The Strategic Framework for Ending Chronic Homelessness in Murfreesboro

Presented by
The Mayor's Task Force to End Chronic Homelessness

PREFACE

In June 2005, following a meeting in December 2004 with Philip Mangano, Executive Director of the U.S. Interagency Council on Homelessness, Mayor Tommy Bragg appointed a task force to develop Murfreesboro's 10-year plan to end chronic homelessness. The task force consisted of representatives from the public and private sectors, advocates for the homeless, members of the faith-based community, and government officials.

As requested by the Mayor, the task force:

- Identified stakeholders,
- Gathered data on homelessness,
- Convened work groups,
- Reviewed research and noted best-practices, and
- Developed strategies to address the problem.

The *Strategic Framework for Ending Homelessness in Murfreesboro* is the result of the dedication and commitment of the task force members to address the key issues associated with the complexities of homelessness. The document is a foundation which can guide the community in coordinating and developing programs and initiatives to break the cycle of homelessness and to prevent future homelessness.

The Homeless Task Force recommends that the next stage of the planning process is to focus on integrating the recommendations of the work groups into a more cohesive whole, engaging more community members in the process, and developing an action plan that includes specific activities, resources and strategies for obtaining those resources, individuals/organizations responsible for implementation, and evaluation measures.

TASK FORCE MEMBERS
Co-Chairs: John Minter and Deborah Johnson
Facilitated by: Mayor Tommy Bragg and Assistant City Manager Rob Lyons

Brandon Anderson, The Guidance Center
Carolyn Banning, Americare VISTA
Mike Bowen, Murfreesboro Police Department
Josh Chestnut, The Guidance Center
Tom Christy, Community Crossroads
William Cope, Rutherford County Sheriff's Department
Bill Dirl, Nashville Field Office of U.S. Department of Housing and Urban Development
Susan Duke, The Guidance Center
Dale Floyd, Cavalry Banking
Tony Ford, VA Homeless Program
Deborah Fox, Murfreesboro Housing Authority
Diana Francis, The Guidance Center
Adam Fresco, Rutherford County Health Department
Janet Fricks, Rutherford County Schools
Linda Arms Gilbert, Middle Tennessee State University
Timm Glover, Middle Tennessee Medical Center
Vonda Gray, Tennessee Department of Mental Health and Developmental Disabilities
Christine Huddleston, Room in the Inn
Cheryl Hultman, Tennessee CASA
Louise Johnson, Volunteer
Kenneth Lancaster, Middle Tennessee State University
Herb Lee, Tennessee State Employment Service
Allison Motley, The Guidance Center
Patsy Noland, Murfreesboro Housing Authority
Sue O'Brien, St. Clair Street Senior Center
Bob Priddy, Department of Human Services
Robyn Schlagheck, The Guidance Center
Bill Shacklett, Shacklett's Photography
Cliff Sharp, Greenhouse Ministries
Ruth Ventrice, United Way of Rutherford County
Dinah Walker, Veterans' Community Care Center
Nicki Wall, VA Tennessee Valley Healthcare System
Adam Wilson, The Salvation Army

WORK GROUP MEMBERS
Co-Chairs: John Minter and Deborah Johnson

Housing Solutions Committee	**Re-entry and Homeless Veterans Committee**	**Health and Behavioral Health Care Committee**	**Mainstream Resources Committee**
Robyn Schlagheck , Chair *The Guidance Center*	Nicki Wall, Chair *VA Tennessee Valley Health Care System*	Brandon Anderson, Chair *The Guidance Center*	Deborah Johnson , Chair *The Domestic Violence Program*
Brandon Anderson *The Guidance Center* Bobby Copeland *Room in the Inn*	Tony Ford *VA Tennessee Valley Health Care System*	Jessica Beckham *Middle Tennessee Medical Center*	Tom Christy *Community Crossroads*
Deborah Fox *Murfreesboro Housing Authority*	Barbara Hobson *Criminal Justice/ Mental Health Liaison for Rutherford County*	Vincent Brown *Hope Center*	Linda Arms Gilbert *MTSU*
Vonda Gray *Tennessee Department of Mental Health and Developmental Disabilities*	Christine Huddleston *Room in the Inn*	Diana Frances *The Guidance Center*	Bob Priddy *Department of Human Services*
Christine Huddleston *Room in the Inn*	Mike Jones *Intern, UT College of Social Work*	Sarah Gharib *The Guidance Center*	Cliff Sharp *Greenhouse Ministries*
Patsy Noland *Murfreesboro Housing Authority*	Keith Prather *Homeless Veterans Outreach Coordinator*	Barbara Hobson *The Guidance Center*	Patsy Noland *Murfreesboro Housing Authority*
Adam Wilson *The Salvation Army*	Vince Brown *Hope Center*	Amy King *Volunteer*	Adam Wilson *The Salvation Army*
		Stephen King *Volunteer*	
		Robyn Schlagheck *The Guidance Center*	
		Lisa Terry *Primary Care/HOPE Clinic*	
		Nicki Wall *VA Tennessee Valley Health Care System*	

INTRODUCTION

The U.S. Department of Housing and Urban Development defines a chronically homeless person as an unaccompanied individual who has been homeless for a year or more, or has been homeless multiple times over a several-year period. This person has been disabled by addiction, mental illness, chronic physical illness or disability, or developmental disability and has frequent histories of hospitalization, unstable employment, and incarceration.

In June of 2005, Mayor Tommy Bragg appointed a task force that brought together representatives from the public and private sectors, advocates for the homeless, members of the faith-based community, and government officials to develop a plan to meet the federal goal of ending chronic homelessness.

After extensive study of the definition of chronic homelessness, the task force realized that the definition excluded several groups of people: children who are homeless with their parents, couples, unaccompanied individuals who have not been homeless long enough to fit the federal definition, and unaccompanied individuals without disabilities.

Because the Task Force believed that it was vital to not only design a plan that would break the cycle of homelessness, but also prevent future homelessness, the group set about to develop a strategic framework that would address the needs of chronically, temporarily, and episodically homeless individuals. The first step in that process was to explore current literature and research in electronic and written formats, to look at the strategic plans of other cities, and to read materials provided by the federal government.

The resources used include:

- Strategic Planning Guidelines of the U.S. Interagency Council on Homelessness
- "Testimony of Philip F. Mangano, Executive Director of the Interagency Council on Homelessness before the House VA/HUD/ Independent Agencies Appropriations Committee"
- Federal guide, "Ending Chronic Homelessness: Strategies for Action"
- Websites of the National Coalition for the Homeless, the U.S. Department of Housing and Urban Development, the U.S. Department of Health and Human Services, and the U.S. Department of Veterans Affairs
- "Strategic Framework for Ending Chronic Homelessness in Nashville"
- "Blueprint to Break the Cycle of Homelessness and Prevent Future Homelessness" in Memphis/ Shelby County
- "Blueprint to End Homelessness in Atlanta in Ten Years"
- Maryland Homeless Veterans, Inc.
- Salvation Army-Rochester Area Services
- Operation Stand Down Nashville

- Veterans Services Division of the State of Washington Department of Veterans Affairs
- Volunteers of America of Kentucky and Tennessee
- Delancey Street Foundation, San Francisco

After looking at various resources associated with strategic planning for the homeless, the task force identified ten recurring themes that affect the lives of homeless:

1. Substance abuse/addiction
2. Persistent health problems and mental disorders
3. Low educational levels
4. Poor financial management
5. Poor job skills and/or job histories
6. Lack of affordable housing
7. Criminal history
8. Lack of transportation
9. Lack of being able to set goals and to take the necessary steps to reach those goals.
10. Lack of public awareness of the homeless problem.

The ten themes were clustered into four work groups:

1. Housing Solutions
2. Veterans and Re-entry
3. Health and Behavioral Health Care
4. Mainstream Resources

Each of the work groups focused on a standardized series of tasks relevant to the group's area of expertise: existing gaps and/or barriers, best practices, and recommendations. The work groups met independently, yet were part of the total task force and reported their findings and recommendations to the entire group at monthly meetings.

The Strategic Framework for Ending Homelessness in Murfreesboro **reflects the findings and recommendations of the work groups as refined by the collaborative efforts of all members of the Homeless Task Force.**

National Perspective on Homelessness

The U.S. Secretary of Health and Human Services estimates that more than 600,000 persons are homeless on any given night. Over the course of a year, nearly 11% of the low-income population becomes homeless.

The 2003 U.S. Conference of Mayor's survey of hunger and homelessness in 25 cities found that families with children account for 40% of the homeless population. Unaccompanied minors constitute 5% of the urban homeless population.

Single homeless adults are more likely to be male than female. 41% of the urban homeless population are single men; 14% are single women.

86% of all homeless adults self-report a history, at some point in their lifetime, of alcohol, drug, or other mental health problem.

Key Definitions

Temporarily Homeless experience only a single, usually short, episode of homelessness that often occurs in times of economic hardship and/or temporary housing loss. After the one episode, the temporarily homeless are usually not seen again by the assistance system.

Episodically Homeless use the assistance system with intermittent frequency, but for short periods of time. These homeless are younger and often have substance addictions.

Precariously or Marginally Housed individuals or families lack a permanent residence and are often living "doubled-up" or "tripled-up" with other family members or friends, subject to having to leave that housing in the very near future. Others are living on a very limited income, often in sub-standard housing, with a high potential for eviction due to non-payment of rent, utility cutoff, or condemnation of the property due to its condition.

Affordable housing describes housing, available to households earning 80% or less of the median family income, that does not cost more than 30% of gross monthly income.

Emergency shelter is temporary shelter that is an alternative to places not meant for human habitation. Emergency shelter provides a place to sleep, humane care, a clean environment, and referrals to other agencies.

Transitional housing is temporary housing that offers opportunities and comprehensive services for up to 24 months in an effort to assist homeless persons in obtaining a level of self-sufficiency.

Permanent Supportive Housing describes permanent, affordable housing linked to health, mental health, employment, and other support services to enable formerly homeless persons to live independently. Options typically range from group homes to single-room occupancy units to apartment units.

Outreach Services are an array of therapeutic services that are delivered directly to the individual outside of traditional service delivery locations and also connect individuals to existing service providers.

Local Perspective on Homelessness

On January 30, 2006, volunteers in Murfreesboro conducted a point-in-time count of the homeless throughout Rutherford County. This type of survey is inherently limited by the transient nature of homelessness, the changes in camp locations, and incomplete numbers due to the multiple homeless persons who reside in motel rooms. However, the January count resulted in a census of 344 persons:

- 31 were members of families with children, and
- 313 were members of households without children.

When describing the conditions of homelessness, it is important to understand that some of this population will periodically, or frequently, stay in shelters, while others will live outdoors:

- 75% (260) Murfreesboro's homeless were located in emergency housing.
- 25% (84) were unsheltered.

Of the 344 persons:

- 148 were chronically homeless,
- 16 were severely mentally ill,
- 23 were chronic substance abusers,
- 18 were veterans, and
- 16 were domestic violence victims.

According to the point-in-time data, the percentages of Murfreesboro's homeless who are veterans and the homeless who have a serious mental illness are much lower than the national average. Nationally, 25% of the homeless have a serious mental illness; Murfreesboro's numbers reflect 5% of its homeless population. Nationally, one-third of the adult homeless population have served their country in the Armed Services; Murfreesboro's numbers reflect 5%.

Task force members who are knowledgeable about these populations feel strongly that the numbers are under-reported and not accurate; they attribute this, in part, to the unique homeless problem that Murfreesboro faces.

While the homeless population in other cities is visible, Murfreesboro's homeless are hidden from the public eye. Concentrations of the homeless population are located at campsites found in underdeveloped areas. This has kept them unseen by the community—in spite of the fact that the growth in numbers of the homeless population has mirrored the community's explosive growth. From January 2005 to January 2006, the homeless population in Murfreesboro/Rutherford County more than doubled. For 2005, the homeless count was 136; for 2006, the count had increased to 344. Given the exceptional rate of growth, as shown by the point-in-time count, the homeless will not stay hidden. These numbers indicate that services for the homeless must increase.

Available Programs

Currently, Murfreesboro/Rutherford County has 134 emergency shelter beds. Emergency shelters include Room in the Inn, Salvation Army, Domestic Violence, Hope Center, Community Benevolence, the Driftwood Inn, and Community Servants.

Transitional housing does not exist in Murfreesboro/Rutherford County.

There is a lack of affordable permanent housing in Murfreesboro/Rutherford County. Currently, there are 32 year-round individual beds and 3 year-round family beds that serve as permanent housing for the homeless through our Shelter Plus Care program.

PAST PLANNING EFFORTS

Since 1993, Murfreesboro has benefited from strong public sector leadership in support of homelessness-related concerns. This leadership has engendered a culture of collaboration among those involved with the homeless population. Community-wide planning activities have taken place in an effort to develop a more comprehensive and effective system of health and mental health care, social services, and housing. As a result, the Homeless Task Force has been able to build on the experiences of the past to develop a plan for the future.

1991

- Room in the Inn is formed.

1993

- Task Force for Homeless is formed by City Council.
- Coordinating services and sharing information begin.
- Room in the Inn is set up as a day shelter.

1994

- Survey is conducted to determine gaps in services results in recommendation for transitional homeless shelter.
- Salvation Army's Center of Hope is opened.
- 521 individuals are moved from temporary shelter to permanent housing.

1995

- Room in the Inn opens a 24-bed facility.

1996

- Task Force for Homeless is dissolved.

1999

- Homeless Task Force Committee is formed and begins to meet monthly.

2000

- Study is conducted to determine the number and nature of the homeless.

2001

- Murfreesboro Housing Authority is awarded a grant through the U.S. Department of Housing and Urban Development Continuum of Care Program for eight (8) vouchers to assist disabled homeless persons in obtaining permanent housing.
- Tennessee Department of Mental Health and Developmental Disabilities awards The Guidance Center the Progress for Assistance in Transition from Homelessness (PATH) Program to provide outreach services to mentally ill homeless.
- Point-in-time survey is conducted.

2002

- Tennessee Department of Mental Health and Developmental Disabilities choose Murfreesboro as a target community for the Creating Homes Initiative (CHI) to promote new permanent housing opportunities for persons who have a severe and persistent mental illness.
- Point-in-time survey is conducted.

2003

- Murfreesboro Housing Authority is awarded a grant through the U.S. Department of Housing and Urban Development Continuum of Care Program for nine (9) vouchers to assist disabled homeless persons in obtaining permanent housing.
- Point-in-time survey is conducted.

2004

- Murfreesboro Housing Authority is awarded a grant through the U.S. Department of Housing and Urban Development Continuum of Care

Program for three (3) vouchers to assist disabled homeless persons in obtaining permanent housing and funding for a Housing Management Information System (HMIS) to allow agencies to track and refer the homeless to services.

- Philip Mangano, Executive Director of the U.S. Interagency Council on Homelessness visits Murfreesboro.
- Point-in-time survey is conducted.

2005

- Murfreesboro Housing Authority is awarded a grant through the U.S. Department of Housing and Urban Development Continuum of Care Program for five (5) vouchers to assist disabled homeless persons in obtaining permanent housing.
- Task Force to Design a Plan for Ending Chronic Homelessness in Ten Years is appointed and merges with the existing Homeless Task Force.
- Point-in-time survey is conducted.

2006

- Point-in-time survey is conducted.
- The Strategic Framework for Ending Chronic Homelessness in Murfreesboro is formulated.

STRATEGIC FRAMEWORK FOR ENDING CHRONIC HOMELESSNESS IN MURFREESBORO

VISION

Within ten years, Murfreesboro will be a community without chronic homelessness by assuring access to safe, affordable, and permanent housing with a comprehensive array of supportive services.

GUIDING PRINCIPLES

1. Permanent supportive housing is a priority.
2. A continuum of supportive services including health, mental health, substance abuse, outreach, and other services, tailored to meet individual needs, are essential to achieving long-term housing and should be available from the onset of first contact with the service system until permanent housing is obtained.
3. All segments of the community (e.g., service providers, law enforcement, government officials, businesses, residents, and hospitals) should receive comprehensive education regarding the homeless and the services available to the homeless.
4. Systems coordination between public and private sector service providers is critical for long-term success.
5. Striving for self-sufficiency and increased self-reliance is the best way to ensure that individuals are able to maintain housing and to live independently. Employment and education are keys to attaining that independence.
6. Evidence-based practices must be imbedded into all services, programs, and endeavors associated with the strategic plan.

HOUSING SOLUTIONS

Homelessness is linked to a shortage of housing for individuals and families with very low incomes. Most of the chronically homeless have little to no income and cannot pay fair market value for a place to call their own. In addition, because they lack a permanent address to give to employers, it is difficult for the homeless to increase their income.

The Murfreesboro Housing Authority has spearheaded attempts to break through the barriers to affordable housing. The Housing Authority has provided supportive housing and has developed two five-bedroom units--one for homeless males and one for females. In addition, a safety net for 35 individuals, whose disabilities prevent them from retaining a stable income, has been established through a Shelter Plus Care grant voucher program.

The Homeless Management Information System (HMIS) has recently been installed in Murfreesboro/Rutherford County. HMIS allows agencies to share information about homeless individuals.

Existing Gaps and/or Barriers

To expand affordable housing for homeless individuals, the following gaps and/or barriers must be addressed:

- Resources for safe, affordable low-income housing have been limited.
- Resources for transitional housing have been non-existent.
- Current housing and shelters do not accommodate individuals with a criminal or drug record.
- Systems of care have not successfully engaged specific subsets of the homeless, such as veterans, the mentally ill, and ex-offenders.
- Some homeless have low motivation for life-change (hopelessness).
- The "not in my back yard" syndrome makes it difficult to locate housing for homeless individuals.
- Homeless individuals often do not know how to set goals (i.e., financial planning and employment) or to take the steps for attaining those goals.
- Some homeless individuals are resistant to traditional housing.
- Some citizens in the larger Murfreesboro community deny that a "homeless problem" exists.
- Individuals/families who are facing eviction or foreclosure do not have access to services and assistance to prevent unnecessary displacement.

Best Practices

Permanent supportive housing has links to health, mental health, employment, and other services and provides a way out of expensive emergency services, generating significant public savings.

For two years, the University of Pennsylvania tracked the homeless in New York City. Researchers found that supportive permanent housing created an average annual savings of $16,282 per person by reducing the use of public services, including a 72% decline in the use of health services and a 23% decline in shelter use.

In addition to the financial savings, permanent supportive housing helps stabilize tenants, with retention rates at 85% after two or more years.

Recommendations

1. **Develop permanent supportive housing opportunities for homeless individuals and families.**

The following should guide permanent supportive housing development in Murfreesboro/Rutherford County:

- Successful housing options for the homeless population must include a variety of alternatives.
- The housing continuum must have a combination of scattered-type (single units, duplexes, etc.), congregate, and single room occupancy units.
- Low-density sites are preferred.
- Permanent supportive housing must have access to public transportation and be located within walking distance of essential services and amenities.
- Community as peer support should be established to help ensure long-term housing stability.
- Ongoing evaluation of adequate housing development must be conducted through annual homeless counts and other monitoring efforts.

2. **Develop the Single Room Occupancy Project to provide transitional housing in the form of furnished efficiency apartments.**
3. **Identify existing funding sources while developing new initiatives to finance transitional housing and permanent supportive housing.**
4. **Develop a community education initiative regarding homelessness.**

Community education on the permanent supportive housing model, including transitional housing, will be essential to successful implementation. A broad community education campaign should include the causes of homelessness, extent of homelessness, human and public cost of homelessness, and cost effectiveness of interventions that use best practices. In addition, issues with recently incarcerated individuals, people with mental disabilities, felons, etc. should be addressed.

The Housing Solutions Committee has a future vision that includes a centralized outreach center and transitional housing:

- A *centralized outreach center* should be established to organize an efficient and effective system of care and to eliminate stagnation in the process of transitioning from homelessness to permanent supportive housing. A centralized center will enable all services available to homeless to be under one roof. Not only will this assist the homeless with moving through the process to permanent supportive housing, but it will assist the agencies in creating flexible, more productive, individual plans so that each person's needs and potential can be better met.
- *Huddleston House* should be established to provide transitional housing for individuals and/or families who do not qualify for assistance through the Murfreesboro Housing Authority due to criminal or credit histories, or who are waiting for background checks to be completed. Huddleston House will provide temporary, safe, affordable housing for the homeless until permanent supportive housing is found. Individuals and/or families will be referred by agencies that service the homeless—Room in the Inn, Salvation Army, etc.—and the needs of each individual will be assessed. Room in the Inn, with its experience and reputation, is willing to administer the program for at least the first formative year.

VETERANS AND RE-ENTRY

Homeless veterans and homeless ex-offenders may suffer from severe trauma, physical or mental illness, medical conditions, substance dependence, or any combination of factors—all of which respond to proper treatment and guidance. In addition, veterans and ex-offenders may be homeless because of a lack of job skills, lack of affordable housing, lack of transportation, criminal history, deficiency in life skills, or a mindset of poverty. Finally, women with dependents, women veterans, or women re-entering society from incarceration experience multiple obstacles to overcoming homelessness.

According to the U.S. Department of Veterans Affairs, the number of homeless male and female Vietnam era veterans is greater than the number of service persons who died during that war; and a small number of Desert Storm veterans are also appearing in the homeless population.

For both the veterans and the ex-offenders, ensuring the availability of stable housing at time of discharge through discharge planning is critical.

Existing Gaps and/or Barriers

To successfully engage veterans and ex-offenders in accessing and managing public benefit programs and job readiness/employment-related activities, the following gaps and/or barriers must be addressed:

- Misperceptions and lack of knowledge about veterans and ex-offenders who are homeless leave the community unaware of how the needs of these groups can be met.
- The business community has not been sufficiently engaged in effectively developing job training and employability programs for difficult-to-serve populations.
- Local employers lack knowledge about incentive programs for training and hiring veterans or ex-offenders.
- Existing programs may target these specific populations but are not effectively coordinated to provide ease of services or to maximize benefits.
- Certain services (respite care, day shelter) are not available to meet the needs of veterans and ex-offenders. Other services (emergency shelter, outreach, detoxification therapy, and substance abuse treatment) are in limited supply.

Best Practices

Successful programs that address homeless veterans or ex-offenders:

- Are aggressive in seeking grants and funding for programming;
- Educate the community about homelessness and solutions;
- Form collaborations between the various sectors of the community—businesses, corporations, faith-based organizations, government entities, and service organizations; and
- Serve individuals in comprehensive services and transitional housing programs for 24-48 months from point of entry.

The continuum of care for veterans and ex-offenders designed to move a homeless person to self-sufficiency includes: assessment, respite shelter, emergency shelter, transitional housing,

appropriate supportive services, and assistance applying for and finding permanent supportive housing.

Longer periods of case management and program participation allow individuals to reach sufficient growth in each stage of their personal development so that they can sustain independent self-supported living. As these individuals reach independence, they are encouraged to become mentors and role models for others going through the process that they have successfully completed.

The most successful programs use their own businesses (restaurants, catering, bookstores, printing shops, construction, janitorial services, moving companies, grounds maintenance, etc.) to produce income for the program and to teach job skills and work ethics to participants.

Discharge planning helps prepare people residing in jails for return or re-entry into the community by linking them with community treatment, housing, and supports. Ideally, such planning begins upon entry into an institution, is ready to be implemented upon discharge, involves input from the individual, and includes time-limited, intensive supports during the transition from incarceration to community-based services.

Employment and education are stressed in every successful program for the homeless. Individuals are encouraged to earn their GEDs or to attend postsecondary or technical training and to acquire three marketable skills.

Recommendations

1. **Create an Interagency Outreach Team to provide outreach and assistance to the jail and workhouse to facilitate inmate transition back to the community following discharge from incarceration.**
2. **Fund a respite shelter to temporarily serve homeless persons who are recovering from medical illnesses or who are too ill to work.**
3. **Fund a day shelter where homeless persons can bathe/shower, do laundry and/or repair belongings, meet with case managers, receive counseling, and receive encouragement to participate in job training/education activities.**
4. **Advocate for transitional housing facilities for ex-offenders and for those who are in an alcohol/drug dependence recovery program.**
5. **Form a business community-faith community collaboration to pilot and operate job readiness/training programs.**
6. **Engage the veterans' organizations and non-homeless veterans in the development of expanded, coordinated outreach to homeless veterans.**

HEALTH AND BEHAVIORAL HEALTH CARE

Homelessness impacts the whole being of a person. Homeless persons often face co-occurring or multiple health, behavioral health, and addiction problems. Providing health care treatment for homeless individuals is difficult; however, health care services are markedly less effective when delivered to persons who are suffering some type of addiction and/or living unprotected from the elements in unsanitary conditions, without refrigeration for food or medicines.

In Murfreesboro/Rutherford County, the Rutherford County Health Department, Primary Care/Hope Clinic, and Middle Tennessee Medical Center provide health care for homeless persons.

The VA Tennessee Valley Health Care System, Pathfinders, and The Guidance Center provide addiction treatment services, and Alcoholics Anonymous and Narcotics Anonymous are available. The Guidance Center's PATH Program helps the homeless who suffer from severe and persistent mental illness to receive health and mental health services, obtain and maintain an income, and locate appropriate housing. Also, faith-based organizations, such as the Hope Center, have programs geared toward those with addiction problems.

Existing Gaps and/or Barriers

Although several providers of health and behavioral health care serve the homeless population, the following barriers to care and gaps in the health care delivery systems that prohibit or limit homeless persons from receiving proper health care must be addressed:

- Many of the health problems of the homeless are directly related to an insufficient amount of permanent supportive housing and a total lack of transitional housing.
- Lack of access to health providers exists because there is no public transportation, and many of the homeless cannot afford personal transportation.
- Criminal sanctions of behavior related to a mental health or substance abuse disorder are ineffective and do not help resolve underlying health problems.
- Because there is limited treatment for addiction and co-occurring disorders, the service system is not always responsive to the needs of the homeless in a timely manner.
- Certain services are not available to meet the needs of homeless and other poor persons (e.g., in-patient detoxification services, day shelters, outpatient services for those without insurance, job training, financial planning, and education).
- Existing programs may target specific populations but are not always coordinated across agencies.
- Low income service providers offering job training and employability programs have not sufficiently engaged business and industry in developing outcome-based activities for the homeless who are willing and able to work.
- There is a lack of awareness, coordination, and involvement of the faith community in developing more comprehensive and effective ways to break the cycle of homelessness, particularly for those

individuals who do not meet the criteria for government programs.

- There has been a lack of private and government funding for shelters and health care for the homeless with addiction or health issues.

Best Practices

Outreach, the first and most important step in providing access for homeless individuals to needed services, includes extending services or help in order to develop a relationship of trust and to engage homeless persons in treatment and service programs, to provide basic materials to homeless persons, or to publicize the availability of various types of assistance to a homeless person.

Homeless individuals need access to a range of comprehensive services that respond to their multiple, complex health care needs. Those services include an analysis and assessment of an individual's health problems and the development of a treatment plan; assisting individuals to identify and understand their health needs; providing directly or assisting individuals to locate, provide or secure, and utilize appropriate medical treatment, preventive medical care, and health maintenance services, including in-home health services and emergency medical services; providing appropriate medication; and providing follow-up services as needed.

Effective approaches for providing substance abuse treatment to the homeless include activities designed to prevent, deter, reduce, or eliminate substance abuse or addictive behaviors. These include a comprehensive range of personal and family counseling methods, early interventions, treatment for opiate abusers, and detoxification treatment for alcohol and other drug abusers. Treatment services may include intake and assessment; treatment matching and planning; behavioral therapy and counseling appropriate to the client and the severity of the problem; substance abuse toxicology and screening; clinical and case management; outcome evaluation; pharmacotherapies; and self-help and peer support activities. Services may be provided in outpatient settings and alternative living arrangements such as institutional settings and community-based halfway houses.

Access to coordinated treatment for co-occurring mental health and substance use disorders is necessary and superior to other approaches. Therefore, people who are homeless must have access to a full range of mental health and counseling services. These include services that apply therapeutic processes to personal, family, situational, or occupational problems. Component services may include crisis interventions, individual supportive therapy, family or group therapy sessions, the prescription of psychotropic medications or explanations about the use and management of medications, and combinations of therapeutic approaches to address multiple problems.

Recommendations

1. **Develop a public relations/ community education campaign that involves public notification of fundraising efforts and community meetings, and educates the business, faith-based, medical, educational, and volunteer communities about the causes and solutions of homelessness, with specific focus on co-occurring or multiple health, behavioral health, and addiction problems.**
2. **Aggressively seek new funding for job training and employment programs.** This should include federal grants that target homeless individuals, collaborations with the Chamber of Commerce and various members of the business community, and partnerships with other interested parties.
3. **Compile a list of service providers and services available to the homeless, and distribute that list to agencies/organizations that serve the homeless.**
4. **Engage the faith-based community in the development of expanded, coordinated outreach to homeless and precariously/marginally housed individuals and families by providing programs and services such as food pantries, funding and advocating for housing, addiction treatment, and job training programs.**
5. **Promote interagency collaboration and service coordination.**
6. **Implement a Mental Health Court as well as a Drug Court in Murfreesboro/Rutherford County.**
7. **Increase involvement of the business community in addressing homelessness issues that affect the business community directly—workforce development, efforts to reduce the numbers of persons living on the streets, etc.**
8. **Develop a comprehensive, coordinated outreach program which will include intensive, aggressive outreach to locate, engage, and assist individuals whose mental illness and/or substance abuse has rendered them unable, reluctant, or unwilling to accept shelter, treatment, recovery services, and supportive housing, as appropriate.**

MAINSTREAM RESOURCES

Homelessness is a complex, multi-faceted challenge to Murfreesboro/Rutherford County. Homelessness arises from multiple causes, cannot be "fixed" by one organization or one kind of expertise, and must be addressed with vision, determination, and collaboration. Both practice and research have shown that the chronically homeless person will probably face a service system that is fragmented and providers who are not able to summon the flexible or comprehensive set of treatments and services the person needs.

The broad system of services and housing in Murfreesboro/Rutherford County must be seamless and coordinated. Service providers must actively communicate and collaborate to ensure efficiency and effectiveness of programs and practices.

Existing Gaps and/or Barriers

Because homelessness impacts all segments of the community, solutions must be found by all segments of the community. Systems coordination between the public and private sectors is critical to the success of implementing the elements of the Continuum of Care. In order for this to occur, the following gaps and/or barriers must be eliminated:

- Limited program funding exists for preventive programs such as adult education, computer literacy and job skills training, etc.
- There is a lack of emergency shelter beds for medically fragile, chemically dependent persons.
- While a limited number of faith-based organizations are actively involved with assistance to the homeless, the vast majority are not.
- Transportation, on a regular basis, for taking the homeless to work and to services continues to be a barrier.
- Being able to set goals and to take the necessary steps to reach those goals is difficult for many of the homeless.
- Often, flexibility and choice are not part of the service programs for the homeless individual.
- Homeless persons, persons with a mental illness, ex-offenders, and persons with a substance abuse disorder are often stereotyped by the public and by the media. Frequently, this leads to barriers in acquiring access to services.
- Fragmentation and lack of clear responsibility within the service providers negatively affect optimal care.

Best Practices

Homelessness is not caused merely by a lack of shelter, but involves a variety of underlying, unmet needs—physical, economic, and social. Dealing effectively with the problems of homelessness requires a comprehensive system of housing and necessary services for each stage.

The U.S. Department of Housing and Urban Development has identified the Continuum of Care as one system that provides the resources required to move a homeless person to self-sufficiency. The Department has adopted the Continuum of Care approach as being necessary to prevent homelessness and to meet the diverse needs of individuals and families experiencing homelessness.

Seven components make up the Continuum:

- Prevention
- Outreach, intake, and assessment
- Emergency shelter
- Transitional supportive housing
- Supportive services
- Permanent supportive housing
- Permanent affordable housing

Hand-in-hand with the Continuum of Care are the core services and supportive services that have been identified by the Department of Health and Human Services.

Core services are those needed to move people from the streets into housing and to stabilize their conditions.

Core services include:

- Information and referral
- Outreach and engagement
- Health related and home health services, including HIV/AIDS
- Alcohol and drug abuse services
- Mental health and counseling services
- Inpatient services
- Supportive case management services
- Intensive case management services
- Income management and support
- Residential treatment services
- Discharge planning

Supportive services are those that are needed to reintegrate people into the community, such as services associated with jobs, education, and socialization.

Supportive services include:

- Life skills services
- Child care services
- Education and training services
- Employment services
- Legal services
- Transportation services

To be effective, these services must be accessible and provided in a coordinated and flexible manner. This includes the option of being offered in non-office based settings and during non-standard operating hours, being able to increase or decrease service levels to accommodate changing needs over time, and keeping case files open during periods of inactivity so that eligibility does not have to be re-established when an individual is ready to engage or re-engage.

Recommendations

1. **Provide specialized training on issues related to homelessness, i.e., how to help the homeless identify education and employment goals and the steps necessary to meet those goals, along with creating benchmarks of success.**
2. **Develop transitional housing programs that offer opportunities and comprehensive services for up to 24 months to assist the homeless in obtaining a level of self-sufficiency.**
3. **Educate each agency staff so that they know the available services and the process for moving a homeless individual from point of contact to permanent housing.**
4. **Facilitate broader participation by and closer coordination between the business community and faith-based organizations to develop a safety net of support and outreach services for the homeless. Develop collaborations so that life skills development and employment possibilities move beyond the traditional service providers and merge with the larger community.**
5. **Conduct a comprehensive assessment of available services and barriers related to housing, utilities, transportation, health and behavioral health services, education, and job skills training.**
6. **Identify what policies, systems, and programs exist to assist inmate transition, veteran transition, and post-addiction transition back to the community.**
7. **Develop a formal referral protocol for discharging homeless and physically or mentally impaired individuals to community service providers following medical or psychiatric hospitalization.**
8. **Develop and implement an "Adopt-a-Family" or "Adopt-a-Person" program that pairs churches with formerly homeless or at-risk families or individuals being assisted by case managers from experienced agencies.**
9. **Seek increased funding for day treatment programs.**