

AN OUTLINE OF SUPPORTIVE HOUSING NEEDS IN CAMBRIDGE

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Contents

Executive Summary

Findings

Recommendations

I. Background to the Report

II. Methodology

III. The Concept of Supportive Housing

IV. Populations in Supportive Housing: Characteristics, Resources, and Unmet Needs

A. Mentally Ill Persons

B. Alcoholics/Substance Abusers

C. Mentally Retarded Persons

D. Adolescents

E. Other Client Populations

1. Elderly Persons

2. Battered Women

3. Ex-offenders

V. SRO Residents

VI. Homeless Persons

A. Characteristics of the Homeless Population in Cambridge

B. Shelters and Other Resources

C. Unmet Shelter Needs

VII. Conclusions

VIII. Recommendations

Appendices

i. Survey Instrument

ii. Tables

- Results of One-Night Survey
- Summary of Supportive Housing Needs

iii. Partial List of Informants

iv. Partial Bibliography

Summary

This report, commissioned by the Cambridge Department of Human Services Programs in March 1987, provides a preliminary assessment of the need for supportive housing in Cambridge, elucidates some of the connections between supportive housing need and homelessness, and outlines resources for the development of a more comprehensive system of housing options for residents who need supportive services.

"Supportive housing" is defined to mean any housing option incorporating staffing or social services, and thus includes a range of models from emergency shelter to community group homes, congregate housing, and staffed lodging houses. The need for supportive housing is a common denominator for many groups of dependent persons: the mentally ill, the retarded, alcoholics, runaway adolescents, and others. The concept is also critical to understanding the needs of homeless people; while some persons on the street may be merely "houseless," most need more than a roof over their heads to re-establish a stable existence.

The DHSP study included a one-night survey of homeless persons, interviews with over eighty direct service staff and administrators, and review of client records in five local service agencies, as well as collation of existing

studies on homelessness and supportive housing needs in the Boston area.

Conclusions drawn from this study include the following:

1) Significant unmet needs for supportive housing exist in every client population surveyed. In some client groups, such as mentally ill adults, five to ten potentially appropriate applicants exist for every supported residence bed.

2) A large degree of overlap exists between the population of special-needs clients in need of supportive housing and homeless persons. Members of these client groups are at increased risk of becoming homeless in the absence of appropriate supportive housing.

3) Re-housing homeless persons requires the creation of new supportive housing options. In general, services to the homeless are most effective when they supply transitional housing, as well as walk-in emergency shelter which supplies basic survival needs. Transitional housing accommodates guests for periods of three months to over a year; it can incorporate social services such as job training, housing search assistance, benefits counseling, and other long-range interventions. Such stabilization programs can help break up the "circuit" of homeless persons travelling among Cambridge and Boston

shelters, allowing Cambridge to take care of its own more effectively.

4) Characteristics of residents in Cambridge
"single room occupancy" (SRO) housing also overlap those
of the homeless population. SRO housing options are increasingly threatened, and it is reasonable to conjecture that the disappearance of these beds (which share some characteristics of supportive housing) would create increased homelessness among a group of persons with many social service needs and few housing alternatives.

5) Creation of new supportive housing in the past ten years has been minimal, due to a number of barriers, of which restrictive zoning and lack of public acceptance are the most significant. Other barriers to new development include difficulty in locating appropriate properties and in developing capital resources.

Recommendations presented in this report include:

1) Institution of a coordinated planning process for the development and preservation of supportive housing. Such a planning process should reflect the regional nature of homelessness, by including representation from Boston and Somerville. A planning group will need to recognize the interrelated needs of many distinct client

populations, and the contributions of a diverse set of institutional actors, including appropriate city departments, nonprofit groups, state agencies, and local churches, in developing a unified response to the problem of homelessness. The group should have the capacity to conduct long-range planning and systematic re-evaluation of changing needs, as well as to react to the current crisis by identification of specific development goals.

2) Municipal action to reduce barriers to creation of supportive housing. Cambridge service providers have demonstrated a remarkable collective capacity for the development and management of supportive housing. Some relatively simple municipal activities could enable these agencies to be significantly more effective in developing housing. Such actions might include review of relevant zoning ordinances by the City Council, assistance in locating available properties and funding sources through the Community Development Department, and public education on the need for supportive housing through the Department of Human Services.

3) Reorientation of services for the homeless toward provision of transitional housing. While the outstanding need for walk-in emergency shelters must be met, shelter operators should be assisted to develop longer-term supportive housing options for their guests. Other

elements of the homeless service system--intake procedures, case management, day shelters--should also be seen as parts of a stabilization process designed to return homeless individuals to their home communities.

The present report is intended to provide a statistical and conceptual framework for planning supportive housing services. It underlines the size and complexity of the problem, but also suggests that Cambridge has an unusually strong complement of resources with which to develop appropriate housing for its most vulnerable residents.

I. Background

In the winter of 1986-87, Cambridge experienced greater demand for services to the homeless than ever before. This increase appeared to be consistent with national trends: some major cities reported a 50% increase in homelessness over the year. Family homelessness, in particular, was rising. The problem of homelessness, which emerged as an urban issue in the late 1970s and assumed chronic status in the early eighties, was clearly taking a malignant course, unaffected by continued national, regional, or municipal prosperity.

By 1986, a body of information about the homeless had been developed, allowing them to be characterized:

The homeless population has changed markedly over the last several years. The widespread impression that most of the homeless are chronically alcoholic, or addicted to drugs, and prefer street life, has proven to be inaccurate. Increasingly, the homeless population has been found to consist of deinstitutionalized or other mentally ill people, evicted tenants, laid-off workers, families, victims of domestic violence and the elderly poor.

- Massachusetts House Ways and Means Committee,
FY 87 budget

Based on the information gathered in local and national research efforts, a general consensus among service providers was being formulated, as well, about the causes of homelessness. In essence, a declining supply of affordable housing was seen as squeezing out low and moderate income persons, hitting hardest those whose adjustment to the community was already marginal. Among this latter group were persons with various disabilities, including the mentally ill deinstitutionalized in the 70's and 80's. While housing shortages and rising housing costs threatened tenants across the board, some specific kinds of housing utilized by "marginal" persons, for example, single room occupancy (SRO) hotels and lodging houses, were almost eliminated by market forces.

In such a context, a municipal response to homelessness clearly required more than the provision of shelter. While homeless persons needed affordable housing, many also needed special services to replace the community supports which had

failed them, or to help compensate for disabilities which might leave them vulnerable to repeated loss of housing.

In many respects, circumstances in Cambridge seemed to be consistent with this picture. A group of social service agency representatives meeting with the Department of Human Services in mid-March agreed that the number of homeless persons in Cambridge was increasing, and the number of homeless persons with serious social service needs was apparently rising. At the same time, providers of housing for special needs groups were experiencing increased demand for limited services. Lodging house beds were disappearing, and affordable housing of all kinds was increasingly scarce. Families--many with no obvious problems aside from inability to locate housing within their budgets--were seeking shelter beds, or being forced out of Cambridge altogether.

These trends--distinct, but apparently converging--required verification and analysis. Specifically, the following questions were identified:

- Who are the homeless in Cambridge? To what extent can generalizations based on Boston-area studies of the homeless be applied to the Cambridge population?

- What are the housing and social service needs of homeless persons in Cambridge? How are the housing needs of

the homeless related to those of other dependent groups served by Cambridge agencies?

- What kinds and numbers of housing units need to be developed in Cambridge to rehouse the homeless, and to provide appropriate accommodations to persons at risk of homelessness?

II. Methodology

This report is based on four sources of information: interviews with local providers of supportive housing services; review of selected client records provided by local supportive housing facilities; review of existing local studies of homeless or "marginally housed" populations; and a one-night survey of persons sheltered in Cambridge emergency facilities.

Eighty-one brief interviews were conducted. Every provider of supportive housing services was represented by at least one interview; in most cases, an attempt was made to interview both the executive director of the agency and one or more direct service staff (the intake coordinator if that position existed). Interviews were open-ended but based substantially on the format used by Paul McGerigle in his 1986 assessment of services to the homeless in Boston. Particular emphasis was placed on obtaining the following:

- a characterization of the client population and services offered to them;

- unduplicated numbers of clients served, and unduplicated referrals unserved due to lack of beds;
- a description of the position of the facility in its service network--e.g., referral sources, other similar facilities, situations to which residents were discharged;
- staff impressions of major unmet housing needs in the service network.

Interview data was supplemented, where possible, by a review of intake logs and other client records. In general, informants appeared to be conservative in their estimates of need. The numbers of unserved clients cited in appendix ii are based on actual referrals except where otherwise noted. Since these numbers reflect only expressed demand (and in many cases demand which has been artificially suppressed), they are likely to be substantial underestimates of actual need. In some cases, existing systems aggregate client service data on a two-city (Cambridge-Somerville) basis; in others no formal records are kept of unserved referrals. The numbers should, therefore, be considered as illustrative of minimum levels of desirable housing development, and should not be construed as exact counts of clients in need.

The existing literature on supportive housing need is not extensive, or well collated. A substantial fraction of

the data concentrates on the special needs of homeless persons. Some of the principal local sources of data are listed in Appendix iv.

Since the housing needs of homeless persons represent a critical unknown, and existing materials, such as the 1983 and 1986 UCPC studies, are derived from Boston shelter information, it was decided to conduct a one-night survey of sheltered homeless persons in Cambridge. The assistance of Professor Russell Schutt of the University of Massachusetts at Boston was enlisted in planning this survey, which was carried out by an interviewing team of five students on April 13, 1987. The survey concentrated on obtaining basic demographic information, as well as a limited housing history and some data on available sources of support (see appendices i and ii). Preliminary frequency information from the survey was incorporated into this report; more detailed analysis will be available by May 30.

A few caveats apply to the interpretation of this survey data. The survey was not intended to count homeless persons in Cambridge, nor is it adequate to fully characterize the demography or social service needs of this population. It is very much a preliminary "snapshot" of shelter residents.

Overall, the data compiled here are sufficient to allow some preliminary conclusions about the types of populations in need of supportive housing and the relative adequacy of the resources available to each.

III. The Concept of Supportive Housing

"Supportive housing" is a unifying concept which allows the housing needs of several very different groups to be discussed together. The term is used, in this report, to include any form of housing which incorporates social services or staff assistance to residents.

It is a new name for a traditional concept. There have always been members of the community unable to manage the tasks of independent living without help. Historically, they received assistance in one of two settings: the extended family and the institution. Neither setting exists today in the form it had twenty years ago. With the decreased capacity of the family to offer prolonged support, and the emptying of large institutions, a range of new community-based options has evolved--some, like group homes, foster care, and congregate living, designed to be supportive; others, like emergency shelters and lodging houses, more the result of contingency than planning.

While the kinds of supportive housing needed by different populations vary, there are common factors. To a greater or lesser extent, most models incorporate:

- a mechanism for grouping residents by category of disability, so that facilities are specialized, often as part of a state-level service system;
- staff support, supervision and protection;
- the use of educational, socialization, or therapeutic programs to move clients toward their highest potential level of independent functioning;
- an attempt to integrate the client as much as possible into the life of the community.

Variables which distinguish one type of supportive housing from another include:

- physical structure, including facility size, and balance between private and common space;
- intensity of staffing;
- degree to which participation in treatment or habilitation progress is required;
- length of stay--which is usually related to the goals of the program and the degree of independence clients are expected to achieve;
- referral mechanisms and specificity of entrance requirements.

These variables are loosely associated, so that the following progression can be seen from highly structured programs to virtually complete independence:

- group homes or halfway houses, which ordinarily accommodate 6-10 persons, involve shared space and household tasks, are heavily staffed, and have specific treatment or habilitative goals;

- supervised apartments, small programs which may have less staff supervision, and which may be a kind of 'graduate' program for group home members;

- congregate living, staffed group residences which may be fairly large (6-25 residents), incorporating spare bedrooms and some common space, but frequently with less-intense programming than a group home, and longer-range residency;

- staffed lodging houses, which may be indistinguishable from traditional SRO housing, aside from the presence of some level of staff support;

- emergency shelter, characteristically a walk-in program for homeless persons which provides a bed and basic necessities for a short stay, usually not exceeding 3 days or a week;

- transitional housing, longer-term housing for homeless persons with structured social service

interventions aimed at "re-settling" the client in a stable situation;

- independent living with supports, an ordinary apartment with supervision and the availability of specific services, but no on-premises staff.

Several specific population groups are currently seen as in particular need of supported housing:

- adolescents who have run away, have been abused, or who are estranged from their families for other reasons, and who are not appropriate for individual foster placement;

- alcoholics and drug abusers who have graduated from detoxification programs and are attempting to move back to independent living;

- mentally ill persons, either former inpatients or community residents, who need a structured situation;

- mentally retarded persons, who are capable of living outside institutions with some level of support, varying from intense support for the most handicapped, who may never be independent, to temporary habilitation, for those who may eventually maintain themselves;

- ex-offenders after release from prison, who need re-acclimation to the 'outside';

- battered women who need a safe place to reconstitute their lives after leaving an abusive situation;

- homeless individuals, who may fall into one or several of the above categories; and

- homeless families.

IV. Specific Populations: Characteristics, Resources and Unmet Needs

In the following sections, the special housing needs of seven distinct population groups are discussed: The mentally ill, retarded persons, alcoholics and substance abusers, the elderly, battered women, ex-offenders, and adolescents. The needs of two other groups, defined by their current residence, are also discussed: homeless persons and residents of SRO-type lodging.

In each section information is provided on the incidence and "natural history" of the problem, a description of the specific housing and support needs implied, the supportive housing resources available in Cambridge, and the best current estimate(s) of unmet need for housing. Also noted are current initiatives in the development of housing, and barriers to housing development in the past.

A. Mentally Ill Persons

Major mental illness is not uncommon, affecting one out of every 75 adult Americans. The Cambridge and Somerville Mental Health and Retardation Center (CSMHRC) estimates that there are 800 chronically mentally ill persons living in Cambridge, most of whom would benefit from some level of community-based support services.

Deinstitutionalization has meant that more mentally ill individuals are living in community settings than at any other point in the century. The state Department of Mental Health has, since the beginning of the process, recognized the need for a high level of support services, including residential services, to maintain these individuals in the community. DMH funds supportive housing in ten categories, including group homes, staffed apartments, congregate housing, foster care, and "independent living with support services." However, the creation of services has never kept pace with need.

The Department of Mental Health conducted a statewide survey of its clients in August 1985. In the Cambridge/Somerville area 510 DMH clients were identified, in a range of situations including jails, shelters, nursing homes, and acute-care hospitals. Based on information from local mental health providers, DMH estimated that housing these clients appropriately would require the creation of 24 group homes, 5 supervised apartments and ten congregate-living or staffed lodging house projects.

For example, the Cambridge unit at Metropolitan State Hospital has had an average census of 140 over the past year, up from 103 five years ago. The census increase is, in part, related to the lack of housing for these patients. Whereas five years ago patients were frequently admitted

from extended family situations or boarding houses, now the average admission is from an independent apartment which will usually be lost during hospitalization. In consequence, 86-90% of hospitalized patients have no home. Staff have estimated that about 50% of patients could utilize a rooming-house type of residence, with some supportive services; an approximately equal number would be appropriate for a group home, while a small fraction--2 to 5%--are expected to resist any structured placement. At present 25 to 30% of patients in the Cambridge ward are there solely because there is no appropriate situation to which they can be discharged.

While the CSMHRC is in the process of developing an expanded case management system, currently it is quite difficult for the hospital to keep track of patients after discharge. Ambulatory Community Services (ACS) tracks 27 Cambridge post-discharge clients, ACS staff suggest that about 50% of their caseload is in need of group care, while an additional 40% could function in an apartment or lodging house with supportive services attached. Currently most are in individual apartments with limited support, or at the state hospital.

Many of the DMH clients lost to follow-up are living in shelters or in SRO-type lodgings. As noted by Carol

Johnson, DMH Coordinator of Homeless Services, "...formerly institutionalized mental patients were placed in SRO's without case management follow-up during the first wave of deinstitutionalization of 1965-70. During the second wave of deinstitutionalization (1975-80) the housing crisis was already so severe that many patients were discharged to shelters, then an acceptable address for DMH discharge." While shelter placement is no longer DMH policy, a large number of former patients nevertheless are found in shelters.

Staff in Cambridge shelters have estimated that 30 to 60% of guests have psychiatric illness severe enough to impair functioning; these reports are in general agreement with more controlled studies in Boston which diagnosed 25 to 40% of shelter guests and 35% of individuals on the street as suffering from major mental illness (Schutt, 1986). Recently, DMH, in collaboration with the Cambridge Department of Human Services, funded a mental health outreach worker to assess and treat mental health issues among shelter guests. This worker's preliminary estimate is that 30% of shelter guests in Cambridge have some diagnosable mental disease; of these, perhaps half would be appropriate for group home placement.

The high number of mentally ill persons in SRO housing is also well documented. A 1985 study of independent lodging

houses conducted for the Department of Human Services suggested that 10-20% of residents had psychiatric histories; the largest SRO providers in Cambridge, the YMCA and YWCA, estimate that 20% and 30% of residents, respectively, have some mental health problems. Staff estimate that a total of 78 persons in both programs need a more structured program, such as a group home, while 108 could maintain themselves more adequately if additional staff support were available in their current situation.

Supportive housing for mentally ill persons is provided in Cambridge by the Cambridge and Somerville Cooperative Apartment Program, Inc. (CASCAP), a part of the CSMHRC network, and by Wellmet, Inc., which services private patients.

CASCAP is funded by DMH and receives referrals through the CSMHRC system. Currently, the agency operates two community residences, one of which is located in Cambridge. Both residences house ten clients and provide 1:1 staffing on a twenty-four-hour basis. A new residence, planned for 8 beds, is expected to open in Cambridge during 1988. The existing Cambridge residence serves Cambridge clients almost exclusively, and gives preference to persons being released from Met State. Average length of stay is over three years.

CASCAP also operates an expanding number of staffed apartments in the community; 22 now exist, and 17 are projected for the next three years. About 7 of these apartments are sited in Cambridge, in CHA buildings. They house "graduates" of the group homes and others who need a lower level of supervision. Through its subsidiary, OECHO (Organization for Elder Cooperative Housing Options), CASCAP also runs a 10-bed group residence for elderly women, most of whom have some mental health history.

In addition, CASCAP manages 9 rooms at the YMCA and 6 rooms at the YWCA which are reserved for persons with chronic mental illness.

CASCAP maintains a limited "active" waiting list, amounting to 30-40 persons for its combined programs; however, over 350 persons are listed in the "inactive" file, representing a more accurate picture of demand for this service.

The "Y" program beds are funded through a combination of Chapter 707 subsidies, through EOCD, and a DMH service contract which provides case management. Currently the beds are utilized mostly for referrals from Met State. Over its one and a half years of operation, the program has served clients who are less impaired than those seen in the apartment or residence programs. A 1:8 staff ratio is maintained, and although staff are not on the premises, they

are available by "beeper." Clients usually work during the day, and many have continuing psychiatric therapy. Some clients have moved on to independent housing, although this is not a major program goal.

Wellmet, Inc., is a private organization which receives no public funding. It serves adults with chronic mental illness, including referrals from private hospitals and other individuals not in the state hospital system. Wellmet runs two residences in Cambridge with a total of 24 beds; the program lasts 6 months to three years, and turnover is slow, amounting to about 10 beds per year. In general, the program is less structured than its publicly-funded counterparts. Since it is a private-pay operation, it is characteristically utilized by persons who have enough family support to manage rates of \$450 to \$800 per month. Wellmet receives 100 to 150 applications per year, of which it places 15 individuals on a short-term waiting list.

Need for expansion of residential resources has been clearly identified by both operators. Wellmet, which is not presently seeking public funds, finds capitalization a major barrier to the establishment of new facilities. For CASCAP, locating funds for acquisition of and operation of new facilities has not been problematic; the agency has energetically explored a number of state and federal

sources, and has enjoyed a high level of success in competition funding processes, due in part to a successful partnership with the Cambridge Housing Authority. However, difficulty in the location of appropriate properties whose zoning permits use as a residence, and the management of community opposition to residence programs has made expansion of this type of housing problematic; the projected Aberdeen Avenue residence is the first to be approved in ten years, and took approximately seven years to date to develop. Set-aside of units in CHA properties has, however, allowed the apartment program to expand, and prospects seem favorable for the extension of the "Y" program as well.

B. Alcoholics/Substance Abusers

The Department of Public Health Division of Alcohol and Substance Abuse uses the following epidemiological estimates in determining regional needs for service: about 5% of the population is alcoholic; of all alcoholics, about 20% seek treatment; for 1.6% the treatment of choice includes residence in a halfway house. These estimates yield a total alcoholic population in Cambridge of about 5,000, with 80 persons in need of community residence services.

In substance abuse treatment, the first step is detoxification--the resolution of physical addiction. Since withdrawal from alcohol or other drugs can be life-threatening, this is carried out in an inpatient medical

setting. Detoxification may be followed by referral to a hospital inpatient residential treatment program or to a community halfway house. Halfway house programs usually have a maximum stay of about six months. Residents may participate in therapy groups and individual counseling, and ordinarily work outside the house during the day.

In Cambridge, CASPAR (Cambridge and Somerville Program for Alcohol Rehabilitation) is the publicly-funded lead agency. CASPAR operates a 20-bed detox program, 48 beds in mens' halfway houses, 20 beds in a women's halfway house, a 15-bed "graduate house" and a 55-bed emergency shelter for actively drinking alcoholics as well as outpatient programs of various kinds. The shelter, the women's house, and one men's house are in Cambridge. Private facilities in the area include a 15-bed detox at Central Hospital in Somerville and outpatient programs at Mt. Auburn Hospital.

A concrete estimate of local need can be derived from CASPAR's referral figures. The emergency service center is usually stretched to accommodate 60 to 70 persons nightly; the detox facility turns about 10 persons away each day; the halfway houses have 20 men and 20 women on short-term waiting lists; currently 8 persons are waiting for places in the graduate house.

The need for residential treatment facilities does not end here. Needs have also been identified for the following specialized resources:

- an adolescent halfway house;
- programs for pregnant women;
- a program for alcoholic elders;
- additional 'holding' beds between detox and halfway house placement;
- SRO-type housing with supportive services;
- programs for individuals with poly-drug addiction.

Over the past year the Department of Public Health has consolidated administrative services for drug and alcohol abuse, and is encouraging greater emphasis on 'poly-drug addiction,' since an increasing number of new clients have more than one dependency.

Cambridge has one drug treatment facility, the North Charles Institute for the Addictions, which provides outpatient treatment. For inpatient treatment, clients must go to Boston or more distant sites, and the need for some local inpatient beds is recognized.

The relation of substance abuse to homelessness is a reciprocal one. Alcohol is a dramatic and almost ubiquitous feature of street life, a major factor in physical illness and a barrier to rehousing many homeless persons.

Drug abuse of other kinds, although not as readily

identified, is also felt to be significantly present in homeless populations. Shelter providers in Cambridge estimate that 30-60% of guests in "dry" shelters have some problem with alcohol, a figure that agrees well with more clinical Boston studies. Conversely, DPH estimates that statewide 26.6% of persons in detox programs and 18% of residents in halfway houses have no permanent address to which they can return. Of 1,950 (duplicated) admissions to the CASPAR detox facility in 1986, 85% were from the emergency service center; of 1,372 (duplicated) discharges, 3% were to halfway houses, 2% to short-term rehab programs, 5% to "holding" beds at CASPAR, 17% to home, family or friends, and 73% to the street.

CASPAR has sought to expand its programs to respond to emergency needs, but has met barriers in zoning and neighborhood opposition; funding for construction and operation has not been a problem. For example, 6 of 8 administrative areas statewide have adolescent treatment programs; Cambridge does not, despite a well-documented need, due to the difficulty in siting such a facility.

C. Mentally retarded persons

Since mental retardation is a lifelong condition, and the incidence of retardation is quite constant at 2 per

100 persons, the needs of this population are not subject to great fluctuation.

In Cambridge, mentally retarded persons are served by the Walnut Street Center, a branch of the Cambridge and Somerville Mental Health and Retardation Center. Walnut Street, in turn, operates housing programs under the aegis of a separate nonprofit subsidiary, CARE, Inc. The Walnut Street Center houses 76 clients in the Cambridge and Somerville area, of which 19 live in Cambridge at one of three group apartments.

Currently the Department of Mental Health funds six categories of residence programs, from "intensively staffed apartments," which have 2.5 staff members for each 4 residents, to "co-op apartments," in which staff are available on-call, but not on the premises. Small projects (4-6 residents each) are the rule; in Cambridge, there are two apartments integrated into public housing and one free-standing model residence. After a period of training and habilitation, most clients continue to need some level of support services. Few clients move out; the 1-2 vacancies per year in Walnut Street's programs are largely attributable to deaths.

Referrals to residential programs in the area are constant at 1-2 per week. Very limited waiting lists are maintained; the Housing Office of DMH has identified 11

clients in the area who are in need, and remain unserved; approximately 10 new names are expected to be added to this list in the next year, as '766' students turn twenty-two. Since most referrals from the community are from clients currently living with family, a large number can be deferred. Walnut Street's current goal is to add 4-6 beds to the residential programs annually; this is seen as sufficient to keep supply in line with demands.

However, one indication of suppressed demand is the status of the Center's respite care home (in Somerville). Established in 1983 to take clients for short stays, its 5 beds are now continuously full--occupied by clients who have nowhere else to go. Walnut Street is seeking funding for four more respite beds.

One other pressing need seen in the area is for specialized residences for clients with severe behavioral problems or concomitant medical conditions serious enough to need nursing supervision.

Mentally retarded persons seldom "slip through the cracks"; or at least, according to local service providers, they can be identified readily when they do. This assumption is generally supported by other providers. The 1983 UCPC study of homeless persons in Boston suggested that 1.7% of shelter residents were significantly retarded,

and one or two persons with possible retardation have been identified as shelter guests in Cambridge.

D. Adolescents

In the past three years it has become apparent that several groups of adolescents need some form of supportive housing. These needs have emerged recently enough that services to meet them are still evolving. This process is complicated by the fact that of the three major state systems serving adolescents--the Department of Social Services, the Department of Youth Services and the Department of Mental Health--none has the provision of housing as a primary mandate. Four principal groups of adolescents need supportive housing:

1) Adolescents who have run away from or been forced out of their parental home need emergency shelter. In the Cambridge area, this kind of shelter is provided by Shortstop, Inc., located in Somerville. Shortstop has been licensed by the Office for Children and DSS since 1983; it provides seven beds for DSS Region IV (which includes Somerville and Cambridge) and 1 bed for Region III. About 90% of referrals are from DSS. Clients can stay for a maximum of 30 days, with a two-week extension if ordered by a court. The population seen is changing; whereas most used to be runaways on their way home, the majority are now involved with institutional systems--DYS, DSS, DMH--and are

unable to return home; they need permanent housing. Some idea of the demand for adolescent shelter may be formed by noting that Shortshop receives over 125 referrals per month from a region extending to mid-state.

2) Adolescents 13 through 17 years of age need group residences oriented to a variety of problems. These young people are unable to live at home--whether on account of abuse, rejection by parents, the intensity of emotional problems--but they are not ready to live alone. They are characteristically involved with DYS, DSS or DMH. In Cambridge two residence programs, Hastings House and Castle School, serve this population, concentrating on emotionally disturbed youth. Hastings House is somewhat more a "halfway house" in nature, with some ADL groups but no formal counseling; it accommodates 12 young people for 6 to 12 months each. Many are referred from Shortstop or similar shelters in Boston. About 2-5 referrals per month are received from all over Massachusetts; about 20% are from Cambridge. Fifty to sixty percent of "graduates" need to find independent living quarters where they can receive follow-up; in the local housing market, this is extremely difficult. A significant number are still too young or too needy to live alone, and need congregate or cooperative housing which does not exist locally.

Castle School has more extended therapeutic goals. The faculty takes 10 youth for 1 1/2 to 2 years, and receives about 20 referrals per month, from all areas of the state. Again, graduates need independent living quarters or congregate housing.

(Another similar facility, Charles River Academy, closed in 1986. The building and its associated operating licence will apparently be lost for use as a community residence; other groups in Cambridge which were offered the property have been unable to raise the market price.)

DMH has no residential program contractors in Cambridge, although it does sponsor group homes in the catchment area which includes Cambridge. Currently, DMH identifies 9 homeless adolescents needing emergency shelter and 10-15 mentally ill adolescents in need of group care in the Somerville-Cambridge area.

3) Adolescents in age-based entitlement programs face a lack of options when they turn 18 and are no longer categorically eligible for service. (For some, services are extended to age 22). They may need either group homes or supervised apartments. These resources do not exist in Cambridge. (There is a group home in Brighton operated by Bridge Over Troubled Waters, and a 20-bed supervised apartment project in Jamaica Plain operated by Volunteers of America). Older adolescents who have not been involved with

one of these systems but come to the attention of authorities when they are 17 or 18 are in a very similar predicament.

4) Finally, adolescents in particular kinds of difficulty sometimes need specialized supportive housing.

An apartment program for 4 parenting teens 16-17 years old, operated by Catholic Charities, receives over 60 referrals per month; alcohol and drug-abusing adolescents need separate residential treatment facilities as noted earlier.

There are some geographic anomalies in youth programs. Since these programs are highly specialized--age groups and types of need can't be mixed effectively--they need to draw from a wide population base. They are also very scarce programs. Consequently, referrals come from a wide area; and frequently it is in the best interest of the young person to house him or her at some distance from family and old associations. While state policy favors placement within the "area of meaningful ties," these factors mean that out-of-city residents are sheltered in Cambridge, while local young people are hosted by other communities.

E. Other Client Populations

There are a number of other groups in the population in need of supported housing. Elderly persons, for example: as individuals age and become less capable physically, various

in-home services in apartment or congregate settings can be highly effective mechanisms for maintaining them in the community. Elders are currently by far the largest consumers of supportive housing in Cambridge, if one includes the 900-odd individuals receiving services in their own homes or in public housing, and it is noteworthy that many models of congregate care now being promoted for other impaired groups were first developed for older people. However, elders are excluded from this survey because in Massachusetts their needs are the focus of an extensive supportive service network, and because the problems facing providers in delivering services to elders differ radically from those faced by advocates for other groups.

Battered women are a significant group in need of supported housing. Their first need is for a safe place to stay; frequently they need to access shelter on an emergency basis, and often they will need to bring children with them.

Cambridge has one shelter for battered women, Transition House, which can accommodate 7 families: 7 women and 8-10 children. Transition House serves 300 women per year. Of these guests, 25% move on to other shelters, 25% find housing of their own; 5% are lost to follow-up, and 5% either move to other temporary quarters or go "home." Some need only to find affordable housing, but for many the ideal

situation would be a 1-2 year transitional setting offering safe shelter but also assistance with parenting, job training and help with services, income, support around security issues and counseling around incest, abuse, and other major barriers to reestablishing a stable family life.

Since battered women, for their own safety, need to be housed at some distance from their abuser, residents at Transition House are not from Cambridge; shelters in other areas accommodate Cambridge women.

Ex-offenders are universally recognized as one of the most difficult populations to house in the community. At a given time, about 200 Cambridge residents are in state or federal correctional institutions; according to Mark Corrigan, Director of the Institute for Sentencing Alternatives, approximately 30% of these prisoners would benefit from some period in a community halfway house upon release. According to the Director of Planning for Department of Corrections parole programs, Ed Dolan, some prisoners eligible for parole need halfway house placements to learn or re-learn life skills in a structured living environment. For offenders who fit this category, the lack of community-based programs means a longer prison stay. In fact the Massachusetts Department of Corrections operates

relatively few ex-offender programs, due to budget constraints and the difficulty involved in siting them.

Needs for supportive housing are fluid. Populations deemed in need of supportive housing arise in response to large-scale social and economic processes, and their numbers change with time. It can be expected that groups currently unrepresented in this outline--people with AIDS, perhaps, for one--will be identified in the future.

V. Lodging House and SRO Residents

Lodging houses and other SRO accommodations are not formally structured as supportive housing, and residents in lodging houses are not necessarily impaired or in need of social services. However, lodging houses have some features which make them attractive to individuals whose ability to maintain themselves in private housing is marginal. Their physical structure provides privacy, but also offers the company of other people--without pressure to associate. Some level of supervision and assistance may be provided by the operator, and domestic chores are kept to a minimum. Above all, SRO's are still one of the cheapest forms of lodging, averaging \$50-85 per week.

According to the 1985 licensed lodging house list (prepared by the Licensing Department, City of Cambridge) there were 1,144 lodging house rooms in Cambridge. By 1987 that total had decreased to 1,068. Of the remaining

rooms, 278 are in fraternities, 98 are not currently licensed, 83 are hotel rooms, and 28 are shelter or community residence beds.

These beds represent 22 lodging houses, compared to approximately 300 in the mid-fifties. Every year since 1960 has seen a decline in beds. This loss of SRO and lodging house stock is being seen in urban areas nationwide. In New York City, for example, the decline was seen as such a crisis that a conversion moratorium was enacted for SROs in 1973.

Of the remaining operators of independent lodging houses, a recent study by the Department of Human Services suggests that 45% are planning to leave the business within 10 years. Reasons cited are uneconomical operation, difficulty with city regulations, and difficulty in obtaining loans for repair. About 20% of operators also cited problems with alcoholic or mentally ill residents. Interestingly, the most common reason for staying in business was "helping people." As one operator said, "These men have no place else to go and I'm the only family they've got."

Management problems caused by residents with major social service needs are felt even more acutely by the largest operators of SRO-type beds, the Cambridge YMCA and YWCA. The YMCA staff, for example, estimates that

of 147 residents, 20% are appropriate for the YMCA with services which currently exist; 40% would be appropriate if more supportive services could be provided on the premises; 25-30% would do better in a more structured environment, and 2-5% might be appropriate for immediate hospitalization. Alcohol and mental illness were seen as affecting 40% and 35% of residents, respectively.

Similarly, the YWCA recently conducted a resident survey which indicated that 30% of residents had significant mental health problems, 25% abused alcohol, and 40% had social service needs of other kinds--including help with employment, budgeting, and obtaining benefits.

For these residents, there are few alternatives. Yet the "Y" operators, not established to offer "supportive housing" in any formal sense, find their resources over-taxed in meeting even the minimal service and supervision needs of residents. Nationally, YMCA's and YWCA's have been leaving the residence business; a few facilities, such as the Kansas City, Kansas YWCA and the Vanderbilt YMCA in New York, have consciously transformed their programs into permanent or transitional housing for individuals with significant social service needs.

VI. Homeless Persons

A. Characteristics of the Homeless Population in Cambridge Individuals

The available data indicate that homeless families and individuals in Cambridge are similar, demographically, and in terms of service needs, to their more intensively-studied counterparts in Boston. In both cities, family homelessness seems to be a distinct phenomenon, with a different etiology, and different associated needs and resources.

Characteristics of Homeless Families

Family homelessness is increasing statewide; in the Executive Office of Human Services' 1985 Report on Homelessness, it was noted that almost "75% of the incidence of homelessness now occurs as family units; the number of homeless families identified is increasing in every area."

Information gathered from DSS and local shelter providers indicates that homeless families in Cambridge share a cluster of characteristics with other homeless families across the state.

Perhaps the dominant characteristic of homeless families is their struggle to maintain local ties and support systems. In their efforts to preserve as much normality in life as possible--to keep children in school, for example--families will "double up" or "triple up" with friends or

relatives, sometimes cycling among several local contacts for short stays. As a result, one hundred percent of homeless families seen by Cambridge agencies were originally housed in Cambridge; families tend not to move out of their home community unless they have no other option.

In general, families also "do everything they can to avoid going to a shelter," according to a local service provider, and local welfare offices encourage these efforts. One effect of this close tie to local communities is that family homelessness is largely a hidden problem, submerged in an unknown amount of overcrowding.

Economic factors represent the overwhelming reasons behind family homelessness. Homeless families are predominantly young mothers with one or two young children, a demographic characterization supported by Ellen Bassuk's 1986 study, as well as by data from DSS, DPW and local service providers. These young families typically have very limited economic resources; UCPC's 1983 survey suggested that a minimum of 72% were dependent solely on AFDC payments, while some studies cite higher figures.

According to Mitchell and Bernstein, 1986, a study of 61 homeless families in all areas of the state indicated that "immediately preceding their homelessness [housing] costs consumed fully 87% of their average monthly income." Given that the median AFCD benefit in Cambridge is \$450 per

month, and that the Section 8 "fair market rent" for an unheated one-bedroom apartment in Cambridge is \$487, this finding clearly has great local relevance. The expectable consequence of this rental burden is that "the acute precipitant [of homelessness] for the largest percentage of families was the legal loss of real estate" (Ellen Gallagher, 1986). This finding is also borne out by the experience of Cambridge service providers.

One other significant characteristic of homeless families is their relative freedom from the debilitating problems--alcoholism, psychiatric illness--which can make rehousing homeless individuals so difficult. While a number of resarchers (Bassuk, Gallagher et al) have identified a sub-group of "multi-problem families" with significant, long-standing social service needs, it appears that only about 13% of homeless families can be considered "chronically" homeless as a result. However, as a family remains homeless, its resources are eroded and its weaknesses exacerbated. Children, in particular, suffer "critical social emotional and intellectual needs which remain unaddressed. They manifest developmental delays, poor school performance and severe anxiety and depression" (Gallagher, 1986). Over a period measured in months, "families become much harder to resettle; their financial

and social assets are depleted," according to a shelter operator. A not-infrequent result of homelessness is the breakup of families, i.e., the separation of couples and the removal of children documented by Paul McGerigle in 1983.

Two Cambridge case studies suggest how families with deep roots in the community can be displaced, in effect transformed into urban nomads:

Mrs. R. is a thirty-five year old mother of two. Her children, ages 10 and 16, have gone to Cambridge public schools since kindergarten, and one of her biggest concerns is making sure that they finish school in Cambridge. They are both in class every day, although this entails leaving their motel in Lynn at five o'clock each morning. Mrs. R. and her children have been homeless since October 1986, when her husband left their Cambridge apartment. Without his support she could not continue the lease. The family stayed at a Cambridge shelter until granted Emergency Assistance, and subsequently alternated between the houses of relatives and spells in DPW-funded motels in Brockton, Lynn and the North Shore. Mrs. R. has a Chapter 707 certificate which will pay up to \$640 per month for an apartment, but she and the housing search staff working with her have not yet found an appropriate place.

Mrs. C. is a twenty-year-old black woman, mother of two small children, who has been homeless since September. Mrs.

C's family has lived in Cambridge for three generations; her mother, well-known as a leader in community volunteer work, died last year. When Mrs. C.'s family became homeless, she and her children were housed in a series of area shelters and DPW-funded motels. Now Mrs. C. is staying in a DHSP-funded transitional room at the YWCA. She works and attends a local community college; under a DSS plan, her grandmother-in-law cares for the children while Mrs. C. saves her wages toward a security deposit for an apartment.

2. Individuals

Homeless individuals in Cambridge, according to the one-night census conducted in April, are overwhelmingly white men (12% are female; 11% are black, and 4% of other races). They are single (43%) or divorced (52%). About 76% have family in the Boston area, but nevertheless their social resources are slim; only 8% were able to stay with a relative or friend over the past two months. Half received some kind of government benefits, and 22% worked, either full or part time, about 15% had no source of income. Over half of the respondents were veterans.

Based on the limited information available, some distinctions can be made between subsets of this population. One of the most apparent is the difference between CASPAR Emergency Service Center grants and residents in other

shelters, consistent with the ESC's specific focus on street alcoholics. The ESC restricts itself to serving residents of CASPAR's catchment area, and consequently 75% of guests cite a last permanent address in Cambridge, compared to 10% of other shelter guests. CASPAR guests are significantly older, with a average age of 52, than are other shelter residents, for whom the average age is 35. They are a much more chronic population; 90% have been homeless for more than a year, and 42% for more than seven years. Of non-CASPAR guests, fully 62% were homeless less than a year, and 21% less than one month.

Among non-CASPAR guests, a distinction can be made between a group appaently on its way to chronicity--with a year or more of homelessness, more numerous problems with mental health and alcohol, and fewer apparent sources of social and financial support--and a group whose homelessness was of short duration, who tended to be working full or part time and utilizing some social supports. About 30% of the sameple fell into the 'semi-chronic' category; the 'temporary' homeless were clearly identified by shelter staff as "good risks," and seemed to be about 20% of the total. The remainder of respondents did not fit clearly into either category.

Alcohol abuse and psychiatric illness are prevalent. Outside of the ESC, where all clients can be assumed to be actively drinking alcoholics, 23% were self-identified as having a "problem with drinking"; shelter staff surveyed suggested that 30 to 60% of guests had such a problem. Twenty-one percent of persons surveyed identified themselves as having had "treatment for a mental or nervous problem"; shelter operators and DMH workers estimated that 30 to 40% might be a more reflective figure, based on clinical observation and on client tracking through ACS and other elements of CSMHRC. Drug abuse was suspected in individual cases by four out of five shelter operators, but no more precise information was available.

Other issues which shelter staff observed as significant, but which were not included in the survey, included problems with the law (anecdotally, it was recognized that perhaps ten percent of shelter guests had been in jail) and domestic violence (again anecdotal evidence and brief survey of cases indicating an incidence around 10-20%).

Patterns of shelter use indicated that homeless individuals form a highly mobile group. Although some shelters exert themselves to provide longer lengths of stay, the average is just over one week. There is a continual rotation of clients among shelters in Cambridge and Boston,

with 87% of all non-CASPAR clients having stayed recently at more than one. According to review records at three shelters, some 50 to 60% of clients had recently spent time in Boston shelter locations. Many guests have also used other shelter expedients: friends and family, "the airport," "a car," hotels or motels.

Despite their mobility, shelter residents are a group which is, on the whole, fairly well known to shelter providers. In the two months for which intake records were reviewed, no shelter saw more than 15% "new arrivals," most guests were either regulars at a given shelter or were known from previous stays.

Among non-CASPAR guests, the location of the last permanent address was in the Boston area for 51% of the respondents; 10% cited residence in Cambridge proper; 18% are apparently from other cities and towns in Massachusetts, while 26% are originally from out of state. Paul McGerigle reported for UCPC in 1985 that 7% of guests in Boston-area shelters were from Cambridge. In the UCPC study, "greater Boston" included several Cambridge shelters; 6 of 339 persons surveyed in shelters located in Boston identified Cambridge as last permanent address. He and other researchers suggest that the local homeless population may constitute an "ecosystem" comprising Cambridge, Boston,

Somerville and other neighboring towns accessible by public transportation.

B. Shelters and Other Resources

1. Families

Resources for Homeless Families

There are currently only 5 family shelter slots in Cambridge: three at Shelter, Inc., and two at the Cambridge YWCA. (Shelter, Inc. also operates a 35-bed facility in Boston.) Over the past year, Shelter, Inc. served 58 families at its Boston and Cambridge locations and turned away 156 other requests for assistance from families. This lack of local shelter beds has meant that homeless Cambridge families are displaced, often to hotels and motels under the DPW-administered Emergency Assistance Program.

Emergency Assistance provides one-time assistance to families who meet AFDC financial criteria and who are faced with "urgent and immediate needs." It provides, among other forms of help, hotel and motel vouchers as a "last resort" for homeless families who cannot be placed in shelters.

Currently, five Cambridge families are living in hotels or motels in locations as distant as Lynn, Everett and Revere (no hotels in Cambridge accept vouchers). The Department of Public Welfare also identifies ten Cambridge families who are "doubled up" or in immediate danger of losing their homes, as well as five families recently placed

out of hotels and motels. These twenty families are being provided with housing counseling and supportive services through the Department of Human Services under contract with the DPW Housing Search Program.

Statewide, as well as in Cambridge, the number of hotel/motel placements is increasing, as is the average length of stay, which now approaches three months. As noted by the 1986 report of the Massachusetts Committee for Children and Youth, hotels and motels "do not meet the needs of children, and are extremely detrimental environments for childrearing." Their cost is also extreme: the Commonwealth pays an average of \$1,400 per month to keep one family sheltered in this setting.

2. Individuals

Shelter, Inc. has been in operation for 12 years. Its Cambridge facility, a converted two-family house, accommodates nine men, six women and two families nightly, providing them with meals and small group bedrooms. Guests are accepted on a referral basis only, with a preference given to Cambridge agencies; persons who are actively drinking, violent, or otherwise disruptive are screened out. The "official" length of stay is three days, but for many guests this limit is repeatedly extended, so that the average length of stay seen over the past three months was

14 days. Length of stay has increased over the past three years, due to difficulty in placing guests elsewhere, and to the staff's efforts to stabilize guests with an increasingly severe range of psychosocial problems. Referrals to Shelter, Inc. are received from over 100 agencies, led in frequency by the Salvation Army, other local shelters, and the Cambridge police. Over the past year, Shelter, Inc. served an unduplicated total of 536 individuals and turned down 1,073 requests for shelter from individuals. Shelter, Inc. maintains a staff social worker position and attempts to help guests resolve problems which prevent them from maintaining permanent homes. Over the past year, 39 guests were placed in permanent housing; other placements were in other shelters, halfway houses and institutional settings such as nursing homes and chronic-care hospitals.

The University Lutheran Church shelter evolved from a soup kitchen in 1983. It houses 23 individuals--usually 20 men, 3 women--on cots in the church basement. Guests are considered on a first-come, first-served basis, but accepted guests can "reserve" a bed for two weeks. This allows for some stabilization. The shelter is administered and operated by Phillips Brooks House, and is staffed largely by student volunteers; social service interventions are provided on an outplacement basis by various agencies. The shelter philosophy is to accept as wide a range of clients

as possible. This tolerance, and its lack of a referral requirement, has meant that it houses "problem" clients, often clients who have been banned elsewhere. Limited client records suggest that about 200 persons are served annually, with about a 20% turnover in guests in each 6-month period. The shelter operates from November through April.

First Church Congregational has operated a 12-bed men's shelter since December 1986 in the church basement. A small paid staff, augmented by volunteers, runs the shelter and offers limited social service assistance to clients. The average length of stay for guests is 21 days, and it appears from available records that about 40 unduplicated persons total have been served in the facility's last year of operation. The population has been a relatively stable one, with about 15% turnover in the two months for which client records were reviewed. Beds are available on a referral basis. The shelter is relatively forgiving of rule violations but does bar active drinking and violence. Initially about 80% of the caseload was referred from University Lutheran (representing the most stable clients at that shelter); more recent referral sources have included Shelter, Inc., Boston facilities, and the DHSP. Discharges have been made to other shelters, hospitals, and the street.

This was established as a winter shelter and is slated to close in May.

Albany Street Emergency Service Center, operated by CASPAR since 1980, houses from 60 to 70 public inebriates each night. It is a walk-in shelter with no referral required, and operates basically on a first-come, first served basis (although some debilitated clients are allowed to stay inside during the day). Actively drinking men and women are accepted, and there is no limit on the length of stay. Guests will be assisted in making contact with social services if they request help. Most of the guests are "regulars" and about 60% have used the center since it opened seven years ago; about 10 new guests are identified each month. Long-term residence at the shelter is limited to residents of Cambridge and Somerville, although intoxicated persons from outside this area will be admitted for one night. It appears that an unduplicated total of over 150 persons is served annually. Clients are mostly self-referred, although some come from detox programs, the police, or other shelters; guests are not formally discharged, but many are returned to detox programs or to other inpatient hospitals.

The Armory Shelter, located in the Concord Avenue National Guard facility, opened in February 1987, with a capacity of 20 men. Begun under the auspices of the

Department of Human Services, responsibility for daily operation was transferred to volunteers from Philips Brooks House shortly after opening and has now returned to the DHSP. Admission to the shelter is by referral, and guests can reserve a bed for two weeks. Initially, some 70% of the shelters' beds were filled by referrals from University Lutheran; referrals now come from other shelters and the DHSP. Since its opening the shelter has served about 80 unduplicated clients. Discharges were principally to other shelters, but permanent placements were also made; in the month of April, at least 5 clients located stable housing. Originally established to run through May 1, efforts are now being made to extend operations into the summer.

YMCA and YWCA rooms

The Cambridge YWCA maintains three rooms utilized for homeless clients: two, identified as "transitional" placements are funded and supervised by the Department of Human Services. The third is utilized as a "walk-in" shelter. The YMCA also maintains 9 DHSP-funded transitional rooms. Efforts are underway to expand these resources through a combination of DPW funds for staffing and 707 certificates, through the Cambridge Housing Authority, for rental subsidies.

3. Other resources for the homeless

In addition to a total of 123 shelter beds incorporating room and board and some varying level of staff assistance, other resources specifically for the homeless include meal programs, drop-in programs, outreach medical and social services and case management/referral services of various kinds. Cambridge agencies, public and private, offer 12 meal programs serving approximately 180 persons per week, and three drop-in day or early evening programs, amounting to about 40 hours per week. Medical outreach services have been initiated through Cambridge Hospital, and a jointly funded position sponsored jointly by DMH and the DHSP has begun psychiatric assessment and treatment in shelters. The DHSP currently fields three staff persons providing case management, counseling and housing assistance to homeless persons, and administers a DSS-funded housing search contract which provides resettlement services to AFDC families in emergency hotel or motel placement. Similarly, the Salvation Army provides a full-time social worker concentrating on housing and benefits issues with homeless persons. Finally, several agencies, including DHSP and Catholic Charities, provide emergency financial assistance to persons in need. A multi-service center incorporating a range of colocated services for the homeless is scheduled to open under the auspices of the DHSP in May 1987.

C. Unmet Shelter Needs

The goals of housing programs for the homeless are twofold. The first goal is to supply homeless people with shelter and the necessities of a safe existence; the second is to relocate them in stable living situations.

Cambridge is much closer to reaching the first goal than the second. On April 13, during the University of Mass. one-night census, the Cambridge service system had a capacity of 143 beds; while five persons were turned away at Shelter, Inc., a total of 7 beds in various shelters were also unoccupied for the night. One-night counts conducted by the Department of Human Services during the winter months of 1986-87 showed a consistent turnaway rate of 15-20 per night; after the opening of 20 new beds at the Armory shelter, this declined to an average of 5-8 persons per night.

Although expressed demand cannot be considered exactly equivalent to unmet need, Cambridge appears close to meeting the expressed demand for shelter beds. As part of a large system in which the need for shelter is overwhelming (Paul McGerigle estimated in 1985 that there were 2,000 homeless persons in Boston) it is in fact doubtful if the demand can ever be met exactly; unless Cambridge "residence" is required of guests, there appears to be a virtually unlimited pool of unhoused persons in

Boston which will fill new beds, and generate some unfilled requests for service, as well.

Requiring proof of residence from homeless people is not a serious possibility. However, measures which would tend to define a separate population of clients in the Cambridge service system might have several benefits. They would help service agencies plan more effectively and deliver better services to clients; they would help shelter guests establish a stable home base; and would be more humane than the current circuit to and from Boston. Such measures would include those recommended by Carol Johnson, Homeless Coordinator for DMH, who suggests that municipalities strive to develop a "closed system," with uniform intake procedures, case management, and lengthened shelter stays.

Cambridge shelter operators are already encouraging this kind of stabilization, by moving toward a transitional model of sheltering. Some, such as Shelter, Inc., have gradually increased the average length of stay, while concentrating on social work interventions; the most recently established shelter options--the Armory, First Church Congregational, the YMCA/YWCA rooms--have identified themselves as "transitional" from the outset, allowing clients to reserve a bed for an extended period, and targetting staff assistance to the problem of finding permanent housing.

These modifications have seen modest but real success, in terms of clients placed. Operators who have studied rehousing programs in other cities have observed that the effectiveness would be increased by the addition of daytime shelter programs, and by the availability of more staff for intensive casework. The opening of the Central Square Multi-Service Center in May, with outplaced staff from several state agencies as well as full-time social workers, should be useful in this regard.

Based on the characteristics of the sheltered population seen in this survey, it seems likely that significant numbers of the Cambridge homeless will not, however, be permanently rehoused through short-term transitional programs. Some subgroups of the population require a longer period of intensive staff assistance; some can be expected to require supportive housing indefinitely.

Based on the judgment of operators and the material collected in this study, the need for the following shelter types exists:

- 1) Transitional shelter for families. Transitional housing for at least ten families is needed to meet the immediate demand; i.e., to return hotel/motel families who have been displaced from Cambridge to their community. Some of these families would require only a short-term stay, but at least 90% would need a period of three to six

months with intensive support services to find affordable housing and prepare a stable system of community supports.

Some "multi-problem" families identified by Bassuk, et al., and others with very few potential sources of support or significant psychosocial problems, will need a longer-term housing option. Need for at least one regional resource providing shelter and support services for a year or more is indicated; it would house 5-6 families at most.

2) Emergency shelter for individuals. During the winter months Cambridge appears to have adequate bed capacity in this "walk-in" category. However, it would be desirable to continue 15-20 additional "winter" beds through the summer months. This kind of shelter would ideally serve two kinds of clients: persons who have lost their homes recently and need immediate shelter for a short time, and individuals who resist any more structured service. Triage to identify the needs of new clients is important in this rung of the sheltering system, since some of the short-term homeless can be rehoused quickly, while other cases need transitional housing. Given the presence of a chronic mentally ill population group in shelters, it may be desirable to consider a small (6-10 bed) separate facility for service-resistant persons.

3) Short-stay transitional shelter for individuals.

This kind of shelter offers a reserved bed for two weeks to one month, and provides intensive social work services concentrating on benefits, income and housing issues. It appears to be effective in rehousing clients whose needs are most severe. Cambridge could utilize up to 40 beds in this category.

4) Long-term transitional housing for individuals.

Clients with more severe psychosocial problems, and those whose homelessness has been prolonged, are not rehoused effectively in two weeks. A six-month to 18-month program appears more appropriate for severely impaired persons, who may suffer primarily from alcoholism or mental illness. Such a program would be similar to a community halfway house, with the distinction that residents, drawn from emergency shelters or short-term transitional shelters, would have some special needs resulting from the experience of homelessness. Clear indications exist for at least one facility housing 8-10 persons who have diagnosed mental illness or alcoholism, and are evaluated as capable of returning to more independent living.

5) Transitional shelter for adolescents. Young people are also most effectively rehoused from short-term shelters. At least 5-10 transitional beds, and perhaps significantly more, could be utilized to accommodate

adolescents who leave Shortstop, Inc. and other youth programs with no permanent destination.

6) Permanent supportive housing. A fairly large number of currently homeless individuals will need indefinitely continued supportive housing: group homes, congregate living, or staffed lodging houses. Staff estimates suggest that 40% of the sheltered population falls into this category, indicating a need for 50-60 units. Ideally, homeless persons with permanent problems affecting their ability to live independently would move from short-term transitional housing to a permanent placement.

7) Follow-up and continued supportive services in independent housing. Almost without exception, families and individuals moving out of an emergency or transitional shelter will need some level of continuing service in the home. While the scope of the in-home service required may be expected to vary widely, the experience of workers who place families and individuals suggests that long-range (3 to 12 month) services should be available. This assumes, of course, the suitability of the permanent housing to which the client moves--in particular, its affordability. Without an adequate stock of affordable housing--and workable subsidy arrangements, such as Chapter 707 or Section 8 certificates--the cycle of homelessness will be repeated.

VII. Conclusions

"Supportive housing" is a new term, but it usefully capsulizes the major social service needs of a large number of Cambridge residents. Like all cities, Cambridge is home to persons with mental illness, mental retardation and alcoholism; some of its youth is troubled; some of its most vulnerable families and individuals become homeless. For many members of these groups, a combination of social services and affordable housing can make life in the community possible. Such combinations of housing and services come in a wide variety of forms, some intended to be permanent, some serving as stepping stones to independence.

In Cambridge, the supply of supportive housing of all kinds is insufficient to meet the needs of residents. Some of the most critical unmet needs include:

- group homes, supervised apartments and congregate housing (such as staffed lodging houses) for persons with mental illness;
- specialized group homes for retarded persons;
- emergency shelter and halfway houses for recovering alcoholics.
- emergency shelter, group homes, and supervised apartment housing for adolescents.

The lack of supportive housing alternatives tends to put vulnerable individuals at increased risk of homelessness. The guests in Cambridge shelter facilities show a high incidence of mental illness, alcohol abuse, and other disabilities which would make them appropriate candidates for supportive housing. In addition, the debilitating effects of life on the street create special needs for support.

Consequently, rehousing the homeless requires the availability of an increased stock of supportive housing. Some of the specific types of shelters, transitional living arrangements, and permanent supportive housing needed by the Cambridge homeless population are:

- walk-in emergency shelters for the newly homeless individuals and persons who will not accept more structured environments;
- short-term "stabilizing" or transitional shelter for individuals and families, linked to day programming and social service assistance;
- long-term transitional housing for individuals and families, designed to help place persons with significant special needs in independent housing;
- group homes, congregate housing, or staffed lodging houses for homeless individuals who have permanent disabilities which prevent them from attaining independence.

An additional barrier to the provision of effective transitional services for special-needs groups, and the homeless, is the scarcity of affordable housing and rental subsidies. This generally means that program "graduates" are placed outside Cambridge.

SRO's and lodging houses are a form of affordable housing which is not formally "supportive," but which is critical to maintaining marginal individuals in the community. Privately run lodging houses are disappearing very rapidly in Cambridge, leaving the only major operators of SRO stock, the YMCA and YWCA, with a high-need population which they are not equipped to serve. Further erosion of the city's SRO stock will almost certainly contribute to increased homelessness.

Creation of new supportive housing--whether by groups set up to serve special-needs populations or by agencies which shelter the homeless--has been extremely slow over the past ten years, despite the continuous efforts of providers. At least 17 agencies have attempted to develop supportive housing in Cambridge since 1978; in that time, only one new free-standing facility has been built. All other increases in the stock of housing have been attributable to CHA set-asides of new units; new shelters have been established only

in makeshift quarters--the National Guard armory and church basements.

The barriers to new development have been threefold. In the cases of 5 out of 17 agencies, access to capital and operating funds was an issue. All 17 agencies cited difficulty locating a suitable property (i.e., one that was not extortionately expensive, in good enough condition to be rehabbed, located close to services). And all agencies experienced difficulty with current zoning requirements for community residences, combined with lack of community acceptance upon action to seek permits and variances.

VIII. Recommendations

Several tactics are available for the development of a more adequate stock of supportive housing.

The complexity of the problem and the protracted timetable of housing development suggest the institution of a formal long-range planning process for supportive housing. Such a process would involve appropriate municipal departments and provider agencies from the community in the creation of a multi-year plan. The planning process could take into account the regional nature of problems such as homelessness through liaison with providers in other cities.

Such a group should identify and prioritize specific development goals for a range of client populations and

identify resources for construction and operation of facilities. Development goals should be flexible, and provision for periodic reassessment of changing needs is desirable.

In the near term, some specific municipal actions could significantly increase the opportunities for existing nonprofits to develop supportive housing. These might include review of existing zoning restrictions on community residence sitings. Very minor modifications in siting requirements--for instance, a change from "facilities per 1,000 population" to "beds per 1,000 population" would create a window for development without running the risk of 'over-institutionalizing' neighborhoods.

Zoning has proven to be the single highest barrier to the creation of supportive housing, but other measures could also have a useful effect. A unified effort to identify potentially usable properties would eliminate some duplication of effort. Various strategies for improving the capital financing picture for nonprofits, such as land banking, earmarking linkage payments, or pooling some property assets, could be explored. A campaign of community education--not linked to a particular property acquisition--could also be tried.

While efforts are made to stimulate new development, the preservation of existing resources--such as SRO beds--should also be considered.

Finally, providers in the emergency service system should be encouraged to emphasize the development of transitional services, both longer-term housing and "stabilization" services such as daytime shelter, case management, and coordinated intake.

Cambridge Homeless Shelter Questionnaire

Hello. I represent the Cambridge Department of Human Services. We are trying to find out who is here tonight so we know what are the shelter needs of people in Cambridge. If you don't mind, I will ask you some questions: Your answers are and will remain completely anonymous.

- 1) How old are you? _____ years
- 2) Are you: 1. female 2. male?
- 3) What is your race/ethnicity?
 1. white
 2. black
 3. Hispanic
 4. other
- 4) Are you married?
 1. single
 2. married
 3. divorced/separated
 4. widowed
- 5) Are you a veteran?
 1. no
 2. yes
- 6) Do you have any family in the area?
 1. no
 2. yes
- 7) When did you last have a regular place to stay? ___/___/___
- 8) Where was that?
 1. Cambridge
 2. Boston
 3. Somerville
 4. Other Mass.
 5. Other _____
- 9) What kinds of places have you stayed at during the last two months?
 1. own house/apt.
 2. relative's/friend's
 3. shelter _____
 4. rooming house/hotel
 5. street/subway
 6. other _____
- 10) Do you receive any financial benefits (welfare, SSI, AFDC, foodstamps)?
 1. No
 2. Yes. Specify: _____
- 11) Have you worked during the last two months?
 1. No
 2. yes, part-time
 3. yes, full-time
- 12) Do you feel you have any problem with drinking?
 1. No
 2. Yes
- 13) Compared to most people your age, is your health better than most, about the same as most, or worse than most?
 1. Better than most
 2. about the same
 3. worse than most
- 14) Have you seen someone for a mental or nervous problem in a hospital mental health center in the last year?
 1. Yes
 2. No
 3. Unsure

Figure 1
One-night Survey of Cambridge Sheltered Population

Characteristic	Not CASPAR (N = 39)	CASPAR (N = 53)	Total (N = 92)
AGE (years)			
Median	34	52	43
Mean	35	48	42
Range	20-52	27-78	20-78
SEX			
M	(33) 85%	(48) 91%	(81) 88%
F	(6) 15%	(5) 9%	(11) 12%
RACE			
White	(29) 74%	(46) 87%	(75) 82%
Black	(7) 18%	(3) 6%	(10) 11%
Hispanic	(1) 3%	(0)	(1) 1%
Other	(2) 5%	(1) 2%	(3) 3%
MARITAL STATUS			
Single	(21) 54%	(19) 36%	(40) 43%
Married	(2) 5%	(1) 2%	(3) 3%
Divorced	(16) 41%	(32) 60%	(48) 52%
VETERAN STATUS			
Yes	(17) 44%	(31) 58%	(48) 52%
No	(21) 54%	(21) 40%	(42)
FAMILY IN AREA			
Yes	(22) 56%	(48) 91%	
No	(17) 44%	(3) 6%	
TIME HOMELESS			
1 mo.	(8) 21%	(0) 0%	
1-3 mos.	(14) 36%	(1) 2%	
4-11 mos.	(2) 5%	(4) 8%	
1-3 yrs.	(14) 36%	(15) 28%	
4-6 yrs.	(0) 0%	(12) 23%	
7+ yrs.	(1) 3%	(22) 42%	

46%

(70) 76%
(20) 22%

(8)
(15)
(29)
(2)

Figure 1 (cont'd)

Characteristic	Not CASPAR (N = 39)	CASPAR (N = 53)	Total (N = 92)
LOCATION OF LAST PERMANENT HOME			
Cambridge	(4) 10%	(40) 75%	(44) 48%
Somerville	(3) 8%	(8) 15%	(11) 12%
Boston	(13) 33%	(2) 8%	(15) 16%
Massachusetts	(7) 18%	(0) 0%	(7) 8%
Not Mass.	(10) 26%	(0) 0%	(10) 11%
OTHER PLACES RECENTLY UTILIZED			
Other shelter	(34) 87%	(2) 4%	(36) 39%
Own home	(5) 13%	(0) 0%	(5) 5%
Relative/Friend	(7) 18%	(0) 0%	(7) 8%
Lodging house/Hostel	(1) 3%	(0) 0%	(1) 1%
Street	(7) 18%	(19) 36%	(26) 28%
Other	(2) 5%	(0) 0%	(2) 2%
BENEFITS			
None	(21) 54%	(26) 49%	(47) 51%
Welfare	(4) 10%	(7) 13%	(11) 12%
Food stamps	(6) 15%	(0) 0%	(6) 7%
SSI	(4) 10%	(18) 34%	(22) 24%
AFDC	(2) 5%	(0) 0%	(2) 2%
Disability	(1) 8%	(0) 0%	(3) 3%
FR	(5) 13%	(0) 0%	(5) 5%
Other	(1) 3%	(0) 0%	(1) 1%
RECENTLY WORKED?			
No	(22) 56%	(50) 94%	(72) 78%
Full-time	(9) 23%	(0) 0%	(9) 10%
Part-time	(8) 21%	(3) 6%	(11) 12%
PROBLEM WITH DRINKING			
Yes	(9) 23%	(52) 98%	(61) 66%
No	(30) 77%	(0) 0%	(30) 33%
HEALTH			
Better than average	(9) 23%	(0) 0%	(9) 10%
Average	(24) 61%	(34) 64%	(58) 63%
Worse than average	(6) 15%	(19) 36%	(25) 27%
MENTAL HEALTH PROBLEM			
Yes	(9) 23%	(10) 19%	(19) 21%
No	(30) 77%	(42) 79%	(72) 78%

Figure 2

Estimates of Unmet Need for Supportive Housing

Population	Housing type	Beds Available	Unmet Need		
			Based on local waiting lists ³	DMH client survey ⁴	YMCA, YWCA, & Met. State ⁵
1. Mentally Handicapped Adults					
I.	Highly structured group home	10 ¹	20	24	40
II.	Moderately structured group home	24	15)	39	35
III.	Staffed apartment	16	10)		
IV.	Independent apt. living with services available	12		189	
V.	Staffed lodging house or congregate	0		47	110
Totals		62	45	299	185

Notes

- 1, 2 This is a two-city catchment area. All figures shown are for Cambridge only. Additional resources are available in Somerville.
- 3 These numbers are taken from "active" waiting lists. Cumulative "inactive" waiting lists total over 400 individuals.
- 4 Results of an August 1985 client survey, identifying clients in need of residential services (and not then in residential placements)
- 5 Staff estimates of Y residents and Met. State patients awaiting discharge to residential placement.

Providers

CASCAP, Inc. YMCA/YWCA in cooperation with CASCAP
 Wellmet, Inc.

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet Need
			Based on unserved/ underserved client information provided to DMH
2. Mentally Retarded Adults	I. Highly structured apartment program	12 ¹)
	II. Moderately structured apartment program	7 ²	
	III. Respite care	0 ³	4 ⁴
	IV. Specialized group home (for clients with specific behavioral or medical problems)	0	4 ⁵
Totals		19	24

Notes

1, 2, 3 This is a two-city catchment area. Figures shown are for Cambridge only. Additional resources are available in Somerville.

4 Five "respite" beds exist in Somerville, but cannot be used their intended purpose because the original "respite" client has no alternative placement.

5 Based on existing case files.

Providers

Walnut Street Center, Inc.

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet need Based on referrals
3. Adolescents	I. Emergency shelter	7 ¹	140 (28) ²
	II. Group residences for youth under 18	36 ⁶	240 (36) ³
	III. Group residences for youth 17 1/2 - 18	0	10 - 12 ⁴
	IV. Staffed apartments for parenting teens	4	4 - 6
Totals		47	82

Notes

1 Facility in Somerville

2, 3 These are regionally scarce resources which attract a large number of referrals from outside the local area. Figures in parentheses are staff estimates of Cambridge referrals.

4 Staff estimate not based directly on referrals

6

Providers

Hastings House
 Castle School
 Shortstop, Inc.
 Catholic Charities of Cambridge/Somerville

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet need Based on referrals
5. Battered women	I. Specialized family shelter	10 ¹	10 - 15 ²
	II. Transitional family housing	0	10 - 15 ³
Totals		10	30

Notes

- 1 Battered women from Cambridge are housed outside the city, notably at Respond and Waltham Support Committee shelters.
- 2, 3 Staff estimates of Cambridge referrals. A total of approximately 350 referrals are unserved each year at Transition House due to lack of space.

Providers

Transition House

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet need Based on referrals
4. Alcoholic/ Substance-abusing	I. Emergency shelter	55	15 - 20
	II. Detoxification	30 ¹	10
	III. Halfway house	40	20
	IV. "graduate" house	15 ²	10 ³
	V. Specialized halfway house		
	- elderly	0	6 - 8 ⁴
	- adolescent	0	10 - 15 ⁵
	VI. Residential treatment facility--substance abuse	0	8 - 10 ⁶
	VI. Community residence post-treatment substance abuse	0	10 ⁷
Totals		140	103

Notes

1, 2 Facilities in Somerville. This is a two-city catchment area. All other figures shown are for Cambridge only. Additional resources in Somerville.

3 - 7 Staff estimates from case files

Providers

CASPAR, Inc.
Central Hospital
North Charles Institute

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet need Based on referrals
6. Homeless individuals	I. Emergency shelter (walk-in)	24 ¹)	20 current referrals
	II. Short-term stabilized shelter (up to 1 mo.)	56 ²)	
	III. Long-term transitional shelter	0	30-40 staff estimate
	IV. Specialized transitional shelters		
	- MH	0	20-30 staff estimate
	- parenting adolescents	0	4-10 staff estimate
	V. Staffed lodging house or congregate housing	0	10-20 staff estimate
Totals		80	120 (duplicated count)

Notes

1, 2 A total of 55 beds are available only between November and April.

This is a very fluid, multi-city population. Additional resources are available in Somerville and Boston.

The number of unduplicated clients served by all Cambridge shelters exceeds 500; approximately 7-8% of sheltered homeless persons in Boston are judged to be former Cambridge residents (UCPC, 1983, 1986).

Figure 2 (cont'd)

Population	Housing type	Beds Available	Unmet need Based on referrals
7. Homeless families	I. Emergency shelter	12 ¹ families	6 - 20 ²
	II. Long-term transitional shelter	0	10 - 12
Totals		12 families	32 families

Notes

1 DPW/DSS caseloads represent a two-city catchment area; numbers shown represent Cambridge only.

2, 3 DPW referrals and staff estimates.

Families are not as mobile as homeless individuals, but the scarcity of shelter resources does produce a high number of Boston referrals to Cambridge resources. Over 400 families referred to Shelter Inc. (Boston and Cambridge facilities) were refused service during the past year for lack of space.

Providers

Shelter, Inc.) Families
 DPW/DSS)
 Shelter, Inc.
 University Lutheran Church
 First Church Congregational
 Armory Shelter
 YWCA
 YMCA

Partial List of Informants

Mental Health

- CASCAP - Michael Haran, Director
- Louise Marks, formerly "Y" program manager,
now DMH Homeless Outreach Worker.
- Wellmet, Inc. - Maria Altamore
- ACS - Ginny Lorentz, Cambridge team leader
- DMH-MH - Carol Johnson, State Homeless
Coordinator
- Mark Pomerantz)
- Barry Kling) Housing Services
- Marian Cummings)
- Metropolitan State Hospital
- Ed Golowka,
- Cambridge Hospital
- Alan Segal, M.D. Director, Department
of Psychiatry
- Mary McCann, Intake Coordinator
- Ellen Sinnot, R.N., Psychiatric
Emergency Nurse

Mental Retardation

- Walnut Street Center - Claire Olsen, Director
- DMH-MR - Linda Loving)
- Debra Grzywacz) housing services

Adolescents

- DHSP - JoAnne Barbour, Adolescent Services
Coordinator
- Shortshop - Tom Hall, Director

- CEOC - Steve Meacham, Tenant Assistance
- DSS Area Office - Susan Abole, Family coordinator
- DPW Area Office(s) - Diane Yonkers) Housing Workers
- Diane Punch)
- Long Island Shelter - Sr. Debbie Chaussee, Asst. Dir.
- Pine Street Inn - Richard Ring, Director
- DSS - Laura Liscio, Homeless Coord.
- DMH - Carol Johnson, Homeless Coord.
- United Community Planning Corporation
- Paul McGerigle

Battered Women

- Transition House - Carol Post

Offenders

- Massachusetts Halfway Houses, Inc.
- J. Bryan Riley, Director
- Governor's Criminal Justice Commission
- Patrick Hamilton
- National Institute for Sentencing Alternatives
- Mark Corrigan, Director

Alcohol/substance Abuse

- CASPAR - John Grand, Director
- North Charles Institute for the Addictions
- Jan Kaufman, Director
- Massachusetts Substance Abuse Providers Assoc.
- Linda Perlmutter, Director

- DPH - Div. Alcoholism

- Harriet Robbins, Area Director
- Jack O'Neill, Former AD
- Dennis McCarty, M.D., Research Dir.
- Joe Vallely, Housing and Homeless Specialist

- Central Hospital - Martha Spires, R.N., Detox Nurse

Mixed Populations

- EOCD

- Sally Rizzo
- Nancy Kaufman

- CHA

- Barbara Galvin, Tenant Services
- Steve Swanger, Director Tenant Services
- Terry Lurie, Dir. Planning
- Kathleen Potter, Emerg. Applications
- Judy Fines, Planner

- YWCA

- Molly Lovelock, Director
- Val Hinderlie
- Helen Siciliano, Residence Director
- Anne Winestock, Resource Developer

- YMCA

- Richard Foote, Director
- Ronald Lahti, Residence Counselor

- Urban Initiatives, Inc.

- Liz Rosenbaum, Dir.

- Massachusetts Council of Human Services Providers

- John McManus, Director

- Community Program Innovations

- Lisa Kaplan, Director

- Vanderbilt YMCA, New York, NY

- Jim Raines, Director

- YMCA National Board

- John Farrell, Director

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Ellen Gallagher, No Place Like Home: A Report on the Tragedy of Homeless Children and their Families in Massachusetts, Massachusetts Committee for Children and Youth, Inc., September 1986.

The Gerontology Institute, College of Public and Community Service, University of Massachusetts at Boston, Licensed Lodging Houses, City of Cambridge Department of Human Services, Organization for Elder Cooperative Housing Options, Inc., November 1986.

Greater Boston Adolescent Emergency Network, Massachusetts Committee for Children and Youth, "Ride a Painted Pony on a Spinning Wheel Ride..."--A Survey of Massachusetts Youth in Need of Permanent Homes, September 1985.

House Committee on Ways and Means, Commonwealth of Massachusetts, A Capital Plan for the Department of Mental Health: Commitment to the Future, February 23, 1984.

Interagency Homeless Planning Group, Executive Office of Human Services, Commonwealth of Massachusetts, The Family Think Tank Report, September 1986.

Massachusetts Organization of State-funded Shelter providers, A Service Model for Homeless Families, August 20, 1986.

Ontario Task Force on Roomers, Boarders and Lodgers, A Place to Call Home: Housing Solutions for Low-income Singles in Ontario, Ministry of Housing, Province of Ontario, December 1986.

Russell K. Schutt, Boston's Homeless: Their Backgrounds, Problems, and Needs, Department of Sociology, University of



City of Cambridge
Department of Human Service Programs
51 Inman Street, Cambridge, Massachusetts 02139, 498-9076

TO: Robert W. Healy
FROM: Jill Herold *JH.*
RE: Reports on Supported Housing and Homelessness
DATE: May 1, 1987

Attached are two reports which provide an overview of the availability and need for supported housing in the City and an outline of the City's response to the needs of the homeless population. The first document, An Outline of Supported Housing in Cambridge, provides an inventory of the supported housing currently available in the City, an assessment of the unmet need for these various housing options, and some recommendations for future direction. The second document, The City's Response to Homelessness, specifically focusses on the services which the City is developing to respond to the needs of homeless individuals and also includes recommendations for next steps. The two documents should serve as tools in establishing an overall policy for affordable housing for Cambridge's most vulnerable populations.

Community and Youth Services
498-9037/9072
Council on Aging/Elderly Services
498-9039

Recreation
498-9028
Community Learning Center
547-1589

THE CITY'S RESPONSE

TO HOMELESSNESS

IN CAMBRIDGE

MAY 1, 1987

Department of Human Service Programs

BACKGROUND AND PURPOSE

At the City Council's request this past January, a report on "The City's Response to Homelessness in Cambridge" was created to detail the City's initiatives in providing support and services for the homeless. The report included a summary of existing programs and staff and outlined series of new initiatives which increased the City's ability to respond to the problems of the homeless. The final sentence in that report serves as a fitting preamble to the current state of our efforts:

"There is more to be done but the City's deliberate and continued efforts will address the diverse problems of homelessness and create a Cambridge more responsive to the needs of its most vulnerable citizens."

More has been done. In addition to the implementation of the "new initiatives" mentioned in that previous report, over the past few months, the City has created, and is in the process of creating, a number of new supports and programs specifically oriented to the needs created by the "diverse problems" which victimize the homeless. Prior to detailing what "more" is being done and planned, the following is an update on the implementation of the "new initiatives" outlined in our previous report.

UPDATE OF JANUARY'S INITIATIVES

1. MULTI-SERVICE CENTER FOR THE HOMELESS - The City's Department of Public Works' crew is completing the rehabilitation of the space that will house a number of service providers and case workers. The Center will open in early May to provide homeless individuals, adolescents, and families a place to access much needed resources including help with income, benefits, finances, and housing.

2. EMERGENCY COMMUNITY CASE WORKER - This worker has been working with the homeless in Cambridge since February providing counselling and case management. Bilingual, with a mental health background, he has provided on-site case work at meal sites and shelters as well as expertise in locating and securing permanent housing for homeless individuals.

3. MENTAL HEALTH HOMELESS WORKER - This joint Department of Mental Health and City position was created to provide coordination, consultative, and crisis intervention services in addressing the mental health needs of the homeless. In offering on-site consultation and a mental health presence at meal sites and shelter programs, she is providing a support that has been previously lacking.

Additionally, she has organized a workshop for shelter providers and a meeting with the state's DMH Coordinator of Homeless Services.

4. MEAL PROGRAMS - Since January several new meal/drop-in programs have been added to the ones created in November and December. The City has coordinated the creation of these new efforts to insure that there is now a meal for the homeless on every night of the week. The combined work of social service agencies, including the Committee of Elders and the Salvation Army, and churches, including Our Lady of Pity, Pilgrim Congregational, St. Paul's, and the Harvard Square Churches, has dramatically increased the number of meals available to the homeless in the last four-month period.

5. CHILD CARE DROP-IN CENTER - This innovative child care program for the children of homeless families is based at the Salvation Army and has been in operation since the first week of January. In addition to coordinating the opening, the City is providing funding along with the Salvation Army, the Department of Social Services, and several private foundations.

6. FEMA MONIES - While the first round of this federal emergency funding provided assistance for persons faced with utility arrearages that would threaten their housing status, the recently received round of funding will

enable the City's Department of Human Services to maintain through the summer its four emergency shelter rooms at the two Cambridge Y's.

7. COMMUNITY OUTREACH - With the addition of the DMH/City Mental Health Coordinator, and the Emergency Community Case Worker to the family and Adolescent Caseworker and its Coordinator of Emergency Services, the City has intensified its outreach efforts to service providers to provide efficient and easily accessible services to the homeless.

The implementation of the above initiatives has provided a new measure of support and care for the homeless in Cambridge. Together with the other "on-going services" and "new initiatives" detailed in the last report, these efforts by the City represent a heightened commitment to address and resolve problems facing the homeless. As was indicated previously, all such efforts are rooted in the sense that collective action through heightened collaboration of all sectors of society is the best remedy.

"MORE TO BE DONE" - POST JANUARY INITIATIVES -
OPERATIONAL AND PROPOSED

While the initiatives described above, along with the on going services and other efforts detailed in the last report, address a range of problems faced by various segments of the homeless population, there remained a continuing sense that some basic needs and approaches were unattended. In a number of areas - emergency shelters, information and referral, transitional shelter, benefits and income, day program, family shelter, permanent housing, adolescent shelter, medical assistance, institutional involvement, and outreach - more needed to be done to insure the increased resources so vitally needed by the homeless.

As each area surfaced either through the needs assessment and planning process of the Department of Human Services or through direct interaction with the homeless or homeless advocates outside of the Department, a deliberate and collaborative approach was undertaken to coordinate resources in response to the presenting need. In responding with these "post-January initiatives", indicated below, the City has, wherever possible, attempted to go beyond a limited emergency response to further the process of creating a stable, comprehensive, and concrete program for Cambridge's homeless. Those areas of concern and the City's initiatives to access and target resources to them are as follows:

1. EMERGENCY SHELTER - Through a series of censuses conducted by the Department of Human Services during December, 1986, and January, 1987, it was determined that between fifteen and twenty individuals were unable to secure beds at Cambridge shelters and were turned away each night. Attempts to locate an additional site for this anticipated overflow has been ongoing since October, 1986 without success. A group of advocates from the Harvard Square Churches identified the National Guard Armory on Concord Avenue as an appropriate site and asked the City to explore that possibility with the State.

After negotiations with the Executive Office of Human Services, the Department of Public Safety, and the National Guard, the City secured the Armory as an emergency shelter. While the paperwork at the State was being finalized, the City opened the doors of the Tobin School to the shelter effort for a week and then transferred the operation to the Armory in late February.

The City operated the shelter for a week while evaluating proposals and subsequently granted the Phillips Brooks House, operators of the University Lutheran Emergency Shelter, the operational responsibility until April 15. As of April 16, the City resumed operation of the shelter. At the same time, given the closing of the

"Uni-Lu" Shelter and the impending closing of the twelve-bed First Church shelter, the City began negotiations with the National Guard and EOHS to extend the shelter operation beyond the previously agreed upon closing date of April 30. Permission to extend was secured as of April 28 and the City will continue its operation of the shelter into May and June.

In addition to a bed for the night, the program provides both dinner and breakfast. The City's Community Case Worker, its DMH worker, and the Coordinator of Emergency Services have provided additional case work on-site.

2. INTAKE AND REFERRAL - With the opening of the Armory as the fifth Cambridge shelter, there was increased need for coordination of shelter resources as well as for appropriate shelter referrals. In early March the newly hired intake and receptionist staff person for the Multi-Service Center began the process of planning for a future shelter referral process. Such a process is a critical element in multi-shelter systems to insure appropriate referrals. Additionally, this staff person began working with the Community Case Worker in helping homeless persons obtain social services.

3. TRANSITIONAL SHELTER - The City is committed to help locate a site for a twenty bed, twenty-four hour transitional shelter for homeless individuals. In that almost all shelter programs for individuals are closed during the day, this program would provide additional resources and social services for its homeless guests. The City has arranged for a Community and Development staff person to work with service providers in locating a suitable site for the program.

4. TRANSITIONAL HOUSING ROOMS FOR INDIVIDUALS - While a permanent site is being sought for the shelter described above, there are a number of "housing-ready" homeless individuals who are capable of independent living but who unfortunately are often priced out of available apartments in Cambridge. To address the need for temporary, transitional, affordable housing for these homeless persons, the City is joining with the Executive Office of Human Services, the Department of Public Welfare, and the two Cambridge Y's to make available funding and Y rooms for a transitional program. Between fifteen and twenty rooms will be secured over a period of months and will be utilized to temporarily house housing-ready homeless persons. These rooms, along with the rooms already secured at the Y's as emergency rooms, will add twenty beds for the homeless in Cambridge.

5. BENEFITS, SUBSIDIES, JOBS, AND TRAINING - To help in the stabilization of homeless persons placed in the Y rooms, increased access to benefits, subsidies, job training, and jobs will be necessary. Through increased income resources, "housing-ready" homeless persons have a better chance to find and secure permanent housing.

The City, in conjunction with EOHS and DPW support, will be hiring a social worker to aid homeless individuals in the Y rooms. Again, this worker's support will help both to increase income and to stabilize life, allowing heightened opportunities for permanent housing.

6. DAY PROGRAM FOR THE HOMELESS - Given that most shelters are not operative during the day for anywhere from ten to fifteen hours, there is a need to create a day drop-in program. The City has already begun negotiations with the Executive Office of Human Services to earmark money for such a program in anticipation of a suitable site being found. There is a commitment from EOHS that such funds are in "escrow."

7. FAMILY SHELTER - At the present time, homeless Cambridge families who receive Emergency Assistance from the Department of Public Welfare are displaced from Cambridge, usually to the Route 1 "motel strip" in

Revere, Malden, and Lynn. Often separated from their normal bases of support, cut off from families and friends, unable to cook or maintain normal family life, the conditions of the families deteriorate. Re-placement in permanent housing thereby becomes much more difficult. The need to keep these families in Cambridge in a suitable transitional apartment is critical for the well-being of the family members, especially the children. Further proximity and ready access to services will facilitate the re-placement effort.

At present, the City has identified a City-owned building to be utilized for family housing as a transitional shelter for five or six families. The Department of Human Services is coordinating the effort to identify a provider and to begin the program as soon as possible. Such a shelter will greatly aid homeless families being served by the program below.

8. HOUSING SEARCH FOR HOMELESS FAMILIES - The homeless AFDC families mentioned above are placed in hotels or motels for a specified period of time during which they are to be seeking permanent housing. There is a Department of Welfare program known as Housing Search which the Department of Human Services applied for and was granted in February, 1987. This program enables the

Department of Human Services to work with displaced, Cambridge families in their attempt to secure permanent housing in Cambridge or nearby.

The Department has hired two staff people to work with the families - one helping the families with benefits, subsidies, and income, the other helping the families to locate permanent housing. These two staff people work closely with the Department of Social Services case worker in helping stabilize the disrupted lives of these families. Obviously, the provision of a transitional family shelter in Cambridge will keep these families closer to personal and municipal resources and ultimately will make re-placement in permanent housing a less difficult process.

The Department of Human Services is also advising and supporting the YWCA in its commitment to create two new family shelter rooms in that facility. Since there are now only four family shelter rooms in all of Cambridge, the addition of the City building shelter and the Y rooms would increase this resource by 200%.

9. ADOLESCENT SHELTER - In the creation of the Teen Transitional Resource Center, the City and a number of collaborating agencies focused on the needs of older adolescents, especially those needing to develop

independent living skills. Often these older teens are displaced from their families and do not have access to social service resources available to younger or older persons. A number of young people in this homeless situation have been identified in Cambridge. Currently there are no housing resources available to meet their needs.

The City has identified a portion of a City-owned property which may serve as transitional housing for a program targeted at these teenagers. The Department of Human Services' Case Manager for Adolescents is presently seeking to identify a service provider to operate the program.

10. MEDICAL SUPPORT FOR HOMELESS PROGRAMS -

Increasingly, service providers have identified various medical problems of the homeless in meal and shelter programs. Often, without experienced medical volunteers or staff, the providers were faced with making a superficial response or attempting the time consuming task of securing medical assistance at the Emergency Room of the Hospital. In the late fall of 1986, service providers from meal and shelter programs approached the City and requested medical services.

Within a relatively short period of time, a medical team was organized at Cambridge City Hospital to provide on-site medical assistance. A team of nurses and doctors from the hospital are now directly involved in health care for the homeless both at homeless programs and at the hospital. The team has also linked up with a doctor from Harvard Medical Services who provided medical counsel for a shelter.

11. COMMUNITY INVOLVEMENT - In the past homelessness has often been perceived as an isolated problem impacting a given stereotyped population. With increased awareness of the varied population, the potential for greater community involvement is present.

The City negotiated with Harvard University to supply the food for two evening homeless meal programs. Currently, Harvard is supplying 250 full meals per week for the homeless.

Following up on a City Council recommendation, the Department of Human Services joined with the Chamber of Commerce requesting donations for the homeless. The resultant "Cambridge Fund for the Homeless" has collected over \$1,100 thus far along with a number of donated shelter items.

12. REGIONAL OUTREACH - A number of the most experienced homeless "researchers" in the Boston area speak of the homeless "ecosystem" which includes the cities of Boston, Cambridge, and Somerville. They speak of the "shared" population of homeless persons moving through the three cities and point out that Boston, with the largest population of homeless, has very little coordination and communication between service providers.

The City of Cambridge has actively sought the advice and counsel of such researchers and has attempted to integrate their findings, impressions, and recommendations into its planning process for the homeless. Dialogue concerning a regional approach to homelessness has been established with Carol Johnson, formerly the Director of the Massachusetts Coalition for the Homeless, and now the DMH Coordinator of Homeless Services; with Paul McGericle, whose studies of homelessness in Boston have been pivotal in that city's response; with Ellen Gallagher whose report "No Place Like Home" is based on the experiences of families in shelters; and with Ira Grieff, who is the director of Boston's largest day program for the homeless, St. Francis House. Additionally, the Department of Human Services maintains close relationships with the Massachusetts Coalition for the Homeless, the Greater Boston Housing Advocates Group, and the Interfaith Assembly for Housing and Homelessness.

Close working relationships also have been formed and nurtured with the other city in the "ecosystem", Somerville. Through shared programs such as fuel assistance and housing search, and through shared sponsorship of the Cambridge/Somerville Committee on Homelessness, the two cities have begun to address the problems of homelessness with a more regional approach.

In the past few months a closer relationship around homeless issues has also been created with the two state agencies whose policies most impact homeless issues, the Executive Offices of Communities and Development (EOCD) and Human Services (EOHS). In securing increased resources from these Offices for Cambridge homeless, the City has also laid the foundation for future program initiatives.

THE COLLABORATIVE APPROACH: COMMUNITY, STATE, AND REGION

All of these new City responses and initiatives are elements of a coordinated plan to fill the identified gaps in services to the homeless. As was stated in the January report, a collaborative approach is at the center of the City of Cambridge's response to homelessness. Even with all the on-going programs, the implemented

initiatives, and the projected plans, a collective effort of all sectors of our community is essential in addressing the problems of the homeless. Educational, institutional, religious, non-profit, governmental, and community groups all have a role to play and must do so to ensure the complementary services needed to bring relief to the homeless. That collaboration continues to develop and offers hope in finding solutions.

While collective efforts are essential within the community, the City also recognizes the need to collaborate closely with the State. A number of homeless initiatives originate at the State level and an aggressive outreach is being conducted to bring all such resources to Cambridge. Further, the neighboring cities of Boston and Somerville are being drawn in as part of the overall collaborative strategy. This regional cooperation is vital for the success of Cambridge's plan.

CITY INITIATIVES IN A CONTINUUM OF SERVICES

Model for the Strategy

In her formulation of "A Comprehensive Policy Approach to Homelessness", Nancy Kaufman, Secretary of the State's Executive Office of Human Services, described a "Continuum of Services" necessary to develop long-term

solutions to the problems of homelessness. She identifies four specific service orientations which acknowledge short-term emergency responses while addressing more long-term, permanent solutions. Her four point approach involves prevention, emergency, supportive, and stabilization services to the homeless.

The implemented and proposed City of Cambridge initiatives are part of an overall strategy on the part of the City to provide an enhanced continuum of services to homeless persons in Cambridge. The City strategy calls for the linking of municipal efforts to state initiatives and to local, private responses.

All of the individual efforts described above are made in the context of a coordinated strategy which addresses short and long-term emergency and permanent solutions. Rather than isolated reflex responses to the complex nature of the problems of the homeless, the City has called for, and acted out of, a deliberate, collaborative approach to formulate and create supportive services. As was pointed out in the January report, this intergovernmental, interagency, intergenerational, and decentralized approach sometimes appears slow-moving and cumbersome; but in its allowance of specific and varied responses in the framework of a coordinated strategy, this approach best ensures services focused on the special needs of the heterogeneous homeless population.

Bases of the Strategy

The City's plan of a collaborative, coordinated strategy to address the needs of the homeless can be seen in the specifics of the concrete efforts to provide emergency and permanent responses for homeless individuals and families. The strategy calls for:

1. Provision of preventative, emergency, support, and stabilization services.
2. Coordination of state, city, religious, educational, community, and non-profit resources.
3. Identification and support of local providers to create new programming for the homeless, especially a twenty-four hour transitional shelter for individuals, a family shelter, an adolescent shelter, and a day program.
4. Placement of housing-ready homeless in permanent housing with on-going supportive services.

Elements of the Strategy and the New Initiatives

Preventive Services - With the addition of the Community Case Worker, the Intake and Referral Worker, and the Multi-Service Center, the City will have provided a necessary link for individuals and families facing the loss of their apartments, and available, preventive resources. These new workers and the Center will better enable at-risk persons to secure all of the state, federal, municipal, non-profit, and charitable benefits designed to prevent displacement. Such programs include welfare assistance through AFDC, general relief, emergency assistance, emergency relief, fuel assistance, FEMA funds, housing services, legal aid, food pantries, and advocacy. On-going and new City programs are designed to bring together at-risk persons with these varied benefits to prevent homelessness.

Emergency and Supportive Services - Emergency services are the first step in stabilizing the lives of homeless persons. Shelter rooms and meal programs provide the essentials. The recent creation of the Armory Shelter and a number of nightly meal programs have supplemented existing emergency provisions. The proposed family and adolescent shelters will provide a new source of emergency assistance for these populations.

These crisis responses are essential elements in an overall plan, but are only the first stage of support. They can be viewed as the cornerstone of the continuum of services. However, further services are needed to help homeless persons move beyond the crisis to stability in rehousing.

For homeless individuals emergency winter shelters have provided relief in the coldest season. Only Shelter, Inc. and CASPAR have run year round programs for individuals. The addition of the Armory Shelter has provided more necessary winter beds. The proposal of a twenty-four hour, year round transitional shelter would create the transitional living situation necessary for homeless individuals to feel secure and stable. That stability, when complemented with social services, is a move away from crisis to stability, from homelessness toward rehousing.

The proposed Y rooms serve that same purpose. Intended for housing ready and recently homeless persons, they provide a resource for the transition from crisis to stability.

The Multi-Service Center and the proposed Day Program provide access to additional stabilizing resources. Increased support services and benefits will be available

through the Multi-Service Center, and the Day Program will provide a stable location and support services for persons in limited-hour shelter programs.

The provision of the additional beds of transitional housing, the Multi-Service Center, and the Day Program, along with on-site medical and mental health services, creates the next step in the continuum. These programs provide the now missing link between emergency response and permanent housing for homeless individuals.

The proposed family shelter will provide not only emergency relief, but also transitional housing for displaced families. On-site social services will enable households to move out of a crisis mode to the stability prerequisite for permanent placement.

Stabilization Services - Once individuals and families are placed in transitional housing, the next step in the continuum is re-placement in permanent housing. For homeless individuals, the Community Case Worker, the City Housing Assistance Program, and the proposed Social Worker will provide counsel and housing search services. Homeless families will be served by the City administered Housing Search Program. They will be further served by the City supported emergency child care program. The move

from emergency response through stabilization to permanent housing is the basis of the City's response to homelessness. All new initiatives are part of the continuum of services that support that transition. Coordination of federal, state, municipal, religious, non-profit, and community resources is integral to the continuum and another emphasis of the City's response. Without both the continuum and coordination of services, initiatives are isolated; with both, the initiatives are knit together in a needed comprehensive system of care for homeless persons.

LONG TERM SOLUTIONS: NEEDS

To address the housing needs of the homeless in Cambridge efforts must be expended to create increased supported and permanent housing. These efforts must include zoning modifications, creation of affordable housing for low and very low income persons and families, and support for existing affordable and transitional housing resources, specifically the two Cambridge Y's and lodging houses.

Special attention also needs to be given to accessing all available federal and state resources, especially through EOHS and EOCD, targeted for the at risk and homeless population. Given that many of these programs relate to housing - whether in the form of funds for transitional

housing, low-interest loans to create subsidized housing, or rental assistance subsidy programs intended for homeless families - they touch on a most critical need of the homeless. A coordinated effort of appropriate City and non-profit agencies is necessary to secure all such resources. The Mayor's Commission on Homelessness could provide the structure for such an enhanced collective effort.

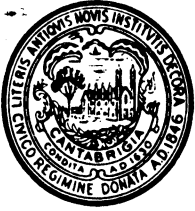
CONCLUSIONS

1. The Problem of Siting Programs

The intent, the will, the expertise, the collaboration, the access to resources, and the social service providers are all present in Cambridge to respond to the needs of the heterogeneous homeless population. At present the siting of programs continues to be the greatest impediment to creating a comprehensive system of response. Several of the proposed initiatives are wanting only for a location. The initiatives are having an impact, but the strategic plan requires the siting of several more programs in Cambridge. Until such critical programs can be established, efforts to provide long-term solutions will be frustrated.

2. The Problem of Re-Housing the Homeless

The benefit, subsidy, income, supportive, and stabilization resources are now being developed in Cambridge to establish homeless individuals and families as housing ready. At present the lack of available, affordable housing in the City continues to be a major obstacle facing such housing-ready individuals and families. A number of persons are wanting only for an affordable apartment. Once again the new initiatives are having an impact, but the fulfillment of the strategy requires housing. Until such housing is provided, efforts to end homelessness for even the housing ready will be frustrated.



CITY OF CAMBRIDGE

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EXECUTIVE DEPARTMENT
ROBERT W. HEALY
City Manager

RICHARD C. ROSSI
Deputy City Manager

May 4, 1987

To the Honorable, the City Council:

Enclosed please find copies of two reports from the Department of Human Services: "The City's Response to Homelessness in Cambridge", and "An Outline of Supportive Housing Needs in Cambridge".

Very truly yours,

Robert W. Healy
City Manager

RWH/mbf
Encs.

Re: enclosed copies of two reports from the Dept. of Human Services: "The City's Response to Homelessness in Cambridge", and "An Outline of Supportive Housing Needs in Cambridge".

In City Council,

May 4, 1987

*Referred to the Mayor's
Committee on the Homeless*

*Copy sent to Philip Mangano,
Human Services 5/18/87 mlh
-with transmittal letter-*