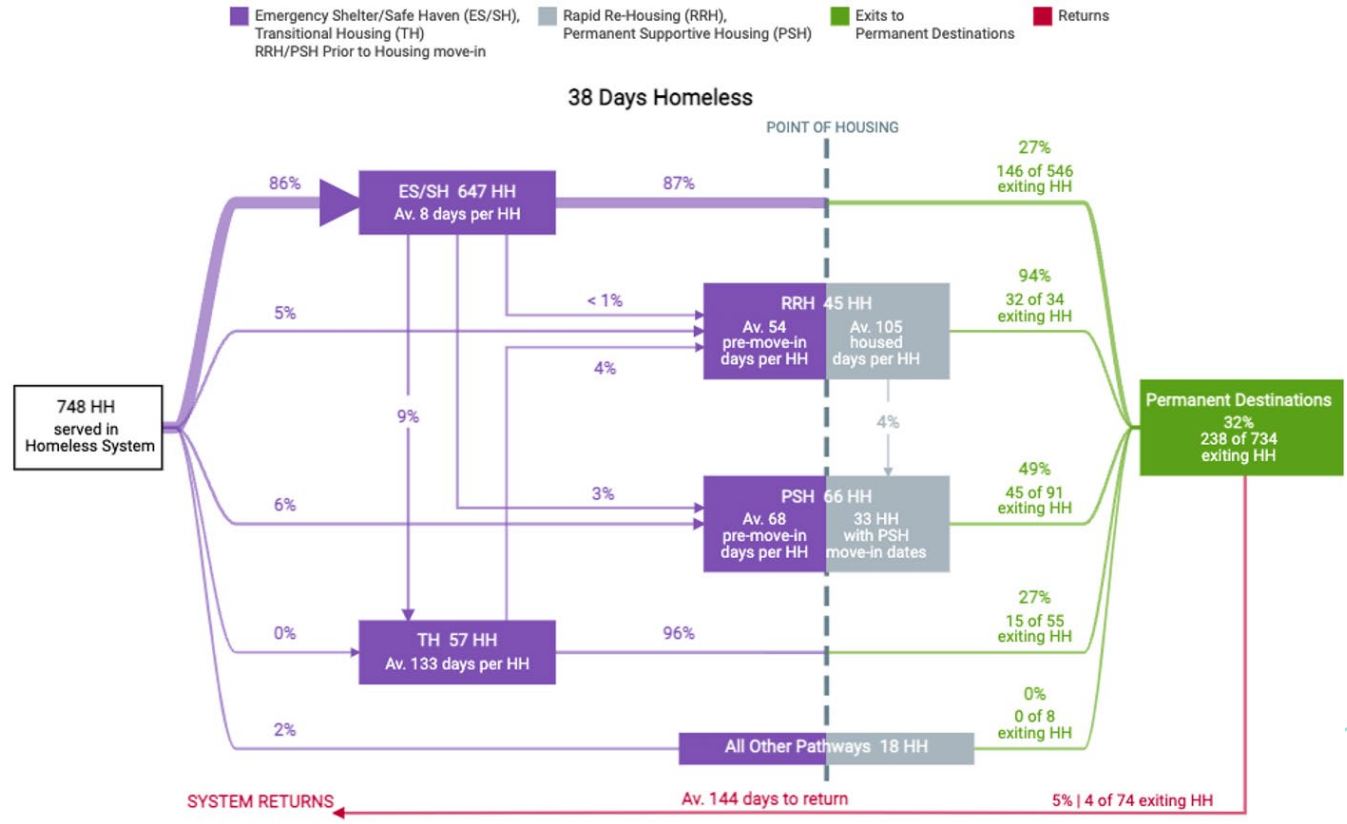
Summary:

- Across the state, the majority of households who enter the system only touch Emergency Shelter. For fiscal year 2021, 68% of households in the Salt Lake CoC only touched ES; 76% of households in the Mountainland CoC only touched ES, and 75% of households in the Balance of State only touched ES.
- The combined rate of permanent exits from Emergency Shelter is 10%.
    - For those 10% exiting to permanent destinations from Emergency Shelter, 14% return to homelessness.
- Low rates of exits to permanent destinations from TH and PSH project types indicates that more housing options are needed for folks who do not move into self-sufficiency. Perhaps there needs to be some investment in move on strategies, aftercare, and/or supportive services for those leaving PSH.

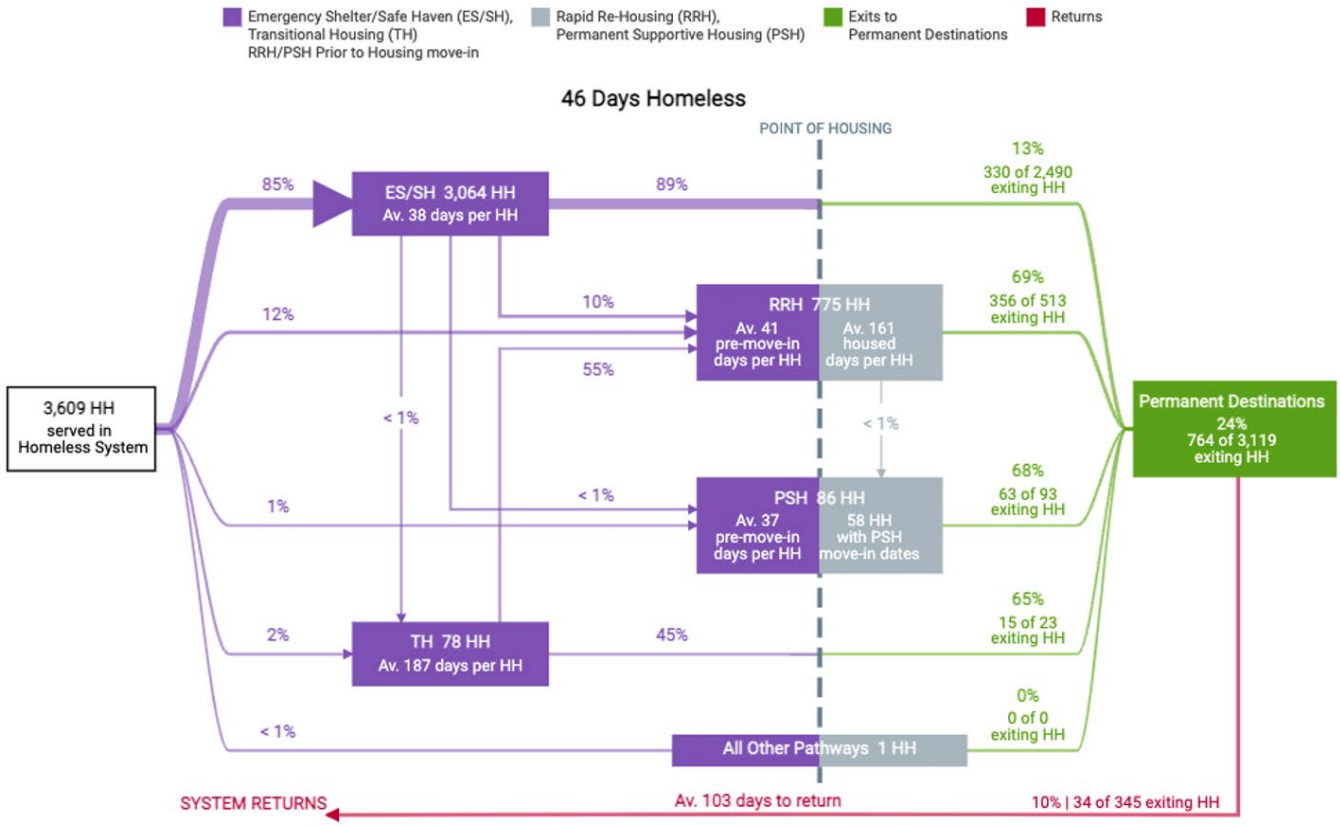
Salt Lake CoC



Mountainland CoC



BOS CoC


Emergency Shelter/Safe Haven (ES/SH), Transitional Housing (TH) RRH/PSH Prior to Housing move-in
Rapid Re-Housing (RRH), Permanent Supportive Housing (PSH)
Exits to Permanent Destinations
Returns
46 Days Homeless
POINT OF HOUSING
3,609 HH served in Homeless System
85%
ES/SH 3,064 HH
Av. 38 days per HH
89%
13%
330 of 2,490 exiting HH
12%
10%
RRH 775 HH
Av. 41 pre-move-in days per HH
Av. 161 housed days per HH
69%
356 of 513 exiting HH
55%
< 1%
< 1%
1%
< 1%
PSH 86 HH
Av. 37 pre-move-in days per HH
58 HH with PSH move-in dates
68%
63 of 93 exiting HH
2%
TH 78 HH
Av. 187 days per HH
45%
65%
15 of 23 exiting HH
< 1%
All Other Pathways 1 HH
0%
0 of 0 exiting HH
Permanent Destinations
24%
764 of 3,119 exiting HH
SYSTEM RETURNS
Av. 103 days to return
10% | 34 of 345 exiting HH

DEMOGRAPHICS AND HOUSEHOLD TYPE

For the following analyses, we have included 60,316 deduplicated people across all projects between 1/1/2018 to 4/29/2022.

There were a total 85,686 deduplicated people across all projects between 1/1/2016 – 4/29/2022. To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

Demographics by Project Type Access

The following table looks at the proportion of clients to have ever accessed an HMIS project type by CoC and by demographic.

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[6].										
All	All HMIS	CE	HP	DS	SO	SSO	ES/SH	TH	RRH	PSH/OPH
Total	60,316	13,617	9,408	11,145	7,911	16,310	33,994	1,264	11,814	3,145
	100%	22.5%	15.6%	18.5%	13.1%	27%	56.4%	2.1%	19.6%	5.2%
Percentages										
White race (any)	80.70	80.42	76.42	78.08	83.37	82.27	80.12	85.23	80.07	80.96
No White race	19.30	19.58	23.58	21.92	16.63	17.73	19.88	14.77	19.93	19.04
Latinx	22.65	21.73	25.20	20.72	18.90	20.23	21.81	16.80	25.71	17.92
BIPOC	41.94	41.39	49.08	42.07	36.06	38.04	41.79	30.75	46.34	37.40
White only	58.06	58.61	50.92	57.93	63.94	61.96	58.21	69.25	53.69	62.60
Male only	57.14	59.14	48.59	68.45	61.64	57.98	60.91	65.69	47.90	57.25
Female only	42.22	39.95	50.90	30.38	37.47	41.38	38.28	32.81	51.77	41.66
More than M/F	0.64	0.91	0.51	1.17	0.89	0.63	0.81	1.51	0.33	1.08
Veteran	5.80	5.35	4.10	6.82	4.61	6.83	5.28	40.41	8.14	13.33
Senior	3.91	5.15	1.98	4.52	4.12	4.27	4.08	10.14	2.71	7.51
Chronic	12.40	-	1.18	19.20	-	-	15.32.	6.61	7.96	32.75
Disabling condition	41.64	-	25.93	47.81	-	-	42.37.	64.55	37.88	78.29
DV history	-	-	-	22.65	-	-	-	-	-	-
Unsheltered History	44.75	58.10	11.42	76.75	100	55.58	56.44	44.15	34.89	58.76
Average number of enrollments: mean, (median)	4.45 (2)	1.08 (1)	1.15 (1)	1.64 (1)	1.76 (1)	1.73 (1)	4.02 (2)	1.18 (1)	1.56 (1)	1.38 (1)
AO	61.28	69.46	19.62	98.21	92.47	70.36	70.69.	73.66	27.67	69.41
TAY	10.32	8.90	14.52	13.54	6.66	8.40	10.58.	22.45	7.56	4.21
AC	34.57	25.72	72.25	0.94	6.45	28.23	25.21.	25.24	72.29	30.52
CO	2.79	.09	7.83	0.67	0.38	1.05	3.32.	0.95	0.01	0
Unknown HoH	1.36	4.73	0.31	0.17	0.71	0.36	0.18.	0.16	0.03	0.06

Blue highlights = significantly disproportionate *over*-access compared to overall representation in HMIS.
Yellow highlights = significantly disproportionate *under*-access compared to overall representation in HMIS.

- We hypothesize that "family type" is driving demographic differences.
- People identifying as "more than only male or only female" seem to have higher rates of participation in TH, DS, and perhaps PSH.
- Veterans have higher rates of access to TH and PSH/OPH.

[6] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

Adult-Only Households: Demographics by Project Access

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[7].										
Adult-Only Households	HMIS	CE	HP	DS	SO	SSO	ES/SH	TH	RRH	PSH / OPH
Total	37,978	9,489	1,898	10,966	7,357	11,595	24,327	931	3,295	2,186
Percentages										
White race (any)	82.87	82.07	85.75	78.01	83.28	84.00	81.96	84.94	84.65	84.99
No White race	17.13	17.93	14.26	2,324	16.72	16.00	18.04	87.39	15.36	15.01
Latinx	18.35	18.85	16.84	20.37	17.60	16.52	17.78	12.61	13.57	13.39
BIPOC	35.30	36.65	31.72	41.83	34.79	32.48	35.79	26.80	29.38	28.64
White only	64.70	63.35	68.28	58.17	65.21	67.52	64.21	73.20	70.62	71.36
Male only	64.56	64.84	68.84	68.75	62.95	63.71	67.36	78.15	63.15	62.25
Female only	34.68	33.94	30.26	30.09	36.10	35.59	31.79	20.02	36.15	36.28
More than M/F	0.76	1.22	0.90	1.16	0.95	0.70	0.85	1.83	0.70	1.47
Veteran	8.41	6.95	15.53	6.93	4.89	8.74	6.99	53.40	23.80	18.16
Senior	6.00	6.98	8.80	4.59	4.39	5.93	5.63	13.75	9.07	10.75
Chronic	*	*	5.95	19.34	*	*	21.03	8.46	24.41	44.35
Disabling condition	*	*	64.51	47.92	*	*	49.93	74.87	69.61	93.07
DV history	*	*	*	22.62	*	*	17.02	21.43	24.38	*
Unsheltered History	65.02	72.41	37.09	77.44	100%	71.81	71.77	54.56	75.48	74.57
Average number of enrollments [mean (median)]	5.48 (2)	1.09 (1)	1.12 (1)	1.64 (1)	1.80 (1)	1.84 (1)	4.62 (2)	1.21 (1)	1.20 (1)	1.33 (1)
TAY (subset of adult-only)	10.43	8.91	14.44	13.57	6.63	8.42	10.67	22.45	7.53	4.25
BOS	30.47	27.57	37.51	0%	18.09	43.86	33.52	16.22	41.12	25.75
Mountain-land	6.88	6.78	4.79	4.59	3.78	13.75	5.89	23.52	3.52	14.27
Salt Lake	62.65	65.65	57.69	95.41	78.13	42.39	60.60	60.26	55.36	59.97

* = missing more than 10% of the data and cannot provide accurate analysis
Blue highlights = significantly disproportionate *over*-access compared to overall representation in HMIS.
Yellow highlights = significantly disproportionate *under*-access compared to overall representation in HMIS.

- Veterans are more Male and more White (as compared to other races) than the rest of the population experiencing homelessness. While this may contribute to disparities in access by Race (since the state as a whole seems to prioritize Veterans' access to housing programs), it does not explain the entirety of the disparity.

There is some evidence (see table below) that there is disparity in access to housing process for those who are BIPOC. After excluding Veteran populations, BIPOC adult-only households accessed TH, RRH, and PSH at lower rates than non-BIPOC adult-only households.

[7] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[8].								
Adult-Only House-holds: Veteran vs. Non-Veteran	HMIS (37,978)		TH (931)		RRH (3,295)		PSH / OPH (2,186)	
	Non-Vets	Vets	Non-Vets	Vets	Non-Vets	Vets	Non-Vets	Vets
Total	33,919	3,116	430	493	2501	781	1776	394
Percentages								
White race (Any)	82.69	85.08	83.61	86.01	84.30	85.62	84.94	85.68
No White race	17.31	14.92	16.39	13.99	15.70	14.38	15.06	14.32
Latinx	19.01	9.88	17.25	8.20	14.78	9.78	14.50	8.29
BIPOC	36.09	25.34	30.77	23.00	30.74	25.19	29.80	22.94
White only	63.91	74.66	69.23	77.00	69.26	74.81	70.20	77.06
Male only	61.98	91.45	62.41	91.72	53.26	94.62	55.69	91.62
Female only	37.23	8.13	34.57	7.47	45.98	4.87	42.51	8.38
More than M/F	0.79	0.42	3.02	--	--	--	1.80	0
Veteran	0	100	0	100	0	100	0	100
Senior	4.69	20.64	3.01	23.23	6.52	17.29	6.59	29.95
Chronic	*	*	12.56	4.96	25.71	20.62	47.02	23.83
Disabling condition	*	*	69.53	79.72	69.20	71.69	93.33	91.84
DV history	*	*	35.22	10.56	26.49	16.59	*	*
Unsheltered History	65.37	61.52	71.06	39.80	75.33	76.18	78.01	58.88
Average number of project enrollments [mean(median)]	5.55 (2)	4.77 (3)	1.09 (1)	1.32 (1)	1.16 (1)	1.33 (1)	1.35 (1)	1.26 (1)
TAY (subset of adult-only)	11.28	1.80	46.53	1.41	9.52	1.28	5.19	0%
BOS	30.98	31.35	7.18	24.24	43.74	33.16	24.94	28.93
Mountainland	7.35	3.31	48.15	--	4.36	--	17.12	2.03
Salt Lake	61.67	65.34	44.68	74.14	51.90	66.07	57.94	69.04

Red -- = sample size < 10; too small to report on

Percentages in table do not include unknown or missing data

* = missing more than 10% of the data and cannot provide accurate analysis

Blue highlights = significantly disproportionate *over*-access compared to overall representation in HMIS.

Yellow highlights = significantly disproportionate *under*-access compared to overall representation in HMIS.

[8] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

TAY Households: Demographics by Project Access

For Transition Age Youth (TAY; a subset of adult-only households), we again see a disparity between White-only and BIPOC in terms of access to TH, RRH, and PSH.

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[9].										
Transition Age Youth (TAY)	HMIS	CE	HP	DS	SO	SSO	ES / SH	TH	RRH	PSH / OPH
Total	4,305	847	247	1539	513	1003	2788	209	250	94
Percentages										
White race (Any)	75.46	78.23	85.61	76.57	82.34	81.27	78.98	74.88	83.53	81.91
No White race	20.28	21.77	14.39	23.43	17.66	18.27	21.02	25.12	16.47	18.09
Latinx	24.54	22.97	24.54	27.00	22.49	21.56	22.76	26.21	23.29	18.09
BIPOC	43.43	44.39	38.83	48.59	38.04	37.90	42.84	46.60	38.55	38.30
White only	56.57	55.61	61.17	51.41	61.96	62.10	57.16	53.40	61.45	61.70
Male only	59.23	57.73	55.88	61.12	57.95	57.95	63.27	65.22	54.80	52.13
Female only	37.92	36.48	41.54	35.16	38.23	39.54	33.59	30.43	42.80	37.23
More than M/F	2.86	5.23	--	3.72	3.82	2.52	3.14	--	2.40	10.64
Veteran	1.40	--	--	0.92	--	1.53	1.38	--	--	0%
Senior	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Chronic	12.49	*	4.53	9.78	*	*	13.90	5.97	17.34	50.00
Disabling condition	42.57%	*	35.71	47.20	*	*	38.98	50.00	54.03	88.04
DV history	*	*	*	29.23	*	*	18.67	*	23.14	23.26
Unsheltered History	57.47	68.00	31.02	67.32	100%	66.10	66.61	58.37	69.60	77.66
Average number of project enrollments [mean(median)]	5.97 (2)	1.09 (1)	1.06 (1)	1.56 (1)	1.54 (1)	1.44 (1)	5.97 (1)	1.13 (1)	1.09 (1)	1.24 (1)
BOS	32.17	31.17	68.25	0%	18.32	48.26	36.08	--	36.80	15.96
Mountainland	6.30	6.14	4.01	3.05	4.48	16.45	4.34	5.72	1.60	17.02
Salt Lake	61.53	62.69	27.74	96.95	77.19	35.29	59.58	92.82	61.60	67.02

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[9] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

Adult(s) with Children Households: Demographics by Project Access

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[10].										
Adult(s) with Children Households	HMIS	CE	HP	DS	SO	SSO	ES/SH	TH	RRH	PSH / OPH
Total	22,099	3,531	6966	109	527	4,740	9,347	321	8,587	969
Percentage										
White race (Any)	76.48	76.26	72.84	81.35	84.57	77.94	74.53	86.60	78.40	71.92
No White race	23.52	23.74	27.16	18.35	15.43	22.06	25.47	13.40	21.60	28.08
Latinx	29.58	29.41	26.30	40.37	35.26	28.91	31.88	27.16	30.36	28.05
BIPOC	53.31	53.84	53.64	55.96	52.34	51.31	57.84	40.32	52.72	56.99
White only	46.69	46.16	46.36	44.04	47.66	48.69	42.16	59.68	47.28	43.01
Male only	43.29	43.79	43.39	47.71	41.71	43.39	44.55	31.15	41.94	45.76
Female only	56.59	56.13	56.56	52.29	57.90	56.48	55.30	--	57.86	54.03
More than M/F	0.12	--	--	0	--	--	0.15	--	0.20	--
Veteran	1.34	0.95	1.93	0	--	1.97	0.88	0	1.70	--
Senior	0.30	--	0.33	0	--	--	0.27	0	0.26	--
Chronic	1.63	*	--	*	12.22	1.88	2.49	--	1.71	9.02
Disabling condition	22.63	*	16.90	*	*	23.25	24.91	35.31	25.94	45.13
DV history	*	*	*	*	*	*	*	*	*	*
Unsheltered History	16.36	30.33	4.84	38.53	100	81	24.33	15.26	19.65	23.22
Average number of enrollments [mean (median)]	3.11 (2)	1.05 (1)	1.15 (1)	1.01 (1)	1.06 (1)	1.31 (1)	2.26 (1)	1.07 (1)	1.68 (1)	1.44 (1)
BOS	34.27	37.64	34.90	0	33.21	32.70	29.73	13.40	34.44	6.60
Mountainland	5.72	4.93	3.50	0	2.66	22.70	5.63	0%	2.73	6.40
Salt Lake	60.00	57.43	61.60	100	64.14	44.60	64.64	86.60	62.84	87.00

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Some TH projects do not allow male parents to be on the premises (some of the families have experienced DV and may not feel comfortable with men on the premises). Therefore, if the father is a part of the household, the family is not eligible for the service (in this case, TH). However, if the TH project is scattered site, then each CoC should look deeper at why men and BIPOC persons are less likely to access TH than other projects.

Adult(s) with Children households that eventually get into RRH are enrolling – in a RRH project – an average of 1.68 times, which is much higher than enrollment averages for other project types. The standard deviation for this (SD) is 1.18; having an average of 1.68 means that a fairly large proportion of people in families are enrolling in RRH 2-3 times into RRH. This means they exit the RRH project, then re-enroll in RRH, which means they aren't exiting into some other kind of permanent housing ("leasing up").

[10] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

Child-Only Households: Demographics by Project Access

Demographics (other than "total" line, everything is %), 01/01/2081 - 2022[11].										
Child-Only Households	HMIS	CE	HP	DS	SO	SSO	ES/SH	TH	RRH	PSH / OPH
Total	1,897	12	764	89	31	179	1,209	12	--	0
Percentage										
White race (Any)	86.09	--	87.23	80.25	--	85.14	*	--	--	--
No White race	13.91	--	12.77	19.75	--	14.86	*	--	--	--
Latinx	33.55	--	36.03	47.13	39.29	30.51	*	--	--	--
BIPOC	46.56	--	48.45	64.37	53.57	55.37	*	--	--	--
White only	53.44	--	51.55	35.63	46.43	44.63	46.68	--	--	--
Male only	46.90	--	46.06	52.81	--	46.37	47.76	--	--	--
Female only	48.28	--	50.13	43.82	--	43.58	5.56	--	--	--
More than M/F	4.82	--	3.81	--	--	10.06	*	--	--	--
Veteran	0	0	0	0	0	0	0	0	0	0
Senior	0	0	0	0	0	0	0	0	0	0
Chronic	0	0	0	0	0	0	0	0	0	0
Disabling condition	*	*	13.44	37.21	*	*	25.82	--	--	--
DV history	*	*	*	*	*	*	*	*	*	*
Unsheltered History	11.97	--	9.55	51.69	100%	17.88	11.83	--	--	--
Average number of enrollments [mean (median)]	2.00 (1)	1 (1)	1.08 (1)	1.10 (1)	1.06 (1)	1.23 (1)	1.85 (1)	1(1)	1(1)	1(1)
BOS	34.48	--	54.45	0	--	82.68	24.73	0	0	0
Mountainland	38.85	--	25.00	0	--	--	52.94	0	0	0
Salt Lake	26.27	--	20.55	100	--	15.64	22.33	100	100	0

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Yellow highlights = significantly disproportionate *under*-access compared to overall representation in HMIS.

Child-only populations are quite high in the Balance of State and Mountainland CoCs.

[11] To observe demographics across all project types, we had to cut enrollments that started before January 1, 2018, because of poor data quality.

DEMOGRAPHIC PROFILES

Chronic Homelessness

Of the people currently enrolled in the system at the time of this analysis, 20% (2,245 people) are chronically homeless.

- BoS CoC: 11.5% (284 people) are currently chronically homeless (at the time of this analysis).
- MTL CoC: 20.6% (178 people) are currently chronically homeless (at the time of this analysis).
- SL CoC: 22.7% (1,783 people) are currently chronically homeless (at the time of this analysis).

Each year, about 10% of those newly entering the system will be chronically homeless.

Disabling Condition

Of those currently enrolled in the system at the time of this analysis, 55% (6,302 people) have a disabling condition.

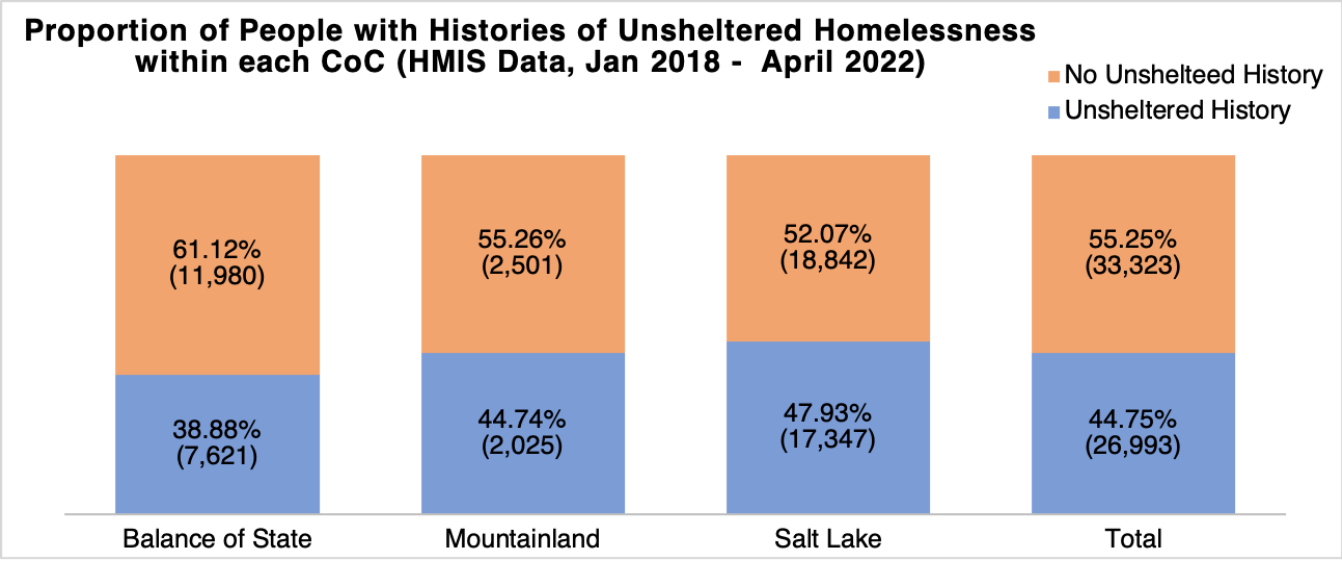
- BoS CoC: 46.2% (1,165 people)
- MTL CoC: 63.6% (552 people)
- SL CoC: 56.8% (4,585 people)

An estimated 38% of people newly entering the system each year will have a disabling condition. (This percentage of people with a disabling condition may increase over time as they stay in the system, as homelessness can cause various disabilities.)

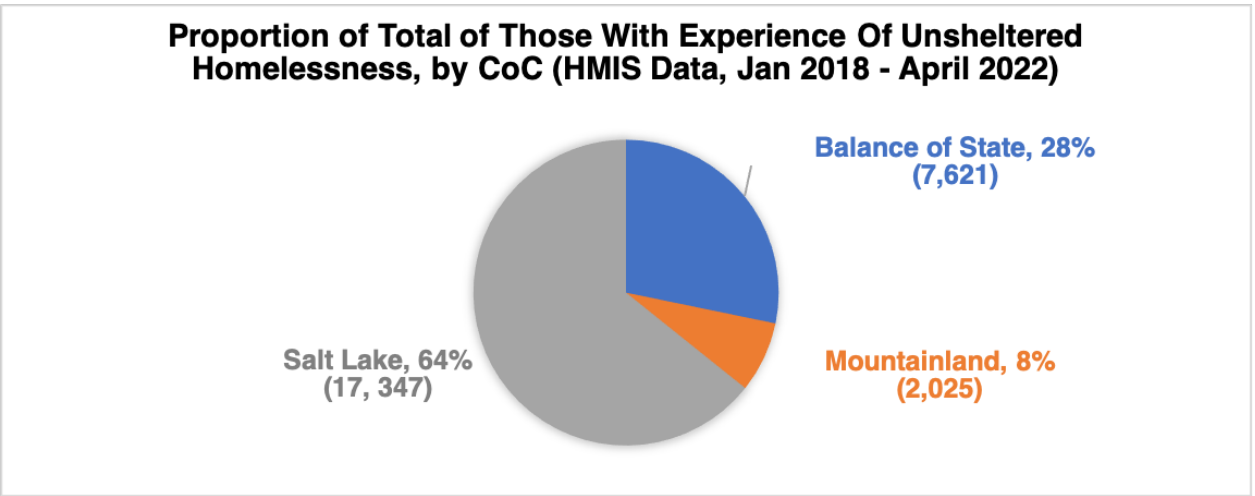
Unsheltered

Unsheltered is defined by (1) those who have a recorded prior location as on the street, (2) those who have a recorded exit destination to the street, (3) and those who have been in a street outreach project. (Keep in mind that many destinations are missing; please treat unsheltered analysis as an estimate.)

Of all of the individuals in Utah who have experienced homelessness since 2018[12] and enrolled in the system of care, over 55% had a history of unsheltered homelessness.



[12] Due to poor data quality for unsheltered homelessness prior to 2018, these data are for Jan 2018 – April 2022.



HMIS data shows that about 53% of those currently experiencing homelessness and enrolled in the system of care have experienced unsheltered homelessness. Each CoC has the following percentages of persons currently active in the homeless system of care who have experienced unsheltered homelessness:

- Balance of State CoC: 49.4% (1,341 people) of those currently enrolled have experienced unsheltered homelessness.
- Mountainland CoC: 65.7% (584 people) of those currently enrolled have experienced unsheltered homelessness.
- Salt Lake City CoC: 52.9% (4,665 people) of those currently enrolled have experienced unsheltered homelessness

Further, an estimated 39% of people newly entering the system each year will have experienced or will experience unsheltered homelessness. Certain subpopulations experience unsheltered homelessness at a higher rate. For example, those who are considered chronically homeless have experienced unsheltered homelessness at higher rates (87.5%) than those who are not considered chronically homeless (38%) and adult-only households make up 61% of the total homeless population but 89% of those who are unsheltered.

No History of Unsheltered Homelessness vs. History of Sheltered Homelessness by CoC

The following table shows how many individuals in the homelessness system of care (2017-2022) had a history of unsheltered homelessness, as well as the proportions of these individuals across CoCs and within CoCs.

No History of Unsheltered vs. History of Unsheltered by CoC	BoS	Mountainland	Salt Lake	Total
No (has never been unsheltered)	11,980	2,501	18,842	33,323
Percent of total across CoCs	35.95%	7.51%	56.54%	100.00%
Percentage of total within CoC	61.12%	55.26%	52.07%	55.25%
Yes (has been unsheltered)	7,621	2,025	17,347	26,993
Percent of total across CoCs	28.23%	7.50%	64.26%	100.00%
Percentage of total within CoC	38.88%	44.74%	47.93%	44.75%
Total	**19,601**	**4,526**	**36,189**	**60,316**
Percent of total across CoCs	32.50%	7.50%	60.00%	100.00
Percentage of total within CoC	100.00	100.00	100.00	100.00

Unsheltered Homelessness by Household Type and CoC

The following table shows how many how many of each household type in the homeless system of care (HMIS Data 2017-2022) had a history of unsheltered homelessness by CoC.

Unsheltered Homelessness by Household Type and CoC	Balance of State	Mountainland	Salt Lake	Total
Adult Only	6,397	1,825	15,804	24,026
% Of unsheltered adult-only households across the state	26.63%	7.6%	65.78%	100%
% Of unsheltered adult-only households within this CoC	83.94%	90.12%	91.11%	89.01%
Adults + Children	1,141	176	1,420	2,737
% Of unsheltered family households across the state	41.69%	6.43%	51.88%	100%
% Of unsheltered family households within this CoC	14.97%	8.69%	8.19%	10.14%
Child Only	52	13	67	132
% Of unsheltered child-only across the state	39.39%	9.85%	50.76%	100%
% Of unsheltered who are child-only within this CoC	0.68%	0.64%	0.39%	0.49%
Unknown	31	11	56	98
% Of unsheltered unknown households across the state	31.63%	11.22%	57.14%	100%
% Of unsheltered unknown households within this CoC	0.41%	0.54%	0.32%	0.36%
Total	7,621	2,025	17,347	26,993
% Of unsheltered across the state	28.23%	7.5%	64.26%	100
% Of unsheltered who are within this CoC	100%	100%	100%	100.00

- Adult-only households make up 61% of the total homeless population but 89% of those who are unsheltered.
- Adult(s) with Children make up a larger percentage of the unsheltered population in BOS when compared to the average across the state and other CoCs
- The proportion of TAY making up the unsheltered population looks consistent across CoCs.
- Veterans appear to be experiencing unsheltered homelessness at a higher rate than the non-Veteran homeless population (60% of Veterans have experienced unsheltered homelessness, whereas only 45% of the rest of the homeless population has experienced unsheltered homelessness).
- Those who are considered chronically homeless have experienced unsheltered homelessness at higher rates (87.5%) than those who are not considered chronically homeless (38%).

Unsheltered First-Time Access

For those who have experienced unsheltered homelessness, through what project do they access the homeless system of care for the first time? (Data is for those who first entered the system on or after 01/01/2017.)

- 61% come into the system through day or night shelters
- 25% come into the system through SSO or SO project types.
- Only 6% come into the system through CE.
- The rest (between 0% and 4% for each) first enter the system through HP, TH, RRH, or PSH/PH.

Once in the system, what housing resources are individuals accessing?

Project Type Access by Unsheltered History	Have experienced unsheltered homelessness	Have *not* experienced unsheltered homelessness
Emergency Shelter	79%	53%
Homelessness Prevention	5%	29%
Transitional Housing	3%	3%
Rapid Rehousing	19%	29%
Permanent Supporting Housing / Other Permanent Housing	9%	6%
Permanent Housing	25%	32%

Only 5% of those who have experienced unsheltered homelessness have accessed Homelessness Prevention (HP), while nearly 30% of those who have not experienced unsheltered homelessness have accessed HP resources.

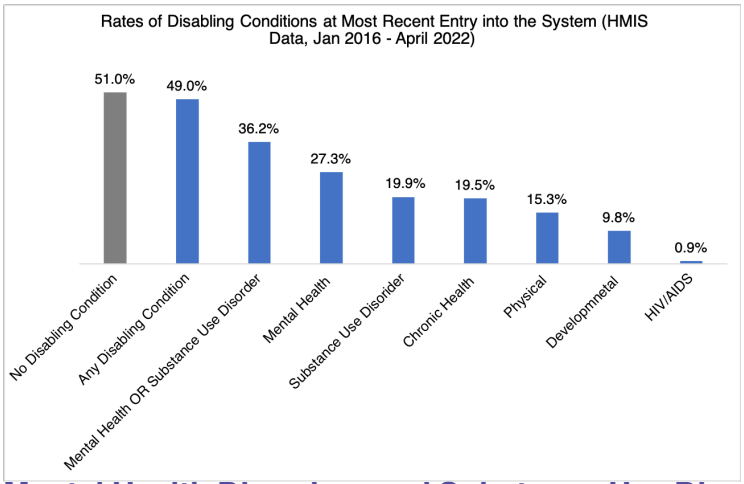
DISABILITY STATUS

The population of people who had a recorded disabling condition includes entry, exit, and at annual assessment. Overall, 14% of enrollments changed disability status during the life of the enrollment, and slightly more enrollments start with disability recorded as yes than end with them (e.g., disability status is removed by the time the person exits).

- Missing data issues:
  - 13% missing data
    - missing data > 10% = Coordinated Entry, Supportive Services Only, and Street Outreach.
  - Therefore, we cut CE data as it had the most missing data of those with high quantities of missing data.
- Keep in mind: identifying the specific disabling condition is not required for all project types at all times (see this link page 74 for expectable data errors in UT
- There are many missing or incorrect disability determinations of for PSH- disability required.

Disabling Condition Category	Number (77,409)	Percent of Total Ever Enrolled in the Homeless System (Jan 2016 – April 2022)
Any Disabling Condition	37,925	48.99%
MHD OR SUD	27,904	36.23%
Mental Health Disorder (MHD)	20,959	27.33%
Substance Use Disorder (SUD)	15,302	19.92%
Alcohol Use Disorder (AUD)	6,899	8.99%
Drug Use Disorder (DUD)	12,447	16.24%
MHD AND SUD	8,357	10.80%
Chronic Health Condition	14,972	19.48%
Physical Disability	11,757	15.30%
Development Disability	7,376	9.61%
HIV/AIDS	659	0.90%

*** 7.5% (6, 274) missing data was not included in this table** *** CE not included due to poor data quality**



Mental Health Disorders and Substance Use Disorders

The following section review both 2022 PIT Count data and HMIS data to estimate how many individuals experiencing homelessness and in the homeless system of care experience a mental illness and/or substance use disorder.

2022 PIT Count Data

2022 PIT Count: Reported Mental Illness and Reported SUD by Sheltered vs Unsheltered			
	Sheltered	**Unsheltered**	**Total**
Reported Mental Illness	28%	25%	27.5%
Reported Substance Use Disorder	15%	20%	16.1%

It is likely that there is overlap between these two groups (reported mental illness and reported substance use disorder), as about 1/3 of US adults who experience a mental illness also experience a substance use disorder[13]. HMIS data provides evidence for this overlap. These numbers are also reflective of national statistics for those who are housed.

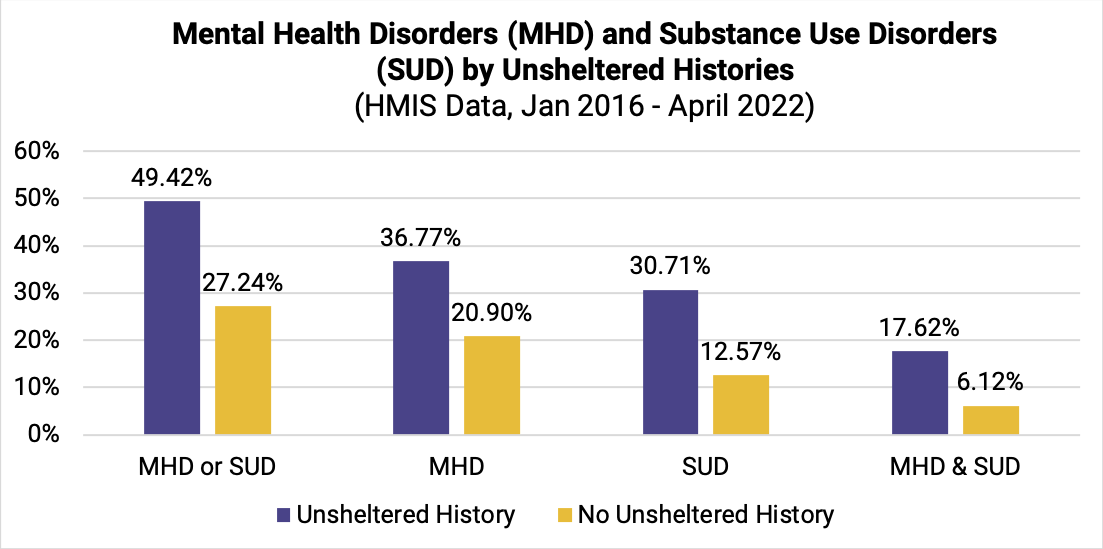
HMIS Data

According to the HMIS data, approximately 49% of people with unsheltered histories (of those enrolled in the system of care in the last five years) also had records of mental health disorders (MHD) and/or substance use disorders (SUDs). The chart below shows how many people with unsheltered and sheltered histories are reported has having a mental health and/or substance use disorder across the state.

MHD and SUD by Unsheltered History (HMIS Data Jan 2016 – April 2022)		
	Unsheltered History (31,434)	**No Unsheltered History (45,957)**
MHD or SUD	49.42% (15,422)	27.24% (12,470)
MHD	36.77% (11,397)	20.90% (9,546)
SUD	30.71% (9,564)	12.57% (5,738)
MHD and SUD	17.62% (5,539)	6.12% (2,814)

Only 18% of PATH enrolled clients with severe mental illness (SMI) are leaving the project to a known

[13] Around 21% of US adults experienced a mental illness in 2020 (1 in 5 adults). About 7% (1 in 15) of adults experienced co-occurring mental illness and SUD. Around 5.6% of adults (1 in 20) experienced a Severe Mental Illness (SMI). Of those with an SMI, 25% (1 in 4) also have an SUD (1.25% of adults, or 1 in 80 adults).
NAMI Mental Health Stats: https://nami.org/mhstats; SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, Mental Health, Detailed Tables available at: https://www.samhsa.gov/data/population-data-nsduh
https://www.nimh.nih.gov/health/statistics/mental-illness



housed destination. PATH (Projects for Assistance in Transition from Homelessness) is a block grant from the Department of Health and Human Services to provide outreach and case management to those with serious mental illness (SMI) experiencing homelessness. PATH projects operate as both Street Outreach (SO) and Supportive Services Only (SSO) project types across the State of Utah.

Comparison to National Statistics on MHD and SUD

Severe Mental Illness (SMI) is distinct from general Mental Health Disorders, and data for the PIT Count and from HMIS do not make this distinction. **Mental illness in general** includes any "mental, behavioral, or emotional disorder" from mild to severe, but not seriously interfering with major life activities (National Institute of Mental Health). **Serious or severe mental illness** (SMI) is defined as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities (National Institute of Mental Health).

SMI is associated with an increased risk of homelessness, whereas mental illness in general is not. SMI is not a direct cause of homelessness; rather, SMI may lead to factors that contribute to homelessness, such as a lack of supports that enable them to access or maintain housing.

Further, the PIT Count only reports "severely mentally ill" (it does not report prevalence of mental health disorders more broadly) and those reports, for unsheltered homelessness especially, are typically based on observation or short questions asked by surveyors who are rarely trained mental health professionals that are qualified to diagnose SMI or mental health disorders more broadly. Thus, the PIT Count only provides a snapshot of estimated information, not precise diagnostic data.

National statistics on mental illness and co-occurring substance use disorder (SUD) are aligned with those from HMIS for those who have not been unsheltered (mental health disorders: 21% nationally vs. 20.9% in HMIS; substance use disorders: 7% nationally vs. 6.12% in HMIS). However, there is no reliable homelessness data distinguishing between general mental illness and severe mental illness (nationally, around 5.6% of adults [1 in 20] experienced a Severe Mental Illness; of those with an SMI, 25% also have an SUD [1.25% of adults, or 1 in 80 adults]).

WHAT PROJECT TYPES LEAD TO SUCCESSFUL HOUSING OUTCOMES?

The following analyses examine each project type looks at:

- *Connections to other resources* in the system from that project type (the project type is the initial enrollment into the system)
- *Rates of exits to permanent destinations* from that project type (the project type is their last enrollment in the system)
- *Overall exits from the system* from that project type (the project type is their last enrollment in the system)
- R*eturns to homelessness* when that project type was the final enrollment before exit.

How do we define a "successful" project type?

- The project type has high rates of exits to permanent destinations
- The project type has low rates of returns to the system
- Nuances
    - There are different kinds of permanent destinations
    - Sometimes, a client exits to an "unknown" destination, but does not return within 12+ months, so we can assume a permanent exit
    - What project type someone returns to can tell us about the success of the project (e.g., if a person accesses HP twice, but then is exited long-term, that can be considered a success).

The below table “Exits and Returns for First Exit Category” looks at each project type, the rates of exits rates and rates of return for permanent destinations, non-permanent destinations, and unknown destinations.

Exits and Returns for First Exit Category						
	Permanent Destinations		Non-Permanent Destinations		Unknown Destinations	
	% Exits to Permanent Destinations	**% Returns from** Permanent Destinations	**% Exits to** Non-Permanent Destinations	**% Returns from** Non-Permanent Destinations	**% Exits to** Unknown Destinations	**% Returns from** Unknown Destinations
Street Outreach	3%*	10%*	10%*	90%*	85%*	91%*
Emergency Shelter	22%*	30%*	28%*	73%	50%*	66%
Transitional Housing	63%	19%	31%	68%	6%	61%
Rapid Rehousing	79%	24%	12%	65%	9%	42%
*Permanent Supportive housing / Other permanent housing**	62% (80%)	15%	31%	65%	6%	52%
Homeless prevention	78%	26%	8%	61%	14%	36%
* = excluding retention ( ) = including retention						

Summary:

- **Emergency Shelter**
  - 11.6% of those who come into the system utilize Emergency Shelter and then exit homelessness without the support of CoC housing projects. This 11% is likely much higher, but due to poor data we can't be sure.
- **Street Outreach**
  - SO clients are exiting the system at the lowest rates compared to Emergency Shelter, Transitional Housing, and Permanent Housing projects.
- **Transitional Housing**
  - By looking at those who goes from TH to permanent housing projects or a temporary destination, we can see that a high percentage of people need ongoing support after TH.
- **Rapid Rehousing**:
  - Currently, there is a large amount of people enrolled in RRH without move in dates for permanent housing (almost 2,000 people).
  - Improve data quality to decrease the percentage exiting to unknown destinations.
- **Permanent Supportive Housing / Other Permanent Housing**
  - 90.41% of people enrolling in PSH/OPH move into their housing. Of those who move in, 80% exit to permanent housing or retain their housing.
  - If retention in a permanent housing program is considered an "exit", returns to homelessness are closer to 10% (as compared to 15%).

Street Outreach

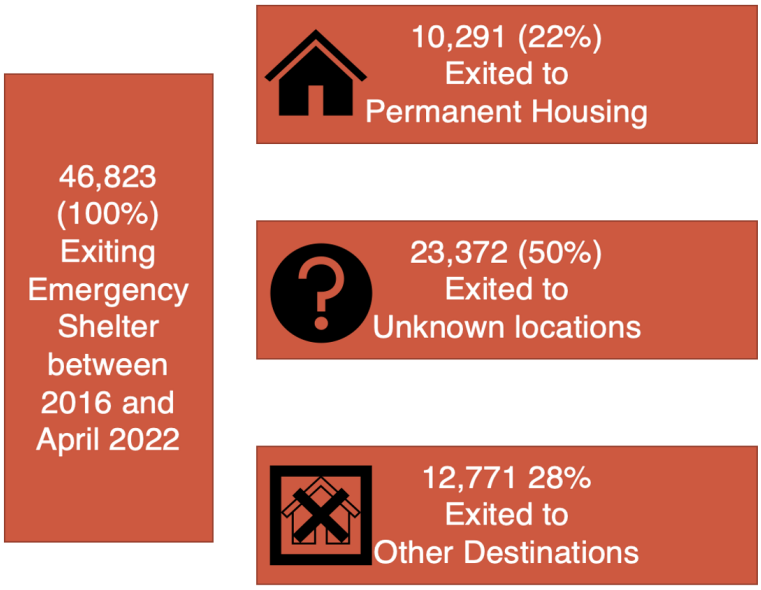
For Street Outreach (SO), there is a large amount of "unknown" data (e.g., someone's exit destination is unknown), which can make it difficult to determine the success of SO in regard to clients permanently exiting the system.

- Connections to resources:
  - Only 11.73% of those who come to the system through SO access housing projects, while the average VI-SPDAT scores for this group are high.
- Exits to permanent destinations:
  - 85% of exits from SO are to unknown destinations and therefore not much can be said about the "success" of Outreach with regards to exits.
- Overall exits from the system:
  - SO clients are exiting the system at the lowest rates compared to Emergency Shelter, Transitional Housing, and Permanent Housing projects.
    - Only 65.13% of clients that accessed SO project have left the system.
    - 34.87% remain in the system *or* have exited to an unknown status (and since it has not yet reached a year since their unknown exit, they cannot yet be counted as permanently exited).

Emergency Shelter

While there is too much missing data for significant quantitative analysis, numerically, there are many people leaving to permanent destinations from Emergency Shelter (ES).

- Since 2016, 10,291 persons (at least 22% those who exit from ES) are known to have exited from Emergency Shelter to permanent destinations.
- While we can't understand this number in terms of broad trends of ES functionality, we can see that ES *is* working for many people.
  - Of the 10,291 (22%) who exited to permanent destinations, 5,407 (11.6% of those who exit ES) did not go to CoC permanent housing projects. Instead, they exited to the following places:
    - 3,455 exited to family and friends
    - 1,392 exited to "self-housed" locations
    - 560 exited to RRH/PSH/Other Housing *outside* the homeless system of care.
  - **This means that at least 11.6% of those who come into the system utilize Emergency Shelter and then exit homelessness without the support of CoC housing projects. This 11% could be higher, but due to poor data we can't be sure.**
- People leaving the system from ES as their final enrollment make up 35% of all system exits (23,695 of 67,700 total exits from the system).
  - Of those who leave the system with ES as their final enrollment (23,695), 92% (21,799; 32% of all system exits) never access CoC Permanent Housing projects.
- 80% of people touching ES eventually leave the system.



Transitional Housing

Transitional Housing has slightly more success than SO or ES projects in connecting clients to Permanent Housing, and VI-SPDAT scores for those in TH tend to be lower than individuals in SO or ES.

Enrollment Time Point by PH Project Access and VI-SPDAT Score					
Enrollment time point	Ever access PH Projects	Never access PH Projects	Median Individual VI score	Median Family VI score	Median TAY VI score
SO First Enrollment	11.73%	88.27%	10	12	9*
SO Ever Enrolled	25.26%	74.74%	10	11	7*
ES First	18.96%	81.04%	7	9	7
ES Ever	23.00%	77.00%	8	9	7
TH First	36.72%	63.28%	6	11*	0*
TH Ever	43.79%	56.21%	7	11	5.5*
RRH	100%	100%	7	9 (9.6**)	7*
PSH/OPH	100%	100%	10	10	9*

* Sample size is below 25
** The maximum score for families (19) is different than individuals.

- Of those who exit TH, 62% are going to a permanent destination:
  - 30% of exits were connections to permanent housing projects
  - 23% were to self-housing
  - 9% were to family and friends
- Returns to the system:
  - Of those exiting from TH to permanent destinations (30% of permanent destination exits from TH), 18.65% return to the system.
  - Of those exiting from TH to self-housed locations or to friends and family (32% of all permanent destination exits from TH), 35.41% return to the system.

Rapid Rehousing

Currently, there is a large amount of people currently enrolled in RRH without move in dates for permanent housing (almost 2,000 people).

- Of those who exit the system from RRH:
  - 9% have unknown exit destinations.
  - 79.21% exit to permanent destinations.
    - If unknown destinations are excluded from the analysis, 87.23% exit to permanent destinations.
    - Of those exiting to a permanent destination from RRH, 30.5% go to another RRH project or a PSH project.
  - 77.77% move into an apartment as a result of RRH.
- 89.85% of people with RRH enrollments as their last enrollment exit the system.
- 23.57% of people return to the system after exiting RRH (regardless of exit type).
  - A significant amount of people exiting RRH are needing more support.

Permanent Supportive Housing and Other Permanent Housing

- Exits to Permanent destinations
  - 90.41% of people who enroll in PSH/OPH move in.
    - Of those who move in, 80% exit to permanent housing or retain their housing.
  - 14.55% return to the system after a permanent exit.
    - However, when looking at just those who exit to family/friends or a self-housed situation, the rate of return is 26.72%.
  - If retention in a permanent housing program is considered an "exit", returns to homelessness are closer to 10%.

Homelessness Prevention

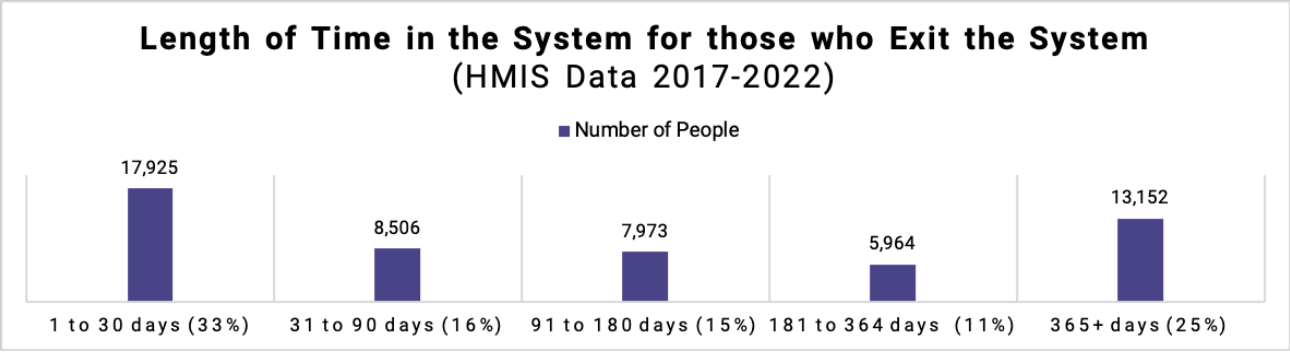
- Exits to permanent destinations:
  - Of those who exit the system from HP, 78% exit to a permanent location
- Exits from the system by last project type:
  - Of those who exit the system from HP, 97% fully exit the system regardless of recorded destination (e.g., permanent, or not). Therefore, exits to permanent destinations are probably better than the data indicates.
- Rates of return by project type:
  - Of those who return to the system after exiting to family, friends, or self-housed locations (with their last enrollment having been HP), 25.67% return to the system after exiting to a permanent destination.
  - Of those 25.67% who return after exiting to a permanent destination, 54.88% return to HP for an additional enrollment, and 83% (of those returning) have a last enrollment as HP. This means that even for those coming back to HP, HP is the right solution.

LENGTH OF TIME HOMELESS

Length of Time from Enrollment to Permanent Exit

This analysis examine the length of time from enrollment into the system to exit[14] from the system for an individual:

- Median time to exit = 92 days
- Mean time to exit = 275 days
- Range of days to exit = 1 – 2,258 days

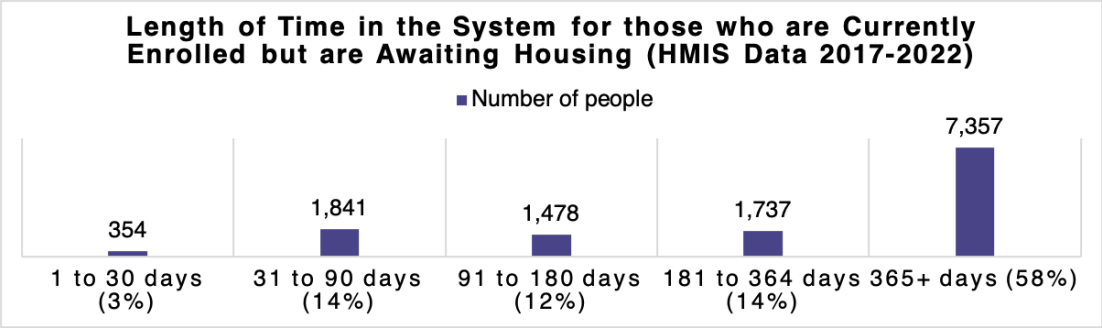


[14] Exit = if the person has moved in to RRH or PSH, if they have been exited for a year and have not returned (regardless of exit type), or if they exited to a permanent destination.

Length of Time in the System while Awaiting Housing

This analysis examines the length that those without a housing project move-in date have been in the system (e.g., they are waiting for housing):

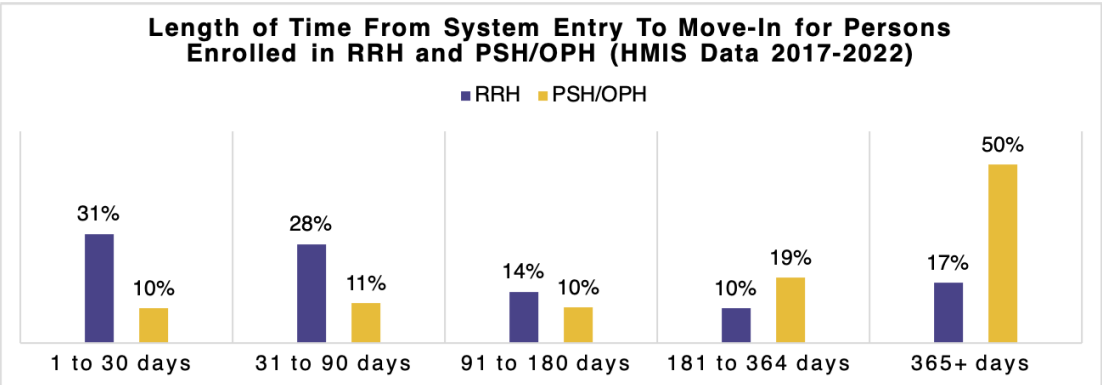
- Median time to exit = 503 days
- Mean time to exit = 799 days
- Range of days to exit = 19 – 2231 days



Length of Time from System Entry to Housing Project Move-In Date

This analysis examines the length of time it takes someone from the time of entering the homeless system of care until their housing project move-in date (e.g., How long does it take the system to "house someone"?):

- All Housing Projects
  - Median time to exit = 79 days
  - Mean time to exit = 253 days
  - Range of days to exit = 1 – 2195 days
- Rapid Rehousing
  - Median time to exit = 66 days
  - Mean time to exit = 205 days
  - Range of days to exit = 1 – 2195 days
- Permanent Supportive Housing / Other Permanent Housing
  - Median time to exit = 373 days
  - Mean time to exit = 513 days
  - Range of days to exit = 1 – 2141 days



Days in the system to move-in by housing project type (number of people)		
Number of days	**RRH**	**PSH/OPH**
1 to 30	3,027	175
31 to 90	2,743	203
91 to 180	1,417	181
181-364	960	334
365+	1,658	910

Length of time in Emergency Shelter. A majority of clients whose most recent enrollment into the system is Emergency Shelter are new to homelessness. However, there are also many people in the system for a long time, likely waiting for certain housing opportunities.
For those whose most recent project type was Emergency Shelter:

- Median time in the system for those in ES = 27 days
- Mean time in the system for those in ES = 276 days (for those enrolled less than 1 year)
- Range of time in the system for those in ES = 0 – 2,311 days (> 6 years), which is the reason for the large difference in the median and mean above.

The length of time in the system by final project type highlights that there are people in RRH and TH that may need more permanent support. There are individuals in TH and RRH that have been in the system for 6 years who likely need PSH options, but instead have been continually enrolled in TH (likely because there are not PSH options available or because they do not qualify for PSH for some reason).

Appendix 3: State-Wide Survey Analysis

EXECUTIVE SUMMARY

As part of the planning process for the Five-Year Homelessness Strategic Plan, Homebase, the Utah Office of Homeless Services, the Utah Homelessness Council's Strategic Plan Advisory Group, and other stakeholders distributed an online survey to gather feedback and perspectives from community members and stakeholders to identify community experiences of and priorities for addressing homelessness.

More than 600 people from a wide cross-section of the state responded to the survey and provided their views on needed resources and strategies for addressing homelessness. Survey respondents overwhelmingly prioritized **affordable housing, rent control, living wage policies, and prevention efforts** as ways to address homelessness across the state.

Further, respondents discussed the need for **Housing First approaches with wrap-around supportive services** that allow unhoused neighbors to find stability in housing and address urgent needs (such as healthcare) prior to engaging in other efforts toward self-sufficiency and long-term stability (e.g., employment).

Participants were given the opportunity to rank their top three priorities within each subcategory of strategies to address homelessness. However, respondents also emphasized the **need for a diversity of strategies** tailored to the needs of each individual experiencing homelessness, and that homelessness is not going to be solved with just a handful of approaches or strategies.

The survey results provide deeper insights into information also gathered through quantitative data. The results and comments provided also reveal the breadth of perspective across community stakeholders, as well as areas in which public education and outreach could help align communities around targeted and effective solutions.

BACKGROUND

Methodology

This state-wide survey was conducted for the purpose of gathering additional information to inform the State of Utah Strategic Plan to address homelessness. The survey was created by Homebase with direction and feedback from the Utah Office of Homeless Services (OHS) and the Chairs of the Strategic Plan Advisory Group.

The online survey was open between mid-June and mid-July 2022 and was advertised widely. Homebase and OHS reached out to the following groups to advertise the survey and requested to each that they send the survey to their networks, including social media:

- **Homelessness Summit participants contact list (700+ contacts):** Front-line service providers, service provider leadership, state and local leadership, state department executives and staff, advocates, individuals with lived experience
- **Utah Homelessness Council members**
    - Department of Health and Human Services
    - Department of Workforce Services social media
- **Utah Homeless Network** – Local Homeless Council (LHC) leadership sent out to LHC networks
    - Salt Lake Valley Coalition sent in newsletter, and OHS staff presented about it in their meeting
    - Pioneer Park Coalition posted on their website
- **Governor's Subcabinet on Homelessness**
- **Mayor's Offices for those on the UHC** – disseminated to constituents
- **CoC Collaborative Applicant**s – disseminated to their CoC contact lists
- **Formerly Homeless Board**
- **Emergency Shelter Contacts:** Washington ES, Iron ES, Men's HRC Gail Miller HRC, King HRC, Midvale Family Shelter, Weber-Morgan Emergency Shelter, Bear River (CAPSA)
- **Emergency Shelter Leadership:** The Road Home, Lantern House, VoA, Switchpoint, Shelter the Homeless, Youth Futures.
- **Physical and Behavioral Health Contacts**: Valley Behavioral Health
    - Behavioral health/substance use providers (1st Step House, NAMI)
    - Physical health (IHC, 4th street)
- **Higher education contacts**: University of Utah and Utah State University

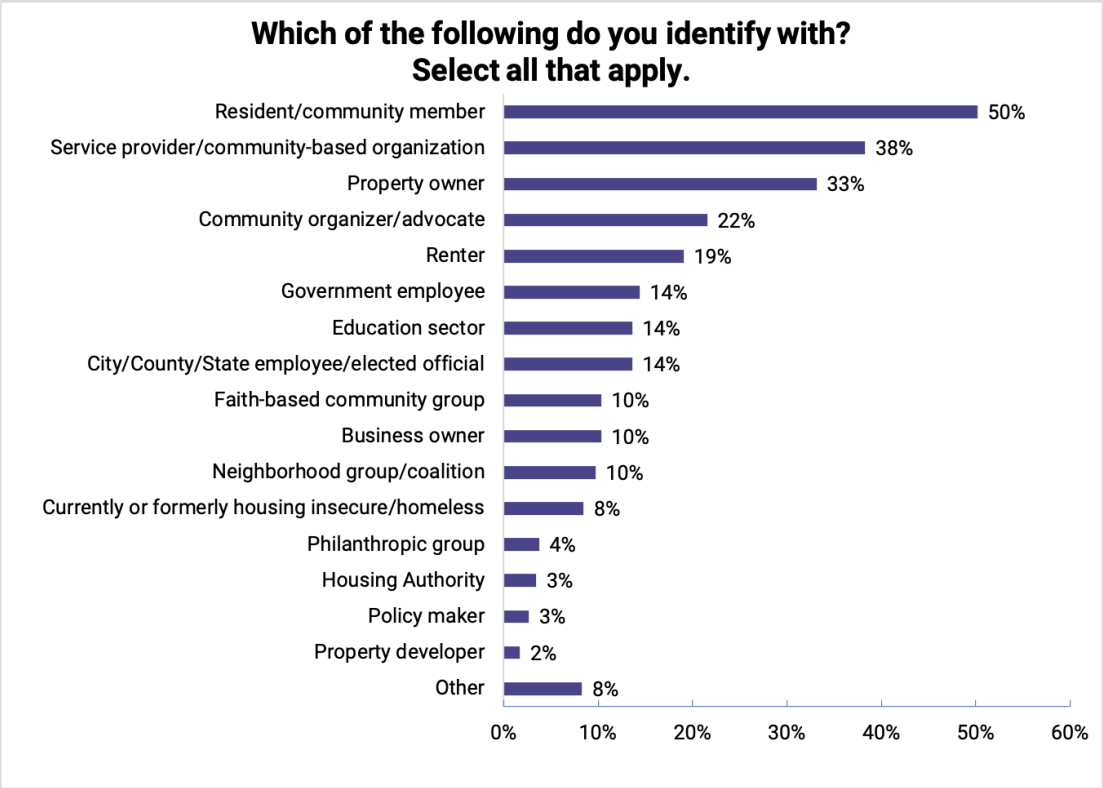
Purpose of the Survey

The purpose of this survey was to gather a wide cross-section of individual perspectives on homelessness across the state.

These perspectives are important to understand as they help to inform what communities observe about homelessness in their communities; what they may support or propose in regard to solutions to homelessness (and where community buy-in may need to be generated); where there are perspectives that could benefit from communication and education campaigns; and sometimes point to issues surrounding homelessness that are not currently part of the statewide discussion.

Respondents Demographic Summary

There were more 600 responses to the survey, with individual questions receiving between 618 and 640 responses. The tables below outline demographic information to show the degree of representation across different groups among survey participants.



County	
Salt Lake County	62.54%
Utah County	9.40%
Weber County	5.96%
Davis County	3.13%
Washington County	3.13%
Iron County	2.98%
Cache County	2.04%
San Juan County	1.72%
Grand County	1.57%
Uintah County	1.41%
Tooele County	1.25%
Summit County	1.10%
All other counties 0-1%	3.47%

Racial Background	
White	83.06%
Black or African American	0.97%
Asian	1.29%
American Indian or Alaska Native	1.45%
Native Hawaiian or Other Pacific Islander	0.81%
Multiple Races	4.68%
Prefer not to say	6.13%
Other (please specify)	1.61%

Ethnicity	
Hispanic or Latinx	7.00%
Non-Hispanic or Non-Latinx	82.41%
Prefer not to say	8.63%
Other (please specify)	1.95%

Gender Identity	
Female	65.38%
Male	26.57%
Trans/ non-binary/ gender non-conforming	3.54%
Prefer not to say	3.54%
Other (please specify)	0.97%

Age	
Under 24	3.04%
24 – 34	26.92%
35 – 44	24.84%
45 – 54	20.03%
55 – 61	8.17%
62+	13.30%
Prefer not to say	3.69%

HIGHEST PRIORITIES FOR SOLVING HOMELESSNESS

Respondents were first given six broad categories related to homelessness solutions and asked to rank them in order of importance. (*"Please rank the following categories in order of importance for solving homelessness in your community."*)

Ranked importance for solving homelessness:	
1	Housing initiatives / support (financial assistance, more units, etc.)
2	Supportive services for those experiencing homelessness
3	Healthcare services (including behavioral healthcare) for those experiencing homelessness
4	Greater coordination across agencies and services
5	Education / employment opportunities for those experiencing homelessness
6	Community education about homelessness and related issues

While we asked about each of the above categories in greater detail, respondents continually noted that all of the potential services and strategies proposed are likely needed. For the following categories, respondents were asked to indicate their top three solutions *within that category*.

HOUSING

Respondents overwhelmingly indicated that **deeply affordable housing units** are needed across Utah. A distant second was permanent supportive housing, followed by low-income housing.

Top 3 Housing Programs or Solutions		
Rank	Strategy	Percentage of Respondents who Selected
1	Deeply affordable housing units in the community	72%
2	Permanent supportive housing	58%
3	Housing for low- and moderate-income people	50%

Affordable Housing

When asked to elaborate on their selections, many respondents again described the unaffordability crisis of housing across Utah as both a cause of homelessness and a reason that Utah is not successfully addressing the homelessness that exists.

- "**Wages have not come anywhere near keeping up with housing costs**. So many people experiencing homelessness have jobs or recently lost their job because they lost their home. Regardless of whether you work or not, **everyone deserves housing, and we as a community have to make that happen**. I think permanent supportive housing is another important piece to the puzzle, as there will always be a need for some people to have support for the rest of their lives. My next-door neighbor has a cognitive disability. His mother took care of him until she passed away. Fortunately he has family to support him staying in his home. Not everyone has that family support, and that's where the community has to step up." – Survey Respondent

Similarly, other respondents shared concerns about the lack of affordable housing in Utah:

- "**There are not enough affordable and no-barrier housing options**. Housing is a human right and we as a community are failing at providing it." – Survey Respondent
- "This is a large question but **one of the biggest issues facing Salt Lake County is deeply affordable housing**. The cost of living is almost not affordable for most, especially those who are homeless who cannot work or who do work but still cannot afford to stay anywhere. What individuals make hourly cannot cover the cost of rent let alone other expenses such as food." – Survey Respondent
- "Just give people housing. Stop letting **developers and real estate** hoarders continue to buy up property to make ugly cheap 'luxury' housing that's **displacing poor and brown people**." – Survey Respondent

Related to the need for affordable housing, respondents discussed ways to prevent homelessness through financial support for housing before someone becomes homelessness:

- "**Intervention needs to happen before individuals become completely homeless**. Housing insecurity and unaffordability create low quality of life, even for those who are 'sheltered'." – Survey Respondent
- "We do not have funding or resources enough to support people experiencing homelessness now. **We have to look to upstream causes**, namely landlord greed, and **protect renters** in our communities in order to reduce the number of people entering homelessness." – Survey Respondent

Housing First

Numerous survey respondents also expressed support for Housing First programs: no-barrier housing that offers wrap-around supportive services.

- "Programs that **combine affordable housing with other services**, including education, employment and case management are more effective in setting a person up for actual success in making sure their experience with homelessness is brief and non-recurring. **Services offered need to be tailored towards meeting the individual where they're at** – 'what does this person need to be able to successfully maintain housing, not just now, but long-term.' Housing plus a goal towards creating self-reliance for individuals needs to be the focus." – Survey Respondent
- "**Housing is a human right, not a luxury, and should be made available**. If someone's main focus doesn't have to be immediate survival, they can then focus on other aspects of life and society." – Survey Respondent

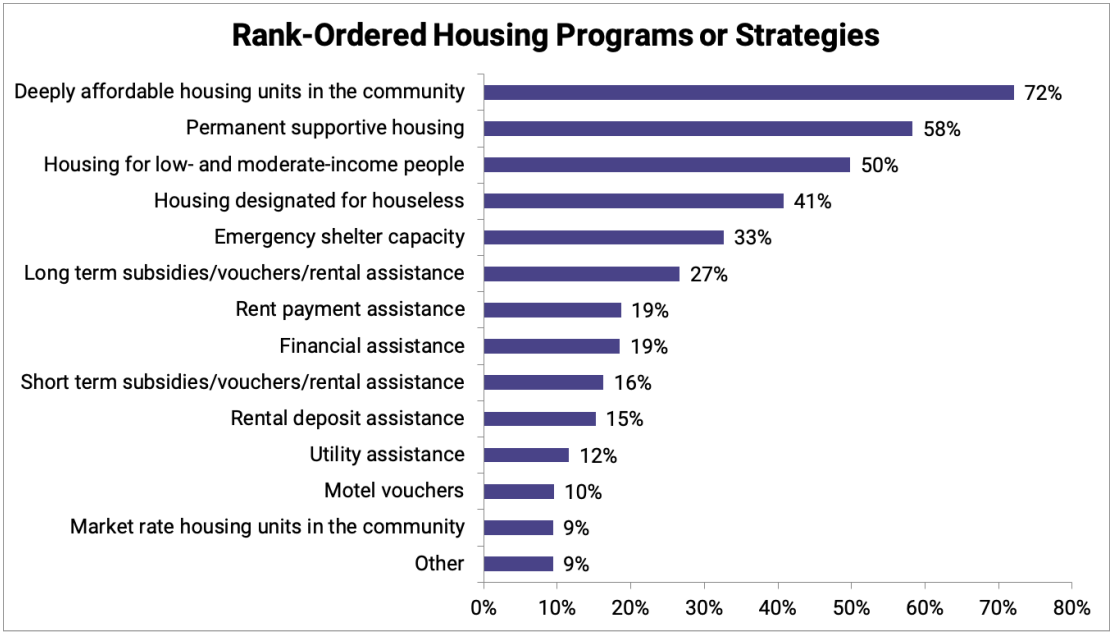
This was echoed throughout other responses:

- "When a person has a home and a roof over their head, they can begin to start working on next steps towards being able to take care of their needs." – Survey Respondent
- "People cannot keep and hold jobs when they don't have a permanent residence, and a place to shower and stay clean. Without these resources people cannot be expected to 'pick themselves up'."– Survey Respondent

Systemic Issues

A number of respondents also pointed to the systemic issue of homelessness and how multifaceted approaches are needed in order to solve it in Utah.

- "**Homelessness is a symptom of societies where property developers, businesses and billionaires control the housing market and urban planning**. As long as property developers are enabled by our politicians and policy makers to continue to buy up housing, creating a housing shortage and crisis, we will see no end to homelessness." – Survey Respondent
- "With inflation, imminent recession, rising home/rental prices, heavy medical expenses, and below average wages**, the chances to experience homelessness are growing**. Securing housing, permanent supportive housing, and housing assistance needs to be emphasized. It cannot be these three things alone, but they can help buy time while other considerations for long term approaches are made." – Survey Respondent
- "**We do not have deeply affordable housing available for our population**. At the same time, fixed incomes, and people between the 30% to 50% of AMI income are having more hardships keeping their units. Long term subsidies and rental assistance actually help the community to relieve the hardship they live." – Survey Respondent



SUPPORTIVE SERVICES

This question in the survey was meant to capture respondents' perspectives on other (outside of the above services) supportive services that are needed to help address homelessness across Utah. Respondents ranked the following as the top three supportive services needed:

Top 3 Supportive Services		
Rank	Strategy	Percentage of Respondents who Selected
1	Wrap-around supportive services	67.35%
2	Case management	52.46%
3	Homelessness prevention / diversion	40.25%

It is important to note, however, that respondents also stressed that all of the listed services are needed.

Wrap-Around Supportive Services

As described in the above sections, respondents again emphasized the need for a Housing First approach to providing services to those experiencing homelessness:

- "**Housing with wrap-around services on site. That is the solution**. Homeless people are not able to keep track of appointments most of the time, because they live on the streets and carry all of their belongings with them. Of course things get lost in the shuffle. We need to get them housed, provide food and other material resources, we need to provide medical care, mental health care, and substance use treatment. All located in or around their housing, so that they can easily access it and move forward successfully. Requiring people to navigate multiple agencies and multiple systems spread out throughout the city and valley is ridiculous. Until we bring the resources to them, we are setting them up for failure." – Survey Respondent
- "Wrap-around services are extremely helpful, coupling housing with everything else an individual/household might need means they don't have additional barriers to services." – Survey Respondent
- "Wrap-around supportive services is the largest need and would produce the most helpful results in solving homelessness. This could address multiple needs and eliminate the barrier of seeking different providers for different needs and having to build rapport with multiple agencies." – Survey Respondent

Case Management

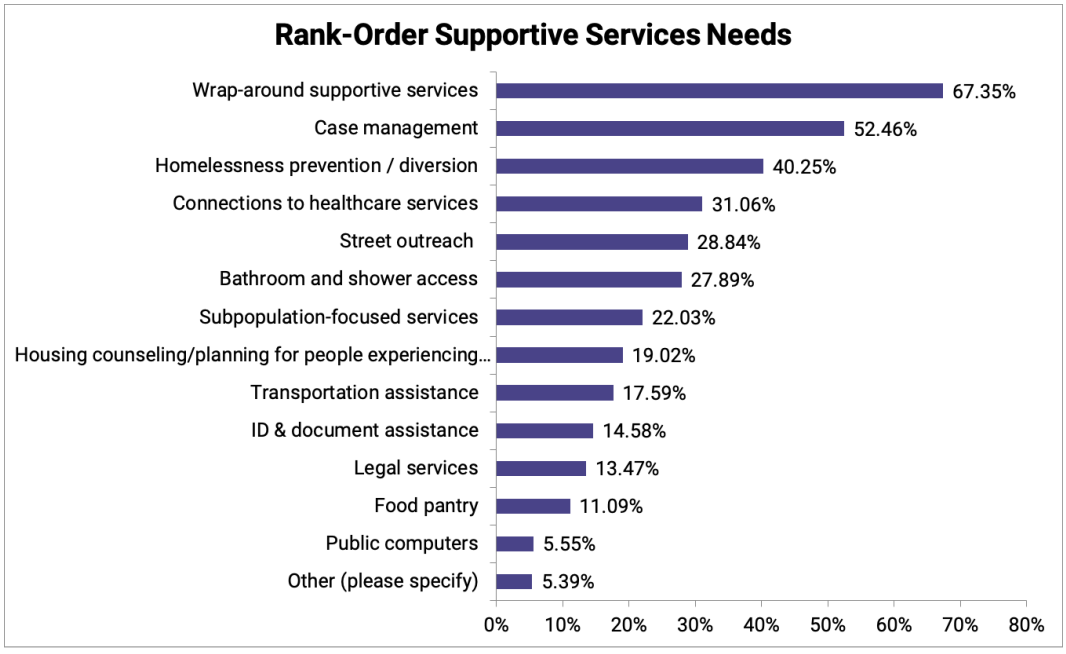
Respondents also indicated a need for more case management services, given the difficult of navigating the homeless system of care for many clients:

- "While supportive services are so helpful, most are not going to solve homelessness unless housing is the end goal. This is why more case managers (specifically outreach case managers) are needed to reach clients that don't have access to this service in shelters, etc. **The housing process is nearly impossible to go through on your own while living outside, so the support of a case manager who has access to more resources is necessary**." – Survey Respondent

Prevention / Diversion

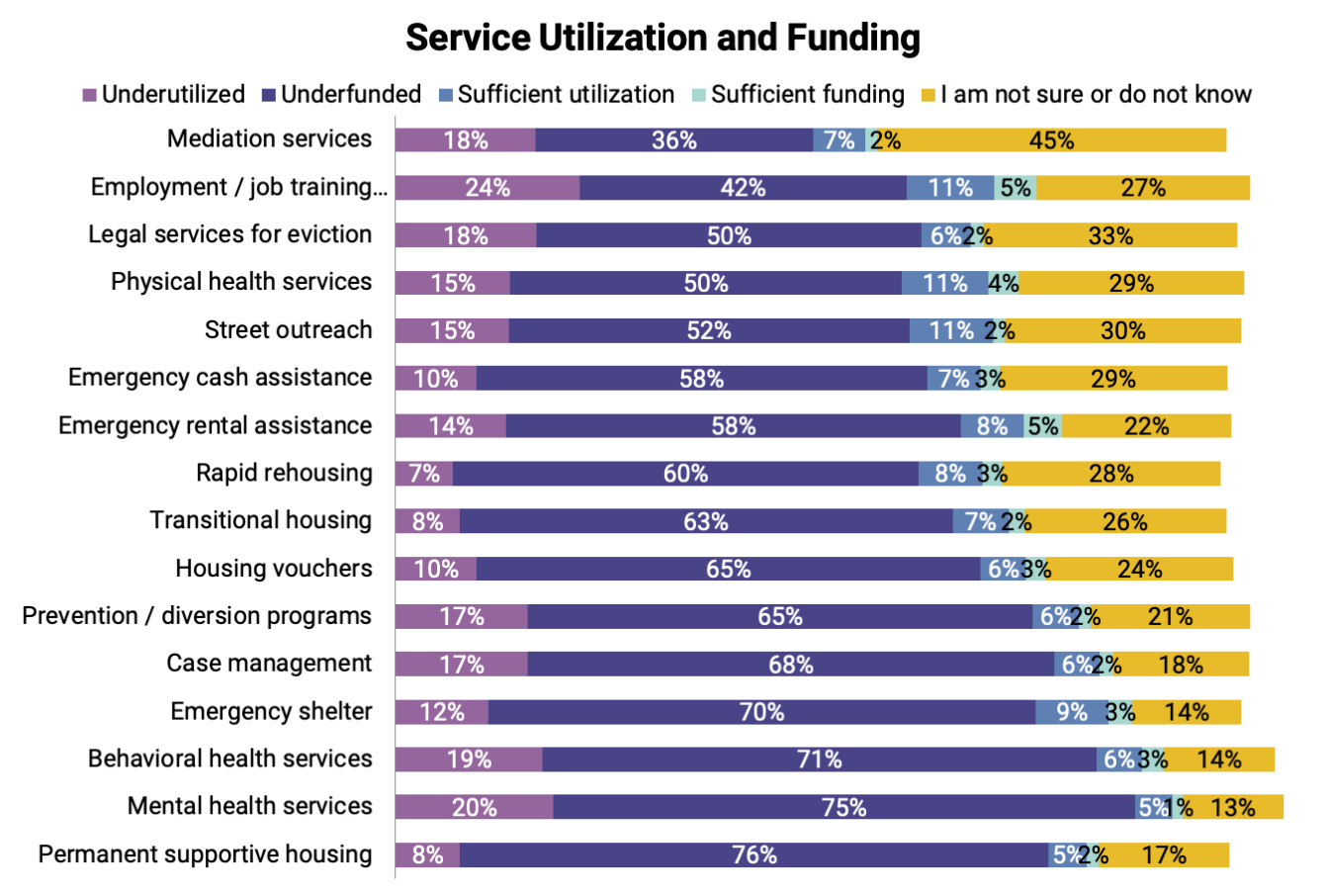
Related to prevention and diversion, respondents noted that keeping people housed (through, in part, certain supportive services) is more efficient than trying to re-house someone once they are unhoused:

- "If we can keep people housed long enough to get them back on their feet, we would prevent a LOT of chronic homelessness." – Survey Respondent
- "Keeping people housed is always more effective than trying to get them housed again if they become homeless." – Survey Respondent



Service Funding, Utilization, and Capacity

Respondents were asked to indicate whether different services were under- or over utilized and funded. Respondents overwhelmingly indicated that services are underfunded (see Table below, "Service Utilization and Funding").



Underutilized Services

Respondents were also asked to indicate why certain services are underutilized.

Top 3 Reasons Services are Underutilized		
Rank	Strategy	Percentage of Respondents who Selected
1	Lack of staff resources to effectively outreach to clients	54.36%
2	Requirements for use of these services (e.g., documentation, income level, etc.)	40.25%
3	Need more staff to help get clients into services	34.44%

Related to the above, respondents described that requirements for services can create barriers to their use:

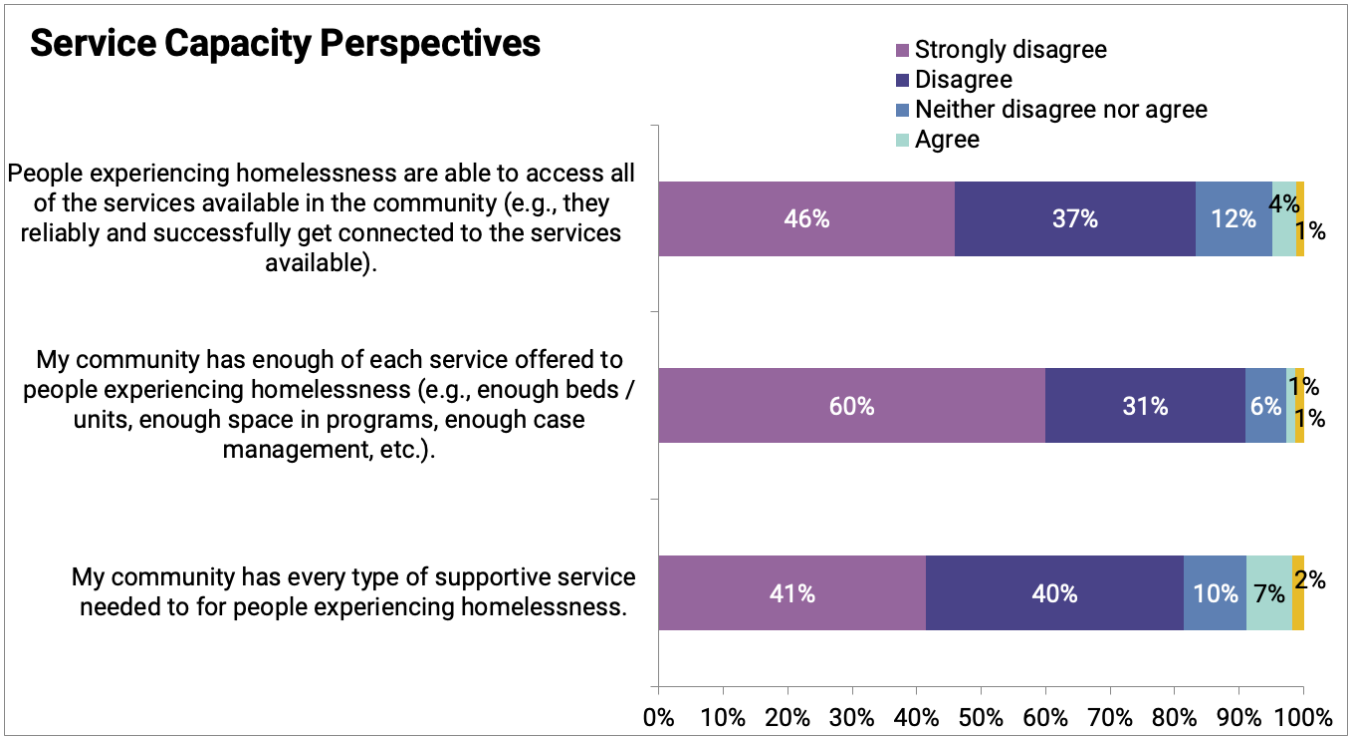
- "Requirements needed are too high for people who need them, they often are available when it's already too late, and folks do not know about them and there are not enough people helping with accessing them for them to be effective. Folks often are focused on base needs first, and without having those base needs met, and unable to access the other supports they could utilize that would help them." – Survey Respondent

Service Capacity

Similar to the above data, respondents indicated that their communities do not have all of the types of services needed, do not have enough of the services available, and that people experiencing homelessness may not be able to access all of the services.

When asked to describe the barriers that clients may have in accessing the services they need, respondents indicated that there are not enough of the services available, long waiting periods, a lack of transportation to access services, lack of documentation, and other interconnected barriers:

- "**Long wait times** for healthcare, beds are full, not enough case management, not enough vouchers, too much documentation/red tape when trying to access services, clients have legal barriers or evictions that prevent them from utilizing vouchers, not enough beds for survivors of domestic violence, nowhere near enough rapid rehousing for single adults, clients don't feel safe in the shelters for various reasons, clients keep getting pushed to spots that make it incredibly difficult for outreach to find them and continue providing services for them, lack of access to technology for clients." – Survey Respondent
- "Homelessness has been criminalized by Salt Lake City. People's dignity and rights have been removed; they are always in fear that they will be involved in a camp abatement. **Those experiencing homelessness have no reason to trust the people offering services.** We need to show our homeless neighbors some respect and compassion and not criminalize them. And we need to remove the systemic barriers to basic needs." – Survey Respondent
- "Trauma, instability, criminal backgrounds, substance use, access to healthcare, documentation, employment, education, food instability, shelter space **and not enough staff/ staff underpaid and overworked**, lack of service capacity to truly spend the time and energy working with folks to overcome barriers and provide wraparound services to help address barrier removal because it is often so intensive and staff are stretched too thin to properly support people in the capacity needed to help them access all the services." – Survey Respondent



Prevention and Diversion

Related to the above section's comments on prevention and diversion services as a part of supportive services, we also specifically asked survey respondents about what specific prevention and diversion strategies are most needed.

Top 3 Prevention and Diversion Services		
Rank	Strategy	Percentage of Respondents who Selected
1	Homeless prevention financial assistance	66.61%
2	Homeless diversion financial assistance	62.62%
3	Connections to services and/or public assistance benefits	35.78%

The first two related to financial assistance were ranked far above the other options listed.

- "**Helping people not lose housing in the first place is critical**. Access to assistance with eviction prevention and mediation, financial assistance, and ongoing support for those in need is cheaper and more effective than the alternative. Follow-up to provide budgeting and employment assistance should be part of financial assistance to help prevent the repeated need for financial support." – Survey Respondent
- "Assistance that is available quickly and low-barrier is crucial to help those who have just become homeless or at high risk. Make this funding easy to access, not have a bunch of requirements, and educate individuals that it is available for them." – Survey Respondent

Evictions

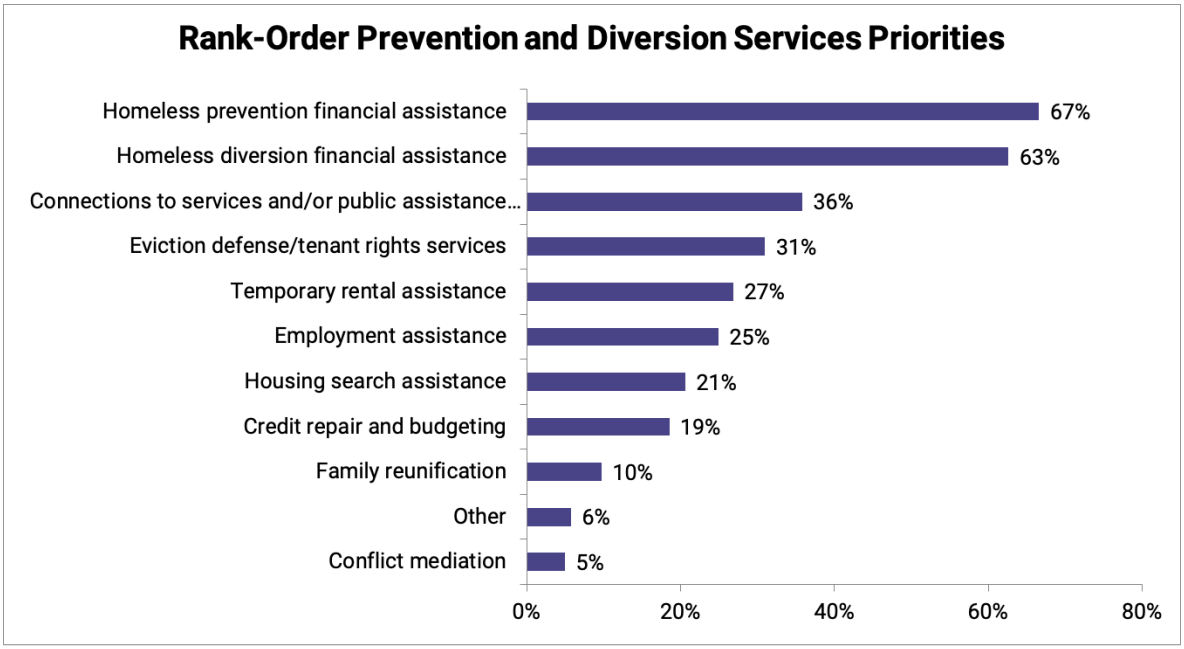
Respondents also discussed the issues surrounding evictions and how that contributes to homelessness as well as difficulty getting into housing once unhoused:

- "In Utah it is worse to have an eviction than it is to have criminal charges. **It is almost impossible to be housed with an eviction on your credit** and with the pandemic a lot of individuals and families have this due to medical needs, loss of employment, and many other reasons. They need help to be able to qualify for rentals, then to find them and get into them. Application fees can be impossible on someone or a family already struggling to feed themselves and/or their children. Let alone pay for all the fees needed to be housed." – Survey Respondent
- "Bad credit and evictions are a huge barrier for people getting into a place. So **if we can help people with fixing their credit scores and staying in a place or helping to pay for them not to get an eviction, they would be the most helpful when they find a new place**." – Survey Respondent

Housing Availability and Policies

While prevention and diversion financial assistance were noted as crucial, respondents also noted that this financial assistance needs to be coupled with an increase in affordable housing in the community, along with other policy changes to allow those with evictions, criminal records, or poor credit get into housing:

- "There's a less than 2% vacancy rate for housing in Salt Lake. **So even if someone has a voucher, many people have trouble finding a unit within their voucher standards before it expires**. Many people think vouchers are the solution to all, but searching for a unit, especially when someone has barriers (evictions, criminal background, poor credit, etc.), they still may not even get into housing." – Survey Respondent
- "Utah legislature is filled with real estate investors, developers, and landlords. Laws protect landlords, and squeeze renters. I'm a homeowner, and even I think I have too much power over non property owners. **There should be regulations on allowable rent increases during a fixed time**." – Survey Respondent



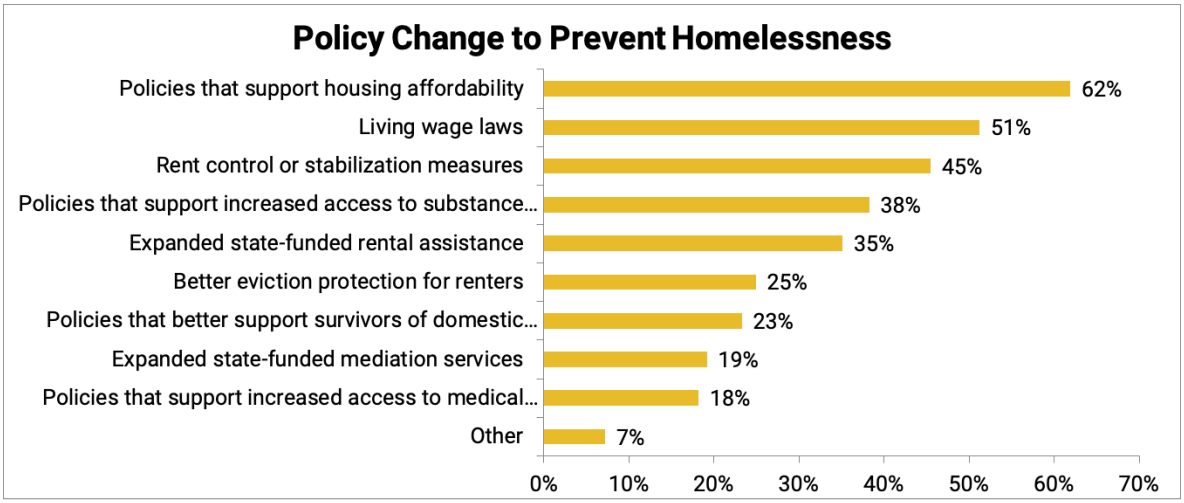
Policy Changes to Prevent Homelessness

In order to enact many of the potential strategies or solutions to homelessness touched on in this survey, the State, along with its counties and cities, will need to consider and implement policy changes that address the causes of homelessness. Survey participants were asked to select the top three policy changes they could support to help prevent homelessness:

Top 3 Policy Changes to Prevent Homelessness

Rank	Strategy	Percentage of Respondents who Selected
1	Policies that support housing affordability	61.90%
2	Living wage laws	51.23%
3	Rent control or stabilization measures	45.48%

In alignment with the rest of the survey, respondents advocated for policies that support housing affordability, living wage laws, and rent control.



HEALTHCARE

Respondents indicated that they believe the greatest need for healthcare falls into behavioral healthcare, followed by mental health support and then general medical care.

Top 3 Healthcare Services		
Rank	Strategy	Percentage of Respondents who Selected
1	Behavioral health care	91.30%
2	Mental health support	88.77%
3	Medical care	69.15%

Respondents explained that it seems like behavioral healthcare is underfunded and understaffed:

- "Mental and behavioral health seem to be major factors for homelessness, and it seems that these are areas where we are greatly underserved and understaffed." – Survey Respondents
- "Mental health services need to be improved across the board. There should be more service providers that provide outreach and emergency services for individuals experiencing crises." – Survey Respondent

Respondents emphasized that, while healthcare is definitely needed to help solve homelessness, it needs to be paired with housing:

- "Housing ends homelessness; accessible/affordable health care options can keep people from being unable to afford their housing because of medical costs." – Survey Respondent

Behavioral Healthcare is Not a Solution for All

Respondents noted that, while behavioral health may be where the most need is, that is not necessarily reflective of what the general population of those experiencing homelessness need:

- "While a significant number of those experiencing homelessness have mental health and behavioral health issues, the majority of people don't. **It is critical to ensure that those who need targeted services have access to it, but general medical (preventative and acute care) and dental are also huge**." – Survey Respondent

Survey participants also emphasized that healthcare should be provided, but not required:

- "Not all unsheltered folks need or want mental healthcare. **Being medicated or treated by a mental health professional should not be a barrier to access for resources**." – Survey Respondent

Housing First

Similarly, participants advocated for a Housing First approach to providing services:

- "These services are critical but often don't have the impact we'd hope when the person is still homeless. **These services are most impactful when the person has housing or a stable place to stay**." – Survey Respondent
- "Mental health/ general wellbeing is a larger need. **Once housing needs are met (the foundation for safety/stability), the next support is to support overall mental health/wellbeing**. Most all of us need additional support these days that things will be 'okay'." – Survey Respondent
- "Without greater housing opportunities, homelessness will remain. After receiving medical/mental-health care, **people still will have nowhere to go**." – Survey Respondent

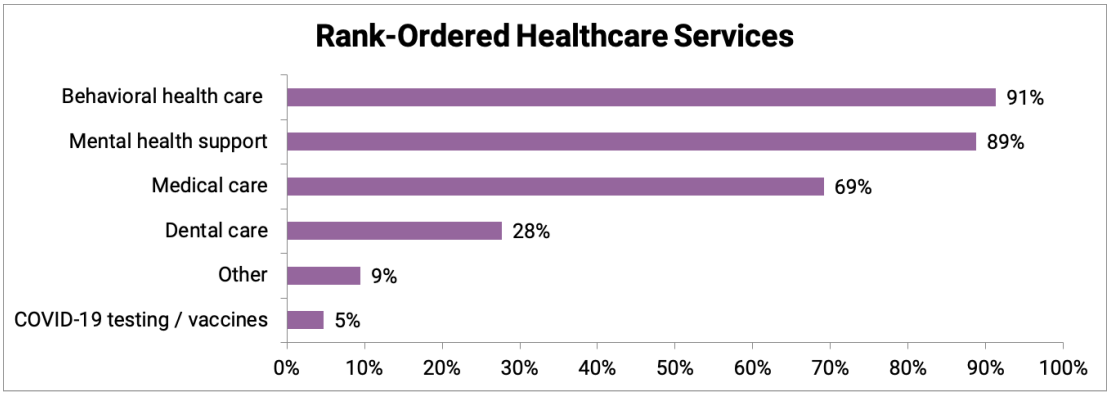
Cost of Healthcare

Overall, numerous participants described that healthcare is expensive, and that can be both a cause of homelessness and a barrier to receiving quality healthcare once a person is unhoused:

- "Medical debt is a significant contributor to financial bankrupts and vulnerability for many people, including middle-class people with employer-based health care. Given that most people, especially

renters, live paycheck-to-paycheck, **it does not take much in order for a medical expense to become a significant burden and contributor to someone's homelessness**. We need to lower healthcare costs and access by passing state legislation to expand medical coverage to all Utahans, regardless of income." – Survey Respondent

- "**Healthcare is so expensive and daunting**, even for those of us with jobs and insurance. Medical care needs to be more accessible." – Survey Respondent
- "The average American has little or no savings, so **when a medical emergency strikes, that could be the breaking point for many**." – Survey Respondent



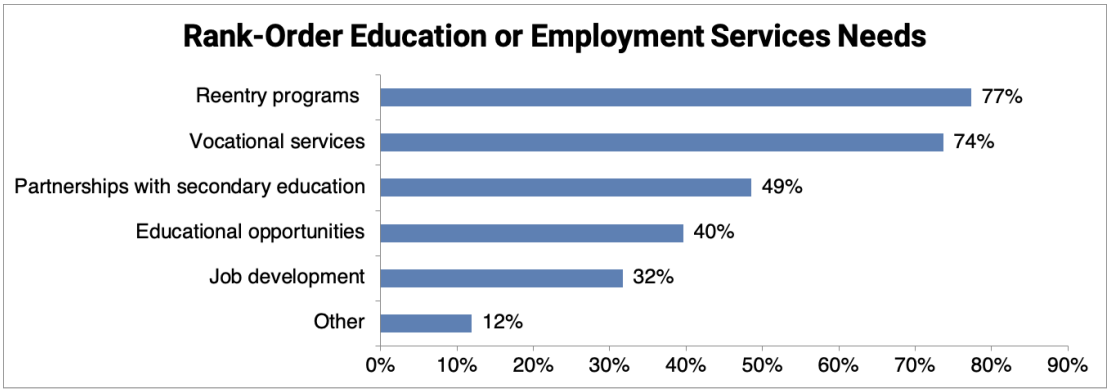
COMMUNITY COORDINATION AND EDUCATION

Participants were asked "Which of the following **community education and coordination** solutions does your community need to help solve homelessness?" The top three solutions were as follows:

Top 3 Community Education and Coordination Solutions		
Rank	Strategy	Percentage of Respondents who Selected
1	Policy changes to prevent homelessness	65.73%
2	Elected-official education about homelessness	57.28%
3	Partnership / coordination across agencies	53.52%

Respondents listed out specific areas that they believe the community and elected officials need education on related to homelessness, such as trauma-informed care, laws that harm the unsheltered population, and the importance of having a variety of housing in neighborhoods (cited as a way to combat "NIMBY" ism). They also described coordination needs, such as between housing programs and other service systems (e.g., healthcare).

- "**Education, advocacy, and initiatives to incentivize landlords to give homeless individuals a chance in housing**. Many are denied housing and unable to get their own place despite having a voucher that will pay for it. Even more landlords are not very understanding with applicants who are homeless." – Survey Respondent



EDUCATION AND EMPLOYMENT

Survey respondents suggested the following as the top three education or employment services that are needed in their communities to help address homelessness:

Top 3 Education or Employment Services		
Rank	Strategy	Percentage of Respondents who Selected
1	Reentry programs (e.g., for those leaving the criminal legal system)	77.39%
2	Vocational services (e.g., support to help people gain employment)	73.73%
3	Homeless service partnerships with local and community college or universities	48.57%

In line with the above ranking, respondents explained that having a history of incarceration can make education and employment opportunities difficult to acquire:

- "Severely lacking is the support and opportunity for formerly incarcerated individuals to become independently stable and successful. **There are systemic barriers that keep them from gaining stable employment** and their voice is taken away in our government by restricting their access to vote." – Survey Respondent

Survey respondents also pointed out that the same barriers that make it difficult for these individuals to acquire employment also make it difficult for them to find housing:

- "Reentry programs are needed not only in helping people get jobs, but **we also need to make it easier for people with criminal records to get housing**. Many people are forced into homelessness because they cannot find a place where they can sign a lease because of their record." – Survey Respondent

Living Wage

Respondents emphasized that, while these services may be helpful, they will not be beneficial if individuals are not able to make a living wage:

- "Ultimately, employers need to pay more and be willing to hire people experiencing homelessness." – Survey Respondent
- "I know the minimum wage is not a service, but it's really the core of the issue. We don't necessarily need more jobs; we need more jobs that pay a living wage. **You can have all the services and programs you want, but if they go through those programs only to be paid $10/hour, they will not be able to afford housing**. Many people experiencing homelessness have jobs, but their jobs don't pay enough to afford housing." – Survey Respondent
- "Ultimately, **employers need to pay more and be willing to hire people experiencing homelessness**." – Survey Respondent

Housing First

Respondents again emphasized the need for a Housing First approach when thinking about employment and education:

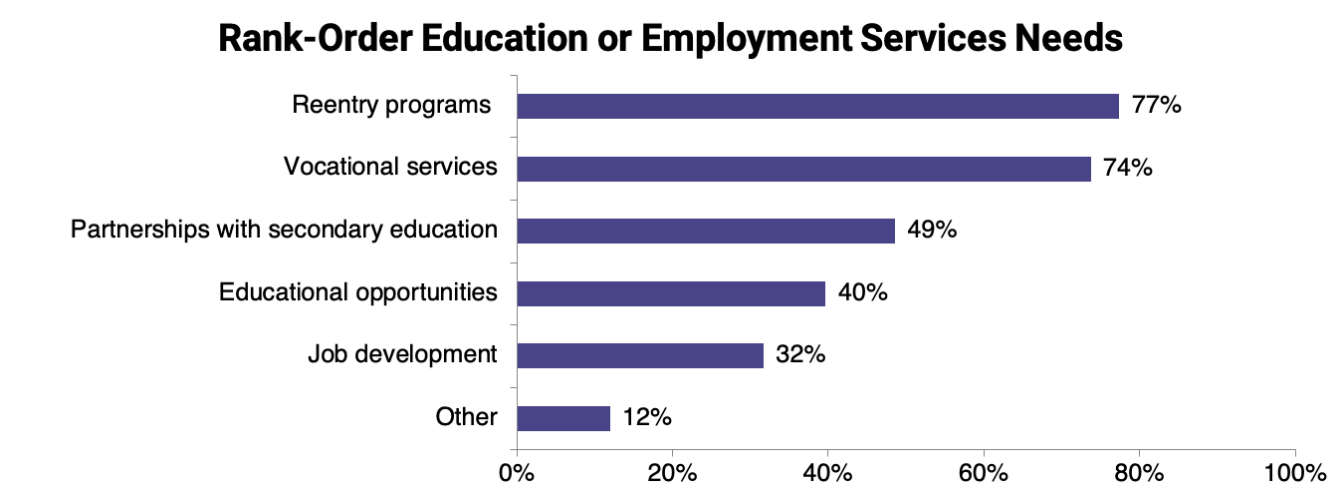
- "They need *housing* before they can really commit to a job. Where will they keep their work clothes? How will they shower? Where will they get rest so they can perform at a job? **Job options are great, but they are meaningless until we get these people *housed***. We lack affordable housing. We lack housing without restrictions. Make is easier for people to become eligible for housing, and you will be amazed at how quickly our homeless population decreases." – Survey Respondent
- "Almost all our clients express the need for a stable home before they can even think about working

again." – Survey Respondent

- "Education and/or employment services will not help solve homelessness. Throughout my years working with homeless individuals and families, I have learned that they are in crisis and their top priority is shelter, food, and safety. **We need to take them out of the crisis situation so they can focus on employment and education**." – Survey Respondent

Similarly, respondents pointed out that, until other barriers to engaging in education or employment programs are addressed, they may not be successful:

- "Work programs, temp work programs, and skill development would be helpful, *and* **we need additional medical and behavioral services so that clients can address immediate medical or behavioral health needs so that they can be productive in these programs**." – Survey Respondent



UNSHELTERED SOLUTIONS

Survey participants were asked to select the top three strategies they would support to address unsheltered homelessness:

Top 3 Solutions for Unsheltered Homelessness

Rank	Strategy	Percentage of Respondents who Selected
1	Permanent supportive housing	69.32%
2	Affordable permanent housing	62.66%
3	Hotel/motel conversions to permanent housing or shelter	43.83%

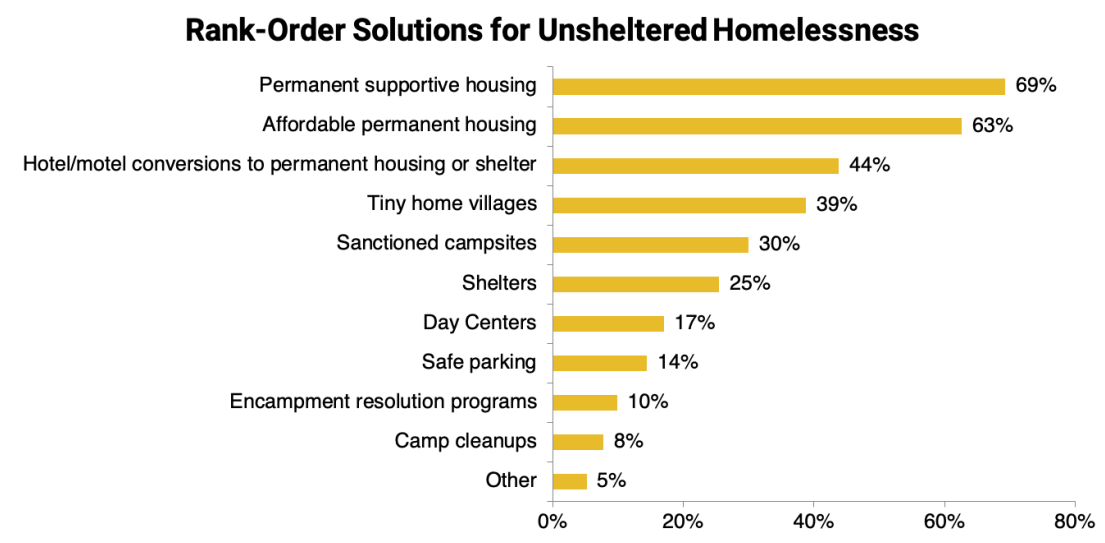
Parallel to the rest of the survey data, respondents indicate that permanent and affordable housing are the top solutions they would support to help address unsheltered homelessness in the state.
In the open-ended responses, participants offered support for legal camping and advocated for incorporating all of the listed strategies for unsheltered homelessness. Further, respondents advocated for stopping camp abatements and cleanups, citing how harmful this is to the unsheltered community.

- "**All camping should be legal.** I am shocked that camp cleanups is still worded as a potential solution to unsheltered homelessness given that we know it does not work. Sanctioned campsites are problematic because you are essentially dictating when and where it is legal for a human being to exist when the current policies and economic possibilities banish individuals into unsheltered homelessness. Tiny home villages often seem to be continuously posed as housing for all when often there are hidden requirements for individuals who wish to reside there." – Survey Respondent

- "I do believe that there are people experiencing homelessness who do not want 4 walls and a roof. We need to do a better job at providing alternatives. This might help with those who are sleeping on the street and help the community feel safer as a result. **Forcing people to 'move' or 'leave' by putting up fences or policing areas is not the solution - it only transfers the issues and challenges to another city or neighborhood**." – Survey Respondent
- "I am strongly opposed to camp cleanups and abatements. We should allow people to develop communities; **if the state is unwilling or unable to provide sufficient support to homeless individuals then we should *not* destroy the support networks that they create**. If homeless shelters were designed to aid individuals, and create environments of comfort and safety, rather than punish them for being poor and homeless with increased surveillance, restrictions, and policies, more people would choose to use them. As it is, there is still more demand for beds than there are beds, despite the fact that people experience terrible things in homeless shelters. I selected affordable permanent housing as one of the three solutions because that would support people in the long run and create a society where people are less likely to become homeless; but we are already at a point where too many people are homeless and need support, so we need to expand shelter capacity and services to help them." – Survey Respondent

While respondents overwhelmingly objected to encampment resolution and camp cleanups (and only 8-10% of respondents selected these as potential solutions to unsheltered homelessness), a small number of respondents also expressed frustration with encampments.

- "Homeless camps should not disrupt a city or business or its citizens. Follow the law." – Survey Respondent
- "Just keep people off the streets." – Survey Respondent



SUBPOPULATIONS

Survey participants were also asked which groups experiencing homelessness need the most focus or are most at-risk in their community.

Top 3 Groups Experiencing Homelessness Who Need the Most Focus

Rank	Strategy	Percentage of Respondents who Selected
1	Those with a mental illness	51.13%
2	Families with children	38.51%
3	Those who are chronically homeless	35.76%

Top 3 Groups Most At-Risk of Homelessness		
Rank	Strategy	Percentage of Respondents who Selected
1	Those with a mental illness	65.54%
2	Those with a substance use disorder	48.15%
3	Criminal justice-involved individuals	32.53%

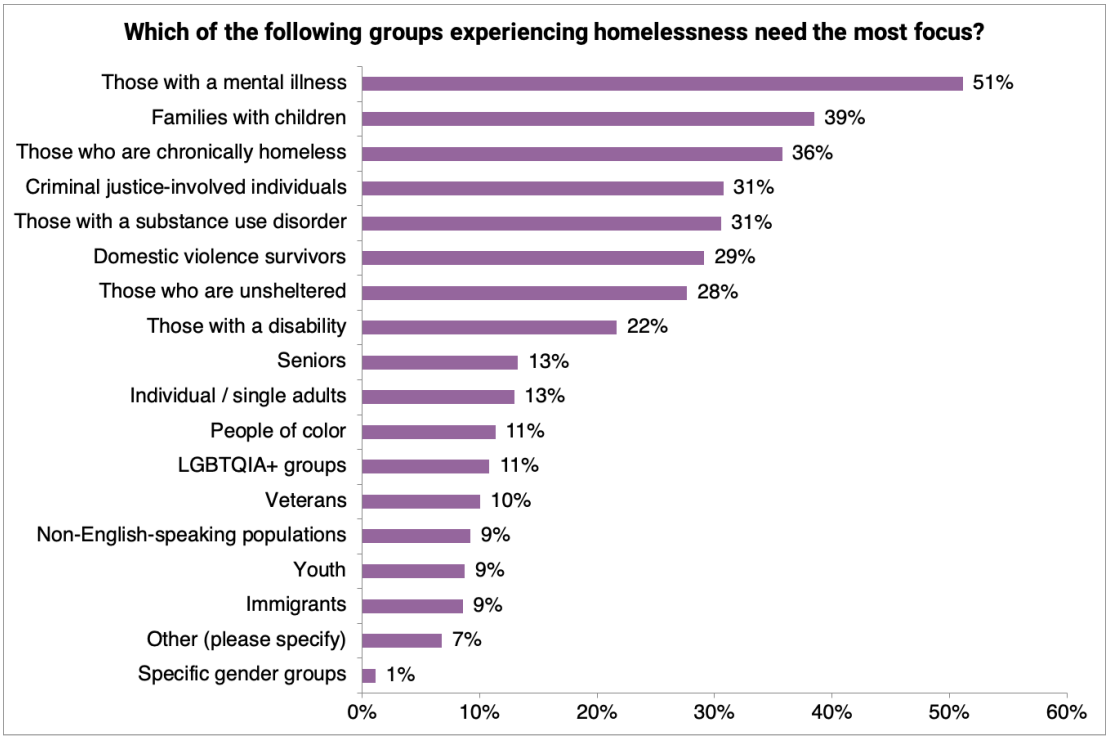
Throughout the open-ended responses to these questions, participants stressed that every group listed needs to be supported and have services available to address their particular circumstances. Importantly, there is overlap between all of the groups listed, and approaches to supporting these groups should consider the intersectional identities and experiences that each individual is facing.

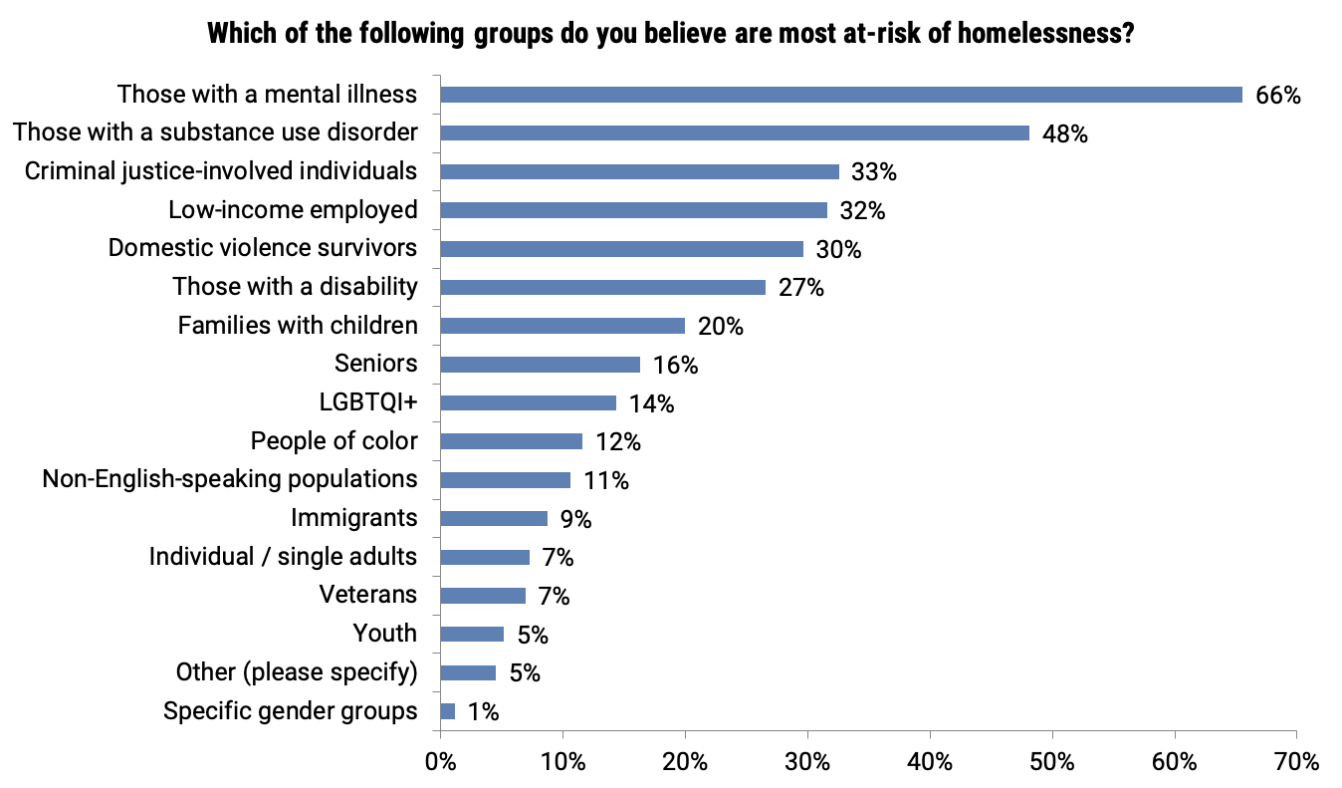
- "The problem with this list is that they all need assistance... Everyone should have a home. Those with children should take precedence. Those with disability or having been a victim of DV and those marginalized communities need extra support." – Survey Respondent

Some respondents, however, reported their perceptions that the majority of people experiencing homelessness are in need of mental health services and/or substance use.

- "High majority of those struggling with homelessness struggle with mental illness and substance abuse and are in the justice system somewhere." – Survey Respondent
- "Most homeless people I encounter seem to suffer from mental health issues." – Survey Respondent

These comments were outliers in the survey at large but reflect the challenges described by other respondents in educating community stakeholders and aligning communities around shared solutions.





PERSPECTIVES ON THE CAUSES OF HOMELESSNESS

Survey participants were asked to select what they believe to the top three causes of homelessness in their communities.

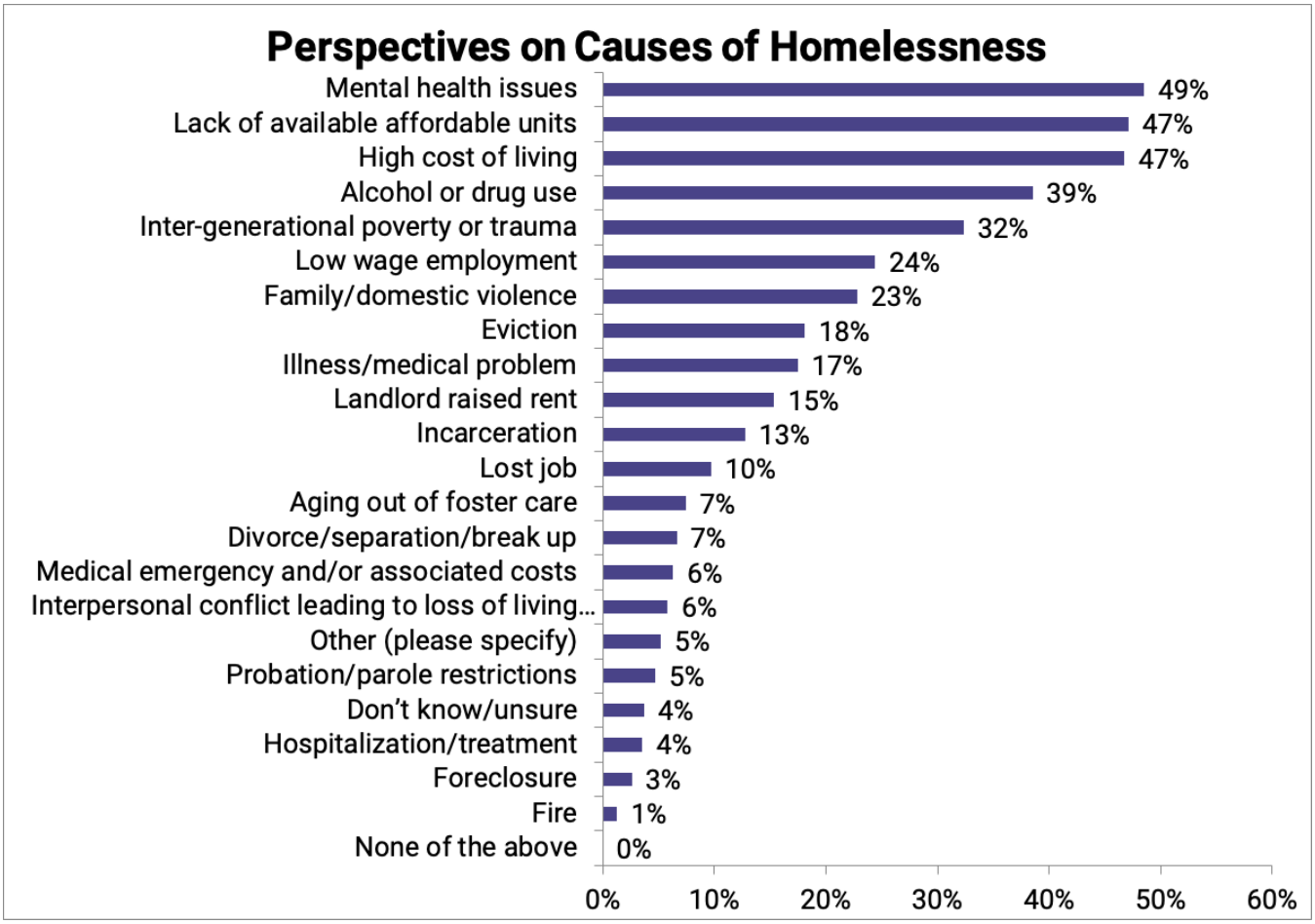
Survey Respondents' Opinions on the Top 3 Causes of Homelessness in their Communities		
Rank	Strategy	Percentage of Respondents who Selected
1	Mental health issues	48.54%
2	Lack of available affordable units	47.09%
3	High cost of living	46.76%

Survey respondents reported mental health, lack of affordable housing units, and high cost of living as the top three causes of homelessness.

- "The cause of homeless is poverty. The mental illness myth needs to be expelled. There may be truth to it when discussing the traumas of living while homeless, but not as a cause. Entering the realm of homelessness, people become vulnerable to any ailments, such as declining mental health or crime or substance abuse or health problems." – Survey Respondent
- "Many of our homeless appear to be physically or mentally ill. The cost of living associated with medical expenses creates an unmanageable barrier to people remaining housed." – Survey Respondent
- "I think mental health is often overlooked and stigmatized. Almost every person I know has some form of depression or anxiety. Every single person experiencing homelessness is living in survival mode every single day. They have to search for food, water, and shelter, all while carrying all of their earthly possessions with them at all times and trying to protect their bodies in the meantime. They do not sleep for fear of being attacked or robbed. Their bodies are constantly in a state of adrenaline. If that does not cause at least a little 'mental health issue' then I do not know what will. Left untreated, these can inhibit a person's ability to function." – Survey Respondent

- "While all of these things may increase your risk of becoming homeless, the things that are more direct 'causes' are lack of affordable and supportive housing units. If these types of units were sufficient in the community, people would not be losing their housing because of things like drug use or mental health/medical problems or because of financial concerns. Added support would help them maintain their housing." – Survey Respondent

While there is an abundance of research providing data on the causes of homelessness, this question can help us understand community perspectives of homelessness – the perceptions and beliefs that community members hold toward people who are unhoused, which can help the State approach community alignment in solutions to homelessness.



OTHER FEEDBACK

In addition to providing direct responses to the survey questions, several respondents offered perspectives on the survey itself.

- "I am a researcher at the University of Utah who is highly invested in the wellbeing of people experiencing homelessness and frequently interviews individuals experiencing homelessness. Based on my research-based understanding of homelessness in Utah, **I am deeply concerned that this survey is asking folks to rank/prioritize actions that can and should all be done in tandem**. The community at-large and policymakers should be educated about homelessness, not just its causes and potential solutions but also the lived experiences of individuals who have or are currently experiencing it in order to instill humanity in our discussions surrounding homelessness. At the same time, we should be instituting housing first policies immediately that truly advocate for housing first without pre-requisites. These policies should be accompanied by access to healthcare (mental and physical), access to employment resources, mentoring, community spaces, food and clean water, and an end to

all abatements. With regard to SLC's history of inhumane and morally wrong abatement procedures, an individual's survival and existence must not only be made legal but be decriminalized in all forms. Open bathrooms, showering facilities, and safe-use spaces should be built in areas of high need. Public transit should be free throughout the city. Empathetic and welcoming education/vocational training programs should be made accessible for those experiencing homelessness and should directly involve resource providers. And so much more. This all is rooted in (1) a need for funding - we need to prioritize money in all discussions where we aim to end homelessness - and (2) a deep need to develop empathy within our citizens and especially those making the decisions which ultimately decide life or death for those experiencing homelessness in SLC." – Survey Respondent

- "I think that, wherever possible, solutions to homelessness should come from collaboration with homeless individuals. They are the ones who will know their own needs the best, and they will know more than anyone about what solutions are actually effective." – Survey Respondent
- "If you are not already doing so, I urge and implore you to **ask every homeless person you can possibly find** in the whole state, to **learn from them directly what their actual stories and needs are**. They know their issues and needs intimately; the rest of us can only guess, and we will often get it wrong, which leads inevitably to ineffective and actively bad 'solutions'." – Survey Respondent

Appendix 4: Stakeholder Interview Analysis

OVERVIEW AND METHODOLOGY

In order to expand upon the data previously collected and analyzed, as well as to move the strategic plan towards development of tangible goals and strategies, Homebase conducted interviews with the following groups and individuals:

- Local Homeless Councils (LHCs)
- Continuum of Care leadership
- State agencies (e.g., Department of Health and Human Services; Department of Corrections; Department of Public Safety)
- Providers (e.g., Emergency Shelter leadership; Domestic Violence providers; Eviction and Rental Assistance providers)
- Persons with lived experiences of homelessness (e.g., Community Advisory Board; Youth Advisory Board)
- Strategic Partnerships and Funders (e.g., Utah Impact Partnership; Prosperity Center of Excellence; Community foundation philanthropy groups)

These conversations focused on overarching challenges related to homelessness and what strategies might be needed related to housing and supportive services.

THEMATIC ANALYSIS OF NEEDED STRATEGIES TO ADDRESS HOMELESSNESS

Overall, stakeholders across the state emphasized rapidly growing communities that need affordable housing and supportive services, reflecting both the HMIS data and the survey data presented earlier in this document.

Affordable Housing and Partnerships

Interviewees discussed the current lack of affordable permanent housing, some of the causes of this dearth, and how this creates barriers to addressing homelessness. Stakeholders also discussed the need for various partnerships and support in order to make affordable permanent housing a reality, including partnerships between governments, developers, and landlords.

Affordable Permanent Housing

- "There is a lack of housing, a lot of inventory is going to Airbnb or student housing. A lot of people on fixed incomes have been priced out. A lot of seniors going into homelessness. There are a lot of people who have jobs but nowhere to live." – LHC Representative.
- "We need to dedicate funding to deeply affordable housing. Not more shelters – I think that is the wrong approach. Yes, we need to have the ability to deal with homelessness. But deeply affordable housing is what we need to do that. The housing first model is what I want to follow, stable housing first. When we see the biggest improvement is when the clients are paying for the housing themselves, they have some ownership in that. We see low turnover in those facilities where they are paying rent." – LHC Representative.
- "A huge barrier is housing. If you are homeless that means you have no home. The prices of housing in the state make it much more difficult to house people. In this type of economy, it is hard to get people into something they can call home that is safe and stable. We don't have enough truly deeply affordable housing in the state." – County Representative.

- "The biggest barrier to ending homelessness is affordable housing. Our county has very expensive housing, and it is very difficult for anyone earning less than $25/hour to find something they can afford. If you add barriers on top of that, such as substance abuse or a criminal background, etc., landlords can be very picky because there are no vacancies. That is a big barrier to people getting in housing." – LHC Representative.
- "We have lost a lot of private landlords, no one is incentivizing people using properties for rentals. Property managers have a lot of criteria for renting units, they don't fix things in their units. If you don't make 2-3 times the rent, that is an issue." – Utah Community Action Representative.

Developer Partnerships and Support

- "It would be great if, when developers go to city councils/rural areas, they were told that you have to do a percentage of affordable housing. The county has a housing authority that does not believe they should provide housing to people who are homeless, but they should be building housing other than workforce/voucher housing." – LHC Representative.
- "The point on development where we get hurt is the focus on making money. There should be more education on this with developers to show how these projects can be financially viable and to be able to show developers different successful models." - LHC Representative.

Landlord Partnerships

- "There needs to be an incentive for landlords to have deeply affordable units for the senior population. They are in the 30% AMI range, maybe 40%. But we have run out of that housing. A lot of these incentives are in the mixed range, so higher AMI. So, unless you have voucher you don't get 30%. Many seniors don't qualify for the vouchers." – LHC Representative.

Supportive Services

Resource Centers (especially for suburban or rural areas)

- "A resource center/drop in works to build connection, wanting to keep connection open with clients, celebrate success, continue to educate community about what is successful." – LHC Representative.
- "The resources to provide a true homeless resource center has been a struggle. We know what we want to do, what works, but we haven't been resourced to serve people experiencing homelessness. The State Council has looked at sheltering system as a way to reduce homelessness. They look to us and say, we changed the system, but there is more unsheltered homelessness, and so they ask us what we are doing wrong. Need a focus on support services. We have been talking about the fact that we are the last resort, so we have people with severe needs, and we don't have the resources to support them. They need more than just congregate shelter but that is all we have, so we are adding to their trauma." – Provider / LHC Representative.

Case Management / Housing Stability

- "We need to fund [more] staff positions to makes sure what we want to do can get done." – LHC Representative
- "We need more PSH with an emphasis on structured wrap-around services. Case management is critical for those who lack housing right now... It would be great to have a strategic plan that emphasizes case management." – LHC Representative.
- "We need increased housing vouchers for those people who are chronically homeless and higher need; need more case manager capacity to help sustain those people in their housing." – Emergency Shelter Provider.
- "There needs to be more case management and support for people exiting the criminal justice system. The cost of re-incarceration is high, and funds are better spent on case management, half way houses, and supports to keep people out of prison/jail." – Department of Corrections Representative.

Behavioral Health & Health Coordination and Staff

- "The state and the counties both have roles in how they are funding mental health for those with highest need. The current structure has a hole that our people fall through. We have known this for years, but that is a huge issue. The way our partners are funded prevents them from doing the outreach mental

health services our clients need. That is something the state should take on. State mental health should have that discussion - around behavioral health services." – LHC Representative.

- "Emergency Shelter is not a mental health hospital, but we are being asked to provide that type of care for individuals...we have elderly that we cannot house in assisted living, but they cannot take care of their daily functioning needs. The shelter is the gap that is trying to take care of these people, but we do not have capacity to meet their needs. We are trying to connect them to other systems that should be able to help them, but it is challenging because they don't always qualify for services and support." – Emergency Shelter Provider.
- "We currently are very assertively fundraising for an LCSW. We just need one to help with behavioral health crises. We need them to be able to meet with anyone in crisis no matter what insurance they have, etc. We have very little support for that in our system." – Provider.
- "Shelter is not the best environment for someone to be in treatment. They need to be in housing for that. We have the burden of trying to connect them to treatment, but they aren't stable enough, so we need to be able to support them in housing first." – Provider.
- "Hospitals are supposed to be investing in housing in communities. Can see data by state. When they do invest in that, you can see people are stabilizing. Utah is not investing any." – Utah Housing Corporation Representative.

Homeless Prevention

- "We need to focus more on preventing homelessness to avoid people from falling into our system, help keep people where they are." – Provider.
- "We don't have available affordable housing. You have people who are chronically homeless that need PSH, but then you also have people that were evicted because they can't afford their rent anymore. Prevention is housing." – Utah Homeless Council Member.

Overall Funding and Structure for LHCs

- "LHCs really need support and funding. Costs get absorbed in our organizations. There has to be more support so people can participate." – LHC Representative.
- "We need some identification of who is in charge of an LHC. A person or entity. Since no one is technically in charge, getting anything accomplished is nearly impossible." – Provider.
- "If you're new to an LHC you don't know what your role is. We need education in what is required for participation. The national perspective as well as the state and local perspective." – County Representative.

Equity

- "People of color and low-income communities have been more impacted, but it is not addressed. There is not cultural competency within [resource] centers. When we think about our homeless response, we are often thinking about white people who speak English. We don't meet the needs of people of color, immigrants, people who speak other languages [...] The wages are not keeping up with housing. If you go to a homeless center, people do not speak other languages aside from English, and people get frightened by that." – Utah Housing Corporation Representative.

Additional Considerations

- "We need to think about the long-term effects of having available housing to help future generations; not everyone needs 3,200 square feet of housing on a half-acre lawn; it can also be tiny home or trailer park. What about KOA [but amplified]: $25k can get a camping trailer, then be managed with case management. We need to think outside the box. We have lots of land, that's not the obstacle. Finding funding and getting it built is the obstacle." – LHC Representative.
- "We don't want certain areas to exclusively be affordable housing. Want to spread it throughout to make good connections to schools, grocery stores etc. We need to work on education across the state, so more people are willing to have these developments built in their neighborhood." – LHC Representative.

- "[The county] is less than 5% private property. If there is a lack of housing they are forced to push into agricultural land. Being able to be able to use federal land for affordable housing opens up a broader window of resources that was set up for federal land that states can use." – County Representative.
- "Developing some housing for people in crisis or DV opens up a little more opportunity. They also have a lot of youth that are couch surfing. Would be great to have resources to support those folks and impact couch serving." – LHC Representative
- "Transportation has to be addressed. If we don't have ways to get people to supportive services, what's the point? There is not a lot of county support on transportation." – LHC Representative.