

The Hidden Homeless: Addressing the Obstacles of the Rural Homeless in Rockbridge County, Virginia

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Abstract: Rural homelessness is an understudied subset of homelessness population in the United States. Yet, the rural homelessness has important distinguishing characteristics and barriers to care that make addressing the problems of this population more difficult than their urban counterparts. Given that rural communities face barriers of their own, HUD's Continuum of Care framework allows for such communities to overcome these barriers in the long-term. As such, there are a variety of ways in which a Continuum of Care can be devised to address the unique needs of each community's homeless population. Moreover, since rural homelessness differs from urban homelessness in important ways, communities, specifically Rockbridge County, should consider initial key factors as it begins to address its own population of rural homelessness. These factors include: invisibility and awareness consideration; coordination of services and diversity of needs; and scarcity of services and limited resources. As such, this paper argues that HMIS is the key driver for the process of Rockbridge County effectively addressing these three key factors, which in turn will lead to long-term implications for preventing homelessness in the community.

Introduction

Poverty, often misunderstood and hard to define, involves a complicated web of connections between various different elements. Likewise, homelessness occurs from a variety of circumstances. Yet, wherever it occurs, homelessness is inextricably linked to poverty and has been characterized as the “extreme end of poverty” (Post, 2002). With nearly 550,000 people experiencing homelessness in the United States, homelessness has become a major problem facing our country (AHAR Part 1, 2016). The Federal government and communities around the nation are striving to prevent and eliminate homelessness in the United States. However, until recently, an important subset of the homeless population has largely been left out of the discussion. While the geography of homeless may vary, there has historically been a lack of focus on the rural homeless, even though the consequences of it are remarkably similar to urban homelessness (Post, 2002). The importance of examining rural homelessness is to not only document the prevalence of the problem, but to also examine ways in which it can be differentiated from urban homelessness, and in which ways agencies can serve the unique needs of the rural homeless population (Robertson et al., 2007; NACRHHS, 2014).¹

Although rural homelessness has certain particular differences than urban homelessness, one should not discount that poverty, the number one predictor for homelessness overall, manifests itself in similar ways in both urban and rural environments (Robertson et al., 2007). Nationally, rural areas tend to have higher rates of

¹ Indeed the National Advisory Committee on Rural Health and Human Services (NACRHHS) has recommended the United States Interagency Council on Homelessness (USICH) to “consider how the rural population of individuals and families experiencing homelessness may need different policy solutions and practice models than those living in urban areas.” With USICH special populations working groups in place, including a family and youth working group, a veterans working group, and a chronic homelessness working group, the special needs of the rural homeless have been left of out the picture. (NACRHHS, 2014)

poverty and deep poverty, factors that contribute to homelessness (NAEH, 2009). Trends such as falling incomes from low-wage, seasonal or temporary jobs, rising rents, and severe shortages of low-cost housing also contribute to homelessness (HCH Clinicians' Network, 2001). Additionally, inequality in rural areas is widening against urban areas as "median family income among rural residents declined more significantly than among urban residents during the 1980s." In sum, "rural homelessness has become a symptom of the growth in rural poverty" (First et al., 1994). Yet, although poverty is measured similarly among rural and urban populations, homelessness looks quite different in rural areas compared to its urban counterpart (Shamblin et al., 2012).

Homelessness has become a serious and increasing problem in rural America. Not only are rural individuals between 1.2 to 2.3 times more likely to be poor than people in urban areas, but also from 2007 to 2010 the number of people in rural areas who used homeless shelters increased 57 percent (USICH, 2010). Additionally, the relative burden of the homeless that rural communities face is much heavier than those in metropolitan areas. While the overall number of homeless person is more numerous in urban areas, the prevalence of homelessness has been estimated to be higher in rural areas than in urban areas (Lawrence, 1995; Post, 2002; Robertson et al., 2007).² This higher incidence of the proportionate homeless in rural area presents in some cases even more of a challenge than in urban areas as the scale, density, and resources available of such rural communities is much more limited to provide services to the homeless than their urban counterparts (Patton, 1988; Lawrence, 1995).

² In some rural counties, the incidence of homelessness per 1,000 population is proportionately comparable to or greater than that in New York City, Los Angeles, and Washington, DC, the areas of highest rates of homelessness nationally. Some rural counties in Iowa, for instance experienced ten times the incidence rates as these cities (Lawrence, 1995; HCH, 2001; 2016 AHAR Part 1)

Based upon the Department of Housing and Urban Development's (HUD) mandated Continuum of Care (CoC) model for homelessness prevention, it is important to consider how communities should work within this framework so as to improve the well being and central capabilities of their own domestic rural homeless populations. Because the chief problems facing a rural homeless population are invisibility, diversity of needs, and lack of resources, Rockbridge County should, as a crucial initial step, increase awareness, facilitate deeper collaboration and coordination of services, and implement HMIS. To be clear, however, these are only initial steps, which, if successfully applied, are likely to have positive compounding effects to create capacity and ultimately address the larger needs of a rural homeless population.

1) How to Define and Distinguish Rural Homelessness

i) Defining Rural Homelessness

There are two main aspects that make defining what rural homelessness is difficult – one is what is 'rural' and, two is who is 'homeless.' One problem of studying rural homelessness is that there is no single definition of 'rural' to distinguish it from 'urban' locales (Levinson, 2007; HAC, 2008). To date, federal agencies and researchers have not settled on one definition of 'rural' but rather construct definitions specific to various uses (Robertson et al., 2007). Two of the more common definitions are based on the Office of Management and Budget (OMB) and the Bureau of the Census standards. Both define rural areas as those that fall outside certain areas: "metropolitan statistical areas (MSAs) in the OMB standard, or "urbanized areas and urban clusters" in the Census definition (Levinson, 2007). Further, a rural community can be defined to include

“(1) a county where no part is contained within a metropolitan statistical area, (2) a county located within a metropolitan statistical area, but where at least 75% of the county population is in nonurban Census blocks, or (3) a county located in a state where the population density is less than 30 people per square mile, and at least 1.25% of the acreage in the state is under federal jurisdiction” (Perl et al., 2015).

There also exist several different approaches on distinguishing between rural and urban environments. In distinguishing between urban and rural, a number of studies separate individuals into central cities, suburban and urban fringe areas, and rural areas (Burt et al., 2001).³ Additional variations include dividing rural communities into four types, including rural adjacent (contiguous to or within a metropolitan area), rural nonadjacent (not contiguous to a metropolitan area), urbanized rural (with a population of 25,000 or more and not adjacent to a metropolitan area), and frontier (fewer than six people per square mile) (Post, 2002). Moreover, under HUD’s Continuums of Care, rural areas typically fall under the ‘Balance of State’ classification, which can include both rural and suburban communities, with no distinction between the two. These cross-sectional geographic variations lead to the problem of drawing hard lines between urban and rural areas, as ‘rural’ areas can sometimes fall within an ‘urban’ area depending on the definition used. The lack of consensus on which communities are ‘rural’ and which are not has lent itself to unique problems in quantifying the rural homeless (Robertson et al., 2007; First et al., 1994; Post, 2002). Moreover, these various classifications crosscut

³ Central cities are defined as “the main or primary cities of MSAs;” suburban and urban fringe areas as “what is left of MSAs after central cities are taken out and can include smaller cities, suburbs, towns, and even open land if it is in the counties making up the MSA;” and rural areas as “all areas outside of MSAs that may also include small cities, under 50,000 people, towns, villages, and open land (Burt et al., 2001)

other geographic definitions making it difficult to separate pockets of rurality that are located in both metropolitan and non-metropolitan areas. Therefore, developing a coherent definition which distinguishes the rural and urban continuum is necessary for comparing findings across studies in order to better understand the problems of the rural homeless (Robertson et al., 2007).

The other definitional issue that affects rural communities is how to define 'homeless.' Over time this definition has changed – for example, before the implementation of the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act definition of homelessness, people experiencing persistent housing instability were not defined as homeless (Feldhaus et al., 2015). However, the HEARTH Act amended and reauthorized the McKinney-Vento Homelessness Assistance Act, which included a change in definition. This new definition of homeless includes four broad groupings including: literally homeless; imminent risk of homelessness; homeless under other statutes; and fleeing or attempting to flee domestic violence (Feldhaus et al., 2015). However, individuals who are living temporarily with family and friends in “doubled-up” situations, a common feature of rural homelessness, are not defined as homeless under this definition. Additionally, many service providers use simplified definitions, such as SMAHSA’s PATH or CHAB definitions, when working with programs that do not mandate the use of HUD definitions.

Along with defining homelessness is the problem of establishing parameters for ‘adequate’ housing. For instance, “in urban areas, researchers have the option of including selective groups of people with temporary housing, such as the portion of the homeless served by shelters. In truly rural areas, such an option is unavailable because

formal services such as shelters are virtually nonexistent; residents who become homeless must rely on friends, neighbors, and relatives for temporary housing (Patton, 1988).”

Moreover, “although persons living in housing that has been condemned can be defined as homeless by HUD, a formal and consistent condemnation process does not exist in most rural communities. This means that a structure considered ‘not fit for human habitation’ in Washington, D.C., would not be designated as such in Viper, Kentucky” (Robertson et. al., 2007; NACRHHS, 2014)”. These differences of who is included as being homeless, especially considering rural-specific factors, such as sub-standard housing and the action of ‘doubling-up’, makes it difficult not only to differentiate the rural homeless population from the rural low-income housed population, but also makes it burdensome to effectively track the homeless since definitions are not truly comparable (Robertson et al., 2007).

ii) Characteristics of the Rural Homeless

As the following two sections demonstrate there are a number of key characteristics of the rural homeless, perhaps none more important than invisibility. The current population of the rural homeless owes part of its unique characteristics to specific historical events that have in turn affected rural homelessness. Demographic changes in rural communities since the early 1970s have contributed to persistent poverty, changed the ability for friends and family to mobilize support to help neighbors in times of financial distress, overwhelming former local support networks, and have led to escalating housing costs (Patton, 1988; Blau, 1992; Johnson, 2006; Robertson et al., 2007). Additionally, there was a small migration of the homeless towards urban centers, not for shelters, but mainly for better housing and work (Levinson, 2007). These

demographic shifts from rural counties to urban areas and out of state helped add to the economic distress in rural areas, helping contribute to rural homelessness in general (Lawrence, 1995).

Rural communities have also faced a reorientation of their economies in recent decades. From 1981 to 1987, 650,000 farm foreclosures occurred with an estimated 500,000 jobs lost in low-wage, labor-intensive rural manufacturing industries, leading to an agricultural decline and uneven transformation of rural labor forces (First, 1994; Lawrence, 1995). This “economic restructuring” during the early 1980s helped form some of the structural factors that the rural homeless currently face (Robertson et al., 2007). Because of these factors “the homeless could [suddenly] be found in cars in Coventry, VT, under bridges in Des Moines, IO, and in caves near Glenwood Springs, CO” (Blau, 1992). In sum, these economic and demographic factors, along with the geographic climate in general, have contributed to rural homelessness having uniquely different characteristics from the urban homeless.

The rural homeless exhibit distinct tendencies that distinguish themselves from their urban counterparts. For instance, the rural homeless tend to have lower educational levels (more than twice as likely to drop out of high school). Likewise, while they tend to have higher rates of employment, these jobs are often seasonal, low-paying and with no benefits (Post, 2002; Levinson, 2007; NACRHHS, 2014). They are also more likely to receive income assistance from friends and family and less likely to receive government benefits (Post, 2002; NACRHHS, 2014). Additionally, they are more likely to be residing in their county of birth, hinting at the strong familial and cultural ties the rural homeless feel (Post, 2002). The rural homeless are also more likely to be without health insurance.

In addition, they tend to have less access to medical care. More importantly, according to clinicians, health problems seen in both rural and urban homeless populations tend to be more advanced in rural patients, who typically have more untreated, chronic health problems (Patton 1988, Post, 2002).

The rural homeless also have different experiences with being homeless. Importantly, in contrast to their urban counterparts, they are typically homeless for the first time and experience shorter and fewer episodes of homelessness during their lifetime (Post, 2002; Levinson, 2007; NACRHHS, 2014). In fact, 55 percent of the rural homeless have been homeless for three months or less, compared with 22 to 27 percent of the urban homeless (Burt et al., 1999). Because of this, the rural homeless are less likely to wind up on the streets, as is the case with urban homelessness. Instead, they are more likely to sleep in their vehicles, or in state or federal campground areas, or in substandard housing (Fantasia, 1994; Post, 2002; NACRHHS, 2014). They are also two to four times more likely to live temporarily in private housing with friends or family, a term called ‘doubling-up’ (Post, 2002; NACRHHS, 2014).

Compared to the urban homeless, the rural homeless have different histories with drugs, alcohol, and the police (Post, 2007; Levinson, 2007). However, similar proportions (64 to 68 percent) of both the urban and rural homeless have a current mental health and/or alcohol and/or drug problem. Yet, the urban homeless (~21 percent) are more likely than rural clients (11 percent) to have problems with both mental health and alcohol and/or drug use (Burt et al., 1999). Nonetheless, they are nearly six times more likely to report having an alcohol-only problem during the last year (Post, 2007; Levinson, 2007). However, one should note that the lower percentages present in rural homeless

populations could be due to individuals not reporting drug or alcohol problems due to the stigma of reporting and social costs of being known as a user. Similarly, the rural homeless tend to have higher rates of incarceration (Post, 2002). For instance, 64 percent of the rural homeless have spent time in juvenile detention, jail, or state or federal prison, compared with 55 percent of those from central cities and 44 percent from suburban areas (Burt et al., 1999). This is due in part to the stigmatization of being homeless in small communities, as small, rural communities typically attach a stigma to those seeking government assistance (O'Hare & Johnson, 2004; Robertson et al., 2007). As a result of this stigma, among various other factors, the homeless in rural areas are typically more criminalized than their urban counterparts, resulting in higher incarceration rates – the cultural stigmatization compounds these issues.

Demographically, the rural homeless tend to be younger, include more women, fewer minorities, and more migrant and seasonal workers (Fantasia, 1994; Levinson, 2007). For instances, 26.4 percent of the sheltered homeless in rural and suburban areas were children compared to 20.7 percent in cities. Likewise, 32.3 percent of sheltered individuals in these areas were women, compared to 28.7 percent in cities (AHAR Part 2, 2015). Additionally, a 2008 analysis by the National Alliance to End Homelessness also suggests that rural areas have a higher than average rate of family homelessness (NACRHHS, 2014). Within BoS CoCs, which are typically proxies for the counting the rural homeless, 41 percent of the homeless were in families, compared to 35 percent in major cities and 34 percent in smaller cities and regions. Additionally, these CoCs have a lower share (12%) the national total of sheltered veterans (17%) (AHAR Part 1, 2016).

Finally, rural areas typically provide a varying range of services from urban areas as well as exhibiting differing trends of deploying such services. Rural areas tend to dedicate a larger share of their bed inventory to emergency shelters compared to more urban areas favoring permanent supportive housing (PSH) (NAEH, 2009). However, this trend seems to be reversing as the number of PSH individuals in rural and suburban areas increased 22.4 percent between 2014 and 2015 while the number of shelter programs decreased 3.2 percent. Likewise, between 2010 and 2015, there was a 37.5 percent increase of PSH individuals with a 26.1 percent decrease in sheltered homelessness (AHAR Part 2, 2015). Yet, the number of homeless families, specifically those with children, is increasing. Between 2007 and 2015, homeless sheltered families with children increased by 38 percent in rural and suburban areas, but decreased 5.5 percent in urban areas (AHAR Part 2, 2015). More alarming, is that the percent of families with children who are unsheltered homeless is nearly double the percentage than those in urban areas. In addition, during the same time, the number of individuals experience sheltered homelessness dropped 16 percent in cities but rose 7 percent in rural and suburban areas (NAEH, 2009).

iii) Why the Rural Homeless Have Been Overlooked

Rural homelessness has typically been left on outskirts of the broad discussion of homelessness within society, leaving the issues of rural homelessness invisible. For instance, rural locales were left out of HUD's evaluation of its Continuum of Care program in 2002, and USICH has mentioned in its government-wide homelessness report that knowledge about rural homelessness needs to be increased (HUD, 2002; USICH, 2010). Moreover, researchers of rural homelessness have realized that the "experience

and trajectory” of rural homelessness is not well documented (Robertson et al., 2007). Much of the early research on homelessness focused on urban areas, whereas researchers are still in the early stages of acknowledging and understanding the intricacies of rural homelessness (Robertson et al., 2007; Cloke et al., 2000). Two main issues have limited the degree to which rural homelessness has been the focus of research; they include: invisibility as well as structural concerns and difficulties in measurement.

Geography along with the unique characteristics of the rural homeless affects the issues of visibility and measurement of the problem of rural homelessness. For one, urban homelessness is more visible given the homeless on the street, whereas the rural homeless are largely out of sight due to cultural and infrastructure factors, among others. Since the rural homeless do not usually sleep in visible spaces, there has become a general perception that this problem does not exist in rural communities (Burt et al., 1999). This has led to a dominant construction of homelessness taking place within the space of urban, more concentrated, visible settings. In turn, this has left rural homelessness largely out of sight of policy discourse as the traditional view of homelessness has been framed in an urban context and as an urban issue (Cloke et al., 2000; Cloke et al., 2001; Cloke et al., 2007; NACRHHS 2014). HUD recognizes this visibility concern as it states in a guide for rural CoCs: “People taking shelter in seasonal hunting or fishing cabins, campgrounds, abandoned barns, trailers or in vehicles are simply not visible to the general public or government officials. This lack of visibility can make it difficult to engage the community to take action or to persuade government officials to invest public resources in affordable housing and services to the homeless” (NACRHHS 2014).

Another significant problem for increasing awareness and knowledge of the rural homeless population arises from the inability to accurately measure the extent of the problem. Not only does the definitional issue exacerbate this problem, but so does the extent to which service providers can locate and sample the homeless. For example, as illustrated earlier, the rural homeless sleep in hard-to-find or invisible areas across a very broad region, making the costs of canvassing these large expanses prohibitive. Some have even said enumerating the rural homeless is “virtually impossible” (Robertson et al., 2007). Currently, there is no national survey that quantifies the number of rural homeless, although HUD’s Point-in-Time (PiT) count can act as a proxy for counting the rural homeless by using Balance-of-State CoC estimates as the preferred measurement of counting the rural homeless. However, this measure is not optimum and the heterogeneity between rural and urban areas across CoCs makes it difficult to separate the rural homeless from the urban homeless. Moreover, PiT counts consist of counts of the homeless in shelters, or know areas of congregation, whereas shelters or congregated locations are not as prevalent in rural areas, adding another layer of difficulty to the problem (Feldhaus et al., 2015; HAC, 2016). More importantly, is that this discrepancy leads to a vast undercount of the homeless in rural locations (Patton, 1988, First, 1994; Robertson et al., 2007; HAC, 2008; NACRHHS, 2014; Feldhaus et al., 2015). The effect of such undercounting leads to challenges of determining need, which in turn hinders policy creation as well as funding to address the problem of rural homelessness. In sum, invisibility of the problem are significant characteristic that make addressing rural homelessness difficult.

2) The Issue of Barriers

i) Barriers Facing the Homeless

While the rural homeless face a variety of barriers to obtaining adequate access to services, including cultural as well as personal factors, the majority of the barriers are structural. The interaction between these factors is difficult to untangle, yet rural homelessness is “fundamentally” due to an interaction between these aspects (Vissing, 1996; Robertson et al., 2007). Thus, while the variety of these barriers are the most significant challenges to addressing rural homelessness, certain important measures need to happen, namely addressing invisibility and coordination, before these barriers are overcome.

There are a number of structural factors, which act as barriers to care, that have rooted themselves in rural areas. They include: higher rates of poverty, low-income, unemployment or lack of employment opportunities, and exposure to the elements, as well as the chronic stress inherent in finding food and shelter (Patton, 1988; Post, 2002, NACCRHS, 2014). However, these factors can typically be found in urban settings. Nonetheless, the rural homeless still face a more severe set of structural factors than do their urban counterparts.

One important overarching barrier is that rural communities typically have fewer service providers than urban areas thereby limiting the variety of services and care available (Cloke et al., 2000; HAC, 2008; NACRHHS, 2014). More importantly, there are few homeless-specific providers present in rural areas and mainstream services, which the homeless may need, are not typically organized to accommodate homeless populations. Likewise, there is a general lack of access to healthcare in rural communities.

Examples include lack of health insurance and other entitlements, inaccessible or inadequate mental health and substance abuse services, dental care, limited access to secondary & tertiary care, and various barriers related to primary care, such as linguistic and cultural ones (Vissing, 1996; HCH Clinicians' Network, 2001; Post, 2002; Robertson et al., 2007). Furthermore, because of factors such as persistent poverty and the general lack of medical facilities and practitioners in rural areas, it becomes arguable that homeless families and children are at even a greater risk for health problems than their urban counterparts. Likewise, interviews of rural homeless clinicians show that morbidity from chronic medical conditions are often greater in rural areas than in urban areas because the rural homeless often remain untreated for longer durations (Post, 2002; Robertson et al., 2007). Though these barriers are not unique to rural populations, they are more severe among this population due to the isolation and geography of rural places and the sparse populations present in them.

One other main issue they face is a shortage of high-quality, affordable housing (Patton, 1988; Cloke et al., 2000; NACRHHS, 2014; NAEH, 2016; HAC, 2016). Within rural areas, there is a lack of low-cost affordable housing that limits the ability of impoverished individuals and families to obtain housing, which in turn may lead to homelessness. Additionally, even when subsidized public housing is available, it is typically located in larger rural or suburban towns and not in the smaller communities where the rural homeless are found. Yet, even regardless of location, the waiting list for such habitations can stretch for years (Patton, 1988). Moreover, the availability of housing options which may provide permanency are, in increasing proportion, often out

of financial reach for the rural homeless population and fall below standards of acceptability (NACRHHS, 2014).

Another substantial issue is the lack of transportation (Patton, 1988; Fitchen et al., 1992; Post, 2002; USICH, 2010; NACRHHS, 2014; NAEH, 2016). The lack of transportation impedes the rural homeless' access to jobs, services, healthcare, education, and affordable housing. The geography of rural areas also compounds these problems as large distances must be travelled in order to reach these sparse services, and often there is limited or no public transportation available. Research has even found that lack of transportation was often associated with homelessness in rural areas (Fitchen, 1992). In essence the problem can be measured not only in lack of transportation options available, but also in both distance and travel time.

Outside of the structural factors that can act as barriers to care provision, there occur some specific cultural influences that affect the access to services for the rural homeless. In general, rural communities show characteristics of having close social ties, especially between family and friends, reluctance to seek outside help, a desire for privacy, especially with regards to private problems such as drug or alcohol abuse, and a tradition of providing voluntary support to others within the community (Robertson et al., 2007). Specifically as it affects homelessness, there is a 'blame the victim' mentality present in many rural communities, where individuals tend to blame the homeless on individual failure instead of structural problems (Lawrence, 1995; HCH Clinicians' Network, 2001; Post, 2002). Additionally, the tradition of providing help to friends and family has waned in prevalence as negative economic pressures have affected the effectiveness of these informal support systems, thus increasing the relative burden of the

growing rural homeless on rural communities. Likewise, a few personal factors, such as specific strategies to deal with homelessness, act as barriers to the rural homeless themselves. One strategy is to ‘move in’ with friends and family until they find suitable housing or wear out their welcome. Another is to ‘make do’ with limited opportunities and to go without certain services. Likewise, some ‘move out’ to substandard housing or other areas such as abandoned shacks or campgrounds. Finally, some ‘move on’ to more urbanized areas where services are more readily available (Cloke et al., 2000; HCH Clinicians’ Network, 2001).

ii) Barriers Facing Rural Communities and Service Providers

Many of the same barriers that face the rural homeless also face the communities, which try to serve this population. Issues such as lack of transportation, substandard housing, and lack of adequate medical care affect the effectiveness of outreach of services to the rural homeless (Stefancic, 2013). More specifically, low population density makes it difficult for rural areas to justify the existence of a full range of services for the homeless in every community. Instead, these services are typically dispersed across a large geographic region, further compounding the effectiveness of service provision. Moreover, rural areas tend to have “generic services” rather than homeless-specific ones due to lack of resources, as well as variability in demand (Burt et al., 2001). Likewise, many of the local philanthropic organizations present in rural communities are not able to effectively address the needs of the rural homeless (USICH, 2010). Though, even if homeless-specific services are available, they are typically small and geographically dispersed (Patton, 1988). More importantly, services providers in general face various problems that affect their effectiveness. For one, many services are scarce.

Additionally, some service providers may be implementing inappropriate service models for the rural environment, may lack the competence to treat the various problems of the homeless, and may exhibit smaller scale teams due to lack of resources (Laudan, 2006; Robertson et al., 2007). As it regards healthcare, primary care physicians, already short in number, are the main source of healthcare for rural communities. As such, they may lack the adequate training to address the diverse health and behavioral health problems of the rural homeless population. This is compounded by the fact that specialists are typically lacking in rural communities.

Additionally, there is the general problem of definitional issues and measurement concerns that make it difficult for rural areas to adequately assess the need of the rural homeless in their communities. Not only does this affect their ability to deploy resources and services effectively, but also makes it difficult to justify the need for funds. Compared to the similarities between the barriers that face the rural homeless and rural communities, the primary structural barriers of communities include geographic dispersion and low population densities. Not only does this contribute to the low number of effective services, but it also increases the cost of services per capita compared to urban areas.

Similar to this issue is the availability of funding to rural communities, which can ultimately affect the lack of resources. For instance, federal funding for homelessness programs in rural areas has been historically low. However, the HEARTH Act has sought to remediate the problem of funding within rural areas in that not less than 5% of CoC Program be set aside for rural communities (Perl, 2015). Additionally, rural communities have more flexibility in access to funds in that P.L. 111-22 provides that HUD may

award grants to rural communities to be used for (1) rehousing or improving the housing situation of those who are homeless or are in the worst housing situations in their geographic area, (2) stabilizing the housing situation of those in imminent danger of losing housing, and (3) improving the ability of the lowest-income residents in the community to afford stable housing. While these provisions help to provide needed funds to rural communities, there exists a significant disparity in federal spending between rural and urban community development – two to five times more per capita is spent in urban areas (Robertson et al., 2007). Moreover, while 5% of CoC Program funds must go to rural areas, ‘rural’ under this definition includes BoS CoCs meaning that rural areas must negotiate, plan, and compete for resources on a regional or statewide basis.

3) The Role of Continuums of Care in Addressing Homelessness

In order to address the diversity of needs of homeless populations, coordination, through a Continuum of Care, will set the stage for overcoming the aforementioned barriers eventually. The Department of Housing and Urban Development’s framework of Continuums of Care has evolved through a few different phases during the past three decades, continually adapting to data-driven and evidence-based best practices to combat homelessness in the United States. The first significant federal measure to prevent homelessness was the McKinney-Vento Homeless Assistance Act of 1987, which, among other things created the Interagency Council on the Homeless made up of heads of 15 federal agencies, reflecting the need for coordination due to the “fact that homelessness is a problem that relates to a large number of existing problems” (Hambrick and Rog, 2000). Seven years later in 1994, HUD implement its CoC approach to streamline the existing competitive funding and grant-making process under the McKinney-Vento Act as well as

to encourage communities to better coordinate resources and services for homeless individuals and to reduce fragmentation within service systems (HUD, 2002; Culhane and Metraux, 2008; Ellen and O’Flaherty, 2010).

The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 then reauthorized and amended the McKinney Vento Act. The HEARTH Act consolidated HUD’s competitive grant process, changed the definition of homelessness and chronic homelessness, and placed greater emphasis on performance and prevention resources, such rapid rehousing and permanent supportive housing (HUD, 2002; NAEH, 2016). It also mandated three homeless prevention programs, including the CoC Program, which provides funding to nonprofit, government, and other entities that serve persons experiencing homelessness within a defined geographic area, the Emergency Solutions Grants Program, which provides grants to states, metropolitan cities, and urban counties to help homeless person quickly regain stability in permanent housing after a housing crisis, and the Rural Housing Stability Assistance (RHSA) Program, which grants rural areas that choose to participate flexible funds and broader eligibility for people needing assistance. To date, however, RHSA has not been funded so rural communities are still formally operating within the CoC Program (HAC, 2016; Feldhaus and Sloane, 2015; HUD, 2002).

As such, a review how CoCs operate is beneficial to understand before analyzing best practices certain rural communities have used to fight and prevent homelessness in their areas. In sum, CoCs now guide the award of competitive McKinney-Vento Act funds, incentivize localities to coordinate services and to develop long term plans, and continue the “evolution of public policy responses” to acknowledge the multifaceted

nature of homelessness (Wong et al., 2006). Thus, involvement in a CoC will in turn help overcome the barriers the rural homeless and community face in the long-term.

i) Overview of Continuums of Care

Arrangement of CoCs has both mandated and unmandated specifications to facilitate different models for homeless service delivery. CoCs include four different programmatic services, which include outreach, intake, and assessment; emergency shelters; transitional housing; and permanent supportive housing (Wong et al., 2006; NACRHHS). An entire CoC, however, includes seven distinct components – prevention, outreach and assessment, emergency shelter, transitional housing, permanent supportive housing, and permanent affordable housing, as well as supportive services in all of these components (HUD, 2002). An important aspect of the CoC program is that there is no federal pre-specification of how CoC planning is configured within communities, as doing so would run the risk of weakening the varied organizational patterns pursued by many communities (HUD, 2002). Ultimately, the exact configuration of housing and services depends upon the needs and preferences of the population (HUD, 2002). However, most CoCs commonly organized around two main goals – planning the homeless housing and service system in the community and applying for funding from the HUD’s competitive McKinney-Vento Act programs (HUD, 2009).

While communities may differ in their approach to organizing their response to homelessness prevention, in order for communities to receive HUD funding through the CoC Program, they must follow certain guidelines. One of the main requirements is that homeless service providers must coordinate with other mainstream services in the

community to provide a more streamlined connection to services for homeless persons (USICH, 2010). A component includes the stipulation that local communities establish CoC advisory boards made up of representatives from local government agencies, service providers, community members, and formerly homeless individuals. The goal of such a board is to determine local priorities and establish strategies to combat homelessness within their communities, which develops into adopting a written CoC plan, as well as application for and distribute HUD funds (Perl et al., 2015).

Additional guidelines community organizations must follow focus on effectiveness and measurement concerns. Community organizations are expected to collect needs data and inventory service capacity to help outline the community's existing capacity to serve its homeless population. This includes participating in HUD's biannual PiT counts of the entire United States' homeless population by completing one at least once every other year (HUD, 2009). Finally, as a part of the application process, HUD requires that communities present a gaps analysis, which illustrates the disparity between the need of the homeless population and the current inventory of programs and services that meet that need. Projects are then proposed that meet at least part of said identified need to HUD to compete for funding (HUD, 2002). HUD also expects that each CoC implement its Homeless Management Information System (HMIS), which collects and manages data based off of HUD's reporting standards for homelessness.

Communities can also implement varying mechanisms to facilitate differing types of entry into homeless assistance networks. HUD defines three broad classifications to achieve this. The first is "fragmented" where homeless individuals people may "directly approach any provider in the network, may (or may not) gain entry, and may or may not

get connected to other programs and services.” The second is “no wrong door” where homeless individuals “gain access by approaching any program, after which program staff augment these first contacts with shared knowledge of what is available and systematic linkages that help clients get to the right programs and services.” Finally, there is the “centralized” intake method, where there is one linked point of entry, which allows for uniform intake and assessment and helps ensure equity of access to services.

It should be noted, however, funding for homelessness does not only come from HUD through the CoC program. In fact, research shows that no single funding source contributed to 50% or more a program’s budget (Wong et al., 2006). As such, HUD urges communities to take advantage of coordinating mainstream programs, such as public housing and vouchers programs, SNAP, SSI, SSDI, TANF, job training, health care, mental health care, substance abuse treatment, and veteran programs, in order to better respond to the diverse needs of the homeless population (HUD, 2002). Ultimately, the overall goal and impetus for coordination among systems of care is to create an inclusive environment where “the unique needs of each client are provided for by bridging services, thereby creating an individualized and comprehensive care system” where communities establish priorities together and in consultation with one another (Skott et al., 2008; Hambrick and Rog, 2000). Thus, the ideal CoC model is a system wide planning process in each community, which results in a “seamless system of services that enables individuals and families to receive the appropriate set of services depending upon their own unique needs,” (Hambrick and Rog, 2000). In sum, a CoC is “a community plan to organize and deliver housing and services to meet the specific needs of people who are

homeless as they move to stable housing and maximize self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness” (HUD, 2002).

ii) Issues with Continuums of Care

HUD’s CoC Program is not without its detractors or issues, however. One of the main arguments against CoCs is that they are a linear model, where the homeless must progress through certain steps to ‘make’ them ready for permanent housing, which is offered only at the end of a series of interventions. In response to this linear continuum, Housing First emerged as an alternative approach, which instead prioritized providing housing as quickly as possible along with the provision of voluntary supportive services. However, CoCs are not designed as linear continuums. Figure 1, borrowed from HUD, illustrates the different components of the CoC framework. It helps to illustrate that there is no required direction or set of steps that every homeless person is expected to pass through. Moreover, HUD notes that the “solid arrows in the figure reinforce this lack of linearity, showing that people may pass from outreach to any one of the housing components, or from emergency shelter directly to transitional, permanent supportive, or affordable housing” (HUD, 2002). Thus, while linear models do differ from the Housing First approach, CoCs are not linear models and are more dynamic to the needs of the homeless.

Nonetheless, permanent supportive housing (PSH), along with the other program features of the CoC framework, has often been seen as different from the Housing First approach. However, Housing First is not precluded from the CoC framework as communities ultimately decide how they want to configure their resources and services.

Moreover, USICH and HUD both endorse Housing First as a proven approach to helping end homelessness (HUD, 2007; USICH, 2010; HAC, 2016). Two common program models currently follow the Housing First approach. The first, PSH, is targeted to those with chronic or complicated problems who need long-term rental assistance and supportive services. The other, rapid rehousing, focuses on a wide array of homeless individuals and provides short-term rental assistance and services (NAEH, 2016). HUD in fact encourages a permanent supportive housing model using the Housing First approach and outlines ways in which it can be implemented in different types of PSH settings (HUD, 2002; USICH, 2010). Thus, Housing First is an evidence-based approach, which HUD endorses and encourages within different CoCs (HUD, 2002; HUD, 2007).

Even so, there are still several issues within the CoC framework that can limit its effectiveness. Research in other fields, specifically mental healthcare, have showed that “although an integrated continuum of care [provided] better access, greater continuity of care, more client satisfaction and less restrictive care, it was more costly and did not affect clinical outcomes” (Bickman, 1996; Hambrick and Rog, 2000). However, these studies only provide indirect evidence against the CoC model implemented by HUD. Thus, the extent to which these findings apply to the diverse and complicated issue of homelessness is uncertain (Hambrick and Rog, 2000). Another potential issue with CoCs is the implementation of HUD’s HMIS software. While such a streamlined and standardized system of data collection and management does have its benefits, there still exist significant barriers to its successful execution. One large issue is the cost of implementing and operating HMIS, which includes both time and resource constraints. Time constraints include the time to train staff and volunteers and the time to go through

the many actions needed to successfully implement and maintain an HMIS system.

Resource constraints include funds to troubleshoot any technical problems as they arise as well as potential salary for a data systems manager (HUD, 2002). Additionally, it might be hard for community organizations to request volunteers to learn a new software program for they may be more comfortable with the way they have been collecting data, if any.

Service providers might also already be using existing data systems other than HMIS to meet other federal or state data requirements that differ in purposes than HUD's HMIS, which leads to compatibility issues. Finally, there are concerns about confidentiality of client data and sharing case management or client data to other providers with access to the CoCs HMIS.

iii) Affirmation for Continuums of Care

While HUD's CoC program does have some potential issues, many of its benefits have achieved the goal of increasing cooperation among service providers, which has ultimately helped reduce the number of the homeless within the United States. Since its implementation one of the most notable developments is the "collective impact approaches" to ending homelessness (USICH, 2010). Previously, homeless services experienced a high level of fragmentation, with organizations working independently and without shared goals to eliminate homelessness. Moreover, the set of human services available to individuals has developed segmentally whereby housing services are separate from mental health services, which are separate from employment services etc. Each of these different categories of service providers also has different funding streams as well

as separate set of regulations to follow (Hambrick and Rog, 2000).

The need for collaboration and connection between varied resources is especially important long-term to overcome the barriers of the rural homeless given that they typically deal with a full range of problems. Thus, the ability for CoCs to connect a wide breadth of human services, which are relevant to the homeless population, allows homeless individuals to gain access to multiple agencies and service systems. The success of the CoC model lies in its capability to link unrelated resources, such as social, psychological, financial, medical and others, which are important and relevant supports to the diverse needs of the homeless population (Skott et al., 2008). Importantly, this coordination of a variety of social supports has helped reduced the incidence of homelessness in communities (Skott et al., 2008; Hambrick and Rog, 2000).

Coordination under the CoC model has also led to investments that are directed towards evidence-based practices and has increased data-driven decision-making among communities. As outlined in requirements of CoCs, stakeholders must collaboratively work towards setting specific and measurable goals, whereby resources are leveraged, coordinated, and aligned across various silos and sectors (USICH, 2010). As a result, there has been a significant increase in communication and information-sharing, which has led to different components of the assistance network knowing which services are available and how to develop joint or coordinated programming to deploy these resources to at-risk populations, specifically the homeless (HUD, 2002). Research has also shown that such collaboration and coordination has decreased costs, increased community building, and reduced duplication and waste in service delivery (Robertson et al., 2007). In sum, effective coordination should improve the scope of resources and services

available to the homeless population. Furthermore, communities who take part in CoCs have mentioned that HUD's funding structure under the CoC framework has moved service providers towards greater planning, which, over the years, has come to include a broader scope of services and involve more stakeholders (HUD, 2002). The incentive of federal funding has also helped bring such communities towards coordination within a CoC (Burt et al., 2001). These communities also mentioned that there have been major beneficial effects on their respective homeless assistance network by requiring a coordinated community-wide approach (HUD, 2002).

Finally, data from the Annual Homeless Assessment Report (AHAR) to Congress provides evidence that CoCs seem to be working in preventing homelessness. Since the first AHAR in 2007, there has been a 13 percent decline in the amount of homeless on a single given night in January. Moreover, this long-term decrease has been driven “entirely by reductions in the number of people living on the street or in other unsheltered locations, a population that dropped 32 percent between 2007 and 2015.” In addition, between 2007 and 2015, the number of the total number of individuals who experienced homelessness within an entire year (1.48 million) dropped 7 percent (104,019 fewer homeless). As further evidence, during this eight-year time span, two important federal initiatives were implemented, including the 2009 HEARTH Act, which increased the role of CoCs, and the 2010 USICH Federal Strategic Plan, which outlined a broad-based approach to ending homelessness through coordination of various federal departments (HUD, 2015).

4) Effectiveness of CoCs in Rural Communities: Evidence and Trends

Given the uniqueness of rural homelessness in relation to urban homelessness, it is useful to examine what strategies and measures successful CoC have executed, both generally and specifically in rural areas. One thing to note is that, given the flexible nature of CoC implementation, it is difficult for anyone to develop generalizations of what might work well in one community will work equally well in the next. Nonetheless, there are general best practices which community agencies should attempt to fulfill in order to operate most effectively and efficiently within the CoC framework. In doing so, communities will be able to better address the diversity of needs of the rural homeless population. Ultimately, while the underlying factors that cause homelessness in rural and urban areas are similar, the strategies that work in urban areas might not be effective in rural areas given how homelessness manifests itself differently in rural areas (HUD, 2009).

i) General Trends of Successful CoCs

Broadly, successful CoCs exhibit general trends that fall within the following categories: enhanced coordination, programmatic elements, measurement performance, and leadership. Successful CoCs tend to have year-round planning processes that are inclusive and outcome-oriented, while at the same time identifying and incorporating potential stakeholders. Specifically, the most impactful CoCs recognize that mainstream agencies need to be involved in the larger planning processes rather than just in the application process for HUD funding. As such, they leverage mainstream services outside of those focused solely on homelessness and integrate their services and delivery system into the overall homeless assistance system. In integrating these mainstream services and

systems, according to HUD, different communities have used a variety of the following strategies to achieve increased levels of mainstream agency involvement (HUD, 2002):

- Having staff with the responsibility to promote systems/service integration,
- Creating a local interagency coordinating body,
- Co-locating services mainstream services within homeless-specific agencies and programs, and
- Having a centralized authority for the homeless assistance system,
- Adopting and using an interagency management information system

Another unique feature successful CoCs exhibit is their emphasis on intensive case management and motivational interviewing. This practice has increased not only attention to the specific individual needs of each homeless person but also increased the level of trust between the service agency and client (NCFH, 2009). Outreach was another important operational factor, which many CoCs pursued. Many focused their outreach on the hardest to serve homeless individuals, such as those who might not use services due to lack of awareness or active avoidance, and who would otherwise be ignored or underserved (HUD, 2002). The ultimate goal of such outreach methods was to provide linkages to services and resources and help people get connected to needed services. Additionally, HUD's identification of some of the most successful CoCs shows that the majority of the communities complete their HUD applications for funding with paid positions to orchestrate the planning process and write the application (HUD, 2002).

Successful CoCs also continually monitor, measure, and reevaluate the performance of both providers within the system as well as the system itself. This

includes a review of current operating policies and procedures to enhance coordination with other service providers and to identify ways to streamline and shorten the referral and admission process (Wong et al., 2006). Such monitoring helped guide CoCs when they began long-term planning as it provided, in some cases, evidence-based solutions and helped facilitate data-driven decision-making (HAC, 2002). Strong leadership is another core feature of successful CoCs. HUD has noted that a “lead organization that has strong leadership, access to resources, and high visibility can provide a continuum with the credibility needed to attract broad-based participation in the community” (HUD, 2009). HUD has also noted that strong leadership is “essential” to an effective CoC. Additionally, strong leadership has shown to help long-term planning as well as coordination among service providers (HAC, 2002). However, as with CoCs in general, there are many ways in which this leadership presents itself in different CoCs.

Given the uniqueness of the challenges that rural communities face, different success factors are more relevant in rural environments. For instance, NAEH identified five “critical success factors” for rural communities. They include (NAEH, 2016):

- An identified “glue person” that maintains both a high level understanding and detailed perspective of the Continuum and its activities
- A “champion” for ending homelessness that has the trust and respect of community members, as well as the skills to build relationships both inside and outside of the homeless system
- A high level of stakeholder involvement and leadership in the Continuum of Care planning process

- Implementation strategies that reinforce inclusion, coordination, and collaboration across homeless system agencies and programs, both public and private
- A willingness to think “outside of the box” to achieve key goals within the homelessness assistance system

The “champion” NAEH identified within communities works closely with the “glue person” and other leaders in the CoC to progress forward. NAEH recognized the “champion” as one person, usually per rural locale in the CoC, who people trust and listen to, such as a faith-based or community leader, and who believes in the work and proposed solutions of the CoC framework. The “glue person” is the one who holds it all together and is typically the administrator or coordinator of the regional CoC.

Likewise, as with successful CoCs elsewhere, coordination and involvement of mainstream and other community services is critical for rural communities, though the arrangement of such services typically differs. The NAEH study illustrates that working with such agencies can “provide a more comprehensive, interconnected safety net for consumers, as well as increasing the resources available to a homeless assistance system,” a crucial aspect given the lack of services in rural areas (NAEH, 2016). Collaboration with local providers, such as, faith-based groups, schools, and other non-traditional partners, as well as businesses, foundations, and government agencies, has been a typical feature of successful rural CoCs. Additionally, building strong partnerships with local landlords and tenants has, in some cases, led to successfully housing many of the homeless population without the need for subsidies. In sum, it is important for rural CoCs to go beyond the border of the homeless services assistance system to access a variety of other services given not only the general lack of services in rural communities, but also

the limited amount whose sole focus is specifically related to homelessness. However, given the wide variety of rural communities, including different community size and proximity to urban areas, the organization and delivery of such services takes different forms (Aron, 2006). As such, one emergent theme of high importance among rural communities is the ability to build capacity among service providers and stakeholders while at the same time managing the various responsibilities of partners. This is especially important given the broad and very diverse base of potential partnerships that all have different service provision focuses (HUD, 2009). In order to successfully build sufficient capacity to provide the services needed to address rural homelessness, rural communities should consider the following: establishing a dedicated continuum coordinator, providing year-round technical assistance from sources such as hired consultants or partnering with non-profits, building skills among “jack-of-all-trades” through educational workshops/lectures or through distribution of relevant information on rural homelessness, and emphasis on coordinating services in areas with diverse needs (HUD, 2009).

Operationally, there are a few key general factors that successful rural continuums demonstrate. Since rural areas have low population densities, rural service providers typically wear many hats and thus operate as “jack-of-all-trades.” One of the problems with this is that it limits the capacity of continuums to measure progress in a formal way. However, rural continuums have solved this problem through a combination of assistance from local universities, obtaining technical assistance either through in-house hiring or hiring consultants, and developing simple yet concrete examples of a program’s effects on clients to illustrate progress (HUD, 2009). Another issue faced by

resource-constrained rural providers is navigating the application process, which in some cases is one of the main obstacles in joining a continuum. Yet, there are a few ways in which continuums have overcome this. One of the most common is forming statewide and regional CoCs not only to help ensure that small, rural jurisdictions receive funding, but also to provide support for the application process. Other solutions include hiring specialty consultants, or forming partnerships with other service providers to tackle the application together (HAC, 2002; HUD, 2009).

One other large operational factor to consider is outreach and engagement, especially given the spread out geography of where rural communities are situated. Some common themes that have led to successful implementation of outreach and engagement include the following: (Robertson and Meyers, 2005)

- Agencies engage in good public relations with the community
- Outreach staff doesn't engage individuals until they are ready
- Staff is dedicated and committed
- Agencies collaborate and pool resources with others
- Agencies demonstrate commitment to education and training
- Outreach staff is sensitive to cultural and ethnic diversity
- Outreach staff treat people with dignity and respect
- Outreach staff understands that homelessness is caused by a combination of structural barriers and personal vulnerabilities

Additionally, continuums can increase outreach in other ways given the unique feature that many rural communities are close-knit and have a history of taking care of

their own. Since community members are more likely to be interested in helping their fellow neighbor, then continuums should focus on reaching out to local organizations so that they have information on who to contact in the continuum if they learn someone is housing insecure (HUD, 2009). Finally, it is important to educate clients about the services available to them and how to access them so that they are more willing to obtain help for themselves.

Other issues rural CoCs face include lack of affordable housing and transportation; however, communities have pursued general actions to overcome these issues, at least in part. For instance, where renting is a characteristic of the housing insecure, landlord-tenant mediation and legal support has had success in helping families work out terms and avoid eviction. Legal support is also beneficial to helping homeless individuals resolve legal issues, such as restoration of their driving license, which in turn can help with employment opportunities (HUD, 2009). Where transportation barriers have made it difficult to connect the homeless with services needed, continuums have found advanced coordination with service providers via email or phone has been invaluable in partially addressing this issue (HUD, 2009). Additionally, several service providers, especially those in remote areas, have found success in bringing service directly to their client as a form of mobile service. Yet, this method makes it much harder to provide an adequate continuum of care to individuals, though it does help address part of the transportation issue.

ii) Case Studies of Successful Rural CoCs

Based on these broad general trends of effective rural CoCs, it is more useful to investigate what unique strategies specific continuums have pursued to overcome barriers their own communities. However, as mentioned before, each community faces different circumstances and as such the implementation of a successful tactic in one continuum may not always translate to success if employed in another, separate continuum. Nonetheless, reviewing specific methods helps provide guidance for how rural communities should think about addressing their own unique needs. The general categorization of these barriers for the below discussion is as follows: invisibility and awareness considerations; coordination of services and diversity of needs; and scarcity of services and limited resources.

a) Invisibility and Awareness Considerations

The invisible nature of rural homelessness, along with the issue of measuring the extent of the problem to increase awareness, is a major problem rural areas face in building support to prevent homelessness in their communities. One large problem rural communities have faced in homelessness prevention is the barrier of NIMBY (“not-in-my-backyard”) or straight rejection that homelessness exists in the community. For instance, a study in one small town in Iowa found that it had a large number of homeless; however, this finding was vehemently denied. For example, the president of the local bank even said, “Homeless people are on the street. We don't have that problem” (Vissing, 1996). In other communities, such as Mohave County, Arizona, a local religious leader has stalled construction on a homeless facility given opposition faced by community members who tried to prevent its building by using local zoning ordinances (HAC, 2002). However, in response to this issue, the Mohave County Health department,

which provided services to the homeless, began to focus their projects with which the community at large and elected officials were comfortable while at the same time still serving their homeless population, just in a different way (HAC, 2002). NIMBY problems can also provide setback for approved and zoned homeless facility projects, which ultimately drives up costs through delay.

However, some communities have helped overcome this by increasing awareness through help from local government official and politicians. In Montana, part of one of their continuum's plans is for tribes to learn more about homelessness in rural or reservation settings (Robertson et al., 2007). The state of Mississippi has been actively working on educating local elected officials and the public by distributing information on rural homelessness and using informational booths at public events (HUD, 2009). Thus, given the problem that some communities might face with NIMBY, it is utterly important to increase awareness of the problem of rural homelessness to prove that it is there. Importantly, HUD recommends that initiating a public awareness campaign to highlight the issue of homelessness can help drive support for ending it in rural communities. With enough awareness-driven inertia, communities might be able to come together cohesively to enact real change and address the needs of the rural homeless population (HUD, 2009).

Definitional and measurement concerns have also become an issue for rural continuums seeking to increase awareness and support for preventing homelessness. HUD provides general guidelines for increasing the effectiveness of measurement counts within rural areas. For instance, HUD recommends collecting count data over multiple days to reach those who are not typically located in areas on concentration. Announcing the count in advance is also encouraged to help locate homeless individuals who would

self-report, while also allowing time for recruitment and training of volunteers to help administer the count. Additionally, they provide leeway in allowing continuums to count people who do not meet the formal definition of ‘homeless,’ such as those who are living doubled-up or those at risk of losing their housing if the reason for the risk is provided (HUD, 2009). Specific continuums have expanded on these recommendations to increase the effectiveness of their measurements and thereby awareness of the problem. For instance, the state of Georgia began using a modified data collection method in 2008, which it presented at a 2010 conference. Its leaders stipulated that the strength of the modification was that it was “grounded in knowledge of unique rural problems” (Rural PA). Mississippi has also found that their counts are more effective if they bring goodie bags filled with personal care items, food, and blankets to those they are counting. This helps facilitate increased dialogue as homeless individuals are more likely to provide pertinent information when they are offered something in exchange (HUD, 2009).

Finally, moving towards a consolidated state-level data collection such as HMIS has increased understanding between community partners about the clients they serve and the unique problems of the rural homeless in their communities. In order to improve understanding of the rural homeless it is necessary to increase the dialogue between those collecting data on homelessness, typically government agencies and researchers, and those who directly serve homeless populations. Codifying data under the HMIS system allows for this dialogue to be greatly increased as there is more cohesion with the data and better understanding of homelessness given the specifics of what data HMIS collects (Feldhaus and Sloane, 2015).

b) Coordination of Services and Diversity of Needs

Another large obstacle rural communities that are already resource-constrained face is coordination of a variety of services to address the variety of needs that homeless individuals often exhibit. Additionally, there is evidence that mainstream services are not readily accessible to homeless individuals and as such coordination is crucial in connecting the homeless to needed services (HUD, 2002). Therefore, coordination among community partners helps to address the diverse needs of rural homeless populations in the most effective and efficient manner.

SKYCAP, in Hazard, Kentucky, for example, has helped overcome this barrier. It provides management for homeless individuals in a two-county region. Three organizations in this program handle coordination of the network of more than 80 agencies through a management information system that tracks social services, housing status, and clinical and environmental factors affecting the health of identified and potential clients. Thus far, the number of homeless individuals within their region has decreased by 68% since 1993 (Post, 2002). One of the discernable attributes to this success is not only the coordination of services, but also the use of lay workers who are familiar with the populations they serve along with an “organizational culture that doesn’t give up on people” (Robertson et al., 2007).

The WSOS CoC in Ohio, on the other hand, has employed a different strategy to overcome the issue of coordination of services. They have made partnerships with United Way in each county they service and have formed partnerships with local sheriff’s departments, school districts, and universities. These partnerships have led to an improved ability to connect clients to services when picked up by police (NAEH, 2016). Cattaraugus County, situated in Northwest Alabama with nearly 70% the population

living in rural areas, exhibits an extremely well-coordinated, cooperative system comprised of 12 housing and service providers and dozens of supplementary organizations. This extensive coordination is the result of a decade-long collaboration between organizations and providers to support each other for the good of the communities they serve (HAC, 2002). In Fargo, North Dakota, a community where coordination among service providers is already well developed, there is a PATH Coordinator who acts as the ‘front-door’ to clients to help the homeless navigate the assistance system to obtain the services needed (Robertson and Meyers, 2005).

Another CoC program that has had considerable success in coordination of services is the Minnesota Supportive Housing and Manager Care Pilot. The Pilot focused on creating an intensive service model featuring low caseloads and a range of specialty service providers. In order to accomplish this, the Pilot program increased the pool of funding available for housing and services and ensured that both specialized and mainstream services were available and accessible. Through the successful coordination of services, as well as the building of trusting relationships between providers and clients, participants in the program experienced “significantly improved residential stability, fewer mental health symptoms, and a lesser use of alcohol and/or drugs” (NCFH, 2009).

Finally, the Maine Balance of State Continuum has experienced considerable success in coordinating services in rural environments. One way it has accomplished this is its focus on including *all* programs, agencies, and activities in the state who are working to end and prevent homelessness. Example agencies categorizations include: homeless service providers, social service/non-profit agencies, state and local government, public housing authorities, veterans services, advocacy groups and

consumers, non-profit housing developers, youth providers, and domestic violence service providers. In order to facilitate cooperation and coordination, the continuum has distributed information to all partners so the community itself can decide which pieces of the program it wants to focus their resources on, has shared resources between working groups, and has leveraged resources through development of new forms and consistency (Mondello et al., 2009). The Maine BoS continuum has also benefitted from an investment in a 2-1-1 Maine information and referral system that provides a phone health and human services referral system for all counties in Maine. The implementation of this helpline has had considerable success in helping to centralize assistance resources in rural counties (Mondello et al., 2009).

c) Scarcity of Services and Limited Resources

Finally, the shortage of homeless-specific services available, which is compounded by the general lack of mainstream services and lack of funding, is another barrier rural communities face. As it is hard to make resources available where they don't exist, it is important for communities to effectively and efficiently use those that are available in unique ways. Insufficiency of services can include lack of health and mental healthcare providers, lack of adequate housing, and a general lack of effective transportation methods.

One grouping of services that are typically deficit in rural areas is general healthcare and mental healthcare providers. However, where they exist, certain continuums have developed methods to maximize the provision of what is available and accessible. For instance, as has been discussed earlier, the Minnesota Supportive Housing

and Manager Care Pilot focused on providing routine healthcare to the rural homeless by moving away from costly and disruptive institutional services (NCFH, 2009). Through focus on outpatient mental health and pharmaceuticals, instead of on emergency services, participants were able to access needed healthcare attention, some even lifesaving. This also led to vast cost-savings as the homeless population in this community frequently used emergency rooms as a primary care vehicle, which adds to crowding and waiting time for all seeking emergency care (Mondello et al., 2009). In New York, Assertive Community Treatment (ACT) teams have been established to meet the mentally disabled homeless in rural locations where they are, when they are ready, and at their pace. They then help these individuals seek immediate care while at the same time moving them into permanent housing at a rapid pace. The results of this outreach and access to care have resulted in 84% of the 500 people served staying housed with many obtaining the help the need for their disabilities (Robertson and Meyers, 2005).

Housing is another category that is in short supply within rural areas; however, some communities have been able to overcome the lack of adequate housing through innovative strategies. One of the most successful models continuums have generally found is implementing permanent supportive housing programs, specifically with a Housing First approach. Within Maine, the results of such implementation focused on the disabled homeless are astounding. Along with a significant reduction in homelessness overall, the program has helped achieve a 57% reduction in mental healthcare costs, a 99% reduction in shelter costs, a 95% reduction in jail costs, a 32% reduction in ambulance service costs, and a 14 % reduction in emergency room costs, leading to an overall cost-savings of \$1,348 over six months per individual served (NAEH, 2016;

Mondello et al., 2009). In sum, the total six-month cost avoidance to the system of care totaled \$219,791 (Mondello et al., 2009). The key finding of cost study performed in Maine's rural program is that there are large cost savings and cost-effectiveness in providing permanent supportive housing to the rural, disabled homeless.

Cattaraugus County has overcome its issue with limited housing through forming a Homelessness Task Force that prioritizes the lack of transitional and PSH as one of its most urgent needs. In order to meet these needs, the Task Force implemented the Family Development model to help homeless individuals access resources and effectively stay housed. Since the implementation of this model, 80 of the 85 high-risk homeless families identified by the Task Force and served using the model during 1997-98 remained housed for the next few years following (HAC, 2002). Other continuums, such as the Northwest Alabama Continuum of Care Council, have coordinated with housing authorities to open up Section 8 wait lists for application, as some experience exorbitant waiting times. However, such strategies can have limited effectiveness in rural areas (HAC, 2002). Finally, it must be noted, that lack of housing is a large problem facing many rural areas and is a very hard barrier to overcome due to factors outside of structural ones, such as exclusionary zoning and NIMBY issues, which compound the difficulty in developing adequate housing for the rural homeless (HUD, 2002).

Similar to the housing issue, there is also an inherent problem rural communities face in transportation as it limits the success of providing access to needed services. Southwestern Pennsylvania provides a unique example of how a continuum has partially removed this transportation barrier. The CoC in Southwestern Pennsylvania covers 25 communities and consists of five rural counties, three of which are not contiguous to the

other two. Distance from north to south as well as topography of the Alleghenies separate these counties. Moreover there is little or no public transportation connecting the counties to each other, or places within each county to each other. However, in order to overcome this discrepancy the five counties did not aspire to become a single, integrated continuum given the geographical distance. Instead, they operate independently, sharing information and resources as necessary to help each other out. They have found this more localized approach to modeling a CoC in geographically large regions has helped mitigate the effects of lack of transportation and believe it is the most rational strategy for dealing with their dilemma (HUD, 2002).

Lancaster County CoC in Pennsylvania provides an interesting example of how they have dealt with the transportation issue. The City of Lancaster and local providers within its immediate metropolitan area are geographically situated in the middle of rural mountainous and agricultural areas. In order to provide access to services, the continuum partners with churches through the region and has established seven satellite community action agencies (CAP) to help serve Lancaster's rural homeless population. Notably, this model has allowed Lancaster provider to travel to their adjacent rural areas to work directly with the homeless being served by their local church or CAP agency (NAEH, 2016).

Some continuums have also implemented a 'hub-and-spoke' model to address their problem of lack of transportation. This model includes driving out into the rural area to directly interact and provide services to the homeless. For instance, in Kingman, Arizona, a staff person at the country mental health clinic works out of a PATH-funded car and travels around the county to conduct outreach and provide food, clothing, and

camping gear (Robertson and Meyers, 2005). In Billings, Montana, a service team has a once-a-week 'field day' where they use their own vehicle to seek out clients to build trust among them and engage when they are ready to receive services (Robertson and Meyers, 2005). In Connecticut outreach workers go to places where they know the homeless typically congregate and bring different sorts of items to be used as engagement tools. During this phase, workers work to cultivate trust among the homeless as well as begin to set into motion services for each client (HAC, 2002). Still other continuums have established their own transportation programs using cars to connect the homeless to needed services. In many cases, they have partnered with a variety of agencies to obtain funding to purchase a dedicated vehicle for outreach (HUD, 2009). Some have even set up a system of donating used cars to homeless individuals so that they can provide transportation ability to themselves directly. A program in Georgia and one in Wisconsin effectively follow this strategy, though their implementation differs slightly (HUD, 2009). Such mobile outreach can be especially effective in communities that either experience large geographical distances or in communities where NIMBY sentiment is especially prevalent among residents.

Funding also plays an important role in addressing the issue of limited resources in rural communities. For instance, there are substantial resources that must be used to effectively work on and complete a McKinney application to compete for funds but many local organizations often do not have the technical knowledge or ability to efficiently complete such applications (HAC, 2002). Thus, an effective model that has worked with numerous rural communities is to take advantages of economies of scale by joining BoS CoCs. Not only does this enhance coordination of resources in many rural places but also

maximizes the funding potential of rural communities (HUD, 2009). Ohio BoS is a perfect example where a statewide model was adopted in order to ensure that smaller, rural jurisdictions would be more competitive and receive adequate funding for developing their homelessness prevention projects (HAC, 2002).

Rural CoCs have also made use of variety of mainstream funding avenues. These include state and local public housing agencies, rural development offices, and state and local agencies that administer CDBG and HOME grants to increase their breadth of funding avenues. Other key programs for additional funding include Section 515 (USDA Rural Rental Housing Program), Section 538 (USDA Rural Rental Housing Guaranteed Loan Program), Section 811 Supportive Housing for Persons with Disabilities, Section 8 Housing Choice Voucher program, Project-Based Section 8 Voucher Program, and USDA Multi-Family Housing-Rental Assistance Program (Section 521) (HUD, 2009). Additionally, incorporating a variety of services in discussion of the broader homeless assistance system will help advocacy for much needed funding to go towards homelessness prevention (HUD, 2009). For instance CoCs in Utah have worked towards building strong partnerships with the Department of Workforce services, which helps fund rapid re-housing initiatives through the state's TANF program, to help transform their operations in their assistance system along with using HPRP funds (NAEH, 2016).

Finally, in order to be more competitive for federal funding, some communities have implemented unique processes to rank projects. The RACoC has one representative from each of its 13 areas of services, a representative from the state homeless coalition, and the state homeless coordinator's office, plus one or two additional people come together to rank the CoC's proposed projects. When ranking the projects, these decision

makers review three things: renewal implications, adjusted pro-rata/fair share considerations, and the ‘permanent housing bump’ (HAC, 200).⁴ In sum, USICH recommends that in order to attain value for money, agencies and communities should work towards directing resources on evidence-based and cost-effective solutions, like PSH based on the Housing First approach and rapid re-housing, and to use data to measure performance and quality to help bolster the case for additional funding and bring solutions to scale (USICH, 2010).

5) Ethical Considerations

Given the complexity of rural homelessness, compounded by the numerous barriers and resource constraints on service providers, one is beckoned to ask why we should care about the rural homeless in the first place? There are a few moral arguments one should consider when viewing the problem of homelessness in rural communities. The most salient to consider is Peter Singer’s view on moral obligations. He argues that if there is a bad situation, such as human suffering through homelessness, and that if an action can avoid the situation without sacrificing something of comparable worth, importance, or significance, then one ought to do it. Put more succinctly: “if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it” (Singer, 1972). Ultimately, it comes down to a cost-benefit analysis between two different sacrifice packages – one of

⁴ Renewal implications consider the importance of continuing support for projects that already exist; the adjusted pro rata factor reviews groups who were told what the area could expect to receive from HUD funding and the implication this would have relative to the budgets that were proposed; the permanent housing bump is an “bump” that HUD gives to permanent housing projects so the group considers the impact this could have on the final budget that is awarded.

who can help and one of who is in need of help. Each will necessitate a sacrifice depending on which is selected. The importance is determining which option will ensure that the relative sacrifice between one of the parties is minimized. In other words, one option will result in the loss of some things, while the other might result in the loss of something of more value – determinate balance must be shown.

Put in the context of rural homelessness, it comes down to computation of a moral calculus where the key factor is the duty to do something. If one is able to help contribute to preventing rural homelessness, and in doing so does not sacrifice something of comparable moral value, then one ought to it. Thus, one should care about rural homelessness because it is within one's power to act to help prevent its negative effects on human individuals. More importantly, one, morally, ought to do something to help prevent the suffering of the rural homeless if one, in their ability, can. Thus, while one might deny that rural homelessness exists in their community, if evidence proves it otherwise, it is then that person's moral obligation to do something to alleviate the problem if it is within their bounds to do so. Moreover, working to address the problems of the rural homeless ultimately helps serve the purpose of community organizations to provide help to those in need. As such, the recommendations put forth in this paper assists service providers in accomplishing their goals of helping members of their community. In sum, many community organizations actually wish to help people and my recommendations help to facilitate this goal.

Rural homelessness also deserves the same attention that society has given to other forms of homelessness. Singer notes that "moral attitudes are shaped by the needs of society." Within our society it can be argued that homelessness in general is something

of moral importance – one only has to look at the vast resources dedicated to eliminating this problem. However, rural homeless does not receive equal attention, as do other types of homelessness, such as chronic, veterans, mentally disabled, and children and families. If our society cares about or at least shows its apparent commitment towards preventing other types of homelessness, then this commitment should apply to rural homelessness as well – like cases should be treated alike. Marion Young has argued that a primary principle of justice is equal treatment. Given the lack of policy and community focus on the issue of rural homelessness, there is an apparent inequality of treatment present. Young claims, “equality involves full participation and inclusion of everyone in a society’s major institutions, and the socially supported substantive opportunity for all to develop and exercise their capacities and realize their own choices” (Young, 1990). Thus, the rural homeless not only deserve the equal attention afforded to other variations of the homeless in the United States, but they should ultimately be offered the capability to fully participate in our society. Therefore rural homelessness should be given a fair assessment of the severity of problem the same ways in which other forms of homelessness have been given attention. Yet, this cannot be accomplished if the problem of rural homelessness is overlooked.

Finally, there is the question of why resource constrained organizations should devote an already limited amount of time and energy to coordinating services to help alleviate the effects of rural homelessness. This is especially salient to mainstream providers who have core focuses that are not centered on rural homelessness, so why should they commit to addressing it? Singer’s argument of moral calculus is relevant here, for if such organizations can help alleviate some of the ills faced by a homeless

individual, then they ought to do it, morally. For instance, if a mental health facility is able to provide services to a homeless individual it ought to do it, even if it strains time, resources, and costs further. The reasoning is that while providing services to more individuals, while a cost to the organizations, is not a sufficient enough cost to justify not providing services. Likewise, if it merely provides an inconvenience to service providers too coordinate services and implement data management systems like HMIS, then this is not a valid excuse for it is not a sufficient moral sacrifice.

Another issue that could possibly arise is partial infringement upon the autonomy of organizations, as they would in part be sacrificing some of their autonomy through participation in a continuum of assistance services. This is an especially important consideration to deal with given that the intended goal of coordination among services in providing better access to clients is uncertain as it is in the future. However, the fact that things are uncertain does not mean that everything else is uncertain – evidence has shown that CoCs do increase service provision to the homeless and help to reduce the incidence of homelessness overall. Moreover, besides the ethical benefit of providing services to at-need populations, there are also tangible benefits to service, such as increased ability to successfully apply to federal grants, which can lead to cost savings across the board to better utilize limited resources.

6) Recommendations for Rockbridge County, Virginia

Within the regional community of Rockbridge County, Virginia, there are several immediate recommendations service providers and stakeholders should pursue if the community wants to make a difference in addressing its rural homeless population. The

bulk of this paper has focused on educating interested community members on the intricacies and uniqueness of rural homelessness and how it is addressed through HUD's CoC framework most effectively. Here, a reasonable approach is proposed, based on research, current community capacity, and the community's current status on addressing its homeless population.

Building awareness and gaining understanding of its local homeless population should be a core focus of Rockbridge community members. This is especially important given that even nationally we are in the initial stages of understanding the complexities of rural homelessness in general. Moreover, Rockbridge is in the very first stages of grasping the extent of the problem within its region. As such, initial efforts should focus on understanding whom the community intends to serve. A better understanding of whom the community is serving as well as the magnitude of the population is crucial if Rockbridge is to eventually implement successful homeless prevention services. Two ways to increase the understanding of the local population include increasing outreach as well as determining a better count of the homeless population within the region.

Given the variety of best practices outlined in the above sections for doing each of these things, there are a few that seem most beneficial to Rockbridge's unique geography. Assuming there are relatively few known areas of congregation within the county, the best way to conduct outreach would be building relationships based on trust with clients to not only assess their needs but also gain information on other individuals who might be homeless or housing insecure. This will also help with gaining more accurate measurements, as the outreach will be able to gauge the extent of the problem, at least in part. Announcing the count also seems to be a simple, yet effective way to boost accuracy.

Coordination will also help increase knowledge of who is accessing care and who needs care as service providers would be encouraged to share data to more effectively understand their clients and implement solutions targeted at their needs.

Along with understanding the characteristics of the local rural homelessness, awareness of these individuals and families must be increased to bolster community response to this problem. Only through increased awareness of the problem will community members likely react to the fact that rural homelessness is a problem within the county. Awareness will also be critical in convincing community service providers to collaborate and coordinate services. Through awareness, the problem of rural homelessness within Rockbridge would be recognized, with the ultimate hopes that such recognition of problems would lead to a community focus on alleviating, preventing, and defeating those problems. While there could be pushback on such increased awareness campaigns, the recognition that there is a problem is the first step to addressing the problem.

Once enough awareness and response has been built in the Rockbridge community, the community should continually pursue a cohesive system of coordinated services to best address its own obstacles. Based on the research outlined in above section on the effectiveness of CoCs, Rockbridge service providers would reap several benefits from increased coordination and communication across varied, cross-sectional, and relevant services. A beneficial first step in coordinating these services is first determining what services exist within the community, which can be accomplished through a thorough mapping of resources. This will include division of services according to pertinent categories and collecting data on exactly what types of services they provide

and who are the clients they serve, among other things. Additionally, in order to effectively maintain a coordinated system, strong partnerships and alliances between service providers must be achieved. This includes reaching out to different community members and stakeholders similar to the ones pursued by the case CoC examples.

Finally, successful implementation of HMIS among community partners will help facilitate the different goals of boosting knowledge, awareness, and coordination outlined above. Through successful application of the data management software, relevant data would be collected more efficiently, helping to increase understanding and awareness of the homeless population, shared with a broader basis of service providers, leading to increased participation and facilitation of which goals to pursue as a coordinated community, and demonstrated in HUD funding applications to be more competitive at receiving federal funding. Ultimately, this increase in funding, through provision of evidence of the problem, would need to be coopted with plans to pursue evidence-based solutions to deal with the unique needs of the homeless as identified through the HMIS system. More importantly, the success of realizing the benefits of HMIS would be dependent on the success of conducting effective outreach to the local homeless. If the two can work in tandem, then there should become an increased understanding of the population Rockbridge is serving.

Thus, the first step towards addressing the long-term problem of rural homelessness in Rockbridge is comprehending the needs of this population, which is first achieved through increased outreach, knowledge, awareness, and coordination, which can be facilitating through broad implementation of HMIS. Only then can it implement cost-effective and evidence-based solutions, thereby utilizing resources most effectively and

increasing the probability of accessing additional and renewal funding from HUD. In the end, it all comes back to understanding what the problem looks like within the community. Thus, the short-term focus should be facilitating this understanding through outreach, awareness, coordination, and HMIS implementation. All of these factors compound and reinforce the effectiveness of each other so each should be pursued in tandem so as to lead to more effective responses and solutions to addressing the homeless population in Rockbridge. HMIS, however, is the immediate, primary driver that would work towards enacting these factors. The eventual long-term goal for Rockbridge should be establishment of evidence-based approaches to ending homelessness, such as rapid re-housing of permanent supportive housing with a Housing First approach. This is an especially important end goal to keep in mind as “the principal challenge facing communities in eradicating homelessness continues [is] centered on the lack of permanent affordable housing (HUD, 2002).

7) Concluding Remarks

In conclusion, researchers, policy makers, service providers, and community members are still gaining knowledge of the unique complexities of rural homelessness. As rural homelessness continues to gain awareness and traction in these fields, there will be a continued need for more research, which ultimately will be achieved through effective collaboration and data collection. As more research is gathered, more recognition of the problem will be built, paving the way for more discussion in the policy arena for more minds to meet together and consider solutions to the problem of rural homelessness. The Rockbridge community finds itself in a unique position to contribute to this important dialogue of how best to address the problem of rural homelessness in the

United States as it is in the first stages of combatting the problem. In the end, however, success in preventing homelessness in rural areas will depend on eliminating poverty and increasing the amount of affordable housing stock (First et al., 1994).

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