

We must measure the results of our work by whether it makes a difference in the lives of the people we serve.

“When assistance is restricted to those who are homeless tonight, not much can be done to prevent homelessness tomorrow.”

—Burt (2001)

Objectives, Strategies, and Action Steps

Objective 1: PREVENTION

Prevent individuals and families from becoming homeless through comprehensive discharge planning, targeted resources, research, and advocacy.

Outcome: A reduction in the number of people with identified risk factors for homelessness who become homeless.

Statement of Need: Preventing homelessness is more cost-effective and humane than allowing people to become homeless in the first place; any community effort to end homelessness must include substantial prevention resources. Indeed, as Burt (2001) notes, “When assistance is restricted to those who are homeless tonight, not much can be done to prevent homelessness tomorrow.”

Prevention Action Team: To include, among others, Wake County Human Services, Wake County Public School System, Dorothea Dix Hospital, Men’s and Women’s Prison, Wake County jail, area hospitals, Wake Continuum of Care, Wake Re-entry Cluster, Raleigh Organizing for Action and Results (ROAR), Triangle Interfaith Alliance, and advocacy and consumer groups.

Strategy A: Create and execute comprehensive discharge plans for people leaving institutions. Create and execute comprehensive, client-centered discharge plans coordinated with community agencies for individuals leaving foster care, mental health facilities, jails and prisons, and medical facilities who are at risk of homelessness.

Action Steps:

1. Develop a city/county plan that increases collaboration among facilities in discharge planning and prohibits publicly funded agencies and facilities from discharging any individual to the streets, to shelters, or to any other housing option that has not been independently confirmed.

Benchmark: Discharges to unstable housing options decrease by 80%.

2. Undertake a demonstration program for 18-21 year olds aging out of foster care. Require that prior to discharge from the system, clients have six continuous months of the

following: residence in safe, affordable housing (based on their preference); participation in education/training programs or a stable job or other source of income (e.g., disability benefits); involvement with community social/recreational activities; and regular contact with a community-based volunteer mentor/advocate.

Benchmark: 90% of proposed youth enrolled.

3. Require that caseworkers assigned to individuals leaving mental health facilities make a discharge plan with each client, with emphasis on community-based mental health treatment (including Assertive Community Treatment (ACT) teams), access to medications, housing, and social support services, such as a psychosocial clubhouse or peer-run drop-in center. This effort must focus on community transition plans for long-term patients as Dorothea Dix Hospital prepares to close.

Benchmark: 80% of individuals leaving mental health facilities have a discharge plan that successfully links them to housing and appropriate community-based treatment and support.

4. Design and implement a jail “in-reach” program that assigns community caseworkers for comprehensive discharge planning with offenders who are multiple recidivists. Follow-up with special emphasis on obtaining housing, employment or education, life skills training, and linkage to needed mental health, substance abuse, and medical care services.

Benchmark: 90% of proposed offenders are enrolled.

Strategy B: Design and implement an integrated prevention effort. Design and implement a prevention effort for individuals and families at risk of homelessness, combining emergency assistance funds with short-term intensive support from professional caseworkers, and follow-up by local faith-based or other nonprofit organizations.

Action Steps:

1. Identify and bring together key stakeholders, including targeted prevention programs, faith-based and other nonprofit organizations, as well as consumer representatives, to review existing research and design an integrated prevention plan. Address issues such as agency roles and responsibilities, participant criteria, volunteer recruitment, follow-up processes, training needs, and the implementation timetable.

Benchmark: An integrated prevention plan is adopted for implementation.

2. Carry out the integrated prevention plan.

Benchmark: 80% of clients proposed for the first phase are being served; new benchmarks are set for succeeding years.

Strategy C: Pursue prevention activities within the public school system. Target prevention activities within the public school system to all school-aged children to provide education on homelessness and provide “in-reach” services to identify those who are at greater risk of becoming homeless.

Action Steps:

1. Work with the Wake County School Public School System to develop a specific curriculum of activities to educate school aged children about homelessness, factors contributing to homelessness and our plan to end homelessness.

Benchmark: Curriculum is developed, approved and implemented.

2. Increase the number of social workers in relation to students (currently at 1 to 2,714) to the nationally-recognized standard of 1 to 800, to ensure that social workers can identify and

offer early intervention to children and youth at risk of dropout, suspension, or homelessness and their families.

Benchmark: The standard of 1 social worker to 800 students is achieved in 90% of schools.

3. Strengthen program to train peer mentors to work with their peers who are at risk of dropout, suspension, or homelessness.

Benchmark: Peer mentors are trained and available in 75% of public schools.

4. Develop and deliver educational programs about domestic violence that offer children and youth the tools they need to be safe, self-confident, and secure.

Benchmark: 80% of public middle school students attend domestic violence education classes.

5. Engage faith-based and other voluntary organizations in efforts to create more high quality before and after-school activities for children and youth who are homeless or at-risk of homelessness.

Benchmark: There is a 75% increase in high quality before and after-school programs provided by faith-based and other nonprofit organizations.

Objective 2: ENGAGEMENT

Expand and coordinate outreach and engagement efforts and create short-term housing capability to engage or re-engage people who are homeless into permanent housing and the health, behavioral health, and social service systems.

Outcome: Decrease the time between initial outreach contact and engagement in health, behavioral health, housing, and social services and reduce the number of people who are chronically homeless.

Statement of Need: Once believed to be a nontraditional service, outreach to disengaged homeless people, often street and woods dwellers, is now considered the first and most important step in engaging and connecting/reconnecting individuals with needed mental health, substance abuse, healthcare, and social services and to housing (SAMHSA, 2003).

Engagement Action Team: To include, among others, Wake County Human Services, Haven House, The Women's Center, CASA, Raleigh Rescue Mission, Helen Wright Center for Women, Wake Continuum of Care, Passage Home, Weed and Seed Steering Committee, advocacy and consumer groups.

Strategy A: Develop Safe Havens. Develop Safe Havens (low demand supportive housing) as engagement housing for people who are chronically homeless and who have serious mental illnesses and/or substance use disorders.

Action Steps

1. Plan for the first Safe Haven: identify location, number of units, recruitment criteria and strategy, length of stay, staff support, etc.

Benchmark: Safe Haven funding request is submitted to HUD.

2. Open the first Safe Haven.

Benchmark: The Safe Haven is at 80% capacity; 50% of residents have transition plans in place.

Family homelessness is growing by an estimated 11% each year.

...outreach to disengaged homeless people, often street and woods dwellers, is now considered the first and most important step...

—SAMHSA, 2003

3. Develop one to three additional Safe Havens, refining the strategies used for the first one.

Benchmark: One to three additional Safe Havens are operating.

Strategy B: Create and implement a 24/7 Housing Crisis Response Plan.

Develop a 24/7 service for the community that provides immediate information, referral and crisis management for persons currently experiencing housing emergencies.

Action Steps:

1. Review current and potential resources and needs for short-term (generally one to two nights) crisis housing.

Benchmark: An inventory of current and potential resources, including hotels/motels, along with crisis housing needs, is completed.

2. Develop a coordinated housing crisis response plan, including centralized referral and ability to enlist hotels/motels for crisis housing on an as-needed basis.

Benchmark: The Housing Crisis Response Plan is finalized to address referral, housing, and information.

3. Carry out Housing Crisis Response Plan.

Benchmark: 80% of individuals and families meeting the criteria for crisis housing will be placed for short-term stays (generally one to two nights) in crisis housing.

Strategy C: Phase down shelters and transitional housing and replace with service-enhanced short-term housing that links people with permanent housing. Gradually replace emergency shelters and transitional housing with targeted short-term housing models that will provide a brief and supportive transition to permanent housing.

Action Steps

1. Develop short-term housing standards and processes, including staffing, services, supports, recommended lengths of stay, and interagency linkages that enable individuals and families to quickly and successfully move to permanent housing.

Benchmark: Service-enhanced short-term housing models are adopted, tailored to specific groups, e.g., mothers with children, individuals with histories of chronic homelessness, youth without homes.

2. Review shelter and transitional housing resources, assess short-term housing needs, and create plan to gradually phase down shelter beds and to replace shelters and the various types of transitional housing with the service-enhanced short-term housing models designed to link individuals and families to permanent housing.

Benchmark: A shelter phase-down and short-term housing plan is in place, including

timelines, staffing needs, and costs, and implementation begins.

3. Hire and train additional case managers to help residents of short-term housing make plans for permanent housing and self-sufficiency and provide services or make referrals to mainstream services.

Benchmark: 80% of new case managers are in place and trained.

4. Connect short-term housing consumers to the network of permanent housing resources to increase their access to permanent, affordable housing.

Benchmark: 90% of short-term housing consumers access the housing resource network services.

Strategy D: Strengthen and coordinate outreach and engagement efforts. Strengthen outreach and engagement efforts by eliminating duplication of effort, addressing gaps in services, and providing key services at a central location.

Action Steps

1. Determine overlaps and gaps in outreach services.

Benchmark: Overlaps and gaps in outreach services are identified.

2. Develop and implement a plan to eliminate duplication of effort, coordinate care, track savings, and use savings to fill gaps in outreach services, including adding outreach capacity to address unmet need.

Benchmark: Planned outreach capacity is added, funded through savings.

3. Enhance willingness and ability of providers such as law enforcement, health care providers (including first responders), and public housing authorities to call on outreach teams to avoid crises and connect people who are homeless or at risk of homelessness with appropriate services.

Benchmark: Referrals to crisis intervention programs from specified providers increase by 25%.

4. Strengthen the ability of community groups and individuals, such as churches, small businesses, neighborhood organizations, and community members to respond to individuals in need of outreach and call on outreach teams to respond.

Benchmark: There is a continued increase in referrals of people who are homeless to outreach teams from community groups and individuals.

5. Expand availability, resources and use of drop-in centers, including phones, showers, laundry, clean clothes, storage area for personal belongings, a place to receive mail, Internet access, community voicemail, and linkage to a range of housing, health and behavioral health services, and social services.

Benchmark: Use of drop-in services increases by 25%.

Objective 3: HOUSING

Expand the availability and choices of permanent housing that are affordable to individuals and families with extremely low incomes.

Outcome: Establish and meet target increases in the availability of safe, affordable, permanent housing appropriate to the needs of individuals and families who are homeless or at risk of homelessness.

Statement of Need: It goes without saying that people are homeless because they have no place to live. In Wake County, there remains a gap of at least 25,000 units of affordable

housing, and more than 15,000 people are precariously doubled up with relatives or friends. But the mantra of “housing, housing, housing” as the answer to the crisis of homelessness has given way to the understanding that many individuals and families, especially those with mental illnesses and/or substance use disorders, need supportive services to help them remain in housing.

Single men who are homeless are much more likely to go without shelter and be chronically homeless than single women who are homeless.

In Wake County, there remains a gap of at least 25,000 units of affordable housing, and more than 15,000 people are precariously doubled up with relatives or friends.

Housing Action Team: To include, among others, City of Raleigh Community Development Department, Wake County Housing and Community Revitalization Department, Wake Continuum of Care, NC Housing Financing Agency, NC Division of DD/MH/SA, Raleigh Housing Authority, Wake County Housing Authority, Campaign for Housing Carolina partners, nonprofit housing developers, banks and other financial institutions, advocacy groups.

Strategy A: Establish a Housing First model.

Establish a Housing First model of permanent supportive housing consistent with individuals’ needs, preferences, and priorities to serve people who are homeless. The Housing First model provides permanent housing immediately to persons who are homeless and offers the residents voluntary supportive services as long as they need them.

Action Steps

1. Develop a model of Housing First that responds to the unique needs of the homeless population and corresponds to the housing resources in Raleigh and Wake County.
Benchmark: A Housing First model is developed and adopted, with a designated agency leading the effort.
2. Fund and implement the Housing First model in 20 housing units.
Benchmark: The Housing First project is at 80% capacity; new benchmarks are set for additional Housing First projects.
3. Create a Housing First 20-unit pilot project with Raleigh Housing Authority and Wake County Housing Authority.
Benchmark: The Housing First pilot project is at 80% capacity.

Strategy B: Increase the supply of permanent affordable housing. Increase the supply of permanent housing affordable to individuals and families at 0-40% of area median income to meet the deficit.

Action Steps:

1. Address regulatory and policy barriers to affordable housing development, which will lead

to an increase in housing units for renters at 0-40% of area median income (assuming some level of subsidies/rental assistance).

Benchmark: 10% more units are available for renters at 0-40% of area median income in the first phase; new benchmarks are set.

2. Increase local funding for permanent housing for those at 0-40% of median income through targeting Wake County Capital Improvement Plan (CIP) funds and establishing a city/county Housing Trust Fund with a minimum of \$2,000,000 available annually.

Benchmark: Local funding for permanent housing for those at 0-40 percent of median income is increased by 20%.

3. Increase number of units available for persons at or below 15% of median income through incentives and funding for tax credit projects (those that put aside 25% of units for rents at or below a percentage of area median income, in return receiving bonus points and state credits).

Benchmark: 20 units are developed and ready for occupancy in the first phase; new benchmarks are set.

4. Develop a low-interest or interest-free loan program to help bring rental properties up to code.

Benchmark: 30% of rental properties that were not up to code are habitable due to the loan program.

5. Increase the annual allocation to the North Carolina Housing Trust Fund to \$50 million for housing production and rental subsidies for persons at 40% and below of area median income.

Benchmark: 50 units of housing and 20 rental subsidies are established through Housing Trust Fund funding in the first phase; new benchmarks are set.

6. Work to re-establish previous HUD policy, which allows the Raleigh Housing Authority and Wake County Housing Authority to negotiate the best value for Section 8 rental vouchers with area landlords.

Benchmark: The housing authorities provide a proposal to the appropriate HUD contacts to reinstate the negotiated rent policy, and enable housing authorities to distribute 10 additional rental subsidies with the savings from the negotiations.

Strategy C: Develop resources for supportive services available to those in supportive housing. Develop resources to fund and provide access to supportive services to those in housing at levels appropriate to those individuals and families who have been chronically, acutely or intermittently homeless as well as those who are at risk of being homeless.

Action Steps:

1. Increase the capacity of the Supportive Housing Program at Wake County Human Services, and similar programs, to serve individuals and families who are at risk of being homeless through an array of services, including financial literacy, daily living skills, links to employment and health resources, and assistance with landlord communication.

Benchmark: An additional 130 households through the WCHS Supportive Housing Program, and an additional 40 in public housing developments, receive supportive housing services in the first phase of the initiative; new benchmarks are set.

2. Increase the capacity of current providers (non-profit and government) to provide appropriate services to those who move from interim to permanent housing so persons successfully maintain their housing. Services must be specialized and provided at levels

appropriate to those individuals and families who are chronically, acutely or intermittently homeless.

Benchmark: New staff for participating agencies are hired and trained.

3. Work with local congregations, faith-based groups and other voluntary organizations to develop a volunteer network to help support newly-housed individuals and families, including volunteer recruitment and training, availability of expert advice, and access to crisis intervention resources.

Benchmark: 50 newly-housed individuals/families have volunteer support in the first phase of the initiative; new benchmarks are set.

According to the 2000 census, 11.5% of Raleigh residents are living below the poverty line, defined for that year as \$8,794 for a single person and \$17,603 for a family of four.

We will work with local congregations, faith-based groups and other voluntary organizations to develop a volunteer network to help support newly-housed individuals and families.

Strategy D: Educate funders, developers, and citizens. Promote a variety of affordable housing choices throughout Raleigh and Wake County for individuals and families.

Action Steps

1. Sponsor an annual Affordable Housing Development Forum for funders, developers, and consumers of services to provide information about incentive programs, address concerns, and share successful local models and models from other communities.

Benchmark: An Affordable Housing Development forum is held in year one, and scheduled annually.

2. Strengthen relationships and communication among city and county housing, zoning, and homeless services officials and landlords and owners' associations—including the Raleigh Housing Authority, Wake County Housing Authority, Triangle Apartment Association, and other private landlords.

Benchmark: Two meetings between city/county officials and landlords and owners' associations are held, with future bi-annual meetings scheduled.

3. Develop Good Neighbor Agreements, patterned after those created by the Ohio Community Shelter Board, to promote communication, respect, and trust among neighbors, residents of permanent supportive housing, service providers, and funders.

Benchmark: 80% of Citizen Advisory Councils have Good Neighbor agreements in place.

Objective 4: EMPLOYMENT/EDUCATION

Create education, job training, and competitive employment opportunities specific to the needs of individuals and families who are homeless, recently homeless, or at risk of homelessness, including those with mental illnesses and/or substance use disorders and youth ages 16-21.

Outcome: Increase competitive employment and employment-related education/training opportunities for people who are homeless, recently homeless, or at risk of homelessness.

Statement of Need: People who are homeless want and need to work at jobs that enable them to support themselves and their families. A survey of homeless assistance providers revealed that their clients cited “help finding a job” as their number one need, followed by help finding affordable housing, and help paying for housing (Burt et al., 1999).

Employment Action Team: To include, among others, Capital Area Workforce Development, Wake Tech, Triangle United Way, Wake County Public Schools, JobLink, Wake County Human Services, Wake Continuum of Care, Vocational Rehabilitation, Greater Raleigh and other Wake County Chambers of Commerce, top area employers, Wake County Public Libraries, consumer and advocacy groups.

Strategy A: Design and implement education, job readiness, and training

programs. Establish strategic alliances with the business and educational communities to design and provide education, job readiness, and training opportunities for individuals and family members who are homeless, recently homeless, or at-risk of homelessness.

Action Steps:

1. Support and enhance local business organizations, such as the Business Advisory Council and Chambers of Commerce to create models for training, hiring, and supporting people who are homeless, recently homeless, or at-risk of homelessness.
Benchmark: A minimum of 20 business leaders commit to hiring people who are homeless, recently homeless, or at risk of homelessness in the first phase of the initiative, with new benchmarks set for succeeding years.
2. Convene local business and education representatives to develop and deliver affordable, brief retraining courses designed to help people who are homeless and have a work history re-enter the competitive job market.
Benchmark: A minimum of 40 people who are homeless, formerly homeless, or at risk of homelessness are enrolled in re-training courses, with new benchmarks set for successive courses.
3. Target existing and design and implement new vocational training in skilled jobs (e.g., electrical work, plumbing, welding, automotive repair, etc.) through Wake Technical Community College’s Vocational Technology Division.
Benchmark: A minimum of 20 people who are homeless, formerly homeless, or at risk of homelessness are enrolled in pre-existing and new vocational training courses, with new benchmarks set for successive courses.
4. Work in concert with the business community to re-establish a comprehensive program providing: job readiness and needs assessment, counseling, job development and placement, comprehensive case management, and peer support services for unemployed or under-employed adults seeking permanent employment (similar to the former Wake County Human Services Jobs for the Homeless Program.)
Benchmark: 80% of proposed number of clients for the first phase of the program are engaged in program services, with new benchmarks set.
5. Together with educational institutions, create a supported education program (e.g., GED, ABE) that offers individualized services to enable people who are homeless, at risk of homelessness, or recently homeless to enroll in or return to school, with a special emphasis on youth ages 16-21.

Benchmark: 80% of proposed number of clients for the first phase of the supported education program are enrolled, with new benchmarks set.

Strategy B: Establish an “Employment First” program for residents of supportive housing. Establish employment opportunities that enable residents of supportive housing who express a desire to work to do so.

Action Steps:

1. Plan strategies to link employment to permanent supportive housing, with a focus on an “Employment First” approach.

Benchmark: A plan is developed and adopted.

At 19%, Wake County’s population of people who are chronically homeless is nearly twice the national average.

Unbeknownst to most community members, the majority of adults who are homeless in Raleigh and Wake County work at full or part-time jobs.

2. Target “Employment First” opportunities through the agencies that serve permanent supportive housing residents (e.g., service agencies, housing agencies).

Benchmark: Employment opportunities are available and designated agencies (housing and service) have information about job openings for case managers to access for clients.

3. Work with the business community to create positions designed for permanent supportive housing residents in area service industries (fast food, hospitality, etc.)

Benchmark: A minimum of 25 positions designed for permanent supportive housing residents in area service industries are available in the first phase of the initiative; new benchmarks are set.

4. Create a menu and system utilizing existing and new “Employment First” opportunities to enable case managers to offer employment resources to any permanent supportive housing resident who expresses a desire to work.

Benchmark: A minimum of 10 permanent supportive housing residents are employed in the first phase of the initiative; new benchmarks are set.

Strategy C: Fund services that support employment. Fund services and supports that enable individuals and family members who are homeless, recently homeless, or at risk of homelessness to participate fully in employment opportunities.

Action Steps:

1. Create additional subsidized day care openings for parents returning to work.

Benchmark: 80% of the new day care slots are filled for the first phase of the effort; new benchmarks are set.

2. Work to expand public and other transportation to individuals returning to work, including providing subsidies, increasing availability of public transportation on nights and

weekends, and providing reverse commute rides (from urban areas to the suburbs).

Benchmark: Affordable transportation is available to 30% of homeless people who need such assistance to return to work; new benchmarks are set.

3. Provide professional or volunteer job coaches to offer on-the-job and follow-up support to individuals who are or have recently been homeless and need such services to maintain employment.

Benchmark: Professional and volunteer job coaches are hired/trained and begin work with clients; new benchmarks are set for the number of individuals who are homeless and have failed in at least two previous job placements who are linked with a job coach.

Strategy D: Develop specialized training and employment services for people who are or have recently been homeless and have disabilities. Develop specialized job training and employment services for people who are homeless and have mental illnesses and/or substance use disorders.

Action Steps:

1. Conduct a needs assessment and gaps analysis to determine the type of services that people who are homeless and have mental illnesses and/or substance use disorders need to gain and maintain employment and explore how to develop model programs.

Benchmark: Analysis of the needs assessment and gaps analysis is complete.

2. Develop a targeted supported employment program for people who are or have recently been homeless and improve access to existing employment programs serving people who have disabilities.

Benchmark: 80% of proposed clients for the first phase are enrolled in the supported employment program for people with serious mental illnesses and/or substance use disorders; new benchmarks are set.

3. Develop and operate social enterprises that provided employment for people with serious mental illnesses and/or substance use disorders who are or have recently been homeless, building on the success of currently operating social enterprises.

Benchmark: 80% of proposed social enterprise slots for the first social enterprise initiatives are filled; new benchmarks are set.

Objective 5: SERVICES AND SUPPORTS

Enhance services and supports for people who are homeless, at-risk of homelessness, or recently homeless to help them achieve maximum independence and self-sufficiency.

Outcome: Increase the ability of the mainstream service system to provide comprehensive services that promote stability for individuals and families who are homeless, at risk of homelessness, or recently homeless, including groups with special needs.

Statement of Need: Housing is necessary but not sufficient to help people who are homeless—particularly those with multiple physical health, mental health, and social service needs—achieve residential stability, psychiatric stability, and sobriety. Many individuals and families require some level of supportive services, which will vary in type and intensity depending on individual and family needs.

Services and Supports Action Team: To include, among others, Wake County Human Services, Haven House, The Women’s Center, CASA, Raleigh Rescue Mission, Helen Wright Center for Women, Wake Continuum of Care, Passage Home, Triangle Interfaith Alliance, ROAR, consumer and advocacy groups.

Strategy A: Expand the capacity to serve people with mental illnesses and/or substance use disorders. Expand the ability of publicly funded and private, non-profit community providers to better serve people with mental illnesses and/or substance use disorders who are homeless or at risk of homelessness.

Action Steps:

1. The Healing Place for Women and Children is created based on the successful model of The Healing Place for Men.

Benchmark: The Healing Place for Women and Children is open and accepting clients.

We are spending far too much on the 19% of people considered “chronically homeless,” who rotate in and out of shelters, jails, and hospitals, rather than providing them with treatment and services that will end this vicious cycle.

Housing is necessary but not sufficient to help people who are homeless...Many individuals and families require some level of supportive services

2. Cross-train outreach workers, case managers, advocates, primary health care workers, and mental health and substance abuse treatment providers to recognize the signs and symptoms of mental illnesses, substance use disorders, and co-occurring mental illnesses and substance use disorders, and the co-occurring effects of these disorders.

Benchmark: A program of ongoing training, affordable and accessible to all levels of staff, both paraprofessional and professional, is funded and scheduled.

3. Increase the availability of an integrated approach to appropriate assessment, treatment, and services for persons with co-occurring mental illnesses and substance use disorders.

Benchmark: Pilot testing of an integrated approach to assessment, treatment, and services for persons who are homeless with co-occurring mental illnesses and substance use disorders begins.

4. Increase access for individuals who are homeless to innovative psychosocial rehabilitation services, such as the Clubhouse model.

Benchmark: The number of clients who are or have recently been homeless who are involved in innovative psychosocial rehabilitation services increases to 80% of the proposed number for the first phase; new benchmarks are set.

5. Expand peer support, counseling, and mentoring capacity, including peer counselor certification.

Benchmark: A peer mentor employment program is established and begins matching consumers with peer mentors; new benchmarks are set for succeeding years.

6. Work with policy experts to develop a proposal to expand Medicaid coverage (e.g. under the Rehabilitation Option and/or through Medicaid waiver programs) for appropriate treatment and services for people with serious mental illness in community settings.

Benchmark: A proposal for increased Medicaid coverage is developed and presented to the state Medicaid authority and legislators.

Strategy B: Expand current multi-service centers to serve as “one stop shops.”Expand current multi-service centers (Cornerstone, Bason Street Center, Women’s Center) to serve as a “one-stop shop” for individuals and families who are homeless or at risk of homelessness who need health, mental health, substance abuse, and social services, as well as housing, help obtaining public benefits, employment assistance, transportation, and child care.

Action Steps:

1. Plan and carry out an analysis of current clients and their service requests at Cornerstone, Haven House, and Women’s Center. Analysis will include outcome of service requests.

Benchmark: Analysis is complete.

2. Develop and implement service integration and expansion strategies, to include stationing staff from all relevant Wake County Human Services departments at multi-service centers to expedite access to housing, health and behavioral health, and social services.

Benchmark: Out-stationing begins; individuals and families access mainstream resources at multi-service centers.

Strategy C: Implement targeted services for those with special needs.Implement targeted efforts for individuals and families who are chronically, acutely or intermittently homeless as well as those who are at risk of being homeless, with a special emphasis on survivors of trauma (domestic violence, sexual assault, or child abuse), youth aging out of foster care, immigrants and refugees, veterans, ex-offenders, underserved minorities, and gay, lesbian, bisexual, and/or transgendered youth.

Action Steps:

1. Increase the capacity of current providers (non-profit and government) to provide appropriate services to those who move from short-term to permanent housing so persons successfully maintain their housing.

Benchmark: New staff for participating agencies are hired and trained.

2. Ensure that current programs serving individuals and families in short-term housing provide needed services such as life skills training.

Benchmark: Individuals and families in short-term housing are receiving life skills training and other identified service and support needs.

3. Expand the availability of short-term housing and specialized support services for survivors of trauma and their children.

Benchmark: 25 additional beds, along with appropriate services, are available for survivors of trauma and their children.

4. Train community providers in culturally competent service delivery and ensure that translators are available, so that services are accessible and appropriate to those who need them, with a special emphasis on recent immigrants and refugees.

Benchmark: 50% of community providers have received cultural competence training and have access to translators on an as-needed basis; new benchmarks are set for succeeding years.

5. Undertake a demonstration program for 18-21 year olds aging out of foster care requiring that, prior to discharge from the system, clients have experienced the following on a continuous basis for six months: residing in safe, affordable housing (based on their preference); either participation in education/training programs or a stable job or other source of income (e.g., disability benefits); involvement with community

social/recreational activities or resources; and regular contact with a community-based volunteer mentor/advocate.

Benchmark: The demonstration program is underway with 90% of proposed youth enrolled.

6. Create a mentoring program for ex-offenders with volunteers and/or paraprofessionals to advocate on their behalf with employers, landlords, and neighborhood groups to create a seamless discharge plan and ease their transition to the community.

Benchmark: Program begins; ex-offenders have a mentor assigned to them upon release.

Homelessness is a challenging problem with no single or simple solution.

In Wake County, 83% of female-headed homeless households have recent domestic violence as one contributing factor to their homelessness.

Strategy D: Promote an integrated, comprehensive system of care. Work closely with mainstream providers to promote an integrated, comprehensive system of care that enhances the ability of individuals and families who are homeless or at risk of homelessness to walk in any service door, be assessed, and be provided with, or referred for, services (the “no wrong door” approach to service provision).

Action Steps:

1. Develop a standard comprehensive intake assessment of client needs that multiple agencies will use and periodically reassess, to determine the appropriate level of service needed by individuals and families.

Benchmark: 90% of providers are using a standard intake form for assessment and determination of service needs.

2. Work with the Social Security Administration (SSA) to develop and implement an outreach project designed to reach those individuals who are homeless who are eligible for but not receiving SSA benefits.

Benchmark: There will be an increase in the number of successful SSA applications from among the target population.

3. Increase the capacity of mainstream providers both public and non-profit, to provide services, such as mental health and substance abuse treatment, employment assistance, and veterans’ services, at key locations where persons who are homeless present for services (e.g., Cornerstone, the Healing Place, South Wilmington Street Shelter, add others Haven House, Women’s Center).

Benchmark: Staff from mainstream providers are stationed at locations where persons who are homeless present for services.

4. Train mainstream providers, including health care, behavioral health, police, jail, and

school staff, to identify clients with risk factors for homelessness, provide prevention assistance as it falls within the scope of their roles, and refer individuals to appropriate community prevention resources.

Benchmark: A community-wide interagency referral system, including staff training plans and follow-up to track referrals, is adopted and begins operating.

5. Increase the ability of faith-based and other voluntary organizations to serve at-risk and recently homeless individuals through volunteer opportunities, including mentoring and ongoing support.

Benchmark: Faith-based or other voluntary organizations begin volunteer recruitment for new or expanded opportunities to work with people at risk of homelessness or who have recently been homeless.

We know what works to end homelessness and we know why we have to do it. Now is the time to act.

FOR MORE INFORMATION: www.raleighnc.gov/endinghomelessness