How Winston-Salem/Forsyth County, NC, Achieved an End to Veteran Homelessness

By Andrea Kurtz, Senior Director of Housing Strategies, United Way of Forsyth County

Overview

Forsyth County covers 413 square miles in the northwestern part of North Carolina, and includes the city of Winston-Salem. According to U.S. Census Bureau estimates, the population of Forsyth County was 371,511 in 2016, of which 7%, or 24,562, were Veterans. In 2016, 1,558 people experiencing homelessness sought help from HMIS-participating agencies in our county. About 144 were Veterans. While we saw a 3% decrease in our population of people experiencing homelessness overall from the prior year, we had an 18% decrease in Veteran homelessness.

Our community has one 24-bed Grant and Per Diem program that serves Veterans with disabilities. We are served by the W. G. (Bill) Hefner VA Medical Center, which is located outside our county in Salisbury, North Carolina.

When and why did you decide to tackle this issue?

In 2007, when our community began implementing our strategic plan, The Winston-Salem/Forsyth County Ten Year Plan to End Chronic Homelessness, we saw that Veterans were significantly over-represented among our population of people experiencing homelessness in general, and specifically among those experiencing chronic homelessness. At the time, we began discussions and evaluations of how to best address this disparity. In 2014, our Mayor, Allen Joines, was one of the first mayors to commit to the Mayors Challenge to End Veteran Homelessness.

Who were the most important partners to have at the table?

As we began our work on ending Veteran homelessness, we first took time to define which "table" we would gather people around in order to develop plans on addressing the needs of Veterans experiencing homelessness. Our community was committed that the "table" was the Winston-Salem/Forsyth County Continuum of Care (CoC), and that while we may break off into side conversations, the primary work would be done through the structure of our CoC.

In assessing who needed to be a part of the conversation, we identified three subsets of providers: 1) Veteran service providers; 2) homelessness service providers; and 3) key mainstream service providers and sectors. Within these categories, we identified:

Veteran Service Providers

- Veterans Affairs HUD-VASH and Grant and Per Diem program staff, outreach workers, Homeless Liaisons, and key staff from the Veteran Benefits Administration
- Veterans Helping Veterans Heal, our local Grant and Per Diem program
- Forsyth Rapid Re-Housing Veterans Program
- Local Veteran service organizations

Homelessness Service Providers

- Area homeless shelters, including shelters for single adults and families
- Forsyth Rapid Re-housing Collaborative
- Experiment in Self Reliance, our local community action agency

Other Mainstream Services and Sectors

- Housing Authority of Winston-Salem
- Forsyth County Department of Social Services
- Goodwill Industries of Northwest North Carolina
- Vocational Rehabilitation
- Private Landlords
- Local businesses

In addition to these key players, who were the primary developers of our plans, we had unwavering support from Mayor Joines' Office. His contribution to maintaining the political will, not just from local elected officials, but more generally across the community, helped make the work of system improvement that much easier.

What key strategies do you use to identify all Veterans experiencing homelessness (criteria 1)?

Part of our groundwork was to make sure that we had a system to identify all known Veterans experiencing homelessness, whether they are on the streets, in shelters, or couch surfing. In order to do that, the core team identified all of our CoC's outreach teams/resources and sites in the community where we knew we could find Veterans experiencing homelessness in order to educate these staff on "who and how" people should be referred to our community's coordinated assessment system for homeless Veteran services. Key partners in this work include the Veterans Affairs Homeless Outreach staff, the Homeless Liaison at our public library, The Empowerment Team (a local street outreach team), our local managed care entity, and our winter overflow emergency shelter provider.

As with most of our improvements, the first step was relationship building between staff at the different agencies and cross training them on the different resources and interventions each organization had available. In addition, we worked with all the staff at each partner to focus on connecting anyone that they thought was a Veteran—or even might be a Veteran—to our coordinated intake center, where they could be more thoroughly assessed.

What key strategies do you use to provide shelter immediately to any Veteran experiencing unsheltered homelessness who wants it (criteria 2)?

The most important strategy we use to ensure that all Veterans experiencing unsheltered homelessness are offered shelter is communication. This includes communication among all the outreach staff in our community—whether they are doing street outreach or working at the public library—to know what shelter services are available in our community and how to connect a Veteran to these services. All outreach staff always ask an unsheltered person if they would like to come into shelter, and if a Veteran indicates they do, to help facilitate them getting connected to the right shelter. If the Veteran chooses not to come in, outreach staff encourage them to at least consent to connecting to Coordinated Assessment so they can get connected to supportive housing programs.

If we know there is an unsheltered Veteran in our community, we make a concerted effort to have outreach staff connect with them on a regular basis to continually offer shelter options while a permanent housing strategy is implemented.

What key strategies do you use to make sure your community only provides service-intensive transitional housing in limited instances (criteria 3)?

In our CoC, we see transitional housing programs not as a broadly needed stepping stone to permanency, but rather as a critical specialized service to be used when other permanent options have proven unsuccessful because of an individual's needs, generally around substance abuse and mental health issues. We have a very limited number of service-intensive GPD beds. These beds, while technically open to any Veteran from our VA Medical Center's catchment area, primarily focus on serving Veterans from our CoC and the surrounding counties from our Balance of State who have significant needs for substance abuse and mental health services. The CoC, VA, and GPD staff maintain regular conversations about keeping the work of the GPD focused on Veterans who are in need of intensive services because other interventions, such as permanent supportive housing or rapid re-housing, have proven unsuccessful.

What key strategies do you use to make sure your community has the capacity to assist Veterans to swiftly move into permanent housing (criteria 4)?

Our coordinated assessment system is our primary driver for moving Veterans quickly into permanent housing. Once we have identified an individual as a potential Veteran, we can usually verify their discharge status and any active duty periods within 24 hours, which helps our coordinated assessment staff better understand which programs they may be eligible for. From there, our coordinated assessment staff can connect the Veteran, based upon our CoC-adopted housing prioritization plan, into a housing program that offers the least intensive services necessary to help stabilize the Veteran and their family in permanent housing. We work very closely with the VA to ensure that there is coordination between our coordinated assessment and the VA's intake staff.

What key strategies do you use to make sure you have the resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future (criteria 5)?

With our SSVF program, we offer a limited amount of prevention services for Veterans. In addition, our CoC has developed a process of continuous quality improvement. This process continually monitors our performance data and evaluates the needs and gaps in our system both for Veterans and non-Veterans. Through our quarterly action planning meetings, we are able to develop short, medium, and long-range plans to ensure that our system is able to meet the emergent needs of people in our community facing a housing crisis.

What are the top three things your community has done to make sure you are sustaining your progress?

1) Build and invest in relationships
2) Focus on continuous improvement
3) Monitor resource use and allocation to make sure that we have the right resources reaching the right populations of Veterans