ENDING HOMELESSNESS IN TEN YEARS: HARRISONBURG AND ROCKINGHAM COUNTY, VIRGINIA

A PLAN

OCTOBER 2010

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Ten Year Plan Development Steering Committee

Chair: **Michael Wong**, Executive Director, Harrisonburg Redevelopment and Housing Authority

The Honorable **Kai Degner**, Mayor, City of Harrisonburg

Stephen King, Deputy County Administrator, Rockingham County

*__Donald Driver__, Executive Director, Harrisonburg and Rockingham County Department of Social Services

Rich Harris, Director, Community Service - Learning, James Madison University

*__Betsy Hay__, Executive Director, United Way of Harrisonburg and Rockingham County

*__Elroy Miller__, Director, Social Work Program and Associate Professor of Social Work, Eastern Mennonite University

*__June Nabers__, Community Development and Grant Coordinator, Harrisonburg Redevelopment and Housing Authority

*__Candy Phillips__, Executive Director, First Step: A Response to Domestic Violence

John Whitfield, Executive Director, Blue Ridge Legal Services

Lacy Whitmore, Executive Director, Harrisonburg and Rockingham County Community Services Board

*Denotes Work Group Chair

Executive Summary

Welcome to the plan to prevent and end homelessness in Harrisonburg and Rockingham County in ten years.

Our vision as a community is that by 2021, every citizen of Harrisonburg and Rockingham County will have access to a home, as well as the services and supports they need to thrive and achieve self-sufficiency. The common understanding of this ten year plan is that homelessness is solvable. However, we acknowledge the need for a renewed and focused effort that mobilizes the community to make ending homelessness a priority.

In late 2009, community leaders opted to begin the process of creating a ten year plan to prevent and end homelessness. A ten year plan is a community planning tool, used by over 300 urban, suburban, and rural communities across the nation and 12 communities in Virginia, that prescribes a concrete set of strategies designed to overcome the challenges to ending homelessness.

The process itself, in addition to the end result, is critical. Already the ten year plan process has made a significant impact on the community's understanding of homelessness and its complexity; it has brought new partners to the table; it has generated dialogue on new ideas and data-driven and research-focused best practices; it has increased public awareness of the reality of homelessness in this community; it has called for community collaboration to improve our community response to homelessness. It will be the continued dedication and commitment of old and new partners that will make this plan a reality. The Harrisonburg and Rockingham County Ten Year Plan to End Homelessness is the result of the insight, time, and dedication of many community members as well as those who have experienced homelessness firsthand.

This ten year plan includes concrete measurements of success to track the impact of the plan in reducing rates of homelessness. Over the next ten years, we will steadily:

- Decrease rates of homelessness among all populations with a special focus on decreasing the number of homeless children in City and County public schools.

- Increase the percentage of homeless people who are entering permanent, stable, and adequate housing.
- Increase the percentage of formerly homeless people who remain in permanent, stable, and adequate housing for designated lengths of time.
- Decrease recidivism (return to homelessness.)
- Decrease the length of time it takes homeless people to access permanent, stable, and adequate housing.
- Maximize self-sufficiency skills and services people at risk of and formerly experiencing homelessness.
- Increase the knowledge base of best practices including prevention activities; increase utilization of best practices.

The community agreed on these key priorities to prevent and end homelessness:

Priority 1: Prevent homelessness before it occurs.

Priority 2: Create a full spectrum of affordable, stable and quality housing options for those experiencing homelessness and those at-risk of homelessness.

Priority 3: Better coordinate and improve outcomes in services for those at risk of homelessness, those currently experiencing homelessness and for those who have experienced homelessness.

Priority 4: Utilize data and research to better align services with need and evaluate the impact of current approaches to homeless prevention and assistance.

A major tenet of this plan is its implementation strategy which will ensure the accountability of our community in moving the plan forward. We have divided our planning process into three phases. This plan documents the results of Phase One. Phase Two,

which begins January 1, 2011 and ends June 30, 2011, will create a blueprint for implementation and concentrate on identifying concrete housing and service targets and setting annual benchmarks. The final ten year plan and blueprint will include specific strategies and action steps, identify lead and key partners for each strategy, and propose timetables to maintain accountability among all parties and ensure that the plan moves forward.

We accept that homelessness does not have to exist - at least not at the elevated level that it is now. Solving this problem will require our leadership and focus as a community to implement and evaluate creative solutions. It will also require partnerships with those experiencing homelessness who desire better lives for themselves and commit to taking personal responsibility to make their dreams reality.

Our Planning Process

Why a Ten Year Plan?

In late 2009, Harrisonburg and Rockingham County leaders opted to create a ten year plan to prevent and end homelessness. Ten year plans have been created by over 300 communities and 11 of Virginia's communities (including single cities or counties and regions.) It is a community planning tool which brings a diverse group of stakeholders together to utilize data and research to understand the needs of those experiencing homelessness, identify gaps in homeless prevention and assistance, coordinate and streamline existing services, and plan for new evidence-based practices. It prescribes a concrete set of strategies designed to overcome the challenges of ending homelessness.[1]

Research has documented that many communities across the nation have seen concrete results from the creation and pro-active implementation of ten year plans. These results include decreases in rates of homelessness across all populations and / or among particular sub-populations, new funding resources, better coordinated and streamlined services, a community understanding of what it will take to end homelessness, and research and adoption of new strategies that have proven to improve outcomes for clients. In addition, the federal government, specifically the US Department of Housing and Urban Development, encourages the creation of ten year plans and awards additional points to federal Continuum of Care[2] funding applications that are aligned with local ten year plans.

The belief underlying ten year plans is that homelessness is solvable, and the community can and must mobilize their energy and resources towards solving this tragedy.

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[1] Virginia Coalition to End Homelessness. 10 Year Plan Document.

[2] Communities that apply for federal McKinney-Vento Homeless Assistance Grants are required to form or join a local Continuum of Care to coordinate the community's response to homelessness, identify gaps in services, and collaboratively plan for how to fill these gaps.

Community Planning Process

A Steering Committee (member list on page 1) was formed, with input from the Continuum of Care as well as other community partners, to guide the development of the plan. The Steering Committee elected Harrisonburg Redevelopment and Housing Authority (HRHA) Executive Director Michael Wong as Chair. HRHA issued a Request for Proposals (RFP) to hire a consultant to provide technical support for the development of the ten year plan. The Steering Committee hired the Virginia Coalition to End Homelessness to (1) create dialogue, networking, and community input events that encourage and promote the creation of a plan to end homelessness, and (2) act as chief author of the plan which incorporates best practices as promoted by the U.S. Department of Housing and Urban Development (HUD) and current research. VCEH was selected for their experience at the national, state and local levels with best practice policies and programs in homeless prevention and assistance strategies.

The Steering Committee was charged with oversight of the development of the ten year plan and final decision making authority over the contents of the ten year plan. The Steering Committee met multiple times between January and November 2010.

Review of National, State, and Local Best Practices

The Steering Committee reviewed new federal requirements and expectations of local ten year plans as outlined in the HEARTH Act - federal legislation which makes sweeping changes to the HUD Continuum of Care program. The Data and Research Work Group, community members and VCEH also brought forward best practices that have been proven effective through data and research from other communities across the state and across the nation.

Community Input

The Steering Committee sponsored a Community Forum on July 15, 2010, at the Lucy Simms Center to solicit community input into the goals and strategies that would bring the community closer to ending homelessness. Four Work Groups were formed to fur-

ther refine the ideas and strategies that were suggested in breakout sessions during the Community Forum. The work groups and work group chairs were:

Prevention: Don Driver

Serving Those Currently Experiencing Homelessness: Candy Phillips

Ensuring Housing Self Sufficiency: Betsy Hay

Data and Research: Elroy Miller and June Nabers

Additional community input was sought. Three public hearings were held in mid September as well as a focus group with the Continuum of Care and two focus groups with people experiencing homelessness. Revisions were made to the ten year plan document based on community input.

The Planning and Implementation Phases

The Steering Committee decided to divide ten year plan development into three phases. This report documents the results of Phase One of the planning process. More information about implementation is included later in this document.

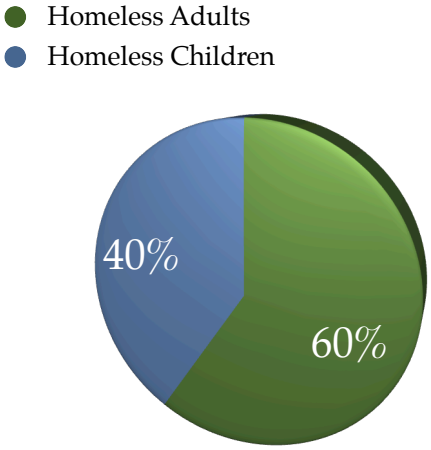
Phase One (January - December 2010): The community creates a plan which will guide the community efforts to prevent and end homelessness.

Phase Two (January - June 2011): Task Forces (to include among others: Housing, Services, Prevention, Data & Research, Public Awareness) are formed to establish performance benchmarks, identify lead entities and key partners for each strategy, and begin the implementation process. The product of this process is a blueprint to guide implementation.

Phase Three / Year One (July 2011 - June 2012): Ten year plan implementation officially begins.

What We Know About Homelessness

Who Experiences Homelessness in Harrisonburg and Rockingham County?[3]



163 people experienced homelessness on one point in time during the January 2010 Point in Time count.

This includes 97 adults

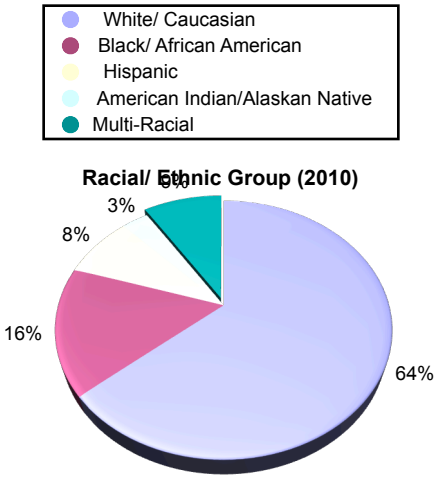
This includes 66 children

Of the 163 people,

64 percent were White/Caucasian

16 percent were Black/African American

8 percent were Hispanic



Among sheltered adults,

46 percent of respondents were between the ages of 22-35

29 percent were between the ages of 36-50

22 percent of respondents were older than 51 years of age

[3] This data is based on the annual point in time count and survey - an enumeration of the number of people experiencing homelessness. This count uses the federal definition of homelessness as defined by the US Department of Housing and Urban Development. The survey is of those who opted to participate.

Why Are People Homeless?

The number one reason stated for homelessness in this community is the inability to find work.

71 percent of the respondents reported the inability to find work as their top reason for homelessness[4]

The top two other reasons reported were:

Inability to find affordable housing (69 percent)

Medical problems (23 percent)

What is their level of education?

41.3 percent had a high school diploma or GED

25.2 percent were college graduates, or had some college, or had received a technical / vocational / associates degree

32.3 percent had less than a high school education

Are people homeless for the first time or have they been homeless for years?

21 percent were homeless for the first time

16 percent had experienced four or more episodes of homelessness in the past three years, were single adults, and had one or more disabling conditions. This is defined as chronic homelessness.

[4] Based on the annual point in time survey of those residing in emergency shelter and transitional housing programs.

For what length of time are people homeless?

The majority of survey respondents had been in the homeless situation for various lengths of time, as follows:

61 percent have not had their own place for 1-6 months

18 percent of respondents have been homeless for a year or more

13 percent homeless for less than 1 month

Do they work?

In the 6 months prior to January 28, 2010:

34.66 percent of the respondents had been employed

Full Time (more than 30 hrs/wk): 17.33 percent

Part Time (less than 30 hrs/wk): 17.33 percent

71 percent received food stamps

19 percent received Social Security Income (SSI) or Social Security Disability Income (SDI)

What else do we know about people living in emergency shelter and transitional housing in this community?

16 percent of respondents related of receiving TANF support

The majority surveyed lack health insurance

56 percent have no coverage

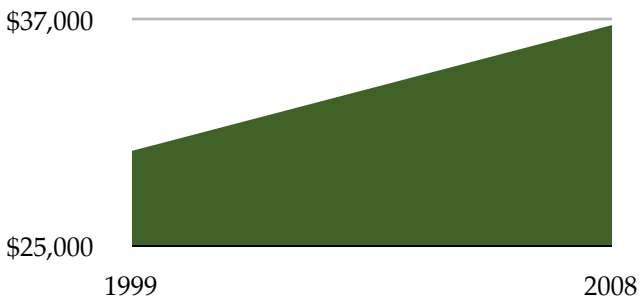
77 percent use the Emergency Room when sick

What We Know About Poverty and Affordable Housing in Harrisonburg & Rockingham County

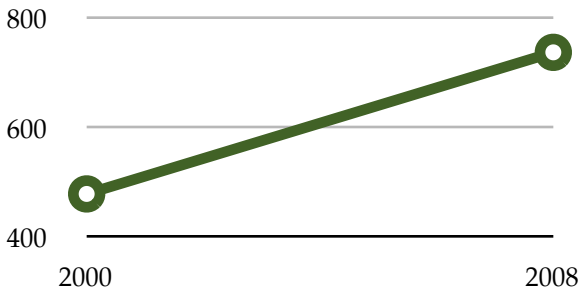
Harrisonburg and Rockingham County (HRC) have multiple and contrasting factors which contribute to rural homelessness and lack of affordable housing. The HRC area has experienced considerable population growth in the last twenty years due to an increase in the numbers of college students and the immigrant and minority population. However, household income has not sufficiently kept up with the increased costs of rent and homeownership. As a result, many families in Harrisonburg are limited in their capacity to own homes and to pay the prevailing rental rates.

Household Income

Between 1999 and 2008, the median Harrisonburg household income has increased from $29,949 to $36,606 (up 18 percent) and Rockingham County household income has increased from $46,262 to $51,652 (up 11 percent). In spite of the good news in household income, approximately 10 percent of Harrisonburg households and 31.7 percent of individuals live below the poverty level. These numbers are impacted by the student population. In Rockingham County, between 5.4 percent and 8.9 percent of households live below the poverty level. These percentages have been relatively consistent for the last 10 years.[5]

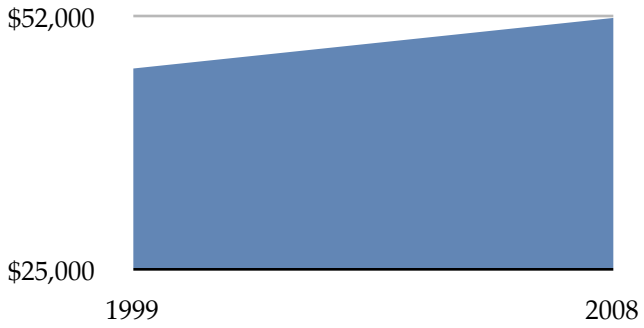


Harrisonburg Median Household Income

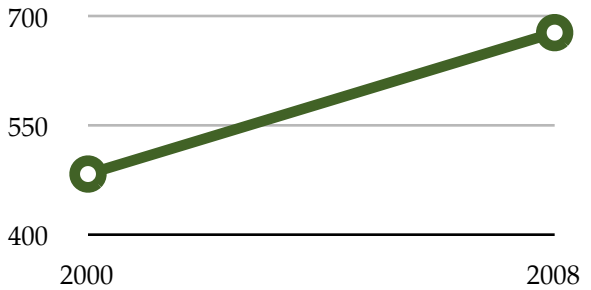


Harrisonburg Average Rental Cost

[5] American FactFinder- U.S. Census Bureau, 2010.



Rockingham County Median Household Income



Rockingham County Average Rental Cost

Between 2000 and 2008, the median cost of a Harrisonburg home increased in cost from $122,700 to $201,100, an increase of 61 percent in cost. During the same time, the median cost of a Rockingham County home increased in cost from $107,700 to $192,399, an increase of 44 percent. The rental cost in Harrisonburg jumped from $480 to $739, up 35 percent, and the rental cost in Rockingham County jumped from $485 to $679, up 29 percent.[6]

Population

Harrisonburg's current approximate population is 46,896 and Rockingham's is 75,962. Since 2000, Harrisonburg has increased its population by 14 percent and Rockingham by 11 percent.

HRC has grown by 29 percent in the last two decades, from 88,189 to 122,858 (Economic Overview: The Central Shenandoah Valley Region, 2010). According to the U.S. Census Bureau, the minority population has also expanded considerably during this time: Hispanic/Latino from 3,580 to approximate 5,759, a 38 percent increase; African American from 2,394 to 2,659, a 10 percent increase; and Asian American from 1,257 to 1,931, an increase of 35 percent.

Housing

In the last decade, HRC's number of housing units has increased by 19 percent. In the year 2008, Harrisonburg had approximately 15,595 housing units and Rockingham

[6] American FactFinder-U.S. Census Bureau, 2010

County had 31,908 housing units, for a total of 47,503 units (U.S. Census Bureau and the American Community Survey [ACS]).

Between 2000 and 2008, Harrisonburg's percentage of single-family detached housing units decreased from 42.2 percent to 32.4 percent of the total, and the duplex and town house unit percentages increased from 15.6 percent to 23.4 percent of the total units. During the same time, the Rockingham County single-family detached units increased by 9 percent and the duplex and town house unit percentages increased slightly, from 9 percent to 10 percent. The possibility of developing single-family detached units in Harrisonburg is limited due to the accessibility of land. The development of duplex and town house units is largely due to the increased demand for affordable housing.

Home Ownership

According to the US Census Bureau, Harrisonburg has a 39 percent home-ownership rate, the 5th lowest in Virginia. In contrast, Rockingham County has a 78 percent home-ownership rate, 10 percent higher than the state of Virginia at large. These percentages have changed little since 1990.

In 2000 Harrisonburg had approximately 5,125 owner-occupied housing units and 8,008 renter-occupied units. By 2008 these numbers increased significantly to 5,642 (9 percent increase) owner-occupied housing units and 8,649 (8 percent increase) renter-occupied housing units.

In 2000 Rockingham County had approximately 19,787 units of owner-occupied housing and 5,568 units of renter-occupied housing. By 2008 these numbers also increased significantly to 21,547 (8 percent increase) owner-occupied housing units and to 7,257 (24 percent increase) in renter-occupied housing. Clearly the rental-occupied homes are increasing significantly in Rockingham County.

A significant factor in the HRC's changes in home ownership and rental property ratios since 1990 has been the approximately 47 percent increase in college student enrollment. Bridgewater College, Eastern Mennonite University and James Madison University student enrollments grew from 12,300 to 23,088 (University Web Sites, 2010). During

the 2008-2009 academic year, JMU housed approximately 5,774 (26 percent) of the undergraduate students in campus residence halls and the rest, approximately 10,264, lived in the community. During the 2007-2008 academic year, EMU housed approximately 962 students (58 percent) and the rest, 272 students, lived in the community (Harrisonburg-Comprehensive Plan Review, 2010). The growth of the student population has attracted a large group of investors to the Harrisonburg community giving rise to the larger rental market.

Currently, the Harrisonburg home vacancy rate is 0.4 percent and the rental vacancy rate is 1.9 percent. The Rockingham County home vacancy rate is 1.3 percent and rental vacancy rate is 3.7 percent. These 2008 numbers are low, and likely do not accurately reflect the 2010 vacancy rates due to the slow down of the U.S. economy in the last two years. [7]

[7] American FactFinder-U.S. Census Bureau, 2010.

Research Findings on Homelessness

Compiled by the Data and Research Work Group - September 2010

What We Are Learning

Since the 1980s, homelessness has increased three-fold in the USA and has become a formidable national challenge in urban and rural communities. Why? Housing has become more expensive because low income housing stock has worn out, was demolished for urban renewal, or has been upgraded in the gentrification process. As a result, according to Culhane (March 2010), 5.5 million American families spend more than 50 percent of their incomes on housing.

Other systemic reasons for increasing rates of homelessness in the last 30 years are stagnant incomes for the lower 50 percent of American families, immigration and deinstitutionalization of the mentally ill. Also, there are more homeless single mothers with children who are a one-part time job loss away from homelessness. According to Culhane (2010), approximately 45 percent of the homeless had worked in the past 30 days. Bassuk (2010) writes that one in 50 American children will experience homelessness.

Most individuals and families are homeless for 30-60 days and are in and out of traditional shelter programs. It is for that reason the Obama administration and the US Department of Housing and Urban Development has emphasized Homelessness Prevention and Rapid Re-Housing programs. Approximately 20 percent of families have homeless episodes of a year or more. A small number, approximately 5 percent, have multiple homeless episodes and cycle in and out of shelter and transitional programs.

In 2009, accordingly to Culhane (2010), 2 million people were homeless and of those, approximately 112,000 fit the federal definition of "chronic homelessness." According to Gladwell (2006) and Sten (2008), approximately 15 percent of the "chronic homeless" receive approximately 50 percent of all the resources spent on the homeless population. The few are costing localities approximately $30,000 to $60,000 a year per person in housing, health/medical services, employment support and counseling, incarceration and case management services. Critical to understanding the "chronic homeless," ac-

cording to Sten (2008), is to appreciate that the "chronic homeless" suffer most from alienation and the loss of hope for themselves.

Multiple studies have found that families that experience homelessness are very similar to other low-income families with a few exceptions. African-American families are disproportionately represented. Parents tend to be younger, most families are headed by a single woman age 30 or under, and over 50 percent of children in homeless families are under the age of six. A high proportion of young homeless parents were in foster care as children. Studies have found that families that become homeless are also poorer than their housed counterparts and may have fewer social supports upon which they can rely.

The January 2010 Harrisonburg Rockingham Continuum of Care, Homeless Point-In-Time Housing Needs Survey identified 163 individuals and families (97 adults and 66 children) who were experiencing homelessness. Over half had no health insurance and 77 percent received their primary medical care in the emergency room. Approximately 10 percent of the respondents said they were chronically homeless for a year or more. Respondents identified their main barriers out of homelessness as difficulty with finding employment, obtaining assistance with job training/placement and having medical/dental problems, past incarcerations and issues with substance abuse. This community's experience with homelessness mirrors that found in other cities and communities.

Sten (2008) found in Portland, OR, that first the community needs to research the real cost of "housing the few." The homeless and professionals from different city or county agencies and service providers must talk with each other, including health providers and jail keepers. Communities must learn what the "chronic homeless" are costing the community in real dollars.

What communities have learned over the years is that, while funds for homeless assistance have increased, homelessness has not decreased. This led many communities to experiment with new housing-focused strategies including permanent supportive housing for those experiencing chronic homelessness and rapid re-housing for those indi-

viduals and families who are newly homeless and / or their homelessness is a result of the impact of a poor economy and high unemployment rates and / or the family needs only a minimal amount of assistance (eg, security deposit plus one month's rent) to get back on their feet and be stably housed. In addition, communities have refocused their efforts on prevention to prevent homelessness before it occurs which is more humane to the individual or family as well as more cost effective (prevention assistance is usually less expensive than homeless intervention assistance). To maximize the impact of prevention resources, programs must be well-targeted to the families most likely to experience homelessness. This targeting has been among the greatest challenges communities face, as the number of families facing housing-related hardship (although not necessarily homelessness) has increased enormously due to the recession which began in 2008.

Successful Intervention

Successful intervention depends on the following. Communities need to:

- Identify the "chronically homeless," via comprehensive community research, including data from the jails and hospitals.
- Develop differentiated programs and services for all populations including the "chronically homeless."
- Develop a Permanent Supportive Housing (PSH) program, including permanent housing, employment and case management (health/mental health care, drug treatment, employment training, transportation, connection to necessary services, support groups and churches).
- There are a range of promising strategies that communities have developed to target families at greatest risk of entering shelter. Strategies include:
    - using communities' own shelter data to develop profiles of people at risk of homelessness;
    - developing outreach programs that identify people at greatest risk who normally would not seek assistance; and

- providing diversion assistance to families who have already lost their housing and are applying for shelter.

Defining Homelessness and At Risk of Homelessness

For the purposes of the ten year plan, the Harrisonburg and Rockingham County communities have adopted the definition of homelessness used by the U.S. Department of Housing and Urban Development as revised by the HEARTH Act.

The Definition of Homelessness

The term "homeless person" means—

- an individual or family who lacks a fixed, regular, and adequate nighttime residence;

- an individual or family with a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

- an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, congregate shelters, and transitional housing);

- an individual who resided in a shelter or place not meant for human habitation and who is exiting an institution where he or she temporarily resided within 90 days;

- an individual or family who—

    - will imminently lose their housing, including housing they own, rent, or live in without paying rent, are sharing with others, and rooms in hotels or motels not paid for by Federal, State, or local government programs for low-income individuals or by charitable organizations, as evidenced by—
        - a court order resulting from an eviction action that notifies the individual or family that they must leave within 14 days;
        - the individual or family having a primary nighttime residence that is a room in a hotel or motel and where they lack the resources necessary to reside there for more than 14 days; or

- credible evidence indicating that the owner or renter of the housing will not allow the individual or family to stay for more than 14 days, and any oral statement from an individual or family seeking homeless assistance that is found to be credible shall be considered credible evidence for purposes of this clause.

- has no subsequent residence identified; and

- lacks the resources or support networks needed to obtain other permanent housing; and

- unaccompanied youth and homeless families with children and youth defined as homeless under other Federal statutes who--
  - have experienced a long term period without living independently in permanent housing,

  - have experienced persistent instability as measured by frequent moves over such period, and

- can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse, the presence of a child or youth with a disability, or multiple barriers to employment.

- Also considered to be homeless is any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life- threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.

The Definition of At Risk of Homelessness

The term `at risk of homelessness' means, with respect to an individual or family, that the individual or family—

- has income below 30 percent of median income for the geographic area;

- has insufficient resources immediately available to attain housing stability; and

- has one or more of the following:
    - has moved frequently because of economic reasons;
    - is living in the home of another because of economic hardship;
    - has been notified that their right to occupy their current housing or living situation will be terminated;
    - lives in a hotel or motel;
    - lives in severely overcrowded housing;
    - is exiting an institution within 90 days; or
    - otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness.

- includes all families with children and youth defined as homeless under other Federal statutes.

Goal, Vision, and Values

The Goal to End Homelessness

Our goal is to prevent and end homelessness in ten years in Harrisonburg and Rockingham County, Virginia.

Our Vision

By 2021, every citizen of Harrisonburg and Rockingham County will have access to a home, as well as the services and supports they need to thrive and achieve self-sufficiency.

To bring about the ultimate goal of an end to homelessness in Harrisonburg and Rockingham County, our aim is to:

- Gain recognition from community leaders of the urgency of this issue and a commitment to ending homelessness within the next ten years;
- Convene community leaders to develop an actionable strategy to prevent and end homelessness in Harrisonburg and Rockingham County by 2021;
- Engage new partners and attract new resources for the fight against homelessness;
- Develop an evaluation and assessment system that will draw on new research and reaffirm that the strategies in the plan are working;
- Review the ten year plan annually, evaluate it against clear and achievable benchmarks, and modify it as needed;
- Bring the plan to fruition.

Our Values

These values inform and guide us as we move towards achieving our vision:

COMMUNITY -- We value every person in our community and believe that no one should be without a stable, safe and affordable home.

COLLABORATION -- We value local and regional community collaboration and the engagement of old and new allies including public, private, community-based and faith-based organizations, people with the experience of homelessness, and concerned citizens and business partners. We believe that only through working together can we identify and implement strategies to prevent and end homelessness that are best for our unique community.

DATA AND RESEARCH DRIVEN PROCESS -- We value a research based and data driven methodology for determining how to prevent and end homelessness and ensure that no family or individual is left without a roof over their heads.

EFFICIENCY -- We value an efficient use of resources in order to serve and adequately address the needs of the maximum number of families.

EXISTING PROGRAMS, SERVICES, AND ORGANIZATIONS -- We value the current programs, services, and organizations that are laboring day in and day out to prevent and end homelessness. The work they have done is invaluable and we plan to expand on the foundations they have laid.

MEASURABLE RESULTS -– We value tangible measurements of the results of our efforts that will indicate whether we are succeeding in decreasing rates of homelessness.

PERSONAL AUTONOMY AND DIGNITY -- We believe in the dignity of each individual and respect the right of each person to choose his or her future path to stability and well-being.

SELF SUFFICIENCY AND PERSONAL RESPONSIBILITY -– We value the efforts of the individual to maintain a self-sufficient lifestyle, and we accept that some circumstances are impossible to predict or control. We hope to create many opportunities to remain or become self-sufficient within the community.

Performance Indicators to Measure Our Success

Over a period of ten years, we will steadily:

1. Decrease rates of homelessness among all populations with a special focus on decreasing the number of homeless children in City and County public schools.
2. Increase the percentage of homeless people who are entering permanent, stable, and adequate housing.
3. Increase the percentage of formerly homeless people who remain in permanent, stable, and adequate housing for at least 6 months, 12 months, and 18 months.
4. Decrease recidivism (return to homelessness).
5. Decrease the length of time it takes homeless people to access permanent, stable, and adequate housing.
6. Maximize self-sufficiency for people at risk of and formerly experiencing homelessness.
7. Increase the knowledge base of best practices including prevention activities; increase utilization of best practices.

The current data collection tool utilized by the community through the Continuum of Care process - HMIS (Homeless Management Information System) - can document progress on the following performance measurements listed above: numbers 1, 2, 4, and 5.

For those performance measurements that cannot be documented through the use of existing tools, the community will consider the following tools for the following measurements:

#3 -- program evaluation that tracks clients after they enter permanent, stable, and adequate housing;

#6 -- the Arizona Self Sufficiency Matrix; and

#7 -- to be determined.

The Tools

There are many current and new tools that the community will utilize to achieve the intended goal of preventing and ending homelessness and reducing rates of homelessness over ten years. The information below provides brief information on each model.

Data Collection

HMIS (Homeless Management Information System): The Homeless Management Information System is a computerized data collection application in place in Harrisonburg and Rockingham County. It can be used to measure the majority of the performance indicators called for by this ten year plan.

HMIS is designed to capture client-level, system-wide information over time on the characteristics, service needs, and history of those experiencing homelessness. It provides an unduplicated count of clients served within the community's system of homeless services. HMIS can provide data on client characteristics and service utilization. Analysis of HMIS data increases understanding of the local extent and scope of homelessness, identifies service gaps, and informs systems design and policy decisions.

Point in time count and survey: The point in time count and survey is also a tool in place in Harrisonburg and Rockingham County. The point in time count documents whether rates of homelessness in the community are increasing, decreasing, or remaining the same. The point in time count is a one night count held biennially in January of sheltered and unsheltered people experiencing homelessness. It indicates an estimated number of people experiencing homelessness on any given night, according to the federal definition of homelessness used by HUD. HUD requires that those communities submitting Continuum of Care applications for federal homeless assistance funds conduct a biennial count although many communities, including Harrisonburg and Rockingham County, conduct the count annually.

The point in time survey is used to understand the characteristics of those experiencing homelessness - including demographics, employment history, and mental health status - and can identify service needs of those experiencing homelessness. The point in time count is a low estimate as it does not capture those who are doubled up and those who will be imminently homeless,it is the best tool communities have to document change in rates of homelessness.

Identifying Those At Risk of Homelessness and Targeting Services to Them

Discharge planning: It has been documented that those exiting institutions - including state and private hospitals, jails and prisons, nursing homes, and foster care - may be at higher risk of homelessness for a variety of reasons. The ten year plan calls for the creation and / or evaluation of the impact of discharge plans for individuals exiting these institutions. The discharge plans must include a realistic housing plan for each individual and will ideally be linked to housing and service supports as needed.

Prevention pilot program: The Harrisonburg and Rockingham County community will implement a pilot program to prevent homelessness among school-age children and their families. This pilot will be a collaboration between the Harrisonburg Redevelopment and Housing Authority, Harrisonburg Public Schools, Rockingham County Public Schools, and the Harrisonburg and Rockingham County Department of Social Services and other service providers. The program will include assistance to help families pay rent as needed.

The program will be thoroughly evaluated to assess whether housing and service supports prevented the family from entering the homeless assistance system, the impact of the housing subsidy on preventing literal homelessness, the impact of and need for an array of support services to prevent literal homelessness, and whether stable housing impacted children's school performance. The goal of the pilot, in addition to effectively serving families, is to better understand the characteristics of people at risk of homelessness and to evaluate the impact of services in preventing homelessness.

Increasing Affordable Housing Options

Accessing existing affordable housing stock: Many agencies and community organizations have developed partnerships with landlords, and these partnerships have resulted in access to affordable housing options for those experiencing and at risk of homelessness. The partnership is an agreement that the landlord will rent to this population and, in some cases, the service agency agrees to maintain contact and provide services to help the household remain stably housed. It is a win-win situation for all parties in that the person accesses affordable housing, the service agency helps to house their clients, and the landlord has a source of support if any problems with the tenant arise.

Permanent supportive housing: Permanent supportive housing has been identified as a solution to homelessness for a sub-set of the population -- those who experience homelessness for long periods of time (the chronically homeless) with multiple barriers to housing stability including mental disabilities, chemical dependence, and other chronic health conditions. Permanent supportive housing provides, first a home, and then continuing supportive services to help individuals maintain that home. These support services either directly provide or connect individuals to services in their community. Support services include case management that focuses on housing stabilization and can also include direct or coordinated care in the areas of mental health, substance abuse, health care, dental care, education, employment, and access to benefits.

There are multiple types of housing that can be utilized as permanent supportive housing. One type is a Single Room Occupancy unit (SRO) and the Harrisonburg and Rockingham County Continuum of Care had already developed a Committee to identify how to develop SROs in the community.

***Rapid re-housing*:** Rapid re-housing is a strategy to assist families and individuals experiencing homelessness to access housing as quickly as possible and then deliver uniquely tailored services to help them maintain stable housing. It fol-

lows a "housing first" philosophy which says that individuals and families experiencing homelessness need housing first, and then they need services.

Rapid re-housing differs from traditional homeless assistance approaches in that it does not require a family or individual to live in emergency shelter or transitional housing for a certain length of time prior to returning to permanent housing. It can, however, be delivered in an emergency shelter or transitional housing setting and is not mutually exclusive from emergency shelter and transitional housing programs.

Services are consumer-driven in that the person, with the help of a case manager, determines the services that she or he needs to maintain their housing. Services are critical to help a family maintain their housing, access and maintain employment, and increase their self sufficiency and well-being. It is the housing AND the services that make rapid re-housing an effective permanent solution to homelessness.

Service Coordination and Enhancement

Interdisciplinary case management team: The goal of interdisciplinary case management team approach is to assist persons experiencing homelessness including persons experiencing chronic homelessness to move towards stability in housing. This model is intended for those individuals who have high service needs and need multiple services to be successful in maintaining stability. Multiple agencies would participate in coordinating a person's or family's action plan and aligning services with the needs of each individual. Agencies would utilize a universal housing and service barrier assessment and would then refer individuals to the case management team.

Single point of entry and no wrong door: The community achieved consensus on the need to create a centralized location of resources as well as streamline access to existing services. The ten year plan documents the need to consider a "single point of entry" and / or "no wrong door" approach to accessing services.

Both approaches will eliminate the frustration of people in need of assistance who do not know how to access services. Each approach will also streamline existing services and identify gaps and / or overlap of services. Each approach needs to be evaluated to understand which would best fit the community or whether components of each approach should be adopted.

Mentoring: Many who are at risk of homelessness or currently experiencing homelessness are in this situation because they do not have a support network on which they can rely and they do not have the financial literacy skills to prevent a homeless episode. Another major theme of community input was the need to expand on existing mentoring programs to provide support to persons experiencing or at risk of homelessness.

Creating Consumer-Oriented Services: There are many barriers to services access and utilization. People in need do not always know how or where to access services. Services must be made accessible and be uniquely tailored to the individual based on their unique needs. A consumer-oriented service philosophy will be further explored and applied to programs as needed. This service philosophy will be further explored and applied to programs as necessary.

Employment: The goal of all programs is to assist people to achieve increased self-sufficiency, recognizing that self-sufficiency may be different from one individual to the next (eg, people with severe disabling conditions may not be able to access and sustain employment in the same way that non-disabled persons can). Employment is key to increasing income and increasing self-determination. The Ten Year Plan sets employment as a key strategy and outlines several options to increase employment and job skills of persons experiencing and at risk of homelessness.

SSI / SSDI Outreach, Access and Recovery (SOAR): Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) are disability income benefits administered by the Social Security Administration (SSA) that generally

also provide either Medicaid and/or Medicare health insurance to individuals who are eligible.

For people who are homeless with mental health problems that impair cognition, or who are returning to the community from institutions (jails, prisons or hospitals), access to these programs can be extraordinarily challenging. The application process for SSI/SSDI is complicated and difficult to navigate. Nationally, about 37 percent of individuals who apply for these benefits are approved on initial application. Appeals take an average of 2 years to complete. Yet, accessing these benefits is often a critical first step in recovery.

SOAR is a solution to this challenge. SOAR provides strategic planning and training to increase access to Social Security benefits for people experiencing homelessness. These benefits can increase access to housing, treatment, and supports. Many, but not all, people experiencing homelessness have disabilities and are eligible for disability benefits. It is difficult to obtain these benefits, however, and many are rejected multiple times in the application process.

SOAR has resulted in success rates of 71 percent on initial SSI / SSDI applications as compared to the usual 10-15 percent for applicants experiencing homelessness.

Key Priorities, Objectives and Strategies

Key Priorities for Implementation

The implementation of the ten year plan to prevent and end homelessness is built around four key priorities:

Priority 1: Prevent homelessness before it occurs.

Priority 2: Create a full spectrum of affordable, stable and quality housing options for those experiencing homelessness and those at-risk of homelessness.

Priority 3: Better coordinate and improve outcomes in services for those at risk of homelessness, those currently experiencing homelessness and for those who have experienced homelessness.

Priority 4: Utilize data and research to better align services with need and evaluate the impact of current approaches to homeless prevention and assistance.

Objectives and Strategies

Priority 1: Prevent homelessness before it occurs.

Objective 1.1: Evaluate effectiveness of prevention activities.

Strategy 1.1.a: Incorporate all existing prevention services into HMIS to identify whether existing prevention services are preventing homelessness before it occurs.

Objective 1.2: Create discharge plans from "points of entry into homelessness" - hospitals, foster care, jails and prisons - that ensure appropriate housing options upon discharge.

Strategy 1.2.a: Create or evaluate the impact of discharge plans from state and private hospitals.

Strategy 1.2.b: Create or evaluate the impact of discharge plans from jails.

Strategy 1.2.c: Create or evaluate the impact of discharge plans from state correctional facilities.

Strategy 1.2.d: Create or evaluate the impact of discharge plans for youth aging out of foster care without a permanent family.

Strategy 1.2.e: Create or evaluate the impact of discharge plans from group homes, nursing homes, and other similar institutional settings.

Strategy 1.2.f: Establish programs providing support to those exiting prison six months prior to community re-entry.

Objective 1.3: Divert those at risk of homelessness from jails and prisons.

Strategy 1.3.a: Identify methods to divert people from jails and prisons.

Objective 1.4: Establish flexible, rapid, and priority services and resources for those at risk of homelessness.

Strategy 1.4.a: Establish a baseline of existing prevention activities and develop a plan for increasing services and resources by 10-15 percent.

Strategy 1.4.b: Create and implement a pilot program to reduce the number of children experiencing homelessness. Explore the possibility of replicating a program that targets at-risk families by partnering with the school system to identify children whose school performance is suffering (a possible indicator of housing instability).

Strategy 1.4.c: Expand self-sufficiency programs via family self-sufficiency and individual development accounts (IDA) programs.

Strategy 1.4.d: Establish a Community Chest to provide flexible funds to prevent homelessness, including short-term grants and loans.

Strategy 1.4.e: Expand legal aid services to assist people to maintain their housing including, but not limited to, victims of domestic violence and those experiencing eviction or foreclosure.

Priority 2: Create a full spectrum of affordable, stable and quality housing options for those experiencing homelessness and those at-risk of homelessness.

Objective 2.1: Identify the need for additional affordable housing opportunities.

Objective 2.2: Evaluate the impact of housing programs in preventing recidivism.

Objective 2.3: Create permanent supportive housing (Single Room Occupancy dwellings linked with supportive services) for individuals experiencing homelessness with severe needs, including chronic homelessness.

Objective 2.4: Increase and expand rapid re-housing programs for those with less intensive service needs.

Objective 2.5: Cultivate a network of landlords who will rent to people experiencing homelessness.

Strategy 2.5.a: Explore the creation of a community-wide landlord relationship program to intervene to prevent evictions and to re-house people experiencing homelessness.

Strategy 2.5.b: Explore the need for a landlord contingency fund to mitigate real and perceived concerns of landlords that tenants will create a cost burden due to need for repairs to units.

Objective 2.6: Expand the number of subsidized rental units available to people experiencing homelessness.

Objective 2.7: Expand the number of subsidized rental units available to those with low incomes.

Objective 2.8: Increase unsubsidized permanent housing options without services.

Priority 3: Better coordinate and improve outcomes in services for those at risk of homelessness, experiencing homelessness and for those who have experienced homelessness.

Objective 3.1: Coordinate and streamline existing services.

Strategy 3.1.a: Map out existing services and assess how accessible these services are to people at risk of homelessness.

Strategy 3.1.b: Map out existing services and assess how accessible these services are to people experiencing homelessness.

Strategy 3.1.c: Explore creation of "single point of entry" and / or "no wrong door" approaches.

Strategy 3.1.d: Stretch limited resources further by targeting programs and services to those with intensive needs.

Objective 3.2: Utilize an interdisciplinary case management team of professionals to coordinate and implement plans for individuals and families experiencing homelessness on a path to self-sufficiency and stability.

Objective 3.3: Expand temporary housing with supports.

Strategy 3.3.a: Create additional overnight year-round shelter beds, without client restrictions as necessary.

Objective 3.4: Increase access to services and supports including medical care, transportation, and child care.

Strategy 3.4.a: Expand on existing mentor programs for persons experiencing homelessness.

Strategy 3.4.b: Expand access to transportation.

Strategy 3.4.c: Expand access to child care.

Strategy 3.4.d: Create a Healthcare for the Homeless program to deliver health care to people experiencing homelessness.

Objective 3.5: Increase income for those experiencing homelessness and for those who have experienced homelessness.

Strategy 3.5.a: Explore partnerships with employers and existing workforce development programs.

Strategy 3.5.b: Encourage the prioritization of people experiencing and at risk of homelessness in workforce investment board programs.

Strategy 3.5.c: Identify appropriate job placements for people experiencing homelessness and arrange for required job training, as necessary.

Strategy 3.5.d: Expand legal aid services to assist people to apply for disability, unemployment benefits, and other public benefits.

Strategy 3.5.e: Implement SOAR (SSI / SSDI Outreach, Access and Recovery) to expedite access to mainstream disability benefits.

Priority 4: Utilize data and research to better align services with need and evaluate the impact of current approaches to homeless prevention and assistance.

Objective 4.1: Improve and / or expand current data collection methods.

Strategy 4.1.a: Improve the point in time count and survey.

Strategy 4.1.b: Increase utilization of HMIS.

Objective 4.2: Incorporate new data collection and evaluation tools to better understand and assess the scope of homelessness.

Strategy 4.2.a: Evaluate the impact of programs and services based on increased client self-sufficiency.

Strategy 4.2.b: Obtain and compare hospital, jail, and state correctional facility data to identify the overlap between populations.

Strategy 4.2.c: Identify and evaluate strategies specific to Harrisonburg and strategies specific to Rockingham County, as needed.

Strategy 4.2.d: Keep abreast of new research and best practices from across Virginia and across the country.

Strategy 4.2.e: Continue receiving feedback and input from the people who have experienced homelessness through focus groups, participation on ten year plan implementation task forces, and a consumer council.

Objective 4.3: Use data and research to educate the community on the causes of and solutions to homelessness.

Strategy 4.3.a: Identify trends from the analysis of the point in time count and survey.

Strategy 4.3.b: Develop and implement a public education and media strategy.

Implementation Structure

This report completes Phase One of the ten year plan development process. Phase Two will begin January 1, 2011 and end June 30, 2011. Year One Implementation will begin July 1, 2011.

Developing a ten year plan takes work but the real work begins after the plan is completed and once the implementation phase commences. It is essential that the ten year plan include a structure for ensuring effective implementation of the plan and maintaining accountability among all the partners in the implementation process.

Phase One (March - Dec 30, 2010) Ten Year Plan Development Structure:

Phase One Implementation has been guided by a Steering Committee who is responsible for general oversight of the plan, assuring that community input is included in the final plan, and adhering to best practices research from other communities and across the nation. Phase One also included the creation and engagement of work groups on Prevention, Housing Self-Sufficiency, Serving Those Currently Homeless, and Data and Research.

Phase Two (January 1, 2011 - June 30, 2011) Implementation Structure:

A Steering Committee will be responsible for:

- General oversight of the completion of the ten year plan and the work of the task forces described below;
- Assurance that the ten year plan fits with national, state, and local best practices and research;
- Assurance that the strategies included in the final ten year plan reflect the strengths of the community;
- Recruitment of members for the task forces who have interest in and responsibility over resources that could be utilized to implement the strategies; and

- Identification and solicitation of current and / or new resources needed to implement each strategy.

The Steering Committee will appoint Task Forces on Housing, Services, Prevention, Data and Research, and Public Awareness, others to be determined, and as needed. The Task Forces will be responsible for:

- Identification of benchmarks to meet the intended measurements of success;
- Agreement on the lead entity and key partners for each strategy;
- Creation of additional action steps for each strategy as needed; and
- Initial identification of current and / or new resources needed to implement each strategy.

The major activity in this phase will be the identification of specific housing and service goal targets. The Task Forces, with the leadership and guidance of the Steering Committee, will review the services needs of those at risk of homelessness and those currently experiencing homelessness, will match service needs with available housing and services in the community, and will record new housing and service supports needed.

Year One (begins July 1, 2011) Implementation Structure:

At the end of Phase Two, the Steering Committee will continue its oversight role as described above. The Steering Committee will be re-appointed by the City, the County, the existing Steering Committee, and input from the Continuum of Care.

The Steering Committee will include:

- City Representative
- County Representative
- Executive Director, Harrisonburg Redevelopment and Housing Authority

- Executive Director, Harrisonburg-Rockingham County Department of Social Services
- Executive Director, Harrisonburg-Rockingham County Community Services Board
- Executive Director, United Way
- 4 or more Representatives of the Harrisonburg-Rockingham County Continuum of Care

The Steering Committee may include:

- Chamber of Commerce / Business
- Community Foundation
- Faith Leaders
- People formerly or currently experiencing homelessness
- Hospital Representative
- Jail and / or State Correctional Facility
- Nonprofit / homeless services providers
- Police
- Researchers
- Universities / colleges

The Steering Committee - with the input of task forces and other community members - will identify the need to continue or modify the Task Forces (Housing, Services, Prevention, Data and Research, and Public Awareness) who will be responsible for implementation by topic area in Year One.

Metrics and Evaluation

Creating Benchmarks, Target Goals, and Timelines

Phase Two of the planning process will concentrate on identifying concrete housing and service targets and set annual benchmarks. The process will begin from analyzing information collected from the people themselves - those who have experienced homelessness - through the annual point in time surveys as well as additional focus groups as needed. The result will be concrete housing and service goals by which the community can measure its success.

The final Ten Year Plan will include specific strategies and action steps, identify lead and key partners for each strategy, and include deadlines to maintain accountability among all parties and ensure that the plan moves forward.

Annual Evaluation

The Steering Committee and Task Forces will evaluate the impact of the Ten Year Plan and progress in ten year plan implementation annually. We will report annually to the City and County on progress made in implementing the Ten Year Plan and will issue an annual report for community review.

The Steering Committee will review the Ten Year Plan on an annual basis for possible moderate revision. The decision to revise will take into account new funding and resource opportunities, shifts in the population at risk and / or experiencing homelessness, and new research and best practice information. The use of current and new data collection and evaluation tools - including the Point in Time Count and survey, HMIS, the Arizona Self Sufficiency Matrix and results of the prevention pilot program - will increase the community's understanding of the impact of the ten year plan and programs and services and will dictate possible future changes in direction.

Appendix A: Glossary

A) Chronic Homelessness

HUD defines a chronically homeless individual or family as an individual or family who

(i) is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter;

(ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least 4 separate occasions in the last 3 years; and

(iii) has an adult head of household (or a minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002)), post traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.

B) Continuum of Care.

The US Department of Housing and Urban Development requires communities applying for federal homeless assistance funds to organize themselves into "Continuums of Care" to submit a community collaborative application with the goal of identifying gaps in services and streamlining the response to homelessness.

C) HEARTH Act.

The Homeless Emergency Assistance and Rapid Transition to Housing Act, passed in 2008, is federal legislation that reauthorized the McKinney-Vento Homeless Assistance program - the main source of federal funds for homeless assistance through the US Department of Housing and Urban Development. The legislation makes sweeping changes to the McKinney program (often referred to as the Continuum of Care) with a new focus on prevention and a continued focus on affordable housing solutions to homelessness.

D) Homeless Management Information System (HMIS)

HMIS is an electronic data collection system that stores longitudinal person- level information about persons who access the homeless services system in a Continuum of Care (CoC). HMIS is a valuable resource because of its capacity to integrate and unduplicate data from all homeless assistance and homelessness prevention programs in a CoC. Aggregate HMIS data can be used to understand the size, characteristics, and needs of the homeless population at the local, state, and national levels. Today's advanced HMIS applications offer many other benefits as well. They enable organizations that operate homeless assistance and homelessness prevention programs to improve case management by collecting information about client needs, goals, and service outcomes. They also help to improve access to timely resource and referral information and to better manage operations.[8]

E) Permanent Housing

The term `permanent housing' means community-based housing without a designated length of stay, and includes both permanent supportive housing and permanent housing without supportive services. The community generally agrees that this housing must be safe and stable and adequate.

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[8] U.S. Department of Housing and Urban Development, Office of Community Planning and Development. *Homeless Management Information System (HMIS) Data Standards Revised Notice*. March 2010.

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