Barriers within the Safety Net

A study of family homelessness in Somerville, Massachusetts and the availability, accessibility, and effectiveness of social services

An honors thesis for the Program of Community Health

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"…it is not sufficient simply to shelter, feed, and clothe the public dependents inside of institutions supported by taxation. Such institutions may, and unhappily do, often, become the means of still further degrading the miserable beings who crowd into them. To make them useful at all, it is necessary that they should be governed by those who recognize that the prevention and permanent cure of pauperism, vice and disease are the objects to be sought, and the whole system of public relief must be based upon that principle."

- Josephine Shaw Lowell, 1884

Introduction

For several decades, family homelessness remained practically invisible in the United States. By keeping families off the streets and in shelters, the evidence of extreme poverty in one of the richest nations in the world was hidden. However, the recent economic contraction, the largest since the Great Depression, has brought public attention to the problem as hundreds of thousands of low-income and even middle-income families fall into homelessness each year. Family homelessness, which did not exist in the United States before the 1980s, is rapidly becoming an unavoidable societal problem. Burdened with shrunken incomes and unshakable unemployment, many parents have had no choice but to seek homes of cheaper rent in a market where low-income housing is already exceedingly rare. Limited affordable housing at a time of few resources has played a large role in the recent rapid rise of family homelessness. As poverty has escalated, affordable housing has declined placing more and more families at risk for homelessness. The resources from public and private supportive services are being stretched thin as more and more people seek help from welfare offices and nonprofit agencies.

Homeless families, once nonexistent, are now the most rapidly growing demographic of the homeless, comprising 34 percent of the population. In any given year, approximately 420,000

- 600,000 families are homeless (Rog 2007; National Alliaince, "Family Homelessness" 2007). More recent statistics state that in 2008 nationwide, 1.6 million people were homeless (Bello 2010). Most families are homeless for less than a year and are labeled as "short-term" homeless, yet during this time, parents and children can develop severe mental and physical health problems. While the characteristics and causes of family homelessness have been thoroughly researched, fewer studies have focused on the effectiveness of supportive programs that aim to help families exit homelessness; at a time of such great need, it becomes even more relevant to study this forgotten topic.

The homeless support system that exists in the United States today is the product of years of piecemeal additions and adaptations. Rather than have a single, unified service organization to provide aid for homeless individuals and families, the U.S. system is based on complicated interactions between federal and state government programs, nonprofit agencies, and local community groups. While all service providers attempt to give aid to the homeless, services are often inadequate, inaccessible, or unacceptable to the population, presenting barriers to service usage. Limited funding and a rapidly growing homeless population have consumed available resources and limited the amount of aid that can be provided. Additionally, lack of information on government programs and especially nonprofit service providers constrict people's access to service providers. Finally, certain service rules and stipulations make programs unappealing to parents who as a result, try not to use them, hindering the effectiveness of the programs and harming families who do not use the services.

Interventions have been made on all levels of service provision to increase the number of programs available for homeless families; however, their effectiveness is rarely studied. Additionally, few if any studies investigate the opinions of clients utilizing such services. While

the creation of public health and social services is important, if the programs are not accessible or are considered unacceptable to the target population, interventions will have limited effectiveness. In this study, interviews with parents of homeless families affiliated with Somerville Homeless Coalition allowed for the investigation of the barriers and facilitators that shape families' experiences accessing and using homeless services.

Through this research, the opinions of clients from Somerville Homeless Coalition were used to study the availability, accessibility, and acceptability of supportive services in Somerville. Additionally, studying the history of the U.S. welfare and homeless system provided insight to how the accidental and unorganized creation of supportive services has led to the incomplete safety net that exists today. The purpose of this study was not only to identify the problems families encountered when receiving services, but to be able to determine implementable solutions to make improvements.

Overall, ten interviews were conducted with volunteer participants who were parents of homeless families. Their stories made clear the inadequacy of the information parents have regarding social services. While parents received aid from government and occasionally nonprofit services, they all shared experiences of having found the homeless system very hard to navigate alone. Parents described troubles with unhelpful case workers at the Department of Transitional Assistance, complicated applications for housing, and a lack of knowledge of nonprofit service providers, all of which were barriers to accessing homeless services. If the U.S. is to have an adequate safety net that meets the needs of the rising number of homeless families, the barriers and gaps in the homeless system must be addressed. Ultimately, no matter what support system is present, changes must be made that address the societal causes of family homelessness.

This paper is divided into several chapters. The first chapter presents background information on homeless families and the causes of homelessness in the U.S. Additionally, the chapter goes into detail explaining the current supportive services, both government and nonprofit, that exist for low-income and homeless families and the history behind these services. The second chapter presents a description of the locations for the study, the methods of data collection, and the analysis conducted on the ten collected interviews. The third chapter presents the results. The results included participants' reasons for homelessness as well as similarities and differences among interviewees' experiences using supportive services. The last section of the third chapter describes the barriers and facilitators reported by participants during the interviews. Finally, the fourth chapter presents a discussion, providing explanations of the results and proposed solutions to help improve the current problems in the homelessness system identified during this study.

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CHAPTER 1:
THE HISTORY OF FAMILY HOMELESSNESS AND HOMELESS SERVICES IN THE UNITED STATES

The first chapter is divided into several sections. The first section describes the demographic characteristics that place certain families at increased risk of homelessness. The second section discusses the development of environmental pressures as the source of homelessness, poverty and lack of low-income housing. The third section presents the current statistics of the environmental causes of homelessness both within the U.S. and in the Boston area. In order to present information on available supportive services in the United States, the history of welfare creation and its later reforms are presented in the fourth section followed by the history of the homeless system in the fifth. Government supportive programs, both welfare

and subsidized housing, are described in the sixth section. The seventh section presents the history of nonprofit supportive services in the United States, followed by a brief conclusion.

The purpose of this chapter is to present information through which one can understand the causes of family homeless in the United States and the societal conditions which continue to propagate this phenomenon. Additionally, through detailed examination of the various social services, the complexity of the supportive service system in the United States is made clear.

I. CHARACTERISTICS OF HOMELESS FAMILIES

Homeless families are a diverse population whose characteristics vary between regions, states, and cities. Due to the rising prevalence of homeless families in the 1980s, many studies were conducted to identify the characteristics of homeless families that would provide information on the risk-factors that result in homelessness. Though such studies continue to be conducted, researchers and service providers are beginning to understand that environmental conditions which affect a wide array of families play a more significant role in causing homelessness than personal characteristics.

While finding a concrete list of "identifiers" for homelessness is impossible, there are several trends among homeless families worth identifying. Eighty percent of homeless families are homeless for less than a year and have only one incident of homelessness; these families are designated "short-term". A smaller population has repeated histories of homelessness for longer periods of time and these families are characterized as "chronic." Almost all families are unstably housed for some time until a random event tips them into homelessness (Seltser 1993). While environmental conditions are the source of at-risk families, understanding the personal

characteristics that place a family at added risk for homelessness illuminate societal inequities and help service workers provide better targeted aid for especially needy populations.

A. General Demographics

The majority of studies that attempt to differentiate between families that become homeless and those that stay housed have collected information on families in shelter and compared them to poor housed families. Qualifications for "homelessness" can vary by study but usually the family has recently entered or applied for shelter. Low-income and housed families on welfare who do not have histories of homelessness act as the control group in most studies. The definition of "family" is a single mother or two parents living with at least one child under eighteen; pregnant women are also considered to fall under the category of "homeless family."

The heads of homeless families are frequently single-mothers who are 25 to 30 years old and are more frequently of a racial or ethnic minority (Shinn 1996; Shinn 1998). Taking into account that that minorities are highly represented in the population in poverty, minority families are found to be even more prevalent among homeless families (Rossi 1994; Shinn 1996). While intact homeless families exist, the majority of homeless families are headed by a single woman, who are at higher risk of living in poverty, and thus at a greater risk for homelessness (Seltser 1993; Rossi 1994; Shinn 1996).

Many homeless mothers are pregnant or have a young, recently born baby (Shinn 1998). Pregnant women make a unique and significant subgroup of homeless families. A New York City study interviewing families in shelter found that of the homeless women interviewed, 35% were pregnant and 26% had given birth in the past year (Bassuk 1993). Consequently, the children of homeless mothers tend to be younger than those of housed mothers (Bassuk 1996).

Homeless pregnant women are frequently young, have experienced serious disruptions to their families as children, and tend to suffer from chronic health problems tied to pregnancy and limited access to medical care (Bassuk 1993). Pregnancy and the birth of a newborn are highly associated with homelessness perhaps because the birth of a child forces a single woman who was living doubled-up to need to leave the home (Bassuk 1993; Shinn 1998).

Homeless families frequently have had a history of living in poverty. Most families barely managing to stay housed for several years before becoming homeless (McChesnesy 1992). Among single-parent families, the parent has less time to work due to child rearing and as a result the family is more likely to be in poverty. Parents tend to be unemployed or underemployed because they cannot find work and the jobs they find are for unskilled labor and underpaid. Many homeless mothers have a poor employment history because they have a lower level of education than poor, housed mothers and are less likely to have completed high school. While homeless and poor housed families are frequently on some kind of welfare, the money they are given is not enough to support their family and many parents work to supplement their welfare checks (Rossi 1994; Bassuk 1996; Shinn 1996).

B. Social Networks

Having a supportive social network is important to family stability. For many people, their social networks are comprised of friends and family members and they are generally part of a larger community (Jackson 2000).When families first become homelessness, it is common for many to live doubled-up with a friend or family member for some time before seeking public shelter (Shinn 1991; Shinn 1998). Some policy-makers and researchers believe that the families who seek public shelter are those with poor supportive networks. However, even families who

lived doubled-up for a period of time may be asked to leave by the primary tenant due to crowding or disputes with members of the household (Shinn 1991). Living in close quarters strains relationships, diminishing families' social networks (Toohey 2004).

While a lot of research has been dedicated to studying the supportive networks of homeless families and how they compare to those of poor families, the results are fairly inconsistent (Shinn 1996). In some studies, female heads of families identified fewer members in their supportive network than housed woman (Bassuk 1996; Bassuk 1997). One study that had more in-depth questioning found that housed heads of families were more likely to report that at least one of their listed contacts could provide them with shelter. However, the same study reported that homeless families had more network members than housed families. Though homeless families frequently have a mother, grandmother, close relative, or close friend in their supportive networks, housed families reported more frequently that these network members could provide them with housing if necessary (Shinn 1991; Toohey 2004). An explanation may be that the network members of homeless families have fewer basic resources than those of housed families (Bassuk 1996). Homeless families may still have a strong social network but its members do not have the room or the money to support another family doubled-up (Shinn 1991).

Researchers had hypothesized that homeless women would identify more of their relationships as "negative" than "positive," but results from in-depth interviews were contradicting. Though housed women had a greater tendency to report a higher average number of positive relationships per network than homeless women, both housed and homeless women had the same number of negative relationships (Toohey 2004). Finally, homelessness itself can have a negative impact on the social networks of families. Besides straining relationships in doubled-up situations, homeless families tend to get housed in new neighborhoods and in a

different location from the majority of the members of their social networks. Additionally, while in shelter, families may have diminished communication with their supportive network (Toohey 2004).

C. Mental Illness

The heads of homeless families do not have an increased prevalence of schizophrenia, anxiety, or other severe mental illness compared to poor families and the rates of psychiatric hospitalization among homeless parents is much lower than homeless single adults (Seltser 1993; Bassuk 1996; Shinn 1996). However depression and post-traumatic stress disorder (PTSD) are both prevalent among the heads-of homeless families and can be debilitating to parents, making it difficult for them to support their families. People with serious depressive and anxiety disorders struggle to work, maintain jobs, and keep an organized budget (Trimmer 1994; Bassuk 1996). In an unstable living situation with multiple children to take care of and a low-income job, it is a huge challenge for parents with PTSD or depression not to fall into homelessness. In addition, the presence of mental illness can complicate doubled-up living situations causing a family to have to move into public shelters (Weinreb 1990).

D. Substance Abuse

In the past, the prevalence of substance abuse was much lower among homeless families than among homeless individuals but more recently service providers are reporting an increase in numbers of homeless mothers who are substance abusers (Weinreb 1990; Rossi 1994). Although a combination of environmental conditions and personal characteristics put families at risk of homelessness, substance abuse by the head or heads of the family is one of the more definitive

risk factors that tip families into homelessness (Weinreb 1990; Rossi 1994). Drug and alcohol abuse are more prevalent among homeless mothers compared to housed mothers and it is likely that substance abuse not only interferes with a parent's ability to maintain a home but can also cause families to remain homeless longer by hampering parents' abilities to find housing, jobs, and support (Weinreb 1990; Bassuk 1996). When parents are substance abusers, the medical and psychological problems in both parents and children are worsened and children are at higher risk of being abused and neglected (Weinreb 1990).

E. Domestic Violence

Domestic violence is common in the history of homeless mothers but as a single variable has not been found to constitute a risk factor for homelessness; unfortunately, violence is prevalent in the lives of both homeless and housed women (Bassuk 1996; Bassuk 1997). Low-income women and children are at higher risk for violent victimization (Salomon 2002). In a self-reported study conducted on men in the U.S. in 1985, one in eight respondents reported having acted physically against their partners. Since the information was gathered from individuals willing to report acts of violence, it is likely that domestic violence is even more prevalent in the United States than the study indicated (Browne 1997). A more recent study reported that 60 percent of a total sample of homeless and housed women reported experiencing several physical assault by a male partner. Of this sample 26.7 percent of the homeless women reported having had to seek medical attention due to the abuse (Browne 1997).

Although domestic violence alone is not a risk factor for homelessness, it can exacerbate other risk factors, leaving a family at greater risk for homelessness. A study on women who sought welfare found that women who reported physical or sexual violence in their histories

were more likely to be living below the federal poverty line (Browne 1997). Women who are victims of repetitive violence are also at increased risk for substance abuse and are significantly more likely to develop drug abuse within two years after partner violence occurred (Weitzman 1992). Finally, victimized women are at risk of severe depression, anxiety disorders, parenting difficulties, suicidal behavior, and inability to work (Bassuk 2007). All of these risk factors triggered by domestic violence can increase the likelihood of family homelessness. Additionally, women who are abused are more likely to suffer from PTSD especially when they have histories childhood sexual molestation (Weitzman 1992). Unfortunately, childhood sexual molestation and sexual abuse are common in the histories of homeless women. Among a sample of homeless and housed women, 42.2 percent of the sample reported having been sexually molested as a child and 20.2 percent of this sample was homeless (Browne 1997). The strong correlation between domestic violence and other risk factors indicates it has a significant negative impact on the lives of homeless families.

F. Disruptive Childhood Experiences

Certain disruptive childhood experiences have been shown to have a strong correlation with family homelessness. Although significant research has yet to be performed investigating these risk factors in depth, women with childhood experiences of foster care, child abuse, and family separation have an increased risk of future homelessness (McChesney 1990; Browne 1997; Bassuk 2007). Serious physical and emotion problems during childhood, such as those caused by childhood molestation and abuse, are strong risk factors for homelessness and one study found that mothers who had been placed in foster-care and other out-of-home situations reported childhood abuse more frequently than housed mothers (McChesney 1990; Zlotnick

1999). In addition, substance abuse by a female caretaker has also been shown to be a risk factor for future homelessness because it can be seriously disruptive to a child (Bassuk 1997).

G. Mother-Child Separation

Separation of children from their parents is more common in homeless families than poor, housed families due to increased involvement of child welfare in the lives of homeless families. In one study, 24 percent of sheltered children had some kind of involvement with child welfare and 18 percent had been placed in out-of-home care (Park 2009). While most children are placed with family members, a significant number are placed into foster-care (Bassuk 2007). In other situations, parents set up arrangements independent of child welfare for their children to live in other homes; one study reported that 61.5 percent of homeless mothers had at least one child living elsewhere, including both foster-care placements and out-of-home placements (such as living with other family members) (Zlotnick 1999). Child welfare involvement has been found to increase when domestic violence has occurred or in cases of recurrent shelter entries and longer shelter stays (Park 2009).

There are several explanations for increased child welfare involvement. Homelessness has strong negative impacts on family stability and can cause family fragmentation that continues to exist after the family regains housing (Park 2009). Living in shelters where there is less privacy and diminished support from family and friends can increase stress in relations between parents and children (Zlotnick 1999; Park 2009). Additionally, homelessness may magnify familial dysfunctions, such as substance abuse, which may necessitate the involvement of child welfare services. Finally, families in shelter are under heightened scrutiny from shelter

staff and service providers which increases the chance that they will be reported to child welfare services (Park 2009).

H. The Health of Homeless Parents and Children

Members of homeless families have worse mental and physical health than members of poor, housed families. Homeless families frequently suffer from medical conditions including asthma, upper respiratory infections, skin infections, gastrointestinal problems, and parasites (Burt 2007). Both children and adults frequently suffer from mental conditions including depression, anxiety, and behavioral problems (Burt 2007). Pregnant women are at especially high risk for health problems since they frequently receive insufficient prenatal care. Their babies are at higher risk of low birth weight and having medical and developmental problems and there is a higher incidence of infant mortality (Bassuk 1993). Children are more likely to be underimmunized or receive their immunizations later than housed children (Molnar 1990). In addition, homeless children have a higher incidence of trauma, acute illness, anemia, and elevated lead levels (due to previously living in dilapidated housing) (Molnar 1990).

Every night, approximately 68,000 children are homeless in the United States. Over the course of a year, 744,000 school-aged children are homeless (Buckner 1999). Homeless children are more likely to suffer from developmental problems compared to housed children and to struggle in school which are attributed to residential instability. Several studies have shown that young children have impaired language skills, social skills, and motor development (Molnar 1990). Among older children, switching schools frequently seriously impedes their education. In one study, 70 percent of homeless children, compared to 32 percent of housed children, had changed schools within one year (Buckner 1999). Homeless children have poorer attendance in

schools and their attendance rates decline faster over time than those for the general student population (Molnar 1990). They have a greater tendency to repeat a grade and have a lower rate of scoring at or above grade level in reading and math compared to all students (Molnar 1990). Special education is more common among homeless children compared to children of the general population (Molnar 1990).

Mental health and behavioral disorders are common among homeless children and worsen the longer a child is homeless (Weinreb 1990). While reports of physical abuse are comparable between homeless and poor, housed children, sexual abuse is more common among homeless children (Buckner 1999). Although homeless and poor housed children have similar rates of depression, behavioral and conduct disorders are twice as common among homeless boys as housed boys (Buckner 1999). Homeless children have a higher rate of co-occurring mental disorders than housed children, though studies have indicated a relationship between poverty and a higher prevalence of mental and developmental disorders in poor children who are either housed or homeless (Buckner 1999).

II. ENVIRONMENTAL CAUSES OF HOMELESSNESS

Family homelessness has existed in American society for several decades. While certain personal characteristics increase a family's risk of homelessness, it would be incorrect to assume that most families become homeless solely because of personal "defects." More significantly, it is an environment of increasing poverty and income disparity along with a massive shortage for low-income housing that has placed hundreds of thousands of families in incredibly precarious positions where at any time, they risk falling into homelessness. Families become homeless

because U.S. society has placed them in a situation in which they cannot afford the housing that is available; at most, family demographics dictate which families are more likely to fall.

Since family homelessness did not exist prior to the 1980s, it is possible to determine what changes occurred in American society to cause the first reappearance of family homelessness since the Great Depression. Following World War II, the United States entered a period of significant economic growth and prosperity. In 1949 Congress passed a national policy for "the realization as soon as feasible of the goal of a decent home and suitable living environment for every American family" (Howenstine 1993). In order to reach this goal, Congress created the Housing and Urban Development Act in 1968 with the goal to produce 26 million housing units in ten years, 6 million of which would be for low and moderate income families (Howenstine 1993). It was believed that if successful, sub-standard housing would be eliminated by 1978 and all American families would have a decent home.

In the end, the plan did not work out as well as Congress hoped. Though there was a significant improvement in the quality of American housing after World War II and despite the fact that the number of housing subsidies to low and moderate income families increased from 3 million in 1977 to 5 million in 1989, family homelessness developed throughout the 1980s and by the 1990s, was well entrenched, quelling hopes that family homelessness would simply "go away" (Howenstine 1993). The following sections will discuss the environmental factors that have created the setting in the U.S. which has propagated family homelessness.

A. The Decline in Affordable Housing

The U.S. economy of the 1980s was marked by a period of rapid inflation and as a result, the cost of housing increased throughout the market (Trimmer 1994). For many families,

purchasing a home became impossible because the initial down payment was unaffordable so low-income families remained in the renting market. However, the rising cost of home purchases began to place an upwards pressure on rents which became increasingly expensive (Trimmer 1994).

While houses and rent became more expensive, there was also a decline in the number of affordable housing units. From 1973 to 1983, 4.5 million privately owned housing units were permanently removed from the market (Howenstine 1993). Specifically, from 1970 to 1989 the number of low-income rental units declined by 14 percent (Trimmer 1994). One of the reasons for the decline was gentrification; areas of low-income housing were purchased by developers and converted into apartments and homes to sell to middle and high income owners, displacing families who had previously resided in those neighborhoods. In addition, several urban renewal projects led to the demolition of homes in poor neighborhoods to be replaced with public buildings such as hospitals, airports, and sports arenas; the promised funding to rebuild the destroyed homes never arrived, further depleting available low-income housing (Trimmer 1994). Simultaneously, slumlords allowed available low-income housing in the inner-city to decline by purposefully failing to maintain rental properties. They abandoned the buildings when they become condemned, at which point the tenants were evicted, and the cities took over the properties (Trimmer 1994).

As the number of affordable housing units declined, government policies exasperated the situation. Public housing construction did not increase in order to make up for the deficit in housing units; instead, federal low-income housing programs declined. During the Reagan Administration, federal funding for subsidized housing construction went from $32.2 billion in 1981 to $6 billion in 1989. The enormous decrease meant that only 20,000 subsidized housing

units were constructed in 1989 compared to 183,000 constructed in 1980 (Trimmer 1994). Government policy also caused public housing to become widely unpopular. By requiring that families be evicted when their income rose above the eligibility requirements, public housing developed a large concentration of the lowest income families and quickly gained a reputation as being located in dangerous neighborhoods where drugs and violence were rampant. Even if this reputation was not true for all public housing projects, support for the public housing program declined (Trimmer 1994).

To make up for the lack of public housing, the Reagan Administration enacted voucher programs intended to provide low-income families with funding that would make private housing more affordable (Howenstine 1993). Vouchers have remained in place as one of the country's main forms of housing subsidization. Voucher holders pay 30 percent of their income towards rent and the rest is paid by the government (Howenstine 1993). In order to qualify, families must live in housing that meets federal quality standards while not exceeding Fair Market Rents. Fair Market Rents are established annually by the Department of Housing and Urban Development (HUD) and are defined as the dollar amount below which fall forty-five per cent of standard quality rental housing units in a local market (Howenstine 1993).

Voucher programs directly reduce the burden of housing for a family and allow a family the freedom to choose their own home. Families have the opportunity to move to better neighborhoods and many feel more ownership for the home they receive with a voucher (Howenstine 1993). Despite these benefits, the program has serious faults. The voucher program does nothing to increase the supply of low-cost housing, improve the condition of preexisting housing, or reduce inflating housing costs (Howenstine 1993). A second problem with the program is that it draws high administrative costs because families have to be individually

evaluated to determine whether they are eligible for the program (Howenstine 1993). Finally, the vouchers do not help all the people in need; families with incomes too high to qualify yet two low to be stably housed remain unaided. Even families with vouchers may struggle to find housing at fair market rent in a condition that meets federal standards (Howenstine 1993). Two-thirds of poor renters received no subsidies during the Reagan administration and remained vulnerable to homelessness due to increasing housing costs (Koegel 1996).

B. Increasing Poverty

As housing costs rose throughout the 1970s and 80s, the population of the poor grew from 25.4 million in 1970 to 31.9 million in 1988. The mean income of the poorest 20% of families dropped by 34% and the next poorest fifth dropped by 20% between 1973 and 1984 (McChesnesy 1992). When looking at poverty statistics, it is important to remember that during its creation, the poverty line was originally defined as three times the amount necessary to purchase the lowest-cost, nutritionally adequate diet for a family of appropriate size, a definition that is still used today. Although the poverty threshold has been adjusted for inflation, it has not altered to account for changing expenses faced by families such as medical costs, transportation, and clothing. As a result, the poverty line does not adequately represent all the families that are struggling to make ends meet (Trimmer 1994).

There are several reasons for the rise in poverty. The U.S. economy has been in a period of deindustrialization throughout the past several decades. Available "unskilled" labor jobs have been shifting from high-paying, unionized manufacturing jobs to lower-paying, temporary service jobs. The economy has become more centered on "higher-services" such as finance, insurance, and medicine and less on the production of goods (Trimmer 1994). Manufacturing

jobs are decreasing due to technological breakthroughs that reduce the need for laborers and many manufacturing companies are moving overseas where the cost of labor is cheaper, further depleting jobs available in the U.S. (Trimmer 1994). In addition, the increasing population has meant that more people are willing to work for lower pay, part-time, and without benefits in order to compete in the job market (Trimmer 1994).

While the availability of well-paid unskilled labor jobs is decreasing, changes in societal structure have increased the financial burden placed on families. Since the 1960s, divorce has become much more common in American families and women who raise their children alone find themselves especially hard hit by financial constraints (Trimmer 1994). With high child care costs that have been increasing over the past 30 years and only one breadwinner, single-parents have more difficultly remaining stably housed (Bassuk 2006). In addition, employment and pay discrimination continue to plague minorities who remain marginalized and struggle more than whites.

Changes in government policies have placed struggling families at even higher risk for homelessness by reducing the availability of welfare programs. In 1981, half a million families lost federal assistance payments and one million lost food stamps; federal budget cuts caused more than one-half million people to fall below the federal poverty line (Morse 1992). In addition, eligibility for SSI (Supplemental Security Income) and SSDI (Social Security Disability Insurance) became more stringent and almost half a million disabled individuals were removed from receiving welfare (Hopper 1996).As will be discussed in more depth in the following portions of this paper, the reduction in social supports severely impacted poor families by tightening eligibility requirements for welfare programs.

C. The Result

The combination of decreasing availability of low-cost housing and increasing poverty within the United States, not surprisingly, has left many families struggling for housing stability. In 1989, 3.78 million unsubsidized households had incomes 25 percent below the area mean but did not receive housing assistance; of this population 70 percent paid over half of their income towards rent and utilities and 22 percent were living in substandard housing (Trimmer 1994). Since, according to HUD, housing should not consume more than 30 percent of a family's income to ensure stability, for many families, having stable housing became near-impossible. In an effort to remain housed, many families were forced to double-up. Nearly 3 million households were doubled up in 1987, demonstrating that a vast number of families were strongly impacted by the negative effects of the housing and income environment (Trimmer 1994).

Problems were aggravated for the poorest people in the population and since minorities make up the majority of the poor, they were disproportionately impacted. Minority houses were, and still are, more likely to live in overcrowded dwellings and substandard housing. In 1989, African-Americans and Latinos combined occupied 18 percent of households in the U.S. but 37 percent of these homes were deficient units with problems including rat infestations and holes in the ceiling and floor (Trimmer 1994). Minorities were also more likely to be denied housing because of discrimination and as a result, a greater percentage remained in poor neighborhoods and in substandard housing (Trimmer 1994).

III. CURRENT STATISTICS

The economic crash at the end of 2008 has had a large impact on housing and poverty trends. Though changes in housing policy in the 1980s and 90s help perpetuate a diminished

low-income housing market, recent home foreclosures and bankruptcies have increased vacancies throughout the U.S. However, the increasing availability of homes has not ameliorated family homelessness. Homes that are vacant, despite being at reduced rates, are still not affordable for many Americans as a plummeting job market has increased poverty. As the number of families struggling to make ends meet rises, there has been an increase in competition for affordable housing.

A. The Housing Market

A report was released by U.S. Census Bureau in July 2007 studied housing affordability in the United States from 2002. At that time, only 56% of families could afford to purchase a modestly priced home in their state (Savage 2007). Not surprisingly, housing was less affordable for minorities. One out of five White married renters could afford to buy a home, but only one in twenty Black couples could afford to do so (Savage 2007). Interestingly, the report concluded that in order to increase housing affordability, interest rates and required down payments should be lowered for home buyers, two situations that, ironically, contributed to the crash of the housing market and the economy in 2008.

In 2001, mortgage interest rates were the lowest they had been in forty years. Simultaneously, housing was competitive, causing an increase in house and property value (Joint Center, 2009). Through 2004 to 2006, buyers continued to acquire homes despite their increasing costs due to relaxed down payment and debt-to-income requirements from lenders (Joint Center, 2009). People were able to afford previously unaffordable housing so long as homes could be refinanced or sold to get out of debt. However, when housing prices began to decline in 2007 and 2008, home-owners no longer had their homes as security. Loans entered foreclosure and

investors took money out of the mortgages and securities they had backed. The crashing housing market forced financial institutions to make large write-offs on mortgages, leading to a banking crisis. In response, consumers lost their confidence in the stock market which plunged forty-one percent and the economy fell into a severe recession (Joint Center, 2009).

Clearly, the recession has had a large impact on the housing market. As families can no longer afford their homes, a large number of foreclosures have occurred. Foreclosures have been higher in minority neighborhoods and highest in low-income minority neighborhoods; the result is that the poorest people are those who are losing their homes the most rapidly (Joint Center, 2009). Foreclosed properties have been sold at huge discounts causing a decline in housing prices which further degrades the market. In addition, the demand for housing is incredibly low with the number of vacant lots for rent or sale at record highs (Joint Center, 2009).

Though more homes are available at decreased value, they are still not affordable for many families (Joint Center, 2009). The downturned economy has caused families who currently live in subsidized or low-income housing to not have the necessary financial improvement to move, resulting in two-year long waitlists for subsidized housing. With affordable housing still scarce and in a failing job market, families are struggling to afford their homes. Families who spend more than half their incomes on housing jumped by 30 percent in 2007 to 17.9 million (Joint Center, 2009). The burden is greatest for the poor where 51 per cent of low-income renters and 43 per cent of low-income owners spent over half their income on housing in 2007. (Joint Center, 2009)

The incidence of poor quality housing declined between 2001 and 2007. However in 2007, 10 percent of bottom income quartile still lived in substandard housing and nearly half of the population paid over fifty per cent of their income towards housing (Joint Center, 2009).

Between 2001 and 2007 the incidence of doubled-up housing had also declined so that by 2007, only 2.3 percent of homes were defined as "crowded." (Joint Center, 2009) However, job loss and foreclosures may force many more families to live doubled-up.

B. Poverty, Unemployment, and Housing Affordability

The economic crisis has led to a rapid rise in poverty. Reports from the U.S. Census Bureau indicate that in 2008, 39,829,000 people in the U.S. (13.2 percent of the population) were living in poverty, a 0.7 percent increase from 2007 (Income, Poverty, and Health Insurance, Table 4). Of the population in poverty, 28,564,000 people were in families and only 8,147,000 individuals were householders (Income, Poverty, and Health Insurance, Table 4). As always, a disproportionate burden was carried by minorities; from the population identified above, 9,379,000 (24.7 percent) identified as Black and 10,987,000 (23.2 percent) identified as Hispanic. One of the rapidly growing demographics within the population in poverty has been children. In 2008, 14,068,000 (19.0 percent) people below the poverty line were under eighteen years old, a one percent increase from 2007. Single-women remain a significant demographic living in poverty; while 4,163,000 people below the poverty line are single-women heads of household, within the total population of these women, 28.7 percent are below the poverty line (Income, Poverty, and Health Insurance, Table 4).

The economic crisis has caused a large decrease in assets for families and individuals alike due to decreased income and increasing unemployment. By October of 2009, unemployment was up to 15.7 million people, 10.2 percent of the potentially employable U.S. population. Mirroring poverty statistics, unemployment rates are higher for minorities with 15.7 percent of Blacks and 13.1 percent of Hispanics unemployed. For women, 8.1 percent were

unemployed (Bureau of Labor Statistics, 2009). Though wages had been increasing for several years, in 2007 they decreased due to the recession; the decline was especially high for low-wage jobs. Working full-time at a minimum-wage job for 52 weeks of the year in 2007 earned a person $13,624, placing him or her 25 percent below the federal poverty line of $18,310. Having sustainable housing under such an income is near-impossible. In order to pay 30 percent of one's income for a two-bedroom rental apartment at fair market rent in a median state, a minimum-wage worker would have to work 87 hours each week. As a result, without subsidization, most housing remains unaffordable for minimum-wage workers (National Alliance, "Family Homelessness" 2007).

Increasing poverty has caused housing to be an even greater burden for people than it was in previous years. In 2007, it was estimated that 15.8 million households in the U.S. were spending fifty per cent or more of their income on housing (National Alliance, "Affordable Housing Shortage" 2007). The majority of this burden was carried by low-income households with 74 percent of households who were classified as having a housing cost burden also qualify as extremely low-income (National Alliance, "Affordable Housing Shortage" 2007). The estimated number of people in poverty in the U.S. overall increased by 1.1 million to 39.1 million in 2008 (Bishaw 2009).

The increasing poverty rates and burden of housing costs have led to an increased need for low-cost housing within the U.S. However, as discussed above, housing continues to be unaffordable for many American families, a situation exacerbated by continuing declines of subsidized housing. Between 1999 and 2006, the funding for public housing declined by 25 percent and over the past decade, hundreds of thousands of both public and private subsidized homes have been lost to deterioration (National Alliance, "Affordable Housing Shortage" 2007).

Housing voucher programs have not been enough to compensate for the lack of housing. In 2007, 15.8 million households were eligible for tenant based housing subsidies but only nine million received them. In addition, The Housing Choice Voucher Program (also called Section 8) lost over 150,000 subsidies between 2004 and 2007 due to policy changes and low funding. Wait lists for subsidized housing remain years long (National Alliance, "Affordable Housing Shortage" 2007).

C. Statistics for Boston

The most recently reported U.S Census Bureau unemployment rate for Boston was developed from economic characteristics collected between 2005 and 2007. It shows that 5.4 percent of the population over sixteen years old was unemployed at the time. Approximately 30.7 percent of households and 25.4 percent of families had an income of less than 25,000 dollars a year; of these families, 16.7 percent reported having an income below the federal poverty level in the past twelve months, 19.3 percent had children under five years old, and 33.7 percent of families were headed by a single mother. (Income Characteristics, American Housing Survey 2007)

Within Massachusetts, similar to the U.S. as a whole, many people struggle to find affordable housing. Results from the American Housing Survey conducted in 2007 indicate that within Boston, 2,197,000 people spent fifty per cent or more on rent. Of this population, 222,000 thousand (10.1 percent) identified as Black, and 20.1 thousand (9.1 percent) as Hispanic, and 74.9 thousand (34.1 percent) are below the federal poverty line. The same survey indicated that 20.8 percent of households were spending over fifty per cent of their income on rent. This is the most recent housing survey to-date for the Boston area. The economic crash of 2008 has likely

worsened the situation. With higher unemployment rates and more people being obliged to work part-time, it is very likely that more households are putting a higher percentage of their income towards their housing than reported in 2007 (American Housing Survey 2007).

Middlesex County, in which Somerville is located, has a population of approximately 1,482,478 according to the 2008 1-Year Estimates of the American Community Survey. Of this population, 1,426,111 people, or 96.2 percent of the population was identified in a household leaving 4 percent in unidentified housing. The unemployment rate for people sixteen years and older is around 3.3 percent and of the 566,249 families in the city, 5.4 percent are living in poverty. Poverty is more significant for families headed by single-women; these families constitute 9.4 percent of the population of families, but 19.6 percent of female-headed households are in poverty and 42.3 percent of female householder families with children under 5 years are in poverty (American Community Survey 1-Year Estimates 2008).

IV. THE HISTORY OF SOCIAL SECURITY, WELFARE AND THE HOMELESS SUPPORT SYSTEM

The majority of the supportive services relied on by the poor in the U.S. come from government programs. Families and individuals deemed deserving of services can participated in welfare programs that include income supplements for housing, food, and basic living expenses. However, the supportive service system provided by the federal and state governments falls far short of helping all who are in need and qualify for its services; in addition, many of the services do not provide enough aid to those who are receiving them. In recent years, the social security and welfare systems have been sharply reformed, creating more stringent eligibility requirements and diminishing aid which have had a large impact on homeless and at-risk families.

When studying the welfare system of the United States, terminology can become very confusing because of discrepancies between common use of certain jargon and its original meaning. The term "welfare" is now considered synonymous with the supportive service of cash benefits to poor single mothers and their children (Nadasen 2009). Yet welfare, which comes from the Middle English phrase *wel faren* "to fare well," means, by definition, aid provided to any individuals in need, generally in the form of money or necessities. Many other government assistance programs can also be qualified as welfare including Supplemental Security Income, Aid to the Disabled, Medicare and Medicaid, unemployment insurance, public housing, veteran's benefits, and food stamps (Nadasen 2009). Within this text, "welfare" will refer to general supportive services and aid provided by government structures and additional specificity will identify which program is being discussed when necessary.

A. The Original Formation of Social Security

The history of welfare in the United States traces back to early "poor laws" that provided relief to the "deserving" poor who were in poverty through no fault of their own, such as having a disability. Able-bodied poor were generally considered to be responsible for their own poverty by not participating in the labor market and did not qualify for charity. The same basic mentality exists today and continues to structure welfare programs and policy. The beginning of an organized, federal, welfare system within the United States was the passage of the Social Security Act in 1935 under President Roosevelt. The president and the Committee on Economic Security designed what Roosevelt called in his message to Congress an "American Program" that would provide, "the security of the men, women, and children of the Nation against certain hazards and vicissitudes of life" (Roosevelt 2003).

Though the Social Security Act caused a huge change in public policy for supportive services within the U.S., it was a long time in coming. Other western nations in Europe had already adopted unemployment compensation laws almost a decade before the U.S (Berkowitz 1997). Conditions in 1935 finally pushed for the development of Social Security. The growth of an industrial economy provided the economic surplus that allowed workers to be taxed so money could be set aside for social programs (Berkowitz 1997). In addition, industrialization, in a sense, created unemployment. Previously in an agrarian society, people were never, technically "unemployed" because there was always work to be done on their farms. However in an industrial economy, work could be terminated following the needs of the employer based on conditions over which a laborer had little control (Berkowitz 1997). The Social Security Act was, in part, a response to the new presence of unemployment within the U.S. Finally, the recent Depression had convinced the public that supportive services could no longer depend solely on the private sector and local governments (Berkowitz 1997). Policy makers could not ignore the demand for social services, allowing for the passage of Social Security Act.

In forming the Social Security Act, Roosevelt and his advisors were attempting to create permanent supportive programs and end relief programs organized under the Federal Emergency Relief Administration created due to the recession (Leighninger 2009). Roosevelt wanted to form social insurance programs that followed the models used in Europe (Leighninger 2009). The key structural component of the Social Security Act was that the service programs would be paid out of workers' paychecks and employer contributions through taxation (Leighninger 2009). Workers contributed to social security throughout their years of employment, making them worthy of old age insurance when they retired or unemployment assistance when they fell on

hard times. Through this structure, the system followed American values of hard-work and self-help, making it more appealing to policy-makers (Leighninger 2009).

The product of the Social Security Act was several service programs that targeted specific populations. Two programs which were especially important to Roosevelt were Unemployment Insurance and Old Age Assistance. In addition, the act passed federal assistance programs to provide aid to two groups: poor children, under the Aid to Dependent Children (ADC) program, and the blind, through Assistance to the Blind (Leighninger 2009). All assistance programs were organized through joint collaboration between the state and federal governments (Leighninger 2009). States accepted for participation in the programs would set their own eligibility standards and impose requirements to identify "worthy" participants. They would receive matching funds from the federal government for the expenses incurred in the program (Leighninger 2009). Under this policy, a system began that screened applicants based on their moral character and personal histories as qualification for supportive services.

Originally assistance programs had several important limitations. Self-employed individuals including agricultural and domestic workers were excluded from Unemployment and Old Age Insurance because their incomes were not taxed. In addition, temporary, part-time, and seasonal workers did not qualify for social insurance programs (Nadasen 2009). Since many of part-time workers were minorities and women, these populations were those who were most frequently excluded; 55 percent of African American workers (87 percent black women) and 80 percent of all women workers remained without coverage (Nadasen 2009). Over the years after its creation, social insurance would continuously be expanded and reformed many times to increase coverage and benefits.

B. Aid to Families with Dependent Children

Easily one of the most controversial programs that formed under the Social Security Act was Aid to Dependent Children (ADC). ADC would be reformed in future years and its name would change along with its structure. ADC was and continues to be the primary source of public assistance for poor families, especially poor single mothers. Since the modern version of ADC remains one of the most important forms of aid for homeless families, it is worth studying ADC and its controversy in greater detail.

Poor, single mothers first began drawing attention in the early 20th century. Due to increased urbanization, the poor and the middle-class were living in closer proximity and middle-class women began promoting the need to improve the lives of low-income single mothers (Nadasen 2009). Following a maternalistic perspective, the prevalent view at the time was that children needed to be reared affectionately by their mothers so reformers argued for mothers' pensions that would allow poor mothers to stay at home and raise their children, instead of work (Mink 2003; Nadasen 2009). Rather than try to increase women worker's wages, influential women's organizations which were dominated by the middle-class, pushed for mother's aid to remove women from the workplace (Nadasen 2009). Early mothers' aid programs were under the same scrutiny to promote moral character as previous, locally run welfare programs had been. Programs required single women to agree to not have sexual relations out of marriage and practice frugal spending. As a result, the recipients of mothers' pensions were generally limited to white widows (Nadasen 2009).

When the Social Security Act was formed in 1935, ADC was modeled following the same maternalistic philosophies that had been prominent in the past with the goal to sustain poor mothers so they did not have to work. Since ADC was the only program available to most

women workers, many of whom were temporary workers or self-employed, it became the program that was relied upon by those excluded from social insurance (Mink 2003). However, it did not receive as much support and attention as other social insurance programs and as a consequence, suffered from unequal funding. Rather than fully fund ADC, the federal government provided reimbursements to states for a portion of their spending. ADC benefits and eligibility criteria varied from state to state and many excluded minorities and persons they deemed were of poor character, including unwed mothers (Mink 2003).

Despite the barriers, benefits were expanded as federal funding increased (Nadasen 2009). In 1939, the demographic of ADC recipients began to change. The Old Age and Survivors Insurance (OASI) program had been passed, providing money for widows which pushed the ADC program to service single, divorced, or deserted mothers (Nadasen 2009). As ADC developed a reputation as the welfare program for the poor, the program itself became synonymous with the terms "welfare" and "public assistance" which would impact public opinion of all social welfare programs and influence future reforms.

C. Early Social Security and ADC Reforms and Amendments

After its implementation, Social Security engendered a lot of controversy along with appeals for its expansion. For several years, state public assistance programs continued to provide pensions to citizens who were poor and old, determining who qualified for these programs using the old system based on personal character (Berkowitz 1997). For some time, state programs reached more people and provided better benefits than the federal program, causing many to doubt the need for Social Security; this changed in 1950 when Congress finally

agreed to raise taxes 3 percent allowing benefits to increase 77 percent and coverage to expand to include self-employed people (Berkowitz 1997).

Social Security benefits increased steadily for several years as the amount of money being collected was higher than that being spent. In 1956, disability insurance (SSDI) was created despite the concerns that disabilities were hard to define, making it difficult to determine eligibility (Berkowitz 1997). Additional reforms in 1965 allowed for the creation of Medicare and Medicaid; Medicaid was especially influential since it was designed as the health insurance for welfare participants (Berkowitz 1997).

Throughout the period of reforms, changes were made to ADC alone which had significant effects on the program. For years, states continued dictating eligibility requirements and refused to increase benefits to compensate for inflation, making it harder for families to subsist on ADC funds. One policy allowed states to deny benefits to families if their home and was considered inappropriate for child-rearing was used to deny benefits to certain groups of people, especially minorities (Nadasen 2009). The result was that unwed women were still excluded from ADC, the majority of which were African American (Reese 2005; Nadasen 2009). In the 1950s Congress passed a "caretaker" provision to expand ADC so it covered mothers and not only their children. In addition, the previously mentioned reforms that expanded Social Security also increased benefits for the ADC program by raising federal matching funds (Nadasen 2009). ADC was constantly opposed by welfare critics who argued that the program was promoting family breakdown and personal deviance since it supported single, unmarried women. In addition, racists viewed welfare with disgust because it helped African Americans who they believed were not deserving of such support (Nadasen 2009).

In the 1960s, the Civil Rights Movement helped ignite the Welfare Movement which brought attention to poverty within the United States and triggered a variety of amendments to the ADC legislation. In 1962, welfare amendments specifically for ADC required states to provide rehabilitation services in order to encourage families on welfare to become more self-sufficient and less reliant on the government (Nadasen 2009). ADC was changed to Aid to Families with Dependent Children (AFDC) emphasizing the program's goal to improve the families as a whole; along with this reform, ADC began accepting employable men (Nadasen 2009). Contrary to previous policy that aimed at keeping women in the home to raise their children, women were now being encouraged to improve their economic stability and become employed (Nadasen 2009).

In 1967 in response to increasing enrolment, Congress made work mandatory for the recipients of welfare for the first time (Nadasen 2009). In addition, due to conservative criticism of the sexual histories of welfare recipients, Congress declared that states would "freeze" benefits to unwed mothers including those deserted by their husbands (Nadasen 2009). Welfare activists argued against the provision promoting the new view that welfare recipients had the freedom to be in relationships of their choosing and that welfare families were not dysfunctional but instead lacked economic resources (Nadasen 2009). The views promoted by activists would provide a new perspective to the welfare debate.

D. Later Reforms and the Rise of Conservatism

In the 1970s, politics began to grow more conservative and the liberal trend that had characterized the expansion of welfare in previous years was halted. Conservative academics promoted the ideas that liberal government programs encouraged dependency on welfare.

Conservative think tanks, funded by business leaders, promoted conservative politics and philosophies (Reisch 2009). In addition, a changing economy helped conservative ideas gain popularity. The economic prosperity of the 1960s had ended and the U.S. found itself in competition with many new markets due to globalization. As businesses moved manufacturing abroad, unionized manufacturing jobs were lost and wages began to decline as poverty increased (Nadasen 2009). Conservatives blamed the declining economy on welfare, arguing that high tax rates and funding were the reasons for the economic recession, even though welfare only accounted for 1 percent of government spending (Nadasen 2009). They seemed to have not considered the Vietnam War (which spanned from 1959-1975) as a possible cause for economic decline during the decade. Businesses looking for lower taxes and labor costs supported conservative politics and Democrats began promoting "balanced-budget conservative" of less federal spending and lower taxes (Reese 2005).

Along with economic policies, the Republican party began championing conservative social practices as well. Buying into previous societal distrust and dislike for welfare recipients, conservative politicians and scholars promoted ideas that welfare dependents had poor moralities, avoided marriage and work, and allowed welfare to support their "lazy" lifestyles. Using the arguments that had been made for decades, they declared that welfare was encouraging poor behavior, increasing promiscuity, and ruining society.

In 1972 under the Nixon administration, Social Security was changed and benefits were indexed to inflation and not a declared rate of increase (Reisch 2009). However in the 70s, inflation caused the cost of living to increase beyond wages and it became more difficult for Social Security to provide people with benefits on which they could sustain themselves (Berkowitz 1997). Nixon's administration tried to impose a 10 percent cap on federally provided

funds that states could spend on welfare. The goal, following American ideals of self-reliance, was to reduce dependency on welfare programs by decreasing benefits. However the increased rate of inflation caused an increase in spending and the cap did not give states large enough budgets to provide services or create comprehensive services to aid independence from welfare (Reisch 2009). Though Congress increased taxation on wages, the economy continued to worsen and Social Security became more expensive. Throughout the Nixon, Ford, and Carter administrations, the government did not successfully aid the growing number of low-income families (Reisch 2009).

When Reagan was elected to office, he made welfare reform one of the top issues for his domestic policy, relying on preexisting, derogatory stereotypes of welfare recipients to promote his ideas for cutting back welfare (Nadasen 2009). In 1981, the Omnibus Budget Reconciliation Act (OBRA) was passed which led to drastic decreases in funding for AFDC, Food Stamps, Medicaid, disability insurance, unemployment insurance, legal services, and low-income energy assistance (Nadasen 2009). As a result of OBRA, 408,000 families lost their welfare and 299,000 had their benefits reduced (Stoesz 2009). In 1983, amendments to the Social Security Acts increased the qualification age for benefits, started a six-month delay in benefit increases, and augmented federal withholding tax (Stoesz 2009). Finally in 1988, the Family Support Act mandated that mothers, except those exempt due to personal conditions, were required to find work, or participate in job training or educational opportunities. Participants who refused to find work would lose their benefits (Stoesz 2009).

The election of a democrat, Bill Clinton, to presidential office did not end the cuts in welfare. Though liberal-minded in pro-choice and affirmative action policies, Clinton pursued conservative economics and in 1996, passed the Personal Responsibility and Work Opportunity

Reconciliation Act (PRWORA) (Stoesz 2009). Under PRWORA, AFDC was terminated and replaced with Temporary Aid for Needy Families (TANF) (Stoesz 2009). TANF was organized under block grants rather than matching funds that would be provided to states to enforce finite funding. States continued to dictate how the grants were distributed and who was eligible for aid. Most significantly, TANF placed a 5-year limit on the receipt of welfare and states were allowed to place a shorter time limit if they wished (Stoesz 2009). In addition, immigrants were excluded from receiving TANF, Food Stamps, and other benefits until they had been legal residents for more than five years (Nadasen 2009).

Supporters for PRWORA believed that it discouraged single-motherhood, promoting better ideals for society (Nadasen 2009). In addition, the tax cuts and reduced welfare spending made it appealing for many conservatives who were happy to see a drastic decline in the number of families receiving welfare. In 1996, 4.5 million families were enrolled but by 2002, only 2.1 million were (Nadasen 2009). Many former recipients of welfare took up low-wage jobs, few of which provided benefits. Rather than pushing low-income families towards self-improvement as intended, PRWORA forced the poor into deeper poverty and economic instability. In addition, PRWORA was passed at a time of increasing disparity between rich and poor and in effect, limited welfare for the people who needed it most (Nadasen 2009).

E. The Impact of Welfare Reforms on Families

The welfare reforms of the 1980s and 1990s had strong impacts on low-income families throughout the United States. As desired, reforms led to a substantial drop in the number of welfare recipients throughout the U.S. and TAFDC became a much more selective program, helping poorer families with worse health and lower marriage rates (Frogner 2009). TANF led to

an increase in marriage and cohabitation for families who had left the welfare programs, though protests were made that mothers had been forced back into unsafe relationships as a result (Frogner 2009). Some families who managed to remain within the program experienced increased income though this was primarily due to increased SSI and SSDI benefits. While TANF applications were declining, SSI participation increased from 13 percent in 1999 to 16 percent in 2005 (Frogner 2009).

Many families who lost their benefits were not so lucky. The poorest 20 percent of families had their incomes decline an average of $577 a year due to lost benefits (Schorr 2001). While employment did increase, income from employment was not enough to offset the decline in income from lost benefits including health care and Food Stamps (Frogner 2009). Employment that provided sufficient income let alone benefits was difficult to find since many former welfare recipients had limited work-histories and education (Schorr 2001). Childhood poverty was not alleviated and rates remained between 17 and 18 percent, the highest in the industrialized world (Nadasen 2009). Families remained dependent on other forms of assistance including nonprofit supportive service organizations.

The result of multiple welfare reforms is the current system that provides very little public assistance to poor families including those who are homeless. The homeless service system has adapted with changing public policies to become more centered on the private sector. Understanding the history of welfare helps explain the structure of supportive services currently available to homeless families.

V. HISTORY OF THE HOMELESS "SYSTEM"

A. Homelessness before the 20th Century

For over 200 years, the homeless "system" was simply part of the charitable help that was available for the general poor (Leginski 2007). Homelessness has always existed in the United States and the methods which provide support have evolved throughout the past centuries. In the 16th century, the poor received help from churches and individuals if their own families could not help them (Hopper 1996). In the early 17th century, shelters began forming, organized by churches that not only took responsibilities for the "vagrants" of the street but also provided health care and organized care for orphaned children (Hopper 1996).

In the 19th century the rise of industrialization caused economic expansion that depended on laborers so families and individuals began migrating to cities, and found work in industry, agriculture, service work, and prostitution (Hopper 1996). Though not all of these people were homeless, many lacked stable housing and would move through various one-room apartments, relying upon local charitable organizations (Hopper 1996). Those who did not have any shelter stayed at police stations that had a room set aside for transients to spend the night (Hopper 1996). The first shelters began being constructed at the end of the 19th century but had limited success since many residents were resentful of the managers who tried to enforce "improvement" programs on them (Hopper 1996).

B. Homeless Systems of the 20th Century

In the 1920s, many of the homeless were concentrated in degraded parts of cities frequently referred to as "skid rows." Skid rows contained cheap apartments and one-room hotels and most residents were single men looked down upon for failing to meet the norm of supporting

a family (Hopper 1996). They found temporary work and day jobs and their lives remained separated from most of society. As a result, homelessness and deep poverty remained segregated and easily ignored (Hopper 1996). Though people knew of the presence of skid-rows, homelessness was not considered a societal problem due to the prevalent view that the poor were that way because of personal defects. Stigmatized as drunks and the insane, little was done to help them (Hopper 1996).

In the late 1970s and 1980s, homelessness became impossible to ignore. The destruction of skid rows and one-room occupancy hotels meant that for the first time, the homeless were no longer invisible as they migrated into the more prosperous parts of cities and towns. In addition, economic changes increased the number of homeless and the population began including families. Though people continued using old stereotypes of the homeless as irresponsible substance abusers, others began demanding that the government act to ameliorate the situation (Leginski 2007).

In 1978 began the first demonstrations that finally brought public awareness to homelessness (Hopper 1996). In the early 1980s, coalitions to fight homelessness began organizing including the Coalition for the Homeless which would become the National Coalition of the Homeless two years later (Hopper 1996). Similar organizations formed in major cities throughout the U.S. to organize efforts for legislation and education on the plight of the poor and homeless (Hopper 1996). Other advocacy groups that formed during these years and continue to be very influential today were The National Low-Income Housing Coalition and the National Alliance to End Homelessness.

In 1986, the National Coalition for the Homeless along with ten other groups drafted a bill which would lead to the first legislation in fifty years to address homelessness. The bill, the

"Homeless Persons' Survival Act" provided a guide for federal action to end homelessness. Congress only approved a version of Title I of the Act which consisted of the emergency relief provisions. The legislation that passed was called the "Stewart B. McKinney Homeless Assistance Act" and was signed into law by Reagan (Hopper 1996). It authorized the formation of national program to provide emergency services; the result was funding limited to temporary shelters, food programs, and limited health care (Hopper 1996; Leginski 2007). The implemented services did nothing to ameliorate the root causes of homelessness such as limited low-income housing and poverty. The McKinney Act received several new provisions in 1990 to provide funding for the schooling of homeless children and programs to aid homeless persons with severe mental illness and disabilities (Hopper 1996).

In 2000, the National Alliance to End Homelessness published a proposal to end homelessness by 2010. The goal reignited the debate about homelessness policy but policy makers did not endorse tackling the entire homeless population. Instead, the secretary of HUD announced a goal to end chronic homelessness which was endorsed by President Bush (Leginski 2007). The term "chronic homeless" was developed at a time when research results had increased awareness that the homeless population was far from homogeneous and that groups within the population had different behaviors and needs (Leginski 2007). The chronic homeless are comprised of people who have multiple bouts of homelessness over several years. Many have histories of substance abuse and mental instability which place them at higher risk for homelessness. They may remain homeless for years and though they comprise between 5-15 percent of the homeless population, they use 50 percent of monetary resources through homeless shelters, hospital emergency rooms, and psychiatric facilities, amounting to between $30,000 and $50,000 per person per year (Culhane 2007). The chronic homeless population is relatively small

so ending chronic homelessness appeared a feasible goal that would free up resources that could be spent on others. As a result, much of present day federal policy is targeted towards the chronically homeless with one third of community programs focused on this population (Leginski 2007). Though targeting can be effective if well designed and implemented, it also results in other populations, including homeless families and children, receiving less attention and fewer resources (Leginski 2007).

Homeless policy has had a history of simply being responsive rather than preemptive. From the Colonial Era in which homeless persons relied on charity from private organizations to the present-day when federal funding is still channeled towards emergency services, little has been done to ameliorate environmental risk factors of homelessness. While the societal causes of homelessness have been thoroughly studied and are well-understood, few homeless programs target the true sources of homelessness. Instead, most existing programs help the currently-homeless, providing them with services, such as shelter, that are very expensive to maintain. Little is done for the people at imminent risk of homelessness even though homelessness prevention is a significantly more cost-effective solution. During the current recession, service provider organizations do not have the funding to aid the increasing number of homeless individuals and families. Programs that simply provide services are not sustainable when so many people are in need.

The following section will examine existing governmental and non-governmental programs that provide services for the homeless population. By studying the funding and organization of these programs as well as the services they provide and the populations they aid, the resources that are available to aid the growing population of homeless families may be better understood.

VI. SUPPORTIVE PROGRAMS

A. Government Welfare Programs

Most poor families in the U.S. rely on state and federal governments to provide the majority of the aid they receive. Families approach their local Department of Transitional Assistance (DTA) to apply for Social Security, TAFDC (previously TANF), Food Stamps, and other welfare programs. While the DTA oversees the majority of welfare programs, the Department of Housing and Community Development (DHCD) administers and places families in shelter. Most programs offered at the DTA are nation-wide though they are administered by state governments that determine eligibility. Programs require written applications, interviews that can be several hours long, proof of U.S. citizenship, and proof of income and assets. When applying for shelter, an individual or family must have proof of homeless status; they are directed to a DHCD worker who places them in whatever appropriate location may be available. For all welfare programs, applicants are assigned a case-manager who not only determines their initial eligibility for welfare but maintains their records and cases. The following are some of the most commonly used programs by homeless and at-risk families, followed by a description of the program and its eligibility requirements:

SNAP (Supplemental Nutrition Assistance Program, formerly known as Food Stamps): SNAP allows eligible participants to purchase food items using an Electronic Benefit Transfer card (EBT) which works similar to an ATM card. Only food items may be purchased with SNAP benefits. Participants are low-income individuals, families, the elderly, the unemployed, and the disabled. Proof of legal residency is required; without a

green card or Legal Permanent Resident status, a person is not eligible for SNAPs. However, immigrant parents can apply for SNAPs for their U.S. born children. Eligibility is based on income and assets with certain accepted deductions including child care and medical expenses. SNAP is a federally funded program and administered by local DTAs throughout each state.

TAFDC (Transitional Aid to Families with Dependent Children): TAFDC is a cash grant program that gives families cash benefits based on their incomes and assets. To be eligible for TAFDC, a parent must have children under the age of 18 or 19 who are full time students. Parents are required to work, participate in job-training, or be in school unless they have children under the age of two. For parents with older children, their required hours of work depend on the age of their children. Parents have a right to child care so long as they are working. Within Massachusetts, families eligible for TAFDC are automatically enrolled in MassHealth insurance. The federal governments provide the states with grants for TAFDC benefits which each state can distribute as it wishes.

SSI (Supplemental Security Income): SSI is a federal government program available for children and adults who have a disability that is expected to last over twelve months and that significantly limits function. It is expected that applicants have little or no income. In order to be eligible, participants must be legal residents of the U.S. and be under the income and asset limits. Applicants who do not have a good work history can still qualify for SSI.

SSDI (Social Security Disability Insurance): SSDI is a form of disability insurance for workers and their families who have qualified for Social Security. The worker must have been employed with a good work history for some time before becoming disabled. During the time of employment, he or she paid into his or her disability insurance program through the Social Security Administration which later provides benefits to disabled workers and their families. Due to their work history and disability insurance, individuals have the potential to make more money under SSDI than SSI. Since it is run through Social Security, SSDI is a federal program. The definitions for disability are the same for SSDI as SSI and it is expected the worker has no income or assets.

WIC (Women, Infants, and Children) Nutrition Program: WIC is a supplemental nutrition program for low-income pregnant and postpartum women and their children up to five years of age. WIC is funded by federal grants to states who set eligibility standards and benefit limits. WIC provides food packages which contain proteins, fruits and vegetables, and grains to eligible families; WIC encourages breastfeeding, by providing food packages with a limited amount of infant formula.

EAEDC (Emergency Aid to the Elderly, Disabled, and Children): EAEDC is a Massachusetts disability benefits program that is run through the DTA. It provides benefits to disabled adults and the elderly who are not receiving SSI or SSDI and children and their families who are not receiving TAFDC; many recipients are waiting for approval for federal welfare programs. Families and individuals have to meet low-income and asset limits and be U.S. citizens or eligible noncitizens. Benefits vary by family size.

MassHealth: Within Massachusetts, low income individuals and children receive health insurance under the MassHealth insurance plan. Eligibility depends on family size, income, assets, disability status, and age of the applicants. MassHealth allows participants to receive health care from a number of providers and works in conjunction with CommonHealth and Health Safety Net. CommonHealth is available to disabled individuals who are employed 40 hours per month and do not qualify for MassHealth because of their income. The Health Safety Net (HSN) pays hospitals and health care centers for treating uninsured and underinsured Massachusetts residents.

Energy and Utility Assistance: The Fuel Assistance program helps eligible participants pay their utility expenses for heat or helps pay for rent if utilities are included. Eligibility is determined by income and assets. In addition, utility companies in Massachusetts are required to offer gas, electricity, and telephone discounts for families receiving public assistance.

Department of Transitional Assistance website

B. Welfare Utilization

Welfare programs are targeted to specific, needy populations who are considered worthy of public assistance based on eligibility standards. Though programs are diverse, they provide limited benefits which do not necessarily guarantee stable living conditions for low-income families. TAFDC remains the predominant form of welfare for low-income families, including the homeless. By requiring participants to work and enforcing a time-limit on benefits, TAFDC,

as described by its name, is designed to provide *transitional* aid to families with the intent that they become self-supporting during their time on welfare. However many families face both individual and environmental barriers that prevent them from doing so. As described before, minimum-wage jobs and lack of low-income and subsidized housing make it nearly impossible for a low-income family to be stably housed, let alone allow them rise out of poverty. In addition, poor education, histories of domestic violence, mental illness, and substance abuse histories add even more barriers to stability (Bassuk 1996).

Families that receive welfare tend to follow the same demographic characteristics of homeless families. Both housed and homeless women on welfare have high rates of violent victimization and sexual molestation (Bassuk 1996; Salomon 1999). They struggle with mental illness, most prominently PTSD and major depression, and many have chronic medical conditions including asthma, anemia, and bronchitis (Bassuk 1996; Salomon 1999). Many single-mothers remain without child support from estranged fathers of their children. Mothers who were victimized by their partners are frequently unwilling to demand child support for fear of further abuse (Bassuk 1996). When facing so many obstacles, welfare benefits can help a parent keep her family out of homelessness but benefits under TAFDC are limited and most parents are required to supplement them with other sources of income.

Thousands of families rely on public assistance and welfare in the Boston metropolitan area alone. The American Housing Survey of 2007 identified that 396,000 households have SSI as a primary source of income and 206,000 households rely on other forms of public assistance and public welfare. In addition, 429,000 households rely on SNAP benefits and 339,000 households received some kind of disability payments or worker's compensation (American Housing Survey 2007). Focusing on Middlesex County alone, in 2008 it was estimated that 1.7

percent of the population used cash public assistance and 4.6 percent of the population received SNAPs (American Community Survey 1-Year Estimates, 2008). Welfare benefits and food assistance are important to households in Somerville and the surrounding Boston area, providing them with income and nutrition assistance without which many more families would be homeless and hungry.

C. Subsidized Housing

For many low-income families, affordable housing at market value is almost impossible to find. Low-income affordable housing has a greater tendency to be substandard, located in neighborhoods with high crime, or be too small to meet the needs of most average-sized families. With most homes too expensive to afford, families have several options which they can turn to in order to receive subsidized housing. Subsidized housing allows families to live in homes for a fraction of the rent, the remaining portion of which is paid for by the government or a nonprofit organization, such as SHC. Subsidized housing is managed through the DHCD. The following programs are available to low-income families, the elderly, and the disabled who meet income and asset eligibility requirements:

State Aided Subsidized Housing: Public housing developments are built and subsidized by the state or federal government and are managed by the local housing authority. Inhabitants pay a portion of their income towards rent, generally around 30 percent, which varies depending on the payment of utilities; the state or federal government finances the rest of the rent. Housing is assigned with priority for people who are homeless due to natural disasters, public action, or an

emergency situation (such as domestic violence). Waitlists for public housing in Massachusetts are, on average, two years or longer.

Rental Assistance: Rental assistance programs help low-income individuals and families pay their rent for apartments that are not within public housing developments and already subsidized. There are three forms of rental assistance within Massachusetts:

- **Section 8 Housing Choice Voucher Program:** Section 8 is funded by the federal government which provides money to HUD that is distributed to local housing authorities who provide benefits to voucher holders. Eligibility for Section 8 is determined by income and assets; limits are currently set by the state and vary by family size. Currently the wait list for Section 8 is several years long and due to the recession, there has been a freeze on the distribution of Section 8 vouchers. Participants generally pay 30 to 40 percent of their income towards rent and the rest is paid for by federal funds.
- **The Massachusetts Rental Voucher Program (MRVP):** The MRVP is a rental assistance program funded annually by the state of Massachusetts. Participants can receive either a "mobile" voucher to be used anywhere in the state or a "project-based" voucher which is limited to certain apartments. Similar to Section 8, eligibility is determined by family size and income and participants pay 30 percent of their income towards rent. The MRVP waitlist is several years long and was closed as of January 2004.
- **The Massachusetts Alternative Housing Voucher Program:** This voucher program is run by the state of Massachusetts and is only available for persons under 60 years of age who are eligible to live in elderly/disabled state assisted public housing.

D. The Effectiveness of Subsidized Housing

Families at-risk of homelessness and those exiting homelessness are significantly more stably housed when receiving subsidized rent. A study that examined the stability of previously homeless families found that residential stability was 20.6 times higher for families receiving subsidized housing compared to families that did not (Shinn 1998). Other studies that have focused on the exit and reentry of families into homeless shelters found that shelter readmission was lowest for families that received subsidized housing when exiting the shelter, around 8 percent readmission, compared to families that exited to other housing arrangements, around 37 percent (Wood 2007).

Besides improving housing stability, voucher programs have also been shown to reduce over-crowding in many households (Wood 2007). Receiving a voucher allows families who were previously living with friends and family members to move into their own homes and sometimes escape unhealthy living situations, including domestic violence (Wood 2007). Housing vouchers can also increase families' total cash income by allowing them to spend less money on housing costs, leaving more money for other basic needs. However vouchers do not provide enough funds for families to collect substantial savings (Wood 2007). Studies that have examined the effect of housing vouchers on employment have reported conflicting results and more reliable evidence is needed in order to better understand the correlation (Wood 2007). Overall, housing vouchers have been shown to substantially increase housing stability for many families, thus reducing the risk of homelessness.

VII. NONGOVERNMENTAL AND NONPROFIT ORGANIZATIONS

A. Structure and Funding

Welfare reforms significantly decreased benefits and restricted eligibility for state and federal public assistance programs, simultaneously increasing the importance of nongovernmental service providers. Nonprofit organizations have become prominent in the past few decades, providing services and case management and helping to fill in the gaps from a significantly shrunken public safety net. Programs vary by structure, size, and services. They are comprised of everything from large hospitals to small daycares to national charities. The two broad distinctions of non-governmental service organizations are faith-based organizations (FBOs) and secular organizations. Roughly one-fifth of all nonprofit human service organizations have religious affiliation (Allard 2009). FBOs tend to address temporary material needs by organizing meal programs, clothing drives, and providing temporary cash assistance to certain needy families (Allard 2009). Secular organizations generally provide services that require trained staff members such as mental health treatment, substance abuse programs, and case management programs to find housing, employment, and schooling (Allard 2009). Both programs receive funding from private grants and donations but the increase in government funding on both the state and federal level has helped promote the nonprofit service sector (Allard 2009).

Funding of nonprofit programs is often complex and built off of a myriad of sources. In the past, private grants and donations provided the majority of funding for nonprofit agencies, contributing over 60 percent of revenues from 1977 to 1997. In more recent years, though private groups are still an important source of funds, the proportion of revenues drawn from these groups for nonprofits has declined. For close to 60 percent of nonprofits, less than one-quarter of total

revenues are generated from private sources and instead, many nonprofits, especially large organizations, have become more reliant on public funds (Allard 2009). Government funding provides more than half of total revenues for 51 percent of providers (Allard 2009). The increase has corresponded to the government's enhanced reliance on the private sector to provide the social assistance which it does not. Within the United States, over $150 billion is spent every year on nongovernmental social service programs which is 15-20 times more than what is spent on public welfare cash-assistance programs (Allard 2009).

Nonprofit programs have certain strengths which supporters argue make them efficient service providers. First, being private organizations, nonprofit groups can provide services without gaining public approval, which is necessary in forming government services (Salamon 1999). In addition, private organizations can provide more specialized programs targeted to particular populations whose needs are not met through broad government organizations (Salamon 1999). Second, private organizations can take innovative approaches to providing services and aid that may be met by more resistance in a public service system which tends to favor more traditional approaches. In this way, private organizations help promote diversity and freedom of choice by giving consumers the ability to draw services from a variety of programs (Salamon 1999). Third, nonprofit organizations have a strong history of advocacy, bringing attention to societal grievances and mobilizing larger public action (Salamon 1999). Finally, the fourth advantage of private nonprofits is the close attachments they share with communities, allowing them to gain the communities' trust and thus provide more effective and community-oriented services (Salamon 1999).

Though nonprofit service organizations have several benefits, they also contain significant weaknesses that threaten the entire structure of private service providers. The main

weakness that plagues nonprofits is their unpredictable funding. Since funds depend on grants and donations, they can vary significantly from year to year (Allard 2009). Even modest budget cuts can lead to decreased caseloads and staff and fewer provided services; in extreme cases it can cause organizations to have to shut down, leaving communities without the service provider on which it previously relied (Allard 2009). Nonprofits located in low-income neighborhoods tend to be harder hit by budget cuts than organizations in higher-income communities, the primary reason being that they are more reliant on one main monetary source, generally the government, and have more trouble replacing funding when their primary source is cut (Allard 2009). As a result, services in poorer neighborhoods have a greater propensity to be cut back or shut down.

Another crutch hampering nonprofit service providers is that they do not have as much freedom as people assume. Many government grants come with requirements on the kinds of services that they fund, the clients that are eligible for services, and the qualifications staff must hold to be employed by the organization (Allard 2009). Several federal grants are provided to nonprofits to run specific programs that they design, allowing the government to use nonprofits as a vehicle to run their own service systems rather than promoting a diversity of services as usually advertised. Examples of such programs in the homeless support system include Shelter + Care, the Better Homes program, Passages, and Sobriety and Stability. These programs are designed by the government and are funded by HUD but run by nonprofit organizations; they offer a variety of supportive services which vary by program and are targeted to specific populations of the homeless. Similarly, private donations may be provided to an organization to fund a particular project, placing further restrictions on nonprofits.

Finally nonprofit services vary significantly by geography. While over half of private supportive service providers are located in neighborhoods of low or moderate rates of poverty, one third of providers are located in neighborhoods with poverty rates below 10 percent (Allard 2009). Not only access but also available services vary by neighborhood. For example, 49 percent of providers in extremely high-poverty areas offer adult education whereas only 29 percent of providers offer these services in low-income areas. For outpatient mental services, 40 percent of providers are located in low-poverty areas and 25 percent are located in extremely high-poverty areas (Allard 2009). The variety in services offered may follow the needs of the community yet simultaneously, it limits the services available to certain communities and populations. Since neighborhoods can be racially divided, persons of certain ethnicities may have reduced access to service providers. Neighborhoods that have high percentages of minorities, namely Blacks and Hispanics, have far lower access to social service providers than predominately white neighborhoods (Allard 2009).

B. Shelters

As homelessness has become increasingly prevalent in the United States, various shelter systems have been designed to ameliorate the problem. Some of these programs offer intensive supportive services aimed at making individuals and families better "equipped" and "responsible" so they can successfully maintain their housing. Other programs try to minimize shelter stays by putting families into shelters as quickly as possible. For many homeless families, the majority of aid they receive is through the shelters and their workers.

Emergency shelters are generally restricted to overnight shelters that give residents a place to stay temporarily and generally only meet people's basic needs. The case management

provided through them can vary from barely any to intensive services (Locke 2007). Emergency shelters are funded by the Federal Emergency Management Administration (Rossi 1994). Alternatively, residents apply for transitional housing programs which are funded under the McKinney Act (Rossi 1994). Transitional housing provides participants intensive supportive service programs and subsidized housing or shelters while they "transition" into permanent housing; the goal is for the services to give individuals and families the skills they are believed to lack so they maintain their housing in the future (McChesney 1990). Traditionally, participants must comply with the program guidelines, working with case managers and participating in all required programs which can vary from therapy, to budgeting, to job searches. Similarly, permanent supportive housing is a system in which residents receive case management services and housing support indefinitely and is frequently targeted to disabled individuals (Locke 2007). Transitional and permanent housing has been shown to be effective in helping families with high needs maintain their housing (Locke 2007).

Currently, due to the rise of homelessness, the DHCD is struggling to place applicants in shelters, almost all of which are full. According to Massachusetts policy, all families are guaranteed shelter. In order to shelter all the new families, the DHCD has begun placing people in hotels and motels throughout the state and in scattered site housing in various districts. Scattered sites are apartments operated by the DHCD that act as temporary lodging for homeless families.

The focus on chronic homelessness has amplified funding to supportive housing programs. As a result, many of the services receiving funding are limited to people with mental or physical disabilities (Burt 2007). For example, the Shelter + Care program is designed to provide permanent housing for persons with disabilities and is funded through McKinney-Vento

appropriations (Locke 2007). However the program has drawbacks. Since residents are required to accept services in order to receive housing, many needy people are reluctant to participating in supportive housing programs.

Shelters are not an effective way to handle the problem of homelessness. In Massachusetts, the cost of sheltering a family for one year was $47,000 on average in 2004, making shelters incredibly cost ineffective (Locke 2007). The expense of running shelters for both families and individuals is enough to pay the rent for their apartments and this information has helped promote the Housing First model. Under Housing First, homeless individuals and families are rapidly placed in housing and receive limited supportive services unless they ask for more help (Locke 2007). Besides its cost effectiveness, the program diminishes the negative effects of homelessness on the mental and physical health of children and adults by reducing shelter stays. In addition, though Housing First does not require participation in as many supportive services, it has been shown to effectively house families with parents who were former substance abusers or who have mental illness. So far, the program has been shown to keep families stably housed at diminished costs (Locke 2007).

Shelters are generally run by a variety of nonprofits who receive the majority of their funding from the government through HUD. Many shelters have admission restrictions and screen their clients for eligibility. Family shelters are especially notorious for this practice and frequently target specific demographics of homeless families. For example, battered women's shelters provide emergency shelter for mothers and children escaping abusive relationships while rehabilitation shelters offer space to mothers who are recovering substance abusers and their children. Family shelters, not surprisingly, aim to meet the needs of parents and children yet many restrict which members of the family are allowed into the shelter and teenage boys and

older men are frequently denied entry for safety reasons. As a result, some shelters force families to split up; the mother will stay with the children in a family shelter while the husband or partner goes to a shelter for single adults (Rossi 1994). Shelters have also reported turning away parents who are currently substance abusers or have severe mental illness. In such situations, families are generally limited to specialized facilities (Rossi 1994).

Shelter admission policies can significantly impact the information researchers gather on homeless families because they influence the demographics of homeless families that are visible. By not admitting men and teenagers, more women tend to be recorded as single-mothers with young children (Rossi 1994). In addition, fewer women may be reported as substance abusers since alcohol and drugs are prohibited in most family shelters. Some policy makers have argued that shelters help propagate homelessness by sustaining people who do not wish to take care of themselves (Burt 2007). Besides the obvious argument that shelters provide housing that few would desire over a home of their own, the presence of shelters did not cause family homelessness, it only made it visible. It has been documented that many mothers will try avoid being homeless with their children at almost any cost by remaining in abusive situations or in unsafe substandard housing (Rossi 1994). Shelters allow families to escape these situations and consequentially, family homelessness depends on the shelter system because without it, the families would remain invisible (Burt 2007). So long as there are families living in highly unstable, unsafe, or unsatisfactory living conditions, increases in shelter size will increase the population of homeless families (Rossi 1994). By affecting the size of the visible population of homeless families, shelters can impact the reported size of the homeless population.

As described before, shelters have exorbitant costs and do not provide the ultimate solution to homelessness. Even families who are defined as having “short” periods of

homelessness tend to be homeless for about one year; families who are homeless for longer or chronically homeless are even more expensive to sustain. As a source of funding, many shelters charge shelter fees. In traditional shelters, the fee can be a portion of whatever income a family has, including TAFDC payments. Transitional housing programs that are supported by HUD funds are required to charge families 30 percent of their income towards rent (Rossi 1994).

The cost-effectiveness and success of currently existing service programs to aid homeless families has not been studied in depth which leaves doubt as to whether the methods being used to resolve homelessness are really the correct ones. Homeless families are particularly understudied and little is known of the costs of child welfare, health, mental health, and education services associated with family homelessness (Culhane 2007). One specific program showed that precariously housed families who received financial assistance before becoming homeless did not use a shelter within twelve months of assistance (Locke 2007). Providing aid to prevent families from falling into homelessness is significantly cheaper than housing families in shelter. The success of preventative programs demonstrates that families in shelter are not there because of personal problems but rather due to policy and environmental factors which promote unstable housing and long shelter stays (Culhane 2007). Many families do not need as many supportive services as previously assumed and preventative approaches to aiding families at-risk of homelessness can be effective. However, due to the diversity within the population of homeless families, it is still exceedingly difficult to identify families who will be homeless in the future from those who will manage to sustain themselves. In addition, it is hard to distinguish between families who simply need subsidized housing or help with several months' rent from those who would benefit from additional, more intensive, supportive services (Locke 2007).

More research is needed to better understand the effectiveness of currently implemented supportive services and the needs of homeless families.

CONCLUSION

Societal conditions in the United States have propagated family homelessness for the past three decades. The number of homeless families continues to increase as the cause of homelessness, namely poverty, remains unresolved. During the current economic recession, family homelessness has become even more evident as not only low-income but additionally middle-income families fall into homelessness.

Certain histories including substance abuse, mental illness, and domestic violence, and personal characteristics such as being a minority, being a young, single mother, and having young children, place certain families at higher risk of homelessness. However, these individual characteristics should not be regarded as the *cause* of homelessness. Rather, families living in poverty live at risk of homelessness because their jobs do not generate enough income, low-income housing is scarce, and safety-nets including welfare remain incomplete and insufficient. An enormous number of families in the U.S. live at risk of homelessness each day; personal characteristics simply dictate which families are more likely to be homeless. Until family homelessness is recognized as a problem caused by our societal organization rather than an unfortunate circumstance families bring onto themselves, we will not take the correct steps to ameliorate and end family homelessness.

Poverty became exacerbated in the 1980s and 90s when welfare reforms cut the support systems on which many of the poor relied. Since then, government programs to aid homeless families remain constrained and do not meet the needs of a growing number of families. Instead,

the government has invested in private groups to provide supportive services to homeless families. The complexity of the U.S. supportive safety net can pose as an impediment to families attempting to find aid. Various nonprofit, community, and government programs interact through complicated eligibility requirements and overlapping jurisdictions and target populations which entangle the service system and make it difficult to navigate. As nonprofits and other programs become increasingly relied upon to provide case management, supportive housing, rehabilitation services, counseling, and other services, it is important to examine how successful these various programs and organizations really are; unfortunately, few studies have done so. While many studies have identified the negative effects of homelessness on both parents and children, there is a dearth of information regarding the usage patterns and histories of supportive services by families.

In response to this lack of information, this study examines the issue of the accessibility and availability of supportive services in Somerville, Massachusetts. Through in-depth interviews with parents of families who were previously homeless or are currently homeless, information was gathered on the service histories of various families including the experiences they had when interacting with service providers and the barriers they faced when attempting to find and access services. The stories recounted through the interviews helped to illustrate service usage in Somerville. The experiences had by the parents of homeless families demonstrated the ways in which supportive services provide important and necessary aid for families and the areas in which they fail. While the ultimate cause of family homelessness remains the societal structure of the U.S., it would be inexcusable to leave homeless families without an effective and complete safety net; as long as homelessness exists, supportive services will continue to be needed and utilized. Learning from the lives of a community of homeless families, this study

discusses the strengths and weaknesses of the homeless support system of Somerville in an effort to identify areas for possible improvement and growth.

* * *

CHAPTER 2:
METHODS OF DATA COLLECTION AND ANALYSIS

I. SETTING

Somerville is a city located two miles north of Boston in Middlesex County, Massachusetts. With a population of approximately 77,000 residents living on a little over 4 square miles, it is the most densely populated community in New England. Somerville has a diverse group of residents including blue-collar workers, college students, young professionals, and immigrant residents from countries including Brazil, Haiti, and El Salvador (Somerville 2008). Though previously a lower-income city, recent development and gentrification have significantly changed the appearance of several neighborhoods and city squares. Somerville, like any city, battles homelessness and on any given night, approximately 275 people are homeless (Alston-Follansbee). Homelessness in Somerville began to increase when the T Metrorail was extended into Alewife, making Somerville easily accessible by public transport. Homeless individuals and families began moving to Somerville where the shelters were smaller and safer (Alston-Follansbee). As a community, grass-roots response to rising homelessness in the 1980s, Somerville Homeless Coalition (SHC) was started. Beginning as an emergency shelter in a church basement, SHC has grown to become a nonprofit organization that provides shelter, case-management, and supportive housing for over one thousand men, women, and children in Somerville, Massachusetts. In conjunction with Project Soup, a food support program started in the 1960s, SHC runs a food pantry program to provide monthly allotments of groceries to needy

individuals and families. SHC was critical to the success of this research, providing an inlet through which to recruit parents willing to participate in the study.

SHC runs an extensive case-management program working with clients including young adults in recovery, single adults, and families. Some of the case-management participants are in supportive housing programs run by SHC. "Better Homes I and II" provide permanent supportive housing for individuals and families; participants receive case management and subsidized housing for as long as they remain in the program. "Sobriety and Stability (S&S)" is a supportive housing and case management program for young adults recovering from substance abuse. "Shelter-Plus-Care (S&C)" works in collaboration with the Somerville Housing Authority to move disabled adults into subsidized housing while providing them with supportive services and case management through SHC. Under "Passages," SHC case managers work with homeless individuals who apply for the program including residents of the SHC Adult shelter, Boston shelters, and CASPAR shelters. CASPAR is a nonprofit group that provides services and shelter for individuals with substance-abuse disorders; they run multiple rehabilitation services including a program for pregnant and post-partum women called New Day. Finally, SHC runs preventative services through their PASS program. PASS is a rapid re-housing and prevention program through which individuals and families at-risk of homelessness receive time-limited rental subsidies so that they can maintain housing; families who have recently become homeless are moved into subsidized apartments almost immediately. The program receives the majority of its funding through United Way and recently, a portion from the stimulus bill from the Obama administration. Participants must apply and be approved for the PASS program.

SHC works in collaboration with several important nonprofit groups in Somerville. SHC formed a community-based coalition in 1996 called the Somerville Homeless Providers Group

with Somerville Community Corporation, Cambridge-Somerville Legal Aid, the Community Agency of Somerville, CASAPR, and St. Patrick Shelter for Women. The group applies for funding from the state for Somerville homeless projects.

The central offices of SHC are located in Davis Square. In separate locations are the Family Shelter, housed on a single floor in the back of a church, and the sixteen-bed Adult Shelter, run out of a church basement. The SHC Family Shelter, unlike many others, houses husbands and teenage boys so families can stay together. It has twenty beds distributed over five rooms and its total capacity is for five families. Near the entrance of the Family Shelter is an office for the case manager and shelter manager who work there during daytime business hours. The case manager and shelter manager help residents apply for housing and find supportive services including health care, schooling, child care, and therapy. In addition, the shelter manager settles disputes between residents and oversees other staff members. Several women work as shelter administrators on evenings, nights, and weekends so that the shelter is supervised twenty-four hours a day. The office room has a Plexi-glass window that looks out over the communal living room, dining tables, and kitchen. The living room has four couches and a TV, which is always on. Separating the living room from the kitchen is a half-sized child door to keep toddlers out. The kitchen has a standard, four-burner gas stove and single refrigerator. To store additional food, closets, pantries, and a large, white ice box are located in the living room. Running from the living room is a hallway along which are five bedrooms, one for each family. The bathrooms, one for men and one for women, are at the end of the hallway as is a clothes washer, dryer, and playroom. The playroom is kept locked unless opened by shelter staff when volunteers come to play with the children.

II. RESEARCH DESIGN AND INTERVIEW STRUCTURE

The content for the research study was centered on semi-structured, in-depth interviews held with parents of homeless families. Case managers at SHC and the shelter manager of the Family Shelter approached parents who they believed would be willing participants. Ten interviews were performed overall, six with families in the SHC Family Shelter, two with parents in the Better Homes program, and two with mothers from CASPAR's New Day program participating in Passages.

Oral consent was obtained from all participants before conducting the interviews, which were tape-recorded. The consent forms were signed by the interviewer (me) in order to maintain anonymity of the participants.[1] The interviews were loosely-guided, running between forty-five minutes to over an hour in length, varying by participant. Participants were asked to describe the events that had caused them to seek out homeless services and to share their experiences receiving services from the Department of Transitional Assistance (DTA), SHC, CASPAR, and any other service providers. In addition, participants were asked whether they had had trouble accessing certain programs or were in need of particular services they had not yet received. Most participants guided the interviews themselves, discussing topics and experiences important to them. As a result, the interviews were diverse and provided a wealth of data for analysis.

Participants from the SHC Family Shelter were invited to conduct the interviews wherever they wished in the shelter; four interviews were conducting in the living room and two in the playroom. The other participants came to the central offices in Davis Square and interviews were conducted in a private office. All participants were compensated with twenty dollars for their time and effort.

[1] See "Consent Form" in Appendix

III. ANALYSIS

All interviews were transcribed in their entirety, word for word, for further analysis. The three interviews conducted in Spanish were translated as they were transcribed and were only transcribed in English. A coding scheme was designed to help identify particular subjects of interest.[2] Several different codes were created to identify the demographics of the participants and common themes in participants' responses when discussing supportive services. Some codes were preconceived following the main question of the study, the accessibility and availability of supportive services. Other themes and their codes were created based on the contents of interviews, following topics that were brought up by participants and were shared by several families, such as the importance of neighborhood safety in applying for subsidized housing.

The coding scheme was designed to include individual codes for each service provider and type of supportive program; additional codes described the participant's experience and identified barriers and facilitators he or she had had when accessing services. The method of coding was driven by the theory behind the study which aimed to explore the relationships between service providers, services, and the barriers and facilitators faced by families in the homeless system. It was hypothesized that families would have both positive and negative experiences within the homeless system which would vary according to service and service provider. By labeling sections of interviews with overlapping codes, it was possible to identify trends among various components of homeless services and how they impacted families' outcome and shaped experiences.

The first created coding scheme was applied systematically by hand to the first eight interviews to see whether it met the study's needs for analysis. Codes and overlapping codes

[2] See "Coding Tree" in Appendix

were used in the same way among all the interviews in order to highlight common themes. After the trial, the coding tree was edited with several minor changes before being reapplied to all ten interviews by hand.

Once the coding was complete, the interviews were uploaded onto a software program marketed for qualitative analysis. The program, N6 (NUD*IST 6), allows coded data to be retrieved from all the interviews that share common codes and code overlaps. The interviews were coded on N6 and the software allowed the sections of selected intersecting codes from all ten interviews to be retrieved. Multiple intersections were examined in order to study the relationships between service providers, supportive programs, client demographics, and client experiences. The analysis helped explore both interviewee-directed topics and the themes important to the original hypothesis of the study. Interviewee-directed themes included the importance of case managers in accessing services, the effectiveness of smaller programs including Mass Rehab and Alcoholics Anonymous, and the impact of service rules on client experience and accessibility of support. Other themes related to the original hypothesis behind the study included the ways in which clients learned about government and non-government, nonprofit services, positive and negative experiences with various service providers and services, accessibility to shelter and housing services, and differences in the demographics, histories, and reasons for homelessness among the interviewees.

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CHAPTER 3:
RESULTS OF THE INTERVIEWS

The results of this study drew attention to several significant barriers faced by families navigating the homeless system in Somerville, indicating that the programs are not as available and accessible as service providers may wish. Parents described being denied service, finding it

difficult to contact and access service providers, not knowing of many nonprofit services, and needing certain services that were unavailable. Additionally, certain housing programs were unacceptable to parents who refused to live in dangerous housing with their children. The results presented in this chapter demonstrate the impact that flaws and barriers in the homeless system can have on parents and children.

This chapter is divided into several sections highlighting the portions of interviews specific to discussion of homeless supportive services. To present important background information on the participants, the first section describes the general demographics of the interviewees in this study followed by the second section which discusses the various reasons for homelessness described during the interviews. The following sections are devoted to the access of supportive services. The third section compares different methods through which participants heard of both government and nonprofit supportive services. The fourth section presents the experiences clients had with government supportive services while the fifth section illustrates client experiences with nonprofit providers including SHC. Finally, the fifth and sixth sections are devoted to barriers and facilitators, respectively, identified during the interviews.

I. PARTICIPANT CHARACTERISTICS

The ten interviewees of the study all held a "homeless" status. Nine of the interviewees were women, and one was a man; three were Hispanic (all women) and the others were White. Two of the interviewees, the man (who will be known as Greg) and a woman (Lisa), were in permanent supportive housing under the Better Homes program run by Somerville Homeless Coalition. Lisa had previously lived in the Family Shelter of SHC. Two women, Tracy and Charlotte, were in the rehab program, New Day, run by the nonprofit group CASPAR. Charlotte

was pregnant with her first child and Tracy lived with her newborn daughter while her mother took care of her older son. Tracy and Charlotte received case management services from Somerville Homeless Coalition through the Passages program to help with housing searches.

The six remaining interviewees lived in the Family Shelter with their children. Georgia lived with her husband and two teenage children. The rest of the women, Alex, Elizabeth, Rosa, Juana, and Cecilia, were single mothers who had young children between several months and 9 years of age. Lisa, Tracy, Charlotte, and Alex reported histories of drug abuse; other interviewees did not volunteer the information and were not asked directly about their histories. Elizabeth, Rosa, Juana, and Lisa all had lived doubled-up with friends or family member in the past before moving into a shelter.

II. REASONS FOR HOMELESSNESS

The reasons for homelessness among the interviewees were diverse and multi-faceted. However, some general trends did emerge. Reasons for homelessness reported by the participants included participating in a rehabilitation program, having to leave doubled-up housing, and being unable to afford rent; however, it should be remembered that these are simply the triggers of homelessness and other factors in are culpable for placing families at risk for homelessness.

A. Entering a Rehabilitation Program

Tracy, Charlotte, and Alex had become homeless upon entering rehabilitation programs for drug abuse. Alex had had a job and an apartment that she had given up when she had entered her rehabilitation program.

> *...because like, at that point in time I didn't think I had a problem using drugs or drinking, like I thought I was just a normal teenager. Like, but they saw different,*

> *you know what I mean? Like I thought I was, I was doing it 'cause I had the job, I had the apartment, and like, like I functioned as an addict but they saw it differently. (Alex)*

Having finished her program, Alex had moved into a transition program in order to remain in a structured environment where she could maintain sobriety. She was forced to leave the transition program for not complying with their housing policy – a theme that will be discussed more in depth later in the chapter. Having nowhere else to go, Alex applied for shelter at the Department of Transitional Assistance (DTA) and was placed in the SHC Family Shelter.

> *But that was, like we did an aftercare plan, like when I was there like four months, like what do you plan on doing to keep yourself clean and to keep your kids and this and this. And I said, "I want to go into another, like a house, where I still have someone over my head knowing that I still have to be clean. (Alex)*

Describing the transition program, she said,

> *You have to have six months clean to go there. You still like on urines, and still have to go to certain meetings, comply with a case manager, all that. But it wasn't like this. Like this is the first time I've ever been in this, I've always been in a treatment. (Alex)*

Tracy and Charlotte were in CASPAR's New Day rehabilitation program. Both were planning on staying in the program for the maximum allotted time, one year, and were working with SHC case managers to determine where they would live next. Tracy hoped to find housing or enter a sober house.

> *No it's nine to twelve months. Like you have to leave within twelve months. Yeah so, if I don't have housing, which I doubt I will by then, by June, then I have to um, go into a sober house. (Tracy)*

Charlotte was anticipating staying at New Day for a year and did not know say where she would go next. She had been homeless prior to entering New Day because she had been in a different rehabilitation program called Sheppard House.

> *I can finish in six but it's a nine to twelve month program so I can stay up to a year if I choose. So I, I'm not plannin' on going anywhere so we'll see…. Um,*

yeah technically I was homeless. Like, technically I was in another program before that and I left the program. (Charlotte)

B. Having to Leave Doubled-Up Housing

Several participants reported becoming homeless when they had to leave homes where they had previously lived doubled-up with friends or family. Such was the case for Elizabeth, Rosa, Juana, and Lisa. Greg lived in doubled-up housing with family in between stints living on the street, but he did not live doubled-up prior to becoming homeless. The participants did not view their status when "doubled-up" as homeless or unstable. After separating from her children's father, Elizabeth lived with her parents for some time before she had to leave.

No I was living with my parents and they rent. It was only a three bedroom and they were already, my parents in one room, each of my brothers had a room so I was in a tiny room in the basement, with two kids, like tiny. [The landlord] didn't want me living in the basement. Plus they had lead paint and stuff like that so it wasn't okay for the kids. And he and his wife were getting divorced and thinking of selling the house anyway. So my father was like, if they're selling the house we're moving and all you kids need to find somewhere to go. So either way, I had to leave. (Elizabeth)

Rosa, Juana, and Lisa had all lived with friends before applying for shelter. Rosa lived with a friend who finally could not house her anymore and drove her to the DTA so she could apply for shelter. Lisa was living with friends and sought shelter with the help of the Department of Social Services (DSS).

...I told [the DTA worker], "I'm homeless," you know, basically living where I was living and I had a letter from DSS because they knew, you know, where I was living and there were only two bedrooms and there were about five adults living there, you know... (Lisa)

Rosa had returned to Boston, homeless, after living in North Carolina for two months with a friend. Prior to North Carolina, she had lived in federally subsidized housing in Boston which she had received after living in a shelter; however, she left when the rent became too expensive.

Before her first incident of homelessness, Rosa had been living with a friend until the overcrowding became a problem with the landlord.

> *Also because before I lived in the house of a family, not my family, the family of the father of the kids. And I couldn't stay in that house anymore. You understand? It's like when someone has an apartment and the landlord or someone finds out that a person has more than the people who are there, it seems that they give them a month to leave the apartment. (Rosa)*

Describing her apartment she said,

> *What happened was my program was Federal. And the help that Welfare was giving me would all go to the apartment. That's where all the money would go. You understand? So I couldn't maintain it anymore. (Rosa)*

C. Medical and Legal Reasons

Finally, some cases of homelessness were caused by bad luck. Like Rosa, Georgia's family became homeless when they could no longer afford rent for their apartment. Georgia's husband had become sick after a work accident and had to be hospitalized for several weeks. The loss of income was enough to force the family to leave their home and seek shelter.

> *And he was on antibiotics every three, four hours. So he had to stay in the hospital. So that went on for a little over maybe about four weeks. The business kinda, it started folding because he wasn't there working. There was no money. There was nothing. There was nothing I could do…. When he would try to go back to the back to work there was no work because he hasn't been there. And there was no money so rent was coming. Went to DTA about three months after that because we had no money nowhere to go. (Georgia)*

Greg had to leave his home because his wife divorced him. She filed for a restraining order, saying that he had threatened her.

> *I was married for twenty years, four kids, and then my wife decided I wasn't good enough or whatever so she ended up, uh, going to court and getting an order to remove me from the house so she could have the kids and she got custody over the kids. (Greg)*

Families fall into homelessness for a variety of reasons but what most of these narrations have in common (with the exception of Greg and Alex) is that the families were unstably housed and at-risk for homelessness for some time prior to seeking shelter. Though the participants who lived doubled-up did not consider themselves homeless in those conditions, they essentially were as they had no home of their own for their family. It is important to note that the ultimate causes of homelessness among these ten interviewees differed quite significantly, even for a small sample size. Homeless prevention programs will need to recognize the diversity in the causes of homelessness if they are to devise successful approaches that can target them.

III. FINDING SERVICES

Faced with homelessness, participants found help for their families in a variety of ways and from several different sources. The results from the interviews indicate that the most utilized service provider was the DTA. The DTA provides a wide variety of services including shelter placement which, in part, explains its popularity. In addition, it was frequently the only provider the interviewees were aware of when they first became homeless. To determine the best method to expand knowledge of other service providers and preventative services, the various pathways through which parents learned about service providers were studied. In this section, the ways participants found out about DTA services will be examined, followed by nonprofits.

A1. Finding the DTA by Word of Mouth

Many of the participants in this study originally heard about the DTA through friends or family members. In several interviews, it was apparent that the services at DTA were simply "common knowledge." Some interviewees had previous experience with the Food Stamps program, having learned about it through friends or family. Participants had gone to the DTA to apply for Food

Stamps before becoming homeless and thus when they became homeless, were aware of the shelter-placement services the DTA offered. When asked how she had found out that Food Stamps were distributed by the DTA, Elizabeth responded,

> *Um, through friends and online. Yeah….Yeah because I had been there for the Food Stamps so I knew when I was going to be homeless,I just went there and talked to a different person. (Elizabeth)*

A2. Finding the DTA from Other Service Programs

Some participants did not have friends or family who could tell them about services for which they qualified. Instead, they learned about government support programs through other nonprofit service providers, as exemplified by Rosa who learned about Food Stamps through a health clinic.

> *Because now in pediatrics you are filling out a paper, they ask you what you ate that month, if you want help to eat, for assistance for food and this and the other. And now you put the name of the baby, and that's it. (Rosa)*

B. Finding Drug Rehabilitation Programs

The DTA was not always the first service provider sought by the participants. Drug rehabilitation programs were a common initial supportive service for several participants. Interviewees first found a rehabilitation programs through detoxification programs, social services, and friends. Charlotte described learning about Sheppard House saying,

> *I just, I don't know, probably in a detox most likely. Or in a soap program or a CSS program. (Charlotte)*

Charlotte later moved to CASPAR's New Day program which she had also learned about through word-of-mouth. Alex had first learned about her rehab program through a lawyer who had defended her in a custody battle for her children against the Department of Social Services.

> *And my lawyer had worked with girls like the same situation as me, like lost their kids due to the same thing as me so he said, "There's this place called the Genesis house." (Charlotte)*

Tracy was told about New Day while in prison by a social worker.

> *I was held for probation in Framingham. I was attending Framingham. Prison. And uh, for thirty days. And a woman who works up there, she got me into a residential program. Like released on terms of probation to a program. (Tracy)*

C. Finding Nonprofit Service Providers

Many participants were receiving services from nonprofit groups such as SHC, schooling programs, and legal aid. In contrast to DTA services, it was more common for interviewees to hear about nonprofits from a previous service provider rather than a friend or family member. All of the participants receiving case management from SHC had been referred by a previous service provider or through an arrangement between their shelter (ex. Caspar) and SHC as described by Charlotte.

> *Um, well I'm in a program called New Day. Like, once you get to a certain step in the program, like, you have to start to accumulate permanent housing through the, through the Somerville Homeless Coalition. (Charlotte)*

Others, including Greg, were referred to SHC by a doctor or social worker.

> *Yup the social workers at the hospital, they told me, they said, "Listen, call this number when you get out. And start because you have no place to stay. This will at least get you going, maybe." So that's what I did when I got out I knew what to do because the social workers told me in there and I got in touch with [SHC] and they did. (Greg)*

Several clients utilized nonprofit education services. Elizabeth's case manager at the SHC Family Shelter put her in touch with a program through the Boston Public Library to help her find funding for nursing school.

> *So I just applied to Bunker Hill. You know, they gave me all the resources, she found a place you go to the Boston Public Library and they help you for free find like, all kinds of scholarships and grants and financial aid and stuff. (Elizabeth)*

Receiving ESL services was an important educational service for Hispanic participants who had limited English. SHC frequently put clients in touch with available services. However, it should be noted that waiting lists, sometimes several months long, could prevent parents from gaining access to schooling. Rosa described entering ESL with help from the SHC Family Shelter case managers. She mentioned that she was attending school out of her own volition and not because she had to fulfill the requirements for TAFDC.

> *Yes. The ones of the shelter where the ones who told me. Right? I'm going to school because you have to do something. But not yet because Welfare is sending me, DTA is sending me. (Rosa)*

D. Finding Massachusetts Rehabilitation Commission (Mass Rehab)

Many interviewees were participating in education programs. Education programs simultaneously gave participants an advantage in the job market and helped them qualify for TAFDC benefits. Participants learned of Mass Rehab in a variety of ways. Some, as Lisa described above, were put in touch with program by as case managers.

> *Yeah [Mass Rehab will] help you, like they have like certificate programs. Which you know, you can work, you can be a counselor and work in addiction and stuff like that so I called and there's like a three month wait, waiting period, you know, for them to get more funding so I'm on a waiting list with Mass Rehab but you know, the Coalition does you know point you in the right direction and like, you know, to utilize, you know, whatever services are available. (Lisa)*

In contrast, Tracy heard about Mass Rehab through word-of-mouth from people at the detox she attended. Charlotte did not mention how she first became involved with Mass Rehab but she was receiving services from them.

> *I just remember hearing about it from when I was in like detox, people in the detox were saying, "Oh Mass Rehab paid for like laptop for me." And, "Mass Rehab gave me a voucher." (Charlotte)*

E. Using the Internet to Find Services

Less frequently mentioned, though still important, some clients used the internet to find information on available service providers. Lisa and Elizabeth both mentioned using online resources. Lisa used the internet to find legal services and additional nonprofit programs while Elizabeth researched DTA requirements in order to bring all necessary paperwork to the DTA when seeking shelter.

> *That's where I did a lot of my research, you know, when I was in the shelter and they were you know when they threw me out and I went through all those transitions I spent a lot of my time at the library, you know, using the computers there, you know, and that's how I found the Somerville-Cambridge Legal Aid. (Lisa)*

F. Finding the SHC Family Shelter

Parents who were living in the SHC Family Shelter had been placed there by DTA, specifically DHCD, shelter services. DHCD placement into shelter is the only way to receive shelter placement at the Family Shelter.

As described above, participants found supportive services in numerous ways. Word-of-mouth and the advice of service providers were especially important sources of information. It is also significant to note what was *not* described in the interviews. None of the parents learned about DTA services through advertisements, brochures, or other outreach programs, indicating that families who do not learn about supportive services from another person (whether it be a friend, family member, or service provider) have significantly less information on available programs. Additionally, nonprofit programs were equally remote. Interviewees did not describe finding nonprofit service providers on their own or having common knowledge of their existence;

instead, nonprofits were brought to a parent's attention by social workers or case managers from other programs.

IV. GOVERNMENT SERVICE PROVIDERS AND SERVICES

The focus of the study was the use of services and service providers by homeless families in Somerville. Consequentially, service providers were studied in depth to determine which were relied on most and the shared experiences clients had with providers. This section will examine participant experiences with services provided through the government programs DTA, DSS, and Mass Rehab, followed by nonprofit services.

The Department of Transitional Assistance (DTA)

Among the participants from the study, the Department of Transitional Assistance was by far the most utilized service provider. While all the participants utilized resources from Somerville Homeless Coalition, the DTA provided a wider range of services and many parents had received services from the DTA prior to being homeless. Receiving a variety of services including Food Stamps, shelter placement, TAFDC, SSI, and SSDI meant that participants had a wide range of experiences at the DTA which often varied according to the service being sought.

A. Experiences with Food Stamps

Overall, almost all interviewees had had positive experiences at the DTA when seeking Food Stamps (now called SNAP). Food Stamps were easy to apply for and many parents felt that their case managers were helpful and approachable. Food Stamps helped clients afford food for their families and meet their nutritional needs. The experiences of the majority of parents can be exemplified by Georgia who describes seeking and utilizing Food Stamps.

> *'Cause when [my husband] was starting the business, you know how you start out it gets a little low, and you know, the money was okay but not enough to feed the whole family. So I went down there with all this paperwork and everything and we qualify. So we went on food stamps and that was really cool, you know, they were really nice about it. (Georgia)*

Lisa and Elizabeth had their Food Stamp benefits cancelled due to mismanagement but both reported that the Food Stamps were returned quickly once they contacted their case managers or the office.

> *So we went there and fixed it. And I got my Food Stamps back the next day. (Elizabeth)*

> *And, and, you know, and once a year you have to recertify. And like I said, this was the only, I had filled all the paperwork and sent it in but I make a copy of everything. So when my Food Stamps weren't there I'm like, you know, I called my worker…. And I faxed it over to him and, and uh I had made another copy and I mailed a copy too. So I didn't have to go back in there like most people do because I had saved it, you know, and I was turned back on, you know. (Lisa)*

B. Experiences with TAFDC

Six of the participants were receiving money from TAFDC, more commonly identified as "welfare." Parents who were not receiving TAFDC benefits were getting child support from their previous partners, SSI, or already had a source of income they would have had to give up in order to receive fewer benefits through TAFDC. TAFDC is both a service and a service provider. As a welfare program, it dispenses cash to needy, low-income families acting as a "service." However, TAFDC is also a "service provider" since clients receive case management services as a part of the program. Case workers organize clients with Food Stamps and Medicaid if they are not already receiving these services. Experiences with TAFDC were varied among the participants, depending on the case worker handling the case. Some participants had positive experiences, as shown by Tracy who had a very helpful case worker.

And then as soon as I had the baby I had to just call, and um make an appointment to go down, and I was in and out of there. I just showed the mother's letter, like from the hospital, and that was all within, I think, a day. The next day I had benefits so that was easy. (Tracy)

In contrast, Cecilia was initially denied TAFDC. In the end, a case manager from another program intervened to help her get benefits.

No, the woman who helped me, to apply for [welfare] told me that they couldn't give me the money at the time because they had to check many things.

Participants also indicated that having too many children could be a barrier to receiving TAFDC benefits. They reported that parents received fewer additional benefits for each subsequent child they had.

Yeah. Oh yeah, and definitely family size. And um, like if you have a baby within a certain time period from within your first baby, it's called like a "cap child" I guess. And like they don't give you as much benefits. (Tracy)

In addition, Rosa said she was worried that with her third child she would have less time to remain unemployed on TAFDC benefits before she was required to work in order to keep her welfare.

Right. But I'm also waiting for the card from them. Because I don't know, because I don't know if the baby, when the baby is, after how long, they send you. Three months? I don't know.

C. Experiences with TAFDC and Child Care Services

In order to receive child care services, parents receiving TAFDC must be fulfilling a certain number of job, job training, or school hours per week. However, without the correct letter of employment or acceptance into school, parents receiving TAFDC do not receive child care services except through other service programs, such as DSS.

So then I think, if I was told, if I understood correctly, as soon as I get the acceptance letter, they'll be able to get full-time daycare for [my son] because

I'll be in full time. And then [my daughter] could only get half time, half a day. (Elizabeth)

Not having a child care voucher before being employed can also prevent mothers from being able to accept a job. Without the initial voucher for child care, they cannot begin working right away as is asked by many employers.

Yeah I had a job but I couldn't take it because I didn't have the voucher. (Cecilia)

Before the interview, Cecilia had also reported that her employer would not give her an official letter of employment which posed another barrier to child care. Many clients described a need for child care services yet TAFDC requirements made it difficult to receive the necessary voucher for free care.

D. Experiences with SSI or SSDI

Only two of the participants had interactions with the Social Security office. Greg was receiving SSDI and Georgia was applying for Social Security (although it was unclear whether she was going to be awarded SSI or SSDI). Greg had had a good experience applying for SSDI, in part because he was simultaneously receiving help from a case manager at SHC.

Sent me back upstairs. But they were helping me, step for step. And then the TFDC guy he was really nice too, uh, Kaplan his name was, Rich Kaplan, and he was like, "OK Bill, bah bah bah bah. I understand what you've been through. You know what, you need to go to Social Security a couple doors down." So I went down, further down into Davis, Social Security, brought back what he needed. And then from there, like I said, it took time, but they walked me through everything. (Greg)*
**DTA*

However Greg had also initially received fewer SSDI benefits than what he was entitled. His case manager at SHC identified the problem and told him to have it checked. Ultimately, the SHC case manager was right.

So I went down and sure enough, they were shorting me like two hundred dollars a month. They were giving me four-hundred ninety bucks a month or something like…. And I went down there and they upped it to seven twenty or whatever. (Greg)

Georgia was applying for Social Security. She was having a more frustrating experience because she had been denied twice and was reapplying a third time.

…. It's a long process when you go and fill out your application, you plan on bein' there at least four to five hours and they say that to you. So yeah. I'll be there sometime in probably, next, probably by the end of the winter. I have my appointment. So yeah, I'll be getting' that done. Now this time, like [my husband] said, and um my doctor, they said that um, I would get it, I would probably get it the third time. So, wait and see and see what happens. (Georgia)

Georgia also discussed how the process routinely took five to six hours and that she had had to see several doctors assigned to her case by the DTA in order to verify her disability. Without the necessary paperwork from the doctors, it was impossible to receive SSI benefits.

E. Experiences with WIC

The mothers who were receiving benefits from WIC were, on the whole, happy with the program and the service it provided.

WIC is when you get, like the vouchers for certain foods like milk, milk and cheese and um, beans, and stuff. But they just added bread and rice and tortillas and stuff like that, healthy stuff for the kids. I can't get it anymore because I'm not pregnant, but the kids can get it until they're five. Yeah so that helps. (Elizabeth)

I think so. I think it might have been. I really don't remember. But they're really good down at the WIC office. And um, they give you like whatever, like they give you a choice on the check like if you want more cheese and less milk and you know what I mean? You can kinda, they have new things now like um, when the baby's six months they'll give you jars of baby food. And um cereal. (Tracy)

Tracy also mentioned that WIC benefits were provided using a check they received in the mail. The check could be cumbersome and difficult to use in stores.The other mothers with children under five (Cecilia, Juana, Rosa, and Alex) did not mention using WIC.

F. Experiences with MassHealth

Several of the parents were using MassHealth as their health insurance provider. Parents receiving TAFDC benefits qualify for MassHealth automatically. Before receiving MassHealth, some interviewees reported using free or cheap health care at various clinics in Boston. Charlotte initially experienced some difficulty using her MassHealth insurance at her health clinic.

> *The only thing with like now like, 'cause I was getting the free care at BMC that's where I was. And now that I have Mass Health, they only accept two plans of Mass Health at BMC. It's the BMC plan that I'm not eligible for because I work or one other plan, it's the Personal Care Physicians something plan and, like, they didn't know they accepted that one. Like they were convinced they only accepted BMC. And like, so, that freaked me out that I was going to have to pay for everything or like transfer. But like, I had to sit on the phone with Mass Health for like, two days to like, straighten all that out. (Charlotte)*

Tracy, Elizabeth, Alex, and Juana were all on MassHealth and did not mention any problems with the program. Tracy and Elizabeth were happy with the coverage it provided for them and their children.

> *I have MassHealth, yeah, so I don't really have to, I don't have to pay for anything and you know they help me for what I need and the kids, we all go to the same doctor which is easy it's in Arlington so I catch the bus right around the corner that way. (Elizabeth)*

G. Experiences being placed in shelter

Participants had mixed experiences when applying for shelter but on the whole, they were negative. Specifically, many interviewees felt that the case workers handling their cases at the DTA were unnecessarily rude or unhelpful. Though currently shelter placement is handled by DHCD, many participants identified their shelter provider as a DTA agent. For this reason, for the purposes of these results, DHCD shelter placement will be grouped with DTA services.

Um, prior to them, like getting into the actual, um, shelter I had to go through DTA. And I had this, really, really bad, at the time, when DTA was actually here in Somerville, they had like a whole different housing um like um basically a homeless section. Like, the lady's name was Georgiana, I can't think of her name, but I remember her because she gave me such a hard time. (Lisa)

We went upstairs like I said 'cause it's two floors. We went back upstairs after lunch and the lady said, "Alright come in," and they took down like little things like, "Well do you have this?" Doug's like, "No." "Do you have a bank account?" "No." "Do you have, like, a car?" "Of course I do." "Well, how much is your car worth?" And, "You might have to get rid of it." And I'm like, "It's my only means of transportation." I'm lookin' at Doug and Doug's lookin' at me and I'm sayin' to myself, "I don't have nothin' for nothin' for nothin'," I said. And I go, "You're gonna tell me to sell my car?" So whatever you have or whatever you have to get rid of. (Georgia, Doug is her husband)

She was just rude. She was just rude about it. Like she acted like I knew what was going on and how it worked and I didn't. So she looked at me like I was asking stupid questions, and, you know what I mean, that just, I was pissed by the time I left there because they were, she was just so rude about everything. (Elizabeth)

Other participants had negative experiences when asking for help from the receptionists at DTA.

So I went downstairs and I had my cigarette. And I heard her call my number 'cause my husband was upstairs see, I wasn't alone. So I was comin' up and um, she's like, "Didn't you hear me?" In front of the whole place. And she was talkin' and swearin'. I go, "Doug, she's havin' a bad day." (Georgia)

And whoever answers the phone, the secretary, whoever she is um told me I had to deal with Dudley, told me I had to deal with Dudley. I'm like, "Look my case already got transferred to you guys. Like I got an application for Food Stamps in the mail…. From you guys. And she was like still screaming at me, she was wicked rude. (Charlotte)

But um, they just don't even want to talk to you, like at all, the front desk, the phone, you get no where. (Tracy)

Alex described how the receptionist at the DTA almost prevented her from seeing a case worker.

Yup I went to the reception and said, "I need to be placed somewhere." And the woman said, "Here's a card and phone number. Come back, she made you an appointment next week." And I said, "What the fuck you mean next week, I'm here right now." And I faught with the woman. I said, "It's against the law to put a woman and her children out on the street right now." So I sat down and I'm like, "I'm going to wait…"

H. Experiences with Initial Shelter Placement

Of the participants living at the SHC Family Shelter, some were initially placed in hotels or scattered sites before being placed in shelter. It was common for interviewees to have negative experiences at their placements outside the shelter. Elizabeth and Juana had not received any case management services when they were placed in hotels by the DTA.

> *... they don't give you the resources and the help that they do when you're in the shelter. And you don't know, they don't know how long. They can never ever tell you how long it could be. It could be a month, it could be a year you could be in the hotel. (Elizabeth)*

> Interviewer: *So you got to the DTA, they put you in a hotel, how long were you in the hotel?*
> *Two months.*
> Interviewer: *When you were in the hotel, did someone help you look for a house?*
> *No. (Juana)*

But Cecilia did have a supportive case manager working with her at the hotel without whom she would have fared much more poorly.

> *She helped me. She helped me, when I arrived I didn't have food, I didn't have anything. She bought me everything. She's a really good person. She helped me with many things. She also helped me fill applications.*

Only one of the interviewees, Georgia, was placed in a scattered site. She and her family were placed in an apartment in Dorchester. She felt it was unsafe for her and her family to live there and asked the DTA to move them, resulting in their placement at the SHC Family Shelter.

> *Only about three and a half weeks. It felt like years. Years. Kept the blinds closed, you know what I mean? During the day and everything was just shut down like no one lived there, I mean it was really bad. And to go outside we'd make sure it was like in the mornin' kinda early when no one was kinda really reminiscing and we'd be home before 3 o'clock because I mean that was before school got out and we wanted to make sure they were in the house and stuff. That was no way to live. (Georgia)*

The Department of Social Services (DSS)

Several participants had worked with social workers from DSS. Parents who had lost custody of their children for a period of time generally reported negative feelings towards DSS. However, some parents felt that DSS case managers had provided them with several services that they needed and had good experiences with their case managers. For example, Alex had lost custody of her children due to drug abuse and later regained custody after entering a rehab program. Despite the experience, she acknowledged that DSS had had a positive impact on her life.

> *Yeah, I don't really like them. But without them in my life, I'd probably be, I don't know, I don't know where I'd be. Probably still getting high. Probably shooting dope. So, grateful. I'm grateful that they're in my life. (Alex)*

In addition, she was receiving subsidized housing and child care through DSS.

> *My Section 8 is through DSS. I got on a list through DSS. I was approved at the beginning of the year and then because of the budget cuts I got denied. So I've been on this waiting list and they've said that it's going to come up in October… (Alex)*

Similarly, Lisa also reported that her DSS social worker provided her with additional support and help.

> *… but uh, like, you know, I, I had services through the Department of Social Services, DTA sucked but you know, DSS was really good, uh, I mean I think they kept my case open just to help me out, you know. My daughter went to camp and stuff like that through them. (Lisa)*

DSS had also intervened to help Lisa find shelter placement.

> *… I had a letter from DSS because they knew, you know, where I was living and there were only two bedrooms and there were about five adults living there, you know, and then my daughter and myself, so you know, when she placed me having a letter from DSS, Department of Social Services, really helped me… (Lisa)*

Cecilia had become involved with DSS after her partner had sexually abused her children. She was receiving TAFDC and case management services through SHC but relied upon DSS for additional support. When she was having disputes with the shelter manager, she called DSS.

> *Because a staff hit my daughter's hand. She was watching the T.V., I don't know what she did, she threw her hands on one way. So I got mad and I called DSS. I called them and said that they touched my kids. So DSS came to talk to them and the director got mad that I brought DSS and that someone was looking at my case. (Cecilia)*

In contrast to the experiences of the participants described above, Tracy felt that DSS had not given her the support she needed. She had lost custody of her children due to drug use and felt that DSS had presented her with unfair stipulations she had to meet to regain custody.

> *And um, they like, I asked them, they were like, "Alright you need to have a job, you need to have an apartment, and you need to have, like, this amount of sober time to get your son back." And I'm like, "How the hell am I supposed to get an apartment by like this amount of time? That's impossible, can you like provide an apartment for me, like an emergency?" And they're like, "No." So DSS through Malden was like, horrible. You know? It was just like they, they gave you like, things that they knew you, like, you weren't going to fulfill, accomplish, those kind of things. "You've got to find housing within six months." Like, impossible. (Tracy)*

Massachusetts Rehabilitation Commission (Mass Rehab)

As mentioned previously, Mass Rehab is a service provider that Charlotte, Tracy, and Lisa all utilized. The three women were using the program to help pay for their tuition for school but it should be remembered that Mass Rehab is an extensive program with many different services.

> *Um, like I want to go back to school. I want to go to U Mass for drug and alcohol counseling. Um, all I know is that the class starts in February. Um, but, like not everyone wants to go back to school. Like, they'll set you up with like, like people who will help you with your resumes or like stuff like that. Um, job fairs, stuff like that. (Charlotte)*

Participant experiences with government programs varied widely by service. While interviewees on the whole were happy with Food Stamps, WIC, Mass Rehab, and MassHealth, experiences with services that required case management including shelter placement, TAFDC, SSI/SSDI, and/or DSS services were less homogenously positive; these experiences tended to be affected by case manager-client relations. Some parents were initially denied TAFDC, SSI/SSDI, and

shelter placement and others faced numerous barriers to accessing services due to the wide range of requirements necessary to qualify for aid. Finally, the later services required more administrative work and took longer to arrange, resulting in long, uncomfortable waiting periods for parents and their families. In contrast, interviewees reported that Food Stamps, WIC, Mass Rehab, and MassHealth were on the whole, easy and did not have a long or complicated application processes.

V. NONPROFIT SERVICES AND SERVICE PROVIDERS

While government service providers and the supportive programs they run were important to many of the interviewees, nonprofits were another significant source of aid for the homeless families in this study. Families accessed a variety of nonprofit services including legal aid, case management, and health care.

A. Experience with SHC Case Management

Due to the nature of recruitment for volunteers for this study, all of the participants were receiving case management services through SHC, either at the Family Shelter or through one of the programs run at the central office. For many participants, the most important role of their case managers was to help them find subsidized housing and to help them with the applications. Many parents said they had not known about all available subsidized housing in Massachusetts prior case management. Lisa's statement below exemplifies the opinions of almost all the participants.

> *But in the process too at the shelter you fill out applications for housing you know and stuff. I never knew anything about housing like when I lived in Lawrence, I never you knew anything about housing you know, and getting a housing certificate and you know, you know. (Lisa)*

Some clients had tried to apply for housing programs before receiving case management and had found the experience very difficult, as exemplified in the interview with Charlotte.

> *I mean like, I had, went to Boston and just got the housing application to like fill out. And I put it in a drawer and just left I there because I couldn't even look at it without like being overwhelmed. Because it's just, you don't know how to answer some of the questions that they ask you. (Charlotte)*

In addition, as discussed before, SHC case managers helped clients find services for schooling, including MassRehab, and also helped them navigate the requirements of TAFDC and other service programs. However, the most utilized service was always housing assistance.

B. Experiences in SHC Family Shelter

Most of the residents of the SHC Family Shelter did not mention specific problems they had with the shelter itself. However, some mentioned certain problems they had with the rules or with workers.

> *Do everything that they tell you to do here. And follow the rules. It's hard, it makes you depressed here. Imagine. (Juana)*

> *Some days are a little more overwhelming than others. There's rules that I never thought of. Like I see more than I ever did, livin' here. (Georgia)*

> *[The worker who] comes in the evening and [the] one that comes at night that is also friends with her and [the worker] bothered me. And one day she yelled at me, here, in front of everybody, that I go to sleep. So I went in my room and she made a report that I had stayed outside, that I had yelled at her, that I had insulted her. And I don't know English. And so the director accepted that warning and I called DSS again. (Cecilia)*

Especially problematic for many residents was the rule that all residents at the Family Shelter had to apply to twelve housing programs each month. As a result, parents had to apply for housing they did not want in neighborhoods they felt were unsafe places to raise their children.

Alex described how she had gotten kicked out of her previous transitional housing program for not complying with the housing rules which were the same as those at SHC.

> Interviewer: *So then they said, "Okay because you're not applying to every single place you can, you need to leave."*
> *Yes, I wasn't in compliance with the rules. 'Cause I wasn't doing it.*
> Interviewer: *Is that rule here?*
> *Yes.*
> Interviewer: *You have to apply everywhere?*
> *Twelve a month. (Alex and interviewer)*

Elizabeth also discussed housing and how to best approach the DTA application requirement.

> *There's a lot, there's a lot to apply for. But you know, if you don't want to go somewhere you can't apply there because if they, if, they send you back a letter like if you apply somewhere you don't really want to go to, you're just applying to places, you have to pick that place or you will. Like if you say no, you'll get kicked out and you can't come back for another year. (Elizabeth)*

Another rule that bothered clients was that a portion of their income, whether it be through welfare or Food Stamps, went towards shelter fees.

> *It was a hundred dollars less than a usually get. And I didn't know why and I found out it's because we have dues that we pay to live here. So, if I got cash benefits they would take it out of my cash benefits but since I only get food stamps, they took it out of my food stamps. They take out like a hundred dollars from my Food Stamps. (Elizabeth)*

C. Experiences in Other Shelters

Charlotte, Tracy, and Alex discussed their experiences living in shelters other than the SHC Family Shelter. Charlotte and Tracy were living in the New Day shelter. Tracy was upset with certain aspects of the shelter but was having a good experience with the new case manager from her CASPAR program.

> *Um, at first, it sucked. Like the workers like the staff there were horrible. Totally horrible like they just ran the house like half ass. Like they didn't know what they were doing, they didn't understand addiction, I just don't think that they were right for the job. And they're both now gone and we have two new staff members and they're great. Like, they're very approachable and um, just like, they care,*

> *you know what I mean? They're not just there because they have to work, like, they're interested in helping you and seeing what kind of services they can help you with. Like my case worker, um, asks me like, "Do you want me to do this for you?" and like you know what I mean? (Tracy)*

Tracy also disliked the system used to purchase groceries. Food Stamp benefits were combined for all the members of the house and one of the staff members did the shopping for the entire house. Tracy felt that she and the other residents were not getting their fair share of groceries and that she should be allowed to choose the food she wanted for herself and her daughter.

> *And um the Food Stamps, they just take it right off your card. Like, they don't have your card. Like the benefits come on like an ATM card kinda, and like they have everyone's numbers that are across the card and everyone's like pin. And they scan it through this main like system and I don't even know how this works I never even heard of it until I came to the house. And they scan your card through and then all the food stamps from like your card and all the other girls go on this one card that Cindy has and she does the food shopping. And what the girls get in the house like as a total is a lot of Food Stamps and she don't even spend that much that she should be spendin'. So that's a big question on where the Food Stamps are going. (Tracy)*

Charlotte said that though the house had strict rules, she felt they were justified.

> *Yeah. Yeah. Most days. Yeah it's not, it's not bad. I mean, it's not necessarily a lot of freedom but right now, that's kinda what I need, I guess. (Charlotte)*

The New Day program, like the SHC family shelter also had a housing fee. Charlotte was applying for TAFDC because she needed a source of income after she stopped working as a waitress when her baby was born.

> *Well it's kind of a requirement in the house, like if you don't have a job you need an income. And being pregnant, I qualify. (Charlotte)*

In contrast to Tracy and Charlotte, Alex had not utilized CASPAR services. After going through rehab, she had lived in a transitional program before moving into the SHC Family Shelter. As mentioned before, she had refused to abide by the rules of housing assistance program of her shelter and had gotten kicked out.

No, because of a situation. I got kicked out because I wasn't going to my housing appointments. Because it was it's pointless to me. Like I've applied to all these different housings and I'm waiting for the one that I want. Like, I don't want to go to a projects. I don't want to raise my kids there. I don't want to be there myself because I know what goes on there. And like my kids deserve better than growing up in the projects. (Alex)

D. Health Care Clinics

Juana and Charlotte mentioned using a health clinic as a service provider for affordable health care. Cecilia and Rosa also went to health clinics and had received not only health care, but also help from social workers who directed them to additional service providers who could provide them the aid they needed. Both Cecilia and Rosa received TAFDC but since they were not specifically asked about Mass Health, did not mention the program. As discussed above, Rosa learned about Food Stamps at her clinic from a social worker. In addition, the social worker gave her advice when she was initially denied shelter.

Yes. There where the kids go, I go. She told me that I also tell her that they can't turn me away because I was also pregnant. I couldn't stay in the street. And she told me that if that if they turn me away again, that they do it written, because they couldn't do it verbally. And that they give me a card too and also where I could find more help. And she told me to bring that card and then we'll go to the lawyers so that they intercede for [me]. (Rosa)

E. Alcoholics Anonymous/Narcotics Anonymous

Alex and Tracy both participated in Alcoholics (or Narcotics) Anonymous and shared their experiences during the interviews. For both women, AA and NA helped them maintain their sobriety and the groups provided social networks of friends whom they relied upon for support.

I go to um, I try to get to two meetings every day, a noontime meeting and then a night meeting. And um, I go on commitments like at detoxes, I'll go up there 'cause they can't get to meetings in a detox. So I'll go up there and I'll talk to them. And um, like I have a sponsor and um, it's just like the twelve steps of AA. And I go through those with my sponsor. And yeah, I'm wicked involved in AA. (Tracy)

Like, I got there faithfully every day and like just sat there and listened and it got me. You know what I mean? Like I didn't want to be there, I hated it there but like, three months in I was like, "This is my life. Like, this is all I do. And it's keeping me straight and it's keeping me not thinking about going and getting high." So, it worked. (Alex)

Like I know that when I feel like killing someone, when I feel happy, when I feel anything like I know, I'll go to a meeting and there are people there who have seen me grow and change. (Alex)

F. Legal Services

Lisa and Greg were the only participants who had sought legal services. Greg got help in a custody battle for his children from Shelter Legal Services; his case manager at SHC had put him in touch with the program. For some time, he could not find legal services that would take up his case.

So when you're fightin', when there's a custody battle going on, lots of legal services, person who has custody of the kids they will work for, but someone who's tryin' to get it, so they were lookin' and sayin' no…. It was hard. We went everywhere and we couldn't get anyone. And then finally Shelter Legal stepped up and even when they took it they were like, "You know, this is a shot in the dark, but, it's a shot. We're not promising you nothing, but it's going to be tough. You know we work with Somerville Homeless Coalition quite a bit so. And they said this is a case they would like to see us work with. (Greg)

Lisa had found legal services on her own using internet research. With the help of Cambridge Legal Aid, she appealed DTA's decision to withhold shelter services from her for a year.

So I appealed it and I won by like a landslide. Like, the person who did the appeal said, "ha!" and also I got legal aide. I got somebody, her name was Ellen, and through Somerville or Cambridge Legal Aid and she was great, like she, literally, like worked it for me. Like, she went above and beyond what she really needed to do. (Lisa)

Nonprofits are important service providers for homeless families. They provide many different forms of support including legal services, addiction support groups, health care, shelter, and case management. Experiences will vary by provider and client; however, on the whole clients spoke

positively about their experiences with nonprofits. The exception was among programs that had strict rules, most often shelters; the rules alone could make a service or provider unappealing to a family. However, overall, clients benefitted from additional services besides those received through government providers.

VI. BARRIERS

Clients faced a variety of barriers when seeking services from both the DTA and nonprofits. Barriers included outright denial of services, language barriers, lack of information or understanding of services and their rules, or simply not having the necessary services available. Clients may have also faced disadvantages due to drug histories or limited social networks of family and friends, though such barriers are harder to identify in a small study. As a result, the focus will be the barriers that clients themselves identified.

A. Being Denied Shelter

Approximately half of the participants in this study encountered significant barriers when seeking shelter. Several clients were denied public shelter by the DHCD/DTA for varying reasons. Cecilia was told that there was no shelter space available for her and her family.

> Interviewer: *Okay so you went and they told you, why did they tell you they didn't want to give you shelter?*
> *Because there were a lot of people asking and there are people who don't qualify. Many things, they put on me. (Cecilia and interviewer)*

Rosa was told she did not qualify for shelter having failed to fill out the appropriate paperwork when she left her federal subsidized housing several months prior.

> *When I came from North Carolina when I was applying to get into the shelter, I was pregnant, I had the two kids and I was pregnant, I had, I was about, like six months already. So I went to ask for assistance for a shelter but they told me that they had a policy this thing a policy that I didn't give in my apartment. But I had given in my apartment. (Rosa)*

Alex was not denied shelter outright but, as described before, was told by the DTA receptionist that she should return in a week to meet with a case manager. Lisa was told that due to her dismissal from the SHC Family Shelter, she would be withheld Emergency Shelter for a year. Though Lisa did not end up needing Emergency Shelter, having been accepted into the SHC Better Homes program, she was still concerned about the possibility of not having shelter when she needed it and ended up seeking legal help to appeal the DTA's decision.

> *... you know she mailed me a letter stating, you know, that I was thrown out of the shelter and that basically I could never get Emergency Housing again, like, because I was thrown out of the shelter. (Lisa)*

In contrast to the other participants who had trouble accessing DTA shelter, Charlotte faced a different barrier. She was initially denied entry to a CASPAR rehabilitation program and as a result entered Sheppard House, a program run by a different nonprofit. Charlotte did not like Sheppard House (she said in her interview that their "harm reduction" policy allowed residents to get high while in the program) and later transitioned to CASPAR's New Day program.

> *It's a drug and alcohol program. And they wouldn't accept my referral because um, I was, like a few years ago my mom got sick and she passed away and I was put in a crisis unit for five days and like they said it was too soon for me to go into the program from the time I was in the crisis unit to go into their program. (Charlotte)*

B. Speaking Spanish

From the interviews and quotes included in the section above, it should be noted that only Spanish-speaking clients were told outright that there was no more space in shelter or that they did not qualify. Rosa and Cecilia both reported that they were told that there was no shelter was available for them or their families, despite the Massachusetts law that a family cannot be denied

shelter. Both women eventually found social workers who advocated for them, without whom they may have never have received shelter.

> *Understand? So they rejected me two times. But the girl who was there, my worker to find the apartment, right, the helper there for the coordinator of housing*? She told me that she was going to help me, that she was going to do everything possible. But in the end, she got it for me. (Rosa)*
> ** from her previous subsidized housing program*

> *So I called the woman, her name is Sylvia, Sylvia –*, and she told me no, because of the case I had they had to give me shelter. And she herself went to talk to the director of there. (Cecilia)*
> ** a case manager from a different program*

Though Rosa and Cecilia were both initially barred from shelter services, Juana (who does not speak any English) said she did not have any trouble applying for shelter and was quickly placed in a hotel before being moved to the SHC Family Shelter.

C. Understanding the Requirements of Service Providers and Services

Several clients mentioned that certain TAFDC or Food Stamp rules dissuaded them from applying for services. Misinformation made clients question whether it was worth applying for services because they were not sure they would receive any benefits.

> *I mean basically now you can do things online like I didn't even realized I was eligible for Food Stamps, I mean I just reapplied last year, because I thought I made too much money. Like, a lot of people that like made the same amount of money as I did were only getting like ten dollars. (Lisa)*

Cecilia thought she would have to leave her job to receive Food Stamps. She did not know Food Stamps was a program aimed to help all families without sufficient income to meet the nutritional needs of their families. Cecilia said that the DTA workers told her she did not qualify for the program due to her employment, despite making less than the income limit for a family of four.

> *Because one of my friends is alone with her kids also. And she had that program. But to me they didn't want to give it to me either because they told me that I worked, that I would have to leave my job. (Cecilia)*

Charlotte was worried that her baby's father would have to pay back the money she received through TAFDC. As a result, she was hesitant to apply for welfare because she did not want to place an unnecessary burden on him. However, TAFDC is for families without sufficient income and does not seek reimbursement from fathers for child support.

> *Well I don't know. It's not like I have to pay the money back but like, the baby's father might have to pay the money back. And like he'll probably like take care of the baby anyways, like, he's a good guy. We talk all the time and stuff like that. So, I don't really know. But like I haven't sat down with a case manager and got to really like learn anything about it so I don't really know, like. (Charlotte)*

D. Concern for Family Safety in Housing

Several parents expressed a desire to keep their children out of particular neighborhoods. Refusing to apply to certain housing projects not only limited the services a family had available to them, it also meant that parents were at risk of being barred from shelters for not following DTA regulations. The following statement made by Georgia exemplified the opinions of many parents:

> *Yeah. And the projects but I don't want to go to the Projects. That's something that, I don't want to bring my kids there, you know what I mean. 'Cause it's just something that, I don't know I have a thing with the projects. I think there's more violence when it comes to the projects, more drugs, more you know just a lot of alcohol. Things like that. And I never brought my kids around stuff like that or around things like that. (Georgia)*

E. Getting Low-Income Housing

Many clients were homeless simply because they had nowhere else to go while they waited for subsidized housing to become available. Alex described before how, having applied to the housing programs she was interested in, she simply had to wait for an opening. Lack of low-

income housing was the biggest barrier clients faced that forced them to remain homeless. Several clients could not afford certain private low-income housing projects because they did not have sufficient income which further limited their housing options.

> *I was denied housing for numerous places, um, 'cause it wasn't enough income. I mean I forget all the, I have a stack of papers like this. At least about, maybe a good two and half inches, maybe three inches, you know paperwork that I've already applied to for different cities. I even went as, to go to Maine. (Georgia)*

Waiting lists for subsidized housing, many of which are several years long, and lack of Section 8 vouchers not only keeps families from becoming housed but can also pose additional barriers. For Greg, not having housing was preventing him from regaining custody of his children.

> *"Boy this doesn't look to good right now." You know, homeless, which was a big thing at the time. They're like, "You don't even have a place to keep the kids if you win." (Greg)*

F. Ineffective Case Managers or Lack of Case Managers

Certain programs including TAFDC, Food Stamps, and shelter placement require clients to be assigned to a case manager. Frequently, as described previously, a clients experience will hinge on whether or not they have an effective or ineffective case worker. Having an unhelpful worker can prevent families from getting the services they need. Charlotte was having trouble applying for TAFDC because her case manager would not return her phone calls.

> *I can't get a hold of my case manager, like I can't get an appointment. I'm not going to take a day off of work to just like go sit there all day when like, they should be returning my phone calls.(Charlotte)*

When Juana and Elizabeth were in hotels, neither of them had a case manger that helped them apply for housing or find services. They felt that there was nothing they could do but simply wait to be placed in a shelter where someone would be available to help them.

> *Yeah they don't have anybody helping you. They just throw you in there. And that's it so you're just sitting in a hotel waiting. (Elizabeth)*

The diversity of problems that inhibited clients including language barriers, educational barriers, program rules, and ineffective case workers demonstrate the complexity of the homeless system and the numerous ways in which it can fail. While some barriers are due to the personal attributes of a family (such as language or educational barriers), many barriers, such as having an unhelpful or unwilling case worker at the DTA, are outside a parent's control. Regardless, barriers have a strong impact on the future of a family and must be addressed. Finally, it is clear that certain people with greater knowledge or experience have an advantage over others when navigating the homeless system in Massachusetts; it is not an even playing field for all families. Families should not be blamed for the lack of information they possess; rather, more should be done for them to gain information and access to services.

VII. FACILITATORS

A. Workers Who Speak Spanish

Finding a case manager or social worker who spoke Spanish was very important to the success of Spanish-speaking participants. For both Food Stamps and case management programs including TAFDC, Hispanic participants said they were assigned to a Spanish speaking case-manager. Additionally, Rosa and Cecilia found social workers or case workers who spoke Spanish and advocated for their shelter placement. At the SHC Family Shelter, Rosa, Cecilia, and Juana all depended on the presence of one of the shelter workers who translated between them and the case manager.

B. Having an Effective Case Manager

Several clients mentioned that their case managers had helped find them services including housing, Food Stamps, and Mass Rehab. Case managers also advocated for their clients when

they were denied aid or did not receive all the benefits for which they qualified. Case workers could be a part of government or nonprofit service programs and case managers outside the DTA sometimes helped clients with problems they were having with DTA services. As described before, a social worker at a health clinic helped Rosa when she was denied shelter and Greg's SHC case manager was the one who recognized that he was not receiving enough SSDI benefits. Charlotte discussed how her case manager at SHC helped her when she could not get in touch with her DTA worker.

> *And every time I might have called, her voice mailbox is full and cannot take messages. Like last Friday, I had Erin call. And she left a message and I don't know if, like, she's gotten back to Erin. But she hasn't called me. (Charlotte)*

Help from DSS case workers, as described earlier in this chapter, was very important to both Lisa and Alex. Lisa's case worker helped her receive shelter and arranged for reimbursement for transportation fees. Alex received a Section 8 voucher and child care services through DSS. Both women benefitted from having a case worker who helped them gain services (especially Alex's subsidized housing voucher) that were unavailable to parents who did not have DSS involvement. Case workers who are true advocates for their clients and try to get them every service for which they qualify are invaluable to homeless families.

C. Being able to Advocate for Yourself

Several clients said that in order to receive services and navigate the homelessness service system, the most important quality anyone can possess is determination and the ability to advocate for oneself. The ability to advocate correlates with knowledge of services that are available. For example, Alex knew that it was against the law for families to be denied shelter and argued with the DTA receptionist to be granted shelter. Similarly, Lisa did research to learn

about supportive programs she could use. Lisa described having to work hard to be accepted into SHC's Better Homes program.

> *I'm pretty, I, I advocate for myself pretty well, I think, and so I usually know where to go and what to do. (Lisa)*

Parents have to be demanding if they hope to be noticed and get services. When denied shelter, Rosa's insistence that she needed shelter for her and her family eventually convinced a case worker to advocate on her behalf.

> *No me being there from so much insisting, insisting, insisting with her. She would tell me, "Send me the paper by fax." I didn't, I would go there to drop it off. So I don't know, like she saw me, right, like how much need I had for the shelter. (Rosa)*

There were not as many reported facilitators that had improved clients' access to services as there were barriers. Namely, the majority of facilitators that helped participants were the opposite to the listed barriers such as having Spanish-speaking workers, understanding the rules of DTA and nonprofit programs, being able to find available services and advocate for oneself, and having a helpful case worker. By understanding the barriers that inhibit families, it is easier to recognize how facilitators can be created which make access and navigation of the homeless system easier for families.

CONCLUSION

The results reported above demonstrate the complexities of the homeless system and the resources families depend on to navigate it. Parents described different ways with which they found supportive programs through word of mouth or alternatively from other service providers; the different methods indicate which services are known of among the general population and which are not. The varying experiences families had both between different services and within

the same service provider is evidence of the heterogeneity of the homeless system. Despite overarching rules and regulations, a families experience is mostly left to chance. Parents described being unable to access certain programs (TAFDC, shelter, and housing), unavailable services they needed (child care and housing), and programs they considered unacceptable for their families (housing projects in rough neighborhoods), all of which were different kinds of barriers to services. Not only does the complexity of the homeless system and the barriers that exist cause families to be reliant on case managers, the system itself forces parents to depend on case workers to administer services to them. The majority of services a family receives at the DTA are only available to them after having been assigned a case worker. As a result, parents cannot navigate the homeless system alone, even if they wish to do so, and the barriers to services are insurmountable without help from an administrative authority.

* * *

CHAPTER 4:
DISCUSSION OF RESULTS AND PROPOSALS FOR IMPROVEMENTS FOR HOMELESS SERVICES

Through interviews with a variety of homeless parents working with SHC, it was possible to identify the barriers and facilitators heads of homeless families experienced when finding and utilizing supportive services. The results suggest overall trends in the experiences families had with certain service providers and variability in the barriers families faced. It is possible to hypothesize why families had certain experiences and how both barriers and facilitators are the result of the convoluted creation and current structure of the existing homeless system. Certainly, part of the reason for the variation in participant experiences had to do with the clients themselves. However, the strength in this study is that it does not focus on why a *client* might be at fault for causing him/herself to have a negative experience. Instead, the goal is to understand why certain services are better able to meet the needs of a wide variety of clients while others are

not. Using a community-based approach in which participants were asked to identify where they struggled to get services lent particular strength to the study. Clients were able to describe the problems with services that had most negatively affected them and in this way, indicate what areas in homeless services that are in greatest need of attention.

The study has several potential limitations that should be considered. Primarily, there was a small-study group limited to the clients of Somerville Homeless Coalition. As such, the clients could have, potentially, shared certain factors in common that differentiated them from other homeless families in Somerville, making this study less applicable to the general population. However, the diversity of clients working in programs within SHC, especially those who resided in the Family Shelter, is representative of the broad range of homeless families in Boston and speaks to the validity of the study.

A second limitation was that the study focused on residents in Somerville and as a result, the clients' reports on nonprofit and DTA services are limited to Boston services and specifically, the DTAs located in Malden, Revere, and the old DTA office that was previously located in Somerville. While results cannot be generalized to all of Boston, it is generally well-known that there are problems at DTA offices throughout the United States and that there is a practically nation-wide need for improvement. Unfortunately, this study could not include interviews with DTA workers. Attempts were made to interview workers at the DTA in Revere but interview requests were denied without previous approval from a supervisor. Though initial correspondence was made, the contacted DTA supervisor stopped responding to emails after receiving a project description of the study.

The study was limited to the reports volunteered by the participants. As a result, any information they chose to omit or did not include because they had not been directly asked was

lost which could have impacted the results. Participants may have felt uncomfortable answering certain questions on the quality of services rendered if they felt their answers could have negative repressions in the future. Furthermore, several participants living at the Family Shelter chose to conduct their interviews in the common-space so they may have altered their responses in case they should be overheard. Such complications are impossible to eliminate entirely from qualitative studies but their impact on the results should always be kept in mind. Analysis of the interviews was performed by a single person (me) which increased the chance for bias.

This chapter will discuss the implications of the study's results and describe possible methods for improving the homeless social service system. The first section presents the meanings of the varying ways in which families learned about social services. The second section investigates possible reasons behind the varying experiences clients had at the DTA. The third section focuses on client experiences in shelters, hotels, and scattered sites. The fifth section discusses limitations of nonprofit services and the sixth section looks into the inadequacy of available housing. The sixth section presents personal characteristics that help families survive. The seventh and eighth sections present both short-term and long-term solutions for improving the homeless system of the U.S. Finally, the ninth section provides possible avenues for expansion of this research in future studies.

I. HEARING ABOUT SERVICES

During the interviews, participants described how they found various services. Several interesting trends existed among the participants. The most obvious was that government services, including Food Stamps and TAFDC, tended to be heard about by word of mouth from friends and family while nonprofit services, including rehab programs and SHC, were learned

about from service providers. Few clients reported learning about any service providers or services through advertisements, such as brochures or posters, or through their own private research. Among the majority of participants, the DTA was a well known service provider and most clients treated it as "common knowledge" that from there one had access to Food Stamps, welfare, and shelter services. It is important to recognize the situations in which this was an exception: Rosa, a Hispanic immigrant from South America, learned about Food Stamps through a health clinic that recognized her need for food assistance for her children. With a limited social support network compared to the other interviewees, Rosa had less of an opportunity to learn about government assistance through friends or family.

The ways in which interviewees learn about different services can strongly impact service use and access. Services that are well known are more relied upon than those that are more obscure. Since the majority of participants knew about the DTA, they were more likely to have accessed its services on their own. Additionally, the DTA was frequently the first place clients went for help and often they only went once they were already homeless (with the exception of Food Stamps which participants used prior to being homeless). None of the clients who applied for shelter reported seeking preventative services to try to maintain their housing.

None of the interviewed participants had accessed nonprofit rental assistance or case management programs before becoming homeless. Nonprofit case management can be an important source of additional information on service providers and thus is an important facilitator in increasing service use. For example, several participants described learning about educational opportunities or legal aid through their SHC case managers. However, because participants learned about nonprofit services once they were already homeless, they had had no exposure to preventative services. As a result, nonprofits acted as reactionary service providers.

If nonprofit programs are to be relied upon as the primary providers of preventative services, there is an enormous need to increase knowledge and education on available nonprofit services in Somerville. Federal policy change indicates that the U.S. government is hoping to increase use of private service providers while diminishing use of federal services but until people know about the nonprofit services that are available, the diminishment of federal programs will simply leave more and more people without the support they need.

II. VARYING EXPERIENCES WITH GOVERNMENT SERVICES

Participants reported a myriad of experiences with government services, some good and others unpleasant. Additionally, participants who received the same service often had varying experiences. In general, participants had a good experience when applying for and receiving Food Stamps and WIC, but had more mixed experiences with shelter placement and TAFDC services.

A. Comparing Experiences With DTA Services

Most participants reported that they were satisfied with the services they received through the government food assistance programs. Parents reported that SNAP, and WIC if they had young children, helped them feed their families when income was tight. Additionally, the majority of parents reported that SNAP had a straightforward application process that did not take long and that they were satisfied with the case workers.

In contrast, interviewees had mixed experiences when applying for shelter and TAFDC. Many participants had a negative experience when applying for shelter. Parents reported that the application process could take the entire day or more. Some families were not placed in shelter

the same day they applied and Cecilia and Rosa were initially denied shelter. Participants had to wait in small rooms with their children until a case manager who worked in shelter placement was available. Many reported that the receptionists were rude and lacked compassion and several interviewees felt that the case managers who placed them in shelter treated them as though they were ignorant. In contrast, other women including Junana and Alex had good experiences with the case managers that handled their shelter placement.

Similarly, clients had mixed experiences when accessing TAFDC services. Some clients had many problems with their TAFDC case managers. Charlotte could not get in touch with her case manager and Cecilia was initially denied TAFDC until another worker advocated on her behalf. Others, like Tracy, had case managers who were efficient and helpful and quickly got them the benefits they needed.

Client experiences tended to vary by case manager as well as service. While the participants who were interviewed had received services from DTAs in a variety of locations (namely Malden and Revere), the location of the DTA did not have a strong impact on the quality of the services. Additionally, not enough information was gathered to successfully compare client experiences at different DTA locations.

B. Potential reasons for varying experiences

There was an impressive amount of variability among client experiences with DTA services. DTA services are intended to be normalized by overarching policy guidelines yet interviewees who went to the same office had completely different experiences. Part of the variability is due to the differences in service structure and requirements between services. For example, SNAP and TAFDC have very different requirements and as a result, vary considerably

in their provision of services. The SNAP program is currently attempting to expand its services and reach more of the eligible population of the United States (DeParle 2009). As a result, SNAP enrolment is encouraged and requirements are kept simple. Eligibility is determined based on income and assets alone. Clients provide proof of their income, assets, and family size and within several hours case workers can award them SNAP (DeParle 2009). Similarly, WIC has straightforward eligibility criteria and an easy application process. By reducing organizational control, more clients are helped and services are provided quickly.

In contrast, TAFDC and shelter provision are two programs that have a large number of regulations and "red tape" in order to limit eligibility and reduce expenditure. Due to limited shelter capacity and funding for welfare, both programs are constantly trying to reduce the number of clients they help and services they provide. In contrast to SNAP which has expanded, in the past twenty years federal policy has attempted to reduce TAFDC use and expenditure by increasing restrictions on eligibility. As a result, clients must present extensive amounts of paperwork and are interviewed to determine whether they are needy enough to qualify for aid. Additionally, in both the shelter and TAFDC programs, case workers are constantly tracking their clients to ensure that they continue to meet the requirements for each program (such as applying for housing or working enough hours). The additional requirements and restrictions of TAFDC and shelter services cause the intake and processing of clients to take longer, adds to the workload of case managers, and decreases the number of participants in the programs.

Within TAFDC and shelter services, some participants had good experiences with their case workers while others did not, suggesting variability among the case managers who work within different programs. It is not surprising that all case workers do not all handle their clients in the same way and a significant amount of research has been dedicated to determining why and

how case workers differ in the impact they have on the clients. Before examining the differences among case workers at the DTA, it is important to look at their similarities. Being a case worker is an incredibly stressful and demanding job. Case managers frequently work in poor conditions, with difficult clients, and in unsafe neighborhoods (Maynard-Moody 2000). Often, they juggle over one hundred cases, all of which include clients in varying states of distress, require a large amount of paperwork and attention, and consistently demand the repetitive process of determining eligibility (Watkins-Hayes 2009). For her book, *The New Welfare Bureaucrats*, Celeste Watkins-Hayes interviewed case managers from vocational rehabilitation and welfare programs in Massachusetts. One case manager described her work as, "Case maintenance and eligibility [determination] is a good 75 percent of your job…. You don't really have time to sit down and work with people. You deal with people and you may hear their problems, but there's only an extent to which you deal with it" (Watkins-Hayes 2009, 49). That being said, each case manager handles her cases differently and in choosing whether to involve herself more or less with her clients. The result is varying experiences among clients using DTA services.

In her study, Watkins-Hayes identifies several variables that differentiate case workers and the ways in which they interact with clients. She found that some case managers were "distrustful and terse" with clients (Watkins-Hayes 2009). Part of the reason for a more administrative approach was that it increased efficiency and helped case workers to quickly weed-out ineligible applicants; in addition, some case workers said it helped them detect "fraud" (Watkins-Hayes 2009). In contrast, other case managers tried to find any and all programs their clients qualified for and helped them maneuver the complicated welfare system. As one worker put it, "'My question is what can I do to help them out, make it a little easier.'" (Watkins-Hayes 2009, 53) While all case workers have to deal with the same legislative and administrative

constraints, what ultimately impacts the experience of a client are the attitudes of the case worker and how he chooses to handle his job. In a paper contrasting different case workers and the ways in which they work with clients, Steven Maynard-Moody and Michael Musheno summed up the idea described above by saying, "[Rules are] an essential aspect of bureaucratic life, yet rules and procedures provide only weak constraints on and loose parameters around street-level judgments. Street-level work is, ironically, rule saturated but not rule bound." (Maynard-Moody and Musheno 2000, 334) Essentially, the authors found that while case workers had to follow an extensive number of guidelines and procedures that dictated the decisions they should make, the ways in which case managers handled clients was their own decision. There is no way for every case and every client to fit within the rules and it is up to the judgment of the case worker to determine what will be done in each situation (Maynard-Moody 2000).

In their work, case managers simultaneously wield a lot of power and have none at all. While their discretion decides who gets aid and who is denied, they are at the bottom of the administrative hierarchy and cannot control the conditions they work in or the rules they work under. Case workers can be motivated by a number of pressures. For most, there is the desire to help their clients and improve lives. However simultaneously, case workers can be motivated by self-interest to make decisions that will make their work easier, safer, and more productive; by choosing to take on easy clients and refusing services to more troublesome ones, the self interest of case workers impacts their work (Maynard-Moody 2000).

Training and professionalism, in addition to self interest and personal beliefs, has a strong influence on case workers. Watkins-Hayes found that case workers who considered themselves social workers and had training as such handled their cases differently than the workers who did not believe they did social work. Case workers frequently help clients find job training programs

and work so that they can continue to meet the requirements for TAFDC. Social workers tended to be more creative when helping clients, trying different methods to make them self-sufficient and providing them with multiple forms of aid; social workers were also more likely to allow their clients to make their own decisions regarding their job training and in forming their "professional identities" (Watkins-Hayes 2009). In contrast, employees who did not see their work as social work believed their agency had less of a responsibility in meeting the job training needs of their clients and did not encourage client involvement in developing their professions (Watkins-Hayes 2009). As indicated by the results of this study, case workers can act as either a barrier or facilitator and have a large sway on a family navigating the homeless system. While an ingrained component of the homeless system, the reliance on case managers results in a support system that forces families to depend on external players completely.

While case managers play an important role in determining the services clients receive and the ease with which they attain aid, clients themselves also influence their experiences with DTA services. As mentioned before, clients whose cases are complex or whose personalities make them more difficult to interact with are less likely to receive aid while clients that appear especially needy or "nicer" are more likely to receive special treatment (Scott 1997). While clients must be willing to submit themselves to the authority of their case managers, clients who are more demanding or more knowledgeable of available services are more likely to receive aid. Therefore, clients with knowledge of the welfare system and its intricacies have a distinct advantage over others (Scott 1997). Conversely, clients who do not know the welfare or shelter rules are at a greater risk of being denied services; this was demonstrated in the interviews with Cecilia and Rosa who were denied shelter despite being homeless with their children and who

did not know that by law, they had to be granted shelter. Additionally, clients who do not know of available services or who believe they are illegible are less likely to seek aid.

C. Experiences with the Department of Social Services

The Department of Social Services (DSS) was an important resource for several parents who had had previous DSS involvement before becoming homeless. Experiences were varied; some mothers accepted and desired help from their DSS workers while others resented DSS involvement and preferred to dissociate themselves from them. Parents who were involved with DSS had either been at risk of losing custody of their children or had temporarily lost custody. The placement of children into foster care is a controversial issue, especially among homeless families where parent-child separation is more common than among housed families. However, in this study, the mothers who lost custody were separated from their children due to drug-abuse, before they applied for shelter and thus separation was not due to homelessness. Separations can be very traumatic for both parents and children so it is not surprising that some parents expressed resentment against the DSS. Studies have shown that children in foster care are at higher risk for mental health problems due to both the trauma from separation and the potential mistreatment they had when living with their parents (Clausen 1998).

Despite the evidence which demonstrates the ill-effects of parent-child separation, it cannot be denied that in certain situations, separation from a parent is the lesser of two evils for children in unsafe households. Additionally, successful DSS case workers can provide extra support to parents through subsidized housing, child care, and other programs which are intended to help stabilize a family so the parents and children can be reunited. The mixed DSS experiences among participants in this study were most likely due to differences among case

managers which varied for the same reason that participants had mixed experiences with their case managers at the DTA. While Alex and Lisa had helpful case managers who gave them the resources they needed, the case manager in Tracy's story made little effort to help her accomplish the provisions set forth by the DSS so she could regain custody. Once again, case workers can act as both a barrier and a facilitator in helping homeless families.

III. EXPERIENCES IN SHELTERS, HOTELS, AND SCATTERED SITES

A. Hotels

When parents sought shelter at the DTA, they had the chance of being place in one of three locations: a family shelter, a hotel room, or a scattered site. Families who did not enter a shelter remained at their designated location (scattered site or hotel) until space in a shelter became available. Participants reported several problems with the hotels in which they stayed. While the hotels previously had case managers present at least once a week, participants found that most case management programs have been cut due to budget cuts. Homeless families in hotels did not have access to case management to the same extent that families in shelter did and simply waited until they were placed in shelter, sometimes for several months, to receive case management. During the waiting period, lack of information or knowledge of available supportive services was detrimental to families. Parents did not know of nonprofit supportive programs that were available outside the DTA so they did not know they could seek aid from a nongovernment source. Additionally, many parents reported not knowing of available subsidized housing and only Elizabeth filled out applications for the housing programs of which she was aware. Without the necessary knowledge of additional nonprofit services within the homeless system, families simply waited in the hotel for help, as they were instructed by the DTA.

Families in hotels are without the resources to help them exit homelessness or the necessary tools to find these resources themselves. Additionally, the location of the hotels outside Boston was a barrier that prevented parents from being able to look for housing, jobs, or supportive programs. Furthermore, Elizabeth reported that she was required to be present at the hotel at midday each day to hear from the DTA whether she was to be moved into shelter; such rules can further limit parents' ability to find help, jobs, or housing themselves. The combination of lack of resources, poor locations, and restrictive rules are all barriers that keep families in hotels from exiting homelessness. The longer families are homeless, the more expensive they are for the government and the higher risk they have for detrimental health and mental health condisions. Overall, hotels act as a significant barrier in ending family homelessness. While they do provide temporary shelter, they are an expensive solution that simply exacerbates the problem by keeping families stagnant within the homeless system.

B. Scattered Sites

Only one family in this study was placed in a scattered site before being moved to the SHC Family Shelter. Though this is by no means a large enough sample size to make conclusions on scattered sites in Boston, it should still be noted that Georgia's main complaint was that her family was unsafe in their apartment in Dorchester. She did not mention that lack-of-access to a case manager was a problem but the lack of safety was enough for her to demand that her family be moved.

C. SHC Family Shelter

All the families in this study who were initially placed in hotels or scattered sites were eventually placed in the SHC Family Shelter. They, along with the parents who had been placed there directly by the DTA, reported both positive and negative experiences in their shelter stay. Participants were very satisfied with the case manager who helped them locate and apply for subsidized housing and find additional supportive services. Several participants reported that without the case manager, they would not have been able to find housing or aid alone, echoing the statements of parents in hotels who did not find housing or supportive programs on their own. Once again, the stories show how critical a good case manager is for facilitating navigation of the homeless system and that many parents simply do not have the information they need to be able to find housing and aid alone.

Though parents rarely spoke directly of the problems they were having, the overall rigidity of the shelter rules makes living there very difficult for families. Shelter rules are created both by the DTA and SHC shelter administrators. There are curfews, restricted times in which parents can cook or do laundry, and only one night out (of shelter) each week for parents. Parents who spend more than one night out of shelter are considered by the DTA to no longer be homeless and in need of shelter. It is argued they have another place where they can stay and are kicked out. Parents did not speak too extensively about the problems they had within the shelter or disputes they had had with other shelter residents and workers, probably for fear that it would have negative repercussions. However, the one shelter rule parents were most openly opposed to was the requirement to apply to twelve housing programs each month. The rule is enforced by the DTA in order to ensure that families are making an effort to exit homelessness and are not staying in shelter unnecessarily. For many families, the rule forces them to apply for housing in

areas where they do not wish to live or that they feel are unsafe for them and their children. Alex explained how she did not want to move back into a neighborhood in which she had previously used drugs, both for her children's sake and hers. Parents who do not follow shelter rules, especially those enforced by the DTA, are at risk of being kicked out of the shelter and denied Emergency Services in the future.

DTA shelter rules, though arguably needed to maintain some organization among homeless shelters, are still a notable barrier between families and resources. Parents who harbor resentment against the shelter manager or case manager for the rules they enforce may be less cooperative which can create tension within the shelter and impact the help they receive. Additionally, families who are kicked out of shelters are frequently barred from additional shelter services, as seen in Lisa's story. It is necessary to review shelter rules in order to determine which are necessary and which create more problems than they are worth.

IV. NONPROFITS

The stories recounted by the parents of this study show both the importance and the limitations of nonprofit services in the homeless system. All the participants of the study were receiving case management from SHC and benefitted enormously from it, reporting good experiences with case managers. However, at the same time, participants said that they did not use many additional nonprofit services, unless directed to them by their SHC case managers. Furthermore, the results showed that most participants accessed nonprofits having learned about them from a different service provider, most often a case manager. The limited use of nonprofits and the inadequate independent knowledge of nongovernmental services indicate that there is a dearth of information and education on nonprofit services among low-income families. The

inadequacies of nonprofit services are partly due to the methods in which they are created. Nonprofits are frequently a community response to a local social problem and thus incapable of filling the large gap left by the shrinking welfare system.

A. Nonprofits' History and Structure in the U.S.

Nonprofit organizations have existed since colonial times in the form of hospitals and children services. However, until the 1950s, nonprofit funding was largely private and it was believed that the government should assume most of the responsibility over social problems (Smith 1993). Federal funding of nonprofits began in 1964 with the establishment of the Office of Economic Opportunity (OED) as a government response to public pressures to expand social services. Both government-sponsored agencies and community agencies developed as a result of the new funding. Government-sponsored agencies were created through collaboration between government officials and social welfare advocates to create additional service programs (Smith 1993). Community agencies were generally formed through a grass-roots volunteer effort (Smith 1993). During the Reagan era, social programs experienced a significant cut in funding. However, through the Stweard B. McKinney Assistance Act passed in 1987, homeless services received an increase in funding with spending concentrated on single adults and drug and alcohol programs (Smith 1993). At present, nonprofits continue to grow and are increasingly relied upon as a social service provider yet remain without the funding to keep up with inflation and the increasing poverty in the U.S. (Smith 1993).

The increased government funding has correlated with increased government involvement in the organization, structure, and service administration of nonprofits. While government involvement can help establish a "standard of care" that ensures the public receives

services of quality through private providers, it simultaneously limits nonprofits to rely upon more accepted, not necessarily better, and often antiquated, service philosophies (Smith 1993). For example, the government administration implements the rules on housing applications and out-of-shelter nights on families in the SHC Family Shelter. The rules are not only a barrier for families but also add difficulties to the nonprofit administrators who have to enforce them. In addition to directing service administration, government involvement sways the election of directors and employment of personnel so that the organization can meet government regulations. Directors are required to have experience with fiscal and managerial responsibilities rather than simply being dedicated community activists while workers are expected to have the proper training and credentials (Smith 1993).

B. The Impact on Clients

Despite their limitations, nonprofit services should not be underestimated. Participants of the study reported satisfaction with many of the nonprofit services they received including health care, legal services, and drug rehabilitation. Nonprofits are able to provide important and necessary services to clients that, for the most part, meet their needs. Nonprofit programs, which reach a smaller population of clients than public programs, tend to provide more personal services including better case management. Participants of this study universally reported positive experiences with their SHC case managers while experiences with public DTA or DSS case managers were more varied. In part, this may be due to the smaller caseloads of SHC case managers (between 5 and 30-40, depending on the program) and DTA case workers (over 100). However, at the same time, the limited size of nonprofits leaves many families and individuals without support. Nonprofits are only capable of helping a certain number of clients due to

financial constraints are limited in the extent they can respond to massive increases in need, such as during an economic recession, unless there is an appropriate increase in funding from the government.

Nonprofits, due to their small size, generally dedicate themselves to a single service. Some may focus on service provision, such as a legal-aid program, while others, like SHC, provide case management to direct clients to available programs from other groups. Despite the availability of nonprofits in Boston, SHC case managers rely extensively on government services for their clients, directing them to programs such as SNAP, Mass Rehab, and MassHealth, indicating that nonprofits alone are not enough to provide the services clients need. Nonprofits tend to reach small populations because they are not as well-known and can have a limited geographic scope, an exception being Alcoholics Anonymous which was very important to several participants and is a nationwide program. In contrast, government services, more well-known and universally accessible, are more heavily relied upon by the low-income population. While the nonprofits of Boston are providing important services to their clients and filling the gaps in the safety net which result from diminishing government programs, government services remain the more universal and known service provider among homeless families in Somerville. In the immediate future, increasing education on existing nonprofits will help needy families have a better knowledge of available services. Later, if nonprofits are to become more extensive service providers, they will need the appropriate funding to increase their targeted population, geographic scope, and provided services.

V. HOUSING

Housing is an important topic for any homeless individual and the families in this study were no exception. When asked what services they lacked, several participants responded that what they needed most was housing. In addition to simply having to wait for affordable housing to become available, participants reported trouble finding housing programs and difficulty with the applications.

A. A Lack of Affordable Housing

Among the participants who were currently residing in shelter, the universal problem they all faced was a lack of housing which is, ultimately, the cause of every case of homelessness. The absence of affordable housing is a relatively new phenomenon in the United States that has driven a huge rise in homelessness among both families and individuals. Every single participant of this study who was residing in a shelter was waiting for affordable housing to become available, including the mothers participating in CASPAR's New Day program.

In addition to a general lack of affordable housing, many participants were upset at the lack of safe housing that was accessible to them in Boston. As discussed previously, participants were opposed to applying for subsidized housing in unsafe neighborhoods because they did not want to expose their children to drugs and violence. Parents who refused to applying to certain housing projects not only reduced the pool from which they could find affordable housing but also risked getting kicked out of shelter for noncompliance.

With the cost of maintaining a family in shelter significantly higher than the cost of simply paying the rent, it remains unfathomable as to why families have no choice but to remain in shelter for months at a time as it does not benefit anyone. Part of the reason is simply habit.

For years, the United States government has supported an antiquated homeless system that focuses more on providing emergency shelters and supportive programs for the chronically homeless than it does on prevention programs that keep families and individuals housed. Despite the evidence that a family who receives preventative services to maintain their housing is likely to remain stable, preventative programs have not been as widely recognized or supported. However, the antiquated mentally may be beginning to change. A recent report by the Department of Housing and Urban Development conducted on 9,000 homeless families and individuals confirmed that the federal government spends more providing short term shelter and service than it would paying the rent for permanent housing (Bello 2010). It was estimated that the city of Washington D.C. spends between $2,500 to $3,700 to provide shelter for a homeless individual per month (Bello 2010). Though costs vary widely throughout the U.S., with 1.6 million people homeless in 2008, the resulting cost is still very high (Bello 2010). The government is reacting to the evidence. The Obama administration included $1.6 billion dollars in the stimulus package to promote preventative homeless programs (Bello 2010). However, there is still significant opposition to preventative and rapid rehousing programs from the public. Many people are of the opinion that homeless parents have failed at supporting their families simply for lack of trying. The America where anyone can succeed if they try hard enough, it is difficult to promote housing-support programs to the general public. Despite the attempts to move families out of shelter, families can still remain in shelter for up to a year until they can find the appropriate funds and, more importantly, appropriate housing they can afford (Bello 2010).

B. Applying for Housing

Besides the lack of affordable housing, it is also worthy to mention the difficulties participants reported in applying for housing without the help of a case manager. Several participants said that they tried to apply for subsidized housing on their own, before being placed in a shelter where a case manager was available, but they either did not know of housing programs or how to fill out the necessary applications. The experiences clients had attempting to find housing on their own mirrors other narrations on the homeless system. Without a case manager, one simply cannot navigate it. The forms are complicated, the program rules extensive, and people do not know where they can go for help. Once again, the complexities of the U.S. safety net act as a burden to homeless families who are inhibited rather than helped by a system that uses a vast number of rules and regulations to limit the number of people it aids.

VI. HOPE AND TENACITY AMONG HOMELESS FAMILIES

Before discussing possible solutions to improve the ways homeless families are given aid, there is one final conclusion that must be drawn from the results that is perhaps the most important of all. The families in the study demonstrated incredible perseverance and tenacity in overcoming the numerous barriers they faced while navigating the homeless system. They remained resilient and found resourceful ways to survive. Furthermore, despite the difficulties they all faced, parents still maintained their hopes of finally getting housing and leaving the shelter. Parents expressed concerns for the education of their children, holding dreams of college and several were pursuing their own careers and advancing their educations. Alex completed her training to be a Medical Assistant two weeks after being interviewed and wanted to pursue a nursing degree in the future. Lisa was working towards her GED and was considering becoming

a drug counselor. Both Charlotte and Tracy were working with Mass Rehab to get funding for classes at the University of Massachusetts as drug rehabilitation counselors. Elizabeth received funding to pursue nursing and Juana, after learning English, wanted to go to school to study computer sciences. Finally, Rosa was excited about her ESL class and was hoping to keep studying in the future. Overall, the participants of the study were steadfast in their determination to provide well for their children and themselves.

VII. SHORT TERM IMPROVEMENTS IN THE HOMELESS SYSTEM FOR FAMILIES

A. Increasing Education and Information on Nonprofit Services

Already mentioned at several points throughout this chapter, one of the key results from this study was the apparent lack of knowledge homeless parents had on available nonprofit services. The majority of participants utilized nonprofits they were directed to by case managers or social workers. None of the interviewed participants had sought preventative services to keep themselves housed. Additionally, families in need of case management but without access to it, such as the families living in hotels, did not seek additional aid from nonprofit programs. The results suggest that among the population of families living at-risk of homelessness in Somerville and the greater Boston area, there is little knowledge of the nonprofit resources that are available. Thus, one of the first ways in which families can be helped is by expanding information on nonprofit services. Making information more easily attainable and multilingual could help many families in need.

When providing information on nonprofit services to at-risk families, there are several limitations that must be kept in mind. Many nonprofits, including Somerville Homeless Coalition, have limited faculty and can only help a certain number of clients. Nonprofits may

only accept clients who have referrals from other programs or through an application process. Additionally, many nonprofit programs are already working at capacity and are unable to take on more clients. Every time a client leaves, a new client is at the door waiting to take his place because there are more people in need than there is aid. As a result, nonprofits may be averse to extensive advertising of their services for fear that it will simply attract more clients who they cannot help. Despite the potential unwillingness of nonprofits to advertise their services, it remains important to expand information on available resources to at-risk families. Even if the result is that a family approaches a nonprofit that cannot help them, the nonprofit's service providers can refer the family to other available programs, in this way continuing to expanding access to aid and information. By increasing information, more low-income families will become aware and take advantage of the preventative services that are available to help them. Families who receive services will help promote nonprofit programs through word-of-mouth, helping to spread knowledge on service providers and programs. As the federal and state governments become increasingly reliant on nonprofit programs to provide social services, there is an increased responsibility to educate the public on these services.

In expanding knowledge of homeless services, information must be provided through multiple mediums and in a variety of languages. Somerville is a diverse city and the homeless population reflects this diversity so multilingual information is critical. Additionally, the internet alone is not an effective way to provide information since families may not have access to a computer and are not always aware of library services. Keeping brochures and pamphlets up-to-date and available in community spaces including churches, supermarkets, schools, and health clinics will help expand information of services to those in need. Additionally, families are more likely to trust community members as reliable sources of information. Community involvement

is critical to raising awareness of services for needy families because the general knowledge within a community ultimately dictates the services families seek.

B. Increasing Information on Government Services

Research has shown that individuals with more knowledge on the welfare system's rules and services are more successful at getting aid. Within this study, it was evident that some case workers tried to take advantage of the lack-of-knowledge certain participants had, denying them services, including shelter, for which they qualified. If parents know the programs and aid they are entitled to, they are more capable of ensuring that their needs and those of their children are met. Clients will also be more likely to apply for programs for which they are eligible. Furthermore, educating clients on the DTA system can help them during the application process. Parents will bring the necessary paperwork to the DTA when applying for Food Stamps, Social Security, TAFDC and/or other programs. It also is possible that clients who better understand the system will know to schedule appointments and fill in applications available online, thus expediting the application process and improving client experiences at the DTA. Having more informed clients would help diffuse tension and stress among case managers by making their work easier and less tedious and could improve the environment at the DTA.

C. Improving the DTA

From the interviews collected in this study, it is clear that the DTA is in serious need of remodeling. Homeless parents will say that there are hundreds of ways in which the DTA could be improved but the most important is simple politeness. All homeless families have suffered significant trauma which adds to the psychological distress that comes from being homeless. The

psychological problems that many parents suffer as a result of homelessness are an impediment to successfully applying for services, finding a job, and getting out of homelessness. The parents in this study expected to receive some compassion when they reached the DTA and those who were treated poorly by the receptionists or their case managers were understandably very upset. It is important to remember that despite the huge numbers of homeless families in the U.S. today, each family is comprised of individuals who have suffered enormously. Even if a DTA office processes hundreds of families each day, they each have unique stories and grievances and cannot be treated as simply "another family asking for money" as is commonly done. Educating families cannot be the only method relied upon for improving the Boston area DTAs. The environment itself must be changed. Educating employees on family homelessness is critical, as well as simply emphasizing the importance of politeness and professionalism among all workers. Additionally, since case workers with social work training have been shown in some studies to be more willing to work for their clients and find them the services, providing social work training to all case workers could significantly improve client experiences.

Part of the reason that workers at the DTA become frustrated and resentful towards their clients is the simple burden of being overworked. With over a hundred cases each, it is not possible for case workers to give the necessary, personal attention to each family. Employing more workers would help reduce the work burden and would improve the quality of case management that each family receives. However, case management is a significant reason for the high cost of welfare services. In order to reduce costs, the application process for programs including TAFDC and Food Stamps could be simplified so more clients could complete applications on their own, reducing the cost of running DTA services and the burden on case workers.

While not all clients provided with additional information and resources could successfully navigate the homeless system without the help of a case manager, it is equally incorrect to assume that none could. Parents would benefit from having more control over their situation in the homeless system. Many of the complaints of the participants in this study can be traced back to a lack of control. Whether it be losing SNAPs, being denied shelter, or frustrations with housing applications, the parents in this study resented being treated as though they were incompetent. They did not want to be directed from one case manager or one program to the next. They simply wanted to do whatever it took to get out of homelessness; yet the homeless system makes it very difficult for an individual to do so. Despite U.S. attitudes that promote individualism, when it comes to social services, a family becomes simply a "case" and parents are seen as incapable of taking care of themselves or their families. As a result, they become trapped in their dependency of a support system that does not always provide support.

D. Improving Communication between Government and Nonprofit Services

A simple change that would drastically improve the way families navigate the homeless system would be to increase the communication and cooperation between nonprofit and government services. Interviews with case managers at SHC made it clear that they resented the workers at the DTA for making the application process difficult for their clients, shutting of their services and denying them entry in programs. Similarly, case workers at the DTA probably dislike case managers who intervene on their clients' behalf, interfering with the way in which they conduct their work. If the case managers at nonprofits and government agencies began to work with each other, it could increase the efficiency of the homeless system. Service providers from both public and private systems could learn from each other's experiences. For example, if

a nonprofit developed an innovative way of providing case management, they could provide training to DTA workers. Likewise, the workers at the DTA could share their observations on population trends and needs. If the DTA workers remarked on an increase in the number of Hispanic homeless families, nonprofits could expand their bilingual services or hire translators accordingly. Finally, increasing collaboration would help meet the needs of clients by making the search for services easier; DTA workers could recommend different nonprofits to their clients, increasing information on programs and access to services for families.

VIII. LONG TERM IMPROVEMENTS OF THE HOMELESS SYSTEM FOR FAMILIES

Short term solutions that will improve the homeless system for families, while important, are not enough. While the welfare system that is in place to take care of homeless families must be improved, there are larger changes that should be made in the provision of services to better meet the needs of families. Parents in the study were satisfied with SNAP, WIC, and Mass Health, but spoke of a large need for child care programs and expanded case management, especially in hotels housing homeless families.

The importance of SNAP and WIC in helping parents feed their children emphasizes the need to continue to maintain and expand both programs. Furthermore, it should be noted that none of the families described a lack of access to health care because of the availability of health insurance for very low-income families through Mass Health. Without public health insurance, many parents would have been much less satisfied with the availability of medical care and mental therapy. Despite the strengths in government services, the lack of child care and case management in hotels were both large gaps in service-provision. Parents reported that being

without child care was a barrier to employment and how the lack of case management in hotels resulted in longer homeless stays as they had to wait until they were in shelter before successfully applying for housing. Both gaps in service provision need to be addressed in order to reduce the barriers that keep homeless families from receiving necessary services in Massachusetts.

The families in this study were homeless for a number of reasons including drug use and subsequent entrance into rehabilitation programs, health catastrophes that led to loss of income, and loss of doubled-up housing. The diversity of causes suggest that to try to categorize predictive measures that can distinguish between at-risk families and those who will actually become homeless is very, very difficult. Preventative programs, while important and cost-effective because they help reduce the numbers of homeless families, cannot be the only system relied upon to end family homelessness. Prevention programs can never successfully predict and thwart all cases of homeless nor can they be sustainable if family homelessness continues to rise. Instead, the environmental factors that place families at risk will have to be addressed.

Ultimately, family homelessness should not exist at all. Family homelessness was unheard of in the United States before the 1980s and there is no reason why it should continue to be an accepted social phenomenon in 2010. Family homelessness is becoming increasingly prevalent and it is no longer restricted to the poorest segment of the population. As the population of homeless families rises, it becomes increasingly less arguable that it is a quality of the families that leads to their lack of housing. More so there is something wrong in the U.S. societal structure that places many poor families at risk of homelessness and in need of shelters. U.S. policy must begin to focus on the escalating poverty that has created so many at-risk

families. The lack of low-income housing and the disastrous impact it is having on both low and increasingly middle-class families can no longer be ignored.

IX. FUTURE STUDIES

There are many ways in which future studies could strengthen and develop the results collected in this report. Primarily, projects that expand the sample size to interview a greater number of participants or that compare participants' experiences among families in different U.S. cities would help determine the barriers that exist throughout the U.S. which obstruct homeless families from services. Comparison solely between urban homeless families is important; it is likely that rural homeless families experience a different set of environmental conditions and as a consequence face different barriers that would require their own study. Finally, Massachusetts differs from the other U.S. states in that universal health care was enacted in the state in 2006. As a result, the families in this study did not describe significant barriers to health care which in all likelihood differs significantly from homeless families in other states. With the new federal bill to universalize health insurance in the United States, it is hopeful that homeless families throughout the country no longer face barriers to receiving care.

* * *

CONCLUSION

Thousands of families are homeless each night in the United States. Unstably housed due to economic constriction, homelessness can be caused by any number of triggers but ultimately remains the result of poverty and income inequity. As parents attempt to navigate a convoluted support system comprised of multiple services and service providers, each imposing their own rules and restrictions, they face multiple barriers to services. It is clear that changes must be

made to expand the awareness of nonprofit services, improve the conditions and supportive services of government programs, and increase communication between government and nonprofit service providers. Without change, the homeless system will remain inadequate in meeting the needs of the rising number of homeless families.

This study made evident the diversity of families who are homeless in Somerville and the variability in the barriers that can impede their access to supportive services. Families were denied services, did not know where to seek aid, and found the rules of certain programs unacceptable. The U.S. mentality which judges homeless families for their situation accepts a model that restricts access to supportive services; many believe that homeless families are "deserving" of their situation and thus should not be given aid. If this attitude continues, the number of homeless families will continue to rise until the limited safety net that exists today becomes completely overburdened and ineffective. In order to substantially improve the social service system that aids low-income families and the environmental conditions that propagate homelessness, the collective U.S. mentality towards homeless and needy individuals must first be changed.

It is always difficult to revolutionize a social service model. The U.S. system, while flawed, was created with good intentions and still manages to provide aid to millions of individuals. However, so long as the U.S. continues to cling to antiquated methods of service provision from an uncoordinated and ineffective service model, the needs of at-risk and homeless families will continue to be unmet. The current service system within the U.S. relies on incorrect assumptions of the services families need most. Continuing to fund emergency shelter, transitional housing, and extensive supportive system programs aimed to "improve" families so they can maintain their housing will do nothing to reduce the number of homeless families

whose single-most need is affordable housing and the jobs with which to sustain it. Though admittedly difficult to implement, social changes within the U.S. that alleviate poverty and increase the availability of affordable housing will be the only true solution that ends family homelessness.

APPENDIX

CONSENT FORM

Invitation to Participate and Project Description

You are invited to be part of this research study because you have recently obtained services related to food or housing in Somerville. This part of the evaluation has been designed to learn more about your knowledge about and experiences obtaining these services in your own words. You must be at least 18 years of age to participate in this study.

In order to decide whether or not you wish to be a part of this evaluation, you should know enough about what you will be asked to do and about the study's risks and benefits to make an informed decision. This consent form gives you detailed information about the study, including its purpose, procedures, risks, and possible benefits. If you have any questions during or after this description, please be sure to ask them. Once you feel that understand the study, you will be asked if you wish to participate.

Description of the Procedures

If you agree to take part in this study, you will participate in an interview designed to help us learn more about your daily life, including your recent experience with homelessness or risk of homelessness, and your experiences obtaining services in Somerville. The interview will take approximately 40-60 minutes for which we will provide you with a voucher. We would like to record each interview so that we have the most accurate account of what you share with us. These recording will be erased after they are transcribed and any identifying information is removed. However, you may decline to be recorded if you prefer.

Because the information is personal and can involve sensitive subject matter, we are collecting these data in strictest confidence. Your participation is anonymous and your name will not appear on any study materials. Access to all information will be limited to study staff. This does not include the staff of any other program. We will not share any information you provide, except in completely anonymous form, with anyone except study staff. The PI (Kevin Irwin) will store these data in electronic form for 3 years after he completion of the study. You should know that if you share information about suspected or known sexual or physical abuse of a child or older person, or threaten violence to yourself or others, we are obligated to make a report to the appropriate authorities. By agreeing to participate in this evaluation you also give us permission to publish the study results as long as your identity is protected.

Risks and Inconveniences

There are no risks associated with participating in this study interview. We may discuss issues that are personal and may make you uncomfortable or distressed. You are free to take a

break or stop completely at any time. Your choices about participation will not jeopardize your relationship with any agency or program.

Benefits

There are no immediate benefits to you except the opportunity to share your experiences in your own words. After we conduct the study, you and other people with similar circumstances may benefit from improved programs based on your contributions.

Voluntary Participation

You are free to choose not to participate in this study, and if you do consent to participate, you are free to withdraw at any time without damaging your relationship with the researchers or the staff. You do not have to answer any questions that you prefer not to answer. You do not give up any of your legal rights by signing this form. Your choices about participation will not jeopardize your relationship with GTBHC or your housing in any way.

Questions

Please feel free to ask us about anything you do not understand. Consider carefully the research and the consent form. If you have any questions about participation in this study, you may contact the Principal Investigator, Kevin Irwin, anytime at (203) 809-1058. In addition, you may contact Yvonne Wakeford at the Office of the Institutional Review Board at Tufts University (617) 627-3417.

Date _____Person Obtaining Consent Sign_____

CODING TREE

(1) DATA TYPE
- (1 1) In-Depth Interview
- (1 2) Survey

(2) SEX OF INFORMANT
- (2 1) Female
- (2 2) Male

(3) HOMELESS STATUS
- (3 1) In Shelter
- (3 2) In Permanent Supportive Housing
- (3 2) Previously homeless, currently housed
- (3 4) At-risk

(4) SUBSTANCE ABUSE HISTORY
- (4 1) Yes
- (4 2) No

(5) PROVIDER OF SHELTER
- (5 1) DTA
- (5 2) DHCD
- (5 3) Rehabilitation Program

(6) TYPE OF SERVICE
- (6 1) Food Stamps (SNAPs)
- (6 2) Mental Therapy
- (6 3) Medical Care
  - (6 3a) Child
  - (6 3b) Adult
- (6 4) Child Care
- (6 5) Legal Services
- (6 6) WIC (Women, Infants, and Children)
- (6 7) Rehab Program
- (6 8) Shelter
- (6 9) Case Management
  - (6 9a) Yes
  - (6 9b) No
- (6 10) TAFDC
- (6 11) SSI or SSDI
- (6 12) Receptionist
- (6 13) Detox
- (6 14) Schooling
- (6 15) Transportation

(7) SERVICE PROVIDER
- (7 1) Somerville Homeless Coalition (SHC)

(7 2) DTA (Department of Transitional Assistance)
(7 3) DHCD (Department of Housing and Community Development)
(7 4) TAFDC (Transitional Aid to Families with Dependent Children)
- (7 5) DSS (Department of Social Services)
- (7 6) An NGO, nonprofit
  - (7 6a) AA/NA
- (7,7) Mass Rehab

(8) HOUSING

(9) SELF-MANAGEMENT AND ADVOCACY/INDEPENDENCE

(10) PARENT-CHILD SEPARATION

(11) RULES AND PROVISIONS

(12) SUPPORT
- (12 1) Family
- (12 2) Friends
- (12 3) Groups

(13) FINDING SERVICE
- (13 1) Word of Mouth
- (13 2) Internet
- (13 3) Other

(14) INITIAL SHELTER PLACEMENT
- (14 1) Shelter

(14 2) Hotel
(14 3) Scattered Site

(15) LOCATION
- (15 1) Somerville
- (15 2) Medford
- (15 3) Revere
- (15 4) Malden
- (15 5) Charlestown
- (15 6) Dorchester
- (15 7) Other

(16) CONCERN FOR CHILD
- (16 1) Safety
- (16 2) Adequate Food/Nutrition
- (16 3) School
- (16 4) Health

(17) EXPERIENCE
- (17 1) Positive
- (17 2) Negative
- (17 3) Mixed

(18) SPEAKS SPANISH
~~(19) None~~
(20) BARRIER
(21) FACILITATOR
(22) TIME

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