Understanding Homelessness –General Assembly Presentation
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Numbers of the homeless throughout the year do not follow the trends of the Point in Time (PIT) count. To get a truer picture of total homeless throughout the year, we must utilize the aggregate reporting of the HMIS system. In 2021, 2423 individuals were homeless in Asheville/Buncombe County, with the understanding that not all homeless providers input all the homeless that they serve into the database. What are the trends?

ABCCM has learned to identify three levels of homeless.

1. **Local** homeless who are victims of poverty with its extremes of lost jobs or intermittent income leading to eviction and homelessness. It includes domestic violence, persistent addiction, severe mental illness, and economic homelessness.
2. **Regional** homeless who have come to the Asheville area because it is the hub for clinical substance use treatment and mental health treatment. This area also has the two largest hospitals, Mission and Charles George VA; four prisons, four clinical treatment centers; and
3. **Transients** are drawn here because of jobs and low unemployment; also because Asheville is touted around the country as one of the greatest places to live, to retire, and to be part of beer city. This attracts homeless who are **Travelers** and **Nomads**. It also attracts homeless **Activists** who see the area as fertile ground to fight their advocate battles over property rights and the right to camp, free drug use, legalizing sex workers, demanding co-shelter with pets, demanding inclusion of transgender persons, acceptance and housing for registered sex offenders, and the list goes on.

Each community is left with determining their shared community values, their community capacity for each level of homelessness, and their community response to determine what their Homeless Service Network will look like. Our community's traditional approach to homelessness was to offer people a place that was safe, that was sober, that led to jobs and permanent housing. In other words, we offered hospitality to the homeless with an invitation to join our community and be part of our community.

The new rules by the CDC during the pandemic were to shelter in place. That was interpreted to cities and communities to let the homeless shelter outside, in camps and not enforce any laws or ordinances that would have them move and infect others or themselves. This had huge unintended consequences. Encampments sprung up everywhere. Drug use in these camps was unbridled. Drug pushers could test out new opioids on the homeless leading to the highest number of overdose deaths in history.

The criminals moved in with free range drug trafficking and then sex trafficking. Violent crime escalated. Panhandling escalated.

Why did panhandling escalate? The criminal mind set is simple. If someone is making hundreds of dollars a day on a street corner, then they need protection. We understand this exploitation of the homeless standing on those exit ramps. Most of you have seen that these persons are dropped off in shifts, and you may notice that someone at an east exit in the morning is at a south exit ramp in the afternoon. Some see them get picked up and dropped off in coordinated fashion. Yes, it is a criminal racket. Yes, panhandlers have to "pay" or turn in their money and only keep a portion. Yes, most panhandlers are not really homeless, but the few that are generally are victims in another criminal exploitation. NO, we do not believe that you should give money to panhandlers. Panhandlers are a new gateway to telling newcomers where the drugs can be had, where sex workers and trafficking is occurring, where the camps are, etc.

The transient population tends to expand from April to October (7 months) each year, while from November to March (5 months) each year the numbers decrease. We know from the 5 winter months that in January, we consistently see the lowest numbers which have fluctuated over the past 5 years between 500-560 homeless persons. In the 7 warm months, we consistently see the highest numbers which have fluctuated over the past 5 years between 2000-2500 in round numbers.

While our regular emergency shelter beds decrease in the warm months with the loss of code purple beds, there has been a fixed number of emergency beds always available by each agency, around 210 beds (prior to the pandemic) and 325 transitional beds bringing the total beds available to 535. This is adequate for our winter season of need. In the winter months, we generally only have about 85-100 who need code purple beds to expand and meet whatever left over transient or chronic population is still choosing to stay and be unsheltered.

From April to about October, our homeless numbers swell, but not because these persons are seeking to be part of our community and looking for hand up. Most are a new breed of tourists known as Travelers, those on the trail, nomads, and new hippies. These new segments of the emerging unsheltered are those choosing to "camp" or "tent" and form homogenous groups. The early groups to arise were those who were committed to an opioid or addictions lifestyle. A growing number of ex-offenders, not welcome back to family or home, choose camping. Persistent and serious mental illness is also on the rise, leading to those with severe depression or schizophrenia or even functional Asperger individuals (plus their new emotional support animals) to form groups and congregate. There had been a smaller number of those traveling with pets,

but now, another group in encampments began pet adoptions and now a large number of pets are self-appointed "service" animals. There were also alternative life-style groups such as those who were self-proclaimed activists using their "camp" and unsheltered status to demonstrate or proclaim legalization of drugs, the elimination of property rights, proclamation of various housing rights, and alternative medicines. Those in the LGBT community generally found acceptance into emergency shelters in life-threatening weather, but the transgender or gender neutral individuals were screened out or not allowed in shelters. Another group emerged which was a result of increased domestic violence and homelessness with women, moms/dads with children, and intact families or couples. This produced more homeless "advocates" calling on traditional shelters to serve a wider variety of special population needs. Requests for additional funding were not available. Traditional shelters are all built on the congregate model, but many of these special needs groups were requesting and needing single room occupancy or permanent supportive housing (PSH) accommodations. This has led to calls both for more PSH apartment units, and for a new "low-barrier" shelter with more flexibility to serve the emerging variety of unsheltered needs.

Another unexpected demand for emergency shelter came from those institutions that had to discharge people with no home/house to go to. Mission Hospital needed emergency respite beds, estimated at 60-70 per month just in Buncombe County. Detention Centers (jails) and prisons needed emergency shelter beds or had to discharge people to the street. Front line Emergency Medical Services (EMS) or police (law enforcement) would be called for someone having a melt-down due to drugs or brief mental breakdown who needed emergency shelter rather than jail or leave them unsheltered.

Each community is left with determining their shared community values, their community capacity for each level of homelessness, and their community response to build collaboration around their Homeless Service Network.