ASSESSMENT OF WEST VIRGINIA HOMELESS POPULATION

Homelessness Metrics and
Consensus Building Findings

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES
Bureau for Behavioral Health

Assessment of West Virginia
Homeless Population
Bureau for Behavioral Health
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Executive Summary

West Virginia Senate Bill 239 comprises eight objectives addressed in three reports written by the West Virginia University Health Affairs Institute for the West Virginia Department of Human Services (DoHS), Bureau for Behavioral Health (BBH). This report includes findings for the Legislative Objective 4.

- Identify key metrics to measure homelessness across West Virginia in a more consistent manner

Background

In February 2023, the West Virginia Legislature passed Senate Bill 239, which tasked its Department of Health and Human Resources (DHHR), now known as the Department of Human Services (DoHS), with undertaking a study to deepen the State's understanding of who comprises its homeless population, of resources available to meet their needs, of factors that may influence geographic location and relocation of those who make up this population, and of metrics used to quantify and determine eligibility of services for these residents.

To complete this study, DoHS partnered with West Virginia University's Health Affairs Institute. The Health Affairs team in turn engaged with the State's four Continuums of Care, all 13 comprehensive behavioral health providers, substance use disorder providers, municipal leaders and county government leaders across the state, as well as direct service providers, agencies, and organizations to conduct this work.

Addressing these legislative directives, including identification of key metrics to measure homelessness across West Virginia in a more consistent manner, required several components. The research team first developed a baseline understanding of West Virginia's homelessness landscape. By conducting federal policy research and stakeholder outreach, the team learned about services provided throughout the State, definitions that federal funders require for determining service eligibility for individuals and families, and existing data that is collected from or about this population. The team also researched definitions of homelessness used across the United States, arriving at a concentrated focus on the border states surrounding West Virginia within the Appalachian region. From there, the team was able to determine what additional information would be needed to address the legislation and relied on the expertise of those in the field to learn specifically about current metrics in use.

Through environmental scans of policy, rich information gathered from those stakeholders working directly to meet the needs of this population, and a modified Delphi process with a panel of experts, the Health Affairs team was able to gain an overall perspective of the metrics currently in use to measure homelessness and understand this population in West Virginia.

The expert panel indicated individuals experiencing homelessness in West Virginia are diverse, and a single definition may not adequately capture the complexities of this population. The panel agreed on the importance of identifying metrics to better understand and monitor those experiencing homelessness in the state, without eliminating others who may also be homeless.

Panelists agreed the state should monitor metrics defined by federal reporting requirements for those who are literally homeless, at risk of homelessness, homeless families, and homeless youth, children, and minors. There was also a high level of consensus that the state should include, as key metrics, veterans who are experiencing homelessness, individuals fleeing from or attempting to flee domestic violence, and individuals facing imminent risk of homelessness among others.

Our methods, process, results, and the careful thought and input of those on the ground serving residents experiencing homelessness are outlined in this report.

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List of Tables

Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
AWVHP	Assessment of West Virginia Homeless Population
CoC	Continuum of Care
DoHS	West Virginia Department of Human Services
Health Affairs	Health Affairs Institute
HEARTH	Homeless Emergency Assistance and Rapid Transition to Housing
HHS	U.S. Department of Health and Human Services
HUD	U.S. Department of Housing and Urban Development
RHYA	Runaway and Homeless Youth Act
VA	U.S. Department of Veterans Affairs
WVU	West Virginia University

Project Purpose

West Virginia Senate Bill 239 comprises eight objectives, with each addressed through a study culminating in three reports. The AWVHP Homelessness Metrics and Consensus Building Findings Report, the AWVHP Homelessness Demographic Report, and the AWVHP Policy Analysis Report. How each report works to answer the eight Legislative Objectives is outlined in Table 1.

Table 1: Assessment of West Virginia Homeless Population Reports

Report Name and Purpose	Legislative Objectives
Report 1: Homelessness Metrics, Consensus Building Findings Detailed Report • Key metrics to measure and define homelessness consistently.	**Legislative Objective 4:** Identifying key metrics to measure homelessness across West Virginia in a more consistent manner
Report 2: West Virginia Homelessness Demographic Detailed Report • Demographic information • Epidemiological analysis • Location and relocation information	**Legislative Objective 1:** Presenting a breakdown of homelessness demographic information throughout West Virginia and regionally
	Legislative Objective 3: Conducting an epidemiological analysis of homeless populations in West Virginia
Report 3: Exploration of Policies Related to Homelessness • Resources by region • Concentrations of individuals experiencing homelessness (and possible reasons)	**Legislative Objective 2:** Quantifying and inventorying of homelessness resources by region
	Legislative Objective 5: Conducting an analysis of whether West Virginia's homeless populations concentrate in certain counties or municipalities and any reasons for such population concentrations
	Legislative Objective 6: Determining if state policies cause the state's homeless population to relocate to certain counties or municipalities
	Legislative Objective 7: Determining the percentage of homeless individuals that lived in another state or jurisdiction in the past three years or are from another state or jurisdiction
	Legislative Objective 8: Conducting an analysis of whether any health and human services benefits offered in West Virginia attract populations that are homeless or at risk of homelessness

Introduction

In West Virginia (WV), four primary Continuums of Care (CoCs) collect data about community members experiencing homelessness as part of federal funding requirements for provision of services. Individuals and families experiencing homelessness are included in an annual Point in Time Count each January.[1] This agency-driven, coordinated effort at the community level aims to take an accurate census of each community's population experiencing homelessness on a single day of the year. Additionally, federal funding for provision of emergency shelter beds as part of daily agency operations is reliant upon adherence to data collection standards established by the U.S. Department of Housing and Urban Development (HUD), the U.S. Department of Health and Human Services (HHS), and the U.S. Department of Veterans Affairs (VA). Accurate data collection about services provided aligns agencies with federal participation and reporting requirements.[2]

In February 2023, the WV Legislature passed Senate Bill 239, requiring additional study of this overall population. The bill asks the West Virginia Bureau for Behavioral Health, to engage service providers to study and better understand many aspects of this population's experience, including demographic characteristics, location, service needs and uses, and reasons for relocation. Senate Bill 239[3] aims to supplement and add context to existing data, which could help state and local agencies better understand the needs of this complex population. Additionally, the bill asks DoHS to establish more streamlined metrics for measuring homelessness in West Virginia, where multiple definitions are currently in use.

To address the legislative requests, to better understand service needs, and to establish a more streamlined and purposeful definition of homelessness out of desire to collect more accurate metrics about this population, DoHS partnered with West Virginia University (WVU) Health Affairs Institute (Health Affairs). This team evaluated existing federal and state definitions of individuals experiencing homelessness, convened a panel of experts to determine elements of a definition of homelessness specific to the WV context, and established a consensus around a recommendation to the State Legislature for a streamlined definition of homelessness for West Virginia.

Currently, three major definitions of homelessness are in use by federal agencies and those funded by them at the state level: the education definition included in the McKinney-Vento Act[4],

[1] Point-in-Time Count and Housing Inventory Count. hudexchange.info. Updated 2023. Accessed August 23, 2023. https://www.hudexchange.info/programs/hdx/pit-hic/
[2] HMIS Data Standards. Updated 2023. Accessed November 11, 2023. https://www.hudexchange.info/resource/3824/hmis-data-dictionary/
[3] Senate Bill 239. wvlegislature.gov. Updated 2023. Accessed August 23, 2023. https://www.wvlegislature.gov/Bill_Status/bills_text.cfm?billdoc=sb239%20sub1%20enr.htm&yr=2023&sesstype=RS&billtype=B&houseorig=S&i=239
[4] The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

the HUD definition[5], and the Runaway and Homeless Youth Act (RHYA) definition.[6] There is some variation to both the usage of and living situations covered by these definitions. The McKinney-Vento definition is used in elementary and secondary education settings, and by agencies working under the Individuals with Disabilities Education Act, the Higher Education Act, the Head Start Act, the Child Nutrition Act, or the Violence Against Women Act. It covers various living situations that define homelessness but does not address "at risk of homelessness" within its text. HUD's current definition from the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act is used by agencies delivering HUD-funded homeless assistance programs. Living situations covered under this definition are generally more limited than McKinney-Vento, but it does address "at risk" within its text. The RHYA definition is used by agencies administering HHS-funded programs for this sub-population. Living situations covered within its text are more similar to McKinney-Vento (also applicable to youth) than to the HUD definition, and though it also does not address "at risk of homelessness", it does differ from McKinney-Vento in that it acknowledges youth at risk of separation from their families.[7]

In addition to federal definitions, states follow their own definitions[8] for some provision of services. Whether or not an individual or family meets required definitions of homelessness determines whether they are eligible to receive services, meaning inconsistencies in definitions of homelessness can cause inconsistencies in services provided. Inconsistencies in definition can also mean an inconsistent data picture of how many residents are experiencing homelessness, and where, at any given time.[9]

To address this portion of Senate Bill 239, the Health Affairs project team, in partnership with DoHS, conducted an expert assessment of the current definitions of homelessness using a modified Delphi approach. Steps of this approach include a pre survey, a panel discussion, and a post survey.

Methods

Multiple federal definitions of homelessness are used to assess someone's housing status, and DoHS requires information about which metrics are most representative of individuals who are homeless in WV. A three-stage online modified Delphi approach (pre survey, a panel discussion, and a post survey) was used to attempt consensus around metrics of a definition or definitions of homelessness for government agencies in WV. Modified Delphi is an iterative approach to attempt to establish consensus from a group of experts around a desired outcome, such as clinical

[5] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

[6] The Runaway and Homeless Youth Act. Updated 2023. National Center for Homeless Education. Retrieved November 15, 2023 from https://nche.ed.gov/legislation/runaway-youth/

[7] Definitions of Homelessness for Federal Program Serving Children, Youth, and Families. www.acf.hss.gov. Date Unknown. Accessed September 18, 2023.

[8] Who is Homeless? Different Definitions of Homelessness by State. Updated 2016. https://www.nn4youth.org/wp-content/uploads/Different-Definitions-of-Homelessness-by-State-NN4Y-2015-2-25-2016.pdf

[9] Who is Homeless? Different Definitions of Homelessness by State. Updated 2016. https://www.nn4youth.org/wp-content/uploads/Different-Definitions-of-Homelessness-by-State-NN4Y-2015-2-25-2016.pdf

practice guidelines[10] or patient diagnosis and treatment.[11] The online modified Delphi approach facilitated iterative interactions with a panel of experts who represent organizations serving individuals experiencing or at risk of experiencing homelessness across WV. The goal was to determine the following: which definition metrics were most important when working with those experiencing homelessness in WV, if the State government needs a definition of homelessness of its own, and if so, what metrics that definition should contain.

Environmental Scan

Federal definitions and regulations are important because they establish guidelines for supporting and funding state programs that address individuals at risk for and experiencing homelessness and determine eligibility for programming. From September 21, 2023 to October 4, 2023, the project team performed an environmental scan of federal agency and state definitions of homelessness. The results of the scan were incorporated into modified Delphi activities. In addition to federal definition discussion points, the definitions from West Virginia's neighboring states of Maryland, Pennsylvania, Ohio, Kentucky, and Virginia provided examples the group would use to attempt to reach consensus. These discussion points included various metrics and examples of sub-populations who are experiencing homelessness in these neighboring states that also lie within the Appalachian region.

Modified Delphi

The three stages of the online modified Delphi[12] started on September 18, 2023 and concluded on November 7, 2023. The stages consisted of a pre survey, a virtual discussion with an expert panel, and a post survey. The purpose of each iteration was to identify metrics from existing definitions of homelessness that panelists deemed important both generally and specific to the WV context, and to reach consensus about what should and should not be included in a WV state definition. The pre survey gathered information to assess the level of agreement among panelists by asking them to select and rank metrics within each definition, as well as include additions to metrics the project team had not identified. The virtual panel provided an opportunity for open discussion of existing definitions, allowed participants to again identify additional metrics that had not been identified, and to begin steps toward consensus. The post survey measured consensus among panel participants.

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[10] Grant, S., Armstrong, C., & Khodyakov, D. Updated 2021. Online modified-Delphi: a potential method for continuous patient engagement across stages of clinical practice guideline development. Journal of General Internal Medicine, 36, 1746-1750.

[11] Eubank, B. H., Mohtadi, N. G., Lafave, M. R., Wiley, J. P., Bois, A. J., Boorman, R. S., & Sheps, D. M. Updated 2016. Using the modified Delphi method to establish clinical consensus for the diagnosis and treatment of patients with rotator cuff pathology. BMC medical research methodology, 16, 1-15.

[12] Grant, S., Armstrong, C., & Khodyakov, D. Updated 2021. Online modified-Delphi: a potential method for continuous patient engagement across stages of clinical practice guideline development. Journal of General Internal Medicine, 36, 1746-1750.

Panelist Selection and Timeline

Potential participants were selected with the goal of maximizing representation from organizations across WV that serve people experiencing or at risk of homelessness. Panelists were identified using a list of the 118 contributors to the plan outlined in the report "Opening Doors in West Virginia: A Plan to Prevent and End Homelessness / 2015-2020.[13] The project team referenced this list to learn who was still actively involved with this work, and to find publicly available contact information for potential participants. Of this list, 42 potential participants were identified, and an additional three were recommended by project sponsors.

Once the panelists were identified, each was sent an invitation letter by email. The letter contained a short summary of the goals and informed potential participants that they were invited to attend a virtual discussion group. The letter informed recipients that the discussion group would be held September 28, 2023, and that they would receive two follow-ups: 1) a calendar invite and 2) a follow-up email with a pre survey about the definitions of homelessness. The pre survey email contained instructions for accessing the survey by URL link or by QR code and two reference materials: 1) a copy of the survey, and 2) a table comparing metrics of the federal definitions of homelessness.

Pre Survey

The pre survey consisted of 11 questions and was administered anonymously using Qualtrics.[14] Respondents were asked:

- The organization they represented
- The definition of homelessness their organization used
- To review a list of federal homelessness metrics, selecting each for either inclusion or exclusion in a potential state definition for WV
- To identify the strengths and weaknesses of different metrics included in federal definitions
- To list any additional metrics important in a West Virginia context

Responses from the pre survey informed the topics covered in the virtual discussion.

Virtual Panel Discussion

The virtual meeting provided an opportunity for the project team to interact with and draw on the expertise of the selected panelists who could attend. The virtual meeting was conducted and recorded using Zoom (version 5.16.2) on September 28, 2023, and lasted about 75 minutes. One member of the project team served as the facilitator for the meeting, and another took notes. A presentation was used to provide key information for the discussion including background, a word

[13] West Virginia Interagency Council on Homelessness. Updated 2015. Opening Doors in West Virginia: A Plan to Prevent and End Homelessness / 2015-2020.
[14] Qualtrics. (2023). Qualtrics cloud-based software. In (Version October 2023) Qualtrics. https://www.qualtrics.com

cloud activity to solicit preliminary thoughts about elements necessary for inclusion in a definition of homelessness, a review of federal and state definitions, and a final revisit of the initial word cloud question to gather additional thoughts that discussion may have prompted. Information gathered from notes, the word cloud activities, and the recording of the virtual meeting informed the development of the post survey (i.e. inclusion or exclusion of metrics and ranking metrics by importance).

Post Survey

After the virtual discussion, each participant was sent an invitation for the post survey including instructions, a web link, and a QR code. Invitations were sent by email on October 10, 2023, and were followed by a reminder email three days later. On October 19, 2023, a third email reminder was sent along with a call-in option.

The post survey consisted of 11 questions and was administered through Qualtrics. The goal of the post survey was to establish consensus around metrics necessary for inclusion in a state definition for WV. In the post survey, the respondents were asked to identify:

- The organization they represented
- Their role within the organization
- The county or counties in which their organization provided services

Respondents were then asked to select from a list of metrics those they believe should be included in a definition of homelessness for West Virginia. Metrics were grouped into the following topics (Table 1):

- Subpopulations
- Location
- Stability or Safety
- Families and Youth

After making choices within each topic area to indicate metrics necessary for inclusion, the respondents' selections were displayed back to them as a new list, and they were asked to rank each from most to least important.

Table 2: Federal definition metrics presented to survey participants in the post survey

Definition Topic	Federal Definition Metric
Sub-populations	Those who are literally homeless
	Those facing imminent risk of homelessness
	Those fleeing/attempting to flee domestic violence
	Unaccompanied youth under 25 years of age
	Families with children and youth who do not otherwise qualify as homeless, but who have not had permanent housing in the 60 days prior to needing assistance, who have two or more moves in the preceding 60 days, and who can be expected to continue in this way due to special needs or barriers
	Homeless veterans
	Those recently discharged from incarceration or other setting
	Victims of human trafficking
	Other (text entry allowed)
Location	Unsheltered locations
	Emergency shelters and transitional housing
	Motels and hotels
	Staying with others (“doubled-up”)
Stability or Safety	At risk of homelessness
	Violence or domestic violence
	Safety of the place the person is staying
	Stability of the place the person is staying
	Not having legal rights or legal access to the place the person is staying (eviction)
	Insufficient resources
	Loss of employment
	Lack of income
	Lack of adequate support
	Lack of belonging
	Lack of affordable housing
Family and Youth	Homeless family
	Physical custody of homeless youth, child, or minor (living with relative)
	Entering or exiting foster care, juvenile justice, or child welfare
	Homeless youth, child, or minor
	Age for homeless youth, child, or minor

Survey Data Analysis

Results from the pre survey and post survey were analyzed qualitatively and quantitatively. Each metric that respondents identified as important to include was counted and ranked. The counts were used to calculate an agreeance percentage for each metric to be included. The rankings were calculated using an average rank, allowing for ties, using a Kendall Rank Correlation Test. The rankings were also separately examined using a Plackett Luce model for assurance.

Summary of Findings

Environmental Scan

Federal Definitions

During the environmental scan of definitions of homelessness, the following were identified from federal legislation:

- the McKinney-Vento Act,
- the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act (Appendix B), and
- the Runaway and Homeless Youth Act. The HEARTH Act amended and reauthorized the McKinney-Vento Act. A key amendment of the HEARTH Act expanded the definition of homelessness to include those at-risk of homelessness[15].

Federal education programs and agencies use definitions of experiencing homelessness from Section 725 of Subtitle VII-B of the McKinney-Vento Act.[16] The McKinney-Vento Act authorized programs that required states to provide access and support for students experiencing homelessness in public schools. The Runaway and Homeless Youth Act also defines homelessness for runaway or otherwise homeless youth with final rules established by the United States Department of Health and Human Services.[17]

The United States Department of Housing and Urban Development (HUD) uses definitions of individuals and families experiencing homelessness from Section 103 of Subtitle I of the McKinney-Vento Act with amendment from the HEARTH Act. HUD has translated definitions established by both Acts into regulations that guide grant funding and federal programming to support those experiencing homelessness across the United States.[18]

State Definitions

Definitions of homelessness from across all 50 states were included in the environmental scan. Those used in WV's five border states - Kentucky, Maryland, Ohio, Pennsylvania, and Virginia, all of which have portions that lie within the Appalachian region – were found to be conclusive for the team's needs. These results informed the modified Delphi. Metrics included within the definitions from these five states (Table 2) were assessed by respondents of both pre and post surveys and were also discussed by the expert panel.

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[15] What is Reauthorization? Updated 2021. https://dcpartners.iel.org/wp-content/uploads/2021/09/What-is-Reauthorization-session-6.pdf
[16] Part B—Education for Homeless Children and Youths, Updated 2015. https://uscode.house.gov/view.xhtml?path=/prelim@title42/chapter119/subchapter6/partB&edition=prelim
[17] Runaway and Homeless Youth Program Authorizing Legislation. (2023). Family and Youth Services Bureau. Retrieved November 19, 2023, from https://www.acf.hhs.gov/fysb/law-regulation/runaway-and-homeless-youth-program-authorizing-legislation
[18] What is Reauthorization? Updated 2021. https://dcpartners.iel.org/wp-content/uploads/2021/09/What-is-Reauthorization-session-6.pdf

Table 3: State definition metrics presented to survey participants in the pre survey

State Definition	Definition Metric
Pennsylvania House Bill no. 127; Virginia Administrative Code 8VAC20-780-10	Awaiting foster care placement
Code of Virginia § 22.1-3	Unaccompanied youth/parental custody
Maryland Code of Regulations 07.01.17.02 and 13A.05.09.02	Defining the group (e.g., homeless women, homeless family unit, homeless student, State resident)
Ohio Administrative Code 122:6-1-01	Defining homeless prevention or keeping someone out of homelessness
Kentucky. Rev. Stat. § 198A.700	Mention of rural/urban area
Maryland Code of Regulations 07.01.17.02	Different ways of describing the residence/length of time (e.g., voucher hotel, 90 days)
Maryland Code Regs. 05.05.09.03	Lack of support networks for at-risk of homelessness

Modified Delphi

Pre-Survey

Five individuals responded to the pre-survey. Those who participated answered questions about metrics included in definitions of homelessness that were informed by the environmental scan. Almost all metrics received a response indicating some level of importance. The rankings of these metrics did not reach consensus due to low response rate and partial responses. However, enough information was provided by this respondent group to inform materials developed for facilitation of the follow-up modified Delphi panel discussion. In addition, one key stakeholder who did not respond to the pre-survey questionnaire but participated in the panel discussion sent an email response with information related to the questionnaire to help inform the planned discussion.

Virtual Panel Discussion

The modified Delphi panel that followed the pre survey was comprised of eight participants representing a range of entities. These included Continuums of Care, service organizations working to meet the needs of families, senior citizens, those in need of employment or recovery services, and more. Health Affairs team members facilitated a robust discussion with this group to understand current uses of federal definitions of homelessness as required by funders, professional perspectives about metrics within these definitions as well as those of other states, and panelists' thoughts about whether there are any populations (or sub-populations) experiencing homelessness in WV who are "missed" by the definitions currently in use.

The discussion began with hesitancy from panelists regarding redefining or attempting to define homelessness in WV. While panelists understood the importance of a clear definition, they expressed reluctance due to the complexity of this population, which is incredibly diverse. Panelists concurred that those experiencing homelessness represent multiple populations with

diverse needs. They also expressed two important needs around metrics for this population. One is related to defining the population, which may not be possible due to its diverse nature. The second is monitoring the needs of the population. The panelists expressed the importance of having clear metrics to monitor and understand the needs of those experiencing homelessness while at the same time not using them to define the population.

In terms of defining those who are experiencing homelessness, panelists felt that federal definitions required for determining eligibility for benefits do generally apply to individuals and families with service needs related to housing. However, the expert panel also asked the Health Affairs team to consider limitations that may affect individuals or groups, even if not an overall sub-population of residents.

Participants noted no identifiable ways in which these definitions consistently limit provision of services. While definitions do not outright exclude any particular sub-populations or groups, panelists shared some scenarios where an individual or family's particular situation may exclude them from services as the definitions are currently written. For example, when those providing services are working to house an individual or family who does not have a place of their own and is staying in a hotel or motel, they are considered homeless only if an agency or organization is paying for the hotel room. In this scenario, someone may have no home, use the last of their saved income to stay in a hotel on Monday, and may find themselves unsheltered and ineligible for housing services on Tuesday.

Another sub-population panelists asked the research team to consider in this regard were those exiting an institutional setting. Definitions require service providers to assess where a person stayed on the night before they entered an institutional setting such as hospitalization or incarceration. In some scenarios, that metric would define them as "not homeless" based on their situation on that single night, but in reality, they still may not have a place to go upon exiting the institution and are not eligible for services.

Though panelists raised these and other discussion points, the group did not have any overall critiques of the definitions currently in use by their organizations. While the group did not support the need for a revised definition of homelessness in WV, they did note the importance of continuing to ensure equity for subpopulations including:

- Those experiencing or fleeing domestic violence
- Those who experience chronic homelessness or who are imminently at risk of becoming unsheltered
- Those who do not have a permanent residence, affordable housing options, or who otherwise have unmet housing needs
- Unsheltered veterans and those who have been recently discharged from the military or another institution

Overall, the group concurred regarding the importance of metrics as a tool to understand the needs of those experiencing or at risk of experiencing homelessness in the state and to monitor or measure trends related to these metrics. They were hesitant to use those metrics to land on a specific definition of homelessness due to the varied and changing nature of this population.

Post Survey

Of the eight experts who attended the panel discussion, seven provided responses to the post survey. The expert panel was unable to reach consensus around what metrics should be excluded from a WV definition of homelessness. That is to say, every metric included in the post survey was identified as having at least some level of importance by at least one expert. This likely speaks to the discussion during the panel around the diversity of those experiencing homelessness across the state and the need to monitor and measure different homelessness-related metrics. While the panelists could not reach complete agreement on any metric being excluded, they did reach consensus regarding inclusion of elements of the different definitions presented to them. Again, likely as metrics that should be monitored but not used to necessarily define this population.

Compete Consensus

In particular, 100% of the panelists agreed that those who are literally homeless (Table 4), as defined by HUD, should be included in metrics used to study and/or monitor homelessness in WV. In addition, all the panelists indicated that individuals staying in unsheltered locations should be included, as should those who are at-risk of homelessness, homeless families, and homeless youth, children, or minors. While they agreed these should be included as metrics, how they ranked them varied. This may reflect that panelists interact more with certain sub-populations, and they ranked those they tend to interact with the most first.

Table 4: Metric, Who Defined It, and What It Means

Metric	Defined By	What It Means
Literally Homeless	HUD	a.) Primary nighttime residence is not meant for human habitation b.) Living in a shelter designed to provide temporary living arrangements c.) Is exiting an institution where (s)he has resided for 90 days or less, and where (s)he met either criteria a.) or b.) on the night before entering the institution
At-Risk of Homelessness	Hearth Act	• Income <30% median • Insufficient resources to attain housing • Has moved frequently due to economic reasons • Is living with others • Has been notified of eviction or need to leave • Lives in a hotel or motel • Lives in overcrowded housing • Is exiting an institution, or • Otherwise lives in housing that is associated with instability and an increased risk of homelessness
Homeless Families	HUD	This metric falls under the criteria for "literally homeless", and "family" is not defined separately from individual in these cases
Homeless Youth, Children and Minors	US Department of Education (McKinney-Vento Act)	Children and youths who lack a fixed, regular, and adequate nighttime residence and includes: • Those sharing housing with others due to loss of their own, economic hardship, or similar reasons • Those living in hotels, motels, campgrounds, emergency or transitional shelters, who are abandoned in hospitals, or who are awaiting foster care placement • Those whose primary nighttime residences are places not designed or ordinarily used for sleeping accommodations for human beings • Those living in cars, parks, public spaces, abandoned buildings, substandard housing, transit stations, or similar settings • Migratory children who qualify as homeless due to meeting criteria outlined above

Consensus

The final survey also found 70% or more of respondents agreed that other metrics were important to understand homelessness in West Virginia. Those metrics identified by at least 70% of panelists included:

- Veterans who are experiencing homelessness
- Those fleeing from or attempting to flee domestic violence
- Those facing imminent risk of homelessness
- Those staying in an emergency shelter and/or transitional housing
- Those not having legal rights or legal access to the place they are staying (e.g., someone who has been evicted)

These were ranked differently by different panelists, again likely reflecting the panelists' level of interaction with individuals who would fit within each of these categories.

Near Consensus

Half (50%) or more of panelists identified additional metrics that should be monitored. These metrics include:

- Unaccompanied youth under 25 years of age
- Victims of human trafficking
- Staying with others (“doubled-up”)
- Lacking affordable housing

Several additional metrics that fell below 50% were identified, such as loss of employment, loss of adequate support, and those entering or exiting the foster care, juvenile justice, or child welfare systems.

Limitations

The panel is limited based on its small size. While a modified Delphi has been shown effective with small expert groups[19] the identified diversity of this population and differentiation in rank, which likely relates to who panelists are most likely to interact with in their daily lives, suggests that a definition of homelessness may be based on individual experiences with this population. In addition, panelists may have felt some definitions were captured by others. For example, HUD’s definition of literally homeless includes an individual or family’s nighttime residence in a public or private place not meant for human habitation.[20] While panelists indicated the importance of calling

[19] Currie, J., Grech, E., Longbottom, E., Yee, J., Hastings, R., Aitkenhead, A., Larkin, M., Jones, L., Cason, A., & Obrecht, K. (2022). Development of the Homeless Health Access to Care Tool to identify health-related vulnerability among people experiencing homelessness: Delphi study, Australia. BMJ open, 12(3), e058893. https://doi.org/10.1136/bmjopen-2021-058893

[20] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

this aspect out during the discussion, and thus it was included in the final survey, some may have felt it was part of the literally homeless metric and was not otherwise needed.

Discussion

Metrics currently used in federal and state definitions of homelessness informed a robust process with experts who directly serve those experiencing or at risk of homelessness in West Virginia. Through the pre and post survey processes, the research team learned that all metrics currently in use through federal definitions are appropriate for inclusion for the populations they serve, in addition to many metrics discussed that are used by neighboring states that border West Virginia. Thinking about our own people, populations, and sub-populations, no current metrics were identified as ones that should be considered for absolute exclusion from the state's use, which reflects the complexity of this population. That said, panelists were in agreement regarding metrics that absolutely should be included when monitoring this population. Providers and policy makers could consider maintaining a thorough understanding of those who are literally homeless, those staying in unsheltered locations, those who are at-risk of homelessness, homeless families, and homeless children and youth.

Members of the expert panel agreed throughout the discussion that the definitions of homelessness required by the federal government adequately capture those presenting to the state's service providers with unmet needs. Participants reminded the research team that although they do generally see these definitions as applicable to overall populations experiencing or at risk of experiencing homelessness, that does not mean that every member of those subpopulations is eligible for services according to these definitions. Though the group identified no consistent barriers, time was taken to discuss some particular examples of times when someone who does seemingly need housing services could potentially be ineligible according to the definitions funders require agencies to use.

Overall, the results of this process show that the definitions currently used usually allow service providers to meet the needs of residents who come to their agencies for help, despite some present but inconsistent barriers. Service providers do not see a need for the state of West Virginia to adopt its own definition, or to alter what is currently being used. They noted that better provision of services lies not only in closer study or better use of metrics, but also in widening our lens to consider some circumstances that precede an individual or family arriving at a West Virginia provider's door for shelter or services. A striking example for the research team to hear was of gaps that can exist when individuals leave institutional settings, and a need for thorough discharge planning to ensure those reentering society are set up for successful independent living.

ASSESSMENT OF WEST VIRGINIA HOMELESS POPULATION

Homelessness Demographic Report

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Bureau for Behavioral Health

Assessment of West Virginia Homeless Population

Bureau for Behavioral Health

Executive Summary

West Virginia Senate Bill 239 comprises eight objectives addressed in three reports written by the West Virginia University Health Affairs Institute for the Department of Human Services Bureau for Behavioral Health. This report includes findings for Legislative Objectives 1 and 3.

- Legislative Objective 1: Present a breakdown of homelessness demographic information throughout West Virginia and regionally
- Legislative Objective 3: Conduct an epidemiological analysis of homeless populations in West Virginia

Background

In the United States, policies directly related to homeless populations are typically understood within the framework of three federal definitions of the term "homeless." These are used across federal agencies and the organizations they fund. This report primarily focuses on literal homelessness, defined by the U.S. Department of Housing and Urban Development (HUD) as an individual or family who lacks a fixed, regular, and adequate nighttime residence.[1]

The HEARTH Act consolidates multiple HUD programs into the Continuum of Care (CoC) program[2], which provides funds to programs and services for individuals experiencing homelessness. CoCs are integrated systems that track clients over time across an array of agencies and services. There are four Continuums of Care in West Virginia referenced throughout the report:

- Cabell-Huntington-Wayne CoC (CHW)
- Kanawha Valley Collective CoC (KVC)
- Northern Panhandle CoC (NPH)
- Balance of State CoC (BoS), divided into eight geographic regions

To provide services with dollars awarded by HUD, agencies must ensure individuals and families requesting those services meet HUD's definition of "homeless". In West Virginia, agencies providing services with HUD dollars are organized into CoCs, which helps them consistently track clients to meet reporting requirements related to their funding.

Assessment Design

[1] Homelessness Definition. HUD Exchange. Accessed June 27, 2024. https://files.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

[2] Homeless Emergency Assistance and Rapid Transition to Housing Act. https://www.hudexchange.info/homelessness-assistance/hearth-act/

This assessment used existing numeric data from the Homelessness Management Information System (HMIS) and qualitative data collected from the end of 2023 through the beginning of 2024 through 33 interviews with individuals who were currently or had recently experienced homelessness and nine focus groups with homelessness and community service providers, law enforcement, emergency services, and elected official from across West Virginia. HMIS information is collected continuously and at each time an individual enrolls in a project using HMIS. Data analyzed for this report were collected Jan. 1, 2018, through Dec. 31, 2023. Because individuals may enroll in multiple projects, information from the most recent project entry date (or most recent enrollment) was used for counts of individuals. When presented by geographic location, counts of clients from one through 10 are suppressed or not shown to protect individual privacy.

Findings

Presenting a Breakdown of Homelessness Demographic Information throughout West Virginia and Regionally

- From Jan. 1, 2018, through Dec. 31, 2023, there were 28,651 individuals with a project entry date for a HUD-funded shelter project, street outreach project, or permanent housing project in West Virginia. Of those clients, more than three in four (76%) were experiencing literal homelessness.
- The average number of HMIS clients experiencing literal homelessness based on their most recent enrollment was 3,624 clients per year. This is higher than PIT estimates, which averaged 1,318 per year over the same period. The higher number is likely due to differences in data collection, with HMIS data collected continuously and PIT collected at one time in January.
- Nearly one in six (15%) individuals self-reported as fleeing domestic violence, nearly one in 10 (11%) were designated as an unaccompanied youth or were enrolled in an unaccompanied youth project, and about one in 18 (6%) individuals self-reported as having served in the US Armed Forces or being a Veteran.
- Nearly one in six (16%) experienced chronic homelessness as specified by the HUD definition of chronic homelessness at their last intake.
- Interviewees across four generations often described a series of compounding life events that contributed to their becoming homeless, and some discussed the role substances played in this as well.
- Focus group participants also noted that mental health and substance use were drivers of homelessness.

Demographics

- Almost half (48%) of HMIS clients experiencing literal homelessness were aged 25 to 44 years, while more than one in five (23%) were 24 years of age or less, which may suggest that housing and prevention projects focus on youth and older adults or prioritize these age groups in some way. It is also possible that among individuals aged

55 years or over who are experiencing homelessness, the age at death is younger than the age at death for the general population, impacting the number in this age group.

- Most individuals who were experiencing literal homelessness self-reported their gender as male (58%) and their race as White (78%).
- Statewide, the percentage of individuals experiencing literal homelessness and self-reporting as Black or African American (13%) was higher than the percentage of the total population of WV who identified as Black or African American alone (3.7%) as reported by the 2020 U.S. Census.[3]
- In HMIS, most clients reported they did not have a source of income (84%), which included cash benefits, and they did not receive non-cash benefits (60%) at their most recent project enrollment.
- Data from interviews and focus groups suggest individuals are receiving assistance in identifying benefits they may be eligible for once they are connected to a homeless service provider, so this information would not show up in HMIS at enrollment. Access to benefits prior to becoming homeless may help some individuals stay in housing. West Virginia could explore how to support this as one potential avenue to increase housing stability.

Conducting an Epidemiological Analysis of Homeless Populations in West Virginia

- The HMIS definition of mental health disorders includes a broad range of mental health issues. Among HMIS clients enrolled from 2018 through 2023, 35% reported a mental health disorder, which is higher than estimates for the general adult population in WV and suggests a high burden of mental health disorders in this population.
- Substance use disorder was reported by more than one in five (22%) individuals experiencing homelessness, more than one in 10 (11%) self-reported having an alcohol use disorder statewide, and nearly one in 10 (8%) clients reported having both alcohol and substance use disorders at the same time.
- Interviewed individuals reported a range of physical and mental health conditions, often in relation to why they were homeless. They described how physical health conditions and disabilities made it difficult for them to gain and keep employment, which in turn led to homelessness, or prevented them from exiting homelessness. During focus groups, participants identified mental illness and addiction as major drivers of homelessness and of associated issues being faced by their communities. Focus group participants indicated a large proportion of individuals experiencing

[3] 2020 Census Results. Census.gov. September 21, 2023. Accessed November 15, 2023. https://www.census.gov/programs-surveys/decennial-census/decade/2020/2020-census-results.html.

homelessness in West Virginia had either a mental illness, substance use disorder, or both.

Conclusions

Data are likely to underrepresent the total number of individuals experiencing homelessness, as this is a difficult population to count. Individuals who are experiencing unsheltered homelessness in HMIS are only captured if street outreach projects exist in that community or county. Individuals not enrolled in HMIS are not included in the numeric data in this report, though the wider populations experiencing homelessness – regardless of program participation – were a topic of qualitative discussion.

Among HMIS clients who had accessed housing, shelter, or street outreach projects, there were trends in clients experiencing homelessness based on their demographic and epidemiological characteristics. Differences in some characteristics by geographic location suggest there are different needs based on rurality, population concentrations, and availability of housing. CoCs are likely concentrating efforts and funding on projects to best serve the needs in their areas.

Interviewed individuals often described a series of unfortunate life events leading them to becoming homeless. They also discussed challenges in relation to exiting homelessness, such as a disability making it difficult to maintain employment and access a regular income. Those working most closely with these populations in West Virginia communities – providers, local elected officials, law enforcement, emergency services – often expressed that much of the state's current homelessness can be attributed to mental health and substance use issues. Qualitative data recorded numerous experiences of generational substance use contributing to homelessness, and of young people facing adulthood without support.

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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
AHAR	Annual Homelessness Assessment Report
AWVHP	Assessment of West Virginia Homeless Population
BBH	Bureau for Behavioral Health
BoS	Balance of State Continuum of Care
BMS	Bureau for Medical Services
CoC	Continuum of Care
CHW	Cabell-Huntington-Wayne Continuum of Care
DHHR	West Virginia Department of Health and Human Resources
DoHS	West Virginia Department of Human Services
DOJ	U.S. Department of Justice
ED	West Virginia Department of Education
EMS	Emergency Medical Services
FG	Focus Groups
FYSB	HHS - Family and Youth Services Bureau
GAO	United States Government Accountability Office
HEARTH	Homelessness Emergency Assistance and Rapid transition to Housing
HHS	U.S. Department of Health and Human Services
HIC	Housing Inventory Counts
HIPAA	Health Insurance Portability and Accountability Act
HOPWA	Housing Opportunities for Persons with AIDS
HMIS	Homeless Management Information System
HUD	U.S. Department of Housing and Urban Development
HUD-VASH	HUD - Veterans Affairs Supportive Housing
HRSA	Health Resources and Services Administration

Acronym	Definition
KII	Key Informant Interviews
KVC	Kanawha Valley Collective Continuum of Care
MSAs	Metropolitan Statistical Areas
NCHE	National Center for Homeless Education
NPH	Northern Panhandle Continuum of Care
PIT	Point-in-Time
RHYA	Runaway and Homeless Youth Act
SAMHSA	Substance Abuse and Mental Health Services Administration
SNAP	Supplemental Nutrition Assistance Program
SSI	Supplemental Security Income
TANF	Temporary Assistance for Needy Families
USDA	United States Department of Agriculture
VA	U.S. Department of Veterans Affairs
WIC	Special Supplemental Nutrition Program for Women, Infants and Children
WV	West Virginia
WVU	West Virginia University

Project Purpose

West Virginia Senate Bill 239 outlined eight objectives to better understand homelessness in the state. Each objective is addressed through a study and included in one of three reports, the Metrics Report, the Homelessness Demographic Report, and the Policy Report. How each report works to answer the eight objectives is outlined below:

Table 1: Assessment of West Virginia Homeless Population reports

Report Name and Purpose	Legislative Objectives
Report 1: Homelessness Metrics, Consensus Building Findings Detailed Report • Key metrics to measure and define homelessness consistently.	**Legislative Objective 4:** Identify key metrics to measure homelessness across West Virginia in a more consistent manner
Report 2: Homelessness Demographic Detailed Report • Demographic information • Epidemiological analysis • Location and relocation information	**Legislative Objective 1:** Present a breakdown of homelessness demographic information throughout West Virginia and regionally
	Legislative Objective 3: Conduct an epidemiological analysis of homeless populations in West Virginia
Report 3: Exploration of Policies Related to Homelessness • Resources by region • Concentrations of individuals experiencing homelessness (and possible reasons)	**Legislative Objective 2:** Quantify and inventory of homelessness resources by region
	Legislative Objective 5: Conduct an analysis of whether West Virginia's homeless populations concentrate in certain counties or municipalities and any reasons for such population concentrations
	Legislative Objective 6: Determine if state policies cause the state's homeless population to relocate to certain counties or municipalities
	Legislative Objective 7: Determine the percentage of homeless individuals that lived in another state or jurisdiction in the past three years or are from another state or jurisdiction
	Legislative Objective 8: Conduct an analysis of whether any health and human services benefits offered in West Virginia attract populations that are homeless or at risk of homelessness

Background

In the United States, demographic information about individuals experiencing homelessness is typically viewed within the framework of three federal definitions of the term “homeless” (Table 2). These definitions are used across federal agencies and by the state-level organizations they fund, and they dictate who is eligible for services through their funding opportunities to states and agencies. This means that while federal definitions do generally apply to those experiencing homelessness in West Virginia, they may not always adequately capture the complexities of this population. In addition, while the federal definitions do not outright exclude any particular sub-populations or groups, there are often scenarios where an individual or family’s particular situation may exclude them from services as the definitions are currently written.[4]

These federal definitions dictate who is eligible for services through their funding opportunities to states and agencies. The three definitions are the definition used by the U.S. Department of Education included in the McKinney-Vento Act, the U.S. Department of Housing and Urban Development (HUD) definition included in the Homelessness Emergency Assistance and Rapid transition to Housing (HEARTH) Act, and the Runaway and Homeless Youth Act (RHYA) definition.[5,6,7] The HEARTH Act consolidates the HUD programs administered by the McKinney-Vento Act into the Continuum of Care (CoC) program.[8] This program provides funds to nonprofit providers, states, Indian Tribes, or tribally designated housing entities, and local governments to provide access to programs and services to individuals experiencing homelessness.[9] The HEARTH Act amended previous definitions of the term “homeless” as well as “at risk of homelessness,” including definitions from other statutes, such as RHYA and the Violence Against Women Act.[10] Changes under the HEARTH Act allow for greater response to the needs of those facing homelessness in America, including a key amendment that expanded the definition of homelessness to include those at-risk of homelessness.

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[4] Sullivan, A. A. (2023). What Does it Mean to be Homeless? How Definitions Affect Homelessness Policy. Urban Affairs Review, 59(3), 728-758. https://doi.org/10.1177/10780874221095185

[5] The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

[6] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/

[7] The Runaway and Homeless Youth Act. Updated 2023. National Center for Homeless Education. Retrieved November 15, 2023. https://nche.ed.gov/legislation/runaway-youth/

[8] The McKinney-Vento homeless assistance act, as amended by S. 896 homeless emergency assistance and rapid transition to Housing (Hearth) Act of 2009 - Hud Exchange. HUD Exchange. May 2009. https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/.

[9] Continuum of Care Program. HUD.gov / U.S. Department of Housing and Urban Development (HUD). Retrieved November 15, 2023. https://www.hud.gov/program_offices/comm_planning/coc.

[10] The McKinney-Vento Homeless Assistance Act As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. https://www.hud.gov/sites/documents/HAAA_HEARTH.PDF

Table 2: Definitions of Homelessness

Federal Statutory Reference	Definition	Living Situations Covered
McKinney Vento [11] *Section 725 of Subtitle VII-B of the McKinney-Vento Act*	Individuals who lack a fixed, regular, and adequate nighttime residence[10]	**1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Motels and Hotels; and **5)** Staying with Others ("Doubled-Up") **Federal programs and agencies using this definition:** *Elementary and Secondary Education (ED), Individuals with Disabilities Education Act, Higher Education Act (ED), Head Start Act (HHS), Child Nutrition Act (USDA), Violence Against Women Act (DOJ)*
HUD[12] *Section 103 of Subtitle 1 of The McKinney-Vento Homeless Assistance Act As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009*	The condition of people who lack a fixed, regular, and adequate nighttime residence[11]	**1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Hotels and Motels, if: • Rooms are paid for by programs or organizations • The individual or family cannot afford the room beyond 14 days and cannot otherwise obtain housing • The individual or family is fleeing domestic violence or other life-threatening conditions and has nowhere to stay • Unaccompanied youth or families with youth are homeless or have barriers to stable housing and **5)** "Doubled-Up", if: • Loss of housing is imminent after the next 14 days • The individual or family is fleeing domestic violence or other life-threatening conditions and has nowhere to stay

[11] The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

[12] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

		• Unaccompanied youth or families with youth are homeless or have barriers to stable housing This definition also includes children and youth who are at risk of homelessness, with or without their families, for a variety of reasons defined under other federal statutes. **Federal programs and agencies using this definition:** *Homeless Assistance Programs (HUD)*
RHYA[13] *Section 387 of the Runaway and Homeless Youth Act*	Individuals (under age 21) for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement[12]	If a youth cannot live with relatives and has no other place to go, this definition covers: **1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Motels and Hotels; and **5)** "Doubled-Up". This definition also covers "youth at risk of separation from family" as defined under this statute. **Federal programs and agencies using this definition:** *Runaway and Homeless Youth Act Programs (HHS)*

[13] The Runaway and Homeless Youth Act. Updated 2023. National Center for Homeless Education. Retrieved November 15, 2023 from https://nche.ed.gov/legislation/runaway-youth/

Background on Homelessness in the United States

Homelessness in the United States has changed throughout history, with spikes during the colonial period, pre-industrial era, post-Civil War years, Great Depression, and today. Homelessness is a public health issue that impacts cities, suburbs, and rural towns in every state,[14] first becoming a national issue in the 1870s when establishment of a national railroad system enabled populations of (largely) men to travel across the country in search of work. Some saw this lifestyle as an unfortunate departure from domestic life, but public perception began to soften when immigrant labor entered the mix. What is considered the modern era of homelessness began in the 1980s when many social forces came together, such as: inner city gentrification, deinstitutionalization of individuals experiencing mental illness, high unemployment, an economic recession, and an inadequate supply of affordable housing.[15]

The U.S. Interagency Council on Homelessness reports 1.25 million people experienced homelessness at some point in 2020, the most recent year with complete HUD data available. The same year, U.S. Health Resources and Services Administration (HRSA) data indicate 1.29 million people experiencing homelessness were served by health center programs administered by this agency.[16] HRSA operates under the umbrella of the U.S. Department of Health and Human Services (HHS), which uses a broader definition of homelessness than HUD. The following situations are considered homeless by HHS for the purposes of service eligibility but are not considered "literally" homeless by HUD: those exiting incarceration, exiting treatment, exiting supportive housing, those who are couch-surfing ("doubled-up" with others), and those who are at-risk of homelessness.[17]

The Point-in-Time (PIT) counts, which provide an annual snapshot of the number of people experiencing homelessness, estimate that 653,100 people experienced homelessness on a single night in January 2023. This is an increase from 582,500 in 2022 across all household types and homeless populations and is the highest count since PIT reporting began in 2005.[18]

The National Center for Homeless Education (NCHE), funded by the U.S. Department of Education, reports that during the 2021-2022 school year, 2.4% of all U.S. enrolled public school students experienced homelessness. This represents a 10% increase from the prior academic year, with the number of students experiencing homelessness evenly distributed across grade

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[14] United States Interagency Council on Homelessness. Homelessness Data & Trends. United States Interagency Council on Homelessness. https://www.usich.gov/guidance-reports-data/data-trends.

[15] The history of homelessness in the United States. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. July 11, 2018. https://www.ncbi.nlm.nih.gov/books/NBK519584/

[16] United States Interagency Council on Homelessness. Homelessness Data & Trends. United States Interagency Council on Homelessness. https://www.usich.gov/guidance-reports-data/data-trends.

[17] Where does homelessness happen. National Health Care for the Homeless Council. January 5, 2024. https://nhchc.org/where-does-homelessness-happen/.

[18] Sousa T de, Andrichik A, Prestera E, Rush K, Tano C, Wheeler M. The 2023 Annual Homelessness Assessment Report to Congress. HUD User. December 2023. https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf.

levels. Of these youth, 11% lived in shelters or transitional housing, 9% were staying in hotels or motels, and 4% lived in unsheltered places. The remainder were “doubled-up” or living with family members or others.[19] NCHE data reports that 3.6% of all public school students enrolled in West Virginia experienced homelessness in 2021-2022, which is 50% higher than the national data (2.4%). According to NCHE, during the 18 years in which these data have been collected, numbers of youth experiencing homelessness have increased steadily regardless of the economy and other social impacts.[20]

A deeper review of these and other data suggest that while homelessness can impact anyone, it disproportionately impacts some groups and populations across the country. For example, people of color and those with preexisting health conditions are more likely to experience homelessness than individuals who identify as White or as being in good health. Although homelessness rates are high for individuals with severe mental health or substance use issues, most people experiencing homelessness do not have mental health or substance use disorders. Additionally, most Americans with mental health and substance use disorders do not experience homelessness.[21]

Statewide, the annual Point-in-Time count estimates suggest that West Virginia experiences lower numbers of individuals experiencing homelessness than neighboring states. In 2023, PIT identified 1,416 individuals experiencing homelessness in the state, an increase of about 3% from the previous year (1,375) (Figures 1).[22]

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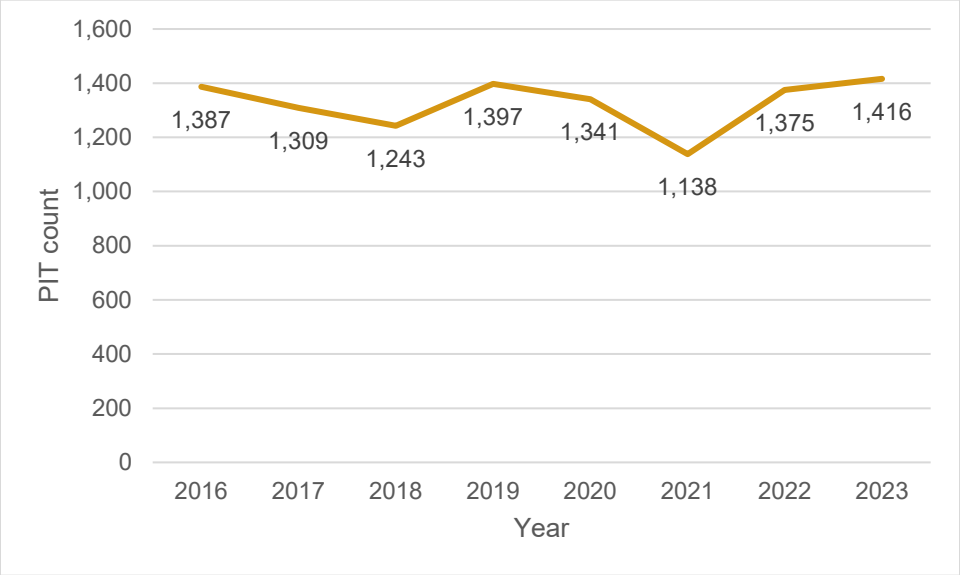
[19] Student Homelessness in America: School Years 2019-20 to 2021-22. Published 2023. https://nche.ed.gov/wp-content/uploads/2023/12/SY-21-22-EHCY-Data-Summary_FINAL.pdf.

[20]Student Homelessness in America: School Years 2019-20 to 2021-22. 2023. https://nche.ed.gov/wp-content/uploads/2023/12/SY-21-22-EHCY-Data-Summary_FINAL.pdf

[21] United States Interagency Council on Homelessness. Homelessness Data & Trends. United States Interagency Council on Homelessness. https://www.usich.gov/guidance-reports-data/data-trends

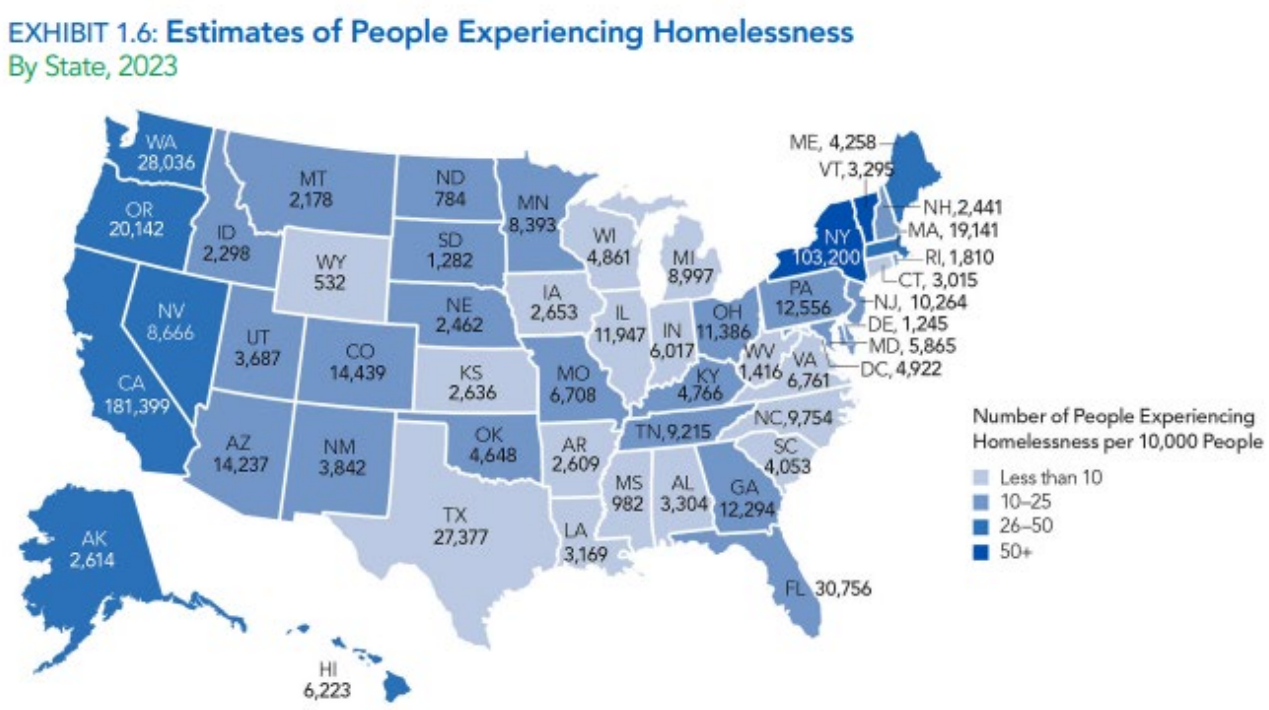
[22] West Virginia Homeless PIT Rate Per 1000 Population. West Virginia Coalition to End Homelessness. 2024. https://wvceh.org/data/.

Figure 1: West Virginia Point-in-Time Count, 2016-2023.



Regionally, Point-In-Time (PIT) estimates suggest West Virginia experiences lower numbers of individuals experiencing homelessness than neighboring states. Figure 2 displays two things: 2023's PIT counts of individuals experiencing homelessness are shown as a number overlaying each state. In addition, the light-to-dark blue shading shows the rate, or how many individuals there are experiencing homelessness per 10,000 and thus what places experience more homelessness – New York is the brightest blue while West Virginia is a relatively pale blue showing New York not only has more individuals experiencing homelessness but there is a higher rate of homelessness as well.

Figure 2: Point-in-time estimates of people experiencing homelessness in 2023. (Source: 2023 Annual Homelessness Assessment Report (AHAR) to Congress by the U.S. Department of Housing and Urban Development.)



NCHE data reports that 3.6% of all public school students enrolled in West Virginia experienced homelessness in 2021-2022, which is 50% higher than the nation (2.4%). According to NCHE, during the 18 years in which these data have been collected, numbers of youth experiencing homelessness have increased steadily regardless of the economy and other social impacts.[23]

[23] Student Homelessness in America – School Years 2019-20 to 2021-22. https://nche.ed.gov/wp-content/uploads/2023/12/SY-21-22-EHCY-Data-Summary_FINAL.pdf

Continuums of Care

Federal funding to address homelessness and entry into service projects are managed through Continuums of Care (CoCs). CoCs are integrated systems that track clients over time across an array of agencies and services.[24] Regulations itemize the purpose of CoCs as such:[25]

1. Promote community-wide commitment to the goal of ending homelessness.
2. Provide funding for efforts by nonprofit providers, states, and local governments to quickly re-house people experiencing homelessness and families while minimizing the trauma and displacement caused to individuals, families, and communities by homelessness.
3. Promote access to and effective utilization of mainstream programs by people experiencing homelessness and families.
4. Optimize self-sufficiency among individuals and families experiencing homelessness.

There are four Continuum of Care organizations in West Virginia (Figure 3):[26]

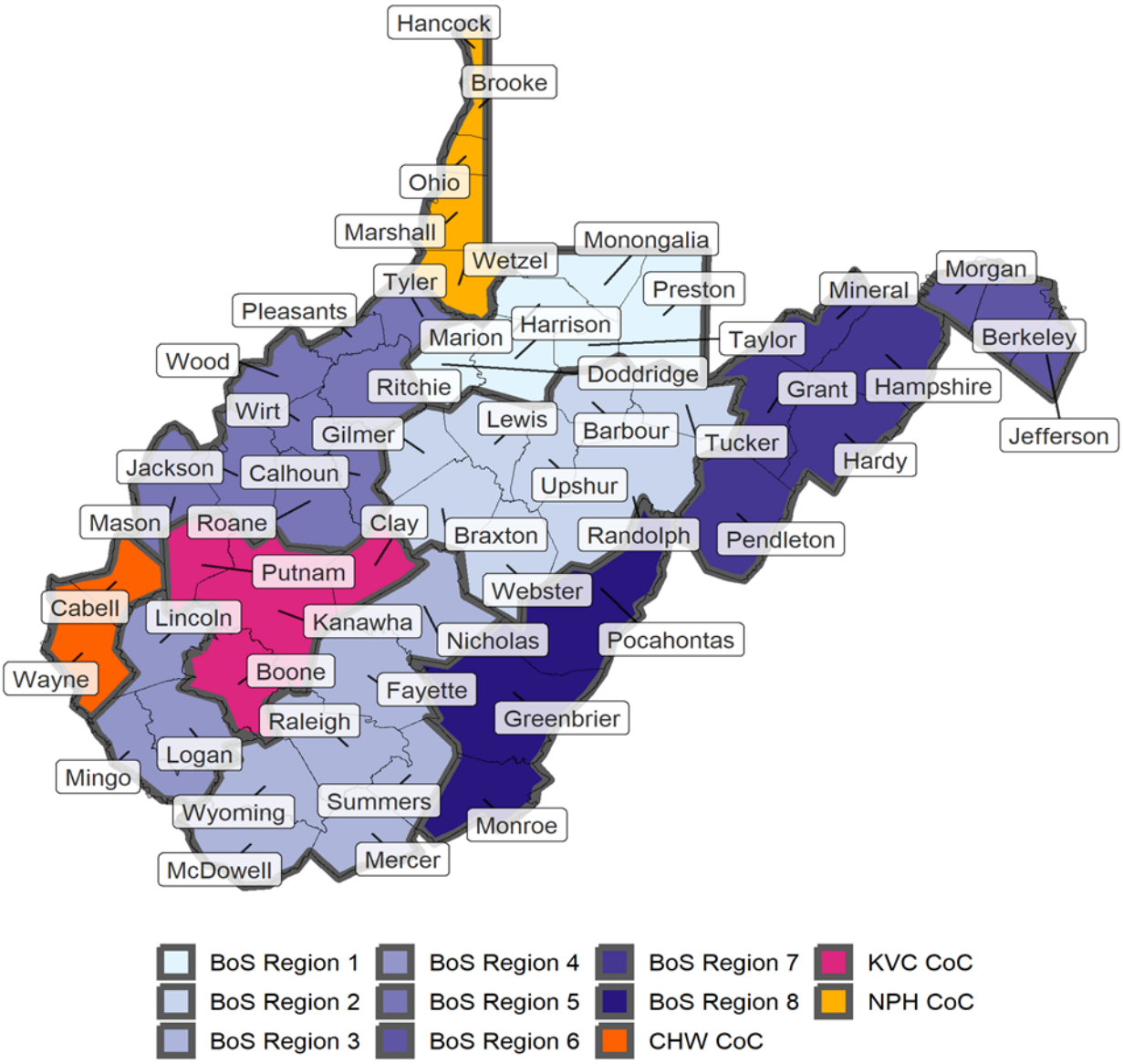
- Balance of State CoC (BoS), divided into eight geographic regions
- Cabell-Huntington-Wayne CoC (CHW)
- Kanawha Valley Collective CoC (KVC)
- Northern Panhandle CoC (NPH)

[24] Evashwick C. Creating the continuum of care. *Health Matrix*. 1989;7(1):30-39.

[25] What is the purpose of the COC program? HUD Exchange. July 2014. https://www.hudexchange.info/faqs/1544/what-is-the-purpose-of-the-coc-program/.

[26] WV CoC Coverage Map. 2021. https://wvcad.org/assets/files/esg/WV-CoC-Map-2021.pdf.

Figure 3: Map of the service delivery areas for each of the four Continuum of Care (CoCs) in West Virginia, including regional divisions of the Balance of State CoC.



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle*

The Cabell-Huntington-Wayne Continuum of Care (CHW) works to address homelessness in Cabell and Wayne counties. The lead agency for this CoC is the Cabell-Huntington Coalition for the Homeless, an entity that formed in the late 1980s as a result of the mayor's Task Force on Homelessness. This Coalition has provided emergency shelter and other services to the community for more than 30 years.[27] It includes participation by more than 60 agencies which support affordable, quality, accessible housing, and supportive services.[28]

The Kanawha Valley Collective is a Continuum of Care (KVC) comprised of numerous social service organizations, state and federal agencies, city representatives, clinical entities, and community members working to address homelessness and remove barriers to housing. The Kanawha Valley Collective serves Kanawha, Boone, Clay, and Putnam Counties, and agencies that make up this CoC collectively provide emergency shelter, emergency utility and rental assistance, food and meals, clothing, medical and dental assistance, resource referrals, veterans programs, and employment assistance.[29]

The Northern Panhandle Continuum of Care (NPH), led for 27 years by The Greater Wheeling Coalition to End Homelessness and more recently by the City of Wheeling, works to address homelessness in Brooke, Hancock, Ohio, Marshall, and Wetzel counties.[30,31] NPH is comprised of more than 40 organization members who collectively provide services related to emergency shelter, rapid re-housing, homelessness prevention, transitional and residential housing, community mental health and substance use treatment, veteran services, education and employment, and more.[32]

The Balance of State Continuum of Care (BoS) is comprised of the remaining 44 counties in West Virginia, divided into eight regions (Figure 3). The Balance of State classification is used throughout the United States and are defined by HUD as CoCs that "includes all the jurisdiction in a state that are not covered by another CoC."[33] West Virginia's BoS CoC, includes metropolitan and non-metropolitan areas and smaller cities. West Virginia Coalition to End Homelessness is

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[27] Cabell Huntington CoC About Us. Harmony House WV. Updated September 22, 2023. https://www.harmonyhousewv.com/about-us/continuum-of-care/.

[28] Northern Panhandle CoC. Help & Hope WV - Get Connected. https://helpandhopewv.org/sor-orn-trainings.html.

[29] Northern Panhandle CoC. Help & Hope WV - Get Connected. https://helpandhopewv.org/sor-orn-trainings.html.

[30] Northern Panhandle Continuum of Care Governance Charter. WV NPCoC. May 13, 2024. https://wvnpcoc.org/about-us/.

[31] Northern Panhandle Continuum of Care. wvnpcoc.org. Accessed June 20, 2024. https://wvnpcoc.org/.

[32] Northern Panhandle CoC. Help & Hope WV - Get Connected. https://helpandhopewv.org/sor-orn-trainings.html.

[33] Balance of state continuum of Care Toolkit. HUD Exchange. https://files.hudexchange.info/resources/documents/Balance-of-State-Continuum-of-Care-Toolkit.pdf.

the lead agency for this Continuum.[34] WVCEH provides services statewide and is the state's lead agency for the client-level Homeless Management Information System database.[35]

Project Funding and Key Collaborators

The Assessment of the West Virginia Homeless Population project is funded by the West Virginia Department of Human Services. The West Virginia University Health Affairs Institute worked closely with key collaborators to ensure the scope and accuracy of the assessment. These included the Department for Human Services (DoHS), Bureau for Medical Service (BMS) and Bureau for Behavioral Health (BBH), for whom this reporting was completed, along with representatives of the state's four Continuums of Care: Balance of State CoC, Cabell-Huntington-Wayne CoC, Kanawha Valley Collective CoC, the Northern Panhandle CoC, and many stakeholders across the state who were invested enough to provide their time and insights.

The project team is grateful for the contributions of many others who directly serve West Virginians every day, and who generously shared their time, expertise, and recounted what each of their unique communities has been experiencing: elected officials and other municipal leaders, members of law enforcement and emergency services, and local service providers of all kinds.

Thirty-three individuals spanning four generations sat down with members of this project team to share their personal experiences of homelessness among the hills of West Virginia. To those individuals who took time away from their day-to-day priorities of working, parenting, caregiving, and surviving without the safety and security of home, we extend our deepest gratitude.

Overview of Study Design, Collected Data, and Secondary Data

Overview

The Assessment of West Virginia Homeless Population used available secondary data as well as qualitative data collected for the purpose of the project through interviews and focus groups. Data were analyzed and then interpreted using triangulation, a mixed methods approach to exploring complex questions that uses multiple methods, including quantitative and qualitative approaches, as well as different data sources or perspectives to gain a more comprehensive understanding of questions being considered [36]. Information on the demographics of those experiencing homelessness, their health challenges, their ability to access healthcare and benefits, and where they are in WV was gathered from the Homelessness Management Information System (HMIS). Interviews with key informants experiencing homelessness in WV were conducted to get more in-depth information about navigating and obtaining support and challenges they face in accessing services. Focus group discussions, facilitated by project team members, were used to get more

[34] Northern Panhandle CoC. Help & Hope WV - Get Connected. https://helpandhopewv.org/sor-orn-trainings.html.

[35] Who We Are. West Virginia Coalition to End Homelessness. https://wvceh.org/who-we-are/.

[36] Plano Clark, V., & Ivankova, N. (2016). What is mixed methods research? Considering how mixed methods research is defined. In Mixed Methods Research: A Guide to the Field (pp. 55-78). SAGE Publications, Inc., https://doi.org/10.4135/9781483398341

in-depth information about what providers, law enforcement, emergency services, and elected officials thought were challenges for their clients and what challenges they faced in serving these populations in their communities.

The results from analyzing each of these pieces of information were then integrated to answer two of the eight legislative objectives from Senate Bill 239:

- **Legislative Objective 1:** Present a breakdown of homelessness demographic information throughout West Virginia and regionally.
- **Legislative Objective 3:** Conduct an epidemiological analysis of homeless populations in West Virginia.

Data Collection

Initial Outreach

An outreach plan was developed to establish connections with stakeholders throughout West Virginia. Communication with individuals and agencies interfacing with this population was necessary to understand the landscape of homelessness in WV, to understand the lived experience of individuals who are unhoused or struggling to maintain housing, and to carry out many of the objectives of Senate Bill 239. This began with outreach to every county in the state, including municipal leaders, behavioral health providers, and substance use disorder providers. They and their recommended contacts were the basis of the project team's outreach to those doing this work on the ground in communities, with further recommendations added to the contact list from there.

Methodology for conducting this initial outreach, as well as the focus groups and key informant interviews that followed, are detailed in Appendix A. Project plans were reviewed by West Virginia University's Institutional Review Board. To ensure more accurate responses and to maintain relationships for any future studies, the information collected is confidential. Any quoted information that could lead to the identification of participants, places, or agencies has been removed. Quotes are used throughout the report and reflect the grammar and speech patterns of the participants and are the perceptions and opinions of individuals based upon their best understanding of the topics at hand.

Focus Groups

Nine virtual focus groups were conducted in December 2023 and January 2024 to learn the perspective of providers, law enforcement, emergency services, and elected officials on a variety of topics regarding this population. Focus groups are a way to quickly gather rich information about participants' perspectives and experiences on a topic or topics. A trained moderator guides a small group, ideally six to eight individuals, through a predetermined set of topics, allowing for interaction and follow-up questions. Focus groups were used for this assessment to understand

the population, to explore how participants might agree or disagree about at topic, and to learn what is working or not working in programs or communities.[37]

Key Informant Interviews

Thirty-three virtual key informant interviews were conducted in April and May of 2024 with individuals experiencing homelessness, or who had been recently housed, in various parts of the state. Key informant interviews are typically conducted one-to-one with individuals who have experience with the topic of interest. This kind of interview is often ideal for discussing sensitive topics, to get information about community issues, to understand individuals' motivations and beliefs about particular issues, and for getting candid and in-depth information beyond what focus groups can sometimes offer.[38]

Interviewees shared their lived experiences related to what led to their homelessness, perceptions of and experiences related to seeking and receiving services, access to needed clinical care, where they have lived, what they think could improve access to housing, and any other topics they felt the research team should know. To identify key informants, the research team obtained assistance of homeless service providers.

Through initial outreach, the research team was able to learn what providers had interest and capacity in assisting with this portion of the work. Initial communications to coordinate key informant interviews were extended to these individuals and agencies. Additional outreach to the state's largest municipalities was also conducted. Participation by geography was dictated by the ability/willingness of communities to assist with connection to individuals.

HUD Data Sources

- Homeless Management Information System (HMIS),
- Point-in-Time (PIT) counts, and
- Housing Inventory Counts (HIC).

Providers of services that receive HUD funding to address homelessness are required to routinely report client information to HUD. Three sources of this data collected by CoCs are used or referenced throughout this report:

HMIS is a local information technology system that providers use to enter information about clients experiencing or at risk of experiencing homelessness, and those formerly defined as literally homeless but who are now housed in a permanent housing project. Information is collected continuously throughout the year. HMIS data includes individual client and enrollment information, and is used to produce demographic, epidemiological, and geographic client information required to receive HUD funding. HMIS data collection and management is overseen by an HMIS Lead for each CoC (Table 3), and each CoC uses HUD's data standards guidance to determine the most

[37] Focus Groups. Student Affairs. March 18, 2022. https://studentaffairs.jhu.edu/viceprovost/assessment-analysis/assessment-tools-methods/focus-groups/.

[38] Section 4: Key informant interviews. Health Policy UCLA. https://healthpolicy.ucla.edu/sites/default/files/2023-08/tw_cba23.pdf.

appropriate software to use. HUD data standards outline what pieces of information are required to be included in the HMIS client record for reporting purposes.[39] Each CoC has the option of requiring additional data to be collected, which impacts the quality and interpretation of data across regions.

Table 3. Homeless Management Information System leads for each Continuum of Care in WV

Continuum of Care	HMIS Lead
Cabell-Huntington-Wayne	The Cabell-Huntington Coalition for the Homeless
Kanawha Valley Collective	Kanawha Valley Collective, Inc.
Northern Panhandle	The City of Wheeling
Balance of State	West Virginia Coalition to End Homelessness

PIT counts include sheltered and unsheltered people experiencing homelessness at a designated point in time. Housing Inventory Counts (HIC) includes the number of housing units and beds for people who are experiencing and or who were experiencing homelessness. CoCs are required to conduct PIT counts for sheltered people and HIC once each year in January. PIT counts of unsheltered people are required every other year in January.[40] However, HUD offers CoCs incentives for conducting annual PIT counts that include people who are unsheltered.[41] Each CoC has the choice of using their HMIS data to generate their PIT sheltered counts.

HMIS is the main source of data used in this report. HMIS data are collected throughout the year and provide more detailed information than PIT counts. HIC includes data on living situations, demographics, receipt of benefits, and includes county location data along with other information that local CoCs consider relevant to the clients they serve.

Publicly available PIT counts contain more limited information than HMIS on living situation, demographics, receipt of benefits, physical, mental, and behavioral health status, and location, which is typically reported at the CoC level but not always required. In this report, county-level data are included in select maps for better understanding of client locations and concentrations throughout WV.

PIT counts and HIC are reported to the U.S. Congress annually in a report titled the Annual Homelessness Assessment Report (AHARs) and are the main source of publicly available data

[39] FY 2024 HMIS Data Standards Manual. HUD Exchange. Updated February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

[40] Point in Time Count and Housing Inventory Count. HUD Exchange. 2024. https://www.hudexchange.info/news/hdx-20-open-for-cocs-to-submit-2024-hic-and-pit-count-data/.

[41] Homelessness: Better Hud Oversight of data collection could improve estimates of homeless population. U.S Government Accountability Office. July 14, 2020. https://www.gao.gov/products/gao-20-433.

about people experiencing homelessness.[42] In this report, PIT counts are used in making comparisons to HMIS results. HIC data contains information on the type, number, and location of shelter and permanent housing projects and their capacity represented as bed counts. HIC data are collected at the same time in January during PIT counts. In this report, HIC data were used to supplement project location information in HMIS data.

HMIS Data Analysis

Overview of the Homeless Management Information System

Client tracking or "coordinated entry" by providers within each CoC is facilitated with the Homeless Management Information System (HMIS). All HUD-funded projects and their federal partners are required to utilize this system to track client level data for reporting purposes as stated by CoC Program interim rule 24 CFR Part 578.[43] Agencies use HMIS to share client-level demographic, health status, and living situation information across sites, reducing administrative burden, and tracking client needs over time.

HUD partners with other federal agencies to establish HMIS requirements and ensure that data is available to fulfill congressional mandates for the Annual Homelessness Assessment Report (AHAR) to U.S. Congress.[44] In addition to HUD offices, other federal agencies that utilize HMIS are the U.S. Department of Veterans Affairs (VA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Family and Youth Services Bureau (FYSB).[45] HUD programs that utilize HMIS include Housing Opportunities for Persons with Acquired Immunodeficiency Syndrome (AIDS) (HOPWA) and HUD-Veterans Affairs Supportive Housing (HUD-VASH).

In the "Homelessness Metrics, Consensus Building Findings Detailed Report" (Report 1, Table 1), definitions used to assess someone's housing status were analyzed to determine which of these metrics are most representative of those experiencing or at risk of homelessness in this state.[46] A modified Delphi approach was used to identify, select, and consult a panel of experts that assessed and discussed existing federal and state definitions of homelessness and how suitable they are for homelessness in WV. Modified Delphi is an iterative approach to attempt to establish consensus from a group of experts around a desired outcome, such as clinical practice

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[42] AHAR reports - Hud Exchange. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/ahar/.

[43] Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program. July 31, 2012. https://www.govinfo.gov/content/pkg/FR-2012-07-31/pdf/2012-17546.pdf.

[44] AHAR reports - Hud Exchange. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/ahar/.

[45] Federal Partner Participation - Hud Exchange. HUD Exchange. https://www.hudexchange.info/hmis/federal-partner-participation/.

[46] FY 2024 HMIS Data Standards Manual. HUD Exchange. Updated February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

guidelines[47] or patient diagnosis and treatment.[48] Experts were selected from initial outreach contacts, with the goal of maximizing representation from organizations across WV.

The expert panel indicated individuals experiencing homelessness in West Virginia are diverse and a single definition does not capture their complexities. Existing federal definitions were determined to be important tools for understanding the needs of those experiencing or at risk of experiencing homelessness and for monitoring trends related to these metrics. Experts consulted during the modified Delphi indicated that data from HMIS and PIT counts based on HUD definitions of homelessness were assumed to accurately reflect the population experiencing homelessness in West Virginia, though these definitions do sometimes exclude individuals or families in certain situations from service eligibility.

A period of six years from 2018 through 2023 was used to account for the impacts of COVID-19 on HMIS enrollments by including pre- and post-COVID-19 data. The analysis of HMIS data in this report shows how many individuals accessed CoC services through a HUD funded housing project over a period of six years, starting from Jan. 1, 2018, until Dec. 31, 2023. Some individuals had project enrollment dates before 2018 but continued to be enrolled in a project on Jan. 1, 2018. These individuals were included in the data set.

Because HMIS data were continuously collected when individuals enrolled in projects over this period, some individuals were enrolled in multiple projects. For accurate demographic information, duplicate enrollments were eliminated so that information for each individual was counted only once. HMIS data standards instruct that any updates to client information such as life experiences, health conditions, or insurance coverage be updated at enrollment. To stay consistent with federal guidance, information collected at the most recent enrollment was used to reflect the most up-to-date status of homelessness in WV. In cases where individuals had multiple enrollments, the information from the most recent project entry date was used for counts of individuals.

However, data associated with previous homeless episodes can be captured, and these non-required intake questions can provide a client record even if someone is in and out of services. This can help better understand trends over time.

Counts based on individual enrollees include most recent living situation, demographics, and health conditions. When living situation is shown, counts of clients are grouped by sheltered, unsheltered, homelessness prevention, or permanent housing projects. Clients who were experiencing literal homelessness were most recently enrolled in an unsheltered (street outreach) or sheltered project (Table 4). Street outreach projects are only for people experiencing homelessness and who are unsheltered, meaning sleeping in a location not meant for human

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[47] Grant, S., Armstrong, C., & Khodyakov, D. Updated 2021. Online modified-Delphi: a potential method for continuous patient engagement across stages of clinical practice guideline development. Journal of General Internal Medicine, 36, 1746-1750.

[48] Eubank, B. H., Mohtadi, N. G., Lafave, M. R., Wiley, J. P., Bois, A. J., Boorman, R. S., & Sheps, D. M. Updated 2016. Using the modified Delphi method to establish clinical consensus for the diagnosis and treatment of patients with rotator cuff pathology. BMC medical research methodology, 16, 1-15.

habitation (Table 4). Clients most recently enrolled in a street outreach project were considered unsheltered and are reported as unsheltered throughout this report. Clients most recently enrolled in homelessness prevention projects were assumed to be at risk for homelessness. Clients most recently enrolled in a permanent housing project were considered formerly experiencing homelessness.

HMIS data are presented by deduplicated client counts (where each person is represented only once) and also by counts of housing project enrollments (how many times a service was requested). Throughout this report, individual client counts are presented for the state, by CoC, and by county for living situations, select demographic categories, and health conditions. Project enrollments (or total services) were grouped by month using the dates that clients experiencing literal homelessness completed intake for project entry. Altogether, this allowed the team to understand trends about need independently of simply counting individuals. This is important because one single person may, over the course of a year, request a bed or other services in more than one place. Client counts (people) are interpreted by reporting the proportions or share of total individual clients that reported a demographic characteristic or condition. These are presented as proportions of the total number of clients in the state, of clients experiencing literal homelessness, or of clients in a selected CoC or county.

Table 4. Summary of HMIS data element definitions for housing projects from the 2024 HMIS Data Standards Manual[49]

HMIS Project Data Elements	Description
Sheltered – Literal Homelessness	
Day Shelter	A project that offers daytime facilities and services (no lodging) for people experiencing homelessness.
Emergency Shelter	Entry Exit: A project that offers temporary shelter (lodging) for people experiencing homelessness in general or for specific populations of people experiencing homelessness. Night-by-Night: The NbN emergency shelter type may be used by some high-volume shelters and shelters where a significant proportion of clients spend a night at the shelter as needed on an irregular basis.

[49] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Transitional Housing	A project that provides temporary lodging and is designed to facilitate the movement of individuals and families experiencing homelessness into permanent housing within a specified period of time, but no longer than 24 months.
Safe Haven	A project that offers supportive housing that (1) serves hard to reach people experiencing homelessness with severe mental illness who have been unsheltered and have been unwilling or unable to participate in supportive services; (2) provides 24-hour residence for eligible persons for an unspecified period; (3) has an overnight capacity limited to 25 or fewer persons; and (4) provides low demand services and referrals for the residents.
Unsheltered – Literal Homelessness	
Street Outreach	A project that offers services necessary to reach out to people experiencing unsheltered homelessness, connect them with emergency shelter, housing, or critical services, and provide urgent, non-facility-based care to those who are unwilling or unable to access emergency shelter, housing, or an appropriate health facility. Only persons who are residing on streets or other places not meant for habitation should be entered into a street outreach project.
Permanent Housing – Formerly Experiencing Homelessness	
Rapid Re-Housing	A permanent housing project that provides housing relocation and stabilization services and/or short- and/or medium-term rental assistance as necessary to help an individual or family experiencing homelessness move as quickly as possible into permanent housing and achieve stability in that housing.
Permanent Supportive Housing	A project that offers permanent housing and supportive services to assist people experiencing homelessness with a disability (individuals with disabilities or families in which one adult or child has a disability) to live independently.
Housing with Services	A project that offers permanent housing and supportive services to assist people experiencing homelessness to live independently but does not limit eligibility to individuals with disabilities or families in which one adult or child has a disability.
Housing Only	A project that offers permanent housing for people experiencing homelessness but does not make supportive services available as part of the project.
Homeless Prevention – At Risk of Homelessness	
Homelessness Prevention	A project that offers services and/or financial assistance necessary to prevent a person from entering an emergency shelter or place not meant for human habitation. Eligible people most meet the criteria for “at risk of homelessness” definition in § 576.2 of Title 24—Housing and Urban Development

	Subtitle B Chapter V Subchapter C and have an annual income below 30 percent of family median income for the area.[50]

Processing HMIS Data

HMIS data required multiple assumptions to complete analyses, which are detailed below. Assumptions were developed in coordination with the HMIS Lead at the WV Coalition to End Homelessness, which serves as the lead organization for the BoS and provided HMIS data from CHW, KVC, and NPH CoCs.

Assumptions include:

- Missing information for income status, insurance, non-cash benefits, Human Immunodeficiency Virus (HIV) or AIDS status, or disabilities were interpreted as not having that item or characteristic (i.e., no income, no insurance, not receiving benefits, not having HIV or AIDS, or not having disabilities).
- Age categories are based on the date of most recent enrollment relative to a client's self-reported date of birth.
- Unaccompanied youth included individuals enrolled in an unaccompanied youth program. However, according to a conversation in April 2024 with the Director of Data Management of WVCEH, HMIS enrollments in unaccompanied youth programs and HUD housing projects only included individuals between the ages of 18 through 24. Age at most recent enrollment was used to identify any other individuals aged 24 and under. If those individuals self-reported as a child-only household, they were included in the unaccompanied youth category.
- Street outreach project enrollment in HMIS was used to estimate the number of people who were unsheltered (Individuals or families sleeping in a place that is not ordinarily used as a sleeping accommodation for human beings."[51]
- Homelessness prevention project enrollment in HMIS was used to estimate the number of people who were considered at risk for homelessness.
- Missing information about the county where clients were enrolled were filled in using project location information from the HIC data. If county location information was still missing after merging HIC address, the most populous county in the three smallest CoCs (Ohio County for NPC, Cabell County for CHW, and Kanawha County for KVC) was used. BoS CoC was excluded from the assumption as the geographic area contains 44 counties, many with major population centers that did not permit simple assumptions about assignments to specific counties
- For one in four (24%) clients statewide, information about prior location was collected including their most recent prior location over the past two years. Data on prior location included asking enrollees what county or state they had lived in prior to enrollment, and these questions are optional per HUD regulatory guidance and are not part of the many questions

[50] Code of Federal Regulations Title 24. June 2024. https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-576/subpart-A/section-576.2.

[51] Federal Register/Vol. 77, No. 147/Tuesday, July 31, 2012/Rules and Regulations https://www.govinfo.gov/content/pkg/FR-2012-07-31/pdf/2012-17546.pdf

required to receive funds. Based on their most recent enrollment, there were answers to most recent prior location for 35% of clients in the BoS CoC, 27% of clients in the CHW CoC, 3% of clients in the KVC CoC, and no clients in the NPH CoC. There were no records of this data prior to 2020 in HMIS.

Data Suppression: Not Reportable

Results of the HMIS analysis are presented following standard guidance from the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services.[52] This guidance states that when counts of individual clients are between one through 10 (less than 11), the numbers are suppressed or not shown in tables and figures. While these data are suppressed in reporting, they are counted in summaries and are used in calculations. Suppressed values are indicated as Not Reportable (NR). Data are suppressed to protect individual safety and privacy, as it is sometimes possible to identify individuals from reported characteristics when counts of individuals with that characteristic are low especially in small populations. Suppression includes percentages and values that could be used to calculate the original low number. In addition to suppressing values, some counts and percentages may be presented in a larger aggregate. For example, counts or percentages may be presented for CoC regions instead of county level to reduce or resolve the need to suppress information.

Geographic Analyses

Maps were constructed to display the number and proportions of HMIS clients who enrolled in a project and were experiencing literal homelessness, defined as most recently enrolling in a sheltered or unsheltered project, in each WV county and CoC. The proportions of unsheltered and sheltered living situations and select physical, mental, and behavioral health conditions, diseases, and disorders based on their most recent enrollment are shown from 2018 through 2023. Client counts were combined with county estimates from the 2020 US Census to display estimated rates of clients per 10,000 county residents.[53]

HMIS client proportions and counts were shown for each of the four CoC coverage areas. Each CoC coverage area is defined by the groups of counties they service. BoS includes the most counties (44), followed by NPH (5), KVC (4), and CHW (2). The BoS CoC divides the 44 counties it serves into eight regions (Figure 3) with three to eight counties in each. In some instances, project location was missing for individuals in the HMIS data. Some of that missing information was resolved by merging HMIS enrollment records with location information from each project included in HIC data using the HMIS Project ID number. This provided address information so that the enrollment event could be assigned to the appropriate county in WV.

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[52] CMS cell size suppression policy. Research Data Assistance Center. January 26, 2024. https://resdac.org/articles/cms-cell-size-suppression-policy.

[53] 2020 census results. Census.gov. September 21, 2023. Accessed November 15, 2023. https://www.census.gov/programs-surveys/decennial-census/decade/2020/2020-census-results.html.

Findings

Presenting a Breakdown of Homelessness Demographic Information throughout West Virginia and Regionally (Legislative Objective 1)

Types of Homelessness Experienced in West Virginia

The project team reviewed information reported by individual clients during their most recent service project entry date in HMIS – anytime from January 1, 2018, to December 31, 2023 – and determined counts and percentages of reported living situations. From 2018 through 2023, a total of 28,651 individual clients had a project entry date for a HUD-funded shelter project (day or emergency shelters, transitional housing, or safe havens), street outreach project (counted here as unsheltered), or permanent housing project (rapid re-housing, permanent supportive housing, housing only, and housing with services) in WV (Table 5). Of those clients, more than three in four (76%) were experiencing literal homelessness, meaning they were most recently enrolled in a street outreach for those living in unsheltered situations (17% statewide) or in a sheltered project (59% statewide). Nearly one in four (24%) clients in the WV HMIS system were seen at a CoC project that provided permanent housing (Table 5).

Table 5: Proportion of HMIS clients who were sheltered, unsheltered, or permanently housed based on most recent project entry date from 2018 through 2023.

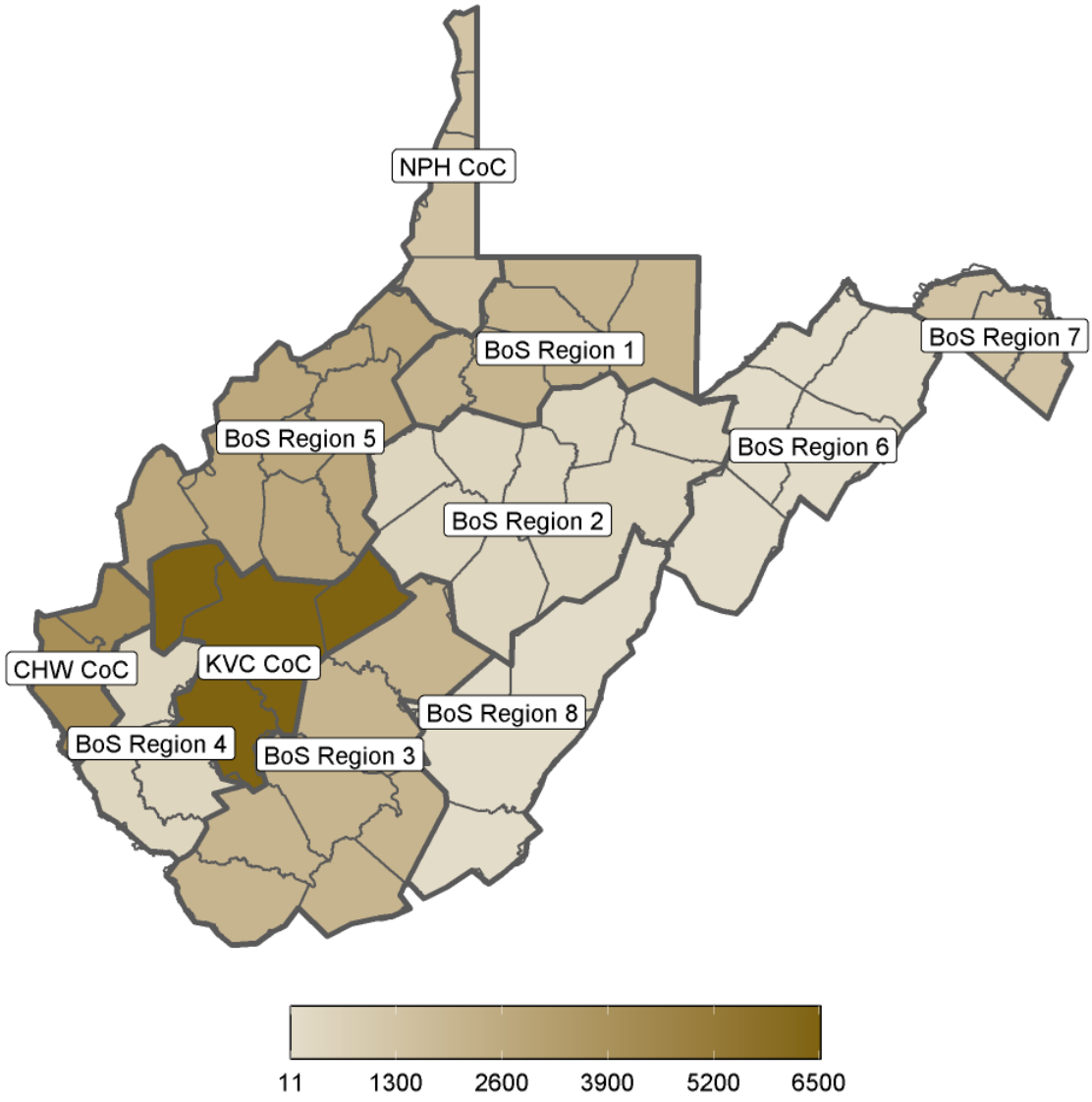
	Continuum of Care				
Most Recent Living Situation	**Balance of State** 44 Counties	**Cabell-Huntington-Wayne** Two Counties	**Kanawha Valley Collective** Four Counties	**Northern Panhandle** Five Counties	**State**
Sheltered	48% (6903)	70% (3633)	76% (5522)	54% (915)	59% (16973)
Unsheltered (Street Outreach)	21% (3048)	7% (388)	14% (987)	20% (345)	17% (4768)
Permanent Housing	31% (4564)	23% (1188)	10% (734)	25% (424)	24% (6910)
Total	**100% (14515)**	**100% (5209)**	**100% (7243)**	**100% (1684)**	**100% (28651)**

NOTES: *Unsheltered clients include those enrolled through street outreach.*

From 2018 through 2023, the total number of clients experiencing literal homelessness (sheltered or unsheltered) was 21,741. Dividing this total by six years, the average number of HMIS clients experiencing literal homelessness, based on their most recent enrollment, was 3,624 clients per year. The number of clients experiencing literal homelessness varies across CoCs in WV (Figure 4). The BoS CoC served the most individual clients experiencing literal homelessness (9,951 sheltered and unsheltered clients, Table 5) based on their last completed intake from 2018 through 2023, those clients were located across eight BoS subregions covering 44 counties (Figure 4). The KVC CoC served 6,509 clients and CHW CoC served 4,012 clients experiencing literal homelessness during that period in a coverage area that included five and two counties, respectively.

Sheltered projects accounted for the most individual clients in HMIS in all CoCs. The proportions of total clients in each CoC ranged from nearly half of clients (48%, BoS) to more than three in four (76%) clients in KVC (Table 5). The BoS CoC enrolled the most individual clients who were unsheltered during their last intake (21%) and had the lowest proportion of clients in a sheltered project (48%). The CHW CoC had the lowest percentage of individual clients who were unsheltered (7%), and the second highest proportion of clients sheltered (70%). The proportion of clients most recently enrolled in permanent housing ranged from more than one in three clients (31%, BoS) to one in 10 (10%) clients in KVC (Table 5).

Figure 4: Counts of HMIS clients experiencing literal homelessness (sheltered or unsheltered) in each Continuum of Care (CoC) region and Balance of State (BoS) subregion based on most recent project entry date from 2018 through 2023.



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*

From 2018 through 2023, a total of 4,397 of client records indicated a most recent enrollment in a homelessness prevention (at risk of homelessness) project (Table 6). This represented 13% of the total number of clients experiencing literal homelessness and in permanent housing projects during that time. Note that for clients to be in a homeless prevention project, clients also had to be enrolled in permanent housing. Nearly all homelessness prevention enrollments occurred in 2020, during the COVID pandemic, and it may have impacted the behavior of persons experiencing a housing issue and the options available to them.

Table 6: Proportion of HMIS clients who were at risk for homelessness based on being enrolled in a homelessness prevention project as their most recent project entry date in 2020.

	Continuum of Care				
Most Recent Living Situation Characteristics	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Total Clients, N	17696	5209	8003	2140	33048
Homelessness Prevention Project, % (n)					
Homelessness Prevention Program [2]	18% (3181)	0% (0)	9% (760)	21% (456)	13% (4397)

NOTES: *NR=Not reportable due identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. This data is not visible in the table but is used for all summaries and calculations.*
1. Each category estimate represents the percentage of all clients in sheltered projects at most recent project entry date.
2. Percentage of all clients in HMIS.

3. Each category estimate represents the percentage of all clients in permanent housing projects at most recent project entry date.

In summary, the HMIS and the PIT count provide distinct estimates of homelessness in WV. From 2018 through 2023, the unduplicated average number of HMIS clients experiencing literal homelessness based on their most recent enrollment was 3,624 clients per year. This is likely an underestimate of average number of clients served each year because each person with multiple enrollments in separate years would only have been counted once, so if someone was homeless in 2018 but found housing in 2019 and 2020 but was then homeless again in 2021, they were still only counted once. In comparison, PIT counts of individuals experiencing literal homelessness on

one night in January averaged 1,318 per year from 2018 through 2023.[54] Both data sources are valid and useful to understanding the landscape of homelessness in the state.

The discrepancy between HMIS and PIT counts could be at least partially explained by differences in data collection. HMIS data are collected continuously throughout each year at points of service, so people who are homeless at any point during the year are likely to be counted in HMIS. PIT counts are conducted once each year in January and show only a cross section of people who are experiencing homelessness during that one night or seven-day period. There are also differences in how PIT counts capture unsheltered individuals across communities when compared to street outreach services going to areas that individuals are already known or suspected to be located. In some places, particularly rural areas, PIT count volunteers may canvass areas where street outreach projects do not typically visit. This means that while overall PIT counts are lower than HMIS client counts, the act of conducting the PIT in a community may reach individuals who do not seek services.

A recent study of data quality by the U.S. Government Accountability Office (GAO), found that HMIS and HIC datasets were more reliable and comprehensive sources of data on sheltered homelessness than PIT counts. While PIT counts do often include unsheltered individuals who are not captured in HMIS project enrollments, PIT counts were found to be less reliable when comparing counts between years. GAO attributed variation in counts between years to several factors including numbers of people that participated in data collection, inclement weather events, and visibility of unsheltered people experiencing homelessness.[55] Additionally, GAO found that urban PIT counts had more consistency than suburban and rural counts, which is critical to understand when considering PIT count implications for this largely rural state.

Each of the four CoC regions showed different patterns in the types of living situations people experienced at their most recent intake into the system. The BoS and NPH CoCs share some similarities. They include the lowest percentages of sheltered clients, the two highest percentages of unsheltered clients, and the two highest percentages of permanent housing clients at most recent project enrollment. CHW and KVC CoCs sheltered a larger percentage of their enrollees, who appeared to be split between day and emergency shelter projects among their most recent enrollments. The difference in patterns suggests that individuals experiencing homelessness have needs and living situations that vary within and between CoCs.

An important limitation in using HMIS client data and PIT count data is that enrollments reflect those who have been enrolled in and served by a HUD-funded project or another federal agency project that utilizes HMIS. PIT counts also rely on shelter counts and information from street outreach enrollments on the night of those counts. This means these numbers are likely underestimates of the actual number of West Virginians experiencing homelessness. Additionally,

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[54] PIT and HIC data since 2007 - HUD Exchange. HUD Exchange. December 2023. https://www.hudexchange.info/resource/3031/pit-and-hic-data-since-2007/.

[55] Homelessness: Better Hud Oversight of data collection could improve estimates of homeless population. U.S Government Accountability Office. July 14, 2020. https://www.gao.gov/products/gao-20-433.

these data do not include services that may have been received by non-HUD funded projects that are not required to enter client and project information to HMIS. Differentiating between whether there was no service available or whether there was no enrollee who accessed the service is difficult to determine using HMIS or PIT count data.

Characteristics of Individuals Experiencing Homelessness in West Virginia

Populations Specified in Federal Definitions of Homelessness

HUD uses specific criteria to determine if someone meets the definition of homelessness. Within these criteria unaccompanied youth under the age of 25 and individuals who are survivors of and attempting to flee domestic violence are defined as homeless (Table 7). Of those with data in the HMIS system from 2018 through 2023, based on their last intake, nearly one in six (15%) self-reported as fleeing domestic violence (Table 7), and nearly one in 10 (11%) self-reported information that led to being designated as an unaccompanied youth or were enrolled in an unaccompanied youth project.

Table 7: Proportion of HMIS client life experience characteristics for those experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

	Continuum of Care				
Characteristic	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Characteristics Related to Homelessness Definitions, % (n)					
Veteran	6% (627)	5% (217)	5% (332)	6% (73)	6% (1,249)
Missing	1% (139)	1% (24)	2% (140)	NR	NR
Domestic Violence Survivor	16% (1,551)	21% (851)	11% (713)	14% (181)	15% (3,296)
Missing	19% (1,864)	5% (194)	22% (1,442)	13% (158)	17% (3,658)
Unaccompanied Youth	10% (1,035)	9% (342)	10% (680)	19% (240)	11% (2,297)
Missing	0% (39)	NR	2% (142)	NR	NR
Experienced Chronic Homelessness	18% (1,767)	25% (1,014)	8% (538)	17% (212)	16% (3,531)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

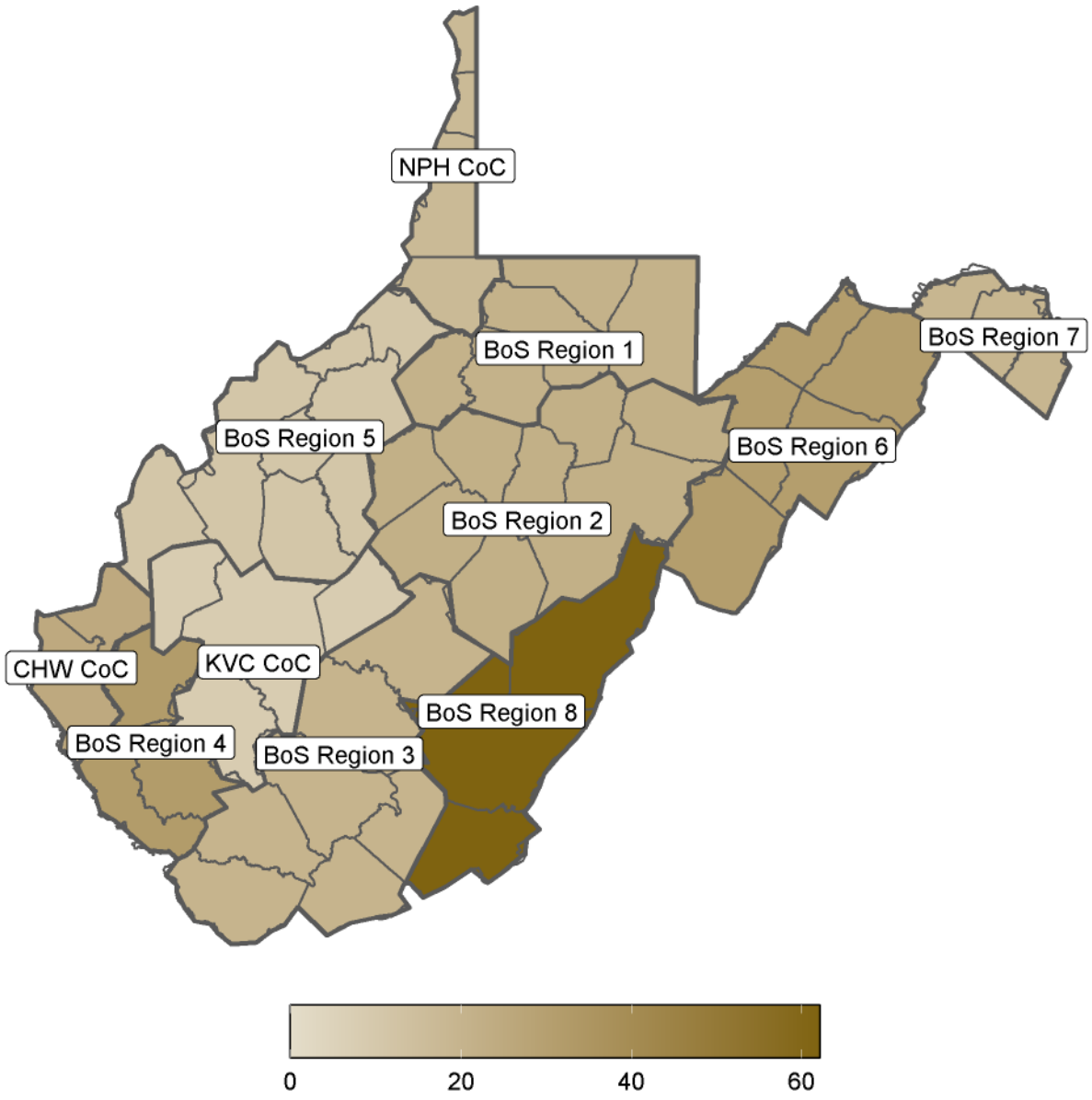
There are special projects and initiatives that can be accessed by individuals experiencing homelessness if they are veterans; HMIS also includes information on veteran status.[56] About one in 18 (6%) individuals experiencing literal homelessness from 2018 through 2023 self-reported as having served in the U.S. Armed Forces or being a Veteran (Table 7). The percentages of clients who were veterans ranged from 5% of clients in CHW and KVC CoCs to 6% of clients in BoS and NHP CoCs.

In terms of individual distribution across the CoC regions, the percentage of clients reporting as fleeing domestic violence was highest in the CHW CoC (21%) and lowest in the CVC CoC (11%, Table 7). Responses were missing for fleeing domestic violence for 17% of clients statewide, and clients may be reluctant to provide information around this sensitive topic. Across CoCs, percentages of unaccompanied youth ranged from 9% of clients in CHW CoC to 19% of clients in NPH CoC.

HMIS includes criteria to assess individuals for chronic homelessness using the HUD definition of chronic homelessness, which determines if someone has been homeless for an extended period or has had multiple periods of homelessness within a defined period of time. Using this definition, nearly one in six (16%) individuals experienced chronic homelessness at their last intake (Table 7). The percentages of those experiencing chronic homelessness ranged from less than one in 10 (8%) clients in KVC to one in four (25%) clients in CHW. Within BoS specifically, region 8 had more than 60% of clients experiencing chronic homelessness followed by regions 4 and 6 (Figure 5). These rural regions do not contain major urban or metropolitan areas. The KVC CoC had the lowest proportion with nearly one in 10 (8%) clients experiencing chronic homelessness. KVC has multiple urban centers.

[56] Veterans Affairs Homeless Programs. March 9, 2012. https://www.va.gov/homeless/.

Figure 5: Proportion of total HMIS clients experiencing literal homelessness who self-reported as experiencing chronic homelessness by Continuum of Care (CoC) region and Balance of State (BoS) subregion based on most recent project entry date from 2018 through 2023.



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*

Qualitative data provided information regarding individual experiences with being homeless in West Virginia in relation to personal characteristics. Interviewees often described life events

outside of their control, which led to their homelessness or contributed to an inability to maintain stable housing. A significant number of interviewees reported experiencing domestic violence, abusive childhoods, illness or disability, sexual violence, or other trauma such as catastrophic injury. For some, these events happened during childhood or young adulthood, and were further compounded by additional events happening throughout their lives. Other interviewees shared having had relatively predictable lives prior to a traumatic event that upended their stability. Like many who experience trauma, individuals experiencing homelessness describe these experiences as contributing to mental illness and/or substance use, further compounding their issues and adding to the barriers standing between themselves and housing stability.

As one interviewee described their path to homelessness: ***"And I had a job, and I lost my job because I was raped...that really [omitted] me up mentally and emotionally, like not the same for real. But I think that's really where, like my route of homelessness came from, was all that happening to me and stuff."***

Interviewees shared their experiences with foster care during childhood, juvenile detention in young adulthood, and/or adult incarceration. These experiences either directly contributed to or exacerbated existing issues that ultimately led them to homelessness. Through the telling of their stories, they painted a clear picture of how difficult it can be for individuals to exit those systems and obtain employment, income, and stable housing.

Focus group participants also indicated many individuals experience a series of compounding events, such as those described by interviewees, that contribute to becoming homeless. Providers and local elected officials also repeatedly noted mental health and substance use were drivers of homelessness. As one interview participant said, ***"My problem has been addiction – substance addiction. As you know the main two causes of homelessness [are] mental illness and addiction. I have both. The first time…my family just wouldn't let me in their home any more; I was in my early twenties."*** Some interviewed individuals also added the context that a trauma proceeded their becoming addicted to substances.

> ***"Whenever I was 16 years old, I had a motorcycle accident. I got [traumatically injured] and I got addicted to opiates. My mom passed away…and me and my dad moved here, and we got ourselves clean for a while. Then we got addicted to heroin…for a pretty long time, and we got put in jail and got ourselves clean and been clean for years now."***

In summary, characteristics of individuals experiencing homelessness vary. Geographic variation was identified for some characteristics, such as being chronically homeless, with a greater concentration of individuals experiencing chronic homelessness along the eastern border. Other characteristics, such as being a veteran, remained fairly constant across the state. Individuals described traumatic life events that upended their lives as the precursors to homelessness, which was echoed by focus group participants.

Demographics

Among HMIS clients who were experiencing literal homelessness based on their most recent enrollment in a sheltered or unsheltered project from 2018 through 2023, a higher percentage of clients self-reported their gender as male (58%) compared to female (41%), with small numbers of clients identifying as other (not reportable, Table 8).

Table 8: Proportion of HMIS clients by their self-reported gender among those experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

	Continuum of Care				
Gender, % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Male	59% (5,867)	60% (2,405)	55% (3,585)	64% (808)	58% (12,665)
Female	40% (4,028)	40% (1,597)	44% (2,860)	35% (444)	41% (8,929)
Other	NR	NR	NR	NR	NR
Missing	NR	NR	NR	NR	NR
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

The highest percentages of clients were aged 35 to 44 years (23%) followed closely by 25 to 34 years (22%) based on self-reported date of birth at most recent project enrollment (Table 9). Counts of clients who reported their age as 65 years or over were suppressed due to low numbers (one through 10). The number of individuals where age was not known was also suppressed due to low values (one through 10) and because, with this information and that of other age groups, it may be possible to calculate suppressed numbers. Statewide, however, these two categories accounted for 6% or less of HMIS clients, a proportion lower than all other age groups (65 and over).

More than one in seven (15%) of HMIS clients experiencing literal homelessness were youths from birth through 18 years (Table 9). Among CoCs the percentage of youth clients ranged from 20% in the KVC CoC to 12% in the NPH CoC. The statewide percentage of clients aged 19 to 24 years was nearly one in 10 (8%). Among CoCs, the percentage of clients aged 19 to 24 years ranged from 7% in the KVC CoC to 11% in the NPH CoC.

Table 9: Proportion of HMIS clients by their self-reported age among those who were experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

Continuum of Care					
Age in Years [1], % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
0-18	14% (1,348)	13% (507)	20% (1,313)	12% (154)	15% (3,322)
19-24	9% (879)	8% (313)	7% (464)	11% (140)	8% (1,796)
25-34	24% (2,347)	24% (951)	20% (1,274)	23% (292)	22% (4,864)
35-44	23% (2,300)	28% (1,114)	20% (1,274)	22% (277)	23% (4,965)
45-54	15% (1,506)	15% (615)	15% (1,000)	15% (189)	15% (3,310)
55-64	11% (1,105)	9% (358)	12% (773)	12% (148)	11% (2,384)
65 or over	NR	NR	NR	NR	NR
Missing	NR	NR	NR	NR	NR
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

1. Age at most recent entry date.

Clients experiencing literal homelessness at most recent project intake most often self-reported their race as White (78%) followed by Black or African American (13%, Table 10). The percentage of people experiencing literal homelessness that were Black or African American ranged from nearly one in five (18%) in the KVC CoC to more than one in 10 (10%) in BoS and CHW CoCs. Only 2% of individuals self-reported their ethnicity as Hispanic, while 95% said they were non-Hispanic.

Table 10: Proportion of HMIS clients by their self-reported ethnicity and race among those who were experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

Characteristic	Continuum of Care				
Ethnicity, % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Non-Hispanic	94% (9,373)	96% (3,854)	95% (6,176)	95% (1,194)	95% (20,597)
Hispanic	2% (222)	3% (110)	2% (150)	2% (27)	2% (509)
Missing	4% (356)	1% (57)	3% (183)	3% (39)	3% (635)
Race, % (n)					
White	81% (8028)	83% (3334)	72% (4691)	77% (975)	78% (17028)
Black or African American	10% (1003)	11% (434)	18% (1199)	13% (163)	13% (2799)
Other Race	3% (310)	3% (113)	5% (331)	4% (51)	4% (805)
Missing	6% (610)	3% (140)	4% (288)	6% (71)	5% (1109)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

HMIS also includes information about client family structure (Table 11). If enrollment includes multiple people who identify themselves as a household or family, then one person is identified as the head of household.[57] The family or household is then described by linking their relationships to the head of household. Clients who reported themselves as head of household or who were alone accounted for 77% of all clients. “Family members” accounted for 15% of all clients followed by “spouses,”, reported at 7%.

[57] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Table 11: Proportion of HMIS clients by their self-reported relationship to head of household among those who were experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

Continuum of Care					
Relationship to Head of Household, % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**Statecms**
Self	80% (7,895)	80% (3,207)	68% (4,419)	90% (1,137)	77% (16,658)
Spouse	7% (658)	7% (272)	8% (485)	4% (53)	7% (1,468)
Family Member	13% (1,301)	13% (525)	20% (1,260)	5% (68)	15% (3,154)
Missing	1% (53)	0% (13)	4% (289)	0% (0)	2% (355)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

Focus group participants reported most of the individuals they serve are White, but there was also a great deal of diversity in this population. During the focus group discussions, participants noted that they see a diverse age range. While some noted fewer individuals under 18 years old, others reported seeing more teenagers, families, and people from various age groups than they had in the past. In terms of gender, opinions varied: some saw more men, some saw more women, and some observed an equal distribution of both.

Gender did not come up often during interviews. When it did, one interviewed individual said she experienced gender-based discrimination when seeking services. Other women discussed feeling unsafe either in homeless encampments, at a shelter, or both. ***"I have been abused and it's really hard to get away from those men when you have nowhere to go and when you're living out here next to them."***

During interviews, individuals also indicated experiencing discrimination, most often because they were homeless. Others had experienced discrimination due to previous or current substance use, having a criminal record, having a disability, or because of their race. A small number indicated experiencing discrimination for multiple reasons.

One interviewee who self-identified as non-White shared their experience attempting to gain employment alongside a similarly aged White peer also staying in an emergency shelter. ***"I tried to be positive…but there really have been times when I've been trying to apply, and I would put my applications in on Indeed…and I showed my face, and nothing happened. …I had another kid my age, he got a job before me, but he was White. I don't understand…what I am doing wrong."***

Another had to say of navigating day-to-day life with a criminal record, ***"They just throw you in a classification of 'you're no good,' but you just stumbled and made a bad judgement call."***

In summary, the largest percentage of HMIS clients experiencing literal homelessness were aged 35 to 44 years. There were lower percentages of HMIS clients aged 24 years or younger and lower percentages among people aged 45 years or older. This may suggest that housing and prevention projects focus on youth and older adults or prioritize these age groups in some way. It is also possible that, among individuals aged 55 years or over, the age at death is lower than the age at death for the general population, impacting the number in this age group. Life expectancy in the United States is currently estimated at 77 years.[58] In a study of people over the age of 50 and experiencing homelessness in California, the median age of death was 65 years.[59] In another study of adults experiencing homelessness in Boston, Mass., the mean age of participants at death was 51 years.[60]

Statewide, the percentage of clients experiencing literal homelessness and self-reporting as Black or African American (14%) was higher than percentage of the total population of WV who identified as Black or African American alone (3.7%) as reported by the 2020 U.S. Census.[61] Nationally, rates of homelessness among individuals who identified as Black or African American were the second highest (48.2 per 10,000 people) compared to rates among individuals who identified as White (11.6 per 10,000 people) in 2022. [62]

Focus group participants described the population of people experiencing homelessness as diverse. Interviewed individuals indicated facing discrimination for multiple reasons, including because they were homeless. Individuals within this population may face unique challenges based on the fact they are homeless, their personal characteristics, and individual life experiences.

Benefits

About 84% of clients experiencing literal homelessness reported not having a source of income during their most recent project intake, while 5% reported earnings that were assumed to be from employment (Table 12). Only a small percentage of clients reported receiving income from benefits, with about 5% reporting they received Supplemental Security income, 3% reporting receiving Social Security Disability benefits, and 2% reporting other sources of income.

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[58] Arias E, Xu J. National Vital Statistics Reports Volume 71, Number 1, ... CDC.gov. August 8, 2022. https://www.cdc.gov/nchs/data/nvsr/nvsr71/nvsr71-01.pdf.

[59] Brown RT, Evans JL, Valle K, Guzman D, Chen YH, Kushel MB. Factors Associated with Mortality Among Homeless Older Adults in California: The HOPE HOME Study [published correction appears in JAMA Intern Med. 2023 Feb 1;183(2):171. doi: 10.1001/jamainternmed.2022.5820]. *JAMA Intern Med*. 2022;182(10):1052-1060. doi:10.1001/jamainternmed.2022.3697

[60] Baggett TP, Hwang SW, O'Connell JJ, et al. Mortality among homeless adults in Boston: shifts in causes of death over a 15-year period. *JAMA Intern Med*. 2013;173(3):189-195. doi:10.1001/jamainternmed.2013.1604

[61] West Virginia population declined 3.2% from 2010 to 2020. Census.gov. August 25, 2021. https://www.census.gov/library/stories/state-by-state/west-virginia-population-change-between-census-decade.html.

[62] 2022 Annual Homelessness Assessment Report (AHAR to Congress). huduser.gov. December 2022. https://www.huduser.gov/portal/sites/default/files/pdf/2022-ahar-part-1.pdf.

Table 12: Proportion of HMIS clients by their self-reported source(s) of income among those who were experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

Continuum of Care					
Income Status [1], % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
No Source of Income	84% (8,445)	82% (3,355)	87% (5,665)	81% (1,029)	84% (18,494)
Employed	5% (484)	5% (213)	5% (298)	7% (95)	5% (1,090)
Social Security Disability Insurance (SSDI)	4% (363)	4% (160)	3% (201)	3% (38)	3% (762)
Veteran with Disability	1% (64)	0% (16)	0% (15)	NR	NR
Supplemental Security Income (SSI)	5% (513)	7% (266)	4% (259)	6% (82)	5% (1,120)
Other [2]	2% (152)	2% (78)	1% (86)	2% (21)	2% (337)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

1. Categories are not mutually exclusive. Some individuals self-reported multiple sources of income and would be counted in more than one category.

2. Other includes: Alimony or other spousal support, child support, general assistance, pension or retirement income from another job, private disability insurance, retirement income from Social Security, student loans grants, TANF, unemployment insurance, and worker's compensation.

Most clients experiencing literal homelessness, about three in five (60%), reported that they were not receiving any non-cash benefits at their most recent project intake (Table 13). The highest percentage of clients reported receiving SNAP benefits (37%), followed by WIC (3%). TANF, Rental Assistance, and other income sources were suppressed due to low numbers (being between one and 10) and related identifiability concerns. Each accounted for less than 3% of clients experiencing literal homelessness at most recent enrollment.

Table 13: Proportion of HMIS clients by their self-reported non-cash benefits among those who were experiencing literal homelessness (sheltered or unsheltered) based on the most recent project entry date from 2018 through 2023.

Continuum of Care					
Non-cash Benefits [1], % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
No Benefits	64% (6,478)	52% (2,159)	60% (3,991)	51% (659)	60% (13,287)
TANF	0% (33)	0% (18)	0% (18)	NR	NR
SNAP	34% (3,419)	44% (1,833)	37% (2,475)	46% (593)	37% (8,320)
WIC	2% (154)	2% (94)	1% (72)	2% (24)	2% (344)
Rental Assistance	0% (40)	1% (32)	1% (68)	NR	NR
Other	0% (50)	0% (14)	0% (19)	NR	NR
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

1. Categories are not mutually exclusive. Some individuals self-reported receiving multiple non-cash benefits and would be counted in more than one category.

Individuals who shared their experiences and participants in focus groups all described a range of ways clients linked to different benefits. Some shared that the benefits they received generally met their needs, and others described the processes of attempting to obtain needed services. As one person said in an interview, ***"Right now I have a SNAP benefit card, and through the state I have health insurance."***

Others described periods when they needed benefits but had to wait to receive them. Individuals described pending Supplemental Security Income (SSI) applications and long eligibility processes for housing. One interviewed person explained, ***"I went ahead and signed up for WIC and stuff like that…there's so many clients here that it takes a while for the case manager here to get to someone."***

Interviewed individuals also described their appreciation for service providers, such as case workers, who often assisted them in identifying benefits. One interviewee described struggling to connect with needed benefits until her children's school homelessness liaison was able to help

assist with clothing, housing, and more through federal McKinney-Vento funds available through the U.S. Department of Education to support children experiencing homelessness.

Focus group participants often described a need for additional funds to provide support for this population, particularly around housing. In one discussion, a participant described homeless individuals not being successful in the winter because providers could not fund enough cold shelter beds to meet the community's need.

In summary, HMIS data indicates that most clients did not have a source of income, including from cash benefits, or reported not receiving non-cash benefits at their most recent project enrollment. Rates of receiving benefits are low based on HMIS information from clients' last project intake into HMIS. Qualitative information suggests individuals are receiving assistance in identifying benefits they may be eligible for once they are connected to a homeless service provider.

Enrollment in Projects by Individuals Experiencing Literal Homelessness In West Virginia

Multiple social, economic, and environmental factors may affect patterns observed in HMIS data. The study period (2018 through 2023) covers the COVID-19 pandemic, which likely affected project enrollment. In March 2020, states began to implement shutdowns, social distancing was implemented, and mask-wearing guidelines and recommendations were issued by the federal government to limit the transmission of SARS-CoV-2 virus that caused the COVID-19 pandemic.[63] To evaluate enrollment trends from 2018 through 2023, all enrollments (including repeat enrollments for the same client) were included in Figure 6. Client enrollments in HMIS typically peaked during the winter months (December through February) in WV except in 2020. A downward trend in enrollment is observed beginning in the Fall of 2019 (Appendix C, Table 21). Enrollments increase again following the drop, peaking around the end of 2021 and beginning of 2022, and then returning to pre-COVID-19 pandemic levels around September 2022.

At that time, there was also a significant drop in client enrollments in shelters (Figure 6). In subsequent months, various pandemic measures likely caused changes in enrollments due to restrictions, lockdowns, and factors affecting project operations as well as behavioral and economic factors affecting personal housing situations. Sheltered enrollments rose to the levels prior to transmission preventions measures through April 2020 until the end of 2021. Though PIT counts for 2021 are available, in the latest AHAR report for 2023, sheltered and unsheltered counts are not included for 2021 because of COVID-19 interruptions across the United States.[64]

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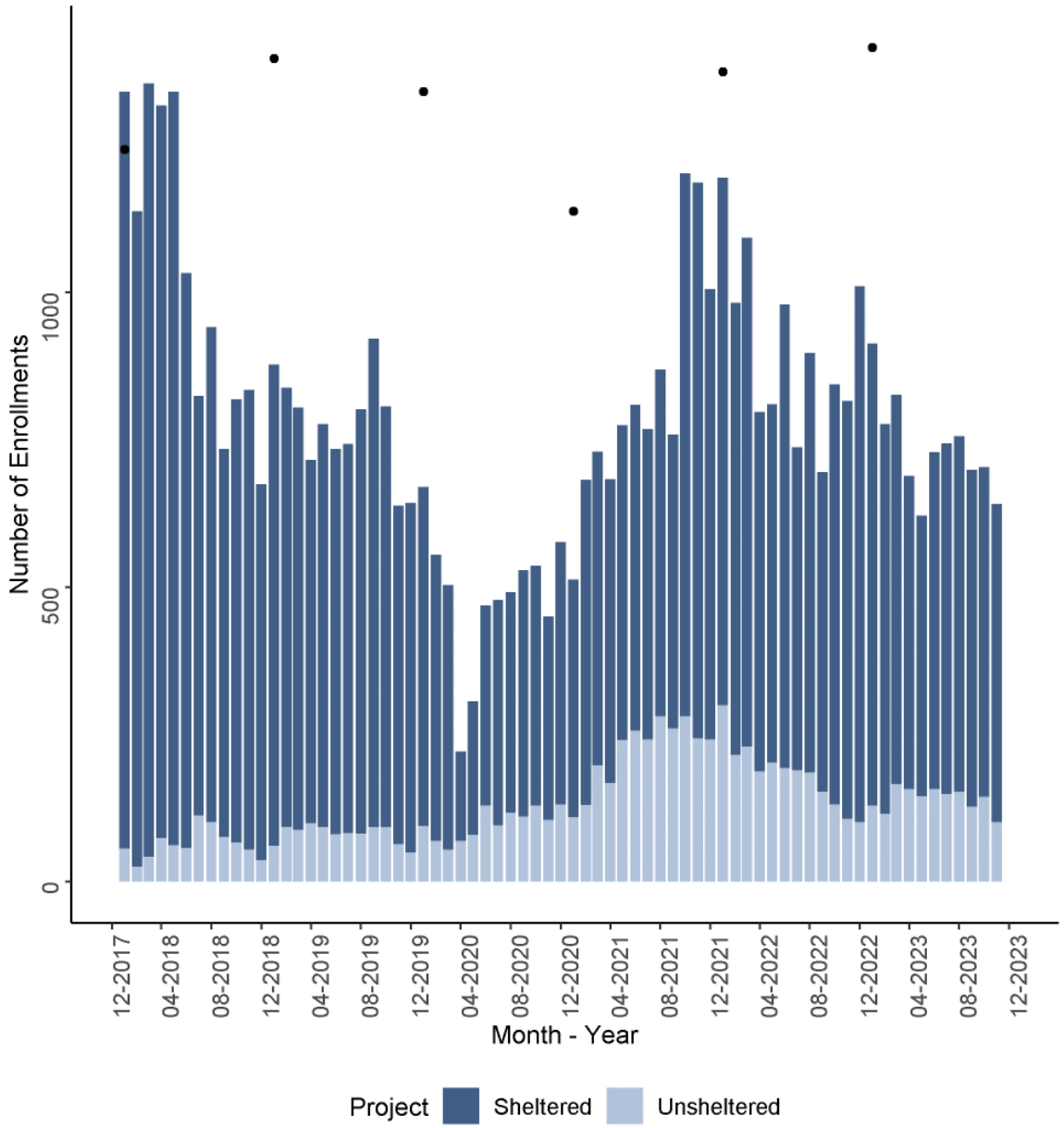
[63] CDC Museum Covid-19 Timeline. Centers for Disease Control and Prevention. March 15, 2023. https://www.cdc.gov/museum/timeline/covid19.html#Early-2021.

[64] AHAR reports - Hud Exchange. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/ahar/.

Figure 6: Number of all individual Homelessness Management Information System (HMIS) client project enrollments each month from 2018 through 2023 for West Virginians experiencing literal homelessness (sheltered and unsheltered). Black dots represent annual Point-In-Time counts of sheltered and unsheltered individuals conducted each January.



Conducting an Epidemiological Analysis of Homeless Populations in West Virginia (Legislative Objective 3)

Health Issues Faced by West Virginians Experiencing Literal Homelessness

An analysis of available HMIS data on physical health, health insurance status, substance use disorder, and mental health conditions allows for a better understanding of the health challenges facing those who were experiencing literal homelessness (sheltered or unsheltered) at the most recent project enrollment from 2018 through 2023. Multiple available years were used because some communities may not have enough data to report on for a single calendar year. Information on physical disabilities and developmental disabilities was collected from clients at intake.[65] Note this information is self-reported and does not require a clinical diagnosis.

Physical and Mental Health

HMIS defines a physical disability by asking if the client has a physical disability and if that disability is "expected to be of long-continued and indefinite duration and substantially impair the client's ability to live independently." Among those experiencing literal homelessness, nearly one in five (18%) reported having a physical disability (Table 14). Across CoCs, the percentage clients who reported having a physical disability ranged from the highest percentage of nearly one in four (24%) clients in CHW to more than one in seven (15%) in KVC CoC.

Table 14: Self-reported physical health conditions and mental health disorders among HMIS clients who are experiencing literal homelessness (sheltered or unsheltered) based on most recent project entry date from 2018 through 2023.

Characteristic	Continuum of Care				
Physical Health Condition, % (n	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Physical Disability	17% (1,884)	24% (1,171)	15% (1,054)	16% (222)	18% (4,331)
Developmental Disorder	5% (548)	7% (361)	4% (267)	3% (37)	5% (1,213)
Chronic Health Condition [1]	14% (1,475)	23% (1,143)	9% (608)	16% (215)	14% (3,441)
HIV/AIDS	0% (49)	2% (101)	1% (96)	NR	NR
Total	30% (3,004)	46% (1,856)	24% (1,535)	NR	NR

[65] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Mental Health Condition, % (n)	Balance of State	Cabell-Huntington-Wayne	Kanawha Valley Collective	Northern Panhandle	State
Mental Health Disorder	32% (3,175)	52% (2,096)	27% (1,774)	47% (598)	35% (7,643)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

1. A chronic health condition is defined in the HMIS 2024 Data Standards as "a diagnosed condition that is more than three (3) months in duration and is either not curable or has residual effects that limit daily living and required adaptation in function or special assistance." A full list of conditions is presented in the Approach section of this report.

A developmental disorder is defined in HMIS as "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."[66] About one in 20 (5%) clients in WV reported having a developmental disorder (Table 14). Across CoCs, percentages of clients reporting having a developmental disorder ranged from 7% in the CHW CoC to 3% in the NPH CoC.

Chronic health conditions are defined as a diagnosed condition that lasts more than three months and either, 1) is not curable or 2) the effects of the condition "limit daily living" and require special support.[55] Examples of chronic health conditions are heart disease, severe asthma, diabetes, arthritis, cognitive impairments, migraines, liver conditions, and stroke. Nearly one in seven (14%) clients self-reported having at least one chronic health condition across WV (Table 14). Across CoCs, clients reporting chronic health conditions ranged from nearly one in 10 (9%) clients to nearly one in four (23%) clients.

Though some data are suppressed to protect clients from possible identification in categories where only one to 10 individuals indicated they had the condition, individuals reporting HIV/AIDS ranged from a value between one to 10 clients in the NPH CoC to 2% of clients in the CHW CoC (Table 14). Among CoCs, percentages of clients experiencing physical health conditions were highest in the CHW CoC. The KVC CoC had lower percentages than the other two CoCs in all categories of physical health conditions except percentages of clients reporting HIV/AIDS (1%).

HMIS defines mental health disorders as a "range from situational depression to serious mental illnesses."[55] More than one in three (35%) clients self-reported a mental health disorder in WV. Percentages of self-reported mental health disorder ranged from roughly half of clients in CHW (52%) and NPH (47%) CoCs, respectively, to more than one in four (27%) clients in KVC CoC.

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[66] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Interviewed individuals report a range of physical and mental health conditions, often in relation to why they were homeless. As one person said, “I have a rare blood disorder, and I had a stroke years ago and I ended up in the hospital for quite a long time. During that time my dad went into the hospital, too…so [when I was discharged] I didn’t really have any place to go.” Aging was also a factor for some who shared their lived experiences. An interviewed person explained, “My physical health is no longer, you know, I’m not able to get around as easily…I have arthritis and stuff and my knees, I hobble and it’s just not as easy as it used to be. I’ve started to see how much I’ve destroyed my body with drugs and not taking care of myself and not keeping up with doctors and stuff like that.”

Adjusting to new health conditions or to new treatment was identified as a barrier to stable housing, or to steady employment. An interviewed person said, “I knew that if I didn’t take my medication, I wouldn’t be able to make it right now. I’m on good medication. I feel a lot better; I feel like I can function more. You know, I’m not trying to sleep all day, but the first month was terrible because I couldn’t even function…because the meds kept making me want to go back to sleep.”

Interviewees described how physical health conditions and disabilities made it difficult for them to gain and keep employment, which in turn led to homelessness. One person said, “I am always open about the fact that I have [a chronic disease] and that I used to be a cancer patient…in case I have a medical emergency and I can’t speak for myself. I feel that whoever I’m working with should know what I have, so it wouldn’t come as a surprise to anybody. When I tell [potential] employers that I have [a chronic disease], I get an email, ’*We decided to go with another candidate*.’ …That’s definitely gotten in my way here because they automatically assume disability with a lot of time off. In the last year I have missed two days of work because of my [chronic disease]. …I don’t call out. I’m trying to work as much as I can, so that I can survive.”

Other individuals described disabling conditions and trying to maintain income while working through benefits systems. One person said, “A lot of physical problems…makes it hard for me to work. So, I’ve applied for disability, and I had a hearing already about six weeks ago, so I’ve still got some time to wait. I’ve applied for a couple jobs around, but I haven’t heard anything back yet.”

During focus groups, participants identified mental illness and addiction as major drivers of homelessness and indicated a large proportion of individuals experiencing homelessness in West Virginia had either a mental illness, substance use disorder, or both. HMIS self-reported data do not show that most individuals experience these compounding issues alongside homelessness. Focus group information represents people’s perceptions and interview data represents a few individuals’ experiences. Individuals with poor mental health were seen to self-medicate with substances. In addition, focus group participants identified a need for additional supports for people with mental illness and for discharge planning for individuals with mental illness when they leave or are released from care.

Health Insurance

The proportion of clients reporting having any health insurance coverage was low in HMIS data. Only roughly two in five (ranging from 35% to 40%) of clients reported having any insurance coverage at their most recent enrollment from 2018 through 2023. Medicaid was the leading

insurance coverage self-reported by clients experiencing literal homelessness in WV at their most recent enrollment, with nearly one in three (32%) reporting having this coverage (Table 15). The second highest proportion was 4% of clients who reported having Medicare coverage.

Table 15: Self-reported insurance status among HMIS clients who are experiencing literal homelessness (sheltered or unsheltered) based on most recent project entry date from 2018 through 2023.

	Continuum of Care				
Insurance Status [1], % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Employee Insurance	0% (48)	0% (14)	1% (39)	NR	NR
Medicaid	30% (3,034)	35% (1,446)	34% (2,274)	30% (386)	32% (7,140)
Medicare	4% (365)	5% (189)	4% (275)	4% (52)	4% (881)
VHA Insurance	1% (138)	1% (36)	1% (41)	NR	NR
Other Insurance	1% (119)	1% (46)	1% (71)	2% (31)	1% (267)
Total Number Insured [2]	35% (3,463)	40% (1,592)	39% (2,544)	36% (454)	37% (8053)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations. VHA = Veterans Health Administration.*

1. Categories are not mutually exclusive. Some individuals self-reported having multiple insurance coverages.

2. Total Number Insured is a variable in HMIS and was not generated from other variables.

In terms of qualitative information, most individuals interviewed were either already on Medicaid or were in the process of trying to obtain it, and most shared that they were able to take care of most or all health needs with this coverage. This is likely because interviewed individuals were identified through service providers who would have assisted them in connecting to benefits. One person said, “I’m lucky in the sense that a majority of my doctors are [very nearby]. All, with the exception of my own neurologist and my primary care. They’ve been with me for about four years, and they’ve helped me more than I can imagine.” One person also said of their process accessing services, “I was able to sign up for Medicaid at the clinic. That’s not too far from the shelter. It was quick, a quick process. I have a temporary Medicaid card, just in case I need any medical services.”

Substance Use

More than one in five (22%) clients self-reported having a substance use disorder and more than one in 10 (11%) self-reported having an alcohol use disorder statewide. Nearly one in 10 (8%) clients reported having both alcohol and substance use disorders at the same time. Statewide, nearly one in three (29%) clients reported in the affirmative that they either had a substance use, alcohol use, or both types of disorders (This table is not mutually exclusive, as it allows multiple instances of self-reporting via enrollments over time.)

Table 16: Self-reported substance and alcohol use disorder among HMIS clients who are experiencing literal homelessness (sheltered or unsheltered) based on most recent project entry date from 2018 through 2023. [1]

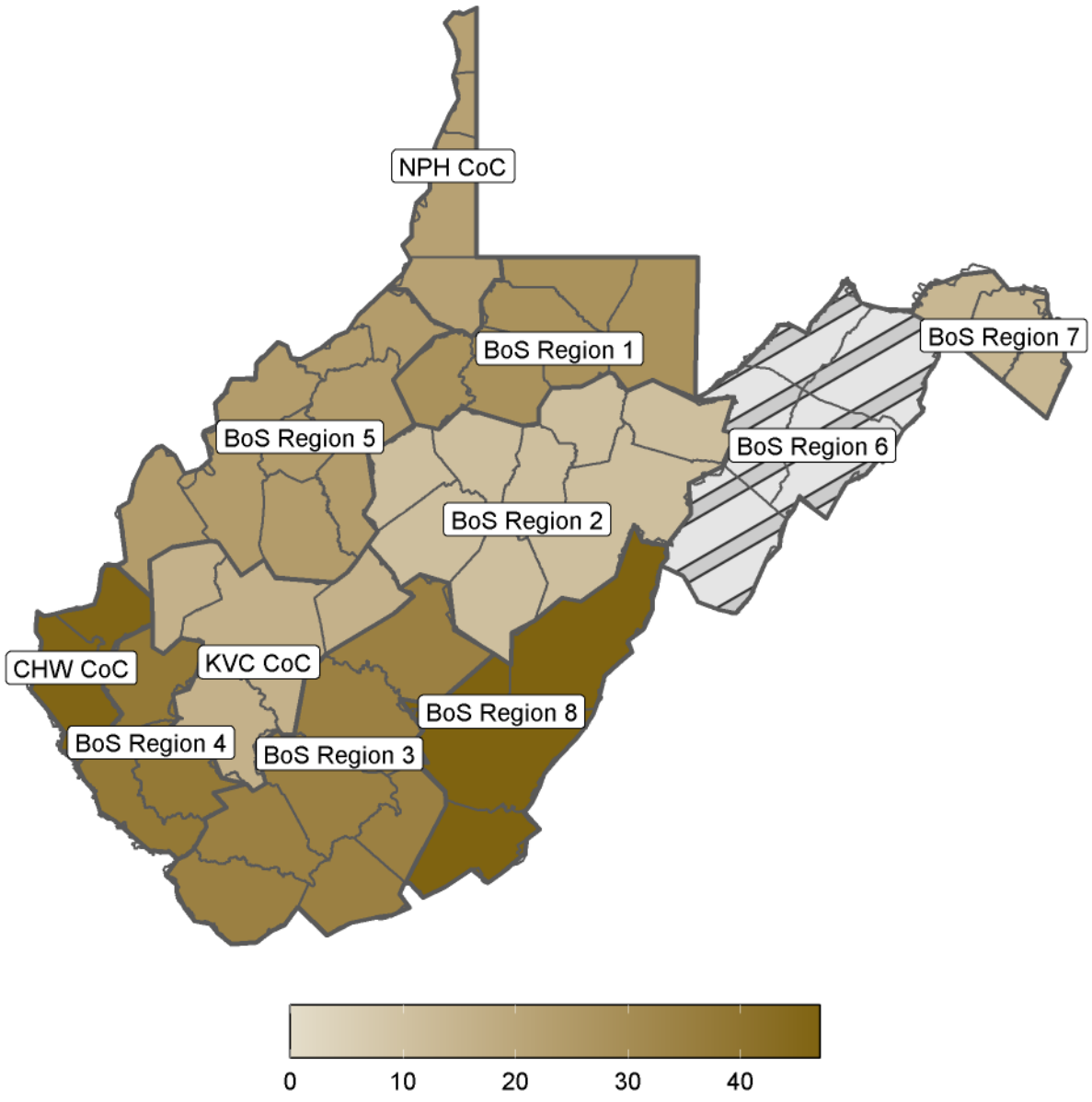
	Continuum of Care				
Substance Use Disorder [1], % (n)	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Substance Use Disorder	22% (2,517)	32% (1,859)	15% (1,072)	19% (275)	22% (5,723)
Alcohol Use Disorder	9% (1,051)	19% (1,145)	8% (593)	10% (146)	11% (2,935)
Both Alcohol and Substance Use Disorder	6% (694)	15% (895)	5% (398)	6% (79)	8% (2,066)
Total with at Least One Response	28% (2,800)	51% (2,031)	19% (1,241)	27% (336)	29% (6,408)
Total Clients, N	**9,951**	**4,021**	**6,509**	**1,260**	**21,741**

Among CoCs, the CHW CoC had the highest percentage of people reporting at least one or both disorders with more than half (51%) of clients experiencing literal homelessness, while KVC had the lowest percentage of clients with at least one or both disorders with fewer than one in five (19%, Table 16). CHW also had the highest percentages of people with each disorder with nearly one in three (32%) clients reporting substance use disorder and nearly one in five (19%) clients reporting alcohol use disorders. More than one in seven (15%) clients reported having both alcohol and substance use disorders in CHW. KVC had the lowest percentages with each disorder, with more than one in seven (15%) clients having a substance use disorder and nearly one in 10 (8%) having an alcohol use disorder. KVC also had the lowest percentage with both disorders at one in 20 (5%) clients.

Further analysis of proportions of clients who were experiencing literal homelessness and reported substance use disorder that includes BoS subregions reveals higher proportions of clients in subregions in the southern parts of the state (Figure 7). The highest proportion of clients

is in BoS subregion 8 with about 45% of clients experiencing literal homelessness reported also having a substance use disorder, higher than the 32% of clients in CHW. Proportions were near 30% in BoS regions 3 and 4, completing the pattern of the highest proportions of self-reported substance use among those experiencing literal homelessness in southern parts of WV.

Figure 7: Percentage of total HMIS clients experiencing literal homelessness who self-reported as having a substance use disorder in each Continuum of Care (CoC) region and Balance of State (BoS) subregion based on most recent project entry date from 2018 through 2023.



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*

Hatched gray color indicates not reportable due identifiability concerns defined as between one and 10 clients in a category.

Interview and focus group participants often discussed substance use and abuse. As mentioned above, many focus group participants see the current levels of homelessness in their communities as directly tied to addiction to substances in general. Focus group participants also discussed the ongoing opioid crisis in West Virginia as well as other more recent trends in substance use that they see in their communities. Interviewed individuals talked of substance use in workplaces or in the shelters themselves and spoke of generational patterns of use within their own families.

In interviews, some individuals described their general experience with other people's substance use or with substance use in their communities. One person said, "Around this area…it's every day that EMS is here 'cause somebody's OD'd. …last night I had no OD. …what they need to start doing is anybody that is selling any of that stuff they need to start prosecuting them, put them in prison."

Within these conversations, there was also much talk of recovery, and of how individuals have been able to "get clean." One person said, "I've come a long ways from where I was before. I'd drink alcohol and used to do drugs and all that. I do a stimulant, but I don't drink anymore. I gave everything up one day. It's been going on seven years that I've been sober from alcohol and all that. It took a long time."

Even when people talked through the challenges they experienced throughout their lives, some shared ways they were able to stop using substances. "The [residential home for children], that's where I was raised from 10 years old until I graduated high school. That was my home, so I am from [here]. My work and everything I have ever had over the years. I just had gotten in trouble for drugs two and a half years ago…and went to a halfway house. I haven't drank alcohol in 17 years, but knowing and understanding what the addiction is…is a big part of getting better."

Recovery pathways sometimes included medication-assisted treatment. As one person explained, "I'm on Methadone, so that helps me a whole lot. I go to the Methadone clinic Monday through Saturday. I get what they call a take-home for Sunday." Another person described receiving a newer kind of treatment, "In 2022, I had [treatment omitted] for substance abuse…it was a [type of doctor] that helped me out with a great deal..."

Where Clients with Health Conditions Seek Shelter

Across WV, the majority of individual HMIS clients whose most recent intake was in a shelter project were seen at an emergency shelter — about two in three (68%, Table 17). More than one in four (26%) clients had their most recent intake at a day shelter, which split across CHW and KVC CoCs; there were no day shelter clients in BoS and NPH. Combined, the transitional housing and safe haven shelter categories had a higher percentage of clients in NPH than the other CoCs, but values were suppressed in these categories due to low numbers or numbers from one through 10.

Of individual clients seeking permanent housing services statewide at their most recent enrollment, rapid re-housing projects had the most (79%) followed by permanent supportive housing (17%). This type of housing is available for clients or families with at least one individual with a disability, which can include substance use and mental health disorders in addition to physical and developmental disabilities. The CHW CoC showed a different pattern than the other three CoCs, with the lowest proportion of clients in rapid rehousing among CoCs with more than

half (54%), but the highest proportion of clients in permanent supportive housing at almost half (45%).

Table 17: Proportion of HMIS clients who were most recently enrolled in a sheltered or permanent housing project from 2018 through 2023.

Continuum of Care					
Most Recent Living Situation Characteristics	**Balance of State**	**Cabell-Huntington-Wayne**	**Kanawha Valley Collective**	**Northern Panhandle**	**State**
Sheltered, % (n)					
Day Shelter	0% (0)	45% (1,622)	52% (2,866)	0% (0)	26% (4,488)
Emergency Shelter	92% (6,370)	54% (1,972)	45% (2,488)	79% (724)	68% (11,554)
Transitional Housing	NR*	NR*	NR*	NR*	NR*
Safe Haven	NR*	NR*	NR*	NR*	NR*
Total	100% (6,903)	100% (3,633)	100% (5,522)	100% (915)	100% (16,973)
Permanent Housing, % (n)					
Rapid Re-housing	84% (3,833)	54% (644)	86% (630)	81% (342)	79% (5,449)
Permanent Supportive Housing	10% (470)	46% (544)	14% (104)	19% (82)	17% (1,200)
Housing with Services	0% (17)	0% (0)	0% (0)	0% (0)	0% (17)
Housing Only	5% (244)	0% (0)	0% (0)	0% (0)	4% (244)
Total	100% (4,564)	100% (1,188)	100% (734)	100% (424)	100% (6,910)

NOTES: *NR=Not reportable due to identifiability concerns defined as between one and 10 participants in a category. Values are also suppressed when mathematics could be used to successfully calculate a suppressed value. These data are not visible in the table but are used for all summaries and calculations.*

In summary, the 2021 West Virginia MATCH Survey found that about 24% of adults in WV reported having depression, anxiety, or post-traumatic stress disorder.[67] In 2021 and 2022, the National Survey on Drug Use and Health (NSDUH) discovered that 26% of adults in WV reported any mental health illness in past 12 months.[68] The HMIS definition of mental health disorder includes a broad range of mental health issues, and HMIS data cover a six-year period, including the COVID-19 Pandemic. However, 35% of HMIS clients enrolled from 2018 through 2023 reported a mental health disorder, which is higher than estimates for the general adult population in WV. The percentages of clients self-reporting mental health disorders in CHW and NPH CoCs are nearly double those for the general population of adults, suggesting a high burden of mental health disorders and need for treatment services among those experiencing literal homelessness.

Key informant interviews and focus group participants provided additional context regarding health issues faced by this population. Aside from substance use disorders and struggles with mental health, which were identified as drivers of homelessness, interviewees also discussed physical health issues. Physical health conditions – chronic and acute – were often identified as the catalyst that resulted in homelessness. Interviewees described costly medications, health issues leading to physical disability, as well as issues they have lived with their whole lives – examples of the complexity of homelessness at the individual and community levels.

Conclusions

All data sources on homelessness are likely to underrepresent the total number of individuals impacted. Individuals who are experiencing unsheltered homelessness in HMIS are only captured if street outreach projects exist in that community or county. Individuals not enrolled in HMIS would not be included in the numeric portions of this report, though qualitative work included discussion of some unsheltered, unenrolled individuals experiencing homelessness, especially in more rural areas. Among HMIS clients who had accessed housing, shelter, or street outreach projects, there were trends in clients experiencing homelessness based on their demographic characteristics, health conditions, and location that provide some initial but incomplete answers to objectives of this project. Many of these issues are more prevalent among HMIS clients in some CoCs, suggesting that there are different needs based on rurality, population concentrations, and availability of housing. Thus, it is expected that CoCs are concentrating their efforts and funding on projects to best serve those needs. To better understand the distribution and needs of those experiencing homelessness in West Virginia, policy makers could consider providing additional funds to support more robust data collection among members of this population.

Many of those interviewed who were experiencing homelessness were employed at the time of their interview in industries such as: construction, lawn care, food service for restaurants and care facilities, physical labor like tree work, heavy equipment operation, nursing, peer recovery, mechanical, and welding services. The number of individuals reporting benefit enrollments in

[67] West Virginia Department of Health and Human Resources. (2023). *2021 Mountain State Assessment of Trends in Community Health (MATCH) Findings Report, 2021.*

[68] 2021-2022 NSDUH: Model-based estimated prevalence for states. SAMHSA.gov. February 15, 2024. https://www.samhsa.gov/data/report/2021-2022-nsduh-state-prevalence-estimates.

HMIS was low, while the number who reported them interviewed was high. Service providers assist individuals in accessing benefits once they are homeless. Policy makers could consider providing additional information around available benefits to those facing homelessness as a way to help people find benefits that might assist them in staying in their homes.

Those working most closely with these populations in West Virginia communities – providers, local elected officials, law enforcement, and emergency services – often expressed that much of the state's current homelessness can be attributed to the opioid crisis, as well as ongoing and evolving substance use trends that vary by region. Qualitative data recorded numerous experiences of generational substance use contributing to homelessness, and of young people facing adulthood without support or needed basic documentation.

Appendix A: Qualitative Methods

Initial Outreach

Initial outreach was conducted throughout the state of West Virginia by key members of the project team, and was guided by the language of the legislation and by DoHS sponsors. An outreach email was drafted to briefly introduce the purpose of the work, as well as to gather any information available about the following:

- Services and service providers for people experiencing or at-risk of homelessness,
- Laws, ordinances, and policies related to people experiencing or at-risk of homelessness, and
- Additional potential stakeholders, such as non-profit or religious organizations, that provide services for or have knowledge of people experiencing or at-risk of homelessness.

This initial outreach email was first sent to each county commissioner in WV's 55 counties. Contact information was gathered online, and if unavailable there, phone calls were made by the project team to counties where information was needed. Most commissioners received individual emails; some counties manage a group email address, and these addresses received a single email with all commissioners addressed by name in the salutation. Emails that did not receive an initial response were followed by an additional two follow-up attempts to ensure multiple opportunities for input were provided to each county.

From there, the same outreach email was extended to mayors of the ten most populous municipalities in WV, and to mayors of the municipalities within the ten most populous counties. Finally, the initial outreach email was sent to contacts at the thirteen Comprehensive Behavioral Health Centers, which anchor WV's publicly funded community-based behavioral health system. The same *three-attempts* method was used for these groups of contacts as well to reduce the risk of missing opportunities.

These initial outreach attempts resulted in many suggestions for potential participants, forwarded emails to other contacts, invitations to discuss on the phone, and direct e-introduction connections to others. All contacts gathered through this round comprised the team's "snowball", and these new individuals received a communication from the team about the purpose of this project work thus far, and the same request for the bulleted information that initially went out to elected officials and others. Many of these new contacts made further suggestions, which were added to the snowball and contacted as described above in a third and final round of outreach.

Stakeholder Engagement

Focus groups

Participants of nine focus groups were asked to discuss their expert opinions and perceptions of homelessness in their communities, of the individuals and families they serve and interact with, and of service needs and barriers these community members faced when accessing needed services and housing. These discussions also sought to inform the project team about available services, as well as local policies and ordinances affecting these populations.

Focus Group Eligibility

Focus group invitations were first sent to all contacts who expressed interest during outreach efforts, either in participation in a focus group explicitly, or more generally in any opportunities to provide more input. Additional outreach communications were made to emergency medical services (EMS) and law enforcement representatives at this stage of the work to attempt broader inclusion from this field. These invitees, if initially unresponsive, received two additional follow-up emails, allowing opportunities to indicate interest in participation.

Focus Group Sampling

Focus group invitations were extended to 62 providers and other stakeholders, 31 members of EMS and law enforcement, and 25 elected officials.

Focus Group Guide

A discussion guide was developed with the goal of soliciting information from the group that would help address the objectives in the legislative directives. Participants were asked about the following: primary causes of homelessness in their area, characteristics of people experiencing homelessness, available services, relocation of people experiencing homelessness from counties or states, challenges unhoused populations face, policies affecting them, and suggestions for improvement.

Focus Group Setting

Focus groups were conducted via Zoom, a communications platform that allows users to connect using video, audio, phone, and chat.[69] Participants were able to join with or without video as they preferred. Many joined via computers, while others called in via phone. Focus group sessions were recorded and housed in HIPAA-secure storage.

Focus Group Transcription

Transcriptions were produced using meeting recordings. These files were housed in HIPAA-secure storage and cleaned of all identifying information: names of individuals or agencies, cities, towns, and other locations.

Thematic Analysis of Qualitative Data - Inductive Coding

Focus group transcriptions were analyzed using inductive coding, where categories, or codes (themes) emerge from the collected data with no prior assumptions by the research team.[70] For this work, this means that the information shared by participants of focus groups drove the outcome of the data analysis, and that the initial list of relevant themes was developed directly from these discussions.

A team of three researchers independently coded each focus group transcription, and an independent researcher with advanced expertise in qualitative analysis developed themes.

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[69] Zoom Video Communications. 2024. https://zoom.us/.

[70] Daniels K. Box 4.3, three approaches to analysis in systematic reviews of qualitative studies - evidence synthesis for health policy and systems: A methods guide - NCBI bookshelf. National Center for Biotechnology Information. October 8, 2018. https://www.ncbi.nlm.nih.gov/books/NBK569586/box/ch4.box12/?report=objectonly.

Themes were reviewed by members of the coding team and by the individual who facilitated the focus group to ensure they aligned with key elements of conversations.

Key Informant Interviews

Key Informant Interview Eligibility

Key informant interviews were conducted with adults 18 and older currently experiencing homelessness, or who had recently been housed. To identify these individuals, the project team worked through outreach to learn who had the capacity and desire to assist with coordinating these key informant interviews. An initial list of individuals and agencies was assembled from these outreach efforts, and an email extended to these contacts to begin coordination of interviews with those who wished to participate. At the same time, the research team extended additional outreach communications to the state's larger municipalities with whom an initial line of communication had not yet been successfully established. Together, these efforts culminated in 33 interviews with key informants, adults currently experiencing homelessness, or who had recently been housed.

Key Informant Interview Sampling Strategy

Given the complex nature of this population, the project team conducted interviews with a convenience sample of individuals who had the ability and desire to participate. Some interviewees had cell phones, jobs, and permission from their employers to take a break from their workday to provide an interview. Others were coordinated on shorter notice, when their life situations found them at the agencies of the providers who were assisting the research team, and the opportunity to conduct an interview presented itself. Interviewees ranged from young adults to senior citizens spanning four generations and were of a variety of races and ethnicities. All interviewees were either experiencing homelessness - that is, they were living in emergency shelter situations, or were sleeping in unsheltered locations – or had been recently housed.

Key Informant Interview Guide

Through stakeholder outreach, the research team learned from providers that to optimize time with interviewees, the interview duration should be kept to approximately the length of intake for services – about 10-15 minutes. The total time of completed interviews ranged from 9 to 36 minutes. An interview guide was developed with the goal of informing the participant of the purpose, reviewing consent, and asking questions that could collectively provide thematic context for legislative objectives within the suggested interview duration. Interviewees were asked questions about their life experiences including the following: age, place of origin and location over the last three years, veteran status, current housing and/or sleeping arrangements, circumstances leading to homelessness, health and social services benefits, and an opportunity for anything else they believed to be valuable and wished to share.

Key Informant Interview Setting

Interviews were conducted virtually via Zoom. Participants were able to join their interview call from the setting that worked best for them, with or without a camera on according to their preference, and with or without a case manager present according to participant preference. Many participants completed their interviews via an agency computer and with a case manager nearby in case assistance was needed. Others were interviewed independently while they used private rooms at shelters, agencies, or the housing where they lived. Some participants chose to be

outdoors in the community for their interview, while others took breaks from their workdays and were interviewed in an environment of their choosing.

Key Informant Interview Incentives

Interview participants were given a $50 stipend in the form of a physical gift card to compensate them for their time.

Key Informant Interview Transcription

Transcriptions were produced via Zoom recordings as with the focus groups, moved to HIPAA-secure storage, and cleaned of all identifying information: names of individuals or agencies, cities, towns, and other locations.

Key Informant Interview Thematic Analysis of Qualitative Data – Deductive/Inductive

Key informant interview transcriptions were analyzed using deductive analysis, or an up-front framework of understanding informed by existing knowledge.[71] The research team began with themes identified as a result of the focus group analysis. Key informant interviews were coded using these themes, as well as inductively for the addition of anything new that arose directly from discussions with this population. An independent researcher with advanced expertise in qualitative analysis developed themes. Themes were reviewed by members of the coding team and by the individual who facilitated the interviews to ensure themes aligned with conversations.

[71] Daniels K. Box 4.3, three approaches to analysis in systematic reviews of qualitative studies - evidence synthesis for health policy and systems: A methods guide - NCBI bookshelf. National Center for Biotechnology Information. October 8, 2018. https://www.ncbi.nlm.nih.gov/books/NBK569586/box/ch4.box12/?report=objectonly.

Appendix B: Policy Analysis Approach

Environmental Scan of Policies, Ordinances, and Regulations

The project team conducted a policy environmental scan to assess use of interventional and restrictive policies in West Virginia. In tandem, the team also gathered additional local policy information through a variety of stakeholder engagement activities. Together, this information helped the team understand the landscape of policies in West Virginia, and their effects on not only the population of study, but also the providers and agencies who work to meet residents' needs.

The policy environmental scan included state, counties, municipal websites, and google in addition to two legal databases (Municode and the American Legal Publishing Corporation).[72,73] Municode and ALP host code storage for municipalities in a secure, searchable database for local governments which do not wish to host policies on their own websites. The following search terms were used to find the relevant documents:

> *Homeless, homelessness, housing, unhoused, housing insecurity, affordable housing, chronic homeless, veterans homeless, youth homeless, family homeless, women homeless, LGBTQ+ homeless, racial and ethnic disparities in homelessness, homeless prevention, homeless criminalization, supportive housing, permanent housing, McKinney-Vento Homeless Assistance Act, Continuum of Care, CoC, National Alliance to End Homelessness, National Coalition for the Homeless, housing ordinance, housing code, public welfare codes.*

Focus group participants, partners who were engaged in local-level discussions throughout the work, and key informants from around the state all contributed policy perspectives to the qualitative data that was gathered by the team. This information provided further details and context about how providers, agencies, and the individuals and families they interact with and are affected by policy. Nine focus groups were held in December 2023 and January 2024 to learn from providers, elected officials, municipal leaders, law enforcement, and emergency services. In April and May 2024, 33 key informant interviews were conducted with four generations of individuals experiencing homelessness around West Virginia.

After completion of the policy environmental scan and qualitative data collection, the project team analyzed the regulations and ordinances alongside the federal data. The team sought to understand the goals of policy actions taken by counties and municipalities, as well as any known outcomes and unforeseen repercussions. For example, some places have issued camping bans in an attempt to relocate individuals experiencing homelessness away from areas where they may be thought to be inappropriately congregating, such as near community centers or businesses.

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[72] Municode. CivicPlus. May 16, 2024. https://www.civicplus.com/codification-software-services/.

[73] American Legal Publishing. Accessed June 27, 2024. https://amlegal.com/.

While location goals may be achieved, added distance can make it harder for this population to meet their needs.

Table 18 below presents a list of policy categories, the specific policies within each, and the actions associated with each policy. The research team identified which of these policy actions a county or any of its municipalities had taken. The project team then quantified the policies based on the number of actions in each county or any of its municipalities. For example, if a municipality within a county had enacted a camping ban, it is counted as one restrictive policy for that county. If multiple municipalities within the same county enacted the same policy, such as a camping ban, it still counted as one policy for that county. The number of policy actions quantified for each county provided an overall estimate of interventional policies and restrictive policies across West Virginia.

Table 18: Policy categories and associated actions

Category	Policy	Actions
Interventional Policies	Housing assistance	Emergency shelters
		Temporary shelters
		Transitional housing
		Permanent housing
		Rent assistance
		Homebuying assistance
		Other financial assistance
		Eviction relief
	Supportive services	Physical health care
		Mental health care
		Substance use disorder services
		Domestic violence services
		Food pantries and meals
	Preventive measures	Case management
		Job skills training
		Counseling
		Outreach efforts
		Partnership with agencies
Restrictive Policies	Criminalization	Loitering
		Panhandling
		Trespassing
	Removal	Camping ban
		Encampment removal
		Encampment relocation
		Homeless service ban
		Homeless service relocation
		Homeless service removal
		Housing demolition

Resource Guide

The Homelessness Resource Inventory was developed through the consideration of the legislative language alongside what was learned during outreach early in the project period, which informed an initial list of resource categories. The research team reviewed recipients of federal funding statewide, as well as DoHS and local agency websites to learn about available services throughout the state. Outreach discussions contributed more information to this list throughout the work of the project.

The team considered housing, case management, basic needs, and other resources that may be commonly thought of as those serving this population. Additionally, the Resource Inventory includes behavioral health providers, substance use disorder resources, and medical resources. Sources of information included, but were not limited to:

Table 19: Service categories and information sources

Service Category	Information Source
Community Resources	Catholic Charities WV Community Action Locations Family Resource Network Locations United Way Locations
DoHS Public Information	Aggregate Homeless Shelter Directory Comprehensive Behavioral Health Centers Domestic Violence Shelters Free Health Clinic Locations Health Facility Locations (including SUD) WIC Clinic Locations
State Resources	211 Directory Public Housing Authorities in WV WV Food Link WVARR Certified Program List WV State Veterans Administration
Federal Resources	HUD Data Federal Funding Provided to WV

Table 20: Service categories and description of services

Service Category	Description of Services
Housing	Emergency Shelter Rapid Re-Housing Permanent Supportive Housing Rental and Utility Assistance Public Housing Street Outreach Case Management
Basic Needs	Food/Meals Hygiene Goods/Services Household Necessities Clothing Transportation
Veterans Services	Services for Veterans and their Families
Behavioral Health	Counseling Therapy Intellectual and Developmental Disability Services Crisis Response
Substance Use Disorder	Peer Recovery Services Harm Reduction Treatment - Inpatient Treatment - Outpatient Treatment - Medication Assisted Treatment - Long-Term Residential Recovery Housing Recovery Meetings Prevention Services
Community and Family Resources	Baby/Infant Needs Parenting Services Adult Learning
Domestic Violence	Domestic Violence Shelters
Youth Resources	Emergency Youth Shelters
Medical Resources	Primary Medical Care Dental Services Vision Services Health Education Health Screenings Emergency Services
Vulnerable Populations	Trafficking Survivors Services
Faith-Based Resources	Ministry (Church Services)
Public Assistance Programs	Supplemental Nutrition Assistance Program (SNAP) Payee Services Legal Services
Employment Resources	Job Placement Services Job Training Services Job Interview/Clothing Resources

Appendix C: Number of HMIS Enrollments by Month for Sheltered, Unsheltered, and Permanent Housing

Table 21: The number of project enrollments for each HMIS living situations for each month.

	Year						
Living Situation Characteristics by Monthly and Annual Average	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**All Years (Mean Annual Count)**
Total Enrollments, N	14,458	11,892	8,313	12,833	13,190	10,884	71,570
***Sheltered* Enrollments, % (n)**							
January	11% (1,289)	10% (867)	13% (585)	5% (404)	10% (899)	11% (784)	10% (4,828)
February	10% (1,118)	9% (776)	11% (489)	7% (552)	9% (780)	9% (662)	9% (4,377)
March	11% (1,316)	9% (737)	10% (458)	7% (533)	10% (871)	9% (661)	10% (4,576)
April	11% (1,248)	7% (617)	3% (152)	7% (529)	7% (612)	7% (533)	8% (3,691)
May	11% (1,280)	8% (685)	5% (227)	7% (539)	7% (609)	7% (477)	8% (3,817)
June	8% (980)	8% (657)	7% (340)	8% (559)	9% (788)	8% (572)	8% (3,896)
July	6% (713)	8% (665)	8% (383)	7% (529)	6% (550)	8% (595)	7% (3,435)
August	7% (843)	9% (727)	8% (374)	8% (590)	8% (713)	8% (604)	8% (3,851)
September	6% (663)	10% (832)	9% (419)	7% (502)	6% (551)	8% (574)	7% (3,541)
October	6% (756)	8% (715)	9% (407)	13% (929)	8% (716)	8% (560)	8% (4,083)
November	7% (809)	7% (582)	7% (346)	13% (946)	8% (711)	8% (544)	8% (3,938)

Year							
Living Situation Characteristics by Monthly and Annual Average	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**All Years (Mean Annual Count)**
December	6% (664)	7% (627)	10% (445)	10% (771)	10% (911)	9% (612)	8% (4,030)
Total	81% (11,679)	71% (8,487)	56% (4,625)	58% (7,383)	66% (8,711)	66% (7,178)	67% (48,063)

Unsheltered **Enrollments, % (n)**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**All Years (Mean Annual Count)**
January	7% (56)	6% (71)	7% (111)	4% (127)	13% (324)	8% (148)	8% (837)
February	3% (27)	8% (98)	5% (81)	6% (171)	10% (241)	8% (152)	7% (770)
March	5% (44)	8% (94)	5% (69)	8% (240)	11% (262)	10% (187)	8% (896)
April	9% (76)	11% (124)	6% (88)	7% (199)	9% (216)	9% (169)	8% (872)
May	8% (66)	9% (110)	7% (112)	9% (260)	9% (224)	9% (176)	9% (948)
June	7% (60)	8% (99)	11% (173)	10% (307)	9% (215)	9% (179)	9% (1033)
July	15% (121)	9% (101)	8% (118)	9% (278)	8% (205)	9% (168)	9% (991)
August	15% (124)	9% (104)	10% (154)	11% (324)	9% (212)	10% (188)	10% (1,106)
September	10% (81)	9% (101)	9% (130)	9% (286)	7% (178)	8% (147)	8% (923)
October	9% (72)	10% (113)	12% (178)	10% (310)	6% (142)	8% (161)	9% (976)
November	7% (56)	8% (88)	9% (141)	9% (265)	5% (123)	6% (115)	7% (788)
December	5% (40)	5% (64)	10% (153)	8% (256)	5% (120)	6% (112)	7% (745)
Total	6% (823)	10% (1,167)	18% (1,508)	24% (3,023)	19% (2,462)	17% (1,902)	15% (10,885)

Permanent Housing Enrollments, % (n)	2018	2019	2020	2021	2022	2023	All Years (Mean Annual Count)
January	7% (130)	7% (164)	13% (290)	5% (132)	8% (170)	11% (191)	9% (1,077)
February	7% (137)	9% (197)	10% (211)	6% (153)	9% (183)	7% (122)	8% (1,003)
March	8% (151)	9% (208)	7% (145)	8% (197)	14% (283)	12% (213)	9% (1,197)
April	6% (119)	9% (194)	5% (110)	7% (179)	6% (127)	8% (150)	7% (879)
May	9% (169)	8% (173)	6% (137)	9% (220)	9% (179)	7% (135)	8% (1,013)
June	11% (208)	8% (179)	8% (174)	9% (215)	7% (140)	8% (152)	8% (1,068)
July	8% (162)	8% (188)	6% (128)	10% (246)	6% (114)	8% (146)	8% (984)
August	10% (196)	11% (241)	11% (233)	9% (214)	11% (224)	8% (143)	10% (1,251)
September	9% (170)	7% (165)	7% (159)	12% (300)	6% (125)	8% (144)	8% (1,063)
October	11% (218)	9% (198)	9% (191)	9% (223)	8% (158)	10% (175)	9% (1,163)
November	8% (152)	7% (148)	9% (186)	9% (211)	8% (169)	7% (119)	8% (985)
December	7% (144)	8% (183)	10% (216)	6% (137)	7% (145)	6% (114)	7% (939)
Total	14% (1,956)	19% (2,238)	26% (2,180)	19% (2,427)	15% (2,017)	17% (1,804)	18% (12,622)

***NOTES**: Monthly percent estimates represent the percentage of enrollments that occurred in that month across all years out of the total enrollments for the respective category of living situation (e.g., Sheltered, Unsheltered, or Permanent Housing).*

ASSESSMENT OF WEST VIRGINIA HOMELESS POPULATION

Policy Analysis Report

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

Bureau for Behavioral Health

Assessment of West Virginia Homeless Population

Bureau for Behavioral Health

July 1, 2024

Executive Summary

West Virginia Senate Bill 239 comprises eight objectives addressed in three reports written by the West Virginia University Health Affairs Institute for the West Virginia Bureau for Behavioral Health (BBH). This report includes findings for Legislative Objectives 2 and 5 through 8.

- **Legislative Objective 2:** Quantify and inventory homelessness resources by region
- **Legislative Objective 5:** Conduct an analysis of whether West Virginia's homeless populations concentrate in certain counties or municipalities and any reasons for such population concentrations
- **Legislative Objective 6:** Determine if state policies cause the state's homeless population to relocate to certain counties or municipalities
- **Legislative Objective 7:** Determine the percentage of homeless individuals that lived in another state or jurisdiction in the past three years or are from another state or jurisdiction
- **Legislative Objective 8:** Conduct an analysis of whether any health and human services benefits offered in West Virginia attract populations that are homeless or at risk of homelessness

Please note: sources used in this Executive Summary are cited in the body of the report.

Background

In the United States, policies directly related to homeless populations are typically understood within the framework of three federal definitions of the term "homeless." These are used across federal agencies and the organizations they fund. This report primarily focuses on literal homelessness, defined by HUD as an individual or family who lacks a fixed, regular, and adequate nighttime residence.

The HEARTH Act consolidates multiple HUD programs into the Continuum of Care (CoC) program, which provides funds to programs and services for individuals experiencing homelessness. CoCs are integrated systems that track clients over time across an array of agencies and services. There are four Continuums of Care in West Virginia referenced throughout the report.

- Cabell-Huntington-Wayne CoC (CHW)
- Kanawha Valley Collective CoC (KVC)
- Northern Panhandle CoC (NPH)
- Balance of State CoC (BoS), divided into eight geographic regions

Overview of Study Design, Collected Data, and Secondary Data

This assessment used existing numeric data from the Homelessness Management Information System (HMIS) and qualitative data collected at the end of 2023 through the beginning of 2024 through 33 interviews with individuals who were currently or had recently experienced homelessness and nine focus groups with homelessness and community service providers, law enforcement, and elected officials from across West Virginia. HMIS information is collected

continuously and at each time an individual enrolls in a project using HMIS. Data analyzed for this report were collected January 1, 2018 through December 31, 2023. Because individuals may enroll in multiple projects, information from the most recent project entry date (or most recent enrollment) was used for counts of individuals. When presented by geographic location, counts of clients from one through 10 are suppressed or not shown to protect individual privacy.

The HMIS is one of the main sources of data used in assessing homelessness throughout the United States. The other two data sources often used were also used for this report which include Point-in-Time (PIT) and Housing Inventory Counts (HIC). PIT and HIC counts are conducted at the same time in January each year. PIT counts include sheltered and unsheltered people experiencing homelessness. HIC includes the number of housing units and beds for people who are or were experiencing homelessness. CoCs are required to conduct PIT counts for sheltered people and HIC once each year in January. PIT counts of unsheltered people are required every other year in January. HUD offers CoCs incentives for conducting annual PIT counts that include people who are unsheltered.

Policies related to homelessness exist across multiple levels of authority, including federal, state, county, and municipality. Multiple policies may exist that address the same issue simultaneously and may overlap with one another. An environmental scan reviewed policies and ordinances at the federal, state, and county level to better understand the landscape of laws affecting this population. The scan explored policies in the municipalities within the 10 most populous counties in West Virginia, in addition to two other larger municipalities – Weirton in Brooke County and Wheeling in Ohio County. In total, the study covers 55 counties and 66 municipalities. Policies were divided into two categories. Interventional policies aim to mitigate the causes of homelessness, to help address issues that can be exacerbated by homelessness or prevent someone from exiting homelessness, or to provide housing and other services to individuals experiencing or at-risk of homelessness. Restrictive policies aim to approach homelessness through relocation of individuals experiencing homelessness away from public spaces, preventing groups from gathering in specific areas, or minimizing community interactions such as panhandling. These policies are by design aimed at demotivating people experiencing homelessness from choosing such locations.

To better understand potential resources available to individuals experiencing or at risk of homelessness, federal, state, and local sources were explored and an inventory of service providers and other entities were captured and organized into 12 categories: housing services, basic needs, veterans' services, behavioral health providers, substance use disorder resources, community and family resources, domestic violence resources, youth resources, medical resources, entities serving vulnerable populations, faith-based resources, and public assistance programs. Information collected was used to create a compendium of services or service guide. Locations of services from the guide were cross walked with the locations of populations experiencing or at-risk of homelessness.

Key Findings

Analysis of Whether West Virginia's Homeless Populations Concentrate in Certain Counties or Municipalities

- People experiencing literal homelessness are generally concentrated in the most populous counties with larger cities and metropolitan areas. Where there are more people, there are more likely to be more people experiencing homelessness and potentially more resources, economic opportunities, and transportation networks with public transportation options.
- Each CoC coverage area in West Virginia contains at least one Metropolitan Statistical Areas (MSAs) or urban area with high population densities that are connected by transportation networks, high densities of housing, contain central business districts, industries, and large economic markets. Just as MSAs are attractive to all residents, they are also attractive and essential for West Virginians experiencing homelessness who have immediate needs for housing, employment opportunities, access to health providers, treatment facilities, and social support.
- Of the 10 MSAs at least partially located within West Virginia, six of the 10 include residents from West Virginia and at least one additional neighboring state.
- In all but eight counties, there was at least one HMIS client experiencing literal homelessness based on their most recent enrollment. The six counties with the highest county populations in West Virginia based on the 2020 U.S. Census also had the highest counts of clients in HMIS. Half of those counties are found within MSAs, two of which include other states (Ohio and Maryland).

Quantifying and Inventorying Homelessness Resources by Region and Analyzing Potential Reasons for Concentrations of Homeless Populations

Basic Needs

- Resources that provide basic needs for people experiencing homelessness appear to be the most concentrated in four of the state's 10 most populous counties: Kanawha, Monongalia, Mercer, and Ohio. This may reflect a greater availability of resources within them because of their urban centers. Generally, urban areas tend to have more resources of certain types than rural communities.
- Interviewed individuals discussed a wide range of basic needs, such as accessing food and blankets. Some noted differences in available services for meeting basic needs depending upon where in the state someone might be experiencing homelessness. Focus group participants shared serious repercussions that could come from limited resources and discussed service provider challenges related to having the funds to meet the amount of need in their communities.
- While provider perceptions of need varied, they agreed that more services are still needed, especially given some individuals' complex circumstances that might include chronic health conditions, mental and behavioral health disorders, and/or involvement with the criminal justice system.
- Many individuals experiencing homelessness would benefit from support with basic necessities and assistance with transportation. One way to facilitate access is to continue

to cluster needed services in population centers where individuals experiencing homelessness already reside.

Mental Health

- Within HMIS, mental health disorder is a broad category and does not refer to a specific mental or behavioral health condition but allows clients to self-report conditions that range from situational depression to serious mental illnesses. Mental health services appeared to concentrate in Cabell, Kanawha, Wood, and Ohio counties, and similar patterns were observed in the density of individuals experiencing literal homelessness and reporting a mental health disorder at most recent intake.
- Some interviewed individuals indicated mental health needs were a factor in their becoming or remaining homeless. Service providers who participated in focus groups also noted that many of the individuals they serve either have mental health challenges, use substances, or both, and that individuals with mental health issues may self-medicate with substances.
- Focus group participants identified addiction and mental illness as major causes of homelessness, with some participants noting there are not enough services available for those with mental health or addiction needs in general, and there is limited support to sustain treatment for individuals experiencing homelessness along with substance use and/or mental health issues.

Providers of Services Related to Substance Use Disorder

- For comparisons of substance use disorder service providers with individuals experiencing homelessness, only counts of individuals who were experiencing homelessness and who self-reported a substance use disorder at their most recent intake were included. Substance use disorder resources appeared to be concentrated in Kanawha and Cabell counties. Raleigh and Monongalia counties also appeared to have more of these services than other parts of the state. As with other services, there was a similar pattern in density in terms of counties with a greater number of substance use disorder resources and counties with a greater number of clients with a substance use disorder.
- Statewide, information collected through interviews and focus groups indicated substance use disorder as a driver of homelessness and a key barrier to individuals exiting homelessness. Some interviewed individuals spoke of using and seeking treatment for substances, including substance use playing a role in their becoming homeless. Focus group participants noted that many individuals experiencing homelessness fell into addiction or were experiencing homelessness because of addiction.

Medical Resources

- Counties with more medical resources were often also counties and population centers with more HMIS clients with chronic health conditions at their most recent intake. While at least one medical resource was found in every county, it is important to note these services

may vary widely and additional exploration by provider type, or qualitative research about these resources, may offer richer understanding.

Assessing the Impact of State and Local Policies on Homeless Policy Relocation

- Multiple counties and municipalities implemented interventional policies and ordinances aimed at mitigating the causes of homelessness. These measures included rental assistance in six counties, permanent housing assistance in five counties, and homebuyer's assistance in four counties. There were several counties across West Virginia where no policies were identified.
- In general, counties issued more ordinances regarding housing assistance than other types of interventional policies.
- In terms of restrictive policies, camping bans were the most common restrictive action taken, followed by penalization of loitering, panhandling, and trespassing. Counties with the most restrictive policies also tended to have the most individuals experiencing homelessness. This may suggest counties with increased numbers of individuals experiencing homelessness are more likely to adopt restrictive policies, but it is unclear from this analysis how these policies affect these populations.
- Qualitative data supported the notion that people do sometimes relocate to be able to access a shelter bed or other housing options.

Relocation to West Virginia from Out-of-State

- HMIS collects information on whether someone has moved in the past two years, both within West Virginia and across state lines. It also asks whether this was for services, family, or some other reason. This question is not required for funding and may not be prioritized due to the time needed to complete questions required for funding reporting. In addition, people who indicated they had not moved in the past two years sometimes went on to say why they were in their current location. In these cases, the reason given was treated as why they stayed in their community, or why they had moved to it prior to the past two years.
- In WV, most providers entering data into HMIS did not collect responses to optional HMIS relocation questions at enrollment. From 2020 through 2023, just one third (30%) of records for clients experiencing homelessness included responses (4,804 out of 15,786 records).
- Data regarding whether individuals moved in the past two years was provided by only a small portion of those in HMIS. When looking at individuals who had provided information related to relocation at intake, services were the top reason individuals indicated they were in their current county. Of those experiencing homelessness, 4% indicated moving to another county to access a service, while 1% for family and other reasons. In terms of moving from out of state, 3% of individuals experiencing homelessness indicated having moved to access services, while 2% moved to West Virginia for family and other reasons.

- Data from interviews and focus groups suggests that migration goes both ways and has more to do with proximity to a shelter bed than with state borders. This data also suggests that migration also includes rural to urban – homeless residents of these counties often relocate to larger municipalities for shelter, regardless of state borders.

Analyzing the Attraction of Health and Human Services Benefits

- Of the 999 individuals who had moved from one county to another in the previous two years, 4% of them said they did so to seek services, and out of 1,245 individuals who had moved from out of state in the previous two years, 3% arrived in West Virginia seeking services of some kind.

- Interviewed individuals indicated a variety of reasons for moving to West Virginia, and it was sometimes for services but more often for other reasons, such as to be near family. Focus group participants also spoke of places where services do not exist at all – e.g., rural residents or providers who live in counties with no shelter – and sometimes moves were to access services that exist but that could not serve all participants due to capacity, barriers to entry, limited funding, or other issues.

Conclusions

People experiencing literal homelessness generally concentrated in the most populous counties with larger cities and metropolitan areas. Services also appeared to be most readily available in these areas. While provider perceptions of need varied, they agreed that the resources available were not enough to adequately address existing needs. This is especially true with complex clinical circumstances that might include chronic health conditions, mental and behavioral health disorders, or substance use disorder. It is equally complicated when serving those involved with the criminal justice system, and those whose networks of relationships and support have been ravaged by substance use.

Policies and ordinances related to homelessness – or which frequently affect these populations – were a mix of interventional and restrictive. Across the state, the most common interventional policy was rental assistance, followed by permanent housing, homebuyer's assistance, and temporary shelter. Most interventional actions were in McDowell, Pendleton, and Morgan counties. These are counties where HMIS data reflects relatively few individuals experiencing homelessness. Restrictive policies tended to be camping bans followed by criminalization of panhandling and of trespassing. Counties with the most restrictive policies were Kanawha and Mercer. Counties with larger populations of individuals experiencing homelessness also had more restrictive policies.

People moved for a variety of reasons, most specifically to be near family or to access services. Many people experiencing homelessness in West Virginia are from West Virginia or have lived in the state for a long time. Of those who are moving from other states, this may partly relate to counties and communities sharing a state line with communities in other states.

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Document Acronyms

The following acronyms are used throughout this document:

Acronym	Definition
DoHS	West Virginia Department of Human Services
WVU	West Virginia University
MATCH	Mountain State Assessment of Trends in Community Health
HIC	Housing Inventory Count
HMIS	Homeless Management Information System
PIT	Point-in-Time
CoC	Continuum of Care Organization

Project Purpose

West Virginia Senate Bill 239 outlined eight objectives to better understand homelessness in the state. Each objective is addressed through a study and included in one of three reports, the Metrics Report, the Homelessness Demographic Report, and the Policy Report. How each report works to answer the eight objectives is outlined below:

Table 1:Assessment of West Virginia Homeless Population Reports

Report Name and Purpose	Legislative Objectives
Report 1: Homelessness Metrics, Consensus Building Findings Detailed Report • Key metrics to measure and define homelessness consistently.	**Legislative Objective 4:** Identify key metrics to measure homelessness across West Virginia in a more consistent manner
Report 2: West Virginia Homelessness Demographic Detailed Report • Demographic information • Epidemiological analysis • Location and relocation information	**Legislative Objective 1:** Present a breakdown of homelessness demographic information throughout West Virginia and regionally
	Legislative Objective 3: Conduct an epidemiological analysis of homeless populations in West Virginia
Report 3: Exploration of Policies Related to Homelessness • Resources by region • Concentrations of individuals experiencing homelessness (and possible reasons)	**Legislative Objective 2:** Quantify and inventory of homelessness resources by region
	Legislative Objective 5: Conduct an analysis of whether West Virginia's homeless populations concentrate in certain counties or municipalities and any reasons for such population concentrations
	Legislative Objective 6: Determine if state policies cause the state's homeless population to relocate to certain counties or municipalities
	Legislative Objective 7: Determine the percentage of homeless individuals that lived in another state or jurisdiction in the past three years or are from another state or jurisdiction
	Legislative Objective 8: Conduct an analysis of whether any health and human services benefits offered in West Virginia attract populations that are homeless or at risk of homelessness

Background

Description and Definitions of Homelessness

In the United States, demographic information about individuals experiencing homelessness is typically viewed within the framework of three federal definitions of the term "homeless" (Table 2). These definitions are used across federal agencies and by the state-level organizations they fund, and they dictate who is eligible for services through their funding opportunities to states and agencies. This means that while federal definitions do generally apply to those experiencing homelessness in West Virginia, they may not always adequately capture the complexities of this population. In addition, while the federal definitions do not outright exclude any particular sub-populations or groups, there are often scenarios where an individual or family's situation may exclude them from services as the definitions are currently written.[1]

These federal definitions dictate who is eligible for services through their funding opportunities to states and agencies. The three definitions are the education definition included in the McKinney-Vento Act, the U.S. Department of Housing and Urban Development (HUD) definition included in the Homelessness Emergency Assistance and Rapid transition to Housing (HEARTH) Act, and the Runaway and Homeless Youth Act (RHYA) definition. [2,3,4,5] The HEARTH Act consolidates the HUD programs administered by the McKinney-Vento Act into the Continuum of Care (CoC) program.[6] This program provides funds to nonprofit providers, states, Indian Tribes, or tribally designated housing entities, and local governments to provide access to programs and services to individuals experiencing homelessness.[7] The HEARTH Act amended previous definitions of the term "homeless" as well as "at risk of homelessness," including definitions from other statutes, such as RHYA and the Violence Against Women Act.[8] Changes under the HEARTH Act allow for greater response to the needs of those facing homelessness in America.

[1] Sullivan, A. A. (2023). What Does it Mean to be Homeless? How Definitions Affect Homelessness Policy. Urban Affairs Review, 59(3), 728-758. https://doi.org/10.1177/10780874221095185
[2] The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/
[3] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/
[4] The McKinney-Vento Homeless Assistance Act amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. https://www.hud.gov/sites/documents/HAAA_HEARTH.PDF
[5] The Runaway and Homeless Youth Act. Updated 2023. National Center for Homeless Education. Retrieved November 15, 2023. https://nche.ed.gov/legislation/runaway-youth/
[6] The McKinney-Vento homeless assistance act, as amended by S. 896 homeless emergency assistance and rapid transition to Housing (Hearth) Act of 2009 - Hud Exchange. HUD Exchange. May 2009. https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/
[7] Continuum of Care Program. HUD.gov / U.S. Department of Housing and Urban Development (HUD). Retrieved November 15, 2023. https://www.hud.gov/program_offices/comm_planning/coc.
[8] The McKinney-Vento Homeless Assistance Act As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009. https://www.hud.gov/sites/documents/HAAA_HEARTH.PDF

Table 2: Definitions of homelessness

Federal Statutory Reference	Definition	Living Situations Covered
McKinney-Vento[9] *Section 725 of Subtitle VII-B of the McKinney-Vento Act*	Individuals who lack a fixed, regular, and adequate nighttime residence[9]	**1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Motels and Hotels; and **5)** Staying with Others ("Doubled-Up") **Federal Programs and Agencies Using This Definition:** *Elementary and Secondary Education (ED), Individuals with Disabilities Education Act, Higher Education Act (ED), Head Start Act (HHS), Child Nutrition Act (USDA), Violence Against Women Act (DOJ)*
HUD[10] *Section 103 of Subtitle 1 of The McKinney-Vento Homeless Assistance Act As amended by S. 896 The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009*	The condition of people who lack a fixed, regular, and adequate nighttime residence[10]	**1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Hotels and Motels, if: • Rooms are paid for by programs or organizations • The individual or family cannot afford the room beyond 14 days and cannot otherwise obtain housing • The individual or family is fleeing domestic violence or other life-threatening conditions and has nowhere to stay • Unaccompanied youth or families with youth are homeless or have barriers to stable housing and **5)** "Doubled-Up", if: • Loss of housing is imminent after the next 14 days • The individual or family is fleeing domestic violence or other life-threatening conditions and has nowhere to stay • Unaccompanied youth or families with youth are homeless or have barriers to stable housing This definition also includes children and youth who are at risk of homelessness, with or without their families, for a variety of reasons defined under other federal statutes.

[9] The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

[10] HUD's Definition of Homelessness: Resources and Guidance. Updated 2019. HUD Exchange. Accessed November 15, 2023. The McKinney-Vento Homeless Assistance Act. Updated 2023. National Center for Homeless Education. Accessed November 15, 2023. https://nche.ed.gov/legislation/mckinney-vento/

		Federal Programs and Agencies Using This Definition: *Homeless Assistance Programs (HUD)*
RHYA[11] *Section 387 of the Runaway and Homeless Youth Act*	Individuals (under age 21) for whom it is not possible to live in a safe environment with a relative and who have no other safe alternative living arrangement[11]	If a youth cannot live with relatives and has no other place to go, this definition covers: **1)** Unsheltered Locations; **2)** Emergency Shelters; **3)** Transitional Housing; **4)** Motels and Hotels; and **5)** "Doubled-Up." This definition also covers "youth at risk of separation from family" as defined under this statute. **Federal Programs and Agencies Using This Definition:** *Runaway and Homeless Youth Act Programs (HHS)*

[11] The Runaway and Homeless Youth Act. Updated 2023. National Center for Homeless Education. Retrieved November 15, 2023 from https://nche.ed.gov/legislation/runaway-youth/

Project Funding and Key Collaborators

The Assessment of West Virginia Homeless Population project is funded by the West Virginia Department of Human Services. The West Virginia University Health Affairs Institute worked closely with key collaborators to ensure the scope and accuracy of the assessment. These included the West Virginia Department for Human Services (DoHS), Bureau for Medical Service (BMS) and Bureau for Behavioral Health (BBH), for whom this reporting was completed, along with representatives of the state's four Continuums of Care: Balance of State CoC, Cabell-Huntington-Wayne CoC, Kanawha Valley Collective CoC, the Northern Panhandle CoC, and many stakeholders across the state who were invested enough to provide their time and insights.

The project team is grateful for the contributions of many others who directly serve West Virginians every day, and who generously shared their time, expertise, and recounted what each of their unique communities has been experiencing: elected officials and other municipal leaders, members of law enforcement and emergency services, and local service providers of all kinds.

Thirty-three individuals spanning four generations sat down with members of this project team to share their personal experiences of homelessness among the hills of West Virginia. To those individuals who took time away from their day-to-day priorities of working, parenting, caregiving, and surviving without the safety and security of home, we extend our deepest gratitude.

Overview of Study Design, Collected Data, and Secondary Data

Study Design: Environmental Scan of Ordinances and Policies Related to Homelessness in West Virginia

To meet the objectives outlined in this report, the project team used a mixed methods approach. This meant pairing quantitative (or numerical) information provided by individuals at intake for program services with qualitative information collected through interviews with individuals experiencing homelessness and focus groups with service providers, emergency medical services, law enforcement, and elected officials or other municipal leaders. This approach was selected to ensure the team gathered the most complete picture possible related to the objectives and was able to provide context around them. This section provides an overview of the approach. For a more detailed description of the methods used across reports, please see Appendices A and B.

It is necessary to read this report with the context that the policy scan was conducted by the project team in late fall 2023, when the climate around these issues was changing and new policies were in various stages of development. For example, the city of Wheeling implemented a camping ban during the writing of the report in early 2024, so it is not reflected in the policy scan sources. Also of note is timing of this work with *Johnson vs. Grants Pass*, a Supreme Court case discussed below and potentially affecting the sort of policies discussed within this report. This case was taken up after the completion of the work reported here. The intended audiences of this report may at once be reviewing these findings, the outcomes of the federal court case, and any possible new local policy options resulting from its determinations.

It is also important to understand how the project team determined the location of a particular policy. For the purposes of this work, a policy was counted only in its county of origin, but not in additional counties or municipalities that may be part of a broader service area. For example, an organization which could potentially provide housing support services to a broad multi-county service area was counted only once in the county where it is physically located. Altogether, this means that policies cited within this report may have changed during the course of conducting the work, or may apply to areas, individuals, and families beyond what is cited here.

Issues related to homelessness are regulated by policies across multiple levels of authority, including federal, state, county, and municipality. Multiple policies may exist that address the same issue simultaneously and may overlap with one another, covering different jurisdictions and geographic areas. To complete this report, the project team conducted an environmental scan, reviewing policies and ordinances at the federal, state, and county levels to better understand the landscape of laws affecting this population. The scan explored policies in the municipalities within the 10 most populous counties in West Virginia, in addition to two other larger municipalities – Weirton in Brooke County and Wheeling in Ohio County. In total, the study covers 55 counties and 66 municipalities. The project team searched for and identified policies that named or directly addressed homelessness, such as bans against sleeping in public places, as well as less direct policies or those that may not have named homelessness specifically, such as ordinances against panhandling. Further details of the methods for conducting this environmental scan are found in Appendix B.

Qualitative Evaluation of Ordinances and Policies Related to Homelessness

In addition to existing publicly available and other secondary data, themes from qualitative data were used to provide context for and to better understand the quantitative findings. Qualitative data were gathered via nine focus groups with service providers, elected officials, law enforcement, Emergency Medical Services (EMS) assorted service providers in December 2023 and January 2024, and by conducting key informant interviews with 33 individuals experiencing homelessness, or who have been recently housed after a period of homelessness. Focus group participants and key informants provided additional information and context about existing policies, things working and not working well in their communities, and their own suggestions for improvement. Qualitative information was gathered from across the state of West Virginia. Project plans were reviewed by West Virginia University's Institutional Review Board. To ensure more accurate responses and to maintain relationships for any future studies, the information collected is confidential. Any information in quotes that could lead to identification has been removed. In addition. In addition, quotes are used throughout the report and reflect the grammar and speech patterns of the participants.

Homelessness Resource Inventory

Part of Senate Bill 239 tasked DoHS with quantifying and inventorying homeless resources by region. To accomplish this, the project team used federal, state, and local sources to assemble a list of potentially available resources to meet the needs of those experiencing or at risk of homelessness. Also included were agencies and providers identified through outreach communications.

Service providers and other entities included in this guide were organized into 12 categories: housing services, basic needs, veterans' services, behavioral health providers, substance use disorder resources, community and family resources, domestic violence resources, youth resources, medical resources, entities serving vulnerable populations, faith-based resources, and public assistance programs. In addition to functioning as a resource, this guide was used to create a crosswalk of service locations and locations of populations who need those services.

Federal Data

Providers of services that receive HUD funding to address homelessness are required to routinely report client information to HUD. Three sources of this data collected by CoCs are used or referenced throughout this report:

1) Homeless Management Information System (HMIS),
2) Point-in-Time (PIT) counts, and
3) Housing Inventory Counts (HIC).

HMIS is a local information technology system that HUD-funded projects and their HMIS participating federal partners must use to track client level data for reporting purposes.[12] Data are collected year-round as services are provided, and, by design, can also provide an unduplicated count of individuals, information on demographics, and data on service needs over time. Annual PIT counts and HIC are conducted at the same time in January each year. PIT counts are reported to the U.S. Congress annually and are available to the public. They are the main source of data used in analyses of information about people experiencing homelessness in the U.S.

HMIS includes individual client level information, which is used to produce demographic, epidemiological, and geographic estimates for populations experiencing homelessness. Maintaining data in HMIS is required by the HEARTH Act. [13] The HEARTH Act governs CoCs and providers which receive funds from the CoC Program or Emergency Solutions Grants.[14] HUD partners with other federal agencies, listed below, to establish HMIS requirements and ensure data are available to fulfill congressional mandates for the Annual Homelessness Assessment Report (AHAR) to the U.S. Congress. In addition to HUD offices, other federal agencies that utilize HMIS are the U.S. Department of Veterans Affairs (VA), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Family and Youth Services Bureau (FYSB).[15] HUD programs that utilize HMIS include Housing Opportunities for Persons with AIDS (HOPWA) and HUD-Veterans Affairs Supportive Housing (HUD-VASH).

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[12] WV Balance of State Homeless Management Information System. Accessed June 21, 2024. https://www.wvboshmis.org/.
[13] The McKinney-Vento homeless assistance act, as amended by S. 896 homeless emergency assistance and rapid transition to Housing (Hearth) Act of 2009 - Hud Exchange. HUD Exchange. May 2009. https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/.
[14]HMIS Requirements. HUD Exchange. Accessed May 8, 2024. https://www.hudexchange.info/programs/hmis/hmis-requirements/
[15] Federal Partner Participation. HUD Exchange. https://www.hudexchange.info/hmis/federal-partner-participation/

Client information is collected by the local service provider upon entry into a program and entered into HMIS. HMIS data collection and management is overseen by an HMIS Lead. There is a lead designated for each CoC (Table 3), and each CoC uses HUD guidance to determine the software used to collect the required HMIS data. HUD publishes data standards, which include the requirements for client information that must be recorded in HMIS. [16]

Table 3: WV Continuums of Care

Continuum of Care	HMIS Lead
Cabell-Huntington-Wayne	The Cabell-Huntington-Wayne Coalition for the Homeless
Kanawha Valley Collective	Kanawha Valley Collective, Inc.
Northern Panhandle	The City of Wheeling
Balance of State	West Virginia Coalition to End Homelessness

The PIT counts include sheltered and unsheltered people experiencing homelessness at a designated point in time. HIC includes the number of housing units and beds for people who are experiencing and/or who were experiencing homelessness. CoCs are required to conduct PIT counts for sheltered people and HIC once each year in January. PIT counts of unsheltered people are required every other year in January.[17] However, HUD offers CoCs incentives for conducting annual PIT counts that include people who are unsheltered.[18] Both PIT and HIC estimates are included in the Annual Homelessness Assessment Report (AHAR) presented by HUD to the U.S. Congress. [19]

Each CoC has the choice of using their HMIS data to generate their PIT sheltered counts. There is flexibility in the ways CoCs can collect counts of unsheltered individuals based on the geography of the CoC's coverage area and concentration of individuals.[20] This includes a complete coverage approach where all unsheltered individuals are attempted to be visited and counted during one night in January. The count is based on individual encounters or known locations identified by previous outreach efforts. Another acceptable approach is using a service-based approach which allows monitoring service locations where unsheltered people are known to visit over a period of seven days after the count night. CoCs can employ a combination of random samples, visiting known locations, or a service-based approach for less population dense or large areas.

[16] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.
[17] Point-in-Time Count and Housing Inventory Count. https://www.hudexchange.info/programs/hdx/pit-hic/#pit-count-and-hic-guidance-and-tools
[18] Office USGA. Homelessness: Better HUD Oversight of Data Collection Could Improve Estimates of Homeless Population. 2020. GAO-20-433. July 14. https://www.gao.gov/products/gao-20-433
[19] AHAR reports - Hud Exchange. HUD Exchange. https://www.hudexchange.info/homelessness-assistance/ahar/.
[20] Point-in-time count methodology guide HUD Exchange. https://www.hudexchange.info/resource/4036/point-in-time-count-methodology-guide/.

Both HMIS and PIT collect information about an individual's living or sleeping situation, chronic homelessness, demographics, benefits, physical, mental, and behavioral health status, and location. HMIS data can also include additional details required for specific programs funded by HUD or other federal agency projects. For example, projects using Housing Opportunities for Persons with AIDS (HOPWA) funding are required to collect HIV status of each client. [21]

A recent study of data quality by the United States Government Accountability Office (GAO) found HMIS and HIC provided more reliable and comprehensive data on sheltered homelessness than PIT counts.[22] While PIT counts capture unsheltered individuals who are not enrolled in programs and thus not captured through HMIS, PIT counts were still found to be less reliable when comparing counts between years. The GAO attributed variation in counts between years to several factors including numbers of people that participated in data collection, acclimate weather events, and visibility of unsheltered people experiencing homelessness. Additionally, GAO found that urban counts displayed less variation year-to-year than suburban and rural counts.

In this report, HMIS data was the main source of data, because it is collected throughout the year, and provides more detailed information on living situations and county location. This level of detail was necessary for comparisons of service availability and concentrations of people experiencing homelessness throughout WV. HIC data were used as a main source of housing resources which included the Homelessness Resource Inventory. They were also used to supplement program county information about client location during intake if it was missing from HMIS, but the project ID was known and could be matched to HIC information. For more detailed information on HMIS data analyses see the Homelessness Demographic Report.

A period of six years from 2018 through 2023 was used to account for the impacts of COVID-19 on HMIS enrollments by including pre- and post-COVID-19 data. The analysis of HMIS data in this report shows how many individuals accessed CoC services through a HUD funded housing project over a period of six years, from January 1, 2018 until December 31, 2023. Some individuals had project enrollment dates before 2018 but continued to be enrolled in a project on Jan. 1, 2018; these individuals were included in the dataset.

Because HMIS data are continuously collected when individuals enroll in projects, some individuals were enrolled in multiple projects during the time period covered in the data set. For accurate demographic information, it was necessary to reduce duplicate enrollments so that information for each individual was counted only once. HMIS data standards instruct that any updates to client information such as life experiences, health conditions, or insurance coverage be updated at enrollment. Thus, information collected at the most recent enrollment was used to reflect the most up-to-date picture of client information. In cases where individuals had multiple enrollments, the information from the most recent project entry date was used for counts of individuals.

[21] Housing Opportunities for Persons With AIDS. HUD Exchange. https://www.hudexchange.info/programs/hopwa/
[22] Office USGA. Homelessness: Better HUD Oversight of Data Collection Could Improve Estimates of Homeless Population. 2020. GAO-20-433. July 14. https://www.gao.gov/products/gao-20-433

Overview of Trends in Policies Related to Homelessness

Policies affecting those experiencing or at risk of homelessness are dynamic, changing with the economic climate and social forces. These policies can be laws or ordinances related to the rights of an individual, documentation requirements for accessing housing or healthcare, policies designed to address use of public spaces, and more. Federal, state, and municipal-level policies can directly affect this population, sometimes in ways that overlap or that can change within a short period of time.

At the writing of this report, policies related to homelessness are of interest at the level of the United States Supreme Court, which has begun to hear evidence in the landmark case of *Johnson vs. Grants Pass*. This case addresses municipalities' abilities to bar individuals from sleeping and camping in public spaces using rudimentary protection from the elements, or in vehicles parked in these spaces, in municipalities that do not have emergency shelter services. Grants Pass is a city in Oregon whose population size is between that of Morgantown and Huntington. The case questioned whether five municipal ordinances, and strict city enforcement of them, inappropriately penalized individuals experiencing homelessness in a city that offered no shelters for those experiencing homelessness. While this case does not establish the right for persons who are involuntarily homeless to sleep any place they choose, nor does it require jurisdictions to cede public spaces to these populations, the outcome of it could be highly impactful. A Supreme Court decision is expected by summer of 2024.[23] The outcomes may have sweeping impacts on cities and towns across the nation, including West Virginia. Municipalities that have existing policies governing camping in public spaces may need to revisit/revise these regulations, and residents who shelter in these types of situations may face a change in circumstances overnight.

For the purpose of reviewing policies for this report, the evaluation team considered policy through two broad criteria: interventional and restrictive. These policies are found in laws, regulations, rules, and ordinances at the federal, state, county, and municipal levels.

Interventional policies aim to mitigate the causes of homelessness, to help address day-to-day issues that can be exacerbated by homelessness or prevent someone from exiting homelessness, or to provide housing and other services to individuals experiencing or at-risk of homelessness. These policies are largely designed to support people while they are homeless or if they are at risk of being homeless. Policies in this category include:

- Housing Assistance: emergency, temporary, transitional, and permanent housing assistance.
- Supportive Services: services that help individuals experiencing homelessness address day-to-day challenges that may affect anyone, such as physical and mental health issues, substance use issues, food insecurity, and domestic violence.
- Prevention Measures: services that can help prevent homelessness, such as case management, counseling, job training, and outreach efforts.

[23] City of Grants Pass, Oregon, Petitioner v. Gloria Johnson, et al., on Behalf of Themselves and All Others Similarly Situated. https://www.supremecourt.gov/docket/docketfiles/html/public/23-175.html

Restrictive policies aim to approach homelessness through relocation of individuals experiencing homelessness away from public spaces, preventing groups from gathering in specific areas, or minimizing community interactions such as panhandling. These policies are by design aimed at demotivating people experiencing homelessness from choosing such locations for their day-to-day activities. The most common policies in this category are:

- Criminalization: laws and regulations that criminalize or restrict activities individuals experiencing homelessness engage in for survival or day-to-day existence, such as loitering, trespassing, panhandling, or camping in public spaces.
- Removal: the relocation of homeless services and/or encampments to designated areas with the goal of removing individuals experiencing homelessness and/or service providers from business districts or specific neighborhoods.

Table 4: Definition of Interventional and Restrictive Types of Policies

	Policy Type	
	Interventional	**Restrictive**
Definition	Aim to mitigate the causes of homelessness, to help address day-to-day issues which can be exacerbated by homelessness or prevent someone from exiting homelessness, or to provide housing and other services to individuals experiencing or at-risk of homelessness.	May focus on relocation of individuals experiencing homelessness away from public spaces, on preventing groups from gathering in specific areas, or on minimizing community interactions such as panhandling.
Examples	**Housing Assistance:** emergency, temporary, transitional, and permanent housing assistance. **Supportive Services:** services that help individuals experiencing homelessness address day-to-day challenges that may affect anyone, such as physical and mental health issues, substance use issues, food insecurity, and domestic violence. **Prevention Measures:** services that can help prevent homelessness, such as case management, counseling, job training, and outreach efforts.	**Criminalization:** laws and regulations that criminalize or restrict activities individuals experiencing homelessness engage in for survival or day-to-day existence, such as loitering, trespassing, panhandling, or camping in public spaces. **Removal:** the relocation of homeless services and/or encampments to designated areas with the goal of removing individuals experiencing homelessness and/or service providers from business districts or specific neighborhoods.

Interventional and restrictive policies can have positive and negative impacts on populations experiencing homelessness. For example, a policy decision in 2012 required HUD-funded services to be organized into state-level Continuum of Care (CoC) Programs.[24] This is an interventional policy strategy that aims to assist individuals and families experiencing homelessness with service needs, and more broadly work to promote community-wide planning, strategic use of resources, improvements to coordination and integration between programs, improvements to data collection, and allow each community to tailor programs according to its own strengths and challenges.[25] Conversely, restrictive policy decisions have driven higher rent prices and mortgage rates, while housing stock decreases, leading to a lack of affordable housing for many individuals and families.[26]

One of the strongest policy actions to support homeless populations is to address the lack of affordable housing for low-income households.[27] For example, there are four federally-funded programs that provide housing for more than 5 million people nationwide: Tenant-Based Rental Assistance, Project-Based Rental Assistance, Public Housing Operating Funds, and Public Housing Capital Grants.[28] Assistance programs like these remove barriers to accessing housing, such as rent or utility deposits, for individuals and families.

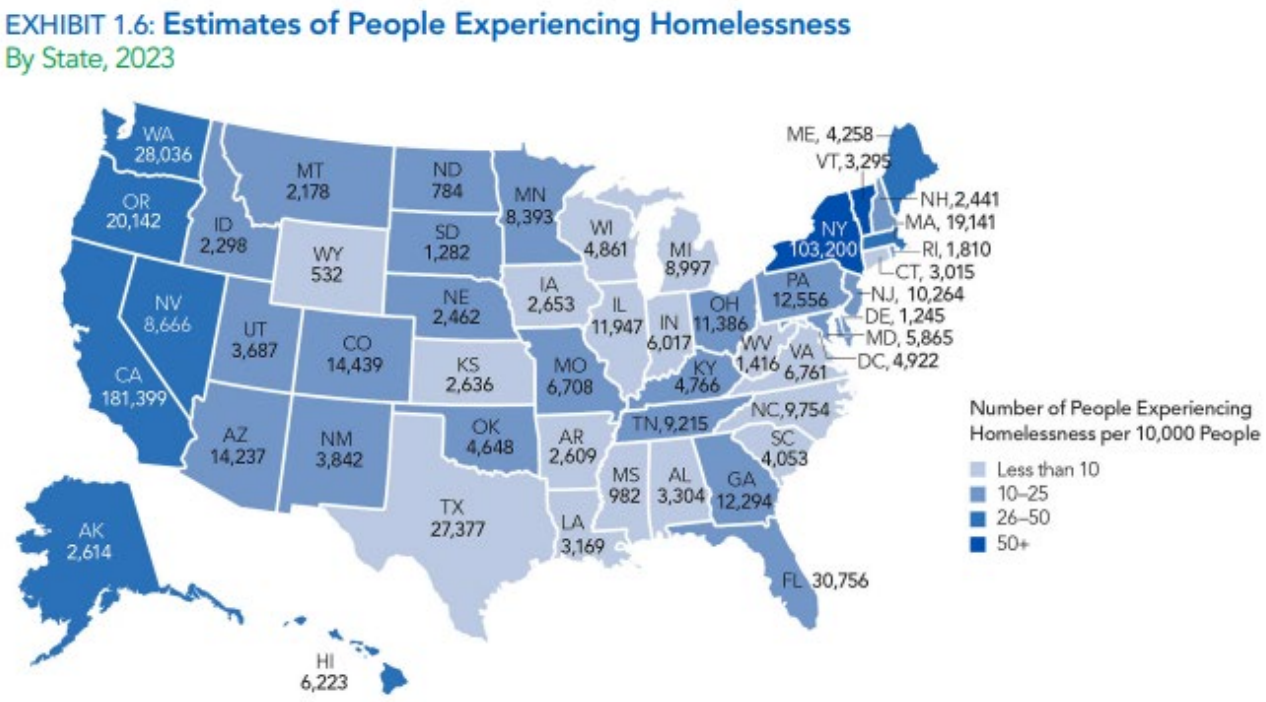
In some cases, policies that are seemingly unrelated to housing can affect those who are homeless or at risk in unintended ways. For example, even short jail stays can increase the likelihood of lost employment and inability to maintain housing. In some places, an incarcerated individual with no stable address must remain in jail once time has been served until housing conditions are met.[29] Data from the Prison Policy Initiative show that those who are released from incarceration are 10 times as likely as the general population to experience homelessness.[30] During the writing of this report, federal, state, and local leaders gathered for the first-ever National Reentry Housing Symposium. The Council of State Governments Justice Center partnered with

[24] HUD. CoC Program Interim Rule. HUD Exchange. Updated July. https://www.hudexchange.info/resource/2033/hearth-coc-program-interim-rule/
[25] Continuum of Care (CoC) Program Eligibility Requirements. HUD Exchange. https://www.hudexchange.info/programs/coc/coc-program-eligibility-requirements/
[26] The Affordable Housing Crisis Grows While Efforts to Increase Supply Fall Short. U.S. Government Accountability Office. Updated October 12. https://www.gao.gov/blog/affordable-housing-crisis-grows-while-efforts-increase-supply-fall-short
[27] Kushel M, Moore T. Toward a New Understanding: The California Statewide Study of People Experiencing Homelessness 2023. June. https://homelessness.ucsf.edu/resources/reports/toward-new-understanding-california-statewide-study-people-experiencing
[28] Policy: We can end homelessness in America. National Alliance to End Homelessness. https://endhomelessness.org/ending-homelessness/policy/
[29] Responding to Homelessness: Strategies for Law Enforcement and Partners. Bureau of Justice Assistance. https://bja.ojp.gov/program/pmhc/responding-homelessness
[30] Affordable housing. gao.gov. https://www.gao.gov/affordable-housing

the Bureau of Justice Association and HUD to focus on the bold new vision, “zero returns to homelessness” upon reentry from a criminal justice setting.[31]

Other policies more directly address individuals and families who are experiencing homelessness, such as those that restrict where a person can sleep outside. While state and local policies and policy enforcements vary, individuals in violation are sometimes charged fines; those unable to pay fines may face additional penalties or jail time or must make choices between paying fines or their other financial needs, such as healthcare and food.

Figure 1: Point-in-time estimates of people experiencing homelessness in 2023. (Source: 2023 Annual Homelessness Assessment Report (AHAR) to Congress by the U.S. Department of Housing and Urban Development.)



Regionally, Point-In-Time (PIT) estimates suggest West Virginia experiences lower numbers of individuals experiencing homelessness than neighboring states (PIT is an attempted census of individuals experiencing homelessness that happens one night a year in January). The map in Figure 1 displays two things: 2023’s PIT counts of individuals experiencing homelessness are shown as a number overlaying each state. In addition, the light-to-dark blue shading shows the rate, or how many individuals there are experiencing homelessness per 10,000 and thus what places experience more homelessness – New York is the brightest blue while West Virginia is a relatively pale blue showing New York not only has more individuals experiencing homelessness but there is a higher rate of homelessness overall. In 2023, PIT identified 1,416 individuals

[31] Hayashi J. Federal, State, and Local Leaders Gather for First-Ever National Reentry Housing Symposium. Justice Center The Council of State Governments. Updated January 29. https://csgjusticecenter.org/2024/01/29/federal-state-and-local-leaders-gather-for-first-ever-national-reentry-housing-symposium/

experiencing homelessness in WV, an increase of around 3% from the previous year (1,375). From 2016 through 2020, PIT counts of persons experiencing homelessness in West Virginia ranged between 1,200 and 1,300.[32] The WV PIT count dropped in 2021 to 1,138, [33] which may relate to additional financial assistance programs available during the COVID pandemic. Estimates based on data from HMIS and reported in the demographics report that accompanies this one, suggest numbers are higher.

Federal funds to address homelessness are administered by DoHS's Homeless Services Grant Program (HSGP) and are managed in partnership with the West Virginia Coalition to End Homelessness (WVCEH). These dollars are directed at establishing a coordinated system of crisis providers to address housing and services needs for individuals and households experiencing, or at imminent risk of homelessness. Agencies using these funds for service provision are expected to collaborate with their local Continuum of Care (CoC).[34] (Figure 2).

In West Virginia, federal funding to address homelessness and entry into service projects are managed through Continuums of Care (CoCs).[35] CoCs are integrated systems that track clients over time across an array of agencies and services. [36] Regulations itemize the purpose of CoCs as such: [37]

1. Promote community-wide commitment to the goal of ending homelessness;
2. Provide funding for efforts by nonprofit providers, states, and local governments to quickly re-house individuals experiencing homelessness and families while minimizing the trauma and displacement caused to individuals, families, and communities by homelessness;
3. Promote access to and effective utilization of mainstream programs by individuals experiencing homelessness and families; and
4. Optimize self-sufficiency among individuals and families experiencing homelessness.

There are four Continuums of Care in West Virginia (Figure 2): [38]

- Balance of State CoC (BoS)
- Cabell-Huntington-Wayne CoC (CHW)
- Kanawha Valley Collective CoC (KVC)
- Northern Panhandle CoC (NPH)

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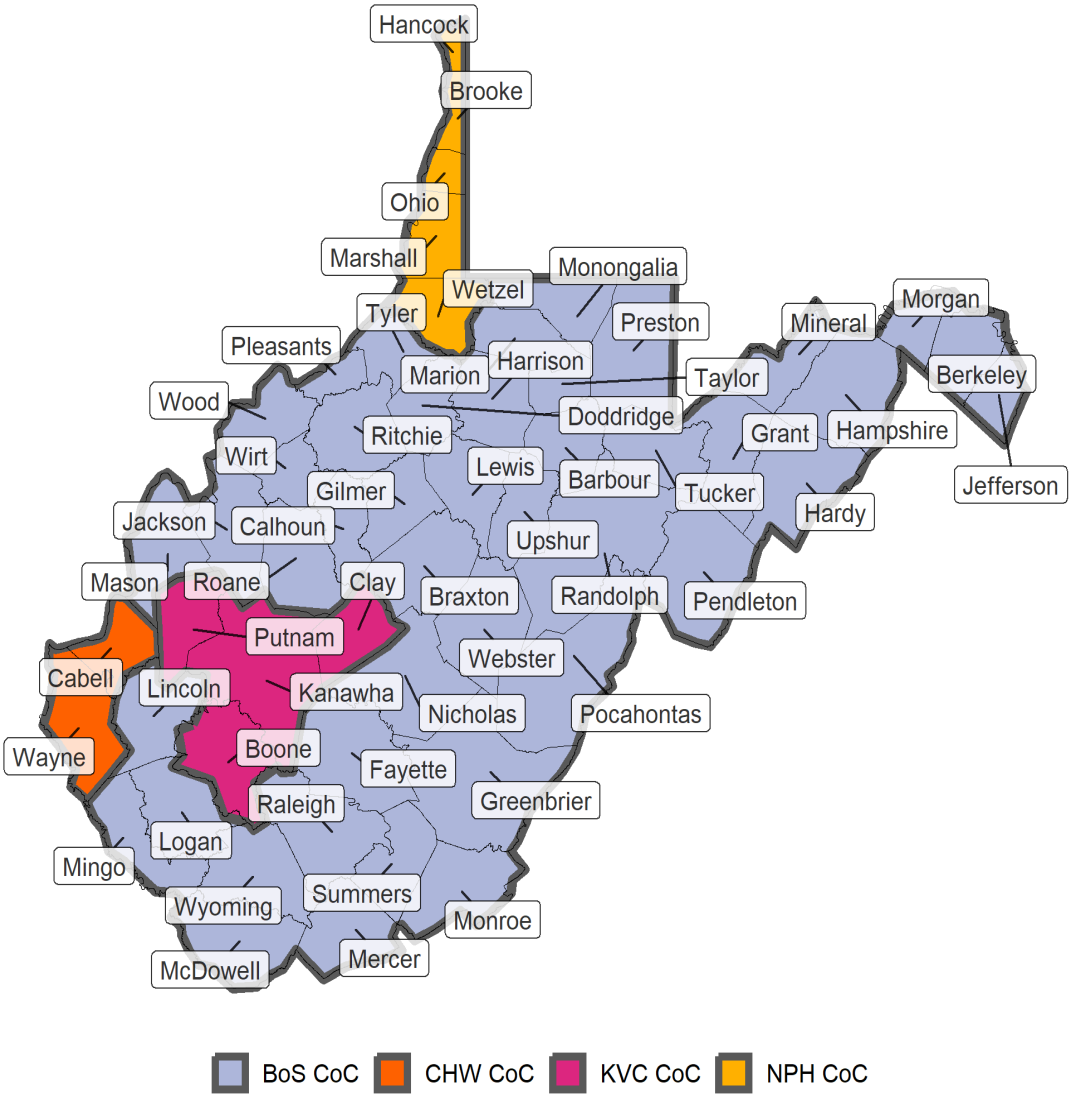
[32] WV CoC Performance Profile. HUD Exchange. Accessed June 24, 2024. https://files.hudexchange.info/reports/published/CoC_Perf_State_WV_2020.pdf.
[33] WV CoC Performance Profile. HUD Exchange. Accessed June 24, 2024. https://files.hudexchange.info/reports/published/CoC_Perf_State_WV_2021.pdf
[34] Homeless Services Policy. 2024. https://dhhr.wv.gov/bss/policy/Documents/Homeless%20Services%20Policy%20May%202024.pdf
[35] Continuum of Care Program. U.S. Department of Housing and Urban Development. Updated May 4. https://www.hud.gov/program_offices/comm_planning/coc
[36]. Evashwick C. Creating the continuum of care. Health Matrix. 1989;7(1):30-39. https://pubmed.ncbi.nlm.nih.gov/10293297/
[37] What is the purpose of the CoC Program? . HUD Exchange. Updated July. https://www.hudexchange.info/faqs/1544/what-is-the-purpose-of-the-coc-program/
[38] Program ESG. WV Continuums of Care (CoC) Coverage Map. West Virginia Community Advancement and Development. https://wvcad.org/sustainability/esg

Figure 2: Map of Continuum of Care service delivery areas in West Virginia



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*

Surrounding State Policies Related to People Experiencing Homelessness

States surrounding West Virginia address homelessness through various policy measures. Exploring how they address homelessness can inform such efforts in West Virginia, and their policies may suggest reasons for some of the population changes in West Virginia's neighboring areas. For example, comparing policies between the combined two-county area of Bluefield, WV and Bluefield, VA is needed to understand what is happening in that overall community. The same may be true for other border communities: Martinsburg, WV and Hagerstown, MD or Winchester, VA; Morgantown or Weirton and neighboring Pennsylvania communities; Wheeling or

Parkersburg and their Ohio River neighbors; and, Huntington and Ashland, KY or Chesapeake, OH.

Maryland's Interagency Council on Homelessness is a group made up of state agency representatives working alongside appointees of the Governor. This group provides policy recommendations statewide, educates the public, coordinates data sharing between local Continuums of Care (CoCs), conducts affordable housing analysis and recommendations, and solicits input statewide to identify and tailor service needs.[39]

In Pennsylvania, a Homeless Program Coordination Committee, composed of public agencies, providers, and other partners of the homeless community, serves as the working body for the state's Interagency Council on Homelessness. This group oversees broad planning responsibilities and coordination of all resources in the state. [40]PA's Department of Human Services Homeless Assistance Program maintains a publicly available county contact list for local help with housing and other services statewide.

In Ohio, housing and homelessness programs are administered locally, with the Office of Community Development providing technical and financial assistance to local governments and organizations. This assistance supports project activities that aim to conserve and expand affordable housing, address the issue of homelessness in Ohio, and provide assorted types of rental assistance and other public services.[41]

Kentucky administers a number of services at the intersection of homelessness and mental health care. Services are offered either via local Community Mental Health Centers which may have their own rental-assistance programs, or via collaborative arrangements with area public housing agencies. The Olmstead Housing Initiative (meeting needs of those with serious mental illness who are transitioning out of long-term institutionalization or are at risk for homelessness) provides services through contractual relationships with housing organizations, through federal Projects for Assistance in Transition from Homelessness (PATH) funds, and through the SSI/SSDI Outreach, Access, and Recovery (SOAR) program designed to increase access to Supplemental Security Income and Social Security Disability Income (SSI/SSDI). Finally, in Kentucky, the Homelessness Prevention Project attempts to address institutional discharge into homelessness.[42]

The state of Virginia's rate of homelessness is among the lowest in the nation.[43] Virginia Homeless Solutions Program (VHSP) is a funding source that supports statewide development and implementation of local crisis response systems with housing-focused, coordinated activities

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[39] Maryland's Interagency Council on Homelessness. Maryland.gov. https://dhcd.maryland.gov/HomelessServices/pages/interagencycouncil.aspx
[40] Homelessness in PA: Homeless Information in Pennsylvania. Pennsylvania Department of Community & Economic Development. https://dced.pa.gov/housing-and-development/community-services/homelessness-in-pa/
[41] Housing & Homelessness. Ohio Department of Development. https://development.ohio.gov/community/housing-and-homelessness
[42] Housing and Homeless Programs. Commonwealth of Kentucky. Accessed May 2024. https://dbhdid.ky.gov/dbh/housing-resources.aspx
[43] Virginia's Homeless Programs 2019-2020 Program Year. https://www.dhcd.virginia.gov/sites/default/files/Docx/vhsp/Homeless_report_19_20_%20%20final%20draft.pdf

designed to reduce length of homelessness, number of households becoming homeless, and the overall rate of formerly homeless households returning to homelessness. VHSP providers can include local governments, nonprofits, planning district commissions, and public housing authorities that are active participants of a Continuum of Care or local planning group.[44]

Findings

This section presents findings related to locations of individuals experiencing homelessness, ordinances, policies, and resources that aid individuals experiencing homelessness, investigating their potential links to the distribution and mobility of families and individuals seeking shelter in West Virginia. In addition, the Findings section includes a crosswalk of known locations of residents who are homeless with interventional and restrictive policies, and with resources that may help address, prevent, or exit homelessness.

Analysis of Whether West Virginia's Homeless Populations Concentrate in Certain Counties or Municipalities (Legislative Objective 5)

Metropolitan Areas and Population Centers in WV

Each CoC coverage area in WV contains at least one Metropolitan Statistical Areas (MSAs).[45] Metropolitan areas consist of networks of urban areas with high population densities that are connected by transportation networks, high densities of housing, contain central business districts, industries, and large economic markets.[46] Because of higher concentrations of people, housing, and economic opportunities, there are also higher densities of health networks and social services to serve those populations. Due to higher connectedness, travel distances within the MSAs are shorter and public transportation is more available than in rural areas. Thus, for MSAs that span state lines, it is easier for residents of these areas to travel and relocate to other states contained within the MSA. MSA populations included in this report were estimated by the US Census Bureau in 2020.[47]

Just as MSAs are attractive to all residents, they are also attractive and essential for West Virginians experiencing homelessness who have immediate needs for housing, employment opportunities, access to health providers, treatment facilities, and social support. Of the 10 MSAs at least partially located within WV, six in 10 (60%) include residents from WV and at least one additional neighboring state (Table 5).

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[44] Virginia Homeless Solutions Program (VHSP). Virginia Department of Housing and Community Development. https://www.dhcd.virginia.gov/vhsp
[45] OMB Bulletin 23-01. The White House. July 21, 2023. https://www.whitehouse.gov/omb/information-for-agencies/bulletins/.
[46] Loibl W, Etminan G, Gebetsroither-Geringer E, Neumann H-M, Sanchez-Guzman S. Characteristics of urban agglomerations in different continents: History, patterns, Dynamics, drivers and Trends. IntechOpen. March 21, 2018. https://www.intechopen.com/chapters/59481.
[47] Metropolitan and Micropolitan Statistical Areas Population Totals: 2020-2023. Census.gov. Accessed June 20, 2024. https://www2.census.gov/programs-surveys/popest/tables/2020-2023/metro/totals/cbsa-met-est2023-pop.xlsx.

The Eastern Panhandle counties of WV are all participants in the BoS CoC. There are three MSAs that include three of the counties in the Eastern Panhandle, connecting them to urban centers in Maryland and Virginia. The Arlington-Alexandria-Reston, VA-WV Metro Division within the Washington-Arlington-Alexandria, DC-VA-MD-WV Metro Area was the largest metro population (3,121,435, Table 5) in 2020 and includes Jefferson County.

The CHW CoC coverage area services a part of the second largest MSA, the Huntington-Ashland, WV-KY-OH Metro Area or Tri-State Area with a population of 376,141 residents in three states (Table 5). This area contains Cabell, Putnam, and Wayne counties in WV. The Charleston, WV Metro Area borders the Huntington-Ashland Metro Area along the Kanawha-Putnam County line. The Charleston Metro Area also includes Boone and Clay counties and has a population of 210,605 residents.

Both MSAs serviced by the NPH CoC, the Weirton-Steubenville, WV-OH Metro Area and the Wheeling, WV-OH Metro Area, include OH residents along with WV residents, both with total populations of more than 100,000 residents. Brooke and Hancock counties are included in the Weirton-Steubenville Metro Area. Marshall and Ohio counties are included in the Wheeling Metro Area.

Table 5: Metropolitan Statistical Areas that are partially or fully within West Virginia (WV) and partially or fully within each CoC coverage area based on 2020 United States Census estimates[48]

Continuum of Care	Metropolitan Statistical Area	Population	States Included in Metropolitan Statistical Area
Balance of State	Arlington-Alexandria-Reston, VA-WV Metro Division*	3,121,435	WV and VA
	Beckley, WV Metro Area	115,066	WV
	Hagerstown-Martinsburg, MD-WV Metro Area	293,845	WV and MD
	Morgantown, WV Metro Area	140,034	WV
	Parkersburg-Vienna, WV Metro Area	89,489	WV

[48] Metropolitan and Micropolitan Statistical Areas Population Totals: 2020-2023. Census.gov. Accessed June 20, 2024. https://www2.census.gov/programs-surveys/popest/tables/2020-2023/metro/totals/cbsa-met-est2023-pop.xlsx.

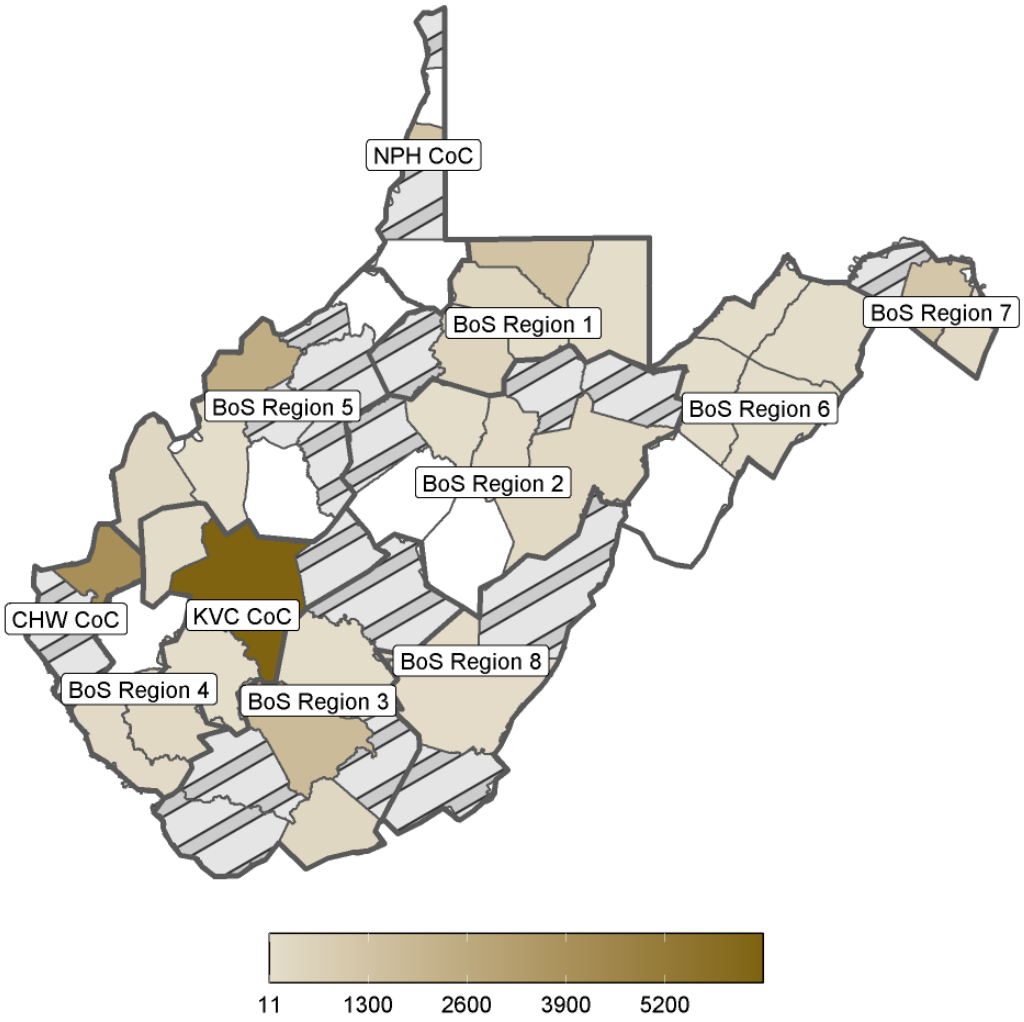
	Winchester, VA-WV Metro Area	142,636	WV and VA
Cabell-Huntington-Wayne	Huntington-Ashland, WV-KY-OH Metro Area	376,141	WV, KY, and OH
Kanawha Valley Collective	Charleston, WV Metro Area	210,605	WV
Northern Panhandle	Weirton-Steubenville, WV-OH Metro Area	116,892	WV and OH
	Wheeling, WV-OH Metro Area	139,520	WV and OH

NOTES: **Arlington-Alexandria-Reston, VA-WV Metro Division is within the Washington-Arlington-Alexandria, DC-VA-MD-WV Metro Area that has a total population of 6,278,594 based on 2020 U.S. Census estimates.*

Where West Virginians Experience Literal Homelessness

In all but eight counties of WV, there was at least one HMIS client who was experiencing literal homelessness based on their most recent enrollment occurring from 2018 through 2023 (Figure 3). In 19 out of 55 counties (36%), that number was not reportable (NR) meaning only between one to 10 clients had most recently enrolled in that county. Kanawha and Cabell had the highest counts of clients experiencing literal homelessness followed by Wood, Raleigh, Monongalia, and Berkeley counties (Figure 3). Thus, the six counties with the highest county populations in WV based on the 2020 U.S. Census also had the highest counts of clients in HMIS. Half of those counties are found within MSAs, two of which include other states (Ohio and Maryland).

Figure 3: Counts of HMIS clients who were experiencing literal homelessness (sheltered or unsheltered) in each county based on most recent project entry date from 2018 through 2023.



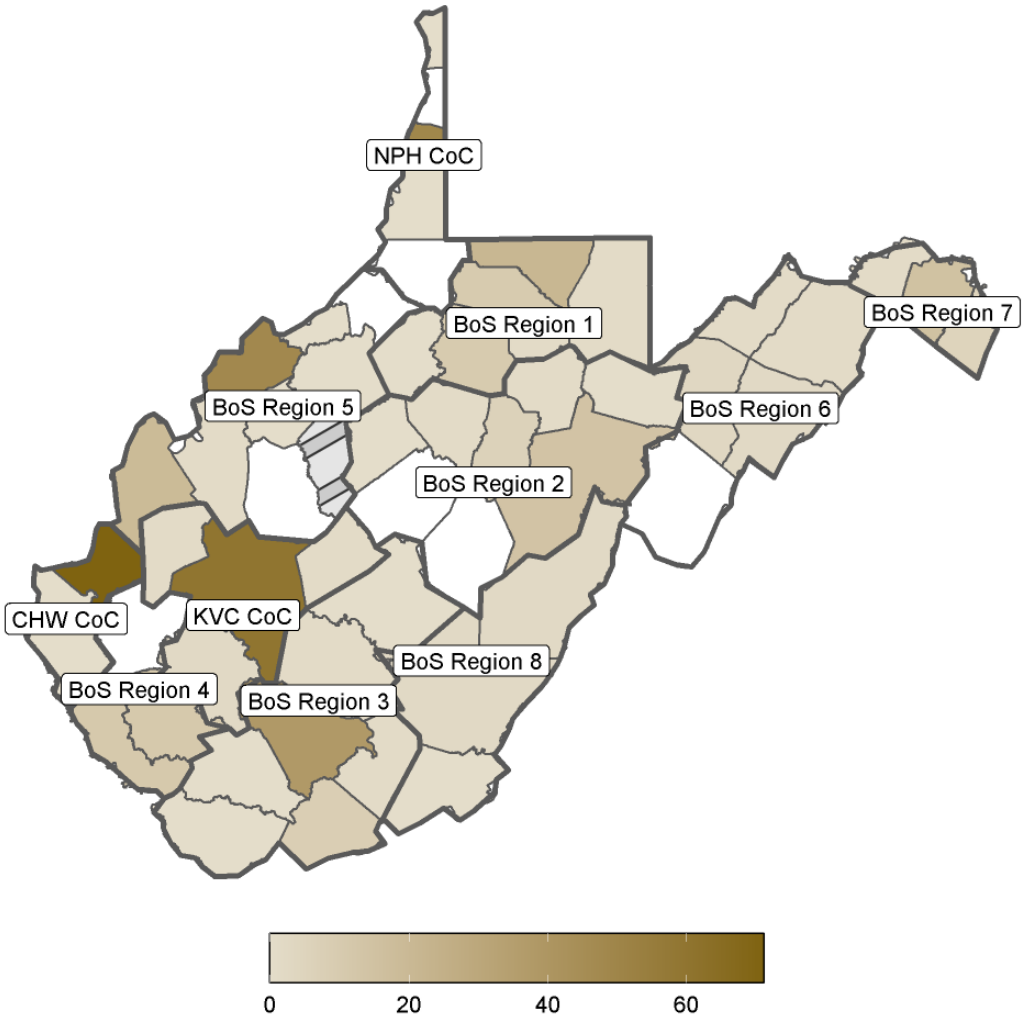
NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*
Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.
If address information was missing for the most recent enrollment, but the CoC where the enrollment occurred was known, then the client was assigned to Kanawha County for the KVC CoC, to Cabell County for the CHW CoC, or to Ohio County for NPH CoC. However, for the 9% (909/9951) of the enrollments in BOS COC that had missing address information, the client was not assigned to a county due to the large geographic area covered by BOS COC.

The highest concentrations of clients were in Cabell (CHW CoC), Kanawha (KVC CoC), and Ohio (NPH CoC) counties based on their most recent enrollment from 2018 through 2023, where there

were more than 60 clients per 10,000 county residents (Figure 4). All three counties are also included within MSAs, two that include counties in Ohio.

The BoS CoC contains Wood (BoS Region 5) and Raleigh (BoS Region 3) counties with the next highest concentrations of clients ranging between 40 to 50 per 10,000 residents (Figure 4). Four of these counties represent four of the top 10 most populated counties in WV, all with significant urban centers. Any of the counties with darker coloration fall within the top 30 most populated counties in WV. Of those, Mason, Upshur, Mingo, and Logan counties have the lowest county populations and exhibit rates of about 10 clients per 10,000 residents.

Figure 4: Annual average count of HMIS clients experiencing literal homelessness (sheltered and unsheltered) per 10,000 county residents in each county based on most recent project entry date from 2018 through 2023.



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***NOTES**: CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*

Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.

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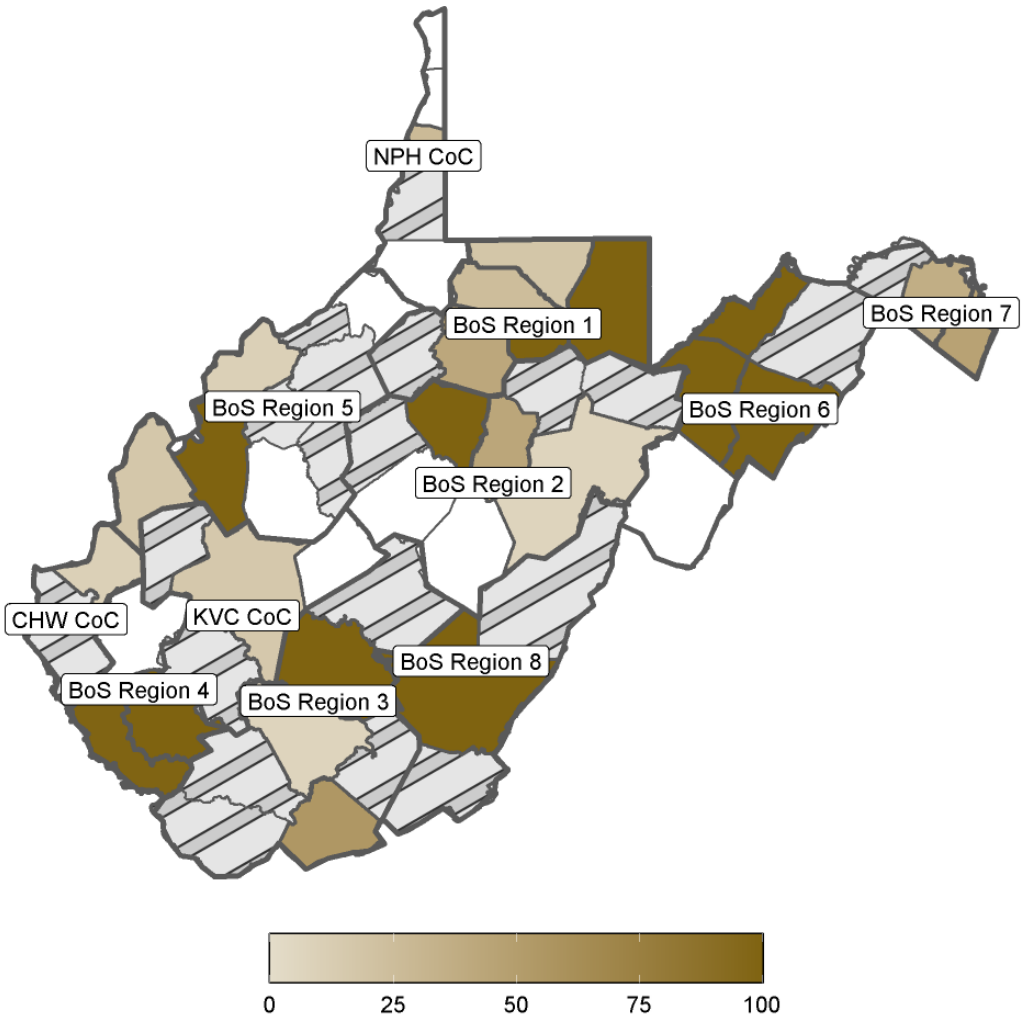
In 45 out of the 55 (82%) WV counties, at least one HMIS client had most recently enrolled in an unsheltered project (Figure 5). There were 11 where 100% of HMIS clients experiencing literal homelessness whose most recent intake was through an unsheltered project (Figure 6). Fewer counties (22 out of the 55 or 40%) had at least one HMIS client most recently enrolled in a shelter project (Figure 6).

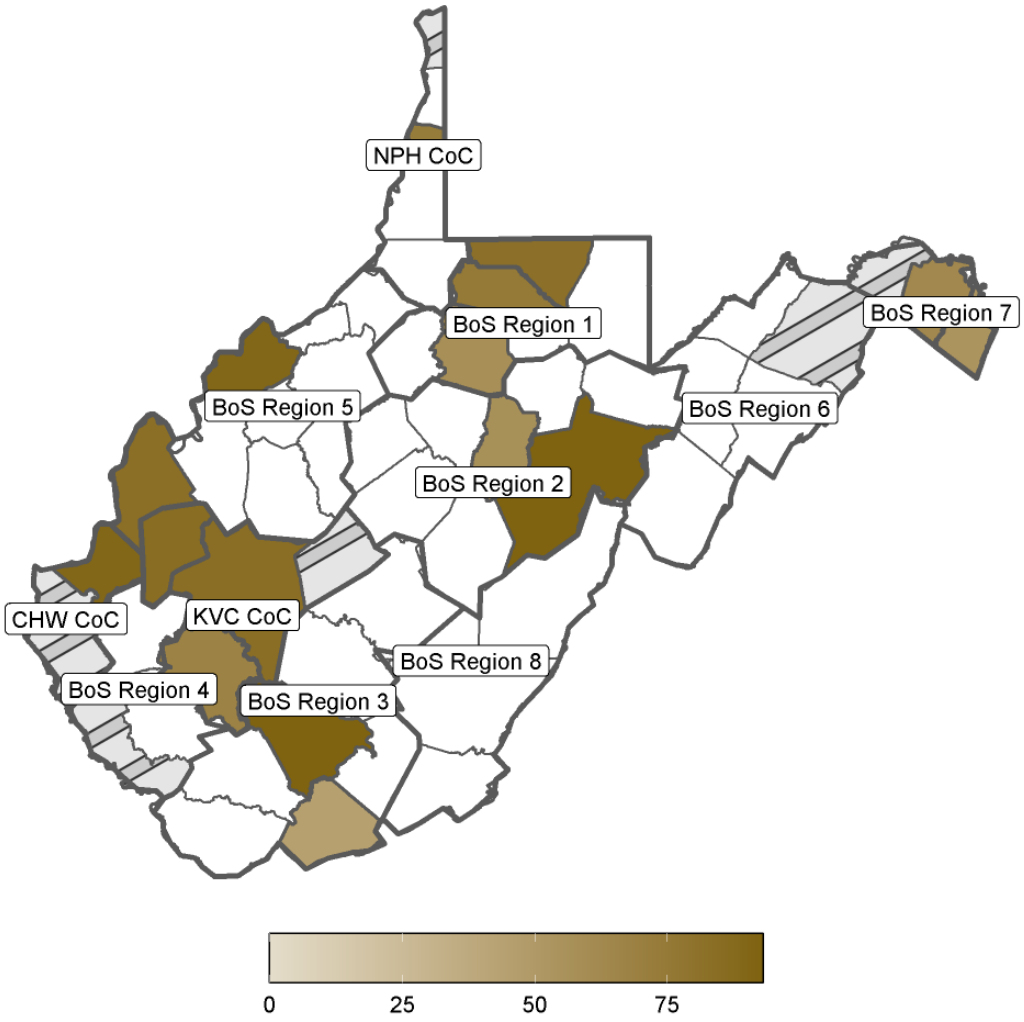
Counties with significant urban populations including Kanawha, Cabell, Monongalia, Wood, Raleigh, and Berkeley had lower proportions of their clients most recently enrolled in unsheltered projects. Counties with lower percentages of unsheltered clients (Figure 5) and higher numbers of clients whose most recent intake was through a sheltered project (Figure 6). Examples include Kanawha, Monongalia, Wood, and Raleigh counties, each with at least one neighboring county that had 100% of clients enrolled in unsheltered projects.

*Figure 5: Percentage of total HMIS clients who enrolled in an **unsheltered** project in each county based on most recent project entry date from 2018 through 2023.*



NOTES: *CoC = Continuum of Care; BoS = Balance of State; CHW = Cabell Huntington Wayne; KVC = Kanawha Valley Collective; NPH = Northern Panhandle.*
Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.
If address information was missing for the most recent enrollment, but the CoC where the enrollment occurred was known, then the client was assigned to Kanawha County for the KVC CoC, to Cabell County for the CHW CoC, or to Ohio County for NPH CoC.

*Figure 6: Percentage of total HMIS clients who enrolled in a **sheltered** project in each county based on most recent project entry date from 2018 through 2023.*



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If address information was missing for the most recent enrollment, but the CoC where the enrollment occurred was known, then the client was assigned to Kanawha County for the KVC CoC, to Cabell County for the CHW CoC, or to Ohio County for NPH CoC.

In summary, people experiencing literal homelessness are generally concentrated in the most populous counties with larger cities and metropolitan areas. Where there are more people, there are more likely to be more people experiencing homelessness and potentially more resources, economic opportunities, and transportation networks with public transportation options.

Quantifying and Inventorying Homelessness Resources by Region and Analyzing Potential Reasons for Concentrations of Homeless Populations (Legislative Objectives 2 and 5)

To address the legislature's question about whether West Virginia's populations experiencing homelessness concentrate in certain counties or municipalities, and to understand the possible reasons for such concentrations, the project team first needed to quantify and inventory homelessness resources by region. To create this Resource Inventory, the project team collected details of approximately 3,040 providers, agencies, and housing locations across twelve service categories: housing services, basic needs, veterans' services, behavioral health providers, substance use disorder resources, community and family resources, domestic violence resources, youth resources, medical resources, entities serving vulnerable populations, faith-based resources, and public assistance programs. Then, to address objective 5, the project team used the Resource Inventory as a reference to create a regional crosswalk of known resources and known locations where individuals and families experience homelessness. From the crosswalk, the team developed maps and explored them alongside qualitative feedback from outreach communications, focus group participants, and key informant interviews.

In terms of maps, categories of identified services are provided first, with maps labeled A showing the location of select services, including basic needs, behavioral health, substance use disorder services, housing resources, and medical services, respectively. Maps labeled B show the numbers of individuals experiencing homelessness from 2018 through 2023 (based on their most recent intake) at the county level.

Services

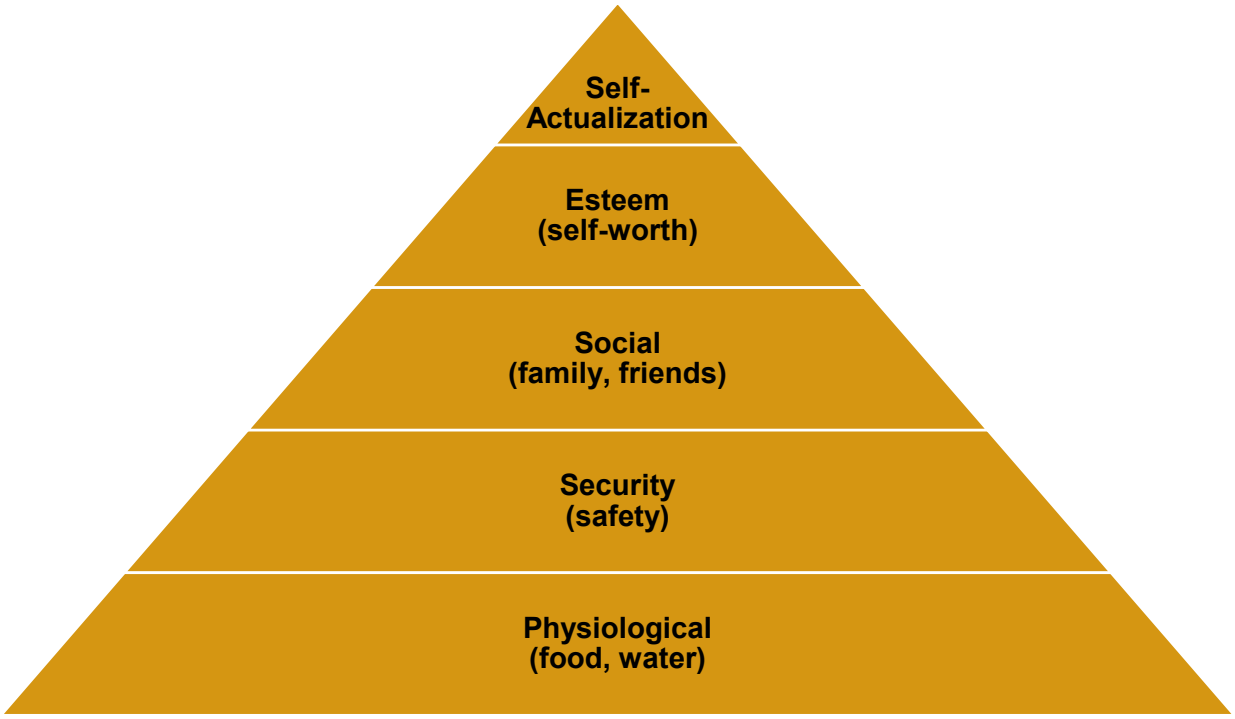
This section begins with information comparing the location of services with the location of individuals experiencing homelessness at their most recent intake with an HMIS provider from 2018 through 2023. According to and building upon legislative directive, services include basic needs, behavioral health, substance use disorder services, housing resources, and medical resources. A discussion of the distribution of community and family resources, domestic violence resources, and veteran services follows.

Basic Needs

Basic needs include things like food pantry services or hot meals, clothing and hygiene assistance, and help with transportation. A common way of contextualizing basic needs was provided by Abraham Maslow who described human needs using a pyramid (Figure 7). At its base the pyramid includes physiological needs, such as food, potable water, shelter, and warmth. At the next highest level are security needs, such as safety. Social needs create the third stratum, including familial relationships, intimacy, and belonging. The next level is esteem, where one establishes self-worth, and the last level is self-actualization, also described as inner fulfillment or reaching one's full potential. Maslow suggested individuals are unable to move up the hierarchy

until their needs at each lower level are fulfilled, although some individuals are able to forgo lower levels to achieve needs required at a higher level, such as engaging in a hunger strike to make a political point. However, for most people, it is difficult to focus on establishing self-worth when they do not have enough to eat.[49] Maslow's Hierarchy of Needs is provided to highlight the importance of needs discussed in each service category, but particularly the first.

Figure 7: Maslow's Hierarchy of Needs[49]



Resources that provide basic needs for people experiencing homelessness appear to be the most concentrated in Kanawha, Monongalia, Mercer, and Ohio counties (Figure 8A). These are among the state's ten most populous counties and may reflect a greater availability of resources within them because of their urban centers. [50] Generally, urban areas tend to have more resources of certain types than rural communities. For example, many rural communities lack basic healthcare facilities, with rural residents facing chronic shortages of different types of healthcare providers, or the need to travel to urban centers to access care. [51]

Similar patterns were observed between the number of providers offering resources related to basic needs in each county (Figure 8A) and of individuals experiencing literal homelessness (defined by HUD as an individual or family who lacks a fixed, regular, and adequate nighttime

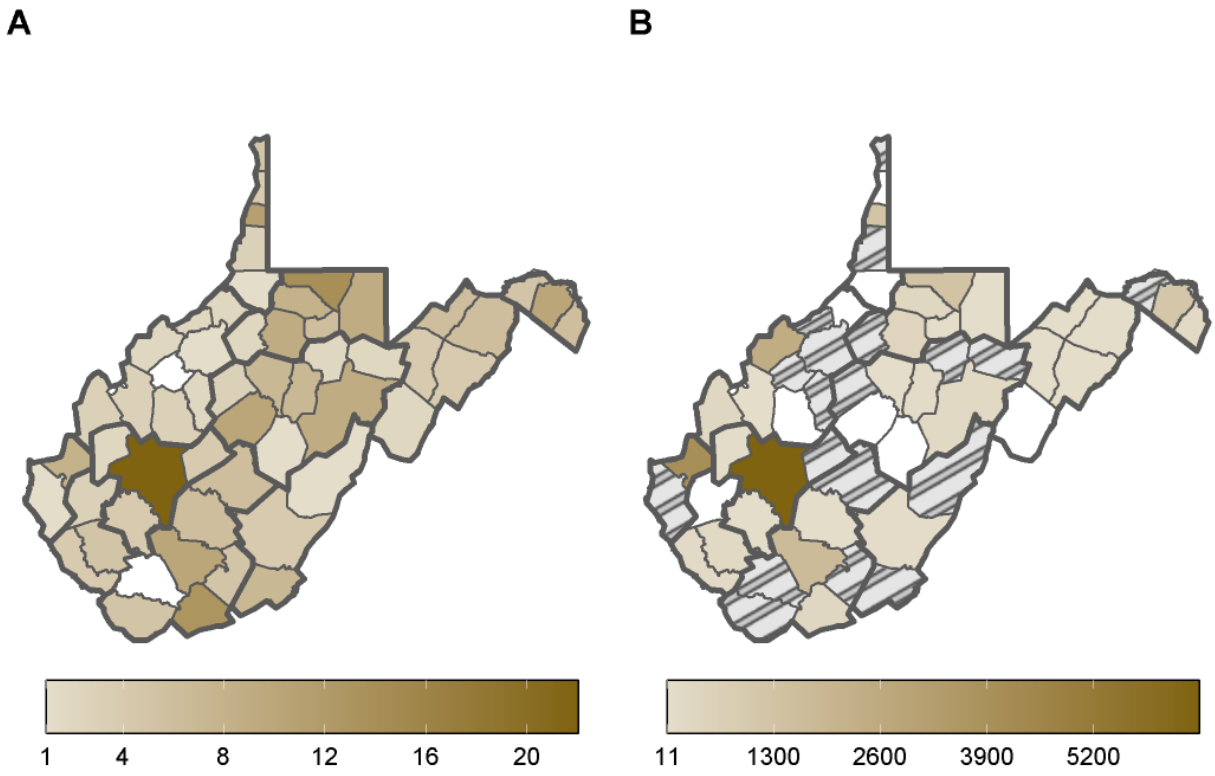
[49]Maslow's hierarchy of needs. ucf.edu. Accessed June 24, 2024. https://pressbooks.online.ucf.edu/lumenpsychology/chapter/maslows-hierarchy-of-needs/.
[50] Loibl W, Etminan G, Gebetsroither-Geringer E, Neumann H-M, Sanchez-Guzman S. Characteristics of urban agglomerations in different continents: History, patterns, Dynamics, drivers and Trends. IntechOpen. March 21, 2018. https://www.intechopen.com/chapters/59481.
[51] Cogme Rural Health policy brief 1. July 17, 2020. https://www.hrsa.gov/sites/default/files/hrsa/advisory-committees/graduate-medical-edu/publications/cogme-rural-health-policy-brief.pdf.

residence) based on their most recent intake with an HMIS provider from Jan. 1, 2018, through Dec. 31, 2023 (Figure 8B). Counties with more providers offering basic needs, compared to other counties, were often also counties with a greater number of HMIS clients experiencing literal homelessness. For example, Kanawha County had the greatest number of individuals and the greatest number of resources (darkest colors on both maps in Figure 8). However, this pattern did not apply to all counties. The numbers of providers offering resources related to basic needs appeared similar in Wood and neighboring counties (Pleasants, Ritchie, and Jackson counties) but Wood County had a higher number of individuals experiencing literal homelessness. There were also two counties where no providers offering resources related to basic needs were found: Wirt and Wyoming. In both counties, the number of clients experiencing literal homelessness suppressed, meaning counts were low (below 10).

Figure 8: Side-by-side county maps of basic needs resources and HMIS clients experiencing literal homelessness.

A. Counts of providers in each county that offer basic needs services such as food, hygiene services, household necessities, clothing, or transportation.

B. Total count of HMIS clients who were experiencing literal homelessness (sheltered or unsheltered) in each county based on most recent program entry date from 2018 to 2023.



NOTES: *Map A and Map B: White color indicates zero resources or zero clients in a category. Map B: Hatched grey color indicates not reportable due to identifiability concerns defined as between one and 10 clients in a category.*
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell-Huntington-Wayne CoC, or to Ohio County for Northern Panhandle CoC.

Interviewed individuals discussed a wide range of basic needs, such as accessing food and blankets. As one person said, “They do provide food. It’s not bad food. It’s good food. They still provide me a way to wash and clean my clothes, a bed to sleep in. Like, I may have had things, but it’s still a place. I’ve not been like put under physical harm while I’ve been here. I’m not scared for my life or anything while I’m here. Like, you know, I’m not hearing, you know, if you don’t like do a sexual favor then you can’t stay. I’ve heard nothing like that.”

Some noted differences in available services for meeting basic needs depending upon where in the state someone might be experiencing homelessness. One participant noted that in some cities, there are drop-in centers or places where someone can shower during the day, but in other cities and small municipalities there are no such resources. This makes it difficult to maintain basic hygiene and health, impacting employment opportunities. One interviewed individual explained how, without necessities, it could be difficult to exit homelessness, “...I mean, I know what that’s like. I mean, that’s horrible when you smell so bad and you can smell yourself you know. But you can’t, it’s kinda, how are you gonna get a job. How are you gonna go talk to people when your clothes are real dirty...”

Focus groups also mentioned a need for personal care items, as one participant explained when talking about the needs at their location: “And personal care items and all that kind of stuff because we house women and children.” Another participant explained, “[I] mean, they make do as best they can in the outside elements, but you know, access to a shower, access to water, other than what they obtain through natural resources or other ways for oral hygiene, etc.”

Individuals also discussed a range of service providers who helped support them in meeting their basic needs, often with gratitude but also sometimes indicating they were unable to access what was needed. One person described the importance of having providers located closely together to make help accessible: “I’ve had really a lot of luck with the services in in this area. Like, everyone’s very, very easy to access, and it’s all kind of in in one block area like this is few blocks apart. You know, you got the [name omitted] in in their area, and then you got, you know, the [name omitted] and then [name omitted] here, and then the soup kitchen down the street. So, it’s all very localized, and everyone’s very, you know, helpful in any time with things you need.”

Focus group participants shared serious repercussions that could come from limited resources. For example, one participant shared, “One of the things that with the winter months on right now we’ve seen a few, a little bit of an increase in patients with borderline hypothermia. Things of that nature because they didn’t have the resources to stay warm.”

They also discussed service provider challenges related to having the funds required to meet the amount of need in their communities. Providers in focus groups noted that the rising cost of essential items due to inflation was challenging and had resulted in a decreased capacity to serve residents. They explained that this loss further exacerbated the greater issue, with more need than there were services available. “Unfortunately, one of the biggest is that that funding issue and being able to do a lot of the things on a, whether it be a larger scale, or just being able to try to help a greater number of people in need. And that, and whether it be people’s finances, or whether it be inflation or just increased costs of everything to live. It's just getting harder and harder to accomplish trying to make a bigger footprint.”

Mental Health

Mental health disorder is a broad category in HMIS. It does not reference any specific clinical diagnosis but allows clients to self-report conditions that range from situational depression to serious mental illnesses. [52] In the comparison of mental health service providers with individuals experiencing homelessness, only counts of individuals who were experiencing homelessness and who self-reported a mental health disorder at their most recent intake in HMIS between Jan. 1, 2018 through Dec. 31, 2023, were included.

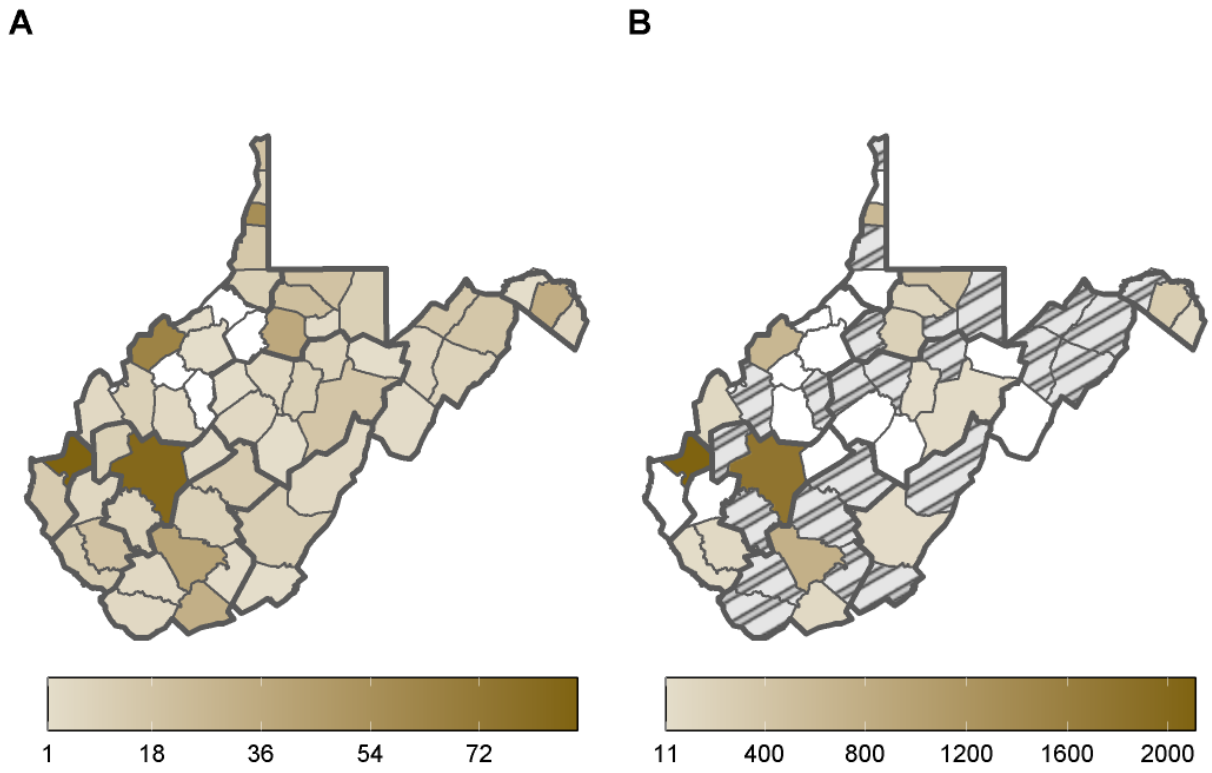
Mental health service providers included counseling, therapy, intellectual and developmental disability services, and crisis response services. These resources were identified by the project team and include the state's comprehensive behavioral health centers, relevant health facility locations included in The Office of Health Facility Licensure and Certification program lists. Some additional provider information was gathered through discussions with and suggestions from those who participated in outreach activities. Full methodology details are included in Appendix A. Mental health services appeared to concentrate in Cabell, Kanawha, Wood, and Ohio counties (Figure 9), and similar patterns were observed in the density of individuals experiencing literal homelessness and reporting a mental health disorder at most recent intake during the specified time (Figure 9B). There were four counties where no mental health offices were physically located in the county, though other agencies are assigned to serve residents of these counties (Figure 9A): Tyler, Doddridge, Wirt, and Calhoun. Two of these counties, Tyler and Wirt, had zero counts of clients experiencing literal homelessness with mental health disorders. In Doddridge and Calhoun counties, the number of clients experiencing literal homelessness was suppressed, meaning counts were low or from one through 10.

[52] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Figure 9: Side-by-side maps of countries offering behavioral health services and clients experiencing homelessness self-reporting mental health disorders.

A. Counts of providers in each county that offer behavioral health services including counseling, therapy, intellectual and developmental disability services, and crisis response.

B. Total count of HMIS clients experiencing literal homelessness who self-reported as having a mental health disorder in each county based on most recent program entry date from 2018 to 2023.



NOTES: *Map A and Map B: White color indicates zero resources or zero clients in a category. Map B: Hatched grey color indicates not reportable due identifiability concerns defined as between one and 10 clients in a category.*
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell Huntington Wayne CoC, or to Ohio County for Northern Panhandle CoC.

Multiple interviewed individuals identified their own mental health needs. Some also indicated those needs were a factor in their becoming or remaining homeless. As one participant explained, *"I cannot work. I've been diagnosed with PTSD, bipolar, anxiety, and stuff like that. So, if there's a crowd around, you know, I kind of freak out and I feel like everyone's against me, or you know they're plotting to hurt me and stuff like that...."*

Service providers who participated in focus groups also noted that many of the individuals they serve either have mental health challenges, use substances, or both, and that individuals with mental health issues may self-medicate with substances. Focus group participants identified addiction and mental illness as major causes of homelessness, with some participants noting there are not enough services available for those with mental health or addiction needs in general, and there is limited support to sustain treatment for individuals experiencing homelessness. In particular, they noted there is not enough mental health treatment capacity, including not enough short- or long-term care facilities for individuals experiencing homelessness to stay in and receive treatment. Focus groups identified related challenges such as limited staff to provide care, which in turn related to high turnover among providers.

A reoccurring theme found throughout focus groups was the need for transitional recovery from substance use and mental health treatment. Multiple focus group participants said there was a lack of follow-up or discharge planning for individuals with mental health issues. Instead, individuals who received treatment were sent back into the world after treatment without a plan and no or limited follow-up. In the words of one participant, “You need mental health transitional housing. You need recovery transitional housing, and you need homeless transitional housing. I mean, everything is kind of specific, I realize is what we’re saying, but it works differently for everyone.” And another said, “The discharge planning does not take place. So, you’re not supposed to discharge someone from anywhere without a housing plan. And this is another situation where they get them some transportation to [town]. And they’re on the street. They’re literally discharged to the street after whatever period of treatment.”

While focus group participants identified several challenges to ensuring people received treatment, they also noted some individuals with poor mental health may not want assistance or stabilization and turn away from treatment.

Providers of Services Related to Substance Use Disorder

In the comparison of substance use disorder service providers with individuals experiencing homelessness, only counts of individuals who were experiencing homelessness and who self-reported a substance use disorder at their most recent intake in HMIS between January 1, 2018 through December 31, 2023 were included.

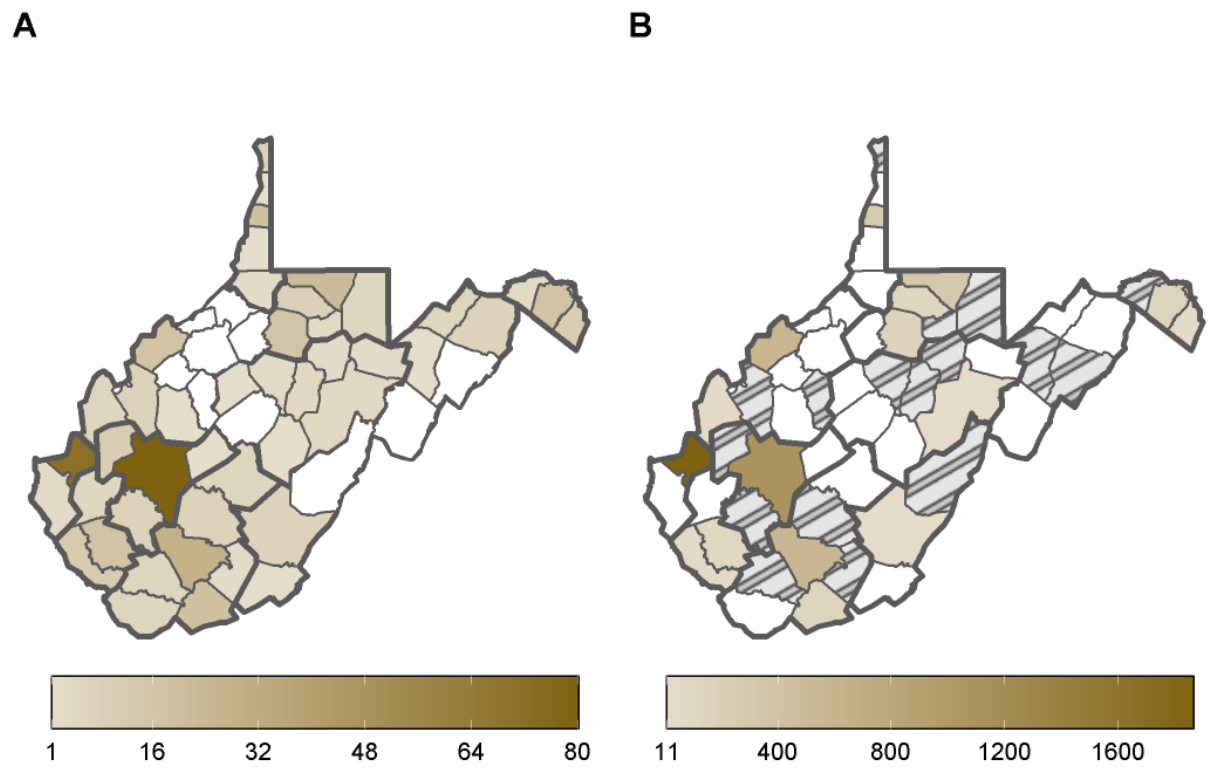
Providers included those that delivered services related to substance use disorder as their primary line of service, including inpatient, outpatient, long-term residential care, medication-assisted treatment, peer recovery resources, harm reduction, recovery housing units, recovery meetings, and prevention services. Providers did not include other types, such as behavioral health, which primarily address other issues but may also offer SUD treatment among their service provisions – these are reflected in the Mental Health section and map above. Providers whose primary services are substance use disorder resources appeared to be concentrated in Kanawha and Cabell counties. Raleigh and Monongalia counties also appeared to have more these services than other parts of the state. As with other services, there was a similar pattern in density in terms of counties with a greater number of substance use disorder resources and counties with a greater number of clients with a substance use disorder. Cabell and Kanawha counties had the greatest number of individuals and the greatest number of resources (darkest colors on both maps in Figure 10). There were 10 counties where no substance use resources were found (Figure 10A). Seven of those counties had zero counts of clients experiencing literal homelessness with a

substance use disorder at their most recent intake. In Calhoun, Hardy, and Pocahontas counties, the number of clients experiencing literal homelessness was suppressed, meaning counts were low or from one through 10.

Figure 10: Side-by-side maps of counties offering substance use disorder services and total count of HMIS clients experiencing homelessness who self-reported as having substance use disorder

A. Counts of providers in each county that offer substance use disorder services including peer recovery services, harm reduction, inpatient treatment, outpatient treatment, medication assisted treatment, long-term residential treatment, recovery housing, recovery meetings, and prevention services.

B. Total count of HMIS clients experiencing literal homelessness who self-reported as having a substance use disorder in each county based on most recent program entry date from 2018 to 2023.



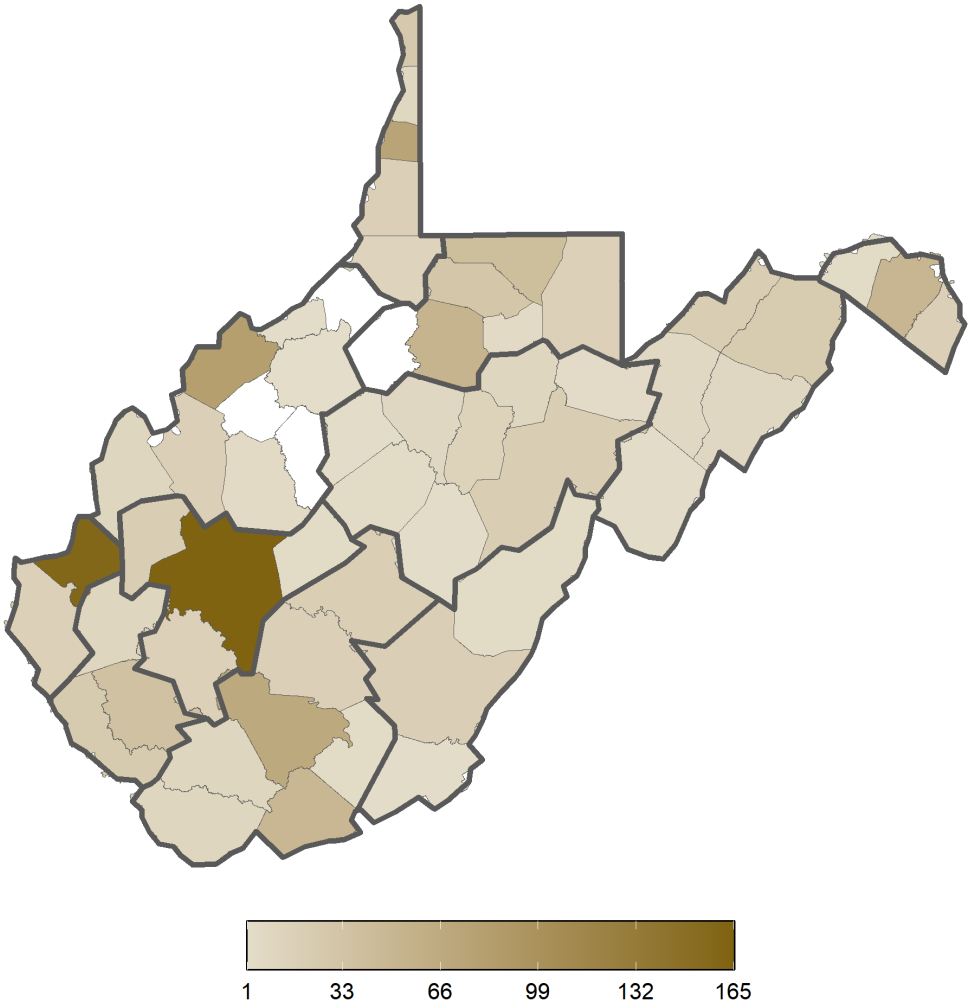
NOTES: *Map A and Map B: White color indicates zero resources or zero clients in a category. Map B: Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.*
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell-Huntington-Wayne CoC, or to Ohio County for Northern Panhandle CoC.

Behavioral health is a broad field that encompasses human behaviors and how those behaviors affect health. Behavioral health can include mental health, substance use disorders, and stress-related physical health among others. Because many service providers who are behavioral health providers in licensure and classification status provide substance use disorder treatment services, among others, these provider categories were combined to explore how it might affect distribution. (Figure 11)

Much of the data included in the Resource Inventory, which informed the maps shown here, were gathered from the West Virginia Office of Health Facility Licensure and Certification as well as from the West Virginia DoHS's Office of Drug Control Policy. The combined map for behavioral health and substance use disorder services shows locations of providers. It does not account for beds or for how many unique programs are offered by each included entity. Additionally, the project team recognizes other limitations in the snapshot provided: this combined map does not show us hospitals whose emergency departments offer medication assisted treatment induction or peer recovery services, for example, because entities which primarily provide medical care have not been included here.

Altogether, behavioral health and substance use disorder service providers are most prevalent in Kanawha County, followed by Cabell County, and then Wood County, showing a clear concentration of these types of providers in this region of West Virginia.

Figure 11: Counts of behavioral health and substance use disorder service providers in each county.



NOTES: *White color indicates zero resources in either of these two categories. Counts include providers in each county that offer behavioral health services including counseling, therapy, intellectual and developmental disability services, and crisis response and substance use disorder services including peer recovery services, harm reduction, inpatient treatment, outpatient treatment, medication-assisted treatment, long-term residential treatment, recovery housing, recovery meetings, and prevention services.*

Statewide, collected qualitative information indicated substance use disorder as a driver of homelessness and a key barrier to individuals exiting homelessness. Some interviewed individuals spoke of using and seeking treatment for substances, including substance use playing a role in their becoming homeless. “I started getting into like, you know, experimentals and stuff at an early age and that kind of led me to, you know, drop out of school, and I just, you know, I mean I kind of snowballed, and I ended up getting kicked out of my house when I was like 18-19

years old, and then I pretty much couch surfed after that for a good while... Whenever the drug use got real bad, then I ended up actually sleeping on the streets, and I was off and on homeless like on the streets homeless for about three [or] four years”

Focus group participants noted that many individuals experiencing homelessness fell into addiction or were experiencing homelessness because of addiction. As previously noted, some providers identified addiction and mental health issues as the primary drivers of homelessness in the state. Just as individuals talked about poor mental health driving people to self-medicate with substances, there was discussion of substance use, particularly opioids, leading to chronic mental health issues. In addition, focus group participants said some individuals experiencing homelessness receive services and can resolve their issues, but those experiencing homelessness and who have challenges related to substance use have a harder time and may end up needing ongoing assistance. A lack of basic necessities made it harder for individuals experiencing homelessness to find work, a substance use disorder was seen as a barrier to finding employment and through that a place to live.

Focus group participants also noted, as with mental health, addiction treatment needs exceeded current capacity in the state, with some individuals experiencing homelessness being sent out of state to receive services. This was noted as a particular barrier because it delayed treatment, which had the potential to derail someone’s desire to receive care. One person said, “We’ve sent several tenants to rehabs. We’ve sent them to different agencies to get help with different things. We’ve, you know, we’ve done a lot of those things [another participant] was just talking about, and you know when we send them to rehabs, we have to send them two hours away on the border of Maryland, or you know, three hours away because there’s just really not that help here as much. And so, we're sending them other places. But...as we all know, getting them to go into rehab in the first place is difficult. One day when we were calling for transportation to rehab, they were like well we can’t do it today. Can they go tomorrow? And I’m like listen, if they’re in my office telling me they want to go to rehab now, I need to send them now. Tomorrow will not be an option. I guarantee you, tomorrow they are not going to want to go to a rehab. They want to go right now.”

One participant suggested younger generations tended to be more fixated on drugs while older generations may be more fixated on alcohol. This individual simultaneously connected substance use to past trauma, something also noted by interviewed individuals. "When we’re looking at some of the folks that we serve when we’re the older population of people that are experiencing homelessness, it's generally looks more, it can be more like trauma or alcoholism. At least where it started, and maybe moving into harder drugs as it goes it with the younger folks. It’s trauma and street drugs. Maybe they, you know, used alcohol at a young age, but it quickly moved on from there. They generally didn’t have a history of that where some of the older folks that we work with have had a history of alcoholism and continue that way rather than moving exclusively into other drugs.” It was also observed that many individuals experiencing homelessness lacked familial support that might have helped them stay in or obtain housing, which was at least in part related to their addiction.

According to one participant, individuals experiencing homelessness might not always receive withdrawal treatments in hospitals, potentially due to discrimination. As one interviewed individual experiencing homelessness explained, “I think that addiction and homelessness is looked more

down upon here in [part of the state] than it is further [direction], which I would have thought it would have been different. That was until I moved, you know, like went [direction]…that's not a huge jump but it's a bit of a jump, and you know my addiction and stuff like that was handled with more concern."

While many service providers across the state accept Medicaid, one focus group participant indicated there is a lack of addiction service providers who accept it, or who are currently at capacity for who they can serve at that time. "Most of our folks have Medicaid, and there's nowhere in [omitted] that even takes Medicaid." Another participant discussed the high cost of treatment, in particular sober living facilities: "The meetings, therapies, treatment – you have to work full time or more to be able to afford the costs, at least in this area." Learning more about why people may perceive there to be a lack of providers who accept Medicaid, and providing education and information about those who do, is one potential way to assist those in need of services.

During focus group discussions, participants highlighted addiction as a barrier to accessing services. Some individuals experiencing homelessness avoided shelters that mandated drug testing. Additionally, the observation was made that campsites often experience significant substance use, raising public concern.

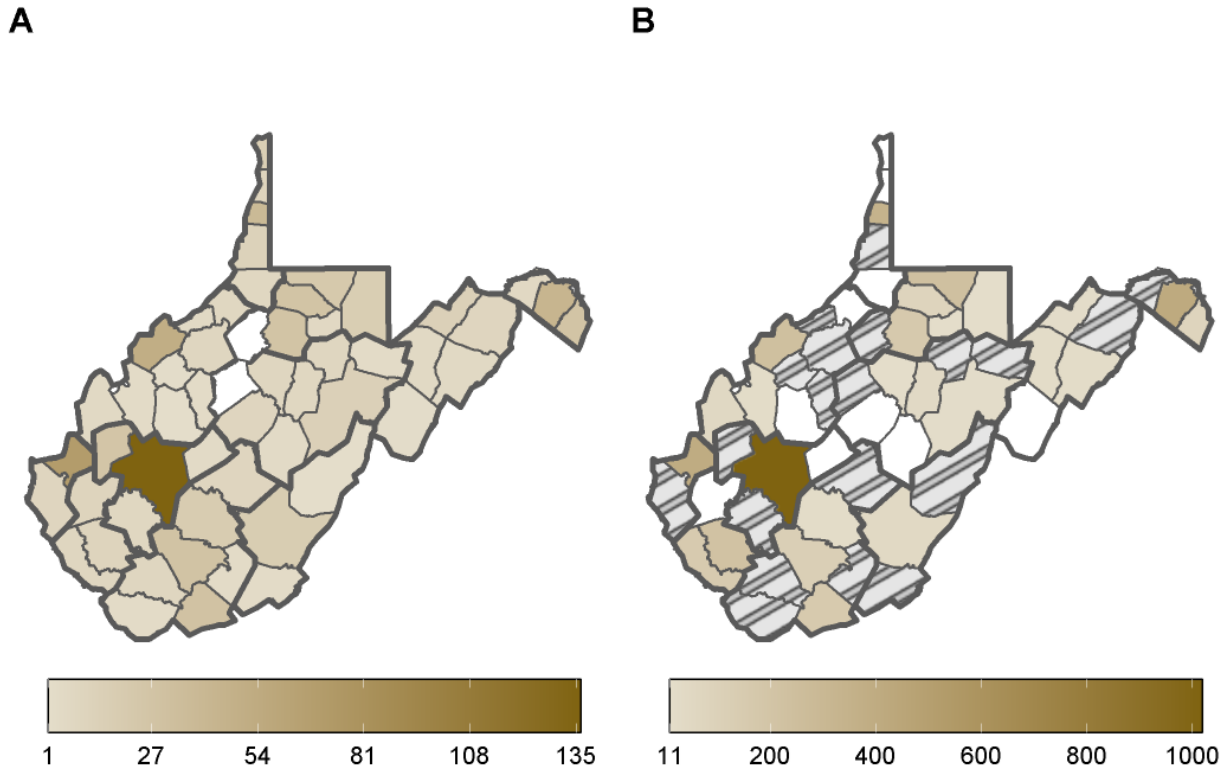
Housing Resources

Comparing housing resources with individuals experiencing homelessness, only counts of individuals who were experiencing homelessness and who were enrolled in an unsheltered project at their most recent intake in HMIS between January 1, 2018 through December 31, 2023 were included. Housing resources include HUD-funded and other emergency shelter beds, HUD-funded public housing such as USDA housing units, and Section 8 vouchers. Housing resources providers appear to be concentrated largely in Kanawha, Cabell, Wood, Berkeley, and Ohio counties, and similar patterns were observed in the density of providers offering resources related to housing in each county and the number of unsheltered individuals experiencing literal homelessness based on first intake between January 1, 2018 through December 31, 2023 (Figure 12). Counties with a greater number of housing resources were often also counties with a greater number of these individuals. There were two counties where no housing resources were found: Doddridge and Gilmer. In both counties, the number of unsheltered HMIS clients experiencing literal homelessness was suppressed, meaning counts were low or from one through 10.

Figure 12: Combined map showing substance use disorder service providers and behavioral health service providers together (many behavioral health providers offer SUD treatment services)

A. Counts of providers in each county that offer housing projects including emergency shelter, rapid re-housing, permanent supportive housing, rental and utility assistance, public housing, street outreach, and case management.

B. Total count of HMIS clients who enrolled in an unsheltered project in each county based on most recent program entry date from 2018 to 2023.



NOTES: *White color indicates zero resources are based in either of these two categories.*
Map B: Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell Huntington Wayne CoC, or to Ohio County for Northern Panhandle CoC.

While some qualitative data gathered from key informant interviews and from focus group participants spoke to the quality or availability of housing options, many discussed costs. Focus group participants discussed a lack of and long waiting lists for affordable housing, and the high cost of housing was identified as a challenge for individuals and families. Some focus group participants discussed landlords driving up prices to ensure people who could not afford these prices stayed out. Participants also indicated some places had artificially inflated prices due to surrounding businesses, such as hospitals or universities or because they were near large metropolitan areas, such as Washington DC. “In our county, the median rental price for a one-bedroom closet right now is $800 a month. And if you are a family, it’s right around [$1,500] to $1,800 a month. So, our problem...is that...people can’t afford to rent. And we struggle with that

simply because of the geographical area, us being a bedroom community for [city outside West Virginia] pushes the rents up."

Despite finding employment and securing housing, interviewees highlighted that the combined expenses of rent, utilities, and food posed significant challenges to survival. For example, one participant who was experiencing homelessness said, "You know [employers] are starting to pay more…starting at 10 bucks, it's no longer minimum wage. But even then, whatever they are paying to you, you're still paying at the store. And they're not updating the amount of money you can make. So, if you make $840 a month you don't qualify for benefits. But my rent is a thousand dollars a month, and that doesn't include trash, sewer, utilities. I didn't even get to the groceries yet, much less my car's insurance, if I have a car. How are you supposed to survive like that?"

Focus group participants shared that once someone loses their place to live, it can be difficult to maintain employment due to a lack of necessities, as discussed above. "Then it becomes the issue of the basic needs, such as being able to shower and be clean for your job, to wash your clothes for your job. So, it's almost as though they're already beaten down. And then they have all these other things when they are trying that just beats them down even more."

While housing assistance is intended to help reduce barriers to affordable housing, there are often widely known wait lists and a shortage of available housing units, as confirmed by some focus group participants. For example, the Housing Choice Voucher Program (also referred to as Section 8) is a housing assistance program offered through the federal government; the program is meant to assist very low-income families, the elderly, and disabled afford decent, safe, and sanitary housing on the private market.[53] Because there is such high demand for assistance, long waiting periods and associated wait lists for Section 8 vouchers are common. One focus group participant described his perception of individuals coming to West Virginia to obtain vouchers but not using them here, "We've had people who come, get the voucher, and they don't actually move here. I mean, it's a mess." It is not clear if this is happening but may be useful to explore. However, other focus group participants said they had vouchers that were not being used because there were not enough landlords who accept them. One mentioned working with landlords and trying to get them to see the benefit of accepting vouchers:

> **"I know one of the things we've been trying to work with the housing authority on is meeting and engaging new landlords, educating them on the benefits of working with section 8 and public housing, and that's just something we're ongoing with."**

Findings from interviews echoed the challenges with vouchers. Participants mentioned being on the waitlist, and one participant talked about having a difficult time finding landlords who would take vouchers. One individual experiencing homelessness also described having their access to a voucher derailed by a missed appointment because they did not have transportation to it. "I had

[53] Housing Choice Voucher Program section 8. hud.gov. January 11, 2022. https://www.hud.gov/topics/housing_choice_voucher_program_section_8.

HUD once before, and I missed the appointment, so they cancelled it. …I was approved for Section 8, and I was trying to get into a place, and then I missed the appointment because I didn't have no way to get there."

When it comes to accessing affordable housing, individuals experiencing homelessness face multiple barriers beyond limited transportation. One significant challenge is having a criminal record, which can further complicate their ability to secure housing. A focus group participant explained, "Because felons are a hard one to house, and especially depending on the felony. Sex offenders, almost impossible. Anything with a meth charge, almost impossible." During interviews, individuals described their struggle trying to find a job due to having a criminal record, which made it difficult to afford rent and escape homelessness. As one person explained, after describing growing up in a household affected by substance use:

> **"…I have three felonies, one for breaking and entering, one for armed robbery, and one for assault. It is a little bit hard at the age of [young age omitted] to find a job with no past or background to actually solidify a position."**

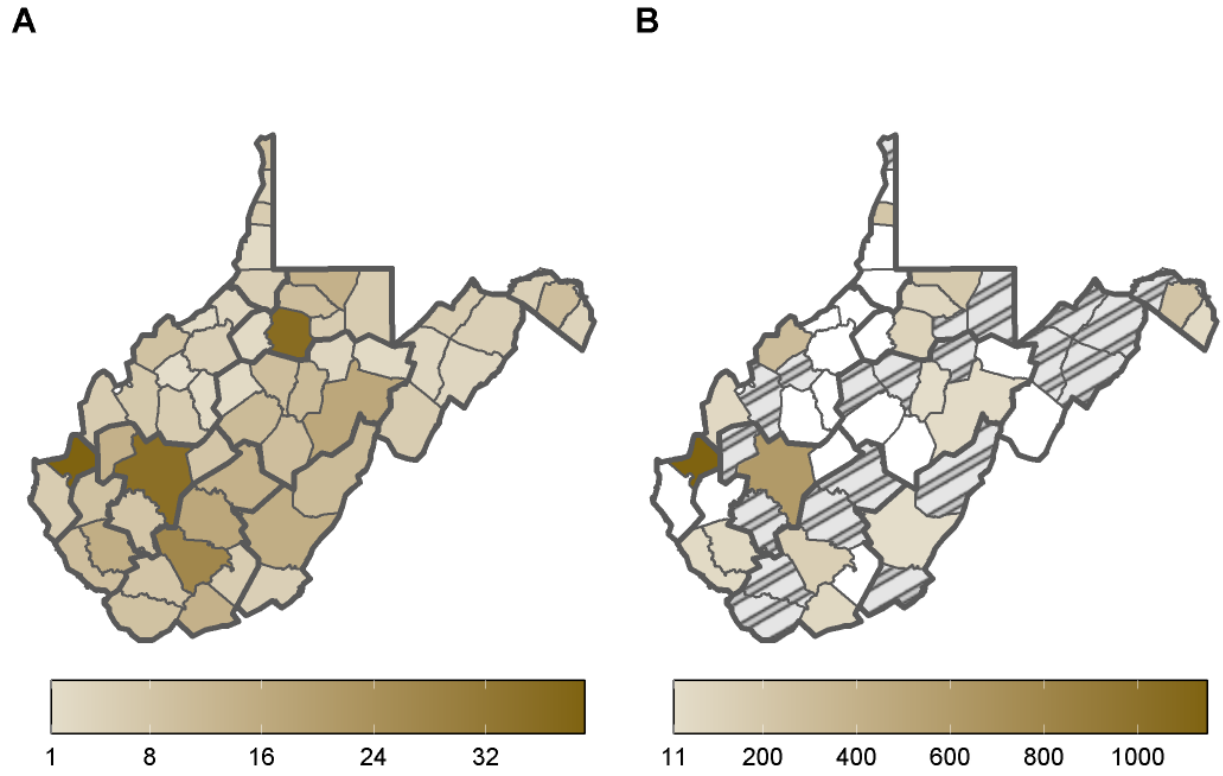
Medical Resources

This study compared medical resources across WV with the number of individuals experiencing homelessness who self-reported a chronic health condition at their most recent intake in HMIS between January 1, 2018 through December 31, 2023. Medical resources included in the comparison spanned a continuum of types of care: primary medical care, dental, vision, emergency services, health screenings, and health education. Medical resource providers appear to be most concentrated in Cabell, Kanawha, Harrison, and Raleigh counties. Counties with a greater number of medical resources were often also counties with a greater number of HMIS clients with a chronic health condition at their most recent intake. For example, Cabell and Kanawha counties have the greatest number of individuals and the greatest number of resources (darkest colors on both maps in Figure 13). While at least one medical resource was found in every county, it is important to note these services may vary widely and additional exploration by provider type may offer richer understanding (Figure 13).

Figure 13: Counts of providers in each county that offer medical services and total count of HMIS clients who self-reported as having a chronic health condition

A. Counts of providers in each county that offer medical services including primary medical care, dental services, vision services, health education, health screenings, and emergency services.

B. Total count of HMIS clients experiencing literal homelessness who self-reported as having a chronic health condition in each county based on most recent program entry date from 2018 to 2023.



NOTES: *Map A and Map B: White color indicates zero resources or zero clients in a category. Map B: Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.*
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell-Huntington-Wayne CoC, or to Ohio County for Northern Panhandle CoC.

During interviews, participants described a range of medical conditions requiring care; these are discussed in more detail in the demographic and epidemiological sections of the Demographic Report. For some, an illness or injury was a catalyst into homelessness. Most interviewed individuals had access to Medicaid, and some discussed their experiences accessing care. One individual said, “I had [omitted] medicine until I moved back to [town] and so I’ve had really great healthcare in [town], and then when I got here, I tried a doctor that I had at a rehab, and it just wasn't working. Well, I’ve been there since June. They had started my physical therapy or anything like that I started a new doctor this last Thursday through [omitted], and they already have my physical therapy scheduled. They have a mammogram scheduled; a colonoscopy scheduled. So, it’s much better like access.”

Emergency Service Providers indicated individuals experiencing homelessness sometimes came to hospital emergency rooms when it was cold, and they had nowhere else to go. Emergency Service Providers also reported some individuals experiencing homelessness would request ambulance support and then use ambulances as a form of transportation, signing themselves out of the emergency room when they arrived at the hospital.

Other Resources

Examining the Homeless Resource Inventory alongside HMIS clients and PIT counts of individuals experiencing homelessness in West Virginia from Jan. 1, 2018 to Dec. 31, 2023 provided a better understanding of how three other types of services are distributed: domestic violence shelters, veterans' services, and community and family resources. Domestic violence shelters and licensed veterans' services agencies were not concentrated in any area of the state. Instead, these service providers were intentionally located around the state to better provide access to individuals in all counties. Similarly, community and family resources, such as baby and infant needs, parenting services, and adult learning services are found throughout the state.

To summarize, many individuals experiencing homelessness would benefit from support with basic necessities and transportation. One way to facilitate access is to continue to cluster needed services in population centers where individuals experiencing homelessness already reside. While provider perceptions of need varied, they agreed that more services are still needed, especially given some individuals' complex circumstances that might include chronic health conditions, mental and behavioral health disorders, and/or involvement with the criminal justice system.

The Distribution of Emergency Shelter Across West Virginia

To understand the potential impact of policies and resources on the homeless population in WV, an important step was to compare the distribution of available emergency shelter beds with locations of those experiencing unsheltered homelessness. To understand the potential impact of policies and resources on the homeless population in WV, an important step was to compare the distribution of available emergency shelter beds with locations of those experiencing unsheltered homelessness. Unsheltered homelessness is defined as "an individual or family with a primary night-time residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground."[54]

Additional data were available about emergency shelter bed counts that were not available for other types of services previously presented. Housing Inventory Count (HIC) data are a point-in-time inventory of projects within Continuums of Care that provide beds and units for individuals experiencing homelessness; these data are commonly used as a count of emergency shelter beds. HIC data were used to examine the locations of HUD-funded emergency shelter beds in West Virginia in 2023, and the number of deduplicated HMIS clients who were unsheltered in the same counties during 2023.

[54] Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program. govinfo.gov. July 31, 2012. https://www.govinfo.gov/content/pkg/FR-2012-07-31/pdf/2012-17546.pdf.

In Figure 14, the first map (A) shows the number of emergency shelter beds in each county as reported in 2023 HIC. The second map (B) shows the number of HMIS clients that had their most recent intake in a street outreach (unsheltered) project in 2023. The emergency shelter bed maps assume:

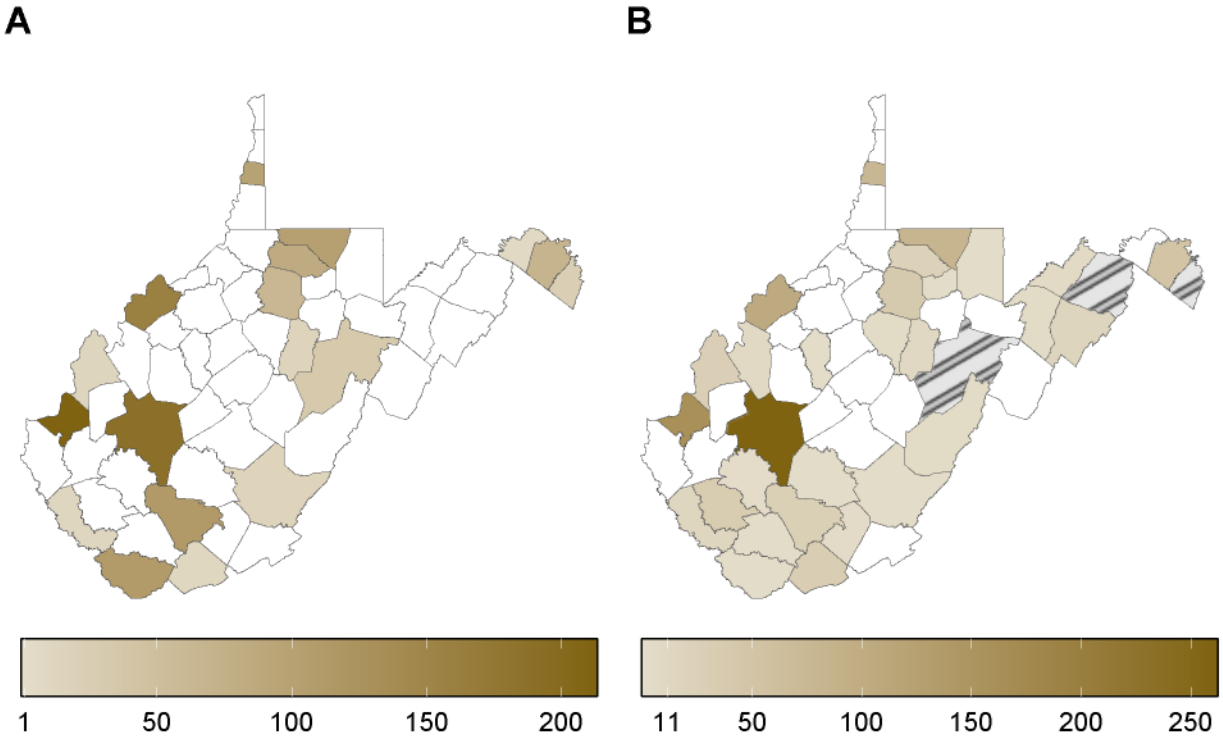
- Individuals are only included in these maps if they were enrolled in an HMIS street outreach project for the unsheltered.[55] It does include people who are experiencing unsheltered homelessness and did not enroll in 2023;
- The number of unsheltered HMIS clients does not account for how many times an HMIS client enrolled in HMIS projects through 2023 (in the same county or different counties) and may underrepresent actual use of services;
- The number of beds does not account for turnover or one individual leaving and another taking or not taking their place, which may fluctuate. For example, there may be a surge of individuals needing beds during colder months or periods of economic stress;
- The 2023 HIC was conducted during one period in January and does not include changes in bed availability through the rest of the year; and
- Maps contain only HUD-funded beds and exclude providers not required to enter beds into HIC, so the actual number of beds in the county may be higher.

[55] FY 2024 HMIS Data Standards Manual. HUD Exchange. February 2024. https://files.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2024.pdf.

Figure 14: HIC Emergency Shelter Beds and HMIS Unsheltered Client Counts (2023)

A. HIC Counts of emergency shelter beds across West Virginia counties.

B. HMIS total number of clients in 2023 for the same type of beds across counties.



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If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell Huntington Wayne CoC, or to Ohio County for Northern Panhandle CoC.

Emergency shelter beds were available in 18 of the 55 counties in WV in 2023 (Figure 14 A). In 15 counties there were HMIS clients who were unsheltered and enrolled in a street outreach project, but there were no emergency shelter beds available (Figure 14 B). The comparison of beds to the number of individuals who are unsheltered suggests that there are some parts of the state where there are more shelter beds than individuals seeking services and vice versa. These findings were echoed during focus groups; participants suggested beds were concentrated in specific areas or some areas had a disproportionate number of services.

While the maps above provide a snapshot of availability of emergency services, qualitative data provide insights from both individuals experiencing homelessness and providers into mixed

experiences using those services. Many interviewed individuals expressed appreciation for shelters and the services they provide, often mentioning specific shelters and help they received. As one person said, “The mattresses are all clean…clean linens and everything like that. Towels…shampoo and conditioner and things like that if you need it. When I got here, I had on a hoodie, and you know everything else has been passed on or given to me. So, I want you to know that…it’s a decent place, and you get to stay in all day. You don’t have to leave and come back, so that part is good.”

Interviewed individuals also indicated having negative experiences at shelters. Some reported feeling unsafe, challenges related to other shelter clients or staff, or barriers due to shelter rules, such as needing to be at the shelter by a specific time to obtain a bed or the shelter not allowing their dog. During focus groups, participants spoke about how not all shelters offered the same experience. It was shared that sometimes people seek services at shelters that provide what the individual feels is a better, safer, or more accessible experience. It should be noted this may be different for different people. Focus group participants also noted that some individuals are unable to use some shelters due to criminal records, such as felonies, violent crimes, or sexual offenses. “So, one of those problems that we’re seeing here is, while we have shelters in place, we really need what [other participant] has provided here, low barrier shelters, because we do have one place in town that can house 35 people. But there are only three currently there because they have to have an ID to get in, or there’s, you know, red tape. So, and of course we have, you know, sex offenders that can’t get in any anywhere; people with violent crime. So, from our perspective here, you know, those folks. How I’m tying this all together is those folks that can’t get into a shelter or place.”

Some focus group participants also indicated that people experiencing homelessness relocated for shelter beds, perhaps more so than for other types of services. For example, one participant explained that while there were services to meet basic needs, there were no or not enough shelters in their community, “We in [County name], we don’t have what we would call any kind of formal shelter….We do have a lot of, you know, services that handle food and clothing and necessities and things like that through the churches and food banks and things like that. We do have a small organization in some of the groups in [County name] that deal with some of the addiction and mental issue, so we do have treatment there. Though as far as housing, you know, we do not have that, I know. If we have a particular person, we need to put up you know, it’s just a hotel room for a few nights, and that to me is insufficient for that need.”

Overall, this comparison of shelter beds to people can help us understand the landscape of emergency shelters to serve the needs of individuals experiencing homelessness in the state. While the ratios are useful in identifying gaps, the analysis of quantitative and qualitative data indicate the complexity of the issue. Location and number of beds are important, as are proximity to other needed services, conditions and staff of the shelters, shelter rules, among other factors.

As recently as 2022, West Virginia’s DoHS Homeless Services Policy manual instructed staff at their local offices to direct those in need of housing services to “a local CoC, local emergency shelter, *or another department contracted shelter,”* directing individuals out of county as a last

resort.[56] "*Another department contracted shelter*" was not included in the updated version of the Homeless Services Policy manual that was released during the writing of this report. The combination of the crosswalk maps and qualitative information, particularly that from focus groups, suggest individuals experiencing homelessness who need shelter may go where there are emergency beds, even if that is in another county. This may be more complex than simply seeking an open bed, as individuals and providers may also consider someone's experiences at these locations or ability to access them. For example, contextual factors, such as whether they feel safe, whether they are allowed to enter, or whether the shelter will accept their pet may be considered. Service providers may help direct individuals and families to beds using their expertise, professional networks, and available resources.

When speaking with providers, local elected officials, key informants, and others who participated in focus groups, this was a common theme: areas without available shelter beds, out of necessity and according to policy or common practice, send those in need to places which have available beds. Required utilization of the HMIS system ensures that providers can always see who has beds – and what kind – so that they can locate a place where the client in need can find shelter. Beyond emergency shelter, basic needs like food and clothing assistance did not appear to be an incentive for moving or relocation when discussing these topics with key informants and with focus group participants.

Assessing the Impact of State and Local Policies on Homeless Population Relocation (Legislative Objective 6)

The environmental scan provided information on federal, state, and municipal level ordinances and regulations that can affect this population. Specifically, the environmental scan identified policies addressed throughout this section of the report. For additional details on how the scan was conducted, please see Appendix A. Qualitative data are also included to provide the necessary context for understanding how policies affect individuals experiencing homelessness who are working to maintain or regain stability in their daily lives. This section begins with an overview of interventional and restrictive state policies related to homelessness.

State Policies

In West Virginia, the right of individuals experiencing homelessness to access necessary services was established by the decision of the Supreme Court of Appeals of West Virginia in *Hodge v. Ginsberg*, 172 W. Va. 17, 303 S.E.2d 245 (1983). The Court decision mandated that the Department of Human Services provide shelter, food, and medical services to those experiencing homelessness, but did not identify resources, programs, benefits, qualifications, or funding mechanisms to address this mandate. Table 6 displays examples of policies to support *Hodge v. Ginsberg*.

[56] Homeless Services policy. DHHR.wv.gov. November 2022. https://dhhr.wv.gov/bss/policy/Documents/Homeless Policy November 2022.pdf.

Table 6: Examples of State Policies to Support Individuals Experiencing Homelessness

Need	Resource	WV Code
Housing	Affordable housing	§31-18-20d
	Veteran housing	§9A-2-1
	Rental assistance	§5B-2L-2
	Tenant's rights	§37-15-6
Treatment for SUD	Voluntarily seeking treatment	§15-2-55
Food insecurity	Food banks for senior citizens	§5B-2D-3
Employment	Job training	§5B-2D-4
Education and Life Skills	Access to public schools and programs for children, irrespective of housing status	§18-8A-1

Some examples of eligibility guidelines for service recipients can be found here:[57] The policies outlined in Table 6 have the potential to help bring stability to the lives of individuals experiencing or at risk of experiencing homelessness by connecting them and their families to needed resources.

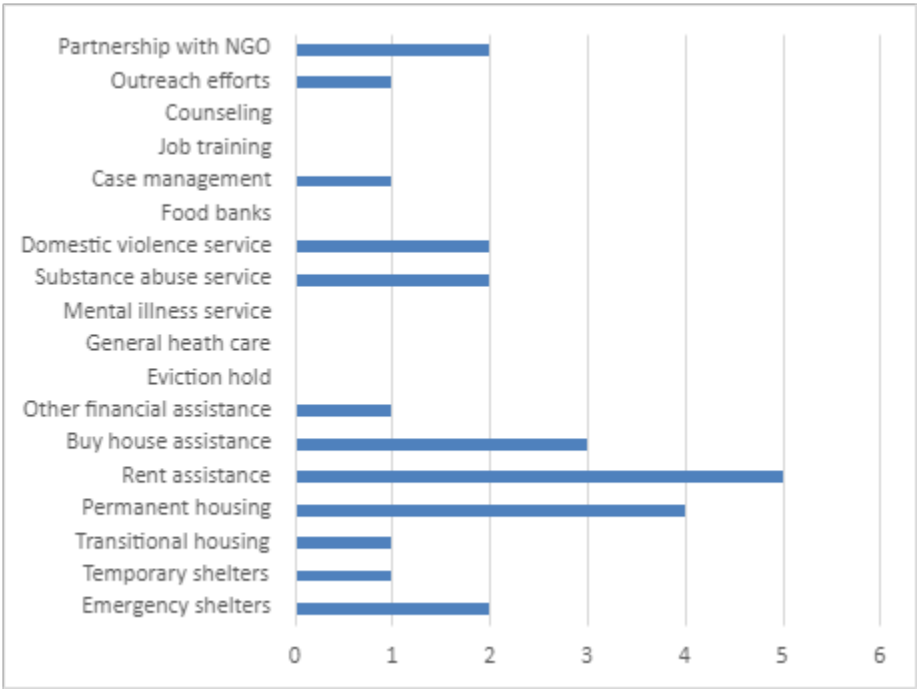
There were three clauses in WV codes that may impact individuals experiencing homelessness in a restrictive way, even though they do not target individuals experiencing homelessness directly. These included policies which criminalize loitering, involving minor children in panhandling, and trespassing[58,59,60]. Beyond these, the WV legislature has enacted regulations for repairing, altering, improving, closing, and demolishing buildings that are deemed to be unsafe, unsanitary, dangerous, or detrimental to the public safety[61] (WV Code; §8-12-16). Though the purpose of this code is public safety, it may affect unsheltered individuals who may seek shelter in vacant buildings.[62]

[57] Homeless Services policy. DHHR.wv.gov. November 2022. https://dhhr.wv.gov/bss/policy/Documents/Homeless Policy November 2022.pdf.
[58] West Virginia code section 17-19-3. West Virginia Code. Accessed June 24, 2024. https://code.wvlegislature.gov/17-19-3/.
[59] West Virginia code section 61-8-25. West Virginia Code. Accessed June 24, 2024. https://code.wvlegislature.gov/61-8-25/.
[60] West Virginia code section 61-3B-2. West Virginia Code. Accessed June 24, 2024. https://code.wvlegislature.gov/61-3B-2/.
[61] West Virginia code section 8-12-16. West Virginia Code. Accessed June 24, 2024. https://code.wvlegislature.gov/8-12-16/.
[62] Homeless Services policy. DHHR.wv.gov. November 2022. https://dhhr.wv.gov/bss/policy/Documents/Homeless Policy November 2022.pdf.

Interventional Policies

Interventional policies such as housing assistance, supportive services, and preventative measures aim to mitigate the causes of homelessness, and to provide housing and other services to individuals in need. Within the state, policies identified through the environmental scan varied across counties. Multiple counties and municipalities implemented interventional policies and ordinances aimed at mitigating the causes of homelessness. These measures included rental assistance in five counties, permanent housing assistance in four counties, and homebuyer's assistance in three counties. In general, counties issue more ordinances regarding housing assistance than other types of interventional policies (Figure 15).

Figure 15: The Frequency of Interventional Actions taken by Counties



McDowell County had the highest number of interventional policies at seven, followed by Morgan County at four, and Kanawha, Marion, and Mason at three each. Ohio County had two, and Berkeley, Lewis, and Wood counties each had one identified policy. There were several counties across West Virginia where no policies were identified.

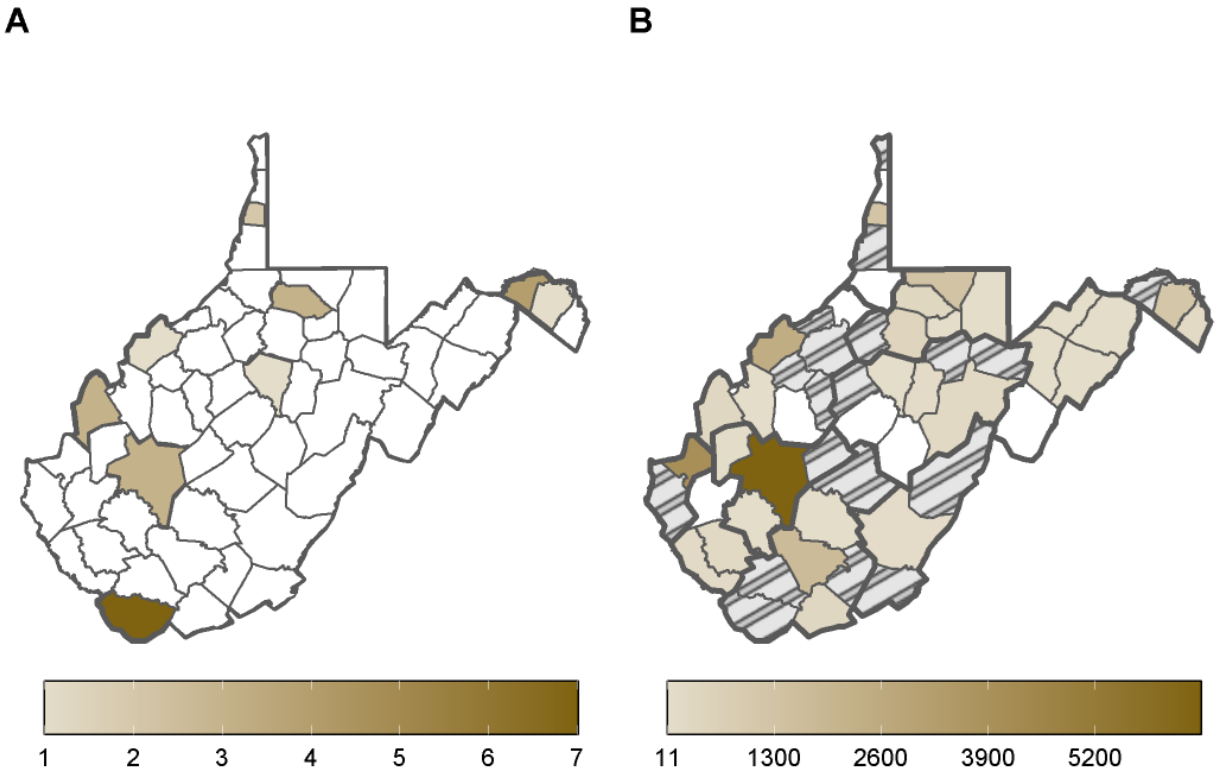
A similar pattern was observed in the number of interventional policies in each county (Figure 16) and the number of individuals experiencing literal homelessness at their most recent intake with an HMIS provider from 2018 through 2023. McDowell had the most interventional policies aimed at assisting individuals experiencing or at risk of literal homelessness, but the number of individuals experiencing literal homelessness was suppressed, meaning it was low or a value from one through 10. While it is not possible with currently available data to attribute low numbers of homelessness to the number of interventional policies in the county directly, the overlap may

indicate a positive association. The context of the county, including population decline and poverty, may also be factors that explain the data.

Figure 16: Side-by-side maps of interventional policy counts and total count of HMIS clients who were experiencing literal homelessness (sheltered or unsheltered) in each county.

A. Interventional policy count

B. Total count of HMIS clients who were experiencing literal homelessness (sheltered or unsheltered) in each county based on most recent program entry date from 2018 to 2023.



NOTES: *Map A and Map B: White color indicates zero resources or zero clients in a category. Map B: Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category.*
If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell Huntington Wayne CoC, or to Ohio County for Northern Panhandle CoC.
This figure has been amended as of August 17, 2024 to reflect a technical error: the initial report mistakenly included two counties which are not counties of interventional policy origin, but whose residents may be eligible for services provided by organizations located in neighboring counties.

Qualitative information from key informant interviews and focus groups indicated a statewide reliance upon available shelter beds. In addition, individuals and providers rely on various

community policy decisions to safeguard them from the elements, including options like temporary shelters or financial assistance for hotel and motel accommodations. A focus group participant said, “The thing that was really, truly a lifeline was the [cold shelter]. That was the big thing that was the biggest help and saved so many lives.” Focus group participants also discussed a need for additional funds for housing to assist this population, with some noting the special needs of families and youth.

The qualitative data indicates that the discharge and reentry of individuals from state and federal correctional facilities, inpatient health stays, or other institutional settings is a policy-related topic that can significantly impact this population. Individuals may be released in the counties where these facilities are located, but oftentimes resources are provided for these individuals to relocate to locations where emergency shelter beds, recovery housing options, or other resources are more readily available to meet a particular individual’s housing need. After institutionalization, individuals who were originally stably housed may find themselves unable to return to their previous location. As a result, they could become homeless in the county where they were paroled or discharged from an institutional or clinical care setting. Focus group participants indicated lack of discharge planning is a statewide issue, though both state and federal correctional facilities require inmates to have an approved “home plan” prior to release. Individuals are sometimes discharged onto the streets with no follow-up or assistance.

Three types of organizations interact with individuals who may need transition assistance after discharge or release: prisons or jails, recovery housing, and hospitals. Release from state and federal correctional facilities was the most often cited of these topics from focus groups and key informant interviews. One focus group participant said, “And the fact that, you know statewide, we are not supposed to, the jails, and the prisons are not supposed to release somebody without a home plan. Mental hospitals not supposed to release somebody without a home plan. Guess what, yeah, they do it all the time.” Another said:

> **“And the [name omitted] releases to the street, so people that are brought from other counties that are not necessarily our jurisdiction are then released to the street. I’ve worked with several families in that situation, and they don't have anywhere to go because they don’t have family waiting for them from wherever they came because they’ve been incarcerated.”**

An interview participant said, “I recently became homeless [time omitted] years ago, after getting out of juvenile detention, getting arrested, going to jail, and then getting released again. In that time, I’d been bouncing around.” Finding housing was especially difficult for some based on the types of crimes committed. A focus group participant explained, “So they come to us on the bus, and they say, ‘Check in with your federal probation officer, your federal parole officer, Monday morning.’ And they’re just like here. And then we all talk, you know. So much of our work is done through text messages. Somebody will text and be like, ‘Oh, we've got another one we need to make, we need to put them up.’ The only place you can put them is a hotel. When they’re sex offenders, and I mean they’re pretty forthright about that. But we’re back to the discharge planning.

They're being released with no housing plan, and we're never going to be able to solve the problem when we're not turning off the faucet."

Recovery housing and other substance use treatment programming is another setting that can often lead to homelessness, according to qualitative data. Often, problems arise when participants in treatment programs discontinue involvement, lose that housing as a result, and have nowhere else to go. One focus group participant stated, "So there are issues at crisis points with crisis centers and recovery centers and hospitals. And then we also lack, in many places, any sort of permanent supportive housing solution. So even if you can move somebody successfully into treatment and out, the next steps are really hard. I mean, there's some of it in [town]. There's some in [town], but in other places it's just not there. And unless there's a commitment to providing those, like to really work closely with crisis providers as well as long term recovery providers, we're going be where we are just dealing sort of in the middle with a people that are cycling in and out of acute situations until they die, which is what we see regularly."

Finally, challenges were identified with discharge from hospitals and other clinical settings. A focus group participant said, "We also see folks getting dumped here. Patients dumped here from outside hospitals outside agencies. They bring them here because we do have the services here, but there's no follow-up care for them. There's no case management provided for them. They just have to flounder on their own without the capability of even making proper decisions for themselves." An interview participant explained, "I have a rare blood disorder, and I had a stroke [omitted] years ago and I ended up in the hospital for quite a long time. And then after that well, during that time my dad went into the hospital too because he [injury omitted]. So, I didn't really have a place to go."

One provider described a client's struggle to connect with services and maintain health. "She has mentioned her [chronic health condition] she has been turned down services from service providers for not being able to stay awake during the daytime. With the accident…she was put into a…medically induced coma, and then they released her from the hospital in my humble opinion way too soon. She had a broken neck…and was not ready to be homeless again."

Another policy-related concern that was often referenced as a driver of homelessness, or as an issue preventing individuals from exiting homelessness, was the cost and availability of affordable housing. Participants described an inability to afford housing, in addition to other expenses. An interview participant explained, "So, after I paid HUD…I'm left with about 200 bucks. I still got to buy groceries. Because I work, I don't have EBT. I had a lapse in my Medicaid at that point because I was making too much." Others described a broad lack of housing affordability in their communities. "I really feel like something they need to do is lower this rent…It's unlivable. People are working jobs like [restaurants], you know at [grocery store], and they're paying $850 to $950 a month. Almost $1,000. …I mean, I just think about the people working those kinds of jobs with kids and families…how is anyone supposed to live a healthy life? Things might not be great around here, but I guarantee you, if rent became affordable, and people knew they could feed their kids every paycheck, things would get a lot better. At least start to get better."

Distribution of HUD and Section 8 voucher availability around the state was a topic that was often raised throughout focus groups and interviews. Some participants who were using emergency

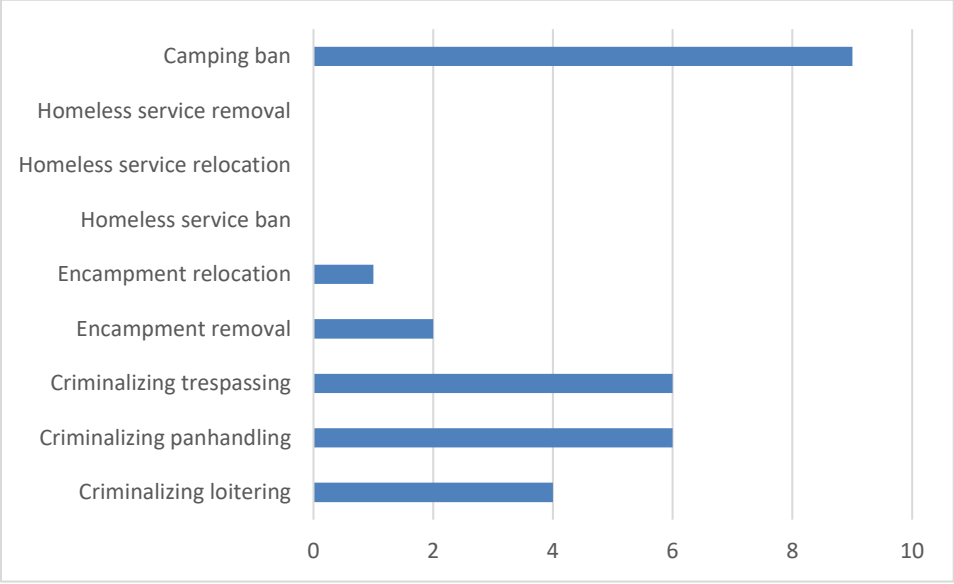
shelters at the time of their interview were on waitlists for this housing support, which is a result of interventional policy and is intended to help individuals with lower incomes gain or maintain housing. “We’re on the housing waiting list and…the workers here are doing everything they can to help us find a place…we’ve been here so long.” There was a two-fold challenge identified in focus groups related to vouchers, with some participants expressing a need for more and others saying they had vouchers but not enough landlords who would accept them.

Restrictive Policies

The project team also explored restrictive policies, including those that penalize actions that may be taken by members of this population. At the local level, both restrictive and interventional policies were identified across West Virginia counties and municipalities. The number of restrictive policies were aggregated by the county and its municipalities. Policies included penalization of certain behaviors such as loitering and trespassing, or by relocation of service providers or encampments.

Camping bans were the most common restrictive action taken, followed by penalization of loitering, panhandling, and trespassing. For this work, the project team included a few different things in the category called “camping bans”: policies which overtly ban camping anywhere in a municipality, as well as policies that ban camping in city parks, parking RVs to sleep on city streets, or any others that functionally restrict residents from sleeping outdoors when they do not have anywhere else to go. Many counties in West Virginia have low numbers of individuals experiencing homelessness, and so have not taken policy actions to directly address this population. A summary of actions by counties are presented in Figure 17.

Figure 17: The Frequency of Restrictive Actions taken by Counties



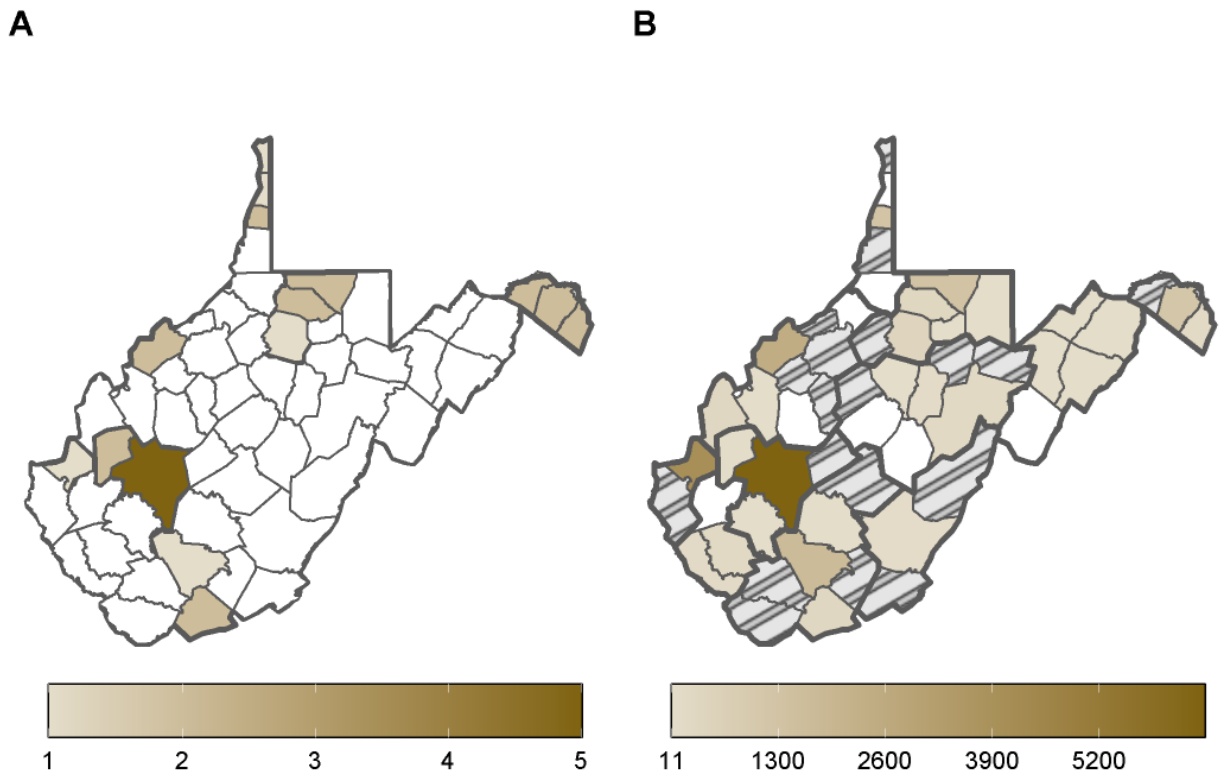
Additionally, Kanawha County has the highest number of restrictive policies – five – followed by several counties which have two each: Berkeley, Jefferson, Marion, Mercer, Monongalia, Morgan, Ohio, Putnam, and Wood counties. In contrast, Brooke, Cabell, Hancock, Harrison, and Raleigh counties each have one restrictive action.

A similar pattern was observed in the number of restrictive policies in each county and the number of individuals experiencing literal homelessness at their most recent intake with an HMIS provider from 2018 through 2023 (Figure 18). Counties with the most restrictive policies also tended to have the most individuals experiencing homelessness. This may suggest counties with increased numbers of individuals experiencing homelessness are more likely to adopt restrictive policies. It is unclear from this quantitative analysis how these policies affect these populations.

Figure 18: Side-by-side maps of restrictive policy count by county and number of HMIS clients experiencing literal homelessness.

A. Restrictive policy count by West Virginia county as of November 2023.

B. Total count of HMIS clients who were experiencing literal homelessness (sheltered or unsheltered) in each county based on most recent program entry date from 2018 to 2023.



NOTES: Map A and Map B: White color indicates zero resources or zero clients in a category.
Map B: Hatched gray color indicates clients one through 10 – the actual number is not reportable (NR) due to identifiability concerns. White color indicates zero clients in a category. If address information was missing for the most recent enrollment, but the Continuum of Care (CoC) where the enrollment occurred was known, then the client was assigned to Kanawha

County for the Kanawha Valley Collective CoC, to Cabell County for the Cabell Huntington Wayne CoC, or to Ohio County for Northern Panhandle CoC.
This figure has been amended as of August 17, 2024 to reflect a technical error: the initial report mistakenly included a restrictive policy that was scheduled to receive public input at a city council meeting during the time of the environmental scan. However, this potential policy should not have been included at that stage of development based upon the methodology of this policy report, and it did not come to pass in its city of origin.

Focus group participants, including local elected officials, law enforcement, and key informants experiencing homelessness, provided additional insights related to restrictive policies in their communities. Camping bans were most commonly discussed. One person indicated police are unlikely to seek out tents but will follow up if they receive complaints and ask individuals to move. "As the police have said, you know, we were talking to [omitted] the other day and as he said, we're not going out looking for the people camping. If somebody complains, though, we have to go. He's like, I'm not riding around looking for tents, but if somebody calls me and says, he goes, then we will ask them to move along, and then we will come back and check and see if they moved along. And if they didn't, that's when the next steps go into play."

Focus group participants sometimes discussed unintended consequences of different ordinances. For example, when talking about camping bans, one focus group participant discussed issues related to where individuals were allowed to camp, saying "The current site where people are allowed to camp is not accessible. So that's one of the things I said was, 'If you're going to arrest the people violating this, you're going to only be arresting literally disabled people.' Because people in wheelchairs can't access the site."

Relocation to West Virginia from Out-of-State (Legislative Objective 7)

To understand what percentage of individuals experiencing homelessness lived in another state or jurisdiction in the past three years or were from another state or jurisdiction, the project team considered both HMIS client records and qualitative data collected. HMIS intake data collection includes three optional questions related to the topic of relocation which could help address legislative objectives:

- In the last two years, have you lived anywhere other than this county/community? (with responses options including moved county, moved state, did not move)
- What is the primary reason you came to this community?
- What is the biggest barrier to getting housing? Pick the top reason.

The relocation questions are optional per HUD regulatory guidance. In WV, most providers entering data into HMIS did not collect responses to these questions from those experiencing homelessness or at risk of homelessness. From 2020 through 2023, just one third (30%) of records for clients experiencing homelessness included responses - 4,804 out of 15,786 records. (These numbers include those in homelessness prevention services and permanent housing, as well as unsheltered and sheltered.)

While responses were not required, the records with responses available provide a snapshot of experiences related to relocation.

Table 7: HMIS client responses to questions about prior location in the past two years for those experiencing literal homelessness based on the most recent program entry date from 2020 to 2023.

Questions	Prior Location				
In the last two years, have you lived anywhere other than this county/ community?	**Did Not Move, % (n)**	**Moved County, % (n)**	**Moved State, % (n)**	**Missing, % (n)**	**Total Clients Experiencing Literal Homelessness, % (n)**
Client Response	16% (2560)	6% (999)	8% (1245)	70% (10982)	100% (15786)
What is the primary reason you came to this county/ community?					
Family	1% (190)	1% (182)	2% (359)	84% (13222)	5% (731)
Service	1% (152)	4% (558)	3% (540)	84% (13222)	8% (1250)
Other Reason	0% (70)	1% (213)	2% (300)	84% (13222)	4% (583)
What is the biggest barrier to getting housing? (Pick the top reason)					
Unemployment	2% (253)	1% (173)	1% (218)	77% (12119)	4% (644)
Unable to Afford Rent	6% (944)	4% (563)	4% (679)	77% (12119)	14% (2186)
Other Barrier	2% (327)	1% (224)	2% (286)	77% (12119)	5% (837)

Some individuals indicated they had not moved in the prior two years but went on to share their primary reason for being where they currently lived. Those responses were treated as information about why they moved to where they are – it may have been they moved more than two years ago as the question asked – or why they chose to remain if they were completing an intake for services in a location they lived for many years or throughout their lives.

When looking at individuals who had provided information related to relocation at intake, services were the top reason individuals indicated they were in their current county. Of those experiencing homelessness, 4% indicated moving to another county to access a service, while 1% for family and other reasons. In terms of moving from out of state, 3% of individuals experiencing homelessness indicated having moved to access services, while 2% moved to West Virginia for family and other reasons.

In terms of barriers to acquiring housing, 14% percent reported that an inability to afford rent was their primary barrier. Unemployment was selected by 4%, and 5% said there was another barrier not included in the listed options. Write-in responses were not provided, but with nearly a quarter indicating another reason, which may be worth exploring in the future.

There were mixed reports from focus group participants regarding whether people moved from out of state to West Virginia. Many reported it was uncommon and others, particularly along the state line, had more experience with this in their communities. One focus group participant explained, “We have had a couple of instances where people have come here from other states. Those are very rare and whenever they do happen.” However, another person said, “We have a lot of people that come from different states. One is just to get away from domestic violence and hiding from people, and we do have, you know, a domestic violence shelter for, you know, women and children…But that’s a lot to do with it is, you know, domestic violence and hiding away from whoever.” Thirteen of West Virginia’s shelters are in counties that border other states, and inversely, West Virginia has 15 counties where the nearest shelter may be out-of-state. Qualitative data suggests that migration goes both ways and has more to do with proximity to a shelter bed than with state borders. Similarly, 20 of the 25 interior counties in WV do not have shelters, many of which are very rural. Qualitative data suggests that migration also includes rural to urban – homeless residents of these counties often relocate to larger municipalities for shelter, regardless of state borders.

Interviewees who had come to West Virginia from another state largely did so either to come back home, to be near family, or to be with a spouse or spouse’s family. Of the exceptions to this theme, one participant described West Virginia as a place they felt they could gain stability due to employment and housing options. This young individual arrived from a border state and initially had a place to stay with a local resident, but eventually found themselves unsheltered. “When I got out of foster care I didn’t have any family. I didn’t have any friends. I didn’t have anyone to call…so I kinda walked and wandered and got rides and stayed with people here and there until I got somewhere where I felt like I could start doing something.”

This person, relatively new to the state, also shared how difficult it could sometimes be for someone living in an emergency shelter to find transportation to a job, though in their perception employment is more available where they were than in many other places. “I know plenty of people right now who walk almost an hour every day to their job because they got these bus

passes [that are not usable every day]. Your shift's not going to care about the bus…what time it comes, so you're going to have to go."

Another person in another part of the state described their choice to relocate back to West Virginia as being as much about the people in the state as the available services. "You know why I came back [to this area], 'cause I lived here 12 years ago, and I knew there was good people. I chose this city because I knew that I could get the help I needed, and I said, you won't go hungry. …so I knew I could come here and get fed and get good healthcare, though I don't have health problems." One interviewee described their decision to move as driven by the need to provide care for a family member. "Originally, I had moved, maybe about 12 years ago…I decided to come back because my mom called me. She was sick and…a couple of days after me being back, she fell and went into a coma and stuff like that, so I ended up staying."

While a majority of interviewed individuals were from West Virginia, around one-third were from out of state. The reasons interview participants gave for why they moved, if they had relocated, were most often unique and personal. Only four of the thirty-three individuals said they came to West Virginia to access services. Besides those already mentioned, other participants described coming to West Virginia for relationship reasons. "I had gotten together with somebody else, and we decided to move to West Virginia. Now, I don't have any kind of family…or anything like that. It's just me here. And she wanted to come to West Virginia to be closer to her parents."

Analyzing the Attraction of Health and Human Services Benefits (Legislative Objective 8)

For the objective of analyzing whether any health and human services benefits offered in West Virginia attract populations that are homeless or at risk of homelessness, Table 7 suggests that a number of individuals experiencing homelessness relocated to connect to needed services but does not indicate which services. The similarity in proportions of those moving within the state and across state lines suggests, while movement happens within WV and across state lines for many reasons, it is often a West Virginia resident arriving in a new place for services.

Participants in focus groups and interviewees described service use across the state. Discussions ranged from availability of shelter beds to cleanliness and safety of facilities. Focus group participants and interviewed individuals indicated that there were a variety of reasons individuals experiencing homelessness moved to West Virginia, and it was sometimes for services. Participants also sometimes spoke of places where services do not exist at all – e.g., rural residents or providers who live in counties with no shelter – and sometimes moves were to access services that exist but that could not serve all participants due to capacity, barriers to entry, limited funding, or other issues. This appeared to be particularly true in communities near or on the state line, especially when the neighboring community had less available services. Of the 33 individuals interviewed, four indicated coming to the state for services. As one person interviewed said:

> **"I am here for the housing…The shelter has been a blessing…I am supposed to be getting a call today about my apartment. The ladies here was good at contacting [out-of-state agency], and they stayed in contact with each other, and I thank God for this place, cause it helped me get back on my feet and back to my family."**

As indicated above, individuals who moved to West Virginia also came for a variety of other reasons, such as family connections. One focus group participant pointed to the low cost of housing compared to other places as a driver of relocation, “Yeah, I was just gonna say, as far as statewide I think you’re gonna see that on the perimeters there is a lot of border, you know, hopping for a better lack of a better word. Virginia coming in Kentucky, even and some of the neighboring counties with Kentucky, Ohio. But I think it’s more of what [name] said. It’s a lack of good housing that is reasonably priced and people just, you know, don’t have the income to sustain these types of rentals. And when you have somebody that that is, you know, either a couple or a family trying to crush themselves into a two-bedroom or a one-bedroom space then it's just, you know, it’s not feasible so...”

Conclusion

People experiencing literal homelessness generally concentrated in the most populous counties with larger cities and metropolitan areas. Services also appeared to be most readily available in these areas. While provider perceptions of need varied, they agreed that the resources available were not enough to adequately address existing needs. This is especially true with complex clinical circumstances that might include chronic health conditions, mental and behavioral health disorders, or substance use disorder. It is equally complicated when serving those involved with the criminal justice system, and those whose networks of relationships and support have been affected by substance use. Some individuals may have a perception that services are not available through Medicaid, and policy makers could consider exploring why that perception is there and if additional advertising of available services might help connect people to needed care.

Policies and ordinances related to homelessness – or which frequently affect these populations – were a mix of interventional and restrictive. As a state, the most commonly implemented interventional policy was rental assistance, followed by permanent housing, homebuyer’s assistance, and temporary shelter. Most interventional actions were in McDowell, Pendleton, and Morgan counties. These are counties where HMIS data reflects relatively few individuals experiencing homelessness, while other counties with much higher populations of individuals experiencing homelessness, such as Berkeley, Lewis, Wirt, Wood, have more minimal interventional policies. Restrictive policies tended to be camping bans followed by criminalization of panhandling and of trespassing. Counties with the highest number of restrictive policies were Kanawha and Mercer. Counties with larger populations of individuals experiencing homelessness also had a higher number of restrictive policies.

People moved for a variety of reasons, most specifically to be near family or to access services. Many people experiencing homelessness in West Virginia are from West Virginia or have lived in the state for a long time. Of those who are moving from other states, this may partly relate to counties and communities sharing a state line with communities in other states. Additional funding and support to agencies to assist in collecting this information may assist in better understanding movement and reasons for it.

Appendix A: Qualitative Methods

Initial Outreach

Initial outreach was conducted throughout the state of West Virginia by key members of the project team and was guided by the language of the legislation and by DoHS sponsors. An outreach email was drafted to briefly introduce the purpose of the work, as well as to gather any information available about the following:

- Services and service providers for people experiencing or at-risk of homelessness,
- Laws, ordinances, and policies related to people experiencing or at-risk of homelessness, and
- Additional potential stakeholders, such as non-profit or religious organizations, that provide services for or have knowledge of people experiencing or at-risk of homelessness.

This initial outreach email was first sent to each county commissioner in WV's 55 counties. Contact information was gathered online, and if unavailable, phone calls were made by the project team to counties where information was needed. Most commissioners received individual emails; some counties manage a group email address, and these addresses received a single email with all commissioners addressed by name in the salutation. Emails that did not receive an initial response were followed by an additional two follow-up attempts to ensure multiple opportunities for input were provided to each county.

From there, the same outreach email was extended to mayors of the ten most populous municipalities in WV, and to mayors of the municipalities within the ten most populous counties. Finally, the initial outreach email was sent to contacts at the thirteen Comprehensive Behavioral Health Centers, which anchor WV's publicly funded community-based behavioral health system. The same *three-attempts* method was used for these groups of contacts as well to reduce the risk of missing opportunities.

These initial outreach attempts resulted in many suggestions for potential participants, forwarded emails to other contacts, invitations to discuss on the phone, and direct e-introduction connections to others. All contacts gathered through this round comprised the team's "snowball", and these new individuals received a communication from the team about the purpose of this project, work thus far, and the same request for the bulleted information that initially went out to elected officials and others. Many of these new contacts made further suggestions, which were added to the snowball and contacted as described above in a third and final round of outreach.

Stakeholder Engagement

Focus Groups

Participants of nine focus groups were asked to discuss their expert opinions and perceptions of homelessness in their communities, of the individuals and families they serve and interact with, and of service needs and barriers these community members faced when accessing needed services and housing. These discussions also sought to inform the project team about available services, as well as local policies and ordinances affecting these populations.

Focus Group Eligibility

Focus group invitations were first sent to all contacts who expressed interest during outreach efforts, either in participation in a focus group explicitly, or more generally in any opportunities to provide more input. Additional outreach communications were made to emergency medical services (EMS) and law enforcement representatives at this stage of the work to attempt broader inclusion from this field. These invitees, if initially unresponsive, received two additional follow-up emails, allowing opportunities to indicate interest in participation.

Focus Group Sampling

Focus group invitations were extended to 62 providers and other stakeholders, 31 members of EMS and law enforcement, and 25 elected officials.

Focus Group Guide

A discussion guide was developed with the goal of soliciting information from the group that would help address the objectives in the legislative directives. Participants were asked about the following: primary causes of homelessness in their area, characteristics of people experiencing homelessness, available services, relocation of people experiencing homelessness from counties or states, challenges unhoused populations face, policies affecting them, and suggestions for improvement.

Focus Group Setting

Focus groups were conducted via Zoom, a communications platform that allows users to connect using video, audio, phone, and chat. [63] Participants were able to join with or without video as they preferred. Many joined via computers, while others called in via phone. Focus group sessions were recorded and housed in HIPAA-secure storage.

Focus Group Transcription

Transcriptions were produced using meeting recordings. These files were housed in HIPAA-secure storage and cleaned of all identifying information: names of individuals or agencies, cities, towns, and other locations.

Thematic Analysis of Qualitative Data — Inductive Coding

Focus group transcriptions were analyzed using inductive coding, where categories, or codes (themes) emerge from the collected data with no prior assumptions by the research team. [64] For this work, this means that the information shared by participants of focus groups drove the outcome of the data analysis, and that the initial list of relevant themes was developed directly from these discussions.

A team of three researchers independently coded each focus group transcription, and an independent researcher with advanced expertise in qualitative analysis developed themes.

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[63] Zoom Video Communications. 2024. https://zoom.us/.

[64] Daniels K. Box 4.3, three approaches to analysis in systematic reviews of qualitative studies - evidence synthesis for health policy and systems: A methods guide - NCBI bookshelf. National Center for Biotechnology Information. October 8, 2018. https://www.ncbi.nlm.nih.gov/books/NBK569586/box/ch4.box12/?report=objectonly.

Themes were reviewed by members of the coding team and by the individual who facilitated the focus group to ensure they aligned with key elements of conversations.

Key Informant Interviews

Key Informant Interview Eligibility

Key informant interviews were conducted with adults currently experiencing homelessness, or who had recently been housed. To identify these individuals, the project team worked through outreach to learn who had the capacity and desire to assist with coordinating these key informant interviews. An initial list of individuals and agencies was assembled from these outreach efforts, and an email extended to these contacts to begin coordination of interviews with those who wished to participate. At the same time, the research team extended additional outreach communications to the state's larger municipalities with whom an initial line of communication had not yet been successfully established. Together, these efforts culminated in 33 interviews with key informants, adults currently experiencing homelessness, or who had recently been housed.

Key Informant Interview Sampling Strategy

Given the complex nature of this population, the project team conducted interviews with a convenience sample of individuals who had the ability and desire to participate. Some interviewees had cell phones, jobs, and permission from their employers to take a break from their workday to provide an interview. Others were coordinated on shorter notice, when their life situations found them at the agencies of the providers who were assisting the research team, and the opportunity to conduct an interview presented itself. Interviewees ranged from young adults to senior citizens spanning four generations and were of a variety of races and ethnicities. All interviewees were either experiencing homelessness — that is, they were living in emergency shelter situations, or were sleeping in unsheltered locations – or had been recently housed.

Key Informant Interview Guide

Through stakeholder outreach, the research team learned from providers that to optimize time with interviewees, the interview duration should be kept to approximately the length of intake for services – about 10 to15 minutes. The total time of completed interviews ranged from nine to 36 minutes. An interview guide was developed with the goal of informing the participant of the purpose, reviewing consent, and asking questions that could collectively provide thematic context for legislative objectives within the suggested interview duration. Interviewees were asked questions about their life experiences including the following: age, place of origin and location over the last three years, veteran status, current housing and/or sleeping arrangements, circumstances leading to homelessness, health and social services benefits, and an opportunity for anything else they believed to be valuable and wished to share.

Key Informant Interview Setting

Interviews were conducted virtually via Zoom. Participants were able to join their interview call from the setting that worked best for them, with or without a camera on according to their preference, and with or without a case manager present according to participant preference. Many participants completed their interviews via an agency computer and with a case manager nearby in case assistance was needed. Others were interviewed independently while they used private rooms at shelters, agencies, or the housing where they lived. Some participants chose to be

outdoors in the community for their interview, while others took breaks from their workdays and were interviewed in an environment of their choosing.

Key Informant Interview Incentives

Interview participants were given a $50 stipend in the form of a physical gift card as compensation for their time.

Key Informant Interview Transcription

Transcriptions were produced via Zoom recordings as with the focus groups, moved to HIPAA-secure storage, and cleaned of all identifying information: names of individuals or agencies, cities, towns, and other locations.

Key Informant Interview Thematic Analysis of Qualitative Data – Deductive/Inductive

Key informant interview transcriptions were analyzed using deductive analysis, or an up-front framework of understanding informed by existing knowledge.[65] The research team began with themes identified as a result of the focus group analysis. Key informant interviews were coded using these themes, as well as inductively for the addition of anything new that arose directly from discussions with this population. An independent researcher with advanced expertise in qualitative analysis developed themes. Themes were reviewed by members of the coding team and by the individual who facilitated the interviews to ensure themes aligned with conversations.

[65] Daniels K. Box 4.3, three approaches to analysis in systematic reviews of qualitative studies - evidence synthesis for health policy and systems: A methods guide - NCBI bookshelf. National Center for Biotechnology Information. October 8, 2018. https://www.ncbi.nlm.nih.gov/books/NBK569586/box/ch4.box12/?report=objectonly.

Appendix B: Policy Analysis Approach

Environmental Scan of Policies, Ordinances, and Regulations

The project team conducted a policy environmental scan to assess use of interventional and restrictive policies in West Virginia. In tandem, the team also gathered additional local policy information through a variety of stakeholder engagement activities. Together, this information helped the team understand the landscape of policies in West Virginia, and their effects on not only the population of study, but also the providers and agencies who work to meet residents' needs.

The policy environmental scan included search engines like Google, state, counties, and municipal websites in addition to two legal databases (Municode[66] and the American Legal Publishing Corporation[67]). Municode and ALP host code storage for municipalities in a secure, searchable database for local governments that do not wish to host policies on their own websites. The following search terms were used to find the relevant documents:

> *Homeless, homelessness, housing, unhoused, housing insecurity, affordable housing, chronic homeless, veterans homeless, youth homeless, family homeless, women homeless, LGBTQ+ homeless, racial and ethnic disparities in homelessness, homeless prevention, homeless criminalization, supportive housing, permanent housing, McKinney-Vento Homeless Assistance Act, Continuum of Care, CoC, National Alliance to End Homelessness, National Coalition for the Homeless, housing ordinance, housing code, public welfare codes.*

Focus group participants, partners who were engaged in local-level discussions throughout the work, and key informants from around the state all contributed policy perspectives to the qualitative data that was gathered by the team. This information provided further details and context about how providers, agencies, and the individuals and families they interact with and are affected by policy. Nine focus groups were held in December 2023 and January 2024 to learn from providers, elected officials, municipal leaders, law enforcement, and emergency services. In April and May 2024, 33 key informant interviews were conducted with four generations of individuals experiencing homelessness around West Virginia. Full details of stakeholder and key informant engagement processes, activities, and methods for conducting thematic analysis of this work are shared above.

After completion of the policy environmental scan and qualitative data collection, the project team analyzed the regulations and ordinances alongside the federal data. The team sought to understand the goals of policy actions taken by counties and municipalities, as well as any known outcomes and unforeseen repercussions. For example, some places have issued camping bans in an attempt to relocate individuals experiencing homelessness away from areas where they may be thought to be inappropriately congregating, such as near community centers or businesses.

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[66] Municode. CivicPlus. May 16, 2024. https://www.civicplus.com/codification-software-services/.
[67] American Legal Publishing. Accessed June 27, 2024. https://amlegal.com/.

While location goals may be achieved, added distance can make it harder for this population to meet their needs.

Table 8 presents a list of policy categories, the specific policies within each, and the actions associated with each policy. The research team identified which of these policy actions a county or any of its municipalities had taken, looking specifically at the county or municipality of origin and not any broader service areas or populations that may be eligible for services. Future reporting on this topic may benefit from looking not only at location of an agency or organization, but at overall service areas, funding sources, and service provision requirements for a more robust and detailed picture of where residents are eligible for services, when, and how eligibility criteria are met.

The project team then quantified the policies based on the number of actions in each county or any of its municipalities. For example, if a municipality within a county had enacted a camping ban, it is counted as one restrictive policy for that county. If multiple municipalities within the same county enacted the same policy, such as a camping ban, it still counted as one policy for that county. The number of policy actions quantified for each county provided an overall estimate of interventional policies and restrictive policies across West Virginia. Below are policy sources for each included in this environmental scan.

Table 8: Policy categories and associated actions

Category	Policy	Actions
Interventional Policies	Housing assistance	Emergency shelters
		Temporary shelters
		Transitional housing
		Permanent housing
		Rent assistance
		Homebuying assistance
		Other financial assistance
		Eviction relief
	Supportive services	Physical health care
		Mental health care
		Substance use disorder services
		Domestic violence services
		Food pantries and meals
	Preventive measures	Case management
		Job skills training
		Counseling
		Outreach efforts
		Partnership with agencies
Restrictive Policies	Criminalization	Loitering
		Panhandling
		Trespassing
	Removal	Camping ban
		Encampment removal
		Encampment relocation
		Homeless service ban
		Homeless service relocation
		Homeless service removal
		Housing demolition

Policy Sources

Berkeley county

County Level

1. Ordinance Facilitating the Free Flow of Motor Vehicle Traffic on Streets and Roadways in the County and Promoting the Health, Safety and Welfare of Pedestrians. Berkeleywv.org. February 23, 2017. Accessed August 29, 2024. https://www.berkeleywv.org/DocumentCenter/View/8267/2020-Rules-and-Regulations-PDF.
2. Berkeley County, WV: Official Website. Accessed August 29, 2024. https://www.berkeleywv.org/.
3. County ordinances. Berkeleywv.org. Accessed August 29, 2024. https://www.berkeleywv.org/287/County-Ordinances.

Martinsburg

4. Municipal code | City of Martinsburg, WV. cityofmartinsburg.org. Accessed August 29, 2024. https://www.cityofmartinsburg.org/government/municipal-code.
5. Martinsburg, WV Laws. American Legal Publishing. January 9, 2024. Accessed August 29, 2024. https://codelibrary.amlegal.com/codes/martinsburg/latest/overview.
6. Codified Ordinances of Martinsburg, American Legal Publishing. Passed July 21, 2021. 1329.16 Vehicle Parking. https://codelibrary.amlegal.com/codes/martinsburg/latest/martinsburg_wv/0-0-0-23262
7. Codified Ordinances of Martinsburg, American Legal Publishing. Passed May 5, 1981. 1101.04 Nuisances Affecting Peace and Safety. https://codelibrary.amlegal.com/codes/martinsburg/latest/martinsburg_wv/0-0-0-11297
8. Codified Ordinances of Martinsburg, American Legal Publishing. Passed July 21, 2021. 1327.07 Principal Uses. https://codelibrary.amlegal.com/codes/martinsburg/latest/martinsburg_wv/0-0-0-22576

Brooke county

Weirton

1. City of Weirton, West Virginia code of Ordinances. American Legal Publishing. May 9, 2022. https://codelibrary.amlegal.com/codes/weirton/latest/weirton_wv/0-0-0-1.
2. Codified Ordinances of Weirton, American Legal Publishing. May 9, 2022. 521.07 House of Assignation. https://codelibrary.amlegal.com/codes/weirton/latest/weirton_wv/0-0-0-2887

3. Codified Ordinances of Weirton, American Legal Publishing. Passed December 10, 1979. 541.13 Trespass. https://codelibrary.amlegal.com/codes/weirton/latest/weirton_wv/0-0-0-3213

Cabell county

Huntington

1. City of Huntington Code of Ordinances, Municode Library. December 12, 2023. 1111.04 Unlawful Camping. PART ELEVEN - HEALTH AND SANITATION CODE | Code of Ordinances | Huntington, WV | Municode Library
2. City of Huntington Code of Ordinances, Municode Library. December 12, 2023. 1111.05 Unlawful Storage of Personal Property in Public Places. PART ELEVEN - HEALTH AND SANITATION CODE | Code of Ordinances | Huntington, WV | Municode Library

Hancock County

County Level

1. Ordinances | Hancock County, WV. Ordinances (hancockcountywv.org). Accessed August 29, 2024.
2. Ordinances | Hancock County, WV. Abandoned Buildings Ordinance. Passed April 1, 1999. Hancock County Abandoned Building Ordinance.pdf (hancockcountywv.org)

Harrison County

Clarksburg

1. Codified Ordinances of Clarksburg, American Legal Publishing. January 2024. 1123.10 Limit of Stay; Street Parking Overnight. 1123.10 LIMIT OF STAY; STREET PARKING OVERNIGHT. (amlegal.com)
2. City of Clarksburg, West Virginia Code of Ordinances. American Legal Publishing. January 1, 2024. CODIFIED ORDINANCES OF THE CITY OF CLARKSBURG, WEST VIRGINIA (amlegal.com)
3. Codified Ordinances of Clarksburg, American Legal Publishing. Passed June 19, 1982. 961.05 Regulated Activities. 961.05 REGULATED ACTIVITIES. (amlegal.com)

Jefferson County

Harper's Ferry

1. Ordinances | City of Harper's Ferry, WV. 533.02 Trespass. ordinances_current copy (harpersferrywv.us)

Ranson

1. City of Ranson Code of Ordinances, Municode Library. Sec. 18-202. Prohibition of parking commercial vehicles, recreational vehicles, machinery and other specified vehicles and equipment on public roadways and rights-of-way. Passed October 10, 2014. ARTICLE VIII. - STOPPING, STANDING AND PARKING | Code of Ordinances | Ranson, WV | Municode Library

Kanawha County

Charleston

1. City of Charleston Code of Ordinances, Municode Library. Sec. 26-2. Unauthorized, unrestricted, unregulated begging or solicitation prohibited. July 17, 2024. Chapter 26 - CHARITABLE SOLICITATIONS | Code of Ordinances | Charleston, WV | Municode Library
2. Tent City, USA. 2017. National Center on Homelessness & Poverty. Tent_City_USA_2017.pdf (homelesslaw.org)
3. Litigation Manual Supplement: Criminalization of Homelessness Case Summaries 2022. National Homelessness Law Center. HNH_Supplement_to_Litigation_Manual.pdf (homelesslaw.org)
4. Dindak, D. (2022, Feb 21). Advocacy Groups React To Removal of Homeless Encampment under Virginia Street Bridge. *Eyewitness News.* Retrieved from Advocacy groups react to removal of homeless encampment under Virginia Street Bridge (wchstv.com)

Clendenin

1. Ordinances | Town of Clendenin, WV. November 11, 2017. Town-of-Clendenin-WV-Ordinances-2022-11-17.pdf (clendeninwv.gov).

Dunbar

1. Codified Ordinances of Dunbar, American Legal Publishing. January 2023. 533.02 Trespass. 533.02 TRESPASS. (amlegal.com)

Glasgow

1. Ordinances | Town of Glasgow, WV. 2020. 8.1.10 Vagrancy. Chapter-8.pdf (townofglasgow.org)
2. Ordinances | Town of Glasgow, WV. 2020. 4.1.1 Trespass. Chapter-4-.pdf (townofglasgow.org)
3. Ordinances | Town of Glasgow, WV. 2020. 7.1.15 Loitering. Chapter-7.pdf (townofglasgow.org)

4. Ordinances | Town of Glasgow, WV. 2020. 11.1.1 Public Solicitations. Chapter-11.pdf (townofglasgow.org)

Marmet

1. Codified Ordinances of the Town of Marmet, American Legal Publishing. Passed February 21, 2011. 509.07 Loitering. 509.07 LOITERING. (amlegal.com)
2. Codified Ordinances of the Town of Marmet, American Legal Publishing. Passed March 17, 2014. 549.03 Nuisance Activities. 549.03 NUISANCE ACTIVITIES. (amlegal.com)

Montgomery

1. Codified Ordinances of the City of Montgomery, Municode Library. Passed March 12, 2019. 18-46- Loitering. CHAPTER 18 - OFFENSES—MISCELLANEOUS* | Code of Ordinances | Montgomery, WV | Municode Library
2. Codified Ordinances of the City of Montgomery, Municode Library. Passed November 9, 1982. 18-54 – Same – Real Property; Trespassers on Public or Private Property Responsible for Vehicle Towing Charges. CHAPTER 18 - OFFENSES—MISCELLANEOUS* | Code of Ordinances | Montgomery, WV | Municode Library

Nitro

1. Code of Ordinances of Nitro, WV, American Legal Publishing. 2024. 134.16. Trespass. § 134.16 TRESPASS. (amlegal.com)

South Charleston

1. Codified Ordinances of South Charleston, WV, American Legal Publishing. Passed June 1, 2021. 533.12. Unauthorized Use of Dumpsters. 533.12 UNAUTHORIZED ACCESS OR USE OF DUMPSTERS. (amlegal.com)
2. Codified Ordinances of South Charleston, WV, American Legal Publishing. Passed April 20, 2017. 533.02. Trespass. 533.02 TRESPASS. (amlegal.com)

St. Albans

1. St. Albans Housing Authority. Accessed September 1, 2024. Saint Albans Housing Authority – Find Local West Virginia Housing At OfficialHousingAuthority.com
2. Codified Ordinances of the City of St. Albans, American Legal Publishing. 2023. 531.02. Trespass. 531.02 TRESPASS. (amlegal.com)
3.

Lewis County

County Level

1. Hope, Inc. Taskforce on Domestic Violence and Sexual Assault. Lewis County, WV. Accessed September 1, 2024. Hope, Inc. | Lewis County, WV (lewiscountywv.org)

Marion County

County Level

1. To Apply For West Virginia Community Participation Funds. December 5, 2012. Microsoft Word - mccmin12-5-12 (revize.com)

Mason County

County Level

1. Point Pleasant Housing Authority. Accessed September 1, 2024. https://ppha-wv.com/.
2. Home Mason County WV. Accessed September 1, 2024. https://masoncountywv.gov/.

Fairmont

1. Home - Fairmont West Virginia. Accessed September 1, 2024. Fairmont, WV - Official Website | Official Website (fairmontwv.gov)
2. Codified Ordinances of the City of Fairmont, American Legal Publishing. Passed August 14, 2001. 509.05 Loitering Generally; Penalties. 509.05 LOITERING GENERALLY; PENALTIES. (amlegal.com)
3. Codified Ordinances of the City of Fairmont, American Legal Publishing. February 2024. 533.02 Trespass. 533.02 TRESPASS. (amlegal.com)

McDowell County

County Level

1. McDowell County Comprehensive Plan. April 2021. McDowell County Commission. mcdowellcocompplan-1.pdf (mcdowellcountycommission.com)
2. Families, Agencies, Children Enhancing Services (FACES) Family Resource Network. Accessed September 2, 2024. Resource Directory - McDowell County F.A.C.E.S. (facesfrn.org)
3. SAFE Inc., WV. Accessed September 2, 2024. About Us | Stop Abusive Family Environments | West Virginia (safeincwv.org)

Mercer County

County Level

1. Ordinances | County of Mercer, WV. Passed July 2017. Noise Ordinance. Noise_Ordinance.pdf (mercercountywv.org)

Athens

1. Ordinances | Town of Athens, WV. Accessed September 1, 2024. Town of Athens, WV

Bluefield

1. Code of Ordinances of the City of Bluefield, WV, Municode Library. April 27, 2022. Code of Ordinances | Bluefield, WV | Municode Library

Monongalia County

County Level

1. Ordinances | Monongalia County, WV. Accessed September 2, 2024. https://cms2.revize.com/revize/monongaliawv/document_center/Ordinances/Panhandling.pdf

Morgantown

1. Codes of Ordinance of the City of Morgantown, Municode Library. July 18, 2024. Sec 941.05. Regulated Activities. CHAPTER FIVE - OTHER PUBLIC SERVICES | Code of Ordinances | Morgantown, WV | Municode Library

Star City

1. Codified Ordinances of Star City, WV, American Legal Publishing. Passed March 7, 2023. 1102.03 Unlawful Camping. 1102.03 UNLAWFUL CAMPING. (amlegal.com)
2. Codified Ordinances of Star City, WV, American Legal Publishing. Passed March 7, 2023. 1102.04. Unlawful Storage of Personal Property in Public. 1102.05 ENFORCEMENT. (amlegal.com)

Westover

1. Codified Ordinances of the Westover, WV, American Legal Publishing. Passed August 11, 1975. 951.04 Rules and Regulations. 951.04 RULES AND REGULATIONS. (amlegal.com)
2. Codified Ordinances of the Westover, WV, American Legal Publishing. Passed September 19, 2022. 1123.03. Unlawful Camping. 1123.03 UNLAWFUL CAMPING. (amlegal.com)

3. Codified Ordinances of the Westover, WV, American Legal Publishing. Passed September 19, 2022. 1123.04. Unlawful Storage of Personal Property in Public Places. 1123.05 ENFORCEMENT. (amlegal.com)

Morgan County

County Level

1. Home. Morgan County West Virginia. Accessed September 1, 2024. https://morgancountywv.gov/.
2. Morgan County, WV Population and Housing. Accessed September 1, 2024. SOffice Cop19062611110 (morgancountywv.gov)
3. Drug treatment. Morgan County West Virginia. Accessed September 1, 2024. Drug Treatment – Morgan County West Virginia (morgancountywv.gov)
4. Ordinances | Morgan County, WV. 2022. Unsafe Structure Ordinance. https://morgancountywv.gov/wp-content/uploads/2022/08/Unsafe_Structure_Ordinance.pdf

Ohio County

Wheeling

1. Codified Ordinances of the City of Wheeling, American Legal Publishing. Passed September 25, 1979. 509.02 Loitering. 509.02 LOITERING. (amlegal.com)
2. Codified Ordinances of the City of Wheeling, American Legal Publishing. Passed 1961. 509.07 Begging. 509.07 BEGGING. (amlegal.com)
3. City of Wheeling West Virginia. Greater Wheeling Coalition for the homeless. Accessed September 1, 2024. https://www.wheelingwv.gov/maps/location/GreaterWheelingCoalitionfortheHomeless.

Putnam County

County Level

1. Ordinances | Putnam County, WV. Panhandling Ordinance. Passed April 27, 2010. KM_224e-20200930105658 (putnamcountywv.gov)

Hurricane

1. Ordinances of Hurricane, WV, Municode Library. Sec 967. 04. – Regulated Activities. Passed March 5, 2018. ARTICLE 967. - PARKS AND RECREATION | Code of Ordinances | Hurricane, WV | Municode Library

Nitro

1. Code of Ordinances of City of Nitro, American Legal Publishing. Passed November 1, 1983. 94.05 Regulated Activities. § 94.05 REGULATED ACTIVITIES. (amlegal.com)

Raleigh County

County Level

1. Zoning Ordinances | County of Raleigh, WV. May 7, 2019. Microsoft Word - P&Z ordinance 2019.doc (raleighcounty.org)

Beckley

1. City of Beckley Code of Ordinances, Municode Library. Chapter 15 – Zoning. May 1, 2024. Chapter 15 - ZONING | Code of Ordinances | Beckley, WV | Municode Library

Wood County

Parkersburg

1. Aaron B. (2023, Sep 23). Parkersburg Officials Approve Ordinance to Curb Homeless Camping in City Parks. *Eyewitness News.* Retrieved from Parkersburg officials approve ordinance to curb homeless camping in city parks (wchstv.com)
2. Bevins E. (2020, Nov 11). Parkersburg City Council Creating Homeless Outreach Coordinator Position. *The Parkersburg News and Sentinel.* Retrieved from (Parkersburg City Council creating homeless outreach coodinator position | News, Sports, Jobs - News and Sentinel

Vienna

1. Codified Ordinances of the Town of Vienna, American Legal Publishing. Passed August 12, 1999. 951.13 Camps. 951.13 CAMPS. (amlegal.com)

Resource Guide

The Homelessness Resource Inventory was developed through the consideration of the legislative language alongside what was learned during outreach early in the project period, which informed an initial list of resource categories. The research team reviewed recipients of federal funding statewide, as well as DoHS and local agency websites to learn about available services

throughout the state. Outreach discussions contributed more information to this list throughout the work of the project.

The team considered housing, case management, basic needs, and other resources that may be commonly thought of as those serving this population. Additionally, the Resource Inventory includes behavioral health providers, substance use disorder resources, and medical resources. Sources of information included but were not limited to:

Table 9: Service categories and information sources

Service Category	Information Source
Community Resources	Catholic Charities WV Community Action Locations Family Resource Network Locations United Way Locations
DoHS Public Information	Aggregate Homeless Shelter Directory Comprehensive Behavioral Health Centers Domestic Violence Shelters Free Health Clinic Locations Health Facility Locations (including SUD) WIC Clinic Locations
State Resources	211 Directory Public Housing Authorities in WV WV Food Link WVARR Certified Program List WV State Veterans Administration
Federal Resources	HUD Data Federal Funding Provided to WV

Table 10: Service categories and description of services

Service Category	Description of Services
Housing	Emergency Shelter Rapid Re-Housing Permanent Supportive Housing Rental and Utility Assistance Public Housing Street Outreach Case Management
Basic Needs	Food/Meals Hygiene Goods/Services Household Necessities Clothing Transportation
Veterans Services	Services for Veterans and their Families
Behavioral Health	Counseling Therapy Intellectual and Developmental Disability Services Crisis Response
Substance Use Disorder	Peer Recovery Services Harm Reduction Treatment - Inpatient Treatment - Outpatient Treatment - Medication Assisted Treatment - Long-Term Residential Recovery Housing Recovery Meetings Prevention Services
Community and Family Resources	Baby/Infant Needs Parenting Services Adult Learning
Domestic Violence	Domestic Violence Shelters
Youth Resources	Emergency Youth Shelters
Medical Resources	Primary Medical Care Dental Services Vision Services Health Education Health Screenings Emergency Services
Vulnerable Populations	Trafficking Survivors Services
Faith-Based Resources	Ministry (Church Services)
Public Assistance Programs	Supplemental Nutrition Assistance Program (SNAP) Payee Services Legal Services
Employment Resources	Job Placement Services Job Training Services Job Interview/Clothing Resources

Appendix C: Municipalities Covered in the Study

The list of municipalities covered in the study:

County	Municipalities
Berkeley	Hedgesville
Berkeley	Martinsburg
Brooke	Weirton
Cabell	Barboursville
Cabell	Huntington
Cabell	Milton
Harrison	Anmoore
Harrison	Bridgeport
Harrison	Clarksburg
Harrison	Lost Creek
Harrison	Lumberport
Harrison	Nutter Fort
Harrison	Salem
Harrison	Shinnston
Harrison	Stonewood
Harrison	West Milford
Jefferson	Bolivar
Jefferson	Charles Town
Jefferson	Harpers Ferry
Jefferson	Ranson
Jefferson	Shepherdstown
Kanawha	Belle
Kanawha	Cedar Grove
Kanawha	Charleston
Kanawha	Chesapeake
Kanawha	Clendenin
Kanawha	Dunbar
Kanawha	East Bank
Kanawha	Glasgow
Kanawha	Handley
Kanawha	Marmet
Kanawha	Montgomery
Kanawha	Nitro
Kanawha	Pratt

County	Municipalities
Kanawha	Smithers
Kanawha	South Charleston
Kanawha	St. Albans
Marion	Fairmont
Mercer	Athens
Mercer	Bluefield
Mercer	Bramwell
Mercer	Matoaka
Mercer	Oakvale
Mercer	Princeton
Monongalia	Blacksville
Monongalia	Granville
Monongalia	Morgantown
Monongalia	Star City
Monongalia	Westover
Ohio	Wheeling
Putnam	Bancroft
Putnam	Buffalo
Putnam	Eleanor
Putnam	Hurricane
Putnam	Nitro
Putnam	Poca
Putnam	Winfield
Raleigh	Beckley
Raleigh	Lester
Raleigh	Mabscott
Raleigh	Rhodell
Raleigh	Sophia
Wood	North Hills
Wood	Parkersburg
Wood	Vienna
Wood	Williamstown

Appendix D: Inclusive and Restrictive Policies

Interventional Actions by County

COUNTY NAME	Number of Interventional Actions
McDowell	7
Morgan	4
Kanawha	3
Marion	3
Mason	3
Ohio	2
Berkeley	1
Lewis	1
Wood	1

Restrictive Actions by County

COUNTY NAME	Number of Restrictive Actions
Kanawha	5
Berkeley	2
Jefferson	2
Marion	2
Mercer	2
Monongalia	2
Morgan	2
Ohio	2
Putnam	2
Wood	2
Brooke	1
Cabell	1
Hancock	1
Harrison	1
Raleigh	1