Ethnographic Assessment of Homeless Street Populations

Report Provided
To
United Way of King County

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Forward

In 2007, United Way of King County set out to make a deep and durable difference on the issue of homelessness in our region. Our efforts include a $25 million Campaign to End Chronic Homelessness, with an emphasis on housing and services for those who have been on the street the longest, cost health and other systems the most, and face the greatest challenges in changing their circumstances.

Fundraising for the Campaign to End Chronic Homelessness is at its halfway point, and the associated resources are now beginning to be deployed in the community. To ensure that we and our partners truly understand the shape and scale of the problem, and use our resources to the best possible effect, we commissioned this Ethnographic Assessment of Homeless Street Populations. It is Washington State’s first-ever effort to take a probing, anthropological look at the people and places of King County homelessness, and capture the diversity of the homeless experience.

Not everyone who is lingering on the street is homeless, and not everyone who is homeless is on the street. Drug and alcohol use is widespread, but hardly universal, and different ages of the homeless have different preferences in substances.

For some homeless people, life will turn around if there is a dependable roof overhead. For others, the challenge is deeper, and success will hinge on supportive services, including mentorship in regaining critical social skills.

All this and more emerges from this rich, textured, and challenging report. As we move forward in United Way of King County’s work to end homelessness, the report will guide our effort to be as comprehensive and effective as possible in our approach.

Homelessness is a community problem of many faces. But if we all work together with commitment, creativity and heart, it’s a problem we can end.

Vince Matulionis
Director – Out of the Rain
United Way of King County
I. Project Background and Methods

United Way of King County has initiated a public/private partnership to develop and implement strategies to end chronic homelessness in Seattle/King County. Recent research and model programs in Seattle and other cities suggest that new approaches intended to end chronic homelessness may result in more efficient use of public resources, improve the safety and well-being of an extremely vulnerable population, and decrease numbers of “visibly” homeless people on the streets as they move into more stable and supportive environments.

Planning is underway between the primary partners; United Way of King County, the City of Seattle, King County, the Seattle Housing Authority, and King County Housing Authority, to move chronically homeless individuals into permanent housing. The planned components of the initiative are 1,000 units of permanent housing and supportive services; including discharge planning, outreach/case management, centralized intake, and employment strategies. The planning is grounded in research on the components necessary for successfully reducing chronic street homelessness, which include Housing First principles, relaxing requirements for drug and alcohol rehabilitation prior to housing, and acceptance of harm reduction approaches to substance abuse.  

United Way commissioned this ethnographic assessment of homeless street populations in conjunction with the “Ending Chronic Homelessness” initiative. The aim of the assessment is twofold:

1. Provide a current description of the diverse subgroups of the street population and subsets of the homeless population, and
2. Generate information with practical relevance for policy and planning for the initiative.

Key focus areas of the assessment were designed to:

- Develop a more complete picture of subsets of the street population,
- Provide further definition and characterization of visibly homeless people,
- Identify desirable outcomes relative to this homeless population,
- Add the perspective of those affected by homelessness, and
- Generate relevant variables for a larger empirical study.

Methods

The timeframe for the project was limited to approximately four months. Given the short time frame and global nature of the key questions, the general approach used was a Brief (Rapid) Ethnographic Assessment. Methods for this approach include intensive techniques of observation, key informant interviews, case studies, group discussions, and literature reviews. This approach allows researchers to explore social conditions and issues in depth and to identify factors and relationships that may not be elicited through other methods. Ethnographic assessment methods generate data in a short time frame, provide a broad overview of a group or

sub-culture, and insights that can inform or modify policy and programs. This method is particularly useful for generating research questions for future fully developed research studies.

Ethnographic Methods – The methods used in the assessment combined the following qualitative approaches:

- Observation of homeless and other street populations in the street environment and in service environments with a service liaison. Observations were completed independently in several service environments and with the Metropolitan Improvement District workers, Seattle Police Department, and Department of Corrections.
- Interviews (individual and group) with 30 key service providers and policy stakeholders. (A list of interviews and agencies contacted are provided in the Appendix.)
- Five in-depth case studies with homeless individuals using semi-structured interviews.
- Fifteen brief interviews with homeless and street involved individuals.

Areas of inquiry included:

- The composition of the street population,
- Who is homeless and where groups are on a homeless continuum,
- Impact of housing on street based activities and street presence,
- Cultural assumptions of homelessness,
- Why housing is not utilized by some groups,
- Impediments to service access,
- Gender issues.

Literature Review – An extensive review of current relevant research, evaluations, reports, and strategies on homelessness was completed in the first phase of the project. The literature review provided background information on homelessness, current consensus and debates in the field, and knowledge gaps. In addition, the literature review helped situate this project within the larger picture of policy and practice in the area of homelessness.

Geographical Assessment Areas - The assessment focused primarily on the downtown core of Seattle, particularly within the boundaries of the Seattle Police Department's West Precinct. Additional areas included Capitol Hill, the University District and, to a smaller degree, Rainier Avenue South. Data were also collected through interviews from key stakeholders in South King County.
II. Ethnographic Findings

A. Homeless Street Populations

The category “chronic homelessness” emerges from a pattern of social inequities and individual problems that are situated within convergent domains of homelessness and street-based lifestyles and activities. Defining “chronic homelessness” as a stand-alone category has proven useful from a policy perspective, but they are a subset of the street population and occupy one point on a continuum of homelessness.

Observable street populations extend beyond the chronic homeless population, and face challenges to their livelihood presented by poverty and a lack of affordable housing. It has been shown that significant numbers of people who are housed continue to use homeless- targeted services. The National Survey of Homeless Assistance Providers and Clients (NSHAPC) completed in the mid-1990’s included data collected from homeless programs in 76 metropolitan and non-metropolitan areas. Analysis of the sample indicated that among those interviewed, 54 percent were homeless. Twenty-two percent were not currently homeless, but had been in the past. The remaining 24 percent were not currently homeless, but used services that were provided for the homeless. These data speak to the fluidity of the sheltered/unsheltered boundary and call for understanding the needs and characteristics of more broadly defined street populations.

- What other groups comprise the observable street population?
- Are they homeless?
- What factors contribute to homelessness across chronic street populations?

Service providers, police officers, and individuals experiencing homelessness concur that a majority of the visible street population are homeless. That they are homeless is not the end of the story; the visible reality of the street homeless population as a whole requires a clearer differentiation of its subgroups for broader policy application.

Perceived homeless street populations can be differentiated along several dimensions including: stages of homelessness, street activity, criminal activity, drug use, mental illness, survival skills, vulnerability to victimization, and subculture association. Subgroups and stand-alone categories of homelessness have other characteristics and attributes that generate questions regarding the anticipated impact of policy initiatives directed toward visible street populations. These questions include:

- Is homelessness the most significant group characteristic?

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Will housing modify street based activity?
Where are groups located on a homeless continuum?
What service parameters are relevant for each subgroup?
What types of housing and supportive services are appropriate?
What are specific system coordination needs for subgroups?

The primary focus of this assessment is the broader street population. The differences between subsets of street-based and homeless groups are discussed within the context of the chronic homeless initiative, the potential impact on visible street populations, and implications for policy and practice. This section of the report concerns six meaningful subgroups that comprise the street population and are involved in street based lifestyles.

1. Drug Addicted Offender Population

On a weekday morning in the Department of Corrections office at the Seattle Police Department (SPD) West Precinct, there are seven people, three males and four females, lined up in chairs, awaiting their fate for the day. Of the seven, five are people of color. All seven need a shower, clothing, and food. As part of the Neighborhood Crimes Initiative (NCI), a Department of Corrections (DOC) officer collaborates with Seattle police officers to manage a caseload of offenders on probation and parole, who engage in high risk behaviors on the street. The West Precinct makes 80-100 contacts per day. The East Precinct averages 30 or more per night. One DOC officer is assigned to each SPD precinct. Officers from the West Precinct estimate there are 500 homeless (not sheltered) individuals in the area between First Hill and the waterfront and between Belltown and Safeco Field. Sitting in the chairs is nearly the complete spectrum of street homeless groups in the downtown core. They are all waiting to find out if they will go to jail today.

<table>
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<th>“Do you know what you are going to do with us yet?”</th>
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Jerome has the facial signs of fetal alcohol effects, and an officer confirms he is severely mentally challenged. He is in his late 20’s and African American. Jerome sits numbly waiting to find out what will happen to him, waiting for someone to take care of him.

John sits on his anger, barely in control. He appears disoriented and frantic. Sitting next to the door, he looks like he may try to run. John is in his early 30’s, Caucasian, and the police have known him for years. He is a drug dealer and was selling fake heroin. He was arrested before a violent incident arising from his sale of fake drugs could take place.

Cheryl is addicted to crack cocaine and methamphetamine. She is sweating and her movements are uncontrolled and unpredictable. It feels dangerous to be near her as she is coming off a drug high and worried about getting to her next one. Her eyes are darting all over and her speech is barely intelligible. The DOC officer takes Cheryl into her office. Cheryl told the officer who picked her up that she had been raped, but this is the third time she has given this story when rearrested. Previously, she was taken to Harborview; there was no evidence of rape, but she was able to escape from custody.
when hospital staff discharged her without notifying her police escort. This time the questioning is brusque; she admits she was not raped. The blood staining her pants is not from trauma; it is menstrual blood. She needs to get drugs now.

**June** is in her 30s, but she looks 20 years older. She has lost most of her teeth. June is Caucasian, balding and in generally poor health. She sleeps on the street most nights. She is an addict who supports her habit through prostitution, theft, and selling drugs when she can. June has been on the street since she was a teenager, trapped at an early age.

**Tisha** and **Linnette** are both back on the street, using drugs and engaging in prostitution. They had been in housing through Sound Mental Health. They had not planned to use again, but everyone in their housing complex used or sold drugs and they fell back into it. What could they do with everyone around them getting high, they say.

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**Alex: “I can’t not use.”**

Alex is 20 years old and has been homeless three months, this episode. He just got out of jail and was caught stealing on video tape, wearing the same clothes he had on at his last arrest. He was easy to seize; the police know exactly where Alex hangs out all day. Alex left his mother’s home because his stepfather was physically abusive. For awhile he lived with his grandmother. He dropped out of school and started using drugs, then actually went back to high school and finished the 11th grade. While in high school, he started selling cocaine and became addicted to crack. “I tried to go to school,” he says. He had a lot of money, and was caught selling and sniffing powder in school. By then he was addicted.

“I don’t have any plans; I am an addict, a smoker. The drug is so powerful. Drugs are a powerful force.”

He feels he holds to high standards on the street:

“I don’t twist people; I don’t sell fake dope like poor hustlers. I am a laid back guy and I don’t get out of pocket, I avoid conflict.”

“I do a lot for other people, I want to help, but all they want is a crack hit, there are no friends on the street.”

Alex had been awake four days and was deciding it was time to sleep. Then he would smoke “tuff” and sell more crack.

“After 3 or 4 days its time to go back to sleep, but first I am going to find a lady’s company.”

Alex had not used any services and could not name any services for youth or adults:
“This is a revolving door. I don’t trust anyone, and I don’t want any services. I don’t want housing, Karma runs it, and for every action there is a reaction, no guts no glory.”

Like many addicts, he believed he was in control and separated himself from other addicts, although he freely admitted he was an addict.

“I can control the volume of what I use, but I can’t not use. Other people are aliens, they can’t control the volume, and they are zombies”

Alex wanted a foot in the normal world; he described how he was calm and respectful to the “civilians” on the street. Over the last few weeks of this project, Alex was arrested and jailed three times.

“I don’t want no shelter. I don’t want no service,” he repeated.

The NCI program in the West Precinct report they have a list of 2,000 names of offenders like those described above, whom they have managed on the street over the last seven years. They work with about 250 people per month and see them 2-3 times a day across the downtown core. They are primarily addicted to heroin, cocaine, and meth, although they use other drugs, including alcohol. The NCI officers know where each person tends to hang out during the day and where they sleep:

“They all have their specific areas. If they are not in their area, it is because they are doing something bad like selling fake drugs. John, for example, is always in Belltown. If he is in the International District then we know he is selling blank. Violence follows selling bunk (fake) drugs, so we try to intervene before there is violence or another crime.”

Discharge Order: Don’t use heroin.

It is 7:30 a.m. in Freeway Park, downtown Seattle. The NCI team is looking for offender clients on probation/parole from their daily log sheet. This morning there are 36 on the list, 25 males and 11 females. They go in to wake up William, who they recognized laying on the ground and who has an 8:00 a.m. probation appointment. William is in his mid-20s and African-American. He is lying amid various drug paraphernalia. The police find a yellow form by his blanket, which states that he received treatment for a heroin overdose in the Harborview emergency room the night before. His discharge instructions: “Don’t use heroin.” The police wake him up and decide to arrest him because of drug paraphernalia and a small vile they find on the ground. He tells them he is “dope sick” now and pleads for a chance to get heroin before they take him in. The police put William in the cell compartment at the back of the van and later take him to the King County jail.

There are seven other heroin addicts in the park. Two, a couple, are awake and fairly well kempt. They did not spend the night outside and tell police they have an apartment and point up the hill. They just happen to be in the park because they came down to get the free coffee across
“We have been clean for 10 days because my girlfriend is trying to get her daughter back.”

At fourth and Pine, the team finds Oscar. Although he is 38, he looks like he could be in his 60’s. Oscar has been on the street since he was a teenager. A heroin addict, he has a part of needle works, which he says was given to him to drain an infected toe. Oscar knows what he can carry on him and what he cannot to avoid arrest. Today they let him go; he is compliant, non-violent, and generally does not bother anybody or commit other crimes. He speaks to the police as if they are old friends. In a way they are, they have kept him alive more than once.

The police van moves down Yesler, past Courthouse Park, which will fill up later in the day. The team says they have had days when they arrest nearly 50 people in this area alone. The van turns down Second Avenue. The police spot two males relieving themselves in the alley. Another turn and eight people wrapped up in gray shelter blankets can be seen asleep in a row on the sidewalk across from the Union Gospel Mission. The police say they are all addicts who do not want to be in the shelter. The police wake them up to move them off the street and out of the doorways. A few make their way across to the mission for breakfast. One person just does not seem to wake up. The police shake the blanket and see it is a young woman, about 20. When she finally wakes up, she is smiling and her youthful face is visible. She pats her hair and tells the police “I am really not a morning person.”

Service providers and law enforcement concede that the addicted offender population tends to be “service resistant”, at least as services are currently presented. There is diversity within this group as well. Providers describe individuals with ADHD who self medicate with cocaine. Some would use shelters, but often miss the curfew or cannot get in because of their active use and offender records. As soon as they get out of jail the goals are clear: “Get high, get laid, and eat”. Service providers readily recognize that all drugs are free when you get out of jail. The suppliers will find you. The routine is to get high and stay awake all night on the street.

Several studies have examined the relationship between homelessness and imprisonment. Compared to the general population, homeless populations include a higher proportion of former prisoners and homeless people are overrepresented in prisons. Substance abuse and mental illness are key risk factors for both homelessness and imprisonment. Homeless people with both disorders have low rates of treatment and increased risk for recidivism. Overall, homeless persons who have a history of imprisonment have higher rates of substance abuse disorders, mental health and psychiatric disorders, physical health problems including HIV infection, as

well as involvement in illegal activities than homeless persons without jail and prison histories. The intersection of imprisonment, homelessness, substance abuse, and unemployment is ruinous, as evidenced by the daily release of prisoners from the King County jail and the Department of Corrections drop-off in downtown Seattle.

**Addict Careers and Recent Drug Abuse Trend Data**

General drug use trends in the Seattle-King County area provide a framework for understanding significant drug trends among homeless and street populations.

**Heroin**

Drug-related deaths involving heroin in King County totaled 56 in 2006. This number represents a decline in heroin drug deaths from 1998, but it remains a serious issue. The majority of drug-related deaths involving heroin continue to result from the simultaneous use of multiple narcotics. The number of drug treatment admissions to all modalities of care for which heroin was primary totaled 1,589 in 2006, a drop from the two most recent years for adults. Adult Helpline calls for heroin totaled 594 in 2006, higher than in 2005, but similar to earlier years. Data for an Emergency Detoxification (ED) unit adjacent to downtown Seattle indicate that heroin was mentioned in 442 intakes, 9% of all intakes, more than double the proportion of any of the 5 other EDs from around the state. DAWN Live! data for heroin indicate 2,310 reports, second only to cocaine among the illegal drugs.

**Cocaine**

Drug deaths involving cocaine totaled 111 in King County in 2006, the highest number in a decade. Admissions for cocaine totaled 1,935 in 2006, similar to 2005, but a substantial increase from prior years. Drug treatment admissions for youth for cocaine remained low.

For adults, one in four calls to the Helpline were related to cocaine, similar to recent years and the most common illegal or prescription drug mentioned. About one in eight youth related calls to the Helpline were for cocaine over the past 3 years. Emergency Services department data sources indicate that cocaine is a major drug reported by patients. Data for ED visits screened at Seattle’s Harborview Medical Center indicates cocaine is the second most common drug reported after marijuana.

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Age and Ethnicity
Data indicate that, on average, heroin users tend to be older than other drug users entering treatment, and the average age is increasing. In the period from 1999 to 2004, the proportion of those ages 45-54 increased from 27 to 34 percent. An increase was also seen among those ages 55-64, from three to six percent of admissions involving heroin.
The proportion of treatment admissions involving cocaine increased from 38.7 percent in 2003 to 40.1 percent in 2004. Those entering treatment were older in 2004 than in 1999, with 22.6 percent ages 45-54 compared with 10.4 percent, respectively. The largest group (60%) remained those ages 30-44 in 2004.

The 2006 drug trend data revealed that 43 cocaine related deaths involved only cocaine. Of these deaths, 30 were African American. It was also reported that most were over the age of 50 and most were male. The reporters speculated that the reason for the substantial increase in cocaine-only deaths might be due to an aging cohort of users for whom the cumulative physiological effects of cocaine are taking their toll. The impression of the medical examiner was that most of these deaths involved crack cocaine.

These data raise key points relevant to homeless policy. Addict careers can endure for many years if the drug of choice is heroin or cocaine. Police and service providers find addicts of all ages up through 60 plus years. Treatment data indicate that addicts tend not to seek treatment until they are beyond their 20s. The data also underscore the severe impact of street drugs on the African American community, which is over-represented in homeless street populations.

Crutchey was a well know crack user and panhandler on Capitol Hill. He was called Crutchey because he only had one leg and walked on crutches. Although he looked 70, he was only in his early fifties. An NCI officer from the East Precinct knew him well and saw him on a regular basis. He would go to the central area to buy crack everyday. Eventually, the officer was able to get him an apartment on Boylston on Capitol Hill. According to the officer, he used the room, but never changed his behavior. He had not asked for housing and he continued to pursue his drug cycle. Then, Crutchey disappeared and was not seen for two years. Thinking Crutchey was dead; the officer was surprised to see him one night in a store. He looked quite different, was well dressed and had stopped using. Crutchey said, “I got to the end.” He reached a point where he thought he would die, sought treatment, and ended his cocaine habit in his mid-fifties.

Another drug trend relevant to street populations is the use of PCP, known as “sherm,” which is on the rise again. Overall, PCP use tends to occur in younger groups, particularly in the Capital Hill area where younger groups of heroin and cocaine users are found. Police and service providers see this drug as extremely destructive. As with meth, there is not a long life expectancy. Users deteriorate rapidly: “They won’t be here ten years from now.” The NCI officer offered the contrast of the older African American men who may smoke crack and use heroin for a long time and were more amenable to services and housing options as they aged.

Policy Opinions
The police and DOC officer in the West Precinct were not convinced that Housing First without mandatory treatment was a credible approach for homeless street drug addicts. Their experience
with the NCI caseload is that approximately 80 percent of the addicts do not attend treatment and are not successfully engaged by treatment approaches. Like Alex, they are committed to the drug lifestyle, not interested in housing or services, and cannot maintain housing without extraordinary support services. The police also find that housing for active drug users becomes a cover for various criminal activities and illegal drug use, as was the case with Linette and Tisha. They differentiate the older alcoholic population from the younger heroin, cocaine, and meth abusers.

The law enforcement experience leads them to support a treatment continuum beginning with involuntary 28-day minimum in-patient treatment. Other providers are in agreement, but also noted the need for lower barrier shelters for addicts who are often excluded from emergency housing, in order to begin breaking the street addiction cycle. The age of the addict offender may be a critical factor in predicting successful use of housing options.

### Areas for Additional Study

1. Explore a pilot project for treatment on demand services. The San Francisco Department of Public Health is a resource.
2. Analyze the breakdown in the involuntary treatment system for chemical dependency.
4. Review evaluations of programs in other cities implementing Housing First models for addictions other than alcohol.
5. Explore low barrier shelters and housing for those who are addicted to illegal drugs (in contrast to chronic inebriates).

### 2. Mentally Ill and Mentally Ill Offenders

The National Resource and Training Center on Homelessness and Mental Illness (2003) reports approximately 20 - 25% of the single adult homeless population suffers from some form of severe and persistent mental illness. Although there is debate as to how deinstitutionalization may have contributed to homelessness among the mentally ill, it is hard to dismiss the impact of denial of services by managed care programs, tiered systems, and a lack of discharge planning on the disproportionate numbers of seriously mentally ill on the street and homeless. This vulnerable population is further compromised by a lack of adequate community-based care, medication management and monitoring, and, of course, a housing shortage. Low-income mentally ill people are at risk on many fronts for homelessness.

The prevalence of co-occurring psychiatric and addictive disorders is a dominant characteristic of this homeless group. Both disorders require treatment in an environment of scarce resources for homeless and low-income populations. Provider groups have noted an increase in triple diagnoses.

Conversely, the stress of life on the street contributes to the mental health problems of individuals who are trapped in a cycle of victimization and on the edge of survival (Blau 1992). However, Axis I diagnoses -- depression, anxiety disorders, bipolar disorder, ADHD, and schizophrenia -- are evidently not tiered by mental health services available to the homeless population.
It also appears that many homeless individuals with Axis 2 disorders do not receive treatment because of a lack of mental health resources. Axis 2 disorders include developmental and personality disorders such as anger issues, antisocial behaviors, personality disorders, PTSD, developmental delays, and FAS/FAE. There is a lack of care for those who have suffered from head injuries or other types of physical disabilities. Individuals with these impairments have extreme difficulty navigating complex systems and often cannot cope with even the most user-friendly services and low barrier housing.

**Population Subsets of Mentally Ill**

There are subsets of the mentally ill homeless population beyond the categories of their disorders. Providers tend to divide the mentally ill street population into groups. The “dangerously” mentally ill are often not on medication or self medicate with narcotics. A lack of medication leads to very dangerous and extreme behavior. A second group is often schizophrenic or has Axis 1 disorders. They are characterized by their isolation and are often called “service resistant.” Both adapt to street life in different ways despite their lack of coping skills. They often walk around all night long, avoiding shelters because they cannot cope with noise and other intrusions. One coping mechanism is to find their spot on the street, which is their retreat. Surprisingly, providers report that many do not use alcohol or drugs. They attempt to be “normal” and usually are targets for victimization and exploitation. Many in this group are able to get some side jobs for some support.

The NCI team reports they have many untreated mentally ill offenders on their caseload. This population tends to report as directed everyday. The community probation arrangement offers some structure, safety, and a point of orientation for these homeless individuals, which the mental health system does not provide. However, the police express severe frustration at the lack of treatment and treatment supervision. They hear “This is his baseline,” recognizing that nothing will be done for many individuals they manage on the street.

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**This is his baseline.**

Larry was diagnosed as schizophrenic some years ago. Officers from the East Precinct would find him routinely on 15th and Madison, trespassing at a convenience store. He was arrested 15 or more times for being on the property and spent quite a bit of time in jail. About two weeks ago, the NCI team succeeded in finding him housing and paid for a room for him at a hotel. He leaves his hotel room daily and usually can be found at 15th and Madison, on the property of the convenience store.

The mentally ill homeless population have multiple issues that overlap with criminal behavior and substance abuse. Many suffer from a “diagnosis gap,” a lack of medication management, and do not receive evaluations while in custody. The characteristic of mental illness is so pervasive among the homeless population that providers indicate their numbers approach 1,000 or more!

There are a number of support services required by this population to maintain housing. They often exhibit disruptive behavior and are ejected from housing. It is difficult for them to manage
their behavior without medications, and it is difficult to manage their medications appropriately if they have them. Thus, their behavior is unpredictable. A similar dilemma applies to homeless individuals who are diabetic. If their diet and insulin are not controlled, moods and behavior are affected. One can only imagine the difficulty in managing diabetes while living on the street.

Most importantly for the mentally ill homeless people, their mental disorders and coping mechanisms may continue to present if they have housing. Larry was no longer homeless, but still presented on the street routinely.

Areas for Additional Study

1. Appropriate housing models and resources for mentally ill homeless, which include options from independent units to group settings.
2. Expand generic outreach and case finding programs for mentally ill homeless people.
3. Solutions and resources to extend mental health services to include the disorders most commonly found among the homeless population.

3. Chronic Public Alcoholics

Homeless chronic inebriates are perhaps the most researched subset of homeless people. James Spradley’s classic Seattle-based ethnography, You Owe Yourself a Drunk (1970), constructed the subculture view of jail and treatment, which provided a striking contrast to public perceptions and official policies. Innovative work continued in this area with the opening of the St. Martin’s program on Westlake in 1987. St. Martin’s was one of the early facilities for chronic inebriates, which allowed drinking. Its founders took note of the social and resource network of the street subculture of older chronic alcoholics. They implemented support services to create a sense of community including a buddy system. Anecdotal reports of early outcomes suggest that nearly 50% significantly reduced their drinking and about 40% got jobs. Once people were out of “survival mode” and had their basic needs met, they were able to begin reconstructing their lives. About 15% of the population was not able to maintain in this program.6

The Downtown Emergency Service Center (DESC) program for chronic alcoholics (1811 Eastlake Project) is the most recent implementation of the Housing First philosophy, providing 75 units for male and female chronic alcoholics. Support services for this program include mental health and chemical dependency treatment, access to primary health care, along with meals and counseling. An evaluation of this program is due for completion soon and outcome data will then be available. Another innovative approach, the Reach program housed at the Sobering Center, provides an innovative case of an outreach program targeted toward the highest utilizers of public services among the known chronic homeless population.

Chronic public alcoholics are pervasive across the city and county areas and comprise the majority of the chronic homeless and shelter populations. Specific ordinances and programs

6 Information based on interview with Jon Hoskins, Safe Harbors Program Manager, City of Seattle.
(Seattle Downtown Association Metropolitan Improvement District [MID] program) target the chronic homeless inebriate. Police details and MID workers begin at 5:30 a.m. and 7:30 a.m. each morning to move these homeless individuals from business doorways and public walkways.

Hal is in the same doorway every morning near 5th and Virginia. The doorway is not posted, so he sleeps here every night. In the morning, the MID workers move him along. He finds a meal and then a way to get his beer. One morning, it is the police who wake him up, but they do not find Hal. It is a man and a woman sleeping under the blanket, who cannot be together in a shelter. The police get their names and they both have shoplifting records. They pack up their belongings and move on. Someone heard Hal was now at the Sobering Center.

Hank is in the alley near 2nd and Stewart behind the Nordstrom Rack. He is so inebriated, the MID workers cannot stir him; they call for medical backup. Before help arrives, a store manager comes out, screams, and pushes at Hank to get out of the alley. Hank, who can barely stand, soils himself and holds on to the building for balance. While the MID workers are talking with the manager, Hank disappears.

It is common to find chronic alcoholics spread out across the city and county in groups of 3-4, camping or living under structures. There are many encampments of homeless people across the city. Camps can be seen at the Yesler exit from I-5 south, on Dearborn near Goodwill and under I-5 in numerous locations. There are camps on the south end of Alaska Way, behind Harborview Hospital, and in the Arboretum. Homeless people do not like downtown because of crime and they have survival skills that allow them to sleep outside and take minimal care of themselves. They can be seen in alleys and neighborhoods foraging for food and other needs. Many have shelter experience and choose the outdoors over the rules and chaos they find in many shelters. Conversely, some cannot get into shelters because of their substance abuse, criminal records, and/or disruptive behavior. Finally, there are not enough shelter beds anyway. It is common for a homeless person to give up trying to get into a shelter after they have been denied two or three times.

The street population of chronic public alcoholics may be the edge that sharpens perception regarding the housing needs for homeless and low income individuals. Operation Nightwatch provides shelter beds for 212 people per night, turning away 45-65 nightly. Staff believes the county is short as many as 2,500 shelter beds.

I did not have time to work because it took so much time to survive.

I met Don through Real Change. He has a room in the University District now, but was homeless for two years and lived in a camp near University Village and also in a park on lower Queen Anne hill. The police seldom bothered him; he had a small TV and kept to himself. Don has a series of problems; he is an alcoholic, has a mental disability, and suffers from depression. Don has several broken bones from various injuries over the years and is physically disabled. He has had several “white hat” jobs, such as selling concessions at Safeco Field and day labor. These jobs provided him with enough money that he was able to save up and pay for a room. He is trying to get disability support, but
does not know how to get a copy of his birth certificate. Don did not want to reveal any information about his family; he has been in Seattle for about 10 years and has been transient since he was 21; he is now 38. He thinks there may be a trust fund available for him if he was willing to contact his family.

Like many chronic homeless, Don preferred living outside to living in shelters; there was more privacy and freedom. He had used a shelter on Rainier Avenue for a short time. He found that chores, service appointments for food stamps, or just getting his wash done at a separate facility would take up most of his day. He would spend so much time surviving and meeting his basic needs, he did not have time to work.

The question often posited to the homeless, “Would you accept shelter?” is not deemed a fair question by some providers. If you ask people if they would accept an independent room or apartment, the answer is more likely to be “yes”. This was true for Don who moved into a rooming house in the University District. Other tenants are a problem for him because of their drug use, partying, and conflicts over the kitchen. He is still out on the street a lot because of the noise. Don tries to stay out of downtown and goes to Bellevue or Madison Park because “it is nicer” and “you don’t have to deal with crazies.”

It took two years, but Don now has housing. However, because of his injuries, he cannot work and is on the edge again. He has not been able to pay all of his rent and expects to be evicted. He has approached a number of services, but has not been able to get rental assistance. “I just need a place that feels like a home.”

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### Areas for Additional Study

1. There are evidenced-based practice models for chronic alcoholics. However, finding the property and buildings to expand the models are problematic. Service providers and non-profits generally do not have the access or leveraging power to get these resources. Different partnerships with key players need to be explored to increase housing availability for all subsets of homeless.

2. Review evaluations or implement a meta-evaluation of Housing First programs to ascertain best practices for population subsets to inform new programs.
4. Chronic Homelessness

Chronic homelessness is a convergence of factors, which characterize other homeless groups and street populations. Recent studies of homelessness and chronic homelessness have provided clear descriptions and characterizations that are useful for policy development. Studies of chronic homelessness by Culhane and others have now been completed on samples nationally and internationally. Common features of the “visibly” homeless have been verified by client data from several organizations in Seattle: poverty prevails along with serious and persistent mental illness, vulnerability due to disabilities, mental, and physical health problems, addiction to alcohol and other drugs, severe psychiatric symptoms, and co-occurring mental illness and substance abuse disorders. These characteristics function as arbitrary boundaries to distinguish street-based groups from one another, but can be found across all street subcultures. Once one reaches the stage of chronic homelessness, these characteristics are described as “severe.” The more marginalized groups tend to manifest more serious social, economical, physical, and psychological problems.

The chronically homeless are disproportionately African American and Native American, underscoring the distinctive marginality of these groups. Preliminary data from the Safe Harbors HMIS indicate a very significant overrepresentation of African Americans among shelter and transitional housing clients for the first six months of 2007. There are some indications from provider data that the population is aging; the mean age may have increased by two years based on some client data samples. An analysis of DESC Supportive Housing Clients from 2006 (N=600), show that clients earned less than $7,000 annually, 83% were mentally ill, 61% were chemically dependent, and 30% had physical disabilities such as diabetes, HIV/AIDS, and physical impairments. The chronically homeless individuals tend to be single males; a small subset can occasionally work. Many providers cautioned that they were seeing an increase in women in this category.

Policies Contribute to Chronic Homeless Street Population

As with other street involved populations, chronically homeless individuals cycle through shelters, the criminal justice and mental health systems. Within this group are subsets of high utilizers of public services. The very characteristics used to define these individuals as “chronically homeless” are also the characteristics that screen them out of housing and some services, leaving them very visible on the street. They generally cannot meet program requirements or requirements for housing; they cannot follow rules; they cannot maintain in various programs, such as employment, that may be available.

This group is understood well enough that adequate descriptions are available to operationalize “chronic homelessness” for policy initiatives and service responses. They are on the street because they do not have housing and have not had housing for a year or more. They make their

\footnote{Preliminary data from Safe Harbors HMIS on a sample of 3,821 shelter and transitional housing clients indicate that nearly 40% are African American. The top five contributing factors to homelessness in this group are listed as substance abuse, 25%; economic reasons, 23%; alcoholism, 13%; displacement, 11%; and eviction, 11%. Although informative, the data records may be duplicated and do not include information from some key and large service providers.}
spaces and identify their territories and corners where they can be both safe and found by others. The image of the homeless person is in some ways created by service policies. Most shelters are only open at night (there are exceptions, such as DESC) forcing the homeless to be on the street during the day, carrying their belongings.

Now, there are evidence-based practices for serving the chronic homeless population. Positive results have been found for models that incorporate Housing First principles, recovery first models, generic outreach, employment options, day centers, harm reduction, and motivational interviewing approaches to chemical dependency. Seattle has yet to develop a coordinated effort incorporating all of these components. However, as reported earlier, MID workers noted a clear difference on the street with the opening of the 1811 Eastlake Project (DESC) for chronic alcoholics and Real Change, which provides the opportunity to earn cash by selling papers. The innovations of Housing First principles have transformed the service philosophy toward this group in recent years. Equally transformative approaches are needed for other homeless street-based populations.

Addressing the housing needs for chronically homeless people is likely to have an immediate and visible impact on the number of homeless seen in the evening and early morning hours, sleeping in doorways of businesses and other public spaces. Additional services could begin to alleviate the ancillary issues of chronically homeless people during the day -- such as more day centers -- as modeled in other metropolitan areas.

5. Visible Street-based Livelihoods

There are numerous street-based lifestyles, many of which have been described in the ethnographic literature. Reports indicate involvement in street subcultures is generally the result of the intersection of structural inequities such as poverty, racism, and economics, with individual vulnerabilities such as child abuse/neglect, addiction, mental illness, lack of education, and lack of family support. All age groups can be seen on the street, from small children of homeless families to adolescent-centered subcultures; and the middle aged and elderly, characterized by poverty, mental illness, and addiction.

The street-based lifestyles of youth and young adults include:

- Street drug cultures,
- Gangs (including nascent gang alliances),
- Homeless youth including runaways, youth exited from foster care, the juvenile justice system, and youth displaced from families and service systems,
- Diverse counter-culture and alternative culture groups.

Police and service providers are quick to place responsibility for street youth on a failed juvenile justice and juvenile rehabilitation system and foster care system. Some of the most active street presence is from youth in their late teens and early 20’s who steal cars, deal narcotics, and are

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generally out all night. Police described incidents arresting youth dealing from rented cars. The NCI team has at times arrested over 40 people dealing narcotics near Third and Yesler.

There are core adult street subcultures that occur in urban areas, which have overlapping characteristics and many subsets. These subcultures often have well-structured organizations, defined power bases, socially defined categories, rules for financial exchanges, group specific language, and other defining cultural boundaries. These include:

- Prostituted women, pimps, male hustlers, and associates of the sex worker industry as it manifests on the street,
- Drug users, dealers, and runners compose another segment of street based groups who are further diversified by types and methods of drug use and degrees of addiction,
- Recently discharged inmates from jails or mental institutions, who are usually reabsorbed back into their drug subculture or street routine,
- Panhandlers,
- Stigmatized groups based on distinctions of gender identity or sexual orientation, such as transgender individuals.

**Housing Status of Street-based Populations**

Individuals emerged in these street-based lifestyles and subcultures generally **would not** describe themselves as homeless. They are visible on the street because the street is where they conduct their business. The successful “players”, drug dealers, gang leaders, prostituted women, and assorted hustlers may support themselves and others, maintaining housing for long periods. Involvement in street-based lifestyles is, however, an indicator of risk for long-term homelessness, despite stories of successful times when the money was easy.

Housing for these groups may be unstable, transient, and precarious. However, sleeping on the street (rough sleeping) is avoided because it is unsafe, unclean and marks you in the lower status segments of street hierarchy. Drug dealers/users may avoid homelessness depending on the size of their habit and the success of their hustle. Youth in gangs and starting their street hustles often are living at home with relatives or other kin care arrangements. Sleeping on the street is characteristics of those who have lost control; they are looked down on and become easy prey within street cultures.

Within the subcultures and associated livelihoods listed above, individuals experience episodes of homelessness. Those lower in the street hierarchy are more precariously housed. Individuals are high risk for long term or chronic homelessness within all of these groups. The ranks of the chronically homeless are continuously replenished through avenues discussed in this report. At any time, individuals in these groups may be defined as homeless if a broader definition of homelessness is used:

> [Individuals] lack a fixed and adequate nighttime residence including those temporarily living in emergency shelters, hotel rooms for less than 30 days, vouchers for public or private places, or in places not designed for sleeping accommodations for human beings.
Housing situations and street visibility vary by group, as the examples below suggest, but many are on a path to visible homelessness. As individuals dissolve into their addictions, extend their criminal record, and sever stable relationships, homelessness becomes their reality.

**Prostitution**

Individuals involved in the sex industry are housed as a part of the lifestyle; they maintain hotel/motel or other rooms to work from or have enough consistent income to maintain housing. If they are prostituting from the street, they are likely to be addicted, involved with a pimp, and more susceptible to arrest; all factors that lead quickly to homelessness. As their addiction begins to take over, they make less money and the money they have goes for drugs. These women are subject to violence from customers, pimps, and virtually every exploiter on the street. If they survive, they will become part of the visibly homeless population.

*It is about 8:00 a.m. on a weekday morning. The MID-workers are walking up what is known as “crack alley” near Fourth and Bell. We see a small woman, less than 90 pounds, with thinning hair, folding up her cardboard bed. She stuffs it behind a doorway quickly as she spots the workers. “She is here everyday. How old do you think she is?” “In her 20’s” was the answer. “She is what some would call a ‘crack whore’; they are all through this neighborhood.”*

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**Being on the street was like being in a herd, being herded.**

*Sheila* was married to a drug user: “I became so angry supporting his habit that I started to use myself. I didn’t understand how quickly you got addicted.” Once addicted, her husband “controlled her”. She did everything for him and for the drug, including prostitution and serving three prison terms. Sheila went from owning a condominium (paid for by drug money) to sleeping on the streets, prison and back to the streets three times over 30 years. (We did not count the number of times she was arrested and put in the city or county jails.) Sheila was imprisoned for welfare fraud and various drug offenses. During her last time in prison, her children contacted her and let her know they still loved her. She was convinced that if she did not stop using this time, she would die. So while still in prison, she practiced being “normal”. Along with reading the bible everyday, she would practice in her head doing routine house chores. “Your body forgets these things,” so she would think through the steps of cooking and grocery shopping.

To be released from prison, Sheila needed an address. She wrote to shelters and received support from a staff person at a shelter she had stayed at between prison terms. According to Sheila, she was the first person this agency had agreed to let be released to a shelter. She stayed for a little over a year between two shelters and now volunteers for both. She is also attending community college at age 61, attends a recovery group for women of color, and is a volunteer.
She recalls her time on the street as being “sick,” “I was mentally ill.” Sheila associated with a large group of young addicts: “It was like being in a herd, no one thought. It was like being herded.” Sheila believes many young African American girls need guardian angels. When she sees women she used to be, she will talk with them and try to get them off the street. However, she say, “They don’t want to miss nothing.”

What would have helped Sheila when she was on the street and did not want to miss anything?

“More outreach and people trying to make a connection with me.”

Service providers report an increase in the number of women on the street from as recently as two years ago. Staff from Operation Nightwatch reported that, historically, they would only see one woman per night seeking shelter. Now they see 30 or more and they are characterized by mental illness and drug addiction. The NCI team also reported an increase in women on the street. Their homelessness odyssey would usually begin with domestic violence. The police often find women living in their cars, they may sell drugs to keep going and then drift into criminal activity, prostitution, drug use, and street homelessness.

Homeless women represent a rapidly growing subpopulation of the homeless. It is not surprising to find that homeless women have major health problems and are repeatedly victimized on the street. Because they often lack “protection,” and resort to panhandling, dealing drugs, and prostitution to survive, they suffer high rates of robbery, assault, and mental illness.

Prostitution and drug addiction are interrelated. It is generally believed women turn to prostitution to support a drug habit or the drug habits of others (men). It is also true that prostituted women turn to drugs to cope with prostitution.

Street prostitution has traditionally occupied the lower rung of the hierarchy associated with the prostitution subculture. Reflecting the structural racism of society as a whole, more women of color involved in prostitution are visible on the street. Visible street prostitution has decreased in recent years, mostly due to technological innovations. Women who are on the street are generally addicted and desperate. Women of color can be seen in the downtown core, particularly around Yesler, on MLK Way, and in the Central Area. Caucasian women more often work around Denny Park and Aurora Avenue. Pacific Highway South continues to be an area highly frequented by prostituted women and their customers. The prostitution subculture has a distinct hierarchy and all are vulnerable to violence from pimps and customers.

**Homeless Youth**

Over the past decade, estimates of homeless youth have ranged from 500 to 1,000 in Seattle and up to 2,000 throughout all of King County. Data from the City of Seattle Human Services Department indicate that approximately 800 youth are receiving homeless youth services in

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Seattle, and over 1,000 countywide. These numbers increase to over 1,000 for Seattle and to nearly 2,000 countywide with the inclusion of estimates for under-counted groups. These groups include youth of color, immigrant youth, couch surfers, and other uncounted groups.10

Clinic data from Seattle King County Healthcare for the Homeless provide an additional perspective. In 2006, 46 unduplicated youth ages 11-17 reported at intake that they had slept on the street “last night”; for ages 18-24, the number was 138. Among those aged 11-17, 185 reported being housed in a shelter; for ages 18-24, 254 reported at intake they were in a shelter “last night.”

Data from the City’s Pro Youth case management program provide the best indicators of the numbers and locations of homeless youth who are either on the street or in precarious housing situations at intake. Of a sample of 415 homeless youth, the largest percentage, 33% (152), were living with friends. Nineteen percent (88) were living outdoors or in a “squat”, 13% (61) had been in an overnight shelter, 8% (39) had just left home that day, and 5% (24) were living in motels night by night.

Studies conducted by local researchers with Seattle-area homeless youth provide clear descriptions of the underlying causes and need for early intervention. A sample of 354 youth 13-21 years of age participated in a study through YouthCare’s Orion Center in the mid-1990’s.11 The average age of the first homeless episode for youths was 14.7 years old. The most frequent reason given for leaving home was physical abuse (21%), followed by violence at home (19%), drug use by a family member (12%), and neglect (12%). Although it was not always reported as the immediate reason for leaving home, entry onto the streets was often preceded by physical and/or sexual abuse. Among males, 45% reported they had been physically abused, 19% reported they had been sexually abused. Among females, 41% reported they had been physically abused and 47% reported sexually abuse.

Characteristics of youth who are homeless mirror the adult homeless population. Family functioning issues extend into other forms of adverse childhood experiences. Eighty-five percent reported that at least one family member had an alcohol or drug problem. As may be expected coming from homes with high rates of chemical dependency issues, 40% of the youth reported having used alcohol or drugs more than ten times in the past month. Whether due to assaults, rape or health problems, almost a third (31%) reported that they had spent time in the emergency room or a hospital in the last three months. Not surprisingly, youth in the sample also experienced very high levels of emotional distress and diagnosable mental illness. About two thirds (68%) of all youth interviewed met criteria for at least one diagnosis (based on DSM-III-R criteria). In addition, almost half had attempted suicide. A majority of youth (66%) reported

10 Human Services Department, City of Seattle. (2007 Available online: http://www.seattle.gov/humanservices/fys/homelessyouth/default.htm
they had dropped out of school at some time although, interestingly, more than half reported having attended some school program in the previous three months.

The majority of youth who leave home and are seen in services have suffered abuse and neglect. Unfortunately, all too often these youth are revictimized on the streets. For boys this is generally in the form of physical assault (66%). A sub-study examining the rates of abuse according to age and prior history of sexual abuse found that among girls age 14 years and under who had experienced prior abuse, a full third had been raped within their first six weeks on the street. These experiences result in further trauma, substance abuse, and vulnerability and isolation on the street.

Given the preponderance of addiction issues with the adult homeless populations, the availability and efficacy of treatment for adolescents is a matter of critical concern. Currently the treatment gap rate for adolescents ages 12-17 is 76.5% statewide. In 2003, 19,106 adolescents who were in need and eligible for services from the Washington State Department of Alcohol and Substance Abuse, were not served. Additionally, studies of at-risk and homeless runaway youth indicate that most require further chemical dependency treatment after discharge and about half require mental health treatment. Few receive these additional services, according to reports from the National Institute on Drug Abuse.

The small number of detoxification beds available throughout King County further compromises treatment services for youth. Providers and staff from the City of Seattle Human Services Department have estimated approximately 800 youth are in need of outpatient mental health services, many, like adults, have dual diagnoses. Providers also believe that about 200 homeless youth are in need of inpatient mental health treatment, but only about 25 homeless youth per year receive more than a 72-hour assessment. There are very few therapists available to homeless persons and fewer than 100 youth receive these services per year.

Street youth, not unlike their adult counterparts, are often characterized by abuse histories, mental illness, addictions, and developmental deficits from inadequate or a complete lack of parenting and adult support. The trajectory for street youth (without intervention) involves drift into adult subsets of street lifestyles and subcultures. Service providers report seeing up to 4 generations of families involved in street life and homelessness.

The entry points for involvement in youth homeless and street subcultures are centered in the University District, Broadway, Belltown neighborhoods, and the Westlake area. Youth present a very visible street presence in these areas that are also the gateways for drug use, sexual bartering, and association with established street subcultures. Street-based lifestyles include networks of people that provide a precarious safety net for needs, including housing. Youth and young adults commonly “couch surf”, crash with friends, or live with larger groups in squats. Runaway youth may find an adult that will house and feed them in exchange for sex; sugar daddies and sugar mommas. All of these situations are generally short lived, and individuals in

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these situations will spend nights on the street. Alex, described earlier in the report, is an example of a young man currently on a path to long-term homelessness and addiction.

**Panhandlers**

Panhandling is available to anyone seeking/needling money, regardless of his or her homeless status or primary/presenting characteristic. Sometimes homeless people who are housed will panhandle because they still need funds for personal items or to pay their portion of the rent. In general, providers find that the panhandlers seen along freeway entrances, for example, have housing. They are considered a different subset and should not be included in the homeless population. A focused study of panhandling was beyond the scope of this project, but a full inquiry of the housing status, needs, and other characteristics of panhandlers would be important for a full understanding of this subset of the street population for homeless policy.

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**Areas for Additional Study and Recommendations**

1. Invest in housing and employment programs for homeless and marginalized youth and youth without positive adult support.
2. Advocate and invest for increased treatment resources for adolescents already marginalized and homeless.
3. Invest in best practices and effective theoretical approaches for adolescent substance abuse such as: Motivational Enhancement, Brief Substance Abuse Treatment, and other harm reduction approaches.
4. Enhance substance abuse services in homeless youth programs. Examples of existing models are the Adolescent Treatment Enhancement Project and the Group Home Chemical Dependency Programs.
5. Utilize the resources of the University Of Washington Alcohol And Drug Abuse Institute.\(^{13}\)

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**6. Less Visible Homeless Groups**

Homelessness cuts across all demographic categories and there are multiple paths to homelessness ranging from substance abuse, economic instability, housing shortages and evictions, to displacements of various sorts such as domestic violence or migration.

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Transient/labor – Within this group are the classic “hobos,” men who travel for work and rely on day labor. This is a less visible group whose networks and activities are generally not street-based, but who may rely on shelter services.

Invisible homeless populations “you see, but you don’t you see” according to providers. They look like everyone else and have jobs, but do not have stable housing. The invisible homeless are working at McDonald’s, construction jobs, video stores and are the low skilled “jack of all trades” who are particularly victimized by the tight housing market and condominium conversions. Providers find individuals in this group have low education levels and are often illiterate. Literacy is a major issue. Filling out the simplest forms may prove formidable and exclude people from help. They will “duck under” different places, sleep at construction job sites where they work, find tool sheds and out buildings to shelter themselves, or sleep in their cars.

Immigrant transient population – This group is generally comprises Hispanic seasonal workers. They tend to travel in groups and often have alcohol issues. They will seek out shelters and are seen regularly at Operation Nightwatch, for example.

Immigrant Mentally Ill – Providers report seeing a growing subset of immigrants with mental illnesses, some with dual diagnoses who have been cut off from cultural supports. The groups named most often included Somali and Southeast Asian groups.

Sobriety through poverty – Providers report seeing individuals who practice sobriety by staying poor. They tend not to apply for services, because if they have money they will drink or use. They use the shelter and meal systems.

People who cannot go home – Shelter providers report individuals experiencing episodic homelessness who are not allowed home or with other relatives because they are drunk or using.

Undocumented people – People in this group are generally seeking work but, because of their lack of documentation, are not eligible for many services and benefits. There are enough people in this situation to be recognized as a subset of the homeless population.

There are also those experiencing one-time and short-term homelessness characterized by recent job loss, family dissolution, and other marginalizing factors including those dispossessed by racism. It should not be forgotten that, since the 1990’s in particular, there has been a growing contingent of people who are simply poor. This cohort is aging, resulting in an increase in the elderly poor seen in increasing numbers on the street (Blau 1992).

The list above presents barely more than a glossary of the multiple levels of homelessness that may present within the visibly impoverished street population. A lack of housing is the unifying factor, although each group is distinctive and may require services specific to their condition. The saliency of generic outreach programs is underscored by this diversity. This array of characteristics cannot be meaningfully subdivided across systems, as has been done in many
respects for the mentally ill or addicted homeless individuals. Addressing the shared conditions of homelessness and poverty at the outset may be the most productive policy.

**B. Housing and Street Presence**

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<th>Since I have been in housing, I have never been so poor.</th>
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Chronic homelessness and other street-based lifestyles are organized and visible in public places associated with services, alcohol and drug availability, and other features that sustain street subcultures. Because of the basic organization of street life, housing, while humane and essential, does not mean that chronically homeless individuals or other homeless street-based populations will become invisible.

It is easy to observe heroin addicts near needle exchange programs. The NCI team finds many of their mentally ill clients close to their mental health agency. There is a camp of 50 or homeless people behind Harborview Hospital; most are crack addicts. If they overdose or are sick, they are close to treatment and back out close to their supply.

There are various reasons people will continue to be drawn to the streets. Service policy drives some of these reasons for continuing to spend time on the streets; others are fostered by the street culture. Beyond housing, the other needs of people whose four walls are the street need to be incorporated into policy and practice. Below is a list of factors that contribute to continued street presence of homeless individuals who may have obtained temporary or transitional housing or maintain private housing, although not stable, on their own or through relatives and friends.

**1. Service Policies Issues**

**Shelters**

- **Most shelters are open only at night** (DESC is one exception). The homeless people who use shelters have no choice but to spend days on the streets and carry their belongings on their backs or in carts and bags.

- **Subsidized housing generally requires tenants to contribute to their rent.** This may range from 30% of their income to a nominal payment as low as $25.00. A requirement as minimal as $25.00 may push individuals to panhandle or find other means to meet the requirement.

- **Homeless who are housed still need money** for food and personal hygiene items, clothing, etc. Service providers are aware their clients and tenants are on the street begging and/or engaging in other illicit activity in order to have money for personal needs or to support addictions. Some people feel they are poorer now in housing than they were on the street. They have less cash because of financial obligations and bills than they had when they were living on the street.

- **“You can lose your mat.”** Time limits, curfews, and other rules are often necessarily imposed by shelters to ensure safety and order as they attempt to manage large and difficult populations on shoestring resources. Many homeless individuals are simply
unable to conform and react poorly to the lack of privacy and other intrusions of the shelter environment. Although many, many individuals are provided care, there are many more left out. Criminal history, substance use, and mental illness resulting in disruptive behavior are examples of criteria that exclude many homeless people from services.

- **The availability of food makes street life tolerable** and manageable if shelter or housing is not available or desired. Seattle is a generous environment for the needy regarding meals. “No one goes hungry in Seattle.” Three meals per day, seven days per week are available across the service sector.

**Transitional/Housing Programs**

- **Housing programs operate with competing expectations** between achieving outcomes and serving a target population that often cannot meet the housing program requirements. There is such a huge housing shortfall that it is very easy to find the less problematic tenants. There is concern among some members of the provider community that the most vulnerable are not being served. Screening barriers, including substance use, criminal history, mental health issues, and credit history, leave the most vulnerable ineligible for housing. The fragmentation of housing and housing services presents another dilemma. When the most vulnerable are served and they fail in housing, often they are not retained within a system to prevent them from becoming disconnected from services, and they are soon isolated on the streets again.

- **Housing criteria is not flexible** enough to be inclusive of street populations of homeless. Moreover, within this group there is a marked lack of skills to approach a daunting and not particularly user-friendly housing system. Conversely, homeless individuals who are less vulnerable and less ill than others are not perceived as high need, and fall down on the service lists.

**2. Streets as Center for Subculture Interactions**

- Addictions generate most of the visible presence and interactions of street homelessness. Individuals who are addicted will go to the streets to buy and sell drugs and make their connections. Addicts will scavenge for food, items to sell, and opportunities to commit crimes to get money, drugs, and alcohol.
- Territories and corners become individual spaces connected to street identity and are used as a sort of fixed address. They are also familiar and predictable spaces, particularly for the mentally ill. These public spaces are privatized by homeless people and incorporated into the routines of street life by which the homeless individuals structure their days. This does not always change with housing.
- The street is the meeting ground for social interactions and street commerce of homeless and low-income groups involved in street-based lifestyles.
- Homeless individuals seek out services, refuge, and basic needs and move from place to place. The streets pattern their daily activity and social interactions.
Areas for Additional Study

1. Explore additional day centers and homeless services outside the downtown core.
2. Improve system coordination to reduce barriers to accessing services by the homeless.

C. Homelessness in South King County

The dynamics of homelessness affect all parts of King County. Rural poverty and homelessness have tended to be unseen because they were believed to be urban issues. It has also been difficult to arrive at accurate estimates of these problems in rural areas because they are difficult to count. A full assessment of homelessness issues outside of Seattle was beyond the scope of this project. A focus on South King County has been included to emphasize some key points:

- Homelessness is not just an urban problem,
- As urban areas expand in South King County, as well as other parts of the county, social services must confront both urban and rural characteristics of poverty and homelessness,
- Urban, suburban, and rural homelessness interface at many levels, and require a holistic and integrated policy and service approach.

Numbers

The Seattle/King County Coalition on Homelessness expanded their count areas for the 2007 One Night Count to include 12 cities across the county and unincorporated areas. Within these areas, 570 individuals were counted as unsheltered outside of Seattle. The highest counts were found in East Urban areas (128), Federal Way (106), Kent (90), Renton (56), North End (47), and White Center (19). Because of the difficulty in covering the largely rural areas of King County, additional interviews were conducted among individuals utilizing meal and food bank programs in four areas. An additional 30 individuals were counted who were sleeping in cars, tents, or on the streets in the four areas. There are numerous reports of homeless people camped in state parks, along river banks, near Tiger Mountain, and seen coming out of the woods in rural areas near small towns and outlying developments. It is easily concluded that the number of homeless individuals in King County, outside of Seattle, is significantly underestimated.

One participant in a South King County provider focus group offered alternative methods to estimating the numbers of homeless. According to this individual, approximately 480 individuals in the DSHS system self-identify as homeless in the Kent, Des Moines, and Federal Way area. Anecdotal information on school district data suggests that as many as 1,500 parents reported experiencing homelessness. The complexity of gaining accurate counts of homelessness in South King County requires multiple methods.

Providers did register concern over the potential use of the chronic homeless category. Some believed it was simply a way to redefine homelessness and make the number smaller. They
found it alarming that equally needy homeless people, including small children, might not be prioritized appropriately.

**Characteristics of Homelessness in South King County**

There is an emerging population of the visibly poor and homeless within the boundaries of the 16 separate municipalities that form South King County. At the same time, significant numbers of homeless people are hidden, difficult to count, and difficult to serve.

Providers have registered concern over the growing number of long time residents in the area who are increasingly marginalized by changing economics, housing shortages, and other factors that contribute to homelessness. More and more people are living in their cars and “doubling up” with friends and family, but could be evicted at any time. The expansive green areas of the county allow people to camp, uncounted and often unnoticed. According to providers, many homeless prefer sleeping in the woods because it is perceived as safe, they are still close to their home territory, and perhaps family or friends are nearby.

Providers estimate that 80% of individuals served in the 60-bed men’s shelter would be accurately described as chronically homeless. The PATH outreach program, administered by Sound Mental Health, has approximately 150-175 individuals enrolled who would most likely meet the definition of chronically homeless. Debbie Thiele (King County Housing Authority) did point out that not all of these have disabilities that would make them Medicaid eligible.

A housing program for 25 chronically homeless individuals has been launched successfully in South King County.\(^{14}\) The project, based on a Housing First approach, includes support services based on the PACT model. The program began in November 2006 and by June 2007 25 individuals were housed. The housing participants share characteristics of other chronically homeless people and are described in the narrative report on the Housing First pilot project. Participants have served time in jail or prison and many have felony and/or misdemeanor convictions that screen them out of housing. Histories include evictions and psychiatric problems. The report points out that most participants led productive lives for a time until circumstances precipitated their becoming homeless. Prior to the housing in the pilot project, individuals were living in the woods, at the Catholic Community Services shelter and other church shelters available in the South County, couch surfing, living “outside,” riding the bus at night, under the bridge by the Renton Library, and camping along the Green River. The length of time participants were homeless ranged from 3.9 years to as long as 13 years.

Women are served through a 9-bed shelter and with hotel vouchers. As in Seattle, services have seen an increase in women who are homeless and affected by domestic violence, substance abuse, and a variety of health problems. It is believed that youth who are homeless tend to go to the city (Seattle) because they do not stand out so much, can find a larger peer group, and more

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\(^{14}\) The South King County Housing First Pilot Project, A Narrative Report (2007) Report Prepared by: Debbie Canavan Thiele, Homeless Housing Initiatives Director, King County Housing Authority debbiet@kcha.org, 206.574.1355. United Way of King County, King County Department of Community and Human Services, and King County Housing Authority.
youth services are available. However, there are homeless youth providers in the county who regularly work with runaway and homeless youth, such as Auburn Youth Resources.

Crack cocaine and methamphetamine users are seen across all age groups in the south county area. Areas around SeaTac, West Hill Highway, and South Park are areas known for a prevalence of drug users. Providers point out the challenge of getting clients into drug treatment. Waiting lists are long and undercut client motivation. In addition, the ITA system is apparently under-resourced and difficult to use. One provider stated they had never succeeded at getting treatment for a client through the involuntary treatment process. The challenges of the substance abuse treatment system were confirmed by the experience of staff in the Housing First Pilot Project. It was reported that one individual waited more than 6 weeks to be admitted into treatment and another participant got into detox, but was reportedly discharged because the treatment staff said he was too intoxicated and unresponsive to work with.

The increase in homelessness in South King County intersects with the decrease in affordable housing. One focus group participant reported that 48% of annual household incomes in this area are under $49,000. In addition, there has been a net loss of apartment units, overall increases in rents, and the condominium conversion phenomenon. There is a very low vacancy rate (about 4%). Housing is simply out of reach for many and property owners can be very selective in their screening process.

The population characteristics of South King County are dynamic and interesting. The population has changed dramatically over the past two decades. Because rents had been more affordable than in Seattle, resettlement and aid agencies have placed refugees in this area. There has been a large flow of refugees, which partially accounts for the changing demographics of school districts, four of which are more than 50% children of color. One focus group participant reported that a particular resettlement agency had not placed a refugee in Seattle in over six years. A lack of adjacent support services and no transportation make it very difficult for people to succeed in these conditions.

Much of the start up work to establish Housing First models in South King County has been accomplished with the pilot project for chronic homeless:

- Outreach and engagement models are being tested,
- Relationships have been developed with property owners, and
- A service network around homeless people in communities is being formed.

As homelessness becomes more visible it will become important to educate communities about street lifestyles of the homeless so they are recognized and change community perceptions that homeless individuals are “resistant” to services and housing. There is also concern that many people experiencing long-term homelessness do not have disabilities and they will continue to be on the street if housing programs with flexible criteria cannot serve them. Finally, in an expansive area, support services and transportation are critical to the success of housing programs and present a huge challenge to the homeless population and service providers.
Earl and Jeanne have been homeless off and on for over a decade. They have moved between Seattle, South King County, and Tacoma following services, shelter, and housing. Earl, who is 73, had just gotten out of the hospital when they were evicted from their apartment in Tacoma a few days ago.

“We were only behind in our rent two weeks.”

They had been burglarized and admitted, “Maybe we made some poor choices.” They were referring to parties they had in their rented apartment. They had to find a place to live and described Tacoma as “crazy.” They had both lived in Seattle previously and were familiar with the services. Jeannie was well acquainted with Angeline Center and was very well-informed about all of the services in downtown Seattle. They came back to Seattle, after being evicted, because they said, “We would have a better chance.”

Earl and Jeannie say they have been married 17 years. Both are alcoholics, Jeannie has a mental disability, and Earl is now elderly and sick. He has a Veteran pension and social security. He said he had his papers transferred to Seattle, but is confused by the bureaucracy and does not seem to be collecting his checks.

“I have to get up there to straighten it out.”

“Inside of one month, the whole thing blew up”

“The landlord did not like our friends. Now we are at this motel in Federal Way and have just four days there. I am hoping to get well, but we will be back at a shelter if we don’t find a place.”

They comment on how amazed they are by the mental health problems of other people in the shelters, “They are all in the corner screaming and cussing. We can’t stand it.”

They do not want to go back to a shelter and they do not want to be separated. In fact, they have used about four shelters in the last month, including one in South King County.

A few years ago, they were both homeless, “We were sick and did not think straight.” Earl was referring to their drinking.

Neither of them can work anymore. They come to Seattle to use the services and get food. They will take the bus back to their motel. They have applied for housing, but it seems Earl is denied repeatedly because of a criminal record. They do not have the money for rent either. They do not have the deposit combined with the first and last month rent requirement, nor do they have a good credit history.

Earl says it would be okay if he were on his own. He could live on the street, though he does not think he would survive now. They applied for senior housing, but Jeannie is too
young and they were denied. This seems to have happened more than once; he was eligible, but Jeannie was not.

Jeannie is selling papers and is sending Earl back to the hotel to go to bed. They keep in contact with each other with their cell phones, but that is something else they need to do, “Got to straighten out the phone bill.”
III. Policy and Practice Issues

A. Impact of Defining “Chronic Homelessness”

| Policy Issue: Will operationalizing the category “chronic homelessness” result in an unintended consequence of denying services to visibly homeless who do not meet the criteria? |

The widely accepted definition of “chronic homelessness” comes from research analyzing shelter use patterns in New York and Philadelphia (Culhane & Kuhn 1997). How “chronic homelessness” is defined determines the number of individuals counted as among the chronically homeless population and ultimately drives policy responses to the problem. A "chronically homeless" person is defined as "an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more, or has had at least four episodes of homelessness in the past three years. (This definition is accepted by the Department of Housing and Urban Development, Department of Health and Human Services, and the Department of Veterans Affairs.) Different funding interests, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), define the disabling condition as a serious mental illness or co-occurring mental and substance abuse disorder reflecting the agency’s interest. Substance abuse and mental illness appear to be the most frequent conditions observed and recorded in emergency shelter environments.

A broader definition of “homeless” is “a person sleeping in a place not meant for human habitation (e.g., living on the streets), in emergency homeless shelters (including domestic violence shelters), or transitional housing.” This definition would include chronically homeless individuals without a disabling condition that would meet service thresholds.

Policy and Practice Points

The term “chronic homeless” is problematic to service providers for many reasons. For some it reflects social intentions to medicalize homelessness and ignore structural inequities and causes such as poverty, racism, and lack of affordable housing. Thus, society can abdicate its responsibility for creating homelessness. Chronic homelessness is seen by some as an artificial category that could lead to the unintended result of excluding some homeless individuals from assistance when the definition becomes the basis for qualifying for services. By default, a category of “non-chronic” homelessness is created, and services may be denied or restricted. Service providers tend to support a broader definition of chronic homelessness because of the range of people in need of homeless services and the need to prevent “chronic” homelessness.

Another complication in applying the category of chronic homeless is that providers of services to the homeless do not collect data on disabilities uniformly or systematically. When information on disabilities is recorded, mental illness and substance abuse are often the categories with the highest frequency among emergency shelter populations. These categories may also be the most perceptible. The 2007 One Night Count Report acknowledges that while the existing data on disabilities should not be ignored, there is simply not enough information
collected for an accurate description of the population. The unintended result could be to mischaracterize the chronically homeless population and/or overlook the prevalence of other debilitating conditions that should be addressed in the design of services. Finally, there is concern among service providers that the definition of chronic homelessness is problematic because the relationship between long-term poverty, long-term homelessness, and the debilitating effects of experiencing homelessness are neglected.

The concerns outlined above should be balanced with knowledge gained from numerous empirical investigations of homelessness over the past fifteen years. Findings from these studies have generated reasonable and practical methods for defining the scope of the problem and evidence-based practices for social policy. “Chronic Homelessness” is a mutable category that should simply provide policy guidance for identifying a subset of the most vulnerable and generate reasonable estimates of the numbers, thus narrowing any potential credibility gap between knowledge, policy, and practice. Using the definition of chronic homelessness in a rigid and exclusionary way would ultimately leave many sick and vulnerable homeless people on the street.

**B. Chronic Homeless as High Utilizers of Public Services**

<table>
<thead>
<tr>
<th>Policy Issues: Is high utilization an accurate indicator of attributes characterizing the chronic homeless population? In what areas will there be costs reductions and cost increases; what are the real costs of services?</th>
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</table>

It is widely accepted that from 10 to 15 percent of the estimated one million homeless people in the United States are responsible for a large portion of expenses incurred by the homeless overall because of their frequent use of public social services, including law enforcement, jails, drug clinics, psychiatric facilities, and hospital emergency rooms (Green, 2006). The cost analysis has significantly influenced acceptance of Housing First principles and innovative service approaches, such as the DESC 1811 housing program for chronic alcoholics. Sobriety first requirements are increasingly criticized as unrealistic, particularly in the face of scarce treatment resources. There is a trend toward reducing barriers to services related to substance use (at least alcohol) and implementing harm reduction and motivational interviewing strategies as the basis for substance abuse treatment.

A variety of engagement service strategies have developed across the country, where the sobriety requirement has been suspended. These include day centers, case finding outreach and case management programs, and innovative shelter and housing programs based on Housing First principles and harm reduction models. Typically described as “engagement models,” chronically homeless individuals are provided alternative safe shelter, reducing the risk of public intoxication and subsequent use of public services. The service engagement model has been found to reduce jail time and emergency room visits, reducing health care and criminal justice costs. Engagement in services also facilitates access to benefits such as Social Security Disability and Medicaid, which further reduces costs on one side of the public ledger (Green, 2006, Culhane, et al., 2002).
Numerous positive benefits to permanent supportive housing have been observed in programs across the country: improvement in physical and mental health and reduction of need for services, such as inpatient mental health care and hospitalization. Permanent supportive housing results in the formerly homeless increasing their incomes because they work more, have fewer arrests, and make progress toward recovery. Policy makers and service providers are being encouraged to reduce administrative barriers to housing, ease screening criteria, and improve access to housing.

Housing First principles and Harm Reduction models for substance abuse treatment have truly transformed service strategies for those labeled chronically homeless. There are several reports and studies underway to evaluate these models, which have been implemented in Seattle, New York, Philadelphia, Denver, and Portland, Oregon.

**Colorado Coalition for the Homeless** designed a comprehensive housing and supportive services program for chronically homeless individuals with disabilities. This model uses a Housing First strategy combined with assertive community treatment services and integrated health, mental health, substance treatment and support services. The stated goals were to increase residential stability, improve health status, and reduce the utilization and costs of emergency services provided to chronically homeless people. A cost/benefit analysis documented an overall reduction in emergency services by 73%. Emergency room care, inpatient medical and psychiatric care, detox services, incarceration, and emergency shelter utilization significantly declined with participation in the program. There was an increase in outpatient health costs because participants used more appropriate and cost effective health programs. The population averaged 8 years of homelessness prior to entry in the program. By the end of the study, 77% continued in housing, 80% maintain housing for 6 months, and there was overall improvement in health and mental health status. Although only 15% decreased substance use, 64% reported overall improved quality of life (Perlman and Parvensky, 2006).

**Policy and Practice Points**

There are both philosophical and pragmatic reasons for comprehensive housing and supportive services programs for chronically homeless individuals. Reduction in utilization of public services may result in reduced public costs and easing demands on emergency services, thus improving quality of service for other utilizers. Reviews of cost/benefit studies indicate costs of housing, meals, and other supportive services are generally not included in analyses. Intensive (assertive) treatment strategies are costly to sustain and these are not short-term services.

Service providers offered additional critiques of the high utilization argument for providing intensive services to chronically homeless people. Counterpoints include:

- The high utilization argument begs the question of chronic homelessness prevention,
- There are more vulnerable subsets of the chronic homeless population,
- High utilizers are not necessarily representative of the chronic homeless population,
There may be a relationship, but not a perfect correlation, between high utilizers and many sick people who are NOT high utilizers and generally do not cause problems or use services.

Corresponding to the critique of creating the chronic homeless category, providers suggested it would be more productive to focus simply on people who are sick and vulnerable. “High utilization” could likewise become a screening tool for services, creating an artificial and not particularly useful category for identifying the majority of chronically homeless individuals on the streets. Although it is impactful to demonstrate reductions in public service costs, it would also be important that accurate descriptions and full disclosure of all real costs encumbered with services for high utilizers be calculated and made available.

C. Number of Chronic Homeless in Seattle/King County

<table>
<thead>
<tr>
<th>Policy Issue: Are the estimates of chronic homeless individuals reliable for policy and planning?</th>
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Arriving at a count of chronically homeless individuals can only be described as a heuristic process: it may not be true, but may lead to something that is true. There is no single data source for counting homeless individuals and information from various sectors has to be pieced together. There is evidence that the number of homeless and chronically homeless in Seattle King County has been increasing significantly over the last decade (Burt, et al., 2004). Annual One Night Counts conducted by the Seattle King County Coalition on Homelessness between 1999 and 2002 showed an increase of 81% in the “traditional count areas”. The number increased from 983 to 1,779 in this period. The increase in the homeless count occurred despite a 21% increase in the number of homeless individuals who were in shelter or transitional shelter, leading the authors to make the point that Seattle was “losing ground”.

Data presented in the 2007 One Night Count Report (p.5) reflect improved counting methods and increased geographical areas. The 2007 unsheltered street count was 2,159 with another 5680 in emergency shelter and transitional housing, for a total of 7,839. A count of 1,870 people was taken in areas traditionally counted and the remainder was in new count areas, including areas of South King County and Metro buses. One Night Count data along with other methods of extrapolation have led to a commonly used number of 2,500 for the chronic homeless (the number of 2,500 chronic homeless is incorporated into the 10 Year Plan to End Homelessness, for example.). One Night Count data indicate a larger number than 2,500 may be at risk or may actually be in the chronically homeless category depending on the definition used.

Additional Data Points

The 2007 One Night Count found 5,680 individuals either in emergency shelter (2,368) or in transitional housing (3,312). By far, the age category with the highest frequency was 26-54 years in emergency shelter (1,177) and an additional 476 individuals were aged 55-65+ years in emergency shelters. Understandably, data are not complete and it is unclear when counts are unduplicated in the One Night Count. Nevertheless, data on instances of reported disabilities and chronic homelessness show 1,169 persons in either shelter or transitional housing with mental
illness, and 1,118 with alcohol or substance abuse issues, and 888 as chronically homeless. With
the more restrictive definition of chronic homelessness, the 2,500 count approximates the
findings of the One Night Count.

2006 data collected from the Health Care for the Homeless Network (HCHN) Annual Report
offer another perspective on the number of chronic homelessness. Services were provided to
7,897 people defined as homeless. An analysis of length of time of homelessness was done on a
subset of 3,837 clients. Below, is a chart on length homelessness for single adults in the subset.

<table>
<thead>
<tr>
<th></th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Of those homeless for less than 1 year (n=2,463)</td>
<td>35% (862) were single adults.</td>
<td></td>
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<tr>
<td>Of those homeless 1-3 years (n=745),</td>
<td>62% (462) were single adults</td>
<td></td>
<td></td>
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<tr>
<td>Of those homeless more than 3 years (n=629),</td>
<td>90% (566) were single adults.</td>
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</table>

These data confirm other findings suggesting that the chronic homeless population consists of
single adults. In this subset, 49% (1,890) were single adults indicating an approximation to the
2,500 number.

The HCHN Annual Report (2006) provided a brief summary of descriptive data on clients served
within the network and in Public Health sites; 7,897 unduplicated clients were provided services.
Of these, 1,979 listed their housing status as on the street and 5,095 in shelters. SKCHCH (Janna
Wilson) provided additional analysis of these categories to help determine characteristics that
might be associated with chronic homelessness. Among the subset of 1,077 people seen in
HCHN contract sites, 76% (n=815) were male, and 85% (n=915) were single adults. Of the
males (n=815), 86% (n=703) were ages 25 – 84 years, with the age 35-59 years having the
highest frequency. Of males in emergency shelter (n=1,356) 73% (n= 986) were in the 25-85+
year age categories. These data are clinic data and cannot be generalized beyond the clinic
population, but they do offer comparable numbers of single males living on the street. The two
charts below describe two groups, sheltered and unsheltered.

**2006 Demographics -- Street Where Slept Last Night**
Health Care for the homeless Network
Run 8-1-07

<table>
<thead>
<tr>
<th>AGE/GENDER</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>6 through 10</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>11 through 13</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>14 through 17</td>
<td>31</td>
<td>14</td>
<td>45</td>
</tr>
<tr>
<td>18 through 24</td>
<td>41</td>
<td>97</td>
<td>138</td>
</tr>
<tr>
<td>25 through 34</td>
<td>43</td>
<td>99</td>
<td>142</td>
</tr>
<tr>
<td>35 through 59</td>
<td>135</td>
<td>563</td>
<td>698</td>
</tr>
<tr>
<td>60 through 74</td>
<td>6</td>
<td>38</td>
<td>44</td>
</tr>
<tr>
<td>75 through 84</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>85+</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>TOTAL</td>
<td>262</td>
<td>815</td>
<td>1,077</td>
</tr>
</tbody>
</table>
2006 Demographics -- Emergency Shelter Where Slept Last Night  
Health Care for the Homeless Network  
Run 8-1-07

<table>
<thead>
<tr>
<th>AGE/GENDER</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>109</td>
<td>134</td>
<td>243</td>
</tr>
<tr>
<td>6 through 10</td>
<td>53</td>
<td>46</td>
<td>99</td>
</tr>
<tr>
<td>11 through 13</td>
<td>32</td>
<td>32</td>
<td>64</td>
</tr>
<tr>
<td>14 through 17</td>
<td>62</td>
<td>59</td>
<td>121</td>
</tr>
<tr>
<td>18 through 24</td>
<td>155</td>
<td>99</td>
<td>254</td>
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<tr>
<td>25 through 34</td>
<td>305</td>
<td>99</td>
<td>404</td>
</tr>
<tr>
<td>35 through 59 *</td>
<td>707</td>
<td>763</td>
<td>1,470</td>
</tr>
<tr>
<td>60 through 74</td>
<td>54</td>
<td>117</td>
<td>171</td>
</tr>
<tr>
<td>75 through 84</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>85+</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1,480</td>
<td>1,356</td>
<td>2,836</td>
</tr>
</tbody>
</table>

*includes 3 male to female transgendered

The Hygiene Center sees 3,000 unduplicated individuals annually. DESC serves 7,000 unduplicated individuals annually and 3,500 unduplicated in their shelter, the majority of whom they describe as chronically homeless based on their vulnerability screening. St. Martin de Porres shelter houses 212 men per night and turns away 45-65.

The chart below provides a summary of the chronic homeless count from different programs.

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</thead>
<tbody>
<tr>
<td>1,779</td>
<td>2,159 (unsheltered)</td>
<td>1,777 ages 26-54 in emergency shelter</td>
<td>1,169 in shelter with mental illness</td>
<td>888 described as chronic homeless</td>
<td>1,979 clients reported slept on street last night</td>
<td>703 males age 24+ years slept on street</td>
<td>3,500</td>
</tr>
</tbody>
</table>

Policy and Practice Points

There are approximately 2,700 shelter beds and 2,368 persons were in shelter for the 2007 One Night Count; 2,159 people were counted without shelter. The United Way of King County target of 1,000 units would make a significant impact on the number of homeless individuals on the street and currently using emergency shelter as their primary housing. Although opinions differ, data suggest additional programs for immediate housing (such as voucher program used in Portland, Oregon) would be needed for perhaps as many as 1,000 more individuals across the
county. Providers, some of whom suggest the county is short as many as 2,500 beds or units,
confirm this perspective.

Despite the fluid boundaries of homeless categories, there are sufficient data to approximate the
magnitude of chronic homelessness in Seattle and King County. While most likely
undercounted, the current estimates of the chronically homeless population can be viewed as
“good enough” for strategic planning and policy development.
IV. Summary

Research by Kuhn and Culhane (1998) identified patterns of chronic homelessness and characteristics of single adults who became homeless. Nearly all were found to have a disability or significant behavioral health problem that impeded their ability to exit homelessness without supportive services and subsidized housing. In the Kuhn and Culhane study, the chronically homeless made up about 10% of the homeless population overall.

Agency staff agree they are indeed providing services to large numbers of individuals who would meet the definition of chronically homeless. Nevertheless, there are significant numbers of homeless individuals who may fall short of the definition but who are desperately needy. Moreover, there are significant numbers of people whose livelihoods are based from the street and are precariously housed.

It is clear from a decade of one-night counts that there is not enough housing and, as other systems fail, homelessness increases. The number of housing units simply falls short. Staff from DESC state they have 185 clients accepting mental health services who do not have housing. Other supportive services, such as case management, cannot mitigate the lack of housing. Conversely, there is a large population of “street homeless” who do not seek out services at all.

Targeting chronically homeless individuals for housing is essential and humane. It should be kept in mind, there is not a perfect correlation between providing housing for chronically homeless individuals and modifying the presence of the visibly poor, addicted, and mentally ill on the streets, including those among them who are already housed.

The 1811 Program has demonstrated the potential for making an impact, but we do not know to what extent this program will be effective for subsets of the chronic alcoholic population or if it can be successfully applied with other addictions. In addition, there are factors beyond homelessness associated with street-based livelihoods that continue to both attract individuals to the street environs and make it the place of last resort. Applying the definition of “chronic homeless” or “high utilizer” as thresholds for access to new housing would most likely leave many visibly poor people on the street and would exclude others who are on a trajectory toward that status.

**Summary Points**

1. There is a clear need for more housing and housing program options that are sensitive to the particular needs of homeless people. Some individuals will thrive in independent units; others require the support of group environments to succeed and stay within a service structure.

2. Sheltered populations and individuals involved with street-based subcultures are likely to continue to be visible on the street during the day. Employment or daily activity alternatives need to be included in housing support services.
3. Drug addicts will continue to be visible on the street and require a different configuration of interventions from chronic alcoholics.

4. There appears to be less opportunity for females to access work, such as day labor. Women on the street are characterized by repeat victimization and are perhaps most in need of mental health services to address trauma.

5. Age is a key factor for services involvement and successful housing outcomes.

Service and System Issues and Recommendations

Services for homeless people in Seattle are still accurately characterized as fragmented and restricted. Although the safety net is somewhat effective, there are significant gaps. To truly impact the quality of life of people experiencing long-term homelessness, specific philosophies and service strategies need to be adopted.

Recommendations have been made at national and local levels regarding homeless services. Two fundamental principles identified are “no wrong door” and “centralized services.” These principles are summarized below from the Denver, Colorado program design:

“No wrong door”—homeless people gain access by approaching any program, after which program staff augment these first contacts with shared knowledge of what is available and systematic linkages that help clients get to the right programs and services. A few of our communities fall into this category, and a few more would do so if we expanded our concern to include an integrated approach to assessment and service delivery through multi-service centers, in addition to intake.

Centralized—one or a few linked points of entry. According to proponents, centralized entry minimizes prolonged and misdirected searches for emergency shelter and services, and allows for uniform intake and assessment, which helps ensure equity of access to services. Five of our communities have centralized family intake, while one has a centralized intake mechanism in place for everyone.

Interviews with agency staff, service providers, and homeless individuals identified specific services and systems issues that are needed to support success in housing programs:

1. Foremost is the need for more housing. As one provider put it, “You can tinker with services but we need more housing.” Providing an additional 1,000 units of housing will have a truly dramatic effect and will no doubt significantly improve the quality of life of many individuals who need help.

2. The efficacy of Housing First models for chronic alcoholics is gaining empirical support. There should be increased investment in these models for homeless populations characterized by mental illness and other addictions.
3. **Low barrier shelters** for drug addicts, who are often screened out of shelters, need to be put in place for earlier intervention in the street/drug cycle.

4. Pilot programs for homeless street populations addicted to illegal drugs need to be implemented. One suggestion is a pilot program for **addiction treatment on demand**. The current system is failing to engage and maintain large numbers of addicted individuals involved in street subcultures who are becoming part of the visibly homeless and chronic homeless populations.

5. Develop and support **generic and coordinated street outreach** based on engagement principles. Currently, there are separate outreach efforts specific to different groups. These programs are doing exceptionally good work, but clients could benefit from improved coordination and access across systems. Case management information is often lost when a client moves from one system to another and from one case manager to another. Generic outreach programs would improve services by cutting across independent service domains and maintaining case management information on individuals through time and across services.

6. Improvement of the **housing referral system** and make it more accessible to the homeless population.

7. **Expansion of mental health services** for disorders that are most common among the homeless and chronically homeless street populations.

8. Implementation of a **cross-system database** for service coordination, client records, and provision of a feedback loop for program adjustments.

9. Coordinate services to support the capacity to **plan for shelter exits** into housing options.

10. Invest in ongoing **supportive service and retention models**. Support services cannot end with housing placement.

11. Invest in and support the development of innovative mental health and **addiction recovery models attached to housing**.

**Leadership**

Service providers are adamant that people do not choose to be homeless and they do not choose the consequences of homelessness. With appropriate support and opportunity, they will accept housing. In many interviews, I was encouraged to communicate the effectiveness of service models implemented in Philadelphia and Portland in particular. In these conversations, the issue of leadership arose. In one interview, the point was made that social service staff in Portland were able to communicate their city’s plan to end homelessness and knew exactly what steps were in progress. This person wondered why, given their involvement in homeless issues over the years, the Seattle/King County plan was not as easily articulated and understood at the direct service level.
There was a feeling that Seattle was behind, and behind because of a lack of leadership. A number of individuals interviewed believed United Way of King County was in a position to leverage resources and exercise leadership necessary to keep moving forward on ending homelessness objectives.
V. Questions for Further Research

An additional component to this work is identifying exploratory variables and areas of inquiry for future empirical study. Recommendations are listed below:

1. **First Systems** – What were the initial services and systems involvement of currently chronically homeless and addicted homeless individuals? The focus for this inquiry would be development of prevention strategies. Foster care experience would be a key variable to explore.

2. What is the prevalence and typology of disabilities among homeless individuals? Where are the opportunities for prevention of homelessness?

3. **Intervention Research** – What are the long-term outcomes for Housing First and Harm Reduction approaches in supportive housing models for chronic alcoholics, compared to other addictions.

4. What are promising practices for retaining individuals within systems of support if they fail in housing?

5. What are the most promising practices for chronically homeless individuals who abuse illegal drugs (as opposed to alcohol)? Pilot projects for recovery models and treatment on demand models could be developed and evaluated.

6. What housing options are most successful for different homeless and street populations?

7. There appears to be an increase of women seen in services and on the street. What are the trends, characteristics, and needs of homeless women?
VI. References


Wright, E., Littlepage, L., Federspie, and C., (2007) Issues for Policy Makers: Serving the Homeless Well Could Save Taxpayer Dollars. Center for Health Policy, School of Public and Environmental Affairs, Indiana University-Purdue University Indianapolis (IUPUI), 342 N. Senate Ave., Suite 300, Indianapolis, IN 46204.
VII. Appendix 1

List of Agencies Contacted
List of Staff Interviewed

**Downtown Emergency Service Center**
Bill Hobson, PhD. Executive Director
Nicole Macri, Director of Development
Dan Malone, Director of Housing Programs
Graydon Andrus, Director Clinical Programs

**Real Change**
Rachel Myers

**Operation Nightwatch Emergency Shelter**
Rick Reynolds

**Dutch Shisler Sobering Support Center**
Emergency Services Patrol Supervisor
Wendy Pompey

**Compass Center**
Kim Saither Manager Shelter Day Services

**Healthcare for the Homeless**
Jana Wilson
Trudi Fajans

**Plymouth Housing**
Tara Connor

**St. Martin de Porres Shelter**
Bob Goetschius

**Metropolitan Improvement District (MID)**
Peggy Dreisinger, Director of Field Operations
Group discussion with workers and accompanied.

**Evergreen Treatment Services**
Ron Jackson

**Reach Program**
Chole Craig

**Seattle King County Coalition for the Homeless**
Alison Esinger

**King County Community Services/Homeless Housing Program**
Kate Spelt
Seattle Police Department (two officers)

**Department of Corrections** -
Leslie Mills, West Precinct
Steve Lambert, East Precinct

**Safe Harbors**
Jon Hoskins

**King County Housing Authority**
Debbie Thiele

**South King County** (Focus group)