



Homelessness in Knoxville and Knox County, Tennessee 2017-2018:

2018 Biennial Study,
Knoxville-Knox County Homeless Coalition

2017 Annual Report,
Knoxville Homeless Management Information System



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Other Reports of Interest:

To view the KnoxHMIS Community Dashboard on Homeless
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Table of Contents

Homelessness in Knoxville-Knox County: Introduction	5
Biennial Study Methodology.....	6
KnoxHMIS Annual Report	7
Homelessness in Knoxville-Knox County: Literature Review	8
Defining Homelessness.....	8
Housing After The Great Recession.....	10
Historical Contributing Factors and Myths.....	13
Characteristics and Subpopulations.....	18
Chronic Homelessness.....	19
Veterans.....	20
Unaccompanied Youth.....	21
Families.....	22
Seniors	23
Street Homeless.....	23
Ongoing Efforts and Opening Doors.....	25
Knoxville-Knox County Coalition for the Homeless Biennial Study on Homelessness.....	28
Note to the Reader	28
Study Design	30
Comments and Case Studies	33
Demographics.....	39
Characteristics.....	40
Background.....	40
Family	44
Social Support.....	47
Homelessness.....	50
Residence Prior.....	50
Causes	51
Barriers to Housing.....	52
Duration.....	54
Daily Experiences	55
Vulnerability.....	56
Income & Employment	57
Legal History and Deinstitutionalization	60

	4
Health.....	62
Physical Health.....	62
Mental Health	65
Substance Use History.....	67
KKCHC Supplemental Unsheltered Analysis	70
October 2017 Broadway Avenue/I-40 Overpass Survey	74
2017 Knox Homeless Management Information System Annual Report	78
Executive Summary.....	79
2017 New Clients.....	80
2017 Housing Status of New Clients	81
Service Entry Point of New Clients Added to KnoxHMIS in 2017	82
2017 Active Clients.....	83
2017 Housing Status of Active Clients	83
Count of Active Clients (2007-2017) by Subset.....	84
2017 Causes of Homelessness as Reported by Head of Household	85
2017 Residence Prior as Reported by Adults	86
Demographics of Active Clients in KnoxHMIS in 2017	87
Age Distribution of Active Clients in KnoxHMIS in 2017	88
Disability Types of Active Clients in KnoxHMIS 2017	89
Health Insurance Type of Active Clients 2017.....	90
Income Type of Head of Household 2017.....	91
2017 Subgroups of Active Clients.....	92
Summary – Subgroups of Active Clients in KnoxHMIS in 2017	94
Families Active Clients in KnoxHMIS in 2017.....	95
Youth Active Clients in KnoxHMIS in 2017	96
Veterans Active Clients in KnoxHMIS in 2017	97
Chronically Homeless Active Clients in KnoxHMIS in 2017	98
Street Homeless Active Clients in KnoxHMIS in 2017.....	99
Seniors Active Clients in KnoxHMIS in 2017	100
Case Collaboration and Performance Measures	101
Average Number of Case Notes Per Client.....	102
2017 Exit Outcomes by Program Type.....	103
2017 KnoxHMIS Housing Outcomes in Days	104
2017 KnoxHMIS Data Completeness (2010-2017)	105

Homelessness in Knoxville-Knox County: Introduction

While it is easy to assume, generalize, or stereotype who is homeless, the intersecting causal and persisting factors get minimized. This document represents data analysis from the Knoxville-Knox County Homeless Coalition (KKCHC) and the Knoxville Homeless Management Information System (KnoxHMIS) regarding Knoxville-Knox County's homeless population. **This document includes four reports: KKCHC Biennial Study, Supplemental Unsheltered Analysis, October 2017 Broadway/1-40 Overpass Survey, and the 2017 KnoxHMIS Annual Report.** The intention of this document and the studies within it is to illuminate the realities of Knoxville residents experiencing homelessness while also highlighting empirical realities and the results of service agencies' interventions. The literature review included in this document explores:

1. **What is the recent history of homelessness?** There are several definitions of homeless from federal and local entities that can impact eligibility for services. This section reviews historical definitions of homelessness. This section also highlights historical economic and financial realities that have impacted housing affordability.
2. **What causes homelessness?** Being without shelter dramatically affects all domains of life including education, employment, and physical and mental health. Just as all these areas of life are affected by homelessness, the interconnected levels of stress and hardship are often catalysts leading to homelessness.
3. **Who are the individuals and families experiencing homelessness?** Homelessness and housing instability affects a community at large. However, the ways in which homelessness is experienced differs among groups of people. For example, the housing and support needs of a senior (someone older than 62 years) will be different than the needs of an unaccompanied youth (ages 12—24). By exploring different subpopulations and their traits, interventions can be tailored to each group's specific needs.

Biennial Study Methodology

Knoxville's success in having 17 Biennial Studies dating back to 1986 allows for in-depth analysis over a time period as well as the ability to look for and find meaningful trends. The Biennial Study is conducted every other year while our community is simultaneously conducting the federal point in time count (PIT) for the Department of Housing and Urban Development (HUD).

The Biennial Study is a supplemental study follows a Point-In-Time (PIT) model, during which a survey is conducted during one point in time versus over time. PIT counts are mandated by HUD to "measure homelessness on a local and national level"¹ as well as continuing to meet the goals of Opening Doors.

To be responsive to the needs of persons experiencing homelessness in the community, CoCs need to understand how many individuals and families are being served by their homeless services system, as well as how many are unsheltered and might still need access to services.²

HUD PIT counts occur the same night across the country. Late January is chosen as the time for these counts because counting and interviewing people sleeping in unsheltered locations during the winter months can provide a more precise count of people who are unable or unwilling to access emergency shelter or other crisis response assistance. Additionally, conducting the count during the end of the month helps to count people who cycle in and out of homelessness and who may be able to pay for temporary housing (e.g., motel) at the beginning of the month when public benefit payments are available but are unable to do so at the end of the month. Lastly, these counts are important local benchmarks that help measure changes in need at the population and subpopulation level. Counts should help CoCs adjust their interventions to be more effective.³

The Biennial Study is conducted from a survey of 140 questions based around the different domains of life that may affect or be affective to a life unsheltered with four additional questions to assess individual proctors of the survey. Domains include family of origin, social support, vulnerability, employment and education, incarceration, physical health, mental health, and substance use history. The Biennial Study offers in-depth analysis of the lives of homeless Knoxvilleans. Through use of convenience sampling, information from the Biennial Study can be used to "estimate the number and characteristics of the entire homeless population."⁴

However, there are also limitations to the Biennial Study. Participants are found through convenience sampling – homeless adults who agree to be interviewed from persons housed in emergency shelter, transitional housing, and a couple of outdoor events, all of which are specific to serving persons experiencing homelessness. Because the Biennial Study is conducted

¹ U.S. Department of Housing and Urban Development (2014). Point-in-Time Count Methodology Guide. Retrieved February 23, 2018, from <https://www.hudexchange.info/resources/documents/PIT-Count-Methodology-Guide.pdf>

² Ibid.

³ Ibid.

⁴ Ibid.

through convenience sampling during a short time period, the sample size is small. The Biennial Study is to be used as a snap-shot of what homelessness is like in our community. **The 2018 Biennial Study analysis also offers two additional sub-reports that include a supplemental analysis with attention to unsheltered persons and a summary from a KKCHC survey conducted in October 2017 on Broadway Avenue under the I-40 Overpass. Both of these additional sub-reports are specific to the unsheltered or “street homeless” and were conducted by the KKCHC to better understand the characteristics and connection to services of persons in outdoor locations.** For picture of homelessness throughout the year, the reader is encouraged to utilize results from the 2017 KnoxHMIS Annual Report.

KnoxHMIS Annual Report

In contrast to the Biennial Study, the KnoxHMIS Annual Report details homeless across the whole of Knoxville-Knox County's. The data is exported directly from KnoxHMIS, which is populated by twenty community partner agencies that enter data into the KnoxHMIS database. The total persons entered into KnoxHMIS is analyzed holistically and subpopulations (youth, veterans, families, chronically homeless, literally homeless) are drawn out specifically. Data is also split between new and continuing clients. This divide allows for the KnoxHMIS Annual Report to pinpoint the increases and decreases in the homeless population.

The KnoxHMIS Annual Report has a much larger sample size (N=8,938) than the Biennial Study (n=215). Additionally, the KnoxHMIS Annual Report draws data from the entirety the continuum of care unlike the Biennial Study which surveys shelters and a selection of outdoor locations, excluding supportive services and rapid re-housing programs. The KnoxHMIS Annual Report can be used by local communities who want to better understand the number, characteristics, and service needs of people using homeless services. Information from the KnoxHMIS Annual Report can be used to inform the public and direct community planning activities, coordinated assessment system planning, strategic plans to end homelessness, consolidated plans, and funding applications.⁵

⁵ Ibid.

Homelessness in Knoxville-Knox County: Literature Review

Defining Homelessness

Historically, various agencies and social service providers have defined homelessness in a multitude of different ways; likewise, the definition of homelessness varies in legislation as well as in practice. In order to move toward a common definition, the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act was passed the U.S. Congress in 2009 to revise the McKinney-Vento Homeless Assistance Act with the intention of consolidating HUD's competitive grant programs, create the Rural Housing Stability Assistance Program, refine definitions of homelessness and chronic homelessness, as well as increase both prevention resources and emphasize service delivery performance⁶.

The HEARTH act defines homelessness within four categories⁷:

1. Individuals and families who ***lack a fixed, regular, and adequate nighttime residence*** and ***includes a subset for an individual who is exiting an institution*** where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution;
2. Individuals and families who ***will imminently lose their primary nighttime residence*** (imminently defined as within 14 days);
3. ***Unaccompanied youth and families with children and youth*** who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or
4. Individuals and families who are ***fleeing, or are attempting to flee***, domestic violence, dating violence, sexual assault, stalking, or other ***dangerous or life-threatening conditions*** that relate to violence against the individual or a family member.

These categories, however, apply only to programs, which receive HUD funding. Because of the wide breadth of experience of those experiencing homelessness, additional definitions have emerged from other service domains. The Department of Health and Human Services defines homelessness less strictly because of the department's focus on the intersection of health, housing, and homelessness.

⁶ U.S. Department of Housing and Urban Development. (n.d.). Housing emergency assistance and Rapid Transition to Housing Act. Retrieved February 2, 2018, from <https://www.hudexchange.info/homelessness-assistance/hearth-act/>

⁷ U.S. Department of Housing and Urban Development. (2014, September). Expanding opportunities to house individuals and families experiencing homelessness through the Public Housing (PH) and Housing Choice Voucher (HCV) programs. Retrieved February 2, 2018, from <https://www.hud.gov/sites/documents/PIH2013-15HOMELESSQAS.PDF>

HHS defines homelessness as⁸:

1. An individual who **lacks housing**, including an individual whose primary residence during the night is a supervised public or private facility (e.g., shelters) that provides temporary living accommodations, and an individual who is a resident in transitional housing;
2. An individual **without permanent housing** who may live on the streets; stay in a shelter, mission, single room occupancy facilities, abandoned building or vehicle; or in **any other unstable or non-permanent situation**;
3. Individuals who are **“doubled up,”** a term that refers to a situation where individuals are unable to maintain their housing situation and are forced to stay with a series of friends and/or extended family members; other terms include **“precariously housed,”** and **“couch surfer;”** or
4. Individuals released from detention (prison, jail, or juvenile detention) or a hospital (medical or psychiatric) with no stable housing situation to which they can return **regardless of length of stay.**

Additional considerations must be given to the different temporal dimensions of homelessness (situational, episodic, and chronic). **Situational** homelessness often stems from discrete events such as house fires, the loss of employment by the primary wage earner, eviction, or fleeing domestic or family violence. **Episodic** homelessness is recurring; examples include a person who works seasonally and has lodging or disability benefits which are sufficient for a single room occupant 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. **Chronic** homelessness is ongoing; the person remains on the street (or any other location unfit for long-term human habitation) indefinitely often in relation to severe mental illness and/or substance use⁹. While the chronically homeless are usually the most visible, they likely represent the smallest segment of the homeless population.

While there are multiple working definitions of homelessness, one must be aware that no single definition or characteristic describes all persons experiencing homelessness. **The KKCHC Biennial Study and the KnoxHMIS Annual Report reflect the intersections of individual conditions, socio-economic structures, and environmental circumstances.** Rather than maintaining an artificial dichotomy of individual factors or systemic economic and market forces, these studies offer a map of the dynamic interactions of the elements of homelessness through a holistic and ecological model “including individual factors (e.g., personality, developmental experiences, health-mental health, race, and ethnicity) and social factors such as resource availability, policies, culture, discrimination, and social situations.”¹⁰

⁸ National Health Care for Homeless Council. (2018). What is the official definition of homelessness? Retrieved February 2, 2018, from <https://www.nhchc.org/faq/official-definition-homelessness/>

⁹ Nooe, R. M. & Cunningham, M. L. (1990). *Homelessness in Knox County: Revisited*. Knoxville, TN: Coalition for the Homeless.

¹⁰ Nooe, R. M., & Patterson, D. A. (2010). The ecology of homelessness. *Journal of Human Behavior in the Social Environment*, 20(2), 105-152. Retrieved February 2, 2018, from <http://www.tandfonline.com/doi/pdf/10.1080/10911350903269757>

Housing After The Great Recession

In the fall of 2008, major U.S. financial markets lost more than 30% of their value.¹¹ Subprime mortgages, mortgages with higher interest rates and variable payments, began increasing in popularity in 1999 when the Federal National Mortgage Association (Fannie Mae) focused their effort on courting individuals with lower credit and less savings than was typically required. The role of Fannie [Mae] and Freddie [Mac] is to repurchase mortgages from the lenders who originated them and make money when mortgage notes are paid. Thus, ever-increasing mortgage default rates led to a crippling decrease in revenue for these two companies.¹²

Immediate impacts were seen when “dozens of mortgage lenders declare[d] bankruptcy in a matter of weeks [... and] foreclosure rates double[d] year-over-year during the latter half of 2006 and in 2007.”¹³ Exiting the “official” period of the recession (just before Q3 2009), the rental vacancy rate for the United States was 11.1%. Nearly ten years later, total available rental vacancies had dropped to 6.9%.¹⁴

Mark Uh analyzed data from the American Community Survey (2006-2014) “to uncover who saw the biggest shift from being a homeowner to a renter by age, gender, race, and income in the 50 largest U.S. metros.”¹⁵ This analysis highlights specific populations who have been negatively affected by the housing and rental market such as older Millennial (young adults 26 to 34), Hispanic households and residents of Las Vegas. However, Uh’s conclusion was that **everyone** in the U.S. suffered. That’s because the average rent rose 22.3% in the 50 biggest housing markets (the cumulative rate of inflation for the period between 2006 and 2014 was 17.4%). Worse, the increase came at a time when the U.S. median household income (for the entire nation, not just the top 50 markets) fell 4.2%.¹⁶

The scope of this change in markets cannot be overstated. “110 million Americans, representing 35% of the population, live in rented accommodations.”¹⁷ A survey of over 1,300 American renters reports that 62% cite the largest barrier to successful rentals is **properties being outside of the potential renter’s price range**. This 62% is nearly double the second highest ranked barrier – searching takes longer than expected (36%).¹⁸ This same survey of renters shines a significant light on the additional barriers faced by individuals with evictions in their history. “89% of evictees experienced significant struggles finding an affordable place to

¹¹ Kosakowski, P. (2017). The fall of the market in the fall of 2008. *Investopedia*. Retrieved February 14, 2018, from <https://www.investopedia.com/articles/economics/09/subprime-market-2008.asp>

¹² Ibid.

¹³ Barnes, R. (2018). The fuel that fed the subprime meltdown. *Investopedia*. Retrieved February 14, 2018, from <https://www.investopedia.com/articles/07/subprime-overview.asp>

¹⁴ U.S. Bureau of the Census (2018). Rental vacancy rate for the United States [RRVRUSQ156N]. Retrieved February 14, 2018, from <https://fred.stlouisfed.org/series/RRVRUSQ156N>

¹⁵ Uh, M. (2016). From own to rent: Who lost the American dream? *Trulia*. Retrieved February 14, 2018, from <https://www.trulia.com/blog/trends/own-to-rent/>

¹⁶ Ibid.

¹⁷ Hunt (n.d.). On the hunt: The struggles of apartment hunting in America today. *hunt*. Retrieved February 14, 2018, from <https://hunt.com/insights/struggles-of-apartment-hunting>

¹⁸ Ibid.

rent,” and while former evictees believed it would take up to 30 days to find new housing, the median actual search time was 52 days. This is an additional 5 days compared to the 47-day median search time for renters without an eviction history. Taking longer to find a new rental property may be an inconvenience to some, but the situation very well may be an exclusionary barrier to those paying more than 30% of their income for housing. For instance, in Knoxville, a 22-day extended hotel stay to bridge the gap in housing could cost up to \$1,310 for a family of three. This cost can be seen as prohibitive when paired with the data that “41% of renters said a \$50 increase in their monthly rent would make them find a new place to live.”¹⁹

The economic ripples of the subprime mortgage crisis are constant specters in the domain of housing for renters and landlords. Former homeowners who lost their mortgages through default and foreclosure are putting further stress on the already depleted rental market. Affordable housing, as defined by earning a Housing Wage, is not available for those individuals and families who seek it. The current housing crisis is both a manifestation as well as an outgrowth of the 2008 financial crisis. This disruption in the housing market (including pricing and the number of available units) has resulted in deserted and blighted neighborhoods and urban centers.²⁰

According to HUD, households cannot find affordable units to rent because there is a national shortage of low-cost housing units. “With tight rental markets, units that are affordable [costs including utilities not exceeding 30% of income] to extremely low-income households or very low-income households often are occupied by higher-income households.”²¹ This fact is illustrated by the decrease in affordable and available units to extremely low-income renters (0-30% Area Median Income) and very low-income renters (0-50% Area Median Income). Between 2013 and 2015, extremely low-income renters and very low-income renters saw the viability of affordable units decreasing 1.1 and 3.1 points respectively. In practice, this creates a market with no point of entry for low-income renters. For every 100 extremely low-income renters, only 37.9 units are affordable and available.²²

Numerous journalistic pieces and industry reports have taken “the position that predatory lending had a central role in creating and feeding the housing bubble, particularly through subprime loan originations.”²³ Agarwal et. al. presented the first systematic evaluation of lending techniques and the subprime crash. However, in academic literature, predatory lending is modeled after the access which lenders have to “private information about borrowers’ future ability to repay loans;” because of the high difficulty in observing lenders’ informational advantage over borrowers, “measuring the size of the phenomenon and assessing its role in precipitating the subprime mortgage crisis is hard.”²⁴

¹⁹ Ibid.

²⁰ Zwiers, M., Bolt, G., Van Ham, Maarten, & Kempen, R. (2016). The global financial crisis and neighborhood decline, *Urban Geography*, 37(5), 664-684.

²¹ U.S. Department of Housing and Urban Development (2017). Preview of 2015 worst case housing needs. Retrieved February 23, 2018, from <https://www.huduser.gov/portal/sites/default/files/pdf/Worst-Case-Needs-Preview.pdf>

²² Ibid.

²³ Agarwal, S., Amromin, G., Ben-David, I., Chomsisengphet, S., & Evanoff, D. D. (2014). Predatory lending and the subprime crisis. *Journal of Financial Economics*, 13, 29-52.

²⁴ Ibid.

Because of the difficulty in tracking causal relationships, examining cultural norms and public reactions allows for hypothesizing. For example,

when lenders made it easier for potential homebuyers to increase their mortgage debt, borrowers [...] voraciously consumed mortgage debt [...] *Renters* were desperate to become homeowners principally because they believed in the hype associated with the "American Dream of Homeownership.[...] Whether greed, naïveté, or some other human factor caused borrowers to purchase homes they could not afford using mortgage products they often could not understand, once deregulation made it possible for consumers to borrow, borrow they did [...] Sadly, the current foreclosure rates (which are the highest they have been in three decades) and the depth of the financial crisis are the result of this gamble.²⁵

During the 2017 KnoxHMIS annual reporting period, **26%** of all active clients reported **housing affordability** as the primary cause of their homelessness (see page 85). In a survey of landlords in middle America, Matthew Desmond found that evictions were found to be a consistent barrier to rentals. It is not uncommon that landlords blacklist potential renters if there is an eviction on their record within the last three years. Some landlords go so far as to exclude potential renters even if they only had *dismissed evictions* on record.²⁶ During the second annual Knoxville Knox County Homeless Coalition Landlord Summit (2017), these findings are supported by local data. When landlords attending the summit were asked what potential leasing limitations were, 50% cited criminal records, 36% cited a poor or lacking rental history, and 21% cited a poor or lacking credit history.²⁷

When looking forward to how this environment can affect Americans who are already at-risk of housing instability, the holistic and comprehensive understanding of evictions is a must. Matthew Desmond sums the experience up as follows:

Eviction's fallout is severe. Losing a home sends families to shelters, abandoned houses, and the street. It invites depression and illness, compels families to move into degrading housing in dangerous neighborhoods, uproots communities, and harms children. Eviction reveals people's vulnerability and desperation, as well as their ingenuity and guts.²⁸

For a further explanation of consequences of eviction, please see **housing wage** and **legal history** (see page 14).

²⁵ Dickerson, A. M. (2009) Over-indebtedness, the subprime mortgage crisis, and the effect on U.S. cities. *Fordham Urban Law Journal*. 36. 395-426.

²⁶ Desmond, M. (2012). "Eviction and the reproduction of urban poverty." *American Journal of Sociology* 118(1): 88-133.

²⁷ Knoxville Knox County Homeless Coalition (2017). Landlord summit. Retrieved from www.KnoxHMIS.org

²⁸ Desmond, M. (2016). *Evicted: Poverty and profit in the American City*. New York City, NY: Broadway Books.

Historical Contributing Factors and Myths

Within the last 30 years, American homelessness has been increasing. This is due primarily to a “growing shortage of affordable rental housing and a simultaneous increase in poverty.”²⁹ While affordable housing, stagnation of wages, and poverty are key contributing factors to housing instability, it is critical to underscore that **homelessness is due to multiple interacting factors**. This section offers an introductory look at how common contributing factors compound with one another and may ultimately lead individuals to experience homelessness and/or increase the duration of their homelessness. Additionally, this section explores commonly held myths surrounding how one becomes homeless and why it may appear that some individuals choose to remain out of shelter.

Lack of employment is often considered to be a key contributing factor of whether individuals will experience homelessness or not. National numbers of unemployment have been steadily decreasing since 2010; in January 2010, the national unemployment rate was 9.8%, whereas January 2018 saw the unemployment rate drop to 4.1%. This data appears promising, but a closer look at how terms such as “unemployment” are defined illustrate that this number is not necessarily reliable or reflective of the community at large.³⁰ The federal unemployment definition includes:

1. Persons [who...] do not have a job, have actively looked for work in the prior 4 weeks, and are currently available for work.
2. Workers expecting to be recalled from layoff [...], whether or not they have engaged in a specific job-seeking activity.
3. In all other cases, the individual must have been engaged in at least one active job search activity in the 4 weeks preceding the interview and be available for work (except for temporary illness).

By focusing the unemployment rate only on those who are currently actively searching for a job, over “5.5 million Americans [who] said they want a job, but don’t have one, [...] are not considered a part of the labor force. If these people were included in the unemployment rate, it would jump to 8.2%.”³¹ Additionally, this number does not represent individuals who are underemployed (someone who is “involuntarily working part time or is overqualified for their

²⁹ National Coalition for the Homeless (2009). *Why are people homeless?* Retrieved February 5, 2018, from <http://nationalhomeless.org/factsheets/why.html>

³⁰ United States Bureau of Labor Statistics (2018). Labor force statistics from the current population survey in *Databases, Tables, and Calculators by Subject*. Retrieved February 23, 2018, from <https://data.bls.gov/timeseries/LNS14000000>

³¹ Kopf, D. (2017) If the US unemployment rate included everyone who says they want a job, it would be nearly double, *Quartz*. Retrieved February 23, 2018, from <https://qz.com/877432/the-us-unemployment-rate-measure-is-deceptive-and-doesnt-need-to-be/>

current position"³²). Underemployment rates for all college graduates 22-65 remained relatively stable at 33% for the past 30 years³³.

However, 30% (n=60) of individuals interviewed in the 2018 Biennial Study identified their primary daytime activity as working or looking for work. Many people are homeless because they cannot afford rent. In 2013, 1 in 8 poor families were unable to pay rent and expected eviction.³⁴ Most minimum wage workers cannot meet a "**housing wage**" to sustain shelter -- 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 89 hours per week to afford a one-bedroom rent at the fair market rent of \$648 per month and 110 hours per week to afford a two-bedroom fair market rent of \$798 per month.³⁵ For many minimum wage earners, stable housing is out of reach. The National Low Income Housing Coalition estimates that in 2017, the housing wage was \$15.34 an hour to rent a two-bedroom unit in Knoxville, TN, exceeding the \$13.91 hourly wage earned by the average Knoxville renter by \$1.43 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 average³⁶, the availability of affordable housing is a barrier to maintaining permanent housing for many low-income people.

An individual's **legal history** is another contributing factor to instability in housing as well as a barrier to successful housing interventions. An individual's legal history is often understood to be in relation to one's criminal history. As described under deinstitutionalization, homelessness and mental illness all too often develop a criminal record secondary to arrests for misdemeanors associated to living on the streets. This is illustrated by fact that individuals who lack consistent housing are also lacking a "place that can be delimited as [their] own and serve as a base from which relations with an exteriority ... can be managed."³⁷ This is to say that the legal system is ever present in the lives of those who are unsheltered. Through privatization as well as the gentrification of cities, public spaces have been disappearing. This lack of private space and the increasing lack of safe public space "serve as an obstacle to [...] survival by subjecting [individuals experiencing homelessness] to increasingly punitive measures in both the criminal justice and welfare systems."³⁸

A critical element of individuals' legal histories that is often overlooked is debt, liens, foreclosures, and evictions. While foreclosures have been well documented and attributed to the subprime mortgage crisis, "tenant evictions tend to be carried out invisibly and deemed the

³² Lutz, J. (2017) The underemployment phenomenon no one is talking about. *Forbes*. Retrieved February 23, 2018, from <https://www.forbes.com/sites/payout/2017/07/21/the-underemployment-phenomenon-no-one-is-talking-about/#124ef4025a01>

³³ Steffy, K. (2017) Willful versus woeful underemployment: Perceived volition and social class background among overqualified college graduates. *Work and Occupations*, 44 (4), 467-511

³⁴ Desmond, M. (2016). *Evicted: Poverty and profit in the American City*. New York City, NY: Broadway Books.

³⁵ National Low Income Housing Coalition (2017). Out of reach. Retrieved February 7, 2018, from <http://nlihc.org/oor/tennessee>

³⁶ Knoxville Chamber (2016). Quality of life. Retrieved February 7, 2018, from <http://www.knoxvillechamber.com/quality-life>

³⁷ Bertie, M. (2010). Handcuffed access: Homelessness and the justice system. *Urban Geography*, 31(6), 825-841. Retrieved February 8, 2018, from <http://www.tandfonline.com/doi/abs/10.2747/0272-3638.31.6.825>

³⁸ Ibid.

exclusive result of individual failure.”³⁹ Much like other contributing factors, one instance of legal trouble (criminal or financial) will predicate another instance that leads to a self-sustaining cycle. This is illustrated by the over 650 companies “that gather information on prospective tenants’ credit records, criminal backgrounds and landlord-tenant (civil) court filings” as part of the *de facto* tenant screening process that is considered to be “efficient, effective and professional risk management.”⁴⁰ Missing a single payment, therefore, can put individuals into the “circle of dispossession, [which is] reproduced both materially and ideologically.”⁴¹

Another contributing factor is an individual’s **education level**. Shelton, Taylor, Bonner, and van den Bree illustrate that academic underachievement including expulsion or voluntarily dropping out is “significantly and independently related to homelessness.” In addition to a “lack of educational qualifications reduce[ing] the prospect of individuals’ reintegrating into society, which can increase the risk of chronic homelessness.”⁴² Education level and the quality of said education relates directly to the aforementioned connection between low-to-non-skilled labor and an unsustainable living wage.

Substance abuse may cause homelessness, but more often, substance abuse (and use) is a result of homelessness and housing instability.⁴³ Substance abuse, drug or alcohol, is often used as a means to self-medicate in addition to being a primary coping skill. Ending substance use can be even more difficult for an individual experiencing homelessness because of the ease of access to drugs or alcohol. Substance use is also a risk factor to homelessness on its own as seen by “two-thirds of homeless people report[ing] that drugs and/or alcohol were a major reason for their becoming homeless.”⁴⁴ Additionally, “many programs for homeless people with mental illnesses do not accept people with substance abuse disorders, and many programs for homeless substance abusers do not treat people with mental illness.”⁴⁵ . Fifty-two percent of Biennial Study respondents report current substance use (see page 67). Seventeen percent of study respondents report difficulty finding treatment (see page 68).

Mental health appears to be one of the largest contributing factors to individuals experiencing homelessness. Severe mental illness is likely to cause individuals significant difficulties in maintaining essential functions of daily life including money management, self-care/self-image maintenance, and the ability to sustain positive relationships with family, care-givers, and/or friends who may act as protective factors for maintaining housing.⁴⁶ Poor mental health can also act as a predictor for substance abuse and poor physical health. Serious mental

³⁹ Purser, G. (2016) The circle of dispossession: Evicting the urban poor in Baltimore. *Critical Sociology*, 42(3), 393-415. Retrieved February 8, 2018, from <http://journals.sagepub.com/doi/pdf/10.1177/0896920514524606>

⁴⁰ Ibid.

⁴¹ Ibid.

⁴² Shelton, K. H., Taylor, P. J., Bonner, A., and Van den Bree, M. (2009). Risk factors for homelessness: Evidence from a population-based study. *Psychiatric Services*, 60(4), 465-472. Retrieved February 7, 2018, from <https://ps.psychiatryonline.org/doi/full/10.1176/ps.2009.60.4.465>

⁴³ National Coalition for the Homeless (2009). Substance abuse and homelessness. Retrieved February 5, 2018, from <http://www.nationalhomeless.org/factsheets/addiction.pdf>

⁴⁴ Ibid.

⁴⁵ Ibid.

⁴⁶ National Coalition for the Homeless (2009). Mental illness and homelessness. Retrieved February 5, 2018, from http://www.nationalhomeless.org/factsheets/Mental_Illness.pdf

illness can also “cause people to misinterpret others’ guidance and reaction irrationally”⁴⁷ which compounds with a prominent lack of confidence in available services. Kryda and Compton suggest that in order to combat service-resistance, an approach must be adopted which “incorporates giving individualized attention from outreach workers, using an empathetic listening approach, minimizing stereotyping, providing greater choices, and employing formerly homeless people as outreach workers.”⁴⁸ Of all 2017 KnoxHMIS active clients, 419 (6%) individuals self-reported that mental health was the primary reason for their homelessness. Mental health is the fourth most common primary reason for homelessness (see page 85). Eleven percent of KnoxHMIS active clients self-reported having some form of disability, with 34% (n=343) identifying a mental health disability.

The history of **deinstitutionalization** plays an active role in the current landscape of homelessness. Beginning in the 1950s, deinstitutionalization refers to “moving individuals out of state public mental hospitals” and later “improving and expanding the range of services and supports for those now in the community.”⁴⁹ The gap in time between releasing former patients and implementing more robust community health programs led to homelessness and criminalization of those newly released. While deinstitutionalization primarily refers to the release from psychiatric facilities, it can also refer to release from prisons, jails, and children’s institutions such as foster care and juvenile detention.

Unfortunately, homelessness and mental illness have become intertwined within the criminal justice system. There is mounting evidence of an increasing number of severely mentally ill persons in jails and prison. People experiencing homelessness and/or mental illness have become criminalized, and in a sense, jails are becoming today’s asylums.⁵⁰ The interaction of these factors is seen in the finding that non-homeless mentally ill persons going into jail have a significantly increased risk of housing loss upon release.⁵¹ The cost of this recycling from homelessness to incarceration and back is costly, and supportive housing treatment programs provide a feasible alternative.⁵² This is of critical importance when one considers that 34% of active clients report having some form of mental illness.

Of active clients surveyed in KnoxHMIS during 2017, 11% (n=982) identified as having experienced **intimate partner violence** (IPV; also commonly termed domestic violence). Of IPV survivors surveyed, 81% (n=800) had experienced intimate partner violence whereas the rate for *men* was 19% (n=182). It is critical to note that domestic violence is likely higher and may be underreported due to client and/or agency hesitance to report domestic violence in an HMIS

⁴⁷ Ibid.

⁴⁸ Kryda, A. D., & Compton, M. T. (2008). Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. *Community Mental Health Journal*, 45, 144-150. doi:10.1007/s10597-008-9163-6

⁴⁹ Koyanagi, C. (2007). *Learning from history: Deinstitutionalization of people with mental illness as a precursor to long-term care reform*. Retrieved February 5, 2018, from <https://www.kff.org/medicaid/report/learning-from-history-deinstitutionalization-of-people-with/>

⁵⁰ Lamb, H. R. & Weinberger, L.E. (1998). Persons with severe mental illness in jails and prisons: A review. *Psychiatry Services*, 9, 483-492.

⁵¹ Solomon, P. & Draine, J. (1995). Issues in serving the forensic client. *Social Work*, 40(1), 25-33.

⁵² Rosenheck, R., Kasprow, W., Frisman, L., & Liu-Mares, W. (2003). Cost-effectiveness of supported housing for homeless persons with mental illness. *Archives of General Psychiatry*, 60(9), 940-951.

database.⁵³ This fact is illustrated by 39% of active clients (n=3,482) having no response (null) recorded for questions concerning domestic violence. Common data quality errors include not asking *male* or *youth* clients about their experiences with family violence. Of the null clients, 55% (n=1,917) are male and 31% (n=1,084) are 18 years old or younger. This falls in line with the 2017 Bureau of Justice Statistics report that stated that just over half (56%) of all instances of intimate partner violence are reported to law enforcement.⁵⁴

Structural and individual factors are often inextricably linked in the cycle of poverty and homelessness. These co-occurring contributing factors tend to re-enforce each other, as these factors are manifest as the social, political, and economic realities of American society.⁵⁵ When individuals live at or below the poverty line (often with the aid of public assistance and/or “living paycheck to paycheck”), any unforeseen expense has the ability to disrupt self-sufficiency and result in housing instability or a housing crisis.

The current housing crisis is multi-factorial with ***no single reason for homelessness***. As such, service providers may find that the adoption of an ***“ethics of care”*** can construct environments that encourage collaboration between clients and staff. According to Sweeney and Rhinesmith, an ethics of care “emphasizes the importance of relational and situational knowledge, pluralistic voices and experiences, and relationships bound by *natural interdependence*.”⁵⁶ An ethics of care is explicitly feminist in nature, meaning goals of effective care will “cultivate civic intelligence, enhance democracy, develop social capital, build communities, spur economies, empower individuals and groups, and result in many forms of positive change.”⁵⁷ This contrasts traditional neo-liberal conceptualizations of care which results in “ways in which the normative distribution and implementation [of services] are often implicated in maintaining, rather than subverting, social exclusion and inequity.”⁵⁸

One of the core tenants of neo-liberal care is the belief that individual misfortune causes the need for care. Feminist ethical care counters this belief by stating that all humans *need* and *deserve* care. This mentality actively works to dismantle the beliefs that the individuals in need of care (for example, those who are experiencing homelessness) are lazy, criminal, addicted, or severely mentally ill. On the contrary, the aforementioned contributing factors show that these individuals are parts of a larger systemic housing crisis.

Why then is there such seeming resistance from potential clients to social service interventions? Kyra and Compton interviewed twenty-four chronically homeless unsheltered individuals on the reasons why they avoided traditional social service interventions.

⁵³ 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

⁵⁴ Reaves, B. A. (May 2017). Police response to domestic violence, 2006-2015. NCJ 250231.

⁵⁵ Weinberger, D. (1999). The causes of homelessness in America in Ethics Kin; Ethics of development in a Global Environment. Retrieved February 12, 2018, from https://web.stanford.edu/class/e297c/poverty_prejudice/soc_sec/hcauses.htm

⁵⁶ Sweeney, M. E., and Rhinesmith, C. (2016). “Creating caring institutions for community informatics.” *Information, Communication & Society* 20(10): 1482-1497.

⁵⁷ Ibid.

⁵⁸ Ibid.

Reasons why these individuals refuse services include a pervasive mistrust of outreach workers and the agencies that employ them, as well as a prominent lack of confidence in available services. These findings suggest a need for an approach to outreach that incorporates giving individualized attention from outreach workers, using an empathetic listening approach, minimizing stereotyping, providing greater choices, and employing formerly homeless people as outreach workers.⁵⁹

Crucially, outreach and ethical care cannot be effective if individuals have extreme amounts of mistrust and skepticism for the social services system or if individuals do not believe that services being offered would be applicable or “help” their unique situation. Shelters are characterized by service-resistant clients as unsafe and only “short-term solutions.” Interviewees also complained that “hand-outs” of food and clothing are common but unhelpful because of their short-term impacts.

“It is of critical importance to ask people who are homeless what their needs are rather than assuming what their needs are based on an outsider’s perspective.”⁶⁰ Ethical care underscores the fact that needs are contextual and culturally defined, care is a process rather than a service or commodity, expertise is situational, relational, and distributive between and amongst the clients and staff, perhaps most importantly, “care is a shared responsibility; therefore, distribution of care through casework is a political act”⁶¹ which ultimately seeks to operationalize an effective use of resources and plurality of experience.

Characteristics and Subpopulations

Homelessness and housing instability can influence multiple dimension of a person’s life and community. All segments of society are touched by and are present in discussions of homelessness. While there are general considerations and interventions that may be used for anyone experiencing homelessness, there are additional sub-groups, or special populations, which “experience distinctive forms of adversity resulting from both societal structures and personal vulnerabilities, and has unique service delivery needs.”⁶² Subpopulations as defined by HUD standards include those who are experiencing chronic homelessness, veterans, victims of intimate partner violence, unaccompanied youth (>24 years old), families, seniors (62+ years old), and individuals who are street homeless.⁶³ ⁶⁴Within the Knoxville-Knox County CoC,

⁵⁹ Kryda, A. D., & Compton, M. T. (2008). Mistrust of outreach workers and lack of confidence in available services among individuals who are chronically street homeless. *Community Mental Health Journal*, 45, 144-150. doi:10.1007/s10597-008-9163-6

⁶⁰ Ibid.

⁶¹ Sweeney, M. E., and Rhinesmith, C. (2016). “Creating caring institutions for community informatics.” *Information, Communication & Society* 20(10): 1482-1497.

⁶² Rosenheck, R., Bassuk, E., & Salomon, A. (1999). Special populations of homeless Americans. Practical Lessons: The 1998 National Symposium on Homelessness. Retrieved February 19, 2018, from <http://homelesshub.ca/resource/special-populations-homeless-americans>

⁶³ Ibid.

⁶⁴ U.S. Department of Housing and Urban Development Community Planning and Development. (2016). Notice for Housing Inventory County (HIC) and Point-in-Time (PIT) data collection for Continuum of Care (CoC) program and the Emergency Solutions Grants (ESG) program (24 CFR Part 578, 42 U.S.C. 11371, et seq.).

subpopulations include: families, youth, veterans, chronic homelessness, street homeless, and seniors.

Chronic Homelessness

As of January 15, 2016, HUD changed its data standards and practices for chronic homelessness to include self-report and collaboration with third-party documentation.

“HUD adopted the Federal definition which defines a chronically homeless person as “either an unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more, OR an unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years.”⁶⁵

This definition was adopted in hopes to cross-reference self-reports with community record keeping. However, the Institute for Children, Poverty and Homelessness (ICPH) argues that “the narrowness of this definition excludes many homeless single adults and even more parents and children [...] The original argument was that targeting resources to chronically homeless people will ‘free up’ resources to serve other homeless populations -- eventually.”⁶⁶

This flat prioritization leaves gaps in care for other populations experiencing homelessness even when those other populations have been identified as having more urgent needs. The HEARTH Act also introduced to term “functionally zero” which is defined as “the availability of resources in the community exceeds the size of the population needing the resources. Whether homeless people use those resources or are successful with them is not relevant.”⁶⁷ ICPH stresses that targeting those who currently meet the criteria for chronic homelessness does nothing to prevent individuals from entering chronic homelessness. ICPH underscores that “housing is necessary, but not sufficient” because housing first frames homelessness entirely outside of its complex causes such as intergenerational “deep poverty, lack of education, lack of childcare, lack of employment options, and a severe shortage of affordable housing.”⁶⁸

In order to combat thin resources and shifting goalposts, HUD has defined five essential elements needed for communities to proactively address their communities of chronically homeless individuals. These elements include a **paradigm shift** (often brought on by a trigger event such as “evictions” of tent cities; this event positions community members in such a way that they are more likely to be involved in the community’s discussions of homelessness), community wide approach, organizational structure and leadership specifically for reducing

⁶⁵ U.S. Department of Housing and Urban Development Community Planning and Development. (2015). Homeless emergency assistance and rapid transition to housing: Defining “Chronically homeless.” (24 CFR Parts 91 and 578, FR-5809-F-01).

⁶⁶ Duffield, B. for Institute for Children, Poverty and Homelessness. (2016, October). Are we creating chronic homelessness? The past, present, and future of federal homelessness policy [Press release]. Retrieved from http://www.icphusa.org/wpcontent/uploads/2016/10/Duffield_Creating-Chronic-Homelessness.pdf

⁶⁷ Ibid.

⁶⁸ Ibid.

chronic street homelessness, clear goal set, and mainstream agency involvement.⁶⁹ During 2017 in Knoxville-Knox County, 461 clients (5% of all homeless clients) met the criteria of being chronically homeless (see page 98).

Veterans

Despite a federal goal of ending veteran homelessness by 2015, 2017 was the first year since 2010 that federal counts of homeless veterans increased from the year before.⁷⁰ Housing First models have placed 480,000 veterans and families of veterans into permanent housing. However, contributing factors such as posttraumatic stress disorder and traumatic brain injuries require interventions beyond only housing. Veterans as a whole (n=799) accounted for 9% of Knoxville's homeless population (see page 97).

According to the U.S. Department of Veterans Affairs (VA), individuals are considered veterans "based upon discharge from active military service under other-than dishonorable conditions."⁷¹ Homeless veterans, including in Knoxville, tend to skew male, single, urban, and having a mental and/or physical disability. Black veterans, however, "are substantially overrepresented among homeless veterans, comprising 39% of the total homeless veteran population but only 11% of the total veteran population."⁷² During 2017, Knoxville-Knox County veterans experiencing homelessness were 90% (n=718) male and 27% (n=213) black despite Knoxville having a total black population at 9%.⁷³

Women veterans face a greater risk of becoming homeless — 2.4% — compared to male vets, who face a 1.4% risk. Contributing factors include post-traumatic stress disorder; loss of employment; dissolution of marriage; and a lack of gender-specific support [...] Additionally, one-fifth of homeless female veterans have dependent children, which places added emphasis on the need for support services like child-care.⁷⁴

⁶⁹ U.S. Department of Housing and Urban Development Community Planning and Development (2004). Strategies for reducing chronic street homelessness: Final report. Office of Policy and Research and Development.

⁷⁰ Shane, L. III (December 6, 2017) Number of homeless vets rises for first time in seven years. *Military Times*. Retrieved April 23, 2018, from <https://www.militarytimes.com/veterans/2017/12/06/number-of-homeless-veterans-nationwide-rises-for-first-time-in-seven-years/>

⁷¹ National Coalition for Homeless Veterans (2017). Background and statistics. Retrieved February 20, 2018, from http://nchv.org/index.php/news/media/background_and_statistics/

⁷² National Alliance to End Homelessness (2015). Veteran homelessness. *Resources*. Retrieved February 20, 2018, from <https://endhomelessness.org/resource/veteran-homelessness/>

⁷³ U.S. Census Bureau Quick Facts (2017). <https://www.census.gov/quickfacts/fact/table/knoxcountytennessee/PST045217>

⁷⁴ Clark, J. (2018) The obstacles facing VA in its fight to end veteran homelessness. *Task & Purpose*. Retrieved February 20, 2018, from <https://taskandpurpose.com/va-obstacles-veteran-homelessness/>

Unaccompanied Youth

On a single night in 2017, nearly 41,000 (40,799) unaccompanied youth were counted as homeless [in the U.S.]. Of those, 88 percent were between the ages of 18 to 24. The remaining 12 percent (or 4,789 unaccompanied children) were under the age of 18.⁷⁵ Because of this distinction in literature, Knoxville defines unaccompanied youth primarily as young adults from 18 to 24 years old. Children below the age of 18 are primarily counted as members of families (unless the youth is unaccompanied or has children of their own). It is also important to recognize that these numbers are more than likely under representative of the population. Therefore, communities are working to improve data collection – specifically the data collection techniques used during Point-In-Time counts.

Youth who are experiencing homelessness are at-risk to unique barriers to care and/or service. Income and housing instability for youth lay the framework for potentially profound damage “including substance abuse, mental health problems and physical abuse, as well as sexual exploitation. Many get caught up in the criminal justice system. Up to 40% of homeless youth are lesbian, gay, bisexual or transgender.”⁷⁶ Considering that LGBT youth represent an estimated 7% of the total youth population, these numbers are disproportionately high. Based on the 2018 Youth Point-in-Time (YPIT) report, 20% of the youth who are experiencing homelessness in Knoxville identify as gay, lesbian, bisexual, or questioning (n=23).⁷⁷

As youth are in a different life stage than adults who are experiencing homelessness, it is of critical importance to recognize this group’s unique needs as well as the detrimental effects of homelessness on children including “compromised development, emotional problems, and poor school performance.”⁷⁸ However, often youth homelessness is addressed, as a homogenous population with collective and cohesive group needs. In reality, services might more usefully be targeted to specific youth subgroups that are experiencing multiple unique difficulties.⁷⁹

During 2017, homeless youth accounted for 8% (n=747) of persons in KnoxHMIS (see page 96). Among those between 18 and 24, the mean age is 21. For those 17 and younger, the mean age is 8.5 (see page 47). The 2018 YPIT reports a 25% of youth are currently enrolled in either middle or high school, 20% reported either graduating high school or obtaining their GED. Fifty-five percent of homeless youth, then, are not connected to educational services in anyway.⁸⁰

⁷⁵ National Alliance to End Homelessness (2017). Youth and young adults. *Who Experiences Homelessness?* Retrieved February 20, 2018, from <https://endhomelessness.org/homelessness-in-america/who-experiences-homelessness/youth/>

⁷⁶ Wiltz, T. (2017). A hidden population: Youth homelessness is on the rise. *Huffington Post*. Retrieved February 20, 2018, from https://www.huffingtonpost.com/entry/a-hidden-population-youth-homelessness-is-on-the-rise_us_595f942fe4b08f5c97d068db

⁷⁷ Knox County Knoxville Homeless Coalition (2018). *2018 Youth PIT analysis: Unaccompanied youth ages 12-24 in Knoxville-Knox County*. Retrieved from HMIS www.KnoxHMIS.org

⁷⁸ Huntington, N., Buckner, J. C., & Bassuk, E. L. (2008). Adaption in homeless children: An empirical examination using cluster analysis. *American Behavioral Scientist*, 51(6), 737-755.

⁷⁹ Ibid.

⁸⁰ Knox County Knoxville Homeless Coalition (2018). *2018 Youth PIT analysis: Unaccompanied youth ages 12-24 in Knoxville-Knox County*. Retrieved from HMIS www.KnoxHMIS.org

Families

According to HUD data standards, a **family** includes, but is not limited to: any group of persons presenting for assistance together with or without children and irrespective of age, relationship, or whether a member of the household has a disability [...] regardless of marital status, actual or perceived sexual orientation, or gender identity.⁸¹

This definition contrasts the working KnoxHMIS definition of a **family household**: a minimum of two individuals with at least one of which must be under the age of 18.

Of families experiencing homelessness, 76% are female-headed (see page). Possible explanations for these statistics are that many family shelters do not accept men into their programs, which causes families to separate when they lose shelter⁸² and that 92% of homeless women have experienced severe physical or sexual abuse at some point in their lives with 63% having been victims of intimate partner violence as adults.⁸³ Additionally, the desire for family emergency shelter increases as it is not uncommon that “shelter policies regarding adolescent children can lead to family separation as older and adolescent males are frequently required to be housed in male, adult shelters.”⁸⁴

Family homelessness, once viewed as episodic and sporadic in nature, has become prevalent, with families accounting for 37% of the overall national homeless populations and 50% of the sheltered population.⁸⁵ Potential contributing factors include the historical increase in evictions. Since 2000, one in five renting families nationwide missed payments and received disconnection notices from their utility company. In Milwaukee alone, roughly 50,000 households were disconnected from utilities for non-payment within a year.⁸⁶

During 2017, individuals in families (n=1,784) composed 20% of Knoxville-Knox County's homeless population as reported in the KnoxHMIS Annual Report (see page 95). The mean age for adults was 43 and 8 for youth 17 and under. Females (n=1,084) compose 61% of this subpopulation in contrast to composing only 40% of Knoxville-Knox county's total homeless population (page 87).

⁸¹ U.S. Department of Housing and Urban Development Community Planning and Development (2014). How is the definition of 'family' that was included in the Equal Access to Housing in HUD Programs – Regardless of Sexual Orientation or Gender Identity apply to recipients and subrecipients of ESG and CoC Program funds, *HUD Exchange FAQ (id#1529)*.

⁸² Green Doors (n.d.) Family homelessness facts. *Homes through community partnership*. Retrieved February 21, 2018, from <http://www.greendoors.org/facts/family-homelessness.php>

⁸³ Doorways for Women and Families (2018). The facts about family homelessness. *About the issues*. Retrieved February 21, 2018, from <https://www.doorwaysva.org/our-work/education-advocacy/the-facts-about-family-homelessness/>

⁸⁴ United States Interagency Council on Homelessness (June 2010). USICH briefing paper -Youth homelessness. Retrieved from https://www.usich.gov/resources/uploads/asset_library/BkgrdPap_Youth.pdf

⁸⁵ Ibid.

⁸⁶ Desmond, M. (2016). *Evicted: Poverty and profit in the American City*. New York City, NY: Broadway Books.

Seniors

Definitions and benchmarks for age statuses vary from study to study. Social Security benefits and Medicare are available to individuals 65 years and older. However, subsidized housing is available at age 62.⁸⁷ In addition, there appears to be a clear upward trend nationally in the representation of persons aged 50-64 among the homeless population. Additionally,

The Sixth Annual Homeless Assessment Report to Congress found that the sheltered homeless population age 51 to 61 has grown from 18.9% of total sheltered persons in 2007 to 22.3% in 2010. These increases primarily coincide with the aging of the population of persons known as “baby boomers” in the population as a whole. Research by Dr. Dennis P. Culhane has documented that this cohort has had an “elevated and sustained risk for homelessness over the last twenty years” due to a combination of social and economic factors.⁸⁸

KnoxHMIS captures data on seniors as defined by individuals who are 62 years or older. This senior cohort (n=881) represents 10% of Knoxville-Knox County’s total homeless population. It is important to note, though, that for men the modal age is 52 and 56 (see page 88.)

This population, specifically older men, is burgeoning despite not belonging to a population of interest/special homeless sub-population.

However, there is a growing consensus that persons aged 50 and over should be included in the “older homeless” category. Homeless persons aged 50-65 frequently fall between the cracks of governmental safety nets: while not technically old enough to qualify for Medicare, their physical health, assaulted by poor nutrition and severe living conditions, may resemble that of a 70-year old.⁸⁹

Street Homeless

HUD ranks its categories of homelessness in 4 categories: literally homeless, imminent risk of homelessness, homeless under other federal statutes, and feeling or attempting to flee domestic violence. Category 1 refers to those who are literally homeless, also referred to as street homeless or the unsheltered homeless. Inclusion criteria is that an individual or family “lacks a fixed, regular, and adequate nighttime residence” which is further defined as having a primary nighttime residence that is a public or private place not meant for human habitation (abandoned buildings, streets or parks, cars, campgrounds, bus stations, or railways), living in a publicly or privately operated shelter designated to provide *temporary* living arrangements

⁸⁷ National Alliance to End Homelessness (2017). Elder homelessness. *Who Experiences Homelessness?* Retrieved February 20, 2018, from <http://nationalhomeless.org/issues/elderly/>

⁸⁸ The National Convening on Ending Elder Homelessness (2011). Ending homelessness among older adults and elders through permanent supportive housing. Retrieved February 21, 2018, from https://www.chapa.org/sites/default/files/ELL_policypaper_final.pdf

⁸⁹ National Coalition for the Homeless (2009). Homelessness among elderly persons. Retrieved February 21, 2018, from <http://www.nationalhomeless.org/factsheets/Elderly.pdf>

(mission-style shelters, transitional housing, or hotel/motel vouchers from charitable organizations), and/or exiting an institution (jail, prison, hospital, or psychiatric facility) where the individual has resided for 90 days or less *and* resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.⁹⁰

Literature suggests that self-autonomy and the desire to regain control and decision-making powers are often involved in the choice to remain unsheltered or to “sleep rough.” Previous experiences with service providers are the most likely indication of whether someone will attempt to engage with social services again. Core components of past characterizations include: infantilization, the idea that homeless agency staff know better than homeless people what services they need, what problems they have, and how services are best delivered as well as the client perception of being treated as a child, being subject to arbitrary rules, being treated disrespectfully by staff, experiencing objectification, being treated as a number or “thing,” and the medicalization of homelessness. In summation, “staff and guests function as institutional agents whose job it is to govern ‘the homeless’ through a regime of surveillance, discipline, and personal enhancement [...] A ‘normal’ person is to be made by governing a ‘deviant’ homeless person.” Once again, the myth of self-sufficiency and the narrative of “bootstrapping it” “fix blame on needy, dependent individuals rather than on broken or ineffective institutions or larger impersonal social, economic and political forces. The result is often a bizarre system of victim blame and pious self-righteousness from which many homeless people ‘opt out’.”⁹¹

An estimated 37% of individuals experiencing homelessness in the U.S. are unsheltered.⁹² Yet of the total 2017 homeless population of Knoxville-Knox County, unsheltered street homeless made up only 16% (n=1,421) (see page 99). A possible explanation for this difference in counts is the difficulty in capturing data on unsheltered populations. Knoxville’s CAC (Community Action Committee) estimates there are 80 homeless camps throughout Knox County.⁹³ However, this number is not static. As more long-established camps are being removed, Knoxville law enforcement agents are now receiving a larger number of complaints from new areas of town. Additionally, emergency shelters such as KARM are not seeing significant increases in their numbers. However, this does not mean necessarily that the unsheltered population is waning. Instead, according to street outreach workers, it appears that the unsheltered homeless are simply “hiding better.”⁹⁴ With raising reports of criminal activity and a degraded environment notable in the Mission District of the Broadway Corridor, it is of critical importance to consider how agencies serving this subpopulation of homeless individuals can more effectively address their specific needs.

⁹⁰ U.S. Department of Housing and Urban Development Community Planning and Development (n.d.). Homeless Definition, *HUD Exchange*. Retrieved February 21, 2018, from https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf

⁹¹ Donley, A. M., & Wright, J. D. (2012). Safer outside: A qualitative exploration of homeless people’s resistance to homeless shelters. *Journal of Forensic Psychology Practice, 12*(4), 288-306. doi:10.1080/15228932.2012.695645

⁹² Ibid.

⁹³ Burgess, A. S. and Nelson, K. L. (2018). Hard road to home: Knoxville’s homeless face more challenges without camps. *KnoxNews*. Retrieved February 21, 2018, from <https://www.knoxnews.com/story/news/local/2016/10/10/hard-road-home-knoxvilles-homeless-face-more-challenges-without-camps/91757980/>

⁹⁴ Ibid.

Ongoing Efforts and Opening Doors

In May 2009, President Obama initiated the United States Interagency Council on Homelessness and tasked the group of 19 Cabinet Secretaries and agency heads to produce a “national strategic plan” to end homelessness to present to Congress. In June 2010, “Opening Doors,” the national initiative to end homelessness, was introduced as a collaborative effort between “Congress, mayors, legislatures, advocates, providers, nonprofits, faith-based and community organizations, and business and philanthropic leaders to achieve the vision of Opening Doors: ‘No one should experience homelessness -- no one should be without a safe, stable place to call home.’”⁹⁵ Opening Doors was revised and amended in 2012 and 2015. The strategic plan is anticipated to be revised again in 2018. According to HUD’s Office of University Partnerships, the 2015 amendments and the September 2017 strategic update⁹⁶ reflect the most recent initiatives and recommendations for Opening Doors.⁹⁷ It is worthwhile to note that there is often a lag between projected implementation and practice during the initial transition between administrations.

In the 2015 amendments, Opening Doors set priority goals to:

1. Prevent and end homelessness among Veterans in 2015;
2. Finish the job of ending chronic homelessness in 2017;
3. Prevent and end homelessness for families, youth, and children in 2020; and
4. Set a path to end all types of homelessness.⁹⁸

Opening Doors offers an operational definition for ending homelessness. Opening Doors recognizes that changing economies, personal crises, and family and community violence may cause situations where individuals could experience, re-experience or become at-risk for experiencing homelessness. To “end homelessness,” “every community will have a systematic response in place that ensures homelessness is prevented whenever possible or is otherwise a rare, brief, and non-recurring experience.”⁹⁹

As of January 2018, Knoxville implemented a coordinated entry system, CHAMP (Coordinated Housing Assessment and Match Plan) in order to not only address Opening Doors’ Objective 10 (“Transform homeless services to crisis response systems that prevent homelessness and rapidly return people who experience homelessness to stable housing”), but to also link all CoC agencies into a single community assessment and referral system. This strategic initiative allows any potential client to begin the path to housing at any CHAMP participating agency. More fundamentally, CHAMP is a community-based response to

⁹⁵ Poppe, B. (2010). Opening doors. *The White House Blog*. Retrieved February 23, 2018, from <https://obamawhitehouse.archives.gov/blog/2010/06/15/obama-administration-unveil-national-strategic-plan-prevent-and-end-homelessness>

⁹⁶ United States Interagency Council on Homelessness (2017) *Opening Doors*. Retrieved February 23, 2018, from <https://www.usich.gov/opening-doors>

⁹⁷ Burnell, A.C. Personal communication with HUD Office of University Partnerships, April 6, 2018.

⁹⁸ United States Interagency Council on Homelessness (2015) *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness As Amended in 2015*. Retrieved February 23, 2018, from https://www.usich.gov/resources/uploads/asset_library/USICH_OpeningDoors_Amendment2015_FINAL.pdf

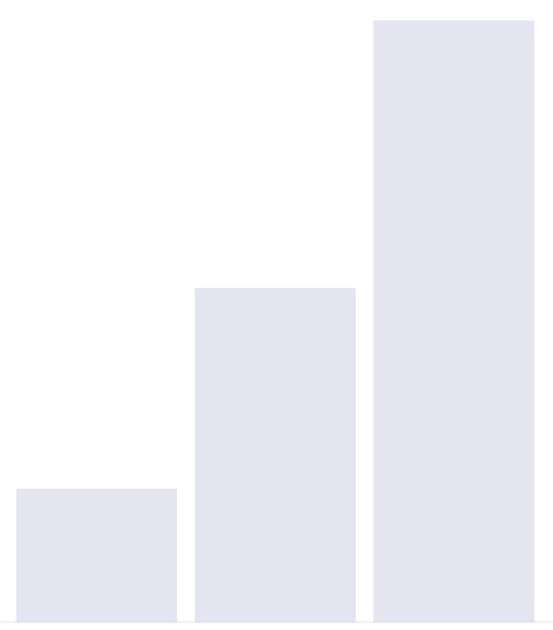
⁹⁹ Ibid.

homelessness wherein decisions are made collectively to prioritize Knoxville's most vulnerable homeless to better maximize the use of available housing units. Additionally, CHAMP offers the ability to assess potential clients' vulnerabilities in order to rank referrals by level of client acuity (those who are most vulnerable are placed as priority) as well as match clients with the agency best suited to their housing needs. Through CHAMP, the idea is to maximize available service and housing options by uniformly assessing and then prioritizing homeless circumstances. Prioritization scores will then link that individual or family to the agency and/or service that can most appropriately respond to the unique needs presented at intake.

Additionally, KnoxHMIS offers a Community Dashboard (<http://www.knoxhmis.org/dashboard/>) that is updated every quarter. The Community Dashboard presents at-a-glance data on community homelessness including the number of clients served, new clients entered, client lengths of stay (in Permanent Support Housing, Transitional Housing, and Emergency Shelters), self-reported causes of homelessness, subpopulation data, as well as community wide bed utilization/bed availability.

For more information on CHAMP and other Knoxville initiatives to combat homelessness, please direct attention to the Note to Reader written by Gabrielle Cline, President of the Knoxville/Knox County Homeless Coalition (see page 28).

Knoxville Knox County Homeless Coalition Biennial Study 2018



Knoxville-Knox County Coalition for the Homeless Biennial Study on Homelessness

Note to the Reader

In November 1985, the Knoxville City and Knox County executives appointed 25 community leaders to explore the extent of homelessness in Knoxville and to make recommendations for services. Dr. Roger Nooe, University of Tennessee College of Social Work Professor Emeritus, served as the first chair of this group and, in February 1986, the first comprehensive study on Homelessness was conducted. The group began meeting monthly to discuss emerging trends and to develop standards of care and practice for effectively working with and for those experiencing homelessness. The group, now the Knoxville-Knox County Homeless Coalition, has conducted the study biennially since, making this the 32nd year and the 17th study on Homelessness in Knoxville.

Each study is a monumental effort requiring a vast amount of resources, volunteers, and time. In the months prior to the study, members of the Coalition began planning for the event, creating the questionnaire, and scheduling times and places for training and interviewing. In the 2018 Study, 72 volunteers interviewed 215 Knoxville residents experiencing homelessness in 19 programs provided in shelters and outdoor locations. Each interview lasted an average of twenty minutes, meaning that approximately 72 hours of interviews were collected. After the interviews were completed, additional hours of work were devoted to analyzing and crafting the information you are now viewing.

I would be remiss if I did not acknowledge that the Coalition's Homeless Youth Council also undertook a Youth Specific Point-In-Time count to coincide with the Biennial Study. As noted in the literature review (see page 21), the needs and service utilization of youth experiencing homelessness are different from those of adults. This is only the second time our community has undertaken a Youth PIT count. The extraordinary efforts of the Youth Council to identify and survey youth will help us better understand how to develop services to address the needs of those under the age of 24 who become homeless or who are at risk of homelessness.

It would be impossible for me to adequately acknowledge and thank all the individuals who contributed to completing the 2018 study. That being said, I would like to recognize the agencies who allowed us into their programs and provided staff to facilitate the interviews. I appreciate that agencies permit us to disrupt their normal provision of services in order to contribute to this community effort. Most importantly, I would like to thank the individuals and families who are experiencing homelessness who were generous and courageous enough to share their stories with us.

With the continued guidance of Dr. Nooe, the Coalition has aimed to maintain the high standards for the study established in 1986. The 2018 study has relied more heavily than ever on the resources of the Knoxville Homeless Management Information System (KnoxHMIS). While there are many in the KnoxHMIS office that have contributed, the bulk of the work to prepare, conduct, and complete this year's study was done by Lisa Higginbotham, KnoxHMIS Program Manager and Sam Edwards, SWORPS Publications Specialist. We are grateful for their skills and expertise.

Within this report, you will find a great deal of data, extrapolations, and interpretations. While we hope this information will educate, our primary goal in presenting this study is to bring attention to the issues plaguing those who experience homelessness and to encourage strategic action to prevent, reduce, and end homelessness. Please receive this 2018 study from the Knoxville-Knox County Homeless Coalition as an invitation to join us in our efforts. It is hoped that the information that follows will aid in advising and guiding our collective community response.

Respectfully,
 Gabrielle Cline, LCSW
 President, Knoxville-Knox County Homeless Coalition

Biennial Study Volunteers

Anne Maiden	Denise Evertson	Meagan Vinson
Aaron Burnell	Dustin Heffner	Megan Lappas
Alison Duncan	Dustin Starnes	Melissa Ward
Allison Ward	Dyrl Higdon	Michael Hodges
Andrew Call	Elizabeth Preuss Gollither	Mike Dunthorn
Annette Beebe	Emma Parrot	Nina Levison
Ashley Long	Erin Lang	Opal Bryant
Ashley Myrick	Gabrielle Cline	Rachel Bronstein
Ashley Walker	Gerald Witt	Randall Morrison
Ashley Weaver	Isaac Merkle	Rebba Omer
Barbara Disney	Jane Crowe	Rebecca Wolfe
Betsy Payne	Jay Gordon	Rhea Ennist
Bri Knisley	Jered Croom	Roger Nooe
Bruce Spangler	Joshua Dillard	Roosevelt Bethel
Caitlen Ensley Watson	Kaitlen Olmstead	Rosie Cross
Carl Williams	Katlyn Gass	S. Oliver
Carl Witt	Kristin Milanich	Scott Payne
Catherine Bearden	Lauren Mohler-Stovall	Shawn Griffith
Chris Cook	Leslie Kimsey	Sissy Flack
Chris Smith	Lexi Jantz	T. Wallace
Cindy Manginelli	Lisa Higginbotham	Tiffany Gordon
Connie Vogt	Lisa LaDuca	Tiffany Higginbotham
Debbie Taylor-Allen	M. Tyree	Torrie Dreier
Deborah Parker	Mari Hanchar	Wright Kaminer

Study 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 Biennial 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, 2014, 2016, and 2018). 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 design of previous studies included concurrent interviews in shelters between 6:00 pm and 9:00 pm on Thursday evening. A sample of non-shelter users, or “campers,” was conducted on the preceding Wednesday evening between 7:00 and 8:00 pm, and early morning visits to camps by a small team of interviewers occurred the following Friday. Past studies also include an enumeration based on shelter census during the month of February. However, in 2012 the shelter census was dropped and KnoxHMIS data was used in its place.

The current study was conducted in January 2018. It followed the basic design of previous studies, including interviews with a sample of persons in the shelters, as well as the Wednesday evening and Thursday evening outreach programs. After careful consideration, the decision was made to eliminate Friday morning visits to camps and focus on the two outreach programs to sample campers. The decision to omit camp interviews that had been an integral aspect of the biennial studies was based on a number of circumstances. The clean up (elimination) of campsites, media publicity about camps, community complaints, and police presence has resulted in increased tension and an often held perception that allowing interviewers or outreach workers into camps results in camp elimination by the city. While past studies have maintained a policy of not identifying campsites and using experienced interviewers, the existing tension and suspiciousness suggested an unacceptable level of risk this year. Thus, all of the unsheltered respondents (n=37) were sampled from outdoor outreach events.

In 2018, the interview locations included Family Promise, Helen Ross McNabb Center Family Crisis Center, Helen Ross McNabb Center Great Starts, E.M. Jellinek Center, Hi-ways and By-ways Ministry, KARM Family, KARM Overnight, KARM Serenity, KARM The Bridge, KARM LaunchPoint, KARM Berea, KARM Relapse Prevention, Lost Sheep Ministries, Salvation Army Joy Baker Center, Salvation Army Transitional Housing, Catholic Charities Samaritan Place Emergency Shelter, Steps House, and YWCA Keys of Hope.

In addition to the KnoxHMIS Annual Report and biennial data, this year’s study includes a summary of an “under the bridge” survey conducted in October 2017 at the Broadway Avenue/1-40 Overpass. This effort was conducted by staff from Knoxville-Knox County Community Action Committee, Knox Area Rescue Ministries, and the Helen Ross McNabb Center as requested by the City of Knoxville. This request was in light of the large number of individuals camping and/or congregating on Broadway Avenue “under the bridge.”

The questionnaires used in biennial 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. In 2018, questions about housing access, the use of housing vouchers, denial of access to emergency shelter, and common daily activities were added. 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 2018, seventy-two 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 and rather to record the answer given. All interviewers signed a pledge to maintain confidentiality.

Interviews were conducted at a point-in-time during the week of January 21, 2018. 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 24th. Shelters were visited on Thursday, January 25th. 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. A total of 215 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 2017 KnoxHMIS Annual Report 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 2017, 8,938 individuals sought services 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.

Comments and Case Studies

The Biennial Study includes the participants' 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 summarized comments about experiencing homelessness:

- A lot of people really want jobs. But when you use a shelter address on an application, it keeps employers from looking at the application. All we want is a permanent job. A serious job program would help a lot.
- Homeless is [a] hard situation, [it] is a job, finding residency, finding food and sustenance. Trust is an issue.
- Being homeless and young is really hard in Knoxville, because there aren't many specific programs for young adults.
- There needs to be more mental health help. A lot of times people are not educated enough on how to get help.
- It's really hard to get into a rehabilitation center around here.
- I work the third shift. I need some place to sleep during the day.
- I came here [emergency shelter] from the hospital and really wanted to go to a nursing home. I can't afford it and don't qualify for the kind of help I need, and now I am here.
- Doctors and caseworkers change positions too often; this makes it hard to form connections. It is also frustrating to have to re-explain your situation to each new doctor or caseworker.
- Biggest obstacle to housing is being able to get a job while having a criminal record.
- I think that there should be a dental program for indigent individuals that offers more options.
- Being homeless is eye opening, makes you realize how much you have and how easily it can be taken away.
- I have concerns with the way the system has failed individuals with terminal illnesses.
- I'm frustrated that there isn't help for mentally ill homeless people. They fall through the system.
- We are not homeless because we choose to be.

- [We need] help people pay rental and security deposits because this can be a huge barrier to getting housing.
- I'd really rather not be homeless. I don't feel I deserve to be.
- There is a stereotype with being "homeless." Just because you may be homeless doesn't mean we don't care about our first impression with other people.
- [There is a] great lack of dignity, lack of integrity and kindness among homeless population. [There is] no privacy in shelter. [It's] too noisy.
- I don't want to take it for granted that you can come to a place like this and get food and shelter, because no one wants to give you anything for free. It's a blessing and I don't take it for granted.
- Everybody that is homeless is not addicted to drugs or liars. People currently homeless are spiritually, mentally, and physically broken. These programs are a light in a very dark place.

Knoxville-Knox County Homeless Coalition partners provided case studies. 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 Center, Knoxville Knox County Community Action Committee, Knoxville's Community Development Corporation, Knoxville Leadership Foundation, The Salvation Army, and Volunteer Ministry Center.

Mary's Story

Mary, age-18, was a senior in high school when she became homeless. Mary's family home was unstable and often violent. Her stepfather was physically abusive to both Mary and her mother. She later told her case manager that she became "fed up" not knowing if she was going to be coming home to a safe environment. Mary approached her school's counselor who quickly referred her to a youth homeless service program.

Mary and her case manager recognized how important it was to find stable housing so she could continue her studies. Instead of waiting for a traditional youth transitional housing program, she opted for a program that served women in substance abuse recovery. Program participants were required to give up phones and get permission from staff to come and go from the facility. Mary felt out of place and isolated, however the case manager continued to work with her until a more appropriate youth housing program became available.

Mary's story speaks to the difficulty many of our community's **unaccompanied youth** face as they attempt to find housing with limited, age appropriate resources.

Andrea's Story

Andrea was a single, working mother with two preschool-aged daughters who was laid off from one of her jobs and subsequently was unable to pay the rent for their apartment. Evicted and without family support, Andrea and her daughters had to live in their car. Homeless outreach workers approached Andrea and started working with her to find housing resources. After two weeks on a waiting list, they were admitted to a family shelter program.

In the shelter, Andrea continued working with her case manager. Together, they were able to access a two-year housing subsidy, that made housing affordable given her limited income. Andrea began her apartment search approaching private complexes, but quickly learned that despite having a subsidy, very few affordable housing opportunities existed. When she was able to locate available housing, she found that a past eviction – failure to pay rent – presented another obstacle. With the help of her case manager, Andrea was able to locate a private landlord that was willing to take a risk on housing the family. In addition to the housing subsidy, another agency was able to help pay the first month's rent with rapid rehousing funds.

Andrea's story reflects the common reality of many homeless families receiving housing vouchers but being unable to use them because of **lack of affordable and/or subsidized housing**. Too, it points to how critical it is for homeless service programs to build and maintain positive landlord relationships.

Xavier's Story

Xavier is a single father of a 13-year-old son. Despite receiving some income through Social Security Disability Income, they lived paycheck to paycheck. When his son became ill, requiring several days of hospitalization, a financial crisis ensued. The hospital costs made it difficult for Xavier to pay his monthly rent. While his landlord was initially understanding, allowing time to catch up with payment, after several months he evicted Xavier and his son. The family's only perceived option was to sleep in their car.

Xavier was terrified that, if anyone found out that they were living in a car, he would lose custody of his son, thus was very reluctant to seek assistance. He did, however, feel comfortable approaching his mental health therapist, who made an appointment for him with the agency's case management program. Because local shelters are unable to serve single fathers caring for teenage children, Xavier and his social worker approached a faith-based nonprofit program that paid for a motel room. This stability gave Xavier the opportunity to look for employment that would supplement his disability income. His case manager secured gasoline vouchers so that Xavier could apply for jobs and attend free employment preparation classes offered by another agency that also provided funding for work boots and uniforms. After several weeks of job searching with the ongoing support of his case manager and employment program he found employment as a delivery truck driver.

Xavier's story illustrates the multiple agencies and organizations, such as behavioral healthcare providers, who work closely with the homeless. It also points to the many challenges faced by **single parent families** in housing crises.

Casey's Story

After her partner left her, Casey, a single mother who was seven months pregnant, could not afford the rent the two had been splitting. Forced to leave her home, she searched for emergency shelter services. Shelter staff promptly referred Casey and her family to a housing program in for assistance in applying for subsidized housing. The case manager at the housing program helped her submit a pre-application for an affordable apartment at a local housing authority and she was placed on the waiting list. Her hope was to find housing near her children's school and her work.

Casey utilizing available services at the emergency shelter and housing program was ultimately able to pay the outstanding balances on her car loan and utility bill. After a year on the waiting list, an apartment complex contacted Casey with a housing application and she was offered a three-bedroom apartment for her family four months later. In addition to helping with the housing search, her case manager assisted in applying for subsidized childcare and was able to help her secure furniture and household items.

Casey's story illustrates the **length of time** which is often **required to obtain subsidized housing**. In addition, her story points to the many case management tasks involved in a housing search and placement.

Max's Story

For over 20 years, Max and his wife lived in their own home in Knoxville. They paid their monthly mortgage with their combined Social Security income. After his wife died, he could not afford the mortgage payments and lost his home to foreclosure. At age 70, Max was in poor health with numerous ailments and disability. While local shelters offered emergency services, accessing those services was burdensome for Max given his frailty. Max decided to live in his van. Being illiterate, Max approached a homeless service program for assistance in applying for housing. His case manager was able to help him locate a complex with wraparound case management specifically for senior citizens where he currently resides.

Max's story reflects the difficulty many **senior citizens**, specifically those who are experiencing complex health and mental health issues, face when attempting to access emergency services and housing placement.

Gina's Story

Gina, a 35-year-old, single mother of two sons (ages 17 and 8), worked two part-time jobs, which made childcare difficult, especially after school. While Gina owned the family's mobile home, she paid a monthly rent to the trailer park. When the landlord announced a 50% increase in rent, Gina realized that she could not afford the rent or the cost of relocating the mobile home, necessitating the family moving into her van.

Gina refused to use emergency shelter services because her oldest son would be forced to live in the men's barrack-style section of the facility, away from the family. The trailer park owner sold the lot's debt to a collection agency that began to garnish Gina's wages. The younger son began acting out in school and complaining of being constantly tired and hungry, which led to an intervention from his school's guidance counselor and social worker. This intervention prompted referral to housing outreach workers who were able to enroll the family in a program that offered ongoing shelter and kept the family intact. The family's case manager

was able to link the children to an after-school community center where they gained a consistent and safe place to spend time when their mom was at work. A referral was also made to financial advisors and legal advocates who helped Gina explore her rights regarding her mobile home and housing.

Gina's story illustrates the precarious relationship many renters have with their landlords/leasers as well as how **homelessness effects all members of a family system**. Additionally, Gina's story underscores the difficulties that may arise in attempting to offer emergency services to **families with male children over 11 years old**.

Vince's Story

Vince, an Army veteran, was honorably discharged from service with a 40% veteran disability classification after he received a combat injury. He had suffered a traumatic brain injury, which affected his ability to self-regulate his mood. This injury made it difficult to gain and maintain employment. When he lost his job at the packing plant, he was unable to pay for his apartment and subsequently spent much of his savings renting motel rooms. When his savings were depleted, he started staying at an emergency shelter and utilizing a community day center. Through his involvement in the day center, he met other veterans who encouraged him to reach out to a veteran's service program that would help him utilize his Veterans Affairs benefits. In this veteran service program, Vince began attending a peer support group where he was able to talk to others who, like him, were having difficulty reintegrating into civilian life with a disability.

Vince's story illustrates the **unique ways** in which different **sub-populations experience homelessness** and how provider collaboration (between emergency shelter, community day space, and veteran-specific services) can successfully support a client's transition out of homelessness.

Tommy's Story

Tommy had been on the streets for decades. He could be seen walking all over town during the day. For several years, street outreach case managers checked at camping spots where they typically saw him to make sure he was safe and to try to get him interested in housing and other supportive services. One Fall, Tommy talked with street outreach case managers about getting some help from them. When asked why he was seeking housing now, Tommy responded that the physical toll associated with homelessness had become too much and that he did not believe he could survive another winter on the streets. With severe anxiety, Tommy was uncomfortable staying in dormitory-style emergency shelters, so opted to camp outside. With the help of his case manager, Tommy was able to find housing in a permanent supportive housing program in. Prior to obtaining housing, Tommy went to the hospital emergency room 2-3 times each month, usually transported by an ambulance. The case managers at the housing program were able to help him secure health care through a primary care physician, make sure he had transportation to his medical appointments, and facilitate a living environment that supported his health. Tommy has lived at his new home for approximately 6 months. In that time, he has been to the hospital once – transported there by his housing case manager.

Tommy's story highlights how **fragile** the **health of the homeless** can become as well as the associated community benefits of street outreach and supportive housing programs.

Harry's Story

Harry grew up in an affluent neighborhood and was well supported by his parents, teachers, and community. While he was sometimes described as "an odd boy," he was well-liked and had many friends. At age-19, Harry experienced his first psychotic episode that was diagnosed as schizophrenia. During the next 25 years, Harry was in and out of psychiatric hospitals and treatment centers. His parents remained his primary support, paying for his behavioral health care treatment, providing him space in their home, and acting as his biggest advocate as he navigated adulthood with a severe and persistent mental illness. Harry became homeless after his mother died 3 years ago, which was 6 years after his father's death. Without his parents' support, Harry struggled to maintain his mental health. When he met his new case manager, he explained that he had not seen his therapist in over 9 months. In working with Harry to obtain housing, the case manager was cognizant of the importance of ongoing mental health care and a social support system. The case manager linked him to available indigent care services and a peer support program. The stability provided by through mental health treatment. provider, the work of the case manager in securing suitable housing, and a growing support system, enabled Harry to sign his first lease earlier this year.

Harry's story points to the often-complex array of services needed to house and support homeless individuals experiencing **mental illness**.

Lenny's Story

Lenny has been living in Permanent Supportive Housing for approximately 2 years. He suffers from schizophrenia, is illiterate, and could not perform basic daily living skills when he moved in. Symptomatic of his mental illness, Lenny hoards clothing that he finds at either thrift stores or in the trash. As a result, Lenny developed a bed bug infestation. Lenny was unable to do the required preparations necessary to get his apartment treated and did not understand the advice given to him by his property manager and case manager about bed bug prevention. Lenny was failing his apartment inspections and these infractions put him at risk for eviction.

Case management intervened by hiring a specialized cleaning service and arranging funds from his bank account to pay for service. The cleaning service prepared Lenny's apartment so that it could be treated and cleared of bed bugs. Case management also arranged for ongoing upkeep of the apartment by helping Lenny hire a monthly cleaning service. Case management then developed a weekly routine of assisting Lenny in learning how to do laundry and monitoring clothes/items brought in from thrift stores. Lenny is no longer at risk of losing his housing and is still able to enjoy shopping trips, which are important to him and give him a sense of worth.

Lenny's story highlights the **unique needs of many experiencing homelessness** and problem-solving skills by case managers to help those suffering from severe and persistent mental illness to maintain their housing.

Demographics

This section details demographics of Biennial Study respondents. The data in the table is a comparison of demographics of respondents between the 2016 and 2018 studies. Please note that the table includes a new field for “transgender” for “gender.” “Multiple Races” is a new category representing persons who reported “bi-racial,” “mixed,” or more than one race. Additionally, 1% of respondents indicated “other” race as “Hispanic/Latino,” although it is typically qualified as an ethnicity rather than as a race. Another 2% indicated “Other” race as “Native American.”

Demographics of Biennial Study Participants		
	2016 (N=249)	2018 (N=215)
Age		
Under 18	0%	8%
18-24	8%	13%
25-61	81%	72%
62+	10%	7%
Null	1%	0%
Mean age:	44	43
Male	46	45
Female	42	41
Gender		
Male	62%	58%
Female	37%	41%
Transgender	0%	1%
Null	1%	0%
Race		
White	74%	74%
Black or African American	19%	17%
Multiple races	0%	3%
Other	7%	3%
Null	0%	3%

Source: KKCHC Biennial Study 2018

Characteristics

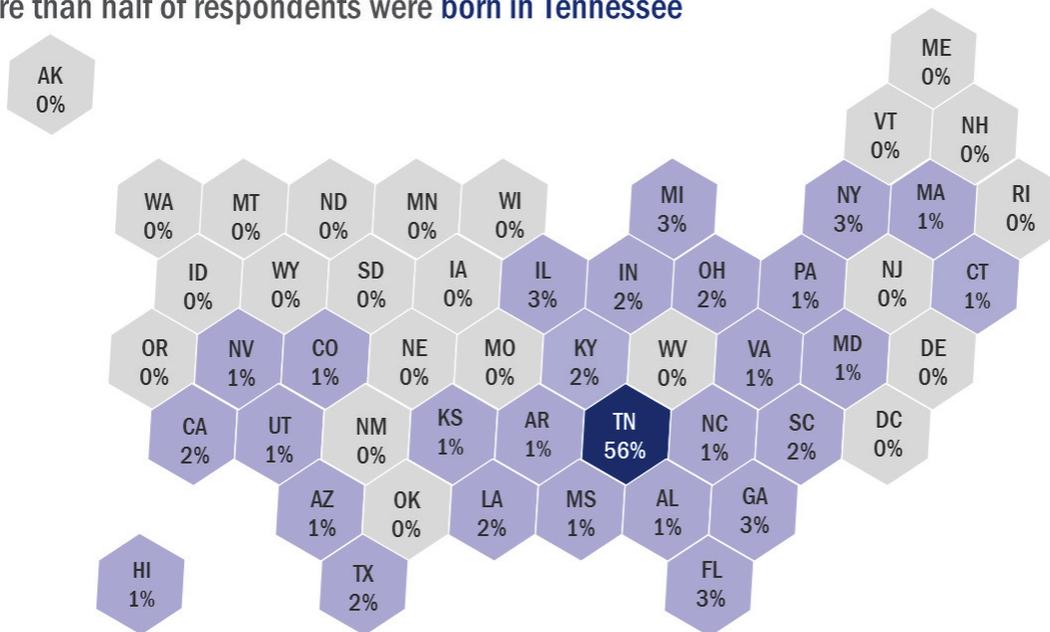
Biennial Study questions explore the early experiences of persons interviewed prior to their becoming homeless. The *Characteristics* section provides insight into *background, family, and social support* of respondents.

Background

The Biennial Study asks questions related to birthplace and residence prior to becoming homeless to better understand the background of respondents. This section looks at stability of persons experiencing homelessness in Knox County.

56% of Biennial Study respondents (N=215) report their birth state as Tennessee.

More than half of respondents were born in Tennessee

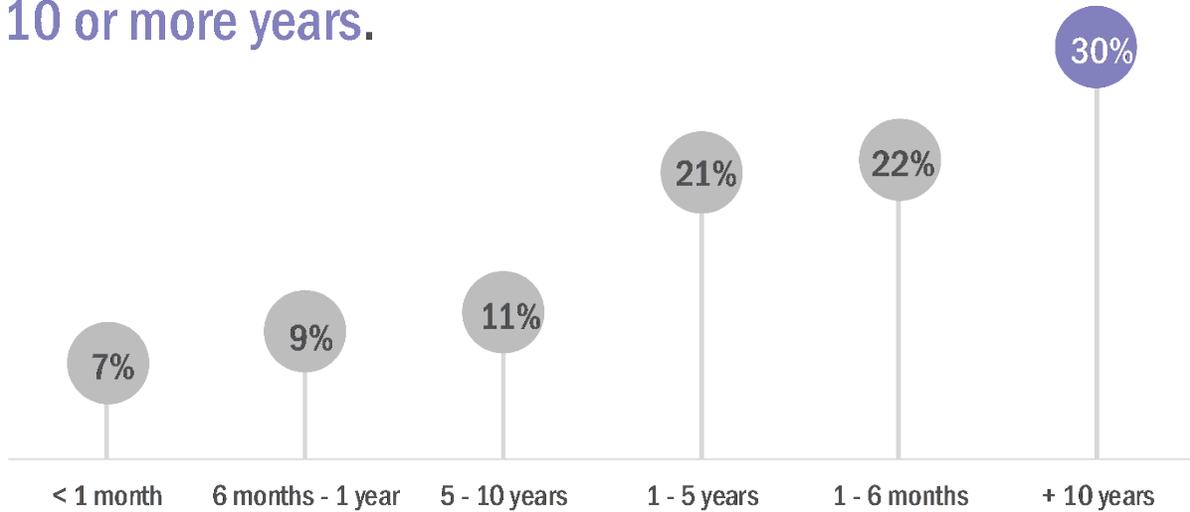


N=215
Source: KKCHC Biennial Study 2018

U.S. census data indicates that 62% of Knox county residents were born in Tennessee (2012). The number of respondents having grown up in Tennessee is in-line with United States Census data and has been consistent over the study's 30-year history with an average of 60%. It is likely that of the 62% of Tennessee residents, per Census data, some portion were born in Tennessee but outside of Knox County. Although 38% (n=46) of Biennial Study respondents that were born in Tennessee (n=121) were born in Knox County, 56% (n=120) of all respondents consider Knox County as their home.

Although 38% were born in Knox county, they may have moved around during their life-span. To further explore permanency in Knox County, a question was asked about how long the respondent has lived in Knox County. **30% of Biennial Study respondents report living in**

Most respondents have lived in Knox County for 10 or more years.



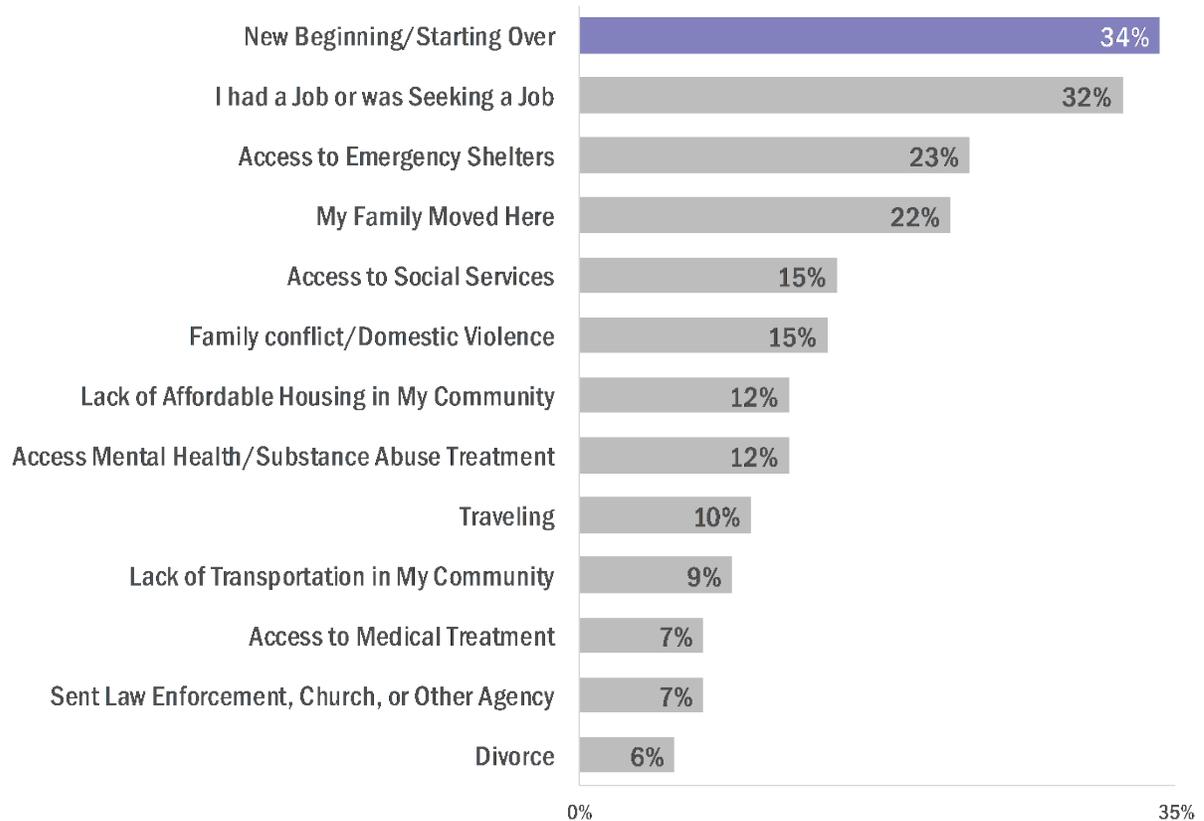
(n=179)

Source: KKCHC Biennial Study 2018

Knox County for more than ten years.

Respondents who report relocating to Knoxville-Knox County during their adult life (n=179), were asked to identify the three most important reasons for coming to Knox County. Thirty-four percent of respondents (n=61) that relocated from other Tennessee counties (n=179) reported “new beginning/starting over” as their reason for relocating to Knox County, TN. Similarly, in 2016 the primary reason for relocation was “New Beginning/ Starting Over” (32%).

New Beginning/Starting Over was the lead reason reported for relocation to Knox County.

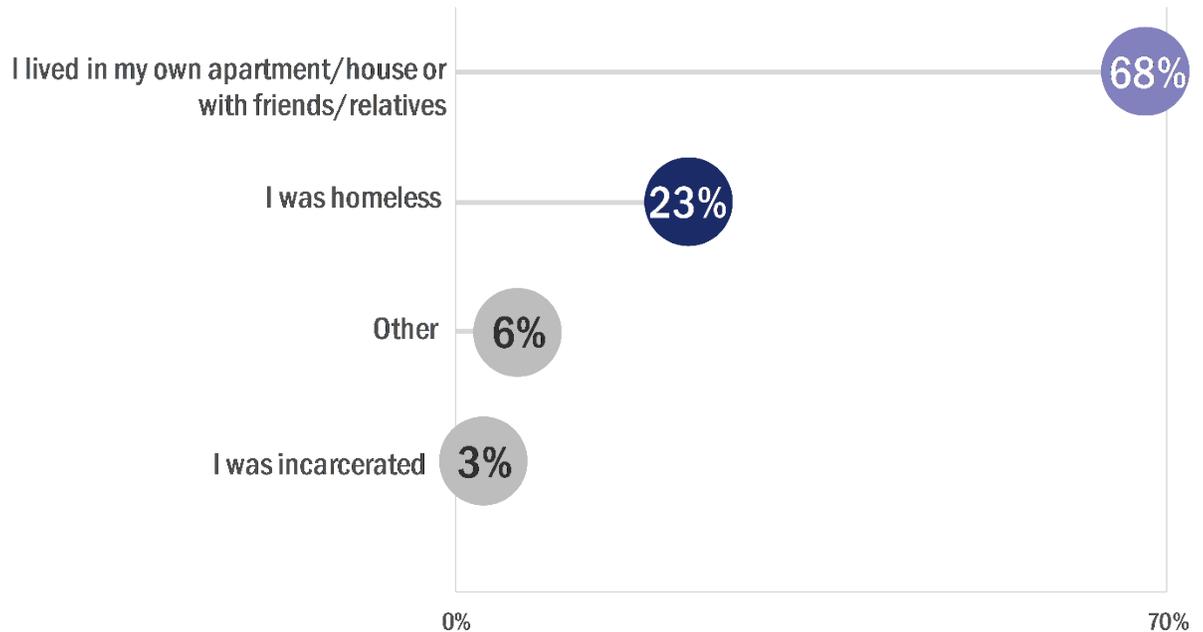


Multiple responses were accepted. Total will not equal 100%.

(n=179)
Source: KKCHC Biennial Study 2018

68% were housed (n=122) prior to relocating to Knox County (n=179). Whereas, **23% were homeless** (n=40) prior to relocation.

Most people had housing prior to relocating to Knox County but a quarter were homeless.



The items "I lived in my own apartment/house" and "I lived with friends/relatives" were combined, as were "I was homeless for a week or more" and "I was homeless for less than a week."

(n=179)

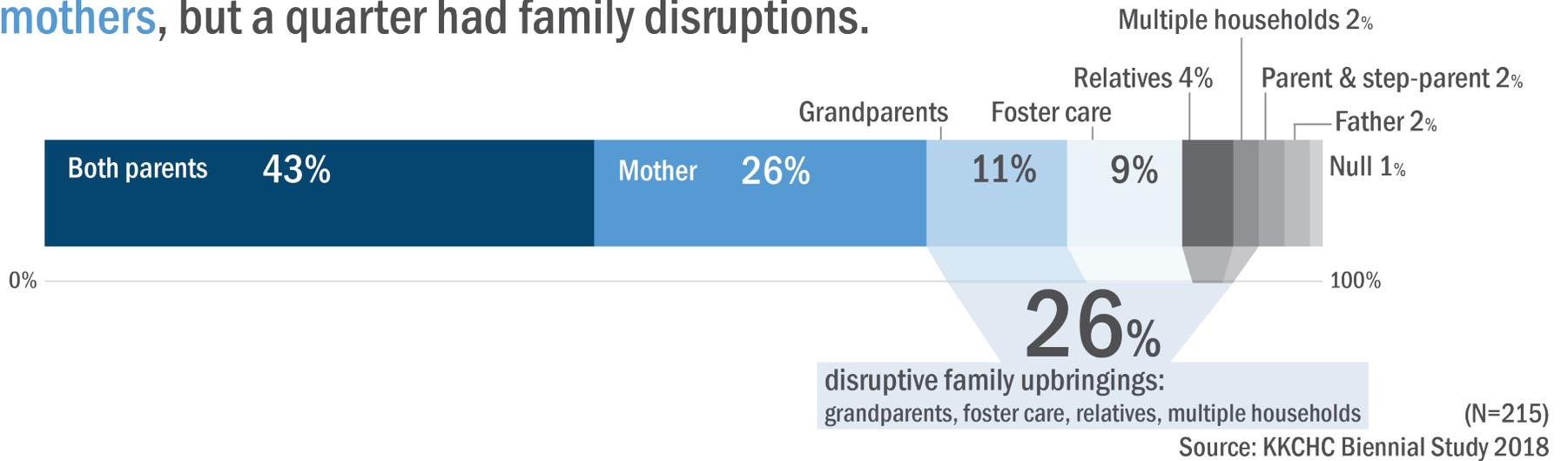
Source: KKCHC Biennial Study 2018

Family

The Biennial Study asks questions about home life while growing up to better understand how adverse childhood experiences may have impacted future homelessness. This section looks at primary living arrangement during childhood, family

disruption, trauma-related experiences, marital status, and current family composition. Additionally, this provides information on respondents who had their children with them during the study period.

Most individuals experiencing homelessness lived with both parents or their mothers, but a quarter had family disruptions.



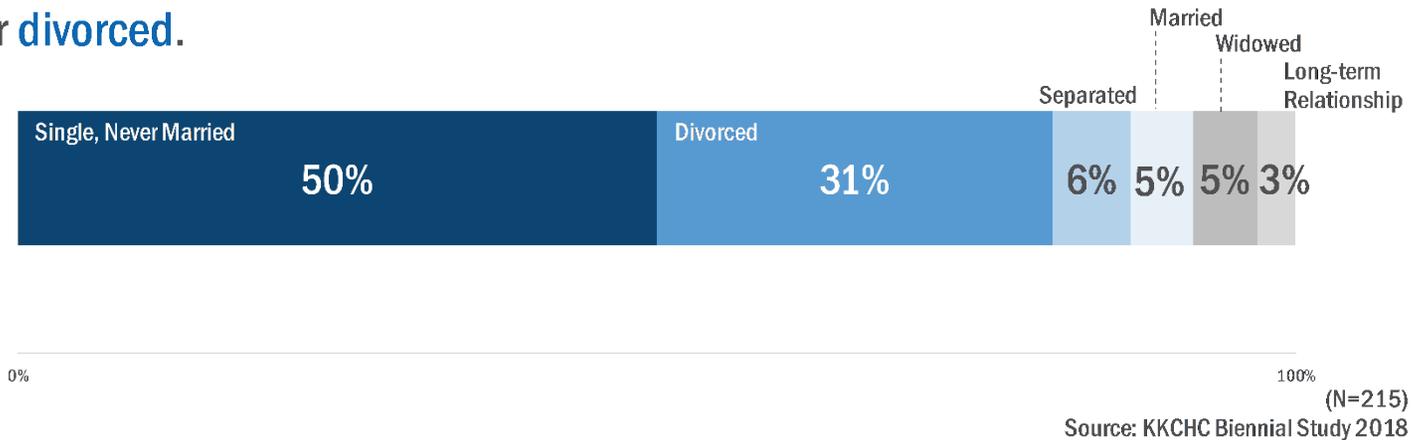
Overall, family disruption during childhood has increased among Biennial Study respondents:

- **Twenty-seven percent of respondents had been in state custody (n=58), which is a higher than in previous studies (18% in 2016, 22% in 2014).**

- Also, a history of foster care has increased among study respondents (22% in 2018, 12% in 2016, and 14% in 2014).** Among those in foster care (n=47), 45% had been in only one foster care placement, with approximately 21% percent having been in two to four placements, and 34% in five or more placements. Thirty-four percent (n=16) of those in foster care (n=47) were discharged from foster care at 18 years old. Among the total who were terminated from foster care (n=47): 38% went to live with relatives, 34% went home, 9% were adopted, 9% percent were discharged to the street or shelter, 6% went to a group home, 2% went to jail or prison, and 2% went to "other" locations.
- In terms of trauma related experiences, **46% of respondents (n=99) reported having experienced abuse as a child** compared to 35% in 2016. Twenty-eight percent of those who shared the type(s) of abuse experienced (n=69) reported experiencing multiple types of abuse. The most common forms of abuse cited (n=69) included: physical [29%], sexual [20%], verbal [11%], emotional [7%], and spiritual [2%].
- To further explore adverse childhood experiences, the study asked about childhood history of homelessness. Thirteen percent reported that their families had experienced homelessness during their childhood, which is nearly double the 7% reported in 2016 and 6% in 2014.

The study also asks respondents about their current household composition.

Most persons currently experiencing homelessness are single, never married or divorced.



During the study 67% of respondents (n=144) reported having children, with 54% reporting having children under the age of 18 (n=78). Fifteen families were interviewed during the Biennial Study who had children under the age of 18 years old in shelter with them; there were forty-two persons in those households with children. Household size of respondents who had their children with them on the night of the study varied: household with one child (6 households), household with two children (4 households), household with three children (3 households), household with four children (1 household), and unknown family household size (1 household). One-third of families with children in shelter during the Biennial Study report that they became homeless because "their family asked them to leave;" this does not, however, identify the root cause of their homelessness. The KnoxHMIS Annual report highlights that 17% (n=109) of family head of households (n=641) report feeling domestic violence as a primary reason for homelessness (see page 85). It is important to note that although the Biennial Study interviewed 15 families there were more families who were homeless on the January 25, 2018 point-in-time, which will be posted by the Department of Housing and Urban Development in Fall 2018.

Social Support

It has been argued that persons experiencing homelessness 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 continues to explore the relationship between social support and social networks among respondents.

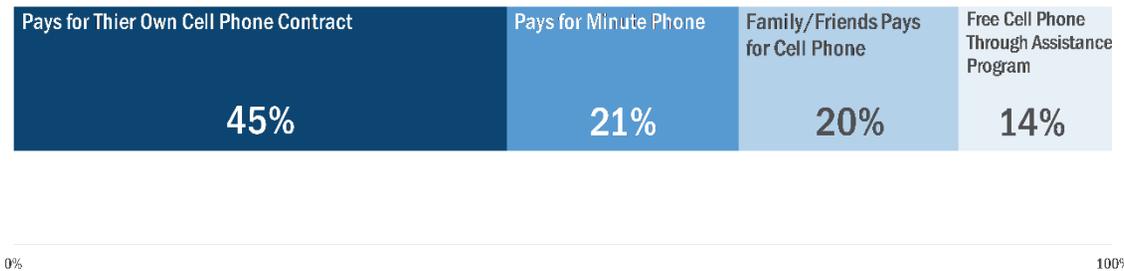
In terms of family support, 45% of all respondents indicated having family in the Knoxville area (n=97), compared to 51% in 2016. The majority of those respondents (58%; n=56) had regular contact with their social support within the previous week; whereas the remainder of respondents had more sporadic contact with their support network: 14% had family contact within

the past month, 10% within the year, 13% over a year ago, and 3% reported never contacting family.

Because little is known about the best methods to communicate with persons experiencing homelessness, questions were added to the study in 2014. Results of the 2014 study were presented and published (Patterson, Ensley, West, and Nooe, 2014) and 2016 results presented at the 2017 American Public Health Association Fall conference. Preliminary findings on Information Communication Technology (ICT) Usage for the 2018 Study are highlighted in this document and warrant further analysis. The study asked respondents if they had a cell phone, how often forms of ICT was utilized, where ICT was used most often, and purposes for which ICT was used.

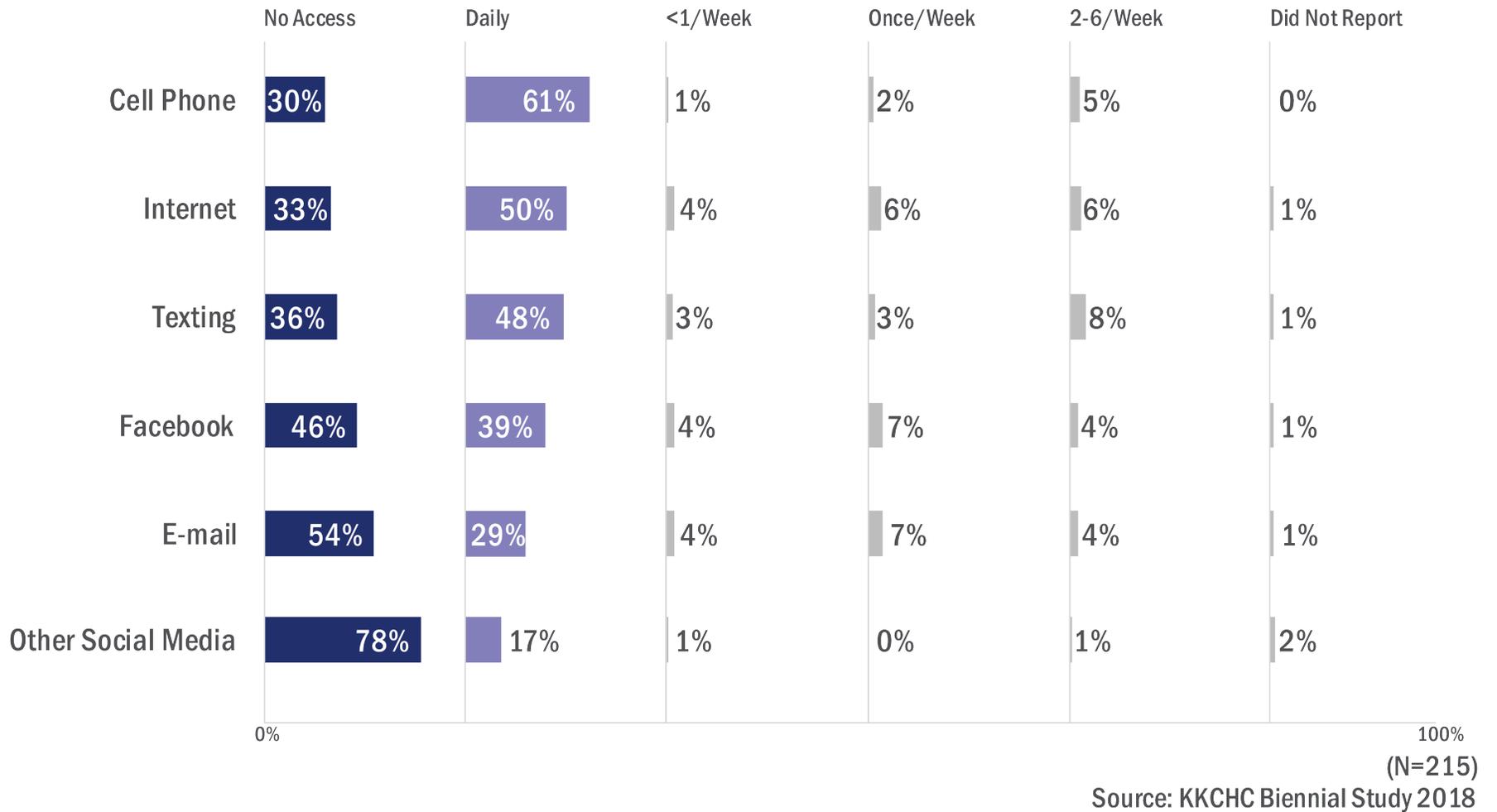
Sixty-eight percent of Biennial Study respondents report having a cell phone (n=143). Sixty-six percent of cell phones are paid for by the respondent without assistance; where as 34% are paid for through the help of family/friends or cell phone assistance programs. 61% of study respondents report using their cell phones daily.

More than half of persons experiencing homelessness pay for their own cell phone.

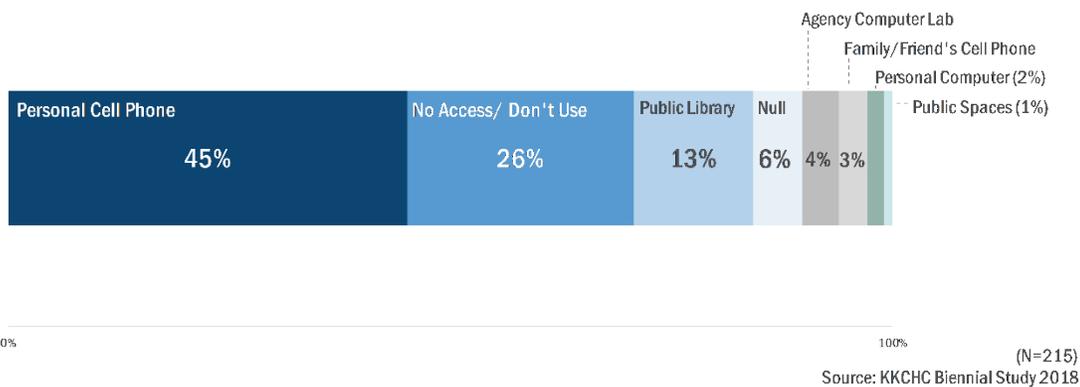


(n=143)
Source: KKCHC Biennial Study 2018

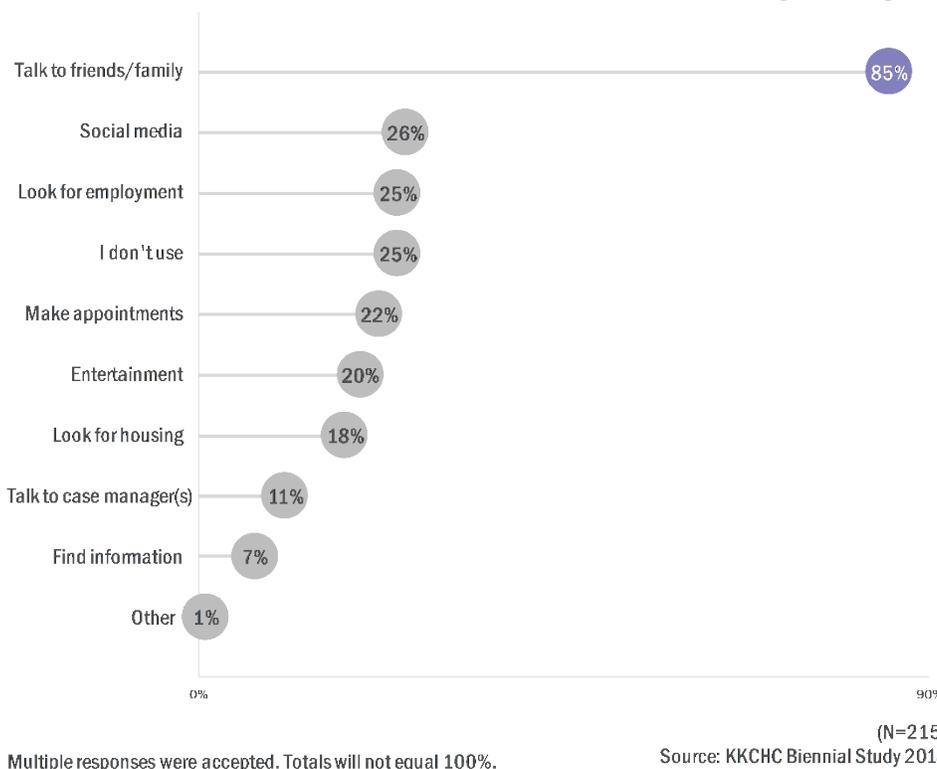
Frequency of Information Communication Technology Usage by Type



Where Information Communication Technology is used most often.



Purpose of Information Communication Technology Usage



Multiple responses were accepted. Totals will not equal 100%.

Multiple responses were accepted for the purpose of ICT usage, to which eighty-five percent of study respondents more frequently reported using ICT to communicate with family and friends. **However, when responses were reviewed as a group, fifty-four percent reported using ICT to improve their situation (e.g. looking for employment, make appointments, looking for housing, and talking to case managers).** Additionally, the category of "Entertainment" was generically defined and also includes responses such as "sports" and "playing games." The category of "Find Information" includes responses such as: *research, addresses, directions, news, history, and weather.* The "other" category was used as a general descriptor during study interviews. The "other" category was used as a general descriptor during study interviews.

Homelessness

This section explores the residence prior to experiencing homelessness, causes of homelessness, duration of homelessness, and daily living experiences while homeless.

Homelessness involves several, compounded factors, and conclusions drawn from this section must recognize the complex interaction of those elements.

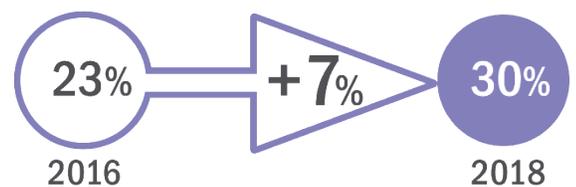
Residence Prior

Questions about residence prior to homelessness were asked during the Biennial Study. This year new questions were added to further explore potential barriers to accessing housing. Included were questions related to public housing application, housing voucher usage, housing barriers, and housing case management utilization.

Forty percent (n=86) of study respondents were renting prior to homelessness, which is a 3% decrease from the 2016 Biennial Study. Of the 40% of study respondents who indicated their residence prior as "rental," 12% reported that they were living in public housing or utilizing a section 8 voucher for housing (n=23). When asked to give further detail on why they were no longer living in public housing or utilizing a Section 8 voucher, 49% (n=16) generally cited "other." Additional responses given included: *Landlords not accepting vouchers (12%), voucher expiration (9%), ineligibility due to housing authority preferences (9%), cannot find housing that meets personal preferences (6%), and having an eviction history from the housing authority (15%)*. Overall, 8% (n=17) of all study respondents report a history of eviction within the past two years, which is a 4% decrease from 12% reported in 2016.

Thirty percent (n=64) of respondents were precariously housed prior to homelessness or were "couch homeless" (i.e. staying or living with a family member or friend) prior to homelessness. To further explore *couch homelessness*, study respondents were asked, "Have you stayed with friends or relatives within the past year?" to which 55% (n=119) answered, "Yes." Many funding streams have specific criteria that exclude *couch homelessness* by requiring that a person experience literal homelessness (street or shelter homelessness) before they gain access to services, thus disqualifying those experiencing *couch homelessness*. Further, funds dedicated for homelessness prevention can only be used for persons at imminent risk of homelessness, which is another eligibility criteria that excludes serving "couch homelessness."

Persons who lived with families/ friends prior to homelessness increased.



(n=64)

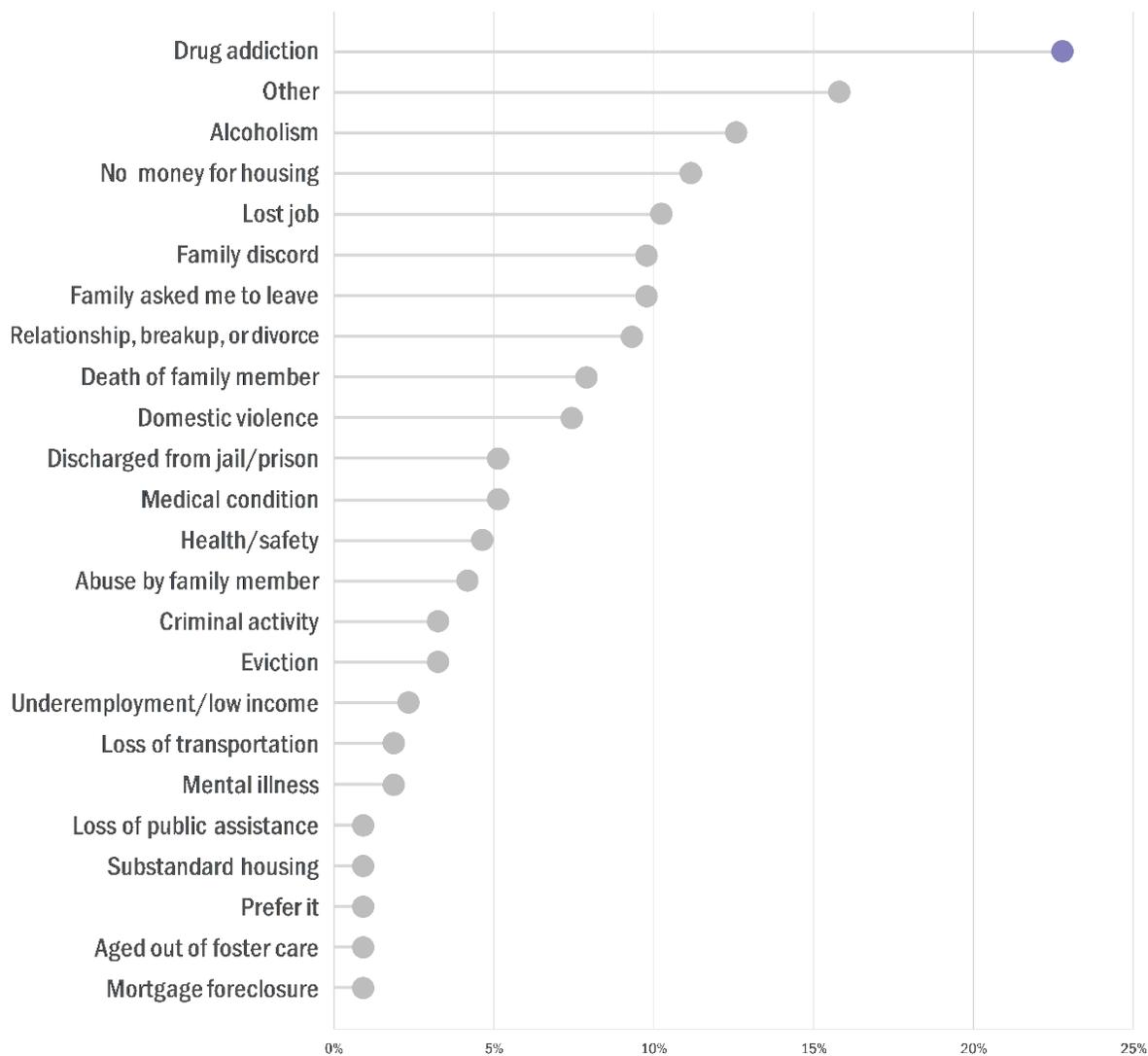
Source: KKCHC Biennial Study 2018

Causes

The study asks respondents "What caused you to be homeless?" and multiple responses were allowed during the interview. The answer options for the study questions mirror the "Primary Reason for Homelessness" captured in the Knoxville Homeless Management Information System (KnoxHMIS); 2017 KnoxHMIS annual data on causes of homelessness are summarized in this document (see page 85).

The "Other" category includes responses such as: bad choices, bug infestation, lack of sober living environment, LGBTQ+ and lack of acceptance, house fire, human trafficking, hurricane evacuation, roommate situation, and relocation. The 2018 findings for "causes of homelessness" are consistent with both the 2016 and 2014 studies. Further, the top five reasons in both the 2018 and 2016 studies are congruent.

Drug addiction is the leading self-reported cause of homelessness.



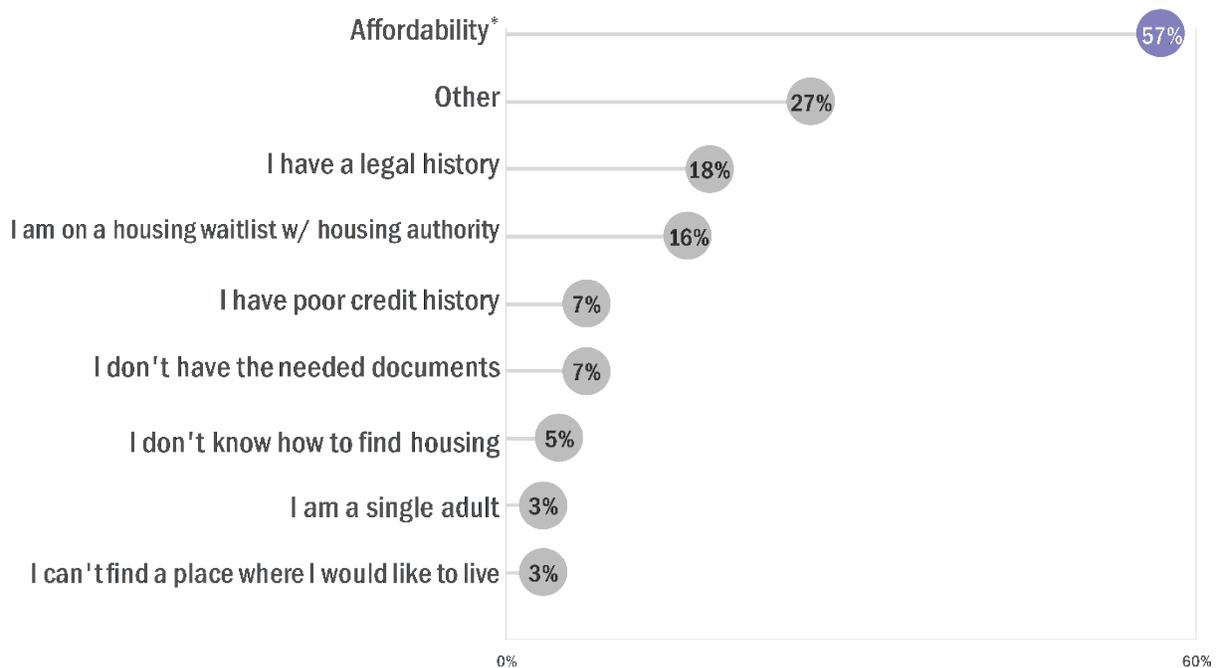
Multiple responses were accepted. Total Percentage will not equal 100%.

(N=215)
Source: KKCHC Biennial Study 2018

Barriers to Housing

Access to affordable housing is becoming a growing concern among Biennial Study participants. Fifteen percent of study participants (n=32) indicated that they are on a waitlist for public or Section 8 housing (16% in 2016 and 12% in 2014). The majority have been **waitlisted for an average of 9 month(s) with a minimum of at least one month.**

Affordability is the greatest housing barrier.

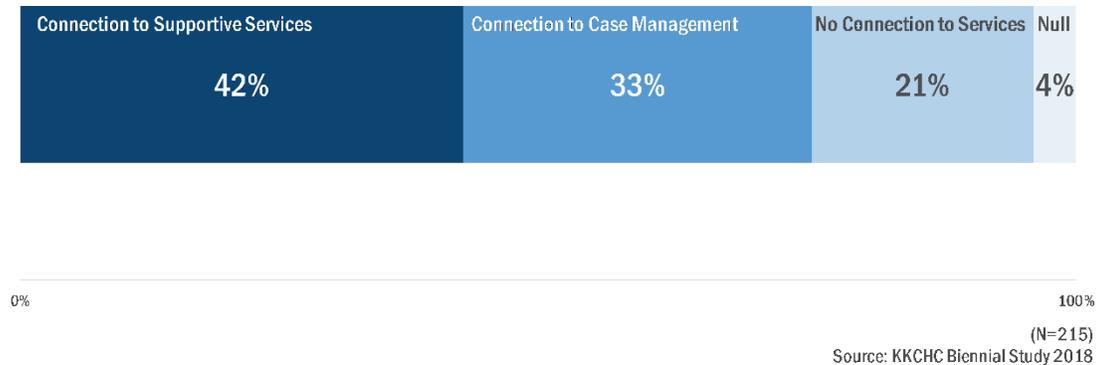


*Affordability combines items "I don't have enough income," "I don't have income at all," and "I can't find a place I can afford."

(N=215)
Source: KKCHC Biennial Study 2018

To further explore access to affordable housing, this year’s study included a question to determine if persons interviewed were currently connected to housing case management.

Social Service Connection of Biennial Study Respondents

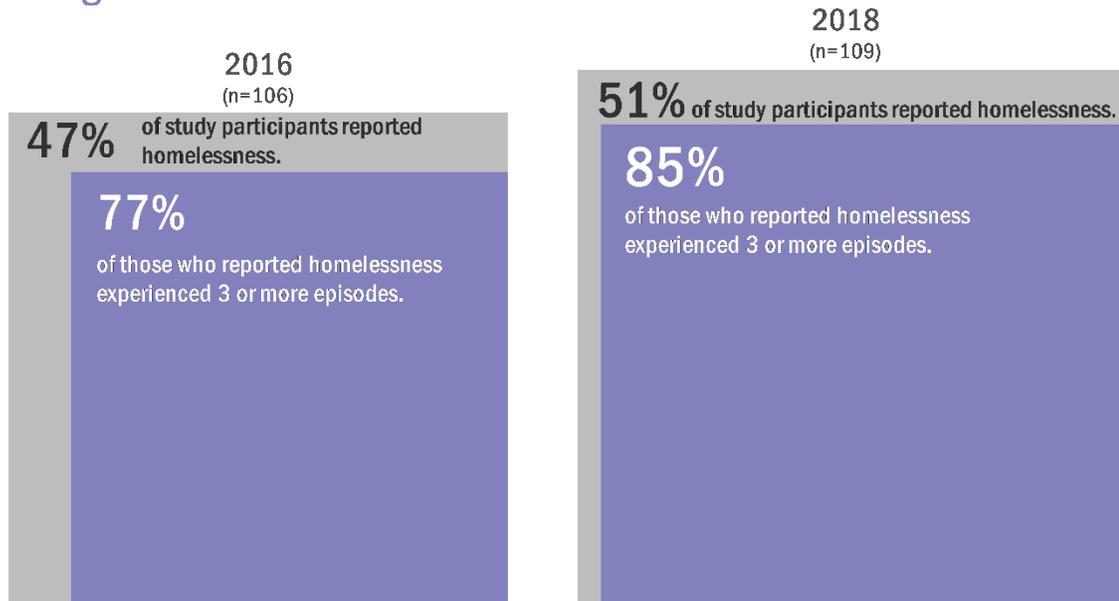


Although, forty-two percent were connected to *some type* of supportive service, it is unknown if those services were one-time or on-going. Only 33% were connected *specifically* to case management focused on housing goals.

Duration

More long-term homelessness was evident in the 2018 Study compared to 2016. Of the 51% (n=109) who reported prior homelessness, 85% reported experiencing three or more episodes prior to the study—reflecting their experience of long-term homelessness. By comparison, in 2016, 47% (n=106) of respondents reported prior homelessness, with 77% of those reporting three or more episodes of homelessness.

Long-term homelessness increased in 2018.



Source: KKCHC Biennial Study 2018

There was a 4% decrease in first time homelessness among Biennial Study participants. Forty-nine percent of the Biennial Study respondents reported that prior to this episode they had never been homeless before (n=106), compared to 53% in 2016.

Eighty-three percent (n=178) of respondents were interviewed in shelter locations such as emergency shelter or transitional housing programs; whereas, 17% (n=37) were interviewed at street outreach events for unsheltered individuals. The analysis of the “most common sleeping locations” of study respondents was impacted because fewer interviews were conducted in outdoor locations; thus, a comparison table is not included in this year’s study. Consistent with our former Biennial Studies, 76% (n=112) of those interviewed commonly utilize emergency and transitional shelter (compared to 77% in 2016); this data could also be affected by the fact that the majority of study respondents were interviewed in shelter locations. **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 of emergency shelter stay.

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 access transportation and spend their day. This section details their responses.

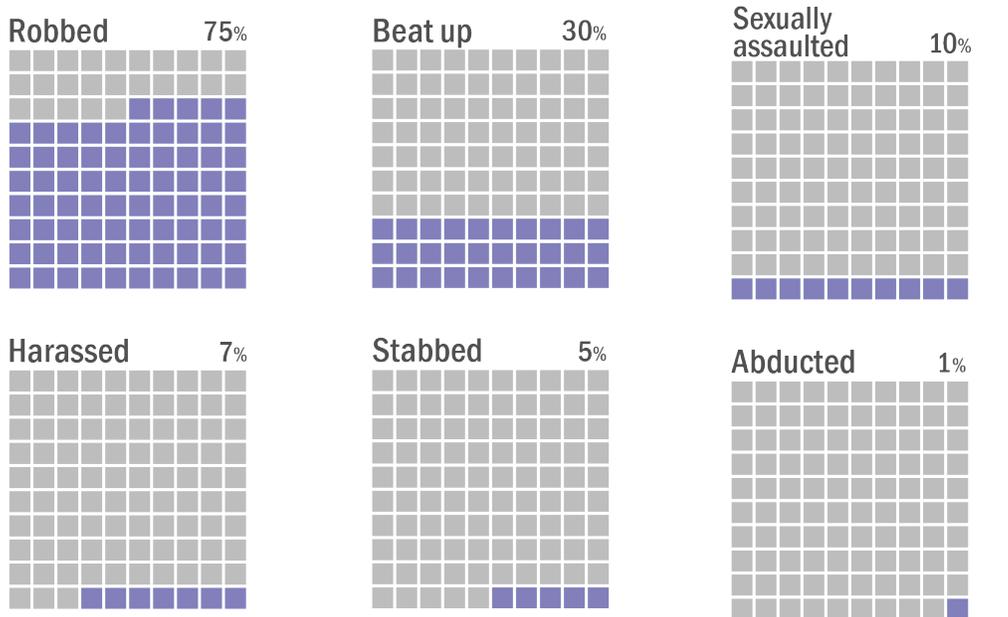
Access to transportation is often cited as a barrier to housing, employment, and treatment (e.g. medical, mental health, and/or substance rehabilitation services). **Twelve percent (n=25) report walking as their sole source for transportation, whereas 88% report utilizing some form of vehicular transportation.** The most common forms of vehicular transportation include: Knoxville Area Transit [66%], emergency shelter bus [16%], friend's car [13%], case manager's car [13%], family/relative's car [11%], personal vehicle [8%], CAC transportation [6%], TennCare assisted transportation [6%], other [6%], ETHRA transportation [3%], bicycle [4%], hitch-hike/thumb [4%], and mentor/sponsor [<1%]; please note that percentage will not equal 100% since multiple responses were accepted.

When asked, **"How do you spend your day?"** **The top five responses included: at the shelter [30%], hanging out [20%], looking for work [16%], walking [15%], and at the library [13%].** Additional responses include: *drinking/drug use* [<1%], *childcare* [<1%], *school* [2%], *under the bridge* [3%], *Broadway Avenue* [5%], *KARM LaunchPoint* [5%], *looking for housing* [6%], *visiting family/friends* [6%], *inside agency day room* (9%), *active in treatment/ agency programs* (12%), and *other* (21%). Please note that multiple responses were accepted and thus cannot be added to equal 100%.

Vulnerability

Homeless persons are vulnerable to being victims of crime. Most crimes go unreported or are not linked to homelessness in the local media. The study specifically asks participants if a crime has been committed against them while homeless. **Thirty-nine percent (n=83) of Biennial Study respondents indicated they had a crime committed against them, which is 4% higher than in 2016.**

Individuals experiencing homelessness were most likely to be victims of robbery.



Multiple responses were accepted.
Total percentage will not equal 100%.

(n=83)
Source: KnoxHMIS Annual Report 2017

“Abductions/Kidnapped,” was added to the study in 2016 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. **44% of all respondents (N=215) responded that they had been a victim or survivor of domestic violence (n=94), which is an 8% increase from the 36% reported in 2016.** Of those reporting domestic violence, 66% percent were women (n=62) and 34% were men (n=32). Sexual assault, human trafficking, and domestic violence are believed to be underreported.

8%
domestic violence
increase since 2016.

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 homelessness and lack of income or employment. **Sixty-seven percent (n=143) of 2018 study respondents report that they receive income, with 69% of those reporting multiple sources of income.**

Average income decreased from 2016 to 2018.

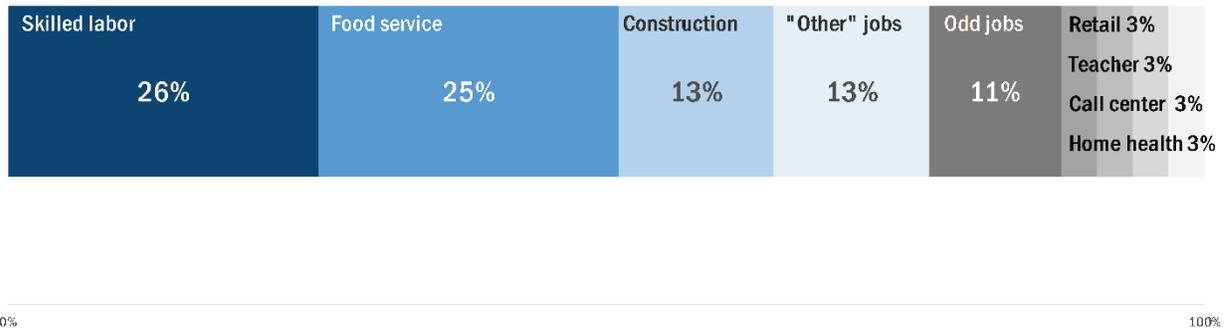


Caution should be used when interpreting income information reported since this is a more sensitive area of the study. Respondents may be reluctant to report their income or sources of income for concern of scrutiny from program staff. Further, sporadic income sources such as shelter work programs, canning, and day labor are often perceived as having "employment" or ongoing income among those experiencing chronic homelessness, whereas those sources of income would not be considered stable income or eligible for proof of income.

Only 18% (n=38) of all respondents are currently employed with:

- 29% of those employed full-time (n=11) and
- the remaining 71% (n=27) as having either part-time work [47%] or day-labor [24%], thus indicating employment instability.
- There has been a 6% decrease in current employment, which was 24% in the 2016 study.
- 22% of all respondents (N=215) reported that they needed additional job training (n=47).

Almost half of persons who report employment were employed in **food service** or **skilled labor**.

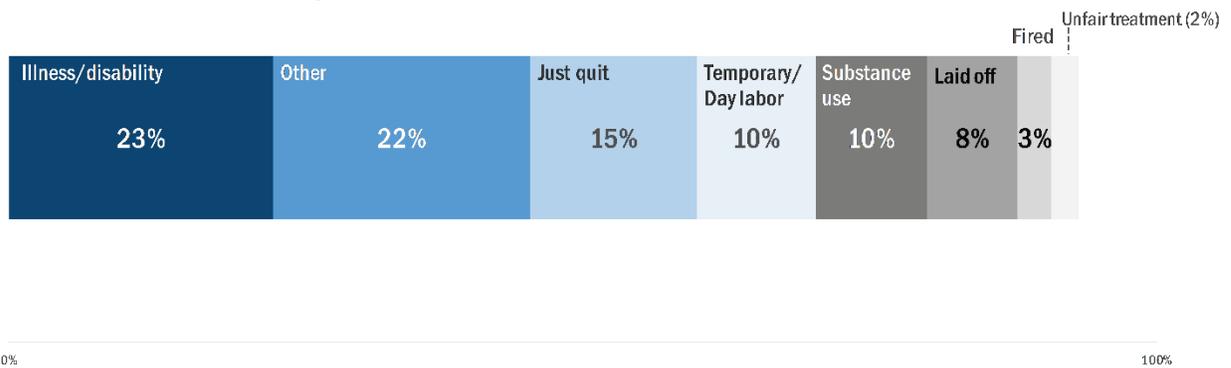


(n=38)

Source: KKCHC Biennial Study 2018

Four percent (n=8) of study respondents report that they have *never worked*, 1% did not report, and **77% report not currently working or unemployment (n=165)**.

Reasons for Unemployment



7% did not report.

(n=165)

Source: KKCHC Biennial Study 2018

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. Twenty-eight percent (n=14) of those receiving SSI or SSDI (n=50) had a payee other than self, which is a 5% decrease from the 33% reported in 2016.

43%
of respondents' only income were non-cash benefits or infrequent sources (food-stamps, friends, panhandling).

43% (n=93) of all respondents report non-cash benefits and/or infrequent sources as their only source of income (e.g. food-stamps, relatives, friends, plasma centers, or handouts/panhandling). Twenty-eight percent (n=61) of all respondents indicated that they had lost government benefits during the past two years as compared to 19% in 2016 and 24% in 2014. Thirty percent of the respondents indicated that they had engaged in illegal activity at some time to support themselves compared to 25% in 2016 and 23% in 2014.

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. The lack of personal identification is on the rise since 2016. Thirty-nine percent (n=84) of all respondents did not have a copy of their birth certificate (compared to 41% in 2016), 68% (n=147) did not have a driver's license (compared to 59% in 2016), and 27% (n=59) did not have a social security card (compared to 20% in 2016). **Without these forms of identification, obtaining housing and employment can be greatly hindered.**

39% lack a birth certificate.

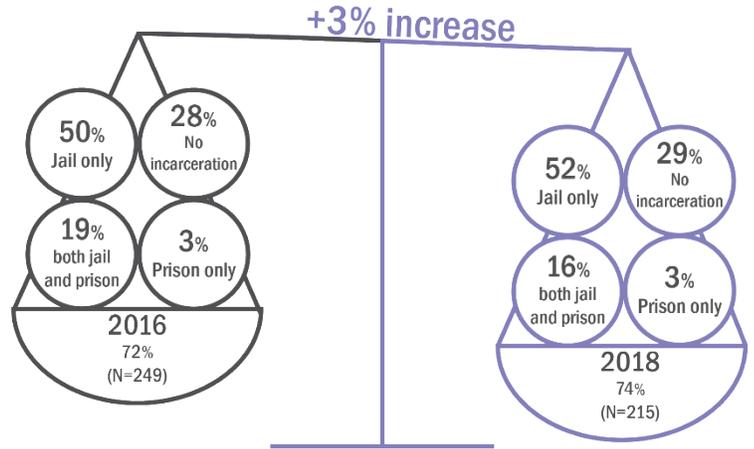
68% lack a driver's license.

27% lack a social security card.

Legal History and Deinstitutionalization

Another facet that greatly affects 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. **21% (n=32) of respondents report having been denied housing specifically due to having a legal history.** To further 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 in the Study.

Respondents reported **slightly higher incarceration rates from 2016 to 2018.**

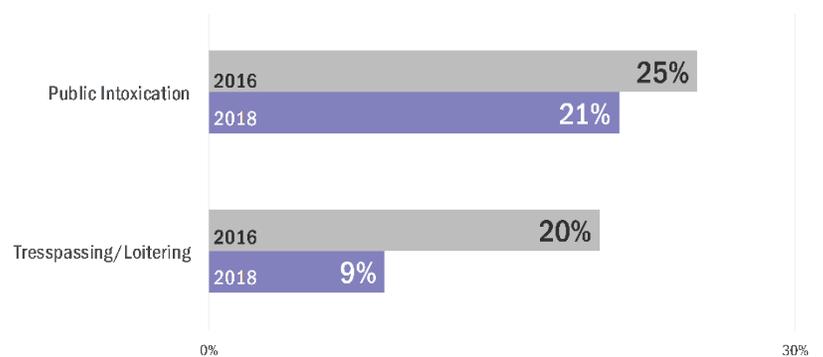


Source: KKCHC Biennial Study 2018

In 2018, there was a 3% increase of respondents reporting a history of incarceration. As in previous studies, the most frequently cited reasons for jail time included: aggravated assault, domestic violence assault, driving under the influence of alcohol, drug possession, failure to appear, fraud, public intoxication, theft, trespassing, and violation of probation.

Public intoxication and trespassing/loitering have decreased in 2018.

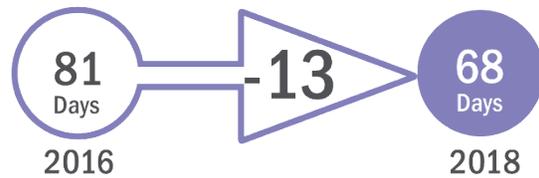
The study asks more specifically about public intoxication and loitering arrests because these charges are typical misdemeanors that can become barriers to future housing. **There was a significant decrease of trespassing and loitering arrests reported by respondents in 2018.**



(N=215)
Source: KKCHC Biennial Study 2018

The average number of days incarcerated in the past year has also significantly decreased overall for all persons incarcerated (n=154).

The average number of days incarcerated in 2018 decreased.



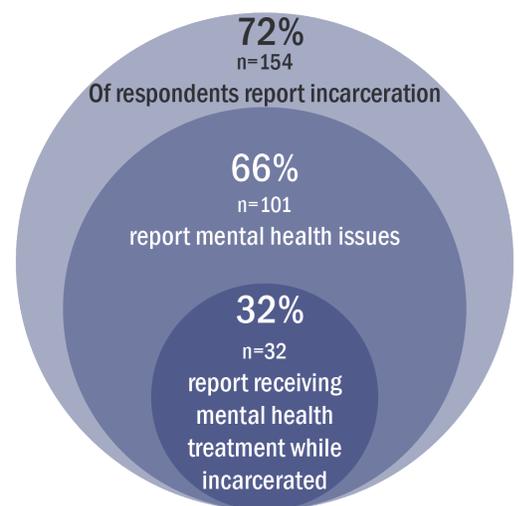
Source: KKCHC Biennial Study 2018

The study also looks at how mental health issues affect incarceration. **66% (n=101) of respondents who report incarceration history (n=154) also report having a mental health issue. People who report receiving mental health treatment while incarcerated served 83 more days than persons who did not report receiving mental health treatment while incarcerated.** The issue merits further examination, including research on incarceration of homeless mentally ill persons as compared to non-homeless persons charged with similar offenses.

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.

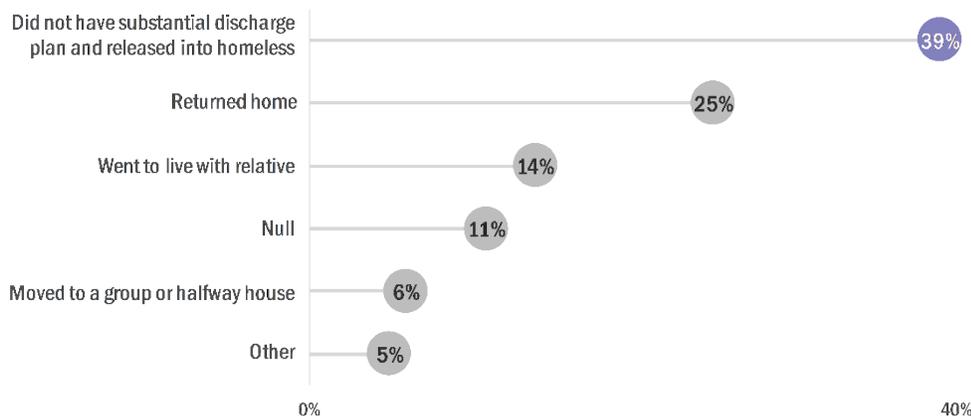
Because a significant percentage of discharges were directly onto the streets is an area of concern that could be mitigated with improved connections. When compounded mental health and incarceration history, Emergency shelters often do not have the supervision, support, or services that may be necessary to help a person successfully achieve reintegration back into the community. Homelessness will likely increase the chance of repeated incarceration.

Incarceration and Mental Health Treatment



Source: KKCHC Biennial Study 2018

Almost half of persons incarcerated were discharged into homeless.



(n=154)

Source: KKCHC Biennial Study 2018

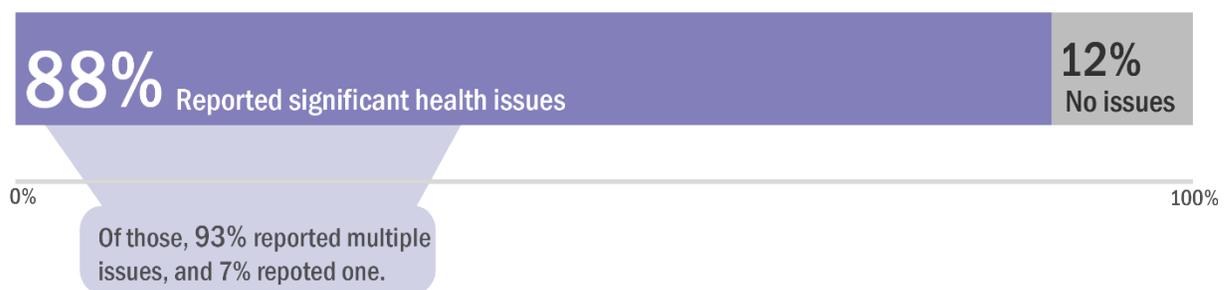
Health

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. Fifty-seven percent (n=123) rated their health as good to excellent. This finding was interesting given that 45%(n=96) also perceived that they have chronic health problems.

The majority of persons experiencing homelessness report significant health issues.



(N=215)

Source: KKCHC Biennial Study 2018

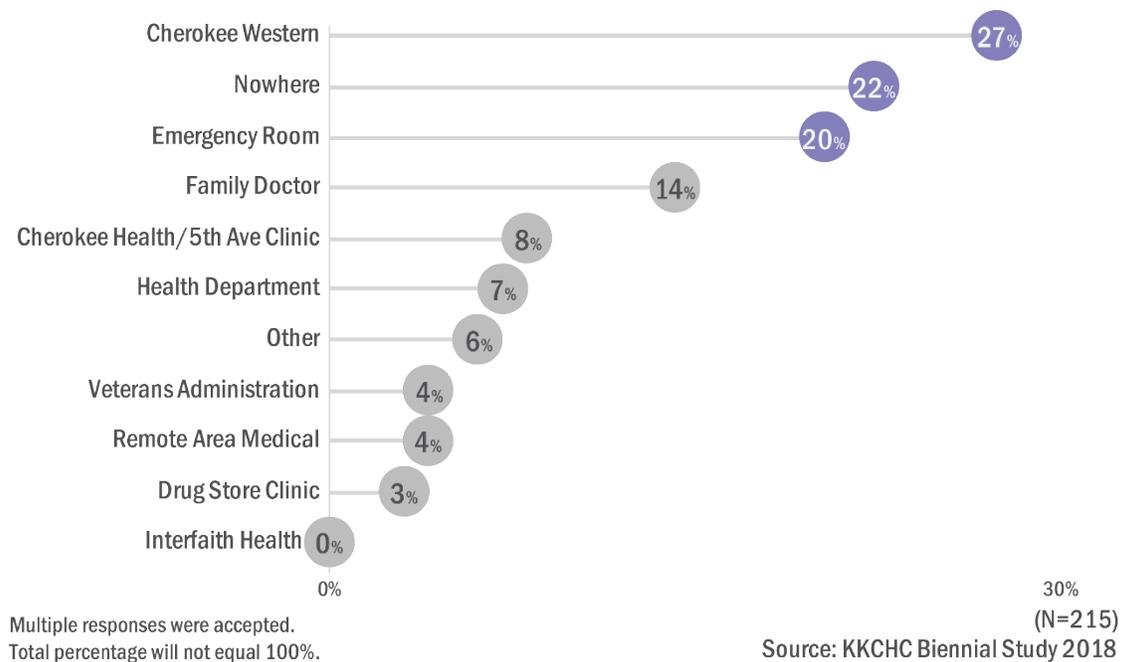
Only 12% (n=26) reported that they had experienced no illnesses while homeless. 88% (n=189) reported having a significant health issue while homeless (n=189), of which 7% (n=13) reported one major issue and 93% (n=176) reported multiple issues. Persons who had multiple health conditions reported the following (note that percentages will not equal 100% due to multiple responses being accepted): dental [46%], respiratory (ear, nose, throat) [43%], eye [36%], severe headaches [36%], blood pressure [33%], feet [30%], personal accidents [23%], pneumonia [23%], hepatitis [20%], skin [20%], heart [14%], diabetes [8%], seizures [10%], other (including cancer, liver disease, bone issues, gastrointestinal issues, arthritis, Dysentery, heat stroke, etc.) [10%], pregnancy while homeless [6%], HIV [<1%], and Tuberculosis [<1%].

Questions about insurance access were also asked. those receiving insurance (n=103), the following is a breakdown of insurance types (note that percentages will not equal 100% due to multiple responses being accepted): Medicare [60%], Medicaid [15%], Indigent Care [8%], private insurance [6%], VA Medical Benefits [6%], employer insurance [3%], don't know [2%]. Forty-eight percent (42% in 2016) reported having received TennCare. Of those not receiving insurance (n=112), 27% indicated that they could not afford insurance, 19% were not sure of their options, 11% were on approval, 22% reported that they did not qualify, 4% stated that they did not need/want insurance, and 14% reported other reasons for not having insurance. Seven percent (n=15) report being refused medical care while homeless but reasons for denial were not explored in the Study.

48%
of respondents reported having health insurance.

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, 68% (n=146) had seen a physician/nurse, which is a 9% increase over 2016. Twenty-four percent (n=51) had seen a dentist within the past year. Further, respondents were asked specifically where they went with a health or medical problem not requiring hospitalization.

Sources for Treatment Not Requiring Hospitalization



Questions were asked about medical hospitalization. Fifty-one of respondents (n=110) said that they had been hospitalized while homeless, **which is a 5% increase since the 2016 Study [46%]**. Illness was the most frequent reason for hospitalization [49%] and other reasons included: other [19%], accidental injury [14%], alcohol related problems [11%], surgery [10%], drug overdose [7%], physical assault [2%], knife wound [2%], gunshot wound [1%], and sexual assault [1%]; please note that the total percentage will not equal 100% because multiple responses were accepted. It is important to note that some of these conditions are reported

with different numbers elsewhere in the study (see page 56) and that these percentages reflect seeking hospital treatment for the condition. Those respondents who had been hospitalized while homeless (n=87) were asked how many days/nights they had been spent in the hospital during the past year. On average, respondents had stayed 12 cumulative (not consecutive) nights in a hospital over the past year.

Days/nights in the hospital while homeless		
Response	2016 Percent (n=114)	2018 Percent (n=87)
None in the past year	19%	10%
One	18%	15%
Two	7%	5%
Three	8%	8%
Four	5%	5%
Five or Greater	43%	54%

Source: KKCHC Biennial Study 2018

A separate question asked all respondents how many times they had been to an emergency room during the past year. Thirty percent (n=64) had not been to an emergency room; however, for the remaining 70% of respondents (n=151), responses ranged from one to eighty times. The average number of emergency room visits for the sample was three visits, which is consistent with the 2016 study; however, the most common response of those who had been to an emergency room was one visit (34%; n=51).

Another question asked respondents if they had been transported to a hospital or emergency room by ambulance during the past year. Fifty-one percent (n=110) indicated ambulance transportation, **which is 10% increase over 2016**. Ambulance services ranged from one to sixty times; 42% reported only one transport, 25% reported two transports, 11% reported three transports, and 22% reporting more than three times.

There is growing concern that persons are being discharged from hospitals directly into homelessness. Seventy-four percent (n=72) of those being discharged(n=97) 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 sheds light on institutional discharge planning.

71%
of respondents who had been to a medical hospital were discharged to the street or an emergency shelter where their ability to thrive is unknown.

Mental Health

Chronic mental illness and deinstitutionalization continue to be cited as major reasons underlying homelessness. **Sixty-four percent (n=138) of the total sample reported a history of mental health treatment (compared to 58% in 2016), with 48% (n=66) reporting that they were currently receiving mental health treatment. Thirty-three percent (n=70) of the respondents are also actively engaged in outpatient mental health services.** Of those who reported currently receiving mental health services (n=66), duration of services varied: **one year or less [52%]**, more than one year but less than three years [15%], three to five years [11%], and more than five years [22%]. **Indicating that those currently receiving mental health services were new to services.**

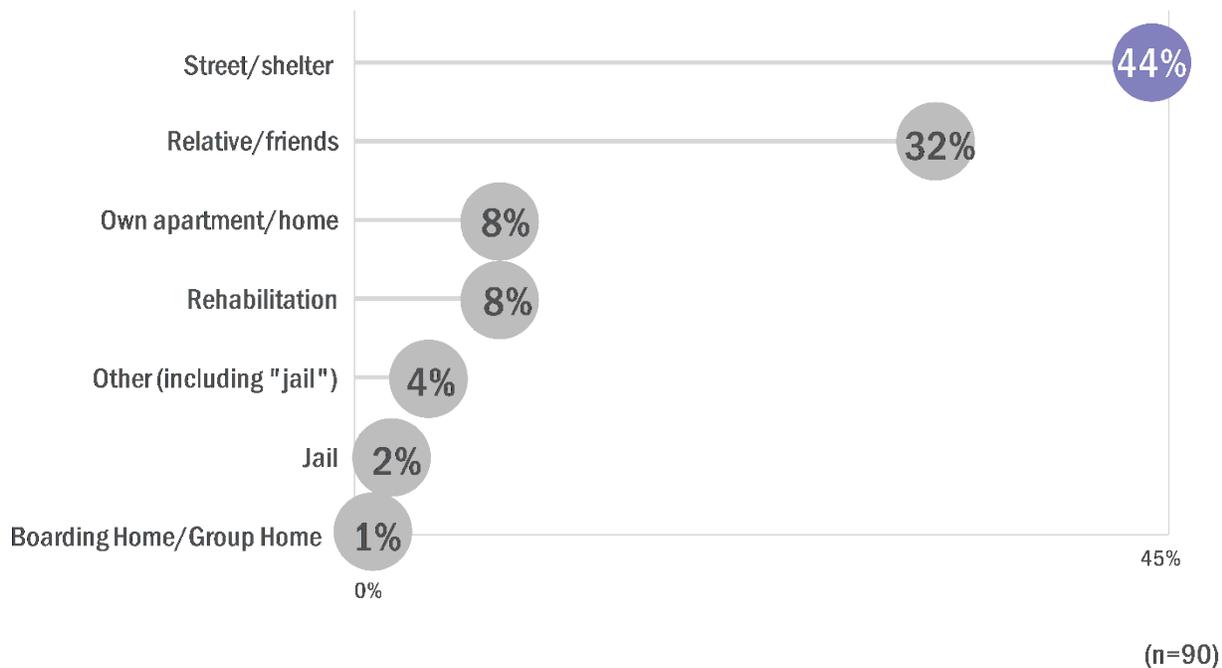
Sixty-six percent (n=90) of those with a mental health treatment history (n=138) had been hospitalized. Among those individuals reporting hospitalization for mental health issues:

- For 53% (n=48), psychiatric hospitalization had occurred within the year, which is an increase from 49% reported in 2016.
- 30% percent reported only one hospitalization, 36% percent had been hospitalized between two and five instances, 27% hospitalized more than five instances, 7% did not report hospitalization instances.
- The length of most recent hospitalization varied: *less than one week* [44%], *one week to one month* [43%], *one month to a year* [8%], *over one year* [2%], and *did not report* [3%].
- Of those that had a psychiatric hospitalization within the past year, locations of hospitalizations included: *Peninsula* [44%], *Ridgeview* [13%], *Tennova* [6%], *Helen Ross McNabb Center Crisis Stabilization Unit* [21%], *Moccasin Bend* [4%], *Middle Tennessee State Hospital* [2%], *Other TN state hospital* [10%], *out of state hospital* [6%], and *other facility* [25%].
 - 6% those with hospitalization in the past year indicated having a history of Lakeshore hospitalization prior to its closing in 2012.
 - Percentages do not equal 100% because multiple responses were accepted.
- 28% (n=60) of all respondents report having a history with the mobile crisis team, which is an increase from 25% in 2016.

The study examined discharge planning by asking participants where they went after being discharged from a psychiatric hospital or program. **Forty-four percent (n=40) of persons discharged from psychiatric hospitalization(n=90) went directly to the streets or shelters from psychiatric facilities.**

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=90), 83% (n=75) percent had been discharged on medication, but almost half (43%; n=32) of them were not taking it. When asked about the primary reason they stopped taking the prescribed medication, responses included: "didn't like how it made them feel" [31%], "could not afford it" [28%], other [22%], "The Dr. told me to stop" [10%], "prescription ran out" [6%], and "lost it" [3%].

Most respondents who stayed in psychiatric hospitals were discharged to the street or shelter.



Percentages do not equal 100% due to rounding.

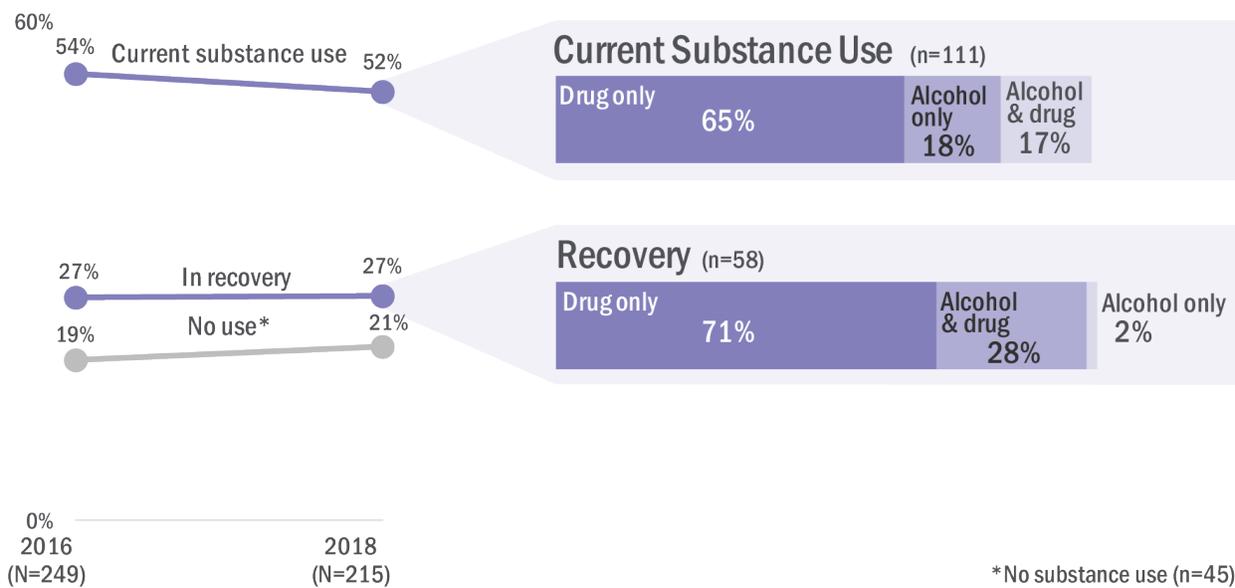
Source: KKCHC Biennial Study 2018

The prevalence of mental illness among homeless persons is exceptionally high is further supported by the perception of depression among study respondents. Seventy-one percent (n=153) said that they experienced depression, with 39% (n=59) of those saying they were depressed every day. Twenty-six percent (n=56) of all respondents perceived their "nerves" as bad.

Substance Use History

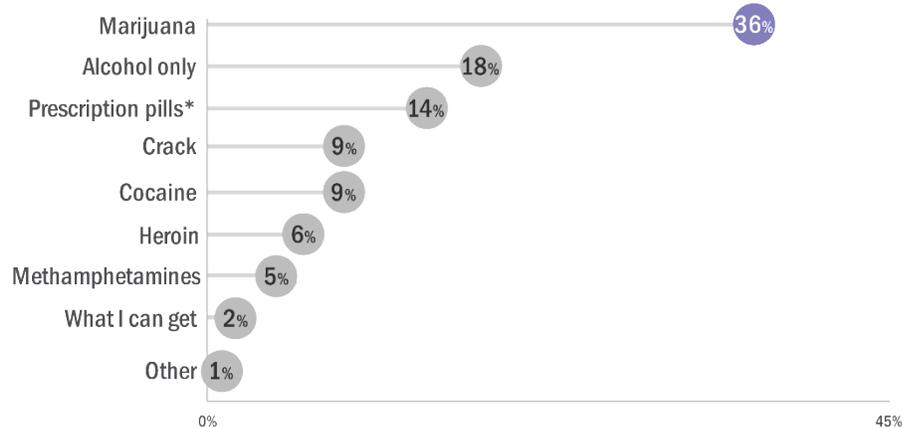
Substance use history is self reported and has increased over the years since the study's inception. The study explores both past and current substance use. Answer options include *in recovery* and *no longer use* to explore past use. Questions such as, "Do you consider yourself an alcoholic?" and "Do you or have you consider yourself addicted to drugs?" were asked to gauge *current* substance addiction. 79% (n=169) of all respondents self report having used alcohol and/or drugs *at some point*. The substance use history year to year comparison chart details a comparison between the 2016 and 2018 studies. Additionally, the substance use history chart delineates primary substances of choice for both those currently using substances and those who are in recovery.

Substance Use History Year to Year Comparison



Source: KKCHC Biennial Study 2018

Of respondents currently using substances, Marijuana is the most often self-reported drug used.

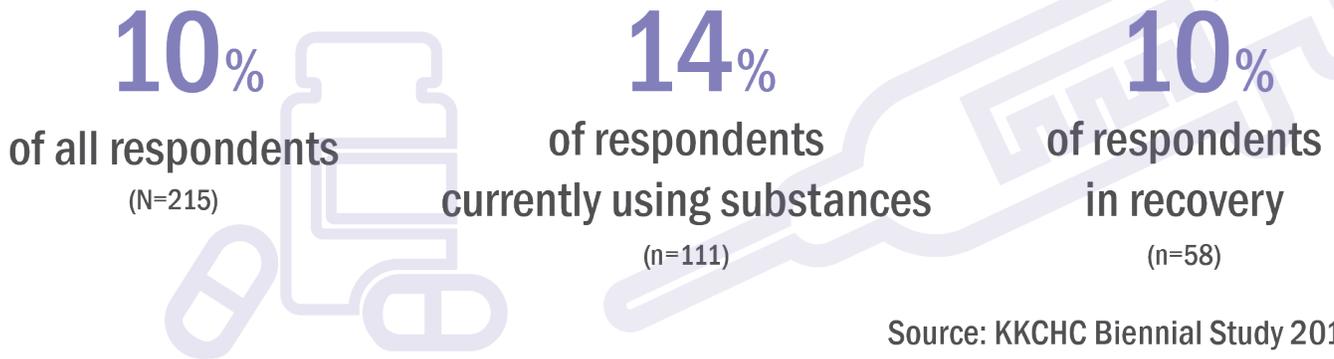


* Prescription pills include OxyContin, Hydrocodone, Xanax, Roxys, or Roxicodone.

(n=111)

Source: KKCHC Biennial Study 2018

Who has experienced an overdose?



- 37% (n=80) percent of all respondents (N=215) reported receiving inpatient treatment for alcohol or other drug problems and 28% (n=60) report receiving outpatient treatment.
- 17% (n=29) of persons reporting alcohol and/or drug use history (n=169) indicated addiction report difficulty finding treatment.

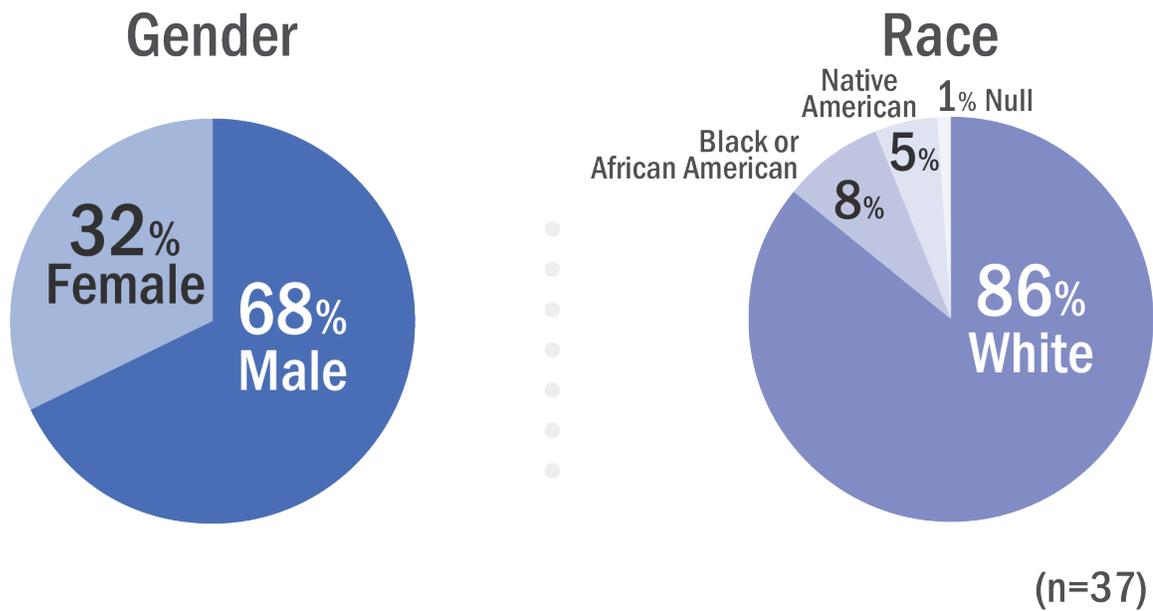
KKCHC Supplemental Unsheltered Analysis



KKCHC Supplemental Unsheltered Analysis

As noted in the Study Design (see page 30), interviews in camps were suspended, but individuals who stayed in camps were included in the Biennial Study by interviewing at Lost Sheep and Highways and By-Ways Ministries. Interviews were conducted with thirty-seven persons in those unsheltered locations. The thirty-seven unsheltered persons were included in the overall Biennial Study analysis; however, this section is a supplemental analysis of select characteristics of the unsheltered only, excluding persons that were interviewed in emergency shelter and transitional housing.

Demographics of non-sheltered persons



Source: KKCHC Biennial 2018 Supplement

Age	2018 (n=37)
Under 18	-
18-24	5%
25-61	89%
62+	5%
Null	1%
Mean age:	
Male	45
Female	44

Source: KKCHC Biennial 2018 Supplement

Background

The majority of respondents (57%) had grown up in Tennessee and 73% now consider Knox County home. When Tennessee was not the respondent's home state, thirteen other states were identified, with Kentucky and Florida being the most frequent. The age of initial homelessness ranged from 13 to 57 years with an average of 33.7 years. The length of homelessness ranged from one month to 37 years with a mean of 3.7 years. However, eliminating three outlying respondents who had been homeless for 14 years or longer produced a mean of 2.1 years. Job seeking and social services (including shelters) were the most frequent cited reasons for coming to Knox County. However, multiple responses were accepted, with "family moved here," and "new start" being most frequently cited. Only two respondents among the campers reported military service and both had received honorable discharges.

Homelessness and Daily Experiences

- Multiple reasons were cited as the cause of homelessness, with alcohol/drug addiction identified by approximately one-third of respondents. Family discord (break-up, divorce, abuse) was frequently cited as well as "no money for housing." The citing of reasons illustrates that causes usually involve multiple factors.
- As expected, most identified their usual sleeping locations as abandoned buildings and outside. However, approximately half reported using emergency shelter, with an average of 46 nights in shelter per year.
- Multiple responses were accepted for the question, "Where do you spend the day?" "Looking for work," "Library," or "Walking," with "On the streets" being most frequent. Four people reported "Work."
- Fifty-nine percent had cell phone access. And twenty percent used email. Fifteen percent said that they had no access to social media (email, internet, Facebook).

46

average nights in an
emergency shelter per year.

Health, Mental Health, Substance Use History

Seventeen of the campers (46%) had been transported to a hospital by ambulance with a mean of 2 times. The majority returned to the street upon leaving the hospital. When asked about visits to the Emergency Room (ER), twenty-five (65%) had been to the ER, with a range of one to eight visits with a mean of 2.5 visits. Forty-seven percent reported mental health treatment with 65% of those having been hospitalized.

The number of campers reporting mental health treatment is lower than that reported by persons utilizing shelter, which is consistent with previous KKCHC Biennial Studies; this likely reflects shelter users' greater willingness to engage with a range of services. Most of those who had been hospitalized returned to the street or to relatives after discharge.



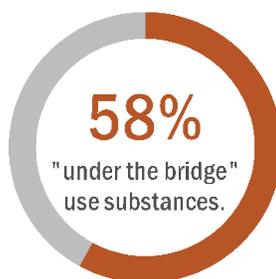
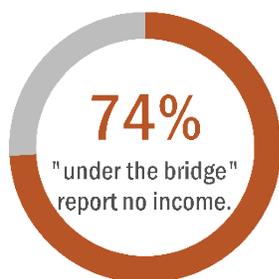
Seventy percent of the campers reported drug use, with eight identifying alcohol addiction, and nine addicted or in recovery from other drugs. Six respondents had been seen by Mobile Crisis. Approximately one-third had received inpatient treatment for substance abuse. Nine had been arrested for public intoxication with a range of 1 to 30 times (mean = 8 times).

October 2017
Broadway Avenue/
I-40 Overpass
Survey



October 2017 Broadway Avenue/I-40 Overpass Survey

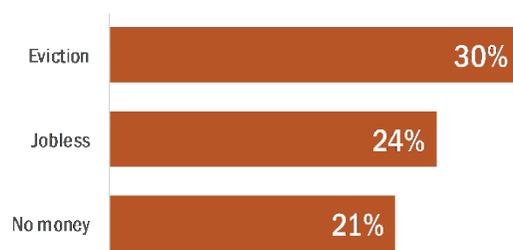
In October 2017, KKCHC Coalition partners worked together to create a survey in attempt to better understand how to link persons "under the bridge" to social services for wrap around care. Because there has been an observable increase in the number of people congregating and/or sleeping under the I-40 overpass on Broadway Avenue, staff from the Knoxville-Knox County Community Action Committee, Knoxville Area Rescue Ministries, and the Helen Ross McNabb Center conducted a survey on October 26, 2017, to identify characteristics and service linkages of persons under the bridge. **This survey was not part of the 2018 Biennial Study; the Broadway Avenue/I-40 Overpass survey was conducted a few months before the Biennial Study.** The questionnaire with eleven items was administered to one hundred respondents. Participants were given a grocery gift card for completing the survey. This section summarizes findings from this October 2017 survey.



The length of homelessness ranged from less than a month to over six years. Approximately one third had been homeless one to three years, however 40% had been homeless six months or less. When asked about cause, multiple responses were accepted, including eviction (30%), jobless (24%), no money (21%), mental illness (14%), legal history (13%), drug addiction (7%), and alcoholism (6%). Relationship breakup (8%) and family conflict (11%) were also cited.

Several other questions were pertinent to causes. When asked about their current income, 74% reported none. Among those with income, SSI/SSDI were the most frequent sources. While alcohol and other drugs were cited as a cause by less than 10%, fifty-eight percent (58%) reported getting high or drinking alcohol, with beer, liquor/wine, and marijuana most frequently cited. "No money" was primarily cited as preventing housing, but criminal history (30%) was significant. Most persons surveyed (86%) reported the street or outside as their usual sleeping place. "Banned" was the most frequent (19%) reason for not staying in a shelter. However, 54% said they would not go back to a shelter if allowed.

Top 3 causes of homelessness "under the bridge."



(n=100)

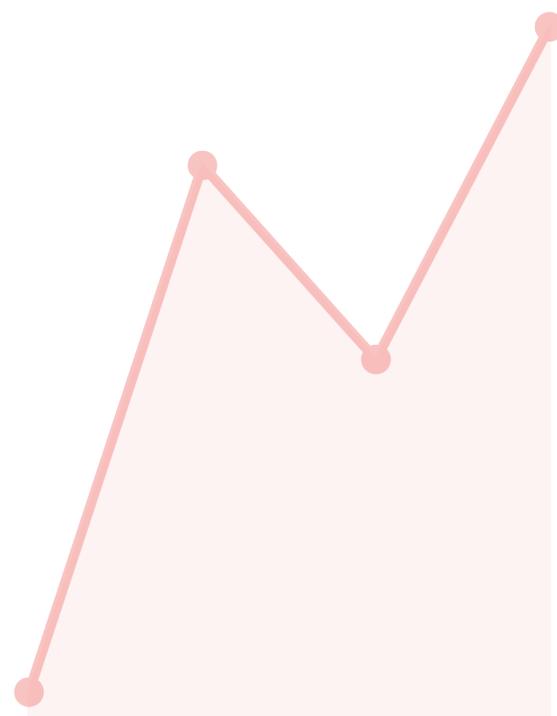
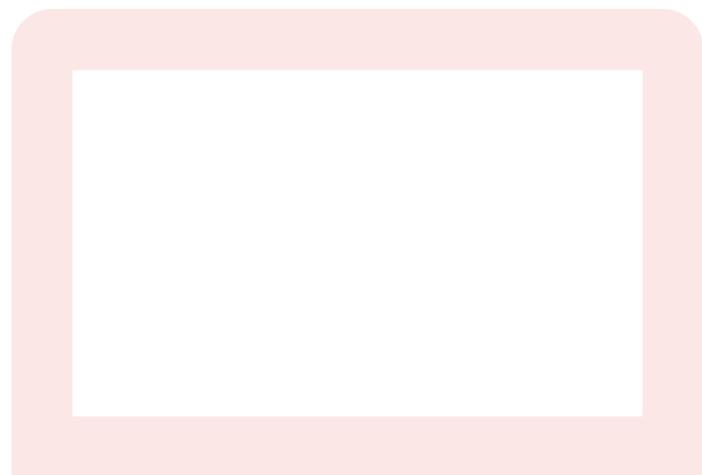
Source: October 2017 Broadway Avenue/I40 Overpass Survey

A critical issue addressed in the October 2017 survey was whether services were being accessed/utilized. Fifty-four of the respondents (n=94) identified using some type of service, although the level of service was not specified. A number of social service organizations were identified as places where they had received assistance, however, 43% of the respondents (n=94) were not accessing services that would assist in escaping homelessness. Multiple responses (n=66) were allowed with "Not ready/Just haven't done it yet" (n=23), "Don't want services" (n=13), and "Don't know how" (n=9) being most frequently cited.

Main reasons not to use services

1. "Not ready/Just haven't done it yet."
2. "Don't want services."
3. "Don't know how."

2017 Knox Homeless Management Information System Annual Report



2017 Knox Homeless Management Information System Annual Report

The Knox Homeless Management Information System (KnoxHMIS) Annual Report has been completed every year since 2007. This report provides information on persons who accessed a service from one of 20¹⁰⁰ KnoxHMIS' partner agencies for the 2017 calendar year (January—December 2017). It should be noted that individuals included in this report includes all four types of homelessness a defined by the United States Department of Housing and Urban Development (HUD) and this includes both literal homelessness and at imminent risk of losing housing.

There were 8,938 persons reporting homelessness in 2017 among KnoxHMIS partners. **The overall active clients (N= 8,938) decreased by 5% when compared to the 9,373 reported in 2016. The number of new clients increased by 18%, while continuing clients¹⁰¹ decreased by 15%.** The reasons for these percentage change in overall clients reported as well as both new and continuing clients are examined in the body of this report.

This report is divided into 5 sections that include:

- (1) an executive summary,
- (2) new clients to KnoxHMIS partners,
- (3) active clients (including new persons and those continuing engagement from previous year,
- (4) subgroups of active clients (i.e. families, unaccompanied youth, veterans, persons experiencing chronic homelessness as defined by HUD, street homeless, and senior citizens), and
- (5) case collaboration and performance measures.

This report is meant to provide clearer picture of homelessness in Knoxville so that our community can continue to develop an informed community response.

¹⁰⁰ KnoxHMIS partner agencies include: Catholic Charities of East Tennessee, Church of the Redeemer, Compassion Coalition, C.O.N.N.E.C.T. Ministries, Family Promise of Knoxville, The Helen Ross McNabb Center, Knoxville Community Action Committee, Knoxville Community Development Corporation, Knox County Public Defender's Community Law Office, Knoxville Area Rescue Ministries, Knoxville Leadership Foundation, Mental Health Association of East Tennessee, Parkridge Harbor/Positively Living, Salvation Army, Steps House, Volunteer Ministry Center, Volunteers of America, and YWCA.

¹⁰¹ Continuing is defined as any client who was entered into HMIS **before** the first day of the reporting period (Jan 1, 2017 – Dec 31, 2017).

Executive Summary

2017 KnoxHMIS Percentage Change



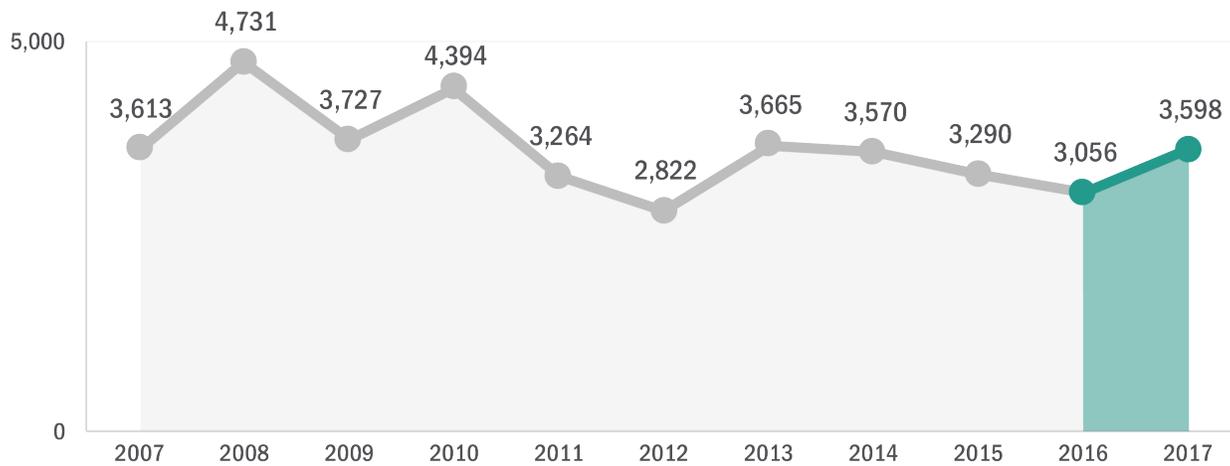
Source: 2017 KnoxHMIS Annual Report

- 86% (n=7692) of last zip code of permanent address are in Knox County.
- 48% (n=1,729) of new client are entering services through emergency shelter.
- 11% (n=1,005), report disability, which is a 3% increase from 2016 (8%).
 - 34% (n=343) of persons reporting disability indicated a mental health diagnosis.
 - 56% (n=562) of all persons reporting a disability diagnosis do not have health insurance.
- 12% (n=1,048) report domestic violence:
 - with 81% (n=854) female domestic violence victims/survivors and 19% (194) male domestic violence victims/survivors;
 - and 61%(n=641) family head of households.
- There have been increases in new clients among subgroups reported year to year.
- 10% of active clients had case notes entered by providers.
- 68% of housing exits were to positive housing destinations.
- The average time to housing for rapid re-housing was 80 days.
- The average duration in permanent supportive housing was 989 days.

2017 New Clients

“New clients” are individuals either receiving services from KnoxHMIS partner agencies or having an entry/exit into a partner agency program in the year 2017 who have not previously accessed resources in years prior.

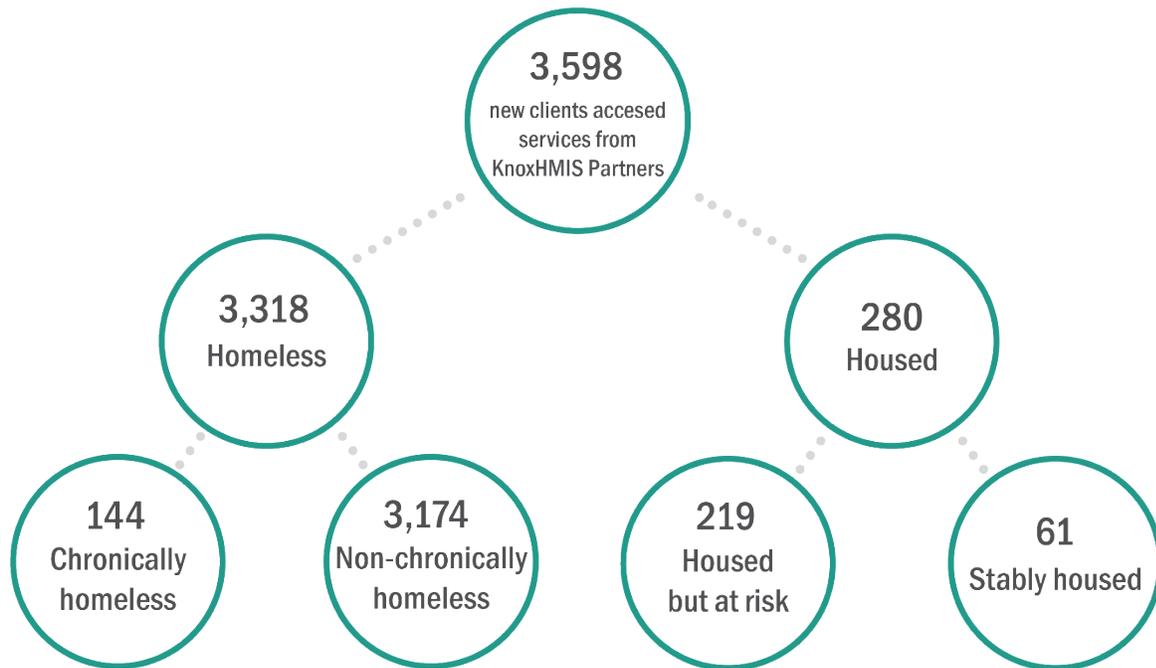
New clients have **increased** in KnoxHMIS between 2016 and 2017



Source: KnoxHMIS Annual Report 2017

The 18% increase in the number of new clients may be due to a higher number of continuing clients gaining positive exits from programs which allows for a larger percentage of new clients to be served. Additionally, new staff have been hired to engage with youth street homelessness. This new outreach, therefore, allows for more youth to be served who were not identified in prior years, which increases the total clients input into KnoxHMIS.

2017 Housing Status of New Clients

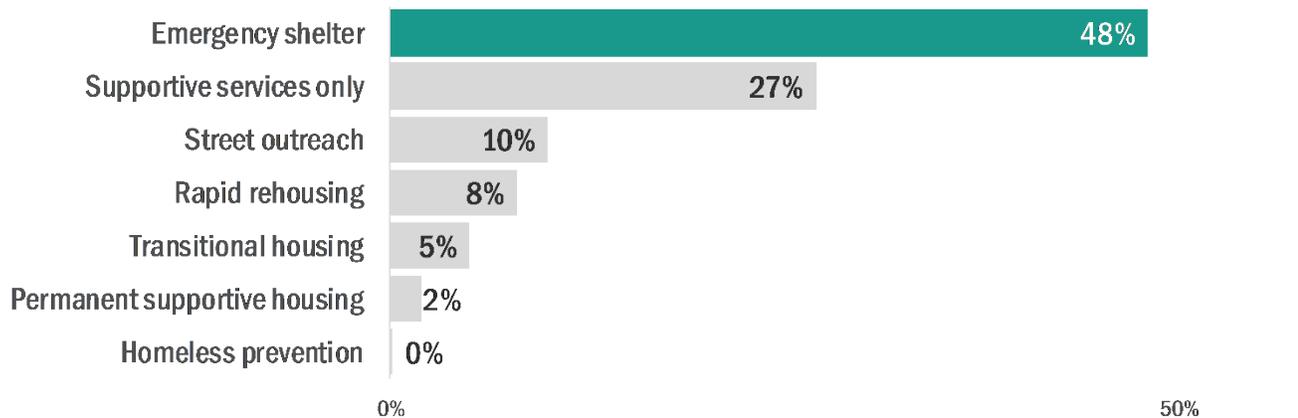


Source: KnoxHMIS Annual Report 2017

2017 Housing Status of New Clients illustrates the different housing statuses of individuals included in the clients new to KnoxHMIS in 2017 (n=3,598). Ninety-two percent (n=3,318) of individuals accessing services who were new to KnoxHMIS are homeless.¹⁰² Additionally, 8% (n=280) of new clients accessed non-housing emergency prevention assistance provided to individuals at risk of homelessness. Since 2016, there has been an 8% decrease in the number of new clients who are housed/at-risk, which may be due to a decrease in funding for homelessness prevention.

¹⁰² For the purposes of this report, KnoxHMIS is defining “homeless” as any individual staying in emergency or transitional housing, a safe haven, a place not meant for human habitation such as sleeping in a public place, car, abandoned building, and/or camping outdoors, or staying with family or friends on a temporary basis with no alternative permanent option.

Service Entry Point of New Clients Added to KnoxHMIS in 2017



50%
(n=3,598)
Source: KnoxHMIS Annual Report 2017

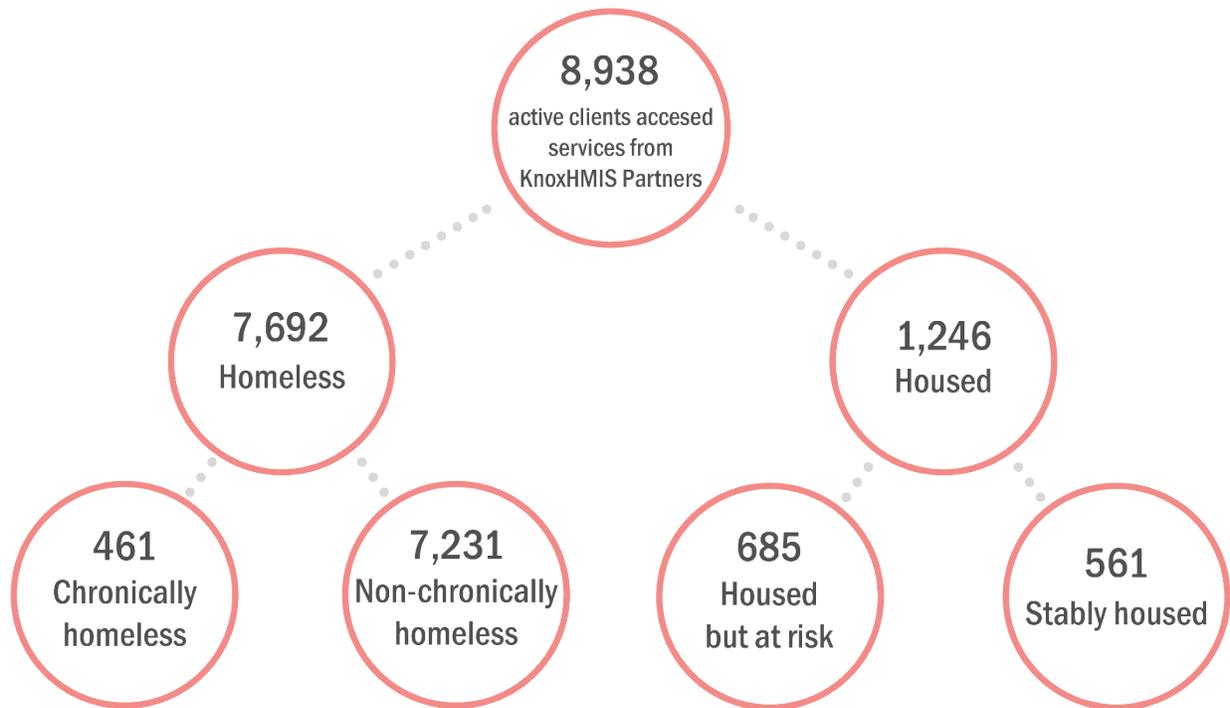
Nearly half of new clients (48%; n=1,729) enter services through emergency shelter.

Approximately 27% (n=963) of clients new to homelessness are not necessarily going to the streets or to shelters, but instead they are tapping into safety net resources through supportive services. It is important to note that although an individual enters through one program type, they may be accessing multiple services simultaneously (e.g. accessing supportive services and staying in emergency shelter).

2017 Active Clients

“Active clients” are individuals either receiving services from KnoxHMIS partner agencies or having an entry/exit into a partner agency program in the year 2017. This *includes “new clients” and clients continuing to be engaged in services from the prior year.*

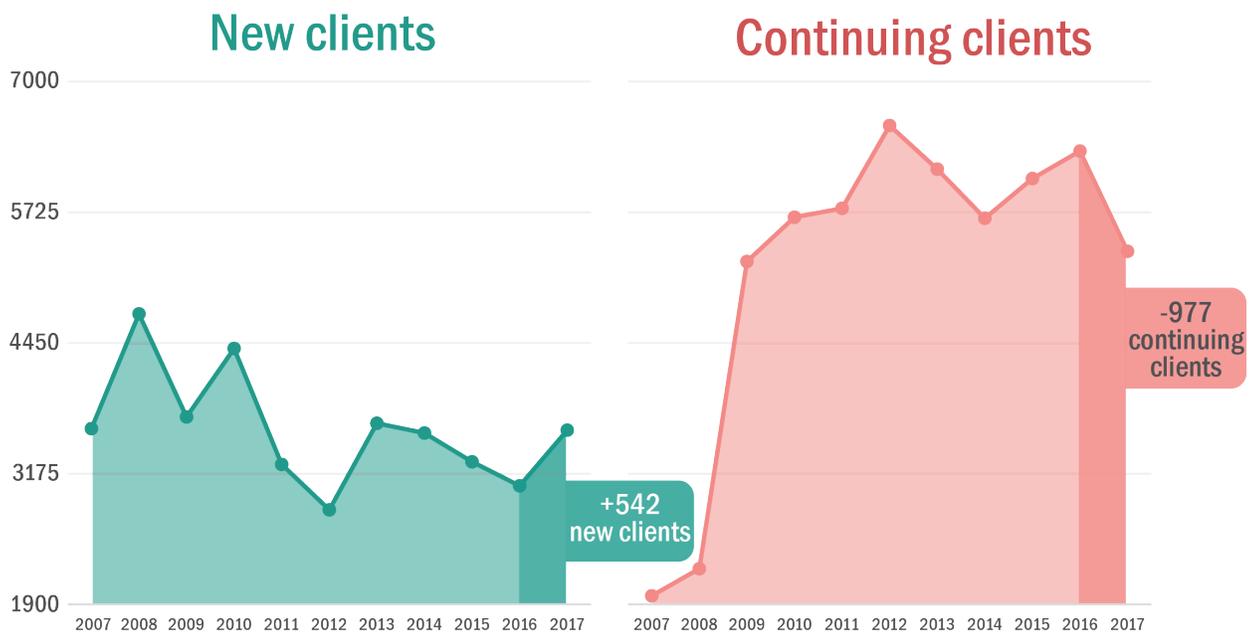
2017 Housing Status of Active Clients



Source: KnoxHMIS Annual Report 2017

2017 Housing Status of Active Clients shows the housing status of all active clients in 2017. Between 2016 (N=9,373) and 2017 (N=8,938), there has been an approximate 5% decrease among active clients. While 86% (n=7,692) of active clients are homeless, 14% (n=1,246) are housed, having been formally homeless or are housed but at imminent risk of becoming homeless, while continuing to receive supportive services to stabilize housing.

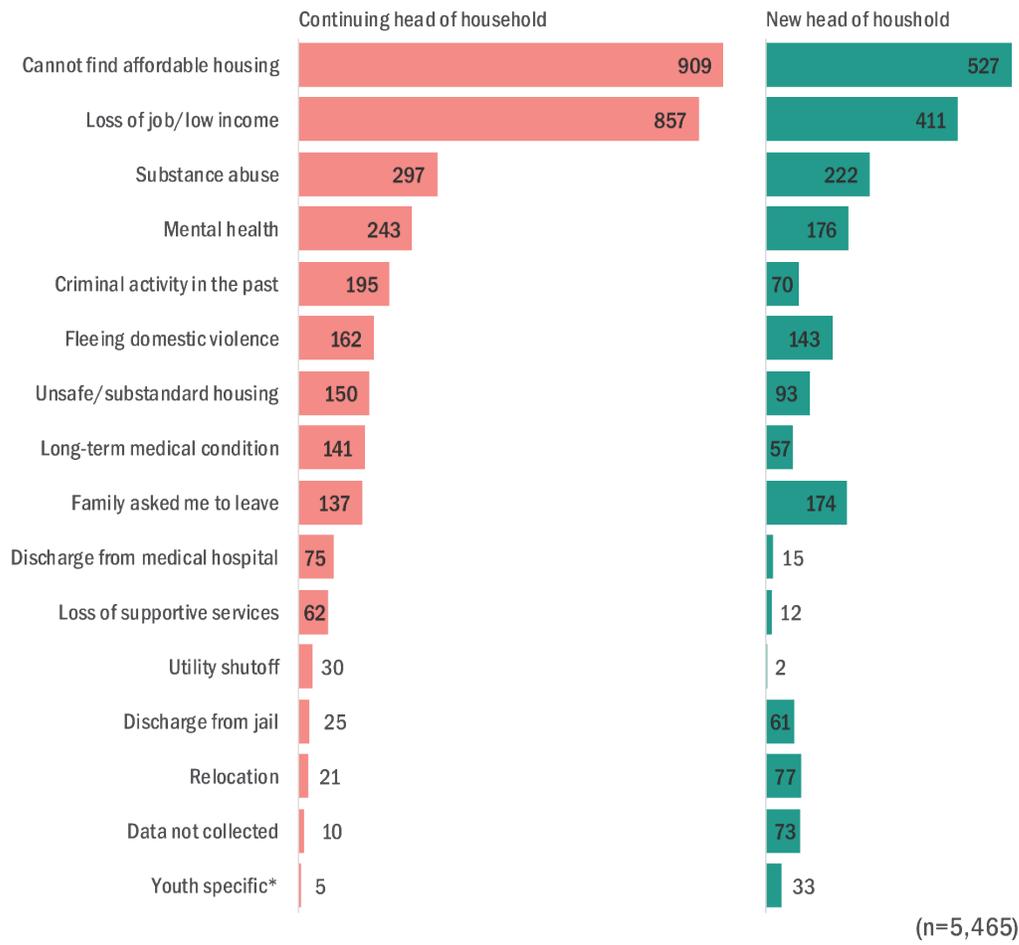
Count of Active Clients (2007-2017) by Subset



Source: KnoxHMIS Annual Report 2017

Count of Active Clients (2007-2017) By Subset represents the total number of active clients, those that are new to KnoxHMIS and those who are continuing to receive services, each year since 2007. The count of active clients is the sum of new and continuing clients. It is important to note that the increase in active clients since 2007 is potentially indicative of improvements in agency data quality, increased utilization of KnoxHMIS, and the additional new partner agencies since 2013 – not necessarily an increase in the number of individuals experiencing homelessness or at-risk of homelessness.

2017 Causes of Homelessness as Reported by Head of Household

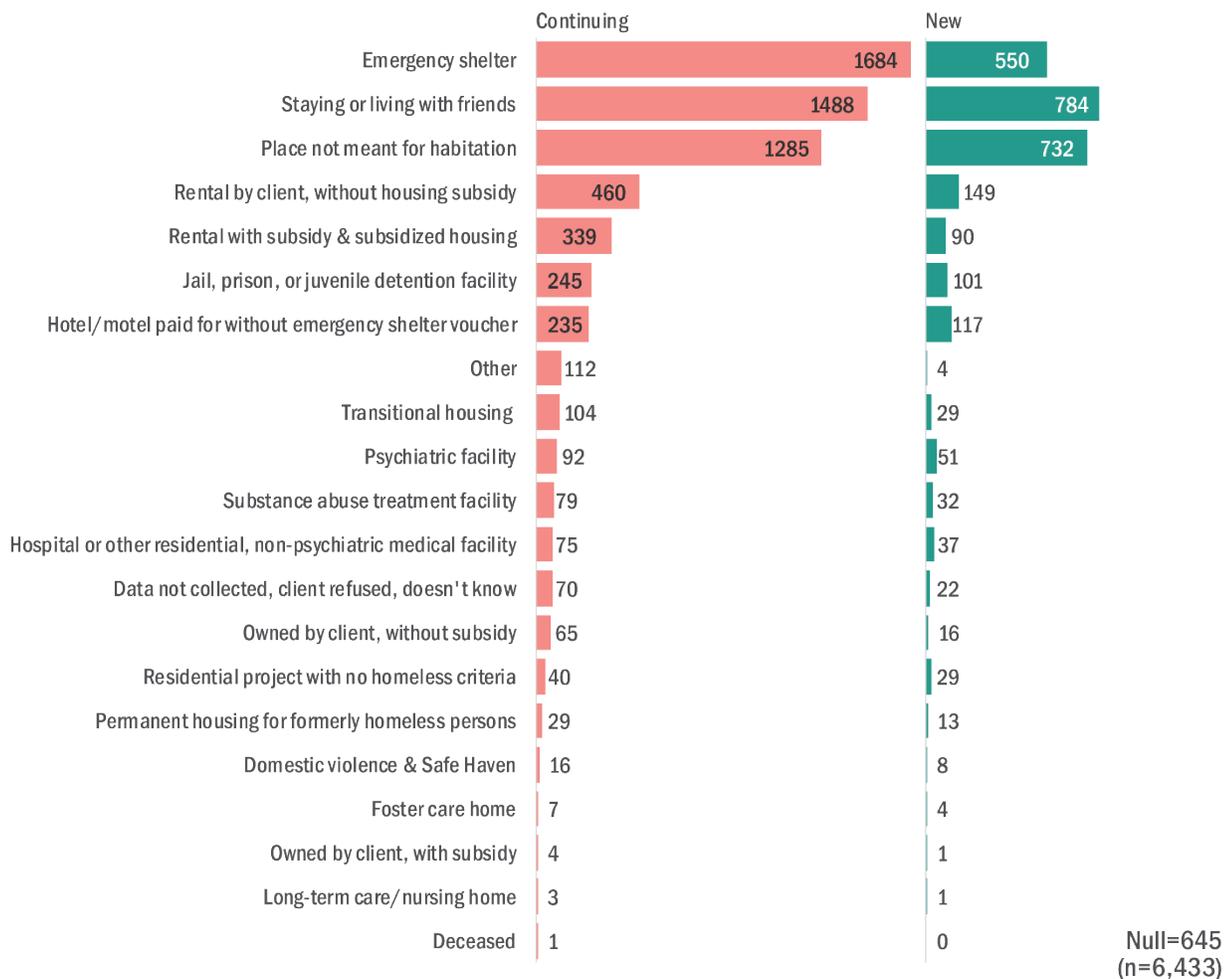


*Runaway, parent relationship, aged out of foster care

Source: KKCHC Biennial Study 2018

2017 Causes of Homelessness as Reported by Head of Household delineates the causes of homelessness (or *primary reason for homelessness*) among active *head of household* clients, both those new and continuing services. Overall, the top three reasons *reported* for homelessness by head of household (n=5,465) were: cannot find affordable housing (26%), loss of job (23%), and substance use (9%). Variables labeled as "YOUTH ONLY" reflect data from youth only programming (such as runaway homeless youth or youth street outreach). "NULLS" reflect data not captured at program intake. Nulls are not included as "reported." Null results for continuing clients are n=498, and for new clients, null results are n=1,650. 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.

2017 Residence Prior as Reported by Adults



Source: KnoxHMIS Annual Report 2017

2017 Residence Prior¹⁰³ as Reported by Adults delineates where the client was living prior to being entered in KnoxHMIS among adults (ages 18 and older) clients. Thirty-seven percent of active adults reported a residence prior that could have been addressed through homeless prevention services (i.e. residence prior of owning a home [1%], renting a property [14%], or staying/living with family/friends [30%]). Twenty-nine percent (n=2,234) unsheltered locations such as a public place, car, abandoned building, or camping outdoors.

¹⁰³

¹⁰³ Residence prior is *not* the residence where the client was staying prior to the current episode of homelessness. Rather, it is where they were staying prior to entering the program for which they are seeking services.

Demographics of Active Clients in KnoxHMIS in 2017

Gender	Male (n=4,994)	Female (n=3,601)	Null Gender (n=343)	Active Clients (n = 8,938)
Mode	56	35	-	57
Mean	42	37	-	39
Standard Deviation	17.36	17.90	-	17.83

Race	Male (n=4,994)	Female (n=3,601)	Null Gender (n=343)	Active Clients (n and percent)
White	3,167	2,261	1	5,429 (61%)
Black or African American	1,384	1,076	0	2,460 (28%)
Other	65	69	0	134 (1%)
Null	378	195	342	915 (10%)

Ages	Male (n=4,994)	Female (n=3,601)	Null Gender (n=343)	Active Clients (n and percent)
0-17	478	508	25	1,011 (11%)
18-24	366	380	1	747 (8%)
25-55	2,889	2,089	4	4,982 (56%)
56-61	688	314	2	1,004 (11%)
62+	573	308	0	881 (10%)
Null age	0	2	311	313 (4%)
Mode	56	35	-	57
Mean	42	37	-	39
Standard Deviation	17.36	17.90	-	17.83

Ethnicity	Male (n=4,994)	Female (n=3,601)	Null Gender (n=343)	Active Clients (n and percent)
Non-Hispanic /Non-Latino	4,457	3,265	1	7,723 (86%)
Hispanic/Latino	106	98	1	205 (2%)
Null	431	238	341	1,010 (11%)

Source: KnoxHMIS Annual Report 2017

The tables represent demographic information on active clients in 2017. The table presents the percentage of all active clients and delineates age, race, and ethnicity demographics into gender categories. The percentage breakdown for gender, race, and ethnicity are consistent with the 2016 data. Further, KnoxHMIS data reflects that 28% of active clients are African American. Notably, Knox County's population is comprised of 9% African American individuals. Approximately 17% of Tennessee's total population identifies as African American. Therefore, a disproportionate percentage of individuals experiencing homelessness in both Knox County and the state of Tennessee are African American.

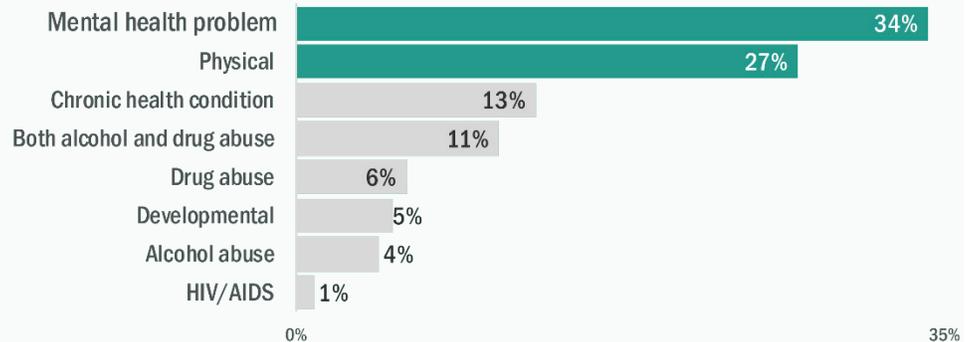
Age Distribution of Active Clients in KnoxHMIS in 2017



In 2017, the **average** age for all clients was 39 (age 37 for females; age 42 for males). Of particular interest is the **peak age concentration** (mode) for women experiencing homelessness is age 35, which is 21 years younger than the peak age concentration for men which is age 56. The peak age concentration for all clients is 57. Standard deviation (defining the dispersion of values within the data set) for men and women is 17.83, for men it is 17.36, and for women it is 17.90.

Disability Types of Active Clients in KnoxHMIS 2017

11%
of active clients
report having a
disability.

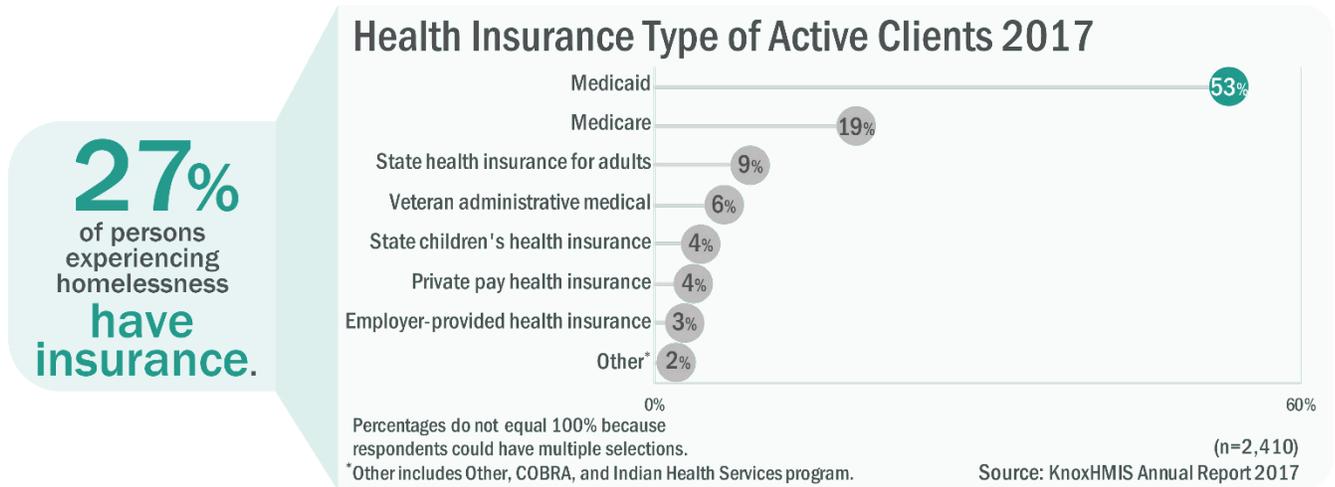


Percentages do not equal 100% because respondents could have multiple selections.

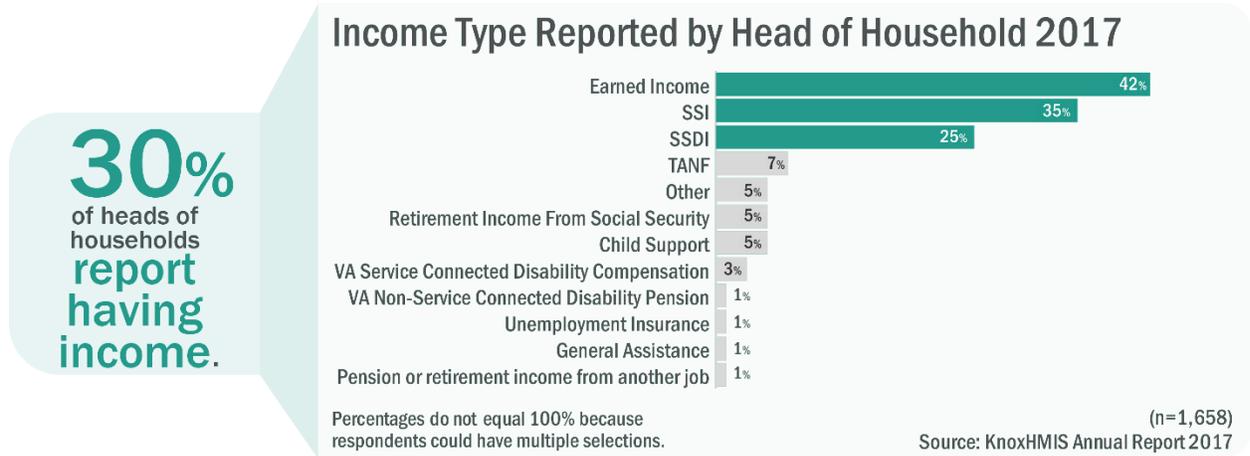
(n=1,005)

Source: KnoxHMIS Annual Report 2017

Disability Types of Active Clients in KnoxHMIS 2017 shows the number of active clients with a reported disability. In 2017, 11% (n=1,005) of active clients reported having a disability. **This percentage is likely *underreported* due to updates in the 2014 HUD Data Standards that determine disability based on a series of assessment questions that indicate an “expected long-continued and indefinite duration” of the disability. When filtering for clients who report a disability status, but do not meet this additional HUD requirement, the number of active clients with a reported disability comes out to be *n=6,160*. The discrepancy is likely due to partner agency data quality issues regarding the definition of “disability.”** HUD also provides guidance that disability data is to be captured on *all* clients participating in HMIS, *both adults and children under 18*. It is likely that disability is further underreported because parents may be less likely to share the disability of children in the household. Further, disability data is typically captured during the client intake, when the client may not feel comfortable sharing disability information. It should be noted that a person can report more than one disability type, so disability counts will be greater than the total number of persons who reported a disability. It is also of interest that 56% (n=562) of all persons reporting a disability diagnosis do not have health insurance.



Health Insurance Type of Active Clients 2017 illustrates types of insurance accessed by persons experiencing homelessness. In 2017, 27% (n=2,410) of persons experiencing homelessness reported having insurance. 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 18*. Due to the relatively recent introduction of insurance data fields, the total persons accessing insurance is likely underreported. It should 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.



Income Type of Head of Household 2017 illustrates types of income accessed by persons experiencing homelessness. In 2017, 30% (n=1,658) of persons experiencing homelessness reported having income. Income reported is likely low due to reluctance to report income at program entry and data quality issues. Only five of the twenty KnoxHMIS HUD funded, which requires detailed income information.

2017 Subgroups of Active Clients

Six subpopulations (families, youth, veterans, chronically homeless, street homeless, and senior citizens) are included in the KnoxHMIS Annual Report because they are either a national or a local priority initiative. Addressing *Street* and *Senior* homelessness are local partner priorities. Ending family, youth, veteran, and chronic homelessness are national initiatives issued by the United States Interagency Council on Homelessness, *Revising and Strengthening the Federal Strategic Plan to Prevent and End Homelessness*¹⁰⁴ (2017).

According to the USICH *Strengthening the Plan* (2018), *Opening Doors* has helped drive significant national progress such as a reduction in overall homelessness including reductions in family, chronic, and veteran homelessness—but there is much more work ahead. While national rates decrease, local community rates in Knoxville present a somewhat different story. Similar to national estimates, overall homelessness in Knoxville has decreased by 5%. Homelessness among sub-groups illustrates both increases and decreases. Various factors affect changes in the subgroups such as the amount of funding designated to services can increase or decrease the number of persons served within a sub-group, mandated data reporting and input can increase the number of persons included in KnoxHMIS, and data quality can increase or decrease the number included in a sub-group. **This section looks at both changes in sub-groups year to year (both new and continuing) and details characteristics of the sub-groups in comparison to the overall number of active clients served in KnoxHMIS during 2017.**

¹⁰⁴ For more information, see the full United States Interagency Council on Homelessness, *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness* at <http://www.usich.gov/opening-doors> as well as the most recent revisions at https://www.usich.gov/resources/uploads/asset_library/federal-strategic-plan-participation-guide.pdf

Subgroups¹⁰⁵ of New Clients (2016–2017) compares the number of individuals categorized into subgroups of those who were newly entered into KnoxHMIS between 2016 and 2017. It is important to note that not all clients new to KnoxHMIS fall into one of these categories, and some clients may fall into more than one category. Therefore, the total number of clients in this table for each year will not be equal to the total number of new clients added to KnoxHMIS for the same year.

The increase in families (i.e. households with minor children) may be due to increased funding specifically to programs designated to rapidly re-house persons with families that are new to homelessness.

The increase in youth (i.e. persons 12–24 who are unaccompanied and serving as their own head of household) may be due to increased services for youth experiencing homelessness. New staff have been hired to engage with youth experiencing street homelessness. This outreach, therefore, allows for more youth to be served which increases the total number of active clients input into KnoxHMIS. Further, the increase in Youth may be due to better coordination between the school system and the KKCHC Youth Council’s advocacy for increased awareness and agency collaboration.

The decrease in veteran homelessness may be due to designated funds from the Department of Veteran’s Affairs specific to homelessness prevention and rapid-rehousing for veterans and families as well as mandated reporting in HMIS¹⁰⁶. This mandate to report and improved coordination allows for verification of self-reported veteran status.

The increase in chronically homeless (i.e. an unaccompanied individual with a disabling condition who has been homeless and living continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions

Subgroups of new clients change from 2016 to 2017



2016 (n=3,056)
2017 (n=3,598)

Source: KnoxHMIS Annual Report 2017

¹⁰⁵ 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 Child Services Bureau, Knoxville City government, Knox county government, and KnoxHMIS partner agencies.

¹⁰⁶ U.S. Department of Veteran’s Affairs (2017). VA Medical Center Participation in the Continuums of Care Coordinated Entry System (VAIQ#7844648). Retrieved from <https://www.hudexchange.info/resources/documents/VA-Participation-in-Coordinated-Entry-Guidance.pdf>

equal at least 12 months) is most likely due to a better capturing of data as well as *compounded time of persons served by KnoxHMIS partners*– that is to say that those clients who remain in KnoxHMIS may, over-time, develop higher levels of acuity and needs due to increased duration of homelessness.

The increase of street homelessness (i.e. persons living in places not meant for human habitation such as camping, living in their car, etc.) may be due to an increased community effort to engage street homeless through street outreach workers and shelter. Further, data input among street outreach workers has improved and increased youth outreach has impacted this number.

The increase in Seniors (i.e. persons age 62+) experiencing homelessness may be due to persons who are in the KnoxHMIS system that have aged into being designated as a senior citizen.

Summary – Subgroups¹⁰⁷ of Active Clients in KnoxHMIS in 2017

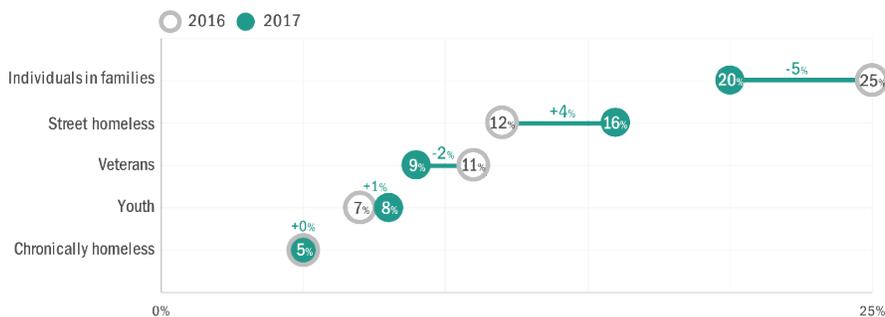
compares the number of individuals categorized into subgroups of all clients served by KnoxHMIS, both new and continuing, between 2016 and 2017.

Subgroups of Active Clients 2017				
	2016 (n=9,373)	% of 9,373 Active Clients	2017 (n = 8,938)	% of 8,938 Active Clients
Individuals in Families	2,382 (782 families)	25%	1,784 (641 families)	20%
Youth	642	7%	747	8%
Veterans	1,053	11%	799	9%
Chronically Homeless	440	5%	461	5%
Street Homeless	1,143	12%	1,421	16%

Source: KnoxHMIS Annual Report 2017

Relative Proportion of Subgroups Year to Year Comparison illustrates the growth rates among each of the subgroups of active clients rather than in the overall population.

Relative Proportion of Subgroups Year to Year Comparison.



Source: KnoxHMIS Annual Report 2017

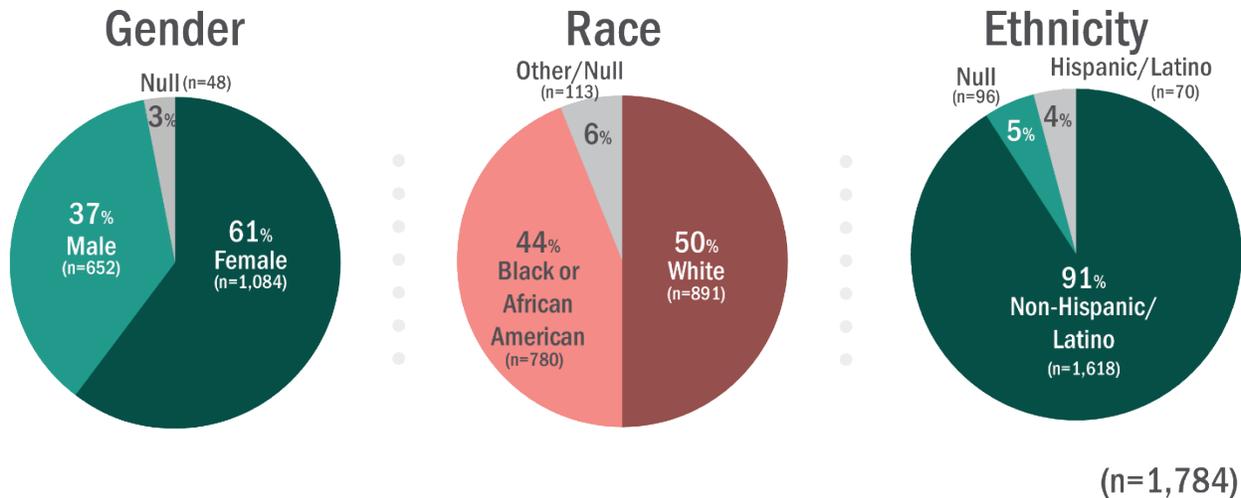
¹⁰⁷ Subgroups were determined by priority initiatives as designated by the U.S. Department of Housing and Urban Development, the Department of Veteran Affairs, Family and Youth Services Bureau, Knoxville City government, Knox County government, and KnoxHMIS partner agencies.



Families

Active Clients in KnoxHMIS in 2017

vFamilies 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.



Source: KnoxHMIS Annual Report 2017

Ages of Individuals in Families (n=1,784)			
	Average	Mode	Standard Deviation
Adults	34	33	10.40
Children	8	4	5.08

Source: KnoxHMIS Annual Report 2017

In 2017, 641 family households were served and included 1,784 individual family members. Quick facts include:

- 32% (n=206) of family households included 4 or more members.
- 76% (n=478) are female-headed households.
- 21% (n=133) of family households were unaccompanied youth¹⁰⁸ head of households.
- 21% (n=133) of family households were parenting youth¹⁰⁹.
- 17% (n=109) of family head of households (n=641) report feeling domestic violence as a primary reason for homelessness.
- 65% (n=415) of family households were literally homeless.
- 14% (n=88) of family households were at-risk of homelessness.
- 7% (n=46) of family households had an indeterminate housing status¹¹⁰.

¹⁰⁸ Unaccompanied youth defined by HUD are individuals ages 12-24 who serve as the "head of household."

¹⁰⁹ Parenting youth defined by HUD are individuals ages 12-24 parenting another youth under the age of 18.

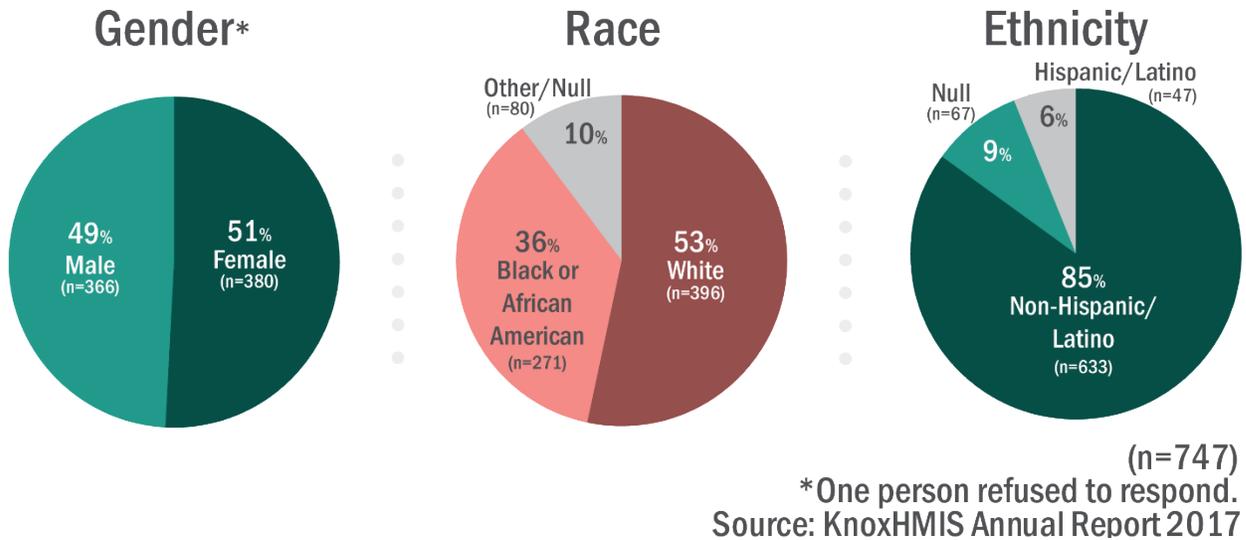
¹¹⁰ Indeterminate housing status includes clients who were not determined to be literally homeless, at imminent risk of losing housing, homeless under other federal statutes, fleeing domestic violence, at-risk of homelessness, or stably housed.



Youth

Active Clients in KnoxHMIS in 2017

Youth are defined by KnoxHMIS as persons ages 12-24 and follows HEARTH Act and Runaway Homeless Youth Act guidance.¹¹¹



Ages of Youth (n=747)		
Average	Mode	Standard Deviation
21	21	1.88

Source: KnoxHMIS Annual Report 2017

In 2017, **747 youth** were served by KnoxHMIS partners. Quick facts include:

- 38% (n=284) of youth reported a residence prior that could have been addressed through homeless prevention services (i.e. residence prior of owning a home [$<1\%$], renting property [6%], or staying/living with family/friends [31%]).
- 32% (n=237) of youth reported an economic related primary reason for homelessness (i.e. no affordable housing [12%], eviction [7%], job loss [5%], or underemployment/low income [7%]).
- 11% (n=81) of youth reported a primary reason for homelessness as non-violent family discord.
- 60% (n=449) of youth were literally homeless.
- 13% (n=95) of youth were at-risk of homelessness.
- 23% (n=174) of youth had an indeterminate housing status.

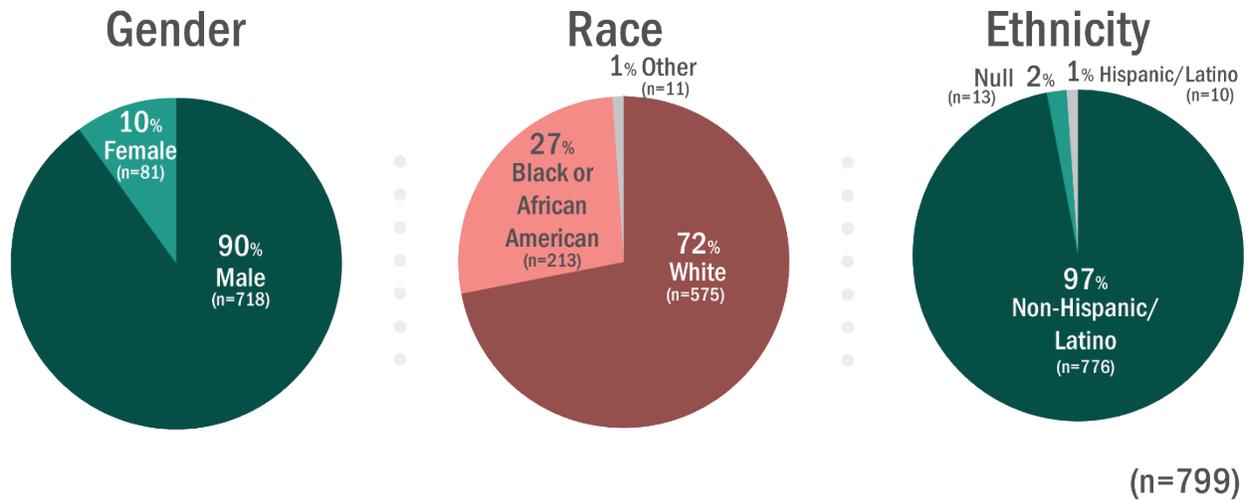
¹¹¹ "Runaway and Homeless Youth Program Authorizing Legislation" (2018). <https://www.acf.hhs.gov/fysb/resource/rhy-act>



Veterans

Active Clients in KnoxHMIS in 2017

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 a referral eligibility for HUD VASH voucher.



Source: KnoxHMIS Annual Report 2017

Ages of Veterans (n=799)		
Average	Mode	Standard Deviation
53	62	12.59

Source: KnoxHMIS Annual Report 2017

In 2017, **799 veterans** were served by KnoxHMIS partners. Quick facts include:

- 30% (n=238) of veterans reported emergency shelter, including hotel or motel paid for with an emergency shelter voucher.
- 17% (n=138) of veterans reported staying/living with family/friends.
- 17% (n=137) of veterans reported a place not meant for human habitation.
- 43% (n=347) of veterans reported an economic related primary reason for homelessness (i.e. no affordable housing [11%], eviction [8%], job loss [17%], or underemployment/low income [7%]).
- 64% (n=509) of veterans were literally homeless.
- 11% (n=84) of veterans were at-risk of homelessness.
- 20% (n=158) of veterans had an indeterminate housing status.

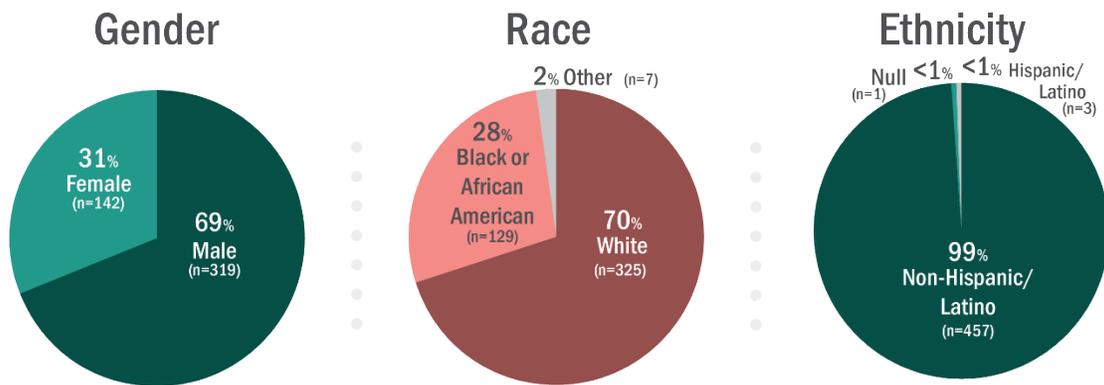


Chronically Homeless

Active Clients in KnoxHMIS in 2017

As defined by the United States Department of Housing and Urban Development (HUD), chronically homeless describes:¹¹²

- 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.



(n=461)

Source: KnoxHMIS Annual Report 2017

Ages of chronically homeless individuals (n=461)		
Average	Mode	Standard Deviation
48	52	10.59

Source: KnoxHMIS Annual Report 2017

In 2017, **461 chronically homeless** individuals were served by KnoxHMIS partners. Quick facts include:

- 32% (n=148) of chronically homeless reported a residence prior of emergency shelter, including hotel or motel paid for with an emergency shelter voucher.
- 53% (n=246) of chronically homeless reported a residence prior of a place not meant for human habitation.
- 81% (n=375) of chronically homeless individuals were literally homeless.
- 3% (n=15) of chronically homeless individuals were at-risk of homelessness.
- <1% (n=3) of chronically homeless had an indeterminate housing status.

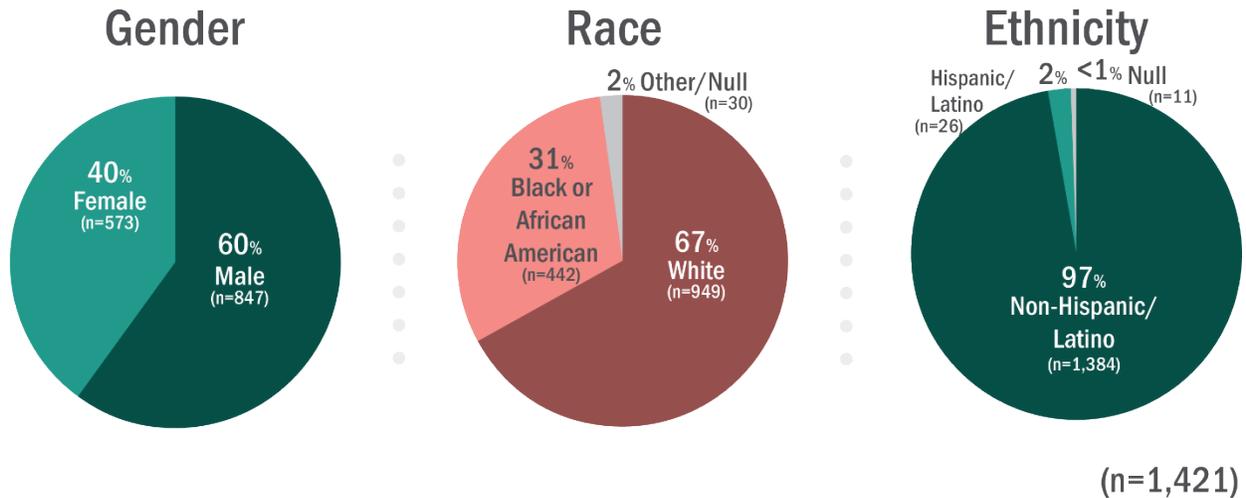
¹¹² U.S. Department of Housing and Urban Development (2007). *HUD's Homeless Assistance Programs: Defining Chronic Homelessness: A Technical Guide for HUD Programs*. Retrieved from <https://www.hudexchange.info/resources/documents/DefiningChronicHomeless.pdf>



Street Homeless

Active Clients in KnoxHMIS in 2017

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.



Source: KnoxHMIS Annual Report 2017

Ages of street homeless individuals (n=1,421)		
Average	Mode	Standard Deviation
41	56	16.5

Source: KnoxHMIS Annual Report 2017

In 2017, **1,421 street homeless** individuals were served by KnoxHMIS Partners. Quick facts include:

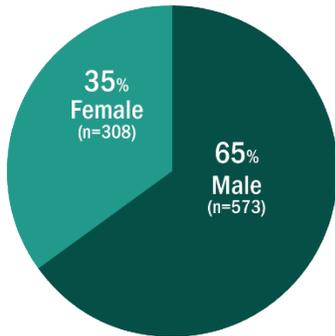
- 100% (n=1,421) of street homeless individuals reported a residence prior of a place not meant for human habitation.
- 40% (n=573) of street homeless reported an economic related primary reason for homelessness (i.e. no affordable housing [11%], eviction [12%], job loss [11%], or underemployment/low income [6%]).



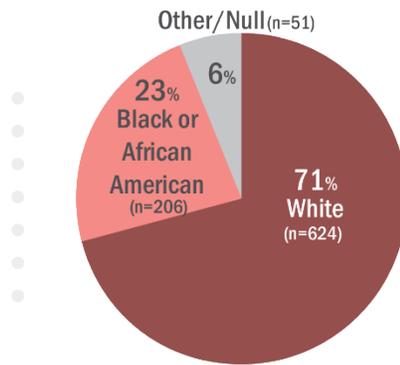
Seniors

Active Clients in KnoxHMIS in 2017

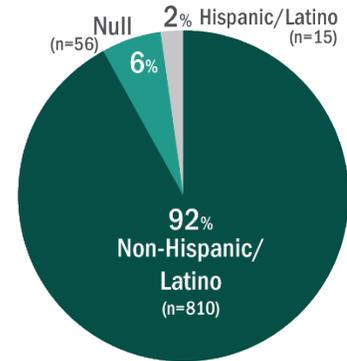
Gender



Race



Ethnicity



(n=881)

Source: KnoxHMIS Annual Report 2017

Ages of seniors (n=881)		
Average	Mode	Standard Deviation
66	62	4.68

Source: KnoxHMIS Annual Report 2017

In 2017, 881 Seniors (ages 62 or greater) were served by KnoxHMIS partners. Quick facts include:

- 26% (n=227) of seniors reported emergency shelter, including hotel or motel paid for with an emergency shelter voucher.
- 11% (n=99) of seniors reported staying/living with family/friends.
- 13% (n=113) of seniors reported a place not meant for human habitation.
- 37% (n=329) of seniors reported an economic related primary reason for homelessness (i.e. no affordable housing [15%], eviction [10%], job loss [7%], or underemployment/low income [5%]).
- 49% (n=430) of seniors were literally homeless.
- 15% (n=133) of seniors were at-risk of homelessness.
- 24% (n=208) of seniors had an indeterminate housing status.

Case Collaboration and Performance Measures¹¹³

Operationalized definitions of performance measures are taken from HMIS and program standards set by HUD.¹¹⁴ Performance measurement is a *process* that *systematically evaluates* whether CoC and agency *efforts* are making an *impact* on the clients being served by looking at outcomes rather than data quality alone. HUD encourages agency buy-in through information sharing¹¹⁵: Program directors, managers and front-line staff must understand the reasons for making changes in program operations. From a programing perspective, regularly checked data quality can be used to leverage funding, streamline client referrals, and expedite a client's placement in housing. Information sharing promotes the idea that "we are all in this together" and furthers collaborative care coordination for persons experiencing homelessness. If information sharing is fluid, program directors, managers and front-line staff can learn from one another; it is not a one-way (top-down) process. This open and transparent process creates an environment where all providers are empowered to make data driven decisions.

¹¹³ Operationalized definitions of performance measures are taken from *HMIS Training Setting the Standard: Program Level Performance Measurement: HMIS and Measures that Matter* (2008) available at <https://www.hudexchange.info/resources/documents/ProgramLevelPerformanceMeasurement.ppt>

¹¹⁴ *HMIS Data Standards Manual* (2017) available at <https://www.hudexchange.info/resources/documents/HMIS-Data-Standards-Manual-2017.pdf>

¹¹⁵ "System Performance Improvement Briefs (2017) available at <https://www.hudexchange.info/resource/5291/system-performance-improvement-briefs/>

Because case managers in **2017** had...

8,938
total active
clients

but only



of clients had
case notes

and

each client
averaged
15 notes

case managers **may not be utilizing case notes** to their full potential to better coordinate services.

Source: KnoxHMIS Annual Report 2017

Average Number of Case Notes Per Client (2009-2017)			
Year	Total Clients with Case Notes	Average Case Notes per Client	Percentage of Active Clients with Case Notes
2009	1,560	6.5	17%
2010	1,411	7.9	14%
2011	994	12.8	11%
2012	1,025	11.2	11%
2013	1,326	11.4	14%
2014	1,291	10.5	14%
2015	1,106	10.5	12%
2016	867	13	9%
2017	852	15	10%

Source: KnoxHMIS Annual Report 2017

The case notes feature in KnoxHMIS allows case managers to record detailed information on clients that they are assisting. In 2017, KnoxHMIS partner agencies recorded 12,804 case notes on 852 clients, averaging 15 case notes per client. This data suggests that case managers are not utilizing case notes to document work with clients in KnoxHMIS, which has the potential to largely contribute to better coordinated services.



In 2017, more than half of housing outcomes were to positive housing destinations.



..... Source: KnoxHMIS Annual Report 2017

“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). For example, if a person is in ES and returns to the streets, this would result in a “negative” placement. In cases where the person starts in ES and moves to TH or PH, this would result in a “positive” placement. “Indeterminate” placements in this example would include “no exit destination,” “client refused,” etc.

2017 Exit Outcomes by Program Type				
Program Overview	Positive	Negative	Indeterminate	Total
Transitional Housing	307 (45%)	167 (24%)	213 (31%)	687
Rapid Re-Housing	75 (70%)	1 (>1%)	31 (29%)	107
Permanent Supportive Housing	24 (23%)	38 (36%)	44 (41%)	106
Homelessness Prevention	35 (52%)	14 (21%)	18 (27%)	67
Emergency Shelter	308 (75%)	33 (8%)	67 (17%)	408
All Programs	1,338 (68%)	282 (14%)	355 (18%)	1,975

Source: KnoxHMIS Annual Report 2017

Overall, in 2017 68% (n=1,338) of program exits (n=1,975) were positive housing destinations.



In 2017, newly homeless individuals can expect ...

80 days for the average time to housing for Rapid Rehousing programs



to stay in permanent housing for an average of **989** days.

Source: KnoxHMIS Annual Report 2017

This table shows the **time to housing** for rapid re-housing programs. The expectation is that duration would decrease over time for rapid re-housing programs. The **average time to exit** is also represented for emergency shelter [ES] and transitional housing [TH], along with the length of stay for permanent housing [PH] programs. The expectation for ES and TH is that the time to exit would decrease over time; whereas, the **length of the stay** for PH would increase over time as residents gain stability. Distortion may occur, if residents have not been exited from the programs, thus reflecting a high time to exit or length of stay.

2017 KnoxHMIS Housing Outcomes in Days					
Program Type	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Average Days
Time to Housing Rapid Rehousing	84	95	77	65	80
Time to Exit Emergency Shelter	50	53	56	43	51
Time to Exit Transitional Housing	171	150	135	119	144
Length of Stay Permanent Housing	978	959	1,019	998	989

Source: KnoxHMIS Annual Report 2017

The "quarters" in the table are based on the 2017 calendar year.

KnoxHMIS data completeness of active clients



(2017 Active Clients n=8,938)

Source: KnoxHMIS Annual Report 2017

2017 KnoxHMIS Data Completeness (2010-2017) displays the percentage of HUD required data elements that are completed on an annual basis. Data represented in this graph includes the HUD universal data elements for all entry/exit programs and excludes night-by-night shelter and service only programs. It is important to note that data quality from 2010-2013 is evaluated using the 2010 HUD Data Standards, whereas data quality for 2014-2016 uses the 2014 HUD Data Standards. 2017 data from January 1 to September 30, follows the 2014 HUD Data Standards. However, effective October 1, 2017, HUD issued version 1.3 of the Data Dictionary and Data Standards Manual. Therefore, data from October 1 to December 31, 2017 reflect versions 1.3 of the Data Dictionary and Data Standards Manual.¹¹⁶

¹¹⁶ U.S. Department of Housing and Urban Development (Apr 2018) 2017 HMIS Data Standards. Retrieved from <https://www.hudexchange.info/resource/3824/hmis-data-dictionary/>

Thank you to our community partners for your relentless efforts to serve our most vulnerable neighbors:

