



# University of Central Florida

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Living Rough:  
A Qualitative Study of Homeless People in Outdoor Camps in  
East Orange County, Florida

Final Report

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## Executive Summary

Focus groups with 39 unsheltered homeless people living in the woods in East Orange County, Florida, showed that:

- The unsheltered homeless are mostly white males, with a sprinkling of women (28% ) and non-whites (20%). Most are long term Florida residents (average tenure of 16.5 yrs) and have been living in the woods for more than 5 years. Average age is 46. About a third are veterans of the US armed forces.
- Family ties are weak to non-existent. Most describe their fellow campers as “my family.”
- About three quarters admitted to alcoholism, drug addiction, mental illness, or physical disability. Focus group observations suggest that the true rate of disability approaches 100%. There is a great deal of untreated mental illness in this population, particularly untreated bipolar disorder, PTSD, and schizophrenia. Most of these physical, mental, and behavioral disabilities are sufficiently severe to effectively rule out conventional labor force participation.
- Most of the encampments we studied are small (fewer than five in the group) and temporary, but each has a definite social structure, with rules, informal social sanctions, leadership, a division of labor, and means of communication.
- Daily life in the camps is consumed by the quest for income and food. The main source of food is “dumpster diving,” followed by food made available through area churches. The main sources of income, in approximate descending order of importance, are “scrapping” (scavenging recyclable metal), day labor and panhandling.
- The downtown facilities for the homeless are generally avoided by this population first because downtown is perceived as a dangerous and unfriendly place with a high crime and murder rate, many temptations from drug dealers, etc.; and secondly because of real or perceived “issues” with the downtown homeless facilities (high cost, physically dangerous, crime-riddled, dirty, drug-infested, etc.)
- Interestingly, the most frequently mentioned concern about physical safety living in the woods is not exposure to the elements or victimization by criminals and drug dealers, but rather being hit by cars on Highway 50.
- Our participants report frequent and usually unpleasant encounters with law enforcement and believe that these encounters are at least partly responsible for keeping them homeless.

- Much of the evident alcoholism present in this population is self-medication of psychiatric symptoms by the chronically mentally ill, a pattern of co-morbidity that is frequently observed in homeless populations.
- The level and severity of physical disabilities observed in this population is little short of astonishing and include traumatic amputations (three), other major traumatic injuries often secondary to being hit by cars, advanced emphysema, chronic asthma, uncontrolled and untreated diabetes, bone cancer, brain tumors, heart disease, liver disease, impaired vision, and advanced hearing loss. Nearly without exception, the only health care our respondents received was that made available through the Hope Team and the Health Care Center for the Homeless.

Our team's **short term recommendations** are as follows:

- Help in acquiring identification to meet requirements for employment, housing, and social service assistance should be an outreach priority. We were struck by how many of these participants became homeless in the first place because they had lost all means to identify themselves.
- There is a definite need for free, accessible bathing, showering and laundry facilities somewhere in East Orange County.
- Many of these people need assistance applying for social security disability benefits, assistance in appealing the routine denials, and trustworthy third-party payee assistance to manage.
- Code and law enforcement should be reasonable and balanced. To the extent possible, law enforcement should be oriented towards diversion programs that would put these people in touch with social service providers.
- There is a need for an accessible, co-ed, pet-friendly facility where people can shower regularly, do laundry, get a nutritious meal, and seek refuge during extreme weather conditions, whether it is in the overnight shelter business or not.

We also advance the following **medium to long term recommendations**:

- The main connection between this population and social and health services is the Hope Team, which is two people and a van that do outreach in an area of about 3,000 square miles. The three counties need to find the means to expand the Hope Team's excellent outreach efforts.

- Orlando's homeless services and facilities are concentrated downtown, but the regional homeless population is not. There is a clear need for some system of decentralized day shelters or drop-in centers that provide meals, showers, laundry facilities, referrals, and, critically, access to a case manager or a social worker for homeless people who are ready to accept services.
- Perhaps the most pressing long-term need is for expanded treatment programs for the dually diagnosed, those disabled both by addiction and by poor mental health, which would describe at least half and possibly more than half of our participants.

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## Introduction

According to the Health Care Center for the Homeless (HCCH) HOPE Outreach Team, there are some fifty to sixty homeless “camps” in East Orange County, i.e., identifiable outdoor locations where groups of homeless people ranging from two or three to more than twenty live and sleep. Altogether, this population of homeless people numbers some several hundred. Most or all of these camps are along US Highway 50 (Colonial Avenue), with the encampments often located near restaurants, gas stations, and other commercial outlets.

With funding from Orange County, Florida, we undertook a series of focus groups (five in all) with a total of 39 homeless people who live in the East Orange homeless camps. All focus group participants were recruited for us by the HOPE Outreach Team and transported by them to and from the focus group site (the Union Park Neighborhood Center for Families, whose assistance we gladly acknowledge). Focus groups began on February 15 and concluded on February 26. In addition to homeless participants, each group included a discussion moderator, at least two note-takers, representatives from the Hope Outreach Team, and other observers. Careful notes were kept in lieu of audio-taping the sessions in order to preserve the confidentiality of participants.

Each session lasted about two hours. Each session opened with an explanation of the consent procedure and a request for participants to sign a Consent Form. All did. The focus groups themselves dealt with issues covered in the Guiding Questions, a copy of which is attached below as Appendix One. Each session ended with participants filling out a brief questionnaire, this to assure that we had basic demographic information on all participants. Marginal results for all questions contained in this brief survey appear below as Appendix Two. Please note: The questionnaire was a front-and-back form and several participants failed to complete the back side, which accounts for the high rate of missing data on some of the later survey items.

Contrary to the impressions of many, getting our participants to open up was simple. As a group, they were exceedingly easy to engage. They seemed flattered that people from the University had taken an interest in them and clearly enjoyed talking about themselves and their situations. Within the limitations imposed by their addictions and mental illnesses (see below, *A Closing Note on Mental Illness*), they seemed almost without exception to give open, honest answers to everything we asked them.

### Results: The Survey

Participants in the focus groups were comprised of 11 women (28%) and 28 men (72%). Most were white; 18% were Hispanic; only one was African-American. Average age was 46 years. According to the Hope Team, these

results are probably characteristic of the demographic composition of the unsheltered homeless in East Orange County.

On average, our participants had been living in the woods for ~5.2 years. The most common prior living arrangement was to have been living in their own rented room or apartment (47%) followed by living in a house they owned (16%). About one in ten had been living with a family member, 8% were in jail or prison, and another 8% were sleeping in various outdoor locations before they began living in the East Orange woods. No other response was mentioned by more than one person each.

Although most of these homeless people came to Orlando from somewhere else (about one in five was born in Florida), they are relatively long-term residents, having lived in Orlando an average of 16.5 years.

One of the ten women (who answered a question on veteran's status) was a veteran of the US armed forces; among men (who answered the question), the figure was 30% (7 of 23). These figures are comparable to the figures reported by HUD for the general US homeless population<sup>1</sup> and definitely higher than the rate for adult US men in general, of whom only 13% are veterans.<sup>2</sup> We note later the experiences of these veterans with Veterans' Administration services.

About four in five of our participants lived in the woods alone, with the other fifth paired up with another adult (usually but not invariably a legal spouse). None of our participants reported having minor children living in the woods with them, although one had an adult son who also lives in the woods.

We asked participants if they had ever been told by a doctor, social worker, case manager or other professional person that they had a mental health problem, an alcohol problem, a drug problem, or a physical disability. Just under half (45%) reported a previous mental health diagnosis; 56% said they had a drinking problem; 37% told us about a previous drug problem; and 42% reported being physically disabled. Based on our observations in the focus groups, all of these, particularly the first three, are underestimates. All together, over 70% admitted to one or more of these diagnoses.

Finally, the survey asked, "what is the number one reason why you are homeless right now?" Issues of jobs and money were most frequently mentioned, cited by 41%, followed by medical and disability issues, noted by 18%. No other response was chosen by more than 2 or 3 people. So despite rather widespread mental illness, alcohol abuse and drug addiction in

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<sup>1</sup> US Department of Housing and Urban Development, *The Annual Homeless Assessment Report to Congress* (February, 2007).

<sup>2</sup> US Census, *Census 2000 Briefs: Veterans 2000*. US Bureau of the Census, May 2003.

this population, very few see these disorders as a primary reason for their homelessness.

### **Focus Group Observations**

What follows are the common themes that emerged in the focus groups, as recorded by moderators, note-takers, and observers.

*Demographics:* Educational attainments were predictably modest, with most not having progressed beyond high school and with a sizable minority lacking even a high school diploma or GED certificate. Virtually all have had some labor force experience ranging from professionals to unskilled laborers and including at least one of each of the following: land surveying engineer, real estate business owner, cook, mason, furniture mover, newspaper deliverer, furniture mover, restoration worker, construction worker, waitress, certified nursing assistant (C.N.A), and general laborer. Likewise, virtually all are now disabled, either mentally, physically, or because of addictions, to the point where regular, sustained labor force involvement (i.e., a “real job”) is not a realistic alternative.

Most were loosely attached, at best, to their primary and extended families—with the exception of a few married couples who participated and a few other paired-up couples who comprised unmarried homeless family units. In fact, the overwhelmingly most common response to our guiding question about having “family or friends you can count on if you really needed to” was, “These people are my family,” indicating relatively close bonds among homeless people living in the woods. Still, most did indicate that they had family living somewhere in the area or state, although contact was minimal at best.

Participants offered various reasons for their loose or non-existent family ties. The most common reason was their perception of having been rejected by their families. Typical comments in this connection included, “they’re snobs,” “I can’t put up with them,” or “I don’t get along well with my dad [kids, brother, etc.]” Other reasons given for strained family relationships included keeping away from loved ones so they “won’t worry about me,” death of the family patriarch or matriarch, or illness of a key family member (who, more often than not, was also the primary source of financial support or the housing provider for the participant); and divorce or separation. Interestingly, none mentioned distance as an impediment to sustaining close family ties although, as indicated earlier, most of our participants originated in other states.

Relatively few participants (perhaps a third) had children of their own; among those with children, contact with them was infrequent. As noted, one participant reported an adult son who also lives in a local homeless camp and with whom he had recently reconciled; another, that his only son was killed in the Iraq war two years ago. But most of the children of our participants

reside in other states or with former spouses. With only very rare exceptions, these children do not represent a resource on which our participants might draw.

As indicated previously, the majority had been homeless for quite some time and many had experienced numerous bouts of homelessness throughout their lives. However, one young couple had been homeless for only a few months (living for most of the time in their car) and had been living in the camps for only a few weeks.

*The Camps:* The focus groups averaged about eight participants each and on average, those eight people came to us from either two or three distinct camp sites. Boundaries between camps are not necessarily well-defined but most of our participants had a definite sense of who they lived with and who lived in other camps. Information is shared across camps mainly at the day labor outlet and at other common meeting spaces.

The largest camp size represented among our participants was five or six members. Most camps were small, averaging two to three members each. Camp members usually first met at the labor pool; one camp member would meet a new person at the labor pool and ask if the new person wanted to join their camp. The smaller camps were usually married or paired-up couples.

Most participants lived in tents or lean-to shacks built from scavenged scrap materials. A few couples lived in their cars, while still others lived in abandoned RVs or vacant buildings. One couple had built a whole house out of scrap. One woman in one of the larger camps (she was clearly the leader of this particular group) took evident pride in running a drug-free camp (even though one of the members of this camp admitted to a previous drug problem). Several participants kept dogs for security, companionship, and, on the chillier nights, warmth. Indeed, as we discuss later, these dogs are definite barriers to utilization of existing resources and services for homeless people.

It became obvious that the various homeless camps and people in East Orange County are connected by a "grapevine" through which pertinent information travels quickly – information about food availability, what's happening at the day labor outlet, law and code enforcement activities, and the presence of new people in the woods. (To be sure, the quality of the information degrades the further down the grapevine it travels.) Another interesting finding was the degree of informal social control that exists within the camps. As with all other human groupings, social structure quickly emerges in these camps, with someone in charge, a division of labor (daily "chores"), group rules (e.g., about drugs, camp security, newcomers, and the like), and informal social sanctions for rule violations. Many camps have specific "no drugs allowed" policies; many others exist precisely for the purpose of acquiring and using drugs. All have rules against theft from one

another and insist on mutual respect for one another's security and things. Drifters, rule-breakers, and other troublemakers are known throughout the population and are often "blacklisted" specifically to encourage them to move on from Orlando.

*Residential backgrounds:* As reported, most participants, although born elsewhere, are long-term residents of the state, having lived in Florida for an average of more than sixteen years. A few, of course, are recent arrivals, some having come to Florida in the previous few months. Reasons for moving to Florida were diverse: some came to reconnect with a long-lost family member; some came with pre-determined plans to stay with a relative; many came to seek employment or get "a fresh start;" quite a number of the veterans came to Florida once they had mustered out of the service; and some were drifters who just "seemed to end up here" after a period of wandering, more or less aimlessly, from place to place.

*How People Became Homeless.* As in virtually all other homeless populations ever studied, by far the most common theme that emerged as the catalyst for homelessness among people living in the woods was **unexpected adverse life events** from which they were never able to recover. For those whose homelessness resulted from a traumatic life event, the onset of homelessness was literally within a few months.

Commonly reported adverse life events that led to homelessness included: moving to Florida, often with no safety net or even a definite plan in place, hoping to find employment that never materialized; loss of personal identification, often through theft, which in turn made it impossible for them to secure a job, housing, or access to social services; sudden death of, or severe financial reversal suffered by, a loved one on whom they were dependent for housing or financial support; loss of a job; arrest or other law enforcement action, such as a drivers license suspension; and disabling injuries. We were struck in particular by how often the loss of the ability to prove who one was surfaced as a precipitating event that led to someone becoming homeless.

For many others, of course, the downward drift into homelessness was the result of alcohol or drug addiction, or the effects of being impaired by major mental illnesses—primarily bipolar disorders, as we discuss more fully below.

*Daily Routines.* The daily lives of these people are consumed in the struggle to find food, income, and a measure of physical security. In Maslow's hierarchy of needs, they occupy levels one and two: tending to physiological needs such as food, water, sleep, and excretion; and worrying about physical security and safety. Few have the time, energy, or inclination to pursue esteem and self-actualization goals although most express a degree of pride in their cleverness and survival skills and most seem very sociable, even jovial, in their interactions with others.

Not every participant was associated with a camp or a specific group; some chose to live alone. Without exception, however, they enjoyed close and regular interaction with each other, either as individuals or as members of a specific camp group. One gentleman who lives by himself nevertheless told us, "food is less important to me than interaction with fellow campers."

Although a few just "hang around" their camps for the day (often to secure the camp from intruders), the daily routines for most are dominated by efforts to secure food and income by various means, both legal and illegal.

(a) Securing Money. All, men and women alike, have engaged in one or more the following types of economic activity, to varying degrees:

- "Scrapping," which involves selling scavenged scrap metal and other "junk" to scrap yards, recycling centers, or junk buyers. From all accounts, this activity is potentially the most lucrative "job" available, with several participants reporting earnings of up to \$100 a day or more. We are not accustomed to thinking of homeless people in the woods as being in the recycling business, but they perform an important public service in helping to keep the roadsides clean.

One woman we interviewed "scraps" every day. She has a device that she calls her "scrapper" that has been manufactured from an old shopping cart. She has rigged the scrapper so it can be towed behind her bicycle. And that is how she transports her scrap to a scrap yard in Casselberry, an hour and a half bike ride *in each direction*. (The only other option locally is a scrap yard in Bithlo.)

- Day labor, principally out of the day labor pool at the corner of Colonial and Forsythe. This is the least popular source of income because of the long hours and comparably low hourly wages. Problems in the day labor industry are well-described elsewhere.<sup>3</sup> Several of our participants were banned from the day labor pool because of lack of identification. Other commonly mentioned problems: (1) You need to get to the day labor outlet by 5:00 AM to have a chance at the best assignments, a routine difficulty for people without alarm clocks. (2) Costs of transportation to and from the work site, and often lunch, are deducted from the daily pay, further reducing effective wages. (3) Payment is by check. Our participants do not have bank accounts and must therefore cash these checks at various check-cashing services in the area, usually for a fee of 10%, again reducing the effective wage rate. (4) Dispatchers at the day labor outlet are described as frequently indifferent at best and abusive at worst. Between the low wages, various deductions, and the check

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<sup>3</sup>Abel Valenzuela et al., *On the Corner: Day Labor in the United States*, Los Angeles: UCLA Center for the Study of Urban Poverty, January, 2006, pp. 39.

cashing fee, 8 or 10 hours of day labor might net a person \$35 or \$40 in income, barely enough for much other than beer and cigarettes.

Notwithstanding these issues, it is apparent that (a) work in the day labor outlet is as close as our participants usually get to a "normal" job situation; (b) day labor is a principal source of income to the group; and (c) the day labor outlet is a key node in the informal socio-matrix that ties the East Orange homeless into a loosely-knit "clan" who share information and resources.

- Panhandling. Most of the people we interviewed – not all! – panhandle at least occasionally and a sizably large fraction do so regularly (i.e., daily). Panhandling takes two forms: normal panhandling, where people are approached as they enter or exit various business establishments or in other public places and asked for spare change or a few dollars; and "flying a sign," where people stand or sit by the sides of the roads or in the medians displaying signs ("Will work for food," "Homeless veteran," "Please help") in the hopes that passersby will toss them some cash.

It is hard to say just how lucrative the panhandling business can be. There were at least two participants who claimed with great braggadocio to be "the best panhandler in Orange County" and who claimed daily profits in excess of a hundred dollars. We found it impossible to take these claims seriously. The woman with the scrapper fashioned from a shopping cart was rather more believable. She said she panhandled only rarely, only when she was "really desperate," because she always made better money scavenging trash metal. Several who panhandled more frequently than this woman seemed to indicate that thirty or forty bucks would be a pretty good day, which is, ironically, about what these same people would earn in day labor.

The downsides of panhandling are obvious and quickly expressed by many participants: People treat you with scorn and sometimes worse (a few participants recounted tales of physical assault because of their beggary), and there is always the possibility of being arrested for "soliciting without a permit," "obstructing traffic on a public right of way," etc. As we discuss later, these arrests are often very costly.

It was also clear that the participants most heavily involved in panhandling were also much more alcohol and drug abusive than others.

- Odd jobs. Construction contractors and others with needs for temporary workers sometimes cruise up and down the areas of Colonial frequented by our participants offering odd jobs for the day or week. One of them even called the principal investigator for the

study (Wright) to comment favorably on the quality of their work “when you can get them to work.” Many, he noted, have experience in the construction trades and reasonably well-developed skills but lack discipline and “work ethic.” His chief complaint was their tendency to resist authority and to dislike being told what to do. Several people that we interviewed also supplemented their income by selling blood products at every opportunity.

With the exception of day labor, which requires working a full 8-hour shift or longer, the length of time spent in each of the above revenue-generating activities would typically range from 1 to 4 hours per day. Most seemed to set daily income goals and would end their “workday” when those goals were achieved; a few sought to maximize income by “working” each day as long as they could.

It needs also to be mentioned that at least one of our respondents had a conventional job working for a nearby motel as a maid and that a very small number survived on Social Security Disability Income.

(b) Securing Food. Rather to our surprise, food was not difficult to come by for most of our participants, although most reported only eating one or at most two meals a day and a few recounted instances where they had gone two or three days with no food at all.

By a wide margin, the primary means of acquiring food was “dumpster diving,” a term our participants use to describe the practice of scavenging edibles from dumpsters used by restaurants and supermarkets to discard their leftover or date-expired food items. Typically, those who share a camp space also share the responsibility for acquiring food for those in their group—a responsibility that requires the responsible party to arrive at the local restaurant and supermarket dumpsters by 5:00 or 5:30 in the morning, before the night’s discards have begun to rot. Everything edible is removed from the dumpsters and stored in what amounts to a communal pantry to be shared by everyone in the group.

As we listened to the tales of the dumpster divers, it became entirely obvious that the “best pickings” were those provided by certain workers at the fast food restaurants and convenience stores who would carefully wrap food about to be discarded in clean paper and place it off to the side in the cleaner parts of the dumpster, knowing full well that homeless people would be coming through later for their daily “harvest.” It was also obvious that each diver had his or her favorites: discarded fried chicken, for example, or “expired” subway sandwiches. None of the people we interviewed seemed the least bit squeamish about any of this, although they freely admitted that in the hot, humid months, the entire food-scavenging process could be a little dicey.

Next to the dumpsters, various local churches were the most common source of food. Several area churches dispense canned goods to needy people and some offer hot breakfasts or lunches at occasional times during the month. A few churches even deliver food to nearby camp areas. In addition to food, the churches also provide blankets, bedding, camp supplies, clothes, and personal items such as soap, shampoo or laundry detergent. Among our participants, expressions of gratitude for the assistance provided by area churches were common and, so far as we could tell, entirely sincere. "They're good people." "I don't know what we'd do without them." And so on.

Only two of the people we interviewed reported receiving Food Stamps, although nearly all would seemingly qualify. One couple responded to the question by asking, "What are food stamps?" and when told what they were followed up with the question, "How do we get them?" (They were comparatively new to the woods and to homelessness.) Ironically, the focus group site is one of the community resource centers where needy people could apply for this benefit, which they did once the session ended.

*Gender.* One might guess that living in the woods would pose special dangers or challenges for the women, but this did not seem to be the case. In fact, the women seemed to feel very safe either because of the protection offered by their group or from the fact that most were coupled up in committed relationships that apparently mitigate their personal safety concerns.

Females also seemed more inclined to resist the negative stereotypes associated with being homeless. The males often seemed to accept themselves as 'losers' who were homeless "by choice" or personal failings (but see below, *A Closing Note on Mental Illness*). The women, in contrast, tended to see their homelessness as resulting from circumstances over which they had no control – an accident that left them unable to work, a foreclosure, and like situations.

*Utilization of Downtown Services for the Homeless.* While many of our participants reported having been downtown once or twice either to eat at Daily Bread or the Coalition or to seek shelter at one of the downtown facilities, all of them, without exception, described their experiences with downtown and downtown services in negative terms and would not venture back downtown for any conceivable reason, no matter how many services might be available to them there.

First, our participants perceived downtown Orlando as a dangerous and unfriendly place. Many mentioned the crime rate, the recent upturn in murders, and the thugs and "druggies" as their principal reasons for avoiding downtown. As mostly white people, "we stick out like a sore thumb" in the neighborhoods where most services are located. As one young guy put it, "there ain't no woods downtown – I'd have no place to hide." Virtually all of

our respondents told us they felt much safer in the East Orlando woods than they would ever feel downtown.

Adding to the hesitance, most of our participants would be accurately described as “country people,” people who grew up mostly in small towns and rural areas and who feel uncomfortable, even intimidated, in urban settings. When a member of the Hope Team was asked if, in his opinion, racism had anything important to do with their avoidance of downtown, he said, “They don’t hate blacks, they hate cities.” (At the same time, the near-total absence of African Americans from these focus groups and the heavy preponderance of African Americans in the downtown shelters make it hard to deny some degree of racial self-segregation as an explanatory factor for the pattern.)

Other reasons cited for avoiding downtown were: difficulties getting downtown on public transportation; fear of being harassed by law enforcement in the downtown neighborhoods; prior experiences of being victimized by theft or assault when downtown; desire to avoid the temptations of drugs and alcohol that are ubiquitous in many downtown neighborhoods; and fear of violence.

Many participants also recounted previous negative experiences at the Coalition for the Homeless, the Union Rescue Mission, and the Salvation Army as additional reasons to avoid downtown. Here the complaints focused on (1) the costs incurred in staying at these facilities, particularly the Rescue Mission and the Salvation Army; (2) the rules and regulations enforced in these facilities; (3) the widespread perception, correct or not, that these facilities are dangerous and drug-infested hellholes; (4) filth in the bathrooms; (5) the general “chaos;” and (6) being robbed or victimized while staying in these facilities. Others avoided the downtown agencies simply because living in the woods was (to their minds) more quiet, peaceful, or comfortable. Nearly all of the couples we interviewed said they would not use the downtown facilities because they would be separated into different sleeping and living quarters. Finally, many of our participants would not go downtown because doing so would force them to abandon their pets.

**Comment by Wright:** *Many of the male participants in the focus groups recounted a story about staying at the Coalition that I have heard told literally dozens of times, nearly always in exactly the same terms, and that is the story about having one’s pocket slit open with a knife and the contents removed while sleeping. “I woke up and all my money was gone.” Hearing this precise same story told to me for the umpteenth time by several of our East Orange “campers,” I made a point during my next visit to the Coalition of speaking with Jesse Dixon, Manager of the Coalition’s Men’s Pavilion, where these artful thefts allegedly occur. In the two years that Mr. Dixon has been in charge of the Pavilion, **not one** such theft has ever been reported to him, this in a population that is prone to complain about nearly everything. Getting your pocket slit open while sleeping in the Men’s Pavilion*

*and having the cash removed is almost certainly an urban legend rife among homeless people in this region.*

*Transportation Issues.* As intimated earlier, distance is one barrier to using downtown services and this point illustrates that transportation issues play a large role in the mobility patterns of our participants. For the most part, they get around on foot or ride bikes, taking the bus only when necessary (i.e., to get to a downtown appointment). A few of our participants had working automobiles and gave rides to others who needed them; another few had friends or family members who could help in this respect. A surprisingly large number use bicycles as their customary form of transportation (the theft of which is also commonly reported).

*Personal Safety.* Physical safety was a constant concern to many of our participants, both safety from predators and, somewhat more commonly expressed, safety from the threat of being hit or run over by cars. Many take measures to reduce their risks of predation: they keep dogs or weapons (clubs, machetes, but only rarely firearms) in their camps; take turns keeping watch; stay alert to intruders and strangers. But many feel completely vulnerable to the reckless, often aggressive, red-light-running motorists who have made Colonial Drive the most dangerous stretch of roadway in Florida:

*"I been hit twice."* Both times this respondent was hit while riding her bike near Colonial Drive, once during the early morning hours (around 10:30 – 11:00 AM) and the other around 3:00 in the afternoon. On the first occasion the driver stopped and accepted responsibility for her medical care. The second time was a hit-and-run that did permanent damage to our participant's back and has left her in more or less constant pain.

And in the same vein:

*"I know eight people who got hit on Hwy 50 (Colonial Drive)"*

*"My friend got hit by a lady who just drove away"*

*"So many people have died from being hit on 50 (Colonial Drive)"*

*"I got hit on 436, but I just threw my bike away and walked away"*

*"My friend [name of friend] got killed"*

*"People keep dying from being hit on 50 because drivers run red lights but people don't care [about them because they are homeless people]."*

It is an interesting and somewhat disturbing finding that errant drivers seem to pose a greater risk to life and limb of these homeless people than the thugs, druggies, and thieves, but such, apparently, is life in our sprawling

metropolitan area. (It is also possible that many of these “accidents” are in fact suicides or suicide attempts; see below, *A Concluding Note on Mental Illness*.)

Exposure to the elements is another personal safety issue confronted by our participants. Extreme hot or cold weather did not seem to pose an undue hardship. When asked, “What do you do when the weather turns cold?” they replied with some humor, “Build a bigger fire!” Other cold weather strategies included dressing in layers, “snuggling up,” or sleeping with their dogs. One couple said they enjoyed the colder weather because they could build a fire and roast hot dogs and marshmallows, “just like Girl Scout camping!” Some sought abandoned vehicles or buildings for cold-weather shelter.

As indicated earlier, most of our participants slept in tents or in crude structures that kept them dry in rainy weather. Several also reported with evident pride that they had simply “rode out” the hurricanes that swept through the region in 2004, although one stated adamantly that he “would not stay in the camps” during a hurricane threat; a few reported going to a shelter or hotel to wait out a passing hurricane; and a few others reported being taken in by friends. One man spent Hurricane Charlie in what he thought was the comparative safety of a motel, but when he went outside to check on his truck, he was blown through a plate glass window and had his right arm severed at the elbow. (He is now more than two years into his wait for a disability declaration and showed up at the focus group in a tee-shirt that read, “Do I look like a fucking people person?” And yet, he proved a surprisingly articulate and jovial informant.)

*Law Enforcement.* While one focus group was fairly positive about their interactions with law enforcement, the other groups voiced strongly negative reactions to these interactions. One officer in particular was mentioned repeatedly as “hating homeless people” and taking every opportunity to harass and intimidate them. Most complained of arrests on what they felt were comparatively trivial grounds: “molesting a dumpster,” “impeding the flow of foot traffic on a public sidewalk,” or “solicitation of funds without a permit.” Some described city police as “vicious” in comparison to county law enforcement and cited this as a reason they avoided going downtown if at all possible. Virtually all our participants reported numerous arrests, averaging as many as one arrest a month in many cases.

While not everyone objected to the occasional night in jail (jail is comparatively safe and has hot showers and decent food), most looked on their arrests and re-arrests as one of the causes of their continuing homelessness. Said one, “We wouldn’t be on the streets if the police stopped putting [us] in jail.” First, these arrests generate police records that surface in police background checks; this then becomes a barrier to both employment and housing. Felony arrests linger in the record even longer than misdemeanors and a federal felony (a federal “number”) stays on the record forever. Several men believed ardently that their federal “number”

would keep them homeless and unemployed for the rest of their lives and many others looked on their criminal records as significant barriers to successful reintegration.

Much more significantly, these arrests typically net one a night or two in jail and assessed court costs of ~\$250. If the fine is not paid within a certain number of days, a bench warrant is issued, the offender is re-arrested, and another fine is assessed. In this manner, many of our respondents run up debts to the county amounting to hundreds or even thousands of dollars, debts that they can only repay by more panhandling, which is often what gets them arrested in the first place. More than a few expressed evident despair at ever getting themselves out of this cycle.

*Housing Needs.* Although many respondents adamantly expressed their preference for continuing to live in the camps because of their sense of camaraderie and their satisfaction in living with, supporting, and depending on one another for survival, there was also an undertone of ambivalence about their perceived shelter needs. When we asked what they saw as the alternative to their current life circumstances, most seemed taken aback by the question. It was not, we felt, a question that they had given any thought to, for the simple reason that many literally could not conceive of living in any other way – perhaps the deepest in a wide range of tragedies that mark these broken lives.

Virtually everyone we spoke with considered themselves to be “survivalists,” fiercely self-sufficient and independent, but most nevertheless expressed some desire to get off the streets if the conditions were right. Said one, “Yeah, it’s OK, but I know I can’t keep this up forever. I’m tired.” Many were quick to add that life in the woods was “hard,” much harder than a conventional existence. “It’s a real job just trying to survive.” Throughout these discussions, there was an undertone of fatalism that is characteristic of people with untreated mental illness.

When we asked what would be necessary to get them out of the woods and into some sort of sheltered existence, the common themes were these:

- Within convenient range of the geographic areas they currently occupy
- Must be safe
- If not emergency shelter but “real housing,” then it has to be very affordable, without a 1<sup>st</sup> month’s rent and security requirement
- There must be accommodations for married or co-habiting couples and dogs or other pets
- Most importantly, there should be no limits placed on their freedom to come and go as they please

- On the whole, less interest was expressed in emergency overnight shelter than in a drop-in center with facilities for showering and laundering and hot meal service.

*Alcohol, Drug, and Mental Health Needs and Issues.* Drug and particularly alcohol dependency is an ongoing struggle for the large majority of our respondents. Most bore the visible *externalia* of a lifetime of heavy drinking and, indeed, freely admitted their alcoholism to us. Among the drinkers, beer is the drink of choice and, with food itself readily available in the dumpsters, one principal reason why they need cash (cigarettes being the other). In addition to alcohol, whose daily use is nearly universal in this population, most also said they smoked marijuana occasionally, when it was available. A few admitted to current hard drug use (cocaine, heroin) and several more to having had drug issues in the past. One focus group consisted of four men from the same camp, three of whom were active heroin abusers – the only concentrated hard drug abuse we found in any of the groups. (Interestingly, this group of heroin users was primarily Latino and reported less police harassment, more reliance on the labor pool for income, and less panhandling than any other group.) Overall, the consequences of their addictions have been severe; some have had their drivers licenses suspended, others have lost close friends to drug-induced deaths, and still others attribute their homelessness to their alcohol or drug dependency.

Yet in spite of it all, there was very little interest in alcohol or drug treatment programs. For most, alcohol was the *solution*, not the problem. A few stated that they had recently completed some sort of treatment program, had been clean for a year or more, and only needed to avoid downtown and its many temptations to remain “successful.” Others said candidly that treatment would be useless to them because they had no desire to stop their addictive behavior. A few said they had been in treatment before and it never really “took.” “Drug and alcohol treatment programs don’t do you any good if you don’t want to stop.” Added another, “I enjoy it. I don’t want to stop.” We could not escape the overwhelming sense that most of the enjoyment these people got from their lives was found at the bottom of a bottle. It was also obvious that many drank to self-medicate the symptoms of their untreated psychiatric illnesses. See below, *A Closing Note on Mental Illness*.

Like the addictions, which were freely admitted, mental health difficulties were also widespread and readily discussed. About half were able to report to us a specific mental health diagnosis, the most common of which were bipolar disorder, schizophrenia, depression, and post-traumatic stress disorder (PTSD). In every group, there were also some participants whose demeanor and behavior were strongly suggestive of undiagnosed or undisclosed mental illnesses.

The ease and terminology with which these participants discussed their mental health diagnoses is evidence that most had been under the observation or care of a mental health worker at some time in the past, but were no longer. Many flatly stated that their drinking and drug use was self-medication of their psychiatric illnesses. Many had been prescribed psychotropic or neuroleptic medications but could not afford to fill their prescriptions. One man stated flatly that if he took all the medication that had been prescribed for him, it would cost him \$1200 a month. "Beer don't cost me nearly that much..."

*Physical Disabilities:* In addition to widespread addictions and mental health disorders, we were struck by the general ill health of this population. This is perhaps to be expected in a population that drinks and smokes heavily and eats leftovers scavenged from garbage cans. Still, two of our participants were amputees, several were suffering from major traumatic injuries, several more were suffering from advanced emphysema or chronic asthma, and still others reported being disabled by diabetes, bone cancer, brain tumors, heart disease, liver disease, impaired vision, advanced hearing loss, etc. Virtually without exception, the only health care any of our respondents received was what was made available to them through the Hope Team and the Health Care Center for the Homeless. In the survey, as reported earlier, 42% of the participants reported having been told by a medical professional that they were physically disabled and that number is entirely consistent with what we were able to observe.

*A note on veterans.* Nearly a third of the men were veterans of the US armed services and those that were expressed unanimous and at times bitter frustration over their dealings with the Veterans Administration, who, they said, would routinely deny them health care, pension or domiciliary benefits and who treated them with indifference bordering on contempt. As best as we could tell, only one of the veterans had a dishonorable discharge, although this was not a question that we specifically asked. Some saw their past military service as a direct cause of their current situation. One vet stated that after living in the jungles of Vietnam, surviving on bugs and roots, he could no longer function in "normal" society.

*Unmet but Addressable Short-Term Needs.* Our participants are in obvious need of housing, jobs assistance, more and better health care, alcohol and drug treatment, and, above all, mental health assistance, just like every other population of homeless people. Setting these ambitious aims aside for the moment, our participants also need:

- Help in acquiring identification they need to meet requirements for employment, housing, and social service assistance. Lacking an address, a telephone, and an adequate supply of lucid, sober moments, their chances of acquiring identification without assistance are virtually nil. And yet all of them are clearly humans who were

born somewhere to someone. Help in obtaining identification should be an outreach priority.

- Free, accessible bathing, showering and laundry facilities. One couple who owns a working car goes to a regular campsite (like a KOA or Good Sam's) to shower. Another remarked, "How can I go on a job interview? I smell nasty!"
- Assistance applying for social security disability benefits and appealing the routine denials, along with trustworthy third-party payee assistance to manage funds on behalf of those who require such assistance. A couple of our mentally disabled participants had gotten a favorable SSDI ruling, had a payee assigned because they were personally unable to manage the money, only to have the money stolen from them by the payee.
- Social control efforts by code and law enforcement should be reasonable and balanced. To the extent possible, practical, and lawful, law enforcement might focus less on making arrests for what are, after all, survival strategies used to acquire the necessities of daily living and focus instead on diversion programs that would put these people in touch with social service providers. Rousting homeless people from one camp site only to have them settle into another accomplishes very little. Law enforcement should also be as vigilant about the crimes committed against these residents as they are about the crimes they commit.
- There is also a clear need for an accessible, co-ed, pet-friendly facility where people can shower regularly, do laundry, get a nutritious meal, and seek refuge during extreme weather conditions, whether it is in the overnight shelter business or not.

### *Medium-to-Long Term Needs and Recommendations*

(1) Practically the only connection between the East Orange homeless and any sort of social service or system of care is that provided by the Hope Team, which is two people and a van to cover the needs of the unsheltered homeless in three counties sprawling over an area of just under 3000 square miles. The three counties (Orange, Seminole and Osceola), all of which harbor a population of indigenous unsheltered homeless people, need to find the means to expand the Hope Team's excellent outreach efforts.<sup>4</sup>

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<sup>4</sup>Indeed, if nothing else comes of this project, we can at least acknowledge the outstanding work of the Hope Team in assisting the unsheltered homeless in our region. Without exception, participants expressed sincere admiration and gratitude for their efforts, and so do we.

(2) At present, most of the homeless services and facilities in the Orlando metro area are concentrated in downtown Orlando, and yet the homeless population is widely dispersed across the region; and among the people we studied, there is an unmistakable aversion to going downtown. While it is probably unreasonable to expect a network of full-blown homeless shelters and service centers equally dispersed around the region, a system of decentralized day shelters or drop-in centers that provide meals, showers, laundry facilities, and, critically, access to a case manager or a social worker for homeless people who are ready to accept services seems within the boundaries of the feasible. Certainly there is a need for such a facility somewhere in East Orange.

(3) Perhaps the most pressing long-term need is for expanded treatment programs for the dually diagnosed, those disabled both by addiction and by poor mental health, which would describe at least half and possibly more than half of our participants. Granted, many will be resistant to treatment, but some will not be. And others who are resistant now may be “ready” in the near future. A particular need is for access to appropriate medication management and subsidies, especially in view of the stated reasons for current psychiatric medication non-compliance: (1) at an estimated \$800 per month and up, the cost is prohibitive for those who report only being able to get mental health medications “when I go to jail;” (2) co-morbidity with other physical and mental illnesses that increase the likelihood of medication interactions; and (3) negative medication side-effects like those which one respondent said left him feeling like “a zombie.”

(4) Finally, we stated earlier that most of the people we studied were homeless mainly because of some adverse life event from which they were unable to recover. In the long run, the only real solution to homelessness is prevention, and prevention means financial, social and medical safety nets to help people when they hit the rough spots in life’s road. Absent these safety nets, adverse life events turn into financial and health disasters that will continue to propel the weak and vulnerable into perpetual homelessness.

*A Closing Note on Mental Illness.* Most of our participants say they do not want or need alcohol or drug treatment programs, deny any wish to quit drinking, insist that they are either homeless “by choice” or because their own personal failings, and profess an overarching desire mainly to be left alone. Given the substantial numbers with diagnosed or evident but untreated psychiatric illnesses, however, it would be short-sighted to take everything they have told us at face value. A common feature of untreated bipolar disorder is to believe in the manic phase that nothing is wrong and to believe in the depressive phase that nothing can be done to help. The chronic mental illness so evident and widespread in this population often leads to a fatalism that is easily mistaken for a carefree, nonchalant, or even happy disposition.

Likewise, there is every reason to believe that at least some portion of the widespread alcohol abuse (and to a lesser extent, drug abuse) found among participants may only reflect efforts to relieve psychiatric symptoms through self-medication, a common feature in co-morbid homeless populations.

Current scientific thinking about substance abuse among the dually-diagnosed concurs that traditional substance abuse treatment programs (e.g., Twelve Step or therapeutic community approaches) are ineffective for those whose addictions are driven by efforts to self-medicate their mental illness, a form of addictive behavior observed most frequently among persons suffering from bipolar disorder (a diagnosis strongly over-represented among our participants). The widespread denial of any need for substance abuse treatment in this group is best seen as an attestation that these traditional interventions have failed them in the past and will do so in the future. What is needed are evidence-based interventions that have been shown in clinical trials to be effective in treating addictions rooted in mental illness. Interestingly, such programs almost always embrace a residential component, i.e., are only effective once a mentally ill homeless person's housing situation has been stabilized. Effective treatment will require far more than just opening additional detox beds for this population.

A great deal of what might be called the "world view" of the homeless people we studied cannot be adequately understood in isolation from their untreated mental illnesses. The survivalist views espoused by many; the extreme sensitivity to perceived police injustices; the fatalistic resignation to the cards one has been dealt; the evident need to form close, family-like attachments to other "outsiders" – all this is highly suggestive of the characteristic thought processes of mentally ill people and illustrates the need for sustained and timely access to mental health care as a critical component of any overall treatment plan.

It is even possible, indeed rather likely, that the extreme numbers of traffic "accidents" and fatalities reported among our participants and their associates are in fact disguised suicides. This is, in any case, a plausible surmise given what is known clinically about the course of disease progression typical of persons with untreated schizophrenia, chronic depression, or bipolar disorder, all common diagnoses in our population.

## Appendix One

### Guiding Questions for the Focus Group Discussions

#### I. WHO ARE THEY?: GENERAL DESCRIPTIVE INFORMATION

- How long have you lived in Florida? How long in this part of FL? Where did you live before here? How long have you lived where you live now?
- What is your normal day-to-day routine like?
- How far did you go in school? What kind of jobs/careers did you have before now?
- Do you have family/friends you can count on if you really needed to in an emergency?
- Anyone have children? How many? What ages? Do they know how to find you? If no, why not (i.e., they live in a different state...)?
- What do you think is the main reason you live they way you do today?

#### II. DAY-TO-DAY ROUTINE DETAILED INFORMATION

- How do you get around town each day? Bus? Car? Bike? Someone takes you?
- How do you get food each day? How often do you eat each day? Do you ever go without food/skip meals? What's longest went without food? Why?
- Do you ever go to the Daily Bread or other agencies for food? Which meals? What about the Coalition for the homeless—ever go there for food? Why/Why not?
- Have you used services from any other agencies? What agencies? What services? Why/Why not?
- If you knew of other agencies who can help you with housing, food, etc., would you use them or prefer to stay where you are? Why/Why not?
- Do you have to any daily appointments that you have to make (i.e. doctor, social service, re-hab)? What happens if you miss these appts?
- When was last time you needed medical assistance? Where did you go? How did you pay? How did you get there? What about medications, do you have medications that you have to take every day? What are they for?
- Do you ever take other drugs, like street drugs? How often? Why? How do you get them (buy it, friends/family...)
- Do you think that you could benefit from any type of service for alcohol or drug treatment or mental health treatment?
- Which type of treatment? Have you ever had treatment for any of these issues? Do you think treatment is currently available? If yes, are you planning to take advantage of these options?

### **III. FINANCIAL SUPPORT**

- How do you financially support yourself? Day labor? Family/friends help? Disability? Medicaid? Panhandle?
- Do you have friends that live where you do that work? What do they do? How do they get there?

### **IV. PERSONAL SAFETY**

- Are you ever concerned about your personal safety?
- What makes you most concerned?
- How do you protect yourself from this danger to your personal safety?

### **V. HOUSING ALTERNATIVES**

- On really cold or hot days/nights what do you do for shelter? Do you ever go to the Coalition for the Homeless on these types of days? Why/Why not?
- What about during severe weather, like when there is a hurricane coming—what do you do then? Do you ever go to the Coalition then? Some other agency? Just toughen it out right in the camps? Why/why not?
- If you knew of other housing alternatives would you use them? If not, why not? What would it take for you to use them?
- Do you consider yourself homeless? What does being homeless mean to you? How do you refer to yourself?
- Are you homeless/or (however you refer to yourself) because you prefer it over other alternatives?
- Do you consider yourself a survivalist? What does this mean to you (i.e. being a self-sufficient, rugged, individualist...)?
- Do you ever wish life in Florida today was the way it used to be when you were growing up here (for those who have been life-long Floridians)? Does living in the woods remind you of those times? Is this a reason why you live in the woods or have nothing to do with why you live there?
- Do you want help from people/agencies or do you prefer to have everyone to just leave you alone to live the way you want to live?

### **VI. WRAP-UP QUESTION**

- Is there anything you'd like to add about why you live as you do or what you need that we haven't talked about?

Appendix Two  
Marginal Frequencies for All Survey Items

***Gender of respondent***

Gender of respondent

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 Male	28	71.8	71.8	71.8
	1 Female	11	28.2	28.2	100.0
	Total	39	100.0	100.0	

***About how long have you been sleeping out of doors in these camps in Orange County (in days)***

Statistics

*About how long have you been sleeping out of doors in these camps in Orange County (in days!)*

N	Valid	34
	Missing	5
Mean	1886.12	

**About how long have you been sleeping out of doors in these camps in Orange County (in days!)\***

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	14	2	5.1	5.9	5.9
	90	1	2.6	2.9	8.8
	120	2	5.1	5.9	14.7
	210	1	2.6	2.9	17.6
	240	1	2.6	2.9	20.6
	330	1	2.6	2.9	23.5
	365	3	7.7	8.8	32.4
	420	1	2.6	2.9	35.3
	540	2	5.1	5.9	41.2
	730	5	12.8	14.7	55.9
	900	1	2.6	2.9	58.8
	1460	2	5.1	5.9	64.7

	1825	1	2.6	2.9	67.6
	2190	2	5.1	5.9	73.5
	2555	2	5.1	5.9	79.4
	2920	1	2.6	2.9	82.4
	3650	1	2.6	2.9	85.3
	5110	1	2.6	2.9	88.2
	5475	1	2.6	2.9	91.2
	6205	1	2.6	2.9	94.1
	9125	2	5.1	5.9	100.0
	<b>Total</b>	<b>34</b>	<b>87.2</b>	<b>100.0</b>	
<b>Missing</b>	<b>99999</b>	<b>5</b>	<b>12.8</b>		
<b>Total</b>		<b>39</b>	<b>100.0</b>		

\*Note: Responses were taken in days, weeks, months or years and converted by multiplication to a number of days.

#### Living arrangement of respondent prior to sleeping out of doors

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>2 Transitional housing for the homeless</b>	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>2.6</i>
	<b>4 Psychiatric facility</b>	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>5.3</i>
	<b>5 Substance abuse treatment facility</b>	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>7.9</i>
	<b>6 Hospital</b>	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>10.5</i>
	<b>7 Jail, prison, detention facility</b>	<i>3</i>	<i>7.7</i>	<i>7.9</i>	<i>18.4</i>
	<b>10 Room, apartment, house rented</b>	<i>18</i>	<i>46.2</i>	<i>47.4</i>	<i>65.8</i>
	<b>11 Apartment or house owned</b>	<i>6</i>	<i>15.4</i>	<i>15.8</i>	<i>81.6</i>
	<b>12 Stay with family member</b>	<i>4</i>	<i>10.3</i>	<i>10.5</i>	<i>92.1</i>
	<b>16 Place not meant for habitation (car, street, boat)</b>	<i>3</i>	<i>7.7</i>	<i>7.9</i>	<i>100.0</i>
		<b>Total</b>	<i>38</i>	<i>97.4</i>	<i>100.0</i>
<b>Missing</b>	<b>System</b>	<i>1</i>	<i>2.6</i>		
<b>Total</b>		<i>39</i>	<i>100.0</i>		

## Statistics

*About how long have you lived in the Orlando area? (in days, again)*

<b>N</b>	<b>Valid</b>	<b>36</b>
	<b>Missing</b>	<b>3</b>
<b>Mean</b>		<b>6038.75</b>

**About how long have you lived in the Orlando area? (in days, again)**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>20</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>2.8</i>
	<b>90</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>5.6</i>
	<b>180</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>8.3</i>
	<b>240</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>11.1</i>
	<b>420</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>13.9</i>
	<b>730</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>16.7</i>
	<b>1095</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>22.2</i>
	<b>1460</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>25.0</i>
	<b>2190</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>27.8</i>
	<b>2555</b>	<i>3</i>	<i>7.7</i>	<i>8.3</i>	<i>36.1</i>
	<b>3650</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>41.7</i>
	<b>4015</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>44.4</i>
	<b>5110</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>47.2</i>
	<b>5475</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>52.8</i>
	<b>5840</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>55.6</i>
	<b>6205</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>61.1</i>
	<b>6570</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>63.9</i>
	<b>7300</b>	<i>4</i>	<i>10.3</i>	<i>11.1</i>	<i>75.0</i>
	<b>8030</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>77.8</i>
	<b>9125</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>83.3</i>
<b>13140</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>86.1</i>	
<b>14600</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>88.9</i>	
<b>15695</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>91.7</i>	
<b>16425</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>97.2</i>	
<b>18250</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>100.0</i>	
<b>Total</b>		<b>36</b>	<b>92.3</b>	<b>100.0</b>	
<b>Missing</b>	<b>99999</b>	<i>3</i>	<i>7.7</i>		
<b>Total</b>		<b>39</b>	<b>100.0</b>		

**Where did you live before you came to Orlando?**

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	Arizona	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>2.6</i>
	Atlanta	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>5.1</i>
	Boston	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>7.7</i>
	Boston, Maryland	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>10.3</i>
	Buffalo, N.Y.	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>12.8</i>
	California	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>17.9</i>
	Daytona, FL	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>20.5</i>
	Fort Myers	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>25.6</i>
	Ft. Lauderdale	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>28.2</i>
	Gary, Indiana	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>30.8</i>
	Indian	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>33.3</i>
	Indiana	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>35.9</i>
	Kentucky	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>38.5</i>
	Maryland	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>41.0</i>
	Miami	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>43.6</i>
	Michigan	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>48.7</i>
	Missing	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>51.3</i>
	New Jersey	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>53.8</i>
	North Carolina	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>56.4</i>
	NYC	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>61.5</i>
	Ohio	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>66.7</i>
	Orlando	<i>3</i>	<i>7.7</i>	<i>7.7</i>	<i>74.4</i>
	Pennsylvania	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>76.9</i>
	Puerto Rico	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>82.1</i>
	Redding, PA	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>84.6</i>
	Rhode Island	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>87.2</i>
	Seattle, Washington	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>89.7</i>
	Tucson, Arizona	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>92.3</i>
Virginia	<i>1</i>	<i>2.6</i>	<i>2.6</i>	<i>94.9</i>	
Washington, D.C.	<i>2</i>	<i>5.1</i>	<i>5.1</i>	<i>100.0</i>	
<b>Total</b>	<b><i>39</i></b>	<b><i>100.0</i></b>	<b><i>100.0</i></b>		

## Are you Hispanic or Latino?

### Are you Hispanic or Latino?

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>0 No</b>	27	69.2	79.4	79.4
	<b>1 Yes</b>	7	17.9	20.6	100.0
	<b>Total</b>	34	87.2	100.0	
<b>Missing</b>	<b>99</b>	5	12.8		
<b>Total</b>		39	100.0		

### What is your race?

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>	<b>1 American/Indian</b>	1	2.6	3.1	3.1
	<b>3 Black/ African American</b>	1	2.6	3.1	6.3
	<b>5 White</b>	28	71.8	87.5	93.8
	<b>6 Other</b>	2	5.1	6.3	100.0
	<b>Total</b>	32	82.1	100.0	
<b>Missing</b>	<b>99</b>	7	17.9		
<b>Total</b>		39	100.0		

### Other race

		Frequency	Percent	Valid Percent	Cumulative Percent
<b>Valid</b>		17	43.6	43.6	43.6
	<b>99</b>	18	46.2	46.2	89.7
	<b>American Indian</b>	1	2.6	2.6	92.3
	<b>Hispanic</b>	1	2.6	2.6	94.9
	<b>Indian</b>	1	2.6	2.6	97.4
	<b>White Hispanic</b>	1	2.6	2.6	100.0
	<b>Total</b>	39	100.0	100.0	

**Have you ever served on active duty in the military?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	25	64.1	75.8	75.8
	1 Yes	8	20.5	24.2	100.0
	Total	33	84.6	100.0	
Missing	99	6	15.4		
Total		39	100.0		

**Current marital status**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Single	14	35.9	40.0	40.0
	2 Married	6	15.4	17.1	57.1
	3 Divorced	10	25.6	28.6	85.7
	4 Separated	4	10.3	11.4	97.1
	6 Other	1	2.6	2.9	100.0
	Total	35	89.7	100.0	
Missing	99	4	10.3		
Total		39	100.0		

**Do you have any family members that are with you now?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	29	74.4	80.6	80.6
	1 Yes	7	17.9	19.4	100.0
	Total	36	92.3	100.0	
Missing	99	3	7.7		
Total		39	100.0		

**Statistics**

*How many adults?*

N	Valid	7
	Missing	32
Mean		1.29

### How many adults?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1	6	15.4	85.7	85.7
	3	1	2.6	14.3	100.0
	Total	7	17.9	100.0	
Missing	88	29	74.4		
	99	3	7.7		
	Total	32	82.1		
Total		39	100.0		

### How many children?

		Frequency	Percent
Missing	88	36	92.3
	99	3	7.7
	Total	39	100.0

### Has a professional ever told you that you have a....psychological, emotional, or mental health problem?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	16	41.0	55.2	55.2
	1 Yes	13	33.3	44.8	100.0
	Total	29	74.4	100.0	
Missing	99 Missing	10	25.6		
Total		39	100.0		

**Has a professional ever told you that you have a....drinking problem?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	14	35.9	43.8	43.8
	1 Yes	18	46.2	56.3	100.0
	Total	32	82.1	100.0	
Missing	99 Missing	7	17.9		
Total		39	100.0		

**Has a professional ever told you that you have a....drug problem?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	19	48.7	63.3	63.3
	1 Yes	11	28.2	36.7	100.0
	Total	30	76.9	100.0	
Missing	99 Missing	9	23.1		
Total		39	100.0		

**Has a professional ever told you that you have a....physical disability?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	19	48.7	57.6	57.6
	1 Yes	14	35.9	42.4	100.0
	Total	33	84.6	100.0	
Missing	99 Missing	6	15.4		
Total		39	100.0		

**Has a professional ever told you that you have ....HIV/ AIDS?**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	29	74.4	100.0	100.0
Missing	99 Missing	10	25.6		
Total		39	100.0		

Were you ever in the foster care system?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	0 No	31	79.5	86.1	86.1
	1 Yes	5	12.8	13.9	100.0
	Total	36	92.3	100.0	
Missing	99 Missing	3	7.7		
Total		39	100.0		

What is the number one reason why you are homeless right now?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 Employment/ financial reasons	14	35.9	41.2	41.2
	2 Alcohol usage	2	5.1	5.9	47.1
	3 Drug usage	3	7.7	8.8	55.9
	4 Mental illness	2	5.1	5.9	61.8
	5 Medical/ disability problems	6	15.4	17.6	79.4
	8 Housing issues	2	5.1	5.9	85.3
	10 Family problems	2	5.1	5.9	91.2
	12 Natural/ other disasters	2	5.1	5.9	97.1
	14 Some other reason	1	2.6	2.9	100.0
	Total	34	87.2	100.0	
Missing	99	5	12.8		
Total		39	100.0		

age

Statistics

age

N	Valid	36
	Missing	3
Mean		46.3333

age

		<b>Frequency</b>	<b>Percent</b>	<b>Valid Percent</b>	<b>Cumulative Percent</b>
<b>Valid</b>	<b>20.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>2.8</i>
	<b>23.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>5.6</i>
	<b>29.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>8.3</i>
	<b>36.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>11.1</i>
	<b>39.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>13.9</i>
	<b>42.00</b>	<i>7</i>	<i>17.9</i>	<i>19.4</i>	<i>33.3</i>
	<b>43.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>36.1</i>
	<b>44.00</b>	<i>4</i>	<i>10.3</i>	<i>11.1</i>	<i>47.2</i>
	<b>47.00</b>	<i>3</i>	<i>7.7</i>	<i>8.3</i>	<i>55.6</i>
	<b>48.00</b>	<i>3</i>	<i>7.7</i>	<i>8.3</i>	<i>63.9</i>
	<b>49.00</b>	<i>4</i>	<i>10.3</i>	<i>11.1</i>	<i>75.0</i>
	<b>51.00</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>80.6</i>
	<b>53.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>83.3</i>
	<b>54.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>86.1</i>
	<b>55.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>88.9</i>
	<b>57.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>91.7</i>
	<b>61.00</b>	<i>2</i>	<i>5.1</i>	<i>5.6</i>	<i>97.2</i>
	<b>84.00</b>	<i>1</i>	<i>2.6</i>	<i>2.8</i>	<i>100.0</i>
		<b>Total</b>	<b>36</b>	<b>92.3</b>	<b>100.0</b>
<b>Missing</b>	<b>System</b>	<i>3</i>	<i>7.7</i>		
<b>Total</b>		<b>39</b>	<b>100.0</b>		