A Place to Call Home

10 Year Plan to End Homelessness

"Homelessness is too common to be exceptional."
Dennis Culhane, University of Pennsylvania

Prepared by

COUNCIL of COMMUNITY SERVICES
Gateway to information and planning.

November 2006

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"I used to look at homeless people or women in crisis situations and think less of them, think they were lazy or low class, etc. Now, through my own experiences and problems, I realize that domestic violence, homelessness, etc. can happen to anyone no matter what walk of life they come from."

Roanoke City-Roanoke County/Salem Continuum of Care

Acknowledgements

Steering Committee Members

Joe Cobb ~ Roanoke Valley Interfaith Hospitality Network

Jane Conlin ~ City of Roanoke Department of Social Services/Human Services

Calvin Curry ~ Roanoke Redevelopment and Housing Authority

David Diaz ~ Downtown Roanoke, Inc.

Joyce Earl ~ Roanoke County Department of Social Services

Ted Edlich ~ Total Action Against Poverty

Hope Hollingsworth ~ Downtown Roanoke, Inc.

Jason Holt ~ City of Roanoke Police Department

Malora Horn ~ City of Roanoke Schools

Thomas Housenfleur ~ Community Volunteer

Karen Michalski-Karney ~ Blue Ridge Independent Living Center

Pamela Kestner-Chappelear ~ Council of Community Services

Molly O'Dell, MD ~ Roanoke City Health Department

Barbara Smith ~ Refugee and Immigration Services

Wayne G. Strickland ~ Roanoke Valley Alleghany Regional Commission

Carol Tuning ~ City of Roanoke Homeless Assistance Team

Abby Verdillo ~ United Way of Roanoke Valley

Audrey Wheaton ~ Rescue Mission

Susan Williams ~ Local Office on Aging-Area Agency on Aging

Council of Community Services Staff

Paula L. Prince, PhD

Karen Saunders, Intern Hollins University

Introduction

In 1987, the Roanoke City Manager's Task Force on Housing and Homelessness, renamed Roanoke Regional Task Force on Homelessness, conducted a four month study of the needs of individuals experiencing homelessness. The report, *No Place to Call Home*, was the result of this effort. Some of the recommendations from this first report have been accomplished. Outcomes include:

- Expansion of TRUST House to include transitional housing
- Expansion of the Rescue Mission to include a women's treatment program
- Creation of the City of Roanoke Rental Inspection program
- Updated list of all subsidized housing maintained by the City of Roanoke
- Funding for housing programs made available through CDBG and City of Roanoke Human Services grant programs
- Home maintenance programs for low income homeowners and the elderly created by Total Action Against Poverty [TAP] and League of Older Americans [LOA]
- Increase in the number of religious congregations who provide funding for the emergency and short term needs of those homeless through Roanoke Area Ministries [RAM]
- Creation of the Roanoke Valley Interfaith Hospitality Network
- Continued focus on the importance of planning for discharge from institutions such as jail, prison and mental health facilities
- Services to and advocacy for individuals experiencing homelessness expanded by committees such as HELPS and the Continuum of Care
- Creation of a program for homeless veterans at the Salem VA Hospital
- Creation of the Roanoke Regional Task Force on Homelessness

However, since 1987 the number of people identified as experiencing homelessness has increased from one hundred twenty-two [122] in January, 1987 to 381 in January, 2006, approximately triple [**Appendix I**]. These numbers are very likely an undercount of people who are homeless because this number does not include those who are doubled-up in the homes of family and friends or those who live in substandard housing. It does not include those women and children who are at the domestic violence shelter, Salvation Army Turning Point. It does not include all of those individuals who choose to remain out of shelter on the street. In addition, those people who are most at risk of <u>becoming</u> homeless are very often invisible until the inevitable happens.

The U.S. Department of Health and Human Services estimates that over a five-year period, about 2–3 percent of the U.S. population (5–8 million people), will experience at least one night of homelessness. Those who are homeless include children, families and individuals categorized as *chronically*[1] homeless. The National Alliance to End Homelessness reports that addressing the needs of people who are chronically homeless can be particularly expensive. The costs include increased use of emergency rooms, more lengthy hospital stays, more psychiatric hospitalizations, more costly drug and alcohol interventions, increased risk of incarceration and use of more costly emergency shelters. Not calculated is the cost of the loss of future productivity. Agencies that provide services to people who are homeless were surveyed for this Plan. They report that the value of the services they provide, including cash, in-kind and volunteer, is $4,754,389 for 2004-2005.

The decision to again investigate the issue of homelessness was influenced by several factors. These include:

- the increase in the number of people experiencing homelessness in the Roanoke Valley;
- the number of people from surrounding areas unable to access services in their home communities;
- the apparent lack of success at addressing the barriers to housing experienced by those who are chronically homeless; and
- the shift in focus on the national level from a “Continuum of Care Model” to a “Housing First” model.

This report, *A Place to Call Home,* is the result of a ten month planning process that included homeless service providers, city and county administration, representatives from the business community and people experiencing homelessness in the Blue Ridge Continuum of Care Region[2]. A Steering Committee, made up of stakeholders and interested parties, was created to study the issue of homelessness in the Region and to create a plan with strategies that would end chronic homelessness in ten years. The Steering Committee began by educating itself on the various dimensions of homelessness and the barriers individuals face in finding and remaining housed. This planning process included data collection and focus groups held with individuals who are homeless and merchants in the Roanoke City Market area. Other Virginia communities that also have developed 10 year

[1] Glossary **Appendix 2**

[2] Alleghany County, Botetourt County, the City of Covington, Craig County, the City of Roanoke, Roanoke County and the City of Salem.

plans are Alexandria, Arlington City, Fairfax County, Norfolk, Portsmouth, Richmond, and Virginia Beach.

A Place to Call Home is a long range, comprehensive plan which combines information management, prevention, and infrastructure strategies. Goals of the plan are:

- Reduction in the number of people who become homeless;
- Increase in the number of homeless people placed into permanent housing;
- Increase in the number of homeless people outside of the Roanoke Metro area that are able to remain in their home locality;
- Decrease in the length and disruption of homeless episodes;
- Implementation of a web-based Homeless Management Information System; and
- Improvement in the provision of community based services and supports.

The principles guiding the recommendations in this Plan are based on:

- Evidence-based and promising practices
- Measurable results
- Galvanizing the regional community
- Consumer-centered services
- Cultural competence
- Resilience and recovery

As with all plans to end homelessness that primarily focus on those individuals whose homelessness is chronic, the recommendations in *A Place to Call Home* will also result in the reduction of all types of homelessness including among families, youth and single adults. This plan's success will depend on several factors. These factors are:

- Participation by all localities in the Blue Ridge Continuum of Care
- Funding, public and private, at local, state and federal levels
- Commitment of stakeholders in the outcome and the power to make decisions to implement the plan's strategies
- Monitoring, reviewing and updating the plan on a regular basis

The Demographics of Homelessness

How many people are homeless?

As part of its mandate to monitor all issues facing the Continuum of Care region's homeless population, the Roanoke Regional Task Force on Homelessness conducts an annual shelter survey. Data collection is carried out by members of the Task Force, with the help of the City of Roanoke Homeless Assistance Team and other community volunteers. According to the January 2006 survey, an estimated 381 homeless people reside in emergency shelters, transitional housing facilities, treatment centers, and in other areas not designed for sleeping in the Roanoke Valley each night. All of the shelters serving the Continuum of Care area participated in the survey process which was conducted on one day, January 25, 2006. In addition, those people who lived on the street were approached to participate. Two hundred and thirty-four [234] people who were homeless agreed to answer the survey questions. This represents sixty-one percent [61%] of those who were identified as homeless during the survey period.

2006 Count of Homeless Persons

Blue Ridge Continuum of Care

Homeless Population	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of Families with Children (Family Households):	20	12	0	32
1. Number of Persons in Families with Children:	58	30	0	88
2. Number of Single Individuals and Persons in Households without Children:	101	174	18	293
Total Persons:	159	204	18	381

Homeless Subpopulations	Sheltered	Unsheltered	Total
a. Chronically Homeless	1	3	4
b. Severely Mentally Ill	11	4	15
c. Chronic Substance Abuse	103	5	108
d. Veterans	8	1	9
e. Persons with HIV/AIDS[3]	0	0	0
f. Victims of Domestic Violence	17	1	18

[3] It is likely that there are people who are HIV+ in the region's homeless population. Due to confidentiality requirements this is not a statistic that is collected and available for publication.

Children and Youth

More than one hundred-fifty children were reported to be living in Roanoke Valley homeless shelters during the 2005-2006 school year. Approximately seventy-five percent of those children were in kindergarten to 5th grade. If children can be formally defined as "homeless" they will be provided transportation from shelter to enable them to remain in their own school. This provides a measure of stability which is particularly needed. Every locality in the Commonwealth of Virginia is required to have a Homeless Student Liaison who links children and youth with services in addition to providing training for school staff about the needs of children who are homeless.

Unaccompanied youth can be categorized either as homeless or runaway. The National Runaway Switchboard reports that as many as 2.8 million run away and homeless youth live on the streets in the United States. The City of Roanoke Police Department investigated 503 cases of homeless or runaway youth in 2004.

A review of client files [1998-2000] found that fifty-five percent of the youth who find shelter at the Sanctuary Runaway and Homeless Youth Program report that leaving their home was a result of family turmoil. Youth who have runaway have done so because of fear resulting from physical, emotional or sexual abuse. Thirty-eight percent of the youth reported psychological issues such as depression, poor self-image, abandonment and sexual identity. Alcohol and drug abuse, either their own or of a household member, was reported by twenty-six percent of youth as the reason they ran away. Eight percent were the direct or indirect victims of domestic violence. Many of the homeless youth (32%) were dealing with a lack of social skills, problems with peers, violent behavior, survival sex, prostitution and drug dealing.

What do we know about the people who are homeless?

2006 Winter Shelter Survey

Homeless more than 6 months	71.8%
Male	68.3%
White	48.7%
Veteran	22.6%
Slept last night	
Transitional housing	33.8%
Emergency shelter	31.6%
Hospital	20.5%

Never homeless before	32.5%
Homeless 4+ times before	10.3%
Have children with them	11.2%
High school diploma or more	73.1%
Employment	
Full time	25.6%
Part time	16.7%
Mean age	42.48 years
Oldest	72 years
Youngest	19 years

What is the reported cause of homelessness?[4]

Substance abuse issue	27.4%
Unable to pay rent	13.7%
Evicted [missed rent]	7.3%
Family problems	12.0%
Institutional discharge	7.3%
Domestic violence	6.4%
Unemployment	4.7%

Additional information about the reasons for homelessness was obtained at a focus group held at the Roanoke Valley day shelter, RAM[5] House, in May, 2006. Twenty RAM clients participated in the discussion of issues of homelessness. All of the participants reported job related reasons for their homelessness. They were either unemployed or income from their job [day labor] was insufficient for them to afford an apartment. One participant had recently been released from jail and was unable to find a job even with assistance from TAP VA Cares. The biggest challenges for the participants were:

- Finding a job that pays enough to afford housing
  - *"[It is] difficult to obtain a job within the private sector when living in transitional housing. An….employer calls and is immediately notified of my homeless status."*
- Transportation – buses do not run at night
- Loss of self-esteem
  - "*People look down on you*"
  - *"It is so depressing. [I] can't wait to get a set of keys in my hand."*
  - *"It is so demeaning it can't be put into words."*

[4] 2006 Winter Shelter Survey
[5] Roanoke Area Ministries

- Shelters want to tell you how to spend (or save) your earnings
- Difficulty finding housing if you are a convicted felon
- No place to stay after completion of a substance abuse treatment program – end up with friends who continue to use drugs and/or alcohol so end up back on drugs

Some of the issues that need to be addressed for prevention and reduction of homelessness are discussed in more detail below.

(1) Mental health and substance abuse interferes with the ability of people to obtain and retain housing.

> *"It is estimated that up to 600,000 persons are homeless on any given night. Many homeless individuals, in particular those who experience chronic homelessness, tend to have disabling health and behavioral health problems. Nationally, one-half of homeless adults have histories of alcohol abuse or dependence and one-third have histories of drug abuse. About 20-25% of homeless adults have lifetime histories of serious mental illness. Between 10-20% have a co-occurring substance abuse/mental health disorder."* [6]

Blue Ridge Behavioral Healthcare reports that during 2005-2006 the Projects for Assistance in Transition from Homelessness [PATH] worker interacted with 150 homeless persons, and opened 91 as PATH clients. Two-thirds of those clients were referred to mental health services, substance abuse treatment, and other local support services. Individuals who access these services have been shown to increase the likelihood that they will successfully locate and maintain housing. PATH staff reports that the nature of mental illnesses is frequently the barrier to receiving help. Paranoid feelings toward outreach workers often make these homeless individuals resistant to attempts to get them into services.

In surveys prior to the 2006 Shelter Survey participants were asked, "What do you consider to be your major medical problems?" Many participants were forthcoming in reporting that their major medical problems included *bipolar, manic depression, depression, anxiety, substance abuse, alcoholism, hearing voices, post traumatic stress disorder [PTSD], panic attacks and unspecified mental disorders.* The question was more general in 2006 and participants reported that they:

- Have emotional or mental health concerns 42.7%

[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Administration *Action Plan – Homelessness,* 6/07/06.

- Currently receive mental health services 32.9%
- Previously received mental health services 44.0%
- Ever needed alcohol/substance abuse treatment 59.0%
- Presently have alcohol/substance abuse problems 35.5%

Mental health and substance abuse issues are particularly common among the chronically homeless who frequent the area around the Roanoke City Market. Merchants who otherwise would be sensitive to homeless individuals cite the negative impact of antisocial behavior of certain individuals, most homeless, but some not. Most of these individuals appear to have unmet mental health and substance abuse needs. Those most disruptive are often resistant to the typical housing and services available. Intensive street outreach may be a first step in addressing merchant concerns and client needs. Information obtained from a focus group held with Market area merchants highlights their concerns.

Downtown Roanoke, Inc. – City of Roanoke Market Area Businesses

A focus group was held May 31, 2006 with representatives from Market area businesses, cultural entities and law enforcement present. Participants reported that the situational homeless "come and go" but it was the chronically homeless that they see frequently and come to know by name. Police officers present estimated that 80-90% of the homeless they deal with are veterans. All agreed that the major difficulty they had was with those who appear to have unaddressed alcohol, substance abuse and mental health problems. There are about fifteen who fit into this category and are "regulars" in the Market area. These individuals have a negative financial impact on businesses and are a detriment to economic development because of:

- Socially unacceptable personal behavior
- Abuse of property
- Panhandling
- Use of unacceptable language
- Intimidation of business customers and patrons

Focus group participants report that, even with the difficulties they experience, there have been noticeable changes in the last few years. Things they felt created a positive impact include:

- Increased presence of law enforcement

- Closing the downtown ABC Store
- Removal of benches [to be replaced with “mushroom” benches summer, 2006]
- Legislation which allows judges to bar people from using alcohol after 10 alcohol related convictions in a year

The continuing challenges they report include:

- Transient individuals not allowed to remain in shelter during the day
- Ineffective loitering and panhandling legislation
- Individuals pulled to the City because of services available
- Unaddressed mental health issues
- Individuals who refuse assistance and shelter

The focus group participants have met as a group on many occasions over the years in an attempt to find solutions to the problems they face with chronically homeless individuals. Their strategies include those that they feel would not only solve their problems but also help those who are homeless. They include:

- Employment assistance, including job training
- Programs at shelters during daytime hours
- Alternative seating away from Market area
- A Single Room Occupancy [SRO] program so people would have a place of their own to be during the day time hours
- Move the bus station out of the immediate downtown area
- Institute a zero-tolerance policy for panhandling and anti-social behavior
- Discourage services [such as half-way houses] from locating in neighborhoods around the downtown area
- Make sure people know what services are available
- Attach expectations of behavioral change to services provided

(2) Work doesn’t pay enough to cover the cost of food, healthcare and other necessary living expenses.

Twenty-one [21] percent of 2006 Survey respondents reported a poverty-related inability to find and/or retain housing. A review of Roanoke Valley area cost of living data illustrates how easily people can slip into poverty and lose housing when unemployed or with a low or minimum wage job.

Expenses	1 Parent/1Child	2 Parents/2 Children
Monthly housing	$586	$586
Monthly food	$265	$587
Monthly child care	$597	$904
Monthly transportation	$275	$375
Monthly health care	$289	$401
Monthly other necessities	$230	$317
Monthly taxes	$306	$259
Monthly total	$2,548	$3,429
Annual total	**$30,576**	**$41,148**

U. S. Government 2006 Poverty Guideline[7]

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

- **Median Household Income[8]** **Families Below Poverty Level[9]**
  - Alleghany County $37,257 11.1%
  - Botetourt County $51,972 6.3%
  - City of Covington $31,609 12.7%
  - Craig County $38,779 9.6%
  - City of Roanoke $31,451 16.9%
  - Roanoke County $50,232 6.9%
  - City of Salem $40,314 8.4%

- 4,850 people, 3.2% of the population, were known to be unemployed in the Roanoke Metropolitan Statistical Area [MSA] in April 2006.[10]

- *57.7% of homeless people surveyed in 2006 were unemployed and 5% reported that lack of employment was the reason they had become homeless.*

- 16.7% people reported that they worked only part time.

[7] [Federal Register: January 24, 2006 (Volume 71, Number 15) Page 3848-3849]

[8] U.S. Census 2003 Small Area Income & Poverty Estimates [90% Confidence interval]. Median income means that half the population earns more and half of the population earns less than the amount reported.

[9] U.S. Census 2003 Small Area Income & Poverty Estimates [90% Confidence interval].

[10] The Roanoke MSA consists of Botetourt County, Craig County, Franklin County, City of Roanoke, Roanoke County and City of Salem.

(3) There isn't enough affordable housing.

- In the Roanoke MSA there are 30,968 rental units[11]
  - City of Roanoke 18,371 [Median rent $448]
  - Roanoke County 7,933
  - Botetourt 1,436
  - Salem 3,228
  - Franklin County 3,577

National Low Income Coalition data for the 6th Congressional district show:

- Extremely low income household – income below 30% of area median
  - Of the 16,521 extremely low income households over half 51.6% [8519] spend more than 50% of income on housing.

- Very low income household – between 30% and 50% of area median
  - Of the 13,159 very low income households 13.5% [1783] spend more than 50% of income on housing.

- "In Virginia, the Fair Market Rent (FMR) for a two-bedroom apartment is $852. In order to afford this level of rent and utilities, without paying more than 30% of income on housing, a household must earn $2,842 monthly or $34,099 annually. Assuming a 40 hour work week, 52 weeks per year, this level of income translates into a Housing Wage of $16.39 per hour.

	One Bedroom	Two Bedroom
Virginia	$741	$852
Alleghany County	$402	$483
Botetourt County	$456	$589
Clifton Forge City	$402	$483
Covington City	$402	$483
Craig County	$456	$589
City of Roanoke	$456	$589
Roanoke County	$456	$589
City of Salem	$456	$589

Public efforts to address the availability of affordable rental housing are through the Roanoke Redevelopment and Housing Authority. Total Action Against Poverty [TAP], a non profit agency, manages affordable rental property and administers a Section 8 Voucher program.

Section 8 Housing Choice Voucher Program

The Section 8 Voucher Program provides housing assistance, in the form of direct payments to a private landlord, secured from a local housing authority, that

[11] US Census/Development Strategies, Inc: City of Roanoke 2006 Strategic Housing Plan.

can be used by low-income people to rent apartments and homes on the private market. Certificates are available from the Roanoke Redevelopment and Housing Authority [RRHA] and from Total Action Against Poverty [TAP]. There are approximately 400 landlords in the area who participate in the Section 8 Housing Choice Voucher Program. The average assistance provided is approximately $362.41 per unit per month.

- **Roanoke Redevelopment and Housing Authority**: The average wait time for RRHA Section 8 vouchers is approximately one to three years. For RRHA programs there are 1,379 units that meet the Housing Quality Standards and have reasonable rents. The waitlist was closed at the time this report was being written and is only opened when there are not enough people on the list to fill the vacant voucher program within 12 months. Waitlist last opened on December 5-6, 2005 and received 1,500 applications in those two days.

- **Total Action Against Poverty.** TAP administers 83 Section 8 vouchers through the Housing Choice Voucher Program. The average wait time for a voucher administrated by this program is two to three years. The waiting list was closed at the time this report was being written due to the large number of people on the waiting list. If opened to take applications, the list would have more than 300 people on it.

Even with waiting lists, public housing and Section 8 Housing Vouchers are currently underutilized with units standing empty. At the time this report was written 150 public housing units were vacant. Individuals on the waiting list with substance abuse or mental health problems are often viewed as inappropriate for public housing because they have the potential to be a problem for other residents. Private property owners are reluctant to provide housing for tenants who they perceive will be disruptive. Intensive case management for these individuals should reassure the Housing Authority and private property owners that applicants will be good tenants. Previous felony conviction makes a person ineligible for Section 8 Housing vouchers.

(4) Fleeing domestic violence

Staff from the Salvation Army Turning Point domestic violence shelter report that during 2005-2006 three families and two single women became homeless due to domestic violence. The three families included five children who were with their mothers at the shelter. As victims of physical abuse, these women had no other choice than to become homeless. They left Turning Point to go to the YWCA, the

Rescue Mission and to friends or relatives. Women who leave their home, or the Shelter, and stay with friends and/or relatives become part of the uncounted homeless.

Though not a secure domestic violence shelter, approximately fifty percent of homeless families residing at the Total Action Against Poverty [TAP]-Transitional Living Center are there because of domestic violence. Homeless shelters are often not safe places for the victims of domestic violence. Women may be in secure domestic violence shelters many miles away from home which limits access to any social network they might have been able to call on.

Women who have been made homeless by domestic violence often have other issues that must be addressed. They may have mental health issues including Post Traumatic Stress Disorder [PTSD], untreated physical injuries and/or illnesses, and if in a shelter are more likely to be low income.

SERVICES IN THE BLUE RIDGE REGION

In addition to interviews with the staff of agencies that provide shelter and services to people experiencing homelessness, a survey of providers was conducted to determine the extent of community resources directed at homelessness. Forty-four agencies/programs, including faith-based organizations, responded to the survey [**Appendix III**].

Services provided include:

- Emergency Shelter 13.6% [6]
- Transitional Shelter 4.5% [2]
- Both emergency and transitional 6.8% [3]
- Breakfast 18.2% [8]
- Lunch 18.2% [8]
- Supper 11.4% [5]
- All meals 6.8% [3]
- Groceries 34.1% [15]
- Utility assistance 29.5% [13]
- Rent assistance 29.5% [13]
- Medication assistance 38.6% [17]
- Auto repair assistance 15.9% [7]
- Greyhound tickets 20.5% [9]
- Storage unit assistance 6.8% [3]
- Food financial assistance 31.8% [14]
- Child care assistance 11.4% [5]
- Auto fuel assistance 22.7% [10]
- Clothing (adults and/or children) 31.8% [14]
- Infant and baby supplies 9.1% [4]
- Congregational nursing 4.5% [2]
- Medical assistance 13.6% [6]
- Senior companions 4.5% [2]

- Domestic violence shelter 9.1% [4]
- Employment assistance 22.7% [10]
- Drug/alcohol treatment/AA/NA 11.4% [5]
- Photo ID assistance 18.2% [8]
- Valley Metro passes 20.5% [9]
- Personal hygiene assistance 27.3% [12]
- Furniture 15.9% [7]
- Kitchen utensils 18.2% [8]
- Mental health screening 6.8% [3]
- Other 9.1% [4]

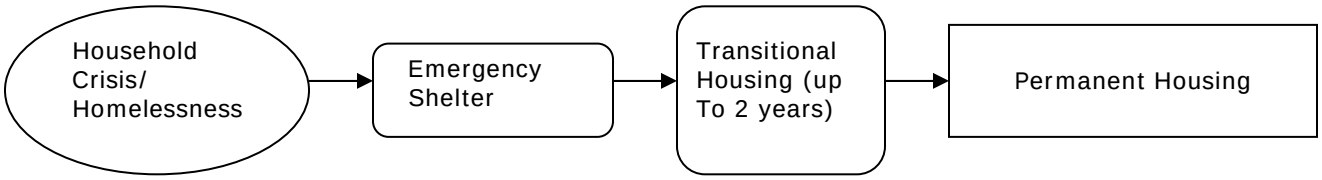
Twenty-one agencies and congregations reported the estimated amount of their 2004-2005 budget that was dedicated to homeless services. Additionally, the number of hours that volunteers gave to assist agencies providing those services was reported and the monetary value calculated:

Cash	$4,345,439	
In-kind	114,400	
Volunteer value	294,550	[39,294 volunteer hours]
Total	**$4,754,389**	

Specific information about shelter and other homeless service programs is contained in **Appendix IV**. Services to the homeless will continue to be provided. However, a new view of how to provide these services in a time of scarce resources is needed.

ENDING CHRONIC HOMELESSNESS - A CHANGE IN APPROACH

The Continuum of Care Model

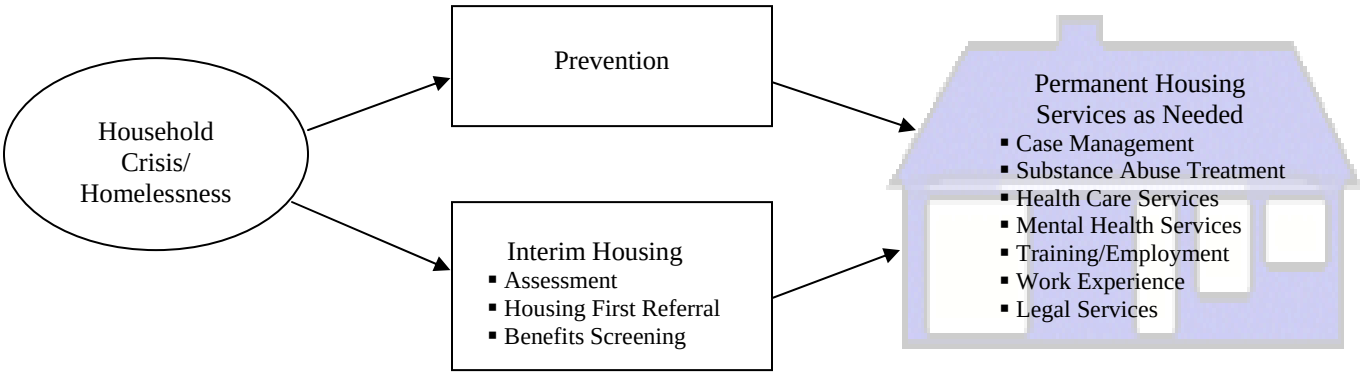


The Continuum of Care model's primary focus is to help those who are homeless gain the skills and resources they need to become successfully housed. People move along the continuum when they have proven "ready" for a specific type of housing. For example, after a crisis situation requiring emergency housing a person may move to a transitional living situation for up to two years before moving into permanent housing. The housing readiness model requires that those

participating be compliant with service and treatment plans. Services are available only as long as the person is living at the program site. The chronically homeless are unable to move along the continuum because they are never "ready".

The need for emergency and transitional housing will never go away because of the effectiveness of these programs for those who are likely to be temporarily homeless, such as domestic violence victims. Short term housing options allow people to get back on their feet in a supportive environment. For example, substance abuse programs can be successful because residents are sharing the recovery process. For many of the chronically homeless, however, these programs have not been successful. As previously discussed, those who are homeless multiple times, for long periods of time and who prefer to live on the street rather than in shelter are costly to serve. An innovative solution to challenges of these individuals is the Housing First Model.

The Housing First Model



The Housing First model centers on providing homeless people with permanent housing as quickly as possible and then linking them to needed services.

The common values and philosophical perspectives which underpin the model are:

- Housing is a fundamental need and provides a stabilizing context for service success.
- The lack of affordable, permanent housing is a systemic, structural problem not simply an issue of personal responsibility.

Studies conducted show:

> "A housing first approach rests on the belief that helping people access and sustain permanent, affordable housing should be the central goal of work with people experiencing homelessness. By providing housing assistance, case management and supportive services responsive to individual or family needs (time-limited or long term) after an individual or family is housed, communities can significantly reduce the time people experience homelessness and prevent further episodes of homelessness. A central tenant of the Housing First Approach is that social services to enhance individual and family well-being can be more effective when people are in their own home."[12]

Housing First programs consists of three components:

- **Crisis intervention, emergency services, screening and needs assessment**. There is an early screening of the challenges and resources that will affect the success of permanent housing.
- **Permanent housing services**. Clients need assistance identifying affordable housing, housing resources and negotiating leases. They may need help to overcome some barriers such as poor credit and/or tenant history. Part of a successful Housing First program is a roster of landlords willing to work with the program.
- **Case management services**. Appropriate case management is provided to identify service needs before clients move into permanent housing and to work with clients to address problems which may put them at risk of becoming homeless again.

The Housing First approach has a wide variety of program models. The depth of services changes from those that target families to those that focus on people who are chronically homeless. Services that have been proven to be particularly useful for families that are homeless include assistance managing conflict with landlords, dealing with unanticipated household expenses, accessing and sustaining employment, mental health and/or substance abuse programs, child care, recreation and support services for children.

Individuals who are chronically homeless need intensive wraparound services and supports to promote a successful permanent housing outcome. These programs typically target people who have failed in other programs or who have been unwilling to enter shelters or programs. A significantly larger portion of a

[12] The National Alliance to End Homelessness, Inc., *What is Housing First?,* February 17, 2006.

community's resources are used to provide assistance to this population due to repeated time spent in jails, emergency shelters and hospital emergency rooms. Evidence has shown that the Housing First approach is appropriate not only for families but for those who are chronically homeless. Evaluations done of Housing First interventions with chronically homeless individuals found that many who have remained outside of housing for years can remain in housing with a subsidy and provision of wrap-around supports thus saving scarce resources.

Housing First programs typically included the following elements:

- Services targeted to specifically defined need
- Assistance locating rental housing, relationship development with private market landlords, and lease negotiation
- Housing assistance – ranging from security deposit and one month's rent to provision of a long-term housing subsidy
- A housing placement that is not time-limited
- Case management to coordinate services [time-limited or long-term] that follow a housing placement

Housing First programs offer services with varying levels of intensity and only for as long as needed. Unlike the Continuum of Care model with "transitional housing" the Housing First model has "transitional services". Programs which target chronically homeless individuals typically provide intensive case management services coupled with providers who are able to address both substance abuse and mental health treatment needs over the long term. Families in Housing First programs, on the other hand, typically receive case management services lasting only 6 to 12 months. Services tend to phase out as families stabilize and networks of supportive services are in place.

Measuring the effectiveness of Housing First programs depends upon the collection of valid and reliable data. The primary outcomes for families, individuals and the community are:

- How rapidly are individuals or families being housed?
- Are individuals or families remaining housed?
- Do individuals or families reenter shelter?
- Is there a change in employment or income?
- Has children's school performance improved?
- Have there been changes in emergency room visits or hospital stays?
- Has the length of time the target population is homeless changed?

The primary outcomes for programs that serve the chronically homeless are:

- How much has alcohol or drug consumption decreased?
- Have individuals entered treatment?
- Have residents received appropriate and timely mental and physical health care?
- Have individuals remained off the street?
- Is there a reduction in the use of crisis responses such as emergency rooms and detoxification facilities?
- Do Market merchants report a decrease in the number of individuals they encounter that are engaging in anti-social or disruptive behavior?

The differences in outcomes reflect the difference in challenges faced by individuals and families who are temporarily homeless and those faced by individuals who are chronically homeless.

The implementation of a Homeless Management Information System [HMIS], a computerized data collection system designed to capture client-level information on the characteristics and service needs of households and individuals experiencing homelessness, will greatly enhance the ability of the Continuum to show the effect of an increase in permanent supportive housing and Housing First projects on the prevention and reduction in homelessness. Individuals experiencing homelessness and accessing any related services in the Roanoke Valley will become part of the HMIS database.

Discussion

We know a great deal about homelessness. We know how many people are in shelter [Appendix I] and can estimate the number of the "street people" who are homeless. We know what individuals say about their experience of being homeless. We know what services are presently available [Appendix IV] and that the services provided by the community have helped many people leave homelessness.

"[It is] difficult to obtain a job within the private sector when living in transitional housing. A potential employer calls and is immediately notified of my homeless status."

The goals of this plan start with the reduction in the number of people who become homeless. Strategies must address all barriers and challenges faced by individuals who are in danger of becoming homeless or who have already lost housing. Not only does affordable, appropriate housing have to be made available but supports need to be in place to insure that people will have the resources they need to remain successfully in that housing. This includes support for legislation that provides working people with a living wage. A significant number of human services are available in the Roanoke Valley area. One gap in services appears to be a way to get the information to people in a coordinated, rather than piecemeal, fashion. There are many opportunities for collaboration among service providers that will make a "one stop shop" a viable method of connecting people with information and services. It is often the case that when informed of a service or program that is available people will say, "well, I never knew this even existed."

"[It is] difficult because the kids behave like kids. It's giving me structure right now. I'd love to get my own place."

We also learned that some of the services we do provide have not been consistently successful in helping people with multiple and difficult problems such as alcohol/substance abuse combined with mental illness. The chronically homeless

are accessing a disproportionate share of community resources and losing the basic goodwill of Downtown merchants and visitors. It is a difficult problem to solve.

"It's so demeaning it can't be put into words."

"Lack of money is why we are here and money would get me out."

"It's so depressing. [I] can't wait to get a set of keys in my hand."

"Poverty and homelessness can be viewed as an industry because it keeps some people in cushy jobs."

Looking around the country at other localities that have individuals with the same challenges we have learned that a different approach has reduced the cost of chronic homelessness paid by the homeless individuals and their communities. The types of programs that have proven successful are those that provide housing for people and then address the issues that led to them to homelessness. Intense and sustained case management has made successfully addressing the barriers to permanent housing for the chronically homeless possible. Appropriate case management can also contribute to less time spent homeless for individuals and families with far fewer barriers to permanent housing.

With these lessons in mind the 10 Year Plan to End Homelessness Steering Committee has devised a four-pronged action plan. It will require the commitment of regional municipal governments, human service agencies, faith-based organizations and volunteers to make the program a success.

The Action Plan[13]

GOAL 1: Information Management

Strategy: Implement Homeless Management Information System (HMIS)[14]

Action Steps

1. Memoranda of Understanding [MOU] and policy statements created by HMIS Advisory Committee.

Responsible Party	Completion [Estimated]
Council of Community Services	*September, 2006*

   Expected Outcome(s)
   - *100% of participating agencies have signed MOU and policy statements.*

2. MetSYS software installed at participating agencies.

Responsible Party	Completion [Estimated]
Council of Community Services *MetSYS, Inc.*	*February, 2007*

   Expected Outcome(s)
   - *100% of participating agencies have MetSYS software installed on at least one computer*

3. Initial trainings held for users of MetSYS software/HMIS

Responsible Party	Completion [Estimated]
Council of Community Services *MetSYS, Inc.*	*February, 2007*

   Expected Outcome(s)
   - *100% of participating agency intake staff attend trainings.*

4. Participating agencies begin entering data into the HMIS using HUD Federal Register standards.

Responsible Party	Completion [Estimated]
Council of Community Services	*February, 2007*

[13] Action Plan timelines are categorized as Short Term [1 to 3 years], Intermediate Term [4-6 years], Long Term [7 to 10 years] and Ongoing. Action Steps presently underway and to be completed in under 12 months are given target dates. Outcomes dependent on non profit agency activity are all subject to the availability of appropriate funding.

[14] The HMIS is a computerized data collection system designed to capture client-level information on the characteristics and service needs of households and individuals experiencing homelessness. The database will be housed at the Council of Community. Partner agencies will be equipped with a web browser located on each user's computer. Users will connect to the system by logging on to the HMIS application.

Expected Outcome(s)

- *100% of participating agencies entering client data into the HMIS system*
- *Client data from the City of Roanoke Homeless Tracking system imported into the HMIS system*

5. Analysis of data collected by the HMIS system about individuals experiencing homelessness in the Blue Ridge Continuum of Care service area.

Responsible Party	Completion [Estimated]
Council of Community Services	*Ongoing*

Expected Outcome(s)

- *Reports will be available for the Blue Ridge Continuum of Care, the Roanoke Regional Task Force on Homelessness, and others, on an as needed basis.*

6. Database of programs and services available to people who are homeless, or in danger of becoming homeless, will be contained in the 2-1-1 VIRGINIA system and used to make appropriate referrals.

Responsible Party	Completion [Estimated]
Council of Community Services	*Ongoing*

Expected Outcome(s)

- *100% of database entries updated yearly.*

Strategy: Analyze HMIS data to effect improvements in program and services

Action Steps

1. Use HMIS to identify the number of homeless, reasons for becoming homeless, interventions and their effectiveness.

Responsible Party	Completion [Estimated]
Council of Community Services *HMIS Advisory Committee* *Blue Ridge Continuum of Care*	*Ongoing*

Expected Outcome(s)

- *HMIS data is used for the Roanoke Regional Task Force on Homelessness annual shelter count and point in time survey.*

2. Use HMIS data to develop priorities and strategies for improvements throughout the Continuum so that the maximum numbers of people are served in the most effective manner.

Responsible Party	Completion [Estimated]
Council of Community Services *HMIS Advisory Committee* *Blue Ridge Continuum of Care*	*Ongoing*

Expected Outcome(s)

- *HMIS data is used by the community for program development*

3. Implement and evaluate strategies to improve the provision of services to people who are experiencing homelessness.

Responsible Party	Completion [Estimated]
Council of Community Services *HMIS Advisory Committee* *Blue Ridge Continuum of Care* *Roanoke Regional* *Task Force on Homelessness* *H.E.L.P.S. Committee*	*Ongoing*

Expected Outcome(s)

- *HMIS data is used to evaluate programs serving individuals experiencing homelessness.*

GOAL 2: Prevention of Homelessness

Strategy: Create a homelessness prevention system to identify and assist people who are homeless or at risk of becoming homeless.

Action Steps

1. Establish a *community housing resources center* outside of but convenient to the downtown area to provide improved access to

   a. Intake and screening
   b. Short and long term rental assistance
   c. Transportation, including travelers assistance
   d. Legal services
   e. Social services
   f. Substance abuse treatment
   g. Mental health services
   h. Primary health care services
   i. Services for persons with disabilities
   j. Immigration services including interpretation and translation
   k. Outreach to special populations
   l. Home repair and maintenance
   m. Workforce preparation

Responsible Party	Completion [Estimated]
Blue Ridge Continuum of Care *Valley Metro* *Legal Aid of Roanoke Valley* *Roanoke Area Ministries [RAM]* *Refugee and Immigration Services* *Commonwealth Catholic Charities* *Roanoke Homeless Assistance Team* *Workforce Development Board*	*Intermediate*

Total Action Against Poverty-Homeless Prevention Program

Expected Outcome(s)

- *Increase in numbers of services accessed by homeless and potentially homeless individuals*
- *Increase benefit enrollments*
- *Decrease in numbers of persons becoming homeless and on the street or entering emergency shelters*
- *Increase in percent of previously homeless individuals remaining in permanent housing over six months*

2. Create a written protocol to be used by publicly funded institutions or systems of care to reduce referrals and/or discharge to emergency homeless shelters by enhancing the coordination of care. Protocol will include (a) referral to the community housing resource center and (b) identification of oversight responsibility.

Responsible Party	Completion [Estimated]
Blue Ridge Continuum of Care *Blue Ridge Behavioral Health Care* *Carilion Health System* *VA D.O.C. Community Correction Division* *Virginia Correctional Facilities* *Salem VAMC*	*Short term*

Expected Outcome(s)

- *100% of publicly funded institutions/systems of care in the Blue Ridge Continuum of Care service area have signed the protocol.*
- *Increase in number of persons discharged from institutions and correctional facilities to shelters and the streets with sound residential plans.*
- *Protocol reviewed and updated biannually.*

3. Conduct workshops to increase consumer/landlord understanding of rental responsibilities to reduce homelessness caused by illegal and/or improper eviction procedures.

Responsible Party	Completion [Estimated]
Legal Aid of Roanoke Valley *Total Action Against Poverty (TAP)* *Housing Department* *Roanoke Fair Housing Board* *Roanoke Regional Housing Network*	*Ongoing*

Expected Outcome(s)

- *Tenants increase awareness of responsibilities of renters.*
- *Landlords increase awareness of their responsibilities for their properties and toward their tenants*

4. Create a “Circuit Rider” program to provide Information & Referral, training and direct advocacy in each jurisdiction of the Continuum of Care.

Responsible Party
Blue Ridge Continuum of Care
Council of Community Services
211 VIRGINIA

Completion [Estimated]
Intermediate

Expected Outcome(s)

- *"Circuit Rider" will make presentations to those serving the homeless in each locality in the Blue Ridge Continuum of Care area at least twice yearly.*
- *Increase in knowledge of municipalities and services providers about the dimensions of homelessness and the resources available to address them.*

5. Create a written protocol to be used by providers of services to homeless individuals who do not communicate in English. Protocol will include access to interpretation services, both local and by telephone.

Responsible Party
Blue Ridge Continuum of Care

Completion [Estimated]
Short term

Expected Outcome(s)

- *100% of service providers will have at least one bilingual staff member, preferably Spanish speaking.*
- *Protocol reviewed and updated biannually.*

GOAL 3: Reduction in Time Spent Homeless

Strategy: Increase supply of affordable and permanent supportive housing.

Action Steps

1. Develop a "housing first" permanent supportive housing pilot project for persons who are chronically homeless.

Responsible Party
Blue Ridge Continuum of Care
Housing First Work Group

Completion [Estimated]
Short term

Expected Outcome(s)

- *Two permanent housing options using the Housing First model are made available to chronically homeless individuals annually.*
- *All supportive services needed by residents to remain housed are available.*

2. Implement the *Home Without Barriers* permanent supportive housing with case management program.

Responsible Party
Total Action Against Poverty [TAP]
Housing Department

Completion [Estimated]
Pending HUD Continuum of Care Funding

Expected Outcome(s)

- *Percent of persons remaining in permanent housing program over six months will increase to eight-six percent.*

3. Increase utilization of Shelter Plus Care housing units.

Responsible Party	Completion [Estimated]
City of Roanoke Shelter+ Care	*Long term*

Expected Outcome(s)

- *Twenty new permanent housing slots created by 2016.*

4. Encourage the donation of surplus property to a non profit organization for renovation for low/moderate income housing.

Responsible Party	Completion [Estimated]
Housing and Neighborhood Services *Roanoke County* *Salem* *Botetourt County* *Craig County* *Alleghany County*	*Long term*

Expected Outcome(s)

- *At least one surplus property is made available in <u>each</u> locality of the Blue Ridge Continuum of Care*

5. Decrease under use of public housing and Section 8 Housing Vouchers using increased supportive case management.

Responsible Party	Completion [Estimated]
Roanoke Redevelopment and Housing Authority *Total Action Against Poverty Housing Department* *Service agencies* *Blue Ridge Continuum of Care* *Blue Ridge Behavioral Healthcare*	*Ongoing*

Expected Outcome(s)

- *10% annual decrease in number of empty public housing units and unused Section 8 vouchers.*

Strategy: Minimize the time needed for individuals/families to move from shelters to permanent housing.

Action Steps

1. Provide enhanced employment referral and skill building services with access to child care for homeless participants.

Responsible Party	Completion [Estimated]
Workforce Investment Board/VEC *TAP This Valley Works* *Roanoke Area Ministries [RAM]* *YWCA* *Blue Ridge Independent Living Center* *VA Department of Rehabilitative Services* *Goodwill* *Blue Ridge Behavioral Healthcare*	*Ongoing*

Expected Outcome(s)

- *Increase in numbers of homeless underemployed or unemployed individuals who access skill building services*
- *Decrease in the unemployment rate among individuals experiencing homelessness.*

2. Increase access to appropriate affordable child care.

Responsible Party	Completion [Estimated]
Council of Community Services *Child Care Resource and Referral*	*Short term*

Expected Outcome(s)

- *A thorough assessment of child care needs of homeless individuals and families has been completed with strategies to address gaps in services*

3. Improve number of transportation options available by advocating for extended hours of operation for public transportation [bus] and expanding routes into Roanoke and Botetourt Counties to employment opportunities.

Responsible Party	Completion [Estimated]
Blue Ridge Independent Living Center *Valley Metro*	*Intermediate*

Expected Outcome(s)

- *Monday through Friday Valley Metro bus service extended to midnight*
- *Two new routes in areas previously not served by public transportation are added to the system.*

4. Create a consortium of Homeless Program Education Coordinators to improve educational outcomes for children who are homeless.

Responsible Party	Completion [Estimated]
Roanoke City Schools, Malora Horn	*January, 2007*

Expected Outcome(s)

- *100% of Homeless Program Education Coordinators belong to consortium*
- *Coordinators increase their level of knowledge of educational resources and opportunities for children whose families are experiencing homelessness.*

5. Organize biannual resource fairs to bring information on services to people experiencing homelessness or in danger of becoming homeless.

Responsible Party	Completion [Estimated]
Blue Ridge Continuum of Care *Roanoke Regional Task Force on Homelessness* *Council of Community Services* *Salem VAMC*	*Ongoing*

Expected Outcome(s)

- *The first annual "Help for the Homeless" resource fair held Spring 2007*

Strategy: Reduce street homelessness and its effects**.**

Action Steps

1. Create a mental health street outreach program, housed in the *community housing resources center*, for those individuals with mental health or substance abuse problems.

Responsible Party	Completion [Estimated]
Blue Ridge Continuum of Care *Downtown Roanoke, Inc.*	*Intermediate*

Expected Outcome(s)

- *Decrease in the number of incidents reported to police related to mental health issues of homeless individuals.*
- *Merchants, and others, are provided education about crisis intervention.*

2. Create a program for market area merchants that provide information about mental health and substance abuse among street homeless and contacts with service providers.

Responsible Party	Completion [Estimated]
City of Roanoke HAT Team *Blue Ridge Behavioral Healthcare* *Downtown Roanoke, Inc.*	*Intermediate*

Expected Outcome(s)

- *Increase in knowledge of market area merchants about the dimensions of homelessness.*

- *Increase in the knowledge of market area merchants about the responses to the mental health and substance abuse challenges of chronically homeless individuals.*

3. Research strategies used by other similar communities to address loitering and panhandling issues..

Responsible Party	Completion [Estimated]
Downtown Roanoke, Inc.	*Short term*
Local governments	

Expected Outcome(s)

- *Development of an anti-loitering/panhandling action plan is recommended to local legislators.*
- *Decrease in the number of incidents of loitering in the market area and the surrounding residential areas.*

GOAL 4: Public Policy

Strategy: Promote improvements in the infrastructure which deals with issues related to homelessness.

Action Steps

1. Increase regional participation in efforts to reduce homelessness

Responsible Party	Completion [Estimated]
Roanoke Regional Task Force on Homelessness	*Ongoing*

Expected Outcome(s)

- *A representative of each municipality in the Blue Ridge Continuum of Care participates in at least one quarterly meeting of the Task Force.*
- *Representatives from municipalities and services in the New River Valley and other areas of far Southwest Virginia will participate in planning activities to address homelessness.*

2. Pursue opportunities for public and private funding for critical supportive services for special populations.

Responsible Party	Completion [Estimated]
Blue Ridge Continuum of Care	*Ongoing*

Expected Outcome(s)

- *One new funding source is identified annually.*

3. Join with other groups such as the Virginia Organizing Project [VOP] or the Service Employers International Union [SEIU] to advocate for an increase in the Commonwealth minimum wage.

Responsible Party — Completion [Estimated]
Roanoke Regional Task Force on Homelessness — *Ongoing*

Expected Outcome(s)
- *The minimum wage is increased from $5.15 per hour.*

4. Update the *10 Year Plan*. Action Steps will be evaluated to determine if they continue to support the plan's goals. New Action Steps will be created in response to this evaluation and the changing community environment.

Responsible Party — Completion [Estimated]
Roanoke Regional Task Force on Homelessness — *Ongoing*

Expected Outcome(s)
- *The 10 Year Plan to End Homelessness Action Plan is evaluated yearly by the Roanoke Regional Task Force on Homelessness and the results are reported to the community*

5. Initiate performance-based funding and evaluation of homeless and social service programs based on measurable outcomes related to housing, income and services.

Responsible Party — Completion [Estimated]
Blue Ridge Continuum of Care
City of Roanoke Human Services Committee — *Annually*

Expected Outcome(s)
- *Recommendations for HUD Emergency Shelter Grant funds are based on evaluation of measurable program outcome objectives.*

6. Identify a neutral location to house and administer the Roanoke Regional Task Force on Homelessness.

Responsible Party — Completion [Estimated]
Roanoke Regional Task Force on Homelessness — *September, 2006*

Expected Outcome(s)
- *The Task Force is now located at the Roanoke/Alleghany Regional Commission*

Appendix I

NIGHTLY AVERAGES – 1987 Thru 2006
(All figures exclude Turning Point Shelter)

YEAR	AVERAGE
January 1987	122
January 1989	151
January 1991	215
January 1993	194
January 1995	281
January 1997	291
January 1999	309
July 1999	340
July 2000	310
January 2002	327
June 2003	416
January 2005	393
January 2006	381

Nightly average of homeless during 2005 Winter Survey period – **393**

Clients (undifferentiated count) who completed 2005 surveys - **204**

* "Nightly average" excludes the census from the day shelters and the Turning Point

Appendix II
Glossary of Terms

Affordable housing: Housing, either ownership or rental, for which a household will pay no more than 30% of its gross annual income.

Case Management [Supportive Services]: Supportive case management services are services or activities for the arrangement, coordination, monitoring, and delivery of services to meet the needs of individuals and families who experience homelessness. Component services and activities may includes individual service plan development; counseling; monitoring, developing, securing and coordinating services; monitoring and evaluating client progress; and assuring that clients' rights are protected.

Chronically homeless: (HUD definition) An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. Individuals who are in transitional housing or permanent supportive housing programs are not considered chronically homeless even if they have been in the program for more than a year.

Continuum of Care: (HUD definition) a community plan to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness.

Discharge Planning: Discharge planning prevents chronic homelessness by preparing people residing in hospitals, shelters or jails for return or re-entry to the community by linking them with community treatment, housing and supports. Such planning ideally begins upon entry to an institution, is ready to be implemented upon discharge, involves input from the individual, and includes time-limited, intensive supports during the transition from the facility to community-based services.

Emergency shelter: (HUD definition) any facility the primary purpose of which is to provide temporary or transitional shelter for the homeless in general or for specific populations of the homeless.

Homeless: (HUD) (1) an individual who lacks a fixed, regular, and adequate nighttime residence; and (2) an individual who has a primary nighttime residence that is (a) a supervised publicly or privately operated shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill); (b) an institution that provides a temporary residence for individuals intended to be institutionalized; or (c) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

Housing first: (from the National Alliance to End Homelessness). A "housing first" approach rests on two central premises: (1) Re-housing should be the central goal of work with people experiencing homelessness; and (2) Providing housing assistance and follow-up case management services after a family or individual is housed can significantly reduce the time people spend in homelessness. Case management ensures individuals and families have a source of income through employment and/or public benefits, identifies service needs *before the move into permanent housing,* and works with families or adults *after the move into permanent housing*, to help solve problems that may arise that threaten their tenancy including difficulties sustaining housing or interacting with the landlord to connect families with community-based services to meet long term support/service needs.

Housing plus: Refers to housing where residents are encouraged to accept support services necessary to help them maintain their housing. The term is another way of referring to "permanent supportive housing," but puts the emphasis on "housing *plus* intensive service" for people with serious disabilities.

Income: *Extremely low-income*: Defined as at or below 30% of the area wide median income. *Low income*: Defined as at or below 80% of the area wide median income. *Very-low income*: Defined as at or below 50% of the area wide median income.

Juvenile Homelessness:

- Homeless Youth – an individual not more than 21 years of age for whom it is not possible to live in a safe environment with a relative; and who has no other safe alternative living arrangement.
- Runaway Youth – a person under 18 years of age who absents himself or herself from home, or place of legal residence, without the permission of his or her family.
- Street Youth – an individual who is runaway youth; or indefinitely or intermittently a homeless youth; and spends a significant amount of time on the street or in other areas that increase the risk to such youth for sexual abuse, sexual exploitation, prostitution, or drug abuse.

Permanent Support Housing: (HUD Definition) Long-term, community-based housing that has supportive services for homeless persons with disabilities. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting. The supportive services may be provided by the organization managing the housing or coordinated by the applicant and provided by other public or private service agencies. Permanent housing can be provided in one structure or several structures at one site or in multiple structures at scattered sites.

Point-in-Time enumeration: Refers to a "snapshot" of the homeless population taken on a given day, and is different than a longitudinal enumeration that counts the number of persons who experienced being homeless for at least one day during an extended period (usually one year, or annually).

Section 8 Certificate: Housing assistance, in the form of direct payments to a private landlord, secured from a local housing authority, that low-income people can use to rent apartments and homes on the private market.

Single Room Occupancy / SRO: (HUD Definition) A residential property that includes multiple single room dwelling units. Each unit is for occupancy by single eligible individuals. The unit need not, but may, contain food preparation or sanitary facilities, or both.

Supportive services: (HUD Definition) Services that assist homeless participants in the transition from the streets or shelters into permanent or permanent supportive housing, and that assist persons with living successfully in housing.

Transitional housing: (HUD Definition) A project that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months).

Appendix III
Service Provider Survey Respondents

Blue Ridge Behavioral Healthcare
Blue Ridge Independent Living Center
Calvary Baptist Church
Central Church of the Brethren
Christ Episcopal Church
City of Roanoke Department of Social Services
City of Roanoke Police Department
College Evangelical Lutheran Church
Commonwealth Catholic Charities
Cornerstone Church
Covenant Presbyterian Church
Huntington Court United Methodist Church
Interfaith Hospitality Network
Legal Aid Society
Mt. Pleasant Methodist Church
Our Lady of Nazareth
Our Savior Lutheran Church
Parkway Wesleyan Church
Penn Forest Church of God
Price Memorial AMEZ Church
Raleigh Court Presbyterian Church
Roanoke Area Ministries [RAM House]
Red Shield Lodge [Salvation Army]
Refugee and Immigration
Rescue Mission
Roanoke County Department of Social Services
Roanoke Redevelopment and Housing Authority
Sr. Mission Ministry
Salem Church of the Nazarene
Salem Police Department
Samaritan Inn
St. Philip Lutheran Church
St. James Episcopal
Sweet Union Baptist Church
Total Action Against Poverty [Women's Resource Center]
Total Action Against Poverty [Housing Program]
Total Action Against Poverty [Transitional Living Center]
Thrasher United Methodist Church
Trinity Lutheran Church
TRUST House
Turning Point Shelter [Salvation Army]
YWCA

Appendix IV

Agencies Providing Shelter and Housing to Individuals Who are Homeless in the Blue Ridge Continuum of Care Service Area

Emergency shelter and transitional housing

- **The Rescue Mission**
  - 99 transient men's beds
  - 52 Family Shelter beds
  - 60 Men's Recovery Program beds
  - 14 Jubilee Acres Retreat beds [children's camp]
  - In 2005 the Rescue mission served over 280,000 meals
  - Provides clothing and shoes
  - Funding sources private/thrift stores.

- **Roanoke Interfaith Hospitality Network**
  - 29 religious congregations providing temporary housing and meals for families with children
  - 14 emergency beds in congregational facilities or houses owned by congregations
  - Evening meal prepared by congregation volunteers; breakfast and lunch food supplies provided every day
  - Full-service Family Center with laundry, kitchen, phone, shower, mail, transportation
  - Case Management to empower families toward employment, housing and independence in the community
  - Funding sources public and private

- **Salvation Army Red Shield Lodge [Men only]**
  - 50 emergency beds
  - 20 transitional beds
  - Breakfast and dinner with bag lunch for those employed
  - 12 step alcohol/drug program
  - Case management, job search, credit counseling, financial planning, and life skills classes
  - Funding sources both public and private

- **Salvation Army Turning Point [Women only]**
  - Only domestic violence shelter in the Continuum region
  - 60 beds
  - Staffed 24 hours a day 365 days a year
  - Funding sources both public and private

- **Sanctuary Outreach and Shelter [for youth]**
  - Funded by a grand from the U.S. Administration for Children and Families, Family and Youth Services Bureau
  - Has operated for 16 years and worked with over 600 runaway and homeless youth
  - Sixteen bed temporary shelter for up to 15 days

    - Activities include outreach, shelter, individual and group counseling, family counseling, links to services, aftercare, and recreational services
    - Aftercare, with families involved, up to 8 months.

- **Total Action Against Poverty Transitional Living Center [TAP-TLC]**
    - 50-55 family beds
    - Long-term supportive housing and comprehensive services including case management, employment skill development and life skills training.
    - Residents may remain at TLC for 24 months while working toward self-sufficiency
    - Funding sources both public and private

- **TRUST House**
    - 24 beds, including beds for families and singles
    - Transitional program participants are able to do their own activities of daily living including meals and laundry.
    - Four tier Life Management Plan
    - Funding sources both public and private

- **YWCA of Roanoke Valley**
    - 28 transitional housing beds for women
    - 11 beds for children (boys only if under the age of 5)
    - If physically able, women must find employment within 30 days of intake. Women pay 30% of income for rent.
    - Funding sources both public and private.

Day shelters

- **Roanoke Area Ministries [RAM]**
    - Open from 8:00 AM to 4:00 PM daily
    - Provides hot midday meal
    - Employment counseling and placement
    - Emergency financial assistance
    - Funding sources both public and private

- **Samaritan Inn**
    - Open from 8:30 AM to 2:00 PM daily
    - Provides breakfast and lunch for approximately 40-125 individuals in addition to clothes and toiletries
    - Food pantry
    - Funding private/thrift store.

Food – Groceries

- Baptist Community Center, Roanoke
- Baptist Friendship House Food Pantry, Roanoke
- Cornerstone Church Food Pantry, Roanoke
- Presbyterian Community Center Food Pantry, Roanoke
- St. Marks Lutheran Church Food Pantry, Roanoke

Other

- **City of Roanoke Homeless Assistance Team**
  - Outreach – conducts shelter and "street sweeps" weekly. HAT Team members search for new homeless sites and response to reported homeless sightings on a daily basis.
  - Case Management – provides guidance to homeless persons by assisting with a service plan, directing clients to supportive services and making referrals to community resources.
  - Supportive Services – counseling for housing, transportation, photo ID, food, clothing, prescriptions financial management and other services.

- **Total Action Against Poverty Homeless Intervention Program**
  - Monday-Friday 11:00 AM to 2:00 PM
  - Time-limited financial and housing counseling assistance to low income individuals and families at risk of homelessness or homeless
  - Clients must have clearly demonstrated capacity to be self-sufficient and willingness to work cooperatively with HIP staff.
  - Eligible clients receive grants or loans for rent, mortgage and/or security deposits

- **Blue Ridge Behavioral Healthcare – Projects for Assistance in Transition from Homelessness [PATH]**
  - Program created by the McKinney-Vento Act as a Federal grant to deal with homeless individuals who have serious mental illness, as well as co-occurring substance abuse disorders.
  - One full-time outreach worker
  - Outreach in shelters, parks and other areas frequented by homeless individuals to identify those who would benefit from services for problems related to mental illness

- **Rescue Mission Medical Clinic**
  - Primary and preventative medical care for homeless individuals

- **Blue Ridge Independent Living Center**
  - Case Management for Shelter Plus Care participants
  - Housing placement for people with disabilities