March 2021

An Environmental Scan and System Analysis of the Homeless Response System in St. Louis County, MN Continuum of Care (CoC)

Prepared by:
Patty Beech Consulting
222 E Superior Street #324
Duluth MN 55802
218-525-4957; pattybeechconsulting@gmail.com

Project Leadership

St. Louis County Continuum of Care (CoC): Heading Home Governing Board

St. Louis County CoC Evaluation and Planning Committee

St. Louis County CoC Housing Response Committee

St. Louis County Housing and Homeless Program Team

Laura Birnbaum
Housing and Homelessness Programs Team Supervisor

Courtney Cochran
Continuum of Care (CoC) Coordinator

Kevin Radzak
Housing and Homelessness Program Specialist

Stacy Radosevich
Senior Planner

JoAnn Solin
Housing and Homeless Unit Support

Data Collection Assistance Provided by: Institute for Community Alliances

Table of Contents

I. Project Overview

The St. Louis County Public Health and Human Services division, acting as staff for the Duluth/St. Louis County Continuum of Care (CoC) engaged Patty Beech Consulting to:

- Identify existing homeless system assets and gaps within the St. Louis CoC.
- Identify existing relationships and partnerships between organizations that strengthen the system of services for people experiencing or at risk of homelessness.
- Identify strategies, resources and partnerships that could improve outcomes.

Research Questions

- What organizations, and resources exist to support the homeless response system?
- What are the gaps in the homeless response system?
- What organizations or systems are not engaged that could be?
- What new stakeholder connections and resources are needed?
- What are opportunities to improve the SLC Homeless response system?

Methodology

Planning was led by the CoC Evaluation and Planning Committee with input from the CoC Housing Response Committee, Heading Home Governing Board, and key stakeholders.

Environmental Scan

Multiple data sources were collected and analyzed to document the needs of people without housing stability, the existing resources, and the ways people experiencing homelessness are connected to and supported by regional resources.

System Map

A system map was developed to illustrate the general participant flow through the SLC homeless response system, the capacity of shelter and housing resources for homeless people, key system outcomes, and important data points related to need.

Key Informant Interviews

Phone interviews were conducted with twenty-one key stakeholders to better understand the strengths and weaknesses within St. Louis County's homeless response system and to assess areas of opportunity for improving the local response to homelessness.

Interviews with Persons with Lived Experience

The project team had difficulties completing interviews with persons with lived experience of homelessness due to limitations caused by the pandemic. A phone interview was completed with one person with lived experience whose story is included in this report. It is recommended that input from persons with lived experience be integrated into future planning initiatives to improve the local response to homelessness.

St Louis County Continuum Care Homeless Response System

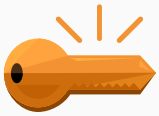
Outreach: Engages with people experiencing homelessness on the streets, vehicles and other public places.

Homelessness Prevention: Helps individuals and families who are about to lose their housing to remain housed where they are or to move to new permanent housing.

Emergency Shelter: Short-term, safe place to sleep for people experiencing homelessness

Coordinated Entry System: Matches people who are homeless to the County's transitional, rapid rehousing and permanent supportive housing programs.

Transitional Housing: Temporary housing and services for people experiencing homelessness. Typically two years or less.



Rapid Rehousing: With financial assistance and support services, helps households obtain permanent housing and increase income so they can remain housed on their own.

Permanent Supportive Housing: Helps individuals and families with disabilities maintain permanent housing with rental subsidies and support services.

II. Environmental Scan

Data Highlights

- Homelessness disparately impacts People of African Heritage, People who are Black or Indigenous, and other People of Color, who make up 18% of the people in poverty in St. Louis County but 42% of the population served in the homeless response system.[1] On the Coordinated Entry Priority List, 44% of households are People of African Heritage, People who are Black or Indigenous, or other People of Color.[2]
- The total number of people who are homeless continues to increase. The number of sheltered and unsheltered homeless people increased 25% from 2015 – 2020.[3]
- 46% of people counted in the 2020 Point in Time Count were unsheltered. 54% were sheltered in Emergency Shelter or living in Transitional Housing.[3]
- A total of 2,188 households were served by programs for homeless people in the County in the year ending September 30, 2020.[4]
- Adults without children continue to have higher rates of homelessness than families. Of all households served by homeless programs, 82% were households without children.[4]
- As of September 30, 2020, there were 1,888 households experiencing homelessness on the Coordinated Entry System (CES) Priority Lists.[2]
- 94 households exited the CES Priority Lists and entered permanent housing between April 1 and September 30, 2020.[2]
- People without housing experience high levels of disabilities.[2] Of all households on the Coordinated Entry Priority List, 73% have a disability of long duration.[5]
- Multiple episodes of homelessness are common. 60% of households on the CES Priority list meet Minnesota's definition of long-term homelessness.[2]
- Financial, credit and background issues are the top challenges to securing housing.[6]

[1] American Community Survey 2013-2017 5-year estimates; HMIS Core Report, 10/1/2019 – 9/30/2020
[2] HMIS Coordinated Entry Monitoring Report 4/01/2020 – 9/30/2020.
[3] https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/?filter_Year=&filter_Scope=CoC&filter_State=MN&filter_CoC=MN-509&program=CoC&group=PopSub
[4] HMIS MN Core Homeless Programs Report – All St. Louis County CoC Programs, 10/1/2019 – 9/30/2020
[5] See definition of disability of long duration in the Appendix, page 33.
[6] Wilder Research Center, 2018 Homeless Survey Results for St. Louis County.

Areas for Focus

- Address the root causes of homelessness and prevent more episodes of homelessness among People of African Heritage, People who are Black or Indigenous, and other People of Color.
- Increase emergency shelter beds or prioritize shelter beds for unsheltered people.
- Increase permanent supportive housing resources for homeless adults without children, especially those with long histories of homelessness, disabilities, and barriers to securing rental housing.
- Expand resources to meet the needs of households experiencing housing instability but waiting on the CES Priority List. Expand diversion and navigation activities.[7]
- Increase referrals to permanent supportive housing from the CES lists.
- Reduce episodes of homelessness and returns to homelessness. This will decrease the number of people experiencing homelessness and the number experiencing long-term homelessness and chronic homelessness.[8]

Key Questions

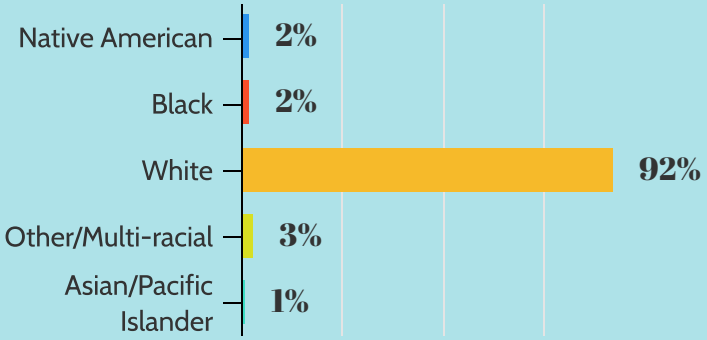
- What do people of African Heritage, People who are Black or Indigenous, and other People of Color identify as solutions to reducing homelessness within these populations?
- Are there people whose episodes of homelessness could be prevented so that more shelter beds could be available for unsheltered people?
- What diversion, access, and/or navigation resources could be utilized to assist people on the CES Priority List whose wait for housing is too long?
- How can more permanent supportive housing be created for singles who are hard to house due to disabilities including substance abuse disorder and mental illness?
- What strategies are effective to keeping households housed and preventing returns to homelessness?
- How can we ensure that strategies are culturally responsive and trauma-informed?

[7] Diversion prevents homelessness for people on the CES lists by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them retain or return to housing. Housing navigation is the process by which homeless clients that have entered the CES system are provided ongoing engagement, document collection, and case management services to facilitate a match to a housing resource.
[8]. See definitions of long-term homelessness and chronic homelessness in the Appendix, pages 32-33.

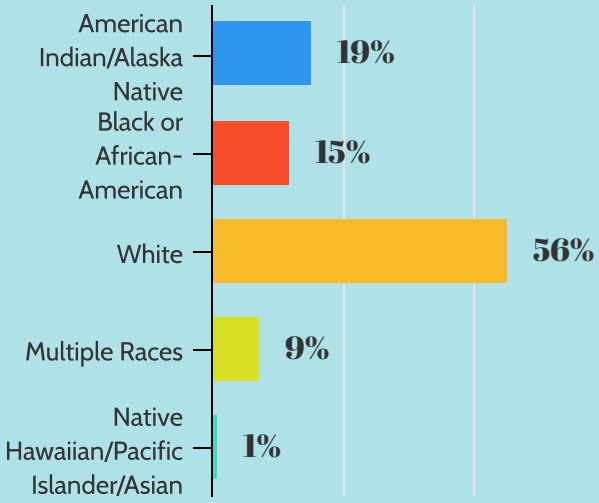
St. Louis County Continuum of Care
Racial Disparities in the Homeless Response System

The information on this page compares the race of the general population and the population of people in poverty in St. Louis County with the racial percentages of people seeking and receiving assistance through the homeless response system in St. Louis County.

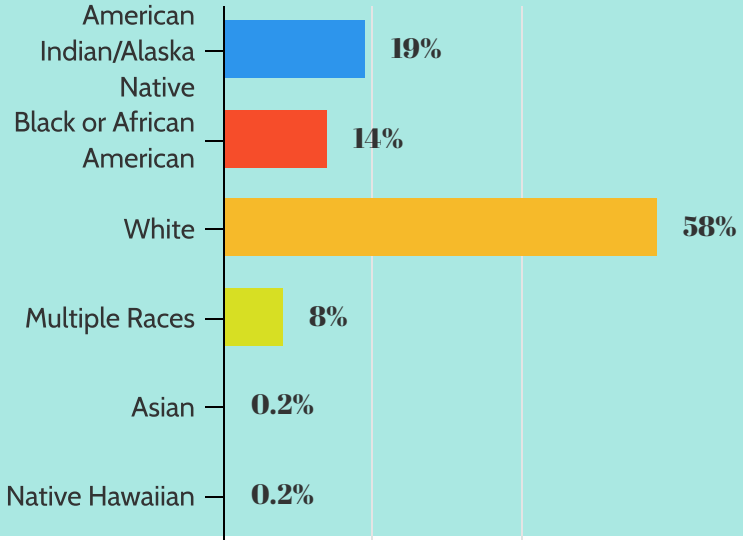
Race of General Population



Households by Race on Coordinated Entry Priority Lists



Households by Race: Homeless Programs



Exits from Homeless Programs to Permanent Destinations

22% of American Indian households

25% of households of Multiple Races

41% of Black or African American households

44% of White households

American Indian people and People of Color are:

8% of people in the county

18% of people in poverty

39% of people who are unsheltered

42% of people in the county's homeless programs

Data Sources: CoC Racial Equity Analysis Tool 2.1: https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/
MN HMIS Core Homeless Programs Report for St. Louis County : 10/1/2019 - 9/30/2020, Institute for Community Alliances
Coordinated Entry (CE) Monitoring Report for St. Louis County: 4/1/2020 - 9/30/2020, Institute for Community Alliances

St. Louis County, Minnesota
Homeless Point in Time (PIT) Count Overview
January 22, 2020

284 Unsheltered People

328 Sheltered People

Emergency Shelter - 192
Transitional Housing 136

17 family households
25 adults and
18 children

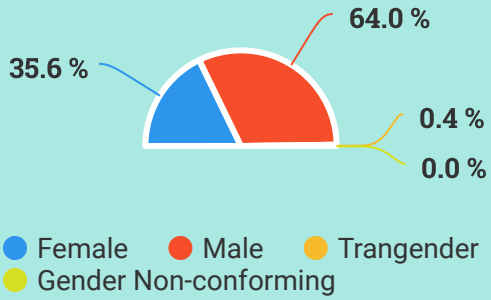
52 family households
61 adults and
93 children

4 unsheltered veterans

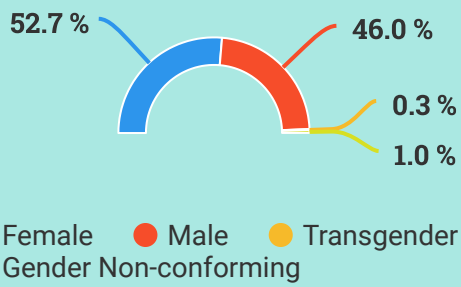
15 sheltered veterans

612 Total Homeless People

Gender of Unsheltered People



Gender of Sheltered People



The Point-in-Time (PIT) count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. It is conducted nationwide as part of HUD's requirement for receiving Continuum of Care funds.

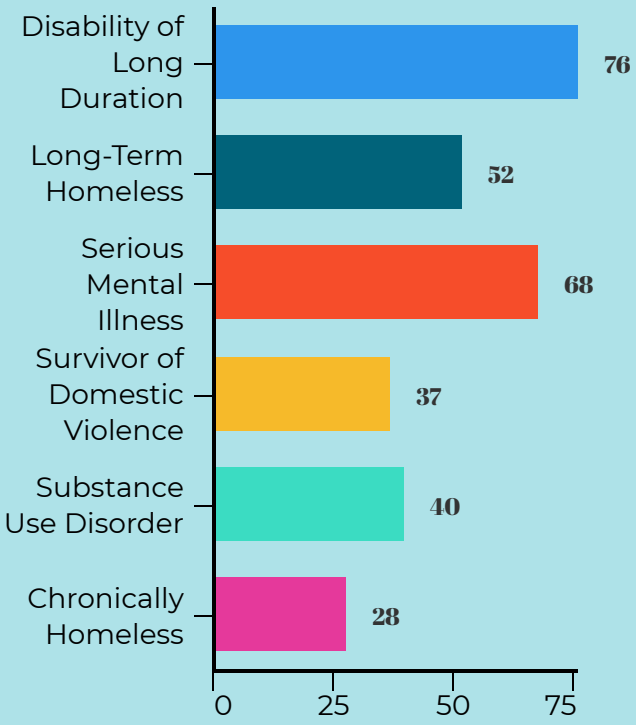
Data Source: https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

St. Louis County CoC: Core Homeless Programs Report

Data for All Programs

Organizations with HUD or State of Minnesota funding to provide services or housing to people who are homeless collect data in the Homeless Management Information System (HMIS). The Core Report summarizes all the data collected.

Percent of Households in Each Subpopulation



Exits to Permanent Destination

29% of American Indian households
53% of African-American households.
51% of White households

Key Data

3,170
Homeless People Served

2,188
Households Served

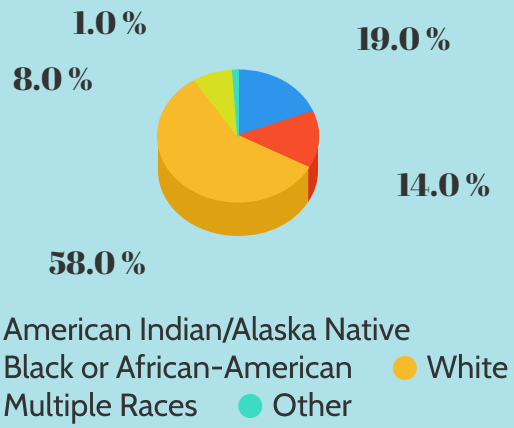
1,354
Households Exited

38%
Exited to a Permanent Destination

5%
Exited to Homelessness

43%
Homeless at Entry

Households by Race



St. Louis Co. CoC: Coordinated Entry System Report

Coordinated Entry System (CES) Data

CES is used to prioritize households for vacancies in housing for homeless persons. Each household is assessed and given a score that indicates their level of vulnerability. They can then be referred to a housing type that meets their need. CES data are collected in HMIS. This report summarizes CES data from 4/1/2020 - 9/30/ 2020.

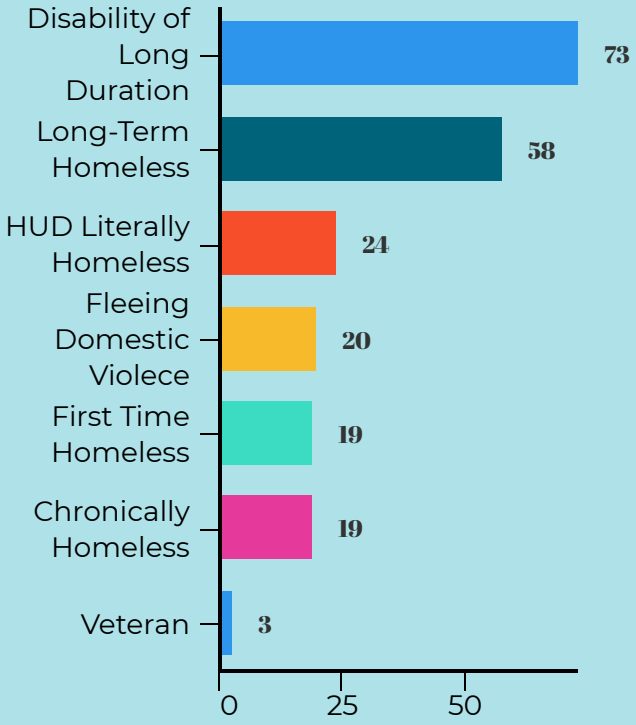
Key Data

1,888
Households Assessed

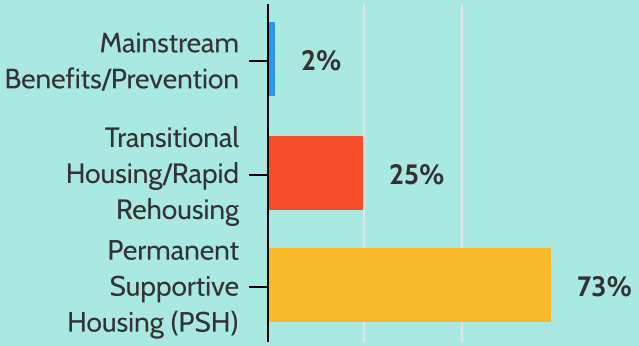
541
Households Exited

94
Households were Housed in Permanent Housing

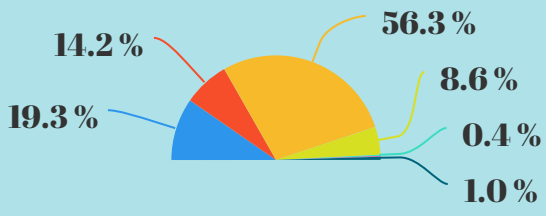
Percent of Households in Each Subpopulation



Housing Needs Based on Assessment Scores

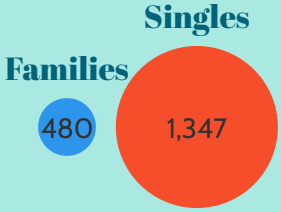


Households by Race



- American Indian/Alaska Native
- Black or African-American
- White
- Multiple Races
- Asian
- Native Hawaiian or Pacific Islander
- Missing/Don't Know/Refused

Household Type



III. System Map and Housing Intervention Assessment

Data Highlights

- St. Louis County's Emergency Shelters operate at full capacity.[1]
- Average length of time homeless is increasing.[2]
- Many households (48%) stayed with family or friends before becoming homeless (defined as staying in a shelter or in a place not meant for human habitation).[3]
- In 2020, 751 people experienced homelessness for the first time.[4]
- In Duluth, the average wait time for a housing referral for households on the CES Priority Lists is 14 months. The average wait for permanent supportive housing is 6+months. In Northern St. Louis County waits are much shorter.[5]
- 165 people entered shelter from an institution: jail, corrections, hospital, psychiatric hospital, substance abuse treatment, halfway house, foster care/group home. [6]
- 42% of people who exit Emergency Shelter return to homelessness[7].
- 21% of all people who exit the homeless response system return to homelessness within one year.[7] Families return to homelessness at much lower rates.
- 90% of people who receive Rapid-Rehousing assistance exit to a permanent destination. In Transitional Housing, 75% exit to a permanent destination.[8]
- 45% of people who participate in Permanent Supportive Housing exit to a permanent destination when they leave Permanent Supportive Housing.[8]
- Just 34% of people served in the homeless system exited to rental housing, with or without a subsidy. For Rapid Rehousing, 48% moved to a rental unit with no subsidy.[8]

[1] HMIS Data SLC-FED-10-BED-239 10/1/2019 – 9/30/2020
[2] HUD Performance Profile MN-509: Duluth/St. County CoC:
[3] Wilder Research Center, 2018 Homeless Survey Results for St. Louis County
[4] HUD CoC System Performance Measures – Duluth/St. Louis County CoC 10/1/2019 – 9/30/2020
[5] HMIS Coordinated Entry Monitoring Report 4/01/2020 – 9/30/2020.
[6] HMIS Annual Performance Report (APR) SLC Emergency Shelter 10.1.2019-9.30.2020
[7] HMIS Data SLC MN-00-SAG-054 10/1/2019 – 9/30/2020
[8] HMIS Annual Performance Reports: All Programs, Permanent Supportive Housing, Transitional Housing, Rapid Rehousing 10/2/2019 – 9/30/2020

Areas for Focus

- Decrease the number of people who are unsheltered.
- Reduce returns to homelessness.
- Improve rate of exit to permanent destinations for participants in Permanent Supportive Housing.
- Reduce discharges to Emergency Shelter from jail, corrections, hospitals, substance abuse and mental health treatment.
- Increase affordable rental housing options, including rental subsidies, for people leaving the homeless response system.
- Maintain or increase Transitional Housing, particularly for the populations that are successfully achieving housing stability through participation in TH.
- Maintain or expand Rapid Rehousing to increase successful transitions from the homeless response system to permanent housing.
- Increase Permanent Supportive Housing for singles who face the highest barriers to their physical health, mental health, substance abuse, and criminal background.

Key Questions

- To determine whether there should be a focus on decreasing the length of time homeless (staying in an emergency shelter or transitional housing), are increased stays increasing the number of households that move to a stable housing situation?
- Where do people go when they leave Emergency Shelter?
- Why are some participants in St. Louis County's homeless response system returning to homelessness? What is working to increase housing stability for families that isn't working as well for singles without children?
- How can more episodes of homelessness be prevented to decrease the demand for the homeless response system?
- Can the informal shelter system (family and friends) be supported so that fewer people leave doubled-up situations for homelessness?
- Are there ways to transition long-term participants in Permanent Supportive Housing to other forms of affordable housing with less support, so more PSH beds become available for people in Emergency Shelter or unsheltered?

St. Louis County CoC Provider Agencies

Region Served	Homeless Prevention	Emergency Shelter	Transitional Housing	Rapid Rehousing	Permanent Housing (Permanent Supportive Housing & Other Permanent Housing)

North	• AEOA
	• Bois Forte Human Services
	• Range Transitional Housing
		• Advocates for Family Peace DV
		  ○ Hotel/motel vouchers for persons fleeing DV
		• AEOA
		  ○ Bill's House
		  ○ Hibbing ES
		  ○ Hotel/motel vouchers
		• Bois Forte Human Services
		  ○ Hotel/motel vouchers
		• Range Transitional Housing
		  ○ Hotel/motel vouchers
			• AEOA
			• Range Transitional Housing
				• AEOA
				• Bois Forte Human Services
					• AEOA
					• Bois Forte Human Services
					• Another Path LLC (Housing Support)
					• Range Mental Health Center
					• Range Transitional Housing

Countywide (North & South)	• St. Louis County Public Health & Human Services		• MACV	• MACV	• Hearth Connection (LTHSSF Program)

Sources: 2020 St. Louis County Housing Inventory Count (HIC), Key Informant Interviews

South	• CHUM
	• Life House
	• Salvation Army
		• AICHO (DV)
		  ○ Daabinoo'Igan DV Shelter
		• Bob Tavani Medical Respite House
		• CHUM
		  ○ Congregate shelter
		  ○ Family shelter
		• Life House
		  ○ The Loft
		• Loaves and Fishes
		  ○ Dorothy Day House
		  ○ Olive Branch
		• Lutheran Social Services
		  ○ Another Door Bethany Crisis Shelter
		• Safe Haven (DV)
		• Union Gospel Mission
		  ○ Martin Inn Emergency Room
			• Center City Housing Corp.
			• Life House
			• Lutheran Social Services
			• Salvation Army
			• YWCA of Duluth
				• CHUM
				• Life House
				• Salvation Army
					• AICHO
					• Center City Housing Corp.
					• CHUM
					• Drew Shaine LLC (BDS Housing Support)
					• Duluth HRA
					• Lutheran Social Services
					• MACV
					• New Opportunities (Housing Support)
					• October Allen (Grace Place Housing Support)
					• Union Gospel Mission
					• Wolf Family, Inc. (Housing Support)

		Total Year-Round ES Beds: 199	**Total TH Beds: 169**	**Total RRH Beds: 101**	**Total PSH & OPH Beds: 993**

Housing Inventory Count (HIC) Reports provide an inventory of housing conducted annually during the last ten days in January. The HIC report tallies the number of beds and units available on the night of the count by program type. It includes beds dedicated to serve persons who are homeless as well as persons in Permanent Supportive Housing.

Target Populations: Youth, Veterans, DV Domestic Violence

Sources: 2020 St. Louis County Housing Inventory Count (HIC), Key Informant Interviews

Available Intervention Types

There is a broad range of services available to individuals experiencing or at risk of homelessness in St. Louis County. These include programs and projects that offer temporary and permanent housing, as well as a variety of services. This section briefly describes the available resources in the community but is not intended to be comprehensive as additional resources are continually being added[1]. Intervention types include:

Outreach and Engagement – Existing outreach efforts include outreach staff and programs targeted to adults and youth countywide – providing ongoing outreach, engagement, assessment, and connections to housing and services. Outreach models differ in the North and South regions of the county because of the differing geography, needs, and resources that exist between the rural and urban areas. Outreach is a critical step in connecting households to CES and other resources that can support their housing stability. There have been continued efforts to expand outreach, and new outreach positions were recently added in two Duluth agencies.

Emergency Shelters – There are eleven (11) shelter providers in St. Louis County. Eight (8) providers serve the South (Duluth) and three (3) providers serve North St. Louis County. This includes two (2) domestic violence shelters, one (1) medical respite house, and one (1) shelter for youth ages 15-19 in the South. There is one (1) site-based shelter located in Virginia, MN, and the remaining shelter options in the North are primarily voucher-based services that temporarily shelter persons experiencing homelessness in hotels or motels. There are approximately 199 year-round emergency shelter beds available throughout the county.

Transitional Housing – There are eight (8) transitional housing providers in St. Louis County. This includes one (1) provider who serves veteran households. It also includes a Safe Harbor program in the South that serves underage victims of sex trafficking and other forms of commercial sexual exploitation and a young mother's program

This includes a program for survivors Additionally, there is one (1) transitional housing provider who specifically targets veteran households.

There are approximately 169 TH beds available throughout the county.

Rapid Rehousing – Rapid rehousing provides homeless individuals and families with a short term rental subsidy, after which they take over responsibility for paying their own rent. Services include help locating housing, as well as time-limited case management focused on maintaining stability in housing. Currently, there are six (6) rapid rehousing (RRH) providers in St. Louis County, which includes one (1) RRH provider in the North, three (3) providers in

[1] Data on providers and beds comes from the Duluth/St. Louis County 2020 Housing Inventory Count. It reflects providers and beds in the inventory as of the last week of January 2020.

the South, one (1) countywide veterans provider, and one (1) provider on Bois Forte Reservation.

There are approximately 101 RRH beds available throughout the county.

Permanent Supportive Housing & Other Permanent Housing – **Permanent supportive housing (PSH)** helps individuals and families with disabilities maintain permanent housing with rental subsidies and ongoing support services. It is designed for households with the most severe service needs, particularly those who are chronically homeless and/or have significant behavioral disabilities.

St. Louis County's **Other Permanent Housing (OPH)** provides similar programming through support services and rental subsidies with broader eligibility requirements. The region's OPH inventory is largely made up of Long Term Homeless (LTH) Housing Support programs[2].

There are eighteen (18) PSH and OPH providers in the region. This includes four (4) providers in the North (including one (1) provider on Bois Forte Reservation), twelve (12) providers in the South, and two countywide providers.

There are approximately 993 PSH and OPH beds available throughout the county.

Homeless Prevention – Homeless prevention programs and strategies are designed to assist households to avoid becoming homeless and entering the homeless response system. St. Louis County currently has seven (7) prevention providers, which includes two (2) providers in the North, one (1) provider on Bois Forte Reservation, three (3) providers in the South, and the County Public Health and Human Services who serves both regions. Additionally, St. Louis County provides funding to Legal Aid Services of Northeastern Minnesota through their FHPAP and Emergency Solutions Grants (ESG) programs to provide countywide eviction prevention services for households who are facing eviction.

[2] Housing Support, formerly known as group residential housing (GRH), is a state-funded income supplement for housing (room and board) and housing supports (supplemental services) for eligible seniors or adults with disabling conditions. In order to prevent and/or reduce homelessness or institutionalization, this funding provides financial support for rent, utilities, household needs, and, under some circumstances, food and/or services for eligible individuals. (St. Louis County PHHS Housing Support Program Supportive Housing Program Provider Manual)

St. Louis County, Minnesota Homeless Response System

EMERGENCY SHELTER
199 year-round beds
Utilization Rate[1]
Duluth: 103%
North SLC: 138%
1095 people served[1]
961 people left ES[1]
16% exit to a permanent destination[1]

New ES beds coming in 2021 through a Housing Support cost neutral transfer of approx. $1.8 million

PREVENTION & DIVERSION
580 prevention clients
90% exited to a permanent destination

PERMANENT SUPPORTIVE HOUSING
549 PSH beds
1172 people served[1]
45% exit to a permanent destination[1]

PSH ACCESS
799 people entered PSH [1]
59% entered PSH from homeless situations[1]
Avg. wait time for CE referral:
Duluth: 6+ months[4]
North SLC: 2+ months[4]

21% who exit the homeless response system return w/in 1 year[1]
- 31% of households w/o children return to homelessness[1]
- 4.5% of households with children return to homelessness[1]

AT RISK OF HOMELESSNESS
751 people experienced homelessness for the first time[1]
Top reasons for homelessness:
1.Eviction or lease not renewed
2.Couldn't afford rent or house payments
3.Lost job or had hours cut[2]

Coordinated Entry Access: 2-1-1
Central Access Point to Regional Homeless Programs

CE WAIT TIME
1,888 people on CE lists[4]
Avg. wait-time: Duluth: 14+ months[4]; North SLC: 3+ months[4]
Vulnerability[4]: 73% High (PSH); 25% Medium (TH/RRH); 2% Low (Mainstream)[4]

RAPID RE-HOUSING
101 RRH beds/slots
494 people served[1]
393 people exited[1]
90% exit to a permanent destination[1]

RENTAL HOUSING
32% of people served exited to rental housing with (17%) or without (15%) a subsidy[1]

Start Here

STREET OUTREACH

UNSHELTERED/LITERALLY HOMELESS
612 were homeless (sheltered or unsheltered) in a one-day count[3]
46% (284 people) were unsheltered [3]

The places people stayed when they lost their last regular housing were:
1. With friends or family in regular housing they had – 48%
2. In an emergency shelter – 16%
3. Outside or some other open place, including camping – 15%[2]

DENIED SHELTER ENTRY OR EXITED
25.4% of people were turned away from a shelter because there was no space available.[2]

TRANSITIONAL HOUSING
169 TH beds
267 people served[1]
124 people exited[1]
75% exit to a permanent destination[1]
9% of all exits return to homelessness [1]

WARMING CENTERS
2 warming centers available during winter months in 2020—2021 as alternatives to shelter

MEETING THE NEED
3,170 people (2,188 households) were served in programs[1]
38% leave programs to permanent destinations[1]
42% of people who exit shelter return to homelessnes[1]
73% of people in CE have a disability of long duration[4]
Avg. LOT homeless increased from 8.5 months to 11 months in one year (2018 – 2019)[1]
LOT = Length of Time

LEGEND
ES Emergency Shelter
RRH Rapid Rehousing
PSH Permanent Supportive Housing
CE Coordinated Entry
TH Transitional Housing
PH Permanent Housing

Data Sources: 1. HMIS data 10/1/2019—9/30/2020, 2. Wilder Homeless Survey 2018, 3. Point-in-Time Count 2020 4. CE HMIS Data 04/01/2020—09/30/2020
Note on CE vulnerability: Vulnerability indicated by VI-SPDAT scores: High = 9+ families, 8+ singles/youth; Medium = 4-7 singles/youth, 4-8 families; Low = 0-3 singles/youth/families.

System Map design provided by: Technical Assistance Collaborative
Prepared by: Patty Beech Consulting

Temporary Housing Interventions
Emergency Shelter

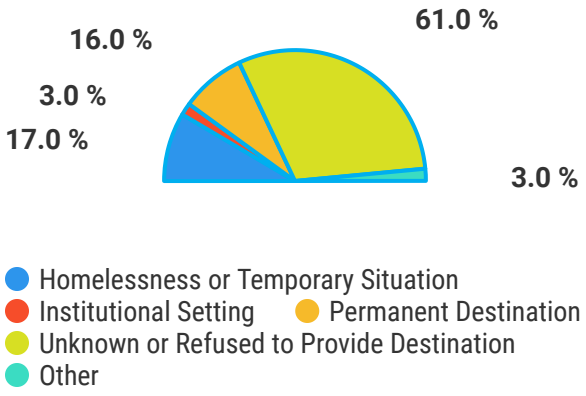
Where did People Stay before Shelter?

Location	Number	Percent
Place not meant for human habitation	299	30%
Emergency shelter, including hotel or motel paid for with voucher	97	10%
Safe Haven	17	2%
Transitional housing for homeless persons	4	0%
Jail, prison or juvenile detention	46	5%
Hospital or other medical facility	36	4%
Substance abuse treatment or detox	31	3%
Psychiatric hospital or other facility	24	2%
"Residential project /halfway house"	24	2%
Foster care home or group home	4	0%
Staying or living with a friend	215	21%
Staying or living with family	97	10%
Hotel paid without shelter voucher	81	8%
Rental by client, no housing subsidy	19	2%
Rental by client, other subsidy (including RRH)	9	1%
Owned by client, no subsidy	4	0%
Permanent housing for formerly homeless	1	0%
Rental by client in public housing	1	0%
	1011	

Exits from Shelter: 961

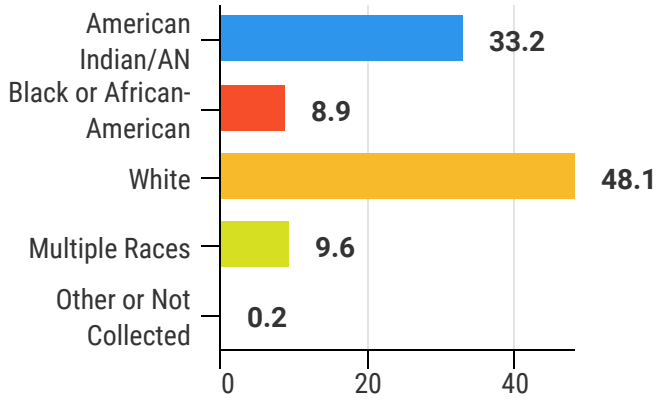
74% stayed 30 days or less
12% stayed 1 month - 2 months
12% stayed 2 months - 6 months
2% stayed 6 months - 1 year

Exit Destination



41% of shelter guests were literally homeless prior to entering shelter.

Race of Shelter Participants - by Percent



Average stay in Emergency Shelter is 27 days.

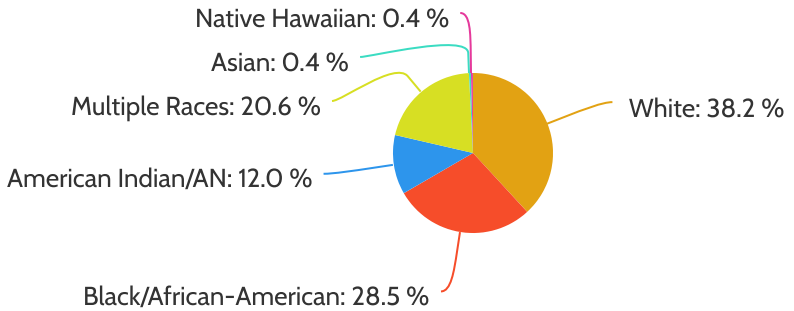
Temporary Housing Interventions

Transitional Housing

Where did People Stay before TH?

Location	Number	Percent
Emergency shelter including hotel or motel paid with voucher.	85	53%
Staying or living with a friend	19	12%
Staying or living with family	20	12%
Place not meant for human habitation	16	10%
Substance abuse treatment or detox	5	3%
Transitional Housing for homeless persons	4	2%
Residential project/halfway house	2	1%
Rental by client, no subsidy	2	1%
Safe Haven	1	1%
	160	

Race of TH Participants

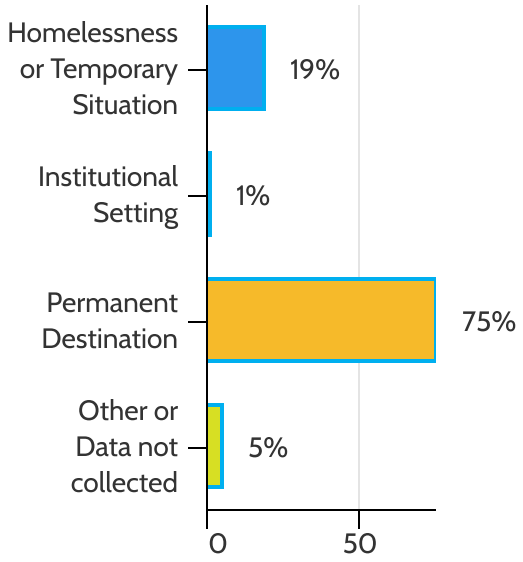


Exits from TH: 124

10% stayed 30 days or less
23% stayed 1 month - 6 months
11% stayed 6 months - one year
40% stayed 1-2 years

Average stay in TH is 394 days.

Exit Destination



49% of all Households that exit Transitional Housing move to a subsidized rental.

Permanent Housing Interventions
Permanent Supportive Housing (PSH)

Where did People Stay before PSH?

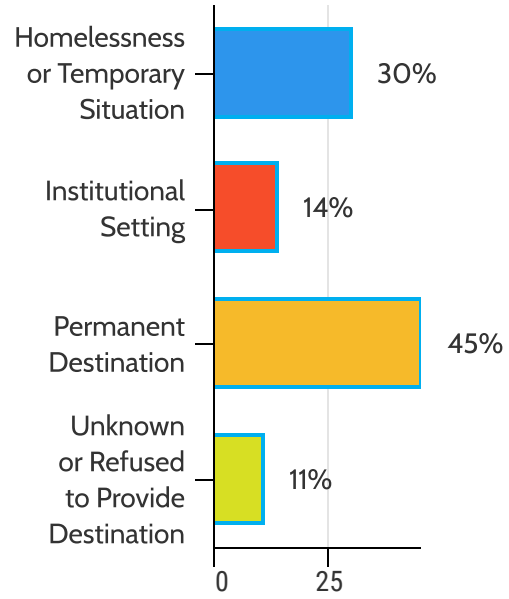
Location	Number	Percent
Place not meant for human habitation	199	25%
Emergency shelter, including hotel or motel paid for with voucher	243	30%
Safe Haven	2	0%
Transitional housing for homeless persons	31	4%
Jail, prison or juvenile detention	9	1%
Hospital or other medical facility	1	0%
Substance abuse treatment or detox	90	11%
Psychiatric hospital or other facility	10	1%
"Residential project /halfway house"	6	1%
Foster care home or group home	3	0%
Staying or living with a friend	74	10%
Staying or living with family	88	11%
Hotel paid without shelter voucher	8	1%
Rental by client, no housing subsidy	10	1%
Rental by client, other subsidy (including RRH)	10	1%
Permanent housing for formerly homeless	13	2%
	799	

Exits from PSH: 227

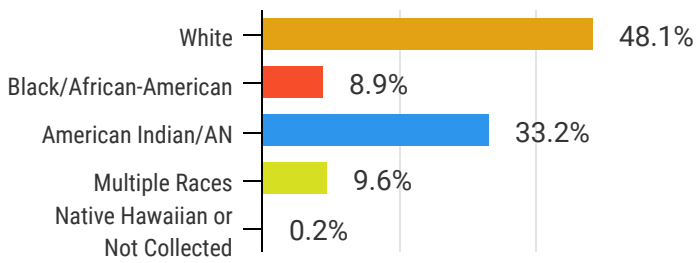
Less than 1% stayed 30 days or less
3% stayed 1 month - 2 months
13% stayed 2 months - 6 months
21% stayed 6 months - 1 year
30% stayed 1-2 years
16% stayed 2-4 years
16% stayed more than 4 years.

Average stay in PSH is 751 days

Exit Destination



Race of PSH Participants



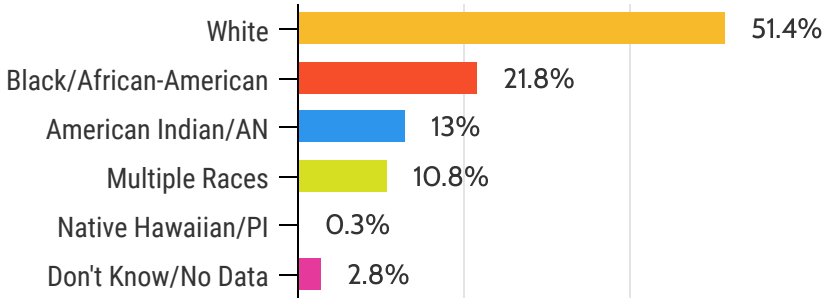
Of people who exited permanent supportive housing 45% exited to a permanent destination. 30% went to a temporary destination, primarily to stay with family or friends, and 14% went to an institutional setting.

Permanent Housing Interventions
Rapid Rehousing (RRH)

Where did People Stay before RRH?

Location	Number	Percent
Place not meant for human habitation	42	16%
Emergency shelter, including motel with voucher	84	32%
Safe Haven	3	1%
Transitional housing for homeless persons	8	3%
Jail, prison or juvenile detention	2	1%
Hospital or other medical facility	4	2%
Substance abuse treatment or detox	8	3%
Psychiatric hospital or other facility	1	0%
"Residential project /halfway house"	1	0%
Foster care home or group home	1	0%
Staying or living with a friend	34	13%
Staying or living with family	28	11%
Hotel paid without shelter voucher	10	4%
Rental by client, no housing subsidy	18	7%
Rental by client, other subsidy (including RRH)	12	5%
Owned by client, no subsidy	4	0%
Permanent housing for formerly homeless	1	0%
	260	

Race of RRH Participants

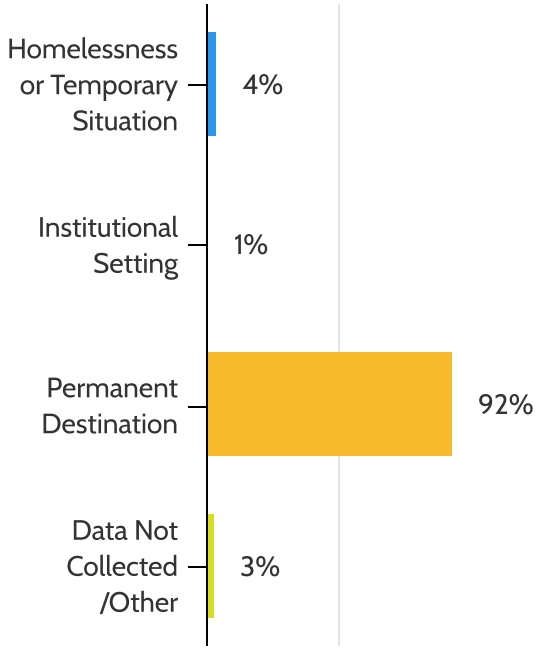


Exits from RRH: 227

38% stayed 30 days or less
19% stayed 1 month - 2 months
22% stayed 2 months - 6 months
11% stayed 6 months - 1 year
10% stayed 1-2 years

Average stay in RRH is 113 days.

Exit Destination



48%

of people who left RRH

moved to a rental unit with no subsidy.

IV. Key Informant Findings on Resources and Partnerships

Interview Themes:

Collaboration

- There are multiple strong collaborative efforts with many partner organizations that are effectively meeting the needs of people without housing and expanding resources.
- St. Louis County leadership has helped build strong partnerships, brought in new funding, and improved processes for connecting clients to county resources.
- Tribal services have been left out of the CoC for long time. They are still catching up.
- Culturally specific service providers are engaged in planning but are spread thin in their ability to be in spaces to advocate for policy and systems change. Engagement and support should be focused on including more American Indian people and People of Color in planning to address homelessness.
- More involvement in preventing and ending homelessness is desired from the following sectors: mental health, medical, schools, chemical health, and jail/corrections.

Homeless Response System

- Street Outreach conducted by CHUM and HDC is critical and more outreach staff would help to reach the growing numbers of people who are unsheltered.
- Emergency Shelter is one of the most impactful resources in the homeless response system. It opens doors to other resources that require that people meet homeless eligibility criteria.
- Emergency Shelters are overfilled, and more beds would reduce the numbers of people sleeping outside or in places not meant for human habitation.
- Permanent Supportive Housing is one of the most valuable resources for persons experiencing homelessness. More units would better address the high demand.
- Housing Support (GRH) beds are increasing and meeting a need, especially for single adults with little or no income. Program expansion is welcomed.
- Additional housing and shelter options for people actively using alcohol or drugs are needed. San Marco units rarely turn over for new residents.

- Case management is essential to guide people through all stages of the homeless response system. Current case managers are stretched thin and their case loads are overwhelming. Additional housing navigators would alleviate this pressure.

Racial Equity and Cultural Responsiveness

- More outreach to is needed People of African Heritage, People who are Black or Indigenous, and other People of Color.
- People of African Heritage, People who are Black or Indigenous, and other People of Color face higher barriers to accessing employment and market rate housing.
- Service providers should reflect the population being served in the homeless system.
- More culturally specific service and housing providers are needed.
- Training would help to build more culturally responsive and culturally relevant services.

Coordinated Entry

- The Coordinated Entry System is improving and has created stronger partnerships and collaborations between service and housing providers.
- More units are needed for households who are waiting on the CES Priority Lists.
- The Coordinated Entry System is designed for funders and organizations that provide housing that serves people without housing. It is not user friendly for participants.

Affordable Market Rate and Subsidized Rental Housing

- Property Management rules and policies vary by property and can limit access to people who need affordable housing. The appeal and accommodation processes are time-consuming for housing advocates, navigators, and case managers.
- Advocacy and relationship building with rental property owners has been a successful method for overcoming barriers to access to market rate rental housing.
- The most common reasons for housing denials include criminal backgrounds, bad credit, and lack of references.

Resources

- Transportation is a huge barrier for people without housing, especially in Northern SLC.
- Many key resources are in short supply: mental health treatments, dental care, and domestic violence resources. In Northern St. Louis County, there are not enough mental health care providers. Getting into substance abuse treatment can take too long in St. Louis County.
- Maintaining employment is difficult due to transportation, housing instability, and mental health.

St Louis County Key Informant Themes

Areas of Racial Disparities

- Employment
- Property Management
- Build Trust with St. Louis County
- Create Stronger Connections with Corrections

Gaps

- More Street Outreach
- Sober Living Options
- Culturally Specific Services
- Staff who look like People Served
- Housing for Singles with High Barriers
- Substance Abuse Treatment - shorter waits
- Dental Care
- Utility Deposits
- Transportation
- More GRH/ Housing Support
- Furniture and Storage for Donations
- Non-phone based services for DV Survivors
- Address generational Homelessness
- Create a Collaborative Culture
- More engagement with Tribal service providers

Bottlenecks

- Mental Health Services
- CES
- Property Management
- Resources for Vets with less than Honorable Discharge
- Housing for people with highest barriers

Successful Strategies and Initiatives:

Key informants identified the following strategies and initiatives as working well to prevent and address homelessness in the region.

Coordinated Entry System (CES)

A key aspect of St. Louis County CoC's regional homeless response is the Coordinated Entry System (CES). CES is the pathway to regional homeless assistance programs and has centralized and streamlined how individuals and families can access transitional housing (TH), rapid rehousing (RRH), permanent supportive housing (PSH), and other permanent housing (OPH).

Households who are experiencing homelessness or who are at imminent risk of homelessness can access CES through a central access point (2-1-1), eliminating the need for households to go to multiple agencies and retell their stories to apply for programs. CES utilizes standardized assessment tools and referral practices to ensure those with the most severe service needs are prioritized for homeless programs. Households are added to the CES priority list in the South, North, or both, depending on where they want to live.

Strong partnerships are key to the success of CES in St. Louis County. Homeless program staff collaborate during weekly case manager meetings to identify the best available resources to meet the needs of households on the CES Priority Lists.

The St. Louis County CoC has continued to expand the capacity of CES through strategic and creative investments of federal and state resources. HUD CoC funding supports two CES Manager positions, one in each region, who oversee CES referrals, policies, marketing, and education. The St. Louis County CoC has also leveraged state funding, such as Housing Support for Adults with Serious Mental Illness (HSASMI), Substance Use Disorder (SUD), Community Living Infrastructure, and Long Term Homeless Support Services Fund (LTHSSF), to support outreach and navigation for households to access CES, collect needed eligibility documents, connect to resources, and identify housing.

Landlord Incentive Program

St. Louis County was one of only a few pilot projects for the Minnesota Housing Landlord Risk Mitigation Fund that started in 2016. The Landlord Incentive Program provides landlords with access to an insurance fund to incentivize renting to households with high housing barriers (poor rental or credit histories or criminal records) who they may otherwise have not rented to. Insurance funds can be used to cover costs related to lease termination, eviction, and damages to the property if the rent does not abide by the terms of the lease. This expands opportunities for housing for high barrier populations in a tight rental market.

Renters also have access to case management and supportive services to help maintain stability in housing.

The Minnesota Department of Veterans Affairs also has a similar incentive program that is available to veterans. The Homes for Veterans Housing Incentive Fund offers financial incentives and risk protection for landlords who rent to Veterans currently experiencing homelessness.

Innovative Use of Existing Funding Resources to Meet Gaps

St. Louis County utilizes existing funding sources in creative ways to meet regional gaps in the homeless response system. As stated above, HSASMI and SUD funding provide outreach and navigation services to people experiencing mental health or substance use issues. Mental health and substance use have been identified as some of the largest barriers to housing stability by community partners. St. Louis County also utilizes Family Homeless Prevention and Assistance Program (FHPAP) funds to support eviction prevention efforts through Legal Aid services, preventing households from having to access limited available homeless resources.

Housing Support Cost Neutral Transfer

St. Louis County partnered with the Minnesota Department of Human Services (DHS) to facilitate a cost neutral transfer of Housing Support base rate and supplemental service rate beds that expands available shelter and services to people experiencing homelessness within the county. Through this cost neutral transfer, a total of $1,760,218 will be distributed to AEOA, American Indian Community Housing Organization (AICHO), Bois Forte, CHUM, Life House, and Safe Haven. This steady funding stream will fill gaps in staffing and increase capacity to fund vouchers and expand available shelter beds for people experiencing homelessness. Examples of activities funded through this initiative include increased emergency shelter beds in the North and the South, including shelter for youth, single women, domestic violence victims/survivors, and Bois Forte band members. Funding will also be used to support CHUM's efforts to assist clients transitioning from shelter, increase operations of CHUM's Health and Wellness Center, provide overnight winter warming center staff, and expand food services. Safe Haven will utilize these funds to add additional crisis advocates and case managers, increase access to shelter services via Crisis Advocate phone support, and expand their Self-Sufficiency Program to support victims/survivors of domestic violence.

Areas for Focus:

- Support partnerships that are having a positive impact on preventing homelessness and increasing housing stability. Ensure that these partnerships have adequate staff and administrative capacity to be successful.
- Build a homeless response system that is focused on efficiency and convenience for people interacting with the homeless response system instead of providers.
- Incorporate culturally responsive and person-centered approaches.
- Expand resources for navigation to help people experiencing housing instability to move through the system. Navigators help people collect documents, complete forms, look for rentals, and connect to available resources. They maintain contact with people in need of homeless services and find them when there are openings.
- Create more permanent supportive housing for singles with high barriers: criminal records, substance abuse history, chronic homelessness, and mental illness.
- Reduce barriers to accessing housing through housing authorities and property management companies.
- Increase mental health crisis management resources.
- Support staff working directly with people experiencing homelessness. Increase wages for case managers, assessors, and navigators. Employ more street outreach workers.

Key Questions:

- What is needed to replicate and expand successful partnerships and bring in new resources to support them?
- What suggestions do People of African Heritage, People who are Black or Indigenous, and other People of Color have to recruit service providers who better reflect the people being served in the homeless system?
- What steps should be taken to diversify homeless planning bodies?
- How can systems that are already stretched (mental health, substance abuse, medical and criminal justice) participate in collaborative efforts to expand resources, prevent homelessness, and better meet the needs of people without housing?
- What are options for training and support to incorporate culturally responsive and person-centered approaches into all aspects of the homeless response system?
- What steps can be taken to continue to improve CES and to make it more friendly and accessible for people being served in the homeless response system??

Partnership Descriptions

Coordinated Entry System

CES

Coordinated entry is a process developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their strengths and needs. All people without housing can access the system by calling 211.

Substance Use Disorder

SUD

The SUD Project's goal is to link homeless persons experiencing substance use disorders to services and and to expedite the process for this population to access and maintain safe housing.

Housing Supports for Adults with Serious Mental Illness

HSASMI

HSASMI grants provide supportive services for adults with serious mental illness who are homeless or who are exiting institutions, and who have complex needs and face high barriers to obtaining and maintaining housing.

Family Homeless Prevention and Assistance

FHPAP

FHPAP prevents homelessness , minimizes the number of days homeless and eliminates repeat episodes of homelessness. Funds are used for direct assistance or services to households who are homeless or at imminent risk of homelessness.

Clarity

Clarity is a community-based initiative to address gaps in the mental health continuum with a goal to improve individuals' access to quality and appropriate mental health and substance use care at the right time and place and in so doing decrease crisis recidivism.

Community Intervention Group

CIG

CIG is a partnership that includes: Duluth Police Department, courts, Center for Alcohol and Drug Treatment, hospitals, County , Human Development Center, and Corrections. The purpose is to reduce contact with law enforcement and corrections (i.e. help decriminalize homelessness) and to provide appropriate pathways to improved stability and well-being.

Long Term Homeless Supportive Services Fund

LTHSSF

The Northeastern Regional Project is a collaboration among counties, bands, government and service agencies offering services and affordable housing to people with long histories of homelessness and complex barriers to health, housing and stability.

Assertive Community Treatment

ACT and T-ACT

An Assertive Community Treatment (ACT) team delivers services in a collaborative team model to individuals with histories of hospitalizations and diagnosis with psychosis who have personal goals of living in the community. A T-ACT team focuses on teens.

Partnership Descriptions

Health and Wellness Clinic

The CHUM Health and Wellness Clinic, staffed by a Registered Nurse (RN) 20 hours per week, provides basic health screenings, referrals to community health providers, and health education. Through a relationship between the U of M Duluth Schools of Medicine and Pharmacy, CHUM hosts the HOPE Clinic for CHUM clients without medical insurance.

Continuum of Care

CoC

The St. Louis County Continuum of Care (CoC) is a coalition of organizations governed by the Heading Home Governing Board that coordinates the County's homeless response system and HUD CoC funding for programs for homeless families and individuals.

Health Care and Homelessness Committee

This Committee includes CHUM, Essentia Health and St. Luke's. This group's goal is to improve the quality and coordination of care for people experiencing homelessness, especially at transitions of care between CHUM and the health care providers

Housing Access Coordination

Housing Access Coordination allows The Arc Minnesota to assist adults with disabilities who are currently receiving an eligible waiver (such as Brain Injury Waiver, Community Alternative Care Waiver, Community Alternatives for Disabled Individuals Waiver, or the Developmental Disabilities Waiver) in finding and moving to independent homes of their own

Medical Respite

The Duluth Family Medical Residency Program, CHUM and Loaves & Fishes provide a safe shelter at the First Covenant Church parsonage for people experiencing homelessness and acute medical conditions.

Landlord Incentive Program

The Salvation Army and AEOA operate this program that gives incentives to landlords for renting to tenants with criminal backgrounds. Landlords can be reimbursed to cover the cost of lost rent, damages to their property, or other expenses

South St. Louis County Veteran's Treatment Court

This a special program designed to assist veterans involved in the criminal justice system who are diagnosed with a mental health or substance use disorder. The court promotes sobriety, recovery, and stability through a coordinated response.

Lake Superior Diversion and Substance Use Response Team

This program improves community outreach to overdose events by expanding outreach efforts to those with amphetamine-related substance use disorders and those who experience amphetamine-related overdoses. An Opioid Technician provides outreach and advocacy for people who are suffering from addiction.

IV. Lived Experience Interview

The project team had difficulties completing interviews with persons with lived experience of homelessness due to limitations caused by the pandemic. It is recommended that input from persons with lived experience be integrated into future planning initiatives to improve the local response to homelessness.

One phone interview was completed with an individual who has experienced homelessness in St. Louis County. Her input has been incorporated into this report and her story is included below.

A Mother's Journey through the St. Louis County Homeless Response System.

Ericka (*not her real name*) is a St. Louis County resident who has experienced homelessness. Ericka was stably housed in market rate housing with her partner, but she faced a housing crisis when the relationship ended and she wasn't able to afford rent on her own. Inability to pay rent combined with ongoing issues with property management led to her eviction during the holiday season. She leaned on Legal Aid for help fighting the eviction in court, but ultimately was ordered to pay her past due rent and court costs. Ericka wasn't aware of financial assistance that could have helped prevent her homelessness, but she said this may have helped her stay in her home at the time.

Throughout the next four years, Ericka faced homelessness while battling with addiction. During this time, she said she wasn't really looking for housing or assistance. Everything changed when Ericka found out that she was pregnant. She slept on her mom's floor and got sober, and she reached out for help.

Loaves and Fishes is credited as one of the most helpful supports in Ericka's housing journey. She stayed in their shelter throughout her pregnancy while searching for a place to call her own. "Loaves and Fishes gave me a place to bring my son home to. They were so kind and amazing. They just let me do my thing." The "amazing people" at Loaves and Fishes have "a lot of knowledge," and they helped connect Ericka to Coordinated Entry.

Ericka completed a Coordinated Entry (CE) assessment and was placed on the CE priority list for homeless programs. She shares that it's hard to explain the next steps in the process after completing the CE assessment and that there's no way of knowing how long the wait might be

before you get housing. She said she wasn't willing to wait around for her name to come up. She was actively calling any housing or programs that she might qualify for and asking for applications. After a total of five years of homelessness and five months after her CE assessment, Ericka was referred to a transitional housing program. About a year-and-a-half after that, she moved into subsidized housing where she still lives with her son.

Ericka says that her knowledge, persistence, and networking skills are the strengths she built on to get stable housing. She also credits her "amazing support system," which includes Loaves and Fishes, and most of all, she credits her son. "I do it for my kid. That's where my strength comes from. I have a kid who relies on me, and if I don't do it, no one's gonna do it for him. I can't let him fall through the cracks."

Her suggestions to improve the homeless response system include stronger agency collaboration and streamlining the process for people who need the services. Resources should be under one roof, and the response to homelessness should be a team effort among agencies, so that a person who is struggling with homelessness doesn't need to worry about how they'll get to the resources they need. "I would want to have to only go to one spot. It would be way more helpful with one or two places to go instead of like five."

Now Ericka is an advocate for others who face housing instability in St. Louis County.

"When people think of people who are homeless, they think of that guy who's dirty with a scruffy beard or the bag lady. I lived in my car for a winter one time. I made sure my car didn't look like I lived in it. Normal people experience homelessness. It's not always because people are lazy. There's so much more to the story. I really wanted to be part of making the connect between the actual person and the people on the other side."

VI. Next Steps

1. Build on current strengths in preventing and ending homelessness in St. Louis County:

- Strong and dedicated partners
- Successful outreach, shelter, transitional housing, rapid re-housing, permanent supportive housing, and affordable housing program.
- Multiple, effective partnerships for planning, implementing, and expanding resources to prevent and address homelessness.
- Expanding resources dedicated to preventing homelessness and increasing housing stability.

2. Share the information in this report broadly with a range of stakeholder groups including people who interact with the homeless response system, Communities of Color, Indigenous people, government and Tribal partners, and housing and service providers. Seek input and suggestions on areas for improvement in the following areas:

- Reduce racial disparities in homelessness.
- Decrease unsheltered homelessness.
- Expand permanent supportive housing for single adults with high barriers to housing stability.
- Improve system performance, particularly in the areas of returns to homelessness, and exits to permanent destinations.
- Support continuous improvement in the Coordinated Entry System, including the expansion of housing navigation and assessment resources.
- Increase engagement of sectors that intersect with the homeless response system: criminal justice, mental health, substance abuse treatment, and health.

3. Analyze existing homeless response system funding from HUD, State of Minnesota, and local sources. Identify any areas where funds can be better aligned to meet homeless system performance goals and address high priority needs as identified by the community.

4. Use data from the Environmental Scan, System Map, and Key Informant Interviews, along with broad community input to develop specific goals and strategies to improve St. Louis County's homeless response system. Adopt a plan at the Heading Home Governing Board to guide the St. Louis County Continuum of Care (CoC)'s planning efforts.

Appendix

A. Point in Time (PIT) Data Summary

B. Coordinated Entry Data Summary

C. Core Homeless Programs Data

D. Statewide Homeless Survey Analysis

E. Key Informant Interview Summary

F. Definitions and Acronyms

A. Point in Time Data Summary

Point in Time (PIT) Count Data Summary
MN-509 Duluth/St. Louis County Continuum of Care

The PIT count is a count of sheltered and unsheltered people experiencing homelessness on a single night in January. HUD requires that Continuums of Care conduct an annual count of people experiencing homelessness who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night. Continuums of Care also must conduct a count of unsheltered people experiencing homelessness. Each count is planned, coordinated, and carried out locally, and results are reported to HUD. [1]

Duluth/St. Louis County PIT Count Results, By Year:

	2014	2015	2016	2017	2018	2019	2020
Sheltered Households without children	123	120	117	112	108	134	163
Unsheltered Households without children	99	125	138	166	112	132	198
Sheltered Households with adults and children	59	59	63	61	50	62	62
Unsheltered Households with adults and children	3	10	2	4	8	5	17
Sheltered Households with only children	2	19	15	17	25	8	7
Unsheltered Households with only children	0	0	0	1	0	0	8
Total Households Experiencing Homelessness	**286**	**333**	**335**	**361**	**303**	**341**	**445**
Sheltered persons age 18 to 24 in households without children	30	27	36	23	26	18	29
Unsheltered persons age 18 to 24 in households without children	18	24	11	32	18	20	28
Sheltered persons over age 24 in households without children	95	94	125	90	87	119	137
Unsheltered persons over age 24 in households without children	95	118	141	146	105	149	193
Total Persons in households without children	**238**	**263**	**313**	**291**	**236**	**306**	**387**

[1] https://www.hudexchange.info/programs/hdx/pit-hic/

	2014	2015	2016	2017	2018	2019	2020
Sheltered children in households with adults and children (under age 18)	110	114	116	106	87	117	93
Sheltered persons age 18 to 24 in households with adults and children	25	18	26	26	21	25	16
Sheltered persons over age 24 in households with adults and children	43	50	50	48	31	48	45
Unsheltered children in households with adults and children (under age 18)	5	10	3	6	14	7	28
Unsheltered persons age 18 to 24 in households with adults and children	2	4	0	3	3	1	1
Unsheltered persons over age 24 in households with adults and children	4	11	3	2	8	6	24
Total persons in households with adults and children	**189**	**207**	**198**	**191**	**164**	**204**	**207**
Sheltered persons in households with only children	2	20	17	19	25	9	8
Unsheltered persons in households with only children	0	0	0	4	0	0	10
Total persons in households with only children	**2**	**20**	**17**	**23**	**25**	**9**	**18**
Total persons experiencing homelessness	**429**	**490**	**528**	**505**	**425**	**519**	**612**
Sheltered chronically homeless persons (adults and children)	50	54	70	22	27	39	54
Unsheltered chronically homeless persons (adults and children)	64	151	40	116	81	116	152
Total chronically homeless persons	**114**	**205**	**110**	**138**	**108**	**155**	**206**
Sheltered Veterans	15	14	13	13	9	13	15
Unsheltered Veterans	9	12	8	8	3	4	4
Total Veterans	**24**	**26**	**21**	**21**	**12**	**17**	**19**
Sheltered Unaccompanied Youth (up to age 24)	--	37	47	42	51	23	37
Unsheltered Unaccompanied Youth (up to age 24)	--	24	11	32	18	14	35
Total Unaccompanied Youth (up to age 24)	**--**	**61**	**58**	**74**	**69**	**37**	**72**

B. Coordinated Entry Data

Coordinated Entry System (CES) Homeless Management Information Systems (HMIS) CE Monitoring Report Summary:

The CES Monitoring Report summarized Coordinated Entry HMIS data to help CoCs identify gaps in the coordinated entry process and to inform resource planning. The Coordinated Entry System is a streamlined process that people without housing can use to access housing programs for homeless people. Participants are assessed for their needs, placed on priority lists based on the type of housing opportunity that would meet their needs, and referred to openings when there are vacancies.

Coordinated Entry System Participants

Between April 1, 2020 and September 30, 2020, 1,888 households were assessed for Coordinated Entry (CES) in HMIS in the St. Louis County Continuum of Care:

Number of Households on Priority list during Period: 1888

Number on the Priority List First Day of Period: 1374

Number Entering During Period: 514

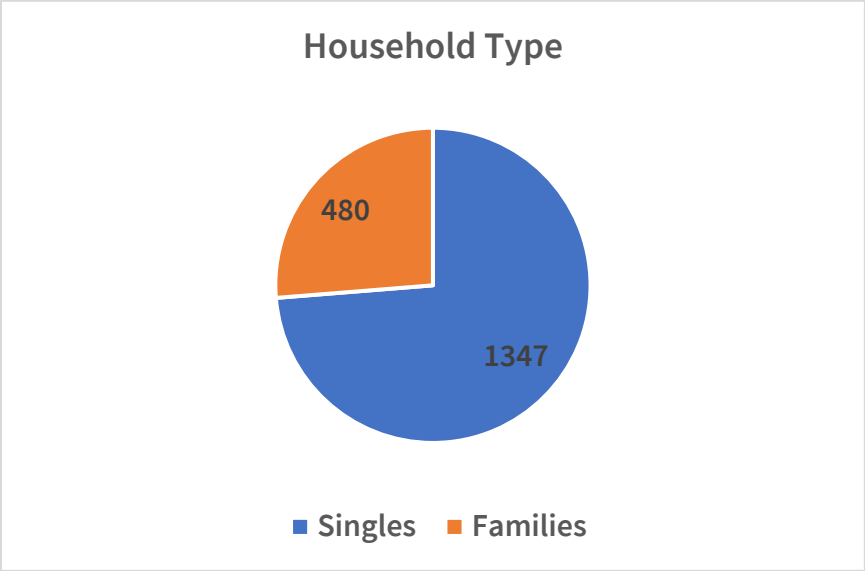
Number Leaving During Period: 424

Number on the Priority List on the Last Day of the Period: 1464

Net Change (Last day – First Day): 90

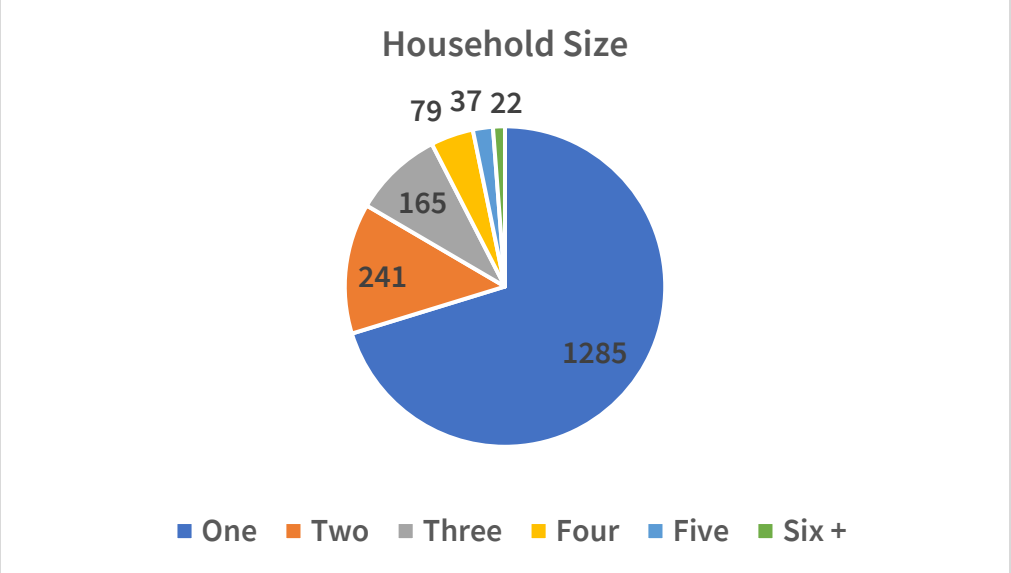
Household Composition

Single Households made up 71% of homeless persons assessed for CES; Family Households made up 25%. For sixty-one households (3%), no household information was available.



Household Size

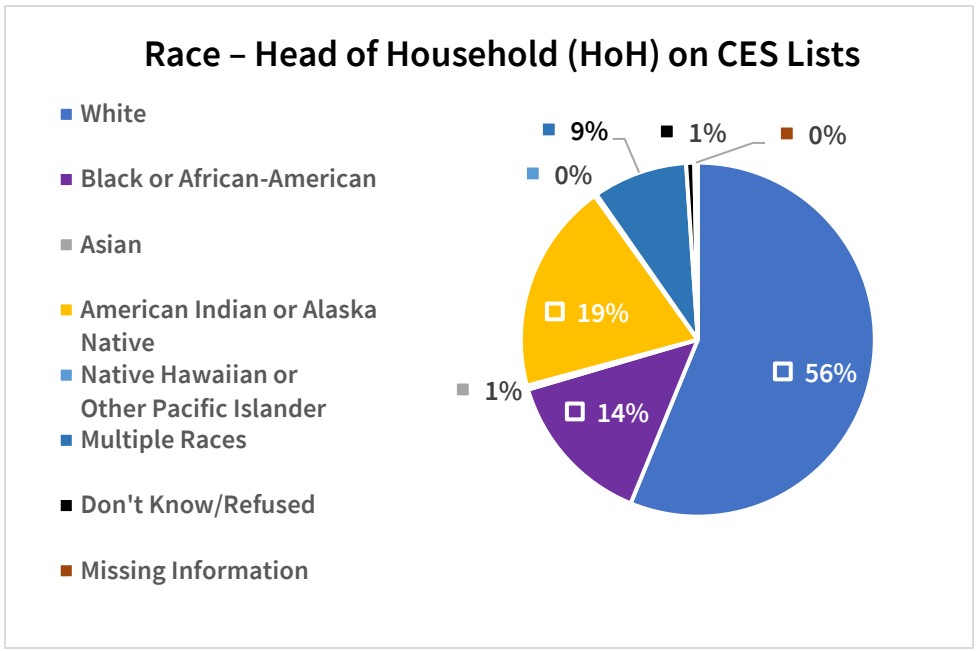
Most households (70%) assessed for CES are one-person households. Two person households make up 13% of households assessed, and three person households make up 9% of all persons assessed for CES.



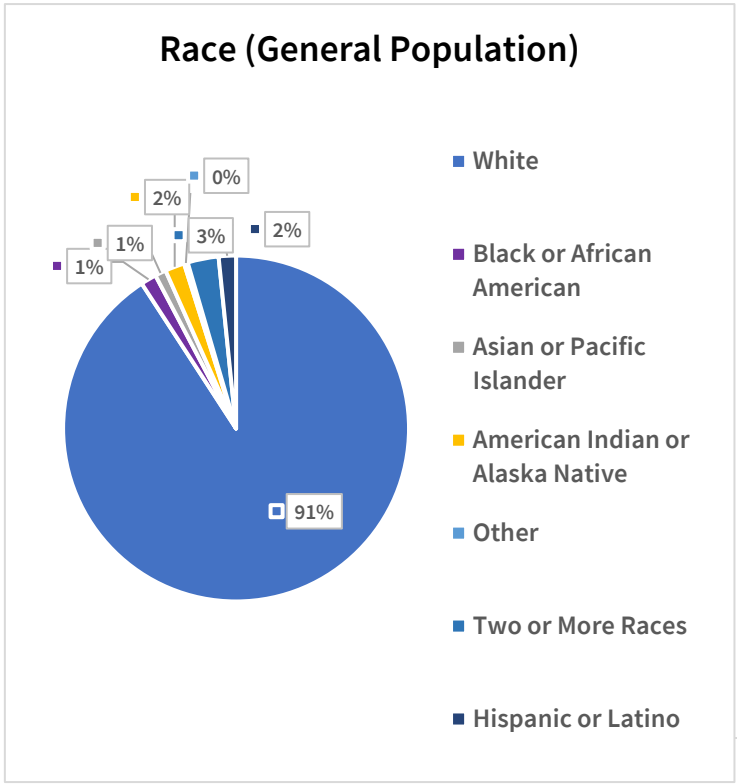
Race and Ethnicity

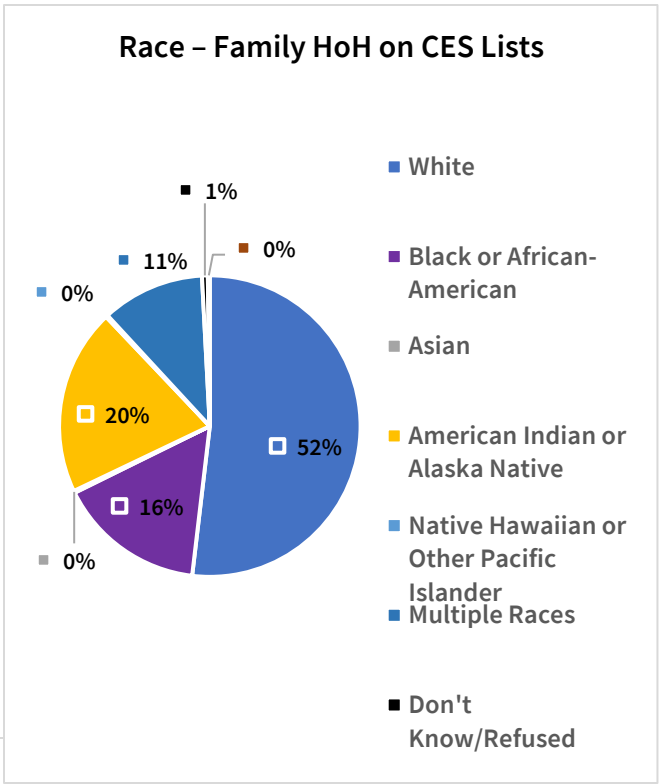
Over half (56%) of CES participants in St. Louis County are white; 44% are American Indian, Black/African American, Asian, Native Hawaiian/Other Pacific Islander, or Multiple Races. Most, 96%, identified as Non-Hispanic/Non-Latino.

By comparison, in the general population of St. Louis County, People of African Heritage, People who are Black or Indigenous, and other People of Color make up 9% of the population.



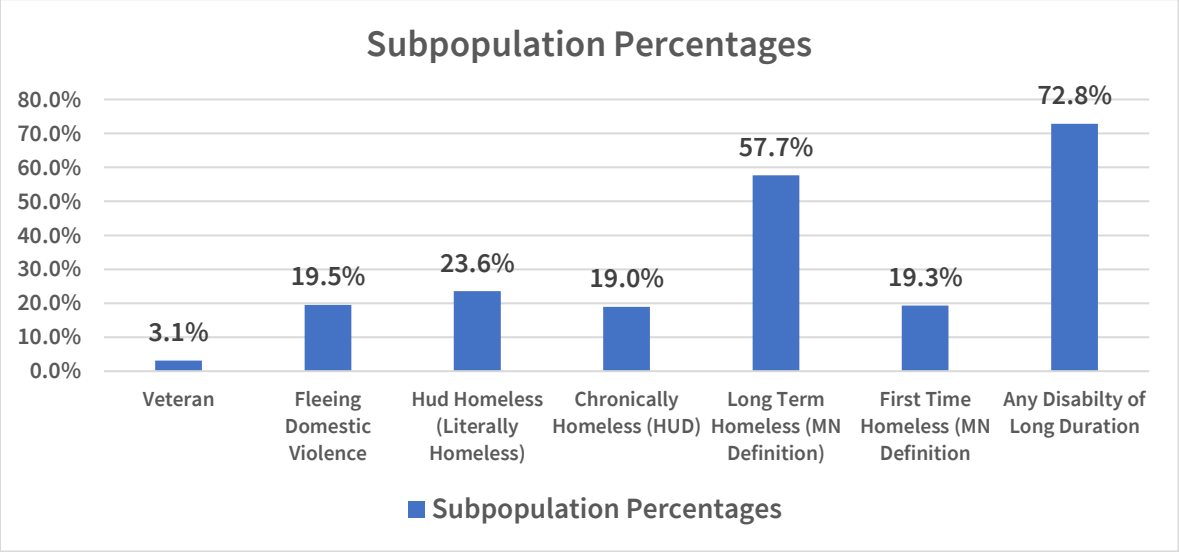
The percentage of Family Households assessed for Coordinated Entry who identify as Black, American Indian, Asian, or Multiple Races is higher than the total population of CES participants.



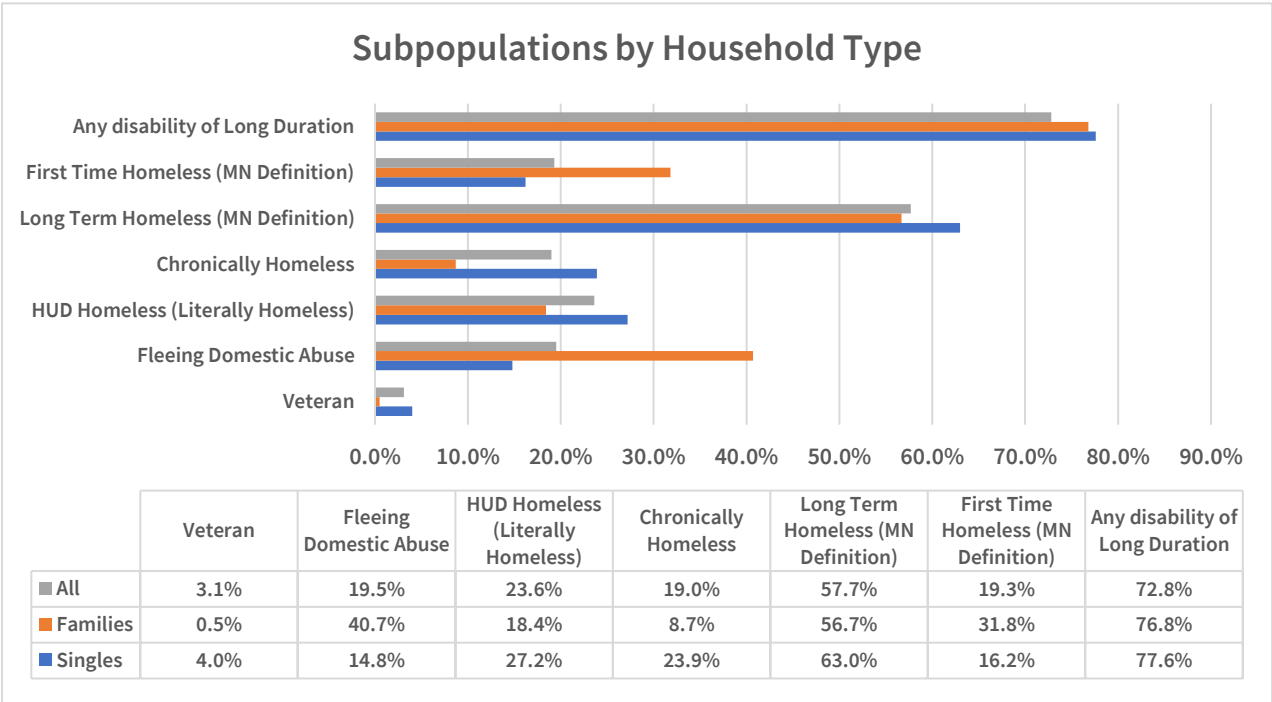


Subpopulations

Seventy-three percent of all CES households have a member with a disability of long duration, and more than half (57.7%) meet Minnesota's definition of long-term homelessness.



Families are more likely to be homeless for the first time. Adults without children/Singles are more likely to have a disability of long duration or to have multiple episodes of homelessness.

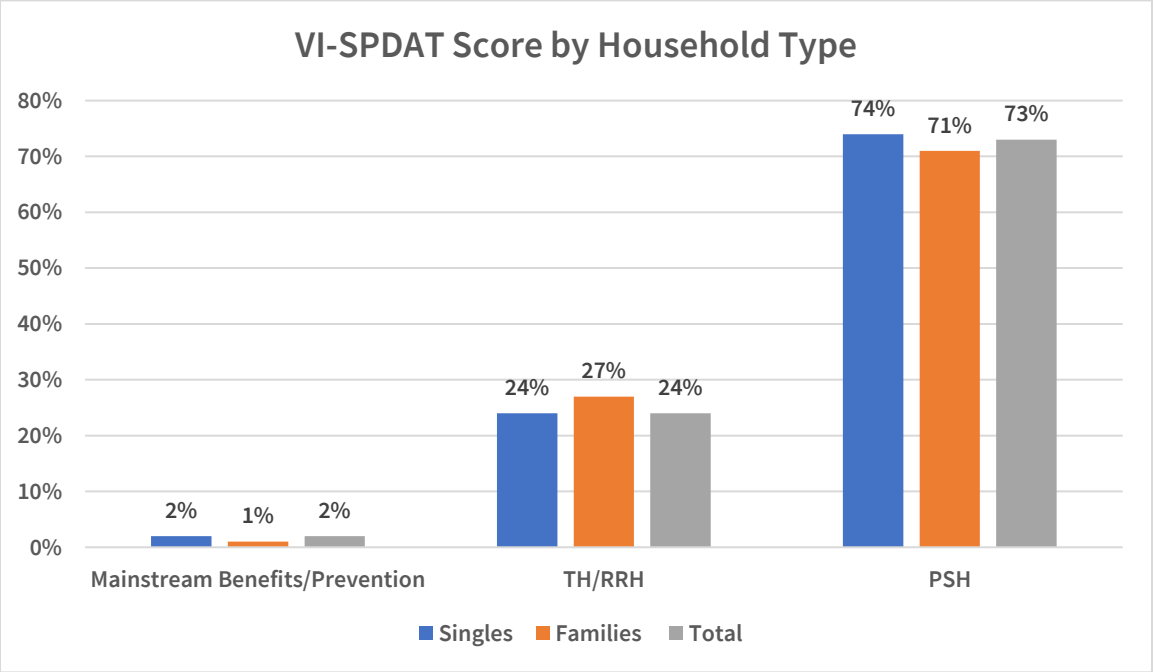


	Veteran	Fleeing Domestic Abuse	HUD Homeless (Literally Homeless)	Chronically Homeless	Long Term Homeless (MN Definition)	First Time Homeless (MN Definition)	Any disability of Long Duration
All	3.1%	19.5%	23.6%	19.0%	57.7%	19.3%	72.8%
Families	0.5%	40.7%	18.4%	8.7%	56.7%	31.8%	76.8%
Singles	4.0%	14.8%	27.2%	23.9%	63.0%	16.2%	77.6%

Single households are more likely to have longer episodes of homelessness, to be disabled, and to be veterans. Family households are more likely to be fleeing domestic violence and to be homeless for the first time.

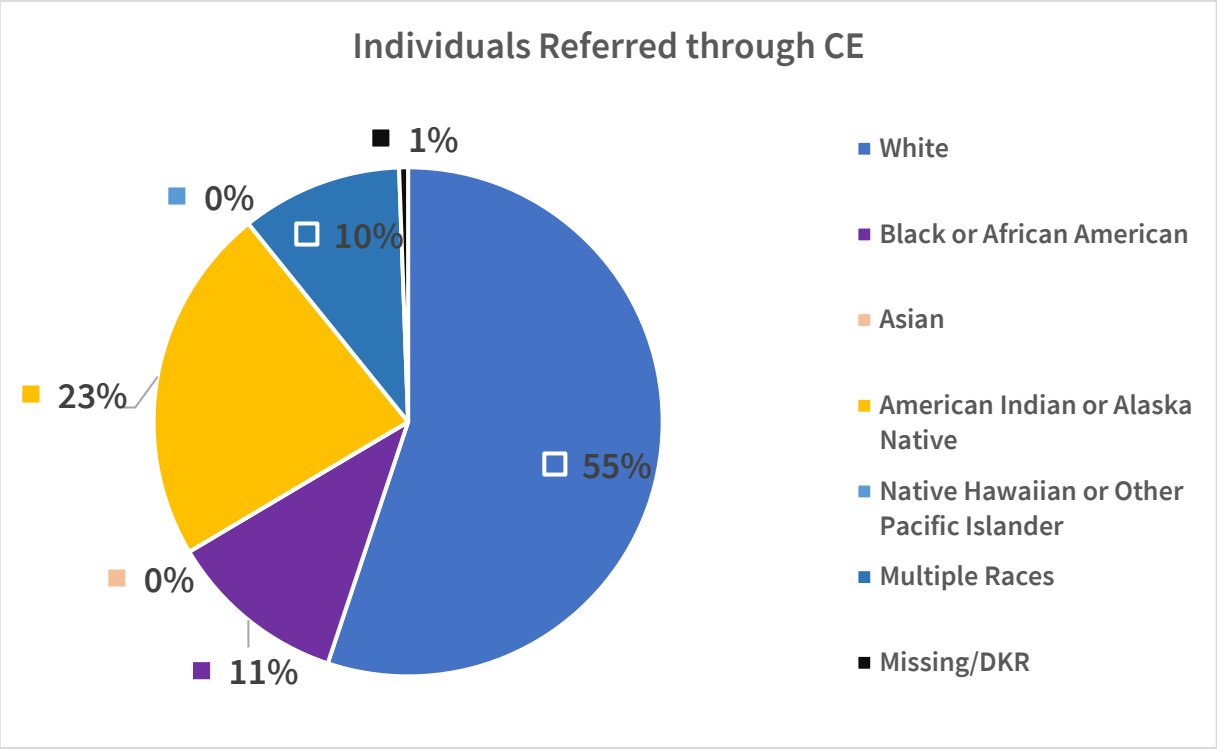
VISPADT (Vulnerability Index System Performance Decision Assistance Tool) Score

Most households assess for housing vulnerability on the Coordinated Entry System (CES) Priority list, score for Permanent Supportive Housing (PSH). A total of 1,346 total households received a score indicating that they needed permanent supportive housing. For families, 281 scored for PSH, and for singles there were 996.

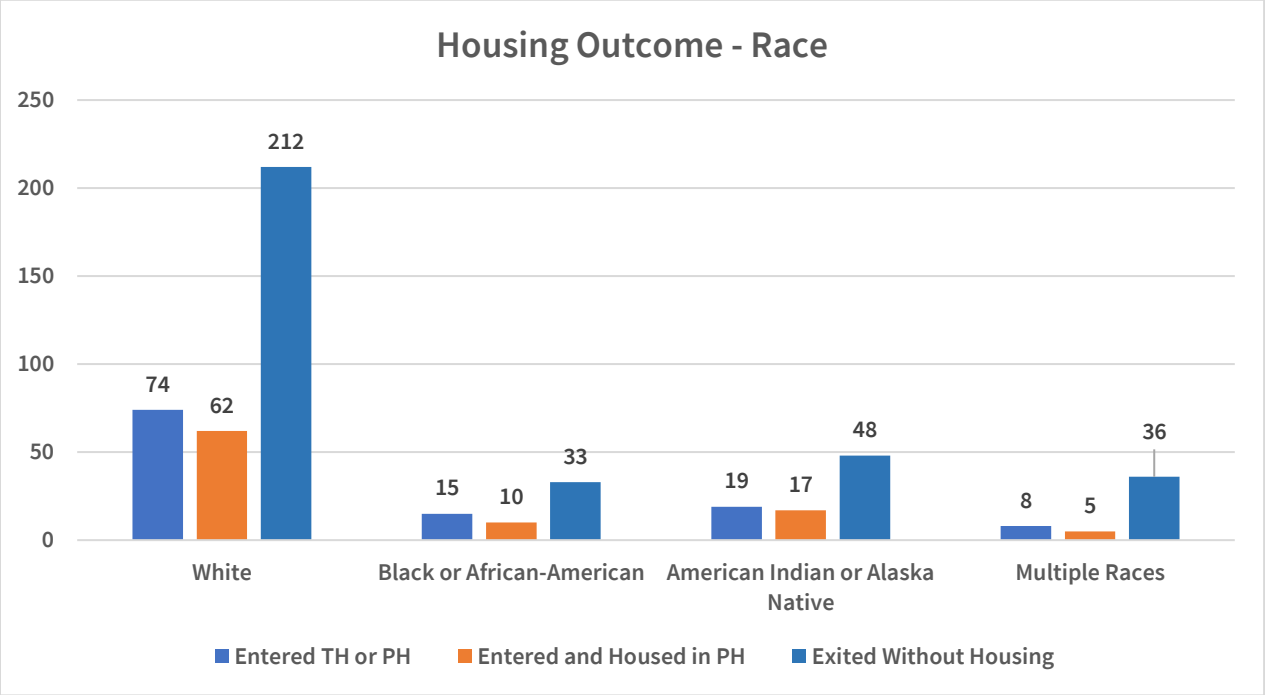


Coordinated Entry Referrals by Race

- 9% of all White Heads of Household (HoH) on the CE List (97 of 1061) received a referral to a housing project.
- 7% of all Black or African American HoH on the CE list (20 of 269) received a referral to a housing project.
- 11% of all American Indian or Alaska Native HoH on the CE lists (40 of 364) received a referral to a housing project.
- 11% of all HoH of Multiple Races (18 of 163) received a referral to a housing project.



Housing Outcomes by Race



A small percentage of households left the CES lists and entered permanent housing during this time period. Overall, 541 households out of 1,888 exited the CES lists (29%), and 94 households (5% of all people on the lists) entered and were housed in permanent housing.

Of the 541 households who exited, 17% entered and were housed in permanent housing.

Entered Transitional Housing (TH) or Permanent Housing (PH) – All Households on the CES Lists

- 7% of White Heads of Household (HoH) on the CE lists (74 of 1061) entered TH or PH
- 6% of Black or African American HoH on the CE lists (15 of 269) entered TH or PH
- 5% of American Indian or Alaska Native HoH on the CE lists (19 of 364) entered TH or PH
- 5% of HoH of Multiple Races on the CE lists (8 of 163) entered TH or PH
-

Entered and Housed in Permanent Housing – All Households on the CES lists

- 6% of White HoH on the CE lists (62 of 1061) were entered and housed in PH
- 4% of Black or African American HoH on the CE lists (10 of 269) were entered and housed in PH
- 5% of American Indian or Alaska Native HoH on the CE lists (17 of 364) were entered and housed in PH
- 3% of HoH of Multiple Races on the CE lists (8 of 163) were entered and housed in PH

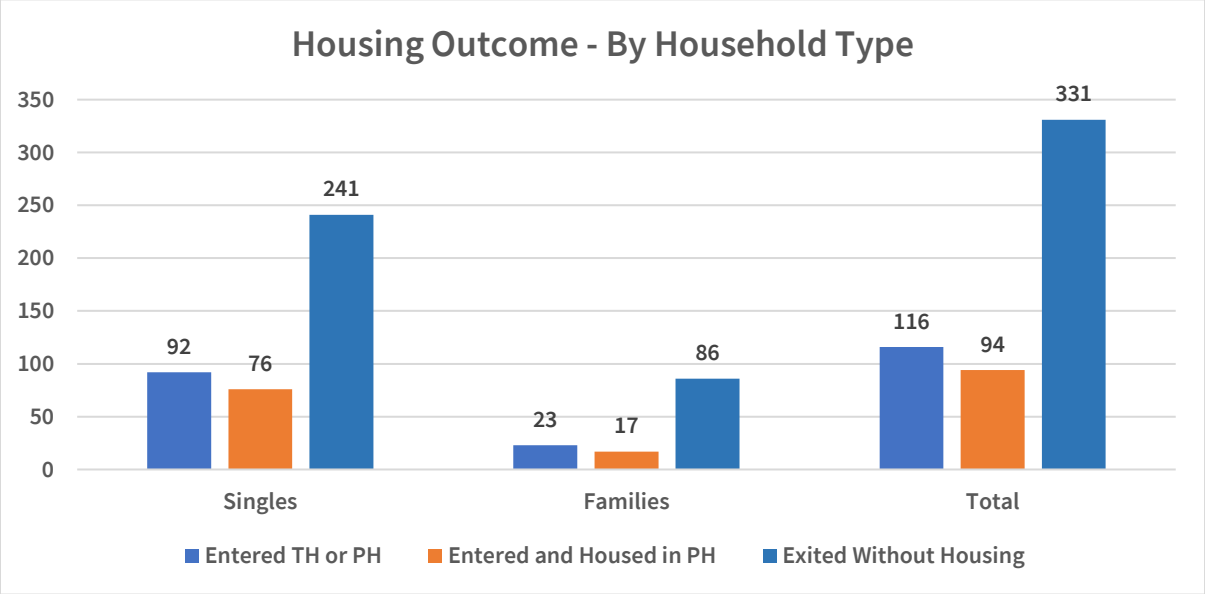
Exited without being housed – All Households on the CES lists

- 20% of White HoH on the CE lists (212 of 1061) exited the CE lists without being housed (not housed through a program in CE)
- 12% of Black or African American HoH on the CE lists (33 of 269) exited the CE lists without being housed (not housed through a program in CE)

- 13% of American Indian or Alaska Native HoH on the CE lists (48 of 364) exited the CE lists without being housed (not housed through a program in CE)
- 22% of HoH of Multiple Races on the CE lists (36 of 163) exited the CE lists without being housed (not housed through a program in CE)

Housing Outcomes by Household Type

Of households that exited the CES lists, 19% of single Head of Households (HoH) entered and were housed in permanent housing. For family households, 13.5% entered and were housed in PH. Overall, 17% left the CES lists and were housed in permanent housing.



C. Core Homeless Programs Data

Minnesota Core Homeless Programs Report Summary 10/1/2019 – 9/30/2020

Programs that assist people who are homeless and that receive funding from HUD or the State of Minnesota are required to report data on program participants in the Homeless Management Information System (HMIS). Minnesota's Core Homeless Report summarizes HMIS data for all programs in a specific geographic area.

MN Core Homeless Programs Data Summary: St. Louis County

Summary of Households Served

Total Households Served	2188
Total Leavers (Households who exited):	1354
Stayers (Households with No Exit):	834

Demographics (All Persons Served)

Total People Served	3170
Type of Household	
Singles without children	1849 (58%)
Families with children	1321 (42%)
Gender	
Female	1476 (47%)
Male	1671 (53%)
Trans Male (FTM)	4 (<1%)
Trans Female (MTF)	5 (<1%)
Gender Non-conforming	5 (<1%)
Race	
American Indian/Alaska Native	684 (22%)
Black or African American	485 (15%)
Multiple Races	366 (10.6%)
White	1636 (52%)
Native Hawaiian or Other Pacific Islander	4 (<1%)
Asian	0

Subpopulations	
Veterans (Adults)	157 (6.8%)
Chronically Homeless (Adults/HoH)	630 (27%)
Long-term Homeless (Adults/HoH)	1191 (51%)
Discharged from jail/prison (Adults/HoH)	269 (11%)
Survivor of Domestic Violence (Adults/HoH)	838 (27%)
Disability of Long Duration	1840 (58%)
Chronic Health Condition	233 (13%)
Physical Disabilty	441 (24%)
Serious Mental Illness	1225 (66%)
Substance Use Disorder	699 (38%)
Developmental Disability	173 (9%)

Demographics (Heads of Household)

	Permanent Housing (PH) Providers
Total Households Served	2188
Type of Household	
Singles without children	1787 (82%)
Families with children	401 (18%)
Gender	
Female	992 (45%)
Male	1183 (54%)
Trans Male (FTM)	4 (<1%)
Trans Female (MTF)	4 (<1%)
Gender Non-conforming	5 (<1%)
Race	
American Indian/Alaska Native	418 (19%)
Black or African American	303 (14%)
Multiple Races	173 (8%)
White	1278 (58%)
Native Hawaiian or Other Pacific Islander	4 (<1%)
Asian	5 (<1%)
Subpopulations	
Veterans (Adults)	154 (7%)
Chronically Homeless (Adults/HoH)	604 (28%)
Long-term Homeless (Adults/HoH)	1142 (52%)
Discharged from jail/prison (Adults/HoH)	264 (12%)
Survivor of Domestic Violence (Adults/HoH)	810 (37%)
Disability of Long Duration	1664 (76%)

Chronic Health Condition	220 (13%)
Serious Mental Illness	1146 (68%)
Substance Use Disorder	665 (40%)
Physical Disability	420 (25%)
Developmental Disability	138 (8%)

Exit Destination by Residence Prior (Heads of Household)

Total Exits	1337	
Exits to Permanent Destinations	512 (38%)	
Exits to Homeless Situations	62 (5%)	
Permanent Exits by Residence Prior		
Homeless Prior to Entry	Total Exits	Exits to PH
	500	154 (31%)
Living in an Institution Prior to Entry	Total Exits	Exits to PH
	165	33 (20%)
Living in Permanent or Transitional Housing Prior to Entry	Total Exits	Exits to PH
	650	308 (47%)

Exit Destination by Race (Heads of Household)

	Permanent Housing (PH) Providers	
Permanent Exits by Race		
White	Total Exits	Exits to PH
	800	350 (44%)
Black or African-American	Total Exits	Exits to PH
	191	79 (41%)
American Indian or Alaska Native	Total Exits	Exits to PH
	232	52 (22%)
Native Hawaiian or Other Pacific Islander	Total Exits	Exits to PH
	2	1 (50%)
Asian	Total Exits	Exits to PH
	3	2 (67%)
Multiple Races	Total Exits	Exits to PH
	104	26 (25%)

Exit Destination by Subpopulation (Heads of Household)

Permanent Exits by Race		
Chronically Homeless	Total Exits	Exits to PH
	333	68 (20%)
Long-Term Homeless	Total Exits	Exits to PH
	583	146 (25%)
Veteran	Total Exits	Exits to PH
	100	48 (48%)
Domestic Abuse Survivors	Total Exits	Exits to PH
	416	158 (38%)
Persons with Any Disability of Long Duration	Total Exits	Exits to PH
	957	346 (36%)
Chronic Health Condition	Total Exits	Exits to PH
	135	32 (24%)
Persons with a Serious Mental Illness	Total Exits	Exits to PH
	610	173 (28%)
Persons with Substance Abuse (alcohol or drug)	Total Exits	Exits to PH
	363	64 (18%)

D. Statewide Homeless Survey Data

Wilder Research Center Homeless Survey Summary:

Every three years, Wilder Research conducts a statewide survey of people experiencing homelessness or living in temporary housing programs. The 2018 study took place on October 25, 2018 and included two components that captured information on that date: 1) face-to-face interviews with people throughout the state who were experiencing homelessness and 2) a count of people experiencing homelessness. [1]

Analysis of 2018 Homeless Survey Results for St. Louis County

1. Number of Homeless People in St. Louis County, Minnesota

On the night of the 2018 Statewide Homeless Survey, coordinated by the Wilder Research Center on October 25, 2018, there were a total of 760 persons counted as homeless in St. Louis County.

There were 264 unaccompanied youth and adults who were living in a battered women's shelter, emergency shelter, transitional housing, or youth overnight shelter on the night of the survey. These 264 people had 106 children under the age of 18.

On the same night, there were 345 homeless adults who were living in informal arrangements or unsheltered. Persons in informal shelter were likely to be in a house, apartment, or room in which they were allowed to stay on a temporary basis; a motel room they paid for; or in a jail or detox facility from which they had no place to go when they were released. Unsheltered persons were more likely to be in cars or other vehicles, transportation depots, 24-hour businesses, building that are abandoned or unfit for habitation (lacking plumbing, electricity, or heat) or outdoor locations.

The households of the unsheltered people included 45 children.

Persons Sheltered on 10/25 /2018			**Persons Unsheltered on 10/ 2 /2018**			**Total**
Unaccompanied Youth under 18	Adults	Children with Parents	Adults	Unaccompanied Youth under 18	Children with Parents	
23	241	106	345	0	45	760

[1] http://mnhomeless.org/

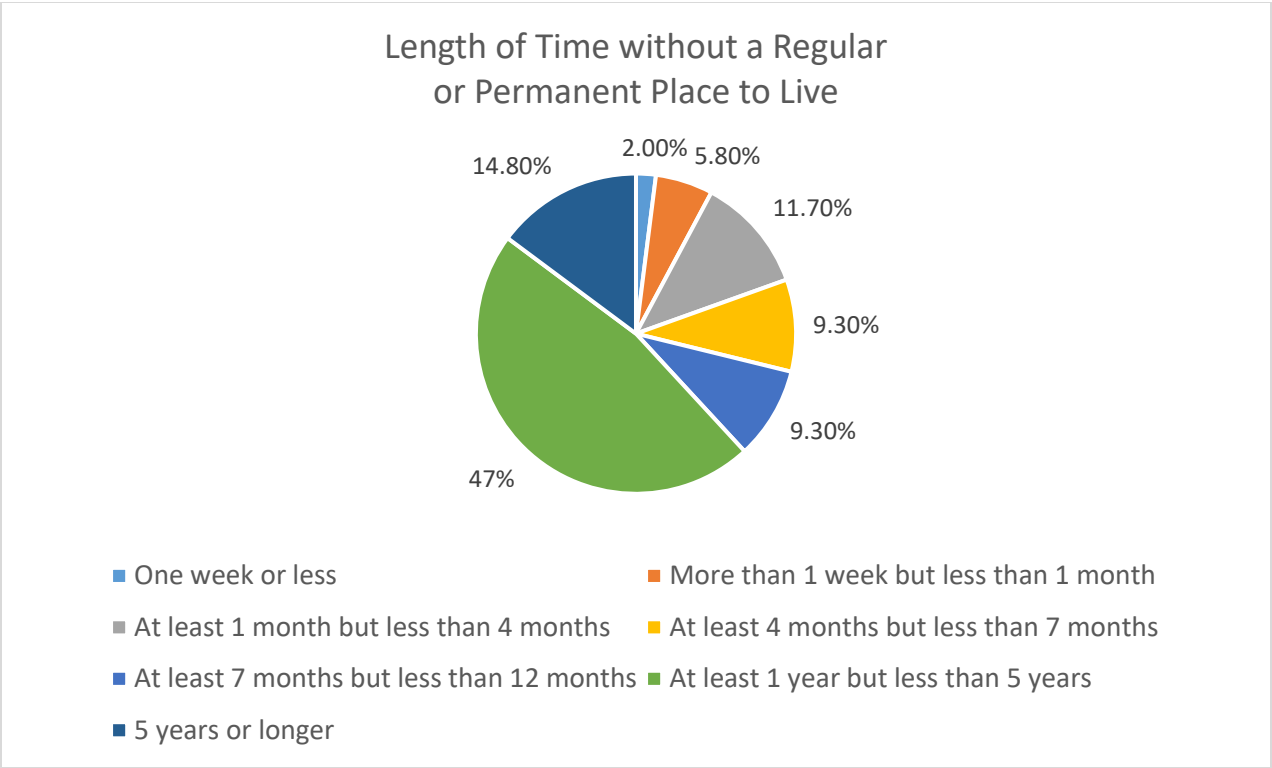
2. Characteristics of Homeless People in St. Louis County, Minnesota

Demographics

- The average age was 37.
- 54.6% were male; 44.8% were female. 1.4% were transgender.
- 87.0% were heterosexual or straight; 13% were gay or lesbian, bisexual, unsure, or self-identified.
- 9.8% of men and 1.3% of women have served in the U.S. Military.
- 49.3% were white or Caucasian; 15% were African American; 23.7% were American Indian; 10.1% were Multi-racial.
- 4.2% were of Hispanic or Latino origin.
- 68.8% had never married, 18.1% were divorced, 6.1% were separated, 3.6% were married, and 3.3% were widowed.
- 51% grew up in Greater Minnesota. 71% grew up in Minnesota.
- 10.6% have lived in Minnesota for 11 to 19 years; 64.0% have lived in Minnesota for 20 years or more.
- Overall, 6% of respondents served in the U.S military (9.8% of males and 1.3% of females).

Homelessness/Housing History

- 68.3% of people met Minnesota's definition of long term homeless. This included:
    - 44 men and 17 women in emergency shelter,
    - 16 women in domestic violence shelter,
    - 28 men and 39 women in transitional housing,
    - 128 men and 85 women who were unsheltered.
- 35.1% of people met HUD's federal definition of chronic homeless. This included:
    - 41 men and 13 women in emergency shelter,
    - 5 women in domestic violence shelter,
    - 19 men and 4 women in transitional housing,
    - 73 men and 28 women who were unsheltered.
- In the last three months, 25.4% of respondents were turned away from a shelter because there was no space available.
- Two thirds of respondents, 65.9%, are currently on the waiting list for Section 8 housing or some other type of housing that offers financial assistance. The average amount of time on the waiting list is 9 months.
- The average number of nights that survey respondents had spent outside was 9. The average number of nights males had spent outside in the last month was 11, and or females, it was 7.
- The average number of nights that survey respondents spent doubled up in the last month was 7 days. The average number of nights that males had spent doubled-up in the last month was 6. For females, it was 9.
- Most respondents had been without a regular or permanent place for more than one year.



Incarceration

- 59.8% of survey respondents spent time in a correctional facility. Over half, 53.4%, were in a county jail or workhouse for a month or more; 27.0% were in a juvenile detention center or other juvenile facility or camp; and 26.4% were in a state or federal prison.
- Of those who left a correctional facility in the past 12 months, 21% had a stable place to live when they left that facility.
- Of those who left a correctional facility in the past 12 months, just 24.7% received help finding a stable place to live when they left.

Education/ Income and Benefits

- 40.2% graduated from high school or received their GED. 37.1% completed education beyond high school.
- 9.2% are current enrolled in adult education, college, or a job training program.
- 21.4% currently have steady employment as an income source.
- Main sources of income are:

	Total	
Source of Income	**N**	**%**
General Assistance	113	22.2%
Another Social Security program like Disability Insurance	110	21.5%
Steady or Temporary employment	84	16.4%
No income source indicated.	66	12.9%
MFIP or another family welfare program.	43	8.5%
Any other source	42	8.2%
Asking for money on the street	22	4.2%
Social Security (old age or survivor benefits)	5	1.1%
Child Support payments	3	0.6%
Emergency Assistance	2	0.4%

- Median total monthly income from all sources is $210 for males, $500 for females, and $400 total.

- During the month of October, people surveyed reported using or receiving the following benefits.

	Total	
Service or Benefit	**N**	**%**
Free Hot meals	365	70.1%
Food Stamps or SNAP	344	65.9%
Free or almost free clothing shelves	268	51.7%
Drop in Centers or Opportunity Centers	261	50.3%
Transportation assistance (including bus tokens or cards)	241	46.2%
Food shelves	240	46.1%
Medical or dental services	227	44%
Outreach Services	192	37%
Mental Health Services	193	36.9%
Emergency room	155	29.6%
Help getting financial or other public benefits	146	28.1%
Help getting an ID	92	17.6%
Help finding a job	81	15.4%
Free voicemail or cell phone service	57	10.9%
WIC (Women Infant and Children Food Program	35	6.8%
None of the above services and benefits indicated as received	8	1.6%

- Respondents said that Food Stamps/SNAP helped them the most (45%).
- The public benefit received by the most respondents is public medical benefits (Medicare, MinnesotaCare, Medical Assistance), with 80.9% receiving medical benefits.

Employment

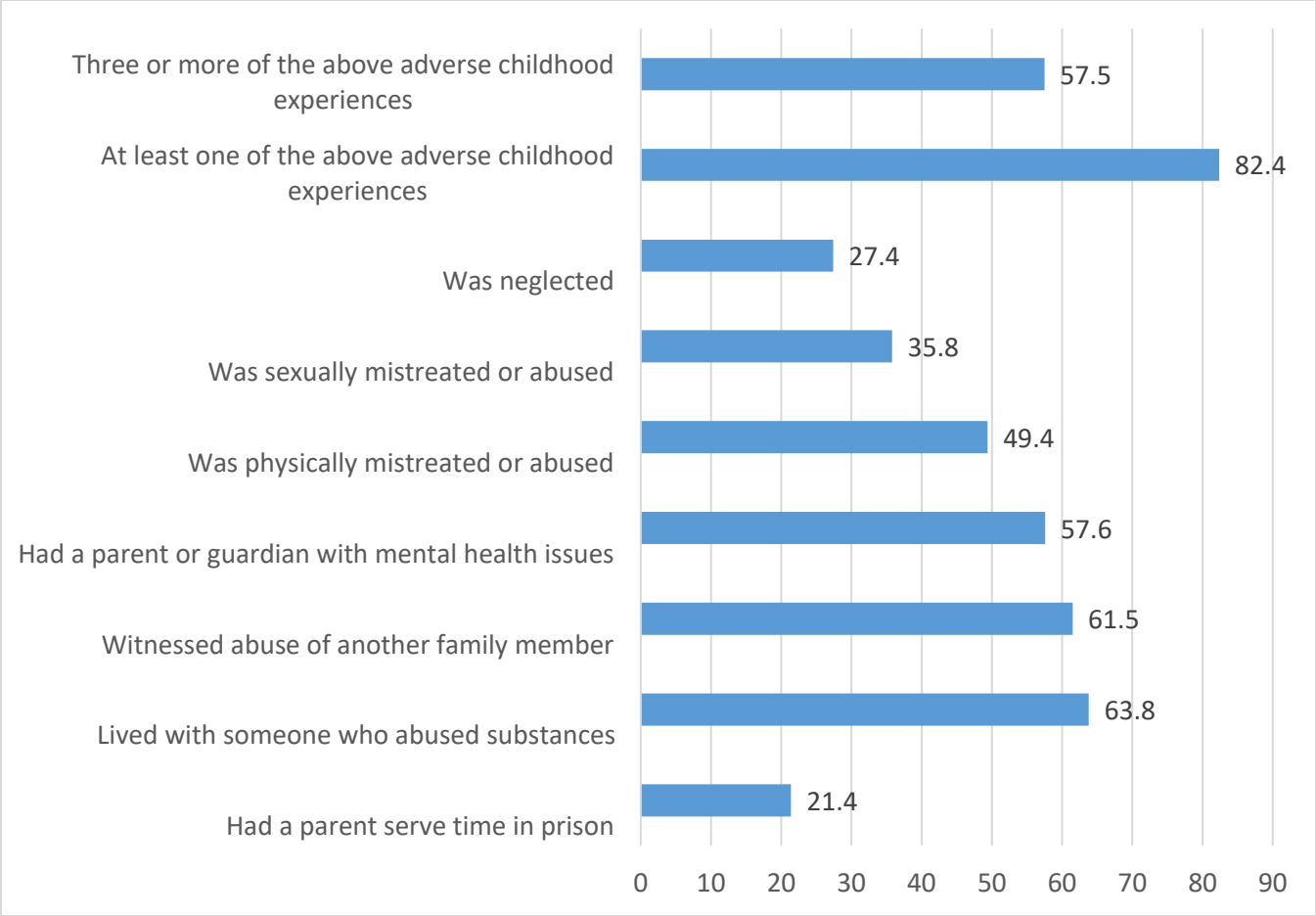
- 20.3% of survey respondents are currently employed.
- Of those not employed, 49.3% are currently looking for work.
- For those not employed, the biggest barriers or problems to getting a job now are:
    - Physical health
    - Transportation
    - Mental and chemical health (including TBI)
    - Housing (lack of, shelter rules prevent some types of work, lack of stability)
    - Lack of resources needed to work or look for work (ID, clean clothes, phone, etc.)
    - Criminal history
    - Personal reasons (family issues, legal issues, can't find appropriate work, etc.)
    - Lack of Childcare
    - Lack of employment opportunities (no available jobs, pay too low, no jobs in area, etc.)
    - Lack of job experience/poor work history Lack of education (certification / job skills, language barrier, etc.)
    - Age (too old or too young)
    - Miscellaneous (including retired, would lose benefits if employed, etc.) C
    - Children (health, safety of)
    - Discrimination / prejudice / race

Physical and Mental Health

- 56.8% had a chronic health condition.
- 36.2% felt they needed to see a health professional about a physical health problem.
- 51.8% felt they needed to see a health professional about a mental health problem.
- 52.1% needed to see a health professional about a tooth or gum problem.
- 31.2% were not taking medicine or prescriptions that they were supposed to be taking.
- 22.4% had a physical, mental, or other health condition that makes it hard to bath, eat, get dressed, get in or out of bed, or get around.
- 75.6% had been told by a doctor or nurse, in the past two years, that they had a mental health diagnosis.
- 37.2% had been told by a doctor or nurse, in the past two years, that they had a chemical dependency diagnosis.
- A total of 216 survey respondents, 42.2%, consider themselves to be an alcoholic or chemically dependent. Half, 51.4% have been treated in an outpatient alcohol or drug treatment program.

Adverse Childhood Experiences

Survey respondents reported the following adverse childhood experiences.



Homeless Adults with Children

Overall, adults who were interviewed in St. Louis County are parents of 412 children age 17 or younger. This includes children who were not with parents on the day of the survey. The average age of these children is 7.

Parents identified the following challenges for children living with them:

- 11.4% reported that they have at least one child who has a chronic or severe physical problem that interferes with daily activities.
- 36.4% reported that they have at least one child with an emotional or behavioral problem that interferes with daily activities.
- 46.8% were unable to get regular childcare for their children.
- 32.3% were unable to get regular dental care for their children.
- 17.4% were unable to get physical health care for their children.
- 18.0% were unable to get mental health care children.
- 4.1% reported that their children had to skip meals in the last month due to lack of money to buy food.
- 62.0% have children with learning or school problems that resulted in the child receiving additional services such as tutoring, summer school, or special education assessments.

3. Causes of Homelessness in St. Louis County

Homeless people in St. Louis County, Minnesota reported that they left their last regular or permanent housing for the following reasons:

	Male	Female	Total
Eviction or lease not renewed.	132	118	250
Couldn't afford rent or house payments:	9	5	14
Lost job or had hours cut	97	88	185
Breakup with spouse or partner	99	70	169
Substandard or unsafe housing	33	45	77
Entered treatment, jail or residential program:	62	78	140
Abuse by someone you lived with	32	81	113
Violence in neighborhood	71	47	119
Medical expenses or health care-related debt.	79	89	168
Problems getting along with other people they lived with:	69	65	134
Home you owned or were renting went into foreclosure	19	9	28

People experiencing homelessness in St. Louis County also reported that they have had difficulty renting an apartment or getting housing because of the following reasons:

	Male		Female		Total	
	N	%	N	%	N	%
No housing you could afford:	151	53.1%	146	62.6%	297	57.4%
Credit problems	105	36.8%	121	52.4%	226	43.8%
Criminal background	131	45.7%	63	27.2%	194	37.4%
No local rental history	107	37.3%	71	31%	178	34.5%
Eviction action, unlawful detainer, or bad rental history	69	24.1%	88	38%	156	30.3%
Alcohol or chemical use by you or anyone in household.	74	25.7%	47	20.1%	112	23.2%
No transportation	56	19.5%	52	22.4%	109	20.8%
Mental health problem	45	15.7%	45	19.1%	89	17.3%
Your race or the race of a family member:	28	9.8%	19	8.3%	47	9.1%
Family size	13	4.4%	21	9%	34	6.5%
Age	15	5.4%	8	3.4%	23	4.5%
Physical disability	11	3.8%	11	4.5%	21	4.1%

65.9% of survey respondents reported that they are currently on a waiting list for public housing, Section 8 housing, or some other type of housing that offers financial assistance. The average time they were on the waiting list was 7 months.

4. Comparisons of Homeless Survey Data in 2009, 2012, 2015, and 2018

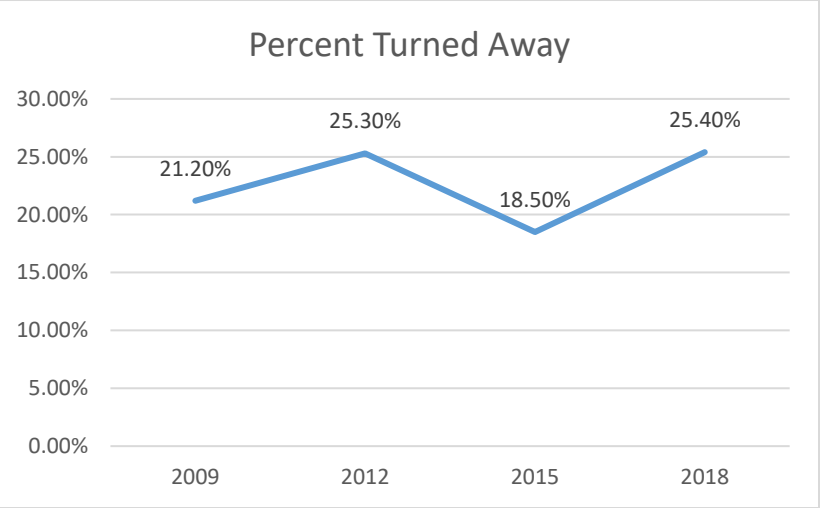
Number of Homeless Individuals and Families

	2009	2012	2015	2018
Who did you stay with last night?				
Alone	51.6%	46.2%	60.6%	57%
Spouse/Partner/Significant Other	7.9%	9.5%	13%	17.6%
Children age 17 or younger	15.6%	29%	21.9%	18.7%

The total percentage of homeless adults staying with children age 17 or younger decreased from 2012 to 2018.

The total percentage of homeless individuals that stayed alone the prior night has increased from 2012 to 2015, and then decreased slightly in 2018. But people staying alone made up the majority of survey respondents in 2018.

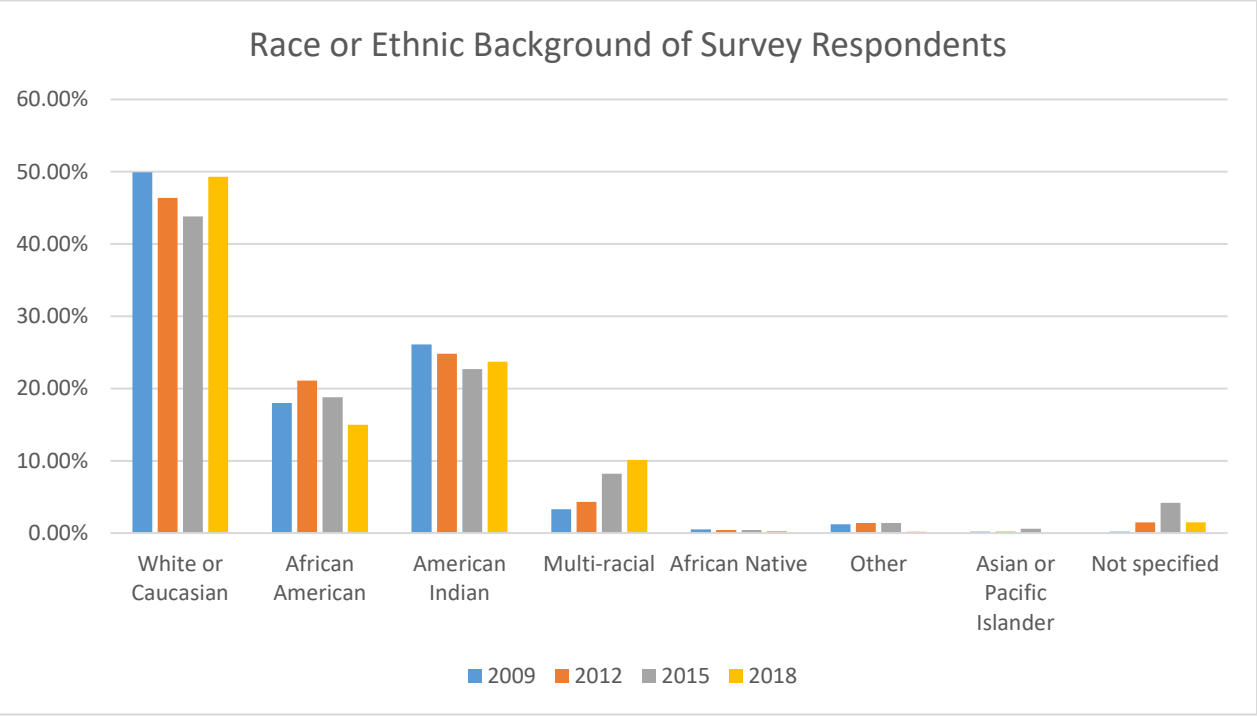
Shelter Turn Away



	2009	2012	2015	2018
Turned away from shelter over the last 3 months because there was no space available.	21.2%	25.3%	18.5%	25.4%

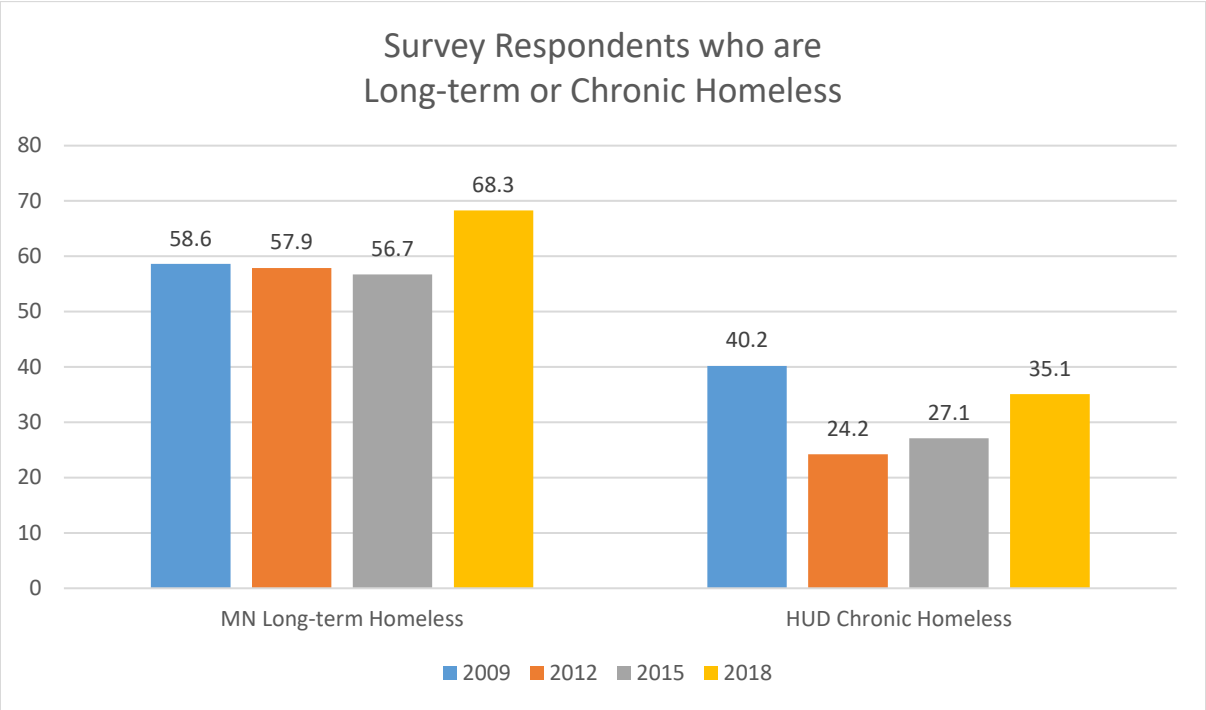
The percentage of homeless individuals that reporting having been turned away from shelter due to a lack of space decreased from 2009-2015, but then increased again in 2018.

Racial or ethnic background



Race or Ethnicity	**2009**	**2012**	**2015**	**2018**
White or Caucasian	49.9%	46.4%	43.8%	49.3%
African American	18%	21.1%	18.8%	15.0%
American Indian	26.1%	24.8%	22.7%	23.7%
Multi-racial	3.3%	4.3%	8.2%	10.1%
African Native	0.5%	0.4%	0.4%	0.3%
Other	1.2%	1.4%	1.4%	0.2%
Asian or Pacific Islander	0.2%	.2%	0.6%	0.0%
Not specified	0.2%	1.5%	4.2%	1.5%

Long term Homelessness



	2009		2012		2015		2018	
	N	%	N	%	N	%	N	%
Meet criteria for Minnesota's definition of long-term homelessness.	365	58.6%	285	57.9%	219	56.7%	358	68.3%
Meet criteria for HUD's federal definition of chronic homeless	251	40.2%	119	24.2%	105	27.1%	184	35.1%

The percentage of survey respondents that met the HUD definition of chronic homelessness decreased from 2009 to 2015 but increased from 27% to 35% from 2015 to 2018. The percentage who met Minnesota's definition of long-term homeless also increased from 57% to 68%.

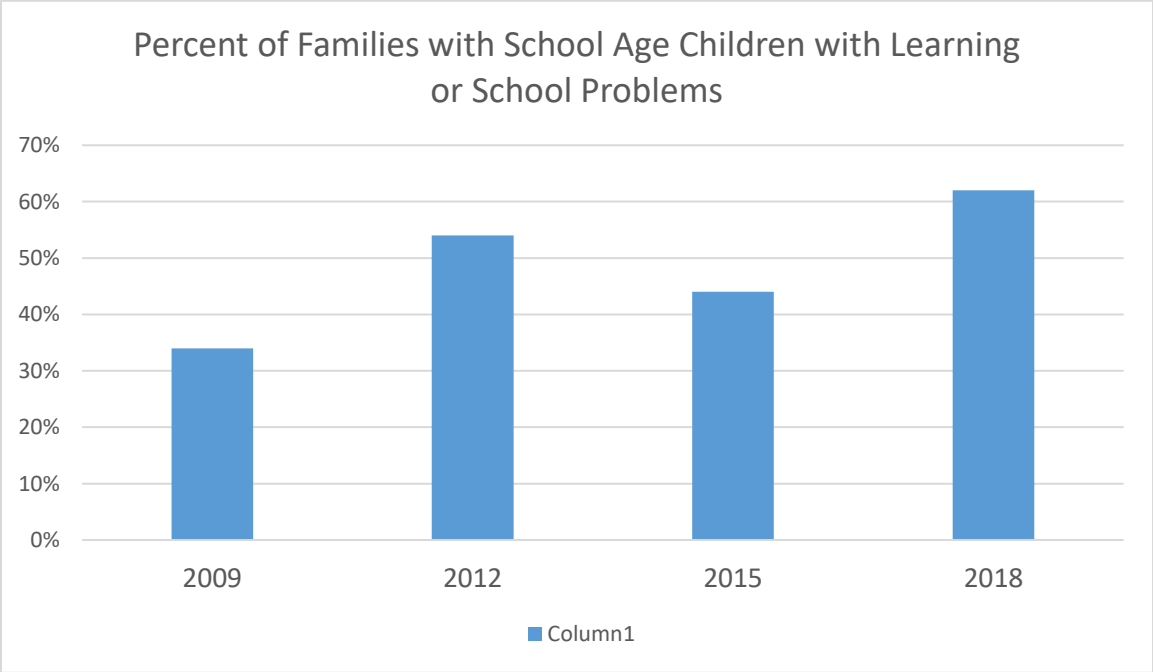
At the time of the 2015 Statewide Survey, HUD defined "chronic homeless" as: (1) An individual who: (i) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years, where each homeless occasion was at least 15 days; and (iii) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the

Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

For the State of Minnesota, "long-term homelessness" means lacking a permanent place to live continuously for one year or more or at least four times in the past three years; and

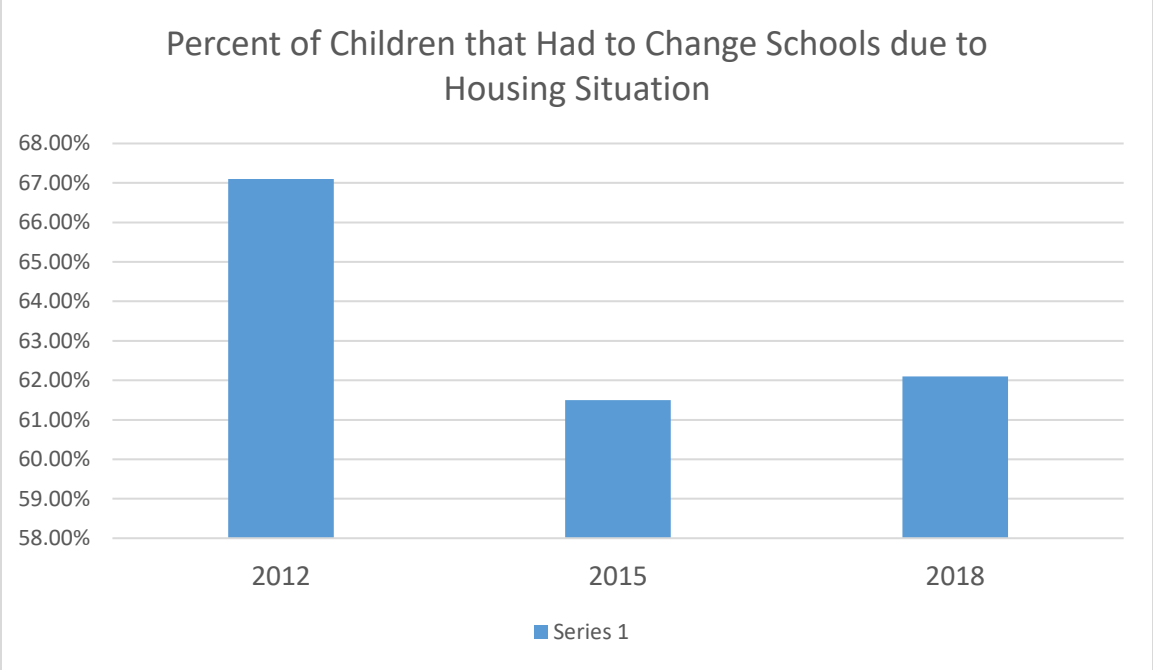
Homeless Adults with Children

Children and Schooling



	2009	2012	2015	2018
Families with school-aged children that have learning or school problems the resulted in requesting additional services.	34%	54%	44%	62%

In 2012, fifty-four percent of homeless parents indicated that their children had learning or school problems; in 2015, 44% of parents indicated that their children have learning or school problems that resulted in requesting additional services such as tutoring, summer school, or a special education assessment. In 2018, the percentage jumped to 62%.



	2012	2015	2018
School-aged children that have had to change schools due to housing situation	67.%	61.6%	62.1%

The percentage of parents that have indicated that their children have had to change schools due to their current housing situation decreased from 2012 to 2015, and then increased very slightly in 2018.

For more information about the Wilder 2018 Homeless Study, please visit MNHomeless.org.

E. Key Informant Interview Summary

Methodology:

Project consultants from Patty Beech Consulting received contact information from St. Louis County Homeless Program staff and Committee members from the St. Louis County Continuum of Care's Evaluation and Planning Committee. Key informants were selected based on their knowledge and expertise in services and housing that are available for people who lack housing or face housing instability. Key informants were also selected based on their lived experience of homelessness or their knowledge of the needs of community members without housing.

Twenty-one interviews were conducted. Most were conducted by phone or Zoom, but some Key Informants also completed the questions on Survey Monkey. The following questions were asked:

- What program, resource, or service that your organization offers is having the biggest impact on preventing or ending homelessness for your clients?
    - What factors make this program/resource/service successful?
- What bottlenecks or roadblocks do your clients experience in moving through St. Louis County's homeless response system? (The homeless response system spans all the resources and services, from outreach and emergency shelter to permanent housing, that are designed to help households attain housing stability).
    - What actions can be taken to address these challenges?
- What are they key partnerships (with other organizations or departments) that your organization has to address homelessness?
    - What partnerships are having the biggest impact?
- Thinking about the whole SLC homeless response system, on a scale of 1 (very difficult) to 5 (very easy), how difficult or easy would you say it generally is for people experiencing homelessness to connect to various resources:
- Have you observed any differences in how Indigenous People and People of Color are able to connect to resources in St. Louis County?
    - If yes, do you have any suggestions for improving these connections?
- Which sectors do you think should be more involved in efforts to prevent and end homelessness?
- What specific resources (programs, partnerships, funding sources, policy changes) would help St. Louis County to better meet the needs of people who lack stable housing?

- What other suggestions do you have for improving St. Louis County's homeless system?
- Do you have ideas for other people that we could talk to about improving the St. Louis County homeless response system?

Survey responses are summarized below.

Resources Having the Most Impact

1. Emergency Shelter
2. Permanent Supportive Housing
3. Case Management

Coordinated Entry

- **Coordinated Entry has improved overall since it started a few years ago.** The time between calling the access point (2-1-1) and getting an assessment has decreased.
- The Coordinated Entry process in Northern St. Louis County is working well for connecting clients to resources.
- **Coordinated Entry has created stronger partnerships and collaboration between providers.**
- **More housing is needing for people on the priority list** – Most people who get on the priority list aren't connected to housing through Coordinated Entry. There is a long wait for those who do get into housing.
- **Coordinated Entry needs more funding to support all aspects of the system.** There is not enough capacity to keep up with the needs of Coordinated Entry.
    - Assessors are overwhelmed by the amount of work that is required to get people onto the priority list. In the South, assessing clients and getting them onto the list takes up most of assessor's capacity. There is limited capacity for following up with clients or to provide navigation support.
    - Providers expressed that there is a need to build capacity for Coordinated Entry management in the South. The amount of work that is required to support this system is too much for 1 FTE. Better oversight is needed to ensure accountability of all providers utilizing Coordinated Entry.
- **The Coordinated Entry process is not set up for people experiencing homelessness.** The system is designed for the efficiency of providers and does not start with the client. It's difficult for clients to get connected to the resources that they need. People get frustrated and give up on the process before they even get onto the priority list.
- The community needs more education about what **programs are available through Coordinated Entry** and the **eligibility** for those programs is needed.

Outreach

- CHUM's street outreach team is critical to connecting unsheltered persons to resources in Duluth.
- More street outreach staff is needed to support this work.

Emergency Shelter

- Shelter is reported as being one of the most impactful resources in St. Louis County's homeless response system.
- Shelters are often overfilled, which can lead to people choosing not to stay in shelter or to people being turned away.
- More shelter is needed both on the Range and in Duluth.
- People in shelter can access supports and get connected to resources. Being in shelter can help people get into housing faster.
- Bob Tavani Medical Respite is a helpful resource.

Housing Programs

- **Permanent Supportive Housing (PSH) is noted as one of the most valuable resources for persons experiencing homelessness in St. Louis County.**
- **More permanent supportive housing is needed to meet the demand.**
- **Housing Support (formerly GRH) is a key resource to addressing the need for more supportive housing options.** Housing Support has grown in St. Louis County and there is a desire from key informants for this program to continue expanding.
- **More housing and shelter options for people in active use (drugs and/or alcohol) are needed.** San Marco is noted as a key resource to meet the housing need in Duluth, but this needs to be expanded.
- **There is a need to streamline the process to accessing housing programs.** Homeless service providers, HRAs, and property management should streamline their intake requirements to make accessing housing easier and faster for the client.

Market Rate and Subsidized Housing

- Property management is one of the most cited barriers to accessing housing. Property management denies people for housing for what providers consider to be minimal things. The appeal process and accommodation requests can take multiple months.
- The most cited reasons for housing denials included criminal backgrounds, bad credit, and lack of references.
- Criminal backgrounds impact where clients can live.
    - Clients on probation are limited to where they can live.
    - Sex offenders have limited options for housing due to legal restrictions on where they can live.
- Advocacy and relationship building with landlords has been a successful method to overcome barriers to accessing market rate housing.
    - Agencies building direct relationships with landlords is a helpful tool to overcoming barriers to housing access.
    - Landlord assemblies make a big difference in helping clients get into housing.
- The Landlord Incentive Program has made a huge difference in helping clients to get into housing. There is support for continuing to grow this resource.

Resources

- **Transportation is a huge barrier in St. Louis County, especially in Northern St. Louis County.**
    - In Northern St. Louis County, there is a lack of transportation options. Agencies may be able to provide transportation funds, but there aren't enough transportation options to utilize the funding or the costs are too high.
    - Lack of transportation limits people's ability to get employment, access medical care, access treatment, and meet probation requirements.
    - In the South, clients who rely on the bus for transportation are limited to housing options that are located on the bus line.
- There aren't enough **mental health providers** to meet the needs.
- The length of time to get into **substance use treatment** is too long.
- **Dental healthcare** – dental care is difficult to get for people experiencing homelessness. For those who are able to get dental appointments, the bills are unaffordable and can impact their housing.
- **Domestic violence resources** – There aren't enough resources to meet the needs across the county.
- **Medical care** – Accessing medical care through emergency rooms and urgent care is easier for persons experiencing homelessness than accessing primary care. Getting access to medical care in general is much more difficult in Northern St. Louis County.
- **Employment** – Gaining employment in St. Louis County is relatively easy. Building relationships with employers and connecting clients to employment services helps with this process. Maintaining employment is difficult for people experiencing homelessness due to things like transportation, housing instability, and mental health.

Case Management

- **Case Management is reported as being one of the most impactful resources** for persons experiencing homelessness in St. Louis County.
- **Case Management is essential to guide clients through all stages of the homeless response system.**
    - This provides people with a consistent source of support who can help them connect to resources to prevent or resolve their housing crises.
    - Case Management is also a helpful tool for getting clients into housing. Landlords are more likely to rent to clients when they have case management services through an agency.
    - Having a Case Manager check in with clients creates accountability and helps keep them on track with their goals.
- **More case management is needed to meet the need.** Current case managers are stretched thin and their case loads are overwhelming.
- **Client motivation impacts the effectiveness of case management services**.

Collaboration

- Collaboration and Partnerships Having the most impact:
    - Clarity Group
    - CIG Group
    - Affordable Housing Coalition
- Partnerships with other providers were reported as important by all providers.
- Overall, community partners feel that collaboration to address homelessness is strong.
- Providers report feeling more supported by St. Louis County Health and Human Services (HHS) and that the resources that St. Louis County HHS provides (HSASMI, SUD, FHPAP, etc.) are critical to addressing homelessness.
- Weekly case management meetings (North & South) are reported as strengths of the homeless response system.
- There is some uncertainty about the role of the Continuum of Care (CoC) and who to contact in the CoC for guidance.
- Competition over limited funding impacts provider collaboration and creates territorial issues.
- St. Louis County leadership has helped build stronger partnerships, brought in new funding opportunities, and improved processes for connecting clients to county resources.
- Culturally specific service providers are engaged in planning efforts, but their capacity is challenged to be in spaces to advocate for policy and systems change. It is difficult to give energy to engaging with the systems when you're a lone voice.
- Tribal services have been left out of the CoC for a long time. They are still catching up.
- Sectors who should be more involved
    - Mental health providers
    - Medical providers
    - Schools
    - Chemical health
    - Corrections – More work needs to be done to get clients into stable housing before they exit incarceration. There is a need to address who is responsible for working with clients to get into stable housing and to stay in stable housing after they exit incarceration.

Racial Equity and Cultural Responsiveness

- More outreach to People of African Heritage, People who are Black or Indigenous, and People of Color is needed.
- People of Color face higher barriers to accessing employment and market rate housing.
    - Getting services through a provider makes it easier for clients to get into housing.

- Providers should be educated about and acknowledge historical trauma and structural racism.
- **Service providers should reflect the population that we're serving.** There needs to be a conscious effort to recruit more Indigenous People and People of Color to provide services.
- There aren't enough culturally responsive support services available.
- Culturally specific service providers are engaged in planning efforts, but their capacity is challenged to be in spaces to advocate for policy and systems change. It is difficult to give energy to engaging with the systems when you're a lone voice.
- Implement training to build more culturally competent and culturally relevant services, starting with outreach.

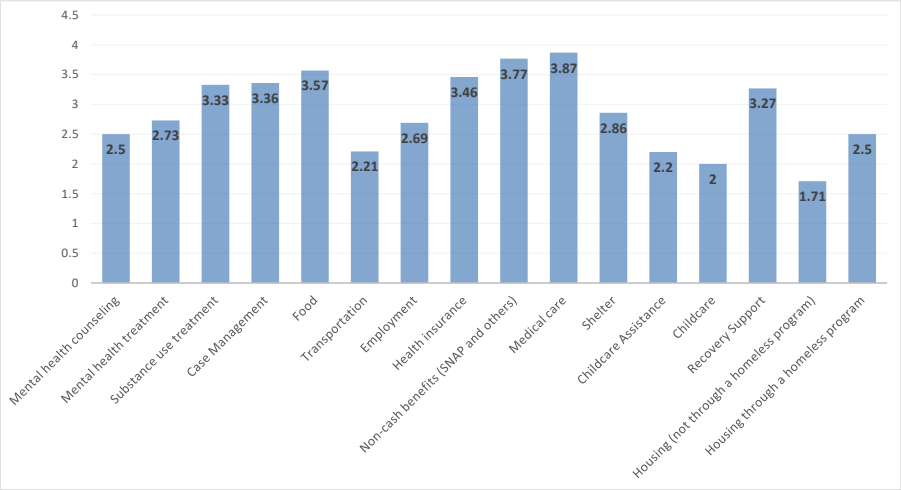
Recommendations to Improve the Homeless Response System

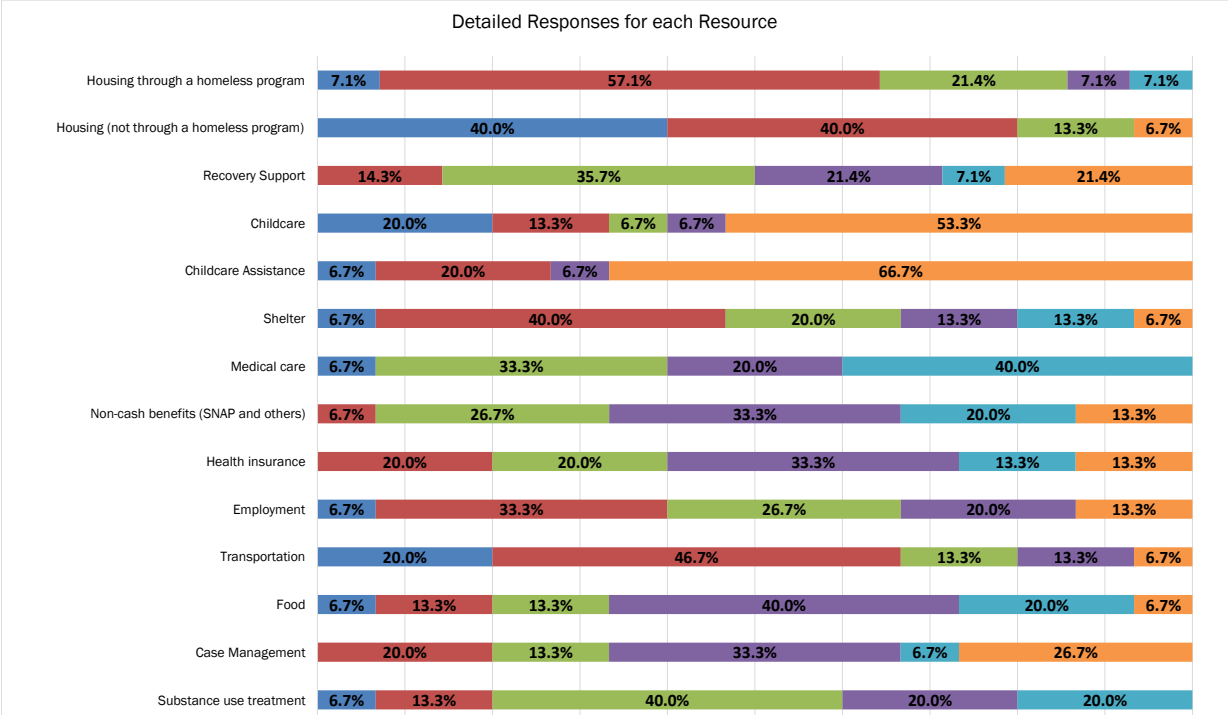
- **More focused effort on addressing chronic homelessness is needed.**
- **Mental health crisis intervention resources are needed.** Provide more resources for responding to mental health crises for people experiencing homelessness. Advocate and educate existing mental health crisis centers about the need to address mental health crises for persons experiencing homelessness.
- **Use a strengths-based approach and focus on building off of people's resiliency to address the homelessness crisis.**
- **Build a system that is focused on efficiency and convenience for clients instead of for providers.** The pathways to access, hours of operation, and should be centered around client needs and built to accommodate clients in crisis. Accessing services should not require clients to use phones and computers or to have access to scanners and fax machines.
- **Reduce the amount of paperwork and steps that are required to get connected to resources.** Clients are overwhelmed by the amount of paperwork that is required to apply for resources or to access housing.
- **Bring in Coordinated Entry navigation support to help guide people through their housing journey** – Clients needs support to connect to resources, submit applications, and stay updated on the steps required to access housing and services.
- **Strong leadership at the CoC level is needed.** CoC leadership needs to have the capacity to guide providers and support collaborative efforts. Leadership should listen to providers and listen to the needs of the people doing the work on the ground.
- **Advocate for reduced barriers to accessing housing through the local housing authorities.** Providers are often prepared for clients to be denied by the HRA for housing opportunities, although clients are ultimately accepted through the appeal process. Reducing the barriers upfront would eliminate the added amount of time that people remain homeless.
- **Streamline background check processes**. Eliminate the need to complete two separate background checks for one unit.

- **Provide training to providers** on topics such as trauma-informed practice, racial equity, culturally responsive approaches, and collaborative work.
- **Incorporate culturally responsive and person-centered approaches into all aspects of the homeless response system.**
- **Provide forums on issues of homelessness** that includes a highly skilled facilitator who can promote a fair sharing space.
- **Partner with Lake Superior Community Health to secure a Health Care for the Homeless Grant** which would help bridge gaps to accessing medical care for people experiencing homelessness.
- **Increase the amount of case managers who are providing services and ensure that case managers are adequately paid.**

Key Informant Question on Connections to Resources

Thinking about the whole St. Louis County Homeless Response System: On a Scale of 1 (Very Difficult) to 5 (Very Easy), How Difficult or Easy is it for People Experiencing Homelessenss to Connect to the Following Resources?





F: Definitions and Acronyms

Extent of Homelessness by Minnesota's Definition: The State of Minnesota defines as homeless "any individual, unaccompanied youth or family that is without a permanent place to live that is fit for human habitation." Doubling-up is considered homeless if that arrangement has persisted less than 1 year.

The State of Minnesota defines an individual, unaccompanied youth or family as **"Long-Term Homeless**" if they are without a home for a year or more OR have had at least four (4) episodes of homelessness in the past three (3) years. Any period of institutionalization or incarceration (including transitional housing, prison/jail, treatment, hospitals, foster care, or refugee camps) shall be excluded when determining the length of time the household has been homeless.

HUD homeless definition: HUD Funded Program- HUD established four categories of Homelessness.

Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. Has a primary nighttime residence that is a public or private place not meant for human habitation;
2. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); OR
3. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Imminent Risk of Homelessness: An individual or family who will imminently lose their primary nighttime residence, provided that:

1. Residence will be lost within 14 days of the date of application for homeless assistance;
2. No subsequent residence has been identified; AND
3. The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Homeless Under other Federal Statutes: Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless as defined above, but who:

1. Are defined as homeless under the other listed federal statues;
2. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
3. Have experienced persistent instability as measured by two moves or more during the preceding 60 days; AND
4. Can be expected to continue in such status for an extended period of time due to special needs or barriers.

Fleeing/Attempting to Flee DV: Any individual or family who:

1. Is fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking;
2. Has no other residence; AND
3. Lacks the resources or support networks to obtain other permanent housing.

HUD Chronic Homeless Definition: A chronically homeless individual is defined to mean a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility.

To meet the chronically homeless definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Disability of Long Duration: (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is **(a)** expected to be of long-continued and indefinite duration, **(b)** substantially impedes an individual's ability to live independently, and **(c)** of such a nature that such ability could be improved by more suitable housing conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.

Physical Disability: A physical impairment which is **(a)** expected to be of long-continued and indefinite duration, **(b)** substantially impedes an individual's ability to live independently, and **(c)** of such a nature that such ability could be improved by more suitable housing conditions.

Developmental Disability: A severe, chronic disability that is attributed to a mental or physical impairment (or combination of physical and mental impairments) that occurs before 22 years of age and limits the capacity for independent living and economic self-sufficiency. Accepted forms of documentation include written verification from a state-licensed professional, such as a medical service provider or a health-care provider, the Social Security Administration, or the receipt of a disability check (i.e., SSDI check or VA disability benefit check).

Chronic Health Condition: A diagnosed condition that is more than three months in duration and is either not curable or has residual effects that limit daily living and require adaptation in function or special assistance. Examples of chronic health conditions include, but are not limited to, heart disease (including coronary heart disease, angina, heart attack and any other kind of heart condition or disease); severe asthma; diabetes; arthritis-related conditions (including arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia); adult onset cognitive developments (including traumatic brain injury, post-traumatic distress syndrome, dementia, and other cognitive related conditions); severe headache/migraine; cancer; chronic bronchitis; liver condition; stroke; or emphysema.

Mental Health Problem: May include serious depression, serious anxiety, hallucination, violent behavior, or thoughts of suicide.

Recent Institutional History: Definitions for some options:

- **Drug or Alcohol Treatment Facility**: Includes inpatient treatment and detox.
- **Foster Home:** This term applies to youth only.
- **Group Home**: Includes all facilities for people with disabilities (cognitive or physical); may also be used for corrections clients. Includes adult foster care. Placement done through social services or corrections departments.
- **Half-way House**: Includes placement for corrections clients after jail or prison OR for clients after chemical dependency treatment.
- **Mental Health Treatment Facility or Hospital**: Includes regional treatment centers (state hospitals), Intensive Residential Treatment Services (IRTS), crisis residences, and psychiatric inpatient units at local hospitals.
- **Residence for People with Physical Disabilities**: Includes nursing homes, long-term care facilities, and rehab hospitals.

Acronym List

Acronyms			
AHAR	Annual Homeless Assessment Report	**MFIP**	Minnesota Family Investment Program
APR	Annual Progress Report	**MTC**	Minnesota Tribal Collaborative
ARD	Annual Renewal Demand	**MOU**	Memorandum of Understanding
CE/CES	Coordinated Entry/Coordinated Entry System	**NOFA**	Notice of Funding Availability
CH	Chronic Homeless	**OEO**	Office of Economic Opportunity
CoC	Continuum of Care, Federal program stressing permanent solutions to housing	**OPEH**	State Office to Prevent and End Homelessness
Con Plan	Consolidated Plan	**P&E**	Performance & Evaluation Committee
CPD	Community Planning & Development (HUD office of)	**PBRA**	Project Based Rental Assistance
DHS	Department of Human Services	**PIT**	Point in Time
EA	Emergency Assistance	**PRN**	Pro Rata Need
EGA	Emergency General Assistance	**PSH**	Permanent Supportive Housing
ESG	Emergency Solutions Grant (Emergency Shelter Grant; previous name)	**RFP**	Request for Proposals
FHPAP	Family Homeless Prevention & Assistance Program	**RHSP**	Rural Housing Stability Program
FMR	Fair Market Rent	**RHY**	Runaway and Homeless Youth Act
GIW	Grant Inventory Worksheet	**RRH**	Rapid Re-Housing
GRH	Group Residential Housing	**S+C**	Shelter Plus Care
HDX	HUD Exchange (online data submission tool for reporting to HUD)	**SAGE**	Portal to enter annual progress reports for all HUD COC funded programs
HEARTH Act	Homeless Emergency Assistance and Rapid Transition to Housing	**SHP**	Supportive Housing Program
HHA	Heading Home Alliance	**SOAR**	SSI/SSDI Outreach, Access and Recovery
HIC	Housing Inventory Count	**SPMI**	Serious and Persistent Mental Illness
HMIS	Homeless Management Information System	**SRO**	Single Room Occupancy
HOPWA	Housing Opportunities for Persons with AIDS	**SSI/SSDI**	Social Security Income / Disability Income
HPRP	Homeless Prevention & Rapid Re-Housing program	**SSO**	Support Services Only
HQS	Housing Quality Standards	**SuperNOFA**	HUD's consolidated approach to issuance of Notice of Funding Availability
HRE	Homelessness Resource Exchange	**TANF**	Temporary Assistance for Need Families
HUD	U.S. Department of Housing and Urban Development	**TBRA or TRA**	Tenant Based Rental Assistance
ICA	Institute for Community Alliances (HMIS administrator)	**TH**	Transitional Housing
IHS	Indian Health Services	**VASH**	Veteran's Affairs Supportive Housing
LSA	Local System Administrator	**Veteran's GPD**	Veteran's Grant and Per Diem program
LSA	Longitudinal Systems Analysis	**Veteran's SSVF**	Supportive Services for Veteran's Families
LTH	Long Term Homeless	**VI SPDAT**	Vulnerability Index (VI) & Service Prioritization Decision Assistance Tool
LTHSSF	Long-Term Homeless Supportive Services Fund		