

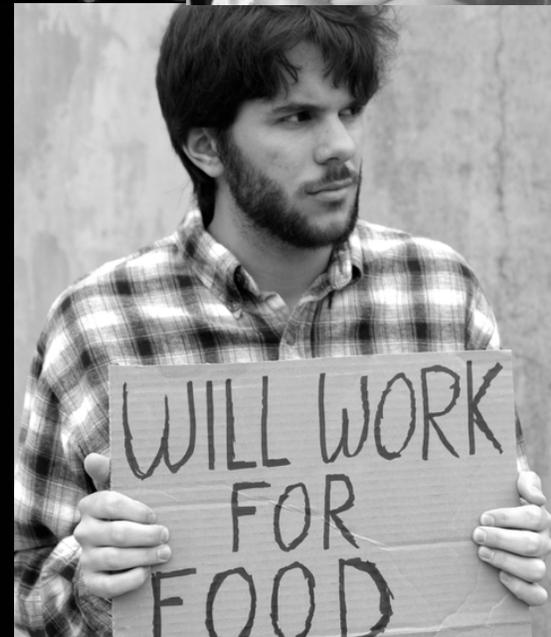


no longer

Homeless in Montana

a Report on the
State of Homelessness
and a Ten Year Plan to End It

2006 — 2014



My Fellow Montanans —

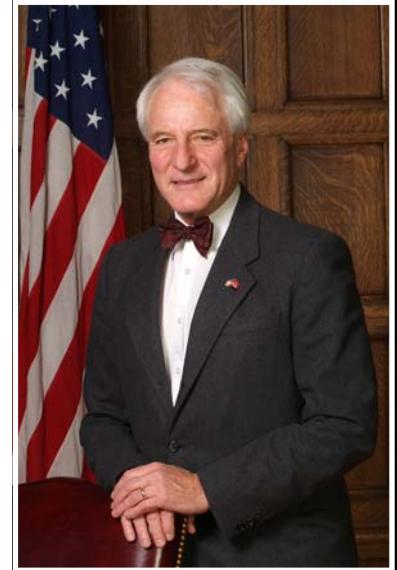
As Co-chair of the Montana Council on Homelessness, I am pleased to present this report on the state of homelessness in Montana. Homelessness is a difficult and complex issue that too often remains out of sight. These are truly people who have fallen through the cracks of our society.

Many, if not most, of Montana's homeless residents exist in shadows. They sleep on couches, in cars, the woods, and often – when life spirals completely out of control – in our jails and hospitals. Even so, when volunteers conducted the annual *Survey of the Homeless* on January 31, 2006, they identified 2,311 homeless Montanans. We believe this point-in-time count is just the tip of an iceberg.

The United States is a bountiful, prosperous and blessed land. There is no reason why any American should be without shelter. It is time to recognize our homeless neighbors, and to remind ourselves that we have an obligation to them. The Schweitzer/Bohlinger Administration has taken — and will continue to take — steps to address homelessness in Montana. Governor Schweitzer recently signed Executive Order 40 to continue the work of the Montana Council on Homelessness. This biennial report on homelessness is also part of the ten-year strategy to end homelessness in Montana.

When we pass our homeless neighbors on the street, we must not look away. *We can be the light for those in need.* The responsibility lies with each of us.

Sincerely,
Lt. Governor John Bohlinger



A Message from the Chairman _____ Hank Hudson

Many of us see homeless people every day. Although each has a different story, those who are homeless all face unique combinations of the most complex problems of our times: disability, addiction, mental illness, co-occurring disorders, domestic violence, deep poverty, lack of education, employment or training... and the list goes on.

This document discusses the facts of homelessness as it exists in Montana and offers an initial plan to eradicate it. This is a living document, the product of input from the 16 members of the 2004-06 Montana Council on Homelessness as well as more than 100 people with expertise in the issues rising from and contributing to homelessness. Five work-groups comprised of content-area experts from across the state came together to advise the Council, generously offering their time to define issues and strategize solutions around access to and delivery of mainstream services; special needs populations; housing; education, employment and training; and finance and resource development.

Homelessness is not a situation we should be prepared to tolerate, not in Montana, not anywhere. This document is a means to an end — an end to one of the great injustices of our times.

— Hank Hudson, December 2006

Homeless: Without safe, permanent and stable housing or at risk of losing housing.

— Montana Council on Homelessness
(MTCoH) definition

Homeless in Montana

Table of Contents	Page #
About this Report	4
Chapter One	6
• The Data — an Overview	6
• Factors Influencing Homelessness	12
• The Price of NOT Addressing Homelessness	24
Chapter Two: Chronic Homelessness	32
Chapter Three: Family Homeless	48
• Homeless Children and Youth	54
Chapter Four: Glossary, End Notes, Resources	58

About this report

This report is comprised of four chapters.

- An Overview of Homelessness in Montana
- Chronic Homelessness
- Homeless Families
- Resources and End Notes

This report and plan were created to serve as the underpinning of a comprehensive initiative to end homelessness in Montana. They provide some of the information needed by agents of change as they focus on addressing particular aspects of the complex interactions among social systems, homeless individuals and homeless families.

Each of the first three chapters offers a demographic overview and examines causes for homelessness among subpopulations, as based on the statewide 2005 and 2006 surveys of the homeless. Each of these chapters is designed to serve as a stand-alone document. The fourth chapter provides a glossary, bibliography and additional resources.

The information and recommendations provided by this report attempt to address the broad spectrum of homeless issues in Montana, and to offer strategies specific to the needs of various subpopulations, including the chronically homeless and homeless families with children. The chronically homeless and homeless families are subsets of the aggregate of the homeless population as a whole. Addressing the needs of these populations will require very different strategies.

The goals, objectives and strategies that make up the plan to end homelessness appear at the end of each chapter. The plan itself is labeled as a *Draft* because the first tasks of the 2007-2008 Council on Homelessness will be to review, revise, approve and begin implementing the plan. They will also be tasked with prioritizing strategies, firming up timelines, and creating manageable action steps.

Who are our homeless neighbors?

You might be surprised. The “typical” homeless person could be male or female, young or old, Native American or White. About one in four homeless adults is working part- or full-time. The majority have been in the cities where they are homeless for *at least* a year.

The night of January 31, 2006, volunteers identified 2,311 homeless persons in Montana. Each has a different story.



Stories of our homeless neighbors

Andy

- *It's hard to get a job because they see me as a liability. I am either too overweight, too much of a high risk on the health insurance, too short, or my criminal background is a problem. We don't have transportation or real control over our daily lives, since we depend on the routines of shelters, soup kitchens and marginal jobs to meet our most basic survival needs.*

Jenna

- *Last July, I had to throw all of our clothes into the car, take my son and leave my husband. We stayed at the shelter for six weeks — long enough to find day care and a job. That worked fine until the baby started to get sick and had to have tubes put in his ears. First I got fired. Then the car broke down and I couldn't find another job. I lost the apartment. It's hard because you feel like you're not good enough as a parent. You can't even buy your kid diapers and what kind of a parent can't afford diapers, what kind of a parent can't put a roof over her kid's head? I feel so helpless sometimes, because I have no*



Except for Desa Rae's story, the vignettes on this page were excerpted from focus groups convened in 2005 by Marcial Ornales, MTCOH VISTA. Names have been changed. Photos do not depict those interviewed.

Desa Rae



- *All my life, I have been in and out of homes, detention centers and facilities. I have been in and out of trouble since the age of 8. Violence has taken a major toll in my life. Violence goes way back to when I was maybe 4 years old. I have been abused in many ways. I have seen my Mom get beat time after time. My mother was in an abusive relationship, which put me and my sister in danger also. I lived in a world of darkness and couldn't find my way out... the way they would describe it, I was a lost child¹.*

Mack

- *Some people get arrested because there is no place to go. At least in jail you are supplied with food and a warm place to stay. I know people who have intentionally gotten arrested in the winter so they can go to jail and get out of the cold.*



Homeless in Montana

Chapter One

2006 Survey of the Homeless²

An annual point-in-time survey of Montana’s homeless population is

sponsored by the Intergovernmental Human Services Bureau of the Department of Public Health and Human Services (DPHHS), the Human Resource Development Council (HRDC) Association and the Montana Continuum of Care Coalition. It is administered statewide on dates consistent with those established nationally by the Department of Housing and Urban Development (HUD). Volunteers in Montana’s population centers reach as many of Montana’s homeless people as possible, and there is no duplication among those surveyed. While the survey cannot be considered scientifically valid because the methods of administration vary from city to city, the results offer a valuable one-day snapshot of homelessness in Montana.

Homelessness in Montana wears many guises, but is often nearly invisible. Montana’s homeless can be found sleeping in cars, tents, abandoned buildings, or staying with family or friends. They might be in motels, hospitals, treatment facilities, jails, emergency or transitional shelters, but most are *not* on the streets. Although traditional street homelessness appears to be growing in Montana, the homeless are often difficult to locate and to quantify. Direct service providers statewide say that the numbers they are called to serve are growing, so it is probable that the survey reflects a fraction of the homeless population of Montana. The following numbers include respondents plus identified family members.

- 2,311 homeless persons identified January 31, 2006
- 2,097 homeless persons identified January 27, 2005

The numbers

In 2006, 96 percent of all of the homeless persons identified during the annual *Survey of the Homeless*^{2,3} were found in the seven largest population centers. In order by number of homeless persons identified, these cities were: Billings, Missoula, Kalispell, Helena, Great Falls, Bozeman and Butte.

Gender

- In 2006, more females than males were identified during the Survey of Homeless.

2005–06 Surveys of the Homeless Homeless Respondents + Family Members by Gender ^{2,3}		
	2005	2006
Male	1,168	1,135
Female	920	1,153
Missing or Unknown	9	23
Total	2,097	2,311

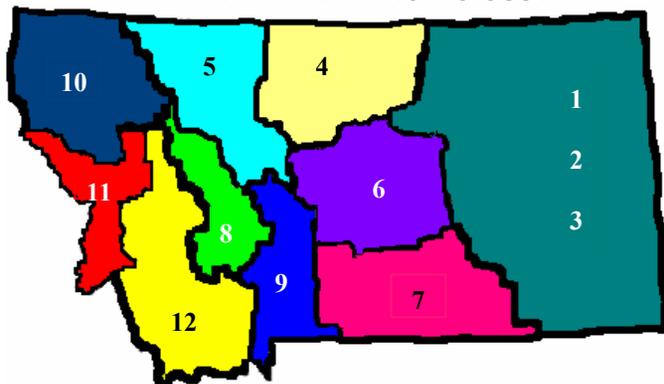
- In 2005, females represented 44 percent of all homeless persons identified.

Age

- The population of homeless persons in Montana appears to be getting younger.
- The *number* of identified homeless persons under the age of 18 nearly doubled between 2005 and 2006, proportionately rising from 2.7 to 5.3 percent.
- The percentage of respondents aged 18 — 29 also went up slightly, from 26 percent in 2005 to 26.7 percent in 2006.

2005–06 Surveys of the Homeless Number of Homeless by Age ^{2,3}		
Age of Respondents	2005	2006
Under 18	41	83
18– 29	398	419
30 – 59	903	916
60 – 64	47	46
65+	30	30
Unknown or N/A	114	78
Total Respondents	1,533	1,572

Where are people homeless?



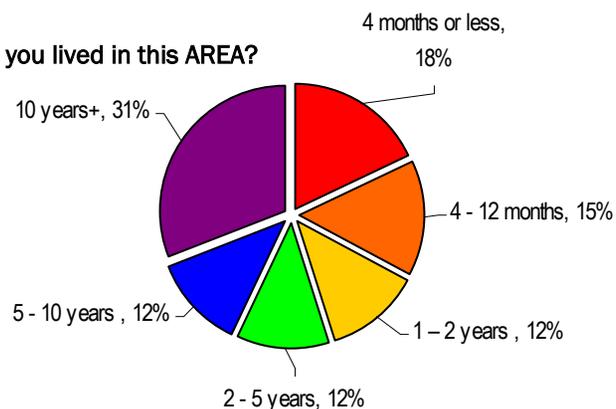
Human Resource Development Council (HRDC) Districts

2005–06 Surveys of the Homeless Number of Homeless by HRDC District ^{2,3}		
	2005	2006
District 1–2–3	43	23
District 4: Havre	26	28
District 5: Great Falls	173	164
District 6: Lewistown	25	30
District 7: Billings	807	614
District 8: Helena	171	316
District 9: Bozeman	58	121
District 10: Kalispell	344	379
District 11: Missoula	356	536
District 12: Butte	66	95
Missing or unknown	28	5
Total Homeless	2,097	2,311

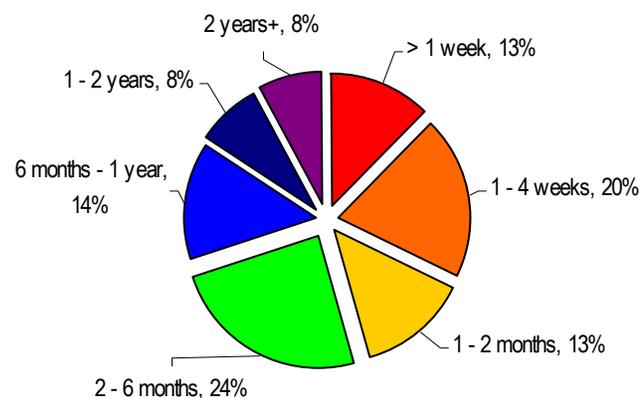
Length of time in area and place

The majority (67 percent) of respondents to the *2006 Survey of the Homeless*² and their families had been in the *area* for at least a year; 31 percent had been in the area for 10 years or more and 420 (18 percent) were lifetime residents of the area. When asked how long they'd been staying at the current *place*, the numbers changed dramatically. Only 8 percent had been staying in the current place for more than a year.

How long have you lived in this AREA?



How long have you been at this PLACE?



375 respondents and family members identified in the *2006 Survey of the Homeless* stated that they would have to move in one week².

Length of Time Homeless

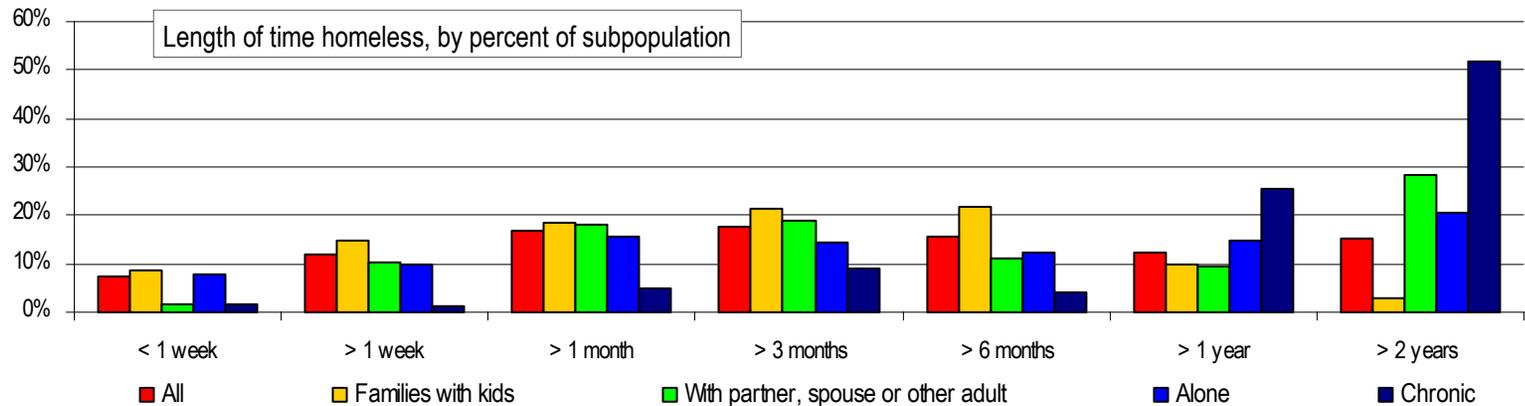
Families with children tend to be homeless for shorter periods of time than their individual counterparts. Of the homeless families identified during the *2006 Survey of the Homeless*², 63 percent had been homeless for less than 6 months. In contrast, about half (49 percent) of homeless adults with partners and single adults (48 percent) had been homeless for *more* than six months. More than half (52 percent) of those who met the definition for chronic homelessness had been homeless for more than two years.

Length of Time Homeless by Subpopulation²

2006 Survey of the Homeless ²	All	Families with kids	With partner, spouse or other	Alone	Chronically homeless
< 1 week	175	72	4	92	3
> 1 week	272	123	26	118	2
> 1 month	391	154	46	184	8
> 3 months	405	179	48	171	15
> 6 months	358	182	28	147	7
> 1 year	285	83	24	177	42
> 2 years	348	24	72	246	85
Missing or N/A	77	17	7	52	2

Note: Subpopulations do not add up to total homeless number of 2,311

The night of January 31, 2006, surveyors across Montana identified 633 people who'd been homeless for at least a year: 48 were aged 60+, 13 were younger than 18, 32 were pregnant and 135 were military veterans.



Where did you sleep the night of January 31, 2006?

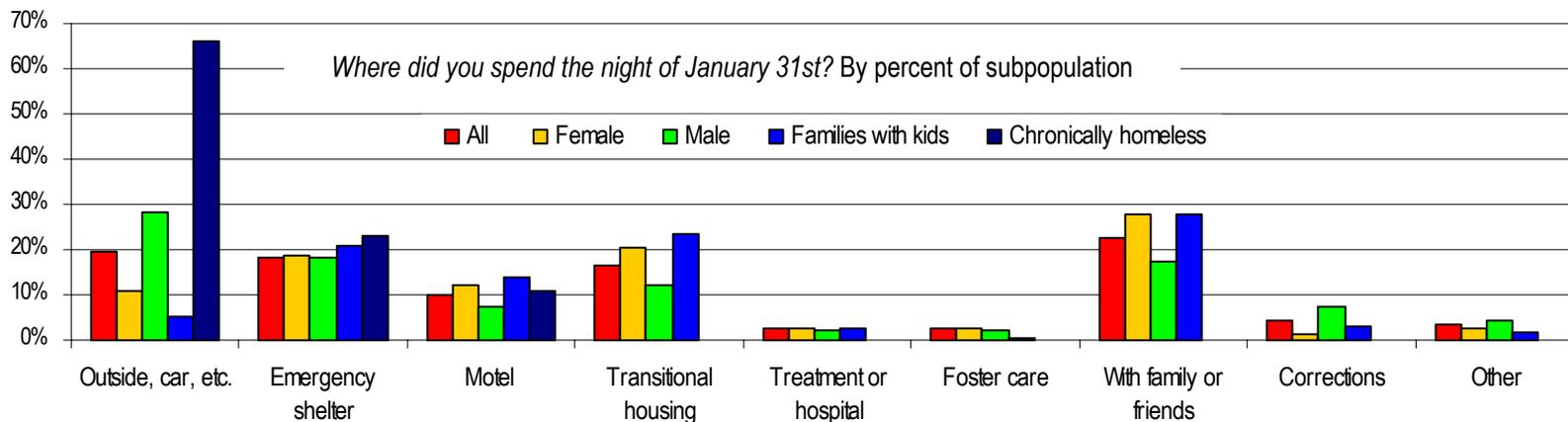
Respondents to the *2006 Survey of the Homeless*² were asked where they had spent the night. The most common response was with family or friends, but there were significant differences among the various subpopulations. The most common place the chronically homeless spent the night was outdoors, in a car or other place not fit for human habitation. Fifty-nine youth spent the night of January 31st in foster care, and 100 persons spent the night in jail, prison or prerelease. About one fourth of families with children reported staying in a transitional housing facility, which included domestic violence shelters.

Where did you sleep the night of January 31, 2006?²

	All	Female*	Male*	Families with kids	Chronically homeless
Outside, car, etc.	452	124	317	42	128
Emergency shelter	422	216	205	175	45
Motel	229	141	85	117	21
Transitional housing	375	237	134	196	
Treatment or hospital	56	29	26	23	
Foster care	59	32	26	5	
With family or friends	516	320	196	233	
Corrections	100	17	83	27	
Other	80	32	48	16	
Missing or N/A	22	5	15	—	
Totals	2,311	1,153	1,135	834	194

*Male and Female tallies do not add up to "All" because 23 people chose not to report their gender.

452 respondents to the *2006 Survey of the Homeless*² spent the night outside, on the street or in another place not meant for human habitation (e.g., in a vehicle, abandoned building, campground, or bus station). Nearly 10% were in families with children.



Race and Ethnicity

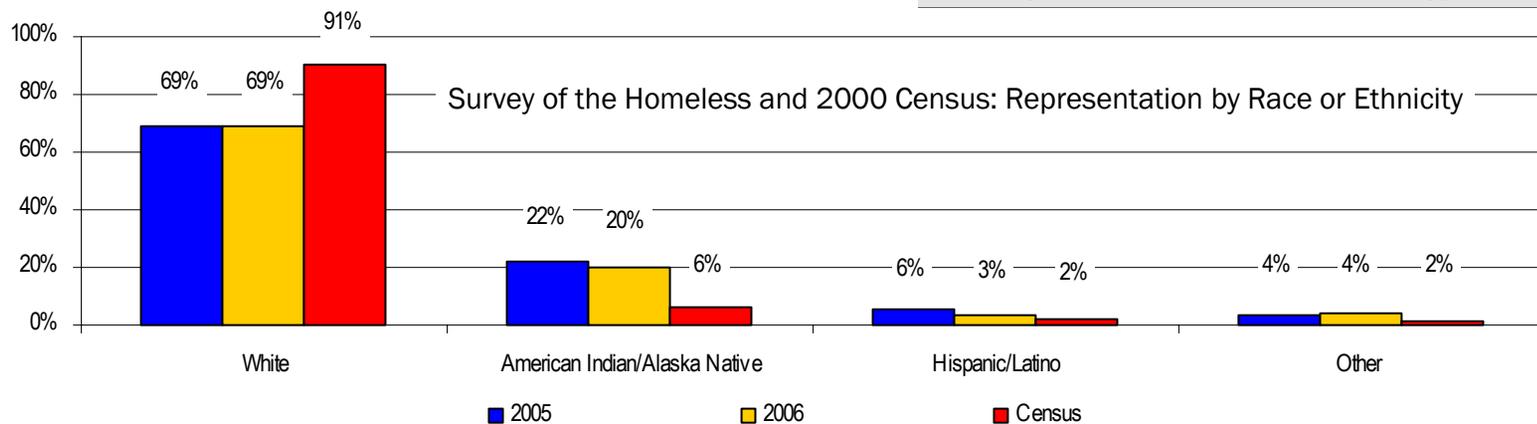
American Indians represent the largest minority population in Montana, comprising 6.2 percent of the population reported by the 2000 Census⁴. They are disproportionately represented among the homeless surveyed, at 20 percent of all identified homeless persons. Other races represent very small percentages of the Montana population, but they, too, are overrepresented among the homeless. In the chart below, “Other” includes Black, Native Hawaiian, Asian and Other. This group represents four percent of all identified homeless persons in the 2005 and the 2006 surveys^{2,3}, but just two percent of the Montana population as a whole.

American Indian people are also over-represented among those in poverty in Montana. According to 2000 Census data⁴, 12.7 percent of all White persons in Montana were living at or below poverty levels in 1999 while 38.4 percent of all American Indian persons were living at or below poverty levels.

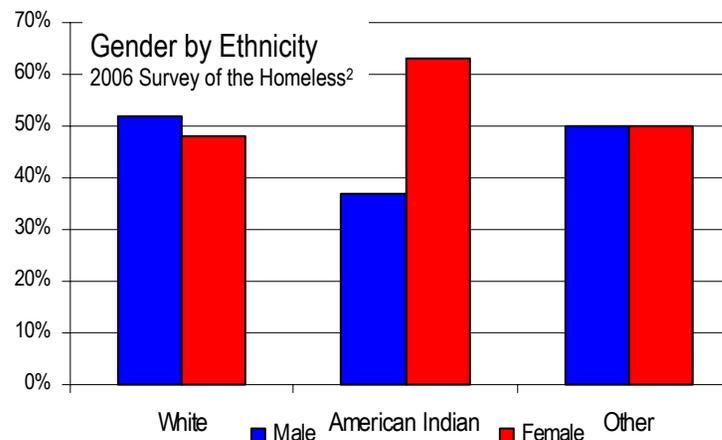
Montana’s American Indian people were represented among the homeless identified January 31, 2006 at 3.2 times the rate that would be expected based on Census data.

2005–06 Surveys of the Homeless Number of Homeless by Race ^{2,3}		
	2005*	2006
White	1,489	1,597
American Indian/Alaskan Native	471	459
Hispanic/Latino	121	74
Black	42	50
Native Hawaiian	23	17
Asian	5	8
Other	9	24
Missing or unknown	—	82
Total Homeless	2,160*	2,311

*2005 totals more than 2,097 identified homeless persons: respondents asked to choose all that applied.

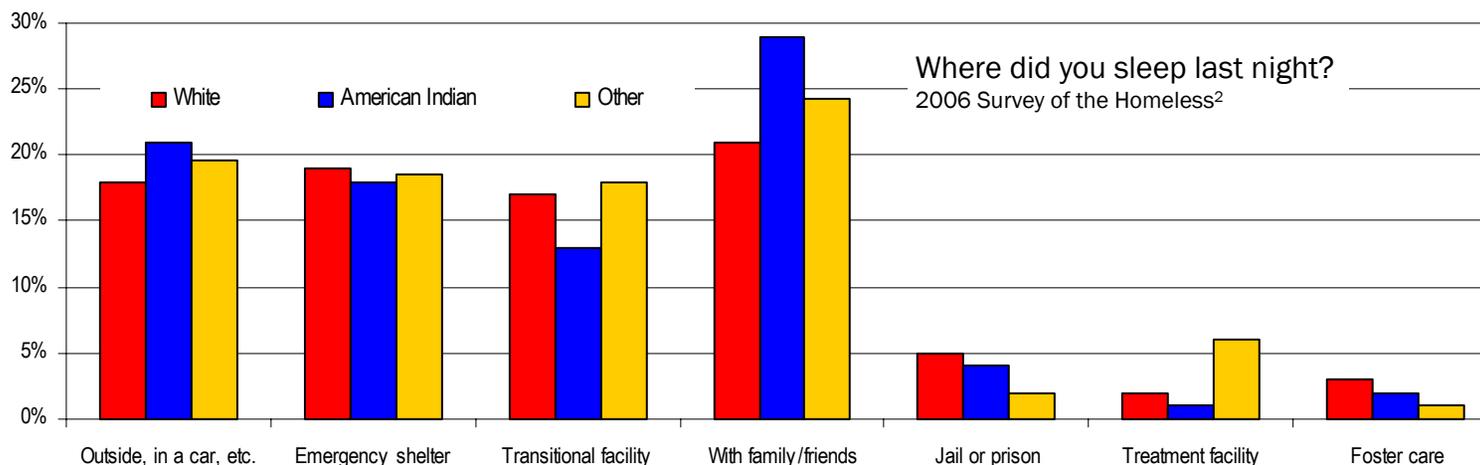


The data collected through the *2006 Survey of the Homeless²* revealed a significantly higher percentage of females (63 percent) among American Indians who were homeless. There were slightly more males (52 percent) among persons who were White and homeless. Although the discrepancy in genders by ethnicity wasn't as great in the 2005 survey data, there were still more identified American Indian females (53 percent) than males (47 percent).



2006 Survey data also revealed some interesting disparities by ethnicity in terms of where people slept on January 31, 2006. While in all cases, the most likely place cited was *staying with family or friends*, American Indian people were more likely than the other races to stay with family or friends, or to stay outside, in a car, or other place not fit for human habitation. White persons were more likely than those of other races to stay in an emergency shelter, jail, prison or foster care. This data must be considered in context with the *numbers*: Whites far outnumber other races (1,597 Whites, 459 American Indians and 106 *Other*).

Note: "Other" includes Hispanic/Latino, African American, Asian, Native Hawaiian/Pacific Islander and Other.



Why are people homeless in Montana?

Barriers exist at systems and personal levels.

Systemic factors:

- Lack of low-income housing has led to a statewide waiting list in excess of 8,200 persons, with an 18 month to 7 year wait for a Section 8 voucher in some areas of Montana⁵.
- Some eligibility policies screen people out of public housing.
- Fragmented and largely uncoordinated programs make it difficult for homeless persons to access mainstream services. Each program has its own eligibility standards and requirements. None can meet all of the needs of homeless individuals or families.
- Limited numbers of living wage jobs coupled with lack of education and training make it difficult to access and hold living wage jobs.
- Discharge or re-entry planning often does not include transition to wraparound services.
- There are no systems to bring housing, treatment and employment together in one sustainable package.
- Public dollars are shrinking.

Personal barriers can include combinations of deep poverty, disability, poor health, chemical dependency, co-occurring disorders, lack of education or training, isolation, domestic violence, histories of trauma and lack of the knowledge and sophistication needed to piece together a personal safety net from a fragmented, complex system.

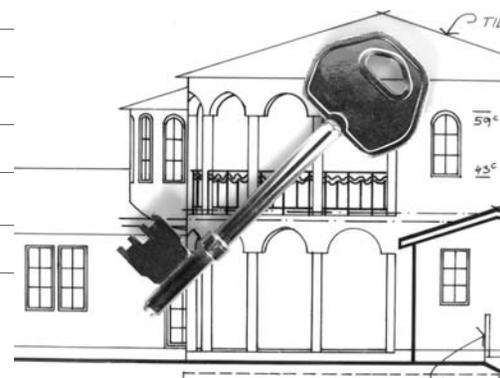
Three factors influence homelessness.

- The **1st** is **structural** – the interrelation of income, housing cost, and availability.
- The **2nd** is **personal vulnerability**, which might include mental health, substance abuse, cognitive or physical ability.
- The **3rd** is **social policy**, which can either ameliorate or worsen the other factors.

2006 HHS Poverty Guidelines⁷

Family Size	Poverty
1	\$ 9,800
2	13,200
3	16,600
4	20,000
5	23,400
6	26,800
7	30,200
8	33,600
For each additional person, add	3,400

— Martha Burt, Director
Social Service Research Program
Urban Institute⁶

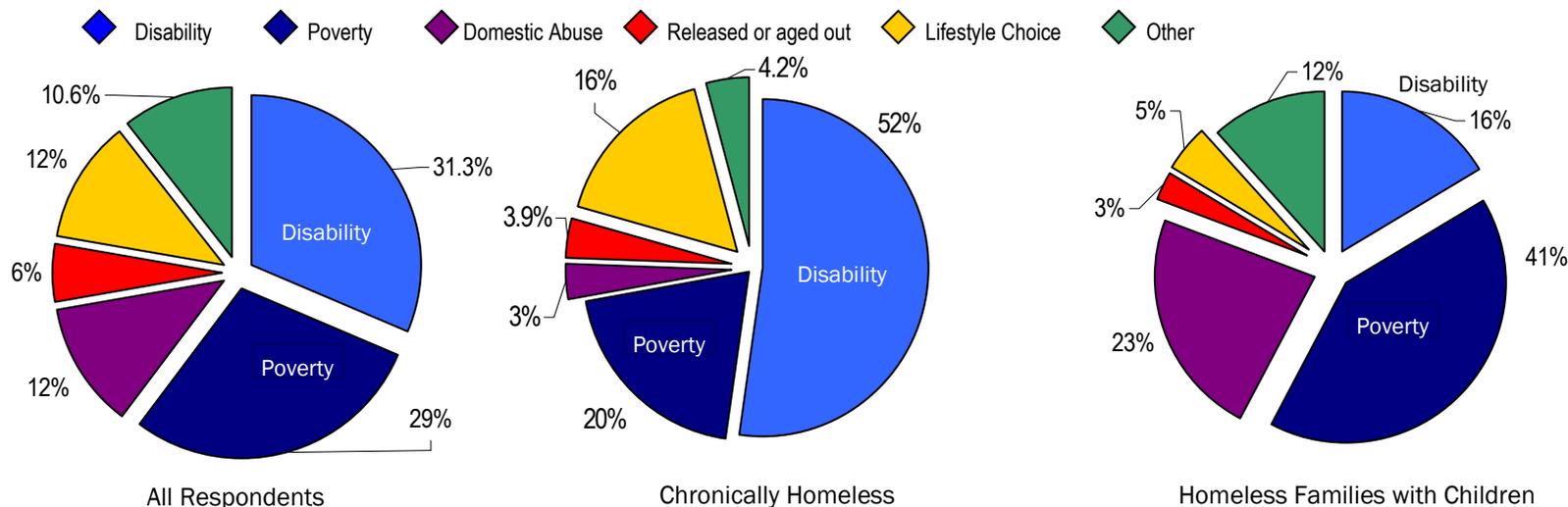


Causes: The 2006 Survey of the Homeless² presented respondents with a list of 13 possible causes for their homelessness. Respondents averaged 2.4 responses each, for themselves and their family members. The choices could be categorized in overarching issues: disability, poverty, domestic abuse, release from a facility, lifestyle choice and other. The predominant response varied significantly by group, with 60 percent of all responses falling into the disability and poverty categories combined. More than half (52 percent) of chronically homeless persons cited disability; 64 percent of homeless families with children cited poverty or domestic abuse. Clearly, ending homelessness for these subpopulations require individualized solutions.

Are you homeless due to any of the following? (Check all that apply)

- | Disability | Persistent Crisis Poverty | Domestic Abuse | Released or Aged Out of System | Lifestyle Choice | Other |
|--|--|--|--|--|---|
| <ul style="list-style-type: none"> • Drugs and/or alcohol • Mental health • Physical disability • HIV/AIDS | <ul style="list-style-type: none"> • Lost job or no job skills • Evicted • Car problems | <ul style="list-style-type: none"> • Domestic abuse | <ul style="list-style-type: none"> • Aged out of foster care • Released from prison, jail or prerelease center | <ul style="list-style-type: none"> • Lifestyle choice • Migrant worker | <ul style="list-style-type: none"> • Other |

Note: Respondents were not presented with categories. They were asked to choose causal factors from among the bulleted items.



Note: Graphs reflect percentages of all responses to causes of homelessness for each disaggregated group.

Structural

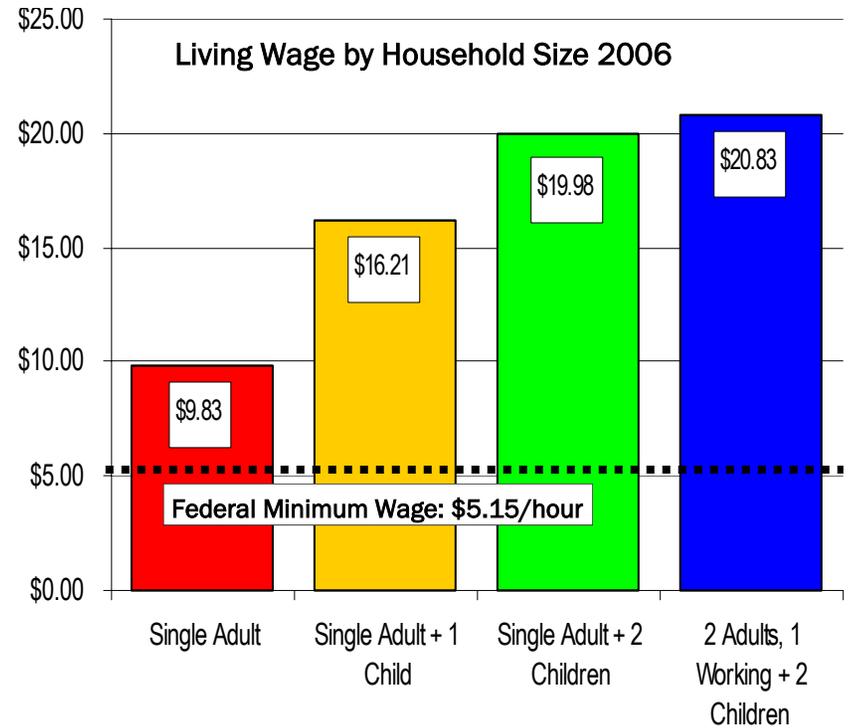
The interrelation of income, housing cost, and availability

Income: According to the *Northwest Job Gap Study*⁸ released in September 2006, only 14 percent of all jobs in Montana currently pay enough to support a two parent, two child household where one parent stays at home. Single parents raising two children are also unlikely to be working in a job that pays a living wage: only 16 percent of jobs pay the \$19.98/hour needed to support this household type.

Families with two wage earners are also struggling. *Northwest Job Gap Study* findings show that working full time is often not enough to maintain an adequate standard of living. Even dual-income families, in which both adults use all resources at their disposal, are often not earning enough. Many must choose from among adequate health care, balanced nutrition, or paying the bills. These tradeoffs can have severe consequences, including hunger, ill health...and homelessness.

Positive First Step: In November 2006, Montana voters approved Initiative 151, which raised the minimum wage from the federally mandated \$5.15/hour to \$6.15 per hour. Passage of the initiative also means yearly adjustments tied to the cost-of-living.

The Census Bureau's 2004 poverty estimates for Montana indicate that approximately 14.2% of Montanans were living below the federal poverty level, as were 26.5% of all children under age 5⁹.



Living Wage by Household

Montana Source: 2006 NW Job Gap Study ⁸	Single Adult	Single Adult with 1 Child	Single Adult with 2 Children	2 Adults, 1 Working with 2 Children
Living Wage (hourly)	\$9.83	\$16.21	\$19.98	\$20.83
Living Wage (annually at 2,080 hours/year)	\$20,449	\$33,721	\$41,549	\$43,330
Percentage of jobs that pay a living wage	63%	27%	16%	14%

Housing Cost and Availability

Cost: The generally accepted definition of affordable housing is that a household pays no more than 30 percent of its annual income for housing. Families paying more than 30 percent are considered to be “cost burdened” and may have difficulty affording necessities, including food, clothing, transportation and medical care.

A family with one full-time worker earning the minimum wage cannot afford the local fair-market rent for a two-bedroom apartment anywhere in the United States¹⁰.

An estimated 24,531 Montana households were paying *at least* 40 percent of their income for rental housing at the time of the 2000 Census; 17,101 households were paying more than 50 percent of their annual incomes for *rental* housing. Nearly one in four (23.3 percent) rental households in Montana were paying more than 40 percent of their income for housing in 1999⁴.

Montana Average Advertised Rent May to August 2005 ¹¹		
1 Bedroom	2 Bedroom	3 Bedroom
\$419	\$539	\$684
Monthly take home pay for full-time minimum-wage work: single parent with one child: \$746.66		

The lack of affordable housing is a significant hardship for low-income households, preventing them from meeting their other basic needs, including nutrition and healthcare, or saving for the future.

Availability: Section 8 housing assistance vouchers provide an excellent tool to get people housed and ensure that they can remain housed. Vouchers allow very low-income families* to pay 30 percent of the gross adjusted household income toward rent and utilities. The balance is subsidized with public dollars.

In its *Annual Performance Report (April 2005 to March 2006)*¹², the Montana Department of Commerce Tenant Based Section 8 Housing Assistance Program stated that it was assisting 3,803 households. Among these households:

- 2,947 had incomes of 50 percent or less of area median
- 2,358 had incomes of 30 percent or less of area median;
- 876/1,096 special needs households receiving Section 8 rental assistance had incomes at 30 percent or less of area median.

*Very low-income families have incomes of 50 percent or less of the HUD median family income for the county in which the family resides.

More than 8,200 families are on the Montana Department of Commerce waiting list⁵ for housing vouchers. They are served on a first-come, first-served basis. Depending on the area, the wait can last from 18 months to 7 years. At any point, approximately 600 Montanans hold vouchers and are seeking housing. They have a maximum of 120 days to secure it. If unsuccessful, the voucher reverts to the next eligible person on the list.

Persistent Crisis Poverty

Homeless in Montana

“Poverty is often defined as *“being without sufficient funds or material goods,”* but I have come to believe that it has less to do with money and *stuff*, and more to do with the lack of the host of the intangible resources many of us take for granted.

“A Framework for Understanding Poverty by Ruby Payne, Ph.D., offers insights that have changed the way I view poverty. Payne likens resources to a pie comprised, for most of us, of many, many pieces. The pieces might include health, mental health, a strong family background, education, intelligence, good role models, healthy community networks, housing, transportation, childcare, healthcare, a good job...and of course, financial resources. The list could go on and on. According to Payne, the more pieces of the resource pie a person is missing, the less likely it is that s/he will ever climb out of poverty. That resonates. Think about not *having* access to safe, affordable housing, food, transportation and all of the other things we take for granted every day. Think about being so disenfranchised that there is absolutely no one to turn to.” *Prevention Connection Newsletter: The Vicki Column. Summer 2006.*¹³

2006 Survey of the Homeless²

- 392 of the homeless survey respondents were working either part- or full-time.
- Of the 392 working respondents:
 - 281 had a high school education or less;
 - 101 were members of families with children; 25 were pregnant.



At very low income levels, an emergency that would seem minor to someone in the middle class — a sick child, a car breakdown, a high utility bill — can be enough to precipitate a crisis that spirals into homelessness.

Working full-time, year-round for the minimum wage of \$5.15/hour equates to an annual wage of \$10,712. This falls short of the 2006 federal poverty rate for a family of two by \$2,488.

Personal Vulnerabilities

The word “homeless” implies that the solution is a home. In many cases, this is true. But chronic homelessness is almost always a symptom of treatable problems, substance abuse, untreated mental illness, social disaffiliation — or a combination of the three. This is not a one-faceted problem. Nothing — not a house, income, food, treatment or training — will solve homelessness in isolation. This is a multi-faceted problem that requires complex solutions.

The 2nd factor influencing homelessness is personal vulnerability, which might include mental health, substance abuse, cognitive or physical ability.

In 2005, respondents to the Survey of the Homeless were asked if they *had* any disabling conditions and asked to choose all that applied³.

This language changed in 2006², when respondents were asked if they were currently disabled with a “*diagnosed condition*.” This is a small change with important implications. Even though the total number of homeless persons identified by the survey of the homeless was higher in 2006, the numbers of those stating that they had a specific disability was down in every case but developmental disability.

Disabled with Diagnosed Conditions vs. Disabling Conditions

Survey of the Homeless ^{2,3}	2006: Are you currently disabled with a DIAGNOSED condition?	2005: Do you currently HAVE ANY disabling conditions?
No	1,275	973
Yes	876	1,066
Missing or Not Applicable	160	58
Total Homeless	2,311	2,097
Which diagnosed conditions?		
Mental Illness	408	519
Alcohol or drug abuse	348	482
Physical disability	272	337
Developmental disability	57	42
HIV/AIDs or related disorders	19	27
Other	141	89
Don't know	Not applicable	138

Personal Vulnerabilities

Homelessness Causes Poor Health

As a consequence of poor nutrition, inadequate hygiene, exposure to violence and the elements, increased contact with communicable diseases, and the constant stress of residential instability, people without homes suffer from ill health at much higher rates [than their housed counterparts]. Homelessness also complicates the delivery of health care. Health conditions requiring uninterrupted treatment — such as diabetes, cardiovascular diseases, tuberculosis, HIV, addiction, and mental illness — are extremely difficult to manage without a stable residence¹⁴.

Disease

in general is more prevalent among the homeless than among the general population, with hypertension, asthma and Hepatitis C the most commonly reported diseases in 2006².

In 2006, for the first time, respondents to the Survey of the Homeless² were asked whether they had specific diseases.

Have you been diagnosed with any of the following?

Hypertension (high blood pressure)	253
Heart Disease	91
Asthma	243
Hepatitis C	204
Bronchitis	146
Diabetes	118
TB	25
HIV/AIDS	18

persons who have a history of sexual exposure without any other risk factors. Recovery is uncommon, and about 85 percent of infected persons become chronic carriers of the virus. The disease typically results in death or the need for a liver transplant¹⁵.

Heart disease is a leading cause of death in middle-aged homeless persons (45–64 years).

Because of the difficulty in accessing bed rest and proper diet, treatment requires earlier hospitalization among the homeless population.

Asthma is a chronic inflammatory disease of the airways. Prevalence rates are significantly higher among homeless people. Exposure to environmental toxins trigger or exacerbate asthma, emphysema and chronic bronchitis in susceptible individuals, and help to account for the disproportionately high prevalence of these chronic lung diseases among homeless people.

Hepatitis C Virus (HCV) is spread primarily by direct contact with blood. Injection drug use is the most common risk factor, accounting for 50 to 60 percent of all identified cases in national studies, but approximately 20 percent of cases involve

Although chronologically younger, health and functional problems of homeless adults in their 40s and 50s resemble those of geriatric persons in the general population¹⁵.

Addiction

Substance Abuse and Mental Health Services Administration, Treatment Episode Data for 2004¹⁶ reveals four common drugs of abuse in Montana, which together combine 92 percent of the 7,410 treatment admissions to the publicly funded chemical dependency system.

- Alcohol only: 31.2%
- Alcohol with secondary drug: 26.1%
- Marijuana: 19.2%
- Amphetamines: 15.5%

The 7,410 served in Montana’s publicly funded system in 2004 represented only a fraction of the estimated 21,000 Montanans needing but not receiving treatment for illicit drug use, and 70,000 needing but not receiving treatment for alcohol use¹⁸. (Estimates from the Substance Abuse and Mental Health Services Administration.) According to data from Montana’s Alcohol and Drug Information System (ADIS), 442 homeless persons were served by the publicly funded treatment system in 2003. In 2006, 599 of the homeless persons surveyed and in 2005, 592 of those surveyed stated that substance abuse was a cause for their homelessness.



Homeless in Montana

According to a *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders*¹⁶, substance use is both a precipitating factor and a consequence of being homeless. Substance use and abuse frequently lead to loss of housing, and make it more difficult for individuals to find safe, sober housing once they become homeless. People with substance use disorders who are homeless face enormous competition for limited treatment slots. Those who do receive treatment are more likely to get care for a co-occurring mental illness.

2004 Montana State Estimate of Substance Use¹⁸

Past Year Dependence, Abuse & Treatment ¹⁸	Age 12+	
	Percent	Number
Illicit Drug Dependence	1.85%	14,000
Illicit Drug Dependence or Abuse	2.98%	23,000
Alcohol Dependence	3.95%	31,000
Alcohol Dependence or Abuse	9.81%	76,000
Alcohol or Illicit Drug Dependence or Abuse	10.90%	84,000
Needing But Not Receiving Treatment for Illicit Drug Use	2.73%	21,000
Needing But Not Receiving Treatment for Alcohol Use	9.09%	70,000

- 599 respondents to the 2006 Survey² identified chronic drug and/or alcohol abuse as a cause of their homelessness:
- 363 were male, and 231 were female;
- 182 spent the night of January 31st outside, in a car or other place not fit for human habitation;
- 365 of them were between the ages of 30 and 59; and
- 162 were aged 18 to 29.

Mental Illness

People with serious mental illness are highly vulnerable to discrimination, stigma and violence.

The symptoms of serious mental illnesses can decrease housing

stability and increase vulnerability to homelessness — people with mental illnesses may disturb their neighbors, forget to pay bills, or present a threat to themselves or to others. Many with mental illnesses have difficulty developing and maintaining social relationships. This can lead to isolation, conflicts, job loss and difficulty connecting with the mainstream services that could help.

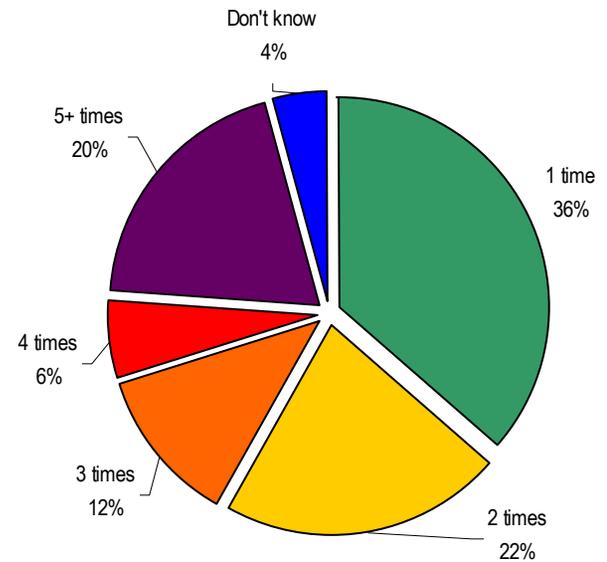
Homeless persons with serious mental illnesses are more likely than other groups to have had contact with the justice system, often for minor offenses such as trespassing, petty theft, shoplifting, drinking in public or loitering. Studies reveal that a person with a mental illness has a 64 percent greater chance of being arrested for committing the same offense as someone who does not have a mental illness¹⁷.

“Many of the patients at Montana State Hospital either don't have homes to begin with or lose their residences when they enter the hospital. Although there isn't a waiting list to get in, there are often waiting lists for community-based mental health services. This can result in prolonged hospitalization, particularly among those who are either homeless or at high risk for homelessness.”
— Ed Amberg, Administrator

- Despite the stigma attached to mental illness, 408 of the 2,311 persons identified during Montana's 2006 *Survey of the Homeless* revealed that they were currently disabled with a *diagnosed* mental illness.

- 456 of the 2,311 identified during the 2006 Survey listed mental illness as a cause of their homelessness.
- 60 percent of the 408 homeless persons diagnosed with a mental illness in 2006 had been homeless more than once in the past three years.

Persons with Diagnosed Mental Illness: Times Homeless in Past 3 Years

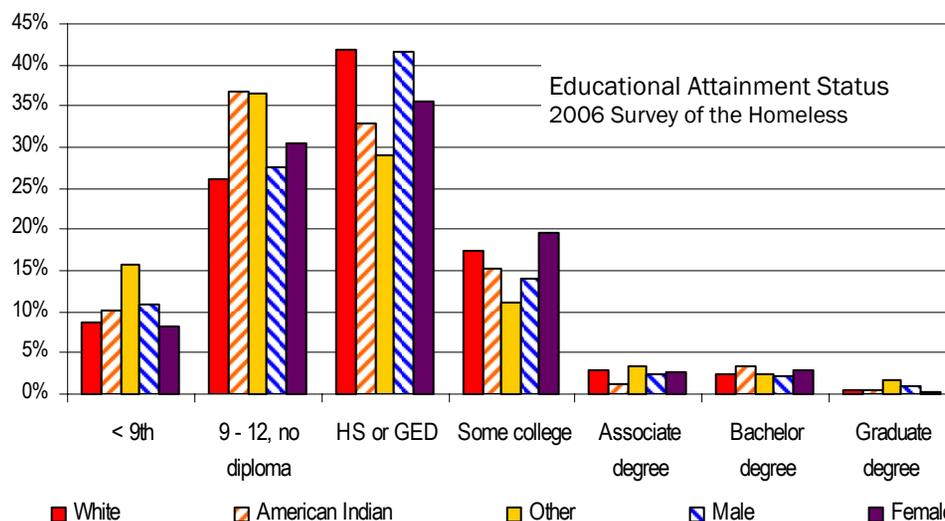


About 5% of people with serious mental illnesses are homeless at any given time, but as many as 2/3 of *all* people with serious mental illnesses have experienced homelessness or have been at risk of homelessness at some point in their lives¹⁷.

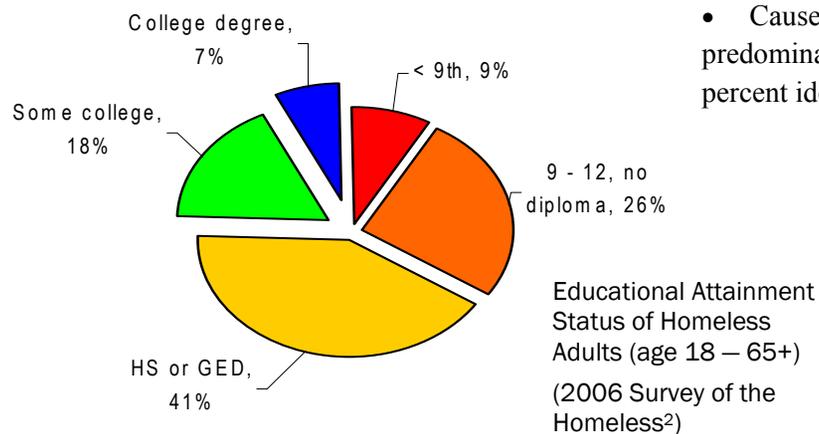
Education:

76% of all adults (age 18 – 65+) identified during the 2006 Survey² had a *high school education or less*. Just 7 percent had a college degree. There were some differences when the data for the 2006 Survey was disaggregated by ethnicity and by gender, demonstrated by the bar graph at right.

According to a study by Martha Burt of the Urban Institute, there is little difference between the educational attainment status of homeless persons and those who are poor and remain housed¹⁹. A low educational attainment status correlates with lack of ability to access and maintain employment that pays a living wage. 2006 Survey² results reveal that:



- Among homeless adults with a high school education or less (1,524), 28 percent (418) were working either part- or full-time.
- Causes of homelessness among adults with a high school education or less were predominantly poverty related: 25 percent identified lost job or no job skills; 17 percent identified eviction; and 6 percent identified car problems.



Educational Attainment Status: Adults ^{2,4}	2006 Survey of the Homeless	2000 Census
< 9th	9%	4%
9 - 12, no diploma	26%	9%
HS or GED	41%	31%
Some college	18%	26%
Associate degree	3%	6%
Bachelor degree	3%	17%
Graduate degree	1%	7%
High school or more	57%	87%

The 3rd factor influencing homelessness is social policy, which can either ameliorate or worsen the other factors.

The roots

Family crises are not new, nor are addiction, disability, losing a job, poverty or domestic abuse. These may not be the roots of homelessness, but are often precipitating factors.

The growing population of homeless people in Montana is relatively new, but the roots of the problem have been gaining a stranglehold for nearly 30 years: the loss of low-cost housing, shrinking public resources, wholesale deinstitutionalization and wages that haven't kept pace with rising costs have all contributed to the growing crisis.

Effective policy-based solutions would include a living rather than minimum wage; accessible health care; education and training that provide the tools to get and hold living-wage jobs; more subsidized housing; effective prevention protocols; urban planning that encourages housing for all income levels; and access to adequate social services for people of all ages.

Solutions: A growing body of research suggests that it would be less expensive to *end* homelessness continuing to manage it.

Montana is taking a 7-pronged approach to end homelessness:

1. Increase access to, and coordination of, mainstream services.
2. Prevent homelessness by providing targeted, flexible one-time assistance for families
3. Coordinate discharge from institutions with housing and services.
4. Craft and systematize solutions to meet the needs of specific populations, including the chronically homeless, homeless families, unattended youth, and the disabled.
5. Create and/or retain low-income housing geared to meeting the needs of those living on incomes of 0 — 30 percent of the Area Median Income.
6. Develop sustainable resources specifically targeted to ending homelessness.
7. Measure success and document savings.

The research: When “*housing first*” strategies are employed and people move from the streets into permanent, supportive housing, about 90 percent remain housed. In the past, supportive housing was considered prohibitively expensive, but it has emerged as a good investment, substantially reducing the use of other publicly funded services. In at least one study, the reduced use of acute care services nearly offset the costs of the permanent supportive housing²⁰.

Solutions: the MTCoH

The Montana Council on Homelessness

(MTCoH) was originally convened by Executive Order in June 2004. The Council was charged with looking at overarching issues, obstacles and solutions to homelessness as it exists in Montana.

Consistent with national models, the Council included policymakers and stakeholders from multiple sectors including Corrections, Public Health, Veterans Affairs, Education, Housing, Tribal, the Montana State Hospital, Labor, Health Care for the Homeless, HUD, Social Security, the Board of Crime Control, the Governor's Office, the statewide Continuum of Care Coalition, private and non-profit sectors and direct service providers. This group was charged with coming up with systems level strategies that would begin to address the issue of homelessness from a policy level.

The Council initiated five workgroups to look at specific facets of the issue: housing; access to mainstream services; special needs populations; education, employment and training; and finance and resource development. Over the course of two years, the Council elicited input from over 100 Montanans with expertise and experience in the broad arena of homelessness. There have also been focus groups, interviews and surveys. This work was synthesized into a draft 10-year plan to end homelessness in Montana that will be reviewed and approved by the MTCoH named by Executive Order for 2007-08.

MTCoH Members: *June 2004 – April 2006*

- Co-chair Lieutenant Governor John Bohlinger
- Co-chair Hank Hudson, Administrator, Human and Community Services Division, Department of Public Health & Human Services
- Ed Amberg, Administrator, Montana State Hospital
- Bob Andersen, Governor's Office of Budget and Program Planning
- Gordon Belcourt, Executive Director, Montana/Wyoming Tribal Leaders' Council
- Joe Bischof, Executive Director, Missoula Poverello Center
- Bob Buzzas, Coordinator, Montana Continuum of Care
- Ingrid Childress, Administrator, Workforce Services Division, Department of Labor
- Mike Ferriter, Director, Montana Department of Corrections
- Joe Foster, Administrator, Montana Board of Veterans' Affairs
- Lori Hartford/Judy Stewart, Director, Montana Healthcare for the Homeless
- Donald Ketcham, Executive Officer, Social Security Administration
- Sherry Matteucci, J.D., Matteucci Law Firm
- Roland Mena, Executive Director, Montana Board of Crime Control
- Mark Simonich/Anthony Priete, Director, Montana Department of Commerce
- Eric Sells, PATH, Western Montana Mental Health Center
- Terry Teichrow, McKinney-Vento Homeless Assistance Act Program Specialist, Office of Public Instruction
- Ex-officio: Tom Friesen, Montana Field Office Director, Department of Housing & Urban Development
- Jim Nolan, Sponsor, Chief, Intergovernmental Human Services Bureau, Department of Public Health and Human Services
- Sherrie Downing, Coordinator
- With special thanks to Bruce Brensdaal, Montana Board of Housing, Marcia Armstrong, Montana PATH Program Director, and Marcial Ornelaz, Montana Prevention Resource Center VISTA

Ending, rather than managing, homelessness is not only the right thing to do, it's by far the most cost-effective alternative.

Chronically homeless persons present a complex set of challenges

to service providers and utilize multiple high-end services, including jail, in-patient treatment, emergency rooms and shelters. They share characteristics that include disability, extreme poverty, poor job skills, lack of education, and histories of childhood trauma.

Chronically homeless persons, who typically represent about 10 percent of the overall homeless population, tend to be extremely socially isolated, with limited or nonexistent support systems.

Meeting the needs of this population through emergency shelters and other temporary measures is expensive, so preventing homelessness or ensuring quick transition into permanent housing yields significant savings.

Health Problems Cause Homelessness

Half of all personal bankruptcies in the United States result from health problems. It is a short downhill slide from bankruptcy to eviction. Some health problems prevalent among homeless people – including addictions, mental illnesses and HIV/AIDS – also undermine the family and social supports that serve as protective factors against homelessness.

Homelessness Causes Health Problems

People without homes are exposed to the elements, violence, communicable disease, infestations and infections. Circulatory, dermatological and musculoskeletal problems commonly result from excessive walking, standing, and sleeping sitting up. Homelessness and malnutrition go hand-in-hand, increasing vulnerability to acute and chronic illnesses.

Numerous studies put the average age of death for homeless persons at 47. In Montana, the mean age of death overall is 73.

Hospitalization and Medical Treatment

According to a report in the *New England Journal of Medicine*, homeless people spent an average of **four days per hospital visit longer** than comparable non-homeless people. This extra cost was directly attributable to homelessness.

- The Centers for Medicare and Medicaid Services provide data about the costs associated with short-stay inpatient care for each state. For Fiscal Year 2004, Medicaid reimbursements for short-term hospital stays averaged \$1,428/day. The average short-term inpatient stay in Montana lasted 4.6 days. Adding four days jumps the total cost from \$7,711 per episode to \$12,281.

Emergency Room Costs

According to a Medical Expenditure Panel Survey completed in January 2006, the average cost for an emergency room visit in 2003 was \$560. Studies indicate that homeless persons access emergency room services, on average, 2.6 times annually.

Jail

National averages indicate that homeless individuals spend 10 days annually in local jails. In Montana, the cost per day for time in a county jail is \$54.

Treatment

The median length of an acute inpatient stay at the Montana State Hospital is 10 days, at a cost of \$292/day.

The estimates at right reflect publicly funded services commonly used by chronically homeless persons throughout the year. Every homeless person will not utilize every service, but research indicates a strong likelihood that a homeless individual will use a combination of these and other services. Emergency room visits, use of emergency shelter, short-term hospital stays, use of services from Health Care for the Homeless, time in jail and time at the State Hospital are common among the chronically homeless in Montana. Use of the Chemical Dependency Center may be less common unless mandated by the courts, due to a waiting list for admittance.

The Price of *not* Addressing Homelessness in Montana

Service	Mean Days	Cost /Day	Annualized Cost
A. Emergency Shelter	137	\$38	\$4,932
B. Short-term Hospital Stay	4.6	\$1,428	\$7,711
C. Emergency Room Visits	2.6	\$560	\$1,456
D. Health Care for the Homeless	5	\$80	\$400
E. Jail	10	\$54	\$540
F. Montana State Hospital	10	\$292	\$2,920
G. Montana Chemical Dependency Center	34	\$160	\$5,450

Note: Average service use was largely based on national studies, but the days projected for Montana State Hospital reflects the median length of stay for acute care. The time for the Chemical Dependency Center reflects the average days of inpatient treatment. Service costs, inasmuch as possible, are Montana specific. Cost detail is included on page 77.

*The services listed above account for 203 days *if* all services were used. That leaves 44% of the year unaccounted for. The costs attached to many services, including meals at soup kitchens, medications, or vouchers for motels, are difficult to quantify and have not been counted.

Permanent supportive housing is the most effective tool at our disposal. Research on the impact of supportive housing on service use for homeless persons with mental illness in New York City (Dennis Culhane, Ph.D., et. al.) demonstrated that in the 12 months after entering supportive housing, resident visits to emergency rooms dropped by 56 percent. Short-term hospitalizations dropped by 45 percent. Rockefeller Foundation data indicate a 50 percent decrease in jail time. With permanent housing, the need for Health Care for the Homeless services drops, as does the need for emergency shelter.

The average monthly cost of a single-room occupancy (SRO) unit in Montana? \$351. The savings on public systems? Measurable. The effect on quality of life? *Priceless.*

Stepping Stones: Overarching Strategies

Goal: End Homelessness by 2014

Vision: Ending homelessness in the last, best place



Homeless in Montana

Goal I: Enhance state-level coordination around the issue of homelessness DRAFT

Objectives	Milestones	Critical Partners	Target Date
<p>Objective 1.1: Enhance coordination among state-level policymakers in order to create a sustainable, multi-systemic infrastructure for addressing homelessness</p>	<p>Establish a Montana Council on Homelessness to serve as a broad-based policy-making body that has the authority to begin creating and implementing system-level strategies</p> <ul style="list-style-type: none"> Enhance multi-systemic awareness of homelessness as a growing issue in Montana Encourage local state workers to participate in local Continuums of Care 	<p>Health & Human Services, Social Security, Labor, Corrections, the Office of Public Instruction, the Montana Board of Crime Control, American Indian leadership, the Continuum of Care, the Board of Housing, the Addictive and Mental Disorders Division of HHS, Veterans Affairs, HUD, non-profit providers, constituents, and private sector representatives</p>	<ul style="list-style-type: none"> June 2004: Executive Order forming the Montana Council on Homelessness (MTCoH) MTCoH convenes at least 4 times annually
<p>Objective 1.2: Extend and expand the broad-based efforts to address homelessness through continuation of the Montana Council on Homelessness</p> <ul style="list-style-type: none"> Ensure that consumers have a voice and that their needs and wants are heard and incorporated 	<p>Continue the MTCoH through an Executive Order by Governor Brian Schweitzer</p> <ul style="list-style-type: none"> Provide an initial in-state Policy Academy for the new MTCoH members Use consumer focus and advisory groups; practice inclusion at every level 	<p>A broad spectrum of community appointees by the Governor that includes partners not typically associated with the issue of homelessness; create a state and federal coordinating team comprised of the partnering agencies listed above</p>	<ul style="list-style-type: none"> Executive Order #40, 12/2006 State orientation or Policy Academy by 4/2007
<p>Objective 1.3: Create an overarching definition of homelessness to use in a variety of ways, including grants and policies, while recognizing that programs may have to conform to definitions specific to funding source.</p>	<p>Homeless in Montana (MTCoH): Anyone without safe, permanent and stable housing or at risk of losing their housing.</p> <ul style="list-style-type: none"> Recognize various definitions of homelessness (e.g., HUD, McKinney-Vento, HCH) and list as appendix or cross-referencing matrix. 	<p>MTCoH; State of Montana agencies; Governor's Policy advisors</p>	<p>Created: February 2005</p>

Goal II: Prioritize services for the homeless *DRAFT*

Objectives	Milestones	Critical Partners	Target
Objective 2.1: Create and adopt an immediate response to the needs of homeless persons, coordinated across needs and resources	Focus on prevention and ensuring access to benefits in 5 systems (Social Security/SSI, TANF, Medicaid, Food Stamps and Veterans). Provide cross-training for case managers on completing applications for such programs as SSI and food stamps.	DPHHS, SSA, SOAR Team, DDS, PATH, Veterans Administration	SSI: 2006 Food Stamps: 2007 All: 2008
Objective 2.2: No one will be discharged into homelessness by Montana institutions, including the mental health system and Department of Corrections.	<ul style="list-style-type: none"> Assist those discharged from public institutions with links to public benefits and housing. Strengthen partnerships with State Hospital, Department of Corrections and local law enforcement to ensure that the mentally ill are not discharged into homelessness Facilitate training for discharge planners and case managers on available resources, e.g., SSI/SSDI. Encourage policies that prevent discharge into homelessness. 	Addictive and Mental Disorders Division, Department of Corrections, local law enforcement SOAR SSI training team; Social Security Administration; Parole, Probation, Community Corrections.	2005 and ongoing

Goal III: Enhance access to permanent, affordable housing *DRAFT*

Objective 3.1: Support legislation designed to create additional housing annually for the next 10 years (for populations across the continuum of housing needs)	<ul style="list-style-type: none"> Identify/develop sustainable funding stream(s) Draft an Executive Planning Process (EPP) request for General Funds for housing, to be added to the base budget. Draft legislation and find champion(s). Explore tax incentives for those willing to provide additional housing for the homeless. 	Association of Counties; HOMEWORD; Homeownership Network; Association of Realtors; Building Industry Association; Salish Kootenai Housing Authority; Rocky Mountain Development Council; Home Choice Coalition; MTCoH	Legislative Session 2007 and ongoing
Objective 3.2: Formulate concrete housing plan that includes a continuum of housing choices, from permanent affordable rentals through first time homebuyers assistance.	<ul style="list-style-type: none"> Participate in the evolution of Montana's <i>Housing for Montana Fund</i>, which will accommodate a wide range of housing. Ensure that the populations to be served by the fund include those living on incomes of 0-30% of the Area Median. 	Association of Counties; HOMEWORD; Homeownership Network; Association of Realtors; Building Industry Association; Salish Kootenai Housing Authority; Rocky Mountain Development Council; Home Choice Coalition; MTCoH	Legislative Session, 2007

Goal IV: Initiate and support pilot projects that assist local communities with ending homelessness

DRAFT

Homeless in Montana

Objectives	Milestones	Critical Partners	Target Date
<p>4.1: Initiate and support partnerships with local communities; provide technical assistance, access to stakeholder agencies, and the information needed to create local plans to address the issue of homelessness at the community level.</p>	<p>Using the annual Montana Survey of the Homeless for baseline data, approach Montana cities with the largest documented populations of homeless persons with the offer of partnership in a citywide effort to address homelessness. Facilitate and convene citywide strategy sessions in:</p> <ul style="list-style-type: none"> • Billings; • Helena; • Kalispell; • Great Falls; • Missoula; • Butte; and • Bozeman. 	<p>City and/or county governments, Continuums of Care; health departments, SSA, law enforcement, mental health service providers, substance abuse service providers, business, case managers, PATH, housing authorities, schools...as well as MTCOH and all agencies affiliated through the coordinating team</p>	<ul style="list-style-type: none"> • 2006: Billings • 2007 – 2015 – at least one city per year
<p>4.2: Support the 2006 Billings Commission on Homelessness as it identifies needs through technical assistance, linkages, information and resource identification and access.</p>	<ul style="list-style-type: none"> • Mayor announces the formation of the Billings Committee on Homelessness, names interested stakeholders to serve on the council, and convenes council. • Mayor announces formation of a Billings Provider Network Workgroup to assist the Committee on Homelessness. 	<p>Billings Mayor and interested stakeholders</p>	<p>Summer 2006</p>
<p>4.3: Initiate and support a re-entry pilot project to prevent homelessness among women leaving the Montana Women's Prison.</p>	<ul style="list-style-type: none"> • Establish the partnerships needed to help a population with corrections and addictions backgrounds access permanent affordable housing and wraparound support services. • Enhance access to existing system supports and Develop Memorandums of Understanding (MOUs) with participating providers and private sector partners. • Eliminate barriers to successful re-entry for pilot project participants, by identifying appropriate candidates and establishing relationships with them 3 to 6 months in advance of their reentry. • Seek re-entry funding to assist with project. 	<p>Department of Public Health and Human Services, Department of Corrections, Montana State Prison, local agencies</p>	<p>2008</p>

Goal IV: Initiate and support local communities with projects to end homelessness *DRAFT*

Objectives	Milestones	Critical Partners	Target Date
Objective 4.4: Facilitate and support understanding and implementation of a social enterprise consistent with Pioneer Human Services, offering living wage jobs, access to treatment and safe housing for the homeless, those in recovery and former prisoners by using contracts for the production of goods and services as sustainable funding.	<ol style="list-style-type: none"> 1. Visit Pioneer Human Services in Seattle to observe their model. 2. Share concept with communities and MTCoH. 3. Seek training, funding, support and partners with the capacity to implement model. 	<ol style="list-style-type: none"> 1. DPHHS Intergovernmental Human Services Bureau, MBCC, H&CS Division, MTCoH, Pioneer Human Services 2. Billings stakeholders 3. MTCoH 	<ol style="list-style-type: none"> 1. Summer 2005 2. Fall 2005 3. 2006 and beyond

Goal V: Strengthen political will to end homelessness *DRAFT*

Objective 5.1 Generate awareness that homelessness is an issue in Montana, and use the enhanced awareness to create a call to action	<ul style="list-style-type: none"> • Generate and disseminate information highlighting the issue using a range of venues including the reports on the state of homelessness in Montana, the state of homelessness in various cities, the 10-Year Plan, E-news Updates, television and newspaper articles. 	DPHHS; MTCoH; local media; Montana leadership, including Governor, Lt. Governor, policy advisors	Initiated in 2004; ongoing
Objective 5.2: Generate awareness, create and publicize information about homelessness as it exists within specific subpopulations, including adults without children, the chronically homeless, homeless families with children, unattended youth, and re-entry populations	<ul style="list-style-type: none"> • Support evolution of MTCoH workgroups from issue-specific to population-specific, to create strategies for subpopulations of the homeless. • Create and disseminate information specific to subpopulations, and generate plans to address homelessness within those populations. • Initiate partnerships with tribes to determine what homelessness looks like in the rural or reservation setting; create strategies to address homelessness in a culturally competent manner consistent with tribal needs. • Ensure that case managers have access to cultural competency training for groups including American Indians, the mentally ill, and homeless populations 	<p>Montana Council on Homelessness, statewide stakeholders</p> <p>Governor's Commissioner on Indian Affairs; Montana/Wyoming Tribal Leaders Council; tribal human services departments.</p>	2006 and ongoing

Goal VI: Develop the financial capacity and resources needed to address homelessness in Montana

DRAFT

Homeless in Montana

Objectives	Milestones	Critical Partners	Target Date
<p>Objective 6.1: Seek new and or additional funding and resources – Using best-practice methods, use additional resources to ensure that homeless persons or those at imminent risk of homelessness have access to the services and resources needed to either stay housed or to achieve rapid rehousing (e.g., childcare, transportation, treatment, emergency funds for heat or energy, rental deposits, training, education or job mentoring, case management, or a combination of these and other personalized services).</p>	<ul style="list-style-type: none"> • Redirect state, county and/or city funds. • Participate in application for SAMHSA Access to Recovery funding that includes vouchers for treatment and other services. • Identify and seek grant funding from other federal, state and private foundation sources. • Recruit VISTA/AmeriCorps volunteers. • Utilize federal technical assistance to the extent possible. • If funding is needed, ask divisions and departments who stand to benefit, and make general fund requests as needed. 	<p>MTCoH; DPHHS; Department of Corrections; Department of Commerce; local governments; Policy Academy partners; United Way; Big Sky Economic Development Association; others TBD</p>	<p>2005 and ongoing</p> <p>VISTAS approved and recruited: 2004-05 and 2006-07 cycles</p>
<p>Objective 6.2: Establish incentives for those willing to provide housing for homeless, reentry and recovering populations.</p>	<p>Explore tax incentives for those who provide additional housing for this population:</p> <ul style="list-style-type: none"> • Draft potential legislation; and • Seek out legislative support. 	<p>Montana departments of Public Health, Commerce and Corrections, legislators TBD, MTCoH</p>	<p>2009 legislative session</p>

GOAL VII: Document savings, potential savings, and success *DRAFT*

<p>Objective 7.1: Collect and integrate data about the homeless using one agreed-upon system (e.g., the DPHHS Homeless Management Information System).</p>	<ul style="list-style-type: none"> • Support the continued administration of the annual Survey of the Homeless for use in providing baseline and benchmark data • Explore South Carolina data warehouse option so that data from other systems can be “dumped” into one central location for analysis 	<p>DPHHS Intergovernmental Human Services Bureau; stakeholder agencies; local agencies participating in demonstration project; MTCoH</p>	<p>2007 and ongoing</p>
---	---	--	-------------------------

<p>Objective 7.2: Establish baselines and reasonable benchmarks for use in documenting progress toward reducing and ultimately ending chronic homelessness in Montana</p>	<ul style="list-style-type: none"> • Set reasonable goals, such as reductions in survey counts, reductions in demand on emergency shelter services, number of additional permanent supportive housing slots added, and/or reductions in need for high-end services, including jail, court services, emergency room visits • Facilitate 2007-08 MTCoH in prioritizing strategies and activities, breaking them into short- and long-term goals 	<p>MTCoH, DPHHS, Corrections, community-level services</p>	<p>2005 and annually (Survey of the Homeless), others to be established 2007 and ongoing</p>
<p>Objective 7.3: Create a Cost Benefit Analysis that defines the savings of addressing rather than managing homelessness</p>	<p>Partner with local community to do a cost benefit analysis of 20 chronically homeless individuals – include jail time, emergency room, emergency shelter, treatment, Montana State Hospital, chemical dependency treatment centers, and other high-cost services. Track historic use for past 6–12 months, and follow for at least 6 months.</p>	<p>MTCoH, local communities TBD</p>	<p>2007 and 2008</p>

Goal VIII: Support, promote and encourage systems-level thinking for prevention and intervention

DRAFT

<p>Objective 8.1: Authorize use of existing funding streams to create a pool that could be used to provide a flexible array of services focused on helping people move toward recovery and self-sufficiency.</p>	<p>Services could include mental health and substance abuse assistance, medical and pharmaceutical services, mental health services, education, case management and referral, with funding sources that might include TANF, Corrections re-entry funds, chemical dependency or mental health block grants, housing funds, economic development funds, education funds, and others</p>	<p>State agencies, community agencies, Governor’s Office, and MTCoH</p>	<p>2007 and ongoing</p>
<p>Objective 8.2: Encourage and support the legislation needed to prevent and/or shorten homelessness</p>	<ul style="list-style-type: none"> • Create, monitor and adhere to a list of cross-sector priorities for ending homelessness • Actively support initiatives that further progress toward those priority goals and strategies • Resubmit EPP request in 2008 for funds to conduct a demonstration project around addressing the needs of a specific number of the chronically homeless 	<p>MTCoH, pertinent state and federal agencies, Governor’s office, local communities, legislators, and others</p>	<p>2007 and ongoing</p>

Chapter Two: Chronic Homelessness

Who are our chronically homeless neighbors?

We see the chronically homeless on the streets, in shelters, holding signs at intersections. They have packs or push carts, and who often wear multiple layers of clothing because they have nowhere to store it. These people struggle with multiple, interrelated problems with deep roots, including histories of childhood abuse and trauma, deep poverty, illness and lack of connection to the broader community. Together these factors create personal environments that include poor educational achievement, unstable work histories and lack of skills.

The chronically homeless share a host of characteristics that make them difficult to serve, particularly within context of traditional service systems. Chemical dependence, mental illness, physical and developmental disabilities are common. The behaviors that rise from these issues often lead to incarceration or institutionalization, multiple hospitalizations and emergency room use.

Rick had been laid off for a year and a half when he was interviewed. He speaks with conviction and great meaning. “It’s the tragedies that have happened in your life — some people can recover and some people have a very hard time. People who are homeless are very fragile. They have been beaten up by society, by their families...by anyone. You have psychological problems to begin with — perhaps they were on drugs and took the wrong road, or it could be anything. It’s a love and hate thing. Love is like glass and hate has a tendency to crack it. It’s like having an open wound because you are very open to everything that is going on and looking for a band-aid but can’t find one and you just have to cover your wound and get up while it’s infected by whatever is going on...²¹”

HUD Definition of Chronic Homelessness: A “chronically homeless” person is “an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least 4 episodes of homelessness in the past 3 years.”

Chronic Homelessness



Chronically homeless in Montana



The January 27, 2005³ *Survey of the Homeless* identified 245 chronically homeless persons in Montana's eight largest population centers, using the parameters of the Department of Housing and Urban Development (HUD) definition. This amounted to 12 percent of all the homeless persons identified that night. On January 31, 2006², 164 chronically homeless persons were identified, which accounted for 7 percent of all homeless persons counted that night.

This fluctuation is normal because the surveys reflect snapshots in time. Nationally, the chronically homeless represent about 10 percent of the homeless population.

Surveys of the Homeless ^{2,3}	2005	2006
Identified as chronically homeless	245	164
<i>With</i> a disability	242	153
Homeless more than 1 year	213	127
Homeless 3 or more times in last 3 years	165	95

Where are the chronically homeless?

2005–06 Survey of the Homeless Chronically Homeless Identified by District ^{2,3}		
	2005	2006
District 1–2–3	—	3
District 4: Havre	1	2
District 5: Great Falls	26	11
District 6: Lewistown	—	5
District 7: Billings	124	77
District 8: Helena	20	23
District 9: Bozeman	26	9
District 10: Kalispell	19	15
District 11: Missoula	18	22
District 12: Butte	—	5
Total	245	164



Human Resource Development Council Districts

Chronic Homelessness

Health The facts of daily life for chronically homeless persons include exposure to violence and the elements, poor nutrition, inadequate hygiene, increased contact with communicable diseases, and extreme fatigue. Cumulatively, these factors equate to ill health, which often prevents people from exiting homelessness. Relatively benign conditions that could be addressed through routine medical or dental treatment often escalate to acute or even life-threatening conditions among this population.

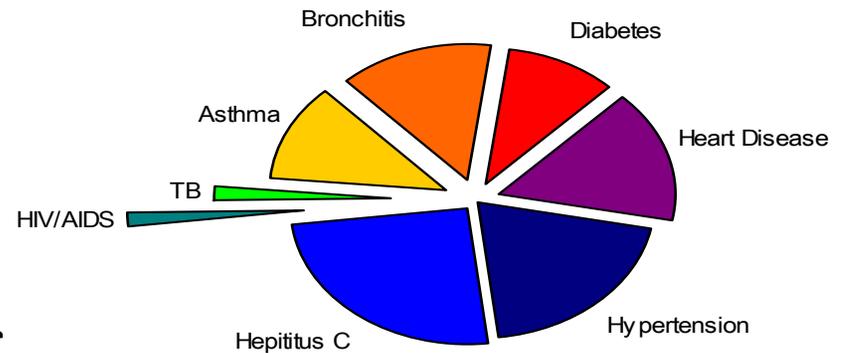
Health problems can be categorized in three intimately linked domains: physical illness, mental illness and substance abuse disorders. Common health issues among homeless adults include tuberculosis, AIDS, malnutrition, severe dental problems, upper respiratory tract infections, trauma, hypertension, skin and ear disorders, hepatitis and gastrointestinal diseases. Health problems that exist quietly at other income levels become critical among those who have no shelter, means for personal hygiene or access to nutritious, balanced diets.



Faces of our homeless neighbors: At the free medical clinic held by Yellowstone County Healthcare for the Homeless, a 53-year-old man came in for the 8th time in 3 weeks, troubled by an infected wrist. He suspected he'd been bitten by a spider. The physician assistant explained that the sore was caused by a dangerous staph infection that does not respond to regular antibiotics. His advice? Keep the wound clean and dry...easy enough for most, but a tough prescription to fill for a homeless, part-time dishwasher²².

“People who are homeless are *people* first. They also may have disorders including serious mental illnesses and substance use. The fact that they have illnesses that may significantly disrupt their lives doesn't diminish their rights, their responsibilities, or their dreams. People with serious mental illnesses and/or co-occurring substance use disorders become homeless because they are poor, and because mainstream health, mental health, housing, vocational, and social services programs are unable or unwilling to serve them. They also are subject to ongoing discrimination, stigma, and even violence.²³” (From *A Blueprint for Change*)

Diseases of the chronically homeless in Montana



The 164 chronically homeless respondents to the 2006 Survey² revealed 120 incidences of disease. The most common were:

- Hepatitis C (30);
- Hypertension (24);
- Heart disease (19); and
- Bronchitis (17).

Diseases: 2006²

Hepatitis C	18%
Hypertension	15%
Heart disease	12%
Bronchitis	10%
Asthma	9%
Diabetes	7%
TB	1%
HIV/AIDS	1%

Disability and Causes of Homelessness

According to a *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders*²³, substance use is both a precipitating factor and a consequence of being homeless. Substance use and abuse frequently lead to loss of housing, then make it difficult to reestablish safe, sober housing. People with substance use disorders who are homeless face enormous competition for limited treatment slots. Those who do receive treatment are more likely to get care for a co-occurring mental illness.



Jim

...meth took over after the very first time. A lot of people think if they don't get caught, they're getting away with it. What they don't know is that this drug steals from them every time they use it. I

lost a 14-year marriage along with all my principles and morals, but I didn't realize they were going because I was too busy doing the drug to notice. Meth took away my family, my health, my self respect. Meth got everything I had²⁴.

Of the 245 chronically homeless persons identified in January 2005³, 141 (58%) reported alcohol and/or drug abuse as one of the causes of their homelessness, as did 70 of the 164 identified in 2006² (43%).

Chronic Homelessness

Chronically Homeless: Disabilities and Causes

Disabilities: 2006²

Mental illness	44%
Drug or alcohol abuse	46%
Physical disabilities	44%
Developmental disabilities	4%
HIV/AIDS	3%
Other	4%

Note: percentages of disabilities are based on the 153 who stated they were disabled.



Causes of homelessness: 2006²

Drug or alcohol abuse	48%
Mental health	35%
Lifestyle choice	36%
Physical disabilities	30%
Lost job/no skills	20%
Evicted	18%
Released from corrections	9%
Domestic violence	7%
HIV/AIDS	1%
Other	9%

Mental illness

and chronic homelessness

Most of the homeless persons identified as chronically homeless stated that they are also disabled. In 2006², 153/164 (93.3%) and in 2005, 242/245 (98.8%) told surveyors that they were disabled in some way, many with mental illness.

- In 2006, 68/164 chronically homeless persons — approximately 41.5 percent — stated that they had been diagnosed with a mental illness².
- In 2005, 109/245 chronically homeless persons — approximately 44.5 percent — stated that they had a mental illness³.
- In 2006, 58/164 (35.4%) and in 2005, 93/245 (38.0%) stated that mental illness was one of the causes of their homelessness².

Among the most difficult challenges of caring for severely mentally ill homeless persons are the cognitive difficulties intrinsic to their illnesses. Persons with serious mental illness may not understand that they are ill and need care. Severe and persistent mental illnesses (including schizophrenia, bipolar disorder, major depression and dementia) impair judgment, conceptual understanding and the capacity to behave appropriately. People with these disorders frequently misinterpret what others say and may react with irrational fear or anger²⁶.

Lifestyle choice as a cause for homelessness may be a contradiction in terms when coupled with mental illness, addiction and/or developmental disabilities.

What Works?

Permanent Supportive Housing

Research documents the benefits of permanent supportive housing for those who are mentally ill and chronically homeless.

- **Positive impacts on health.** Decreases of more than 50 percent in tenants' emergency room visits and hospital inpatient days; decreases in use of emergency detoxification services by more than 80 percent; and increases in the use of preventive health care services.
- **Positive impacts on employment.** Increases of 50 percent in earned income and 40 percent in the rate of participant employment when employment services are provided with supportive housing, resulting in significant reductions in dependence on entitlements. This amounts to approximately \$1,448 in decreased costs per tenant each year.
- **Positive impacts on treating mental illness.** At least a third of people living on the streets and in shelters have severe and persistent mental illness. Supportive housing is an effective approach that can offer independence with supports as needed.
- **Positive impacts on reducing or ending substance use.** Once people with histories of substance use achieve sobriety, their living situation is often a factor in their ability to stay clean and sober. A one-year follow-up study of 201 graduates of Eden Program chemical dependency treatment in Minneapolis found that 56.6 percent of those living independently remained sober; 56.5 percent of those living in a halfway house remained sober; 57.1 percent of those living in an unsupported SRO remained sober; while **90 percent of those living in supportive housing remained sober**²⁵.

Co-occurring Disorders



Co-occurring substance abuse and mental illness are considered the *expectation* rather than the *exception*. Nationally, at least half of severely mentally ill homeless people are estimated to have co-occurring mental health and substance abuse disorders. Substance abuse exacerbates cognitive impairment and makes addiction treatment more difficult. It wreaks havoc with personal finances

and increases health risks, exposure to violence, social isolation and all of the hardships associated with extreme poverty.

Permanently rehousing homeless mentally ill persons is not a simple matter. Treatment of serious mental illness is difficult or impossible without some measure of residential stability, making residential stability an important element of any effective therapeutic strategy for the homeless mentally ill.

Patients with severe mental illnesses who are housed:

- have fewer complications;
- are less likely to have co-occurring disorders that exacerbate the illness; and
- adhere more easily to treatment²⁶.

Why Are People Homeless?

Homelessness rises at the intersection between personal hardship and systemic breakdown.

Personal hardship

- Generational poverty;
- Lack of family and social networks;
- Lack of education and job skills;
- Domestic violence or divorce;
- Serious illness;
- Mental illness and/or addiction.

Systemic breakdown

- Lack of affordable housing;
- Cutbacks in health, mental health and alcohol and drug treatment services;
- Lack of other key services, including affordable child care, transportation, education and job training; and
- Lack of living wage employment opportunities²⁷.

What works?

- A study of nearly 900 homeless people with mental illness provided with supportive housing found 83.5 percent of participants remained housed a year later, and that participants experienced a decrease in symptoms of schizophrenia and depression²⁸.
- In another study, almost 5,000 homeless individuals with mental illness were placed in supportive housing. Nearly 80 percent remained housed a year later, and 10 percent were able to move on to live in independent settings²⁹.

Personal Characteristics

While chronic homelessness may partially be identifiable by duration, chronically homeless persons share other characteristics.

Disability: The presence of a disabling condition is almost universal. Serious mental and physical health conditions are common. Disability becomes highly relevant when considering that documented disability can serve as an eligibility portal for many assistance programs, including Supplemental Security Income (SSI) and Social Security Disability Income (SSDI).

Heavy Use of Services: Persons experiencing chronic homelessness are heavy users of the homeless assistance system and of other services. Although they constitute 10 percent of overall homeless population, but national data indicates that they consume about 60 percent of the shelter days provided by the emergency shelter system. Emergency room usage, uncompensated care, and involvement with the criminal justice system all contribute to the significant cost of *not* ending homelessness.

Engagement with Treatments: *Chronically homeless* persons are often isolated, with few ties to the community and support systems. Many are reluctant to interact with systems they do not understand and that do not understand them.

Multiple Problems: Chronically homeless individuals typically present a complex set of challenges to service providers. In addition to the issues noted above, extreme poverty, poor job skills, lack of education, and negative childhood experiences are common among the chronically homeless³⁰.



Jon was a 46-year-old man with a history of alcoholism. He'd been a Health Care for the Homeless client (HCH) at the Yellowstone City-County Health Department for seven years.

In the winter of 1999, Jon fell on the street and injured his shin. At the time, he was sleeping on the floor of the local mission. Two weeks later, Jon came into the clinic complaining of a sore on his leg and lifted his jeans. His open wound had become gangrenous, and was draining from just below his knee to his ankle. After much urging, he went to a local hospital, where he was diagnosed with an infection of the bone and muscles of his shin. He remained at the hospital for four months, undergoing multiple surgeries that included bone, muscle, and skin grafts.

As part of his discharge plan, Jon agreed to meet an HCH nurse every day for a dressing change. Even though he'd been expelled from the shelter because of his alcohol use, Jon managed to find the nurse two or three times a week. Eventually, he was taught to change his own dressing and was given a 2-day supply that he carried in his jacket.

Over the next year, Jon's wound healed. In 2003, he was granted a back settlement of Social Security disability assistance, which he used to purchase a small mobile home. Stable housing and regular care have meant that Jon has not had to return to the hospital³¹.

Justice system involvement

- 14 chronically homeless respondents to Montana’s 2005 Survey of the Homeless³ revealed that they had been in jail or prison prior to becoming homeless.

Homeless people, especially those with mental illnesses and/or co-occurring substance use disorders, come into frequent contact with the criminal justice system both as offenders and as victims. Often, homeless people are arrested for relatively minor offenses, including trespassing, petty theft, shoplifting and prostitution. People with substance use disorders who are homeless are more likely than persons who have not experienced homelessness to have arrest histories, to have been arrested in the past year, and to report felony convictions³².

According to a study by the federal Bureau of Justice Statistics, 12 percent of state prisoners were homeless at the time of their arrest. The Interagency Council on the Homeless has reported that 18 percent of all homeless people have spent time in a state or federal prison. Moreover, among parolees who have been reincarcerated, 19 percent were homeless at the time of arrest³³.

Barriers to housing subsequent to involvement in the criminal justice system are significant. Federally subsidized housing providers may — and sometimes must — deny housing to people with criminal histories involving drugs or violence. Ex-offenders may not have the financial resources to rent and those who are homeless can be difficult to contact, making employment difficult. These factors make it difficult for ex-offenders to find permanent housing and to establish stable lives. They also contribute to recidivism.

Where did you sleep last night?

The majority of our chronically homeless neighbors slept outdoors, in a car or other place not suited for human habitation, despite the brutality of January weather in Montana.

	Where did you sleep last night? ^{2,3}	
Survey of the Homeless	1/27/2005	1/31/2006
Outside, in a car, etc.	185	112
Emergency shelter	54	40
Motel with voucher	6	12
Total chronically homeless	245	164

How long have you been homeless?

The majority of chronically homeless persons — 86.9 percent in 2005³ and 77.4 percent in 2006² — had been homeless for at least a year.

How many times have you been homeless?

The majority — 63.7 percent in 2005³ and 56 percent in 2006² — of chronically homeless persons reported that they had been homeless four or more times.

How long have you been in the area?

Those who are chronically homeless in Montana are not strangers. Only 6.7 percent in 2006² and 7.8 percent in 2005³ had been in the area for a month or less. The majority (66.5 percent in 2005³ and 68.3 percent in 2006²) had been in the area for at least 2 years. Approximately 18 percent had been in the area all their lives.

82.3% of the chronically homeless persons identified in 2006 and **80.8%** of those identified in 2005 had a high school education or less.^{2,3}

Homeless Vets

National Department of Veterans' Affairs (VA) data estimates that nearly 25 percent of homeless adults are veterans³⁴, as compared to 15.6 percent of all 2006 respondents and 16.1 percent of all 2005 respondents to the Montana Survey of the Homeless^{2,3}.

The percentages of chronically homeless veterans was more consistent with national norms. In 2005, 27.3 percent of the chronically homeless were veterans; in 2006, the number dropped to 25.6 percent. Among 1,572 veteran respondents in 2006, 41 reported income from veterans' disability or pension programs.

In Montana, FY 2004, the VA:

- Spent nearly \$291.5 million to serve 102,605 veterans;
- Provided health care to 27,185 people in VA facilities;
- Paid out \$147.6 million in pensions and compensation;
- Spent approximately \$12 million in education and rehabilitation³⁴.

Among homeless veterans, 1/3 to nearly 1/2 have co-occurring mental illnesses and substance use disorders³⁵.

Chronic Homelessness

2005 and 2006 Montana Survey of the Homeless ^{2,3}	All Veteran Respondents		Chronically Homeless Veteran Respondents	
	2005	2006	2005	2006
Total Veterans	247	245	67	42
Service Era				
2nd Gulf War	2	10	2	-
1st Gulf War Era	23	22	3	3
Vietnam Era	95	98	28	17
Vietnam In-country	13	12	5	6
Korea	6	14	3	6
WWII	2	2	-	-
Receiving VA Disability	37	33	6	6
Receiving VA Pension	15	8	23	2

The 57th Legislature requested a study of veterans' issues. The State Administration and Veterans' Affairs Interim Committee conducted hearings, received expert testimony and examined

research over 14 months. Using 2000 data, the Interim Committee found that Montana's population of nearly 107,000 veterans and 170,000 family members ranks Montana second in the nation in the number of veterans per capita (11.9%). Veterans and their families constitute more than 25 percent of Montana's population. Census data revealed that more than 80,000 were combat-era veterans and more than 36,000 were Vietnam-era veterans. The largest group

was aged 50 to 65³⁵.

The U.S. Department of Veterans Affairs estimates that more than half of combat theater veterans suffer from serious and disabling post-traumatic stress disorder, and that twice as many veterans as non-veterans experience homelessness. Many have complex needs requiring medical and nursing home care, treatment, housing, education and training, job and family support. The children and families of veterans who do not get help are also at risk³⁶.



The Department of Veterans' Affairs

The U.S. Department of Veterans Affairs (VA) says that about 97 percent of homeless veterans are males. The majority are single, most come from poor, disadvantaged communities, 45 percent suffer from mental illness, and with a great deal of overlap, over 70 percent have substance abuse problems. Currently, the number of homeless male and female Vietnam era veterans is greater than the number of service persons who died during that war. The VA estimates that on any given day, 200,000 veterans are homeless and that about twice as many experience homelessness during the year³⁷.

The VA is the only federal agency that offers substantial hands-on assistance to the homeless. It has the largest network of homeless assistance programs in the country, offering outreach, clinical assessment, medical treatment, long-term shelters and job training.

Homeless veterans in Montana receive outreach services including primary health care, mental health and substance abuse counseling and case management services at the Fort Harrison medical center outside Helena. Primary care is available to homeless veterans in community outpatient clinics with referrals to the medical center for specialized care. Partnerships with shelters, community-based outpatient clinics and others have been established. Homeless veteran program coordinators from the medical center and the VA Regional Office routinely visit homeless shelters. From this referral network, homeless veteran program coordinators act as access points for homeless veterans seeking services³⁸.

What works? The most effective programs for homeless and at-risk veterans are community-based, nonprofit, "veterans helping veterans" groups. The best programs feature transitional housing in structured, substance-free environments with fellow veterans who are succeeding at bettering themselves⁴².

Claims Backlog

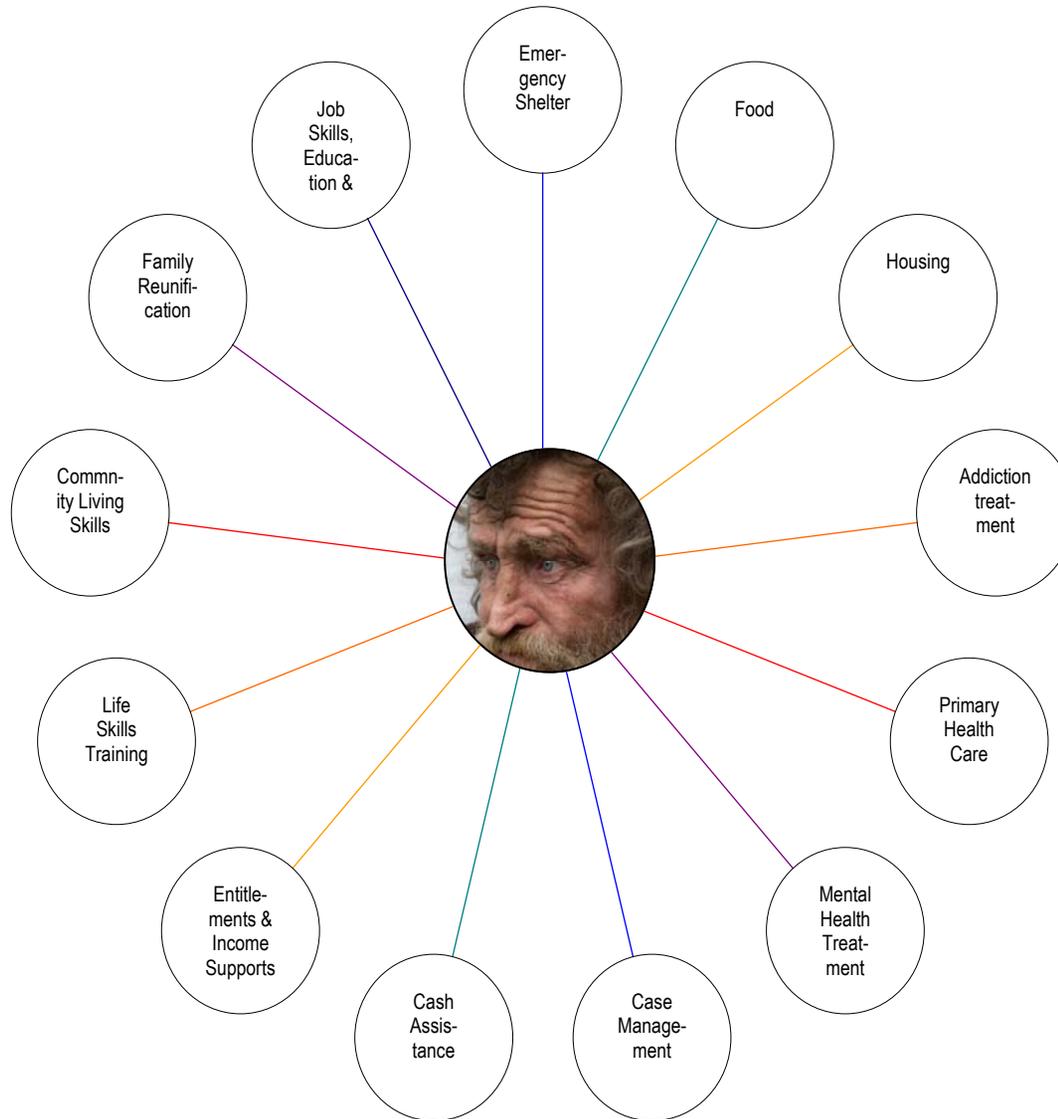
In 2005, more than 500,000 veterans had claims pending with the Department of Veterans Affairs for veterans' benefits, and approximately 100,000 of these claims are over one year old and still without resolution³⁹.

Nationally, the VA has set a goal of reducing its backlog from a high of 432,000 claims to fewer than 250,000, but the department's most recent projections have it rising to nearly 400,000 by the end of 2007. The average time to process claims, is projected to increase in 2006 and 2007 to more than 180 days⁴⁰.

Between 40 and 50 percent of cases are sent back to a regional office for further work, often because documentation is incomplete or errors were made in deciding the case. In 2005, the average response time for a board decision to an appeal was 622 days⁴⁰.

Navigating a complex system and lengthy waits are extremely problematic for homeless veterans struggling with multiple issues.

Chronic Homelessness



The needs of a chronically homeless person cross many system boundaries.

What's **Wrong** with this Picture?

Chronically homeless people, especially those with serious mental illnesses and/or co-occurring substance use disorders, typically require client-centered, wrap-around services, with assistance that ranges from treatment to housing, from health and dental care, to legal assistance. Each service is provided by a separate agency, with its own distinct mission, vision, requirements...and funding streams.

What's *wrong* is that the burden of coordination falls on the individual, and yet people with serious mental illnesses or co-occurring disorders — especially those who are homeless — rarely have the skills or capacity to self-advocate for a package of services gleaned from a confusing, complex and often fragmented service system.

Ending Chronic Homelessness: *Strategies that Work*

Chronically homeless persons struggle with levels of disability and poverty that are likely to make them eligible for a number of mainstream programs, and yet homelessness presents many challenges to providers. To be effective, services must be accessible, coordinated and flexible. This might mean using non-office based settings or operating during non-standard hours. Effective strategies include accommodating changing needs over time and keeping case files open during periods of inactivity so that eligibility does not have to be re-established. Other effective strategies include operating under a “no wrong door” philosophy. Strategies such as co-location of services in one stop settings can help reduce fragmentation and increase access.

The SOAR Initiative: One hopeful initiative is SOAR: SSI/SSDI Outreach, Access and Recovery, a technical assistance and training initiative that increases access to SSA disability benefits for homeless persons with disabilities, particularly mental illness.

- Nationally only 11 percent of the homeless population is estimated to receive SSI/SSDI benefits. In Montana, the 2006 Survey of the Homeless² revealed that 13.8 percent were receiving them.
- Nationally, 37 percent of SSA disability applications are approved upon initial submission. Approvals increase to 53 percent after appeals, a process that can take years.
- Through the SOAR Initiative, initial approval rates can jump as high as 90 percent.

Montana was in the first group of states to participate in the SOAR Train-the-Trainer activity. In Montana, PATH (Project for Alternatives in Transition from Homelessness), Disability Determination Services, and the Montana Council on Homelessness now come together in a unique collaboration to provide the training. For more information, visit: www.pathprogram.samhsa.gov/SOAR.

Montana participated in the fourth national Policy Academy focusing on chronic homelessness, which convened in May 2003 in Chicago, Illinois. The 2003 Policy Academy Team included:

- Bob Andersen, Governor’s Office
- Dan Anderson, Addictive and Mental Disorders Division
- Joe Bischof, Executive Director, Povarello Center
- Bob Buzzas, Montana Continuum of Care
- Leslie Colbrese, HRDC Directors Association
- Leslie Edgcomb, HOME Program
- Joe Foster, Montana Veterans Affairs Division
- Gail Gray, Department of Public Health and Human Services
- Michael O’Neill, Home Choice Coalition and AWARE
- Eric Sells, PATH Outreach
- Emily Stonington, Montana State Senate

The vision of the original Policy Academy Team was: *to provide the state-level leadership and coordinated effort that will end chronic homelessness.*

This vision has been implemented at a variety of levels, starting with the formation of the Montana Council on Homelessness by Executive Order in June 2004, a strategy included in the overarching chapter at the beginning of this document. The Montana plan to address chronic homelessness is based on discussions begun during the Policy Academies, and refined by the Montana Council on Homelessness and its workgroups. The following plan on ending chronic homelessness is a crucial part of Montana’s 10-year plan to end homelessness.

Stepping Stones

Goal: End Chronic Homelessness by 2014



Chronic Homelessness

Goal CH-I: Enhance access to mainstream services for the chronically homeless *DRAFT*

Objectives	Strategies	Critical Partners	Target and/or Outcomes
<p>Objective CH-1.1: Increase access to mainstream resources for chronically homeless persons by providing on-going and specific training for case managers</p>	<p>Apply for participation in the federal SSI/SSDI Outreach, Access and Recovery initiative.</p>	<p>MTCoH; PATH Program/Addictive and Mental Disorders Division; SOAR; Policy Research Associates</p>	<ul style="list-style-type: none"> • Application submitted: 5/27/2005 • Approved: 7/2005 • Participate in initial organizational calls and activities: 8/2005
	<p>Create a broad-based training team to participate in SSI/SOAR Train-the-Trainer Activities.</p>	<p>Sherrie Downing, MTCoH Marcia Armstrong, PATH Program/Addictive and Mental Disorders Division Michelle Thibodeaux, Disability Determination Services Bureau</p>	<ul style="list-style-type: none"> • Participated in training 12/6–12/8, 2005: Alexandria, VA
	<ul style="list-style-type: none"> • Conduct 2-day state- and Billings-level planning session around enhancing access to SSI resources among chronically homeless persons. • Create state-level and Billings plans to promote access to the SOAR training, 	<p>MTCoH, PATH, DDS, SSA, SOAR initiative staff, Healthcare for the Homeless, Montana State Hospital, Billings Housing Authority, mental health center, HRDCs, etc.</p>	<ul style="list-style-type: none"> • Sessions held that included about 20 key stakeholders 12/2–12/3/2005 • City-and state-level plans created, implemented and completed by 3/2006
	<ul style="list-style-type: none"> • Provide training for at least 250 case managers annually, who will learn to create SSI applications that can be approved at the earliest point. • Hold trainings in various locations for a maximum of 30 case managers/session. 	<p>MTCoH, PATH, DDS</p>	<ul style="list-style-type: none"> • Trainings held in February, March, April, May, June and scheduled for September and October 2006 • More trainings scheduled in response to demand

Objectives	Strategies	Critical Partners	Target and/or Outcomes
Objective CH-I.2: Create mechanisms with SSA and DDS offices to provide expedited service for SOAR applications	<ul style="list-style-type: none"> Establish partnerships with DDS and local SSA offices Created protocols for submission of SOAR applications for chronically homeless, mentally ill Teach strategies to case managers who participate in SOAR Include SSA personnel in SOAR trainings 	SOAR, MTCoH, DDS, SSA	2/2006 and ongoing Projected Outcomes: 85 percent of SOAR applications will be approved and clients will not be subject to consultative exams or appeals processes.
Objective CH-I.3: Enhance linkages to other mainstream services, including housing, through case management relationships established during the SOAR application process	<ul style="list-style-type: none"> Encourage case managers to help C.H. mentally ill clients access additional benefits, particularly housing through use of SSI benefits and by accessing Section 8 waiting lists 	SOAR training participants, including PATH, HRDC, HCH, Housing Authority and other direct service providers	2/2006 and ongoing Projected Outcomes: All approved SOAR clients will achieve stable housing and access to mainstream benefits
Objective CH-I.4: Work with Montana Food Bank Network to create application for resources to teach case managers techniques for completing food stamp applications	<ul style="list-style-type: none"> Apply for new resources to provide training for case managers to help them complete food stamp applications for their C.H. clients Link case managers & agencies trained in SOAR to the food stamp training 	Montana Food Bank Network, MTCoH	Application submitted: 4/2006 Awarded 8/2006

Goal CH-2: Enhance access to permanent, affordable housing for the chronically homeless *DRAFT*

Objective CH-2.1: Create new public housing beds for chronically homeless persons	<p>A. Convene sessions around creating housing for C.H. persons in Billings</p> <p>B. Encourage and support applications for new S+C vouchers, starting with the Department of Commerce in 2005, and the Billings Housing Authority in 2006</p> <p>C. Watch for and apply or provide technical assistance for applicants for grants designed to help provide housing for CH persons, e.g., HUD's Housing for People who are Homeless & Addicted to Alcohol</p> <p>D. Watch & apply for additional Housing Opportunities for People With Aids (HOPWA) funds</p>	<p>A. Billings Housing Authority, Continuum of Care, MTCoH, Department of Commerce, PATH</p> <p>B. Varies by year</p> <p>C. MTCoH and others to be determined</p> <p>D. Intergovernmental Human Services Bureau of DPHHS</p>	<p>DOC application submitted 2005, awarded 2006</p> <p>IHSB applied 2005; awarded '06</p>
--	--	--	---



Stepping Stones

Goal: End Chronic Homelessness by 2014

Chronic Homelessness

Objectives	Strategies	Critical Partners	Target or Completion Date
<p>Objective CH-2.2: Create new housing vouchers coupled with intensive case management for CH persons</p> <ul style="list-style-type: none"> – Establish partnerships to allow a population with corrections and/or addictions backgrounds to access housing through the new voucher program 	<ul style="list-style-type: none"> • Write and submit an Executive Planning Process (EPP) Budget Request for State General Funds to provide a limited number of housing vouchers coupled with intensive case management services for CH individuals • Once in place, ensure that all participants access all available and appropriate benefits and programs with an eye to transitioning out • Track outcomes for those served, i.e., housing stability, benefits, employment • Create a cost/benefit ratio that defines cost savings 	<p>MTCoH, DPHHS, Department of Commerce, Governor Schweitzer</p>	<p>Projected Outcome: At least 40 chronically homeless persons over the biennium will be housed and served with wraparound services as the first steps toward recovery</p> <ul style="list-style-type: none"> • Demonstrate success and savings • At least 80% of the CH persons who receive permanent housing will remain housed at the end of 12 months • Legislative Session: 2009
<p>Objective CH-2.3: Formulate housing plan that serves a continuum of housing needs, from permanent affordable rentals for persons with incomes of 0–30% of the Area Median Income (AMI) through first time homebuyers</p> <ul style="list-style-type: none"> – Once approved, participate in the rules process to ensure that there are incentives for developing housing for the lowest ranges of the income continuum 	<ul style="list-style-type: none"> • Participate in the evolution of Montana's Affordable Housing Trust Fund to the <i>Homes for Montana Fund</i>, which will accommodate a wide range of housing • Articulate populations to be served, particularly those living at 0-30% of AMI • Identify and develop sustainable funding stream(s) • Assist with drafting an Executive Planning Process (EPP) request for General Funds for housing, to be added to the base budget • Participate in drafting legislation and finding champion(s) 	<p>Montana Association of Counties; homeWORD; Montana Homeownership Network; Montana Association of Realtors; Montana Building Industry Association; Salish Kootenai Housing Authority; Rocky Mountain Development Council; Montana Homechoice Coalition; Montana Council on Homelessness (MTCoH)</p>	<p>Legislative Session, 2007</p> <p>Projected Outcome: 500 units of housing created annually for the next 10 years (for populations across the continuum of housing needs and including those at 0-30 percent of the Area Median Income)</p>

Objectives	Strategies	Critical Partners	Target or Completion Date
<p>Objective CH-2.4: Provide opportunities for collaboration around affordable housing</p>	<ul style="list-style-type: none"> A. Collaborate with PATH to access federal technical assistance through Policy Research Associates designed to begin looking at city-level solutions for CH mentally ill persons B. Invite four cities and the state to participate in a 2-day forum in Missoula C. Provide TA from Ann Denton, Director of the Enterprise Foundation of Texas and Margaret Lassiter or Policy Research Associates D. Bring TA providers back to look at progress in Helena, Great Falls, Billings and the state level and map out next steps 	<p>PATH, MTCoh, Board of Housing, city and state housing stakeholders from Missoula, Great Falls, Helena and Bozeman</p>	<p>A and B: April 2005 Accomplishments: started the conversation between PATH and housing providers; created resource maps; named next steps</p> <p>C. April 2006 Accomplishments: beginning discussion of a second chance home in Billings; connection between Housing Authority & mental health center in Great Falls; TA on housing trust fund at the state level</p> <p>Projected outcomes: Additional housing for CH in Billings and Great Falls by 2009</p>

Goal CH-3: Improve access to services and supportive transitional housing for homeless vets

DRAFT

<p>Objective CH-3.1: Identify and support applicants willing to seek VA Per Diem grants for creating structures and ongoing services support</p>	<p>Conduct outreach to veterans and housing groups to ensure knowledge of and promote interest in Veterans Per Diem Grants</p> <p>Help facilitate providing at least 30 homeless veterans annually with transitional housing and services, with the intent of helping them move into mainstream housing, services and employment.</p>	<p>Veterans Administration; housing providers; veterans groups; MTCoh</p>	<p>2004: Missoula Housing Poverello Center awarded per diem grant to create Valor House. Opened August 2005, with room for 17 veterans</p> <p>2005: Montana Veterans Foundation awarded grant and per diem funding for 12-person transitional facility</p> <p>2006: Billings Rimrock Foundation considering submission</p> <p>2007 and ongoing: Continue to identify need and assist applicants as possible</p>
---	---	---	---



Stepping Stones

Goal: End Chronic Homelessness by 2014

Goal CH-4: Prevent high-risk individuals from becoming chronically homeless *DRAFT*

Chronic Homelessness

Objectives	Strategies	Critical Partners	Target or Completion Date
<p>Objective CH-4.1: Work with Montana State Hospital and the Department of Corrections to assist with strategies to help re-entry populations access supportive and mainstream services prior to discharge, and ensure that benefits are ready to kick in as soon as possible after release</p>	<p>Do eligibility determinations/applications for re-entry populations with disabilities including severe and persistent mental illness:</p> <ul style="list-style-type: none"> • SSI/SSDI • Medicaid • Food stamps • Job training or education <p>Provide training for case managers on completing applications for such programs as SSI and food stamps</p> <p>Projected outcomes: At least 50% of severely mentally ill or disabled ex-offenders and MSH patients will have applied for SSI benefits so that they have potential financial and medical supports as soon as possible after release to communities</p>	<p>MTCoH; Lead agency; case managers and direct service providers; DPHHS; Department of Corrections; SSA; Disability Determination Services</p>	<ul style="list-style-type: none"> • 2/2006: Provide SOAR training to MSH transition team • 2/2006: Include MSH on State-level SOAR planning team • 4/26 – 4/27/2006: provide first SOAR training for probation, parole and prerelease workers in collaboration with DOC • 4/2006: MTCoH Chair spoke to DOC Community Corrections committee • 5/2006: provide SOAR overview to psychologists at MSH to facilitate better SSI applications • 2006 and ongoing: continue to build relationships and strategies to prevent reentry populations from becoming chronically homeless • 2006: Form Re-entry and Chronic Homelessness Workgroups in MTCoH workgroup restructuring. Ensure collaboration between the two.

Goal CH-5: Track Results *DRAFT*

Objectives	Strategies	Critical Partners	Target or Completion Date
Objective CH-5.1: Encourage use of one agreed-upon data source (e.g., HMIS)	<ul style="list-style-type: none"> • Closely track all participants through SOAR • Collect and practice frequent reviews of data and change course of project as needed • Use historical and progressive data collected from demonstration project targeting a limited number of chronically homeless individuals to create a cost/benefit analysis 	Participating agencies; DPHHS; Department of Corrections	2006 and ongoing

Goal CH-6: Create political will *DRAFT*

Objective CH-6.1: Improve awareness of chronic homelessness as a growing issue for Montana, as well as one that can be addressed	<ul style="list-style-type: none"> • Create a Call to Action through enhanced awareness of chronic homelessness • Participate in disseminating information highlighting the issue using a range of venues • Participate in enhancing awareness through involvement of local communities in community-based initiatives to end homelessness • Participate in and help publicize local stand-downs organized at the community level 	MTCoH; local media; Billings Council on Homelessness; veterans groups; homeless missions; Montana leadership, including Governor, Lt. Governor, policy advisors	Initiated in 2004; ongoing
Objective CH-6.2: Analyze areas where chronic homelessness is most prevalent and focus resources around working with the community toward finding community solutions	<ul style="list-style-type: none"> • Analyze and disseminate information about the number of CH individuals in the community, starting with the City of Billings 	MTCoH, Continuum of Care	2006 and ongoing

For more information, contact:

- Hank Hudson, Co-chair, MTCoH: 406.444.5901 or HHudson@mt.gov
- Sherrie Downing, Coordinator, MTCoH: 406.443.0580 or Sherrie@MTCoH.org
- Jim Nolan, Sponsor, MTCoH: 406.447.4260 or JNolan@mt.gov
- Or visit: www.MTCoH.org

Chapter Three: Homeless Families

Who are Montana's homeless families?

Homeless Families

Women are disproportionately represented among Montana's homeless families. They are typically young, very poor and undereducated. Many are single parents.

- In 2006, 255 survey respondents were members of homeless families with children — 78 percent were female.
- 77 percent of all 834 identified members of homeless families were female.
- 92 percent of the single parent respondents were female.
 - 37 percent of single parents respondents had not completed high school; 74 percent had a high school education or less.
 - 12 single-parent families with children spent the night of January 31 in a car, abandoned building or other place not fit for human habitation. The families included 18 children under age 13; 3 women were pregnant.
- Native Americans were disproportionately represented at 27 percent of homeless family members, compared to about 6.2 percent of the population as defined by the Census.
- The most common reasons for homelessness among families with children were domestic abuse and poverty.

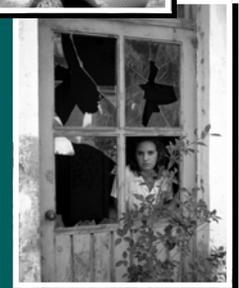
Tina

lives one small emergency away from homelessness. Her baby is a month old and when he starts to fuss, she pours a scanty inch of formula into a bottle, shaking her head. "This baby thinks he's starving all the time."

The trailer is nearly bare – there's not even a table in the kitchen. The floor is plywood because Tina pulled up the linoleum, trying to get rid of the smell of urine that still permeates the place. The windows are covered with plastic. It helps a little, but there's so little insulation that it's a struggle to stay warm.

The trailer is 35 minutes from the school where Tina is a full-time student. She has a job waiting for her when she finishes, but for now, her car barely runs and she lives in daily fear of a breakdown.

Source: *The Many Faces of Poverty*. Rocky Mountain Development Council, Helena, Montana. 2001.



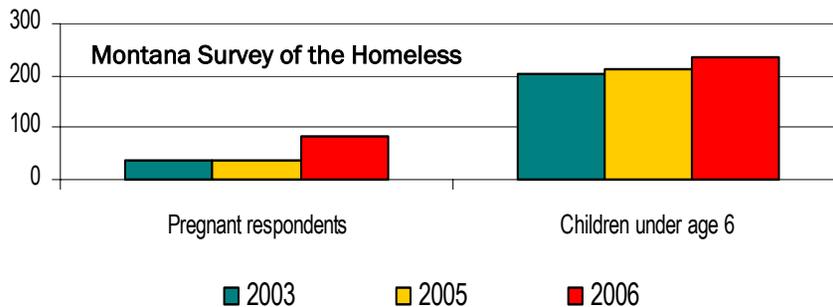
Homelessness: The state or condition of being without permanent housing, including living on the streets, staying in a shelter, mission, abandoned buildings, or vehicles or other unstable or non-permanent situation. An individual or family may also be considered to be homeless if that person is doubled- or tripled-up. (Definition consistent with McKinney Vento and Health Care for the Homeless definitions)

Homeless Families with Children: During Montana’s 2006 *Survey of the Homeless*, surveyors identified 255 homeless families with children. These families included at least 460 children between the ages of 0 and 17 — 236 under age 6; 84 respondents were pregnant. The most dramatic change was in the number of identified children between the ages of one and five, which jumped 40.7 percent from 2005 to 2006.

The surveys offer a valuable snapshot in time, and annual variations are normal. The jump in young children and pregnant women, if sustained, are cause for concern.

Ages of Children Identified by Homeless Respondents		
MT Survey of the Homeless	2005	2006
Under age 1	67	32
1–5	145	204
6–13	162	151
14–17	72	73
18–20	15	32

Montana Survey of the Homeless	1/27/2005	1/31/2006
Homeless families with children	268	255
Children under age 6	212	231
Pregnant respondents	38	84



Where are the homeless families with children?



Human Resource Development Council Districts	2005	2006
District 1-2-3	9	3
District 4: Havre	6	5
District 5: Great Falls	23	20
District 6: Lewistown	5	3
District 7: Billings	80	36
District 8: Helena	23	32
District 9: Bozeman	3	10
District 10: Kalispell	46	43
District 11: Missoula	61	98
District 12: Butte	8	5
Unknown	4	
Total Families with Children	268	255

Homeless Families

Reasons for family homelessness

Income Inequality has grown. In the early 2000s, the income of the wealthiest 20 percent of families in Montana was 5.9 *times* that of the poorest 20 percent. Between the early 1980s and early 2000s, in dollar terms, the income of the poorest 20 percent increased an average of \$70 per year, compared to the average annual increase of \$990 for the richest fifth⁴⁶.

- 2000 Census data reveals that females working full-time, year-round in Montana earn 69 cents for every dollar their male counterparts earn.
- In 1999, full-time, female workers in Montana earned a median wage of \$20,914, as compared to the \$30,504 earned by males⁴.
- Nearly 60 percent of Montana women earn less than a living wage, or a wage that allows a family to meet basic needs without public assistance, and which provides for some ability to deal with emergencies and to plan ahead⁴⁷.
- 68.5 percent of Montana women earned \$20,000 or less at the time of the 2000 Census.

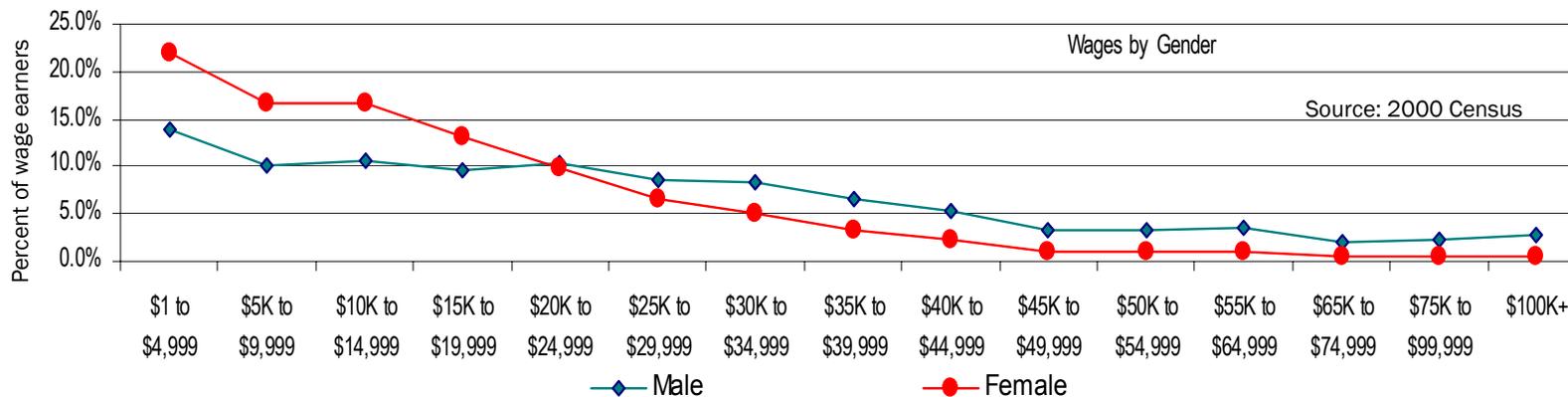
Women are disproportionately represented in low-wage jobs. The federal minimum wage of \$5.15/hour had not been raised since 1997⁴⁷ until Montana voters approved an increase to \$6.15/hour in November 2006.

Area Median Income versus Poverty

The Department of Housing and Urban Development (HUD) calculates Area Median Income (AMI) for each county and three Metropolitan Statistical Areas (MSAs) in Montana on an annual basis. Area Median Incomes for a family of four range from a low of \$33,600 in Roosevelt County to a high of \$58,000 in Jefferson County (2006). The average AMI for 2006 was \$44,031 for a family of four, more than twice the Health and Human Services (HHS) poverty rate. HUD bases eligibility for its housing programs on a percentage of the Area Median. Among the 7,707 families waiting for Section 8 Vouchers, 88 percent were living on incomes of 0 — 30 percent of AMI⁵¹.

According to the National Low Income Housing Council, in 2005, a full-time, minimum-wage worker had to work 85 hours per week, 52 weeks a year to afford a 2-bedroom unit at a Fair Market Rent of \$571/month. A full-time minimum wage earner (earning \$5.15 per hour) can afford monthly rent of no more than \$268/month⁵².

Housing Affordability: The generally accepted definition of affordability is that a household pays no more than 30 percent of its annual income on housing. Families who pay more are considered “cost burdened” and may have difficulty affording necessities such as food, clothing, transportation and medical care. According to US Census data (2000), 35.3 percent of all rental households in Montana were paying 30 percent or more for their housing in 1999.



More reasons for family homelessness

Respondents to the Survey of the Homeless were asked to state the reasons for their homelessness. They could choose all the reasons that applied from a list offered by the surveyor.

Domestic abuse was the most common cause of homelessness noted by the 255 respondents to the 2006 Survey² who represented homeless families with children. When the three poverty-related causes are considered together (lost job or no job skills, eviction and car problems), these are by far the most common causes for family homelessness.

This was also true in 2005. Among the 268 respondents living in homeless families with children in 2005³, the most frequent type of reason named was poverty-related: 78 had lost their job or had no job skills; 77 had been evicted; and 26 cited car problems as causal.

Are you homeless due to any of the following?		
2006 Survey of the Homeless: Respondents for Homeless Families with children	Number	Percent
Domestic Abuse	94	37%
Lost Job or No Job Skills	74	29%
Evicted	61	24%
Car Problems	17	7%
Drugs and/or Alcohol	48	19%
Physical Disability	13	5%
Mental Health	12	5%
Other	48	19%
Released from Corrections Facility	12	5%
Aged Out of Foster Care	1	0.4%
Lifestyle Choice	20	8%

39.6 percent of all respondents for homeless families with children were working either part- or full-time.

- Poverty** can't be equated with lack of effort.
- In 2006², nearly 40 percent of survey respondents who were members of homeless families with children were employed either part or full time.
 - Montana tied with Wyoming for the 3rd highest multiple jobholding rate in the nation, with an estimated 9% of those employed holding more than one job⁴⁸.
 - In each year from 1999 — 2004, Montana's average wage per job was the lowest in the nation⁴⁹.
 - 58.5% of Montana's female householders who had children under age 5 lived in poverty at the time of the Census⁴.
 - 19.9% of all Montana children under 18 were living in families with incomes below the federal poverty levels, ranging from 11.9% in Stillwater County to 36.4% in Roosevelt County⁵⁰.
 - In 2003, 40,983 Montana children (age 0—17) lived in poverty⁵⁰.

HOMELESS FAMILIES: January 31, 2006²

Montana Survey of the Homeless	Respondents	Additional Family Members
Single parents with children	172	342
With spouse or partner and children	83	237
With spouse or partner, no children	100	73
Other	29	53
Pregnant	84	182



“My daughter and I live just one major expense from disaster... I cannot get ahead, I can't save for emergencies, or birthdays, or even a little vacation. All I can do is just pray that we stay healthy and manage to keep our heads above water.” — a single, working mother with an 18-month old daughter; Billings, Montana⁵⁴

Unused Benefits

Relatively few of the families surveyed were participating in the programs that that might help stabilize their lives.

In 2005³, only 86/268 homeless parents with children were receiving TANF benefits and just 8/244 identified children were receiving SCHIP (State Children's Health Insurance Program) benefits.

In 2006², 69/255 homeless respondents with children were participating in TANF and just 8 families/255 families with children were participating in SCHIP.

In one study, among *housed* low-income families, 55 percent spend more than 30 percent of their income on housing and 49 percent have doubled-up with family or friends in the past two years⁵⁸.

Trauma and Homelessness

A landmark 6-year research project on family homelessness and poverty was conducted by the National Center on Family Homelessness in Worcester, Massachusetts. Researchers gathered a wide range of personal, health and demographic information from homeless and housed very low-income families with single female heads of household. Participants included 220 homeless female heads of household, 216 housed low-income female heads of household, and 627 children (aged 3 months to 17 years).

- 92% of homeless women had experienced severe physical and/or sexual assault at some point in their lives.
- Over 66% of homeless women who experienced abuse experienced severe physical violence by a caretaker and 43% had been sexually molested during childhood.
- 60% of homeless women had been abused by age 12.
- 63% of homeless women had been victims of intimate partner violence.
- Over 39% of homeless women who had been abused have experienced Post Traumatic Stress Disorder (PTSD), more than three times the level of the general female population; 47% had had a major depressive disorder, more than twice the rate of the general female population.
- 41% of homeless women victimized as children did not complete high school and 49% had a high school degree or GED⁴³.

Clinical research over the past century has confirmed that the psychological effects of physical violence and/or sexual abuse persist long after the traumatic event.

Posttraumatic stress disorder (PTSD) is the name given to the broad spectrum of psychological and somatic disorders characteristic of many trauma survivors. Complex PTSD describes the psychological effects of prolonged trauma, which may be particularly severe in individuals subjected to abuse as young children. The psychological symptoms of PTSD fall within three main categories:

- **Hyperarousal**, “the persistent expectation of danger:” startles easily, reacts irritably to small provocations, sleeps poorly.
- **Intrusion**, “repetitive reliving of the traumatic experience in thoughts, dreams and actions:” static, sensory flashbacks and nightmares accompanied by terror and rage.
- **Constriction**, “the numbing response of surrender:” detached states of calm or dissociation impeding voluntary action, initiative, critical judgment and perception of reality. PTSD symptoms reflect the brain’s normal response to trauma; they are not evidence of psychosis⁴⁴.

*Physical abuse during childhood
is a powerful risk factor for
adult homelessness.*

Disability and homeless women

14.6 percent of all Montana women aged 16 — 64 had a disability at the time the 2000 Census⁴ was taken. The disability rate among the homeless females identified during the 2006 Survey² was more than double this rate: 33 percent revealed that they had a diagnosed disabling condition. Many reported more than one disabling condition. The most common was mental illness.

HOMELESS FEMALE: 2006 SURVEY OF THE HOMELESS²

Universe: 1,153 women & girls	All Females
Are you currently <i>diagnosed</i> with a disabling condition?	381
Mental Illness	177
Alcohol or drug abuse	138
Physical disability	99
Developmental disability	28
HIV/AIDS and related diseases	12
Other	72

Note: The number of disabling conditions is equal to about 1.4 conditions per person among the 381 with a disabling condition.

A 1997 study analyzed data from 436 homeless and housed mothers receiving welfare. Between 69 — 71 percent reported suffering from at least one mental health disorder at some point during their lives, as compared to 47 percent of women in the general population. Almost twice as many reported depression and three times as many reported PTSD as compared to the general population⁴⁵.



Poor health appears to be a consequence of deep poverty: in one study, nearly 1/3 of homeless and housed low-income mothers report a current chronic health condition, with particularly high rates of asthma, anemia and ulcers, despite the fact that the average age of the women in the study was 27⁵³.



HOMELESS FEMALE: 2006 SURVEY OF THE HOMELESS²

Universe: 1,153 women & girls	All Females
Have you been <i>diagnosed</i> with any of the following?	
Asthma	164
Hypertension	95
Hepatitis C	73
Bronchitis	61
Diabetes	53
Heart Disease	30
Tuberculosis	6

Lack of Housing

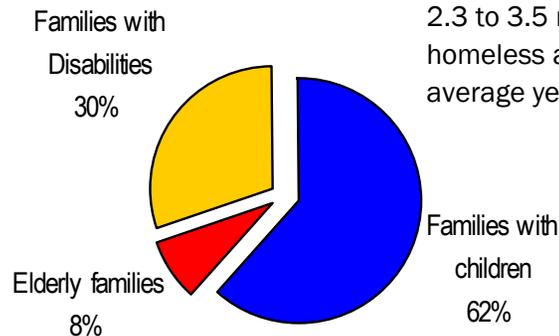
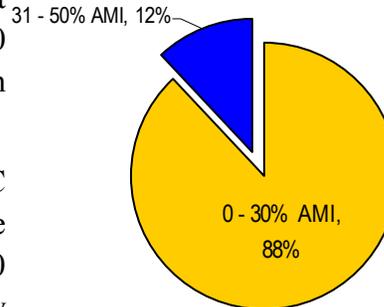
In its *Streamlined Public Housing Plan for Fiscal Year 2006*⁵⁵, the Department of Commerce states that there were 7,707 families on its wait list — almost twice the 3,716 vouchers it administers. About 1,000 vouchers turn over annually. Applicants can remain on the wait list for as long as 5-7 years.

Families are chosen for participation in the MDOC units from the wait list on a first-come, first-serve basis. At any point in time, approximately 600 Montanans hold housing vouchers and are actively seeking housing. They have a maximum of 120 days to secure housing. If unsuccessful, the voucher reverts to the next eligible person on the list.

- According to the *2005 Northwest Job Gap Study*⁵⁴, just 29 percent of *all* jobs in Montana pay the \$14.89 hourly wage needed for a single adult to support herself and one child.

Who is waiting for housing vouchers?

Source: Streamlined Public Housing Plan for FY 2006⁵⁵.
AMI: Area Median Income



Between

1997 and 1999, the number of housing units affordable to renters with extremely low incomes dropped nationally by 750,000 units (13 percent); the total number of units affordable to renters with very low incomes fell by 1.14 million (7 percent); 2.3 to 3.5 million people went homeless at some point during an average year in the late 1990s⁵⁷.

Homeless Families

There is no jurisdiction in the U.S. where a minimum wage worker working full-time, year-round can afford a one-bedroom apartment⁵⁷.

Homeless Kids

The January 2006² survey identified 543 homeless children and youth, including 83 survey respondents under age 18, as well as 460 children and youth cumulatively identified by survey respondents. An additional 84 women were pregnant. Not counting the pregnancies, this means that 23.5 percent (nearly one in four) of all homeless persons identified in 2006 were under age 18.

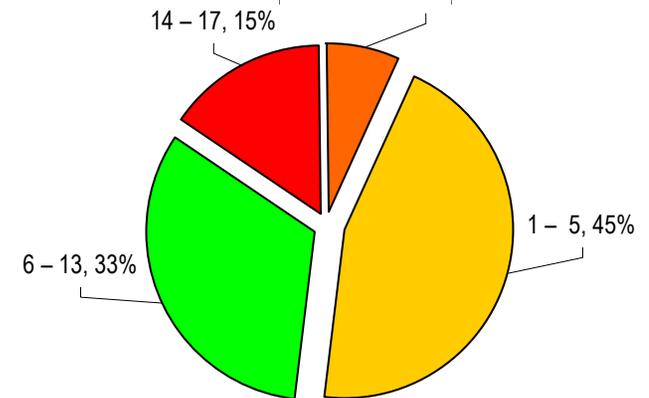
Homeless children face hardships that include frequent mobility, poor nutrition, substandard living conditions, emotional stress and lack of access to health care. The National Center of Family Homelessness states that homeless children get sick twice as often as their housed peers. Additionally, homeless children have:

- Twice as many ear infections;
- Four times as many asthma attacks;
- Five times more stomach problems;
- Six times as many speech problems;
- Twice as many hospitalizations;
- Go hungry twice as often as other children; and
- 47 percent of homeless school-age children have problems such as anxiety, depression or withdrawal, compared to 18 percent of other children⁵⁸.



Homeless Children: Montana's Survey of the Homeless

	1/27/2005	1/31/2006
Pregnant Mothers	38	84
Children under 1 year	67	32
Ages 1-5	145	204
Ages 6-13	162	151
Ages 14-17	72	73
Respondents under age 18	41	83



Age breakdown of children in homeless families:
Montana Survey of the Homeless, 2006²

Are accompanying children in school?

Most of the 225 homeless, school-aged children identified in 2006 *were* attending school. Just 18 children were *not*². Among those *not attending*,

- 4 has been out of school for less than 3 months;
- 2 had been out of school for at least 3 months;
- 7 had been out of school for at least 6 months;
- 5 had been out of school for a year or more.

One of the greatest risks to homeless children is sporadic education because of high family mobility.

Unattended Youth

Eighty-three (83) homeless youth under the age of 18 responded to the 2006 Survey of the Homeless².

- Most unattended males (36) did not identify family members.
- The 46 female respondents identified an additional 32 family members; 9 were pregnant.
- 12 respondents under age 18 were together parenting 11 children under age five. All but one were female; only one had completed high school.
- Almost a third (36/116) stayed with family or friends on January 31st; 11 spent the night in foster care and 26 stayed in transitional shelters.
- The most common reasons cited for homelessness included: drugs and/or alcohol, mental health, lifestyle choice, and domestic abuse. Nearly half (46.6%) cited “Other” as their reason for homelessness. Though undefined, this may include runaway, abandoned or throwaway kids.

These numbers are double those of 2005³, when 41 unattended youth responded to the survey, together identifying 13 additional family members.

Homelessness is particularly dangerous for unattended youth. It puts them at risk for physical and sexual assault or abuse, physical illness, anxiety disorders, depression, post traumatic stress disorder and suicide. Homeless youth are also more likely to engage in a variety of dangerous and illegal behaviors⁶⁰.

Kids on Montana’s Streets

Tumbleweed Runaway Program, Inc., in Billings, Montana, is a non-profit agency that provides emergency services to runaway, homeless and other at-risk youth. This is the largest such project in the state, serving 1,500 to 1,600 youth annually, 95 percent of whom are able to return home or move to a safer, more positive living situation than the ones they have left. The other five percent — approximately 75 kids in 2005 — are homeless and have nowhere to go.



Sally Leep, Executive Director of Tumbleweed, estimates that 150 to 200 teens are homeless in Billings, Montana at any given time. Some live on the streets. Many move from house to house as friends and acquaintances allow. Others have been kicked out of their homes by their parents.

Findings from the *Northwest Foster Care Alumni Study* (2005) revealed that young adults coming out of foster care are not faring well. More than one in five alumni (22.2%) experienced homelessness after leaving foster care⁶².

Addiction

Alcohol remains the most common drug of abuse in Montana, but methamphetamine is wreaking havoc on every social system in the state. Methamphetamine is a central nervous system stimulant that

increases dopamine and norepinephrine production in the brain. Generally speaking, it acts on the brain's pleasure centers. In the short term, the drug causes euphoria, increased wakefulness and physical energy. Heart and breathing rates rise, and the user often has a dry mouth. Within a relatively short time, however,

meth can induce paranoia, stroke, violent behavior, delusions, auditory hallucinations, open sores, tooth loss and dramatic weight loss⁶³.

Methamphetamine abuse results in consumption of a disproportionate share of Montana's law enforcement, social service, corrections and treatment resources. In 2005, 1,246 patients admitted to Montana's state-approved treatment centers listed methamphetamine as their primary drug of addiction, a 70 percent increase over the past six years. Of 1,246 admissions in 2005, 535 were women — 65 percent between the ages of 18-34⁶⁴.

In the 2006 Survey², drug and/or alcohol abuse was listed as a cause for homelessness among 142/834 (about 17 percent) of all members of homeless families with children.

Among the 255 homeless families with children identified in the 2006 Survey of the Homeless², 48 families reported that drugs and/or alcohol were a cause for their homelessness. This may be low: parents are often reluctant to self-report for fear of losing their children.

Most women

sent to prison have committed offenses that range from possession or manufacturing, to committing

property crimes to get money to buy drugs.

Those women often get deferred or suspended sentences, then fail while on probation because this addiction is extremely difficult to break. Persons addicted to methamphetamine tend to have

poor outcomes in traditional treatment modalities, and do poorly at meeting the requirements of probation and parole.

Addiction can be strongly linked to homelessness — directly, through the loss of employment, transportation, and homes...and indirectly because it becomes difficult if not impossible to rent after having been convicted of a drug-related felony.

On 3/9/2006, 308 women were in the custody of the Montana Women's Prison: 224 were on site⁶⁷.

Darla is tiny, with long dark hair and green eyes that never settle long. She's a pretty girl who might be prettier in repose, but it's hard to be certain: she never stops fidgeting. Darla has lived in Helena most of her 21 years, though she's spent the last six months at Family Transitional Shelter. "I've had a bad drug addiction problem with meth since high school," she says, plucking at her sweater. "After high school, I got into a relationship with an abusive boyfriend and fell into the wrong crowd." She shrugs, then goes on.

She went to Washington and claims she was doing well there, but that she was still homeless. Finally she came back and fell into her old crowd...and drugs. Eventually Darla got busted for conspiracy and had to go to jail. While she was there, she lost her Section 8 housing, her car...and almost lost her child.

"My mother saved me from losing my son," she says. "Now I'm a single mom because my husband is in prison. Since I came to the shelter, I have applied for college and started a job. Things are coming together. They are coming together slowly, but they are coming together. At least here you have to be in by a certain time," she says, watching the street. "That helps because at least I'm not out on the street doing something that might get me in trouble."⁶⁵

Justice system involvement puts ex-prisoners and their families at substantial risk of homelessness. This population is growing. According to the Department of Corrections website (www.corr.mt.gov), the June 30, 2006, male prison population was 2,440 offenders and is expected to grow by about 6 percent per year. The June 30, 2006, female prison population was 297 offenders and is expected to grow by 17 percent per year.

Approximately 85 percent of the population of Montana's women's prison are nonviolent offenders. About 47 percent of all adults currently in prison are there because they could not maintain clear conduct and alcohol/drug free urinalyses⁶⁶.

Multigenerational Homelessness

Research reveals strong links between a history of family homelessness and risk of school failure, mental health issues and substance abuse. Homelessness is a pattern that can repeat generation after generation. This is especially alarming in context with the fact that nearly 1 in 4 homeless Montanans is under 18.

*"One of the most tragic parts of homeless children's lives is their loss of education. Many repeat grades in school, some never learn to read, and others drop out, all because they had no quiet place to study, no stable place to stay, and no place to call home. Today, homelessness is no longer simply about housing. Today, it is about education, about families, and more than ever, about children."*⁵⁹

Family Violence

There is no one physical act that characterizes domestic violence: it includes a continuum of behaviors ranging from verbal to physical abuse. Most victims suffer multiple forms of abuse and a variety of physical and psychological injuries. Indicators include:

- Frequent visits to doctor's office
- Multiple sites of injury
- Gastrointestinal problems
- Eating disorders
- Psychological distress: depression, suicidal ideation, anxiety
- Evidence of sexual assault
- Indication of injury to breast or abdomen of pregnant females.



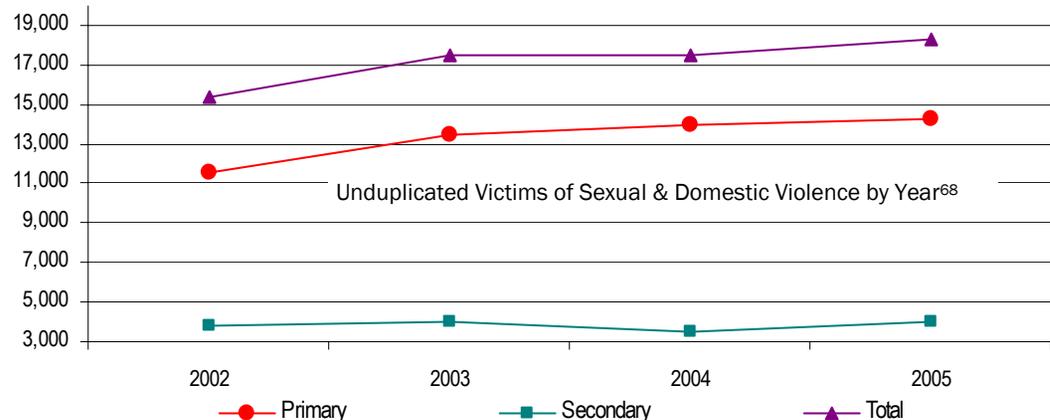
Homeless Families: When a woman leaves an abusive relationship, she often has nowhere to go. This is particularly true of women with few resources. Lack of affordable housing and long waiting lists for assisted housing mean that many women and their children are forced to choose between abuse at home or the streets. Persons fleeing their homes to escape domestic violence in a shelter are considered homeless by HUD.

- Of the 255 unduplicated homeless families with children identified in January 2006², 94 cited partner or family member violence as one of the causes of their homelessness. In 2005, 78 of 268 homeless families were homeless at least partially due to domestic violence.

The number of unduplicated victims of sexual and domestic violence in Montana surged 23.2 percent between 2002 and 2005. In 2005, there were 18,279 unduplicated victims of domestic and sexual violence in Montana, including 14,244 primary victims and 4,035 secondary victims⁶⁸.

Victims range in age from infants to 65+, and include both genders. Nationally, the health care costs associated with domestic violence are estimated to be in the hundreds of millions each year. There are also significant financial and social costs that impact the survivor, her children, the health care system, schools, the criminal justice system, business and the community.

Domestic violence is not uncommon: 31 percent of American women report being physically or sexually abused by a husband or boyfriend at some point in their lives. Nearly 25 percent report being raped and/or physically assaulted by a current or former spouse, cohabiting partner, or date⁶⁹.



The common ground among homeless families is deep poverty. There is a substantial gap between minimum wage, housing and the other basic costs of living.

Compared to other families in poverty, homeless families tend to be poorer and have younger heads of household; they are more likely to come from an ethnic minority; and they are less likely to have a housing subsidy. They are *not* more likely than other poor families to have mental illness or to suffer from depression, and they tend to have levels of education similar to other poor families⁷⁰.

A primary cause of homelessness is the lack of housing affordable to very low income people. Housing prices are high and the the problem of affordability is getting worse.

- In 1970, there were 300,000 more affordable housing units available nationally than there were low-income households needing to rent them⁷¹.
- By 2001, there were 4.7 million more low-income households that *needed* housing than there were affordable housing units⁷².

Montana participated in the fourth national Policy Academy focusing on homeless families with children, which was convened on November 1-3, 2005, in Anaheim, California.

The 2005 Policy Academy Team included:

- Hank Hudson, Chair, Montana Council on Homelessness
- Sherrie Downing, Coordinator, Montana Council on Homelessness
- Patricia Flynn, Rimrock Foundation
- Christie Hill-Larson, Montana Head Start Association
- Sally Leep, Executive Director, Tumbleweeds Runaway Program
- Roland Mena, Executive Director, Montana Board of Crime Control
- Tammera V. Nauts, Deputy Director, Western Montana Addiction Services
- Judy Stewart, Director, Montana Healthcare for the Homeless
- Veronica Whitaker, Lead Clinical Program Officer, Children's Mental Health Bureau

Following is the plan created by the Policy Academy Team, which is consistent with the work done by the Montana Council on Homelessness and its standing workgroups.

Many studies demonstrate that most families who exit homelessness with a housing subsidy will be able to sustain that housing⁷³.

Stepping Stones

Goal: End Family Homelessness by 2014

Vision: Homes for all in the last, best place



Homeless Families

GOAL FI: Prevent families from becoming homeless *DRAFT*

Objectives	Strategies	Critical Partners	Target Date
Objective F-I.1: Enhance linkages with mainstream resources, starting with demonstration project in Billings	<ul style="list-style-type: none"> Identify core provider “direct services” team members and help bring them together Ask labor union to join team (to promote livable wage) Hold a “service fair” using a Katrina-style, one-stop model, starting with Billings community 	Billings Commission on Homelessness; HRDC 7; Billings Housing Authority; OPA; labor union; Job Service; Healthcare for the Homeless; McKinney-Vento liaisons; MTCOH; RSVP	2005 and ongoing
Objective F-I.2: Identify and implement prevention strategies	<p>Establish protocols to identify families at high risk of becoming homeless</p> <ul style="list-style-type: none"> Connect families with mainstream benefits Explore one-stop shopping options, starting with Billings Demonstration Community Implement “No Wrong Door” philosophy 	Offices of Public Assistance; Housing Authorities; Human Resource Development Councils; Head Start and Early Head Start; schools; Continuum of Care; MTCOH	2006 and ongoing
Objective F-I.3: Target an initial pool of \$200,000 in TANF funds to keep at-risk TANF families housed	<p>Create a pool of \$200,000 in TANF funds to meet one-time-only housing-related expenses</p> <ul style="list-style-type: none"> Provide emergency assistance with rent, deposits, utilities or other housing-related costs Train housing agencies so that they are aware of the pool of emergency funds and its uses Train and empower TANF and OPA workers in the discretionary use of this pool of funds 	Offices of Public Assistance; Housing Authorities; Department of Public Health and Human Services Human & Community Services Division; MTCOH	<ul style="list-style-type: none"> Announce funds: 6/2006 Start training: 8/2006 Begin disbursement: 9/2006
Objective F-I.4: Increase awareness of and access to quality early childhood education	<ul style="list-style-type: none"> Inform HS & EHS providers about homelessness in Montana Increase Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) screening 	Head Start and Early Head Starts; Resource Development Councils; MTCOH	<ul style="list-style-type: none"> Focus annual Head Start Conference on homelessness: April 2006

GOAL F-2: Enhance access to permanent, affordable housing *DRAFT*

Objective	Strategies	Critical Partners	Target Date
<p>Objective F-2.1: Formulate concrete housing plan that includes a continuum of housing choices, from permanent affordable rentals through first time homebuyers assistance</p>	<p>Create 500 units of housing annually for the next 10 years (for populations across the continuum of housing needs)</p> <ul style="list-style-type: none"> • Participate in the evolution of Montana’s Affordable Housing Trust Fund to the <i>Homes for Montana Fund</i>, which will accommodate a wide range of housing • Articulate the needs to be addressed by the fund, including persons living at 0-30% of Area Median Income • Identify/develop sustainable funding stream(s) • Draft an Executive Planning Process (EPP) request for General Funds for housing, to be added to the base budget • Draft legislation and find champion(s) 	<p>Department of Commerce; Board of Housing; DPHHS:Montana Association of Counties; homeWORD; Montana Homeownership Network; Montana Association of Realtors; Montana Building Industry Association; Salish Kootenai Housing Authority; Rocky Mountain Development Council; Montana Homechoice Coalition; Montana Council on Homelessness (MTCoH)</p>	<p>Legislative Session, 2007</p>

GOAL F-3: Strengthen political will *DRAFT*

<p>Objective F-3.1: Improve awareness of homelessness as a growing issue for Montana families</p>	<ul style="list-style-type: none"> • Create a Call to Action through enhanced awareness of homelessness as an issue that affects families • Participate in disseminating information highlighting the issue using a range of venues including the 10-Year Plan, E-news Updates, television and newspaper articles • Participate in enhanced awareness through involvement of local communities in community-based initiatives to end homelessness 	<p>MTCoH; local media; Billings Commission on Homelessness; Interfaith Hospitality Network(s); Montana leadership, including Governor, Lt. Governor, policy advisors</p>	<p>Initiated in 2004; ongoing</p>
--	--	--	-----------------------------------

GOAL F-4: Demonstrate impact *DRAFT*

<p>Collect data; integrate use of one agreed-upon system such as the DPHHS Homeless Management Information System (HMIS)</p>	<ul style="list-style-type: none"> • Create cost/benefit analysis • Explore and coordinate research partnerships with higher education with U of M and MSU • Explore South Carolina data warehouse option 	<p>DPHHS Intergovernmental Human Services Bureau; agencies participating in demonstration project; Montana universities; MTCoH</p>	<p>2007</p>
--	--	--	-------------



Goal: End Family Homelessness by 2014

GOAL F-5: Initiate reentry pilot to prevent homelessness among families of women leaving prison

DRAFT

Homeless Families

Objectives	Strategies	Critical Partners	Target Date
Objective F-5.1: Prevent homelessness among women leaving the Montana Women's Prison, who are at high risk of homelessness in the Billings area	<ul style="list-style-type: none"> Determine pilot project population size Identify best practices for such strategies as umbrella leases and advocacy practices Establish strategies to protect landlords Establish "pride partnerships" with tenants 	Billings Commission on Homelessness; Department of Corrections; community corrections; MTCoH; MBCC; and others TBD	2007 – 2010
Objective F-5.2: Establish partnerships to allow those with corrections and addiction backgrounds to access housing	<ul style="list-style-type: none"> Identify lead agency to spearhead the project Seek private and public sector partners to secure an appropriate number of decent, affordable housing units of scattered site housing 	Billings Housing Authority; homeWORD; landlord's association; MTCoH; Billings Commission	2005 and ongoing
Objective F-5.3: Establish incentives for those willing to provide housing for this population	<p>Explore incentives for those who provide additional housing for this population by providing a continuum of funding through the Housing for Montana Fund (formerly the Affordable Housing Trust Fund)</p> <ul style="list-style-type: none"> Draft potential legislation Seek out legislative support 	Montana Department of Commerce	<ul style="list-style-type: none"> 2005: initiate conversations and workgroup 2007: present to legislature
Objective F-5.4: Enhance access to existing system supports	<ul style="list-style-type: none"> Establish and utilize relationships with existing agencies, organizations and groups Develop Memorandums of Understanding with participating providers and private sector partners 	Human Resource Development Councils; Children's Mental Health Bureau Kid's Management Authorities	2006 and ongoing
Objective F-5.5: Establish mechanisms for identifying appropriate candidates	<ul style="list-style-type: none"> Establish relationships with parole, probation and community corrections Identify a readiness assessment tool and criteria to help identify appropriate candidates Establish relationship with candidates 3 to 6 months before release Eliminate participant barriers to successful re-entry Bundle individualized services Ensure participating service providers have adequate training, and understand trauma and poverty 	Community and state corrections	<p>Establishing relationships: 2006 and ongoing</p> <p>Pilot project: 2007 – 2010</p>

Objectives	Strategies	Critical Partners	Target Date
<p>Objective F-5.6: Ensure participants' access to all appropriate services.</p>	<p>Determine participants' eligibility for supportive and mainstream services prior to discharge, and ensure that benefits are ready to kick in as soon as possible after release. Determine eligibility for:</p> <ul style="list-style-type: none"> • TANF • Medicaid • SSI/SSDI • Food stamps • Child care • Job training or education <p>Provide cross-training for case managers on completing applications for such programs as SSI and food stamps</p>	<p>Lead agency; case managers and direct service providers; DPHHS; SSA; Disability Determination Services</p>	
<p>Objective F-5.7: Seek new and or additional funding and resources</p>	<ul style="list-style-type: none"> • Redirect state, county and/or city funds • Recruit VISTA/AmeriCorps volunteers • Identify and seek grant funding from federal, state and private foundation sources • Utilize federal technical assistance as much as possible • If funding is needed, ask divisions and departments who stand to benefit and/or submit request for Governor's Budget process 	<p>MTCoH; DPHHS; Department of Corrections; Department of Commerce; local governments; Policy Academy partners; United Way; Big Sky Economic Development Association; others TBD</p>	
<p>Objective F-5.8: Establish corporate and other partnerships</p>	<ul style="list-style-type: none"> • ID corporate partnerships (e.g., EXXON) • Build on social enterprise dreams • Establish grant writing team through multi-agency team collaboration 	<p>Participating agencies</p>	
<p>Objective F-5.9: Track results using one agreed-upon data source (e.g., HMIS)</p>	<ul style="list-style-type: none"> • Closely track all participants • Collect and practice frequent reviews of data and change course of project as needed 	<p>Participating agencies; DPHHS; Department of Corrections</p>	

For more information, visit www.MTCoH.org or contact:

- Hank Hudson, Co-chair, MTCoH: 406.444.5901 or HHudson@mt.gov
- Sherrie Downing, Coordinator, MTCoH: 406.443.0580 or Sherrie@MTCoH.org
- Jim Nolan, Sponsor, MTCoH: 406.447.4260 or JNolan@mt.gov

Chapter Four: Resources and End Notes

Definitions of Homelessness

The definition of homelessness varies from agency to agency. The Montana Council on Homelessness recognizes that programs must utilize and abide by the definitions that serve the purposes of individual funders, but uses the following overarching definitions to frame homelessness for Montana:

- **Homeless:** Without safe, permanent and stable housing, including doubling or tripling up.
- **Imminently homeless:** At immediate or high risk of losing existing housing.
- **Chronically homeless:** Homeless for an extended period or episodically homelessness over a period of years.

Homelessness: a Glossary

Stewart B. McKinney Homeless Assistance Act, Public Law 100-77	In 1987, the Stewart B. McKinney Homeless Assistance Act, Public Law 100-77, was enacted to provide relief to the nation's rapidly increasing homeless population. The intent of the Act was to provide funding for emergency food and shelter, education, transitional and permanent housing, as well as to address the multitude of health problems faced by people who are homeless.
Homelessness McKinney-Vento Act	Lacking a fixed, regular and adequate nighttime residence.
McKinney-Vento Act: Education of Homeless Children and Youth Program (Title VII-B of the McKinney-Vento Act, as Amended by the No Child Left Behind Act of 2001)	The McKinney-Vento Act now specifically includes children and youth who are: sharing the housing of others due to a loss of housing, economic hardship or a similar reason; living in motels, hotels, trailer parks or campgrounds due to the lack of alternative adequate accommodations; staying in shelters; sleeping in cars, parks, abandoned buildings, substandard housing, bus/train stations or public places; or awaiting foster care placement. Reauthorization requires every school district to designate a liaison to implement the law. Duties include: identifying homeless children and youth; ensuring school enrollment and opportunities for academic success for homeless children and youth; assisting with transportation and preschool enrollment; posting notice of rights; working with parents and youth; and mediating enrollment disputes.
Chronically Homeless (Department of Housing and Urban Development – HUD)	An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years.
Chronically Homeless (Community Definition)	Homeless for 12 or more months during the past 3 years, without regard to household composition or disability status.

Homelessness: a Glossary

<p>Homeless (HUD)</p> <p>Section 8; Section 202; and the HOME Investment Partnership Program use the HUD definition of homelessness.</p>	<p>A person is considered homeless only when he/she resides in one of the places described below:</p> <ul style="list-style-type: none"> • In places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings (on the street). • In an emergency shelter. • In transitional or supportive housing for homeless persons who originally came from the streets or emergency shelters. • In any of the above, but spending a short time (up to 30 consecutive days) in a hospital or other institution. • Is being evicted within a week from a private dwelling unit, no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing. • Is being discharged within a week from an institution, such as a mental health or substance abuse treatment facility or a jail/prison, in which the person has been a resident for more than 30 consecutive days, no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing. (For example, a person being discharged from prison after more than 30 days is eligible only IF no subsequent residence has been identified and the person does not have money, family or friends to provide housing.) • Is fleeing a domestic violence housing situation and no subsequent residence has been identified and lacks the resources and support networks needed to obtain housing.
<p>Homeless Person (Health Care for the Homeless)</p>	<p>An individual without permanent housing who may live on the streets, in a shelter, mission, single room occupancy facility, abandoned building or vehicle, or in any other unstable or nonpermanent situation. An individual may also be considered homeless if that person is “doubled up,” a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family.</p> <p>Statutory Authority: The addition of Section 340 to the PHS Act established the Health Care for the Homeless (HCH) program, the only Federal program with responsibility for addressing the primary health care needs of homeless people. In 1996, the Health Care for the Homeless program was re-authorized as Section 330(h) of the Health Centers Consolidation Act (HCCA), which amended the PHS Act by consolidating the HCH program with other community-based health programs. The HCCA was re-authorized in 2002.</p>
<p>Homeless Individual (Public Service Health Act, Section 330(h)(5)(A))</p>	<p>An individual who lacks housing (without regard to whether the individual is a member of a family), including an individual whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations and an individual who is a resident in transitional housing.</p>
<p>Transient (Social Security Administration)</p>	<p>“Transient” is used to define homelessness. A transient is an individual with no permanent living arrangement, i.e., no fixed place of residence. A transient is neither a member of a household nor a resident of an institution. A transient can be: a homeless individual (e.g., someone who sleeps in doorways, overnight shelters, parks, bus stations); or a person who stays with a succession of friends or relatives and has no permanent living arrangement on the first moment of the month.</p>

Homelessness: a Glossary

Definitions of Homelessness

Homeless (Food Stamp Program: <i>U.S. Department of Agriculture</i>)	The Food Stamp program uses The McKinney-Vento definition of homelessness. An applicant is considered homeless if he or she 1) has no place to sleep; 2) lives in a shelter or halfway house; 3) lives in someone else's home temporarily (fewer than 90 days); or 4) lives in a doorway, lobby, bus station, or some other place where people do not usually live. Homeless people have all the same rights under the Food Stamp Program that any other people do; they also have some special rights.
Homelessness (U.S. Department of Health and Human Services)	The TANF (Temporary Assistance for Needy Families) Program in Montana does not use a definition of homelessness, but does provide services to families at risk of becoming homeless through the State's Emergency Assistance program.
Homelessness (Department of Energy)	The Department of Energy uses the McKinney-Vento definition of homelessness.
Homelessness (Wikipedia)	A situation in which a person does not have a long term place of ongoing residence. This is distinguished from nomadic cultures in which that condition is considered normal. Homelessness is most visible in the poor sections of large cities and suburbs, though the homeless frequently co-exist less visibly within communities where most residents are not poor. The term '(of) No Fixed Abode' (NFA) is often used officially as an alternative to 'homeless'.
Homeless (Word Net 2: Princeton University 2003)	adj. 1: without nationality or citizenship; "stateless persons" [syn: stateless] 2: physically or spiritually homeless or deprived of security; "made a living out of shepherding dispossessed people from one country to another"- James Stern [syn: dispossessed, roofless] noun 1: someone with no housing; "the homeless became a problem in the large cities" [syn: homeless person] 2: people who are homeless; "the homeless lived on the city streets."
Homeless person (The Australian Supported Accommodation Assistance Program Act 1994)	A person is homeless if, and only if, he or she has inadequate access to safe and secure housing. A person is taken to have inadequate access to safe and secure housing if the only housing to which the person has access: <ul style="list-style-type: none"> • damages, or is likely to damage, the person's health; or • threatens the person's safety; or • marginalizes the person through failing to provide access to: adequate personal amenities; the economic and social supports that a home normally affords; places the person in circumstances which threaten or adversely affect the adequacy, safety, security and affordability of that housing.

Homeless: Having no home or haven. – American Heritage Dictionary

Homelessness: a Glossary

Segments of the homeless population
(Developed by Chamberlain and Mackenzie, 1992, and used by the Australian Bureau of Statistics)

Primary Homelessness (absolute): People without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars or railway carriages for temporary shelter.

Secondary Homelessness (relative): People who move frequently from one form of temporary shelter to another. It covers: people using emergency accommodation (such as hostels for the homeless or night shelters); teenagers staying in youth refuges; women and children escaping domestic violence (staying in women's refuges); people residing temporarily with other families (because they have no accommodation of their own); and those using boarding houses on an occasional or intermittent basis.

Tertiary Homelessness (relative): People who live in boarding house on a medium to long-term basis. Residents of private boarding house do not have a separate bedroom and living room; they do not have kitchen and bathroom facilities of their own; their accommodation is not self-contained; and they do not have security of tenure provided by a lease.

Continuum of Care (CoC) (HUD)

A coordinated, strategic approach to planning for programs that assist individuals and families who are homeless. The CoC approach reorganized the way HUD homeless assistance program funds for Shelter Plus Care, Supportive Housing Program, and Section 8 Moderate Rehabilitation were awarded, consolidating them into a single competitive grant process. This change was made to encourage communities to develop comprehensive systems to address the range of needs of different homeless populations. To apply for these funds, jurisdictions must submit a Continuum of Care Plan that demonstrates broad participation of community stakeholders and identifies the resources and gaps in the community's approach to providing the range of homeless services including: outreach; emergency, transitional, and permanent housing; and related services. Key elements of the CoC approach include strategic planning, data collection and Inclusive processes that draw on system- and client-level sources of information to establish priorities.

Emergency Shelter (HUD)

Any facility, the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

Transitional Housing (HUD)

One type of supportive housing used to facilitate the movement of homeless individuals and families to permanent housing. Basically, it is housing in which homeless persons live for up to 24 months and receive supportive services that enable them to live more independently. The supportive services may be provided by the organization managing the housing or coordinated by them and provided by other public or private agencies.

Housing First

An alternative to the current system of emergency shelter/transitional housing, based on the belief that vulnerable and at-risk homeless individuals and families are more responsive to interventions and social services support after they are in permanent housing, rather than while living in temporary/transitional facilities or housing programs.

State of Montana Resources

- Montana Board of Crime Control: www.mbcc.mt.gov
- Governor Brian Schweitzer: www.governor.mt.gov
 - Governor's American Indian Nations (GAIN) Council: <http://gain.mt.gov/>
 - State Tribal Economic Development Commission: <http://tribal.mt.gov/>
- Montana Department of Commerce: www.commerce.mt.gov
 - Board of Housing: www.housing.mt.gov
- Montana Department of Corrections: www.corrections.mt.gov
- Montana Department of Labor and Industry: www.dli.mt.gov
- Department of Public Health and Human Services www.dphhs.mt.gov
 - Addictive and Mental Disorders Division www.dphhs.mt.gov/amdd
 - Disability Services Division www.dphhs.mt.gov/dsd
 - Human and Community Services Division www.dphhs.mt.gov/hcsd
- Montana Office of Public Instruction: www.opi.mt.gov
- Montana Prevention Resource Center: www.prevention.mt.gov
- Office of the Commissioner of Higher Education www.montana.edu/wwwoche
- Montana Veterans' Affairs: www.dma.mt.gov/mvad

More Montana Resources

- Montana Coalition Against Domestic and Sexual Violence: www.mcadsv.com/
- Montana Home Choice Coalition <http://69.144.243.26/awareinc/montanahomechoice/main.asp>
- Montana Human Resource Development Councils <http://www.dphhs.mt.gov/programsservices/energyassistance/eligibilityoffices.shtml#hrdc>
- Montana Law Help: www.montanalawhelp.org
- Montana Legal Services Association: www.mtlsa.org
- Montana Mental Health Association: www.montanamentalhealth.org/
- Montana Public Housing Authorities www.hud.gov/offices/pih/pha/contacts/states/mt.cfm

Montana's Indian Nations

- Montana Indian Nations Official State Travel Information Site <http://indiannations.visitmt.com/>
- Montana Primary Care Association, Inc. Links to Urban Indian Clinics <http://www.mtpca.org/uic.htm>
- Montana-Wyoming Tribal Leaders Council <http://www.mtwytlc.com/>



A Few Best Practices & National Resources

Ending Homelessness

- National Alliance to End Homelessness: www.endhomelessness.org/best/
- US Interagency Council on Homelessness: www.ich.gov/
- 10-Year Plans to End Chronic Homelessness: <http://www.ich.gov/slocal/10yrchronic.html>
- Serving the Homeless Through a One-Stop System: a Case Study: www.gao.gov/new.items/d02485t.pdf
- Health Resources and Services Administration Homeless Policy Academies: www.hrsa.gov/homeless/index.htm
- Center for Law and Social Policy: www.clasp.org/
- Department of Housing and Urban Development: Homeless: www.hud.gov/homeless/
- Office of Human Services Policy: aspe.hhs.gov/hsp
- Policy Research Associates: <http://www.prainc.com/>
- The Urban Institute: www.urban.org/

Accessing Mainstream Resources

- Assess Eligibility for Benefits: www.GovBenefits.gov
- SOAR: SSI/SSDI Outreach, Access and Recovery: www.pathprogram.samhsa.gov/soar/
- Social Security Administration <http://www.socialsecurity.gov/onlineservices/>

Children and Youth

- Homes for the Homeless: Institute for Children and Poverty www.homesforthehomeless.com/
- National Association for the Education of Homeless Children and Youth: www.naehcy.org/
- Youth Transition Funders Group: www.ytfg.org

Data

- US Census: www.census.gov
- The United States Conference of Mayors Status Report on Hunger and Homelessness in America's Cities 2005 www.usmayors.org/uscm/hungersurvey/2005/HH2005FINAL.pdf
- Montana: 2005 Survey of the Homeless: www.nth-degree.com/mthomeless/hud/
- Montana: 2006 Survey of the Homeless: www.nth-degree.com/mthomeless/

Health and Disability

- National Health Care for the Homeless Council: www.nhchc.org/
- National AIDS Housing Coalition: www.nationalaidshousing.org/

Housing

- Corporation for Supportive Housing: www.csh.org/
- Housing Assistance Council: ruralhome.org
- Housing Research Foundation: www.housingresearch.org/

Mental Health, Substance Abuse & Co-occurring Disorders

- National Resource and Training Center on Homelessness and Mental Illness: www.nrchmi.samhsa.gov/
- Mental Health Publications: www.mentalhealth.samhsa.gov/publications/browse.asp
- National Governor's Association Center for Best Practices: www.nga.org/portal/site/nga
- National Mental Health Association: www.nmha.org/
- Projects for Assistance in Transition from Homelessness: www.pathprogram.samhsa.gov/

1. Prevention Connection Newsletter: Trauma & Kids. Winter 2004. Notes from the Edge column. www.prevention.mt.gov
2. 2006 Survey of the Homeless in Montana. <http://nth-degree.com/mthomeless/svg06.html>
3. 2005 Survey of the Homeless in Montana. <http://nth-degree.com/mthomeless>
4. 2000 U.S. Census. www.census.gov
5. Streamlined Annual Plan for Fiscal Year 2006 (7-1-2005 to 6-30-2006) & Progress Report for goals set by Montana Department of Commerce for the Streamlined 5-Year Plan for Fiscal Years 2005 – 2009. 5/31/2006. <http://housing.mt.gov/Includes/S8/mt901v05.doc>
6. Burt, Martha R. *What will it take to end homelessness?* Urban Institute. October 2001. www.urban.org/url.cfm?ID=310305
7. 2006 HHS Poverty Guidelines: <http://aspe.hhs.gov/poverty/>
8. 2006 Northwest Job Gap Study. Northwest Federation of Community Organizations. <http://www.nwfco.org/>
9. 2003 Small Area Income & Poverty Estimates: Model-based Estimates for States, Counties & School Districts. U.S. Census. <http://www.census.gov/cgi-bin/saie/saie.cgi>
10. Out of Reach 2004. National Low Income Housing Coalition. <http://www.nlihc.org/oor2004/introduction.htm>
11. Montana Department of Commerce Economic & Demographic Analysis – Volume III. www.housing.mt.gov
12. State of Montana Consolidated Plan: Annual Performance Report April 1, 2005 to March 31, 2006. <http://housing.mt.gov/includes/cp/pdf/O6perfrpt.pdf>
13. Turner, Vicki. The Vicki Column. *The Prevention Connection Newsletter*: Summer 2006. www.prevention.mt.gov
14. McMurray-Avila M., Gelberg L. and Breakey W. *1998 Symposium on Homelessness Research*. www.nhchc.org/Advocacy/PolicyPapers/2004/Homelessness&Health2004.pdf
15. Healthcare for the Homeless. www.nhchc.org
16. Substance Abuse and Mental Health Services Administration, Treatment Episode Data: 2004. www.drugabusestatistics.samhsa.gov.
17. A Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders: www.mentalhealth.samhsa.gov
18. 2004 State Estimate of Substance Abuse. Office of Applied Studies, Substance Abuse and Mental health Services Administration: www.oas.samhsa.gov/2k4State/States.htm
19. Burt, Martha. *Findings from the 1996 National Survey of Homeless Assistance Providers and Clients*. www.urban.org/publications/410496.html
20. Culhane, Dennis. University of Pennsylvania. www.endhomelessness.org/pub/Toolkit.pdf
21. Missoula Focus Group, 9/29/05 by Marcial Ornales, MTCOH VISTA
22. Medical providers offer care at clinic sites." *Billings Gazette*. January 9, 2006. www.billingsgazette.com
23. A Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders: www.mentalhealth.samhsa.gov

24. Arneson, Jim. *Notes from the Edge*. The Prevention Connection Newsletter, Summer 2001. www.prevention.mt.gov
25. Corporation for Supportive Housing. <http://www.csh.org>
26. Healing *Hands*. Health Care for the Homeless Clinicians' Network, National Health Care for the Homeless Council. Vol. 4, No. 5, October 2000. www.nhchc.org/Network/HealingHands/2000/October2000HealingHands.pdf
27. Ending Homelessness in Ten Years: A County-Wide Plan for the Communities of Contra Costa County. www.cchealth.org/topics/homeless/pdf/10_year_plan.pdf
28. US Dept. of Health and Human Services. *Making a Difference: Report of the McKinney Research Demonstration Program for Homeless Mentally Ill Adults*. 1994.
29. Corporation for Supportive Housing. <http://www.csh.org>
30. Ending Chronic Homelessness, Strategies for Action. Chapter 2: Defining Chronic Homelessness & Understanding Treatment and Support Needs. <http://aspe.hhs.gov/hsp/homelessness/strategies03/index.htm>
31. Adapted from a Case Study: a Publication of the HCH Clinicians' Network. Vol. 8, No. 3_June 2004. Article by Lori Hartford, BSN, RN, Yellowstone City-County Health Department.
32. Fisher and Breakey, 1987, cited in *Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders*. www.mentalhealth.samhsa.gov.
33. *Preventing Homelessness Among People Leaving Prison*. Vera institute of Justice. December 2003. www.vera.org/publication_pdf/209_407.pdf
34. Veterans Administration data by geographic area, 2004: Source: www.va.gov/vetdata
35. Kaspro, Rosenheck et al., 2002, as cited in *A Blueprint for Change: Ending Chronic Homelessness for Persons with Serious Mental Illnesses and Co-occurring Substance Abuse Disorders*. www.mentalhealth.samhsa.gov
36. Veterans' Services and Youth Challenge The Anatomy of Federal and State Veterans' Services and the National Guard Youth Challenge Program Addressing Issues From Hunting to Homelessness. A Report to the 57th Legislature by the State Administration, Public Retirement Systems, and Veterans' Affairs Interim Committee: 1999-2000. November 2000. http://leg.mt.gov/css/publications/committees/interim/1999_2000/state_administration/staffreports.asp
37. United States Department of Veterans Affairs. Overview of Homelessness. <http://www1.va.gov/homeless/>
38. US Department of Veterans Affairs. Montana State Summary. July 2006. www1.va.gov/opa/fact/statesum/mtss.asp
39. 109th CONGRESS: 1st Session. H. R. 616. Department of Veterans Affairs Claims Backlog Reduction Act of 2005.
40. Adams, Chris: Lawmakers address problems with VA programs. Knight Ridder Newspapers. McClatchy Washington Bureau. Veterans Latest Updates. Posted March 2006. www.realcities.com/mld/kriwashington/news/special_packages/veterans/past_coverage/14001936.htm.
41. State Summary: Montana. Montana and the US Department of Veterans Affairs. July 2006. www1.va.gov/opa/fact/statesum/mtss.asp
42. National Coalition for Homeless Veterans: <http://www.nchv.org/background.cfm>

END NOTES CHAPTER THREE

43. Violence in the lives of homeless women. www.familyhomelessness.org/pdf/fact_violence.pdf.
44. Trauma and Homelessness. *Healing Hands*: HCC Clinicians' Network. Volume 3, #3. April 1999. www.nhchc.org/Network/HealingHands/1999
45. Mental Health and Substance Abuse Problems Among Women on Welfare; Women's Programs Office, American Psychological Association. December 1998. www.apa.org/pi/wpo/mhsaproblems.pdf
46. Economic Policy Institute/Center on Budget and Policy Priorities, *Pulling Apart: A State-by-State Analysis of Income Trends: Montana*. January 2006. <http://www.epinet.org/studies/pulling06/states/1-26-06sfp-fact-mt.pdf>
47. Kindrick, Terry. The Montana Women's Report: Accomplishments, Challenges and Strategies for the Future. December 2002. <http://www.wordinc.org/cpacc/index.php>
48. Eldridge, Brad, Ph.D. Multiple Jobholding in Montana. Montana Economy at a Glance, January 2006. Montana Department of Labor and Industry, Research and Analysis Bureau. www.ourfactsyourfuture.org/admin/uploadedPublications/1270_Jan_06_Multi_Job_Art.pdf.
49. Turner, Tyler. Annual Average Wages by State 1999 – 2004. Montana Department of Labor and Industry. www.ourfactsyourfuture.org/article.asp?ARTICLEID=926&PAGEID=148&SUBID=.
50. Small Area Income and Poverty Estimates 2003. US Census Bureau. <http://www.census.gov/cgi-bin/saipe/saipe.cgi>.
51. HUD Area Median Incomes 2006. www.efanniema.com/sf/refmaterials/hudmedinc/.
52. Out of Reach Montana 2005: National Low Income Housing Coalition. www.nlihc.org/oor2005/data.php?getstate=on&state%5B%5D=MT.
53. National Center on Family Homelessness. familyhomelessness.org.
54. 2005 Northwest Job Gap Study. http://www.nwfc.org/job_gap.htm
55. *Streamlined Public Housing Plan for Fiscal Year 2006*. Montana Department of Commerce. <http://housing.mt.gov/Includes/S8/mt901v05.doc>.
56. National Health Care for the Homeless Council. Policy Papers 2006. www.nhchc.org/Advocacy/PolicyPapers/Housing2006.pdf.
57. National Low Income Housing Coalition: Out of Reach 2005. <http://www.nlihc.org/oor2005/>.
58. National Center on Family Homelessness. *America's Homeless Children*. www.familyhomelessness.org/pdf/fact_children.pdf.
59. Leonard N. Stern, Montana Office of Public Instruction Website. www.opi.mt.gov
60. National Alliance to End Homelessness. *Fundamental Issues to Prevent and End Youth Homelessness*. www.endhomelessness.org/youth/youth_brief_one.pdf
61. *Billings Gazette*. www.BillingsGazette.net. 3/2/2006
62. Northwest Foster Care Alumni Study (2005). Casey Family Foundation: www.Casey.org
63. Montana Board of Crime Control. *2004–2005 Biennial Report*. www.mbcc.mt.gov.
64. Meth Free Montana: Get Help. www.methfreemt.org/help.asp.
65. God's Love Focus Group, 6/26/05, by Marcial Ornalez, MTCoH VISTA.

66. Director Bill Slaughter, 2005 Report to the Legislature. Montana Department of Corrections. www.cor.mt.gov/Resources
67. Montana Department of Corrections Daily Populations Report. www.cor.mt.gov
68. Unduplicated Victims of Sexual & Domestic Violence. PDQ Data. MT Coalition Against Sexual and Domestic Violence. www.mcadsv.com/
69. Domestic Violence is a Serious, Widespread Social Problem in America: the Facts. <http://endabuse.org/resources/facts/>
70. Culhane, Dennis. Family Homelessness: Where to Go From Here? University of Pennsylvania. www.endhomelessness.org/back/FamilyHomelessness.pdf.
71. Daskal, J. *In Search of Shelter: The Growing Shortage of Affordable Rental Housing*. Washington DC: Center on Budget and Policy Priorities. June 1998.
72. Alexander, B. *The State of the Nation's Housing: 2003*.
73. What You Should Know About Family Homelessness: The National Alliance to End Homelessness, Inc. www.endhomelessness.org/families/srcbk/familyinfo.pdf.

Calculation Notes on Annualized Costs of Not Addressing Homelessness, page 23.

- A. Cost of emergency shelter in Montana based on calls to Montana emergency shelter 8/2006. Calculation: Annual budgets for 5 Montana shelters/total number of beds = Annual cost per Emergency Shelter Bed. Annual cost/365 days per year = Cost per bed day. The mean days were pulled from the National Alliance to End Homelessness: Supportive Housing is Cost Effective. February 2006. www.endhomelessness.org/pol/McKinney_Vento/2007_McKinney-Cost_Savings.pdf
- B. Cost of short-term hospital stays: Centers for Medicare and Medicaid Services 100% MEDPAR Inpatient Hospital Fiscal Year 2004: 6/05 Update. Short Stay Inpatient by State. (Total Medicare reimbursement / Total Days) * Average Total Days www.cms.hhs.gov/MedicareFeeforSvcPartsAB/Downloads/DRGState04.pdf
- C. Average cost of emergency room visits: Medical Expenditure Panel Survey January 2006. www.meps.ahrq.gov/papers/st111/stat111.pdf Average number of visits: A San Francisco study (Braun) cited that homeless persons averaged 2.5 visits to the emergency department each year. A similar study (Taube) cited 2.7 visits per year. The median was used for mean days. <http://www.nhchc.org/Publications/utilization.html>
- D. Health Care for the Homeless is the average annual cost per unduplicated client in Montana, cited by Judy Stewart, Director, Montana Health Care for the Homeless 8/2006.
- E. Average cost per jail day in Montana from *Minutes: Montana House of Representatives – 59th Legislature, Regular Session. Joint Appropriations Subcommittee on Corrections and Public Safety*. Montana Department of Corrections Breakdown of FY 2005 Supplemental. Prepared January 12, 2005. <http://data.opi.state.mt.us/legbills/2005/Minutes/House/Exhibits/jch08a040.TIF>. Average number of days from National Alliance to End Homelessness: Supportive Housing is Cost Effective. February 2006. Cost detail of mean days used by homeless persons prior to supportive housing. www.endhomelessness.org/pol/McKinney_Vento/2007_McKinney-Cost_Savings.pdf
- F. Median length of stay per treatment episode for acute care and cost per day at the Montana State Hospital: Addictive and Mental Disorders Division: State Fiscal Year 2004 data.
- G. Cost per day and average days for Montana Chemical Dependency Center: Addictive and Mental Disorders Division Annual Report: 2003. <http://www.dphhs.mt.gov/amdd/chemicaldependencieservices/2003annualreport.pdf>



The Montana Council on Homelessness and the Intergovernmental Human Services Bureau of the Department of Public Health and Human Services attempt to provide reasonable accommodations for

any known disability that may interfere with a person participating in this service. Alternative accessible formats of this document will be provided upon request.

- You may make copies of sections of *no longer Homeless in Montana, a Report on the State of Homelessness and a 10-Year Plan to End It* for noncommercial, educational use. No reprint of this document or parts thereof should be used in a way that could be understood as an expressed or implied endorsement of a commercial product, service or company. To use this document in electronic format, permission must be sought from the Intergovernmental Human Services Bureau of the Montana Department of Public Health and Human Services. Please be sure to include acknowledgement of the *Report on the State of Homelessness in Montana* in any reproductions. All other rights remain the property of the Montana Council on Homelessness through the Montana Department of Public Health and Human Services.
- This publication was supported by the Intergovernmental Human Services Bureau of the Human and Community Services Division of the Department of Public Health and Human Services. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Department of Public Health and Human Services.
- 1,000 copies of this public document were published at an estimated cost of \$3.40 per copy, for a total cost of \$3,400, which includes \$3,400 for printing and \$0.00 for distribution.
- For more information or to request a copy of the *Report on Homelessness in Montana and 10-Year Plan to End It*, contact:
Jim Nolan, Chief
Intergovernmental Human Services Bureau
1400 Carter Drive or P.O. Box 202956
Helena, MT 59620-2956
Telephone: 406-447-4260 or JNolan@mt.gov

Sherrie Downing, MTCOH Coordinator
Telephone: 406-443-0580 or Sherrie@MTCOH.org

With great appreciation to:

- The 2004-2006 MTCOH members
- Jim Nolan, MTCOH Sponsor
- MTCOH Co-chairs Lt. Governor John Bohlinger and Hank Hudson, DPHHS
- The Montana Continuum of Care Coalition
- Prevention Resource Center VISTA Project
 - Marcial Ornelaz, 2004-05 MTCOH VISTA
 - Dana LaBoy, 2006-07 MTCOH VISTA
- All those who generously participated in the Access; Special Needs Populations; Finance and Resource Development; Education, Employment & Training; and Housing workgroups.
- The Homeless Policy Academies, Policy Research Associates, Margaret Lassiter and Marty Fleetwood.
- A special thanks to istockphoto.com, for the royalty free images used in this publication.



Meanwhile...

by Carmen Gonzales, 2005

Today, many of you have come together to speak
On the chronically homeless and their right to a home.
Your intent is grand and greatly appreciated,
But the time frame for a solution
Has been truly underestimated.

This will take more than a week, a month or a year
Meanwhile, can't you see me?
I am right here, outside looking in,
Crying, hungry and full of fear.

Meanwhile...

I pray every day that while you work
On your plan for the future
You would not forget about me
And my immediate need for nurture.

Meanwhile...

It's so cold out here
As I watch you work,
I watch each of you develop
A mission for help and a plan for hope.

Meanwhile...

The wind is blowing while I am outside
looking in,
While you talk of shelters
And places that have heat
Did you know, that meanwhile, I am still freezing
And I can barely stand on my feet.



For hours you speak of
Our right to respect and dignity
Yet, I am here now, can't you see me?
I am outside, looking in.

I pray that while you are looking for answers
For those homeless yet to come,
That you don't forget about me.

Look outside your window,
And when you see me, please don't run.
For I am homeless now, I am hungry and sick,
I sleep under a tree with no leaves
No shelter and no one to love me.

I am dirty and in need of clothes
And while you're here,
Could you please look at my feet?
They're red, swollen and blue,
And my friend said he thinks I have the flu.

Well, it's getting late and your meeting's almost
done.

I honestly can't say that it's been fun.
But as long as you're looking for an answer
In my eyes, you'll be number one.

I'll be back next month to see if you're here
And maybe then I will be on the inside, looking out.
Because if you really want to know about homelessness,
Ask me, I will tell you what it's all about.



no longer

Homeless in Montana

a Report on the
State of Homelessness
and a Ten Year Plan to End It

2006 — 2015

www.mtcoh.org