Homelessness in Knoxville and Knox County, Tennessee 2013-2014

A Study Conducted by the Knoxville-Knox County Homeless Coalition and Knoxville Homeless Management Information System (KnoxHMIS)

Contact Information

Knoxville-Knox County Homeless Coalition
R. Chris Smith, LCSW, President
KKCHCoalition@gmail.com

Roger M. Nooe, Ph.D.
Professor Emeritus, UT-College of Social Work
Director of Social Services, Community Law Office
rnooe@pdknox.org

Knoxville Homeless Management Information System
David A. Patterson, Ph.D., Director
dpatter2@utk.edu

Table of Contents

ACKNOWLEDGEMENTS ..... **V**

NOTE TO THE READER ..... **VI**

INTERVIEWERS ..... **VII**

CLIENT STORY CONTRIBUTORS ..... **VII**

INTRODUCTION ..... **VIII**

SECTION I **1**

DEFINING HOMELESSNESS 1

Numbers *1*

REVIEW OF CONTRIBUTING RISK FACTORS 4

Housing *5*

Current Economic Crisis *6*

Deinstitutionalization and Mental Illness *8*

Employment *10*

Substance Abuse *12*

Education *13*

Personal Crises *14*

Other Risk Factors *15*

Homelessness as a Lifestyle *18*

SECTION II **19**

EXECUTIVE SUMMARY OF HOMELESSNESS IN KNOXVILLE AND KNOX COUNTY, TN: 2013-2014 19

KNOXHMIS 2013 ANNUAL REPORT 21

Executive Summary *21*

New Clients Entered into KnoxHMIS *22*

Active Clients Utilizing Services *25*

Basic Demographic Information on Active Clients 27

Disability Status of Active Clients 29

Self-Reported Primary Reason for Homelessness of Active Clients 30

Subpopulations of Active Clients 31

Chronically Homeless 31

Seniors 34

Veterans 34

Female Single Parents 34

Street Homeless 35

Children 35

Services Captured in KnoxHMIS *36*

Emergency Shelter and Transitional Housing *37*

Housing Outcomes *37*

Permanent Supportive Housing *38*

Casenotes *38*

Maps of Zip Code of Last Permanent Address *39*

KnoxHMIS Data Quality *42*

AHAR, PIT, and HIC *43*

Annual Homeless Assessment Report (AHAR) 43

Point-in-Time (PIT) Count 43

Housing Inventory Count (HIC) 44

KKCHC 2014 BIENNIAL STUDY 48
Design *48*
Demographics *49*
Roots *50*
Family *52*
Military Service *54*
Causes of Homelessness *54*
Housing *56*
Employment *56*
Health *57*
Mental Health *59*
Alcohol and Other Drugs *60*
Crime *61*
Life on the Streets *62*
Women *65*
Family 67
Causes of Homelessness 67
Housing 67
Health 68
Mental Health 68
Alcohol and Other Drugs 68
Crime 68
Life on the Streets 68
Interview Respondent Commentary *69*
KKCHC Commentary *69*

SECTION III 71
RESOURCES IN KNOXVILLE 71
Agape *71*
Angelic Ministries *71*
Catholic Charities of East Tennessee *71*
Compassion Coalition *72*
E. M. Jellinek Center *72*
Family Promise of Knoxville *72*
Helen Ross McNabb Center *73*
Knoxville-Knox County Community Action Committee's Homeward Bound *75*
The Next Door *77*
Positively Living *77*
The Salvation Army *77*
Veteran's Administration *78*
Volunteer Ministry Center *78*
YWCA *79*
REFERENCES 80

Acknowledgements

Homelessness in Knoxville/Knox County: 2014 represents twenty-eight years of studies sponsored by the Knoxville/Knox County Homeless Coalition. 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, Andy Black, Preacher Bob Burger, Sister Mary Christine Cremin, Leann Human-Hilliard, Barbara Kelly, Mary Thomson LeMense, Marigail Mullin, Sheila Pellasma, Maxine Raines, Burt Rosen, Major Alberto Villafuerte, Ginny Weatherstone, and Patrick White, were supportive of the study. Dr. David Patterson, Misty Goodwin, Lisa Higginbotham, Issac Merkle, Father Ragan Schriver, and Chris Smith were tremendous resources in planning and conducting the study. Shelter and agency staff — Terry Bray, Amy Canfield, Phil Clark, Richard Stein, Rev. Mychal Spence, Alle Lily, Angela Lister, Larry Lindsey, Cynthia Russell, Betsy Martin, Joy McNeil, Anne Umbach, Rick Walker, and Donna Wright were most cooperative and helpful in our data collection. The Homeward Bound staff, Barbara Disney, Erin Lang, Sissy Flack, Debbie Bruce, and Beatrice Irwin did extra work in interviewing and assisting with the study. Carl Williams and Roosevelt Bethel were essential in surveying outside locations.

My colleagues at the Community Law Office, Chris Smith, Phillip Carrigan, Sarah Buchanan, and Wright Kaminer, were very helpful. My graduate students, Stefanie Pilkay, Rachel Lauber, and Maryssa Dishinger, conducted interviews and helped as needed. A special thank you goes to my administrative assistant, James Young. Mark Stephens, Knox County Public Defender, has provided countless resources and allowed us to use meeting rooms for interviewer training.

Michael Dunthorn, project manager of Knoxville's Plan to Address Homelessness, was instrumental in sponsoring this study. The City of Knoxville provided support for the study.

~Roger M. Nooe, Ph.D.

Note to the Reader

For the past twenty-eight years, the Knoxville/Knox County Homeless Coalition has attempted to capture the story of homelessness in Knoxville through a biennial study. It is a phenomenal effort requiring a vast amount of resources, volunteers, and hours. To create the study, approximately forty volunteers interviewed 236 homeless individuals in various shelters, day rooms, and homeless camps. Each interview lasted, on average, twenty minutes, so, in sum, approximately eighty hours of interviews were collected. Once that information was gathered, hours of thorough work were spent assimilating, digesting, and crafting the information into the document you are now viewing. I have not even mentioned the work it took to plan the event, create the interview, and schedule times and places where the study could happen. Again, it is a huge undertaking, and it would be impossible, given the limited space provided for me to write this note, to thank everyone who deserves acknowledgement.

That said, I would like to give a special "thanks" to the agencies that allowed us space, use of their resources, and the ability to disrupt their services long enough for us to complete our interviews. This study requires a community effort and a collective "buy-in" that the end result (biennial study) is worth the effort. I would also like to notice the homeless individuals and families who were kind (and courageous) enough to share their stories with us.

Dr. Roger Nooe, University of Tennessee Professor Emeritus, College of Social Work and Director of Social Services of the Knox County Public Defender's Community Law Office, has been as integral in this year's study as he has been in each of the preceding studies. In the 2014 study, we have once again asked the Knoxville Homeless Management Information System (KnoxHMIS) to strengthen our understanding of homelessness using the data they retrieve from homeless service providers in Knoxville. While there are many in the KnoxHMIS office that have offered their support, Lisa Higginbotham, Data Analyst, deserves a special acknowledgement of gratitude for the use of her skills and expertise at every stage of the process. Thank you, Dr. Nooe and Lisa.

Within these pages, you will find plenty of data, extrapolations, and interpretations. While the information is meant to educate, our primary goal in presenting this information is to bring attention to the various issues plaguing homelessness and incite and/or inform action to prevent, reduce, and end homelessness. To offer the reader of this study a "window" into homelessness is a secondary – albeit necessary - goal of the Knoxville/Knox County Homeless Coalition.

The release of this biennial study is timely. On April 1, 2014, Knoxville's City Council chose to (unanimously) approve a proposed plan to address homelessness. That plan outlines a specific set of principles, goals, and strategies and sends a clear message to the community that homelessness in Knoxville is not acceptable. The plan leans heavily on the Knoxville/Knox County Homeless Coalition to, among other things, develop community-wide standards of care and accountability and for ongoing input toward the implementation and outcomes of the plan as a whole. I feel comfortable in speaking for the Coalition as a whole that we are up for the charge and poised to move forward with our community as we strive to put an end to homelessness.

Please receive this 2014 study as not only a gift from the Knoxville/Knox County Homeless Coalition to you and our community partners, but also as an invitation join us in our efforts. It is hoped that the information that follows will aid in advising that collective response.

Respectfully,
R. Chris Smith, LCSW
President
Knoxville/Knox County Homeless Coalition

"The mission of the Knoxville/Knox County Homeless Coalition is to foster collaborative community partnerships in a focused effort that seeks permanent solutions to prevent, reduce and end homelessness."
Adopted January 27, 2009

Interviewers

Barbara Disney
Beatrice Irwin
Ben Marlow
Caitlin Ensley
Carl Williams
Carolyn Hansen
Cassie Hagstrom
Chris Smith
Debbie Bruce
Donna Ellstrom
Dr. David Patterson
Dr. Roger Nooe
Erin Lang
Fr. Ragan Schriver
Gabrielle Cline
Issac Merkle
James Young
Jessica Greene
Judy Blackstock
Lauren Thomas
Lindsey Collier
Lisa Higginbotham
Mark Stephens
Mary Lou Hammer
Maryssa Dishinger
Mike Dunthorn
Phillip Carrigan
Rachel Lauber
Rebecca Jones
Roosevelt Bethel
Sarah Buchanan
Dr. Shandra Forrest-Bank
Shauna Stubbs
Sharise Culverson
Sissy Flack
Stefanie Pilkay
Torrie Dorschug
Vanessa Hensley
Wright Kaminer

Client Story Contributors

Knoxville Knox County CAC: Homeward Bound
Knoxville Knox County CAC: Project LIVE
Catholic Charities of East Tennessee: Samaritan Place
Helen Ross McNabb: Kent C. Withers Family Crisis Center
Knox Area Rescue Ministries: Family Emergency Service
Knox Area Rescue Ministries: LaunchPoint
Knox Area Rescue Ministries: Serenity Ministries
Knox County Public Defender's Community Law Office
Volunteers of America: Supportive Services for Veterans and Families
Volunteer Ministry Center: Case Management
Volunteer Ministry Center: Minvilla Manor

Additional Contributions

Sarah B. Garlington, MSSW - Edits
Shauna Stubbs, University of Tennessee, MSSW Student – Edits
Shawn Poynter Photography – Cover Photo

Introduction

Homelessness in Knoxville-Knox County 2014 is the sixteenth study of homelessness in Knoxville-Knox County sponsored by the Knoxville-Knox County Homelessness Coalition and highlights twenty-eight years of collecting data. The first study was conducted in 1986 with regular studies conducted biennially thereafter, plus two smaller intermediate studies. When initially appointed in November 1985 as the Knoxville Coalition for the Homeless, the coalition was charged with three major responsibilities: (1) to ascertain the extent of homelessness in Knoxville, (2) to determine services available to the homeless and make recommendations concerning deficient or nonexistent services, and (3) to increase communication and coordination of services among existing agencies and organizations working with the homeless.

The Coalition continues to meet on a monthly basis and, in addition to sponsoring studies, serves as a forum for exchange of ideas and information. It has taken an increasingly active community role through public education activities, supporting implementation of the *Ten Year Plan to End Chronic Homelessness,* and developing housing for the homeless. In July 2011, the Coalition adopted and continues to work towards housing accessibility, supportive services, and proactive community response as target areas to prevent, reduce, and end homelessness. More details on the Coalition's work plan can be found at: https://sites.google.com/site/kkchcoalition/Knoxville-Knox-County-Homeless-Coalition/Permanent-Solutions.

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 represented the first community plan to address homelessness in a comprehensive, coordinated manner. The plan's central theme, *Housing First*, offered a different approach to homelessness and built on agencies' efforts 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. Subsequently, Mayors Daniel Brown and Tim Burchett appointed the Compassion Knoxville Task Force, which helped gather and organize public opinion on homelessness in our community. More recently, Mayor Madeline Rogero convened the Mayor's Roundtable on Homelessness that developed *Knoxville's Plan to Address Homelessness.*

In recent years, Knoxville homeless service providers have worked together to build collaborative programs that move people out of homelessness. For example, the *Knoxville-Knox County Community Action Committee's Office on Aging* has led the charge of homelessness prevention through offering case management in the high rises of KCDC and by administering the homeless prevention and rapid rehousing programs. Volunteer Ministry Center provides case management to place individuals in permanent housing throughout the community and has Minvilla Manor that provides permanent supportive housing for 58 formerly chronically homeless individuals. In 2012, *Knoxville Leadership Foundation* opened Flenniken Landing in South Knoxville, a permanent supportive housing facility that houses 48 individuals.

Knoxville Homeless Management Information System (KnoxHMIS) serves as an empirical window into homelessness in Knoxville-Knox County. KnoxHMIS is a secure,

Internet-based database of demographic and service delivery information for individuals experiencing homelessness. Sixteen agencies participate which includes over fifty programs and 130 partner agency users. Since operation began in 2004, approximately 31,500 individuals have been entered into the database. *KnoxHMIS* is an important management tool for coordinated case management as well as monitoring the extent of homelessness.

This report incorporates much of the narrative from the earlier reports. The research findings from 2014 are reported and compared with the 2012 data. The description of resources has been updated. Previous introductory material on definition, causes, and patterns is still quite relevant, with 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 2014 study. These composites were submitted by agency staff and do not violate the confidentiality of study respondents or agency clients.

Despite the experience of studying homelessness for more than twenty-eight years, a number of variables continue to impact findings such as: 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 determing methods of enumeration poses a formidable challenge. Likewise identifying contributing factors is not a simple task. A brief examination of these issues illustrates the complexities encountered in studying homelessness.

Section I

A. Defining Homelessness
B. A Review of Contributing Risk Factors

Defining Homelessness

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, 2013; National Law Center on Homelessness and Poverty, 2011). These findings along with other available studies suggest that many people experiencing homelessness may be *"couch homeless"* living with friends or relatives in temporary arrangements (Hoback & Anderson, 2006; Wright, Caspi, Moffit, & Silva, 1998). This "*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, while extremely vulnerable to homelessness, are generally not included. The Annual Homeless Assessment Report (AHAR) study (Khadduri & Culhane, 2010) underscores the high risk of homelessness and resulting utilization of homeless residential services for persons "doubled up" or precariously housed. In fact, persons temporarily staying with friends or family together make up 30.2% of those accessing homeless residential assistance nationally.

The term "homeless" itself is misleading in that it implies that the 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 Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (Public Law 111-22). The act defines homelessness as including persons,

> (1) who resided in a shelter or place not meant for human habitation and who are exiting an institution where he or she temporarily resided; (2) people who are losing their housing in 14 days and lack support networks or resources to obtain housing; (3) people who have moved from place to place and are likely to continue to do so because of disability or other barriers; and (4) people who are victims of domestic violence and sexual assault.

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

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 recognized the range of findings and noted the difficulties in enumeration:

> 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 (Hombs & Snyder, 1983). 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 & 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 *United States Interagency Council on the Homeless* (USICH) 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 (Nooe & Lynch, 1988a & 1988b). This new federal position emphasized that homelessness had been previously underestimated.

A continuing major difficulty in examining the extent of homelessness lies in the use of different sources. In 2013 for example, the State of Homelessness in America Report indicated that as many as 640,000 people are homeless on any given night and approximately 3.5 million people, 1.3 million of them children, experience homelessness each year (National Alliance to End Homelessness, 2013a; National Law Center on Homelessness and Poverty, 2011). It is has been estimated that 6.2% of the U.S. population will be homeless at some point in their lives (Toro et al., 2007). More recent studies suggest that the total number of homeless persons increased by less than 1% between 2011 and 2012. A snapshot of homeless persons in 2012 found that over 633,000 were homeless on a given night, with approximately 1.48 million people spending at least one night in a shelter between October 2011 and September 2012 (Solari, Cortes, & Brown, 2013). According to the *U.S. Conference of Mayors* (2013) survey, hunger and homelessness continue to rise in major American cities. In the twenty-five cities that responded to the survey, the number of families experiencing homelessness increased by an average of four percent in 2013 (*U.S. Conference of Mayors*, 2013).

The methodology to use in counting individuals experiencing homelessness is also a major issue. For example an early study by Link et al. (1994) 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 (Rossi, 1989), and (3) not including people who experience short or intermittent episodes (Link et al., 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 the people experiencing homelessness (Wright & Devine, 1995; Straw, 1995). The 2010 census used a service-based enumeration (*SBE*) that focused on counting persons at shelters, soup kitchens, and outdoor locations where homeless persons were known to be present. The recommendation following the 2000 "dress rehearsal" detailed that SBE appears to be a successful method of including people who otherwise would not be counted.

Another consideration in counting the homeless is whether the count is a point-prevalence or period-prevalence estimate. Point-prevalence estimates are made at a given time,

but do not account for turnover or variability over time. On the other hand, the period-prevalence counts reflect the size of the population for a specified period of time. Consequently, period-prevalence counts typically exceed point-prevalence counts (Quigley & Raphael, 2001). The Knoxville *Homeless Management Information System* (KnoxHMIS) that was initiated in 2004 should increase accuracy in counting the homeless as well as charting variations.

In sum, 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 is a dynamic population that can best 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; for example, a home burns, the wage earner is laid off, a family is evicted, or family abuse causes unexpected homelessness. Episodic homelessness is recurring; for example, a person works seasonally and has lodging or disability benefits which 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 may have meals at shelters. Chronic homelessness is ongoing; the person remains on the street indefinitely and may experience alcoholism or severe mental illness (Nooe & Cunningham, 1990).

These different patterns offer explanation for differences in enumeration and also public perceptions of homelessness. While the chronically homeless are usually the most visible, they likely represent the smallest segment of the homeless population. The category of situational homelessness is the largest when measured over time.

Review of Contributing Risk Factors

The homeless population continues to be one of the fastest growing sub-populations, despite the United States having periods of significant economic growth. The impact of the economic crisis being experienced by the United States since 2008 is continuing to be examined. According to the U.S. Conference of Mayors (2013), thirteen of twenty-five cities surveyed reported an increase in homelessness, and eight reported adopting new policies aimed at preventing homelessness among households that have lost their homes due to foreclosure during the last year.

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, 2009a). In a sense, homelessness represents the "*poorest of the poor"*. In 2012, people below the official poverty threshold numbered 46.5 million, a 2.5% increase from poverty rates reported in 2007, which was prior to the economic recession (U.S. Conference of Mayors, 2013).

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. 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). In 2005, TANF helped a third of the children that AFDC helped reach above the 50% poverty line. Unfortunately, TANF has not been able to keep up with inflation. In 2006-2008, TANF caseload has continued to decline while food stamp caseloads have increased. Moreover, extreme poverty is growing more common for children, especially those in female-headed and working families. This increase can be traced directly to the declining number of children lifted above one-half of the poverty line by government cash assistance for the poor. As a result of loss of benefits, low wages, and unstable employment, many families leaving welfare struggle to get medical care, food, and housing (Children's Defense Fund and the National Coalition for the Homeless, 1998).

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 when in 1996, President Clinton signed into law P.L. 104-193, also known as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Changing public attitudes toward welfare produced revisions that resulted in stricter guidelines for subsidies and services (Kilty & Segal, 2006). Resources such as AFDC have been important in preventing homelessness, but more exclusionary guidelines have increased vulnerability to homelessness (Institute for Children, Poverty, & Homelessness, 2014; Ji, 2006; Miles & Fowler, 2006).

While the foregoing and other studies present a case for structural or external factors such as lack of affordable housing, income, and employment opportunities (U.S. Conference of

Mayors, 2013; Lee, Price-Spratlen, & Kanan, 2003; Sosin, 2003; Quigley & Raphael, 2001; McChesney, 1995; Timmer, Eitzen, & Talley 1994), there is considerable evidence that homelessness is also due to personal problems or internal factors such as mental illness, substance abuse, disability, or domestic violence (U.S. Conference of Mayors, 2013; Corliss, Goodenow, & Austin, 2011; Shelton, Taylor, Bonner, & Van den Bree, 2009; Donohoe, 2004; Sosin, 2003; Sullivan, Burnam, & Koegel, 2000; Jencks, 1994; Baum & Burnes, 1993; Lamb & Lamb, 1990; Bassuk, Rubin & Lauriat, 1984). 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; Forchuk et al., 2010). Perhaps Burt (1993) 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 and the decrease of available public assistance due to federal budget cuts are major contributors to homelessness. Families living in poverty pay an average of forty percent of their annual income in order to maintain permanent housing (Bureau of Labor Statistics, 2013a), leading households to have to choose between meeting other basic needs such as food or healthcare (McMahon & Horning, 2013). While federal rental assistance programs are available to assist low-income households with high housing costs, they unfortunately reach only a small share of those eligible. It is currently estimated that over 10 million American households pay fifty or more percent of their income on housing, a fact that places these individuals at an increased risk for homelessness (Center on Budget and Policy Priorities (CBPP), 2013).

In 2012, it was estimated that over 2 million families in the United States utilized housing vouchers (CBPP, 2013). Due to the debt-ceiling crisis and government sequestration of 2013, it is estimated that as many as 185,000 low-income families could lose their housing vouchers (Rice, 2013). In addition, Cohen, Wardrip, & Williams (2010) explain that about 200,000 low rent units were lost over the past decade due to demolition, thus resulting in fewer housing options for low-income families. The Joint Center for Housing Studies (2013) estimated a gap between affordable units and low-income renters of more than 4.9 million units in 2009. 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 Knoxville citizens can remember private sector hotels and rooming houses that provided cheap

lodging, but many of these have been demolished 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).

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

Finding permanent housing may be complicated by poor payment history, prior criminal offenses, and substance abuse. 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* (2007) 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.

In some respects Knoxville has more housing resources than other metropolitan areas. The combination of public housing, private facilities, and emergency shelters in Knoxville results in only fourteen percent of the homeless either living in or choosing to live in outside locations (HUD, 2014d). Some cities report that the greatest numbers of homeless are living in outside locations, and in the 2013 Annual Homeless Assessment Report to Congress, thirty-five percent reported sleeping on the streets or in other places not meant for human habitation, such as cars or abandoned buildings (Henry, Cortes, & Morris, 2013; U.S. Conference of Mayors, 2013). Knoxville's revised *Plan to Address Homelessness* includes as one of its five goals the goal of creating and maintaining access to a variety of decent, appropriate, and affordable permanent housing for Knoxville's homeless. Further, 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 (Knoxville's Plan to Address Homelessness, 2014; Homelessness in Knoxville-Knox County, 2012).

Current Economic Crisis

In 2008, the United States endured a substantial economic crisis that began with the failing and subsequent bailouts of numerous national financial institutions. Considered by some to be the worst financial crisis since the Great Depression, the crisis has since stabilized; however, the debt-ceiling crisis of 2013 and subsequent government shutdown once again threw the U.S. into the fray of financial worry. The total cost of the shutdown, which was estimated at $2 to $6 billion, was not only financial but halted numerous services, including the processing of veterans' disability claims, Head Start, and home loan decisions for rural families (U.S. Office of Management and Budget, 2013). Further, as a result of the shutdown, funding for numerous programs that aid vulnerable populations was cut, including a $9 billion cut to Food Stamps (O'Keefe, 2014).

The recession of 2008 and the debt-ceiling crisis are still affecting citizens in terms of employment, access to social services, and the ability to obtain housing. People experiencing homelessness or extreme poverty are especially at risk during times of national economic strain (Olivet, Paquette, Hanson, & Bassuk, 2010). Specifically, the number of people experiencing

homelessness increased by 20,000 following the first year of the 2008 economic crisis (Sermons & Witte, 2011).

Prior to the recession of 2008, the unemployment rate in the United States was 5.0%; as of January 2014 it was 6.6%, with a peak unemployment rate of 10% in October of 2009 (Bureau of Labor Statistics, 2014). With the unemployment rate still high, more people have been left without the ability to afford housing, health insurance, and other basic needs necessary for survival. The declining number of available jobs especially affects persons experiencing homelessness.

In addition, the United States government has implemented federal budget cuts to social service funding. In 2013, due to the federal budget sequestration, the Department of Health and Human Services incurred a budget cut of $15.5 billion (U.S. Department of Health and Human Services, 2013). The U.S. Department of Housing and Urban Development's budget was cut by 9 percent, or $4.4 billion, with the most severe cuts (45%) to the Community Development Block Grants (CDBG) and the HOME Investment program (33%)(*New York Times* Editorial Board, 2013). The CDBG Program provides communities with resources to address wide range of unique community development needs, and the HOME Investment Partnerships Program is the largest federal block grant program to assist states to build, buy, and rehabilitate affordable housing (HUD, 2014b; HUD, 2014c). As a result of the sequestration, programs that assist those who are homeless or at risk of becoming homeless are either losing federal funding or ceasing to exist altogether.

Peter was married for twenty years and divorced around the same time he lost his job. He stayed with his ex-wife briefly after the divorce since he had very little money. Due to conflicts, he left and ended up living in his truck. He has two adult children with his ex-wife. Because he could not make payment on the truck, it was repossessed, and he had nowhere to go. Peter felt that he had no option and decided that it would be best for everyone if he were gone. He attempted suicide by intentionally walking in front of a car. At the last moment, he changed his mind and pulled himself back to the curb seconds before he would have been hit. He realized he needed help and sought shelter services. During his shelter stay, he was accepted into programming and received case management. Program staff were aware of some past problems with Peter, but he did not reveal his continued suicidal thoughts until after his program completion. Staff helped him get admitted to a crisis stabilization unit. After discharge from the crisis unit, Peter returned to the shelter program where he continued to receive support. Peter is now living in his own apartment. He meets weekly with a counselor and his mental health has stabilized. He regularly takes his medications that treat his depression and anxiety. He just recently obtained a part-time job, repaired his relationship with one of his children, reunited with his grandson, and has reconciled his relationship with his ex-wife. He has accepted that he and his ex-wife will not re-marry but is enjoying their friendship. He has expressed that he wakes up every morning ready to start a new day and is thankful that the shelter staff and his case manager never gave up on him.

The national housing market has also been detrimentally affected by the economic crisis. According to The National Low Income Housing Coalition (2013), the nation is currently

experiencing a deficit of 2.5 million affordable housing units. Individuals and families already experiencing difficulty obtaining permanent housing, such as those in extreme poverty or with low-income, are now finding it even more difficult. The economic crisis has caused more than 4.8 million home foreclosures since September 2008 (CoreLogic, 2013). However, foreclosures are currently at their lowest levels since 2007. According to the *National Coalition for the Homeless* (2008), there was a direct correlation between the economic crisis of 2008 and the increase in national homelessness. While the government sequestration and shutdown had minimal impact on homeless assistance programs (NAEH, 2013b), it is estimated that budget cuts made in 2013 and 2014 will significantly impact those who are vulnerable to homelessness, including the elderly or disabled, and those who are currently homeless or formerly homeless (NAEH, 2013c).

Deinstitutionalization and Mental Illness

The role of mental illness and deinstitutionalization has been heavily debated. By definition, deinstitutionalization is "the release of institutionalized individuals from institutional care to care in the community" (Merriam-Webster's online dictionary, n.d.). While this most commonly refers to psychiatric hospitals, it can also refer to prisons and children's institutions.

Deinstitutionalization was a movement starting in the 1950s with a focus on moving individuals out of state public mental hospitals back into the community; however, it was not until later that individuals recognized that community services were not available or adequately sustained, especially for those with serious mental illness. This lack of community services and lack of planning for those discharged led to homelessness and criminalization of those with serious mental illness (Lamb, 1984). Further, federal human service program cuts in the 1980's left many without an adequate income for housing, leading to a significant increase in those persons becoming homeless (Koyanagi, 2007). While some studies reflected the finding that deinstitutionalization led to an increase in homelessness, others found low incidence rates of serious psychiatric symptoms among the homeless (Snow, Baker, Anderson, & Martin, 1986).

Knoxville history mirrors the deinstitutionalization movement elsewhere in the country. Opened in 1886, the East Tennessee Hospital for the Insane at its peak in the 1960s housed nearly 3,000 people. The facility was renamed the Lakeshore Mental Health Institute in 1977. Shortly thereafter, the state began to make plans to shift remaining patients into the community (Shannon, 2013) in the hopes to eventually to close the Institute. Closed on June 30, 2012, the remaining 90 patients were moved into other community or state mental health programs. While Lakeshore significantly downsized prior to its closing, in the preceding six months, the hospital admitted and discharged more than 500 patients (Lake, 2012). The 2011-2013 Knoxville study cited deinstitutionalization as one of the major reasons underlying homelessness in Knoxville, with 33% of those with mental illness reporting hospitalization at some point in their lives. The effect of the closing of Lakeshore on homelessness in Knoxville, especially for those with serious mental illness, is not fully known.

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 tend to have higher rates of mental illness than do non-sheltered homeless persons. At one point in time in January 2013, HUD indicated that roughly twenty percent of sheltered and unsheltered homeless were severely mentally ill, with fifty-six percent residing in shelters (U.S. Department of Housing and Urban Development, 2014a). The 2011-2012 Knoxville study

found that approximately 40% of the homeless individuals surveyed had been treated for emotional problems (Spangler, Nooe, & Patterson, 2012). However, these estimates are likely conservative, given the incidence of untreated individuals and those who are in jails, prisons, or otherwise unidentified (Toro et al., 1995; Lamb & Weinberger, 1998; Susser et al., 1997; Sullivan, Burnam, & Koegel, 2000; Steadman, Osher, Robbins, Case, & Samuels, 2009). 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 five times as likely to become homeless (Shelton, Taylor, Bonner, & Van den Bree, 2009; Schmidt, Hesse, & Lykke, 2011). While figures vary based on location, studies have found that persons discharged from psychiatric hospitals may become homeless after discharge or are discharged directly to shelters (Forchuk, Russell, Kingston-MacClure, Turner, & Dill, 2006). For persons with mental illness, homelessness has a detrimental effect and like any other crisis may cause psychological trauma (Goodman, Saxe, & Harvey, 1991; National Health Care for the Homeless Council (NHCHC), 2000; NHCHC, 1999).

Lauren had been chronically homeless, traveling in and out of emergency shelters and occasionally living on the streets in places not meant for human habitation for many years. She was diagnosed in her early twenties as having schizophrenia and dissociative identity disorder. Her delusions and alter personalities led to arguments and legal issues, which estranged Lauren from her family and friends. Lauren worked with multiple case managers over the years, but she experienced little change in her illness due to instability with her housing and the intermittent care she accessed from health care professionals. Through a referral by one of her case managers and a housing case manager, Lauren began living in permanent supportive housing at age thirty-five. Once placed in housing, she began receiving daily service coordination, affording an opportunity to diagnosis and treat her medical and mental health issues. During the past year, Lauren's health and stability have dramatically improved, so much so that former friends and case workers hardly recognize her. With her housing case manager's assistance, Lauren was given the opportunity to apply for and gain a part time job at a workforce development agency. After several months, Lauren was able to move into fulltime employment at a restaurant, where she continues to be employed. Lauren also volunteers her time to plan movie nights, bingo, reading groups, and other holiday activities for fellow residents.

Unfortunately, homelessness and mental illness have become intertwined within the criminal justice system. There is mounting evidence of an increasing number of severely mentally ill persons in jails and prisons (Greenberg & Rosenheck, 2008a; Greenberg & Rosenheck, 2008b; Lamb & Weinberger, 1998; Fazel & Seewald, 2012). People experiencing homelessness and/or mental illness have become criminalized, and in a sense, jails are becoming today's asylums – with as many as 360,000 persons being incarcerated (Lamb & Weinberger, 2011; McNiel, Binder, & Robinson, 2005). The interaction of these factors is seen in the finding that non-homeless mentally ill persons going into jail have a significantly increased risk of housing loss (Solomon & 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, Kasprow, Frisman, & Liu-Mares, 2003).

Jeff, age forty-eight, had been refused services at several area shelters due to non-compliance with shelter regulations and his aggressive actions towards shelter staff and guests. However, over time, Jeff built a relationship with outreach case workers, who advocated with shelter staff to allow him to receive services. Jeff was in prison starting in adolescence for twenty-seven years. His attitude about his past and physical disabilities, including trouble hearing and walking, were barriers to his participation in shelter rehabilitation programming and relationships with others. Constantly rehashing his record as a felon and limitations with his physical disabilities, he kept despairing that regarding housing everything was hopeless. Through shelter rehabilitation program case management, he was connected with another agency's intensive case management team who helped him apply for housing. Throughout the process he struggled with his mental health including depression. He continually expected failure and to be denied housing. He was denied, resulting in a downward spiral; however, shelter staff and his intensive case manager continued to support him and encouraged him to appeal the housing denial. Jeff went to the appeal with his case manager. Shortly thereafter, to Jeff's surprise, he received a letter from public housing telling him he had been accepted. This changed Jeff's perspective and motivated him to complete his case management plan. Within a month of graduating shelter programming, Jeff was able to move into and has kept his housing. While on the housing wait-list, Jeff was able to obtain part-time employment. He continues to maintain stability and be an encouragement to others.

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. The current value of the minimum wage has not kept up with economic growth, and this is particularly detrimental. The growing disparity between the rich and poor is especially stressful for low-wage earners as the real value of the federal minimum wage in 2011 has only risen 10.7% since 1973 (Mishel, 2013). Further, during the economic recovery of 2009-2011, real wages fell for the bottom ninety percent of the wage distribution but rose for the top five percent (Mishel & Finio, 2013). In 2012, the federal minimum wage was $7.25 per hour – if the minimum wage had kept up with inflation, the minimum wage would be $10.75 per hour (American Federation of Labor and Congress of Industrial Organizations (AFL-CIO), 2014).

Burt et al. (1999) found that the median monthly income for persons who were homeless was about 51% of the federal poverty level. While the value of the minimum wage has not kept up with inflation (AFL-CIO, 2014), there has also been a decline in manufacturing jobs and a corresponding increase in low-skill service occupations (Autor & Dorn, 2013;

Bureau of Labor Statistics, 2013b), which are additional factors in wage decline (Burt et al., 1999).

Leslie married her high school sweetheart and shortly thereafter became pregnant. They both decided she would quit her job to raise the child. Her husband took on extra shifts and worked into a management position. Things were tight financially, but they paid the rent on their mobile home, kept up with the utilities, and - with food stamps – managed to have enough to eat. Leslie gave birth to two more children. Eventually, her marriage fell apart, and she was without a home or income. She went to her mother's house to "get back on her feet." After three months she was asked to leave. Her mother could not handle the noise that accompanied the three young children. At the time, Leslie was working full time at a grocery store. Leslie found a two-bedroom apartment for $600 a month. Her mother agreed to baby-sit two days a week but told Leslie she would have to get childcare for the rest of the work week. Leslie worked forty hours a week at minimum wage and tried to keep her work hours during the school day so she only had to pay childcare for one child. For a year, she maintained on $1200 a month, but then her work dropped her day-time hours and offered her full time in the evening. Leslie could not work evenings because of childcare, so she took the twenty hours a week. She began applying for a second job and filled out an application for government housing that would reduce her monthly rent payment. She was finally able to get a second job at a grocery competitor to supplement her hours. She was averaging sixty hours a week at minimum wage and was maintaining a $1600 a month budget. Months later, her long time employer discovered that she was working at a competitor's store and terminated her employment. Again, Leslie found herself back down to half time employment. Within the month, she fell behind on her rent, her electricity was shut off, and she was evicted. Leslie and her children sleep in a homeless shelter while she continues on the waitlist for affordable housing.

Maintaining housing on minimum wage or in part-time jobs is extremely difficult. Many of the jobs held by homeless persons are part-time, temporary, or do not provide sufficient wages for self-sufficiency. Burt et al. (1999) recognized that employment prospects are dim for those who lack appropriate skills or adequate schooling. As the labor market shifts, for some there is loss of employment and income ultimately leading to housing instability (Shier, Jones, & Graham, 2012). Employment instability and the lack of employment benefits have both been identified in several studies as a risk factor for homelessness (NCH, 2009a; Wagner & Perrine, 1994). Women and minorities experience fewer employment opportunities and higher rates of workplace discrimination (Skaggs & Bridges, 2013; U.S. Equal Employment Opportunity Commission, 2013). The duration of homelessness may decrease the prospects of employment (Ferguson, Bender, Thompson, Maccio, & Pollio, 2012). It is not surprising that homelessness itself may further diminish one's chances of employment; as prolonged idleness may cause greater loss in skills, work habits, responsibility, and

commitment to employment. Knoxville's 2014 *Plan to Address Homelessness* calls for increased economic opportunities for homeless persons. Achieving maximum economic self-sufficiency will involve improving access to employment assistance programs and maximizing access to job training and placement programs.

Substance Abuse

Habitual heavy substance abuse is both a major contributor to homelessness (Tam, Zlotnick & Robertson, 2003; Johnson, Freels, Parsons, & Vangeest, 1997) and a consequence of homelessness. According to most recent estimates, 22% of homeless persons reported chronic substance abuse (HUD, 2014a). Also concerning is the rate of homeless individuals who die of drug overdose – estimated by one study to be 17% of all homeless deaths (Baggett et al., 2013). 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 et al., 1995). In any case, substance abuse is a major factor as illustrated by a study estimating that roughly 47% of homeless men experience lifetime alcoholism and/or other substance use disorders (McQuistion, Gorroochurn, Hsu, & Caton, 2013). Substance abuse disorders are also prevalent among homeless women (Bassuk, Buckner, Perloff & Bassuk, 1998; Edens, Mares, & Rosenheck, 2011).

The relationship between homelessness and substance abuse may be more complex than it first appears. The lack of access to affordable health insurance and the ability to meet required copayments may be a barrier in dealing with addiction (Brubaker, Amatea, Torres-Rivera, Miller, & Nabors, 2013). Further, policy changes in 1997 reducing eligibility for Social Security Income (SSI) based on chronic substance abuse likely increased the risk for loss of housing and homelessness (Norris, Scott, Speiglman, & Green, 2003). However, the Affordable Care Act of 2010, coupled with other recent health reforms, will likely increase the funding available for substance abuse treatment (Buck, 2011). A remaining barrier for the homeless are policies that result in persons convicted of alcohol or drug abuse or sales being barred from public housing (Curtis, Garlington, & Schottenfeld, 2013).

Further complicating the issue is the fact that many individuals are dually diagnosed, suffering from both a major mental illness and substance abuse (Hartwell, 2004; Barber, 1994). These dually diagnosed individuals frequently fall between the cracks because neither mental health nor substance abuse treatment facilities provide comprehensive services, with an estimated 9-18% of programs providing both (McGovern, Lambert-Harris, Gotham, Claus, &Xie, 2014). Further, 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 (Thompson, Wall, Greenstein, Grant, & Hasin, 2013).

Rosalyn moved around a lot as a child. Her father was an alcoholic and could not manage money. They were often evicted and lived at extended relatives' homes sleeping on the couch. They never stayed anywhere long enough for her to get a good education. Her mother signed papers for her to get married at sixteen years old. Rosalyn's husband left her and their daughter for another woman when she was twenty-three years old, and that is when she started drinking. During this time, she learned that her husband was molesting their daughter. In addition, several close family members died causing a downward spiral. Due to her drinking, she started experiencing health problems, lost custody of her daughter, and became estranged from her family. She ended up homeless staying in and out of shelters. Rosalyn had periods of being sober, but battled alcoholism for several years. Finally, Rosalyn sought in-patient substance abuse treatment. Initially, she was reluctant and experienced barriers to sobriety such as fear, anxiety, low income, lack of credit, and physical disabilities. During her stay she reconnected with her faith and embraced the program's structure. She has formed a new social network of friends, overcome financial barriers, found housing, and maintained sobriety.

Education

Inadequate education has not been clearly identified as a causative factor in studies focused on homelessness (Caton et al., 2005). However, Burt, Aron, & Valente (2001) state that less than 38% of the homeless population has obtained a high school degree by the age of eighteen . In the 2012 Knoxville study, twenty-six percent of the respondents reported having graduated from high school, with 36% 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.

Due to family problems, Jason came to Knoxville from a neighboring county to live with his father. He enrolled in high school but found the adjustment overwhelming. He could not catch up, and with added peer pressure, he began smoking marijuana. He also suffered from depression and low self-esteem. His father was a heavy drinker and arguments over his grades resulted in Jason moving in with an elderly relative. Unable to maintain grades, Jason quit high school. He was then taken to the shelter and dropped off by his family. Jason found temporary work but was discouraged by the low wage and the extreme heat of outside manual labor. He became ill. He was nineteen, without a diploma or job skills, and became even more depressed. Jason had medical insurance and he was able to seek treatment. He was linked to a youth program that evaluated his situation and arranged a resource team of support services, including a family support provider, clinical supervisor, and mental health consultant. Jason enrolled in GED classes and continued to engage in services. He was interviewed and accepted into a transitional living program. With support and encouragement, he completed the GED and found employment. While he waits for supportive housing, Jason gives peer support to other youth. He has established friendships, reestablished family ties, and maintains sobriety.

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 (1999) 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 (Baker, Billhardt, Warren, Rollins, & Glass, 2010). A recent study shows that one in four women will experience domestic abuse within their lifetime, and 39% of cities name domestic abuse as the leading cause for female homelessness (NCH, 2009b). In addition, women who have experienced violence may encounter discrimination from landlords who are relunct to rent to them (NCH, 2009b; *Anti-Discrimination Center of Metro New York*, 2005). Likewise, 16% of the cities surveyed by the U.S. Conference of Mayors identified abuse as a major cause of homelessness (2013).

Cynthia is a twenty-four year old single mother of two young children. Until a year ago, she lived in income-based housing and had a full time job at a restaurant. While working and raising her children, she also attended GED classes and obtained her diploma. Shortly after, she became involved in a relationship with an individual who eventually became abusive. That person persuaded her to give up her apartment and rent a house together. After repeated mistreatment, she left the relationship. On the day she moved out of the house her abuser attacked and brutally assaulted her. Cynthia moved into a homeless shelter with her children, and obtained an Order of Protection against her former partner. Her landlord agreed to allow her to break her lease without penalty. While in the shelter, Cynthia completed a training program through the shelter and was hired at a local department store. A case manager with a local homeless service provider assisted her with bus passes to get to work and with obtaining clothing to meet her employer's dress code. She applied and was approved for public housing. After being offered an apartment she discovered that her ex-partner had called and impersonated her to have the utility service turned back on at their home. She was then faced with a $1200 outstanding balance that had to be paid before she could get service at her new apartment. The bill was paid through grant funding and donations from several local churches. With the help of her case manager, she has now been living in her apartment for six months and works full time.

In 2013, the U.S. Conference of Mayors reported that food and housing insecurity rates for families headed by single women are substantially higher than the national average. A number of studies have found that female-headed households have greater risks for poverty

(National Center for Law and Economic Justice, 2013) and subsequently have greater risks of homelessness (Caton, Shrout, Dominguez, Eagle, Opler, & Cournos, 1995; DiBlasio & Belcher, 1995). The National Center for Law and Economic Justice (2013) notes that 31% of single female households are poor while only 6.3% of two-parent households are impoverished. As Jencks (1994) observed, "married couples hardly ever become homeless as long as they stick together."

Other Risk Factors

Increased research on homelessness has resulted in identification of risk factors for homelessness. For example, the National Coalition for the Homeless (2009) suggested the following risk factors: foreclosure, poverty, eroding work opportunities, decline in public assistance, unaffordable housing, lack of health care, domestic violence, mental illness, and addiction disorders. Wagner and Perrine (1994) identified similar factors in comparing housed vs. homeless women, recognizing that homeless women had higher rates of mental illness, were more likely to be unstably employed or housed, and have a history of abuse, substance abuse, and fewer social skills.

At age sixty, Vera was referred to homeless prevention services shortly after her husband of over forty year passed away. After his death, she lost the majority of their income, and their home of over twenty years was foreclosed. She had nowhere to go and was without family support as her children lived out of state. The main challenge was to quickly identify appropriate housing that was affordable and could be sustained on her limited income. Her case manager identified and worked with local permanent supportive housing for seniors that she was able to access shortly after intake. One year later, Vera continues to live there, is stable, doing well, and has a network of other seniors and staff.

Homeless families are most frequently headed by single mothers (Rog & Buckner, 2007). The National Coalition for the Homeless (2009b) found that previously abused women are more likely to become homeless and develop depression, anxiety, or substance abuse disorders (Howard, Feder, & Agnew-Davies, 2013). Just as gender may increase the risk of homelessness, minority status may also increase vulnerability to homelessness. In 2012, minority status as a risk factor is illustrated by the finding that over a quarter of Hispanics and 27.4% of Blacks were living in poverty (National Center for Law and Economic Justice, 2013). 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 housing, employment, and education discrimination (Institute for Children, Poverty, and Homelessness, 2012).

Sarah is a forty one-year-old survivor of domestic violence. For several years, she endured emotional, verbal, psychological, financial, and physical abuse from her ex-husband, with whom she and her young child were living. She ultimately made the difficult decision to leave her abuser and thus fled the dangerous situation. Unfortunately, as a result, Sarah became homeless. Sarah, like so many other women fleeing domestic violence, became homeless because she had nowhere to go. Sarah sought refuge at the local emergency shelter for women fleeing domestic violence. The emergency shelter addressed her safety needs through safety planning and provided for her other basic needs of shelter, food, hygiene, and clothing. Sarah was assigned an advocate who worked very closely with her to set goals, empower her to achieve these goals, get her life back on track, and provide advocacy. Shelter staff provided emotional support and counseling during her time in shelter. While working with her advocate, Sarah was assisted in accessing community resources, including signing up for public housing, linking to resources for addiction recovery, applying for WIC benefits, obtaining a copy of her birth certificate and other legal documents, and referrals to career resources for employment. Sarah is not currently employed, but wants to seek a job once her life becomes a bit more stable. Thanks to the shelter that is providing a home for her during this difficult time, Sarah and her child are safe and living free from violence. Sarah is working to start her life over and obtain her own stable permanent housing.

Several studies have examined childhood risk factors for adult homelessness. Economic and residential instabilities, along with poverty, are examples of childhood antecedents (McQuistion et al., 2013; Burt, 2001; Koegel, Melamid & Burnan, 1995; Miller, Donavan, Este & Hofer, 2004). Increasingly, research is showing that disruption in childhood, such as foster care placement, inadequate parenting, and neglect result in a greater chance of adult homelessness (Pecora et.al., 2005; Roman & Wolfe, 1997; Tyler & Melander, 2010), as well as substance use and unemployment (Vaughn, Ollie, McMillen, Scott, & Munson, 2007; Tam, Zlotnick & Robertson, 2003). There is an especially strong link between homelessness and childhood sexual and physical abuse (Keeshin & Campbell, 2011; Johnson, Sternglanz, & Weylin, 2006; Nyamathi, Longshore, Keenan, Lesser & Leake, 2001).

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. Often, among minimum wage paying jobs, employers will not provide health insurance to their employees. While the Affordable Care Act (ACA) is expected to make affordable health coverage available to more Americans, it is not yet known how effectively this law will work in practice (Silvers, 2013). States that expanded Medicaid under the ACA expanded insurance coverage to all eligible persons whose earnings are less than 133% of the federal poverty level regardless of disability or family status. However, in the states that did not expand Medicaid, health insurance will likely remain too expensive for most homeless and working poor (USICH, 2013). This lack of health insurance or unavailability of basic health care for the working poor may result in loss of employment and eventual eviction, ultimately resulting in homelessness.

Various groups may experience unique risk factors for homelessness. For example, Vietnam-era veterans appear to be more vulnerable than other veterans (Perl, 2013). 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 & Tessler, 2003; Rosenheck & Fontana, 1994).

Mike had been on the move most of his adult life. Having survived Vietnam, Mike became estranged from his family. Truck driving became a large part of his life. After living in his pickup truck for fifteen years, Mike suffered health problems and had to seek emergency shelter. There he accessed their wrap around case management services and began working on a more sustainable plan for his future. Staff connected him with a program serving veterans to help him secure veteran's benefits to address his health needs and provide support for employment, such as uniforms and clothing. Shelter staff also helped him identify and rent an apartment. A church provided furniture. He continues to stay connected with the shelter wrap around program staff and to learn about resources in the community near his new home. After many years, Mike has a home that is not on the road.

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 & Wolfe, 1997), with one study finding as many as 46% experiencing homelessness at least once by age 26 (Dworsky, Napolitano, & Courtney, 2013).

Jordan lived with his father until he was seven years old when he was placed in a foster care home due to neglect. As he grew up, Jordan often got into trouble at school for foul language or violence. He was sent to alternative school in fifth grade, where he returned each year after getting into trouble at school. Jordan befriended individuals who experimented with drugs and vandalism. In his teens, he and his friends were caught vandalizing school property and were charged in juvenile court. He was arrested for possession of an illegal substance shortly after his vandalism charge and was taken into custody. Jordan was moved through seven different foster homes until he aged out of the foster care system at age 18. Now, at age nineteen, Jordan stays on the streets, or at an emergency shelter when it gets too cold. Because of his juvenile record, he is unable to find employment. Without employment, Jordan cannot afford a home. Because of his erratic foster care history and delinquent friends, it is hard for him to trust anyone so he tends to isolate himself and does not reach out for help.

Regardless of the factors identified in the foregoing discussion, 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 (1999), for example, found that low levels of support from friends were associated with homelessness following completion of a substance abuse treatment program. Similarly, adolescents running away from or being kicked out by families are at risk for homelessness (Kort-Butler, Tyler, & Melander,

2011). 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 range of 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 (Tyler & Melander, 2013; Toro et al., 1995). These 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 Lifestyle

The discussion of contributing factors underscores the complexity of and different paths to homelessness. However, the question periodically arises, "Don't some just want to be homeless?" In other words, 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, it is likely that the number is quite small. 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.

Section II

A. Executive Summary
B. 2013 KnoxHMIS Annual Report
C. Knoxville-Knox County Homeless Coalition Biennial Study

Executive Summary of Homelessness in Knoxville and Knox County, TN: 2013-2014

Since 1986, the Knoxville-Knox County Homeless Coalition (KKCHC) has conducted a biennial survey and enumeration of individuals experiencing homelessness in Knoxville. In 2004, the director of the study, Dr. Roger Nooe, partnered with Dr. David Patterson of the UT College of Social Work to implement the Knoxville Homeless Management Information System (KnoxHMIS), a secure online database to connect service providers and generate community-wide statistics about homelessness in real-time. Each year since its inception, KnoxHMIS has generated an annual report detailing the characteristics of individuals experiencing homelessness, services provided, and housing outcomes. In an effort to provide a single, authoritative source of information on homelessness for our community, data from KnoxHMIS and the 2014 Biennial Knoxville-Knox County Homeless Coalition Study are presented jointly.

Some questions asked in the online KnoxHMIS assessment and the KKCHC survey are very similar. Both request information from clients regarding demographic information, e.g. gender, age, primary race, ethnicity, etc. However, some questions are asked differently; for example, the KnoxHMIS assessment asks about the primary reason for homelessness and allows for only one answer. In contrast, the KKCHC survey asks for the causes of homelessness and allows for multiple responses.

In addition to the framing of questions, KnoxHMIS data are collected over the course of the year on individuals who access services from partner homeless service agencies. Data for the KKCHC study are collected over the course of three days in February from shelters, outside locations, substance abuse treatment centers, and outdoor meal programs. Data gathered by KnoxHMIS include individuals who are seeking services for homelessness prevention; are currently experiencing homelessness; or are housed, but still engage in case management or other services. The KKCHC sample includes only individuals who were homeless during the time of the study.

The authors of this report urge the reader to view these two sources of data as complimentary. Each takes a different perspective and thus has respective strengths. The KKCHC data provide a detailed and in-depth look at 236 individuals currently experiencing homelessness. KnoxHMIS data provide a comprehensive overview of 9,806 individuals accessing services from area homeless service providers.

KnoxHMIS reports that the average age of women seeking services is 35; in contrast, the KKCHC data report the average age of women acutely experiencing homelessness to be 42. This difference may be explained by the aforementioned different population samples. Statistically speaking, larger samples are more representative of populations. Conversely, the depth of psychosocial information provided by the KKCHC expands our understanding of this complex population and may sample individuals who avoid services. As a result, this report contains a vast array of information allowing readers to better understand the scope and complexity of

homelessness in Knoxville and Knox County.

The data compiled for this study show an increase in the overall number of individuals accessing services for homelessness, while national data from the Annual Homelessness Assessment Report to Congress show a modest decrease in these numbers. However, the economic recession of 2008 appears to have negatively impacted some groups more than others. Family homelessness, while increasing between 2007 and 2010, has decreased in recent years across the nation. In contrast, family homelessness continues to rise in the Knoxville-Knox County Area. Chronic homelessness has been slowly trending downward nationally and in our community. Some of these increases may be explained by improved data collection techniques. Here are a few key points:

- Each month in 2013, an average of 1,989 people accessed services for homelessness. For the year, the total number of individuals utilizing services was 9,806 — an 11% increase over 2012*.
- Fifteen percent of individuals accessing services self-report a mental illness*; 62% have received treatment for mental illness while homeless^.
- Between 14-25% of individuals report that loss of a job caused them to become homeless*^.
- Sixteen percent of individuals that were homeless during 2013 are employed^.
- Thirty-one percent of individuals experiencing homelessness report a disability of long duration*.
- Single female parents comprise 7% of the total population experiencing homelessness*.
- Seventy-seven percent of individuals experiencing homelessness in Knoxville and Knox County report a last permanent address in Knox or a surrounding county*.
- Sixty-one percent of homeless individuals are originally from Tennessee^.
- In 2013, 962 children under the age of ten accessed homeless services with a family member*.

*KnoxHMIS 2013 Annual Report
^2013-2014 Biennial Study of Homelessness in Knoxville/Knox County

KnoxHMIS 2013 Annual Report

Executive Summary

KnoxHMIS data for 2013 reflect complex manifestations of homelessness in our community and efforts to address this complex social problem by the array of service providers in the area. As evidenced in Chart 3 (page 33) there was a 3% decrease in individuals new to homelessness in Knoxville. Conversely, the number of individuals receiving services to prevent homelessnes rose from 332 to 1106. A portion of this increase may be due to improved data capture and quality.

A total of 9,806 individuals accessed homeless services from KnoxHMIS partner agencies[1]. This figure represents an 11% increase from 2012 (8,857). Thirty-two percent of active clients (3,140) were either "housed and at risk of homelessness" or "stably housed" and receiving services. Chronically homeless individuals represented 20% of all active clients. On average, 1,989 active clients sought services each month from KnoxHMIS partner agencies.

- 40% were female
- 31% were reported to have a disability
- 50% of those indicating a disability reported experiencing mental health problems
- 26% of men reported primary reason for homelessness as "loss of job"
- 15% of women reported primary reason for homelessness as "domestic violence victim"
- 16% were children
- 11% were veterans
- 7% were female single parents
- 8% were street homeless
- 7% were seniors
- 79% had zip code of last permanent address captured
- 68% had last permanent address in Knoxville/Knox County
- 77% last permanent address in Knox or a surrounding county

Services and Outcomes

The capture in KnoxHMIS of casenotes and services delivered by partner agencies facilitates the coordination of care, reduction of duplication of services, and measurement of resources delivery. In 2013, there was a 1% decrease in recorded services delivered[2].

- The average length of stay in emergency shelter was 30 days (SD=53.7)[3].
- The average length of stay in transitional housing was 174 days (SD=199).
- Since July 2008, 5,522 individuals have been placed in housing.
- Fifteen percent of active clients had casenotes recorded (6% decrease from 2012).

---

[1] KnoxHMIS partner agencies include: Knoxville-Knox County Community Action Committee, Catholic Charities, Community Law Office, Family Promise, Helen Ross McNabb, Knoxville Area Rescue Ministries, Knoxville Leadership Foundation, Positively Living, Redeeming Hope, Salvation Army, Steps House, Tennessee Valley Coalition to End Homelessness, The Next Door, Volunteer Ministry Center, Volunteers of America, and YWCA

[2] The decrease in the number of services recorded could be due to program decision to exclude some services from being recorded in KnoxHMIS.

[3] SD= Standard Deviation

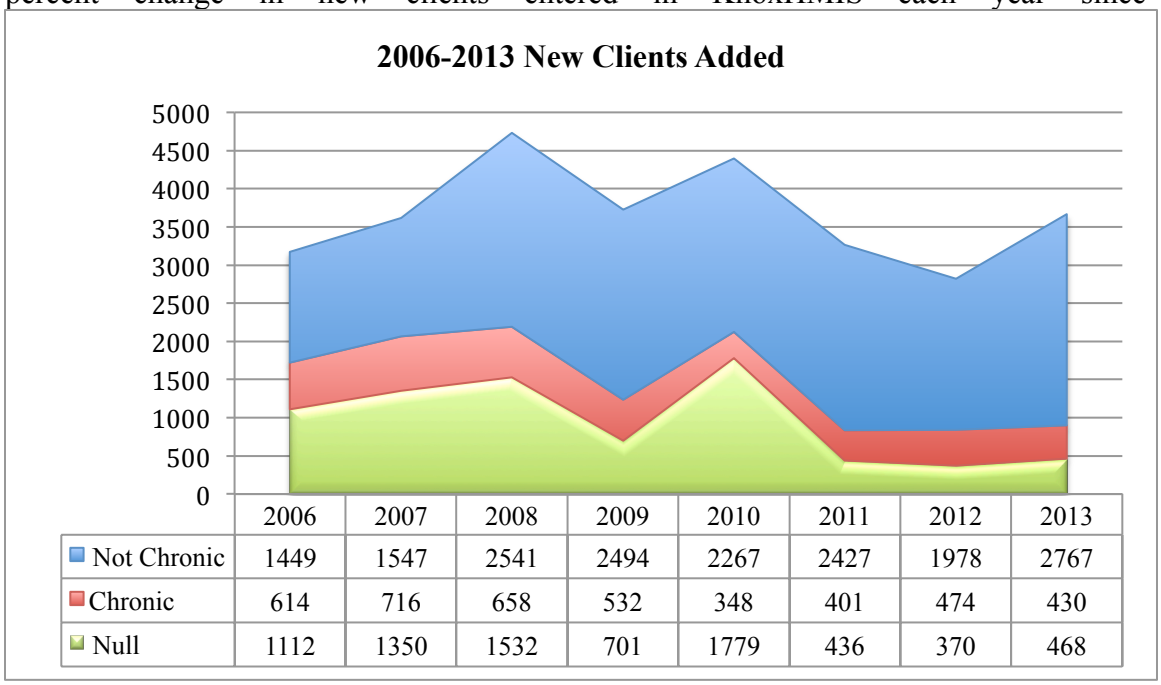
The KnoxHMIS Annual Report has been completed every year since 2007. This report provides information on clients who are new to the information system and have accessed a service in 2013. It should be noted that not all individuals included in this report are literally homeless. Approximately 32% of individuals served indicated they were housed, meaning that Knoxville's service providers are providing them with services to enable them to maintain their housing and thereby preventing them from becoming homeless.

Table 1: Percent Change in Number of Clients Entered (2007-2013)

2007	+12% (3,613)
2008	+31% (4,731)
2009	-21% (3,727)
2010	+17% (4,394)
2011	-25% (3,264)
2012	-14% (2,822)
2013	+30% (3,665)

New Clients Entered into KnoxHMIS

In 2013, 3,665 new clients were entered into KnoxHMIS representing a 30% increase from 2012 (Table 1)[4], however as detailed below, this increase was driven by efforts to prevent homelessnes and not an actual increase in individuals new to homelessness. The adjacent table shows the percent change in new clients entered in KnoxHMIS each year since 2006.



	2006	2007	2008	2009	2010	2011	2012	2013
Not Chronic	1449	1547	2541	2494	2267	2427	1978	2767
Chronic	614	716	658	532	348	401	474	430
Null	1112	1350	1532	701	1779	436	370	468

Chart 1: New Clients Added from 2006 to 2013

Chart 1 shows the trend in "New Clients Added between 2006 and 2013." "Not Chronic" refers to new clients added to KnoxHMIS who were homeless or at risk of being homeless, while

[4] This significant increase in the number of new clients added to KnoxHMIS could be due to the addition of new programs, inclusion of clients who had previously declined to be entered into KnoxHMIS, or improved data quality.

"Chronic" refers to those entering KnoxHMIS who were experiencing chronic homelessness (definition can be found on page 40 of this report). The "Null" category indicates the number of new clients added to KnoxHMIS who did not answer whether they were homeless or chronically homeless upon entry or did not have their status recorded in KnoxHMIS. The decrease in null instances from 1,779 to 484 in Chart 1 reflects an improvement in data quality since 2010.

The figure in Chart 2 illustrates the different sub-groups of individuals included in the clients new to KnoxHMIS. Non-housing emergency assistance to individuals at risk of homelessness accounts for over 80% of the 943 individuals who indicated that they were stably housed.

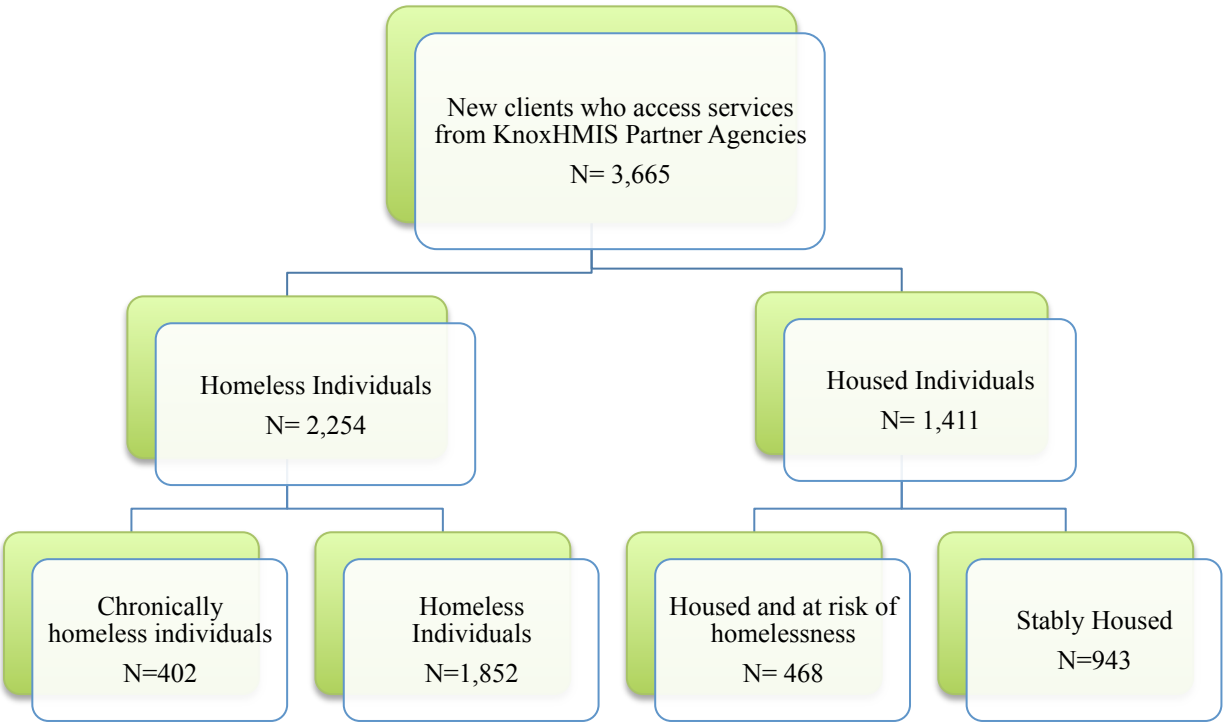


Chart 2: 2013 Subgroups of Clients New to KnoxHMIS

Chart 3 details client answers to the question, "Are you homeless?" From 2012 to 2013 there was a notable decrease in the percentage of new clients that indicated they were homeless and an increase in those that indicated that they were not homeless. This is likely evidence that the number of prevention services in Knoxville/Knox County is increasing, thereby preventing homelessness.

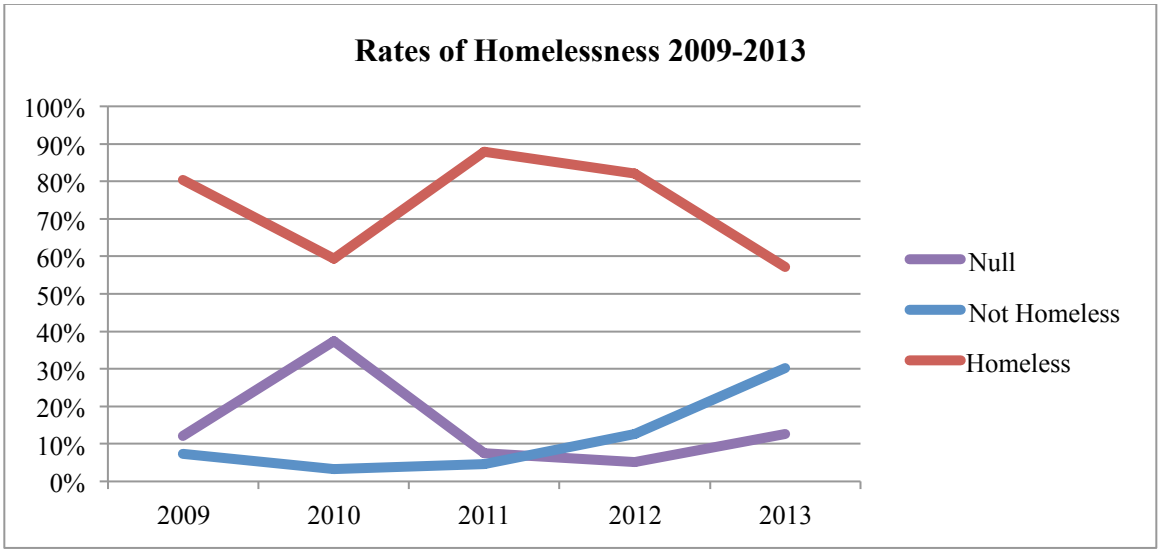


Chart 3: Rates of Homelessness from 2009 to 2013

Table 2 compares the number of individuals in identified sub-groups of the population of individuals who are homeless or at risk of becoming homeless that were newly entered into KnoxHMIS in 2012 and 2013.[5] Of new clients entered in 2013, there was a decrease in the following subgroups: individuals in a female single parent household, people with a disability of long duration, and chronically homeless individuals. Most notably, there was a 40% increase in the number of females, a 33% increase in the number of children, and a 25% increase in the number of Black or African Americans.

Table 2: Subgroups of New Clients Added (2012-2013)

	2012 n=	**2013 n=**	**Percent Change**
Females	1100	1536	40%
Individuals in a Female Single Parent Households	649	645	-1%
Black or African Americans	705	884	25%
Children	480	637	33%
People with a disability of long duration	790	763	-3%
Chronically homeless individuals	474	431	-9%

[5]The subgroups in Table 2 are potentially overlapping, and therefore the columns do not sum to 100%.

Active Clients Utilizing Services

For the purposes of this report, "active clients" are individuals either receiving services from KnoxHMIS partner agencies or having an entry/exit into a partner agency program. While the majority of active clients are homeless (N=6,666), some active clients are housed (N=3,140), having been formerly homeless or they are housed but at risk of becoming homeless. The figure in Chart 4 illustrates the different sub-groups of individuals included in the active client population.[6]

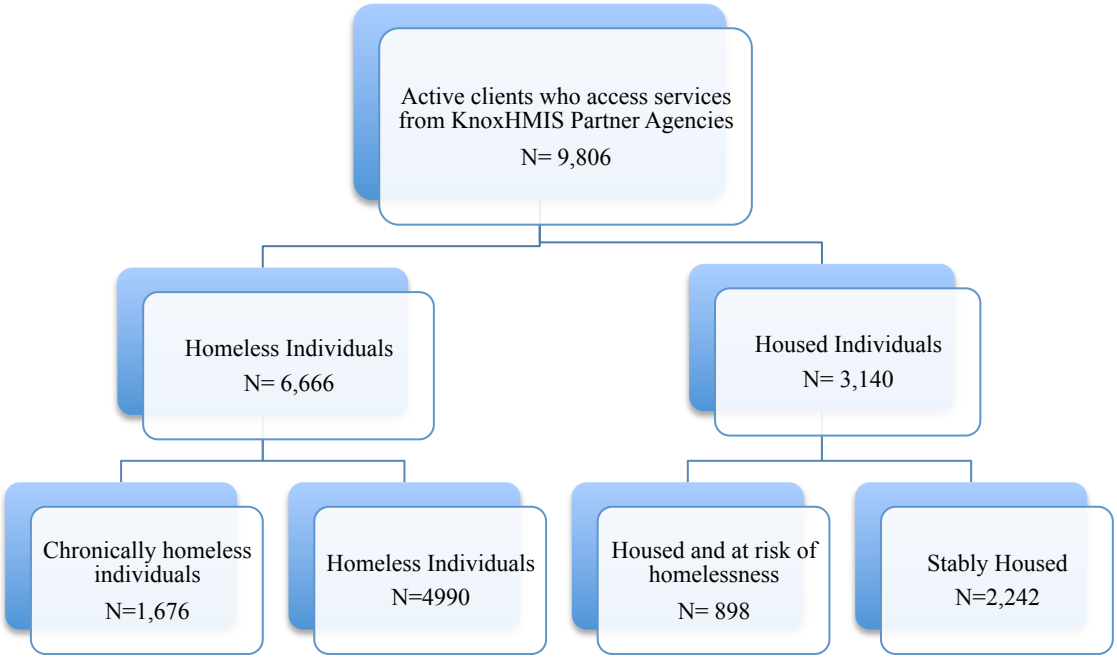


Chart 2: 2013 Subgroups of Active Clients[7]

In 2013, there were 9,806 active clients in Knox County. This count represents an 11% increase from 2012 in the number of active clients (See Chart 5). The percentage of active clients who were chronically homeless decreased in 2013 from 23% in 2012 (2,027/8,857) to 20% in 2013 (1995/9806)(See Table 3).

It should be noted that in KnoxHMIS' annual reports on homelessness prior to 2012, the number of "active clients" was calculated by simply counting the number of individuals receiving services during the year-long report period. However, not all of our partner agencies capture services; instead they may track entries into their agency programs. In order to provide a more accurate count of active clients, KnoxHMIS will henceforth include both services and program entries as indicators for client activity.

---

[6] Individuals categorized as homeless meet HUD's definition for homelessness.

[7] In previous reports, housed individuals only included clients who indicated a housing status of "stably housed." In this year's report, we are also including clients who are "imminently losing their housing" and "unstably housed and at risk of losing their housing."

As is evident in Chart 5, the number of active clients has increased approximately 75% since 2007. This could potentially indicate improvements in agency data quality, increased utilization of KnoxHMIS, and the addition over the last five years of new partner agencies who are serving clients not previously captured in KnoxHMIS. Chart 5 details the number of active clients between the years of 2007 and 2013.

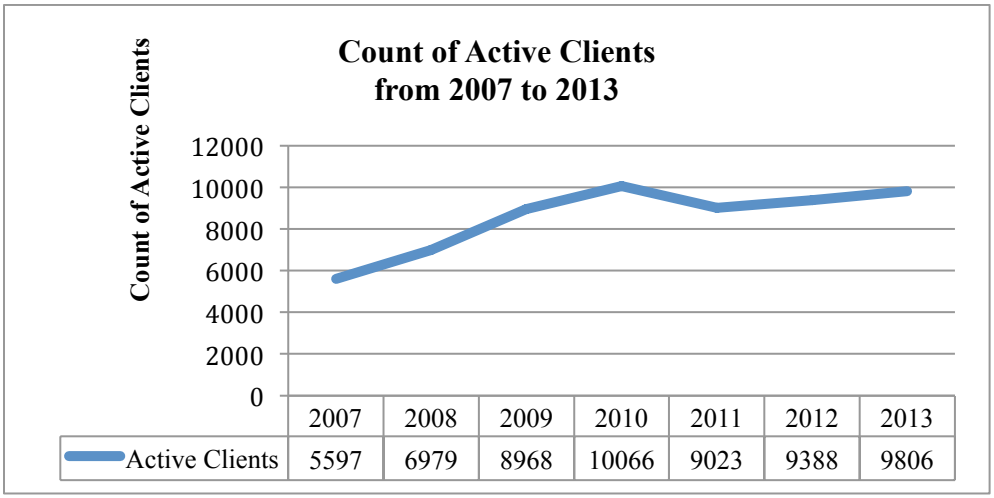


Chart 5: Count of Active Clients from 2007 to 2012

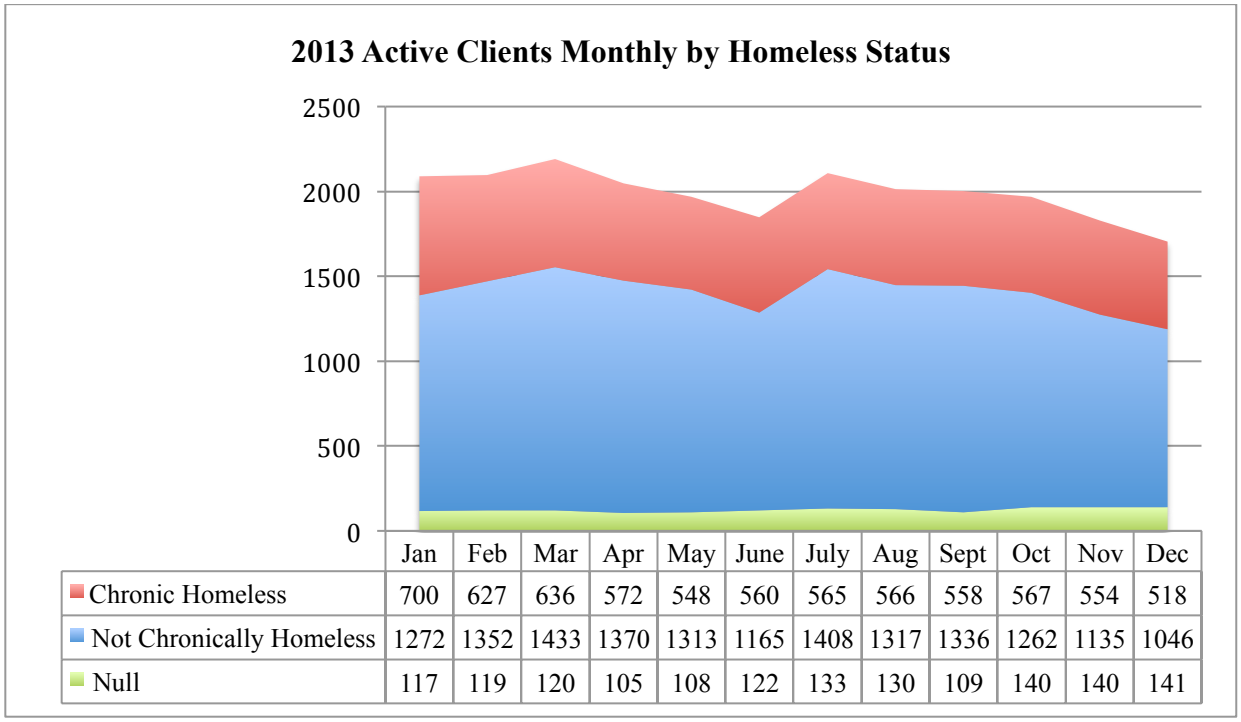
Table 3 displays the percent change from 2012 to 2013 in the non-chronically homeless population, chronically homeless population, and the total active client population.

Table 3: Active Clients by Homeless Status (2012-2013)[8]

	2012 n=	**2013 n=**	**Percent Change**
Not Chronically Homeless	5693	6889	+21%
Chronically Homeless	2027	1995	-1.6%
Null	1137	922	-19%
Totals	8857	9806	11%

On average, 1,989 clients sought services per month. Of those clients, an average of 581 were chronically homeless per month. The monthly numbers for each category are detailed in Chart 6. Please note that the sum of active clients by quarter and month will not reflect the total number of unduplicated active clients (9,806) as the clients may be served in multiple months.

[8] 2012 data has been corrected to represent chronic homeless status of all active clients. In previous reports, "Null" was reflective of both null housing status and null chronic homelessness. The current table reflects only null chronic homelessness.



	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec
Chronic Homeless	700	627	636	572	548	560	565	566	558	567	554	518
Not Chronically Homeless	1272	1352	1433	1370	1313	1165	1408	1317	1336	1262	1135	1046
Null	117	119	120	105	108	122	133	130	109	140	140	141

Chart 6: Active Clients Monthly by Homeless Status in 2013[9,10]

Basic Demographic Information on Active Clients

The charts below provide demographic information on active clients in 2013. The percentage breakdown for gender and race is consistent with 2012 data; however, the percentage of "White" individuals has decreased slightly from 68% in 2012 to 65% in 2013. Notably, while "African Americans" represent 17% of Tennessee's statewide population, they make up only 9.1% of people in Knox County.[11] Therefore, a disproportionate percentage of African Americans sought services compared to the percentage of African Americans represented in Knox County and the state of Tennessee. The category of "Other/Multiracial" constitutes 7% of active clients and includes individuals who report their race as *American Indian, Alaskan Native, Asian, Native Hawaiian, Multiracial*, and those with null values.

[9] The numbers represented in this chart may be an underrepresentation as not all KnoxHMIS partners record services that were provided but instead indicate a client is being served on an on-going basis.
[10] The peak present in July is likely due to ESG funding cycles that allow programs to serve more clients.
[11] 2012 US Census Bureau (quickfact.census.gov)

	N=	KnoxHMIS Percentage
Age		
0-17 years	1,461	16%
18-30 years	1,624	17%
31-61 years	5,677	61%
62+ years	611	7%
Gender		
Male	5,590	57%
Female	3,946	40%
Other or Null	270	3%
Race		
White	6,384	65%
Black or African American	2,714	28%
Other	699	7%
Ethnicity		
Non-Hispanic/Non-Latino	8,751	89.2%
Hispanic/Latino	238	2.4%
Null/Don't Know	817	8.3%

Table 4: Active Clients Demographics Summary

Chart 7 illustrates the age distribution of active clients by gender[12]. In 2013, the most common age (mode) for homeless men was 53, while the most common age for homeless women was 29 years old. Of particular interest is that the peak age concentration for homeless women is 24 years younger than the peak age concentration of homeless men. Age statistics are detailed in Table 5.

Table 5: Age statistics of active clients[13]

Client Type	N=	Mode	Mean	Standard Deviation	Skewed
All	9376	53 years	38 years	17.84 years	Yes
Male	5453	53 years	40 years	17.58years	Yes
Female	3896	29 years	35 years	17.83 years	No

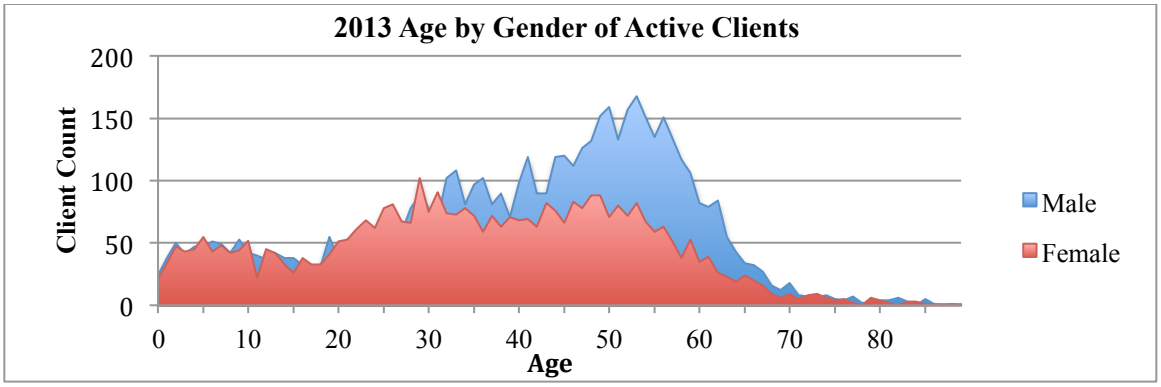


Chart 7: 2013 Age Distribution of Active Clients by Gender

[12] The data on age represents only those individuals who have a date of birth recorded in KnoxHMIS and/or gender.
[13] This table only includes individuals who have age recorded in KnoxHMIS.

Disability Status of Active Clients

In 2013, 31% of active clients reported having a disability. Chart 8 shows the percentage of active clients with disability types by homeless status. Both the chronically homeless and non-chronically homeless populations most frequently report having a mental health disability.[14]

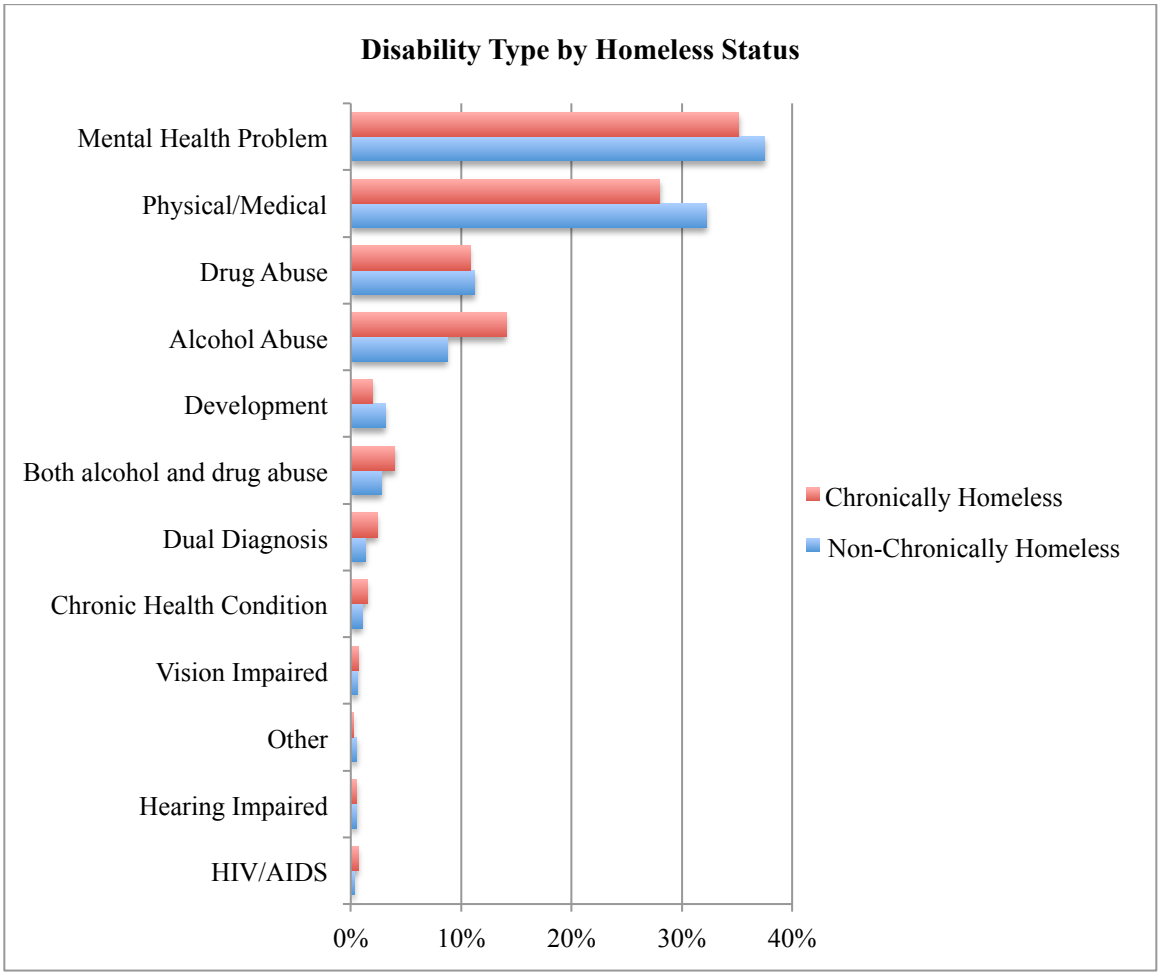


Chart 8: Disability Type by Homeless Status

[14] These percentages on disability types represent only those individuals who have a recorded disability type in KnoxHMIS (n=4,045).

Self-Reported Primary Reason for Homelessness of Active Clients

As illustrated in the chart below, differences in primary reason for homelessness varied by gender in 2013. Adult males most frequently report "Loss of Job" (26%) as primary reason for homelessness, while adult females most frequently report "Domestic Violence Victim" (15%).[15] This variable is based on the client's perception of his or her primary reason for homelessness. Therefore this variable is subject to the social desirability bias in which individuals tend to respond in ways that will be viewed favorably by others. Further, domestic violence may be underreported due to client[16] or agency hesitance to report domestic violence in HMIS.

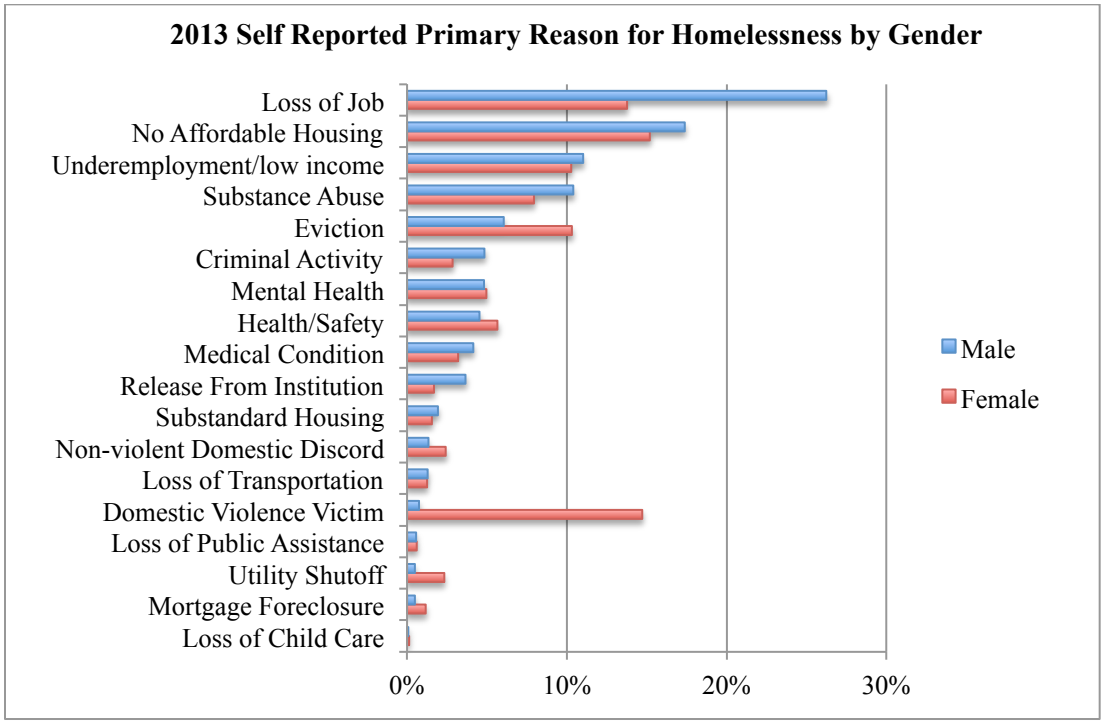


Chart 9: Self-Reported Primary Reason for Homelessness by Gender

Table 6 shows the percentage of adult women active clients between 2010 and 2013 who reported domestic violence as the primary reason for homelessness. In 2013, 14.7% (n=341) of female clients reported domestic violence as primary reason for homelessness.

Table 6: Percent of Women Clients Citing Domestic Violence as Primary Reason for Homelessness

2010	15.2%
2011	15.4%
2012	17%
2013	14.7%

[15]These percentages on primary reason for homelessness represent only those individuals who have a recorded primary reason for homelessness in KnoxHMIS (n=6,201).

[16] Gracia, E. (2004). Unreported cases of domestic violence against women: Towards an epidemiology of social silence, tolerance, and inhibition. *Journal of epidemiology & community health, 58*. 536-537. doi: 10.1136/jech.2003.019604

Subpopulations of Active Clients

In this section, the following five sub-populations are examined: chronically homeless, veterans, female single parents, street homeless, and children. For the purposes of this report, individuals identified as "street homeless" were living in a place not meant for human habitation (i.e. on the street, in a vehicle, or camping). Table 7 shows the percentage of all active clients as designated into five subpopulations.

Table 7: Percent of All Active Clients in Subpopulations

	All Active Clients n=9,806
Chronically Homeless	20%
Children	16%
Veterans	11%
Street Homeless	8%
Female Single Parents	7%
Seniors	7%

The tables under each subpopulation reveal the degree of overlap among these subgroups. Of particular interest is that while 20% of all active clients are chronically homeless (Table 7), street homeless individuals and veterans are a larger percentage (18% and 20% respectively) of the chronically homeless population than they are of the general homeless population.

Chronically Homeless

As defined by United States Department of Housing and Urban Development (HUD)[17], chronically homeless describes an individual or family who has been homeless for at least a year or has had at least four episodes of homelessness in the past three years AND the head of household in a family or the individual has a disabling condition.

Table 8: Characteristics of the Chronically Homeless Population

	Chronically Homeless Population (n=1,995)
African American	29%
Veterans	20%
Street Homeless	18%
Female Single Parents	4%

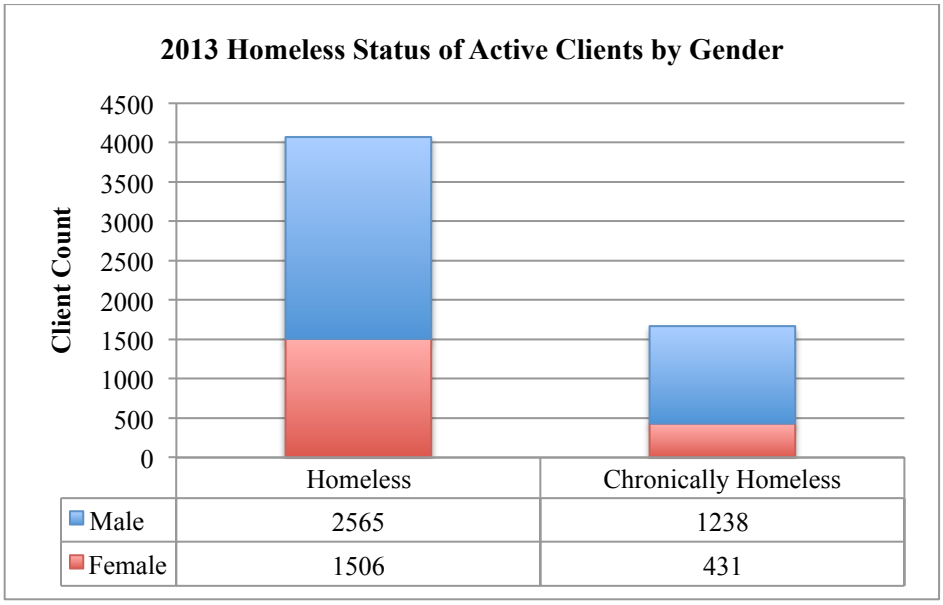


Chart 10: 2013 Homeless Status of Active Clients by Gender

[17]https://www.onecpd.info/resources/documents/homelessassistanceactamendedbyhearth.pdf

With the exception of gender, the demographic characteristics of chronically homeless individuals are similar to the demographic characteristics of the non-chronically homeless individuals. Seventy-four percent of the chronically homeless population was male compared to only 63% of the non-chronically homeless population (Chart 10).[18]

Charts 11 and 12 below illustrate the differences in the age distribution of chronically homeless males and females. As is evidenced in Chart 11, a notably large percentage of chronically homeless males are between the ages of 40 and 60, whereas the distribution of chronically homeless females does not have a pronounced peak.

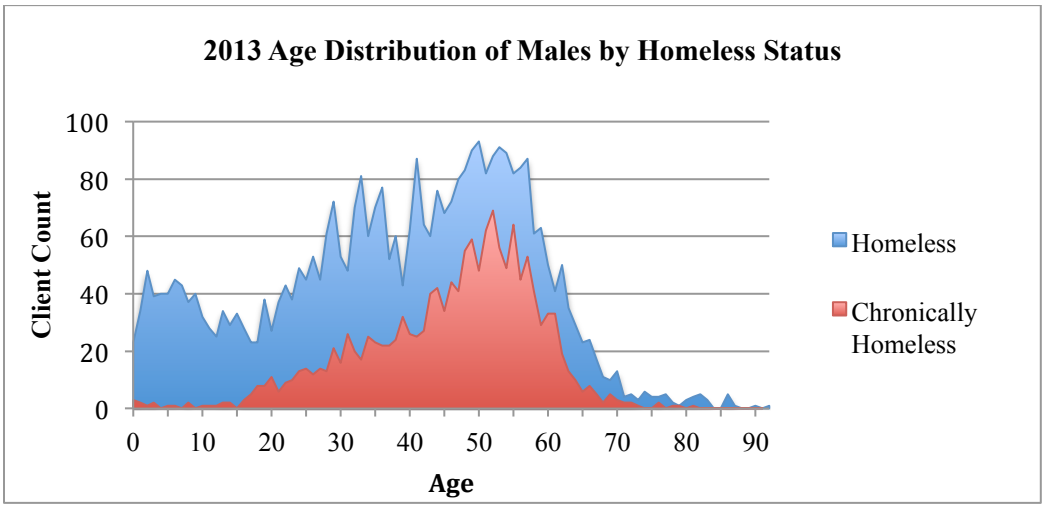


Chart 11: 2013 Age Distribution of Males by Homeless Status

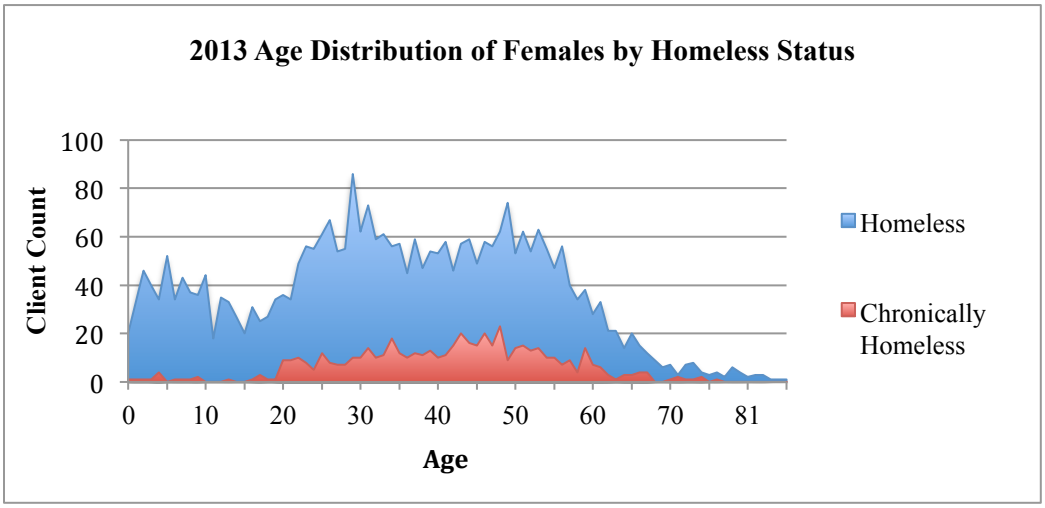


Chart 12: 2013 Age Distribution of Females by Homeless Status

[18]Charts 10, 11, and 12 only display data on individuals with chronically homeless status and gender reported.

The following chart compares the self-reported primary reason for homelessness of the chronically homeless and non-chronically homeless populations.[19] Chronically homeless individuals were more likely to report *substance abuse, criminal activity, a medical condition, mental health, release from institution, loss of transportation, and loss of public assistance* as primary reasons for homelessness compared to non-chronically homeless individuals. Again, these figures could be impacted by the social desirability bias in which individuals tend to respond in ways that reflect positively on themselves.

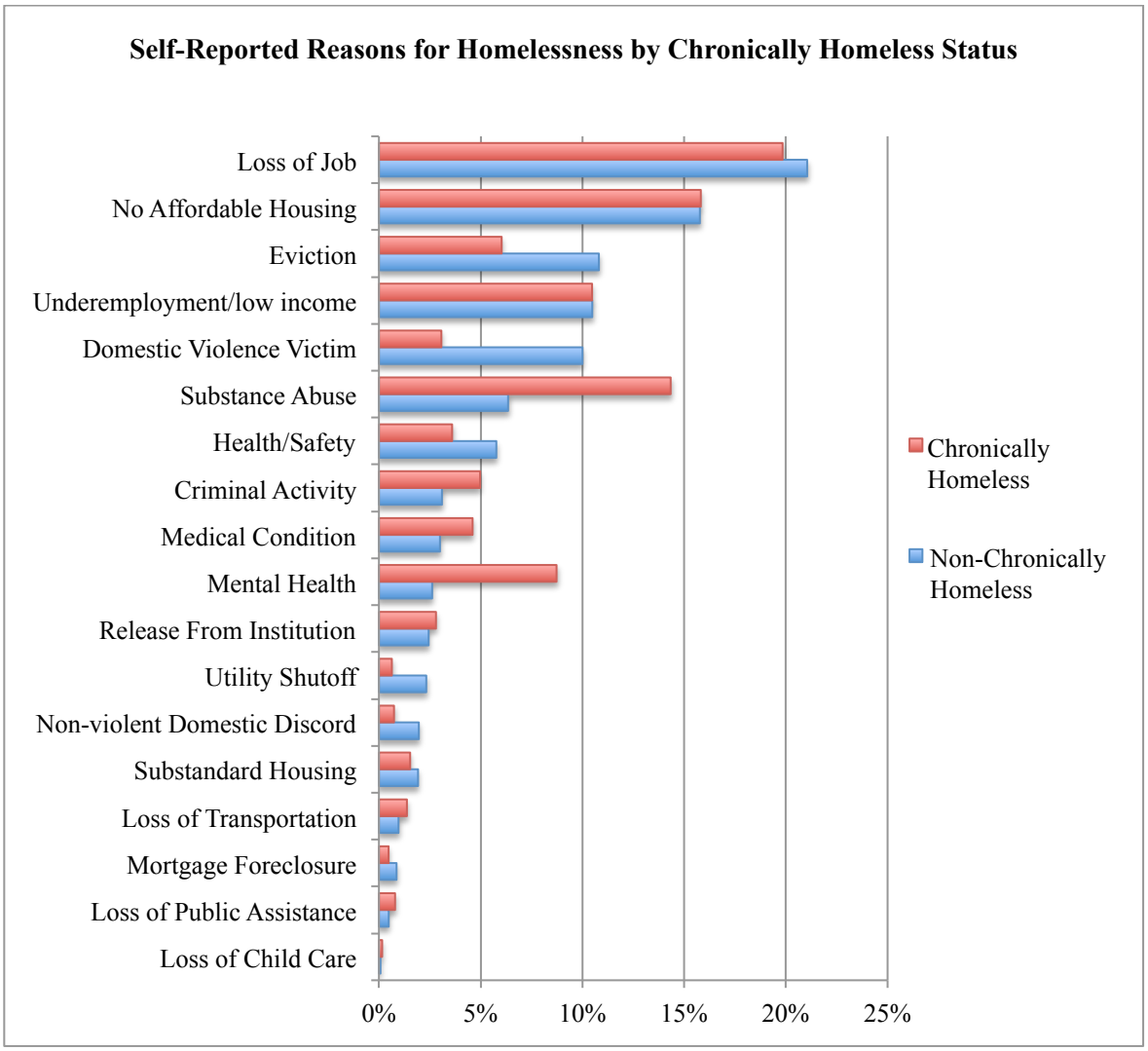


Chart 13: Self-Reported Primary Reason for Homelessness by Homeless Status

[19]The percentages on "primary reason for homelessness" represent only those individuals who have a recorded primary reason for homelessness and a homeless status in KnoxHMIS (n=7,088).

Seniors

Seven percent of active clients in KnoxHMIS were seniors aged 62+ years old. Nineteen percent cited "no affordable housing" as their primary reason for homelessness, followed by "health/safety" (15%) and "loss of job" (15%). Of seniors with disabilities (n=223), 74% reported having a physical or medical disability and 38% reported having a mental health problem.

Table 9: Characteristics of the Senior Population

	Seniors (n=611)
Disabled	36%
Chronically Homeless	23%
African American	23%
Street Homeless	12%

Veterans

Eleven percent of active clients in KnoxHMIS were veterans. According to the 2012 Annual Homeless Assessment Report to Congress (AHAR), nationally 13% of sheltered homeless individuals were veterans**.** KnoxHMIS data suggest that veterans are frequently engaging with emergency services and are not engaging with case management from our partner agencies as frequently. Furthermore, 36% of active clients who are veterans were described as chronically homeless in 2013.

Table 10: Characteristics of the Veteran Population

	Veterans (n=1,116)
Chronically Homeless	36%
African American	27%
Street Homeless	12%
Female Head of Household	1%

Female Single Parents

In 2013, 7% of active clients were female single parents with their children. The average female single parent was 36 and had 1.4 children. Furthermore, of these single female parents, 21% reported domestic violence as the primary reason for homelessness followed by eviction (11.2%) and lack of affordable housing (10.7%). Female single parent households constituted 26% of all households seeking services in 2013 (Chart 14).

Table 11: Characteristics of Female Single Parents

	Female Single Parents (n=721)
Chronically Homeless	9%
Street Homeless	5%
Veterans	2%

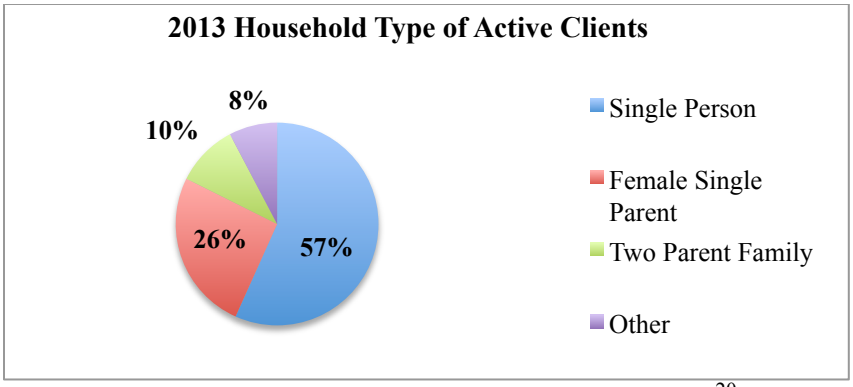


Chart 14: 2013 Percentage of Household Type[20]

[20] "Other" households include: couples with no children, male single parent households, grandparents and children, non-custodial caregivers, and foster parents.

Street Homeless

As defined by HUD, an individual who is street homeless currently lives in a place not meant for human habitation. Of the 796 individuals who were street homeless in 2013, 68 percent were male and 7 percent were children. 24 percent of these individuals spent more than one year living in a place not meant for human habitation. The street homeless population accessed a total of 26,848 services in 2013, meaning that each individual accessed an average of 34 services. Of those services, the street homeless most frequently accessed meals and emergency shelter. Thirty-nine percent of the street homeless population reported a disability. Chart 15 displays the disability types of individuals with a reported disability.

Table 12: Characteristics of the Street Homeless Population

Street Homeless (n=796)	
Chronically Homeless	43%
African American	27%
Veterans	17%
Children	7%
Female Single Parent	4%

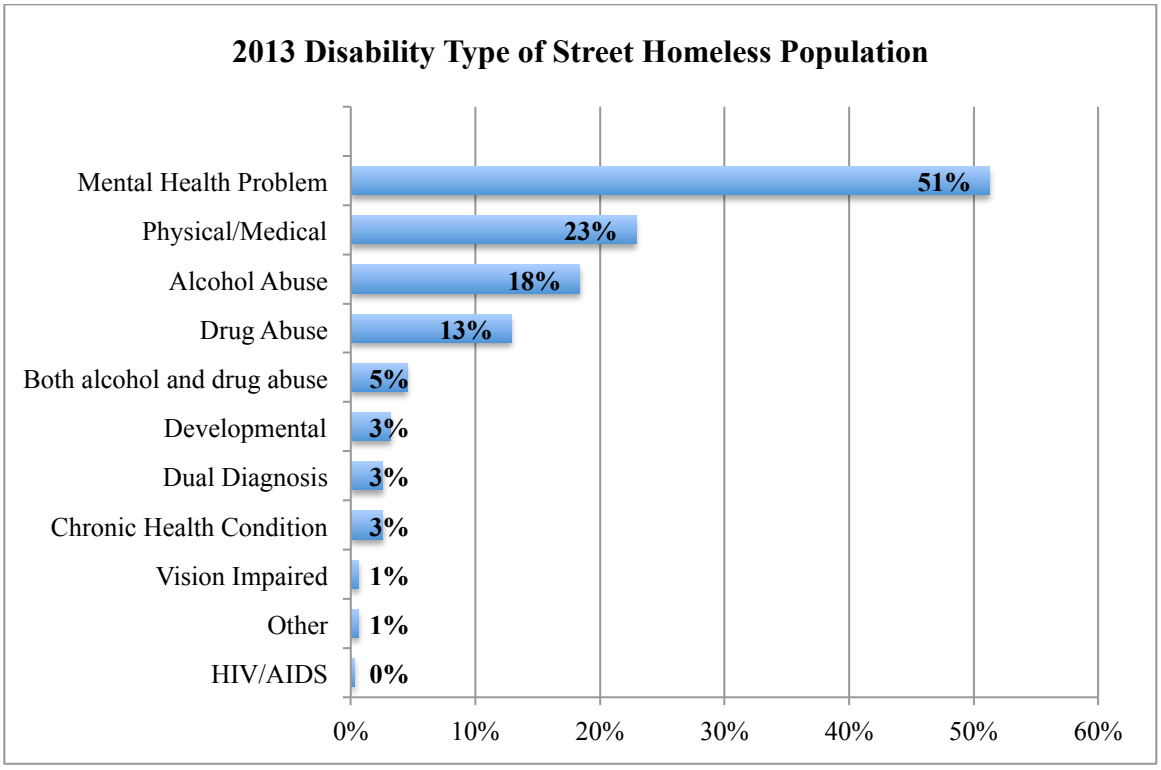


Chart 15: 2013 Disability Type of Street Homeless Population

Children

In 2013, 16% of active clients were under the age of 18 (1,461 clients), and 66% of those under the age of 18 were ten years old or younger (962 clients). The average age of active client children was eight years old. Additionally, 71% of these children were in female single parent households, and 20% were in a two-parent household.

Services Captured in KnoxHMIS

The services feature in KnoxHMIS allows agencies and programs to record detailed information on how they are assisting clients. This allows for improved collaboration among various service providers by eliminating unnecessary duplicative services. The number of services provided per year has changed from 409,456 in 2012 to 404,833 in 2013, a 1% decrease. Chart 16 illustrates the number of services per year over the last five years.

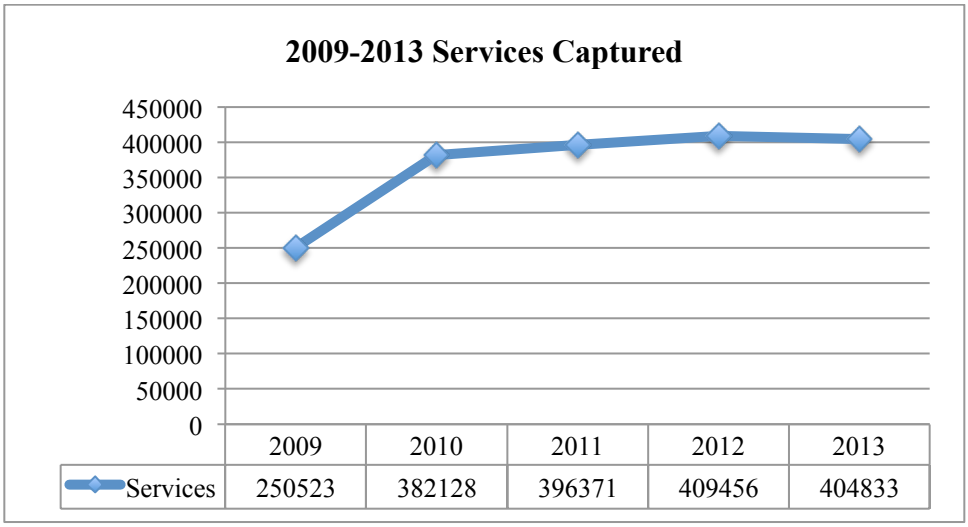


Chart 16: Services Captured in KnoxHMIS 2009-2013

The charts below display that 20% of clients receiving services in 2013 were chronically homeless (Chart 17) while the chronically homeless population accounted for 40% of all services delivered in 2013 (Chart 18). Therefore, the chronically homeless population consumed a larger proportion of services than the non-chronically homeless population. These findings are consistent with the previous data in 2012 in which the chronically homeless population consisted of 21% of clients receiving services but accounted for 42% of all services provided.

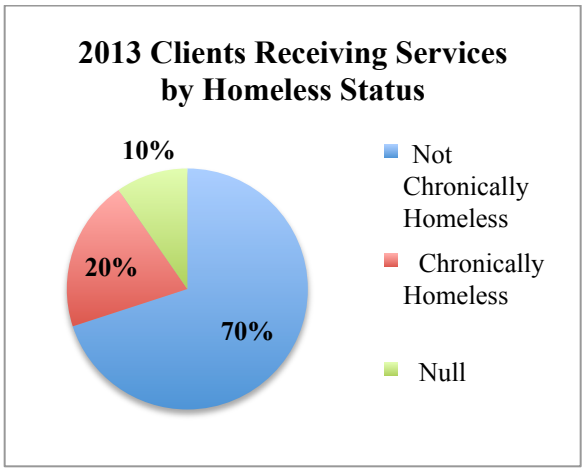


Chart 17: Percent of Clients Receiving Services by Homeless Status

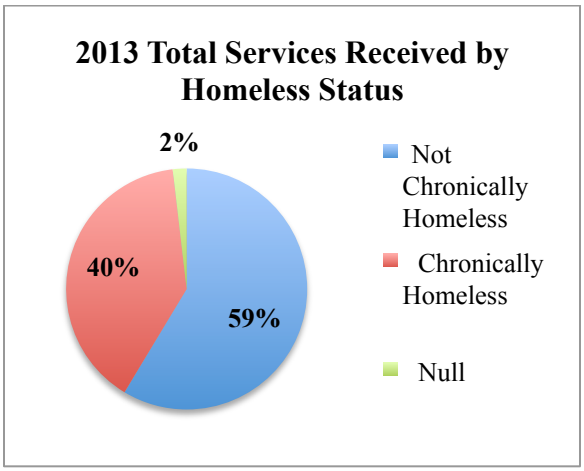


Chart 18: Percent of Total Services Received by Homeless Status

Emergency Shelter and Transitional Housing

Also important to the understanding of homelessness in Knoxville is the utilization of local emergency shelters and transitional housing facilities. Table 13 displays the average, mode and maximum nights stayed in Emergency Shelters and Transitional Housing during 2013.

Table 13: 2013 Average Nights Stayed in Emergency Shelter and Transitional Housing

	Average	Standard Deviation	Mode	Maximum
Emergency Shelter	30.14	53.70	1	367
Transitional Housing	174.47	199.17	54;129	949

Housing Outcomes

Since July 2008 when KnoxHMIS began capturing data on housing outcomes, KnoxHMIS partner agencies have housed 5,522 individuals. Of these housing placements, 1,729 individuals have been placed in permanent supportive housing; 1,600 individuals rent a house or apartment without a subsidy; and 92 individuals own their own homes. Chart 19 illustrates the number of individuals placed into each housing type since July 2008.

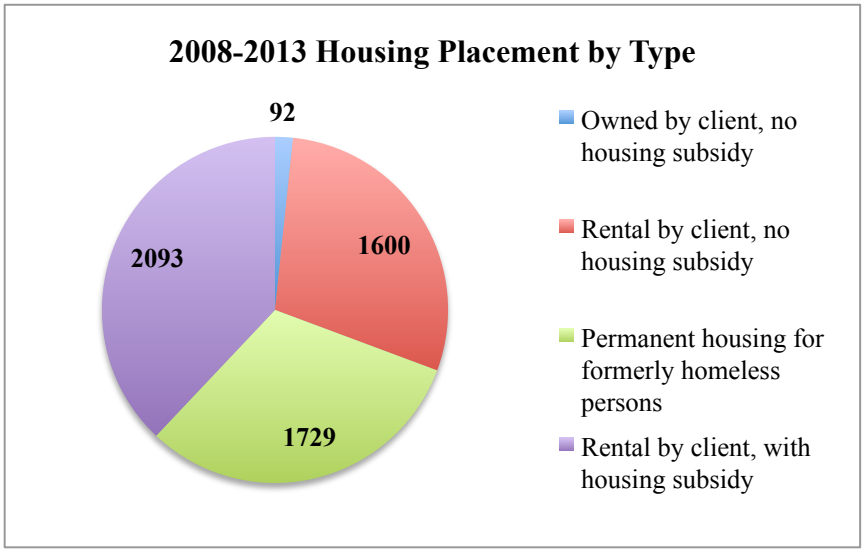


Chart 19: Housing Placement Data by Type

In 2013, of the 2,254 clients new to homelessness, KnoxHMIS partner agencies have housed[21] 14% (n=326). Of these housing placements, 6 individuals have been placed in permanent supportive housing, 130 rent a house or apartment without a subsidy, and 9 own their own homes. Table 14[22] details the top five exit destinations for clients new to homelessness in 2013.

Table 14: Top Exit Destinations for clients new to homelessness in 2013

Exit Destination	N=
Rental by client, with housing subsidy	204
Don't Know	329
Rental by client, without housing subsidy	130
Staying with family or friends	191
Emergency Shelter	155

[21] Clients are counted as being "housed" if they exited to a property they owned, rented, or permanent supportive housing

[22] Note that the numbers outlined in Table 14 will not reflect the total number of clients exiting to a permanent destination aa clients may be duplicated between categories

Permanent Supportive Housing

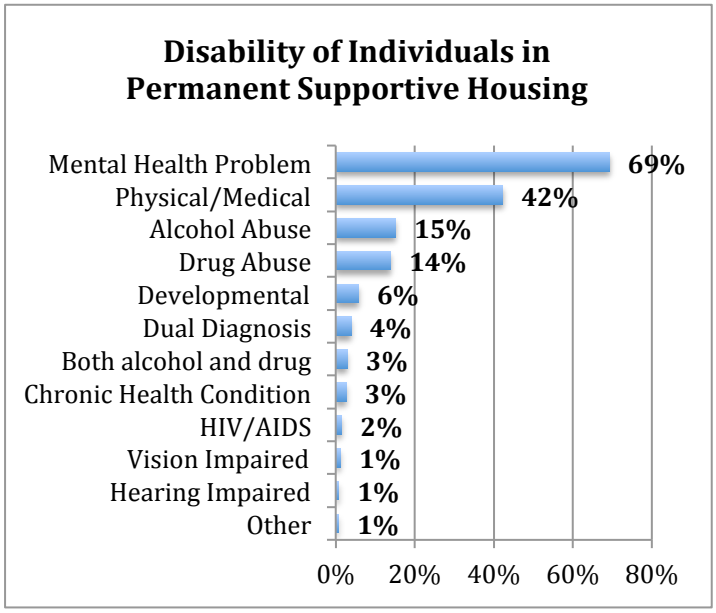


Chart 20: Disability Type of Formerly Homeless Individuals in Permanent Supportive Housing

The number of males (n=907) slightly exceeds the number of females (n=821) among those housed in permanent supportive housing.

Of the 1,729 individuals that have been housed in permanent supportive housing since 2008, 59% have a reported disability type. Of those individuals, 69% had a mental health problem followed by 42% with a physical/medical problem. Disability types of those housed in permanent supportive housing is detailed in Chart 20.

Casenotes

The casenote feature in KnoxHMIS allows case managers to record detailed information on clients that they are assisting. In 2013, KnoxHMIS partner agencies recorded 15,166 casenotes on 1,325 clients, averaging 11.2 casenotes per client. The following figures indicate a slight increase in the number of casenotes per client (Table 16) and a decrease in the number of active clients with casenotes from 2012 (Table 15). Of particular interest is the increase in the number of total casenotes; however, the percentage of active clients with casenotes has decreased (Table 15)

Table 15: 2009-2013 Percentage of Active Clients with Casenotes

	Percentage of Active Clients with Casenotes
2013	14%
2012	22%
2011	13.6%
2010	20%
2009	28%

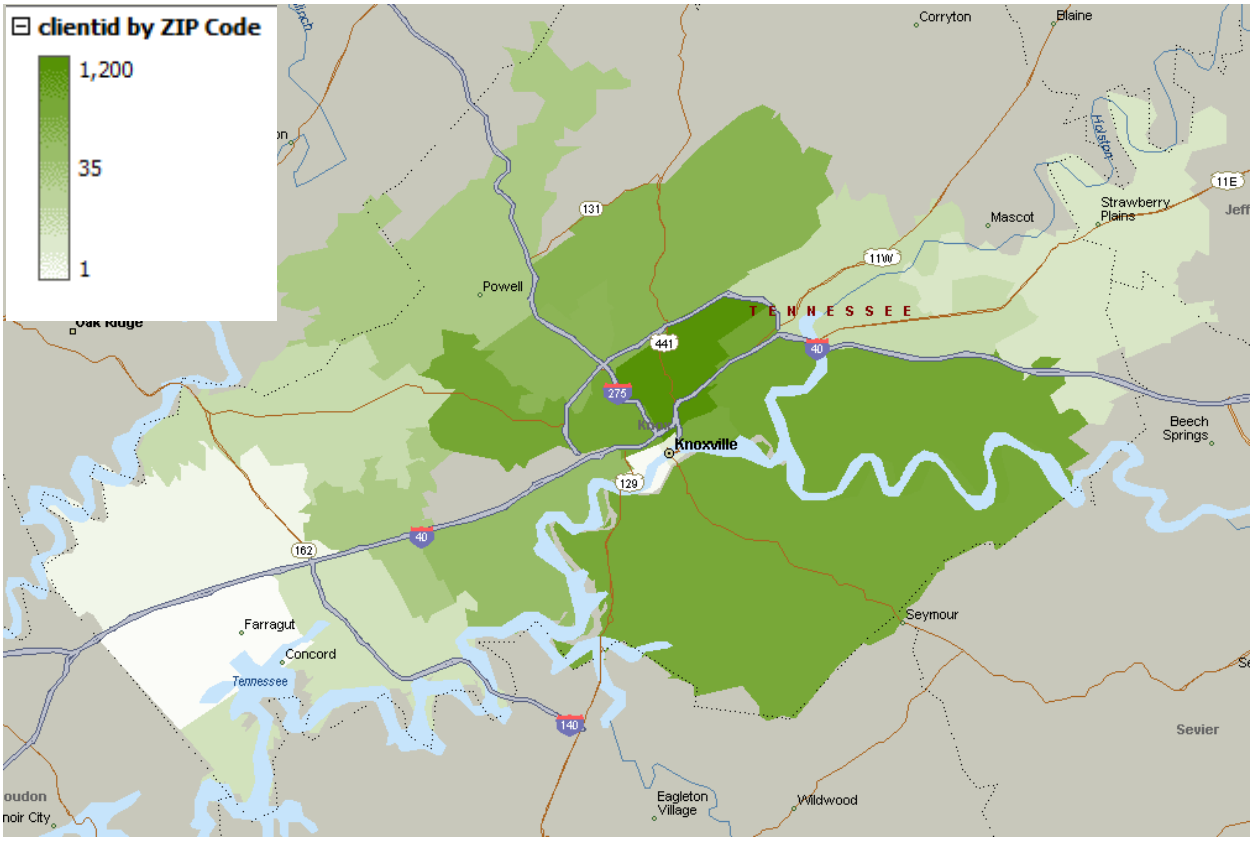
Table 16: 2009-2013 Average Number of Casenotes per Client

	Total Casenotes	**Clients with Casenotes**	**Average Casenotes per Client**
2013	15,166	1,326	11.4
2012	11,451	1,025	11.2
2011	12,701	994	12.8
2010	10,505	1,411	7.9
2009	10,265	1,560	6.58

Maps of Zip Code of Last Permanent Address

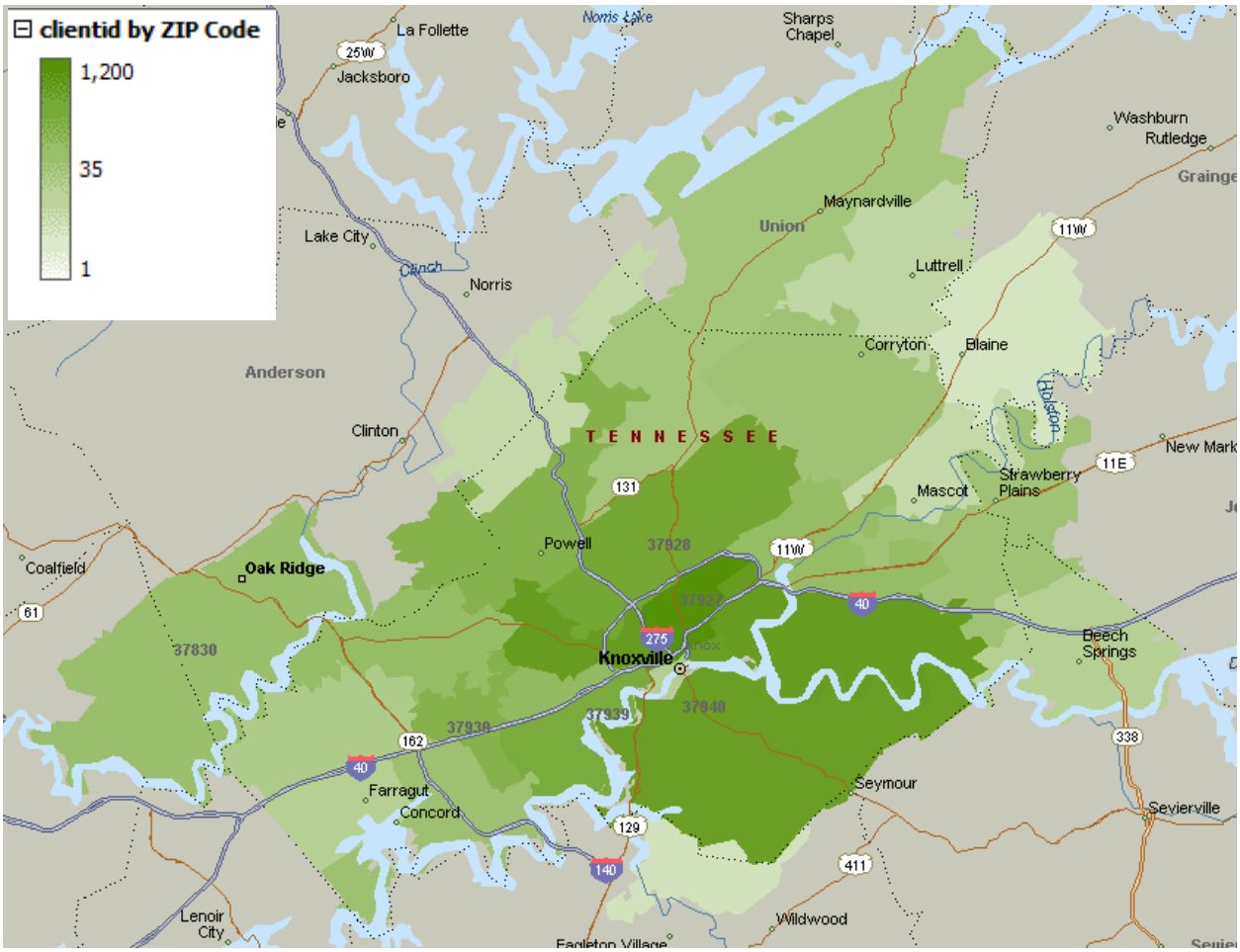
The following maps show the distribution of clients who received services in 2013 by the client's zip code of last permanent address. Zip code was recorded for 79% of active clients. These maps illustrate that the 68% of active clients who had zip code recorded had a last permanent address in the Knoxville-Knox County area. This represents a 6% increase from last year. In addition, 77% of individuals experiencing homelessness in Knoxville in 2013 report their last permanent address in Knox or a surrounding county.

Map 1 illustrates the distribution of last permanent address within the Knoxville City Limits. The highest concentration of clients had a last permanent address located in 37917 and 37921. Please note that some zip codes may only partially fall within the city of Knoxville and are therefore included in Knoxville.



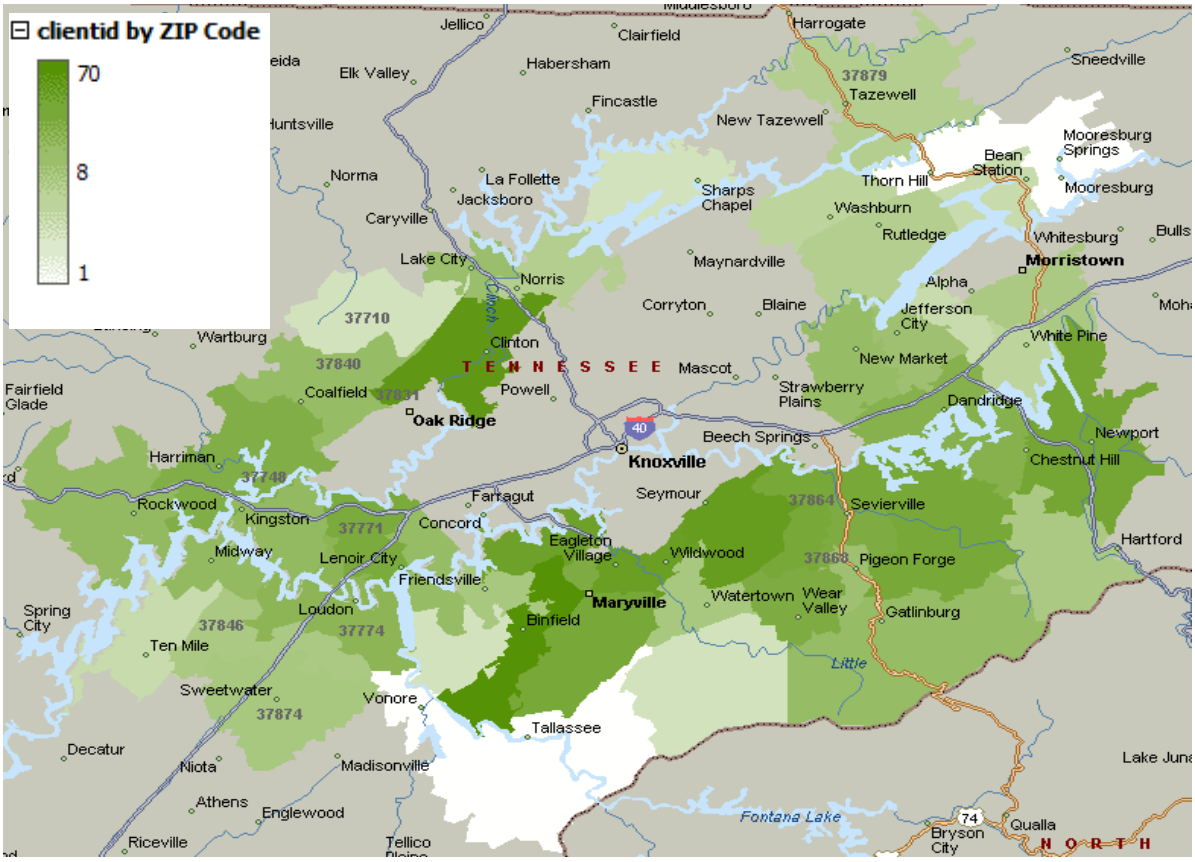
Map 1: Distribution of Clients in Knoxville by Zip Code of Last Permanent Address

Map 2 illustrates the distribution of clients by zip code of last permanent address within Knox County. Sixty-eight percent of clients had a zip code within the Knox County limits.



Map 2: Distribution of Clients in Knoxville-Knox County by Last Permanent Address

Map 3 illustrates the distribution of clients by last permanent address in Knox County and the surrounding 13 counties[23]. Seventy-seven percent of clients had a last permanent address within Knoxville or the surrounding counties. Map 4 shows the distribution of clients across the entire state of Tennessee. Please note the accompanying legend that indicates areas shaded white represent only one client within that zip code.



Map 3: Distribution of Clients in Surrounding 8 Counties by Last Permanent Address

Map 4: Distribution of Clients Across Tennessee by Last Permanent Address

[23]The surrounding 13 counties include: Anderson, Claiborne, Campbell, Monroe, Hamblen, Jefferson, Union, Grainger, Jefferson, Sevier, Blount, Cocke, and Loudon.

KnoxHMIS Data Quality

The data quality of information stored in KnoxHMIS is central to the functioning of the system. With better data quality, agencies and case managers can more accurately coordinate services for the homeless population. Data quality also affects the ability of KnoxHMIS to report on a federal level by participating in the Annual Homeless Assessment Report to Congress. Furthermore, data quality is also important to the Knoxville community so that accurate and meaningful data are reported on the efficacy of programs assisting the homeless population.

Chart 21 displays the percentage of HUD required data elements that are incomplete on an annual basis. New clients data quality refers to the data quality of clients newly entered into the system.

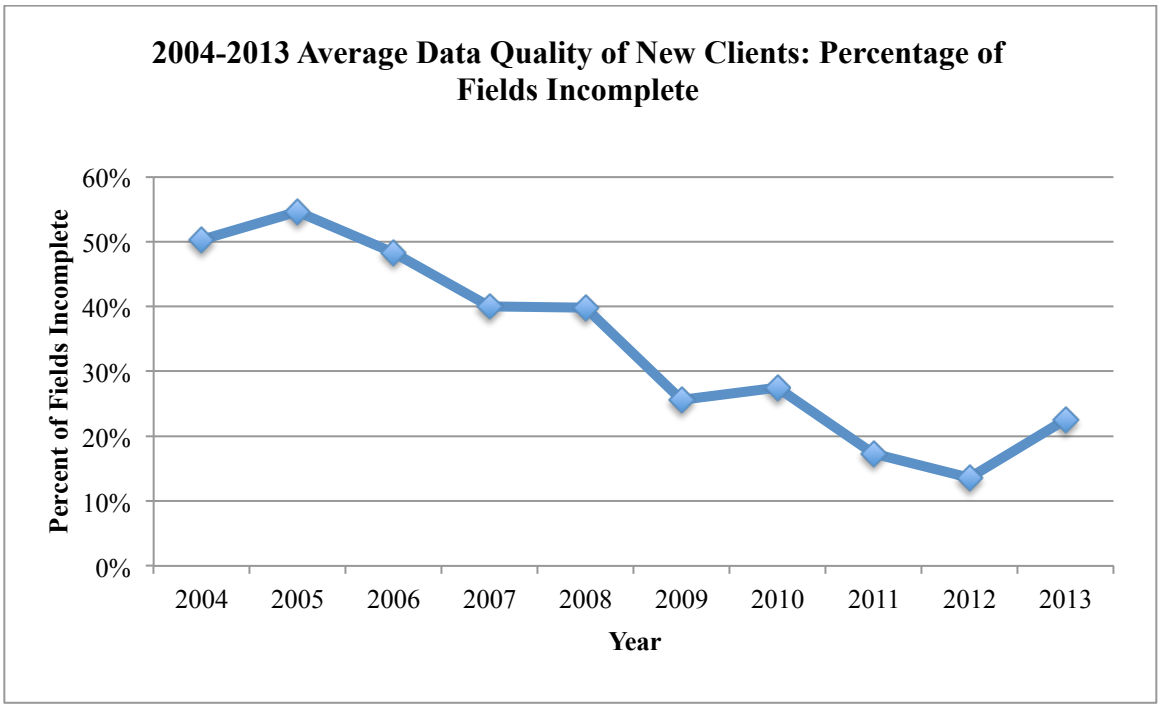


Chart 21: 2013 Average Data Quality of New Clients: Percent of Fields Incomplete

AHAR, PIT, and HIC

Annual Homeless Assessment Report (AHAR)

The AHAR is a report of the U.S. Congress on homelessness in America. It has become the central resource for national data on homelessness, used by federal, state, and local policy-makers to understand trends in homelessness and inform their policies[24]. Communities receiving HUD funding, Continuums of Care (CoCs), are required to submit demographics on those experiencing homeless in their communities. KnoxHMIS, The City of Knoxville Office on Homelessness, and KnoxHMIS partner agencies coordinate and contribute data for the AHAR submission in December each year. the information is then aggregated with national data. AHAR reports are available through HUD[25].

Point-in-Time (PIT) Count

According to HUD, the Point-in-Time (PIT) count is a count of sheltered and unsheltered homeless persons on a single night in January. HUD requires that CoCs conduct an annual count of homeless persons who are sheltered in emergency shelter, transitional housing, and Safe Havens on a single night[26]. In 2012, Knoxville's PIT Count was done on January 26th. In 2013, Knoxville's PIT Count was done on January 24th.

Table 17: 2012-2013 KnoxHMIS PIT Data Comparison

	2012 N=	**2012 Percentage of total homeless**	**2013 N=**	**2013 Percentage of total homeless**	**Percent Change 2012-2013**
Total homeless	854		993		+ 16%
Sheltered	721	84%	850	86%	+18%
Unsheltered	133	16%	143	14%	+1%
Household Type					
Homeless as an individual	771	90%	891	90%	+16%
Homeless in a family	82	10%	96	10%	+17%
Unaccompanied children and youth	1	<1%	6	<1%	+500%
Subpopulations					
Veterans	82	10%	99	10%	+21%
Chronically Homeless	174	20%	165	17%	-5%
Severely Mentally Ill	98	11%	96	10%	-2%
Chronic Substance Abuse	121	14%	108	11%	-11%
Victims of Domestic Violence	100	12%	86	9%	-14%

[24] U.S. Department of Housing and Urban Development. (October 2013). An Introductory guide to the Annual Homeless Assessment Report.
[25] https://www.onecpd.info/hdx/guides/ahar/
[26] https://www.onecpd.info/hdx/guides/pit-hic/

During 2013, there was a 16% increase in the number of homeless individuals counted in Knoxville's PIT, compared to a 4% decrease nationally. Compared to the national picture of homelessness obtained from the PIT, Knoxville's homeless are more likely to be homeless as an individual and to be twenty-five or more years old. Knoxville's number of veterans, chronically homeless, and victims of domestic violence are comparable to national levels of these subpopulations. However, it should be noted that data reported in KnoxHMIS indicate that Knoxville has lower rates of homelesss individuals that are severely mentally ill or have chronic substance abuse problems than at the national level. The comparison between Knoxville's 2013 PIT and the Federal 2013 PIT are detailed in Table 18.

Table 18: 2013 KnoxHMIS and National PIT Data

	N=	**KnoxHMIS Percentage**	**National N=[27]**	**National Percentage[21]**
Change in number of homeless from 2012 to 2013	2012=854 2013=993	16% Increase	2012=633,782 2013=610,042	4% decrease
2013 Sheltered	850	86%	394,698	65%
2013 Unsheltered	143	14%	215,344	35%
Household Type				
Homeless as an individual	891	90%	387,845	64%
Homeless in a family	96	10%	222,197	36%
Unaccompanied children and youth	6	<1%	46,924	8%
Age				
0-18 years	63	6%	138,149	23%
18-24 years	52	5%	61,541	10%
25+ years	878	88%	410,352	67%
Subpopulations[28]				
Veterans	99	10%	58,063	10%
Chronically Homeless	165	17%	109,132	18%
Severely Mentally Ill	96	10%	124,152	20%
Chronic Substance Abuse	108	11%	133,230	22%
Victims of Domestic Violence	86	9%	63,836	10%

Housing Inventory Count (HIC)

In addition to the AHAR and PIT, HUD also requires each CoC to conduct an annual Housing Inventory Count (HIC). The HIC is an inventory of housing for which housing is dedicated to serve persons who are homeless. Conducted in the last ten days of January, coinciding with the PIT Count, the HIC provides community leaders, service agencies, and HUD with knowledge of

[27] 2013 AHAR PIT Data: https://www.onecpd.info/resources/documents/AHAR-2013-Part1.pdf

[28] National numbers for subpopulations from: 2013 Continuum of Care Homeless Assistance Programs Homeless Populations and Subpopulations; https://www.onecpd.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf

unmet need in the community.[29]

Table 19 provides a local, statewide, and national comparison of total beds available for household and bed type.

Table 19: 2013 Housing Inventory Count for Knoxville, Tennessee, and the United States

	Knoxville/ Knox County[30]	Tennessee	National[31]
Family Beds	463	4,383	343,718
Adult-Only Beds	1,074	6,908	382,541
Child-Only Beds	14	46	4,117
Total Year-Round Beds	1,428	11,337	730,376
Seasonal Beds	0	559	20,822
Overflow/Voucher Beds	41	259	27,233

Thirty-two percent of the total year-round beds reported in the HIC are designated for emergency shelter, while 29% are transitional housing, and 39% are permanent supportive housing. Table 20 provides the bed coverage rate for the Knoxville-Knox County CoC.

Table 20: Knoxville 2013 CoC Bed Coverage		
Program Type	**Total Beds**	**Bed Coverage Percentage by Program Type**
Emergency Shelter (excluding DV Beds)	446	
Non-HMIS Beds	5	
HMIS Beds	441	99%
Transitional Housing (excluding DV Beds)	403	
Non-HMIS Beds	142	
HMIS Beds	261	65%
Permanent Supportive Housing (excluding DV Beds)	448	
Non-HMIS Beds	94	
HMIS Beds	354	79%

[29] https://www.onecpd.info/resource-library/coc-housing-inventory-count-reports/
[30] https://www.onecpd.info/reports/CoC_HIC_State_TN_2013.pdf
[31] https://www.onecpd.info/reports/CoC_HIC_NatlTerrDC_2013.pdf

Director's Commentary

KnoxHMIS is an empirical window into homelessness in Knoxville/Knox County, enabling the community to see more clearly the scope and magnitude of this most challenging social problem. This 2013 KnoxHMIS Annual Report summarizes a vast quantity of data compiled over the last year by the 131 licensed system users in our 16 partner agencies who provided food, shelter, and array of other services to the 9,806 individuals experiencing or at risk of homelessness in our community. The purpose of this Director's Commentary is to offer context and perspective on the wealth of data about the lives of people living in poverty presented here.

Who are the homeless individuals and families of Knoxville/Knox County?

A diverse group of 9,806 individuals received services in the last year as a result of being homeless, at risk of homelessness, or now stably housed but accepting supportive services. They represent a number of at-risk and overlapping subpopulations including veterans (11%), chronically homeless individuals (20%), children (15%), female single parents (7%), members of racial (35%) and ethnic minority (10.7%) groups, seniors (6%) and with HUD specified disabilities (31%). The demographic, medical, and behavioral health complexity of this population underscores the nontrivial challenges faced by the KnoxHMIS partner agencies in addressing the multifaceted needs of these individuals and families.

Once again this year, we found that contrary to the often-stated belief that most homeless individuals come to Knoxville from elsewhere, a majority (68%) are from Knox County, and the vast majority (77%) are from Knox County and the surrounding counties. Additionally, it is important to point out that the demographic profile of the people experiencing homelessness in Knoxville and Knox County is strikingly reflective of national demographic data published in the HUD Annual Homelessness Assessment Report to Congress (see Table 18).

What are the causes of homelessness in Knoxville/Knox County?

Homelessness in now widely understood to result from a complex interaction of individual, structural/economic, and environmental factors. This interaction is evident in data reported here. As in past years, the dominant self-reported reasons for homelessness among female active clients are poverty (loss of job, no affordable housing, underemployment/low income) and domestic violence, which taken together account for 51% of the reported explanations. Notably, women make up 40% of all active clients. For men, loss of job, no affordable housing, and underemployment/low income account for 55% of the reported reasons for homelessness. The daunting challenges of poverty are amplified by and interact with the high levels of medical and behavioral health disabilities (31%) identified in individuals experiencing homelessness in this community.

What are the challenges?

The age distribution represented in Chart 7 illustrates one of the perhaps insufficiently addressed subpopulations among the homeless population of this area. The blue peaks on the right side of the figure, representing males 40 to 60 years old, indicate a notably large proportion of the population. Chart 11 further illustrates the skewed distribution of aging males among the homeless and the chronically homeless population. The disproportional size of this age group points to the necessity of greater analysis and understanding of the needs and challenges of this group. Moreover, targeted interventions to address the housing and employment needs of this

significantly large subgroup could be an important strategy for reducing their homelessness and associated social, medical, and behavioral problems as well as the resulting costs to the community.

It is also noteworthy, that of the 2,254 individuals who were new to homelessness last year, 31% were reported as housed. This figure illustrates several challenges faced by the homeless service providers of the community. First, as indicated in Table 20, there are only 448 permanent supportive housing beds in the community, most of which are already occupied. Second, it is not uncommon for first-time and episodically homeless individuals to be lost to follow-up by their case managers due to a host of reasons. This phenomenon results in the high number of Exit Destinations of "Don't Know" (335) reported in Table 14. Finally by report, there is a very limited number of low-cost housing options in Knoxville/Knox County, thereby amplifying the challenge of finding housing for homeless and impoverished individuals and families.

Many thanks…

2014 marks the tenth anniversary of KnoxHMIS. This community outreach partnership and research endeavor is the result of the collaboration of local homeless service agencies, a variety of funders, the City of Knoxville, Knox County, Comcast, the Knoxville/Knox County Homeless Coalition, and the University of Tennessee College of Social Work. KnoxHMIS was born out of a mutually recognized need for a means to centralize the collection of information on the homeless population of the community, the services they receive, and the outcomes achieved in order to better understand our collective efforts, to coordinate care, and to maximize the effectiveness of limited resources. We are deeply grateful to our collaborators and the KnoxHMIS partner agencies for their sustained support over the last ten years.

The KnoxHMIS Annual Report would not be possible without the ongoing data collection efforts of the 131 licensed users in our 16 partner agencies and the support of their dedicated directors. We greatly appreciate their work to serve the individuals and families who are homeless in our area and to document their endeavors in this data system. We also offer our thanks to the all too numerous individuals and families experiencing homelessness who gave their permission to have their information entered into KnoxHMIS. The resulting data enable us to serve the public by providing critical information to the community, our partner agencies, the City of Knoxville, Knox County, and HUD. We believe the information presented in this report is critical to reducing duplication of services and fostering efforts to address the multiple needs of persons experiencing homelessness in this community.

This report is a result of the combined efforts of the KnoxHMIS team including Lisa Higginbotham, Deidre Ford, Don Kenworthy, and our most excellent MSSW graduate intern Caitlin Ensley. Lisa and Caitlin put in countless hours running numerous data analysis procedures necessary to produce this report. Without their remarkable efforts, there would be no KnoxHMIS Annual Report. Well done!

David A. Patterson, Ph.D.
Director KnoxHMIS
Endowed Professor in Mental Health Research and Practice
DSW Program - Director
College of Social Work
The University of Tennessee

KKCHC 2014 Biennial Study

Since its formation in November of 1985, the *Knoxville-Knox County Homeless Coalition* 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, 2008, 2010, and 2012). 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 statewide study; the state effort was not published.

Design

The current study was conducted in January and February 2014. It included interviews with a sample of persons in shelters and outside locations during an evening/early morning period. Past studies included an enumeration based on shelter census during the month of February. However, in 2012 the shelter census was dropped and HMIS data were used. The shelter sites included *AGAPE, Catholic Charities of East Tennessee Samaritan Place, E.M. Jellinek Center, Family Promise of Knoxville, The Helen Ross McNabb Center (Family Crisis Center, Great Starts and Transitional Living), Knoxville Area Rescue Ministries (Family Emergency Services, Men's Transitional Living, Overnight, and Serenity), The Salvation Army (Joy Baker Center, Operation Bootstrap, and Transitional Housing), Steps House,* and the *YWCA Women's Housing Program.* Outside locations included various camps as well as *Lost Sheep Ministries* and *Highways-Byways Ministries*.

The questionnaires used in studies during the past twenty-eight 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, substance abuse, domestic violence, foster care, and experiences with social service agencies were added. In 2010, the 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.

Thirty-nine 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.

Interviews were conducted the week of January 27, 2014 and on February 5, 2014. Shelters were visited on Thursday, January 30th, and early morning interviews were conducted the following morning at area camps. Interviewers at outside feeding programs were conducted Wednesday, February 5, 2014 due to inclement weather the previous week. The evening interviews were started at approximately 6:30 p.m. This time was selected to allow shelters to complete 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. In the morning following the shelter interviews, six interviewers visited areas where persons were in outdoor individual "camps." On Wednesday, February 5, 2014, six interviewers visited the weekly *Lost Sheep Ministry* feeding program; typically these interviews are conducted the same week as shelter and camp interviews, however, inclement weather had resulted in cancellation of the program. Interviews at *Lost Sheep Ministries* were rescheduled soon thereafter and the same interviewers from the camps were utilized to prevent duplication of study respondents. A total of two hundred and thirty-six (236) interviews were completed. All respondents were paid $3.00 after being advised of their right not to participate and of their right to refuse to answer any question during the interview. Women were slightly oversampled to allow analysis of this segment of the population.

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 that focuses on individuals who are staying in shelters or outside locations. In spite of these constraints, the sample of shelters and outside locations was viewed as representative of the area homeless population.

In addition to the data available through this sample, the accompanying 2013 study from *Knoxville Homeless Management Information System* (*KnoxHMIS*) should be used for comparison. In examining the combined information provided by KnoxHMIS and The Coalition, the reader should be aware that the *KnoxHMIS* data is based on service users; for example "in 2013, 3,665 individuals sought services for the first time from *KnoxHMIS* partner agencies." In contrast the coalition study was a "point in time" sample; the sample was drawn at agencies and also from persons in outside locations who may or may not have been service users. The reader should also note that the data sources are not asking the same questions, resulting in variation. Thus, the findings while not identical can be viewed as complementary.

Demographics

The demographics for both the 2012 and 2014 studies were based on the interview sample. **Table 1** offers comparisons of 2014 and 2012 demographics. The mean age, gender, race, marital status, education, and military service represent adult population characteristics.

Comparison of the data for 2014 and 2012 indicated similarities, including the number of women and minorities. The findings on race were eighty-one percent white in this study. 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.

TABLE 1: CHARACTERISTICS OF KNOX COUNTY HOMELESSNESS 2012 AND 2014		
Item	**2012 Percent (n=236)**	**2014 Percent (n=236)**
Age:		
Under 18	0%	0%
18-30	20%	16%
31-60	73%	77%
61+	5%	5%
	Mean = 42.3	Mean = 43.9
	Male = 46.4	Male = 45.2
	Female = 40.3	Female = 41.6
Gender:		
Male	62%	65%
Female	38%	35%
Race:		
White	81%	73%
Black	17%	18%
Other	1%	8%
Military Service:		
Veteran	20%	12%
Marital Status:		
Single/Never-Married	36%	42%
Married	10%	8%
Divorced/Separated	47%	46%
Widowed	6%	5%
Education:		
8 years or less	8%	9%
Some high school	31%	17%
High School Grad, Incl. GED	39%	42%
Post high school	22%	31%
*Due to rounding error, all totals may not equal 100		

Roots

During the past twenty-eight years the number of homeless persons "having grown up in Tennessee" has been fairly consistent as shown in **Chart 1**. 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 data indicates that sixty-two percent of Knox County residents were born in Tennessee, whereas the 2014 Biennial Study indicated fifty-seven percent of those in the study were born in Tennessee. It is likely that of the sixty-two percent of Knox County residents

born in Tennessee indicated per the Census, and fifty-seven percent in the 2012 Biennial study, some portion were nonetheless born in Tennessee but outside Knox County, in addition to those born out of state. When considering the percentage of homeless individuals represented in the Biennial Study who are "not from Knox County" as compared to the general housed population reported in the Census, the percentages are not notably different. **Table 2** identifies states that were prominent in the 2012 and 2014 studies. Twenty-eight states were represented in the 2012 and 2014 surveys. 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.

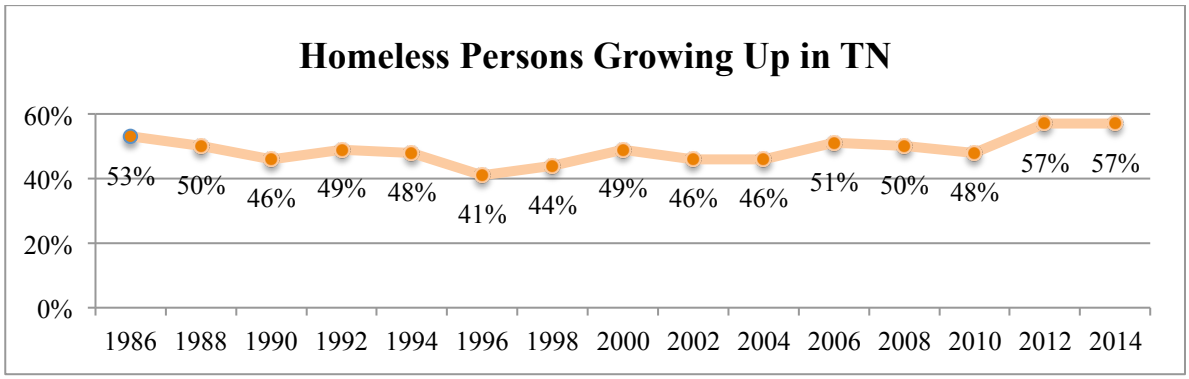


Chart 1: Homeless Persons Growing up in Tennessee

TABLE 2: STATE OF ORIGIN		
STATE	**2012 PERCENT (N=236)**	**2014 PERCENT (N=236)**
TENNESSEE	57%	57%
NORTH CAROLINA	3%	2%
FLORIDA	4%	4%
GEORGIA	3%	1%
KENTUCKY	4%	1%
OHIO	5%	5%
MICHIGAN	4%	3%
INDIANA	2%	4%
CALIFORNIA	2%	2%
NEW YORK	2%	3%
PENNSYLVANIA	2%	3%
OTHER STATES	13%	16%

This study's question, "where did you grow up?" and its data is interpretation has become important in local policy discussions. It is useful to examine data collected by *KnoxHMIS* from homeless service providers. *KnoxHMIS* asks for the zip code of clients' last permanent address, a question that may offer understanding of individuals who have become homeless after coming to Knox County. The *KnoxHMIS* annual report for 2013 shows a distribution of clients who have received services and provides information about their last permanent address. This data indicates that the majority of new homeless clients cite the Knoxville/Knox County area as their last permanent address. Sixty-eight percent of clients who responded had a zip code with a '379' prefix, corresponding to Knox County, and seventy-

seven percent of all service users had a prior permanent address in the '37' prefix, that includes Knox and surrounding contiguous counties. These data suggest that homeless service providers in Knox County are primarily serving people who became homeless while living in the local area.

In the 2014 study, respondents were asked to identify the three most important reasons for coming to Knox County. Available social services/treatment facilities or a family move to the county were frequently identified.

TABLE 3: REASONS FOR COMING TO KNOX COUNTY

Response	2012 PERCENT (N=236)	2014 PERCENT (N=236)
Job or Seeking Job	22%	13%
Traveling	22%	5%
Social Services/Treatment	28%	19%
Family Moved Here	23%	19%
Sent (by police or agency)	12%	5%
Shelters	24%	6%
Family Conflict	N/A	4%
Other	28%	6%

*Totals may not equal 100 since multiple responses were accepted

**Includes mental health, substance abuse, and medical treatment

"Family moved here" and "Social Services" were the most frequent responses. The "Other" category included responses such as "*relationship*", "*deceased spouse*", and "*housing*" as **Table 3** indicates multiple responses by respondents were accepted, reflecting that a combination of reasons were often involved.

Respondents were asked about their housing status prior to coming to Knox County. One percent had been homeless for less than a week, while seventeen percent had been homeless for a week or more (compared to fifteen percent in 2012). Additionally, thirty percent had been living with friends or relatives. Twelve percent provided other responses suggesting unstable living arrangements including incarceration, foster care, hospitals, living in cars and various combinations. Approximately thirty-eight percent of those coming to Knox County were living in their own homes or apartments prior to arrival (compared to twenty-five percent in 2012).

To further explore permanence in Knox County, a question was asked about how long the respondent had lived in Knox County. The most frequent response by those not born in or living in Knox County most of their lifetime was "*one month to six months*" (twenty percent) followed by "*more than 10 years, but not all my life*" (twenty percent). Surrounding counties such as Anderson, Blount, Hamilton, Sevier, and Loudon were most frequently identified when asked where the individual lived prior to Knox County.

Family

Since the original study in 1986, questions have explored family characteristics, backgrounds, and experiences growing up. The following refers to experiences of all respondents except where otherwise indicated. Respondents were asked about childhood developmental experiences. In the 2014 study, twenty-two percent had been in state custody,

and fourteen percent of adult respondents had been in foster care at some time. **Table 4** identifies with whom the individual primarily lived while growing up.

TABLE 4: PRIMARY LIVING ARRANGEMENTS DURING CHILDHOOD		
	2012	**2014**
Parents	45%	44%
Father	6%	5%
Mother	31%	33%
Grandparents	1%	8%
Relatives	11%	4%
Foster Parents	3%	3%
Other	3%	1%
*Due to rounding error, all totals may not equal 100		

In terms of family disruption, six percent reported that their families had experienced homelessness during their childhood. As noted, fourteen percent had been in foster care, which was similar to reports from previous studies, as detailed in **Chart 2**. Among those in foster care, thirty-three percent had been in only one foster care placement, with approximately eighteen percent having been in two or three placements. Among the total who had been in foster care, fifty-five percent went home (similar to fifty-four percent in 2012). Approximately nine percent went to the streets or shelters. Three percent went to group homes. Forty-one percent of the respondents in 2014 reported some form of child abuse (the same as in 2012).

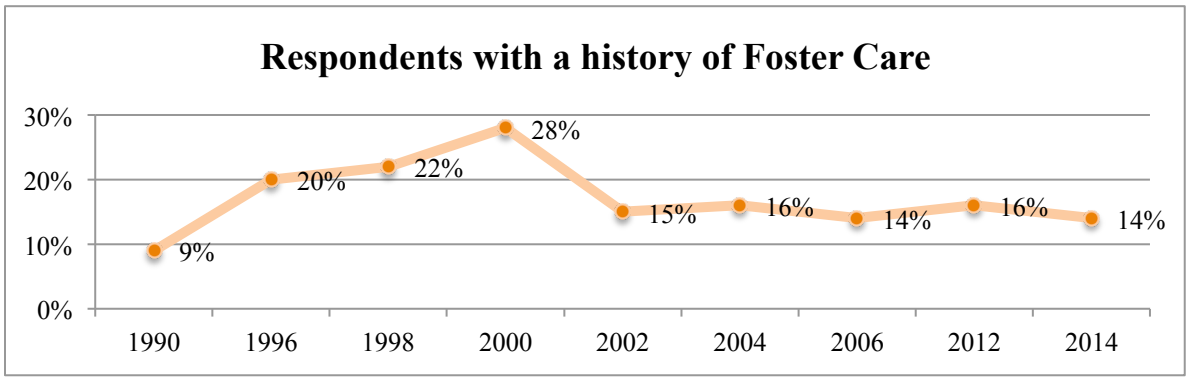


Chart 2: Respondents with a history of Foster Care

As adults, forty-two percent reported never having been married, eight percent were married, and forty-six percent were separated or divorced. Sixty-seven percent had children. Fifty-seven percent of those with children had children under 18 years of age, but only nineteen percent of these parents (n= 89) had their children with them. These percentages are fairly consistent with those in the 2011-2012 study, and suggest why there are fewer young children in shelters.

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

Military Service

The number of respondents reporting veteran status has decreased. Twelve percent of respondents identified themselves as veterans in 2014, while twenty percent did in 2012. **Table 5** displays service by year of discharge. Vietnam era veterans continued to account for a large portion of those with military service.

TABLE 5: YEAR OF DISCHARGE

Period	2012 Percent (n=48)	2014 Percent (n=28)
1950 or before	2%	0%
1971-1980	50%	36%
1981-1990	31%	32%
1991-2000	13%	21%
2001-2010	4%	7%
Unknown	0%	4%

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

TABLE 6: MILITARY EXPERIENCE

	2012 Percent (n=48)	2014 Percent (n=28)
Branch of Service		
Army	46%	50%
Navy	19%	25%
Air Force	6%	0%
Marines	25%	21%
Other	4%	4%
War Zone Experience	35%	21%
Type of Discharge		
Honorable	69%	71%
General	13%	7%
Dishonorable	8%	4%
Medical	2%	0%
Other	8%	18%
Service Related Disability	19%	14%

*Totals may not equal 100 due to rounding

According to *Veterans Administration,* there were 131,000 homeless veterans on a given night in 2008 (NCH, 2010). This figure has since declined to 57,849 per night in 2013 (Henry et al., 2013).

Causes of Homelessness

In the introduction to this study, factors contributing to homelessness were identified. These factors were identified in responses when individuals were asked about the causes of

homelessness. The 2014 responses reflect a range of overlapping factors. In early studies, family relationship problems and lack of work were the most frequently cited responses; however, substance abuse has been prominent in recent studies, followed by relationship problems and other personal problems. The reader is reminded that these multiple responses indicate that homelessness usually involves several factors, and the conclusions drawn must recognize the complexity of the problem. **Table 7** provides a summary of identified causes. In 2014, the survey question "What caused you to be homeless?" had additional answer codes added to parallel the KnoxHMIS question, " Primary reason for homelessness?" **Table 7** indicates fields not captured in the 2012 study as "NA."

In 2014, job loss and alcohol and drug addiction were frequently identified as factors, as was no money for housing. Approximately six percent identified mental illness as a factor in becoming homeless while four percent cited a medical condition.

TABLE 7: CAUSES OF HOMELESSNESS

Causes	2012 Percent (n=236)	2014 Percent (n=236)
Abuse by Family Member	9%	3%
Alcoholism	16%	15%
Drug Addiction	28%	23%
Eviction	8%	8%
Family Asked Me to Leave	9%	9%
Lost Job	28%	25%
No Money for Housing	18%	19%
Medical Condition	6%	4%
Criminal Activity	4%	7%
Mental Illness	5%	6%
Discharged from Jail/Prison	5%	6%
Aged Out of Foster Care	2%	1%
Prefer It	2%	2%
Domestic Violence	NA	5%
Substandard Housing	NA	0%
Under Employment/Low Income	NA	8%
Utility Shutoff	NA	1%
Family Discord	NA	11%
Loss of Transportation	NA	4%
Loss of Public Assistance	NA	0%
Health/Safety	NA	1%
Death of a Family Member	NA	9%
Relationship/Breakup or Divorce	NA	14%
Mortgage Foreclosure	NA	0%
Other	10%	2%

*NA = Not Available
**Percentages may not equal 100 as multiple responses were allowed

Various other factors were mentioned including family discord (eleven percent) and relationship breakup or divorce (fourteen percent), disability, and numerous life stresses, many of which can be seen in Clara's story below. In both this study and the *KnoxHMIS* data, loss of employment was frequently cited. However, the 2014 study responses indicated a much higher rate of self-reported alcohol and drug abuse as causative in contrast to the *KnoxHMIS* data. It should noted that Biennial Study respondents did not have to identify themselves as they do when seeking services from providers; the anonymity of the study may lend to a more candid response.

Clara, a seventy-eight year old woman of European descent was referred to a local emergency shelter three months after the unexpected death of her daughter. Clara had been living with her daughter Eileen and her grandson Jonathan. While Clara and her daughter got along, Clara's relationship with her grandson was turbulent. After her daughter's death, Jonathan and his friends started using drugs in the house and would regularly steal from Clara. She does not drive and has limited mobility, attributed to her arthritis, which makes accessing services difficult. Clara was hospitalized with injuries after an argument with one of her grandson's friends. Jonathan did not pick his grandmother up from the hospital, and she came home to find the locks changed. With the little money left in her bank account, Clara rented a motel room but only had enough for one night. With nowhere else to go, Clara arrived at the homeless shelter.

Housing

The current study asked several questions about housing, particularly evictions. In 2014, ten percent (eight percent in 2012) had experienced eviction in the two years prior to becoming homeless. Of those who had been evicted, forty-two percent had been evicted due to loss of income or poor payment history. Fifty-five percent were living in private housing and twenty percent were living in a relative's or friend's home. Lack of funds was most frequently cited (forty-eight percent) as a reason for not being able to get into housing. Twelve percent indicated that they were currently on a housing waitlist, waiting an average of approximately eight months. Of all respondents, nineteen percent had been denied housing because of past criminal behavior.

Employment

When asked about employment, sixteen percent of the respondents said that they had a job, considerably lower than the forty-six percent reported in 2006 and 2008, and likely reflects the economic climate. Caution should be exercised in interpreting this statistic since shelter work programs, collecting cans, and spot labor are often viewed as having a job. Respondents were asked about their usual line of work. **Table 8** identifies the usual line of work.

TABLE 8: USUAL LINE OF WORK

Occupation	2012 Percent (n=236)	2014 Percent (n=236)
Unskilled Labor	20%	16%
Skilled Labor	19%	19%
Construction	10%	12%
Restaurant	19%	20%
Professional	4%	4%
Truck Driver	2%	3%
Nurse's Aid/Day Care	4%	4%
Clerical	4%	1%
Clerk/Sales	3%	6%
Factory	0%	4%
Student	3%	1%
Other	11%	10%

*Totals may not equal 100 due to rounding error

The findings in 2014 were similar to those in the previous study; however, the percentage identifying themselves as unskilled laborers decreased. There is likely some overlap between skilled and unskilled work as well as between unskilled and restaurant or construction.

Those who had worked (again this must be interpreted cautiously because "canning" and shelter work may be included) offered various reasons for termination of jobs. Several respondents in the "other" category cited being in programs that did not allow work. The responses "*no work*", "*laid off*", "*temporary*", "*seasonal*", and "*day labor*" appear interrelated. **Table 9** summarizes the reasons cited for termination of employment in 2014 and 2012.

TABLE 9: REASONS FOR TERMINATION

Reason	2012 Percent (n=236)	2014 Percent (n=236)
No work, laid off, out of business, or seasonal/temporary/day labor	30%	23%
Illness or Disability	15%	17%
Just Quit	15%	15%
Fired	19%	11%
Unfairness/discrimination	2%	3%
Alcohol/Drugs	NA	10%
Other	19%	17%

*Totals may not equal 100 due to rounding error

In light of the lack of stable employment, the research explored perceived reasons for not working (*n*=236). A common response (thirty percent) was "*disabled*". There was 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. Twenty percent reported not working because "*no jobs are available*." Alcohol and drugs were cited by six percent. No transportation was cited by eight percent. Several respondents said "*program restrictions*", however many of these could be considered as in treatment or pursuing training for employment.

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

Health

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

The study asked about health problems since being homeless. The respondents (*n*=236) reported various conditions including: dental (forty percent); respiratory, ear, throat (forty-two percent); eye (thirty-three percent); feet (thirty-two percent); severe headaches (thirty-three percent); accidents/injury (eighteen percent); blood pressure (thirty-seven percent); pneumonia (eighteen percent); skin (seventeen percent); personal accidents (nineteen percent); hepatitis

(fifteen percent); heart (fourteen percent); seizures (eight percent) and diabetes (eleven percent). Sixteen percent of the women reported pregnancies while homeless.

When asked about health care in the past year, sixty-five percent had seen a physician/nurse, and twenty-three percent had seen a dentist. Thirty-seven percent of respondents said that they had been hospitalized while homeless (thirty-three percent in 2012, twenty-eight percent in 2010, and twenty-nine percent in 2008). Illness was the most frequent reason for hospitalization, but the reports of injury, assault, and alcohol related problems suggested that these are also frequent among the chronically homeless. The "other" category included various physical ailments, infections, and emotional problems. Those respondents who had been hospitalized while homeless were asked how many days/nights had been spent in the hospital during the past year. **Table 10** identifies the length of hospitalizations.

TABLE 10: DAYS/NIGHTS IN THE HOSPITAL

Response	2012 Percent (n=91)	2014 Percent (n=103)
None in the past year	16%	22%
One	17%	13%
Two	4%	12%
Three	10%	11%
Four	9%	6%
Five to Ten	21%	20%
Eleven to Twenty-One	12%	4%
Twenty Two or more	10%	12%

Another question asked respondents if they had been transported to a hospital or emergency room by ambulance during the past year. Forty-three percent (one-hundred and two persons) indicated ambulance transportation. Ambulance services ranged from one to fifty-two times; forty percent reported only one time, and nineteen percent reported two times.

Respondents were also asked where they went with a health or medical problem not requiring hospitalization. The responses have changed in recent studies due to the opening of the *Broadway Clinic* and *Cherokee Health Systems* providing indigent care. **Table 11** 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 11: TREATMENT NOT REQUIRING HOSPITALIZATION

Response	2012 Percent (n=229)	2014 Percent (n=231)
Cherokee Health/Broadway Clinic	30%	26%
Health Department	16%	7%
Interfaith Clinic	4%	3%
Emergency Room	24%	24%
Family Doctor	9%	10%
Cherokee Western	9%	8%
Remote Area Medical	0%	1%
Nowhere	17%	23%
Other	13%	16%

*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. Thirty-eight percent had not been to an emergency room; however, for the remaining sixty-two percent, responses ranged from one (thirty-three percent) to fifty-two times. The average number of emergency room visits for the total sample was two visits. Forty-seven percent (forty-two in 2012) reported having received *TennCare;* nineteen percent were currently receiving it, and three percent were unsure.

Mental Health

Chronic mental illness and deinstitutionalization continue to be cited as major reasons underlying homelessness. Sixty-two percent of all respondents (n=236) reported treatment for mental illness. Sixty-four percent of those receiving treatment for emotional or mental illness (n=146) had been hospitalized. Among those individuals reporting hospitalization, thirty-eight percent had been at *Peninsula Hospital*, twenty percent had been at *Lakeshore* at some time, and twelve percent had been at both *Lakeshore* and *Peninsula Hospital*. Four percent had been in a *Veterans Administration Hospital*. Four percent had been at other state hospitals in Tennessee, and fifteen percent had been at state mental health institutions in other states. Twenty-six percent identified various other hospitals.

Among those who had been hospitalized (n=94), twenty-eight percent reported only one hospitalization while forty-four percent had been hospitalized between two and five times. Fourteen percent had been hospitalized six to ten times, with the remaining fifteen percent having eleven or more hospitalizations. For fifty-six percent, hospitalization had occurred more than one-year earlier. However, thirty-four percent had been discharged within the previous six months. The length of most recent hospitalization varied: thirty-four percent reported less than one week, and forty-eight percent had been hospitalized between one week and one month. Among those hospitalized (n=94), eighty-six percent had been discharged on medication, but approximately half (forty-six percent) of them were not taking it. Many said that they "didn't like how it made them feel." Thirty-one percent of all respondents (n=236) perceived their "nerves" as bad. Seventy-three percent said that they experienced depression, with thirty-nine percent of those saying they were depressed everyday. Twenty-two percent had been seen by the mobile crisis team (twenty percent in 2012).

Table 12 illustrates post-hospital residence and indicates that a large number of persons discharged went directly to the streets or shelters from psychiatric facilities. The substantial percentage increase since the initial study in 1986 parallels bed reductions and closing of state facilities.

TABLE 12: POST-HOSPITAL RESIDENCE

Residence	2012 Percent (n=76)	2014 Percent (n=94)
Relative/Friends	24%	30%
Boarding Home/Group Home	9%	3%
Own Apartment/Home	24%	16%
Street/Shelter	36%	40%
Rehabilitation	NA	6%
Other (Incl. "Jail")	8%	4%

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

Sixty-two percent of the total sample (n=236) reported receiving mental health treatment at some time. While reporting previous treatment does not mean that the respondent is currently mentally ill, sixty-two percent of the homeless respondents reporting mental illness is significantly higher than the national estimate of one out of four citizens or twenty five percent having diagnosable mental illness (Kessler, Chiu, Demler, & Walters, 2005). The validity of the finding that the frequency of mental illness among homeless persons is exceptionally high is supported by interviewer observations. When asked at the completion of the questionnaire if the respondent had mental health problems, forty-eight percent were so identified. Additionally, forty percent of those persons who reported mental health treatment at some time (n=146) report currently accessing outpatient mental health services.

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. In 2014, twenty-one percent reported alcohol or drug addiction, and six percent reported co-occurring alcohol and drug addiction, while another twenty percent reported that they were in recovery. In other words, fifty-seven percent reported being addicted to alcohol and/or other drugs at some point. **Table 13** reflects the responses about alcohol and drug addiction.

TABLE 13: ALCOHOL AND DRUG ADDICTION

Responses	Percentage 2012 (n=236)	Percentage 2014(n=236)
Alcohol Only	12%	14%
Drug Only	13%	7%
Both Alcohol and Drug	11%	6%
Recovery	19%	20%
Don't Know	0%	1%

Drug use other than alcohol has increased significantly since the 1990s. In 2014, sixty-eight percent of the total (*n* = 236) indicated use of drugs (seventy-three percent in 2012). A follow-up question asked, "Do you consider yourself addicted to drugs?" Among the users (*n* = 160), twenty percent considered themselves addicted, with another twenty-three percent identifying themselves as being in recovery. These data suggest that twenty-nine percent of the total interviewed (*n* = 236) believed that they were currently or had been addicted to drugs (thirty-one percent in 2012). Among those reporting drug use (*n* = 160), twenty-six perecnt indicted prescription drug abuse. In terms of frequency, thirty–eight percent indicated daily use (compared to twenty-eight percent in 2012); twelve percent reported using substances several times per week (compared to eight percent in 2012); and five percent said drugs were used once or twice per month. In the total sample, thirty-nine percent (*n* = 92) had received inpatient treatment in a detoxification facility (forty-six percent in 2012). Thirty-one percent of all respondents reported receiving outpatient treatment for alcohol or other drug problems; ten percent of whom indicated having difficulty finding treatment.

Crime

Homeless persons are vulnerable to being victims of crime. Many of these crimes go unreported, but in most years there are at least one or two media accounts of the murders of homeless people. In 2014, thirty-seven percent of respondents had been victims of crime since being homeless as compared to thirty-four percent in 2012. These are below the highest rate of forty-three percent in 1996. Responses are detailed in **Table 14**.

TABLE 14: TYPE OF CRIME		
Response	**2012 Percent (n=80)**	**2014 Percent (n=88)**
Robbed	39%	36%
Theft	46%	42%
Stabbed/Assaulted	38%	29%
Beaten up	33%	18%
Shot	2%	2%
Other	8%	8%
*Due to the acceptance of multiple answers, all totals may not equal 100%		

Ten percent had been sexually assaulted, with thirty-eight percent of these reporting multiple assaults. As noted in previous studies, the aged or infirm are particularly vulnerable to crime. Deinstitutionalized individuals, chronic alcoholics, loners, and recipients of Supplemental Security Income (SSI) or other benefits are at greater risk.

In contrast to being victims, respondents were also asked if they had served time in correctional facilities. The comparison between 2014 and 2012 offered in **Table 15** indicates a consistency in the frequency of incarceration in jail. The interview asked if the respondent had been arrested for trespassing or loitering, and eighteen percent answered in the affirmative. 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. Violation of probation and failure to appear were also cited.

TABLE 15: INCARCERATION		
	2012 Percent (n=236)	**2014 Percent (n=236)**
Jail/Detention	68%	75%
State or Federal Prison	19%	21%
*Due to multiple responses, totals may not equal 100%		

Since the 2002 study, several questions about public intoxication have been included. Twenty-six percent had been arrested for public intoxication within the last three years as compared to twenty-nine percent in 2012. Thirty-five percent reported one arrest and another thirty-two percent had two or three arrests. Approximately nine percent had over ten arrests during the three-year period. The range was from one to over one hundred arrests.

Respondents were asked about the total number of days spent in jail or prison during their most recent incarceration. Responses ranged from one day to twenty-six years. Among those who had been incarcerated in jail, the average was 99.7 days; for those incarcerated in state or federal prison, the average was approximately 3 years. A follow-up question was asked about the number of days spent in jail or prison in the past year. Among those incarcerated, the average was 95.3 days.

Comparing the statistical means for length of incarceration for homeless who have or have not been treated for mental health issues illustrates a pronounced difference. Those homeless who reported having received mental health treatment had a mean or average of 88.4 days of incarceration compared to 103.6 days for those homeless who have not been treated for mental health problems. In addition, only thirty individuals (seventeen percent) reported having received mental health treatment while incarcerated. Previous Biennial Studies have found the result that those who have been treated for mental health problems had longer incarcerations than those without mental health problems. It should be noted that other research has not found a significant relationship between mental illness status and detention length (James & Glaze, 2006; Draine, Wilson, Metraux, Hadley, & Evans, 2010). The issue merits further study, including examinations of incarceration of homeless mentally ill persons as compared to non-homeless persons charged with similar offenses.

Respondents who had served time were also asked where they went when released the most recent time. This question did not discriminate among jail or prison. Thirty-one percent returned home, fourteen percent went to live with relatives, nine percent moved to a group or transitional facility, and thirty-seven percent were homeless (shelter/street).

Despite the small sample, the findings that approximately thirty-seven 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 2014 findings suggested that the majority of homeless persons preferred and stayed in shelters at some time. Many respondents report a combination of sleeping locations, including shelters, outside sites, abandoned buildings, cars, single resident occupancies, and with friends; approximately five percent said that they stayed in hotels. The 2014 percentages include multiple responses and are identified in **Table 16.**

TABLE 16: USUAL SLEEPING LOCATIONS

Location	2012 Percent (n=236)	2014 Percent (n=236)
Abandoned Building	2%	1%
Car	4%	2%
Friend/Relative	8%	3%
Hotel	4%	2%
Street/Outside	24%	18%
Public Place	3%	2%**
Shelter	82%	83%

*Due to multiple responses, all totals may not equal 100%
** Churches are included in "Public Place"

Most respondents stay in shelters at least one or two nights per month, so the shelter total may be under reported because the question asked "*usual sleeping location.*" Respondents were asked how many nights they stayed in a shelter during the past year. Of those who answered (n=234) Eighty-four percent reported some shelter stay with only sixteen percent reporting *none* in 2014 (compared to three percent saying *none* in the 2012). Thirty-three percent stayed in shelters thirty nights or less. Ten percent reported "every night" during the

past year. The shelter stays ranged from *one* to *three hundred and sixty-fiv*e, with an average shelter stay of 110 nights within the past year; it is important to note that the average does not indicate consequtive nights.

Sixty-seven percent of all respondents indicated that they had a permanent address in Knox County for receiving mail. In 1986, only thirty-nine percent had a permanent local address for receiving mail; however, policy changes as well as residency in transitional facilities may have influenced this finding. Forty-seven percent said that they had family in the Knoxville area, and sixty percent of these individuals had been in contact with them during the past week. Eight percent of persons with area relatives reported over a year since last contact. Several questions were asked about staying with friends and relatives during the past year. Sixty-one percent had stayed with friends or relatives during the past year.

The 2014 study included questions about transportation. **Table 17** summarizes the responses to usual means of transportation. The "*other"* category included bike, agency transportation, and other forms of transportation. While walking has been the most frequent form of transportation, the finding of seventy-three percent in 2014 using buses underscores the importance of public transportation.

TABLE 17: TRANSPORTATION

Transportation	2012 Percent (N=231)	2014 Percent (N=236)
Own Car	11%	9%
City Buses	64%	73%
Walk	70%	69%
Hitch-hike	5%	6%
Friend's Car	21%	21%
TennCare	5%	5%
Other	16%	18%

*Totals may 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 numerous activities. **Table 18** summarizes daytime activities.

TABLE 18: DAYTIME ACTIVITIES

Response	2012 Percent (n=236)	2014 Percent (n=233)
Working	17%	18%
Loafing/On the Streets/Woods	12%	13%
Looking for work	28%	23%
Walking	26%	25%
At the Shelter	33%	34%
At the library	19%	19%
Day Room (VMC)	7%	7%
Child Care	1%	3%
Canning	7%	6%
Crossroads/Welcome Center	13%	6%
School	2%	2%
Looking for housing	7%	5%
Drinking/drugs	5%	3%
Treatment agency programs	19%	17%
Visiting family/friends	5%	6%
Other	12%	13%

*Totals may not equal 100 due to multiple responses

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

The most sensitive area in the interviews has always been questions regarding 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 reluctance to identify sources. **Table 19** summarizes average weekly income.

TABLE 19: WEEKLY INCOME		
Amount	**2012 Percent (n=236)**	**2014 Percent (n=236)**
$0	28%	32%
$1 - $50	31%	22%
$51 - $100	11%	8%
$101 - $200	16%	19%
$201 - $300	8%	11%
$301 or more	7%	6%

Those respondents reporting some income were asked about the source of income. Food stamps, relatives/friends, and work were the largest categories. The "*other"* category included various sources such as shelter allowances, child support, pensions, and alimony. **Table 20** summarizes the sources of income.

TABLE 20: SOURCES OF INCOME		
Source	**2012 Percent (n=219)**	**2014 Percent (n=219)**
Work	33%	31%
Government Assistance	13%	11%
Plasma Center	2%	4%
Handouts	12%	8%
Relatives/Friends	35%	34%
Food Stamps	50%	49%
Canning/Scrapping	15%	11%
Disability	NA	17%
Other	10%	14%
*Totals may not equal 100% due to multiple responses		

Twenty-four percent of the respondents indicated that they had lost government benefits during the past two years as compared to twenty-two percent in 2012. Earlier studies also reported loss of benefits as shown in **Chart 3**. Twenty-three percent of the respondents, (twenty-eight percent in 2012), indicated that they had engaged in illegal activity at some time to support themselves.

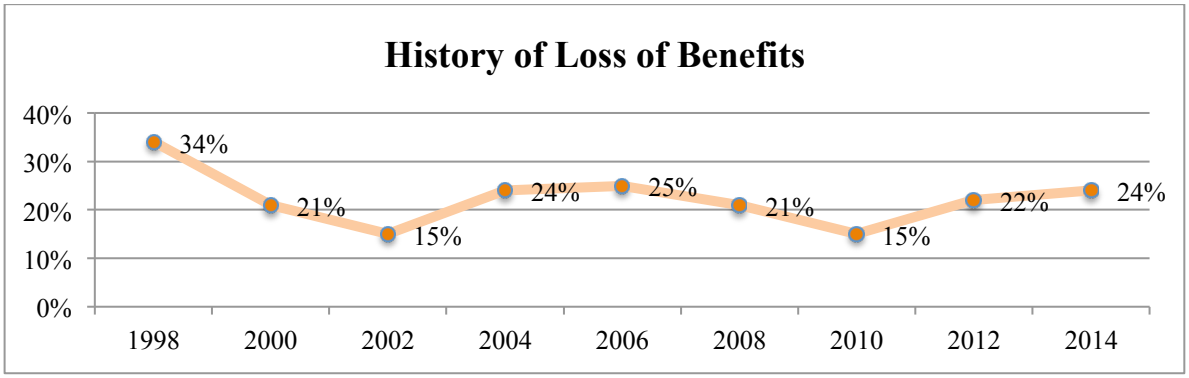


Chart 3: History of Loss of Benefits

A consistent observation in the studies has been that there is a lack of accountable payees or guardians for those receiving disability checks. Many receiving assistance did not seem to have the skills or ability to effectively manage those funds and were vulnerable to exploitation. In 2014, twenty-four percent of those receiving SSI or SSDI had a payee other than self, which was up from four percent in 2012. The issue about responsible payees remains an area needing more examination.

Women

In early studies, the number of homeless women was reported, but comprised a relative small segment of the sample. Beginning in 1998, the studies oversampled sites where women stayed in order to examine this segment of the population in more depth. In 2014, eighty-two (*n* = 82) women were interviewed using the standard questionnaire. **Table 21** summarizes the characteristics of women in the sample.

TABLE 21: CHARACTERISTICS OF WOMEN		
Item	**2012 Percent (n=89)**	**2014 Percent (n=82)**
Age:		
Under 18	1%	0%
18-30	30%	23%
31-60	63%	74%
61+	6%	2%
	(Mean = 40.3)	(Mean = 41.6)
Roots:		
Tennessee Native	61%	61%
Race:		
White	80%	76%
Black	17%	13%
Other	2%	11%
Marital Status:		
Single/Never-Married	36%	41%
Married	11%	10%
Divorced/Separated	7%	30%
Widowed	0%	9%
Education:		
8 years or less	4%	6%
Some high school	36%	16%
High School Grad, Incl. GED	29%	45%
Post high school	30%	33%
Reasons for Homelessness*		
Abuse	22%	18%
Family Conflict (incl. divorce)	11%	38%
No money for housing	16%	15%
Drugs	37%	26%
Alcohol	15%	5%
Eviction	9%	18%
Lost Job	20%	22%
Mental Illness	5%	2%
Other	13%	41%
Length of Homelessness:		
Less than one month	13%	2%
One to six months	32%	45%
Over six months to a year	21%	16%
Over one to three years	17%	24%
Over three years	13%	12%
Military Service:		
Veteran	3%	1%
*Multiple responses were accepted		

Family

When asked about experiences growing up, twelve percent reported that their families had been homeless at some time (thirteen percent in 2012). Sixteen percent had been in foster care, and twenty-two percent had been in state custody. Fifty-nine percent had been abused as a child.

Causes of Homelessness

While the researchers recognized that multiple factors leading to homelessness are usually involved, respondents were asked to identify what they viewed as the cause(s) of their homelessness. Substance abuse remained the most frequently cited reason for homelessness. (Twenty-six percent reported drug abuse, and five percent reported alcohol abuse). Examination of other factors contributing to homelessness suggests that family problems including abuse, conflicts, separation, and divorce were major causes of homelessness. The causes did not appear mutually exclusive. For example, some of those citing drug abuse also cited alcohol abuse. Twenty-two percent of the women reported loss of job as a reason for homelessness. Eviction (eighteen percent) and no money for housing (fifteen percent) were also identified. Eighty percent (n=66) of women responded that they were not currently working. Thirty-three percent reported that they are not working because they are disabled, and eighteen percent said there were no jobs available. Substance abuse was cited by twelve percent. Mental illness as a cause of homelessness was cited by two percent of the women. Several indicated that a death of a family member had forced them into homelessness. Other reasons included underemployment/low income, loss of transportation, or criminal activity.

Chelsea, a twenty-six year old single mother from Alabama, was homeless in Knoxville. Due to abusive parents, Chelsea quit school during her teen years, ran away from home, and acquired a juvenile record due to theft. Later in life, she was able to get her nursing assistant certification and receive her high school diploma. Shortly thereafter, she started a relationship with a man in Tennessee and relocated to live with him. She was unable to find employment despite turning in multiple job applications. The man she had moved in with went to jail several months after she became pregnant with their child. Because he was her primary support and she was unemployed, she was evicted from their apartment. She and her infant moved in with his parents, but their relationship was turbulent. She decided to leave when she found her mother-in-law was verbally abusive to her baby. She contacted an emergency shelter for help and moved in quickly. During her stay, her case manager has helped her gain employment, find housing, and receive childcare.

As illustrated in Chelsea's story, the reasons that women become homeless are complex. Additional factors of female homelessness are detailed in subsequent sections.

Housing

Forty-nine percent of the women had been homeless before the current episode. Forty-five percent of those had experienced three or more prior episodes of homelessness. Seventeen percent had been evicted or lost subsidized housing during the past two years. Eighteen percent of the respondents (twelve percent in 2012 and twenty-three percent in 2010) had been denied

housing because of criminal behavior. Eighty-five percent usually sleep in a shelter with nights spent in shelters during the past year, ranging from zero to three-hundred and sixty-five.

Health

Regarding health, forty-three perent of women considered their health as *fair or poor* as opposed to the fifty-five percent reporting their health as *good to excellent*. Forty-nine percent of women had been transported to medical facilities while homeless with a range of one to fifty-two times. Sixty-eight percent had been seen at an emergency room while homeless. Thirty-five percent of women had been hospitalized while homeless. Sixty-three percent of women considered themselves as having chronic health problems. Sixteen percent of women had been pregnant while homeless as compared to twelve percent in 2012.

Mental Health

Seventy-four percent of the eighty-two women reported treatment for emotional problems (as compared to sixty-seven percent in 2012) with forty-six percent of those having been hospitalized. 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. Forty-four percent were currently in treatment. Seventy-two percent of the total reported depression with forty-three percent of those indicating feeling depressed several times a week or continually.

Alcohol and Other Drugs

When asked about alcoholism, sixteen percent of the women considered themselves an alcoholic, and another eleven percent were in recovery. Seventy-one percent of the total had used drugs. Twelve percent of the users reported being addicted (compared to twenty-four percent in 2012), and twenty-two percent were in recovery. Thirty-five percent had been inpatients in a detoxification facility for alcohol or other drugs (compared to forty-three percent in 2012). Thirty percent has received outpatient substance abuse treatment, with twelve percent reporting difficulty in finding substance abuse treatment.

Crime

Women who are homelessness often share having experienced trauma. Sixty three percent of women reported being a domestic violence victim/survivor; although, the percentage citing domestic violence as a primary reason for homelessness was less. Thirty-four percent of the women said that they had been victims of crime while homeless (twenty-seven percent in 2012). Twenty-nine percent reported having been sexually assaulted while homeless (compared to sixteen percent in 2012). Thirty-eight percent of those who reported being a victim of crime while homeless (n=29) also reported sexual assault while homeless. In contrast to being victims, seventy-eight percent of women had spent time in jail (sixty percent in 2012), and thirty-three percent had been in prison (three percent in 2012). Fifteen percent of women who had been incarcerated received mental health treatment while there. Twenty-eight percent of females reporting that they had engaged in illegal activity to support themselves while homeless.

Life on the Streets

Fifty-six percent of the women had family in the Knoxville area, and thirty-four percent of women had contacted family within the last week. Various sources of money were cited: twenty percent- work; sixteen percent- government assistance; seventeen percent- assistance from relatives (thirty-four percent in 2012); and sixteen percent- friends. Fifty-six percent reported having food stamps. Sixty-six percent had received *TennCare*, and twenty-eight percent were currently receiving *TennCare.* Thirty percent of females reported having lost

benefits such as food stamps, SSI, TANF, or *TennCare* within the last year. Forty-three percent of women indicated needing job training.

Seventy-three percent had a copy of their birth certificate, and seventy-nine percent had a social security card. Forty-eight percent had a valid driver's license.

Interview Respondent Commentary

Respondents were asked "Is there anything about being homeless that we haven't asked that you think we should know" and "Do you have any other comments or questions about the things we've talked about." Some of the answers given were as follows:

> "The homeless are discriminated against and lumped in one category...Most people in this country are one paycheck away from being homeless."
>
> "You can be homeless and not be on drugs or be an alcoholic. It can happen to anybody."
>
> "I think people don't understand the loneliness, the frustration we go through to survive. I think people are ashamed of us."
>
> "Fear can be a big motivator to discriminate against the homeless."
>
> "The focus is on getting housing but there is little help to get jobs. Rather there is help to get identification not applications. If someone works third shift there is no where they can have shelter to sleep in during the day."
>
> "The process to get social security card, birth certificate, and driver's license is lengthy and time consuming. Can't apply for housing or work until you have this documentation."
>
> "[There is] not enough to empower folks. People are undereducated. [There is a] need to incentivize training and skill building. Homeless people need to feel valued."
>
> "All we ask is that we are treated with respect. We feel bad enough; we don't need to be looked down on. I've experienced it trying to get help, in the public. I notice it more being in a family."

KKCHC Commentary

The Knoxville-Knox County Homeless Coalition will celebrate its 29th anniversary in November 2014. The Coalition was appointed in 1985 when homelessness began to be recognized as a profound social issue. The drastic increase in homelessness seen in the 1980's was influenced by several economic and social changes. These included a decrease in the availability of affordable housing, a lack of growth in real earnings, the closing of institutions that had housed the mentally ill and substance abusers, an increased number of discharges from correctional institutions, persons aging out of foster care, and loss of benefits. During the past twenty-eight years, Knoxville and Knox County witnessed an increase from 800 persons in a given month to a high of approximately 1900 persons per month seeking homeless and homeless prevention services.

The studies of homelessness conducted by the Knoxville-Knox County Homeless Coalition and KnoxHMIS have highlighted a number of conclusions. Many of the conclusions from previous studies can be repeated and amplified.

First, the incidence of homelessness remains significant, but there is increasing evidence of progress as individuals and families move into housing.

Second, homelessness reflects a diverse group of individuals, including women and children.

Third, homelessness experienced by children will likely have long-term consequences as evidenced by the findings that suggest childhood disruptions increase the risk for adult homelessness and other problems.

Fourth, mental illness and substance abuse are major risk factors for homelessness; jails continue to be the main houser of the homeless mentally ill.

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 persons continue to be from East Tennessee, many having come to the area to seek employment or be near family.

Eigth, chronic homelessness is costly in terms of human potential and community resources.

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

Homelessness continues to be a major challenge for the community. While there are no simple solutions, the complexity underscores the need for different sectors, social services, government, and businesses to work together. The devleopment and implementation of the Knoxville-Knox County *Ten Year Plan to End Chronic Homelessness* was an important first step in reducing homelessness. Subsequently, the Compassion Knoxville Task Force helped solicit community input and involvment. More recently, Mayor Rogero convened the Mayor's Roundtable on Homelessness that developed *Knoxville's Plan to Address Homelessness*. The evolution of these efforts represents a community effort to have a coordinated, comprehensive plan. The tenacity of homeless service providers is shown through efforts to develop effective prevention and intervention programs, the increasing involvement and initiatives of the faith-based community, 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."

Section III

A. Resources in Knoxville and Knox County
B. References

Resources in Knoxville

Shelter and specialized housing resources in Knoxville have changed significantly over the years. This is due in part to:

- Changes in available funding,
- Community planning efforts to better coordinate care and increase efficiency,
- And an emphasis ending homelessness rather than simply mitigating the difficulties presented by life on the streets.

Knoxville has a number of specialized housing options and supportive services for persons experiencing homelessness. Primary homeless service providers are listed alphabetically:

Agape

Agape, located at 428 East Scott Avenue, offers a six-month individualized program for chemically dependent adult women. Three houses provide residence for eight clients, for a total capacity of twenty-four. Services include individual and group treatment and referrals. There is an $11.00 per day rent that is paid bi-monthly. Currently, there is no residential charge for the first six weeks of service.

Angelic Ministries

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

Catholic Charities of East Tennessee

Catholic Charities of East Tennessee operates two programs to house the homeless: *Samaritan Place,* located at 3009 Lake Brook Boulevard, includes an emergency shelter, transitional housing, and permanent suportive housing for people fifty-five years of age and older. To be eligible for programs, one must be able to manage individual daily living skills. *Samaritan Place* offers a range of case management and supportive services (e.g. employment counseling, referrals, assistance with legal, medical referrals, and basic needs). Follow-up case management services are provided for clients placed in community housing. *Elizabeth's Home* is a transitional housing program for homeless families. The case coordinator is located at 119

Dameron Avenue and housing is provided at multiple sites throughout the county. Families who are homeless in the Knoxville and surrounding areas are eligible to apply. Referrals to this program are provided by area shelters and agencies.

City of Knoxville Office on Homelessness

The *Office on Homelessness* is responsible, in cooperation with the *Mayor's Roundtable on Homelessness,* for coordinating the community's work to implement *Knoxville's Plan to Address Homelessness.* The Mayor of the City of Knoxville convenes the *Roundtable,* which is made up of executive-level leadership of local agencies, organizations, and ministries that provide services, shelter and housing for individuals and families that are experiencing or at-risk of homelessness. The *Plan* is a comprehensive approach to coordinate community resources around a shared set of goals and strategies to prevent, reduce, and end homelessness in Knoxville.

Cherokee Health Services

Cherokee Health Systems, a comprehensive health care organization and community health center with multiple Knoxville locations, provides medical, dental, and behavioral health services to all ages regardless of the patients' ability to pay.

Compassion Coalition

Compassion Coalition, comprised of a number of local churches, represents a coordinated effort to assist existing agencies serving the homeless. A number of churches and other organizations provide meals; *Church Street United Methodist Church, Lost Sheep Ministry,* and the *Love Kitchen* for example, have provided meals on specific days of the week for several years. Other churches sponsor meals through the shelters. Preacher Bob Burger leads the *Highways and Byways Ministry* that provides meals and outreach services. The *Compassion Coalition* also houses *Circles of Support*, a faith-based mentoring program that recruits and trains teams of volunteers from local congregations and matches them up with recently housed individuals who are working with a case manager. The *Circle of Support* mentors then assist the new neighbor's case plan in order to help them remain in housing and reconnect with the community. Mentors visit an hour each week for a minimum of one year.

E. M. Jellinek Center

E. M. Jellinek Center, located at 130 Hinton Avenue, 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. It has a capacity to serve forty-five and the length of stay is six months to one year. There is a $65/week charge for employed residents.

Family Promise of Knoxville

Family Promise of Knoxville operates three programs in collaboration with thirty-nine Knoxville congreagations and organizations to address family homelessness. The *Interfaith Hospitality Network* operates on a weekly rotating basis, four times a year, during which sixteen families are accepted for housing in congregation classroom space that has been converted into temporary housing. The program accepts single parent families, two parent families, expectant

parents, and multi-generational families. Partners help furnish meals and volunteer host families. Case managers help families develop a housing plan and provide community referrals. The *Family Promise Academy* further assists families by teaching life skills, including personal management, socialization skills, home and family management, vehicle safety and maintenance, transportation, budgeting, employment, and education development. Once families identify housing and graduate, they are invited to participate in *Going Home, Staying Home program,* an aftercare program designed to support families in maintaining housing.

Helen Ross McNabb Center

The Helen Ross McNabb Center (HRMC) provides mental health, addiction, and social services in twenty-seven East Tennessee locations, serving adults, children, and families. *HRMC* offers specific programming for individuals experiencing homeless with severe and persistent mental illness. *PATH* and *Children and Youth Homeless Programs* outreach workers engage individuals in mental health treatment, securing housing, obtaining income, and linkage to community resources.

HRMC has developed and maintains safe, affordable housing for individuals with mental illness who can reside independently. Eligibility and additional requirements vary by site; however, general requirements for housing include being homeless, having an Axis I mental health diagnosis, and receiving a regular income source below 50% of the adjusted area median income. All units are monitored by a resident manager. Most units also offer community-based case management to assist residents in maintaining housing. Referrals are accepted from homeless shelters, hospitals, social services, private physicians or therapists, family members, or self-referral. The following is a listing of current permanent supportive housing sites offered by *HRMC* (rent is based on income):

- *Morgan Street Apartments*- two buildings with a capacity of twelve tenants
- *College/Daily/Ginn Homes*- three houses serving nine tenants (shared common areas)
- *The Willows at Third Creek*- a two building complex offering 16 one-bedroom units
- *Maple Grove Apartments*- a family complex offering 8 two-bedroom units to single women and their children
- *New Hope Apartments*- 2 four-bedroom units with a capacity of eight tenants
- *PleasanTree Apartments*- is a two building complex offering a total of 23 two-bedroom units and 1 one-bedroom unit for single women with or without their children.

The *Family Crisis Center* provides shelter to adult and child domestic violence victims. The shelter has a capacity for sixteen individuals with potential for slight expansion to twenty in emergent situations. Services include crisis intervention, housing assistance, victim advocacy, case management, support groups, individual counseling, assistance to female stranded travelers experiencing domestic violence, and transportation. Length of stay is thirty days; however, extended stays are available depending on need. *Transitional Housing* provides a continuum of support beyond the *Family Crisis Shelter* and offers six single family units (3 one-bedroom units and 3 two-bedroom units). Services include case management, victim advocacy, employment support, and financial support for rent, utilities, transportation, and food. Length of stay and access to services is six to twenty-four months.

The Runaway Shelter provides short-term shelter and counseling for runaway and homeless youth, ages twelve to eighteen years, with a capacity for five individuals. Services include

individual, group, family, and crisis counseling. *The Transitional Living Program* provides residential and case management services to homeless or street youth ages sixteen to twenty-one years. The main center has a capacity for five individuals with scattered community-based sites available for additional clients. Services include independent living skills assessment, individual and group counseling, and case management services.

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

Great Starts/New Beginnings Structured Living 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. An on-site nursery is provided to address the complex problems of children born as drug-exposed, HIV positive, developmentally delayed, or medically at-risk. The program's capacity is twenty-two women and thirty-eight children. Treatment services include alcohol and drug support 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 is six months and can be extended based on treatment progress and individual need.

Great Starts/New Beginnings Transitional Housing services sustain recovery and improve the homeless status for women and children as a continuum of support after discharge from treatment settings. This "step down" site contains four units ranging from one-bedroom to three-bedrooms. Aftercare services include on-site case management, housing assistance, support group, crisis intervention, and attendance to community based Alcholics Anonymous or Narcotics Anonymous groups. Resident's children can continue in programs's nursery as a child care resource while the mothers work or attend education and employment programs. Residents pay income-based rent, and the length of stay is twelve to twenty-four months.

Knox Area Rescue Ministries (KARM)

Knox Area Rescue Ministries (KARM), located at 418 North Broadway, provides emergency supportive services for those experiencing homelessness or in need. Emergency shelter services include *Samaritan Place, Hope Haven*, and *Family Emergency Services*. *Samaritan Place* serves 200 men, *Hope Haven* serves 103 women, and Family Emergency Services fourteen single mothers with children with limited case management. In addition, *KARM*'s *Abundant Life Kitchen* provides three meals a day, seven days a week for guests and indigent persons throughtout the community who may have to choose between food and other basic needs. *KARM's Crossroads Welcome Center* serves as the starting point for individuals to connect to KARM services and community resources, with a focus on addressing the causes of their homelessness. In October 2013, *NaNew's Courtyard* was opened, providing a safe and welcoming outdoor space including a secure gated entry, performance stage, concessions area, shaded tables and benches, restrooms, charging stations for wheelchairs and telephones, and luggage storage.

KARM LaunchPoint is an innovative program designed to reignite hope and determine readiness for change. This four-week program helps particpants begin a new life journey, during

which they begin discovering God's purpose for their lives, develop an indivual Life Plan, and learn to implement manageable goals.

The *Men's Transitional Program*, launched in December 2013, provides a structured, supportive "next step" from homelessness to interdependent community living. The program offers a healthy and focused environment for executing the *LaunchPoint* Life Plans, providing the opportunity to engage in a more thoughtful and measured response regarding employment, housing, and other supportive services.

KARM's Jobs Initiatives Team focuses on job placement, coaching, and training programs. Programs include *The Abundant Life Kitchen Food Service Training* program and *Clean Start*, which prepares individuals for employment in the commercial cleaning field. Both of these programs include classroom training and hands-on experience inside *KARM's* operations.

KARM offers long-term residential recovery programs for both women and men. *Serenity Shelter*, located at a confidential site, the has the capacity to serve twenty-five women while providing case management, education, referral, work rehabilitation, alcohol and drug counseling, and other services to assist women in breaking the cycle of domestic violence, substance abuse, and homelessness. *Lazarus Hall* is *KARM's* residential recovery program for men. *Lazarus Hall* is currently being re-formatted and is not accepting applicants at this time. However, *KARM* will assist any man in need of recovery services with a referral to another rescue ministry out of the area. All recovery programs are designed to assess and provide multiple interventions to break the cycle of homelessness.

KARM Thrift Stores operates fifteen stores in Knox County and five surrounding counties, offering a variety of select clothing, household items, and furniture. *Corners Of Your Field* is a partnership through local churches that encourages attendees to be intentional about selecting their gently used household items for donation to *KARM Stores*. The stores then return a portion of the value of these items in the form of gift cards to the church to be used to help those directly in their care.

Knoxville's Community Development Corporation (KCDC)

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 rental assistance towards rent in the private rental market. *Low Income Public Housing* offers help toward rent through a project based rental assistance program.

Knoxville-Knox County Community Action Committee's Homeward Bound

The Knoxville-Knox County Community Action Committee's Homeward Bound programs are specifically designed to provide services to homeless persons. *Homeward Bound*, follows the *Housing First* model, seeking to move people into permanent housing as quickly as possible. *Homeward Bound* programs promote self-sufficiency by offering case management to enable job training, employment and stable housing, family reintegration, life skills training (i.e. employability, budget management, parenting, and anger management), outpatient alcohol and drug treatment, and assertive outreach to people living on the streets. Many of the homeless served by *Homeward Bound* have been banned from subsidized housing due to past criminal offenses, civil violations, or financial obligations. *Homeward Bound* case managers attend appeals to restore eligibility for subsidized housing and have built relationships with private landlords who agree to take "difficult to place" families and individuals when subsidized housing

is not an option. *Homeward Bound* Programs include the *REACH* program that sends a team of workers into the field to offer case management, housing, employment, and other services to the chronically homeless living on the streets, in camps, abandoned buildings, cars, etc. The outreach team (Roosevelt Bethel and Carl Williams) has been in operation since 1995 and has taken the lead in engaging the outside homeless and moving them toward permanent housing. *CAC* also has the *Project Succeed and Families in Need* programs that offer outreach, case management, and supportive services (e.g. housing placement, adult education, budgeting, parenting) to promote self sufficiency for families who are living on the streets, in their cars and in shelters. Other programs include: *CAC's Office on Aging's Project LIVE* program that currently has one case manager who is working to place low income seniors living in hotels, on the streets, or in shelters into permanent housing; and the *CAC Case Management Project* that is addressing the homelessness prevention component 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. Funding from the *Emergency Solutions Grant* provides financial resources to assist clients who are participating in our programs to achieve or regain housing stability.

Knoxville Leadership Foundation

Flenniken Landing is a *KLF Southeastern Housing Foundation* intiative. *Flenniken Landing*, located in South Knoxville, provides forty-eight permanent supportive housing apartments for men and women who have experienced chronic homelessness. Residents have access to on-site support twenty-four hours a day to address all ongoing and emergency needs. Each resident receives on-site case management and service coordination, allowing for the development of an individualized plan aimed at improving their quality of life and reintegration into the community. Through the identification of each individual's needs, service coordinators set measurable goals focused on accessing healthcare, strengthening social support, obtaining stable employment and improving basic life skills. The service coordinator's role is to provide feedback, offer resources and recommend problem-solving skills to help resident's maintain housing and a healthy lifestyle.

Legal Aid of East Tennessee

Legal Aid of East Tennessee provides free legal help on a range of civil legal matters encountered by homeless persons, including consumer issues, family law matters, domestic violence, housing and foreclosure, public housing admissions, public benefits, and other miscellaneous civil matters.

Lost Sheep Ministries

Lost Sheep Ministries has over one hundred volunteers that provide food, worship, music, and clothing for homeless men, women, and families every Wednesday night through the *Under the Bridge Ministry*. *Rehabilitation Support* provides adults and teens with financial and transportation asisstance to enter local and out-of-state rehabilitation programs. *Medical and Dental Services* are provided on-site during the *Under the Bridge Minsitries* via a mobile unit to deliver medical screenings, aid, and dental extractions and cleaning.

The Next Door

The Next Door is a residential transitional living facility for women with substance abuse issues coming out of incarceration or other programs. The *Residential Treatment Program* is a comprehensive, high intensity, and structured inpatient treatment program where clients meet multiple hours each day during week days/nights and have continuous structured yet less intensive programming on weekends. Programming explores the underlying issues of mind, body, and spirit associated with chemical dependency, co-occurring mental illness, and trauma.

Positively Living

Postively Living, located at 1501 East Fifth Avenue, provides case management, alcohol and drug treatment, housing services, and meals. It offers services to persons with HIV/AIDS in Knox and surrounding counties. There is a twenty-four bed capacity for men who were formerly homeless. The agency provides permanent supportive housing for the dually diagnosed mentally ill.

Redeeming Hope Ministries

Redeeming Hope Ministries *(RHM)* is located at 1642 Highland Avenue. *RHM* provides advocacy through *The Amplifier*, a newspaper circulated through street vendors. Vendor positions provide an income source for homeless and formerly homeless individuals. To be eligible one must make an appointment. *Market Day* is offered every first and third Wednesday of the month, during which individuals and families receive grocery assistance. *Lunch* is provided every second and fourth Wednesday of the month. Anyone is welcome at these events with no restrictions. Additionally, *RHM* provides assistance with securing documents, travel, and housing search and placement in partnership with other organizations.

The Salvation Army

The Salvation Army Center, located at 409 North Broadway, operates three residential programs. Residential programs serve individuals facing a complex obstacles, including homelessness, domestic violence, shortage of affordable housing, mental illness, and a lack of family and social support network. *Operation Bootstrap* is a 90-day program that can house up to seventy men experiencing homelessness. The *Transitional Housing* program is a job development program for single homeless individuals (both men and women) who need assistance in finding employment and establishing a savings plan to end the cycle of homelessness. Eighteen slots are designated for single women and forty-eight are designated for men. The *Joy Baker Center* is a twenty-eight bed facility that serves women, with or without children, some of which may be affected by domestic violence. All residents are provided daily meals.

The Salvation Army additionally offers supportive services. The *Career Center* assists homeless individuals with job searches, resume writing, specialized employment training, and job placement to help connect residents to appropriate employment opportunities enabling them to move from being consumers of community resources to becoming contributors. *The Emergency Assistance* program helps prevent homelessness by providing timely help with utilities, food, clothing, and furniture for low-income, families, and individuals.

The Salvation Army operates one family store in Knoxville and three stores in surrounding counties. Clothing and furniture are provided, free of charge, to individuals referred by the

Salvation Army Emergency Assistance Program. All stores stock an array of items including clothing, appliances, and other household items, all for sale to the general public. Proceeds from the thrift stores are used to support the various social services and shelter programs of *The Salvation Army*.

Steps House

Steps House, founded in 1991, is located at 712 Boggs Avenue. It offers a residential program for alcohol and drug recovery. The capacity is 145 with one section designated for veterans (sixty beds) and the other (eighty-five) for indigent males over eighteen. Services include case management and group counseling. The fee for non-veterans is $120/week. There is no limit on length of stay.

Veteran's Administration

The *Veteran's Administration* has the *Veteran's Administration Supportive Housing* (*HUD—VASH) Program* that partners with *HUD* to provide housing vouchers to thirty-five homeless veterans in both Knoxville and Oak Ridge. An outreach worker from the *Veterans Administration Medical Center* in Johnson City is housed at the Vet Center; in addition to linkage with the medical facilities, readjustment counseling is available.

Volunteer Ministry Center

Volunteer Ministry Center, located at 511 North Broadway, provides a variety of social services to assist in overcoming and preventing homelessness. These services are offered in the following four program areas:

The Resource Center is a transitional day program for individuals experiencing homelessness. Based on a modified yet effective strategy of *Housing First* with a client-centered and a case-manager assisted program, participants work towards the achievement of permanent housing as a priority with an appropriate level of pre- and post-housing supportive services. Matched with a case manager, the participant develops a case plan that is mutually prepared and supported. Case managers assist with obtaining birth certificates, social security cards, submitting housing applications, and applying for disability and other mainstream benefits. Operating during the hours of 7 a.m. – 5 p.m. daily, *The Resource Center* offers a variety of amenities to support the transition to housing including but not limited to private shower facilities, laundry access, meals, and numerous life enriching classes. Anger management and alcohol and drug process/education classes are offered for both personal enrichment and overcoming housing barriers. Other classes offered on a weekly, bi-weekly, or monthly rotation are housing options and choices workshop, personal responsibility class, disability legal advice, introduction to computers, the Twelve Steps and spirituality, self esteem, a sheltered workshop experience to define or refine basic employment soft skills, family of origin and self-discovery, basic housekeeping, and social events.

The Bush Family Refuge offers services to individuals at risk of becoming homeless and individuals who are experiencing homelessness. Providing assistance with utility and rent requests, this program also offers access to eye exams and glasses, prescription co-pays and, in some circumstances, full payment on low-cost drugs. *The Bush Family Refuge* is open Monday-Friday during the hours of 9:30 a.m. – Noon and 12:30 p.m.-2:30 p.m.

The VMC Dental Clinic offers dental cleanings, fillings, extractions and a denture clinic through the services of volunteer dental practitioners. Open with limited hours from 8am- Noon

on Tuesdays and Fridays, the *VMC Dental Clinic* serves both individuals experiencing homelessness and the low-income. For eligibility, please contact the clinic.

Minvilla Manor, a permanent supportive housing facility, offers fifty-seven units for former chronically homeless women and men who need moderate support services to maintain housing. *Minvilla Manor* accepts Project Based Vouchers (PBV) issued through Knoxville's Community Development Corporation (KCDC). Case management supportive services are offered in-house during the day and on-call outside of regular office hours. Residents have access to laundry, computer, telephone, and a community room with a television. In coordination with their case plan, residents may participate in the amenities and offerings of the *Resource Center.*

Volunteers of America

Volunteers of America Tennessee (VOA), serves veterans in a twelve county area, including Knox county. Several programs are offered for veterans including *Homeless Veterans Reintegration Program (HVRP)*, *Supportive Services for Veterans and Families (SSVF)*, and the *Homeless Female Veterans and Veterans with Families (HFVVF)* program. Each program provides case management and support to meet housing goals. The *HVRP* program's primary focus is case management to enable employment such as providing clothing, tools, transportations, and referrals. The *SSVF* and *HFVVF* programs primarily work with very low-income veteran families and/or female veterans who reside in or are transitioning to permanency housing by providing intensive case management and assisting participants to obtain VA benefits and other public benefits. Through these programs, the U.S. Department of Veteran Affairs aims to improve the housing stability of veterans experiencing homelessness.

YWCA

The *YWCA* is located at 420 West Clinch Avenue. The *Women's Housing Program* (*WHP*) houses fifty-eight single women up to twenty-four months. Each woman has her own private room while sharing a community life with common bathrooms, showers, living room, full size kitchen, and twenty-four hour staff available seven days a week. There are washers and dryers on site, with health and fitness programs specially designed for the *WHP* women, including a heated pool for water aerobics, open swim, and adult swimming lessons. All this is included with rent. Each resident meets with the *WHP* social worker for *KnoxHMIS* entry, goal planning, and a self-care plan with three month follow ups to check accomplishments. Each woman is required to take a budgeting course, taught in-house by a *WHP* staff member. The move in fee is $140.00, which includes the first and last week with a $20.00 non-refundable deposit and $60.00 per week rent.

Various organizations play active roles in the provision of supportive services and advocacy for those experiencing homelessness and include: *the Department of Housing and Urban Development, the Department of Human Services, Home-based Employment, Inc., Highways and Byways Ministries, Knox County Health Department*, *Knox County Public Library*, *Knox County Schools*, *Mental Health Association of East Tennessee*, *National Alliance of the Mentally Ill*, *National Safe Place*, *Peninsula Behavioral Health*, *Ridgeview*, *Scarecrow Foundation*, *University of Tennessee Law School*, *the Veterans Center*, and *Wings of Hope Ministries*.

References

American Federation of Labor and Congress of Industrial Organizations. (2014). *Minimum Wage*. Retrieved from http://www.aflcio.org/Issues/Jobs-and-Economy/Wages-and-Income/Minimum-Wage

Anti-Discrimination Center of Metro New York. (2005). *Adding insult to injury: Housing discrimination against survivors of domestic violence.* Retrieved from http://www.antibiaslaw.com/sites/default/files/files/DVReport.pdf

Autor, D. H., & Dorn, D. (2013). The growth of low-skill service jobs and the polarization of the U.S. labor market. *The American Economic Review, 103*(5), 1553-1597. http://dx.doi.org/10.1257/aer.103.5.1553

Baker, C. K., Billhardt, K. A., Warren, J. Rollins, C., & Glass, N. E. (2010). Domestic violence, housing instability, and homelessness: A review of housing policies and program practices for meeting the needs of survivors. *Aggression and Violent Behavior, 15*(6), 430-439. http://dx.doi.org/10.1016/j.avb.2010.07.005

Bagget, T. P., Hwang, S. W., O'Connel, J. J., Porneala, B.C., Stringfellow, E. J., Orav, E. J., … Rigotti, N. A. (2013). Mortality among homeless adults in Boston. *JAMA Internal Medicine, 173*(3), 189-195. doi: 10.1001/jamainternmed.2013.1604

Bassuk, E. L., Rubin, L., & Lauriat, A. (1984). Is Homelessness a Mental Health Problem? *American Journal of Psychiatry*, *141*, 1546-50.

Bassuk, E. L., Buckner, J. C., Perloff, J. N., & Bassuk, S. S. (1998). Prevalence of Mental Health and Substance Use Disorders Among Homeless and Low-Income Housed Mothers. *American Journal of Psychiatry, 155*(November), 1561-1564.

Barber, J. G. (1994). Working with resistant drug abusers. *Social Work, 40*(1), 17-23.

Baum, A. S., & Burnes, D. W. (1993). Facing the Facts About Homelessness. *Public Welfare, 51*(2), 20-27.

Bazelon Center for Mental Health Law. (2008) "Individuals with Mental Illness in Jail and Prison." Retrieved November 22, 2008 from http://www.bazelon.org/issues/criminalization/factsheets/criminal3.html.

Brubaker, M. D., Amatea, E. A., Torres-Rivera, E., Miller, M. D., & Nabors, L. (2013). Barriers and supports to substance abuse service use among homeless adults. *Journal of Addictions & Offender Counseling, 34*(2), 81-98. doi: 10.1002/j.2161-1874.2013.00017.x

Buck, J. A. (2011). The looming expansion and transformation of public substance abuse treatment under the Affordable Care Act. *Health Affairs, 30*(8), 1402-1410. doi: 10.1377/hlthaff.2011.0480

Bureau of Labor Statistics. (2013b). *Industries with the fastest growing and most rapidly declining wage and salary employment.* Retrieved from http://www.bls.gov/emp/ep_table_203.htm

Bureau of Labor Statistics. (2013a). *Table 1101- Quintiles of income before taxes: Annual expenditure means, shares, standard errors, and coefficient of variation, Consumer Expenditure Survey, 2012* [Data file]. Retrieved from http://www.bls.gov/cex/2012/combined/quintile.pdf

Bureau of Labor Statistics. (2014). *Labor force statistics from the current population survey.* Retrieved from http://data.bls.gov/timeseries/LNS14000000

Burt, M. (1993). *Over the edge: The growth of homelessness in the 1980s.* New York, NY: Russel Sage.

Burt, M. (2001) "What Will It Take to End Homelessness?" Washington: Urban Institute. Available: http://www.urban.org/publications/310305.htm.

Burt, M., & Cohen, B. E. (1989). *America's homeless: Numbers, characteristics, and the programs that Serve Them.* Washington, D.C.: Urban Press.

Burt, M. R., Aron, L. Y., Douglas, T., Valente, J., Lee, E., & Iwen, B. (1999). *Homelessness: Programs and the people they serve.* Retrieved from http://www.urban.org/UploadedPDF/homelessness.pdf

Burt, M. R., Aron, L. Y., & Valente, J. (2001). *Helping America's homeless: Emergency shelter or affordable housing?* Washington, DC: Urban Institute.

Caton, C. L., Shrout, P. E., Dominguez, B., Eagle, P. F., Opler, L. A., & Cournos, F. (1995). Risk Factors for Homelessness Among Women With Schizophrenia. *American Journal of Public Health*, *85*(8), 1153-1156.

Caton, C. L. M., Dominguez, B., Schanzer, B., Hasin, D. S., Shrout, P. E., Felix, A., … Hsu, E. (2005). Risk factors for long-term homelessness: Findings from a longitudinal study of first-time homeless single adults. *American Journal of Public Health, 95*(10), 1753-1759.

Center on Budget and Policy Priorities. (2013, November 11). *National and state housing data fact sheets.* Retrieved from http://www.cbpp.org/cms/index.cfm?fa=view&id=3586

Children's Defense Fund and National Coalition for the Homeless. (1998). *Welfare to what: Early findings on family hardship and well-being.* Washington, DC: National Coalition for the Homeless.

Cohen, R., Wardrip, K., & Williams, L. (2010). *Rental housing affordability- A review of the current research.* Retrieved from http://www.nhc.org/media/files/RentalHousing.pdf

CoreLogic. (2013, December). *CoreLogic national foreclosure report.* Retrieved from http://www.corelogic.com/research/foreclosure-report/national-foreclosure-report-december-2013.pdf

Corliss, H. L., Goodenow, C. S., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American journal of public health, 101*(9), 1683-1689.

Crook, W. P. (1999). The new sisters of the road: Homeless women and their children. *Journal of Family Social Work, 3*(4), 49-64.

Cummins, L. K., First, R. J., & Toomey, B. G. (1998). Comparisons of rural and urban Homeless Women. *AFFILIA: Journal of Women and Social Work, 13*, 435-453.

[you're missing a reference here to Curtis, Garlington, Schottenfeld (2013)

Deinstitutionalization. (n.d.). In *Merriam-Webster's online dictionary*. Retrieved from http://www.merriam-webster.com/dictionary/deinstitutionalization

DiBlasio, F. A. & Belcher, J. R. (1995). Gender differences among homeless persons: Special services for women. *American Journal of Orthopsychiatry, 65*(1), 131-137.

Dolbeare, C. (1996). Housing policy: A general consideration, in *Homeless in America,* Edited by Jim Baumohl; Washington DC: Oryx Press.

Donohoe, M. (2004). Homelessness in the United States: History, epidemiologu, health issues, women, and public policy. *Medscape ob/gyn & women's health, 9*(2).

Draine, J., Wilson, A. B., Metraux, S., Hadley, T., & Evans, A. C. (2010). The impact of mental illness status on the length of jail detention and the legal mechanism of jail release. *Psychiatric Services, 61*(5), 458-462.

Dworsky, A., Napolitano, L., & Courtney, M. (2013). Homelessness during the transition from foster care to adulthood. *American Journal of Public Health, 103*(S2), S318-S323. Doi: 10.2105/AJPH.2013.301455

Edens, E. L., Mares, A. S., & Rosenheck, R. A. (2011). Chronically homeless women report high rates of substance use problems equivalent to chronically homeless men. *Women's Health Issues, 21*(5), 383-389. http://dx.doi.org/10.1016/j.whi.2011.03.004

Fazel, S. & Seewald, K. (2012). Severe mental illness in 33,588 prisoners worldwide: systematic review and meta-regression analysis. *The British Journal of Psychiatry, 200*, 364-

Ferguson, K. M., Bender, K., Thompson, S. J., Maccio, E. M., & Pollio, D. (2012). Employment status and income generation among homeless young adults: Results from a five-city, mixed-methods study. *Youth & Society, 44*(3), 385-407. doi: 10.1177/0044118X11402851

Forchuk, C., Montgomery, P., Berman, H., Ward-Griffin, C., Csiernik, R., Gorlick, C., … Riesterer, P. (2010). Gaining ground, losing ground: The paradoxes of rural homelessness. *Canadian Journal of Nursing Research, 42*(2), 138-152.

Forchuk, C., Russell, G., Kingston-MacClure, S., Turner, K., & Dill, S. (2006). From psychiatric ward to the streets and shelters. *Journal of Psychiatric and Mental Health Nursing, 13*, 301-308.

Gamache, G., Rosenheck, R., & Tessler, R. (2003). Overrepresentation of women veterans among homeless women. *American Journal of Public Health, 93*(7), 1132-1136.

Greenberg, G. A. & Rosenheck, R. A. (2008a). Jail incarceration, homelessness, and mental health: A national study. *Psychiatric Services, 59*(2), 170-177. doi: 10.1176/appi.ps.59.2.170

Greenberg, G. A. & Rosenheck, R. A. (2008b). Homelessness in the state and federal prison population. *Criminal Behavior and Mental Health, 18*(2), 88-103. doi: 10.1002/cbm.685.

Goodfellow, M. (1999). Rural Homeless Shelters: A Comparative Analysis. *Journal of Social Distress and the Homeless, 8*, 21-35.

Goodman, L., Saxe, L., & Harvey, M. (1991). Homelessness as psychological trauma: Broadening perspectives. *American Psychologist, 46*(11), 1219-1225.

Hartwell, S. (2004). Triple stigma: Persons with mental illness and substance abuse problems in the criminal justice system. *Criminal Justice Policy Review, 15*(1), 84-99. doi: 10.1177/0887403403255064

Henry, M., Cortes, A., & Morris, S. (2013). *The 2013 annual homeless assessment report (AHAR) to Congress: Point-in-time estimates of homelessness.* Retrieved from https://www.onecpd.info/resources/documents/AHAR-2013-Part1.pdf

Hoback, A. & Anderson, S. (2006). *Proposed method for estimating local populations of precariously housed.* National Coalition for the Homeless. Retreieved from http://www.nationalhomeless.org/publications/precariouslyhoused/Hobackreport.pdf

Hombs, M. E. & Snyder, M. (1983). *Homelessness in America: A forced march to nowhere.* Washington, D. C.: Community for Creative Nonviolence.

Homeless Emergency Assistance and Rapid Transition to Housing Act. (2009). Public Law No. 111-22.

Howard, L. M., Feder, G., & Agnew-Davies, R. (2013). *Domestic violence & mental health.* London: RCPsych Publications.

Institute for Children, Poverty, & Homelessness. (2012). *Intergenerational disparities experienced by homeless black families.* Retrieved from http://www.icphusa.org/filelibrary/ICPH_Homeless%20Black%20Families.pdf

Institute for Children, Poverty, & Homelessness. (2014). *A home by any other name: Enhancing shelters addresses the gap in low-income housing.* Retrieved from http://www.icphusa.org/filelibrary/ICPH_PolicyBrief_AHomeByAnyOtherName.pdf

James, D. J. & Glaze, L. E. (2006). Mental health problems of prison and jail inmates. *Bureau of Justice Statistics Special Report*. Retrieved from http://www.bjs.gov/content/pub/pdf/mhppji.pdf

Jencks, C. (1994). *The Homeless.* Cambridge, MA: Harvard University Press.

Ji, E. (2006). A study of the structural risk factors of homelessness in 52 metropolitan areas in the United States. *International social work, 49*(1), 107-117. doi: 10.1177/0020872806059407

Johnson, T. P., Freels, S. A., Parsons, J. A., & Vangeest, J. B. (1997). Substance abuse and homelessness: Social selection or social adaptation? *Addiction, 92*(4), 437-445.

Johnson, R., Rew, L., Sternglanz, R., & Weylin, R. (2006). The relationship between childhood sexual abuse and sexual health practices of homeless adolescents. *Adolescence, 41*(162), 221-234.

Joint Center for Housing Studies of Harvard University. (2013). *America's rental housing: Meeting challenges, building on opportunities.* Retrieved from: http://www.jchs.harvard.edu/sites/jchs.harvard.edu/files/jchs_americas_rental_housing_2013_1_0.pdf

Keeshin, R. & Campbell, K. (2011). Screening homeless youth for histories of abuse: Prevalence, enduring effects and interest in treatment. *Child abuse and neglect, 35* (6). http://dx.doi.org/10.1016/j.chiabu.2011.01.015

Kessler R.C., Chiu W.T., Demler O., & Walters E.E. (2005). Prevalence, Severity, and Comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry,* Jun; *62*(6), 617-27.

Khadduri, J. & Culhane, D. (2010). "The 2010 Annual Homeless Assessment Report to Congress." Retrieved from *U.S. Department of Housing and Urban Development Office of Community Planning and Development.* http://www.huduser.org. publications/pdf/ahar.pdf

Khadduri, J.; Culhane, D.; Holin, M.; Buron, L.; Cortes, A., & Poulin, S. (2007). "The First Annual Homeless Assessment Report to Congress. Retrieved from *U.S. Department of Housing and Urban Development Office of Community Planning and Development.* http://www.huduser.org. publications/pdf/ahar.pdf

Kilty, K. M. & Segal, E. A. (2006). *The promise of welfare reform: Political rhetoric and the reality of poverty in the twenty-first century*. Binghampton, NY: Haworth Press

Kingree, J. B., Stephens, T., Braithwaite, R., & Griffin, J. (1999). Predictors of homelessness among participants in a substance abuse treatment program. *American Journal of Orthopsychiatry, 69*(2), 261-266.

Kort-Butler, L. A., Tyler, K. A., & Melander, L. A. (2011). Childhood maltreatment, parental monitoring, and self-control among homeless young adults: Consequences for negative social outcomes. *Criminal Justice and Behaior, 38*(12), 1244-1264. doi: 10.1177/0093854811423480

Koyanagi, C. (2007). *Learning from history: Deinstitutionalization of people with mental illness as precursor to long-term care reform.* Retrieved from http://www.nami.org/Template.cfm?Section=About_the_Issue&Template=/ContentManagement/ContentDisplay.cfm&ContentID=137545

Knoxville Coalition for the Homeless. (1986). Homelessness in Knox County. Knoxville, Tennessee.

Knoxville's Plan to End Homelessness. (2014). Retrieved from http://www.cityofknoxville.org/development/homelessnessplandraft2014.pdf

Koegel, P., Melamid, E., & Burnam, M. A. (1995). Childhood risk factors for homelessness among homeless adults. *American Journal of Public Health, 85*(12), 1642-1649.

Kozol, J. (1988). A reporter at large: The homeless and their children. *The New Yorker*. January, 65-84.

Lake, H. (2012, June 29). Lakeshore mental health institute in Knoxville closes its doors for good. *WBIR*. Retrieved from http://archive.wbir.com/rss/article/224962/2/Lakeshore-Mental-Health-Institute-in-Knoxville-closes-its-doors-for-good

Lamb, H. R. (1984). Deinstitutionalization and the homeless mentally ill. *Hospital & Community Psychiatry, 35*(9), 899-907.

Lamb, H. R. & Lamb. D. M. (1990). Factors contributing to homelessness among the chronically and severally mentally ill. *Psychiatric Services, 49*(1), 483-492.

Lamb, H. R. & Weinberger, L. E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatric Services*, *9,* 483-492.

Lamb, H. R. & Weinberger, L. E. (2011). Meeting the needs of those persons with serious mental illness who are most likely to become criminalized. *The Journal of the American Academy of Psychiatry and the Law, 39*(4), 549-554.

Lee, B. A., Price-Spratlen, T., & Kanan, J. W. (2003). Determinants of Homelessness in Metropolitan Areas. *Journal of Urban Affairs*, *25*(3), 335.

Link, B. G., Susser, E., Stueve, A., Phelan, J., Moore, R. E., & Struening, E. (1994). Lifetime and Five-Year Prevalence of Homelessness in the United States." *American Journal of Public Health*, *84*(12), 1907 - 1912.

McChesney, K.Y. (1995). A Review of the Empirical Literature on Contemporary Urban Homeless Families. *Social Service Review,* (September) 429-460.

McGovern, M. P, Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: An assessment of programs caross multiple state systems. *Administration and Policy in Mental Health, 41*, 205-214. doi: 10.1007/s10488-012-0449-1

McMahon, S. & Horning, J. (2013). *Living below the line: economic insecurity and America's families*. Washington, DC: Wider Opportinities for Women. Retrieved from http://www.wowonline.org/wp-content/uploads/2013/09/Living-Below-the-Line-Economic-Insecurity-and-Americas-Families-Fall-2013.pdf

McNiel, D. E., Binder, R. L., & Robinson, J. C. (2005). Incarceration associated with homelessness, mental disorder, and co-occurring substance abuse. *Psychiatric Services, 56*(7), 840-846. doi: 10.1176/appi.ps.56.7.840

McQuistion, H. L., Gorroochurn, P., Hsu, E., & Caton, C. L. M. (2013). Risk factors associated with recurrent homelessness after a first homeless episode. *Community Mental Health Journal.* doi: 10.1007/s10597-013-9608-4

Miles, B. & Fowler, P. (2006). Changing the face of homelessness: Welfare reform's impact on homeless families. In K. Kilty & E. Segal (Eds.), *The promise of welfare reform: Political rhetoric and the reality of poverty in the twenty-first century*. Binghamton, NY: Haworth Press

Miller, P., Donahue, P., Este, D., & Hofer, M. (2004). Experiences of Being Homeless or at Risk of Being Homeless Among Canadian Youths. *Adolescence, 39*(156), 735-755.

Mishel, L. (2013, February 21). Declining value of the federal minimum wage is a major factor driving inequality. *Economic Policy Institute.* Retrieved from http://www.epi.org/publication/declining-federal-minimum-wage-inequality/

Mishel, L. & Finio, N. (2013, January 23). Earnings of the top 1.0 percent rebound strongly in the recovery. *Economic Policy Institute.* Retrieved from http://www.epi.org/publication/ib347-earnings-top-one-percent-rebound-strongly/

National Alliance to End Homelessness. (2013a). *State of homelessness in America 2013*. Retrieved from http://www.endhomelessness.org/library/entry/the-state-of-homelessness-2013

National Alliance to End Homelessness. (2013b). *Alliance online news: Government reopens, debt ceiling deadline pushed back.* Retrieved from http://www.endhomelessness.org/library/entry/government-reopens-debt-ceiling-deadline-pushed-back

National Alliance to End Homelessness. (2013c). *Sequestration.* Retrieved from http://www.endhomelessness.org/pages/sequestration

National Center for Law and Economic Justice. (2013). Poverty in the United States: A snapshot. Retrieved from http://www.nclej.org/poverty-in-the-us.php

National Coalition for the Homeless. (2007). *Addiction Disorders and Homelessness.* Retrieved from http://www.nationalhomeless.org/publications/facts/addiction.pdf

National Coalition for the Homeless. (2008, April 15). *Foreclosure to homelessness: the forgotten victims of the subprime crisis.* Retrieved from http://www.nationalhomeless.org/publications/foreclosure/foreclosure_report.pdf

National Coalition for the Homeless. (2009a). *Why are people homeless?* Retrieved from http://www.nationalhomeless.org/factsheets/Why.pdf

National Coalition for the Homeless. (2009b). Domestic violence and homelessness. Retrieved from http://www.nationalhomeless.org/factsheets/domestic.html

Health Care for the Homeless Clinician's Network. (1999). Trauma & homelessness. *Healing hands, 3*(3). Retrieved from http://www.nhchc.org/wp-content/uploads/2012/02/hh.04_99.pdf

National Health Care for the Homeless Council. (2000). Mental illness and chronic homelessness: An American disgrace. *Healing Hands*, *4*(5). Retrieved from http://www.nhchc.org/wp-content/uploads/2012/03/Oct2000HealingHands.pdf

National Law Center on Homelessness and Poverty. (2011). "*Simply unacceptable": Homeless and the human right to housing in the United States.* Washington, DC: NLCHC

National Low Income Housing Coalition. (2013). America's affordable housing shortage, and how to end it. *Housing Spotlight, 3*(2), 1-6.

New York Times Editorial Board. (2013, June 22). Extreme budget cuts of 2014. *The New York Times.* Retrieved from http://www.nytimes.com/2013/06/23/opinion/sunday/extreme-budget-cuts-of-2014.html?_r=0

Nooe, R. M. & Cunningham, M. L. (1990). *Homelessness in Knox County: Revisited.* Knoxville, TN: Coalition for the Homeless.

Nooe, R. M. & Cunningham, M. L. (1992) Rural dimensions of homelessness: A rural-urban comparison. *Human Services in the Rural Environment, 15,* 5-9.

Nooe, R. M. & Lynch, M. (1988a). *Homelessness in Knoxville.* Knoxville, TN: Knoxville Community Action Committee

Nooe, R. M. & Lynch, M. (1988b). *Homelessness reexamined: A two-year follow-up of homelessness in Knoxville.* Knoxville, TN: Knoxville Coalition for the Homeless.

Norris, J., Scott, R., Speiglman, R., & Green, R. (2003). Homelessness, hunger and material hardship among those who lost SSI. *Contemporary Drug Programs, 30,* 241-273.

North, C. S. & Smith, E. M. (1994). Comparison of white and nonwhite homeless men and women. *Social Work, 39*(6), 639-647.

Nyamathi, A., Longshore, D., Keenan, C., Lesser, J., & Leake, B. D. (2001). Childhood Predictors of Daily Substance Abuse Use in Women of Different Ethnicities. *American Behavioral Science, 45*(1), 35-50.

Olivet, J., Paquette, K., Hanson, J. & Bassuk, E. (2010). The future of homeless services: An introduction. *The Open Health Services and Policy Journal, 3*, 30-33.

O'Keefe, E. (2014, January 8). Farm bill talks nearing conclusion with about $9 billion in food stamp cuts. *The Washington Post.* Retrieved from http://www.washingtonpost.com/politics/farm-bill-talks-nearing-conclusion-with-little-concern-for-food-stamp-cuts/2014/01/08/26b5a2aa-786f-11e3-b1c5-739e63e9c9a7_story.html

Pecora, P. J., Kessler, R. C., Williams, J., O'Brien, K., Downs, A. C., English, D., … & Holmes, K. (2005). *Improving family foster care: Findings from the Northwest Foster*

Care Alumni Survey. Retrieved from http://www.casey.org/Resources/Publications/pdf/ImprovingFamilyFosterCare_FR.pdf

Perl, L. (2013). *Veterans and Homelessness.* Washington, D.C.: Congressional Research Service.

Quigley, J. M. & Raphael, L. S. (2001). The economics of homelessness: The evidence from North America. *European Journal of Housing Policy, 1*(3), 323-336. doi: 10.1080/14616710110091525

Rice, D. (2013). *Sequestration could cut housing vouchers for as many as 185,000 low-income families by the end of 2014: Families using vouchers may also face rising rents, fewer housing options*. Washington, DC: Center on Budget and Policy Priorities.

Rog, D. J. & Buckner, J. C. (2007). Homeless families and children. *National Symposium on Homeless Research.* Retrieved from http://www.huduser.org/publications/pdf/p5.pdf

Roman, N. P. & Wolfe, P. B. (1997). The relationship between foster care and homelessness. *Public Welfare, 55*, 4-9.

Rosenheck, R. & Fontana, A. (1994). A model of homelessness among male veterans of the Vietnam War generation. *American Journal of Psychaitry, 151*(3), 421-427.

Rosenheck, R., Kasprow, W., Frisman, L., & Liu-Mares, W. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. *Archives of General Psychiatry, 60*(9), 940-951.

Rossi, P. H. (1989). *Down and Out in America*. Chicago, IL: University of Chicago Press.

Schmidt, L. M., Hesse, M., & Lykke, J. (2011). The impact of substance use disorders on the course of schizophrenia- A 15-year follow-up study: Dual diagnosis over 15 years. *Schizophrenia Research, 130*(1-3), 228-233. http://dx.doi.org/10.1016/j.schres.2011.04.011

Sermons, M. W., & Witte, P. (2011). *State of homelessness in America*. Retrieved from http://b.3cdn.net/naeh/4813d7680e4580020f_ky2m6ocx1.pdf

Shannon, C. (2013, October 31). Former mental hospital leaves mark on Knoxville community. *The Daily Beacon*. Retrieved from http://utdailybeacon.com/news/2013/oct/31/former-mental-hospital-leaves-mark-knoxville-commu/

Shelton, K., Taylor, P., Bonner, A., & van den Bree, M. (2009). Risk factors for homelessness: Evidence from a population-based study. *Psychiatric Services, 60* (4).

Shier, M. L., Jones, M. E., & Graham, J. R. (2012). Employment difficulties experienced by employed homeless people: Labor market factors that contribute to and maintain homelessness. *Journal of Poverty, 16*, 27-47. doi: 10.1080/10875549.2012.640522

Silvers, J. B. (2013). The Affordable Care Act: Objectives and likely results in an imperfect world. *The Annals of Family Medicine, 11*(5), 402-405. doi: 10.1370/afm.1567

Skaggs, S. & Bridges, J. (2013). Race and sex discrimination in the employment process. *Sociology Compass, 7*(5), 404-415. doi: 10.1111/soc4.12037

Snow, D. A, Baker, S. G., Anderson, L., & Martin, M. (1986). The myth of pervasive mental illness among the homeless. *Social Problems, 33*(5), 407-423. doi: 10.2307/800659

Solari, C. D., Cortes, A., & Brown, S. (2013). The 2010 Annual Homeless Assessment Report to Congress: Volume II. Retrieved from *U.S. Department of Housing and Urban Development Office of Community Planning and Development.* https://www.onecpd.info/resources/documents/2012-AHAR-Volume-2.pdf.

Solomon, P. & Draine, J. (1995). Issues in serving the forensic client. *Social Work,* 40(1), 25-33.

Sosin, M. R. (2003). Explaining adult homelessness in the US by stratification or situation. *Journal of community & applied social psychology, 13*, 91-104. doi: 10.1002/casp.716

Spangler, B., Nooe, R. M., & Patterson, D. A. (2012). *Homelessness in Knoxville and Knox County, Tennessee 2011-2012.* Retrieved from: http://www.cityofknoxville.org/Homelessness2012.pdf

Steadman, H. J., Osher, F. C., Robbins, P. C., Case, B., & Samuela, S. (2009). Prevalence of serious mental illness among jail inmates. *Psychiatric services, 60*(6), doi: 10.1176/appi.ps.60.6.761

Stewart B. McKinney, Homeless Assistance Act. (1997). Public Law No. 100-77, codified at 42 U.S.C. 11301-11472.

Straw, R. B. (1995). Looking Behind the Numbers in Counting the Homeless; An Invited Commentary. *American Journal of Orthopsychiatry, 65*(3), 330-333.

Sullivan, G., Burnam, A., & Koegel, P. (2000). Pathways to homelessness among the mentally ill. *Social psychiatry and psychiatric epidemiology, 35*, 444-450.

Susser, E., Valencia, E., Conover, S., Felix, A., Tsai, W. Y., & Wyatt, R. J. (1997). Preventing recurrent homelessness among mentally ill men: A 'critical time' intervention after discharge from a shelter. *American Journal of Public Health, 87*, 256-262.

Tam, T. W., Zlotnick, C., & Robertson, M. J. (2003). Longitudinal perspective: Adverse Childhood Events, Substance Use, and Labor Force Participation Among Homeless Adults. *American Journal of Drug and Alcohol Abuse, 29*(4), 829-846.

Thompson, R. G., Wall, M. W., Greenstein, E., Grant, B. F., & Hasin, D. S. (2013). Substance-use disorders and poverty as prospective predictors of first-time homelessness in the United States. *American Journal of Public Health, 103*(S2), S282-S288. doi: 10.2105/AJPH.2013.301302

Toro, P. A., Bellavia, C. W., Daeschler, C. V., Owens, B. J., Wall, D. D., Passero, J. M., & Thomas, D. M. (1995). Distinguishing homelessness from poverty: A comparative study. *Journal of Consulting and Clinical Psychology, 63*(2), 280-289.

Toro, P. A., Tompsett, C. J., Lombardo, S., Philippot, P., Nachtergael, H., Galand, B., … Harvey, K. (2007). Homelessness in Europe and the United States: A comparison of prevalence and public opinion. *Journal of Social Issues, 63,* 505-524. doi: 10.1111/j.1540-4560.2007.00521.x

Timmer, D., Eitzen, D., & Talley, K. (1994). *Paths to homelessness: Extreme poverty and the urban housing crisis.* Boulder, CO: Westview Press.

Tyler, K. A. & Melander, L. A. (2010). Foster care placement, poor parenting and negative outcomes among homeless young adults. *Journal of Child and Family Studies, 19*, 787.

United States Census Bureau. (n.d.). *1990 Overview*. Retrieved from http://www.census.gov/history/www/through_the_decades/overview/1990.html

United States Census Bureau. (2012). *American community survey*: *Social characteristics in the United States.* Retrieved from http://www.factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk

United States Conference of Mayors. (2013). *Hunger and homelessness survey.* Retrieved from http://www.usmayors.org/pressreleases/uploads/2013/1210-report-HH.pdf

United States Department of Health and Human Services. (2013, March 8). *15th Annual tribal budget and policy consultation: Executive summary*. Retrieved from http://www.hhs.gov/iea/tribal/docs/15th_annual_tribal_summary.pdf

United States Department of Housing and Urban Development. (1984). *A Report to the Secretary on the Homeless and Emergency Shelters.* Washington D. C.: Office of Policy Development and Research.

United States Department of Housing and Urban Development. (2014a). *HUD's 2013 continuum of care homeless assistance programs: Homeless populations and*

subpopulations. Retrieved from https://www.onecpd.info/reports/CoC_PopSub_NatlTerrDC_2013.pdf

United States Department of Housing and Urban Development. (2014b). Community development block grant program. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/community development/programs

United States Department of Housing and Urban Development. (2014c). HOME investment partnerships program. Retrieved from http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/affordablehousing/programs/home/

United States Department of Housing and Urban Development. (2014d). 2007-2013 PIT Counts by CoC. Retrieved from https://www.onecpd.info/resource/3031/pit-and-hic-data-since-2007/

U. S. Equal Employment Opportunity Commission. (2013, January 28). *EEOC Reports nearly 100,000 job bias charges in fiscal year 2012*. Retrieved from http://www.eeoc.gov/eeoc/newsroom/release/1-28-13.cfm

United States Interagency Council on the Homeless. (1992). *Implementation of Actions for the Federal Plan to Help End Homelessness.* Washington, DC: Interagency Council on the Homeless.

United States Interagency Council on the Homeless. (1994). *Priority: Home! the federal plan to break the cycle of homelessness.* Washington, DC: Interagency Council on the Homeless.

United States Interagency Council on the Homeless. (2013). *The Affordable Care Act's role in preventing and ending homelessness.* Retrieved from http://usich.gov/resources/uploads/asset_library/FactSheet_ACA_Homelessness_09_11_2013.pdf

United States Office of Management and Budget. (2013). *Impacts and costs of the October 2013 federal government shutdown.* Retrieved from http://www.whitehouse.gov/sites/default/files/omb/reports/impacts-and-costs-of-october-2013-federal-government-shutdown-report.pdf

Vaughn, M. G., Ollie, M. T., McMillen, J. C., Scott, L., Jr., & Munson, M. (2007). Substance use and abuse among older youth in foster care. *Addictive Behaviors, 32*(9), 1929-1935. http://dx.doi.org/10.1016/j.addbeh.2006.12.012

Wagner, J. K. & Perrine, R. M. (1994). Women at risk for homelessness: Comparison between housed and homeless women. *Psychological Reports, 75,* 1671-1678.

Wong, Y.-L., Culhane, D.P., and Kuhn, R. (1997) Predictors of Exit and Reentry Among Family Shelter Users in New York City. *Social Service Review* (September) 441-462.

Wright, B. R. E., Caspi, A., Moffitt, T. E., & Silva, P. A. (1998). Factors associated with doubled-up housing: A common precursor to homelessness. *Social Service Review, 72*(1), 92-111.

Wright, J.D., & Devine, J.A. (1995). Housing Dynamics of the Homeless: Implications for a Count. *American Journal of Orthopsychiatry, 65*, 320-329.