
Looking Homeward:

The 10-Year Plan to End Homelessness

Asheville and Buncombe County
North Carolina

January, 2005



EXECUTIVE SUMMARY

Approximately 2,000 people experience homelessness in Asheville and Buncombe County at some time during the course of each year. Thousands more live doubled-up in the homes of family and friends, or they are at imminent risk of homelessness, living in substandard or overcrowded housing they cannot afford.

Looking Homeward: the 10-Year Plan to End Homelessness in Asheville and Buncombe County is the culmination of a six-month planning effort by homeless service providers, government administrators, housing developers, community leaders, and homeless people themselves. *Looking Homeward* is a long-range, comprehensive plan to help homeless people in our area return to healthy and stable lives in permanent housing. Its recommendations are evidence-based, and draw from the best practices of innovative programs and initiatives throughout the country.

Looking Homeward is intended to end long-term, or “chronic,” homelessness. This emphasis reflects a growing body of research demonstrating that members of this group are poorly served by existing efforts even though they use a disproportionate share of emergency services and resources. In Asheville and Buncombe County just 37 of approximately 300 chronic homeless people cost the community over \$800,000 each year; this figure does not reflect the costs of the other 260+ chronic homeless.

Research also shows that the chronic homeless population is best served by utilizing a Housing First/Housing Plus model. This approach focuses on moving people out of homelessness and into housing as quickly as possible. A participant does not have to be sober or be treated for a mental illness to receive the housing. Supportive services are provided in permanent housing, not in emergency or transitional shelter. An Assertive Community Treatment Team (ACT Team) provides the service in a non-threatening, consumer-driven approach. Housing First/Housing Plus projects across the nation have seen phenomenal results. After 5 years, as many as 90% of participants have remained in permanent housing.

Under the leadership of the United States Interagency Council on Homelessness, a national consensus has emerged that all levels of government must focus on improving efforts to house chronically homeless individuals and families. *Looking Homeward* is consistent with, and complementary to, the federal government’s efforts in this area. Likewise, the state of North Carolina, through its Interagency Council on Coordinating Homeless Programs, is creating a plan that will coordinate state efforts with federal and local plans. Federal, state, and local plans must complement each other, because each level of government will play an integral part in implementation.

Other North Carolina and Southeastern localities developing plans include: Durham City/Durham County, Raleigh/Wake County, Winston-Salem, Gastonia, and Henderson/Vance County, North Carolina; Chattanooga and Memphis/Shelby County, Tennessee; Richmond, Portsmouth, and Norfolk, Virginia; and Atlanta, Albany, Athens/Clark County, and Augusta, Georgia.

The scope of *Looking Homeward* is not limited to chronic homelessness alone. When implemented over the next decade, the policy recommendations will also result in a significant reduction of all types of homelessness, including among families, youth and single adults who experience episodic homelessness. Successful implementation will depend on funding availability at local, state, and federal levels. This plan does not state what sources of funding should be used, or how much should be made available. Funding decisions are left to the elected officials who charged the committee with creating this plan.

Looking Homeward will end chronic homelessness and reduce all types of homelessness over the next decade by investing our resources in a coordinated, sustained effort that addresses the underlying causes of homelessness. This effort will:

- ❖ Reduce the number of people who become homeless
- ❖ Increase the number of homeless people placed into permanent housing
- ❖ Decrease the length and disruption of homeless episodes
- ❖ Provide community based service and supports that prevent homelessness before it happens and diminish opportunities for homelessness to recur.

These goals will be accomplished through a five-prong approach:

- ◆ **Leading the Way: Designation of a lead entity** – an organization must be chosen that will oversee implementation of the plan.
- ◆ **Developing the Infrastructure: HMIS** – a Homeless Management Information System, or HMIS, must be utilized to link all services, screen for program eligibility, and gather data needed to monitor progress of implementation.
- ◆ **Closing the Front Door: Prevention** – Steps must be taken to stop individuals and families from becoming homeless. These steps include better coordination of financial assistance and discharge planning for people leaving public institutions.
- ◆ **Opening the Back Door: Housing First** – Development and implementation of a community-wide Housing First program that will include permanent housing for all homeless.
- ◆ **Keeping it Going: Housing Plus** – Necessary services must be provided to ensure that homeless individuals and families placed in permanent housing can remain housed long-term.

INTRODUCTION

Asheville and Buncombe County are located in the mountains of Western North Carolina. Asheville is the largest city west of Charlotte and is a regional hub. People from every county in Western North Carolina come to Asheville and Buncombe County to access services, entertainment, cultural activities, and employment. The county population was estimated to be 212,672 in 2003 by the United States Census Bureau. Also located in Asheville and Buncombe County are:

- ◆ a Veterans Administration hospital
- ◆ three correctional facilities
- ◆ two regional substance abuse treatment facilities
- ◆ a public transportation system
- ◆ and a large regional hospital

Myth: Charitable groups will take care of the homeless.

Fact: The growth of homelessness has far exceeded the capacity of charitable groups. Homelessness is a societal problem that requires a partnership between private charities and the government, with active public support.

Of the thousands of people who live in Buncombe County, more than 689 have nowhere to call home. Visitors to our downtown area cannot miss the small groups of homeless people gathered at Pritchard Park. Each morning the A-HOPE Day Center is abuzz with activity from the 100 or more homeless people who are served there daily. In the afternoons, homeless individuals and families are lined up to access a warm meal and a bed at the Salvation Army, Western Carolina Rescue Mission, and Asheville Buncombe Community Christian Ministries (ABCCM) shelters. Each night a group of homeless women sleep in various local church basements through Room in the Inn.

Homelessness costs the community millions of dollars annually; the human cost of homelessness is immeasurable. In response to urgent recommendations from the United States Interagency Council on Homelessness, the United States Department of Housing and Urban Development, and the North Carolina Interagency Council on Coordinating Homeless Programs, Asheville City Council and the Buncombe County Commission came together to form a steering committee to develop a 10-Year Plan to End Homelessness in Asheville and Buncombe County. The committee, comprised of 33 local business, non-profit, and government leaders, began meeting in June 2004 and presented this plan to City Council and the Commission in January 2005. The full committee included:

Jerome Jones, Chair
George Bond, Buncombe County Health Center
Steve Buie, Mental Health Professional
Kristy Carter, Hospitality House of Asheville
Brian Cole, Church of the Advocate
Anne Dachowski
James Dennis, Mountain Housing Opportunities
Sandra Feutz, New Vistas Adult Behavioral Health Services
Michael Godwin, Housing Authority of the City of Asheville
Vic Howard, Western Carolina Rescue Ministries
Travis Israel, Salvation Army
Jason Klein, Asheville Homeless Network

Ted Lambert, Asheville Police Department
John Lauterbach, Caring for Children
Rachel Nygaard, United Way/211
Richard Olejniczak, WNC Housing, Inc.
Edith Pope, Craggy Correctional Facility
Sylvia Portenier, Veterans Administration Medical Center
Dee Robertson, Buncombe County Emergency Management Services
Ross Robinson, Asheville Police Department
Scott Rogers, Asheville-Buncombe Community Christian Ministries
Florence Rowe, National Association for the Mentally Ill
Robby Russell, Wachovia Bank
William Stafford, Buncombe County Jail/Sheriff's Department
Amanda Stone, Buncombe County Department of Social Services
Mac Swicegood, Duckworth, Jacobs, Naeger, Swicegood & Thrash, LLC
Larry Thompson, Western Highlands LME
Earnestine Turner, Social Security Administration
Pamela Turner, Mills Manufacturing
Jerry Vehau, Buncombe County Emergency Management Services
Ramona Whichello, Mission Hospitals
Doug Wilson, McGuire, Wood & Bisette

Jerome Jones chaired this committee; staffing was provided by Charlotte Caplan for the City of Asheville, along with Cynthia Barcklow, and Lucy Crown for Buncombe County. Technical assistance, facilitation, and writing were provided by Robin Merrell of Pisgah Legal Services. Heather Gray edited and formatted drafts of the plan. Cover photographs were taken by Kenneth Kidd and Robin Merrell. Internal photographs were contributed by Kristy Carter.

SUSIE

Susie is a 33-year-old mom of two children, ages 13 and 15. Finding herself homeless and living at a neighborhood motel, she found sanctuary at in a local transitional housing program. Now having a stable home environment for herself and her children, she was able to quickly establish steady employment. Her residency has incurred its ups and downs, including the recent loss of her mother to cancer. The transitional housing staff provided counseling, case management, transportation, and referral to other community agencies which helped her through the grieving process. Her life is taking an upswing now because a car was recently donated to her with which she can travel to work, on recreational outings with her children, as well as visit her ailing grandmother.

A SNAPSHOT OF HOMELESSNESS

Currently, services and shelter for the homeless are provided through the agency and governmental members of the Asheville-Buncombe Coalition for the Homeless (hereinafter “Homeless Coalition”), an unincorporated group that meets monthly to plan and prioritize around homeless issues. At least once a year, the Homeless Coalition conducts a point-in-time count to document the number of homeless people in the area. The last count was held April 24, 2004 and found a total of 689 homeless.

The Homeless Coalition has been conducting point-in-time counts since 1996, and the numbers have fluctuated based on agency participation.

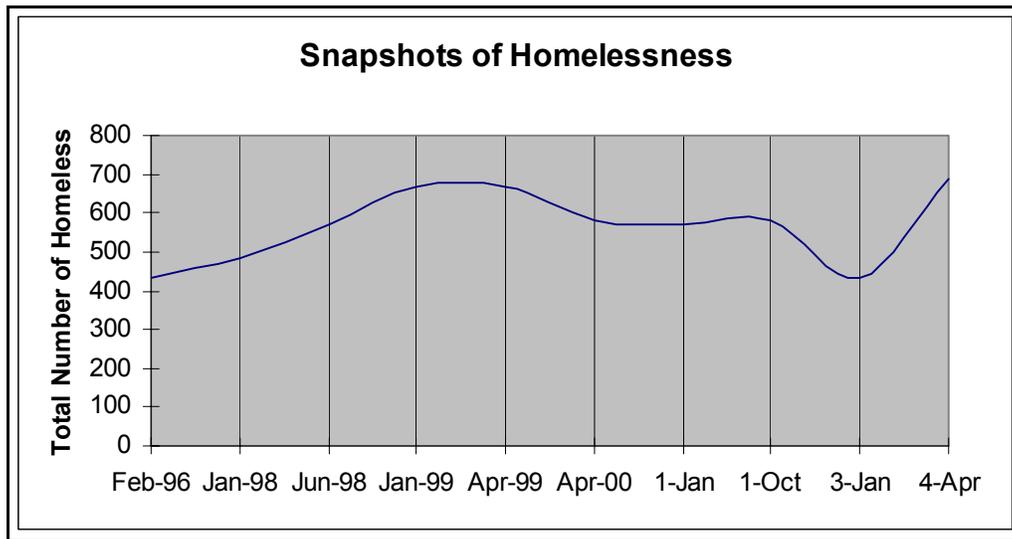


Table 1 Point-in-Time Study, 1996 – 2004

Myth: Establishing services for homeless people will cause homeless people from all around to migrate to a city.

Fact: Homeless people who move to new areas do so because they are searching for work, have family in the area, or for other reasons not related to services. A recent study found that 75% of homeless people are still living in the city in which they became homeless.

However, the point-in-time count is only a one-day count. Looking at who utilizes the services offered by the A-HOPE Day Center, we find more than 2,000 different homeless individuals in Asheville and Buncombe County in one year.

In addition to the point-in-time count, the A-HOPE Day Center tracks who is chronically homeless in our community. The United States Department of Housing and Urban Development (HUD) defines the chronic homeless as “an unaccompanied individual with a disabling condition who has been homeless for a year or longer or had four episodes of homelessness in three years.” The vast majority of the chronic homeless suffer from some type of mental illness, and most of those also have a substance abuse problem. In 2003, A-HOPE counted 293 chronic homeless people in our community who fit this definition. What is particularly significant about the chronically homeless population is the percentage of resources they consume. Approximately 80% of homeless individuals and families are homeless for a very short period of time, i.e., six weeks or less. They obtain the

services needed and move-on to stable housing. The next 10% stay in the homeless system a while longer, – usually about six months, – but they, too, obtain the services they need and are re-housed. The chronic homeless population, representing approximately 10% of the homeless population, uses more than 50% of the available resources. Finding more cost-efficient ways to serve this population will make more resources available for the other 90% of homeless individuals and families.



Within the chronic homeless population, a smaller group of approximately 37 homeless men and women who are referred to as the “chronic urban homeless,” are constantly causing problems for downtown businesses, residents, and tourists, and are frequently arrested for minor offenses. The community costs of this sub-population will be examined in the next section. Some recommendations in this plan are specifically for this population.

A CHANGE IN APPROACH

Services are currently delivered to the homeless through a Continuum of Care using a “housing-readiness” approach. The Continuum of Care model stretches all levels of housing on a continuum, beginning with emergency shelter and ending with permanent housing.

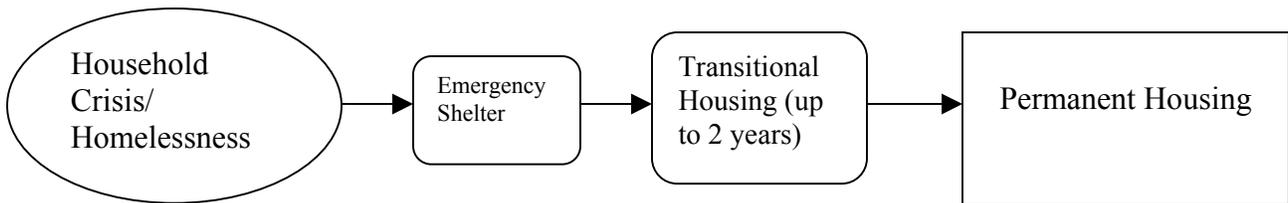


Figure 1 Continuum of Care Model

People move along the continuum when they are “ready” for a specific type of housing, usually by articulating a desire for change. The chronic homeless do not move along the continuum, because they are never “ready.” The housing readiness model requires compliance with service and treatment plans, and services are only available as long as a person lives at the program site. The mentally ill chronic homeless are focused on surviving from one day to the next, often not realizing the existence of their illness. They cannot move along the Continuum, off the street, into transitional or permanent housing using the

traditional components of the Continuum of Care with their high demand for cooperative, goal-oriented, and consistent behaviors. A different service delivery model has to be utilized to house the chronic homeless population.

A Housing First/Housing Plus approach seeks to assist persons to exit homelessness as quickly as possible by placing them in permanent housing and linking them to needed services. This approach assumes that the factors that have contributed to a household's homelessness can best be remedied once the household is housed rather than in emergency shelters or transitional settings. It also accepts that for some lifelong support may be required to prevent the reoccurrence of homelessness. Hence it seeks to maximize utilization of mainstream resources. The model also seeks long-term self-sufficiency, promoted through a wraparound service philosophy.

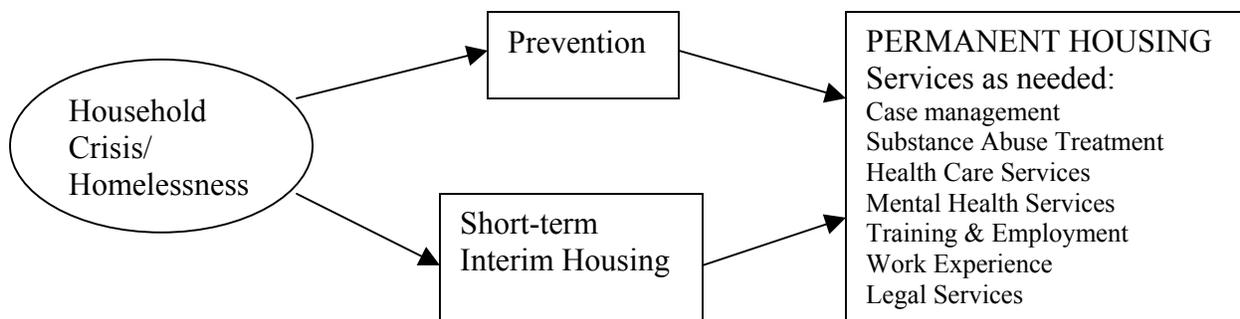


Figure 2 Housing First Model

Within this Housing First model, two core principles define permanent housing:

- ◆ choice regarding the location and type of housing
- ◆ no predetermined limit on the length of time that the household can remain in the housing unit.

Accordingly, the form of permanent housing will vary according to the needs and desires of each household. For some, permanent housing will mean Shelter Plus Care, for others a unit in a subsidized multi-family development with on-site supportive services. For others, permanent housing will be individual apartment units with a temporary rent subsidy, monthly case management, and facilitated access to community supportive services. For many, the type of permanent housing may change over time.

WANDA

Wanda was asked to leave every emergency shelter in town. Wanda's mental illness was more than most programs could handle. She was frequently agitated, cursed at people, threw things and often claimed people were trying to hurt her. Wanda had nowhere to go. She began spending her mornings at A HOPE, her afternoons in a park and her evenings walking around. She wasn't sleeping or eating. Eventually, due to extensive outreach efforts, she began staying at the A-HOPE Safe Haven. Wanda has applied for and now receives SSI, Medicaid, and Food Stamps. She regularly sees her mental health counselor, and has her own apartment.



THE COST OF HOMELESSNESS

Because homeless people have no regular place to stay, they use a variety of public systems in an inefficient and costly way. People who are homeless are more likely to access costly health care services by utilizing emergency rooms instead of primary care physicians. They also spend more time in jail or prison, often for crimes such as

loitering or public drunkenness, which is tremendously expensive. Homelessness both causes and results from serious health care issues, usually including addictive disorders. Treating homeless people for drug and alcohol related illness in less than optimal conditions is expensive and ineffective. Substance abuse increases the risk of incarceration and HIV exposure, and it is itself a substantial cost to our medical system.

We examined the costs to our local systems of 37 chronic homeless people over a three year period. The results were consistent with data from other communities across the United States.

Myth: They are dangerous and they break the law.

Fact: In general, the homeless are among the least threatening group in our society and are more likely to be victims of crime. Although they are more likely to commit non-violent and non-destructive crimes, they are less likely to commit crimes against person or property.

Jail

The 37 individuals were arrested a total of 1,271 times over three years, resulting in a total jail cost of \$278,000. This figure does not account for police costs, prosecution costs or court costs, only for housing them in the Buncombe County Jail. When police costs, prosecution costs and court costs are added in, the total cost, according to the Asheville Police Department, climbs to about \$10,000 per person per year.

Hospital and EMS

The same 37 individuals used the EMS service 280 times over the same three-year period, costing \$120,000. Their hospitalization costs at Mission Hospitals for the same time period was \$425,000. Conversely, this group rarely utilized the Buncombe County Health Center and Blue Ridge Mental Health Services, where they could receive services for non-emergency health issues, resulting in only \$7,000 in expenses for the Buncombe County Health Center and \$65,000 for Blue Ridge Mental Health over the same time period. The total documented medical costs amount to approximately \$5,500 per person per year.

Emergency Shelter

Emergency shelter is a costly alternative to permanent housing. While it is sometimes necessary for short-term crises, it too often serves as long-term housing. At ABCCM, the annual cost for an emergency bed is \$3,700, while the cost of a bed in A Vet's Place (transitional housing for homeless veterans) is \$9,900 annually. The average annual cost of

an emergency shelter bed is approximately \$7,200 per year, accruing a total cost of \$266,400 per year to house the 37 chronic homeless in shelters.

Cost of Homelessness	Per Person Per Year	Total Per Year
<i>Jail/Court</i>	\$10,000	\$370,000
<i>Medical</i>	\$5,500	\$203,500
<i>Shelter</i>	\$7,200	\$266,400
<i>Total Cost of Chronic Homelessness</i>	\$22,700	\$839,900

Table 2 Rising Cost of Homeless

THE ALTERNATIVE: A Better Way

Housing First, described earlier, is a less expensive and effective alternative to the current system. The New York New York Agreement Cost Study found that an overall savings of 30% was achieved when a homeless mentally ill person was housed through Housing First rather than remaining on the streets and relying on public systems. State psychiatric center use decreased 60%, use of acute care hospitals reduced 87%, and use of jails was reduced by 40%. Use of outpatient services increased by 75% (note that outpatient services are less expensive than inpatient services). Pathways to Housing, a Housing First program in New York City reported that after five years, 88% of program participants remained in permanent housing.

The previous section described the costs of just 37 of the approximately 300 chronic homeless in Asheville and Buncombe County. Providing rental subsidy to an already constructed one-bedroom apartment in the Asheville area can cost up to \$6,400 annually, depending on the tenant’s ability to pay. ACT Team services are currently reimbursed by the state of North Carolina at the rate of \$828 per month. Therefore, housing a current chronically homeless person with no income who utilizes ACT Team services would cost a little more than \$16,000 annually.

Housing First is sometimes criticized as being a “government handout,” or “giving something for nothing.” The reality is that the program is successful and can transform a community. Once a homeless, mentally-ill person has a place to live and does not have to worry about where to sleep, what to eat, or potential violence, life changes dramatically. Pathways to Housing found that not only do participants drink less, they desire treatment for their mental illnesses. As their bodies heal, they desire employment and other activity. Many participants

Myth: Homeless people don't work and get most of their money from public assistance programs.

Fact: Many homeless people are among the working poor, and a relatively small percentage of them receive government assistance. A nationwide study in 1987 found that only 20% of 1,704 homeless people received public assistance. A study done in Chicago found that 39% of the homeless people interviewed had worked for some time during the previous month.

in Housing First become functioning members of society who work jobs, pay taxes, and participate in their communities. If a participant does not achieve these goals, Housing First does remove them from the street and provide services in a cost-effective manner. Participants will no longer congregate in public areas inebriated, will not be arrested as often as before, and will not use the emergency room as a primary care physician. The program creates substantial savings to the community, as well as alleviating the difficulties of business owners and shoppers to the downtown district.



Guiding Principles

In developing our plan, we used the following guiding principles:

- Recognition that homelessness and near-homelessness are growing problems in Buncombe County – and that a shortage exists of housing affordable to people with extremely low incomes.
 - Commitment to the belief that more can be done to prevent homelessness and to more effectively serve people in need.
 - Recognition that the vast majority of homeless people are not homeless by choice, even though their own actions may have contributed to and perpetuated their homelessness.
- Support for the concept that better coordination among agencies is needed to address the multiple factors that contribute to homelessness, including poverty, domestic violence, substance abuse, and lack of education and job skills.
 - Agreement that mainstream organizations – not just groups that serve only homeless people – must become more involved to develop an effective community response. People in need will be better served if the justice, mental health and welfare systems; child protective services; employment assistance programs; housing developers; neighborhood organizations; and other areas of the public and private sectors do more, individually and collectively, to eliminate homelessness.
 - A belief that homeless and near-homeless people should become as independent as possible, for their own dignity, to contribute as much as they can to society, and to limit the costs homelessness places on society. To assist them in reaching this goal, people in need should receive appropriate support services.
 - Agreement that realistic goals must be set for assisting homeless and near-homeless people to move out of crisis and toward self-sufficiency. In addition, mechanisms should be established to evaluate progress toward meeting these goals.
 - Recognition that the plan we are developing should not become a document gathering dust on a shelf. The steering committee should establish recommendations for providing oversight to ensure that the 10-year plan is carried out and to provide adjustments to the plan as needed.

Our plan has five major components:

1. Leading the way: designation of a lead entity
2. Developing the Infrastructure: HMIS
3. Closing the Front Door: Prevention
4. Opening the Back Door: Housing First
5. Keeping it going: Housing Plus

LEADING THE WAY: Designation of a Lead Entity:

To ensure progress toward the goal of ending homelessness in Asheville and Buncombe County, a lead entity will coordinate implementation of the plan and be accountable to the community, homeless service providers and local government. This non-governmental entity should have a proven track record of staff quality, advocacy, fundraising and institutional accountability. The entity should have established relationships with service providers, funders, elected officials, law enforcement agencies, and other stakeholders. The entity should be a non-profit, rather than a governmental entity, to ensure that realization of the plan's goals transcends electoral cycles. The lead entity must have strong board leadership. The steering committee recommends the Affordable Housing Coalition of Asheville and Buncombe County (AHC) as the lead agency. Funding will be needed for the lead entity to staff the position. Staff will need expertise in grant writing, management, homelessness, and mainstream resources.

Function of the lead entity will include:

- ◆ Managing HMIS. (HMIS is described in the next section.) The lead entity will work with service providers to better coordinate and communicate through using HMIS. The lead entity will help agencies increase their capacities to implement the HMIS. The lead entity will produce periodic reports and monitor the results of the service providers.
- ◆ Identifying and obtaining additional public and private resources including consulting with local philanthropies and local government about gaps in services and funding priorities. Develop a funders' collaborative to periodically consider funding needs to implement this plan.
- ◆ Coordinating service provider agencies and local governments.
- ◆ Acting as a liaison to local government.
- ◆ Providing regular progress reports to the community.

DEVELOPING THE INFRASTRUCTURE: HMIS

Each locality has been directed by HUD to begin utilizing an HMIS (Homeless Management Information System). HMIS, at the very least, is a computer software system that collects a variety of information on homeless people and compiles data. Ideally, the system can be used to coordinate services, link resources, centralize intake, and manage housing placement. The Homeless Coalition several months ago made the decision to join the statewide collaborative that formed to work on implementing a statewide HMIS. The advantages of the statewide system are integration with other communities resulting in state-level data, and

hopefully, reduced cost. It is the recommendation of the steering committee that the entire community, including mainstream resources, join this HMIS if the software can be tailored to meet our specific needs.

Strategies to Build the Infrastructure:

- ◆ Develop HMIS
- ◆ Establish a “no-wrong door” entry into the homeless network
- ◆ Link all intake forms, service plans, referral protocols, and housing resources with HMIS
- ◆ Use HMIS to screen for program and service eligibility

CLOSING THE FRONT DOOR: Prevention

The most humane strategy for addressing homelessness is to prevent its occurrence in the first place. Prevention efforts include strategies such as one-time or short-term rent or mortgage assistance, legal assistance programs, representative payee and direct payment programs, and housing placement services. They also include more systemic strategies that seek to prevent homelessness by ensuring that people leaving institutions such as jails, prison, or treatment facilities are not discharged to the streets or shelter system, as well as strategies that seek to forestall homelessness in cases of family crises such as domestic violence. By far the most common prevention approach is the provision of one-time or short-term financial assistance.

Myth: They're to blame for being homeless.

Fact: Most homeless people are victims. Some have suffered from child abuse or violence. Nearly one quarter are children. Many have lost their jobs.

Strategies to prevent homelessness:

- ◆ Better coordinate and expand legal assistance and housing resources available for one-time, short-term and transitional financial assistance that can be used to avert eviction. Pisgah Legal Services, Homeless Coalition members, and Buncombe County Department of Social Services should work together to better utilize their services and resources
- ◆ Increase linkage to permanent housing and services for people leaving institutions through the creation of a mobile, 24-hour discharge team that can collaborate on placements upon discharge. This discharge team should include representatives of discharging institutions, the Homeless Coalition, and housing providers
- ◆ Set up zero tolerance for discharge to homelessness policy including hospitals, jail, prison, foster care, shelters, recovery programs, transitional programs, and halfway houses
- ◆ Utilize 211 for referrals
- ◆ Link households assisted by prevention programs to mainstream resources to support their sustainability. Receipt of assistance should trigger eligibility assessment for mainstream resources
- ◆ Landlord education of homelessness and services available to homeless. This strategy can be accomplished by the lead entity in cooperation with local landlord groups

OPENING THE BACK DOOR: Housing First

Housing First should be utilized for those who are already homeless or for whom homelessness cannot be prevented. For Asheville and Buncombe County, this approach requires a fundamental shift in our shelter strategy, away from the current system to a model in which short-term housing is provided for the minimum time needed to access permanent housing, with services focused on an immediate and comprehensive needs assessment, resource acquisition, and housing placement. Ideally, individuals and families will be homeless for three months or less. Upon entry into the homeless service system, each individual and family will be assessed for eligibility of mainstream resources. Housing placement and job training services will be provided along with primary health care, mental health and substance abuse services. Case management will be provided as necessary. Any and all of these services will follow the family or individual into permanent housing and will be available as long as necessary, even indefinitely.



Upon entry into the homeless service system, each individual and family will be assessed for eligibility of mainstream resources. Housing placement and job training services will be provided along with primary health care, mental health and substance abuse services. Case management will be provided as necessary. Any and all of these services will follow the family or individual into permanent housing and will be available as long as necessary, even indefinitely.

Currently, the closest thing we have to a Housing First program is Shelter Plus Care. This housing program is run by New Vistas Behavioral Health Services and subsidizes rent for 35 individuals and families who are homeless and mentally ill. The individuals and families are also provided with mental health treatment and other services to make sure they remain housed. After five years, 80% of participants have remained in permanent housing.

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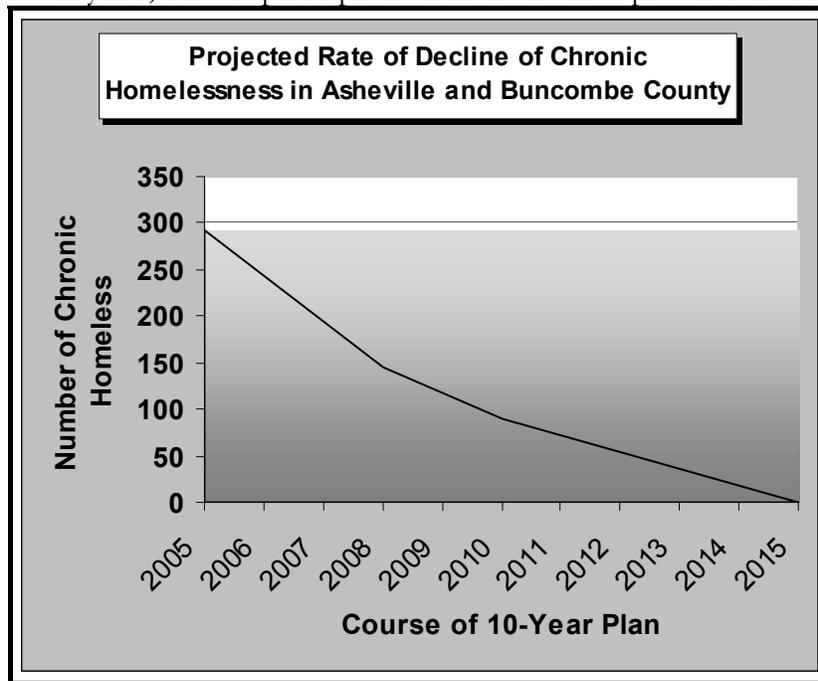


Table 3 Ten-Year Plan Grid

Within the next 12-18 months, additional units will be available at Woodfin Apartments and Griffin Apartments. Woodfin Apartments, once rehabilitated, will have 19 units for various sub-populations of homeless people, some of whom will be chronic homeless. Services for residents of the Woodfin will be provided by New Vistas. Griffin Apartments, once constructed, will include 15 units for homeless people, some of whom will be chronic homeless. There are plans for services to be provided on-site by Hospitality House of Asheville.

While this plan does not mandate that existing shelter programs transition into Housing First, this plan does recognize that over the course of 10 years, as current shelter residents are moved into permanent housing, the need for emergency shelter will be dramatically reduced. Existing emergency shelter programs will need to change their programming in order to better serve the homeless population. A wide range of services will be needed to ensure that formerly homeless people remain in their housing units.

Goals for 2005-2006

- Provide Housing First accommodation to 30 chronic homeless in Woodfin Apartments, Griffin Apartments, and Housing Authority of the City of Asheville apartments. Participants will be selected by the Homeless ACT Team operated by New Vistas and the Lead Entity.
- Develop plan to identify or construct 70 units of permanent supportive housing each year.

Strategies for continued implementation of Housing First:

- ◆ Creation of new permanent supportive housing units with project-based housing subsidies for persons with serious and persistent disabilities.
- ◆ Utilize existing housing market by making public housing more accessible and working with landlords to further acceptance of rental subsidies.
- ◆ Use local public funding to create or subsidize more housing units for homeless individuals, families, and youth.
- ◆ Develop more rental subsidies that are both project-based and tenant-based.
- ◆ Develop appropriate housing first models for families and homeless youth.
- ◆ Modify the Uniform Development Ordinance (UDO) so that more affordable, multi-family housing can be developed within the city limits.
- ◆ Link SocialServe.com with HMIS to create a clearinghouse of affordable housing units.
- ◆ Intensive outreach to homeless populations, particularly campers.
- ◆ Landlord education of homelessness and services available to homeless. This strategy can be accomplished by the lead entity in cooperation with local landlord groups.

KEEPING IT GOING: Housing Plus

Housing Plus, also known as wraparound services, is the key to keeping a formerly homeless person or family in housing. These supports include: affordable healthcare with mental health and substance abuse services; livable wage employment and/or other income supports; and for families, childcare. The Housing first approach is a comprehensive service provision model that guarantees that any and all services needed by an individual or family are integrated through a cohesive, individualized service plan that guides all service provision. This service approach should be used in all components of the homeless service delivery system.

Currently, service referral is a component of most homeless service provision, but in the absence of more active and integrated case management, referral-based case management often results in fragmented care, and fails altogether when the homeless person does not persist in seeking it. The implementation of a wraparound services approach will mean that case managers across agencies must work together to develop one plan of action for each client, with each agency contributing, according to its strengths and resources, to support the individual or family in achieving housing stability and long-term self-sufficiency, with or without the client's active cooperation. Because service intensity is determined upon client need, this may mean that initially an agency provides daily or weekly contacts, which may shift to monthly or on-call assistance for an extended period of time. For some, service will always remain an integral part of the residential environment. For others, this support will be transitional, sufficient to ensure that employment and community-based resources, such as health care, schools, social services, civic organizations, and communities of faith are secured.

Myth: Homeless people are mentally ill or substance abusers.

Fact: About 25% of the homeless are estimated to be mentally ill, about 40% are alcohol or substance abusers, and about 15% suffer from both disabilities. One percent may need long-term hospitalization.

Goals for 2005-2006:

- Expand to two Homeless ACT Teams adding substance abuse expertise.
- City of Asheville, Pisgah Legal Services and Lead Entity to track progress of Services to End Long Term Homelessness Act (SELHA) and Samaritan Initiative, other legislation and appropriations, and aggressively pursue all available state and federal funding.

Strategies to implement Housing Plus:

- ◆ Expand the provision of community-based case management services that embody a wraparound services approach through treatment teams, such as ACT Teams.
- ◆ Develop formal systems integration strategies between the Housing First system and mainstream service systems, such as public entitlements (TANF, Medicaid, Social Security and Food Stamps), employment training and placement, public health,

community mental health and substance abuse, to ensure that formerly homeless households have streamlined access to the array of formal supports available in the community.

- ◆ Establish a working group to identify alternative resources to fund targeted supportive services for persons with severe and persistent disabilities and/or substance abuse disorders placed in permanent supportive housing. Priorities should include: funding for services for substance abuse disorders, and development of a wide range of teams offering population-appropriate services.
- ◆ Set up emergency detoxification center for chronic homeless in conjunction with law enforcement.

JOSEPH

Joseph moved into the Calvary Shelter during the holidays. He's a very shy, quiet man who suffers from a severe mental illness, substance abuse issues and had been camping outside for some time. Joseph recently moved...into an apartment he will share with his brother. This comes as a result many hours of collaborative work between Hospitality House, Blue Ridge Center, and the Affordable Housing Coalition. The agencies shared their expertise in different areas in order to find safe, affordable, independent housing for these two men. Joseph did his share of the work, keeping appointments and carrying paperwork between agencies.



LOOKING FORWARD: 2015

Ten years from now, the plan should be completed. What will be the results?

- No homeless people living on the streets or in camps.
- Sharply reduced number of dormitory-style emergency shelter beds.
- Hundreds of formerly homeless individuals and families living independently with varying levels of support services.
- Day programs offering social activities for the disabled.
- Transitional housing for individuals and families who are temporarily homeless because of economic crisis, family breakdown, or abuse.
- Multiple entry points into a system with coordinated services for people who become homeless or need help to prevent homelessness.
- Measurably reduced burden on courts, police, jail, EMS, and emergency rooms.

This plan resulted from months of meeting, discussion, and research. It is a beginning; implementation will take time, effort, and resources. The community must not lose its focus or accept less than the stated goal: ending homelessness.

Myth: Homeless people are a fixed population who are usually homeless for long periods of time.

Fact: The homeless population is quite diverse relative to their length of homelessness and the number of times they cycle in and out of homelessness. Research indicates that 40% of homeless people have been homeless less than six months, and that 70% of homeless people have been homeless less than two years.

GLOSSARY OF TERMS:

2-1-1: United Way's 2-1-1 of Western North Carolina is a free, 24-hour community service information line that connects people with the resources they need in order to get help.

A-HOPE: A day-center and Safe Haven for the homeless operated by Hospitality House of Asheville; only program of its type in North Carolina.

ABCCM: Asheville-Buncombe Community Christian Ministries, a local non-profit organization that provides cash assistance, emergency shelter, food, medical services, and other services to low-income residents.

ACT Team: Assertive Community Treatment Team, includes people with a range of specialties who together provide services for clients in a wrap-around approach.

Chronic homeless: an unaccompanied individual with a disabling condition who is homeless for a year or longer or has 4 episodes of homelessness in 3 years.

JULIE

Julie was homeless - often living at hotels and wherever else she could with her two children. She was a former public assistance client that had difficulty in making the transition from "Work First" to a meaningful job that would support her family. With a history of being underemployed, coupled with living on the verge of homelessness, she struggled just to make ends meet. She moved into transitional housing and developed an intensive case management plan with the program director. This plan targeted specific areas to improve on the overall stability of her life. The plan included looking for stable employment, acquiring reliable transportation, and obtaining counseling for her children, impacted by years of unstable living. Through her hard work and the close relationship of the Transitional Housing Director with many community partners, Julie accomplished all of these goals. She now works full time with a local Health Agency, she received a donated car, and her children continue to make forward strides in their work with a counselor. Julie has done so well that just recently she was able to move her family into permanent housing.

Continuum of care: A service delivery model where homeless families and individuals move from step to step along the continuum until they reach permanent housing.

Episodic homelessness: An individual or family who is homeless for a short period of time, and may or may not become homeless again.

HMIS: Homeless Management Information System – a computerized data collection application designed to capture client-level information over time on the characteristics and service needs of people experiencing homelessness, while also protecting client confidentiality. It is designed to aggregate client-level data to generate an unduplicated count of clients served within a community’s system of homeless services.

Homeless Coalition: an unincorporated group of homeless service providers, local government, and other community members who meet monthly to coordinate services for homeless people.

Housing First/Housing Plus: A housing model that provides permanent housing for participants along with wrap-around services, often through a team.

HUD: United States Department of Housing and Urban Development.

Point-in-time count: A one-day count of all homeless people in a defined area.

Safe Haven: a form of supportive housing serving hard-to-reach homeless people with severe mental illness or other debilitating behavioral conditions who are on the streets and have been unwilling or unable to participate in supportive services.

Samaritan Initiative: legislation proposed by President George W. Bush that would allow several federal departments to jointly fund programs for homeless individuals and families. Currently being considered by Congress.

SELHA: Services to End Long-Term Homelessness Act – Legislation before Congress that would appropriate additional funding for services for homeless individuals and families.

Shelter Plus Care: A HUD funded supportive housing program that provides rental subsidy and supportive services to disabled homeless individuals and families.

Short-term assistance: Up to 90 days.

Wrap-around services: Services which are coordinated to meet all of a client’s needs in order to remain housed and not return to homelessness.

Myth: Homeless people are mostly single men.

Fact: Families constitute a large and growing percentage of the homeless population. A recent study found that families comprise 38% of the urban homeless population. Other research has found that homeless families comprise the majority of homeless people in rural areas.