EQUITY ANALYSIS

Addressing Homelessness in Sangamon County

Prepared by LathanHarris, Inc. for Heartland Continuum of Care
2022

Equity Analysis for Sangamon County

Consistent with state trends, Springfield, Illinois, and Sangamon County has been significantly impacted by homelessness. In Illinois, an estimated 10,199 individuals experience homelessness on any given day according to the Continuums of Care to the U.S. Department of Housing and Urban Development (HUD). Like many other communities, homelessness is a growing concern for the City of Springfield and Sangamon County. The elimination or reduction of homelessness plays a major role in impeding over-reliance on emergency shelters, emergency room visits and incarceration. In response to the need to eliminate or reduce homelessness in the city of Springfield and Sangamon County, the strategic planning process will foster activities that take into consideration and continuously interweave elements that elicit, acknowledge, and consider socio-historical nuances and norms, inequities and conditions that have historically and presently dominant efforts to reduce and prevent homelessness.

The strategic plan is in response to the need to respond to the high population of chronically homeless residents who are significantly more likely to have unmanaged behaviors and physical health needs and are over-reliance on emergency shelters, emergency room visits and incarceration. By virtue of their life circumstances, people who experience homelessness lack or have limited social determinants of health. To future exacerbate their life challenges, they are often faced with being a recipient of preventable inequities that future move them to chronic homelessness and limited access to essential services. This document will highlight existing inequities along with viable equity-based solutions regarding homelessness in the City of Springfield and Sangamon County.

Table 1: Homeless Cases by demographic variables for last 3 years

IL-513 Homeless Data						
	IL-513 Experiencing Homelessness (4/21 to 4/22) n=965		IL-513 Experiencing Homelessness (4/20 to 4/21) n=918		IL-513 Experiencing Homelessness (4/19 to 4/20) n=1,230	
Variables	**#**	**%**	**#**	**%**	**#**	**%**
Race	n=960		n=915		n=1227	
White	452	47.1%	438	47.9%	592	48.2%
Black or African American	490	51.0%	458	50.1%	614	50.0%
American Indian/Alaskan	14	1.5%	13	1.4%	16	1.3%
Asian/Pacific Islander	2	0.2%	2	0.2%	2	0.2%
Native Hawaiian or Other	2	0.2%	4	0.4%	3	0.2%
Ethnicity	n=959		n=917		n=1217	
Hispanic/Latinx	40	4.2%	42	4.6%	47	3.8%
Non-Hispanic/non-Latinx	919	96.8%	875	95.4%	1170	96.2%
Gender	n=962				n=1227	
Male	600	62.4%	558	60.8%	730	59.4%
Female	362	37.6%	359	39.1%	497	40.5%
Veteran Status						
Yes (veteran)	51	5.3%	50	5.4%	73	5.9%
Age Categories						
Under 18	159	16.5%	159	17.3%	235	19.1%
18-24	120	12.4%	96	10.5%	124	10.1%
25-43	316	32.7%	304	33.1%	422	3434.0%
44-64	336	34.8%	342	37.3%	415	33.8%
65+	37	3.8%	26	2.8%	34	2.8%
Other Key variables						
Left for Housing	200	20.7%	292	31.8%	358	29.1%
First Time Homeless	322	33.4%	317	34.5%	596	48.5%
Days in project	14	n/a	31	n/a	4	n/a
Returned to Homelessness	32	3.3%	55	6.0%	57	4.6%
Chronically Homeless	314	32.5%	285	31.0%	318	25.9%
*IL-513 Gender included 1 non-binary (0.1%) for 2019-2021 years						

DESCRIPTION OF TABLE

Table 1 outlines the number of persons experiencing homelessness across various variables between 2020 - 2022. The percentage of Blacks/African Americans experiencing homelessness has steadily increased from 50% to 51%. More Blacks/African Americans (51.0%) were homeless compared to Whites (47.1%). This highlights some inequities in the rate of homelessness, which needs to be addressed. Across gender, more males face homelessness than women. For instance, 62.4% men versus 37.6% women experienced homelessness. The rates of homelessness among the age categories, "under 18" and "25–43" decreased within the 3-year period. However, age categories "18-24", "44-64", and "65+" respectively have experienced

increased rates of homelessness within the 3-year period. Regardless of race, individuals in the age range 25-43 and 44-64 had the highest rates of homelessness.

Table 2: Homeless Cases by Race 2021-2022

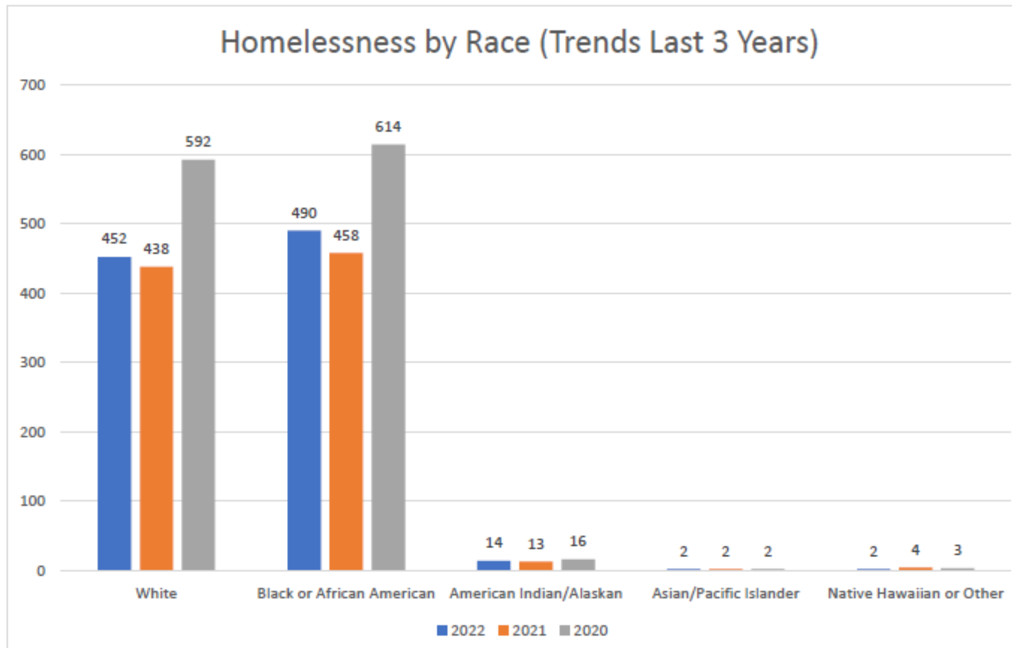
	White n=452		Black n=490		American Indian/Alaskan n=14	
Variables	**#**	**%**	**#**	**%**	**#**	**%**
Ethnicity	n=448				n=13	
Hispanic/Latinx	22	4.9%	13	2.7%	3	23.1%
Non-Hispanic/non-Latinx	426	96.1%	477	97.3%	10	76.9%
Gender	n=450					
Male	296	65.8%	294	60.0%	7	50.0%
Female	154	34.2%	196	40.0%	7	50.0%
Veteran Status						
Yes (veteran)	31	6.9%	18	3.7%	2	14.3%
Age Categories						
Under 18	34	7.5%	121	24.7%	2	14.3%
18-24	41	9.1%	75	15.3%	2	14.3%
25-43	186	41.2%	122	24.9%	5	35.7%
44-64	174	38.5%	156	31.8%	5	35.7%
65+	18	4.0%	18	3.7%	0	0.0%
Other Key variables						
Left for Housing	74	16.4%	116	23.7%	6	42.9%
First Time Homeless	146	32.3%	165	33.7%	3	21.4%
Days in project	20	n/a	11	n/a	4	n/a
Returned to Homelessness	15	3.3%	16	3.3%	1	7.1%
Chronically Homeless	163	36.1%	147	30.0%	4	28.6%
Access permanent Housing	94	23.0%	129	27.0%	6	38.0%

Note: Data excluded for populations less than 1% (Native Hawaiian, Asian/Pacific Islander; Other/Multi-Racial)

DESCRIPTION OF TABLE

In Table 2, the adult cases of homelessness by race between 2021 - 2022 are highlighted. The data shows that Black Non-Hispanic adults experienced higher rates of homelessness (97.3%) compared to their White non-Hispanic counterparts (96.1%). Regardless of race, males experience higher rates of homelessness than females. Among Blacks, 60% males were homeless compared to 40% of females. Likewise, 34.2% of White females experienced homelessness compared to 65.8% White males. Among Whites, individuals aged 25-43 and 44-64 had the highest rates of homelessness (41.2% and 38.5%, respectively). In this population, more Blacks became homeless for the first time (33.7%) compared to Whites (32.3%). While more Blacks exited homeless shelters (23.7%) than Whites (16.4%), the return rates to homelessness were similar (3.3%).

Chart 1



DESCRIPTION OF CHART

The trends in homelessness by race for the last three years are outlined in Chart 1. The highest rates of homelessness were seen in 2020, with 592 Whites, 614 Blacks/African Americans, 16 American Indian and 2 Asian/Pacific Islanders, respectively experiencing homelessness. Between 2020 and 2022, more Blacks faced homelessness compared to Whites (614 versus 592, 458 versus 438, and 490 versus 452 respectively). While the rates gradually decreased from 2020 to 2022, more initiatives need to be in place to provide equal access to affordable housing and other services for the homeless, especially for the Black/African American population.

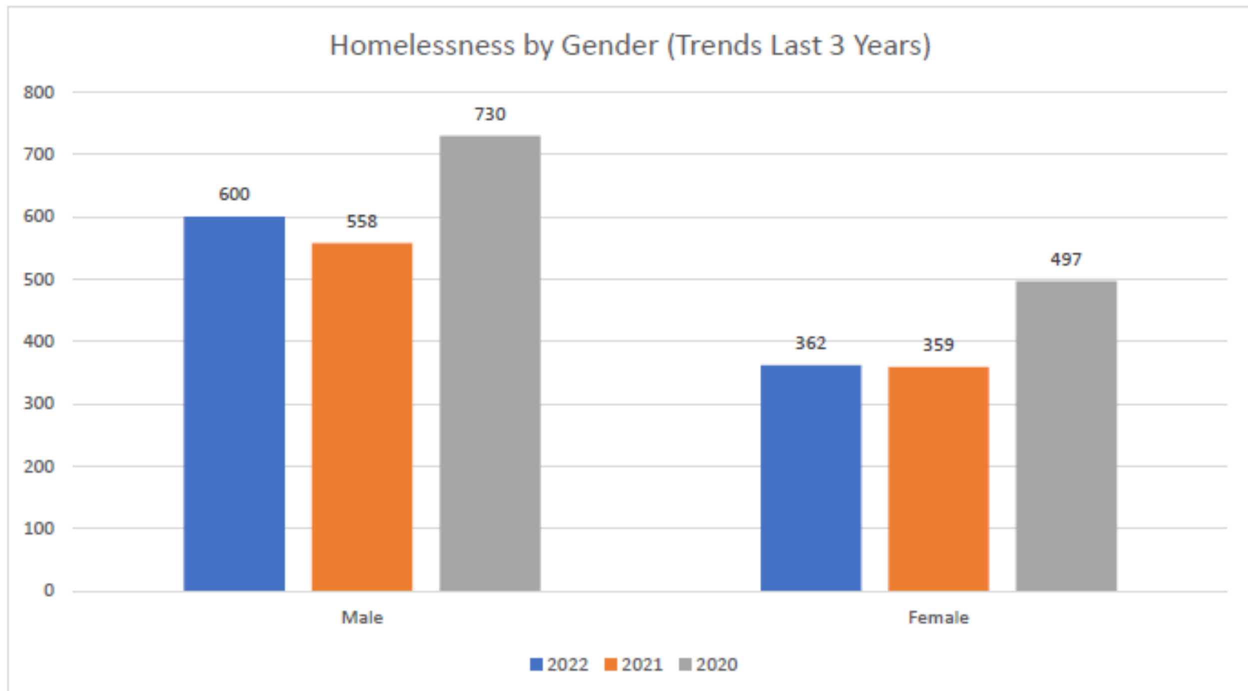
Table 3: Homeless Cases by Gender 2021-2022

	Male n=600		Female n=362	
Variables	**#**	**%**		**%**
Race				
White	296	49.5%	154	42.8%
Black or African American	294	49.2%	196	54.4%
American Indian/Alaskan	7	1.2%	7	1.9%
Asian/Pacific Islander	0	0.0%	2	0.6%
Native Hawaiian or Other	1	0.2%	1	0.3%
Ethnicity				
Hispanic/Latinx	23	3.9%	17	4.7%
Non-Hispanic/non-Latinx	573	96.1%	345	96.3%
Veteran Status				
Yes (veteran)	45	7.5%	6	1.7%
Age Categories				
Under 18	94	15.7%	65	18.0%
18-24	44	7.3%	76	21.0%
25-43	189	31.5%	125	34.5%
44-64	247	41.2%	89	24.6%
65+	28	4.7%	8	2.2%
Other Key variables				
Left for Housing	97	16.2%	103	28.5%
First Time Homeless	197	32.8%	122	33.7%
Days in project	9	n/a	60	n/a
Returned to Homelessness	25	4.2%	7	1.9%
Chronically Homeless	225	37.5%	89	24.6%

DESCRIPTION OF TABLE

Table 3 represents homeless cases by gender from 2021 to 2022. Among Whites, more males experienced homelessness (49.5%) compared to females (42.8%). An opposite effect was found in Blacks/African Americans, with 54.4% females being homeless compared to 49.2% males. More cases of homelessness were also seen among female non-Hispanics (96.3%) compared to their male counterparts (96.1%). Among homeless veterans, more cases were observed for males (7.5%) compared to females (1.7%). The data indicates that among males, those in the age category 44-64 had more cases of homelessness, with the least cases found in persons between the ages of 18-24 (7.3%). Females aged 25-43 had the highest cases of homelessness (34.5%), followed by 44-64. This suggests that middle aged females in this sample may need more services catered to the homeless. Other key variables were examined for both genders. More females exited homeless shelters (28.5%) compared to males (16.2%), however the return rate to homeless was higher in males (4.2%) than females (1.9%). The data also shows that males (37.5%) tend to be more chronically homeless than females (24.6%).

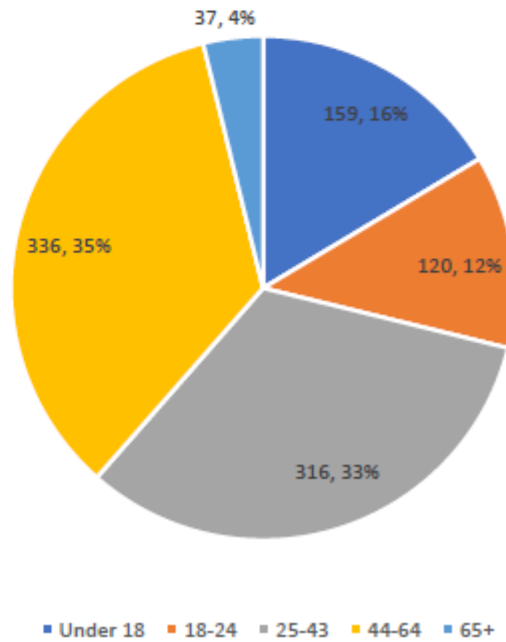
Chart 2



DESCRIPTION OF CHART

Chart 2 shows the trends in homelessness by gender for the last three years, 2020 to 2022. The highest cases of homelessness were observed in 2020 regardless of gender. A possible contributing factor could be the COVID-19 pandemic. From 2020 to 2022, more males experienced homelessness compared to females (730 versus 497, 558 versus 359, 600 versus 362 respectively). While the homeless rates have decreased over the 3-year period, more progress needs to be made to eradicate homelessness, especially when taking the gender differences into consideration.

Chart 3



DESCRIPTION OF TABLE/CHART

Chart 3 shows that individuals in the age category 44-64 years face the highest rates of homelessness (336, 35%), followed closely by individuals aged 25-43 (316, 33%)t66. This suggests that these two age categories constitute a vulnerable population that needs urgent interventions and services. The least cases are observed in seniors aged 65+.

Table 4: Springfield Homeless Data

Homeless Data		
	IL-513 Experiencing "Unsheltered" Homelessness	
Variables	**#**	**%**
Race (n=1,437)		
White	844	58.7%
Black or African American	566	39.4%
American Indian/Alaskan	12	0.8%
Asian/Pacific Islander	3	0.2%
Native Hawaiian or Other	1	0.1%
Multi-Racial	11	0.8%
Ethnicity (n=1,404)		
Hispanic/Latinx	45	3.3%
Non-Hispanic/non-Latinx	1359	96.7%
BIPOC (n=1,437)		
White alone	814	56.7%
BIPOC	623	43.3%
Gender (n=1,441)		
Male	898	62.3%
Female	535	37.1%
Other	8	0.6%
Veteran Status (n=1,442)		
No (not a veteran)	1358	94.2%
Yes (veteran)	84	5.8%
Age Categories (n=1,433)		
18-24	120	8.4%
25-34	337	23.5%
35-44	316	22.0%
45-54	342	23.9%
55-64	264	18.4%
65+	54	3.8%
mean ± standard deviation	*43.2 ± 13.08*	
Physical Health*		
Chronic illness	132	11.3%
Disability	502	55.7%
Individual Access (n=1,219) *		
CE ever	232	19.0%
ES ever	973	79.8%
SO ever	96	7.9%
SSO ever	126	10.3%
TH ever	104	8.5%

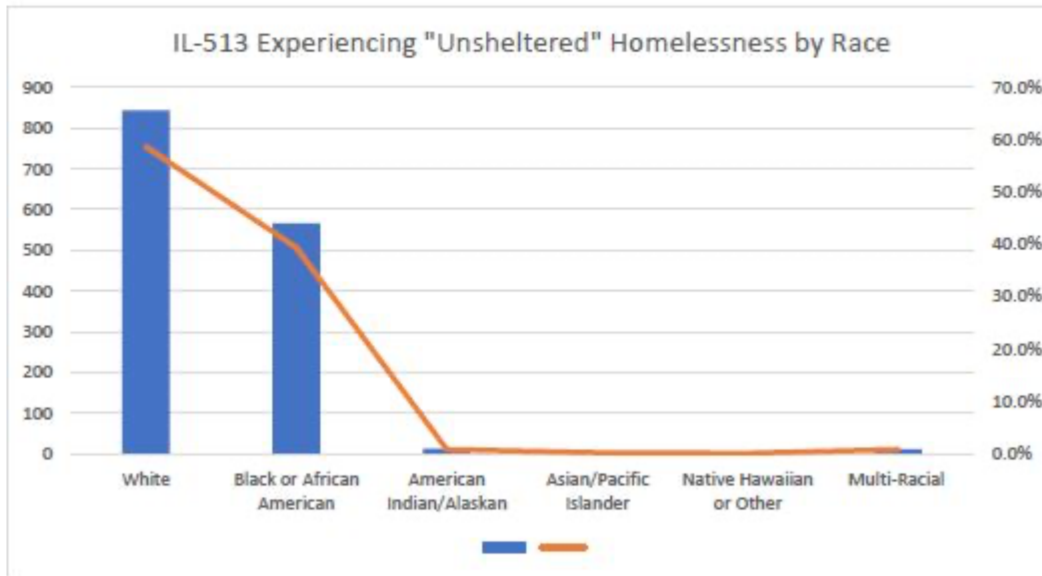
DESCRIPTION OF TABLE

Whites have the highest number and rates of unsheltered homeless (844, 58.7%) as depicted by the data in Table 4. Black/African Americans equally have high rates, at 39.4%. 43.3% of Black, Indigenous and People of Color (BIPOC) face unsheltered homeless compared to Whites alone (56.7%). In terms of gender, there are higher rates of homelessness among males (898, 62.3%) compared to females (535, 37.1%). Additionally, individuals ages 45-54 face the highest rates of homelessness (23.9%), followed by individuals aged 25-34 (23.5%). The age category with the least number and rates of homelessness are seniors aged 65+. Of all individuals experiencing unsheltered homelessness, 55.7% have a disability and 11.3% have a chronic illness.

Table 5: Springfield homeless data by race

	White		American Indian/Alaskan		Asian/Pacific Islander		Black or African American		Native Hawaiian or Other		Multi-Racial	
Variables	#	%	#	%	#	%	#	%	#	%	#	%
PH ever (ref=no)	35	5.2%	0	0.0%	0	0.0%	50	9.5%	1	100.0%	0	0.0%
ES ever (ref=no)	65	36.5%	0	0.0%	0	0.0%	160	47.2%	0	0.0%	8	32.0%

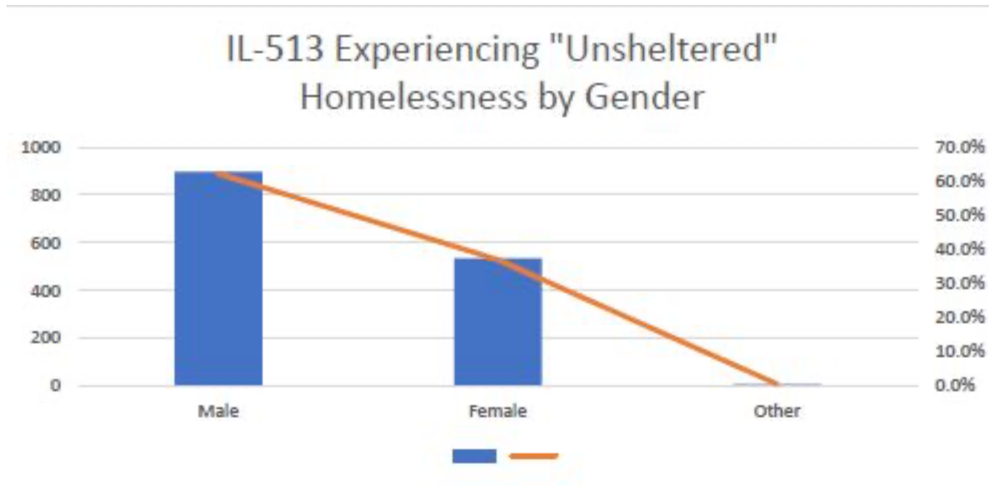
column comparisons
**PH ever white==5.2% stated yes, 94.8% whites stated no*



DESCRIPTION OF TABLE/CHART

Table 5 depicts the homelessness trends by race. The highest number and rates of unsheltered homelessness are observed among Whites (844, 58.7%). Over 40% of Black or African Americans experience unsheltered homelessness. Other races including Asian/Pacific Islanders, Native Hawaiian and multi-racial populations have extremely low rates of homelessness compared to their White and Black/African American counterparts. This is evidence that more services and initiatives should be targeted to the White and Black/African American population in Springfield Illinois.

Chart 4: Springfield homeless data by gender and age



DESCRIPTION OF CHART

In Springfield 62.3% of males experience unsheltered homelessness compared to females (37.1%) and “Other” (0.6%). Chart 4 also indicates that individuals aged 45-54 face the highest rates of homelessness (23.9%), followed by individuals aged 25-34 (23.5%). The age category with the least number and rates of homelessness are seniors aged 65+.

Equity

Racial and ethnic health inequities have long been documented in the United States (U.S.). These systematic differences occur in the context of broader historic and systemic racism, spanning every U.S. system from medical care to housing and hiring to the criminal justice system. Across the nation, the gaps for Black people, other people of color, individuals with behavioral health issues, and LGBT+ identified people are large, persistent and increasing, especially as it relates to homelessness (HUD, 2022). These individuals have persistently longer periods of homelessness, wait longer time periods to be housed, and have higher rates of returns to homelessness.

In the context of housing, equity is proportional representation in opportunities for housing and supportive services that lead to maintaining permanent housing and an improved quality of life (HUD, 2022). This analysis uses an equity framework that will consider race, gender, age and structural inequities. Keep in mind that equity is much different in scope and operation than equality. Equality means a person or group is given the same opportunities or resources, while equity recognizes that certain populations are at a disadvantage and allocates the opportunities and resources needed to reach an equal outcome.

Priority Areas

Priority areas are not listed in prioritized order but are based on literature review, document analysis, and interview and focus group findings.

This document recognizes the inequities in permanent housing and acknowledges the overarching need and inequity of funding for and available permanent housing. This document uses the most extreme inequities in the homelessness system of care as the baseline for the measurement of the six prioritize inequities. Expanded narrative on the need for permanent housing is included in the companion needs assessment document.

Lack of funding to support a comprehensive supportive system for permanent housing for persons experiencing homelessness greatly contributes to the destabilization and inequities of persons experiencing homelessness, impacting geographic communities, as well as the overall county.

Priority areas are comprehensive health, race, gender, LGBT+, community voice/input and Heartland continuum of care membership and role/responsibilities. For each priority area, there are identified factors that are or lead to inequities in the system of care for persons experiencing homelessness. The identified factors prohibit optimal homeless system planning and sustain inequities in policies and practice.

1. HEARTLAND CONTINUUM MEMBERSHIP AND ROLE/RESPONSIBILITIES

Stakeholders play a crucial role in helping organizations achieve their objectives and are usually vested members with a professional or personal stake. Calling attention to the housing needs of homeless men in the county may be a challenge; however, one strategy to build support is to be inclusive by involving stakeholders in the process. Having different stakeholders involved such as community-based organizations, philanthropists, and other vested community members with a personal stake in the housing program may be beneficial for generating innovative ideas or alternative resources to complete an organization's long-range strategies. They may also perform advocacy initiatives to promote the organization's cause by raising awareness, encouraging acceptance of transition housing programs and increasing knowledge through lobbying, press work etc. For these initiatives to be successful, the stakeholders need to be engaged and empowered the benefits of the organization through education. In other words, it would be quite difficult to stand for something without knowing the elements and environment of that which is being advocated.

FINDINGS:

- Increase membership to increase a diverse cross-section of the county with emphasis on populations and communities most impacted by homelessness but not integrated in the process.
- Develop and implement equity standards that are seamless through policies, procedures and program expectations.
- Improve organization capacity to meet eligibility requirements for new and expanded funds that can be used to reduce inequities and expand service provisions.
- Increase private and public and non-traditional partnerships in response to permanent housing needs.

RECOMMENDATIONS TO INCREASE EQUITY IN HOMELESSNESS SYSTEMS OF CARE:

Initial 3 Months

- Increase efforts to identify, target and recruit local stakeholders to be active members
- Identify all organizations in Sangamon County that serve underrepresented persons experiencing homelessness and identify a mutually beneficial roles they can serve on the continuum
- Identify communities/neighborhoods that have been directly impacted by homelessness in Sangamon County and identify mutually beneficial roles they can serve on in the continuum
- Identify persons with lived experiences that do and do not work directly with persons experiencing homelessness and identify mutually beneficial roles they can serve on in the continuum

By End of 6 Months

- Ensure that organizations in Sangamon County that serve underrepresented persons experiencing homelessness have roles that are fully integrated in the Continuum's steering committee's operations.
- Ensure that representatives from communities/neighborhoods that have been historically impacted by homelessness in Sangamon County are fully integrated in the Continuum's steering committee's operations.

By End of 9 Months

- Increase two-way communication regarding funding challenges and successes-, short- and long-term planning, policy updates, and access and placement of services.
- Release official statement and correlative supportive programming and services in regarding permanent housing eligibility for formerly released persons.
- Develop and execute a user-friendly dashboard that provides real time or current data regarding homelessness, relevant training, training registration and training history for providers and community members.
- Include in the dashboard measures by demographics

By End of 12 Months

- Hire clinicians that will consistently conduct mental health assessments and intake assessments to reduce inequities of allocation of affordable housing.
- Develop and implement an equity centered evaluation plan (formative, process, outcome, impact) that measures equity in meeting permanent housing supply and demand for adults experiencing homelessness by priority characteristics.
- Identify inequities in provider organizations and neighborhoods for services (housing, employment, transportation, overpopulation of services, and being a good neighbor) and develop, implement and evaluate action items.
- Improve the use of data to increase equity in service delivery (determine unmet need to reduce inequity, identify solutions, and share data in a user-friendly manner to stakeholders to annually and collectively identify resources

2. COMPREHENSIVE HEALTH

Physical Health

Among all vulnerable populations, the homeless population probably has the least access to health services. They are faced with a lack of financial resources, health insurance, stable housing, and health care providers are often unwilling to serve them (Allukian, 1995).

According to the National Alliance to End Homelessness, high rates of chronic diseases such as diabetes, heart disease, and HIV/AIDS are found among the homeless population (National Alliance to End Homelessness, 2018). Compared to the general population, rates are often three to six times higher. For individuals with mental health and substance use disorders who are unhoused, the severity increased and they are more likely to have immediate, life threatening physical ailments and live in dangerous conditions. Housing instability is a social determinant of health and a predictor of negative health outcomes. Individuals experiencing homelessness are almost ten times more likely than housed Medicaid patients to reappear at the emergency room six months after an initial doctor's visit. Unhoused patients have a higher emergency room utilization and hospital admissions and readmissions than sheltered patients, which puts a burden on the US healthcare system. This type of episodic emergency care neglects the social context and basic needs of unhoused patients and there is a pressing need for consistent access to primary care.

In order to provide equitable and adequate primary care to unhoused patients, health care providers must be willing to meet patients where they are. This would require providers to see unhoused patients where they reside (e.g., a shelter, tent, mattress, or underpass). This is a reimagining of the Home Health Care (HHC) Model and could fundamentally improve the health care system for patients experiencing homelessness and ensure continuity of care (Dommaraju et al., 2021). This type of medicine is called street medicine and this type of care model allows the provider to become acutely familiar with risks and challenges that patients face and builds trust. It focuses on patients' experience, inviting caregivers to understand patients' medical needs in their sociocultural context. Street medicine enables the healthcare provider to contextualize the patient's care plan with a more in depth understanding of individuals' circumstances (Dommaraju et al., 2021). The HHC model would center on the provision of services and housing for people experiencing homelessness by utilizing the Electronic Medical Record system and coordination with other service organizations.

FINDINGS:

- Challenge with adhering to treatment regimen due to limited health literacy and resources
- Limited long-term isolation accommodations and medical post operation and treatment recovery spaces. Resulting in fear and apprehension regarding moving forward with essential treatments and surgeries.
- Mental illness, substance abuse and other priorities served as a deterrent for establishment and maintenance of medical homes.
- Demonstrated needs for ongoing specific services for the aging population regarding chronic diseases and mental decline.

- **RECOMMENDATIONS TO INCREASE EQUITY PHYSICAL COMPREHENSIVE HEALTH**

By End of 6 Months

- Increase health literacy by providing alternate resources for those with limited reading and writing ability. Resulting in increased prescription adherence and attended medical appointments.
- Define and identify funding and priority for outreach and case management
- Define strategies to ensure that all individuals experiencing a medical home and when needed case management and transportation services for medical adherence.
- Identify location and resources to post-operative and procedure recovery

By End of 9 Months

- Assessment and follow-up for all persons experiencing homelessness over the age of 59 years old for mental decline (Alzheimer's and other mental loss)
- Assessment and follow-up for all persons experiencing homelessness over the age of 49 years old for chronic diseases.

By End of 12 Months

- Include housing and other social determinants in electronic medical record and referral follow-up

Behavioral Health

According to the Department of Housing and Urban Development's (HUD) 2020 Annual Homeless Assessment Report, on any given night in 2020, an estimated 580,000 individuals experienced homelessness in the United States. It is estimated that 20 to 25 percent of the United States' homeless population suffers from severe mental illness, compared to 6 percent of the public. The number of unhoused who have experienced substance dependence is even higher at 50 percent or more.

Serious mental illnesses disrupt people's ability to carry out essential aspects of daily life, such as self-care and household management and maintaining stable relationships. As a result of these factors and the stresses of living with a mental disorder, people with mental illnesses are much more likely to become homeless than the general population (National Coalition for the Homeless, 2009). Half of the mentally ill homeless population in the United States also suffers from substance abuse and dependence.

Individuals experiencing homelessness have unique needs and treatment challenges. People experiencing homelessness present unique treatment challenges, as both treatment and housing needs must be concurrently addressed for treatment to be most effective (National Coalition for the Homeless, 2009). Preventive services for people experiencing homelessness, including mental health, substance use, medical care, and social supports, are critical for mitigating risks of SUDs and mental disorders and improving health outcomes.

To best support people in recovery, a variety of supports and services beyond traditional treatment should be available**.** In addition to access to things like talk therapies and medications, support and services that engage people where they are and support them toward where they would like to be critical (National Coalition for the Homeless, 2009). Efforts should be made to secure financing methods for service improvements, including reimbursements for coordination activities, community case management, transportation, and other supports to ensure access to comprehensive services.

FINDINGS

- Need for a homeless centered behavioral health services and resources.
- Integration of behavioral health in all work plans.
- Assistance with behavioral health for those transitioning in the workforce.
- Street outreach integrates behavioral health services and resources.

RECOMMENDATIONS TO INCREASE BEHAVIORAL HEALTH COMPREHENSIVE HEALTH

By the end of 9 months

- Develop, implement and evaluate targeted outreach and case management services for persons experiencing homelessness and exhibit behavioral health services.

By the end of 12 months

- Assess and identify need for service providers that are reflective of race, culture and lived experiences (veteran, formerly incarcerated, gender, substance abuse, and sexual abuse) and hire to meet unmet service provider need.
- Ensure that mental health professional conduct mental health assessment to measure for housing.
- Increase service delivery capacity, support and possibly modify the name of the Diversion Court program to improve perception and increase participation and success rate.
- Increase access to detox beds and services and seamless inpatient services.
  Access to detox.

Dental Care

CDC reports that oral health disparities are profound in the United States (CDC, 2016). Despite major improvements in oral health for the population, oral health disparities exist for many racial and ethnic groups, by socioeconomic status, gender, age and geographic location. Overall, non-Hispanic blacks are among those who generally have the poorest oral health of any racial and ethnic groups in the United States; and blacks aged 35-44 years' experience untreated tooth decay nearly twice as much as white, non-Hispanics (CDC, 2016).

Unhoused individuals have been shown to have more grossly decayed and missing teeth than the sheltered population and their use of dental services is less (Gelberg, Linn, & Rosenberg, 1988; U.S. Department of Health and Human Services, 1998). Unsheltered persons are 12 times more likely than individuals with stable housing to have dental problems. The research also states that individuals living in unstable housing, such as a hotel or the residence of a friend or relative, are 6 times more likely to have dental problems such as periodontal disease and/or missing teeth (Ferenchick, 1992). It is reported that only 53 percent of toothless unhoused individuals have complete sets of dentures, compared with 91 percent of the general population. Also, they are 4.6 times more likely to not have had a dental cleaning in the previous 4 years (Gelberg, Linn, & Rosenberg, 1988). Dental problems such as missing teeth diminish self-esteem and impair an individual's ability to eat and ultimately, return to mainstream society (Allukian, 1996; Gelberg, Linn, & Rosenberg, 1988; U.S. Department of Health and Human Services, 1998).

FINDINGS

- Need for a homeless centered dental clinic.
- Integration of dental care in all work plans.
- Assistance with dental care for those transitioning in the workforce.
- Street outreach integrates dental care services and resources.
- Medical resources and assessment of diseases as a result of poor dental care.

RECOMMENDATIONS TO INCREASE EQUITY IN HOMELESSNESS SYSTEMS OF CARE:

By the end of 3 months

- Met and integration of dental appointments in work plans.
- Conduct assessment of dental needs and make follow-up appointments.

By the end of 12 months

- Identify dental services that will aid in preparation for the workforce.
- Establish at least one new dentist that provides dental services to persons experiencing homelessness.

3. RACE

Contrary to belief, race, not economic status, is the greatest indicator of homelessness in America. Minorities, especially Black Americans and Indigenous people, experience homelessness (US Census Bureau, 2020; Jones Schmitt, &Wilson, 2018). This is due largely to historical and systemic racism. Black Americans only represent 13 percent of the general population, but account for nearly 39 percent of people experiencing homelessness and over 50 percent of unsheltered families with children (US Census Bureau, 2020; Jones Schmitt, & Wilson, 2018).

Many minority groups such as Black Americans, Indigenous, and Latinx people, have been systematically denied rights and access to socioeconomic opportunities which increases their likelihood of becoming homeless (US Census Bureau, 2020; Jones Schmitt, &Wilson, 2018). Black and Latinx communities are over-represented in population poverty rates, and are more likely to live in deep poverty. Poverty is a by-product of systemic inequity and is a strong predictor of homelessness (US Census Bureau, 2020; Jones Schmitt, &Wilson, 2018).

FINDINGS

- Perceptions that culture and life experiences are not regarded or taken in consideration during assessment, engagement and transition to permanent housing.
- Concerned that there is not mirroring representation in staff and limited relationships with external organizations that are more reflective.
- Limited access regarding advocacy or external supportive services that could assist in advancement towards acquisition of permanent housing.
- Limited hope and lack of knowledge of successful outcomes for those who are older with previous long-term incarceration history.

RECOMMENDATIONS TO INCREASE EQUITY BY RACE

By the end of 3 months

- Prioritize and plan to respond to the disproportionate rates of homelessness among racial minorities, especially those who are older.
- Take in consideration representation and culture in hiring, training and engagement.

By the end of 9 months

- Increase knowledge of historical underpinnings when developing outreach and case management plans.
- Integrate plans to deconstruct structural racism, and racial disparities where it might exist.
- Regularly monitor by race and other demographics frequency and rates of in-flow in housing system and outflow to permanent housing.

4. GENDER

Homelessness in the United States (U.S.) is a gendered phenomenon, with men being the overwhelming majority (70 percent) of persons counted in HUD-required annual Point-in-Time (PiT) counts compared to women (29 percent) (Montgomery, Szymkowiak, Culhane, 2017). Men are also more likely than women to be unhoused. In the 2018 PiT, there were 260,284 men compared to 106,119 women.

On a local level when examining Continuum of Care (CoC) Programs across the nation, there were 120 CoCs in 30 states where men represented 50 percent or more of unhoused individuals (National Alliance to End Homelessness, 2019). Forty-nine states had men representing 75% or more of individuals experiencing homelessness. There are many plausible explanations to why men are overrepresented in the homeless system. For instance, men make up an overwhelming majority of individuals in the criminal justice system and supply about 48,000 individuals every year who are coming directly from U.S. jails and prisons (Cho, 2015).

FINDINGS

- Homeless men's work experience is traditionally labor related and limited to administrative skills. The aging population is challenged learning new skills with limitations in education and cognitive abilities. Resulting in less ability to financially maintain a household.
- Identify strategies to educate providers and populations more likely to be chronically homeless and implement prevention strategies.
- Limited structured continuum of care for men who have served long prison sentences during their transition (workforce development, mental health, support systems).
- Ongoing need for comprehensive services in the context of addressing needs of chronic homeless Black men regarding health, mass incarceration, workforce development, mental health and trauma and transitioning out of homelessness.

RECOMMENDATIONS TO INCREASE EQUITY REGARDING GENDER

By the end of 9 months

- Develop a comprehensive plan to address immediate and short-term needs of chronically homeless Black men. The plan should include response to mass incarceration, limited or no support system, under education and skills, inability to increase income, and behavioral health with multiple levels of trauma.

5. **LGBT+**

LGBT+ individuals, especially youth, experience higher rates of homelessness than their heterosexual and cis-gender peers. This population faces significant risks of homelessness (Curry et al., 2017; Rosario et al., 2012) and are overrepresented in the overall population of homeless individuals (Lolai 2015; Cochran et al., 2002). Many of these risks can be attributed to structural inequalities (i.e., discrimination, homophobia, transphobia,), systemic inequalities (i.e., income inequities, a lack of legal protections), interpersonal challenges (i.e., familial disruption and conflict, violence), intrapersonal challenges (i.e., mental health challenges, substance use challenges), and housing challenges (i.e., evictions, landlord discrimination; Caton et al., 2005; Gaetz et al., 2013).

In addition, quantifying unsheltered LGBT+ individuals is a major challenge. Few studies have study the LGBT+ homelessness robustly (Choi et al., 2015). One of the major drivers of this disparity is the lack gender identity and sexual orientation data collected by of homeless services agencies. Many LGBT+ individuals may not use mainstream homeless services or be recorded accurately within organizations (Burwick et al., 2014; Curry et al., 2017). Recorded LGBT+ service users gender identity and sexual orientation often varied between organizations when examined.

FINDINGS:

- There is a need for a more robust method to collect, maintain and use LGBT+ data to adequately address needs and integrate LGBT+ services into mainstream services and programs for youth and adults.
- Experiences during homelessness included heightened levels of violence and isolation.
- Need for LGBT+ programs that intersect and respond to the intersection of poverty, mental illness and addiction.
- Ensure that shelters are designed, and staff are trained to prohibit opportunities for violence and victimization of LGBT+

RECOMMENDATIONS TO INCREASE EQUITY OF LGBT+

By the end of 9 months

- Identify safe spaces to prevent, report and monitor unreported acts of violence in homeless social networks
- Develop and implement culturally specific mental health and substance abuse services
- Develop and implement proactive strategies to address issues of self-worth and abandonment
- Develop and implement targeted outreach and case management services that are link to trauma and cultural centered counseling.
- Monitor and respond through programming of inflow in housing system and outflow to permanent housing.

6. COMMUNITY VOICE AND INPUT

Garnering community input is imperative to the success of initiatives that serve unsheltered populations. Finding the appropriate location for programs that serve individuals experiencing homelessness can be controversial and those decisions often face nuanced ongoing social and political obstacles from communities, government, and law enforcement (Castells, 1983; Grundy et al., 2021; Pile, 1997; Smith, 1994). Resistance to urban issues such as poverty and homelessness, in a specific geographical location depend on these basic structural determinants: the local economy of a community, the culture of the community, and the state/local government (Castells, 1983). For example, opening a new homeless initiative in a community that is made up of close-knit social networks and has experienced major declines in their economies can create place-based political, social, and economic barriers to community support. The barriers often manifest as the "Not In My Backyard (NIMBY)" phenomenon that is associated with individuals who use drugs, who have behavioral health problems, and those experiencing homelessness (Takahashi, 1997). The NIMBY argument is a major barrier to the development of programs that serve these individuals, often sparking valid concerns among community members related to community safety, property values, and neighborhood identity (Davidson & Howe, 2014).

For communities that have experienced social injustices caused by historical violence and systemic and structural racism, incorporating the voices of the community in the planning, implementation, evaluation, and dissemination of interventions would help understand the needs of the total population, and not just those experiencing homelessness.

FINDINGS

- Feeling of lack of regard by eastside communities and residents
- Not aware of actions or services in response to homelessness
- Not aware of opportunities to provide input or hold anyone accountable for advancement
- Want services that residents can also take advantage of…indicated being two paychecks away from homelessness (better jobs, small business development, etc)
- Concerned that soon will be a full-blown city problem with no strategies to reduce the homeless population
- Believes they are considered mean or bad if they do not accept homelessness as a norm for their community

RECOMMENDATIONS TO INCREASE COMMUNITY VOICE AND INPUT

By the end of 9 months

- Maximize social capital of new partners who are community leaders and collaborate to increase open solution-oriented dialog.
- Acknowledge power and control dynamics of some communities and engage them from a collective empower approach using the Continuum as a foundation. (remove us vs. them dynamic).
- Address the lack of representation through members of the Heartland Continuum of Care through intentional diversity recruitment of membership.
- Acknowledge past pains and root cause of inequities (historical mistrust power systems and communication)
- Recognize that long-term economic security is through homeownership and the impact of service delivery of homeownership in communities.

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