



TEN-YEAR PLAN TO END CHRONIC HOMELESSNESS

Winston-Salem/Forsyth County, North Carolina

Approved By

Winston-Salem City Council May 15, 2006

Forsyth County Board of Commissioners August 14, 2006

VISION STATEMENT

Winston-Salem/Forsyth County, with the full support of the community and homeless service providers, will provide effective solutions and accessible services to eliminate chronic homelessness and improve the system's effectiveness for all persons experiencing a housing crisis.

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ACKNOWLEDGEMENTS

This Plan was developed under the leadership of the City of Winston-Salem Mayor Allen Joines and the Winston-Salem/Forsyth County Blue Ribbon Task Force on Homelessness, chaired by Councilman Nelson Malloy. This Plan would not have been possible without the information provided by adult single men, adult single women, and families residing in local homeless service programs, as well as

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feedback from key stakeholders and homeless assistance provider staff members. The Task Force also greatly appreciates the thoughtful guidance and support provided by Dr. Monica Lett and Tim West of the City of Winston-Salem Department of Housing/Neighborhood Development and the Winston-Salem/Forsyth Council on Services for the Homeless Executive Board.

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PART ONE: EXECUTIVE SUMMARY

Overview

Approximately 1,800 people experience homelessness in Winston-Salem/Forsyth County each year. Twenty percent are families; around 200 are children. Over the past 20 years, Winston-Salem has developed a strong, community-based response to this problem, with numerous agencies working to provide short-term emergency services and shelter to people who find themselves homeless. Despite this earnest response and considerable investments of time, energy, and financial resources, our residents continue to experience homelessness—many repeatedly and for long periods of time.

Winston-Salem is not unique in this. *The Status Report on Hunger and Homelessness in America's Cities* released by the U.S. Conference of Mayors in 2004 indicates that requests for shelter rose an average of 6% nationally in the past year. As well, the report notes that in a majority of cities the length of time people remain homeless is increasing. These disturbing trends mean that Winston-Salem must work more effectively to resolve homelessness for our citizens. Our current approach, designed to assist people on a temporary basis, is insufficient to win the battle to end homelessness, particularly for those for whom homelessness has become a chronic condition. We need a new approach. One that takes what works within our existing system and pairs it with strategies that are proving effective in other communities at resolving homelessness for those still falling through the cracks.

Over the past six months, leaders in our community have come together to develop a plan for ending the chronic homelessness of these individuals, and improving the efficiency and cost-effectiveness of our system of care overall. We have demonstrated that we have the commitment for this undertaking. With this Ten-Year Plan as our guiding framework, we are poised to begin.

Winston-Salem/Forsyth County Blue Ribbon Task Force on Homelessness

In December 2004, the Mayor of Winston-Salem, Allen Joines, asked community leaders to participate in a Blue Ribbon Task Force on Homelessness. The Task Force's charge was to assess the needs of people who experience homelessness and develop a plan to end chronic homelessness in Winston-Salem and Forsyth County.

The Task Force agreed upon the following vision statement:

Winston-Salem/Forsyth County, with the full support of the community and homeless service providers, will provide effective solutions and accessible services to eliminate chronic homelessness and improve the system's effectiveness for all persons experiencing a housing crisis.

The Task Force gathered input from the community, examined

local housing services and resources for addressing homelessness, studied service utilization patterns to better understand how persons experiencing homelessness are using the shelter system, and reviewed successful programs operating in other metropolitan areas. This research helped to more clearly define the needs of individuals and families who experience homelessness in Winston-Salem and identify evidence-based strategies and initiatives to resolve homelessness in the most efficient and effective manner.

The Winston-Salem/Forsyth County Ten-Year Plan to End Chronic Homelessness, the culmination of this effort, outlines the initiatives Winston-Salem will undertake to achieve the two broad goals of its vision and the philosophical approach that will guide them.

Specifically, the Plan calls for:

- Creation of approximately **600 new units of permanent, service-enriched housing** for individuals and families who are homeless. Because for many, particularly those for whom homelessness is more chronic in nature and complicated by issues of disability, affordable housing alone will not end homelessness, this housing will include the provision of a range of services.
- Development of **employment services** to ensure that persons who are homeless are assisted in finding work and achieving their employment goals.
- **Strategies to improve collaboration** among service providers.

- Adoption of a **“Housing First” approach** in developing and managing programs.
- A series of general **system enhancements** to ensure that mainstream resources and homeless-specific services are more effective.

A New Approach

The Ten-Year Plan calls for a *“housing first”* approach that emphasizes placing individuals and families who are homeless in safe and affordable housing as an immediate response to their crisis and then ensuring that the necessary supports are in place to sustain that housing. The Plan recognizes that access to housing is a basic human need that should not be conditioned on external measures of client readiness, such as employment, sobriety, or willingness to accept treatment. Housing First is premised on the belief that the underlying causes of homelessness can be more effectively addressed once a person is housed. And, in fact, research shows that people are most successful at addressing issues that often contribute to homelessness such as unemployment, serious mental illness, and addiction when their housing is stabilized first and supportive services are then offered to promote housing stability.

Housing First represents a simple but profound shift in the way that the homeless system responds to those it serves. The Plan calls for quickly placing people in appropriate housing based upon clients’ individual needs and preferences and encouraging them to accept needed support services. These supportive

housing environments can vary greatly—ranging from private market apartments to which subsidies and services are attached, group living settings for persons with disabilities, treatment housing, to housing that mixes persons with disabilities, employed persons and/or other low-income residents. In addition, the Plan calls for a significant investment in a new supportive housing model called Transition in Place. Transition in Place takes advantage of existing private market rental housing and augments it with tailored, flexible supportive services that decrease in intensity over time based on the client's progress toward self-sufficiency. Transition in Place promotes housing continuity, maximizes use of existing housing resources, and reduces the density of homeless services in the central city.

Key Components of the Ten-Year Plan

In its research, the Task Force learned that often the current system is effective at addressing the emergency needs of individuals and families who become homeless. Many of those served simply need temporary assistance in meeting their basic needs (e.g. safe shelter, food, a place to shower, etc.) and access to resources. They are homeless for a short period and are able to resolve their housing crisis with fairly minimal assistance. The current emergency shelter system, however, is not an effective way to address the needs of persons who have been homeless for long periods of time and may struggle with disabilities such as serious mental illnesses, substance abuse, and/or physical disabilities. Persons who experience such chronic homelessness need housing and services that the present system is ill equipped to provide.

For a system to fully and effectively address homelessness it must include a range of housing and service strategies that are tailored to meet the diverse needs experienced by individuals and families who become homeless—strategies that are firmly grounded in an understanding of how those needs vary according to whether homelessness is transitional or chronic in nature. To succeed, the existing homeless service system must alter its approach from one that responds to all individuals experiencing homelessness in similar ways, to one that differentiates between services for persons with short-term needs and those requiring long-term support.

Clients with Short-term Needs

The Plan calls for enhancements to the emergency shelter system to ensure that all persons in need of shelter have access to clean, safe accommodations and essential services, including linkage to community housing and benefits screening. As the front door to the homeless service system, these emergency facilities will serve those who are transitionally homeless and act as a gateway to other housing and support services for those persons who are at risk of becoming long-term shelter users.

In addition to this basic enhancement of the emergency shelter system, Winston-Salem's coordinated response to individuals and families experiencing a transitional housing crisis will include:

- **Expansion of prevention assistance** to include time-limited (up to 3 months) of rental assistance, landlord-tenant mediation, and discharge planning with prisons and medical

facilities to prevent releasing of individuals to homeless situations.

- A **"no wrong door" approach to shelter** so all clients experience enhanced emergency shelter services no matter what program they initially access:
 - **Housing First** response to homelessness with a focus on permanent housing placement and shorter length of stay in shelters (goal of placement within 30 days).
 - **Housing First Resource Center** that serves as a central mechanism to manage information about market-rate and subsidized permanent housing properties; landlord relationships; prevention, transitional and permanent housing subsidies; and risk management activities.
- **Development of 268 Transition in Place units** of permanent housing, providing community-based housing supports to families and individuals.

Clients with Long-term Needs

The Plan calls for development of supportive housing designed for repeat shelter users and persons living outdoors who have significant barriers to housing stability.

- Development of **69 Transition in Place units** of permanent housing.
- Development of **261 Permanent Supportive Housing units**.

Additional System Enhancements

The ultimate success of Winston-Salem/Forsyth County's Ten-

Year Plan will depend, in part, on the availability of other resources and supportive services in the community, and our ability to parlay our efforts into larger systems change. We must work to:

- Improve access through discharge planning and service linkage agreements with mainstream resource systems, such as employment, TANF, food stamps, mental health, and substance abuse treatment.
- Ensure the availability of employment and training services that improve access to job listings, communication technology, transportation, and community workforce development efforts.
- Develop performance measurement strategies to set outcome benchmarks, collect data, and track ongoing performance and needs at the program and system-levels.
- Call for needed change at the State and local levels and across systems of care through additional education and policy advocacy to improve the homeless system in the larger context of mental health reform, the criminal justice system, and accessibility of other mainstream resources.

How We Get it Done

Resources

As detailed in Part Five, the Ten-Year Plan includes estimated costs for development, operation and services for the new system totaling nearly \$1.2 million for the first two years. Some costs may be covered through the reallocation of current resources, but additional local resources will also be required. These include funds to support qualified staff, sites and subsidies for new housing units, additional technology

resources, communications systems, and other infrastructure enhancements.

The Plan identifies several options for the procurement of new financial resources, ranging from establishing dedicated local revenue sources for broad-based affordable housing activities to generating state and federal funding for specific projects.

Private and public sector organizations will play a major role in resource development and in implementation. By working in cooperation to achieve common goals, community resources will be used more efficiently. Although additional resources will be required, they will be managed more effectively through this community-wide collaborative.

Governance

System development and change efforts of the magnitude proposed in the Plan will require careful coordination and management by an entity that is wholly focused on the implementation of the Plan. Therefore, the Winston-Salem/Forsyth County Ten-Year Plan Commission will be created to be responsible for:

- Development and promotion of policies and programs to end homelessness.
- Collaboration with homeless service providers to transition the system to a Housing First model.
- Identification and coordination of funding efforts to support Plan objectives.
- Promotion of long-term system planning and responses to homelessness.

A Call to Action

In creating the Winston-Salem/Forsyth County Ten-Year Plan to End Chronic Homelessness, our community joins the growing number of cities, counties, and states across the country who have committed to not just addressing, but ending chronic homelessness. And, we have gone further, dedicating our efforts to improving the system for all area residents facing homelessness. This work will require time, energy, resources and the sustained effort of many organizations and individuals. Yet we believe it can be done. United in our vision and goals, our community can take bold steps toward ending one of the most intransigent social problems of our time, and in so doing will reaffirm our commitment to our most vulnerable residents.



PA RT TWO: ASSESSING THE NEEDS OF THE HOMELESS

Prevailing Economic Conditions

In this year, over fourteen million Americans will experience critical housing needs that place them at risk for becoming homeless. In North Carolina alone, over two million people live in homes they cannot afford, and 65% of renters with annual incomes of less than \$20,000 cannot afford their rent. Critical housing needs are often the result of low-wage employment, which is insufficient to cover housing related costs such as deposits, rent, mortgage, and utilities. When such a disparity exists between income and the cost of housing, households are forced to make untenable choices in which basic necessities such as food and medical care are prioritized above housing. Thus, it is not surprising that 42% of people experiencing homelessness are employed.

A "living income standard" or LIS refers to the locally defined hourly wage that a worker must earn in order to afford a safe, decent and accessible place to live. The LIS is based on local housing costs and living expenses in each community. The LIS

for the 317,810 residents of Forsyth County is identified in **Table 2.1**.

While the living income standard for a single mother of one residing in Forsyth County requires a wage of just over \$12 per hour, the minimum wage is \$5.15, less than half the living income standard, leaving that mother and child firmly rooted in poverty and highly vulnerable to episodes of homelessness.

Similarly, in a tight housing market in which affordable housing is at a premium it is far more difficult for individuals and families who are more vulnerable—by virtue of serious disability, prior involvement with the criminal justice system, or poor credit or employment histories— to compete; a fact that places them at great risk not only for homelessness but for protracted or chronic homelessness.

Table 2.1 – 2005 Living Income Standard (LIS) Wage Information for Forsyth County, NC

	Adult & Infant	Adult & 2 Children (w/lat & preschool)	2 Adults & 2 Children (w/lat & preschool)	2 Adults & 3 Children (w/lat, preschool & school age)
Housing	\$562	\$562	\$562	\$775
Food	\$256	\$345	\$497	\$593
Misc.	\$254	\$281	\$328	\$424
Child Care	\$429	\$825	\$825	\$825
Transportation	\$182	\$182	\$257	\$257
Health Care	\$247	\$263	\$300	\$319
Total Monthly LIS	\$1,930	\$2,458	\$2,769	\$3,193
Total Annual LIS	\$23,160	\$29,496	\$33,228	\$38,316
LIS Hourly Wage	\$12.06	\$15.36	\$17.30	\$19.95

Extent and Scope of Homelessness in Winston-Salem/Forsyth County

Developing new approaches for resolving chronic homelessness and improving the delivery of care for all those who become homeless necessitates an understanding of the scope of the problem—who and how many people experience it and factors that contribute to or mitigate it. A key challenge in this undertaking is developing a common definition of homelessness. While this might seem simple on its face, a variety of definitions exist which impact both how homelessness is measured and who is considered. For instance, some research only focuses on individuals who are enrolled in services designed for people who are homeless, while other research defines homelessness more broadly to include individuals who are precariously housed in unstable living arrangements with friends or relatives.

The Blue Ribbon Task Force on Homelessness was created by the Mayor of Winston-Salem to assess local needs and develop the most effective plan to end chronic homelessness in the community. For the purposes of this effort, the Task Force adopted the federal definition of homelessness, which was first developed as a component of the 1987 McKinney-Vento Homeless Assistance Act, an emergency relief provision for shelter, food, mobile health care, and transitional housing. In this definition, an individual is considered to be *homeless* if he or she is: 1) temporarily residing in a shelter or transitional housing program designed to assist people who lack a permanent, fixed residence, or 2) living in a place not designed for, or ordinarily used as, a regular sleeping accommodation such as cars, parks, abandoned buildings, or on the street. More recently, the Bush Administration developed a definition of *chronic homelessness*. To be considered chronically

homeless, a person must *experience homelessness for an extended period of time or repeatedly* and must be *living with a disability* such as a serious mental illness, chronic substance addiction, or physical disability. While the primary focus of the Task Force was to develop local solutions for chronic homelessness, the needs of those experiencing transitional homelessness were considered as well.

To provide context for the Plan, data was reviewed regarding the needs of people experiencing homelessness. The data presented is derived from multiple sources, including the 2005 Winston-Salem/Forsyth County point-in-time survey, data reported in the 2004 Winston-Salem/Forsyth County Continuum of Care application, and the results of the National Survey of Homeless Assistance Providers and Clients (NSHAPC) completed in 1997.⁶ NSHAPC was a comprehensive national study of homelessness completed in 1997 to provide updated information on homeless assistance programs and the clients who use them to federal agencies responsible for administering homeless assistance programs. To further inform Plan development, the Blue Ribbon Task Force commissioned a series of three focus groups that were conducted with adult single men, adult single women, and families residing in local homeless service programs. This process also included focus groups with homeless assistance providers and interviews with key stakeholders. While an attempt to calculate a precise count of the number of persons homeless in Winston-Salem was beyond the scope of the Task Force's charge, taken together the information provided from these sources can be extremely useful in developing local

solutions for ending homelessness.

Prevalence Trends

On any given day there are approximately 539 individuals who are homeless in Winston-Salem/Forsyth County. This estimate is derived from a January 26, 2005 point-in-time survey of homeless persons conducted by the Winston-Salem/Forsyth County Council on Services for the Homeless. The Council conducts a census count at least annually to determine the number of persons living in local homeless shelters or on the streets. The street and shelter counts are always conducted concurrently in order to provide comprehensive, unduplicated point-in-time data on the extent of homelessness in Winston-Salem and Forsyth County.

Table 2.2 – Homelessness Estimates for Winston-Salem/Forsyth County

Type of Estimate	Count of Individuals
January 26, 2005 Point-in-Time Count	539
Annual Prevalence based on Burt et al CSH methodology	1,784

To derive an estimate of the number of persons homeless over the course of the year from this point-in-time estimate, the Task Force and its consultants applied an extrapolation methodology recently published for assisting communities to derive annual estimates based upon point-in-time data.⁷ [See Ten-Year Plan Methodology.] Extrapolating from the 539 point-in-time census figure, it is estimated that approximately 1,784 people are homeless in Winston-Salem over the course of a year.⁸ While this annual estimate is sufficiently reliable for the purposes of developing the 10-Year Plan, use of a

community-wide Homeless Management Information System (HMIS) (described later in this Plan) will greatly assist in the gathering of more detailed and precise data throughout the Plan's implementation.

Table 2.3 – WSFC General Homeless Trends in 200 (Individuals)

Sub-Population	Estimated Prevalence	% of total homeless population
Single Adult Men	1,142	64%
Single Adult Women	285	16%
Total Individuals in Families*	357	20%
TOTAL	1,784	100%

Table 2.4 – WSFC General Homeless Trends in 200 (Households)

Sub-Population	Estimated Prevalence	% of total homeless population
Single Adult Men	1,142	72%
Single Adult Women	285	18%
Family Household Units*	155	10%
TOTAL	1,582	100%

Source: 2005 Point-in-Time Count and projections for 2005 Continuum of Care Application for Winston-Salem. *Family & Household Units have at least one adult and one child under the age of 18. The average family size is 2.3 individuals.

The 2004 Continuum of Care application estimates that roughly 80% of those who experience homelessness at any point in time are single adults not attached to families or dependents at the time of homelessness. National research further suggests that the breakdown among single individuals

between female and male is roughly 1:4. Based on this research, **Table 2.3** highlights probable trends in homelessness among individuals and **Table 2.4** estimates homelessness based on households.

The current homeless population in Winston-Salem is heterogeneous, comprised of single men, single women, families, and unaccompanied youth. While needs and the factors that have contributed to their homelessness vary person to person, there are some commonalities within population subgroups, which it is helpful to understand for purposes of service design and delivery.

Table 2.5 – Rates of Behavioral Health Issues for Winston-Salem Homeless Persons

Sub-Population	Annual prevalence rate (%)		Annual prevalence estimate (#)	
	NSHAPC	W-S point-in-time	NSHAPC	W-S point-in-time
Men				
Mental Illness	39%	23%	445	263
Substance Abuse	48%	60%	457	601
Women				
Mental Illness	51%	31%	145	88
Substance Abuse	26%	54%	74	153
Domestic Violence	10%	21%	29	60
Family Household Units				
Mental Illness	36%	18%	56	28
Substance Abuse	19%	27%	29	42
Domestic Violence	16%	30%	25	47

Figures in **Table 2.5** represent estimated ranges for rates of mental illness, addiction to alcohol or drugs, and domestic violence based on the projected prevalence of Winston-Salem homeless population. Rates of behavioral health issues are drawn from both the point-in-time count and NSHAPC. Variations in the estimates are a function of two different sources, each with slightly different survey techniques. The Winston-Salem point-in-time survey represents a local census effort based upon client self-report intended to inform community planning. The NSHAPC survey represents a national sampling effort, analyzed by professional statisticians endorsed by HUD. Taken together they provide a more complete picture of the possible ranges in rates of behavioral health issues.

Single Men

For the purposes of this Plan, single men include unaccompanied males between the ages of 18 and 65 who report to shelter or other emergency services without an adult partner or children. Many of the men classified as Single Men may, in fact, have adult partners and/or be the non-custodial parents of children. However, because the men are single at the point at which they are requesting services, they are categorized as such. Adult single men make up the largest subpopulation of people requesting homeless services in Winston-Salem. It is estimated that 1,142 men access emergency shelter resources in the course of a 12-month period. This represents nearly three-fourths (72%) of all persons accessing shelter.

To develop a better understanding of the needs and cir-

cumstances of single men experiencing homelessness in Winston-Salem, a focus group was conducted with men staying at two local emergency shelters, Bethesda Center and Samaritan Inn. Seven men participated.

All men participating in the focus group reported being long-time residents of North Carolina. Three had been born in Winston-Salem; all but one had resided here for more than five years. In comparison to participants in the focus groups conducted with single women and families, single men evidenced the greatest degree of variation in the cumulative length of time spent homeless. Participants in the men's focus group reported total lengths of time homeless from four weeks to up to 14 years. Single men were also the most likely of the three groups to have experienced multiple periods of homelessness, averaging 2.9 episodes. All but one participant reported drinking as contributing to their homelessness; most also cited job loss or the lack of any income. **Table 2.6** highlights the needs of men experiencing homelessness.

Table 2.6 – Self-Reported Needs of Single Men

General Health & Behavioral Health Care	<ul style="list-style-type: none"> ▪ Health Care for a physical health problem ▪ Help for a drug/alcohol problem
Housing & Shelter	<ul style="list-style-type: none"> ▪ An affordable permanent home for the long term
Jobs and Income	<ul style="list-style-type: none"> ▪ Job training or education program ▪ Help finding a job
Other/Misc.	<ul style="list-style-type: none"> ▪ Transportation ▪ Life skills (money management, counseling)

Single men also reported significant barriers that impede their progress in securing permanent housing or resolving employment issues. The following major barriers were identified:

- Public transportation is too expensive, infrequent, doesn't reach employment centers
- Criminal records limit access to employment and housing
- Employment situation is bleak
- Lack of confidence or self-respect

Single Women

For the purposes of this Plan, single adult women include unaccompanied females between the ages of 18 and 65 who access shelter or other emergency assistance programs. Seven women from Experiment in Self-Reliance (ESR), a transitional housing program, and Salvation Army, and emergency shelter program, participated in the women's focus group commissioned by the Task Force for this Plan.

Like their male counterparts, the majority of women reported being long-time residents of Winston-Salem. Unlike the male participants, nearly half (42%) of the female focus group participants reported their current stay in emergency shelter as their first episode of homelessness. The length of time women reported being homeless ranged from just a few days to nearly a year, with the average being 60 days. Domestic violence was cited by three women, and relationship problems by an additional two, as causes for their homelessness. Five noted mental illness and/or substance abuse as contributing factors.

Women were also more likely to report suffering from physical health problems and difficulty accessing appropriate health care services. Table 2.7 lists the self-reported needs expressed by women during the focus group.

Table 2.7 – Self-Reported Needs of Single Women

General Health & Behavioral Health Care	• Counseling/therapy or medication for mental illness
Housing & Shelter	• An affordable permanent home for the long term • Help with a housing search
Jobs and Income	• Job training or education program • Help finding a job
Other/Misc.	• Transportation • Meals or food assistance • Life skills (money management, counseling)

Single women reported the following barriers that impede their progress in securing permanent housing or resolving employment issues:

- Public transportation is too expensive, infrequent, doesn't reach employment centers
- Societal prejudices against homeless/poor
- Lack of good paying and flexible employment opportunities
- Lack of transportation

Families

For the purposes of this Plan, a family is defined as a household consisting of at least one adult and one child under the age of 18. Although families requesting shelter vary in composition, the most common household configuration is a female single parent with one or two children under the age of

7. Twenty percent of all individuals experiencing homelessness in Winston-Salem over the course of a year are members of families. Eight families residing at the Salvation Army, the primary emergency shelter facility for families in Winston-Salem, participated in the focus group.

Across the three focus groups, families were the least likely to be long-time Winston-Salem residents. This is largely a reflection of the fact that half (4) of the participating families came to Winston-Salem fleeing domestic abuse. As well, families were the most likely subpopulation to have no previous experience with homelessness, with half of families homeless for the first time.

Table 2.8 – Self-Reported Needs of Families

General Health & Behavioral Health Care	<ul style="list-style-type: none"> ▪ Help for a drug/alcohol problem ▪ Counseling/therapy or medication for mental illness
Housing & Shelter	<ul style="list-style-type: none"> ▪ An affordable permanent home for the long term ▪ Money for the first month's rent or utilities
Jobs and Income	<ul style="list-style-type: none"> ▪ Job training or education program ▪ Help finding a job ▪ Help accessing income assistance such as TANF, SSI, SSDI
Other/Misc.	<ul style="list-style-type: none"> ▪ Transportation

Most families in the focus group were living in Winston-Salem when they became homeless. Families reported domestic violence, loss of job or income, and relationship problems as the primary reasons for their homelessness. And, as has been found to be the case nationally, adults in families reported lower incidences of substance abuse and mental illness. Table

2.8 identifies the significant needs described by families participating in the focus group.

Families also reported significant barriers that impede their progress in securing permanent housing or resolving employment issues. The following major barriers were identified:

- Lack of knowledge about available services
- Providers don't treat clients with respect
- Need transportation to find a job
- Need more flexible, affordable, reliable childcare

Across the three focus groups, when asked to identify the most significant needs that persons who are homeless have in order to end their housing crisis, the following services and needs in Table 2.9 were expressed. Responses are listed in rank order.

Table 2.9 – Most Significant Needs

Men	Women	Families
1. Affordable, permanent home	1. Affordable, permanent home	1. Money for first month's rent
2. Transportation	2. Job training or education	2. Affordable, permanent home
3. Help with a physical health problem	3. Transportation	3. Job training or education
4. Help with a drug/alcohol problem	4. Counseling or therapy for mental illness	4. Transportation
5. Job training or education	5. Help with a housing search	5. Help finding a job

Barriers to Resolving Homelessness

During the Assessment phase of the Task Force's work, consultant team members conducted key stakeholder interviews and facilitated information forums with homeless assistance providers. These interviews and forums were used to gather information from a broad spectrum of individuals with

knowledge and an interest in ending homelessness and to compare and synthesize their views with those offered by persons receive homeless assistance themselves. Sixteen (16) key stakeholder interviews were conducted with representatives from the Continuum of Care, faith community, mainstream support systems, public officials and homeless advocates. Provider Forums included nearly forty participants from both single adult and family service systems. All participants were asked to respond to questions about the underlying causes of homelessness, the needs of individuals and families experiencing homelessness, and barriers they face in their struggle to obtain permanent housing. **Table 2.10** lists barriers to resolving homelessness as identified by various stakeholder groups, including those cited by consumers during the client focus groups.

The listing of barriers by key stakeholder group is helpful in understanding the obstacles individuals and families often face in becoming homeless and how perceptions of barriers differ among those experiencing homelessness, providers of homeless services, and community leaders who might plan or fund specific services and interventions.

Table 2.10 – Barriers Identified by Each Stakeholder Group

Barriers	Key Stakeholders	Providers	Clients
Behavioral Health Issues <i>mental illness, substance abuse/addiction, emotional dysfunction</i>	X	X	
Child Care <i>lack of flexible, affordable, accessible child care</i>	X		
Criminal History <i>lack of resources or special barriers for persons with criminal records</i>	X	X	X
Community Socialization <i>culture of poverty, social pressures and conditioning from within clients' community</i>	X	X	
Economy <i>lack of work, low wage jobs, layoffs</i>	X		X
Education <i>lack of education, lack of life skills</i>	X	X	
Housing Inadequate <i>unsafe, unaffordable, sub-standard, lack of housing</i>	X	X	X
Institutional Discharges <i>discharges from mental health facilities, prison</i>		X	
Legal Problems <i>outstanding warrants</i>		X	
Personal Support Systems Lacking <i>lack of family or community support, no connection to support networks</i>	X	X	
Physical Health <i>disabilities, chronic health conditions</i>		X	
Neighborhood Issues <i>affordable neighborhoods and communities do not support client efforts to maintain sobriety, positive changes, stability</i>	X		
Resources Inadequate <i>not enough services or housing to serve all clients and/or client needs</i>	X	X	
Societal Prejudices <i>discrimination against poor</i>	X		X
System Access <i>can't manage or gain access to system, unaware of system resources</i>	X	X	X
Transportation <i>infrequent, inconvenient, too cumbersome public transit</i>	X		X



PA RT THREE: ASSESSMENT OF CURRENT HOMELESS SERVICE DELIVERY SYSTEM

Description of Current Homeless Shelter System

Winston-Salem/Forsyth County has a comprehensive shelter system for single adults and families. For the most part, the system operates separately for the two populations, although the emergency shelter for families is also open to single women. **Table 3.1** lists the aggregate shelter inventory by program type for each population.

Table 3.1 – Current Shelter System in Winston-Salem/Forsyth County

Sub-population	Emergency Shelter	Transitional Housing	Permanent Supportive Housing
Single Men	204 beds	48 beds	64 units (47 for Single Men and 17 for Single Women)
Single Women	42 beds	25 beds	17 for Single Men
Families	33 units (133 beds)	24 units (112 beds)	18 units (46 beds)
Total	279 beds	185 beds	82 units

The system for single adults is comprised of programs operated by several different provider agencies, affording multiple

points of access for single adults experiencing a housing crisis. Individuals can stay at any of the emergency shelters for up to 90 days, as long as they comply with its rules. If an individual has not enrolled in a transitional program or identified permanent housing at the end of that timeframe, he/she can relocate to a different emergency shelter. Since each emergency shelter has its own philosophy and set of program rules, individuals can choose the shelter that best fits their needs. Per bed costs for emergency shelters serving single adults range from \$12.79 to \$29 a night, or \$4,668 to \$10,585 annually, depending on the level of services provided. Because they remain homeless for such protracted periods of time, and thus often have multiple and lengthy shelter stays, individuals who are chronically homeless are the costliest to serve through the emergency shelter system and occupy beds that would otherwise be available to persons experiencing a short-term housing crisis. The system does offer some transitional housing for individuals who are working or have disabilities and a limited number of permanent supportive housing units for adults with disabilities, but the current resources are inadequate to meet the long-term housing needs of those with chronic disabilities. Persons who are chronically homeless also revolve between other residential systems, including hospitals, jails and prisons, and in-patient mental health and substance abuse treatment programs. As will be discussed in Part Four, expanded permanent supportive housing would greatly

improve client outcomes for persons with chronic disabilities at a cost equivalent to or lower than the investments currently required to provide for their care across these systems.

The system for families is much more limited. There is only one general shelter for families, and two small domestic violence programs. Only one agency offers transitional housing and it is designated for working families, and there are a limited number of permanent supportive housing units for families in which an adult member has a disability.

Assessment of Current Homeless Shelter System

Through the Provider Forums, homeless service providers had an opportunity to describe the current system and to assess its effectiveness. Overall, participating providers reported that the system works well in responding to the emergency needs of those persons who are cooperative and committed to addressing their housing crisis and the underlying factors that have contributed to their homelessness. Providers expressed less optimism, however, about the homeless system's ability to help people access permanent housing. And, most representatives agreed that the system is least effective at engaging those who are non-compliant with program rules, a circumstance which is more common among clients with serious disabilities and which may contribute to the level of chronic homelessness. Table 3.2 includes feedback from the homeless provider forums on the limitations of the current homeless system.

Assessment of Mainstream Service System

Since the homeless service delivery system is designed to focus on persons' immediate housing crises, there aren't sufficient resources to address their long-term permanent housing or service needs. Therefore, most persons who are homeless must rely on mainstream services and housing resources to access and sustain permanent housing. Mainstream resources are services that are intended for the general low-income population, and therefore are not targeted to persons who are homeless. They include resources, such as mental health care, substance abuse treatment, subsidized housing, and public benefits. Table 3.3 includes feedback from the homeless provider forums on the limitations of the current mainstream service system.

Table 3.2 – Provider Assessment of System's Ability to Respond to Crisis

Limited Emergency Shelter Options	<ul style="list-style-type: none"> • No options for non-compliant families • Few options for non-compliant singles • No options for active users • Limited options for intact (two-parent) households or families with a male over 18 years old
Limited Transitional Housing Options	<ul style="list-style-type: none"> • No options for non-working families
Case Management	<ul style="list-style-type: none"> • Lack of continuity when clients bounce between programs or move from emergency to transitional housing
System Organization	<ul style="list-style-type: none"> • Services may not always be effectively organized, targeted, or communicated • Funding sources impose artificial outcomes that • Limit programs' ability to provide individualized, client-driven services ability

Table 3.3 – Provider Assessment of the Mainstream System

Limited Permanent Shelter Options	<ul style="list-style-type: none"> • Limited options for persons with bad credit, criminal history • Limited subsidized housing (HOME coupons, Section 8, public housing) and long waiting lists • No subsidized housing for non-disabled, non-working single adults • Subsidized housing isn't accessible for persons with criminal history, bad credit or history of evictions
Behavioral Health System	<ul style="list-style-type: none"> • Specialized assessment and treatment services aren't available on demand and/or don't offer services needed by this population • Lack of timely after-hours assessment/services • No in-patient treatment for women with their children • Difficult to get appropriate, timely diagnosis for permanent supportive housing • Mental health reform has added confusion about service access and availability
Case Management	<ul style="list-style-type: none"> • Limited community-based case management for non-disabled, non-working clients
Public Benefits	<ul style="list-style-type: none"> • Enrollment takes an average of 45-60 days, and may require multiple attempts
System Organization	<ul style="list-style-type: none"> • Lack of communication and formal referral mechanism with mainstream providers

"Treatment is hard to get but once you get it, it's good."

– HOMELESS WOMAN, CITING THE NEED FOR IMPROVED ACCESS TO MAINSTREAM SUBSTANCE ABUSE TREATMENT SERVICES.



PART FOUR: FUTURE SYSTEM PROGRAM MODELS

The Winston-Salem/Forsyth County Ten-Year Plan to End Chronic Homelessness calls for aggressive strategies that will improve the system of care for people who experience homelessness in the short-term and end chronic homelessness altogether within ten years. These strategies will dramatically shift the current approach to addressing homelessness from a shelter-based strategy to a housing-based strategy, Housing First, to immediately place people in permanent housing and provides wrap-around supportive services to help keep them there. Implementation of them will require broad community support, strong public-private partnerships and tremendous stakeholder commitment and investment. Yet, ending chronic homelessness is well worth this effort.

Housing First Approach

As noted, the housing and services proposed in this plan embody a “Housing First” approach. First introduced by agencies in New York, Los Angeles and Hennepin County, Minnesota, the Housing First approach has gained national significance and momentum over the past five years.

Housing First emphasizes placing persons who are homeless in safe and affordable housing as an immediate response to their crisis and then ensuring that the necessary supports are in place to sustain that housing. It recognizes access to housing as a

basic human need that should not be conditioned on external measures of client readiness such as employment, sobriety, or willingness to accept treatment. As well, Housing First is premised on the belief that the underlying causes of homelessness can be more effectively addressed once a person is housed; thus it diverges from many traditional program approaches in its rejection of the prevailing thinking that people who are homeless must be made “housing ready” prior to being placed in permanent housing. The model promotes long-term self-sufficiency, by linking persons who are homeless to employment opportunities and community-based services to support them in their transition. However, it also recognizes that lifelong support may be required for some to prevent the reoccurrence of homelessness. The Housing First philosophy is intended to offer client-focused housing and services that are flexible, engaging and voluntary. In a growing number of communities across the country, the Housing First approach is being successfully employed with both single adults with serious disabilities (primarily mental illness, substance abuse, and HIV/AIDS) and families.

Adopting the Plan’s Housing First approach will require a shift in both program philosophy and service design for emergency shelter and transitional housing providers— from an approach that attempts to address clients’ underlying problems prior to

placing them in permanent housing to one that works first to help homeless households attain residential stability in the form of permanent housing that best meets their long-term needs.

Over the past 20 years, the existing system evolved to respond to both the influx of families into the system and providers' experience that a skeletal shelter approach that only addressed clients' basic and immediate needs was proving insufficient to resolve clients' broader housing and service needs. Thus, providers gradually shifted to providing a fuller and more intensive range of services on-site in programs and permitting longer lengths of stay in the hope that skills could be acquired to prepare clients for permanent independent housing. Unfortunately, until recently we have lacked a body of research and systematic program evaluation data to guide service development and permit assessment of whether the system has become any more effective as a result of this evolution.

Now, however, with the advent of performance-based funding, the findings of several national program evaluation efforts, and technology that permits routine collection of longitudinal, client-level data, we are developing a much clearer understanding of strategies that do and do not effectively end homelessness. This understanding suggests that the current system's assumption that the skills learned in emergency and transitional housing environments are transferable to permanent housing settings may not hold true for many households. Research findings also demonstrate that Housing First program models result in significantly better client

outcomes and are more cost-effective than the traditional shelter approaches, which haven't effectively ended chronic homelessness nor resulted in a reduction of expensive, acute care or criminal justice involvement.

For instance, Pathways to Housing, Inc. in New York City demonstrates that single adults with psychiatric and substance abuse disabilities on the streets, many of whom have been homeless repeatedly or for years, can leave the streets and remain successfully, permanently housed using a Housing First approach. Pathways places individuals in housing and offers Assertive Community Treatment, an intensive community-based case management and treatment approach—their client-level research shows that 88% are still housed five years later. Pathways has also documented that significant savings can be achieved using a Housing First model. In NYC, the program's annual cost per client was \$22,500, as compared to \$65,000 for a community residence; \$40,000 for an SRO with services; \$27,000 for a cot in a public shelter; \$85,000 for a bed in a jail cell; and \$175,000 for a bed in a State Hospital."

The New York-New York Agreement Cost Study, an effort to evaluate the effectiveness of permanent supportive housing, documented that it only cost an additional \$995 per year to house a homeless individual with a chronic mental illness in permanent supportive housing, based on significant reductions in the use of inpatient medical and mental health services, fewer and shorter hospitalizations in State psychiatric centers, and emergency shelter use."

Similarly, families who are provided with housing placement services and time-limited financial assistance and case management are able to access permanent housing quickly and maintain it, with 75% to 90% still housed a year later. Moreover, research on the impact of homelessness on children and families offers a further compelling rationale for adoption of a Housing First approach for families. During the time they are homeless, children fare significantly more poorly across a range of domains (health, school performance, developmental progress, and well-being) than their counterparts who are housed. This is a reflection of the impact of homelessness on their school attendance and mobility and the stress and unpredictability of their life circumstances. It is also a reflection of the toll that homelessness and shelter environments take on parent-child relationships and the disruption they cause to family routines and normal functioning.

That is not to say that the traditional shelter model does not offer benefits. Rather this Plan proposes to strengthen and retool existing system components to improve care for all clients by 1) *identifying the population for whom the traditional transitional housing programs are most effective and targeting these programs to that specific population*, and 2) *creating new transition in place and permanent supportive housing units* to meet the permanent housing needs of those for whom the current system is not effective. In this way, the

existing homeless service system will change from a system that deals with all individuals facing homelessness in the same manner to one that differentiates between services for persons with short-term needs and those with long-term needs.

The primary program models within the proposed Housing First system are: prevention, outreach, emergency shelter, transition in place housing, limited transitional housing, and permanent supportive housing. **Tables 4.1** and **4.2** list the proposed point-in-time system capacity for individuals and families. Each of these program models is described in more detail in the section following the tables. The methodology for deriving these estimates is detailed in [the Ten-Year Plan Methodology](#).

The plan's vision includes two broad goals:

- ending chronic homelessness; and
- improving the system of care for others who are served by the system that face more short-term needs.

Table 4.3 displays the housing strategies organized by these two broad goals and lists the additional underlying infrastructure improvements required to strengthen the system overall.

Table 4.1 – Projected System Capacity for Individuals*

Program Types - INDIVIDUALS	2005 System for Individuals (Units)	Additional Units Needed to End Homelessness	Annual Cost Per Unit	Total Annual Cost
Prevention - One-time Asst	**	2	\$13,500	\$27,608
Prevention - 3 mo Subsidy	0	15	\$4,908	\$75,270
Emergency Shelter	246	***	\$0	\$0
Transition In Place	0	307	\$10,989	\$3,370,937
Transitional Housing	73	***	\$0	\$0
Permanent Supportive Housing	**	252	\$12,408	\$3,128,697
TOTAL	319	576	41,805	\$6,602,512

Table 4.2 – Projected System Capacity for Families*

Program Types - FAMILIES (Pt-In-time Unit Count)	2005 System for Families (Units)	Additional Units Needed to End Homelessness	Annual Cost Per Unit	Total Annual Cost
Prevention - One-time Asst	**	1	\$21,000	\$21,000
Prevention - 3 mo Subsidy	0	3	\$7,703	\$23,108
Emergency Shelter	36	***	\$0	\$0
Transition In Place	0	30	\$13,180	\$395,388
Transitional Housing	24	***	\$0	\$0
Permanent Supportive Housing	**	9	\$18,206	\$163,490
TOTAL	60	70	\$60,088	\$602,986

* All numbers are based on projections and should be periodically reviewed in the context of new data, demand for services and the overall social and economic environment.

** Current inventory isn't relevant for the purposes of these charts, since it isn't accessible to homeless persons.

*** When the Ten Year Plan is fully implemented and other long-term housing support is available, the shelter system for individuals can be reduced to 162 emergency shelter beds and 61 transitional housing units, and the shelter system for families can be reduced to 27 emergency shelter units and no transitional housing.

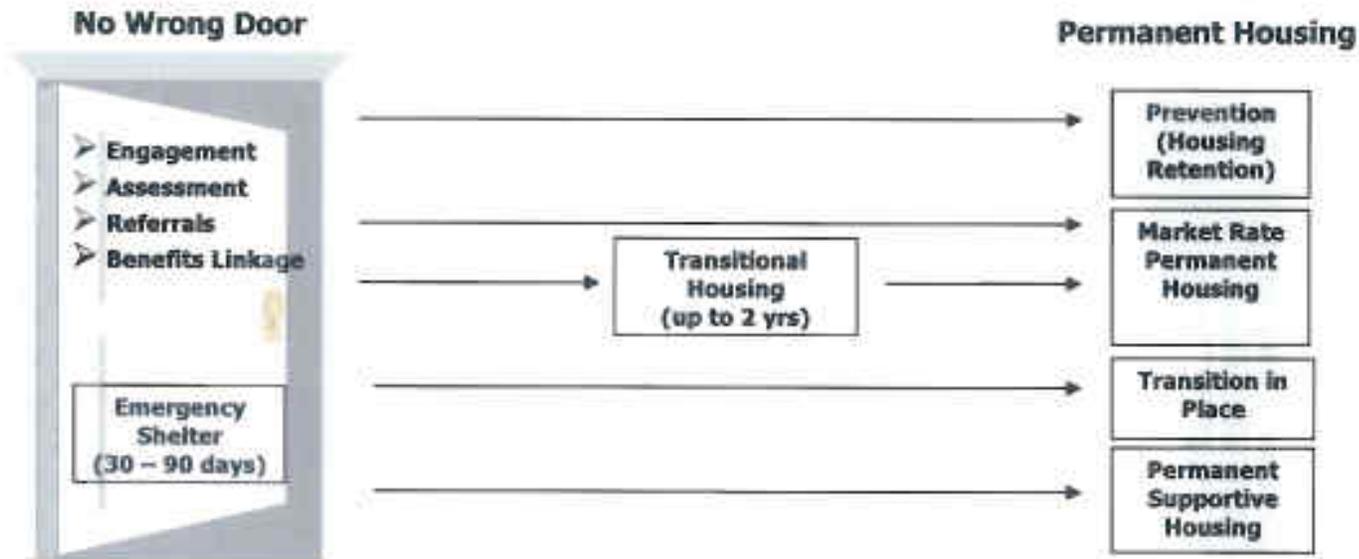
Table 4.3 Housing Strategies Summarized by Plan Goals

Strategies to Assist Persons with Long-term Housing Needs and/or Chronic Disabilities	<ul style="list-style-type: none">• Continuation and enhancement of street outreach efforts to engage persons staying on the streets• Creation of 69 new Transition in Place units• Creation of 261 new Permanent Supportive Housing units
Strategies to Improve the System of Care for Persons with Short-term Housing Needs	<ul style="list-style-type: none">• Expansion of short-term prevention assistance• Enhancement of the current Emergency Shelter system to develop a No Wrong Door approach• Creation of 268 new Transition in Place units• Creation of employment and training services to improve linkage between shelter and employment programs
Additional Infrastructure Improvements to Assist All Populations Experiencing Homelessness	<ul style="list-style-type: none">• Creation of a Housing First Resource Center to coordinate prevention and housing subsidies and develop positive landlord relationships• Development of plans to prevent homelessness of persons discharged from public institutions• Development of formal linkages with mainstream resources, such as employment, TANF, Food Stamps, mental health, and substance abuse treatment• Implementation of a system-level HMIS to collect longitudinal client-level data that can be used for benchmarking program and system-level outcomes and performance evaluation• Implementation of advocacy and communication efforts to promote community awareness and build support of the Ten Year Plan strategies

Program Models

As noted, Housing First calls for a simple but profound change in the way that the homeless system responds to those it serves. The fundamental shift is that homeless services, such as case management, are transitional; the housing in which persons are placed is permanent. This does not mean that consumers may not need case management, substance abuse treatment, employment training or other supports once in housing—

rather, it means that the homeless system should provide immediate short-term supportive services wrapped around their new housing and should link consumers to community-based services that can meet their long-term supportive service needs. The proposed model is shown in **Figure 4.1**.



Prevention

The Plan expands current prevention services in two significant ways: 1) *through time-limited financial assistance* and 2) *broader system-level prevention strategies*, such as enhanced discharge planning. First, the Plan proposes an expansion in one-time and short-term prevention assistance. Through this expansion, one-time prevention assistance may range from a single lump sum to a three-month rent subsidy with linkage to landlord-tenant mediation, credit counseling, and other supportive services. This time-limited prevention is envisioned to be closely coordinated with other rent supports, and may be most effectively managed through the proposed central Housing First Resource Center, as described in the Infrastructure section below.

The specific number of one-time prevention grants referenced in **Tables 4.1** and **4.2** represent the number of grants that will be available each month. These numbers only account for the estimated number of households that are currently becoming homeless whose homelessness could have been prevented if there had been adequate and timely financial assistance available. There are likely many more households who could benefit from comparable cash assistance; however, these families are not currently becoming homeless, thus, their demand is not accounted for in the Plan projections.

Second, the Plan proposes an investment in the development of system-level discharge planning strategies with prisons, medical facilities, and other institutions to prevent individuals

from becoming homeless upon release. This strategy is also described in the Infrastructure Improvements section of this chapter.

Street and Shelter Outreach

Outreaching to adults on the streets and in shelters has proven to be an effective strategy for engaging even the most disabled and “service resistant” individuals into housing and care.¹⁴ The current system includes outreach services from both emergency shelter and mental health providers. Staff from agencies that are currently providing outreach will be offered training on Stages of Change/Motivational Interviewing engagement approaches and be linked with additional resources to support timely permanent housing placement.

Stages of Change/Motivational Interviewing is a best practice for engaging people to address behavioral health and other lifestyle change issues. Pioneered with persons with substance use disorders, stages of change/motivational interviewing interventions have been successfully adapted for persons with mental illness, dual-disorders, and those who are homeless. Such an approach recognizes the importance of assessing where an individual is relative to his/her understanding of a need to change and commitment to the change process. Programs that utilize a Stages of Change approach assess and respect where an individual is in that process and encourage and motivate rather than mandate progress. Use of this approach has been associated with greater treatment participation and outcomes, including: reduced substance use, better social adjustment, and successful referrals to treatment.

Emergency Shelter

Emergency shelter programs are an important component of a Housing First response. While the Plan attempts to shorten the average length of stay within an emergency shelter, these programs remain a critical access point for housing and other supportive services. The existing shelter system will be enhanced to expand its current role of providing basic food and shelter to focus on client assessment, housing placement, referrals and mainstream entitlement benefits linkage.

The proposed emergency shelter system will embrace a “No Wrong Door” approach to shelter so all clients will experience these enhanced emergency shelter services no matter what program they initially access. While the Plan does not set a maximum allowable length of stay in shelter, the Task Force aims for clients to be placed in permanent housing within 30 days, recognizing that a sizable number of clients will move on to other housing on their own without significant support. For those that do require transitional assistance, the Housing First Resource Center (described in the Infrastructure Improvements section below) will facilitate access to information about available permanent housing properties, rent subsidies, and landlords.

Transitional Housing

Although the Plan emphasizes the need for immediate permanent housing placement, it recognizes a role for long-term transitional housing for certain populations. For instance, providers have indicated that individuals battling chronic addictions that are ready to embrace sobriety benefit from a

structured, congregate environment with supportive services and peer mentoring on-site. Thus, the Plan maintains a level of transitional housing to target those populations that benefit most from a staged housing approach. These transitional housing programs are generally part of a continuum of programs offered by a single provider, where a client can seamlessly move from an emergency shelter program to transitional housing where he can stay for up to 24 months. Transitional housing programs also offer extensive housing placement services and follow-up case management to ensure that clients are placed in permanent housing and retain their housing.

Transition in Place

Transition in Place is a new program model proposed within the Plan. The Housing First umbrella encompasses a diverse range of programs that share the following core features: a primary focus on assisting families to obtain and sustain permanent housing and the provision of housing placement, financial assistance, and case management (generally time limited) services to promote this goal. Some programs provide direct rent subsidies, and others rely on market-rate housing or linkage to mainstream housing programs. The Plan proposes six-month transitional rent subsidies and supportive services for households with short-term needs. Longer-term rent subsidies and supportive services, up to 24 months, are proposed for households with long-term needs, such as an individual with a serious mental illness who needs time to resolve present issues but has the income potential (though employment or disability benefits) to sustain market-rate or subsidized

housing.

Permanent Supportive Housing

Coupling housing with flexible, tailored support services available on-site has proven effective at reducing time spent homeless, increasing housing stability, reducing the use (and therefore the cost) of publicly funded services (particularly emergency shelter and state-funded inpatient psychiatric facilities), and improving mental health and substance abuse recovery. Permanent supportive housing programs vary with regard to their structure (project-based, clustered, scattered site) and the nature and intensity of services. As described previously, one approach that has proven particularly successful for single adults with chronic disabilities is a scattered site, Housing First model, Pathways to Housing, that pairs housing and assertive community treatment services, and affords participants significant choice in their housing. In this model, adults are moved directly from the streets or shelters into housing of their choosing, and participation in treatment and other services is voluntary.

Proposed permanent supportive housing environments include market-rate apartments and houses, clustered or scattered site apartments with integrated supportive services, group homes or assisted living settings, treatment housing and mixed-population housing for both persons with disabilities and employed persons and/or general population low-income residents. The Plan will support models in which: clients have choice regarding the location and type of permanent housing; there is no limit on the length of time that the household can

remain in the property; income strategies are integrated into case management to help households increase their incomes and housing stability; and, case management and supportive services are provided in the most appropriate way necessary to keep the individual or family in the housing they choose.

Infrastructure Supports

While some of the proposed changes must occur within specific homeless programs and agencies, other improvements are needed at a system-level to support homeless programs and to efficiently target mainstream systems. As well, the efficacy of all of these changes must be defined, monitored, and evaluated at a broader community level. Action in the following areas is required to enhance the overall effectiveness of the service delivery system.

Homeless Provider Training

Homeless service programs will not be able to provide Housing First-oriented services if staff at these agencies are not trained in the philosophy and approach. In some cases, staff will only need limited training on new strategies and resources to support their daily case management activities. In other cases, more extensive training will be necessary to teach staff new skill sets or a new way of providing services. For instance, shelter-based case managers may need to be retrained to provide community-based case management. Training will build on existing community professional development activities.

Staff training initiatives will address the need for coordinated

staff educational programming among shelter providers, provide context and specific best practice models for Housing First initiatives, and enable staff to stay current with required safety, first aid, and professional certification designations. Additional training will expose staff to the most current and evidence-based successful program models in areas such as chemical dependency; mental health treatment; housing and legal rights; stress management; race and socioeconomic class discrimination; mainstream resource eligibility and access requirements; and other topics as appropriate.

Service Coordination, Discharge Planning and Mainstream Resource Coordination

A higher degree of service coordination among providers of homeless services is also necessary at several levels: within the homeless service delivery system; with institutions that currently discharge persons into the homeless system; and with systems and providers that manage mainstream resources that are critical for the long-term support of persons who experience homelessness.

Enhancements that promote increased service coordination among homeless providers include: coordinated intake, assessment, case management, and service protocols. Standardized intake assessment tools may need to be developed, along with protocols that define roles, responsibilities, and procedures to improve the efficiency and quality of service delivery. Service coordination efforts will improve lines of communication and emphasize multi-disciplinary teams and partnerships between service

organizations.

Equally important are efforts to formalize discharge plans from large institutions (e.g. public and private hospitals, prisons, foster care system, etc.) that may have an opportunity to prevent homelessness for individuals or families through proactive housing placement and service linkage. As well, the homeless system needs to improve its strategies for systematically screening clients and helping them enroll in eligible benefit programs, such as Food Stamps, Medicaid, Social Security and TANF. Providers also need to cultivate formal linkage agreements with mainstream providers, such as mental health providers, substance abuse providers, and the public housing authority, to help their clients quickly access available mainstream resources.

Strategies to improve efforts in all three of these areas will be critical to the success of the Plan.

Housing First Resource Center

To support the shift to a Housing First approach, homeless providers must have access to an effective mechanism to quickly access information about available permanent housing options and resources within the community. The Plan proposes a Housing First Resource Center to serve this function. The Housing First Resource Center will be staffed with trained housing specialists who will cultivate relationships with landlords and manage a database that details available properties by type, number of bedrooms, location, monthly rent, and landlord familiarity and support of the Plan.

The Housing First Resource Center may also be used to centrally administer short-term prevention assistance, Transition in Place and/or Permanent Supportive Housing rent subsidies, in coordination with homeless or supportive service providers. As well, the Center could administer a community risk management pool to be used to mitigate risks of placing clients in market rate housing.

Employment Resources

National research on individuals who are homeless and local focus group results indicate that many persons who are homeless are employed and most who are not employed want to work. For those facing a short-term housing crisis, self-help employment resources, including access to job listings, telephones and transportation, may provide sufficient assistance. For those with greater barriers to employment and those with unique employment and training needs, stable housing is needed before they can begin to address their long-term vocational needs. Active collaboration among homeless providers and mainstream employment and treatment service providers is critical to the success of employment initiatives for formerly homeless individuals and families. New employment initiatives are needed that focus on the needs of persons who are homeless or who have recently been home less. The goal of these employment initiatives will be to link persons, at a pace appropriate to their situations, to mainstream community education, employment and training programs.

The plan proposes integrating additional employment resources into the existing shelter system and incorporating employment program components into all future supportive housing initiatives, to promote a culture of work in the housing environment. Employment success will be defined individually for each resident, according to his/her skills and abilities. For any given person, successful employment may range from a few hours a week, or even occasional informal work, to full-time career-focused employment. Employment initiatives will also help to create non-traditional jobs for those who are unable to compete in the private sector, and transitional employment opportunities that can help persons move into traditional employment.

Outcomes

High-level strategies in the Plan must be translated into concrete, achievable steps for the community, homeless governance board, homeless providers, and persons experiencing homelessness. Only by defining benchmarks for success and monitoring progress towards their achievement can we realize our vision of ending chronic homelessness and improving the system of care for all those who face homelessness. The following outcomes provide a starting point for an outcomes framework for each constituent group:

Community Outcomes:

- ✓ Community is educated about the extent and scope of homelessness in Winston-Salem/Forsyth County.
- ✓ Community supports Plan recommendations, including strategy of developing permanent housing options scattered throughout the community.
- ✓ Chronic homelessness is eliminated in Winston-Salem/Forsyth County.
- ✓ System of care for all homeless persons and families is improved.

Homeless Governance Board Outcome:

- ✓ Community-based services and housing for persons experiencing homelessness are coordinated, efficient, cost-effective, and accessible.

Homeless Service Providers Outcome:

- ✓ Services are provided in a client-centered environment that promotes safety (facility standards); client self-determination (housing first philosophy); quick access to the most appropriate housing options (decreasing client length of stay in shelter and linkage to permanent housing); and access to an array of services (referral and linkage to appropriate services).

Homeless Management Information System (HMIS)

This Plan underscores the importance of enhanced data collection and monitoring capabilities and continuous quality improvement on a system-wide level. A functioning Homeless Management Information System (HMIS), with participation from a broad range of homeless assistance providers, offers the

ability to conduct standard point-in-time and longitudinal counts of the homeless population to inform program and system development and policy making.

Current plans are underway to expand and merge the existing system with the State's HMIS. Participants will also need to comply with the U.S. Department of Housing and Urban Development's HMIS Data and Technical Standards to assure consistency and uniformity of data collection, appropriate client confidentiality protections, and system security.

An enhanced HMIS will include the following:

- Development of an integrated client-level data-base—an automated client tracking system to help coordinate housing and services for people experiencing homelessness;
- Development of outcome indicators for those programs that provide housing and service support for persons who are homeless and have disabilities;
- A periodic survey of providers and users of homeless services that can be used by system planners to identify the service needs of homeless populations; and
- Continuous improvement of the data collection surveys that focus on identifying profiles of homelessness and linkages to promising service strategies.

Evaluation

System-level evaluation will be an important component of assessing progress in achieving the goals of the Ten-Year Plan. To undertake this, Plan goals must be translated into strategic action steps with time frames, assignments of responsibility,

and associated costs. Regular evaluation activities will review progress in achieving goals, communicate results, and recommend possible mid-course corrections and refinements to Plan assumptions. Evaluations of program and system performance must be conducted at least annually with general results communicated to the public on a regular basis.

As noted, an important component of evaluation activities will be the development of an HMIS, which provides a uniform and consistent means for tracking of program and client activity from a community-wide perspective. The HMIS will be used to collect standardized data from each homeless assistance program, track progress in achieving program-level outcomes, and monitor decreases in the extent and scope of homelessness over time.

Advocacy

System enhancements to the Winston-Salem/Forsyth County homeless assistance system alone are not sufficient to end chronic homelessness or dramatically improve the system of care. Ongoing advocacy with mainstream providers is necessary to ensure that public housing, mental health resources, substance abuse treatment, transportation, employment, and physical health resources are accessible and available to persons and families experiencing homelessness. Deliberate and persistent advocacy efforts at the state and national levels are critically important to assure the ongoing accessibility of targeted and mainstream resources.

The State of North Carolina has initiated an effort to adopt a

Ten-Year Plan to End Chronic Homelessness. The State's Plan cites specific numbers of housing units and enhanced program models. Changes in state and federal policy are also key components of North Carolina's strategy to end chronic homelessness. Advocacy and implementation of our Ten-Year Plan must work in conjunction with statewide efforts to advocate for system reforms.

Awareness

To raise awareness and garner support for the Ten-Year Plan, ongoing information sharing and education of the general public, elected officials, funders, and even homeless assistance providers is necessary. A public awareness campaign will identify specific messages that communicate the causes of homelessness and proven strategies for ending it. Establishment of a Speakers Bureau including members of the proposed Ten-Year Plan Commission, former Blue Ribbon Task Force members, City staff, current homeless assistance providers, and former consumers of homeless services will greatly advance this awareness.



PART FIVE: IMPLEMENTATION STRATEGIES – HOW WE GET IT DONE

To oversee implementation of the strategic initiatives described throughout this Plan, a ‘lead entity,’ the Ten-Year Planning Commission (TYPC) will be established. This Commission will include representation from a wide range of agencies and programs involved in ending homelessness such as local government, funders of services and housing for the homeless, the faith community, the business community, and members of the Winston-Salem/Forsyth County Council on Services for the Homeless Executive Board. The primary function of the TYPC will be to effect the vision of this Plan—ending chronic homelessness and improving the system of care for all.

Governance and Accountability Roles

Leadership for homeless system planning and monitoring is currently provided by both the Winston-Salem/Forsyth County Council on Services for the Homeless and the City of Winston-Salem Housing/Neighborhood Development Department. Members of the Council include representatives from approximately 50 organizations and individuals, including local government, homeless assistance providers, mainstream service providers, faith-based ministries, and current or past consumers of homeless services. The City Housing/Neighborhood Development Department is a significant funder of services and housing for homeless persons and coordinates the City of Winston-Salem’s Continuum of

Care application proposal to HUD each year. While this governance structure and staffing has been adequate for the planning activities conducted in the area to date, including shepherding development of the Ten-Year Plan, it is not sufficient for undertaking a task of the magnitude of implementation of the Ten-Year Plan.

Achievement of the Plan’s goals will be best accomplished through creation of the TYPC, whose sole responsibility is to effect and monitor implementation of the Plan. This independent Commission will employ the resources of professional staff to manage the transition process from the current governance configuration to the new TYPC structure. Staff resources may be borrowed from current planning and funding organizations. Initial staffing for the TYPC during the transition may include time-limited consultants or full time employees, depending on the timing, funding availability, and scope of work.

The current Council on Services for the Homeless is extremely effective as a regular information sharing and advocacy organization. This important work of the Council will continue and evolve to support the work of the new TYPC through enhanced service coordination and planning initiatives.

Various standing TYPC Strategy Committees will be

established to inform its work, support its recommendations, and provide an important linkage to community-based neighborhood groups, community organizations, and civic groups for the purpose of promoting plan priorities and leveraging support for Plan activities. Additional TYPC Strategy Committees may be formed on an ad hoc basis to review the ongoing needs and characteristics of specific sub-populations within the general homeless population, such as persons with chronic disabilities, families, youth, and survivors of domestic violence.

The immediate functions of the TYPC will include the following:

- **Implement a TYP Transition Team** made up of a wide variety of potential stakeholders. The Transition Team will focus on short-term action steps (within the next 6 months to 1 year) to support Plan strategies.
- **Identify and secure resources** to support the implementation of the Plan.
- **Create permanent supportive housing** for individuals and families that experience homelessness for long periods of time and struggle with disabilities such as mental illness, substance abuse and addiction, physical disabilities, and developmental disabilities.
- **Transition the current shelter-based system to a Housing First philosophy** that promotes a client-centered approach to engagement, service delivery, and

rapid housing placement. Enhancement of shelter services and development of homelessness prevention and shelter diversion strategies.

- **Develop external infrastructure supports** such as the Housing First Resource Center, employment assistance and training, legal counseling, and treatment for mental illness and addictions. Although the Plan recognizes the necessity to improve housing and services for homeless persons, it also emphasizes the improvement core infrastructure services and resources that enable persons who are homeless to find work, increase income, manage debt, resolve legal problems, and treat disabilities.

Figure 5.1, Winston-Salem/Forsyth County Ten-Year Plan Implementation Structure, identifies the major entities involved in implementation of Plan strategies, graphically illustrates the relationship between these groups in terms of membership and lines of communication, and delineates roles and responsibilities for all community members in enacting Plan strategies.

The immediate action steps identified in this Plan must be managed by an Implementation Transition Team comprised of providers, Task Force members, community members, funders, and public officials. **Table 5.1** lists activities, time frames, and costs for the next two years of Plan implementation. Sources for cost estimates and more detail by line item are included in the [Ten-Year Plan Methodology](#).

Figure 5.1 – Winston-Salem/Forsyth County Ten-Year Plan Implementation Structure

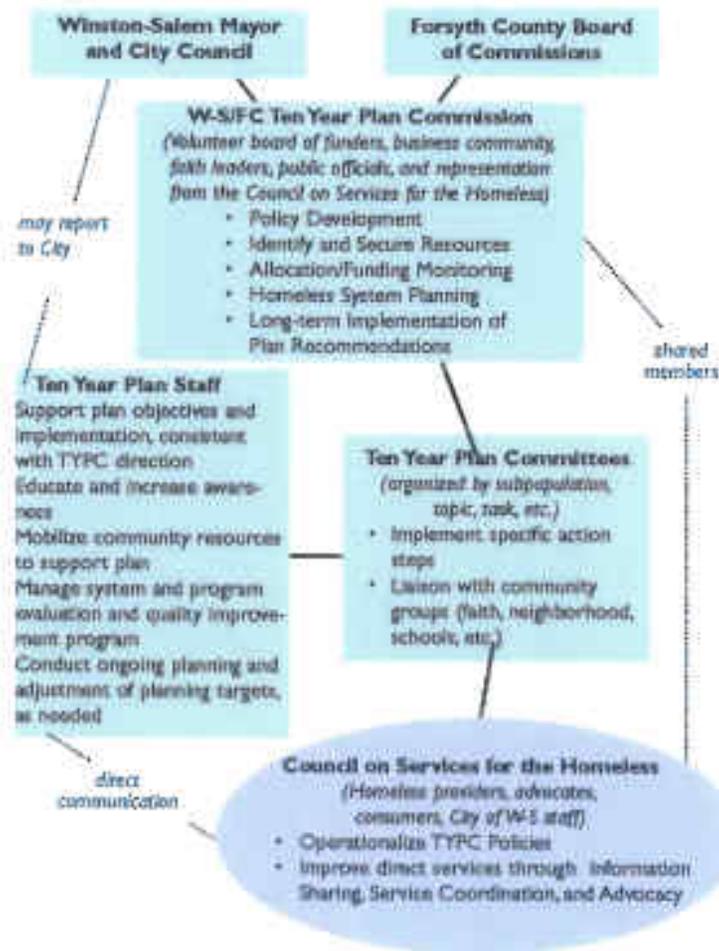


Table 5.1 lists the estimated annual costs that will be required to expand the supply of permanent supportive housing and improve the system of care for others experiencing homelessness. As one of its primary functions, the TYPC will need to identify and secure commitments for resources from a range of federal, state and local sources to implement the Ten-Year Plan. “Resources” include not only financial support, but also qualified staff, sites for housing and program activities, and other infrastructure elements. The final figure listed in the table represents the total level of additional investment that will be required at full implementation of the Plan. The availability of these resources will affect the pace of implementation, and conversely the desired pace will affect resource development targets. The TYPC will also need to prioritize the plan strategies that are of greatest importance and will need to establish a mechanism to allocate resources accordingly throughout plan implementation.

The primary strategies for securing resource commitments from federal, state and local sources include: advocating for additional dedicated federal, state and local resources; capturing some of the cost savings realized by other systems as a result of ending chronic homelessness with permanent supportive housing; developing formal linkage agreements with mainstream systems to provide the services and/or housing specified in the Plan; leveraging agency plans that are already underway to achieve the goals set forth in the plan; negotiating below market rate rents with area landlords and other cost efficiencies; redesigning how current programs operate and/or reprogramming some funds that are currently used to fund shelter-based services; and conducting a Ten-Year

Table 5.1 – Strategic Initiative Short-Term Work Plan

Strategic Initiative and Activities	Near-Term Annual Cost (2007)	Long-Term Annual Cost (2015)
1- Implementation Transition Team		
• Short-term implementation plan	\$25,000	
– Solicit endorsements for Plan		
– Convene funders, draft resource development plan		
– Develop governance and accountability structure for Plan implementation		
• Ten-Year Plan Staff	\$60,000	\$120,000
• Public awareness campaign	\$25,000	
SUB-TOTAL	\$110,000	\$120,000
2 - Permanent Housing		
• Permanent housing projects (Transition in Place and PSH) brought on-line based on 25 new units per year initially, expanding in final years (2007 figure represents 50 units; 2015 figure represents 598 units)	\$620,400	\$7,058,511
SUB-TOTAL	\$620,400	\$7,058,511
3 - Transition current shelter-based system to Housing First Philosophy		
• No Wrong Door - enhancement of shelter services, increased collaboration		\$25,000
• Provider education and training	\$12,000	\$18,000
• Prevention, shelter diversion, and discharge planning strategies (coordinated through Housing First Resource Center)	\$147,000	\$225,000
SUB-TOTAL	\$184,000	\$243,000
4 - External Infrastructure Supports		
• Housing First Resource Center – market-rate rental property listing, landlord relationship development, and prevention assistance coordination	\$170,500	\$205,000
• Employment specialists (3)	\$90,000	\$150,000
• HMIS (Homeless Management Information System)	\$50,000	\$100,000
• Advocacy and awareness efforts for system change at local, State, and federal levels	\$25,000	\$50,000
SUB-TOTAL	\$335,500	\$505,000
Enhanced System	TOTAL	
	\$1,249,910	\$7,926,512

Plan campaign to secure additional local government funds, foundation grants and individual contributions.

Getting it Done

As documented in this Plan, emergency shelter alone cannot end chronic homelessness. An adequate supply of permanent, affordable housing and community supports are critical to breaking the cycle of homelessness and assisting those who are chronically homeless to achieve housing stability and progress toward self-sufficiency. This Plan recognizes that it is going to take the time, resources, and sustained effort of many organizations and individuals to reach this goal. The process, however, has already begun. We must support the organizations that are already working on projects that are consistent with our vision for the future. When occupied, we must celebrate these projects as early achievements towards the Plan's goals. And we must track the outcomes of these programs, and use them to leverage additional investment in our Plan. These individual program changes can help further the shared vision of our community—the end of chronic homelessness in Winston-Salem by 2015 and the initiation of other system improvements that will position us to aim even higher in the decades that follow. However, much more work will be required over the next ten years. The Blue Ribbon Task Force to End Chronic Homelessness has provided the roadmap to guide this important effort. With this Plan and our collective will, together, we can end chronic homelessness.

For More Information

For more information on the Ten-Year Plan to End Chronic Homelessness, please contact:

Housing/Neighborhood Development Department
City of Winston-Salem
P.O. Box 2511
Winston-Salem, NC 27102
(336) 727-8597
(336) 727-2878 fax
Email: Contact Tim West at timw@cityofws.org

Ten-Year Plan materials may be found at:

www.cityofws.org/housingneighborhooddev/homelessness/homelessness.html

Notes:

¹ *North Carolina Low Income Housing Coalition*. www.nchousing.org

² *National Coalition for the Homeless "Welfare to What II," 2001.*
Available at www.nationalhomeless.org

³ *North Carolina Justice and Community Development, "Working Hard is Still Not Enough,"* www.ncjustice.org

⁴ *US Census Bureau 2003 Estimates*

⁵ *Stewart B. McKinney Homeless Assistance Act, 1987*

⁶ *NSHAPC, 1997.* www.huduser.org/publications/homeless.html

⁷ *Martha Burt, Carol Wilkins, Estimating the Need, Corporation for Supportive Housing, 2003.* www.csh.org

⁸ *See Ten-Year Plan Methodology for a description of the enumeration process and methodology for establishing the annual prevalence estimates*

⁹ *Baumohl, Jim, ed. 1996. Homelessness in America. Phoenix: The Gryx Press.*

¹⁰ *Tsemberis, S. & Eisenberg, R.F. (2000). Pathways to Housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric Services, 51(4), 487-493.*

¹¹ *Personal communication with S. Tsemberis, Executive Director of Pathways to Housing, Inc. (3-03)*

¹² *Culhane, D., Metraux, S. & Hadley, T. (2001). The impact of supportive housing for homeless people with severe mental illness on the utilization of the public health, corrections, and emergency shelter systems: The New York-New York initiative. Washington, DC: Fannie Mae Foundation.*

¹³ *Rafferty, Y. & Shinn, M. (1991) The impact of homelessness on children. American Psychologist, 46(11), 1170-1179.*

¹⁴ *Lam, J. & Rosenheck, R. (1999). Street outreach for homeless persons with serious mental illness. Medical Care, 37(9), 894-907.*

¹⁵ *Miller, W.R. & Rollnick, S. (2002). Motivational interviewing: Preparing people for change. Journal of Studies on Alcohol, 63(6), 776-777.*

¹⁶ *Culhane, D. (2001); see above.*

¹⁷ *Tsemberis, S. & Eisenberg, R.F. (2000). Pathways to Housing: Supported housing for street-dwelling homeless individuals with psychiatric disabilities. Psychiatric Services, 51(4), 487-493.*