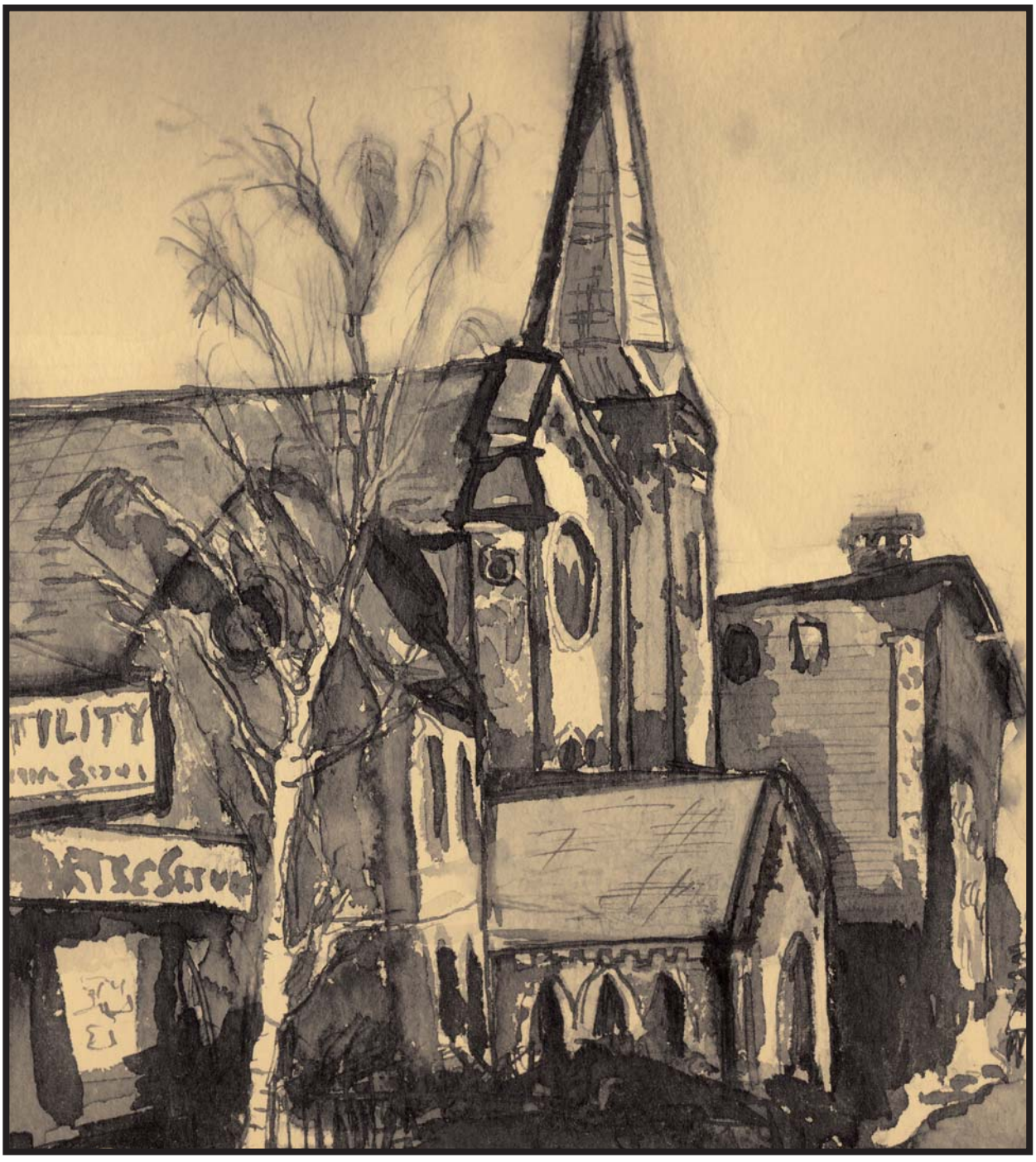

Census of the Homeless and Supportive Housing Populations of Hartford, Connecticut, 2005

Hartford Connecticut Continuum of Care, City of Hartford,
Community Renewal Team, Inc., Hartford Hospital Research Program

Census and Brief Assessment of the Homeless Populations and Supportive Housing of Hartford, Connecticut, 2005

Hartford Connecticut Continuum of Care, City of Hartford,
Community Renewal Team, Inc., Hartford Hospital Research Program

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"South Park Inn, looking North, Hartford Connecticut" by Jason Glasser

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Census and Brief Assessment of the Homeless Populations and Supportive Housing of Hartford, Connecticut, 2005

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Introduction and Methodology

The 2005 point-in-time census of the homeless and supportive housing populations is an enumeration of all individuals and families staying in shelters, transitional housing, supportive housing, and on the street on a specified evening in Hartford, Connecticut in order to obtain an unduplicated count of the homeless population. The census is the result of the collaboration between the City of Hartford, the Hartford Continuum of Care, the Community Renewal Team, and Hartford Hospital. The purpose is to provide useful and timely data for the Continuum of Care gaps analysis for the HUD application from Hartford, and to provide an analysis of patterns of causes of homelessness and the needs that must be met for homeless people to leave the streets, shelters, and transitional housing of Hartford and enter permanent housing.

We define a *homeless* person according to the McKinney Homeless Assistance Act (1987) as a person who lives in a public or private place that is not intended for human habitation, or who utilizes a homeless shelter or a transitional housing program, or who would be homeless if it were not for the housing for homeless and formerly homeless people, as in supportive housing. We distinguish between four types of homelessness: living outdoors, living in shelters, and living in transitional and supportive housing. Living *outdoors* refers to the inhabitation of locations not meant for human habitation. Examples of outside living include living in cars, under bridges, in boxes, in garages and in the woods. *Shelters* are emergency housing facilities that serve individuals and families who have no other place to go. The emphasis is on helping the person in crisis by referring him to services that can help him resolve his problems and gain permanent housing. *Transitional* programs serve as a place for an individual to stabilize their lives and gain needed treatment, if indicated, as they progress from living in shelters or on the street to living in permanent housing. Typically clients stay in transitional housing for up to two years, paying a modest amount for room and board. Most programs either offer treatment programs themselves (generally for substance use or mental illness) or have the clients receive treatment outside of the program. *Supportive* housing is permanent housing for individuals and families who have been homeless, or who are at high risk for homelessness. The programs generally offer housing (often in scattered sites) with support so that the person is better able to retain the housing and not return to homelessness. We consider supportive households to no longer be in the state of homelessness. In the present report, we do not include the precariously housed such as those who are doubled- up with others.

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

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

The City of Hartford has been conducting such studies since 1997 under the direction of the Hartford Continuum of Care of Homeless Service Providers (see Glasser 1997, Glasser 1999, Glasser and Zywiak 2001, McLaughlin, Glasser, and Maljanian 2002, Glasser and McLaughlin 2004). The Continuum of Care utilizes the data to inform the gaps analysis section of their HUD

SuperNOFA application, which allows the homeless service providers of Hartford to secure the funding needed to maintain and improve services for currently and formerly homeless individuals in Hartford, CT. The current point-in-time census of the homeless described in this report was conducted on January 25, 2005.

The protocol for the point-in-time census was reviewed by the Institutional Review Board at Hartford Hospital and found exempt. There were 1,500 anonymous census forms distributed to all of the homeless services within the Hartford Continuum of Care during the two weeks preceding the point-in time census of January 25, 2005. Each program administrator was instructed in how to fill out the census form on each household (individual or family) that slept in their program the night of the census. The transitional and supportive programs were included if they primarily serve homeless individuals.

This year we have tried to be responsive to the users of this report from previous years, who indicated their desire for a shorter and more concise report. If further analyses are needed, we are available to conduct them for Continuum of Care members, in order to learn as much as is possible from the data.

Below is a quantitative presentation of our findings from the 2005 census and text that discusses the patterns of the findings. Please note that the denominators used the in tables (i.e., 371 shelter, 291 transitional, 485 supportive) reflect the numbers of forms received in each category, and not the numbers of responses for each particular item, which may have been slightly less for each item.

Where was the individual or family on the night of January 25, 2005?

Location of individual or family

	Number	Percentage
Outside	7	.6
Shelter	371	32.1
Transitional	291	25.2
Supportive	485	42.0
Total	1,154	100.0

Total Number of People in Households

	Households	Children	Adults	Totals (add children and adults)
Outside	7	0	7	7
Shelter	371	69	376	445
Transitional	291	86	307	393
Supportive	485	124	506	630
TOTAL	1,154	279	1,196	1,475

In contrast to last year (outside = 17, shelter = 390, transitional housing = 263, and supportive housing = 384: see **http://www.crtct.org/Publications2.htm** for the full 2004 report) we see that the most significant difference was in the 100 additional individuals and families in supportive housing. This reflects the growing trend toward providing individuals with permanent, supportive housing. Entry into supportive housing can be accomplished through street outreach, or referrals from shelters or transitional housing. This trend toward supportive housing is especially important given the stabilizing effect of this housing on individual's lives.

Number of Nights in program

Number of Nights in program	Shelter N=371	Transitional N=291	Supportive N=485
Mean	58.93	463.65	901.52
Median	21.00	145.50	690.00
Mode	1	150	690
Minimum	1	1	10
Maximum	2,920	8,322	3,877

When we compare the number of nights spent in each program, we note that there is a progression of number of nights as the individual moves from shelter to transitional to supportive housing, which is expected. The median number of nights spent in a shelter is 21, in transitional housing 145.50 (or about five months) and in supportive housing 690 (almost two years).

Entering the Programs

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

Program	Shelter N=371	Transitional N=291	Supportive N=485
Shelter	34.1	41.1	38.8
Transitional Housing	1.7	6.0	14.4
Supportive Housing	0.0	0.0	3.2
Street	6.6	5.3	5.5
Psychiatric hospital or center	.6	1.1	3.0
Substance Abuse Treatment Program	1.4	6.3	2.5
Hospital or Medical Center	.3	.4	2.5
Jail or Prison	8.3	20.4	1.7
Domestic Violence Shelter	.3	2.8	0.0
Living with Family or Friends	27.4	6.3	10.8
Rental Housing	6.1	1.1	.6
Rental with subsidy	1.1		4.4
Rental without subsidy	4.2	1.1	5.3
Rental, do not know subsidy status	1.7	.4	.8
Public Housing	.3	1.1	.2
Senior Housing	0.0	.4	.2
Privately Owned Housing	.6	.7	.2
YMCA	.6	1.4	2.3
Boarding housing	.6		.4
SRO (single room occupancy)	1.1	1.1	.4
Other	1.4	2.1	2.3
Multiple places checked	1.9	1.4	.2

It is important to understand entry into homelessness, so that measures that prevent homelessness can be supportive. Whereas individuals and families enter transitional and supportive housing through a referral process from other programs that serve homeless or formerly homeless individuals, shelters are good barometers of how individuals enter the state of homelessness. The most frequently cited places where the person was before entering the shelters were other shelters (34.1%), living with friends or relatives, sometimes referred to as "doubled-up" (27.4%), jail or prison (8.3%), the street (6.6%), and rental housing (6.6%). It is interesting to note that there is a slight decrease in the numbers of individuals coming directly out of jail or prison from last year (which indicated 9.9% coming from jails and prisons to shelters in 2004) which may reflect the Department of Correction's expanded residential post-incarceration programs. Some, though not all, shelters have time limitations, which means that some individuals are moving from shelter to shelter.

When we look at the previous place of residence viewed from the point of view of unaccompanied individuals in contrast to families with children, we find some interesting differences among the 361 shelter households for whom the presence of children is known, as shown below:

Where was the individual or family was before coming into the shelter?

Place	With Children N=34	Without Children N=327
Shelter	17.6	35.8
Street	0.0	7.3
Jail or prison	2.9	8.9
Domestic violence shelter	2.9	0.0
Rental housing	23.5	4.3*
Rental housing without subsidy	14.7	3.1*
SRO (single room occupancy)	0.0	1.2

*Pair-wise comparison (with children vs. without children for each place) is significant at adjusted p value of .007 using Fischer's Exact Test.

There are clear implications for prevention when we look at the above differences. For example, though not statistically significant, there is a trend in the direction of the need for post jail or prison programs and alternatives to SROs for individuals. For families, there is need for post domestic violence programs, for those families who have nowhere to go after they are served by domestic violence programs. When we look at the statistically significant associations for coming out of rental housing for families, we can point to the need for eviction prevention, mediation, and affordable housing programs for families. The above data also confirms our knowledge about the episodic nature of living on the street and in shelters for a portion of the single shelter population.

Contributing factors in homelessness

Experiences or situations that applied to the individual or household. (May be more than one category)

Program	Shelter N=371	Transitional N=291	Supportive N=485
Fire	1.6	1.4	.4
Building Unfit	3.5	1.4	1.6
Crime in neighborhood	13.2	12.4	11.5
Over Crowded Apartment	5.1	2.7	3.7
Family problems	30.1	38.8	39.0
Was doubled up and asked to leave	10.5	7.9	7.8
Domestic Violence	6.7	14.0	9.7
Elder Abuse	.8		.2
Medical Problems	15.9	28.9	38.0
Person has HIV/AIDS	4.9	8.9	24.1
Physical Disabilities	7.3	6.2	7.6
Eviction	20.2	16.5	10.9
Benefits Expired	4.3	5.6	1.2
Income does not meet needs	32.0	27.8	49.7
Lack of employment	54.7	44.0	39.2
Lack of affordable housing	47.8	44.3	38.6
Mental Illness	19.1	22.0	52.2
Recently discharged from psychiatric hospital	2.4	.6	7.4
Mental Illness & Substance Abuse	7.3	19.9	31.5
Out of Prison	19.1	29.0	12.6
Relocated from other town/state/country	15.4	11.3	8.9
Alcohol abuse	21.6	16.8	12.4
Drug Abuse	22.4	34.0	23.5
Drug Abuse and Alcohol Abuse	13.2	21.6	19.8
Recently discharged from substance abuse detox/recovery program	5.1	7.9	5.1
Lack of English	7.5	4.5	7.6
Lack of literacy	5.1	5.5	6.8
Other*	6.2	11.0	12.6

* anger management issues, child support, combat violence (PTSD), alimony, DCF involvement, death in family, drug dealing, foster care for children, lack of education, lack of self discipline, lack of understanding, lacks GED, laid off from work, legal problems, loss of medical coverage, lost house in divorce, lost job, prison violence, relationship problems, relocated, safety concerns, no SSI, street violence, young parent, arrest record, child is disabled, closing down building, cognitive deficits, criminal record, prison, deaf, divorce, end of unemployment insurance, hearing impaired (no sign language), husband died, immigrant status, in state custody since age 14, in wheelchair all of life, on probation, lack of education, limited cognitive ability, long arrest record, lost Section 8, medical non-compliance, mental retardation, needed day care, on methadone, pathological gambling, prejudice, previous multiple aliases, prostitution, PTSD (this was mentioned often), legal problems, raising children and grandchild, recent refugee status, sex offender (housing restrictions), transgender status, unable to maintain stable living expectations, veteran, on workers compensation, depression, bipolar, can't get a job because of age, could not afford motel anymore, girlfriend got sick, issues with police, laziness, money management, new apt not ready, no car suspended license, no I.D., police record, pregnant and overweight, probation restrictions, recent injury, robbery crime, senility, TBI, three small children, and transportation.

Transitional and supportive housing programs often have eligibility guidelines which require that the individual be currently or formerly homeless, as well as meet other conditions, such as have a serious mental illness, be in recovery from substance abuse, have HIV/AIDS, have been recently released from prison, or have a physical disability. These eligibility requirements are reflected in the percentages of experiences of the transitional and supportive housing program clients.

It is within the shelter population that we can determine the experiences that have contributed to the person's homelessness, and therefore the services that are most needed by the homeless population, for whom there was no other screening other than being homeless. Note that multiple problems are situations could be endorsed. The top issues of the shelter population were: economic problems including a lack of employment (54.7%), lack of affordable housing (47.8%), income does not meet needs (32.0%); and more personal problems including family problems (30.1%), drug abuse (22.4%), alcohol abuse (21.6%), mental illness (19.1%), and coming out of prison (19.1%).

We note that this year, PTSD (post traumatic stress syndrome) was frequently mentioned as an "other" contributing factor toward homelessness, and so should be added to any checklist of problems contributing to homelessness.

Grouped experiences or situations that applied to the individual or household. (May be more than one category)

Program	Shelter N=371	Transitional N=291	Supportive N=485
Physical Environment	15.6	13.4	12.8
Economic Factors	75.2*	69.8	62.7
Personal or Family Problems	73.9	93.5	96.9*
Coming Out of Prison	19.1	28.5*	18.7
Relocation	15.4*	11.3	8.9
Literacy	10.8	8.6	10.5

Grouped experiences
Physical Environment: fire, building unfit, crime in neighborhood
Economic factors: over crowded apartment, eviction, benefits expired, income does not meet needs, lack of employment, lack of affordable housing.
Personal or family problems: family problems, double up and was asked to leave, domestic violence, elder abuse, medical problems, HIV/AIDS, physical disabilities, mental illness, recently discharged from psychiatric hospital, mental illness and substance abuse, alcohol abuse, drug abuse, drug abuse and alcohol abuse, recently discharged from detoxification program.
Out of prison: out of prison as a cause for homelessness
Relocation: relocation from another town, state or country
Literacy: lack of English, lack of literacy.

* Significantly greater than expected frequency according to Pearson Chi-Square p<.05.

When we examine the grouped experiences, we can see that economic factors more strongly affect the sheltered individuals and families, personal and family problems more strongly affect the residents of supportive housing (probably reflecting the eligibility requirements of the many of the supportive housing programs), coming out of prison more strongly affects the transitional housing residents (again, reflecting the transitional housing set aside for former offenders), and relocation more strongly affects shelter individuals and families.

Below is the distribution of issues and problems that were considered by the shelter directors to be ***the*** *most important* contributing factor for the person's homelessness.

Most Frequently Cited Primary Factors Contributing to Individual or Family's Homelessness

Factor	Shelter N=371	Transitional N=291	Supportive N=485
Family problems	6.7	8.8	4.9
Domestic violence	2.3	4.0	2.5
Medical Problems	5.0	2.9	4.7
HIV/AIDS	.7	1.5	2.7
Eviction	6.4	4.4	1.2
Income does not meet needs	9.4	2.9	5.9
Lack of employment	17.7	6.6	4.2
Lack of affordable housing	7.0	4.4	10.3
Mental Illness	5.4	9.5	22.5
Mental Illness and substance abuse	.3	8.4	8.8
Out of prison	5.4	6.6	2.5
Alcohol abuse	6.0	5.5	2.9
Drug abuse	10.4	18.2	13.7
Drug abuse and alcohol abuse	6.4	7.3	7.1

Again, we see that when the administrators were asked to list only one problem, a mixture of economic factors (e.g., a lack of employment, lack of affordable housing), and personal problems (e.g., drug abuse, alcohol abuse, mental illness) were at play.

When we look at the top primary factors contributing to the individual or family's homelessness from the point of view of individuals in contrast to families with children, we find some interesting differences. Of the 299 shelter households for whom the presence of children is known, the distribution of primary contributing factors is shown below:

Most Frequently Cited Primary Factors Contributing to Individual or Family's Homelessness of the Shelter Clients

Factor	With Children N=30	Without Children N=269
Building unfit	13.3	0.0*
Family problems	0.0	7.4
Domestic violence	20.0	.4*
Medical problems	0.0	5.6
Eviction	26.7	4.1*
Income does not meet needs	16.7	8.6
Lack of employment	3.3	19.3*
Mental illness	0.0	5.9
Alcohol abuse	0.0	6.7
Drug abuse	0.0	11.5
Drug abuse and alcohol abuse	0.0	7.1

*Pair-wise comparison (with children vs. without children for each factor) is significant at adjusted p< .004 using Fischer's Exact Test.

In designing programs within shelters, the data shown above indicate that families with children are most in need of help with finding safe neighborhoods, addressing domestic violence, and eviction prevention, and the increase in income. Single individuals need help with family problems, medical problems, mental health needs, and recovery issues (including alcohol and drug abuse).

Services Needed

One of the major contributions of this kind of census is to assess the kinds of services that are needed by homeless and formerly homeless individuals living in various situations. As can be seen below, in general terms the numbers of unmet needs of individuals and families diminish as they move from shelter to transitional housing and to supportive housing. It is interesting to note that smoking cessation increases as a need, perhaps because once people's immediate needs of shelter and clothes are met, they can focus on their health issues, including prevention.

Kinds of services the individual or family would benefit from but are not currently receiving (May be more than one category)

Program	Shelter N=371	Transitional N=291	Supportive N=485
Anger/Stress Management	12.4	9.6	7.2
Case Management	31.8	6.9	2.3
Clothing	36.7	12.4	4.3
Day Care Services for children	5.1	2.4	1.9
Dental Care	19.9	10.0	7.0
Detoxification from Substances	8.9	2.7	1.9
Domestic violence help	4.3	2.4	1.0
Drop in center or day program	14.6	1.7	3.1
Elderly Services	4.6	.6	0.8
English as a second language	8.0	5.2	4.3
Eye glasses or other eye care	12.1	7.2	1.7
Financial Assistance	43.4	18.9	4.9
Food	25.0	7.6	2.3
Help getting needed documents or ID	10.2	3.0	8.2
Help With Medications	5.9	6.5	1.9
Hospice care	1.3		0.6
Immediate Shelter	17.8	1.7	0.0
Halfway house or transitional living	13.0	4.5	0.0
Long-term, Permanent Housing	69.2	66.1	7.6
Job/Vocational Training	44.2	30.6	13.2
Job Placement	54.4	43.0	10.5
Legal Services	6.7	7.6	2.1
Literacy Training	5.9	8.2	5.2
Life Skills Training	19.7	12.7	6.8
Medical Benefits (health insurance)	11.0	5.5	0.2

Program	Shelter N=371	Transitional N=291	Supportive N=485
Medical Care	12.1	3.8	1.6
Mental Health Care	14.3	9.3	5.4
Money Management	28.9	12.7	8.5
Personal Hygiene Assistance	6.5	2.7	0.4
Recreation	6.7	6.5	6.4
Representative Payee or Conservator	4.3	3.0	0.1
Smoking Cessation	1.6	7.2	9.7
Substance Abuse Treatment (includes detoxification)	21.0	8.9	6.6
Transportation	27.2	21.6	9.5
Veteran's Benefits	3.0	1.0	0.8
*Other	2.1	4.1	0.6

* homecare, physical therapy, someone to assist with apt cleaning/ housekeeping, volunteer opportunities meals programs, educational training -college level, family therapy, GED training, high school education, HIV services, immigration assistance, none, parenting, subsidized housing, homecare, physical therapy, housekeeping help, volunteer opportunities, meals.

When we pose the question of whether moving from shelter to transitional to supportive housing affects the person's need for services, we can observe a generalized diminishing need for services across the three categories. It is important to note that transitional and supportive housing programs tend to be "service rich" and therefore often do address the needs that people have.

When we put these differences in needs between the three types of situations to the tests for statistically significant differences, the following differences remain:

Results of multiple pair-wise comparisons of services needed between individuals living in shelters, transitional, and supportive housing[1]

Comparisons	Shelter vs. Transitional	Shelter v. Supportive	Transitional v. Supportive
Case Management	*	*	NS
Clothing	*	*	*
Dental Care	*	*	NS
Detoxification from Substances	NS	*	NS
Drop in center or day program	*	*	NS
Elderly Services	NS	*	NS
Eye glasses or other eye care	NS	*	*
Financial Assistance	*	*	*
Food	*	*	*
Help getting needed documents or ID	*	*	NS
Immediate Shelter	*	*	NS
Halfway house or transitional living	*	*	*
Long-term, Permanent Housing	NS	*	*
Job/Vocational Training	*	*	*
Job Placement	*	*	*
Legal Services	NS	NS	*
Life Skills Training	NS	*	NS
Medical Benefits (health insurance)	NS	*	NS
Medical Care	*	*	NS
Mental Health Care	NS	*	NS
Money Management	*	*	NS
Personal Hygiene Assistance	NS	*	NS
Smoking Cessation	*	*	NS
Substance Abuse Treatment (includes detoxification)	NS	*	NS
Transportation	NS	*	*

1 In order to compare the percentage distribution of needed services for the three domiciles, the Bonferoni correction was used to obtain an adjusted p value to account for multiple comparisons. With 108 pair-wise comparisons applied to the services needed, the adjusted value for statistical significance is p<.004. Asterisks indicate comparisons that were significant at this adjusted p value using Fischer's Exact Test. NS indicates comparisons there were not statistically significant. If the item does not appear at all in the above table, there was no statistical significance in any of the comparisons.

Out of the 25 differences in rates of need that were statistically significant in comparing the three types of domiciles, the majority (24 out of 25) of differences occurred between the unmet needs in shelters versus the unmet needs in supportive housing. This is logical since we are moving from the most temporary to the most permanent type of housing within the three types of domiciles. But we also see differences (14 out of 25) when we move from shelter to transitional housing, and differences (10 out of 25) when we move from transitional to supportive housing. These assessments of diminishing unmet need is strong support for moving individuals and families out of shelters and into the more permanent transitional and supportive housing.

Kinds of services the individual or family in shelters would benefit from but are not currently receiving. (May be more than one category)

Factor	With Children N=35	Without Children N=336
Case management	28.6	32.1
Clothing	25.7	37.8
Financial Assistance	25.7	45.2*
Food	8.6	26.8*
Long-term, Permanent Housing	65.7	69.6
Job/Vocational Training	48.6	43.8
Job Placement	57.1	54.2
Money Management	28.6	25.6
Substance Abuse Treatment (includes detoxification)	2.9	22.9*
Transportation	22.9	27.7

*Statistically significant difference between households with and without children according to Fischer's Exact Test (financial assistance p=.01; food, p=.007; substance abuse treatment p=.00002).

Although there are some percentage differences between shelter households in terms of unmet needs depending on whether the household does or does not include children, only the differences in financial assistance, food, and substance abuse treatment differences were statistically significant. In these cases, the singles had a greater unmet need for these services than did the households with children. An interpretation of this is that in fact the households with children are eligible for more services (e.g., money and food) and that the singles are more affected by alcohol and drug abuse. In planning needed services within the shelters, it may be important to distinguish the needs of the families in contrast to the needs of singles.

Who Else is Working with the Individual or Family?

Does the individual or family have a case manager apart from the one at the shelter, transitional housing, or supportive housing?

Program	Shelter N=371	Transitional N=291	Supportive N=485
Has other case manager	25.6	32.4	20.4
Does not have other case manager	65.5	64.5	74.6
Do not know	8.8	3.1	5.0

We were interested in knowing if there were any other case managers, apart from the case managers within the programs themselves, who were working with the client. Somewhat surprisingly, it was the clients in transitional services that more frequently worked with a case manager in addition to the case manager of the program. The fact of working with another case manager may be important in the overall amount of help the person is receiving, although it could also indicate that the individual or family has more complicated problems.

Description of the Individuals and Families

Gender

Program	Shelter N=371	Transitional N=291	Supportive N=485
Male	75.9	68.8	48.0
Female	24.1	31.3	51.6
Transgender	0.0	0.0	.4

As can be seen above, the percentage of males diminishes as we move from shelter to transitional to supportive housing. However, it is important to note that of the 35 households with children in the shelters, 88.6 were female headed.

Age

AGE	Shelter N=371	Transitional N=291	SupportiveN=485
Mean	40.72	41.74	43.93
Median	42	43	45
Mode	46	43	42
Minimum	13	19	19
Maximum	74	67	81

The ages of the individuals increases slightly as we move from shelter to transitional to supportive housing.

Race (may be more than one)

Program	Shelter N=371	Transitional N=291	Supportive N=485
American Indian or Alaskan Native	1.1	.7	0.0
Asian	0.3	0.0	0.6
Black	38.8	40.2	37.9
Native Hawaiian	0.8	0.0	0.0
White	21.6	36.4	34.4
American Indian or Alaskan Native and White	.3	1.0	1.4
Asian and White	0.0	0.0	0.4
Black and White	4.6	3.1	4.1
American Indian or Alaskan Native and Black	1.1	0.7	0.0
Multi-Racial	13.2	3.8	12.2

Hispanic Origin

Program	Shelter N=371	Transitional N=291	Supportive N=485
Hispanic	33.7	33.2	32.9
Non-Hispanic	42.3	66.8	67.1

The 2000 US Census Population data from Hartford indicates that the distribution of race and ethnicity in Hartford is 27.7% White, 38.1% Black, .5% American Indian or Alaskan Native, 1.6 Asian, .1 Native Hawaiian and Other Pacific Islander, 26.5% Other Race, 5.4 Multi-Racial, and 40.5% Hispanic (may be any race). We see by the above race and ethnicity distribution in the shelter, transitional housing, and supportive housing sample, that Blacks are represented in all three types of housing proportional to their distribution in Hartford, whites are slightly under represented in the shelters and slightly over represented in the transitional and supportive housing, and Hispanics are under represented in all of the shelter, transitional, and supportive housing situations.

Veteran status

Program	Shelter N=371	Transitional N=291	Supportive N=485
Veteran	11.3	8.4	5.0
Not a veteran	88.2	91.6	95.0

It is important to know the veteran's status in each of the populations affected by homelessness, since there are specific programs for homeless veterans, which means that active referrals can be made to the Healthcare for Homeless Veterans for a variety of programs addressing homelessness within the veteran population.

Source of income (e.g., SSI, SAGA)

Program	Shelter N=371	Transitional N=291	Supportive N=485
Has source of income	40.9	62.1	91.1
Does not have source of income	54.3	35.1	7.9
Do not know	4.7	2.8	1.0

As might be predicted, individuals have access to reliable sources of income as they move from the shelter to the supportive housing system.

Working

Program	Shelter N=371	Transitional N=291	Supportive N=485
Is working	14.0	34.5	17.4
Is not working	83.5	64.5	80.7
Do not know	2.5	1.0	1.9

When viewing the above table, we can keep in mind that despite the percentages above, the administrators of a large portion of all three populations cited job training and job placement as important.

Food stamps

Program	Shelter N=371	Transitional N=291	Supportive N=485
Is receiving food stamps	44.2	26.4	43.9
Is not receiving food stamps	51.3	68.7	44.6
Do not know	4.5	4.9	11.5

When viewing the above percentages it is important to note that it is probable that almost all of the individuals living in shelters are eligible for food stamps, as well as the majority of individuals living in transitional and supportive housing programs. Food stamps tend to be an under-utilized program, due to the some times small amount of food stamps the individual may receive, and at times due to barriers that individuals perceive in applying for the program.

Representative payee or conservator

Program	Shelter N=371	Transitional N=291	Supportive N=485
Has representative payee or conservator	3.7	7.1	28.0
Does not have representative payee or conservator	87.5	87.9	69.4
Do not know	8.8	5.0	2.6

Representative payee or conservators are utilized when the individual is not able to handle receiving a monthly check (e.g., due to their addictions). As might be expected, the largest proportion of individuals with payees or conservators occurs in the supportive housing programs, where the person's need for these services would be more likely to be met.

Chronicity of Homelessness

One of the most frequently asked questions of the yearly homeless census has been related to the chronically homeless. This is in part due to the fact that funding has often been directed to the chronically homeless. This year, we presented the HUD chronic homeless definition to the administrators filling out the census forms, and asked them if each individual did or did not meet the definition.

Chronic Homeless Definition: An unaccompanied homeless individual with a disabling condition who 2has either been continuously homeless for one (1) year or more OR has had at least four (4) episodes of homelessness in the past three (3) years. To be considered chronically homeless a person must have been on the streets or in an emergency shelter, (not in transitional housing) during these episodes of homelessness.

Individuals now chronically homeless

Chronically Homeless	Shelter N=371	Transitional N=291	Supportive N=485
Yes	57.5	24.2	2.4
No	40.5	73.3	96.9
Do not know	2.0	2.5	.7

The currently chronically homeless are most concentrated within the shelter population, with over half of the shelter residents meeting the definition of chronically homeless. It is interesting to note that even transitional housing includes almost one quarter of their clients who are considered to be chronically homeless.

Individuals EVER chronically homeless

EVER Chronically Homeless	Shelter N=371	Transitional N=291	Supportive N=485
Yes	55.8	37.9	43.4
No	38.1	53.9	38.7
Do not know	6.2	8.2	17.9

When we ask if the client has EVER been homeless, we can see that the proportions within the transitional and supportive housing programs rise significantly. In other words, the homeless serving programs of Hartford are in large part reaching the chronically homeless populations.

Description of those found out of doors

Although there were only seven individuals who were identified as sleeping out of doors on the night of January 25, 2005, as described by the outreach team of the Immaculate Conception Shelter and Housing Corporation, these seven people are of concern because they can too easily fall between the gaps in the system. If we reached seven individuals that night, we can believe that there were more out of doors. So these seven serve as a proxy for the other non-sheltered homeless. Who are the seven?

The five men and two women sleeping out of doors had been in living out of doors for an estimated median 1,825 nights (five years). Six out of seven were thought to be chronically homeless. None had children with them. Their median age was 46 years old, with a range of 36 to 56 year old. Five out of seven were white and one was Hispanic. None were veterans.

Six out of seven were thought to be in need of clothing, financial assistance, food, and five out of seven were though to be in need of job placement and transportation. None were thought to have a source of income, although five out of the seven were receiving food stamps. Three out of the seven were thought to have a case manager apart from the outreach worker.

The largest contributing factors related to the individual's homelessness was family problems, eviction, lack of income, lack of employment, lack of affordable housing, and a combination of drug abuse and alcohol abuse.

It is important to note that on the night of January 25, 2005, there was a major snowstorm in Connecticut. Outreach and shelter workers, as well as other community service providers and the police, were active in persuading may people to seek shelter that night. Anecdotal reports indicate that many people found alternative places to stay, rather than their usual places, which are sites unintended for human habitation.

Where Did the Individuals and Families Sleep on January 25, 2005?

Shelters

Program	Number	Percentage
Catherine's Place (Mercy)	16	4.3
CRT McKinney Shelter	73	19.7
DSS Shelter Apartments	10	2.7
Hartford Interval House	6	1.6
Immaculate Conception Shelter	110	29.6
My Sister's Place I	10	2.7
Open Hearth Shelter	13	3.5
Salvation Army Emergency Shelter	51	13.7
Salvation Army Marshall House	12	3.2
South Park Inn Shelter	52	14.0
YWCA Shelter	7	1.9
Salvation Army Marshall House Youth Shelter	11	3.0
Total	371	100.0

Transitional Housing

Program	Number	Percentage
Mercy Housing AIDS Residence	9	3.1
Mercy Housing Respite	9	3.1
My Sister's Place Transitional	17	5.8
Open Hearth Transitional	73	25.1
Project TEACH	20	6.9
Salvation Army Homestead Ave.	46	15.8
South Park Inn Transitional	32	11.0
St. Elizabeth Residential	49	16.8
Supportive Housing Collaborative	16	5.5
YWCA Transitional	9	3.1
Emergency Short Term Housing (Mercy)	11	3.8
Total	291	100.0

Supportive Housing

Program	Number	Percentage
CRT Permanent Supportive Housing	14	2.9
Chrysalis Residential Mental Health	69	14.2
Chrysalis Project HEARRT	64	13.2
Chrysalis HIV/AIDS	21	4.3
Hudson View Commons	15	3.1
Mary Seymour Place Apartments	28	5.8
Supportive Housing Services (Mercy)	53	10.9
The Residence at St. Mary's (Mercy)	6	1.2
Plimpton House	35	7.2
Peter's Retreat	29	6.0
Shelter Plus Care (TRA's)	145	29.9
Tabor House I	6	1.2
Total	485	100.0

Conclusions

The Hartford Continuum of Care has been successful in providing permanent supportive housing for 485 individuals and heads of households in 2005. This number represents housing 300 more individuals and families since the first point in time census was undertaken in 1997. In addition to permanent housing, the Hartford Continuum of Care provides safe refuge 371 individuals and households in shelters, and 291 individuals and households in transitional housing. The Hartford Continuum of Care additionally reaches out to individuals on living out of doors.

Recently, Mayor Eddie Perez of Hartford convened a Commission to End Chronic Homelessness which reviewed evidence based strategies to end chronic homelessness through a regional response to homelessness. Among the many recommendations of the Commission, as discussed in the report, Hartford's Plan to End Chronic Homelessness by 2015, are: the addition of 632 supportive housing units for the long-term homeless population in Hartford; increasing the availability of affordable housing and the improvement in low-income housing stock; assisting chronically homeless with job and vocational training and job placement; and supporting discharge planning policies from institutions (e.g., hospitals, jails, prisons) that facilitate the individual's re-entry into the community. The data presented in this report reinforce the need for these recommendations.

Despite the growth in supportive housing, Hartford continues to respond to the needs for shelter and services for the individuals and families who are without permanent housing. It is hoped that the information provided in this report will be helpful to the Hartford Continuum of Care of Homeless Service Providers and to the City of Hartford as they seek to maintain and improve housing, health and social services for all Hartford residents.

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