
**HOMELESSNESS
IN
KNOXVILLE/KNOX COUNTY:
2008**

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December, 2008

Sponsored by the East Tennessee Coalition to End Homelessness

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ACKNOWLEDGEMENTS

Homelessness in Knoxville/Knox County: 2008 represents twenty-two years of studies sponsored by the East Tennessee Coalition to End Homelessness. Homelessness continues to be a major problem in East Tennessee. Many dedicated people are working toward finding solutions. I am indebted to their help in conducting this study as well as previous ones.

The interviewers who helped contribute their time and skills deserve a special thanks. The agency executives, Major Don Vick, Burt Rosen, Ginny Weatherstone, Fr. Ragan Schriver, Patrick White, Kate O'Day, Frank Kolinsky, Marigail Mullin, Sheila Pellasma, Maxine Raines, Preacher Bob Burger, Katherine Benson and Nicole Craig were supportive of the study. Jamie Brennan, Mark Wolf, Calvin Taylor, Kathy Hatfield, Ola Blackmon-McBride, Rev. Dr. Bruce Spangler and Gabrielle Cline were tremendous resources in planning and conducting the study in their organizations. Shelter and agency staff--Larry Lindsey, Treva Jerigan, Donna Wright, Becky Duncan, Rev. Mychal Spence, Cynthia Russell, Barbara Davis, Mitch Day, Keith Farrar, Annette Beebe, Stephanie Carter, Beverly Lakin, Robert Ownby, Stephanie Goodman, Ginger Dowling were most cooperative and helpful in our data collection. Tamera Saunders provided statistics on homeless children in the schools. Calvin Taylor and the Homeward Bound staff, Barbara Disney, Sandra Wells, and Pat Neal did extra work in interviewing and assisting with the study. Carl Williams and Roosevelt Bethel were essential in surveying outside locations. For several years, Calvin and his staff have consistently taken a major role in interviewing and planning the studies.

Mary Sue Evans, College of Social Work Office of Research and Public Services shared her skills in data analysis. My graduate students, Matt Silvy and Meredith Rappaport were very helpful. I appreciate the assistance of my colleague, Mike Dunthorn, who updated the resource section and helped with collecting information and proofreading.

A special thank you goes to my secretary, Jane Swafford, and Ms. Pat Kerschierter who typed and helped prepare the study. Mark Stephens, Knox County Public Defender, has been supportive of me and allowed us to use meeting rooms for interviewer training.

Jon Lawler, director of the Ten Year Plan to End Chronic Homelessness, was instrumental in this study. The study was made possible by the City of Knoxville Government, and Knox County Government. They provided funding for data analysis and for printing the final report. Mayors Bill Haslam and Mike Ragsdale have supported this study and the Ten Year Plan.

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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 2008 is the thirteenth study of homelessness in Knoxville-Knox County sponsored by the East Tennessee Coalition to End Homelessness and highlights twenty-two years of collecting data. The first study was conducted in 1986 with regular studies conducted biennially, plus two smaller intermediate studies. When initially appointed in November 1985 as the Knoxville Coalition for the Homeless, the coalition was charged with three major responsibilities: (1) to ascertain the extent of homelessness in Knoxville, (2) to determine services available to the homeless and make recommendations concerning deficient or nonexistent services, and (3) to increase communication and coordination of services among existing agencies and organizations working with the homeless. The coalition continues to meet on a monthly basis and in addition to sponsoring studies, serves as a forum for exchange of ideas and information. It has taken an increasingly active community role through public education activities and participation in community education and development of housing for the homeless.

Since 2006, a number of significant activities continue 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. Eleven agencies are participating with others planning to join the system; approximately 14,000 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 2008 are reported and compared with the 2006 data. The description of resources has been updated. Previous introductory material on definition, causes, and patterns is still quite relevant, with a few additional research citations. One feature initiated in the 2002 study was brief case examples that “put a face” on homelessness and this is continued in the 2008 study. These composites were submitted by agency staff and do not violate the confidentiality of the respondents or agency clients.

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

Depending on the definition of homelessness used, persons will be included or excluded from counts; as noted above, definitions may include persons living in single room occupancy hotels (SRO) and/or individuals who stay with friends (“*couch population*”) as homeless. The term itself 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 as many as 842,000 people are homeless on any given night and approximately 3.5 million adults, 1.3 million of them children, experience homelessness each year (*National Coalition for the Homeless*, 2008; Burt, Aron, Lee & Valente, 2001). Projections suggest that approximately 1% of the U.S. population will experience homelessness each year (*Urban Institute*, 2000). Over a five year period, approximately 2-3 percent of the U.S. population will experience homelessness and

between 6 and 7 percent of adults will experience homelessness at some point in their lives (Link, Susser, Stueve, Phelan, Moore & Struening, 1994; *Interagency Council on Homelessness*, 1994). According to the *U.S. Conference of Mayors* (2007) survey, hunger and homelessness 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 (*U.S. Conference of Mayors*, 2005).

The methodology to use in counting the homeless is a major issue. For example, an early study by Link suggested that homelessness was two to three times more extensive than early estimates. Using a household sampling method, the researchers found that approximately 7.4 percent of all adult Americans had at some point experienced literal homelessness. An interesting aspect of the report was recognition of the difficulties in counting the homeless, including: (1) finding the hidden homeless, *i.e.*, those who sleep in boxcars, on roofs, or other obscure locations; (2) encountering respondents who deny homelessness or refuse interviews (see Rossi, 1989); and (3) not including people who experience short or intermittent episodes (Link, 1994). As noted, determining the extent of homelessness is difficult, and reliable studies are scarce. The *National Census* in 1990 and 2000 included a concentrated effort to identify those persons who were homeless; however, counting difficulties continued to hamper this effort. The 1990 effort included S-night (referring to counting street and shelter residents) along with experiments using “*homeless decoys*” in five major cities. A significant number, over one-half were missed, demonstrating the difficulty in counting (Wright and Devine; Straw, 1995).

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

In sum, recent reports have been consistent in recognizing that the homeless population is not static. The Knoxville studies have consistently asserted that the homeless population is not static and that numbers must be explained within a designated time frame. Different patterns of homelessness—situational, episodic, and chronic—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 or friends but have meals at shelters. Chronic homelessness is ongoing; the person remains on the street indefinitely; some may be alcoholic or severely mentally ill. (Nooe and Cunningham, 1990)

These different patterns offer explanation for differences in enumeration and also public perceptions of homelessness. While the 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/RISK 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 impact of the economic crisis being experienced by the United States during 2008 is yet to be determined, however agencies report increasing requests for services. The *National Coalition for the Homeless* asserts that two trends are primarily responsible for the increase in homelessness during the past twenty-five years: a growing shortage of affordable housing and a simultaneous increase in poverty (NCH, 2007). In a sense, homelessness represents the “*poorest of poor*”. In 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, 2007).

These changes in public attitudes and policy have major implications although the effects have not been fully assessed. The United States has witnessed the most dramatic shift in welfare policy since its inception in 1935 (Berger and Tremblay, 1999). Changing public attitudes are producing revisions that result in stricter guidelines for subsidies and services (Dunlap and Fogel, 1998). Resources such as AFDC have been important in preventing homelessness, and more exclusionary guidelines will likely increase vulnerability to homelessness (*Institute for Children and Poverty*, 2001; Butler, 1997).

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

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

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

HOUSING

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

The loss of single room occupancy housing (*SRO*) has been particularly devastating. Dolbeare (1996) estimates that more than one million units were lost in the 1970's and 80's. Many 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 (Hoback and Anderson, 2006; Wright, Caspi, Moffit, & Silva, 1998). This practice results in what has been called the “*couch population*”, and while “doubling up” represents a type of housing, the risk for homelessness is very high. The challenge is to reduce this risk through stable, permanent housing.

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

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

Steve is a 53 year old man who is quiet and soft spoken. He chooses to keep to himself rather than associate with others. Since 2005, Steve has been homeless, sleeping outside, and without income. With Steve's kind eyes and weathered face, it is easy for many to empathize with his homeless situation. However, once Steve's history is revealed many lose their empathy for him. Steve is a convicted sex offender who spent approximately 14 years. Even though Steve has served his time in prison, the consequences for his actions continue. Being a registered sex offender is a serious road block in receiving any services that might help Steve out of homelessness. His status as a sex offender makes him ineligible to receive services at overnight shelters and ineligible to receive subsidized housing. To complicate matters, staff noticed Steve's overall health declining. He was recently hospitalized after planning to jump off a bridge because he could not tolerate to sleeping out in the cold anymore.

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

Bill came to the program, suffering from crack cocaine addiction. Bill began discussing the events associated with his relapse at the beginning of his current stay. He openly identified his triggers and his need for accountability. Since his early days in the program, Bill has demonstrated a desire to help others. He is involved in local church and community activities. He helps out with a local youth ministry that serves at-risk youth. Bill is also a very hard worker and presently holds full time employment with a local business. Housing is next on Bill's agenda as he prepares for the next phase of his recovery and stabilization.

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

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

Sam, age 51, has been homeless for over 4 years. He lost his business and house after his wife died and he began to drink heavily. With no family and few social supports he has been wandering the country and sleeping outside. A work accident about 10 years ago caused chronic severe pain and a noticeable limp. He has been diagnosed with depressive disorder and possible schizophrenia. He is not eligible to receive *TennCare* benefits or SSDI and the only benefit he receives is food stamps. To combat his chronic pain and the voices he hears, Sam copiously drinks alcohol. He has little income and his capacity to get a job has been severely diminished by his injuries, mental health, and substance abuse. Sam is cycling in and out of the legal system due to homelessness, public intoxication and theft.

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

Fred is a 45 year old male with a severe mental illness and possible mental retardation (Fred is not able to give an accurate account of his history and staff has not been able to get copies of his past medical and school records). He was abused as a child and spent time in “reform schools.” Most of his adulthood has been spent in and out of a mental health facility. Due to conflicts with family and his mental illness/behaviors, he was shunned from many places. He arrived in Knoxville a year and a half ago but was soon barred from the shelters and started sleeping outside. Although generally liked and looked out for by both the homeless population and service providers, he was difficult to manage. He requires almost constant attention,

frequently begging for cigarettes and coffee, or inquiring about getting his disability check. Fred is very childlike and case managers tried to help him access outpatient mental health facilities, however, he did not take his medications and he forgets scheduled appointments. Case managers worked very hard to place him in housing. Immediately after moving in, Fred caused continuous disruptions to other residents and damaged his apartment. Fred was a topic of many staff meetings and several staff expressed frustration about the lack of adequate treatment options. Fred was often beaten up on the streets, followed by jail or a mental health facility. Then, he was right back out on the streets continuing the same cycle. Fred did not meet the criteria to be declared incompetent nor have mental health services mandated. Fred was evicted after several months in housing because of his disruptions and is back on the streets.

MENTAL ILLNESS/DEINSTITUTIONALIZATION

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

The estimated rates of mental illness among the homeless are wide-ranging depending on methodology, definitions, sample selection and diagnostic criteria; for example, shelter users seem to have higher rates of mental illness than do non-sheltered homeless persons. The *Annual Homeless Assessment Report to Congress* (2007) indicated that twenty-five percent of shelter residents had a disability, although not specific about the condition. The Knoxville studies have consistently found that approximately 50% of the homeless individuals surveyed had been treated for emotional

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

Charles is a 49 year old man who was a “regular” at the homeless shelters for years. Prior to coming into the shelters, however, he was “street homeless,” as his paranoia made him avoid people. For years, he slept outside and rebuffed attempts from shelter staff who tried to engage him. Staff persisted in trying to building trust, urging him to come inside to eat and sleep in safety. Eventually, after many years, Charles came in with some cajoling... and the offer of a favorite treat... Mountain Dew! Gradually, he came inside more often and slowly began to respond to certain staff people. He became accustomed to his shelter life, walking to the night shelter after dinner and back to the daytime shelter in the morning. With no income and a nicotine habit, Charles would often pick up dirty cigarette butts and would go through the trash to scavenge for leftover food. Even though he was

eating regular meals, his mental illness caused him to hoard items. A few years ago, staff began introducing the idea of moving into a place of his own. Initially, Charles would not discuss it. However, after time and relationship building, he agreed to go through the application process for housing. In February, 2006, Charles signed a lease and moved into his own apartment. Shortly thereafter, Charles secured part time employment, serving as an after-hours custodian. This gave him income which meant he now paid his own rent and bought his own food and cigarettes, no longer needing to scavenge through the garbage. His relationship has grown with staff and other residents. He takes pride in his room being very clean and enjoys his space where he can rest well and watch television. Charles will soon celebrate being in housing for two years.

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

Joe came to the center with a host of problems, including years of alcohol and drug abuse as well as a federally supervised probationary sentence for a felony. He was referred after placement in a residential program. Joe comes from a stable family background and had successfully been in real estate broker. Joe's military service was as a skilled specialist, performing sensitive classified tasks requiring the highest degree of trust and responsibility. During his years in the Army, he was assigned to a sensitive-compartmented-intelligence posting. After leaving the armed forces, Joe completed an Associate of Science degree. It was at this time that the years of substance abuse began to affect his family life, leading to his marriage ending in divorce. After his own acknowledged 'bottoming

out' brought him face-to-face with stark reality in a felony conviction. Joe made a personal and spiritual commitment to turn his life around. He has now graduated from a transitional residential program, and remained drug and alcohol free for more than a year. His work record with his new employer has been exemplary.

EMPLOYMENT

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

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 (*Anti-Discrimination Center of Metro New York*, 2005; *ACLU*, 2004; Butler, 1995). The duration of homelessness may decrease the prospects of employment. It is not surprising that homelessness itself may further diminish one's chances of employment, as prolonged idleness may cause greater loss in work habits, responsibility and commitment to employment.

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

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

SUBSTANCE ABUSE

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

Cycling in and out of jail was not the life that Doug had wanted—he dreamed of playing professional sports and he was living that dream. Doug played sports all through high school and signed a contract with a minor league ball team. Life was good. He was doing what he loved, earning a lot of money and avoiding the temptation of alcohol and drugs that was prevalent in his social circle. “I was one of 12 kids raised by a single mom and was so proud of what I had become.” When he came home for the birth of his first child his life took a dramatic turn. He was shot at the housing project where his girlfriend was living. The shooting was a random act of violence—he was in the wrong place at the wrong time. The injury to his leg required him to stay in the hospital for 11 months of treatment and rehab. For this athlete, the news of possible amputation of his leg and an end of his career was too much to comprehend. He dulled the ache and disappointment with painkillers. Later, still hooked on pain pills, he attempted to return to the minor league team, but didn’t make the cut. The end of his dream his money

gone, Doug started selling drugs. The stress of losing brothers to drugs and a sister being murdered only added to his downward spiral. He also now had six kids to help support. He wasn't equipped for responsibility. The chaotic lifestyle of selling and actively doing drugs was quickly taking over this life. "As a dealer, I was my best customer," he said, and was eventually arrested for stealing and selling drugs. Doug went directly to a shelter upon his release from jail, and is enrolled in the men's residential recovery program. He has gained a new perspective, and is more peaceful and hopeful as he works to restore his life.

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

Joan grew up in an abusive home. She began using drugs at an early age as an escape from the beatings she received. Joan got deeper and deeper into drugs and along the way had two children. She accompanied a boyfriend to rob a store, as a result, Joan was put in jail and her children went into foster care. After release from jail, Joan entered a local drug and rehab program for parents and children. Eventually Joan was able to obtain custody of her children and graduated the program. A case manager helped Joan obtain Section 8 housing after appealing an initial rejection. Joan moved into housing and obtained a job. She received assistance to purchase work clothing, shoes and transportation to maintain her job until she received her first two paychecks. Joan now manages one of the stores where she began working. Although it is still a struggle to raise two children, she is drug free and is off all governmental assistance, except for Section 8 housing.

EDUCATION

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

Tammy came into the domestic violence shelter with her two children. She had not worked in many years, had few job skills and was running from an abusive husband. She was able to obtain a Section 8 voucher and moved into an apartment complex. A case manager helped Tammy apply for food stamps, *Families First*, and child support. She began receiving these benefits and started school. She obtained her Certified Nursing Assistant license and went on to school to complete her Licensed Practical Nurse training. Tammy is now working full time, and will soon be coming off of all governmental benefits. She is stable and has remained in permanent housing with her children.

One reason that studies may fail to identify educational level as a contributing factor is illustrated in an evaluation of an employment program. In comparing those who were successful in gaining employment and housing versus those who were unsuccessful, the educational levels of the groups were similar. However an examination of proficiency levels in reading and math found substantial differences between the successful and unsuccessful groups (Nooe, 1994).

PERSONAL CRISES

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

Kate and her son came to the program from a domestic violence situation. At the time, she was several months’ pregnant, unemployed, and homeless. While in the program, she worked with the staff to secure social services for her family, obtained employment with a local restaurant chain, qualified for housing, and secured a grant to continue her education. She is now in her new apartment, awaiting the birth of her second child. She has moved from homelessness to a bright future due to the combined efforts of a number of agencies on her behalf.

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

Ann and her children came to the program for their second stay after leaving an abusive relationship. Ann knew that life had to change for the better. While in the program, she worked on setting healthy boundaries, establishing firm and loving parenting techniques, and developing a close, personal relationship with God. Ann gained confidence in herself as a person for the first time in her life, and she began to mentor other families struggling with similar issues. Through a supportive housing program, Ann and her children were able to move into a house, and now she is working full-time in child care.

A number of studies have found that female headed households have greater risks for poverty (U.S. Department of Commerce, 1998) and subsequently have greater risks of homelessness (Caton, Shrout, Boanerges, Eagle, Opler & Cournos, 1995; DiBlasio and Belcher, 1995). Similarly, women who have experienced violence, may encounter discrimination from landlords who are reluctant to rent to them (ACLU, 2004). As Jencks observed "married couples hardly ever become homeless as long as they stick together" (1994).

OTHER RISK FACTORS

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

Homeless families are most frequently headed by single mothers (Rog and Buckner, 2007). Banyard and Graham found that homeless mothers had more depression and used avoidant coping strategies more than housed mothers (1998). However, it may well be that depression and avoidance are a consequence rather than cause of homelessness. Just as gender may increase the risk of homelessness, minority

status may also increase vulnerability to homelessness. Minority status as a risk factor is illustrated by the finding that twenty-one percent of Hispanics and 24 percent of blacks live in poverty (*U.S. Census Bureau News 2007*). There may be racial differences among the causes of homelessness, in that whites report more internal causes, such as substance abuse and mental illness, compared to non-whites reporting more external factors such as low income and unemployment (North and Smith, 1994).

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

Several studies have examined childhood risk factors for adult homelessness. Economic and residential instabilities, along with poverty, are examples of childhood antecedents (Burt, 2001; Koegel, Melamid & Burnan, 1995; Miller, Donovan, Este & Hofer, 2004). Increasingly, research is showing that disruption in childhood, such as foster care placement, results in a greater chance of adult homelessness (Pecora, et.al., 2005; Roman & Wolfe, 1997), as well as substance use and unemployment (Tam, Zlotnick & Robertson, 2003). There is an especially strong link between homelessness and childhood sexual and physical abuse (Johnson, et al., 2006; Nyamathi, Longshore, Keenan, Lesser & Leake, 2001).

Lisa, 22, is a victim of childhood sexual abuse had started drinking at age twelve. When she came to the agency, she had lost her home, her job, and her confidence, and was unable to support her son. In the program, her son

received loving support and guidance through an outside source that provides residency for children while Lisa confronted her issues. By the time she graduated, Lisa was ready to be re-united with her son. They now live in their own apartment and Lisa is pursuing a promising career.

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

Mary is a diminutive woman who is mentally ill. She has lived on the street for a number of years, and is at a disadvantage because of her mental illness and also because she lost an eye in a fight a number of years ago. Mary is barely able to take care of herself, depending on shelters and missions to meet her most basic needs. Over the years, Mary's physical condition has deteriorated to the point that she mostly spent her days sitting on the sidewalk. She finally reached the point where she stopped going inside for meals and became very weak. A case manager was able to find out that Mary had been receiving SSDI, but it had been discontinued when she did not claim her checks for a prolonged period of time. Her case was reactivated and 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 (Gamache, Rosenheck and Tessler, 2003; Rosenheck and Fontana, 1994).

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

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

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

In sum, this discussion has emphasized the linkage between homelessness and poverty as well as other factors. It is logical to assume that those living in poverty are most vulnerable to becoming homeless. In recent years greater recognition has been given to the risk factors, reflected in the findings that homeless persons are less likely to be receiving public benefits, more likely to be substance abusers, have higher levels of psychological distress and mental illness, more likely to be victims of domestic violence and to have been abused as children (Toro, Bellavia, Daeschler, Owens, Wall & Passero, 1995). The cost of homelessness is high, both economically and personally (*Knoxville-Knox County Ten Year Plan to End Chronic Homelessness*, 2005). Children in particular suffer as they experience an increased risk of 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 homeless or simply prefer the lifestyle. While there are obviously some who choose to be homeless, the number is quite small, likely less than five percent. These individuals are often more visible than the majority of homeless persons who are in shelters or on the street because of loss of housing, unemployment, mental illness, or abuse.

RESOURCES IN KNOXVILLE

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

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

- (1) *The Salvation Army Center* is located at 409 North Broadway. It operates 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 premises 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. In October of 2008, *KARM* opened the *Crossroads Day Ministry*, a welcome center that

serves as a starting point where the homeless can begin the process of change. People entering the welcome center will connect to resources and services provided by KARM as well as other agencies and ministries, with a focus on addressing the causes of each person's homelessness. KARM also provides several other programs to address homelessness. *Lazarus Hall* is a single men's facility that has a recovery program for 40 men and an overnight care shelter for 200 men. *New Life Inn* is a family program that has 18 family rooms for transitional services for up to 61 individuals. The single women's overnight program, *Hope Haven*, provides emergency overnight services for 40 women. All recovery programs are designed to provide multiple interventions to break the cycle of homelessness. In addition, KARM provides three meals a day, seven days a week for indigent persons in the Knoxville community. KARM also operates the *Abundant Life Kitchen* – a 16 week food service training program that equips people for employment in the food service industry. *Serenity Shelter* provides assistance to women in crisis. Located at a confidential site, the shelter is open twenty-four hours a day, seven days a week and has the capacity for 30 individuals. Like *Lazarus Hall* and *New Life Inn*, *Serenity Shelter* provides case management, education, referral, work rehabilitation, alcohol and drug counseling, and other services to assist individuals in breaking the cycle of domestic violence and homelessness.

(3) *The Volunteer Ministry Center (VMC)* is relocating to 511 North Broadway in early 2009, with all existing programs except the residential apartments

offered at that location. *VMC* provides a specialized *Day Resources Center* for individuals who are on the path from the streets to a permanent living situation. Case management services are available and are encouraged for those seeking their own place as well as for those who have already obtained housing. At the *Day Resource Center*, classes are offered to facilitate the move to successful permanent housing. Additionally, basic services such as meals, showers, and laundry are provided to those who are working with a case manager. Active outreach also takes place off the premises, with case managers engaging with people on the street and in other environments to inform them of their housing options. *The Refuge* provides limited direct assistance as well as referrals and counseling to those in a crisis situation, and works particularly to help the marginally housed maintain housing. *The People's Clinic* offers medical, mental health and dental services to the homeless. Specialty clinics are also regularly conducted and deal with foot care, HIV-AIDS, and medical services to women. *VMC* also operates the *Jackson Apartments*, 16 rent-subsidized apartments for men at 103 South Gay Street. The future *Minvilla Manor*, located at the corner of Fifth Avenue and Broadway, will replace the Jackson Apartments and increase the number of units of permanent supportive housing to 57, and will offer case management services onsite.

(4) *Child and Family Tennessee* operates a number of temporary and permanent housing programs for the homeless. *The Family Crisis Center* offers shelter and other advocacy services to adult and child victims of domestic violence at

a site kept confidential for the safety and security of the clients. The shelter has a capacity for sixteen individuals with potential for slight expansion in emergency situations. Services include crisis intervention, housing assistance, case management, support groups, individual counseling, assistance to female stranded travelers, transportation, children's services, and legal assistance for undocumented immigrants who are victims of crime. Length of stay is 30 days; however, extended stays are available depending on the individual need. Transitional Housing at this site provides a continuum of support from shelter. Services include case management, financial support for rent, utilities, and child care. Length of stay and access to services is 12 to 24 months. *The Runaway Shelter* is located at 2701 E. Fifth Ave, providing short-term shelter and counseling for runaway and homeless youth, ages 12 to 18 years. It has a capacity for five individuals. Services provided include individual, group, family, and crisis counseling. *The Transitional Living Program* is located at 2701 E. Fifth Avenue, providing residential and case management services to homeless or street youth ages 16-21 years. The main center has a capacity for five individuals with scattered community-based sites available for additional clients. Services provided include independent living skills assessment, individual and group counseling and case management services. *Great Starts/New Beginnings Structured Living*, located at 3006 Lake Brook Boulevard is an intensive outpatient program with a residential component. The program houses women with co-occurring disorders who are pregnant or with children in need of treatment. A

therapeutic nursery is provided to address the complex problems of children born drug-exposed, HIV positive, developmentally delayed, or medically at-risk. The program has a capacity to house 22 women and 38 children. Treatment services include alcohol and drug groups, therapeutic counseling, family sessions, transportation, case management, parenting classes, and medical care to provide a holistic approach for chemically dependent women and their chemically exposed children. Length of stay in the program is 6 months and can be extended based on treatment progress and individual need. *Great Starts/New Beginnings Transitional Housing* is located at 114 Dameron Avenue. The service sustains recovery and improves the homeless status for women and children as a continuum of support after discharge from treatment settings. This “step down” site contains eight apartments ranging from one bedroom to three bedroom units. Aftercare services include on-site case management, housing assistance, support group, crisis intervention, and attendance to community based A.A. or N.A. groups. The children can continue in the agency’s therapeutic nursery and can be a child care resource for these women while they work or attend education and employment programs. Residents pay rent, based on their income and ability to pay, and the length of stay is 12 to 24 months. *Pleasant Tree Apartments* is permanent supportive housing for mentally ill homeless women, along with their dependent children. The program provides 24 single-family dwelling apartments at two different sites, located at 2460 E. Fifth Avenue and 1909 Dawn Street. On-site case management is available, including independent

living training, crisis intervention, therapeutic counseling, advocacy, medication management, and transportation. Residents pay rent based on their income and can stay as long as needed. The program averages 3 years length of stay.

(5) *The YWCA* is located at 420 W. Clinch Avenue and has fifty-eight private rooms for single women in transition. To be eligible, women must have verifiable employment or disability income. Move in fees are \$120, which includes first-week rent, last-week rent and \$20.00 non-refundable deposit. Weekly rent is \$50. 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 nine months; however, residents may stay for up to 24 months.

(6) *Agape* is located at 428 E. Scott Avenue. It offers a six-month individualized program for chemically dependent adult women. Three Victorian houses provide residence for eight clients each, for a total capacity of 24. Services include individual and group treatment and referrals. There is an \$11/day fee and a \$100 entrance fee.

(7) *E. M. Jellinek Center* is located at 130 Hinton Ave. It offers a residential rehabilitation program for adult men with substance abuse problems. Services include individual and group counseling along with participation in Alcoholics Anonymous and/or Narcotics Anonymous (AA/NA). It has a capacity of 45 and

length of stay is generally 6 months to one year. There is a \$65/week charge for employed residents.

(8) *Steps House* is located at 712 Boggs Ave. It offers a residential program for alcohol and drug recovery. The capacity is 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.

(9) (9)*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.

(10)The *Helen Ross McNabb Center* has developed and maintains a variety of housing options that provide for safe, affordable housing for individuals with mental illness. Independent living is available in several locations in Knoxville. Apartment buildings located in two buildings in the Fourth and Gill neighborhood, one new and one renovated, offer a total of 8 apartments with a capacity of 12 tenants. A resident manager maintains the facility and monitors the residents for special needs. To qualify to lease an apartment, an individual must be diagnosed as having a severe and persistent mental illness, be homeless, and must have some regular source of income. *New*

Hope Apartments are also located in the Fourth and Gill area. *New Hope* is divided into two apartments with four tenants each and shared common areas. A case manager works with all eight tenants to maintain housing, increase their daily living skills, and to help increase their income. An individual must meet the criteria of *HUD* homelessness, have a stable income, be diagnosed as having a mental illness, and must be able to live independently to qualify for an apartment at *New Hope*. Rent is based on income. A house in South Knoxville offers a family living environment with 5 bedrooms. Two houses in other locations offer housing for three tenants each. A resident manager maintains the facility. *Helen Ross McNabb Center* housing services are available to any seriously and persistently mentally ill consumer who meets the qualifying criteria. Referrals may be made by homeless shelters, hospitals, social service agencies, private physicians or therapists, family members, or self-referral. Over 200 individuals participated in Center housing services.

- (11) *Catholic Charities of East Tennessee* operates two programs that focus on housing the homeless in Knoxville: Samaritan Place a Homeless Shelter for the Elderly is located at 3009 Lake Brook Blvd. It includes an emergency shelter for people 55 years of age and older. An elderly transitional housing program also is located on the premises for clients actively seeking housing but who are unable to secure appropriate lodging. A unique feature is the elderly permanent supported housing wing of the facility. For clients, who are deemed to be at risk of harm if placed back in the community. For clients

successfully housed in the community, follow up case management services are provided. Meals are served daily for residents. Samaritan Place offers a range of case management and supportive services, employment counseling, and referrals. Direct assistance in the form of clothing, food, and furniture is also provided. Elizabeth's Home is a HUD-funded transitional housing program for homeless families. The case coordinator is located at 119 Dameron Avenue, and housing is provided at multiple sites throughout the county. Families in the Knoxville and surrounding areas that are homeless are eligible to apply. Referrals into this program are provided by many of the shelters listed in this book.

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

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

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

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

The Salvation Army operates two thrift stores in Knoxville and five more in the surrounding region. 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, all for sale to the general public. Proceeds from the thrift stores are used to support *the various social* services and shelter programs of the *Salvation Army*.

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

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

seeking to develop new units of permanent supportive housing throughout the community in cooperation with the *Ten Year Plan*. These efforts seek to move the chronically homeless quickly from the streets to permanent housing with supportive services like case management and mental health treatment helping individuals reintegrate into the community. The *Compassion Coalition* is operating *Circles of Support*, a program that recruits and trains small mentoring teams from local congregations, and matches them up with recently housed individuals who are working with a case manager. The mentors then support that new neighbor's case plan in order to help them reconnect with the community. The *Salvation Army* has *Project Peach*, a program designed to work with recently housed individuals to provide specialized employment training and to connect them with appropriate employment opportunities, helping them move from being consumers of community resources to become contributors. The *Knoxville–Knox County Community Action Committee* is addressing the homelessness prevention component of the *Ten Year Plan* by providing targeted case management at four residential high-rise sites operated by *KCDC*. The case managers work with residents who are at risk of eviction and subsequent homelessness in order to help them resolve the issues that would otherwise result in eviction.

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. *Water Angels Ministry*, located at 907 University Avenue, has a Sunday worship service and a clothing room and emergency food pantry. The ministry is open Tuesday through Thursday and in addition to spiritual services, *Water Angels* provides assistance with identification, employment, housing and referrals to rehabilitation and treatment programs.

Various social service agencies offer needed services. *Community Action Committee (CAC)*, *Child and Family Services*, *the Vet Center*, *the 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* all play active roles in the provision of services to the homeless. The local HUD office is available for technical support. *The Knoxville-Knox County Community Action Committee's Homeward Bound Programs* are specifically designed to provide services to homeless persons 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. *Homeward Bound* follows the *Housing First* model, seeking to move people off the streets and into permanent housing as quickly as possible.

Many of the homeless served by *Homeward Bound* have been banned from subsidized housing due to past criminal offenses, civil violations or financial obligations.

Homeward Bound has developed a key “appeal process” to restore eligibility for subsidized housing. Over the past three years, 91% of these appeals have been successful.

The *CAC Reach* program sends a team of workers into the field to offer case management, housing, employment and other services to the chronically homeless. 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 with the *PATH* and Children and Youth Homeless Programs assist by engaging individuals in mental health treatment, securing housing, obtaining supportive income and linkage to resources in the community. *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 Knoxville--Knox County. The initial study was conducted in February 1986, and follow-up surveys and/or enumerations have been completed every two years thereafter (1988, 1990, 1992, 1994, 1996, 1998, 2000, 2002, 2004, 2006, and 2008). The *Coalition* sponsored a small study in July 1987 examining the duration of homelessness. The *Community Action Committee* (CAC) sponsored a survey in May 1988 as part of a state-wide study; the state effort was not published.

DESIGN

The current study was conducted in January and February 2008. It included (1) a review of the shelter census to determine an unduplicated count of individuals who stayed during the month and (2) interviews with a sample of persons in shelters and outside locations during an evening/early morning period. The interviews were conducted on January 23—25 to be concurrent with the HUD Continuum of Care process. The shelter census was conducted during February to be consistent with past studies. The shelter sites included *The Salvation Army, Knoxville Area Rescue Ministries, Volunteer Ministry Center, the Family Crisis Center, Serenity Shelter, the Runaway Shelter, Great Starts, the YWCA, AGAPE, E.M. Jellinek Center, John Tarleton Home, Transitional Living, Steps House, Eagle's Nest, Family Promise, and Catholic Charities*. Outside locations included various camps as well as *Lost Sheep Ministries*.

The questionnaires used in all studies over the past twenty-two 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 2008 study added questions about the use of emergency rooms, hospitalization, and incarceration to examine the cost of homelessness. Questionnaires used in all studies contained the same questions about causes of homelessness, reasons for coming to Knox County, employment history, mental health history and demographics.

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

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

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

shelters to have completed check-in and to have finished the evening meal before interviewers arrived. The project director had contacted the shelters in advance to determine average numbers of individuals staying at the respective shelters so that the number of interviews and team size could be planned. Each shelter designated a staff member as contact person to assist with sampling and to help minimize disruption of the evening routine. On the evening prior to the shelter visit, six interviewers visited the Blackstock area during the weekly 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 forty-seven interviews were completed. In the analysis, data were weighted by gender to be representative of the population estimate of twenty-five percent female and seventy-five percent male. The sample of women used for analysis consisted of ninety-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.

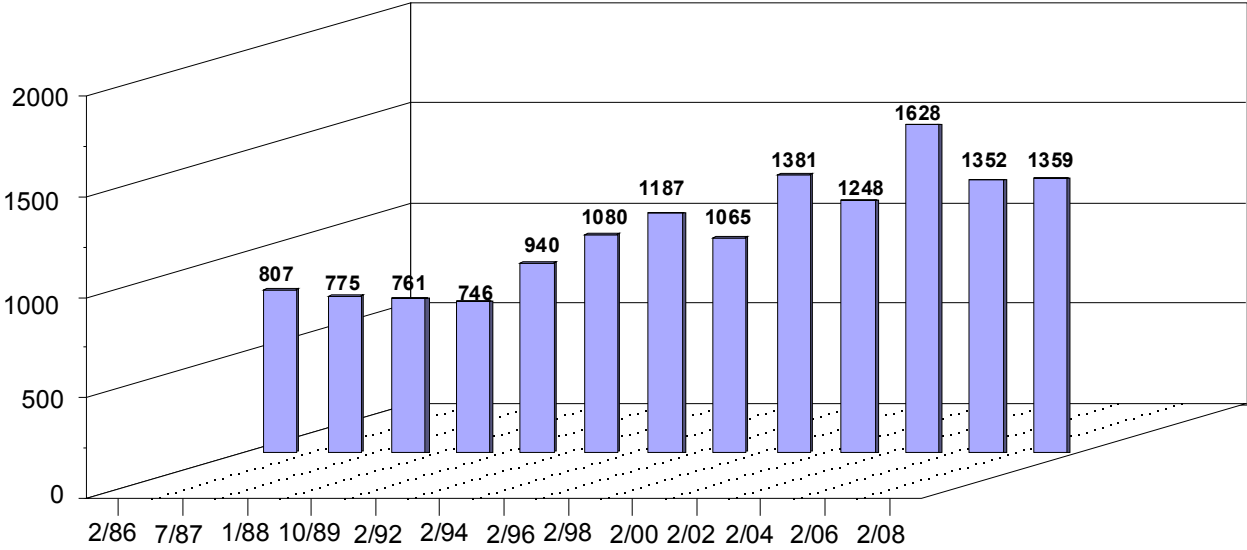
The research design has been used in previous studies; however, there are constraints. The mobility of the homeless population and difficulties in locating subjects make sampling difficult. Even more basic is the question of definition, i.e., who is defined as homeless? Persons living in shacks, SROs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

EXTENT OF HOMELESSNESS

Shelter registration for February 2008 indicated that 1359 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 1659 individuals were homeless at some time during February 2008. This total was very close to the 2006 total, with one agency reporting an increase of twenty clients. The number staying in outside locations appeared consistent with 2006. Several factors may explain the outside numbers. Shelters are less tolerant of substance abuse and rowdy behavior, the one strike policy in public housing, the lack of a public inebriate program, discontinuation of the *Salvation Army Overnight Program*, and cuts in SSI (for substance related disability) and other programs are likely contributing factors.

The ratio used in the Knoxville studies was derived from field and shelter interviews and has consistently indicated more persons in shelters; however, some studies in larger urban areas estimate outside numbers to be larger than those in shelters. The “National Survey of Homeless Assistance Providers and Clients (2000)”, revealed that sixty-six percent had used emergency shelter or accommodations in the previous week, and thirty-one percent had slept on the streets within the week. Using the shelter total of 1359 and an estimate of 300 in outside locations, the findings suggest that a total of 1659 individuals were homeless or without permanent housing during the month. The shelter census of 1359 represented a decrease since the 2004 study, which was the largest. The shelter totals since 1986 are:

TOTALS: 1986--2006



The February 2008 total reported by the two major emergency shelters (*Knox Area Rescue Ministries* and *The Salvation Army*, which were operating in 1986 when the first study was conducted) were 1079 individuals, a slight increase from 2006. This total exceeded the total for all shelters in 1986, when *Volunteer Helpers*, *Volunteers of America*, and *Traveler's Rest* were also providing emergency shelter.

The graph 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 as single room occupancy hotels (SROs) 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: 2008*” focuses on the current sample; however, statistics from the earlier reports, especially 1986, are shared to illustrate trends. As this report was being written, it became apparent that the United States was moving into an economic recession. These economic changes raised questions about whether homelessness would increase. A spot check of statistics for September 2008 in several agencies and shelters found increased requests for meals, food and other services; however, transient overnight shelters had not changed significantly between February and September. There may be a lag between the onset of hard times and homelessness. People use whatever personal resources are available including family or friends, creating a short-term buffer until social capital is exhausted and homelessness occurs.

DEMOGRAPHICS

In compiling the demographics for the studies, both the shelter census and interview sample were examined. The shelter census provided only the number of individuals, genders, and whether less than eighteen years of age. **Table 1** offers comparisons of 2008 and 2006 demographics. The third column illustrates characteristics of 108 individuals in the sample ($n = 247$) who had been homeless one year or longer. The mean age, gender, race, marital status, education and military service represent adult population characteristics.

**TABLE 1: CHARACTERISTICS OF
KNOX COUNTY HOMELESS 2006 AND 2008**

Item	2006 Percent* (n = 223)	2008 Percent (n = 247)	2008 Percent Chronic (n = 108)
Age: Under 18 years 18 - 30 years 31 - 60 years over 60 years mean = 41.4 male = 42 female = 38.5	7 19 70 4	5 22 70 4 mean = 40.5 male = 43.6 female = 35.6	1 13 82 5 Mean = 43.6
Gender: Male Female	73 27	74 26	71 29
Race: White Black Other	65 26 9	68 22 11	68 23 9
Military Service Veteran	22	18	21
Marital Status: Single/never married Married Divorced/Separated Widowed	40 10 42 8	43 11 41 5	44 8 42 7
Education: 8 years or less Some high school High School Grad, incl. GED Post high school	11 25 43 20	27 25 40 29	7 26 44 23
*Due to rounding error, all totals may not equal 100			

Comparison of the data for 2008 and 2006 indicated similarities, including the number of women and minorities. Many of those in the other category are Hispanic and this finding most likely reflected migrant workers who became stranded or otherwise required emergency shelter. The percentage of children decreased in 2008, but unfortunately the actual number was similar. These findings are elaborated in later discussion.

ROOTS

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

TABLE 2: STATE OF ORIGIN			
State/Percent	2006 State/Percent (n = 223)	2008 State/Percent (n = 118)	2008 State/Percent Chronic (n = 108)
Tennessee	51	51	49
North Carolina	2	4	*
Florida	4	4	6
Georgia	3	4	3
Virginia	3	3	3
Ohio	9	1	3
Michigan	2	6	4
Other States	27	27	32

Thirty-four states and one foreign country were represented in the 2008 survey, as contrasted to thirty in 2006. Those classified as chronically homeless identified twenty-seven states. The original 1986 survey identified even fewer states of origin. This increase in states of origin suggests a more transient population even though the Tennessee percentage has remained fairly consistent.

Forty-eight percent of the respondents from Tennessee had grown up in Knox County; and seventy-two percent of these Tennessee natives now consider Knox County as home. Thirty-two percent of those not growing up here had been in Knox County less than six months. Sixty-six percent of the total said that they planned to stay. Asked about growing up in other counties in Tennessee, twenty-one counties were identified (Anderson, Blount, Roane and Sullivan were most frequently listed). Among the Tennessee natives, twenty-nine percent considered other counties as home.

In the 2008 study, respondents were asked to identify the three most important reasons for coming to Knox County. Being born here or a family move to the county were frequently identified.

TABLE 3: REASONS FOR COMING TO KNOX COUNTY			
Response	2006 Percent* (n = 223)	2008 Percent* (n = 247)	2008 Percent* Chronic (n= 108)
Born here	23	26	28
Job or seeking job	25	30	24
Traveling	12	20	19
To be near friends/family	9	8	5
Social Services/Treatment**	18	44	36
Escape abuse/Divorce	2	4	3
Stranded	2	2	2
Family moved here	15	14	9
New Start	4	3	2
Like Area	2	2	2
Trouble in another county	2	2	2
Shelters	13	17	12
Other	7	22	6
*Totals do not equal 100 since multiple responses were accepted.			
** Includes mental health, substance, and medical treatment.			

The responses *being “born here”* and *“job seeking”* have remained consistent during the twenty years of study. Employment or job seeking was the most frequent response. However, social services, medical, mental health, and substance abuse treatment were frequently cited. Medical treatment was cited by twelve percent and mental health treatment or substance abuse treatment were each mentioned by nine percent. These frequencies are combined in **Table 3** and reflect multiple responses by respondents.

Respondents were asked about their housing status prior to coming to Knox County. Two percent had been homeless for less than a week, while fifteen percent had been homeless for a week or more. Additionally, twenty-nine percent had been living with friends or relatives. Other responses suggested unstable living arrangements including incarceration, foster care, hospitals, living in cars and various combinations. Approximately thirty-two 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 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 Anderson, Blount, Sevier, Roane, and Loudon. These five counties were cited by twenty-eight percent of respondents who had lived outside of Knox County during the past two years. Other nearby counties were also identified by multiple respondents.

FAMILY

Since the original study in 1986, questions have explored family characteristics, backgrounds and experiences growing up. The following refers to experiences of all respondents except where otherwise indicated. Respondents were asked about childhood developmental experiences. In the 2008 study, twenty-five percent had been in state custody and eighteen 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)	2008 Percent (n = 247)
Parents	41	47
Father	3	5
Mother	34	28
Relatives	12	9
Other	10	12

The 2008 study did not ask about family size, but in past studies the number of siblings was slightly higher than the national average of 1.86 children per family (*U.S. Bureau of Census, 2000*). When asked about the number of children in their families of origin, the mean was 4.1 children per family in the 2006 study.

In terms of family disruption, eight percent reported that their families had experienced homelessness during their childhood (ten percent had reported family homelessness in 2006). Eighteen 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; sixteen percent in 2004 and fourteen percent in 2006). Among those in foster care, thirty-nine percent had been in only one foster care placement, with approximately fifty percent having been in three or more placements. Among the total who had been in foster care, only twenty-six percent went home. Approximately twenty percent went to the streets or shelters. Others entered the military, group homes and trade schools. Thirty-nine percent of the respondents in 2008 reported some form of child abuse as reported in 2006.

As adults, forty-three percent reported never having been married, eleven percent were married and forty-one percent were separated or divorced. Sixty-nine percent had children. Fifty-nine percent of those with children had children under 18 years of age, but only nineteen percent of these parents had their children with them. These percentages are very consistent with those in the 2006 study, and raise the question of why there are fewer young children in shelters.

Forty-six 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 six percent reported no contact during the past year.

MILITARY SERVICE

Eighteen percent of respondents identified themselves as veterans, which was the lowest in all studies. **Table 5** displays service by year of discharge. Vietnam era veterans continued to account for a large portion of those with military service. One-half of the veterans had been homeless more than one year.

TABLE 5: YEAR OF DISCHARGE		
Period	2006 Percent (n = 48)	2008 Percent (n = 44)
1950 or before	3	--
1951 - 1960	--	--
1961 - 1970	8	6
1971 - 1980	46	32
1981 - 1990	27	38
1991 - 2000	5	19
2001 - present	13	6

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

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

TABLE 6: MILITARY EXPERIENCE		
ITEM	2006 Percent* (n = 48)	2008 Percent* (n = 45)
Branch of Service		
Army	41	46
Navy	15	15
Air Force	12	9
Marines	22	31
Other	10	--
Average Age at Enlistment (Range 14-25 years)	18.6 yrs	18.7 yrs.
Average Years Served (Range 1-25 years)	4.3 yrs	4.5 yrs.
Combat Experience	26	28
Type of Discharge		
Honorable	67	62
General	5	23
Dishonorable	7	3
Medical	10	7
Other	12	6
Service Related Disability	27	18
*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 2008 responses reflect a range of overlapping factors.

In early studies family relationship problems and lack of work were the most frequently cited responses; however by 2000, substance abuse was prominent, followed by relationship problems and other personal problems. The reader is reminded that these multiple responses indicate that homelessness usually involves several factors and the conclusions drawn must recognize the complexity of the problem. **Table 7** provides a summary of identified causes.

TABLE 7: CAUSES OF HOMELESSNESS		
Causes	2006 Percent* (n = 223)	2008 Percent* (n = 247)
Alcohol	25	21
Drugs	35	31
Lack Housing		
No money for housing	12	14
Evicted	9	5
No place	3	3
House burned	2	1
Lost Job	23	13
Family Relationships		
Family asked me to leave /Family Conflict	17	13
Abuse	7	11
Divorce/Separation	14	5
Health/Mental Illness	7	7
Prefer it	2	4
Other	10	18
*Totals do not equal 100 due to multiple responses.		

In 2008 substance abuse was again frequently identified as a factor as were lack of work and family relationship problems. While medical and mental illness were combined,

approximately five percent identified mental illness as a factor in their becoming homeless.

Various other factors were mentioned including death of family member(s), disability, and numerous life stresses. Additionally, the “other” category included responses such as “irresponsibility”, “bad associations”, “legal problems” and “no identification”. Several younger respondents listed “aged out of foster care”. Also, “loss of a family member” and “relationship problems with friends” were offered by several respondents as the cause of homelessness.

LENGTH OF HOMELESSNESS

The number of persons homeless more than one year was forty-eight percent in 2008 (forty-two percent in 2006). The reader is reminded that the largest group of homeless continues to be what can be termed situational or episodic homelessness. The forty-eight percent homeless over one year represents a point in time count, the sample being collected over a forty-eight hour period. The situational and episodic numbers would far exceed this number, decreasing the chronic percentage if the enumeration was conducted during the year.

Length of homelessness ranged from one day to over forty years. The 2008 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)	2008 Percent (n =247)	1986 Percent* (n = 104)
Less than 6 months	48	40	29
Six months to 3 years	26	33	25
More than 3years	26	27	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. For example, in the 1986 study, forty-six percent had been homeless more than three years. The Ten Year Plan to End Chronic Homelessness focuses on individuals who have been homeless more than one year. The findings in the 2008 study suggest

that approximately six hundred and fifty 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. 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-six percent (forty-one percent in 2006) indicated that they had experienced homelessness prior to the current episode. Among these, fifteen percent had one prior episode; twenty-nine percent had two prior episodes; and thirty percent had three or four prior episodes. The remaining twenty-six percent of responses ranged from five to more than twenty.

HOUSING

The current study asked several questions about housing, particularly evictions. In 2008, seventeen 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. Seventeen percent identified drug involvement and six percent identified unruly behavior as reasons for eviction. Six 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.

Immediately prior to becoming homeless, fifty-five percent were living in private housing. Lack of funds was the most frequently cited reason for the loss of housing. Likewise, lack of funds was most often cited for not being able to get into housing.

EMPLOYMENT

When asked about employment, forty-six percent of the respondents said that they had a job, the same percent as in 2006. 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)	2008 Percent* (n = 232)
Unskilled labor (incl. odd jobs, custodial, carnival, farm)	19	23
Skilled labor (incl. carpenter, electrician, brick layer, plumber, mechanic, welder)	14	12
Construction (Incl. painter)	17	15
Restaurant (incl. cook/waiter)	18	23
Truck Driver	3	1
Nurse's aid/Day care	5	3
Clerical	6	3
Clerk/Sales	7	4
Entertainment	1	1
Factory	4	2
Other	12	13
*Totals may not equal 100 due to rounding error		

In 2008, the “other” category included several students. Thirteen respondents said that they were disabled or never worked. 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 and security officers.

Asked about the number of jobs during the previous year, twenty percent reported none, thirty-four percent had one, and forty-six percent had multiple jobs. Respondents used multiple avenues in seeking work. The most frequently cited means of finding jobs was by word of mouth (forty-five percent). Job services (ten percent), newspapers (thirty-four percent) and “just looking” and applying were also identified as means of finding work. Since the original study, day labor pools have developed, and seventeen 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”.

The eighty 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), offered various reasons for termination of jobs. Several respondents in the “other” category cited being in programs that did not allow work. **Table 10** summarizes the reasons cited for termination of employment in 2006 and 2008.

TABLE 10: REASONS FOR TERMINATION		
Reason	2006 Percent* (n = 163)	2008 Percent* (n = 184)
"No work/Laid off/Out of Business"	8	9
"Seasonal/Temporary"/@Day Labor@	27	17
"Illness/Disability"	10	7
"Got Tired/Just Quit"	18	18
"Fired"	10	4
"Unfairness/Discrimination"	4	2
``Other"	23	43
*Due to rounding error, all totals may not equal 100		

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

In light of the lack of stable employment, the research explored perceived reasons for not working. 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. Thirteen percent cited disability as the primary reason for not working. Nineteen percent reported not working because “no one will hire.” Alcohol and drugs were cited by thirteen percent. Several respondents said “not allowed to by rules of shelter”, however many of these could be considered as in treatment or pursuing training for employment.

When asked about the need for job training, thirty-eight percent replied that they needed job training. Several additional questions may relate to employability. Thirty-three

percent had a valid driver's license. Seventy-five percent had a social security card. Sixty-nine percent had used a computer and thirty-eight percent reported having employment related computer skills. Unfortunately, these self reports do not assess the level of literacy or proficiency.

HEALTH

The study included several questions about health. Headaches, ear, nose and throat infections, foot problems, accidents and injuries were frequently reported. The "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.

When asked if medication had been prescribed, 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-seven 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.

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-seven percent said that they had chronic health problems (forty-four percent in 2006). Fifty-five percent said that

medicine had been prescribed for health problems but only forty-one percent were currently taking it. Seventy percent had seen a health care provider during the previous year.

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

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

In the 2008 study, those sixty-eight respondents who had been hospitalized while homeless were asked how many days/nights had been spent in the hospital during the past year. **Table 11** identifies the length of hospitalizations.

TABLE 11: DAYS/NIGHTS IN THE HOSPITAL	
Response	2008 Percent* (n = 68)
None in past year	14
One	17
Two	13
Three	16 (mean = 6.9 days)*
Four	5
Five—Ten	15
Eleven—Twenty-one	11
Twenty-two or more	9

*The responses ranged from none to two hundred and ten (one respondent); the mean was 9.8 days, eliminating the outlying response produced a mean of 6.9 days.

Another new question in 2008 asked respondents if they had been transported to a hospital or emergency room by ambulance during the past year. Twenty-nine percent (seventy-five persons) indicated ambulance transportation. Ambulance runs ranged from one to twenty times with a mean of 2.5 times. Fifty-one percent reported only one time and twenty-two percent reported two times. Those who had been homeless one year or more averaged 3.1 ambulance runs.

Respondents were also asked where they went with a health or medical problem not requiring hospitalization. **Table 12** identifies the sources of treatment not requiring hospitalization. The other category included various clinics, such as the *Veterans Administration* and a number of unspecified clinics.

TABLE 12: TREATMENT NOT REQUIRING HOSPITALIZATION		
Response	2006 Percent* (n = 216)	2008 Percent* (n = 245)
"Health Department"	44	25
"Emergency Room"	28	27
"VMC-People's Clinic"	13	12
"Interfaith Clinic"	2	2
"Family Doctor"	11	11
"Nowhere"/"Don=t know"	3	14
Other	5	30
*Due to rounding error and multiple responses, all totals may not equal 100.		

A separate question asked all respondents how many times they had been to an emergency room during the past year. Forty percent had not been to an emergency room, however, for the remaining sixty percent, responses ranged from one (twenty-two percent) to sixty times. The average number of emergency room visits for the total sample was two visits, while slightly higher for those homeless for over a year (2.4 visits).

When asked in 2008 if they had ever been refused health care, twenty-one percent reported being refused, consistent with twenty-two in 2006, but higher than eighteen in 2004 and fourteen percent in 2002. Forty-nine percent (fifty-four in 2006) reported having received *TennCare*, and fifty-seven percent of these were currently receiving it, but one percent was unsure. January 2005 and 2006 were the dates most frequently cited as when *TennCare* was lost.

MENTAL HEALTH

Chronic mental illness and deinstitutionalization continue to be cited as major reasons for the number of homeless. Fifty-four percent of the total (n = 247) had been

treated for emotional problems. Fifty-seven percent of those receiving treatment for emotional or mental illness had been hospitalized. Stated differently, thirty-one 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 thirty-nine percent had been at Peninsula Hospital. Five percent had been at other state hospitals in Tennessee, and twenty-one percent had been at state mental health institutions in other states. Forty-one percent identified other hospitals including Veterans Administration hospitals.

Among those who had been hospitalized, nineteen percent reported only one hospitalization and another forty-three percent had been hospitalized between two and five times. Nineteen percent had been hospitalized eleven or more times. For fifty-nine percent hospitalization had occurred more than one-year earlier. However, twenty percent had been discharged within the previous six months. The length of most recent hospitalization varied: thirty percent reported less than one week, and fifty-four percent had been hospitalized between one week and one month. Sixty-five percent said that they were ready to be discharged. Among those hospitalized, eighty-two percent had been discharged on medication, but over one-half (fifty-six percent) of them were not taking it. Forty-five percent said that they “never started” the medication, which may reflect being given a prescription and also may overlap “not being able to afford it,” cited by eleven percent. Interestingly, twenty-five percent of those who stopped their medicine cited, “don’t like the way it makes me feel,” as the reason. Eleven percent said the prescription ran out.

At the beginning of the deinstitutionalization movement in the early 1970's, sixty-five percent of persons discharged from institutions returned to live with family; however, this number has declined (Talbot, 1980). **Table 13** illustrates post-hospital residence and indicates that almost half of persons discharged went directly to the streets or shelters from psychiatric facilities—the highest frequency identified in these studies. 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 13: POST-HOSPITAL RESIDENCE		
Residence	2006 Percent* (n = 78)	2008 Percent* (n = 76)
Relatives/Friend	23	25
Boarding Home/Group Home	9	1
Own Home/Apartment	25	13
Street/Shelter	34	47
Jail/Custody	5	2
Other	4	12
*Due to rounding error, all totals may not equal 100.		

Sixty-eight percent were referred to a mental health center at the time of discharge. Forty-seven percent of the total reported treatment at a mental health center at some time. Twenty-eight percent of all respondents perceived their “nerves” as bad. Seventy-

one percent said that they experienced depression, with thirty-six percent of those saying they were depressed everyday. A new question in 2008 asked about mobile crisis. Twenty-three percent had been seen by the mobile crisis team.

ALCOHOL AND OTHER DRUGS

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

TABLE 14: ALCOHOL AND DRUG USE		
Response	2006 Percent yes (n = 223)	2008 Percent yes (n = 247)
Alcoholic	30	31*
Recovering	10	9
Drug Use	55	78
*Another eight percent denied alcoholism but reported having a problem with alcohol		

The frequency of self identified alcoholism has remained high since the original study in 1986. Other drug use has also been frequent since the 1990's, with seventy-eight percent indicating usage in 2008. Among the users (n = 190), twenty-five percent considered themselves addicted, with another twenty-seven percent identifying themselves as being in recovery. These data suggest that thirty-nine percent of the total interviewed

(n = 247) believed that they were or had been addicted to drugs. It appeared that many used both alcohol and other drugs. Among those who used drugs, marijuana was most frequently cited (fifty-six percent), followed by crack (twenty-three percent) and cocaine (twenty-eight percent). Methamphetamine was identified by six percent. Various prescription drugs were also identified. Among the users, thirty-five percent indicated daily use and twelve percent reported using substances several times per week. Twelve percent said drugs were used once or twice per month. The 2008 percentages regarding drug use were significantly higher than previous years, but respondents reported less addiction.

In the total sample, forty-five percent had received inpatient treatment in a detoxification facility. The most frequently cited treatment programs, (eleven percent each) were *Peninsula*, (including the *Lighthouse*) *Centerpoint*, and *KARM*. Respondents identified a variety of local hospitals (six percent), *Lakeshore* (six percent) and programs such as *Jellink*, *Cornerstone*, *Salvation Army*, *Great Starts*, and *Eagles Nest*. Additionally a number of non specific sites were mentioned. Thirty-two percent of those hospitalized reported only one inpatient experience and forty-five percent reported two to five hospitalizations. Thirty percent of those who had been hospitalized reported inpatient detoxification during the past year. Among the total, thirty-five percent had received outpatient treatment for substance abuse.

Since alcohol and other drug use has been frequently reported, several questions were added about obtaining treatment for substance abuse. Eighteen percent ($n = 43$) had experienced difficulty in finding treatment for substance abuse. **Table 15** illustrates the cited difficulties in securing treatment.

TABLE 15: DIFFICULTY FINDING SUBSTANCE ABUSE TREATMENT	
Response	2008 Percent* (n = 43)
"Don't know how to access"	17
"No services available"	28
"Lack of insurance"	51
"Long waiting list"	37
"No transportation"	19
"Don't know about"	8
Other	26
*Due to multiple responses totals do not equal 100.	

AIDS

Recent studies have included questions directed at assessing risk factors for AIDS. Eighty-nine 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 2008 thirty-five percent of respondents had been victims of crime since being homeless as compared to thirty-two percent in 2006 and below the highest forty-three percent in 1996. Sixty-eight percent of these victims had been robbed or experienced theft, and thirty-seven percent of the victims had been stabbed or assaulted while homeless. Sixteen percent identified themselves as victims of other crimes. Five percent had been sexually assaulted, with three-fourths reporting multiple

assaults. As noted in previous studies, the aged or infirm are particularly vulnerable to crime. Deinstitutionalized individuals, chronic alcoholics, loners and recipients of Supplemental Security Income (SSI) or other benefits are at greater risk.

In contrast to being victims, respondents were also asked if they had served time in correctional facilities. The comparison offered in **Table 16** indicates a consistency in the frequency of incarceration in jail. However those homeless longer than one year reported slightly higher rates of jail and prison. Approximately twenty-five percent of respondents who had served time in jail or detention reported one incarceration while half of those serving prison time had only one incarceration. In 2008, the interview asked if the respondent had been arrested for trespassing or loitering; twenty-four percent answered in the affirmative (thirty-two percent of chronically homeless). As in previous studies, the most frequently cited reason for jail time, as contrasted to more serious offenses, was public intoxication or alcohol related infractions, such as DUI. Prostitution was cited by several female respondents.

TABLE 16: INCARCERATION			
FACILITY	2006 Percent* (n = 283)	2008 Percent* (n = 247)	2008 Chronic Percent* (n = 108)
Jail	69	74	80
Workhouse/Detention	25	18	22
State or Federal prison	20	22	27
Due to multiple responses totals do not equal 100			

Beginning in the 2002 study, several questions about public intoxication were included. Thirty-four percent (forty-five percent of the chronically homeless) had been arrested for public intoxication within the last three years (fifty-eight percent in 2006). Most frequently (fifty-two percent) reported was one arrest and another nineteen percent had two or three arrests. Approximately twenty-four percent had over ten arrests during the three year period. The range was from one to three hundred and fifty times in jail (*mean* = 12.7)

In 2008, respondents were asked about the total number of days spent in jail, detention, or prison during the past year. Responses ranged from zero to three hundred and sixty-five days. The average was 43.6 days incarcerated. Comparing the statistical means for length of incarceration for those homeless less than one year to those homeless one year or more illustrates a pronounced difference. Those homeless less than a year had a mean or average of 39 days of incarceration compared to 49 days for those chronically homeless. In other words the chronically homeless individual spent an average of ten more days in jail than other homeless individuals who had been incarcerated during the past year.

Respondents who had served time were also asked where they went when released the most recent time. This question did not discriminate among jail, workhouse, or prison. From the 190 responses, seventeen percent returned home, fifteen percent went to live with relatives, seven percent moved to a group or transitional facility, and forty-one percent were homeless (shelter/street). This is very consistent with the 2006 and 2004 findings of forty-two and forty-three percent, respectively. However fifty-nine percent of those who were homeless over one year went to a shelter or the streets. Other responses (eighteen

percent) 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 findings that approximately forty-one 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 2008 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 2008 percentages include multiple responses and are identified in **Table 17**.

TABLE 17: USUAL SLEEPING LOCATIONS			
Location	2006 Percent* (n = 223)	2008 Percent* (n = 247)	2008 Chronic Percent* (n = 108)
Abandoned Building	7	3	5
Car	7	6	9
Shelters	66	67	57
Friends/Relatives	20	9	6
Outside Locations	21	25	35
Other	18	19	19
*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*”.

This years’ study asked respondents how many nights had they stayed in a shelter during the past year. Fifteen percent ($n = 36$) reported *none*. The remaining responses ranged from **one** to *three hundred and sixty-five*. Fifty percent ($n = 123$) stayed in shelters forty-two nights or less. The mean was 104 nights suggesting a significant number saying for extended periods in shelters.

To explore mobility, respondents were asked about the number of different cities visited during the past year. **Table 18** summarizes the number of different cities visited. The findings suggest that highly mobile homeless individuals represent a relatively small percentage of the population. Seventy 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-six percent said that they had family in the Knoxville area, and sixty percent of these had been in contact with them during the past week. Only six percent of persons with area relatives reported over a year since last contact. It appeared that those without family in the area are more mobile and had less contact with relatives.

TABLE 18: NUMBER OF CITIES VISITED		
Number	2006 Percent* (n = 215)	2008 Percent* (n = 247)
One	41	46
Two	21	25
Three	13	13
Four	4	3
Five	2	3
Six	3	1
Seven or More	8	9
*Totals may not equal 100 due to rounding error.		

Several questions were asked about staying with relatives and time in counties other than Knox. Fifty-four percent (sixty-two percent in 2006) had stayed with friends or relatives during the past year. As noted earlier, fifty percent had lived in Tennessee counties other than Knox County or out of state during the past two years. Among the one hundred and twenty-five who had spent time outside Knox County, most frequently mentioned was *out-of-state* by thirty-three percent. Twenty-eight Tennessee counties were mentioned by individuals. *Anderson* (fifteen percent), *Blount* (ten percent), *Roane* (six percent) and *Davidson* (five percent) were most frequent, followed by nearby counties such as Hamblen, Sevier, Campbell, Green and Sullivan.

Despite the fact that many of the interviews were conducted in shelters or other agencies, fifty-five percent said that they had not used programs to help get out of homelessness. The finding that forty-five percent replied in the affirmative was an improvement from 2004 and 2006 when only thirty-five percent indicated having used a program to help one get out of homelessness.

Respondents were asked about sources of food while homeless. **Table 19** ranks the resources for food by frequency.

TABLE 19: SOURCES OF FOOD	
SOURCE	
<i>KARM</i>	
<i>Salvation Army</i>	
<i>Lost Sheep Ministry</i>	
<i>Volunteer Ministry</i>	
<i>Angelic Ministry</i>	
<i>Preacher Bob</i>	
<i>Church Street Methodist</i>	
<i>Second Harvest</i>	
<i>FISH</i>	
<i>Love Kitchen</i>	
<i>Water Angels</i>	
<i>VOA</i>	
<i>Others</i>	
*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 handouts and food stamps, as well as various church programs that serve the homeless, and specific transitional programs (*e.g. STEPS House, Great Starts and YWCA*). The reader is cautioned that these rankings 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, thirty-four percent of respondents indicated getting enough of the foods they wanted, and thirty-four percent reported enough food, but

not always what was wanted; however, nineteen percent said that sometimes they did not get enough to eat and twelve percent said that they often did not have enough to eat.

The 2008 study included questions about transportation. **Table 20** 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 and sixty-five percent in 2006 and 2008 using buses underscores the importance of public transportation.

TABLE 20: TRANSPORTATION		
Transportation	2006 Percent* (n = 217)	2008 Percent* (n = 247)
Walk	68	77
Bus (incl. trolley)	69	65
Friend’s Car	14	20
Own Car	13	15
Hitch-hike	4	5
Tenn-Care	4	6
Other	11	19
*Totals do not equal 100 due to multiple responses		

In order to achieve a clearer understanding of life on the streets, several additional questions were asked about how time was spent, specifically “*How/where do you spend the day?*” Multiple responses were accepted and the respondents identified 357 activities (1.45 per respondent). **Table 21** summarizes daytime activities.

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

TABLE 21: DAYTIME ACTIVITY		
Response	2006 Percent* (n = 223)	2008 Percent* (n = 247)
"Working"	28	28
"Loafing/On the Street/Woods"	9	8
"Looking for Work"	7	14
"Chores"	2	3
"Walking"	10	10
"At the Shelter"	17	20
"At the Library"	11	12
"Day Room" (VMC)	15	11
"Reading"	4	3
"Child Care"	2	2
"Canning"	2	4
"Trying to Keep Busy"	2	1
"School"	4	6
"Friends House"	4	1
"Looking for Housing"	5	2
"Drinking/Drugs"	4	2
"Watching TV"	1	1
"Treatment/Agency Programs"	12	13
"Visiting Family"	2	2
"Other"	9	9
*Totals do not equal 100 due to multiple responses		

The most sensitive area in the interviews has always been questions about money. Reluctance to talk about money is reflected in inconsistent responses to questions about income. Respondents were asked about approximate weekly income and sources of income. Most likely the responses represented an under reporting of income and sources. **Table 22** summarizes average weekly income.

TABLE 22: WEEKLY INCOME		
Amount	2006 Percent* (n = 213)	2008 Percent* (n = 247)
\$ 0.00	20	24
\$ 1.00 - 50.00	24	19
\$ 51.00 - 100.00	10	11
\$101.00 - 200.00	18	25
\$201.00 - 300.00	13	11
\$301.00 or more	16	11

*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 23** summarizes the sources of income.

TABLE 23: SOURCES OF INCOME		
Source	2006 Percent* (n = 218)	2008 Percent* (n = 247)
Work	57	62
Government Assistance	20	19
Plasma Center	3	4
Handouts	8	12
Relatives/Friends	18	21
Food Stamps	19	29
Canning/Scrapping	2	5
Other	16	8

*Totals do not equal 100 due to multiple responses.

Although work was the largest category, it included day labor. This has been consistent in all studies. The “*other*” category included various sources such as shelter allowances, child support, trading and prostitution. Two percent reported stealing and selling drugs as source of income. Twenty-one percent of the respondents indicated that they had lost government benefits during the past two years. Earlier studies also reported loss of benefits: thirty-four percent in 1998; twenty-one percent in 2000; fifteen percent in 2002; twenty-four percent in 2004; and twenty-five percent in 2006. Eight percent were enrolled in *Families First*, similar to seven percent in 2006. Twenty-eight percent of the respondents, (twenty-eight percent in 2006), 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 (the same as 2006) of those receiving assistance had a payee other than self and fifty-six percent of these were identified as agency employees and twenty-two percent were relatives. The issues about payees remain an area that needs more examination.

Forty-five percent of the 2008 respondents had used or were currently using programs designed to reduce homelessness (thirty-five percent in 2006). 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 study asked, “Which three agencies do you use most?” Fifty-eight different programs were cited. *Knox Area Rescue Ministries* was most frequently identified followed by *Volunteer Ministry Center* and *The Salvation Army*. The *Knox County Health Department*, *Cherokee Health Services*, *McNabb Mental Health Center*, *Water Angels*, and various other agencies were frequently cited. This information will be available to the respective agencies.

CHRONICITY

The foregoing discussion identified a difference between those who were homeless one year or less and those who were homeless more than one year. **Table 24** summarizes several key differences noted.

<p align="center">TABLE 24: COMPARISON OF CHRONIC AND NONCHRONIC HOMELESS INDIVIDUALS</p>		
Category	Homeless One Year or More (n = 108)	Homeless Less Than One Year (n = 139)
<u>Criminal Justice</u>		
Arrested for Public Inebriation	45%	19%
Arrested for Trespassing or Loitering	31%	14%
Spent Time in Jail	80%	51%
Times in Jail	<i>mean</i> = 21.0	<i>mean</i> = 5.4
Days Incarcerated During Past Year	<i>mean</i> = 49 days	<i>mean</i> = 39 days
<u>Medical</u>		
Emergency Room Visits	<i>mean</i> = 2.4	<i>mean</i> = 1.8
Transported by Ambulance	.87	.59
Times Transported by Ambulance	<i>mean</i> = 3.0	<i>mean</i> = 2.0

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 2008, ninety-four ($n = 94$) women were interviewed using the standard questionnaire.

The shelter census-enumeration indicated that three hundred and thirty adult women were in emergency shelters during the month of February 2008. Substance abuse remained a most frequently cited reason for homelessness (thirty-five percent drugs and twelve percent alcohol). Examination of other factors contributing to homelessness suggests that family problems, including abuse, conflicts, separation and divorce were major causes of homelessness. The causes did not appear mutually exclusive.

“Min” and her two children were brought to the Center by her pastor. Min’s pastor told her about the shelter when Min disclosed that her husband is physically and emotionally abusive. Min’s 6 year old son has been diagnosed with autism and her 4 year old daughter is devastated to be out of their home. The family is Asian and her husband views her as his property, so dealing with cultural differences is an ongoing process. After being at the shelter for a few days, an interpreter came to help finish her intake and communicate with her more efficiently, since she speaks little English. Her children were also able to get back to school after working with the homeless liaison from Knox County Schools. Every day Min struggles with the idea of going back to her husband, but with the support of her church, interpreter, and shelter staff, Min is still waiting to go to court for her order of protection. She recently told staff that she loves her husband and does not want her children to be from a broken home but she now knows that if her husband really loved her, he would not treat her the way that he does. Min and her husband own a business, which was her source of income, but now her abuser has cut off her cell phone, access to the bank account, forcing her to choose between homelessness or an abusive home. However, the shelter staff and the interpreter have helped Min gain a new perspective and more respect for herself. Therefore, she plans to stay in shelter until she can rebuild a life free from abuse for herself and her children.

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

When asked about experiences growing up, ten percent reported that their families had been homeless at some time (fifteen percent in 2006). Nineteen percent had been in foster care, with fifty-three percent of those being in three or more foster homes (twenty-nine percent had been in a single foster home). Thirty-five percent had aged out of foster care. Approximately forty-nine percent had been physically and/or sexually abused as a child.

Fifty percent of the women reported current employment. Multiple reasons were given by the other women for not working. Disability or illness (fifteen percent) was often identified. Substance abuse was cited by six percent. Other responses included lack of transportation and child care responsibility. Consistent with cited health reasons, forty-seven 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-four percent indicated a need for job training. **Table 25** summarizes the characteristics of homeless women.

Table 25: Characteristics of Women

Item	2006 Percent* (n = 84)	2008 Percent* (n = 94)
AGE**		
Under 18 years	1	1
18-30 years	25	37
31-60 years	68	62
Over 60 years	5	1
	(mean = 38.5)	(mean = 35.6)
ROOTS		
Tennessee Native	54	57
RACE		
White	71	73
Black	20	18
Other	10	9
MARITAL STATUS		
Single	37	46
Married	14	12
Divorced/Separated	44	37
Widowed	5	5
EDUCATION		
8 Years or Less	6	5
Some High School	22	32
High School/GED	48	29
Post High School	25	34
REASONS FOR HOMELESSNESS*		
"Abuse"	20	24
"Family Conflict" (Incl. Divorce)	14	20
No Money for Housing	20	12
Drugs	43	35
Alcohol	13	12
"Eviction"	7	6
"Lost Job"	16	11
Mental Illness	4	3
Family Member's Addiction	7	3
Other	10	29
LENGTH OF HOMELESSNESS		
Less Than One Month	19	13
One to Six Months	49	34
Over Six Month to One Year	13	19
Over One to Three Years	8	17
Over Three Years	10	18
MILITARY STATUS		
Veteran	1	1
*Multiple responses were accepted.		
**Does not include under 16 years of age.		

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

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

When asked about alcoholism, sixteen percent considered themselves alcoholic, and another eleven percent were in recovery. Fifty-one percent of the total had used drugs. Fifty-seven percent of the users reported being addicted or in recovery. Forty-two percent had been inpatients in a detoxification facility for alcohol or other drugs. Fifteen percent had been arrested for public intoxication within the past two years.

Barbara, a 30 year old mother of three children, entered the program to address her substance addiction. Two of Barbara's children were placed in state care because of her addiction and her husband's incarceration. Barbara and her husband had long histories of substance abuse and

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

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

The 2008 study asked additional questions about incarceration and hospital use. Sixty-two percent of the women had spent time in jail. Fifteen percent of the total reported arrests for public inebriation, ranging from one to twenty-five times with a mean of 4.9 times for those arrested, or a mean of .73 times for the overall sample of women.

Thirty respondents (thirty-two percent) had been transported to medical facilities while homeless with a range of one to ten times. Sixty-four (sixty-eight percent) had been seen at an emergency room with a mean of 2.98 times (or 2.03 times for the overall sample). Twenty-three of the women (twenty-four percent) had been hospitalized while homeless. Nights in the hospital ranged from one to thirty-one, with a mean of 5.78 (or 1.41 for the overall sample).

Fifty-one percent of the women had family in the Knoxville area, and approximately seventy-two percent of those had contacted family within the last week. In regard to source of money, forty-nine percent worked and twenty percent of the women received financial assistance from relatives. Government assistance was reported by thirty-two percent. Nineteen percent had enrolled in Families First. Twenty-five percent reported having food stamps. Seventy-four percent had received *TennCare*, and sixty-five percent were currently receiving *TennCare*. Twenty-eight percent had engaged in illegal activity to support themselves.

Thirty-eight percent of the women had been homeless before the current episode. Eighty percent of those had experienced two or more prior episodes of homelessness (similar to 2006 and 2004). Twenty-eight percent had lost subsidized housing during the past two years. Twenty-one percent of the respondents (eleven percent in 2006) had been denied housing because of criminal behavior.

Thirty-six percent of the women (the same as 2006) reported a loss of government benefits during the past two years. Forty-nine percent had used programs to help them escape homelessness. The women cited *KARM*, *VMC*, *The Salvation Army* and *Tennessee Department of Human Services* most frequently. Nights spent in shelters during the past year ranged from zero to three-hundred and sixty-five, with a mean of one hundred and six nights.

CHILDREN

Among the adult women in shelters, seventy-nine percent (eighty percent in 2006) had children, and seventy-two percent of these women had children under eighteen years

of age. In other words, fifty-three of the ninety-four women had children under eighteen. Thirty-six percent of the women with children under eighteen had their children with them similar to the number in the 2006 study. During the month, seventy-five children of school age or younger were living in shelters.

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

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

The *Stewart B. McKinney Act* provided funding to address the needs of school age individuals. Each state is provided funds for distribution to local school systems. Knox County has had a *Homeless Education Program* since 1993-94, providing a coordinator, transportation resources, funds for tutoring, and a summer enrichment program. Program statistics for the 2006–2007 school year indicated that 256 homeless children were in the program, including 165 in elementary school, 45 in middle school, 30 in high school, 14 in preschool, and 2 completing the GED. In the 2005–2006 school year, 256 homeless children were in the program; this total included 20 preschool, 175 elementary, 39 middle and 22 high school students. In 2003–2004, there were 375 children in this

program, including 45 preschool, 275 elementary, 35 middle and 20 high school students.

Data previously furnished by the program, indicated that during the 2001B2002 school year, Knox County schools had 40 preschool, 200 elementary school, 40 middle school and 30 high school students that could be classified as being from homeless families. This total of 310 students reflected an increase from the 244 identified in the 1999–2000 school year.

Before 17 year old Rick entered the youth shelter, his family was abusing and neglecting him daily. They had kicked him out of the family's home when he reached age 17, and Rick began living on the streets while attending high school each day. It was at school that Rick heard of the agency. He had no food or money, no safe place to live, no consistent adult support, no form of state identification or birth certificate, and he had not completed high school. Staff members met Rick and took him to the agency's shelter. It was at the shelter that Rick was given a home, food, and emotional support, and the help that would meet his basic needs. Shelter staff members helped him through the long process of obtaining his birth certificate, social security card, and state identification. In addition, he completed his GED, and entered the military. Rick still has no connection with his birth family; the staff members who helped him are who he now considers his "family" Rick regularly calls "home" and reports that he is doing well. He now has stable housing, an education, and a future in the military. The shy boy who entered the shelter has grown into a confident and outgoing young man.

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

homeless adolescents who spend considerable time in the Old City or who had been “taken in and exploited by adults, but it was a difficult group to identify and interview.

In the study, ten 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 and seventeen years. Responses consistently suggested a high frequency of family instability. However the statistics did not explain whether this instability was a contributor to or consequence of the adolescents’ behavior. All of the adolescent respondents identified themselves as students. Mobility and possible running away among the adolescents was reflected in responses to questions about number of different cities visited in the past year. The adolescents seemed to maintain contact with families and received some support from them. The responses by the adolescents as well as the adults underscore their need for support systems. Resiliency involves the opportunity to feel good about oneself, to experience support and have the chance for success.

III. COMMENTS

The February 2008 study represents twenty-two 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 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 2008 enumeration was consistent with the 2006 count indicating a monthly total of approximately 1,650 with 1350 of these staying in shelters. This consistency in enumerations, along with available agency data reporting persons being placed in permanent housing is a positive indicator of success in addressing homelessness.

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: **First**, the incidence of homelessness remains significant. **Second**, homelessness reflects a diverse group of individuals; **Third**, 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; **Fourth**, mental illness and substance abuse continue to be major risk factors for homelessness; **Fifth**, many persons cycle in and out of homelessness, with almost half reporting prior episodes; **Sixth**, there are a large number of homeless individuals and families who are living outside emergency shelters and program facilities in outside locations or who are “couch or doubled-up homeless”; **Seventh**, the majority of area homeless continues to be from East Tennessee or have come to the area to be near family or seek employment; **Eighth**, chronic homelessness is costly in terms of human potential and community resources.

There are a number of ongoing concerns and challenges. Perhaps the most glaring concern in the 2008 study was the cost of chronic homelessness in terms of ambulance, emergency room and hospital use, as well as criminal justice involvement, particularly arrests and incarceration. Another serious concern is the state of the economy. As this report is written, the United States is in an economic recession. Economic conditions may increase the number of homeless, reduce financial support for agencies, and hinder escape from homelessness. Even if homelessness can be prevented, the demand on agencies for food and services is sharply increasing.

In 2008, Knoxville–Knox County saw a leveling in the number of homeless persons during the month of February, remaining similar to the numbers in 2006. Several factors likely influenced this finding, but shelters and agencies increasing their efforts to move persons into permanent housing and adopting the “*housing first*” orientation outlined in the *Ten-Year Plan to End Chronic Homelessness* are likely major factors. Along with the housing first approach, the level of agency cooperation and coordination has increased significantly. The reader is reminded that this enumeration is based on persons staying at emergency shelters during the month. While agencies are working to find housing, it appears that many persons are staying in outside locations, living in cars, or doubling up with friends and relatives. 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 implementation of the *Knoxville–Knox County Ten Year Plan to End Chronic Homelessness* provides an exciting opportunity to reduce homelessness as one service provider observed.

“As part of the administrative staff at a local service provider, I work here because I am convinced that we can effectively address homelessness. I have seen so many good, well-intentioned efforts in the span of my career put band aids on problems, never solving, only stemming the breach as best they can. Today is different, there are solutions, and we can fix this problem. My office overlooks the street, and while I do not work directly with our clients, I see and hear them discuss life in their camps and in shelters. Some are angry, lost, preaching to an invisible crowd or screaming obscenities to the air talking to people only they can see. But one day, two gentlemen stood outside my window, the one recounting a great event, excitement in his voice. ‘They told me at that other place I couldn’t get my card (HMIS) but my case manager helped me get it. Look! I got it!’ Such joy in one simple step to being a person; identified; real; one small step toward hope. *Housing First Works.*”

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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