West Central Illinois

Continuum of Care Consortium

IL519

Strategic Plan Guidelines

Draft: October 26, 2015

Executive Summary

THE ISSUE: Homelessness is the result of many convergent factors, both systemic and personal. Ultimately, it is the inevitable result of the gap between a household's income and the cost of living, including housing. Exacerbating factors for some individuals and families can include unemployment or under employment, unexpected medical bills and lack of health insurance, chronic health problems, domestic violence, physical disabilities, mental illness or drug and alcohol addictions. Funding for homeless programs has always struggled to meet the demand, however, the funding climate in which this plan is written is rapidly deteriorating. Due to the lingering effects of the economic crisis of 2008, and the budget crisis of the State of Illinois; important safety net programs such as Housing and Essential Needs (Formerly GAU), Temporary Assistance for Needy Families (TANF), Community Development and Community Services Block Grants, supportive housing funds, emergency food and shelter funds, TANF childcare, and public housing are facing drastic cuts. Despite these dire circumstances, the West Central Illinois Continuum of Care (Continuum of Care or CoC) remains hopeful that we will make progress with whatever funding is available. This will require extensive advocacy on the part of providers and the community at large to save the parts of the system that vulnerable families and individuals rely upon for survival, while transitioning to a system that does more than merely manage homelessness. At the same time, we are beginning to consider how we might address, and hopefully ease, the possibility of mass housing displacement among people currently housed but at very high risk because of the above-mentioned cuts.

STRATEGIC PLAN GOALS: We are aware that even with adequate funding; our system would not support ending homelessness as it is currently designed. The strategies outlined in this plan are designed to shift the system to one that, when adequately funded, can end homelessness. The goals of this plan are to: 1. Centralize entry, intake and referral; 2. Prevent homelessness and rapidly re-house those who become homeless; 3. Maintain and develop affordable and permanent supportive housing; 4. Provide or broker tailored services and treatment in housing and prevention programs; 5. Engage systems designed to increase economic and educational opportunities; 6. Facilitate the continued development of a Homeless Management Information System (HMIS) that accurately captures needs analysis measures the seven performance measures mandated in the HEARTH Act, and is useful to end users; 7. Coordinate funding for homeless programs; and 8. Build the community and political will to end homelessness.

ACCOUNTABILITY: The Continuum of Care is responsible for developing and implementing this plan. The CoC's Collaborative Applicant is responsible for the management of the plan. The major funders investing in ending homelessness in our CoC are U.S. Department of Housing and Urban Development; Illinois Department of Human Services; FEMA; and United Way; are working to align their funding policies and priorities with this plan, and moving toward funding projects that will attempt to accomplish the goals, strategies and action steps outlined in the plan. Funders and providers will be accountable for achieving results with that funding.

MEASURING PROGRESS AND PERFORMAN: The Continuum of Care is responsible for progress toward achieving other federal and state outcomes, including: • Ending chronic homelessness by 2015 • Reducing all homelessness by 50% by 2016 • Reducing family homelessness by 50% by 2021.

The Homeless Emergency and Rapid Transition to Housing (HEARTH) Act of 2009 has an overall goal of "ensuring that individuals and families who become homeless return to permanent housing within 30 days," and the following performance measures:

- reduce the length of time people remain homeless
- reduce recidivism for homelessness
- reduce the total number of homeless people in our community
- increase the income for homeless people
- reduce the number of people who become homeless for the first time
- measure the success of serving homeless who are not literally homeless
- measure the retention rate of permanent housing

Our CoC Council in partnership with providers, the Collaborative Applicant and the CoC's Support Entity; will monitor data in the Homeless Management Information System (HMIS). These measurements will involve a system change and the plan calls for these performance measures to be in place by 2017.

Section 1: Introduction

Continuum of Care IL519 has three strategic plans to end homelessness: one for chronically homeless individuals, one for all populations and one for families with children. In order to provide a clear vision for funding and housing development priorities, stakeholders have integrated these three plans into one set of goals and strategies to end homelessness in our community. For more information on the three plans, please see the "Plan Integration" section in the appendix. Our work is guided by federal legislation (the Homeless Emergency and Rapid Transitional to Housing or HEARTH Act) that directs local continuums of care to make prevention and rapid re- housing the primary tools for ending homelessness rather than emergency shelter and transitional housing which have been the cornerstone of our homeless system for decades. The legislation sets a system-wide goal of reducing time-limited housing stays (including emergency shelter and transitional housing) to 30 days before placement in permanent housing. Essentially, we are working to shift our primary focus away from time-limited housing with supportive services to permanent housing with tailored, transitional subsidies and supportive services.

VISION

The vision of this plan is to create a system that will support ending homelessness. The system must be flexible enough to respond to the needs of the community and new funding requirements, and also work collaboratively with other mainstream systems to end homelessness for shared populations. The current array of homeless housing and services was not consciously designed. Rather, it is the result of years of inflexible fund sources layered or cobbled together as a reaction to trends in homelessness and homeless program policy and funding. The end result is that we have become very good at managing homelessness rather than moving toward ending it. For lasting and effective change to take place, system transformation is required. We strive for a paradigm shift from the status quo to a system that is individual and family centered, provider informed, and funder supported. An individual- and family-centered system necessarily tailors all services and interactions to the needs of those it serves. When services are adequately tailored, families and individuals get the right services, at the right level, at the right time. Funders and housing and service providers will no longer require participation in program components if they are not needed by an individual or family. Providers will receive technical assistance to help them gain an increased understanding about how to assess individuals and families in order to develop a unique approach to each household. This will include both what the primary agency will provide, and what to coordinate with other specialty agencies. Over time, the system will improve its ability to respond to family and individual needs in an effective and timely fashion. Developing a system that is individual and family centered will require changes at a variety of levels.

Specifically, we aim to implement five key practices that have emerged as best practices across the country: coordinated entry, prevention, rapid re-housing, tailored services and economic opportunity.

GUIDING PRINCIPLES

Our Community should:

1. Affirm that housing is a basic human need
2. Provide a continuum of housing and service options that meet the needs of individuals and families
3. Focus efforts on the development of affordable permanent housing, permanent supportive housing, and prevention services
4. Be culturally competent and responsive in all programs and policies
5. Identify funding sources
6. Use data to make informed decisions
7. Practice outcome-based program accountability
8. Provide services that are inclusive and strengths based
9. Seek innovative solutions, and question the status quo.

Section 2: Understanding Homelessness

THE DEFINITION OF HOMELESSNESS

Studies on homelessness are complicated by inconsistent definitions. Federal programs to assist persons who are homeless provide a wide range of services. Many of these programs are targeted to serve the needs of different segments of the homeless population (e.g. veterans or runaway youth), while others are intended to reach a broader number of persons, including those who may be at risk of homelessness. For the most part these definitions share common language that defines homelessness as lacking a fixed, regular, and adequate nighttime residence. Differences in definitions primarily relate to the inclusion both of individuals who are sharing the housing of other persons (i.e. 'doubled-up') due to loss of housing or economic hardship, and of persons living in substandard housing. The latter definition references a much broader population of individuals that may not be living on the streets or in shelters, but could be construed as experiencing homelessness due to housing instability. We use two primary definitions to guide our work at the direction of three different agencies, the US Department of Housing and Urban Development and the US Department of Education. See the appendix for text of the statutory definitions of homelessness that these agencies use to quantify and determine program/funding eligibility.

Essentially, someone experiencing homelessness—regardless of age—meets one or more of following conditions:

- Lacks a fixed, regular, and adequate nighttime residence
- Sleeps in a public or private place not meant or typically used for human habitation, like cars, parks, abandoned buildings, bus or train stations, airports or camping grounds
- Resides in a shelter or other time-limited housing program
- Resides in a hotel or motel with public or private assistance
- Will lose their housing within 14 days
- Has and will continue to experience long term housing instability, including frequent moves and staying with family or friends

The differences in definitions make it difficult to quantify the number of people experiencing and at risk of homelessness in our community. This is one of the reasons we have to use several different sources of data in order to get an idea of how many people are experiencing or at risk of homelessness. Inconsistent definitions also pose challenges with funding and outcomes. For example, federal funding allocations are determined based on how effective we are at decreasing the numbers in our point in time survey of homeless people, and data in HMIS. This is not always a true measurement of the homeless in our community.

CAUSES OF HOMELESSNESS

The West Central Illinois Continuum of Care (IL519) is comprised of the following counties: Adams, Brown, Cass, Hancock, Henderson, McDonough, Morgan, Pike, Schuyler, Scott and Warren. The CoC region is rural with approximately 59% of the population residing in Adams (30%), McDonough (14%) and Morgan (15%) Counties. There are two big-picture causes of homelessness on a national scale and a

local scale: poverty and lack of affordable housing. According to the 2014 Report on Illinois Poverty prepared by the Social IMPACT Research Center at Heartland Alliance, the poverty rates for our CoC are as follows: McDonough-21%; Pike-17%; Adams, Brown and Morgan-16%; Warren-15%; Cass, Schuyler and Scott-13%; and Hancock and Henderson-12%. The poverty rate for the state of Illinois is 14.6%.

The comparison of the wage needed to afford a two-bedroom apartment at Fair Market Value to the mean hourly wage in each county is: Adams $12.25 to $9.54; Brown $14.96 to $13.83; Cass $12.52 to $10.34; Hancock $12.25 to $9.63; Henderson $12.25 to $6.53; $13.52 to $6.78; Morgan $12.52 to $9.40; Pike $12.25 to $7.70; Schuyler $12.25 to $13.28; Scott $12.25 to $11.23; and Warren $13.31 to $8.38. For the state of Illinois it is $17.34 to $14.10. The mean hourly wage is considerable less than what is needed to afford a two-bedroom apartment. Households cannot afford market rate housing. This means they are paying more than 30% of their income toward housing costs, leaving little to pay for child care, transportation and health care. These households are only a paycheck or one medical emergency away from losing their housing. Many must rely on family and friends, housing subsidies and other benefits to survive.

Other exacerbating factors contributing to homelessness include:

- chronic health problems
- criminal background
- drug and alcohol addictions
- exhausted unemployment benefits
- flight from domestic violence
- generational poverty
- job loss
- loss of food, cash or disability benefits
- mental health disabilities
- no family or sick leave
- no retirement benefits
- physical disabilities
- poor credit and or rental histories
- the high cost of child care and transportation
- underemployment
- unexpected medical bills and lack of health insurance

Section 3 Sub-Populations of Homeless

There are many reasons people become and remain homeless. In order to end homelessness, we must target our interventions to the diverse needs of people experiencing homelessness in our community. CoC IL519 providers provide housing and services specific to the needs of different sub populations, including: • Chronically Homeless Individuals and Families • Families with Children • Persons Exiting Institutions • Persons with Serious Mental Illness • Persons with Serious Substance Abuse Issues • Persons with Co-Occurring Diagnoses • Persons with HIV/AIDS • Unaccompanied Youth • Veterans • Victims of Domestic Violence • Populations at Risk of Homelessness

CHRONICALLY HOMELESS INDIVIDUALS AND FAMILIES

"Chronically Homeless" is defined as an individual or family member with a disability who has been homeless for more than one year or 4 times or more in the past 3 years. In 2011 the CoC IL519 began strategically planning to address chronic homelessness. New project applications targeting chronic homeless households were developed for the 2011 CoC competition. Underutilized projects were reallocated to provide more permanent supportive housing that prioritized chronic homeless in our more populated areas.

FAMILIES WITH CHILDREN

Homeless families are considered households with minor children, including single or partnered pregnant females who meet the federal Housing and Urban Development (HUD) definition of homeless. Homeless families with children usually seek doubled-up solutions or remaining in domestic violence situations as opposed to living on the streets. It is much easier to count those in emergency and transitional housing than those who are unsheltered or doubled up. The unsheltered count of homeless families is merely a sample of the actual number because it doesn't reflect doubled-up living arrangements.

PERSONS EXITING INSTITUTIONS

Homeless individuals may experience hospitalization. In each instance, plans need to be put in place to ensure that individuals identified as homeless are moved from the s or health system into stable housing. Hospitals Discharge of homeless patients from the health care or mental health system is a concern, particularly those who still need a low level of care to remain healthy. The costs of extending hospital care past discharge can be costly.

FOSTER CARE and OTHER HOMELESS YOUTH

"Today, the typical homeless person in America is a child. If his or her parent was in foster care as a child, chances are one in four that he or she will enter the foster care system before age eighteen. Youth exiting the Foster Care system at age 18 are at extremely high risk of experiencing homelessness due to adverse life experiences, failure to obtain education, lack of life skills, and extremely low incomes. According to the "Foster Youth Transition to Independence Study" conducted by the Office of Children's Administrative Research (2004) within one year of exiting foster care, approximately:

• 13% had experienced homelessness;
• 50% completed high school or obtained A GED;
• Less than 50% were employed; and of those who were employed 47% were making wages at or below the poverty line; and
• 30% were enrolled in at least one public assistance program.

PERSONS WITH SERIOUS MENTAL ILLNESS

Mental illness often makes it difficult for individuals to find and retain housing, maintain employment, and navigate the health, housing, and social service system. Individuals in poverty with mental illness are at increased risk of homelessness. Homeless individuals with mental disorders remain homeless for longer periods and have less contact with family and friends. Mental illness prevents individuals from carrying out essential aspects of daily life, such as self- care, household management, and interpersonal relationships. Mental health treatment for this population is critical to maintaining housing stability.

PERSONS WITH SERIOUS SUBSTANCE ABUSE ISSUES

While most individuals affected by substance abuse never become homeless, those who are in poverty and addicted are clearly at increased risk. Untreated disorders contribute to homelessness. For many, the onset of an addictive disorder may be the catalyst to homelessness. For individuals who are addicted and homeless, the addiction may be prolonged by the very life circumstance in which they find themselves. Alcohol and drug use distract from activities oriented toward stability.

PERSONS WITH CO-OCCURRING DISORDERS

Persons with a co-occurring mental illness and substance abuse disorder are much more likely to be jailed or homeless. An estimated 50% of homeless adults with serious mental illness have a co-occurring substance abuse disorder. Meanwhile, 16% of jail and prison inmates are estimated to have severe mental and substance abuse disorders. Among detainees with mental disorders, 72% also have a co-occurring substance abuse disorder.5

PERSONS WITH HIV/AIDS

For homeless individuals living with HIV/AIDS the conditions of homelessness are even more dire. The impact of HIV/AIDS on a person's immune system makes homelessness a serious health risk. Homeless shelters, while they provide respite from the elements are often a significant threat to people with HIV/AIDS. Shelter conditions can expose people with HIV/AIDS to dangerous and even life threatening infections such as hepatitis A, pneumonia, tuberculosis, and skin infections. Homelessness not only puts individuals with HIV/AIDS at a high risk of contracting an infection, it also makes obtaining and using common HIV/AIDS medications more difficult. Antiretroviral medications used to treat HIV come with demanding and rigorous regimens. Without stable housing, access to clean water, bathrooms, refrigeration, and food, the likelihood of taking the medication on a regular schedule, which is vital for proper treatment, is severely impaired.

UNACCOMPANIED YOUTH

Homeless, unaccompanied youth are youth under age 18 who are not living with a parent or guardian. In our CoC most unaccompanied youth are living with family or friends. HUD recently included unaccompanied youth who are couch surfing or doubled up in their definition of homelessness under the Department of Education but not under the HEARTH Act. However, this population is inherently difficult to count in our community since there are no shelters in our CoC for homeless youth. Additionally, homeless unaccompanied youth generally run away from home due to abuse, and typically do not want to be found. For this reason it is difficult to engage this population in services. Youth who are homeless under the Department of Education are not eligible for services funded by the HEARTH Act. This makes it difficult to provide services.

VETERANS

Nationally, approximately 12% of the homeless population are veterans. Veterans are released from duty, often with Post Traumatic Stress Disorder (PTSD) and other mental health conditions, Traumatic Brain Injury (TBI), injuries and other physical disabilities, and substance abuse disorders they've acquired in order to cope. Veterans can have trouble finding work when they return due to limited transferable skills. While homelessness among veterans has long been a problem, the Veteran's Administration has enhanced services for all veterans since the wars in Iraq and Afghanistan have produced alarmingly high numbers of veterans that are finding it difficult to successfully reintegrate when their service to the country is done.

VICTIMS OF DOMESTIC VIOLENCE

A sizable portion of the population in poverty experience domestic violence at any given time. Without housing support, many of those in poverty are at risk of homelessness or continued violence. Lack of affordable housing and long waiting lists for assisted housing mean that people experiencing domestic violence may be forced to choose between abuses at home and those they may face on the streets. Frequently, shelters are filled to capacity and must turn away people experiencing domestic violence. Shelters provide immediate safety to those affected by domestic violence and help individuals gain control over their lives.

Section 4 QUANTIFYING HOMELESSNESS

Our CoC attempts to quantify the number of people experiencing homelessness in our region by using the following measures:

- The Homelessness Management Information System (HMIS)
- Coordinated Assessment for homeless housing programs
- Point in Time Survey
- Regional Office of Education homeless student count

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

The US Department of Housing and Urban Development requires every Continuum of Care in the country to enter data into the Homeless Management Information System (HMIS). Every agency and program that receives funding from HUD are required to enter data about their clients into HMIS. This includes prevention programs, emergency shelters, transitional housing and permanent supportive housing. HMIS can be used to generate reports, input case notes, and make referrals to other agencies.

COORDINATED ASSESSMENT

Our CoC began planning for Coordinated Assessment in October 2014. In 2015 the first phase of Coordinated Assessment began. Prior to this time, families and individuals seeking shelter or supportive housing programs had to call every agency in the community, often from outdated lists, until they found an opening; and the agency with the opening wasn't always the best fit. Now, people seeking help need only call one agency where they will be screened for eligibility, and assessed for proper placement. This will yield better data on the demographics of those seeking assistance.

POINT IN TIME SURVEY

The point in time survey is a snapshot of people experiencing homelessness during a 24-hour period in January. It is not and never has been an actual representation of the real number of people experiencing homelessness in the community. At best, it can be considered today's estimate of a continually moving target. The point in time survey has several limitations. We are required to use a very limited definition of homelessness that does not include people in unstable housing situations, such as being doubled up or in an overcrowded situation. Even if we could count this population, getting an accurate count would be impossible due to the hidden nature of this population.

HOMELESS STUDENTS

School districts across the country are federally mandated to provide transportation, enrollment and other assistance to children experiencing homelessness with their families, or unaccompanied. The idea is to maintain consistency in the child's education, despite the instability of homelessness. This mandate is woefully underfunded, and school districts spend significant amounts of money transporting homeless

students to their school of origin. School districts track each student they assist throughout the school year, Hoping Krista or Eileen Worthington can help with this section by giving numbers for each county.

Section 5: Current Housing and Services

Throughout our CoC there are non-profit, community-based agencies providing housing opportunities and services to homeless individuals and families. Services are targeted to certain geographic areas. Some agencies focus on families and others on subpopulations with special needs such as domestic violence victims and the mentally ill. The housing opportunities and services cover a continuum of services from prevention to permanent affordable housing.

PREVENTION

In general, services have included short and long-term rental assistance, short and long-term case management, basic financial literacy workshops, and utility assistance.

DIVERSION

This is a new component to our continuum, inspired by the HEARTH Act. Our CoC will begin diverting Category 4 households from time-limited supportive housing (emergency shelter and transitional housing) and placing them directly into permanent affordable housing or permanent supportive housing. Category 4 households are those fleeing or attempting to flee domestic violence or other life threatening situations.

EMERGENCY SHELTER

Emergency shelter includes any facility, with the primary purpose of providing temporary shelter for all people experiencing homelessness or specific sub-populations. Most funding sources limit shelter stays to 90 days.

TRANSITIONAL HOUSING

Transitional housing is time-limited supportive housing with a stay of 91 days to 24 months. Supportive services are typically provided by the organization managing the housing, and are designed to help the household achieve self-sufficiency. Transitional housing can be provided in one structure, in several structures at one site, or in multiple structures at scattered sites.

PERMANENT SUPPORTIVE HOUSING

Permanent supportive housing is long term, community-based housing that provides supportive services for low income or homeless people with developmental disabilities, severe mental illness, substance abuse, or HIV/AIDS. This type of supportive housing enables special needs populations to live as independently as possible in a permanent setting. Supportive services may be provided by the organization managing the housing, or coordinated by the housing provider and provided by other public or private service agencies.

AFFORDABLE HOUSING

Housing is considered affordable when the household is paying no more than 30% of their income toward rent or mortgage and utilities. In order for market rate housing to be affordable to low and extremely low income households, a subsidy is necessary. Affordable housing can be publicly or privately owned, is permanent, with the household holding the lease. Low income housing is a type of affordable housing that is specifically designed to be affordable to people earning less than 50% of the area median income. This is achieved by securing funding for operating subsidies rather than subsidies attached to individual tenant households.

HOUSING FOR HOMELESS INDIVIDUALS AND FAMILIES IN WEST CENTRAL ILLINOIS

Once a family or individual becomes homeless, they are eligible to receive housing and assistance through a variety of programs funded with federal, state, and local resources, as well as foundation funding. The current inventory of units programmed to provide shelter and housing for people experiencing homelessness includes a wide variety of models. Dormitory-type housing and single-family housing units provide emergency shelter beds and transitional housing for individuals and families. Single- family homes and apartments provide transitional units for individuals and families. Scattered site apartments provide permanent supportive housing for people with disabilities. All housing units serving the homeless have some level of public subsidy. There are, however, limited resources that concentrate on preventing homelessness, such as rental assistance programs or foreclosure prevention activities. All known subsidized housing programs have waiting lists and always report utilization near 100% of existing capacity. In addition, clients often need supportive services, and those programs typically operate at capacity and still do not meet the demand for those services. Sometimes the households receive financial assistance through the Section 8 program for rental of private sector units. In other cases, they may move into a federally funded public housing unit or a unit built with federal, state, or local funding which ensures affordability. Homeless housing and assistance programs will continue to be overwhelmed unless the general need for housing affordability is addressed.

The 2015 Housing Inventory Count for our CoC list the following homeless beds and units available to assist homeless individuals and families:

- Number of beds for households with children: 166
- Number of beds for households w/o children: 130
- Number of beds for households with children only: 8
- Number of total year-round beds: 304
- Number of overflow beds: 82
- Total year-round and overflow beds: 386
- Number of Emergency Shelter beds: 163
- Number of Emergency Shelter that are motel vouchers: 82
- Number of Emergency Shelter that are for victims of domestic violence: 49

- Number of Transitional Housing: 125
- Number of Permanent Supportive Housing: 98
- Number of Transitional Housing Beds for ages 18-24: 14
- Number of Emergency Shelter beds for ages 18 an under: 8
- Number of beds that prioritize Chronic Homeless: 34

Section 6: Cross System Collaboration

In order to be client centered, existing barriers to necessary services must be removed. While we have made progress engaging certain mainstream systems such as mental health, there is much work to be done in engaging several other systems.

CHILD WELFARE AND FOSTER CARE

Families involved with the child welfare system are sometimes homeless or at significant risk of losing their housing. These families often face a "Catch 22". In order for parents to reunite with their children once they have been put into foster care, they must have stable housing. Unfortunately, subsidized housing programs often require that parents have their children in their care in order to qualify. If safe reunification is not possible, children remain in foster care until they turn 18, whether they are ready to be independent or not. According to a national survey, 25% of foster youth reported that they had been homeless at least one night within 2.5 to 4 years after exiting foster care.

PUBLIC EDUCATION

Education is critical to obtaining and maintaining living wage employment. The West Central Illinois CoC has an established, working relationship with the public school district's McKinney-Vento homeless education liaisons in our CoC to focus resources on households working to exit or avoid homelessness. Federal law requires school districts to identify and assist homeless school age children and their families. School districts are also required to provide transportation to and from the school or district the student attended before becoming homeless. One of the goals of this plan is to provide assistance to families so they can remain in their school district of origin to minimize educational and family disruption.

EMPLOYMENT

Living wage employment is critical to obtaining and maintaining housing. Yet many individuals seeking homeless assistance from providers in our CoC lack the basic skills to obtain employment. Through its community assessment, the United Way of Adams County formed the Adams County Work Readiness team to address this barrier to employment. The Adams County Work Readiness team consists of business, education and social service representatives from across Adams County. The group's mission is to develop work ready citizens to become successful, productive members of the regional workforce. The team developed the Work Ready Toolbox that is available to individuals and agencies that work with low-income workers and job seekers to improve their job readiness skills. The United Way of Adams County has representation on the West Central Illinois CoC and chairs its Research and Evaluations Committee. Adams County is the county with the highest population in our CoC. In the 2015 Point in Time Count Adams County reported the highest number of sheltered and unsheltered homeless in our CoC. Although the Adams County Work Readiness initiative is unique to Adams County, it does help address the highest number of homeless in our CoC.

TRANSPORTATION

Housing providers report that one of the biggest barriers to self-sufficiency for their clients is transportation to and from work. Housing near job centers is often unaffordable for low wage earners, forcing them to live far from where they work. While the housing may be affordable in less populated areas, finding and affording transportation to and from work is a huge challenge for low wage earners. Meanwhile, public transportation systems throughout the state are forced to implement service reductions and eliminations in response to budget cuts.

AFFORDABLE, QUALITY CHILDCARE

Another significant barrier to self-sufficiency and a positive work experience is the lack of affordable, quality child care. Until this year, low-income families were eligible for child-care assistance through the Department of Human Services. The State of Illinois recently adjusted its eligibility for child-care assistance programs. The results are that many working families no longer qualify for this subsidy creating a deepened financial burden on the families. The burden is so significant that some family members had to resort to leaving the workforce to care for their families. In other situations, families are forced to leave their children with inappropriate caregivers to continue employment. This drastic cut to child-care assistance has also forced daycares to close.

VETERANS

The United States Veterans Administration (VA) is making substantial investments in homelessness prevention and supportive housing for veterans. Homeless prevention and housing providers are working to identify veterans as they seek assistance, and connect them with the appropriate VA caseworkers.

PUBLIC BENEFITS

Many people who are homeless or at risk of homelessness receive some sort of public assistance, such as Unemployment Insurance Benefits, Temporary Assistance for Needy Families (TANF), Supplemental Nutrition Assistance Program (SNAP/food stamps), Supplemental Security Income (SSI) and Supplemental Security Disability Income (SSDI). It is important to work with the administrative bodies for these benefits to identify shared clients, and work together to help them achieve their highest level of self-sufficiency. Unfortunately, some key public benefits are ending or being significantly reduced, thereby increasing the risk of homelessness for recipients.

HIGHER EDUCATION

Access to higher education will be the key to living wage jobs for many households. Grants to community and technical colleges and Department of Education funded programs that assist low-income prospective students get enrolled in community and technical colleges. Unfortunately, unprecedented increases in tuition costs coupled with decreased tuition assistance are placing additional barriers to higher and technical education for people experiencing and at risk of homelessness.

Section 7: STRATEGIC PLAN GOALS AND OBJECTIVES

The West Central Illinois CoC strategic plan will be guided by Opening Doors "Presented to the Office of the President and Congress on June 22, 2010. Opening Doors is the nation's first comprehensive strategy to prevent and end homelessness. Opening Doors serves as a roadmap for joint action by the 19 USICH member agencies along with local and state partners in the public and private sectors. The plan puts us on a path to end Veterans and chronic homelessness by 2015; and to ending homelessness among children, families, and youth by 2020. The Plan presents strategies building upon the lesson that mainstream housing, health, education, and human service programs must be fully engaged and coordinated to prevent and end homelessness." United States Interagency Council on Homelessness, www.usich.gov.

The West Central Illinois CoC will develop a strategic plan that aligns with Opening Doors. Our CoC will use CoC Planning grants to acquire the technical assistance and make any necessary changes to our Homeless Management Information System (HMIS) to track performance measures outlined in Opening Doors. Our CoC will utilize the Toolkit for Ending Homelessness-Featuring the Ten Essentials for Ending Homelessness in Your Community provided by The National Alliance to End Homelessness.

GOALS AND OBJECTIVES of OPENING DOORS STRATEGIC PLAN TO END HOMELESSNESS

Our CoC's Research and Evaluation Committee will create a workgroup to develop a written strategic plan that aligns with Opening Doors. This Strategic Plan Workgroup will have representatives and input from all the groups affected by the social issue of homelessness: government officials, business leaders, community activists, and other advocates for homeless populations. The SP Workgroup will make every effort to include representatives of each county within the CoC. However, our CoC is comprised of 11 counties throughout West Central Illinois. Our CoC Council membership is representative of the three counties with the largest population. In order to identify and assign the individuals, committees, or organizations that should be responsible for overseeing implementation of specific strategies to prevent and end homelessness, the CoC will seek technical assistance from the Illinois Institute for Rural Affairs. IIRA will identify the key persons/entities for our CoC and provide their recommendation of workgroup members to the Council.

The Strategic Plan will include target completion dates, applicable HEARTH Act performance measures, and the entities responsible for implementing the objectives. We anticipate completing this systems change work within three years (2018).

HEARTH Act Performance Measures:

A. Reduce average length of time persons are homeless
B. Reduce returns to homelessness
C. Improve program coverage of homeless population
D. Reduce numbers of families and individuals who are homeless

E. Improve employment rate and income amount of families and individuals who are homeless
F. Reduce number of families and individuals who become homeless (first time homeless)
G. Prevent homelessness and achieve independent living in permanent housing for families and youth defined as homeless under other Federal statutes.

TEN ESSENTIALS FOR ENDING HOMELESSNESS IN YOUR COMMUNITY

The National Alliance to End Homelessness has created the following checklist as a guide to help communities identify the minimum requirements for an effective permanent solution to prevent and end homelessness. The essentials are based on the Alliance's Ten Year Plan to End Homelessness which draws from over 20 years of research and experience with communities around the country. No essential is more important than another. All require participation from every sector of the community.

It is important to note that West Central Illinois CoC already has many of the essentials in place and many essentials are in the planning stages.

- **Plan**
  Devise a plan of action. The Alliance's Ten Year Plan to End Homelessness is a good place to start – a comprehensive, systematic approach to addressing the different facets of homelessness. While planning, it is important to have representatives and input from all the groups affected by this social issue: government officials, business leaders, community activists, and the like. Every solution starts with a plan.

- **Data**
  Before moving forward, it's imperative to fully understand the problem. With homelessness, that can be a tall order, as the social problem is influenced by the economy, geography, transportation, and a host of other elements. Luckily, most communities conduct a biannual point in time census and have a Homelessness Management Information System (HMIS), required by the Department of Housing and Urban Development (HUD). HMIS collects data about those who interact with the homeless assistance system, and this information can be helpful in understanding the homeless population better and addressing their specific needs. **Our CoC has an established HMIS.**

- **Emergency Prevention**
  As with most things, the most economical and efficient way to end homelessness is to prevent it from happening in the first place. Consider enacting programs and policies that will do just that. Many existing social programs connect vulnerable populations with emergency services, temporary cash assistance, and case management. Consider ways to integrate with these existing systems or adopt your own.

- **Systems Prevention**
  Many people who fall into homelessness do so after release from state-run institutions, including jail and the foster care system. Still others come to homelessness from mental health programs and other medical care facilities. By creating a clear path to housing from those institutions—in the form of case management, access to services, or housing assistance programs—we can reduce the role that state-run institutions play in creating homelessness.

- **Outreach**
  An important role in ending homelessness is outreach to people experiencing homelessness. A key ingredient to this outreach is the ability to connect the homeless population to housing and services. When considering outreach efforts, it's important to understand that many people living on the streets exhibit mental illness, substance addiction, and other negative behavior patterns. As such, it's important to consider low-demand housing that does not mandate sobriety or treatment.

- **Shorten Homelessness**
  A successful homeless assistance program not only works to end homelessness, but minimizes the length of stay in shelter and reduces repeat homeless episodes. In order to do this, assistance programs must align resources to ensure that families and individuals have access to the services necessary to achieve independence as quickly as possible. This often requires immediate

access to housing, home-based case management, and incentives embedded into the homeless assistance system to promote these outcomes.

- **Rapid Re-Housing**
  Navigating the housing market, especially on behalf of clients with lower incomes and higher needs, is a difficult task. A successful homeless assistance program has housing staff that help with just that. Housing locators search local housing markets and build relationships with landlords. Successful program components include incentives to landlords to rent to homeless households, creative uses of housing vouchers and subsidies to help homeless individuals and families afford their rental unit, and links to resources to help clients maintain their housing.

- **Services**
  Services are actually more accessible than they sound – many of them already exist in the community. By and large, homeless individuals can access mainstream programs, including Temporary Assistance to Needy Families (TANF), Supplemental Security Income (SSI), Medicaid, and other existing federal assistance programs. Connecting families and individuals exiting homelessness to these programs is imperative to ensuring their continued independence.

- **Permanent Housing**
  At its root, homelessness is the result of the inability to afford and maintain housing. Remember that any plan to end homelessness must incorporate an investment in creating affordable housing. This includes supportive housing, which is permanent housing coupled with supportive services. This is often used for the chronically homeless population - that is, people experiencing long-term or repeated homelessness who also have mental or physical disabilities.

- **Income**
  In order to maintain housing, people exiting homelessness must have income. Cash assistance programs are available through federal and state government, and career-based employment services can help formerly homeless people build the skills necessary to increase their income. Mainstream services, including the Workforce Investment Act, should be used for this purpose.

GOAL 1: CENTRALIZE ENTRY, INTAKE AND REFERRAL
1.1 Create a Centralized Intake System
1.2 Match those in need of Prevention or Re-Housing to the provider that best fits their circumstances.
1.3 Tailor centralized intake services to the specific needs of each individual or family.

GOAL 2: PREVENT HOMELESSNESS AND RAPIDLY RE-HOUSE THOSE WHO BECOME HOMELESS
2.1 Make a systemic shift to homelessness prevention and rapid re-housing, including conversion of transitional housing.
2.2 Coordinate and expand prevention and rapid re-housing resources through ESG and CoC funds.

GOAL 3: DEVELOP AFFORDABLE AND PERMANENT SUPPORTIVE HOUSING
3.1 Advocate for funding and policy actions that will increase the supply of affordable and permanent supportive housing.
3.2 Guide the development of affordable and permanent supportive housing

GOAL 4: PROVIDE TAILORED SUPPORTIVE SERVICES AND TREATMENT IN HOUSING AND PREVENTION PROGRAMS
4.1 Ensure homeless housing and service organizations are tailoring their services to the needs of their clients.

4.2 Coordinate the provision of tailored services and treatment across agencies and systems.
4.3 Advocate for funding and policy actions that will facilitate the provision of tailored services and treatment.

GOAL 5: ENGAGE SYSTEMS DESIGNED TO IMPROVE ECONOMIC AND EDUCATIONAL OPPORTUNITIES.
5.1 Create/enhance intensive employment and education navigation services for target population.
5.2 Build cross-system partnerships between homeless housing/services and workforce development providers.
5.3 Develop a cadre of employers receptive to working with the target population.
5.4 Provide capacity-building training and technical assistance to agencies serving target population to ensure staff members have resources to connect clients to economic opportunities.
5.5 Provide opportunities for consumers to increase their own economic opportunities.
5.6 Evaluate the effectiveness of employment and education programs and incorporate learning into program improvements.

GOAL 6: FACILITATE THE CONTINUED DEVELOPMENT OF A HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS) THAT ACCURATELY CAPTURES NEED AND IS USEFUL TO END USERS
6.1 Use HMIS data system to collect data designed to track the seven performance measures of Opening Doors.
6.2 Use HMIS data system to collect information on the need for services in our CoC.
6.3 Ensure real-time data is available in the system.
6.4 Ensure HMIS data system is designed to provide end users with reports they will find helpful.

Certified as approved by West Central Illinois Continuum of Care Consortium's governing board, West Central Illinois (WCI) Homeless Assistance Council on November 6, 2015.

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