

# Combating Homelessness in Worcester

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Population Health Clerkship

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## Targeted Population

The US Department of Housing and Urban Development (HUD) defines **homelessness** as a person who primarily resides in a place "not meant for human habitation" such as a car, park, sidewalk or abandoned building, or is being evicted within a week from a private dwelling or institution (jail, recovery home, etc.) with the lack of resources and support to arrange a subsequent housing plan.<sup>3</sup>

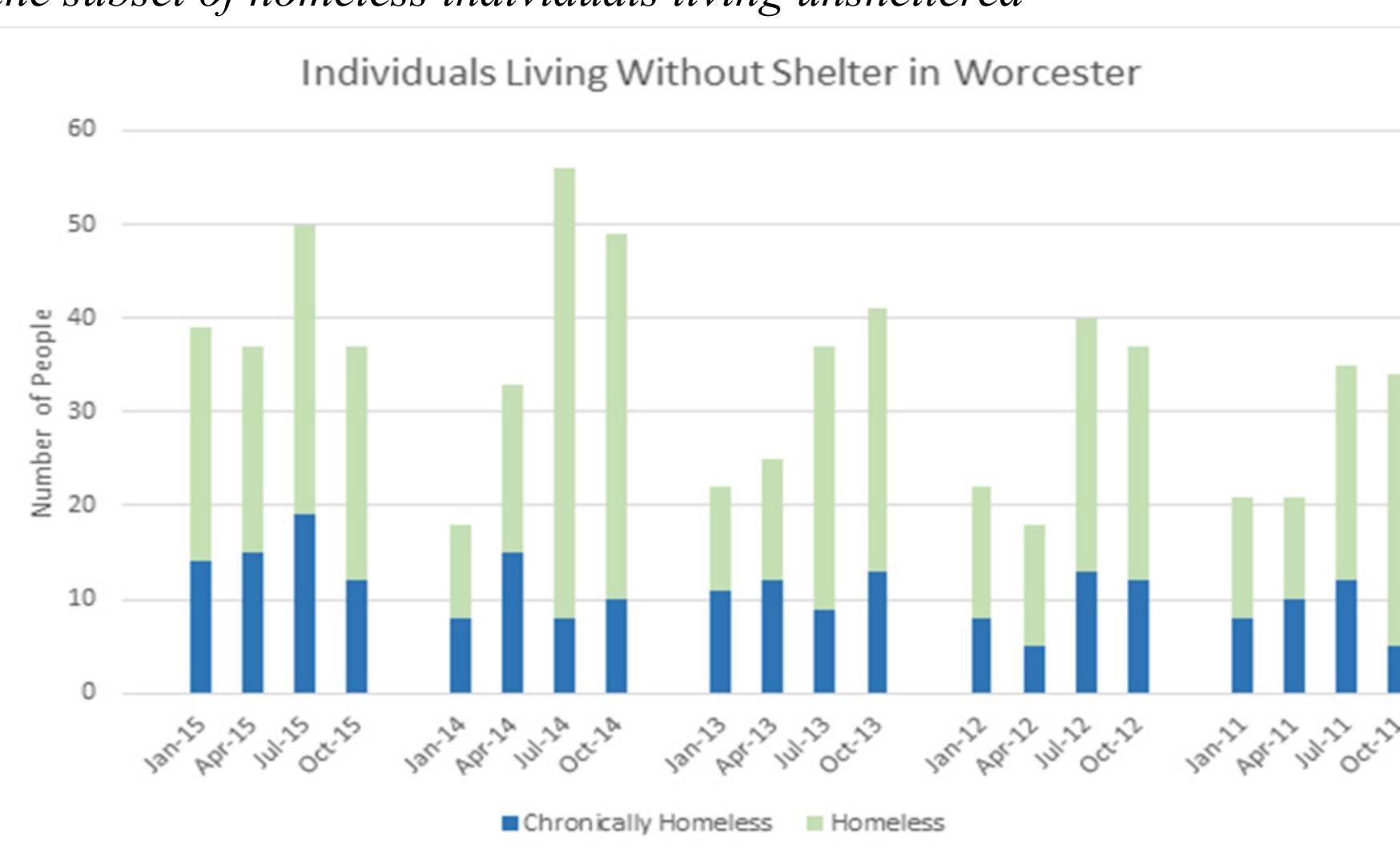
**Chronic Homelessness:** An individual with a disabling condition who has been continuously homeless for over one year OR has had four episodes of homelessness in the past three years.<sup>3</sup>

### Demographics in Worcester (2013):<sup>2</sup>

- Income below poverty line: 30.5%
- 1,796 homeless persons (0.2% of the population)
- Homeless with Mental Illness: 22.2%
- Homeless with Substance Abuse Disorder: 10.8%

## Quarterly Census

4 times a year, Eliot Outreach travels through Worcester to collect data on the subset of homeless individuals living unsheltered<sup>5</sup>

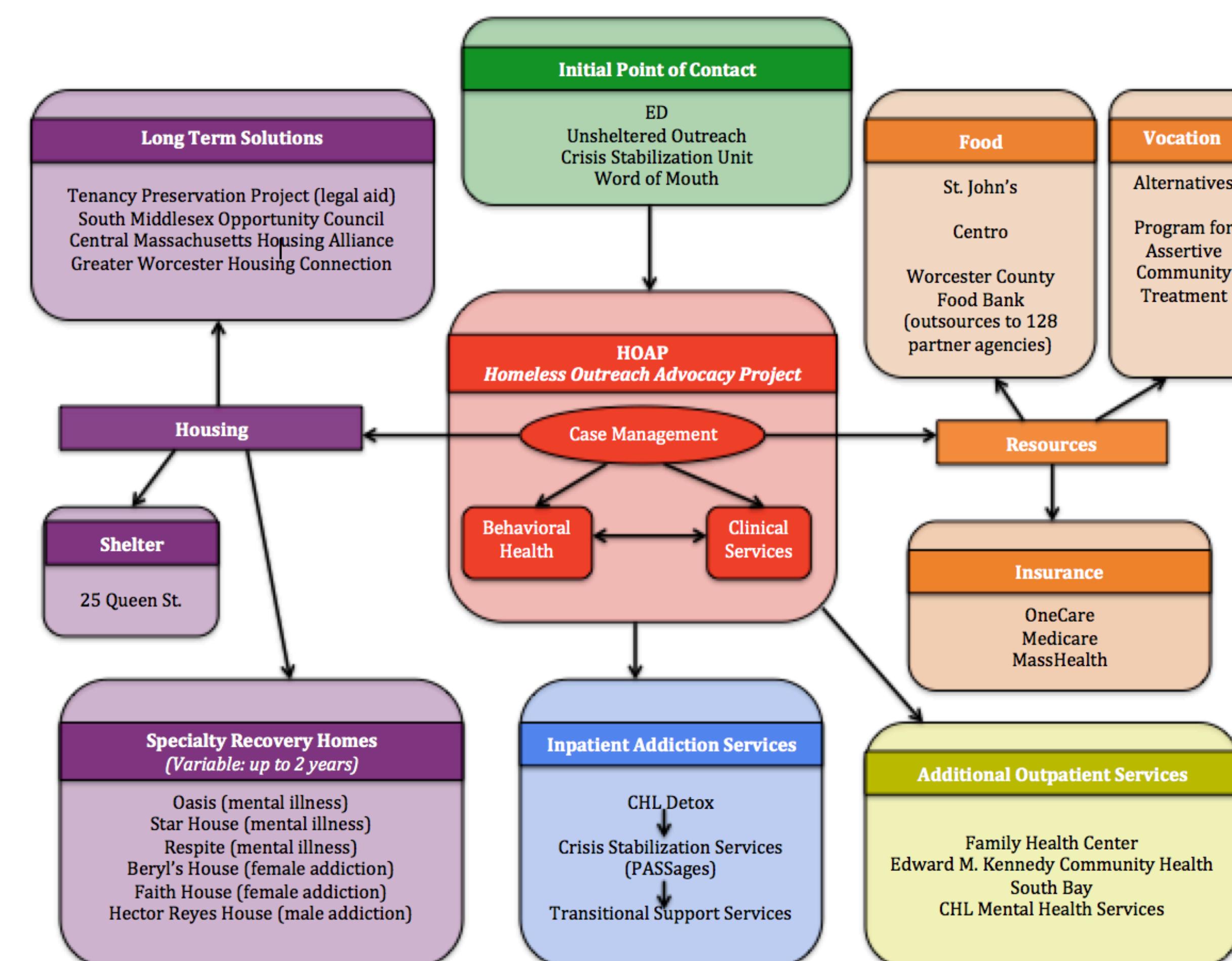


## Cycle of Homelessness

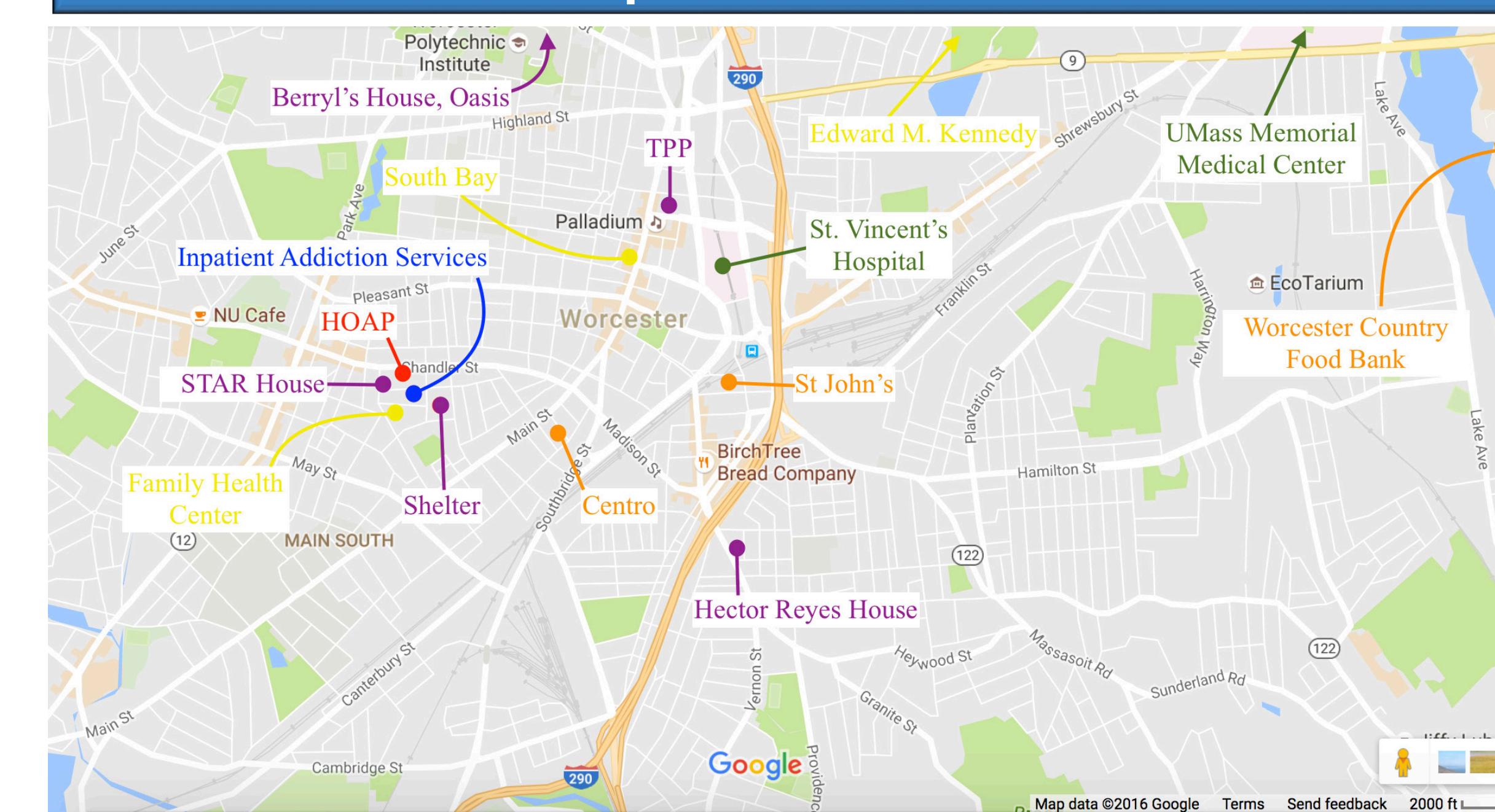


## Community Resources

Worcester agencies focus on the needs of the homeless population through interprofessional resources and collaboration



## Map of Resources



## Focus of Project

- Develop a flow chart and map to better navigate the system of resources available through HOAP to the homeless population
- Emphasize the complex interactions between physical and mental health, substance abuse, and poverty with housing insecurity
- Directly work with and learn from this population and the providers who service them

## Discussion

**Using our Flow Chart and Map:** A visual aid for providers, students and clients to identify available resources and how they connect to HOAP

### Housing First Model

- Clients are more likely to follow through with services and take initiative for their health if first provided with a stable living situation

### Strengths of HOAP

- Flexibility in addressing the unique needs of homeless clients and efficiency in connecting clients to appropriate services
- Interdisciplinary model: all resources are within close proximity and clinicians are in constant contact and communication

### General Takeaways

- Homelessness is strongly interconnected with a lack of social support
- Alleviating homelessness is often a long process that involves re-integration into services and multiple attempts to address the contributing factors

### Our role as Future Clinicians

- Ability to refer clients to pertinent services for their conditions
- Appreciate the complicated backgrounds of these individuals and subsequent comprehensive health needs

## References

1. Central Massachusetts Housing Alliance. from <http://www.cmhaonline.org/>
2. U.S. Census Bureau. from <http://www.census.gov/>
3. U.S. Department of Housing and Urban Development. From <http://portal.hud.gov/hudportal/HUD>
4. UMass Memorial Community Health Link <http://www.communityhealthlink.org/chl/>

## Acknowledgements

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