



SPARC ATLANTA

Initial Findings from Quantitative and Qualitative Research

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Background

The Center for Social Innovation (C4) launched Supporting Partnerships for Anti-Racist Communities (SPARC) in 2016 in response to overwhelming evidence that people of color were dramatically overrepresented in the nation’s homeless population—across the country and regardless of jurisdiction. Since then, SPARC has worked in six communities, using mixed methods research and structured dialogue to understand how people are experiencing systemic racism in relation to homelessness, and to leverage that knowledge toward systems transformation.

Beginning in May 2017, C4 partnered with United Way of Greater Atlanta, Partners for HOME, Mercy Care, and other nonprofit service providers in Atlanta to collect qualitative and quantitative data to examine the racial dimensions of homelessness in the area. This report presents preliminary findings from these data and a discussion of the findings. Participation in SPARC is one way that United Way of Greater Atlanta has prioritized racial equity in its work and works to build culture equity into the department from the beginning.



Glossary of Terms

Racism - A system of advantage/oppression based on race. Racism is exercised by the dominant racial group (Whites) over non-dominant racial groups. Racism is more than just prejudice.

Inequities - Differences in outcomes between population groups that are rooted in unfairness or injustice.

Equity - A situation where all groups have access to the resources and opportunities necessary to eliminate gaps and improve the quality of their lives.

Racial Equity - “Closing the gaps” so that race does not predict one’s success, while also improving outcomes for all. Equity is distinct from equality in that it aspires to achieve fair outcomes and considers history and implicit bias, rather than simply providing “equal opportunity” for everyone. Racial equity is not just the absence of overt racial discrimination; it is also the presence of deliberate policies and practices that provide everyone with the support they need to improve the quality of their lives.”¹

Anti-racism - “An action- oriented, educational and political strategy for institutional and systemic change that addresses the issues of racism and the interlocking systems of social oppression (sexism, classism, heterosexism, ableism).”²

¹ George J. Sefa Dei, *Power, Knowledge and Antiracism Education*, ed. George Sefa Dei and Agnes Calliste (Halifax: Fernwood, 2000), 13.

² Maguire, Angus. “Illustrating Equality vs. Equity.” Interaction Institute for Social Change, 13 Jan. 2016, interactioninstitute.org/illustrating-equality-vs-equity/



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1. Executive Summary

Beginning in May 2017, the Center for Social Innovation (C4) partnered with United Way of Greater Atlanta, Mercy House, Partners for HOME, and other service providers to amplify the issue of racial inequity and homelessness in Atlanta, Georgia. This partnership included a public town hall event, provider training, a planning session of community leaders, and collection/analysis of local quantitative and qualitative data.

In the planning session of community leaders, stakeholders from homeless service organizations identified two “Structural Change Objectives” for our work to address racial equity in our system. These are:

1. **Improving access to public transportation** in the Greater Atlanta area, by improving current infrastructure, expanding public transportation routes, and including greater community involvement in planning.
2. **Affirmatively furthering fair housing**, with a focus on redesigning the evictions process, including fair representation and adequate support services, and supporting efforts to expand inclusionary zoning.

As part of the effort to better understand the intersection of racism and homelessness in Atlanta, SPARC worked with local partners to collect qualitative and quantitative data that would elucidate the racial dimensions of homelessness in the area. Data collection included:

1. Homeless Management Information System (HMIS) data from fiscal years 2011 to 2016.³
2. Qualitative research, including 22 individual interviews with people of color experiencing homelessness and three focus groups— one for people of color experiencing homelessness, one for direct service providers of color, and one for community leaders in the housing and homeless services systems as well as adjacent systems.

³ HMIS includes client-level data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.



This report presents preliminary findings from this research. In the Discussion, we present promising directions for potential systems change and further research, and in the Recommendations, we outline potential short term and long-term action steps. We also explore the links between the data and the objectives identified by the Atlanta community leaders.

1.1 Summary of Preliminary Quantitative Findings

Our analyses of HMIS data from the Atlanta Continuum of Care for fiscal years 2011-2016 explored the demographics of people experiencing homelessness compared to people in poverty and the general population, racial/ethnic disparities in location prior to homelessness and destination at exit, and race/ethnicity as a predictor of exit destination. For some analyses of entry and exit location, we broke the sample into three household statuses: 1) individuals presenting as part of a household, including heads of households 2) individuals aged 25 and older; and, 3) individuals 18 to 24.

Our findings include:

- Though the Black population in Atlanta constitutes 53.5% of the general population, this group is overrepresented among those living in deep poverty (75.7%) and among people experiencing homelessness (87.5%). On the other hand, Whites constitute 40.1% of the general population, but are markedly underrepresented in the deep poverty group (17.6%) and the population experiencing homelessness (11.3%). The disparities between the percentages in poverty and those experiencing homelessness suggests that poverty alone does not explain the overrepresentation of Black people in the population experiencing homelessness.
- Looking at prior location of each household type, entry location categories were proportional with the race and ethnicity breakdown, with the exception of the institutional care category, where Whites were overrepresented.
- Examining families specifically, the majority (55.6%) exited into permanent housing with no subsidy followed by doubled-up (15.9%) and permanent housing with a subsidy (13.6%). Most exit locations were proportional with the overall race and ethnicity breakdown.
- Nearly 40% of individuals 18-24 exited to permanent housing with no subsidy, followed by into a doubled-up situation (27.4%) and back into homelessness (15.0%). There were minimal differences by race and ethnicity.
- Almost a third (29.0%) of individuals 25 and older exited back into a homeless situation



followed by 27% into permanent housing with no subsidy and 19.3% into a doubled-up situation. There were minimal differences by race and ethnicity.

- Compared to Whites across all household types, Blacks were 9.8% less likely to exit into homelessness, and American Indian or Alaska Natives were 43.7% more likely.
- Compared to Whites, Black individuals were 44% more likely to exit into permanent housing with a subsidy and 83% more likely to exit into permanent housing without a subsidy.
- Compared to individuals over the age of 25, individuals in households were almost three times more likely to exit into housing with a subsidy *and* three times more likely to exit without a subsidy.

The findings point to the need for research that examines returns to homelessness, housing stability once exit to housing is documented, and the way age, gender, and other factors interact with race to impact people in intersectional ways.

1.2 Summary of Preliminary Qualitative Findings

- **Pathways into homelessness** were often characterized by:
 - *Network impoverishment*: It is not just that respondents were experiencing poverty — everyone they know was experiencing poverty, too.
 - *Threats to safety*: Narratives of violence and compromised safety, specifically within family and home environment, were common in the narratives of people we interviewed — particularly women.
 - *Unmet health needs*: Instability and trauma correlated with mental health and substance use issues, while medical health issues were also common in respondents' narratives.
- **Barriers to exiting homelessness** are often systemic and include:
 - *Difficulty navigating the system*: People are frustrated with program requirements and find it hard to get what they need from public assistance.
 - *Employment accessibility and economic mobility*: People find it difficult to secure employment that they can find transportation to and that pays a housing wage.
 - *Ineffective behavioral health services*: Unmet mental health and substance use issues was portrayed a barrier to exiting homelessness.



1.3 Recommendations

Based on these data, preliminary recommendations include the following, which are detailed further in the report:

1. Design an equitable Coordinated Entry system.
2. Incorporate racial equity into grantmaking and contracting for homelessness and housing programs.
3. Include racial equity data analysis and benchmarks in strategic planning to end homelessness.
4. Support organizational development to ensure racial equity at the organizational level.
5. Encourage anti-racist program delivery.
6. Promote ongoing anti-racism training for homeless service providers.
7. Collaborate to increase affordable housing availability for all people experiencing homelessness.
8. Utilize innovative upstream interventions to prevent homelessness for people of color.
9. Investigate flexible subsidies to mitigate the effects of network impoverishment.
10. Support innovative health care strategies to meet the health and behavioral health needs of communities of color.

1.4 Implications

This study is grounded in the lived experience of people of color experiencing homelessness, and it offers numerous insights for policy makers, researchers, organizational leaders, and community members as they work to address homelessness in ways that are comprehensive and racially equitable. The demographics alone are shocking—the vast and disproportionate number of people of color in the homeless population in Atlanta is a testament to the historic and persistent structural racism that exists in this country. Collective responses to homelessness must take such inequity into account. Equitable strategies to address homelessness must include programmatic and systems level changes, and they must seriously begin to address homelessness prevention. It is not enough to move people of color out of homelessness if the systems in place are simply setting people up for a revolving door of housing instability. Efforts must begin to go upstream into other systems—criminal justice, child welfare, foster care, education, and healthcare—and implement solutions that stem the tide of homelessness at the point of inflow. This report aims to present initial findings from SPARC’s work in Atlanta, examine what can be learned from these data, and begin crafting strategies to create a response to the homelessness crisis that is grounded in racial equity.



2. Preliminary Quantitative Research

For the preliminary analysis of Atlanta’s Homeless Management Information System (HMIS) data, the SPARC team identified an initial set of research questions:

1. How does the race of people experiencing homelessness compare to those in poverty and the general population?
2. How does the race of people experiencing homelessness relate to the number of homeless occurrences in the three-year period prior to program entry?
3. How does the race of people experiencing homelessness relate to the number of months an individual has experienced homelessness over the three-year period prior to program entry?
4. How does the race of people experiencing homelessness relate to “prior living situation” at program entry?
5. How does the race of people experiencing homelessness relate to “destination” at program exit?

Our team also looked at whether or not race or ethnicity were substantial predictors of exiting programs into homelessness, housing without subsidy, or housing with subsidy.

2.1 Preliminary Quantitative Research Findings

The following analyses used HMIS data from the Atlanta Continuum of Care for fiscal years 2011-2016 which included 78,712 clients. Several slightly different client universes are analyzed in this report, representing a total of 78,712 unique clients with three different household statuses: 1) individuals presenting as part of a household, including heads of households (n=4,583); 2) individuals aged 25 and older (n=48,597); and, 3) individuals 18-24 years of age (n=15,417). Univariate and bivariate descriptions below (Tables 1-4) represent all household groups. In these tables and descriptions, it is important to note that a variable associated with a head of household may apply to all members of that household, which may skew the data in that characteristics of households with more than one affiliated individual will be given more weight. Tables 5-13, alternatively, describe prior residence and exit destination for all three household groups. Logistic regressions are run on all clients with family group type included in the model as a covariate.



As shown in Table 1, the study sample was 58.0% male. The average age for this sample was 36 years (M = 36.16, SD = 17.85). A majority of participants (87.5%) were Black, followed by 11.3% White, 0.8% American Indian or Alaska Native, 0.3% Asian, and 0.1% Native Hawaiian or Other Pacific Islander. Less than three percent (2.7%) of clients identified as Hispanic/Latinx.⁴ Approximately 12% of the individuals (11.6%) were veterans and 45.1% had a disability.

Table 1. Characteristics of people in Atlanta Continuum of Care for fiscal years 2011-2016	
Race	N (%)
Black	67,568 (87.5%)
White	8,710 (11.3%)
American Indian or Alaska Native (AI/AN)	596 (0.8%)
Asian	217 (0.3%)
Native Hawaiian or Other Pacific Islander (NHOPI)	92 (0.1%)
Total N = 77,183	
Ethnicity	
Non-Hispanic/Non-Latinx	76,042 (96.6%)
Hispanic/Latinx	2,126 (2.7%)
Total N = 78,168	
Gender	
Female	32,744 (41.7%)
Male	45,545 (58.0%)
Transgender male to female	216 (0.3%)
Transgender female to male	18 (0.0%)
Age	
Years (Mean, SD)	36.16 (17.85)
Veterans Status	
Yes	9,118 (11.6%)
No	67,145 (85.3%)
Presence of Disability	
Yes	35,487 (45.1%)
No	39,151 (49.7%)

⁴ Latinx is a gender neutral term used in lieu of Latino or Latina.



How do the racial demographics of people experiencing homelessness compare to those in poverty and the general population?

We looked at 2016 HMIS data and compared it to American Community Survey (ACS) general population data, poverty data, and Point in Time (PIT) homeless counts. Though the Black population in Atlanta constitutes 53.5% of the population, this group is overrepresented among people living in poverty (both the 100% and 50% poverty line groups, 76.9% and 75.7%, respectively) and among people experiencing homelessness (HMIS, 87.5%). On the other hand, Whites constitute 40.1% of the general population, but are strikingly underrepresented in both poverty groups (16.6% and 17.6%, respectively) and in the population experiencing homelessness (HMIS, 11.3%). Individuals identifying as Hispanic/Latinx (of any race) have somewhat proportionate representation across poverty but are slightly underrepresented in HMIS and overrepresented in PIT counts. Individuals identifying as two or more races represent only 1.8% of the general population, but 3.6% of the 2016 PIT count.

Race	Percent of total population 2015 ^a	Percent at 100% Poverty 2015 ^b	Percent at 50% Poverty 2015 ^c	Total de-duplicated Percent, HMIS 2016	2016 Homelessness PIT ^d
Black	53.5%	76.9%	75.7%	87.5%	86.6%
White	40.1%	16.6%	17.6%	11.3%	8.7%
AI/AN	0.2%	0.2%	0.2%	0.8%	0.9%
Asian	3.3%	3.1%	4.2%	0.3%	0.2%
NHOPI	0.0%	0.1%	0.1%	0.1%	0.0%
Two or more*	1.8%	1.4%	1.5%	NA	3.6%
Hispanic or Latinx (of any race)	4.8%	5.8%	3.6%	2.7%	5.4%

*Two or more races category not collected in HMIS
^a ACS 5yr 2015 Total
^b ACS 5yr 2015 - 100% poverty line
^cACS 5yr 2015 – 50% poverty line
^d 2016 Point in Time homelessness count



How do racial demographics of people experiencing homelessness relate to the number of homeless occurrences in the three-year period prior to program entry?

For the purpose of this report, “program” is used to refer to a specific “project” in HMIS systems. “Program entry” is defined by the first program (in HMIS data, “project”) entry in our samples for each individual. “Program exit” is defined by last exit in the sample for each individual where an exit location was identified. Table 3 shows the racial breakdown of the number of homeless occurrences experienced by clients in the three-year period prior to program entry. The majority of clients (78.4%) were missing data on this HMIS data element. However, among the sample that was not missing data, the racial breakdown across number of times homeless was essentially proportionate to the broad HMIS sample.

Number of times homeless in the past 3 years	All Races	Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx
1	9665	8402 (86.9%)	1137 (11.8%)	93 (1.0%)	25 (0.3%)	8 (0.1%)	310 (3.2%)
2	2711	2360 (87.1%)	311 (11.5%)	34 (1.3%)	5 (0.2%)	1 (0.0%)	62 (2.3%)
3	1570	1332 (84.8%)	215 (13.7%)	17 (1.1%)	4 (0.3%)	2 (0.1%)	30 (1.9%)
4 or more	2757	2324 (84.3%)	379 (13.7%)	38 (1.4%)	12 (0.4%)	4 (0.1%)	41 (1.5%)

How do racial demographics of people experiencing homelessness relate to the number of months an individual has experienced homelessness over the three-year period prior to program entry?

Table 4 shows the racial breakdown of clients experiencing less than one month, more than one month, and less than 12 months and 12 or more months of homelessness at the point of project entry. Experience of homelessness across racial groups was proportionate compared to the general HMIS population. For those clients experiencing between more than one month but less than 12 months of homelessness at program entry, average months of homelessness was similar across racial groups.



Table 4. Number of Months Homeless in Past Three Years by Race, n (%) (N = 12,611 for Race, N = 12,688 for Ethnicity)						
	Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx (of any race)
1 (this is the first month)	2553 (85.8%)	387 (13.0%)	30 (1.0%)	6 (0.2%)	1 (0.03%)	84 (2.8%)
Average if <12 months, Mean	3.58	3.47	3.91	3.43	2.83	2.89
More than 12 months	3513 (85.0%)	548 (13.3%)	52 (1.3%)	14 (0.4%)	3 (0.1%)	82 (2.0%)

How do racial demographics of people experiencing homelessness relate to “prior living situation” at program entry?

We sought to understand the locations of clients prior to program entry and at final program exit (if program exit occurred as of the end of FY 2016). For the purpose of this report, “program entry” is defined as the first program entry in the dataset for each individual. “program exit” is defined by last exit in the dataset for each individual where an exit location was identified. Tables 4-6 show residence prior to program entry by race for the following three client groups: individuals in households; individuals 18-24, and individuals 25 years of age and older.

Table 5 below shows the distribution by race and ethnicity of the prior living situation of individuals in households. The majority came from a homeless situation (52.6%), followed by a transitional setting, doubled-up, and permanent housing with no subsidy. No individuals in this group came from a correctional facility. Generally speaking, prior location categories were proportional with the race and ethnicity breakdown, with the exception of the institutional care category, where Whites were overrepresented.



Table 5.
*Living situation prior to program entry by race for individuals in households (N=4,583)**

		Race/Ethnicity**						
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	Total
Prior living situation	Homeless	93.9%	5.0%	0.9%	0.2%	0.0%	3.2%	52.6%
	Permanent housing, subsidy	90.2%	9.2%	0.6%	0.0%	0.0%	5.1%	3.8%
	Permanent housing, no subsidy	94.0%	4.3%	1.6%	0.2%	0.0%	4.6%	11.2%
	Institutional care	65.9%	34.1%	0.0%	0.0%	0.0%	1.2%	1.8%
	Correctional facility	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Doubled up	95.0%	4.5%	0.3%	0.1%	0.0%	2.9%	14.9%
	Transitional setting	94.2%	5.1%	0.6%	0.0%	0.1%	3.3%	15.7%
	Total	93.5%	5.6%	0.8%	0.1%	0.0%	3.4%	100.0%

*Percent within location.

**Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



Table 6 below shows the distribution by race and ethnicity of the prior living situation of individuals in under 24 years of age. The majority came from a homeless situation (40.5%), followed by doubled-up (22.9%), permanent housing no subsidy (17.4%), and a transitional setting (13.9%). Prior location categories were proportional with the race and ethnicity breakdown, with the exception of the institutional care category, where Whites were overrepresented.

		Race/Ethnicity**						Total
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	
Prior living situation	Homeless	91.2%	7.6%	0.6%	0.5%	0.1%	3.9%	40.5%
	Permanent housing, subsidy	98.7%	1.1%	0.3%	0.0%	0.0%	2.1%	2.4%
	Permanent housing, no subsidy	95.7%	3.7%	0.3%	0.3%	0.0%	3.5%	17.4%
	Institutional care	53.5%	44.7%	1.8%	0.0%	0.0%	2.7%	1.8%
	Correctional facility	74.8%	23.3%	1.2%	0.6%	0.0%	4.2%	1.1%
	Doubled up	93.2%	5.8%	0.4%	0.4%	0.2%	3.4%	22.9%
	Transitional setting	92.3%	7.0%	0.6%	0.0%	0.0%	3.9%	13.9%
Total		91.9%	7.1%	0.5%	0.3%	0.1%	3.6%	100.0%

*Percent within location.

**Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



Table 7 shows the distribution by race and ethnicity of the prior living situation of individuals 25 years of age and older, which represents the vast majority of the sample. The majority (49.0%) came from a homeless situation followed by permanent housing with no subsidy (16.0%), doubled-up (12.1%) and transitional setting (12.0%). Prior location categories were proportional with the race and ethnicity breakdown, with the exception of the institutional care category, where Whites were overrepresented, and permanent housing no subsidy, where Blacks were overrepresented.

		Race/Ethnicity**						Total
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	
Prior living situation	Homeless	84.2%	14.3%	1.0%	0.3%	0.1%	2.6%	49.0%
	Permanent housing, subsidy	90.3%	8.8%	0.6%	0.2%	0.2%	1.4%	3.6%
	Permanent housing, no subsidy	93.3%	6.0%	0.5%	0.1%	0.0%	2.3%	16.0%
	Institutional care	65.3%	32.9%	1.0%	0.3%	0.4%	2.1%	4.80%
	Correctional facility	77.8%	20.7%	1.0%	0.4%	0.1%	3.3%	2.60%
	Doubled up	89.6%	9.3%	0.7%	0.3%	0.1%	2.3%	12.1%
	Transitional setting	83.4%	15.5%	0.8%	0.2%	0.1%	2.2%	12.0%
Total		85.4%	13.4%	0.9%	0.3%	0.1%	2.4%	100.0%

*Percent within location

**Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



How do racial demographics of people experiencing homelessness relate to “destination” at program exit?

Table 8 shows the distribution by race and ethnicity of the exit destination of individuals in households. The majority (55.6%) exited into permanent housing with no subsidy followed by doubled-up (15.9%) and permanent housing with a subsidy (13.6%). Most exit locations were proportional with the race and ethnicity breakdown. For the categories where Whites were significantly overrepresented (institutional care and correctional facility categories), the actual numbers of individuals exiting into these categories were quite small, at 0.3% and 0.2% of the population, respectively, so we are limited in the conclusions we can draw.

		Race/Ethnicity**						Total
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	
Exit destination	Homeless	95.9%	4.1%	0.0%	0.0%	0.0%	4.7%	5.7%
	Permanent housing, subsidy	94.8%	3.9%	1.4%	0.0%	0.0%	2.1%	13.6%
	Permanent housing, no subsidy	94.3%	4.8%	0.7%	0.3%	0.0%	3.1%	55.6%
	Institutional care	40.0%	60.0%	0.0%	0.0%	0.0%	0.0%	0.3%
	Correctional facility	77.8%	22.2%	0.0%	0.0%	0.0%	11.1%	0.2%
	Doubled up	91.8%	7.6%	0.5%	0.0%	0.2%	3.6%	15.9%
	Transitional setting	93.0%	5.2%	1.3%	0.0%	0.4%	7.1%	6.0%
	Other	89.2%	9.8%	0.0%	1.0%	0.0%	5.0%	2.7%
	Total	93.6%	5.4%	0.7%	0.2%	0.1%	3.4%	100.0%

*Percent within location.
**Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



Table 9 shows the distribution by race and ethnicity of the exit destination of individuals under 24 years of age. The majority of individuals in this group exited to permanent housing with no subsidy (39.6%) followed by into a doubled-up situation (27.4%) and back into homelessness (15.0%). In these categories racial and ethnic breakdowns were generally proportional. For the categories where Whites were significantly overrepresented (institutional care and correctional facility categories), the actual numbers of individuals exiting into these categories were quite small, at 0.9% and 0.4% of the population, respectively, so we are limited in the conclusions we can draw.

		Race/Ethnicity*						Total
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	
Exit destination	Homeless	90.1%	8.3%	1.0%	0.4%	0.2%	5.0%	15.0%
	Permanent housing, subsidy	96.7%	2.8%	0.5%	0.0%	0.1%	2.4%	7.7%
	Permanent housing, no subsidy	95.2%	4.3%	0.2%	0.2%	0.0%	3.1%	39.6%
	Institutional care	54.0%	43.5%	2.4%	0.0%	0.0%	3.1%	0.9%
	Correctional facility	82.4%	17.6%	0.0%	0.0%	0.0%	2.0%	0.4%
	Doubled up	88.2%	10.6%	0.6%	0.5%	0.1%	4.0%	27.4%
	Transitional setting	90.8%	7.7%	0.9%	0.6%	0.0%	3.4%	5.6%
	Other	91.3%	5.9%	2.2%	0.2%	0.4%	6.5%	3.5%
Total	91.9%	7.1%	0.6%	0.3%	0.1%	3.7%	100.0%	

*Percent within location.
 **Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



Table 10 shows the distribution by race and ethnicity of the exit destination of individuals 25 and older. Almost a third (29.0%) of individuals in this group exited back into a homeless situation followed by 27% into permanent housing with no subsidy and 19.3% into a doubled-up situation. In these categories, the racial and ethnic distributions were generally proportional. For the categories where Whites were significantly overrepresented (institutional care and correctional facility categories), the actual numbers of individuals exiting into these categories were quite small, at 2.1% and 0.7% of the population, respectively, so we are limited in the conclusions we can draw.

		Race/Ethnicity**						Total
		Black	White	AI/AN	Asian	NHOPI	Hispanic or Latinx	
Exit destination	Homeless	84.7%	13.7%	1.1%	0.3%	0.2%	2.8%	29.0%
	Permanent housing, subsidy	87.7%	11.3%	0.7%	0.2%	0.0%	1.5%	9.1%
	Permanent housing, no subsidy	91.1%	8.2%	0.5%	0.1%	0.1%	2.3%	27.1%
	Institutional care	66.0%	33.0%	0.7%	0.0%	0.2%	2.2%	2.1%
	Correctional facility	74.5%	23.8%	0.3%	1.0%	0.3%	2.4%	0.7%
	Doubled up	83.2%	15.5%	0.9%	0.2%	0.1%	2.5%	19.3%
	Transitional setting	82.4%	15.8%	1.1%	0.4%	0.2%	2.5%	7.2%
	Other	83.3%	15.4%	0.8%	0.4%	0.2%	2.6%	5.4%
	Total	85.7%	13.1%	0.8%	0.3%	0.1%	2.4%	100.0%

*Percent within location.
**Percent totals across race and ethnicity will not equal 100% because ethnicity includes all races.



2.2 Predictors for Exit Destination

Predictors for Exiting into Homelessness

To examine the effect of race, ethnicity, and other factors on exiting into homelessness, multivariate logistic regression was conducted. Results are shown in Table 11. Using White as a reference group, some race categories were found to have a statistically significant association with the outcome of exiting into homelessness. Compared to White individuals, Black individuals were 9.8% less likely to exit into homelessness while American Indian or Alaska Natives were 43.7% more likely. Men and transgender individuals were 98% and 71.5%, respectively, less likely to exit into homelessness than were women. Compared to individuals aged 25 and older, individuals 24 years and younger were 92.7% less likely to exit into homelessness and families were almost five and a half times (OR=.185, $p < .01$) less likely to exit into homelessness.

Table 11. Predictors of Exiting into Homelessness Among Clients in HMIS System				
Variables	β	SE	Wald $\chi^2(1)$	OR (95% CI)
Race				
Black	-.093	.030	9.779*	.911 (.859-.966)
American Indian or Alaskan Native	.362	.105	11.838*	1.437 (1.169-1.76)
Asian	.274	.179	2.342	1.315 (.926-1.869)
NHOPI	.445	.264	2.834	1.561 (.929-2.620)
Ethnicity				
Hispanic/Latinx	.139	.071	3.859	1.150 (1.000-1.321)
Age				
	.010	.001	118.198	1.010 (1.008-1.012)
Gender				
Men	-.687	.021	1050.318	.503 (.483-.524)
			*	
Other	-.539	.162	11.109*	.583 (.425-.801)
Household Status				
Individual under 24 years	-.655	.039	281.553*	.519 (.481-.561)
Individual in a household	-1.689	.084	405.371*	.185 (.157-.218)
Note. OR = Odds Ratio. CI = Confidence Interval. * $p < .01$. ** $p < .05$				



Predictors for Exiting into Permanent Housing/ Renting with Subsidy

Multivariate logistic regression was also run to examine the effect of race, ethnicity, and other factors on exiting into permanent housing *with* a subsidy. Results are shown in Table 12. Black individuals were 44% more likely to exit into permanent housing with a subsidy than were Whites; no other racial group was statistically significant. Men and transgender individuals were both more likely than women to exit into permanent housing with a subsidy with increased odds of 56% and two and a half times (OR=2.55, $p<.01$), respectively. Compared to individuals over the age of 25, young individuals were 64.6% and individuals in households were almost three times (OR=2.712, $p<.01$) more likely to exit with a subsidy.

Table 12. Predictors of Exiting into Permanent Housing <i>With</i> a Subsidy Among Clients in HMIS System				
Variables	β	SE	Wald $\chi^2(1)$	OR (95% CI)
Race				
Black	.367	.050	53.272*	1.443 (1.308-1.592)
American Indian or Alaskan Native	.064	.180	.126	1.066 (.749-1.518)
Asian	-.249	.395	.398	.780 (.360-1.689)
NHOPI	-.217	.601	.131	.805 (.248-2.613)
Ethnicity				
Hispanic/Latinx	-.230	.124	3.463	.794 (.623-1.012)
Age	.001	.001	.576	1.001 (.998- 1.004)
Gender				
Men	.443	.032	194.851*	1.557 (1.463-1.657)
Other	.938	.328	8.157*	2.554 (1.342-4.859)
Household Status				
Individual under 24 years	.499	.057	76.052*	1.646 (1.472-1.842)
Individual in a household	.998	.072	194.411*	2.712 (2.357-3.121)
Note. OR = Odds Ratio. CI = Confidence Interval. * $p<.01$. ** $p<.05$				

Predictors for Exiting into Permanent Housing/ Renting without Subsidy

Multivariate logistic regression was also run to examine the effect of race, ethnicity, and other factors on exiting into permanent housing *without* a subsidy. Results are shown in Table 13. Using White race as a reference group, people who identified as Black were 83% more likely to exit into permanent housing without a subsidy. Age was also statistically significant in that for



every year older there was a 0.3% increase in likelihood to exit into permanent housing with a subsidy. Compared to women, both men and transgender individuals were more likely to exit without a subsidy at increased odds of 82.3% and 59.8%, respectively. Compared to individuals aged 25 and older, younger individuals were 56.2% more likely and individuals in households were almost three times (OR=2.957, $p < .01$) more likely to exit without a subsidy.

Table 13. Predictors of Exiting into Permanent Housing <i>Without</i> a Subsidy Among Clients in HMIS System				
Variables	β	SE	Wald $\chi^2(1)$	OR (95% CI)
Race				
Black	.604	.033	332.992*	1.830 (1.715-1.953)
American Indian or Alaskan Native	-.094	.125	.567	.910 (.711-1.164)
Asian	-.224	.207	1.165	.800 (.533-1.200)
NHOPI	-.741	.407	3.323	.476 (.215-1.057)
Ethnicity				
Hispanic/Latinx	.015	.068	.045	1.015 (.887-1.160)
Age	.003	.001	9.578*	1.003 (1.001-1.004)
Gender				
Men	.600	.019	1004.992*	1.823 (1.756-1.891)
Other	.469	.170	7.629*	1.598 (1.146-2.228)
Household Status				
Individual under 24 years	.446	.034	170.082*	1.562 (1.461-1.671)
Individual in a household	1.084	.047	530.430*	2.957 (2.696-3.243)
Note. OR = Odds Ratio. CI = Confidence Interval. * $p < .01$. ** $p < .05$				



3. Preliminary Findings from Qualitative Data

3.1 Summary

As of April 2018, the SPARC team has launched research in seven communities. Across the country, the team has collected 171 oral histories and conducted 21 focus groups. While qualitative data are still being analyzed, the most prominent preliminary finding thus far is the widespread impoverishment within communities of color. What we have noticed in every city is that people of color collectively have fewer resources in their networks to draw on should something go wrong. We have begun to refer to this phenomenon as **“network impoverishment.”** Qualitative data from Atlanta evidenced this finding in similar ways.

The SPARC team collected 22 oral histories in Atlanta during one week of May 2017. These interviews were held with people of color who were currently experiencing homelessness. During the same week, the SPARC team also facilitated three focus groups: one for people of color experiencing homelessness; one for direct service providers of color; and one for community leaders in the housing and homeless services systems, and adjacent systems.

In reviewing the oral history interview data, our approach was to allow themes and concepts to emerge organically from the transcripts, rather than approach the data with any set hypothesis. This method is referred to as a Grounded Theory approach.⁵ A team of four reviewers went through each oral history transcript and developed thematic codes. The team used the NVIVO software to code the transcripts and run analyses.⁶

This initial report focuses on **pathways into homelessness** and **barriers to exiting homelessness**. We focused on these areas in order to identify potential intervention spaces. Factors that led to homelessness and barriers to exit may be similar depending on the point in time, but we distinguished these factors based on how people answered our questions (e.g., “What led you here?” vs. “What has not been helpful as you try to get housing?”).

⁵ Charmaz, K., & Belgrave, L. (2012). Qualitative interviewing and grounded theory analysis. *The SAGE handbook of interview research: The complexity of the craft*, 2, 347-365.

⁶ QSR International. (2012). NVivo qualitative data analysis software. Retrieved from <http://www.qsrinternational.com/product>



- Pathways into homelessness were often characterized by:
 - *Network impoverishment*: It is not just that respondents were experiencing poverty — everyone they know was experiencing poverty, too.
 - *Threats to safety*: Narratives of violence and compromised safety, specifically within family and home environment, were common in the narratives of people we interviewed — particularly women.
 - *Unmet health needs*: Instability and trauma correlated with mental health and substance use issues, while medical health issues were also common in respondents’ narratives.
- Barriers to exiting homelessness are often systemic and include:
 - *Difficulty navigating the system*: People are frustrated with program requirements and find it hard to get what they need from public assistance.
 - *Employment accessibility and economic mobility*: People find it difficult to secure employment that they can find transportation to and that pays a housing wage.
 - *Ineffective behavioral health services*: Unmet mental health and substance use issues was portrayed a barrier to exiting homelessness.

For the purposes of this report, we draw on the three focus groups to add additional examples to the themes that emerged from the oral histories. The focus groups provided us with a different format to hear from providers, community stakeholders, and people with lived experience of homelessness. The sections below document these findings.

3.2 Pathways into Homelessness

Network Impoverishment

A recurring feature of respondents’ discussions of their pathways into homelessness was that their narratives demonstrated a striking social dimension. In every SPARC community, people of color had few resources in their networks to draw on should something go wrong. We have begun to refer to this phenomenon as “**network impoverishment.**” Qualitative data from Atlanta further evidenced this finding. People did not come to experience homelessness solely through a lack of capital; they also came to experience homelessness through fragile social networks. The fragility of these networks contained two main, interacting, weak points: lack of capital and lack of emotional support. The following quote from a participant in our Provider Focus Group typifies how lack of capital can strain social support:



Respondent: If the family doesn't have the mainstream resources or medical insurance to connect them to services, then it's likely that, like you said, bridges are burned, because the family is already strained financially. Then it starts trickling down to where, "Okay, I can't take care of you anymore. You've got to do something else." Or you keep exhausting resources if you are the supportive type, you exhaust most of your resources when it is working, and they never have enough. They are never able to make it to where they are not living paycheck to paycheck. It's always that one or two that strain because they are trying to branch all their resources to help family, or those that are affected. So, in my mind I see it on a very common basis, unfortunately, where a lot of individuals, their families trying to get them connected to services. They either got discharged from jail, because they are like, "He can't be paroled here, or she, and I am tired. I can't do this anymore. I need to get them connected to services." So that means that's an exhausted family member who may be poverty level or right there above, very close to.

If one member of a family or community is struggling financially, no one else in their social network is financially able to take on the added expenses. This quote from a provider is an important reflection on their work, and we also heard this theme reflected in the individual interviews with people currently using services. People were not unwilling to double up or to take people in—but they do not have the capital to accommodate the additional consumption of resources (e.g., food and household goods), and that in turn strained relationships. One respondent shared that her siblings were also experiencing homelessness:

Interviewer: No homelessness before this generation, huh? That's interesting. So, would you say you were the first? Were there other brothers and sisters? How many brothers and sisters have you got?...Did they [your siblings] ever become homeless?

Respondent: No. No, my sister is homeless now. She's the one that shared my house. She was the one that put me out in the snow. Now, she is homeless. You don't wanna be bad towards people. The older sister is in lock-up.

It was not just that our respondents were experiencing poverty—everyone they knew was experiencing poverty, too. Respondents' articulation of network impoverishment also included systemic and historical hindrance to economic mobility:

Respondent: You can look at the economy at the ghetto areas or poor areas, there is nothing there for us. We don't own anything. We are used and abused. We don't hold



any power in our own communities. So, what could we do for ourselves? I am not trying to make an excuse, but there are some reasons.

The above quote from an interview participant highlights the historical scarcity of socioeconomic resources and opportunity experience by communities of color, which may help explain the pattern of network impoverishment seen in the data.

Threats to Safety

Many respondents described significant or recurring threats to their safety, including sexual and physical assault. In a number of interviews, people cited the need to avoid further escalation of violence as one of the primary reasons for leaving prior housing. It is important to note that strains on social support were often deep and damaging. For example, this interview respondent recalled her initial arrival to a youth shelter:

Respondent: On my 12th birthday, my mom left me at home with my stepfather. My stepfather told me that my mom was going out of town and she really wasn't, she was going to go buy my birthday cake. And my stepfather came in the room and he took advantage. And from that point on, my stepfather kept taking advantage of me until I was 12. I would tell my mom, I would get beaten for it over and over...From that point on, she dropped me off and I'm at the [Redacted Youth Shelter].

Another respondent similarly described feeling a lack of safety and support in the foster homes and group homes she grew up in. In her case, this was in direct relation to her gender identity and the associated mental health conditions she suffered as a result of the lack of acceptance:

Interviewer: How old were you when you first came into the foster care, group home system?

Respondent: I was two years old when I was taken from my mom ... I was living with an aunt until I was like 10, and I at 10 years old I left my aunt's house because I was ad-, um, I was taken to a mental hospital for self-harm and trying to commit suicide. When I got out, I went back with my aunt but then DFS got involved and I went into a foster home without rela-, you know, relatives. Um, and ever since then I haven't been with a relative. Um, I have been in foster care my whole life ... I've been homeless about three or four times, throughout my life and I'm only 19. And it's been situations where I just left foster homes. Because I just didn't want to be there anymore. I remember I left the foster home one time and went to a total different state because I didn't want to be in foster care. I didn't want to be around people that didn't care about me.



This excerpt exemplifies another pattern in the interview data: that people may leave current housing due to a perceived threat of violence. In the above case, this threat was felt in the lack of acceptance and support the respondent received (“people didn’t care about me”). In other narratives, the threat of violence was physical, and was considered to be more dangerous than homelessness. For example, one respondent shared the following:

Respondent: When I was down bad, like homeless, I came here in 2015. I was here for domestic violence. My stepdad, he assaulted me ... I was making \$500 a week down there. I was working for him basically.

Interviewer: For your stepdad?

Respondent: Uh-huh. He owns a store, and people was coming, they had deals. I was catching a lot of deals on hygiene products, so I was buying hygiene products. I had boatloads of hygiene products, you know, kitchen deals. I was like, I’m just going to keep them because I was getting my apartment too down there. I was like, okay I’m just going to keep this stuff so I can be prepared. But not knowing I was keeping that stuff to be prepared to come down here, you know what I’m saying? So I got assaulted, I wasn’t going to step back a foot in his house, so I just got in my car...

This respondent left a steady job with good income because of her assessment of the danger of staying at home with her stepdad. Their story highlights the risks people sometimes take to avoid and escape unsafe situations. Many respondents who described experiences of violence also shared challenges with behavioral health, including mental health conditions and substance use. One participant in the Stakeholder Focus Group shared:

Respondent: I think there is at least a decent size of our male, Black male population that comes in and out of homelessness over their lifetime, sometimes as a result of drug addiction which was more than likely sparked by, you know, a pre-existing mental health issue, even if it was just depression or anxiety, and/or trauma, PTSD, and in some cases, all of those things.

Unfortunately, many respondents who expressed behavioral health needs also detailed an inadequate response by the healthcare system.

Unmet health needs

Unmet mental and physical health care needs were a characteristic of many respondent narratives. In the Provider Focus Group, the conversation reflected this:



Interviewer: Who would you say is at the greatest risk for homelessness?

Respondent 1: Mental health. Individuals with mental health.

Respondent 2: Substance abuse and substance disorders.

Respondent 1: Or combined, co-occurring, generally that's what we see.

Respondent 3: I kind of agree with co-occurring, the mental health and substance abuse.

Respondent 4: I definitely would say behavioral health.

When asked what led to their experiences of homelessness, many interview respondents described substance use and/or mental health conditions as a part of the pathway. For example:

Interviewer: And could you tell me a little bit more about what led to your situation of being, you know, into different shelters and living on the streets?

Respondent 1: Drugs. Using cocaine, heroin, self-pursuit drugs, alcohol ... so you know livin' whatever I could lay my head at the moment. It was a battle, but the drugs led me that way.

Interviewer: Okay so it's the drugs led you to experiencing homelessness, and how long were you, did that each episode last or from-

Respondent 1: I'd say, I'm being honest with you I say, I was only, I was on drugs for a long period of time okay? I'd say maybe, maybe I'd say maybe about 20 years, 18 or maybe 20 years, but I was seeking help by getting rehab and get full or get fat for a while ... but I get back at drugs.

Respondent 2: I went started staying with my sister ... she was in the military and she was trying to get me to come up there and stay but ... I experienced depression a lot ... and then the medicine that I take make me sleep because if I don't go to sleep I'll go to sleep eventually, but I wouldn't have nowhere to lay down, so I would take it anyway because the doctor said take it, and sometime I have to just to go to sleep in the park.

Both of the above respondents connected their behavioral health needs to their pathways into homelessness. They also touched on inadequate responses by the healthcare system. In both instances, respondents sought professional treatment, and the options provided were ultimately ineffective in the long-term or ill-suited to their specific context.

Medical health conditions were also described as a part of pathways into homelessness. For example, one respondent recounted how a series of complex medical conditions were inadequately treated, leaving her unable to work or to pay rent. This ultimately resulted in her experience of homelessness:



Interviewer: Can you tell me how you first came to experience homelessness?

Respondent: I got sick. Um, sinus infection first. This, that and the other. And then I had a mild stroke. When I had that mild stroke, that was it ... They couldn't fix my leg. They couldn't make it stop being heavy as it was. They couldn't make the numbness go away ... At that particular time, I had a hole in my heart. And my breathing situation wasn't good. I could walk – take two steps and I would be exhausted...

Interviewer: So, when you say – I just want to make sure that I understand this. When you say you had a hole in your heart, you mean like a physical hole in your heart?

Respondent: Mhm.

Interviewer: Was that repaired at any point?

Respondent: Oh, no. This, I'm not going to say what doctor, but I was told, "If you have a heart attack, ma'am, we will repair that hole. Until then you are just going to have to deal with it."

Interviewer: So, it sounds like you had some really complex health issues. And then did that impact – how did that – how did those complex health issues impact your housing?

Respondent: Couldn't go to work.

Interviewer: What were you doing for work?

Respondent: I was a Certified Nursing Assistant... Um, I went back to school. Got a second piece of paper. I guess you could say like a third or fourth piece of paper. But anyway, I went back and got my certificate in medical billing and coding while I was sleeping outside. Um, after that I got sick worse. So, now I have chronic hepatitis C...

Interviewer: Do you know how you contracted it?

Respondent: Yeah, working, doing nurse's aid.

Interviewer: So, you contracted it during work. Does that mean that the treatment for it should – there's someone covering the treatment for it?

Respondent: No.

The excerpt above contains a number of interrelated themes: the respondent experienced a number of complex medical health issues, none of which were adequately treated or appropriately covered financially, and which ultimately forged her pathway into homelessness. This narrative is particularly striking because it highlights the direct connection between healthcare failure and experiences of homelessness. The above respondent held a steady job, but untreated health conditions led her into homelessness.

In addition to the healthcare system not meeting the needs of the people we interviewed, some narratives described a ripple-effect in which the healthcare system impacted interactions with adjacent systems of support. For example, a participant in our Client Focus Group shared:



Respondent: I was driving 18-wheelers ... I was out driving one night and a truck came by and ran me off the road. I rolled over into the curb, broke a bone on my neck, broke a bone in the back, went to the – they airlifted me to the hospital. I am lucky to be alive, but throughout all of that I was trying to get social security and they denied me. I was before a white judge and maybe a black judge would give it if I had come and played the race card, but I was denied. They told me, "It's some kind of job you can do." ... He was like, "Well I feel like there is some kind of work you can do if it involves sitting at a desk. Sit in a chair and look at a monitor," and I am like, well, you've got to go to school for that kind of stuff, you know? These days, you have to go to school. You just don't get a good job sitting down and not having the kind of schooling ... And I mean, I could barely walk. I was in pretty bad shape. This is in 2013. I lost everything ... Finally, they gave me regular SSI after six months. I had to come to Atlanta and down here, and they told me, "You need to appeal that. You mean you didn't get your back pay since 2013?" I appeal that now. I am waiting to go to court. It's everything is just a process to keep from giving me some money that they owe me. Now they are telling me, "You've got to wait another 12 or 13 more months," or something, to go to a hearing.

This respondent's injuries were appropriately treated, but he was left with chronic conditions that hindered his employment. While he was unemployed due to his injuries, he was denied social security; the judge insisted that he could find work in other industries. However, the respondent's lack of education prevented him from pursuing employment opportunities which he would have been physically able to perform. The respondent described interactions with systems that are failing to meet his needs and provide him with support to maintain housing and medical care.

3.3 Barriers to Exiting Homelessness

System Navigation

The interviews and focus groups suggest that burdensome program requirements and difficulty navigating systems are significant hurdles for people of color experiencing homelessness in Atlanta. As a participant in our Client Focus Group stated:

Respondent: Why can't I get out of this? I see that every little thing that we do is something getting in the way to block us. If you are making a move to make more money, they want to stop you. "No, you make too much money. So we can't do this for you." It's like they want to keep you in a circle of poverty. They don't want to see you get advanced and get up where you can take care of yourself, go to work and make the money you need to make to pay your bills and take care of yourself. It seems there is a stoppage in there.



Another respondent also experienced this income threshold for service provision, in addition to difficulty navigating systems which are meant to help him:

Respondent: I lost my home back in 2005, 2004, while I was a soldier in Iraq...

Interviewer: You couldn't do the VA loan?

Respondent: I mean at the time, I was 20 years old. I didn't know anything about how to use any of that. I am still having problems using it today ...because I don't know the process and the protocol, and all the paperwork has to be approved and you have to have this lender with this realtor, with this agency.

Interviewer: Okay. I see what you are saying...All right. So, you just got out of the service recently?

Respondent: I've been out like 11 years.

Interviewer: Okay, so it's been 11 years and so you are still homeless ... How come? You couldn't get housing anywhere as a vet?

Respondent: Sometimes you go through the process of doing it and they disqualified me on the amount of income I get ... Some of the offices in the VA that I went to, to try to receive the help to stop being homeless. They didn't really feel like I was qualified for it and they said I made too much money. I make about \$26,000/year ... And then, that was like the main thing that stopped me from getting anywhere. Then I became disabled from a year after combat. I had PTSD and that stifled my money, because now I am on a fixed income. When I was able to make at least ten times what I make on a yearly basis now. Mm-hm.

Interviewer: So, being diagnosed as PTSD meant you lost money as a veteran?

Respondent: Mm-hm.

Interviewer: Wow. So this situation that you've just described has been going on for 11 years, back and forth?

Respondent: Mm-hm. Right.

This respondent's faced challenges navigating program eligibility requirements. This was a prominent theme in other respondents' narratives as well. For example:

Respondent: I'm still a little confused 'cause I really don't know what all this is all about, where I'm going with this, where it's going to take me. I'm getting some things done though that I couldn't get there and that's why I was out in the streets homeless because there were places that I was going, certain things that I was trying to get done, and people was always turning me away or turning me around or they would send me back the next day. I come back the next day, they tell me why I didn't come that morning ... I went with general assistance. I got the application, told me to come back at 8 o'clock the next day. I came back at 8 o'clock, now they tell me, "Come back at 2 o'clock." So I'm like -- you know stuff like that depresses you, 'cause you're trying to do



something. You're trying to take care of your business and then peoples don't necessarily take their professionalism seriously enough to know that you're putting a person in a certain situation that make them fail.

Like the person above, many respondents reported difficulty in either understanding program requirements, meeting them, or both. The following two excerpts offer additional examples:

Interviewer: Just what your current housing situation is.

Respondent1 : Well, I would say that I have two weeks to find stable housing or I go back to the streets.

Interviewer: Why?

Respondent 1: Because I'm trying to work with this other program and they said they were going to help me, but it's kind of difficult for people to understand the program.

Respondent 2: When you go to these programs, yeah I'm doing an assignment, you have to pass a test, you have to be drug free or you have to meet the qualifications. You don't meet the qualifications, you're still on the street ... People be wanting you to pass these essays or these assessments and stuff like that just to get housing. When you don't pass it, it's like, "Deuces, I can't help you, you didn't pass it, you made a low score." And that's really what happened to me. I had to score 12 to get housing and I scored a 5. So, I didn't get it.

The second respondent felt that programs were testing her, and she was continuously failing to "pass." Feeling set up for failure by burdensome or inequitable requirements, complicated and unclear systems, and seemingly arbitrary treatment by service providers were barriers to exiting homelessness that were frequently cited by people of color experiencing homelessness in Atlanta.

Accessible Employment and Economic Mobility

Based on the qualitative data we collected, many available jobs are not located in proximity to available housing and/or services. Moreover, respondents did not have reliable transportation. Therefore, access to jobs was a significant barrier to exiting homelessness. One respondent described a difficult decision she faced in which she had to either prioritize transportation or housing:

Respondent: Because when I was homeless in my car, I ran up a lot of tickets because I couldn't do nothing but drive, and they targeted me because I had an Alabama tag basically. So I ended up in jail with suspended license, and I was in jail for two weeks for the last – the last two weeks, I was just in jail. So my mom came down here. It took all the little savings I had, because I was stable – I'm jumping in and out because these tickets is really – they took \$2,000 from me from Atlanta and I'm just getting back up.



So the last little – actually my rent money, I had to get my car out because I'd rather have my car.

In order to maintain reliable transportation to her job, the respondent above chose to spend the money she had saved for rent on releasing her car from impound and paying off all of her traffic tickets. She highlighted the priority of keeping her job over finding housing, because, as she sees it, having stable employment means she will eventually find housing. She continues:

Respondent: So right now, I'm really living at work, but I'm not living at work, you know what I'm saying, because I work at night...So I'm really getting by. It's really the universe really playing in my part right now. But I still have room to, you know, to save money to get my own place. I know it's coming because I work hard.

This narrative highlights the difficulty many of our respondents reported in finding employment that was accessible. The above respondent prioritized keeping her car, and as such was able to secure employment, but not housing. Other respondents who did not have access to vehicles described transportation as a significant barrier to finding work.

Another barrier raised by respondents was the location of supportive services and/or housing placements in relation to where employment opportunities were. Often the options provided did not line up with employment opportunities. One participant in our Client Focus Group went into detail about her own experience:

Respondent: But I think also my husband is saying that we are a black couple. We've seen white couples come in here and move faster than we have. They will send my husband and I to ... like the slum areas, but the white couple can go to [Redacted Neighborhoods]. They never even announce those places to us and we tell them that's where we are from. They will not tell us to go to [Redacted Neighborhoods], or the nice places that we are from. They will only send us to [Redacted Neighborhoods] and we've absolutely told them that's not where we want to live. ... So, why would you send me and my husband, because we are black, to just a predominantly black, poor neighborhood when you have a white family that's the same husband and white team to [Redacted Neighborhoods], and those areas where you know the jobs are better, you know the pay rate is better? If you go to [Redacted Neighborhood], the only place you are going to work is at Burger King or a fast food joint.

This narrative highlights the intersection between racial discrimination and a geographic mismatching of housing and employment. The respondent states that White families are housed in more economically developed areas with higher paying jobs, while Black families are



housed in “slum areas,” where the only jobs available do not pay housing wages or allow for much economic mobility.

Ineffective Behavioral Health Services

Respondents described unmet behavioral health needs as a significant barrier to exiting homelessness. For some, lack of access to effective care exacerbated their symptoms or put them at risk for unhealthy coping mechanisms. Participants in the Providers Focus Group discussed self-medicating after mental health system involvement did not effectively help people cope with symptoms:

Respondent 1: Not accurately dealing with, or treating, their mental health, and because of emotional and other issues going on around them, their coping mechanism unfortunately is to use [substances] and just disconnect from mainstream services.

Respondent 2: To add to that, side effects from medications. A lot of the people that take medications, they don't like the side effects ... Then a lot of times too, they don't have anybody advocating for them. Sometimes, the medication might be too strong and there is no one listening here to modify or whatever, and so they just stop taking it altogether, and they just don't want to deal with the system, and they go unnoticed.

Respondent 3: I agree. I think that's a huge piece, not having the advocacy. "You know, I don't know how to say that I don't like the way this makes me feel, so I just stop. You know, or, no one listens to me when I say I don't like the way this makes me feel. So, I just stop."

How can systems prevent people from “going unnoticed?” A participant in our Stakeholder Focus Group also touched on this theme, suggesting that the lack of effective support services may not only exacerbate or ineffectively treat current mental health conditions, but actually trigger new experiences for folks that had not previously had issues with their mental health. They elaborate:

Respondent: I have seen that where substance and mental health may not have been the initial cause of the homelessness, but when you're dealing with your homelessness ... and then because of lack of affordable housing and the fact that there are not job opportunities. You know, they are not somebody that had a substance abuse issue in the beginning. They are not somebody that identified with mental health, but then going into a completely different world and not having the resources have led them to substance abuse or to, you know, to have a break in where all of a sudden, you know you are dealing with mental health issues.



The above respondent describes his experience of homelessness as being surrounded by other Black people who are suffering from untreated mental health conditions, and that this experience was detrimental to his own mental health. Further, he elaborates that the supports and services that are offered are not only ineffective, they are actually adversely affecting his wellbeing. Our findings suggest the need to create culturally responsive, anti-racist behavioral health systems that take into account people's experiences of systematic and everyday racism. Several respondents articulated the links between racism and mental health and the lack of mental health services that work for Black individuals, in particular Black men.

Respondent 1: That's the African-American neighborhood, period. I mean, when you talk about mental health, I mean, the stresses that we've experienced in life, you know, creates a lot of behavior. Then you have the African-American man, the male, who we were speaking about, and how come he is so dysfunctional? He and everybody in the world is calling him n****r...

Respondent 2: In our culture, it is historic, what goes on in this house stays in this house...

Interviewer: When you are talking about the culture of what happens in this house stays in this house, you are talking specifically about black folks and our interactions, lack thereof, right? Mental health systems and having long histories of secrecy, yeah?

Respondent 2: And even when that comes out, now the shame and the guilt piece kicks in. Now, I can't deal with it, because I am ashamed to tell somebody that this is what happened to me ... I've talked to so many men that they can't – they don't know how. They've never had an opportunity or there has never been a platform for them to address these issues in an appropriate way.

Another interview respondent highlighted the inadequate services currently offered to people of color experiencing homelessness. When asked what changes she recommended to make the system more helpful for people of color experiencing homelessness, she said:

Respondent: Until you're in the predicament of homelessness, you wouldn't know how to treat the next one. So I feel like you should be patient, number one, with somebody who is homeless, because a lot of their anger, a lot of their repetitiveness, a lot of their laziness or whatever, it comes from something. It's not just, "Oh, I'm being lazy because I'm homeless and I know y'all are going to help me." No, it could be a state of depression, because this could be a person's first time witnessing homelessness, or it could be a state of devastation or hopelessness. So I just feel like a lot of these organizations are impatient with some of these people and I just feel like they should be because at the end of the day, nobody with common sense wants to be homeless.



Across our SPARC research sites, the need for improved behavioral health services for people of color experiencing homelessness was a prominent theme. Our data in Atlanta further support this finding.

As Atlanta's homelessness response system reflects on new strategies to end homelessness, the themes that emerged in the qualitative findings from this study can help guide objectives and implementation. In the next section, we discuss implications of the findings and important new directions for research and policy. In the final section, we provide a list of concrete recommendations.



4. Discussion: Promising Directions

The sections above report SPARC's initial quantitative and qualitative findings on the experiences of people of color experiencing homelessness in Atlanta. The qualitative themes emerged from the data organically and were not influenced by the Structural Change Objectives selected by Atlanta's SPARC Working Group. This group selected the following areas for structural change:

1. **Improving access to public transportation** in the Greater Atlanta area, by improving current infrastructure, expanding public transportation routes, and including greater community involvement in planning.
2. **Affirmatively furthering fair housing**, with a focus on redesigning the evictions process, including fair representation and adequate support services, and supporting efforts to expand inclusionary zoning.

The research summarized in this report helps guide this work and suggest additional areas for short and long-term action. The narratives we heard repeatedly demonstrated that the network impoverishment of communities of color make homelessness seem inevitable. In this context, how can communities strengthen and stabilize these networks? What are the investments necessary to build socio-economic assets and resiliency to stress in communities of color? How does Atlanta return economic mobility to some of its most disenfranchised citizens? How should that work flow through an anti-racist lens to ensure that it is strengths-focused and empowerment-based rather than paternalistic? How do systems interact to effectively serve people with medical and mental illness?

As we continue to explore the data from this initiative, we are aware that a number of research questions deserve additional attention. In the next section, we discuss the implications of our findings and highlight potential areas of future research on race and homelessness. In the final section, we identify a concrete list of recommendations for the Greater Atlanta community.



4.1 Economic Mobility for Communities of Color

Economic mobility is clearly a pillar of ending homelessness but remains elusive in many communities. As was detailed in the qualitative section of this report, respondents often had a rich job history, but had a great deal of difficulty securing employment that would pay a living or housing wage. Barring a significant shift in federal or state policies regarding minimum wage, it is unlikely that our current workforce development approach will be sufficient to end homelessness. Simply put, if someone comes to experience homelessness while working for minimum wage, transitioning to a different minimum wage job will not make a substantial difference in their life.

The SPARC team has begun to examine in greater detail what respondents had to say about their employment history and employment search. One area requiring more analysis is employment discrimination. Unsurprisingly, respondents have repeatedly reported experiencing interpersonal racism over the course of their job searches. They have also discussed the role of systemic racism in preventing them from attaining career-track jobs, reporting, for example, inequitable access to education or skill development (including vocational training).

As we continue to investigate concrete and immediate steps that we could take in order to drive change in our communities, the SPARC team has begun to look more closely at the way communities spend workforce development dollars. A potential direction to take workforce development would be to reduce the size of cohorts moving through programs and intensify the skills being acquired. For example, rather than moving 150 people through a soft skills development program it might be more beneficial to move 20 people through a UX (user experience) design code academy that is connected to a job placement possibility at several design or technology firms.

Additionally, as mentioned above, it will be important to think about what economic stabilization looks like. Our findings point to upstream intervention sites that are community-based and focused on stabilizing fragile networks through necessary infusions of capital—either through targeted subsidies, flexible emergency funding, or policies that better facilitate pooling income.

Finally, we should consider how soft skill development programs are frequently constructed around behavioral norms for professional conduct that have been established and advanced by White people. What does it mean to engage a 17-year-old Black person in a program that essentially tells them that their way of interacting the world is the wrong way? These kinds of



questions are important to consider in the construction of workforce development programs, but also with regard to the ways in which we consider advancing staff of color on our teams. As we examine why certain staff members do or do not advance, an important consideration must be whether or not they are being passed over because they are not cultural matches with senior leadership.

As we continue to break down the ways in which interpersonal and structural racism exacerbate each other, it could be helpful for programs to engage in honest dialogue about how personal bias might be enabled by structural factors. In the case of supporting people of color in their job search, it might be understanding a person's context and giving second chances, rather than saying, "They've had three weeks to get an interview and they still haven't." With regard to staff of color, it might mean re-working job descriptions rather than saying, "I'm not promoting them because they don't have a B.A.—not because they're Black."

4.2 Upstream and Downstream Stabilization

Our qualitative data suggest that destabilizing factors often occur well before people come to experience homelessness. Upstream stabilization may be best achieved through the development of short-term flexible subsidies. People do not always need large amounts of money, or even money that is dedicated specifically towards housing or utilities. Many respondents expressed having initial difficulty with a non-rent related financial burden. Common examples have been car repairs or food. However, without the money to pay for these non-housing areas, a crisis can rapidly develop. Respondents who cannot pay for their car repairs may be unable to get to work and subsequently lose their jobs, or those who cannot afford food for the whole household may kick adolescents or emerging adults out of the house in order to free up resources for the very young or very old.

Stabilizing these households who are on the precipice requires immediate infusions of capital. However, these subsidies have to be uniquely flexible to cover a wide range of one-time needs. This would represent a new way of thinking about subsidy spending—discretionary spending pots that could live at agencies and be accessed as needed by community members in crisis. While such thinking may be new for homelessness response programs, spending models of this kind have existed for many years in the faith community. It is not uncommon for churches to step into exactly the void that is being described. Unfortunately, network impoverishment affects faith communities as well. As resources become scarce in the broader community, there is less ability to 'take up the collection plate' in order to meet the needs of an individual or family in crisis. In order to address the hemorrhaging of people of color into



homelessness, it will be necessary to replenish (or establish) these kinds of community level safety-nets.

As our qualitative data highlight, inadequate systems responses to experiences of violence, and medical, behavioral, and mental health conditions, has emerged as a significant pathway into experiences of homelessness for people of color. Downstream stabilization thus focuses on recalibrating the boundaries of the homeless response system to incorporate intervention and response services that are specifically dedicated to these issues. As our respondents described, health crises were often the catalysts for experiences of homelessness; but equally, they served as significant barriers to exiting homelessness. We need to begin to ask ourselves how wrap-around homeless services can include public health values and best practices, to ensure that the health of individuals experiencing homelessness does not impact their housing outcomes. Similarly, as many respondents were driven into experiences of homelessness as a result of fleeing violent home-settings, program qualifications and requirements need to be reflective of this pattern.

When looking at affirmatively furthering fair housing, and specifically at the evictions process, downstream stabilization efforts should focus on evaluating the following:

1. Does the eviction process allow for individual assessment and situational analysis of the context of the eviction?
2. What supports, including financial and legal assistance, would be necessary to ensure survivors of domestic violence and/or interpersonal violence are not barred from future housing due to prior survival-driven evictions?
3. Do current requirements for housing subsidies and other housing services take into account the decision folks make to leave prior housing for survival?

With regards to the evictions process, we need to ask ourselves whether all evictions should be handled the same and carry the same repercussions for future housing and program eligibility. Enhancing the capacity of legal representation and support services for people of color responding to evictions histories is critical; but this process must also include a trauma-informed approach which recognizes the necessity of leaving prior housing, which may result in eviction, as a means of survival. Frequently, respondents framed their experience of homelessness as stemming from an assessment of the danger of staying in their prior housing situation, which resulted in a decision to leave that accommodation, even if there was no alternative option for remaining housed. The decision taken to leave previous housing due to violence can often cause, or exacerbate, behavioral health conditions which further aggravate



experiences of homelessness. When approaching strategies for affirmatively furthering fair housing, these common situations must be taken into consideration.

In addition to support services to people of color experiencing homelessness and dealing with prior evictions in the legal system, downstream stabilization strategies should also analyze current policy surrounding housing program requirements specifically in relation to histories of eviction and violence. The frequency of responses in our data surrounding individuals' inability to access services due to eviction history or trauma-related behavioral responses is alarming and requires a significant redesign of current policy.

Finally, many respondents cited difficulty navigating programs and/or inequitable program qualification as the primary barriers they faced in exiting homelessness. Frequently these experiences manifested as feelings of confusion surrounding how programs work, of being "tested" by requirements, and frustration with barriers to program eligibility based on employment or income. These stories highlight a significant problem in the ways programs serve people of color experiencing homelessness, and they require a deeper questioning of the ways these services are designed.

4.3 Hispanic/Latinx Homelessness

Existing literature frequently refers to the "Latino paradox" with regard to the idea that the Hispanic/Latinx population in the U.S. shares risk factors for homelessness with the Black population, but they are underrepresented, not overrepresented, among people experiencing homelessness. Despite this discussion in the literature, we have increasing reason to suspect that these theories are based on inaccurate reporting and weak methodology for counting people experiencing homelessness. Emerging from our research is the finding that in communities that have more intentional outreach to Hispanic/Latinx communities, numbers tend to trend upwards towards overrepresentation.

Our preliminary research suggests the need to focus our attention in meaningful and immediate ways on reaching out to Latinx communities. This will require deliberate cultivation of Spanish-speaking outreach teams made up of members of the communities that they hope to engage. Ideally, these teams would have preexisting relationships that they can leverage to build trust. Additionally, programs might begin to take steps to segregate documentation and immigration status from other components of a client's file and hold it on a "need-to-know" basis, similarly to how HIV/AIDS information is managed under HIPPA. While this policy change would not have a legally enforceable edge, it would be a step towards building trust with



clients regarding whether or not their immigration status will be shared with other staff—and to what extent the circulation of that information puts them at potential risk. Moreover, we might begin to more carefully identify what services we actually require immigration or citizenship information in order to activate. A number of services that may currently request this information may in fact not actually require that it to report to funders or screen individuals in or out of services.

By limiting requests for information regarding documentation status to only those services that absolutely require it and putting strict firewalls around that information, we may begin to have better engagement with Hispanic/Latinx communities experiencing homelessness. With better engagement will come a more accurate understanding of rates of homelessness, characteristics, and needs.

4.4 Trans* People of Color

Our current understanding of the needs of trans* (used here to refer to all trans, gender-expansive, gender-fluid, or non-binary individuals) people experiencing homelessness is similarly limited. While the SPARC team has been lucky enough to engage a number of trans* youth and some trans* adults in our research, we are very far from being able to characterize patterns in trans* experiences of homelessness. While we expect that social rejection and stigma play a role in pathways into homelessness, we do not yet have enough information to suggest appropriate structural interventions.

One obstacle in the way of researching trans* experiences of homelessness is inconsistent administrative data. While there's a great deal of anecdotal evidence around trans* people experiencing homelessness at greater rates, there is still a dearth of data on trans* individuals in service systems. Because of this, we are left with an inaccurate understanding of how many trans* individuals are in need of service, and we are not able to estimate rates of disproportionality across race and gender identity. We advise programs to work diligently to capture sexual orientation and gender identity/expression (SOGIE) data so that policy decisions can be more informed.

Finally, it is important to track requests that trans* clients are making of systems. While the SPARC team will continue to analyze the available data, we believe that the best resource available to programs and systems leaders are the voices of people who are currently utilizing services. By creating a way to track (and document responses to) requests or complaints that come from trans* clients, systems can use the knowledge that is already there while waiting for better research to emerge.



5. Recommendations

There are numerous actions Atlanta can take now and plan to take in the future. SPARC's recommendations include:

1. **Design an equitable Coordinated Entry system.** Coordinated Entry organizes the Homelessness Response System with a common assessment and a prioritization method. This directs clients to the appropriate resources and allows for data-driven decision making and performance-based accountability. Continual review of data from this process for racial disparities can assess whether housing interventions are sufficiently provided to people of color who come into contact with the system. Examination of the data can also help pinpoint additional intervention need. Coordinated Entry is at the root of Atlanta's response to homelessness, and racial equity should be integrated into Coordinated Entry.
2. **Incorporate racial equity into funding and contracting for homelessness and housing programs.** Funders should consider how to infuse a race explicit lens into its contracting, requiring that programs report how their work will address issues of racial equity. Specifically, it is useful to develop criteria in which racial equity is part of the evaluative process for scoring funding proposals. Funders can also play a role by evaluating the racial diversity of agency leadership. Finally, they should encourage agencies to periodically conduct internal program and policy reviews that examine disparities in outcomes based on race.
3. **Include racial equity data analysis and benchmarks in strategic planning to end homelessness.** As Atlanta sets goals around program development, expanding housing capacity, and creating more housing placements, the system should be measuring impact by race and ethnicity. It will be vital to look at how race and ethnicity relate to returns to homelessness. Additionally, it may be helpful to use a formal racial equity tool in organizational decision making. All major organizational decisions, whether explicitly about race or not, should be analyzed through an internal racial equity tool that will highlight potential negative consequences to communities of color.
4. **Support organizational development to ensure racial equity at the organizational level.** Many agencies that provide human services are at a critical point of self-examination. As we continue to unpack the impact of systemic inequity on the populations we serve, the time has also come to investigate the organizational practices, structures, and cultures of serve settings that unconsciously perpetuate



inequity for those same communities. Despite agencies' best intentions to promote equity and justice, many have a long way to go before their internal practices, staff and leadership teams, resource allocation, facilities, and strategic planning reflect and advance these goals. However, promising practices exist and can be leveraged and tailored to organizations that are ready to do the work. Atlanta can support agencies by providing resources to do this work and by disseminating tools and strategies.

5. **Encourage anti-racist program delivery.** SPARC's findings suggest that programs that are strengths-focused, empowerment-based, and trauma-informed, rather than paternalistic, will best serve people of color experiencing homelessness. Programs will need to look internally to answer questions about whether or not they are inadvertently replicating systems of disenfranchisement. Performing internal systems audits and looking at program output data by race and ethnicity for disproportionality can help target the work. These philosophies might also play a key role in inter- and intra-agency equity plans.
6. **Promote ongoing anti-racism training for homeless service providers.** Government and nonprofit staff will benefit from continuous training on the intersection of race and homelessness, on bias, and on strategies to confront racism within their work. Building off of Recommendation 2 (Support Organizational Development), the Continuum of Care (CoC) and other key stakeholders can partner to host inter-agency trainings and support trainings for individual agencies. While organizational development focuses on structural change to organizations, training can focus on interpersonal skills—both for working with clients and for working with our colleagues.
7. **Collaborate to increase affordable housing availability for all people experiencing homelessness.** People in Atlanta described frustration not only in the wait to receive a voucher, but also in the difficult process of trying to find a landlord or apartment complex that would accept it. As the community begins to discuss how best to address homelessness through a racial equity lens, it will be necessary to discuss how people experiencing homelessness could be moved into desirable units and neighborhoods by working with landlords and developers to address issues with accepting housing vouchers.
8. **Utilize innovative upstream interventions to prevent homelessness for people of color.** Homelessness is not inevitable. The data in this report suggest that it may be possible to stabilize people well before they become homeless by identifying pathways and providing support early. Preventing homelessness is a key component of achieving the county's goals, and the community is making efforts to improve its upstream services and homelessness prevention efforts. The CoC should continue focusing on areas where it can have the biggest impact, including targeted eviction prevention for



people at risk of homelessness. Prevention also means working with the criminal justice, child welfare, and public health systems to reduce the number of people exiting into homelessness from programs and institutions within those systems.

9. **Investigate flexible subsidies to mitigate the effects of network impoverishment.** Many financial crises start as non-rent related. For many of our research participants, initial needs were for food, car repair, or bills. This suggests that for some people, flexible subsidies could be used to avert crises that spiral into homelessness. Short-term interventions of this kind can prevent or end homelessness quickly and connect people to other systems and resources, such as employment, health care, child care, and a range of services to support greater stability. It may offer a range of one-time assistance, including eviction prevention, legal services, relocation programs, family reunification, mediation, move-in assistance, and flexible grants to address issues related to housing and employment.
10. **Support innovative health care strategies to meet the needs of communities of color.** Low-income individuals may have more difficulty accessing and paying for health care in states like Georgia where lawmakers have thus far declined to expand Medicaid eligibility to all families and individuals with incomes up to 138 percent of the federal poverty level. Medical and mental health needs emerged as an important feature of people's pathways into homelessness, experience of the system, and barriers to exit. The homelessness response system should collaborate with health providers to increase people's ability to access care with or without insurance.



6. Conclusion

We recognize that equity-based work should not be confined to specific initiatives, but rather should be the lens through which all of the work flows. As communities develop equity approaches, they do not happen in isolation, limited to one program or one response. Instead, racial equity models need to be widely spread across systems and sectors.

We look forward to working with community leaders across the cities engaged in SPARC to continue to develop and hone the skills of equity implementation. Our hope continues to be that we will someday be a nation that does not strive towards equity but has realized the vision of having these values sit at the core of what we do.



7. Appendix

7.1 Entry and Exit Location Groupings

We grouped HMIS data fields for situations at entry into the following categories for our analyses:

- 1. Homeless (Shelter + Street)**
 - a. Place not meant for human habitation
 - b. Emergency Shelter (including motel/hotel with voucher)
- 2. Permanent Housing/Renting w/ subsidy**
 - a. Rental by client with VASH subsidy
 - b. Rental by client with other ongoing subsidy
 - c. Permanent housing for formerly homeless persons
 - d. Owned by client with ongoing subsidy
- 3. Permanent Housing/Renting w/o subsidy**
 - a. Rental by client with no ongoing housing subsidy
 - b. Residential project/halfway house with no homeless criteria
 - c. Owned by client with no ongoing subsidy
- 4. Institutionalized Care**
 - a. Long-term care facility or nursing home
 - b. Substance abuse treatment facility or detox center
 - c. Foster care home or foster care group home
 - d. Hospital or other residential non-psychiatric medical facility
 - e. Psychiatric hospital or other psychiatric facility
 - f. Mental health/psychiatric, physical health, substance use treatment, foster care
- 5. Jail, Prison or Juvenile Detention Facility**
- 6. Doubled Up**
 - a. Staying or living with friends
 - b. Staying or living with family
- 7. Transitional Setting**
 - a. Transitional Housing for homeless persons (including youth)
 - b. Safe Haven
 - c. Hotel/Motel (no voucher)
- 8. Missing Data** (not included in analysis)
 - a. Client does not know
 - b. Client refused



We grouped HMIS data fields for destination at project exit into the following categories for our analyses:

- 1. Homeless (Shelter + Street)**
 - a. Place not meant for human habitation
 - b. Emergency Shelter (including motel/ hotel with voucher)
- 2. Permanent Housing/Renting w/ subsidy**
 - a. Rental by client with VASH subsidy
 - b. Rental by client with other ongoing subsidy
 - c. Permanent housing for formerly homeless persons
 - d. Owned by client with ongoing subsidy
- 3. Permanent Housing/Renting w/o subsidy**
 - a. Rental by client with no ongoing housing subsidy
 - b. Residential project/halfway house with no homeless criteria
 - c. Owned by client with no ongoing subsidy
- 4. Institutionalized Care**
 - a. Long-term care facility or nursing home
 - b. Substance abuse treatment facility or detox center
 - c. Foster care home or foster care group home
 - d. Hospital or other residential non-psychiatric medical facility
 - e. Psychiatric hospital or other psychiatric facility
 - f. Mental health/psychiatric, physical health, substance use treatment, foster care
- 5. Jail, Prison or Juvenile Detention Facility**
- 6. Doubled Up**
 - a. Staying or living with friends (permanent)
 - b. Staying or living with family (permanent)
 - c. Staying or living with friends (temporary) (option at exit only)
 - d. Staying or living with family (temporary) (option at exit only)
- 7. Transitional Setting**
 - a. Transitional Housing for homeless persons (including youth)
 - b. Safe Haven
 - c. Hotel/Motel (no voucher)
- 8. Other**
 - a. Other (True Other; i.e., response option was labeled "Other")
 - b. Deceased
- 9. Missing Data (not included in analysis)**
 - a. Client refused
 - b. Data not collected
 - c. No exit interview completed

