



Homelessness in Knoxville and Knox County, Tennessee 2015-2016:

2016 Biennial Study,
Knoxville-Knox County Homless Coalition

2015 Annual Report,
Knoxville Homeless Management Information System

Acknowledgements



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2016 Biennial Study,
Knoxville-Knox County Homeless Coalition

2016 Biennial Study, Knoxville-Knox County Homeless Coalition (KKCHC)

“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

Note to the Reader

In November 1985, Knoxville Mayor, Kyle Testerman, and Knox County Executive, Dwight Kessell, appointed 25 members to Study the extent of homelessness in the city, as well as make recommendations for services. In February of 1986, Knoxville’s first comprehensive Study on homelessness was conducted. This group began meeting monthly to discuss emerging trends, develop standards of care and practice to effectively and aggressively work with and for the homeless population, and, ultimately, to create an infrastructure in Knoxville that would evolve into a movement focused on getting the homeless into housing. The group, now the Knoxville/Knox County Homeless Coalition, has conducted the Study biennially since, making this the 30th year and the 16th Study on homelessness in Knoxville.

Each Study is a phenomenal effort requiring a vast amount of resources, volunteers, and hours. In the 2016 Study, 53 volunteers interviewed 249 homeless individuals in various shelters, day rooms, and homeless camps. Each interview lasted an average of twenty minutes; in sum, approximately 83 hours of interviews were collected. After the information was gathered, hours of work were devoted to assimilating, digesting, and crafting the information into the document you are now viewing. I have not mentioned the work it took to plan the event, create the questionnaire, and schedule times and places for interviews. 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 acknowledgment. That said, I would like to give a special “thanks” to the agencies that allowed us space, the 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, Director of Social Services at the Knox County Public Defender’s Community Law Office, and Chair of the first Coalition in 1985 has been as integral in this year’s Study as he has been in each of the preceding studies. In the 2016 Study, we have once again asked the Knoxville Homeless Management Information System (KnoxHMIS) to strengthen our understanding of homelessness using the data retrieved from homeless service providers in Knoxville. While there are many in the KnoxHMIS office that have offered their support, Lisa Higginbotham, Program Manager, 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.

Finally, I would like to thank Mark Stephens, District Public Defender, and the staff of the Knox County Public Defender's Community Law Office. Mr. Stephens and his staff allowed us space to train interviewers, a place to gather and plan, and volunteer support for the event. Mark and his staff have been very gracious with their time and resources in this and several previous studies. Their passion and interest regarding the various issues surrounding homelessness is evident and appreciated.

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.

Please receive this 2016 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

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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, which excludes those that are “*couch homeless*” (i.e. living with friends or relatives in temporary arrangements). Likewise, persons living in single room occupancy hotels (SROs) and in substandard housing, while extremely vulnerable to homelessness, are also generally not included.

Further, the methods used in reporting individuals experiencing homelessness is a major issue and limits who is included in homeless counts. A 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, period-prevalence counts do exceed point-prevalence counts to illustrate a larger picture of homelessness over-time (Quigley & Raphael, 2001). Consequently, both point-prevalence and period-prevalence counts typically do not include persons that refuse interviews, deny homeless status, do not access service providers, experience short or intermittent episodes of homelessness, or live in more hidden areas (i.e. rural areas, remote camping, squatting in condemned buildings/private property, train stations, personal vehicles, etc.).

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, employment, and personal disabilities. The most widely utilized definition that has emerged is found in the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 (Public Law 111-22, S.896). The act defines homelessness as including individuals or families,

- (1) who lack a fixed, regular, and adequate nighttime residence;
- (2) who seek nighttime accommodations in a public or private place not meant for habitation including parks, abandoned buildings, car, vacant lot, bus or train station
- (3) who live in an emergency or transitional shelter designated to provide temporary living arrangements (including hotel/motel paid for with federal, state, local voucher, charitable organizations)
- (4) who are losing their housing in 14 days and lack support networks or resources to obtain housing;
- (5) who have experienced a long-term period without living independently in permanent housing, have experienced persistent instability as measured by frequent moves over such period, and can be expected to continue in such status for an extended period of time because of disability or other barriers; and
- 6) people who are fleeing as victims of domestic violence and sexual assault. (Civic Impulse, 2016a)

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

Additionally, one should consider different patterns of homelessness (i.e. situational, episodic, and chronic) when determining 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 single room occupancy unit (i.e. a form of housing in which one or two people are housed in individual rooms) for 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 severe mental illness and/or substance use (Nooe & Cunningham, 1990). 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. These different patterns offer some explanation for differences in enumeration and also public perceptions of homelessness.

In sum, reports have been consistent in recognizing that the homeless population is not static and that factors contributing to homelessness are complex and multifarious. Identifying and securing permanent housing can be complicated by demographics, personal characteristics, and circumstance (i.e. childhood experiences, family history, health, and legal history).

Contributing Factors

In a sense, homelessness represents the "*poorest of the poor*". 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, 2009).

There are fewer places for people with low income to rent. One eighth of the nation's supply of low-income housing has been lost since 2001 (National Law Center on Homelessness and Poverty, 2014). HUD's budget decrease by over 50 percent resulted in the loss of 10,000 units of subsidized low-income housing. In addition, foreclosure of over 5 million homes has occurred since 2008 or one out of every ten homes with a mortgage. Cohen, Wardrip, & Williams explained that during the past decade, 200,000 low rent units were not rehabbed and lost to demolition, thus resulting in fewer housing options for low-income families (2010). Gentrification, whereby high-income households migrate into low-income neighborhoods, has affected affordable housing stock and access for persons with low-income. Neighborhoods undergoing gentrification can bring new housing investment, increased businesses (such as restaurants, retail, galleries, etc.), and improvements in infrastructure; however, both higher rents and housing values accompany these changes, in turn displacing people from these neighborhoods. In the clamor for development of private sector housing, low-income housing is often overlooked.

Families near the poverty line spend approximately half of their monthly income on rent (Quigley, 2014b). It is estimated that over 10 million American households spend fifty or more percent of their income for housing (Center on Budget and Policy Priorities, 2013), forcing households to choose between housing and meeting other basic needs such as food or healthcare (McMahon & Horning, 2013), increasing the risk of homelessness.

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 these jobs do not provide adequate wages and benefits for self-sufficiency. Many of the jobs held by homeless persons are part-time, temporary, or do not provide sufficient wages for self-sufficiency. Securing or maintaining housing on minimum wage or in part-time jobs is extremely difficult. Specifically, the value of the minimum wage has not kept up with inflation.

Many people are homeless because they cannot afford rent. Most minimum wage workers cannot meet a “housing wage” to sustain housing-- that is the amount a person working full-time must earn to afford the fair-market rent on a two-bedroom unit without paying more than 30 percent of his or her income in rent. In Knoxville, a renter earning the Federal minimum wage of \$7.25 per hour would need to work 86 hours per week to afford a one-bedroom rent at the fair market rent of \$628 per month and 107 hours per week to afford a two-bedroom fair market rent of \$774 per month (National Low Income Housing Coalition, 2015). For many minimum wage earners, stable housing is out of reach. The National Low Income Housing Coalition estimates that in 2016 that the housing wage is \$14.88 an hour to rent a two bedroom unit in Knoxville, TN, exceeding the \$11.85 hourly wage earned by the average Knoxville renter by \$3.03 an hour, and greatly exceeding the wages earned by low-income renter households (\$377 a month). Although the cost of living in Knoxville is 11% lower than the national average (Knoxville Chamber of Commerce, 2014), the availability of affordable housing is a barrier to maintaining permanent housing for many low-income people.

The need for increased, affordable, permanent housing is evident. Locally, the need for affordable housing is recognized in the Knoxville *Plan to Address Homelessness*. *The Plan* includes the goal of creating and maintaining access to a variety of decent, appropriate, and affordable permanent housing for Knoxville’s homeless. *The Plan* additionally recognizes the need for comprehensive, supportive services to maintain persons in housing is underscored by the Biennial 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, 2014).

Supportive services for those on the poverty line are dwindling. The decline in public assistance is related to an increase in poverty, which simultaneously contributes to homelessness. With stricter guidelines from the 1996 enactment of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA, P.L. 104-193) (Civic Impulse, 2016b), many low-income families lost much needed benefits. Resources available prior to PRWORA (such as AFDC) had been important in preventing homelessness, but more exclusionary [PRWORA] guidelines increased vulnerability to homelessness (Institute for Children, Poverty, & Homelessness, 2012). PRWORA repealed the AFDC program and replaced it with a block grant program called *Temporary Assistance to Needy Families* (TANF). The National Homeless Coalition emphasizes that most states have not replaced the old welfare system with a working, successful alternative that enables families and individuals to obtain above-poverty employment and to sustain themselves when work is not available or possible (National Coalition for the Homeless, 2008). Although changes in policy have major implications, the effects have not been fully assessed.

While there is a case for structural or external factors such as lack of affordable housing, income, access to supplemental support benefits, and policy implications (U.S. Conference of Mayors, 2013; Quigley & Raphael, 2001a; Sosin, 2003; Lee, Price-Spratlen, & Kanan, 2003), 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; Sosin, 2003; Corliss, Goodenow, & Austin, 2011; Shelton, Taylor, Bonner, & Van den Bree, 2009; Donohoe, 2004; Sullivan, Burnam, & Koegel, 2000;), which vary across those experiencing homelessness. 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...

In sum, the reasons behind homelessness are complex and multiple factors are usually interacting concurrently. In order to understand the causes and experiences associated with homelessness, one should consider risk factors such as: (1) personal risk factors (2) family characteristics, (3) personal crisis, (4) vulnerability, (5) income, (6) legal history, and (7) health (including mental illness and substance abuse). The foregoing Biennial Study sheds light on these risk factors.

Design

Since its formation in November of 1985, the Knoxville-Knox County Homeless Coalition (KKCHC) 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, 2012, and 2014). The *Coalition* sponsored a small Study in July 1987 examining the duration of homelessness. The Knoxville-Knox Community Action Committee (CAC) sponsored a survey in May 1988 as part of a statewide Study; the state effort was not published.

The current Study was conducted in January of 2016. 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 KnoxHMIS data were used. In 2016, the shelter interview locations included *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, The Bridge, Overnight, and Serenity), The Salvation Army (Joy Baker Center, Operation Bootstrap, and Transitional Housing), Steps House, and the YWCA Keys of Hope 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 thirty 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, 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. In 2012, questions were added about technology use among persons experiencing homelessness. Questionnaires used in all studies contained the same questions about causes of homelessness, reasons for coming to Knox County, employment history, mental health history, and demographics.

In 2016, fifty-three persons served as interviewers, where several 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. Volunteer training provided to interviewers considers techniques to eliminate influencing participant responses but rather to record the answer given. All interviewers signed a pledge to maintain confidentiality.

Interviews were conducted as a point-in-time over the week of January 25, 2016. Concentrated locations were chosen to capture both sheltered and unsheltered persons, and to ensure no duplication of participants. Interviews at outdoor programs were conducted Wednesday, January 27th. Shelters were visited on Thursday, January 28th, and interviews were conducted early the following morning at area camps. Experienced Interviewers were used at outside locations to minimize the risk of duplicate interviews. Shelter interviews commenced at approximately 6:30 p.m. This time was selected to allow shelters to complete check-in and finish the evening meal before interviewers arrived. Shelters were contacted in advance by the project director 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 a 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 “camps.” A total of 249 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 makes sampling difficult. Even more basic is the question of definition, i.e., who is defined as homeless? Persons living in obscure locations, single-room occupancy units, 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.

The Biennial Study asserts that the homeless population is not static, as patterns of homelessness – situational, episodic, and chronic – will determine who is homeless at a given time. It is critical to remember that the Biennial Study is a point-in-time interview. In addition to the data available through this sample, the accompanying *2015 Annual Report from Knoxville Homeless*

Management Information System (KnoxHMIS) should be used for comparison as it provides data captured over the calendar year. In examining the combined information provided by KnoxHMIS and The KKCHC, the reader should be aware that the *KnoxHMIS* data is based on service users; for example "in 2015, 3,290 individuals sought services for the first time from *KnoxHMIS* partner agencies". In contrast, the Biennial Study was a "point-in-time" sample, drawn by 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

Table 1 offers comparisons of 2014 and 2016 demographics of persons interviewed during the Study (N=249). This data comparison indicated similarities across gender and race. However, adults ages sixty-one and older increased by 6% from 2014 to 2016. One percent of those being interviewed indicated "other" race as "Hispanic/ Latino," although it is typically qualified as ethnicity. Another 2% indicated "other" race as "Native American."

DEMOGRAPHICS OF BIENNIAL STUDY PARTICIPANTS		
Item	2014 (N=239)	2016 (N=249)
AGE		
Under 18	0%	0%
18-30	16%	15%
31-60	77%	73%
61+	5%	11%
Null	2%	1%
Mean Age:		
	44%	44%
Male		
	45%	46%
Female		
	42%	42%
GENDER		
Male	65%	62%
Female	35%	37%
Null	0%	1%
RACE		
White	73%	74%
Black or African American	18%	19%
Other	8%	7%

Table 1

The veteran sub-population was also considered in the Study. The number of respondents self-reporting veteran status (n=37) has increased to 15% compared to 12% in 2014. Ninety-two percent of veterans were male and 8% were female. Fifty-nine percent of veterans reported their race as white, 22% as Black or African American, and 19% as "other," which included self-reported "race" as Native American, Asian, and Hispanic. Seventy-eight percent of veterans reported honorable discharge, which is a slight increase over 71%

reported in 2014. Thirty-five percent reported serving in a military zone compared to 21% in 2014. Twenty-four percent self-reported a service connected disability compared to 14% in 2014; an additional 8% reported a pending service connected disability. Of those serving in the military, the following branches were represented: Army [59%], Navy [22%], Marines [14%], and Air Force [5%]. Veterans report discharge ranges as the following: 1950 or before [3%], 1961-1970 [5%], 1971-1980 [22%], 1981-1990 [32%], 1991-2000 [16%], 2001-2010 [14%], 2011-present [5%], and null [3%].

CHARACTERISTICS

Since the original Study in 1986, questions have explored the early experiences of persons interviewed prior to their becoming homeless. The *Characteristics* section provides insight into background, family, and social support of persons interviewed.

Background

The Biennial Study asks questions related to birthplace and residence prior to being homeless to better understand the background of respondents. This section looks at the stability of persons experiencing homelessness in Knox County. During the past thirty years, the number of homeless persons “having grown up in Tennessee” has been fairly consistent as shown in **Chart 1**.

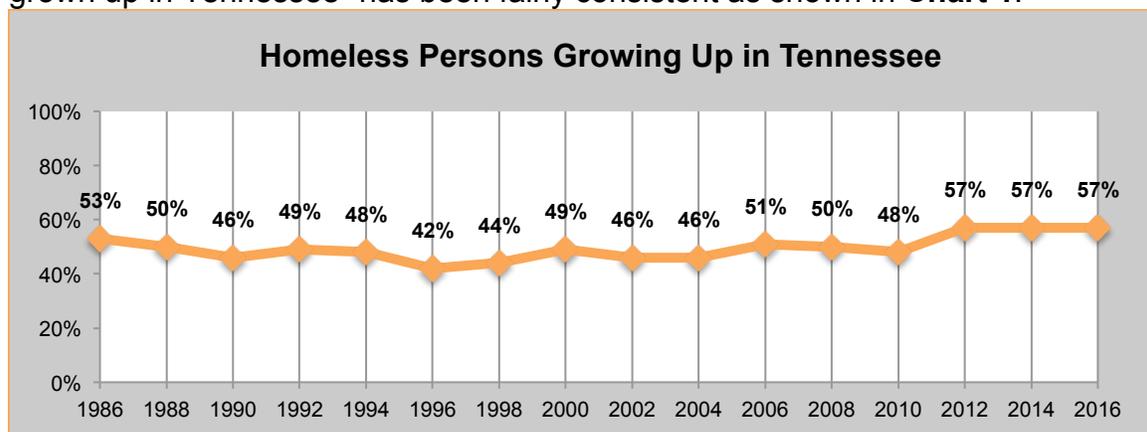


Chart 1

U.S. Census data indicates that 62% of Knox County residents were born in Tennessee, whereas this Study indicates 57% of respondents were born in Tennessee (2012). It is likely that of the 62% of Tennessee residents per Census data, some portion were born in Tennessee but outside Knox County. 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 2014 and 2016 studies. Twenty-seven states were represented in the 2016 Study. 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.

STATE OF ORIGIN		
State	2014 (N=236)	2016 (N=249)
Arkansas	1%	0%
California	2%	2%
Connecticut	1%	1%
Florida	4%	4%
Georgia	1%	1%
Illinois	1%	2%
Indiana	4%	1%
Kentucky	1%	2%
Louisiana	1%	2%
Michigan	3%	2%
New Jersey	1%	1%
New York	3%	4%
North Carolina	2%	4%
Ohio	5%	4%
Pennsylvania	3%	1%
Tennessee	57%	57%
Texas	2%	2%
Virginia	1%	2%
Other States	7%	8%

Table 2

Respondents were asked to identify the three most important reasons for coming to Knox County. **Table 3** identifies responses in the 2014 and 2016 studies.

REASONS FOR COMING TO KNOX COUNTY, TN.		
Response	2014 (N=236)	2016 (N=249)
Job or Seeking Job	13%	17%
Traveling	5%	10%
Social Services/Treatment**	19%	16%
Family Moved Here	19%	24%
Sent (by police, church, or agency)	5%	7%
Shelters	6%	16%
Family Conflict***	4%	11%
New Beginning/Starting Over	NA	32%
Other	6%	9%
*Totals do not equal 100% because multiple responses were accepted		
**Includes social services, mental health, substance abuse, and medical treatment responses		
***Includes family conflict, domestic violence, and divorce responses		

Table 3

Multiple responses were accepted, reflecting that a combination of reasons were often involved in a person's decision to come to Knox County. "Other" responses to "reasons for coming to Knox County included: *death in the family* [4%], *weather* [2%], *public transportation* [2%], and *veteran's benefits* [1%].

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 was *more than 10 years, but not all my life* [21%] followed by *more than one year to five years* [16%], thus indicating some longevity in Knox

County. Counties such as Davidson [6%], Anderson [5%] Blount [4%], Roane [4%], and Sevier [4%] were most frequently cited when asked where the individual lived prior to coming to Knox County. When asked, “Prior to coming to Knox County, what was your housing status?” most had been living in their own apartment/house [41%] or living with friends or relatives [21%]. Sixty-two percent of all respondents consider “Knox County” as their home and 68% reported having a permanent address in Knoxville.

Family

In regard to family composition: 42% of respondents reported being single-never married, 31% divorced, 9% separated, 9% married, 6% widowed, 2% long-term relationship, 1% null marital status. Sixty-nine percent of respondents (n=172) reported having children, with 51% of those persons (n=88) reporting having children less than eighteen years of age. Nineteen percent of persons with children under age eighteen reported having their children with them in shelter at the time of the Study interview.

Several questions about early childhood experiences were asked. **Table 4** identifies with whom the individual primarily lived while growing up.

PRIMARY LIVING ARRANGEMENTS DURING CHILDHOOD		
Response	2014 (N=236)	2016 (N=249)
Both Parents	44%	51%
Father	5%	3%
Mother	33%	22%
Grandparents	8%	11%
Relatives	4%	4%
Foster Parents	3%	5%
Multiple Locations	0%	4%
Other	3%	0%

Table 4

The Study asked questions related to family disruption. Seven percent reported that their families had experienced homelessness during their childhood, which is consistent with 6% reported in 2014. Eighteen percent had been in state custody, which is a slight decrease from 22% reported in 2014. Twelve percent of adult respondents had been in foster care at some time, which is also a slight decrease from 14% reported in 2014. **Chart 2** provides details of responses from previous studies regarding foster care.

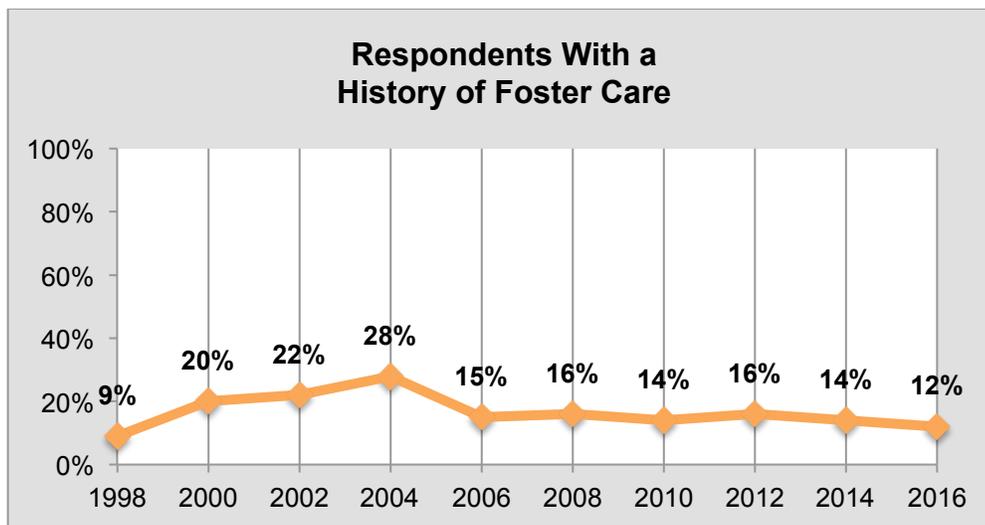


Chart 2

Among those in foster care (n=31), 26% had been in only one foster care placement, with approximately 32% percent having been in two to four placements, and 35% in six or more placements. Among the total who were terminated from foster care: 52% went home, 23% went to live with relatives, 6% percent were discharged to the street or shelter, 3% went to jail or prison, and 16% percent went to “other” locations.

In terms of trauma-related experiences, 35% of respondents (n=86) reported having experienced abuse as a child. Fifty-six percent of those reporting abuse volunteered the type of abuse that was experienced; 32% reported multiple types of abuse. The most common forms of abuse cited were: physical [33%], sexual [30%], emotional [15%], and verbal [12%].

Social Support

It has been argued that the homeless are socially isolated; with low levels of social support and social functioning, and that this lack of social resources contributes to their circumstances (Hwang, Kirst, Chui, Tolomiczenko, Kiss, Cowan, & Levinson, 2009). The Biennial Study explored the relationship between social support and social networks among respondents.

In terms of family support, 51% of all respondents indicated having family in the Knoxville area. The majority of these [63%] had contacted their families within the previous week. Nineteen percent of those with family in the area had contacted family within the past year; whereas, 18% had not contacted their family recently.

In 2014, questions were added to survey cell phone and social media usage among participants. Results of the 2014 Study were presented and published (Patterson, Ensley, West, and Nooe, 2014). Preliminary findings are highlighted here in the 2016 Biennial Study and warrant further analysis. Of those interviewed in 2016, 65% used cell phones with 52% of those reporting daily use. Fifty-three percent of participants used texting, with 39% of those texting daily. Twenty-two percent of participants paid for a cell phone plan/contract; 18% used a minute-by-minute cell phone; 25% received a free phone. In regards to social media, respondents reporting using the following: e-mail [41%], Facebook [38%], Internet [47%], and other social media (e.g. Instagram, Snap Chat, etc.) [12%]. When asked were they most frequently access internet and social media those

who answered (n=106) reported: personal cell phones [66%], agency computers [23%], public library [30%], friend's cell phone [4%], work [2%], other (e.g. family's home, restaurant, and open space Wi-Fi) [5%]. When asked what they use cellphones, social/media, and Internet for, multiple responses were given: talk to friends/family [49%], entertainment [29%], make appointments [19%], look for employment [23%], look for housing [15%], talk to case managers [12%], and other (e.g. news, weather, school, recovery, emergencies, banking) [9%]. Further data analysis will be provided by KnoxHMIS in 2016 and published on the KnoxHMIS website (www.knoxhmis.org)

HOMELESSNESS

This section explicitly explores causes of homelessness, residence prior, duration, and daily experiences. The reader is reminded that homelessness usually involves several factors, and the conclusions drawn must recognize the complex interaction of those elements.

Causes

Table 5 delineates the causes of homelessness as self-reported by the Study participants. The options for the Study questions mirror the "Primary Reason for Homelessness" captured in KnoxHMIS.

CAUSES OF HOMELESSNESS		
Response	2014 (N=239)	2016 (N=249)
Abuse by Family Member	3%	4%
Alcoholism	15%	15%
Drug Addiction	23%	20%
Eviction	8%	7%
Family Asked Me to Leave	9%	4%
Lost Job	25%	16%
No Money for Housing	19%	17%
Medical Condition	4%	4%
Criminal Activity	7%	8%
Mental Illness	6%	5%
Discharged from Jail/Prison	6%	4%
Aged Out of Foster Care	1%	<1%
Prefer It	2%	2%
Domestic Violence	5%	4%
Substandard Housing	0%	1%
Under Employment/Low Income	8%	5%
Utility Shutoff	1%	<1%
Family Discord	11%	14%
Loss of Transportation	4%	2%
Loss of Public Assistance	0%	1%
Health/Safety	1%	2%
Death of a Family Member	9%	5%
Relationship/Breakup or Divorce	14%	8%
Mortgage Foreclosure	0%	2%
Other	2%	11%
NOTE: Percentages will not equal 100% because multiple responses were allowed among the Study participants.		

Table 5

Forty-eight percent of Study participants indicated employment issues/financial loss (i.e. Loss of Job, Under Employment/ Low Income, Loss of Public Assistance, Eviction, Mortgage Foreclosure, No Money for Housing, Utility Shut Off) as contributing factors to homelessness. Relationship problems (i.e. Domestic Violence, Family Discord, Family Asked Me to Leave, Abuse by Family Member, and Relationship Break-up/Divorce) attributed to 34%. Substance abuse followed as a lead cause of homeless by 25%. These findings are consistent with findings in both the 2012 and 2014 studies. It is of interest in the 2016 Study that 3% of the “Other” responses cited poor decision making as a cause of homelessness; additional responses included lack of work skills, property foreclosure, actions of a family member, and natural disaster as causes of homelessness.

In both this Study and the *KnoxHMIS* data, job loss was frequently cited as a primary reason for homelessness. However, the 2016 Study responses indicated a much higher rate of self-reported alcohol and drug abuse as causative in contrast to the *KnoxHMIS* data. It should be noted that Biennial Study respondents did not have to identify themselves as they do when seeking services from *KnoxHMIS* partner providers; the anonymity of the Study may lend to a more candid response.

Residence Prior

Table 6 details prior residence to homelessness as reported to the question, “Immediately prior to becoming homeless, in what type of housing were you living?”

RESIDENCE PRIOR TO THIS EPISODE OF HOMELESSNESS		
Response	2014 (N=236)	2016 (N=249)
Rental	36%	38%
Own	7%	9%
Permanent Housing	11%	4%
Public Housing	8%	6%
Family/Friends	20%	23%
Hospital	<1%	0%
Jail, Prison, or Juvenile Facility	8%	7%
Foster Care	1%	0%
Hotel or Motel	3%	4%
Emergency Shelter	1%	2%
Transitional Housing	<1%	1%
Substance Abuse Treatment	0%	0%
Other	3%	5%
NOTE: Percentages will not equal 100% due to rounding.		

Table 6

Twenty-three percent of respondents reported prior residence of family/friends, which is consistent with 2014 numbers. Prior residence of friends/family is indicative of “couch homelessness” or persons experiencing unstable housing. To further explore couch homelessness, respondents were asked, “Have you stayed with friends or relative in the past year?” to which 56% answered, “Yes.” Many funding streams have specific criteria that require that a person experience literal homelessness before they can gain permanent housing, thus disqualifying those experiencing couch homelessness. This

information can be an important consideration in local policy decisions, funding priorities, and program design.

It is notable that 57% of those interviewed were housed prior to this episode of homelessness (i.e. rental, owning, permanent housing, and public housing) compared to 14% that were literally homeless. Twelve percent report that they are currently on a housing waitlist—most of whom had been waitlisted for a minimum of one month. Twelve percent of respondents also report that they had experienced eviction within the past two years, which is a 2% increase from 2014.

Duration

Information presented in this section of the Study further elaborates on first-time and chronic homelessness. Fifty-three percent of the respondents (N=249) reported that prior to this episode they had not been homeless before. Of the 47% who reported prior homelessness (n=116): one instance of prior homelessness [23%], two instances [32%], three instances [14%], four instances [7%], greater than four instances [24%]. When asked, “How many months have you been homeless,” respondents (N=249) reported the following: two months or less [22%], three to six months [19%], seven to twelve months [16%], two years [14%], three years [9%], five years [5%], ten years [11%], greater than ten years [5%].

Table 7 shows the most common sleeping locations reported by those interviewed. Many respondents report a combination of sleeping locations.

COMMON SLEEPING LOCATIONS		
Response	2014 (N=236)	2016 (N=249)
Abandoned Building	1%	1%
Car	2%	4%
Friend/Relative	3%	6%
Hotel or Motel	2%	2%
Street/Outside	18%	25%
Public Place (library, bus station, post office)	2%	1%
Shelter	83%	77%
Other	3%	2%
NOTE: Percentages will not equal 100% because multiple responses were allowed among the Study participants.		

Table 7

Seventy-eight percent of respondents were interviewed for the Study while in shelter locations such as emergency shelter or transitional housing programs; whereas, 22% were interviewed in unsheltered locations such as camps and street outreach events. When asked how many nights they stayed in a shelter in the past year, nights ranged from zero to three hundred sixty-five days. Within that range, respondents reported the following: zero nights [19%], less than one month [27%], one month [2%], two months [10%], three months [8%], six months [14%], and one year [20%]. The average shelter stay during a year was 98 nights compared to 110 nights in the 2014 Study. It is important to note that the nights reported and the average does not indicate consecutive nights.

Daily Experiences

Little is known about how persons who experience homelessness navigate social systems and much is assumed about how they experience their day. The Study specifically asks how respondents spend their day, access transportation, and if they have been victims of crime. This section details their responses.

Table 8 illustrates the most frequent daily activity as self-reported by respondents.

DAYTIME ACTIVITIES		
Response	2014 (N=236)	2016 (N=249)
Hanging out/ On the street/ Woods	13%	18%
Working/Looking for work	41%	37%
Looking for housing	5%	4%
Walking	25%	16%
At the shelter	34%	25%
At the library	19%	14%
Crossroads Welcome Center (KARM)	6%	3%
Day Room (VMC Resource Center)	7%	6%
Treatment/ Agency Programs	17%	15%
Drinking/ Drugs	3%	3%
Child care	3%	2%
Canning	6%	2%
Visiting family / friends	6%	8%
School	2%	4%
LaunchPoint (KARM)	NA*	4%
Other	13%	23%
NA= This field was not collected during the 2014 Study. NOTE: Percentages will not equal 100% because multiple responses were allowed among the Study participants.		

Table 8

Access to transportation is often cited as a barrier to housing, employment, and treatment (e.g. medical, mental health, and/or substance rehabilitation services). **Table 9** shows common forms of transportation used by persons experiencing homelessness.

TRANSPORTATION		
Response	2014 (N=236)	2016 (N=249)
City Buses	73%	68%
Walk	69%	67%
Hitch-hike/ Thumb	6%	2%
Friend's Car	21%	14%
TennCare Provided Transportation	5%	5%
Bike	NA*	4%
KARM Bus	NA*	18%
CAC	NA*	8%
ETHRA	NA*	4%
Family/ Relative	NA*	17%
Case Manager(s)	NA*	10%
Mentor/ Sponsor	NA*	6%
Other	18%	8%
Own Car	9%	11%
*NA= This field was not collected during the 2014 Study.		
NOTE: Percentage will not equal 100% because multiple responses were allowed among the participants.		

Table 9

Homeless persons are vulnerable to being victims of crime. Most crimes go unreported or are not publicized in local media. The Study specifically asks participants if a crime has been committed against them while homeless. The majority of respondents [65%] reported that a crime had not been committed against them; however, a substantial number [35%] indicated they had a crime committed against them, which is much higher than the general population.

Table 10 represents types of crime inflicted on persons experiencing homelessness.

TYPES OF CRIME AGAINST HOMELESS PERSONS		
Response	2014 (n=88)	2016 (n=87)
Robbed/Theft	78%	63%
Stabbed	29%	8%
Sexual Assault	NA	12%
Beat Up	18%	38%
Shot	2%	1%
Abduction/Kidnapped	NA	0%
Harassment	NA	13%
Other	8%	7%
*NA= field was not collected in 2014 Study		
NOTE: Percentages will not equal 100% because multiple responses were accepted among participants.		

Table 10

Please note that additional response fields were added in 2016. Also the responses “Stabbed” and “Assaulted” were separated in 2016 to be more intentional in capturing “Sexual Assault” experienced among the homeless. Although there were no responses for “Abductions/Kidnapped,” this field is included in the Study to capture potential human trafficking (i.e. harboring and exploitation of a person(s) against their consent and/ or will). In addition, questions about domestic violence were asked; 36% of all respondents (N=249)

responded that they had been a victim or survivor of domestic violence (n=89). Sixty-four percent of which were women (n=57).

INCOME & EMPLOYMENT

The Study asked several questions related to income and employment that included: sources of income, amount, benefits, employment status, types of work, reasons for unemployment, education, and accessibility to non-cash benefits. These questions were asked to not only understand the typical experience of homelessness but to address myths about homeless and lack of income or employment.

The most sensitive area during Study 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 11** summarizes self-reported weekly income.

WEEKLY INCOME		
Amount	2014 (N=236)	2016 (N=249)
\$0	32%	22%
\$1 - \$50	22%	18%
\$51 - \$100	8%	9%
\$101 - \$200	19%	24%
\$201 - \$300	11%	11%
\$301 or Greater	5%	13%
Refused	3%	3%

Table 11

The average weekly income of those who were willing to answer (n=240) was \$157 a week or \$8,164 annually.

Table 12 summarizes income sources self-reported among respondents.

INCOME SOURCES		
Source	2014 (N=236)	2016 (N=249)
Work	28%	35%
Government Assistance	10%	13%
Plasma Center	4%	2%
Handouts	8%	9%
Relatives/Friends	31%	27%
Food Stamps (Use Them)	43%	31%
Food Stamps (Sell Them)	2%	3%
Canning/Scrapping	11%	10%
Disability	16%	25%
Veteran's Benefits	3%	3%
Other	7%	7%
Null	7%	1%
NOTE: Percentage will not equal 100% because multiple responses were allowed among the participants.		

Table 12

Work, disability, food stamps, and relatives/friends were the largest sources of income source reported. The “*other*” category included various sources such as shelter allowances, child support, pensions, and alimony. Twenty-five percent of the respondents, (23% in 2014), indicated that they had engaged in illegal activity at some time to support themselves.

Nineteen percent of the respondents indicated that they had lost government benefits during the past two years as compared to 24% percent in 2014. Earlier studies also reported loss of benefits as shown in **Chart 3**.

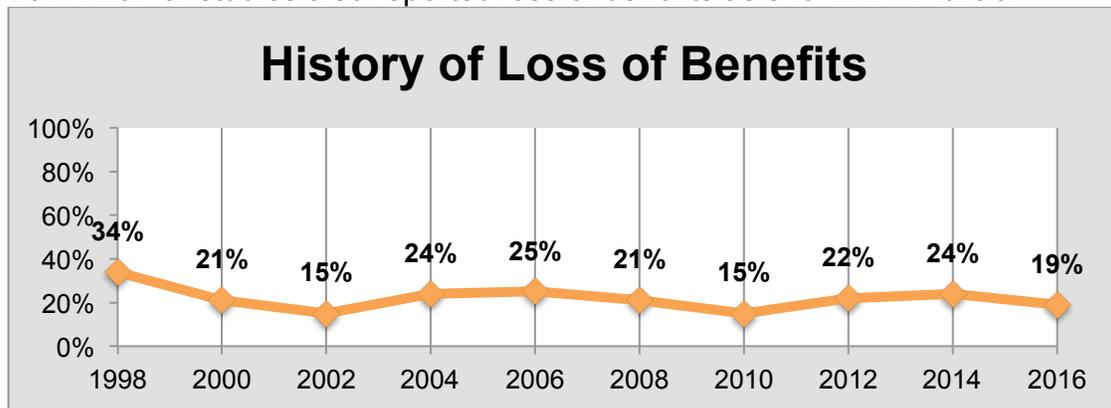


Chart 3

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. Thirty-three percent of those receiving SSI or SSDI (n=63) had a payee other than self, which is consistent with 2014.

Twenty-four percent of all respondents (N=249) reported having current employment, which is an 8% increase over the 16% reported in 2014. Caution should be used when interpreting this statistic since shelter work programs, canning, and day labor are often perceived as having employment among those experiencing chronic homelessness. Of those with employment (n=53), 51% worked full-time, 28% worked day labor, 19% worked part-time, and 2% worked other.

The Study also explored perceived reasons for not working. The most common response among persons without current employment (n=196) was “disabled” [34%] followed by “don’t have my paperwork” [13%], “no jobs available” [10%], and “nobody will hire me/criminal history” [10%]. Additional responses included: no transportation, lack of childcare, only seasonal work, program restrictions, alcohol/drugs, actively looking, retired, don’t want to, and other.

The Study asked all respondents about their work history to gauge a better understanding of their employability. **Table 13** delineates the “usual line of work” among respondents.

USUAL LINE OF WORK		
Response	2014 (N=236)	2016 (N=249)
Unskilled labor	16%	10%
Skilled labor	19%	17%
Construction	12%	10%
Restaurant	20%	13%
Professional	4%	NA
Nursing	NA	3%
Nurse's Aid/ Home Health	4%	2%
Truck driver	3%	2%
Teacher	NA	1%
Clerical/Secretarial	1%	3%
Cashier/Retail	6%	4%
Cleaning/ Janitorial/ Custodial	NA	3%
Factory/Warehouse	4%	4%
Call Center	NA	3%
Daycare	NA	0%
Student	1%	2%
I do not work	NA	10%
Other	10%	14%
NA= this field was not collected in the 2014 or 2016 Study respectively.		

Table 13

Please note that several fields were added in 2016 including: Nursing, Teacher, Cleaning/Janitorial/Custodial, Call Center, Day Care, and I do not work. These fields were added based on feedback from interviewers in the 2014 Study in attempt to further parse out employment/ training backgrounds particularly professional/ skilled labor. It is notable that the percentage of persons identifying work as unskilled labor continues to decrease; in 2016, 10% of respondents indicated an unskilled labor background, whereas in 2012, twenty percent reported unskilled labor. Twenty-seven percent of all respondents (N=249) reported that they needed additional job training.

Several additional questions were asked related to employability. Many employers require that a person have identification such as a birth certificate, driver's license, or social security card to be hired for employment. Forty-one percent of all respondents did not have a copy of their birth certificate, 59% did not have a driver's license, and 20% did not have a social security card—which is consistent with the 2014 and 2012 studies. Without these forms of identification, obtaining housing and employment quickly can be greatly hindered.

LEGAL HISTORY & DEINSTITUTIONALIZATION

Another facet that can greatly affect access to housing and employability is a person's legal history. If a person has a background that includes incarceration, they are less likely to pass background checks that allow them to gain housing and employment. In order to explore the legal history of respondents, questions about loitering, public intoxication, incarceration types, length of incarceration, reason for incarceration, discharge from incarceration, and mental health treatment while incarcerated were included.

The comparison between the 2014 and 2016 Studies offered in **Table 14** indicates a consistency in the frequencies of incarceration in jail and prison.

INCARCERATION		
	2014 (N=236)	2016 (N=249)
Jail/Detention	75%	71%
State or Federal Prison	21%	22%
NOTE: Percentage will not equal 100% because multiple responses were allowed among the participants.		

Table 14

As in previous studies, the most frequently cited reasons for jail time, as contrasted to more serious offenses, included: public intoxication, driving under the influence, drug possession, failure to appear, and violation of probation. Domestic Violence, assault, and theft were also commonly cited as reasons for incarceration. Since the 2002 Study, several questions specifically about trespassing/loitering and public intoxication have been included. Study interviewers asked participants if they had been arrested for trespassing or loitering, and 20% answered affirmatively. Forty-five percent of those arrested for trespassing (n=51) reported one arrest and another 41% had two to five arrests. The range was from one to five arrests. Twenty-five percent had been arrested for public intoxication within the last three years as compared to 26% in 2014. Forty-two percent of those arrested for public intoxication (n=62) reported one arrest and another 38% had two to five arrests. Approximately 15% had over five arrests during the three-year period. The range was from one to sixty 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-two years. Among those who had been incarcerated in jail, the average was 31 days, which is a significant decrease from the 100 days averaged in the 2014 Study. For those incarcerated in state or Federal prison, the average duration of incarceration was 3 years, which is consistent with the average reported in the 2014 Study. A follow-up question was asked about the number of days spent in jail or prison in the past year. Among those reporting incarceration, the average duration was 81 days, which is a decrease from the 95-day average reported in 2014.

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. Persons who reported having received mental health treatment had a mean or average of 93 days of incarceration compared to 64 days for persons who had not been treated for mental health problems, thus indicating that those with mental health issues were incarcerated longer. This is consistent with previous Study findings. In addition, only 32% of those with mental health issues (n=108) reported having received mental health treatment while incarcerated. 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 examination, including research of incarceration of homeless mentally ill persons as compared to non-homeless persons charged with similar offenses. Another issue that warrants research is the impact of the Tennessee Department of Mental Health closure of Lakeshore in 2012. Seventeen percent of respondents who had been incarcerated and report a

history of mental health hospitalization had been treated at Lakeshore, which is a decrease from 24% reported in 2014; 6% of 2016 respondents reported treatment at Moccasin Bend, Tennessee's regional mental health hospital; 10% of 2016 respondents reported staying at the local crisis stabilization.

Respondents who had been incarcerated were also asked where they were discharged when most recently released from incarceration. This question did not discriminate among jail or prison. Twenty-two percent returned home, 16% went to live with relatives, 9% moved to a group or transitional facility, 5% moved to a substance abuse treatment facility, 6% moved to "other," 35% became homeless (shelter/street), 8% did not provide a response. The percentages in 2016 for discharge status are consistent with findings of the 2014 Study.

Despite the small sample, the findings that approximately 35% 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 with mental illness to achieve successful reintegration back into the community from incarceration. Homelessness will likely increase the chance of repeated incarceration.

HEALTH

Health and homelessness are interrelated. Health conditions among persons experiencing homelessness are often co-occurring, with a complex mix of severe psychiatric, substance abuse, and social problems (National Health Care for the Homeless Council, 2011). An injury or illness can start out as a health condition and quickly spiral into homelessness due to loss of employment, lack of healthcare, and/or stress on personal safety nets. Further, homelessness increases one's exposure to communicable diseases and exacerbates common health issues (e.g. high blood pressure, respiratory illnesses, diabetes, etc.) that often go untreated due to lack of healthcare and/or quick access to healthcare. This section explores the respondent's self-reported physical and mental health as well as substance use history.

Physical Health

The Study asked about health problems since being homeless. Forty-nine percent rated their health as good to excellent. This finding was interesting given that 47% also perceived that they have chronic health problems and reported health problems along with mental illness, substance use, and disability in questions about reasons for unemployment. Only 14% reported that they had experienced no illnesses while homeless. Many respondents reported multiple health conditions including: respiratory (ear, nose, throat) [49%], eye [38%], dental [36%], severe headaches [36%], blood pressure [33%], feet [30%], personal accidents [23%], pneumonia [19%], hepatitis [17%], skin [16%], heart [13%], diabetes [12%], other (including cancer, liver disease, cancer, bone issues, etc.) [11%], seizures [10%], pregnancy while homeless [4%], HIV [2%], and Tuberculosis [2%].

Questions about insurance access were also asked. It is commonly assumed that persons experiencing homelessness do not have insurance. Forty-six percent of all respondents reported that they are currently receiving insurance, 52% were not receiving insurance, and 2% refused to answer. Forty-

two percent (47% in 2014) reported having received TennCare. Additional questions were added in 2016 to capture types of insurance and reasons for not having insurance. Of those receiving insurance (n=115), the following is a breakdown of insurance types (note that percentages will not equal 100% due to multiple responses being accepted): TennCare [42%], Medicare [23%], other insurance [14%], private insurance [9%], VA Medical Benefits [6%], employer insurance [4%], don't know [3%]. Of those not receiving insurance (n=129), 35% indicated that they could not afford insurance, 11% were not sure of their options, 11% were on a waiting list, 19% reported that they did not qualify, 7% stated that they did not need/want insurance, 11% reported other reasons for not having insurance, and 6% refused to answer.

Questions were asked about healthcare to gauge access as well as the level of care needed. When asked about health care in the past year, 59% had seen a physician/nurse, and 25% had seen a dentist. Respondents were asked specifically where they went with a health or medical problem not requiring hospitalization. **Table 15** identifies the sources of treatment not requiring hospitalization.

LOCATION OF TREATMENT NOT REQUIRING HOSPITALIZATION		
Response	2014 (n=236)	2016 (n=249)
Cherokee Health/5th Avenue Clinic	26%	24%
Cherokee Western	8%	4%
Drug Store Clinic	NA	4%
Emergency Room	24%	12%
Family Doctor	10%	15%
Health Department	7%	5%
Interfaith Clinic	3%	1%
Nowhere	23%	23%
Other	16%	17%
Remote Area Medical	1%	0%
NOTE: Percentages do not equal 100% because multiple responses were allowed among the participants.		

Table 15

Drug Store Clinics were added as a choice this year due to the recent increase of walk-in clinics available at chain-store pharmacies. The “other” category included various clinics, such as the Veterans Administration and a number of unspecified clinics.

Questions were asked about medical hospitalization. Forty-six percent of respondents said that they had been hospitalized while homeless (compared to 37% in 2014, 33% in 2012, and 28% percent in 2010). Illness was the most frequent reason for hospitalization [56%], but the reports of injury [16%], assault [11%], and alcohol related problems [10%] suggested that these are also frequent among the chronically homeless. Those respondents who had been hospitalized while homeless were asked how many days/nights they had been spent in the hospital during the past year. **Table 16** identifies the length of hospitalizations while homeless.

DAYS/NIGHTS IN THE HOSPITAL WHILE HOMELESS		
Response	2014 (n=103)	2016 Percent (n=114)
None in the past year	22%	19%
One	13%	18%
Two	12%	7%
Three	11%	8%
Four	6%	5%
Five or Greater	36%	43%

Table 16

A separate question asked all respondents how many times they had been to an emergency room during the past year. Thirty-two percent had not been to an emergency room (n=80); however, for the remaining 68% of respondents (n=169), responses ranged from one to twenty times. The average number of emergency room visits for the sample was three visits, which is an increase from two visits reported in 2014; however, the most common response of those who had been to an emergency room was one visit (34%).

Another question asked respondents if they had been transported to a hospital or emergency room by ambulance during the past year. Forty-one percent indicated ambulance transportation. Ambulance services ranged from one to fifteen times; 38% reported only one time and 25% reported two times.

There is growing concern that persons are being discharged from hospitals directly into homelessness where little is known about their level of care post hospitalization and ability to thrive in a street/shelter environment. Seventy-three percent of those who had been to the hospital were discharged to the street or emergency shelter, which is greater than the 44% reported in 2014. Sixty-nine percent of those being discharged were prescribed follow-up care. It is unknown if follow-up care was obtained and thus warrants further examination. A person's coping skills can be exacerbated when compounded with physical illness and poor mental health, which can perpetuate the extent of their homelessness. The mental health section of this report details prevalence of mental health issues and further shed light on institutional discharge planning.

Mental Health

Chronic mental illness and deinstitutionalization continue to be cited as major reasons underlying homelessness. Fifty-eight percent of the total sample reported receiving mental health treatment at some time. While reporting previous treatment does not mean that the respondent is currently mentally ill, 64% of the respondents did report that there were currently receiving mental health services. Additionally, 45% of all respondents reported that they had been seen for outpatient mental health services at some time. Of those who reported currently receiving mental health services (n=72), 33% had been receiving services for 3 to 5 years and 32% for greater than five years. Sixty-four percent of those receiving treatment for emotional or mental illness (n=144) had been hospitalized (n=93).

Among those individuals reporting hospitalization, multiple hospital stays and locations of stay were reported including: Peninsula Hospital [38%], Lakeshore at some time [18%], out of state mental health hospital [12%], crisis stabilization unit [11%], Ridgeview [11%], Moccasin Bend [9%], and another

psychiatric hospital/program [19%]. Twenty-nine percent of respondents were seen by the mobile crisis team (22% in 2014).

Among those who had been hospitalized (n=93), 29% percent reported only one hospitalization while 47% percent had been hospitalized between two and five times. Twenty-four percent had been hospitalized more than five times. For 49%, hospitalization had occurred more than one year earlier, which is a decrease from 56% reported in 2014. However, 47% percent had been discharged from a psychiatric hospital within the year and 27% within the past month. The length of most recent hospitalization varied: 40% percent reported less than one week and 45% had been hospitalized between one week and one month.

The validity of the finding that the frequency of mental illness among homeless persons is exceptionally high is further supported by the perception of depression among Study respondents. Seventy-eight percent said that they experienced depression, with 29% of those saying they were depressed every day. Thirty-five percent of all respondents perceived their “nerves” as bad, which is consistent with the 2014 Study results. The perception of prevalence of mental illness among persons experiencing homelessness is also supported by interviewer observations. When interviewers were asked at the completion of the questionnaire if the respondent had mental health problems, 41% were identified by interviewers.

The Study examined institutional discharge planning implications by asking participants where they went after being discharged from a psychiatric hospital or program. Again, **Table 17** illustrates post-hospital residence and indicates that a large number of persons discharged went directly to the streets or shelters from psychiatric facilities.

POST PSYCHIATRIC HOSPITAL RESIDENCE		
Residence	2014 (n=94)	2016 (n=93)
Relative/Friends	30%	37%
Boarding Home/Group Home	3%	1%
Own Apartment/Home	16%	14%
Street/Shelter	40%	34%
Rehabilitation	6%	6%
Other (Incl. "Jail")	5%	8%

Table 17

The substantial percentage increase of post psychiatric hospital discharge into homelessness since the initial Study in 1986 parallels bed reductions and closing of state facilities. Also, among those that were hospitalized (n=93), 82% percent had been discharged on medication, but almost half (43%) of them were not taking it. Many said that they “didn’t like how it made them feel” (33%), 18% said that they could not afford it, and 15% said that the prescription ran out. This indicates both a lack of follow-up and continuity of after-care.

Substance Use History

The National Institute on Drug Abuse cites drug addiction as the leading cause of death among persons experiencing homelessness (2013). The Study inquired about both substance use history and current substance use. While the Study relied on self-reports, there appears to have been a substantial increase in the incidence of substance use since the 2014 Study. In 2014, 57% reported substance use *at some point*. In 2016, 81% of the respondents self-reported substance use *at some point*. **Table 18** reflects a comparison of responses about alcohol and drug use history between the years 2014 and 2016.

ALCOHOL AND DRUG USE HISTORY		
Responses	2014 (N=236)	2016 (N=249)
No Substance Use	52%	19%
Alcohol Only	14%	3%
Drug Only	7%	59%
Both Alcohol and Drug	6%	18%
Recovery	20%	1%
Don't Know	1%	0%

Table 18

Thirty-nine percent of all respondents reported receiving outpatient treatment for alcohol or other drug problems; 16% of whom indicated having difficulty finding treatment. Among those reporting drug use history, ($n = 190$), the primary substance of choice included: Marijuana [47%], Prescription Drugs [19%], Cocaine [12%], Heroin [5%], Methamphetamine [3%], and Other [8%]. Note that the primary substance of choice was related to substance use history and is not a reflection of *current* substance use.

Further questions were asked to gauge *current* addiction such as, “Do you consider yourself an alcoholic?” and “Do you or have you consider yourself addicted to drugs?” In 2016, 21% of the total ($N=249$) indicated alcoholism, which is similar to the 23% reported in 2014. Self-reported drug addiction decreased from 32% in 2014 to 17% in 2016. In terms of frequency of substance use, 35% reported that they no longer use drugs (23% in 2014) and 40% reported daily use (26% in 2016). Interestingly in 2016, more respondents reported having used drugs but fewer self-reported addiction.

Comments and Case Studies

The Biennial Study included the participant's perspective on homelessness. The Study specifically asked participants, "Is there anything about being homeless that we haven't asked that you think we should know?" and "Do you have any other questions or comments about things we've talked about?" Following are comments from participants about their experience of homelessness:

- *Homelessness is a lot different than you perceive. When I was growing up, I always thought homeless people were derelicts or useless. Now that I am here, I know that everybody has a story.*
- *We are not here by choice. Everyone has life circumstances that take them to this point. Everyone I have met...We are working to get out.*
- *Being homeless is very depressing. It can slow you down and if you don't think positive you'll feel that you are stuck. You don't have to stay homeless. You can get yourself out.*
- *It is a learning experience. It makes you appreciate the smallest things.*
- *We get judged a lot. They [other people] take us for face value and don't listen to us.*
- *There is a very serious stigma attached to being homeless. Not everyone is a drunk or a junkie.*
- *I think that being homeless and not being stable has a lot to do with instability. A lack of a caseworker has affected me. I need an advocate to get through bureaucracy of medical treatments. Once people get into housing they lose because they don't have a caseworker or support.*

Knoxville-Knox County Homeless Coalition partners provided vignettes for the Study. These narratives are based on persons served by KKCHC partner agencies; names and identifying characteristics as well as actual circumstances have been changed to protect client privacy. These case studies emphasize the contributing factors to homelessness, challenges people face in gaining stability, and the characteristics of high-quality care that can improve their lives.

Client Story Contributors included submissions from: Helen Ross McNabb: Family Crisis Center, Knoxville Knox County CAC: Homeward Bound, Knoxville Knox County CAC: Project LIVE, Knox County Community Development Corporation, Knox County Schools: Homeless Liaison Services, Knox County Public Defender's Community Law Office, Knoxville Veteran's Center, The Salvation Army: Operation Bootstraps Transitional Living, Steps House, Volunteers of America: Homeless Veterans Reintegration Project, Volunteer Ministry Center: Case Management, Volunteer Ministry Center: Dental Clinic, Volunteer Ministry Center: Minvilla Manor

Katie's Story:

From an early age, Katie experienced abuse and trauma. Her mother began putting alcohol in Katie's baby bottles when she was an infant. By the time she was four years old, her father was giving her beer straight from the can. Katie started smoking marijuana with her parents at age nine. Eventually, Katie was removed from her home and placed in foster care. After her tenth birthday Katie was hospitalized due to the effects of early alcohol use and physical abuse from her biological family. This led to Katie's later opiate abuse, sending her spiraling further into addiction. Katie began running away from foster care in her early teenage years and dropped out of high school by the time she was eighteen. She eventually married someone who was also addicted to drugs and they had two children. Later she found herself in prison due to crimes related to her addiction. Upon Katie's release, she was required to go into a residential substance use treatment program. Housing staff helped her adjust to life outside of prison and gain success. While at the two-year transitional housing program, Katie stayed sober, obtained her GED, gained employment, learned how to budget her money, purchased her first car, and obtained more permanent housing. A few weeks before graduating from their program, the staff assisted Katie in applying for college and obtaining funding for her education. She continues to frequent the transitional housing program's facility for assistance offered by their career center, and uses the computers there to complete online coursework. Katie has shared with staff that their caring and judgment free approach have helped her gain confidence. Katie also attends weekly life skills sessions where she shares how she is building her future through more positive choices.

Katie's story depicts how early childhood experiences and trauma can increase risk factors leading to homelessness.

**Gary's Story:**

Gary is in his late 50's and became homeless in early 2000 after being incarcerated. Once he was discharged back into the community, his mental health issues began to resurface after a serious relationship fell apart. He used drugs and alcohol to cope with his mental health issues. Gary remained homeless for years struggling with mental illness, substance abuse, and epilepsy – all of which went untreated while homeless. Gary was frequently in the hospital or jail. After almost ten years of homelessness, Gary started working with an outreach program. Case management helped link Gary with a primary care physician and a psychiatrist who helped him address his physical and mental health conditions. He began attending Alcoholics Anonymous meetings and met with his case manager regularly to work toward housing. After several months, he was approved for housing and moved into permanent supportive housing. After achieving housing, Gary continues to work toward positive changes in his life.

Gary's story speaks to how untreated health issues can compound duration of homelessness.

Michael's Story:

Michael served in the Army in the 70's and was honorably discharged. Following his service, he struggled with adjusting to civilian life, experienced untreated Post Traumatic Stress Disorder, drifted into substance addiction, and became homeless. A case manager at the emergency shelter where Michael occasionally stayed reached out to get to know his story. The case manager referred Michael to a homeless veterans program when he expressed interest in getting treatment for his mental health and substance use issues. The veteran program helped Michael obtain his driver's license, social security card, and veteran forms so he could obtain Veteran Affairs medical benefits. The veteran program and a local community mental health provider collaborated to help Michael enter veteran-specific support housing at an apartment complex located on a bus line. They also connected him with bus passes and a pre-paid minute-by-minute phone while he looked for a job. Michael attended an employment club offered by the homeless veterans program until accepting a full time job as a security guard. After securing employment, he was assisted in obtaining necessary work uniforms and a bicycle for transportation. With this job, he now receives employment benefits. After successful completion of the homeless veterans program, Michael also received recognition for ten years of sobriety. He is still employed as a security guard and has recently been offered a promotion.

Michael's story highlights how collaboration and providing services targeted to specific sub-populations can support successful transition from homelessness.

**Tina's Story:**

Tina has not been able to give her children everything she would like, but she has shown them what it means to strive towards personal goals. Tina was a full-time medical assistant earning an online Bachelor's degree in health care management. After becoming a single mother and losing her housing, Tina lived paycheck to paycheck and moved her family into a motel. She was struggling, working seven days a week to provide necessities for her children to thrive. It was very difficult to focus on her career goals. Tina found services through a local program that helps people quickly regain housing after eviction or a period of homelessness. The housing program provided her with a list of possible apartments, and then gave her temporary financial assistance to pay a security deposit and first month's rent as well as basic linens and cleaning supplies. This helped Tina stabilize her situation. Tina shared with case managers that without the help of the program, her children would not have beds or a table to for their meals. Tina reports that she finally sees "the light at the end of the tunnel" thanks to stable housing and a recent promotion.

Tina's story illustrates how underemployment, lack of affordable housing and relationship problems can quickly place someone in jeopardy of homelessness.

Philip's Story:

Philip is a senior citizen who was homeless for over thirty years. He earned a living by doing odd jobs for people/businesses in the downtown and university areas. He usually camped around town and occasionally stayed at the local shelter during the colder months. Due to his long history of homelessness and ability to survive, he resisted offerings of assistance until his older age. He started looking for more stable housing last year. He had an extensive arrest record (mostly public intoxication and criminal trespassing) that was a barrier to housing. Case Managers worked to help him identify housing that would consider his progress rather than his past criminal history and provide a housing first model that would allow him to gradually address his substance abuse. He was able to maintain permanent supportive housing that provided onsite case management. In housing he developed relationships with his case manager, other residents, and connected to a mentoring group. He also found community members that started mentoring him to which he regularly meets for lunch and frequently attends their church functions. Philip has not been arrested since moving into housing and has significantly decreased his drinking. Recently, he told his case manager how much better he is doing/feeling after moving into his own apartment.

Philip's story points to chronic homelessness and strategies for engagement and stability.

**Louis's Story:**

Louis was a refugee from Haiti. He moved into subsidized housing in Tennessee expecting life to be peaceful. But just when things were settling down, everything changed. Louis was assaulted by an individual and fractured his skull on concrete. He was transported to a local hospital and admitted to the trauma unit. After several surgeries, he remained in a coma for an extended time, and was discharged six months after the assault. Fragile, confused, and frightened, he did not have any money and lost his housing. The brain injury left him with seizures and loss of memory. He was fearful of crowds, and worried about being physically harmed again. He and a case manager met almost daily for the next year. He did not complain of his disability, but expressed a strong desire for housing. Due to frequent hospitalizations, his food stamps were discontinued and doctors' appointments and court dates were missed. Finding Louis a housing placement was a challenge. He waited on group homes, was denied housing applications, and turned down for an appeal. Finally, things took a positive turn as his seizures were less frequent and he had regular medical care. A disability attorney took his case and was able to have him approved for medical assistance, food stamps, and social security. He was able to move into permanent supportive housing. Louis continues to receive on-site case management, and has adjusted well to his new home.

Louis's story illuminates how crimes against a person can increase their vulnerability to experience homelessness.

Amira's Story:

With little more than her clothing, Amira fled to a neighbor's house with her infant and called the domestic violence hotline. Her husband had kept her up all night, intermittently hitting and strangling her. Scared to call the police because she thought it would only make her abuser angrier, Amira was desperate to escape. She had left several times before, but without family support and resources, she was forced to go back to him each time. When Amira called, hotline staff talked her through a safety plan and identified immediate options. They helped her decide the safest way to leave and coordinated transportation to the emergency shelter, where she met with an advocate. At the shelter, Amira was helped with basic needs and referred to an outreach program for court advocacy. Amira's abuser threatened her with financial ruin and threatened to take away their baby if she did not return. Shelter staff and local advocates continued to safety plan with her and provided her with the emotional support she needed to gain confidence. Advocates helped her navigate the systems needed to work toward independence, including community resources and housing. Eventually, Amira moved into transitional housing. She meet with her advocate weekly to discuss her goals and well-being. She attended weekly support group and enrolled in other community programs that helped her gain financial stability. She is trying to find stable employment with help from a case manager. She continues to live in transitional housing while she waits for an opening for more permanent housing for her and her baby.

Amira's story shows how personal crisis such as domestic violence can contribute to homelessness.

**Cathy's Story:**

Cathy had been staying at a local shelter for a month before she shared her story with shelter staff. She shared that her biggest goal was to gain a promotion at work so she could earn more money for an apartment. She shared that she believed that a barrier to gaining the promotion at the downtown restaurant was that she had severe dental problems. Shelter staff connected Cathy to a partner agency that offered subsidized dental care. The dental clinic extracted several teeth and provided Cathy with dentures. Several months later, one of the dental clinic staff members was eating at the restaurant where Cathy worked. Cathy came over to the staff member and expressed her gratitude, saying that she was promoted to front of the house rather than the kitchen, which allowed her to gain the money needed to gain an apartment.

Cathy's story spotlights how health issues such as dental care and treatment not requiring hospitalization can impact one's ability to make progress towards stability.

Jason's Story

Jason became addicted to heroin while in college. He did not complete his education, lost contact with his family, and ended up on the street. He primarily survived by eating food he collected from dumpsters behind local restaurants, camping with other persons on the street, and intermittently staying in the local emergency shelter when he was sober. He ended up in prison for almost ten years for theft and violation of probations associated with his drug use. He could not maintain stability after being discharged from prison so he returned to drug usage. He was unable to gain housing because he could not pass drug screenings for employment, had a criminal history and poor credit, and was mostly under the influences of substances. He felt hopeless. One night, Jason was found by paramedics sleeping in a makeshift tent and almost frozen to death. The officers took him to the hospital where he was able to detox from his drug use. He was also connected to a social worker who contacted a transitional living facility specializing in substance abuse treatment and recovery. Over the course of a year, Jason was able to maintain sobriety. Through supportive case management provided in transitional living, he also gained permanent housing and employment as a computer specialist.

Jason's story points to the impact legal history has on employability and housing as well as how substance use history can compound risk factors for homelessness.



Scott's Story:

Scott started living in a local housing program half a year ago. In the last four years, he has dealt with several problems including epilepsy, spinal disc problems, Post Traumatic Stress Disorder, and depression. After a close family member's death, his relationships with family suffered and he had a suicide attempt. Scott eventually fell behind on rent and was evicted, which led Scott to a local emergency shelter. The emergency shelter connected him to a case management program, where he found a new doctor and psychiatrist. He spent a good bit of time in hospitals due to his frequent seizures. Case managers helped Scott appeal a disability denial (due to missed paperwork deadlines from intermittent homelessness). He also completed anger management classes, which provided him with tools to effectively deal with relationship problems. Upon Scott's first application to housing through a community development program, he was denied approval due to his past eviction. He then was able to appeal the denial based on the positive things he was currently engaged in, and was able to be placed on a waiting list for housing. His disability case was approved in the following months. This income was a substantial benefit to him because he has had problems finding employment due to his medical conditions. Scott was recently offered subsidized housing. He recently signed a lease and is very happy with his current situation. Having a home and stable income has made it much easier to cope with his physical and mental health conditions.

Scott's story highlights how significant medical issues affect employability and how access to benefits can help a person gain stability.



2015 Annual Report,
Knoxville Homeless Management Information System
The University of Tennessee College of Social Work
Social Work Office of Research and Public Service

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2015 KnoxHMIS Annual Report, Executive Summary

The KnoxHMIS Annual Report has been completed every year since 2007. This report provides information on persons who accessed a service from one of 18 KnoxHMIS' partner agencies¹ in 2015. It should be noted that not all individuals included in this report are literally homeless. Seventeen percent of those served indicated they were housed and at risk of losing housing, thus were receiving services to prevent them from becoming homelessness.

During 2015, there was an 8% decrease in the individuals *new* to KnoxHMIS partner agencies. The picture is somewhat different for overall clients served (i.e. active clients, including both new and continuing clients). A total of 9,339 individuals accessed homeless services from KnoxHMIS partner agencies. This figure represents a 1% increase from 2014 (N=9,232). The reasons for percentage changes of both new and active clients are examined in the body of this report.

Active Client Summary:

- 13% were reported to have a disability and 57% of those indicating a disability reported experiencing mental health problems
- 73% reported last permanent address in Knox or a surrounding county
- 28% were persons in family households
- 8% were children under 18, of which 7% were unaccompanied (n=66)
- 7% were young adults ages 18--24
- 8% were seniors, ages 62 and greater
- 11% self-reported veteran status, 8% of which were *literally homeless*.
- 3% experienced chronic homelessness²
- 10% were living in a place not meant for human habitation (i.e. *Street Homeless*)

Services and Outcomes Summary:

- In 2015, there was a >1% decrease in recorded services delivered.
- On average, 38,344 services were delivered to clients monthly by KnoxHMIS partners.
- 12% of active clients had case notes entered by providers.
- 1,951 individuals were housed in positive housing placements³
- 3% of persons placed in positive housing returned to emergency shelter

New Clients

¹ KnoxHMIS partner agencies include: Catholic Charities of East Tennessee, CONNECT Ministries, Compassion Coalition, Family Promise, Knoxville-Knox County Community Action Committee, Knox County Community Development
² It is notable that numbers related to disability and chronic homeless status have significantly decreased since the 2014 KnoxHMIS Annual Report. Decreases are largely attributed to changes in the definitions and how the data is collected by KnoxHMIS partners; more information on the specific changes are discussed in the "Subpopulations of Active Clients" section of this report.

³ "Positive," "negative" and "indeterminate" housing definitions vary across program types of emergency shelter (ES), transitional housing (TH), permanent supportive housing (PH), rapid re-housing (RRH), homeless prevention (HP). More detail is given on the definition of housing placements in the "Housing Outcomes" section of this report.

In 2015, 3,290 new clients were entered into KnoxHMIS representing an 8% decrease from 2014. The decrease in new clients added to KnoxHMIS is striking due to the addition of two new partner agencies (i.e. CONNECT Ministries and KCDC HUD VASH) as well as seven new Helen Ross McNabb Programs (i.e. Cedar Crossing, Washington Oaks, Runaway Host Homes, Youth LINC Transitional Housing, Youth LINC Community Living, Youth Street Outreach, and Projects for Assistance in Transition from Homelessness). **Table 1** shows the percent change in new clients entered into KnoxHMIS each year since 2007.

Table 1: Change in Number of New Clients Added (2007-	
Year	Percentage Change
2007	+12% (n=3,613)
2008	+31% (n=4,731)
2009	-21% (n=3,727)
2010	+18% (n=4,394)
2011	-26% (n=3,264)
2012	-14% (n=2,822)
2013	+30% (n=3,665)
2014	-3% (n=3,570)
2015	-8% (n=3,290)

Chart 1 illustrates the different subgroups of individuals included in the clients new to KnoxHMIS. Ninety-one percent of services are directly provided to those literally homeless. Whereas, 9% of services are non-housing emergency prevention assistance provided to individuals at risk of homelessness.

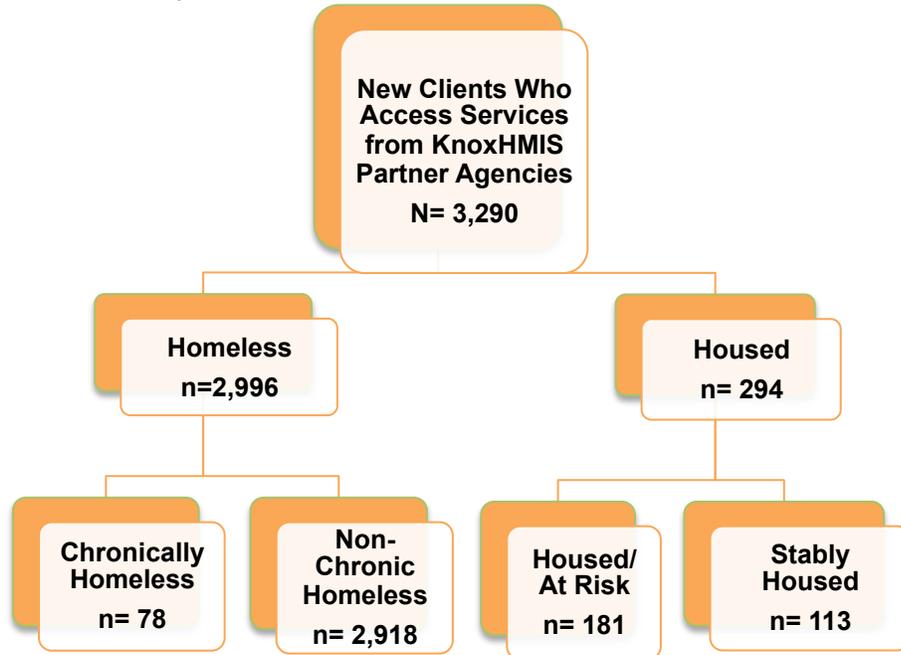


Chart 1: 2015 Subgroups of Clients New to KnoxHMIS

Chart 2 delineates the entry point of new clients into KnoxHMIS by program type. It is notable that 69% of clients new to homelessness access services through homeless prevention or supportive services.

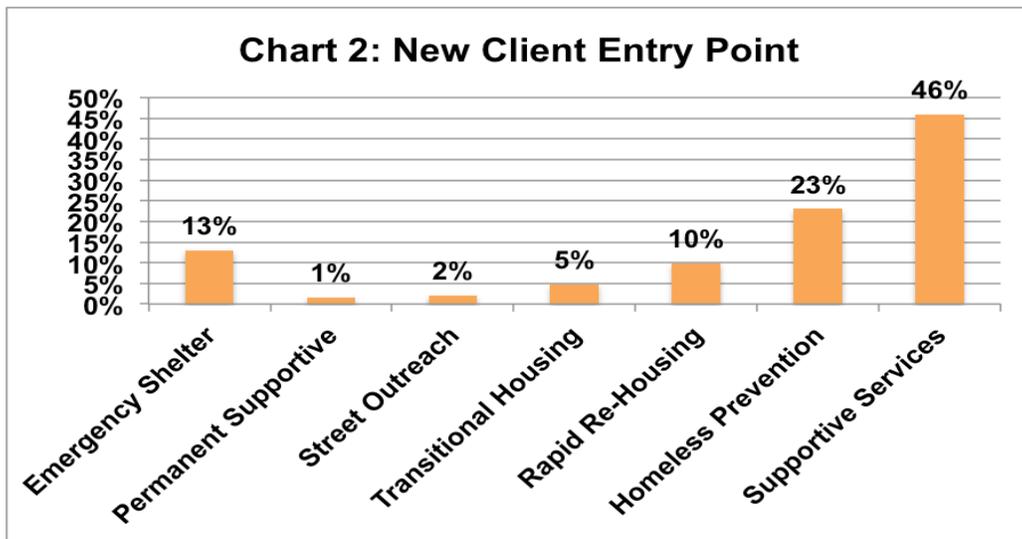


Table 2 compares the number of individuals categorized into sub-groups of those who were newly entered into KnoxHMIS in 2014 and 2015.

	2014 n=	2015 n=	Percent Change
Families	283	254	-10%
Youth	314	364	+14%
Veterans	387	338	-13%
Chronically Homeless	31	78	+60%
Street Homeless	247	303	+18%
Seniors	198	161	-19%

Subgroups were determined by priority initiatives as designated by the U.S. Department of Housing and Urban Development, the Department of Veteran Affairs, Family and Youth Services Bureau, Knoxville City government, Knox County government, and KnoxHMIS partner agencies. More about these initiatives and parameters of each is discussed in the “Sub-populations of Active Clients” section of this report. Again, it should be noted that the definition and data collection for chronic homelessness changed in October 2014 and again in October 2015 thus greatly decreasing the numbers reported for this subpopulation.

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. “New Clients” are *included* in the total active clients. Between 2014 and 2015, there has been a 1% increase among active clients. While the majority of active clients are homeless (n=7,714), some active clients are housed (n=1,625), having been formerly homeless or they are housed but at risk of becoming homeless. The figure in **Chart 3** represents the different subgroups of individuals included in the active client population.

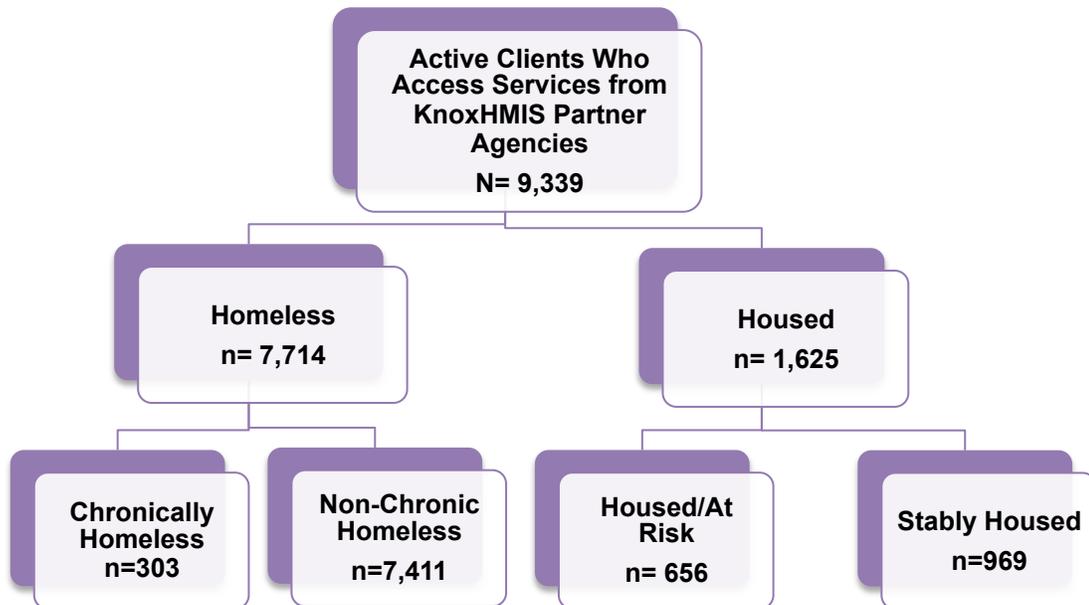
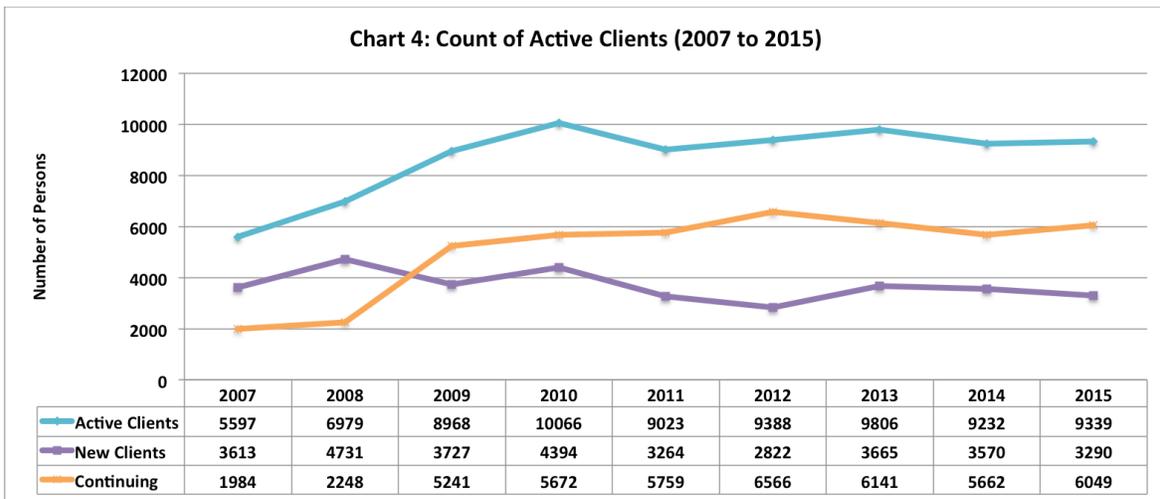


Chart 3: 2015 Subgroups of Active Clients⁴

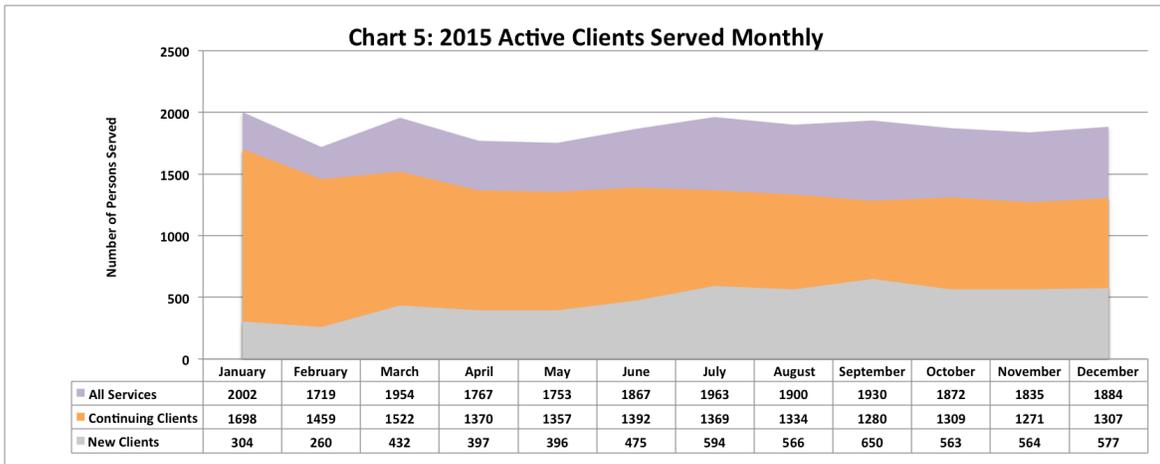
It should be noted that in KnoxHMIS’ annual reports on homelessness prior to 2012, the number of “active clients” was calculated by simply counting the number of individuals receiving services during the year-long report period. However, not all of our partner agencies capture services. Instead they may track entries into their agency programs. In order to provide a more accurate count of active clients, KnoxHMIS started including both services and program entries as indicators for client activity effective in the 2013 annual report.

Chart 4 illustrates a long-term perspective in which the number of active clients has increased 40% since 2007. Overall, this increase is potentially indicative of improvements in agency data quality, increased utilization of KnoxHMIS and the addition, over the last three years, of seven new partner agencies that are serving clients not previously captured in KnoxHMIS. The count of active clients is the sum of new and continuing clients.

⁴ In previous reports, housed individuals only included clients who indicated a housing status of “stably housed.” In the 2013 report, KnoxHMIS started including clients who reported as “imminently losing their housing” and “unstably housed and at risk of losing their housing.”



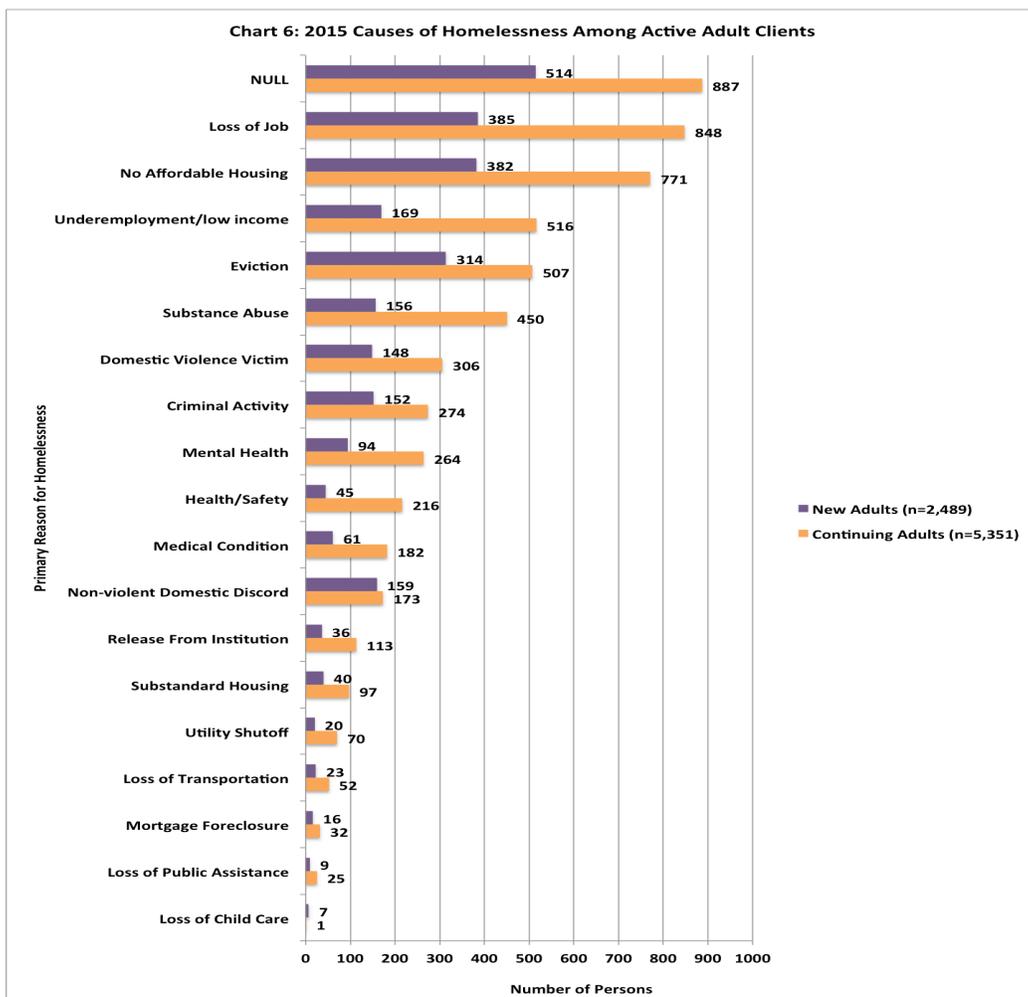
On average, 1,871 clients were served per month. The number of clients served each month is detailed in **Chart 5**.⁵ Please note that the sum of active clients by quarter and month will not reflect the total number of unduplicated active clients (N= 9,339) as the clients may be served in multiple months or some clients may not have had specific services recorded in KnoxHMIS.



Primary Reason for Homelessness of Active Clients

Overall, the top three reasons for homelessness among *adult* active clients (n=7,840) was self-reported as: “loss of job” (16%), “no affordable housing” (15%), and “eviction” (10%). It should be noted that primary reason for homelessness is collected on adults in the household; children under the age of 18 are excluded. **Chart 6** delineates the causes of homelessness (or *primary reason for homelessness*) among active adult clients, both those new and those continuing services. “Nulls” in Chart 6 reflect data not captured and/ or entered at intake.

⁵ The numbers represented in Chart 5 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.



When comparing primary reason for homelessness among gender, adult males (n=4,678) most frequently reported “Loss of Job” (19%) as primary reason for homelessness, while adult females (n=3,106) most frequently reported “No Affordable Housing” (13%) and “Eviction” (11%). It should be noted that this variable is based on the client’s perception of his or her primary reason for homelessness and is self-reported at program intake. 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.

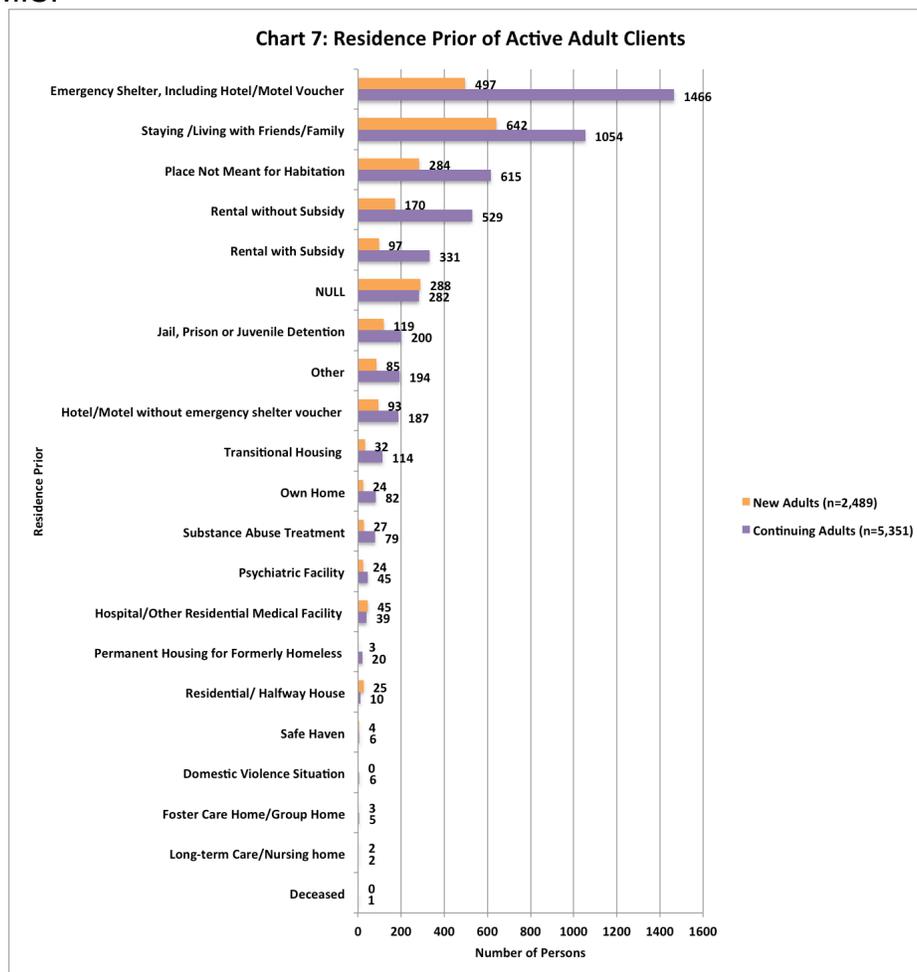
Domestic violence is also captured as primary reason for homelessness in KnoxHMIS, of which 5% of all active clients (both male and female) report as a cause of homelessness. **Table 3** shows the percentage of the active adult females between 2010 and 2015 who reported domestic violence as the primary reason for homelessness.

Year	Percentage of Females
2010	15%
2011	15%
2012	17%
2013	15%
2014	14%
2015	10%

In 2015, there has been a 4% decrease in self-reported domestic violence among female adults. **It is critical to note that domestic violence is likely underreported due to client and/or agency hesitance to report domestic violence in an HMIS database.**⁶ Questions related to domestic violence are additionally captured as HUD universal data elements that specifically ask: “Domestic violence victim/survivor,” “If yes domestic violence victim/survivor, are you currently fleeing?,” and “If yes for domestic violence victim/survivor, when did experience occur?.” Five percent of female domestic violence victims/survivors reported that they were fleeing a domestic violence situation; fifty-one percent reported that the experience occurred within the past year (i.e. 34% within the past three months, 9% three to 6 months ago, 8% six to twelve months ago).

Residence Prior of Active Clients

KnoxHMIS captures “residence prior” to program entry in order to better understand the living situation of persons experiencing homelessness. It should be noted that residence prior is collected on adults in the household; children under the age of 18 are excluded. **Chart 7** breaks down the residence prior among active adult clients, both those continuing services and new to KnoxHMIS.



Thirty-seven percent of active adults reported a residence prior that could have been addressed through homeless prevention services (i.e. residence prior of

⁶ Garcia, 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

owning [1%], rental [14%], or staying/living with family friends [22%]). Twenty-five percent of active adults reported emergency shelter as residence prior, which typically indicates that the person is entering a supportive or case management service after having sought emergency shelter. Eleven percent of active adults reported residence prior as place not meant for human habitation, which includes sleeping in an unsheltered location such as a public place, car, abandoned building, or camping outdoors.

Active Client Demographic Characteristics

Table 4 represents demographic information on active clients in 2015. The table presents the percentage of all active clients and breaks down age, race⁷, and ethnicity demographics into gender categories.

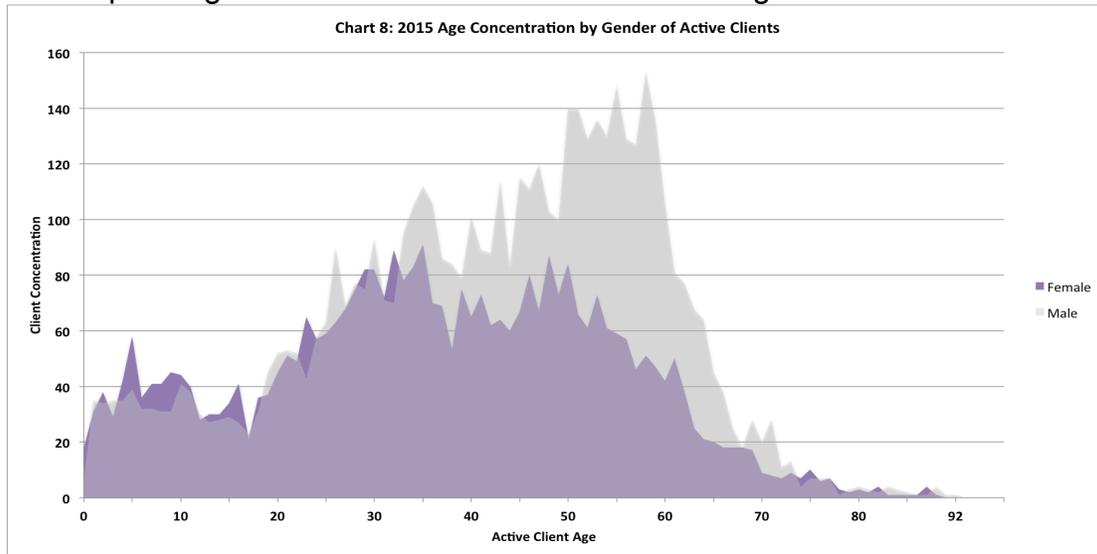
	Male	Female	Other/Null Gender	% of Active Clients (N=9, 339)
GENDER	56%	40%	4%	100%
AGE RANGE				
0—17 years	46%	54%	1%	13%
18—24 years	49%	50%	0%	7%
25—55 years	58%	41%	0%	57%
56—61 years	71%	29%	0%	11%
62 + years	65%	35%	0%	8%
NULL Age	9%	5%	85%	4%
RACE				
White	59%	41%	0%	66%
Black or African American	58%	42%	0%	27%
Other	51%	47%	2%	2%
Null	20%	16%	64%	5%
ETHNICITY				
Non-Hispanic/Non-Latino	59%	41%	0%	89%
Hispanic/Latino	54%	46%	0%	3%
Null/Don't Know	33%	31%	36%	9%

The percentage breakdown for gender, race, and ethnicity are consistent with 2014 data. Further, KnoxHMIS data reflects that 26% of active clients were African American. Notably, Knox County’s population is comprised of 9% “African American” individuals in comparison to 17% of the population of Tennessee.⁸ 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.

⁷ “Other” race includes individuals who reported their race as *American Indian, Alaskan Native, Asian, Native Hawaiian, and Multiracial*.

⁸ 2014 United States Census Bureau (quickfacts.census.gov) and County Data (<http://www.census.gov/quickfacts/table/PST045215/47,47093>) retrieved May 2016

The age ranges were changed this year to reflect the age group of ages 18 through 24, which is consistent with Federal initiatives to address young adult homelessness. **Chart 8** additionally illustrates the age distribution of active clients by gender.^{9,10} In 2015, the average for all active clients was 39 (Age 36 for females; age 42 for males). Of particular interest is that the peak age concentration (mode) for homeless women is age 35, which is 23 years younger than the peak age concentration of homeless men at age 58.



Disability Status of Active Clients

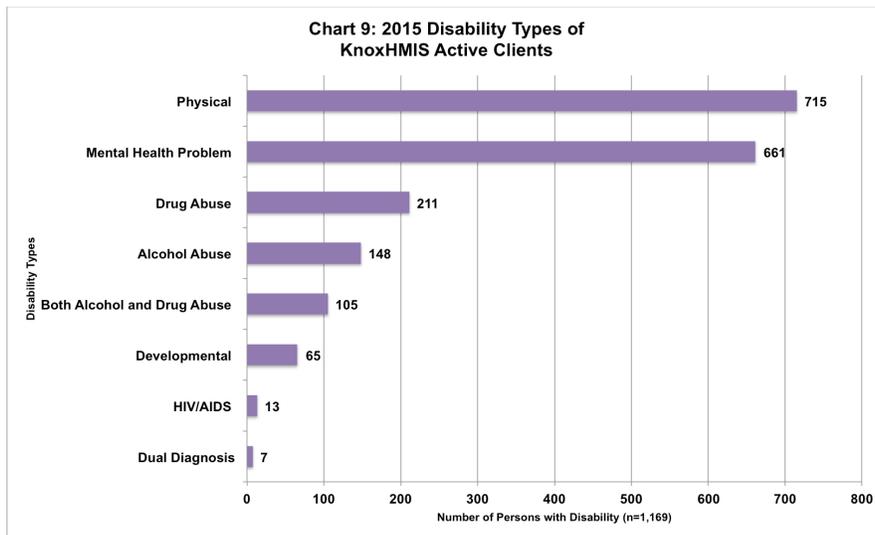
In 2015, 13% of active clients (N=9,339) reported having a disability (n=1,169). The percentage of disability reported is notably lower than the 25% reported in 2014. This is because KnoxHMIS is now using the HUD requirements as detailed in the 2014 HUD Data Standards¹¹ for disability verification. In previous reports, KnoxHMIS followed 2010 HUD guidance and only utilized the question, “Do you have a disability of long duration?” and “yes” responses to report disability counts. Using the 2014 HUD Data Standards, the following KnoxHMIS assessment questions must be answered: “Do you have a disability of long duration?,” “Disability Type” “Disability Determination?,” and “Expected to be of long-continued and indefinite duration?” must also be answered as “yes” in order to report a person as having a disability. HUD also provides guidance that disability data is to be captured on *all* clients participating in HMIS, *both adults and children under age 18*. It is likely that disability is further underreported because parents may be less likely to share the disability of youth in the household. Further, disability data is typically captured during the client intake, when the client may not feel comfortable sharing disability information upon program entry.

Chart 9 shows the percentage of disability types reported by active clients. It should further be noted that a person can report more than one disability type, so disability type counts will be greater than the total number of persons who reported a disability.

⁹ The data on age represents only individuals with a date of birth recorded.

¹⁰ The data on gender represents only individuals with gender recorded.

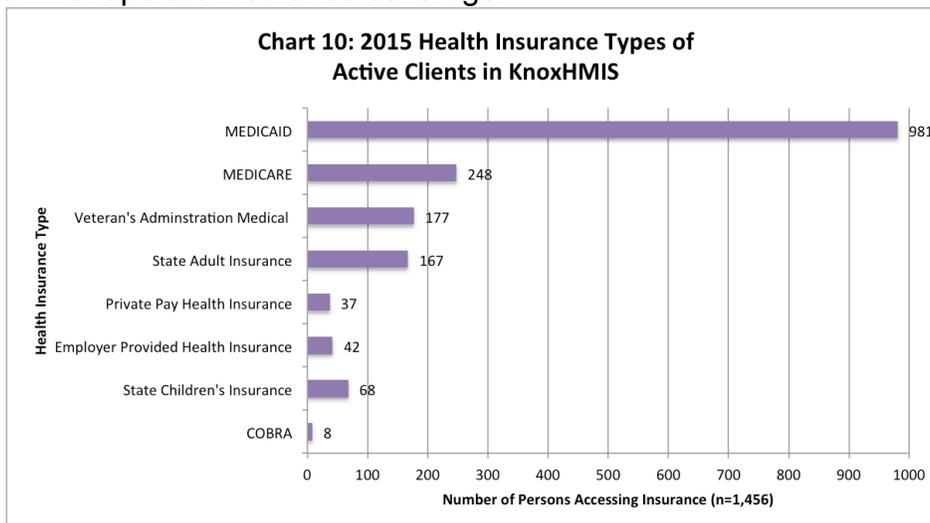
¹¹ 2014 HUD Data Standards: <https://www.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual.pdf> retrieved October 2014



Insurance Coverage of Active Clients

The 2014 HUD Data Standards added new questions on insurance coverage and types of insurance coverage to be collected on *all* persons participating in HMIS, *both adults and children under age 18*. Data on these fields were not reported on in the 2014 KnoxHMIS annual report because the data were new, added mid-year, and data quality was not high enough to warrant validity. In 2015, 16% of persons experiencing homelessness reported having insurance. It is likely that more persons have insurance; however, due to the recent introduction of insurance data fields, the total persons accessing insurance is likely underreported.

Chart 10 illustrates types of insurance accessed by persons experiencing homelessness. It should further be noted that a person can report more than one insurance type, so insurance type counts will be greater than the total number of persons who reported insurance coverage.



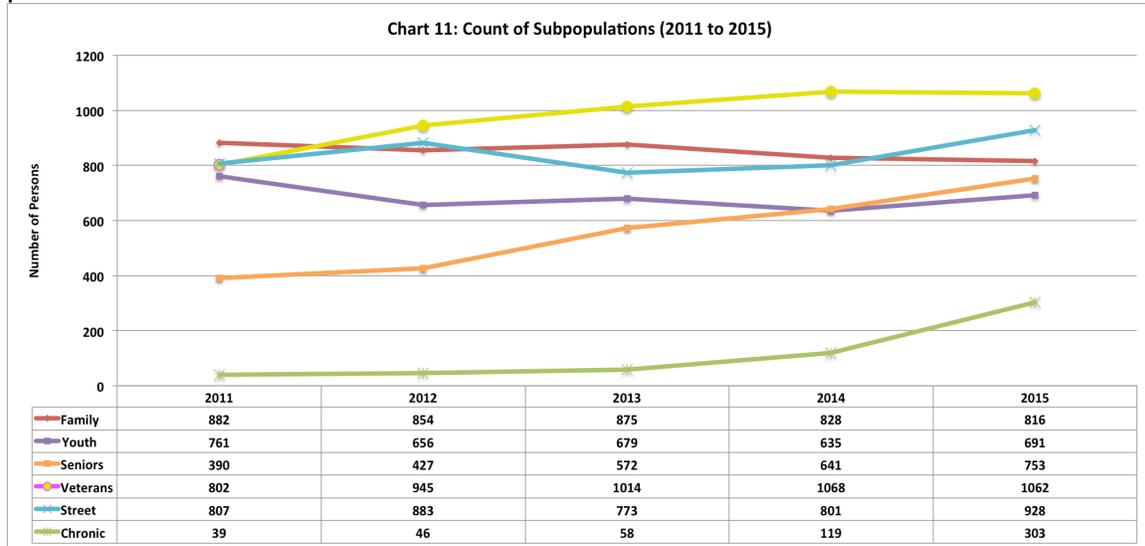
Subpopulations of Active Clients

In this section, subpopulations of persons experiencing homelessness are examined and include the following groups: families, youth, seniors, veterans, street homeless, and chronically homeless. KnoxHMIS has gone back over previously reported annual report numbers using new criteria. These six subpopulations are included in this report because they are national priority initiatives issued by the United States Interagency Council on Homelessness, Opening Doors: Federal Strategic Plan to Prevent and End Homelessness.¹² Opening Doors is the nation's first comprehensive Federal strategy to prevent and end homelessness. It was presented to the Office of the President and Congress on June 22, 2010, and updated and amended in 2015. Goals of the plan are to: prevent and end homelessness for families with children and youth in 2020, prevent and end homelessness among Veterans in 2015, finish the job of ending chronic homelessness in 2017, and for communities to collaborate to end all types of homelessness. The Knoxville-Knox County community homeless service providers are involved in addressing the needs of these subpopulations locally through collaborative efforts of the Knoxville-Knox County Homeless Coalition partners and Continuum of Care. In each subpopulation subsection, parameters defining each are included as well as unique characteristics, facts, and figures. **Table 5** lists the percentage of active clients who may be categorized within a subpopulation.

Subpopulation	Percentage of Active Clients (N=9,339)
Families	28% (n=2,626)
Youth Ages 18-24	7%(n=691)
Seniors	8% (n=753)
Veterans	11% (n=1,062)
Street Homeless	10% (n=928)
Chronically Homeless	3% (n=303)

¹² USICH Opening Doors:
https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf retrieved January 2016

Chart 11 plots the count of subpopulations served over time by KnoxHMIS partners.



Families

Families are defined by KnoxHMIS as a *household consisting of a minimum of two individuals, at least one of which must be under the age of 18*. In 2015, 816 family households were served and included 2,626 persons or 28% of *all* active clients served. This is a 1% decrease over family households served in 2014 (n=828). The following is a summary of family households:

- 38% (n=995) reported “gender” as male, 61% (n=1605) as female, and 1% (n=26) other (i.e. “data not collected” or “transgender”)
- Average age of adults in households was 44 years old; mode of 29 years of age
- Average age of children was 9 years old; mode of 11 years of age
- 55% (n=1,441) reported “race” as white, 39% (n=1,027) as black or African-American, and 6% (n=158) as other¹³
- 95% (n=2,495) reported “ethnicity” as Non-Hispanic; 5% (n=131) as Hispanic
- 39% (n=321) of family households had four or more members
- 16% (n=1,499) of all active clients were children under age 18
- 90% (n=734) of family households (n=816) included male children ages 12—17
- 7% (n=66) were *unaccompanied youth*¹⁴
- 10% (n=82) were households with *parenting youth*¹⁵
- 8% (n=66) were family households including a military veteran
- 47% (n=387) of family households reported “housing status” as literally homeless, as 32% (n=258) at –risk of homelessness, and 21 (n=171)% as indeterminate¹⁶

¹³ “Other” race includes *American Indian, Alaskan Native, Asian, Native Hawaiian, Multiracial, data not collected, client doesn’t know, client refused*, and null responses.

¹⁴ Unaccompanied youth defined as persons ages 12—24 who serve as the “head of household.”

¹⁵ Parenting youth defined as youth ages 12—24 parenting another youth under the age of 18.

¹⁶ Housing status is extracted from the KnoxHMIS assessment question “Housing Status” recorded at program entry; Housing status criteria is defined by HUD.

- 16% (n=132) of adults in the household (n=808) reported “eviction” as the “primary reason for homelessness”
- 29% (n=238) of adults in the household (n=808) reported emergency shelter as their “residence prior,” 23% as staying or living with family/friends, and 23% as rental or owning a home
- 65% (n=529) were positively housed in 2015

Young Adults

Young adults are defined by KnoxHMIS as *persons ages 18—24* and follows HEARTH Act and Runaway Homeless Youth Act guidance.¹⁷ In 2015, 691 young adults experienced homelessness or 7% of all active clients served by KnoxHMIS partner agencies. This is a less than 1% increase over young adults served in 2014 (n=635). The following is a summary of the young adults subpopulation:

- 50% (n=346) reported “gender” as male, 49% (n=343) as female, and 1% (n=2) other (i.e. “refused” or “transgender”)
- The average age was 21 years old
- The most frequent age was 21 years old
- 60% (n=416) reported “race” as white, 34% (n=233) as black or African-American, and 6% (n=42) as other
- 96% (n=666) reported “ethnicity” as Non-Hispanic; 4% (n=25) as Hispanic
- 1% of all veterans served (n=1,062) were youth (n=18)
- 61% (n=425) reported “housing status” as literally homeless, 14% (n=94) as at-risk of homelessness, and 25% (n=172) as indeterminate
- 29% (n=196) reported residence prior as staying or living with family/friends
- 17% reported employment issues as “primary reason for homelessness” (i.e. 10% loss of job and 7% underemployment)
- 30% (n=204) were positively housed in 2015

Seniors

Seniors are defined as *persons ages 62 or greater*. In 2015, 753 seniors were served or 8% of all active clients served by KnoxHMIS partner agencies. This is a 15% increase over seniors served in 2014 (n=641). The following is a summary of the seniors subpopulation:

- 65% (n=487) reported “gender” as male; 35% (n=263) female
- The average age was 76 years old
- The most frequent age was 66 years old
- 73% (n=547) reported “race” as white, 23% (n=175) black or African-American, and 4% (n=31) other
- 99% (n=742) reported “ethnicity” as Non-Hispanic; 1% (n=11) Hispanic
- 18% of all veterans served (n=1,062) were seniors (n=186)
- 49% (n=371) reported “housing status” as literally homeless, 33% (n=246) at-risk of homelessness, and 18% (n=136) indeterminate
- 27% (n=205) reported “residence prior” as renting or owning a home
- 16% (n=124) reported lack of affordable housing as their “primary reason for homelessness”
- 27% (n=205) were positively housed in 2015

¹⁷ Runaway Homeless Youth Act: <http://www.acf.hhs.gov/programs/fysb/resource/rhy-act> retrieved January 2016

Veterans

Veteran status is self-reported by persons served by KnoxHMIS partner agencies. Veteran Affairs (VA) verification of veteran status is typically accessed *only* in cases where case management is assisting the person in obtaining veteran benefits services, the agency mission is veteran focused, or as referral eligibility for HUD VASH voucher. In 2015, KnoxHMIS started working to uphold VA guidance¹⁸ on HMIS participation¹⁹ and is a diligent partner in the national Zero: 2016 initiative²⁰, designated to end veteran homelessness in 2016.

In 2015, KnoxHMIS partner agencies worked collaboratively with both Knox County Continuum of Care and the twelve counties included in the Tennessee Valley Continuum of Care²¹ to reduce veteran homelessness. The collaboration, known locally as Operation Home, meets Zero: 2016 criteria. The Operation Home initiative has involved the development of a master list of homeless²² veterans²³. The master list follows the national model and is shared only among KnoxHMIS partners with permissions to access client-level information. Outreach, Difficult Cases, and Housing subcommittees have been formed as part of Operation Home to locate veterans, provide case management, and reduce barriers to obtaining permanent housing. In 2015, Operation Home was successful in housing 63% (n=324) of veterans eligible for this initiative (n=513).²⁴ **It is important to note that persons served through Operation Home are a combination of both KnoxHMIS and TVCH HMIS, which together covers a 13 county area. Operation Home is a subset of all veterans served in each Continuum of Care.**

In 2015, 1,062 persons self-report veteran status or 11% of all active clients served by KnoxHMIS partner agencies. The following is a summary of the veterans subpopulation of active adult clients, including those eligible for Operation Home:

- 90% (n=960) reported “gender” as male; 10% (n=101) as female
- The average age was 54 years old
- The most frequent age was 56 years old
- 70% (n=741) reported “race” as white, 27% (n=292) as black or African-American, and 3% (n=29) as other
- 98% (n=1,041) reported “ethnicity” as Non-Hispanic; 2% (n=21) as Hispanic
- 1% of all veterans served (n=1,062) were young adults (n=18)
- 18% of all veterans served (n=1,062) were seniors (n=186)
- 21% of all veterans served (n=1,062) were chronically homeless (n=63)
- 13% of all veterans served (n=1,062) were street homeless (n=143)

¹⁸ Veteran Affairs Guidance: <https://www.hudexchange.info/resources/documents/VA-Programs-HMIS-Manual.pdf> retrieved January 2016

¹⁹ VA HMIS Participation: <https://www.hudexchange.info/news/va-releases-guidance-on-hmis-read-only-and-direct-entry-access-policy-q-a/> retrieved January 2016

²⁰ Zero: 2016 Criteria: <https://cmtysolutions.org/what-we-do/zero-2016> retrieved January 2016

²¹ TVCH CoC includes 12 Tennessee Counties: Anderson, blount, campbell, Caliborne, Cocke, Graninger, Hamblen, Jefferson, Loudon, Monroe, Sevier, and Union.

²² “Homeless” is defined by Operation Home as a person who is literally homeless meaning they have indicated that they are living in a place not meant for human habitation or have had an emergency shelter stay within the past 30 days.

²³ “Veteran” is defined by Operation Home as any individual who has served in the military, including boot camp.

²⁴ KnoxHMIS Operation HOME Reports: http://sworpswebapp.sworps.utk.edu/?page_id=9

- 73% (n=770) reported “housing status” as literally homeless, 19% (n=206) as at-risk of homelessness, and 8% (n=86) as indeterminate
- 27% (n=205) reported “residence prior” as renting or owning a home
- 35% reported employment issues as their “primary reason for homelessness” (i.e. 25% loss of job and 10% underemployment)
- 35% (n=370) were positively housed in 2015

Street Homeless

An individual who is “street homeless” is defined by KnoxHMIS as *someone who lives in a place not meant for human habitation such as sleeping in a public place, car, abandoned building, and/or camping outdoors*. In 2015, 928 persons served were street homeless or 10% of all active clients served by KnoxHMIS partner agencies. This is a 14% increase over street homeless served in 2014 (n=801). The following is a summary of the street homeless subpopulation:

- 65% (n=606) reported “gender” as male, 35% (n=322) as female
- The average age was 39 years old
- The most frequent age was 56 years old
- 72% (n=672) reported “race” as white, 25% (n=232) as black or African-American, and 3% (n=24) as other
- 98% (n=905) reported “ethnicity” as Non-Hispanic; 2% (n=23) as Hispanic
- 15% (n=143) of street homeless were veterans
- 86% (n=797) reported “housing status” as literally homeless, 6% (n=59) as at-risk of homelessness, and 8% (n=72) as indeterminate
- 30% reported employment issues as their “primary reason for homelessness” (i.e. 18% loss of job and 12% underemployment)
- 40% (n=365) were positively housed in 2015

Chronic Homelessness

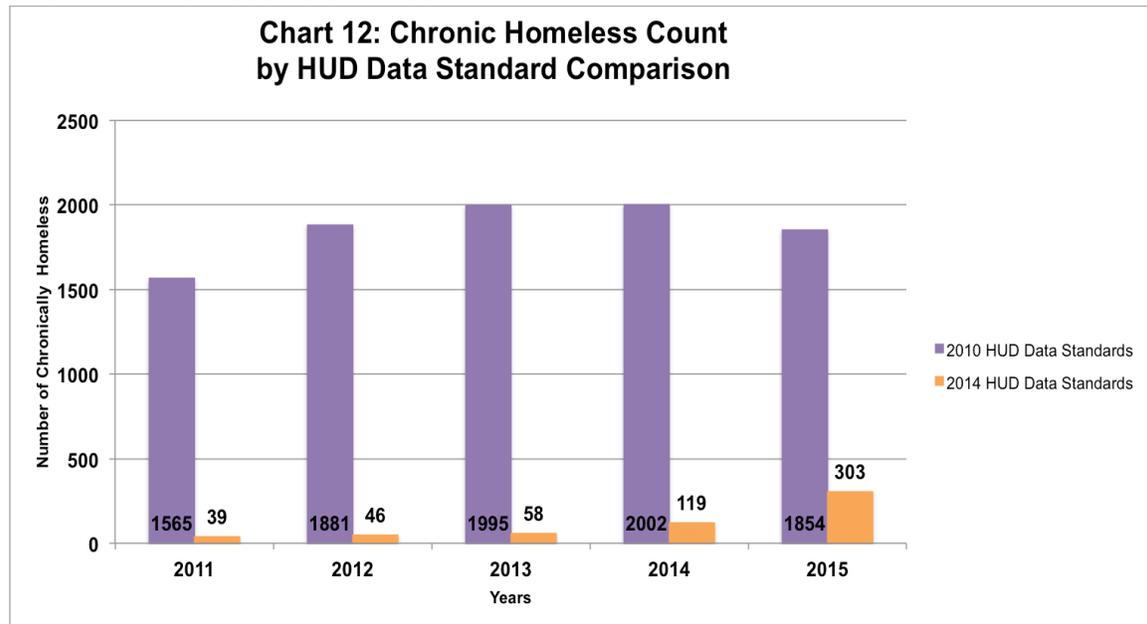
As defined by the United States Department of Housing and Urban Development (HUD)²⁵, chronically homeless describes *an individual or family who has been living in a place not meant for human habitation, safe haven, or emergency shelter continually for at least a year or has had at least four separate occasions of homelessness in the last three years AND the head of household in a family or the individual has a diagnosable disabling condition*. In 2015, 303 persons served were categorized as chronically homeless or 10% of all active clients served by KnoxHMIS partner agencies. This is a 61% increase over chronically homeless served in 2014 (n=119).

It is critical to note that this exponential increase in chronic homelessness is largely due to 2014 and 2015 HUD data standard guidance on how data is collected and reported for this category. Until October 2014, HUD guidance was simply to report on “yes” responses to the question “Is the client chronically homeless?” Starting in October 2014, HUD guidance began requiring that the following questions be considered when reporting chronic homeless status: “[Is] client entering from Streets, Emergency Shelter, or Safe Haven,” “If Yes for ‘Client entering from streets, ES, or SH’ approximate date started,” “Regardless of where they stayed last night—number of times the client has been on the

²⁵ HEARTH ACT: <https://www.onecpd.info/resources/documents/homelessassistanceactamendedbyhearth.pdf> retrieved January 2016

streets, ES, or in SH in the past three years including today,” and “Total number of months homeless on the street, in ES, or SH in the past three years.”

Chart 12 shows a comparison of chronic homelessness as guided by both 2010 and 2014 HUD data standards^{26,27}.



The following is a summary of the chronically homeless subpopulation using the 2014 HUD data standards:

- 74% (n=224) reported “gender” as male; 26% (n=79) as female
- The average age was 46 years old
- The most frequent age was 58 years old
- 71% (n=216) reported “race” as white, 25% (n=76) as black or African-American, and 4% (n=11) as other
- 99% (n=299) reported “ethnicity” as Non-Hispanic; 1% (n=4) as Hispanic
- 21% (n=63) of chronically homeless were veterans
- 85% (n=258) reported “housing status” as literally homeless, 14% (n=43) as at-risk of homelessness, and 1% (n=2) as indeterminate
- 19% (n=57) reported “residence prior” as place not meant for human habitation
- 36% reported a disability as their “primary reason for homelessness” (i.e. 19% substance use and 17% mental health)
- 40% (n=121) were positively housed in 2015

²⁶ 2010 HUD Data Standards:

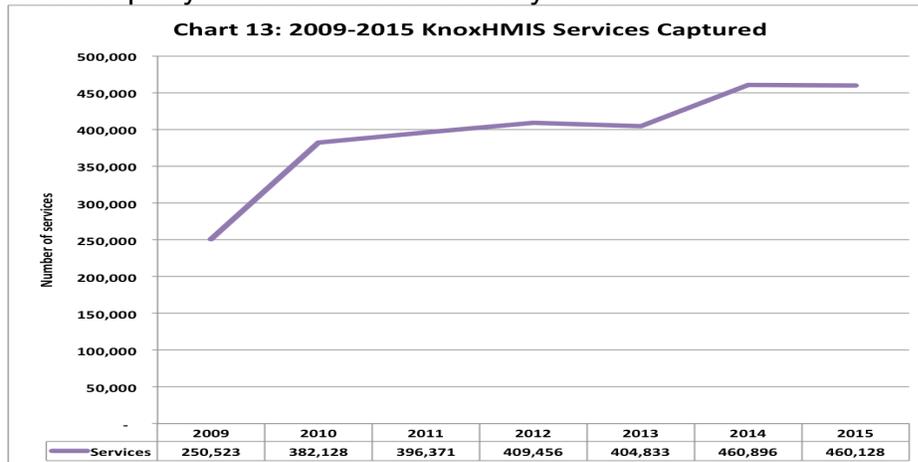
https://www.hudexchange.info/resources/documents/finalhmisdatastandards_march2010.pdf retrieved January 2016

²⁷ 2014 HUD Data Standards: <https://www.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual.pdf> retrieved January 2016

Coordination of Care

Services

The services feature in KnoxHMIS allows agencies and programs to record detailed information on how they are assisting clients. This feature enables for improved collaboration among various service providers by eliminating unnecessary duplicative services. The number of services provided per year has changed from 460,896 in 2014 to 460,128 in 2015, resulting in a 2% decrease. On average, 38,344 services were provided per month. **Chart 13** plots the number of services per year over the last seven years.



Case Notes

The case note feature in KnoxHMIS allows case managers to record detailed information on clients that they are assisting. In 2015, KnoxHMIS partner agencies recorded 11,671 case notes on 1,106 clients, averaging 10.5 case notes per client. The following figures indicate a decrease in the number of case notes per client and a decrease in the number of active clients with case notes from 2014 (**Table 6**).

Year	Total Case Notes	Total Clients with Case Notes	Average Case Notes Per Client	Percentage of Active Clients with Case Notes
2009	10,265	1,560	6.5	28%
2010	10,505	1,411	7.9	20%
2011	12,701	994	12.8	14%
2012	11,451	1,025	11.2	22%
2013	15,166	1,326	11.4	14%
2014	13,492	1,291	10.5	12%
2015	11,671	1,106	10.5	8%

Table 6 suggests that case managers are not utilizing case notes to document work with clients in HMIS, which can largely contribute to better coordinated services. However, it is noteworthy that 62% (n=2,366) of persons enrolled in programs (n=3,819) have case manager recorded.

Housing Outcomes

KnoxHMIS collaborates annually with KnoxHMIS partner agencies and the City of Knoxville Office on Homeless to report housing outcomes for the Knoxville-Knox Continuum of Care (CoC, TN-502). Sections of the HUD Annual Homeless Assessment Report to Congress (AHAR), Point in Time Count (PIT), and Housing Inventory Count (HIC) were published in the 2014 KnoxHMIS Annual Report; Unfortunately, these reports were not issued at the time of publication of the 2015 KnoxHMIS Annual Report. These reports will be released in 2016 and posted on the KnoxHMIS website.²⁸

Beginning in July 2015, KnoxHMIS received funding from the City of Knoxville to produce a Community Dashboard on Homelessness in response to Mayor Rogero's Plan to Address Homelessness.²⁹ The Dashboard (www.knoxhmis.org/dashboard) provides the community with at-a-glance information on the issue of homelessness in Knoxville, TN. Dashboard data is reported quarterly from July-June. Dashboard data represented are aggregated, de-identified client-level data extrapolated from KnoxHMIS. Dashboard data include:

- Homeless Counts (total served, new to homelessness, and at-risk of homelessness)
- Causes of Homelessness
- Housing Outcomes (time to housing, length of housing, housing placements, shelter recidivism)
- Shelter Bed Utilization
- Special Population Information (Veterans, Families, and Youth Homelessness)

Input and feedback on the Dashboard design was sought from representatives attending the Mayor's Roundtable on Homelessness, The Knoxville-Knox County Homeless Coalition, and KnoxHMIS Community Partners. HUD high performing community standards³⁰ and system performance measures³¹ were the primary guides in determining benchmarks.

The "Housing Outcomes" section of the KnoxHMIS Annual report follows the model of the Dashboard, where housing outcomes for the 2015 **calendar year** are reported rather than the City of Knoxville fiscal year (July—June) or federal fiscal year (October—September).

In the 2014 KnoxHMIS Annual report, the "Emergency Shelter and Transitional Housing" and "Exit Outcomes" subsections were included; those subsections are

²⁸ KnoxHMIS website and special reports: www.knoxhmis.org/reports/

²⁹ Knoxville's Plan to Address Homelessness:

http://www.knoxvilletn.gov/UserFiles/Servers/Server_109478/File/CommunityDevelopment/Knoxville's%20Plan%20to%20Address%20Homelessness%202014.2.pdf retrieved January 2016

³⁰ U.S. Department of Housing and Urban Development High performing Community Standards:

<https://www.gpo.gov/fdsys/pkg/CFR-2013-title24-vol3/pdf/CFR-2013-title24-vol3-part578-subpartE.pdf> retrieved January 2016

³¹ U.S. Department of Housing and Urban Development System Performance Measures:

<https://www.hudexchange.info/programs/coc/system-performance-measures/> retrieved January 2016

no longer included. Since the 2014 Annual Report, KnoxHMIS has refined reporting to fall in line with the HUD system performance measures. In this section, KnoxHMIS will present data on exit outcomes, housing placements, recidivism rates, time to housing, time to exit, and mean length of stay. Each of these measures included to reflect the success of KnoxHMIS partners in reducing and ending homelessness in our community.

KnoxHMIS has classified *exit outcomes* based on HUD guidance as positive, negative, or indeterminate.³² To determine the exit outcome of positive, negative or indeterminate, this report compares the residence prior to program entry with the exit destination per program type.

Table 7 provides an overview of exit outcomes by program type^{33,34,35,36, 37}.

Program Type	Positive	Negative	Indeterminate	Total Exits
Emergency Shelter	56%	23%	21%	1455
Transitional Housing	54%	35%	11%	624
Permanent Supportive Housing	44%	42%	14%	139
Rapid Re-Housing	90%	5%	5%	1018
Homelessness Prevention	94%	3%	3%	337
All Programs	68%	19%	12%	3573

Overall, 68% (n=2,445) of program exits (n=3,573) were positive housing destinations, which is 4% increase over 2014 (64%). It is important to note that the “total [clients with exit]” column in **Table 7** will not equal the number of clients exiting programs (n=1,951) because a client may be duplicated between categories, meaning s/he could have been served by multiple programs throughout the reporting period. In reviewing the most recent exit of unduplicated persons enrolled in programs during the report period, **1,951 unique individuals were housed in positive housing placements, which is a 2% increase over 2014 (n=1,901).**

In regards to *recidivism*, HUD high performing community standards require: *Of individuals and families who leave homelessness, less than five percent become homeless again at any time within the next two years; or the percentage of*

³² Positive exit destinations are defined as owning, rental, permanent housing, or living with family/friends permanent tenure. Negative exit destinations include: “jail/prison/juvenile detention,” “emergency shelter,” “place not meant for human habitation.” Indeterminate exit destinations include: “client doesn’t know,” “data not collected,” “client refused,” “no exit interview completed,” “other,” “safe haven,” Hospital/residential non-psychiatric medical facility,” and null.

³³ Emergency Shelter includes any facility whose primary purpose is to provide temporary shelter for the homeless for a period of 90 days or less.

³⁴ Transitional housing (TH) is housing that provides interim stability and support necessary for a person to successfully move to and maintain permanent housing. Transitional housing may be used up to 24 months and provide accompanying supportive services.

³⁵ Permanent Supportive Housing (PSH) is community-based housing without a designated length of stay in which formerly homeless individuals and families live as independently.

³⁶ Rapid Re-housing (RRH) emphasizes housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.

³⁷ Homeless Prevention emphasizes case management supportive services and serves those at-risk of homelessness who may own, rent, or stay with other family/friends and faced with potential eviction.

*individuals and families in similar circumstances who become homeless again within two years after leaving homelessness was decreased by at least twenty percent from the preceding federal fiscal year. **KnoxHMIS partners are successful in meeting this requirement.*** The 2015 recidivism rate was 3% among individuals with an emergency shelter stay in 2015 who also had a positive program exit within the past six months, which is consistent with the 2014 rate. Please note, that KnoxHMIS used HUD system performance measure as a model to determine this number; thus, the number is lower than reported last year because reporting metrics have been refined to more accurately reflect the rate.

KnoxHMIS partners are also making progress towards meeting the *mean length of homelessness* as specified in the HUD high performing community standards: *Either the mean length of episode of homelessness within the Continuum's geographic area is fewer than twenty days, or the mean length of episodes of homelessness for individuals or families in similar circumstances was reduced by at least ten percent from the preceding Federal fiscal year.* The following is a summary of housing outcomes per program type:

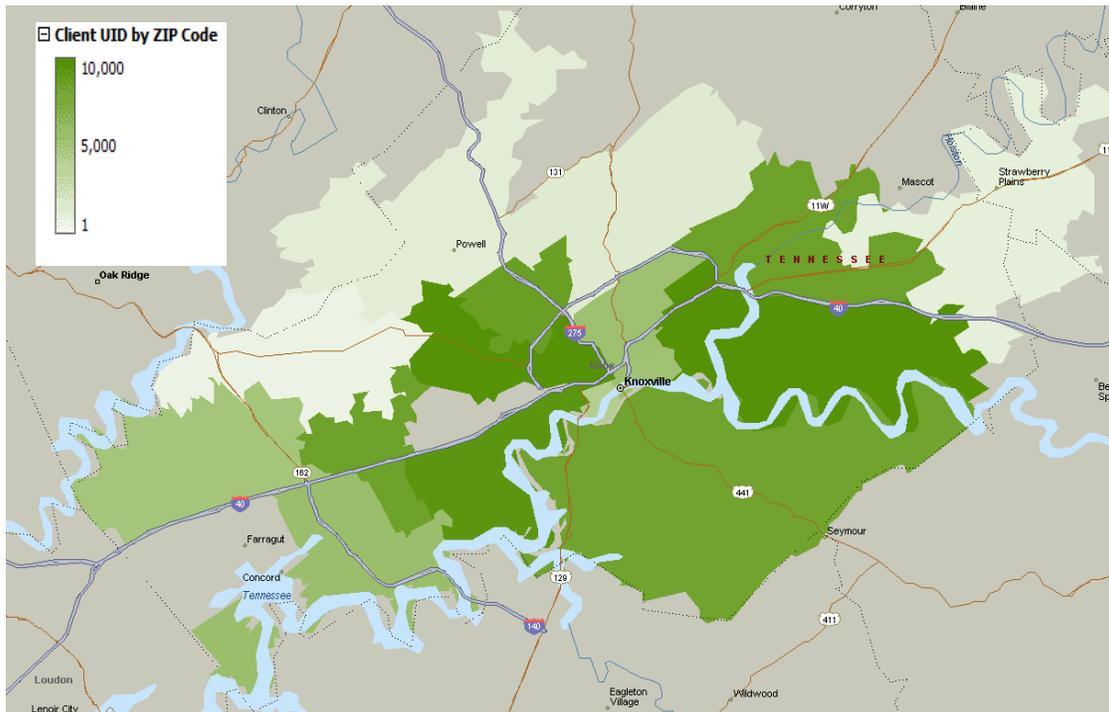
- Rapid-Rehousing programs have reduced time to housing by 53%; that is the time to housing in 2014 was 48 days compared to 28 days in 2015.
- Emergency Shelter programs (excluding night by night shelter) have reduced the time to exit by 8%; that is the time from program entry to exit was 135 days in 2014 compared to 124 days in 2015.
- Transitional Housing programs have reduced the time to exit by 18%; that is the time to exit in 2014 was 299 days compared to 244 days in 2015.

Although not a HUD high performing community standard, it is also important to note that persons placed in Permanent Supportive Housing have maintained housing stability, meaning they have increased their length of stay. Permanent Supportive Housing programs increased resident length of stay by 10%; that is the length of stay in 2014 was 698 days compared to 773 days in 2015.

Maps of Zip Codes

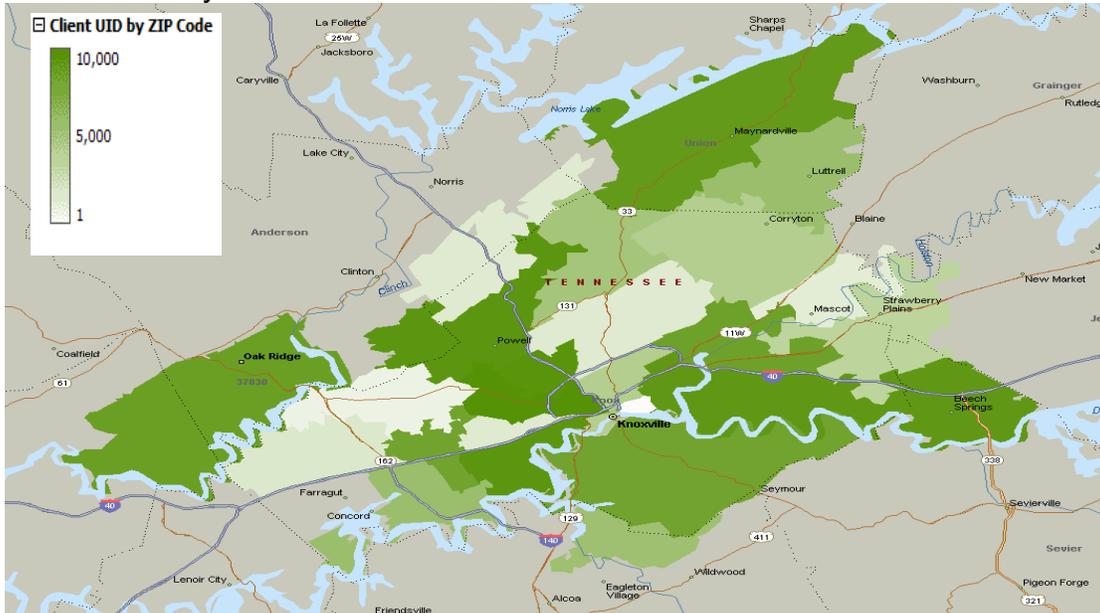
The following maps show the distribution of clients who received services in 2015 by the client's zip code of last permanent address. Zip code was recorded for 73% of active clients, which has decreased by 6%. These maps illustrate that the 65% of active clients who had zip code recorded had a last permanent address in the Knoxville-Knox County area. This represents a 1% increase from last year. In addition, 73% of individuals experiencing homelessness in Knoxville in 2015 report their last permanent address in Knox or a surrounding county.

Map 1 depicts the distribution of the last permanent address within the Knoxville City Limits. The highest concentration of clients had a last permanent address located in 37917 and 37920. Please note that some zip codes may only partially fall within the city of Knoxville and are, therefore, included in Knoxville.



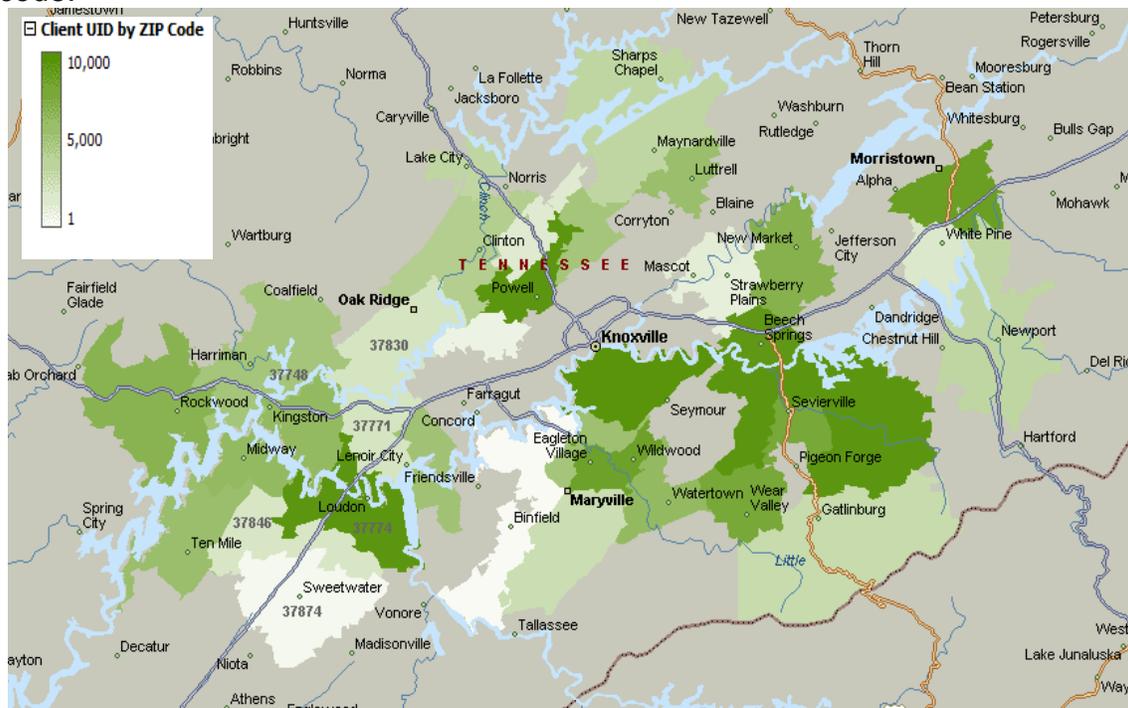
Map 1: Client Distribution in the City of Knoxville by Zip Code of Last Permanent Address

Map 2 shows the distribution of clients by zip code of their last permanent address within Knox County. Sixty five percent of clients had a zip code within the Knox County limits.

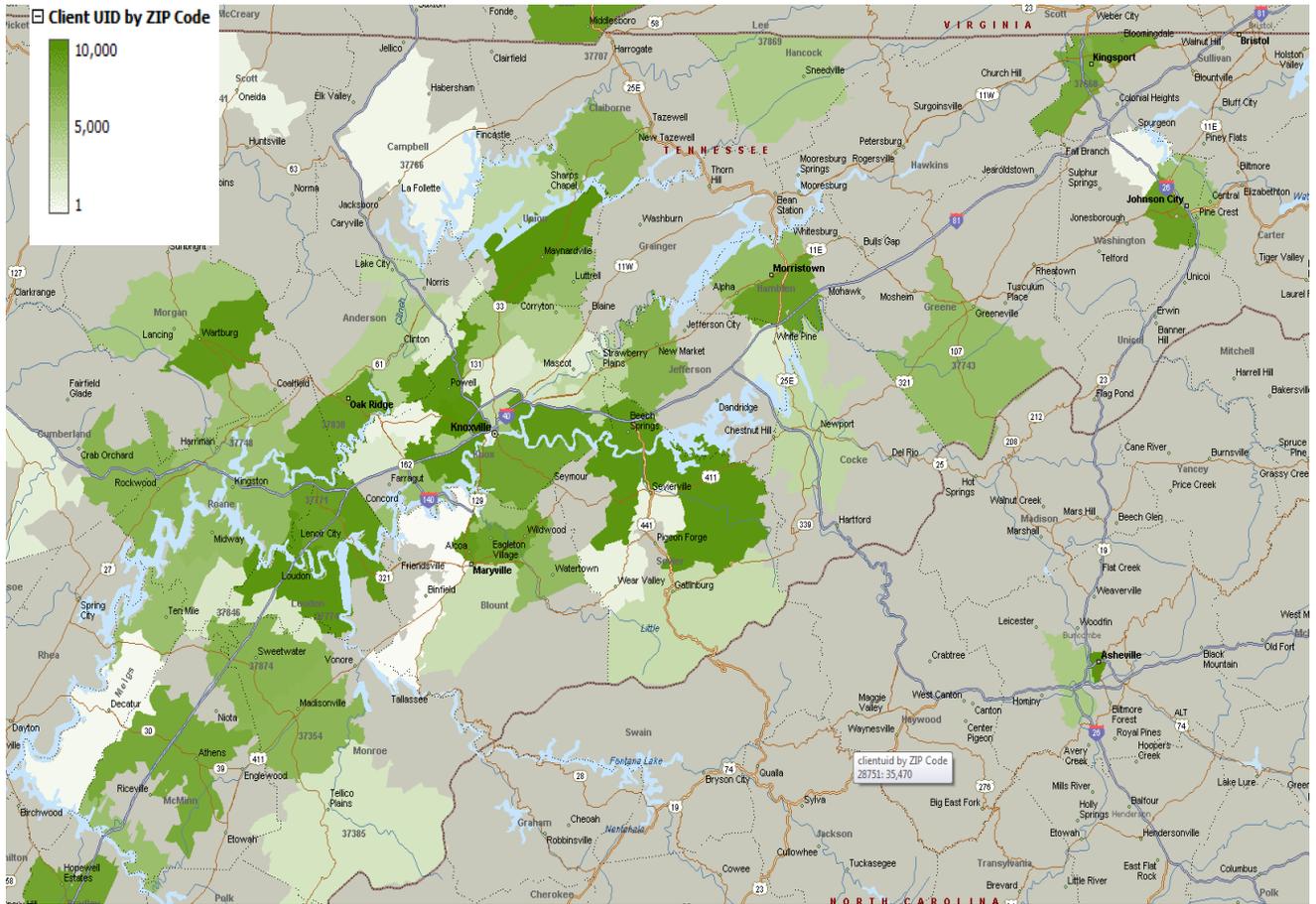


Map 2: Client Distribution in Knoxville-Knox County by Last Permanent Address

Map 3 represents the distribution of clients by the last permanent address in Knox County and the surrounding 8 counties. Ten percent of clients had a last permanent address within 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: Client Distribution in Counties Surrounding Knox Co. by Last Permanent Address

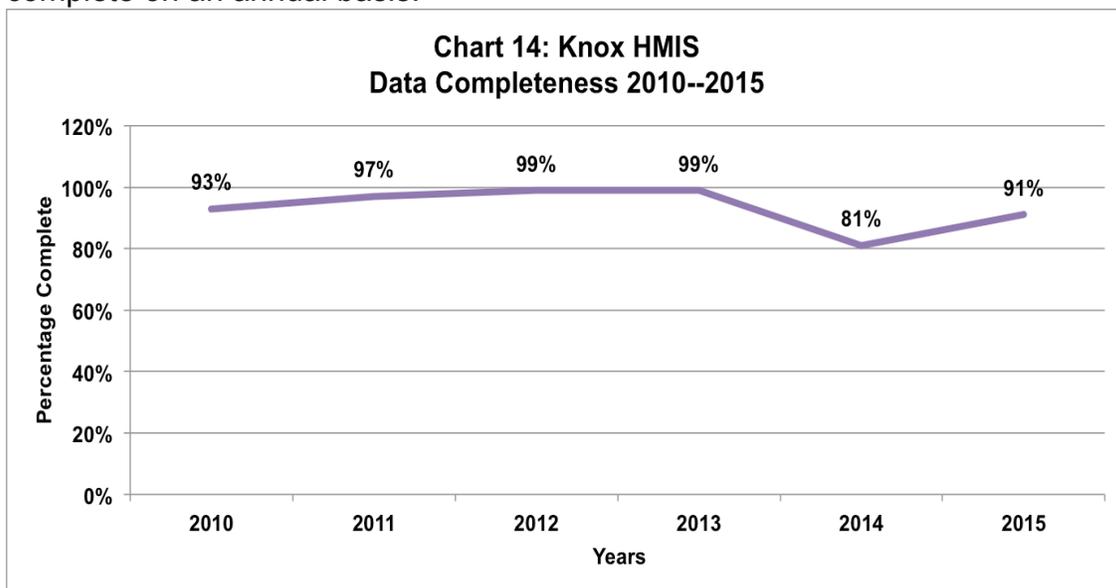


Map 4: Client Distribution Across East Tennessee Region by Last Permanent Address

Data Quality

The quality of information collected and stored in KnoxHMIS is central to the functioning of the services delivery 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. Furthermore, data quality is also important to the Knoxville community so that accurate and meaningful data is reported on the efficacy of programs assisting the homeless population through the Community Dashboard on Homelessness. KnoxHMIS maintains data quality through issuing data quality reports monthly, making partner agency site visits, and managing helpdesk support. Data quality is expected to rise over time. In 2016, KnoxHMIS has taken further steps to ensure high data quality by setting KnoxHMIS assessments to require universal data before allowing partner agency end-users to move forward with saving the client record.

Chart 14 displays the percentage of HUD required data elements that are complete on an annual basis.



Data represented in Chart 14 includes the HUD universal data elements for all entry/exit programs and excludes night-by-night shelter and service only programs. In previous KnoxHMIS annual reports data quality was reflected for new clients *only*, whereas Chart 14 includes data quality on *all* active clients. It is also important to note that data quality from 2010—2013 is evaluated using the 2010 HUD Data Standards and data quality for 2014—2015 uses the 2014 HUD Data Standards.

Director's Commentary

KnoxHMIS continues to be the 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 2015 KnoxHMIS Annual Report summarizes a vast quantity of data compiled over the last year by the 148 licensed system users in our 18 partner agencies who provided food, shelter, and array of other services to the 9,339 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 9,339 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 (13%), chronically homeless individuals (3%), children (8%), female single parents (7%), members of racial (33%) and ethnic minority groups (12%), seniors (8%) and with HUD specified disabilities (13%). 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.

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

Once again this year, we found that contrary to the often-stated belief that most homeless individuals come to Knoxville from elsewhere, a majority (65%) are from Knox County and the vast majority (73%) are from Knox County and the surrounding counties. The causes of homelessness are 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 are loss of job (17%), no affordable housing (16%), underemployment/low income (14%), and eviction (10%); all economically related. Also commonly self-reported factors include substance abuse, domestic violence, mental health and safety issues. The daunting challenges are amplified by and interact with the high levels of medical and behavioral health disabilities (13%) identified in individuals experiencing homelessness in this community.

What are the challenges?

As pointed out last year, the age distribution represented in Chart 8 illustrates one of the perhaps insufficiently addressed subpopulations among the homeless population of this area. The grey peaks on the right side of the figure, representing males 40 to 60 years old, indicate a notably large proportion of the 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.

As noted in this report under Housing Outcomes, the City of Knoxville provided KnoxHMIS with funding to create an online Community Dashboard on Homelessness (www.knoxhmis.org/dashboard). The intention is to provide an at-a-glance informational resource on the issue of homelessness and the performance of homeless service providers in Knoxville, Tennessee. Data represented on the dashboard are compiled from de-identified client-level information extracted from the Knoxville Homeless Management Information System (KnoxHMIS). Visitors to the site can interact with the graphics on the website can for instance compare across time the average number of days clients remain in emergency shelter compared to transitional housing. Refreshed quarterly, the information available on the Community Dashboard now enables agencies, funders, policy makers, and concerned citizens to evaluate the outcomes of efforts to address the housing and service needs of homeless individuals and families.

KnoxHMIS is a community outreach and engagement endeavor of the University of Tennessee and the College of Social Work. In addition to this annual report, we publish peer-reviewed research articles drawn from KnoxHMIS data. In a forthcoming article entitled *No Easy Way Out: One Community's Efforts to House Families Experiencing Homelessness* which will be published in *Families in Society: The Journal of Contemporary Social Services* (Patterson, West, Harrison, & Higginbotham, 2016), we report on the time and factors associated with finding housing for 133 families over the course of three years. Seventy-seven percent of the families found stable housing. While on average it took 152 days for these families to establish stable housing, strikingly it took single, female headed households 211 days. Prior research suggests that some of the challenges to finding stable housing for female headed households may be due to deleterious effects of untreated physical, sexual, and emotional trauma. In our study, families of veterans experiencing homelessness were 491% more likely to be housed. It is noteworthy that the Supportive Services for Veteran Families program is well-funded, has considerable programmatic flexibility, and is very well staffed. Taken together, the findings of this study of the complexities of stably housing families experiencing homelessness point to the need for housing programs to better address associated trauma and for provision of additional resources to rapidly rehouse families falling into homelessness.

Many thanks...

2015 marks the eleventh 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, 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 eleven years.

The KnoxHMIS Annual Report would not be possible without the ongoing data collection efforts of the 148 licensed users in our 18 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 enables us to serve the public by providing critical information to the community, our partner agencies, the City of Knoxville, Knox County, and to 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 Gary Moats. Lisa and Gary put in numerous hours running numerous data analysis procedures necessary to produce this report. Without their remarkable efforts, there would be no KnoxHMIS Annual Report. Well done!

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KNOXVILLE-KNOX COUNTY HOMELESS COALITION COMMUNITY PARTNERS

The Knoxville-Knox County Coalition for the Homeless meets on the fourth Tuesday monthly from 9:00 a.m. to 10:00 a.m. at the L.T. Ross Building located at 2247 Western Avenue, Knoxville, TN 37921. This section provides a listing of partner agencies and a description of homeless services provided.

Catholic Charities of East Tennessee, Inc.

Samaritan Place, located at 3009 Lake Brook Boulevard, includes an emergency shelter, transitional housing, and permanent supported housing for people sixty 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 (i.e. employment counseling, referrals, assistance with legal, medical referrals, and basic needs). Follow-up case management services are provided for clients placed in community housing.



www.ccetn.org
865-524-9896

Cherokee Health Systems

Cherokee Health Systems is a comprehensive health care organization and community health center with 45 clinical sites in 13 Tennessee counties. Cherokee Health Systems provides medical, dental, and behavioral health services to all ages. Cherokee offers convenient hours and have providers on call 24 hours a day for emergencies. Cherokee accepts most insurance and TennCare plans and offers flexible payment schedules.



www.cherokeehealth.com
865-934-6734

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.



www.knoxvilletn.gov
865-215-3103

Compassion Coalition

Compassion Coalition, comprised of a number of local churches, represents a coordinated effort to assist existing agencies serving the homeless.

These churches and other organizations provide meals. For example, Church Street United Methodist Church, Lost Sheep Ministry, Highways and Byways Ministry, and the Love Kitchen have provided meals and outreach services on specific days of the week for several

years. Other churches sponsor meals through the shelters. The Compassion Coalition also houses Circles of Support, a mentoring program that recruits and trains teams of volunteers from local congregations and matches them with recently housed individuals who are working with a case manager. The Circle of Support mentors assist with the case plan to help them retain housing and reconnect with the community. Mentors visit an hour each week for a minimum of one year.



www.compassioncoalition.org
865-251-1591

E.M. Jellinek Center, Inc.

The *E. M. Jellinek Center, Inc.* offers residential treatment for substance abuse and co-occurring disorders. The center offers assessment to determine level of care needed, group and individual therapy, education about addiction and co-occurring disorders, AA and NA 12 Step meetings, and family educational meetings. The center also focuses on teaching new coping and social interaction skills and relapse-prevention planning. The center serves 50 clients in four different levels of residential care with the goal being to transition the client to healthy, successful, independent living.



www.emjellinekcenter.org
865-525-4627

Family Promise of Knoxville

Family Promise of Knoxville provides shelter and support services to families with children. *Family Promise* is the only shelter in Knoxville that can house a two parent family together, a single dad with young children or a mom with boys over age 12. Families are sheltered overnight in our partnering hosting congregations. There are 18 hosting congregations that are supported by 28 congregations representing many denominations and faiths. In addition to shelter, *Family Promise* works with each family to form a sustainable housing plan, seek employment or educational opportunities and connect with any needed services. Once housing is secured, families enter a two-year aftercare program, *Going Home; Staying Home* where families transition from at risk to fully sustainable and self-sufficient lives.



www.familypromiseknox.org
865-584-2822

Helen Ross McNabb Center



The *Helen Ross McNabb Center* (HRMC) provides quality and compassionate care to children, adults and families experiencing mental illness, addiction and social challenges. Several programs benefit those experiencing homelessness including:

www.mcnabbcenter.org
Main: 1-800-255-9711
FCC: 865-637-8000
Youth LINC: 865-523-2689

- The *Family Crisis Center* (FCC) Domestic Violence-Victim Services provides a continuum of care through Emergency Shelter, Transitional Housing, and Outreach.
- *PATH* outreach case-management serves persons with a history of mental illness, experiencing homelessness, and reside within Knox County.
- *Youth LINC Transitional Living Programs* offers residential and community based services for youth ages 17 to 22 experiencing homelessness.
- *Host Homes* provides community-based emergency shelter and supportive services throughout Knox County for runaway and homeless youth ages 12-17 while reunification or other permanent placement options are pursued.
- Permanent supportive housing, Transitional Housing, and Supportive Living Facilities including 163 units of housing in Knox and Hamilton counties for individuals who are homeless and experiencing symptoms of a mental illness.

Knox Area Rescue Ministries

Knox Area Rescue Ministries (KARM) provides comprehensive supportive services that include emergency services, job training, and recovery programs. Emergency Shelter Services include overnight shelter for men, women, and families. Emergency services also include NaNew's Courtyard and Crossroads Welcome Center. NaNew's Courtyard serves as the entry point into Crossroads, a triage center where individuals can connect to KARM services and to



KNOX AREA RESCUE MINISTRIES

Restoring Lives In Jesus' Name

www.karm.org
865-673-6540

other community resources. Additional emergency services include daily meals served to persons in need and seventeen thrift stores in five surrounding counties that offer affordable goods. Job training programs offered to guests include the Abundant Life Kitchen food service training program and Clean Start, which prepares individuals for employment in the commercial cleaning field. As part of its recovery ministry, KARM offers Serenity and The Bridge. Serenity serves as the women's residential recovery program, that provides 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. The Bridge serves as KARM's men's transitional program, that provides a structured, supportive "next step" from homelessness to interdependent community living. KARM also offers group classes through KARM LaunchPoint, an innovative four-week program designed to help participants develop a goal-focused life plan and support system.

Knox County Public Defender's Community Law Office

The *Knox County Public Defender's Community Law Office* (CLO) practices a holistic, client-centered representation model that seamlessly combines vigorous legal advocacy with robust social services and access to community resources. The integrated structure of the legal and social services departments at the CLO creates a meaningful opportunity to partner with clients to help them stabilize their lives and get out of the criminal justice system. It provides comprehensive representation that recognizes the interaction between legal, personal and environmental issues and, in contrast to a more traditional lawyer-centered model, emphasizes the collaboration between client, attorney, and social worker.



www.pdknox.org
865-594-6120

Knoxville's Community Development Corporation

Knoxville's Community Development Corporation commonly known as KCDC, is the housing and redevelopment agency for Knoxville. KCDC's affordable housing opportunities include a variety of Premier Properties and Conventional Properties designed for families, seniors and disabled residents. In addition to managing and maintaining more than 3,500 premier and conventional rental units throughout Knoxville, KCDC also administers Section 8 housing programs. KCDC administers the contract for more than 4000 privately owned dwellings, which qualified participants rent from owners who accept federal subsidy as part of the rent.



www.kcdc.org
865-403-1100

Knoxville-Knox County Community Action Committee

Knoxville-Knox County Community Action Committee's (CAC) Homeward Bound program promotes the goal of helping people quickly regain stability in permanent housing after experiencing homelessness or a housing crisis. Case management with supportive services helps persons to obtain and/or retain housing through housing assistance, education, and employment. *CAC's Office on Aging's Project LIVE* (Living Independently through Volunteer Efforts) program focuses on serving homebound seniors (age 60+) who have limited support and income. The program employs case managers who assess each senior's situation and then link the person to community resources that are available, with a goal of keeping seniors independent in their own homes. *Project LIVE* also partners with Samaritan Place and other local shelters to provide case management and assistance to seniors who are literally homeless who need to regain housing.



Knoxville-Knox County
Community Action Committee

Helping People. Changing Lives.

www.knoxcac.org
865-546-3500

Knoxville Leadership Foundation's Flenniken Landing

Flenniken Landing is a KLF Southeastern Housing Foundation initiative. *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.



KNOXVILLE LEADERSHIP FOUNDATION
Weaving the fabric of a strong community

www.klf.org
865-577-1980

Knoxville Vet Center

The *Knoxville Vet Center* provides free Readjustment Counseling Services for combat veterans and their families. Services provided include:

- Individual Readjustment Counseling
- Group Meetings and Counseling
- Military Sexual Trauma Counseling
- Bereavement Counseling
- Marital and Family Counseling
- Substance Abuse Information and Referral
- Community Education – Trauma, PTSD, First Responder, Suicide
- Custom Training Designed and Presented to meet the specific needs of Community, Corporate Organizations and University School Programs focusing on Veteran-centric issues and needs
- Liaison with Community Agencies regarding Veteran-centric issues and needs



www.va.gov
865-633-0000

Knox County Public Library

The mission of the Knox County Public Library is to serve all residents as an educational, informational, recreational and cultural center through a wide variety of resources, services and programs. As the oldest continuously operating public library in the state of Tennessee, it has a proud heritage. Today, the Knox County Public Library offers more than one million books, periodicals, compact discs, films, audiobooks and downloads through 19 locations across Knox County, including one of the premier historical and genealogical collections in the Southeast.



www.knoxlib.org
865-215-8750

Knox County Schools Homeless Liaison

The duties of the *Knox County Schools Homeless Liaison* are as follows: identify homeless children and youth; ensure that children and youth experiencing homelessness enroll in, and have a full and fair opportunity to succeed in school; ensure that families, children and youth receive educational services for which they are eligible, including Head Start, Even Start and other public preschool programs, and referrals to health care, dental, mental health, and other appropriate services; inform parents and guardians of the educational and related opportunities available to their children and provide them with meaningful opportunities to participate in that education; disseminate public notice of educational rights; ensure that enrollment disputes are mediated; inform families and youth about transportation services and arrange transportation as needed.



www.knoxschools.org

Knox County Veterans Services

The mission of the Knox County Veterans Services Office is to assist Veterans and their dependent in filing applications for VA benefits. Outreach and information is provided to Veterans and surviving spouses on all federal and state benefits earned by Veterans in the service to their country.



www.knoxcounty.org/veterans
865-215-5645

Legal Aid of East Tennessee

Legal Aid of East Tennessee (LAET) provides free legal help to low-income residents facing crisis legal problems in the community. It is the mission of LAET to insure equal justice for low-income people by providing a broad scope of legal assistance and advocacy. LAET works respectfully with individual clients and the client community to identify and meet their needs for legal representation and empowerment. In pursuit of its mission, LAET seeks out and works cooperatively with other attorneys, social service providers, community-based organizations, and government and business leaders.



www.laet.org
865-637-0484

Mental Health Association of East Tennessee

The Mental Health Association of East Tennessee is dedicated to the promotion of mental health awareness, wellness and recovery in several communities. The Peer Recovery Call Center, open Monday through Friday 9 AM to 5 PM, provides referral and support services for individuals in crisis and recovery in addition to family members or friends. MHAET also offers free trainings on a variety of topics and free mental health screenings at mhaet.com.



www.mhaet.com
865-637-0484

National Safe Place

The mission of *National Safe Place Network* (NSPN) is ensuring an effective system of response for youth in crisis through public and private partnerships at a local, state and national level. NSPN envisions a world where all youth are safe. NSPN provides quality training and technical support for youth and family service organizations across the country. As a membership organization, NSPN offers an array of services tailored to meet agency needs in the most cost-efficient manner. These services include individual site visits, conferences, online training curricula, grant reviews, and more. NSPN is committed to agency growth and development, education, professional training and youth advocacy work.



www.nationalsafeplace.org
888-290-7233

Positively Living

Positively 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. It has a twenty-four bed capacity for men who were formerly homeless. The agency provides permanent supportive housing for the dually diagnosed mentally ill.



Positively Living

Caring solutions offering hope and security

www.positively-living.org
865-525-1540

Ridgeview Behavioral Health Services



Ridgeview currently offers an array of comprehensive behavioral health services at numerous sites, located throughout a five-county area. Last year, Ridgeview served over 7,500 individuals and these individuals represented over

www.ridgeview.com
800-834-4178

100,000 encounters. The *Creating Homes Initiative* through the Department of Mental Health and Substance Abuse Services along with Ridgeview Behavioral Services has partnered to provide a Housing Facilitator for Region II. The Housing Facilitator's purpose is to educate, inform, create and expand quality, safe, affordable and permanent housing options for people with mental illness and co-occurring disorders by assertively and strategically partnering with local communities. Contact information can be found at www.recoverywithinreach.org

The Salvation Army

The Salvation Army Center operates three residential programs. The programs cater to individuals who face a complex set of obstacles, including homelessness, domestic violence, shortage of affordable housing, mental illness and a lack of family and social support network.



Operation Bootstrap is the most basic program for men experiencing homelessness. It is a 90-day program

salvationarmytennessee.org/knoxville
865-525-9401

that can house up to seventy men. The *Transitional Housing* program is a job development program for single homeless individuals (both men and women) who need assistance in finding employment and establishing a saving plan to end the cycle of homelessness. Eighteen slots are designated for single 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, affected by domestic violence and also serves as a shelter for homeless women with children. *The Salvation Army* provides meals daily for residents and offers a range of case management and supportive services, including a Career Center that assists homeless individuals with job searches, resume writing, access to the internet and specialized employment training to help connect residents to appropriate employment opportunities that enables them to move from being consumers of community resources to becoming contributors. *The Emergency Assistance* program helps prevent homelessness by providing timely assistance with utilities, food, clothing, and furniture for low-income, families and individuals. *The Salvation Army* operates one family store in Knoxville and two 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 social services and shelter programs of the *Salvation Army*.

Steps House

Steps House is a non-profit, (501c3) corporation located in South Knoxville, Tennessee. Trained staff including several state and nationally licensed counselors are utilized in order to provide the best possible services to those served. Utilizing 42 home sites, Steps House provides three long-term continuum of care programs for our men and women, while addressing the needs associated with addiction and homelessness. The women's program does accept pregnant women and women with children under 2 years old. Steps House also works very closely with the resident's family members, case managers and parole and probation officers to ensure a continuous and complete recovery process for the resident. Steps House is currently a member of the National Homeless Coalition and the National Homeless Veterans Coalition. Steps House serves in an advisory capacity to the Knox County Drug Court, Department of Veterans Affairs and have received numerous organizational and individual awards for excellence including an Outstanding Service Award from the Veterans Administration in 2001.



www.steps-house.com
865-210-5315

Tennessee Valley Coalition for the Homeless

The Tennessee Valley Coalition for the Homeless (TVCH) works to systematically and holistically alleviate the causes and effects of homelessness in our region through services, education, and leadership. TVCH believes that all individuals deserve access to safe, decent, and affordable housing. Envisioning a region where homelessness is rare and lasts less than 30 days, a holistic approach is taken to homelessness, seeking to empower individuals and families with self-sufficiency. Programs include:

- *Supportive Services for Veteran Families (SSVF)* stabilizes veterans by providing supportive services for long term housing success.
- *Permanent Supportive Housing (PSH)* provides homeless individuals with long term housing solutions and case management.
- *Emergency Solutions Grant (ESG)* stabilizes homeless individuals with rapid rehousing solutions and case management.



www.tvchomeless.org
865-859-0749

Volunteer Ministry Center

Volunteer Ministry Center provides a variety of social services to assist in overcoming and preventing homelessness. *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. *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 (e.g. anger management, mental health management, legal advice, job search and employment, and social events). *The Bush Family Refuge* offers utility and rent assistance, access to eye exams and glasses, prescription co-pays and, in some circumstances, full payment on low-cost drugs. *The VMC Dental Clinic* offers dental cleanings, fillings, extractions and a denture clinic through the services of volunteer dental practitioners. *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*. For eligibility, please contact programs.



www.vmcinc.org
865-524-3926

Volunteers of America

Volunteers of America's (VOA) provides several programs for those at-risk or experiencing homelessness. VOA provides outreach, needs assessment, case management, employment counseling, job placement, transportation, and community referrals to homeless veterans or veterans at risk of being homeless in the Knoxville metro area and 12 counties surrounding Knox County. *The Homeless Veterans Reintegration Project (HVRP)* reintegrates veterans into the workforce and links homeless veterans with potential employers with the objective of helping them achieve self-sufficiency. *The Supportive Services for Veterans and Families (SSVF)* promotes housing stability among very low-income veteran families who reside in or are transitioning to permanent housing.



www.voamid.org/hvrpknoxville
865-524-3926

YWCA

The YWCA mission is to eliminate racism and empower women. The Women's Housing Program (WHP) serves women at –risk of or experiencing homelessness. 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.



eliminating racism
empowering women
ywca

www.ywcaknox.com
865-523-6126

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