Homelessness in Hartford 2002:

A Combined Report on the Census of the Homeless of Hartford and the Hartford Homeless Health Survey

Prepared by the Institute for Outcomes Research and Evaluation at Hartford Hospital

Census of the Homeless of Hartford funded by the City of Hartford, Office of Grants Management

Hartford Homeless Health Survey funded by a State of Connecticut Preventative Block Grant through the Hartford Health Department

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A Member of Hartford Health Care Corporation

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Cover art by Jason Glasser

Acknowledgements:

We would like to acknowledge the following individuals and groups for their contributions to this project:

Peter McMullen and other members of the Homeless Outreach Team

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Theresa Nicholson

The Hartford Continuum of Care

The City of Hartford Scientific Advisory Committee

The City of Hartford Public Health Advisory Council

The City of Hartford Homeless Commission

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Sister Pat McKeon
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Executive Summary

Homelessness continues to plague the US, as a portion of the very poor sleep in emergency shelters or out of doors each night. In cities such as Hartford, the proportion of people in poverty continues to grow. According to the 2000 U.S. Census, this proportion in Hartford is now 31%, making it the poorest city in Connecticut (U.S. Census Bureau, 2002).

In order to provide improved services to homeless individuals and families in the City of Hartford, it is necessary to know:

- How many people are without permanent shelter?
- What services are needed in order to help them gain and retain permanent housing?
- What are the major health and social issues faced by this population?

The present report describes a comprehensive and collaborative study of homeless individuals and families in Hartford, undertaken by:

- The Institute for Outcomes Research and Evaluation at Hartford Hospital
- The Hartford Continuum of Care
- The City of Hartford Office of Grants Management
- The Hartford Health Department

This study has two components:

A point-in-time census of the homeless population (2002 Census of the Homeless of Hartford):

- Funded by the City of Hartford Office of Grants Management
- Point in time census of homeless on February 27, 2002
- Enumerated every individual sleeping out-of-doors, in shelters, transitional, or supportive housing that night
- Program administrators and Homeless Outreach Team completed a three page form on each homeless individual and family
- Information was collected on demographics, reasons for homelessness, unmet service needs

A series of in-depth interviews (2002 Hartford Homeless Health Survey):

- Funded through the Hartford Health Department and a State of Connecticut Block Grant

- Interviews conducted in February and March, 2002
- Involved a randomly selected sample of 201 homeless individuals
- Interviews addressed demographics, medical conditions, substance use, access to health care, reasons for homelessness, and the individuals' assessment of their own service needs
- Five of Hartford's out-of-doors homeless individuals were also interviewed by outreach workers already known to them

Results of 2002 Census of the Homeless of Hartford

Count of Hartford's homeless population:
- 1326 homeless households
    - 1351 adults,
    - 236 children living with adults
    - 26 homeless youths living on their own in the City's two youth shelters
- Total count of 1613 homeless individuals on February 27, 2002.

Demographic profile of Hartford's homeless population:
- Largely unchanged since the 1999 Homeless Census.
- 68% Male
- 63% between the ages of 35- 54
- 42.5% African American
- 26.7% Latino
- 27.9% White
- 2.9% Other ethnicity
- Hispanics appear to be under-represented (i.e., fewer Hispanics are homeless than would be expected if homelessness was evenly distributed throughout the population) compared to the general population of the city as delineated in the 2000 U.S. Census.

The top three *primary* reasons for homelessness:
- Have not changed notably since the 1999 Census of the Homeless of Hartford.
    - Substance abuse
    - Mental illness
    - Income problems

Causes of homelessness (when multiple causes could have been reported)
- Family problems
- Income problems
- Lack of employment
- Mental illness
- Substance abuse

The most commonly endorsed *primary* reasons for homelessness
- Income problems endorsed most frequently for those living in shelters (with or without children) and for those living in supportive housing with children.

- Substance abuse endorsed most frequently for those living in transitional programs without children
- Family problems endorsed most frequently for those living in transitional programs with children.
- Mental illness endorsed most frequently for those living in supportive housing without children.
- Important to note that substance abuse is an *eligibility requirement* of some of the transitional housing programs, as is mental illness for some of the supportive housing programs.

Number of services needed:
- Differed significantly according to domicile
- The greatest number of needs endorsed for those living outside
- The least number endorsed for those in supportive housing.

Kinds of services needed:
- Varied as a function of the presence or absence of children
- Services addressing family and income problems were the most pronounced for households with children
- Services addressing mental illness and substance abuse were more prominent for households without children.

Quality-of-life issues:
- Begin to emerge as priorities once basic survival needs are addressed and living arrangements become more stable
- Case management and substance abuse were notable needs for virtually all of those individuals living outside.
- The rate of those reporting recreation as a service need increased for those living in transitional and, more so, for those living in supportive housing.

Multiple unmet service needs:
- Rates were highest for those living outside
- Lower for those in shelters
- Lower still for those in transitional programs
- Lowest for those in supportive housing.

2002 Homeless Census in general provides strong support for the crucial role that supportive housing programs play in improving the quality of life for at-risk clients.

Results of Hartford Homeless Health Survey:

Demographics of respondents:
- Similar to the 2002 Hartford Homeless Census
- Male: 68.9%; Female 31.1%
- 63% between the ages of 35-54

- 12.7% Veterans (compared to 2002 estimate of 9% for State derived from information provided by State of Connecticut Department of Veteran's Affairs).
- African-Americans and Whites were over-represented in the homeless sample, compared to their representation in general population of the City of Hartford.

Causes of homelessness:

- Substance abuse and income problems were the two most frequently cited primary causes of homelessness
- Lack of employment frequently endorsed regardless of housing situation
- The second most endorsed cause was lack of income
    - Over 20% of homeless individuals interviewed were working either full or part time, another 36% were looking for work
    - Over 65% of those interviewed reported that they had not worked at all in the past month.
- Family problems were also frequently cited as a cause of homelessness.

Health care utilization and access:

- Respondents residing in supportive housing
    - Most likely to have had health insurance compared to those in other domiciles
    - Had a tendency to rate their access to health care as more positive (i.e., a smaller percentage of them rated their access as very poor, poor or fair) than did residents of other domiciles.

Medical history and current medical conditions:

- Data correspond well to reports in the current scientific literature on health issues facing homeless individuals
- Over half of the 26 medical conditions had been experienced by at least one in five of those interviewed.
- History of depression, substance abuse and chronic back problems were the most common.
- Rates of lifetime chronic conditions such as depression, other mental illness, substance abuse and chronic bronchitis were from twice to over twelve times as high in the homeless sample in comparison to the general population of Hartford.
- Almost half of the homeless individuals sampled had severe drug or alcohol abuse problems.

Current smoking:

- Rate of current smoking among the sample over twice that of the general population of Hartford.
- Chronic diseases such as heart disease, asthma and bronchitis did not appear to be deterrents to cigarette smoking
    - 55-78% of those with histories of such conditions were current smokers at the time of the interview.
- At least 50% of current smokers reported that they contemplate quitting smoking at least occasionally

- Data strongly support targeted inclusion of homeless persons in smoking cessation programs or development of programs tailored to homeless persons.

Questions that remain unanswered include:

- What are the factors that enable a person living on the streets or in shelters to move into transitional or supportive housing?
- How can we prevent a person who has recently become homeless from becoming chronically homeless?
- How can we prevent the individual from ultimately living on the street, where they will be very difficult to reach?
- How can we identify individuals at risk for homelessness before they become homeless?

Both the census and the interview component of this project have implications for:

- The prevention of homelessness
- The interruption of the cycle of homelessness
- The continued improvement of services for homeless individuals.

Recommendations that address these three factors (compiled from Public Health Advisory Council, Continuum of Care, Commission on Homelessness) are included at the end of the report. A summary of these recommendations are as follows:

I. Issues that pertain to the prevention of homelessness:

1. Improve the capacity of existing substance abuse and mental health treatment programs
2. Expand affordable housing opportunities and seek partnerships between homeless service providers and entities that support employability
3. Establish rapid payee systems within the City
4. Utilize the influence of housing advocacy groups
5. Explore ways to identify at risk populations and windows of opportunity that could be used for homelessness risk- assessment
6. Examine best practices from other parts of the country

II. Issues that pertain to interrupting the cycle of homelessness:

1. Develop and systematically apply screening procedures for service trajectories at the point of entry into homelessness
2. Move away from the emergency shelter-based approach to homelessness prevention
3. Restructure the emergency shelter model
4. Strengthen existing transitional services for individuals recently released from incarceration

III. Issues pertaining to strengthening services for the homeless:

1. Establish partnerships between shelters, soup kitchens and day service providers to offer services on an out-reach basis and to better coordinate services
2. Strengthen disease prevention and chronic disease management instead of episodic health care

3. Strengthen the continuity of health care for homeless persons through closer collaborations between homeless service providers and Federally Qualified Health Care Centers

It is the goal of the authors of this report and the organizations that worked together to develop recommendations that these data support service design and policy making that will help reduce or eliminate homelessness in Hartford. If you have questions about this report please email Tara McLaughlin, PhD, MPE at tmclaug@harthosp.org.

1. INTRODUCTION

Homelessness in the U.S.

Homelessness continues to plague the US, as a portion of the very poor sleep in emergency shelters or out of doors each night. In cities such as Hartford, Connecticut, the proportion of people in poverty continues to grow, and is now reported to be 31% of the population, making it the poorest city in Connecticut (Swift 2002).

Recent reports from The Urban Institute (Burt, 2001) and from the National Law Center on Homelessness and Poverty (1999) have estimated that 700,000- 800,000 individuals in the U.S. may be homeless at any one time. This figure is quite probably an underestimate, because it is very difficult to accurately estimate the number of homeless people living outdoors. In addition to the prevalence of homelessness, are the rates of illness and mortality that accompany a lack of secure housing. Over half of the homeless report having a chronic disease, with hypertension, bronchitis, and psychiatric illness (particularly depression and substance abuse) being most prevalent (Martens, 2001; Lindsey, 1995). Further, it is estimated that the mortality rate for the homeless may be 3.5 to 6 times that of the U.S. population (Hibbs, 1994; Barrow, 1999; Hwang et al., 1997) One longitudinal study compared mortality rates among the homeless in U.S. and Canadian cities and found that homeless individuals in both countries were at increased risk compared with the respective general population (Hwang, 2000). Finally, homelessness in the U.S. has been increasing. For example, studies measuring shelter capacity from 1987- 1997 have indicated that the number of shelter beds in some geographic areas in the U.S. have doubled and tripled (National Coalition for the Homeless, 1997).

Our understanding of the roots of homelessness is grounded in the ecological model (Glasser and Bridgman 1999) which views homelessness as a result of the *interplay* between personal factors, such as alcohol misuse, drug misuse, and/or mental illness, and the structural factors of the scarcity of affordable housing, economic restructuring to a low wage service economy, and the reduction in financial assistance. The ecological model integrates issues of individual vulnerabilities within the broadest cultural and societal landscapes. It recognizes that important housing niches in U.S. cities have been eliminated, and those who are most vulnerable, including those with alcohol and drug misuse, are pushed into homelessness.

Homelessness in Connecticut

According to the Connecticut Coalition to End Homelessness (CCEH, 2001), 16,621 individuals used homeless shelters in the year 2000, including 13,544 adults representing 1,583 families and 3077 children. Within this time period, individuals were turned away over 11,241 times due to lack of bed-space. There is evidence to suggest that homelessness in Connecticut is increasing. At the time of the CCEH report, the number of times that people had been turned away from emergency shelters in the state had

increased 30% since 1998. Additionally, the CCEH reported an increase in the number of two parent families seeking help at area shelters. These statistics are based upon reports from shelters that receive state funding. Therefore, they do not include shelters that do not receive such funding. Nor do they include reports from domestic violence shelters and youth shelters. Further they do not include those people living out of doors, under bridges or in other places not intended for human habitation. Finally, these figures do not include the precariously housed such as people who may be doubled-up in overcrowded conditions. Therefore, as with national estimates, these reports probably underestimate the number of homeless individuals living in Connecticut.

Homelessness in Hartford

In reviewing the history of homelessness in Hartford, Glasser and Zywiak (2000) suggest that Hartford, along with many other US cities, followed a path of becoming a 'postindustrial' city, whose economic basis shifted from manufacturing to service industries and jobs that require a high degree of education. The highway system established in the 1950's facilitated an exodus to the suburbs and the urban renewal movement of the 1960's and 1970's brought the destruction of many of Hartford's affordable housing, including the single room occupancy hotels (SRO's) which housed the single and poor. Over the past twenty years Hartford also saw the movement of patients from psychiatric hospitals into the community. The construction of Constitution Plaza in the mid 1960s meant that an office complex replaced a once thriving (but poor) residential area in the downtown core (Ferrucci 1999). By the 1990's Hartford was being called a "tale of two cities" with the wealthy insurance, finance and corporate sectors standing in sharp contrast to the impoverished neighborhoods comprised of African-Americans and Latinos (Simmons 1998).

Data from the 2000 U.S. Census allow us to assess, to some degree, the rate at which individuals live without conventional housing in Hartford and the way in which this rate may differ from the rates in other Northeastern cities. The U.S. Census Bureau utilized a specially developed Service-Based Enumeration (SBE) Operation to enumerate people without conventional housing in the 2000 Census. These individuals were included in the category of "Other non-institutionalized group quarters (ONGQ)" which enumerated individuals living at: emergency and transitional shelters, protective residential care facilities, shelters for abused women and those living outside in targeted non-sheltered locations. Other individuals also included in this category were those living in hotels and motels used to provide shelter to the non-conventionally housed and those living outdoors at targeted non-sheltered locations. Additionally, the ONGQ category included certain medical staff residing in hospital dormitories who would not be considered "homeless".

In October 2001, the U.S. Census Bureau released a Special Report specifically on the sub- group of the ONGQ population residing at shelters at the time of the SBE Operation (Smith and Smith, 2001). We used these data to get an idea of the rate at which people in Hartford were living in shelters at the time of this enumeration. When the count of the shelter population in Hartford (from Smith and Smith, 2001) was divided by the total population of Hartford (according to the 2000 U.S. Census) the results indicated that

.45% of the population in Hartford may have been residing in shelters on the night of the Census Bureau's enumeration. We used the estimates provided by Smith and Smith and data from the 2000 U.S. Census to compare the .45% obtained for Hartford to rates obtained for other cities. We noted that the rate in Hartford is three times greater than the rate for Bridgeport (.13%) and is more than two times greater than the rates for Stamford, CT (.22%) and Providence, RI (.20%). It is also significantly greater than the rates for New Haven, CT, for Boston, MA and for New York City (.24%, .39% and .34%, respectively). Although the Census Bureau developed the SBE Operation in order to obtain an accurate enumeration of individuals without conventional housing, the authors caution that the figures released represent only a snap-shot of the emergency and transitional shelter population on that given day and should not be used as a gauge of the total population that may have been homeless in any given city during the year 2000.

We assessed the whole ONGQ population in Hartford and found that it represented 1.04% of the total population of the city. In relation to the other 20 Northeastern cities listed in the Smith and Smith's Special Report, Hartford ranked fourth (along with Boston, MA) in terms of the percentage of the total population of the city that was represented by those living in "other non-institutionalized group quarters". In comparison, New York City and Philadelphia, PA were tied for seventh with .85%. These rates should be interpreted in light of the fact that the ONGQ category also includes some individuals who, although lacking in conventional housing, would not be considered homeless. Therefore, in this way, the U.S. Census Bureau's count of the ONGQ population may be an overestimation of the number of people who were actually homeless.

The U.S. Census data provide a snap-shot perspective on the rate of homelessness in Hartford. Although these data might not provide a completely accurate count of the actual number of homeless individuals in Hartford, data from other studies correspond well to the U.S. Census figures. The 1999 Census of the Homeless of Hartford (Glasser and Zywiak, 2000) enumerated 1,365 homeless individuals representing people sleeping out of doors, and in shelter, transitional housing and supportive housing beds on December 13,1999. According to this estimate, approximately 1% of Hartford residents may be homeless at any one time during the winter season. As with the U.S. Census data, this count represents a snap-shot of the state of homelessness in Hartford on this night and should be interpreted with caution since it is difficult to accurately account for all of the homeless people living in various locations, particularly the out-of-doors dwelling homeless.

As part of a continuing effort to address homelessness in Hartford, the Hartford Continuum of Care in conjunction with the City of Hartford Office of Grants Management, and the Institute for Outcomes Research and Evaluation at Hartford Hospital conducted the most recent city-wide point-in–time census of the City's homeless population on February 27, 2002. Virtually every individual or household staying outside, in homeless shelters, in transitional housing designed for the homeless, and in supportive housing for the formerly homeless and for those at risk of homelessness, were enumerated. A second component of the project, funded through the Hartford Health

Department and a State of Connecticut Block Grant, involved the random selection and in-depth interviewing of a sample of 200 homeless individuals that occurred in February and March, 2002. While the 2002 Census assessed the *breadth* of homelessness in Hartford, the interview component provided information on the *depth* of homelessness in Hartford.

Definitions: Homelessness and type of domicile

In the present report, we define a *homeless* person according to the McKinney Homeless Assistance Act (1987). A homeless person is one who lives in a public or private place that is not intended for human habitation or one who utilizes a homeless shelter or a transitional or supportive housing facility as their primary nighttime residence. Thus, as in past work assessing homelessness in Hartford (Glasser and Zywiak, 2000 ; O'Keefe, Maljanian and McCormack, 2000a), we distinguish between four types of homelessness: living outdoors, living in shelters, and living in transitional and supportive housing. Living *outdoors* refers to the inhabitation of locations not meant for human habitation. Examples of outside living include living in cars, under bridges, in boxes, in garages and in the woods. *Shelters* are emergency housing facilities that serve individuals and families who have no other place to go. The emphasis is on helping the person in crisis by referring him to services that can help him resolve his problems and gain permanent housing. *Transitional* programs serve as a segue for clients as they progress from living in shelters or on the street to living in permanent housing. Typically clients stay in transitional housing for up to two years, paying a modest amount for room and board. Most programs either offer treatment programs themselves (generally for substance use or mental illness) or have the clients receive treatment outside of the program. *Supportive* housing is permanent housing for individuals and families who have been homeless, or who are at high risk for homelessness. The programs generally offer housing (often in scattered sites) with support so that the person is better able to retain the housing and not return to homelessness. In the present report, we do not include the precariously housed such as those who are doubled- up with others.

Methodology of the 2002 Census of the Homeless of Hartford

Data collection procedure

In order to accomplish the point-in-time census, the program administrators of each facility (shelter, transitional and supportive housing programs) in the City of Hartford were asked to complete a pre-numbered three-page census form, with no names or other personally identifying information, on each individual (or head of household) staying with them the night of February 27, 2002 . Two programs providing shelter to homeless youth (the YMCA Youth Emergency Shelter and the Salvation Army Youth Shelter) were also included in this year's Census. Based upon the most recent point-in-time census of the homeless population of Hartford (Glasser and Zywiak, 2000), the Hartford Continuum of Care coordinated data collection and distributed a total of 1500 census forms to these facilities. In order to include homeless individuals living out of doors on the night of the census, the Homeless Outreach Team completed census forms on individuals that were known to be living outdoors on February 27, 2002.

In order to insure confidentiality, the program administrators had lists of their clients' names linked to census ID numbers, and each list was kept in a locked place at each respective facility. These lists were necessary for any clarification that may have been needed during data entry and were destroyed at the completion of the reporting process.

Data collection tool

The three- page census form included four sections (type of housing, housing history, demographics, causes of homelessness and services needed). The first section addressed the type of housing (i.e., outside, shelter, transitional or supportive) and the specific program where each person (or household) was residing on the night of the census. The second section addressed housing history, demographics and veteran status. The third section asked administrators to check any of 23 possible causes of homelessness for the individual or the family. The administrators were then asked to rank the primary, secondary and tertiary reason for homelessness. The fourth section asked administrators to check any of 18 services that they believed the individual or family could benefit from but were not currently receiving. The Census form was developed through previous work with the homeless population in Hartford conducted by Glasser and Zywiak (2000) in collaboration with the Hartford Continuum of Care.

Data management and analysis

The SPSS statistical package was used for all analyses. This report will present demographic information, frequencies for each program, primary reasons for homelessness, and services needed by the homeless. Comparisons will be drawn between notable patterns observed in the 1999 Homeless Census.

Methodology of the Hartford Homeless Health Survey 2002

Sampling strategy

The sampling strategy used for the interview component of this project was based upon previous work in Hartford (Glasser and Zywiak, 2000; O'Keefe et al., 2000a) and Rhode Island homeless shelters (Glasser and Zywiak, in press). Previous work in Hartford utilized a 10% random sample of the 1500 pre-numbered Census forms that were distributed for each homeless household in the City of Hartford. Of the 10% sampled (i.e., 150 random number selections), 66 persons were interviewed. The reasons for this small sample size were most likely related to the fact that this methodology had required homeless people to take the flyer that they had received from their program, if they were one of the randomly chosen participants, and bring it to one of the City's four homeless day programs. This meant that homeless individuals would have to go to some effort to be interviewed. In a subsequent study in Rhode Island (Glasser and Zywiak, in press) a random sample was drawn from the roster of individuals staying at the targeted shelters the previous night, using a table of random numbers. Those individuals selected were then invited to participate in the survey, which took place that evening. Most of those randomly selected were still staying in the shelter, and agreed to the interview. This latter method of sampling is preferable to the methods used previously in Hartford since it does not require the participants to go to as much effort to participate in the survey.

In the present study a random selection of homeless individuals staying in the City's shelters, transitional, and supportive housing programs was drawn during the months of February and March 2002 with the goal of interviewing 200 randomly selected individuals. The sample was drawn from the following programs:

- Eight of the City's emergency shelters: We sampled 130 individuals with the goal of obtaining interviews with 100 of those sampled. Thus those in shelters were to represent 50% of the 200 person random sample.
- Eight of the City's transitional programs: We sampled 100 individuals with the goal of obtaining interviews with 70 of them. Thus those in transitional housing were to represent 35% of the 200 person random sample
- Six of the City's supportive housing programs: We sampled 40 individuals with the goal of obtaining interviews with 30 of them. Thus those in transitional housing were to represent 15% of the 200 person random sample.
- Additionally, the Homeless Outreach Team interviewed a small number of out-of-doors homeless people, as he encountered them in his nightly rounds. It is challenging to obtain information on the out-of-doors dwelling homeless and these interviews were not considered part of the random sample. However, they did provide valuable data on the most hard-to-reach segment of the homeless population. As with the randomly selected participants, these individuals were asked to sign explanatory letters and were given telephone cards at the completion of the interview (see description of procedures below).

The selection included programs for single men, single women, and families. The random sample was drawn from the roster of individuals staying a given facility or program the previous night, using a table of random numbers

Inclusion of supportive housing clients.

In previous work in Hartford, there was an under sampling of respondents living in supportive housing. Although they were under-sampled, these individuals provided interesting data. For example, as a group they reported spending none of their time on the street. Thus, supportive housing represents an important sub-population of the homeless who do not consider *themselves* to be homeless and appear to be more similar to the general population than they are to the homeless population. Yet if it were not for supportive housing programs, these individuals would indeed be homeless. Therefore for the purposes of continued funding of these programs, it is important to include these individuals in further research.

Inclusion criteria

In order to have been included in this study, participants from shelters, transitional and supportive housing programs must have been on the roster at one of the facilities listed above the night before the interview and must have been chosen randomly through our selection process. The participant was required to show his or her reminder note as proof that they were randomly selected. The participants were required to be fluent in either English or Spanish and to have been 18 years of age or over.

Procedures and tools

Once an individual was selected and once they had met with the interviewer, they were given an explanatory letter (in either English or Spanish). They were asked if they would like to read the letter themselves or if they would prefer to have it read to them. The letter explained the purpose of the study and insured them that participation was completely voluntary and that they would not lose any benefits if they chose not to participate or if they stopped the interview. The letter also listed a phone number that participants could call with any concerns about the study. The participant were asked to sign the letter and were given a copy of the letter to keep for future reference. Upon completion of the interview, the participant was given a 100- minute calling card and was asked to sign a receipt of this incentive. The interviewer then explained the use of the card to the participant.

The in-depth interview questions were based on the Hartford Health Survey 2000 and in-depth interview questions of the Hartford Homeless Health Survey 1999, with recent revisions based on previous research in collaboration with the Hartford Continuum of Care for the Homeless.
The interviews yielded data on:

- History and patterns of homelessness

- History of drug or alcohol abuse including perceived harm from substance abuse and degree of involvement in substance use (AUDIT-12 ; Campbell, Barrett, Cister, Solliday-McRoy and Melcher, 2001)
- Behavioral risk factors
- Demographic characteristics
- Medical history/ current conditions
- Readiness to quit smoking
- Health care utilization
- Needs and utilization of various social services

Interviews were conducted by a team of five trained interviewers, two of whom were fluent in Spanish. The interview form did not contain identifying information. Only the program administrators had a list of names linked to ID numbers. These lists were kept in a secure place and were destroyed once data entry was complete. All materials including interview, reminder notes and explanatory letters were available in English and Spanish. The in-person interview this year included a tool used by the World Health Organization for assessing alcohol and drug use, the AUDIT (Babor et al., 1992 and modified by Campbell et al., 2001 called the AUDIT-12). The Institute for Outcomes Research and Evaluation (IORE) at Hartford Hospital was responsible for database development, data entry, data analysis and report generation. The SPSS statistical package was used for all analyses.

The present study utilized an approach that was similar to the Hartford Homeless Health Survey 2000 (O'Keefe et al., 2000a), in both sampling and assessment of health needs. However, the present study assessed drinking, drug use and smoking more thoroughly than the 2000 Homeless Health Survey and utilized a recruitment protocol that was more effective. The strength of both studies was that they involved random sampling from a variety of facilities and therefore yielded a more representative picture of the health status and needs of this population than would have a convenience sample. This study was undertaken in order to characterize patterns of homelessness in Hartford and to assess the general health status and health care needs including access to and satisfaction with health care among the homeless of Hartford. As in previous work, we assessed demographic characteristics, patterns of homelessness and rates of chronic diseases, and health risks according to gender and housing situation (i.e., shelter, transitional or supportive programs).

2. Overview of Results of the Hartford Homeless Census 2002

Participating programs

For the 2002 Hartford Homeless Census, information was compiled from 1326 census forms, representing 1351 adults, 236 children living with adults and 26 homeless youths living on their own in the City's two youth shelters for a total count of 1613 homeless individuals. The remaining analyses are based upon the 1326 individuals (including individuals from the youth shelters) or head of households for whom administrators filled out the three-page forms. The distributions of data according to the type of domicile and according to participating programs are presented in Tables 2.1, 2.2, 2.3 and 2.4 below. Brief descriptions of the programs in Hartford are presented in Appendix II.

Table 2.1 Type of domicile

Where did the person (or head of household) sleep on February 27, 2002?

		Frequency	Percent
Valid	Outside	22	1.7
	Shelter	421	31.7
	Transitional	403	30.4
	Supportive	480	36.2
	Total	1326	100.0

Table 2.2 Shelters

Check specific program this household slept in on February 27, 2002: Shelters

	Frequency	Percent
Immaculate Conception	149	35.4
CRT Mckinney Shelter	81	19.2
South Park Inn Shelter	65	15.4
YWCA Shelter	22	5.2
DSS Shelter Apartments	20	4.8
Open Hearth Shelter	18	4.3
Mercy Housing Shelter	17	4.0
Salvation Army Marshall House	14	3.3
YMCA/YES Program (Jewell House)	13	3.1
The Salvation Army Marshall House Youth Shelter	13	3.1
My Sister's Place I	6	1.4
Hartford Interval House	3	.7
Total	421	100.0

Table 2.3 Transitional programs

Check specific program this household slept in on February 27, 2002: Transitional

	Frequency	Percent
The Salvation Army Homestead Ave	80	19.9
Open Hearth Transitional	76	18.9
Mercy H. Transitional	37	9.2
YWCA Transitional	35	8.7
South Park Inn Transitional	32	7.9
Community Partners in Action	31	7.7
CRT Supportive Housing I	25	6.2
House of Bread	18	4.5
CRT Supportive Housing II	15	3.7
Alternative Living Center	14	3.5
My Sister's Place II	13	3.2
Mercy Housing AIDS Residence	9	2.2
ADRC Transitional Living (Recovery House)	6	1.5
Alcohol Drug Rehabilitation Center Coventry House	5	1.2
Mercy Housing Mental Health Respite	5	1.2
Men's ALC SATEP	2	.5
Total	403	100.0

Table 2.4 Supportive Housing

	Frequency	Percent
Shelter Plus Care (TRA's)	101	21.0
Chrysalis Center Programs	72	15.0
Mercy Housing AIDS Supportive Housing	51	10.6
Plimpton House	34	7.1
CHD-CT Outreach	33	6.9
Mercy Housing Mental Health	30	6.3
Hudson View Commons	28	5.8
Shelter Plus Care: Project HEARRT	26	5.4
YWCA Shelter Plus Care program	24	5.0
Mary Seymour Place Apartments	20	4.2
My Sister's Place III	18	3.8
Peter's Retreat	17	3.5
Todd House	13	2.7
Crossover	7	1.5
Tabor House I	6	1.3
Total	480	100.0

Counting the Homeless: 1999 - 2002

The 2002 Hartford Homeless Census enumerated 1326 homeless households, representing 1351 adults, 236 children living with adults and 26 homeless youths living on their own in the City's two youth shelters for a total count of 1613 homeless individuals. The 1999 Census included 1058 completed forms representing 1365 individuals (1097 adults and 268 children) and did not include emergency shelters for youth. It is important to note the differences that exist with regard to the numbers of forms (representing homeless households) received from certain programs this year compared with the 1999 Homeless Census as they could explain some of the discrepancy between the homeless population enumerated in the present census compared to that enumerated in 1999.

For example, 49 census forms were received from Immaculate Conception shelter in 1999. This year 149 census forms were received from this facility. Notable increases in the number of census forms were also observed for three transitional housing facilities, Open Hearth Transitional, Salvation Army Homestead Avenue and the YWCA Transitional facility. Additionally, two programs included in this year's census (CRT Supportive Housing II and Shelter Plus Care Project HEARRT) were not in existence in 1999. For supportive housing 27 more census forms were received from Shelter Plus Care (TRA's) this year compared with 1999. In addition, the 1999 Census did not include the city's youth shelters. However, it did include data from the Hartford Lead Abatement Treatment Shelter Apartments, a program from which census forms were not received this year since this facility was not housing homeless clients at the time of the present census.

One way of assessing the change in the number of homeless households enumerated in 2002 compared with 1999 is to determine the raw percent increase in this number. If 1058 is subtracted from 1326, the resultant figure represents a 25% increase in the number of households enumerated in 2002 compared with 1999. However, this figure does not account for the fact that the 1999 Homeless Census did not include the two emergency youth shelters. Further, the homeless-serving community in Hartford has committed itself to expanding and improving the number of permanent housing units for homeless individuals and the existence of two programs, CRT II and Shelter Plus Care Project HEARRT, reflects success in this effort. In order to obtain an adjusted increase in the number of homeless households enumerated in 2002 compared with 1999, these factors must be taken into account.

In order to obtain an adjusted estimate of the percent increase from 1999 to 2002, the 26 households counted this year in the youth shelters, the 15 households counted this year in CRT II and the 26 households counted this year in Project HEARRT are subtracted from the total number of households enumerated this year (1326 - 67). The adjusted number of households enumerated this year is then 1259. This estimate can be used to derive an adjusted increase in the number of homeless households counted in 2002 compared with 1999. When the number of households from 1999 (1058) is subtracted from the adjusted number of households in 2002 (1259), an adjusted increase of 201 households is

observed. In order to express this increase as a percentage, 201 is divided by 1058 which results in an estimate of 19%. This increase appears to be due in large part to an increase in the use of shelter beds in February 2002 (also in Table 2.5) which reflects the harm-reduction philosophy of some of the shelters not to turn any homeless individual away on a cold winter's night. This philosophy not only helps rescue people from the street, but it also helps to prevent homeless individuals from moving more permanently onto the streets, where services are very difficult to deliver.

Table 2.5
1999 and 2002 Homeless Census: Households in Each Program

Shelters:

Program Name	*# Households 1999*	*# Households 2002*
American Red Cross Emergency Shelter	2	-
CRT McKinney Shelter	78	81
DSS Shelter Apartments	15	20
Hartford Interval House	4	3
Hartford Lead Abatement Treatment Shelter Apts.	7	-
Immaculate Conception	49	149
Mercy Housing Emergency Shelter	24	17
My Sisters Place I	7	6
Open Hearth	16	18
The Salvation Army Marshall House Family Shelter	11	13
South Park Inn	52	65
YWCA Shelter	19	22
YMCA YES Program	-	13
Salvation Army Marshall House Youth Shelter	-	13
Total	284	421

Table 2.5
1999 and 2002 Homeless Census: Households in Each Program, cont.

Transitional programs :

Program Name	*# Households 1999*	*# Households 2002*
Alcohol and Drug Rehabilitation Center (ADRC) Programs	32	27
Community Partners in Action	26	31
House of Bread	23	18
Mercy Housing AIDS Residence	8	9
Mercy Housing Transitional	40	37
My Sister's Place II	12	13
Open Hearth Transitional	62	76
The Salvation Army Homestead Ave	21	80
South Park Inn Transitional	28	32
Mercy Housing Mental Health Respite	-	5
CRT Supportive Housing I	-	25
CRT Supportive Housing II	-	15
YWCA Transitional	17	35
Total	269	403

Table 2.5
1999 and 2002 Homeless Census: Households in Each Program, cont.
Supportive Housing

Program Name	*# Households 1999*	*# Households 2002*
Center for Human Development CT Outreach	37	33
CRT Supportive Housing I	21	-
Chrysalis Center Programs	95	72
Hudson View Commons	19	28
Laurel Street Group Home	7	7
Mary Seymour Place Apartments	20	20
Mercy Housing AIDS Supportive Housing	56	51
Mercy Housing Mental Health	28	30
Mercy Housing Mental Health Respite	5	-
My Sister's Place III	19	18
Plimpton House	32	34
Peter's Retreat	30	17
Shelter Plus Care	74	101
Todd House	0	13
Tabor House I	0	6
YWCA Shelter Plus Care	24	24
Shelter Plus Care: Project HEARRT	-	26
Total	467	480

Demographics

Demographic information is presented in Table 2.6. These data indicate that over 40% of the homeless population in Hartford are of African descent and that over 35% of the homeless are between 35 to 44 years of age. Most live alone. In order to make a comparison between the ethnic distribution of the 2002 homeless population of Hartford and the ethnic distribution of the city as a whole according to the 2000 US Census, the following caveats must first be addressed. First, the US Census provides several classifications for race/ethnicity. Census Table DP-1 (U.S. Census Bureau, 2002 a) provides estimates of race that allow for the endorsement of more than one race per individual. According to this classification, the ethnic/racial distribution for the City of Hartford in the 2000 Census is as follows: 30.8% White, 40.6% African American, and 40.5% Hispanic. However, Census Table QT-PL (U.S. Census Bureau 2002 b)provides estimates of race/ethnicity for Hispanics of any race and then for other racial groups based upon endorsement of one race only. According to this classification scheme , Hispanics of any race comprise 40.5% of the population of Hartford, White (Non-Hispanics) comprise 17.8%, Blacks comprise 36%, Native Americans comprise .3%, Asians comprise 1.6%, Other race .6% and two or more races, 3.2%. Since the classification system used on the Hartford Homeless Census form assumes that 'White' represents 'White (Non-Hispanic)' and since respondents endorsing more than one race were classified as 'Multiracial' it is possible to use the data from Census Table QT-PL for a more direct comparison, as opposed to Census Table DP-1. When U.S. Census data from Table QT-PL are used for comparison, it appears that African Americans and Whites are disproportionately represented among Hartford's homeless population and that Hispanics are under- represented.

Table 2.6 Demographics: Hartford Homeless Census 1999 and 2002

	1999 Homeless Census [1]	2002 Homeless Census
Total Households:	1058	1326
Type of domicile (%):		
Outside	3.6	1.7
Shelter	26.8	31.7
Transitional	25.4	30.4
Supportive	44.1	36.3
Gender (%):		
Male	65.4	65.7
Female	34.6	34.3
Ethnicity of individual or Head of household (%):		
African-descent	40.9	42.5
Native American	.5	.4
Asian/ Pacific Islander	.6	.2
Hispanic/ Latino	22.5	26.7
Multiethnic	1.3	1.4
White	33.2	27.9
Other	.4	.9
Age group (%):		
Less than 18	-	3.1
18-24	-	7.5
Less than 25	7.8	10.6
25 – 34	21.6	18.5
35 – 44	38.2	35.3
45 – 54	23.0	27.4
55 – 64	7.5	7.0
65 – 74	1.4	.9
75 and over	.5	.2
Presence of children in household (%):		
With children	11.1	8.9
Without children	88.9	91.1
Veteran status (%):		
Veteran	10.5	7.0
Not a veteran	89.5	82.4
Unknown		10.6

[1] from Glasser and Zywiak (2000).

Previous housing history

Previous place of residence:

In order to assess previous place of residence, program administrators were asked to indicate where each individual was living immediately prior to entering their program. They were asked to indicate the type of domicile (e.g., shelter, supportive housing) and whether or not this previous place was located in Hartford. Frequencies for previous place of residence are presented below in Table 2.7 for the population as a whole and then separately for shelter, transitional and supportive housing residents (Tables 2.8, 2.9 and 2.10, respectively). Information on previous town and time in current program is also presented for the whole sample and for those residing in shelters, transitional and supportive housing. It is important to note that this information given is often based upon client self- report and it is possible that some clients may not be able to make the distinction between some forms of housing and others (e.g., living in supportive housing may be viewed as having one's own apartment).

Total population

Table 2.7 Previous place of residence :Total population

Where was the individual or family before coming into your program?

	Frequency	Percent
Shelter	369	29.6
Temporarily Living with Family or Friends	141	11.3
Own apartment (with lease)	124	9.9
Jail or Prison	85	6.8
Substance Abuse Treatment Program	84	6.7
Other	75	6.0
Permanently staying with family or friends	74	5.9
Transitional Housing	63	5.0
Psychiatric Facility	63	5.0
Street	56	4.5
renting a room in someone's apartment	37	3.0
Hospital or Medical Center	29	2.3
Supportive Housing	20	1.6
Domestic Violence Shelter	17	1.4
Privately Owned Housing	11	.9
Total	1248	100.0

Previous town:

For the 1196 clients for which information regarding previous town was available, 956 (80%) were living in Hartford immediately prior to entry into their current programs. Out of the 20% not living in Hartford, 218 (18.2% of the total) were living in other towns in Connecticut. 19 were living in another state, two were in Puerto Rico and one was in another country.

Time in program:

Overall, the mean length of time spent at the current program was 443.58 nights (or 1.22 years). The median length of time was 134 nights or approximately 4.5 months.

Shelters

Table 2.8 Previous place of residence: Shelters

Where was the individual or family before coming into your program?

	Frequency	Percent
Shelter	93	22.5
Temporarily Living with Family or Friends	72	17.4
Own apartment (with lease)	52	12.6
Jail or Prison	36	8.7
Permanently staying with family or friends	35	8.5
Other	34	8.2
Street	27	6.5
renting a room in someone's apartment	27	6.5
Hospital or Medical Center	10	2.4
Substance Abuse Treatment Program	9	2.2
Privately Owned Housing	7	1.7
Transitional Housing	6	1.4
Supportive Housing	2	.5
Psychiatric Facility	2	.5
Domestic Violence Shelter	2	.5
Total	414	100.0

Previous town:

For the 393 shelter clients for whom information regarding previous town was available, 300 (76%) were living in Hartford immediately prior to entry into their current programs, 19.6% were living in another town in Connecticut, 3.3% were living in another state, .3% were living in another country and .5% were living in Puerto Rico.

Time in program:

The mean length of time spent at the current program, for shelter clients, was 40.09 nights (or approximately 1.3 months). The median length of time was 24 nights (approximately 3 weeks).

Transitional housing

Table 2.9 Previous place of residence: Transitional housing

Where was the individual or family before coming into your program?

	Frequency	Percent
Shelter	119	30.8
Substance Abuse Treatment Program	60	15.5
Jail or Prison	45	11.7
Temporarily Living with Family or Friends	44	11.4
Permanently staying with family or friends	24	6.2
Other	20	5.2
Own apartment (with lease)	17	4.4
Domestic Violence Shelter	13	3.4
Transitional Housing	10	2.6
Renting a room in someone's apartment	8	2.1
Street	7	1.8
Psychiatric Facility	7	1.8
Hospital or Medical Center	6	1.6
Supportive Housing	4	1.0
Privately Owned Housing	2	.5
Total	386	100.0

Previous town:

For the 377 transitional clients for which information regarding previous town was available, 263 (almost 70%) were living in Hartford immediately prior to entry into their current programs, 28.9% were living in another town in Connecticut and 1.3% were living in another state.

Time in program:
The mean length of time spent at the current program, for transitional clients, was 420.9 nights (or approximately 1.15 years). The median length of time was 145 nights (almost 5 months).

Supportive housing

Table 2.10 Previous place of residence: Supportive

Where was the individual or family before coming into your program?

	Frequency	Percent
Shelter	152	35.3
Own apartment (with lease)	55	12.8
Psychiatric Facility	54	12.5
Transitional Housing	47	10.9
Temporarily Living with Family or Friends	21	4.9
Street	19	4.4
Other	18	4.2
Substance Abuse Treatment Program	15	3.5
Permanently staying with family or friends	15	3.5
Supportive Housing	14	3.2
Hospital or Medical Center	13	3.0
Jail or Prison	4	.9
Domestic Violence Shelter	2	.5
Privately Owned Housing	2	.5
Total	431	100.0

Previous town:
For the 405 supportive housing clients for whom information regarding previous town was available, 373 (92%) were living in Hartford immediately prior to entry into their current programs, 7.7% were living in another town in Connecticut and .2% were living in another state.

Time in program:

The mean length of time spent at the current program, for supportive housing clients, was 813.5 nights (or approximately 2.23 years). The median length of time was 515 nights (approximately 1.4 years).

Summary Previous Housing History:

We noted that overall 80% of homeless clients had been living in Hartford prior to entry into their current programs. This figure was highest for those in supportive housing for which 92% had been living in Hartford prior to entry in their current program. Shelters were most frequently endorsed as previous places of residence prior to entry into a given current program (this was true whether the respondents were currently living in another shelter, in transitional housing or in supportive housing). Other commonly endorsed previous living arrangements included staying with family or friends and living in one's own apartment. The longest length of stay was observed for clients living in supportive housing and the shortest was observed for clients living in shelters, a finding that is not surprising given the nature of these types of housing.

The interview component of this project (Chapter 3) provides more detailed information regarding previously housing history than that obtained in the homeless census. This information will be discussed later in this report. It is important to note that any discussion of the housing history of Hartford's homeless population must be considered in light of the general mobility of the population as a whole. Data from the 2000 U.S. Census (Table P038; U.S. Census Bureau, 2002c), indicate that 43% of the general population of Hartford County and roughly the same proportion of the general population of State of Connecticut was born outside of the state. These rates reflect the notable base rate of mobility within U.S. society at large.

Primary Reasons for Homelessness:

The primary reasons for homelessness from the 2002 and the 1999 Census of the Homeless of Hartford are contrasted in Table 2.11 below. Note that these data are based upon administrator report. In both Census reports, mental illness and substance abuse were the most frequently endorsed *primary* reasons for homelessness. Income problems remained in the top three primary reasons. The rate of endorsement for mental illness as the primary reason decreased from 29.5 % in 1999 to 22.3% in 2002. While this decline was statistically significant, mental illness was second only to substance abuse as the most frequently endorsed primary cause of homelessness in 2002. Thus this issue remains a formidable public health concern. Endorsement of income problems and family problems as the primary reason increased from 1999 to 2002 (14.8% compared with 15.5% and 9.6% compared with 12.3%, respectively although these increases were not statistically significant). Primary reasons by domicile and by presence of children from the 2002 Homeless Census are also presented in Tables 2.12 and 2.13.

Table 2.11 Primary Reason Homeless: 1999 compared with 2002 [1]

	1999 Census [2]		2002 Census	
	Frequency	Percentage	Frequency	Percentage
Building or apartment problems	45	5.0	38	3.2
Family problems	87	9.6	146	12.3
Health problems	38	4.2	43	3.6
Income problems	134	14.8	206	15.5
Mental illness *	268	29.5	265	22.3
Released from prison	61	6.7	61	5.1
Relocated	14	1.5	23	1.9
Substance abuse	260	28.7	361	30.3

*1999 and 2002 rates differ significantly at $p < .001$

[1] NOTE: Each of the reasons listed above are *clusters* of individual reasons for homelessness which were constructed as follows:
Building problems: fire, unfit building, crime in neighborhood, overcrowded apartment, (foreclosure on building and lead also included in 2002 Census)
Family problems: family problems, was doubled up/ asked to leave, domestic violence, "previous divorce" and "domestic problems"
Health: medical problems, HIV/AIDS
Income: eviction (formal and informal), income does not meet needs, lack of employment; 2002 Census also includes "benefits expired", "rent too high" and "foreclosure on house".
Mental illness: In 1999 Census: mental illness, recently discharged from a psychiatric hospital, mental illness and substance abuse; 2002 Census does not include "mental illness and substance abuse" as a category
Substance abuse: In 1999 Census: alcohol abuse, drug abuse, drug and alcohol abuse, recently discharged from a substance abuse or recovery program; In 2002 Census "drug and alcohol abuse" was not a category.
Other (not in table): 2002 Census data also includes 51 households with "other" primary reasons for homelessness. These reasons include lack of education, lack of family support, citizenship status, problems handling finances, criminal history (sex offenders), other violence, cognitive or developmental impairment, life unmanageable, has nowhere to go , pregnant, sexual abuse, shelter is unsatisfactory, hasn't received benefits yet. [2] from Glasser and Zywiak (2000). Census and Brief Assessment of the Homeless of Hartford.

Table 2.12 Homeless Census 2002: Primary Reason Homeless by Domicile[1]

Outside (N=22) *

	Freq	Percentage
Building problems	0	0
Family problems	0	0
Health problems	2	9.1
Income problems	1	4.5
Mental illness	6	27.3
Out of prison	0	0
Relocated	0	0
Substance abuse	13	60.0

Transitional (N=374)

	Freq	Percentage
Building problems	6	1.6
Family problems	50	13.4
Health problems	9	2.4
Income problems	40	10.4
Mental illness	51	13.6
Out of prison	25	6.7
Relocated	5	1.3
Substance abuse	168	45
Other	20	5.6

Shelter (N=400)

	Freq	Percentage
Building problems	18	4.5
Family problems	80	20.1
Health problems	17	4.3
Income problems	129	32.3
Mental illness	17	4.3
Out of prison	20	5
Relocated	16	4
Substance abuse	86	21.3
Other	17	4.3

Supportive (N=394)

	Freq	Percentage
Building problems	14	3.5
Family problems	16	4.1
Health problems	14	3.5
Income problems	37	9.4
Mental illness	191	48.4
Out of prison	16	4.1
Relocated	2	.5
Substance abuse	94	24
Other	10	2.5

[1] NOTE:
Each of the reasons listed above are *clusters* of individual reasons for homelessness which were constructed as follows:
Building problems: fire, unfit building, crime in neighborhood, overcrowded apartment and elevated lead levels
Family problems: family problems, was doubled up and asked to leave, domestic violence, previous divorce, domestic problem
Health: medical problems, HIV/AIDS
Income: eviction (formal and informal), income does not meet needs, lack of employment; 2002 Census also includes "benefits expired", "quit job" and "rent too high" and 'foreclosure on house".
Mental illness: Mental illness, recently discharged from a psychiatric hospital
Substance abuse: Alcohol abuse, drug abuse, recently discharged from a substance abuse or recovery program.
Other : Includes educational issues, lack of family support, elevated lead levels, citizenship status, problems handling finances, criminal history (sex offenders), other violence, cognitive or developmental impairment, life unmanageable, has nowhere to go , pregnant, sexual abuse, shelter is unsatisfactory, hasn't received benefits yet.
* Sample sizes reflect those individuals for whom a primary cause of homelessness was identified.

Table 2.13 Homeless Census 2002: Primary Reason Homeless by Domicile and Presence of Children [1] (*only one* primary reason endorsed per household; expressed as percentage of total)

Primary Reason	Shelter: No children N=357	Shelter: With children N=43	Transitional No children N=338	Transitional With children N=36	Supportive No children N = 362	Supportive With children N=32
Building Problems	3.6	11.6	1.2	5.6	2.2	18.7
Family Problems	20.4	16.3	10.4	**41.6**	3.9	6.2
Medical Problems	4.8	0.0	2.7	0.0	3.3	6.3
Income Problems	**29.4**	**55.8**	9.7	19.4	7.5	**31.3**
Mental Illness	4.5	2.3	14.8	2.8	**50.8**	21.9
Out of Prison	5.6	0.0	7.0	2.8	4.1	3.1
Relocated	3.6	7.0	1.2	2.8	.5	0.0
Substance abuse problems	23.8	2.3	**47.9**	16.7	25.1	9.4
Other	4.2	4.6	5.0	8.3	2.5	3.1

[1] NOTE:
Each of the reasons listed above are *clusters* of individual reasons for homelessness which were constructed as follows:
Building problems: fire, unfit building, crime in neighborhood, overcrowded apartment and elevated lead levels
Family problems: family problems, was doubled up and asked to leave, domestic violence, previous divorce, domestic problem
Health: medical problems, HIV/AIDS
Income: eviction (formal and informal), income does not meet needs, lack of employment; 2002 Census also includes "benefits expired", "quit job" and "rent too high" and 'foreclosure on house".
Mental illness: Mental illness, recently discharged from a psychiatric hospital
Substance abuse: Alcohol abuse, drug abuse, recently discharged from a substance abuse or recovery program.
Other : Includes educational issues, lack of family support, elevated lead levels, citizenship status, problems handling finances, criminal history (sex offenders), other violence, cognitive or developmental impairment, life unmanageable, has nowhere to go , pregnant, sexual abuse, shelter is unsatisfactory, hasn't received benefits yet.
* Sample sizes reflect those individuals for whom a primary cause of homelessness was identified. The most frequently endorsed primary causes for each group are presented in boldface.

Specific causes of homelessness: Domestic violence, HIV, discharge from psychiatric hospital, discharge from substance abuse program and release from prison

The following issues are of particular interest due to their implications for public policy therefore detailed information regarding the distribution of these causes of homelessness is provided below. Note that rates are based upon each item being endorsed as *one possible* cause of homelessness among the *potentially multiple* causes of homelessness that may be endorsed for a given individual.

Domestic violence one possible cause of homeless: Domestic violence was endorsed as one possible cause of homelessness for 113 individuals (8.9% of the population). The distribution of these 113 individuals according to domicile and presence of children was as follows: 3 were in shelters with children, 17 were in shelters without children, 19 were in transitional living programs with children, 36 were in transitional living programs without children, 1 person was in supportive housing with children and 37 were in supportive housing without children.

HIV/AIDS as one possible cause of homelessness: HIV/AIDS was endorsed as a cause of homelessness for 74 individuals (5.9% of the population). The distribution of these 74 individuals according to domicile and presence of children was as follows: none were in shelters with children, 16 were in shelters without children, none were in transitional living programs with children, 14 were in transitional living programs without children, 3 were in supportive housing with children and 41 were in supportive housing without children. Note that these percentages do not take injection drug use, an important underlying issue, into account.

Recent discharge from a psychiatric hospital as one possible cause of homelessness: Recent discharge from a psychiatric hospital was endorsed as a cause of homelessness for 47 individuals (3.7% of the population). The distribution of these 47 individuals according to domicile and presence of children was as follows: none were in shelters with children, 8 were in shelters without children, none were in transitional living programs with children, 19 were in transitional living programs without children, none were in supportive housing with children and 20 were in supportive housing without children.

Recent discharge from a substance abuse, detoxification or recovery program as one possible cause of homelessness: Recent discharge from a substance abuse program was endorsed as a cause of homelessness for 84 individuals (6.7% of the population). The distribution of these 82 individuals according to domicile and presence of children was as follows: one was living out of doors, none were in shelters with children, 18 were in shelters without children, none were in transitional living programs with children, 45 were in transitional living programs without children, one was in supportive housing with children and 19 were in supportive housing without children.

Release from jail or prison as one possible cause of homelessness: Release from incarceration was endorsed as a cause of homelessness for 155 individuals (11.7%) of the population. The distribution of these 155 individuals according to domicile and presence

of children was as follows: 53 were in shelters with no children, one was in a transitional living program with children, 67 were in transitional living programs without children, and 31 were in supportive housing without children.

Unmet Service Needs of the Homeless

Endorsement of multiple needs.

When the number of needs per client was assessed, at least one unmet service need was endorsed for 997 (75%) of population. Out of the 997 for whom at least one service need was endorsed, multiple service needs were endorsed for 698 (78%) clients. Among those for whom at least one service need was endorsed, the average number of service needs endorsed by program administrators was 3.28, the median number of service needs endorsed was 3.00.

Mean and median number of unmet service needs.

Table 2.14 below illustrates the mean and median number of service needs endorsed by program administrators across domicile for all clients (including those for whom no service needs were endorsed). Overall, administrators endorsed an average of 2.39 service needs per client. The mean number of service needs endorsed across domicile differed significantly ($F (3, 1322) = 96.91$; $p < .0001$). It was highest for those living outside and decreased across domicile.

Table 2.14

Mean and median number of service needs endorsed by domicile
number of needed svcs

	Mean	N	Std. Deviation	Median
Outside	*4.3636*	*22*	*2.53632*	*3.5000*
Shelter	*3.4086*	*421*	*2.29374*	*3.0000*
Transitional	*2.6973*	*403*	*2.32821*	*2.0000*
Supportive	*1.1500*	*480*	*1.69809*	*.0000*
Total	*2.3906*	*1326*	*2.33168*	*2.0000*

Unmet service needs by domicile and presence of children

Tables 2.15 and 2.16 below illustrate the patterns of unmet service needs that were observed by domicile and presence of children in 1999 and in 2002, respectively. As in 1999, the patterns of endorsement of unmet service needs in 2002 varied as a function of domicile and presence of children. The patterns observed in 2002 were as follows:

For those living outside, case management and substance abuse treatment remain the most frequently endorsed unmet need. While housing placement and job placement were also frequently endorsed in 1999 (Table 2.15), they were endorsed much less frequently in 2002 (Table 2.16).

For those living in shelters with no children present, housing placement remains the most frequently endorsed unmet need.

For those living in shelters with children, the most frequently endorsed unmet needs remain job placement, job training and housing placement. Day care also appears to be more of a crucial unmet need for those in shelters with children, compared with those with children in other domiciles.

For those living in transitional housing, 1999 data indicate that housing placement and job placement were the most frequently endorsed unmet needed services. In 2002, individuals in transitional housing without children appear to be in need of housing placement, life skills training, job placement and substance abuse treatment. Those living in transitional housing with children appear to be in need of housing placement and job placement.

Marked changes are observed for people living in supportive housing. Compared with 1999 data, the 2002 Census indicates that job training, recreation and, for those with children, legal services substance abuse treatment are services that have increased in the degree to which they are needed by this segment of the population. The 2002 Census also indicates that anger/stress management was endorsed most frequently as an unmet need for those living in supportive housing with children.

Table 2.15 Unmet Needs of the Homeless of Hartford: 1999 Homeless Census [1]

May be more than one service needed per household , expressed as *percentage* within household group.

Services Needed Reason	Outside N=38	Shelter: No children N=237	Shelter: With children N=47	Transitional No children N=259	Transitional With children N=10	Supportive No children N=407	Supportive With children N=60
Case management	84	51	13	6	0	2	0
Day care	3	0	32	1	10	0	20
Financial assistance	29	30	21	18	0	6	10
Housing placement	84	62	45	31	0	5	2
Job training	26	46	62	29	0	11	17
Job placement	79	45	45	30	0	12	12
Legal services	16	5	2	12	10	1	3
Life skills training	68	23	19	8	0	12	22
Medical care	40	15	0	4	0	3	2
Mental health care	34	11	9	6	0	6	22
Recreation	45	3	0	9	0	6	25
Substance abuse treatment	82	33	9	6	0	7	0
Other*	0	2.5	4	6	0	9	7

*****Includes: affordable housing, anger management, citizenship, day program, dental care, dialectical behavior management, domestic violence assistance, education, elderly services, English as a Second Language, entitlements gambling anonymous, group home (elderly or intellectually challenged), help utilizing services, housekeeping, intense family counseling, household furniture, general education diploma, nursing home, parenting skills, psychotherapy, Section 8, self esteem group, sex offender treatment, social security, socialization, stress management, support group, regaining custody of children, vocational training, help for hearing impaired, and services for the mentally ill.

[1] From Glasser and Zwiak (2000). Census and Brief Assessment of the Homeless of Hartford.

Table 2.16 Unmet Needs of the Homeless of Hartford: 2002 Homeless Census

May be more than one service needed per household, expressed as *percentage* within household group.

Services Needed Reason	Outside N=22	Shelter: No children N=378	Shelter: With children N=43	Transitional No children N=367	Transitional With children N=36	Supportive No children N =441	Supportive With children N=39
Anger/ stress Management	22.7	17	14	21.5	11.1	12	31
Case management	100	29.7	14	13.1	0	2.3	7.9
Day care	0	.2	20.9	1.6	0	0	10.5
Domestic violence asst	0	2.4	4.7	4.1	2.8	2	5.1
Financial assistance	31.8	37.1	20.9	23.7	2.8	5.4	15.8
Housing placement	31.8	70.8	58.1	49.5	22.2	2.5	7.9
Education	0	12.5	18.6	12.5	0	25	10.3
Job training	18.2	30.5	44.2	21.8	8.3	19.9	18.4
Job placement	4.5	37.4	62.8	25.3	16.7	13	10.5
Legal services	4.5	10.3	2.3	6	0	1.8	28.9
Life skills training	31.8	13	30.2	28.1	2.8	5.3	0
Medical care	40.9	24	2.3	11	0	2.8	2.6
Mental health care	40.9	16.2	16.3	16.1	2.8	6.6	13.1
Recreation	0	7.7	0	14.7	0	20.9	13.1
Substance abuse treatment	95.5	24.1	2.3	24.3	0	5.6	13.1
Group home	0	5	0	5.4	0	.68	0
Payee	1	2	7	2.2	2.8	3.2	0
Other*	9.1	4.8	2.3	8.7	0	2.0	2.6

*****Includes: Behavior modification, English as a Second Language, translation services, counseling, convalescent home, parenting skills, psychotherapy, SSI, budgeting skills, savings account, credit counseling, driver's license, financial assistance with co-pay for medications, methadone program, more intense psychiatric medicine and treatment, supportive housing, pest control and conservation. Also included are comments that "client declines treatment".

Notable causes of homelessness and unmet service needs in the 2002 Census

The notable causes of homelessness and notable services needed across the four types of domiciles, as delineated by the 2002 Homeless Census, are presented in Table 2.17 below. In this analysis, a "notable" cause or service is defined as one that was endorsed by at least 10% of program administrators. Note that *multiple* causes or service needs could have been endorsed for a given individual.

Causes

Compared with shelter and transitional living clients , living outdoors appears to be associated with a more narrow profile of causes, although it is important to note that these causes are also present for those living in other domiciles. For those living in both shelters and transitional facilities, being released from prison is a notable cause. For both shelter and transitional living clients, eviction is a notable cause. Domestic violence is a notable cause for those living in both transitional and supportive facilities. For individuals in transitional living "other" reasons (which as a category was endorsed by over 10% for each) included no family support, criminal activities, language barriers, lack of education and lack of benefits.

Unmet Service Needs

Regarding notable unmet service needs, substance abuse treatment and case management are notable needs for those in all living arrangements except supportive housing. The rates with which substance abuse treatment is endorsed as an unmet need fall notably across domicile; ranging from 95.5% for those living outdoors to 21-22% for those in transitional facilities and falling to less than 10% for those in supportive living programs. Endorsement rates for mental health treatment and medical care also declined in a similar manner across domiciles. Endorsement of recreation as an unmet need is notable for those living in transitional facilities and it increases for those in supportive housing. Finally, it is noteworthy that program administrators involved in supportive housing programs rated their clients to be in need of fewer services, relative other administrators' ratings of their respective clients' needs. It is important to note that many of the listed services may have already been provided by some of the supportive housing programs. Additionally, enrollment into some treatment modalities is often required for entry into certain types of programs.

Table 2.17 Notable causes of homelessness and unmet service needs across domicile

Outside (N= 22)

Notable causes of homelessness:		Notable services needed:	
Family problems	40.9%	Anger/stress management	22.7%
Income	27.3%	Financial assistance	31.8%
Lack of employment	45.5%	Housing	31.8%
Mental illness	36.4%	Job training	18.2%
Alcohol abuse	59.1%	Life skills training	31.8%
Drug abuse	50.0%	Medical care	40.9%
		Mental health treatment	40.9%
		Substance abuse treatment	95.5%
		Case management	100.0%

Shelter clients (N= 421)

Notable causes of homelessness:		Notable services needed:	
Family problems	30%	Anger/stress management	16.7%
		Case management	28.1%
Medical problems	17.4%	Education	13.1%
Income	40.5%	Financial assistance	35.5%
Lack of employment	51.2%	Housing	69.5%
Out of prison	12.6%	Job training	31.9%
Relocation	13.6%	Job placement	40.0%
Mental illness	15.7%	Life skills training	14.8%
Alcohol abuse	19%	Medical care	21.9%
Drug abuse	29.3%	Mental health treatment	16.2%
Eviction	19%	Substance abuse treatment	21.9%

Transitional Living clients (N= 403)

Notable causes of homelessness:		Notable services needed:	
Family problems	23.6%	Anger/stress management	20.6%
Dbled up/ asked to leave	11.9%	Case management	11.9%
Medical problems	10.7%	Education	11.4%
Income	22%	Financial assistance	21.8%
Lack of employment	25.6%	Housing	46.9%
Out of prison	16.9%	Job training	20.6%
Domestic violence	13.6%	Job placement	24.6%
Mental illness	26.3%	Life skills training	25.8%
Alcohol abuse	36.2%		
Drug abuse	54.6%	Mental health treatment	14.9%
Discharge from program	11.2%	Recreation	13.4%
Eviction	13.4%	Substance abuse treatment	22.1%
Other	10.2%		

Supportive Living clients (N= 480)

Notable causes of homelessness:		Notable services needed:	
Family problems	21.2%	Anger/ stress management	13.5%
Income	39.1%	Job training	20.4%
Lack of employment	15%	Job placement	11.9%
Mental illness	54.3%	Recreation	18.7%
Alcohol abuse	18.7%		
Drug abuse	34.3%		
Other	10%		

Note: Some of these services (e.g., substance abuse treatment) are inherent in some types of domiciles (e.g., some transitional living programs). Needs and services included as "notable" if endorsed by at least 10% of administrators.

Summary of the Hartford Homeless Census 2002

Data from the 2002 Homeless Census indicate that there are a greater number of homeless individuals in Hartford, compared with the 1999 Homeless Census. Hispanics appear to be under-represented (i.e., fewer Hispanics are homeless than would be expected if homelessness was evenly distributed throughout the population) compared with the general population of the city (as delineated in the 2000 U.S. Census). Finally, the demographic profile of Hartford's homeless population has remained largely unchanged since the 1999 Homeless Census.

Several methodological differences exist between the 1999 Homeless Census and the 2002 Homeless Census. First, the 1999 study did not include data from emergency youth shelters. Second, one program, CRT Supportive Housing II, was not in existence in 1999. Finally, there is variability in the degree to which various programs completed and returned census forms in 1999 vs 2002. These caveats must be considered when one attempts to account for the apparent increase in the numbers of homeless individuals enumerated in 2002 vs. 1999. After accounting for the presence of youth shelters and the existence of CRT II, there appears to have been a 21% increase in the number of homeless households enumerated in Hartford.

The top three primary reasons for homelessness, (substance abuse, mental illness and income problems) have not changed notably since the 1999 Census. Endorsement rates for mental illness appear to have dropped while endorsement for income problems appears to have increased. Data from the 2002 Census indicate that family problems, income, lack of employment, mental illness and substance abuse are universal causes of homelessness, across all domiciles. These data further indicate that release from prison or release from other programs, relocation, eviction and domestic violence also seem to contribute to one's utilization of shelters, transitional living facilities and supportive housing programs.

The most commonly endorsed primary reasons for homelessness varied according to domicile and presence of children. Income problems were endorsed most frequently for those living in shelters (with or without children) and for those living in supportive housing with children. Mental illness was endorsed most frequently for those living in supportive housing without children. Substance abuse was endorsed most frequently for those living in transitional programs without children while family problems were endorsed most frequently for those living in transitional programs with children. These patterns reflect, in part, the fact that many transitional and supportive housing programs are specifically designed to serve those concurrently in substance abuse treatment or those living with chronic mental illness.

We observed that being released from prison was a notable cause of homelessness for 12.6% of shelter residents. It is important to note that this observation has implications for the prevention of homelessness since the added burden of recent release from prison can compound the challenges to stability already faced by these individuals. Thus this

group may benefit from additional assistance in making the transition from incarceration to freedom in a way that circumvents an intermediate state of homelessness.

Regarding services needed by the homeless population, several important patterns were observed. First, three-quarters of the administrators endorsed at least one service need per client with 53% of all administrators endorsing multiple service needs. Out of those who did endorse unmet needs , 78% endorsed multiple needs per client. Thus, it was unlikely that an administrator would endorse only one need per client. Second, the number of services needed differed significantly according to domicile with the greatest number of needs endorsed for those living outside and the least number endorsed for those in supportive housing. Third, when 2002 data were assessed across domiciles, case management and substance abuse was a notable need for virtually all of those individuals living outside. In general, the endorsement rate for these services decreased as the type of domicile became less tenuous. Concomitantly, endorsement of recreation increased for those living in transitional and, more so, for those living in supportive housing. This pattern suggests that quality of life issues begin to emerge as priorities once addictions and basic survival needs are addressed and once one's living arrangements become less tenuous.

Data from the 1999 Census of the Homeless of Hartford indicated that services needed also varied as a function of the presence or absence of children. The 2002 Census of the Homeless of Hartford indicates that this pattern has remained consistent although, compared with 1999, individuals living in transitional and supportive housing with children appear to be in need of a greater number of services. Consistent with the 1999 Homeless Census, the 2002 Homeless Census in general provides strong support for the crucial role that supportive housing programs play in improving the quality of life for at-risk clients.

Two other homeless censuses have recently been carried out in Connecticut. One enumerated the homeless in the Torrington / Winsted area (Wayne, 2001) and one enumerated the homeless in Willimantic (Cementina, 2002). Although the methodologies differ somewhat from the present study (clients were surveyed instead of administrators), these reports allow us to make comparisons between the homeless population of Hartford and those of these other regions.

The homeless population of Torrington/Winsted (75% of whom were residing in shelters or living out-of-doors) was similar to that in Hartford in that 80% of the homeless surveyed in Torrington/Winsted identified multiple service needs. A need for vocational rehabilitation was identified by one third of those of those surveyed in Torrington/Winsted. In comparison, it is notable that job training was identified as an unmet need for 32% of the shelter population of Hartford. Almost 70% of those surveyed in Torrington / Winsted identified a need for substance abuse treatment. While substance abuse treatment was endorsed for only 22% of the shelter population of Hartford, it was endorsed for 95.5% of the homeless living out-of-doors. In Torrington/Winsted, mental health treatment was identified as a need by over half of those surveyed. While it was identified as a need for 16% of the shelter population in Hartford, it was identified as a need for 41% of those living out-of-doors. Although very different demographically, it

seems as though the homeless populations of the Torrington/ Winsted area and the City of Hartford are similar in terms of their need for multiple services and in their profiles of needed services.

The census that was carried out in Willimantic utilized a very similar data collection tool as the one utilized in the present report thereby facilitating a more direct comparison to the results of the 2002 Homeless Census in Hartford. Although the homeless population in Willimantic is very different demographically than that of Hartford, there are several similarities between the two populations. The two most commonly reported reasons for homelessness in Willimantic were unemployment (particularly for those residing in shelters) and substance abuse. Lack of employment was also the most commonly endorsed cause of homelessness in Hartford particularly for shelter clients. Lack of income was second in Hartford followed by drug abuse. Regarding services needed, employment issues also figured strongly for the shelter populations of both Willimantic and Hartford with job placement ranking in the top three needed services in both studies. Regarding the primary reasons for homelessness, the most commonly endorsed primary reason in both the Hartford and the Willimantic studies was substance abuse, endorsed by 30% of Hartford administrators and 42% of Willimantic clients.

Some interesting differences were also observed in that recreation was endorsed as a notable unmet service need for both transitional and supportive living clients in Hartford while it was endorsed only twice out of 155 households surveyed in Willimantic. In contrast, transportation and supplemental food were service needs that were commonly endorsed in Willimantic, highlighting some of the differences between the challenges faced by the homeless in a rural vs. an urban environment. While mental illness was the second most commonly endorsed cause of homelessness in Hartford, it was endorsed as the primary cause only 4 times in the Willimantic study, possibly reflecting the large numbers of supportive housing programs in Hartford.

When we compare the patterns observed in the present study to those observed in other regions of the state, we can observe that some issues (i.e., substance abuse and lack of employment) are components of a universal constellation of factors that seem to contribute to homelessness. Other factors, such as lack of transportation, can be expected to have varying degrees of negative impact on homeless individuals. Finally, these studies illustrate that homeless individuals seem to be in need of multiple services across region.

The 2002 Census of the Homeless of Hartford has provided information on the *breadth* of homelessness in Hartford. The next section of this report presents the results of the Hartford Homeless Health Survey 2002 and will provide information on the *depth* of homelessness in Hartford.

3. Overview of Results of the Hartford Homeless Health Survey 2002

The Hartford Homeless Health Survey 2002 involved interviews with 201 randomly selected individuals. Due to the intentional under-sampling of supportive housing facilities, over 80% of the sample were living in shelters or in transitional housing. We obtained interviews with 106 (82%) of the 130 individuals sampled from shelters, with 67 of the 100 individuals sampled from transitional housing and with 28 (70%) of the 40 individuals sampled from supportive housing. We also obtained interviews with five individuals who had been living out-of-doors the night before the interview. Due to sample size constraints, it is difficult to generalize the information obtained on these five individuals to the broader population of those who may be living out-of-doors in Hartford at any given time. Data on the outdoor living homeless are discussed in a separate section of this report. Information on the households interviewed is presented in Table 3.1 below.

Table 3.1 Households interviewed

a. Households interviewed

Total Number of Households Interviewed	206
Total Number of Adults:	213
Total Number of Children:	40
Total Number of People:	253

b. Type of domicile

	Number	Percentage
Outside	5	2.4
Shelter	106	52.4
Transitional	67	32.2
Supportive	28	12.6

c. Number of Adults in Household

	Number	Percentage
One	200	97.1
Two	5	2.4
Three	1	.5

d. Domicile by presence of children

	Number	Percentage
Outside no children	5	2.4
Outside with children	0	0.0
Shelter no children	97	48.1
Shelter with children	9	4.4
Transitional no children	57	27.7
Transitional with children	10	4.9
Supportive no children	28	12.6
Supportive with children	0	0.0
Total	206	100.00

e. Number of Children in Household

	Number	Percentage
None	187	90.8
One	7	3.4
Two	6	2.9
Three	4	1.9
Four	1	.5
Five	1	.5

Table 3.2
Duration of time in program

Duration	Frequency	Percent
Up to one month	81	42.0
More than one month up to six	66	34.2
More than six months up to one year	16	8.3
More than one year up to two	17	8.8
More than two years	13	6.7
Total	193	100.0

Summary:

A total of 206 individuals or heads of households were interviewed, representing 213 adults and 40 children. Over 80% of the respondents were currently residing in either emergency shelters or transitional housing. Less than 25% of those interviewed had been living at their programs for six months or more (Table 3.2 above), reflecting the intentional under-sampling of supportive living facilities. A list of the programs from which the participants were sampled follows below (Table 3.3). The sample included 8 emergency shelters, 9 transitional programs and five supportive housing facilities. The frequencies of individuals sampled reflect the relative housing capacities of each of the listed facilities.

Table 3.3

Programs sampled

Shelters

	Frequency	Percent
CRT Mckinney Shelter	*24*	*22.6*
Immaculate Conception	*24*	*22.6*
Mercy Housing Shelter	*8*	*7.5*
My Sister's Place	*3*	*2.8*
Open Hearth	*10*	*9.4*
The Salvation Army Marshall House	*5*	*4.7*
South Park Inn	*21*	*19.8*
YWCA Shelter	*11*	*10.4*
Total	*106*	*100.0*

Transitional programs

	Frequency	Percent
Community Renewal Team Supportive Housing I	*8*	*11.9*
Community Renewal Team Supportive Housing II	*6*	*9.0*
Mercy Housing Transitional	*5*	*7.5*
My Sister's Place II	*4*	*6.0*
Open Hearth Transitional	*12*	*17.9*
South Park Inn Transitional	*5*	*7.5*
YWCA Transitional	*7*	*10.4*
ADRC: Alternative Living Center	*17*	*25.4*
ADRC: Recovery House	*3*	*4.5*
Total	*67*	*100.0*

Supportive housing

	Frequency	Percent
Project HEARRT Year1 (Chrysalis)	*3*	*10.7*
My Sister's Place III	*11*	*39.3*
Plimpton House	*7*	*25.0*
YWCA Shelter Plus Care program	*3*	*10.7*
525 Hudson St. (Hudson View Commons)	*4*	*14.3*
Total	*28*	*100.0*

Demographics

Demographic characteristics of the interviewed group are presented in Tables 3.4 and 3.5 below. The sample was largely male (almost 70%). Almost 40% of those interviewed were African American, 28% were Hispanic and almost one quarter were White. African Americans and Whites are over-represented, compared with the general population of Hartford, among the city's homeless population. Almost 63% were between the ages of 35- 54 years old. The interviewed sample appears to be quite similar to the general population of homeless individuals enumerated in the homeless census (Table 2.6). However, while 7% of the general population of homeless individuals were veterans, approximately 13% of the interviewed sample reported being veterans (compared to the 2002 estimate of 9% for the State derived from information provided by the State of Connecticut Department of Veteran's Affairs). Thus this is one way in which the interviewed sample differs from the general population of homeless individuals. It is also important to remember that individuals in supportive housing were intentionally under-sampled in the interview component of this study.

Regarding other demographic characteristics of the interviewed sample, over 67% of the respondents had completed high school and 64% of them had never been married. Regarding employment status, the largest percentage (36%) of the respondents were unemployed and looking for work while 16% were receiving disability. Approximately 10% were working full time and 12% were working part time. The majority (67%) reported that they had not worked at all in the past month. Approximately 30% had earned less than $99 in the past month and over 40% had earned less than $5000 in the past year. Finally, while almost 14% reported that they received supplemental security income, approximately 41% reported that they were not receiving any form of financial assistance.

Table 3.4 Demographic Characteristics of Interviewed Group

a. Gender

Type	Number	Percentage
Male	142	68.9
Female	64	31.1

b. Ethnicity of Adults interviewed*

	Number	Percentage
African-American	77	37.7
Native American	5	2.5
Asian or Pacific Islander	2	1.0
Caribbean/Virgin Islander/ West Indian	0	0.0
Hispanic/Latino	58	28.4
Multi-ethnic	10	4.9
White	50	24.5
Other	2	1.0

*The ethnic distribution for Hartford, according to the 2000 U.S. Census is: African-American 36%, Hispanic Origin 40.5% (may be any race), and White 17.8%.

c. Age categories

	Number	Percentage
Less than 25	16	7.9
25 to 34	40	19.7
35 to 44	71	35.0
45 to 54	58	28.6
55 to 64	14	6.9
65 to 74	4	2.0
75 and over	0	0

d. Types of Households

Type	Number	Percentage
With Children	19	9.2
Without Children	187	90.8

e. Veteran Status

Type	Number	Percentage
Veteran	26	12.7
Not a Veteran	179	87.3

Table 3.4 Demographic Characteristics of Interviewed Group (continued)

f. Educational level

Type	Number	Percentage
Less than high school	67	32.7
High school graduation or GED	82	40.0
Greater than high school	56	27.3

g. Marital status

Type	Number	Percentage
Married	9	4.4
Widowed	3	1.5
Divorced/ Separated	61	29.9
Never been married	131	64.2

Table 3.5 Current Employment and Financial Assistance

a. Current employment status

	Number	Percentage
Full-time work	21	10.2
Part-time work	26	12.6
Receiving disability assistance	33	16
Unemployed, looking for work	74	36
Unemployed, not looking for work	34	18
Retired and not working	4	1.9
Full-time homemaker	1	.5
Other	9	4.4

b. Number days worked in the past month

	Number	Percentage
None	138	67
One to ten days	23	11.2
Over ten days	42	20.4

c. Income past month

	Number	Percentage
None	34	16.7
$1 to $99	26	12.7
$100 to $499	71	34.8
$500 to $999	55	27
$1,000 or more	18	8.8

d. Total *household* income before taxes in 2001

	Number	Percentage
Less than $5,000	88	42.7
$5,000 to $9,999	68	33
$10,000 to 19,999	25	12.1
Over $20,000	18	8.7

e. Receipt of financial assistance (may be more than one category per homeless household)

	Number	Percentage
No assistance	84	40.8
Social security	18	8.7
Supplemental security income (SSI)	28	13.6
State Administered General Assistance (SAGA)	43	21
State Supplement	15	7.3
Veteran's benefits	1	.5
TANF/TFA	13	6.3

Housing history of interviewed group

Respondents were asked to identify where they were staying immediately prior to entry into the current program. They were also asked about where they spent the first 18 years of their life and about how long they've living in Hartford (cumulatively.) Previous place of residence is presented below (Table 3.6). It is important to note that this information was based upon self- report and it is possible that some individuals were not be able to make the distinction between some forms of housing and others (e.g., living in supportive housing may be viewed as having one's own apartment).

Table 3.6 Previous place of residence

Where were you living before coming to the present program?

a. Top four categories for respondents currently living in *shelters:*

Was living at a shelter	26.4%
Was in jail/prison	13.2%
Was temporarily staying with family or friends	19.8%
Was in own apartment with lease	9.4%

b. Top four categories for respondents currently living in *transitional housing:*

Was living at a shelter	22.4%
Was in a substance abuse program	16.4%
Was temporarily staying with family or friends	19.4%
Other	9.0%

c. Top four categories for respondents currently living in *supportive housing:*

Was living at a shelter	35.7%
Was in transitional housing	14.3%
Was temporarily staying with family or friends	10.7%
Was permanently staying with family or friends	10.7%
Was in own apartment with lease	14.3%

d. Where was this previous place located?
(% located in Hartford by present domicile):

Respondents currently living in shelters	56.6%
Respondents currently living in transitional housing	61.0%
Respondents currently living in supportive housing	96.4%

Previous places reported according to type of domicile are presented below (Table 3.7).

Table 3.7 Previous Place by Domicile

	Outside	Shelter	Trans	Supp	Total
Shelter	*1*	*28*	*15*	*10*	*54*
	20.0%	*26.4%*	*22.4%*	*35.7%*	*26.2%*
Transitional Housing		*1*	*2*	*4*	*7*
		.9%	*3.0%*	*14.3%*	*3.4%*
Supportive Housing				*2*	*2*
				7.1%	*1.0%*
Street	*1*	*7*	*2*		*10*
	20.0%	*6.6%*	*3.0%*		*4.9%*
Psychiatric Facility			*1*		*1*
			1.5%		*.5%*
Detox/ Substance Abuse Treatment Program		*4*	*11*	*1*	*16*
		3.8%	*16.4%*	*3.6%*	*7.8%*
Hospital or Medical Center		*1*			*1*
		.9%			*.5%*
Jail or Prison	*1*	*14*	*5*		*20*
	20.0%	*13.2%*	*7.5%*		*9.7%*
Domestic Violence Shelter			*2*		*2*
			3.0%		*1.0%*
Temp staying w Family or Friends/ Doubling Up		*21*	*13*	*3*	*37*
		19.8%	*19.4%*	*10.7%*	*18.0%*
Permanently staying with family or friends		*4*	*4*	*3*	*11*
		3.8%	*6.0%*	*10.7%*	*5.3%*
Renting a room in someone's apt.		*3*	*2*		*5*
		2.8%	*3.0%*		*2.4%*
Own apartment (with lease)		*10*	*4*	*4*	*18*
		9.4%	*6.0%*	*14.3%*	*8.7%*
Own house		*4*			*4*
		3.8%			*1.9%*
Other	*2*	*9*	*6*	*1*	*18*
	40.0%	*8.5%*	*9.0%*	*3.6%*	*8.7%*
Total	*5*	*106*	*67*	*28*	*206*
	100.0%	*100.0%*	*100.0%*	*100.0%*	*100.0%*

Tables 3.8 – 3.12 provide information regarding respondents' five year housing history and housing history during the respondent's first 18 years of life.

Table 3.8 Where were you living 5 years ago? (% living in Hartford by present domicile)

Respondents currently living in shelters	37.7%
Respondents currently living in transitional housing	29.9%
Respondents currently living in supportive housing	60.7%

Table 3.9 Where were you born (% born in Hartford by present domicile)

All	28.4%
Respondents currently living in shelters	19.8%
Respondents currently living in transitional housing	41.8%
Respondents currently living in supportive housing	23.1%

Table 3.10 Where is the one place (town) you lived in for the longest period of time during the first 18 years of your life?

	Number	Percentage
Hartford	58	28.2
Not Hartford	148	71.8

Table 3.11 Where is the one place (town) you lived in for the longest period of time during the first 18 years of your life? (% lived in Hartford by present domicile):

Respondents currently living in shelters	21.7%
Respondents currently living in transitional housing	35.8%
Respondents currently living in supportive housing	28.6%

Table 3.12. Where is the one place (state) you lived in for the longest period of time during the first 18 years of your life?

	Number	Percentage
Connecticut	103	50.0
Not Connecticut	103	50.0

Tables 3.13 and 3.14 illustrate the cumulative amount of time that respondents had lived in Hartford by domicile and provide information on the number of days that they were homeless in the past year and the age at which they were homeless for the first time.

Table 3.13 How long have you lived in Hartford?

		Domicile				
		Outside	Shelter	Transitional	Supportive	Total
Less than 1 year	Count	1	26	15		42
		20.0%	24.5%	22.7%		20.6%
At least 1 year, but less than 2 years	Count	1	6	11	1	19
		20.0%	5.7%	16.7%	3.7%	9.3%
At least 2 years, but less than 5 years	Count		11	9	4	24
			10.4%	13.6%	14.8%	11.8%
At least 5 years, but less than 10 years	Count		18	2	8	28
			17.0%	3.0%	29.6%	13.7%
More than 10 years	Count	3	45	29	14	91
		60.0%	42.5%	43.9%	51.9%	44.6%
Total	Count	5	106	66	27	204
		100.0%	100.0%	100.0%	100.0%	100.0%

Table 3.14 Number days homeless past year and age homeless for first time

	How old were you when you were homeless for the first time?	In the past year, how many days have you been homeless?
N	194	177
Mean	33.52	142.73
Median	33.00	90.00
Std. Deviation	12.288	143.801
Minimum	1	0
Maximum	69	365

Summary :

Shelters were most frequently endorsed as previous places of residence prior to entry into a given current program (this was true whether the respondents were currently living in another shelter, in transitional housing or in supportive housing). Other commonly endorsed previous living arrangements included staying with family or friends and living in one's own apartment. Some notable differences between domiciles were observed in that 16% of those living in transitional programs had come from substance abuse programs, 14% of those in supportive housing had come from transitional housing and 13% of those living in shelters had come from prison or jail. It is important to consider the implications for the prevention of homelessness that are associated with this latter 13%. These individuals have much to over come with their re-entry into society and it is likely that their present state of homelessness will be a further detriment to their prospects for work and general stability. Thus this group would benefit from the receipt of assistance in making the transition from incarceration to community living in a way that would avoid an intermediary state of homelessness.

Half of the individuals interviewed had lived in Connecticut as their place of longest residence during their first 18 years of life. Regarding the town in which respondents were living immediately prior to their entry into their current program, 57% of those currently living in shelters had been living in Hartford, 61% of those living in transitional programs had been living in Hartford and 96.4% of those in supportive programs had been living in Hartford. When five year history was assessed, the respondents living in supportive housing were more likely to have been living in Hartford 5 years earlier than were those living in either shelters or in transitional housing (61% compared with 38% and 30%, respectively). This finding is not surprising given the permanence of supportive housing compared with shelters and transitional housing programs.

Regarding place of birth, those living in transitional housing appear to have been more likely to report Hartford as their place of birth and were also more likely to have grown-up in Hartford. Overall, exactly half of the sample had grown up outside of Connecticut. Data from the 2000 U.S. Census (Table P038; U.S. Census Bureau, 2002c), indicate that 43% of the general population of Hartford County was born outside of the State of Connecticut. Further, approximately the same proportion of the general population of State of Connecticut was born outside of the state. These migration rates are comparable to the U.S. as a whole, for which 40% of the general population was born outside of their state of current residence. These data suggest that a sizable proportion of the U.S. is mobile with the population of Hartford County corresponding to this national trend. It is important to note that the housing history of Hartford's homeless population should thus be interpreted within this context.

Reasons for homelessness and unmet service needs

In order to assess the respondents' reports of the factors that led to their homelessness, a list of 22 possible factors were read during the interview. Respondents were asked to indicate whether or not each of these factors contributed to their housing situations. They were then asked to identify the factor that they thought was the most important contributor. In order to assess the respondents' reports of their unmet service needs, a list of 17 services were read during the interview. The respondents were asked to indicate whether or not they were currently in need of each of the services.

Overall, respondents endorsed an average of 4.24 unmet service needs (the median number endorsed was 3.00). Table 3.15 illustrates the mean and median number of unmet service needs endorsed by respondents. The mean number of service needs endorsed across domicile differed significantly ($F(3, 202) = 7.29$; $p < .001$). It was highest for those living outside and decreased across domicile. When respondent self-report is compared to administrator report from the 2002 Homeless Census, administrators endorsed fewer service needs than did respondents, across all domiciles (Table 3.15a, below). Important caveats to consider in the interpretation of this finding will be discussed in the summary below.

Table 3.15 Respondent self-report from Hartford Homeless Health Survey

Mean and median number of unmet service needs endorsed by domicile

	Mean	N	Std. Deviation	Median
Outside	*6.6000*	*5*	*3.64692*	*7.0000*
Shelter	*5.0566*	*106*	*3.47736*	*4.0000*
Transitional	*3.5672*	*67*	*3.27166*	*2.0000*
Supportive	*2.3214*	*28*	*2.03767*	*2.0000*
Total	*4.2379*	*206*	*3.40254*	*3.0000*

Table 3.15a Administrator report from 2002 Census of the Homeless of Hartford

Mean and median number of service needs endorsed by domicile

	Mean	N	Std. Deviation	Median
Outside	*4.3636*	*22*	*2.53632*	*3.5000*
Shelter	*3.4086*	*421*	*2.29374*	*3.0000*
Transitional	*2.6973*	*403*	*2.32821*	*2.0000*
Supportive	*1.1500*	*480*	*1.69809*	*.0000*
Total	*2.3906*	*1326*	*2.33168*	*2.0000*

Primary Reasons for Homelessness

The primary reasons for homelessness have been grouped into four different categories (Table 3.16, below) and the endorsement rates for each of these categories have been presented for the whole sample and subdivided by domicile. Since they were not part of the random sample, information regarding the 5 out-of-doors respondents will be discussed later in a separate section.

Table 3.16 Primary reasons for homelessness according to domicile

All (N=196) *

	Freq	Percentage
Building problems	5	2.6
Family problems	24	12.2
Health problems	10	5.1
Income problems	63	32.1
Mental illness	10	5.1
Out of prison	5	2.6
Relocated	3	1.5
Substance abuse	61	31.1
Other	15	7.6

Shelter (N=102)

	Freq	Percentage
Building problems	5	4.9
Family problems	9	8.8
Health problems	4	3.9
Income problems	41	40.2
Mental illness	1	.98
Out of prison	5	4.9
Relocated	3	2.9
Substance abuse	22	21.6
Other	12	11.8

Transitional (N=67)

	Freq	Percentage
Building problems	0	0.0
Family problems	12	17.9
Health problems	3	4.5
Income problems	13	19.4
Mental illness	4	6.0
Out of prison	0	0.0
Relocated	0	0.0
Substance abuse	32	47.8
Other	3	4.5

Supportive (N=22)

	Freq	Percentage
Building problems	0	0.0
Family problems	3	13.6
Health problems	2	9.1
Income problems	7	31.8
Mental illness	5	22.7
Out of prison	0	0.0
Relocated	0	0.0
Substance abuse	5	22.7
Other	0	0.0

[1] NOTE:

Each of the reasons listed above are cluster*s* of individual reasons for homelessness which were constructed as follows:
Building problems: fire, unfit building, crime in neighborhood, overcrowded apartment
Family problems: family problems, was doubled up and asked to leave, domestic violence
Health: medical problems, HIV/AIDS
Income: eviction (formal and informal), income does not meet needs, lack of employment; 2002 Census also includes "benefits expired", "quit job" and "rent too high".
Mental illness: Mental illness, recently discharged from a psychiatric hospital
Substance abuse: Alcohol abuse, drug abuse, recently discharged from a substance abuse or recovery program.
Other (not in table): Include lack of education, lack of family support, elevated lead levels, citizenship status, problems handling finances, criminal history (sex offenders), other violence, cognitive or developmental impairment, life unmanageable, has nowhere to go , pregnant, sexual abuse, shelter is unsatisfactory, hasn't received benefits yet.
* Includes 5 participants living out of doors who will be discussed separately.

Unmet service needs

In Table 3.17 below, unmet service needs are presented according to domicile and presence of children. Table 3.18 on the following page lists "notable" causes of homelessness and "notable" unmet service needs by domicile. Causes and needs were defined as "notable" if they were endorsed by 10% or more or survey respondents.

Table 3.17 Unmet Needs of the Homeless of Hartford: 2002 Hartford Homeless Health Survey

May be more than one service needed per household, expressed as *percentage* within household group.

Services Needed Reason	Outside N=5	Shelter: No children N=97	Shelter: With children N=9	Transitional No children N=57	Transitional With children N=10	Supportive No children N =28
Anger/ stress Management	20.0	22.2	11.1	28.2	10.0	19.2
Case management	20.0	26.3	11.1	15.8	0.0	0.0
Day care	0.0	1.0	55.6	1.8	20.0	0.0
Domestic violence asst	20.0	3.0	0.0	3.5	0.0	3.8
Financial assistance	80.0	67.7	44.4	40.4	15.4	15.4
Housing placement	80.0	72.7	88.9	54.4	46.2	46.2
Education	0.0	28.3	33.3	31.6	19.2	19.2
Job training	80.0	46.5	55.6	35.1	30.8	30.8
Job placement	80.0	56.6	77.8	45.6	26.9	26.9
Legal services	20.0	20.2	0.0	21.1	7.7	7.7
Life skills training	40.0	19.2	11.1	22.8	11.5	11.5
Medical care	60.0	34.3	22.2	17.5	19.2	19.2
Mental health care	40.0	17.2	11.1	10.5	11.5	11.5
Recreation	40.0	28.3	55.6	21.1	19.2	19.2
Substance abuse treatment	60.0	27.3	0.0	7.0	0.0	0.0
Group home	20.0	9.1	0.0	3.5	0.0	0.0
Payee	20.0	8.1	11.1	5.3	11.5	11.5
Other*	0.0	9.1	33.3	7.0	7.7	7.7

*Includes: Assistance with benefit application, transportation, marriage counseling, budgeting skills, food stamps, therapist, SSI, Section 8, room to cook, children's services, dental care, explanation of medical issues. Interested readers will find more information about the participants' use of food stamps in Appendix I.

Table 3.18 Notable self-reported causes of homelessness and self-reported services needed across domicile *

Shelter clients (N= 106)

Notable causes of homelessness:		Notable services needed:	
Family problems	37.7%	Anger/stress management	21.7%
Doubled up/ asked to leave	33%	Case management	22.5%
Medical problems	19.8%	Education	29.2%
Lack of income	64.2%	Financial assistance	67.0%
Lack of employment	70.8%	Housing	74.5%
Out of prison	25.5%	Job training	47.2%
Relocation	27.4%	Job placement	59.4%
Mental illness	15.1%	Life skills training	17.9%
Alcohol abuse	27.4%	Medical care	34.0%
Drug abuse	43.3%	Mental health treatment	17.0%
Eviction	18.9%	Substance abuse treatment	25.5%
Domestic violence	18.0%	Legal services	18.9%
Benefits expired	20.7%	Recreation	31.0%
Recent discharge from substance abuse program	14.2%	Other	11.3%
Other	19.8%		

Transitional Living clients (N= 67)

Notable causes of homelessness:		Notable services needed:	
Family problems	53.7%	Anger/stress management	25.4%
Dbled up/ asked to leave	26.9%	Case management	13.4%
Medical problems	22.4%	Education	32.8%
Lack of income	52.2%	Financial assistance	37.3%
Lack of employment	50.7%	Housing	52.2%
Out of prison	17.9%	Job training	32.8%
Domestic violence	25.4%	Job placement	43.3%
Mental illness	19.4%	Life skills training	21%
Alcohol abuse	41.8%	Medical care	14.9%
Drug abuse	55.2%	Legal assistance	22.4%
Discharge from s.a.program	17.9%	Recreation	20.9%
Eviction	29.9%	Other	10.4%
Other	14.9%		
Crime in neighborhood	11.9		
Over crowded apartment	23.9		

Supportive Living clients (N= 28)

Notable causes of homelessness:		Notable services needed:	
Family problems	39.3%	Anger/ stress management	17.9%
Building unfit	14.3	Job training	32.1%
Medical problems	25.0%	Job placement	23.0%
Eviction	14.3%	Recreation	17.9%
Lack of income	32.1%	Case management	10.7%
Lack of employment	39.3%	Day care	10.7%
Mental illness	32.1%	Education	17.9%
Alcohol abuse	28.5%	Financial	14.3%
Drug abuse	32.1%	Housing	46.4%
HIV/AIDS	14.3%	Life skills	14.3%
Crime in neighborhood	17.9%	Medical care	17.9%
Doubled up, asked to leave	17.9%	Mental health treatment	10.7%
Other violence	10.7%	Substance abuse treatment	10.7%
Benefits expired	10.7%	Group home	10.7%
Recently discharged (psych)	10.7%		
Relocated	25.0%		
Other	10.7%		

* Note: Enrollment into certain treatment modalities (e.g., substance abuse treatment) is required for admission into some types of programs. Causes and services were included as "notable" if endorsed by 10% or more of respondents. Multiple endorsements possible for both causes and needs.

Summary: Reasons for homelessness and unmet service needs

Primary reasons for homelessness

Consistent with the administrator based data from the 2002 Hartford Homeless Census (Table 2.22), the self-report data from the interview component of this study (Table 3.16) indicate that substance use is one of the most frequently endorsed primary cause of homelessness, second in this sample only to income problems. One marked difference is that the census data indicate the mental illness is also a strong primary cause, endorsed by 22.3% of administrators in the census yet endorsed by only 5.1% of the homeless themselves in the interview. This discrepancy could reflect the fact that supportive housing clients were intentionally under-sampled in the interview component and many supportive housing facilities are utilized by those with chronic mental illness. Consistent with this is the fact that almost 23% of those interviewed in the present report from supportive housing indicated that mental illness was the primary cause of their homelessness.

Notable reasons for homelessness

Regarding notable causes of homelessness it is important to note that each respondent could have endorsed multiple causes for their homelessness. When notable reasons for homelessness are assessed across domicile (Table 3.18), family problems, medical problems, income, lack of employment, eviction, mental illness, and substance abuse were commonly endorsed. However, the frequency with which some of these problems were endorsed decreased from shelter to supportive housing. When notable causes of homelessness self-reported by these respondents are compared to the ratings of the program administrators in the 2002 Hartford Homeless Census (Table 2.17), the clients residing in each type of program appeared to self-report a larger number of causes compared with the administrators of each respective type of program.

Unmet service needs

As observed in the census (Table 2.16), unmet service needs of the homeless individuals in the interviewed sample (Table 3.17) appear to differ according to domicile and presence of children. Although the sample sizes were small, the two unmet service needs that appeared to differ the greatest according to these variables were day care and substance abuse treatment. Housing placement, job training and job placement were endorsed frequently across domicile and presence of children. Clients in shelters, transitional and supportive housing self-report as having a large number of notable unmet service needs (i.e., 14, 12 and 14 notable unmet needs respectively, Table 3.18). However, compared with those in shelters and transitional housing, those in supportive housing appeared to endorse a wide variety of needs less frequently in general. For example, 10 and 9 notable unmet needs were endorsed over 20% of the time by those residing in shelters and transitional programs while only 3 unmet needs were endorsed over 20% of the time by those in supportive housing.

When program administrators' endorsements of unmet service needs from the 2002 Hartford Homeless Census are compared to those from the interviews, some interesting patterns emerge. For example, when the average number of unmet service needs endorsed across domicile by

clients were compared to those endorsed by program administrators in the census (Tables 3.15 and 3.15a), administrators endorsed fewer unmet service needs than were reported by respondents across all domiciles. For both administrators and clients, the endorsement of case management as a notable need declined across domicile from shelter to supportive housing. However, while the census data indicated that endorsement of mental health care, medical care and substance abuse treatment also declined in a similar manner across domicile, clients' self-reports indicated other wise (Table 2.17 and Table 3.18).

The discrepancies that were observed between administrator reports and the self-reports of the interviewed group should be interpreted with caution due to methodological differences between the census and the interview components. First, there is no guarantee that administrators were reporting on the same individuals who were randomly sampled for the interviews. Therefore, the administrator reports from the census and respondent self-report from the interview component are not directly comparable. Additionally, in the interview component we intentionally under-sampled clients from supportive housing programs. Finally, veterans are over-represented in the interviewed group compared with the general population of homeless individuals. In light of these caveats, these data do suggest that ways in which the homeless and the program administrators communicate with each other may be worthy of closer consideration.

General Health Status

The Hartford Homeless Health Survey included the SF12 (Ware et al., 1996), a widely used instrument for assessing respondents' perceptions of their own health. The SF12 addresses the degree to which the respondent feels that they are limited in their daily activities by physical or mental health problems. The most commonly used single item from the SF12 is the general health status measure. Respondents are asked to rate their current health status on a five-point scale from "excellent" through "poor". Previous research on health status in homeless samples has indicated that homeless individuals with mental illness rate their subjective quality of life as being significantly worse than homeless individuals who are not mentally ill (Sullivan et al, 2000). However movement into stable and independent housing has been associated with significant improvements in the subjective quality of life for homeless individuals, both with mental illness and without (Sullivan et al., 2000; Wolf et al., 2001).

Ratings of general health status for homeless respondents from the Hartford Homeless Health Survey 2002 are presented below. In Figure 1, the ratings for the homeless sample are compared to those for the general population of Hartford, as measured in the Hartford Health Survey 2000 (O'Keefe et al., 2000b). In Figure 2, ratings from the homeless sample are compared across type of domicile. The largest percentage of respondents from both the general population sample and the homeless sample rated their health as "good" (Figure 1). However, compared with the general sample, ratings from the homeless sample appeared to be more skewed towards negative responses with only 12.7 % of the homeless sample rating their general health status as "very good" compared to the 30.3% of the general sample who rated their health as "very good". Over 30% of the homeless sample rated their health status as "fair"

or "poor" , a finding that corresponds to previous research on health status in homeless individuals (e.g., Reichenbach et al., 1998; Wojtusik and White, 1998).
Focusing on the health status of the homeless sample according to domicile (Figure 2), the ratings from respondents living in supportive housing appeared to be more skewed towards negative responses with approximately 35% of those interviewed rating their general health status as "fair' or "poor". Given that many of the people living in supportive housing do so because of chronic medical problems and mental illness, this result is not unexpected. A one way ANOVA indicated that ratings of general health status in the homeless sample did not differ significantly according to either domicile or gender.

Fig. 1 Health Status: Hartford general population vs. homeless respondents

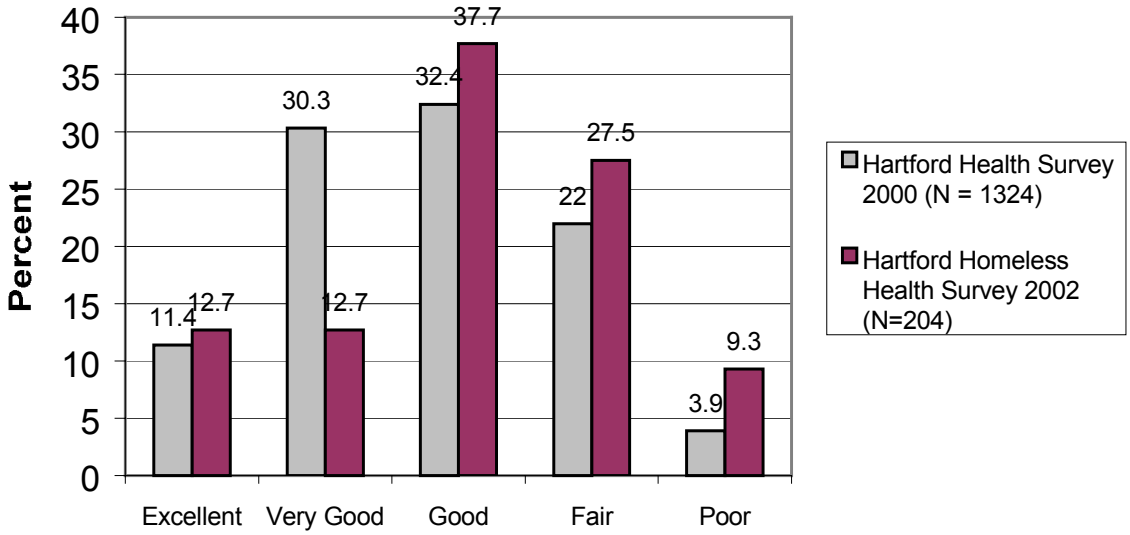
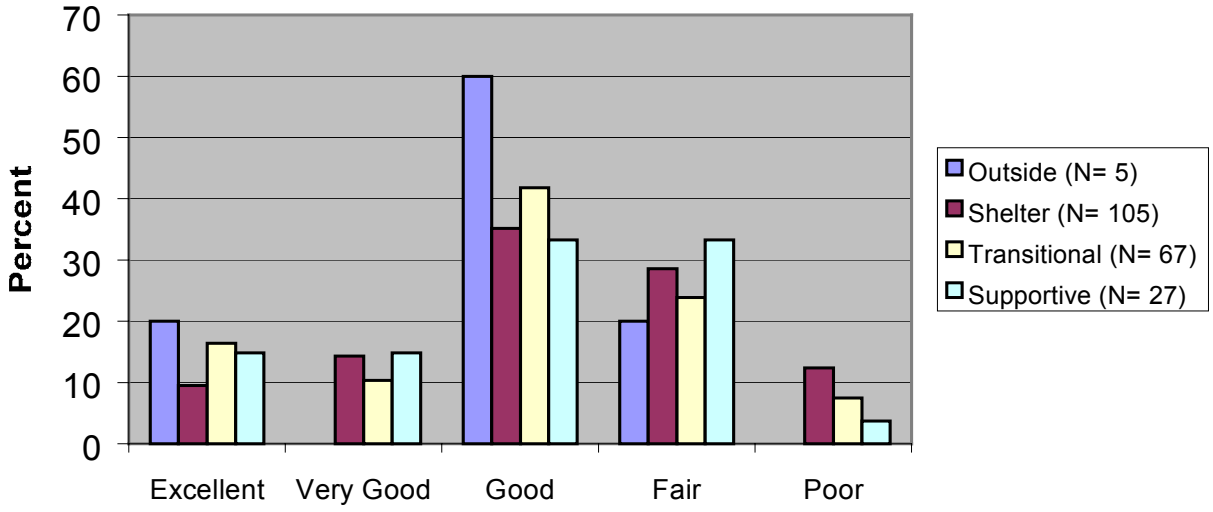


Fig. 2 Health Status by domicile



Medical history

In the interview, respondents were asked whether they had ever had (or had ever been told by a doctor nurse that they had) any of 26 medical conditions. Rates of endorsement for a history of these conditions are presented for the sample and by domicile in Table 3.19, below. Tables 3.20- 3.28 present the respondents' histories of depression, other mental health problems, substance abuse, HIV/AIDS, arthritis, asthma and hypertension according to domicile and gender.

As illustrated in Table 3.19, over half of the 26 medical conditions had been experienced by at least one in five of the clients sampled. Depression and drug abuse ranked among the top three most commonly endorsed conditions. For shelter and transitional clients, alcohol abuse was also in the top three. For clients in supportive housing, asthma was in the top three and rates of diabetes were 3 to 7 times as higher than the rates observed for those in other domiciles. Chronic back problems and severe headaches were also reported often across domicile. Hepatitis was reported by almost 20% of clients living in shelters, by over 25% of those in transitional housing and by almost 18% of those in supportive housing.

Table 3.19 Medical history: Have you ever had (or has a doctor or nurse ever told you that you had) any of the following conditions (% yes by current domicile):

Condition	All (N= 206)	Shelter (N=106)	Trans. (N=67)	Supportive (N=28)
Drug abuse problem	56.3	51.9	65.7	46.4
Depression	53.9	48.1	59.7	64.3
Alcohol abuse problem	43.2	39.6	53.7	32.0
Chronic back problems	37.9	35.8	40.3	42.9
Severe headaches	33.5	29.2	35.8	42.9
Chronic allergies/ sinus trouble	30.6	26.4	37.3	32.0
Trouble seeing (one/ both eyes)	29.6	33.0	29.9	21.4
Other mental health problems	29.6	21.7	35.8	35.7
Toothaches	28.2	25.5	35.8	14.3
Physical disability	27.7	25.5	28.4	35.7
Limited use of an arm or leg	25.7	23.6	26.9	35.7
Asthma	24.8	21.7	19.4	50.0
Arthritis	23.3	22.6	20.9	28.6
Hypertension	20.9	20.8	19.4	28.6
Hepatitis	20.9	19.8	25.4	17.9
Chronic bronchitis/ emphysema	19.9	17.0	17.9	32.1
Other	15.0	15.1	9.0	25.0
Deafness or trouble hearing	13.6	14.2	11.9	17.9
Liver disease	11.7	9.4	14.9	14.3
Stomach ulcers	11.2	12.3	11.9	3.6
Heart disease	8.7	11.3	4.5	10.7
Diabetes	5.8	3.8	3.0	21.4
Cancer	5.8	7.5	3.0	3.6
Tuberculosis	5.3	7.5	3.0	3.6
Heart attack	3.9	2.8	4.5	3.6
HIV/AIDS	3.9	5.7	1.5	3.6
Stroke	3.4	3.8	1.5	7.1

History of chronic medical conditions by domicile and gender

Table 3.20 History of depression according to gender and domicile

		Depression		Total
		Yes	No	
Outside	Male	2	3	5
		40.0%	60.0%	100.0%
	Total	2	3	5
		40.0%	60.0%	100.0%
Shelter	Male	38	38	76
		50.0%	50.0%	100.0%
	Female	15	13	28
		53.6%	46.4%	100.0%
	Total	53	51	104
		51.0%	49.0%	100.0%
Transitional	Male	22	16	38
		57.9%	42.1%	100.0%
	Female	18	8	26
		69.2%	30.8%	100.0%
	Total	40	24	64
		62.5%	37.5%	100.0%
Supportive	Male	7	8	15
		46.7%	53.3%	100.0%
	Female	9	1	10
		90.0%	10.0%	100.0%
	Total	16	9	25
		64.0%	36.0%	100.0%

Depression:

As illustrated in Table 3.20, rates of depression were highest among residents of transitional and supportive housing and among women. Since many supportive housing programs are designed specifically to care for those with chronic mental illness, this trend is not surprising. The gender difference became more pronounced among residents of transitional and supportive housing even though the samples from these types of domiciles were comprised of fewer women than men. Compared with the general population of Hartford, of which 25% had reported a history of depression (O'Keefe et al., 2000b), rates of lifetime depression were more than twice as high (53.9%) in the present sample.

Table 3.21 History of other mental health problems according to gender and domicile

			Mental health problems other than depression		Total
			Yes	No	
Outside	Male	Count	4	1	5
			80.0%	20.0%	100.0%
	Total	Count	4	1	5
			80.0%	20.0%	100.0%
Shelter	Male	Count	21	56	77
			27.3%	72.7%	100.0%
	Female	Count	2	26	28
			7.1%	92.9%	100.0%
	Total	Count	23	82	105
			21.9%	78.1%	100.0%
Transitional	Male	Count	16	23	39
			41.0%	59.0%	100.0%
	Female	Count	8	18	26
			30.8%	69.2%	100.0%
	Total	Count	24	41	65
			36.9%	63.1%	100.0%
Supportive	Male	Count	7	8	15
			46.7%	53.3%	100.0%
	Female	Count	3	6	9
			33.3%	66.7%	100.0%
	Total	Count	10	14	24
			41.7%	58.3%	100.0%

Other mental health problems:

As illustrated in Table 3.21, rates of mental health problems other than depression were higher for men than for women. Rates were lowest among those in shelters and highest among those in supportive housing. Once again this is not surprising given the fact that many supportive housing programs are designed to care for those with chronic mental illness. Compared with the general population of Hartford, in which 6% had reported a history of mental illness other than depression (O'Keefe et al., 2000b), rates of lifetime mental health problems (aside from depression) are approximately five times as high (29.6%) in the present sample.

Table 3.22

History of alcohol abuse problem according to gender and domicile

			An alcohol abuse problem		Total
			Yes	No	
Outside	Male	Count	2	3	5
			40.0%	60.0%	100.0%
	Total	Count	2	3	5
			40.0%	60.0%	100.0%
Shelter	Male	Count	36	41	77
			46.8%	53.2%	100.0%
	Female	Count	7	21	28
			25.0%	75.0%	100.0%
	Total	Count	43	62	105
			41.0%	59.0%	100.0%
Transitional	Male	Count	24	17	41
			58.5%	41.5%	100.0%
	Female	Count	12	14	26
			46.2%	53.8%	100.0%
	Total	Count	36	31	67
			53.7%	46.3%	100.0%
Supportive	Male	Count	5	10	15
			33.3%	66.7%	100.0%
	Female	Count	3	7	10
			30.0%	70.0%	100.0%
	Total	Count	8	17	25
			32.0%	68.0%	100.0%

Alcohol abuse:

Table 3.22 illustrates that rates of alcohol abuse problems were higher for men with this gender difference becoming less pronounced among residents of supportive housing. Overall rates of alcohol abuse problems were highest among residents of transitional living programs, a finding that is not surprising given that enrollment in substance abuse treatment is one criterion for enrollment in many transitional housing programs. Compared with the general population of Hartford, in which 4.7% had reported a history of alcohol abuse (2000 Hartford Health Survey, data unpublished), rates of lifetime alcohol abuse are over eight times as high (43.2%) in the present sample.

Table 3.23

History of drug abuse (other than alcohol) by gender and domicile

			A drug abuse problem (other than alcohol)		Total
			Yes	No	
Outside	Male	Count	4	1	5
			80.0%	20.0%	100.0%
	Total	Count	4	1	5
			80.0%	20.0%	100.0%
Shelter	Male	Count	47	30	77
			61.0%	39.0%	100.0%
	Female	Count	9	19	28
			32.1%	67.9%	100.0%
	Total	Count	56	49	105
			53.3%	46.7%	100.0%
Transitional	Male	Count	30	11	41
			73.2%	26.8%	100.0%
	Female	Count	14	12	26
			53.8%	46.2%	100.0%
	Total	Count	44	23	67
			65.7%	34.3%	100.0%
Supportive	Male	Count	8	7	15
			53.3%	46.7%	100.0%
	Female	Count	4	6	10
			40.0%	60.0%	100.0%
	Total	Count	12	13	25
			48.0%	52.0%	100.0%

Drug abuse:

As illustrated in Table 3.23, rates of drug abuse problems (other than alcohol) were higher for men than for women. Overall rates of drug abuse problems were highest among residents of transitional living programs. Compared with the general population of Hartford (unpublished, from the 2000 Hartford Health Survey), in which 4.0% had reported a history of drug abuse, rates of lifetime drug abuse are over twelve times as high (56.3%) in the present sample.

Table 3.24

History of HIV/AIDS according to gender and domicile

			HIV/AIDS virus		Total
			Yes	No	
Outside	Male	Count		5	5
				100.0%	100.0%
	Total	Count		5	5
				100.0%	100.0%
Shelter	Male	Count	6	71	77
			7.8%	92.2%	100.0%
	Female	Count		28	28
				100.0%	100.0%
	Total	Count	6	99	105
			5.7%	94.3%	100.0%
Transitional	Male	Count	1	40	41
			2.4%	97.6%	100.0%
	Female	Count		26	26
				100.0%	100.0%
	Total	Count	1	66	67
			1.5%	98.5%	100.0%
Supportive	Male	Count	1	14	15
			6.7%	93.3%	100.0%
	Female	Count		10	10
				100.0%	100.0%
	Total	Count	1	24	25
			4.0%	96.0%	100.0%

HIV/AIDS:

As shown in Table 3.24, all of the respondents with HIV/AIDS were men. Most of these respondents were living in shelters. Compared with the general population of Hartford (from the 2000 Hartford Health Survey, data unpublished), in which 1.7% had reported HIV/AIDS, rates of HIV/AIDS were twice as high (3.9%) in the present sample.

Table 3.25

History of arthritis according to gender and domicile

			Arthtritis		Total
			Yes	No	
Outside	Male	Count	2	3	5
			40.0%	60.0%	100.0%
	Total	Count	2	3	5
			40.0%	60.0%	100.0%
Shelter	Male	Count	19	58	77
			24.7%	75.3%	100.0%
	Female	Count	6	22	28
			21.4%	78.6%	100.0%
	Total	Count	25	80	105
			23.8%	76.2%	100.0%
Transitional	Male	Count	9	30	39
			23.1%	76.9%	100.0%
	Female	Count	5	21	26
			19.2%	80.8%	100.0%
	Total	Count	14	51	65
			21.5%	78.5%	100.0%
Supportive	Male	Count	3	12	15
			20.0%	80.0%	100.0%
	Female	Count	4	5	9
			44.4%	55.6%	100.0%
	Total	Count	7	17	24
			29.2%	70.8%	100.0%

Arthritis:

As shown in Table 3.25, rates of arthritis were similar across domicile. Among those living in supportive housing programs, rates were higher for women than for men. Compared with the general population of Hartford (from the 2000 Hartford Health Survey, data unpublished), in which 26.7% had reported a history of arthritis, rates of arthritis were comparable (23.3%) in the present sample.

Table 3.26

History of chronic bronchitis and emphysema by gender and domicile

			Chronic bronchitis and emphysema		Total
			Yes	No	
Outside	Male	Count	2	3	5
			40.0%	60.0%	100.0%
	Total	Count	2	3	5
			40.0%	60.0%	100.0%
Shelter	Male	Count	12	63	75
			16.0%	84.0%	100.0%
	Female	Count	7	21	28
			25.0%	75.0%	100.0%
	Total	Count	19	84	103
			18.4%	81.6%	100.0%
Transitional	Male	Count	6	33	39
			15.4%	84.6%	100.0%
	Female	Count	6	20	26
			23.1%	76.9%	100.0%
	Total	Count	12	53	65
			18.5%	81.5%	100.0%
Supportive	Male	Count	4	11	15
			26.7%	73.3%	100.0%
	Female	Count	4	6	10
			40.0%	60.0%	100.0%
	Total	Count	8	17	25
			32.0%	68.0%	100.0%

Chronic bronchitis/ emphysema:

As shown in Table 3.26, rates of chronic bronchitis/ emphysema were higher for women than for men. Rates were highest amongst those living in supportive housing programs. Compared with the general population of Hartford, in which 7% had reported a history of chronic bronchitis/emphysema (O'Keefe et al., 2000b), rates of lifetime chronic bronchitis/emphysema are more than twice as high (19.9%) in the present sample.

Table 3.27

History of asthma according to gender and domicile

			Asthma		Total
			Yes	No	
Outside	Male	Count	1	4	5
			20.0%	80.0%	100.0%
	Total	Count	1	4	5
			20.0%	80.0%	100.0%
Shelter	Male	Count	16	60	76
			21.1%	78.9%	100.0%
	Female	Count	8	20	28
			28.6%	71.4%	100.0%
	Total	Count	24	80	104
			23.1%	76.9%	100.0%
Transitional	Male	Count	4	35	39
			10.3%	89.7%	100.0%
	Female	Count	9	17	26
			34.6%	65.4%	100.0%
	Total	Count	13	52	65
			20.0%	80.0%	100.0%
Supportive	Male	Count	7	8	15
			46.7%	53.3%	100.0%
	Female	Count	6	4	10
			60.0%	40.0%	100.0%
	Total	Count	13	12	25
			52.0%	48.0%	100.0%

Asthma:

As illustrated in Table 3.27, rates of asthma were higher for women than for men. Rates were highest amongst those living in supportive housing programs. Compared with the general population of Hartford, in which 15% had reported a history of asthma (O'Keefe et al., 2000b), rates of lifetime asthma are higher (24.8%) in the present sample.

Table 3.28

History of hypertension according to gender and domicile

			Hypertension		Total
			Yes	No	
Outside	Male	Count		5	5
				100.0%	100.0%
	Total	Count		5	5
				100.0%	100.0%
Shelter	Male	Count	19	59	78
			24.4%	75.6%	100.0%
	Female	Count	3	24	27
			11.1%	88.9%	100.0%
	Total	Count	22	83	105
			21.0%	79.0%	100.0%
Transitional	Male	Count	6	35	41
			14.6%	85.4%	100.0%
	Female	Count	7	18	25
			28.0%	72.0%	100.0%
	Total	Count	13	53	66
			19.7%	80.3%	100.0%
Supportive	Male	Count	4	11	15
			26.7%	73.3%	100.0%
	Female	Count	4	6	10
			40.0%	60.0%	100.0%
	Total	Count	8	17	25
			32.0%	68.0%	100.0%

Hypertension:
Table 3.28 indicates that rates of hypertension were higher for women than for men among those in transitional and supportive housing but were higher among men for respondents living in shelters. Rates were highest amongst those living in supportive housing programs. Compared with the general population of Hartford, in which 34% had reported a history of hypertension (O'Keefe et al., 2000b), rates of hypertension are lower (21%) amongst the present sample.

Summary of chronic medical conditions:

The interviewed sample of homeless individuals had rates of certain chronic conditions (i.e., depression, other mental health problems, substance abuse, HIV/AIDS, chronic bronchitis and asthma) that were up to twelve times higher than rates of these conditions within the general population of Hartford. These patterns are consistent with those of previous studies on homeless populations (e.g., Lindsey, 1995; Martens, 2001).

Cigarette smoking and history of chronic medical conditions

Data from the 1999 Hartford Homeless Health Survey indicated that almost 76% of the 66 individuals interviewed were current smokers. Almost 86% of those with a history of asthma were current smokers. For those with a history of chronic bronchitis/emphysema, and heart disease, current smoking rates were approximately 87% and 83%, respectively.

Data from the 2002 Hartford Homeless Health Survey indicated that 67% of those interviewed were current smokers (Table 3.29). This rate is over twice that of the general population of Hartford (O'Keefe et al., 2000b). While rates of current smoking were lower among the interviewed homeless in 2002 than in 1999, rates of smoking among those with histories of chronic medical conditions were still alarming. Almost 78% of those with heart disease reported being current smokers (Table 3.30). For those with asthma and bronchitis, 55% and 63% , respectively, reported being current smokers (Tables 3.31 and 3.32).

Table 3.29 Current smoking

What are your cigarette smoking habits?

	Frequency	Percent
Never smoked	*30*	*14.6*
Used to smoke	*37*	*18.0*
Still smoke	*138*	*67.3*
Total	*205*	*100.0*

Table 3.30

		What are your cigarette smoking habits?			Total
		Never smoked	Used to smoke	Still smoke	
Heart disease	Yes	*2*	*2*	*14*	*18*
		11.1%	*11.1%*	*77.8%*	*100.0%*
	No	*27*	*35*	*123*	*185*
		14.6%	*18.9%*	*66.5%*	*100.0%*
Total		*29*	*37*	*137*	*203*
		14.3%	*18.2%*	*67.5%*	*100.0%*

Table 3.31

		What are your cigarette smoking habits?			Total
		Never smoked	Used to smoke	Still smoke	
Asthma	Yes	8	15	28	51
		15.7%	29.4%	54.9%	100.0%
	No	20	22	106	148
		13.5%	14.9%	71.6%	100.0%
Total		28	37	134	199
		14.1%	18.6%	67.3%	100.0%

Table 3.32

		What are your cigarette smoking habits?			Total
		Never smoked	Used to smoke	Still smoke	
Chronic bronchitis/ emphysema	Yes	4	11	26	41
		9.8%	26.8%	63.4%	100.0%
	No	24	26	107	157
		15.3%	16.6%	68.2%	100.0%
Total		28	37	133	198
		14.1%	18.7%	67.2%	100.0%

Current medical conditions

The Hartford Homeless Health Survey 2002 included items asking about respondents' current medical conditions. Respondents were asked whether they now had any of 26 medical conditions. Rates of endorsement for current medical conditions are presented for the sample and by domicile in Table 3.33 below.

Depression and chronic back problems were the most commonly endorsed current medical conditions across domicile. Rates of current alcohol problems were much lower than rates of other current conditions. However, these ratings were based upon self-report and it is possible that a respondent could have been abstinent (i. e., "clean") for a very short period of time (e.g., less than one week) and therefore he or she may not have endorsed a *current* alcohol problem for themselves.

Table 3.33 Do you now have any of the following conditions (% yes by current domicile):

Condition	All (N= 206)*	Shelter (N=106)	Transitional (N=67)	Supportive (N=28)
Depression	44.2	39.6	47.8	53.6
Chronic back problems	35.0	34.9	35.8	35.7
Severe headaches	28.6	25.5	28.4	34.3
Other mental health problems	28.2	23.6	31.3	35.7
Trouble seeing (one/ both eyes)	26.2	27.4	28.4	21.4
Chronic allergies/ sinus trouble	24.8	23.6	28.4	21.4
Physical disability	23.3	22.6	22.4	28.6
Arthritis	22.3	20.8	20.9	28.6
Limited use of an arm or leg	21.4	17.9	22.4	35.7
Drug abuse problem	19.9	23.6	17.9	3.6
Hypertension	17.5	17.0	14.9	28.6
Hepatitis	17.5	17.0	20.9	14.3
Toothaches	17.0	14.2	23.9	10.7
Alcohol abuse problem	13.1	17.0	10.4	3.6
Deafness or trouble hearing	12.1	13.2	10.4	14.3
Other	12.1	13.2	7.5	25.0
Chronic bronchitis/ emphysema	10.2	11.3	6.0	14.3
Liver disease	9.2	7.6	11.9	14.3
Heart disease	7.3	8.5	4.5	10.7
Stomach ulcers	5.3	5.7	6.0	0.0
Diabetes	4.9	2.8	3.0	17.9
HIV/AIDS	3.4	4.7	1.5	3.6
Tuberculosis	2.9	2.8	4.5	0.0
Heart attack	2.4	0.9	3.0	7.1
Stroke	1.0	0.9	0.0	3.6
Cancer	1.9	0.9	3.0	3.6
Asthma	0.5	0.9	10.4	42.9

* Includes 5 respondents living outdoors, who will be discussed separately.
Other: Sleep disorder, UTI, Chrone's Disease, anemia, hypoglycemia, deep vein thrombosis, psoriasis, irritable bowel syndrome, STD, osteoarthritis, multiple sclerosis, heart murmur, palsy, high cholesterol, rash

Health service utilization

The Hartford Homeless Health Survey 2002 included several items measuring health service utilization. Respondents were asked whether or not they had one place that they usually go for health care. They were then asked to endorse all of the places that they go for health care. Items were also included which addressed emergency room usage in the past year.

Over 70% of those interviewed reported that they did have one place that they usually go for health care (Table 3.34). Rates of endorsement were highest for those living in transitional and supportive housing (Table 3.35). In comparison, data from the Hartford Health Survey 2000 (O'Keefe et al., 2000b) indicated that 86% of the general population of Hartford reported that they had one primary place for health care. Regarding emergency room usage, respondents living in shelters were most likely to report utilizing the emergency room for health care (Table 3.36). Those in transitional facilities were most likely to endorse using a community health center. Those in supportive housing were most likely to endorse using a hospital clinic. Interestingly, approximately 18% of those in supportive housing reported that they had received health care at a soup kitchen or a shelter rather than in a clinic or a doctor's office.

Table 3.34 Usual place for care

Is there one place you usually go for health care?

		Frequency	Percent
	Yes	*145*	*71.1*
	No	*59*	*28.9*
	Total	*204*	*100.0*

Table 3.35 Usual place for care by domicile

		Is there one place you usually go for health care?		Total
		Yes	No	
Outside	Count	3	2	5
		60.0%	40.0%	100.0%
Shelter	Count	70	35	105
		66.7%	33.3%	100.0%
Transitional	Count	51	16	67
		76.1%	23.9%	100.0%
Supportive	Count	21	6	27
		77.8%	22.2%	100.0%
Total	Count	145	59	204
		71.1%	28.9%	100.0%

Table 3.36 Where do you go fo health care?
(Multiple endorsements possible)

Whole sample (N= 206)*

	Freq	Percent
MD office	43	20.9
Clinic at hospital	84	40.3
Emergency room	83	39.8
VA hospital or clinic	10	4.9
Community health center	78	37.9
Shelter or soup kitchen	31	15.0
Chiropractor	10	4.9
Rehabilitation facility	23	11.2
Psychiatric facility	30	14.6
Other	12	5.8

Shelter (N=106)

	Freq	Percent
MD office	25	23.6
Clinic at hospital	43	40.6
Emergency room	48	45.3
VA hospital or clinic	5	4.7
Community health center	35	33.0
Shelter or soup kitchen	18	16.9
Chiropractor	4	3.8
Rehabilitation facility	10	9.4
Psychiatric facility	11	8.5
Other	4	3.8

Transitional (N=67)

	Freq	Percent
MD office	9	13.4
Clinic at hospital	24	35.8
Emergency room	21	31.3
VA hospital or clinic	4	6.0
Community health center	35	52.5
Shelter or soup kitchen	7	10.4
Chiropractor	3	4.5
Rehabilitation facility	9	13.4
Psychiatric facility	12	17.9
Other	5	7.5

Supportive (N=28)

	Freq	Percent
MD office	7	25.0
Clinic at hospital	13	53.6
Emergency room	10	35.7
VA hospital or clinic	1	3.6
Community health center	7	25.0
Shelter or soup kitchen	5	17.9
Chiropractor	3	10.7
Rehabilitation facility	6	21.4
Psychiatric facility	6	21.4
Other	3	10.7

*Includes 5 outside dwelling individuals who will be discused in a separate section.
Other includes: After care/relapse prevention, gynecologist, Hospital for Special Care, physical therapist, Planned Parenthood, St, Francis MRI, therapist, Uconn Health Center

Table 3.37

Did you stay in a hospital for one night or more during the past year?

	Frequency	Percent
Yes	*62*	*30.2*
No	*143*	*69.8*
Total	*205*	*100.0*

Table 3.38

Emergency room utilization in the past year

	Frequency	Percent
Self-reported ER visit in past year	*115*	*55.8*
No report of ER visit in past year	*91*	*44.2*
Total	*206*	*100.0*

Table 3.39

Reasons for ER visits in past year
(Multiple endorsements possible; N= 115)

	Frequency	Percent
No other place for health care	16	13.9
No health insurance	5	4.3
Took too long to get appt at doctor's office	10	8.7
Doctor's office closed	8	6.9
I was very sick/ seriously injured	76	66.0
Emergency room convenient	5	4.3
Mental health or substance abuse issue	7	6.1
Other reason	3	2.6

Hospital stays and ER usage: Approximately 30% of those interviewed reported having stayed in a hospital over the past year (Table 3.37). Almost 56% reported visiting the emergency room at least once over the past year (Table 3.38). Being very sick or seriously injured was the most commonly endorsed reason for visiting the ER in the past year (Table 3.39).

Health service access

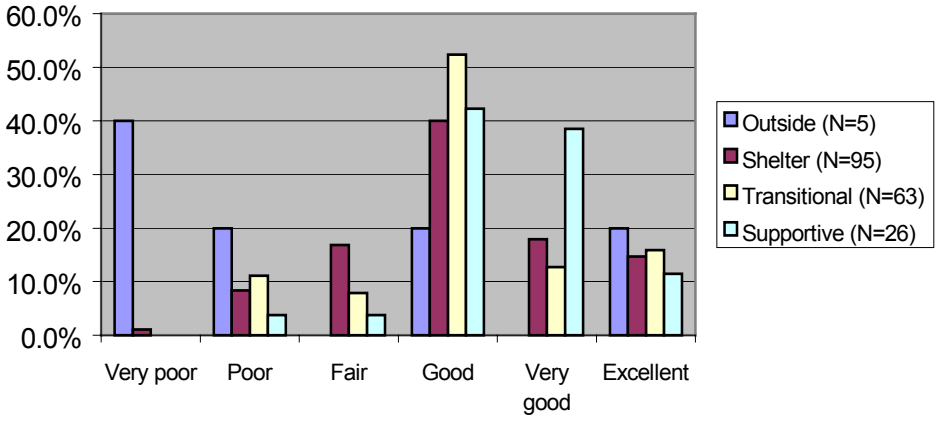
The Hartford Homeless Health Survey included several items measuring respondents' access to health care. Respondents were asked to rate their access to health care whenever they need it on a six point scale. They were also asked whether or not they ever defer seeking health care or skip medications or treatment because they are too expensive. Finally, they were asked about the kinds of health insurance that they had.

Table 3.40

Your access to health care whenever you need it

	Frequency	Percent
Very Poor	*3*	*1.6*
Poor	*17*	*9.0*
Fair	*22*	*11.6*
Good	*83*	*43.9*
Very Good	*35*	*18.5*
Excellent	*28*	*14.8*
No Answer	*1*	*.5*
Total	*189*	*100.0*

Fig. 3 Ratings of Access to Health Care by Domicile (N=189)



Overall, over 75% of those interviewed rated their access to health care as either good, very good, or excellent (Table 3.40) In comparison, data from the Hartford Health Survey 2000 indicated that 83% of the general population rated their access to health care as either good, very good or excellent (O'Keefe et al., 2000b). Approximately 15% of the present sample rated their access as excellent. This rate is lower than that observed for the

general population of Hartford where almost 27% rated their access as excellent (O'Keefe et al., 2000b). Residents of supportive housing seemed to report better access to health care than did those in shelters and transitional facilities (Fig. 3).

Regarding deferment of health care, 35% of those providing information reported that they have deferred visits to the doctor or nurse due to expense (Table 3.42). Over 25% report skipping medications or treatment because of expense (Table 3.43). Regarding health insurance, approximately 50% of those interviewed reporting having Medicaid only (Table 3.44). The next largest percentage of respondents (18.4%) reported that they were uninsured. The highest rate of insurance coverage was observed among clients living in supportive housing (63% of whom received insurance through Medicaid).

Table 3.42

Do you ever put off going to the doctor/nurse because visits are too expensive?

	Frequency	Percent
Yes, often	*24*	*12.1*
Yes, occasionally	*34*	*17.2*
No, never	*110*	*55.6*
Does not apply	*30*	*15.2*
Total	*198*	*100.0*

Table 3.43

Do you ever skip medications or treatments because they are too expensive?

	Frequency	Percent
Yes, often	*18*	*9.1*
Yes, occasionally	*25*	*12.6*
No, never	*119*	*60.1*
Does not apply	*36*	*18.2*
Total	*198*	*100.0*

Table 3.44

		Domicile				Total
		Outside	Shelter	Transitional	Supportive	
Medicaid only, including Medicaid HMO	Count	3	56	28	17	104
		60.0%	53.3%	42.4%	63.0%	51.2%
Medicare only, including Medicare HMO	Count		3	1	2	6
			2.9%	1.5%	7.4%	3.0%
Medicare plus other insurance	Count		2	5	2	9
			1.9%	7.6%	7.4%	4.4%
Health insurance through my work/job	Count		2	6		8
			1.9%	9.1%		3.9%
CHAMPUS (Military insurance)	Count		1		1	2
			1.0%		3.7%	1.0%
Other	Count		22	10	3	35
			21.0%	15.2%	11.1%	17.2%
I do NOT have health insurance	Count	2	19	15	2	38
		40.0%	18.1%	22.7%	7.4%	18.7%
NA	Count			1		1
				1.5%		.5%
Total	Count	5	105	66	27	203
		100.0%	100.0%	100.0%	100.0%	100.0%

Substance misuse in the homeless community

Historically, there is a strong link between homelessness and alcohol misuse. According to Cohen and Sokolvsky (1989:50) the "skid rows" of cities in the United States were the sites of inexpensive lodging for poor and intermittently employed men, who appeared to have lost contact with their families). So strong is the link between alcoholism and homelessness that in some parts of the world the two words are the same. For example, in Finland, until recently, the word for homeless and alcoholic was *puliukko*, which is derived from the words *ukko* (old man) and *puli* (varnish or lacquer, used as a source of alcohol), indicating the strong association between drinking and homelessness (Glasser 1994). In Quebec, Canada one of the words for homeless was *robineux* which is a French adaptation of the English word rubbing (as in rubbing alcohol) (Glasser, Fournier, Costopoulos 1999).

There is substantial evidence that alcohol and drug misuse are the most pervasive health problems of the homeless in the United States (Glasser and Zywiak in press). A recent Urban Institute (1999) study of 4,207 randomly selected clients of homeless-serving agencies found the rate of reported alcohol misuse to be 38% within the past month, 46% within the past year, and 62% within the individual's lifetime. The lifetime reported use of drugs was 58% and the lifetime reported existence of mental health problems was 57%. A full 86% reported having had one of these problems during their lifetime (Urban Institute 1999:24). These rates contrast to the 15% lifetime risk for alcohol dependence and the 5% current alcohol dependence (i.e., the pattern of alcohol use met the criteria over the prior year) when the DSM-IV criteria are applied (Diagnostic and Statistical Manual of Mental Disorders 2000).

Pilot Testing the AUDIT-12

It is important to be able to screen individuals who enter the homeless serving agencies for their possible alcohol or other drug problems. As part of the Hartford Homeless Health Survey, we pilot tested a new screening measure, the AUDIT-12, which was developed in Milwaukee by Campbell et al., 2001 as a relatively rapid way for shelter staff to identify individuals at high risk. This tool provides a Total Score that serves as an index of the severity of a respondent's substance misuse. It also includes sub-scales that address three domains of substance misuse, Involvement, Dependency and Harm. In addition to the AUDIT-12 questions (indicated by asterisks in Table 3.45), the survey included items addressing lifetime alcohol and drug related problems. The results from the 2002 Hartford sample on the sub-scales and for the total scores are presented in Tables 3.46- 3.49. It has been our experience that many individuals in the homeless community either are now actively in treatment (for example, are in the transitional housing recovery programs) or have tried to cut down their alcohol or drug use. The survey items addressing substance use along with the response frequencies observed in the 2002 Hartford homeless sample are presented below (Table 3.45).

Table 3.45 Health Survey Items addressing substance misuse

*1. How often do you have a drink containing alcohol? (N=202)

Frequency of drinks	Frequency	Percent
Never	103	51.0
Monthly or less	31	15.3
Weekly or less	27	13.4
2 or 3 times a week	17	8.4
4 or more time a week	24	11.9

*2. How many drinks containing alcohol do you have on a typical day when you are drinking? (N=193)

Number of drinks	Frequency	Percent
None, 1 or 2	131	67.9
3 or 4	22	11.4
5 or 6	12	6.2
7 to 9	16	8.3
10 or more	12	6.2

*3. How often do you have 5 drinks or more on one occasion? (N=193)

Frequency of drinking 5 or more	Frequency	Percent
Never	123	63.7
Less than monthly	16	8.3
Monthly	15	7.8
Weekly	20	10.4
Daily or almost daily	19	9.8

*4. How often do you use other substances in order to get high or change your mood? (N=203)

Frequency of using other substances	Frequency	Percent
Never	124	61.1
Less than monthly	20	9.9
Monthly	8	3.9
Weekly	11	5.4
Daily or almost daily	40	19.7

*5. How often do you use two or more substances (including alcohol) on the same occasion? (N=199)

Frequency of drinking 5 or more	Frequency	Percent
Never	146	73.4
Less than monthly	21	10.6
Monthly	6	3.0
Weekly	7	3.5
Daily or almost daily	19	9.5

6a. Have you **ever** found that you were unable to stop drinking or using drugs once you started?

	Frequency	Percent
No	77	38.3
Yes	124	61.7

6b. Has this happened in the past year?

	Frequency	Percent
No	128	64.0
Yes	71	35.5

*6c. How often have you found that you were unable to stop drinking or using drugs once you started?

	Frequency	Percent
Never	121	60.8
Less than monthly	9	4.5
Monthly	9	4,5
Weekly	7	3.5
Daily or almost daily	53	26.6

7a. Have you **ever** failed to do what was normally expected from you because of drinking or drug using?

	Frequency	Percent
No	82	40.8
Yes	119	59.2

7b. Has this happened in the past year?

	Frequency	Percent
No	129	64.2
Yes	72	35.8

*7c. How often have you failed to do what was normally expected from you because of drinking or drug using?

	Frequency	Percent
Never	121	60.8
Less than monthly	17	8.5
Monthly	10	5.0
Weekly	19	9.5
Daily or almost daily	32	16.1

8a. Have you **ever** needed a drink or other drug, or to get high first thing in the morning to get yourself going after a night of heavy drinking or drug using?

	Frequency	Percent
No	100	49.8
Yes	100	49.8

8b. Has this happened in the past year?

	Frequency	Percent
No	141	70.5
Yes	58	29.0

*8c. How often have you needed a drink or other drug, or to get high first thing in the morning to get yourself going after a night of heavy drinking or drug using?

	Frequency	Percent
Never	135	67.8
Less than monthly	10	5.0
Monthly	8	4.0
Weekly	7	3.5
Daily or almost daily	39	19.6

9a. Have you **ever** had a feeling of guilt or remorse after drinking or drug using?

	Frequency	Percent
No	73	36.5
Yes	127	63.5

9b. Has this happened in the past year?

	Frequency	Percent
No	124	62.0
Yes	76	38.0

*9c. How often have you had a feeling of guilt or remorse after drinking or drug using?

	Frequency	Percent
Never	120	60.0
Less than monthly	17	8.5
Monthly	14	7.0
Weekly	13	6.5
Daily or almost daily	36	18.0

10a. Have you **ever** been unable to remember what happened the night before because of dinking or using?

	Frequency	Percent
No	108	53.7
Yes	93	46.3

10b. Has this happened in the past year?

	Frequency	Percent
No	154	77.0
Yes	46	23.0

*10c. How often have you been unable to remember what happened the night before because of dinking or using?

	Frequency	Percent
Never	149	74.9
Less than monthly	20	10.1
Monthly	12	6.0
Weekly	11	5.5
Daily or almost daily	7	3.5

*11. Have you or someone else been injured because of your dinking or drug using?

	Frequency	Percent
No	124	63.9
Yes, but not in the past year	42	21.6
Yes, in the past year	28	14.4

*12. Has a relative or friend or doctor or other health worker been concerned about your dinking/drug using, or suggested that you stop using, cut down or get treatment?

	Frequency	Percent
No	75	37.5
Yes, but not in the past year	55	27.4
Yes, in the past year	70	34.8

Table 3.46 Alcohol and Drug Involvement Score (questions 1-5, range 0-20)

Number	188
Mean	4.68
Median	2
Mode	0
Standard Deviation	5.75
Minimum	0
Maximum	20

Table 3.47 Dependency Score (questions 6c, 7c, 8c, range 0-12)

Number	196
Mean	3.43
Median	0
Mode	0
Standard Deviation	4.63
Minimum	0
Maximum	12

Table 3.48 Harm Score (questions 9c, 10c, 11, 12, range 0-16)

Number	191
Mean	4.60
Median	4.0
Mode	0
Standard Deviation	4.49
Minimum	0
Maximum	15

Table 3.49 Total Score (total of all previous questions listed in sub scores, range 0-48)

Number	176
Mean	12.65
Median	5.0
Mode	0
Standard Deviation	13.1
Minimum	0
Maximum	46

AUDIT 12: Hartford, CT and Milwaukee, WI

When we compare the total harm score for the Hartford study to the study of 771 men admitted to a homeless shelter located in Milwaukee (Campbell, Barrett, Cisler, Solliday-McRoy and Melcher 2001) we see that the individuals in the Hartford sample were experiencing less alcohol and drug involvement and related problems than the Milwaukee sample (Table 3.50). However, when we look at only the men in the Hartford sample, we see that the Milwaukee and Hartford scores are very similar (Table 3.51). Further, of the 87 individuals living in shelters with no children with them, 60.9% scored 8 points or higher on the total score

Table 3.50 Mean scores on AUDIT sub-scales

AUDIT-12 Scale	**Milwaukee** (N=771)	**Hartford** (N=176)	**Hartford Men** (N=121)	**Hartford Women** (N=55)
Alcohol/Drug Involvement (items 1-5)	7.61	4.68	6.00	2.68
Dependence subscale (items 6-8)	3.73	3.43	4.07	1.95
Harm Subscale (items 9-12)	5.07	4.60	5.19	3.27
AUDIT-12 Total score	16.50	12.65	14.79	7.96

Table 3.51 AUDIT-12 Score Total Distribution

Total score	0-7	8-15	16-23	24-31	32-39	40+
Milwaukee	26%	25%	21%	14%	10%	4%
Hartford	52%	11%	13%	12%	8%	4%
Hartford men	42%	13%	17%	15%	9%	4%
Hartford women	75%	5%	4%	7%	5%	4%

Note: A score of 8 or greater indicates possible problems with alcohol or other drugs.

Data from the 2002 Hartford Homeless Study indicate that 48% of the sample scored a harm score of 8 or more. Although fewer than the Milwaukee study, where 74% scored 8 or more, these data indicate that almost half of the homeless population of Hartford may have severe alcohol and drug problems. When lifetime substance misuse problems were assessed (i.e., "have you **ever** had a problem with…") we noted that the majority were unable to stop drinking or drug use once they started, had failed to do what was normally expect because of alcohol or drug use, and had felt guilty or remorseful because of their drinking or drug use. Further, almost half reported having needed a drink or drug after

they get up, and had reported having been unable to remember what happened the night before because of alcohol or drug use.

Additional Alcohol and Drug Use Items

In addition to the AUDIT-12 items, the following additional questions addressed alcohol and drug use (Table 3.52). 74% of the sample reported that they had experienced alcohol or drug related problems some time in the past, 38% reported that they had to go to the emergency room because of alcohol or drug use, and 48% reported that they had been hospitalized because of alcohol or drug use. At the time of the interview, 11% of the sample were in a methadone maintenance program.

Table 3.52 Additional alcohol and drug use items

a. When were you having the most problems because of drinking/drug use?

	Frequency	Percent
Never	52	26.0
In the last 30 days	11	5.5
In the last year	51	25.5
In the past	86	43.0

b. Have you ever had to go to the emergency room because of alcohol/drug use?

	Frequency	Percent
No	125	61.9
Yes	77	38.1

c. Have you ever been hospitalized because of alcohol/drug use?

	Frequency	Percent
No	104	51.7
Yes	96	47.8

d. Are you in methadone maintenance?

	Frequency	Percent
No	179	89.1
Yes	22	10.9

Other Psychiatric or Emotional Problems

We also found that the majority of the sample said that they have a psychiatric or emotional problem other than substance abuse, and 30% had been hospitalized for such a problem (Table 3.53).

Table 3.53 Other Psychiatric or Emotional Problems

a. Do you think you have psychiatric or emotional problems other than alcohol or drugs?

	Frequency	Percent
No	98	48.8
Yes	103	51.2

b. Have you ever been hospitalized for psychiatric problems other than substance abuse?

	Frequency	Percent
No	141	70.1
Yes	60	29.9

These results on alcohol, drug and psychiatric problems correspond to the results of the medical history section of the interview, in which 43% of the sample said that they had (now or in the past) an alcohol abuse problem, 56% or had a drug abuse problem, and 54% said that had been told that they had depression. These results underline the importance of providing professional treatment services in the areas of alcohol, drug use and psychiatric problems.

Cigarette Smoking

In addition to alcohol and drug use and abuse, we were interested in the smoking habits among the sampled homeless. When asked about their smoking habits, the majority (67%) of the respondents still smoke.

What are your cigarette smoking habits?

	Frequency	Percent
Never smoked	30	14.6
Used to smoke	37	18.0
Still smoke	138	67.3

When we asked about numbers of cigarettes, the most frequently endorsed amounts were 20 per day, 10 per day, and 3 per day (Table 3.54). Smoking is an expensive habit for a homeless person, and our ethnographic experiences indicate that many poor people are able to only purchase one cigarette at a time.

Table 3.54 Cigarettes smoked per day (N=134)

Number of cigarettes	Frequency	Percent
1	5	3.7
2	7	5.2
3	13	9.7
4	6	4.5
5	4	3.0
6	7	5.2
7	5	3.7
8	2	1.5
9	1	.7
10	30	22.4
11	1	.7
12	2	1.5
15	4	3.0
20	36	26.9
25	1	.7
30	1	.7
40	8	6.0
50	1	.7

Table 3.54a Mean and median number of cigarettes smoked per day

N	134
Mean	13.01
Median	10.00
Mode	20
Standard Deviation	10.22
Minimum	1
Maximum	50

Readiness to quit smoking

We were very interested in exploring the degree to which our sample was ready to quit smoking. We utilized the Contemplation Ladder that asks respondents to identify, on a scale of 1- 10, where they are in their readiness to quit smoking (Table 3.55). This measure has been developed and validated in order to provide a measure for people who are at any stage in readiness to quit from pre contemplation, through contemplation, action or maintenance. The Contemplation Ladder is especially sensitive to the early stages of readiness to quit, either in the pre contemplation or contemplation stage (Biener and Abrams 1991). The median score for quitting cigarette smoking (for current smokers) was 5, which means that at least 50% were contemplating quitting at some time.

One interesting finding concerns the relationship between smoking cessation and incarceration. Since Connecticut prisons are smoke free, individuals who are

incarcerated are not able to smoke during their sentence. In the present sample, 10% of the respondents came from prison. Some of these individuals reported that they were disappointed in themselves for returning to smoking after a period of living smoke free in prison. Of the 20 interviewees who came directly out of prison, 55% still smoke. We have found that smoking cessation is one important health issue that, in general, has not been addressed within the shelter system.

Table 3.55 Readiness to quit smoking (N= 136)

Readiness	Frequency	Percent
1. I enjoy smoking and have decided not to quit for my lifetime. I have no interest in quitting.	5	3.7
2. I never think about quitting smoking and I have no plans to quit.	12	8.8
3. I rarely think about quitting smoking and I have no plans to quit.	10	7.4
4. I sometimes think about quitting smoking but I have no plans to quit	23	16.9
5. I often think about quitting smoking but I have no plans to quit.	26	19.1
6. I definitely plan to quit smoking within the next 6 months	22	16.2
7. I definitely plan to quit smoking within the next 30 days.	4	2.9
8. I still smoke but I have begun to change, like cutting back on the number of cigarettes I smoke. I am ready to set a quit date.	32	23.5
9. I have quit smoking but I still worry about slipping back, so I need to keep working on living smoke free	1	.7
10. I have quit smoking and I will never smoke again.	1	.7

3.55a Statistics on Readiness to quit smoking

(Range: 1 is least desire to quit, 10 is strongest desire to quit)

Number	136
Mean	5.26
Median	5.00
Mode	8
Standard Deviation	2.12
Minimum	1
Maximum	10

Respondents living outside

Demographics:

The in –person interview component of this project includes information on 5 men who were living outside. Four of these men were interviewed by members of the Homeless Outreach Team and one had been interviewed by the Hartford Hospital team at a shelter but had slept outside the previous night and was therefore included in this group of outdoor-dwelling participants. These men were 29, 30, 36, 39 and 49 years of age at the time of the interview. Four were White and one was Hispanic. One of these men was a veteran. Two of them were living under bridges, one was living in an abandoned apartment and one was living in a garage. All of these men had been homeless for the first time in their twenties; two when they were 20, one when he was 22 and two when they were 27. Four out of the five had graduated high school and one had gone to through culinary training after high school. Three had been divorced or separated and two had never been married. All five had earned less than $5,000 in 2001 and only one was receiving financial assistance (SAGA). Regarding employment, one was employed part time through a day-labor agency , two were unemployed and looking for work, one was unemployed and not looking for work and one reported being "self-employed" collecting cans.

Housing history:

All five were living in Connecticut five years ago with four living in Hartford at that time. Three had been living in Hartford for more than 10 years, one had lived there from 1- 2 years and one had lived there less than a year. Three had indicated that they had lived in Hartford for most of the first 18 years of their lives. Regarding chronic homelessness, one had been homeless for 220 days during the past year, and four had been homeless for all (365 days) or for virtually all (364 days) of the past year.

Reasons for homelessness and services needed:

When asked to identify the factor that they believed to be *the most important reason* for their homelessness, two of the five indicated drug abuse. One each indicated that medical problems, lack of income and lack of employment were the most important reasons for their homelessness. The man who was living in the garage reported that this living arrangement was "voluntary" since "it is financially feasible." Regarding services needed, the most commonly endorsed services were financial assistance, housing placement, job training and job placement which were endorsed by four out of the five respondents. Three respondents endorsed substance abuse treatment. Life skills training, mental health treatment and recreation were each endorsed by two respondents. Payee services, anger/stress management, case management, group home and legal services were endorsed by one respondent each. Interestingly, none of the respondents endorsed education as a needed service.

Medical conditions and health insurance:

The most common lifetime medical conditions among these men were drug abuse problems and mental health problems (other than depression), which were endorsed by four out of the five. Three of the men endorsed toothaches. Chronic bronchitis/emphysema, arthritis, depression, severe headaches and alcohol abuse problems were endorsed by two respondents each. Conditions that were endorsed by one respondent each included chronic allergies/sinus trouble, chronic back problems, stomach ulcers, physical disability, heart attack, cancer and asthma. Additionally, head injury and shingles were reported by one respondent each. Regarding health insurance, three of the men reported that they had Medicaid and two reported that they did not have medical insurance.

Summary:

Although these data do not provide a basis on which to make generalizations to the unknown numbers of homeless people who may be dwelling outside in Hartford at any given time, the following observations can be made. First, these men do not appear to be new to the area, with three having lived in Hartford for over ten years. Second, they appear to be chronically homeless or to be approaching chronic homeless (as defined by homelessness lasting for at least one year). Third, in addition to the lifetime medical conditions that were most often observed in the random sample (e.g., mental illness and substance abuse) these men also reported having other lifetime medical conditions (e.g., cancer, heart attack, stomach ulcers) that were observed infrequently among those sampled randomly.

Also of note, several positive interactions occurred as a result of the Homeless Outreach Team's assistance with this project. First, although one of these men declined both the phone card and any offers of aid or assistance, he did welcome the visit by the Outreach Nurse and hoped to be visited again. Second, an Outreach Nurse was able to help another man initiate the process of acquiring veteran's benefits partly through information gained during the interview. Third, although one man declined a referral for substance abuse treatment, he did accept information on places to go for free health care. Another man was given a "Street Sheet" which provided information on places where one can go to wash and to do laundry.

A particularly significant encounter occurred several months after the interviews had taken place. The Homeless Outreach Team encountered one of the study participants ("Mr. X", an Honorably Discharged Veteran of the United States Army) in October 2002, living beneath the same underpass in Hartford where they had interviewed him in March. He had not been seen since May when his temporary shelter was dismantled and removed from the underpass. He remembered having completed the interview in March and he expressed appreciation for having had the opportunity to talk about his issues. At the time of this second encounter, he shared with the team that he had not used heroin for two months (after having relinquished a "10-12 bag- a- day habit") and that he was now

getting full medical care at a local community clinic. Since the interview, he had made many strides towards beginning a more stable life. He was in a methadone maintenance program and he had started to meet with a case manager. Further, he was scheduled to begin work at a local restaurant and his employer was going to provide a room for him in Hartford. Seven months after the interview, this person was well on his way to emerging from homelessness. His main concern, however, was not for himself, but for another man who was also sleeping outside at the time and who was experiencing substance abuse problems as well. Subsequently the homeless outreach team began to make plans to reach out to and offer assistance to this second person and to begin to reach out to other outdoor-dwelling individuals who they had learned about through their second encounter with Mr. X. Thus, one initial interview established the foundation for an expanded social network through which the Homeless Outreach Team became aware of, and made plans to contact, several other outdoor-dwelling homeless individuals.

Interactions and encounters like these underscore the crucial role that social contact plays in the lives of the outdoor-dwelling homeless and illustrate the importance of outreach workers like those on the Homeless Outreach Team in providing them with services, information and interaction. The existence of the out-of-doors homeless also reminds us how difficult it is to deliver services to those who do not utilize the shelter system. This difficulty underscores the importance of preventing people from encountering situations that result in living out-of-doors.

The Chronically Homeless

The discussion below is focussed on the sub-sample of random interviews with those individuals who met the criteria for chronic homelessness. *Chronic homelessness*, in this discussion, is defined as having lived either outside, in a shelter or in a transitional housing program for at least one year. While those who live in supportive housing are, according to the definition presented earlier, technically considered "homeless", those who have lived in supportive housing for more than one year are not included here as "chronically homeless." They are excluded from this definition since it is likely that those who have been living in supportive housing for more than one year do not have the same profiles of needs and challenges as those who have been living outdoors, in shelters and in transitional programs for a similar length of time. This line of reasoning is supported by the fact that many of the participants who were established in supportive housing did not identify with being "homeless" and were occasionally even mildly offended at this description of their situations. The five outdoor-dwelling individuals, who are all either chronically homeless or very near to being so, have been discussed above. Therefore, the present discussion focuses on those who have been living either in emergency shelters or transitional housing for at least one year.

Demographics

The randomly chosen 200 –person sample included 18 people (13 men and 5 women) who may be categorized as "chronically homeless" in that they have been in their situation for one year or more. These individuals ranged in age from 21 – 68. The average age for the group was 43.5 years and the median age was 42 years. Two of these individuals have been living in emergency shelters and the other 16 have been living in transitional housing. Two of these individuals reported that children were also present- one household included three children (ages 17, 8 and 2) and one included five children (ages 10, 9, 7, 6 and 2). Almost 78% of the chronically homeless had been in the current program for less than 2 years. One had been in their current program for 15 years and one for 23 years. The ethnic distribution of these individuals was as follows: 8 were African American, 5 were Hispanic, 4 were White and one was multiracial. Four of these people were veterans. Most (13) had never been married and the remaining 5 had been divorced or separated. Eight were working fulltime and one was working part time. Five were on disability, two were unemployed and looking for work, two were unemployed and not looking for work. Regarding past year's income, 4 had earned less than $5,000 in 2001, 8 had earned $5,000- $9,999, 4 had earned $12,500- $19,999 and one had earned $20,000- $22,499. Supplemental Security Income was the most frequently received form of assistance, received by 5 of the 18. Seven reported that they did not receive any form of assistance. None of these individuals reported receiving veterans' benefits.

Housing history

Over 80% (15) were living in Connecticut five years ago with 7 living in Hartford at that time. Ten had been living in Hartford for more than 10 years. Seven indicated that they had lived in Hartford for most of the first 18 years of their lives. The ages at which these individuals had been homeless for the first time ranged from 15 – 65 with 7 of them being homeless for the first time between the ages of 26 - 37.

Reasons for homelessness and services needed:

When asked to identify the factor that they believed to be *the most important reason* for their homelessness, 7 indicated either alcohol or drug abuse. Three indicated that lack of income was the most important reason. Two each indicated that mental illness and medical problems were most important. One each indicated that family problems, domestic violence and lack of employment were the most important reasons for their homelessness. Regarding services needed, the most commonly endorsed service was housing placement (endorsed by 12). Financial assistance and job placement were endorsed by 5 people. Job training and education/GED were endorsed by 4 people. Three respondents endorsed day care. Two respondents endorsed case management, legal services and substance abuse treatment. Anger/stress management, domestic violence assistance, life skills training and recreation endorsed by one respondent each. Interestingly, none of the respondents endorsed mental health treatment as a needed service although one person did indicate a need for "more outside therapy".

Medical conditions and health insurance:

The most common lifetime medical conditions endorsed by these individuals were depression and alcohol abuse, which were each endorsed by 11 out of the 18. Drug abuse was endorsed by 7 out of the 18. Chronic allergies/sinus problems and limited use of an arm of a leg were each endorsed by 6 respondents. Chronic back problems, toothaches, arthritis, mental illness (other than depression) and hepatitis were endorsed by 5 respondents each. Four respondents each endorsed trouble seeing and physical disability. Five conditions were each endorsed by 3 respondents, including stomach ulcers, asthma, bronchitis, severe headaches and liver disease. Finally, heart attack, diabetes during pregnancy and tuberculosis were endorsed by one person each. Regarding health insurance, 7 of the respondents reported that they had Medicaid, 4 had Medicare, two had insurance through their employer, one had SAGA and 4 did not have insurance and two reported that they did not have medical insurance.

Summary:

Several observations may be made regarding the "chronically homeless". First, similar to those living outside, the chronically homeless individuals in the present sample residing in shelters and in transitional housing are not new to the Hartford area. The primary cause of homelessness endorsed the most often was substance abuse and the needed service endorsed most often was housing placement. Notably, none of these people endorsed

mental health treatment as a needed service although one person did indicate a need for further therapy. Depression and alcohol abuse were the most common lifetime medical conditions but many other medical conditions including tuberculosis, asthma, hepatitis, liver disease and heart attack were also endorsed by these individuals.

Summary: 2002 Hartford Homeless Health Survey

Through interviews with a randomly chosen sample of homeless individuals, we have been able to obtain information on the *depth* of homelessness in Hartford. As observed in the 2002 Hartford Homeless Census, African-Americans and Whites were over-represented in the homeless sample, compared with their representation in general population of the City of Hartford. When we addressed the housing histories of our sample, we noted that less than half of those residing in shelters had been living in Hartford prior to their current residence and that less than half were living in Hartford five years ago. Although these numbers suggest that the shelter population in the Hartford area is quite mobile, it is important to note that over half of the homeless individuals surveyed had lived in Hartford for 10 years or more cumulatively over their life spans and that half of the sample had grown up in Connecticut.

Substance use and income problems were the two most frequently self-reported *primary* causes of homelessness. Mental illness was endorsed as the primary cause of homelessness most often by those in supportive housing. Regarding self-reported *notable* causes of homelessness, lack of employment consistently remained at the top of the list across domicile and, in general, it was followed closely by lack of income. These results correspond to the demographic data indicating that over 20% of the homeless individuals interviewed were working either full or part time (yet were still homeless) and another 36% were looking for work. Over 65% of those interviewed reported that they had not worked at all in the past month. Family problems and substance abuse were also strongly endorsed across domicile as causes of homelessness .

When asked to identify unmet service needs, employment once again emerged as a leading issue for our sample as job training and job placement (as well as housing) were consistently identified across domicile. While the rates of endorsement of the respective service needs were lower for those residing in supportive housing, the number of needs that were notable (i.e., endorsed by at least 10% of the respondents) were similar. We noted that, compared with the reports of the program administrators from the 2002 Hartford Homeless Census, the self-reports of the homeless themselves indicate that there may be an under-reporting of service needs within this population by program administrators, although methodological differences between the census and the interview components of this study preclude a direct comparison of client and administrator report.

Differences according to domicile were also noted when we assessed health care utilization and access. Over 45% of those residing in shelters reported utilizing the emergency room as a regular source of health care. Overall, over 55% of the homeless individuals sampled reported using the ER during the past year. Respondents residing in supportive housing were the most likely to have had health insurance. Further they had a tendency to rate their access to health care as more positive (i.e., a smaller percentage of them rated their access as very poor, poor or fair) then did residents of other domiciles.

This is most likely due to the fact that many people are in supportive precisely because they have some kind of chronic medical condition that requires frequent care.

When medical history and current medical conditions were assessed, the results corresponded to those of other studies in which homeless individuals reported higher rates of chronic disease compared with general population samples. Over half of the 26 medical conditions had been experienced by at least one in five of those interviewed with histories of depression, substance abuse and chronic back problems being the most commonly endorsed. Rates of lifetime chronic conditions such as depression, other mental illness, substance abuse and chronic bronchitis were from twice to over twelve times as high in the homeless sample compared with the general population of Hartford. Rates of all chronic diseases were higher among residents of supportive housing , compared with residents of shelters or transitional housing programs *with the exception* of substance abuse.

The 2002 Hartford Homeless Health Survey included in-depth measures on substance abuse and smoking. Data from the pilot test of the AUDIT regarding drug and alcohol abuse indicated that the homeless men sampled from Hartford facilities were very similar in their profiles of alcohol drug involvement, dependence and harm to the homeless men sampled by Campbell et al (2001) in Milwaukee. The distribution of the general severity of substance abuse problems was also very similar, particularly for the more severe levels. Pilot data from the AUDIT-12 indicated that almost half of the homeless individuals sampled had severe substance abuse problems. These patterns suggest that substance abuse treatment remains an important service need among the homeless of Hartford.

We noted the rate of current smoking among the present sample was over twice that of the general population of Hartford. As observed in the 1999 Hartford Homeless Health Survey, chronic diseases such as heart disease, asthma and bronchitis did not appear to be deterrents to cigarette smoking as 55- 78% of those with histories of such conditions were current smokers at the time of the interview. However, at least 50% of the current smokers in the present sample reported that they contemplate quitting smoking at least occasionally. These data strongly suggest that establishing smoking cessation programs would be a potentially beneficial initiative for homeless service providers to add to their repertoire of services.

In conclusion, data from the Hartford Homeless Health Survey correspond well to previous reports on health issues facing homeless individuals and have delineated important areas for policy making in the prevention of homelessness, the interruption of the cycle of homelessness and the improvement of services for homeless individuals. It is expected that the information obtained from the 2002 Hartford Homeless Health Survey will be valuable to the Hartford Health Department and to the City of Hartford as they seek, through a number of public health Call-to-Action initiatives, to reduce the long-term incidence of chronic disease and to improve the health of all of the city residents.

4. Suggested recommendations on Homelessness provided by the City of Hartford Public Health Advisory Council, the City of Hartford Homeless Commission and the Hartford Continuum of Care

The following are suggested recommendations that have been provided by the Public Health Advisory Council, the City of Hartford Homeless Commission and the Hartford Continuum of Care based upon the data presented in *Homelessness in Hartford, 2002*. These recommendations address three issues: prevention of homelessness, interruption of the cycle of homelessness and strengthening of services for the homeless. Listing of these recommendations does not imply a formal mandate on the part of any of the organizations mentioned above.

I. Issues that pertain to the prevention of homelessness:

1. Improve the capacity of existing substance abuse and mental health treatment programs

Data from *Homelessness in Hartford 2002* indicate that the top three primary reasons for homelessness in Hartford have not changed since 1999. These are substance use, mental illness and income problems. As such, one of the most importance recommendations to emerge from discussions of this report is to improve the capacity of existing substance abuse and mental health treatment programs.

2. Expand affordable housing opportunities and seek partnerships between homeless service providers and entities that support employability

In response to the frequency with which income problems and lack of employment were endorsed as causes of homelessness, either alone or as part of a constellation of causes, recommendations have been made to expand affordable housing opportunities and to seek partnerships between homeless service providers and entities that support employability such as the Connecticut Department of Labor and the Capitol Region Work Force Development Board. Such partnerships would address further opportunities for homeless individuals to gain entry into the workforce. It is important to note that the Continuum of Care has already advanced this recommendation by inviting a member of the Capitol Region Work Force Development Board to join their membership.

3. Establish rapid payee systems within the City

Sometimes, when a client is not able to manage their own financial obligations, a second party (a "payee") is appointed to handle these tasks on his or her behalf. In order to assist the homeless in obtaining and maintaining affordable housing, recommendations have been made to establish rapid payee systems within the City.

4. Utilize the influence of housing advocacy groups
In order to assist the homeless in obtaining and maintaining affordable housing, recommendations have been made to utilize housing advocacy groups to insure that homeless individuals are afforded the fair housing opportunities that they are entitled to by law. Further, our discussions have identified the need for housing advocacy organizations to be represented within the Hartford Continuum of Care and the need to improve the "health" of the housing that is currently available to residents within the City of Hartford.

5. Explore ways to identify at risk populations and windows of opportunity that could be used for homelessness risk- assessment

In order to prevent homelessness, recommendations have been made to explore points at which risk assessment may be used in order to identify those at risk for homelessness and to intervene before homelessness occurs. In order to prevent youth homelessness, it is important to work to identify points at which risk assessments may be inserted within the educational system.

6. Examine best practices from other parts of the country

Finally, it was suggested that examining best practices from other parts of the country might yield information about approaches to homelessness prevention that might be effective in Hartford, CT. The Institute for Outcomes Research and Evaluation and the Connecticut Coalition to End Homelessness continue to compile information on homelessness based upon data from both state-wide and national sources.

II. Issues that pertain to interrupting the cycle of homelessness:

1. Develop and systematically apply screening procedures for service trajectories at the point of entry into homelessness

The degree to which an individual is temporarily or chronically homeless is one of the most important factors that will impact the extent to which a given intervention will be effective in interrupting that individual's trajectory through a potentially re-iterative cycle of homelessness. Our discussions have identified a need within the community of homeless service providers in Hartford to develop and systematically apply a set of screening procedures in order to address this issue for each homeless person. Standardized procedures are needed to identify, at the point of entry into homelessness, those who are employable, who possess marketable skills and who have the potential to maintain employment. These are the individuals who have a high probability of successfully escaping homelessness.

It is also necessary to work to identify other factors that predict successful emergence from homelessness. Once these individuals are identified, funds should be invested into job training, placement and other services to support the temporarily homeless during the

transitional period. Standardized procedures are also needed through which to identify those who are chronically homeless and who would be appropriate candidates for transitional and supportive housing.

The Continuum of Care has provided an invaluable perspective on current screening practices in Hartford. Currently, the screening procedures used by Hartford's homeless care providers differ from facility to facility. Case workers tend to be most aware of services available within their own facility but they may not be aware of those at other facilities. Shelters also vary in their "screen-out" criteria (i.e., who they will and will not admit).

Guidebooks to homeless services in the City exist from program to program but there is currently no centralized "clearing house" of resources available to the homeless or to service providers within Hartford. Many homeless care providers rely on Infoline as they seek to refer clients to needed services. Our discussions have identified a strong need for the development, and continued maintenance, of an accurate, comprehensive guide to services for the homeless in Hartford, CT that may be utilized by government agencies and service providers as they seek to refer homeless individuals for needed services and treatment. Once such a document is created, adapting it to a World Wide Web-based format would be a logical next step toward expanding the accessibility of this information.

2. Move away from the emergency shelter-based approach to homelessness prevention

These discussions have also identified the need to move away from an emergency – shelter-based approach to homelessness prevention and to move toward establishing smaller scale facilities with more intensive case counseling for both temporarily and chronically homeless individuals. Given the development of more day centers, counselors would have expanded opportunities to engage homeless persons in one-on-one therapy in order to help them identify factors that led them to homelessness and to subsequently guide them toward strategies to avoid future homelessness. An issue closely related to the need to move away from the emergency shelter approach involves the need to consolidate services between shelters and soup kitchens (or day centers).

3. Restructure the emergency shelter model

A number of Hartford's homeless service providers have endorsed a restructuring of the emergency shelter model so that homeless individuals could receive continuous and intensive services. The restructured model would:

- Allow for shelters to remain open on a 24 hour basis so that homeless individuals would not have to spend their day-time hours "on the streets" and would thus experience a more stable way of life.
- Call for all shelters to provide three meals per day so that fewer homeless individuals would need to utilize neighborhood soup kitchens.

- Eliminate current limitations on length-of-stay in shelters so that staff can work with clients on a longer-term basis.
- Increase funding for supportive housing programs in order to ultimately reduce the need for emergency shelters. Additionally, increased funding to *some* shelters would be needed in order to increase the capacity of these facilities to remain open 24 hours per day.

4. Strengthen existing transitional services for individuals recently released from incarceration

Data from *Homelessness in Hartford, 2002* have illustrated that being released from jail or prison was reported as a cause of homelessness for approximately 11% of the population enumerated in the *2002 Census of the Homeless of Hartford*. Based upon these data, recommendations have been made to strengthen transitional services that currently exist for individuals recently released from incarceration in order to prevent them from falling into or returning to a state of homelessness upon their return to society.

While recommendations have been made to strengthen and better standardize service trajectories for the temporarily homeless and for those chronically homeless individuals who could adapt to a supportive housing environment, the question of how to best reach the severely disenfranchised chronically homeless remains largely unanswered. These are individuals who are unable to get along in minimally-structured facilities and who live in the often unreachable corners of the urban landscape. The fact that these individuals are extremely difficult to reach and the fact that their real numbers are difficult to ascertain underscore the importance of continued support for services such as those provided by the Homeless Outreach Team who are constantly reaching out to such individuals, providing necessities such as meals, blankets, clothing, information on services and needed social contact.

III. Issues pertaining to strengthening services for the homeless:

1. Establish partnerships between shelters, soup kitchens and day service providers to offer services on an out-reach basis and to decrease non-productive use of services

It is clear from these discussions that the demand for services for homeless individuals in Hartford exceeds the capacity of the current delivery system. Due to barriers in coordination between service providers, many homeless individuals “bounce back and forth” between programs, often interacting with multiple case workers at shelters and at day service facilities. This lack of coordination can lead to the tapping of similar services at various locations, which can add an increased burden to this system and may not provide the depth or the continuity of care that is needed to emerge from homelessness. The shelter system that was initially established as emergency lodging has seemingly become a part of a “way of life” for a growing population of migrant homeless individuals. There is a recognized need for shelters and day service providers to establish

partnerships and to provide services on an out-reach basis, rather than "waiting" for individuals to seek out assistance.

2. Strengthen services that offer disease prevention and chronic disease management instead of episodic health care

Services that offer disease prevention and chronic disease management instead of episodic health care should be strengthened. This includes establishing clinics within transitional and supportive housing systems and insuring that homeless children participate in the HUSKY program and are connected to providers who accept this insurance. The recommendation was made to request support from the Connecticut Department of Public Health in order to establish a system for continuity of primary care within the shelter network. Further discussion should explore Medicaid reimbursement issues and potential gaps in coverage for needy populations such as the homeless.

3. Strengthen the continuity of health care for homeless persons through closer collaborations between homeless service providers and Federally Qualified Health Care Centers

There is a need for homeless service providers and Federally Qualified Health Care Centers to work more closely in order to strengthen the continuity of health care for homeless persons. In the City of Hartford, both the Community Health Center and Charter Oak Health Center offer strong outreach programs to the homeless. However, based upon feedback received from the Continuum of Care, there does not appear to be a strong connection between homeless service providers, local hospitals and these federally qualified health care centers. The Continuum recognizes a need for health care providers to be represented, at the leadership level, among their membership.

IV. Concluding statements

We shall bring these recommendations to a close by acknowledging the depth of understanding with which the Homeless Commission, the Public Health Advisory Council and Hartford Continuum of Care have viewed the present data. The census report provides a "snap-shot" of the homeless population in Hartford, CT as it existed on one Winter evening and does not adequately describe the *magnitude* of homelessness in the City over a year. Simply providing 1613 housing units, for instance, will not adequately address the issues surrounding homelessness in Hartford, CT. As we have observed through the course of this project, and as those who provide services to the homeless will attest, these issues are complex and interwoven. It will require the restructuring of systems at the levels of homelessness prevention, homelessness intervention and service delivery in order to bring about a significant and lasting reduction (and eventual elimination) of homelessness in Hartford, CT. We look forward to working with local government, with public health officials and with homeless service providers to advance these recommendations toward this goal.

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Appendix I:
Need and Use of Food Stamps in the 2002 Hartford Homeless Health Survey

Food Stamp Need vs. Usage in the 2002 Hartford Homeless Health Survey

One item in the health interview asked respondents about their need and use of various community services during the past year. The use of food stamps is of particular interest since this is a service for which virtually all homeless individuals, regardless of domicile, should be eligible. When need and use of food stamps was assessed across domicile, rates of clients reporting that they needed food stamps remained constant across domicile as 73% of interviewed shelter clients, 62% of transitional living clients and 76 % of supportive clients reported needing food stamps during the past year. Of those who reported that they needed food stamps, 17% (13 out of 77) of those in shelters reported that they did not use them. Almost 20% (8 out of 41) of transitional program clients who needed food stamps reported that they did not use them. Approximately 26% (5 out of 19) of supportive living clients who needed food stamps reported that they did not use them. Thus, while food stamp need remained constant across domicile, supportive housing clients reporting that they were in need of food stamps were the least likely to have used them.

Rates of overall food stamp usage from the 2002 Homeless Census were compared to those from the 1999 Homeless Census. In 1999 27/66 or 41% of those interviewed had used food stamps. In 2002, 118/196 or 60% of those interviewed had used food stamps. This difference in percentages was statistically significant ($p < .05$) indicating that a greater percentage of respondents used food stamps in the 2002 study than did in the 1999 study. While rates of food stamp usage have increased in these data, it is important to note that 40% of homeless individuals interviewed reported that they had *not* used food stamps. Since it is highly likely that *all* of those individuals interviewed would have qualified for food stamps, regardless of whether or not they reported "needing" food stamps, this 40% represents a notable gap in this important service.

			Used		Total
			Yes	No	
Needed	Yes	Count	64	13	77
		%	83.1%	16.9%	100.0%
	No	Count	5	21	26
		%	19.2%	80.8%	100.0%
Total		Count	69	34	103
		%	67.0%	33.0%	100.0%

			Used		Total
			Yes	No	
Needed	Yes	Count	33	8	41
		% within Food Stamps	80.5%	19.5%	100.0%
	No	Count	2	23	25
		% within Food Stamps	8.0%	92.0%	100.0%
Total		Count	35	31	66
		% within Food Stamps	53.0%	47.0%	100.0%

			Used		Total
			Yes	No	
Needed	Yes	Count	14	5	19
		% within Food Stamps	73.7%	26.3%	100.0%
	No	Count		8	8
		% within Food Stamps		100.0%	100.0%
Total		Count	14	13	27
		% within Food Stamps	51.9%	48.1%	100.0%

APPENDIX II.

Housing for the Homeless of Hartford: Program Descriptions

Descriptions of Housing for the Homeless of Hartford

Shelters

The following are the *shelters* of Hartford. Shelters are emergency housing serving individuals and families who have no other place to go. Generally the emphasis in the shelter is helping the person in crisis, by referring him to services that can help him resolve his problems and gain permanent housing. Due to fluctuations in needs for specific services, not all programs were represented in the current report.

American Red Cross Emergency Shelter is an emergency shelter for victims of disasters. Length of stay varies from several hours to several months.

Community Renewal Team (CRT) McKinney Shelter is a shelter for men, which is located in a renovated fire station.

Department of Social Services (DSS) Shelter Apartments are called creative apartments, and are 20 to 30 units that are contracted with private landlords to be used by large families who are homeless. The families typically stay for 60 nights, until permanent housing is found.

Hartford Interval House is a shelter for victims of domestic violence.

Hartford Regional Lead Treatment Center Lead Safe House provides temporary housing for families whose children suffer from lead poisoning. There are five units fully furnished apartments, which serve families from northern Connecticut. The families stay from 60 to 80 days while their housing is being made safe, or while they are seeking new permanent and safe housing.

Immaculate Conception is an emergency shelter that houses over 60-100 men each night in a church basement. Immaculate Conception also sponsors a day program and an outreach van which monitors the living-out-of-doors homeless each evening and early in the morning.

Mercy Housing Emergency Shelter is a shelter for single adults. Also in the same building is a transitional program and a community soup kitchen.

My Sisters Place I is a shelter for single women and women with children.

Open Hearth is a shelter for single men. This shelter has been in existence for over 100 years.

The Salvation Army Marshall House Family Shelter is a 30-bed family shelter.

South Park Inn is an 85-bed shelter that houses single men and women, and families.

YWCA Shelter is a shelter serving single women. The length of stay is normally limited to 90 days.

YWCA SACS (Sexual Assault Crisis Services) provides beds for three women for three months, or longer if needed.

Youth Shelters

The Salvation Army Marshall House Youth Shelter has beds for males and females, ages 11 to 14. The stay is optimally 30 to 45 days, although it could be longer. The goal of the program is to find long-term stable living situations for them.

YMCA YES (Youth Emergency Shelter) serves girls, ages 11 to 17. The goal of the program is to place the girls in more permanent settings, such as group home, foster care, or residential programs. The girls are at the YES program for approximately one month, although it could be longer.

Transitional Housing

The following are the *transitional housing programs* of Hartford. Transitional programs serve as a transitional between shelters and the street and permanent housing. Typically clients stay in transitional housing for up to two years. Clients pay a modest amount for room and board, and generally have their own room. Most programs either offer treatment programs themselves (generally for substance use or mental illness) or have the clients receive treatment outside of the program.

Alcohol and Drug Rehabilitation Center programs (Alternative Living Centers, Recovery House, Coventry House, SATEP) include detoxification (three to five days), intensive (28 days) and intermediate (up to 90 days) programs that serve the general community, including many homeless individuals.

The Alternative Living Center is a long term residential facility for homeless chronic male substance abusers of Hartford.

An Alternative Living Center for women is located at the Institute for Living and serves women with substance abuse who may have co-occurring mental illness.

SATEP (Substance Abuse Treatment Enhancement Project) houses and treats six men and five women.

Community Partners in Action serves men coming out of prison.

Community Renewal Team Supportive Housing (I and II) is a housing program for families.

Community Solutions, Cheyney House Project is residential care in lieu of incarceration. The program serves adult men and women who stay for four to six months.

House of Bread serves men in apartments. House of Bread also operates a soup kitchen and day program.

Mercy Housing AIDS Residence serves people with AIDS.

Mercy Housing Mental Health Respite houses individuals with mental illness.

Mercy Housing Transitional is a program for single adults.

My Sister's Place II is a group of apartments for single women and women and children. The building is a renovated factory.

Open Hearth Transitional is a drug and alcohol rehabilitation center for single men.

The Salvation Army, Homestead Ave is a program with an emphasis on drug and alcohol rehabilitation for single men and women. The typical stay is eight months.

South Park Inn Transitional is a program serving single men. South Park Inn is located in a former church.

Tabor House II is transitional housing for women, with a two-year limit of stay.

YWCA Transitional is a program for single women.

Supportive Housing

The following are the *supportive housing programs* of Hartford. Supportive housing is permanent housing for individuals and families who have been homeless, or who are at high risk for homelessness. The programs generally offer housing (often in scattered sites) with support so that the person is better able to retain the housing and not return to homelessness.

Center for Human Development – Connecticut Outreach is services clients who have mental health needs and would be at high risk of eviction and homelessness if the service did not exist.

Chrysalis Center Programs offers housing serves to people with mental illness.

Hudson View Commons is operated by Chrysalis Center, Inc. and 28 units that are subsidized for homeless individuals including people with mental illness, AIDS, and/or substance abuse problems.

Crossover (formerly Laurel Street Group Home) is a group home for people with mental illness, who stay from 18 months to two years.

Mary Seymour Place Apartments serves single adults and families in its subsidized housing program. Many of the people suffer from mental illness, chronic substance

abuse, AIDS, and/or other disabilities, or are low income and are at high risk for homelessness.

Mercy Housing AIDS Supportive Housing serves individuals and families with AIDS in scattered site housing.

Mercy Housing Mental Health is housing for individuals and families with mental illness.

Mercy Housing Supportive Housing programs provide housing units for individuals and families with mental health needs.

My Sister's Place III provides residential support services for single women and women with children.

Plimpton House houses individuals with mental illness in an historic house in Hartford.

Peter's Retreat houses individuals with AIDS.

Shelter Plus Care (TRA's) provides subsidized, scattered-site housing and support services to individuals with mental illness.

Shelter Plus Care : Project HEARRT (Housing, Employment and Risk Reduction Team) is a collaborative project operated by Chrysalis Center, Inc. that is comprised of several greater Hartford based organizations. This program provides housing and case management services to 60 individuals (18 years of age or older) who were previously homeless, struggling with substance abuse, mental illness or HIV/AIDS.

Tabor House I is supportive housing for men with no time limit.

Todd House is supportive housing for adult single people. The goal of the program is for people to make the transition to independent living. It is affiliated with Capitol Region Mental Health.

YWCA Shelter Plus Care Sponsor Based Rental Assistance program subsidizes the on-site housing for single women.