
**HOMELESSNESS
IN
KNOXVILLE/KNOX COUNTY:
A Twenty Year Perspective
1986 - 2006**

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Special appreciation is extended to the following persons who contributed case examples. These examples added to the report by helping to “put a face” on homelessness. They are not based on responses to the questionnaire, but are composites of individuals who are homeless.

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I. INTRODUCTION

Homelessness 2006 is the twelfth study of homelessness in Knoxville-Knox County sponsored by the East Tennessee Coalition to End Homelessness and highlights twenty years of collecting data. The first study was conducted in 1986 with regular studies conducted biennially thereafter. 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 and participation in community education and development of housing for the homeless.

In 2006, a number of significant activities are occurring in Knoxville-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* to assume total responsibility for this service. Currently the major shelters are discussing more effective definition of services.

The development of the *Homeless Management Information System (HMIS)* offers a means of greater service coordination and accountability. Twelve agencies are participating with others planning to join the system; approximately 5,500 names have been entered. The *HMIS* will be an important management tool for coordinated case management as well as monitoring the extent of homelessness.

This report incorporates much of the narrative from the earlier reports. The research findings from 2006 are reported and compared with the 1986 data when that data is available. 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 2006 study. These composites were submitted by agency staff and do not violate the confidentiality of the respondents or agency clients. Before examining the 2006 data, however, it seems appropriate to briefly reflect on 1985-86 when the coalition was formed and the first study conducted.

FORMATION OF THE COALITION

The 1986 study, *“Homelessness in Knox County: Report of the Knoxville Coalition for the Homeless”* described the formation of the coalition:

Knoxville has been no exception in terms of experiencing an increasing homelessness population. The social services, the inner city churches and Knoxville - Knox County governmental agencies have experienced increased pressures to provide services. In early 1985, there was beginning discussion about the need for coordination of services. Inner city churches, through Knoxville United Ministries (KUM) and Knoxville Inner City Churches United for People (KICCUP), and the General Assistance Office of Knox County government were especially active in examining ways of meeting this need. In September of 1985 approximately 15 persons from Knoxville attended the conference on homelessness sponsored by the U.S. Department of Health and Human Services, Region IV, in Atlanta to get a regional perspective and gain understanding of how other communities were addressing the problem. Following this meeting, in November of 1985, Mayor Kyle C. Testerman and County Executive Dwight Kessel appointed the Knoxville Coalition for the Homeless.

Wanda Edmondson and Nancy Reese from Knox County General Assistance were instrumental in advocating for the appointment of a coalition. The coalition initially included 27 persons from various segments of the community, including representatives from agencies serving the homeless, businesses, churches and other persons who were in any way affected by the homeless population in the community. Appendix A identifies the members of the first coalition. (Note while this is termed the first coalition, reportedly there was a "Knoxville Coalition for the Homeless" in 1929.) The present day coalition held its first meeting on November 8, 1985.

The coalition's initial task was to design and implement a research study to identify the extent of and needs of the homeless population in the area. A detailed questionnaire containing 69 items including questions on causes of homelessness, reasons for coming to Knox County, employment history, physical and mental health status, service use patterns and needs, friendship networks, demographics and interviewer impressions was compiled. Forty-five persons volunteered to serve as interviewers and they are listed in appendix B.

Many in the interviewer pool were *University of Tennessee College of Social Work* students; others included members of the Coalition, retired business persons, service providers, Levi Straus employees and members of the press. These volunteers were joined by several homeless persons who acted as guides for the interviewing teams. The volunteers represented a wide range of work experience and community involvement. The common link among this diverse group was a genuine interest in learning about the homeless.

The research design was similar to the one currently used. Teams of interviewers visited the shelters in the evening and then reassembled early the following morning to interview in outside locations. The annual studies have been conducted in February, and 1986 was no exception as the teams visited the shelters at 5:30 pm on February 19th and reassembled at 5:00 am on February 20th (the temperature was 14 degrees with snow showers).

In addition to conducting the study, the coalition reviewed services. Working committees identified as (1) Food and Shelter, (2) Social Service and Health, (3) Employment, (4) Finance, and (5) Community Relations were appointed, and asked to review the status and services in the respective areas and to make recommendations to the larger coalition.

SERVICES IN 1986

When the coalition was initially appointed, Knoxville had seven shelters for the homeless along with a number of meal programs. The shelters included:

1. *Knoxville Union Rescue Mission* at 511 Broadway. The shelter had approximately 60 beds and non program individuals were allowed to stay one night in seven.

2. *New Life Inn* at 411 Gay Street. It was associated with the Union Rescue Mission and had 25 beds for women.

3. *Salvation Army* at 2209 North Central Avenue. It provided 90 beds for men and limited the number of nights per month a person could remain.

4. *Volunteers of America* at 414 West Church Avenue. The shelter had 65 standing beds and housed families or women and children, but no single men.

5. *Volunteer Helpers* at 103 South Gay Street. It had 37 beds, but using the adjoining storefront church chapel, housed as many as 200 persons on cold nights. This shelter had liberal policies regarding length of stay. Additionally there were 27 apartments upstairs.

6. *Traveler's Rest* at 1607 Western Avenue. It had 13 beds but could set up for 36. It housed families and single parents with children.

7. *Family Crisis Center* at 2535 Magnolia Avenue. The facility had 12 beds and provided shelter to homeless and battered women and their children.

In addition to the above, *Hope Haven* with 22 beds was a *Union Rescue* facility that focused on abused and battered women and their children. *Judy Russell House* at 1009 Tulip Avenue was owned by *Volunteer Helpers* and provided short-term shelter for 6 women.

In addition to the above shelters a number of churches and organizations provided meals. For example, *Church Street United Methodist Church* provided lunches on

Thursdays, *St. Johns Lutheran Church* provided a soup kitchen on Saturdays, and *New Bethel AME Methodist Church* provided lunches on Thursdays. The downtown churches, particularly the *Knoxville Inner City Churches United for People (KICCUP)* churches and *Knoxville United Ministries (KUM)* offered various services. In addition to food and shelter, there were a number of social service agencies actively involved with the homeless population. These include such agencies as the *Department of Human Services, Travelers Aid, Knox County General Assistance, Community Action Committee, Child and Family Services, and Catholic Social Services*, and the mental health centers and facilities, such as *Overlook, Helen Ross McNabb, and Lakeshore Mental Health Institute*. The reader will recognize that many of the above have continued to provide services and are currently active in addressing homelessness.

Despite the experience of studying homelessness for twenty 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. The *National Law Center on Homelessness and Poverty* found that in almost

every city the estimated number of homeless people exceeded the availability of emergency shelters and transitional housing (1999). These findings along with other available studies suggest that many homeless people may be living with friends or relatives in temporary arrangements (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. There are a number of variations in definitions. Homelessness has been defined in terms of residence within a geographic area such as “skid row” (Wallace, 1965), the lack of permanent residence (Leach and Wing, 1980), and a personality attribute (Bahr, 1973; Bassuk, 1983). Depending on the definition of homelessness used, persons will be included or excluded from counts; for example, 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 is misleading in that it implies that lack of residence is both the problem and cause, obscuring the broader factors, such as poverty, lack 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.

Recent studies suggest that 760,000 people are homeless on any given night and approximately 2 million adults experience homelessness each year (National Law Center on Homelessness and Poverty, 1996; Burt, Aron, Lee & Valente, 2001). These numbers increase significantly when children are included to 842,000 and 3.5 million (Burt, et al. 2001). 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 survey, hunger and homelessness continues to rise in

major American cities. In the twenty-five cities that responded to the survey the number of homeless families seeking shelter increased fifteen percent in 2003, constituting forty percent of the overall homeless population (2004).

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, the 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 in several cities – were missed, demonstrating the difficulty in counting (Wright and Devine; Straw, 1995).

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 viewed within a designated time frame. Different patterns of homelessness—situational, episodic, and chronic—will determine 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/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 chronic 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

The homeless population continues to be one of the fastest growing sub-populations, despite the United States' recent periods of significant economic growth. 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, 2002). In a sense, homelessness represents the "poorest of poor." In 2002, people below the official poverty thresholds numbered 34.6 million, a figure 1.7 million higher than the 32.9 million in poverty in 2001 (Proctor and Dalaker, 2003).

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, 2002).

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 (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 (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. 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 contributing 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 Knoxvilleians 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 six years. The conversion of the motels from tourist-based facilities to serving a 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 (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.

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

Sam currently lives in the Knox County jail because he cannot access housing due to former offenses. He is released after serving each sentence and the next day intentionally gets arrested again because he has no other means for housing and three hot meals. As with other former offenders he is not eligible for subsidized housing.

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.

Jim presents many of the housing challenges faced by homeless clients. Jim is a 35 year old recently discharged from a mental health facility. Hospital staff actually transported him to the shelter. He has been diagnosed as having schizophrenia, paranoid type, and has been hospitalized four times in the past three years. Jim has lived with relatives, in group homes and at times in his own apartment, but reverts back to the street, usually after stopping his medications. A drug charge and several arrests for misdemeanors make him ineligible for housing although he does receive a disability check.

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 (ICH, 1999).

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).

Betty is a mentally ill woman who has been homeless for approximately five years. She recently was helped to access housing at a local subsidized housing development. She works at a sheltered workshop which is a short distance away. Betty is extremely shy and she is reticent to ask for any help or extra consideration. She recently received notification that her share of the rent had increased to \$126 per month. She was in a panic since she only makes \$200 a month. When her Case Manager visited, Betty told her about this, but also said that she didn’t want to call the Housing Authority since they might become “angry” with her. She wanted to just pay the new amount. After an extended conversation with the Case Manager, Betty was able to make the phone call and explain the situation. The Housing Authority, through some miscommunication, had understood Betty’s income to be \$400 a month rather than \$200. The matter was quickly resolved and her rent was returned to an affordable level. Betty would not have been able to make this phone call alone, nor would she have been able to pay the greater rent over the long term. This simple miscommunication would have resulted in Betty’s return to homelessness. Active case management was the critical resource needed to keep Betty housed.

MENTAL ILLNESS/DEINSTITUTIONALIZATION

The role of mental illness and deinstitutionalization in homelessness is hotly contested. Torrey (1989) argues that deinstitutionalization is a major contributing factor, whereas the *National Coalition for the Homeless* (1997) asserts that deinstitutionalization has had little impact on the number of homelessness. 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 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 (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 mental illness producing disorder where previously it did not exist” (Koegel & Burnam, 1992, p. 96).

Walter an 18 year old homeless white male diagnosed with Bipolar Disorder with psychotic features and Schizoaffective Disorder, had been living with his mother until she began pushing him to move to the mission to build more independence. The Homeless Program intervened and developed a plan to allow Walter to stay with his mother until another form of housing could be obtained; having assessed that his low level of functioning would perpetuate additional risk factors if he went to the shelter. The case manager’s further evaluation of Walter’s situation indicated that he was severely limited in his independent living skills. He often came to his appointments without showering or changing clothes, he frequently missed his mental health appointments, and regularly forgot to take his medication which usually lead to him having suicidal ideations. Walter had extreme difficulty managing his anger and was very limited in his communication with others. The Homeless Program was able to secure housing at a facility for males who have a dual diagnosis. Once in housing, Walter was able to participate in the GED program at the Knox County Alternative High School. Since Walter is only 18 years old, he continues to be insured through TennCare, making him eligible for several programs. He was referred to a long term case management program that continues to assist him with staying in housing and school, maintaining needed mental health services, and improving his independent living skills. All of these above mentioned resources play a vital role in ensuring that Walter will remain in stable housing and continue working towards becoming self-sufficient.

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 (Lamb and Weinberger, 1998). The homeless have become criminalized, and in a sense jails are becoming today's asylums. 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 (Solomon and Draine, 1995).

Harry is mentally ill-diagnosed as having a schizophrenia disorder- and very angry. He admits to hearing voices that tell him to “do bad things”. Harry has been barred from local shelters after breaking furniture and threatening other residents. He has been hospitalized numerous times and although discharged on medication, discontinues it because, “I don’t like the way it makes me feel”. He receives a disability check of approximately \$600/month. He says that he has a case manager, but can’t remember the name. Despite the monthly income, he continues to live on the streets and cycle in and out of jail.

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).

Many of the jobs held by homeless persons are temporary or do not provide sufficient wages to provide 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 (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.

Debbie is a single mother with two children. She was referred to the transitional housing program by another agency. Debbie was in an abusive family situation, suffering both physical and mental abuse. She has always relied on men, usually abusive, to support her and her two children. One day she finally had had enough and sought the refuge of the Crisis Center. However, she found herself homeless and without employment skills. Since she has been in the program, she has found employment, received financial counseling, paid off her debts, and bought a used car. Debbie is attending the local University and hopes to become a nurse. She is increasingly confident, providing for her family, working and attending the University.

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. However, the relationship between homelessness and substance abuse may be more complex than on first appearance. For example, those who are addicted may be more impacted by the decrease in availability of *SROs*. 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/sale 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).

Scarlet is 28 years old and had been living on the streets for three years. She is addicted to crack cocaine and had been paying for her drug use by theft, shoplifting and prostitution. Scarlet had gotten caught stealing and this time unlike her other charges for prostitution she was sent to jail for ten months. Scarlet was able to get clean in jail and started to look at her life. This was not the life her adopted parents wished for her but more like the one her biological mother had led. Scarlet says she told herself she would never do the things she did for her addiction and wanted to change. When Scarlet got out of jail she came to the women's shelter and asked for help. Upon entering the program Scarlet was given a clean safe place to sleep without bars and threats from other street hardened individuals. While in the program Scarlet learned about healthy boundaries and recovery tools that helped her deal with the past. Scarlet became involved with a 12 step recovery program and started to go to church on a regular basis. With the help of her case manager Scarlet went back to school and obtained employment in the medical field. She is currently living in her own apartment and furthering her education.

Many individuals are dually diagnosed, suffering from both a major mental illness and substance abuse (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).

Scott is 43 years old and a father of three. He grew up in Knox County, Tennessee, but had been living for the last ten years in another state. The mother of his two children had started using drugs again after a period of being off of them. Scott, who reports being a drug addict who has been clean for seven years, decided to leave that situation before he relapsed. He reported having had a few drinks of alcohol now and then and being on prescription sedatives, but he still believed he had been clean. Scott had problems with depression and anxiety, and had not been able to keep a job. His sister, who is involved in a twelve step recovery program, suggested he come into the treatment program at the shelter. While in the program Scott came to realize that his dependence on prescription medication and his usage of alcohol was not working as a recovery program. Scott learned about switching addictions and the importance of abstinence in his recovery. The program gave Scott the skills to deal with his anxiety and depression in healthy ways. He started therapy and was referred to mental health services. Eventually Scott was able to obtain skilled employment that pays well and has full benefits. Scott started paying child support and is currently living in his own apartment looking forward to the time he can gain custody rights of his two younger children.

EDUCATION

Inadequate education has not been clearly identified as a causative factor in studies focused on homelessness. 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.

“Matthew” an 18 year old male found himself homeless after aging out of the foster care system, with no family support. With no where to go, Matthew turned to a Transitional Living Program where he lived for two months. The program provided support and guidance from on-site supportive staff with career and life skills training, counseling and most importantly, a supportive and nurturing environment in which to live. At the end of Matthew’s stay in the program, he gained employment with a major construction corporation and moved into his own apartment. Matthew says paying rent, “feels good”.

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. Zorza (1991) reported that 50% 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 (1998).

"Maria" an Hispanic woman about 40 years old contacted the Center for assistance in establishing legal documentation through a U-Visa for immigrant victims of crime in the U.S.. Maria had become a victim of crime and was referred to the Knoxville Police Department's domestic violence unit after receiving an order of protection. Maria's husband was a U.S. citizen and had promised to file legal papers on her behalf with Homeland Security. After the marriage, Maria's husband became physically and emotionally abusive and would threaten to have her deported if she called the police. When she started working with the Center she was working two jobs under false documentation and living from place to place including in her car. Maria was not comfortable going to shelter due to the cultural differences, but eventually was able to rent an apartment that was almost uninhabitable. Maria's case was accepted by the immigrant legal clinic and she was able to retain an immigration attorney at no cost through support from a grant through department of justice. In three months Maria received a temporary work permit, allowing her to work legally and find suitable housing, while the attorneys continued to represent her with Homeland Security to establish a permanent U-Visa.

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

Lisa entered the family shelter in the summer, after her husband's probation officer advised them to seek "stable" housing. At the time, her husband was employed in a family owned business and was being "paid under the table". She was caring for the children from this marriage, ages 1 and 2. Lisa was very reluctant to enter a residential program and therefore was very reserved in her interactions with peers, staff, and case manager. Initially, Lisa reported a desire to "help her husband with his problems." She discussed at

great length financial, legal, and marital problems, but refused to follow up on suggestions and referrals made by her case manager. After many months of working closely with her case manager, Lisa sought therapy for these issues and help for physical health concerns she had ignored previously.

Several months after entering the program, Lisa's husband was discharged from the family program for repeated rule violations. He was referred to another treatment facility and the family was given special privileges for family time. While in the treatment facility, Lisa's husband violated probation and picked up additional charges. He was placed in jail and Lisa was left to care for the children on her own. Lisa met extensively with case manager at this time (on a daily basis and sometimes multiple times during the day). She began to make long-term plans. She enrolled the children in daycare, started receiving benefits through DHS, and began attending classes at a technical school. Lisa also began to seek housing, but with husband's felony on record, this task was difficult.

In the spring of the following year, Lisa received certification in office administration. She began working, paid off debts incurred during the marriage and successfully cared for her children as a single mom. She followed up with legal counsel regarding divorce from her husband. Lisa graduated from the family residential program. She is still employed, has housing and has developed a support system in the area including church, friends and continued contact with her case manager.

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

The 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).

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 the vulnerability to homelessness. 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).

Several studies have examined childhood risk factors for adult homelessness. Economic and residential instabilities, along with poverty, are examples of childhood antecedents (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 (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 (Nyamathi, Longshore, Keenan, Lesser & Leake, 2001).

“Jacey”, a 23 year old female started drinking at the age of 9 and using drugs by age 12. Jacey grew up witnessing domestic violence from her father, who eventually became abusive to the whole family. Jacey’s mother was very supportive but worked full-time and was never around. Jacey and her mother moved around a lot, and as a teenager Jacey started getting into abusive relationships and continuing to do drugs. At age 16 she got pregnant, started getting in trouble with the law and dropped out of school. At age 18 she became pregnant again. In and out of jail and heavily addicted to drugs, she decided to give her mother temporary custody of her children. Jacey tried to enter inpatient rehab facilities but they all had long waiting lists so she continued to use drugs. After finally entering rehab and completing the program, at discharge she was arrested for violating her probation and started running from law enforcement. During this time Jacey found herself homeless, living from place to place. Jacey entered a program that provided her with stable transitional housing with structure and supportive on-site counselors, who are helping her learn how to live clean and sober. She is being reunified with her children and is in the process of completing her GED.

The state of one’s health and 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, at a disadvantage by her illness but also by the fact that she lost one 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 basically 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, which had been discontinued when she did not claim her checks for a prolonged period of time. Her case was reactivated and Mary’s 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 (Rosenheck and Fontana, 1994). There appears to be an increasing number of young adults who become homeless after transitioning out of state custody.

Mike, age 18, had been in foster care since age 12 due to an abusive alcoholic mother. Department of Children's Services returned him to his mother six months before his 18th birthday. Staying on the street to avoid abuse from his mom, Mike had no identification or social security card necessary for housing. Mike has a history of bipolar illness, is developmentally slow, and is addicted to both alcohol and crack. He receives SSI in the amount of \$603. He came to the agency with a pregnant 16 year old girl, and said he was the father of the baby. The case manager encouraged the young girl to call her parents who drove to Knoxville to pick her up. Mike was upset but with assistance from the case manager, applied for subsidized housing, but disappeared before it became available.

Mike reappeared one year later, living on the streets, and he had been assaulted with a knife. He said that his abuser was at the shelter and he could not go there. Mike was placed in permanent subsidized housing after two weeks of living at a motel provided by a youth transition program. Appointments were secured for mental health treatment and he began taking his medications. After a few weeks Mike quit taking his medication and became volatile. He threatened the apartment staff, lost his housing and disappeared 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 on going support for those existing foster care, mental health and correctional facilities is especially critical for avoiding of escaping homelessness.

In sum, the 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. (see: The Ten Year Plan to End Chronic Homelessness). Children in particular suffer as they experience an increased risk of inability 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 or 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

The shelter resources in Knoxville have changed over the years. The closing of *Volunteers of America* in 2002 had a major impact on services for families. This shelter provided emergency housing to twenty families with children and thirty-five single women. However, the other shelters worked to address the need; still housing for transient single women and families remains a critical issue. Another significant change that continues to have reverberation was termination of DRI-Dock's detoxification program for public inebriants. *The Ten Year Plan to End Chronic Homelessness* emphasizes the need for such a facility.

Knoxville has a number of programs for homeless persons. The major shelters are:

- (1) The *Salvation Army Center* is located at 409 North Broadway. It operates two emergency shelters. The *Joy Baker Center* has a capacity of 36 individuals and serves battered women, with or without children and homeless women and children. The *Shafer Center* has a capacity for up to 20 individuals. A transitional housing program also is located on the premise and can house up to 66

individuals; 48 beds are designated for single-homeless males and 18 are designated for single-homeless women. Meals are served daily for residents. The *Salvation Army* offers a range of case management and supportive services, including on-site child care, employment counseling, and referrals. Direct assistance in the form of clothing, food, and furniture is also provided.

(2) *Knox Area Rescue Ministries* is located at 418 North Broadway. The ministry provides multiple programs for homeless men and women and families in the Knoxville and surrounding areas. The single men's program (Lazarus Hall) has a recovery program for 63 men and an overnight care facility for 216 men. The family program (New Life Inn) has 18 family rooms for transitional services for up to 61 individuals. The single women's overnight (*New Hope Haven*) program provides emergency overnight services for 40 women. In addition *KARM* provides three meals a day, seven days a week for indigent persons in the Knoxville community. All recovery programs are designed to assess and provide multiple interventions to break the cycle of homelessness.

(3) *Serenity Shelter*, a facility operated by *Knox Area Rescue Ministries*, 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 30 individuals. In addition to basic food, shelter and other supportive services, the 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 and homelessness.

- (4) *Volunteer Ministry Center* is located at the corner of Gay Street and Jackson Avenue. The center offers daytime shelter, access to restroom facilities, phone service and meal service. Most meals are served by volunteer groups. A case management program offers access to lockers, showers and laundry facilities. Participants and their case manager design a plan for participation in self advancement classes. The Center also offers sixteen rent assisted apartments and sleeping rooms which provide permanent housing to formerly homeless men. *The Refuge*, a *Volunteer Ministry Center* coordinating agency provides some direct financial assistance and counseling. The People's Clinic is open three days a week offering dental services on one day and the services of a Licensed Nurse Practitioner on two days, and a Psychiatric Nurse Practitioner on one day. A Licensed Clinical Social Worker is available for counseling. A Hispanic Clinic is held monthly.
- (5) *The Family Crisis Center* is located at two sites kept confidential in order 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. The east shelter has a capacity for sixteen and the west shelter has a capacity of twelve individuals, both with potential for slight expansion in emergency situations. Services include case management, support groups, individual counseling, transitional housing, assistance to female stranded travelers, legal assistance to undocumented immigrant victims of crime and children's services. Length of stay is 30 days; however, extended stays are available depending on the individual need.

- (6) The *Runaway Shelter* is located at 2701 E. Fifth Ave. It is a program of *Child and Family, Tennessee*, providing short-term shelter and counseling for runaway and homeless youth, ages 12—18 years. It has a capacity for five individuals. Services provided include individual, group, family, and crisis counseling.
- (7) The *Transitional Living Program* is located at 2701 E. Fifth Ave. It is a program of *Child and Family, Tennessee* providing residential and day case management services to homeless and “throwaway youth,” ages 17—21 years. The main center has a capacity for five individuals with scattered site availability for additional clients. Services provided include independent living skills assessment, individual and group counseling, and case management services. Additional support services are available for children and youth ages 16—21 who have “aged out” of the foster care system or have been in the foster care system for one year. Services include job skills training, independent living training, housing assistance (including 2 beds through *Transitional Living*), rent and utilities assistance, and transportation.
- (8) The *YWCA* is located at 420 W. Clinch Ave. It has fifty-eight private rooms for single women in transition. Residents are assisted in developing a plan for employment and utilization of appropriate programs. The facilities include a shared kitchen, living room, laundry room, and food pantry for residents. The average length of stay is six months, however, residents may stay for up to 24 months. There is a \$42.00 weekly rate.
- (9) *Agape* is located at 428 E. Scott Avenue. It offers a six months individualized program for chemically dependent adult women. Three Victorian houses each

provide residence for eight clients, for a capacity of 24. Services include individual and group treatment and referrals. There is a \$10/day fee and a \$100 entrance fee.

- (10) *E.M. Jellinik 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.
- (11) *Steps House* is located at 712 Boggs Ave. It offers a residential program for alcohol and drug recovery. The capacity is 112 with one section designated for veterans (40 beds) and the other for addiction recovery care (72 beds), indigent care is available. Services include case management and group counseling. The fee for non-veterans is \$110/week. There is no limit on length of stay.
- (12) *Great Starts*, located at 2601 Keith Avenue, is a transitional housing program operated by *Child and Family Tennessee*. It houses women with alcohol and drug addiction and provides an on-site therapeutic nursery for children who are drug exposed, HIV positive, developmentally delayed or medically at risk. The capacity is 22 women in the housing program and 38 children in the nursery. Supportive services include parenting classes, A&D groups, case management, family services, medical care, and therapeutic counseling to provide a holistic approach for chemically exposed children and their chemically dependent mother. The

length of stay in the program is 6 months and can be extended based on progress and individual need.

- (13) *Parkridge Harbor*, 1501 East Fifth Avenue, provides case management, alcohol and drug treatment services and housing services. It offers services to persons with HIV/AIDS in Knox and the surrounding counties. There is a 24-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.
- (14) *Pleasant Tree Apartments* are located at three different sites; 2460 E. Fifth Avenue, 114 Dameron Avenue, and 1909 Dawn Street. It is a program of *Child and Family Tennessee* and provides permanent supportive housing for homeless women diagnosed with mental illness. The program provides 25 single family dwelling apartments ranging in size from efficiencies to three bedrooms. On-site case management is available including independent living training, crisis intervention, therapeutic counseling, advocacy, medication management and transportation.

The above resources provide emergency shelter and lodging. In addition a number of agencies/organizations provide specific services. Two of the shelters operate centers providing clothing and household items:

Knox Area Rescue Ministries currently operates two thrift stores—one at 3935 Western Avenue; the other at 115 Sherlake Drive—which offer a variety of clothing, household items, and

furniture. Both 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 on limited resources to assist in the return to community living or to minimize the effects of poverty. In the coming year the stores will offer job training in customer service and cashiering.

The *Salvation Army* operates five thrift stores in the Knoxville area. Clothing and furniture is provided (free of charge) to individuals referred by the *Salvation Army Social Services Department*. All stores stock an array of items including clothing, appliances, and other household items, for sale to the general public at affordable prices. Proceeds from the thrift stores are used to support the various social services and shelter programs of the *Salvation Army*. Hours of operation are from 9:00 a.m. to 5:30 p.m. Monday through Saturday.

A number of churches and other organizations provide meals; *Second United Methodist Church*, *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. The *Concord United Methodist* and *Concord Mennonite Church* have joined together to provide a Monday lunch and clothing closet at “The Spot” in the *Mennonite Church* on Lovell Road. 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. Various social service agencies offer needed services. *Community Action Committee (CAC)*, *Child and Family Services*, *Vet Center*, *Department of Human Services*, *Lakeshore Mental Health Institute*, *Home-based Employment, Inc.*, *Helen Ross McNabb Mental Health Center*, *Knoxville Community Development Corporation*, and *Knox County Health Department* 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* has designed one unit of its organization as *Homeward Bound Programs*. This unit is specifically designed to provide services to homeless persons and includes *Homeward Bound*, a program 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.

A number of programs offer transitional, supportive living, half-way house services, residential or specific services to homeless persons, such as those previously identified. The *CAC Reach* program sends a team of workers into the field to offer case management, housing, employment and other 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, throwaway and homeless youth, ages 12 - 21 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 Services*, a comprehensive health care organization with three Knoxville locations provides medical, dental and behavioral health services regardless of the patients' ability to pay. The *Helen Ross McNabb Center*, an integrated system of care, provides mental health, addiction, and social services in 27 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 assist by engaging individuals in mental health treatment, securing housing, obtaining supportive income and linkage to resources in the community. The *Helen Ross McNabb Center* also offers permanent housing with supportive services (case management) for homeless individuals. The case manager provides linkage to mental health services, medical care and community resources as well as support to maintain in permanent housing. Additional housing options are offered through the Center's independent living program. *Compassion Coalition*, comprised of a number of local churches, represents a coordinated effort to assist existing agencies serving the homeless.

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. 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.

II. SURVEY OF HOMELESSNESS

Since its formation in November of 1985, the *Knoxville Coalition for the Homeless* has sponsored studies designed to determine the extent of homelessness in 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, and 2006). 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 February 2006. 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 shelter sites included *Salvation Army, Knoxville Area Rescue Ministry, Volunteer Ministry, Family Crisis Center, Serenity Shelter, Runaway Shelter, Great Starts, YWCA, AGAPE, E. M. Jellinek Center, Transitional Living, Steps House, Eagles Nest, Interfaith Hospitality Network, and Catholic Charities*. Outside locations included various camps as well as *Lost Sheep Ministries*.

The questionnaires used in all studies over the past twenty 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, problem

solving abilities, and more recently questions about AIDS, substance abuse, domestic violence, foster care, and experiences with social service agencies were added. The 2006 study added questions about families with children, military experience, public intoxication arrests, loss of *TennCare*, and most used agencies. 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-five 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.

On the day of the study, the 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 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 *Volunteer Ministry* day room.

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 twenty-three interviews were completed. In the analysis, data were weighted by gender to be representative of the population estimate of twenty-seven percent female and seventy-three percent male. The sample of women used for analysis consisted of eight-four 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 agency 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 are excluded by a definition which focuses on individuals who are staying in shelters or outside locations, but who in reality could be defined as homeless. In spite of these

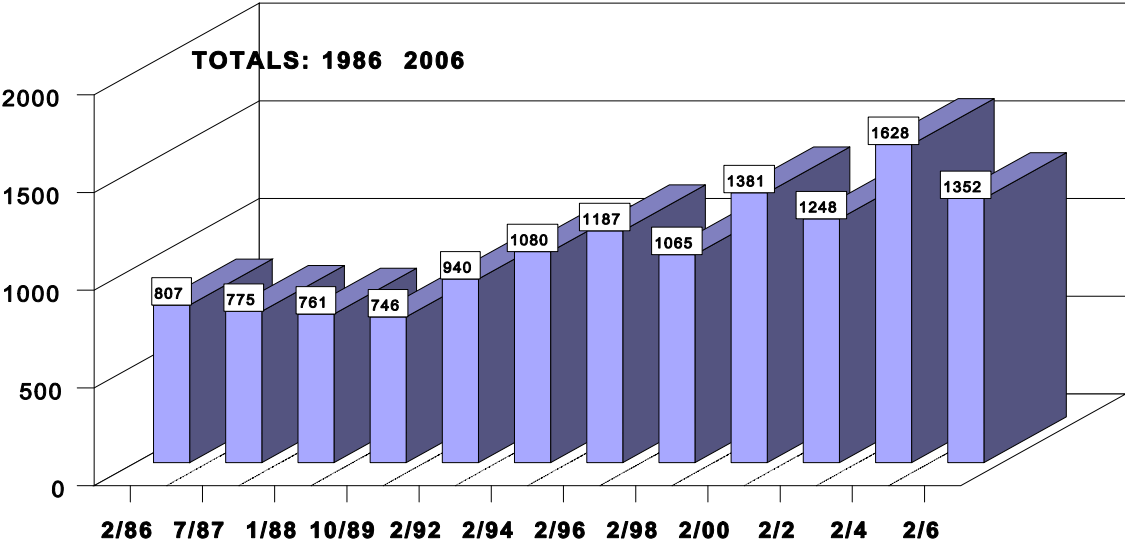
constraints the sample of shelters and outside locations was viewed as representative of the area homeless population.

EXTENT OF HOMELESSNESS

Shelter registration for February 2006 indicated that 1352 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 1652 individuals were homeless at some time during February 2006. Even though the number staying in shelters decreased, observation and discussion with outreach workers suggested that the number staying in outside locations was as large if not larger than in 2004. Several factors may explain this outside total. Foremost is that shelters are less tolerant of substance abuse and rowdy behavior. Also, 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 accommodation in the previous week, and thirty-one percent had slept on the streets within the week. Using the shelter total of 1352 and

an estimate of 300 in outside locations, the findings suggest that a total of 1652 individuals were homeless or without permanent housing during the month. The shelter census of 1352 represented a decrease since the 2004 study. The shelter totals since 1986 are:



Individuals staying in shelters at least one night

The February 2006 total reported by the two major emergency shelters (*Knox Area Rescue Ministries* and *Salvation Army* which were operating in 1986 when the first study was conducted) was 1049 individuals a decrease from 2004, but still exceeding the total for all shelters in 1986. In 1986, *Volunteer Helpers*, *Volunteers of America*, and *Traveler’s Rest* were providing emergency shelter, but no longer do so.

The graph on the previous page 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 comparing the July 1987 census of 775 persons to the January 1988 census of 761 persons, 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 (SRO's) or they represent the "couch population" who spend nights with various friends/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: 2006" focuses on the current sample; however, statistics from the earlier reports, especially 1986, are shared to illustrate trends.

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 less than eighteen years of age. Table 1 offers comparisons of 2006, 1996 and 1986 demographics. The mean age, gender, race, marital status, education and military service represent adult population characteristics.

Comparison of the data for 2006 and 1986 indicated several changes, including an increase in women and minorities. Many of those in the other category are Hispanic and this finding most likely reflected migrant workers who became stranded and/or required emergency shelter. The percentage of children decreased in 2006, but unfortunately the actual number was similar. These findings are elaborated in later discussion.

**TABLE 1: CHARACTERISTICS OF KNOX COUNTY
HOMELESS 1986, 1996 AND 2006**

Item	2006 Percent* (n = 223)	1996 Percent* (n = 143)	1986 Percent* (n = 135)
Age: Under 18 years 18 - 30 years 31 - 60 years over 60 years	7 19 70 4 mean = 41.4 male = 42 female = 38.5	12 19 65 5 mean = 39.4	13 20 59 9 mean = 37.5
Gender: Male Female	73 27	78 22	79 21
Race: White Black Other	65 26 9	81 16 3	88 12 -
Military Service Veteran	22	28	43
Marital Status: Single/never married Married Divorced/Separated Widowed	40 10 42 8	39 10 46 5	35 19 41 6
Education: 8 years or less Some high school High School Grad, incl. GED Post high school	11 25 43 20	19 26 44 16	24 22 31 21
*Due to rounding error, all totals may not equal 100.			

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); and fifty-one percent (2006). 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 2006 homeless study. **Table 2** identifies states that were prominent in the 1986, 1996, and 2006 studies.

TABLE 2: STATE OF ORIGIN			
State	2006 Percent (n = 223)	1996 State/Percent (n =143)	1986 Percent (n = 135)
Tennessee	51	41	53
North Carolina	2	10	*
Florida	4	6	*
Georgia	3	5	*
Virginia	3	1	7
Ohio	8	3	14
Texas	2	3	*
Other States	27	28	26
*Not Available			

Thirty states were represented in the 2006 survey as contrasted to twenty seven in 1996. 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.

Forty-five percent of the respondents from Tennessee had grown up in Knox County; and sixty-eight of these Tennessee natives now consider Knox County as home. Fifty-one percent of those not growing up here had been in Knox County less than six months. Seventy-one percent of the total said that they planned to stay. Asked about growing up in other counties in Tennessee, thirty counties were identified. Among the Tennessee natives, thirty-three percent considered other counties as home.

The questions about reasons for coming to Knox County asked respondents in the 2006 study to identify the three most important reasons for coming to Knox County. Being born here or a family move to the county were frequently identified. In contrast, the 1986 study, asked for a single reason. **Table 3** summarizes these reasons.

The responses being “born here” and “job seeking” have remained consistent during the twenty years of study. More recent studies have shown wider ranges of “other” reasons. Several mentioned education and job training. There were a number of non-specific responses suggesting flight from “trouble” or just wanting to get a “fresh start”. In sum, “seeking employment”, “born here” and “family moved here” continued to be most frequent. The major reason given by those not native to the county was employment or seeking employment, and coming to be near family or friends.

TABLE 3: REASONS FOR COMING TO KNOX COUNTY			
Response	2006 Percent* (n = 223)	1996 Percent* (n = 143)	1986 Percent* (n = 121)
Born here	23(-)	14 (-)	22
Job or seeking job	25(32)	14(16)	22
Job or seeking job	12(16)	13(15)	14
Traveling	9(12)	10(12)	4
To be near friends/family			
Social Services/Treatment	18(21)	8(9)	22
Escape abuse/Divorce	2(3)	7(8)	22
Stranded	2(3)	6(7)	14
Family moved here	15(23)	6(7)	4
New Start	4(5)	5(6)	--
Like Area	2(3)	4(5)	--
Trouble in another county	2(3)	2(3)	--
Shelters	13(17)	2(3)	--
Other	7(9)	9(10)	17
*Totals do not equal 100 since multiple responses were accepted. ## Percentages for 1986 represent single reason given. ### Percentages in parenthesis () represent responses when those born in Knox county are excluded.			

However, there are an identifiable number who came seeking shelter, treatment and social services. In 2006, thirty-one individuals specifically identified the availability of shelter as an important factor in their decision to come to Knox County. Noteworthy is the frequency of “social services”, along with medical and mental health treatment, which may overlap services.

Respondents were asked about their housing status prior to coming to Knox County. Four percent had been homeless for less than a week, while twenty-one percent

had been homeless for a week or more. Additionally, twenty percent had been living with friends or relatives. Other responses suggested unstable living arrangements including incarceration, foster care, hospitals, cars and various combinations. Approximately forty-six percent of those coming to Knox County were living in their own homes or apartments prior to arrival.

To further explore permanence in Knox County, a question was added asking about whether or not the respondent had lived in counties other than Knox County during the past two years. Fifty-four percent responded in the affirmative, however, the most frequent site (thirty-eight percent) by those who had been elsewhere was out-of-state. The most frequently mentioned Tennessee counties were Blount, Anderson, Sevier, Washington, Roane, Loudon, and Jefferson. These seven counties were cited by thirty-eight percent of respondents who had lived outside of Knox County during the past two years. Hamblen and other nearby counties were also identified by multiple respondents.

FAMILY

After the original study in 1986, questions were added to explore 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 2006 study, twenty percent had been in state custody and fourteen percent of adult respondents had been in foster care at some time. Various other arrangements were reported in terms of living with different sets of relatives at times, suggesting considerable change and instability. **Table 4** identifies with whom the individual lived while growing up.

TABLE 4: LIVING ARRANGEMENTS DURING DEVELOPMENTAL YEARS		
Provider	2006 Percent (n = 223)	1996 Percent (n = 143)
Parents	41	53
Father	3	5
Mother	34	20
Relatives	12	10
Institutions/Foster Care	5	6
Other	5*	5
*Includes blends of parent and relatives.		

In regard to family size, the number of siblings was slightly higher than the national average of 2.6 children per family (*U.S. Department of Commerce*). When asked about the number of children in their families of origin, the mean was 4.1 children per family in the 2006 study. Forty percent were middle children, twenty-six percent were oldest, twenty-seven percent were the youngest, and seven percent were only children.

In terms of family disruption, ten percent reported that their families had experienced homelessness during their childhood (five percent had reported family homelessness in 2004). Fourteen percent had been in foster care, which was a similar number to that 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; and sixteen percent in 2004). Among those in foster care, thirty-two percent had been in only one foster care placement, with approximately fifty-five percent having been in three or more placements. Forty-four percent left foster care at age 18 or older. Among the total who had been in foster care, only twenty-six percent went home. Approximately

thirteen percent went to the streets or shelters. Others entered the military, group homes and trade schools. Thirty-nine percent of the respondents in 2006 reported some form of child abuse as compared to thirty-two percent in 2004.

As adults, forty percent reported never having been married, ten percent were married and forty-two percent were separated or divorced. Sixty-nine percent had children. Sixty-four percent of those with children had children under 18 years of age, but only seventeen percent of these parents had their children with them. These percentages are very consistent with those in the 2004 study, and raise the question of why there are fewer young children in shelters.

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

MILITARY SERVICE

Twenty-two percent of respondents identified themselves as veterans, which was similar to 2004. **Table 5** displays service by year of discharge. Vietnam era veterans continued to account for a large portion of those with military service. Noteworthy was the decline in older veterans, and the decline between 1991-2000. However the increase between 2001 to the present likely reflects veterans of the Gulf wars.

TABLE 5: YEAR OF DISCHARGE			
Period	2006 Percent (<i>n</i> = 48)	1996 Percent (<i>n</i> = 39)	1986 Percent (<i>n</i> = 54)
1950 or before	3	--	17
1951 - 1960	--	20	23
1961 - 1970	8	25	25
1971 - 1980	46	38	30
1981 - 1990	27	8	7
1991 - 2000	5	8	--
2001 - present	13	--	--

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

A number of new questions about military service were added beginning in the 2004 study. **Table 6** summarizes these characteristics.

TABLE 6: MILITARY EXPERIENCE

ITEM	2006 Percent* (n = 48)	2004 Percent* (n = 48)
Branch of Service		
Army	41	36
Navy	15	42
Air Force	12	6
Marines	22	14
Other	10	3
Reasons for Joining		
Family Problems	Not	5
Tradition	Asked	11
Serve Country	in	8
Money	2006	11
Learn Skill	--	18
Nothing Else to Do	--	8
Other	--	39
Average Age at Enlistment (Range 16-26 years)	18.6 yrs	18.4 yrs
Average Years Served (Range 1-17 years)	4.3 yrs	4.2 yrs
Stationed Outside Country	21	26
Combat Experience	26	27
Type of Discharge		
Honorable	67	68
General	5	14
Dishonorable	7	3
Medical	10	5
Other	12	11
Service Related Disability	27	19
*Totals may not equal 100 due to multiple responses.		

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 2006 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. The 1986 and early studies grouped responses in general categories such as loss of job, family conflict and alcohol-drugs, whereas responses in later studies were recorded more specifically. **Table 7** provides a summary of identified causes.

In 2006 substance abuse was again frequently identified as a factor as were lack of work and family relationship problems. Various other factors were mentioned including, death of family member(s), disability, pregnancy, and numerous life stresses.

The “other” category included responses such as “criminal record”, “bad choices”, “legal problems” and “loss of driver’s license”. Several younger respondents listed “aged out of foster care”. Also, “loss of a family member” and “family couldn’t care for me” were offered by several respondents as the cause of homelessness.

TABLE 7: CAUSES OF HOMELESSNESS			
Causes	2006 Percent* (n = 223)	1996 Percent* (n = 143)	1986 Percent* (n = 135)
Alcohol	25	29	}19
Drugs	35	21	
Lack Housing			
No money for housing	12	18	17
Evicted	9	5	
No place	3	4	
House burned	2	2	
Lost Job	23	14	35
Family Relationships			}17
Family asked me to leave			
/Family Conflict	17	13	
Abuse	7	11	
Divorce/Separation	14	5	
Health/Mental Illness	7	8	
Prefer it	2	7	4
Other	--	10	8
*Totals may not equal 100 due to multiple responses.			

LENGTH OF HOMELESSNESS

The number of persons homeless less than one year (fifty-eight percent in 2006) has been the largest category and included what can be termed situational or episodic homelessness. Length of homelessness ranged from one day to over forty years. The 2006 data were consistent with the number of persons previously reporting homelessness more than three years. **Table 8** summarizes the length of homelessness.

TABLE 8: LENGTH OF HOMELESSNESS			
Period	2006 Percent* (n = 223)	1996 Percent (n =143)	1986 Percent* (n = 104)
Less than 6 months	48	45	29
Six months to 3 years	26	25	25
More than 3years	26	30	46
*Due to rounding error, all totals may not equal 100.			

Recent findings regarding length of homelessness have been fairly consistent, although there appears to have been a decrease in chronic homelessness since the early studies. The Ten Year Plan to End Chronic Homelessness focuses on individuals who have been homeless more than one year. The findings in the 2006 study suggest that approximately five hundred and sixty-five of those staying in shelters at some time during the month could be classified as chronically homeless. Those living outside would obviously increase this number significantly. The Ten Year Plan Task Force estimated that the number of chronic homeless was around eight hundred. Chronic homelessness remains fairly high, but the encouraging aspect may be that many of the persons homeless for less than six months are not drifting into chronicity.

When asked about previous homelessness, forty-one percent (forty-seven percent in 2004) indicated that they had experienced homelessness prior to the current episode. Among these, sixteen percent had one prior episode; thirty-three percent had two prior

episodes; and twenty-seven percent had three or four prior episodes. The remaining twenty-four percent of responses ranged from five to more than twenty.

HOUSING

The current study asked several questions about housing, particularly evictions; these questions were added in the 2000 study. In 2006, eighteen percent had experienced eviction in the previous two years. Twenty-nine percent of those evicted cited the primary reason as loss of income while another eight percent attributed their eviction to poor payment history. Ten percent identified drug involvement and three percent identified unruly behavior as reasons for eviction. Five percent of the evicted respondents had lost housing because of criminal history. Six 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-one percent of all respondents had been denied housing because of criminal behavior.

Twenty-three percent of all respondents had received agency assistance with housing. Locating housing (thirty-nine percent), rental assistance (fifty-two percent) and housing deposit (twenty-eight percent) were the most frequently cited responses by those who had received agency services. Among those receiving housing assistance, thirty-eight percent lived in the housing for less than one year (twenty-six percent less than six months). “No money for rent,” “just wanted to move” and “evicted” were the major reasons given for the loss of this housing. However, alcohol and drug use, as well as

incarceration were cited. These findings suggest that stabilization of housing is an important issue beyond securing accommodation.

EMPLOYMENT

When asked about employment, forty-six percent of the respondents said that they had a job, compared to thirty-five percent in 2004. In 1986, only sixteen percent reported being employed. 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	2006 Percent* (n = 222)	2004 Percent* (n = 227)
Unskilled labor (incl. odd jobs, custodial, carnival, farm)	19	15
Skilled labor (incl. carpenter, electrician, brick layer, plumber, mechanic, welder)	14	7
Construction (Incl. painter)	17	14
Restaurant (incl. cook/waiter)	18	18
Truck Driver	3	4
Nurse's aid/Day care	5	5
Clerical	6	4
Clerk/Sales	7	5
Entertainment	1	1
Factory	4	**
Other	12	27

*Totals may not equal 100 due to rounding error;
 **Included in "Other"

In 2006, the “other” category included several students and another three percent who identified themselves as “disabled”. One percent said that they never worked and/or panhandled. The findings in 2006 were similar to those in previous years. Several categories (e.g. skilled and unskilled labor) likely overlap since many of those citing construction and restaurant work may be unskilled laborers. The “other” category also included various responses, such as housewives, teachers, computer operators, security officers and unemployed. In 1986, the responses were recorded in more general categories. For example, forty-six percent identified service industry, including food services, and thirty-six percent cited building trades which didn’t differentiate skilled and unskilled jobs.

Asked about the number of jobs during the previous year, twenty-three percent reported none, twenty-seven percent had one, and forty-three percent had multiple jobs. The number of jobs ranged from one to sixty. Respondents used multiple avenues in seeking work. The most frequently cited means of finding jobs was by word of mouth (forty-two percent). Job services (fourteen percent), newspapers (thirty-seven percent) and “just looking” and applying (nineteen percent) were also identified as means of finding work. Since the original study, day labor pools have developed, and twenty-one percent identified labor pools; this may not be mutually exclusive from the response “job service”. As in past studies, other responses included the Internet, television and family. Several respondents reported never seeking work, but might if “something comes along”.

Among seventy-seven percent who had at least one job during the past year (again this must be interpreted cautiously because “canning” and shelter work may be included), twenty-one percent reported that jobs during the past year had lasted less than one

month. Coupled with the findings about number of jobs, the implication was that the majority of jobs were temporary. Whether working, seeking or not seeking work, all respondents were asked about the reasons for termination of past employment. Several respondents in the “other category” cited being in programs that did not allow work. The 1986 study did not ask about specific reasons for termination. **Table 10** summarizes the reasons cited for termination of employment in 2006 and 1996.

TABLE 10: REASONS FOR TERMINATION		
Reason	2006 Percent* (n = 163)	1996 Percent* (n = 123)
"No work/Laid off/Out of Business"	8	15
"Seasonal/Temporary"/"Day Labor"	27	29
"Alcohol/Drugs"	9	5
"Illness/Disability"	10	8
"Got Tired/Just Quit"	18	9
"Fired"	10	12
"Unfairness/Discrimination"	4	1
"Conflicts at Work"	1	--
"Moved"	4	4
"No Transportation"	3	3
"No Child Care"	1	2
"Abuse at Home"	2	1
"Low Pay"	4	2
"Other"	6	9
*Due to rounding error, all totals may not equal 100		

In addition to the reasons identified in **Table 10**, various personal reasons were cited. The reasons for termination are not mutually exclusive. For example “fired” may

have been due to other cited reasons. Likewise “no work” and “day labor” were likely overlapping. 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. 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. **Table 11** identifies the reported reasons of individuals for not working and provides comparison with earlier findings.

The frequency of self reported disability among the reasons for not working raises a number of questions about the nature of the disability and when it occurred. Other reasons included “recent release from prison” (three percent), “leaving soon”, “school”, “lack of housing”, and “lack of identification”. A number of 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, thirty-three percent replied that they needed job training. Several additional questions may relate to employability. Thirty-two percent had a valid driver’s license. Eighty-two percent had a social security card. Thirty-eight percent reported computer skills. Unfortunately these self reports do not assess the level of literacy or proficiency.

TABLE 11: REASONS FOR NOT WORKING			
Resource	2006 Percent* (n = 120)	1996 Percent* (n = 93)	1986 Percent* (n = 101)
"No One Will Hire/No Work"	20	27	36
"Alcohol/Drugs"/"In Recovery"	17	20	8
"Disabled"/"Sick"/"Mental Illness"	35	31	8
"No Transportation"/"No License"	12	4	6
"Drawing Benefits"/"Retired"	2	1	--
"No Child Care"/"Pregnant"	5	3	--
"In a Shelter Program"	20	7	--
"Waiting on Program"/"Job"	2	3	--
"Looking"	4	--	--
"New to Area"	3	4	2
"Don't Want To"	6	6	5
"Other"	13	9	9
*Total does not equal 100 since multiple responses were accepted			

HEALTH

The 1986 study did not identify specific health problems. Headaches, ear, nose and throat infections, foot problems, and accident/injuries were frequently reported. The 2006 "Other" category included arthritis, cancer, virus, and various physical illnesses. Thirteen percent said that they had no health problems while homeless. Comparison with earlier studies suggests that the frequencies of these problems have been very consistent.

The study included several questions about health. It asked if medication had been prescribed for any of the health problems identified. Sixty-one percent indicated that medicine had been prescribed, but less than half (forty percent) were currently taking it. Twenty-one percent stated that they no longer needed it; this is an interesting finding in

that it suggests that the patient may be deciding without medical consultation. However, twenty-eight percent reported lack of money or insurance. Various other responses cited difficulty getting an appointment, lack of transportation, or not wanting to take medicine.

When respondents were asked about their health, fifty-one percent rated it as good to excellent. This finding was particularly interesting given the reported mental illness, substance use and disability reported in questions about employment. **Table 12** identifies the health problems identified by respondents.

TABLE 12: HEALTH PROBLEMS SINCE HOMELESSNESS		
Response	2006 Percent* (n = 213)	1996 Percent* (n = 143)
Pneumonia	25	22
Foot/Feet	35	34
Breathing/Ear/Nose/Throat	45	46
Eyes	36	Not incl.
Tuberculosis	5	3
Headaches	41	53
Skin Problems	12	9
Accident/Injuries	21	31
Epilepsy/Seizures	10	7
Hypertension	29	2
Pregnancy	2	4
Dental	44	Not incl.
Hepatitis	9	Not incl.
Other	15	13
*Totals may not equal 100 since multiple responses were accepted.		

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. Forty-four percent said that they had chronic health problems (forty percent in 2004). Among the ninety-six individuals, various problems were cited, including: back/feet/joint aches, asthma, diabetes, hepatitis, mental health, hypertension, respiratory, seizures, and various other complaints, (e.g. ulcers, cardiac problems, thyroid, kidney disease, and cancer). Sixty-four percent had seen a health care provider during the previous year.

Thirty percent of respondents said that they had been hospitalized while homeless (thirty-five percent in 2004). For the sixty-five individuals hospitalized, treatment had occurred at: Baptist (thirty-four percent), University of Tennessee Medical Center (sixteen percent), St. Mary's (twenty-seven percent), Fort Sanders (sixteen 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. **Table 13** identifies the reasons for hospitalization while homeless.

TABLE 13: REASONS FOR HOSPITALIZATION		
Response	2006 Percent* (n = 65)	1996 Percent* (n = 55)
Illness	55	31
Injury/Accident	20	28
"Beat up"/Stabbed	3	7
Alcohol /Drug Related	10	23
Suicide Attempt	2	8
Pregnancy	1	2
Other	13	1
*Due to multiple responses, all totals may not equal 100.		

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 homeless. The other category included various physical ailments, infections, and emotional problems

Respondents were also asked where they went with a health or medical problem not requiring hospitalization. **Table 14** identifies the sources of treatment not requiring hospitalization. The other category included various clinics, the most frequently cited being the *Veterans Administration* (three percent) and a number of unspecified clinics. This question was not included in 1986, but was in the 1996 study. Interestingly, as health services have become more available (e.g. VMC - People’s Clinic and Cherokee Health Systems), the number responding “nowhere/Don’t know” has decreased.

TABLE 14: TREATMENT NOT REQUIRING HOSPITALIZATION		
Response	2006 Percent* (n = 216)	1996 Percent* (n = 137)
"Health Department"	44	30
"Emergency Room"	28	17
"VMC-People’s Clinic"	13	--
"Interfaith Clinic"	2	1
"Family Doctor"	11	13
"Nowhere"/"Don’t know"	3	19
Other	5	20
*Due to rounding error, all totals may not equal 100.		

When asked in 2006 if they had ever been refused health care, twenty-two percent reported being refused, an increase from eighteen in 2004 and fourteen percent in 2002.

Fifty-four percent reported having received *TennCare*, however forty-eight percent were currently receiving it and three percent were unsure.

MENTAL HEALTH

Chronic mental illness and deinstitutionalization continue to be cited as major reasons for the number of homeless. Fifty-five percent of the total ($n = 223$) had been treated for emotional problems. Sixty-four percent of those receiving treatment for emotional or mental illness had been hospitalized. Stated differently, thirty-five percent of the total had been hospitalized for mental illness.

Among those individuals reporting prior hospitalization, a number reported multiple hospitals; thirty-nine percent had been at Lakeshore, and, forty percent had been at Peninsula Hospital. Nine percent had been at other state hospitals in Tennessee, and twenty-four percent had been at state mental health institutions in other states. Eighteen percent identified local hospitals with psychiatric units. Five percent had been in Veterans Administration hospitals.

Among those who had been hospitalized, thirty-one percent reported only one hospitalization and another forty-five percent had been hospitalized between two and five times. Twelve percent had been hospitalized eleven or more times. For forty-eight percent hospitalization had occurred more than one-year earlier. However, twenty-three percent had been discharged within the previous six months. The length of most recent hospitalization varied: forty-three percent reported less than one week and fifty-five percent had been hospitalized between one week and one month; the percentage hospitalized for less than one week has doubled since previous studies. Sixty-six percent said that they were ready to be discharged. Among those hospitalized, seventy-nine percent had been

discharged on medication, but over one-half (fifty-nine percent) of these were no longer taking it. Interestingly twenty-five percent of those who stopped their medicine cited, “don’t like the way it makes me feel”, as the reason and another eleven percent said that they couldn’t afford it and eleven percent said the prescription ran out. Seven percent said that they “never started” the medication which may overlap not being able to afford it.

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 (Talbot, 1980). **Table 15** indicates post-hospital residence and illustrates the significant number of persons who went directly to the streets/shelters after discharge from psychiatric facilities. Even among persons who go to live with relatives or their own home, studies have suggested that as high 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 15: POST-HOSPITAL RESIDENCE			
Residence	2006 Percent* (n = 78)	1996 Percent* (n = 42)	1986 Percent* (n = 42)
Relatives/Friend	23	32	42
Boarding Home/Group Home	9	8	19
Own Home/Apartment	25	18	12
Street/Shelter	34	36	12
Jail/Custody	5	3	8
Other	4	3	8
*Due to rounding error, all totals may not equal 100.			

Sixty-one percent were referred to a mental health center at the time of discharge. Nineteen percent of the total were currently being seen at a mental health center. Twenty-one percent of all respondents perceived their “nerves” as bad. Seventy-five percent said that they experienced depression, with over a third of those saying they were depressed everyday. Forty-two percent of all respondents reported having been to a mental health center at some time.

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 16** reflects the responses about alcohol and other drugs.

TABLE 16: ALCOHOL AND DRUG USE			
Response	2006 Percent yes (n = 223)	1996 Percent yes (n = 143)	1986 Percent yes (n = 122)
Alcoholic	30	36	30
Recovering	10	5	3
Drug Use	55	41	5

The frequency of self identified alcoholism has remained high since the original study in 1986. In addition, four percent of those who did not consider themselves alcoholic did indicate a problem with alcohol. Other drug use has also been frequent since the 1990's, with fifty-five percent indicating usage in 2006. Among the users (n = 121), forty-five percent considered themselves addicted, with another twenty percent identifying themselves as being in recovery. These data suggest that thirty-three percent of the total interviewed (n = 223) believed that they were or had been addicted to drugs. It appeared that many used both alcohol and drugs. Among those who used drugs, marijuana was most frequently cited (forty-four percent), followed by cocaine (thirty-four percent) and crack (twenty-six percent). Methamphetamine was identified by seven percent. Various prescription drugs were also identified. Among the users, forty-one percent indicated daily use and twenty-four percent reported using substances several times per week. Smoking was the most frequently identified method of use (seventy-eight). These 2006 percentages regarding drug use were slightly higher than 2002 and 2004 statistics.

In the total sample, forty-nine percent had received inpatient treatment in a detoxification facility. Previously, "*Detox*" *Knoxville* was most frequently cited (seventeen percent in 2002), which may refer to *DRI-Dock* that no longer exists. Several respondents still cited *DRI-Dock* and *DRI*, but more frequently mentioned were *Peninsula*, *Centerpoint*, *Cornerstone*, and *KARM*. Respondents identified a wide variety of unspecified facilities in Tennessee and other states; over thirty-six facilities were mentioned which likely reflects the lack of clarity in treatment identity and availability. Thirty-eight percent of those hospitalized reported only one inpatient experience and thirty-two percent reported two to five hospitalizations. Thirty-two percent of those who had been hospitalized reported

inpatient detoxification during the past year. Among the total, thirty-four percent had received outpatient treatment for substance abuse.

AIDS

Recent studies have included questions directed at assessing risk factors for AIDS. Eighty-seven percent said that they take precautions to avoid HIV and sexually transmitted diseases.

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 2006 thirty-two percent of respondents had been victims of crime since being homeless as compared to thirty-nine percent in 1986 and forty-three percent in 1996. Sixty-five percent of these victims had been robbed or experienced theft, and forty-nine percent of the victims had been stabbed or assaulted while homeless. Seventeen percent identified themselves as victims of other crimes, including sexual offenses and being conned out of money. 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 1986 study didn't differentiate between jail and the workhouse even though interviews were conducted at what was then considered the workhouse

where persons usually spend 11 months and 29 days. **Table 17** summarizes incarceration.

The comparison offered in **Table 17** indicates a consistency in the frequency of incarceration in jail. However the highest frequencies of time in jail were in 2002 and 2004 when seventy-six percent reported having been in jail. Respondents who had served time were asked about the offenses that resulted in incarceration. In 2006, thirty-six individuals who had served time in prison identified various crimes including theft/robbery (thirty-six percent), drug related (sixteen percent), and assault/battery (nineteen percent). Several had served time for murder (seven percent). As in previous studies, the most frequently cited reason for jail time, as contrasted to more serious offenses, was public intoxication or alcohol related such as DUI. Prostitution was cited by several female respondents. Examples of other reasons identified, were trespassing, vandalism, shoplifting, neglect, theft, and probation violation.

TABLE 17: INCARCERATION			
FACILITY	2006 Percent* (n = 183)	1996 Percent* (n = 143)	1986 Percent* (n = 123)
Jail	69	67	}44
Workhouse/Detention	25	27	
State or Federal prison	20	32	21

Beginning in the 2002 study, several questions about public intoxication were included. Fifty-eight percent had been arrested for public intoxication within the last three years (thirty-nine in 2004 and thirty-eight in 2002). Most frequent (thirty-five percent)

reported was one arrest and another twenty-eight percent had two or three arrests. Approximately thirty-seven percent had from five to over eighty arrests during the three year period.

Respondents were asked about their last release from correctional facilities. Thirty-seven percent of those released from jail, twenty-seven percent released from detention and six percent released from prison had been out six months or less. 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 157 responses, twenty percent returned home, fourteen percent went to live with relatives, eight percent moved to a group or transitional facility, and forty-two percent were homeless (shelter/street). This is very consistent with the 2004 finding of forty-three percent. Other responses included living with a girlfriend, camping, motel or a rehabilitation program, many of which suggested lack of stable living arrangements.

Despite the small sample, the finding that approximately forty-two 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 2006 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 thirteen percent said that they stayed in hotels. The 2006 percentages include multiple responses and are identified in **Table 18**.

TABLE 18: USUAL SLEEPING LOCATIONS			
Location	2006 Percent* (n = 223)	1996 Percent* (n = 143)	1986 Percent* (n = 135)
Abandoned Building	7	9	--
Car	7	6	--
Shelters	66	69	60
Friends/Relatives	20	10	--
Outside Locations	21	16	--
Other	18	8	40

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

The Table above indicates that the shelters were the most frequently used locations. The number staying in transitional facilities has increased significantly since early studies. Most respondents will stay in shelters at least one or two nights per month, so the shelter total is probably under reported because the question asked “usual sleeping location”. To explore mobility, respondents were asked about the number of different cities visited during the past year. **Table 19** summarizes the number of different cities visited.

The findings suggest that highly mobile homeless individuals represent a relatively small percentage of the population (number of cities was not included in 1986 study). Seventy-two 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-five percent (thirty-eight percent in 1986) said that they had family in the Knoxville area, and sixty-three percent of these had been in contact with them during the past week. Only two percent of persons with area relatives reported never contacting them. It appeared that those without family in the area are more mobile and had less contact with relatives.

TABLE 19: NUMBER OF CITIES VISITED		
Number	2006 Percent* (n = 215)	1996 Percent* (n = 143)
One	41	28
Two	21	25
Three	13	13
Four	4	8
Five	2	3
Six	3	3
Seven or More	8	19
*Totals may not equal 100 due to rounding error.		

Several questions were asked about staying with relatives and time in counties other than Knox. Sixty-two percent (the same as in 2004) had stayed with friends or relatives during the past year. As noted earlier, fifty-four percent had lived in counties other than Knox County during the past two years. Among the one-hundred and twenty who had spent time outside Knox County, most frequently mentioned was out-of-state by thirty-eight percent (twenty-five percent in 2004). Twenty-one other counties were mentioned by individuals.

In regard to living on the streets, fifty-two percent believed it was easier to live alone as opposed to being with a group, which has been consistent in the fifty to sixty percent range since 1986, although it is somewhat surprising in light of the use of shelters. Similarly, only thirty-five percent (the same as in 2004) indicated having used a program to help one get out of homelessness, despite the fact that most used shelter and food programs.

Respondents were asked about sources of food while homeless. **Table 20** summarizes the resources for food.

TABLE 20: SOURCES OF FOOD		
Number	2006* Percent* (n = 213)	2004 Percent* (n = 227)
Shelters/Dayroom	76	92
Food Pantry	19	15
Restaurant	21	12
Grocery	22	13
Churches	6	14
Friends	16	11
Family	3	3
Trash	5	4
*Totals may not equal 100 due to multiple responses.		

The above Table illustrates that most respondents ate at the shelters, but occasionally used different resources. The “other” category included working, panhandling, begging, food stamps, as well as various programs that serve the homeless such as the Day Room (VMC), *Lost Sheep Ministry*, and the specific transitional programs

(e.g. *STEPS House, Great Starts* and *YWCA*). A follow-up question asked respondents if they had eaten at specific programs. These included: *Union Rescue* (sixty-three percent); *Salvation Army* (fifty-two percent); *Volunteer Ministry* (thirty-seven percent); *Church Street Methodist* (nineteen percent); *Second Harvest* (fourteen percent); *Fish* (twelve percent); *Lost Sheep Ministry* (thirty-eight percent); *Love Kitchen* (ten percent); *Second United Methodist* (twelve percent) and several other churches and agencies such as *Preacher Bob's, Ladies of Charity*, various churches and programs. The reader is cautioned that these percentages do not indicate the number of meals served or even the number of times an individual had eaten at a particular location. For example, a person might eat at a shelter seven days per week, and have one meal at another agency or program and thus answer that they had eaten at the respective sites.

When asked about their food situations, forty-five percent of respondents indicated getting enough of the foods they wanted, and thirty-two percent reported enough food, but not always what was wanted; however, eleven percent said that sometimes they did not get enough to eat and ten percent said that they often did not have enough to eat.

The 2006 study included additional questions about transportation. **Table 21** 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 sixty-nine percent in 2006 using buses underscores the importance of public transportation.

TABLE 21: TRANSPORTATION		
Transportation	2006 Percent* (n = 217)	2004 Percent* (n = 227)
Walk	68	77
Bus (incl. trolley)	69	77
Friends' Car	14	17
Own Car	13	13
Hitch-hike	4	4
Tenn-Care	4	6
Shelter Van	2	4
Other	9	8
*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 identified 319 activities.

Table 22 summarizes daytime activities.

Many of the responses were overlapping, for example, several mentioned “classes” at agencies or participating in agency “treatment”. The “other” category included a range of responses including “canning”, “sleeping,” and “riding the trolley”. Only one respondent identified “panhandling” as the major daytime activity.

TABLE 22: DAYTIME ACTIVITY		
Response	2006 Percent* (n = 223)	1996 Percent* (n = 143)
"Working"	28	17
"Loafing/On the Street/Woods"	9	13
"Looking for Work"	7	12
"Chores"	2	10
"Walking"	10	9
"At the Shelter"	17	8
"At the Library"	11	7
"Day Room" (VMC)	15	6
"Reading"	4	5
"Child Care"	2	4
"Canning"	2	3
"Trying to Keep Busy"	2	3
"School"	4	3
"Friends House"	4	3
"Looking for Housing"	5	2
"Drinking/Drugs"	4	2
"Watching T.V."	1	2
"Treatment/Agency Programs"	12	2
"Visiting Family"	2	1
Other	9	6

*Totals do not equal 100 due to multiple responses

The most sensitive area in the interviews has always been questions about money. The 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. The 1986 study did not ask about specific amounts. **Table 23** summarizes average weekly income.

TABLE 23: WEEKLY INCOME		
Amount	2006 Percent* (n = 213)	1996 Percent* (n = 136)
\$ 0.00	20	16
\$ 1.00 - 50.00	24	39
\$ 51.00 - 100.00	10	10
\$101.00 - 200.00	18	24
\$201.00 - 300.00	13	8
\$301.00 or more	16	4
*Due to rounding error totals may not equal 100.		

Weekly income is especially important in helping individuals escape homelessness. The finding that approximately forty-seven percent have a monthly income of \$400.00 or more suggests that they would be candidates for subsidized housing. Respondents were asked about sources of money. Multiple responses were accepted. **Table 24** summarizes the sources of income.

TABLE 24: SOURCES OF INCOME			
Source	2006 Percent* (n = 218)	1996 Percent* (n = 136)	1986 Percent* (n = 135)
Work	57	58	59
Government Assistance	20	27	16
Plasma Center	3	11	35
Handouts	8	14	20
Relatives	16	22	20
Food Stamps	19	35	3
Other	16	13	n/a
*Totals do not equal 100 due to multiple responses.			

Although work was the largest category, it included day-labor. Two percent of the respondents identified picking up cans as a source of income. This has been consistent in all studies. The “other” category included various sources such as friends, child support, trading and prostitution. Three percent reported stealing and selling drugs as source of income. Technically food stamps could be included in government assistance. Among the forty-three citing government assistance, approximately fifty-four percent received SSI; nine percent, received *Families First/TANF*, and another ten percent listed social security disability. Comparison with data from 1996 when several major reforms were started suggested declines, especially in SSI. Twenty-five percent of the respondents indicated that they had lost government benefits during the past two years. Earlier studies reported loss by thirty-four percent in 1998; twenty-one percent in 2000; fifteen percent in 2002; and twenty-four percent in 2004. Seven percent were enrolled in *Families First*, similar to eight percent in 2004. Twenty-eight percent of the respondents, the same as in 2004, indicated that they had engaged in illegal activity at some time to support themselves.

In early studies, there appeared to be a lack of accountable payees or guardians for those receiving disability checks. Some receiving assistance did not seem to have the skills or ability to effectively manage those funds and were vulnerable to exploitation. Eleven percent (twenty-one in 2004) of those receiving assistance had a payee other than self and forty-two percent of these were identified as relatives. The issues about payees remains an area that needs more examination.

ESCAPING HOMELESSNESS

The studies have asked respondents about what resources were needed to escape homelessness. In every study, employment, followed by housing have been the most frequent responses. Approximately sixty-five percent (the same as 2004) of these respondents indicated that they had not used “agency or shelter programs that help people get out of being homeless.” This finding continued to be surprising in that the majority of interviews were conducted inside shelters. It appeared that respondents tend to make a distinction between emergency shelters and the other services that may be offered. One-hundred and forty who said that they had not used services responded to a follow up question about their reasons. While this question was not asked in 1986, **Table 25** summarizes the reasons for not using services as given by respondents in 1996 and 2006.

TABLE 25: REASONS FOR NOT USING AGENCY SERVICES		
Reason	2006 Percent** (n = 140)	1996 Percent** (n = 72)
“Don’t Know About”	25	28
“Don’t Like/Trust/Staff”	7	14
“Don’t Need”	10	13
“No Particular Reason”	13	8
“Don’t Help”	6	6
“Can Get By On My Own”	4	3
“Never Contacted By Them”	2	--
“New In Town”	4	*
“Looking For Work”/“Work”/“Busy”	5	3
Other	24	26
*Included in “Don’t Know About”		
**Totals do not equal 100 percent due to rounding.		

As in past studies, the most frequent reason cited for not using services, was “don’t know about”. This is contradictory in that most of the homeless interviewed were utilizing shelter services and even those outside often ate at the shelters. At the same time, there was a perception among a small number of the respondents that the agencies/shelters were not helpful, or that the agencies had a responsibility to contact them. The other category included a range of responses, such as not considering self homeless, the red tape at agencies taking too long, being transient, other people in the programs, and preferring to be homeless. In the 2006 study, eleven percent said that they were barred or did not qualify for programs.

As in 2004, thirty-five percent of the 2006 respondents had or were currently using programs designed to reduce homelessness. Based on the current and past studies, approximately eighty percent use emergency shelter at some time. Past behavior may have impacted service utilization; for example, twenty-one percent of respondents had been denied housing due to criminal behavior, and a number of outside respondents reported being barred from shelters because of unruly behavior.

The 2006 study added a new question, “Which three agencies do you use the most?” Sixty-five different programs were cited. Knox Area Rescue Ministries was most frequently identified. Volunteer Ministry Center, Salvation Army and the Knox County Health Department were frequently cited also. This information will be available to the respective agencies.

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 2006, eighty-four ($n = 84$) women were interviewed using the standard questionnaire.

The shelter census-enumeration indicated that three hundred and sixty-five adult women were in emergency shelters during the month of February 2006. “Drugs” was the most frequently cited reason for homelessness (forty-three percent), the highest percent of all studies. Examination of other factors contributing to homelessness suggested that family problems, including abuse, conflicts, separation and divorce, were major causes of homelessness. The causes did not appear mutually exclusive. Mental illness as a cause was cited by four percent of the women. Seven percent indicated that a family member’s addiction had forced them into homelessness.

When asked about experiences growing up, fifteen percent reported that their families had been homeless at some time (ten percent in 2004). Thirteen percent had been in foster care, with sixty-four percent of those being in three or more foster homes (thirty-six percent had been in a single foster home). Thirty-six percent had aged out of foster care. Approximately fifty-two percent had been physically and/or sexually abused as a child.

Forty-one percent of the women reported current employment similar to 2004. Multiple reasons were given by thirty-seven women for not working. Disability/illness (twenty-one percent) was often identified. Fifteen percent cited shelter and program participation. Child care responsibilities were identified by six percent. Substance abuse

was cited by ten percent. Lack of transportation was cited by six percent. Consistent with cited health reasons, forty-two percent considered their health as fair or poor, as opposed to good or excellent and forty-eight percent said that they had a chronic health problem. Overall, forty percent indicated a need for job training. **Table 26** summarizes the characteristics of homeless women.

Sixty-four percent of the eighty-four women reported treatment for emotional problems with sixty-three percent of those having been hospitalized. (**Note:** Forty 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 homeless population, however, the women reported a higher percentage of treatment in general and more hospitalization within the past year. Seventy-four percent of the total reported depression with approximately seventy-two percent of those indicating feeling depressed several times a week to continually. When asked about alcoholism, sixteen percent considered themselves alcoholic and another eleven percent were in recovery. Fifty-one percent of the total had used drugs. Forty-six percent had been inpatients in a detoxification facility for alcohol or other drugs. Fourteen percent had been arrested for public intoxication within the past two years.

Twenty-two percent of the women said that they had been victims of crime while homeless, which was consistent with the overall homeless population rate. Eighteen percent reported having been sexually assaulted while homeless. In contrast to being victims, sixty-six percent had spent time in jail and seven percent had been in prison, with alcohol/drug related offenses being the most frequent reasons.



Table 26: Characteristics of Women

Item	2006 Percent* (n = 84)	1996 Percent* (n = 49)
AGE**		
Under 18 years	1	10
18-30 years	25	31
31-60 years	68	51
Over 60 years	5	8
	(mean = 38.5)	(mean = 34.5)
ROOTS		
Tennessee Native	54	49
RACE		
White	71	77
Black	20	21
Other	10	2
MARITAL STATUS		
Single	37	37
Married	14	18
Divorced/Separated	44	39
Widowed	5	6
EDUCATION		
8 Years or Less	6	14
Some High School	22	37
High School/GED	48	37
Post High School	25	12
REASONS FOR HOMELESSNESS*		
"Abuse"	20	35
"Family Conflict" (Incl. Divorce)	14	27
"No Money for Housing"	20	24
"Drugs"	43	8
"Alcohol"	13	6
"Eviction"	7	6
"Lost Job"	16	4
"Mental Illness"	4	--
"Family Member's Addiction"	7	--
Other	10	27
LENGTH OF HOMELESSNESS		
Less Than One Month	19	29
One to Six Months	49	35
Over Six Month to One Year	13	18
Over One to Three Years	8	8
Over Three Years	10	10
MILITARY STATUS		
Veteran	1	2
*Multiple responses were accepted.		
**Does not include under 16 years of age.		

Fifty-two percent of the women had family in the Knoxville area, and approximately eighty-six percent of those had contacted family within the last week. In regard to source of money, thirty-nine percent worked and twenty-one percent of the women received financial assistance from relatives. Government assistance was reported by twenty-seven percent. Among these respondents, *SSI* was most frequent, with *Families First/AFDC* and *SSD* also identified. Twenty-eight percent reported having food stamps. Seventy-five percent had received *TennCare*, but fifty-two percent were currently receiving *TennCare*.

Thirty-eight percent of the women had been homeless before the current episode. Seventy-nine percent of those had experienced two or more prior episodes of homelessness (similar to 2004). Forty-four percent had received assistance with housing, rental assistance, deposits, and locating, but thirty-four percent of those assisted lost the housing within a year. "Just wanted to move", "No money for rent", "Drugs and alcohol", "Jail", "Evicted," and "Not safe" were cited reasons. Eleven percent of the respondents (the same as 2004) had been denied housing because of criminal behavior.

Thirty-six percent of the women (the same as 2004) reported a loss of government benefits during the past two years. Sixteen percent had enrolled in *Families First*. Forty-nine percent had used programs to help them escape homelessness. Whereas *KARM* was most frequently cited in the overall sample, the women cited the *Knox County Health Department* and *Tennessee Department of Human Services* close to the same frequency as *KARM*.

CHILDREN

Among the adult women in shelters, eighty percent had children, and seventy-six percent of these women had children under eighteen years of age. In other words, fifty-one of the eighty-four women had children under eighteen. Approximately eight percent of the women had been pregnant while homeless. Thirty-five percent of the women with children under eighteen had their children with them. On the evening of the interviews, thirty-three children were present with family size ranging from one to three children. During the month, ninety-nine school-aged and younger children 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. Program statistics for the 2005-2006 school year indicated that 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 forty preschool, two hundred elementary school, forty middle school and thirty high school students that could be classified as being from homeless families. This total of 310 students reflects an increase from the 244 identified in the 1999–2000 school year and the 2004 data shows an even greater increase. The data from the summer enrichment program was consistent with the coalition study findings in identifying selected family issues.

Local and national data continue to indicate that homeless children are at risk for emotional and mental health issues, developmental delays, family violence, and a high incidence of substance abuse in the 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.

In the study, eight adolescents were interviewed and many of these would be classified as runaways or children who had been placed in state custody. The adolescents were between ages fourteen to 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 oneself, to experience support and have the chance for success.

III. COMMENTS

The February 2006, study represented twenty years of Coalition-sponsored studies. Coalition members have actively supported the studies through participating as interviewers and ensuring the cooperation of the agencies that they represent. The University of Tennessee College of Social Work has contributed significantly by providing consultation and resources for data analysis. The studies have been designed to provide pragmatic information to service providers and also to promote community awareness about the problems of homelessness.

Homelessness began to be recognized as a profound social issue in the mid 1980's. The drastic increase in homelessness 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 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. A small segment, usually estimated at 10 to 15 percent is chronically homeless. 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 East Tennessee Coalition to End Homelessness, have highlighted a number of conclusions. Many of the conclusions from previous studies can be repeated in the current study. **First, the incidence of**

homelessness is significant. The monthly total more than doubled since 1986. **Second, the number of women and children who are homeless has continued to increase.** Women have become more vulnerable to homelessness as government benefits have been lost, but substance abuse and domestic violence are also significant factors. The 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. **Third, the percentage of homeless persons suffering from mental illness and substance abuse discharged to shelters has continued to increase.** The current data indicate that over half of the homeless adults had experienced emotional problems with many having a history of hospitalization. Area hospitals acknowledge discharging patients to shelters and complain of lack of alternatives. Many others who are discharged to relatives' homes quickly drift into homelessness. Unfortunately, a large number of these persons spend time in jails that have become asylums, ill equipped to provide mental health treatment. **Fourth, many persons recycle in and out of homelessness, with almost half reporting prior episodes.** The challenge for service providers is to find ways to engage persons, especially those who are service resistant, and assist them to find permanent housing and stability. **Fifth, diversity among the homeless population has continued to increase.** There are more women, children and minorities, but also more Spanish-speaking individuals. Many migrant workers stay in crowded motel rooms and are at risk for homelessness. Service providers will increasingly face the challenge to be multi-culturally competent. **Sixth, there are a large number of homeless individuals and families who are living outside the emergency shelters and program facilities.** These include

both those in outside locations and those who are “couch or doubled-up homeless.” **Seventh, the majority of area homeless continues to be from East Tennessee or have come to the area to be near family or seek employment.** There is a perception that Knoxville shelters and services attract large numbers of people from various parts of the country. The data indicate that the more common reason is the individual or family that comes to the area with hope of finding immediate employment and housing, but lacks the skills for self-sufficiency.

Perhaps the most glaring concerns in the 2006 study were the number of homeless persons living outside, the number of “couch” or “doubled-up homeless”, the significant number who are mentally ill and/or substance abusing and spreading of homeless locations. There are various factors that contribute to these findings: a) shelters have developed policies banning persons who are unruly or heavy substance abusers, b) public housing has adopted a “one strike rule” banning those with histories of criminal activity, substance convictions and poor payment records, c) welfare reform including reduction in SSD for substance addiction, d) the closure of shelters, and lack of detox facilities for public inebriates, e) agencies focusing on individuals willing to commit to becoming program participants, and f) a number of persons who avoid group living.

In 2006, Knoxville - Knox County saw a decrease in the number of homeless persons during the month of February. From a high of approximately 1900 persons in 2004, the February 2006 total was 1652. Several factors likely influenced this decline: a) shelters and agencies were increasing efforts to move persons into permanent housing, adopting a “housing first” orientation which was reinforced in the Ten-Year Plan to End Chronic Homelessness, b) unemployment rates were allowing more persons to find work,

even though wage levels still were not adequate for many, c) the Salvation Army discontinued overnight transient shelter, resulting in some going to KARM, but others moving into other living arrangements (perhaps outdoors), d) special initiatives such as Project Homeless Connect linked persons with housing. The reader is reminded that this decrease was in persons staying at emergency shelters during the month. While agencies are working to find housing, it appears that more are staying in outside locations, doubling up with friends and relatives and cars. There is 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, it does underscore the need for different sectors-social services, government and businesses to work together. The adoption and beginning implementation of the *Knoxville – Knox County Ten-Year Plan to End Chronic Homelessness* provides an exciting opportunity to reduce homelessness. Likewise, the development of the Homeless Management Information System, the increasing initiatives of the faith-based community offering housing, and the greater cooperation among agencies offer the potential for achieving positive results.

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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APPENDIX A

1985 - 1986 KNOXVILLE COALITION FOR THE HOMELESS

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1985 - 1986 KNOXVILLE COALITION FOR THE HOMELESS

Lea Earl Acuff
Volunteer Helpers
Lakeshore Mental Health

Marie Hollenbeck
Knoxville Travelers Aid

Major Herbert Bergen
The Salvation Army

Fred O. Debruhl, Sr.
Knoxville Community
Development Corp.

Anne Edens
Knox County Mental Health

Rick Haynes
Helen Ross McNabb Center

Bobbie H. Legg
Mental Health Association
Patient Advocate for Lakeshore

Randolph Mansfield
Downtown Association of Knoxville

Roger M. Nooe
University of Tennessee
College of Social Work

Dixie Petrey
Knoxville-Knox County
Community Action Committee

Richard G. Salter
Volunteers of America

Joyce Williams
West Neighborhood Center

Wanda Moody
Education and Human Services
City of Knoxville

Libby Bailey
Knoxville Travelers Aid

Andy Black
Catholic Social Services

Denny Dukes
University of Tennessee
Hospital

Wanda Edmondson
Knox County General Assistance

Harry K. McRae
Knox County Health Department

Gary D. Jones
KICCUP
St. John's Episcopal Church

Rosemary S. Pearce
Overlook Mental Health

Randal J. Lockmiller
Knoxville Police Department
Detention Unit

Nancy Reese
Knox County General Assistance

Berton Whitaker
St. Mary's Medical Center

APPENDIX A

1985 - 1986 KNOXVILLE COALITION FOR THE HOMELESS (Cont.)

Rev. Joe Bullard
Traveler's Rest Inc.

Sandra S. Davis
United Way of Greater
Knoxville, Inc.

Kay McCampbell
Region II-A
Department of Human Services

Jim Townes
Knoxville Area Urban League

Michael Willard
Beta Homes

Monroe Free
Knoxville Union Rescue
Mission

Maryanne Lynch
University of Tennessee
College of Social Work

Vaughn Nave
Knoxville United Ministries

APPENDIX B
1986 INTERVIEWERS

**APPENDIX B
1986 INTERVIEWERS**

Andy Black

Denny Dukes

Marvin Camfield

Donald Cunningham

Fred Debruhl

Wanda Edmondson

Gary Jones

Vicki Hill

Nancy Reese

Roger Nooe

Jim Townes

Mike Willard

Peggy Bendet

Maryann Marian

Lana Henley

Christine Norman

Samantha Phipps

John Ruggles

John Leeth

Amanda Selvy

Mona Ford

Stephanie Slater

Chuck Jones

William Dockery

Patrick Fitzsimmons

Willie Mae Hammonds

Dianna DeSilva

Barbara Livingston

Teresa Pennington

Charles Breeden

Richard Lee

Gregory Chin

Tom Morrison

Scott Wilson

Tom Riggs

Simon Oliver

Pasquale Amandola

William Nance

Gregory Cruz

APPENDIX B
1986 INTERVIEWERS (Cont.)

Deborah Myers

Grace Gregg Nevins

Ann Schumaker

Bobbie Birkner

Ola Blackman

Brenda Smith

Maryanne Lynch