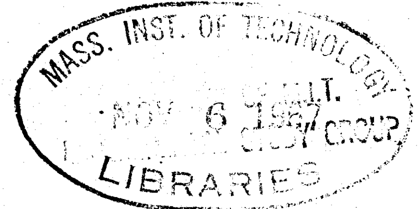
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ALTERNATIVES TO SKID ROW

by

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A.B., Harvard College
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ABSTRACT

ALTERNATIVES TO SKID ROW

James B. Peters

Submitted to the Department of City and Regional Planning on May 19, 1967, in partial fulfillment of the requirement for the degree of Master of City Planning.

Urban renewal projects in skid row areas offer cities the opportunity to seek alternatives to skid row. There is reason to believe that, through the coordinated efforts of a variety of public and private agencies, many men now on skid row can be rehabilitated and successfully relocated within the larger community, and that the proper administration of services to men who cannot be rehabilitated will prevent the formation of new skid rows in vulnerable sections of the city.

Men come to skid row for many reasons; the row offers low living costs, anonymity, the companionship of men from similar backgrounds, and tolerance of deviant behavior. Most skid row residents are extremely poor. They are "homeless men" in the sense that they move frequently, live outside private households, spend very little on housing, and have few family ties. Although drinking is central to the culture of the row, only 30-40 per cent of the men are true alcoholics. But 80 per cent have a seriously- or partially-disabling health problem of some kind. Typically the homeless man lacks the ability to form long-term or emotionally-charged interpersonal relationships.

Arguments have been advanced in favor of maintaining skid row, but its costs seem to outweigh its benefits. Skid row rehabilitation programs must take into account the fact that a homeless man has been more or less assimilated into a deviant subculture. All programs serving the homeless man must work toward encouraging him to leave the row, and helping him to adjust to life in the normal community. A central agency will be required to develop a comprehensive rehabilitation program, provide individual counseling and referral services, and coordinate the work of existing agencies. The referral agency will call on a variety of health and welfare services, including hospitals and nursing homes, and recreation, vocational training, and public assistance programs. All must tailor their services to meet the requirements of the former skid rower. A detoxification center, staffed with specially-trained personnel, must be available to serve the needs of the skid row alcoholic.

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A variety of housing types will serve as relocation resources, including YMCA's, public housing, and foster homes, and planners must also help ensure an adequate number of well-run, well-maintained rooming houses. Renewal activities frequently threaten this type of housing; other problems are the need to establish reasonable code standards and the unavailability of rehabilitation loans. Half-way houses promise to be of great value in skid row rehabilitation programs. They provide a supportive environment in which homeless men can learn to cope with the social and occupational demands of life off the row.

Many skid row businesses will be dispersed or closed by urban renewal, but licensing procedures and code enforcement may also be employed to change the operating methods of bars and other skid row businesses which now help to perpetuate skid row. Not all homeless men will be willing or able to benefit from rehabilitation programs. The operating policies and locations of mission and public welfare programs will determine whether or not these men become the nucleus of a new skid row.

There are several ways in which city planners can contribute to the success of programs to eliminate skid row.

Thesis Supervisor: Bernard J. Frieden
Title: Associate Professor of City Planning

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The list of interviews at the end of this thesis includes the names of too many people whose assistance should be more adequately acknowledged. I must, however, single out two of them: Miss Mary Leno, of the South End Center for Alcoholics and Unattached Persons, who helped me find my way among the agencies serving Boston's homeless men; and Professor Samuel Wallace, of Brandeis University, whose book, Skid Row as a Way of Life, crystallized my interest in the problem of skid row. Professor Wallace also made available a very useful collection of unpublished material.

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INTRODUCTION

Urban renewal plans in cities throughout the country have called for the redevelopment of skid row districts. To civic leaders, downtown businessmen, and the general populace, these districts and their inhabitants are embarrassing eyesores, occupying potentially valuable land adjacent to the central business district and blighting nearby residential and commercial areas.

Some cities have paid no attention to the special relocation problems posed by homeless men on skid row. As single individuals, many apparently transient, they have been given relocation assistance only if they ask for it. Fortunately most do not ask, since few renewal agencies have been prepared to give these men the housing and services they require. City officials may hope that many men will simply leave town; some do, but others scatter throughout the city, or settle in areas containing the seeds of future skid rows.

This is unfortunate, since the redevelopment of skid row districts offers cities a unique opportunity to face the challenge of skid row. It is an opportunity to help the men now on the row and to develop permanent alternatives to the skid row way of life.

Until now, most public and private welfare agencies serving homeless men have actually helped to perpetuate skid row. Missions, for example, as much as any other type of institution, determine the location and ensure the stability of skid row. They cater to the dependency needs of homeless men on the row, attract men from

other areas, and enable men to subsist in this way of life. Yet, in the absence of a coordinated program to develop alternatives to skid row, one cannot criticize the missions for their attempts to ameliorate skid row conditions.

The residents of skid row and the commercial establishments and welfare agencies which serve them constitute a deviant subculture within the larger community.[1] Skid row districts have not developed accidentally. These districts satisfy certain needs of their residents -- for low living costs, anonymity, tolerance of deviant behavior, and dependency -- which are less well satisfied elsewhere. Programs to eliminate skid row must either satisfy these needs in other ways, or provide services -- vocational rehabilitation, medical care, or psychotherapy, for example -- which will eliminate the needs themselves.

A few cities have already made serious attempts to deal with the problems of homeless men. The Urban Renewal Administration has funded demonstration projects in Philadelphia, Sacramento, and Chicago. These studies and others, notably in Minneapolis and New York, have resulted in detailed studies of the characteristics of skid row residents and specific recommendations for programs of relocation and rehabilitation. Unfortunately even the best laid plans will fall through if agencies lack adequate funds and community support for their programs.

Chapter 1 of this thesis, "The Men on Skid Row," describes the characteristics of the skid row population. This chapter draws heavily on data from Chicago, Minneapolis, and Philadelphia.

Chapter 2, "A Relocation and Rehabilitation Program," outlines the variety of services and facilities which will be required to enable men on skid row to re-enter the larger community.

The next two chapters discuss more fully two types of housing which will be key elements in such a program:

Chapter 3, "Rooming Houses," is concerned with the problems of maintaining an adequate supply of this type of housing.

Chapter 4, "Half-way Houses," discusses a particular type of rehabilitation-housing facility which has been used increasingly in recent years to help parolees, mental patients, alcoholics and others to re-enter community life, and which promises to be a central element in a program of skid row rehabilitation.

Chapter 5 seeks to answer the question, "Can Skid Row Be Eliminated?" Although many men will respond to a program of relocation and rehabilitation, evidence shows that we lack the ability to integrate all homeless men into the community. Some men will become permanent residents of institutions, but others will continue to live within the city. It seems to be possible to meet their needs, however, without creating a new skid row.

Finally, Chapter 6, "Alternatives to Skid Row," summarizes the key elements of a program to eliminate skid row.

In the process of preparing this thesis, I have talked with persons actively involved in skid row programs in New York, Philadelphia, and Boston. I have discussed housing needs and other aspects of skid row life with about ten homeless men; most of these

men were spending the night at the Boston Industrial Home. As a token attempt at participant observation, I spent a night in a cubicle hotel on New York's Bowery.

Skid row is an extremely complex phenomenon, a tangle of economic, social, psychological, medical and ethical problems. Programs to eliminate skid row must be equally complex. In this thesis, I have devoted particular attention to the housing issues, as a more traditional concern of city planners, but skid row is one of the urban problems justifying planners' increasing involvement in social welfare planning.

NOTES

1. See Samuel E. Wallace, _Skid Row as a Way of Life_, Totowa, N. J.: Bedminister Press, 1965.

Chapter 1

THE MEN ON SKID ROW

Skid row is not hard to recognize. It is a run-down district in the midst of the gray area adjoining the central business district of the American city. It is a collection of cheap bars, cheap restaurants, cheap hotels, missions, used clothing stores, barber's colleges, and day labor agencies, intermingled with a variety of commercial, industrial, and wholesale uses.

At first glance there seems to be more variety in the commercial institutions of the row than in its residents. But when one looks more closely one discovers that the skid rowers are as notable for their differences as for their similarities. A Chicago study identified six major classes of skid row residents:[1]

(1) Elderly and physically disabled men. Some may have been forced to live on the row only because of the low cost of living. Others also seek relief from loneliness in the companionship of other men from similar backgrounds and with similar problems. Some are outcasts from ordinary society because of mental instability or alcoholism.

(2) Settled and semi-settled workingmen. These men may work so irregularly, or at such low wages, that skid row is the only place they can afford to live. Skid row also acts as an employment center for temporary and unskilled jobs. The unattached, low-skilled working man may also enjoy the social life of the row. Those who consider drinking a major recreation can easily find companionship.

(3) Migratory workers. Migratory workers come to skid row between jobs, to spend the winter, or to find another job. They also seek the low living costs and special social life of the row.

(4) Transient and resident "bums". These men are apparently able to work but choose not to. On skid row a man may survive with a minimum of work. Charitable institutions provide free food and lodging. The "bum" can beg, arrange to get on welfare rolls, or rely on the missions for free food and lodging. As long as he stays on skid row and its fringes, he will be tolerated by the police.

(5) Criminals. Petty thieves find easy victims among the alcoholics and elderly men of skid row. The anonymity of the row makes it a good place to hide from the police. Skid row residents and landlords are used to strangers and they do not ask personal questions.

(6) The chronic alcoholics. There may be alcoholics in any of the groups described above. An alcoholic may come to skid row because the low cost of living permits him to survive while continuing to drink. He may have been ostracized by family and friends. On skid row he can find a certain degree of acceptance, and he does not have to be embarrassed about his appearance or style of life.

The residents of the row have this much in common: they are male, they are homeless, and they are poor, although some residents of skid row could afford to live elsewhere.

The following table presents some selected data from surveys of the skid rows of Chicago, Minneapolis and Philadelphia.[2] While

SELECTED CHARACTERISTICS OF THE SKID ROW

POPULATIONS OF THREE CITIES[a]

	Chicago (1957-58)	Minneapolis (1958)	Philadelphia (1960)
Total population	11,926	2,905	2,857
Male	96%	96%	99%
White	89%	95%	84%
Native born	73%	79%	90%
Median age	c. 49 years[b]	60 years	52 years
Over 60 years	25%[c]	49%	28%
At present address one year or longer	less than 56%[d]	56%	49%
Resided in city for past year	70%	79%	--
Never married	44%	52%	46%
Separated or divorced	43%	30%	37%
Unemployed in week preceding interview	53%	60%	63%
Median years of school completed	8 years	8 years	8 years
Median yearly income	$1083	$960	c. $1000
Year income over $1500	37%	32%	35%
Receiving pension or welfare aid	47%	67%	45%
Living in:			
Mission	8%	10%	26%
Cubicle hotel	67%	42%	42%
Hotel with rooms	14%	}43%	4%
Rooming house	7%		15%

a. For sources, see note 2.
b. Bogue, _Skid Row in American Cities_, op. cit., p. 91.
c. _Ibid._, p. 91.
d. _Ibid._, p. 239. This is the percentage of men who have lived on Chicago's skid row through the preceding 12 months.

the data from these cities reveal no major variations, it would be unwise to assume that all skid rows are very much alike. I have been unable to obtain the full report on Sacramento's skid row,[3] but the Minneapolis report contains the following description:

> The Sacramento skid row is much less similar to Minneapolis than that of Chicago. Population density is relatively low, the average income is very high for a district of this type, and skid row residents play an important part in an agricultural labor market whose maintenance is considered essential and desirable by community opinion. However, the general characteristics of the population are not dissimilar: 97.6% are male, the median age is nearly 55 and has been rising rapidly, [and] there is considerable residential stability, 53% of the men having lived in Sacramento County for five years or more.[4]

Probably the skid row populations described in this chapter are fairly representative of the skid rows of the industrialized Northeast and Midwest.

Bogue reports that "the cities containing the major skid rows appear to be Chicago, San Francisco, Los Angeles, Detroit and New York City," with populations exceeding 5000 men. He also concludes, on the basis of "rather skimpy evidence," that "almost all of the 100 largest U.S. cities contain an identifiable Skid Row neighborhood with at least 250 homeless men, and that most have a homeless man population much larger than this."[5]

Censuses of skid row populations raise some problems of definition. Does "skid row" refer to a particular area, or to a style of life? The geographical definition is usually favored, for four reasons: (1) censuses of skid row populations have usually resulted

from interest in the area for urban renewal; (2) There are no clear-cut criteria for determining whether an individual is living within a skid row life style; (3) Even if there were such criteria, the difficulties of counting the members of a scattered population would be immense; (4) If one views skid row as a subculture and is concerned with the interactions of its residents and institutions, the geographical definition of skid row is far more relevant.

Generally the practice has been to define as "skid row" any area containing a dense concentration of skid row housing -- single room hotels, cubicle hotels, missions, and rooming houses catering to homeless men. Some censuses also count homeless men in certain institutions outside the skid row area, such as missions and jails. Thus a 1964 census of New York's row set the base population at 9000, including 5800 men in the Bowery area, 1800 men in missions and lodging houses in adjacent areas, 1000 men in an out-of-city welfare facility, and others in hospitals and jails.[6]

The Chicago census included the residents of that city's three skid row districts, as well as an estimated 800 homeless men in other areas, in jails, in hospitals, and sleeping out. The Philadelphia census also included jails and other institutions; the Minneapolis census did not. All three censuses were made in winter months, when the skid row population is at its peak.

The large size of the Chicago skid row population is probably explained by the city's role as a transportation center. In the past, thousands of migrant workers passed through Chicago between jobs, and casual labor was needed to load and unload freight.[7]

Even now, one-sixth of the men on Chicago's rows are employed seasonally by the railroads, in spite of increased mechanization of track maintenance and changes in railroad employment practices. The greater supply of casual labor in Chicago is reflected in the lower rate of unemployment.

Skid row is a male society (96% in Chicago, for example). Apparently cultural prohibitions keep most women from an initial contact with skid row life, and the "men only" policy of most skid row lodging houses and missions presents a further barrier to their presence. As we will see later, the predominant psychological characteristics of the men on the row would limit the role of women in skid row life. Another factor may be that women who cannot work because of alcoholism, low skills, or psychological problems are not necessarily excluded from ordinary society; in fact some women may use marriage as a refuge in the way men use skid row.

Although there are variations among skid rows, the median age of the skid row population is very high. In 1960 the median age in the Minneapolis Lower Loop area was 60. This was nearly twice the age of the general population and seven years higher than the median age in the same area in 1940. The Minneapolis researchers conclude "that, to a striking degree, this district has been transformed into a kind of communal rest home for the lower income groups."[8] In both Chicago and Philadelphia, the median age is about ten years lower than in Minneapolis.

About 89 per cent of the skid row residents in Chicago and 84 per cent in Philadelphia are white. In both cases this represents a higher percentage of whites than are in the total city population, but skid row draws its population from the suburbs as well as from the city. In Minneapolis, the situation is somewhat different: the percentage of nonwhites on skid row is 4.5, compared to 1.8 per cent in the total population. One might guess, however, that Negroes would always have a substantially higher representation on skid row, due to their generally low economic status and uncertain employment. One factor preventing this is the discriminatory admission policies of many skid row hotels and missions. It also may be that the skid row-type individual is tolerated within the larger structure of lower-class Negro society, which, with its matriarchal family structure, does not expect or demand a high degree of stability and long-term personal commitment from its male population.[9] In any case, agencies concerned with skid row relocation will not have a large Negro caseload to add to their many other relocation problems.

Skid row men are "homeless" in the sense that they move frequently, live outside private households, spend very little on housing, and have few family ties.

In Minneapolis, for example, only 56 per cent of the men had lived at the same address for a year or more consecutively when they were interviewed, compared to 80 per cent of the city's total male population. The Philadelphia and Chicago populations are somewhat more mobile, probably because they are younger. Two-thirds of the

first 1000 clients of Boston's South End Center for Alcoholics and Unattached Persons could give no address at their initial interview.[10]

But although skid row men may move frequently within the city, skid row is no longer the community of nomads described by Nels Anderson in The Hobo (1923), or George Orwell in Down and Out in Paris and London (1933). The Minneapolis study classified only five per cent of the men as transients; 79 per cent had lived continuously within the city limits of Minneapolis for the preceding year. In Chicago only 5 per cent of the men had spent less than 10 weeks in the city during the preceding year, and about 70 per cent had lived in Chicago throughout the 12 months prior to their interview. Bogue estimates that 80-85 per cent remained within the state.[11] They had therefore satisfied residency requirements for public assistance.

The lack of family ties is striking. Almost one-half of the men on the three skid rows have never married, and another one-third or more are separated or divorced. In 1958, the number of divorced men on Chicago's skid row was nine times the national rate.

In spite of the myth, skid row is not populated by Phi Beta Kappas and former brain surgeons. The median years of school completed is eight years in all three cities. In Minneapolis, 64 per cent of Lower Loop area residents reported unskilled labor and service jobs as their principal lifetime occupations.

Chicago has the lowest unemployment rate of the three cities, yet even here more than half of the men were unemployed at the time of the interview (they had not worked for the past week). However, 86 per cent had worked at some time during the preceding

year. Only half of the men who were currently working had full-time jobs. Employment agencies specializing in temporary labor are among the mainstays of the row. "Muzzling" (distributing advertising circulars), unloading trucks, dishwashing, and seasonal labor on farms and in resorts are common jobs. Although alcoholism and physical disability are definitely a cause of unemployment, there are some employers who are quite willing to hire cripples and alcoholics since they can demand only very low wages.

It is sometimes claimed that skid row is an important source of casual labor. According to a Detroit councilman:

> Economically these man are a necessity to the community; they provide a ready pool of cheap labor to carry out the undesirable tasks of the community; distributing handbills, sweeping and scrubbing floors, washing dishes, etc.[12]

The planners in Sacramento, California, reached a similar conclusion; the skid row labor market was a necessary part of the area's economy.

According to Bogue, however:

> One can scarcely eat in a famous-name restaurant in Chicago's Loop without eating vegetables cleaned and pared by a skid row kitchen-hand served on dishes washed by another skid row kitchen-hand. But it is also true that the entire skid row labor force could disappear from the economic scene and scarcely be missed... Labor shortages are all at the middle and upper levels of the occupational ladder, not at the bottom.[13]

The Minneapolis researchers present a third point of view:

> ...for the community at large, the existence of this facility [the casual labor office of the Minnesota Department of Employment Security], although probably of diminishing importance, still represents a distinct economic asset. However, in view of the fact that 61%

> of the men actually hired were drawn from areas outside of the Lower Loop, and many of these from remote parts of the city, it is fairly clear that the continued existence of a casual labor market sufficient for the needs of local industry and business, does not depend at all upon the continued maintenance of a skid row concentration.[14]

Although agricultural centers may be exceptions, the evidence seems to support the point of view that skid row is not a vital element of a city's economy.

Most homeless men are extremely poor. In 1957, the median income of the average U.S. male 14 years of age or older was $3,684, yet only seven per cent of the men on Chicago's skid row earned more than $3500. The median yearly income was $1083 or $22 per week. Even the wage earners had a median income of only $29 per week. In Massachusetts, Old Age Assistance payments amount to $1632 per year; on the three skid rows, only one-third of the men had annual incomes over $1500.

In New York City, any homeless man without funds can receive chits for food and shelter in a Bowery lodging house on a day-to-day basis. In Boston these chits are theoretically available only six nights a month for Boston residents, and six nights a year for non-residents. In both cities, men who have been residents of the state for one year, have demonstrated that they can handle funds, and are judged to be legitimately in need, can receive general relief aid. In Boston this amounts to $20 a week for a single individual. Since one must have a "permanent" residence before receiving such aid, men are encouraged to live in a rooming house

rather than in a skid row "hotel," but the payment is so low the Welfare Department assumes that most men will take advantage of free mission meals in order to make ends meet.[15]

Skid row housing facilities range from mission dormitories to private rooming houses. Commercial cubicle hotels -- loft buildings subdivided by 7-foot partitions -- are the characteristic form of housing on large skid rows. Chicago, Philadelphia and Minneapolis all report that cubicle hotels were available (c. 1960) at rates as low as 50 cents a night. On the Bowery the standard rate is $1.25 a night and even dormitory beds cost as much as 90 cents.

The alcoholic derelict is the best known resident of skid row, and alcoholism does lead the list of health problems among these men. Physical examinations of 200 men on Philadelphia's row revealed that 40 per cent were alcoholics. Although these men were chosen by sample from the population of the row, the actual figure is thought to be somewhat higher, according to staff members of the Diagnostic and Relocation Center.[16] However, the Chicago study classified only 30 per cent in the categories of "heavy drinker" and "alcoholic derelict;" 14 per cent were teetotalers. Of course, this study was based on interviews with the men and, although great efforts were taken to ascertain their true drinking habits, it seems likely that this method would underestimate the amount of problem drinking.

It is very difficult, in any case, to arrive at a satisfactory definition of "alcoholism." A study of over 400 men who used the Men's Shelter on the Bowery attempted to distinguish the "pathological drinker" from the "addictive drinker." The pathological drinker is one, "whose routine of living is dominated by the use of alcohol" and who drinks enough to interfere with his health, personal relations and work habits. The addictive drinker lacks all control and his drinking "proceeds without regard to the normal life situation." The study showed that while 70 per cent of the men drank excessively, only 43 per cent were really drinking out of control.[17]

Wallace believes that

> To be completely acculturated in skid row subculture is to be a drunk -- since skid rowers place strong emphasis on group drinking and the acculturated person is by definition a conformist. The drunk has rejected every single one of society's established values and wholly conformed to the basic values of skid row subculture. Food, shelter, employment, appearance, health and all other considerations are subordinated by the drunk to the group's need for alcohol. This group constitutes the drunk's total social world and it in turn bestows upon him any status, acceptance or security he may possess. It is the conformity to group norms rather than individual pathological cravings which distinguishes the skid row drunk from the alcoholic.[18]

This view implies that the culture of skid row encourages excessive drinking among men who are not true alcoholics, and, conversely, that many men may be able to reduce their drinking with little difficulty if they are placed in a completely different environment.

On the other hand, attempts to rehabilitate addictive drinkers on skid row will face enormous obstacles. The middle class alcoholic is a deviant individual within middle class culture, and if he attempts to stop drinking he is likely to have psychological support from his family, a place in the community and some economic security. The skid row alcoholic lives in a culture that accepts his drinking as fairly normal behavior; since he probably is poorly educated, unskilled, in poor health and familyless, his alcoholism will be only one of the problems he must overcome in adjusting to life off skid row.

There is still need for a great deal of research into the causes and treatment of alcoholism. Current treatment methods usually involve a combination of techniques, including individual and group psychotherapy, social work counseling, and the quasi-religious approach of Alcoholics Anonymous. A common type of therapy involves the use of Antabuse, a drug which makes a person highly sensitive to alcohol. The patient who takes Antabuse regularly knows that he will react to alcohol with intense feelings of physical discomfort and emotional anxiety. This knowledge enables him to abstain.

The increasingly widespread acceptance of alcoholism as a disease has now been embodied in recent court decisions. This may stretch the definition of the word "disease," since the role of physiological factors in causing alcoholism is still unclear. Prolonged excessive drinking, however, can result in severe damage to

health. In any case, there has been a shift in emphasis from wasteful, punitive measures to programs of rehabilitation. Communities are being forced to develop alternatives to police courts and jails, as a means of dealing with the skid row alcoholic.

Skid row residents suffer from a variety of health problems in addition to alcoholism. The Chicago study revealed that "at most ages, skid row inhabitants may expect to live less than one-half as long as the general population of the same age."[19] They estimate that at least one-half die without medical care.

The Chicago study attempted to determine the extent of health problems, using a National Health Survey questionnaire; only 20 per cent of the men reported no ailments. In the second phase of the Philadelphia study 200 men were given complete physical and mental examinations; only two per cent of these men were free of physical defects. Forty-eight men had tuberculosis in varying stages, 20 in association with alcoholism. Forty-nine of the 200 men were hospitalized for acute medical conditions. There was an almost universal need for major dental treatment. This study does not report any men with missing limbs, although six per cent of the Chicago sample were so disabled.

Thirty-eight per cent of the men on Chicago's skid rows had health problems or physical disabilities that would prevent them from supporting themselves, except in a sheltered workshop. (Another nine per cent were too old to work.) Fifty-four per cent could

support themselves, although half were slightly handicapped and would need assistance in finding a suitable job. (Alcoholism was not classified as a disability in this instance.) A physician with the Chicago study estimated that, with normal medical treatment, the percentage of men able to support themselves in regular work would increase from 54 per cent to 66 per cent. On the other hand, 21 per cent of the men had no serious disability and no serious drinking problem. This study probably underestimated the health problems of the population, as a result of its dependence on questionnaires. It seems possible, however, that the Philadelphia study erred in the opposite direction; men who were very ill may have been more willing to come to the Center for an examination.

Why has the man on skid row chosen to live apart from the main stream of society? Most alcoholics and men who are old, ill, or unemployed live, probably with their families, in residential areas throughout the city. We have noted that some men live on skid row simply because it is cheap. Bogue points out, however, that there are settled working men who live on skid row although they could afford to live elsewhere.[20]

Many writers have described the typical skid rower as "undersocialized." He has, for a variety of reasons, withdrawn from both the rewards and the difficulties of the primary group relationships which others find in their families, peer groups or in their jobs. He now lacks the ability to form complex, long-term, or emotionally charged inter-personal relationships. This interferes with his

ability to live in a family and to hold many kinds of jobs. He withdraws to a world where he has only one sex to deal with, where he needs to make no long-term commitment to a job, a home, or friends.

Rooney points out that excessive use of alcohol can be both the cause and the effect of undersocialization.[21] Certain occupations have a similar function. Transient railroad work or the merchant marines may appeal initially to those who are inept in certain types of interpersonal relations. Such work also, in isolating all-male groups from ordinary community life, weakens family ties and in fact discourages the development of these same interpersonal skills. Heavy drinking is typically an important aspect of the social life of men in these occupations.[22] The mobile worker is disappearing, but any and all of the factors which mold the individual personality -- inherited characteristics, family life, marital relationships -- can act together to produce an individual who is more comfortable within the anonymous life of skid row.

Wallace would substitute the term "desocialized" for "undersocialized." He agrees that skid rowers do not form long-term commitments to jobs, homes and people. He insists, however, that skid row is a culture into which one enters only after he has been desocialized from the larger culture of the community and socialized into the skid row way of life. Skid row is a deviant subculture with its own institutions, language, social stratification* and norms of behavior.[23]

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*Heavy drinkers, for example, may be "lushes," who can afford to drink and socialize in bars; "winos," who share bottles in the street; "rubby-dubs" who drink Sterno or other non-beverage alcohol; or "bums," who are social isolates within the row, and drink alone. Each type of drinkers occupies a distinct social class on skid row.[24]

Rooney's study of the "wino" bottle gang is particularly illuminating.[25] A bottle gang consists of three to five men who pool their funds to buy a bottle of wine which none could afford alone. As the bottle is consumed, certain rigid conventions are respected; for example, the bottle is passed counterclockwise and each man takes two swallows each round -- no more. All share equally in the wine, although they have simply contributed whatever they can afford to its purchase. While drinking they engage in ego-boosting conversation -- relating personal exploits, which are never challenged or criticizing the police. The sociability of the bottle gang is as important as the wine itself, yet there is no feeling of group solidarity. Any individual is substitutable for any other. A stranger will be invited to join a gang if he can contribute to the purchase of a bottle. A group may survive for the length of one bottle or somewhat longer, but close personal ties do not develop.

A high degree of dependency and a hedonistic orientation are other personality characteristics fairly common to skid row men.[26] Again there is no single cause. There is some evidence that a high proportion of these men had overly protective mothers.[27] Certain occupations can also reinforce this pattern. In the Navy, for example, an enlisted man does not have to provide his own food and shelter; this is taken care of for him by others. He does not even have to save part of his pay check to pay rent or buy groceries. His pay can all be spent in one big spree when he goes ashore.

The highly dependent individual may end up on skid row because he is unable to cope within normal society. There he may find a haven within a skid row mission; or he may live in a hotel where the desk clerk will manage his money, taking out the room rent and giving him a daily allowance for food and other expenses. The hedonist will never be able to get enough money together to get off the row, but he can survive day-by-day, picking up spot jobs or depending on the welfare agencies and missions.

It is clear that a skid row rehabilitation program cannot depend on a single remedy. A variety of special programs will be needed, and these, in turn, must be so flexible that they can be tailored to the individual. They must be based on a recognition of the fact that the skid rower has been assimilated, to a greater or lesser degree, into a new culture. His values have changed and he has found some satisfactions in skid row life that were missing in his former life. He may want help with a health problem; he may desperately need a meal or a bed for the night; he may be so sick from excessive drinking that he is willing to go to jail to "dry out" -- but he may be unwilling or unable to reenter the culture he has left behind. For many men a period of re-socialization will be required. Rehabilitation programs will have to provide whatever therapy and training a man needs to help him enter normal society. Since rehabilitation programs will never be completely successful, the community must provide substitutes for some of the institutions of skid row.

NOTES

1. Donald J. Bogue, Skid Row in American Cities, Chicago: Community and Family Study Center, University of Chicago, 1963, Chapter 2.

2. The bulk of the data used in this chapter comes from studies of the skid rows in Chicago, Minneapolis and Philadelphia. The sources are described below:

   Chicago: Donald J. Bogue, Skid Row in American Cities, (Chicago: Community and Family Study Center, University of Chicago, 1963) is an encyclopedia of skid row. This book is an expanded version of a report prepared by the Chicago Tenants' Relocation Bureau, The Homeless Man on Skid Row, (Chicago: Tenants' Relocation Bureau, September 1961). The data were gathered through lengthy interviews with 613 residents of skid row hotels, rooming houses and missions. For some reason, the data in the two publications do not always agree, although the discrepancies are generally minor. I have used data from the Tenants' Relocation Bureau report unless otherwise noted.

   Minneapolis: This study was based on interviews with a sample of 271 skid row residents. The results are reported in: University of Minnesota and Minneapolis Housing and Redevelopment Authority, A General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area, (Minneapolis Housing and Redevelopment Authority, September, 1958).

   Philadelphia: The Philadelphia data are drawn from two related studies. The first study was a census of the entire skid row population of Philadelphia, including homeless men in missions, the House of Correction, and other skid row-related institutions not within the physical boundaries of skid row. A total of 2249 men were interviewed. The results of this survey are reported in: Temple University, School of Medicine, Department of Psychiatry, The Men on Skid Row, (Temple University, mimeographed, December, 1960).

   A second publication reports the results of thorough physical examinations of a sample of 200 skid row men: Philadelphia Diagnostic and Relocation Center, Philadelphia's Skid Row: A Demonstration in Human Renewal, (Philadelphia Redevelopment Authority, undated - c. 1965).

3. Sacramento Redevelopment Agency, *Analysis of the Sacramento Labor Market Area*, Sacramento Redevelopment Agency, 1952.

4. University of Minnesota, *op. cit.*, p. 64.

5. Bogue, *op. cit.*, p. 8.

6. Columbia University, Bureau of Applied Social Research, *A Preliminary Estimate of the Population and Housing of the Bowery in New York City*, prepared for the Department of Welfare, City of New York, by George and Patricia Nash, mimeographed, March 1964.

7. Chicago Tenants' Relocation Bureau, *op. cit.*, p. 5.

8. University of Minnesota, *op. cit.*, p. 21.

9. See U.S. Department of Labor, *The Negro Family*, Washington, D.C., U.S. Government Printing Office, 1965.

   "Yet, as Dollard points out in his discussion of the psychic compensations of 'gains' which accrue to Negro lower-class caste status, the behavior of lower-class Negroes in 'Southern Town' is quite permissive in respect to the expression of aggression and sexuality and apparently, drunkenness." David J. Pittman and Charles R. Synder (eds.), *Society, Culture, and Drinking Patterns*, New York: Wiley, 1962, note p. 210, referring to Dollard's *Caste and Class in a Southern Town*.

10. Boston, South End Center for Alcoholics and Unattached Persons, "Monthly Report - November 1966," mimeographed.

11. Bogue, *op. cit.*, p. 240.

12. Richard Ryan, "After Skid Row, What? Detroit Finds Out," *Toledo Blade*, March (?), 1966.

13. Bogue, *op. cit.*, p. 476.

14. University of Minnesota, *op. cit.*, p. 13.

15. Interview: James Delaney, Social Work Supervisor, Boston Welfare Department (5/2/67).

16. Interview: James E. Quinn, Administrative Assistant, Diagnostic and Relocation Center, Philadelphia (11/25/66).

17. Robert Straus and Raymond G. McCarthy, "Nonaddictive Pathological Drinking Patterns of Homeless Men," *Quarterly Journal of Studies on Alcoholism*, 12:4 (1951), pp. 601-11.

18. Samuel E. Wallace, _Skid Row as a Way of Life_, Totowa, N. J.: Bedminister Press, 1965, p. 181-2.

19. Chicago Tenants' Relocation Bureau, _op. cit._, p. 40, their emphasis.

20. Bogue, _op. cit._, p. 469.

21. James F. Rooney, "Group Processes Among Skid Row Winos: A Re-evaluation of the Undersocialization Hypothesis," _Quarterly Journal of Studies on Alcohol_, 22:3 (1961), pp. 444-60.

22. Chicago Tenants' Relocation Bureau, _op. cit._, p. 29.

23. Wallace, _op. cit._, Ch. 12.

24. Joan K. Jackson and Ralph Conner, "The Skid Row Alcoholic," _Quarterly Journal of Studies on Alcohol_, 14:3 (1953), pp. 468-86.

25. Rooney, _op. cit._

26. Bogue, _op. cit._, pp. 387-8.

27. Temple University, _op. cit._, p. 50.

Chapter 2

A RELOCATION AND REHABILITATION PROGRAM

Rehabilitation programs designed to help skid row men return to the community will face tremendous problems, although there seem to be reasonable chances for success <u>if</u> the community is sufficiently committed to this goal. The community must decide, through the usual administrative and political processes, whether it really wants to eliminate skid row.

Just as skid row offers certain advantages to the men who live there, there are advantages to the larger community as well. We have seen that skid row is a source of casual labor, although it is highly questionable whether this labor source is really important to the economy of most cities. The same Detroit councilman who argued for the retention of the skid row labor force pointed out that "these residents of the row constitute the clientele for a sizable number of businesses: bars, pawnshops, restaurants, flop houses, all-night movies, etc."[1] The community will have to decide if this is a persuasive argument for the retention of skid row. The community may also feel that it is neater, safer, and more efficient to keep public drunks and other unattractive men concentrated in a small area of the city, where a few policemen can keep them under control.[2]

Finally, many people are discouraged by the sheer magnitude of the skid row problem, and doubt that rehabilitation programs will succeed. Past experience has not been encouraging. In a 1955 experiment, the Pennsylvania Prison Society provided intensive

counseling services to 35 skid row men who were about to be released from a correctional institution. Less than a year later, four men were steadily employed, three had settled off the row with pensions or welfare funds, seven had returned to the correctional institution and 21 had disappeared.[3] A group of half-way houses surveyed by Blacker and Kantor reported that an average of 35 per cent of the men were rehabilitated.[4] Figures like these (and they are only a sample) are certainly discouraging. It must be pointed out, however, that they are partly the result of rehabilitation programs that are far from complete.

These are some of the considerations that have caused traditional mission and public welfare programs to concentrate on the amelioration of skid row conditions, rather than on the rehabilitation of homeless men and the elimination of skid row. Should the community decide that skid row is a necessary institution, further improvements can be made along these lines. A day lounge can be provided on the row, so that men who don't drink have a place off the street where they can keep warm and meet friends; meal and lodging tickets can be distributed more liberally, so that no man needs to sleep outside or go hungry; building and health codes can be more strictly enforced in adjacent areas to prevent the spread of blight; and police can step up their arrests of homeless men who are found intoxicated or begging out of the skid row district.

But the land occupied by skid row is usually too strategically located to allow it to remain in this use. Skid row's blighting

effect on adjacent commercial and residential areas and its obvious potential for some "higher" use, are usually the factors that have brought the whole problem to the attention of the community. Of the alternatives, that of leaving skid row where it is is apt to seem the least likely.

Some cities have considered another alternative: move skid row -- lodging houses, bars, missions and all -- to some out-of-the-way, unwanted area of the city. It is conceivable that this could work. Of course some men would scatter throughout the city, which might or might not be desirable; others might end up in areas that contained the seeds of future skid rows -- dilapidated residential areas with concentrations of bars and cheap rooming houses -- and satellite rows might develop. But suppose the moving process were successful, and the skid row population was once more out of sight and out of mind![5] It is safe to say that it will be only a few years before the city begins to value very highly the once "worthless" land occupied by the new skid row.

Obviously the planning, coordination and implementation of a program to develop real alternatives to skid row will be a major effort within an already overburdened city. Will the results be worth the effort? It will be impossible to answer this question with real assurance until that day when we have a system of cost-benefit analysis which really counts all the costs and all the benefits. Until then, two factors might influence a community's decision. First, skid row costs money. Professor Wallace has estimated that New York City spends one and three-quarter million dollars each year

simply to arrest and imprison homeless men. This is probably a *very* low estimate, as it is based on very conservative assumptions about the number of men arrested, the cost of each arrest, and the average length of sentence. Capital expenditures are also not included.[6]

Bogue estimated that Chicago spent almost $750,000 per year for arrest and overnight detention of skid row men, and a total of $4,720,000 per year for all skid row programs. Only 3.2 per cent of this total "might be considered as attempting to improve conditions, help the men toward rehabilitation, and fight actively the complex of factors that create skid row."[7] And there are other cash costs, such as lowered property values and wasted human resources.

There is a second kind of waste: The skid row population is already receiving the services of a surprising number of institutions: missions, public welfare agencies, AA, hospital emergency wards, and tuberculosis hospitals as well as the police and the jails. If the proper effort were made to coordinate their work and direct it toward the common goal of getting men off the row, these agencies might eventually be able to turn their attention to other important social problems.

If the community decides to eliminate skid row, a grave question will remain. What should be done about the man who only wants to be left alone? Does a man have the right to decide that he will work as little as possible, spend as little as possible on food and lodging, in order to have time for loafing and money for drinking,

even if he is killing himself as a result? In some States this matter has been partially settled in regard to the alcoholic; civil commitment is possible, just as it is for the psychotic, if the man is "dangerous to himself or to others." But there will be other men to whom neat rules like this do not apply. Certainly the city should leave room for diversity. This issue will be discussed more fully in the final chapter.

Professor Wallace insists that the community must choose between the two alternatives -- keep skid row, or eliminate it -- and then proceed without ambivalence. "Regardless of whether one or the other policy is adopted, the crucial point is to have all programs working in the same direction, both in theory and in practice."[8] It is tempting to locate rehabilitation programs, even half-way houses, on the row. They are likely to be unwelcome in other parts of the city. But this means that men who are trying to adapt to a new life style will be constantly faced with the temptations and reminded of the short term attractions of their old way of life. While they are trying to save money for a new start, they are likely to be approached for handouts by men to whom they feel indebted by friendship or past favors. Many employers will be reluctant to hire a man who gives a skid row address.

Some communities have hoped that by simply bulldozing skid row it can be made to disappear. At best, the men on skid row will be so widely scattered that they become invisible, and the social problems they represent will be buried in the statistics of the

city as a whole. Some men may even take their problems to other cities. (But these cities will be bulldozing too).

It must be admitted that, to the extent that a skid row district itself reinforces the skid row way of life, successful scatteration of the skid row population may actually solve some problems. Unfortunately, however, there are usually other areas in the city which provide fertile ground for the creation of a new skid row, and the real problem has only been postponed and displaced -- not solved. Redevelopment of Detroit's skid row district was soon followed by the emergence of a new skid row about a mile away, and several smaller skid rows in other parts of the city.[9] In Boston, persons familiar with skid row problems agree that the demolition of Scollay Square simply drove the existing Dover Street skid row more deeply into the South End. If this skid row population is uprooted without adequate relocation services, they expect the row to reappear in Lower Roxbury.[10]

All measures which help to relieve poverty, decrease unemployment, and improve the health of the community, will help reduce the population of skid row. There is evidence that more adequate welfare payments to the elderly, employee pension plans and more adequate social security benefits have already had an effect, although there is room for improvement. Agricultural mechanization and other changes in employment patterns that have reduced the role of the highly mobile, seasonal laborer have undoubtedly led to a reduction in the skid row population. In 1923 Nels Anderson estimated that

the population of Chicago's row "never falls below 30,000 in summer, doubles this figure in winter, and has reached 75,000 and over in periods of unemployment";[11] in 1958 the Chicago study found a winter population of about 12,000. New York researchers have concluded that the Bowery population has decreased at an annual rate of about five per cent in recent years.[12] But the Chicago skid row population is now thought to be "roughly constant in size or growing only slowly,"[13] and the Minneapolis study also found population that had been stable in size for several years.[14]

It seems probable that skid row could be eliminated through programs of social reform directed at the total population. Improved medical services, a prevention-oriented approach to mental health, more attention to the needs of the families of alcoholics, more adequate welfare payments -- all such programs would reduce the size of the skid row population in the long run. But most cities will not want to wait for skid row to disappear by attrition. More direct programs are needed both to help the men who are now on the row and to help those who will find themselves "on the skids" in the future, in spite of our best efforts to prevent it.

It should be clear from the description of the population of skid row that no single program (e.g., higher welfare payments) will end this way of life. Nor will a single group of programs be applicable to each man on the row. Each homeless man will have different problems and a different potential and a program of relocation and

rehabilitation must be tailored to him as an individual.

In 1923, Nels Anderson wrote in The Hobo:

> Many...institutions and agencies regularly or sporadically extend assistance to the homeless man. Yet, in perhaps no other field of social work is there more overlapping and duplication of effort, or so low standards of service.[15]

This description remains accurate, although the same book proposed a new approach to the problem:

> A constructive program for rehabilitation [of the homeless man] demands the coordination of the efforts of all agencies now engaged in serving his needs.[16]

The proposal called for the City of Chicago to establish "a Municipal Clearing House for Non-Family Men":

> i) To provide facilities for the registration, examination, classification, and treatment of homeless, migratory and casual workers in order, on the basis of individual case study,
>
> ii) To secure by reference to the appropriate agency emergency relief, physical and mental rehabilitation, industrial training, commitment to institutional care, return to a legal residence, and satisfactory employment.[17]

Only recently, a few cities have begun to implement similar programs, with some promise of success. The three such agencies with which I am familiar are the Diagnostic and Relocation Center in Philadelphia, Operation Bowery in New York, and Boston's South End Center for Alcoholics and Unattached Persons. The Philadelphia agency is the oldest; it opened in May, 1964.

While these agencies differ in many details, their similarities are strong. Typically, the agency will have a four-part program:

Research: This part of the program will involve finding out more about the characteristics of skid row in general and, even more important, learning more about the size and characteristics of skid row in the city where the agency is located. Different rehabilitation techniques will also be evaluated. The Philadelphia agency concentrated almost exclusively on the research phase of the program in its early years, offering their full services only to a random sample of men from the skid row population. Operation Bowery has contracted with the Bureau of Applied Social Research of Columbia University for studies of the size and characteristics of the Bowery population. Boston has done little research so far but plans a study of the Boston skid row population in the near future.

Planning: These agencies bear the major responsibility for identifying the additional manpower, facilities, services and funds that the city will need if it is to find an alternative to skid row. Planning is typically on an *ad hoc* basis: the agency begins to work with the men but finds it needs certain facilities and services which are not available. The agency then tries to persuade other agencies to fill the gaps. In Minneapolis and Sacramento, however, much more timely planning failed to pay off, since the facilities called for were not provided anyway, prior to the bulldozing of skid row.

Education: If the agency is to carry out its plans successfully, it will have to add an educational (or propaganda) function

to its other duties. City officials and legislators must be persuaded to support rehabilitation programs. The public must be prepared for the introduction of rehabilitation facilities, half-way houses in particular, into residential areas. Physicians must be trained to work with skid row men. Policemen and judges must be acquainted with the program so that their work can be coordinated with that of the agency. Other agencies serving homeless men must be persuaded to take their places within the total rehabilitation program.

Action: These agencies have operated by bringing homeless men into the center (by actual street work, word-of-mouth publicity, or referral from other agencies), analyzing their individual problems and attempting to give the men the variety of services they require. These services will include assistance in finding appropriate housing, treatment for alcoholism and other medical and psychological problems, and help in securing employment, a pension or public assistance. In general the skid row agencies provide diagnostic, referral, and liaison services, but variations are possible, depending on local circumstances. The welfare department may place an employee, on a full or part-time basis, within the skid row agency, or the agency may simply assist the homeless man in his application for welfare. A medical clinic may be located within the agency, or an existing clinic may do work for the agency under contract. Some housing facilities, such as a half-way house, may be operated by the agency. In other cases, the agency

will make use of existing private and public facilities or encourage the development of needed facilities.

Financial support for these agencies has come from a variety of sources. Operation Bowery is part of the New York City Department of Welfare; its director believes that it is the only program of this type financed by local government. The South End Center operated for two years with funds from the Office of Economic Opportunity. The Philadelphia agency was initially funded as an urban renewal demonstration project. Both agencies now operate as part of urban renewal project relocation programs under federal provisions allowing diagnostic and referral services to be included as eligible project costs. The Massachusetts Department of Public Health, Division of Alcoholism, has also contributed funds to the South End Center. Of course these agencies must tap many sources of financial support for therapeutic and treatment services, which are not eligible relocation costs.

Not every city with a skid row would need or could afford to set up a separate agency with responsibility for the problems of the homeless men. But the approach to the problem which is the basis of the three agencies mentioned above could be applied if the "agency's" only staff consisted of one social worker. It is essential that someone give top priority to helping the men to leave skid row. The person or persons assigned this task must understand the culture of the row. They must be acquainted with and able to call upon a wide range of community resources in order to diagnose and treat the multiple problems of the skid row man. The typical service

agency, with an understandable tendency to give top priority to the needs of families and more "deserving" individuals, is not likely to deal effectively with the problems of the homeless men. (On the other hand, it may be that the experience gained in trying to rehabilitate skid row men can be put to use in work with so-called multi-problem families.)

The referral agency should in in a highly visible location on the row. Here it will be convenient for staff members working on the row, it can be easily located by men who wants its services, and the building can act as an advertisement for the services within. (Forty per cent of the patients of the South End Center have been self-referred "walk-ins.")[18] While the need for such a location is obvious enough, the agencies in Boston and Philadelphia had to face opposition from residents and businessmen in adjacent areas, who were afraid that the agency would simply attract more homeless men.

The type of facilities required will vary with the individual program, but typically the agency will require a waiting room for the men, private offices for the staff for interviews and psychological testing, and perhaps a medical clinic, unless physical examinations are conducted in another location. The Philadelphia Center has a dining room where men can get lunch. This means that men who are being processed through the agency can remain in the building at lunch time, and provides additional motivation for men to establish contact with the agency.

In theory, therefore, these agencies provide each man with the range of services he needs to help him solve the problems that have brought him to skid row, and help him adjust to life off the row. In many cases, the agencies have only succeeded in persuading men to enter some long-term care institution, such as a VA domicilliary. While it is hard to get enthusiastic about such "successes" it is also unfair to consider them otherwise. But there is no question that fewer men would have to be confined to institutions, and even fewer men would fail in their attempt to re-enter normal society, if the skid row agencies had the resources required to do the job they were set up to do.

Cash, of course, is the basic resource, and skid row agencies are not likely to be overendowed. It is not surprising, for example, that when Boston's Anti-Poverty program funds were cut back, the South End Center was among the first programs to be cut. (On the other hand, it would be wrong to pretend that only adequate funds are needed to eliminate skid row. Some of the other problems will be discussed in other sections of this paper.)

One resource which skid row agencies have lacked is sufficient manpower. Many homeless men will need to be persuaded to make the initial visit to the agency. They may lack sufficient motivation or ability to get themselves around to all the other agencies from which they must get aid. Many of their problems may not be solved for months, or years -- or ever, and there will be constant temptations to solve their problems by slipping back into the life of the

row. The men must be seen by physicians, psychiatrists, and specialists in job retraining, housing and welfare, but they will also need the services of trained social workers who can assist them in taking advantage of the proper services and see them regularly when they settle off the row, visiting them where they live or work if necessary. Sufficient personnel are also needed to permit the agency to remain open in the evenings and on weekends.

The South End Center in Boston finds that their inability to provide adequate follow-up services is one of the most serious weaknesses in the program. Out of the first 936 patients who came to the Center, only 40 per cent were seen after the initial referral. The Center simply does not have the personnel required to maintain contact with the men.[19] On the other hand, the very successful "outplacement" program of the Brockton Veterans' Administration Hospital provides for weekly visits by social workers to the patients living off the hospital grounds. This program requires the equivalent of twelve full-time social workers to visit 600-700 men. (Usually there is more than one man in the same household.)[20]

The remainder of this chapter describes the resources which the agency must have to help men leave skid row. This paper does not discuss long-term treatment institutions in any detail, however, although such institutions -- mental hospitals, TB hospitals, nursing homes -- will unfortunately be an indispensible part of such a program.

The skid row alcoholic is most likely to come to the attention of rehabilitation agencies when he is at the end of a period

of intensive drinking and is arrested for public intoxication, or finds his way to the emergency clinic of a hospital in need of medical attention. In the past the chronic drunkenness offender has been kept in jail overnight or given a brief jail sentence, depending on his past record, and then released to return to the row. While recent court decisions have ruled against treating the alcoholic as a criminal, typically no alternative is provided. If necessary the police can arrest a man on another charge, such as "vagrancy" or "disturbing the peace." The skid row alcoholic may have been arrested dozens of times since arriving on the row. Pittman calls this process "the revolving door."

The skid row alcoholic may or may not receive better care in a general hospital emergency clinic. At best he is given the immediate medical attention he needs and then sent on his way. On the other hand the physician may be put off by the man's appearance and behavior and consciously or unconsciously see to it that he leaves without even minimal care. The man may be kept waiting for hours without attention, or treated in such a way that he must leave the hospital to salvage some self-respect. Very rarely will the skid row alcoholic receive any follow-up services from the clinic.[21]

In order to help the skid row alcoholic escape from the "revolving door," a special detoxification center should be provided near the row. A man might come to this center of his own volition, or be brought there by the police. He would stay here only a day or two. When he is cleaned up, has received a general physical

examination and emergency medical treatment, has slept and is sufficiently alert, he is interviewed by a psychiatrist and social worker who will prescribe further treatment.

From the detoxification center, a man may be sent to a general or chronic illness hospital or an institution for further treatment of his alcoholism, referred to an out-patient clinic, or simply released. The staff of the central referral agency should be responsible for following through from this point.

In New York, Operation Bowery has asked for a 50-bed detoxification center, to be established at the Men's Shelter. The staff would include clerks, nurses and nurses aides, a psychiatrist, social workers and physicians. Such an elaborate set-up would be impractical for many smaller cities. In all cases, however, there is a clear need for some arrangement whereby the chronic drunkenness offender can be brought to a clinic where his immediate physical needs will be met and where he can be seen by staff members who have some understanding of the special problems of the skid row alcoholic.

The New York proposal calls for the establishment of an out-patient clinic in conjunction with the detoxification center. Here the alcoholic could take part in group therapy, meet with a social worker who would help him handle his day-to-day problems, and perhaps receive Antabuse or other drugs that are being used in his treatment. There has been some question whether the skid row alcoholic would take advantage of out-patient services. Yet an experiment at Massachusetts General Hospital demonstrated that, with the right sort of attention at this critical time, many skid row

alcoholics could be encouraged to return for further treatment.[22] The researchers had noted that alcoholics who came to the emergency ward were easily frustrated by the complicated admission procedure and frequently faced open hostility and rejection from the clinic staff. In this experiment a group of 100 alcoholics, most of them homeless men, were assigned immediately to specially trained teams, consisting of a psychiatrist and psychiatric social worker. These referrals avoided most of the red tape of the usual clinic visit. At this initial contact with the team, the alcoholic was invited to return to the clinic for continued treatment. He was assured that the same team members would continue to see him and that they would be available as frequently as they were needed. Forty-two per cent of this group made five or more visits to the out-patient clinic.

At the same time a control group were given the usual emergency ward treatment. This meant that they had to deal with several persons before actually getting attention in the alcoholism clinic. Although they were routinely invited to make use of the clinic's out-patient services, they were not promised the continued attention of the staff members who saw them at the initial visit. Only five per cent of this group made one return visit to the clinic and only one per cent were seen five or more times.

One might argue that an out-patient clinic should not be located on the row. If a man has found a new home in another part of the city, it would be a mistake to force him to return to the skid row area for treatment. However, the M.G.H. experiment suggests

that the out-patient clinic and the detoxification center should be in the same building, to enable staff members to provide both in-patient and out-patient services. Probably the detoxification center should be in a compromise location -- near the row, but not directly on it.

In most cases it would be both unnecessary and unwise to house either the skid row referral agency or the detoxification center in a new building. As renewal and rehabilitation programs take effect, these services may be reorganized, eliminated, or moved to another skid row area.

The routes out of skid row are as varied as the routes in. Once the homeless man has come to the attention of the central referral agency, on his own initiative, through field work by agency staff, by referrals from other agencies, or at the detoxification center, he and the staff should be able to call upon a wide variety of housing resources and health and welfare services to help him leave the row. In some cases the homeless man will be able to adjust immediately to independent living off the row, although he may need help at first to find a job or to secure adequate welfare or pension funds. Other men will go, temporarily or permanently, into the slightly more protective environment of a halfway house or foster home. Many men will first go to an institution for more intensive medical and psychiatric treatment of problems connected with alcoholism; from there they will return to a halfway house and perhaps eventually to fully independent living. Some will

never leave an institution, others will never leave the life of the row.

The discouraging complexity of skid row rehabilitation is illustrated by the fact that professionals working on skid row have, at different times, stressed the need for a one-quarter-way house, a half-way house, and a three-quarter-way house. The first would provide adequate housing and relevant services for men who have indicated that they no longer want to remain anonymous, but are not yet ready to commit themselves fully to the admittedly drastic steps that might lead to rehabilitation. In the one-quarter-way house, there would be an opportunity to develop rapport between the homeless man and the professionals. The half-way house will be discussed more fully in Chapter 4. It represents a mid-step between skid row and the community, or perhaps even more appropriately, between an institution and the community. But even when he has gone through the resocializing experience of the half-way house, a man may not be comfortable living completely on his own. He may fear the loneliness of an apartment or room; if he is a recovered alcoholic he may want to find the companionship of others who cannot drink. The three-quarter-house would serve his housing needs. It might resemble a YMCA residence, but only recovered alcoholics would be admitted.

Public housing for the elderly, and some units in regular public housing will be suitable housing resources for some skid row residents, particularly for non-alcoholic elderly men and others who have

come to live on skid row only because living costs are low. Recent changes in public housing regulations have made it possible to place non-elderly individuals in public housing, if they have been displaced by urban renewal, as will usually be the case in skid row relocation programs. For many men, the YMCA, or a similar residential facility will be a perfect housing resource. It provides a combination of independent living and privacy, convenience, low cost, and the opportunity for the companionship of other men in planned activities and lobby conversation. In the Boston area, YMCA room rents range from $56 to $80 per month. (The Tyler Street "Y" has fourteen rooms at $23 per month; the desk clerk says that the rooms are "what you might expect" at that price.) There are a limited number of "Y" rooms, however, and the rates will be too high for many elderly and unemployed men from skid row. Similar facilities could be constructed for single elderly men under existing public housing programs.

Rooming houses and, to a lesser extent, apartments are among the private housing resources which can serve as alternatives to skid row lodging houses and missions. Rooming houses are discussed at greater length in Chapter 3.

Many homeless men, even though they may not be alcoholics, will be highly dependent and perhaps unable to budget their money. They will not be able to live independently within the community. Skid row agencies often talk of developing "foster home" programs for these men. The Brockton VA hospital has developed a novel "outplacement" program to take greater advantage of private housing

resources. This neuro-psychiatric hospital provides long-term care for many men who have been skid row alcoholics, in addition to the treatment it provides for men with other types of illness and from other backgrounds. Staff members noticed that most men gave up drinking easily when they were in the protective atmosphere of the hospital and removed from the social milieu that had initiated or encouraged their excessive drinking. The out-placement program is an attempt to duplicate these conditions in the community. Since the program began as an experiment 13 years ago, the Social Service Department of the hospital has made arrangements for many men to live out of the hospital in private housing, following a period of in-patient treatment. Some men live with families as members of the household; others live in small groups in a boarding house or in rest homes. In some cases the woman who provides the foster home is able to give nursing care.

The median age of the men in the out-placement program is 45. After ten years of operation, 550 patients, of which 200 were alcoholics, had been placed in the program. Sixty-three per cent of the patients had never been readmitted to any hospital <u>for any reason</u>. The record is about the same for alcoholics as for non-alcoholics. Twenty per cent of the alcoholics had been returned to the hospital for treatment after drinking, but most returned to the foster home within a month. There is no indication that the program is successful only for a selected group of alcoholic patients, since very few of the patients were released directly into the community, and few have remained as permanent residents of the hospital.

Frederick Glynn, Chief of Social Work Service at the hospital, sees three reasons for the success of the program. First, the hospital takes great care to place each man in the appropriate home, whether it be in the warmer, but more demanding, environment of an individual in a family, or in the more impersonal boarding house environment, which some men prefer. Second, the hospital maintains constant contact with the man and his foster home; social workers visit each foster home once a week and try to handle the problems of the men and their foster "parents." Finally, the hospital staff makes sure that each man is able to pay $30-$35 a week for his care. A woman with two patients can clear about $50 per week. This makes the program very attractive for the mother of a family who wants to earn some extra money without tying herself to a full-time job, or for the widow who needs to supplement her income or simply wants someone to look after.

Very few of the men in this program have jobs (20%) and even fewer have left the foster home to live independently in the community. The social workers who counsel the men do not encourage them to find employment; Glynn believes that most of the hospital's patients cannot be expected to compete in the regular job market and that failure in employment may send the man back to skid row. His theory is that the man who is really ready to work will get a job on his own without encouragement from the social worker. In most cases, the foster home seems to be simply an extension of the institution, rather than a way back to independent living.[23]

The success of this program seems to depend on excellent long-term service to both the patients and the foster "parents," adequate remuneration, and modest expectations.

Vocational training and rehabilitation will be important elements of any skid row program. The Chicago study indicated that some 30 to 40 per cent of skid row men were so seriously disabled that they would be able to work only in a sheltered workshop. The Salvation Army, Goodwill Industries and several other agencies are already providing this type of employment. Men who are fully able to work, but lack skills, can receive training under the Manpower Development Training Act. These programs are operated in Massachusetts by the Division of Employment Security. A single man can receive $43 a week while training for jobs available in the area. Dr. Walter Stanger, Chief Psychologist with the Philadelphia referral agency, has found that former skid row alcoholics have relatively little difficulty finding jobs, but great difficulty keeping them. They are easily upset by small interpersonal problems. This is one reason that they require the support of a half-way house during the first months on the job.[24]

Since many men will be unable to work because of age or disability, recreation facilities must be available. City parks, movie theaters, and library reading rooms are now much used by homeless men. (The Minneapolis survey showed that 19 per cent of the skid row residents had been to the central library during the previous week, although it was three-quarters of a mile from the Lower Loop area.)[25] City recreation departments and private social

agencies are beginning to realize that the elderly need planned recreation programs at least as much as children do. But, although the fear of loneliness is endemic to homeless men, they are generally not "joiners." There must be alternative opportunities for the kind of low-pressure socializing that is now found in hotel lobbies and skid row bars. Small recreation lounges should be available throughout neighborhoods that house a large number of single elderly men and women. These lounges would have the spirit of informal club rooms, with facilities for card playing, newspapers, and coffee. Missions and other private agencies could provide such facilities; professional staffs would not be needed.

To what extent can this web of facilities be planned in advance? A large amount of ad hoc planning is inevitable -- in the course of a program to relocate men from skid row, it will become obvious that there is an unmet need for a certain type of facility or service and steps must be taken to provide it. Screening men for various programs is a very unscientific process at best. No survey can determine precisely what programs will be needed or the number of men they must serve.

But advance planning will still be extremely important. A careful study of the size and characteristics of the particular skid row population will enable planners to estimate the case load of the referral agency. Many questions can be answered in advance: The incomes of skid row men and their eligibility for welfare funds under local conditions can be compared with the supply of low-cost

housing in other areas of the city. There may be an obvious need for particular housing facilities; changes in welfare policies may be indicated. The Minneapolis study demonstrated that the city would need hundreds of additional units of low-cost housing for the large number of elderly men in the Lower Loop area. (The units were never built since it was impossible -- politically -- to find a site for the proposed 500-unit public housing project.[26] It was probably unwise to attempt to locate so many homeless men in a single location.)

An inventory of existing facilities and services is an important -- and surprisingly difficult -- step. My work in the Boston area has indicated that it will be very difficult to compile a complete inventory. Institutions which have been serving homeless men have usually operated for years without coördination or even communication between them and with various goals. In order to make the most effective use of the available resources, planners will need to understand the programs of the various institutions in some detail. In Boston, for example, two half-way houses for alcoholics differ in their allegiance to the methods of Alcoholics Anonymous. A successful program to get men off skid row will benefit from such variety if sufficient information is available to the referral agency. Racial quotas or complete discrimination policies will also limit the effectiveness of some institutions on skid row.

The most difficult task of the program planner will be to achieve coordination within this network of public, semi-public and private agencies which affect the life of the man on skid row. As

gaps in the existing resources become apparent, certain agencies may have to be persuaded to make fundamental changes in their programs. Many people feel, for example, that the missions are now providing services which help to maintain the skid row way of life, and do little to help and encourage men to leave the row. Without a doubt some missions should continue to perform similar services, providing food, clothing, and shelter to homeless men in emergencies. Others may be asked to use their physical facilities, experienced personnel, and financial resources in coordination with other institutions, for programs aimed more directly at rehabilitation.

NOTES

1. Richard Ryan, "After Skid Row, What? Detroit Finds Out," Toledo Blade, March (?), 1966.

2. Samuel E. Wallace, Skid Row and Its Inhabitants, prepared for the Department of Welfare, City of New York, by the Columbia University, Bureau of Applied Social Research, March, 1965, Part VI.

3. Ernest W. Goldsborough and Wilbur E. Hobbs, "Report of the Pennsylvania Prison Society to the Health and Welfare Council on the Homeless Men Project," mimeographed, February, 1956.

4. Edward Blacker and David Kantor, "Half-Way Houses for Problem Drinkers," Federal Probation, June, 1960.

5. See Harold W. Demone and Edward Blacker, The Unattached and Socially Isolated Residents of Skid Row, Action for Boston Community Development, Inc., mimeographed, July, 1961, p. 57: "In this respect the ideas of Kevin Lynch regarding the community's image of the city might be helpful. There may be certain areas which, in the public's mind, are blank spots. It could be that locating either one large facility or scattered facilities into these areas would create the least threat to the community."

6. Wallace, op. cit.

7. Donald J. Bogue, Skid Row in American Cities, Chicago: Community and Family Study Center, University of Chicago, 1963, p. 416.

8. Wallace, op. cit.

9. "Skid Row Gives Renewalists Tough Relocation Problems," Journal of Housing, Vol. 18 (August-September, 1961), pp. 327-336; and Ryan, op. cit.

10. Demone and Blacker, op. cit., pp. 53-4.

11. Nels Anderson, The Hobo, (Chicago: University of Chicago Press, 1923), Phoenix edition, p. 13.

12. Morris Chase, "Planning and Programming for Homeless Men on Skid Row," mimeographed, presented at the Annual Conference, American Orthopsychiatric Association, March 19, 1965, p. 3.

13. Chicago Tenants' Relocation Bureau, The Homeless Man on Skid Row, Chicago, 1961, p. 39.

14. University of Minnesota and Minneapolis Housing and Redevelopment Authority, A General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area, Minneapolis, September 1958, p. 30.

15. Anderson, op. cit., p. 261.

16. Ibid.

17. Ibid., pp. 269-70.

18. South End Center for Alcoholics and Unattached Persons, "Refunding Proposal and Progress Report," mimeographed, December 7, 1966, p. 3.

19. Ibid., pp. 5-7.

20. Interview: J. Frederick Glynn, (3/22/67).

21. Interview: William F. McCourt, M.D., (3/29/67).

22. Morris E. Chafetz, et. al., "Establishing Treatment Relations with Alcoholics," Journal of Nervous and Mental Disease, 134:5 (1962), pp. 395-409.

23. This discussion is based on an unpublished paper by Mr. Glynn, and an interview, 3/22/67.

24. Interview: Walter Stanger, (3/13/67).

25. University of Minnesota, op. cit., Table 58 and p. 147.

26. Journal of Housing, op. cit.

Chapter 3

ROOMING HOUSES

Rooming houses will be a valuable housing resource for agencies concerned with the relocation of homeless men. Thirty-four per cent of the men on Philadelphia's skid row named rooming houses as the type of relocation housing they would prefer, compared with 31 per cent who chose hotels with single rooms and 21 per cent who chose apartments.[1]

Generally a single room is less expensive than an apartment in similar condition, although this is not always true; there is general agreement that "decent" rooms are available in Boston's South End for as little as $8-9 per week. The initial payment is lower for a room and more frequent payments are required -- both helpful to the homeless man who has trouble saving enough money for a full month's rent in advance, and who does a poor job of budgeting his funds. Many homeless men need the attention of a landlady who will provide fresh linen and do some cleaning. The elderly man without family may be better off in a rooming house, where someone will notice if he is ill, than he will be living alone in an apartment or in the relatively impersonal atmosphere of a YMCA or hotel.

Rooming houses play a part in the "foster home" program of the Brockton VA hospital, described in the preceding chapter, and 25 rooming houses have cooperated with Boston's South End Center by agreeing to take men referred by the Center. Landlords are

assured that they can call on the Center for assistance, and some assist the Center by reminding the men of appointments with their counselors.

Other landlords have refused to cooperate when approached by a member of the Center staff; yet when the men themselves have gone to the same rooming houses, explaining that they are clients of the South End Center and are looking for a new place to live, many of the same landlords gave them rooms.[2] (In fact, Minneapolis researchers discovered that many landlords who had said they would not rent to skid row men were willing to rent to a staff member who applied disguised as a skid row resident and smelling of liquor.)[3]

Rooming houses are not the complete solution to the housing problems of skid row men. Not all rooming houses have resident owners or resident managers. Many are poorly managed and are in disrepair. Several skid row men I talked with said they used the dormitory of the Boston Industrial Home since the rooms they could afford were inadequately heated -- apparently many rooming house fires have been caused by tenants using hot plates to supplement the heat. Few landladies who run "respectable" rooming houses will be willing to put up with a tenant who drinks heavily or does not keep his room fairly clean.

It is claimed that some rooming house owners exploit the skid row alcoholic. They will give him a room on payment of two weeks rent in advance, then evict him after a couple of days on the grounds that he has violated the rules by drinking in his room. The advance payment is not returned, and the room is rented to another

man, with perhaps the same results. Even if his rights have been violated, the homeless man is not likely to complain to authorities.[4]

Some men will be very lonely in a rooming house. Men who are spending the night in the dormitory of the Boston Industrial Home often say they cannot stand the "four walls" of a room by themselves. While most want a room of their own for sleeping and occasional privacy, they also want easy access to some form of undemanding companionship, such as a YMCA or a similar facility would provide.

Even with these limitations, rooming houses will be an extremely important resource, and many of these limitations could be overcome. Men from skid row must receive whatever treatment they need, including half-way house experience, to enable them to live independently within the community. Adequate opportunities for recreation and companionship should be near at hand. A neighborhood bar can serve this function well for men who are not alcoholic, but both nondrinkers and alcoholics will require an alternative. A rooming house managed by a recovered alcoholic could serve as a "three-quarter-way house," and could probably operate without a subsidy if all the tenants were employed. Finally, the skid row agency must have sufficient staff to provide follow-up services for as long as necessary. If a man is living on welfare, he will be seen by his caseworker; if he is trying to hold a job and remain independent, he will have an even greater need for counseling and moral support.

Just as social welfare agencies have tended to emphasize service to families, planners and others concerned with housing have neglected the needs of the single individual. Public housing has been unavailable to non-elderly individuals, and even elderly individuals have been given low priority, although exceptions were made for persons displaced by public action in the Housing Act of 1964. Federal urban renewal legislation did not even require cities to provide relocation services to single individuals until 1964. While renewal agencies were likely to give some attention to the needs of individuals occupying houses and apartments, rooming house tenants were frequently dismissed as "transients." (See, for example, the "Relocation Report" for Boston's Government Center project in Scollay Square.) Planners have devoted a great deal of effort to devising zoning codes which are completely free of loopholes that permit rooming houses or other group living arrangements, whether they are for transients or for permanent residents.[5] Planners have devoted much less effort to seeing that enough well-run, well-maintained, conveniently and pleasantly located single rooms are available for those who prefer such accommodations.

Zoning and housing codes which prohibit or greatly restrict rooming houses often seem to reflect social discrimination against rooming house tenants. The same codes which restrict rooming houses to commercial districts may permit fraternity houses in single-family districts, although, as one court decision pointed out:

> The college social and fraternal life about the fraternity or the sorority is well known to all and has, to say the

least, much more adverse effect upon the neighboring residences than a mere rooming house or boarding house.[6]

It is not surprising that the number of rooming houses has decreased rapidly in recent years. There were about 3000 licensed lodging houses in Boston just after World War II; there are now about half that number.[7] Demand has also decreased thanks to growing prosperity and the easing of the post-war housing shortage. Rooming houses have been demolished for urban renewal and private development. They have been converted to apartments or even offices. But there are still many people -- and skid row residents are but a fraction of this group -- who believe that rooming houses are the best answer to their housing problems.

The future of the rooming house is a topic that deserves thorough investigation.[8] In this chapter I can only sketch some of the important issues. There is almost no literature on the topic. Rooming house owners are naturally reluctant to divulge financial data. The information in this chapter has been drawn primarily from scattered material in the files of the Boston Redevelopment Authority's South End site office[9] and from conversations with South End rooming house owners and members of the B.R.A. staff.

Over 900 of Boston's licensed lodging houses are located in the South End Urban Renewal Project area. Although the number of licensed units in this area decreased 40 per cent between 1950 and 1960, rooming houses still represent 25 per cent of all residential

structures, contain about 10,000 rooms, and house about 8000 tenants. Only houses with five or more rooms are licensed. According to one B.R.A. estimate, there are between 400 and 900 unlicensed rooming houses; if they have an average of three occupied rooms, this would represent an additional 1200 or 2700 tenants. As a result, the planners and residents concerned with the successful implementation of the South End Urban Renewal Project had have to grapple with the problems which rooming houses present. The problems cannot be "solved" by demolition.

The typical South End rooming house has been converted from a narrow, four-story, single-family row house. The owner may have an apartment on the ground floor and there can be as many as four sleeping rooms on each of the three floors above. The high cost of heating these large buildings is one of the factors that has encouraged their conversion to rooming houses or apartments. In rooming houses with ten or more rooms, the Boston code requires a bathroom for every eight rooms and running water in each room.

Non-resident owners often appoint a tenant to act as manager of the rooming house in exchange for a reduction in his rent. Some managers choose tenants, collect rents and do minor repairs, but this will be done by the landlord if he is a realtor with a South End office.

An exterior survey made by the B.R.A. in 1962-63 revealed the following building conditions:

	Owner Occupied (512)	Non-Owner Occupied (411)
Satisfactory	6.4%	3.8%
Minor repairs	44.3	38.9
Extensive minor repairs	44.3	44.5
Major repairs	5.0	12.8
	100.0%	100.0%

Thus the survey indicated that 49 per cent of the owner occupied houses and 57 per cent of the non-owner occupied houses needed either major or extensive minor repairs.

In a more detailed investigation, B.R.A. staff members inspected 49 licensed rooming houses in the Pembroke Street Pilot Rehabilitation Area. They found that 44 of the houses required rehabilitation at an estimated average cost of $5000. But they found that three out of four of the 49 houses were "well operated."[10] This meant that they had a stable tenancy, were clean, and were either owner occupied or managed by someone living in the building or on the same block.[11]

The total supply of rooms seems to be adequate, with the overall vacancy rate apparently as high as 20 per cent. There are no statistics available to show the conditions of the vacant units, but a social worker with the Boston Welfare Department reports that his clients have never had any trouble finding rooms in reasonably good condition for $8 or $9 per week.[12] Apparently, even with high vacancy rates, the owner of a single house can add a significant amount to his regular income, and the owner of several rooming houses can earn a healthy income.

In one South End rooming house with ten rooms, rents range from $5 to $12 per week, with an average of $9, or $390 per month gross income. The owner's monthly expenses, including mortgage payments, are about $250 per month, so that net income is about $140 per month when all rooms are occupied. In another case, a single owner occupant lives on the income from 23 rooms in two adjacent houses.

The available information is scanty, but it at least suggests that the rooming house business is profitable enough to continue to attract investors and that, with uniform enforcement of code and rehabilitation standards, competition for tenants may encourage owners to absorb some of the rehabilitation costs. However, since it will be more difficult to manage a rooming house than an apartment house of comparable size, it is reasonable for rooming house owners to want a higher return.

Those concerned with the rooming houses in the South End are now looking for answers to two key questions: (1) What housing code standards are desirable? (2) How can the necessary rehabilitation be financed?

In 1966 the State legislature established the "Special Commission on Lodging Houses in the City of Boston...for the purpose of making an investigation and study relative to the operation and management of lodging houses in the City of Boston." The Commission was instructed to give particular attention to the

"advisability and feasibility of permitting cooking in the rooms of lodging houses under proper safety precautions."[13]

The question of cooking in rooms is a controversial issue. The issue is also somewhat confused; since the Boston Housing Code is not explicit on every point, it is subject to interpretation by individual inspectors. The Code permits rooms to have an electric hot plate of low wattage. Many "light housekeeping" rooms actually have gas hot plates and refrigerators; with the required sink, they become efficiency apartments without bathrooms, and can therefore be considered substandard dwelling units. City officials claim that cooking facilities are a fire hazard, especially since they are often used to supplement inadequate heat, and that cooking in rooms is likely to attract roaches and other vermin.[14]

Rooming house owners say that housing inspectors should simply be sure that rooming houses are adequately heated so that tenants do not need to use stoves for heat. They wonder why cooking in efficiency apartments is more acceptable than cooking in rooms.

One solution would be to permit no cooking in rooms. This solution would be very unpopular with present tenants and therefore with landlords as well. It would be also very difficult to enforce. At best it will cause inconvenience; for many skid row relocatees it will be a more serious matter. Although light housekeeping rooms are about three or four dollars more a week than other rooms, there is a considerable saving in food costs when compared with restaurant meals. The New York City Department of Welfare

allows unemployed single men twice as much for food if they have to eat out. Several skid row residents told me that they wanted cooking facilities in order to lower the cost of meals. Two pointed out that food was available at little or no cost at the market where they worked.

One alternative solution would be to provide a fully equipped kitchen in each rooming house to be shared by the tenants. In this case no cooking facilities would be permitted in the individual rooms. This could create some obvious management problems, however, and rooming house owners have varied reactions to this idea. Another solution, which seems more practical, would be to require the installation of sink, hot plate and refrigerator in a built-in nook. This arrangement would provide some degree of fire control and a counter for food preparation which would be easy to clean. There are already some installations of this type in South End rooming houses.

Another Code change which might be desirable would be a requirement that rooming houses be either occupied by the owner or managed by someone living in the building or on the same block.

If rooming houses in stable residential neighborhoods are to be available to men from skid row, planning and housing officials will have to be particularly careful to see that rooming houses are not a blighting influence on the surrounding neighborhood. Housing codes must be carefully written and then rigidly enforced, not only for reasons of health and safety, but to protect property values and forestall neighborhood opposition.

At least 50 per cent of South End rooming houses need rehabilitation, and owners may have additional expenses if a revised code requires special installations for cooking in rooms. But South End landlords have discovered that banks are extremely reluctant to make rehabilitation loans to licensed rooming houses. One bank official explained that lodging houses had been considered poor risks since they were largely owned by absentee landlords and because they are difficult for a bank to manage in the event of foreclosure. While the official was mistaken in regard to the extent of absentee ownership, banks are still expected to be reluctant to make loans in most cases. Nine owners in the Pilot Rehabilitation area applied for loans. Fifteen banks were contacted, but only one loan was completed.

The crux of the problem is that rooming houses are ineligible for Federal loans or mortgage insurance under any existing program. FHA will not insure mortgages for either licensed or unlicensed rooming houses. Landlords who want FHA financing are forced to convert rooming houses to apartments. The Small Business Administration has made a policy determination that licensed rooming houses do not constitute small businesses. There are additional funds available to very small businesses under the Economic Opportunity Act of 1964, but this program is administered by the SBA using the same criteria. Section 312 direct Federal loans cover most types of owner-occupied commercial and residential property in urban renewal areas, yet even these loans are not available for rooming house rehabilitation.

BRA staff members and South End rooming house owners hope to persuade one of the Federal agencies to change its policies. Failing in this, banks might be more willing to make conventional loans if a loan pool were created through a non-profit rehabilitation corporation.[15]

If solutions can be found to these problems a valuable step will have been taken. Rooming houses for single individuals appear to be the one area in which low income housing can be provided by the private market.

NOTES

1. Temple University School of Medicine, Department of Psychiatry, *The Men on Skid Row*, Philadelphia: Temple University, December 1960, mimeographed, p. 88, Table 8-10.

2. Interview: Many Leno, Housing Specialist, South End Center for Alcoholics and Unattached Persons (2/17/67).

3. University of Minnesota and Minneapolis Housing and Redevelopment Authority, *A General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area*, Minneapolis Housing and Redevelopment Authority, September 1958, p. 189.

4. Interview: Charles Reuell and Francis Jackman, Boston Industrial Home (2/15/67).

5. See American Society of Planning Officials, Planning Advisory Service, *Rooming Houses*, Information Report No. 105, December 1957.

6. Supreme Court of Utah, *Phi Kappa Iota Fraternity v. Salt Lake City*, 212 P. 2d 177, 2 ZD 23 (1949), from *ASPO*, *supra*, p. 15.

7. According to a long-time employee of the Boston Licensing Board.

8. This would be an excellent topic for an M.C.P. thesis.

9. The principal sources are: Boston Redevelopment Authority, *South End Report*, October 1962, mimeographed; and an inter-office communication by David Wylie, Gordon Gottsche, and Walter Little, "Financing Rehabilitation of Lodging Houses," March 3, 1965.

10. Data from "Financing Rehabilitation of Lodging Houses," *supra*.

11. Interview: Gordon N. Gottsche, Director, Housing and Improvement Programs, South End Urban Renewal Project (5/12/67).

12. Interview: James Delaney, Social Work Supervisor, Boston Department of Welfare (5/2/67).

13. *Resolves of 1966*, Chapter 61.

14. Letter to Hon. Samuel Harmon, Chairman, Special Commission on Lodging Houses, from R.R. Thuma, Jr., Building Commissioner, 3/22/67.

15. Principal sources: "Financing Rehabilitation of Lodging Houses" (Note 9); and Interview: James Finigan, Financial Specialist, Boston Redevelopment Authority (5/5/67).

Chapter 4

HALF-WAY HOUSES

Persons whose anti-social or bizarre behavior has caused them to be rejected by normal society often adapt with ease to life in a total institution, such as a correctional institution or mental hospital. Both physically and socially such institutions are structured to absorb the destructive effects of abnormal behavior, both by introducing elaborate controls and by creating an environment where some abnormal behavior is part of the system.[1]

Skid row itself has some of the characteristics of such institutions; some abnormal behavior is expected and tolerated by the men who are members of the community, and by the policemen, businessmen and mission workers who are analagous to the attendants in a mental hospital or the guards in a prison. At the same time, skid row is not a great threat to the larger community, because geographical isolation and the increased attention of the police permits a great deal of control over the effects of such behavior.

Neither skid row nor the total institution encourage saving or other kinds of planning. Like the prison or mental hospital, the skid row way of life makes it possible for many men to obtain the bare necessities of life -- food, clothing, shelter -- without sustained effort. In this way the missions, blood banks, and spot labor agencies help to perpetuate skid row. Obviously prison life may be a lot more comfortable from this point of view; in fact

correctional institutions have often served as a resource for skid row men, who may seek arrest or commit themselves to an institution in times of extreme economic or physical distress.

It is no wonder, then, that the transition from the culture of skid row to the culture of the prison or mental hospital is often accomplished with ease, while the transition from the row or the institution to the normal life of the community may be exceedingly difficult. The homeless man is commonly ill-equipped to compete in the community, by reason of poor physical and mental health, lack of skill and education, yet he must attempt to live with some decorum in a society which makes no concessions to his psychological and physical dependency. In fact his past is held against him.

The skid row man who hopes to reenter the community not only needs attention to his health problems, psychiatric therapy, and probably vocational training -- he needs training in an alien way of life. While some homeless men, the nonalcoholic elderly pensioner for example, may have little trouble adjusting to life off the row, the skid row alcoholic will face an extremely difficult transition. The half-way house was invented to make this transition easier. Used frequently in recent years to help ex-convicts and recovered mental patients to return to the community, the approach has also been increasingly used for skid row alcoholics.

In some cases the homeless man may attempt to go directly from skid row to the half-way house, but the rehabilitation is more likely to be successful if preceeded by a period of institutional

care. The half-way house makes a poor "drying-out" facility. If it is located within the city -- and there is general agreement that this is the proper location -- bars, package stores and former skid row associates will be too accessible to the man who is just beginning to adapt to a life without alcohol. At this withdrawal stage, the alcoholic will need and probably welcome a highly protective and controlled environment. Hospitals with special programs for alcoholics provide the proper setting for intensive medical attention and psychotherapy.

In Philadelphia, the half-way house operated by the Diagnostic and Relocation Center first admitted men directly from the row, with disappointing results. Now alcoholics are accepted only after a stay at a state hospital which provides a 60-day detoxification and treatment period in a rural setting.[2] At an institution of this type, the alcoholic is made aware of the nature of alcoholism and begins to understand what he will have to do to overcome the problem. His progress at the institution will be an indication of his probable success in a half-way house program.

This period in an institution provides an opportunity to identify men who will need a longer period of hospitalization for psychiatric care. Apparently some men have staved off an incipient psychosis by blaming their inner tensions on the day-to-day struggle for existence which they have contrived for themselves on skid row, and by seeking the temporary relief of alcohol. When food, clothing and shelter is provided in a protective institution and liquor is unavailable, the symptoms of schizophrenia may finally appear.[3]

Some men will need further treatment; others will have such severe mental or physical handicaps that they can never return to the community. Other provisions will have to be made for these men if the half-way house is to be truly an intermediate step in the rehabilitation program rather than a final step.

There are hospitals specializing in the treatment of alcoholics that have had a type of half-way house program for many years. Recognizing that the first few weeks out of the hospital and back at work is likely to be a difficult period, they have permitted patients to live in the hospital and go out to work during the day. In this way all the services at the hospital, especially individual counseling, can be immediately called on to handle emergencies that arise during this period. Through group therapy sessions and informal contact, the patient gains sympathy and support from other patients who are also in this transitional program. Typically the men in the hospital half-way house program will eat and live together. An esprit de corps develops among the men which encourages them to remain sober and make a successful return to the community.[4]

These hospital half-way house programs are valuable for the supportive environment they provide for middle class patients with families who are, in a sense, convalescing from a severe illness. They are probably less well able to assist homeless skid row alcoholics who will be challenged by the ordinarily minute problems of community living. Chronic disease hospitals and mental hospitals in particular are frequently isolated from residential areas. Half-

way houses for the skid row alcoholic should be located within a residential area where the men can eventually settle; for most skid row alcoholics, this must be an area with low-cost housing for single men. The house should not be located on skid row. The homeless man should be able to become acquainted with church groups, senior citizens organizations, and perhaps a local AA group while living in the half-way house. When he finally leaves the house, he will not be a stranger in the community. The house must also be conveniently located in relation to other rehabilitation services and jobs.

This type of location makes it possible to use the half-way house as a club for men who have graduated to independent living. Most of the social clubs and fraternal organizations that are attractive and available to the lower-middle class man place a great deal of emphasis on drinking. Many AA groups have a strongly middle-class orientation, and in any case the evangelistic spirit of this organization is not for everyone. If the half-way house is available as a club, it will not only help the men who have left, but the graduates will also serve as encouraging examples to succeeding residents of the house that one can escape skid row.

Ideally the half-way house should be located in a building that is not readily distinguishable from other residential buildings in the area. The Philadelphia half-way house, for example, occupies adjacent row house structures. There is general agreement that the house should not have more than 30-40 residents -- even fewer if economically feasible. John Donahue, the manager of a private

half-way house in Boston, believes that 15 is the ideal size, although two or three nearby houses of this size can be operated as a unit.[5]

Half-way houses should have a variety of sleeping accommodations, including small dorms, double rooms and single rooms. When the man first comes to the house he lives in a dorm; as he becomes more independent he moves to a single room. Other facilities that are either necessary or highly desirable include cooking and dining areas, living rooms for relaxation and group discussion, space for recreation such as cards or pool, living quarters for the manager, and offices where private counseling can take place.

There is no question that few neighborhoods will welcome a half-way house in their midst. Blacker and Kantor point out that one may attempt to win the support of the neighborhood either before or after the half-way house is established, and that both approaches have met with success.[6] Persons I have talked with have favored the latter approach. It is essential that public health officials and skid row referral agencies try to educate the public in this area, but experience has shown that property owners have exaggerated fears in regard to the effect of such institutions. On the other hand, a proper regard for the concerns of the neighbors would suggest that half-way houses should house as few men as possible, so that they can be easily absorbed into the neighborhood.

Within the half-way house, the typical rehabilitation program relies heavily on group therapy. Ideally these sessions are conducted by a professional psychotherapist; they deal with the problems of alcoholism, employment, and adjustment to life in the larger community. Many half-way houses have a degree of self-government, where the men exercise some control over the distribution of chores and house rules in regard to curfew and other matters.

Half-way house programs place varying emphasis on Alcoholics Anonymous techniques. In one Boston half-way house, compulsory AA discussion meetings are held in the house twice a week, and members are also urged to attend a minimum of three open AA meetings each week. In some half-way houses, attendance at AA meetings is optional. In any case, a 1958 survey of half-way houses[7] revealed that all used AA as part of their program.

After an initial period of orientation to the new responsibilities and new freedoms of half-way house life, the men are encouraged to get jobs. At first these will usually be temporary jobs, so that the possibility of failure will be less threatening. Some men will undergo a program of vocational rehabilitation in a sheltered workshop; those who are able may train for more highly-skilled employment.

Each man will be encouraged to become increasingly independent and responsible. As his stay at the half-way house nears an end, he will be encouraged to visit relatives or friends for weekend

visits. He will eventually be expected to find a full-time job and contribute part of his salary toward the cost of the program.

There is some difference of opinion regarding the most appropriate length of stay in the half-way house. Blacker recommends a three-month period; a Philadelphia proposal calls for a six-months stay. According to the 1958 survey, slightly more than half of the houses did not set any limits to the length of stay.[8] Other directors fear that some men will become excessively dependent on the protective half-way house unless the stay is limited.

The more quickly men can leave the half-way house, the more efficiently the facilities and the staff of the house can be used. But half-way house directors have found that some alcoholics without families continue to need the informal support of other alcoholics to help them remain sober. The Diagnostic and Relocation Center hopes to set up a three-quarter-way house program as an extension of its half-way house. Two or three men would live together in apartments near the half-way house and receive minimal supervision and guidance from the staff. A three-quarter-way house program could also be set up in a rooming house, or it might take the form of a YMCA-type residence open only to sober alcoholics. At this stage the men would be employed and could pay their own way, although some staff time will be required to supervise the program.

An interesting variation of the half-way house is represented by the Salvation Army Men's Rehabilitation Center in Boston. This institution, which has a capacity of 120 men, is located in the heart of the city, in a high quality industrial-wholesale district. The Center resembles a half-way house in its in-town location and in the fact that the men are free to go out in the evening and on weekends. Group therapy, AA meetings and chapel services are also part of the program. Every man must take part in the Center's work program which involves the collection, repair and resale of used household articles. This large-scale operation, with nine retail outlets in the Boston area, provides vocational training and enables the Center to be self-supporting in spite of its half-million dollar annual budget.[9] The program has certain obvious limitations, however. It is too large for the staff to give the men much individual attention or to permit a homelike atmosphere and the program is of value only to those men who will benefit from the particular work program and are willing to take part in it.

A half-way house within the Mattapan Chronic Disease Hospital in Boston is open exclusively to tubercular alcoholics. Many of these men have lived in institutions or on skid row for so long that they lack skills that are taken for granted within the larger community; without the support of alcohol, they are unable to cope with unfamiliar people and situations. To help these men, volunteers visit the hospital, and take men to restaurants and sports events in Boston.[10] Not all men on skid row will be "desocialized" to this degree.

There is a great amount of variation in half-way house programs for alcoholics. They vary in size, in their allegiance to AA techniques, in their religious emphasis, and in many other aspects of their rehabilitation programs. This diversity is a good thing; if the central agency which coordinates the skid row rehabilitation program is thoroughly acquainted with the different programs, it can try to direct each man to the type of half-way house which is suited to his particular needs and personality.

The agency should also welcome the fact that private persons and organizations are willing to underwrite some of the costs of the network of facilities and services required for skid row rehabilitation. Some skid row missions may be willing to sponsor half-way houses, as traditional mission programs become obsolete. In Boston, the Salvation Army has expressed an interest in this type of program.[11]

Arthur Pearl, speaking of privately-run half-way houses, points out that, "while there is favorable subjective opinion of their worth,

there is no evidence obtained by rigorous research to prove that half-way houses have been an effective intervention."[12] The point is well taken, although it applies equally well to houses that are publicly run.

The houses surveyed in 1958 reported, on the average, that 35 per cent of their clients had been "rehabilitated."[13] John Donahue reports that 31 per cent of the graduates of Hope House in Boston have maintained abstinence, and that another 32 per cent have relapsed, but have then maintained abstinence. He points out that many alcoholics experiment with "social drinking" at least once after they have apparently been "cured." In most half-way house programs drinking is cause for discharge, although readmission is generally permitted.

A half-way house type program within Boston's Long Island Hospital resulted in a much lower rehabilitation rate. A study in 1956 showed that only 12 of 101 men were able to function successfully independent of the hospital.[14] This hospital is on an island in Boston Harbor, reached by a bridge from Squantum. At that time seventy men were involved in the "half-way house" program. It seems likely that the remote location of the hospital and the large size of the program would severely limit the chances of success. But other factors may be involved: the characteristics of the men in each type of program and the criteria for successful rehabilitation may not be comparable.

There is no question that the quality of care provided in half-way houses will vary. Many privately run houses have no

mental health or social work professionals on their staff. The central agency could make a real contribution by supplying consultive services to the directors of such institutions, who typically are recovered alcoholics or clergymen. Psychotherapists could be made available to direct group therapy sessions, and other types of counseling could be provided within the half-way house or at the offices of the agency.

Although most half-way houses charge a fee -- $20-$25 per week is typical -- these fees rarely pay the full cost of the program. Usually no payment is required until the client has a job, and the client may have other debts that must be paid so that he can get a fresh start when he leaves the house. To make matters more difficult, in Massachusetts half-way houses and other institutions are not considered legal residences, and a client may have trouble obtaining general welfare assistance unless he has established prior residence in the city. Hope House charges $25 per week and receives an average of two-thirds of each man's total bill.[15] A California half-way house reported that only 55 per cent of its clients had paid more than half their bills.[16] If a half-way house accepted only skid row alcoholics, the amount collected from fees might be even lower.

The vast majority of half-way houses are under private auspices, although recently there has been an increase in public support. One Boston half-way house is subsidized by a group of AA members, another by a private foundation. Two hospital-based

programs are supported by the city. A program in Worcester is financed by the city's Department of Welfare.

Although the Philadelphia half-way house was subsidized for three years by the Federal Vocational Rehabilitation Administration as a demonstration project, the Diagnostic and Relocation Center is now seeking funds from the Division of Alcoholism of the State Department of Health.

Action is being taken in Massachusetts to win increased State support for these programs. There are three ways in which the State could help provide half-way house facilities: (1) Direct public operation of half-way houses; (2) Contractural arrangements with privately-run houses, under which the State would pay the salary of the manager or provide professional consultation to the men and the administrative staff; and, (3) Purchase of service in private houses, by paying the fees of men who are not working. Probably the ideal program would include all three approaches.[17]

Half-way houses can be operated at reasonable cost. Sixteen half-way houses in California reported costs ranging from $400 to $1200 per bed per year; the average cost was only $700.[18] Costs as low as this are possible only because most directors are dedicated people who are willing to work at 24 hour, 7 day a week jobs for low salaries. Much of their time is spent scavenging for furniture and supplies and shopping for food bargains. Typically the buildings are in need of repairs for which there are no funds. This description applies equally well to the public and private half-way houses I have seen. Mr. Donahue agrees that, under these conditions, a

half-way house can be operated for little more than $1000 per bed per year. He feels that about $35 per week, or $1800 per year, would be a more reasonable figure; this would permit the half-way house to pay the manager $10,000 per year, and reduce other financial pressures. The subsidy required would amount to only about $1000 per bed per year. At this rate, the men would continue to depend on out-patient alcoholism clinics for professional consultation.[19] The Diagnostic and Relocation Center in Philadelphia is requesting about $110,000 per year from the State for a 35-bed half-way house. This amounts to about $3100 per bed per year, but it includes the salaries of three non-professional managers (day, night, and relief), as well as the salaries of four professional counselors. Some of this cost will be recovered from fees.[20]

There is a special detoxification program for chronic drunkenness offenders in the Massachusetts Correction Institution at Bridgewater; five out of six of the men have been there before.[21] It seems clear, on economic grounds alone, that the State should take steps to help these men make a more successful return to the community.

NOTES

1. See Erving Goffman, Asylums, Garden City, N.Y.: Anchor Books, 1961.

2. Interview: Walter Stanger (3/13/67).

3. Ibid.

4. Joseph Thimann, The Addictive Drinker - A Manual for Rehabilitation, New York: Philosophical Library, 1966, p. 92.

5. Interview: John Donahue (5/4/67).

6. Edward Blacker and David Kantor, "Half-Way Houses for Problem Drinkers," Federal Probation, Vol. 24 (June 1960).

7. Ibid.

8. Ibid.

9. Interview: William Hale (1/10/67).

10. Interview: James Scott (3/21/67).

11. Response to a Boston Redevelopment Authority questionnaire.

12. Arthur Pearl, "The Halfway House," in Frank Riessman, et. al. (eds.), Mental Health of the Poor, New York: Free Press, 1964, p. 501.

13. Blacker and Kantor, op. cit.

14. David J. Myerson, "The 'Skid Row' Problem," New England Journal of Medicine, Vol. 254 (June 1956), pp. 1168-73.

15. Interview: John Donahue (5/4/67).

16. California Department of Public Health, Recovery Establishments for Alcoholics, Sacramento, April 1963, Table 3, p. 105.

17. Massachusetts Department of Public Health, Division of Alcoholism, "Statement on Half-way Houses for Alcoholics (Preliminary Report)," September 19, 1966; mimeographed.

18. California Department of Public Health, op. cit., p. 29.

19. Interview: John Donahue (5/4/67).

20. Interview: Walter Stanger (3/13/67).

21. Paul F. Frechette and Joseph C. Basta, The South End Alcoholic and His Treatment: Detoxification, Referral and Aftercare, Bedford, Mass., Marist College, February 7, 1967; mimeographed.

Chapter 5

CAN SKID ROW BE ELIMINATED?

> [Imagine a man] in his later years, crippled with arthritis, suffering from alcoholism, with no visible income, living in a 50 cent a night cubicle. Upon questioning it is found that his greatest stated desire is to be left alone.[1]

This man symbolizes three apparent barriers to the elimination of skid row:

(1) Society lacks the ability to solve many problems: There is no cure for alcoholism and our efforts to control it will frequently fail. Physicians are still trying to solve many purely medical problems, such as arthritis.

(2) Society lacks the will to solve problems that could be solved: Adequate health care might have reduced the crippling effect of this man's arthritis. More liberal welfare payments or an adequate pension plan might have kept this man off the row.

(3) Society lacks satisfactory answers to many ethical questions in regard to individual responsibility and freedom: Should this man be left alone, or should he be forced to enter an institution? Would the answer be the same if this man were supported by public welfare funds, or if he had tuberculosis? We know there is a point at which concern for the public welfare can override concern for individual freedom. We are often not sure when this point has been reached.

Does this mean that skid row must continue to exist? Not necessarily.

We have seen in Chapter 2 that, in the long run, improved health and welfare programs, improved public education, changes in employment patterns, generally higher wages, and more generous pension plans have all contributed to a reduction in the population of skid row.

This process will be greatly accelerated by a dedicated, coordinated effort to relocate and rehabilitate men now on the row. Yet, of the first 712 men who received intensive service at the Philadelphia Diagnostic and Relocation Center, only 409 were relocated to independent living or to institutions off the row. In a sample of 115 men who had been relocated off the row at least 90 days before, 14 per cent had returned to the row; of 54 men who had been relocated one year, 33 per cent had returned to the row.[2]

In defense of this record, the Center points out that even a temporary stay off skid row is a sign of progress for many men, and that their next effort may be more successful. These data also imply that

> Unless existent community agencies as well as established social institutions are willing to reach out and support these men once they are returned to the community, the mere act of relocation -- no small effort in itself, will have been a wasted effort.[3]

But even the most dedicated program will not succeed in rehabilitating all the men on skid row and relocating them within the normal community; for example, Pittman and others[4] have expressed doubts that many more than 50 per cent of the chronic drunkenness offenders on the row can be rehabilitated. On the other hand,

Bogue believes that the proper program could eliminate Chicago's three skid rows in only five years.[5] These statements are not necessarily contradictory; the community can rehabilitate many men, provide necessary facilities and services for the men who cannot be rehabilitated, and break up the geographically-defined "institution" called skid row.

If we accept the fact that skid row represents a distinct culture, which can trap many men who might otherwise be able to live in the normal community, it becomes important to reform, eliminate, or scatter the businesses which comprise the skid row district and which help to perpetuate the skid row way of life.

In some cases, skid row businesses can be changed by the enforcement of existing regulatory legislation. Skid row bars and package stores should not be allowed to serve intoxicated persons. The laws are there; they are simply not enforced.

In some cities commercial blood banks locate near the row and permit men to earn money at the expense of their health by taking blood at too frequent intervals. This practice should be stopped. Spot labor employment agencies now rake off a large percentage of a man's pay, leaving him poorly rewarded for his day's labor. These employment agencies are widely charged with unethical practices, although I have not seen convincing evidence that they are asking excessive profits when allowance is made for the overhead, salaries and insurance. A thorough study may be needed to determine whether this service can be provided privately at a reasonable cost.

It would be both unwise and impossible to eliminate all of the businesses and institutions characteristic of skid row, including bars, employment agencies, used clothing stores, pawnshops, barber colleges and cheap restaurants, as well as missions. How then can the community end the concentration of these establishments which defines skid row? A successful relocation program which gets homeless men off the row and scatters them through the community will remove much of the basis of support for these businesses and they will have to move or close down. Of course, if urban renewal breaks up the existing skid row, current relocation procedures will ensure that many of these businesses will not survive the move.

A positive approach to this problem would be more desirable, however. Liquor licensing procedures already permit a high degree of control over the operation and location of bars. Theoretically, zoning codes might be written to make the location of certain other types of business subject to a special permit. British codes control all land uses in this way.

When Detroit's skid row was demolished for urban renewal in 1961, the city council passed an ordinance designed to prevent the development of new skid rows.[6] The ordinance prohibits certain "blight producing" uses from locating within 1000 feet of each other. Such uses include pawn shops, shoeshine parlors (?), second-hand stores, hotels, bars, and restaurants serving liquor. Certain areas of the city, including the central business district are exempt from some of the provisions. The requirements can also be waived in

specific instances, if it is determined after a public hearing that no harm will be done.

According to one newspaper report, when the ordinance was first proposed, the planning commission was critical of

> ...the ordinance's tendency to "scatter blight throughout the city, rather than to eliminate it." But since its passage, the planning commissioner said, he has been swung over to the side of the ordinance backers because it actually has resulted in holding down skid row developments.[7]

Apparently the ordinance was only partially effective, however, without a more comprehensive program of relocation and rehabilitation. The same report states that a number of smaller skid rows are now developing in other parts of the city.

Special anti-skid-row zoning ordinances are probably unnecessary. The largest of Detroit's new rows has grown up around the new location of two large missions which supply the men with food and lodging. The location and operating policies of the missions and public shelters will be as important as any other factors in preventing the development of new skid rows. Whenever possible men must be encouraged to leave skid row and, even though it will seem less efficient, their needs for food, lodging and counseling should be provided within the community.[8] When welfare policies encourage men to use skid row missions, immediate reform is called for; the $20 a week General Assistant allowance in Boston is an example of such a policy. Institutions which continue to supply emergency food and lodging services should be located away from rooming house districts and other low income residential neighbor-

hoods where they might act as a catalyst for the growth of a new skid row.

Even after many skid row residents have been rehabilitated and skid row businesses and institutions have been reformed, closed, or scattered, housing will still be needed for many men who are unwilling or unable to be assimilated into the larger community.

Some of these men will suffer from severe physical or mental disabilities and will require institutionalization. Bogue claims that Copenhagen and other Scandanavian cities have no skid rows because chronic alcoholics must undergo compulsory treatment.[9] There is apparently some controversy in this area. Pittman recommends compulsory treatment, and claims that recent studies indicate it can be as effective as voluntary treatment for many patients.[10] Kessel and Walton say that studies have shown just the opposite, although "opinions rendered obsolete by research are still firmly put forward."[11] I am not acquainted with this literature, so cannot comment directly, but I _have_ seen compulsory treatment work in other forms of mental illness.

Thirty-six states now have laws which provide for the involuntary commitment of alcoholics to treatment institutions, typically on the grounds that the alcoholic is "dangerous to himself or to others."[12] Massachusetts (and presumably other states) also has a law enabling public health officials to require the hospitalization of tuberculosis cases that are considered health menaces.

We might ask ourselves whether a man does not have a right to drink himself to death if he chooses. There are certainly important civil liberty considerations here, but a completely *laissez-faire* approach seems more immoral in its inhumanity; we may plead "individual freedom" as an excuse for doing nothing. In the case of the tubercular homeless man, the community's right to protect itself is not in doubt.

If we do resort to compulsory hospitalization, we must do our best to develop institutions which are able to provide real rehabilitation services. Too many of our nursing homes and mental hospitals are providing only custodial care; are we likely to do much more for the skid row alcoholics? Persons who are committed involuntarily should be assured continued access to a lawyer as a check against the power of the hospital.[13]

Some long-time residents of skid row will not require hospital care, but they will have developed habits of dependency and isolation that cannot be changed. They will be unable to handle money; a hotel desk clerk or bartender may have managed their pension check for years. These men would remain lonely outsiders in a family-oriented residential area. Bogue points out that many such men "will have personality disorders of a mild or moderate type that will make them poor risks in neighborhoods where there are children."[14] Housing facilities for these men should be located in a non-residential area, off skid row and away from skid row districts and concentrations of bars. Maximum concern for health

standards and the desires of the men would call for single rooms. Common spaces should be provided for reading, talking and recreation. A small park area should be available. This type of facility could be privately operated on a non-profit or limited profit basis if the city gave some assistance in the form of physical facilities and necessary rent supplements or welfare payments. Missions or responsible operators of skid row lodging houses might do this job. This type of residence could be built as public housing for the elderly.

One type of facility which might be duplicated in other areas is represented by Camp La Guardia, 60 miles from New York City. This is a custodial facility and treatment center operated by the New York City Department of Welfare. One-third of the 1050 residents are elderly homeless men who receive custodial care. Other skid row men are sent there for health and vocational rehabilitation. A bar is open during part of the day. Residence at the Camp is voluntary and there is often a waiting list.

There are also working men on skid row who will choose to remain apart from normal society. They may be fully self-supporting, but will want to devote a minimum of their income and attention to their living quarters. They can be housed in YMCA-type residences or in larger commercial rooming houses in non-residential areas. Adequate code enforcement will be necessary to prevent the deterioration of such districts.

Finally we come to a miscellaneous group which poses very special problems: low-income transients who need a very cheap hotel; recent arrivals to the city who are looking for work; men who have adequate pensions or wages but can never seem to get the money together to pay rent; chronic drifters who move from city to city and work irregularly; "bums" who try to avoid working by panhandling and taking maximum advantage of the services of missions and welfare agencies; petty criminals; non-skid row alcoholics on a bender.

Some members of this group will elude any program of rehabilitation, but others will be newcomers to the row from other neighborhoods or other communities and may respond if given the opportunity. It will be very difficult to distinguish the "deserving" from the "undeserving" poor among these men. What they will have in common is a need for very low cost food and lodging on a day-to-day basis.

At present their needs are met in a variety of ways by public welfare agencies, private entrepreneurs and missions. On the Bowery the New York City Department of Welfare provides meals and lodging on a day-to-day basis to anyone who applies and can convince the staff that they do not have sufficient funds to subsist for that day. Meals are provided at the Men's Shelter, and tickets are given for beds in commercial lodging houses. In Boston a man who presents himself at the Precinct 4 Police Station can get tickets from the Department of Welfare for one night at the Boston Industrial Home

and breakfast at a South End restaurant. A Boston "resident" is entitled to only six tickets a month and a nonresident to only six a year. Until recently, missions and the South End Center also provided tickets and a man who knew the ropes could get several more free nights. Since its recent budget cut, the South End Center no longer hands out these tickets. The rationale for the limitation on tickets is clear: The Welfare Department hopes to respond to emergencies, but discourage dependency. It does not want to encourage homeless men to come to Boston from other cities. Food and sometimes lodging is also provided by missions in both cities, usually in exchange for attendance at a religious service.

If the central skid row referral agency were solely responsible for providing tickets for free lodging, the agency would have a valuable point of contact with men on the row. The agency could help newcomers to leave the row before they were assimilated. Tickets might even be withheld if this seemed to be necessary to force a man to come to grips with his problem. _If_ alternative facilities were available off the row, many men would not have to be referred to the skid row lodging houses at all.

The Boston Industrial Home is an example of one possible approach to emergency skid row housing. The Home, which is operated by a non-profit corporation, has two large dormitory rooms, one with 70 and one with 125 beds. The cost is one dollar a night. Beds may be reserved by paying in advance, but the cost is the same for an extended stay. Men may check in only between 7 and 10:30 in the evening. They are required to check all of

their clothes and other belongings and go through a shower before going up to their bed. This procedure makes it very difficult to bring a bottle of wine into the building. The men must be out by 7 in the morning. Additional personnel would be required in order to keep the building open during the day, but the management also feels that the men should be forced to leave the building so that they will be encouraged to get jobs. Unfortunately, however, the rule also applies to elderly men, who must stay outside a couple of hours before they can go to the Salvation Army lounge or public library, both several blocks away. The building is also closed on Saturdays and Sundays, and some men feel that this gives them the alternatives of walking the streets, spending their time in a bar or, on Sundays, finding some other way to get liquor and companionship.

The dormitory beds at the Boston Industrial Home are very close together and men complain that they are disturbed by coughing, snoring and by others trying to find their way to bed. The State Department of Health, conducts a chest x-ray clinic here once a week. Men who stay at the home are encouraged to have x-rays twice a year, since the crowded dormitory increases the chances that they will contract tuberculosis. The problem is magnified by the fact that the source of infection can seldom be traced, and the man himself frequently disappears. Although attendance at the clinic is completely voluntary, x-rays have detected a 3-5% incidence of TB among the men.[15] This is over one hundred times the national incidence.[16]

Apparently some of the men who stay at the Boston Industrial Home -- and there are men who work regularly who have slept here every night for years -- do so because of the discipline of its regime. Since they must be in by 10:30 and out by 7, they are forced to limit their drinking in the evening; and there is no danger of over-sleeping in the morning. Although the regime and the facilities are far from "home-like", the building is in good condition, the beds are clean, and within the limitations of the system, the home is well managed.

The standard lodging facility in some cities is the commercially operated cubicle hotel. There are 35 of these hotels on the Bowery. These are converted loft buildings which have been subdivided by seven foot wooden partitions. A typical cubicle measures $6\frac{1}{2}$x$4\frac{1}{2}$ feet, which means that there is an 18-inch aisle beside the bed. Each room has a door which bolts from the inside, but cannot be locked from the outside; there is a small locker, however, which can be locked with a key. The ceiling of the loft area is 2-3 feet higher than the partition, which allows for ventilation and heat. Only a few of the cubicles have a window. In New York, these cubicles rent for $1.00-$1.25 a night. Some of the lodging houses also have dormitory beds at a lower price.

Operation Bowery reports that the New York lodging houses are generally in good condition. The structures are sound and interiors are cleaned daily. Each lodging house has a sprinkler system which is connected with a direct alarm to the nearest fire station, and a key system ensures that the watchmen inspect periodically at night.

Plumbing is adequate, in good working order and the fixtures are cleaned daily. Beds are made daily (although sheets are not always changed). The lodging houses are frequently inspected by the Building and Fire Departments.[17]

This description may be reasonably accurate, but it should not obscure the fact that these lodging houses are ugly, depressing places. Some have lobbies, bare rooms with hard chairs and a TV set, but they certainly do not have a home-like atmosphere. The cubicles on the Bowery may be in much better condition than those on other skid rows. Bogue's Skid Row in American Cities contains photographs of cubicles in Chicago that are in an extreme state of disrepair.

There is greater protection from contagious disease in a cubicle although they are more risky in this respect than single rooms, and cubicles can be every bit as noisy as a dormitory since they are open at the top. However, two men told me that they liked the feeling of privacy and security they had when they locked themselves in the cubicle, and, of course, one can bring a bottle to his bed.

What type of housing facility should be available for this residual group of unrehabilitated men?

One school of thought holds that such facilities should be minimal: dormitories for lower cost and greater control, or perhaps cubicles as a concession to the men's desire for privacy or to reduce the risk of contagion. Individuals may have different reasons for holding this point of view. Some believe that if these men can get comfortable housing without committing themselves to a program

of rehabilitation, or sacrificing some of their freedom in an institution, they will have no incentive to change their way of life. Others argue that these men are incorrigible or undeserving "bums" who deserve no better from the community. They fear that the city which provides better than average facilities to homeless men will attract bums from every skid row in the country.

The opposite school of thought points out that some skid row housing is a threat to public health; that men who have a good place to sleep will be healthier and have a greater sense of self-respect and so be better able to pull themselves out of their current situation, and that skid row facilities should encourage stability, not transiency.

In general, social workers and other professionals concerned with skid row rehabilitation feel that housing for "bums" and low income transients should be single rooms, rather than dormitories or cubicles. They would place a lower priority on this request, however, than on other elements of a rehabilitation program.[18]

The typical YMCA hotel -- very small rooms without baths -- would be a good model, although the facility could be located in a relatively low rent commercial-wholesale area. If better rooms or lower rates were available to men who paid by the week, there would be some incentive to plan ahead. Generally, however, counseling services should take the place of unindividualized, artificial methods of discipline.

In his Chicago study, Bogue states that:

> Planners should not overlook the rather elementary fact that the flophouse industry has been an extremely profitable one. The income from low-cost one-room units is very substantial in relation to investment. (His underlining)[19]

But Morris Chase, Director of Operation Bowery, feels that the New York cubicle hotel owners could not afford to improve conditions without charging more.[20] One of the problems is that vacancy rates are extremely high in summer when the Bowery has only one-third its winter population. In effect, Bowery flophouses are subsidized by the city; property taxes are kept low and the Department of Welfare pays for the lodgings of more than one-third of the men.[21] The Salvation Army runs a high quality cubicle hotel on the Bowery. The cost is $1.50 a night and the Army reports that it is operated at a "substantial loss."[22] The Boston Industrial Home also operates at a loss, even though it provides only dormitory accommodations and is tax-exempt.

In 1958 Sacramento had plans to build new housing for its skid row population. The Redevelopment Agency hoped to build 150-bed hotels in groups of 1000 units each. Rooms were to cost one dollar a day. The Agency was convinced that if housing and commercial functions were combined on low cost land, a developer could realize an 8-10% return. The project was never carried out. "The consultant's coverage of the cost and financing of such a venture was very superficial and a prospective builder found the idea to be economically unfeasible."[23]

The evidence suggests that a new transient facility would require a substantial subsidy, which may extend to operating costs, as well as capital expenditures. Since some men will not be able to afford even one dollar a night, welfare departments will have to continue to pay for lodging on an emergency basis.

The central referral agency should always know who is using the emergency shelter. If possible the agency should maintain a staff member at the shelter and be solely responsible for issuing tickets for free food and lodging. In this way, newcomers can receive whatever services they require to keep them off the row, and men who have failed in their attempts to live in the community can be given additional assistance.

NOTES

1. United Community Fund of San Francisco, Social Planning Department, "Social Planning and Social Services in Skid Row Redevelopment," March 1962, mimeographed.

2. Philadelphia Diagnostic and Relocation Center, *Philadelphia's Skid Row: A Demonstration in Human Renewal: An Interim Report*, Philadelphia Redevelopment Authority, 1965, p. 26.

3. *Ibid.*

4. David J. Pittman, and Charles R. Snyder, *Society, Culture and Drinking Patterns*, New York: Wiley, 1962, p. 146.

5. Donald J. Bogue, *Skid Row in American Cities*, Chicago: Community and Family Study Center, University of Chicago, 1963, p. 476.

6. This ordinance and its results are discussed in *Journal of Housing*, Vol. 18, p. 335 and Vol. 19, p. 226, and in Richard Ryan, "After Skid Row, What? Detroit Finds Out," *Toledo Blade*, March (?), 1966.

7. Richard Ryan, *supra*.

8. See Samuel E. Wallace, Columbia University, Bureau of Applied Social Research, *Skid Row and Its Inhabitants*, prepared for the Department of Welfare, City of New York, March 1965, mimeographed, Part VI.

9. Bogue, *op. cit.*, p. 496.

10. U.S. Department of Health, Education and Welfare, *Conference on the Court and the Chronic Inebriate*, Washington, D.C.: Government Printing Office, 1965, p. 14.

11. Neil Kessel and Henry Walton, *Alcoholism*, Baltimore: Penguin Books, 1965, pp. 126-7.

12. See William J. Curran, "Civil Commitment of Alcoholics: A Legal Survey," in Boston University Law-Medicine Institute, *National Conference on Legal Issues in Alcoholism and Alcohol Usage*, Boston, 1965, pp. 36-70.

13. Interview: William F. McCourt, M.D., Head of Alcoholic Unit, Boston State Hospital (3/26/67).

14. Bogue, op. cit., p. 484.

15. Information obtained from the public health nurse at the clinic.

16. U.S. Department of Health, Education and Welfare, Public Health Service, Areawide Planning of Facilities for Tuberculosis Services, Washington, D.C.: Government Printing Office, 1963, p. 1.

17. George and Patricia Nash, Columbia University, Bureau of Applied Social Research, A Preliminary Estimate of the Population and Housing of the Bowery in New York City, prepared for the Department of Welfare, City of New York, March 1964, mimeographed, p. 4-5.

18. See, for example, Chicago Tenants' Relocation Bureau, The Homeless Man on Skid Row, Chicago, 1961, p.

19. Bogue, op. cit., p. 484.

20. Interview (3/14/67).

21. Nash, op. cit., p. 8.

22. Nash, op. cit., p. 10.

23. Kenneth R. Williams, Administrative Assistant, Sacramento Redevelopment Agency, in a letter to the author, 4/14/67.

Chapter 6

SUMMARY: ALTERNATIVES TO SKID ROW

Skid row is an economic as well as a human waste. It occupies potentially valuable center city land, spreads blight to surrounding blocks, and demands a continuous, self-perpetuating flow of public services and private charity. But skid row is an undramatic problem, and city officials cannot be blamed for ignoring it when more fundamental urban problems, involving larger numbers of people, cry for attention.

In recent years, however, city after city has been forced to look at its skid row district, with its all too obvious potential as a site for urban renewal activity. Too few cities have taken advantage of the opportunity renewal offers them to find alternatives to skid row. Skid row renewal projects not only provide funds for diagnostic, referral, and relocation services and offer an opportunity to scatter or eliminate the businesses which support the row -- there is also not likely to be another occasion when the public would support a large-scale program to rehabilitate homeless men.

In this thesis I have tried to show that there are alternatives to skid row, although we may not have the ability to return all men to independent living within the community. Skid row will not be eliminated by public welfare and mission programs that have been designed to support homeless men at a skid row level of

subsistence. All programs must work toward the goal of getting men off the row.

Each city will have different needs and different resources. The program summarized below can only serve to illustrate a general approach to the problem drawn from the experience of several cities.

(1) A central referral agency is required. This agency will be responsible for coordinating the activities of all the public and private services now directed at homeless men, using these and other new and existing services to help men leave skid row. Probably the most important requirement of this agency is that it have a sufficiently large and skillful staff so that men can receive individual attention and extensive follow-up counseling.

(2) The central agency will have to call on a variety of institutions providing medical and psychiatric care. Many of these services will already be available, but most communities will need new institutions to serve the special needs of the skid row alcoholic.

(a) A detoxification center near the row will provide emergency care for the alcoholic and out-patient clinic services for continued treatment. The staff -- physicians, psychiatrists and social workers -- must be specially trained to work with the skid row alcoholic.

(b) Another facility will be needed to provide intensive long-term treatment for alcoholism in a hospital setting, as a basis for permanent recovery.

(3) Some homeless men will become permanent residents of chronic disease hospitals and other institutions, but many men will require special housing programs designed to ease the transition from the environment of skid row or the institution to that of the normal community.

(a) Foster homes will provide a protective environment within the community much like that of the total institution.

(b) Half-way houses will serve as a transitional stage between skid row or an institution and independent living within the community.

(c) Even after half-way house experience, some alcoholics without families will need the continued informal support of other recovered alcoholics to help them remain sober. A three-quarter-way house will provide this support.

(4) Other men can make use of a variety of housing types within the community, including low cost apartments, public housing and housing for the elderly. Most of the men will be living alone, and many will be unskilled and uninterested in keeping house for themselves in an apartment. Therefore, rooming houses, YMCA's, and residence hotels will be important relocation resources.

(5) Sheltered workshops will prepare some men for full employment and provide permanent jobs for others who are seriously disabled. Some men can be trained for skilled and semi-skilled occupations.

(6) Many elderly and disabled men will remain off skid row with relative ease if they are given adequate public assistance or pension funds. Men undergoing treatment for alcoholism or taking part in vocational training programs will require adequate temporary support.

(7) Recreational programs must permit the low-pressure social life and easy companionship now found in the bars and hotel lobbies of skid row.

(8) With an effective program of rehabilitation and relocation, the community will remove much of the basis of support for the businesses and institutions which help to perpetuate skid row. The community can take advantage of urban renewal action, code enforcement, and licensing procedures to break up the remaining concentration of these activities.

(9) A significant number of homeless men -- although probably a minority -- will be unable to live independently within the community, but they will resist all efforts at rehabilitation. Facilities and services designed to meet their needs must be operated and located so as to prevent the formation of new skid rows.

(a) Involuntary commitment to an institution will be justified in some cases. This is certainly true of men with tuberculosis and known criminals. There is some debate in the case of the chronic alcoholic.

(b) Special housing should be provided for elderly and disabled men who remain social isolates. This can

be provided in a rural setting or in a nonresidential area of the city.

(c) Isolated working men can find rooms in residence hotels and commercial rooming houses, but strict code enforcement will be required to prevent the deterioration of such areas.

(d) There will have to be some emergency housing facilities for destitute transients, "bums," and others who need food and lodging on a day-to-day basis. If the central agency has staff members at this facility and control over the dispensing of free food and lodging, it will be able to head off newcomers to the skid row way of life, and give further help to those who have failed previous attempts at rehabilitation.

Apparently no city has yet carried through a sustained and comprehensive program to eliminate skid row. Of the programs I am acquainted with, that of the Philadelphia Diagnostic and Relocation Center seems to approach most closely the model outlined here, but the Center would be the last to claim that the program is complete in all its aspects, or far enough advanced to permit a firm assessment of its chances for success. To a large degree, the activities that follow the demolition of the physical skid row will determine the long-range success of such a program. Thus there is as yet no proof that skid row now can be eliminated, but the costs of skid row are high enough to warrant a sincere effort.

What can city planners contribute to the search for alternatives to skid row?

The day-to-day operation of skid row relocation and rehabilitation programs will be in the hands of social workers, physicians, and personnel in related fields, but planners can contribute their skills at many stages:

(a) They can help determine the size and characteristics of the particular skid row population.

(b) They can analyze the current housing resources of the community and their adequacy for special needs of homeless men. They can use whatever skills and influence they possess to fill the gaps in these resources.

(c) They can assist the central agency in finding sources of support and suitable locations for new services -- detoxification center, referral office, long-term care facilities -- that are required.

(d) They can help to coordinate the individual efforts of the public and private agencies which now affect the lives of homeless men.

(e) They can and must stage urban renewal activities so as to give the central referral agency sufficient <u>time</u> to do a successful job of relocation and rehabilitation.

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