HOMELESSNESS IN KNOXVILLE/KNOX COUNTY: 2010

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Sponsored by the Knoxville/Knox County Homeless Coalition

1985-2010

In Memory

Calvin N. Taylor, Jr.

June 28, 1958 – November 3, 2009

Calvin Taylor was director of the *Homeward Bound Program at Knoxville-Knox County Community Action Committee* for 18 years. He was a leader in community social services. He served as president of the *Knoxville-Knox County Homeless Coalition* and was on the task force that developed the *Ten Year Plan to End Chronic Homelessness*. During the past eighteen years, Calvin was instrumental in planning and conducting the biennial studies of homelessness. This year, interviewers wore blue ribbons on their lapels in memory of Calvin.

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CASE CONTRIBUTORS

Special appreciation is extended to the following persons who contributed case examples for the 2008 and 2010 studies. These examples added to the report by helping to "put a face" on homelessness. The cases are not based on responses to the questionnaire, but are composites of individuals who are homeless.

Jamie Brennan

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I. INTRODUCTION

Homelessness in Knoxville/Knox County 2010 is the fourteenth study of homelessness in Knoxville and Knox County sponsored by the Knoxville/Knox County Homelessness Coalition and highlights twenty-four years of collecting data. The first study was conducted in 1986 with regular studies conducted biennially thereafter, plus two smaller intermediate studies. When initially appointed in November 1985 as the Knoxville Coalition for the Homeless, the coalition was charged with three major responsibilities: (1) to ascertain the extent of homelessness in Knoxville, (2) to determine services available to the homeless and make recommendations concerning deficient or nonexistent services, and (3) to increase communication and coordination of services among existing agencies and organizations working with the homeless. The coalition continues to meet on a monthly basis and in addition to sponsoring studies, serves as a forum for exchange of ideas and information. It has taken an increasingly active community role through public education activities, supporting development of the *Ten Year Plan to End Chronic Homelessness*, and developing housing for the homeless.

A number of significant activities continue in Knoxville and Knox County. The Ten Year Plan to End Chronic Homelessness developed at the request of Knoxville Mayor Bill Haslam and Knox County Mayor Mike Ragsdale represents the first community plan to address homelessness in a comprehensive, coordinated manner. The plan's central theme, *Housing First*, is a different approach to homelessness and builds on agencies' efforts that have evolved to get persons out of homelessness rather than focusing on easing their discomfort on the streets. Previous studies have noted the changing orientation of shelters

and agencies, from providing emergency or crisis services to assisting homeless persons to become stabilized in permanent housing.

Organizations serving the homeless are engaging in greater coordination and cooperation. For example, *The Salvation Army* discontinued overnight transient shelter, allowing *Knox Area Rescue Ministries (KARM*) to assume total responsibility for emergency shelter. KARM has opened the *Crossroads Welcome Center, Volunteer Ministry Center i*s in its new facility providing intensive case management, and the *Coordinated Care of Difficult Cases* group meets on a regular basis and Minvilla Manor has opened.

The development of the *Homeless Management Information System (HMIS)* offers a means of greater service coordination and accountability. Fourteen agencies are participating and *HMIS* continues to be in discussion with potential partners and others planning to join the system. Approximately 20,000 names have been entered. The *HMIS* is an important management tool for coordinated case management as well as monitoring the extent of homelessness.

This report incorporates much of the narrative from earlier reports. The research findings from 2010 are reported and compared with the 2008 data. The description of resources has been updated. Previous introductory material on definition, causes, and patterns is still quite relevant, with a few additional research citations. One feature initiated in the 2002 study was brief case examples that “put a face” on homelessness, and this is continued in the 2010 study. These composites were submitted by agency staff and do not violate the confidentiality of the respondents or agency clients.

Despite the experience of studying homelessness for more than twenty-four years, a number of variables continue to impact findings: how one defines homelessness, the

transitional nature of homelessness, and the complexity of causes of homelessness. Since the initial research, it has been apparent that any study of homelessness poses a formidable challenge including how one determines methods of enumeration. Likewise identifying contributing factors is a complex task. A brief examination of these factors illustrates the issues.

DEFINITION

How one defines homelessness will have a significant impact on estimated numbers and characteristics. Most studies are limited to counting people who are in shelters or on the streets. In almost every city the estimated number of homeless people exceeds the availability of emergency shelters and transitional housing (U.S. Conference of Mayors 2007; National Law Center on Homelessness and Poverty, 1997 and 2004). These findings along with other available studies suggest that many homeless people may be living with friends or relatives in temporary arrangements (Hoback and Anderson 2006; Wright, Caspi, Moffit, & Silva, 1998). "*Doubled-up housing"* (temporary residence with relatives and friends) may not be included in a definition and subsequent count. Likewise, persons living in single room occupancy hotels (SROs) and in substandard housing, extremely vulnerable to homelessness, are generally not included. The 2007 *AHAR* study (Khadduri, et al., 2007) underscores the high risk of homelessness for persons "doubled up" or precariously housed.

Depending on the definition of homelessness used, persons will be included or excluded from counts; as noted above, definitions may include persons living in single room occupancy hotels (SRO) and/or individuals who stay with friends *("couch population")* as homeless. The term itself homeless is misleading in that it implies that lack of residence is

both the problem and cause, obscuring the broader factors, such as poverty, scarcity of affordable housing and employment, as well as personal disabilities. The most widely utilized definition that has emerged is found in the Stewart B. McKinney Homeless Assistance Act (Public Law 100-77). The act defines homelessness as including persons,

> "who lack a fixed, regular, and adequate nighttime residence. It also includes persons whose primary nighttime residence is either a supervised public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings."

While the above provides a working definition, the reader should be aware that no single definition or characteristic describes all homeless people.

NUMBERS

Attempts to estimate the extent of homelessness have shown wide variation over time. Studies of homelessness are further complicated by problems of methodology. The 1996 and 1998 Knoxville studies summarized the range of findings:

> The *U. S. Department of Housing and Urban Development* estimated that 192,000 were homeless (HUD, 1984); in contrast housing activists argued that 3.2 million persons were homeless (Holmes and Snyder, 1982). Later, 1990 government materials relied on a study conducted by the *Urban Institute* that found that on any given night up to 600,000 persons were homeless (Burt and Cohen, 1989). However, activists continued to argue that there were more than three million homeless people in the United States (Kozol, 1988). In 1994, The *Interagency Council on the Homeless* (ICH) published "Priority: Home! The Federal Plan to Break the Cycle of Homelessness." A major conclusion of the ICH was that the homeless population was not a static one, but that large numbers of different people flow through shelters over time (a conclusion that had been emphasized by the Knoxville studies in 1987 and 1988). This new federal position emphasized that homelessness had been previously underestimated.

A major difficulty in examining the extent of homeless lies in the use of different sources. In 2008, for example the *National Coalition for the Homeless* indicated that as many as 842,000 people are homeless on any given night, and approximately 3.5 million adults, 1.3 million of them children, experience homelessness each year (*National Coalition for the Homeless,* 2008; Burt, Aron, Lee and Valente, 2001). More recent studies suggest that the total number of homeless persons dropped slightly between 2008 and 2009. A snapshot of homeless persons in 2009 finds that over 643,000 are homeless on a given night, with approximately 1.56 million people spending at least one night in a shelter between October 2008 and September 2009 (*Annual Homeless Assessment Report*, *2009*). Projections suggest that approximately 1% of the U.S. population will experience homelessness each year (*Urban Institute*, 2000). Over a five year period, approximately 2-3 percent of the U.S. population will experience homelessness and between 6 and 7 percent of adults will experience homelessness at some point in their lives (Link, Susser, Stueve, Phelan, Moore & Struening, 1994; *Interagency Council on Homelessness*, 1994). According to the *U.S. Conference of Mayors* (2007) survey, hunger and homelessness continue to rise in major American cities. In the twenty-five cities that responded to the survey, the number of families seeking shelter increased twelve percent in 2008 (*U.S. Conference of Mayors*, 2008).

The methodology to use in counting the homeless is a major issue. For example an early study by Link suggested that homelessness was two to three times more extensive than early estimates. Using a household sampling method, the researchers found that approximately 7.4 percent of all adult Americans had at some point experienced literal homelessness. An interesting aspect of the report was recognition of the difficulties in

counting the homeless, including: (1) finding the hidden homeless, *i.e.*, those who sleep in boxcars, on roofs, or other obscure locations; (2) encountering respondents who deny homelessness or refuse interviews (see Rossi, 1989), and (3) not including people who experience short or intermittent episodes (Link, 1994). As noted, determining the extent of homelessness is difficult, and reliable studies are scarce. The *National Census* in 1990 and 2000 included a concentrated effort to identify those persons who were homeless; however, counting difficulties continued to hamper this effort. The 1990 effort included S-night (referring to counting street and shelter residents) along with experiments using "*homeless decoys"* in five major cities. A significant number--over one-half--were missed, demonstrating the difficulty in counting (Wright and Devine; Straw, 1995). The 2010 census used a service-based enumeration (*SBE*) that focused on persons who were homeless. The recommendation following the 2000 "dress rehearsal" detailed that SBE appears to be a successful method of including people who otherwise wouldn't be counted.

Another consideration in counting the homeless is whether the count is a point-prevalence or period-prevalence estimate. Point prevalence estimates are made at a given time, but do not account for turnover or variability over time. On the other hand, the period prevalence counts reflect the size of the population for a specified period of time. Consequently, period prevalence counts typically exceed point-prevalence counts (Quigley & Raphael, 2001). The *Homeless Management Information System* (HMIS) that was initiated in 2004 should increase accuracy in counting the homeless as well as charting variations.

In sum, recent reports have been consistent in recognizing that the homeless population is not static. The Knoxville studies have consistently asserted that the homeless

population is not static and that numbers must be explained within a designated time frame. Different patterns of homelessness–situational, episodic, and chronic–reflect who is homeless at a given time.

> Situational homelessness is usually acute; a home burns, the wage earner is laid off, a family is evicted or family abuse causes unexpected homelessness. Episodic homelessness is recurring; a person works seasonally and has lodging, disability benefits are sufficient for a room (SRO) several weeks a month, or the person has a home with family when not drinking. This group includes the "couch population" who usually stays with relatives or friends but have meals at shelters. Chronic homelessness is ongoing; the person remains on the street indefinitely; some may be alcoholic or severely mentally ill. (Nooe and Cunningham, 1990).

These different patterns offer explanation for differences in enumeration and also public perceptions of homelessness. While the chronically homeless are usually the most visible, they likely represent the smallest segment of the homeless population. The category of situationally homeless is the largest when measured over time. The fact that the chronic segment is most costly in terms of use of public services is a key rationale in cities developing a "*Ten Year Plan to End Chronic Homelessness*".

CONTRIBUTING FACTORS/RISK FACTORS

The homeless population continues to be one of the fastest growing sub-populations, despite the United States' having periods of significant economic growth. The impact of the economic crisis being experienced by the United States since 2008 is continuing to be examined. According to the U.S. Conference of Mayors (2008), twelve of twenty-five cities surveyed reported an increase in homelessness due to foreclosures, and thirteen reported adopting new policies as a result of the recent increase in need following the housing crisis.

However, despite the heavy demand for social services, there appears to be a slight decrease in the number of persons homeless (*AHAR*, 2009).

The *National Coalition for the Homeless* asserts that two trends are primarily responsible for the increase in homelessness during the past twenty-five years: a growing shortage of affordable housing and a simultaneous increase in poverty (NCH, 2007). In a sense, homelessness represents the "*poorest of poor".* In 2008, people below the official poverty thresholds numbered 39.1 million, a figure 1.1 million higher than the 2007 estimate (U.S. Bureau of the Census, 2009).

Related to the problems of poverty is the decline in public assistance. The Knoxville studies have included questions about sources of assistance and also loss of benefits. The *National Coalition for the Homeless* offered this finding:

> The declining value and availability of public assistance is another source of increasing poverty and homelessness. Until its repeal in August 1996, the largest cash assistance program for poor families with children was the *Aid to Families with Dependent Children* (AFDC) program. Between 1970 and 1994, the typical state's AFDC benefits for a family of three fell 47%, after adjusting for inflation (Greenberg and Baumohl, 1996). The *Personal Responsibility and Work Opportunity Reconciliation Act of* 1996 (the federal welfare reform law) repealed the AFDC program and replaced it with a block grant program called *Temporary Assistance to Needy Families* (TANF). Current TANF benefits and food stamps combined are below the poverty level in every state; in fact, the median TANF benefit for a family of three is approximately one-third of the poverty level. Thus, contrary to popular opinion, welfare does not provide relief from poverty. (NCH, 2007).

These changes in public attitudes and policy have major implications although the effects have not been fully assessed. The United States has witnessed the most dramatic shift in welfare policy since its inception in 1935 (Berger and Tremblay, 1999). Changing public attitudes are producing revisions that result in stricter guidelines for subsidies and services (Dunlap and Fogel, 1998). Resources such as AFDC have been important in

preventing homelessness, and more exclusionary guidelines will likely increase vulnerability to homelessness (*Institute for Children and Poverty*, 2001; Butler, 1997).

While the foregoing and other studies present a case for structural or external factors such as lack of housing, income and employment opportunities (McChesney, 1991; Trimmer, Eitzen, and Talley 1994; Quigley & Raphael, 2001), there is considerable evidence that homelessness is also due to personal problems or internal factors such as mental illness, substance abuse, and personality deficits (*U.S. Conference on Mayors*, 2005; Bassuk, Rubin & Lauriat, 1984; Lamb & Lamb, 1990; Baum and Barnes,1993; Jenks, 1994; Federal Task Force on Homelessness and Severe Mental Illness, 1992). Most likely, homelessness is due to multiple interacting factors (Nooe and Patterson, 2010). These contributing factors may vary for segments of the homeless population; for example, differences exist in rural and urban homelessness, not only in the environment but also in coping strategies (Goodfellow, 1999; Cummins, First, & Toomey, 1998; Nooe & Cunningham, 1992). Perhaps Burt (1992) sums up the complexity of factors most accurately:

> "...poverty represents a vulnerability, a lower likelihood of being able to cope when the pressure gets too great. It thus resembles serious mental illness, physical handicap, chemical dependency, or any other vulnerability that reduces one's resilience..."

While recognizing that the reasons behind homelessness are complex, and multiple factors are usually interacting, it is helpful to examine risk factors such as: (1) lack of affordable housing; (2) mental illness and deinstitutionalization; (3) labor market changes; (4) substance abuse; (5) lack of education; (6) personal crises [abuse, divorce, death] and (7) personal risk factors.

HOUSING

The increasing shortage of affordable housing, particularly rental housing is a major contributor to homelessness. Approximately 2.2 million low rent units were lost between 1973 and 1993, due to abandonment, conversion to condominiums, or becoming unaffordable because of competition and costs (Daskal, 1998). The *Institute for Children and Poverty* (2001) estimated a gap between affordable units and low-income renters of more than four million units. The significant reduction in private sector low-income housing is often overlooked in the clamor for more public housing.

The loss of single room occupancy housing (*SRO*) has been particularly devastating. Dolbeare (1996) estimates that more than one million units were lost in the 1970's and 80's. Many Knoxvillians can remember private sector hotels and rooming houses that provided cheap lodging, but many of these have since been razed or converted to condominiums in the apparent gentrification of the inner city. It may be that the *new SROs* are the increasing number of suburban motels, offering low rates and catering to a transient population. The availability of various types of housing that includes SROs, as well as subsidized supervised housing and private housing is a critical factor in preventing recurrent homelessness (Wong, Culhane, & Kuhn, 1997).

As noted, an interesting phenomenon in recent years has been the transformation of motels into *SROs*, and the expansion of these into locations outside the central city. This is evidenced in a variety of motels in the Knoxville and Knox County metropolitan area that have become *SROs* over the past ten years. The conversion of the motels from tourist-based facilities to serving low income and working poor families, is resulting in a new distributional pattern of homelessness throughout Knox County. Another aspect of housing mentioned

earlier is the practice of "*doubling-up"*. Staying with friends or relatives commonly precedes homelessness (Hoback and Anderson, 2006; Wright, Caspi, Moffit, & Silva, 1998). This practice results in what has been called the "*couch population"*, and while "doubling up" represents a type of housing, the risk for homelessness is very high. The challenge is to reduce this risk through stable, permanent housing.

> Will is a 50 year old man who was born in the Deep South. He moved to Tennessee with his family as a teenager. With an IQ of 70 and numerous physical impairments, Will lived with his parents. When they passed away, he was unable to handle the responsibilities of living alone and soon was evicted from his apartment due to poor housekeeping. For five years, Will used his SSI check to rent hotel rooms and buy food. However, his money only lasted for two weeks and then he would return to the shelter until his next month's check arrived. When staff at the shelter attempted to talk with Will about his situation, he stated that he really liked living at the hotel. A case manager developed a relationship with Will and he finally agreed to apply for housing. Due to his past history, he was initially turned down for an apartment. However, the landlord agreed to rent an apartment as long as Will would continue to work with his case manager. Soon to celebrate his first full year in his apartment, he still meets weekly with his case manager. They work together on cleaning his apartment, making sure he maintains his certification with Social Security, and talk about current events. Will tells his case manager that he "loves" having his own apartment.

Finding permanent housing may be complicated by poor payment history, prior criminal offenses and substance abuse.

> Steve is a 53 year old man who is quiet and soft spoken. He chooses to keep to himself rather than associate with others. Since 2005, Steve has been homeless, sleeping outside, and without income. With Steve's kind eyes and weathered face, it is easy for many to empathize with his homeless situation. However, once Steve's history is revealed many lose their empathy for him. Steve is a convicted sex offender who spent approximately 14 years in prison. Even though Steve has served his time in prison, the consequences for his actions continue. Being a registered sex offender poses a serious road block to receiving any services that might help Steve out of homelessness. His status as a sex offender makes him ineligible to receive services at overnight shelters and ineligible to receive subsidized housing. To complicate matters, staff noticed Steve's overall health declining. He was

> recently hospitalized after planning to jump off a bridge because he could not tolerate sleeping out in the cold anymore.

There is also the need for supportive housing for those with disabilities, including mental illness and addictive disorders. As the National Coalition for the Homeless (2005) points out, during the last two decades, competition for increasingly scarce low-income housing has been particularly traumatic for those with addictive and mental disorders often increasing the risk for them becoming homeless.

> Clint is a thirty-four year old man, raised in a middle class family who began having problems managing his anger and started drinking and smoking to "calm [his] nerves" in his twenties. His problems escalated, resulting in divorce, and Clint moving back in with his parents. Repeated fights with his family let to admission to a psychiatric hospital and the diagnosis of bipolar disorder; having lost his health insurance, he could not afford his medication. The next family fight landed him in jail with a felony conviction for destruction of property. After eight months in jail, Clint was released on a February night with nothing but the shorts and t-shirt in which he had been arrested. Having never been homeless before, he did not know where to turn. His probation required that he have no contact with his family, so he made his way to a homeless service provider where he was able to connect with a case manager, and begin mental health treatment. He tried to participate in a vocational rehabilitation program but was not successful because his life was still too disorganized. Clint applied for housing that his probation officer approved. He was turned down, but he appealed this decision. Because he had mental health treatment, was following a case plan and had a job, Clint had made positive changes in his life, so a landlord rented to him. Three months after moving into his apartment, Clint was ready to try vocational rehabilitation again. This time, with a place to sleep, a telephone to keep appointments and a case manager to help him, he was successful. Clint has celebrated two and a half years at the same job, two years in his own apartment, and is being inducted into an honors society after his first full year in college.

In some respects Knoxville has more housing resources than other metropolitan areas. The combination of public housing, private facilities and emergency shelters results in less than twenty-five percent of the homeless living in outside locations and this is often

by choice. Some cities report that the greatest numbers of homeless are living in outside locations, and in the NSHAPC study, thirty-one percent reported sleeping on the streets or in other places not meant for human habitation (*U.S. Conference of Mayors, 2007; ICH*, 1999).

> Kristen was often seen in the downtown area, struggling to walk and obviously having physical problems. Kristen suffers from Huntington's Disease, which has led to a movement disorder called Chorea. This disorder causes involuntary twitching of her limbs, which can include complete flailing of the limbs. Her walk is unsteady and her speech is affected. Kristen was chronically homeless, but had briefly lived in an apartment in 2008. She was evicted within a short period of time for not following all terms of the lease, particularly in the number of overnight guests allowed in her apartment. She found herself homeless again and in need of money. She turned to prostitution, which resulted in several arrests. Her application for subsidized housing was denied based on her arrest record. The hearing officer did tell her that her chances of approval would be better if she could go one year without an arrest. Kristen started working with a case manager and had not been arrested for ten months. She followed her case plan and was approved for subsidized housing. She was offered an apartment at a high rise property that caters to persons with disabilities. Kristen states that she "lost one apartment because I didn't follow the rules. It isn't going to happen again". She talks about how nice it is to have her own place and to not have to carry her belongings everywhere she goes.

The *Ten Year Plan* calls for a "*housing first"* approach that combines affordable, permanent housing with the supportive services necessary for the individual to remain in permanent housing. The need for comprehensive supportive services to maintain persons in housing is underscored by the Knoxville studies' consistent findings that many persons placed into housing without support services simply recycle back into homelessness. (*Ten Year Plan*, 2005; *Homelessness in Knoxville/Knox County*, 2004).

> Fred is a 45 year old male with a severe mental illness and possible mental retardation (Fred is not able to give an accurate account of his history and staff have not been able to get copies of his past medical and school

records). He was abused as a child and spent time in "reform schools." Most of his adulthood has been spent in and out of a mental health facility. Due to conflicts with family and his mental illness, he was shunned from many places. He arrived in Knoxville a year and a half ago but was soon barred from the shelters and started sleeping outside. Although generally liked and looked out for by both the homeless population and service providers, he was difficult to manage. He requires almost constant attention, frequently begging for cigarettes and coffee, or inquiring about getting his disability check. Fred is very childlike and case managers tried to help him access outpatient mental health facilities. However, he did not take his medications and he forgets scheduled appointments. Case managers worked very hard to place him in housing. Immediately after moving in, Fred caused continuous disruptions to other residents and damaged his apartment. He was a topic of many staff meetings and several staff expressed frustration about the lack of adequate treatment options. He was often beaten up on the streets, followed by jail or a mental health facility. Then, he was right back out on the streets continuing the same cycle. Fred did not meet the criteria to be declared incompetent nor have mental health services mandated. Fred was evicted after several months in housing because of his disruptions and is back on the streets.

MENTAL ILLNESS AND DEINSTITUTIONALIZATION

The role of mental illness and deinstitutionalization in homelessness has been debated. Torrey (1989) argues that deinstitutionalization is a major contributing factor, whereas the *National Coalition for the Homeless* (1997) initially asserted that deinstitutionalization had little impact on the number of homelessness but more recently identified it as a contributing factor (2008). The Knoxville studies, as well as a number of national studies, present strong evidence that mental illness and deinstitutionalization are significant contributing factors.

The estimated rates of mental illness among the homeless are wide-ranging, depending on methodology, definitions, sample selection and diagnostic criteria. For example, shelter users seem to have higher rates of mental illness than do non-sheltered

homeless persons. The *Annual Homeless Assessment Report to Congress 2009*, indicated that thirty-seven percent of shelter residents had some type of disability. The Knoxville studies have consistently found that approximately 50% of the homeless individuals surveyed had been treated for emotional problems. This level of incidence is consistent with national estimates and represents an increase from estimates cited in the 1990's (*Taskforce on Homelessness and Severe Mental Illness, 1992*, *ICH*, 1994). However, these estimates are likely conservative, given the incidence of untreated individuals and those who are in jails, prisons, or otherwise unidentified (AHAR, 2007; Toro, Bellavia, Daeschler, Owens, Wall, & Passero, 1995; Lamb and Weinberger, 1998; Susser, Lin, Conover, & Struening, 1997). Complicating the incidence of mental illness is the number of mentally ill persons who are substance abusers, i.e., the dually diagnosed. Persons who have a severe mental illness (e.g., schizophrenia or bipolar disorder) and drug dependencies are significantly more likely to become homeless (Olfson, Mechanic, Hansell, Boyer & Walkup, 1999; Dixon, 1999). Studies have found that approximately thirty percent of persons discharged from state psychiatric institutions will be homeless within 6 months (Belcher & Toomey, 1988). For persons with mental illness, homelessness has a detrimental effect and like any other crisis or trauma, may "catalyze and/or exacerbate a mental illness producing disorder where previously it did not exist" (*Mental Illness, Chronic Homelessness: An American Disgrace*, 2000; Koegel & Burnam, 1992, p. 96).

> Charles is a 49 year old man who was a "regular" at the homeless shelters for years. Prior to coming into the shelters, however, he was "street homeless," as his paranoia made him avoid people. For years, he slept outside and rebuffed attempts from shelter staff who tried to engage him.

Staff persisted in trying to build trust, urging him to come inside to eat and sleep in safety. Eventually, after many years, Charles came in with some cajoling, and the offer of a favorite treat: Mountain Dew! Gradually, he came inside more often and slowly began to respond to certain staff people. He became accustomed to his shelter life, walking to the night shelter after dinner and back to the daytime shelter in the morning. With no income and a nicotine habit, Charles would often pick up dirty cigarette butts and would go through the trash to scavenge for leftover food. Even though he was eating regular meals, his mental illness caused him to hoard items. A few years ago, staff began introducing the idea of moving into a place of his own. Initially, Charles would not discuss it. However, after time and relationship building, he agreed to go through the application process for housing. In February, 2006, Charles signed a lease and moved into his own apartment. Shortly thereafter, he secured part time employment, serving as an after-hours custodian. This gave him income, which meant he now paid his own rent and bought his own food and cigarettes, no longer needing to scavenge through the garbage. His relationship has grown with staff and other residents. He takes pride in his room being very clean and enjoys his space where he can rest well and watch television. Charles will soon celebrate being in housing for five years.

Unfortunately, homelessness and mental illness have become intertwined with the criminal justice system. There is mounting evidence of an increasing number of severely mentally ill persons in jails and prisons (Greenberg and Rosenheck, 2006; Lamb and Weinberger, 1998). The homeless have become criminalized, and in a sense, jails are becoming today's asylums (*The Bazelon Center for Mental Health Law*, 2008). The interaction of these factors is seen in the finding that non-homeless mentally ill persons going into jail have a significantly increased risk of housing loss (NCH, 2008; Solomon and Draine, 1995). The cost of this recycling from homelessness to incarceration and back is costly and supportive housing treatment programs provide a feasible alternative (Rosenheck, et al., 2003).

Joe came to the center with a host of problems, including years of alcohol and drug abuse, as well as a federally supervised probationary sentence for a felony. He was referred after placement in a residential program. Joe comes from a stable family background and had successfully been a real

estate broker. Joe's military service was as a skilled specialist, performing sensitive classified tasks requiring the highest degree of trust and responsibility. During his years in the Army, he was assigned to a sensitive-compartmented-intelligence posting. After leaving the armed forces, Joe completed an Associate of Science degree. It was at this time that the years of substance abuse began to affect his family life, leading to his marriage ending in divorce. After his own acknowledged 'bottoming out' brought him face-to-face with stark reality in a felony conviction. Joe made a personal and spiritual commitment to turn his life around. He has now graduated from a transitional residential program, and remained drug and alcohol free for more than a year. His work record with his new employer has been exemplary.

EMPLOYMENT

Lack of employment is often identified as a major cause of homelessness, however, many of the homeless report being employed or having occasional work. The difficulty is that many of these jobs do not provide adequate wages and benefits for self sufficiency Mishel, Bernstein, and Schmitt, (1999) indicate that the value of the minimum wage has not kept up with economic growth. The U.S. Interagency Council on Homelessness found that the median monthly income for persons who were homeless was about 44% of the federal poverty level (1999). While the value of the minimum wage has not kept up with inflation (The Economic Policy Institute, 2005), there has also been a decline in manufacturing jobs and a corresponding increase in low paying service employment, globalization, decline in union bargaining power, and increase in temporary work, that are factors in wage decline (USICH, 1999).

Bee is a twenty-eight year old woman who has now obtained her college degree and is working at a local social service office. She has two boys who are attending school and doing well. Bee was a different person ten years ago, angry and volatile, having just been put out of foster care after turning eighteen years of age and homeless. Her experiences with the foster care system had been traumatic. The homeless case manager helped her client obtain permanent housing and her GED. Her baby had been placed in foster

care. The case manager also helped her regain custody of her child and deal with her emotional issues. The case manager helped her obtain a job, and obtain work clothes and transportation. The lack of work skills let to multiple jobs until she began to internalize the skills that would make her a valued employee. Bee was encouraged to go back to school, and after working and going to school while raising two boys, she obtained her Associates Degree. This client is stable in housing and in her work environment.

Many of the jobs held by homeless persons are temporary or do not provide sufficient wages for self-sufficiency. The Interagency Council on the Homeless (1999) recognized that employment prospects are dim for those who lack appropriate skills or adequate schooling. The labor market has changed, as evidenced by "plant relocations and closures, persistent racial discrimination, changes in industry that have increased the demand for highly educated people, the decline in the real value of the minimum wage, and the globalization of the economy" (ICH. p. 27). Employment instability has been identified in several studies as a risk factor for homelessness (Wagner, 1994). Women and minorities seem to experience fewer employment opportunities (*Anti-Discrimination Center of Metro New York*, 2005; *ACLU*, 2004; Butler, 1995). The duration of homelessness may decrease the prospects of employment. It is not surprising that homelessness itself may further diminish one's chances of employment, as prolonged idleness may cause greater loss in work habits, responsibility and commitment to employment.

The Smith family came to Knoxville in 2007. The Smiths were working for minimal wages and were homeless. After their rental home in another state burned, they decided to start over in Tennessee, but the job that was promised to the dad had fallen through. This left the family stranded in Knoxville with only their vehicles. The Smiths came to the shelter looking for a safe, warm place for their family. It was a challenge for this hard-working couple to accept “help” from an agency because they were used to providing for their family without assistance. While they were in the shelter program, the Smiths’ work ethic was evident; they helped whenever needed

> with general cleaning and special projects. Now, the family is in their own apartment and both parents have jobs.

The *Ten Year Plan to End Chronic Homelessness* calls for increased economic opportunities for homeless persons. Achieving maximum economic self sufficiency will involve developing appropriate training programs, supportive employment, and establishing income management and financial guardianship programs where applicable.

SUBSTANCE ABUSE

Habitual heavy substance abuse is a major contributor to homelessness (Tam, Zlotnick and Robertson, 2003; Marqura, 2000). However, the relationship between homelessness and substance abuse may be more complex than it first appears. For example, those who are addicted may be more impacted by the decrease in availability of *SROs* (*NCH*, 2007). Likewise, the lack of health insurance may be a barrier in dealing with addiction. Policy changes in 1996 reducing eligibility for SSI based on chronic substance abuse have likely increased the risk for loss of housing and homelessness (National Health Care for the Homeless Council, 2005). Similarly, policy changes that result in persons convicted of drug abuse or sales being barred from public housing have created additional dilemmas. Use of drugs other than alcohol has increased dramatically among the homeless. Single homeless men are especially likely to have histories of substance abuse (Toro, Bellavia, Daeschler, Owens, Wall & Passero, 1995). Substance abuse disorders are also prevalent among homeless women (Bassuk, Buckner, Perloff & Bassuk, 1998).

> Alisha is a twenty-three year old female with two children, eight months and four years old. As a child, Alisha had been homeless with her mother and sisters. Her mother was addicted to drugs and eventually Alisha and her sisters found themselves moving from foster home to foster home. When

Alisha was fifteen years old, she was using drugs and met the father of her first child; for several years she endured physical and emotional abuse from him. Alisha found the courage to leave, but had nowhere to go and ended up living on the streets and deep into addiction. She began working for an escort service and dancing in night clubs to raise money for her and her child to sleep in hotels. Alisha entered a new relationship and found herself pregnant with her second child. In denial of the pregnancy and using, she was introduced to crack by her biological mother. *DCS* removed her first child and gave her the option to enter treatment to reunite with her child and keep her second child.

Alisha entered the agency's alcohol and drug treatment for women and their children. Within three months she regained custody of her first child. She delivered her second baby while residing in treatment and because she and the baby were clean, *DCS* closed the case. Alisha and her children have resided in this program and remained clean and sober for a year. Both children attend the on-site nursery and receive developmental and educational services while Alisha attends treatment, becoming independent and self-sufficient. She has applied for a Section 8 voucher, is looking for employment and has a car. She plans to move to transitional housing.

Many individuals are dually diagnosed, suffering from both a major mental illness and substance abuse (Hartwell, 2003; *Task Force*, 1992; Barber, 1994). These dually diagnosed individuals frequently fall between the cracks because neither mental health nor substance abuse treatment facilities provide comprehensive services. Substance abuse contributes to the lack of funds for housing and also may increase family conflict, leading to family unwillingness to allow individuals to remain in the home. The Supplemental Security Income (SSI) policy change in 1996, denying SSI to persons whose disability was based on addiction, resulted in loss of housing for many (National Health Care for the Homeless Council, 2005).

Sam, age 51, has been homeless for over 4 years. He lost his business and house after his wife died and he began to drink heavily. With no family and few social supports he has been wandering the country and sleeping outside. A work accident about 10 years ago caused chronic severe pain and a noticeable limp. He has been diagnosed with depressive disorder and

possible schizophrenia. He is not eligible to receive *TennCare* benefits or SSDI, and the only benefit he receives is food stamps. To combat his chronic pain and the voices he hears, Sam copiously drinks alcohol. He has little income and his capacity to get a job has been severely diminished by his injuries, mental health, and substance abuse. Sam is cycling in and out of the legal system due to homelessness, public intoxication and theft.

EDUCATION

Inadequate education has not been clearly identified as a causative factor in studies focused on homelessness. However, in the study, "Homelessness: Programs and the People They Serve", fifty-three percent of parents in homeless families have less than a high school education (Brent, Aron and Lee, 2001). In the Knoxville studies, more than fifty percent of the respondents reported having graduated from high school, with a significant percent having post-high school education. However, given the increased requirement for technical and educational competence to be self-sufficient, it is logical to assume that poor education is a contributing factor to homelessness.

Mary came to Knoxville with her five year old daughter in January of 2010. Prior to coming to Tennessee, Mary had been held hostage by her husband for over a year. She was only allowed to leave her home with her husband, who would not let her out of his sight. One night while he slept, Mary and her daughter fled on foot to a local domestic violence shelter. A court granted her an order of protection and allowed her to leave the state with her child.

Upon entering the program, Mary had no place to live and few job skills. After working closely with her case manager she obtained housing within one month of entering the program. Today she is employed as a receptionist at a local business. She now enjoys working and raising her daughter in an environment free of abuse.

One reason that studies may fail to identify educational level as a contributing factor is illustrated in an evaluation of an employment program. In comparing those who were

successful in gaining employment and housing versus those who were unsuccessful, the educational levels of the groups were similar. However an examination of proficiency levels in reading and math found substantial differences between the successful and unsuccessful groups (Nooe, 1994).

PERSONAL CRISES

Personal crises involve various stressful situations such as abuse, family conflict, loss of a job or housing, and loss of significant others. Crook notes, "Women are particularly vulnerable to the precipice of homelessness because of four major factors: 1) family dissolution, 2) family violence, 3) lack of affordable housing, and 4) low wage status (p. 52)". Many homeless women are victims of abuse, and while leaving the home may represent a solution to one problem, lack of employment and affordable housing frequently results in homelessness (*Civil Liberties Union*, 2004). Zorza (1991) reported that fifty percent of homeless women had experienced abuse. Likewise, approximately half of the cities surveyed by the *U.S. Conference of Mayors* identified abuse as a major cause of homelessness (2005).

> Donna is currently in a transitional housing program. Donna is disabled and has a daughter who is mentally handicapped and dependent on Donna for her care. Donna was in a relationship, enduring extreme physical and emotional violence. She stayed with her abuser for the sake of her daughter and because she loved him. Her abuser was eventually arrested for assault and sentenced to two years in prison, which left Donna and her daughter unable to financially provide for themselves, eventually becoming homeless. Donna and her daughter stayed in a domestic violence emergency shelter for women and children that referred them to the *Transitional Housing Program*. Through support from the advocate, the program provided assistance for Donna in finding housing, paying the security deposit, rent and utility expenses until she was approved for disability benefits. Donna has been in the transitional housing program for

two years and is fully able to provide for herself and her daughter. Donna's abuser was recently released from prison and has no idea where Donna and her daughter live. Through safety planning and continued support from the advocate, Donna is fully prepared in the event she encounters her former abuser. Donna often expresses how happy she is and thankful for the support of the *Transitional Housing Program.*

Other personal crises such as divorce and widowhood remove support systems and seem to make individuals more vulnerable to homelessness.

Abby accessed the domestic violence shelter after she fled several hundred miles across several states to escape her abuser. Arriving in Knoxville with her two children and nothing but the clothes they were wearing, they were taken in at the shelter and stayed there for a few months. Abby was homeless and jobless; she had no support system and two dependent children. Transitional housing advocates worked together with shelter advocates, *KCDC* and local charities to obtain housing and furnishings for Abby's family. She completed safety plans with her advocate and learned how to keep herself and her children safe. She made goal plans to help her successfully complete a Certified Nursing Assistant (CNA) program at a local technical school and a referral was made to provide transportation assistance. Abby went to work as a CNA and recently began her formal education to become a Registered Nurse at a community college. Now she lives independently in an apartment, caring for her children, attending school and working. She receives very little financial assistance from the program, although she still works with her advocate for support and to update her goal plans. Abby is currently pursuing child support from her abuser. With the help of the shelter, *Transitional Housing Program, KCDC*, and local non-profits, Abby has become a strong, self-sufficient woman as she and her children now live free from abuse.

A number of studies have found that female headed households have greater risks for poverty (U.S. Department of Commerce, 1998) and subsequently have greater risks of homelessness (Caton, Shrout, Boanerges, Eagle, Opler & Cournos, 1995; DiBlasio and Belcher, 1995). Similarly, women who have experienced violence may encounter discrimination from landlords who are reluctant to rent to them (ACLU, 2004). As Jencks

observed "married couples hardly ever become homeless as long as they stick together" (1994).

OTHER RISK FACTORS

Increased research on homelessness has resulted in identification of risk factors for homelessness. For example, McChesney suggested eight risk factors in her model: single female headed household, minority family, young age of head of household, substance abuse, childhood victimization of mother, adult victimization of mother, recent pregnancy, and lack of social support (1995). Wagner and Perrine identified similar factors in comparing housed vs. homeless women, recognizing that homeless women had more mental illness, unstable employment and housing, abuse history, substance abuse and fewer social skills (1994).

> In 2002, Anne almost died. She had been pushed out of a moving truck by her boyfriend. She laid in a hospital bed for days in an induced coma to prevent further swelling of her brain. After several surgeries and months of physical therapy, Anne was released back into a world that had changed completely. She found herself with no home, no job and no place for her or her children to go. She hid from her ex-boyfriend by roaming the streets and went from motel to motel for temporary shelter. Then a friend told her about the shelter for victims of domestic violence, where she stayed until she was able to get into a permanent supportive housing program.
>
> In treatment, Anne was diagnosed with Post-Traumatic Stress Disorder. She battled with nightmares, flashbacks, uncontrollable crying spells and explosive outbursts of anger. To aid her in the recovery process, the agency provided her with an apartment, advocacy, individual therapy, parenting classes, group counseling and social activities. She also received mental health treatment and psychiatric services from another agency. As a result of this collaborative effort, she was able to make a full recovery. Anne has learned to develop healthy relationships, maintain appropriate boundaries and to trust again. She participates in weekly therapy sessions and attends agency activities ranging from playing cards to horseback riding. In addition, she has a safe place to call her own.

Homeless families are most frequently headed by single mothers (Rog and Buckner, 2007). Banyard and Graham found that homeless mothers had more depression and used avoidant coping strategies more than housed mothers (1998). However, it may well be that depression and avoidance are a consequence rather than cause of homelessness. Just as gender may increase the risk of homelessness, minority status may also increase vulnerability to homelessness. Minority status as a risk factor is illustrated by the finding that twenty-one percent of Hispanics and 24 percent of blacks live in poverty (*U.S. Census Bureau News* 2007). There may be racial differences among the causes of homelessness, in that whites report more internal causes, such as substance abuse and mental illness, compared to non-whites reporting more external factors such as low income and unemployment (North and Smith, 1994).

> Susan and her son came to the shelter with the child's father, an illegal immigrant. They had come to Tennessee seeking employment and were stranded after their car broke down and they ran out of money. Down on his luck, the father began drinking and became abusive to them. Susan and her son then became residents at the shelter. Within a few weeks, the child's father was killed in a fall from a roof where he and some other men were sleeping. Assisted by the shelter and other agencies, the family went to a southwestern state for the funeral. While there, Susan began thinking about a permanent move. She has since secured housing for her son and herself in her home state and has taken a job in a real estate office.

Several studies have examined childhood risk factors for adult homelessness. Economic and residential instabilities, along with poverty, are examples of childhood antecedents (Burt, 2001; Koegel, Melamid & Burnan, 1995; Miller, Donavan, Este & Hofer, 2004). Increasingly, research is showing that disruption in childhood, such as foster care placement, results in a greater chance of adult homelessness (Pecora, et.al., 2005;

Roman & Wolfe, 1997), as well as substance use and unemployment (Tam, Zlotnick & Robertson, 2003). There is an especially strong link between homelessness and childhood sexual and physical abuse (Johnson, et al., 2006; Nyamathi, Longshore, Keenan, Lesser & Leake, 2001).

> Lisa, 22, is a victim of childhood sexual abuse had started drinking at age twelve. When she came to the agency, she had lost her home, her job, and her confidence, and was unable to support her son. In the program, her son received loving support and guidance while Lisa confronted her issues. By the time she graduated, Lisa was ready to be re-united with her son. They now live in their own apartment and Lisa is pursuing a promising career.

The state of one's health and the availability of health care are also factors contributing to homelessness. While mental illness has been previously discussed, chronic and acute health problems are frequent among the homeless (National Health Care for the Homeless Council, 2005). The lack of health insurance or unavailability of basic health care may result in loss of employment and eviction resulting in homelessness.

> Mary is a diminutive woman who is mentally ill. She has lived on the street for a number of years, and is at a disadvantage because of her mental illness and also because she lost an eye in a fight a number of years ago. Mary is barely able to take care of herself, depending on shelters and missions to meet her most basic needs. Over the years, Mary's physical condition has deteriorated to the point that she mostly spent her days sitting on the sidewalk. She finally reached the point where she stopped going inside for meals and became very weak. A case manager was able to find out that Mary had been receiving SSDI, but it had been discontinued when she did not claim her checks for a prolonged period of time. Her case was reactivated and her checks were eventually restarted. Mary was temporarily placed in a motel which had a kitchen. The case manager purchased food and checked on her daily. She then set up an appointment for Mary to visit a local nursing home. Mary loved the home and was able to move in within two weeks when a bed became available.

Various groups may experience risk factors for homelessness. For example, some Vietnam-era veterans appear to be more vulnerable than other veterans. Factors such as post-military social isolation, psychiatric disorders, substance abuse, and childhood trauma (including foster care) have been implicated as predisposing factors (Gamache, Rosenheck and Tessler, 2003; Rosenheck an Fontana, 1994).

> Several months ago, Richard was walking down Magnolia Avenue, fresh off the bus from another city in Tennessee, when he saw a sign advertising "Jobs for Vets". Richard had been enrolled in "Operation Stand Down" previously, but moved on to Knoxville looking for greener pastures. An Army veteran who had served on active duty for fourteen years, he had enlisted due to lack of employment opportunities. He found training and a purpose in life working as a Medical Corpsman, and enjoyed his assignments, but something was lacking in his life. After leaving the armed forces, Richard drifted from job to job and became involved in activities he came to regret. Richard lived with relative for a while but found this to be a strain on relations with the family. He was seeking a stable life with a secure job and a chance to find a place of his own; after enrolling in the program for vets and attending orientation, as well as periodic job club sessions, Richard quickly began to turn his life around. After testing for civil service at the state and local level, he was accepted for a permanent position as a government construction worker.

There appears to be an increasing number of young adults who become homeless after transitioning out of state custody. Among children aging out of foster care, estimates suggest that as many as twenty-two percent become homeless within a year (Pecora, et al., 2005; Roman and Wolfe, 1997).

> Angela, an eighteen year old female was referred to the youth transitional living program. Angela was attending high school and working, but lost her job and needed assistance to pay her rent to prevent eviction and homelessness. Through the program's case management services, Angela received support in advocating with the landlord to work out a payment plan to pay back rent. She continued to receive rental assistance while searching for new employment. Due to the program's strong relationship with the housing authority, staff was able to prevent eviction and reduced the amount of back rent owed. Angela continues to search for employment and receives emotional support and referral assistance through the program while

> maintaining her apartment. Angela had no family support during this crisis and without the support of the program she would have been homeless. The case manager will continue to provide support until Angela regains self-sufficiency again.

Regardless of the factors involved, the availability of social support, whether from friends, relatives, or agencies, appears to influence both risks for and recovery from homelessness. Kingree, Stephens, Braithwaite & Griffin, for example, found that low levels of support from friends were associated with homelessness following completion of a substance abuse treatment program (1999). Similarly, adolescents running away from or being kicked out by families are at risk for homelessness (Maclean, Embry & Cauce, 1999). The availability of ongoing support for those exiting foster care, mental health and correctional facilities is especially critical for avoiding or escaping homelessness.

In sum, this discussion has emphasized the linkage between homelessness and poverty as well as other factors. It is logical to assume that those living in poverty are most vulnerable to becoming homeless. In recent years greater recognition has been given to the risk factors, reflected in the findings that homeless persons are less likely to be receiving public benefits, more likely to be substance abusers, have higher levels of psychological distress and mental illness, more likely to be victims of domestic violence and to have been abused as children (Toro, Bellavia, Daeschler, Owens, Wall & Passero, 1995). The cost of homelessness is high, both economically and personally (*Knoxville-Knox County Ten Year Plan to End Chronic Homelessness*, 2005). Children in particular suffer as they experience an increased risk of being unable to succeed in school or community environments (Ziesemer, Marcoux, & Marwell, 1994).

The above factors are not exhaustive, nor are they exclusive. Most likely these factors are interactive and reflect the complexity of homelessness. It is important to remember that they represent not only individual problems, but also issues of public policy.

HOMELESSNESS AS A LIFE STYLE

There is often an impression that people are homeless because they want to be homeless or simply prefer the lifestyle. While there are obviously some who choose to be homeless, the number is quite small, likely less than five percent. These individuals are often more visible than the majority of homeless persons who are in shelters or on the street because of loss of housing, unemployment, mental illness, or abuse.

RESOURCES IN KNOXVILLE

Shelter and specialized housing resources in Knoxville have changed over the years, in part due to changes in available funding, as well as community planning efforts. Significantly, the development in 2005 of the *Knoxville—Knox County Ten Year Plan to End Chronic Homelessness* and subsequent efforts to implement the plan have resulted in a number of changes as agencies seek better coordination, increased efficiencies, and an emphasis on ending homelessness rather than simply mitigating the difficulties presented by life on the streets.

Knoxville has a number of specialized housing options for homeless persons. The major programs are:

(1) *The Salvation Army Center* is located at 409 North Broadway. It operates three residential programs. The programs cater to the needs of those of who face a

complex set of obstacles, including homelessness, domestic violence, shortage of affordable housing, mental illness and a lack of family and social support network. *Operation Bootstrap* is the most basic program for men experiencing homelessness. It is a 90-day program that can house up to eighty men. The *Transitional Housing* program is a job development program for single homeless individuals (both men and women) who need assistance in finding employment and establishing a saving plan to end the cycle of homelessness. Eighteen slots are designated for single females and thirty-eight are designated for single males. *Joy Baker Center* is a twenty-eight bed facility that serves women, with or without children, affected by domestic violence and also serves as a shelter for homeless women with children. Meals are served daily for residents. The *Salvation Army* offers a range of case management and supportive services, including an *Employment Assistance Program* that assists homeless individuals with job searches, resume writing and access to the internet. The *Emergency Assistance* program helps prevent homelessness by providing timely help with utilities, food, clothing and furniture for low-income, working families.

(2) *Knox Area Rescue Ministries* is located at 418 North Broadway. In October of 2008, *KARM* opened the *Crossroads Welcome Center* that serves as a starting point where the homeless can begin the process of change. People entering the welcome center connect to resources and services provided by KARM as well as other agencies and ministries, with a focus on addressing the causes of each person's homelessness. KARM provides several programs to address

homelessness. *Lazarus Hall* is a single men's facility that has a recovery program for forty men and an overnight care shelter for two hundred men. *New Life Inn* is a family program that has sixteen family rooms for transitional services for up to sixty-one individuals. The single women's overnight program, *Hope Haven,* provides emergency overnight services for forty women. All recovery programs are designed to assess and provide multiple interventions to break the cycle of homelessness. In addition, KARM provides three meals a day, seven days a week for indigent persons in the Knoxville community. KARM also operates the *Abundant Life Kitchen* – a sixteen week food service training program that equips people for employment in the food service industry. *Serenity Shelter* provides assistance to women in crisis. Located at a confidential site, the shelter is open twenty-four hours a day, seven days a week and has the capacity for thirty individuals. Like *Lazarus Hall* and *New Life Inn*, *Serenity Shelter* provides case management, education, referral, work rehabilitation, alcohol and drug counseling, and other services to assist individuals in breaking the cycle of domestic violence, substance abuse and homelessness.

(3) *The Volunteer Ministry Center (VMC)* is located at 511 North Broadway. It provides services in four areas: *The Resource Center* is a case management program offered to Knoxville's homeless who acknowledge a desire to end their homelessness. Each individual is matched with a professional case manager, who helps prepare a case plan that will result in the achievement of housing. Each case plan includes the goal of housing and may include

assistance with housing applications, establishing of an income, etc. *The Resource Center* is open during the daytime hours (7:00 a.m. to 5:00 p.m.) and offers the amenities of private showers, laundry and meals to its members. Classes which will enhance the likelihood of successful housing are offered on site. Active outreach to the homeless takes place off site as case managers engage with people on the streets, at the public library and other places where homeless people congregate. The goal of outreach is to help the homeless individual become comfortable with the services which will ultimately lead to their housing. Case management continues as long as necessary after the person has achieved housing to ensure their success in maintaining their new home over the long term. *The Bush Family Refuge* offers referrals, counseling and some direct assistance to those in crisis, particularly to the marginally housed who are at risk of losing their housing. While assistance with rent and utility bills are the most frequent requests, *The Bush Family Refuge* also assists with eye doctor appointments, procurement of eye glasses and prescription medication, transportation, etc. While financial assistance is limited, *The Bush Family Refuge* can network with other agencies and local churches to provide significant assistance. *The VMC Dental Clinic* is located within the *Cherokee Health Systems Broadway Clinic* which is housed in the *VMC* building. Using the services of volunteer dental practitioners, *VMC* is able to offer dental cleanings, fillings and extractions among its services. There is no charge to homeless persons and *The VMC Dental Clinic* is open on Tuesdays and Fridays. *VMC Residential Services* include Minvilla Manor

which was placed in service in November of 2010, replacing the former Jackson Apartments. Minvilla Manor offers fifty-seven units of permanent supportive housing within the confines of the completely renovated former Fifth Avenue Motel. Case Management is offered on site and other activities and classes are scheduled as well. Minvilla offers housing for both men and women who are formerly homeless.

(4) *Child and Family Tennessee* operates a number of temporary and permanent housing programs for the homeless. *The Family Crisis Center* is located in a confidential site to protect clients. It is a program of *Child and Family Tennessee* providing shelter and other advocacy services to adult and children victims of domestic violence and undocumented victims of crime and their children. The shelter has a capacity for sixteen individuals with potential for slight expansion in emergency situations. Services include crisis intervention, housing assistance, case management, support groups, individual counseling, transitional housing, assistance to female stranded travelers, transportation. Length of stay is thirty days; however, extended stays are available depending on the individual need. *Transitional Housing* provides a continuum of support beyond shelter. The program has four agency owned units at a confidential location and utilizes community based housing. Services include case management, employment support, and financial support for rent, utilities, transportation, and food. Length of stay and access to services is twelve to twenty-four months. *The Runaway Shelter* is located at 2701 E. Fifth Ave, providing short-term shelter and counseling for runaway and homeless youth,

ages twelve to eighteen years. It has a capacity for five individuals. Services provided include individual, group, family, and crisis counseling. *The Transitional Living Program* is located at 2701 E. Fifth Avenue, providing residential and case management services to homeless or street youth ages sixteen to twenty-one years. The main center has a capacity for five individuals with scattered community-based sites available for additional clients. Services provided include independent living skills assessment, individual and group counseling and case management services. *Great Starts/New Beginnings Structured Living,* located at 3006 Lake Brook Boulevard is an intensive outpatient program with a residential component operated by *Child and Family Tennessee*. The program houses women with co-occurring disorders who are pregnant or with children in need of treatment. An on-site nursery is provided to address the complex problems of children born drug-exposed, HIV positive, developmentally delayed, or medically at-risk. The program has the capacity to house twenty-two women and thirty-eight children. Treatment services include alcohol and drug groups, therapeutic counseling, family sessions, transportation, case management, parenting classes, and medical care to provide a holistic approach for chemically dependent women and their chemically exposed children. Length of stay in the program is six months and can be extended based on treatment progress and individual need. *Great Starts/New Beginnings Transitional Housing* is located at 114 Dameron Avenue. The service sustains recovery and improves the housing status for women and children as a continuum of support after

discharge from treatment settings. This "step down" site contains four units ranging from one bedroom to three bedroom units. Aftercare services include on-site case management, housing assistance, support group, crisis intervention, and attendance at community based A.A. or N.A. groups. The children can continue in the agency's nursery and it can be a child care resource for these women while they work or attend education and employment programs. Residents pay rent, based on their income and ability to pay, and the length of stay is twelve to twenty-four months. *Pleasant Tree Apartments* is permanent supportive housing for mentally ill homeless women, along with their dependent children. The program provides 24 single-family dwelling apartments at two different sites, located at 2460 E. Fifth Avenue and 1909 Dawn Street. On-site case management is available, including independent living training, crisis intervention, therapeutic counseling, advocacy, medication management, and transportation. Residents pay rent based on their income and can stay as long as needed. The program averages 3 years length of stay.

(5) *The YWCA* is located at 420 W. Clinch Avenue. *The Transitional Housing Program* (*THP*) houses fifty-eight single women for up to twenty-four months. Each woman has her own private room while sharing a community life with common bathrooms, showers, living room, full size kitchen and twenty-four hour staff seven days a week. There are washers and dryers on site, with health and fitness programs specially designed for the *THP* women, including a heated pool for water aerobics, open swim and adult swimming lessons. All

this is included with rent. Each resident will meet the *THP* social worker for *HMIS* entry, goal planning, self-care plan with three month follow ups to check progress and accomplishment. Each woman is required to take a budgeting course, taught in-house by a *THP* staff member. Move in fee is $130.00, which includes the first and last week with a $20.00 non-refundable deposit and $55.00 per week rent.

(6) *Agape* is located at 428 E. Scott Avenue. It offers a six-month individualized program for chemically dependent adult women. Three Victorian houses provide residence for eight clients each, for a total capacity of twenty-four. Services include individual and group treatment and referrals. There is an $11/day fee and a $100 entrance fee.

(7) *E. M. Jellinek Center* is located at 130 Hinton Ave. It offers a residential rehabilitation program for adult men with substance abuse problems. Services include individual and group counseling along with participation in Alcoholics Anonymous and/or Narcotics Anonymous (AA/NA). It has a capacity of 45 and length of stay is generally 6 months to one year. There is a $65/week charge for employed residents.

(8) *Steps House* is located at 712 Boggs Ave. It offers a residential program for alcohol and drug recovery. The capacity is one hundred-thirty, with one section designated for veterans (forty-five beds) and the other for addiction recovery care (eighty-five beds); indigent care is available. Services include case management and group counseling. The fee for non-veterans is $120/week. There is no limit on length of stay.

(9) *Parkridge Harbor* is located at 1501 East Fifth Avenue. It provides case management, alcohol and drug treatment, and housing services. It offers services to persons with HIV/AIDS in Knox and the surrounding counties. There is a twenty-four bed capacity for men who were formerly homeless. The agency provides permanent supportive housing for the dually diagnosed mentally ill. Meals are provided for both resident and nonresident clients.

(10)The *Helen Ross McNabb Center* has developed and maintains a variety of housing options that provide safe, affordable housing for individuals with mental illness. Independent living is available in several locations in Knoxville. Apartments located in two buildings in the Fourth and Gill neighborhood, one new and one renovated, offer a total of eight apartments with a capacity of twelve tenants. A resident manager maintains the facility and monitors the residents for special needs. To qualify to lease an apartment, an individual must be diagnosed as having a severe and persistent mental illness, be homeless, and must have a regular source of income. *New Hope Apartments* are also located in the Fourth and Gill area. *New Hope* has two units, with four bedrooms and shared common areas. A case manager works with all eight tenants to maintain housing, improve their self determination, increase their daily living skills, and to help increase their income. An individual must meet the criteria of *HUD* homelessness, have a stable income, be diagnosed as having a mental illness, and able to live independently to qualify for an apartment at *New Hope*. Rent is based on income. A house in South Knoxville offers a family living environment with five bedrooms. Two houses in other

locations offer housing for three tenants each. To qualify, an individual must meet the criteria noted above. A resident manager maintains the facility. The *Willows* at Third Creek consists of two buildings with a total of sixteen one-bedroom apartments. There is an onsite resident manager and a case manager for tenants. The criteria are mental illness, homelessness, and income or Section 8 voucher. *McNabb* is anticipating opening another eight two-bedroom facility for single families by the end of 2010. In these apartments the mentally ill can be the child or adult. *Helen Ross McNabb Center* housing services are available to any seriously and persistently mentally ill consumer who meets the qualifying criteria. Referrals may be made by homeless shelters, hospitals, social service agencies, private physicians, or therapists, family members, or self-referral. Over two hundred individuals have participated in the center's housing services.

(11) *Catholic Charities of East Tennessee* operates two programs that focus on housing the homeless in Knoxville. *Samaritan Place*, a homeless shelter for the elderly, is located at 3009 Lake Brook Blvd. It includes an emergency shelter for people fifty-five years of age and older. A transitional housing program is also located on the premises for elderly clients actively seeking housing. Additionally, there is a permanent supportive housing wing in the facility for elderly clients who are deemed to be at risk of harm if placed back in the community. Follow up case management services are provided for clients housed in the community. Meals are served daily for residents. Samaritan Place offers a range of case management and supportive services,

(e.g. employment counseling and referral). Direct assistance in the form of clothing, food, and furniture is also provided. *Elizabeth's Home* is a *HUD*-funded transitional housing program for homeless families. The case coordinator is located at 119 Dameron Avenue, and housing is provided at multiple sites throughout the county. Families who are homeless in the Knoxville and surrounding areas are eligible to apply; referrals to this program are also provided by area shelters and agencies.

(12) *Angelic Ministries*, located at 1218 N. Central, operates a faith-based transitional and permanent housing program for men. Housing is provided in several scattered-site group homes, with a total capacity for approximately fifteen men. The program is individualized, based on participants' needs, and may include guidance on past legal issues, participation in the *Christian Men's Job Corps* and assistance in completing a GED.

(13) *Knoxville's Community Development Corporation (KCDC)* provides affordable housing for low income individuals and families, including those who are homeless. For those who are eligible, The *Section 8 Housing Choice Voucher Program* offers help toward rent in the private rental market. *Low Income Public Housing* offers help toward rent through a project based rental assistance program.

The above resources provide emergency and transitional shelter as well as permanent supportive housing. In addition, a number of agencies and organizations provide services that are not necessarily connected to a specific housing facility. Three homeless service agencies operate centers providing clothing and household items.

Knox Area Rescue Ministries operates seven thrift stores which offer a variety of clothing, household items, and furniture. The stores offer discounted merchandise and maintain select clothing. Additionally, with a verifiable referral from a community agency, the stores will provide free select merchandise to persons with limited resources to assist in the return to community living or to mitigate the effects of poverty. The thrift stores also provide *KARM* clients with job and social skills training opportunities.

The Salvation Army operates one family store in Knoxville and three stores in surrounding counties. Clothing and furniture are provided, free of charge, to individuals referred by the *Salvation Army Emergency Assistance Program.* All stores stock an array of items including clothing, appliances, and other household items, all for sale to the general public. Proceeds from the thrift stores are used to support the various social services and shelter programs of the *Salvation Army*.

Angelic Ministries operates a furniture, clothing, and food warehouse for thosein need. Items are free, but require a referral from a local social service agency or ministry.

A number of churches and other organizations provide meals. *Church Street United Methodist Church, Lost Sheep Ministry* and the *Love Kitchen* for example, have provided meals on specific days of the week for several years. Other churches sponsor meals through the shelters. Preacher Bob Burger leads the *Highways and Byways Ministry* that provides meals and outreach services. The *Wings of Hope Ministry* also offers services to those in outside locations. *Water Angels Ministry*, located at 907 University Avenue, has a Sunday worship service as well as a clothing room and emergency food pantry. The ministry is open Tuesday through Thursday and in addition to spiritual services, *Water Angels* provides assistance with identification, employment, housing and referrals to

rehabilitation and treatment programs.

Various organizations and agencies offer treatment and supportive services. *Community Action Committee* (CAC), *Child and Family Services, the Vet Center, the Department of Human Services, Lakeshore Mental Health Institute,* the *Public Defender's Community Law Office*, *Home-based Employment, Inc., Helen Ross McNabb Mental Health Center*, *Cherokee Health Systems, Knoxville's Community Development Corporation*, and *Knox County Health Department* all play active roles in the provision of services to the homeless. The local HUD office is available for technical support.

The Knoxville-Knox County Community Action Committee's Homeward Bound Programs are specifically designed to provide services to homeless persons. *Homeward Bound* follows the *Housing First* model, seeking to move people into permanent housing as quickly as possible. The program promotes self-sufficiency by offering long-term case management to enable job training, employment, and stable housing, family reintegration, life skills training (employability, budget management, parenting, and anger management), outpatient alcohol and drug treatment, and assertive outreach to people living on the streets.

Many of the homeless served by *Homeward Bound* have been banned from subsidized housing due to past criminal offenses, civil violations or financial obligations. *Homeward Bound* has developed a key appeal process to restore eligibility for subsidized housing. Over the past three years, 91% of these appeals have been successful. Other *Homeward Bound p*rograms are *HUD* funded and include: *Reach*, *Project Succeed*, and *Families in Need*. The *Reach* program sends a team of workers into the field to offer case management, housing, employment and other services to the chronically homeless. The

outreach team (Roosevelt Bethel and Carl Williams) has been in operation since 1995 and has taken the lead in engaging the outside homeless and moving them toward permanent housing. *CAC* also has *Project Succeed* that offers outreach, long-term case management and supportive services (e.g. housing placement, adult education, budgeting, parenting) to individuals and families in shelters or transitional facilities; and *Families in Need* that provides case management to promote self sufficiency.

The *Public Defender's Community Law Office Social Services Department* provides services that focus on individuals who are involved with the legal system and are homeless or are at risk of homelessness. The *CLO Social Services Department* works with each individual for a comprehensive assessment, including housing needs. Information, counseling and linkage to community resources are provided to achieve housing placements and increased self sufficiency. Short-term case management is utilized to follow each individual through the housing process and reintegration. In addition to addressing housing needs, attention is focused on other areas of need that contribute to, or are related to housing displacement and involvement with the criminal justice system, including employment services, mental health services, and alcohol and drug services.

The *Street A.R.T.* (*Adolescent Response Team*) program, located at 2701 Fifth Avenue, is a program of *Child and Family Tennessee,* providing outreach assistance and referrals for runaway, and homeless youth, ages twelve to twenty-one years of age. Crisis intervention and short term counseling directed toward harm reduction is available on a twenty-four hour on call basis. Shelter assistance is provided through collaboration with the *Runaway Shelter* and other community programs. Services provided include access to emergency food, clothing, and personal hygiene items.

Cherokee Health Systems, a comprehensive health care organization with three Knoxville locations, provides medical, dental and behavioral health services regardless of the patients' ability to pay. *Cherokee* operates the *Broadway Clinic* in the *VMC* building. *The Helen Ross McNabb Center**,*** an integrated system of care, provides mental health, addiction, (including *CenterPointe)* and social services in twenty-seven distinct locations throughout East Tennessee, serving adults, children, and families. The center offers specific programming for individuals who are homeless with severe and persistent mental illness. Outreach workers with the *PATH* and Children and Youth Homeless Programs assist by engaging individuals in mental health treatment, securing housing, obtaining supportive income and linkage to resources in the community. Several programs focus on homeless veterans. *The Volunteers of America Homeless Veterans Reintegration Project* serves an eleven-county area. It provides case management referrals, clothes, and tools to enable employment. The *Veteran's Administration* has the *Veteran's Administration Supportive Housing* (*HUD-VASH) Program* that partners with *HUD* to provide housing vouchers to thirty-five homeless veterans each in both Knoxville and Oak Ridge. An outreach worker from the *Veterans Administration Medical Center* in Johnson City is housed at the Vet Center; in addition to linkage with the medical facilities, readjustment counseling is available. *Legal Aid of East Tennessee* provides legal representation on eviction and other issues encountered by homeless persons.

The Mayors' Office of the Ten Year Plan to End Chronic Homelessness is supporting a number of new initiatives. In addition to permanent supportive housing developed by *Volunteer Ministry Center* and *Helen Ross McNabb Center*, there are a number of new programs being implemented in direct cooperation with the *Office of the*

Ten Year Plan. *Southeastern Housing Foundation, Inc.* is a nonprofit housing developer seeking to develop new units of permanent supportive housing throughout the community in cooperation with the *Ten Year Plan.* These efforts seek to move the chronically homeless quickly from the streets to permanent housing with supportive services like case management and mental health treatment, helping individuals reintegrate into the community. *Compassion Coalition,* comprised of a number of local churches, represents a coordinated effort to assist existing agencies serving the homeless. The *Compassion Coalition* houses *Circles of Support*, a faith-based mentoring program that recruits and trains teams of volunteers from local congregations and matches them up with recently housed individuals who are working with a case manager. The *Circles of Support* mentors then assist the new neighbor's case plan in order to help them remain in housing and reconnect with the community. Mentors visit an hour each week for a minimum of one year. The *Salvation Army* has *Project Peach*, a program designed to work with recently housed individuals to provide specialized employment training and to connect them with appropriate employment opportunities, helping them move from being consumers of community resources to become contributors. The *Knoxville–Knox County Community Action Committee* is addressing the homelessness prevention component of the *Ten Year Plan* by providing targeted case management at four residential high-rise sites operated by *KCDC*. The case managers work with residents who are at risk of eviction and subsequent homelessness in order to help them resolve the issues that would otherwise result in eviction.

II. SURVEY OF HOMELESSNESS

Since its formation in November of 1985, the *Knoxville/Knox County Coalition for the Homeless* has sponsored studies designed to determine the extent of homelessness in Knoxville and Knox County. The initial study was conducted in February 1986, and follow-up surveys and/or enumerations have been completed every two years thereafter (1988, 1990, 1992, 1994, 1996, 1998, 2000, 2002, 2004, 2006, 2008 and 2010). The *Coalition* sponsored a small study in July 1987 examining the duration of homelessness. The *Community Action Committee* (CAC) sponsored a survey in May 1988 as part of a state-wide study; the state effort was not published.

DESIGN

The current study was conducted in January and February 2010. It included (1) a review of the shelter census to determine an unduplicated count of individuals who stayed during the month and (2) interviews with a sample of persons in shelters and outside locations during an evening/early morning period. The interviews were conducted on January 27—29 to be concurrent with the HUD Continuum of Care process. The shelter census was conducted during February to be consistent with past studies. The shelter sites included *The Salvation Army, Knoxville Area Rescue Ministries, Volunteer Ministry Center, the Family Crisis Center, Serenity Shelter, the Runaway Shelter, Great Starts, the YWCA, AGAPE, E.M. Jellinek Center, Transitional Living, Steps House, Family Promise,* and *Catholic Charities.* Outside locations included various camps as well as *Lost Sheep Ministries*.

The questionnaires used in studies over the past twenty-four years contained many of the same questions. However, modifications were made in the questionnaire as researchers and interviewers identified aspects that needed inclusion or elaboration. For example, specific questions about family background, mental health, health, and more recently, questions about substance abuse, domestic violence, foster care, and residency were added. The 2010 study added questions about the use of emergency rooms, hospitalization, and incarceration to examine the cost of homelessness. Questionnaires used in all studies contained the same questions about causes of homelessness, reasons for coming to Knox County, employment history, mental health history and demographics.

In the current study, the women's shelters and women in outdoor locations were purposely over-sampled to allow greater examination of the characteristics and experiences of homeless women. The decision to focus on women was in response to reports from shelters and service providers that there has been a continuous increase in the number of women living on the streets.

Forty-four persons served as interviewers. Many had participated in previous studies; however, a training session was conducted for all interviewers during the week prior to the study. The session included a review of the questionnaire, instructions about the study, guidelines for research interviewing, and answering questions asked by the interviewers. All interviewers signed a pledge to maintain confidentiality.

Outside feeding programs were visited on Wednesday evening, all shelters on Thursday evening and early morning interviews were conducted on Friday; the evening interviews were started at approximately 6:30 p.m. This time was selected to allow shelters to have completed check-in and to have finished the evening meal before

interviewers arrived. The project director had contacted the shelters in advance to determine average numbers of individuals staying at the respective shelters, so that the number of interviews and team size could be planned. Each shelter designated a staff member as contact person to assist with sampling and to help minimize disruption of the evening routine. On the evening prior to the shelter visit, six interviewers visited the Blackstock area during the weekly *Lost Sheep Ministry* feeding program. In the morning following the shelter interviews, eight interviewers visited areas where persons staying in outdoor locations were known to congregate. These locations included Western Avenue, Second Creek, Market Square, Cumberland Avenue, interstate bridges, individual camps, and the *KARM Welcome Center*.

The sampling design was to select every fourth resident in shelters or outside locations. Family and youth shelters were over-sampled to provide data on those segments of the population. The over sample of women and children in shelters was achieved by interviewing every other resident. All respondents were paid $3.00 and were advised of their right not to participate and of their right to refuse to answer any question.

A total of two hundred and thirteen (213) interviews were completed. In the analysis, data were weighted by gender to be representative of the population estimate of twenty-five percent female and seventy-five percent male. The sample of women used for analysis consisted of seventy-eight (78) respondents. In addition to the survey, the project director worked with the shelters to determine a census based on monthly statistics. These statistics and enumerations by outreach workers provided what appears to be a reliable estimate for the month.

The research design has been used in previous studies; however, there are constraints. The mobility of the homeless population and difficulties in locating subjects make sampling difficult. Even more basic is the question of definition, i.e., who is defined as homeless? Persons living in shacks, SROs or residing sporadically with friends, who in reality could be defined as homeless, are excluded by a definition which focuses on individuals who are staying in shelters or outside locations. In spite of these constraints, the sample of shelters and outside locations was viewed as representative of the area homeless population.

In addition to the data available through the sample and enumeration, the 2010 study had the *Homeless Management Information System* (*HMIS*) Annual Report (Patterson, 2009) for comparison. Fourteen agencies are participating in *HMIS* and over 20,000 names have been entered into the system. In examining the information provided by the 2010 coalition study and the *HMIS* study, the reader should be aware that the *HMIS* data is based on service users; for example, "in 2009, 3,711 individual individuals sought services for the first time from *Knox HMIS* partner agencies." (Patterson) In contrast, the coalition study was a "point in time" sample and enumeration; the sample was drawn at agencies and also persons in outside locations who may or may not have been service users. The reader should also note that the data sources are not asking the same questions, resulting in variation. Thus, the findings while not identical can be viewed as complimentary.

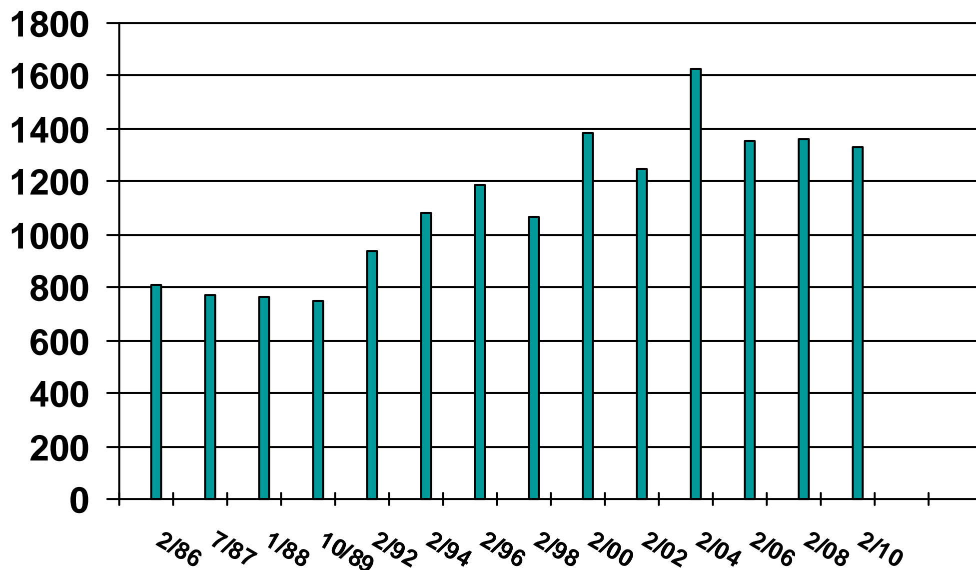
EXTENT OF HOMELESSNESS

Shelter registration for February 2010 indicated that 1328 different individuals stayed in shelters or transitional facilities at least one night during the month. Based on field visits and discussions with outreach workers, the analysis used a conservative ratio of approximately of 80/20 shelter to outside locations consistent with an estimate of 300 individuals in outside locations. Those numbers indicate that 1628 individuals were homeless at some time during February 2010. This total was very close to the 2008 total. The number staying in outside locations also appeared consistent with 2008. Several factors may explain the outside numbers. Shelters are less tolerant of substance abuse and rowdy behavior, the one strike policy in public housing, the lack of a public inebriate program, discontinuation of the *Salvation Army Overnight Program*, and cuts in SSI (for substance related disability) and other programs are likely contributing factors.

The ratio used in the Knoxville studies was derived from field and shelter interviews and has consistently indicated more persons in shelters; however, some studies in larger urban areas estimate outside numbers to be larger than those in shelters. The "National Survey of Homeless Assistance Providers and Clients (2000)", revealed that sixty-six percent had used emergency shelter or accommodations in the previous week, and thirty-one percent had slept on the streets within the week. Using the shelter total of 1328 and an estimate of 300 in outside locations, the findings suggest that a total of 1628 individuals were homeless or without permanent housing during the month. The shelter census of 1328 represented a slight decrease from 2008 and a level number during the past four years. More importantly the past two years reflect a decline in homelessness, despite the

economic recession and high unemployment hovering around nine to ten percent. The shelter totals since 1986 are reflected in the chart below.

TOTALS: 1986—2010



The February 2010 total reported by the two major emergency shelters (*Knox Area Rescue Ministries* and *The Salvation Army,* which were operating in 1986 when the first study was conducted) were 1001 individuals, a slight decrease from 2008. This total exceeded the total for all shelters in 1986, when *Volunteer Helpers*, *Volunteers of America*, and *Traveler's Rest* were also providing emergency shelter.

The graph reflects monthly shelter totals. The findings have demonstrated that during the year, many other individuals will be homeless in addition to those homeless in

February. The Knoxville Studies and the National Survey (2000) illustrate that the homeless population is a changing one. For example, in two small coalition studies, a comparison of the July 1987 census of 775 persons to the January 1988 census of 761 persons, found that only 92 were the same individuals. In a similar manner, the October 1989 census of 746 was compared to the January 1988 census of 761; these two counts, approximately 21 months apart, identified 58 of the same individuals in the two respective months. Also responses to the question, "*How long have you been homeless?*" reflect the turnover of the population. Thus a projection of individuals who will be homeless at some time during the year would be much greater than the monthly total. This projection recognizes the different patterns of homelessness and also the number of transient homeless persons who pass through Knoxville.

The findings underscore the fact that the homeless population is not a static one. As noted previously.

> "The finding that the same individuals are not homeless month to month suggests that persons are being re-established. Services provided by area agencies and shelters may reduce the length of homelessness, and also prevent others from becoming homeless. The meals and large amount of food supplied by shelters, churches, and community groups are likely a major resource for preventing homelessness, as well as enabling some to escape homelessness. Many persons who use these meals only programs live in marginal facilities, such a single room occupancy hotels (SROs) or they represent the "couch population," who spend nights with various friends or relatives and live outside during the day. In many of these situations, meals likely make the difference in allowing scarce financial resources to be used for shelter and other basic needs." (Nooe, 1994, 14).

The report "*Homelessness in Knox County: 2010"* focuses on the current sample; however, statistics from the earlier reports, especially 2008, are shared to illustrate trends. As this report was being written, it was clear that the United States has experienced an

economic recession. These economic changes raise questions about the long-term impact on homelessness and the precariously housed. A spot check of statistics in September 2008 and the 2010 reports from several agencies and shelters found increased requests for meals, food and other services; however, transient overnight shelter populations had not changed significantly. There may be a lag between the onset of hard times and homelessness. People use whatever personal resources are available including family or friends, creating a short-term buffer until social capital is exhausted and homelessness occurs.

DEMOGRAPHICS

In compiling the demographics for the studies, both the shelter census and interview sample were examined. The shelter census provided only the number of individuals, genders, and whether they were less than eighteen years of age. **Table 1** offers comparisons of 2010 and 2008 demographics. The third column illustrates characteristics of 84 individuals in the sample ($n = 213$) who had been homeless one year or longer. The mean age, gender, race, marital status, education and military service represent adult population characteristics.

TABLE 1: CHARACTERISTICS OF KNOX COUNTY HOMELESS 2010 AND 2008			
Item	**2010 Percent* (*n* = 213)**	**2008 Percent (*n* = 247)**	**2010 Percent Chronic (*n* = 84)**
Age:			
Under 18 years	7	5	1
18 - 30 years	19	22	13
31 - 60 years	70	70	82
over 60 years	4	4	5
	mean = 43	mean = 40.5	Mean = 43.6
	male = 45.2	male = 43.6	
	female = 39.3	female = 35.6	
Gender:			
Male	75	74	71
Female	25	26	29
Race:			
White	73	68	76
Black	19	22	20
Other	8	11	5
Military Service			
Veteran	18	18	12
Marital Status:			
Single/never married	40	43	38
Married	8	11	4
Divorced/Separated	45	41	50
Widowed	7	5	8
Education:			
8 years or less	6	27	7
Some high school	23	25	26
High School Grad, incl. GED	47	40	44
Post high school	24	29	23
*Due to rounding error, all totals may not equal 100			

Comparison of the data for 2010 and 2008 indicated similarities, including the number of women and minorities. In comparing these study findings and *HMIS* in regard to

gender, *HMIS* data indicated, "seventy-four percent of the chronically homeless clients are men, versus sixty percent of the clients who are not chronically homeless." The findings on race were seventy-six percent white in this study as compared to seventy percent in the *HMIS* data.

Many of those in the other category are Hispanic and this finding most likely reflected migrant workers who became stranded or otherwise required emergency shelter. The percentage of children was consistent with the previous study. These findings are elaborated in later discussion.

ROOTS

During the past twenty years the number of homeless persons having grown up in Tennessee has been fairly consistent. From a high of fifty-three percent (1986), the trend has been fifty percent (1988); forty-six percent (1990); forty-nine percent (1992); forty-eight percent (1994); forty-one percent (1996); forty-four percent (1998); forty-nine percent (2000); forty-six percent (2002); forty-six percent (2004); fifty-one percent (2006); fifty percent (2008) and forty-eight percent (2010). It is important to consider the number of homeless persons born in Tennessee in the context of the general Knox County population. U.S. Census reports for 2005 indicate that sixty-three percent of Knox Countians were born in Tennessee (U.S. Census Bureau, 2005). Had college students, persons in institutions, homeless persons and other transients been included in this census analysis, it is likely that the percentage would be even closer to the data reported in the 2008 homeless study. **Table 2** identifies states that were prominent in the 2008 and 2010 studies with a comparison of those homeless less than a year or more.

Thirty states and two foreign countries were represented in the 2010 survey, as contrasted to thirty-four states and one foreign country in 2008. Those classified as chronically homeless identified twenty-one states. The original 1986 survey identified even fewer states of origin. This increase in states of origin suggests a more transient population even though the Tennessee percentage has remained fairly consistent.

TABLE 2: STATE OF ORIGIN		
State/Percent	**2010 State/Percent (*n* = 213)**	**2010 State/Percent Chronic (*n* = 84)**
Tennessee	48	48
North Carolina	4	6
Florida	4	4
Georgia	3	6
Illinois	3	4
Ohio	5	5
Michigan	7	7
Indiana	3	--
Other States	23	20

Forty-four percent of the respondents from Tennessee had grown up in Knox County; asked about growing up in other counties in Tennessee, twenty counties were identified with Anderson and Blount were most frequently listed, followed by Loudon, Roane, Campbell, Claiborne, Sullivan and Washington Counties. Eighty-eight percent reported family still living in those counties. Similarly, Blount and Anderson were the Tennessee Counties most frequently mentioned as the immediate residence prior to coming to Knox County.

This study has consistently asked the question, "where did you grow up?" How that data is interpreted has become important in local policy discussions around the issue of homelessness. It is useful for comparison and context to examine data collected by *HMIS* from homeless service providers. *HMIS* asks for the zip code of clients' last permanent address, a question that may offer understanding of individuals who have become homeless after coming to Knox County. The *HMIS* annual report for 2009 shows the distribution of clients who have received services and provides information about their last permanent address. This data indicates that the majority of new homeless clients cite the Knoxville/Knox County area as their last permanent address.

Fifty-nine percent of *HMIS* clients who responded had a zip code with a '379' prefix, corresponding to Knox County, and seventy-nine percent of all service users had a prior permanent address in the '37' prefix, that includes Knox and surrounding contiguous counties. These data suggest that homeless service providers in Knox County are primarily serving people who became homeless while living in the local area. The reader is reminded that the 2010 study sample includes persons who are transient and/or living in outside locations and often not service users.

In the 2010 study, respondents were asked to identify the three most important reasons for coming to Knox County. Being born here or a family move to the county was frequently identified. **Table 3** summarizes the reasons for coming to Knox County.

TABLE 3: REASONS FOR COMING TO KNOX COUNTY		
Response	**2010 Percent* (*n* = 213)**	**2010 Percent* Chronic (*n*= 84)**
Born here	26	29
Job or seeking job	27	26
Traveling	13	14
Social Services/Treatment**	25	23
Family moved here	14	11
New Start	4	2
Shelters	16	17
Other	31	37
*Totals do not equal 100 since multiple responses were accepted. ** Includes mental health, substance, and medical treatment.		

The responses *being "born here"* and "*job seeking"* are most frequent and have remained consistent during the twenty-four years of study. However, social services, medical, mental health, and substance abuse treatment were frequently cited. Medical treatment was cited by five percent overall and by six percent of those homeless over one year. However, mental health treatment or substance abuse treatment were each mentioned by fifteen percent of both. The other category included responses such as "to be near family/friends", "divorce", "new start", and "sent by police or other agencies" These frequencies are combined in **Table 3** and reflect multiple responses by respondents.

Respondents were asked about their housing status prior to coming to Knox County. Five percent had been homeless for less than a week, while thirty-four percent had been homeless for a week or more (compared to fifteen percent in 2008). Additionally, twenty-two percent had been living with friends or relatives. Other responses suggested unstable living arrangements including incarceration, foster care, hospitals,

living in cars and various combinations. Approximately thirty-one percent of those coming to Knox County were living in their own homes or apartments prior to arrival, consistent with the 2008 finding.

To further explore permanence in Knox County, a question was asked about how long the respondent had lived in Knox County. The most frequent response by those not born in or living in Knox County their lifetime was “more than ten years” (nineteen percent) followed by “one to five years” (seventeen percent). Approximately eighteen percent had been here less than six months. Surrounding counties such as Anderson, Blount, and Loudon were most frequently identified as residence prior to Knox County.

FAMILY

Since the original study in 1986, questions have explored family characteristics, backgrounds and experiences growing up. The following refers to experiences of all respondents except where otherwise indicated. Respondents were asked about childhood developmental experiences. In the 2010 study, twenty-two percent had been in state custody and eighteen percent of adult respondents had been in foster care at some time. **Table 4** identifies with whom the individual lived while growing up.

TABLE 4: LIVING ARRANGEMENTS DURING DEVELOPMENTAL YEARS		
Provider	**2010 Percent (*n* = 213)**	**2008 Percent (*n* = 247)**
Parents	46	47
Father	4	5
Mother	29	28
Relatives	10	9
Other	12	12

The 2010 study did not ask about family size, but in past studies the number of siblings was slightly higher than the national average of 1.86 children per family (*U.S. Bureau of Census*, 2000). When asked about the number of children in their families of origin, the mean was 4.1 children per family in the 2006 study.

In terms of family disruption, eight percent (the same as in 2008) reported that their families had experienced homelessness during their childhood. As noted, eighteen percent had been in foster care, which was the same as reported in the previous study (nine percent in 1990; twenty percent in 1996; twenty-two percent in 1998; twenty-eight percent in 2000; fifteen percent in 2002; sixteen percent in 2004 and fourteen percent in 2006). Among those in foster care, half had been in only one foster care placement, with approximately twenty percent having been in two or three placements. Among the total who had been in foster care, fifty-two percent went home (compared to twenty-six percent in 2008). Approximately ten percent went directly to the streets or shelters. These responses did not differentiate how many became homeless later. Three percent went to group homes. Thirty-four percent of the respondents in 2010 reported some form of child abuse, as compared to thirty-nine percent reported in 2008.

As adults, forty percent reported never having been married, eight percent were married and forty-five percent were separated or divorced. Sixty-four percent had children. Fifty-one percent of those with children had children under 18 years of age, but only twenty-five percent of these parents had their children with them. These percentages are fairly consistent with those in the 2008 study, and suggest why there are fewer young children in shelters.

Forty-eight percent of the total had family in the Knoxville area. The majority of these (sixty-six percent) had contacted their families within the previous week. Among those with families in the area, only thirteen percent reported no contact during the past year.

MILITARY SERVICE

Eighteen percent of respondents identified themselves as veterans, which was the same as 2008. However, only twelve percent of those homeless over one year were veterans. **Table 5** displays service by year of discharge. Vietnam era veterans continued to account for a large portion of those with military service. One-third of the veterans had been homeless more than one year.

TABLE 5: YEAR OF DISCHARGE		
Period	**2010 Percent (*n* = 38)**	**2008 Percent (*n* = 44)**
1961 - 1970	--	6
1971 - 1980	43	32
1981 - 1990	33	38
1991 - 2000	15	19
2001 - present	10	6

* Due to rounding error, all totals may not equal 100.

A number of questions about military service have been added beginning with the 2004 study. **Table 6** summarizes these characteristics.

TABLE 6: MILITARY EXPERIENCE		
Causes	**2010 Percent* (*n* = 38)**	**2008 Percent* (*n* = 45)**
Branch of Service		
Army	56	46
Navy	15	15
Air Force	7	9
Marines	13	31
Other	9	--
War Zone Experience	20	28
Type of Discharge		
Honorable	46	62
General	20	23
Dishonorable	3	3
Medical	7	7
Other	25	6
Service Related Disability	20	18

*Totals may not equal 100 due to rounding.

Similar to Knoxville's trends, the number of homelessness veterans has decreased nationally. According to *Veterans Administration* estimates there were 131,000 homeless veterans on a given night in 2008, and this declined to 107,000 per night in 2009 (NCH 2010).

CAUSES OF HOMELESSNESS

In the introduction to this study, factors contributing to homelessness were identified. These factors were reflected in responses when individuals were asked about the causes of homelessness. The 2010 responses reflect a range of overlapping factors. In early studies, family relationship problems and lack of work were the most frequently cited responses; however by 2000, substance abuse was prominent, followed by relationship problems and other personal problems. The reader is reminded that these multiple responses indicate that homelessness usually involves several factors and the conclusions drawn must recognize the complexity of the problem. **Table 7** provides a summary of identified causes.

In 2010, substance abuse was again frequently identified as a factor, as were lack of work and family relationship problems. While medical and mental illness were combined, approximately five percent identified mental illness as a factor in their becoming homeless.

TABLE 7: CAUSES OF HOMELESSNESS		
Causes	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 247)**
Alcohol	22	21
Drugs	32	31
Lack of Housing		
No money for housing	17	14
Evicted	6	5
Loss of Job	25	13
Family Relationships		
Family asked me to leave /Family Conflict	8	13
Abuse	6	11
Divorce/Separation	6	5
Health/Mental Illness	9	7
Prefer it	1	4
Other	22	22

*Totals do not equal 100 due to multiple responses.

Various other factors were mentioned, including criminal activity (six percent) and discharge from correctional facilities (five percent), disability, and numerous life stresses. Several younger respondents (one percent) listed "aged out of foster care". In both this study and the HMIS data, loss of employment was frequently cited. However, the 2010 study responses indicated a much higher rate of self-reported alcohol and drug abuse as causative in contrast to the HMIS data.

LENGTH OF HOMELESSNESS

The number of persons homeless more than one year was forty percent as compared to forty-eight percent in 2008. The reader is reminded that the largest group of

homelessness continues to be what can be termed situational or episodic homelessness. The forty percent homeless over one year represents a point in time count, the sample being collected over a forty-eight hour period. The situational and episodic numbers would likely far exceed this number, decreasing the chronic percentage if the enumeration was conducted during the entire year.

Length of homelessness ranged from one day to over twenty-five years. The 2010 data indicated a slight decrease in the number of persons who reported homelessness lasting more than three years. **Table 8** summarizes the length of homelessness.

TABLE 8: LENGTH OF HOMELESSNESS

Period	2010 Percent* (*n* = 213)	2008 Percent (*n* =247)	1986 Percent* (*n* = 104)
Less than 6 months	33	40	29
Six months to 3 years	45	33	25
More than 3years	22	27	46

*Due to rounding error, all totals may not equal 100.

Recent findings regarding length of homelessness have been fairly consistent, and there has been a decrease in chronic homelessness since the early studies. For example, in the 1986 study, forty-six percent had been homeless more than three years. The Ten Year Plan to End Chronic Homelessness focuses on individuals who have been homeless more than one year, and the findings in the 2010 study suggest that approximately six hundred of those staying in shelters at some time during the month had been homeless one year or more. Those living outside would obviously increase this number. The Ten Year Plan Task Force estimated that the number of chronically homeless was around eight

hundred. Chronic homelessness remains fairly high, but the encouraging aspect is that agencies are reporting an increase in the number of persons placed into and retaining housing.

When asked about previous homelessness, forty percent (forty-six percent in 2008) indicated that they had experienced homelessness prior to the current episode. Among these, eleven percent had one prior episode; thirty-eight percent had two prior episodes; and twenty-eight percent had three or four prior episodes. The remaining twenty-three percent of responses ranged from five to more than twenty.

HOUSING

The current study asked several questions about housing, particularly evictions. In 2010, ten percent (seventeen percent in 2008) had experienced eviction in the previous two years. Fourteen percent of those evicted cited the primary reason as loss of income while another eleven percent attributed their eviction to poor payment history. Twenty-one percent identified drug involvement and three percent identified unruly behavior as reasons for eviction. Nine percent attributed eviction to the behavior of other household members. The “other” category included combinations of these factors, (e.g. “loss of income” and "drug involvement” or “loss of income and poor payment history”). In a separate response, twenty percent of all respondents had been denied housing because of past criminal behavior.

Immediately prior to becoming homeless, fifty-eight percent were living in private housing. Twenty-three percent were living in a relative’s or friend’s home. Lack of funds was most cited (forty-one percent) as a reason for not being able to get into housing.

EMPLOYMENT

When asked about employment, nineteen percent of the respondents said that they had a job, considerably lower than the forty-six percent reported in 2006 and 2008, and likely reflects the economic climate. Caution should be exercised in interpreting this statistic since shelter work programs, collecting cans, and spot labor are often viewed as having a job. Respondents were asked about their usual line of work. **Table 9** identifies the usual line of work.

TABLE 9: USUAL LINE OF WORK

OCCUPATION	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 232)**
Unskilled labor (incl. odd jobs, custodial, carnival, farm)	13	23
Skilled labor (incl. carpenter, electrician, brick layer, plumber, mechanic, welder)	25	12
Construction (Incl. painter)	11	15
Restaurant (incl. cook/waiter)	24	23
Truck Driver	4	1
Nurse's aid/Day care	3	3
Clerical	2	3
Clerk/Sales	4	4
Entertainment	1	1
Factory	1	2
Other	9	13

*Totals may not equal 100 due to rounding error

In 2010, the "other" category included several students. Some respondents said that they were disabled or never worked. The findings in 2010 were similar to those in previous years, however, the percentage identifying themselves as skilled laborers

increased. There is likely some overlap between skilled and unskilled work, as well as between unskilled and restaurant or construction.

Those who had worked (again this must be interpreted cautiously because "canning" and shelter work may be included), offered various reasons for termination of jobs. Several respondents in the "other" category cited being in programs that did not allow work. The responses "no work", "laid off", "temporary", "seasonal" and "day labor" appear interrelated. **Table 10** summarizes the reasons cited for termination of employment in 2010 and 2008.

TABLE 10: REASONS FOR TERMINATION

Reason	2010 Percent* (*n* = 163)	2008 Percent* (*n* = 184)
"No work/Laid off/Out of Business" "Seasonal/Temporary"/"Day Labor"	34	26
"Illness/Disability"	10	7
"Got Tired/Just Quit"	18	18
"Fired"	10	4
"Unfairness/Discrimination"	4	2
"Other"	23	43

*Due to rounding error, all totals may not equal 100

In addition to the reasons listed in **Table 10**, other reasons were variations of those specifically identified as well as several indicating problems with alcohol/drugs or lacking transportation and childcare. The findings have consistently suggested that most jobs tended to be short term.

In light of the lack of stable employment, the research explored perceived reasons for not working (*n*=164). The most frequent response (forty-four percent) was "no jobs

available". There was some indication that persons who were chronically homeless may increasingly perceive themselves as disabled and that there may be an actual loss of job relevant social skills as homelessness endures. Nineteen percent cited disability as the primary reason for not working. Thirteen percent reported not working because "no one will hire." Alcohol and drugs were cited by ten percent. Six percent cited lack of transportation. Several respondents said "not allowed to by rules of shelter", however many of these could be considered as in treatment or pursuing training for employment.

When asked about the need for job training, forty percent replied that they needed job training, similar to prior studies. Several additional questions may relate to employability. Thirty-four percent had a valid driver's license. Eighty percent had a social security card. Fifty-five percent had a copy of their birth certificate.

HEALTH

When respondents were asked about their health, fifty-eight percent rated it as good to excellent. This finding was particularly interesting given the reported health problems identified along with mental illness, substance use and disability reported in questions about reasons for unemployment.

The study asked about health problems since being homeless. Seventeen percent (n=34) reported no health problems. The other respondents (n=179) reported various conditions including: dental (forty-one percent) respiratory, ear, throat (thirty-nine percent); eye (thirty-two percent); feet (twenty-eight percent); severe headaches (twenty-seven percent; accidents/injury (twenty-seven percent); blood pressure (twenty-five percent); pneumonia (nineteen percent); skin (thirteen percent); hepatitis (eleven percent); heart

(ten percent); seizures (nine percent); diabetes (eight percent) and HIV/AIDs (one percent. Nine percent of the women reported pregnancies while homeless.

Respondents were asked if they had chronic health problems, if so, what type, and if they had seen a health care provider in the past year. Thirty-seven percent said that they had chronic health problems (forty-seven percent in 2008). Fifty-eight percent had seen a health care provider during the previous year. Twenty-nine percent had seen a dentist.

Twenty-eight percent of respondents said that they had been hospitalized while homeless (twenty-nine in 2008 and thirty percent in 2006). For the fifty-eight individuals hospitalized, most had been in Knoxville hospitals; for these, treatment had occurred at: Baptist (five percent), University of Tennessee Medical Center (twenty-eight percent), Mercy/St. Mary's (twenty-one percent), Fort Sanders (eight percent) and Park West (two percent). Several children had been in Children's Hospital. The "other" category included hospitals in East Tennessee and out-of-state facilities. The reasons for hospitalization included illness (thirty-one percent), accident/injury (eleven percent), "beat up and robbed" (fifteen percent), surgery, (seven percent) and alcohol related (seventeen percent).

Among those homeless over one year hospitalization was slightly higher (thirty-six percent). Illness was the most frequent reason for hospitalization, but the reports of injury, assault, and alcohol related problems suggested that these are also frequent among the chronically homeless. The other category included various physical ailments, infections, and emotional problems.

Those respondents who had been hospitalized while homeless were asked how many days/nights had been spent in the hospital during the past year. **Table 11** identifies the length of hospitalizations.

TABLE 11: DAYS/NIGHTS IN THE HOSPITAL		
Response	**2010 Percent (*n = 58)***	**2008 Percent (*n* = 68)**
None in past year	12	14
One	18	17
Two	7	13
Three	4	16
Four	8	5
Five to Ten	22	15
Eleven to Twenty-one	21	11
Twenty-two or more	8	9

*The mean for 2010 respondents was 8.9 and the 2008 mean was 9.8 days for all respondents.

Another question asked respondents if they had been transported to a hospital or emergency room by ambulance during the past year. Twenty-eight percent (seventy-five persons) indicated ambulance transportation. Ambulance runs ranged from one to fifteen times with a mean of 2.6 times; fifty-one percent-reported only one time and fifteen percent reported two times. Those who had been homeless one year or more averaged 2.8 ambulance runs.

Respondents were also asked where they went with a health or medical problem not requiring hospitalization. The responses have changed in recent studies due to the opening of the *Broadway Clinic* and *Cherokee Health Systems* providing indigent care.

Table 12 identifies the sources of treatment not requiring hospitalization. The other category included various clinics, such as the *Veterans Administration* and a number of unspecified clinics.

TABLE 12: TREATMENT NOT REQUIRING HOSPITALIZATION		
Response	**2010 Percent* (*n* = 207)**	**2008 Percent* (*n* = 245)**
Cherokee/Broadway	27	--
Health Department	18	25
Emergency Room	26	27
VMC-People's Clinic	**	12
Interfaith Clinic	3	2
Family Doctor	6	11
Nowhere/Don't Know	15	14
Other	12	30

*Due to rounding error and multiple responses, all totals may not equal 100.
** The *Broadway Clinic* is in the *VMC* building.

A separate question asked all respondents how many times they had been to an emergency room during the past year. Thirty-six percent had not been to an emergency room, however, for the remaining sixty-four percent, responses ranged from one (twenty-two percent) to twenty-two times. The average number of emergency room visits for the total sample was two visits, while slightly higher for those homeless for over a year (2.2 visits).

Forty-four percent (forty-nine in 2008) reported having received *TennCare,* and thirty-two percent of these were currently receiving it, but two percent were unsure.

MENTAL HEALTH

Chronic mental illness and deinstitutionalization continue to be cited as major reasons underlying homelessness. Fifty percent of the total ($n = 213$) had been treated for emotional problems. Fifty-three percent of those receiving treatment for emotional or mental illness had been hospitalized. Stated differently, twenty-six percent of the total had been hospitalized for mental illness.

Among those individuals reporting prior hospitalization, a number reported multiple hospitals; forty-three percent had been at *Lakeshore*, and thirty-eight percent had been at *Peninsula Hospital*. Seven percent had been treated at *Ridgeview* and seven percent had been in a Veterans Administration Hospital. Seven percent had been at other state hospitals in Tennessee, and eight percent had been at state mental health institutions in other states. Thirty-six percent identified various other hospitals.

Among those who had been hospitalized, twenty-eight percent reported only one hospitalization and another fifty-nine percent had been hospitalized between two and five times. Eleven percent had been hospitalized six to ten times with the remaining two percent having eleven or more hospitalizations. For sixty-nine percent, hospitalization had occurred more than one-year earlier. However, twenty-five percent had been discharged within the previous six months. The length of most recent hospitalization varied: thirty percent reported less than one week, and fifty-four percent had been hospitalized between one week and one month. Among those hospitalized, ninety percent had been discharged on medication, but over one-half (fifty-three percent) of them were not taking it. Many said that they “never started” the medication, which may reflect being given a prescription and also may overlap “not being able to afford it,” cited by thirty percent. Interestingly, nine

percent of those who stopped their medicine cited, "don't like the way it makes me feel," as the reason. Three percent said the prescription ran out.

At the beginning of the deinstitutionalization movement in the early 1970's, sixty-five percent of persons discharged from institutions returned to live with family; however, this number has declined (Talbott, 1980). **Table 13** illustrates post-hospital residence and indicates that a large number of persons discharged went directly to the streets or shelters from psychiatric facilities. Even among persons who go to live with relatives or their own home, studies have suggested that as much as thirty percent may become homeless within six months (Belcher and Toomey, 1988). The substantial percentage increase since the initial study in 1986 parallels bed reductions and closing of state facilities.

TABLE 13: POST-HOSPITAL RESIDENCE

Residence	2010 Percent* (*n* = 53)	2008 Percent* (*n* = 76)
Relatives/Friend	34	25
Boarding Home/Group Home	10	1
Own Home/Apartment	18	13
Street/Shelter	31	47
Other (incl. Jail/Custody)	7	14

*Due to rounding error, all totals may not equal 100.

Eighty-four percent were referred to a mental health center at the time of discharge. Seventy-two percent of the total reported treatment at a mental health center at some time

and sixty percent of those were currently being seen. Twenty-seven percent of all respondents perceived their "nerves" as bad. Seventy-five percent said that they experienced depression, with thirty-nine percent of those saying they were depressed everyday. Twenty-one percent had been seen by the mobile crisis team (twenty-three percent in 2008).

ALCOHOL AND OTHER DRUGS

Substance abuse has been identified as a major factor in homelessness. While the study relied on self-reports, there appears to have been consistency in the incidence of substance use and abuse in recent years. **Table 14** reflects the responses about alcohol and other drugs.

TABLE 14: ALCOHOL AND DRUG USE

Response	2010 Percent (*n* = 213)	2010 Percent Chronic (*n* = 84)	2008 Percent (*n* = 247)
Alcoholic	32	43	31*
Recovering	9	10	9
Drug Use	75	82	78

*Another seven percent denied alcoholism but reported having a problem with alcohol

The frequency of self identified alcoholism has remained high since the original study in 1986. Other drug use has also been frequent since the 1990's, with seventy-five percent indicating usage in 2010. Among the users (*n*=155), thirty-five percent considered

themselves addicted, with another twenty-one percent identifying themselves as being in recovery. These data suggest that forty-one percent of the total interviewed (*n*=213) believed that they were or had been addicted to drugs (thirty-nine percent in 2008). It appeared that many used both alcohol and other drugs. Among those who used drugs, marijuana was most frequently cited (forty-six percent), followed by crack (twenty-two percent), prescription drugs (twenty-two percent), and cocaine (twenty percent). Methamphetamine was identified by five percent. Various prescription drugs were identified. Among the users, thirty-four percent indicated daily use and seven percent reported using substances several times per week. Thirteen percent said drugs were used once or twice per month. The 2010 percentages regarding drug use were consistent with 2008-reported use.

In the total sample, forty-nine percent had received inpatient treatment in a detoxification facility. The most frequently cited treatment programs, continued to be *Peninsula,* (including the *Lighthouse*) *CenterPointe and KARM*. Respondents also identified a variety of local hospitals along with *Lakeshore* and programs such as *Jelenik Cornerstone*, *Salvation Army and Great Starts*. Additionally, a number of non-specific sites were mentioned. Twenty-one percent of those hospitalized reported only one inpatient experience and forty-five percent reported two to five hospitalizations. Among the total, thirty-six percent had received outpatient treatment for substance abuse. Twenty percent reported difficulty in finding treatment.

CRIME

Homeless persons are vulnerable to being victims of crime. Many of these crimes go unreported, but in most years there are at least one or two media accounts of the murders of homeless people. In 2010, thirty-nine percent of respondents had been victims of crime since being homeless as compared to thirty-five percent in 2008 and below the highest rate of forty-three percent in 1996. Forty-eight percent of these victims had been robbed or experienced theft (thirty-one percent), and forty-two percent of the victims had been stabbed or assaulted while homeless. Since multiple responses were accepted, thirty-three percent said that they had been "beat up", and five percent reported being shot. Fifteen percent identified themselves as victims of other crimes. Six percent (three-fourths being women), reported having been sexually assaulted, with ninety percent of these reporting multiple assaults. As noted in previous studies, the aged or infirm are particularly vulnerable to crime. Deinstitutionalized individuals, chronic alcoholics, loners and recipients of Supplemental Security Income (SSI) or other benefits are at greater risk.

In contrast to being victims, respondents were also asked if they had served time in correctional facilities. The comparison between 2010 and 2008 offered in **Table 15** indicates a consistency in the frequency of incarceration in jail. However those homeless longer than one year reported slightly higher rates of jail and prison. Approximately twenty-five percent of respondents who had served time in jail or detention reported one incarceration and half of those serving prison time had only one incarceration. The interview asked if the respondent had been arrested for trespassing or loitering and twenty-one percent answered in the affirmative (thirty-four percent of the chronically homeless). As in previous studies, the most frequently cited reason for jail time, as

contrasted to more serious offenses, was public intoxication or alcohol related infractions, such as DUI. Several female respondents cited prostitution.

TABLE 15: INCARCERATION			
FACILITY	**2010 Percent* (*n* = 202)**	**2008 Percent* (*n* = 247)**	**Chronic Percent* (*n* = 81)**
Jail	76	74	83
Workhouse/Detention	13	18	19
State or Federal prison	22	22	28
Due to multiple responses totals do not equal 100			

Since the 2002 study, several questions about public intoxication have been included. Thirty-five percent (forty-six percent of the chronically homeless) had been arrested for public intoxication within the last three years as compared to thirty-four percent in 2008. Most frequently reported (thirty-four percent) was one arrest and another twenty-three percent had two or three arrests. Approximately twenty percent had over ten arrests during the three-year period. The range was from one to over one hundred times.

Respondents were asked about the total number of days spent in jail, detention, or prison during the past year. Responses ranged from zero to three hundred sixty-five days, among those who had been incarcerated the average was 44.9 days incarcerated. Comparing the statistical means for length of incarceration for those homeless less than one year to those homeless one year or more illustrated a pronounced difference. Those homeless less than a year had a mean or average of 39 days of incarceration compared to 49 days for those chronically homeless. In other words, the chronically homeless

individual spent an average of ten more days in jail than other homeless individuals who had been incarcerated during the past year.

Respondents who had served time were also asked where they went when released the most recent time. This question did not discriminate among jail, workhouse, or prison. From the 160 responses, nineteen percent returned home, twelve percent went to live with relatives, eleven percent moved to a group or transitional facility, and forty-three percent were homeless (shelter/street). This finding of being released back into homelessness is very consistent with the 2008, 2006 and 2004 findings of forty-one, forty-two and forty-three percent, respectively. In 2010, fifty-six percent of those who were homeless over one year had gone to a shelter or the streets upon release. Other responses (fourteen percent) identified various situations such as living with a girlfriend, at a motel, or in a rehabilitation program, many of which suggested lack of stable living arrangements.

Despite the small sample, the findings that approximately forty-three percent of those incarcerated go directly to emergency shelters or the street upon release remains an area for concern. Emergency shelters do not have the supervision, support, and services that may be necessary to help a person achieve successful reintegration into the community. Homelessness will likely increase the chance of recidivism.

LIFE ON THE STREETS

The 2010 findings suggested that the majority of homeless persons preferred shelters and most stayed in shelters at some time. Many respondents report a combination of sleeping locations, including shelters, outside sites, abandoned buildings, cars, SRO's and with friends; approximately five percent said that they stayed in hotels. The 2010 percentages include multiple responses and are identified in **Table 16.**

TABLE 16: USUAL SLEEPING LOCATIONS

Location	2010 (*n* = 213)	2008 Percent* (*n* = 247)	2010 Chronic Percent* (*n* = 84)
Abandoned Building	8	3	12
Car	6	6	8
Shelters	70	67	61
Friends/Relatives	11	9	12
Outside Locations	23	25	31
Other	12	19	16

*Due to multiple responses, all totals may not equal 100.

The table above indicates that the shelters were the most frequently used locations. The other category included staying in transitional facilities. Most respondents will stay in shelters at least one or two nights per month, so the shelter total may be under reported because the question asked "*usual sleeping location*".

This year's study asked respondents how many nights had they stayed in a shelter during the past year. Fifteen percent (*n* = 33) reported "none", the same as 2008. The

remaining responses ranged from "one" to "three hundred and sixty-five". Forty-five percent (*n* = 96) stayed in shelters thirty nights or less. Nine percent reported “every night” during the past year. Among those homeless more than one year, twenty percent never stayed in shelters, but fifteen percent reported every night. Seventy-nine percent of all respondents indicated that they had a permanent address here for receiving mail. In 1986, only thirty-nine percent had a permanent address for receiving mail; however, policy changes as well as residency in transitional facilities may influence this finding. Forty-eight percent said that they had family in the Knoxville area, and sixty-six percent of these had been in contact with them during the past week. Thirteen percent of persons with area relatives reported over a year since last contact. Among those homeless over one year, forty-three percent had family in the Knoxville area, but nineteen percent reported no contact is over a year.

Several questions were asked about staying with friends and relatives during the past year. Fifty-nine percent (fifty-four percent in 2008) had stayed with friends or relatives during the past year. As noted earlier, seventy-three percent had lived in Tennessee counties other than Knox County or out of state prior to coming to Knox County. Among the one hundred and fifty-five who had spent time outside Knox County, approximately one-half mentioned *out-of-state.* Twenty-nine Tennessee counties were mentioned by individuals. *Anderson* (seven percent), *Blount* (eight percent), Hamilton (four percent) *Davidson* (three percent) and Sullivan (three percent) were most frequent, followed by nearby counties such as Hamblen, Sevier, Roane, Campbell and Jefferson.

The 2010 study included questions about transportation. **Table 17** summarizes the responses to usual means of transportation. The “*other”* category included bike, family

and church or agency transportation. While walking has been the most frequent form of transportation, the finding of seventy-two percent in 2010 using buses underscores the importance of public transportation.

TABLE 17: TRANSPORTATION		
Transportation	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 247)**
Walk	76	77
Bus (incl. trolley)	72	65
Friend's Car	20	20
Own Car	7	15
Hitch-hike	5	5
Tenn-Care	4	6
Other	11	19
*Totals do not equal 100 due to multiple responses		

In order to achieve a clearer understanding of life on the streets, several additional questions were asked about how time was spent, specifically "How/where do you spend the day?" Multiple responses were accepted and the respondents numerous activities. **Table 18** summarizes daytime activities.

The responses "day room" and "at the shelter" may not be mutually exclusive. For a number of years *VMC* operated the day room, however, in October 2008, *KARM* opened the *Crossroads Welcome Center* that allows daytime occupation/activity.

Many of the responses were overlapping, for example, several mentioned "classes" at agencies or participating in "agency treatment" or "working at the shelter". The "other" category included a range of responses including "looking for services", "chores" and

"reading" *or* "watching t. v.". Only one respondent identified panhandling as the major daytime activity.

TABLE 18: DAYTIME ACTIVITY		
Response	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 247)**
"Working"	17	28
"Loafing/On the Street/Woods"	10	8
"Looking for Work"	35	14
"Walking"	23	10
"At the Shelter"	22	20
"At the Library"	22	12
"Day Room" (*VMC*)	10	11
"Child Care"	2	2
"Canning"	6	4
"Crossroads/Welcome Center	7	--
"School"	4	6
"Looking for Housing"	6	2
"Drinking/Drugs"	3	2
"Treatment/Agency Programs"	12	13
"Visiting Family"/"Friends"	7	2
"Other"	9	9
*Totals do not equal 100 due to multiple responses		

The most sensitive area in the interviews has always been questions about money. Reluctance to talk about money is reflected in inconsistent responses to questions about income. Respondents were asked about approximate weekly income and sources of income. Most likely the responses represented an under reporting of income and sources. **Table 19** summarizes average weekly income.

TABLE 19: WEEKLY INCOME		
Amount	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 247)**
$ 0.00	38	24
$ 1.00 - 50.00	31	19
$ 51.00 - 100.00	10	11
$101.00 - 200.00	9	25
$201.00 - 300.00	9	11
$301.00 or more	3	11
*Due to rounding error totals may not equal 100.		

Weekly income is especially important in helping individuals escape homelessness. In 2008, approximately forty-seven percent had a monthly income of $400.00 or more, however, in 2010, only twenty-one percent had this level of income. In any case, this level of income suggests that they would be candidates for subsidized housing. Respondents were asked about sources of money and multiple responses were accepted. **Table 20** summarizes the sources of income.

TABLE 20: SOURCES OF INCOME		
Source	**2010 Percent* (*n* = 213)**	**2008 Percent* (*n* = 247)**
Work	51	62
Government Assistance	11	19
Plasma Center	7	4
Handouts	13	12
Relatives/Friends	22	21
Food Stamps	45	29
Canning/Scrapping	22	5
Other	11	8
*Totals do not equal 100 due to multiple responses.		

Although work was the largest category, it included day labor. This has been consistent in all studies. The "*other"* category included various sources such as shelter allowances, child support, pensions and alimony. A small number reported stealing and selling drugs as source of income. Fifteen percent of the respondents indicated that they had lost government benefits during the past two years as compared to twenty-one percent in 2008. Earlier studies also reported loss of benefits: thirty-four percent in 1998; twenty-one percent in 2000; fifteen percent in 2002; twenty-four percent in 2004; and twenty-five percent in 2006. Thirty percent of the respondents (twenty-eight percent in 2008), indicated that they had engaged in illegal activity at some time to support themselves.

In the studies, a consistent observation has been that there is a lack of accountable payees or guardians for those receiving disability checks. Many receiving assistance did not seem to have the skills or ability to effectively manage those funds and were vulnerable to exploitation. In 2010, only four percent of those receiving assistance had a payee other than self, down from eleven percent in 2006 and 2008. The issues about payees remain an area that needs more examination.

IDENTIFICATION

The 2010 study included several questions pertaining to identification as well as employment potential. Fifty-five percent reported having a copy of their birth certificate. Eighty percent had a social security card and thirty-four percent had a valid drivers license. Sixty-two percent reported having an *HMIS* card.

CHRONICITY

The foregoing discussion identified several differences between those who were homeless less than one year and those who were homeless one year or more. **Table 21** summarizes several key differences noted.

An interesting observation in **Table 21** is those homeless more than one year had many more arrests for public intoxication and trespassing, resulting in greater frequency of being in jail. However the mean for days incarcerated suggest that those homeless less than one year had fewer arrests but longer sentences.

TABLE 21: COMPARISON OF CHRONIC AND NONCHRONIC HOMELESS INDIVIDUALS		
Category	**Homeless One Year or More (*n* = 84)**	**Homeless Less Than One Year (*n* = 129)**
Criminal Justice		
Arrested for Public Inebriation	46%	22%
Arrested for Trespassing or Loitering	34%	12%
Spent Time in Jail	83%	66%
Times in Jail	*mean* = 13.0	*mean* = .4
Days Incarcerated During Past Year	*mean* = 45 days	*mean* = 44 days
Medical		
Emergency Room Visits	*mean* = 2.1	*mean* = 1.9
Transported by Ambulance	37%	34%
Times Transported by Ambulance	*mean* = **2.8	*mean* = **2.3
**Mean is for only those transported by ambulances.		

WOMEN

In past studies, the number of homeless women has been reported; however the number of women in the interview sample was relatively small. Beginning in 1998, the studies over sampled sites where women stayed in order to examine this segment of the population in more depth. In 2010, seventy-eight ($n = 78$) women were interviewed using the standard questionnaire.

The shelter census-enumeration indicated that approximately three hundred women were homeless during the month of February 2010. Substance abuse remained a most frequently cited reason for homelessness (forty percent drugs and thirteen percent alcohol). Examination of other factors contributing to homelessness suggests that family problems, including abuse, conflicts, separation and divorce were major causes of homelessness. The causes did not appear mutually exclusive; for example, those citing drugs also cited alcohol.

> "Min" and her two children were brought to the Center by her pastor. Min's pastor told her about the shelter when Min disclosed that her husband is physically and emotionally abusive. Min's six year old son has been diagnosed with autism and her 4 year old daughter is devastated to be out of their home. The family is Asian and her husband views her as his property, so dealing with cultural differences is an ongoing process. After being at the shelter for a few days, an interpreter came to help finish her intake and to communicate with her more efficiently, since she speaks little English. Her children were also able to get back to school after working with the homeless liaison from Knox County Schools. Every day Min struggles with the idea of going back to her husband, but with the support of her church, interpreter, and shelter staff, Min is still waiting to go to court for her order of protection. She recently told staff that she loves her husband and does not want her children to be from a broken home, but she now knows that if her husband really loved her, he would not treat her the way that he does. Min and her husband own a business, which was her source of income, but now her abuser has cut off her cell phone and access to the bank account, forcing her to choose between homelessness or an abusive home. However, the shelter staff and the interpreter have helped Min gain a new perspective and more

respect for herself. Therefore, she plans to stay in shelter until she can rebuild a life free from abuse for herself and her children.

Mental illness as a cause was cited by three percent of the women. Several indicated that a family member's addiction had forced them into homelessness. Four percent said that release from jail or prison had preceded homelessness. Other reasons included death of a family member, no identification, or relationship difficulties.

When asked about experiences growing up, eleven percent reported that their families had been homeless at some time (ten percent in 2008). Fifteen percent had been in foster care and seventeen percent had been in state custody. Sixty percent reporting foster care had been in three or more foster homes (twenty percent had been in a single foster home). Approximately fifty-one percent had been physically and/or sexually abused as a child.

Seventeen percent of the women reported current employment, a significant decrease from 2008. The other women for not working gave multiple reasons. Disability or illness (thirty-eight percent) was often identified. Fifteen percent said no jobs were available and ten percent reported, "no one will hire me". Substance abuse was cited by eight percent. Other responses included lack of transportation and childcare responsibility. Consistent with cited health reasons, forty-four percent considered their health as *fair or poor*, as opposed to *good or excellent* and fifty-one percent said that they had a chronic health problem. Nine percent had been pregnant while homeless. Overall, forty-four percent indicated a need for job training. **Table 22** summarizes the characteristics of homeless women.

TABLE 22: CHARACTERISTICS OF WOMEN		
Item	**2010 Percent* (*n* = 78)**	**2008 Percent* (*n* = 94)**
AGE**		
Under 18 years	2	1
18-30 years	25	37
31-60 years	70	62
Over 60 years	3	1
	(mean = 39.3)	(mean = 35.6)
ROOTS		
Tennessee Native	55	57
RACE		
White	78	73
Black	14	18
Other	8	9
MARITAL STATUS		
Single	39	46
Married	10	12
Divorced/Separated	43	37
Widowed	8	5
EDUCATION		
8 Years or Less	5	5
Some High School	26	32
High School/GED	43	29
Post High School	26	34
REASONS FOR HOMELESSNESS*		
"Abuse"	21	24
"Family Conflict" (Incl. Divorce)	5	20
No Money for Housing	18	12
Drugs	40	35
Alcohol	13	12
"Eviction	11	6
"Lost Job"	8	11
Mental Illness	3	3
Other	20	29
LENGTH OF HOMELESSNESS		
Less Than One Month	8	13
One to Six Months	41	34
Over Six Month to One Year	21	19
Over One to Three Years	15	17
Over Three Years	15	18
MILITARY STATUS		
Veteran	1	1

*Multiple responses were accepted.
**Does not include under 16 years of age.

Sixty-five percent of the seventy-eight women reported treatment for emotional problems with forty-eight percent of those having been hospitalized. (**Note:** Twenty-three percent of the total number of women had been hospitalized.) These findings are similar to previous years. Hospitalization for emotional problems was consistent with the overall homeless population, however, the women reported a higher percentage of treatment in general and more hospitalization within the past year; thirty-five percent were currently in treatment. Seventy-six percent of the total reported depression, with approximately seventy percent of those indicating feeling depressed several times a week or continually.

> Laura is a 50-year-old woman diagnosed with Depressive Disorder and is a resident in a supportive living apartment. Laura received her degree in computer analysis, but after repeatedly experiencing episodes of mental decompensation, suicide attempts, and hospitalizations, she lost her job and was evicted from her apartment. Subsequently, Laura was arrested for shoplifting and placed in the Knox County Detention Center for three months. After her release, unable to find housing, Laura was referred to a supportive living apartment by her attorney. Laura has maintained stable housing and regularly pays rent every month. Despite her anxiety in social situations, she has made progress by socializing with other residents daily. She has also benefited through the support of onsite case management. Laura has begun receiving food stamps and she is currently in the process of applying for Social Security disability benefits.

When asked about alcoholism, eighteen percent considered themselves alcoholic and another eight percent were in recovery. Seventy-three percent of the total had used drugs. Thirty-seven percent of the users reported being addicted and thirty-three percent were in recovery. Fifty-four percent had been inpatients in a detoxification facility for alcohol or other drugs. Seventeen percent had been arrested for public intoxication within the past two years.

Barbara, a 30-year-old mother of three children, entered the program to address her substance addiction. Two of Barbara's children were placed in state care because of her addiction and her husband's incarceration. Barbara and her husband had long histories of substance abuse and homelessness. The neglect Barbara's children experienced from this caused the Tennessee Department of Children Services (DCS) to become involved with her family. DCS stipulated that Barbara must enter treatment to maintain her parental rights with the third child. Barbara and her son lived in the program, receiving treatment and therapeutic services. Her son received help from the on-site therapeutic nursery for his developmental and emotional needs. Through case management and therapy, Barbara successfully completed treatment. She also completed her GED, gained employment, and secured safe, sober housing for her son and herself through agency transitional housing. They can live in this program up to 24 months. Barbara's son will continue in the nursery until he is old enough to start school. Barbara's family also continues to receive support through aftercare in-home services that help her to stay in recovery and will help her family identify long-term housing resources and ongoing support.

Thirty-three percent of the women said that they had been victims of crime while homeless, which was consistent with the overall homeless population rate. Fourteen percent reported having been sexually assaulted while homeless. In contrast to being victims, sixty-eight percent had spent time in jail and seven percent had been in prison. Responding to a question added in 2010, sixteen percent had received mental health treatment while incarcerated.

Twenty-four respondents (thirty-one percent) had been transported to medical facilities while homeless with a range of one to eight times. Sixty-four (sixty-eight percent) had been seen at an emergency room with a mean of 2.98 times (or 2.03 times for the overall sample). Twenty-three of the women (thirty-four percent) had been hospitalized while homeless. Nights in the hospital ranged from one to thirty, with a mean of 6.6 for the twenty-three women who had been hospitalized (or 1.9 for the overall sample).

Fifty-nine percent of the women had family in the Knoxville area, and approximately seventy-eight percent of those had contacted family within the last week. Various sources of money were cited: nineteen percent work; fifteen percent government assistance; thirty-eight percent assistance from relatives; seventeen percent friends; and eight percent reported canning. Fifty-seven percent reported having food stamps. Seventy-one percent had received *TennCare*, and forty-one percent were currently receiving *TennCare.* Thirty-nine percent had engaged in illegal activity to support themselves.

Forty percent of the women had been homeless before the current episode. Fifty percent of those had experienced three or more prior episodes of homelessness, similar to prior years. Fifteen percent had been evicted or lost subsidized housing during the past two years. Twenty-three percent of the respondents (twenty-one percent in 2008) had been denied housing because of criminal behavior.

Thirty-six percent of the women (the same as 2008) reported a loss of government benefits during the past two years. Seventy-two percent usually sleep in a shelter with nights spent in shelters during the past year ranged from zero to three hundred and sixty-five with a mean of one hundred and four nights (median of sixty nights).

Fifty-six percent had a copy of their birth certificate and seventy-eight percent had a social security card. Forty two percent had a valid driver's license and forty-five percent reported having an HMIS card.

CHILDREN

Among the adult women, seventy-three percent had children, and seventy percent of these women had children under eighteen years of age. In other words, forty of the seventy-eight women had children under eighteen. Thirty-nine percent of the women with children under eighteen had their children with them, similar to the number in the 2006 and 2008 studies. During the month, one hundred and three children of school age or younger were living in shelters.

The findings underscore the special needs of school-age homeless children; however, the statistics may not show special needs such as a place to do homework, school stability, school supplies, transportation, emotional care, physical health care, and compensatory education for developmental delays that these children are facing.

> Jack is a seven-year old elementary student in Knoxville. Chronically homeless since age 3, Jack, his mother and a 4-year-old sister have moved back and forth between shelters, relatives' and friends' homes. Since these relatives and friends live in different counties, Jack has attended different schools. He has been diagnosed as having Attention Deficit - Hyperactivity Disorder. Socially, he tends to isolate himself from classmates and often appears defensive when put into group activities. His mother suffers from Bipolar Disorder and displays a learned helplessness, failing to follow through on referrals or simple tasks.

The *Stewart B. McKinney Act* provided funding to address the needs of school age individuals. Each state is provided funds for distribution to local school systems. Knox County has had a *Homeless Education Program* since 1993-94, providing a coordinator, transportation resources, funds for tutoring, and a summer enrichment program. Tamera Saunders, *BSED,* the *Knox County School Homeless Liaison,* has furnished statistics that describe the number of homeless children. The 2009-2010 school year showed a

significant increase from prior years. There were a total of five hundred and fifty-seven (557) children including 224 in elementary school, 124 in middle school, 154 in high school, 16 in alternative school, 15 in preschool—head start and four completing the GED.

The number of homeless children in school fluctuated in the years prior to 2009—2010. Program statistics for the 2006–2007 school year indicated that 256 homeless children were in the program, including 165 in elementary school, 45 in middle school, 30 in high school, 14 in preschool, and 2 completing the GED. In the 2005–2006 school year, 256 homeless children were in the program; this total included 20 preschool, 175 elementary, 39 middle and 22 high school students. In 2003–2004, there were 375 children in this program, including 45 preschool, 275 elementary, 35 middle and 20 high school students. Data previously furnished by the program indicated that during the 2001—2002 school year, Knox County schools had 40 preschool, 200 elementary school, 40 middle school and 30 high school students that could be classified as being from homeless families. This total of 310 students reflected an increase from the 244 identified in the 1999–2000 school year.

On October 13, 2010 (2010—2011 academic year), there were 195 homeless children enrolled in Knox County schools. This number included 94 in elementary school, 53 in middle school, 25 in high school, six in alternative schools and seven in preschool—head start. While these numbers reflect less than three months of the academic year, the breakdown of where these students reside provides insight into the experience of childhood homelessness. **Table 23** identifies residence.

Table 23: RESIDENCE OF HOMELESS CHILDREN	
Residence	**Percent ** (n = 200*)**
Shelters	34
Doubled up	42
Hotels	13
Substandard Housing	4
Transitional Housing	1
Kinship Care	2
Unaccompanied Youth	1
State Custody	5
* October 19, 2010 ** Totals do not equal 100 due to rounding.	

Local and national data continue to indicate that homeless children are at risk for emotional and mental health issues, developmental delays, family violence, and experience a high incidence of substance abuse in their families. The foregoing described children in shelters where a parent was present. Additionally, there was an adolescent segment of the homeless population that was separated from parents. This group continued to be difficult to enumerate since many avoid shelters and/or programs for the homeless. Service providers and law enforcement officials shared anecdotal evidence of homeless adolescents who spend considerable time in the Old City or who had been taken in and exploited by adults, but it was a difficult group to identify and interview.

> Before 17-year-old Rick entered the youth shelter, his family was abusing and neglecting him daily. They had kicked him out of the family's home when he reached age 17, and Rick began living on the streets while attending high school each day. It was at school that Rick heard of the agency. He had no food or money, no safe place to live, no consistent adult support, no form of

> state identification or birth certificate, and he had not completed high school. Staff members met Rick and took him to the agency's shelter. It was at the shelter that Rick was given a home, food, and emotional support, and the help that would meet his basic needs. Shelter staff members helped him through the long process of obtaining his birth certificate, social security card, and state identification. In addition, he completed his GED and entered the military. Rick still has no connection with his birth family; the staff members who helped him are whom he now considers his "family". Rick regularly calls "home" and reports that he is doing well. He now has stable housing, an education, and a future in the military. The shy boy who entered the shelter has grown into a confident and outgoing young man.

Adolescents interviewed in the study would be classified as runaways or children who had been placed in state custody. The adolescents were between ages fourteen and seventeen years. Responses consistently suggested a high frequency of family instability. However, the statistics did not explain whether this instability was a contributor to or consequence of the adolescents' behavior. All of the adolescent respondents identified themselves as students. Mobility and possible running away among the adolescents was reflected in responses to questions about number of different cities visited in the past year. The adolescents seemed to maintain contact with families and received some support from them. The responses by the adolescents as well as the adults underscore their need for support systems. Resiliency involves the opportunity to feel good about one self, to experience support and have the chance for success.

III. COMMENTS

The Knoxville-Knox County Homeless Coalition celebrated its 25th anniversary in November 2010. The Coalition was appointed in 1985, when homelessness began to be recognized as a profound social issue. The drastic increase in homelessness seen in the 1980's was influenced by several economic and social changes. These included a decrease in the availability of affordable housing, a lack of growth in real earnings, the closing of institutions that had housed the mentally ill and substance abusers, an increased number of discharges from correctional institutions, persons aging out of foster care, and loss of benefits. During the past twenty-four years, Knoxville and Knox County witnessed an increase from 800 homeless persons in a given month to a high of approximately 1900 homeless persons per month in 2004.

Homelessness 2010 is the fourteenth study sponsored by the coalition. The 2010 enumeration is very significant in that the finding of approximately 1628 homeless individuals in February, with 1328 of these having stayed in shelters at some time during the month, is consistent with totals for 2006 and 2008. Despite the severe recession and high unemployment in recent years, the number of individuals and families staying in shelters has been consistent during the past five years. At the same time, agency reports indicate that the requests for supportive services and resources have increased drastically. It may be that these services are allowing those at risk for homelessness to maintain housing or those already homeless to obtain housing or to draw upon family and friends for shelter.

As noted, the 2010 enumeration was consistent with previous counts indicating a monthly total of approximately 1628, with 1328 of these staying in shelters as compared

to 1652 (1352) in 2006 and 1659 (1359) in 2008. This consistency in enumerations, along with available agency data reporting persons being placed in permanent housing is a positive indicator of success in addressing homelessness. Interesting, in the coalition studies, the percent homeless for more than three years was in the mid twenty percent range between 2006 and 2010, much less than the forty-six percent in 1986. In any case, chronic homelessness, defined as lasting more than one year and having a disability, remains an area of concern. While the chronically homeless represent a small percentage, they consume approximately 50 percent of the resources, including emergency medical services, psychiatric treatment, shelters, law enforcement and correctional facilities.

The studies of homelessness conducted by the Knoxville-Knox County Homeless Coalition have highlighted a number of conclusions. Many of the conclusions from previous studies can be repeated and amplified. **First**, the incidence of homelessness remains significant but there is evidence of progress as individuals and families move into housing. **Second**, homelessness reflects a diverse group of individuals; the number of women has increased. **Third**, the number of homeless children, based on school statistics, has increased; however, there are more living "doubled-up" with relatives and friends than in shelters. Homeless experience for children will likely have long-term consequences as evidenced by the findings that suggest childhood disruptions increase the risk for adult homelessness and other problems. **Fourth**, mental illness and substance abuse are major risk factors for homelessness; jails continue to be the main housing for the homeless mentally ill, with approximately six times as many in correctional facilities as in psychiatric institutions. **Fifth**, many persons cycle in and out of homelessness, with almost half reporting prior episodes. **Sixth**, consistent with the

number of children living “doubled-up,” there are a large number of homeless individuals and families who are living outside emergency shelters and program facilities, in outside locations or who are “couch or doubled-up homeless”. **Seventh**, the majority of area homeless persons continue to be from East Tennessee, having come to the area to seek employment or be near family. **Eighth**, the number of homeless veterans has continued to decrease, mirroring national statistics. The V.A. estimated that nationally in 2008, there were 131,000 homeless veterans on any given night but this number decreased to 107,000 in 2009. **Ninth**, chronic homelessness is costly in terms of human potential and community resources.

There are a number of ongoing concerns and challenges. The cost of chronic homelessness in terms of ambulance, emergency room and hospital use, as well as criminal justice involvement, particularly arrests and incarceration remain high. Another serious concern is the state of the economy. As this report is written, the United States is experiencing high unemployment. Economic conditions may increase the number of homeless, reduce financial support for agencies and hinder escape from homelessness. Even if homelessness can be prevented, the demand on agencies for food and services is high.

In 2010, Knoxville–Knox County saw a leveling in the number of homeless persons during the month of February, remaining similar to the numbers in 2008 and 2006. Several factors likely influenced this finding, but shelters and agencies increasing their efforts to move persons into permanent housing and adopting the “*housing first”* orientation outlined in the *Ten-Year Plan to End Chronic Homelessness* are likely major factors. Along with the housing first approach, the level of agency cooperation and coordination continues to increase. While agencies are working together to find housing,

it appears that many persons are staying in outside locations, living in cars, or doubling up with friends and relatives. There remains the ongoing issue of how to engage these individuals in finding housing rather than enabling chronic homelessness.

Homelessness continues to be a major challenge for the community. While there are no simple solutions, the complexity underscores the need for different sectors, neighborhoods, social services, health, government and businesses to work together. The adoption and implementation of the *Knoxville–Knox County Ten Year Plan to End Chronic Homelessness* provides an exciting opportunity to reduce homelessness, however, it has not been without challenges. The opening of Minvilla Manor to house 57 individuals and the progress on the *Flenniken* project are important accomplishments. Likewise, the progress of the *Homeless Management Information System*, the increasing involvement and initiatives of the faith-based community, and the greater cooperation among agencies offer the potential for achieving positive results. The *Ten Year Plan* includes a strategy to "Recognize Homelessness as a Community Challenge". It is essential that different voices from across the community be heard in informed discussion about the complexities and strategies to address homelessness. While differences of opinion may exist and some debate occur, it is critical that we as a community pursue a healthy dialogue around the goal to prevent, reduce and end homeless in Knox County.

In summary, homelessness is an extremely complex problem. Despite this, many agencies and individuals are collaborating and making significant progress toward solutions. Individuals and families are escaping homelessness and becoming self-sufficient. As noted previously, “Perhaps the greater danger is community acceptance of homelessness as inevitable rather than an urgent social issue demanding increasingly effective solutions.”

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