



Seattle-King County Continuum of Care Board Application

Please complete the entire form and email to coc.questions@kcrha.org.

CoC Board Member Expectations and Commitment

CoC Board members are expected to attend one regular meeting and participate in one subcommittee or workgroup each month, in addition to any special meetings that require a CoC Board vote. Responsibilities also include reading and responding to emails and phone calls, as well as completing other administrative tasks – up to 15 hours per month. All applicants must be able to commit to a minimum two-year term.

General Information	
Full Name & Pronouns:	Mercy wainaina
Phone:	[REDACTED]
Email Address:	[REDACTED]
Zip Code:	98036
Are you able to commit up to 15 hours a month for the 3-year duration?	Yes
Please indicate which seat you are applying for:	Homeless Service Provider
Please indicate the King County region you primarily represent. (Select one).	North King County
Please indicate the sub-population(s) you directly represent.	Veterans, Disability Community, Elders (55+), Youth and Young Adults (up to 24), Families, Domestic Violence or Intimate Partner Violence

Application Questions

1. Please describe how you are a representative of the seat for which you are applying.

I am a strong representative for this seat because my professional work directly aligns with the populations and systems this role is meant to serve. As a psychiatric provider, I have extensive experience working with individuals impacted by mental health disorders, substance use, and homelessness—often at the intersection of all three.

In my current role, I lead and provide comprehensive wraparound services that go beyond traditional clinical care. This includes psychiatric medication management, substance use disorder treatment, individual and group therapy, peer support, housing coordination, and transportation assistance. I work closely with individuals across different stages of recovery, including those transitioning from incarceration and those facing significant barriers to stability.

This hands-on experience gives me a practical understanding of both the challenges clients face and the gaps within our systems of care. I regularly collaborate with community partners, correctional facilities, and social service agencies, which allows me to bring a well-rounded, solutions-focused perspective to the table.

I would represent this seat by advocating for integrated, person-centered approaches that address not only clinical needs but also the social determinants of health. My goal is to ensure that policies and decisions are grounded in real-world experience and truly support long-term recovery, stability, and dignity for the individuals we serve.

2. Tell us how you use your influence, authority, or relationships within your representative community or sector to effect change. Please include a specific example.

I use my influence, professional authority, and community relationships to build bridges between systems that often operate in silos—particularly behavioral health, corrections, and housing. By maintaining active partnerships with case managers, social workers, community organizations, and correctional facilities, I am able to advocate for timely, coordinated care that directly impacts client outcomes.

In my role, I also have the authority to shape clinical and operational decisions within our program. I use that position to implement person-centered, trauma-informed approaches and to ensure that services are responsive to the real needs of the population we serve, rather than rigid system limitations.

A specific example of this is my work with individuals transitioning from incarceration into the community. Many of these individuals are at high risk for relapse, psychiatric decompensation, and homelessness due to gaps in continuity of care. Through established relationships with jail social workers and reentry coordinators, I helped develop a streamlined referral and intake process into our wraparound program prior to release. This allows us to coordinate housing placement, initiate or continue psychiatric medications, and connect clients to peer support and therapy immediately upon reentry.

As a result, we have been able to reduce delays in care, improve treatment engagement, and support more stable transitions into the community. This kind of systems-level coordination is how I actively use my influence and relationships to create meaningful, measurable change.



3. Please describe your understanding of the Continuum of Care (CoC).

A Continuum of Care (CoC) is a coordinated, community-based system designed to address homelessness by ensuring that individuals and families have access to a full range of housing and supportive services, from crisis response to long-term stability. It is not just a single program, but a structured network of providers, agencies, and stakeholders working together to deliver integrated, person-centered care.

My understanding is that a CoC includes several key components: outreach and engagement for unsheltered individuals; emergency shelter and crisis services; transitional and supportive housing programs; and permanent housing solutions such as rapid rehousing and permanent supportive housing. It also emphasizes coordinated entry systems to prioritize individuals based on vulnerability and need, ensuring that resources are allocated equitably and efficiently.

Beyond housing, an effective CoC integrates supportive services such as mental health care, substance use disorder treatment, medical care, employment support, and case management. This is critical because homelessness is often driven by a combination of behavioral health challenges, economic instability, and systemic barriers.

In my work providing wraparound behavioral health services, I actively operate within this continuum by collaborating with housing providers, correctional systems, and community partners to ensure continuity of care—particularly for individuals transitioning from incarceration or acute crisis. I see the CoC as essential in reducing fragmentation, improving outcomes, and supporting long-term stability by addressing both immediate housing needs and the underlying factors that contribute to homelessness.

4. What motivates you to be on the CoC Board? Please share your specific field of interest related to the CoC.

I am motivated to serve on the Continuum of Care (CoC) Board because I see, every day, the real impact that housing instability, untreated mental health conditions, and substance use disorders have on individuals and communities—and I also see what works when systems are aligned.

In my work providing wraparound behavioral health services, I support individuals who are often cycling through homelessness, incarceration, and acute care settings. What motivates me is the opportunity to help shift that cycle by contributing to a system that prioritizes coordination, equity, and long-term stability. Being on the CoC Board would allow me to bring frontline insight into decision-making, ensuring that policies and funding priorities reflect the actual needs and barriers faced by the people we serve.

I am particularly driven to advocate for stronger integration between housing and behavioral health services, as well as improved transitions for individuals reentering the community from institutional settings. I believe that stable housing, combined with accessible and consistent support services, is foundational to recovery and overall well-being.

Ultimately, my motivation comes from a commitment to creating sustainable, person-centered solutions that not only address homelessness but prevent it—while promoting dignity, recovery, and long-term success for vulnerable populations.



5. Describe your vision or understanding of a successful CoC Board.

A successful Continuum of Care (CoC) Board is one that is collaborative, data-driven, and deeply grounded in the lived realities of the people it serves. It functions as more than a governing body—it acts as a strategic leader that aligns housing, behavioral health, and community resources into a coordinated system that produces measurable outcomes.

In my view, a successful CoC Board ensures that decisions are informed by both data and frontline experience. It uses performance metrics—such as reductions in homelessness, length of time homeless, and rates of permanent housing placement—to guide funding and program priorities, while also incorporating input from providers, community partners, and individuals with lived experience.

6. Describe your leadership experiences and style.

My leadership experience is rooted in both clinical practice and program development, where I oversee and support multidisciplinary teams providing wraparound services to individuals with complex behavioral health and social needs. In my role, I work closely with psychiatric providers, therapists, case managers, and peer support specialists to ensure coordinated, high-quality care across settings including community programs and correctional facilities.

My leadership style is collaborative, structured, and mission-driven. I prioritize clear communication, defined roles, and accountability to ensure that teams function efficiently without duplication or confusion. At the same time, I value input from all team members and create space for diverse perspectives, recognizing that frontline staff often have critical insights into what is and isn't working.

I also take a solutions-focused and adaptive approach. Working with high-acuity populations requires flexibility and the ability to respond quickly to challenges while maintaining consistency in care. I emphasize problem-solving, continuous improvement, and data-informed decision-making to strengthen both clinical outcomes and operational effectiveness.

Additionally, I am committed to mentoring and empowering staff. I support professional growth by providing guidance, setting clear expectations, and encouraging ownership within each role. This not only strengthens team performance but also improves retention and the overall quality of services provided.

Overall, my leadership approach is centered on building strong systems of care, supporting teams to perform at their best, and ensuring that the individuals we serve receive coordinated, person-centered support that leads to long-term stability.



7. Reflecting on the Theory of Change, please describe one way you incorporate this framework in your professional or personal life. Additionally, explain how you would integrate the Theory of Change into your work on the CoC Board and how you intend to advocate for and support the communities you represent.

KCRHA Theory of Change:

If we create a homeless response system that centers people with lived experience, then we will be able to focus on responding to needs and eliminating inequities, in order to end homelessness for all.

In my professional work, I incorporate the Theory of Change by centering services around the actual needs, experiences, and voices of the individuals we serve. Through our wraparound program, we work with people who have lived experience with homelessness, incarceration, mental health conditions, and substance use. Rather than applying a one-size-fits-all model, we actively involve clients in their treatment planning, respect their autonomy, and adapt services based on what is most effective for their stability and recovery. This approach has helped improve engagement, build trust, and reduce barriers to care—especially for individuals who have historically been underserved or marginalized.

For example, when developing care plans, we prioritize client input on housing preferences, treatment goals, and support systems. We also incorporate peer support specialists—individuals with lived experience—into our model to strengthen connection and relatability. This directly reflects the Theory of Change by ensuring that services are not only accessible, but equitable and responsive.

As a Board member, I would integrate the Theory of Change by consistently advocating for policies and funding decisions that elevate lived experience as a critical component of system design and evaluation. This includes supporting meaningful inclusion of individuals with lived experience in leadership roles, advisory groups, and decision-making processes—not just as participants, but as partners.

I would also advocate for data-driven strategies that identify and address disparities in access, outcomes, and resource allocation. By aligning funding with programs that demonstrate equity-focused, person-centered approaches, the Board can help shift the system toward more effective and sustainable solutions.

Ultimately, I intend to support the communities I represent by ensuring their voices are heard, their needs are prioritized, and the systems designed to serve them are accountable, inclusive, and responsive. Grounding this work in the Theory of Change will help move us closer to a coordinated system that not only responds to homelessness but actively works to eliminate the inequities that sustain it.

6. Do you require any accommodations or support to fully participate as a member of the CoC Board?

No

