2015

COMMUNITY AND FAMILY INSTITUTE HOMELESS REPORT

A COMPREHENSIVE EXAMINATION OF HOMELESSNESS IN WASHINGTON AND BENTON COUNTIES

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HOMELESS REPORT

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Printed in the United States of America
Printed by: PMC Solutions
University of Arkansas
Fayetteville, AR. 72701

ABOUT THE INSTITUTE

The Community and Family Institute (CFI) is located in the University of Arkansas' Department of Sociology and Criminal Justice. CFI was founded in 1997 based on the principle that community improvement, initiative sustainability, and program success are closely tied to assessment of needs, evaluation of community goals, and the development of appropriate and pragmatic responses to problems. CFI is dedicated to helping people build better communities by collecting meaningful data, facilitating information-based planning, and developing custom research strategies for exploring important social issues in the Northwest Arkansas region and beyond.

The Northwest Arkansas Homeless Report is a prime example of evaluating community needs. The goal of this project has been to stimulate dialogue about homelessness in the region and to encourage informed strategies for shaping future policies and actions.

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FUNDING

This report was made possible through the financial and in-kind donations from the following organizations:

Harvey and Bernice Jones Charitable Trust
Northwest Arkansas Continuum of Care
United Way of Northwest Arkansas
Wal-Mart Foundation

University of Arkansas:
J. William Fulbright College of Arts & Sciences
Department of Sociology & Criminal Justice
Community & Family Institute

United Way of
Northwest Arkansas

ACKNOWLEDGEMENTS

This project is made possible by the continued funding and support of the Jones Trust.

There are a number of individuals who provided volunteer effort in collecting the data for this point-in-time census. In addition, we want to thank the paid interviewers who were responsible for collecting the information on the 168 homeless respondents. Without their hard work this bi-annual count and survey would not be possible. In addition, though acknowledged as authors, the Community and Family Institute research staff worked tirelessly on this project.

Finally, we want to thank the "too many to name" government and non-profit agencies that participated in the census and survey. Their willingness to provide access to their clients was instrumental to the overall success of this project. We hope that this report represents a critical basis for the conversation on homelessness, the specific issues confronting Northwest Arkansas, and how resources might be leveled to address solutions and develop pragmatic plans through the 21st Century.

Thanks to Michael Drager for providing the pictures that are used throughout this report.

INTRODUCTION

The number of homeless persons in the United States has been increasing for decades. Nationwide estimates put the number of persons without their own home on any given night at approximately 700,000. As many as 3 million may experience homelessness throughout the year. Given the immense wealth of the United States, numbers of such magnitude are especially troubling. Similar to other parts of the country, homelessness continues to increase in Northwest Arkansas, though the pace of growth has not been as rapid as found in earlier reports on the region (Fitzpatrick et al. 2007-2013).

Many in Northwest Arkansas are concerned and want to know not only why homelessness persists, but why it continues to grow despite evidence of economic recovery in the United States. The answer is a complicated one. Research shows that homelessness is a by-product of both structural forces (e.g. wage structures, affordable housing, job loss) and individual factors (e.g. mental illness, substance abuse, relational problems, diminishing networks of social support). Evidence suggests that neither set of issues have changed significantly in the last two decades as low wages and lack of affordable housing continues to plague metropolitan areas around the country (National Alliance to End Homelessness 2014).

This report is intended to provide reliable, systematic data that can be used to fine-tune and implement Northwest Arkansas' Continuum of Care, and develop effective strategies for its service providers to address homelessness in the region. The data presented here provide critical information concerning basic characteristics of homeless persons, such as residential history, service needs and service use patterns, as well as chronic disabilities. Such information is essential for local governments, the Northwest Arkansas Continuum of Care, and other local planning agencies in identifying various subgroups of homeless with specific needs, while also locating gaps and duplication in the services aimed at assisting the homeless population.

The goal of this study is to provide Washington and Benton County government officials, school district officials, and homeless service providers with reliable empirical information on the current number of homeless, their characteristics, living circumstances, health risks, networks of support, social capital, service use/needs and chronic conditions.

The research reported here derives from **two** distinct data collections. The first one is a point-in-time census (PIT). The 2015 PIT census was conducted in Washington and Benton Counties over a 24-hour period, from 11 a.m. January 29, 2015 until 11 a.m. January 30, 2015. Soup kitchens, day shelters, food pantries and overnight shelters were surveyed between 11 a.m. and 9 p.m. on January 29. Street sites were enumerated on January 29 12:00 p.m. to 3:00 p.m. and January 30 from 6:00 a.m. to 8:00 a.m. Each site was enumerated during one block of time to avoid double counting. The 2015 PIT used the same methodology as previous point-in-time counts beginning in 2007.

The second data collection was an in-depth survey of homeless adults living in Washington and Benton Counties. During the months of April and May in 2015, trained interviewers surveyed a random, representative sample of homeless adults in Washington and Benton Counties. The survey (approximately 45 minutes in length) was designed to assess the circumstances and conditions of homeless persons experiencing a variety of living conditions.

The purpose of phase 1 is to provide reliable, conservative estimates of the size, basic demographics, residential history, service use patterns and service needs of the homeless population in the Northwest Arkansas area. It answers basic questions necessary for the Continuum of Care application to HUD. As such, it places special emphasis on distinguishing the chronic homeless from other segments of the homeless population.

Phase 2 provides detailed information on the nature, causes and consequences of the homeless condition. It employs an intensive, structured interview administered to a systematic, stratified sample of street and sheltered homeless. In analyzing these data, we hope to provide comparisons with earlier work done in Northwest Arkansas. The Community and Family Institute has been tracking homelessness in the region since 2007 and that comprehensive data along with the newest PIT and in-depth survey hopefully will provide a level of understanding in terms of both the depth and the breadth of homeless circumstances in Northwest Arkansas.

We have organized this report to reflect both the breadth of our work as well as providing some depth of understanding homelessness in Northwest Arkansas. After our discussion of the methodology necessary to carry out this work, we will present two separate groups of findings. An assessment of the PIT 2007-2015 will provide a historical perspective to the growing needs of homeless people in the region, followed by an overview of the findings from the 2015 comprehensive survey of homeless adults living in Washington and Benton Counties.

EXECUTIVE SUMMARY

The information contained in this report, and summarized here, derives from two data collection activities: 1) a point-in-time count of **512** homeless persons in a 24-hour period on January 29-30, 2015 that included a two-page survey of basic demographic information and a needs assessment of the homeless; and 2) a 45-minute survey of **168** homeless adults conducted April and May, 2015 providing information on residential and housing histories, duration and causes of homelessness, stressful life events and circumstances, resources, social supports and social capital, mental and physical health, and access to health services.

While there is some data in this report (Chapters 1 & 2) that highlight the results of the 2015 Point-in-Time Homeless Census, this executive summary and Chapters 3-5 highlight the results of the intensive interview survey with 168 homeless adults in Washington and Benton Counties.

Basic Demographics

- **2015 Point-in-Time Numbers**
  Approximately **2,462** persons are estimated to be homeless in the Northwest Arkansas area (Washington & Benton counties). Of this estimate, 512 are survey respondents, **1,195** are K-12 school age youth reported from public schools, 139 are reported children under 6 years old and K-12 age children not currently attending public school, and 616 are projected invisible homeless, including persons living in inaccessible places such as abandoned buildings, doubling up with friends and relatives, and the parents of K-12 children reported from school districts.

- **County & City Interview Sites**
  Based on the population estimates from the point-in-time census, the in-depth survey was carefully stratified across county, city, and site. Thirty percent of the in-depth interviews took place in Benton County and 70 percent took place in Washington County. Just over 54 percent of the interviews took place in Fayetteville; 15.5 percent took place in Springdale, 14.3 percent in Bentonville, 10.7 percent in Rogers. An additional 7 interviews were collected in Siloam Springs, one interview in Prairie Grove, and one interview in Gentry.

- **Age**
  The median age of respondents is 44 years. Sixty percent of respondents are under 50 years old.

- **Gender**
  Over 63 percent of the homeless interviewed are men.

- **Race/Ethnicity**
  About 80 percent are Caucasian/ White, 12 percent are African-American, with the remaining 8 percent in other or multi-racial categories. Four percent of respondents told us they were Hispanic.

- **Education**
  Education levels generally reflect those of the general population of Arkansas. Over 75 percent have a high school diploma; 22 percent have some college; 25 percent have less than a high school diploma.

- **Income**
  Median monthly income was approximately $600. Nearly 9 percent reported no income, while 35.7 percent reported full or part time work as their main source of income.

- **Time Spent Homeless**
  The median time spent homeless is 12 months. Sixteen percent have been homeless a month or less and nearly 30 percent have been homeless for over two years.

- **Military Service**
  37.5 percent have served in the military and over 40 percent of those veterans have seen combat.

- **Places of Residence**
  The most cited places of residency (where they spent the last night) were transitional housing apartment or facility (23.8%) and with a friend or relative (23.2%). Over 17 percent were staying on the street, 13 percent in permanent supportive housing, 11.3 percent at an emergency shelter, 6.5 percent in treatment facility, and 4.8 percent in a hotel or motel.

- **Local vs. Transient**
  The homeless are comprised of both locals and transients. Over 34 percent were born in Arkansas and the median time spent in Northwest Arkansas was 2 years.

Life on the Streets

- **Causes of Homelessness**
  Personal relationships and job loss/ income issues are two of the most often cited reasons for an individual's homelessness.

- **Problems of Homelessness**
  The most common problem associated with being homeless is getting clothing, with 29.2 percent saying they often have this problem.

- **Daily Hassles**
  The most common daily hassle reported was lack of privacy (38.7%).

- **Income**
  Nearly 36 percent of the homeless interviewed said their main source of income is full or part time employment.

- **Work**
  Sixty percent of the sample had not done any paid work in the past week; the main reasons for not having worked were poor health (36.8%), lack of available work (16.8%) and lack of transportation (6.3%).

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- **Victimization**
  Over 20 percent have been the victim of a robbery in the last six months, and 22.6 percent say they have witnessed someone else being attacked in the last six months.

- Forty-seven percent have witnessed someone else carrying a weapon in the last six months.

- **Arrests**
  A large percentage of homeless adults report "ever being arrested" (72%); fifty nine percent have been arrested for a felony.

- **Jail Time**
  Nearly 33 percent report having spent time in jail in the past year.

- **Getting By**
  Fifty percent of women said that it is hard for a homeless person to get by in Northwest Arkansas, compared with 40 percent of men.

- **Religious Affiliation**
  Sixty three percent said that they do have a religious preference and 84 percent of those who do have a religious preference identify as Protestant.

- **Social Support**
  The most common type of support from family members is advice (58.3%), followed by money (37.5%) and a place to stay (35.1%).

- The most common type of support from friends is advice (63.1%), followed by food (46.4%), and transportation (41.1%).

- The least common type of support from friends or family is sick care (21.4% and 17.3%).

- **Social Capital**
  The most common form of group participation other than religious activities are family support groups (36.9%).

Health and Well-Being

- **Physical Health**
  Fifty-six percent rate their physical health as fair or poor.

- From a checklist of 24 physical symptoms, stress-related, respiratory, musculoskeletal, and digestive/ urinary symptoms are especially common.

- Forty-one percent report times since their homelessness when they needed medical care and did not receive it.

- The most common reasons for not receiving needed medical care are lack of money (62.3%) and lack of transportation (50.7%).

- 66.7 percent have a BMI that qualifies them as being either overweight or obese.

- Nearly half of homeless have been told by a doctor that they have high blood pressure (46%).

- 16.7 percent of homeless have been told by a doctor that they have diabetes.

- Forty-two percent report having at least one alcoholic beverage in the past month.

- Just over fifty percent say that alcohol has caused a problem in their life; 45.8 percent report being arrested for some alcohol/drinking behavior; 58.6 percent have been through an alcohol detox program.

- Over 72 percent of the sample report using drugs other than alcohol in the last month; the majority of those reported using marijuana.

- Half of those who said they had ever used drugs also report being arrested for drugs.

- **Mental Health**
  Sixty-three percent reported having some problem with mental illness in their lifetime.

- The two most common mental health symptoms reported are Anxiety and Paranoia.

- The sample averaged a CES-Depression score of 25.9 which was well above the cutoff (16) to be considered for clinical caseness.

- Over 24 percent of homeless interviewed have had suicidal thoughts during their homelessness; 60 percent of suicide attempts occurred while homeless.

TABLE OF CONTENTS

CHAPTER

ONE

COUNTING AND INTERVIEWING HOMELESS IN NORTHWEST ARKANSAS

CHAPTER ONE

As noted earlier, there were two data collections involved in this research. This chapter describes the procedures used in both of them. First, there was a point-in-time count of homeless persons who were given a short survey. This data collection activity was conducted on January 29-30, 2015. It was a single-day census, a count of how many people could be identified as homeless in a 24-hour period. It also included a two-page survey of basic demographic information and a needs assessment of homeless adults.

The point-in-time count provided a snapshot of the Northwest Arkansas area's homeless adults based on **512** face-to-face interviews with homeless adults. The second data collection consisted of an intensive, 45-minute interview with **168** homeless adults. These interviews were conducted between April-May, 2015. Respondents were chosen as representative of the adult homeless population as determined by the results of the point-in-time census; therefore, the results of the detailed survey are generalizable to this larger population.

In general, the point-in-time count and the intensive interview sample include generally homeless persons who are "highly visible" and readily accessible to service providers in the Northwest Arkansas Area (MSA), which only included Washington and Benton Counties.

As was the case in the point-in-time census, interviews were obtained from all the locations homeless persons were living in and all the circumstances they were in as reflected in the PIT census.

Identification of Locations & Gaining the Cooperation of Service Providers

To prepare for the point-in-time census and, subsequently, the intensive interviews, several steps were taken to gain the full cooperation of service providers. First, a master list was developed of shelters and facilities serving homeless persons in the Northwest Arkansas area. This list included 31 facilities ranging from emergency shelters to transitional facilities, domestic violence shelters, and special needs facilities for homeless persons.

Shelters and facilities were called in advance of the upcoming point-in-time survey. The facilities provided updated information including contact persons, telephone numbers, email addresses and physical addresses, an inventory of services delivered, etc.

To our knowledge all service agencies whose missions include substantial services to homeless persons in Washington and Benton Counties participated in the 2015 point-in-time census. Because homeless clients comprise a rather small percentage of their overall client bases, participation was not solicited from mainstream agencies, such as the

Crisis Center, the Department of Human Resources, the Food Stamps Office, and other entities whose main constituencies are permanently housed individuals.

Street homeless were sought primarily in areas noted as places where homeless had been months leading up to the PIT. Using police officers in the four major cities as primary informants, common street locations were established from preliminary drive through all areas as well as information from outreach workers and the police.

On the day of the count, four teams of enumerators were assigned to different geographical regions for the unsheltered count. Experienced interviewers (such as social workers) were chosen as team captains for these unsheltered teams. Interviewers were paired with police officers and instructed to look in specific places for homeless people including: 1) streets, alleys, passageways between buildings; 2) parking decks and garages; 3) parks, vacant lots, and thickets; 4) bridges and overpasses; 5) parked and abandoned vehicles; and 6) all-night restaurants.

Because of security risks, no surveys were conducted in abandoned buildings even though persons were known to sleep in several such places in the area. Many of the homeless persons residing on the streets were actually surveyed at soup kitchens and day shelters.

By not including mainstream agencies such as the Housing Authority and Welfare Assistance Office, and by not seeking homeless persons in inaccessible locations, there is the potential for under-enumeration of homeless persons. However, this under-enumeration was partly compensated for by conducting the point-in-time census in soup kitchens and food pantries which were known to be frequented by homeless persons who typically reside in inaccessible places and are living with friends and relatives.

Volunteer Interviewers

The point-in-time census instrument was administered by trained volunteers, including college students, service providers, and community residents. On January 27, volunteers attended a two-hour training session where they learned the purpose of the survey, interviewing procedures, and the relevance of questions.

In addition, volunteers role-played interviews and were instructed on how to approach people, and how to remain safe while conducting their surveys. Finally, all volunteers were assigned to teams with team captains, and given specific enumeration sites and time slots during which to conduct interviews. Team captains were chosen from a pool of experienced service providers.

Point-In-Time Survey Interview Times

Soup kitchens and food banks were surveyed from 11:00 a.m. to 1:00 p.m. on January 29. Day shelters were enumerated from 1:00 to 4:00 p.m. on January 29. Night shelters were enumerated from 7:00 to 10:00 p.m. on January 29. Street sites were enumerated from 5:30 to 8:00 a.m. on January 30. Table 1.1 includes all locations where interviews were conducted as well as the total number of interviews collected at each of those locations.

Eliminating Duplications

Several quality control procedures were in place to eliminate duplicate responses. First, the point-in-time survey was printed on two-sided yellow paper. The distinctive color facilitated clarity and recognition. At the beginning of the survey, volunteers asked potential respondents if they had already "done the yellow survey." Upon recognizing it, participants appeared eager to refuse if they had previously completed the survey, suggesting that any double-count would be incidental.

Second, respondents were asked for their initials and ages. Double-counts were assessed by matching initials, ages, and other parallel information, such as race. Through this matching effort it was determined that no one had responded to the survey twice.

Another concern was the double reporting of children, when both parents were surveyed. We also obtained initials, ages, and locations of children and others who accompanied a respondent. Again, no evidence of double-counting was found—likely also because most children were accompanied by a single parent, usually the mother.

The total population count for the PIT was **512**. With the quality control procedures that we had in place it would have likely produced only incidental double-counts. Perhaps the procedure of requesting initials for persons accompanying respondents could be eliminated in future point-in-time surveys to save time. (One cautionary note, however, to those who intend to follow our procedures. If respondents were given a significant incentive to participate, such as money, this would encourage double-counts and require extensive quality control procedures.)

Screening of Housed Persons

Question 5 on the point-in time survey was the primary way of screening housed from non-housed persons. It asked, "Where did you spend last night?" Those not fitting the definition of homeless were eliminated. Occasionally interviews were administered to persons who, from the information provided, were determined late in the interview to have places of their own. These responses were also

TABLE 1.1
POINT-IN-TIME
COUNT BY AGENCY

Agency	N
Benton County Helping Hands	5
Community Meals at Central United Methodist Church	32
St. Augustine Foundation	4
Cooperative Emergency Outreach	2
Grace United Methodist Church Food Pantry	1
Decision Point Bentonville	31
Decision Point Springdale	16
Genesis House	5
Havenwood	9
Life Source	3
Manna Center	3
Northwest Arkansas Women's Shelter	13
Bread of Life	6
Hunger and Thirst	8
Salvation Army Bentonville	18
Salvation Army Fayetteville	17

Agency	N
Samaritan Center Rogers	11
Samaritan Center Springdale	25
Second Mile Ministries	3
Seven Hills Day Center	30
Unsheltered Locations	12
House of Hope Rescue Mission	6
VA Rogers House	14
VA HUD/VASH	114
Seven Hills SSFV	13
Walker Family Residential Community	24
Seven Hills Ficasso	9
Oasis	10
Saving Grace	8
Seven Hills Denovo	27
Soul's Harbor	14
Peace at Home	14
Restoration Village	5

eliminated. The **512** homeless adults counted represents only persons who were clearly without their own housing.

Counting School-Age Persons

In addition to the adults counted and estimated, we contacted all of the school districts (14) in Washington and Benton counties for a current enumeration of homeless students. They reported a total of **1195**. Table 1.2 includes all school districts with the total number of children reported from each district.

Of the **1195** students, more than 90 percent were reported as doubling-up with friends or relatives. These students were not interviewed formally, but nevertheless represent an important part of the comprehensive enumeration in the two counties.

The Total Count

The total number of homeless persons in Northwest Arkansas as show in Table 1.3, is based on three separate counts: a) a 24-hour PIT census of homeless adults and youth (under the age of 18) living with them; b) counts of homeless students provided by Benton and Washington County school districts and a corresponding estimate of their parents/guardians; and c) an estimate of "invisible" homeless persons derived from interviews conducted in soup kitchens, food pantries and day centers. These three counts produced an estimate of **2,462** homeless persons in Benton and Washington Counties on January 29-30, 2015.

The data presented in Table 1.2 and Table 1.3 provides an estimate of the magnitude of youth homelessness in Northwest Arkansas.

TABLE 1.2
POINT-IN-TIME
SCHOOL DISTRICTS COUNT

School District	N
Lincoln	0
Gravette	2
Greenland	10
West Fork	12
Elkins	16
Pea Ridge	26
Prairie Grove	33
Farmington	34
Springdale	80
Gentry	91
Rogers	133
Siloam Springs	153
Fayetteville	207
Bentonville	398
Total	1195

Over half (52.2%) of all homeless persons counted in Benton and Washington Counties were less than 18 years of age.

Nearly 90 percent of homeless youth reported doubling-up with friends and relatives; the remainder lived in shelters, hotels/motels, were not accompanied by an adult, or were living in some other homeless situation. Homeless youth attending school were highly concentrated in the area's three largest school districts — Bentonville, Fayetteville, and Rogers. Nevertheless, Siloam Springs and Gentry, reported large numbers of homeless students despite the smaller size of these school districts.

TABLE 1.3
POINT-IN-TIME
TOTAL PERSONS COUNTED

Data Source	N
Survey Responses: Homeless Adults and Accompanying Youth	
Adults (18 years and over, responded to survey)	512
Youth under 6 living with respondents, not present for survey	139
School-Age Youth and Parents/Guardians	
School-age youth reported by school districts	1195
Parents/guardians of youth attending schools*	563
Estimate of Invisible Homeless**	53
TOTAL NUMBER OF HOMELESS (counted + estimated)	***2,462***
Notes * Projection of adults accompanying youth enrolled in local schools who reported "doubling up" with friends or relatives. ** Projection based on survey respondents who reported staying with friends and family.	

Demographic Composition

What are the demographic characteristics of homeless adults in Northwest Arkansas?

As seen in Table 1.4, the "typical" homeless adult is a white male of non-Hispanic origin between the ages of 25 and 54. Despite the fact that most homeless adults in Northwest Arkansas are males, it is important to note that more than a third of the population is female, the majority of whom (58%) are the parent of at least one child. The vast majority of these women (84.5%) are single parents. An estimated 17 percent of homeless adults are members of racial and/or ethnic minority groups. These findings are not particularly unique to Northwest Arkansas.

TABLE 1.4
POINT-IN-TIME DEMOGRAPHIC COMPOSITION

Age	N	%
Less than 20 years	15	2.9%
20-24 years	37	7.2%
25-34 years	125	24.5%
35-44 years	93	18.2%
45-54 years	125	24.5%
55-69 years	60	11.8%
Over 60 years old	55	10.8%
Race		
White/Caucasian	416	81.3%
Black/African-American	55	10.7%
American Indian/ Alaska Native	14	2.7%
Unspecified/Other	22	4.2%
Hispanic Origin		
Yes	28	5.5%
Gender		
Male	316	61.7%
Female	196	38.3%

TABLE 1.5
POINT-IN-TIME HOUSING STATUS & LOCATION

Housing Status	N	%
On the street	51	10%
Emergency shelter	46	9%
Transitional housing	106	20.7%
Hotel or motel	20	3.9%
Hospital or jail	3	0.58%
Treatment facility	43	8.4%
Permanent supportive housing	132	25.8%
In my own private dwelling, being evicted within one week	2	0.39%
With a friend or relative	99	19.3%
In some other homeless situation	10	1.9%
Location	**N**	
Benton County	155	30%
Washington County	357	70%

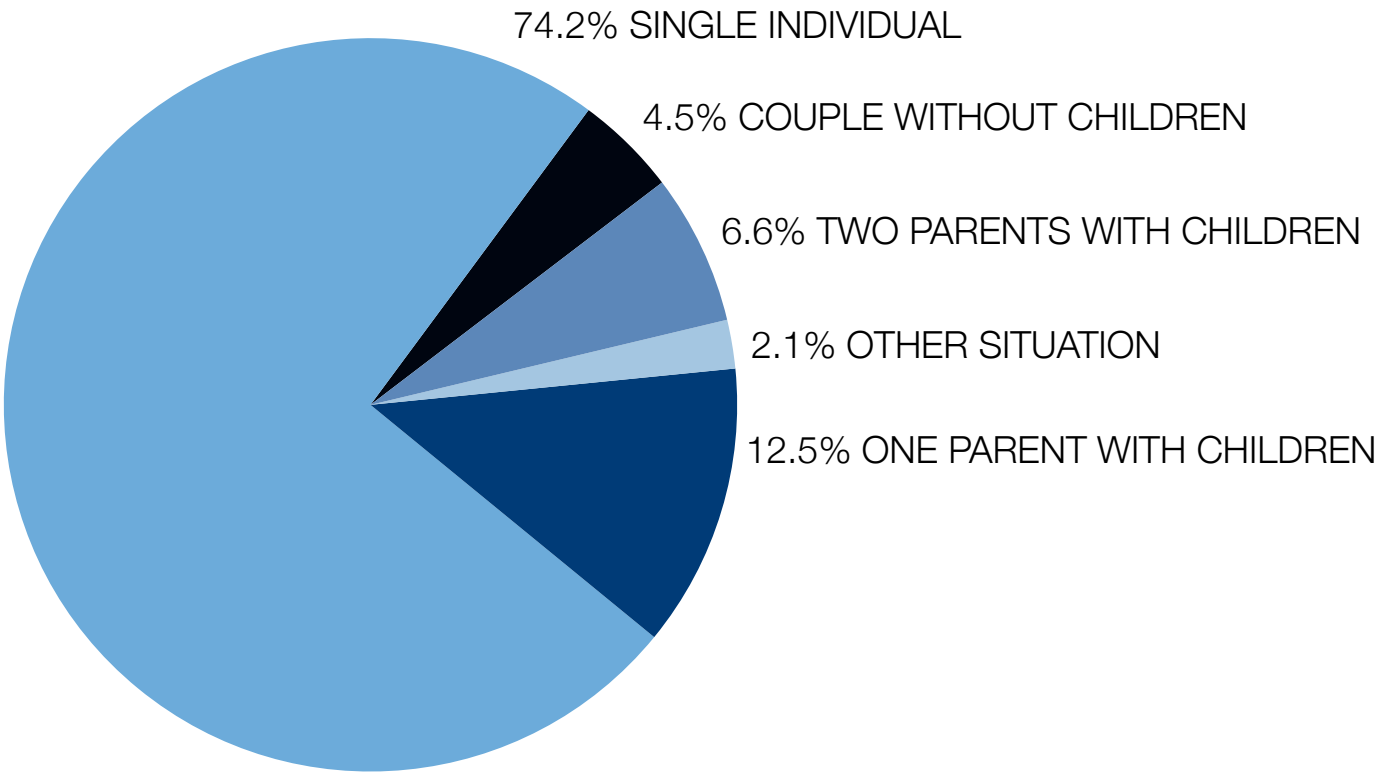
Where do homeless adults in Northwest Arkansas stay?

Respondents to the PIT census survey were asked where they spent the previous night. The results are presented in Table 1.5. Ten percent of those surveyed reported staying in an outdoor location (a tent, a car, or some other location). Fifty-five percent of the persons interviewed said they had spent the previous night in one of three types of housing essential to a Continuum of Care: Emergency shelter (9%); transitional housing (20.7%); and permanent supportive housing (25.8%). Just under one-quarter (19.3%) reported staying with a friend or relative. Seventy percent of respondents told interviewers they spent the previous night at some location in Washington County (70%) versus Benton County (30%).

What is the family structure of homeless persons like?

Approximately 13 percent of homeless adults in Northwest Arkansas reported being "coupled" (e.g. married; boy/girlfriend). Notably, a significant majority (74%) of homeless adults in Northwest Arkansas reported being single on the day of the PIT census. Nevertheless, nearly 20 percent of those interviewed had dependent children--the majority of which were staying with them at the time of the census.

FIGURE 1.1
POINT-IN-TIME
FAMILY STRUCTURE



How often, and for how long, are people homeless?

In addition to being asked where they stayed the previous night, homeless respondents were also asked about the duration of their most recent homeless episode, as well as how many homeless episodes they had experienced in the three previous years. Table 1.6 presents the results from these two census questions.

For the entire sample, the median duration of homelessness for the most recent episode was approximately 150 days (5 months); nearly two-thirds of those respondents sampled in the PIT were homeless for less than a month. In addition, the majority of respondents (55.6%) were experiencing homelessness for the first time; only 23 percent of this year's census respondents had been homeless once or twice before. Overall, the average number of homeless episodes was 1 episode.

TABLE 1.6
POINT-IN-TIME
FREQUENCY & DURATION OF HOMELESSNESS

Frequency of Homelessness (past 3 years)	N	%
First episode	285	55.6%
Second episode	53	10.3%
Third episode	63	12.3%
Fourth episode	35	6.8%
Five or more episodes	41	8.0%
Average homeless episodes (total)	1.07	
Duration of Homelessness (most recent episode)		
Homeless a month or less	320	62.5%
Median months homeless	5	

Chronic Conditions

A chronically homeless person is defined by the Department of Housing and Urban Development (HUD) as "an unaccompanied homeless individual (single) with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years" (HUD 2004). Chronically homeless persons are important to policy makers and service providers because they are a distinct group who tend to consume a disproportionate amount of available resources. Approximately 30 percent of persons interviewed met HUD criteria for "chronically homeless."

Table 1.7 presents the frequency of chronic conditions among those interviewed for the PIT census. The most common chronic condition experienced was mental illness, which was self-reported by nearly 44 percent of the sample.

The second most frequent chronic condition reported was substance abuse (39.6%) and third was physical disabilities and long-term illnesses (29.9%); nearly one in five respondents (17.6%) reported being victims of domestic violence (90%+ of whom were women).

Nearly 70 percent of the PIT interviewees reported at least one disability and more than half reported 2 or more chronic disabilities. This continues to be an important challenge for service providers as they attempt to deal not only with housing and everyday needs of the homeless population, but also the intensive case management challenges presented by chronically occurring conditions.

TABLE 1.7
POINT-IN-TIME
CRONIC & DISABLING
CONDITIONS

Type of Condition	N	%
Substance Abuse (alcohol or drug)	203	39.6%
Physical Disability or Long-term Illness	153	29.9%
Mental Illness	225	43.9%
Domestic Violence	90	17.6%
Developmental Disability	37	7.2%
HIV/AIDS	1	0.2%

Veterans

In recent years, the veteran status of homeless persons has become an increasingly important issue in the United States. More than one-third of homeless adults interviewed for the Northwest Arkansas PIT census were veterans of the United States armed forces. Homeless veterans in Northwest Arkansas share many of the demographic characteristics, experience many of the same disabilities, and face many of the same housing challenges as veterans living in other parts of the country.

The vast majority of homeless veterans interviewed were male (92.5%), white (79.3%), and middle-aged (more than half were over the age of 45). The age distribution of veteran status is particularly notable because it suggests that a large number of Northwest Arkansas homeless veterans are from the Vietnam era. (A 22-year old veteran in 1973 would be 65 years old in 2015. More than 71% of all homeless persons interviewed between the ages of 55 and 59 were veterans.)

Table 1.8 highlights an important part of the story of homeless veterans, not only in Northwest Arkansas, but around the country. More than 80 percent percent of the homeless veterans interviewed for the PIT census reported at least one disabling condition, and 31 percent met HUD criteria for chronic homelessness.

TABLE 1.8
POINT-IN-TIME
VETERAN CONDITIONS &
HOUSING STATUS

Veterans	Conditions	Non-Veterans
59.1%	Substance Abuse	29.2%
60.2%	Mental Illness	35.1%
3.2%	Domestic Violence	26.3%
4.8%	Developmental Disability	8.8%
28%	Physical Disability	31.7%
Veterans	**Housing Status**	**Non-Veterans**
0.5%	Emergency Shelter	14.1%
20.4%	Transitional Housing	21%
1.6%	Hotel/Motel	5.3%
53.8%	Permanent Supportive Housing	9.7%
8.6%	Friend/Family	24.8%
5.9%	Unsheltered	12.5%
7.5%	Treatment Facility	9.1%

Veterans reported significantly higher rates of substance abuse and physical disability than non-veterans.

Service Use & Need

An important part of understanding the climate of need among the homeless in Northwest Arkansas is tied directly to the services they receive and the services they require. Table 1.9 shows what services respondents were currently receiving on the day of the census, as well as the services they felt they needed but were not receiving. Food assistance (70.6%), case management (52.8%), and mental health services (39.9%) were being received by relatively large numbers of homeless adults in Northwest Arkansas.

Relatively few of those interviewed reported receiving services that have been determined to be vitally important for maintaining a homed status, for example, emergency assistance (7.2%), child care assistance (4.3%), and rent/utility assistance (9.4%).

In addition to documenting the frequency with which the homeless are utilizing services, Table 1.9 also highlights important gaps in service delivery. For example nearly 37 percent of homeless adults said that they need transportation assistance but were not receiving it, while only 20 percent said they were currently receiving those services. Likewise, there were a few other instances where the number of people in need of services outpaced the number of people who reported receiving them.

While these gaps are of particular importance to the provider network and should be carefully examined when planning programming and services in the future, these gaps have narrowed since 2013. In fact, Table 1.9 may be showing us for the first time since doing the PIT in 2007, that these service gaps have been closed or are much narrower than years past.

Undoubtedly, there were a number of service provision successes, where the number of people who reported receiving services was substantially larger than the number of those who were in need of services but were not receiving them. These findings suggest that the service network in Northwest Arkansas is performing more efficiently when it comes to meeting the homeless population's need for substance abuse treatment, case management, food assistance, and first aid/medical treatment.

"THE SERVICE GAP BETWEEN USE AND NEED IS NARROWING BUT THERE ARE SEVERAL CRITICAL NEEDS (TRANSPORTATION, MEDICAL AND CLOTHING) THAT ARE STILL GOING UNMET."

TABLE 1.9
POINT-IN-TIME
SERVICE USE & NEED

Type of Assistance	Currently receiving service	Need service, not receiving it
Case Management Services	52.8%	7.6%
Child Care Assistance	4.3%	6.1%
Clothing Assistance	27%	22.1%
Deposit Assistance	16.4%	14.1%
Developmental Disability Services	4.3%	4.1%
Emergency Assistance	7.2%	8.6%
Emergency Shelter	11.9%	5.3%
First Aid/Medical Treatment	32.9%	19.2%
Food Assistance	70.6%	15.9%
Housing Placement Services	29.5%	21.7%
Job Training/Employment Assistance	23.1%	17%
Legal Services	14.5%	15.3%
Life Skills Training	27.6%	6.8%
Medication Assistance	42.2%	19.4%
Mental Health Services	39.9%	12.1%
Physical Disability Services	11%	6.8%
Substance Abuse Treatment	26.4%	6.1%
Transitional Housing	23.7%	9.6%
Permanent Supportive Housing	25.8%	11.7%
Transportation Assistance	20%	36.8%
Other Services Not Listed	5.7%	5.1%

CHAPTER

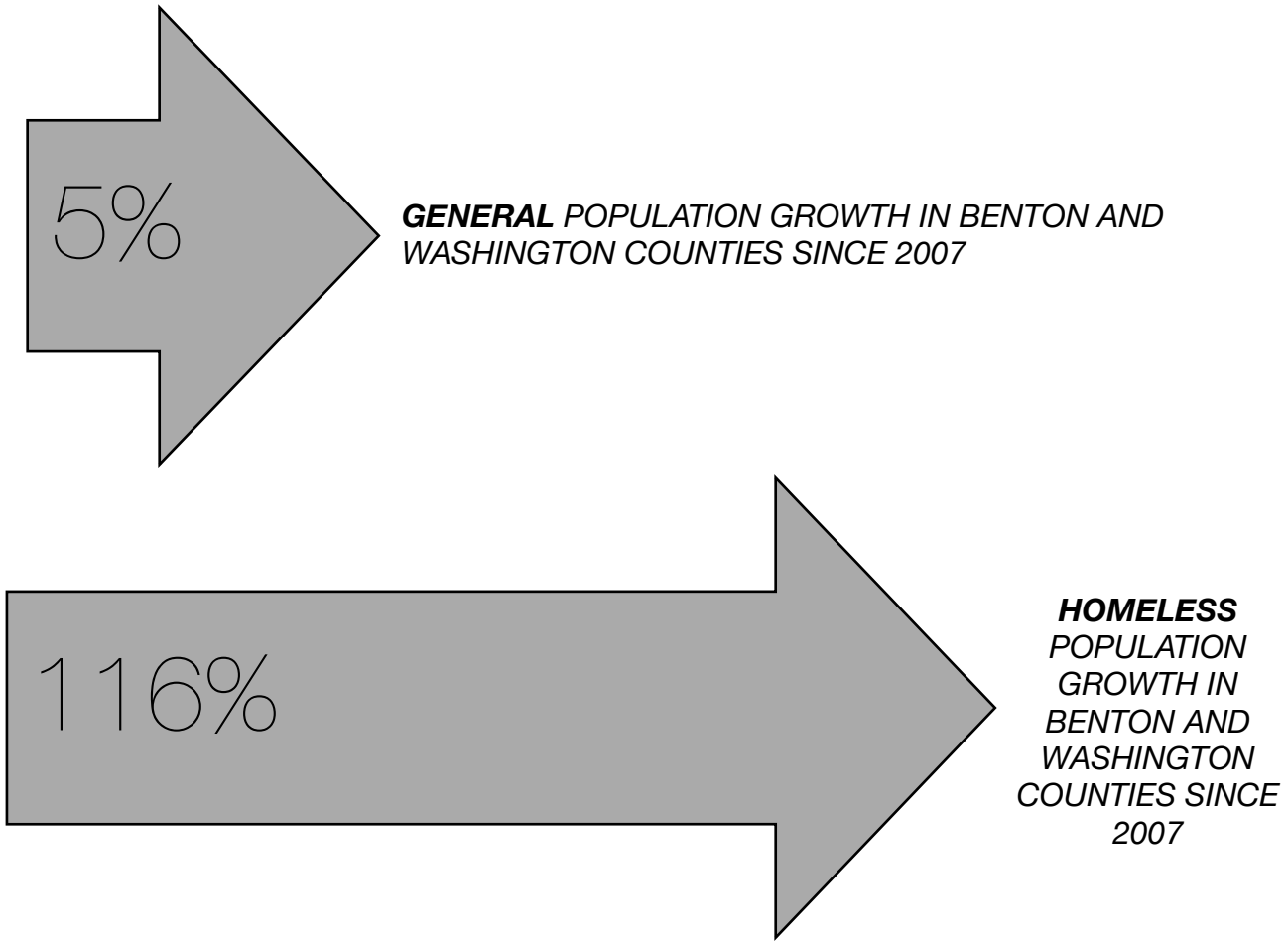
TWO

Northwest Arkansas Homelessness Overtime: PIT 2007-2015

CHAPTER TWO

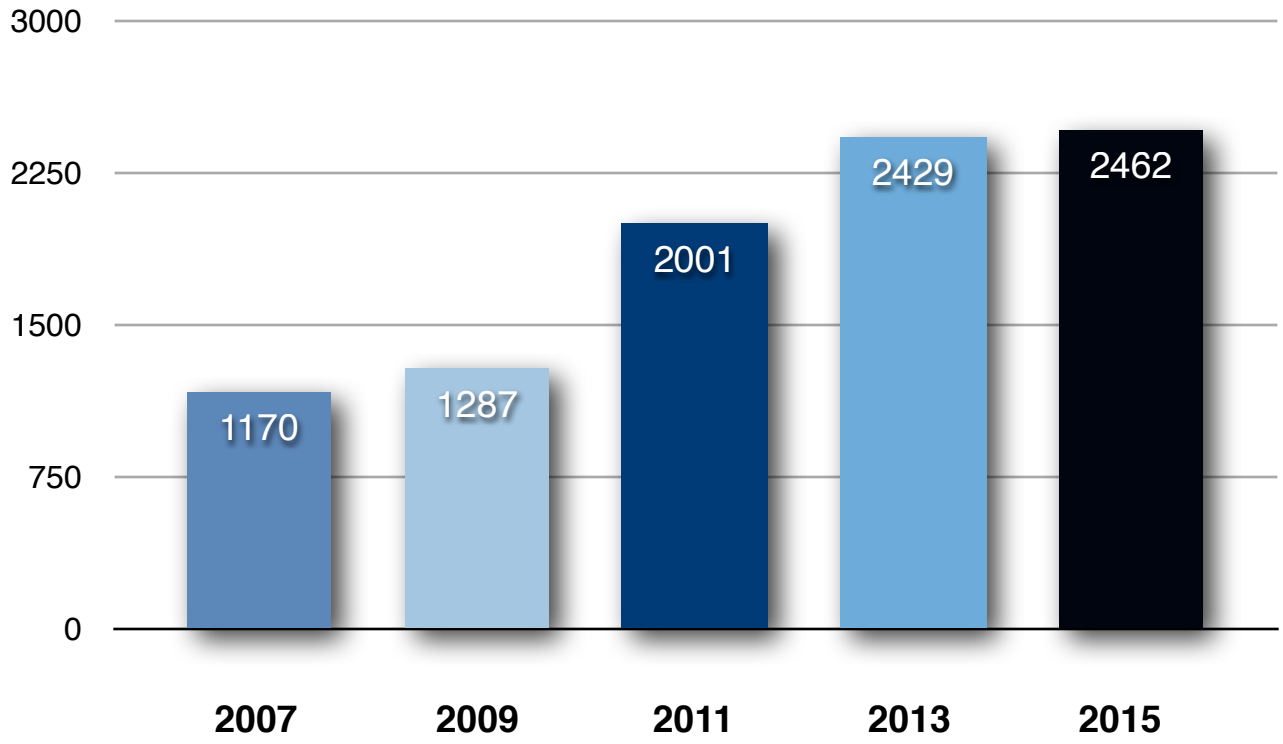
The 2007 Point-in-Time (PIT) homeless census was the first of its kind to be administered in Northwest Arkansas using standard PIT assessment protocols and a clearly defined catchment methodology. How to count the homeless, counting both street and sheltered homeless, and the specific locations and shelters to do the counting were all critical questions that needed to be addressed prior to the administration of the census. Using the same instrument and methodology from 2007, the 2015 PIT census was completed on January 30, 2015. This fifth PIT provides another important part of carefully tracking the growth/decline of homelessness, the changes in the social and demographic composition of the population, as well as a variety of living circumstances and service needs of the homeless population living in Washington and Benton Counties.

FIGURE 2.1
2007 & 2015 POINT-IN-TIME AND GENERAL
POPULATION GROWTH COMPARISON



On the following pages in Chapter 2, we examine changes in the homeless population between 2007-2015. Our interest is in trying to further document shifts in the population already noted in earlier reports. Clearly, the number of homeless persons has increased in the last eight years. Nevertheless, we want to look more carefully at how homeless persons' living circumstances have changed. Beyond documenting the changes in where homeless persons are staying and with whom, perhaps the most significant shift in the last eight years has been the growth in the overall population which climbed by 116 percent while in comparison, the general population growth in Benton and Washington Counties only increased by 5 percent. This dramatic upswing in the numbers of homeless persons in these two counties remains cause for concern (see Figures 2.1 and 2.2).

FIGURE 2.2
2007 & 2015 POINT-IN-TIME
ESTIMATE OF HOMELESS PERSONS 2007-2015



Of course all the categories have increased since 2007. The dramatic increase in the K-12 population continues to be an important part of the story of homelessness in Northwest Arkansas. The data in Table 2.1 reveals an important part of the story of homelessness in Washington and Benton Counties over the past 8 years. Of all the numbers presented, perhaps the most telling is the one in the bottom row of the table: total number of homeless persons. A large part of this increase is attributable to a single demographic group: youth under the age of 18. Since we began examining the number of K-12 students in the Washington and Benton County school districts we have seen that population nearly triple. While the 2015 PIT interviewed more than 500 adults, we note that there were nearly four times the number of children living with respondents compared to 2007 (139 vs. 31).

TABLE 2.1
2007 & 2015 POINT-IN-TIME
TOTAL COUNT

Data Source	2015	2007
Survey Responses: Homeless Adults and Accompanying Youth		
Adults (18 years and over, responded to survey)	512	285
Youth under 6 living with respondents, not present for survey	139	31
School-Age Youth and Parents/Guardians		
School-age youth reported by school districts	1,195	493
Parents/guardians of youth attending schools*	563	199
Estimate of Invisible Homeless**	53	162
TOTAL NUMBER OF HOMELESS (counted + estimated)	***2,462***	***1,170***
Notes * Projection of adults accompanying youth enrolled in local schools who reported “doubling up” with friends or relatives. ** Projection based on survey respondents who reported staying with friends and family.		

Demographic Composition

As seen in Table 2.2, the sociodemographic composition of the homeless adult population adults was similar in 2007 and 2015. The median age of the adult homeless population in 2007 was 41 years of age, compared to a median of 44 years of age in 2015. The population is clearly aging with a significant shift in the age categories from 45-54, 55-59, and 60 and older.

Between 2007 and 2015 there was little change in the percentage of homeless adults who identified themselves as White/Caucasian or Black/African American. In addition, the percentage of homeless adults who reported Hispanic heritage nearly doubled between 2007 (3.9%) and 2015 (5.5%) albeit a small number to begin with.

In 2007, as in 2015, there was a marked gender imbalance among homeless adults, with men far outnumbering women.

The gender gap among Northwest Arkansas Homeless mirrors national estimates; nevertheless, that gap narrowed slightly over the last eight years.

TABLE 2.2
2007 & 2015 POINT-IN-TIME DEMOGRAPHICS

Age	2015	2007
Less than 20 years	2.9%	6.6%
20-24 years	7.2%	12.3%
25-34 years	24.5%	27.4%
35-44 years	18.2%	26.3%
45-54 years	24.5%	24.2%
55-59 years	11.8%	2.5%
Over 60 years old	10.8%	0.7%
Race		
White/Caucasian	81.3%	89.1%
Black/African-American	10.7%	7.4%
American Indian/ Alaska Native	2.7%	2.5%
Unspecified/Other	4.2%	1%
Hispanic Origin		
Yes	5.5%	3.9%
Gender		
Male	61.7%	62.5%
Female	38.3%	37.5%
N=	***512***	***285***

Living Circumstances

Northwest Arkansas is limited in the types of housing that are available to women only or women with children. While several facilities have recently expanded to accommodate more women and women with children (e.g. 7Hills Transitional program, Havenwood, and Peace at Home), there remains a gap in service delivery to this population that will need to be addressed as the number of women with children at risk for homelessness are increasing.

Several notable changes in the housing status of homeless persons have taken place since 2007. First, the percentage of respondents using emergency shelter declined by nearly twenty-six percent. Meanwhile, the frequency with which homeless persons were making use of transitional and permanent supportive housing facilities has been an important shift in opportunity. In 2007, there were no permanent supportive housing opportunities for homeless persons. Now, in 2015, nearly one-quarter of the homeless adults interviewed in the PIT were taking advantage of permanent supportive housing through the work of 7Hills Homeless Center and the Veterans Administration in partnership with HUD. Taken together, these data may serve as evidence that the Northwest Arkansas Continuum of Care (housing component) is expanding and growing to better accommodate changes not only in population needs but also in terms of service provider realignment.

The family structure of homeless persons (Table 2.3) also has also changed since 2007 in that there has been a considerable decline in the number of homeless persons with children. Nevertheless, families with children still represented nearly one-quarter of all family units in 2015. Keeping in mind that Table 2.3 only represents persons interviewed as part of the PIT, because when we add the "invisible homeless" into the number of families with children, that percentage of homeless with children skyrockets.

TABLE 2.3
2007 & 2015 POINT-IN-TIME
HOUSING & FAMILY STATUS

Housing Status	2015	2007
On the street	10%	9.1%
Emergency shelter	9%	37.2%
Transitional housing	20.7%	14%
Hotel or motel	3.9%	2.1%
Hospital or jail	0.58%	---
Treatment facility	8.4%	17.5%
Permanent supportive housing	25.8%	---
In my own private dwelling, being evicted within one week	0.39%	2.1%
With a friend or relative	19.3%	17.9%
In some other homeless situation	1.9%	---
Family Structure		
Two parents with children	6.6%	6.4%
One parent with children	12.5%	22.8%
Couple without children	4.5%	5.7%
Single individual	74.2%	65.1%
Other Situation	2.1%	---

As seen in Table 2.4, the average number of homeless episodes and the median months a person was homeless were virtually unchanged between 2007 and 2015. However, there were significant differences in the percentage of persons who were homeless for the first time; an increase of almost 12 percent. Of course this change was accompanied by a smaller percentage of homeless persons who reported multiple episodes; persons reporting 3-5 episodes in the last three years declined between 2007-2015.

Comparing Service Need

Table 2.5 compares service needs among homeless adults in 2007 and 2015. By far, housing placement assistance and transportation assistance were most frequently needed in both 2007 and 2015. Importantly, however, there was a doubling in the percentage of homeless persons that needed clothing assistance in 2015 compared to 2007. What is encouraging is the comparison of emergency, transitional, and permanent supportive housing service needs between 2007-2015. In all three cases, those needs and were down significantly and this clearly speaks to the improvement by the continuum to meet the diverse housing needs of the homeless population in Northwest Arkansas. Most of the medically-related services remained relatively stable between the two prime points; first aid and medical treatment continues to be a challenge for this underserved population.

One finding that is encouraging is that needed case management services declined by almost 10 percent between 2007 and 2015--perhaps an indication of the service provision network realizing how important this piece is to successfully transition people off of the street and into permanent housing.

TABLE 2.4
2007 & 2015 POINT-IN-TIME FREQUENCY & DURATION

Frequency of Homelessness (past 3 years)	2015	2007
First episode	59.4%	47.4%
Second episode	11.1%	8.1%
Third episode	13.2%	15.4%
Fourth episode	7.4%	12.3%
Five or more episodes	8.6%	14.5%
Average homeless episodes (total)	1.07	----
Duration of Homelessness (most recent episode)		
Homeless < 1 month	33.3%	32.3%
Median months homeless	5	4
N=	***512***	***285***

TABLE 2.5
2007 & 2015 POINT-IN-TIME
SERVICE NEED COMPARISONS

2015	Type of Assistance	2007
7.6%	Case Management Services	17.4%
6.1%	Child Care Assistance	12.1%
22.1%	Clothing Assistance	10.2%
14.1%	Deposit Assistance	NA
4.1%	Developmental Disability Services	3.8%
8.6%	Emergency Assistance	21.6%
5.3%	Emergency Shelter	5.7%
19.2%	First Aid/Medical Treatment	14%
15.9%	Food Assistance	12.9%
21.7%	Housing Placement Services	36%
17%	Job Training/Employment Assistance	37.5%
15.3%	Legal Services	20.1%
6.8%	Life Skills Training	17%
19.4%	Medication Assistance	21.2%
12.1%	Mental Health Services	13.3%
6.8%	Physical Disability Services	7.6%
6.1%	Substance Abuse Treatment	6.4%
36.8%	Transportation Assistance	34.5%
11.7%	Permanent Supportive Housing	28.8%
9.6%	Transitional Housing	33.7%
5.1%	Other Services Not Listed	6.4%
512		***285***

As noted in Chapter 1, understanding the chronic conditions of the homeless population is an important part of understanding the service delivery network and which specific conditions are influencing persons who cannot break the cycle of homelessness.

As reported in Table 2.6, between 2007 and 2015, self-reported substance abuse among homeless adults declined by 5 percent. Unfortunately, the percentage of people reporting physical disabilities increased by nearly 12 percentage points, and there was also a jump in the rate of domestic violence victimization, which is concentrated almost exclusively among women.

Over one-third of the population is chronic, based on the standards outlined by HUD. The increase in the percentage of chronic homeless is troublesome and needs to be addressed as the Continuum of Care begins to examine more carefully what is keeping people on the street and how that cycle can be interrupted.

TABLE 2.6
2007 & 2015 POINT-IN-TIME CHRONIC & DISABLING CONDITIONS COMPARISON

Type of Condition	2015	2007
Substance Abuse (alcohol or drug)	39.6%	46.4%
Physical Disability or Long-term Illness	29.9%	17.2%
Mental Illness	43.9%	23.7%
Domestic Violence	17.6%	12%
Developmental Disability	7.2%	5.5%
HIV/AIDS	0.2%	1.1%
N=	***512***	***285***

Homeless Veterans

As seen in Table 2.7, between 2007 and 2015 there was a significant increase - from 16 percent to 39 percent - in the number of homeless adults who reported prior military service. While the number of homeless veterans living in Benton and Washington Counties increased since 2007, the average frequency of homeless episodes within this group (roughly 2 episodes in the past 3 years) did not change. More encouraging still, there was a significant decline in the average duration of homeless episodes among veterans, from nearly 2 years to just over 18 months.

While there was no appreciable change in rates of substance abuse, domestic violence, or HIV/AIDS among homeless veterans, there were dramatic increases in rates of mental illness among homeless veterans between 2007 and 2015.

Finally, in Table 2.7 we can see significant changes in housing status for veterans. In 2007, nearly 20 percent of veterans reported living outside and that number has dropped to 6 percent in 2015. Because of recent changes in several shelters around the area, and the addition of the 7 Hills supportive housing unit, along with the HUD/VASH program, veterans are being placed in more permanent settings. Our data indicates that their emergency shelter use was nearly eliminated as transitional housing and permanent supportive housing became a more viable option for veterans--another sign that the network delivery system is both responding to and better understanding who it needs to serve.

"VETERAN HOMELESSNESS CONTINUES TO BE A CHALLENGE IN NWA WITH SIGNIFICANT INCREASES IN CHRONIC CONDITIONS FOUND AMONG THIS PART OF THE POPULATION"

TABLE 2.7
2007 & 2015 POINT-IN-TIME VETERAN CONDITIONS & HOUSING STATUS

2015 Veterans	Conditions	2007 Veterans
59.1%	Substance Abuse	54.5%
60.2%	Mental Illness	18.2%
3.2%	Domestic Violence	4.5%
28%	Physical Disability	22.7%
4.8%	Developmental Disability	5.4%
	Housing Status	
0.5%	Emergency Shelter	59.1%
20.4%	Transitional Housing	4.5%
1.6%	Hotel/Motel	0%
53.8%	Permanent Supportive Housing	NA
8.6%	Friend/Family	4.5%
5.9%	Unsheltered	18.2%
7.5%	Treatment Facility	13.6%
186 (36.8%)		***44 (16.1%)***

CHAPTER

THREE

INTERVIEWS WITH 168 HOMELESS ADULTS: SOCIODEMOGRAPHICS & RESIDENTIAL HISTORY

CHAPTER THREE

The Intensive Survey

The intensive interviews gathered extensive information on the demographics, residential histories, current and recent habitation, duration of homelessness, causes of homelessness, stressful life events and everyday life experiences and challenges, personal income and financial sources, criminal victimization, social networks and social supports, mental and physical health, access to medical care and preventive health services, health risks and risky health behavior of homeless adults. The time for completion of the surveys averaged 45 minutes.

The Intensive Survey Sample

The sample size for the intensive survey was **168**. The sampling objective of the intensive interview phase of the study was to obtain a representative sample of the Northwest Arkansas area's "highly visible" homeless adults (age 18 and older). The January 29-30, 2015 point-in-time survey provided the sampling frame to accomplish this objective.

Using this information, for the design of the intensive survey sample, the shelter and day-site locations were treated as sampling clusters, along with a proportional balance between the two counties. Each location or "cluster" was targeted for a number of interviews based on its proportional representation to the total number of homeless counted during the point-in time census in January, 2015.

For instance, if Shelter A had 5 percent of the area's homeless, then 5 interviews (5% of 168) were obtained from that shelter. In addition, quotas were computed based on the point-in-time data, for race, gender and county. For example, if 50 percent of the population were white females, then they were targeted for those interviews (50% of 168). Once on site, with very few exceptions, respondents were selected randomly, using a procedure that randomized demographic features such as gender, as well as other variables. The resulting cluster sample produced a representative cross-section of the Northwest Arkansas area homeless population stratified by race, gender, site location, and county.

Response Rate for the Intensive Interviews

Of the **168** people approached for interviews, fewer than 10 persons walked away or refused to engage before the interviewers could introduce themselves and explain the intent of the project. No respondents refused participation after the interviewer introduction. Thus, the response rate was 158 of 168, or 94 percent. A response rate of 94 percent is exceptionally high for a walk-up interview.

As Table 3.1 shows, the actual sampling quotas were very close to the original planned targets. In a few cases, (unsheltered, permanent supportive housing) we either oversampled or under-sampled these groups but for the most part were very successful in matching targets to actual interviews obtained.

TABLE 3.1
POINT-IN-TIME & INTENSIVE SURVEY
DEMOGRAPHIC PAIRINGS

County	Target %	Actual %
Washington	30%	30%
Benton	70%	70%
Housing Status		
On the street	11%	17%
Transitional	21%	24%
Emergency Shelter	11%	11%
Permanent Supportive Housing	23%	13%
Treatment Facility	10%	6%
Friends or Family	19%	23%
Hotel or Motel	4%	5%
Race		
White	80%	74%
Non-white or mixed race	20%	26%
Gender		
Male	60%	64%
Female	40%	36%

Demographic Composition

Based on the in-depth surveys of 168 adults, the median age of respondents was 44 years; nearly three out of four adult respondents (73%) were between the ages of 25 and 54. Men comprised 64 percent of the survey respondents; they were generally older than women with a median age of 50 years compared to 35 years for women. Because women had a much greater probability of being in one-parent family arrangements, they also were more likely to be accompanied by children (34% to 5%). Men were more likely to reside on the streets (24% to 5%). In general, men on average spent slightly longer amounts of time homeless (130 weeks vs. 96 weeks).

Race and Ethnicity

Seventy-four percent of respondents were Caucasian/White and 12 percent were African-American with the remaining 14 percent comprised of other race/ethnic categories. In a separate question from race, 4 percent of respondents said they were Hispanic.

Educational Level

Respondents generally reflected educational levels of the general population of Arkansas except that a relatively small percentage of homeless persons (about 6%) completed a college degree. About 64 percent of our sample completed a high school diploma and/or had taken some college courses, and 5.4 percent had acquired a trade school or business school certificate. Approximately 24 percent had less than a high school diploma.

FIGURE 3.1
IN-DEPTH INTERVIEWS
EDUCATION & MARITAL STATUS

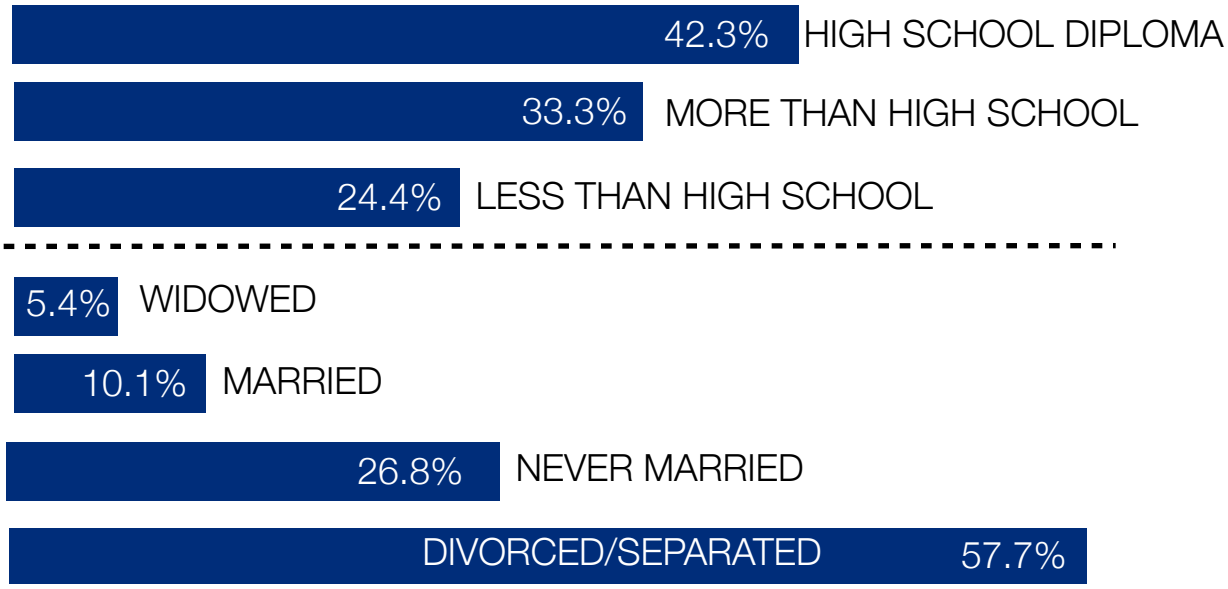
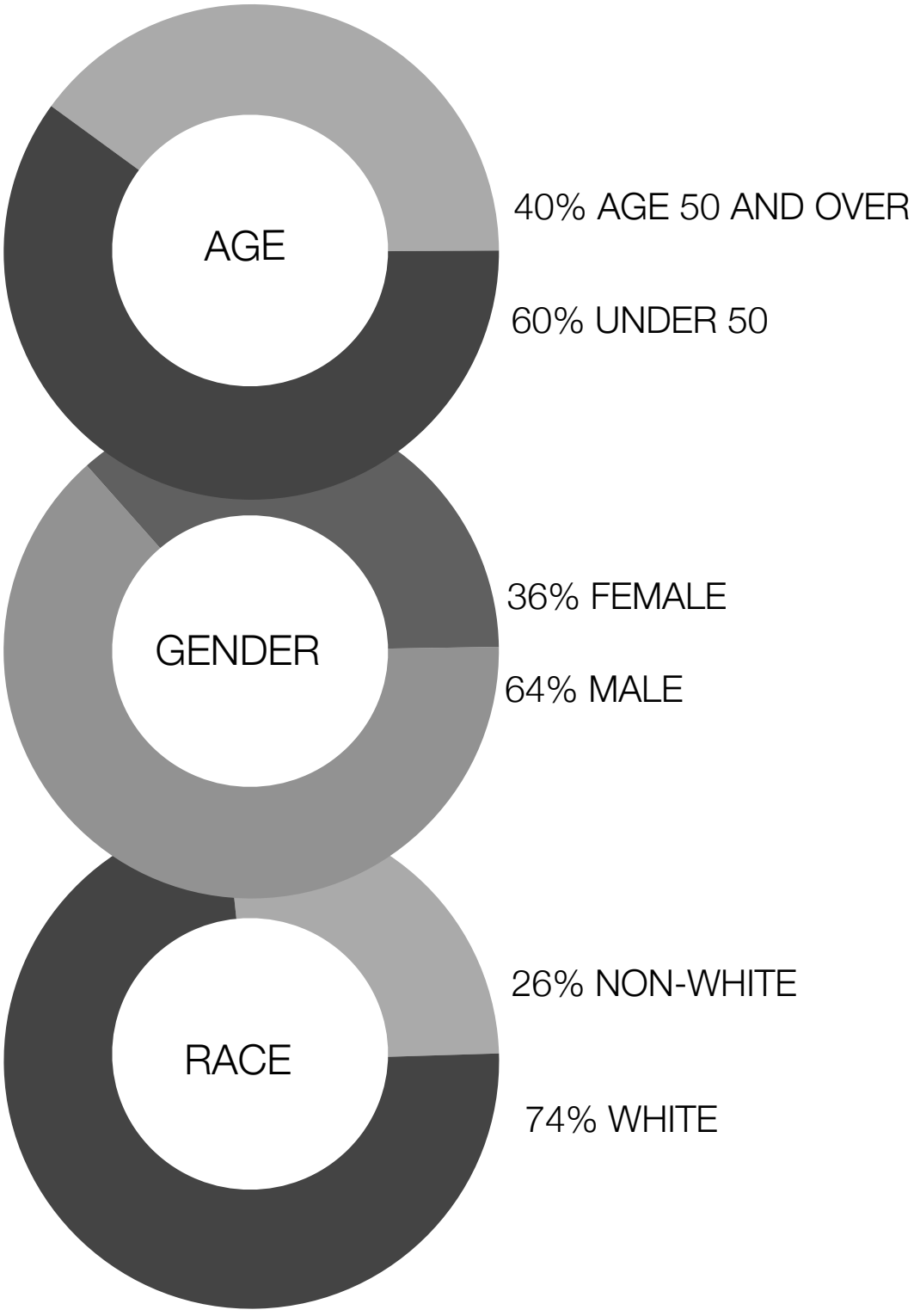


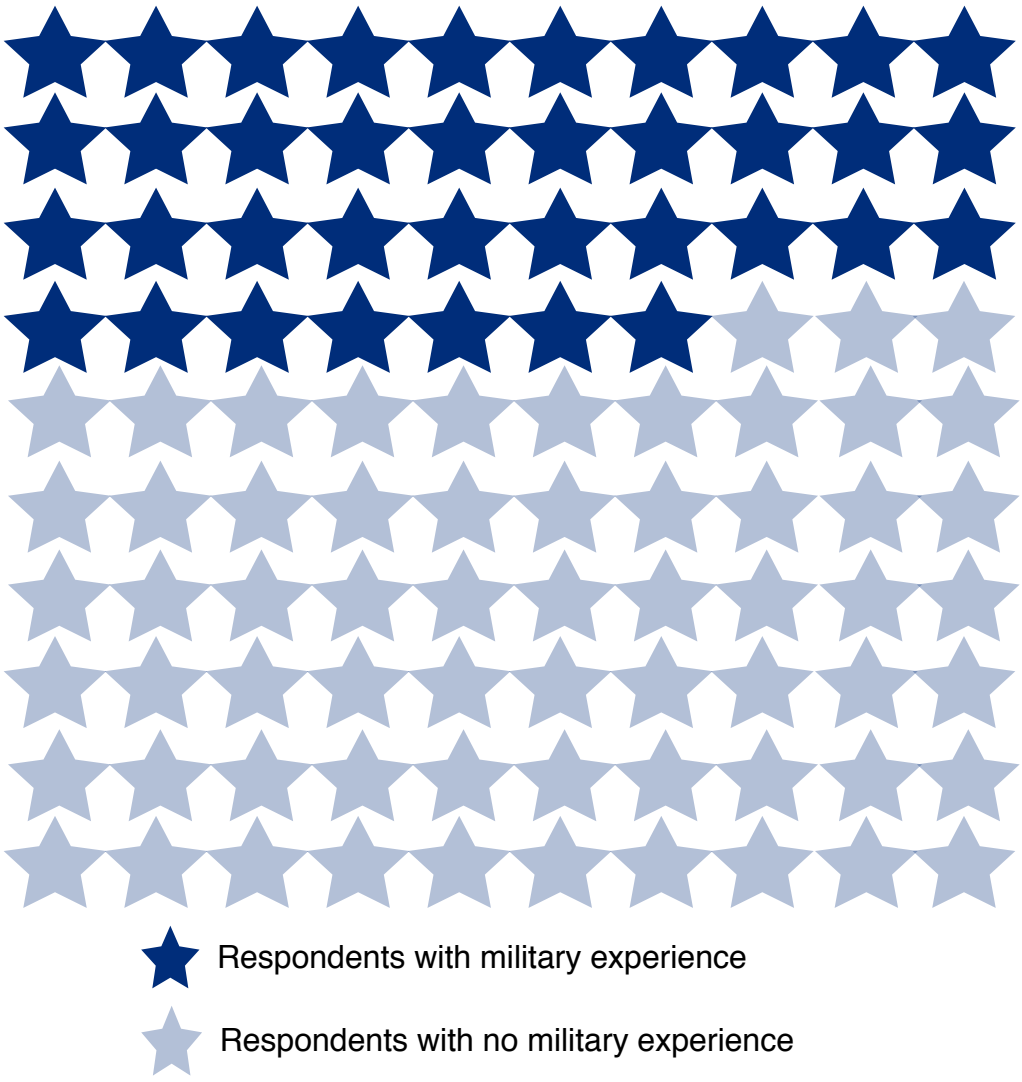
FIGURE 3.2
IN-DEPTH INTERVIEWS
DEMOGRAPHIC CHARACTERISTICS



Military Experience

In both the point-in-time count and in-depth survey, about 37 percent of respondents reported that they had served in the military. These veterans also tended to be older. Their average age was 50 years compared to 43 years for non-veterans. From the in-depth interviews, just over 40 percent of military veterans stated that they had served in combat; all but 11 of the veterans were male. Of all homeless men, 48.6 percent were veterans, of all homeless women, only 18 percent were veterans; 54 percent of veterans said they are currently receiving veteran's benefits.

FIGURE 3.3
IN-DEPTH INTERVIEWS
MILITARY EXPERIENCE



A National Problem Experienced by Locals

Homelessness is a national problem that is experienced in Northwest Arkansas by both locals and transients. The stereotypical portrait of homeless as transients coming to exploit the generosity of the local community is only partly supported by the intensive interview data. The distance traveled by these persons tends to be somewhat shorter than found in other studies around the country.

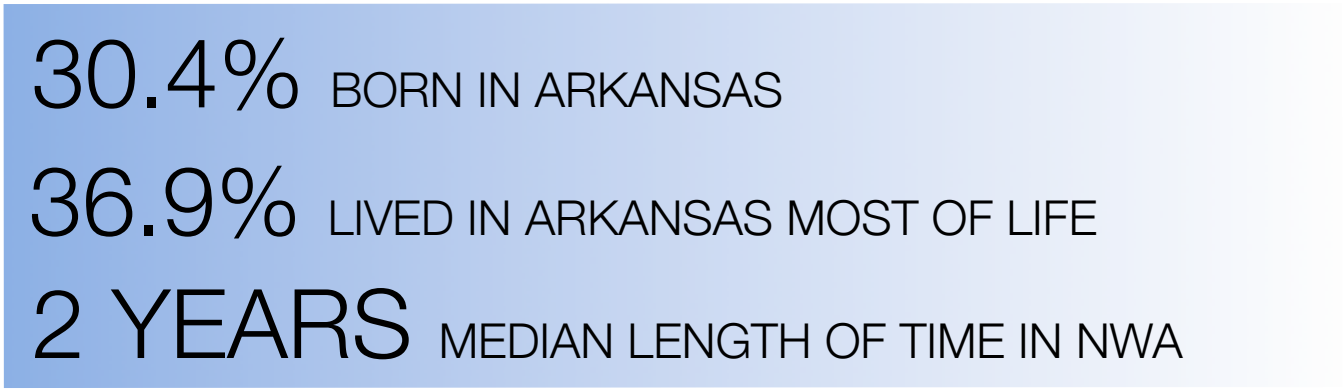
Just over thirty percent of survey respondents said they were born in Arkansas, and nearly 37 percent of the respondents said they lived in Arkansas most of their lives with the majority of respondents born within a six-state radius. Finally, nearly 40 percent have been in Northwest Arkansas for less than a year.

Movers vs. Non-Movers

The issue of whether or not homelessness is a local or a transient problem is of great political significance to local communities. That primarily local residents are experiencing homelessness suggests the critical need for local solutions. Homelessness being experienced by transients suggests a need to look more closely at who they are, where they come from, and why they are here. In either circumstance, an important question to ask is whether or not non-locals are really different from locals to begin with.

Homelessness is a problem faced by locals, but also in part, has been created and continues to be created by transients.

FIGURE 3.4
IN-DEPTH INTERVIEWS
ARKANSAS NATIVES



Mobility Among the Homeless

Although the homeless population is not entirely local in character, some individuals move periodically within the area to seek new opportunities or to address personal issues (seeking work, obtaining treatment for addiction, searching assistance from personal networks, etc.). This pattern is very similar to the mobility pattern of the poor generally. Poverty significantly reduces the economic, social, and psychological security of its victims. This insecurity leads to more frequent mobility. It is thus no surprise that in the last five years, 79 percent of homeless respondents had lived in two or more places.

TABLE 3.2
IN-DEPTH INTERVIEWS
LAST NIGHT VS. MOST FREQUENT SLEEPING PLACE

LAST NIGHT	PLACE	LAST 12 MONTHS
17.3%	ON THE STREET	25.6%
11.3%	EMERGENCY SHELTER	1.8%
23.8%	TRANSITIONAL HOUSING	12.5%
4.8%	HOTEL/MOTEL	2.4%
----	HOSPITAL OR JAIL	1.8%
6.5%	TREATMENT FACILITY	4.2%
13.1%	PERMANENT SUPPORTIVE HOUSING	11.9%
23.2%	WITH A FRIEND OR RELATIVE	25.6%
----	OTHER	14.3%

Current and Recent Habitation: Shelter vs. Street

Where do homeless people stay? As Table 3.2 indicates, 17 percent of the homeless population slept outside in camps, parks, abandoned buildings, cars, or other public places the night of the study. Not surprisingly, men are more likely to be found on the street than are women. In addition, whites are most likely to be on the street or living in treatment facilities.

Why Don't People Go To Shelters?

Street outreach programs are an essential part of any area's Continuum of Care. The Continuum of Care cannot work effectively, however, until homeless persons enter the shelter system and begin receiving case management. It is, therefore, important to know the reasons why some people do not enter the shelter system. The most common reasons respondents report usually involves something regarding the facilities; a lack of privacy, noise, safety for their things, and even having problems with other guests.

Duration of Homelessness

Another important dimension of residential history is the time individuals spend homeless. The median duration of homelessness reported in the survey was 52 weeks.

Compared to other studies, this length of time homeless is much longer (nearly 3 months longer than what we observed in Birmingham with a similar study in 2005 and the Fayetteville study in 2007). As the data indicates, nearly 70 percent have been homeless less than two years—there does not appear to be a large number in the census that report being homeless for very long.

Persons with disabilities such as substance abuse, mental or physical illness, etc. are faced with unique challenges that when compounded with the difficult circumstances of homelessness, can intensify the homeless experience and make it harder to resolve. Such people may, without significant professional and personal assistance, remain homeless indefinitely. While many programs exist to address these problems, it is important to determine whether the disability is related to the time an individual spends homeless.

Connections to the Community

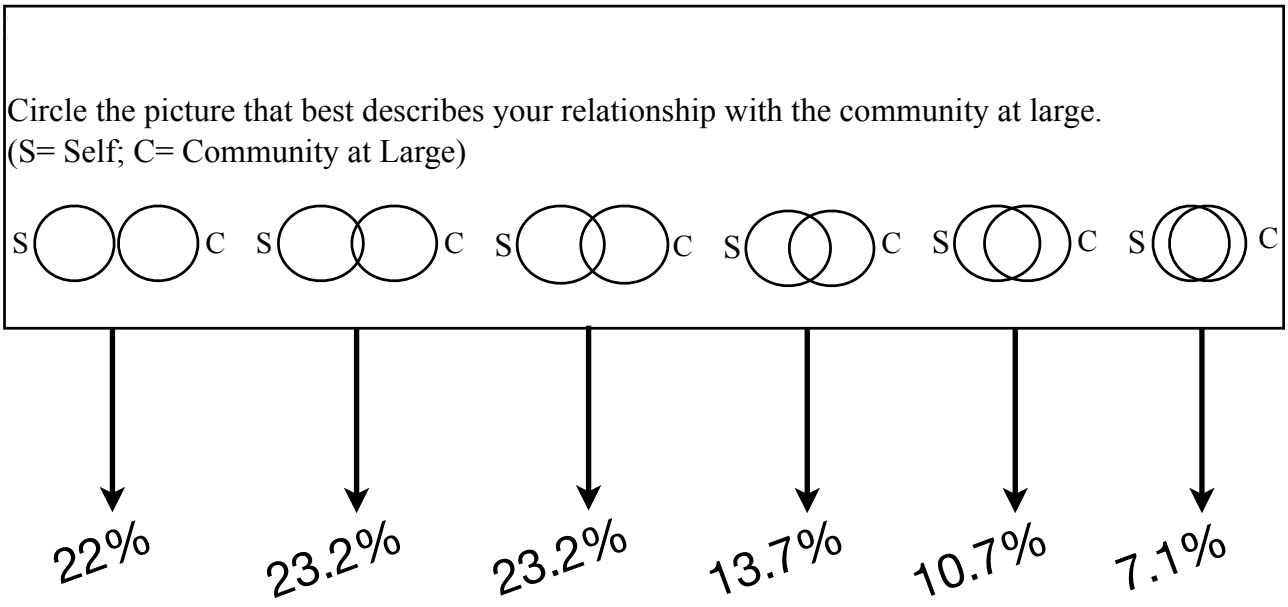
Whether locals or transients, we were interested in looking at how connected the homeless population feels to Northwest Arkansas. Connection to the community is important because feeling that one is part of a community fosters trust, communication, and a sense of belonging. Not only this, but those with a strong connection to the community are more likely to be invested in the community-that is to feel a sense of duty to uphold the values of the community as well as having respect for the physical environment of the community.

Conversely, feeling disconnected to the community breeds misunderstandings, alienation, and a sense of "otherness." Particularly for a group of homeless individuals, the stigma of their life circumstance has already put them at odds with traditional social expectations of what it means to be a member of a community. Do the homeless feel like they are members of this community? Do the homeless feel like they belong within this community?

The Inclusion of the Community in the Self Scale is a single item pictorial scale meant to tap several emotional and psychological elements of community sentiment. Respondents are asked to look at the scale (Figure 3.5) and to choose the picture that best represents their relationship with the community at large. In this case, the "community at large" is Northwest Arkansas. The series of circles comprising the scale range from completely apart at the far left, indicating the self and the community have no over-lap and the respondent therefore feels no sense of connection with the community, to almost completely overlapped, at the far right, representing a feeling of deep connection with the community.

The results, shown in Figure 3.5, indicate that the majority of the sample falls within the lower half of the connection scale (68.4%). While 22 percent feel completely disconnected, only 7.1 percent feel completely connected. Nevertheless, these data indicate that the homeless experience is varied and the perception of how persons feel connected to their community is hardly uniform.

FIGURE 3.5
IN-DEPTH INTERVIEWS
INCLUSION OF COMMUNITY IN THE SELF SCALE



CHAPTER

FOUR

LIFE ON THE STREET

CHAPTER FOUR

Given the complex problems faced by the homeless, it is important to explore measures that assess life on the street and the general quality of life. Homelessness is a devastating life circumstance that significantly challenges the well-being of persons experiencing it. The data in Figure 4.1 explore three quality of life indicators. The perception of danger in Northwest Arkansas is relatively low with just over 18 percent of respondents believing that Northwest Arkansas is very dangerous. However, homeless women were more likely to perceive Northwest Arkansas as dangerous than men (72.4% vs 37.2%), raising important questions about the gender gap in safety.

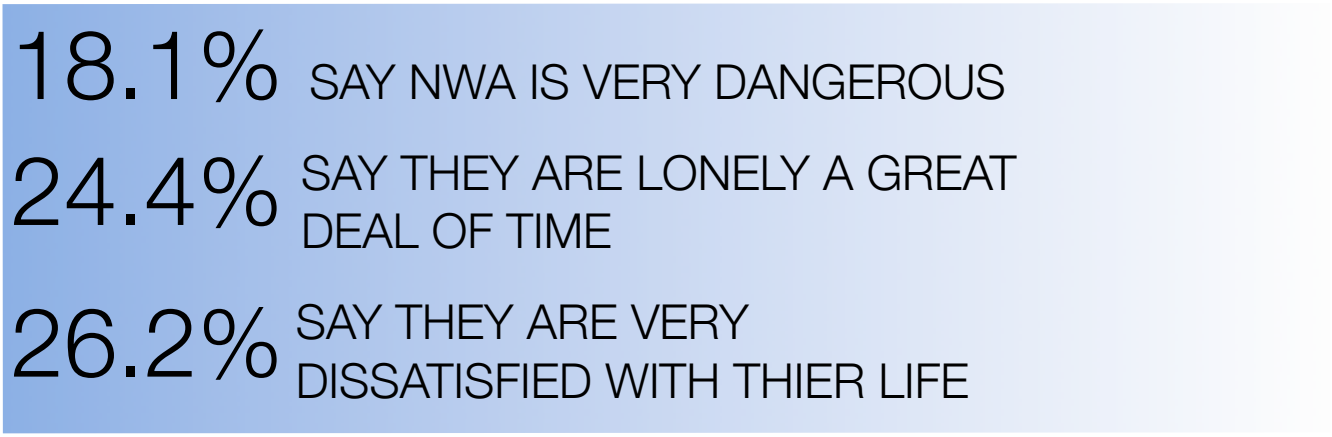
Nearly one quarter of the homeless interviewed reported feeling lonely a great deal of the time, while over one quarter reported being very dissatisfied with their life. Taken together, these quality of life measurements tell us a great deal about the individuals facing homelessness in Northwest Arkansas. With only three respondents reporting they are very satisfied with their life and are never lonely, we find that nearly the entire sample has experienced dissatisfaction and loneliness during their homelessness, if not as a result of their homelessness.

In this chapter, we will explore some of the issues that compound the problem of homelessness and dramatically impact a homeless person's quality of life.

Causes of Homelessness

There are as many causes for homelessness as there are homeless individuals and families in Northwest Arkansas. Homelessness is more complicated than simply being without a house to live in and there are many factors that contribute to a persons homelessness. For these in-depth interviews, respondents were asked

FIGURE 4.1
IN-DEPTH INTERVIEWS
QUALITY OF LIFE VARIABLES



why they were no longer living in a house, apartment, or house trailer. The responses are categorized in Table 4.1. Financial reasons were the number one contributor to homelessness; this includes no longer being able to afford rent or mortgage payments, increase in rent, or leaving to look for work.

Personal crises contributing to homelessness include divorce, separation, disputes or disagreements between other residents, and domestic abuse. Twenty-two percent of respondents cited this as the main reason they are currently without their own housing.

Perhaps the most telling sign that causes of homelessness cannot easily be identified is that nearly 34 percent of those interviewed cited 'Other' reasons as the main contributing factor to their homelessness. These responses varied greatly and included things such as custody disputes, family deaths, or run-ins with the law. Of course, any one of those events could eventually lead to a financial or personal crisis; however, this finding highlights the notion that addressing homelessness also requires addressing the complex web of social and personal problems that those on the precipice of homelessness are facing. For many respondents, several factors intertwined to create an especially complex set of problems leading to their homelessness.

It is often difficult for homeless persons to articulate why they are in the position they are in. Substance abuse, mental health, lack of affordable housing, and employment opportunities are all well-known reasons for persons being without their own home yet often are not mentioned when asked why.

TABLE 4.1
IN-DEPTH INTERVIEWS
REASONS CITED FOR HOMELESSNESS

Reason	% Citing Main Reason
Financial (could no longer afford place, rent went up, left to look for work)	33.3%
Personal Crisis (divorce, separation, could not get along with people there, domestic abuse)	22%
Spatial Change (lease ran out, evicted, place too crowded)	6.5%
Was bored/tired of last place	1.2%
Other reasons	33.9%

Daily Hassles of a Homeless Life

The daily life of those experiencing homelessness includes a struggle for resources that are perhaps taken for granted by those who have never faced homelessness. Table 4.2 and Figure 4.2 break down some of those problems.

First, respondents were asked a series of four questions about some of the problems they might have encountered as a result of their homelessness, including finding a place to sleep, getting clothes, finding a place to clean up, or getting enough to eat. The largest problem encountered was getting clothes, with nearly 30 percent reporting that they often have a problem with this. The least common problem reported was finding a place to clean up, with nearly 64 percent saying they never have a problem with this. This finding could be reflective of the growing number of transitional and permanent supportive housing facilities in Northwest Arkansas, as well as greater use of day centers in the area.

Next, respondents were asked a series of eleven questions about the problems encountered in the place they stayed the night before the interview. These categories reflect only some of the securities that having stable and adequate shelter often provide, including privacy and safety.

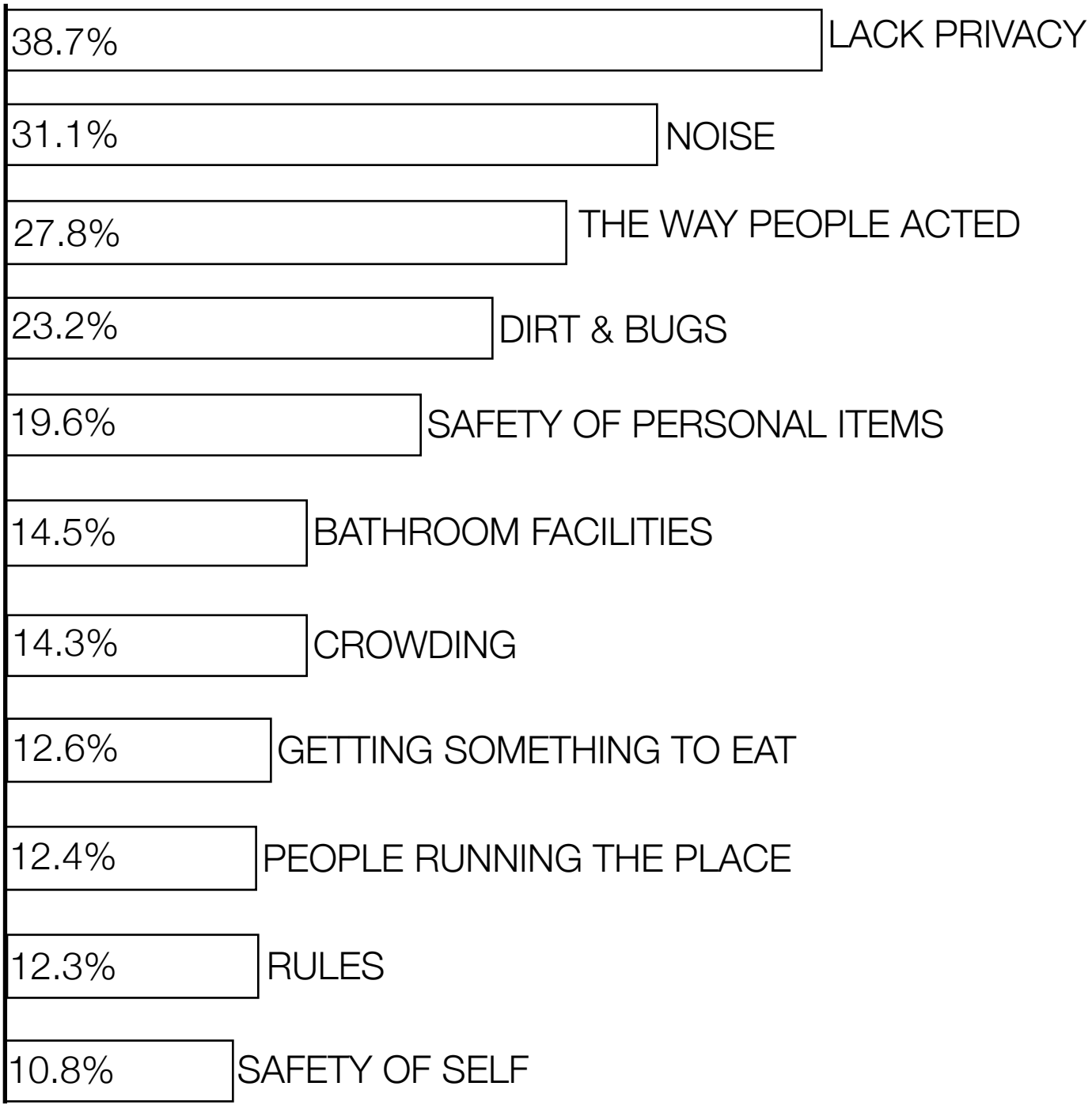
The most common daily hassles reported are the lack of privacy (38.7%), noise (31.1%), and the way other people staying there acted (27.8%). Interestingly, all of these problems, to some extent, are related to how a person perceives others as intruding or disrupting their living space.

The least common daily hassles encountered were safety of self (10.8%), the rules of the place where they are staying (12.3%) and the way the people running the place acted (12.4%).

TABLE 4.2
IN-DEPTH INTERVIEWS
PROBLEMS WITH BEING HOMELESS

% Never	Type of Problem	% Often
47.6%	Finding a place to sleep	26.2%
53%	Getting clothes	29.2%
63.7%	Finding a place to clean up	20.2%
54.2%	Getting enough to eat	26.8%

FIGURE 4.2
IN-DEPTH INTERVIEWS
DAILY HASSLES AT CURRENT LOCATION



Personal Income & Work

Having an income or being able to work are often compounded by many of the problems and hassles described above. When getting clothes and having adequate privacy are constant struggles, being able to maintain an appearance acceptable in many work places can be difficult, if not impossible.

The most common source of income (Table 4.3) for this homeless sample was full or part-time work. As we can see in Figure 4.3, nearly 37 percent reported working in the past week. Men were more likely to have worked in the past week compared to women (40% to 31%).

Social security and disability were also frequent sources of income, which is reflected in Figure 4.3 where we see that 36.8 percent of those who did not work in the past week cited poor health as the main reason. Incomes ranged between zero dollars and 4,000 dollars in the past month, with the median income being 600 dollars (Figure 4.4).

Figure 4.3 again echoes the notion that the causes for homelessness are extremely complex and varied. Nearly 30 percent of the sample cited 'Other' reasons for not working in the past week. These reasons went beyond the typical reasons listed- poor health, no work, lack of transportation- yet remained a large proportion of responses.

TABLE 4.3
IN-DEPTH INTERVIEWS
MAIN SOURCE OF INCOME

SOURCE OF INCOME	%
Full or part-time work	35.7%
SSI	10.1%
SSDI	8.9%
Have no income	8.9%
Other	8.3%
Friends or Relatives	7.1%
Other Disability	5.4%
Pension	4.8%
Panhandling	4.2%
Social Security	2.4%
TANF	1.8%
Selling things you made or owned	1.8%
Selling drugs	0.6%

Forty percent of respondents said they thought they were worse off economically now than they were a year ago.

FIGURE 4.3
IN-DEPTH INTERVIEWS
WORK IN THE PAST WEEK

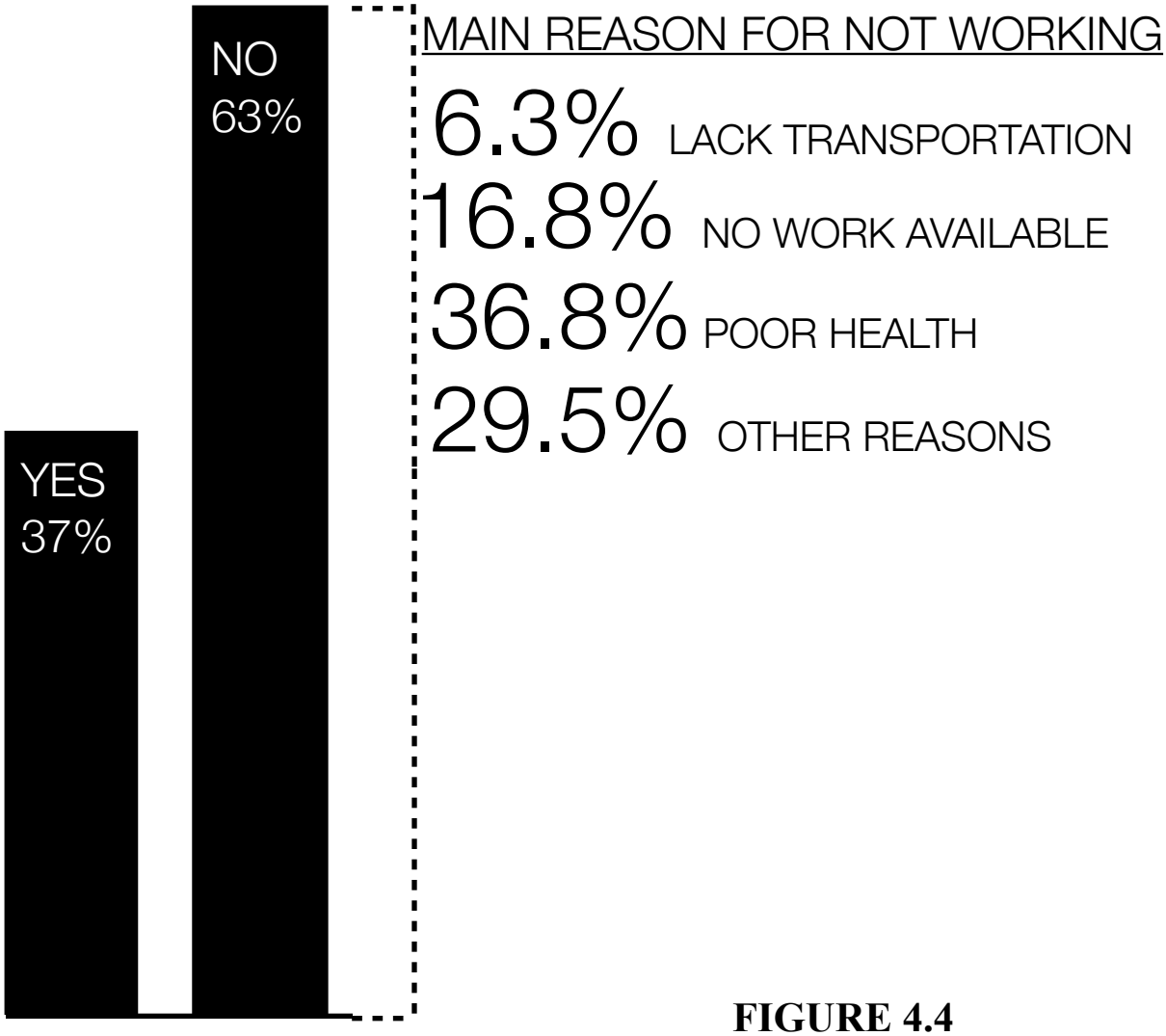


FIGURE 4.4
IN-DEPTH INTERVIEWS
TOTAL MONTHLY INCOME

$0-$4,000 INCOME RANGE REPORTED

$600 MEDIAN INCOME REPORTED

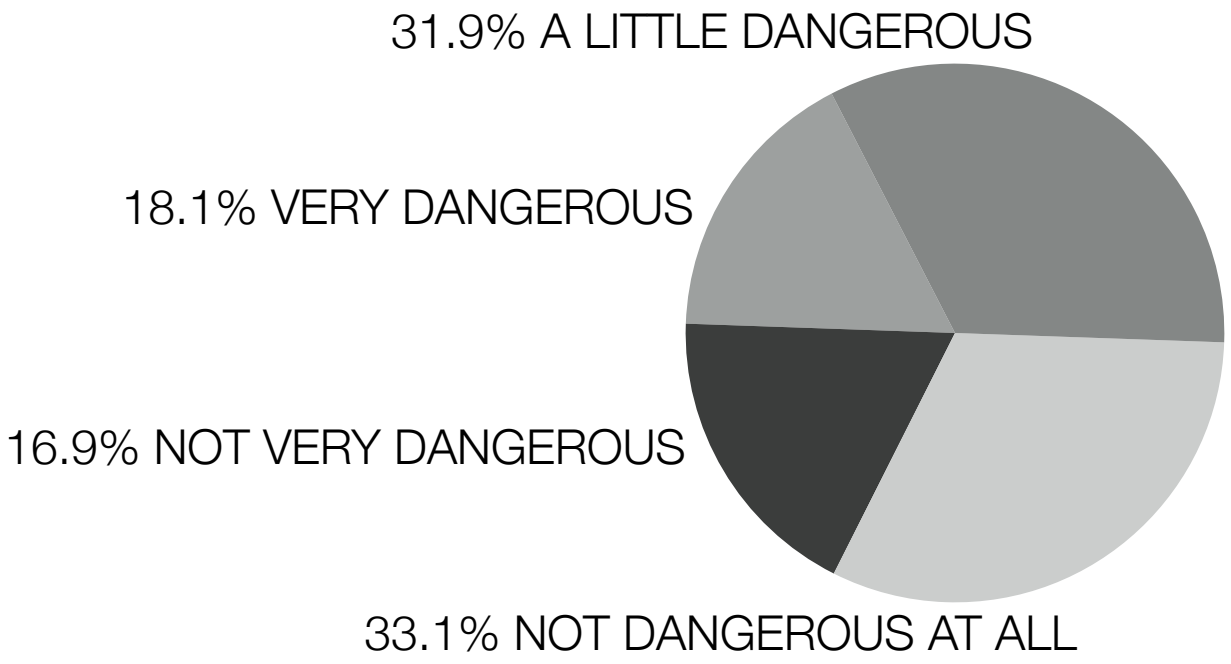
Crime & Violence Among the Homeless

PERCEPTION OF DANGER

The insecurities of a homeless existence go well beyond those of an inadequate income or limited support services. The challenge facing the homeless is particularly apparent when respondents are asked about their overall perceptions of safety and their general exposure to violence. Nearly eleven percent report problems with personal safety at the place where they stay, and nearly 20 percent report problems with keeping their belongings safe.

The perception of Northwest Arkansas as a dangerous place is a divided issue among the homeless. Fifty percent say that Northwest Arkansas is very dangerous or a little dangerous, while fifty percent say that Northwest Arkansas is not very dangerous or not dangerous at all. In 2007, 21 percent of the homeless saw Northwest Arkansas as a place that was not dangerous at all. This year, that number has increased to 33.1 percent. As noted before, the expansion of transitional housing and permanent supportive housing services has also increased in that time which could be contributing to greater stability and a decline in danger for many homeless in Northwest Arkansas.

FIGURE 4.5
IN-DEPTH INTERVIEWS
HOW DANGEROUS IS NWA?



VICTIMIZATION & WITNESSING VIOLENCE

The perception of danger was not completely unjustified, however; there appears to be some relationship between the perception of an unsafe environment and the personal experiences of the homeless. Table 4.4 reports respondents' exposure to violence both as victims and witnesses to specific crimes and criminal activity. Just over 20 percent say they were the victim of a robbery in the last six months. Sixteen percent report being the victim of a physical attack, while an additional 22.6 percent witnessed a physical attack in the last 6 months. Aside from being victims of or witnessing actual attacks and assaults, over 47 percent say they have witnessed someone carrying a weapon in the last 6 months, which could add to the perception of danger in many circumstances.

TABLE 4.4
IN-DEPTH INTERVIEWS
VIOLENCE EXPOSURE IN THE LAST 6 MONTHS

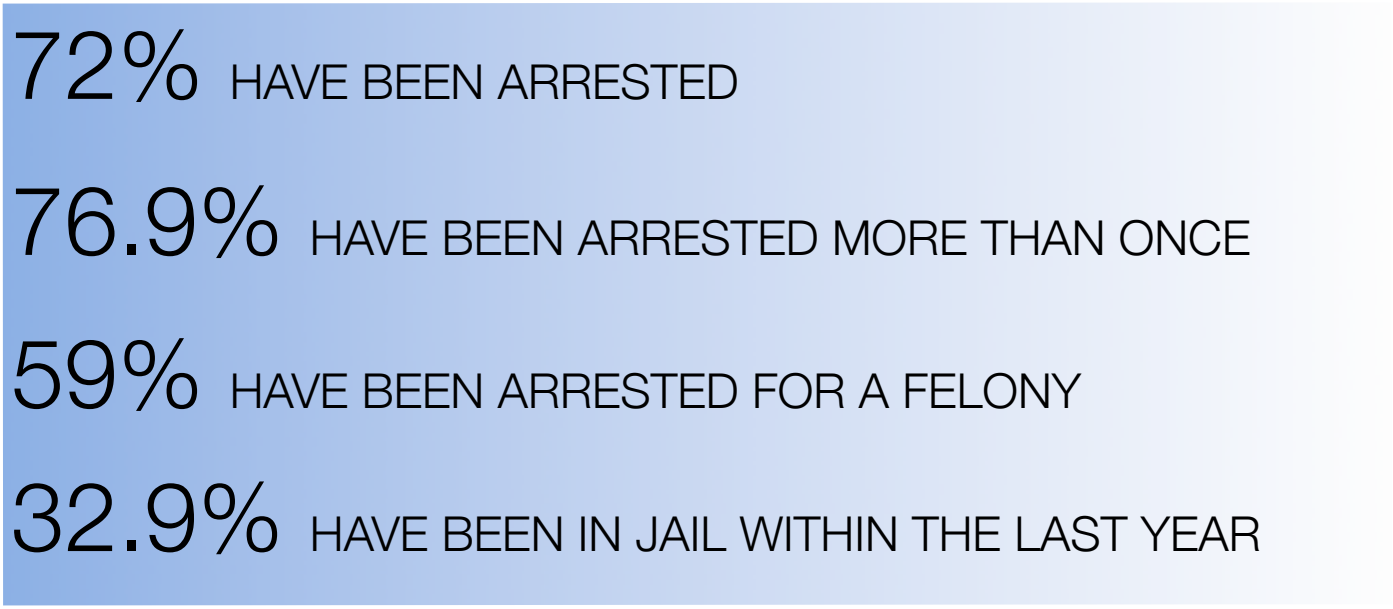
KIND OF ACTIVITY	
Victim of Robbery	20.2%
Victim of Physical Attack	16.1%
Victim of Sexual Assault	1.8%
Victim of Weapon Attack	5.4%
Witnessed Someone Carrying Weapon	47.3%
Witnessed Someone Being Attacked	22.6%
Witnessed Someone Being Assaulted with Weapon	8.3%
Witnessed Someone Being Killed	0.6%
Witnessed a Sexual Assault	0%

ARRESTS, JAIL, & FELONIES

Besides exposure to violence, the homeless, (particularly homeless men), are more likely than the general population to be arrested. Seventy-two percent of respondents had been arrested as an adult; 59 percent reported being arrested as an adult for a felony (Figure 4.6).

The extensive nature of arrests, however, might be partially explained by the unusual circumstances of a homeless environment. Privacy is at a premium for the homeless; indeed, the homeless live out much of their lives in public spaces or in spaces under constant surveillance. Hence, the deviant acts of homeless people are often more visible to police because in fact, many of their arrests are for offenses like drunkenness, vagrancy, trespassing, fighting, etc.- highly visible acts played out in the public arena. Thus, the higher arrest rates found among the homeless, at least in part, may result from spatial factors unique to the homeless situation.

FIGURE 4.6
IN-DEPTH INTERVIEWS
ARRESTS, JAIL, & FELONIES



Getting by in NWA

Given the struggles facing those who are experiencing homelessness, we wanted to know what life was like for the homeless in Northwest Arkansas. We asked the respondents to rate how easy or hard it is to get by in Northwest Arkansas. As we can see in

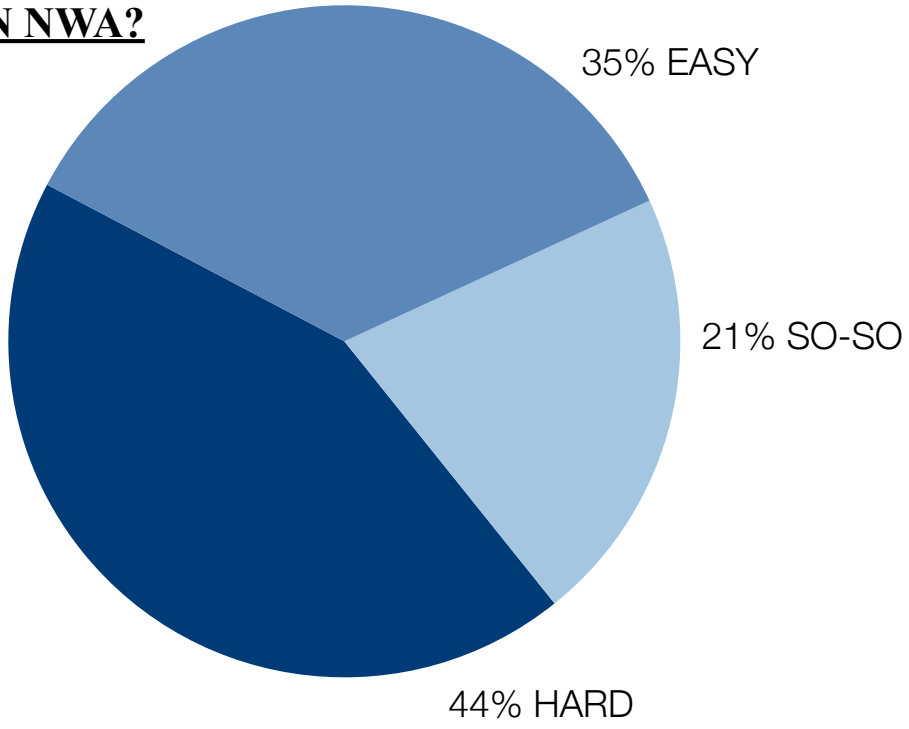
Figure 4.7, the majority of respondents said that getting by in Northwest Arkansas is difficult for a homeless person (44%). Women were more likely than men to say that it is hard to get by in Northwest Arkansas (50% to 40%), while men were more likely to say that getting by in Northwest Arkansas is easy (40% to 28%).

We see such gender disparities throughout this report: homeless women are more likely to have children staying with them, are more likely to perceive Northwest Arkansas as dangerous, and are less likely to have worked in the past week. By contrast, men were more likely to be veterans, more likely to have been arrested for a felony, and less likely to perceive Northwest Arkansas as dangerous. From these findings, we can clearly see that there is no one solution to improving the living conditions for those homeless in Northwest Arkansas.

Religious Affiliation

Religious affiliation and attendance of religious services plays an important role in navigating a homeless life. Many churches in Northwest Arkansas have food pantries and offer free meals, which facilitates a support network for the homeless. Some housing facilities and shelters in Northwest Arkansas also have a required religious component to them,

FIGURE 4.7
IN-DEPTH INTERVIEWS
HOW IS LIFE IN NWA?



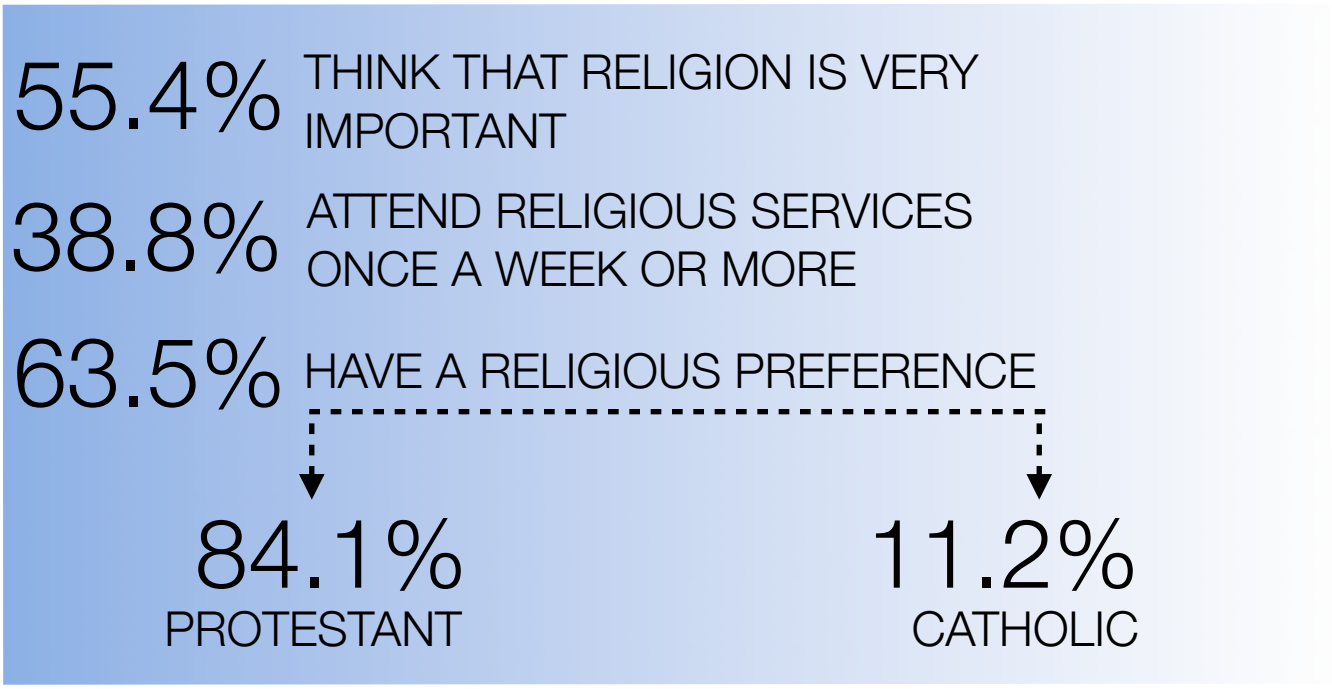
and many drug and alcohol support groups are affiliated with religious organizations. Nevertheless, we really wanted to know about the importance of religion outside of the service arena.

We asked respondents how important they think religion is, and 55.4 percent said that religion is very important to them (Figure 4.8). Additionally, nearly 40 percent say they attend religious services once a week or more. It could be the case that the services the homeless are attending are those required of them through the shelter or sobriety program they are attending. Still, 63.5 percent say they have a religious preference, suggesting that their religious affiliation is a matter of choice rather than circumstance.

Social Support

One important element to surviving daily life on the street is receiving help and support from friends and family. Respondents were asked if they had received money, advice, food, clothes, a place to stay, transportation, sick care, or other forms of support from friends and family in the past six months (Table 4.5). Friends and family both provided the most support in the form of advice, and the least support in the form of sick care. However, family were more likely to provide money, while friends were more likely to provide transportation.

FIGURE 4.8
IN-DEPTH INTERVIEWS
RELIGIOUS VARIABLES



Perhaps it is the intensive nature of sick care that dissuades friends and family from providing needed care. However, the hazardous nature of a homeless life put individuals and families at risk for needing long term health care and treatment.

Social Capital

Aside from religious affiliations and support from friends and family, we also look to other associations from which the homeless might derive social capital. Social capital refers to the extent of participation an individual has in voluntary associations with the community. While homeless persons are not generally thought of as participating in such associations, this study finds that the homeless identify sources of capital mostly through their connectedness to spiritual communities (35.7%), and family support groups (36.9%).

Perhaps less surprising is the finding that only two respondents (1.2%) reported being a member of a local or national political action group. This finding highlights the disconnect that often exists between the homeless and the community at large discussed in the previous chapter. Not only this, but it reinforces the need for the homeless to have advocates within the community, since they themselves are not voices of authority within the community or political landscape.

TABLE 4.5
IN-DEPTH INTERVIEWS
FRIEND & FAMILY SUPPORT

Family	Type of Support	Friends
37.5%	Money	33.9%
58.3%	Advice	63.1%
35.7%	Food	46.4%
22.2%	Clothes	25%
35.1%	Place to Stay	38.7%
29.8%	Transportation	41.1%
21.4%	Sick Care	17.3%

CHAPTER

FIVE

HEALTH AND WELL-BEING

CHAPTER FIVE

Well-Being

Homelessness is a devastating life circumstance that significantly challenges the well-being of persons experiencing it. Table 5.1 gives us a snapshot of six such well-being measures. First, the average number of stressful events is 5.48. These include things such as divorces, deaths, illnesses, arrests, etc. These could be events that contributed to their homelessness, or events that have taken place during their time on the streets, prolonging or exacerbating their homelessness.

Next, we see that the average mastery of fate score is 12.81. Mastery of fate is the sense of control one feels over their life. Scores lower than 15 indicate that the respondents feel they have little control over their life circumstance. Next, is the average CES-D score. CES-D is a measure of depression and a score of 16 or higher meets the criterion for clinical caseness. As seen in Table 5.1 this sample is clearly experiencing high levels of depression; most adult non-clinical averages are well below 16. Finally, the sample reported an average of nearly six physical health symptoms. The details of these physical health symptoms can be found later in this chapter.

TABLE 5.1
IN-DEPTH INTERVIEWS
SELECTED WELL-BEING VARIABLES

CHARACTERISTIC	
MEAN NUMBER OF LIFE EVENTS (EVER)	5.48
MEAN MASTERY SCORE	12.81
DEPRESSION (CES-D SCORE)	25.20
MEAN NUMBER OF HEALTH SYMPTOMS	5.98

Physical Health

The health of homeless people is typically worse than that of other populations, including those living in poverty but with established residences. The conditions of homelessness are widely recognized as health risk factors. Homelessness produces stress-related ailments, both physical and mental. Moreover, exposure to contagion in shelters, the harsh environmental conditions on the streets, and poor nutrition all contribute to poor health. In addition, compared to the general population, the homeless population experiences more risk factors related to health behavior and strained social relationships such as substance abuse, physical and sexual abuse, and victimization.

Self-assessed health status was measured by asking respondents "How would you describe your health right now?" Over 43.4 percent of respondents rated their health as good or excellent, yet the majority (56.6%) rated their health as fair or poor. In addition, respondents were over twice as likely to rate their health as poor than as excellent.

Physical Health Symptoms

A checklist of twenty-four physical symptoms was read to respondents and they were asked to indicate whether each symptom had been experienced in the past month. The results are presented in Table 5.2.

FIGURE 5.1
IN-DEPTH INTERVIEWS
REPORTED HEALTH STATUS

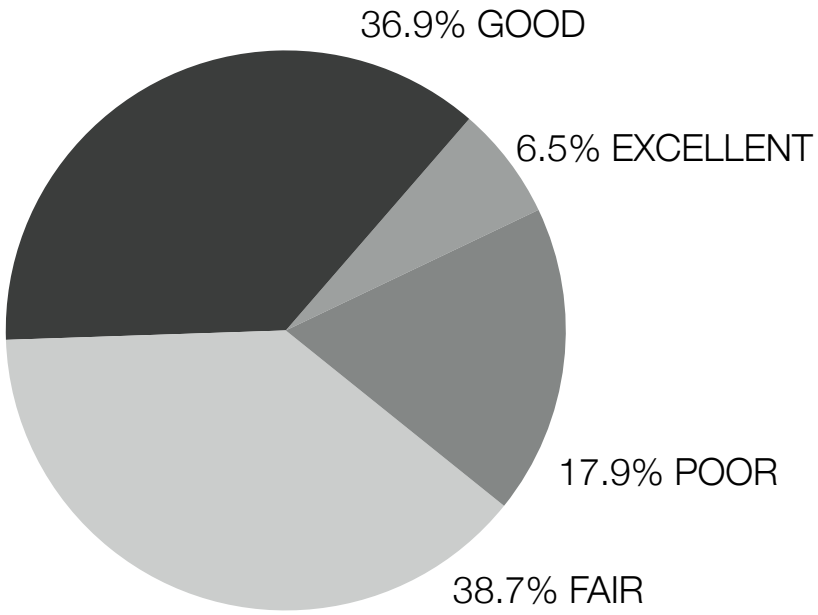


TABLE 5.2
IN-DEPTH INTERVIEWS
PHYSICAL HEALTH SYMPTOMS

Symptom	%
Stress Related Symptoms	
Lost or gained a lot of weight	40.5%
Frequent headaches	41.1%
Pain around heart or chest	20.8%
Heart beating hard or acting funny	24%
High blood pressure	46%
Fainting or blackout spells	11.9%
Respiratory Symptoms	
Sinus trouble, hay fever	45.2%
Sore throat or repeated cough	32.1%
Shortness of breath, trouble breathing	32.1%
Coughed up blood	2.4%
Musculoskeletal Symptoms	
Frequent backaches	47%
Painful or swollen joints, rheumatism	36.9&
Swelling of ankles	20.8%
Broken bones	14.3%
Foot trouble	28.6%

Symptom	%
Digestive/Urinary Symptoms	
Stomach cramps, sour stomach	34.5%
Serious gas pains	16.7%
Loose bowels often	16.1%
Pain, burning when using bathroom	11.4%
Sensory Impairment	
Seeing spots in eyes	20.8%
Earache, ringing in ear	31.5%
Double vision	14.3%
Other Symptoms	
Toothache	34.5%
Skin problems	24.4%
Diabetes	16.7%

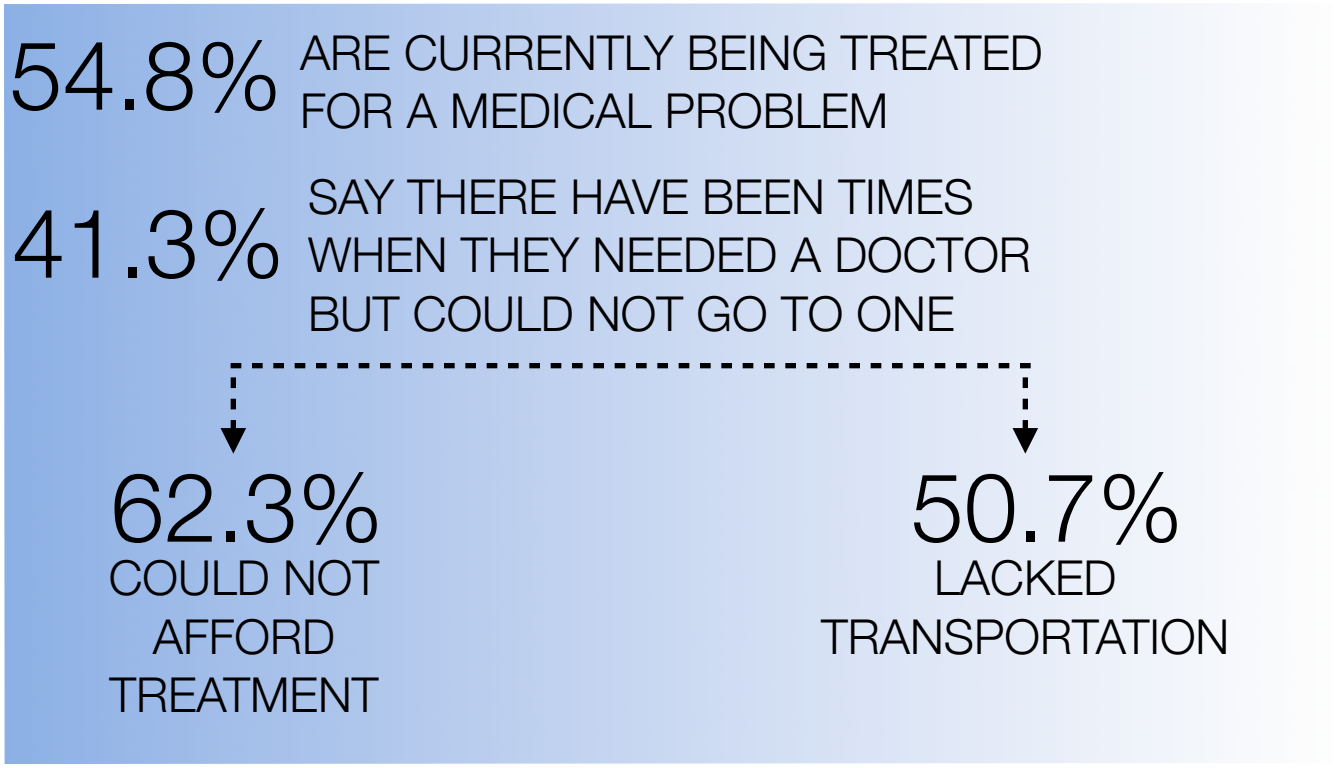
Frequent backaches (47%), high blood pressure (46%), sinus trouble (45.2%), and losing or gaining a lot of weight (40.5%), were the most commonly reported physical symptoms. These reflect the daily stressors, risky environments, and unstable access to resources that accompany homelessness.

Only nine respondents reported zero health symptoms (5.4%). Fifty-eight percent of the sample reported between one and six symptoms, while 35 percent reported seven or more symptoms. Clearly, the physical risks of homelessness are significant and are problematic for a population trying to get back on their feet.

FIGURE 5.2
IN-DEPTH INTERVIEWS
HEATH TREATMENT & ACCESS

Medical Care Utilization & Access

Over half of the sample reported being treated for a medical problem (54.8%), yet a large proportion reported that since their homelessness, there have been times when they needed a doctor but could not go to one (41.3%). When asked why they did not seek needed medial treatment, the top two answers were that they could not afford treatment (62.3%) and that they lacked transportation (50.7%) (note that percentages do not add up to 100 because respondents were able to give more than once response). Likewise the majority responded by saying they needed to see a dentist but the majority had not.



Homelessness is clearly both a contributor to poor health and an obstacle to seeking medical treatment when needed. From a policy perspective, these findings highlight the importance of medical care outreach in Northwest Arkansas. It is not enough to provide services in the community with the expectation that "they will come." Outreach programs must be developed in order to provide health services specially tailored to meet the needs of those without permanent residences, who are experiencing extreme poverty, and who, in many cases, lack transportation to even attend such events.

Controllable Diseases

Three diseases that are common in the United States, especially in the South, are hypertension, diabetes, and obesity. Recently, Arkansas has topped the list as the most obese state at a rate of nearly 36 percent. It is not surprising then that 38.7 percent of the sample is considered obese, with 28 percent being considered overweight. Additionally, 46 percent of the sample suffer from high blood pressure while 16.7 percent have been diagnosed with diabetes.

The prevalence of these diseases among the homeless in Northwest Arkansas reflect the harsh conditions and lack of access to regular health care that accompany homelessness. Homelessness complicates the management of hypertension and diabetes, while poor diet and restricted access to healthy foods contribute to obesity.

The treatment of these conditions can be very costly, yet preventative measures are relatively inexpensive and, thus, cost effective. Providing preventative care for the homeless would not only improve their heath and quality of life, but would be a cost-saving measure as well.

Drug & Alcohol Use

Respondents were asked if they had ever used any drugs, other than alcohol, to get high. Over 72 percent said yes. The most commonly used drug was marijuana. Respondents were also asked if they were currently using any drugs. Again, the most commonly used drug was marijuana.

Half of all those who said they had ever used drugs reported being arrested for using drugs. Additionally, 41.8 percent said they have been to a drug detox program and 52.5 percent said they have attended a Narcotics Anonymous meeting.

Over 42 percent of the homeless sample said they have drank alcohol in the past month. Of those who said they have drank in the past month, they averaged five drinks per month with most reporting they had one alcoholic drink in the past month (29.6%).

Just over half of the sample said that drinking had caused a problem for them (50.6%). Additionally, 58.6

percent say they have been through a detox program, 55.4 percent say they have attended an Alcoholics Anonymous meeting, and 45.8 percent said they have been arrested for drinking.

These results reflect the reality that many of those homeless with severe addiction problems were not currently using drugs or alcohol at the time of their interview. Some respondents were staying in substance abuse treatment facilities or sober living facilities, and therefore less likely to have consumed alcohol or used drugs in the past month. Thus, our findings show that the prevalence of attending rehabilitation services or having been arrested as a result of drug or alcohol use is much higher than the current use of drugs or alcohol as a whole.

"NEARLY ONE-THIRD OF RESPONDENTS SAID THEY LOST FRIENDS BECAUSE OF ALCOHOL; NEARLY HALF REPORTED BEING IN TROUBLE BECAUSE OF DRUGS OR ALCOHOL"

TABLE 5.3
IN-DEPTH INTERVIEWS
DRUG USE

% EVER USED	DRUG	NUMBER CURRENTLY USING
64.3%	Marijuana	22
33.3%	Cocaine	---
18.5%	Crack	1
23.8%	Speed	---
19.6%	LSD	---
13.1%	Heroin	---
8.3%	PCP	---
32.1%	Crystal Meth	2
12.5%	Prescription Pills	2
19%	Other	2

Mental Health

Aside from the physical toll that homelessness takes on a person's body, the mental exhaustion that can accompany a life of struggle is unmistakable. Thus, it is no surprise to note relatively high levels of mental health symptoms among the homeless. Sixty-three percent of the sample said they had experienced mental heath problems during their lifetime. Additionally, 62.3 percent are currently taking medication for a mental illness and 58.1 percent say they have spent time in the hospital for a mental illness.

In order to assess specific symptomatology, we use specific mental health symptom lists contained in the Brief Symptoms Inventory of BSI (Derogatis and Spencer 1982). Because of time limitations in the interview process, we assess only the presence of twenty-six symptoms over a month long period, but did not attempt to measure their intensity. The symptom list includes all the questions in the BSI for the following disorders: Anxiety, Phobic Anxiety, Hostility, Paranoia, and Psychosis. The average number of symptoms for each condition and the percentage of respondents reporting high symptom levels (four or more symptoms), are shown in table 5.4.

Anxiety consists of a set of symptoms that includes panic attacks, feelings of terror, nervousness and tension, and feelings of apprehension. The average number of symptoms reported was 2.35 and over 30 percent of the sample reported four or more symptoms of anxiety.

Phobic Anxiety includes symptoms of agoraphobia, including fear of open spaces and travel, uneasiness in crowds, avoidance

TABLE 5.4
IN-DEPTH INTERVIEWS
MENTAL HEALTH SYMPTOMS

Symptom	Average Number of Symptoms	% Reporting 4 or More Symptoms
Anxiety	2.35	30.3%
Phobic Anxiety	1.56	18.5%
Hostility	1.64	14.3%
Paranoia	2.37	30.3%
Psychosis	1.63	11.3%

behavior, and nervous feelings when left alone. The average number of phobic anxiety symptoms reported was 1.56 and 18.5 percent of the sample reported four or more of these symptoms.

Hostility dimensions of the BSI assess thoughts, feelings, or actions characteristic of deep seated anger, which manifests itself in qualities such as rage and resentment, irritability, and physical aggression. Respondents reported an average of 1.64 hostile symptoms and 14.3 percent of the sample reported four or more hostile symptoms.

Paranoia is associated with a distorted way of thinking and includes feeling that most people cannot be trusted, feeling that people will take advantage of you if you let them, feeling that others are to blame for you problems, and feeling that you are being watched or talked about by others. The sample averaged 2.37 symptoms of paranoia and 30.3 percent of the sample reported four or more symptoms of paranoia. It is important to remember that for the characteristics associated with paranoia, many of these symptoms could be healthy adaptive responses to a homeless environment.

Psychosis consists of five symptoms that include a continuum ranging from mild feelings of alienation (never feeling close to another person, feeling lonely even with other people) to dramatic evidence of psychosis (the idea that someone can control your thoughts, that something is wrong with your mind). The sample averaged 1.63 symptoms of psychosis and 11.3 percent of the sample reported four or more symptoms.

Depression

As noted earlier, the homeless population sampl exhibited high levels of depressive symptoms. A CES-Depression score of 16 and above is considered clinical casesness, and the sample averaged a score of 25. Still, questions remain about the link between depression and homelessness: 1) Is depression among the homeless a healthy response to an unhealthy situation; and 2) Are these measures that we are using tapping into the psyche of a depressed person or into a depressing condition?

Typical depressive symptoms include feelings of apathy, sadness, inadequacy, social withdrawal, fatigue, as well as sleep and appetite problems. Such symptoms may actually intensify the physical deprivations of the homeless condition, leading to chronic problem-solving difficulties, physical challenges, and long-term cycles of homeless episodes.

In addition to this, we found that 27.4 percent of the sample has had suicidal thoughts since being homeless and 33.3 percent of the sample say they have attempted suicide; over 60 percent who said they have attempted suicide did so while homeless.

CHAPTER

SIX

OBSERVATIONS & RECOMMENDATIONS

CHAPTER SIX

Homelessness is a costly social problem that impacts the productivity and well-being of individuals and the quality-of-life in communities. The costs imposed on those who experience homelessness as well as on surrounding communities are extensive. Homelessness impacts individuals and communities' physical, psychological, social, spiritual, and economic welfare. Thus, systematic attempts by communities to end homelessness benefit not only the homeless population, but the entire community as well. If Northwest Arkansas is to succeed in curtailing the homelessness problem, a number of basic steps should be taken.

Data Gathering and Analysis

An essential step in addressing any problem is gathering basic information on its nature and prevalence. For homelessness it is important to know basic things such as: the number homeless persons, their characteristics, the average duration of homeless episodes, basic needs, service use patterns, the causes of homelessness, the degree of interaction with mainstream service systems, and changes in any of these measures over time. It is also critical for the community to actively monitor its homeless management information system (HMIS), which provides a continuous record of homeless services provided. The HMIS system makes it possible to detect changes in usage over time and advance understanding about the ways in which people interact with systems of care, as well as the effectiveness of various interventions. While the data generated by the University of Arkansas Community and Family Institute in this report provide a clear picture of the nature of homelessness in 2015 and what types of changes have taken place since the first PIT in 2007, HMIS offers an additional method for monitoring individual and community progress in terms of its ability to provide detailed, reliable information on patterns of service use. Data from both this report and HMIS should continue to be incorporated into the community comprehensive plan to end homelessness, and all service providers should be participating in this data management plan.

Motivating Public Engagement in the Problem

Addressing a problem like homelessness requires significant buy-in on the part of the public and local officials and entrepreneurs who offer services and products that homeless people need in order to eventually attain and maintain permanent housing. The public must be engaged in the issue. Studies suggest that social problems ebb and flow in the public consciousness, and unless periodically reframed or brought back to the public's attention, they lose momentum

and eventually fall by the wayside. In a world where poverty is still too often partitioned into two parts—the deserving and the undeserving—mainstream homelessness is competing more intensely for scarce services, dollars, and the public's attention. To engage their imagination and attention requires an effective campaign to disseminate the most recent information on homelessness. This can be accomplished by a coordinated effort on the part of the Northwest Arkansas Continuum of Care; the cities of Bentonville, Fayetteville, Rogers, and Springdale; Washington and Benton Counties; and the University of Arkansas Community and Family Institute.

Developing a Strategic Plan

Building better linkages between Northwest Arkansas Continuum of Care (COC) and local governmental decision makers.

The COC is the local coordinating agency between homeless service providers and local government officials, leaders, and entrepreneurs. It should be the agency that helps develop local policy related to homeless service provision, identifies current gaps in services, and coordinates needs-based funding. To work effectively it must be engaged in regular interaction with all of the city administrative offices, particularly those in Community Development and Housing.

Effectively engaging the religious community in the planning and policy aspects of these issues.

Religious social capital represents one of the most significant forms and sources of social capital in Northwest Arkansas and communities like it around the country. While faith-based efforts to address homelessness abound, the efforts of churches are often piecemeal and sometimes work at counter purposes with local service provision. Efforts should be made to promote more effective, coordinated contributions to the Continuum of Care. In many cases, this can be accomplished by the engagement of highly visible local religious leaders in the process of planning and policy development. The COC should make efforts to bring church leaders onto its board.

Homelessness represents a complex personal and social problem that requires multiple resources to ensure people eventually gain permanent housing.

Developing an effective Continuum of Care means engaging a wide spectrum of local agencies and actors. Along with agencies providing

homeless services, local non-profits, funders, and local business should all be brought to the table to address the complex physical and emotional needs of homeless persons, as well as the financial barriers preventing thousands of residents access to affordable housing.

While programming has increased significantly to address the needs of the homeless veteran, nothing has been done to improve the circumstances of those persons living on the street. At anytime throughout the year, this number is fluctuating depending on the season. Nevertheless, estimates suggest that as many as 100 or more homeless adults are living outside throughout the year in Washington and Benton Counties.

If living outside for any person is unacceptable, then the COC and local government officials will need to begin to address this critical need immediately.

Micro-shelters are a viable solution that can bring those living outside, into a warmer, safer, cleaner, and healthier environment. A number of best-practice models exist throughout the country in cities that are committed to ending street homelessness. A solution has been proposed to the City of Fayetteville, and the only need that remains to be filled is a viable piece of property that is located within the service area that homeless persons currently reside in. This property needs to be managed and maintained by a coalition of agencies that can provide services, case management, and safety.

Assisting Persons in Restoring and Repairing Social Capital

The primary reason often given by the homeless explaining their current situation is some sort of personal relationship issue. While homeless people have social networks and use them, they are also prone to exhaust these resources because of the exceptional challenges of the homeless circumstance. Evidence suggests that attempts to assist homeless persons in restoring and rebuilding social capital through effective case management promotes quality of life, improves physical and mental health status, and increases the likelihood of successfully obtaining permanent housing. The struggle to get off and stay off the streets is often about relationships. As evidenced in the data from the intensive surveys, most homeless persons have not lost hope. A good deal of optimism and positive outlook toward the future needs to be supported and developed with continued opportunities to find employment, housing, and ultimately a pathway out of homelessness.

Homeless Prevention. Efforts have been made to prevent chronic homelessness. Nevertheless, in spite of dramatic improvements in the Continuum of Care process in the Northwest Arkansas area,

homelessness continues to grow. Likely no significant reductions to the population can be expected unless homeless prevention programs like Ficasso can be successful. At the moment, new faces quickly replace the successful individuals who negotiate the Continuum of Care and gain permanent housing. Nevertheless, the Ficasso project has had dramatic effects on the near-homeless population over the last several years and programs like it need to be developed and implemented throughout the region.

Emergency Prevention. Currently, most homeless prevention programs are like emergency first aid stations slapping Band-Aids on more serious pathologies. The effort by local agencies to provide emergency assistance for those teetering on the brink of homelessness must continue. Their work in homeless prevention is essential to the safety net the community offers to its residents. The emergency services available need to continue to include food, rent, mortgage, and utility assistance, as well as case management, mentoring, and landlord/lender intervention. These programs, while essential to preventing homelessness, do not address its root causes. Homelessness has structural roots that must be acknowledged and targeted.

Systems Prevention. According to the National Alliance to End Homelessness, mainstream service providers are motivated to shift responsibilities and costs to homeless programs to reduce their costs. This leaves a basic conflict of goals between the two systems, with mainstream services having no incentive to prevent homelessness. The homeless provider system, on the other hand, is not capable of preventing people from becoming homeless, nor can it address at-risk person's needs for housing, income, and services. Only the mainstream system is equipped to do this. This produces a system in which homelessness prevention is not effectively addressed.

Risk Prevention Services. Homelessness is associated with significant health risks. Hypertension and diabetes are prevalent among the homeless, but in both cases fewer than half of those diagnosed with the disease take medication for it. Health risks connected with addictive substances are also quite high. Alcohol consumption causes serious problems in the lives of over half of our respondents. Drug abuse problems are also common. Seventy-seven percent have used drugs at some time in their lives (Fitzpatrick et al. 2007-15). These risk-taking behaviors exacerbate the already debilitating circumstances of homelessness, making homeless persons' progress along the Continuum of Care problematic.

Both homeless prevention and rapid re-housing of the homeless can be improved by enhancing existing risk prevention and risk-reduction programs

for the homeless (drug and school treatment programs, health education, medication assistance, sex education, etc.) It is clear that medication assistance programs are not currently sufficient to meet the needs of those suffering from chronic conditions such as hypertension and diabetes. In addition, substance abuse programs must continue to be available for some as an essential step in a comprehensive program to reduce homelessness. Finally, efforts should be made to explore innovative addiction treatment programs for the episodically and chronically homeless who move in and out of homelessness because of their addictions and resistance to treatment.

Better Integration of Services

Linking Efforts. Homeless providers and their clients often report difficulties accessing mainstream services. There is a need to seamlessly integrate homeless access to general services, particularly healthcare services. Access to prescription drugs and to affordable health services is still a problem regularly confronted by both shelters and their clients. Resolving this issue requires better coordination between the general service system and the homeless system. This need underscores the potential for the Homeless Management Information System (HMIS) to operationally integrate the two service systems. Services provided in the homeless system sometimes duplicate those provided in the general service system. This segregated arrangement is costly and inefficient. Better integration and coordination can lead to a more efficient delivery of services and cost savings. In addition, accessing primary health care continues to be a problem for uninsured or underinsured homeless and low-income, near homeless. Addressing this problem is going to require innovative solutions--mobile health care is one possible strategy for improving access and general health and well-being for this at-risk population. Mobile dental care was introduced in Northwest Arkansas in 2014 and preliminary data indicate that they are serving an at-risk population that was going untreated prior to the mobile solution.

Providing Permanent Housing. Homelessness is fundamentally a housing problem with both structural and individual roots. It is, of course, more than that, but any policy that purports to seriously address homelessness must confront the challenge of providing safe, affordable housing to the poor. Currently, most prevention programs use a patchwork approach, primarily paying bills and offering short-term monies for necessities. While these programs are important, as noted previously, the root of the problem is poverty and access to affordable housing. It is essential to address these problems in the neighborhoods from which the homeless disproportionately come.

The housing problem in Northwest Arkansas is daunting, and with the recent changes in the economy

those problems continue to grow. A large majority of very low-income households in Northwest Arkansas could be defined as "struggling households," paying a disproportionate amount of their total income in rent, as noted in the Community Indicators Report (Fitzpatrick et al. 2008). Homeless prevention programs like the Ficasso Project, along with mainstream housing programs available to low-income individuals and families, need to continue to address the dramatic shortfall of low income housing in the community.

Addressing the affordable housing problem involves a bigger challenge than physically changing sub-standard buildings into comfortable, attractive dwellings. The more basic, more difficult, and in the end, more important challenge is the transformation of dysfunctional neighborhoods into positive, supportive communities. For such a transformation to occur, not only must dysfunctional neighborhoods invest in the effort, but also the private sector needs to be investing in the broader community as well. Neighborhood residents and organizations, as well as outside groups such as banks, foundations, government agencies, churches and service clubs must all engage in the process of change from the planning stages onward. This is particularly true for the unsheltered that require an immediate solution.

Reducing Chronic Homelessness

The chronic homeless in Northwest Arkansas have disproportionately higher service needs than non-chronic homeless persons.They not only use a greater number of services, but also have a greater number of unmet needs. In addition they are the most likely to resist using shelters.

Addressing this group's needs for housing and services is essential to any serious effort to reduce homelessness. Many of these individuals cannot successfully use more stable forms of housing because of their disabilities. They are often barred from shelters or refuse to go to such facilities due to mental illness or substance abuse problems. Some type of temporary housing that can provide a modicum of dignity while unsheltered persons begin to work with case management to find more permanent solutions should be a necessary first step toward addressing these critical needs. Few of the chronic homeless will ever be able to generate significant, stable wages in the job market. Thus, they will require even more long-term subsidization of housing and services than persons experiencing sporadic homelessness. To get them into the required facilities requires good outreach programs that build trust between the homeless individuals and providers.

There is an assumption being made by federal policymakers that if the chronically homeless problem were more effectively addressed, it would free up additional services for the larger population of homeless. However, given the significant problem the poor face in finding safe affordable housing, and given the tenuous circumstances of the poor in general, it is very unlikely that homelessness can be substantially reduced in any community without more adequately addressing the need for homelessness prevention as well.

The Need for a Strong Central Coordinating Authority

The complex nature of the homeless problem requires comprehensive programs, a strategic plan, new definitions of organizational success, and significant buy-in from the community. Because of the necessary complexity of these efforts it also requires a central agency and planning authority whose work is recognized as essential to the success of the area's efforts to end homelessness in Northwest Arkansas. The Northwest Arkansas Continuum of Care (COC) is ideally suited to be this coordinating agency because it represents agencies directly engaged in homeless services, and manages the primary data source for documenting needs and service provision. To be fully successful, the COC should continue to strengthen its relationship with Habitat for Humanity, the United Way of Northwest Arkansas, the major city administrations, and the offices of Community Development and Housing. If this coordination activity is to be located within the COC, adequate resources to carry out their work should be provided. Currently it has both limited organizational capacity and financial resources to do the kind of work it needs to be doing. The larger community of Northwest Arkansas needs to be supportive of the COC and its efforts to work on affordable housing and ending homelessness in the region.

Nothing in this report suggests an easy pathway toward ending homelessness in Northwest Arkansas. However, with a continued coordinated effort on the part of service providers, government officials, local non-profits, funders and stakeholders, we can begin to move the needle and change the life-course of thousands of persons who live in this region without their own home. If our region's future depends on its youngest generation, then we have a social responsibility to begin to work with the schools throughout this region in identifying their greatest needs, working to find suitable housing solutions for the thousands of students and their families without their own home, and to invest in this generation with a frenzied fiscal, emotional, and infrastructural support.

ENDING HOMELESSNESS REQUIRES A COMPREHENSIVE COMMUNITY EFFORT

APPENDIX

IRB Permission

UNIVERSITY OF ARKANSAS

Office of Research Compliance
Institutional Review Board

December 2, 2014

MEMORANDUM

TO:	Kevin Fitzpatrick
FROM:	Ro Windwalker IRB Coordinator
RE:	PROJECT CONTINUATION
IRB Protocol #:	06-10-150
Protocol Title:	*A Proposed Needs Assessment of the Northwest Arkansas Area's Homeless Population*
Review Type:	☐ EXEMPT ☒ EXPEDITED ☐ FULL IRB
Previous Approval Period:	Start Date: 12/13/2006 Expiration Date: 12/12/2014
New Expiration Date:	12/12/2015

Your request to extend the referenced protocol has been approved by the IRB. If at the end of this period you wish to continue the project, you must submit a request using the form *Continuing Review for IRB Approved Projects*, prior to the expiration date. Failure to obtain approval for a continuation on or prior to this new expiration date will result in termination of the protocol and you will be required to submit a new protocol to the IRB before continuing the project. Data collected past the protocol expiration date may need to be eliminated from the dataset should you wish to publish. Only data collected under a currently approved protocol can be certified by the IRB for any purpose.

This protocol has been approved for 600 total participants. If you wish to make *any* modifications in the approved protocol, including enrolling more than this number, you must seek approval *prior to* implementing those changes. All modifications should be requested in writing (email is acceptable) and must provide sufficient detail to assess the impact of the change.

If you have questions or need any assistance from the IRB, please contact me at 210 Administration Building, 5-2208, or irb@uark.edu.

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