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CENTER FOR HEALTH POLICY
RESEARCH FOR A HEALTHIER INDIANA
SEPTEMBER 2007

Homeless Count Shows Needs in Indianapolis

In January 2007, a team organized by the Indiana University Center for Health Policy (CHP) undertook a citywide count of the homeless in the Indianapolis community. This issue brief discusses the findings and details of that count and thoughts for policymakers who are interested in improving the effectiveness of services for this group.

The homeless count was conducted in response to requirements of the U.S. Department of Housing and Urban Development (HUD) which plays an important role in homeless aid and prevention. To qualify for federal funds for homelessness programs, HUD requires communities to participate in periodic surveys so that it can estimate the extent of homelessness in America, provide Congress with information on services, identify service gaps, and make informed funding decisions. The two counts sponsored by HUD are the biennial point-in-time count (a one-night count of sheltered and unsheltered homeless persons) and an annual housing inventory count (an inventory of beds for the homeless, including seasonal and overflow beds).

On cold days in January, such as when the 2007 Homeless Count was taken, some homeless individuals struggle to keep warm. In this photo, a man warms his hands over a fire in a metal can.

With the goal of gaining an accurate picture of the homeless population, HUD has requirements about the type of information that must be gathered and how it is obtained. It requires the count to be done biennially and encourages an annual count, and it requires that the count be taken in one night during the last week of January. It also requires communities to gather information about chronic homelessness and use statistically acceptable methods for data collection. And, in addition to counting the number of unsheltered homeless, it requires sheltered homeless people to be counted who reside in emergency shelters and transitional housing. This includes people in domestic violence shelters, residential programs for runaway and homeless youth, and hotel and motel vouchers paid for by public and private agencies.

The housing inventory count gives HUD data about the bed capacity of local and national shelter systems and the size of the target population served at emergency shelters and in transitional housing. Participation in these HUD counts helps communities compile accurate data in order to understand the scope of the homeless problem locally and improve planning for services. It also gives them a way to evaluate the impact of efforts to end homelessness.

Between 6,000 and 10,000 people may experience homelessness in Indianapolis over the course of a year.

On January 25, 2007, the biennial point-in-time count was held in Indianapolis. These counts have traditionally been administered by the Coalition for Homelessness Intervention and Prevention with the help of other local organizations and volunteers. As pertinent policy decisions are dependent on the data gathered during the counts, a more statistically significant and accurate methodology of information gathering needed to be adopted. Standardization of data collection had been an issue in past counts, so changes were implemented for the 2007 Homeless Count. This year's count employed two different approaches. First, the Indiana University Center for Health Policy (CHP) took a leadership role in refining the methodology for conducting the comprehensive survey by both the shelter and street teams. Second, the field professionals were engaged to actually take the counts and the project relied less on volunteers.

Methods Used to Count the Homeless

To gain an accurate picture of the homeless population in Indianapolis, this year's count focused on improving data collection through a more standardized methodology and process. To prepare for the count, focus groups were conducted by CHP with outreach workers for the purpose of determining areas populated with homeless individuals in metro Indianapolis. The groups identified some growing populations of homeless located outside downtown but in the near surrounding areas, and CHP staff used this information to construct maps of the areas to be canvassed.

The focus groups also said that safety on the streets had diminished. As a result, outreach workers strongly suggested that professionals conduct the street count. Following this advice, count coordinators did not actively recruit lay volunteers, but rather held outreach meetings to enlist the support of outreach teams. All service providers who offered homeless outreach services were invited. Count outreach teams were assembled by organization, and a recorder (usually an IUPUI student) was also assigned to each team. Teams were comprised of three to four outreach workers and one student, with some variations for teams assigned to areas that were more or less populated.

At the outreach meetings, volunteers were asked to indicate their preference of the area where they would work, and team members were pre-assigned when possible. The city was divided into quadrants with two teams in each quadrant: the first team focused on the inner-city areas, those most heavily populated, and the second team focused on the outlying, less populated areas.

The street count teams were organized as follows: 1) northeast, 2) northwest, 3) southeast, 4) southwest, 5) far northeast, 6) far northwest, 7) far southeast, and 8) far southwest. Additional teams were placed in most area emergency rooms.

The Indianapolis Metropolitan Police Department deployed officers to assist with counts at local hotels and motels. The police acquired lists of hotel guests from front desk personnel at hotels that are used solely for homeless individuals.

CHP staff developed surveys—with input from the Coalition for Homelessness Intervention and Prevention, the outreach workers, and students—to capture information about the homeless population. A self questionnaire was also developed for individuals who wanted to complete the forms themselves. The survey gathered information on location, age, race, length of time as homeless, veteran status, mental illness, substance abuse, and HIV/AIDS status.

Homeless Population Findings

According to HUD, a person is considered homeless only when he or she resides in one of the following places at the time of the count: 1) a place not meant for human habitation, such as a car, park, sidewalk, abandoned building, or on the street *(unsheltered homeless person)*; or 2) an emergency shelter or transitional housing for homeless persons who originally came from the streets or emergency shelters *(sheltered homeless person)* (U.S. Department of Housing and Urban Development, 2006).

Under the HUD definitions, the teams counted 2,061 homeless persons in the Indianapolis areas on January 25, 2007, slightly less than the 2,080 counted in 2005. Table 1 shows the actual 2007 count numbers for sheltered and unsheltered homeless, while those in specific homeless subpopulations are shown in Table 2. The last column of Table 2 shows the estimates of the subpopulations based on federal data, which seems to indicate that there may have been underreporting of these subpopulations in the count. The total number of

Table 1: 2007 Count Results, Homeless Population, Indianapolis Area

	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of persons with children*	229	312	0	541
Number of single individuals and persons in households without children	462	631	427	1,520
Total persons	691	943	427	2,061

*Children included in the count.

Table 2: 2007 Count Results, Homeless Subpopulations, Indianapolis Area

Homeless Subpopulation	Emergency	Transitional	Total Sheltered	Estimated Number Based on Federal Percent of Homeless Population Sheltered	Unsheltered	Estimated Number Based on Federal Percent of Homeless Population Unsheltered	Sheltered and Unsheltered from the Count	Estimated Totals Based on Federal Percent Data
Chronically homeless	102	N/A	102	192	27	273	129	465
Persons with severe mental illness	12	25	37	219	6	140	43	359
Chronic substance abuse	213	475	688	294	31	194	719	488
Veterans	73	171	244	121	14	73	258	194
Persons with HIV/AIDS	2	7	9	45	3	15	12	60
Victims of domestic violence	186	203	389	150	22	61	411	211
Unaccompanied youth (under 18)	4	4	8	107	1	49	9	156

Table 3: Comparison of Past Three Biennial Homeless Counts, Indianapolis, 2007, 2005, and 2003

Number of Homeless per Type of Residence	2007	2005	2003
Emergency shelter	691	740	736
Transitional housing*	943	1192	1290
Unsheltered ("street count")**	427	147	204
Total	2,061	2,079	2,230

*Some of the differences in numbers of people in emergency shelters and transitional housing may reflect variations in the ways that shelter providers classify the services they provide.

**The street count includes people living in places not meant for human habitation, such as cars, parks, sidewalks, abandoned buildings, etc.

homeless in Indianapolis appears to be holding steady (Table 3); however, this year's count shows a large increase in unsheltered homeless individuals in the street count. This increase could be attributed to improvement of the street-count methodology.

National experts on homeless counts recommend different formulas for producing estimates based on the single-night counts. Consistent with earlier estimates from the Coalition for Homelessness Intervention and Prevention, we are estimating the number of people actually homeless on a single night by using a ratio of three to five times the number of people actually counted. Using this method, we estimate that between 6,000 and 10,000 people may experience homelessness in Indianapolis over the course of a year. The validity of this estimate is supported by data from nearly 7,000 calls for help to the 2-1-1 urgent number (for quick information and referrals to health and human service organizations) from people who identified themselves as homeless or "doubled up and sharing."

Homelessness Trends in Indianapolis

The demographics of the homeless population have not changed greatly in recent years; however, some trends and general demographics should be considered for policy decisions and program development. The race/ethnicity makeup of the homeless population counted, illustrated in Figure 1, shows that 42 percent of those counted were African American. In comparison to the previous count and in contrast to the growing Latino population in Indianapolis, the Hispanic homeless population remains steady at 3 percent of those surveyed.

Figure 2 shows the location of the approximately 26 percent of those counted who were in families with children (including the children themselves). The 2005 count found that more families are in need, and this can be supported since the number of homeless in families is still a fairly high percentage of those counted. Another important finding of the 2005 count was a noticeable increase in women among the homeless reporting domestic violence. This year, approximately 20 percent of those surveyed said they have been victims of domestic abuse. Totals from the shelter and street counts can be seen in Figure 3.

Figure 1: Homeless Count Demographics, Indianapolis, January 25, 2007

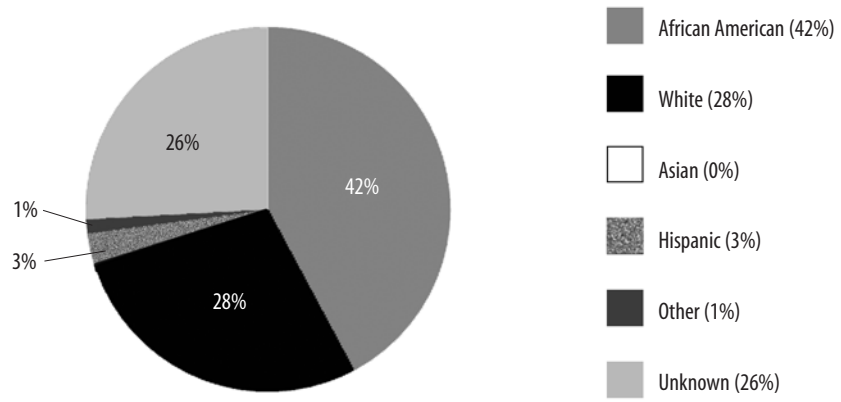


Figure 2: Location of Homeless Families with Children, Indianapolis, January 25, 2007

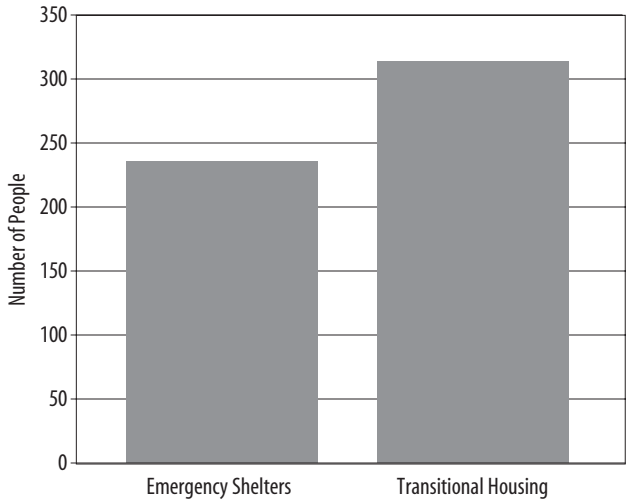
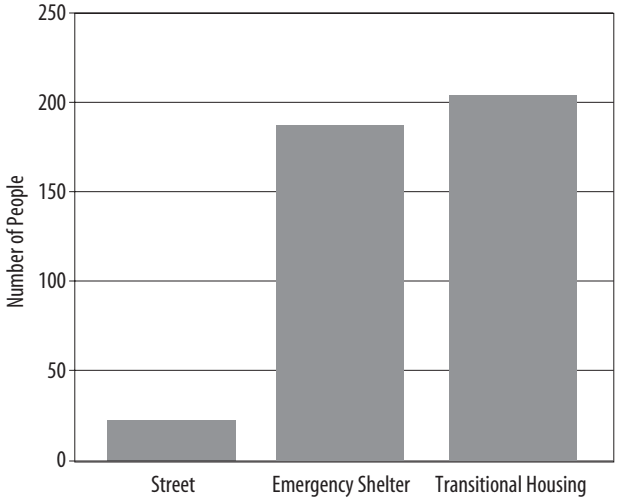


Figure 3: Location of Homeless Victims of Domestic Abuse, Indianapolis, January 25, 2007



Bed and Housing Inventory Results

The Coalition for Homelessness Intervention and Prevention developed the survey for the bed and housing inventory. Once this was finalized at the end of January, the survey was sent via e-mail or mail, depending on the facility, to emergency shelters, transitional housing programs, halfway houses, safe havens, etc. CHP staff made numerous follow-up calls and e-mails over a two-month period to retrieve the surveys. At the end of April, if we had still not obtained a program's data (13 percent of facilities), their 2006 numbers were used.

As shown in Table 4, organizations in the Indianapolis area have approximately 800 emergency shelter beds available, while the need was estimated at approximately 1,100 people (together, the number of emergency sheltered persons and unsheltered persons shown in Table 1). Thus, even if outreach workers were successful in reaching all unsheltered homeless in Indianapolis, there would not be enough emergency shelter beds to serve them. There also can be shortages of beds for specific needs, such as beds for families, persons with mental illness, and youth (see Table 2, page 3, for the categories).

Table 4: Number of Beds/Housing Available for the Homeless in Marion County, 2007

Number of Available Beds	Current Total Year-Round Beds	New Inventory	Under Development	Total
Emergency	767	35	15	817
Transitional	1,101	0	0	1,101
Total	1,868	35	15	1,918

Thoughts for Policymakers

The total homeless population counted on one day in Indianapolis continues to hover at around 2,000 people. The persistently large numbers of homeless in Indianapolis suggest that while much has been accomplished, much more is still needed to provide these people with the help and support they need to find permanent, safe living quarters and to realize the vision for the city outlined in the *Blueprint to End Homelessnes*s.

Some policy implications include the need for an engagement center for those with addictions. An engagement center could provide individuals with safe shelter and a screening process for service needs while reducing their state of intoxication to a level that no longer puts them at risk for arrest for public intoxication. This could be a valuable stepping stone for them and help reduce jail time and unnecessary visits to the emergency room.

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There is also a need for projects to help people more quickly access mainstream subsidies such as disability determination and Medicaid eligibility. Determination of disability would lead to a consistent source of income, while a determination of Medicaid eligibility would lead to better mental and physical health care.

Programs that would improve outreach efforts and help the homeless secure permanent supportive housing would assist them in moving off the streets and out of shelters. The Action Coalition to Ensure Stability developed a demonstration model and cost study that supports the cost effectiveness of a permanent supportive housing approach using a *housing first* approach. According to several studies (Culhane, et al., 2002; Green, 2006), permanent supportive housing improves physical and mental health for the tenants and reduces the need for services, especially expensive inpatient mental health care and hospitalization. It helps tenants increase their incomes and time employed and decreases encounters with the criminal justice system. Ultimately, it enables them to make progress toward recovery and become more productive citizens.

Even with permanent supportive housing, there is a need to reduce the barriers (i.e., long-waiting lists; criminal histories; and poor credit to qualify for longer term housing subsidies such as housing choice vouchers). Often administrative barriers limit access to mainstream programs and decrease the likelihood that people who are homeless will apply for the programs.

With increased short-term funding and improved programs, policymakers may be able to see improvements in the number of homeless people in our communities.

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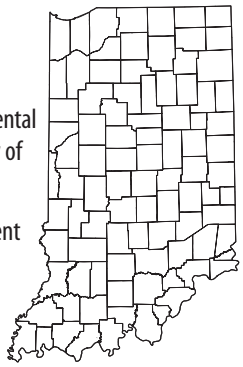
Indiana's Future: Identifying Choices and Supporting Action to Improve Communities



The Indiana University Center for Health Policy is a nonpartisan applied research organization in the School of Public and Environmental Affairs at Indiana University–Purdue University Indianapolis. Researchers at CHP work on critical policy issues that affect the quality of health care delivery and access to health care. CHP is a partner center to the Center for Urban Policy and the Environment.

Publication of this report was funded by a grant from Lilly Endowment, Inc. CHP and the Center for Urban Policy and the Environment are grateful to Lilly Endowment for funding publication of information for leaders and policymakers in Indiana.

The work discussed in this report was conducted under contract with the Coalition for Homelessness Intervention and Prevention that was contracted through a grant from United Way of Central Indiana, funded by the Lilly Endowment.

The Center for Health Policy would like to thank the many people who volunteered and helped make the 2007 Homeless Count a success. We especially want to thank the outreach workers from the local homeless organizations who helped plan and lead the street count teams. We also want to thank the Pedrotti-Hays Consultants for their organizational and logistical support; the Indianapolis Metropolitan Police Department and the Marion County Department of Public Health for their assistance on the night of the count; Horizon House for acting as count headquarters; and the students from IUPUI's Do the Homeless Count service learning course for helping with data collection and collation. Finally, we wish to thank the Coalition for Homelessness Intervention and Prevention for their financial and technical support.

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