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Homelessness in Massachusetts
Perception, Policy, and Progress

Milton Argeriou, Ph.D.

Homelessness is not a new phenomenon in Massachusetts, nor are the "new" homeless of the 1980s and 1990s that different from the "old" homeless of previous decades. What is new is the societal response to the burgeoning population of homeless men, women, and children. Massachusetts's response to the problem of homelessness in the 1980s, as outlined in the Massachusetts Comprehensive Policy Approach, is examined and found to reflect commitment and creativity. However, the problem of homelessness in Massachusetts remains, the community appears frustrated, and current budget cutbacks do not augur well for future services to the homeless.

Homelessness in Massachusetts is not a new phenomenon. Henry Miller reports that as early as 1675, sixty-two refugees from the uprising of Indians in Rhode Island, arrived in Boston, "became public charges, and had to be 'warned away' and removed."[1] The response of the early settlers to these homeless individuals reflects the traditional, though disguised and denied, societal perception of the homeless as "troubled and troublesome individuals."[2] Attributing the cause of homelessness to the deficiencies of the homeless themselves has long provided balm for the social conscience and, more important, justified public policies that did not address the larger social and economic roots of homelessness.[3]

Beginning in the early 1980s, however, the perception of the homeless began to change, largely as a result of human interest stories prepared by reporters and analysts in the course of their documentation of the effects of the 1981–1982 economic recession.[4] In contrast to the undeserving homeless of the past, the "new" homeless were depicted as victims of forces beyond their control; "Homelessness was presented not as an individual problem with bad social consequences, but as a social problem that overwhelms individuals."[5] The homeless of the 1980s and 1990s are indeed different from the stereotypical homeless of preceding decades. The "new" homeless are younger, better educated, heavily populated with racial and ethnic minorities, and marked by higher rates of drug abuse.[6] They are also distinguished by the presence of a variety of subgroups, including large numbers of women,

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women with children, entire family groups, adolescents, veterans, and people with the dual diagnosis of substance abuse and mental illness.[7]

Despite these outward differences, the new homeless resemble the old homeless in many ways. For example, alcohol and drug abuse continues to play a significant role in the lives of homeless men, women, adolescents, and even children. In fact, alcohol and drug abuse is considered to be the most prevalent health problem among today's homeless.[8] According to James Wright, compared to nonabusing homeless, those who abuse alcohol or drugs "are generally in the worst possible shape, more estranged, less intact, sicker and with the poorest prospects for the future."[9] Prevalence estimates of alcohol and drug abuse among the homeless vary, depending on the sample, definition of homelessness, setting (for example, street versus shelter), the methods, and the assessment tools. Pam Fischer's exhaustive analysis of prevalence estimates published in "technically sound" studies during the 1980–1990 decade revealed rates varying from 8 to 68 percent for alcohol problems, and 10 to 20 percent for drug problems among homeless men and women.[10] Prevalence estimates derived from the Robert Wood Johnson Health Care for the Homeless Demonstration Projects showed approximately 38 percent of those serviced by the projects had alcohol problems, and approximately 13 percent exhibited drug-abuse problems.[11]

In addition to high rates of alcohol and drug abuse, other continuities between the old and the new homeless include high levels of mental illness, physical disability, criminality, and similar patterns of social isolation. The new homeless, as the old, are comprised of the most vulnerable of our society.[12]

In the rush to respond to the problems of the new and deserving homeless, the resemblance of the new to the old, and the intransigence and complexity of their problems, may not have been fully appreciated by even the most informed. It was assumed that with the application of sufficient and appropriate resources, the problem of homelessness could be resolved. Charles Hoch and Robert Slayton argue that this approach is misguided and fails to consider the major underlying causes of homelessness.

> Thus, the contemporary homeless are not a new kind of social group, but members of the single working poor victimized by urban policies that encourage the destruction of SROs (single room occupancies) and other types of low-income housing, changes in the national economy that increase unemployment and underemployment among the independent poor, and welfare policies that undermine the social autonomy of the dependent poor. A politics of compassion that identifies the vulnerabilities of the homeless as the cause of their predicament too easily overlooks the social and economic history of the urban working poor and their struggle for affordable shelter.[13]

While Hoch and Slayton may be correct, it remains that federal, state, and local governments were faced with the immediate need to respond to the burgeoning population of homeless men, women, and children. This article examines the Massachusetts response and attempts to assess its impact on the problem of homelessness in Massachusetts.

Massachusetts Homelessness Policy

The Massachusetts Comprehensive Policy Approach to Homelessness was the Michael Dukakis administration's response to the problem of homelessness.[14] The

four-part strategy included prevention, emergency services, supportive services, and permanent housing. It was based on a causal model of homelessness that included "a shrinking supply of affordable housing, poverty, domestic violence, alcohol and drug abuse, mental illness, family turmoil."[15]

Prevention of homelessness was the focus of landmark legislation passed in 1983, MGL Chapter 450: An Act to Prevent Destitution and Homelessness. The act removed the need to have an address to be eligible for state entitlement benefits such as AFDC, General Relief, and food stamps. Other strategies included emergency assistance, information and referral, housing services to prevent eviction, rent and utility payment, fuel assistance, and advocacy. Emergency services provided shelter, food, clothing, and financial assistance. Supportive services included outreach, day care, alcoholism programs, health care, twenty-four-hour crisis services, Medicaid/Medicare programs, housing counseling, and employment counseling. The fourth part of the strategy involved programs to stabilize homeless individuals and families by developing and providing housing, employment, and supportive services. A critical element in the provision of services and supports outlined in these four areas was the addition of a case management component operated to "guide the individual through the homeless crisis to appropriate services and housing," and prevent them from falling "through the cracks" and back into the homeless cycle. Taken together, the Massachusetts plan appeared to contain the ingredients necessary to reduce homelessness.

We are approaching the seventh anniversary of the implementation of the plan, and it is appropriate that we make an effort to assess its impact on the problem of homelessness in Massachusetts. Accordingly, I shall examine each of the four areas addressed by the plan, and attempt to assess progress achieved by examining a variety of indicators of homelessness, and concrete actions taken to reduce homelessness.

Prevention

Presumably, if prevention efforts are effective, the number of homeless individuals and families should decrease, or at least not increase, over time. While enumeration may be an imprecise and an indirect measure of prevention effectiveness,[16] it is instructive to examine available "counts" of the homeless. Enumeration of the homeless in the larger metropolitan cities began in the early 1980s.[17] Boston, one of the first cities to conduct a "one-night" count of the homeless, has carried out this one-night census six times since the first count was made on October 27, 1983. Table 1 presents the results of these enumeration efforts.

While there is considerable variation in the numbers of homeless over time, there is little basis to conclude that the size of the homeless population in Boston is decreasing. However, the possibility exists that the observed increase may be somewhat artifactual in nature. For example, there is some evidence to support the contention that Boston has become "a 'mecca' for the homeless."[18] Boston has had an open-door policy regarding the homeless and exhibited the willingness to increase emergency shelter beds to accommodate demand. This being so, the increase in the number of homeless shown in Table 1 may represent migration to Boston of existent homeless rather than an increase in the absolute number of homeless individuals.

The demand for emergency shelter is another indicator of the number of homeless and whether this number is increasing or decreasing. Since supply is a reflection of demand, an examination of the number of shelter beds available provides another

indication of the number of individuals needing shelter. Based on these data, there is little doubt that the number of individuals seeking shelter has increased dramatically in a brief period of time. In 1983, there were two state-funded shelters in Massachusetts.[19] Today the one hundred shelters supported by the Department of Public Welfare includes twenty-eight individual shelters and seventy-two family shelters. Shelters for individuals are generally larger than family shelters in terms of bed capacity. Overall, approximately twenty-five hundred beds are available in these hundred shelters.[20]

Table 1

Boston Census of the Homeless 1983–1990

	1983	1986	1987	1988	1989	1990
Males	2,056	1,861	2,198	2,150	2,289	2,406
Females	573	687	768	782	985	771
Children (under 17)	138	315	525	521	556	436
Totals	2,767[a]	2,863[b]	3,491[c]	3,453[c]	3,830[d]	3,613[e]

Sources:

[a]City of Boston, Emergency Shelter Commission, *The October Project: Seeing the Obvious Problem* (Boston: Emergency Shelter Commission, 1983).

[b]Raymond L. Flynn, *Making Room: Comprehensive Policy for the Homeless* (Boston: City of Boston, 1986).

[c]Emergency Shelter Commission, *City of Boston Homeless Population Census Winter 1988–89* (Boston: City of Boston, 1989).

[d]Emergency Shelter Commission, *State of Homelessness in the City of Boston Winter 1989–90* (Boston: City of Boston, 1990).

[e]Emergency Shelter Commission, *State of Homelessness in the City of Boston Winter 1990–91* (Boston: City of Boston, 1991).

In addition to shelters supported by the Department of Public Welfare, 153 transitional shelter beds are also provided in four psychiatric shelters supported by the Department of Mental Health, and an unknown number of additional beds are provided in an estimated thirty to forty other facilities supported by private funds. Figure 1 presents a graphic depiction of the growth in the number of shelter beds in Boston from 1983 to 1991.[21] Because approximately two thirds of the shelter beds in the state are located in the Boston area, the Boston data illustrate the growth of shelter beds statewide.

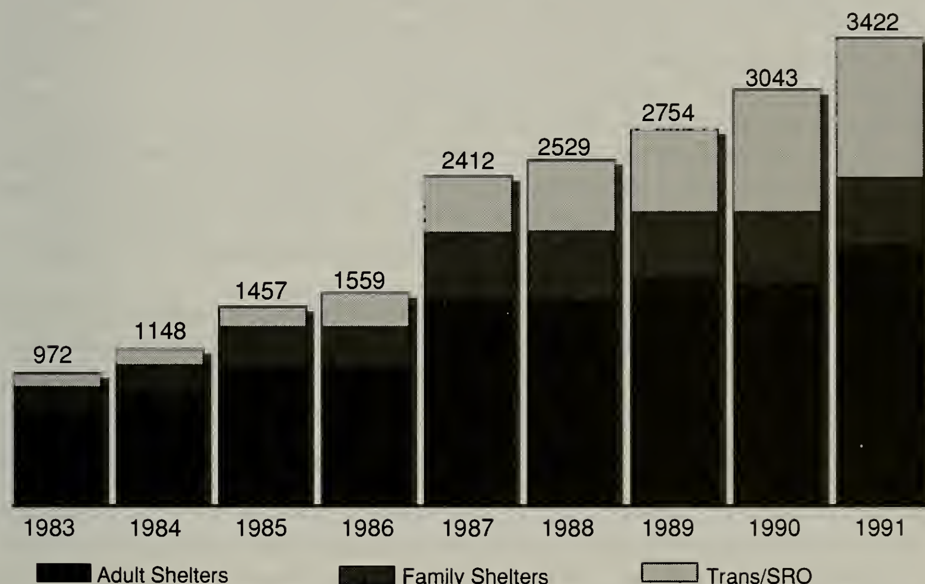
Does this increase in the number of homeless men, women, and children and the demand for shelter mean that prevention efforts have been entirely unsuccessful? The answer is most likely no. It is quite possible that the observed increases would be even higher without efforts to prevent homelessness. According to Massachusetts officials' reporting in 1986, prevention efforts had already provided $32 million to thousands of families to assist them to pay back rent and utility costs and avoid eviction. Another prevention effort involved mediation of landlord/tenant disputes, which involved 12,100 tenants and 7,600 landlords in the first eighteen months of the Housing Services Program begun in 1985. Other efforts included increases in AFDC payments, development of a model housing and employment program for AFDC recipients, modification of discharge policies to prohibit discharging the mentally ill

to the streets and shelters, and enactment of condominium conversion legislation, which "protects low-income and other vulnerable tenants from eviction."[22]

It remains, however, with the exception of efforts to preserve SROs, that many of the prevention efforts described in the Comprehensive Policy Approach to Homelessness are stopgap in nature, responding to immediate crisis situations of specific individuals and families. Such assistance may delay eviction, provide clothing, pay utilities, and so forth, over the short term, but are unlikely to prevent the inevitable loss of housing over the long term. To be truly preventative, efforts need to be expanded to encompass the larger underlying causes of the homeless, which are societal, not personal.

Figure 1

Shelter Beds in Boston



Source: Raymond L. Flynn, *Commitment and Compassion: Boston's Comprehensive Policy for the Homeless — Winter 1990–91* (Boston: City of Boston, 1991), 6.

Emergency Services

The data presented in Figure 1 highlight the commitment of Massachusetts to ameliorate the plight of the homeless and ensure the availability of shelter and food. Most noticeable, however, is the linear increase in the number of shelter beds. Elsewhere, the experience is similar.

> In January of 1983, New York City sheltered 4,676 men and 636 women in 18 shelter facilities, but four years later, the numbers had jumped to 9,000 men and 1,100 women in 18 facilities . . . . In Chicago, the number of emergency beds skyrocketed from approximately 700 beds in November 1982 (none of which were specifically designated for the homeless) to more than 2,000 beds in 1986.[23]

Of particular concern to some observers is the growth of what they term the "shelter industry" and the institutionalization of what began as an emergency response to a crisis situation.[24]

> The provision of temporary accommodations has usually given the homeless important benefits that they could not have obtained otherwise. The very success of these efforts, however, now threatens to transform short-term shelter facilities into long-term caretaking institutions, as officials and caretakers build full-service shelter facilities that simultaneously segregate and rank the homeless and organize their treatment. Classifying the homeless as a special population marked by peculiar vulnerabilities, however, not only perversely sets them apart from other citizens, but relegates them to the inferior status of worthy dependents.[25]

The concern that the condition of homelessness not be institutionalized is well taken. So, too, is the concern that shelters not be considered an adequate response to the problem of homelessness. Moreover, the manifest function of providing shelter does carry with it the latent function potential of establishing shelter living as a way of life.[26] But these concerns should not obscure the positive changes occurring in shelters and the use of shelters as service agencies.

These changes appear to be related to the frustration of shelter providers associated with the futility of providing a "hot and a cot" to growing numbers of individuals on an indefinite basis. Conversely, the changes are related to the desire of shelter providers and other public health workers to seize the outreach and intervention potential inherent in shelter settings. Accordingly, many of the larger shelters have established a variety of programs within them.

One of the earliest programs was the introduction of health care services in shelters in conjunction with the Robert Wood Johnson Foundation grant. Boston was one of nineteen cities selected by the foundation to develop such services. Over twenty thousand homeless men, women, and children have been treated since the Health Care for the Homeless program began in July 1985.

Health Care for the Homeless also developed an innovative respite program at the Shattuck Shelter in Jamaica Plain.

> The respite unit provides recovery care for homeless individuals who are not well enough to walk outside each day but who do not require admission to a hospital. Established in 1985, this program offers comprehensive medical, nursing, social and psychiatric care for up to 25 homeless patients who are unable or reluctant to follow routine treatment plans. It is a cost effective program which provides a less expensive alternative to inpatient hospital care for individuals who are recovering from treatment. The average length of stay in the respite is 17 to 20 days.[27]

Another major effort has been the development of substance-abuse programming in shelter settings. Its effectiveness is illustrated in encouraging results from the Stabilization Services Project, a three-year community demonstration project funded by the National Institute of Alcohol Abuse and Alcoholism under Section 613 of the Stewart B. McKinney Homeless Assistance Act. In contrast to general expectations that large shelters with many guests who are actively drinking and using drugs would be too unstructured and complex to be conducive to the development of effective recovery programs, almost two thirds of the clients assigned to stabilization programs in shelter settings maintained their sobriety and completed the program. Upward of 60 percent of the clients assigned to the Shattuck Shelter and the Long Island Shel-

ter completed a transitional period of postdetoxification residential programming (stabilization) averaging thirty-four days.[28]

In addition to the programs at the Shattuck and Long Island shelters, the Massachusetts Bureau of Substance Abuse Services supports a similar program at the Plowshares Shelter in Topsfield and substance-abuse programming at selected family shelters located across the state. The use of shelter settings for substance-abuse programming has become accepted practice in a brief period of time. Such utilization of shelters makes sense programmatically, logistically, and economically, and reflects the changing use of shelters as interventions in the lives of homeless individuals rather than temporary places to sleep.

Supportive Services

The inclusion of supportive services as part of the comprehensive plan to combat homelessness reflects the recognition that "homeless people need more than a roof over their heads as they move from the crisis of homelessness to a more stable situation."[29] Support services were seen as the "glue" that would tie the four parts of the plan together. One of the first supports to be developed was Family Action Support Teams (FAST) to assist families to gain access to needed services — for example employment/training, transportation, day care, counseling, health care — and to find permanent housing.[30] An interagency team approach involving the Departments of Mental Health, Public Health, and Social Services under the direction of the Executive Office of Human Services was used to carry out the development of supportive services.

Most recently, as indicated earlier, alcohol programming has been introduced in large individual shelters, and substance-abuse family shelters have come on line. But with all the positive gains over the past seven years, support services, particularly case management services, have not been fully developed or evenly distributed across shelter types. "Unlike the family shelters, which offer housing search assistance, family life advocate on staff, and other outreach services, the individuals receive virtually no counseling and services except for Health Care for the Homeless teams or Veteran's Outreach counselors."[31] This assessment by the former secretary of Human Services in the spring of 1990 of the status of support services for the homeless in Massachusetts clearly indicates that considerable additional effort would be required to fully implement the Massachusetts plan to combat homelessness.

Permanent Housing

The commitment of over a billion dollars in housing bond authorizations to develop affordable housing established Massachusetts as a national leader. Massachusetts has also been creative in establishing a variety of programs to service special-needs people. One of these, the 707 Rental Assistance Program, has been used to develop single-room occupancies (SROs) for homeless individuals in recovery from substance abuse. The rental certificates are assigned through local housing authorities to designated nonprofit agencies which use these certificates as guaranteed income (collateral) to borrow the capital necessary to develop the SROs. The Paul Sullivan Trust has developed the largest number of such units using this model. Currently, the trust operates eleven lodging houses with 185 units. All houses include resident managers and external staff who provide support services. All residents have a history of homelessness, and many report histories of substance abuse and/or mental illness. Two other 707-funded special housing projects include the Moultenbray House (24 units)

in Turner Falls, the Easler Building (12 units) in Gloucester, and houses in Hudson and Framingham operated by the South Middlesex Opportunity Council.

A variety of other housing programs have been developed which impact the homeless and near homeless. The Special Needs Housing Program (Chapter 689) is devoted to new construction to house the mentally ill and developmentally disabled people, substance abusers, adolescents, pregnant and parenting teens, and people with physical disabilities. More than $100 million was committed to this program between 1983 and 1988.[32] The Housing Innovations Fund is also designed to attract and direct developers to create housing for special-needs people. Other state programs for low- and moderate-income people include State Housing Assistance for Rental Production (SHARP), Tax Exempt Local Loans to Encourage Rental Housing (TELLER), and the Homeownership Opportunity Program.[33] These data illustrate the commitment of the state to ensure permanent housing for homeless, special-needs, and low- and moderate-income people.

Despite these state efforts, and other housing programs funded by federal dollars through the Stewart B. McKinney Act and the Department of Housing and Urban Development (for example, Section 8, Section 202, Title V), the need for permanent housing remains. Such need is demonstrated not only by the individuals and families residing in public shelters, but also by a two-year waiting period for existing public housing units.

The Future

The Number of Homeless and the Demand for Services

The decline of homelessness in Massachusetts in the immediate future appears unlikely. Recovery from the 1990–1991 recession is projected to take longer than expected, and the recovery, when it comes, is likely to be to a level lower than hoped for. Because homelessness is inextricably tied to the vicissitudes of the national and regional economies, it is unlikely that any sizable reduction in the number of homeless will occur until economic recovery occurs. Other factors that will sustain, and perhaps even increase, the demand for shelter include cutbacks in state funding of existing programs, failure to develop new programs (particularly housing resources), and increases in substance abuse (especially cocaine and crack addiction).

Perception of the Homeless

There are indications that the politics of compassion have become burdensome and that an "exhaustion of sympathy," or as Loni Hancock, mayor of Berkeley, California, calls it, "compassion fatigue," may be occurring among the more fortunate members of American society.[34] Evidence of this change in public attitude toward the homeless is seen in responses of city officials, service providers, and other informed community representatives to questions contained in the U.S. Conference of Mayors Task Force on Hunger and Homelessness Information Questionnaire.[35]

Specifically, informants in thirty cities were asked, "During the last year, have you seen any evidence that public sentiment toward homeless persons is changing?"[36] Respondents in six cities indicated no change in public attitude, three cities saw positive change, eight cities saw both positive and negative changes, and most important, thirteen cities saw only negative changes occurring. Some of the comments derived from these thirteen cities mentioned the intractability of the problem, the desire to move on

to other resolvable issues, and concern with violence associated with homeless individuals. Some cities pointed to "the increasing tendency to blame the homeless for being homeless," and to stigmatize them in a manner reminiscent of earlier times.

It is of particular interest that Boston was one of the thirteen cities which indicated a negative change in public attitudes toward the homeless. "People have become increasingly concerned with the number of homeless mentally ill persons on the streets. They are also commenting on the apparent increase in panhandlers on the street who, while not necessarily homeless, appear as if they are."[37]

Whether this assessment of public attitudes toward the homeless in Boston is accurate is questionable. Based on the positive response of the public to fund-raising efforts by the Friends of the Shattuck Shelter and the Friends of the Long Island Shelter, the "compassion fatigue" factor in Boston would appear to be low. Clearly, other data are necessary before conclusions about public attitudes can be made.

Programming

Public attitudes aside, erosion in benefits and programs directly affecting homeless individuals has recently taken place, attributable to state revenue shortfalls and the need to reduce expenditures. A brief review of some of the cuts experienced by the Department of Public Health's Bureau of Substance Abuse Services, the Executive Office of Communities and Development, and the Department of Public Welfare, illustrates the nature and magnitude of the loss of service.

Substance-Abuse Services. The Bureau of Substance Abuse Services contracts with over 230 community-based agencies for the provision of alcoholism and drug-abuse prevention and treatment services. While these services are available to all residents of the commonwealth, for the indigent and homeless, publicly supported services represent the only substance-abuse treatment services available to them. Consequently, any reductions in the operating budget of the Bureau of Substance Abuse Services automatically has an impact on the homeless and near homeless substance abusers who comprised approximately 18 percent of the 92,000 admissions in fiscal year 1990 to the substance-abuse treatment services supported by the bureau.

State funding for alcoholism and drug-abuse prevention and treatment has declined 30 percent from $40 million in fiscal 1990 to $28 million in fiscal 1992. A decrease of this magnitude requires restructuring and setting priorities of services provided. Since the two most costly services — detoxification centers and recovery homes — are also the two services most heavily utilized by the homeless substance abuser, it is clear that efforts to restructure and streamline these services will affect this population most heavily.

Compounding service reductions caused by cuts in the Substance Abuse Services budget, cuts in the budget of the Department of Public Welfare (DPW) will affect DPW coverage of addiction-treatment services for individuals receiving General Relief. Effective August 21, 1991, payments for detoxification, outpatient, and acupuncture services provided to recipients of General Relief were eliminated. As of December 31, 1991, payment for these services was restored to individuals who received emergency assistance benefits. The overall effect, however, was to reduce sharply the number of individuals eligible to receive these services.

Housing Services. The Executive Office of Communities and Development (EOCD) was established under the Dukakis administration as a cabinet level agency with primary responsibility for developing affordable housing. Most state-funded

housing programs designed to have an impact on homelessness are under the direction of EOCD. Table 2 shows the major reductions in housing programs support caused by fiscal 1992 EOCD budget cuts.

It is not possible within the scope of this article to explore all ramifications of the budget reductions shown in Table 2. However, given the magnitude of the reductions, particularly for 707 rental assistance, housing services, and supportive services, it is clear that housing assistance to the homeless, near homeless, and low-income families has been severely affected. The loss of 707 funding will require recipients to increase their share of the rent, reduce administrative fees paid to housing authorities and regional nonprofits from $45 to $15, and preclude expansion of 707 assistance. The reduction in housing services dollars and the failure to fund supportive services essentially eliminates one of the four components of the Comprehensive Policy on Homelessness described earlier. For homeless individuals and families needing assistance to negotiate the bureaucracy associated with publicly supported housing, the loss of supportive services may effectively preclude them from obtaining such housing, even if it were available.

Table 2

Final Fiscal Year 1992 Housing Budget

Housing Program	FY91	Final FY92 Budget
SHARP State Housing Assistance for Rental Production	$31.4m	$31.4m
RHDAL Rental Housing Development Action Loan	$2.18m	$2.498m
Chapter 707 Rental Assistance	$110m	$77m
Public Housing Operating Subsidies	$28m	$22.4m
CEED Community Economic Enterprise Program	$753,120	$750,000
Housing Services	$564,480	$300,000
Supportive Services	$4.3m	$0
HOP Homeownership Opportunity Program	$2.42m	$0

Source: Summary of the Final FY 92 State Housing Budget (Boston: Citizens Housing and Planning Association, 1991), 3.

Welfare Services. Homeless and near homeless individuals and families are most directly affected by cuts in the Department of Public Welfare (DPW) budget for Emergency Assistance (EA) and General Relief. "Emergency Assistance is a program to help families avoid homelessness, and to help homeless families secure a place to live . . . General Relief is an income assistance program for individuals who are unemployable by reason of disability or lack of training/education/experience."[38] Taken together, the reduction/elimination/suspension of funding for these two programs is likely to increase significantly the demand for shelter services, particularly by women with and without children.

More specifically, as of August 1, 1991, the following EA benefits were suspended for one year:

- First month's rent and security deposits for homeless and at-risk homeless families
- Moving and furniture storage fees
- Transportation, child care, and nutrition allowances for homeless families
- Relocation benefits for disaster victims[39]

The loss of these benefits essentially eliminates the capability to move families out of shelters. Other planned budget cuts would eliminate the EA Arrearage Program, which prevents homelessness by paying back rent and utility and fuel bills (up to three months) for poor families. According to the Massachusetts Coalition for the Homeless, 84 percent of the forty thousand families that used EA benefits in 1990 did so to prevent homelessness.[40] Loss of EA benefits, therefore, removes the only safety net strung beneath the lives of poor families in Massachusetts.

The loss of General Relief (GR) benefits is wide ranging and also carries a significant potential for increasing the ranks of the homeless. For example, the denial of benefits to individuals over age forty-five with little or no work history eliminates the only source of income for thousands of men and women. Other GR cuts include the elimination of Emergency Relief, "a homeless prevention program patterned on the Emergency Assistance Program",[41] the elimination of Employment Training Program, clothing allowances, family reunification benefits, fuel assistance, and major reductions in the GR medical program.

It is interesting to note that this is not the first time GR benefits have been curtailed in response to a fiscal crisis. In 1975, GR was "changed from a needs-based program to one whereby applicants must prove not only financial need, but must fit into a category of eligibility as well."[42] This change resulted in the loss of assistance for approximately eighteen thousand individuals.

Ironically, funding for the provision of emergency shelter services has remained intact. However, such services are likely to be severely strained as the homeless and near homeless enter the winter season without DPW assistance programs. The experience of Massachusetts in the coming months will provide valuable comparative data regarding the impact of public policies on the problem of homelessness. Careful monitoring and documentation of this experience should be carried out to ensure that these data and the lessons learned are not lost.

Shelter Size

It is unlikely that Massachusetts will witness the development of large shelters in the future. Concern about health and safety issues in some of the larger existing shelters has resulted in official recommendations to "begin to phase out larger shelters in favor of smaller community based shelters and transitional housing programs."[43] Small intimate shelters have always been preferred over larger impersonal shelters in the eyes of Massachusetts planners.[44] Despite such recommendations, it is unlikely that the existing large shelters will disappear.

Large shelters have strong advocates who are unlikely to dismantle services considered critical to homeless individuals. Large shelters are also major service providers to homeless substance abusers whose addiction, physical condition, and social deficits make them unlikely, and probably unwanted, candidates for small intimate community-based shelters. The location of the large shelters, efficiency of operation, and laissez-

faire policy make them "attractive" to homeless substance abusers unable to manage their addictions and to large segments of the public who do not want this population in their backyards. This convergence of political, practical, and personal interests may well operate to promote continuance of large shelter operations.

Shelter Functions

The functions of shelters, particularly large ones, have expanded in number and scope in the past eight years. Beginning with the early introduction of medical and respite services provided by the Robert Wood Johnson Health Care for the Homeless Project, services may now include substance-abuse programming, health education (including AIDS education and prevention), employment training, life-skills training, work programs, "holding" individuals in transit between substance-abuse service providers, and transitional housing. It is unlikely that such programming, once initiated, will not continue to operate, and even expand, in the future. Russell Schutt, who has extensively studied the problem of homelessness and the shelter system in Massachusetts, sees some shelters as "likely to serve as new, innovative models for meeting social service needs well into the 21st century."[45]

Shelters can be perceived as "windows of opportunity" to outreach and intervene in the lives of the homeless, particularly the substance abusers. Instead of bringing the client to the service, services are being brought to the client. In Massachusetts, ongoing experimentation with the form and function of shelters reflects the commitment of shelter providers and state officials to exploit the potential of shelters as service agencies.[46]

The productive use of shelters as stable service agencies rather than temporary emergency facilities reflects the recognition that the problem of homelessness is long term and unlikely to disappear in the near future. This is particularly true for the substance abusers whose problems are exacerbated by their homelessness, and vice versa.

It is in response to this latter group of homeless that we may ultimately see the functions of shelters expanded to include social model detoxification.[47] For all practical purposes, such detoxification routinely takes place in shelters as intoxicated guests are allowed to "sleep it off." Given the continuing prospect of further reductions in state funding of substance-abuse services, the development of lower-cost nonmedical (social) model detoxification services may be required.

Double Standard

Caution will need to be exercised to ensure that services for homeless persons do not develop into a two-tiered system in which the "new deserving homeless" are treated differently from the "old undeserving homeless." As Madeline Stoner states,

> By making this distinction (between the old and the new homeless) some of the newly developed services and legislation designed to aid homeless people have reflected the ancient Elizabethan division between the able bodied poor and the impotent poor. It is important to note that the "chronic homeless" were once new.[48]

An indication that some differential allocation of resources may already have occurred in Massachusetts is the lack of counseling and case management in "individual" shelters, as compared to family shelters, noted by former secretary of

Human Services Philip Johnston.[49] In defense of the differential allocation of scarce resources, one can point to data that show a higher probability for certain subgroups of the homeless to move out of the state of homelessness more quickly than others.[50] Such data may support the proponents of economic expediency, but fail to resolve the issue of moral imperatives.

The French expression "plus ça change, plus c'est la même chose" (the more things change, the more they are the same) seems particularly applicable vis-à-vis the homeless. The "new" homeless are not unlike the "old" homeless. What is new is the societal response to the problem. But as we have seen, even that may be changing.

Massachusetts, in general, appears to have done a creditable job in responding to its homeless men, women, and children. There are, however, indications that some of the gains made over the past years may be lost because of the state budget crisis. Mitigating these losses will require new and perhaps unconventional strategies.

An example of such a strategy, taken from the field of substance abuse, is the phenomenal growth and impact of self-supported, self-run, long-term housing for recovering substance abusers known as Oxford Houses.[51] In the brief span of approximately two years, over 250 Oxford Houses have been established across the country using $100,000 revolving loan funds established in each state, as mandated by the 1988 Anti-Drug Abuse Act. Fourteen Oxford Houses have already been established in Massachusetts. The Oxford strategy is simple, efficient, and most important, highly cost effective.

Another strategy is the approach taken by the Plowshares Shelter in Topsfield, Massachusetts, which intends to train and prepare its guests for social reentry. The final program step will be the acquisition of a loan from the state revolving loan fund to establish an Oxford-style residence for program graduates.

These strategies reflect the breaking of "set" and the willingness to experiment with the unknown. They represent the kind of effort and ingenuity that will be required to respond to the continuing problem of homelessness in Massachusetts. ❧

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Notes

1. Henry Miller, *On the Fringe: The Dispossessed in America*. (Lexington, Mass.: Lexington Books, 1991), 26. According to Gary Nash, *The Urban Crucible* (Cambridge: Harvard University Press, 1986), 115, the policy of "warning away" was used in the 1700s in Boston and other cities to prevent strangers from obtaining public assistance — a colonial version of modern-day "Greyhound therapy."

2. Kim Hopper, "Deviance and Dwelling Space: Notes on the Resettlement of Homeless Persons with Drug and Alcohol Problems," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 391–414.

3. Miller, *On the Fringe*, 163, articulates this societal tendency as follows: "It was always more convenient to construe the problem (of homelessness) in terms of the deficiencies of human beings. These deficiencies were once attributed to moral flaws; today they are assigned to medical flaws. The common sense notion that homeless people are poor and that they need wages to purchase food and shelter have been ignored."

Miller also notes the change in language associated with the homeless condition. "The 'drunk' or 'inebriate' has now become the 'alcoholic.' It is a significant change. Whereas the drunkard was a moral weakling, the alcoholic is a victim of forces outside his or her control . . . So, too, the 'vagrant' has become the 'homeless person.' Vagrancy is a crime; homelessness is a condition of being without shelter. *On the surface*, the new term appears to be more neutral, but, like the transition from 'drunkard' to 'alcoholic,' the shift from 'vagrant' to 'homeless' tends to mask the opprobrium concealed within the new language. Homeless people, today, are still thought to be a rather unsavory lot: witness the recent comment of former President Reagan, who claimed that, given the availability of public shelters, the homeless obviously choose their unhappy living state . . . In essence, the transformation of the root cause of a social problem from moral deficiency to illness changes the opprobrium attached to the problem only in form. To be a victim does not necessarily absolve the individual from the binder of stigma." Ibid., 161, 163.

4. Charles Hoch and Robert A. Slayton, *New Homeless and Old: Community and the Skid Row Hotel* (Philadelphia: Temple University Press, 1989), 3.

5. Ibid., 4.

6. Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 301–32; Institute of Medicine, *Homelessness, Health, and Human Needs* (Washington, D.C.: National Academy Press, 1988); James D. Wright, *Address Unknown: The Homeless in America* (New York: Aldine de Gruyter, 1989).

7. Paul Koegel and M. Audrey Burnham, "Traditional and Nontraditional Homeless Alcoholics," *Alcohol and Health Research World* 2, no. 3 (Spring, 1987): 28–33; M. Robertson, "Homeless Veterans: An Emerging Problem?" in *The Homeless in Contemporary Society*, edited by R. Bingham, R. Green, and S. White (Beverly Hills: Sage Publications, 1987); M. J. Robertson, P. Koegel, and L. Ferguson, "Alcohol Use and Abuse Among Adolescents in Hollywood," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 415–52; Peter Rossi, *Down and Out in America* (Chicago: University of Chicago Press, 1989); Ellen L. Bassuk, Allison S. Lauriat, and Leonore Rubin, "Homeless Families," in *Homelessness: Critical Issues for Policy and Practice* (Boston: The Boston Foundation, 1987), 20–23.

8. James D. Wright and Eleanor Weber, *Homelessness and Health* (Washington, D.C.: McGraw-Hill, 1987), 77.

9. Wright, *Address Unknown*, 102.

10. Pam J. Fischer, *Alcohol, Drug Abuse, and Mental Health Problems Among Homeless Persons: A Review of the Literature 1980–1990. Executive Summary.* DHHS Pub. no. (ADM)91-1763(B), ADMHA (Washington, D.C.: U.S. Government Printing Office, 1991).

11. Wright, *Address Unknown*, 98.

12. Rossi, *Down and Out in America*, 40–43.

13. Hoch and Slayton, *New Homeless and Old*, 7–8. It is interesting to note that Hoch and Slayton did not include the policy of deinstitutionalization as a contributing factor to the growing numbers of homeless men and women. While deinstitutionalization has often been cited as a cause of the new homeless, several researchers have argued that the link between deinstitutionalization and the new homeless has been overstated. See W. R. Breakey, P. J. Fischer, A. J. Romanosk, and G. Nestadt, *Severe Mental Illness in the Homeless* (Boston: American Public Health Association 116th Annual Meeting, 1988); J. D. Wright, "The Mentally Ill Homeless: What Is Myth and What Is Fact?" *Social Problems* 35, no. 2: 182–91; D. A. Snow, S. G. Baker, L. Anderson, and M. Martin, "The Myth of Pervasive Mental Illness Among the Homeless," *Social Problems* 33: 407–23.

14. Nancy Kaufman, "Homelessness: A Comprehensive Policy Approach," *Journal of Urban and Social Change Review*, 17 (Winter 1984): 21–26.

15. Philip W. Johnston, Nancy K. Kaufman, and Amy A. Anthony, "The Massachusetts Approach to Homelessness," in *Homelessness: Critical Issues*, 53.

16. Counting the homeless is a difficult task, the value of which has been questioned. See Rossi, *Down and Out in America*, 45–81; Richard P. Applebaum, "Counting the Homeless," in *Homelessness in the United States — Data and Issues*, edited by Jamshid A. Momeni (New York: Praeger, 1990), 1–16. The size of a social problem often depends on where one stands. For example, the estimate of 350,000 homeless in the United States generated under the auspices of the U.S. Department of Housing and Urban Development in 1984 differed significantly from the 1.5 million suggested by homeless advocate Mitch Snyder. See *Report to the Secretary on the Homeless and Emergency Shelters* (Washington, D.C.: Office of Policy and Development, 1984), and Mary Ellen Hombs and Mitch Snyder, *Homelessness in America: A Forced March to Nowhere* (Washington, D.C.: Community on Creative Non-Violence, 1982).

17. See U.S. Conference of Mayors, *The Growth of Hunger and Homelessness and Poverty in American Cities* (Washington, D.C.: U.S. Conference of Mayors, 1986) and U.S. Conference of Mayors, *A Status Report on Homeless Families in American Cities* (Washington, D.C.: U.S. Conference of Mayors, 1987); U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1990: A 30 City Survey* (Washington, D.C.: U.S. Conference of Mayors, 1990).

18. Raymond L. Flynn, *Dignity and Respect: Making Room for Boston's Homeless*, (Boston: City of Boston, 1988), 11.

19. Nancy K. Kaufman, "Access to Housing for Homeless Substance Abusers," paper presented at Homelessness, Alcohol, and Other Drugs, a conference held in San Diego, California, February 2–4, 1989. See *Homelessness, Alcohol and Other Drugs*, (Washington, D.C.: DHHS Pat. No. [ADM] 89-1614, ADAMHA, 1989) for proceedings of the conference.

20. These data are derived from a listing of shelters, dated 4/12/91, provided by the Massachusetts Department of Public Welfare.

21. Raymond L. Flynn, *Commitment and Compassion: Boston's Comprehensive Policy for the Homeless Winter 1990–91* (Boston: City of Boston, 1991), 6.

22. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 54.

23. Hoch and Slayton, *New Homeless and Old*, 224.

24. Ibid., 232.

25. Ibid.

26. Manifest functions are intended consequences of action and recognized by the participants as such. Latent functions are unintended and unrecognized consequences of action. See Robert K. Merton, *Social Theory and Social Structure*, (Glencoe, Ill.: Free Press, 1949), 49–61. Scrutiny needs to be given to policies that may operate to engender the reverse of what was intended. For example, priority access to benefits and housing is given to homeless people. This being so, some individuals may "become" homeless to gain an advantage on waiting lists for subsidized housing or to secure other benefits.

27. Flynn, *Commitment and Compassion*, 45.

28. For a description of the stabilization project, see Dennis McCarty, Milton Argeriou, Milly Krakow, and Kevin Mulvey, "Stabilization Services for Homeless Alcoholics and Drug Addicts," in *Treating Alcoholism and Drug Abuse Among Homeless Men and Women*, edited by Milton Argeriou and Dennis McCarty (New York: Haworth Press, 1990) 31–45. For an in-depth description of the shelter programming, see Milton Argeriou and Dennis McCarty, *Substance Abuse Programming in Shelter Settings* (Rockville, Md.: National Institute on Alcohol Abuse, forthcoming).

29. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 56.

30. Nancy K. Kaufman, *Massachusetts: A Comprehensive Policy Approach to Homelessness*, (Washington, D.C.: American Public Health Association Meeting, November 15, 1985), 8.

31. Johnston, *Homeless Individuals in Boston*, memo to Michael S. Dukakis, May 2, 1990, 3.

32. Kaufman, "Access to Housing for Homeless Substance Abusers," 12.

33. Ibid., 13.

34. U.S. Conference of Mayors, *Status Report — December 1990*, 51.

35. Ibid., 54, Appendix.

36. Ibid., Appendix question 12B.

37. Ibid., 50.

38. Fact Sheet — Massachusetts Coalition for the Homeless (Boston: Massachusetts Coalition for the Homeless, 1991).

39. *Streetlife: The Newsletter of the Massachusetts Coalition for the Homeless*, in press.

40. Ibid., April 1991, 4

41. Ibid.,2

42. Ibid.

43. Johnston, *Homeless Individuals in Boston*, 6.

44. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 55.

45. Russell K. Schutt, "Shelters as Organizations: Full-fledged Programs or Just a Place to Sleep", in *Homelessness: Critical Issues for Policy and Practice*, 47.

46. The transformation of shelters from temporary emergency shelter facilities to permanent multiservice agencies is not achieved without difficulty. As Russell Schutt reports, based on his recent survey of workers at the Shattuck Shelter, "Shelters for homeless persons seek to respond both to their guests' emergency needs and to the fundamental problems of health and welfare that are often associated with homelessness. The need to provide both emergency and long-term services often strains shelter resources and at times creates conflicting demands on shelter staff." See Russell K. Schutt, Robert Burke, Marsha Hogan, Patricia Ingraham, Richard Lyons, Tatjana Merschede, Richard Ryan, Joan Sinkiewicz, Helen Stern, and Andrew Walker, "The Shattuck Shelter Staff: Work Experience, Orientations to Work and AIDS Awareness," unpublished report prepared for the Life Lines AIDS Awareness Prevention Project (Boston: Shattuck Shelter, 1991), 33.

47. Susan Sadd and Douglas W. Young, "Nonmedical Treatment of Indigent Alcoholics," *Alcohol Health and Research World* 2, no. 3 (Spring 1987): 48–49.

48. Madeline Stoner, "An Analysis of Public and Private Sector Provisions for Homeless People," *Urban and Social Change Review* 19 (1984) 3–8.

49. Johnston, *Homeless Individuals in Boston*, 3.

50. Soon to be published data deriving from the NIAAA-funded Community Demonstration Project in Minnesota, show intensive case management efforts with chronic homeless substance abusers to be generally unsuccessful in moving this subgroup out of their homeless/substance-abusing condition. Other data derived from the Health Care for the Homeless projects show short-term homelessness to be associated with gender, ethnicity, family ties, and the presence of dependent children. Women, nonwhites, high levels of family contact, and women with dependent children all show a tendency toward short-term rather than long-term homelessness. See James D. Wright and Eleanor Weber, *Homelessness and Health* (Washington, D.C.: McGraw-Hill, 1987), 55–56.

51. John P. Molloy, *Self-run, Self-supported Houses for More Effective Recovery from Alcohol and Drug Addiction: A Technical Assistance Manual* (Bethesda, Md.: DHHS Publication No. ADM [90-1678], 1990).