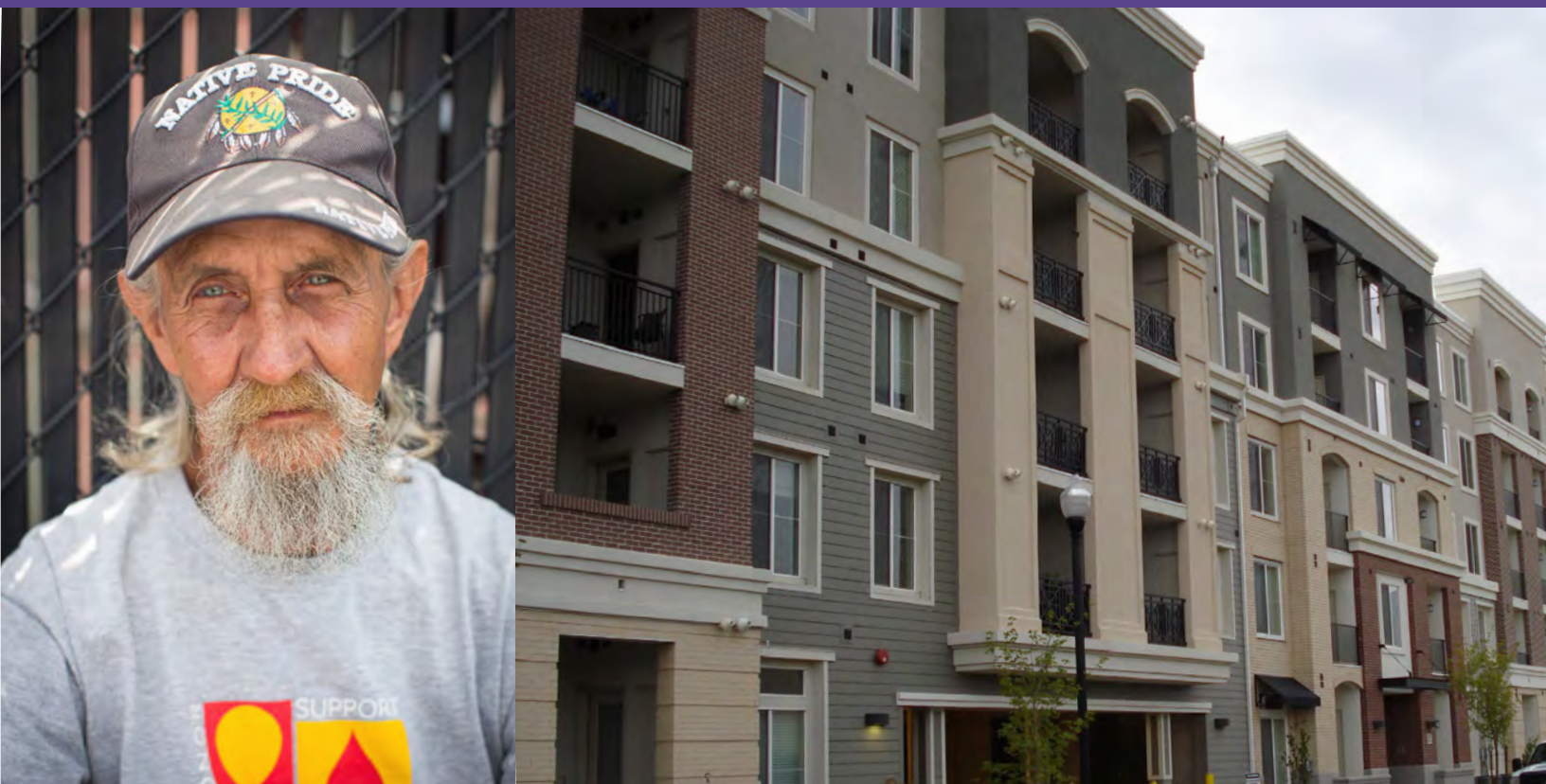


Utah's Approach to **HOMELESSNESS**

August 2018



**WORKFORCE
SERVICES**
HOUSING & COMMUNITY
DEVELOPMENT

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INTRODUCTION

Homelessness is a complex issue. Contributing factors can be personal, societal and cultural and include job loss, divorce, lack of affordable housing, mental illness, physical disability, substance abuse and many more. People experiencing homelessness suffer negative health effects and their children do more poorly in school. On average, they are more likely to be a victim of crime and to be arrested. Large numbers of people living on the streets or in emergency shelters can create public health hazards, with waste, drug use and disease spreading easily.

In Utah, elected officials, government agencies, business owners and community organizations have long recognized the seriousness of homelessness for individuals and communities and have come

together in partnership to create solutions. The State Homeless Coordinating Committee, which makes funding decisions and provides feedback and recommendations for the state’s policy makers and service providers, includes the Lt. Governor, city and county mayors, community advocates, business leaders, law enforcement and nonprofit service providers. They support a robust homeless services system further described in this document.

The Department of Workforce Services publishes an annual report on Utah’s latest homelessness numbers, including data from the Homeless Management Information System (HMIS), Point-in-Time count and performance measures. Find the latest at housing.utah.gov.



“Homelessness is an issue that we have to approach from every angle. We need government, private businesses, churches, community organizations and everyday citizens involved. Working together, we can make a significant difference for our neighbors experiencing homelessness.”

-Lt. Governor Spencer Cox

MEASURING HOMELESSNESS

Homelessness is a challenging issue that is experienced by a fluid population. The complexity of homelessness is underscored by its many definitions, even among federal agencies. The scope of homelessness is difficult to measure because homeless individuals have no fixed residence and move in and out of homelessness, often for short periods of time. In order to measure this population, community leaders must rely on a variety of data sources to inform them about trends, demographics and outcomes.

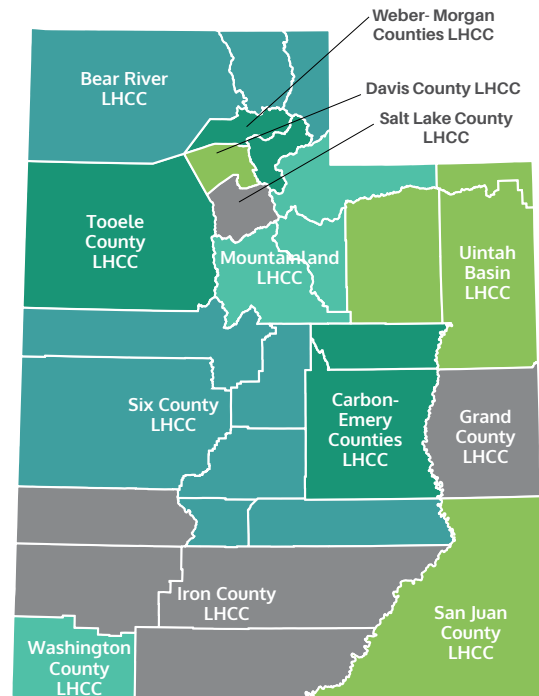
The prevailing data used is collected in a Homeless Management Information System (HMIS), which is a web-based application where homeless service providers can input and track information about individual clients (read more about HMIS below).

THE CONTINUUM OF CARE AND LOCAL HOMELESS COORDINATING COMMITTEES

The Continuum of Care (CoC) is the official body representing a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. Utah has three CoCs: Salt Lake, Mountainland, and Balance of State. The Salt Lake continuum consists of Salt Lake County. The Mountainland continuum consists of Utah, Summit, and Wasatch counties. The Balance of State continuum consists of all other counties not contained in the other two continua.

The large area covered by the Balance of State Continuum of Care (CoC) poses a variety of challenges in coordinating efforts to meet the diverse and varying needs of those experiencing homelessness within its borders. As a result, the CoC has created 11 Local Homeless Coordinating Committees (LHCC), composed of counties with similar geographies and demographics. The LHCCs, under the direction of the CoC, coordinate services

LOCAL HOMELESS COORDINATING COMMITTEES



and carry out CoC initiatives, while ensuring that local needs and concerns are relayed to the CoC. Both the Salt Lake and Mountainland CoCs operate as respective single LHCCs.

THE DEFINITION OF HOMELESSNESS

Understanding terms helps define the work that needs to be done. There are many definitions of homelessness even within the federal governmental agencies. The variation in definitions between these agencies can further complicate data collection.

For example, some agencies, such as the Utah State Office of Education, are guided by other federal definitions and, therefore, include broader estimates, such as the number of school children living in “doubled-up” situations.

This report primarily refers to the U.S. Department of Housing and Urban Development’s (HUD) definition of literal homelessness as defined in the Final Rule of the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act), as described in the following four categories:

1. Individuals and families who lack a fixed, regular, and adequate nighttime residence, including a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution
2. Individuals and families who will imminently lose their primary nighttime residence
3. Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition
4. Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member (U.S. Department of Housing and Urban Development, “HEARTH: Defining Homeless” 2)



NOTE ON LITERAL HOMELESSNESS

This report utilizes HUD’s definition of literal homelessness that is found in the HEARTH Act. This definition of homelessness does not include individuals who move in with family or friends, a housing situation also known as “doubling up” or “couch-surfing.”

UTAH HOMELESS MANAGEMENT INFORMATION SYSTEM

In 2001, Congress asked HUD to take the lead in gathering better-quality data about homelessness.

In order to meet this objective, HUD required federally funded public and nonprofit organizations to implement homeless management information systems (HMIS). Although HMIS was initially mandated for use by specific federal funding sources, additional federal, state and local funding sources have begun to use HMIS as a means of data collection. The three Continua of Care in Utah have chosen to work together and have a single, statewide implementation of an HMIS known as UHMIS.

In Utah, HMIS software applications are designed to record and store longitudinal, client-level information on the characteristics and service needs of homeless individuals. The ability to study and analyze service utilization on both client and system levels is a key strength to an effective HMIS. HMIS implementations are vital in developing unduplicated counts, analyzing utilization patterns of people entering and exiting the homeless assistance system, and evaluating the effectiveness of these systems. HMIS contains client assessment data on housing barriers, income, and other factors that may contribute to their homelessness. The data is primarily self-reported.

HMIS is web based and allows homeless assistance providers to create a coordinated and effective housing and service delivery system. As communities come to understand the complex needs that people experiencing homelessness face, they are better able to provide a more responsive system of homeless service provisions.

Although HMIS is used by a majority of homeless service providers statewide, there are some agencies that do not actively enter data into the system. For example, due to confidentiality laws in the Violence Against Women Act, domestic violence service-provider agencies are not able to

share any identifying information about the people they serve, including names, through HMIS or any other system.



THE COMPLEXITY OF COUNTING

The Point-in-Time (PIT) count is a physical count of all homeless persons who are living in emergency shelters, transitional housing and on the streets on a single night. This count is conducted annually in Utah during the last 10 days in January and provides a snapshot of homelessness on a single night. The data gathered from the PIT can better inform community leaders and providers about who they serve and indicate where Utah stands in its work to help those experiencing homelessness relative to the nation.

The PIT is the result of extraordinary community collaboration and reflects a statewide effort to engage and assess the unsheltered population. The PIT requires participation by all shelters in the state of Utah, including shelters that do not normally participate in HMIS data collection. After the PIT data are collected, it is carefully validated, clarified, and cleaned in order to meet HUD's high data quality standards.

In addition to the PIT, a simultaneous annual inventory is conducted of all housing dedicated to the homeless. The Housing Inventory Count (HIC) is conducted to assess bed capacity against need as measured by the PIT. The number of clients enrolled in housing programs on a single night is compared to the number of program beds available that night. The resulting utilization rate informs communities about the capacity that currently exists within the homeless network and identifies housing types where additional capacity may be needed.

The HIC serves as an annual Point-in-Time count of housing dedicated to homeless individuals and families. For a program's bed to be counted in the HIC, homelessness must be included in eligibility determination. The HIC includes a variety of homeless housing options, including emergency shelters, transitional housing, safe havens, permanent supportive housing and rapid re-housing programs. While the PIT counts homeless families and individuals housed in emergency shelters, transitional housing, and safe havens, the HIC counts beds for those who are homeless in additional settings. As transitional housing programs have shifted and retooled to become better aligned with best practices as permanent housing programs—either rapid re-housing or permanent supportive programs – the number of homeless individuals and families captured on the PIT count has been affected, while the HIC reflects the shift in housing type.

The HIC examines the resources available to serve homeless people on the same night the PIT assesses the number of homeless individuals and families within the system. The number of clients enrolled in a housing program is measured against the number of beds available within that program. Comparing the number of people to the number of beds creates a snapshot of utilization of resources and system capacity.

NOTE ON TRANSITIONAL HOUSING

People who are housed in transitional housing during the Point-in-Time count are counted as homeless. When people change from transitional housing programs to permanent housing such as Rapid Re-Housing, they are no longer classified as homeless on the PIT count.

WHAT IS COUNTED ON THE PIT & HIC

POINT-IN-TIME COUNT:

Persons in:

- Emergency Shelters
- Transitional Housing
- Safe Havens
- Unsheltered Persons (people who are staying in public or private places not designated for or ordinarily used as a regular sleeping accommodation for human beings, including cars, parks, abandoned buildings, bus or train stations, airports or camping grounds during the hours between sunset and sunrise)

HOUSING INVENTORY COUNT:

Number of beds and units available on the night of the PIT, including domestic violence providers:

- Emergency Shelters
- Transitional Housing
- Safe Havens
- Permanent Supportive Housing
- Rapid Re-Housing
- Other Permanent Housing

THE FACES OF HOMELESSNESS

Homelessness is a complex social and economic problem that affects Utahns from all walks of life. While every demographic is represented among people experiencing homelessness, HMIS data and federal requirements focus on several subpopulations, namely chronically homeless, families, youth, domestic violence victims and veterans, each described below.



CHRONICALLY HOMELESS

Chronic homelessness is defined as an unaccompanied homeless adult individual (persons 18 years or older) with a disability who has either been continuously homeless for a year or more OR has had at least four separate occasions of homelessness in the past three years, where the combined occasions total a length of time of at least 12 months (U.S. Department of Housing & Urban Development, “HEARTH: Defining Chronically Homeless” 2). This population experiences a

variety of health and social challenges, including substance abuse, mental health disorders, criminal records and extended periods of unemployment. These challenges can pose significant barriers to maintaining stable housing.

The United States Interagency Council on Homelessness notes, “People experiencing chronic homelessness cost the public between \$30,000 and \$50,000 per person per year through their repeated use of emergency rooms, hospitals, jails, psychiatric centers, detox and other crisis services” (“People Experiencing”).

FAMILIES



While the consequences of homelessness are devastating for anyone, families are particularly impacted. National research from the National Alliance to End Homelessness suggests that families found in shelters generally have younger heads of households and that more than half of the children living in shelters and transitional housing are under the age of five (“2015 Policy Snapshot” 8). The stress and challenges of homelessness often contribute to the break-up of families and adversely affect the development of children (The National Center on Family Homelessness 4-5). Nationally, shelters and transitional housing programs supported about 157,000 families in 2015 (“2015 Policy Snapshot” 8). Of those families, national data indicate between 70 percent and 80 percent exit homelessness to stable housing within six months (9).

The negative impacts of homelessness on children are well documented. Nearly all aspects of life (including physical, emotional, cognitive, social and behavioral) are affected by homelessness (Hart-Shegos 2). Children benefit from the early intervention of housing stability and supportive services (3).

YOUTH

Youth, as identified on the PIT count, are unaccompanied persons under age 25. Little is known nationally about the scope of youth homelessness. As HUD Deputy Secretary for Special Needs Ann Marie Oliva notes:

One of the challenges that we face is that we lack sufficient research and data to help us make more informed decisions about what works to end youth homelessness. We know that the strategies that work for chronic and veteran’s homelessness are not always the right strategies for youth, but we need better data to craft youth-specific strategies. HUD requires communities to include youth experiencing homelessness in their Point-in-Time counts, and we are strongly encouraging communities to improve their outreach to ensure that all youth are counted and that programs serving youth are entering data into HMIS (“Youth Homelessness”).

The need for improved data prompted HUD to require the inclusion of runaway homeless youth data in HMIS (“Framework” 6).

UNACCOMPANIED YOUTH

Unaccompanied youth (as identified on the Point-in-Time count) are unaccompanied persons under age 25 who are not present with or sleeping in the same place as their parent or legal guardian and are not a parent present with or sleeping in the same place as his/her child(ren).

PARENTING YOUTH

Parenting youth are youth who identify as the parent or legal guardian of one or more children who are present with or sleeping in the same place as that youth parent, where there is no person over age 24 in the household.

DOMESTIC VIOLENCE VICTIMS

Safety is an especially important concern for those fleeing a domestic violence situation. Any information that is obtained from victims is not shared publicly but is tracked in an aggregated, de-identified form by the many domestic violence service providers throughout the state.

The 2018 PIT guidance made a major change in the way HUD counted survivors of domestic violence. In past years HUD had communities report all individuals who identified as having experienced domestic violence in the past; for 2018 HUD only included individuals who were currently fleeing a domestic violence situation in the PIT count of survivors. This redefinition resulted in a much lower domestic violence count than in previous years, but does not necessarily indicate a reduction in the number of domestic violence survivors experiencing homelessness.

VETERANS

In late 2009, the U.S. Department of Veterans Affairs (VA) announced an ambitious goal to end veteran homelessness. Since that time, the VA Salt Lake City Health Care System has been working in close collaboration with national and local stakeholders to prevent veterans from becoming homeless and help those who are homeless become housed as quickly as possible. Significant progress towards ending veteran homelessness has been made. Based on the nationwide PIT count, homelessness among veterans has been cut in half in the decade since the goal was established.

The state of Utah has been working closely with the VA Salt Lake City Health Care System, elected officials, community organizations and homeless service providers to make veterans a top priority and end veteran homelessness. Community partnerships are the key to making and sustaining progress. Various housing programs are available for homeless veterans and those at-risk of homelessness. Specific programs include

Housing and Urban Development - Veterans Affairs Supportive Housing, which is like a Section 8 housing voucher but also provides clinical and case-management services through the VA. The Grant and Per Diem program offers transitional housing with supportive services to help veterans achieve stability, increase their skill level or income, and obtain greater self-determination. Supportive Services for Veteran Families assists low-income veterans through rapid re-housing and prevention.

The VA Salt Lake City Health Care System's Homeless Program believes in a comprehensive, integrated approach to ending veteran homelessness. In addition to the community partnership programs mentioned above, VA offers the following programs to provide mental health, substance use and vocational rehabilitation services:

- Health Care for Homeless Veterans – an outreach program to identify and assist veterans
- Homeless Patient-Aligned Care Team – a specialized health care team providing medical and psychiatric care
- Veteran Justice Outreach – a diversion program for legally involved veterans
- National Call Center for Homeless Veterans

Developments in data sharing have improved communication and collaboration between agencies working to assist veterans. Weekly meetings are held to review a by-name list and coordinate efforts to quickly house veterans. Early verification of veteran status is essential to connecting veterans to the array of available programs and services.

Despite the gains being made, there is more work to do to address the many causes of homelessness among veterans. These include poverty, underemployment, lack of access to affordable housing, isolation from family or friends, mental health issues, or substance use that may develop or worsen as a result of service-related injuries, trauma, or housing instability. The VA is committed to working with the community and continuing efforts to end veteran homelessness.

SYSTEM-WIDE APPROACH TO PERSONALIZED SOLUTIONS

While every case of homelessness is unique, system-wide processes and tools allow for the collection of consistent, actionable data and help service providers to set up clients with the best chance of success. Several statewide tools, combined with the Housing First philosophy, help service providers and state agencies to gain a clear picture of homelessness in the state and to utilize the most effective and efficient interventions.

HOUSING FIRST PHILOSOPHY



“Housing First is a paradigm shift from the traditional ‘housing ready’ approach. According to the Housing First philosophy, everyone is ready for housing, regardless of the complexity or severity of their needs,” notes Ann Marie Olivia (“Why Housing First” 1). Housing First reduces thresholds for entry to housing, including sobriety and mandated treatment. National studies indicate that this approach produces higher housing stability rates, lower rates of return to homelessness and reductions in public costs stemming from crisis services and institutions (United States Interagency Council on Homelessness, “Housing

First Checklist” 1). Utah communities recognize the success and embrace the effectiveness of the Housing First approach to housing the homeless.

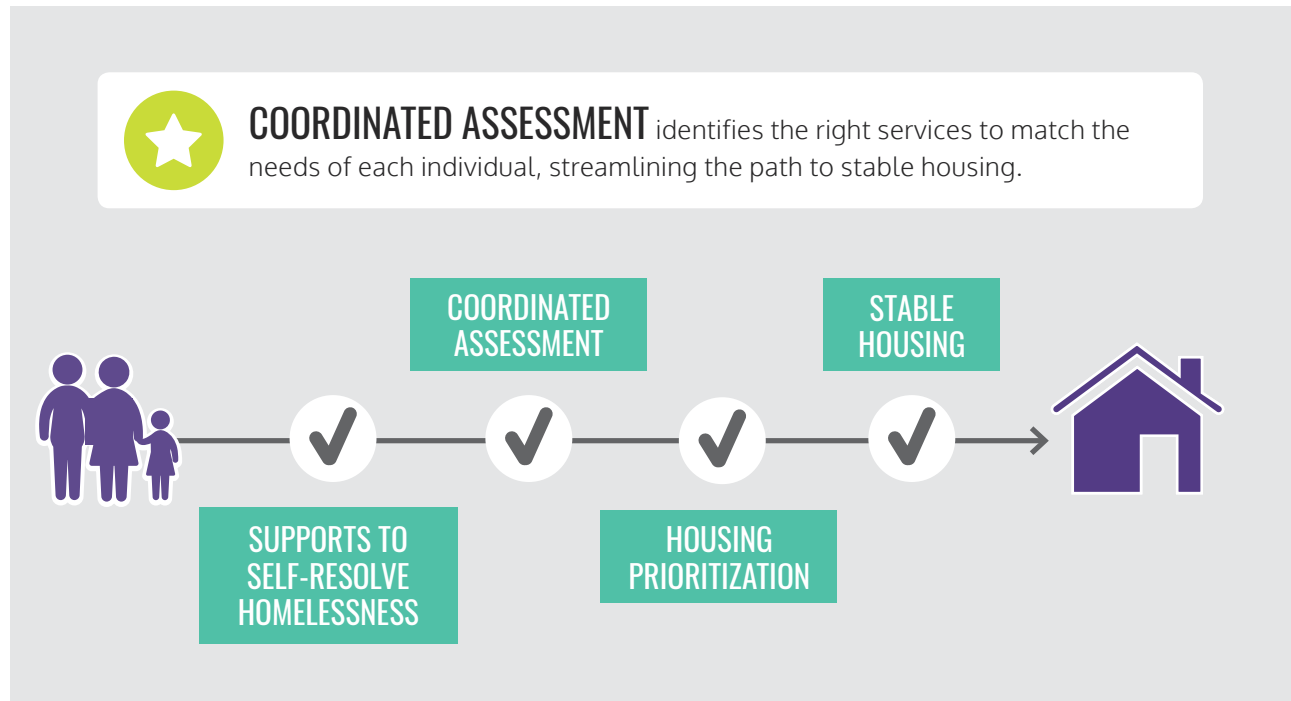
In order for Housing First to be effective, clients’ choices must be available in housing selection and service participation. When a client is able to exercise that choice, he or she is more likely to be successful in maintaining housing and making life improvements. The National Alliance to End Homelessness writes:

Housing First does not require people experiencing homelessness to address all of their problems including behavioral health problems, or to graduate through a series of services programs before they can access housing. Housing First does not mandate participation in services either before obtaining housing or in order to retain housing. The Housing First approach views housing as the foundation for life improvement and enables access to permanent housing without prerequisites or conditions beyond those of a typical renter. Supportive services are offered to support people with housing stability and individual well-being, but participation is not required as services have been found to be more effective when a person chooses to engage (“Housing First Fact Sheet” 1).

COORDINATED ENTRY AND ASSESSMENTS

Coordinated entry and assessment develops tailored interventions and right-sized assistance for Utahns experiencing homelessness. This approach considers an effective system to be person centered, to prioritize those with the greatest need without precondition, to include all subpopulations and to coordinate so that wherever individuals seeking services enter, they will be able to participate in the same assessment and linkage process where providers use a uniform decision-making approach. Communities throughout the state have made significant progress in integrating coordinated entry processes into their homeless service delivery system in a way that both meets the requirement under the HEARTH Act and the unique structure of each community.

As communities proceed with implementation efforts, it has become apparent that coordinated entry and assessment is not only a best practice for serving consumers and a way to more efficiently use available resources, but it is also an excellent tool to shift agency and single-service-minded thinking to holistic services and overall community needs.



ASSESSMENTS AS A TOOL FOR PRIORITIZATION

Communities in Utah have largely adopted a phased assessment approach for coordinated entry, where homeless service providers have access to multiple assessment tools to provide situational assessments. This approach follows the principle of only collecting as much information as is needed at a given time. It avoids a depth of assessment that would be time consuming and unnecessary for a given household's current need. Service providers rely on a variety of different assessment tools in order to assess the needs of the people they serve. One of the more commonly adopted tools includes the Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) to quickly assess the acuity of homeless Utahns. The VI-SPDAT takes approximately eight minutes to complete. It is a triage tool intended to quickly identify persons who should be engaged for a more full assessment such as the Service Prioritization Decision Assistance Tool (SPDAT) and additional services. Much like the way triage would work in a hospital emergency room setting, the VI-SPDAT prescreen is a brief, self-report assessment to help identify the presence of an issue based in that person's own perspective and prioritize persons for the more comprehensive assessment. The results of these assessments help providers identify whether additional assessments such as the longer SPDAT are needed and how to prioritize Utahns experiencing homelessness for housing and services based on greatest need.

THE SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL

The Service Prioritization Decision Assistance Tool (SPDAT) is an evidence-informed tool used to evaluate a person's acuity related to housing stability. It has been recognized nationally as an effective coordinated assessment tool to prioritize individuals and households for housing and services based on need. The Balance of State and Mountainland CoCs officially selected the SPDAT as a coordinated assessment prioritization tool, and all communities in those CoCs are working toward implementation.

There are three distinct functions that Utah hopes to realize by using the SPDAT assessment:

Function 1: Assist with service prioritization

Communities have chosen to use the SPDAT as a coordinated assessment service prioritization tool in order to draw from the highest acuity households when identifying new eligible placements for programming.

Function 2: Help program participants and supportive service providers to identify areas of focus for service delivery

Unlike other measures of self-sufficiency, the SPDAT focuses assessment on domains that directly impact a participant's housing stability. There are several ways in which the SPDAT can be used to augment the work of case management and overall service delivery, from informing individualized service plans to advocating for clinical services.

Function 3: Evaluate how individuals and families are changing over time

Long-term assessment of performance measures such as SPDAT scores and outcome monitoring can be used to track changes in programming and service delivery. Over time, this will lead to healthy discussions about service delivery and show trends in program efficacy.

What the SPDAT is not:

- A case management employee evaluation tool: The SPDAT does not directly measure areas of case manager performance; rather, it helps to measure participant change in acuity in domains that directly impact housing stability.
- A retroactive eligibility tool: It is important that we do not inappropriately apply one function of the tool to make claims regarding an unassociated activity or area. For example, an individual's acuity score once enrolled into a program does not indicate whether or not the client should have been served by that program.
- A replacement for the expertise and experience of an agency: The SPDAT should inform, not dictate, prioritization and supportive services.

HOUSING PRIORITIZATION LISTS

All available resources should be prioritized and offered to individuals at the top of the SPDAT-assessed list and limited only by funding requirements. This list should be continually used by the community. Each of the highest acuity persons should be assigned lead case managers who will attempt diversion exercises, identify needed mainstream resources, and find creative solutions to transition out of homelessness regardless of which resources are and are not available. Communities with limited emergency services will need to work with neighboring communities who provide such services to homeless persons in their areas. When a housing resource becomes available, the hosting agency should identify the first eligible person from the top of the list and assess them for program eligibility and intake. HMIS allows persons anywhere within the Mountainland and Balance of State CoCs to be referred to a housing intervention within their home community. The unified system greatly benefits consumers.

DOMESTIC VIOLENCE VICTIMS AND COORDINATED ASSESSMENT

Due to confidentiality laws in the Violence Against Women Act, domestic violence service providers are not able to share any identifying information of the people they serve, including names, through HMIS or any other system. This has posed a significant challenge for including homeless domestic violence survivors as a part of the coordinated assessment process and could have created a scenario where domestic violence survivors would have been screened out of resources inadvertently. As of August 2015, domestic violence service providers are able to access the coordinated assessment list in HMIS. Using an alias, the survivors they assess with the SPDAT show up in the single community prioritization list to receive services based on acuity.



COMPONENTS OF UTAH'S HOMELESS RESPONSE SYSTEM

Utah communities have refined interventions and housing projects to more appropriately meet the needs of Utahns experiencing homelessness. From programs that divert individuals and families from entering the homeless system to permanent supportive housing projects, the array of options has grown in recognition that one size does not fit all.



DIVERSION

When safety is not a concern, diversion programs target those who are applying for entry to shelter and seek to divert them from entering the homeless system by connecting them with alternative housing resources, including friends and family. Limited financial support may be provided to maintain permanent housing (National Alliance to End Homelessness, “Closing the Front Door” 1-3).

In spring 2017, the state sponsored Ed Boyte from the Cleveland Mediation Center to provide diversion training to homeless service providers statewide. Both Mountainland and Balance of State CoCs officially have adopted diversion as the front door of their coordinated entry system. Diversion funding is now available for homeless service providers throughout the state.

DAY SERVICES

Day services provide safe places for homeless individuals to bathe, do laundry, eat, receive case management services and work on self-resolution of their homeless issues.

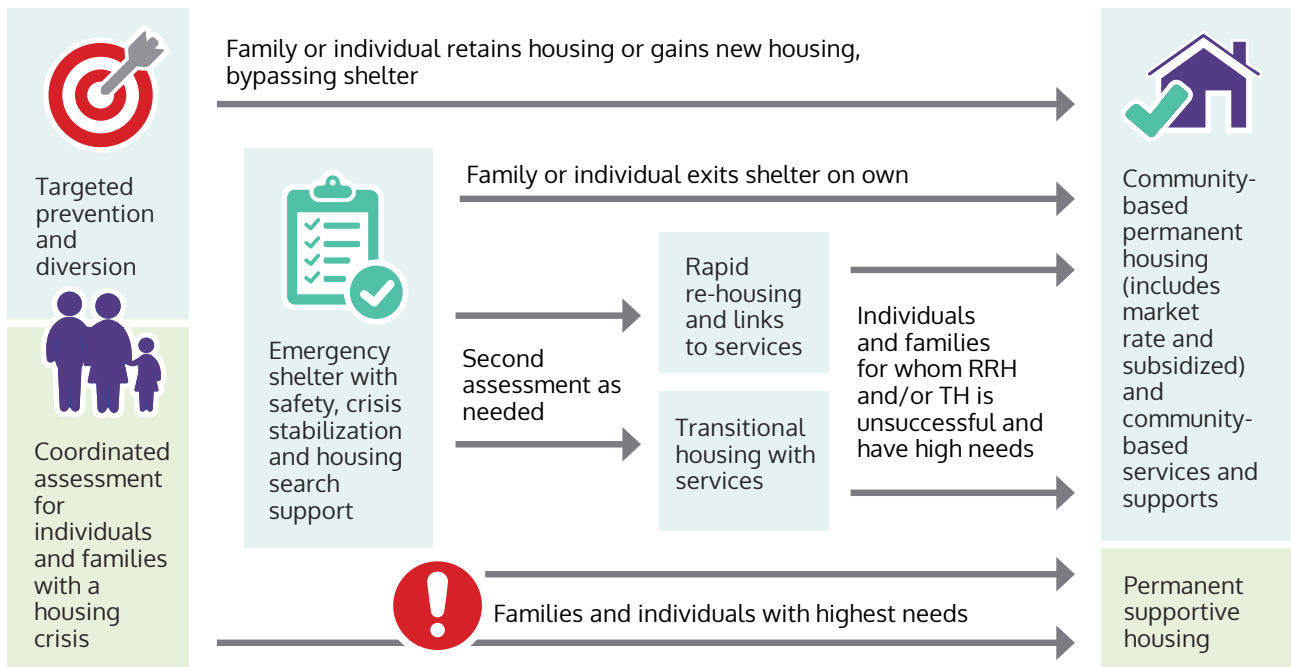
STREET OUTREACH

Sometimes those experiencing homelessness do not proactively seek services. Many agencies throughout the state have developed street outreach programs to find the homeless and connect them with services. Street outreach has grown in recent years in both breadth and depth. More communities have developed qualified teams that seek out unsheltered individuals, families, and youth. Outreach workers connect Utahns living on the streets or in other places not meant for habitation with shelter and services.

EMERGENCY SHELTER

Emergency shelters include any facility designed to provide overnight sleeping accommodations for the homeless. As McDivitt and Nagendra explain, "Emergency shelter serves as temporary, short-term crisis housing with crisis services to alleviate people's immediate housing crisis as a first step to being quickly and permanently re-housed" (56).

HOUSING CRISIS RESPONSE SYSTEM



RRH — Rapid Re-Housing
 TH — Transitional Housing

Source: United States Interagency Council on Homelessness



RAPID RE-HOUSING

Rapid Re-Housing (RRH) is an approach that reconnects an individual or family to housing as quickly as possible and provides limited assistance to re-establish housing stability. Recently, RRH has emerged as a preferred model among several federal agencies, including HUD, the VA and the U.S. Department of Health and Human Services. Federal support stems from several studies, including a Georgia HMIS study which identified persons exiting emergency shelter as being four times more likely to return to homelessness than those exiting an RRH program, and persons exiting from transitional housing being 4.7 times more likely to return to homelessness (National Alliance to End Homelessness, “Rapid Re-Housing” 3). In a study conducted in seven states, 75 percent of RRH clients exited to permanent housing (3). Moreover, recent studies indicate that it is much more cost effective to house families through RRH than to house families in emergency shelters (Spellman et al. 5).

According to the National Alliance to End Homelessness, in order to follow established best practices for an RRH model, there are four necessary activities that RRH programs should provide:

1. **Standard Landlord Outreach:** A RRH provider must have – either on staff or through a formal relationship with an organization – staff who recruit landlords and encourage them to rent to homeless households. The landlord outreach function should result in landlords reducing their barriers to homeless households accessing rental units. Organizations should be able to identify specific landlords that they have recruited into the program.
2. **Financial Assistance:** A RRH provider must provide – either directly or through formal agreement with another organization or agency – financial assistance for permanent housing costs, which may include rental deposits, first month’s rent, last month’s rent or temporary rental assistance. Financial assistance is not contingent upon service compliance but rather upon compliance to the terms of the lease.
3. **Case Management:** A RRH provider must be able to provide home-based case management services – either directly or through a formal agreement with another organization or agency – that link program participants with services in the community, such as child care, employment, education and other services as well as intervene in conflicts between the landlord and program participant.
4. **Assessment of Housing Barriers:** A RRH provider must assess the housing barriers of potential program participants with a focus on the immediate, practical barriers to moving into housing. The housing barrier assessment should be used to help program participants to move into housing. The housing barrier assessment is not a sustainability assessment (“Necessary Activities” 1).

TRANSITIONAL HOUSING

Transitional housing programs offer temporary housing, up to 24 months, as well as supportive services, including case management.

This model may be appropriate for specific subpopulations, including:

- Survivors of domestic violence or other forms of severe trauma who may require and prefer the security and onsite services provided in a congregate setting to other available housing options
- Unaccompanied youth, including those who may be pregnant or parenting youth (ages 16-24), who are unable to live independently (e.g., unemancipated minors), or who prefer a congregate setting with access to a broad array of wraparound services to other available housing options
- Certain individuals and heads of households struggling with a substance-use disorder or individuals in early recovery from a substance-use disorder who may desire more intensive support to achieve their recovery goals

Important to Note: National best practices are showing that many people who historically have been assisted in transitional housing may be served more efficiently in other program models, such as rapid re-housing or permanent supportive housing. The majority of people experiencing homelessness do not require lengthy stays in transitional housing in order to successfully acquire and sustain permanent housing. People whose primary barrier to housing stability is economic in nature do not require transitional housing, nor do people with serious mental illnesses who may be served better by other program models. Long-term stays in transitional housing programs therefore should be reserved for those individuals with severe or specific needs who choose transitional housing over other services that would help them more quickly reconnect to permanent housing (National Alliance to End

Homelessness, "The Role of Long-Term" 1-2). Over the last few years, several of these transitional housing programs in Utah have shifted to a rapid re-housing model as a way to serve more Utahns and better leverage limited resources.

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing (PSH) is the most intensive of housing options and is only offered to those with a disability. It generally serves the chronically homeless. The effectiveness of Housing First philosophy-based PSH programs have been well documented nationally; long-term housing, coupled with wraparound services, improves the stability and health of clients (United States Interagency Council on Homelessness, "Permanent Supportive Housing" 1-2). Moreover, this housing approach also creates a total savings for the system. A study in Denver noted an average net savings of \$2,373 per person housed in PSH. The study examined public costs incurred for common homeless services, including health care and hospital stays, emergency room visits and interactions with law enforcement and weighed these costs against the cost for housing in a PSH project (Snyder).

AFFORDABLE HOUSING

In Utah, the Department of Workforce Services and other government entities believe the solution to homelessness is housing. Connecting homeless people to housing ends their homelessness, but finding the resources to help people access housing isn't always easy. Unfortunately, economic trends are making this task even harder. There simply is not enough extremely affordable housing available in Utah to move people out of homelessness as quickly as needed with very limited housing stock and a tight rental market.

HOW TO HELP

If you would like to volunteer and help make a difference for fellow Utahns experiencing homelessness, there are many opportunities to participate:

1. CALL 2-1-1 OR VISIT 211UTAH.ORG TO FIND LOCAL AGENCIES IN NEED OF ASSISTANCE.
2. CONTACT YOUR LOCAL VOLUNTEER CENTER FOR ADDITIONAL OPPORTUNITIES:
HERITAGE.UTAH.GOV/USERVEUTAH
3. DONATE TO THE PAMELA ATKINSON HOMELESS TRUST FUND.



By caring enough to donate even one dollar, Utahns can give hope to individuals and families experiencing homelessness. All donations to the trust fund go to organizations statewide that provide vital services and assistance to individuals and families experiencing homelessness, and even small donations make a big impact for those experiencing homelessness. Donations can be made on the Utah state tax form each year.

4. CONTACT YOUR LOCAL HOMELESS COORDINATING COMMITTEE (LHCC) AND ATTEND LOCAL MEETINGS:

Salt Lake and Mountainland LHCCs

utahcontinuum.org/ucc/contact

Balance of State LHCCs

utahcontinuum.org/ucc/contact/balance-of-state-contact-information

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