A Passageway Home

A 10-Year Plan to End Homelessness in Arlington County, Virginia

April 2006
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In Arlington, VA county staff, non-profit providers and volunteers provide services to over 1,100 homeless individuals and families annually.

In nearly every American city throughout the nation, there is a serious social issue that impacts governments, businesses, human services and residents in significant and costly ways. That issue is homelessness. Until the early to mid-1980's this problem was rare, and for the most part hidden. Since then, despite increased visibility and a subsequent infusion of federal, state and local resources, the situation has continued to grow in size and complexity, with numbers of homeless families, in particular women and children, joining the homeless population. Arlington County has made a decision to come together to help all our homeless citizens find "A Passageway Home."

In Arlington County, homeless service providers serve over 1,100 households annually, providing emergency housing, medical care, food, clothing, employment services and case management. An additional 600 chronically homeless persons live on the street and are assisted through a variety of outreach efforts.

The price of homelessness is an expensive one. Persons living on the streets suffer from exposure, physical and mental disease and disabilities, malnutrition and victimization, and require interventions from a variety of public safety, medical and human service programs. Homeless families are overwhelmingly families with small children. These children experience a lack of proper nutrition, timely and preventative health and mental health care and poor scholastic outcomes. Mothers and other caretakers of these children can be victims of domestic violence and sexual assault, and often experience the related mental and physical health issues. Most homeless persons are unemployed or underemployed, and lack educational credentials (such as a high school diploma) or marketable skills to gain employment or earn a living wage.

In the recent past, financial resources provided to communities by federal, state, and local governments have often been limited to short-term, immediate interventions that made longer-term permanent housing and prevention efforts difficult. This was often due to the competition for limited community resources, particularly for new and prevention oriented programs. Fund raising for private long-term and prevention dollars is difficult for a variety of reasons, but often is due to the popular American assumption that people are homeless because of personal problems that cannot be fixed by the homeless system; that they would do better to "pull up their bootstraps" and become productive citizens through their own initiative. Arlington's goal is to focus our efforts on holistic, forward thinking, best practice and evidence based approaches that center on a balanced set of prevention activities, permanent affordable housing, employment and training, and a comprehensive network of supportive services.

What have we been doing?

Since the mid 1970's Arlington County has used a combination of private, federal, state, and local funding to address the issue of homelessness through a "Continuum of Care" consisting of outreach, emergency shelters, transitional housing, and most recently, a plan for the long-term development of permanent supportive housing. Despite successes achieved through collaboration and coordination efforts between local government, non-profit providers and citizen volunteers, the problem of the chronically homelessness has not shown the significant improvements the community would like to see. It is recognized that there is a need for a more strategic, comprehensive, and preventative approach that would provide us with a clear, thoughtful, long-term plan, and a broadening of the community support network.
Why develop a ten year plan?

Arlington County’s goal of ending homelessness will be achieved through strategies and action steps that take a long-term, comprehensive approach prioritizing prevention, supportive services, income, and affordable housing programs. Arlington is following in the footsteps of over 200 jurisdictions throughout the country that include the District of Columbia, Allegheny County, PA, Montgomery County, MD, Indianapolis, IN, and Wake County, NC. In Arlington’s case, A Passageway Home will serve as the blueprint for developing strategies that value and respect the needs, uniqueness and potential contributions of all its citizens.

Arlington’s 10 Year Plan will further the goal towards ending homelessness by:

1. Educating Arlington citizens about homelessness and the actions we will take towards ending homelessness.
2. Closing the “front door” to homelessness with efforts that work towards supporting and maintaining individuals and families in their current housing.
3. “Rapid re-housing” for homeless individuals that do enter the “front door.”
4. Increasing the availability of and access to affordable housing.
5. Establishing a “Housing First” model of permanent supportive housing that will assist chronically homeless persons with disabilities.
6. Improving our coordination plans for discharging persons at risk of homelessness from jails, hospitals, and mental health facilities.
7. Improving and expanding our coordinated system of service delivery.
8. Increasing our collaboration with surrounding jurisdictions (Washington DC, Virginia, and Maryland.)

The Benefits of Ending Homelessness

Belief in the need for respecting the worth and dignity of every local resident demands that Arlington take a thoughtful and strategic approach to ending homelessness in our community. As stated in the National Alliance to End Homelessness’ report on family homeless, it is “a problem with a solution.”

First, the benefits to Arlington’s individuals and families:
• Safe, decent, transitional and permanent housing
• Improved health through comprehensive health services
• Long-term support services only for those who need it
• Opportunities for self-sufficiency and contributions to the community through skills training and job placement

Second, the cost benefits:
• Increase in service coordination and integration, through co-locating and streamlining services
• Reduction in use of immediate, emergency, high cost health and public safety services
• Investment in strategies that provide long-term, permanent and proven results.

Finally, benefits to the community as a whole:
• Improved quality of neighborhoods
• Positive experiences for all residents
• Pride in the accomplishment of positive community change
“The math is borne out in national studies...supportive housing costs about $1,000 a month to maintain, while hospital beds cost about $30,000 a month, and jails cost more than $3,000 a month.” – *San Francisco Chronicle, 2005.*
Arlington will have an integrated, community-based support system which will prevent homelessness and provide the necessary resources to end it.

Guiding Principles:
- Commitment from all sectors of the community
- Best practice, evidence based solutions
- Affordable, appropriate housing options
- Culturally competent and consumer-centered services
- Sufficient, committed financial resources

Broad Goals:
- Affordable Housing
- Comprehensive Support Services
- Prevention
- Income Maximization
Present Day Arlington

Arlington County is a 26 square mile, urban community with an estimated population of 198,267 (January 1, 2005). This reflects a 5% increase in population since 2000. It is among the most densely populated jurisdictions in the country, with about 7,700 persons per square mile—higher than cities such as Seattle, Minneapolis, and Pittsburgh.

Arlington's population is racially, ethnically, and culturally diverse. More than 40% of Arlington's residents are Hispanic/Latino, African-American, Asian or multiracial. More than one-quarter of residents were born outside the U.S. Arlington County public school children speak more than 60 different languages. Residents are among the most highly educated in the nation, with over 60% of adults age 25 and older having a bachelor's degree or higher and some 30% having a graduate or professional degree.

Perhaps best known as the home of the Pentagon and Arlington National Cemetery, Arlington boasts many high quality residential neighborhoods. Residents are actively involved in the community, with over 50 civic associations, dozens of citizen boards and commissions, and over 100 community service organizations. The County has almost 200 public parks and playgrounds, 86 miles of biking/jogging trails, 14 community centers, 5 theaters, and 8 libraries.

Arlington is centrally located within a metropolitan area that includes other prosperous and growing communities, such as the District of Columbia, Prince George's and Montgomery County in Maryland, and municipalities in Northern Virginia that include Alexandria City, Fairfax, Loudon, and Prince William Counties. Each of these communities can easily access Arlington by car and public transportation, and a highly skilled labor force has been attracted by an increasingly varied residential and commercial mix. With all the outstanding amenities, Arlington has quickly become sought after for its commercial and residential development opportunities. In part, due to this high quality growth and development there has been a reduction in the number of affordable housing units. Between 2000 and 2005, almost 9,900 affordable units became unaffordable to households at 60% of the area median income (AMI).

There has been a significant increase in the cost of housing in Arlington County. The countywide average rent in 2005 was $1,375 (a 5% increase from 2004). The average assessed value for all homes climbed 24% in one year, rising from $369,600 in 2004 to $458,200 in 2005. The overall vacancy rate for apartments was 3.1% in 2005.

Arlington had an estimated 195,205 jobs as of January 1, 2005. The federal government is the largest single employer in the County. Arlington's top 5 private employers are US Airways, Verizon, Marriott Corporation, SAIC and Virginia Hospital Center. In December 2004, Arlington's unemployment rate was 1.4%. In 2005 the Department of Housing and Urban Development (HUD) estimated the median family income for a family of four for the Washington metropolitan area to be $89,300.

Although Arlington is recognized as a world class community, there continues to be a gap in opportunities and resources for persons who are homeless, and those on the verge of becoming homeless. Significant numbers of Arlingtonians cannot afford one
of the most basic needs - housing. Despite Arlington's affluence there is still poverty that often results in homelessness. Arlington County's overall poverty rate increased slightly between 1990 and 2000. In 2000, 5% of Arlington County families and 9.1 percent of Arlington's children lived in poverty. (The poverty threshold for a family of four in 2000 was $17,603.) Figure B displays the densest concentrations of poverty, which are concentrated in Arlington's Neighborhood Strategic Areas (NSAs). These include neighborhoods in Buckingham, Columbia Heights West, and Nauck—as well as census tracts in Radnor/Fort Myer Heights and in Pentagon City.

Who is providing services in Arlington

On January 26, 2005, Arlington conducted a Point in Time survey, which provides a snapshot of the homeless population in the County. On this date, 420 persons were counted as homeless. However, on an annual basis, the number of homeless persons accessing emergency housing and services far exceeds the number of persons counted in the Point in Time survey.

The statistical breakdown is as follows:
- 48 families (50 adults, 75 children) constituting 30% of the total survey participants.
- 295 (70%) single individuals (majority of them chronically homeless).
- 82% adults and 18% children.
- 225 single adults were listed as unsheltered, chronically homeless, or both.
- 74% of the adults surveyed were not employed.

Specific to subpopulations, the survey indicated:
- 25% were chronically abusing legal and illegal substances.
- 18% of adults were seriously mentally ill.
- 26% of adults were dually diagnosed (both mentally ill and abusing substances).

In this same Point in Time study, 59 persons (14%) were reported as having a history of domestic violence victimization, presenting with still more complex and challenging needs. The incidence of child abuse and neglect of children experiencing homelessness is much higher than in the general population. The issues of trauma and violence in the lives of these adults and children raise many concerns about how to best address the emotional needs, likelihood of mental health problems, and their potential for substance use/abuse frequently used to escape the harsh realities of their existence. Frequently the history of abuse, trauma, and violence in the homeless person's life is not reported immediately, if at all, by the client. As stated by an Arlington shelter resident, “That’s just my everyday life”. Further, 35% of the homeless adults reported chronic health problems or a physical disability, or HIV/AIDS. Additionally, 24% of homeless adults experience language and cultural barriers related to sharing information and seeking and using social service assistance to any degree, making it much more difficult to adequately assess and meet their needs.

Over 100 students (children and youth), in Arlington Public Schools, were identified as homeless at some point during the 2004-2005 school year. Of this number:
- 50% were in grades K through 5th
- 50% were in grades 6th through 12th
- 37% of the children were in Special Education
- 17% were in English Language Learners program

The five shelters in Arlington County annually provide emergency housing and services to over 1,100 households, which includes families with children and unaccompanied youth. A street outreach program provides a variety of services to well over 600 single persons yearly, with the majority being chronically homeless. They reside on the streets, in parks, under bridges, in cars, in bus shelters, and other public areas.
State and National Data

In the Commonwealth of Virginia, from July 2004 through June 2005, 114 participating emergency, domestic violence, transitional, and winter shelters served 19,537 households, representing 27,546 persons. Providers denied 55,000 requests, primarily due to lack of bed space. Almost 25 percent of all persons sheltered in funded programs were under the age of 18.

Nationally, the majority of people who are homeless (66 percent) are single adults, but family homelessness is growing at a higher rate than any other subpopulation. Accompanied children under age 18 make up nearly 25% of the homeless; translating to some 1.35 million children; forty-two percent of these children are younger than five years old.

While the survey data is disturbing enough, the unaccounted for numbers of individuals at risk of homelessness is extremely difficult to capture and potentially even more disturbing. Many sporadically homeless persons live with relatives or friends in temporary, often difficult and unstable environments, but are not caught in homeless surveys. In most cases these situations eventually lead to entry into the “front door” of homelessness.

Local Trends

County and non-profit homeless providers have identified a number of trends in Arlington. These include but are not limited to:

- Increases in length of stays due to the complexity and severity of needs
- An increase in the number of persons who are diagnosed with co-occurring mental health and substance abuse disorders
- An increase of children with serious mental health issues
- A drop in the average income of the working homeless
- An increase in the number of adults who are not sufficiently proficient in English
- An increase in the number of first-generation immigrants

Individual Risk Factors

Like many other jurisdictions, Arlington County recognizes that there are a number of factors that contribute to homelessness and the risks of homelessness, which are evident in the local trends:

- Severe poverty
- Decrease in the number of affordable housing units
- Mental illnesses and/or substance abuse disorders
- Domestic violence
- Chronic health problems including diabetes and HIV/AIDS
- Poor work history and applicable skills to maintain employment at a living wage
- Poor credit histories
- Immigration issues that do not allow immigrants to work
- Language barriers
On a national level, almost half (forty-six percent) of adults who are homeless and use services report chronic physical disorders or disabilities. Sixty-six percent report either substance use and/or mental health problems. At least 40% of adult women who are homeless are also victims of domestic violence. These problems make it difficult for individuals to find and retain adequate housing, seek and maintain employment, establish good credit, use public transportation, and negotiate the complex organizations providing health, housing, and social services.

**History of Services in Arlington**

The Arlington County Department of Human Services (DHS) has worked collaboratively with a variety of community organizations for a number of years by providing funding and facilities, and facilitating the local Homeless Services Coordination Committee. County staff have worked with community non-profits to secure U.S. Department of Housing and Urban Development, Supportive Housing Program funds for new homeless services, including Independence House, a transitional living facility for homeless recovering substance abusers; Adopt-A-Family Program, a scattered-site transitional housing program operated by Arlington Alexandria Coalition for the Homeless; Safe Haven, a model long-term shelter for the chronically homeless; Opportunity Place, a homeless case management center run by Arlington Street People’s Assistance Network; and Treatment on Wheels, a shelter based mental health and substance abuse assessment and support program.

Arlington County DHS operates a co-located, multi-program facility that includes a homeless shelter and substance abuse detoxification and treatment services. Planning for the facility started in earnest in 1990, at which time a County appointed citizen group was charged with examining the need and recommending an appropriate program design. Building construction was started in March of 1991. The program has been operated by Volunteers of America Chesapeake (VOAC) under contract with Arlington since 1994.

The majority of current non-profit homeless providers started as community organizations that saw a need and stepped forward to fill it. Between 1975 and 1990 many of these agencies and programs were developed to specifically assist the poor, the homeless, and battered women and children.

Arlingtonians Ministering to Emergency Needs (AMEN), American Red Cross Arlington Chapter, and the Hispanic Committee of Virginia were each established in 1975 to provide financial and social services and supports. The Arlington Community Temporary Shelters (TACTS), now known as Doorways for Women and Families, began providing short term shelter and case management services to homeless women in 1979. The Safehouse for battered women and children opened its doors in 1983.
In the years between 1984 and 1989, numerous additional programs began to provide shelter, transitional programs, and case management services. These included Salvation Army Men’s Shelter, Arlington Community Residences and the Arlington-Alexandria Coalition for the Homeless (AACH). AACH was founded in 1985 by local churches to address the lack of shelter for homeless persons, particularly women and families.

In 1988 the position of Arlington County Homeless Administrator was created. Increased attention to the needs of the homeless resulted in committing additional funds for emergency needs and motel vouchers to be used for shelter overflow. The One-Stop Arlington Employment Center provides employment services. A Housing Information Center was developed and the HUD funded Section 8 Program became part of the overall system of care. Most recently, significant additional funds have been committed to affordable housing project development, supportive housing, and transitional housing programs.

Parishioners from St. Charles Borromeo Catholic Church, moved by the plight of homeless young mothers and their babies, founded Borromeo Housing, Inc. in 1988. Working closely with the Arlington Housing Corporation, a program was established to provide both safe housing and the opportunity for personal development and self-sufficiency. In 2001, Borromeo Housing, Inc.’s transitional housing program was designated a “Second Chance Home Program” as provided under 1996 welfare reform legislation.

The Arlington Street People’s Assistance Network (A-SPAN) is a non-profit community-based organization whose mission is to assist every homeless person in Arlington County in leaving the streets and living a life of dignity and permanency. A-SPAN began in 1989 when two community members began to deliver food once a week to homeless people living on the streets. In 1992 A-SPAN was awarded a contract to operate an Emergency Winter Shelter, and in 1998 opened a homeless drop-in center, Opportunity Place.
The Costs of Homelessness in Arlington

Arlington’s current system of care is expensive. Responding to the problems of the estimated 1,700 homeless individuals and families that have been identified in Arlington requires many costly public and private services.

There are currently an estimated 200+ chronically homeless single persons in Arlington. Emergency and short-term interventions can cost the County and local nonprofit agencies upwards of $40,000 per year. Such costs include public safety and emergency medical responses, outpatient and inpatient care, emergency shelters, addiction or mental health treatment services, and child welfare services, to name a few. Homeless families in Arlington, many of them made up of mothers with small children, use up to $100,000 of service dollars per family, per year. This includes the cost of providing foster care and other intensive child welfare services where children must be cared for apart from their parents. National research has shown that the cost of providing adequate transitional or “direct to permanent” housing, linked with basic supportive services focused on the identified needs of homeless individuals and families, can be far less costly, in terms of real dollars and successful outcomes, than cycling them in and out of the emergency shelter system.

To detail just some of these costs:

- **Shelters.** The cost of providing overnight shelter to the homeless is substantial. The Arlington County Homeless Services Program estimates that the annual cost of an emergency shelter bed can be between $17,000 and $35,000, inclusive of services. Even without the supportive services component, this is significantly more than the cost of a Federal Section 8 housing subsidy. In the two family shelters in Arlington, Sullivan House and Doorways for Women and Children, total costs range from $49 to $96 per resident per bed night.

- **Child welfare services.** The cost of placing a homeless child in temporary foster care varies from $10 to $15 per day, depending on age. If the child has special needs, such as a disability, the cost can rise to as much as $72 per day or more.

- **Police and other Criminal Justice System services.** A small number of homeless persons become involved with the criminal justice system at frequent intervals, resulting in costs to the County’s court and incarceration facilities. The estimated cost per inmate held in the Arlington Sheriff’s Detention Center is $103 per day.

- **Mental health services.** Arlington County has identified over 140 homeless persons with serious and significant mental illness. Treatment for such individuals, even when they have established eligibility for SSI or Medicaid, results in needed services that must be provided at the additional expense to taxpayers by county government, hospitals or nonprofit service providers. In many instances, treatment is ineffective for transitory individuals faced with the agonizing physical and mental hardships of homelessness.
• **Addiction treatment services.** Arlington County’s Continuum of Care has identified more than 180 homeless individuals who meet the federal definition for chronic homelessness. It estimates that about one-third of these experience chronic substance abuse as their primary disability, seeking repeated treatment resulting in mostly unsuccessful long-term outcomes.

• **Emergency rooms.** Virginia Hospital Center Arlington estimates that each patient who comes to the emergency room costs an average of $250 per visit. Homeless persons use these costly and often crowded emergency room services due to their lack of access to doctors or other primary care medical services. In inclement weather, when shelter beds are full, some homeless persons turn to the emergency room.

• **Acute care hospitals.** Virginia Hospital Center Arlington reports that inpatient services cost an average of $850 per day. The homeless tend to make more use of hospitals than those that are not homeless, in part because they tend to wait longer to access treatment; therefore are sicker when they appear for treatment. Virginia Hospital Center Arlington staff also note that homeless persons often remain longer in the hospital, incurring greater costs, due to the difficulty of finding appropriate facilities into which they can be discharged. According to a report in the New England Journal of Medicine, homeless people spend an average of four days longer per hospital visit than comparable non-homeless people.

• **Unemployment compensation and welfare.** Because homeless persons face serious obstacles to obtaining and maintaining employment, they incur higher public assistance and unemployment compensation costs. Even when job training or employment opportunities are available, it is hard for the homeless to take advantage of them or, if they do, to keep up a regular pattern of attendance.
The net effect of homelessness, beyond its painful impact on the homeless themselves, is to add a very costly burden to already hard-pressed public and charitable human service and housing provider organizations. A pioneering study in New York City by Dennis Culhane of the University of Pennsylvania found that the average homeless person cost that city at least $40,000 per year in public expenditures. New York City's Independent Budget Office found that “…the [City's] Administration for Children's Services spends approximately $3,500 per household annually on preventive housing subsidies. This is substantially less than the $25,000 average cost of a shelter placement for a family”. There is clear and convincing evidence from any number of studies that show that the US Interagency Council on Homelessness is on target when it says: “Chronic homelessness is expensive”.

The Benefits of Ending Homelessness in Arlington

Arlington’s strategic 10-Year Plan seeks to minimize, reduce or where possible, eliminate the costs and realize the benefits described in the preceding sections. Specifically:

**Benefits to the Homeless themselves**

1. **Safe, decent, transitional and permanent supportive housing options.**
   Supportive housing will provide homeless street people with stability and opportunities to re-connect with their community, to become maximally self sufficient, and to experience an enhanced sense of dignity and self esteem.

2. **Improved health through comprehensive preventive health services.**
   Access to preventive and immediate health care has long been shown to achieve improved long-term health outcomes, shorter hospital stays, less reliance on hospital emergency rooms, and overall improved quality of life. Research sponsored by the Corporation for Supportive Housing on supportive housing projects in New York City, San Francisco and Connecticut show that participants made less use of expensive health services, had decreased rates of hospitalization and incarceration and were involved in fewer cases of recurring homelessness.

3. **Long-term support services only for those who truly need them.**
   Short-term, reactive solutions often produce short-term effects, resulting in long-term, sometimes life-time cycles of homelessness. Thoughtful, strategic and comprehensive solutions can produce long-term, permanent stability, allowing communities to target larger portions of limited dollars on persons with permanent disabilities and other populations that need it.

4. **Opportunities for self-sufficiency and contributions to the community through skills training and job placement.**
   Increasing skills and providing meaningful employment opportunities eliminates reliance on public support and contributes to the economic development and vitality of communities.

**Benefits to the Broader Community**

There are important, if hard to measure, benefits to communities and society in general. Arlington prides itself on being a “world-class” community that cares about the well-being of all its citizens. Arlington citizens have a documented history of being generous, proactive and inclusive. Ending homelessness is a goal truly worthy of Arlington’s efforts.
The Planning Process

A special committee, the 10 Year Planning Committee, was established to brainstorm and develop the goals and strategies for ending homelessness in Arlington County. The Committee began its work in the summer of 2005, with assistance from the Boston, MA based Technical Assistance Collaborative (TAC). Participants included representatives from a range of homeless shelter and service providers, the community, and County staff.

The Committee drew some of its members from the Homeless Services Coordination Committee (HSCC), which includes County staff, providers and other community members. Represented in the discussions were a range of nonprofits including Arlington-Alexandria Coalition for the Homeless (AACH), Arlington Street People’s Assistance Network (A-SPAN), Community Residences (CR), Doorways for Women and Families, and Volunteers of America (VOA). A representative from the Arlington Interfaith Council participated throughout and representatives of the League of Women Voters joined later in the process.

The committee was led by Department of Human Services (DHS) staff in the Economic Independence Division, with support from other DHS and county staff from the Community Housing and Planning Division, Behavioral Health Division, and the Child and Family Services Division.

The committee drafted a vision statement, articulated principles to guide the planning and identified the four goal areas (affordable housing, supportive services, prevention and income). Four subcommittees were charged with developing strategies and action steps for implementation of the plan. The full committee analyzed and refined those strategies and actions to formulate the proposed Action Plan for community consideration.

Community input was sought through broad dissemination of the draft Plan, including making the Plan available on the County’s website, meeting with community groups, e-mailing the plan in response to specific requests and a public focus group.

The Mission

Arlington will have an integrated, community based support system which will prevent homelessness and provide the necessary resources to end homelessness for individuals and families living in the county.

Guiding Principles

The following five principles will serve as the guiding force for the broad goals, strategies, and action steps.
Commitment from all sectors of the community.
There is a proverb that states it takes a village to raise a child. We feel that it takes a community to assist in solving and ending homelessness in Arlington County. This includes the collaboration and support of government, non-profits, the faith-based community, the criminal justice system, the business community, and all other Arlington residents.

Best practice, evidence based solutions.
There are several best practice models that have provided promising results in addressing the issue of homelessness. Arlington will employ some best proven practice models throughout the plan.

Affordable, appropriate housing options.
The plan prioritizes development of various types of permanent, affordable housing options that include permanent supportive housing models.

Culturally competent, consumer-centered services.
The face of homelessness has been constantly changing over the past five years. Arlington, like other places across the nation, has experienced an increase in homeless families. In addition to severe poverty, many have additional, unique challenges such as legal status issues, varying customs and traditions, and language barriers. With these thoughts in mind and other challenges previously discussed, the services provided to homeless persons will need to be comprehensive, consumer driven, flexible, and with a focus on meeting the individual client’s needs.

Sufficient financial resources.
Funding resources for human service needs are and will continue to be limited in the foreseeable future. In order to fund changes and new services, Arlington County must make best use of existing federal, state, local and private funding by streamlining, strategic targeting and re-allocating funds towards the plan priorities. Additionally, we must apply for and access any other sources of funding that are or may become available.

Broad goals and strategies
There are four broad goals that have been developed to end homelessness in Arlington County. Each goal has one to three strategies that address a particular aspect of ending homelessness. Accompanying each strategy there are multiple action steps that provide the roadmap for how the strategy will be carried out over the course of next five years. A series of tables will follow this section.
Goal #1 – Affordable Housing

Strategies for Affordable Housing:
1. Increase the supply of housing affordable to homeless individuals and families.

2. Increase the supply of rental assistance provided to homeless individuals and families.

3. Facilitate access to affordable housing for homeless individuals and families.

Goal #2 – Supportive Services

Goals for Supportive Services:
1. Enhance resources for provision of supportive services to those in supportive housing.

2. Develop rapid re-housing plans within each existing homeless shelter.

3. Promote an integrated, comprehensive system of care.

4. Expand the capacity to serve people with mental illnesses and/or substance use disorders.

5. Expand current multi-service centers to serve as “one stop shops.”

Goal #3 – Prevention

Strategies for Prevention:
1. Educate service providers, landlords, persons at risk of homelessness, and others on indications of potential homelessness and availability of homeless preventions services.

2. Develop proactive homeless prevention strategies.

3. Create and implement a 24/7 Housing Crisis Response Plan.

Goal #4 – Income

Strategies for Income:
1. Expand access to employment and training opportunities for homeless persons.

2. Facilitate access to public benefits programs such as Supplemental Security Income (SSI), Veterans’ benefits, and Food Stamps.

3. Educate homeless persons on financial management.
5-Year Action Plan
for the Arlington County 10-Year Plan to End Homelessness

April 2006
5-YEAR ACTION PLAN
FOR THE ARLINGTON COUNTY 10-YEAR PLAN TO END HOMELESSNESS

Vision:
Arlington will have an integrated, community based support system which will prevent homelessness and provide the necessary resources to end homelessness for individuals and families living in the county.

Principles:
• Commitment from all sectors of the community
• Best practice, evidence based solutions
• Affordable, appropriate housing options
• Culturally competent and consumer-centered services
• Sufficient, committed financial resources

For additional information about the 10-Year Plan to End Homelessness, please contact Tony Turnage, Homeless Coordinator, Arlington County Department of Human Services at: ttturnage@arlingtonva.us or 703-228-1319
This Plan prioritizes a “Housing First” best practice approach. The goal is to move the household to permanent housing as quickly as possible. It is based on research showing that people are more responsive to interventions and social services supports after they are in their own home. An expected outcome is reduced utilization of emergency medical and social hospitalizations, jails and criminal justice interventions and mental health admissions.

## 5-YEAR ACTION PLAN

### GOAL: AFFORDABLE HOUSING

#### Strategy #1: Increase the supply of housing affordable to homeless individuals and families.

<table>
<thead>
<tr>
<th>Action #</th>
<th>Action Step</th>
<th>Who will implement</th>
<th>By When</th>
<th>Desired Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-1</td>
<td>Increase the supply of permanent supportive housing units (PSH) as detailed in the County’s approved Permanent Supportive Housing Plan.</td>
<td>DHS, CPHD, Non-profits</td>
<td>Annual</td>
<td>75 PSH added annually (or 375 added by 2011), for individuals and families with disabilities and a critical housing need, including homeless households.</td>
</tr>
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<td>H-2</td>
<td>Review each proposed committed affordable housing (CAF) project for inclusion of studio apartments, as is currently done for inclusion of additional family-sized units.</td>
<td>DHS, CPHD, Non-profits</td>
<td>Annual</td>
<td>10 studio apartments added annually to the committed affordable housing supply.</td>
</tr>
<tr>
<td>H-3</td>
<td>Development of a studio apartment project.</td>
<td>DHS, CPHD, Non-profits</td>
<td>6/11</td>
<td>A 20+ unit studio apartment project with all units to be occupied by chronically homeless persons.</td>
</tr>
<tr>
<td>H-4</td>
<td>Increase the overall supply of committed affordable units (CAFs).</td>
<td>DHS, CPHD, Non-profits</td>
<td>Annual</td>
<td>400 CAFs per year.</td>
</tr>
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1. Committed Affordable Units (CAFs) are all units that are:
   A) wholly owned by nonprofits, excepting any units planned to serve households with incomes above 80% of median family income;
   B) guaranteed by agreement with the federal, state or County government to remain affordable to low and moderate income households for a specific period of time through mechanisms such as site plan requirements, contracts with private owners or IRS regulations governing tax-exempt financing; or
   C) owner-occupied units whose owner received County subsidy to assist with the purchase.

2. The Housing Strategy #1 (Small Scale Development) in the County’s approved Supportive Housing Plan calls for the development of 115 units including a 20 unit studio apartment project. A viable project would be eligible for LPACAP which would help leverage other resources such as McKinney/Vento, Section 8 project-based assistance, state funds, etc.
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<tr>
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<tbody>
<tr>
<td>H-5</td>
<td>Increase outreach to faith-based organizations regarding future development of affordable housing.</td>
<td>DHS, CPHD, Non-profits, Faith-based organizations</td>
<td>6/07</td>
<td>A marketing plan developed and implemented. (Plan would identify affordable housing options for discussion.)</td>
</tr>
<tr>
<td>H-6</td>
<td>Increase the ability of non-profit housing developers to obtain speedy access to funding to secure contracts for properties.</td>
<td>DHS, CPHD</td>
<td>6/07</td>
<td>Special allocation of Affordable Housing Investment Fund (AHIF) monies for non-profit developers to secure property contracts.</td>
</tr>
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<tr>
<td></td>
<td><strong>Strategy #2: Increase the supply of rental assistance provided to homeless individuals and families.</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>H-7</td>
<td>Recommendation that number of slots available in the Transitional Housing Program (THP) be increased.</td>
<td>DHS</td>
<td>9/06</td>
<td>Additional households receive THP assistance.</td>
</tr>
<tr>
<td>H-8</td>
<td>Increase the number of slots for local project-based rental assistance for homeless individuals and families.</td>
<td>DHS</td>
<td>Yearly for first five years.</td>
<td>Slots will be increased yearly by 5% over the first five (5) years for local project-based rental assistance, recognizing that a portion of those units will serve homeless individuals and families with disabilities.</td>
</tr>
<tr>
<td>H-9</td>
<td>Ensure priority status continues for homeless elders, persons with disabilities and working families to access Housing Grants.</td>
<td>DHS</td>
<td>Ongoing</td>
<td>Program-eligible homeless households who are leaving shelters have access to Housing Grants on a priority basis.</td>
</tr>
<tr>
<td>H-10</td>
<td>Ensure that resources to prevent or rapidly re-house households are provided in a timely fashion.</td>
<td>DHS, Non-profits</td>
<td>12/06</td>
<td>Program-eligible households avoid homelessness or are rapidly re-housed.</td>
</tr>
<tr>
<td>H-11</td>
<td>Apply for federal &amp; state resources that can provide housing for homeless individuals and families.</td>
<td>DHS, CPHD, Non-profits</td>
<td>Ongoing</td>
<td>Additional funds are secured.</td>
</tr>
</tbody>
</table>
### Strategy #3: Facilitate access to affordable housing for homeless individuals and families.

<table>
<thead>
<tr>
<th>Action #</th>
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<th>Who will implement</th>
<th>By When</th>
<th>Desired Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>H-12</td>
<td>Develop standardized referral protocol for homeless individuals and families with disabilities to available affordable housing.</td>
<td>DHS, HSCC</td>
<td>12/06</td>
<td>Non-profit organizations will use standardized referral protocol.</td>
</tr>
<tr>
<td>H-13</td>
<td>Provide ongoing training to case managers to improve their capacity to access existing housing programs.</td>
<td>DHS, HSCC</td>
<td>6/07</td>
<td>Training on methods for accessing existing housing programs; developed and implemented.</td>
</tr>
<tr>
<td>H-14</td>
<td>Online training module available to case managers to improve their capacity to access existing housing programs.</td>
<td>DHS</td>
<td>6/08</td>
<td>Housing program training tutorial available to non-profits on extranet (x-Tend).</td>
</tr>
<tr>
<td>H-15</td>
<td>Design a package of Housing Stabilization Services to provide non-clinical supports for homeless individuals and families.</td>
<td>HSCC Subcommittee</td>
<td>6/07</td>
<td>Package developed.</td>
</tr>
<tr>
<td>H-16</td>
<td>Provide a minimum of six months of housing stabilization services for homeless individuals and families.</td>
<td>DHS, CPHD, Non-profits</td>
<td>Annual (as of FY 2008)</td>
<td>15+ households receive six months of stabilization services.</td>
</tr>
<tr>
<td>H-17</td>
<td>Provide outreach/education to landlords about supportive housing and stabilization services.</td>
<td>DHS, CPHD, Non-profits,</td>
<td>6/07</td>
<td>Landlord workshops developed. Workshops conducted twice per year</td>
</tr>
<tr>
<td>H-18</td>
<td>Explore feasibility of development of a Ready to Rent Program like that in Portland, Oregon.</td>
<td>HSCC, CPHD</td>
<td>12/06</td>
<td>Feasibility assessment completed. (Program offers certificate to share with prospective landlords.) If feasible begin development/planning.</td>
</tr>
<tr>
<td>H-19</td>
<td>Explore potential for development of a credit repair program for homeless individuals and families.</td>
<td>HSCC</td>
<td>a. 12/06 b. 1/07</td>
<td>a. Credit repair program feasibility determined. b. If feasible, begin development process.</td>
</tr>
</tbody>
</table>
## Strategy #4: Develop Rapid Re-housing Plans.

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>H-20</td>
<td>Develop shelter protocols aimed at rapid re-housing approaches that enable individuals and families to quickly and successfully move to permanent housing.</td>
<td>DHS, Non-profits</td>
<td>6/08</td>
<td>Tailored rapid re-housing strategies are adopted.</td>
</tr>
<tr>
<td>H-21</td>
<td>Implement rapid re-housing plans.</td>
<td>DHS, Non-profits</td>
<td>6/09</td>
<td>a. Shorter lengths of stay at each shelter b. Higher rates of discharging to permanent housing.</td>
</tr>
<tr>
<td>H-22</td>
<td>Review current and potential resources and needs for short-term (generally one to two nights) crisis housing.</td>
<td>HSCC Prevention Subcommittee</td>
<td>6/07</td>
<td>A completed inventory of current and potential resources.</td>
</tr>
<tr>
<td>H-23</td>
<td>Develop a coordinated housing crisis response plan, including centralized referral.</td>
<td>HSCC Prevention Subcommittee</td>
<td>6/08</td>
<td>Housing crisis response plan developed.</td>
</tr>
<tr>
<td>H-24</td>
<td>Implement housing crisis response plan.</td>
<td>DHS, Non-profits</td>
<td>7/08</td>
<td>80% of individuals and families meeting the criteria for crisis housing needs placed for short-term stays.</td>
</tr>
</tbody>
</table>
## GOAL: SUPPORTIVE SERVICES

**Strategy #1: Enhance resources for provision of supportive services to those in supportive housing.**

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<thead>
<tr>
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</tr>
</thead>
</table>
| S-1      | Expand peer support and mentoring resources related to living in independent supportive housing. | DHS, Non-profits | 6/07 | a. 8 homeless/formerly homeless persons certified as peer counselors.  
b. Training provided. |
| S-2      | Increase the capacity of current providers to provide appropriate services to those who move from short-term to permanent housing so persons successfully maintain their housing, particularly special populations such as victims of violence. | DHS, Non-profits | 6/07 | 80% of staff for participating agencies are hired and trained annually to provide follow-up services. |
| S-3      | Work with local faith-based and other community organizations to develop a volunteer network to support homeless individuals and families moving to permanent housing. | Non-profits | 6/09 | All newly-housed individuals/families who request it have volunteer support in the first phase of their return to independent housing. |
| S-4      | a. Train community providers in culturally competent service delivery  
b. Explore possibility of expanding translation services to non-profits. | DHS/HSCC | a. 6/08  
b. 3/07 | a. 80% of community providers have received cultural competence training.  
b. Feasibility of expanding translation services determined. If feasible, planning initiated. |
| S-5      | Train community providers on service delivery to special populations. | DHS, Non-profits with identified expertise. | 6/08 | a. 80% of community providers have received specialized training.  
b. 80% of special populations retain their housing for 2 years or more. |
### Strategy #2: Promote an integrated, comprehensive system of care.

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<tr>
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</table>
| S-6      | Expand the demonstration program for 18-21 year olds aging out of foster care requiring that, prior to discharge from the system, clients have experienced the following on a continuous basis for six months:  
  - residing in safe, affordable housing;  
  - participation in education/training programs or hold a stable job or have a stable source of income (e.g., disability benefits);  
  - involvement with community social/recreational activities; and  
  - regular contact with a community-based volunteer mentor/advocate. | DHS | 6/07 | 75% of youth proposed for participation in the program are enrolled and are stabilized for 18 months. |
| S-7      | a. Ensure that all homeless service providers implement Collaborative Service System of Arlington (CSSA).<sup>3</sup>  
  b. Use CSSA to generate range of data, from demographics to service needs, to improve program planning. | DHS, Non-profits | a. 6/06  
  b. 7/06 | a. All homeless service providers have implemented CSSA.  
  b. Improved data on homeless households, their service needs, housing and employment obtained, etc. available for tracking outcomes and program planning. |
| S-8      | Develop a means to generate local data on cost effectiveness, cost savings and overall benefits, e.g., the relative cost of homeless prevention funding vs. cost of average stay in a shelter; reductions in hospitalizations and incarcerations, with associated costs; reductions in loss of school time or need for transfer to new schools; improvement in income. | HSCC | a. 6/08  
  b. 6/09 | a. System developed.  
  b. Local data on overall benefits and cost-effectiveness of Housing First approaches available. |
| S-9      | As part of DHS’ update of its client service entry software, link CSSA to the new system. | DHS | 6/08 | CSSA and DHS’ updated client service entry software are linked. |

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<sup>3</sup> The Collaborative Service System of Arlington (CSSA) is a web-based program that allows homeless service providers to produce an unduplicated count of homeless persons served in Arlington County. Additionally, providers are able to track services rendered and referrals made on behalf of a client using the case management module. CSSA system serves as Arlington County Homeless Management Information System (HMIS).
<table>
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<tbody>
<tr>
<td>S-10</td>
<td>Implement the standard CSSA comprehensive intake assessment of client needs for determination of the appropriate level of service needed.</td>
<td>HSCC</td>
<td>7/06</td>
<td>90% of providers are using the standard intake form for assessment and determination of service needs.</td>
</tr>
<tr>
<td>S-11</td>
<td>Increase access for persons who are homeless to innovative psychosocial rehabilitation programs/services.</td>
<td>DHS, Non-profits</td>
<td>Ongoing</td>
<td>40% of homeless/recently homeless persons participate in innovative psychosocial rehabilitation programs/services.</td>
</tr>
<tr>
<td>S-12</td>
<td>Link homeless persons to existing community resources, e.g., literacy classes.</td>
<td>DHS, Non-profits</td>
<td>Ongoing</td>
<td>Homeless persons are integrated into existing community programs.</td>
</tr>
</tbody>
</table>
| S-13     | Standardize methods of accessing credit reports and designing repayment plans. | DHS, Non-profits | a. 6/07  
b. 7/07 | a. Standards for credit repair and financial planning adopted by HSCC.  
b. Standards implemented by the non-profits. |
| S-14     | Continue providing financial literacy training and budget planning. | DHS, Non-profits | Ongoing | 70% of homeless persons show improved financial management skills. |

**Strategy #3: Expand the capacity to serve people with mental illnesses and/or substance use disorders.**

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>S-15</td>
<td>Develop a pilot program providing an integrated recovery-oriented, community-based approach to assessment, treatment and services for persons with co-occurring mental illnesses and substance use disorders.</td>
<td>DHS, Non-profits</td>
<td>12/08</td>
<td>Pilot program implemented and evaluated.</td>
</tr>
<tr>
<td>S-16</td>
<td>Develop proposal to expand Medicaid coverage (e.g. under the Rehabilitation Option and/or through Medicaid waiver programs) to cover additional treatment and services for people with serious mental illness and/or substance abuse in community settings.</td>
<td>HSCC</td>
<td>6/07</td>
<td>A proposal for increased Medicaid coverage is presented to the state Medicaid authority and legislators.</td>
</tr>
</tbody>
</table>

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4 There exist various programs that can be accessed by homeless persons. These programs can address mental health/clinical concerns as well provide job/training skills. Examples of innovative psychosocial rehabilitation programs/services in Arlington County include the Clarendon Clubhouse, Next Step programs, and Job Avenue.
S-17  Provide ongoing training on issues related to mental illnesses, substance use disorders, and co-occurring disorders to outreach workers, case managers, primary health care workers, mental health, substance abuse treatment providers and advocates.  

DHS  Ongoing  A program of ongoing affordable and accessible training for all appropriate and/or interested persons is provided.

S-18  Conduct analysis of the housing needs of persons with co-occurring disabilities, comparing the appropriateness of “Safe Haven” housing and independent living through the “Housing First” approach.  

DHS  12/06  Written analysis of the housing needs of persons with co-occurring disabilities completed.

**Strategy #4: Expand multi-service centers to serve as comprehensive “one-stop” centers.**

<table>
<thead>
<tr>
<th>Action #</th>
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<th>Desired Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-19</td>
<td>Increase the availability of mainstream service providers at “one-stop” centers.</td>
<td>DHS, Non-profits</td>
<td>6/08</td>
<td>Improved access for homeless persons to services.</td>
</tr>
<tr>
<td>S-20</td>
<td>Explore possibility of expanding services at centers to include a place for support groups, showers, laundry, clean clothes, storage area for personal belongings, phones, and a place to receive mail, Internet access, community voicemail, and service linkages.</td>
<td>Non-profits</td>
<td>6/07</td>
<td>Services expanded at “one-stop” centers.</td>
</tr>
<tr>
<td>S-21</td>
<td>Increase capacity of DHS and non-profit providers (both public and non-profit) to provide services for adults, children and parents at key locations such as the shelters or drop-in centers.</td>
<td>DHS, Non-profits</td>
<td>6/08</td>
<td>Broader range of services (e.g., employment assistance, veterans’ services, mental health) provided at shelters.</td>
</tr>
</tbody>
</table>
## GOAL: PREVENTION

**Strategy #1: Educate service providers, landlords, persons at risk of homelessness, and others on indications of potential homelessness and availability of homeless prevention services.**

<table>
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<tr>
<th>Action #</th>
<th>Action Step</th>
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<th>Desired Outcome</th>
</tr>
</thead>
</table>
| P-1      | Assess existing informational materials on homeless and homeless prevention services and resources, identifying need for revisions and new materials designed for targeted audiences. | HSCC Prevention Subcommittee | a. 6/07   
   b. 6/08 | a. Need for revised/new informational materials and types of materials identified. Timeline established for development of materials for specific audiences.  
   b. Selected new informational materials developed. |
| P-2      | Educate property managers about the resources available to tenants who are at risk of eviction. | DHS, CPHD, Non-profits | a. 6/07   
   b. 12/07 | a. Educational handout for landlords completed.  
   b. Property managers refer at-risk tenants to CAB, HIP, faith-based agencies or other homeless prevention agencies identified in the educational materials. |
| P-3      | Engage mainstream providers (e.g., health care, behavioral health, police, and jail staff) in:  
   • identifying individuals with risk factors for homelessness,  
   • providing prevention assistance as it falls within the scope of their roles, and  
   • referring individuals to appropriate resources. | DHS, Non-profits, Institutional care providers | a. 6/08   
   b. 6/09 | a. 4 homeless prevention training workshops provided.  
   b. Referrals to crisis intervention programs from specified providers increase by 25%. |
| P-4      | Increase the ability of faith-based organizations, community groups and Arlington Public Schools to recognize and serve persons at risk of homelessness through volunteer training, mentoring and other supports. | DHS, Arlington Public Schools Non-profits, Institutional care providers | 6/07 | Two homeless annual prevention training workshops provided to schools, faith-based and other community organizations. |
### Strategy #2: Develop additional proactive homeless prevention strategies.

| P-5                      | Partner with institutional staff (hospitals, jails, prisons) to ensure implementation of effective discharge plans. | DHS, Non-profits, Institutional care providers | a. 6/07 | a. Agreed upon discharge plans developed and implemented.  
b. 6/09 | b. No persons with disabilities discharged from hospitals, jails or prisons without identified housing. |
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<tbody>
<tr>
<td>P-6</td>
<td>Evaluate homeless prevention best practice models such as Home Based New York City for possible replication in Arlington.</td>
<td>HSCC Prevention Subcommittee</td>
<td>6/08</td>
<td>Evaluation completed. Implementation of a new program begun, if selected.</td>
</tr>
</tbody>
</table>
### GOAL: INCOME

**Strategy #1: Expand access to employment and training opportunities for homeless persons.**

<table>
<thead>
<tr>
<th>Action #</th>
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</tr>
</thead>
</table>
| I-1      | Educate employers and homeless service providers about tax credits offering incentives for hiring homeless individuals. | AEC: business developer and employment specialists | a. 6/07, b. 7/07 | a. Employer information kit developed.  
     . List of employers willing to employ homeless persons developed.                                                                                      |
| I-2      | Develop a protocol to ensure effective coordination of workforce services provided by state and local workforce systems, faith-based and other community organizations. | AEC One Stop Career Center and partners (e.g., VEC, DRS, VA, non-profits, community organizations) | 6/07          | Protocol developed. Improved collaboration between agencies resulting in better access to training and employment increased earning potential and improved job retention. |
| I-3      | Partner with local businesses to provide training and/or jobs to homeless individuals in supportive housing (i.e. Training Center, Goodwill) | AEC One Stop Career Center, AED, Non-profits | 6/07          | 20% increase in job training slots and/or jobs developed for homeless persons living in supportive housing.                                                                                                   |
| I-4      | Partner with a business or business developer to develop a business enterprise that is a training site as well as a profit-making business. | DHS, Non-profits                             | 6/08          | Business enterprise developed to provide training to homeless clients. Certification of job skills provided, as appropriate to job field.                                                                         |
| I-5      | Advocate for legislation that supports increase in minimum wage.               | Non-profits                                  | 6/09          | Minimum wage increased.                                                                                                                                                                                        |
| I-6      | Advocate for state legislation that supports a living wage.                   | Non-profits                                  | 6/11          | Living wage legislation enacted.                                                                                                                                                                              |
## Strategy #2: Facilitate access to public benefits programs such as Supplemental Security Income (SSI), Veterans’ benefits, and Food Stamps.

<table>
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<tr>
<th>Action #</th>
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</thead>
<tbody>
<tr>
<td>I-7</td>
<td>Develop a toolkit regarding various public benefit programs for use by homeless individuals, services providers, and faith-based organizations.</td>
<td>DHS, Non-profits</td>
<td>6/07</td>
<td>Toolkit on accessing public benefits developed and disseminated.</td>
</tr>
<tr>
<td>I-8</td>
<td>Provide outreach and training on accessing public benefits to a variety of organizations.</td>
<td>DHS, Non-profits</td>
<td>6/08</td>
<td>Semi-annual workshops on income strategies for the homeless provided to interested organizations.</td>
</tr>
</tbody>
</table>
| I-9      | Work with the Social Security Administration (SSA) to improve the application process for clients who are eligible for SSI/SSDI benefits.                                                                      | DHS, Non-profits   | a. 12/06 b. 6/07 c. 6/11 | a. SSA appoints a staff liaison designated to facilitate access to status of applications from homeless persons.  
b. Timeline for processing of applications increased by 15%.  
c. 70% of State-identified eligible population has SSI/SSDI applications submitted to and approved by SSA for SSI/SSDI. |
How will we know we’re on the right track?

The 10 Year Planning Committee feels confident that we have thoughtfully and carefully devised a plan that will address the issues of homelessness in our community in a successful way. A system of care that includes housing and housing supports, and a comprehensive array of intervention methods balanced with preventive measures, will assure that our goal of ending homelessness can be achieved by 2016 in Arlington County, VA. But a project or initiative is incomplete without accountability and a performance management system that tells us whether or not we are headed in the right direction. The following actions steps will be taken to assess direction, and measure progress and performance.

<table>
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<tr>
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<tbody>
<tr>
<td>E-1</td>
<td>Establish an Evaluation Committee that will oversee the development of performance measurement initiative.</td>
<td>DHS/HSCC</td>
<td>10/06</td>
<td>Evaluation Committee established</td>
</tr>
<tr>
<td>E-2</td>
<td>Select a performance management system (i.e. Combination of HMIS and PbViews).</td>
<td>DHS/Evaluation Committee</td>
<td>9/06</td>
<td>Performance management system selected.</td>
</tr>
<tr>
<td>E-3</td>
<td>Develop data measures consistent with desired outcomes, data collection methods, and reporting methods.</td>
<td>DHS/Evaluation Committee</td>
<td>1/07</td>
<td>Data measures, data collection methods and reporting methods developed.</td>
</tr>
<tr>
<td>E-4</td>
<td>Train involved organizations on data collection and reporting methods</td>
<td>DHS/Evaluation Committee</td>
<td>3/07</td>
<td>90% of providers trained and implementing collection and reporting methods.</td>
</tr>
<tr>
<td>E-5</td>
<td>Present 1st 6 months data report to the full HSCC.</td>
<td>DHS/Evaluation Committee</td>
<td>12/07</td>
<td>First 6 months of data reported.</td>
</tr>
</tbody>
</table>
| E-6      | Based on data and assessment of progress, revise and update 5 year action plan; develop an action plan for the remaining 5 years. | DHS/Evaluation Committee    | 7/10    | a. Revised 5 year action plan  
b. Subsequent/remaining 5 year action plan. |
APPENDIX A

A Passageway Home 10 Year Planning Committee

Arlington-Alexandria Coalition for the Homeless
  • Edward Rea, Executive Director

Arlington Interfaith Council
  • Fred Jones, Member

Arlington Street People’s Assistance Network
  • Lawrence Elder, Director of Outreach
  • Lora Rinker, Executive Director

Borromeo Housing
  • Joy Meyers, Executive Director

Doorways for Women and Children
  • Linda Dunphy, Executive Director
  • Caroline Jones, Director of Transitional Housing

Department of Community Planning and Housing Development
  • Fran Lunney, Coordinator of Housing Planning

Department of Human Services
  • Shirley Ali, Behavioral Healthcare Division, TOW Program Manager
  • Sharon Armstrong, Economic Independence Division, Arlington Employment Center
  • Driss Aitbelhaj, Contract Service Representative
  • Nancie Connolly, Behavioral Healthcare Division, Substance Abuse Coordinator
  • Siobhan Grayson, Child and Family Services Division, Child/Family Coordinator

  • Amelia Howard, Economic Independence Division, Arlington Employment Center, Employment Specialist
  • Lynda Schoenbeck, Division Chief, Economic Independence Division
  • Cynthia Stevens, DHS Supportive Housing Coordinator
  • Sara Thompson, Economic Independence Division, Crisis Assistance Bureau, Supportive Services Coordinator
  • Tony Turnage, Economic Independence Division, Homeless Program Coordinator
  • Leslie Weisman, Behavioral Health Division Supervisor
  • Carolyn Woods, Economic Independence Division, Public Assistance Bureau, Eligibility Worker

Volunteers of America
  • Danielle Cole, Program Director
  • Rachel Fielding, Case Manager
  • Mary Savoy-Baucum, Shelter Director
  • Aberra Sumamo, Case Manager

Community Residences
  • Tandis Viziri-Zanjani, Program Manager
APPENDIX B

Vocabulary

Chronically Homeless: An unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. However, persons who are currently residents of transitional or permanent supportive housing are not considered to be chronically homeless. (Families are not counted as chronically homeless).

Chronic Health Conditions: Medical problems such as diabetes, cancer, asthma and arthritis.

Chronic Substance Abuser (CSA): A homeless person with alcohol or drug abuse problem and it is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. Functional impairment is indicated by the following results from the use of any drug/substance: failure to fulfill important roles; repeated use when it is physically dangerous to do so; continued use despite recurrent legal problems; continued use despite social or interpersonal problems.

Continuum of Care (CoC): A coordinated effort to deliver a range of services that homeless individuals and families can access throughout the County. The services include but are not limited to mental health, substance abuse, street outreach, emergency shelter, transitional and permanent supportive housing.

Developmental Disability (DD): A severe, chronic disability that is attributed to a mental or physical impairment (or combination of physical and mental impairments) that occurs before 22 years of age and limits the capacity for independent living and economic self-sufficiency. Persons who have such impairments as a result of head trauma would be considered brain-injured rather than developmentally disabled.

Dually Diagnosed: A person with mental illness and has a substance abuse problem.

Foster Care: A homeless person age 30 or under who has been a recipient of the foster care service.

Language Minority: The native language is NOT English; includes immigrants/international refugees.

Learning Disabled or Emotionally Disturbed: A determination by the school system that the child or adolescent needs these Special Education Services.

Low-Functioning (LF): The person, usually the adult, does not have a formal assessment of retardation, development disability, emotional disturbance, or brain injury, but has evidenced limitations in the ability to function adequately to maintain independence without continuing social or personal supports. This is not a formal diagnostic category, but may be based on factors such as below average IQ, cognitive limitations, or limited ability to make appropriate life decisions.

Mental Retardation (MR): A confirmed diagnosis of mental retardation (i.e. an IQ of 70 or below), manifested before age 18, accompanied by limitations in two or more of the following adaptive skills: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work.

Permanent Supportive Housing (PSH): Housing programs that provide supportive services that can include but are not limited to budgeting, medication monitoring, cooking, cleaning, assistance in abiding with tenancy, etc. These programs are designed to assisted person with disabling conditions that can include SMI, CSA, DD, etc.
Physically Disabled: Person with mobility, vision, hearing, or other sensory impairments.

Serious Mentally Ill (SMI): A mental health problem and it is expected to be of long-continued and indefinite duration and substantially impedes a client’s ability to live independently. It may include serious depression, serious anxiety, hallucinations, violent behavior or thoughts of suicide. Serious mental illness (SMI) occurs in adults age 18 and over who have a diagnosable mental behavioral or emotional disorder that caused a functional impairment which substantially interferes with or limits one or more major life activities.

Seriously Emotionally Disturbed (SED): Diagnosable disorders in children and adolescents under age 18 that severely disrupt their daily functioning in the home, school, or community. These disorders include depression, attention-deficit/hyperactivity, anxiety disorders, conduct disorder, and eating disorders.

Victim of Domestic Violence: A homeless person that is a survivor of domestic violence where violence caused homelessness (includes all household members).

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