Homeless in Cincinnati

Prepared for
The Greater Cincinnati Coalition for the Homeless
The Health Foundation of Greater Cincinnati
The Greater Cincinnati Foundation

Homeless in Cincinnati: A study of the causes and conditions of homelessness

Prepared for
The Greater Cincinnati Coalition for the Homeless

by
Applied Information Resources (AIR, Inc.)

Funded by
The Health Foundation of Greater Cincinnati
The Greater Cincinnati Foundation

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Meet the People Involved

Throughout this paper, we have included stories of people who are homeless. By sharing their stories, we hope to further illustrate the issues that arise when these systems interact. All of these stories are composites based on real individuals.

For More Information

The Greater Cincinnati Coalition for the Homeless is a unified, social action group, fully committed to its ultimate goal: the eradication of homelessness with respect for the dignity and diversity of its membership, the homeless and the community. The coalition performs three areas of work: coordinating services, educating the public, and grassroots organizing and advocacy. Formed in 1984, the Greater Cincinnati Coalition for the Homeless is comprised of individuals, as well as, member organizations that serve the homeless through emergency shelter, transitional living facilities, permanent housing, medical services, social services, soup kitchens, and mental health/addiction services.

For additional copies of the study, please contact the Greater Cincinnati Coalition for the Homeless at (513) 421-7803, or by writing to the Coalition at 1506 Elm Street, Cincinnati, OH 45210.

The data from the surveys used in the study can be accessed at http://www.ihphsr.uc.edu/hfgc/welcome.cfm via the “Enter Foundation Archives” and the “Browse Archive Holdings” links. Using this database, it is possible, for example, to cross tabulate virtually every piece of information with any other piece within the questionnaire as well as make comparisons of health information based on demographics.

Acknowledgments

Funding for this work was provided by The Health Foundation of Greater Cincinnati and the Greater Cincinnati Foundation. These organizations supported this research to enable the community to make informed decisions about allocations to serve the needs of the area's homeless population.

The work in developing the database for the study could only have been accomplished with the dedicated contributions of time and expertise of the service providers who are members of the Greater Cincinnati Coalition for the Homeless. Even more important were the honest contributions and cooperation of hundreds of homeless men and women who supplied the answers to the general health surveys.

The staff of the Greater Cincinnati Coalition for the Homeless and the staff of the Health Foundation are responsible for much of the clarity and accuracy of this report, through skillful guidance, helpful comments, and generous support. Barbara Lyghtel Rohrer served as its principal editor. The cover was designed by Kucia And Associates. The photographs of the children and families were taken by Jimmy Heath.

In addition, Alice Skirtz and Bill Woods of Applied Information Resources (AIR, Inc.) helped immensely, as did a number of people who were responsible for transforming the individual questionnaires into an extremely valuable database. Jessica O'Rourke-Close provided the invaluable statistical skills that translated the questionnaire and database into numbers, charts, and graphs.

The principal author is Edward Lee Burdell.

Foreword

The title of this report, "Homeless in Cincinnati," was not intended to be a play on the title of the romantic comedy hit, *Sleepless in Seattle*. There is nothing funny in this report, and we are long past romanticizing the world of the cheerful hobo or eccentric bag lady. The numbers in this report represent human beings. Their stories are far more real than anything Hollywood can dream up.

The possibility that our society includes people who are simply unable to support themselves and their children flies in the face of today's conventional wisdom. Today we embrace a mindset, as partially evident in welfare reform, that every adult member can engage in gainful employment. This leaves no room for individuals who, for a variety of reasons, cannot.

Over the decade and a half that we have spent studying homelessness, we can see significant changes. Our comparisons with earlier surveys offer insight into the changing nature of homelessness in the Greater Cincinnati area. For example, there are far fewer Vietnam veterans than we found in 1986. Most of them have probably died. The run of prosperity in the 1990s has almost entirely removed couples with children from our categories. How well families will be able to survive any economic downtrend remains to be seen.

Among our findings for this report, we discovered that the most important difference between people who are homeless today and the population that existed fifteen years ago is that today's homeless have fewer personal resources or skills and far more burdens. This is truest in the case of women and their children.

When we initiated the research for the study upon which this report is based, our purpose was to secure information so that those who provide services for the homeless would be able to do so in the most effective manner. The health of people who are homeless was central to this work.

Mental and physical illness is a constant in the life of the homeless and impacts the work of shelter and other service providers who seek to help people who are homeless. Part of the challenge is endemic to the problem of homelessness. If preventative care, good health habits, and nutrition are the starting point for a healthy life, what is to become of people who simply do not have these options available, as is the case with people who are homeless? Next on the list for health purposes is early diagnosis and treatment. Programs do exist, but they need to be greatly expanded. Shelter providers can lead the way, but the community must develop resources to respond.

All studies carry for their researchers one story which won't go away. For me, that story came after touring the Chabad House family shelter. I sat in the office of shelter coordinator Fannie Johnson and we talked about the people who were currently staying there. She mentioned one particular young mother. She asked if I remembered her. I did. Fannie then told me that the reason the young woman had come to

Chabad with her child was that she remembered it as a nice place to stay when she was there as a child with her mother.

Homelessness should not be a part of growing up, like going to school or taking a family vacation, but for some children it is.

What do we want to do about this?

Edward Lee Burdell
Principal Author

Introduction

In 1986, researchers completed a comprehensive study to better understand and quantify homelessness in Greater Cincinnati, a social trend which afflicted not just this region but the entire nation, particularly the urban centers. At that time, the researchers saw their work as a one-time undertaking. They thought that the lessons learned from their subsequent description would improve social services, thereby counteracting homelessness. An improving economy would further hasten the reduction of the number of people who were homeless.

A second study completed in 1993 showed that these expectations had not been met. Not only had the number of people who were homeless increased, but the conditions that pushed people into homelessness had expanded. Social policy changes at the national and state level, such as closing state-funded institutions for people with mental illness, contributed to the growing difficulty in solving the problem of homelessness for many people. And the most disturbing aspect of the problem: Drug abuse was playing a growing role as a condition that worked against recovery from homelessness.

In response to the growing numbers of and issues concerning the homeless, homeless shelters became more sophisticated and specialized. People became professionals in serving the homeless. Federal and state support, particularly for capital improvements, had increased both shelter capacity and improved operating conditions. Transitional housing was created as a bridge between the shelter and permanent housing.

With the completion of the 1993 study, the researchers developed a tracking system that would identify changes in the nature of the problem. By better quantifying the problem, the researchers hoped to identify the best means to stop the growth. Unfortunately, they were unable to secure funding to implement this effort. Early in the year 2001, work began again to understand the problem and define its parameters. In addition, through the efforts of researchers

and advocates, the continuing data collection system has now been implemented.

Part of this work included looking at the health of people who are homeless. Using a grant from The Health Foundation of Greater Cincinnati, researchers asked people who are homeless a series of questions recently used to collect health data from the general population of a 20-county area around Cincinnati. They also looked at data from a number of similar surveys conducted around the nation. The comparisons between the health of the homeless population and the local and national populations are deeply troublesome. The findings leave no doubt that the health condition of the homeless needs to be a top priority if society is to begin effectively responding to the problems of homelessness.

Society may want to start by accurately "seeing" the homeless. The 2000 U.S. Census counted two people living on the street in Cincinnati. The Greater Cincinnati Coalition for the Homeless (GCCH) replicated this count using the vendors of its monthly newspaper, *Streetvibes.* The vendors are people who are homeless or formerly homeless, and they are extremely knowledgeable about the paths and habits of the city's homeless population. These vendors counted visitors to soup kitchens, panhandlers, and people who literally reside on the streets.

Donald Whitehead, a former homeless man and the current Executive Director of the National Coalition for the Homeless, and Susan Knight, Administrative Coordinator of GCCH, undertook a more daunting task to contribute to the count. On a Sunday evening, they made their way to more than a half dozen encampments located on hillsides, beneath interstate bridges, and along the river's edge. The difficulty in reaching some locations limited the number of sites that they could visit, but their efforts, combined with those of the vendors, resulted in a total count of 121 people living on the streets. This figure, in comparison to the "official" count of two, underscores the problems of serving a population that is too often invisible.

Another danger is that the numbers become overwhelming, making it difficult to put a human face to the problem. For

that reason, readers will find composite profiles throughout this report of individuals who are homeless—like the story of Arnold on this page. This is an attempt to humanize the numbers. While these depictions are comprehensive, they are not exhaustive. For example, not represented in the profiles are homeless couples without children. They exist, but are extremely rare, as are families headed by a single male parent.

Determining how best to respond to the homeless crisis is as difficult as trying to accurately count the number of people who are actually homeless. But that is not an excuse for failing to try, even for a society that seems increasingly uninterested in the plight of its weakest members. Consequently, this report tells who the homeless are and describes the status of their health. It gives recommendations as to what needs to be done. Now the community needs to decide how it will respond.

Meet Arnold

Arnold is a 35-year old male. At 14, he ran away from home and was subsequently arrested and put into a boys' group home. Arnold rebelled against the structure and authority, and left the group home. He eventually joined up with a group of wanted felons and became entrenched in a life of drugs and crime. At 16, Arnold shot a man and was imprisoned for four years for attempted murder.

Upon his release, Arnold looked forward to going to college and pursuing a career as a printer for the local paper. As an ex-felon, however, Arnold could not find employment and the local university would not accept him. Arnold returned to crime and once again ended up in prison.

In prison this second time, Arnold went into recovery and continued his education. After he was paroled, he pursued his education at Cincinnati Bible College—the only institution that would accept him—and worked part-time at a local homeless shelter. He graduated with a bachelor's degree, but could not find housing because of his felony record. After several months of sleeping at friends' houses and various other places, he got a job taking care of an elderly man and was permitted to live in the house. Soon after, he became a pastor at a local church, a job that provides housing.

Arnold has since founded Way of Life Ministries, providing food and goods to those in need. He has been in recovery for 7 years.

Who Are the Homeless?

Too many men, women, and children in Cincinnati have no place to call home. Within the past year, an estimated 25,000 people in Greater Cincinnati at one time or another had no home. Many are “doubling up” with family and friends or living in shelters. All are at risk to join those who are already living on the streets.

Who are these individuals and how did they arrive at this point in their lives? Answering that question is a challenge. Every individual is unique, and every person who is homeless is homeless for a variety of reasons. Trying to describe the people and the challenges they face necessarily simplifies where there is complexity, becomes specific where there is a wide range, and uses a research format where there is humanity. Yet some generalizations are possible.

The composition of Greater Cincinnati’s homeless population has changed in the 15 years since the first study on homelessness was conducted. There are now more women and children who are homeless than ever before, and a larger percentage of the homeless population is African American—far more than the percentage of the African American population in the Greater Cincinnati area.

Although 64% of the men who are homeless have a high school diploma and almost 60% of them work, their wages are not adequate to cover the cost of housing. Women who are homeless have not achieved the same level of education as their male counterparts. They primarily lose their housing when their income is cut, which may happen if they are forced off welfare before they have a chance to finish an education that could provide a living wage.

Furthermore, substance abuse and other behavioral health problems are increasing. Ten years ago, the shelters in Northern Kentucky were not encountering infants whose mothers had abused alcohol and other drugs during pregnancy. Today, our cities have too many children whose behavior and life potential were altered before they were born because of alcohol and other drug use by their mothers.

In addition, mental illnesses, including depression, are increasing among the homeless population. And what will be the effect on the mental health of a generation of children who are being raised in homelessness or in constant risk of homelessness?

How Many Are Homeless?[1]

Researchers have struggled for years with the question of how many people are living on the streets and not utilizing shelters. Unlike other urban areas, Greater Cincinnati has not developed a large population of "squatters" who took over vacant or abandoned buildings—a problem that occurred nationally in the 1980s and 1990s. However, Cincinnati still has problems with a growing homeless population.

[1] *See Quantifying Homelessness in the Appendices for an explanation of the calculations used for this section.*

In the past 15 years since homelessness in Cincinnati was first studied, the number of people who are homeless has increased by over 200%. The total number of people experiencing homelessness in a 12-month period from March 2000, to March 2001, was estimated to be 25,308 (see Table 1). This represents a 5,000 person increase from the 1993 study, which itself was double the 1986 study estimate.

Table 1: Annual estimates of homeless people in Greater Cincinnati

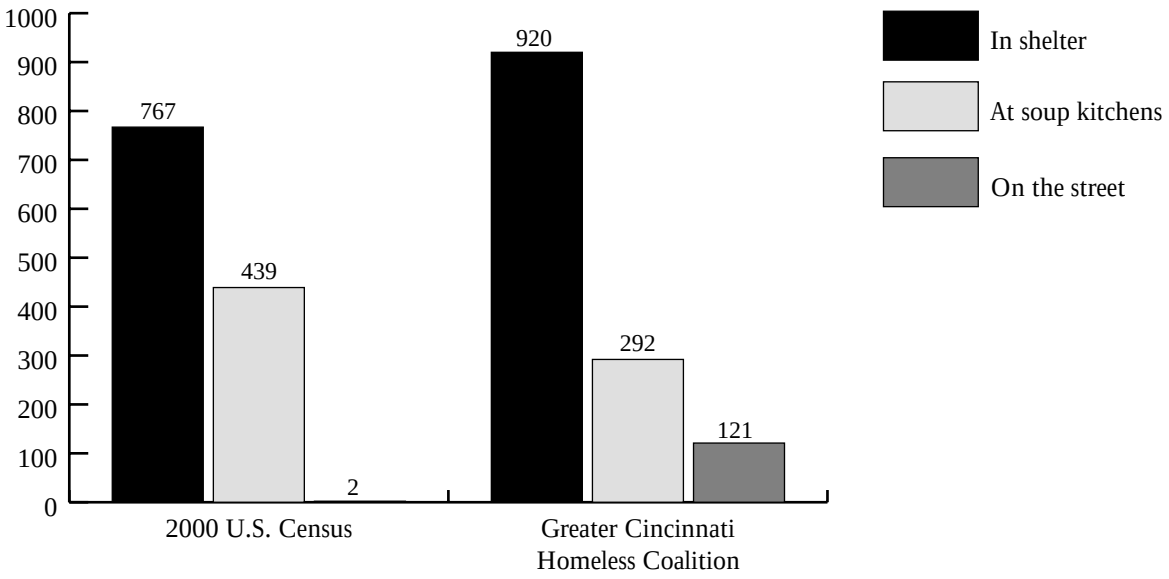
Study year	Annual estimate of the no. of people who were homeless[1]
1986	9,526-11,454
1993	20,394
2000	25,488

[1] These numbers are not precise. However, they do reflect the trends which have occurred.

In their overnight count in Cincinnati, the U.S. Census Bureau reported a street population of two (see Figure 1). In contrast, representatives of the GCCH located 121 people living in various locations in Cincinnati. Based on police

reports and a history of encampments on the shores of the Licking and Ohio Rivers, a complete count including Northern Kentucky would at least triple that number.

Figure 1: Point in time counts of the Cincinnati homeless population



Greater Cincinnati has a permanent population of people (mostly men) who live underneath overpasses, along riverbanks, and in certain heavily wooded areas scattered throughout the community. Soup kitchen populations confirm their existence. A separate community of street people in the Corryville area is composed of runaway teenagers and other young people under the age of 30.

A “snapshot” of the number of people experiencing homelessness at any given time in the 12-month period from

March 2000, to March 2001, is presented (see Table 2)[2]. Please note that these figures represent the unduplicated number of individuals who are homeless in the course of a single month.

Population	Number
Single males in shelter settings	350
Single females in shelter settings	80
Familes in shelter settings[1]	526
Families in transitional housing	304
Special populations in shelter settings[2]	180
Subtotal	1,440
Single people living on the street	300
Families living on the street	30
Subtotal	770
Doubled-up[3]	4,425[4]
Total	6,195

[1] This number represents 175 female-headed households that contain 351 children.
[2] This category includes people living in Lighthouse Youth Services, Prospect House, and First Step Home.
[3] People who live with families and friends after losing their homes.
[4] This figure is based on information from FreeStore/FoodBank records and Project Connect that indicate that for every person who is homeless as listed above, there are approximately 2.5 people living in doubled-up circumstances.

In general, single people move in and out of homelessness more frequently than families or special populations, such as youth or men or women in recovery from alcohol or other drug addictions. These differences are reflected in the turnover rates of shelters (see Table 3). Since the first study of homelessness in Cincinnati, the rate of turnover at area

[2] *In order to arrive at a twelve-month figure, a variety of figures are calculated which reflect the experience of shelters and the results of the surveys upon which this report is based.*

Table 2: Number of individuals in Greater Cincinnati who are homeless in the course of a month

shelters—that is, how often a person or family is replaced by another during a year—has decreased, meaning people are staying in shelters longer.

Table 3: Turnover rates of people who are homeless in Greater Cincinnati

Population	Turnover rate[1]	No. experiencing homelessness in 12-month period from March 2000 until March 2001
Single males in shelter settings	18	6,300
Single females in shelter settings	12	960
Single males or females (special populations)[2]	6	420
Single females with children	6	480
Single males or females on the streets	4	1,200
Families on the streets[3]	12	360
Familes in shelter settings	8	4,208
Families in transitional housing	2.5	760
Subtotal		14,688
Doubled-up[4]	12	10,800
Total		25,488

[1] The number of times a person or family is replaced by another during a year.
[2] These include individuals with problems such as chemical dependency or mental illness.
[3] Families who are forced to the streets generally move quickly to resolve that circumstance. The turnover factor reflects an assumption that over half of the families will move quickly either into the doubled-up or the sheltered populations.
[4] Because of evidence that the overwhelming majority of people who are doubled up will move into shelters within 12 months (and therefore will be counted within the shelter figures), the month-long figure for this population group was reduced by 80% to 885.

Family shelters report fewer people served in 1999 than in previous years, but an increased number of "shelter nights" due to the increase in the average length of stay. This increase in shelter nights means shelters have less room to accommodate the growing number of other people who are also homeless. In one family shelter, the average length of stay increased from 35 nights in 1998 to 41 nights in 1999.

Not all shelters' length of stays increased however. One family shelter had an average length of stay of 7.6 nights in 1999, allowing it to serve three times the number of clients as other shelters. This shelter's capacity to reduce the length

of stay is enhanced by its transitional housing program, considered the best first step from a homeless shelter.

With great effort, all Greater Cincinnati area family shelters have developed transitional housing components[3]. Transitional housing helps stabilize families who are homeless, enhancing their chances of being successful in their move toward self-sufficiency. However, this transition takes time. Consequently, a family's stay in transitional housing is much longer than its stay in a shelter, which then lengthens the average time in shelter for other families waiting for transitional housing. In addition, even if a family in transitional housing is ready to move on, finding safe, sanitary, affordable housing is difficult. In fact, it is an essential commodity with a decreasing number of units.

One of the great difficulties in homelessness research is how to identify and quantify the portion of the homeless population that is doubled-up. Based on survey responses and information from the FreeStore/FoodBank and Project Connect (which serves homeless children on behalf of area school systems), it would appear that there are at least 2.5 people in doubled-up circumstances for every person who is in a shelter. Certainly, all of these people are at risk for homelessness. The U.S. Department of Housing and Urban Development (HUD) does not consider the doubled-up population to be homeless. As a result, there are fewer resources to provide services and determine definitive figures on how many doubled-up people actually enter shelters. However, it appears from anecdotal evidence and from the surveys that more than 67% of people who are doubled-up become homeless within 12 months.

Why Do People Become Homeless?

Men give different reasons than women for becoming homeless. Men report a loss of income as their primary reason for becoming homeless—a finding which has remained consistent over the past 15 years. Almost 25% of men reported becoming homeless due to health-related

[3] People living in transitional housing are considered homeless because this is not a final or permanent housing situation.

Meet Connie

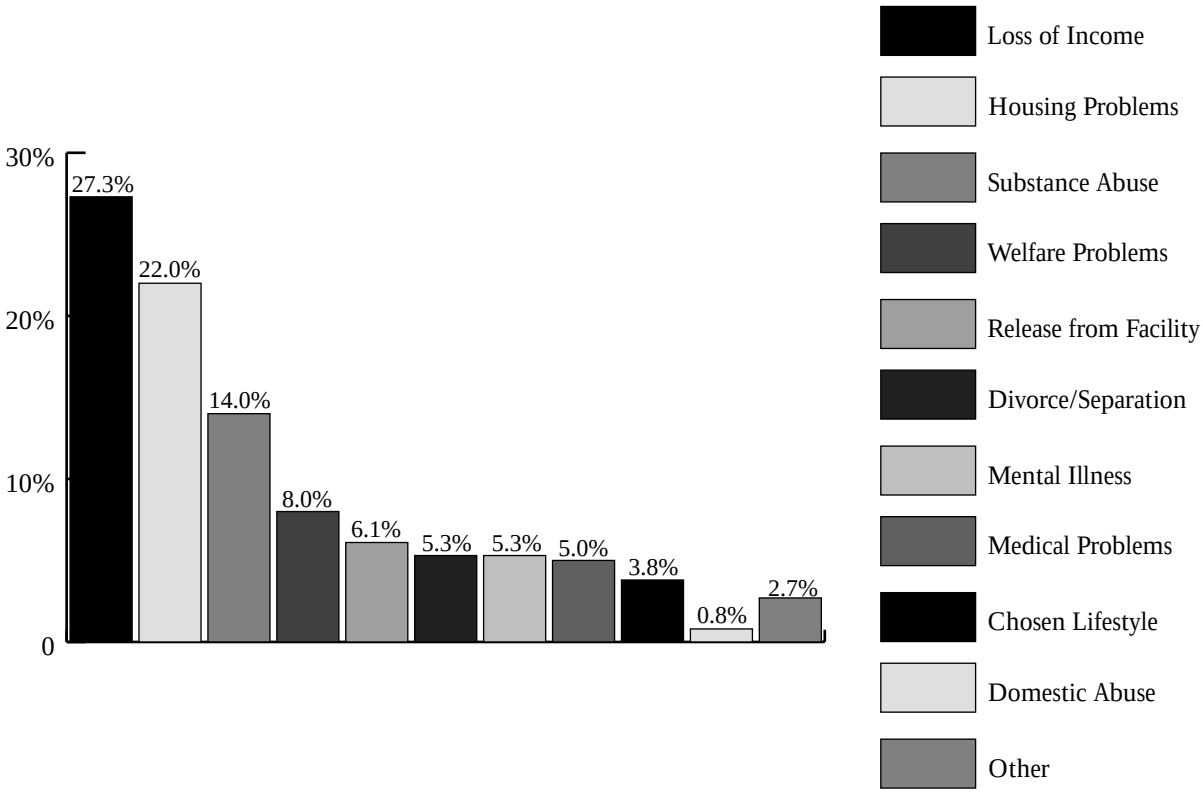
Connie doesn't exactly remember when she became homeless. She has vague memories of having lived in a nice home with a loving mother and father. More recently, Connie remembers the mental health agency's caseworker. The lady tried to be nice, but Connie wasn't comfortable living with other people, and she particularly resisted taking the drugs that were prescribed for her.

Some time in the past, Connie had been married and had children. When her periodic outbreaks became worse, her husband left her. Her children were taken from her and placed in foster care. That was years ago, and she has no idea where they are now.

She has found a small encampment on one of the hillsides that she shares with a number of other "friends." During the day, she may visit the library or check out the dumpsters for food. She would like things to be better, but there really isn't anybody whom she can trust. Her health is failing, and maybe some day soon, she'll stop and see the doctor at the health van.

issues such as substance abuse, mental illness, or other medical problems (see Figure 2).

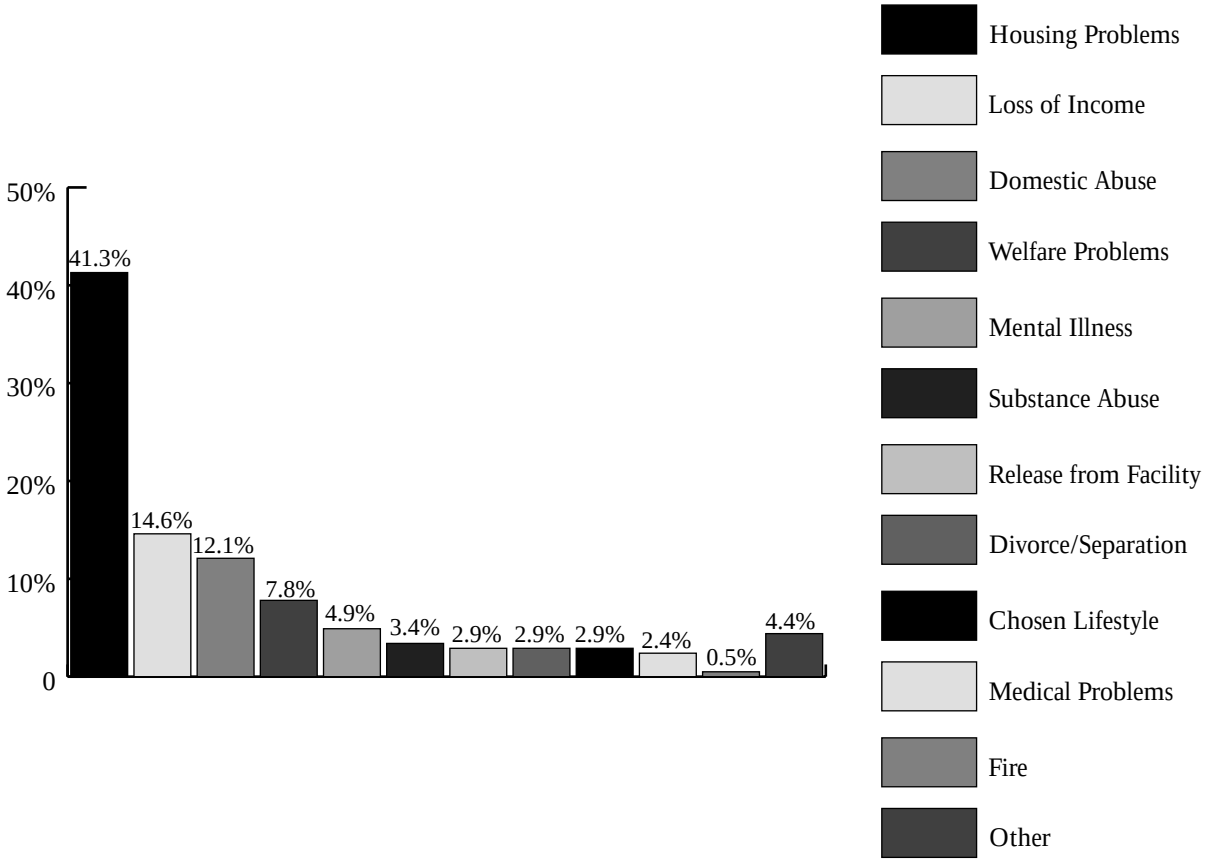
Figure 2: Reasons why Greater Cincinnati men become homeless



Housing problems are the number one reason why women become homeless, a trend that also has continued from the two previous studies. Women's problems with housing may result from a number of issues, but are probably due to a loss of resources—including jobs, spouses' incomes, and welfare benefits—that permit payment of rent. A change in reasons women become homeless from previous years is that loss of income is now number two, and the previous runner-up,

domestic violence, is number three. Almost 11% of women cited health problems as the reason they become homeless (see Figure 3).

Figure 3: Reasons why Greater Cincinnati women become homeless



Demographic Composition

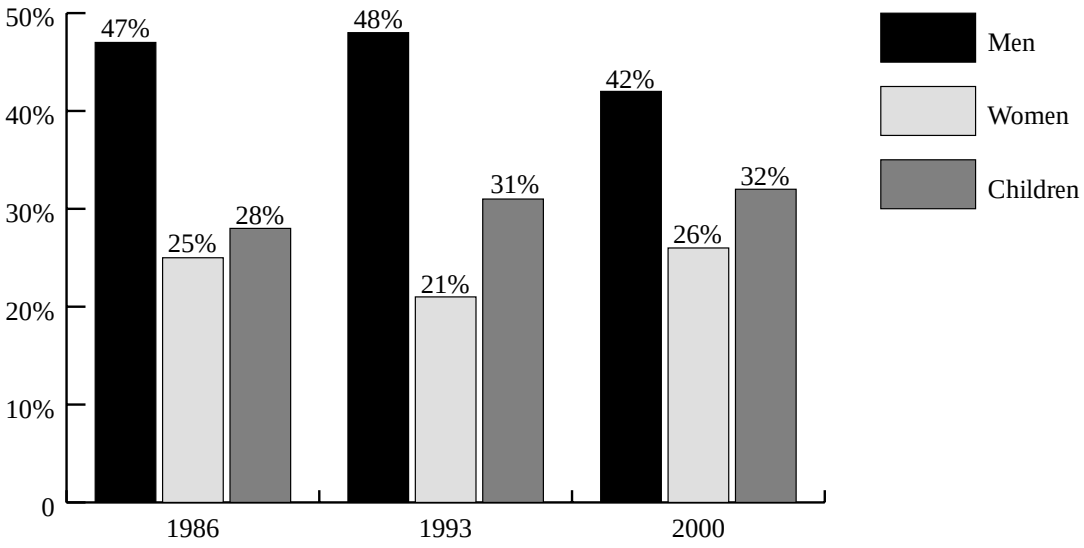
This section blends information from the key informants and from the general survey, bringing statistical details to the problem of homelessness in Greater Cincinnati. Where possible, information is presented in comparison with previous studies of the homeless population, as well as with results from other local and national surveys.

Gender

Although men make up the highest percentage of the homeless population in Greater Cincinnati, the numbers

and percentages of women and children have been rising since the first study of this population in 1986 (see Figure 4).

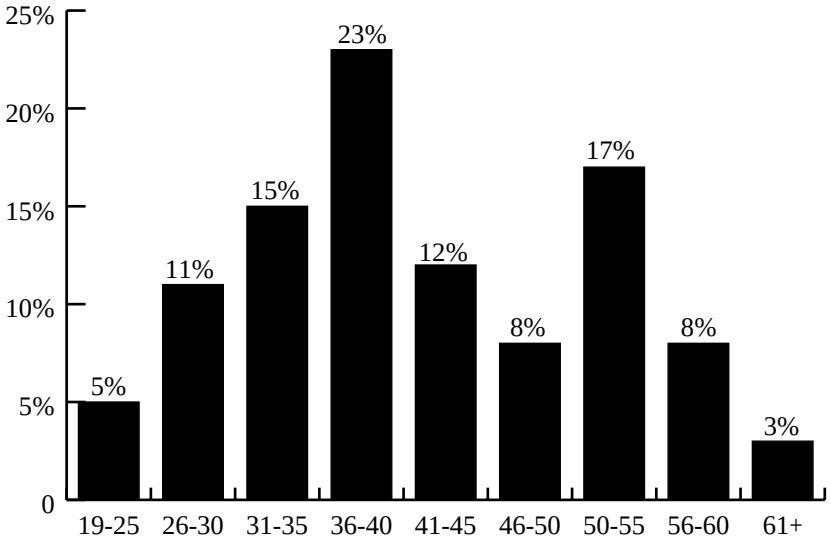
Figure 4: Composition of the homeless population in Greater Cincinnati



Age

Men seem to come later to homelessness and are older than their female counterparts. The ages of men in shelters shows that over a quarter of them are age 50 or older (see Figure 5). The oldest homeless person identified was a 79-year-old male.

Figure 5: Ages of men who are homeless in Greater Cincinnati shelters



In comparison, at the time of the surveys, only one women in a shelter was over age 61[4]. Less than a dozen women were between the ages of 50 and 60 (see Figure 6).

[4] The age of women in shelters does not include children. The teens that are represented in the figure are, in general, heads of households.

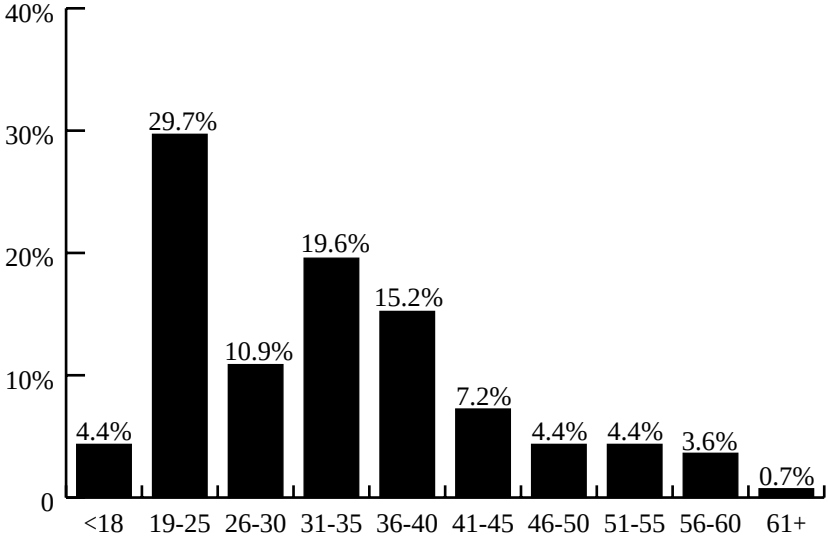


Figure 6: Ages of women who are homeless in Greater Cincinnati shelters

As for the homeless children in Greater Cincinnati, their ages are on par with national findings (see Figure 7). The average age of a homeless child in America is about 8-1/2 years old.

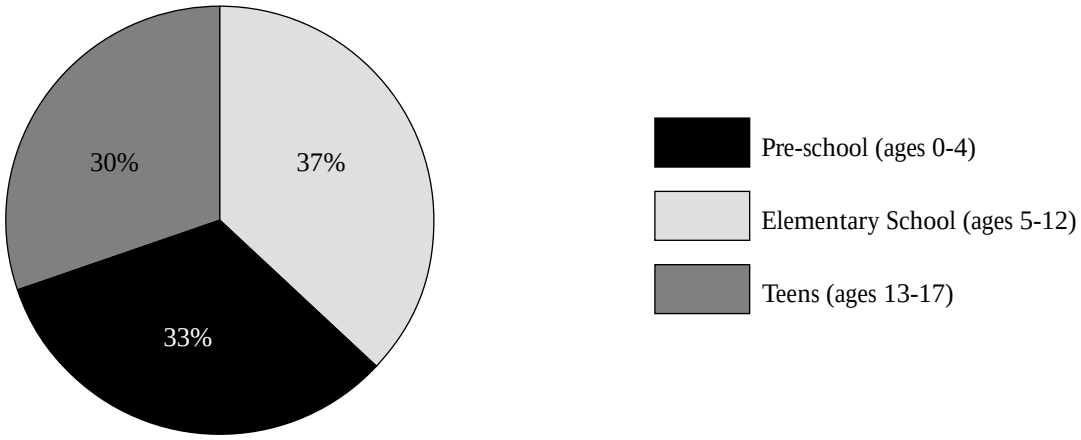


Figure 7: Ages of children who are homeless in Greater Cincinnati shelters

Looking deeper at the number of homeless children in Greater Cincinnati, a troubling reality is found. Of the children living in shelters, younger age groups have approximately equal numbers of girls and boys. However, there are 50% fewer teenage boys than teenage girls living in shelters. Where are they? Interviews with service providers and homeless mothers indicate that teenage boys whose families are under stress are more apt to run away, be pushed out of their homes, or end up incarcerated. In addition, two of the local family shelters do not allow males over 14 years of age to live in the shelters.

Race

The racial composition of the homeless is drawn from the surveys and indicates the continuing increase of African Americans among the homeless population (see Figures 8–10). Although there is an increase in homelessness among Hispanic Americans, 61% of men who are homeless are African American. Family shelters and the FreeStore/ FoodBank increasingly report that the homeless population they serve is overwhelmingly African American. In addition, a black woman with children is far more likely to be homeless than a white woman with children.

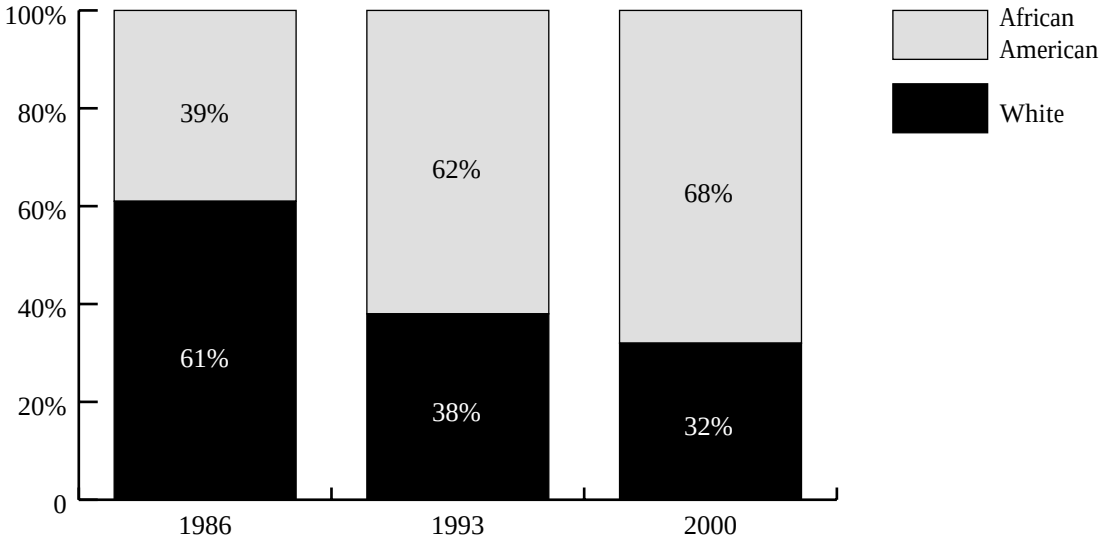


Figure 8: Racial composition of the Greater Cincinnati homeless population

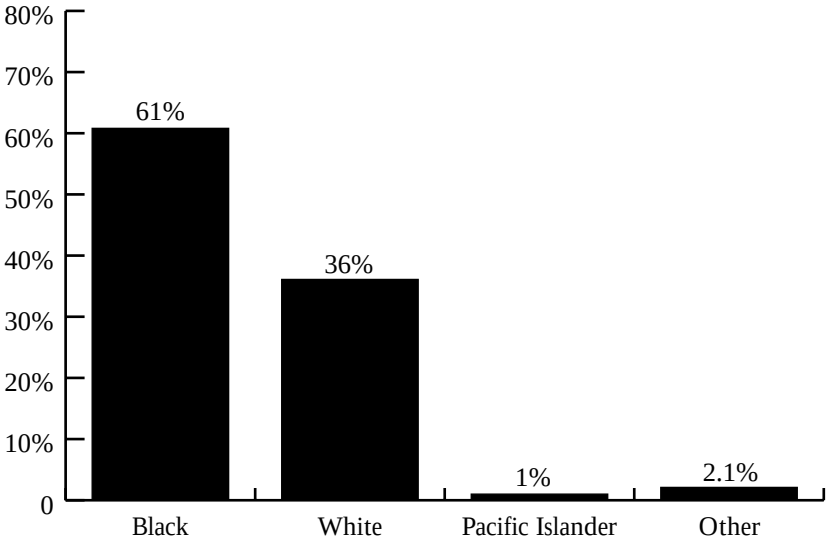


Figure 9: Racial composition of Greater Cincinnati men who are homeless

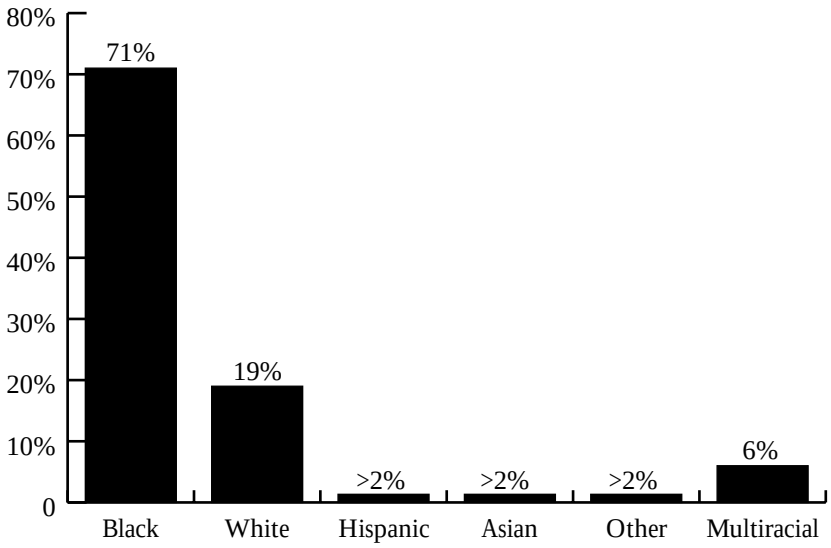
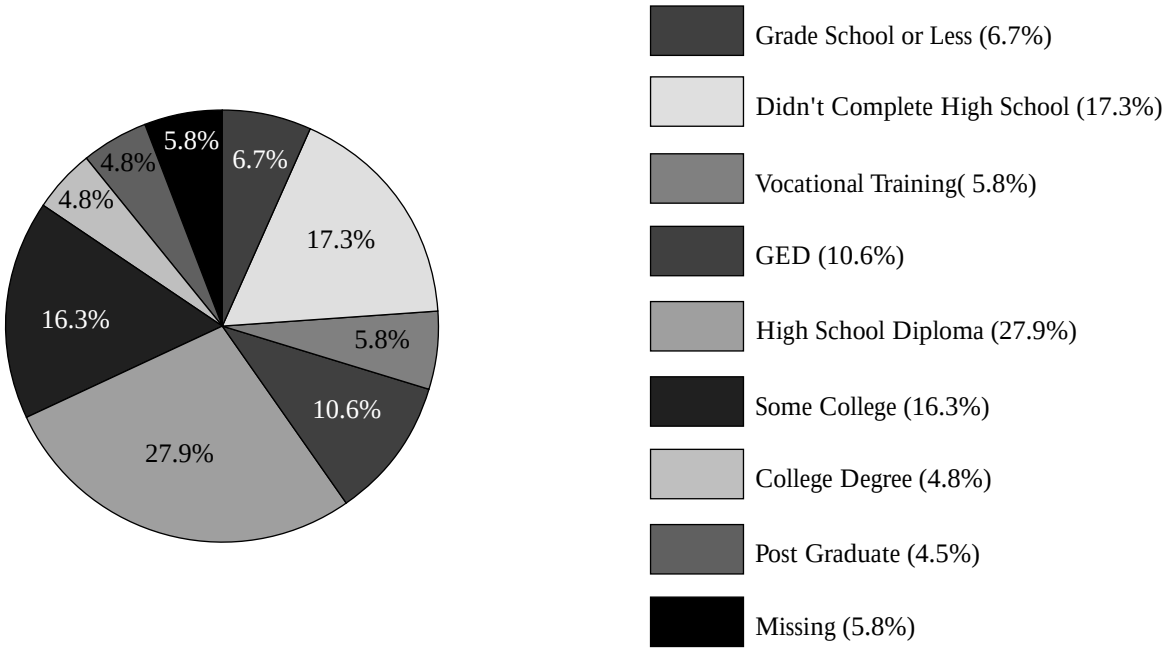


Figure 10: Racial composition of Greater Cincinnati women who are homeless

Education

Almost 60% of the men who are homeless have at least a high school degree—an increase over previous years. Approximately 5% of homeless men have postgraduate experience (see Figure 11).

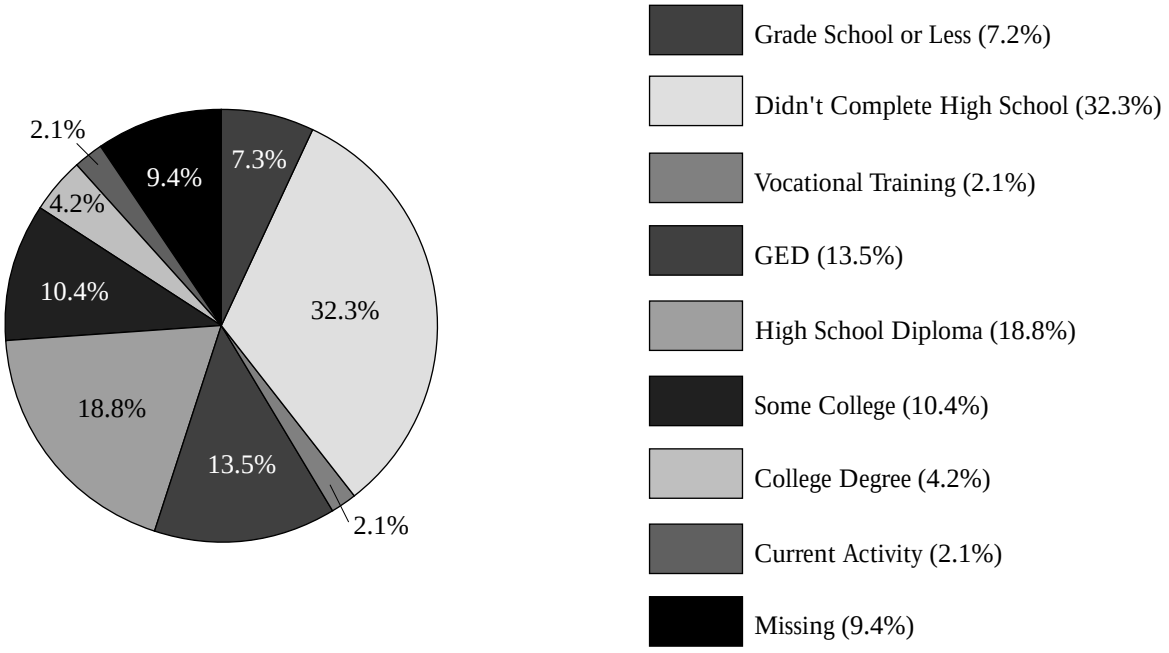
Figure 11: Education levels of Greater Cincinnati men who are homeless



The educational experience of women who are homeless is almost the exact opposite of men. Almost 67% of women who are homeless do not have a high school degree (see

Figure 12), an increase from previous years. It is also startling to note that almost 15% of the women who are homeless report having some college education.

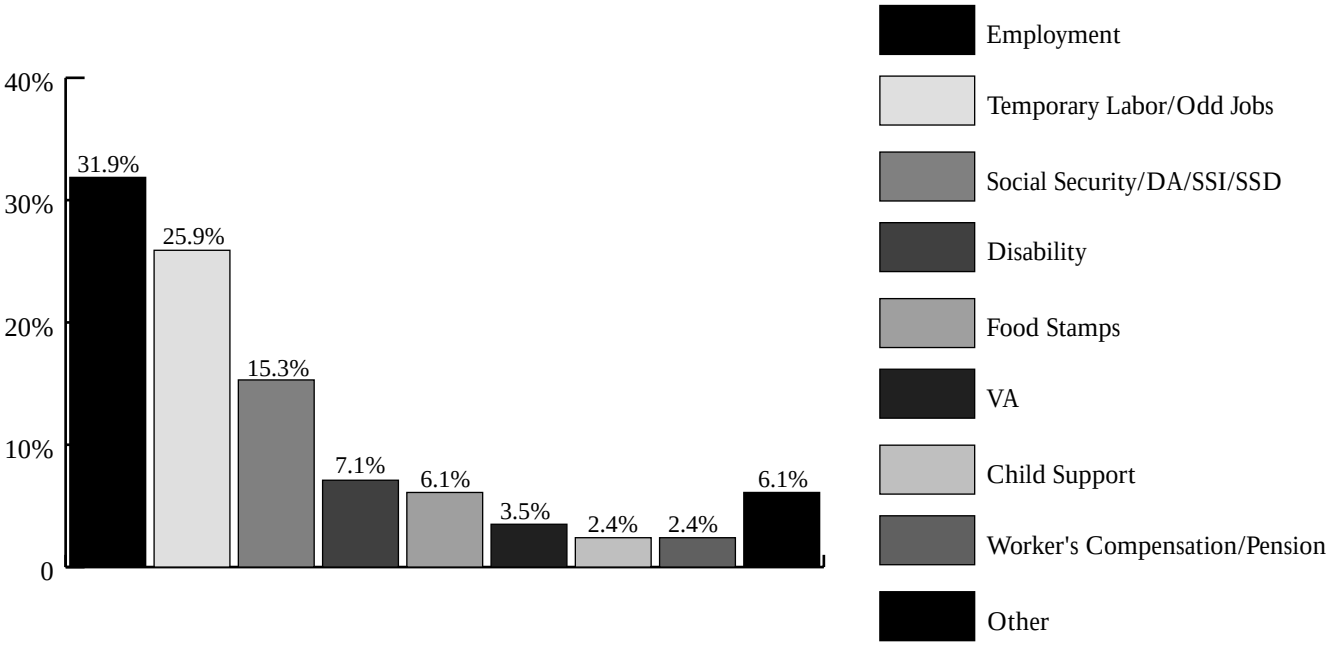
Figure 12: Education levels of Greater Cincinnati women who are homeless



Income

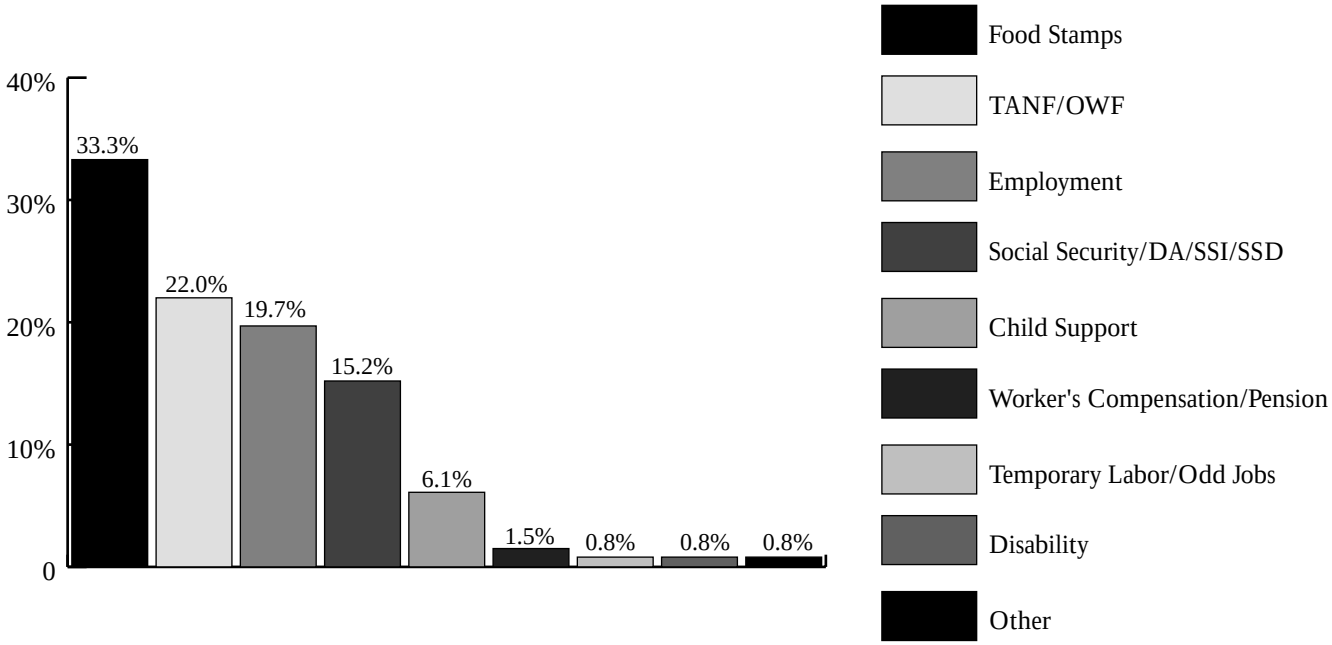
Almost 60% of men who are homeless indicate some type of employment as their source of income (see Figure 13). The tragedy is that this employment is not sufficient to secure and maintain permanent housing.

Figure 13: Sources of income for Greater Cincinnati men who are homeless



Women who are homeless rely more on public support than men (see Figure 14). After Food Stamps, the second highest source of income for women who are homeless is Temporary Assistance to Needy Families/Ohio Works First (TANF/OWF), which contains a work component. However, only 20% of women who are homeless show full or temporary employment as their major income source.

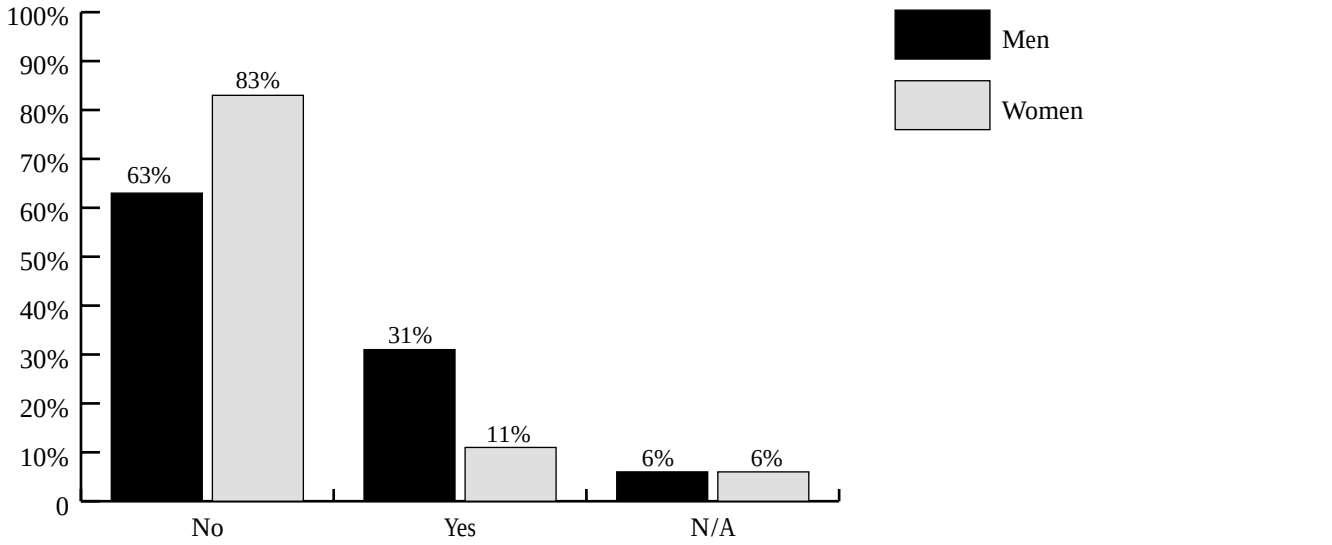
Figure 14: Sources of income for Greater Cincinnati women who are homeless



Contact with Police

Almost three times as many men as women who are homeless have had some contact with the police (see Figure 15).

Figure 15: Percent of the Greater Cincinnati homeless population reporting experiences with police



Health Concerns of the Homeless

The health of the homeless in Greater Cincinnati is a matter of great concern. Often, physical or mental health problems contribute to the onset and continuation of homelessness. In addition, people who are homeless often do not have access to medical care that can cure or alleviate their health problems. The situation of homelessness makes small ailments large, and serious problems catastrophic.

Early identification and treatment of a medical condition are keys to maintaining good health. However, many medical conditions are underdiagnosed within the homeless population. If conditions are diagnosed, they are often not treated. For example, family shelters reported an increase in deteriorating chronic conditions due to their clients' inability to obtain medication. Also, shelter workers have seen an increase in depression among their clients. These and other conditions are self-reported by people who know they need care, but are often too overwhelmed by other problems to seek treatment, even if it is available.

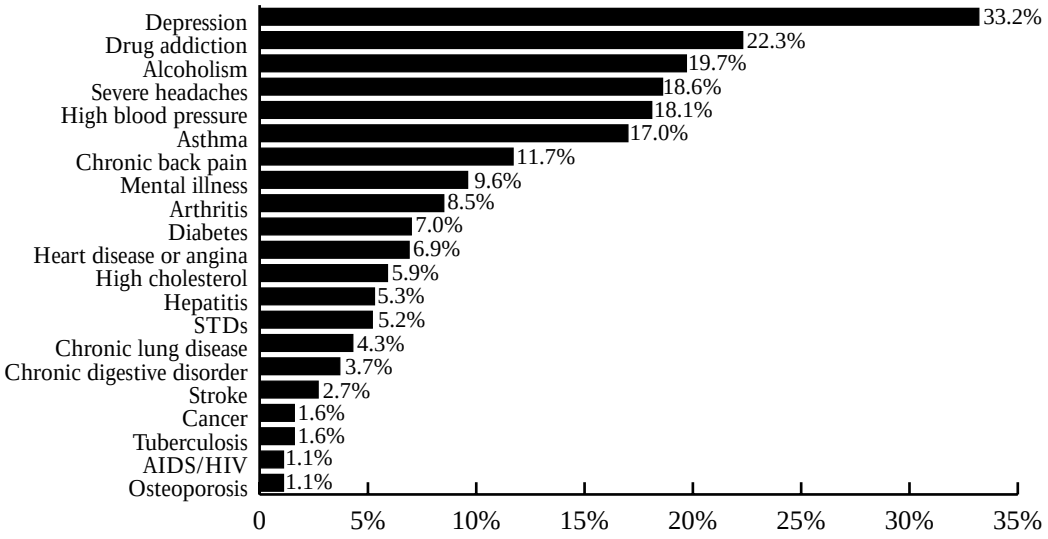
When health problems are not the cause of homelessness, they can still contribute to an individual's inability to change his or her housing status. Health problems may interfere with a person's ability to perform daily activities that could help them find or maintain housing and employment. How are people to overcome homelessness if they remain continually trapped in conditions that help create or maintain their homeless state?

Overall Health Status

Depression, alcoholism, and other drug addictions—also known as behavioral health conditions—are the three most frequently noted health problems by Greater Cincinnati adults who are homeless (see Figure 16). Severe headaches and high blood pressure round out the top five health concerns of the homeless population. Unfortunately, many physical and behavioral health treatment facilities have

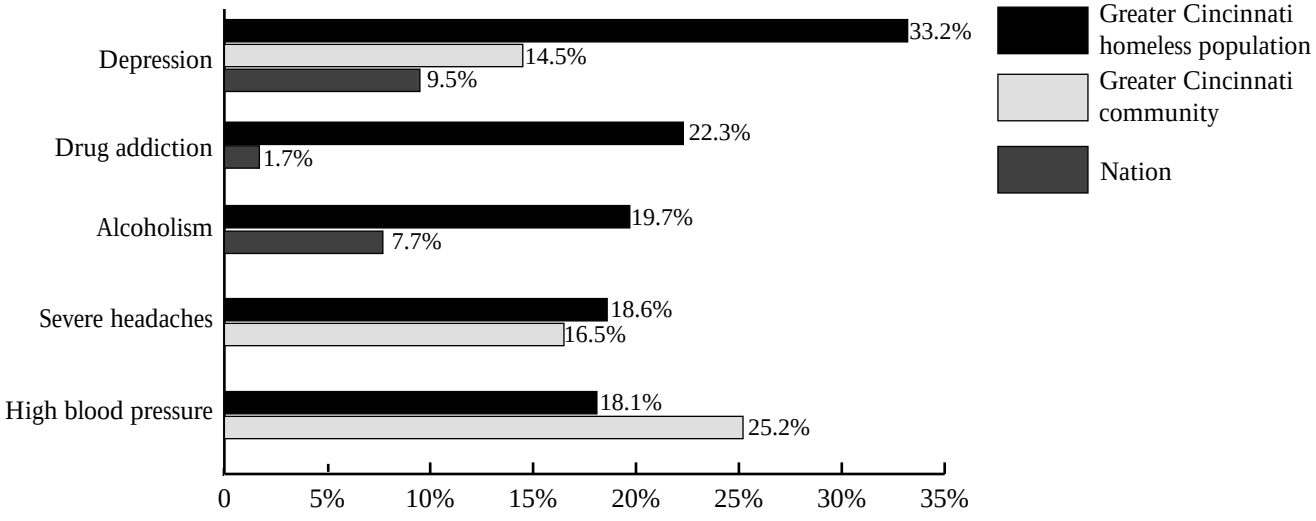
waiting lists for all patients, regardless of housing status. Clinics that specifically serve the health needs of the homeless population are far from adequate to meet the demand.

Figure 16: Prevalence of common health conditions among the Greater Cincinnati homeless population



The top five health concerns of the Greater Cincinnati homeless population are not as prevalent in national and local general populations (see Figure 17). *(Note: Data on the Greater Cincinnati community and national comparisons, unless otherwise noted, come from the* 1999 Greater Cincinnati Area Community Health Survey, *a survey of 20 counties in southwestern Ohio, northern Kentucky, and southeastern Indiana.)* The exception is high blood pressure—the only condition on the list of the top five concerns that may not have readily apparent symptoms. This discrepancy may be because people who are homeless often do not have access to medical care that would diagnose high blood pressure.

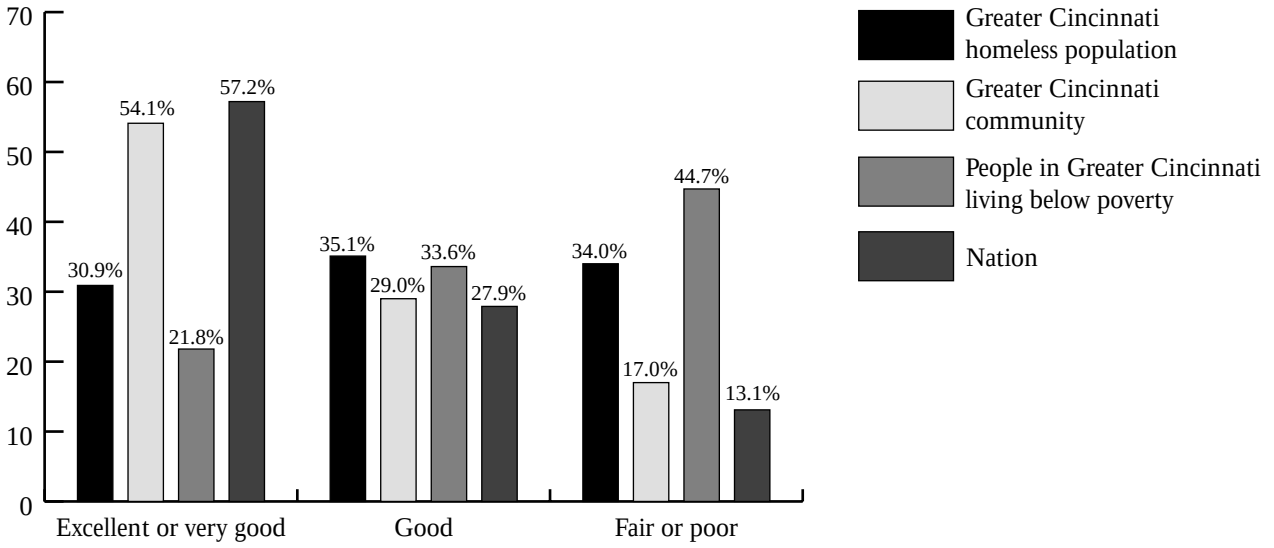
Figure 17: Comparison of the top five health conditions of the Greater Cincinnati homeless population versus national and local populations



People who are homeless recognize that their health is not what it should be, and are far more likely than the general population to rate their health as poor or poorer than average. Because residents in the Greater Cincinnati area rate their health at a level below the national average, people who are homeless in Cincinnati are far below the national rate.

For example, only 13.1% of the national population rate their health as fair or poor (see Figure 18). Within the general population in Greater Cincinnati, 17% of adults rate their health as fair or poor. Among the homeless in Greater Cincinnati, the rate jumps to 34%. Only people in Greater Cincinnati who live below the poverty level perceived their health as fair or poor at a higher rate (44.7%).

Figure 18: Perceptions of health status of the Greater Cincinnati homeless population versus national and local populations



Demographically, the Greater Cincinnati homeless population is more likely to perceive health status as fair or poor along age and gender lines (see Table 4).

Table 4: Demographic breakdown of how the Greater Cincinnati homeless population perceive its health

Most likely to perceive health status as fair or poor	Least likely to perceive health status as fair or poor
Age 51+	Age 24-32
Appalachian and "Other" racial background	African American
Have not had health coverage in the past 12 months	Have had health coverage in the past 12 months
Male	Female

Physical Health

Comparing the physical health of the homeless population with the physical health of the general population gives pause for thought. As the charts in this section will show, people who are homeless, with a few exceptions, report lower rates of some health problems than the general population. One may be tempted to think that people who are homeless are healthier than people who are not homeless. To a certain extent, there are some grounds to this initial impression.

People who are homeless are hardy individuals. If they were not, given the demands of such an existence, they would not be alive. However, this is not an explanation adequate enough to simply conclude that people who are homeless are healthier. In the case of most of the health problems listed in this section, diagnosis by a doctor or other health professional determines the existence of a disease. Because people who are homeless often do not have access to diagnostic care, they are not able to report that they have conditions that require professional diagnoses.

For example, high blood pressure has been dubbed the "silent killer" for good reason. Unless a blood pressure test is administered by a healthcare professional, individuals have no way of knowing if they suffer from this condition—until it's too late. In the cases of conditions such as high blood pressure, high cholesterol, osteoporosis, and cancer, the rate that homeless individuals report these diseases is far less than average likely because they have not been diagnosed and do not realize they suffer from these conditions.

It is interesting to note that the incidence of stroke among homeless individuals is on par with others in the community. Again, diagnosis is the key. When a person has a stroke, some loss of function is experienced, unless the stroke is a minor one. Often the incapacity is significant to the point that even a person focusing on his or her next meal cannot ignore it.

Asthma, a particular health concern, is a condition women are far more likely to suffer from than men, and family shelters report an increase of cases of asthma among children. One shelter reported that on the day of the

Meet Bob

Bob is 53. He was born in Newport, went to high school, and joined the service after he graduated. After 5 years, Bob left the service. In addition to a few work skills, Bob had picked up an education in drinking and doing drugs. He moved to the West Coast and worked for a while in jobs where he could choose to come to work or not. Eventually, he worked his way back to Northern Kentucky.

This year, Bob has been homeless about half of the time. He works almost every day at a temporary job service. Sometimes he takes his daily pay and drinks it away and sleeps on the street. Sometimes he saves his money to get a room at the Ft. Washington or Dennison Hotels. Once, he saved up enough money to get an apartment in Over-the-Rhine, which he was able to keep for 7 months.

He eats dinner most nights at the Drop Inn Center. He knows exactly when to visit other soup kitchens and when the health van is going to come by. Sometimes he will spend the night at the Drop Inn Center, but he doesn't like crowds and would rather be on his own.

Bob would tell you that he is probably an alcoholic, but he's never been able to stick with any rehab program. He continues to go to work almost every day, and hopes he can figure a way to get a little bit ahead so he can get his own place again.

interview, there were 32 residents in house, 15 of whom had inhalers for asthma.

Tuberculosis, which is highly infectious, is another concern. The rate of infection of tuberculosis is significantly higher among the homeless most likely due to the close, crowded quarters of soup kitchens, and other areas where people who are homeless congregate. Interviews with key informants indicated that those suffering from tuberculosis are more likely to have hepatitis, and vice versa. In addition, key informants reported that the rates of STDs were much higher among the homeless populations than among the general community.

Respiratory System Conditions

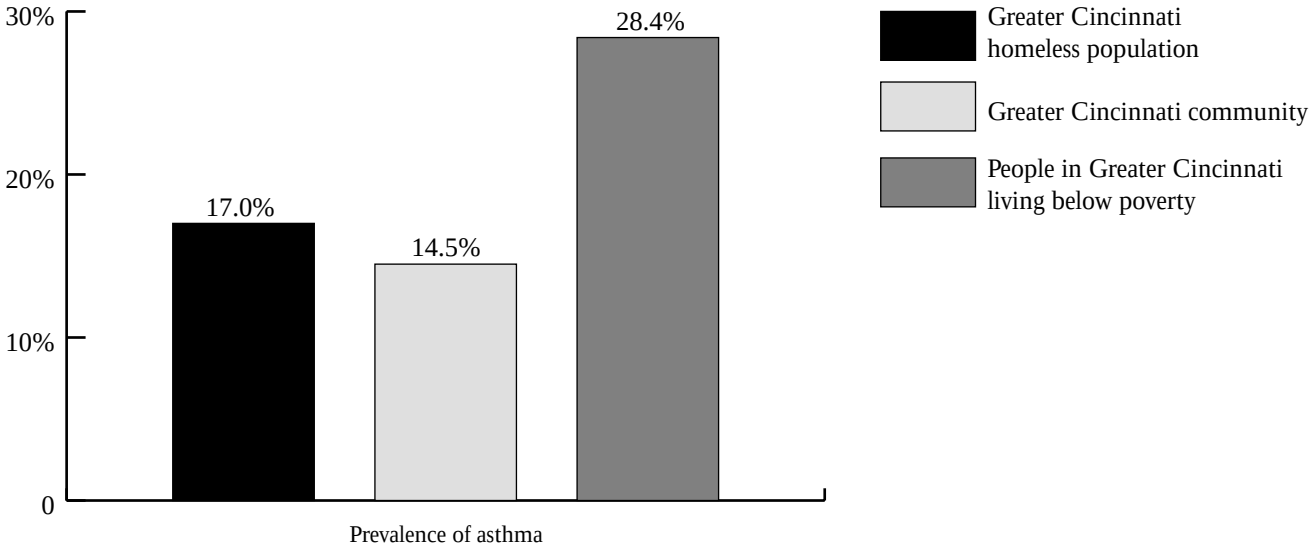


Figure 19: Comparison of the prevalence of asthma among the Greater Cincinnati homeless population versus local populations

Figure 20: Comparison of the prevalence of tuberculosis among the Greater Cincinnati homeless population versus the nation

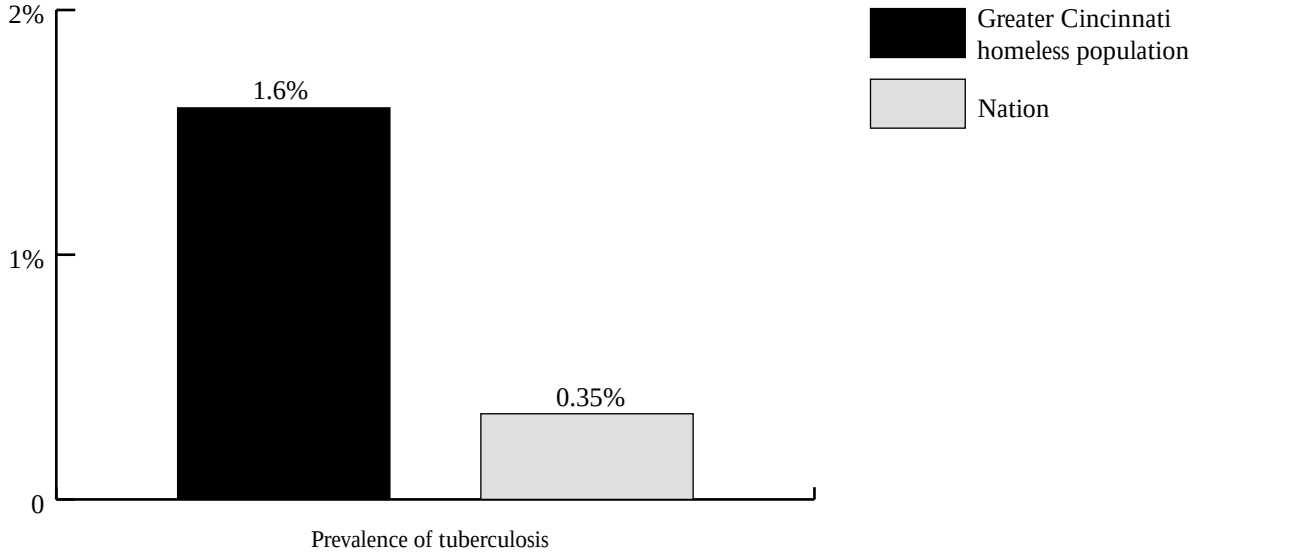
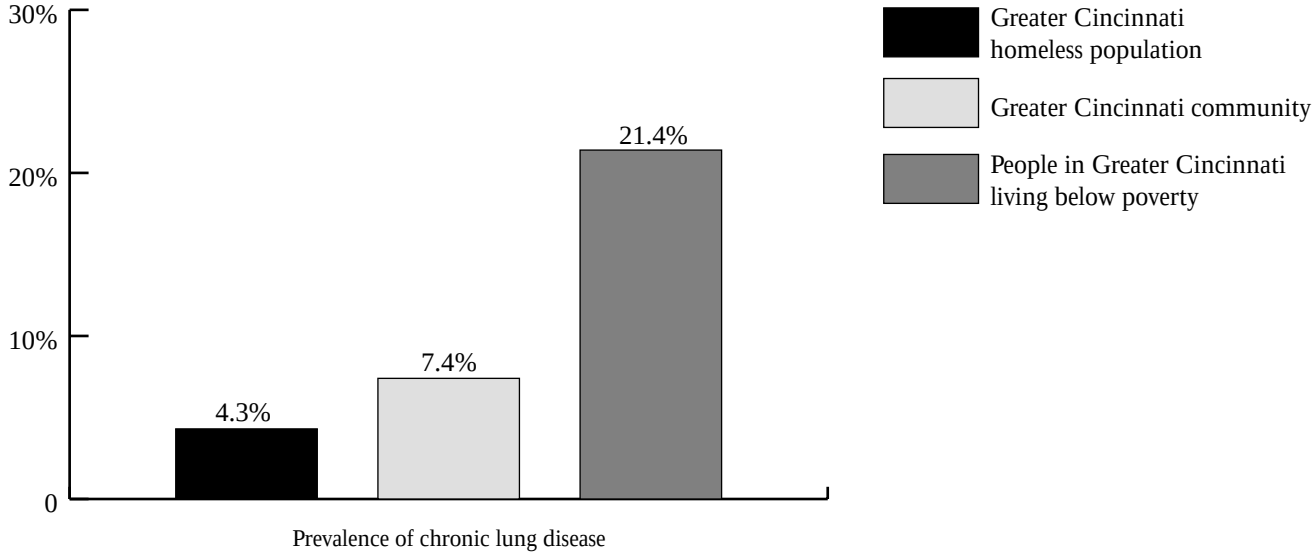
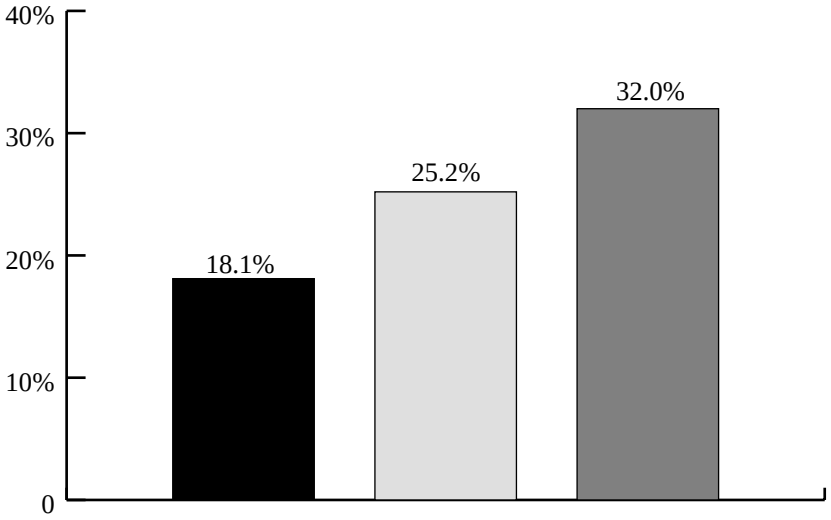


Figure 21: Comparison of the prevalence of chronic lung disease among the Greater Cincinnati homeless population versus local populations



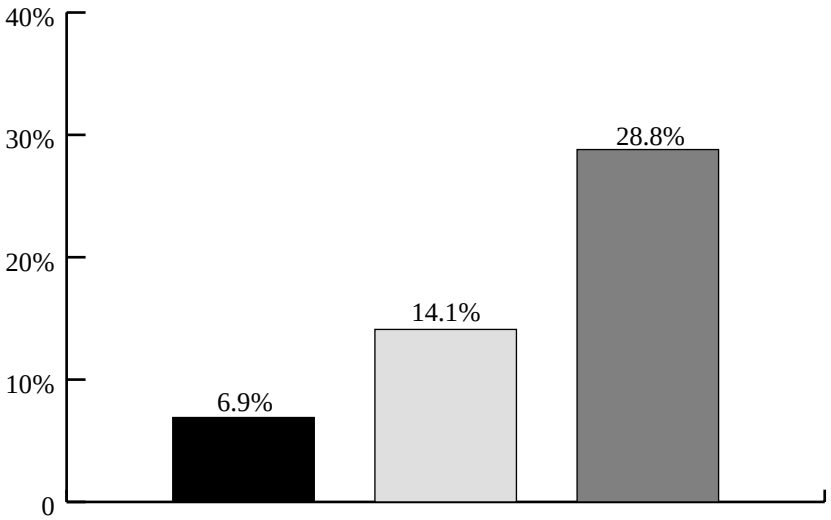
Circulatory System Conditions

Figure 22: Comparison of the prevalence of high blood pressure among the Greater Cincinnati homeless population versus local populations



Prevalence of high blood pressure

Figure 23: Comparison of the prevalence of heart trouble or angina among the Greater Cincinnati homeless population versus local populations



Prevalence of heart trouble or angina

Figure 24: Comparison of the prevalence of high cholesterol or triglycerides among the Greater Cincinnati homeless population versus local populations

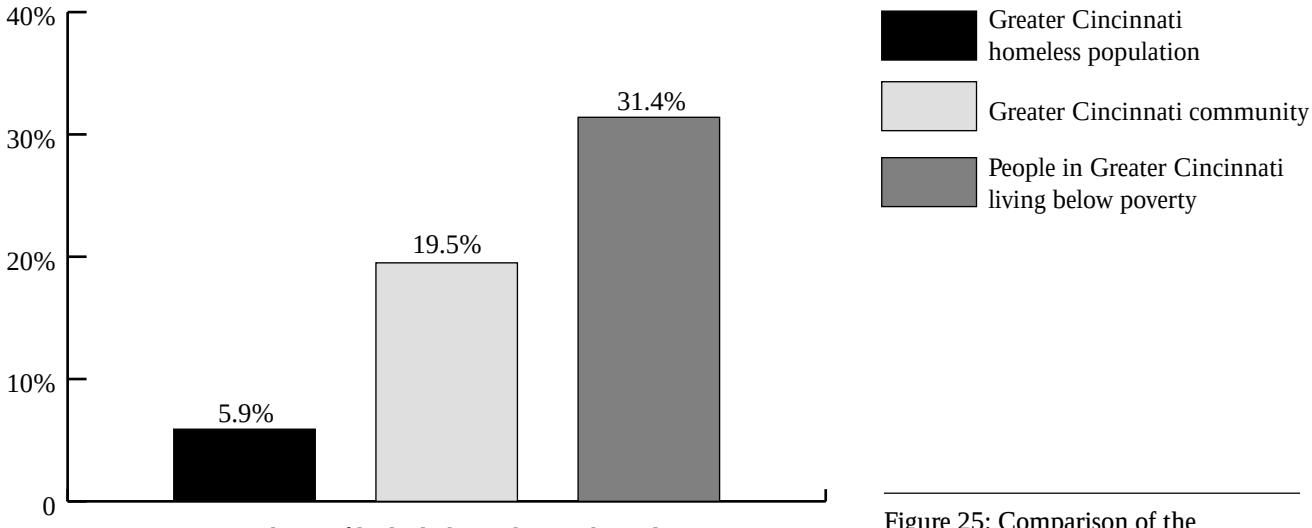
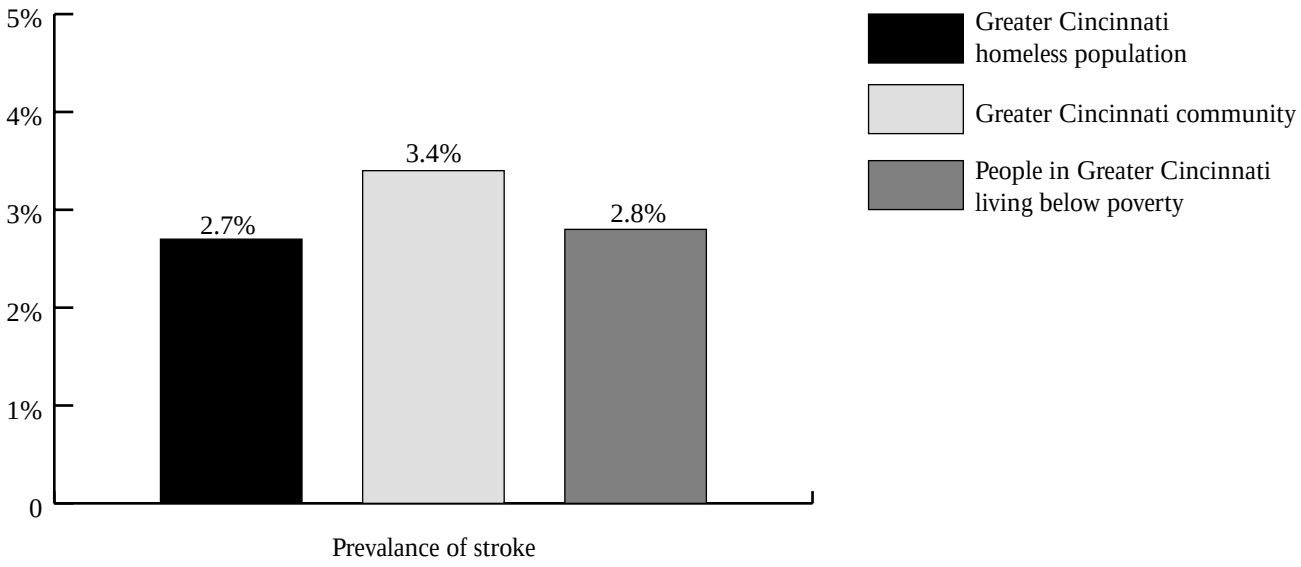


Figure 25: Comparison of the prevalence of strokes among the Greater Cincinnati homeless population versus local populations



Digestive System Conditions

Figure 26: Comparison of the prevalence of diabetes among the Greater Cincinnati homeless population versus local populations

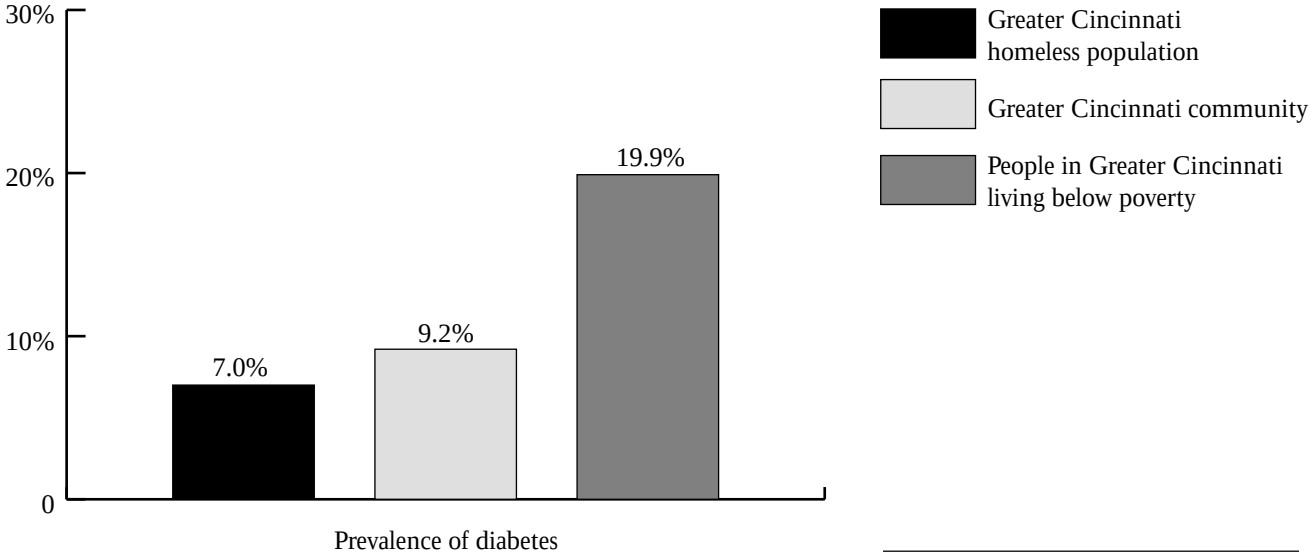
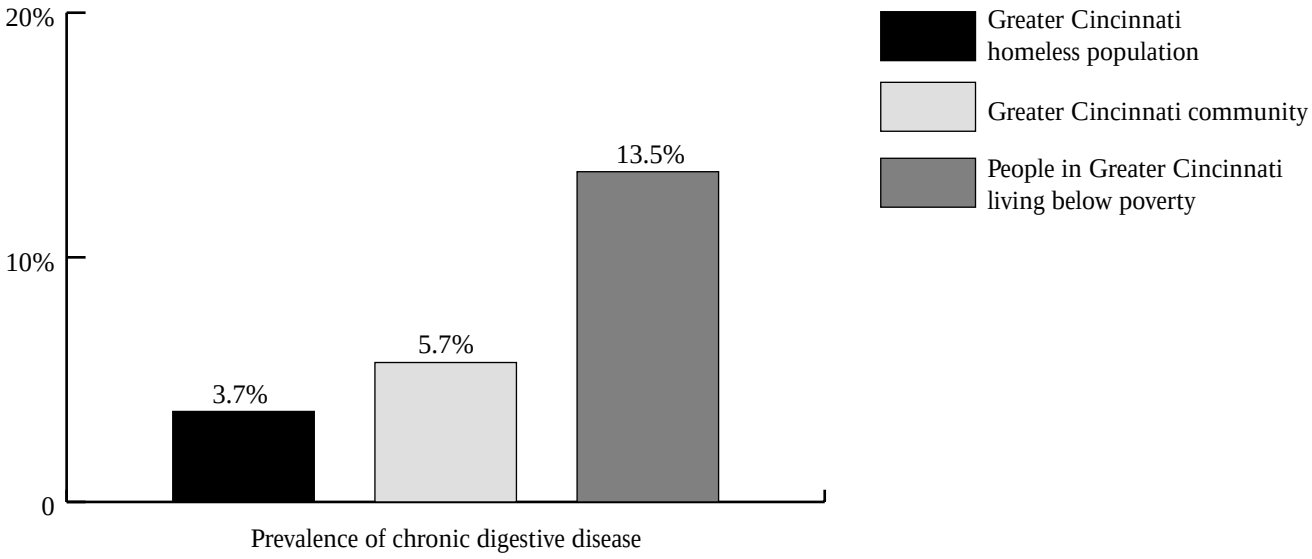


Figure 27: Comparison of the prevalence of chronic digestive disease among the Greater Cincinnati homeless population versus local populations



Bone and Joint Conditions

Figure 28: Comparison of the prevalence of arthritis among the Greater Cincinnati homeless population versus local populations

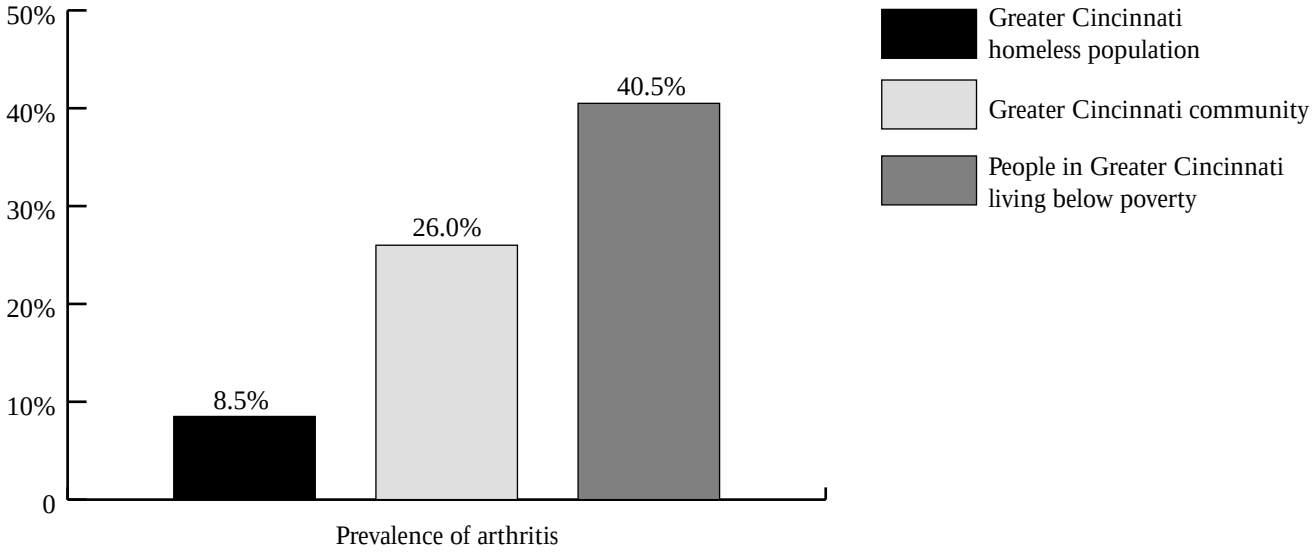
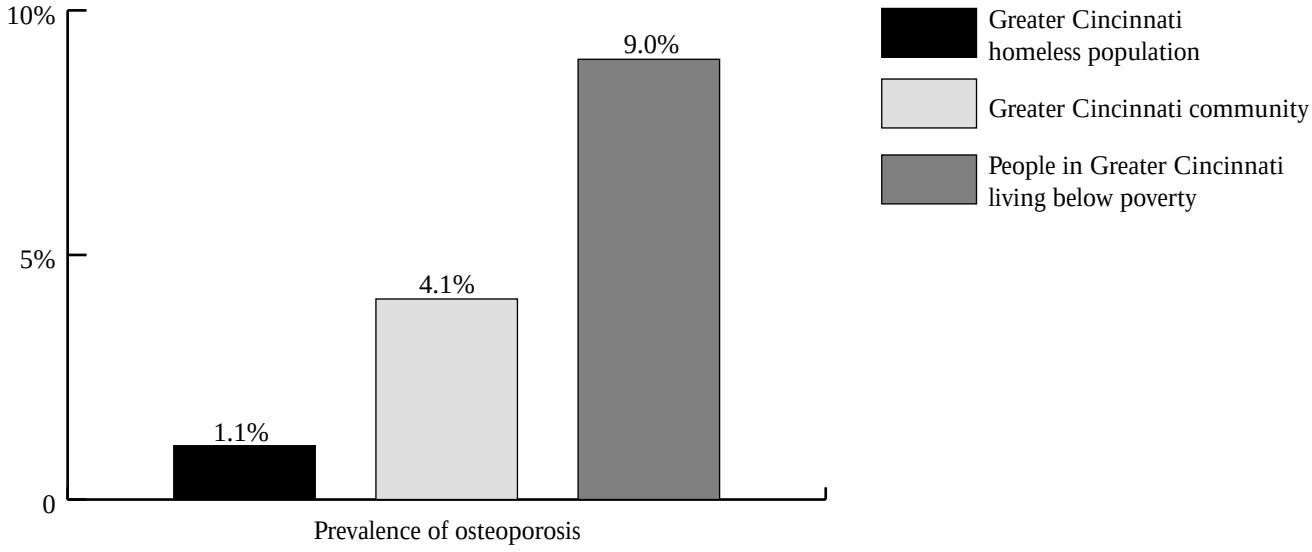


Figure 29: Comparison of the prevalence of osteoporosis among the Greater Cincinnati homeless population versus local populations



Chronic Pain Conditions

Figure 30: Comparison of the prevalence of migraines among the Greater Cincinnati homeless population versus local populations

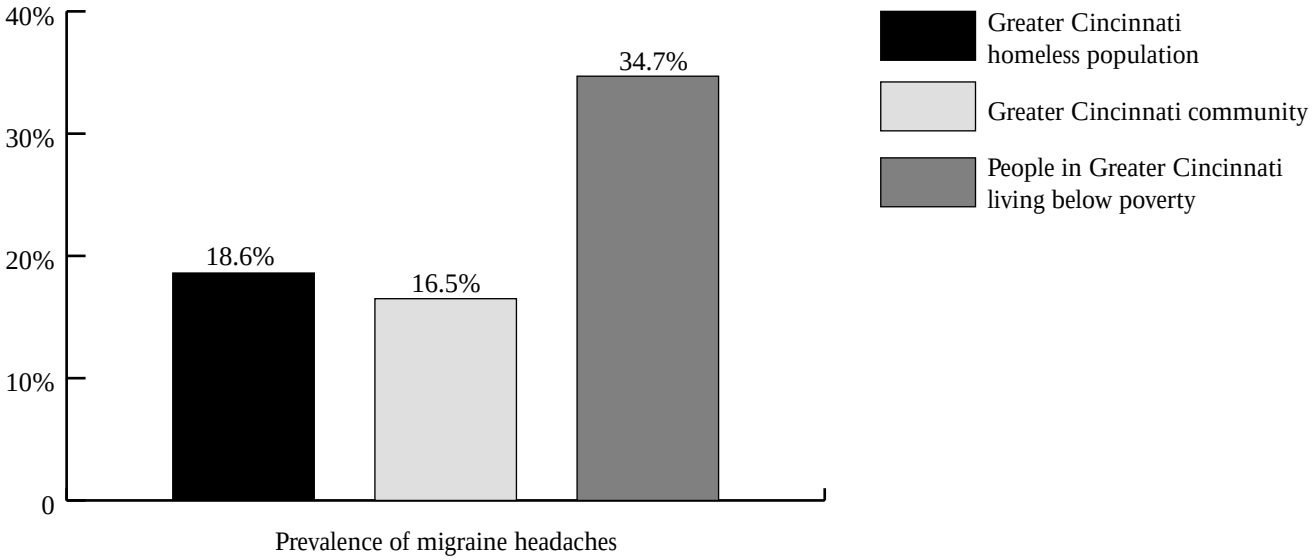
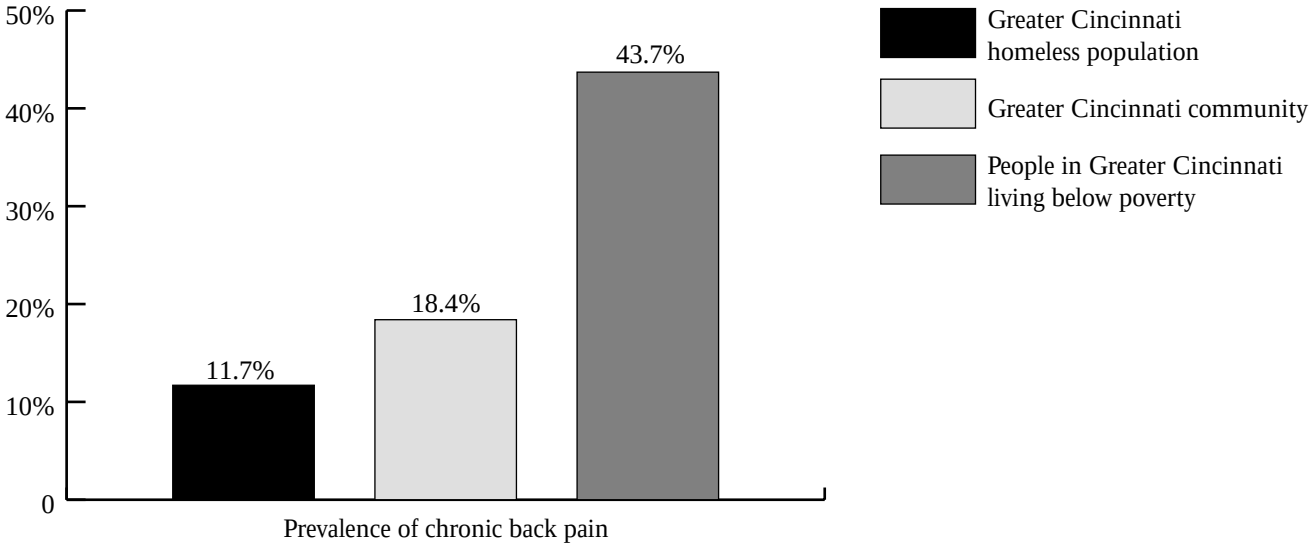


Figure 31: Comparison of the prevalence of chronic back pain among the Greater Cincinnati homeless population versus local populations



Other Health Problems

Figure 32: Comparison of the prevalence of hepatitis among the Greater Cincinnati homeless population versus the nation

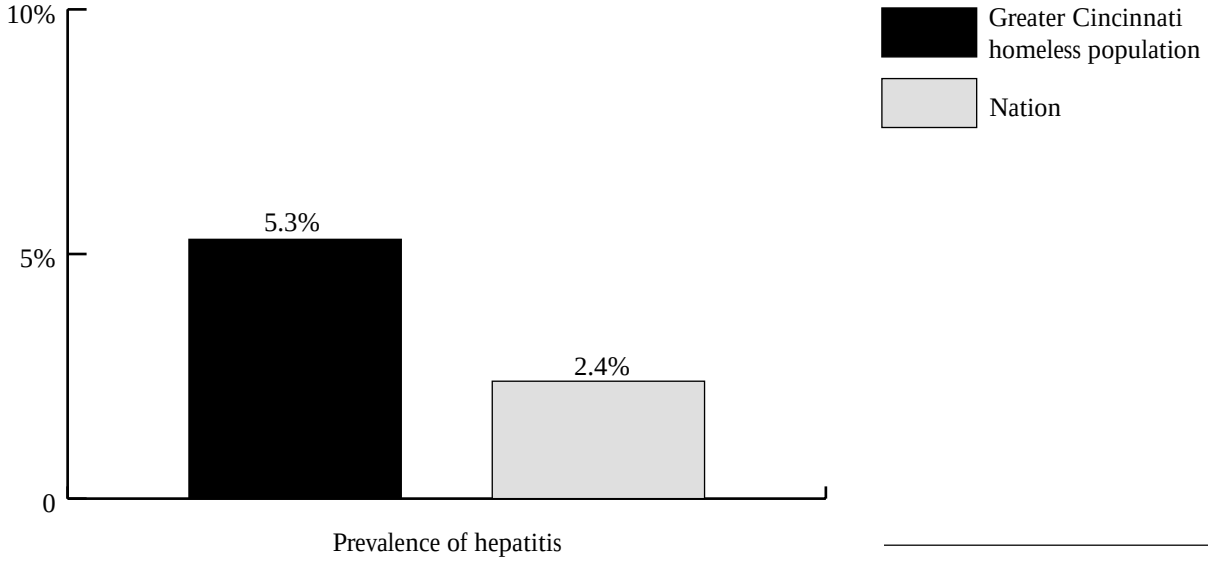
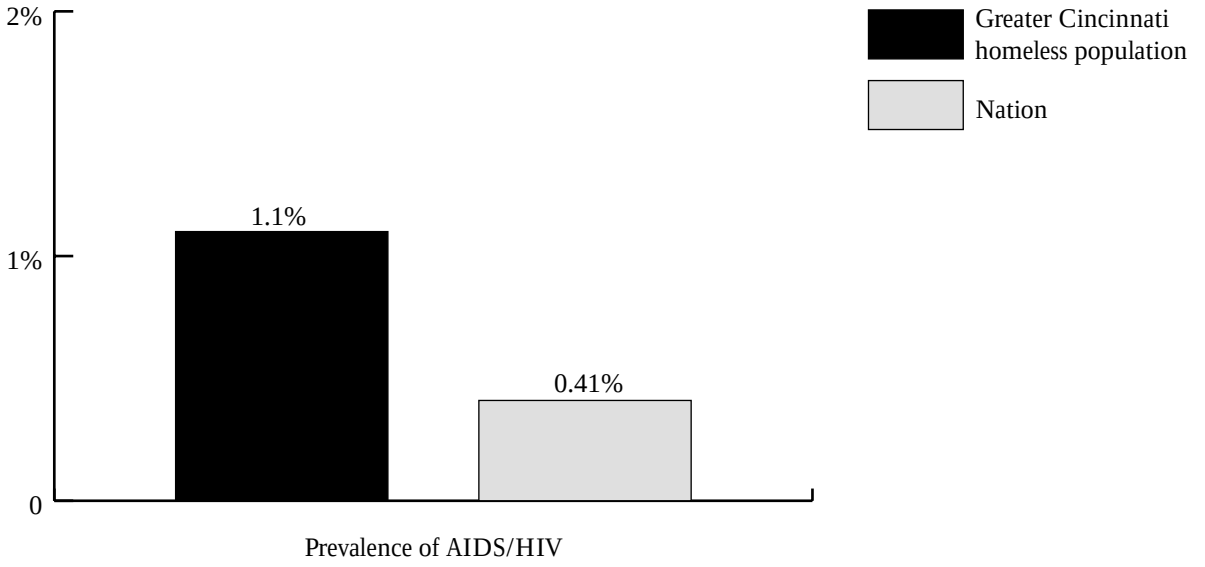


Figure 33: Comparison of the prevalence of AIDS/HIV among the Greater Cincinnati homeless population versus the nation



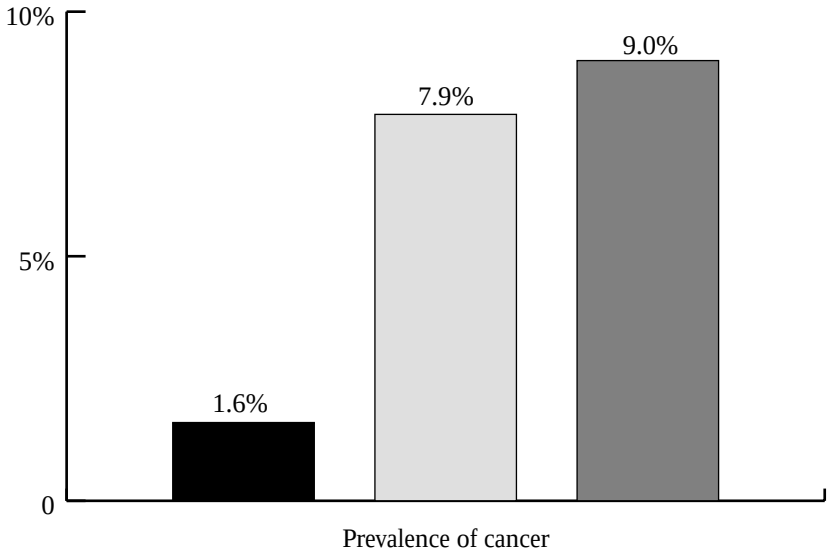


Figure 34: Comparison of the prevalence of cancer among the Greater Cincinnati homeless population versus local populations

Behavioral Health

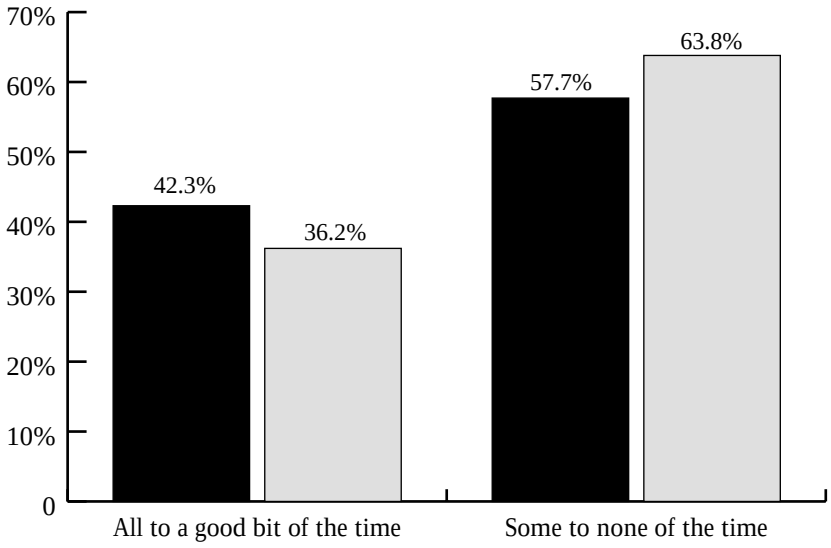
For a growing number of people who are homeless, behavioral health problems—such as substance abuse and mental illness—are daily realities. Even for people who are able to escape alcoholism or other drug addiction, depression is rampant. Not surprisingly, people who are homeless are significantly more likely to feel downhearted and blue, to battle depression, and to suffer mental illness than people in the general community. For some physical health conditions, people living below the federal poverty level have higher rates of problems than people who are homeless. But in the area of behavioral health, this is not the case.

Mental Health

General overall mental health is often assessed by looking at the amount of time one feels blue and downhearted versus

the time one feels calm and peaceful (see Figure 35). For people who are homeless, the experience causes more of the negative and less of the positive.

Figure 35: Perceived mental health of the Greater Cincinnati homeless population



During the month prior to being asked, people who are homeless were more likely to feel blue and downhearted and less likely to feel calm and peaceful than people in the general community (see Figures 36 and 37). Even people who live below the level of poverty—a situation that also can cause depression—are more likely to be calm and peaceful and less likely to be down than people who are homeless.

Figure 36: Comparison of feeling calm and peaceful by Greater Cincinnati homeless population versus local populations

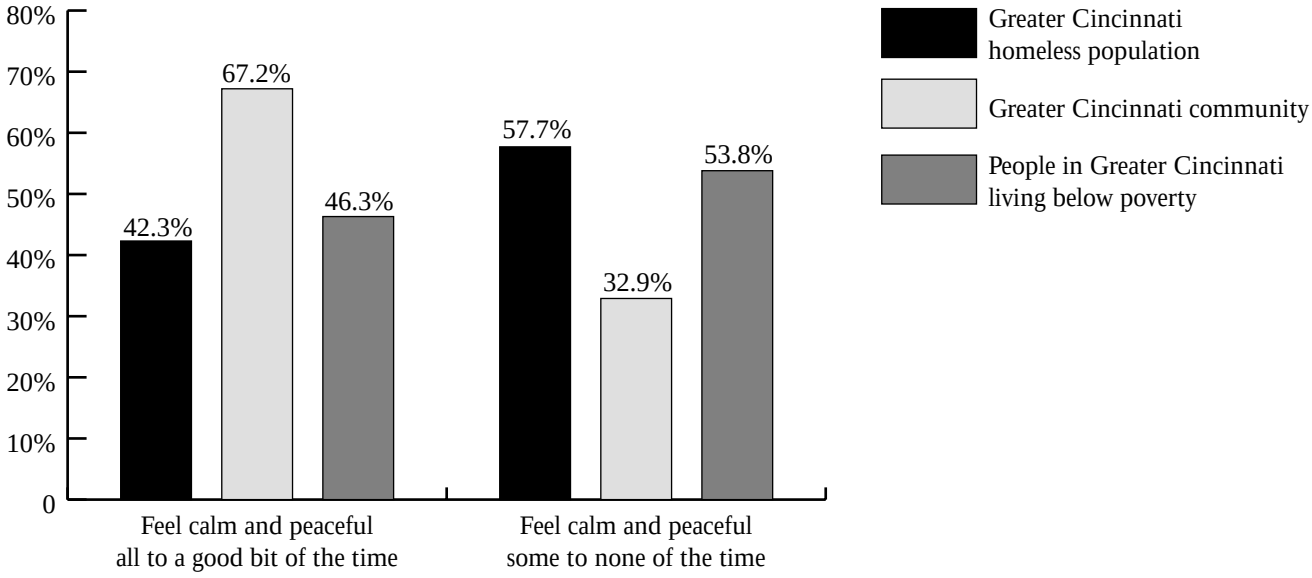
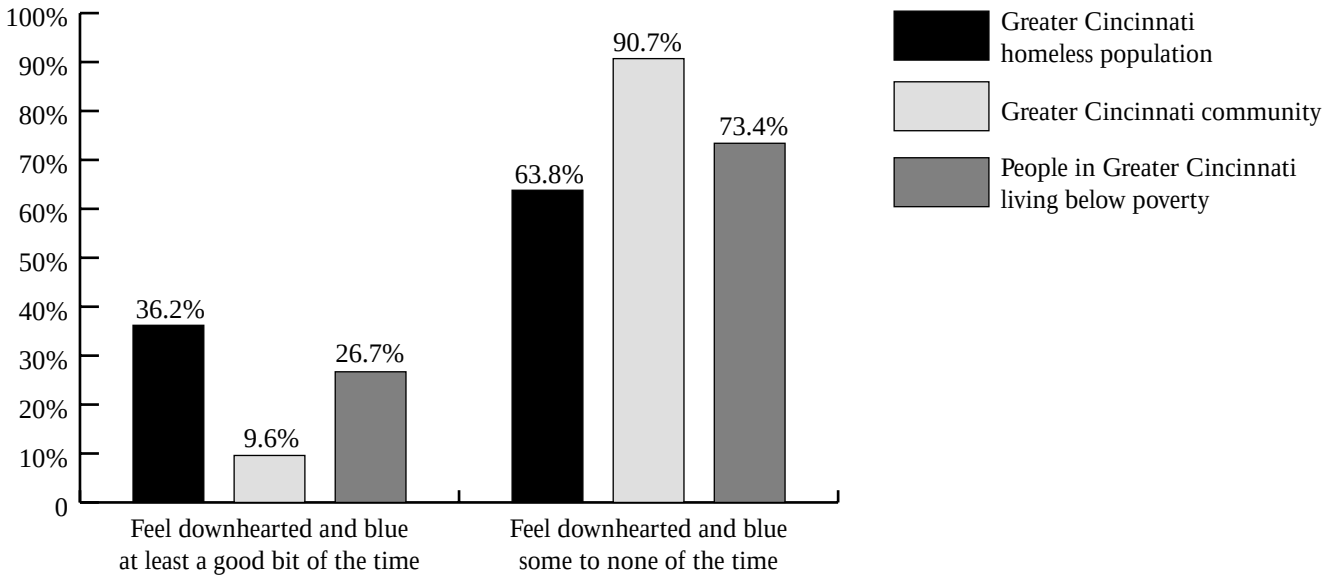
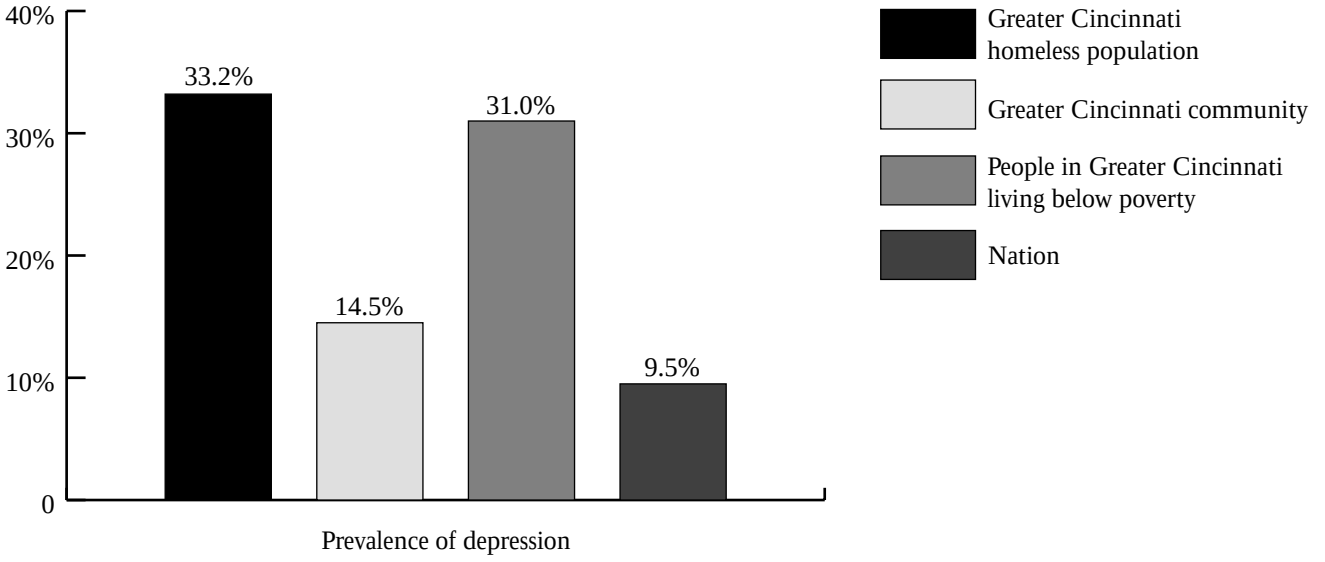


Figure 37: Comparison of feeling downhearted and blue by Greater Cincinnati homeless population versus local populations



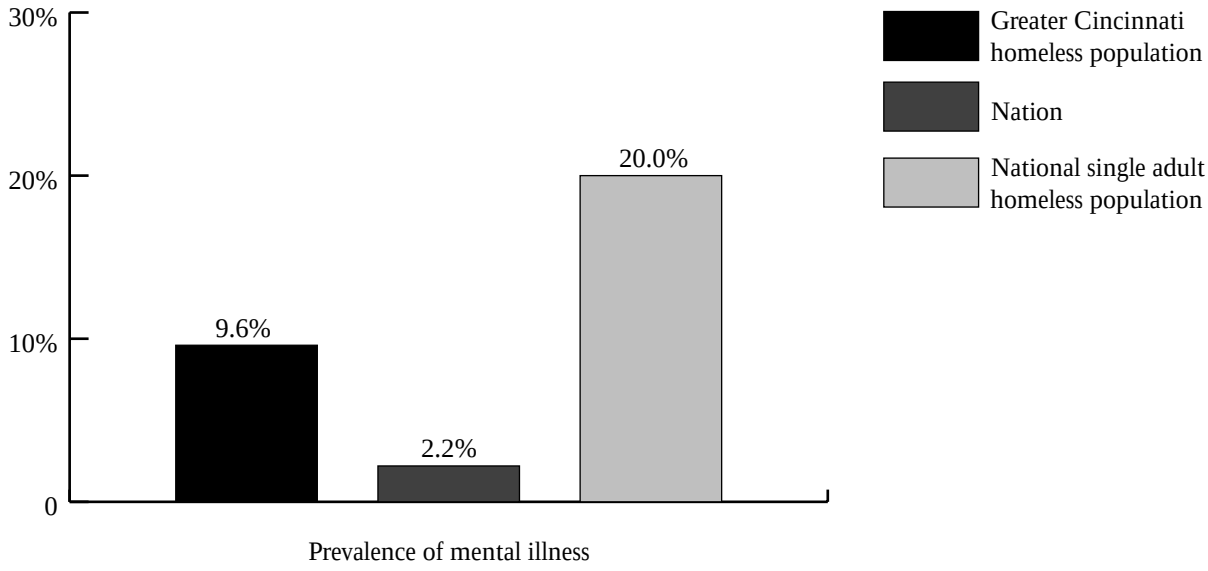
Depression. According to the National Institute of Mental Health, depression affects 9.5% of the adult American population in a single year. However, more than three times that many local adults who are homeless have been professionally diagnosed with depression (see Figure 38). People living in the general Greater Cincinnati community are half as likely to have been diagnosed with depression.

Figure 38: Comparison of depression of Greater Cincinnati homeless population versus national and local populations



Mental Illness. In 1999, the National Coalition for the Homeless reported that 20.0% of the single adult homeless population suffered from some form of severe and persistent mental illness other than depression (see Figure 39). However, only 9.6% of adults who are homeless in Greater Cincinnati have been professionally diagnosed with a mental illness other than depression. Again, as is the case of some physical health conditions, the lack of a diagnosis does not necessarily mean that a health problem does not exist. People who are homeless may not be receiving the care and attention required to diagnose mental illness.

Figure 39: Comparison of mental illnesses of Greater Cincinnati homeless population versus national estimates



Substance Abuse

Alcoholism is a problem that plagues over 7% of the American population, according to the National Institute on Alcohol Abuse and Alcoholism. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that drug addiction is a problem for 1.7% (age 12 and older) of Americans. Among the homeless population in Cincinnati, the percentage of people suffering from

alcoholism or other drug addictions is around 20% (see Figure 40 and 41).

Figure 40: Comparison of alcoholism of Greater Cincinnati homeless population versus the nation

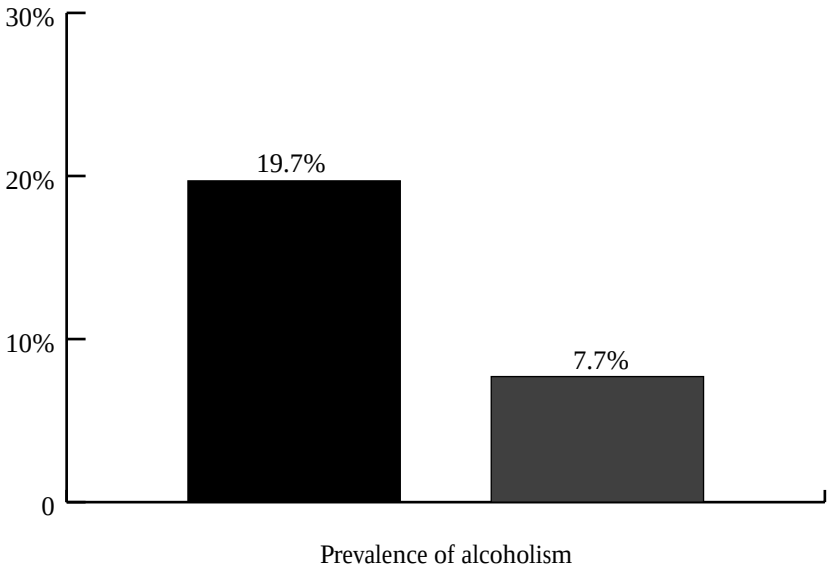
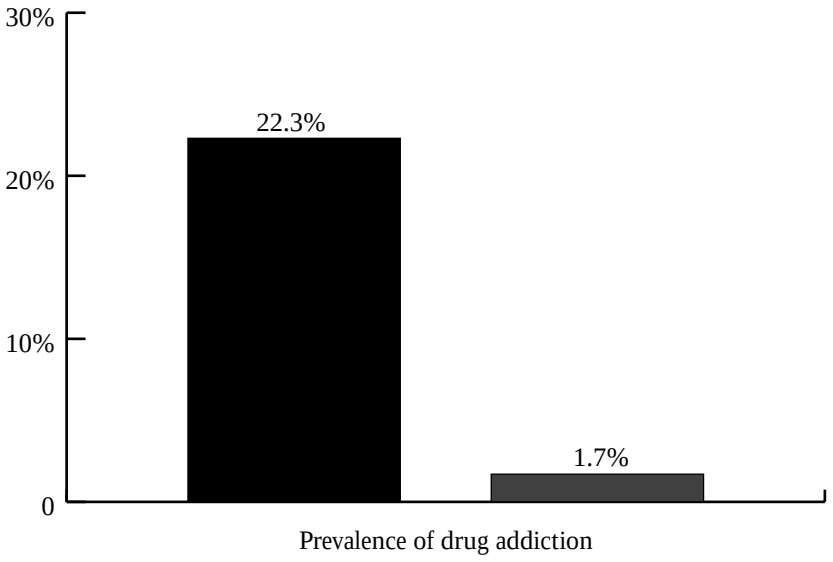


Figure 41: Comparison of drug addiction of Greater Cincinnati homeless population versus the nation

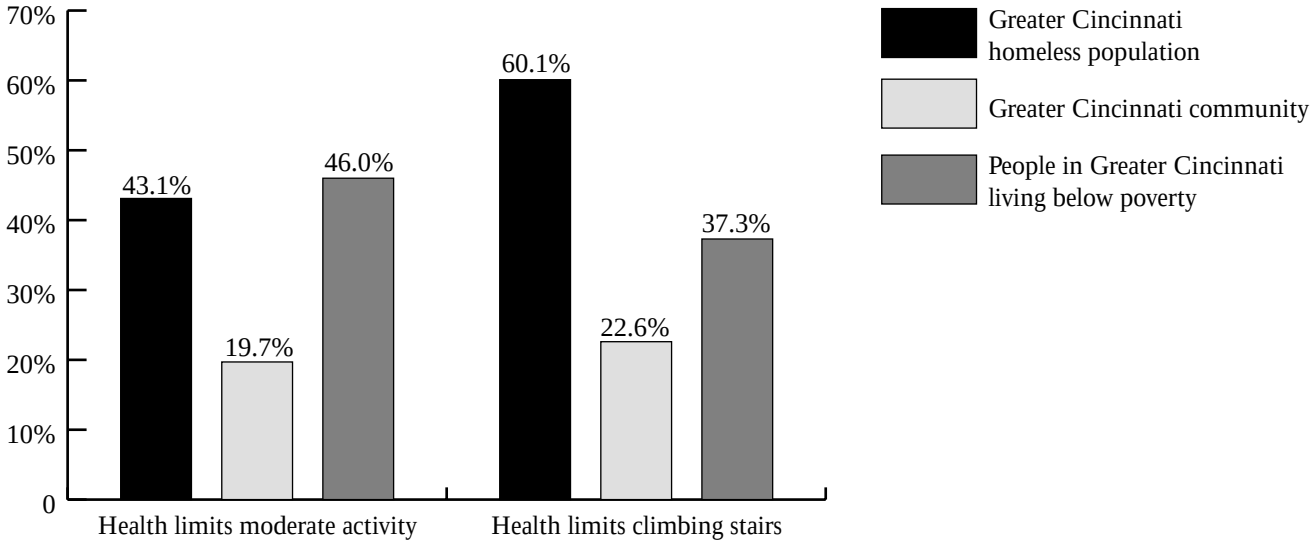


People who suffer from alcohol and other drug addictions are less likely to function at a level that would allow them to maintain some semblance of normalcy, including maintaining a home. However, as discussed in the section entitled “Services for the Homeless,” the availability of treatment options fall far below the need for the general population, let alone for people who are homeless.

Impact of Health Conditions on Daily Life

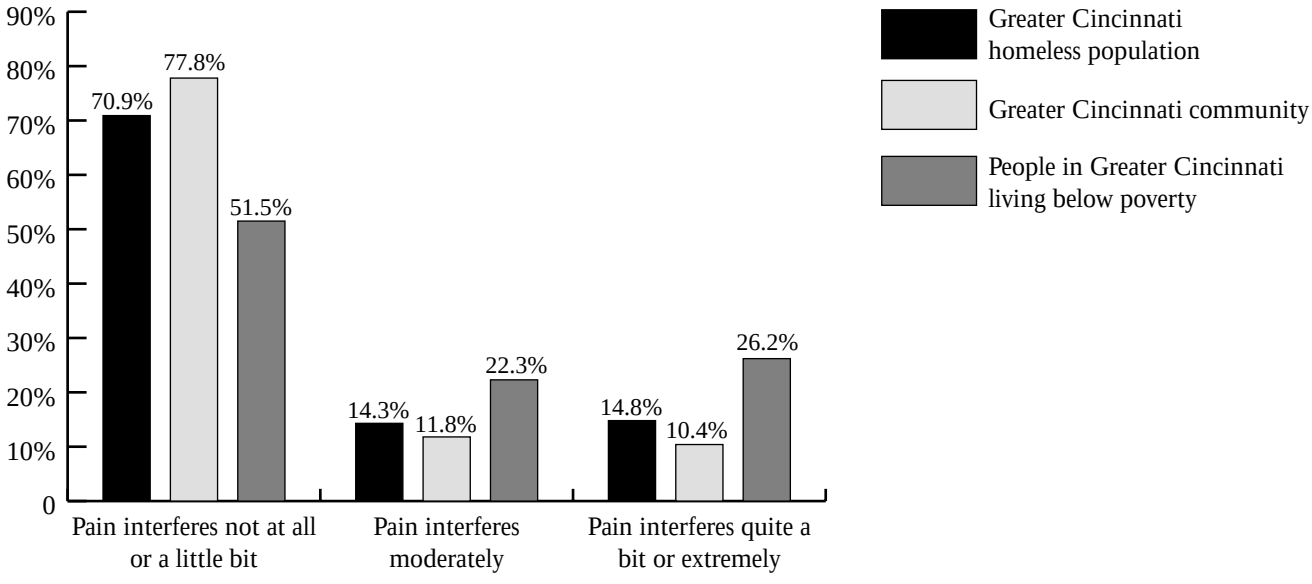
People who are homeless are as much as three times more likely to have health problems that interfere with their ability to function than people in the general population (see Figure 42). Only those people living below the poverty level have health problems at a rate comparable to that found among the homeless population.

Figure 42: Comparison of the interference of health problems on Greater Cincinnati homeless population versus local populations



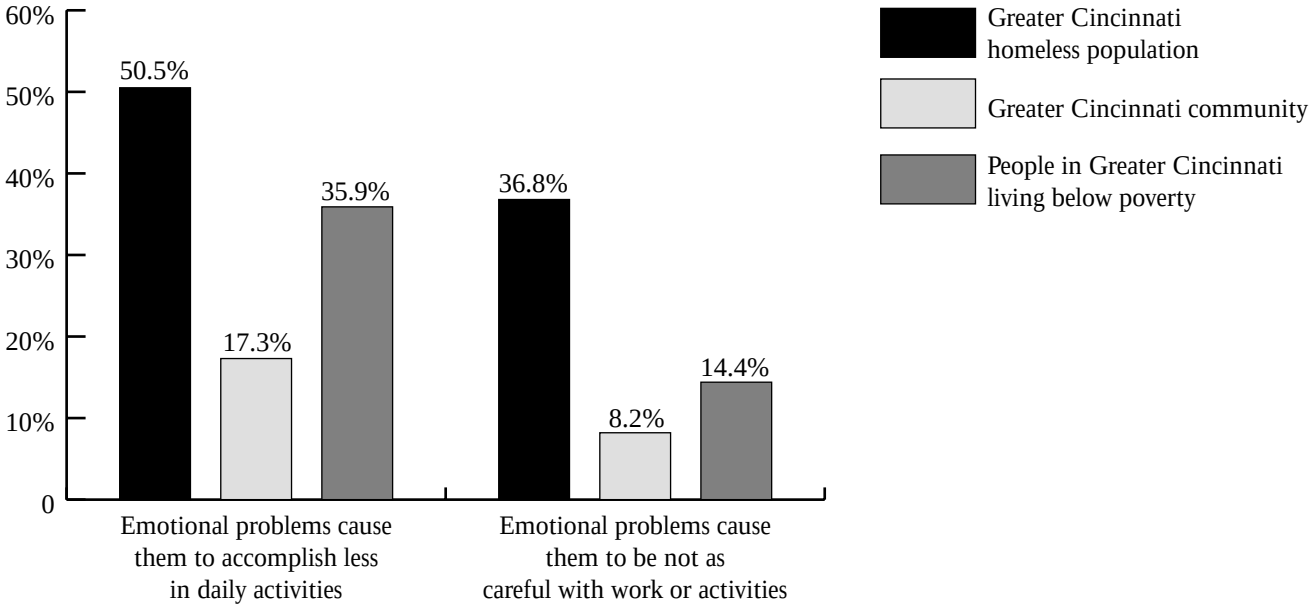
People who are homeless are also more likely to have pain interfere with their daily lives (see Figure 43). They are often limited in the kind of work they can do because of pain or other health problems, and they accomplish less than they would like on a daily basis.

Figure 43: Comparison of the interference of pain on Greater Cincinnati homeless population versus local populations



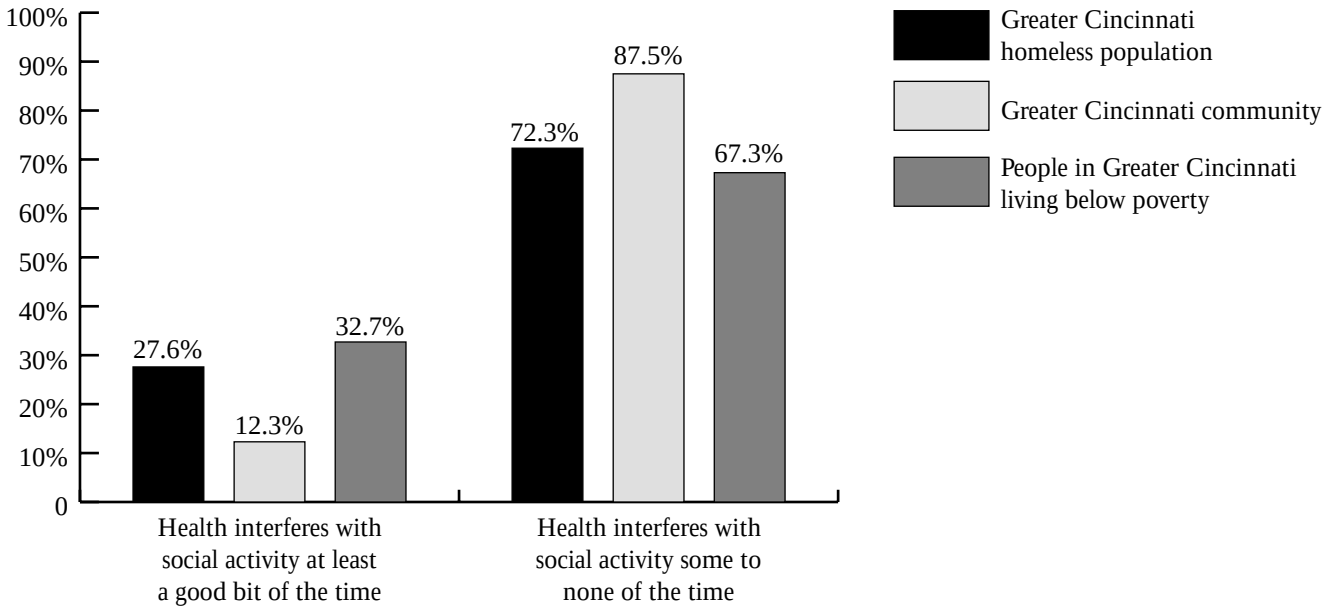
Emotional problems also regularly interfere with the ability of people who are homeless to go about their regular routines or complete tasks as thoroughly or normally as they would like (see Figure 44).

Figure 44: Comparison of the interference of emotional problems on Greater Cincinnati homeless population versus local populations



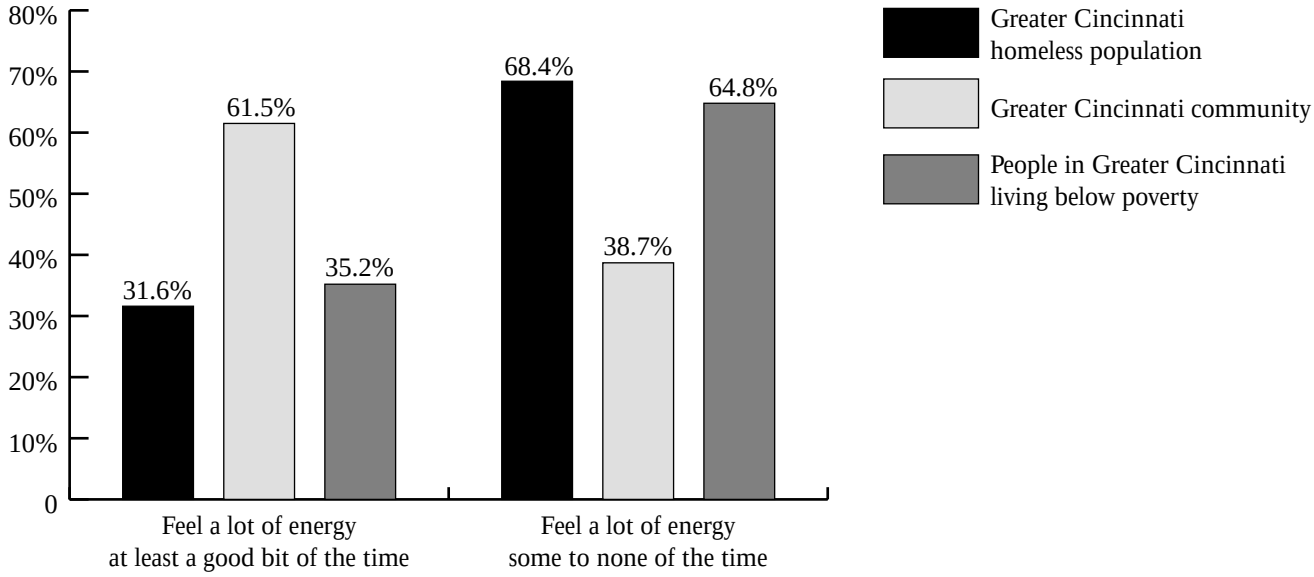
Overall health problems—whether they are physical, emotional, or mental—regularly interfere with the homeless population's ability to participate in social activities, such as visiting friends or relatives (see Figure 45).

Figure 45: Comparison of the interference of health problems on social functioning of Greater Cincinnati homeless population versus local populations



People who are homeless are less likely to feel energetic, and often feel sapped of their vitality (see Figure 46).

Figure 46: Comparison of feelings of vitality of Greater Cincinnati homeless population versus local populations



These interferences—regardless of the source—can equate to a diminished chance of success for people struggling to overcome their homelessness. Breaking out of homelessness is a process that requires physical well being, mental fortitude, and emotional strength. People who are physically ill may not be physically able to keep appointments with service providers. People who can not think clearly because of pain or mental illness may be unable to accurately complete a form, such as a job application. People who are depressed may not have the emotional energy to overcome any obstacle beyond what is necessary for basic survival. The result is that the health condition of people who are homeless may interfere with attempts to achieve self-sufficiency.

Services for the Homeless

Services for the homeless population in Greater Cincinnati begin, as in any city, with the immediate need for shelter. But homelessness, as this report has tried to demonstrate, is a complex issue, and responding to the problem of homelessness requires a multitude of solutions that go beyond basic shelter. If people are to move beyond homelessness, all their needs must be met: healthcare, education, employment, and safe, sanitary, and affordable housing. If not addressed adequately, these needs have the potential to leave too many people in a permanent state of homelessness.

Much is being done in the Greater Cincinnati area in all these areas of need. In fact, since 1996, supportive services for people who are homeless make up the majority of the programming under the City of Cincinnati/Hamilton County's Continuum of Care plan submitted annually to the U.S. Department of Housing and Urban Development (HUD) for federal funding. For example, a number of shelters are now providing shelter "plus care." Along with a bed and a meal, these shelters provide additional assistance to give people who are homeless the supportive services—including health, education, employment, and housing placement services—they need to move beyond their current status.

Generally, people who are homeless are able to access supportive services through various outreach, shelter, and housing systems in the area. While residents of homeless facilities have priority for this assistance, some services—such as for oral healthcare and HIV/AIDS—are available to people who are homeless who are not connected to any other provider.

Unfortunately, what is being done is not enough. One example can be seen in the availability of treatment for people with behavioral health problems. Currently, treatment options for behavioral health problems fall far below the need for the general population. If the general population—who has many resources and is far better equipped to overcome obstacles—can not get treatment,

how can people who are homeless—who often lack resources and support—be expected to get treatment?

Working together, service providers in the Greater Cincinnati area are moving toward the development and implementation of a single, coordinated homeless assistance system. Their aim is to help all people who are homeless, including those with special needs, to move from homelessness to economic stability in affordable, permanent housing within a supportive community. The descriptions of the services that follow are based on the City of Cincinnati/ Hamilton County Continuum of Care plan and apply only to Hamilton County.

Shelter

Although local shelters operate at 79% of their capacity on average, they are always filled to capacity during peak seasons—winter for single homeless people and summer for homeless families—and often have a waiting list or overflow. Despite this periodic crowding, the Continuum of Care plan found that "there appears to be enough generic emergency shelter beds to accommodate persons in need." Beyond maintaining existing shelter beds, it seems that resources need to be directed toward moving people who are homeless into transitional and permanent housing.

Shelters for the homeless population in Cincinnati fall into three broad categories—those serving single men or women, those serving families, and those serving special populations. These special populations include men and women in recovery from alcohol and other drug addictions and people suffering from mental illness.

Shelter for Single Men and Women

The largest shelter in terms of capacity in Hamilton County continues to be the Drop Inn Center, which now has expanded to include facilities for single women as well as single men. It serves the homeless population as the refuge of last resort, particularly on the coldest and most bitter of winter nights. For example, in January 2000, the Drop Inn Center reported over 8,200 shelter nights. This means that for each night that month, an average of 260 people found shelter within its walls.

Other homeless shelters for men have been a part of the community landscape for centuries. These shelters include a number of religiously-oriented facilities that seek to save both the man and his soul. These "pray to stay" facilities remain a vital resource in the community.

Hamilton County also operates a men's shelter in Mt. Airy Forest. This shelter serves one of the higher concentrations of veterans who are homeless, who generally make up over a third of that facility's residents.

Shelter for Families

Family shelters typically serve single-parent (usually female) families with children under age 18, as well as individual women. The operators of these shelters report a dramatic increase in complexity of problems they are seeing among the families they serve. For example, families who at one time may have lost housing due to economic reasons are now losing housing due to rules concerning drug use as well as economic reasons. Family situations are further complicated by an ineligible status for housing assistance because of large indebtedness to the public housing authority or utility companies or because of a criminal record.

One special-purpose family shelter run by the YWCA provides services to the victims of domestic violence. Although this terrible problem crosses all socioeconomic categories, battered women served at this shelter tend to be younger and poorer than the community at large.

An important fact to point out is that some family shelters in Cincinnati do not allow boys over age 14 to stay in the shelter with their families. These young men may be left to find their own shelter, thereby separating them from their families, or their families may choose to stay on the streets in order to remain together.

Shelter for Special Populations

One of the greatest pressures on all shelters is the increasing number of men and women with substance abuse and mental health problems. A few Cincinnati shelters have developed substance abuse treatment programs for their residents. The capacity of these programs remains small due

Meet Charlie and Denise

Charlie and Denise have seen hard times. They have a regular income from Charlie's job, where he makes about $7.50 an hour. This is supplemented by Social Security benefits that Denise receives because of her mental disabilities. But Charlie's work is not steady, and, of course, pays no benefits. They and their three children have been evicted from Cincinnati Housing Metropolitan Authority (CHMA) because of non-payment of rent, and they have serious outstanding obligations with utility companies. Lacking any financial reserves, and unable to stay with family when they were evicted from public housing, they have been forced into a shelter.

Contributing to their difficulties is the fact that both Charlie and Denise have substance abuse problems, and one of their three children has serious asthma. The oldest child, who is in school, has been tested and placed in Special Education classes because of behavior problems. The same fate seems to await the middle child who would normally be starting kindergarten next year.

Shelter providers are working to find appropriate supportive care and housing. Almost as important is finding reliable transportation to work for Charlie, since his job cannot be reached by public transportation.

to the intensity of the treatment and the challenge of transforming lives. These programs have also developed transitional housing programs that offer continued supportive services as individuals reenter the community. Prospect House, a program for men with substance abuse problems, has gone one step further and established permanent housing for graduates of the program. This latter group is not counted among the homeless.

Another special population is made up of clients of the mental health system who through a variety of programs, such as Tender Mercies or Excel Housing, have obtained permanent housing with continuing supportive services. The community has developed these programs to replace the formerly state-run institutions for people with mental illness. However, de-institutionalization continues to place a heavy burden upon urban centers to care for those who cannot fully care for themselves. Many of these people drift into homelessness.

Health

There are approximately six agencies who are dedicated to the health needs of the homeless in Hamilton County. Most of these agencies, however, are designed to address a specific health need, such as substance abuse, or a specific population, such as youth or people living with AIDS. A few agencies are geared toward serving people with a dual diagnosis, such as mental illness and substance abuse or AIDS and substance abuse. The Center for Independent Living Options provides supportive services for people with physical or mental disabilities who are homeless. There is also a network to serve the oral health needs of the homeless.

Despite these efforts, the latest Continuum of Care plan shows that treatment needs, particularly for substance abuse and mental illness, remain high. Treatment needs for those who are dually diagnosed are also a high priority.

Education

There are programs designed to keep children who live in shelters in school, but educational options for adults who are homeless are limited. Adults who lack a high school diploma have access to GED preparation programs and testing, but

often bureaucratic "red tape" creates obstacles to this process that prove to be too much to overcome for individuals overwhelmed by so many other problems. Besides, while earning a GED is not to be discouraged, it does not hold the same weight in the job market as a high school diploma. Also, possessing a GED does not necessarily equate to having employable skills.

Employment

Some agencies—such as the Drop Inn Center, Ohio Valley Goodwill Industries, and the YWCA—provide job training for people who are homeless. Other agencies provide transportation, child care, and other supportive services that help overcome some of the barriers to employment. Employment opportunities are available through several temporary employment agencies. Though these agencies provide needed jobs, they lack benefits and the fees they charge workers for supportive services—such as transportation or special equipment—make employment by these agencies a less attractive option. While employment is certainly a need among the homeless population, the latest Continuum of Care gap analysis shows that this is not a high priority. Other concerns such as health needs and affordable permanent housing have a far greater priority.

Transitional and Permanent Housing

Much is being done to secure transitional, permanent, and permanent supportive housing for the current homeless population. Over 15 agencies have a housing component as part of the services they provide, and efforts to increase the availability of housing for the homeless population are ongoing. Until more permanent housing is available, people living in transitional housing will continue to have a difficult time moving on, which prevents people living in shelters from moving up to transitional housing.

The City of Cincinnati, through its Community Development Advisory Board, places a high priority on the renovation and creation of housing for its low-income population. In addition, the City cites improved opportunities for affordable rental housing as an additional housing goal. Hamilton County also supports the development of permanent affordable housing, but to a lesser extent. Other counties in this region are addressing

Meet Frank

Frank is part of a loosely knit band of people who live in and around the University of Cincinnati and who concentrate their activities in the "Short Vine" area. Most of the group is male—only about one third is female. Like most of his colleagues, Frank is a high school dropout. He grew up in suburban Cincinnati and left (or was pushed out of) home for a variety of reasons. He works intermittently, usually in the kitchen of one of the area restaurants. Frank has no permanent address and moves easily between living on the street and crashing at a friend's house.

Frank's health is problematic, but the absence of insurance and a distrust of free services have kept him from seeing a doctor or dentist.

Alcohol and other drugs are a regular part of Frank's life. He has experimented with crack and heavy drugs and is a regular user of marijuana and prescription painkillers. He acknowledges that he has some emotional problems and frequently feels depressed and downhearted. The idea of talking to a mental health professional has seemed appealing, but he hasn't followed up on it.

The most hopeful thing that can be said about Frank's future is that it seems possible that he will outgrow his current status. Only about 10% of the Short Vine population is older than 30. The rest become stable enough to move onto permanent housing or move to other areas of town where there is an older homeless population.

their needs for housing, as well. This is a regional issue, and no one city or county is solely responsible for the solution. Rather, the region should collaborate to find solutions that work.

Coupled with this simple shortage of housing in general is the shortage of housing for the special populations who need supportive services. These special populations include people who are in recovery from alcohol and other drug addictions, who suffer from mental illness, and who have other chronic or permanent physical disabilities that limit their ability to live on their own.

Convicted felons also, at times, have a problem securing housing. A program currently under study would erase felony convictions from the criminal records of some individuals to increase their ability to access housing.

Recommendations

This description of homelessness in Greater Cincinnati should concern our whole community. How could we not care that the homeless are becoming increasingly African American, that teenage boys cannot find shelter with their families, that homelessness happens increasingly to whole families, that there is little decent, affordable housing available?

In this section, the Greater Cincinnati Coalition for the Homeless presents some interventions that could make a difference. These recommendations come from both the Coalition's day-to-day experience in wrestling with the problems of homelessness and from the findings outlined in this report.

The responses fall into five broad areas. The first three—health, earnings potential, and housing—address the basic survival needs of individuals. The fourth—early intervention with selected high-risk groups—looks at the prevention of homelessness by providing high-risk people with resources to keep them from becoming homeless. The fifth area—race, poverty, and homelessness—grapples with an issue central to our community and critical to the very survival of our society.

Physical and Mental Health

Issues

Fragile physical and mental health are obstacles to individuals trying to resolve their homeless status. Particularly for those suffering from addictions and mental illness, poverty and additional health problems often lead to homelessness.

Possible Responses

To address the health needs of the homeless, physical and mental health treatment, medical, and homeless service providers, county mental health and substance abuse boards,

and the community should consider the following interventions for implementation:

- Train shelter personnel to identify symptoms of two leading health concerns of the homeless—asthma and depression—and to connect individuals to treatment.
- Develop and implement programs for the management of asthma (a chronic disease) and for the prompt treatment of asthma attacks among the homeless.
- Extend Medicaid coverage to eligible single adults and childless couples in poverty, similar to that which now exists for eligible children and their parents.
- Establish additional outreach, resource development, and treatment programs for the homeless population suffering from mental illness and substance abuse.

Discussion

The health data in this report reveal that people who are homeless, when measured against national averages or the community at large, are in poorer health. Two conditions in particular are of concern. Asthma is much higher among the homeless population than the general community, while depression is of epidemic proportions. Both conditions are aggravated by stress. With early identification and treatment for these conditions, people who are homeless would be better able to take advantage of supportive services that could help them permanently resolve their housing problems.

The increasing prevalence of substance abuse and addictive behavior among the homeless is another grave concern. In addition, the Continuum of Care Gap Analysis indicates that there is an increase in homeless people who suffer from both addiction *and* mental illness. These numbers, which have always been higher than the community at large, are growing in comparison to previous studies.

Despite a variety of innovations, the community still has insufficient mental health and substance abuse treatment capacity, particularly for the indigent, and relies upon the criminal justice system to deal with overflow and more violent people. In fact, treatment options are insufficient for the general population, let alone the homeless population.

Locating physical facilities that are suited for such program needs and that are able to meet neighborhood approval is an additional obstacle that needs to be addressed.

Furthermore, recent advances in health insurance for children and their parents are in stark contrast to the circumstances facing single adults and childless couples, but especially single men. Other than the programs of the Cincinnati Health Network, single men are not eligible for free or reduced-cost care and lack access to preventive health resources.

Earnings Potential

Issue

Despite the relationship between education levels and employment, the limited time welfare reform allows for educational activities affects the earning potential of recipients. Consequently, people facing the most obstacles are left further behind. In addition, although almost 60% of homeless men and 45% of homeless women work, they do not earn enough money in these jobs to achieve self-sufficiency.

Possible Responses

To address the income and employment needs of the homeless, homeless service providers, welfare systems, public and private funders, school systems, housing providers, and the community should consider the following interventions for implementation:

- Encourage and support welfare recipients to obtain meaningful education and training which will allow them to earn enough to become self-sufficient.
- Enhance opportunities for at-risk people—especially women—to complete high school or vocational training.
- Develop vocational training options for careers with a high potential to provide a living wage.
- Reduce the numbers of high school dropouts, who have their potential limited by their lack of an education.

Meet George

George is homeless, but disdains shelters and lives in a small encampment beneath an interstate overpass. George is probably Appalachian in heritage and is older, perhaps in his early 50s. He has been on the streets since his 30s following a failed marriage and the loss of his job and home. Alcohol is his prime drug of choice, although when marijuana is available, he will certainly use it. George works three or four days a week at a temporary agency and is adept at using available social services for food, clothing, and an occasional hair cut and shower.

George figures that his health is "fair" to "good" and it doesn't prevent him from doing the things that he needs to do—although he admits from time to time that he is kind of "down" and may be experiencing some emotional problems. This doesn't stop him from getting through the day. Consistent with his use of other services, George makes it a point to stop by the health van every year or so, but costs for dental and mental healthcare keep him away from those services. His wish for the future would be a safe, warm place to live and adequate food.

George's future is probably limited. Living on the streets is a harsh life, and few manage to survive beyond the age of 60.

- Increase funding for jobs programs that demonstrate results in helping people obtain entry-level positions and in coaching people for advancement.
- Train social service employees to better recognize depression and mental disability, both of which, if left untreated, can inhibit a person's ability to learn employment skills and to obtain or retain a job.
- Work together to keep children who are homeless in stable classrooms, thereby decreasing disruptions in education that affect both the children and the classroom environment.
- Develop transitional housing to provide homeless workers with the opportunity to save money for rent deposits for permanent housing while benefiting from supportive services offered in the transitional housing setting.

Discussion

Sustainable self-sufficiency was not the goal of welfare reform; removing people from the welfare rolls was the goal. So although welfare reform has reduced the number of people receiving welfare, it has also transferred the costs of sustaining former recipients to other social service agencies. To help people being moved from the welfare rolls obtain self-sufficiency, welfare programs should better support training and education opportunities for these individuals.

An important change in the composition of the homeless population compared to previous studies is that the education levels of women in shelters have dropped. Surveys show that only about 33% of the respondents had a high school degree or higher levels of education, and few had any college experience. Education and training are necessary to help women who are homeless get jobs to allow them to retain permanent housing.

While just over 22% of women who are homeless reported employment as an income source, another 22% reported TANF/OWF as their primary income source. As TANF/OWF requires the women to work to be eligible for benefits, this means that almost 45% of women who are homeless are employed. However, even though employment is required of these women, the wages they earn are obviously not

sufficient enough to allow them to retain permanent housing.

Other educational and training opportunities could include training programs in specialized fields that also have a link to jobs. For example, some programs require internships or apprenticeships that give students real-world experience. These programs assist students in finding these internships or apprenticeships, as well as help them locate jobs when they finish the program.

Almost 60% of homeless men in Greater Cincinnati work on a regular basis—a fact that challenges the general public perception that homeless men are lazy and do not work. However, many temporary employment agencies where homeless men work exploit workers. These agencies charge fees for supportive services—such as transportation—or for equipment—such as gloves—leaving little in a paycheck and no health insurance, pension or retirement options, or other benefits. Unionizing temporary workers to combat this exploitation is not out of the realm of possibility.

Housing

Issue

People become homeless because they have problems with obtaining and retaining housing. There is not enough safe, affordable housing in the Greater Cincinnati area to provide low-income populations with a permanent place to live. New housing developments in urban areas are priced out of reach for low-income populations and sometimes require the demolition of low-income housing to be built. In addition, suburban and rural zoning ordinances work against mixed-income developments, and many suburban and rural communities are not welcoming of low-income housing in their neighborhoods.

Possible Responses

To provide enough safe, affordable housing for the entire community, landlords, developers, city and county planners, local governments, and the community should consider the following interventions for implementation:

- Work to renovate existing low-income housing to make it safer and more attractive to live in.

Meet Deborah

Deborah, age 24, and her two children are currently staying in an emergency family shelter. She had been taking computer training in anticipation of losing her welfare eligibility. Unfortunately, her training was not completed before her welfare benefits came to an end, and she took a job at a fast food restaurant. In her second month on the job, she got a call from her daycare provider informing her that her children had head lice and had to be picked up immediately. Unable to reach her manager, she closed the restaurant and went to pick up her children. She was fired the next day. Facing eviction, Deborah and her children moved in with her mother, but soon had to move into the shelter.

Deborah acknowledges that she has made some poor life choices. She dropped out of school in seventh grade and became pregnant when she was 18 and went on welfare. At 20, Deborah became pregnant again. The father of this child walked out one day and never came back.

She is determined to build a life on her own for her children. Her comment about welfare sums up the challenges she faces: "It's a tough system; you have to be on top of things to keep your benefits coming. And even when I did make it to all of my appointments, and did all that I was told to do, I could never seem to get ahead. But still, I wish I could have finished my PC training."

- Require that subsidized, market-rate urban housing developments include a certain percentage of low-income housing.
- Work with suburban and rural communities to show them that low-income housing can become a valued and attractive part of their communities.
- Require that developments in suburban and rural areas include a certain percentage of low-income housing.

Discussion

Unfortunately, the "gentrification" of cities has forced many low-income populations out of their homes to make room for high-income urban housing without replacing the low-income units. This leaves low-income populations in housing that is too costly. As they try to find affordable housing, they may end up in less sanitary housing, doubled-up with family or friends, or with nowhere to live but on the streets or in shelters. Developers could do a better job of mixing high- and low-income housing together, making all units safe, affordable, and attractive to their tenants.

Early Intervention with Selected High-Risk Groups

Issue

Homeless children, as well as foster children coming of age and emerging from the foster care system, are often candidates for homelessness as adults. These children may not have the opportunities to learn skills and connect with resources that will keep them from becoming homeless adults. The doubled-up population—people temporarily living with family and friends in overcrowded conditions—is also highly at risk to join the ranks of the homeless.

Possible Responses

To help prevent high-risk populations from becoming homeless, the foster care system, homeless service providers, housing providers, and the community should consider the following interventions for implementation:

- Design an intervention program with a strong component of extensive, continuing support for foster children and homeless children to help keep them from becoming future homeless adults.

- Establish transitional, supportive housing programs for foster children coming of age.
- Develop initiatives that identify doubled-up populations and move them into transitional or permanent housing before they become homeless.

Discussion

The needs of children among the homeless population can be better served. The impact of homelessness on children with parents with substance abuse problems, in particular, is devastating. In addition, children who are homeless switch schools frequently or may not attend school at all, decreasing their future earnings potential and again putting them at risk for homelessness. A system that fails to provide secure and nurturing foster care also puts children at risk as they grow older. The consequences for the community are succeeding generations of individuals who are destined for homelessness.

The glimpse we catch of the doubled-up population is only a fraction of the reality. The problem of identifying and serving those who are doubled-up is complicated by many factors. Based on estimates from a number of sources including shelter waiting lists, FreeStore/FoodBank data, soup kitchen information, and Project Connect, it appears that for every person in a shelter or transitional housing setting, there are likely more than two people doubled-up. In blunt economic terms, efforts that would allow the doubled-up population to by-pass time in shelters and move into more permanent housing would be less costly[5] and would reduce the pressure on shelters. However, the Department of Housing and Urban Development (HUD) does not consider the doubled-up population to be homeless. As a result, fewer resources are available to this population.

[5] *The cost to keep one family in a shelter for one night is about $57 for shelter, food, and supportive services.*

More resources and alternative interventions are needed to keep children and people who are doubled-up from becoming homeless. Prevention practices in other fields, such as substance abuse, have been shown to save society significant costs by reducing future impacts on public systems. Although it remains to be seen if homelessness can be prevented among some populations, there are many people who can be kept from becoming homeless if the right supports and resources are available to and accessible for them.

Race, Poverty, and Homelessness

Issue

Approximately 70% of the homeless in Greater Cincinnati is African American, a segment of the homeless population that has grown alarmingly in the last 15 years. People living in impoverished inner-city neighborhoods have fewer resources available to them and are at the greatest risk of homelessness.

Possible Responses

To address the racial and economic issues of homelessness, public transportation systems, city planners, social service providers, homeless service providers, education systems, policymakers, and the community should consider the following interventions for implementation:

- Develop plans to improve transportation from low-income neighborhoods to better paying jobs.
- Encourage mixed-income developments that do not reduce low-income housing units.
- Collaborate to develop initiatives that foster both economic inclusion and racial integration throughout the entire regional community.
- Develop vocational training programs in low-income neighborhoods to make these programs more accessible and more appropriate for the community's needs.

Discussion

The growing numbers and proportion of African Americans who are homeless are perhaps the most difficult issues that emerge from the study outlined in this report. In the 1986 study, the racial composition of the homeless population roughly mirrored that of the region at large. The significant increase of African Americans in the 1993 study was the first point in an accelerating trend that continues to this day.

Concentrating wealth in a few neighborhoods discourages mixed-income development and perpetuates "NIMBYism"—or the "not in my back yard" philosophy. This also prevents resources, opportunities, and experiences from being shared throughout a community. In addition, schools in impoverished neighborhoods suffer from a lack of resources available to other communities.

Further Discussion and Recommendations

Over the past 20 years, cities across the United States have experienced a huge increase in homelessness, and the City of Cincinnati has not escaped the trend. Cincinnati has seen a 200% increase in homelessness since the late 1980s and continues to see rising numbers of homeless families with children. Today's society has come to accept homelessness as commonplace and as an inevitable social problem to be dealt with through social service programs. The reality, however, is that homelessness does not have to exist, and it can be eradicated with positive and proactive efforts by the entire community.

While it is important to continue to provide quality services for today's homeless population, it is equally as important to provide safeguards for tomorrow. In order to eliminate homelessness, social policy must address the main reasons for homelessness in Cincinnati.

In this section, the Greater Cincinnati Coalition for the Homeless continues their discussion of interventions that can stop homelessness. The following recommendations stem from the overriding principle of the Greater Cincinnati Coalition for the Homeless—that system change is needed in order to eliminate homelessness for tomorrow's children.

These recommendations address three major systems. The first looks at the need for increased education opportunities, the second addresses the need for a living wage, and the third examines the need for affordable housing. Each system is addressed separately, but these issues are inextricably related, as they each address access to resources: Higher educational attainment leads to higher wages, which lead to housing affordability.

The Education System

Under-education is a particular problem among homeless women, who have experienced a decrease in educational attainment since the last homeless study in Cincinnati. A significant number of women surveyed had not completed either high school or the equivalency exam.

Additionally, children in homeless families experience drastic interruptions to their education, severely impairing their earnings potential. Many children change schools as often as they change shelters or living arrangements, and many stop attending school altogether because of their transient lifestyle. This not only disrupts the child's education, it also affects the classroom environments the child is constantly moving into and out of. Homeless children are reportedly 1–2 years behind in reading levels and often find themselves falling behind their housed peers.

Without continued educational opportunities, homeless children run the risk of entering cyclical homelessness. Increased educational attainment is one avenue in which homeless children can escape poverty and reach self-sufficiency. Schools, homeless service providers, and public transportation systems can work together to keep children in stable classrooms despite transience. Only recently did the State of Ohio recognize the rights of homeless students by passing legislation similar to that of federal legislation aimed at increasing access to education for homeless children. However, the legislation included no money for services. Policy makers, including the Cincinnati School Board, need to extend services to homeless children in the mainstream environment by enhancing existing services such as Project Connect.

The Wage System

Nearly 60% of the homeless single men surveyed in the study indicated that they worked at least part-time, but still could not afford housing. Many of the housing crises that these men experience could be eliminated if they were able to pay rent. These crises are not isolated to single men: Women and families with children also list a "lack of income" among the top reasons why they are homeless. Two major issues surface when discussing wage and compensation—a living wage and temporary labor. These two issues are the primary concerns of today's homeless.

Living Wage

Today's poor and homeless are acutely aware that minimum- and low-wage jobs do not meet their economic realities. An individual working a minimum wage job in the United States at $5.15 per hour for 40 hours per week will gross

only $10,712.00 per year. The current federal poverty level for a two-person household is $11,610.00 per year.

According to HUD standards, a person working full-time for minimum wage should be spending no more than $297.00 in rent per month, or 30% of his or her income. However, the average price of a one-bedroom apartment in the Cincinnati Metropolitan area is $416.00 per month. Without a housing subsidy, an individual working 40 hours a week at minimum wage will pay well above the federal standard of 30% of his or her income toward housing. Local, state, and federal policy makers need to move beyond the minimum wage and hold employers responsible for paying their employees a living wage. A living wage exceeds the federal minimum wage and assures that families have access to health care, housing opportunities, childcare, transportation, and other services.

Temporary Labor

Many working homeless find themselves in a cycle with the temporary labor industry, which preys on low-wage and unskilled workers. The temporary labor force provides a cheap and ready source of workers for industry; however, the costs to both the temporary laborer and society are high. Workers, although often paid above minimum wage, may not take home more that $25–$35 per day after the costs of travel, equipment, and other incidentals are deducted from their paychecks.

Solutions to temporary labor issues may include the unionization of temporary labor workers for collective bargaining power to combat the exploitation of these workers. Local policymakers should also examine the costs to society of a temporary labor industry that does not pay enough to allow people to achieve self-sufficiency. Homeless service providers, the welfare system, and charitable organizations—the systems incurring the many costs that result from the temporary labor system—could transfer their costs to the temporary employers. These costs include shelter costs, healthcare costs, welfare costs to support at-risk families; contributions from charitable organizations such as soup kitchen, church outreach, volunteer time and efforts, and the FreeStore/FoodBank; and quality of life costs.

Meet Erica

Erica is 43 years old. The verbal abuse from the man she was living with escalated and she feared for her and her children's safety. She moved out but had nowhere to go. When Erica first tried to enter the shelter, she was told that she and her 8-year-old daughter, Shawna, were welcome, but her 17-year-old son, Tyrone, was not. Fortunately, within a week of living in their car, a space opened at Chabad House, which would accept Tyrone. Erica told the caseworker that their problems began two years earlier when her husband died from lung cancer. Erica had no work experience, and her husband had no life insurance.

Neither Tyrone nor Shawna wanted to go back to school. Tyrone had trouble doing ninth grade work, and Shawna was already two years older than most of her classmates. Shawna still wets the bed, and Tyrone had been classified as a behavior problem for two years.

When Erica finally signed up for welfare, she quickly found it very difficult to meet the work requirements and still care for her children. A long string of missed appointments led to her administrative termination from welfare. Soon after, Erica and her children were evicted from their apartment. She knows that she should get a job, but doesn't see how she can make enough money to support herself and her children.

On a final note, it is important to remember that while job training programs and job skill attainment are important interventions, the labor market is such that jobs for unskilled workers will always exist. Workers performing these jobs also need and deserve a living wage. No working person should be homeless, let alone living in poverty.

The Housing System

The most prevalent reason for homelessness in Greater Cincinnati is a lack of affordable housing. Past policies have not effectively addressed the ongoing housing crisis in Greater Cincinnati and have pitted "low-income" against "market rate" housing. Mixed-income communities, gentrification, and a decreasing stock of "hard" affordable housing units are at the center of the affordable housing debate.

Recent trends in housing development have local officials and developers espousing the virtues of mixed-income communities. Mixed-income development implies that a variety of different household incomes co-exist in a particular neighborhood or region. While the idea of mixed-income communities is appealing and is supported by the Greater Cincinnati Coalition for the Homeless, what mixed-income development is and how it is implemented continue to be topics of debate.

Typically, mixed-income development has occurred in neighborhoods where the current housing proportions lean toward those of low-income. Development, consequently, has taken on a gentrification model, pushing low-income residents out of poor neighborhoods and decreasing the stock of affordable housing units in the name of mixed-income communities. This approach to mixed-income communities does not promote the creation of additional resources, but serves to decrease the number of choices poor people have for housing.

In turn, the choices for those of financial means continue to grow, as market-rate development continues to eliminate affordable housing units. A more appropriate approach to mixed-income development would focus on equitable development that does not lead to displacement. Additionally, policymakers need to require that there be one-

for-one replacement for any low-income unit that is lost due to demolition or development.

Positive solutions to Greater Cincinnati's housing crisis will create opportunities for low-income residents to reside in a variety of different neighborhoods, including those that traditionally have maintained a higher-income status. Development does not need to push forward at the expense of housing for low-income residents if policymakers provide safeguards to insure that all new development includes housing for the spectrum of economic opportunities in Greater Cincinnati. It is recommended that policy makers in Greater Cincinnati create a comprehensive way to assess both market-rate and mixed-income projects that receive public subsidies that will creatively and positively address the need to incorporate affordable housing opportunities into all new development. In addition to responsible development, policymakers need to insure that resources are available for enhanced housing opportunities for people with physical and psychological disabilities, people who need addiction services, and people escaping domestic violence.

Conclusion

Along with the rest of the nation's homeless population, Greater Cincinnati's homeless report a lack of affordable housing and poverty as the top reasons for their homeless state. By providing opportunities to earn a living wage and affordable housing choices, we can eliminate homelessness for generations to come. Homelessness does not have to be inevitable. Instead, through proactive policy, leaders in our community can create opportunities through responsible development and equal access to resources.

Appendix A: Primary Data Notes and Survey Methodology

There are three distinct sets of primary data that were gathered for the purposes of the study upon which this report is based. These include the key informant interviews, the general survey questionnaire, and the health questionnaire.

Key informant interviews were conducted with a number of service providers (see Appendices C and E). The interviews were conducted by staff at Applied Information Resources, Inc., and took an average of an hour and a half. These interviews provided insight into the numbers and the human dimension of the circumstances surrounding homelessness and the efforts to assist people in escaping from it.

The general survey questionnaire, which was administered by service providers, serves as a wealth of new data about the circumstances surrounding persons in homelessness. The six-page questionnaire (Appendix G) was designed by Applied Information Resources, Inc., in conjunction with a study committee of the Greater Cincinnati Coalition for the Homeless. One of the challenges in the questionnaire was to build on the survey instruments used in 1986 and 1993. Consequently, much of the information can be directly compared between the surveys, and hopefully some of the shortcomings of previous efforts have been corrected. The survey was completed by 214 shelter residents and included, as a consequence, data gathered on over 200 children who were related to the respondents.

The third source of primary data was the health questionnaire (Appendix H) that was actually produced with three variations. Of great importance is the consistent set of initial questions. The first eight questions are intended to be directly comparable to data gathered both in Cincinnati and nationally. These questions were drawn from the SF-12, which is an internationally accepted set of questions by researchers to assess the health status of an individual. The five-page health questionnaire was administered to 189 respondents.

The data gathered by the two questionnaires have been compiled in a database using Statistical Package for the Social Sciences (SPSS) software. These data have been archived and are available to other researchers for further examination. They are available at http://www.ihphsr.uc.edu/hfgc/welcome.cfm at the “Browse Archive Holdings” link. It provides additional specialized material. It is possible, for example, to cross tabulate virtually every piece of information with any other piece within the individual questionnaire. The consistent recording of respondent identifiers and basic demographic information will also permit comparison of detailed health information with other defining data gathered in the general survey such as age, race, sex, and number of children.

Appendix B: Quantifying Homelessness

The calculations presented in this report attempt to replicate the formula and element components contained in the 1993 study. The numbers have been adjusted to reflect the changing circumstances and findings as noted here and in the section "How Many Are Homeless."

The base numbers developed for calculation purposes of the different population groups of homeless individuals are a result of the survey data as well as shelter information. These numbers are intended to represent the unduplicated number of individuals who are homeless in the course of a single month.

The 12-month calculation is the experience of shelters and the results of the surveys.

Although the study upon which this report is based used a methodology common to those used in 1986 and 1993 to calculate the total number of persons experiencing homelessness, some interesting changes have been made over time. For example, one key factor in the calculations is the rate of turnover, that is—how often one person or family in a shelter is replaced by another person or family. In 1986, calculation factors suggested that the population turned over twice a month in family and men's shelters. The 1993 study refined that factor, making a distinction between family shelters which turned over less frequently than those housing single people. The current study retained that distinction, and further divided the various categories of people who are homeless.

Two factors have changed substantially over the course of the studies. The first has to do with people who are doubled-up, that is living temporarily with family or friends in overcrowded conditions. Initial estimates did not specifically identify doubled-up people as a category, although persons seeking shelter, but not sheltered, and another group entitled "Persons not seeking or receiving shelter" were considered. The 1993 study identified the doubled-up population as a category. In 1993 and again in this study, the number of people doubled-up is estimated to be approximately two for every one person identified as either sheltered or on the streets. A second number which appeared as a substantial part of the population from 1993 are people living on the streets. That number has been carried through in the 2000 study.

The reader is warned that these numbers are not in any way precise, however they do reflect the trends which have occurred.

Appendix C: Key Informants

- The Rev. Mason Barker, Storehouse Ministries
- Alicia Beck, Executive Director, Greater Cincinnati Coalition for the Homeless
- Annie Bennett, Executive Director, First Step Home
- Stephanie Brown, representing homeless young people of “Short Vine”/Corryville
- Mary Burke, Over-the-Rhine Housing Network
- Pat Clifford, Coordinator, Drop Inn Center
- Robert Donovan, MD; health care for the homeless, City of Cincinnati
- Chris Engle, Shelter Coordinator, Drop Inn Center
- Steve Gibbs, Exec Director, FreeStore/Food Bank
- Sandra Hammers, Fairhaven Rescue Mission, Covington, KY
- Rod Heilman, LISW; Director, Interfaith Hospitality Network
- Donna Howard, Lighthouse Youth Services, Inc.
- Fannie Johnson, Shelter Coordinator, Chabad House
- Steve Knight, LISW; Director, Mt. Airy Shelter, Hamilton County Department of Human Services
- Susan Knight, Greater Cincinnati Coalition for the Homeless
- Kevin Lab, LISW; Director Social Service, Bethany House Services, Inc.
- Susan Lax, LISW; Acting Director, Tender Mercies
- David Logan, Prospect House
- Connie Raigel, Dr. of Ed., ED RMCS, LPCC; Director, Health Resource Center
- Bob Rankin, Services Director, FreeStore/FoodBank
- Andrew Stallworth, Justice Watch
- Carrie Stoudemire, Manager, LINKLINE and Victims Services for Talbert House
- Kathy Whalen, Director, Chabad House
- Donald Whitehead, President, National Coalition for the Homeless and staff to Goodwill Industries
- Rachel Winters, Welcome House
- Linda Young, Executive Director, Welcome House

Appendix D: Survey Sites

	Number of Surveys	
	Health	General
Bethany House, Cincinnati, Ohio	17	21
Chabad House, Cincinnati, Ohio	8	22
Catholic Workers House, Cincinnati, Ohio		20
Drop-Inn Center, Cincinnati, Ohio	87	38
FreeStore/FoodBank, Cincinnati, Ohio		12
Interfaith Hospitality Network, Cincinnati, Ohio	6	4
Joseph House, Cincinnati, Ohio		9
Lighthouse Youth Services, Inc., Cincinnati, Ohio		17
Mercy Franciscan, St. Johns		20
Mt. Airy Shelter, Cincinnati, Ohio		19
Salvation Army, Cincinnati, Ohio	9	
Short Vine	15	
Streets	13	
Tom Geiger House, Cincinnati, Ohio	5	
Welcome House, Covington, Kentucky	11	15
YWCA, Cincinnati, Ohio	18	17
TOTALS	189	214

Appendix E: Homeless Study Interview Questions

Shelter _____

Interviewee _____

Telephone Number _____

Homeless Study Interview Questions

You have been selected for this key informant interview because of your knowledge about homelessness and related issues. Your answers to our questions will be invaluable to our efforts to portray an accurate and in depth picture of homelessness in 1999.

1) This is AIR, Inc. and the Homeless Coalition's third study of homelessness since 1986. In looking at homelessness from the 1980s to today, what changes have you seen over that period?

2) In helping us put together a general overview of homelessness in Greater Cincinnati today, how would you describe it?

3) What are the new factors or issues that cause people to become homeless or to remain homeless today?

4) What factors or issues (if any) have remained relatively constant since homelessness began to grow in intensity during the 1980s?

5) In the 1993 homeless study, we focused a lot of attention on the lack of affordable housing as a major factor leading to homelessness. How do you see housing as a factor in Greater Cincinnati today?

6) Welfare and assistance programs have changed drastically since the 1986 and 1993 studies. Have these changes had an impact on homelessness?

7) We are taking a look in this study at the health problems and issues related to homelessness. What can you tell us about this subject?

8) What are you seeing in terms of substance abuse and mental health problems?

9) Let's talk about your specific experience. (You serve as staff to a woman's shelter.) Give us a thumbnail description of your service or program.

10) From your day-to-day experience as (a shelter staff person), what are you seeing with regard to

a) numbers of clients (plus waiting list and turn-aways);

b) who these clients are (has this changed over the last three years?);

c) the causes or factors that are making people homeless;

d) services for people who are homeless?

e) What kind of forms do you use and records do you keep?

11) What needs to happen in terms of public policies, services, etc. to make things better? What are your final thoughts and words of wisdom?

Appendix F: Year 2000 Homeless Survey Operating Instructions

The following is an attempt to identify the questions you may have while administering the survey. Unfortunately, we are bound to miss some important ones. If you want to, call us [Alice, Bill or Ed at 381-4994] and we will try to clarify things. No matter what, go ahead and use your best judgment, and we're sure it will work out fine.

One important reminder: As it says in the Notes to the Interviewer, your clients must understand that their participation is voluntary and that the information is confidential. If you encounter any questions [particularly concerning substance abuse or mental illness] which you believe would be delicate or place a client's continued stay at risk, do not ask that question.

Question #2: The word "supportive" is intended to cover programs where the client is receiving specific services, such as alcoholism rehab, while in residence.

Question #6: We really need the last 4 digits of the Social Security number. Accept the birth date as an alternative only if the Social Security number does not exist.

Question #21: We are looking for two levels of response here. Almost no one is homeless for a single reason, so we wish to obtain as many reasons as apply to each client. Checking the primary reason will provide us with some additional information regarding what circumstance finally forced the person into homelessness. It may be easier to run through all of the reasons and circle those that apply, and then ask which was the MOST important.

Question #26: It is not necessary that the client receive OWF payments throughout the last three years – just at some time during that period.

Question #28: For family shelters, this question may have a response from both a husband and a wife.

Question #38: Here again, as in #21, we are trying to gather all possible answers and then that which is #1. The mental illness questions should just be checked if they apply.

Interviewer Assessment:

We expect that some interviewers will encounter some clients who, for whatever reason, may not identify themselves as having certain problems even though it seems likely that they do. This is an

opportunity to share that information with us. The question about medications is intended to get to certain problems from another direction. Our understanding is that most shelters are apt to have this information. If not, don't pursue it unless your client volunteers.

Appendix G: Year 2000 Homeless Survey

NOTE TO INTERVIEWER: This survey is essential to the Coalition's study of homelessness, its causes, the effects and the nature of those who are its victims. We expect to use the results of this work to develop new strategies to respond to the problems of homelessness. Based on our previous experience, the study becomes one of our most effective resources in dealing with the questions raised by funders. Feel free to share this information with your clients so they will understand the time involved. Please advise clients that the information is confidential and participation is voluntary.

1. Agency: _____

2. Client's current status [CIRCLE one]: Transitional, Emergency, Supportive*

3. Your initials: _____ 4. Date: _____

5. Client's first name: _____

6. Last 4 digits Social Security # _____ or birth date _____

7. Last permanent address: [city] _____ [state] _____ [zip] _____

8. How long? _____

9. Are you from the Cincinnati area? _____

10. How long in the Cincinnati area? _____

11. Check ü if NO permanent address during the past year: [ ]

12. [Check ü all appropriate lines]	Currently	Last 12 months
Have you been homeless?	_____	_____
Resident in a shelter?	_____	_____
Sheltered at a hotel/motel?	_____	_____

Doubled-up with family or friends? _____ _____

On streets, night to night? _____ _____

Evicted/threatened with eviction? _____ _____

Utilities disconnected _____ _____

13. Client Description [Members requesting service] – Circle one

Female Female with children Couple

Male Male with children Couple with children

14. Marital Status:

Married Never married Divorced/Separated Widowed Living together

15. Size of family:_____ [at shelter] Elsewhere? _____

16. Number of Males: _____ 17. Ages: _____

18. Number of Females: _____ 19. Ages: _____

20: Race: Black _____ Hispanic _____ White _____ Other_____

Appalachian _____ Multi-racial _____ Asian_____ Pacific Islander_____

21. Check [ü] the primary reason for the emergency & also circle all that apply*

Divorce/separation Poor housing Welfare reform: sanctioned/terminated

Loss of benefits Substance abuse Spouse/partner abuse Eviction

Loss of income/reduction Mental illness Child abuse Non-payment rent

Loss of employment Ineligible for public housing Medical problem/expenses

Release from correctional facility/halfway house Utilities disconnected Ineligibility for aid

Chosen life style Fire Doubled-up with friends
Overcrowding

Waiting for benefits Widowed CHMA problems

Other: _____

Release from hospital/treatment center [Circle one]: Medical Psychiatric Substance abuse

22. Amount of monthly income: $ _____ Food Stamps: $ _____

Benefits: Medicaid/Medicare _____ CHIP _____ Section-8 voucher* _____

23. Source of Income [Circle all that apply]

Full-time employment Part-time employment Temporary labor Unemployment compensation

Worker's compensation SSI/SSD Pension TANF/OWF

DA Food Stamps Disability Child support

Veterans Administration Social Security

Odd jobs: _____ Other: _____

24. Have you received cash welfare [ADC/OWF] benefits in the last three years? Yes ____ No ____

25. Have you ever received GA benefits? Yes ____ No ____

26. If client is currently employed, for how long? [CHECK ü one in left column]. If currently unemployed [CHECK ü one in right column]

Employed			Unemployed	
Male	Female		Male	Female
_____	_____	Less than 6 months	___	_____
_____	_____	6 months but less than 1 year	___	_____
_____	_____	More than one year	___	_____
_____	_____	Never worked	___	_____

27. [CHECK ü CURRENT JOB] AND CIRCLE PAST JOBS

Industrial ___ Services [restaurant, etc.]____ Professional ___ Office ___ Temporary ____

Other: [DESCRIBE] _____

28. Is affordable child care necessary to seek/keep employment? Yes _____ No _____

29. Have you found quality child care? _____ Voucher _____ Slot _____ Location _____

30. If employed, do you use earned income tax credit? Yes _____ No _____

31. Client background—Check [ü] any that apply

    Are you permitted to vote? ___ Are you a registered voter? ___

    Did you vote in the last election? ___

    Current client of the mental health system? ___ Past client of the mental health system? ___

    Ex-offender ___

    Veteran ___ Vietnam era ___ In-country ___ Other wars or time periods ___

    Desert Storm ___

32. Do you feel you have been harassed by the police in the last 12 months?
    Yes _____ No _____ Not Applicable _____

33. If any police encounter, was undue force used? Yes ___ No ___

34. In the past 12 months, which [if any] of the following apply. Also, please CIRCLE drug of choice. *

    Drug of choice: Crack cocaine ___ Heroin ___ Prescription ___ Hallucinogens ___ Ecstasy ___ Marijuana ___ Alcohol ___ Pain killer ___

    Mental illness ___ In a treatment program? ___

    Dual Diagnosis [both substance abuse & mental illness] ___

INTERVIEWER ASSESSMENT: [ü]

Health problems? ___ Active Substance use? ___

Substance problem? ___ Mental health problems___

35. Education [CIRCLE ONE FOR THE PRIMARY CLIENT WHO IS RESPONDING]

    Did not complete grade school | G.E.D. | Special Ed./sheltered workshop

    Did not finish high school | Vocational training | Completed high school

    Some college, but no degree | College degree | Post graduate studies

Current education activities

36. Have your children changed schools during the past year? ____ How many times? _____

37. Have your children missed school because of housing needs? ___ If so, how much? _____

38. Monthly housing cost of last permanent address: $_____ Utilities, if separate _____

39. Length of stay at last permanent address: [CIRCLE ONE]

Less than 6 months — 1 year but less than 5 years

6 months, but less than 1 year — More than 5 years

40. In the last 5 years, has the client(s) applied/lived in subsidized housing? [CHECK ü WHERE APPLICABLE]

	Section-8 Vouchers or Certificates	Public Housing Project	Other Income-based Rent Subsidy
Applied/Rejected	_____	_____	_____
Pending	_____	_____	_____
Resided	_____	_____	_____
Section-8 Received but cannot use	_____	_____	_____

If rejected, or can't use, why? _____

41. What type of housing does client(s) need [by interviewer's assessment]; CHECK ü ONE WHICH BEST DESCRIBES NEED

___ Affordable [no special needs]

___ Senior citizens

___ Transitional housing for <u>one</u> of the following conditions:

____ Substance abuse/chemical dependency

____ Physical handicapping condition

____ Mental disability/illness

___ Dual diagnosis [mental illness/substance abuse]

___ Social disability e.g., bad credit, utility arrearage, extra large family, unemployment

___ Other temporary condition. Please name _____

___ Permanent housing for one of the following chronic conditions

____ Physical disability

____ Mental disability/illness

____ Developmental disability/retardation

____ Other chronic condition. Please name _____

Appendix H: Community Health Survey

First Name _____ Last 4 digits _____ Age _____ Sex _____

Race: White ____ African American _____ Appalachian_____ Other _____

Community/neighborhood of origin _____

Highest grade of school completed _____

Current residence: own apartment _____ ; doubled up [one place] _____
crashing [various places] _____ ; on street _____

1. In general would you say that your health is:

   1. Excellent 2. Very good 3. Good

   4. Fair 5. Poor

2. The following questions are about activities that you might do during a typical day. Does your health now limit you in these activities? What about (Read a and b)…does your health limit you in this activity? If so, how much…a little or a lot?

   a. Moderate activities, such as walking 2 blocks, moving a table, pushing a vacuum cleaner? 1. A lot, 2. A little, 3. not at all

   b. Climbing several flights of stairs? 1. A lot, 2. A little, 3. not at all

3. During the past 4 weeks, have you had any of the following problems with your regular daily activities or work as a result of your physical health? What about….

   a. Accomplished less than you would like?

   b. During the past 4 weeks were you limited in the kind of activities you do or other activities as a result of physical health?

4. During the past 4 weeks, have you had any of the following problems with your regular daily activities or work as a result of any emotional problems, such as feeling depressed or anxious?

   a. Accomplished less than you would like

   b. During the past 4 weeks, did you not do work or other activities as carefully as usual as a result of any emotional problems?

5. During the past 4 weeks, how much did pain interfere with your normal activities?
    1. Not at all
    2. A little bit
    3. Moderately [continued next page]
    4. Quite a bit, or
    5. Extremely?

6. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the <u>one answer</u> that comes closest to the way you have been feeling.

    First, how much of the time during the past 4 weeks (Read a to c)…. all of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?

    a. Have you felt calm and peaceful
    b. Did you have a lot of energy
    c. Have you felt downhearted and blue

7. During the past 4 weeks, has a physical health or emotional problem interfered with your social activities such as visiting friends or relatives? (read 1 to 6)
    1. All of the time
    2. Most of the time
    3. A good bit of the time
    4. Some of the time
    5. A little of the time
    6. None of the time

8. Has a doctor or other health provider ever told you that you had:
    a. Asthma
    b. Cancer
    c. Chronic lung disease (i.e. emphysema, black lung)
    d. Diabetes
    e. Chronic digestive disease
    f. Heart trouble or angina
    g. High blood pressure or hypertension
    h. High cholesterol or triglycerides

i. Arthritis or rheumatism
j. Osteoporosis
k. A stroke
l. Severe headaches
m. Chronic back pain
n. Depression
o. Other mental Illness
p. AIDS
q. HIV
r. Alcoholism
s. Drug Addiction [continued next page]
t. Hepatitis
u. Tuberculosis
v. STDs

9. During the past 12 months, did you have health insurance or coverage?

___ All of the time ____ Some of the time ___ None of the time

If All or Some, what was the source? [e.g. Medicaid, CHIP, HMO, Pension Disability] _____
Do you still have it? _____

10. Is there one particular clinic, health center, doctor's office, or other place that you usually go to if you are sick or need advice about your health?

___ Yes ___ No

11. Where _____

12. About how long has it been since you last visited a health care professional for a routine check up?

1. Less than a year
2. 1 to 2 years
3. 3 to 4 years
4. 5 years or more
5. Never

13. During the past 12 months, was there a time when you personally thought that you needed medical care but did not get it, or delayed getting it?

    ___ Yes ___ No

14. If yes, what was the most important reason that you did not get medical care?

    1. Cost
    2. Accessibility
    3. No insurance
    4. Fear, apprehension
    5. Don't want

15. During the past 12 months, was there a time when you thought that you needed dental care but did not get it, or delayed getting it?

16. What was the most important reason that you did not get dental care or delayed getting dental care?

    1. Cost
    2. Accessibility
    3. No insurance
    4. Fear – apprehension
    5. Don't want

17. In the past 12 months, was there a time when you wanted to talk with a mental health professional about emotional or mental health problems, but did not?

    ___ Yes ___ No

18. What was the most important reason that you did not get mental health care?

    1. Cost
    2. Accessibility
    3. No insurance
    4. Distrust
    5. Don't want to

19. Where did you go for treatment? _____

20. During the last year, did you not receive a prescription medication because of the cost?

    ___ Yes ___ No

21. In the past 12 months, have you been arrested?

    ___ Yes ___ No

22. Do you think that drinking, drugs, or mental illness contributed to the problem that led to your attest?

    ___ Yes ___ No

23. In the past 12 months, have you attempted suicide?

    ___ Yes ___ No

24. In the past 12 months, how many times, if any, have you experienced a problem with drugs or alcohol? Record number of times _____

25. A drink is 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average? Record exact number of drinks _____

26. In the past month, have you had at least one drink of any alcoholic beverage such as beer, wine, wine coolers or liquor?

    ___ Yes ___ No

27. What services do you/your friends need in this area? _____

    Where should they be provided? _____

28. In the past month, which (if any) of the following drugs have you used?

    cocaine crack heroin

    ecstasy marijuana pain killers other

29. Have you shared needles?

    occasionally regularly never

30. If the Health van [mobile health services with doctors and nurses] came to Short Vine, would you/your friends use it for confidential health care?

    ___ Yes ___ No

Date of interview _____

Interviewer _____

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