

## **Homelessness Issues**

### **The Face of the Homeless in Longmont**

For the past three years, the City of Longmont has conducted a survey of the homeless population by participating in the Metro Denver Homeless Initiative's Point-In-Time surveys (see Attachment #1 which compares the data from the three surveys). A total of 481 persons in Longmont were counted as homeless on January 27, 2003. This is an increase of 137% from the 2000 survey (the first year that Longmont's counts were totaled separate from Boulder County's).

Of the total homeless persons counted in 2003, 101 (22%) were single adults and 375 (78% were in families. 11 were homeless youth. The number of single adults actually decreased about 39.7% from the 2002 count, while the number of persons in families increased 19%. About 177 of the 375 persons in families were children below the age of 17, an increase of 20% from the previous survey.

Only 24% of the homeless counted are in shelters, transitional housing or in domestic violence shelters. The rest are living on the streets (8.3%), staying night to night in hotels/motels (15.5%), in their car (1%), or are doubled up with friends or relatives (48%).

While point prevalence is important in determining the current need for emergency shelter beds, food and clothing; an annual prevalence estimate of the total homelessness rate over the course of a year is important in determining the ongoing need for supportive housing, permanent housing, job training and education. Results of the 2003 survey suggest that the annual prevalence of homelessness in Longmont is about 1,175 persons each year.

Unemployment and an inability to pay rent or a mortgage were reported as the two highest causes for homelessness (52.2%) among both individuals and families in Longmont. However, about 35% of the homeless have jobs. 8.8% were unable to pay their utilities and 7.5% had a family member or a personal illness which contributed to their homelessness.

17% reported that they have received or are receiving treatment for severe mental illness, and 11% stated that they are undergoing treatment for chronic drug or alcohol abuse.

### **Housing Gaps**

One of the reasons that persons and families become homeless, as shown above and on the chart on Attachment #2, is that because their wages are not sufficient, they lose a job, or have a precipitating event (hospital stay, illness, car loss, etc.) they cannot afford their rent or mortgage payment. According to the 2000 Census, over 42% of renters in Longmont are paying more than 30% of their income for rent, and 17% are paying more than 50% of their income for rent. 25% of all

homeowners are paying more than 30% of their income for housing, and 8% are paying more than 50% of their income.

The poorest in our community are paying too much of their income for housing, forcing them to make critical choices about food, health care, car insurance and child care. Over 70% of renters with incomes below \$35,000 (3,472 families) are paying more than 30% of their income for their housing. 53% or 2,890 homeowners making less than \$50,000 are paying more than 30% of their income for their housing.

Census data suggests that there is a significant gap in the number of housing units available and affordable to the poorest Longmont residents. There are 4,164 households with incomes below \$25,600 (40% of AMI). There are only 2,081 housing units available at rents or sales prices affordable to them. This leaves a gap of 2,083 housing units needed to serve this population. While the city has made progress in meeting its affordable housing goals, most of it has been affordable to those with incomes between 50% and 80% AMI. Housing affordable to families with incomes at or below 40% of the AMI is extremely difficult to provide because of the high cost of construction, the complicated financing needed and the low return on investment. In addition, there have been no new Vouchers added to the housing authorities budgets which would help with rent assistance.

As stated above, there are 1,174 homeless persons estimated to be in Longmont on an annual basis. We have 43 transitional housing units (all full) with turnover every 18 months or so. In addition, there are 10 shelter units for families at the Atwood Shelter, with turnover every 6-8 weeks. The Boulder Shelter has space for about 16 single adults (using the estimate of 10% of their residents are from Longmont), with turnover every 60-90 days; however, they are only in operation from October – April each year. The Safe Shelter has room for 19 persons with up to 20 day stays. This translates to about 565 total shelter or transitional units available on an annual basis. Therefore, about 609 persons remain unsheltered each year.

## **Funding Trends**

### **State Impacts:**

As a result of the last legislative session, Colorado failed to gain any affordable housing units. The state has decreased the General Fund contribution to affordable housing projects by 75% from \$737,630 in 2002-2003 to \$184,504 in 2003-2004. Because of the overwhelming concern over the strained state budget, affordable housing advocates spent the past legislative session struggling to maintain the Division of Housing's budgetary line item for "donations and gifts," so that the line item does not have to be reinstated.

The state legislature also eliminated some psychiatric beds through budget cuts, thereby forcing the release of patients into communities with no pre-arranged housing and often no medications. Although the Boulder County Mental Health Center tries desperately not to discharge people leaving a psychiatric hospital directly to the streets, they have had to do so

on occasion.

Finally, the elimination of “required parity,” which ensures that insurance companies cover the mentally ill at the same percentage rate as other subscribers, will also increase the number of under-served mentally ill who will have no available options other than living on the streets.

### **Federal Impacts:**

The impending loss of Medicaid and psychiatric beds is likely to result in more homeless individuals on a statewide basis. The denial of Medicaid services to recently arrived legal immigrants will cause those who cannot afford needed medication to choose between their medication, their food and their shelter.

While the state’s share of funding under the Supportive Housing and Homeless Programs (funded by HUD) is increasing somewhat (no estimates for 2004 are available yet), funding for affordable housing development programs are decreasing by 3.4%, Section 8 rental assistance is decreasing by 2.9%, and the Emergency Shelter Program funding is decreasing by 4.2%. At the same time, the state is moving the cost of administrative positions from state supported to federally funded, thus further decreasing funding available for programs.

### **Local Impacts:**

The Mental Health Center of Boulder County (BCMHC) has been cut drastically in the last few years and will be cut again in the next fiscal year. These cuts have and will affect the work they are able to do. Because of the budget cuts, the Mental Health Center has lost over 57 FTEs since 2000, with the loss of another 17 anticipated in 2004. While this has happened, eligible Medicaid clients have risen 45.8%. The number of Longmont residents receiving services has increased 63.8% from 2000 to 2003 and the number of Longmont residents as a percent of the total clients receiving service has increased from 21.9% of the total in 2000 to 27.8% in 2003.

Individual agencies that provide services to the homeless are also experiencing cuts to their budgets evidenced by a 23% reduction to the Inn Between and a 4.5% reduction to the OUR Center (see Attachment #3). This is while demand for services are increasing – by as much as 28% in the case of the OUR Center.

## **Economic Repercussions of Homelessness**

Serving the homeless and particularly those homeless persons with mental illness is very expensive to a community. Because of exposure to the weather and other circumstances, they contract illnesses that would otherwise be easily preventable. Once sick, they put off care until an easily treatable illness becomes much more costly and difficult to treat. The homeless must seek medical

treatment from the emergency room or urgent care facilities. They do not have insurance and so the cost of their treatment is born by the hospital or clinic and directly impacts their bottom line and their financial ability to treat others.

Exposure to the illnesses born by the homeless can be devastating to the local community that serves them. One recent incident cost various sectors of the community over \$200,000 because of a single exposure to tuberculosis. 38 staff, volunteers and clients had close contact with the infected individual. All of these folks and some police officers had to be tested for TB. Five of the non-profit employees tested positive and three are now undergoing treatment which lasts nine months (at a cost of \$3,000 each). They will also need to be retested at regular intervals for life. Because the homeless man had mental health issues, he escaped from LUH at least twice and had to be tracked down by Police. Because he did not have a permanent place to live, Health Care workers spent hundreds of hours tracking the person down so that they could administer the medication he needed. Finally, he had to be committed to treatment by the court where he received detention and in-patient treatment. The \$200,000 includes testing for all who came into close contact with the individual, follow up testing, time spent locating affected persons and notification of testing, employees' time off work for testing and treatment, ongoing testing for all staff, hospitalization of the client, police time, court costs and ongoing monitoring.

A police department can be overwhelmed by dealing with homeless persons with drug or alcohol abuse problems, mental illness, etc. Often the only alternative is to lock the person up if he/she is posing a threat to their self or to others. Also, those persons with mental illness are often placed in 72 hour lock-up until they can be evaluated by a mental health professional. Currently, this is what the Police have to do in order to get a mental health evaluation completed.

One of the results of increased mental health clients with the ongoing budget cuts is that the Mental Health Center has started to use more evidence-based practices to provide services more efficiently to clients. This includes treatment for both long-term and short-term clients. One example of this is doing short term, solution-focused treatment instead of providing longer term care with frequent follow-up. Even with moving to this method of treatment, the Mental Health Center will periodically have a wait list to meet the ongoing demand for services.

While the City of Longmont has not done any cost evaluations yet, other communities are experiencing significant costs related to this issue. Some examples are listed below.

- A homeless mentally ill person in New York City uses an average of \$40,449 of publicly funded services over the course of a year.<sup>1</sup>
- The Colorado Department of Human Services shows that a Medicaid-eligible client costs an average of \$52,139 in a Community Mental Health Program (\$3,095 for mental health services and \$49,044 for residential services), while the average cost per bed per year in a Mental Health Institute is \$152,197.

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<sup>1</sup> This figure is stated in 1999 dollars.

## **Past and Current Efforts**

As a result of the homeless surveys and Boulder County's participation in the Metro Denver Homeless Initiative's Continuum of Care model, Longmont and Boulder County's social service and housing agencies began meeting to discuss appropriate responses to the homeless population and to make our needs and desired outcomes known to the larger group. The Longmont Housing Opportunities Team (LHOT) began formal meetings in 2000. The group is comprised of representatives from the City of Longmont (CDBG/AH Division and Police), the OUR Center, non-profit housing providers (both permanent and transitional), emergency shelters, St. Vrain Valley School District, Boulder County Mental Health Center, the faith community, and prison ministries.

As part of research and explorations, LHOT came upon a new initiative called the Housing First model to prevent homelessness. In this model, immediately re-housing the person or family is the central goal. Providing housing assistance and supportive case management services to prepare a plan to deal with the issues that led to homelessness is the next step. Homeless persons spend most of their energy making sure they have a safe and secure place to sleep each night and food to eat. By providing housing immediately, the significant time and energy spent on housing issues can be re-channeled to deal with the substance abuse, domestic violence, employment or other issue which is the underlying cause of the homelessness. Providing strong support during the plan achievement period is the key to successfully keeping folks from returning to homelessness. Communities using the Housing First model are seeing an 80% success rate in keeping the formerly homeless securely housed three years after their homeless incident. Treatment success rates are also up since the clients are choosing to proceed with treatment instead of being forced to seek treatment in order to get into housing.

- Emergency room use is dropping by as much as 75% in Baltimore,
- Medicaid costs per treated individual in Connecticut dropped by 42%,
- Emergency detoxification days in Minnesota dropped by 84%, and
- Mental health hospitalizations in Seattle dropped by 89%, while arrests and incarcerations dropped by 93%.

The Housing First concept was presented to the LHOT group and an expanded group of stakeholders on December 17. The consensus of the group is to proceed ahead with implementation, beginning with a plan to determine how to better collaborate to provide the intensive supportive services needed to make it work, and how to fund the rent assistance needed to provide the housing units.

## **Summary**

Fundamentally, homelessness is linked to poverty. Poor people are frequently unable to pay for housing, food, child care, health care and education. Often chronic mental illness, physical disability, domestic violence, and substance abuse are significant contributing factors. Low wage workers are particularly vulnerable. The real value of the minimum wage in 1997 was 18% less than in 1979.<sup>2</sup> Housing costs take up increasing portions of income. Decreases in subsidized housing, community resistance to multifamily housing, and elimination of the older housing stock (particularly SROs – Single Room Occupancy units) have made more and more people vulnerable to homelessness.

Continued public policies calling for the deinstitutionalization of the mentally ill, combined with the reduction in funding for community-based mental health services results in more and more people, with a minimal ability to care for themselves, living on the street.

Additionally, homeless delivery systems have been linear in their conceptualization. In other words, a homeless person first goes through an intake process, than they are referred to a homeless shelter, where a case management plan is developed. As they meet the terms of their plan regarding education, substance abuse, employment, etc., they are moved to transitional housing where necessary services can be provided and eventually a person is placed in permanent housing.

More recently it has been acknowledged that it is easier and more effective for persons to deal with whatever barriers they have to stability, if they are provided with stable housing first. Under the Housing First concept, regardless of which agency does the initial intake, primary importance is placed on obtaining stable housing as soon as possible (sometimes without a stay in a shelter). Once stable housing is in place, the person or family is better able to benefit and maintain participation in other essential supportive services and treatment.

## **Discussion Questions**

1. Is there a role Council could play by advocating for increased levels of funding for the homeless and for mental health issues?
2. Should the city explore options for funding supportive and/or additional housing services as the Housing First model moves forward?
3. Should the City explore a “first response” team approach to dealing with immediate homeless issues, particularly with homeless persons found at night, after business hours, or that present significant safety issues?

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<sup>2</sup> National Coalition for the Homeless, 1999.

4. Does the City want to increase or shift its housing resources to better address the “bottleneck” in affordable housing: decreasing rental assistance funding and an insufficient amount of housing affordable to persons/families with incomes below 30% AMI?

Attachments:

- #1 – Face of Homelessness and Survey Summary
- #2 – Dominoes to Homelessness
- #3 – Agency Budget Summary and Service Providers

## THE FACE OF THE HOMELESS IN LONGMONT

- ◆ According to the current "point-in-time" survey of the homeless conducted in January, 2003, there were 481 homeless persons in Longmont.
  - ◆ More than 36% were children or emancipated youth, 39% were single women and **78% are families**. In addition, 11% were living on the street or in their car.
  - ◆ 24% were in emergency shelters, hotels/motels or in other short term situations and fully 48% are doubled up and living with friends or relatives.
  - ◆ 56% are white and 44% are Hispanic.
  - ◆ 27% of the persons identified as homeless during the "point-in-time" survey indicated that mental illness contributed to their homeless situation, 28% indicated that domestic violence was a contributing factor.
- ◆ An annual prevalence estimate of total homelessness rates suggests that **Longmont has about 1,175 persons who are actually homeless during the course of an entire year.**
- ◆ The total number of homeless persons is expected to continue to increase since that is the trend for the past three years of the survey. Since 2000, **the number of homeless has increased 137%**, from 203 persons to 481.
- ◆ Unemployment and an inability to pay rent or mortgage were reported as the two highest causes for homelessness among both individuals and families (52.2%) in Longmont.
- ◆ **About 35% of the homeless have jobs.**
- ◆ There are currently over 273 households on the **Longmont Housing Authority's** wait list. Of these, at least 31 are homeless, and many more will become homeless as they wait for a housing voucher. In 2003, 21% of those given housing vouchers were homeless. In 2002, 23% of those given vouchers were homeless.
- ◆ "Colorado has a serious funding crisis for community mental health services for indigent citizens in need. Colorado is already below the national average in terms of providing general funds for community mental health to serve medically indigent and

working poor citizens.” (from the Mental Health Center of Boulder County’s Annual Report, 2000)