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The Quandaries of Shelter Reform: An Appraisal of Efforts to "Manage" Homelessness

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Abstract
In this article, I describe efforts to manage the capacity of homeless shelter programs in Philadelphia and assess the impact of those efforts on providers and consumers of homeless services. Most reforms have focused on reducing the capacity of the shelter system by reducing the average length of stay of persons in shelter and by providing housing relocation assistance. However, these reforms have been compromised by an inability to contol the demand for shelter, particularly the rate of new admissions , and by the extent of need for housing assistance among homeless and near-homeless people in Philadelphia. Alternative methods of financing shelters are described, as are attempts to create a system of specialty shelter providers. The contradictions of shelter reform and the need for a more comprehensive homelessness prevention strategy are discussed.

Keywords
homelessness policy, shelter reform

Comments
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The Quandaries of Shelter Reform: An Appraisal of Efforts to "Manage" Homelessness

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In this article, I describe efforts to mange the capacity of homeless shelter programs in Philadelphia and assess the impact of those efforts on providers and consumers of homeless services. Most reforms have focused on reducing the capacity of the shelter system by reducing the average length of stay of persons in shelter and by providing housing relocation assistance. However, these efforts have been compromised by an inability to control the demand for shelter, particularly the rate of new admissions. and by the extent of need for housing assistance among homeless and near-homeless people in Philadelphia. Alternative methods of financing shelter are described, as are attempts to create a system of specialty shelter providers. The contradictions of shelter reform and the need for a more comprehensive homelessness prevention strategy are discussed.

The emergence of the homeless shelter system in the 1980s in many ways paralleled the proliferation of poorhouses in the early nineteenth century. Both coincided with contractions in "outdoor relief," or cash assistance to the unemployed and indigent, and both systems were promoted, in part, as reforms offering "indoor relief" to society's outcasts. The poorhouse movement was a dismal failure. Despite numerous efforts at reform, it was unsuccessful in fulfilling any of its ambitious promises of rehabilitating the impoverished.[1] Rather, the poorhouse served only to institutionalize destitution among the sick, the old, and the jobless. Does today's shelter system face a similar fate?

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I examine here several efforts to reform the shelter system in Philadelphia and assess the reforms' impact on both providers and consumers of homeless services.

A Decade of Growth: The Organization of Homeless Services in the 1980s

The 1980s witnessed a dramatic expansion in the number of homeless people and the organizations providing services to them. The U.S. Department of Housing and Urban Development (HUD) reports that the number of shelters increased by 190 percent nationally between 1984 and 1988 and that the nightly bed capacity grew from 100,000 to 275,000.[2] Individual cities report even greater increases; for example, Philadelphia's shelter system grew by more than 2,000 percent, from 250 beds in 1982 to 5,400 beds in 1988.[3]

Accompanying this expansion in shelter capacity has been an even larger increase in expenditures on shelter services. The U.S. Department of Housing and Urban Development estimates that shelter spending increased from $300 million in 1984 to more than $1.5 billion in 1988, a fivefold increase. Public-sector revenue sources (federal, state, and local) accounted for 65 percent of those expenditures in 1988 and private-sector sources for the remaining 35 percent. The average per diem cost of shelter services rose from $19 in 1984 to $28 in 1988, a 47 percent increase. Thus, the average annual cost of an occupied shelter bed in 1988 was approximately $10,200. Dividing the estimated annual expenditures by the average per diem cost, approximately 53.6 million nights of shelter were provided to homeless people in 1988.

This tremendous growth in shelter capacity has been interpreted by some as evidence of the strength of volunteerism in America and by others as a growing strain on public resources.[4] Nevertheless, it is the growth in public expenditures that has led many city and state officials to question the efficacy of these efforts and their long-term viability.[5] These concerns have led to strategies to "manage" the homeless problem, primarily through changes in shelter policy intended to make shelters more effective and efficient systems of transitional care.

Reforming the Shelters

Mandating Shelter Provision

The first shelter reform in the 1980s, first applied in the large cities of the Northeast, was the mandate that shelter be provided to all persons and families who sought it. These mandates resulted from consent decrees (New York and Philadelphia), the stated commitment

of city officials to provide shelter (Boston), or the passage of new city ordinances (Washington). Homeless advocates, in many cases supported by shelter providers, scored early victories in the 1980s by obligating city governments to provide this minimal level of service.

For example, in 1985, the city of Philadelphia signed a consent decree with an organization of homeless people, the Committee for Dignity and Fairness for the Homeless, which had protested the restrictive policies and insufficient capacity of Philadelphia's shelter system. The city promised henceforth to provide emergency shelter to all persons who sought it and agreed not to deny shelter to some persons who were previously considered "noncompliant," such as intoxicated persons. Under the consent decree, between 1985 and 1988, Philadelphia's shelter capacity greatly expanded, as shown in table 1. Accompanying this capacity increase was an increase in Philadelphia's homeless budget from approximately $1 million in 1982 to more than $30 million by 1988.[6]

Similar expansions in shelter capacity following shelter provision mandates in Washington, Boston, and New York would suggest that mandates were linked to shelter development. However, as the HUD data indicate, shelter capacity increased in cities across the country, most of which were under no such mandate.[7]

Nevertheless, the shelter system quickly filled a niche in the deteriorating system of community support services throughout our nation's cities. Suspicions have been expressed by some advocates and homeless people in Philadelphia that welfare officials, aware of this new system of service provision, began to use the shelters as a secondary welfare and housing system. In effect, it has been argued that the shelters were being used as an overflow site for other crowded city agencies, including corrections, mental health, substance abuse, housing, and

Table 1

Shelter Capacity in Philadelphia, 1982–1988, by Average Daily Census and Annual Number of Shelter Nights Provided

Fiscal Year	Average Daily Census	Number of Shelter Nights	Growth from Previous Years (in %)
1982	251	91,540	0
1983	429	156,620	71
1984	911	333,266	112
1985	1,620	591,242	77
1986	1,946	710,224	20
1987	3,261	1,190,321	67
1988	4,564	1,670,418	40

Source.—City of Philadelphia, Office of Services to the Homeless and Adults.

child welfare. The mandate of shelter provision provided one of the few open doors to the growing unmet need for housing and social services among the inner-city poor.

The basic problem with this reform was that it was initiated with no guiding purpose and with no incentives to limit shelter growth. Because officials were, in most cases, grateful to find people willing to open a shelter, few demands were made on providers of shelter services. Thus, cities like Philadelphia did not initially develop licensing or programmatic requirements for shelter providers. Moreover, there were no disincentives for clients or for welfare officials to use the shelters, and few incentives existed for moving people out of the shelters once they were admitted. Only the overcrowded and inhumane living conditions discouraged the use of the shelters, and, given the apparently restricted options of some persons, even this was not a deterrent to their use (some street homeless might disagree). The shelters, therefore, had the potential to grow with no outer limit, becoming the gathering place (pejoratively labeled the "dumping ground") for the growing pool of disabled, unemployed, unhoused, recently paroled, or addicted persons unserved and underserved by other public agencies.

Programs to Resettle Families and Individuals in Housing

The first reaction to the growing shelter system and its oppressive reputation was the demand for affordable housing to replace the shelters. City officials in some areas also saw housing development or housing subsidies as their only way out of increasing shelter costs. As an added incentive, housing placement offered the opportunity for cost shifting as well as reduced local spending. In some states, shelter is financed by the county or city, while housing is primarily a state and federal responsibility.

Like other cities, Philadelphia first attempted to relocate homeless families to permanent housing by creating special subsidized housing rehabilitation programs, by setting aside some Section 8 subsidies for homeless families, and by placing homeless families on a priority list for public housing. Philadelphia eventually expanded these programs to include transitional housing programs and single room occupancy housing. The combined effect of these housing programs in Philadelphia was to create financing or placements for approximately 1,300 homeless households in 1990, three-quarters of which were homeless families.[8]

City officials report that providing permanent housing not only housed the homeless but also lowered the probability of readmissions to shelter. In 1987, more than 50 percent of the families placed in shelter were former shelter clients, whereas in 1990 less than 10 percent of the families were former clients.[9]

However, there was a fundamental problem with this method of reducing shelter capacity: it did not address the incidence rate. Nearly 200 new families sought shelter each month in 1990, a rate unaffected by the availability of new housing programs and the decline in readmissions.[10] Given the reported decline in readmissions, this steady rate of new cases would imply that there was in fact an increase in the number of first admissions. Therefore, although providing housing may have helped the city avoid new shelter development, it did not affect the incidence rate or allow for reductions in shelter capacity.

Another problem with this approach is that it may have introduced an incentive for shelter referrals and for people to remain in shelter. In New York City, a similar plan to reduce family shelters through preferential placement of homeless families in public housing is said to have backfired by acting as an enticement for more families to seek shelter.[11] Although the plan initially enabled the city to close some shelters, the arrival of even more new cases—ostensibly seeking preferential public housing placements—forced New York officials to reopen the closed shelters. Again, there are suspicions that some social service agencies encourage marginally housed families to seek shelter because of the perceived advantage of being on a priority list for public housing.

These programs create other perverse incentives as well, such as encouraging longer lengths of stay in shelter and reducing the incentive for some persons to seek other alternatives. For example, to qualify for a permanent housing placement from the Philadelphia shelter system, one must stay in the shelter for 60 consecutive days without any rules violations.[12] Thus, persons who otherwise would have left shelter prior to 60 days may now stay with the hope of obtaining subsidized housing, particularly single persons who have had a high rate of turnover in the Philadelphia shelter system.[13] If a person commits a rules violation, the 60-day count begins again, committing a person to an even longer shelter stay.

Finally, the 1,300 subsidized housing units created through these programs are far too few to address the housing needs of both the homeless population and those at risk of homelessness. Approximately 11,600 households in Philadelphia became homeless in 1990, including 2,500 families, and the vast majority of those found no subsidized housing.[14] Even had subsidized housing been made available to every homeless person, the basic contradiction would remain that without similar entitlements for the near-homeless, demand for shelter would continue.

Prevention: Keeping Families in Housing

Recognizing that preventing homelessness would be far more effective in reducing shelter capacity than just providing housing to persons

in shelter, Philadelphia officials have also supported three programs to assist those threatened with homelessness. In their 1991 budget, the Philadelphia Office of Services to the Homeless and Adults proposed to help 2,300 such households, through either eviction-prevention housing assistance or emergency relocation funds, at a combined cost of nearly $1.3 million.[15] Eviction-prevention housing assistance funds are targeted to households that need short-term cash assistance in order to avoid homelessness or utility disconnections, and emergency relocation funds are for households that have lost their housing due to an emergency such as a fire.

The effect of these programs on the incidence and prevalence of homelessness is hard to estimate given that it is impossible to know whether these persons would have become homeless or sought shelter had these programs not existed. Moreover, given the short-term nature of the assistance, the proportion of these families that would eventually become homeless despite the assistance they receive is unknown. Nevertheless, the city expects that these programs will eventually allow it to downsize some of the family shelters.[16]

The most significant problem with this approach to reducing shelter capacity is the extent of need for housing assistance throughout the city. For example, Cushing Dolbeare has estimated that 129,000 renter households in Philadelphia are in need of housing assistance, based on the criterion that a household should spend no more than 30 percent of its income on housing.[17] This is clearly a far larger number of households than those that became homeless in 1990 (11,607) and many more than the 2,300 who will be assisted with emergency funds. Nevertheless, these 129,000 renters represent the larger population of housing needy from which the homeless come. Dolbeare has estimated that the potential cost of closing the "affordability gap" for Philadelphia renters would be $360 million a year.[18] Thus, it is obviously much cheaper for the city to "micromanage" the housing crisis by running a $15 million shelter system and a $1.3 million emergency assistance fund than it is to develop a more comprehensive subsidy program. However, without a broad program, there may be little hope that the city can reduce its shelter capacity by offering short-term help to just 2,300 households.

Reducing Length of Stay by Increasing Requirements on Clients

As a result of the city of Philadelphia's budget crisis in 1989 and 1990, the Office of Services to the Homeless and Adults lost 58 percent of its 1988 funding, and daily shelter capacity was cut in half. Therefore, the city faced reneging on its 1985 consent decree and had to develop a plan for coping with its smaller shelter system.[19] To do that, the city renegotiated the consent decree and no longer promised to provide

shelter to all persons who sought it. Instead, the city insisted that persons with substance abuse or mental health problems be "in treatment" or on a waiting list for treatment, that shelter residents contribute 15 percent of their income to shelter costs, that shelter residents place 60 percent of their income in a savings account, and that noncompliance with any of these new requirements would lead to the termination of one's access to shelter.[20] This dramatic shift in policy was intended to be a disincentive for clients to remain in shelter and to force providers to become more involved in managing the client population, ultimately reducing the average length of stay in and daily capacity of the shelter system.

As a result of these efforts, the number of beds in the Philadelphia shelter system dropped from a high of 5,400 in 1988 to a low of 2,800 in 1990. When demand for shelter increased in the winter months of 1990, shelter capacity increased to 3,151 beds.[21] However, city officials state that they are handling the same annual caseload with this reduced capacity, meaning that the average length of stay must have proportionately declined, and the rate of turnover proportionately increased.[22]

Many factors contributed to this reduction in the average length of stay. First, in choosing which shelters to eliminate, city officials sought to protect those providers who had historically been the most cooperative with the stated service priorities of the shelter system and to cut those providers who had been the least cooperative.[23] Procedurally, the city simply refused to fill vacancies at those sites identified for closure. In effect, the pool of remaining providers was a select subset of the original total and was presumed to be more compliant with the city's new guidelines.

Second, because the reduced supply of providers greatly lessened the risk of vacancies (unreimbursed beds), providers were virtually assured of their same revenue in the past, even if they more closely scrutinized client compliance and increased terminations of service. Thus, the remaining providers had more freedom to "manage" their client population.

Third, because of the new copayment and savings requirement, and because providers did not have a disincentive for client turnover, clients faced a far more rigid environment in the shelters. It is probable that many homeless had reservations about paying what amounted to "rent" for a shelter bed (via the copayment) and that many did not trust providers with overseeing their savings. Thus, even clients who were not discharged for compliance violations may have had greater incentive to leave the shelters on their own initiative.

Finally, the average length of stay for families was eventually reduced by the housing placement programs. Although the housing placement programs described earlier did not reduce the incidence rate of new families seeking shelter (thereby not initially reducing shelter capacity),

they served to move families out of shelter sooner than in the past. This eventual reduction in length of stay moderately reduced the capacity of family shelters from a 1988 capacity of 1,301 beds to a capacity of 1,206 beds in 1990.

This "success" in lowering shelter capacity and the average length of stay, particularly among single adults, did not occur without costs, however, and requires significant qualification. Although there has been no systematic attempt to document the effects of these changes, some negative consequences have become apparent.

The number of unsheltered homeless in Philadelphia has increased. A survey of Philadelphia's street homeless prior to the massive "phase-down" effort found an estimated 400 persons on the streets, while the U.S. Census Bureau counted slightly more than 1,000 by 1990.[24]

It is also probable that the new requirements on residents may have reinforced and exacerbated the residential instability of some homeless persons and may therefore sustain some demand for shelter over time. This is particularly true for addicted and mentally ill persons who are obliged to be "in treatment" or, more realistically, on a waiting list for treatment. During the long wait for treatment, violations of regulations may be difficult to avoid, thus making it difficult to maintain residence in a shelter. It is also probable that the restrictions will compel many people to return to the undesirable situations from which they came prior to seeking shelter—substandard housing, drugs, or domestic violence—and thus be at risk for future episodes of homelessness.

Given that this reduced system encourages evictions from shelters and terminations of service, it may also lead to the violation of clients' rights by tacitly supporting the capricious behavior of providers. Clients have limited recourse when discharged for compliance violations and must plead their case before shelter system managers to gain readmittance to the system. Although clients may face dire consequences as a result of discharge policies, procedures for the determination of "ineligibility" include no provisions for a client advocate or for an appeal to a "neutral" third party.[25]

Finally, the new regulations could be criticized for lacking a balance between requirements of clients and requirements of providers. If clients are to pay for shelter, then providers should face requirements other than maintaining order, such as being required to offer housing placement services. However, fewer than half the shelter providers in Philadelphia offer on-site social services.[26]

Although this reform measure seems to have been a success from an administrative perspective, having reduced capacity and lowered costs while still providing shelter services, without any systematic evaluation of what happened to former shelter clients, any unqualified declarations of "success" are premature. Indeed, there are compelling reasons to suspect that these reforms have worsened the residential

stability of some clients, thereby extending the demand for shelter services in the future.

Alternative Payment Schemes

In an attempt to reduce shelter costs, Philadelphia developed an alternative payment scheme for its shelter system. Instead of paying exclusively on a per diem basis, which was seen as encouraging clients to move from shelter to shelter and as creating an administrative burden, the city developed a monthly payment mechanism. The assumption was that, by promising providers clients for whom the shelter would be reimbursed on a monthly basis, the city would reduce turnover in the shelters and the risk of vacancies. However, in return, the city capped the monthly payment at $283, or what was the equivalent of payment for 21 days of shelter. The city, therefore, anticipated saving 9 days of shelter costs per month per monthly placement while gaining a simpler administrative system.

Because of the practices of some providers, this system ultimately worked against both the stability of clients and the planned savings of the city. When providers received payment for only 21 days per monthly placement, they had an incentive to discharge persons after 21 days, legitimately or not, and to fill those beds with reimbursable clients. Given the constant demand for shelter, some providers apparently perceived little risk of creating vacancies by following such procedures. This "churning" process angered clients and circumvented the city's cost savings, though it gave providers the benefits of administrative simplicity. The capped payment system was therefore terminated in 1990, although officials retained the administrative advantage of billing for some clients on a monthly basis.[27]

Other payment reforms have also recently been considered in Philadelphia, including facility-based funding. Because several shelter facilities run at greater than 95 percent occupancy, particularly the large shelters for single men (capacity more than 100), city officials have negotiated individual contracts with some providers rather than requiring separate billings for each client. The problem with this system is that the city loses some accountability from the providers and may lose some of its client tracking capacity. An advantage is that the city can focus on developing programs at those shelters and reward program innovations rather than having simply to reimburse on the basis of the number of shelter nights provided.

Specialty Shelter Providers

The last reform considered in this article is the development of specialty shelter providers. In what may be the future of shelter provision, shelters are increasingly defining themselves in relation to specific

client types and designing their services around the particular needs of those client subgroups. For example, in Philadelphia there are now mental health shelters and "clean and sober" shelters, both of which attempt to create a "therapeutic community" for homeless people.

Specialty shelters have several obvious advantages over the open dormitory shelters that serve a more heterogeneous population. By narrowing the range of persons to be served, they make more intensive service delivery possible. Specialty shelters are also more likely to provide a bundle of services on-site, which enables clients to avoid the complexities of finding services on their own. Specialty shelters also have the potential for serving self-help or support group functions. Finally, from an administrative perspective, specialty shelters are simply better at stabilizing the client base, and they are more accessible to the homeless than traditional forms of treatment for mental illness or substance abuse.

There are, however, a few potential problems with this approach. It is doubtful that all or most homeless people can be neatly sorted into special service groups. Many would undoubtedly be misclassified, others could be cross-classified, and still others might defy classification. An ambition of poorhouse reformers was that the poorhouse too could be improved with greater definition of client subgroups.[28] However, subgroups could not always be distinguished by poorhouse administrators. Moreover, the overriding motivation for creating these subgroups—saving money—was incompatible with the goal of providing better and more comprehensive services.

It is also unclear whether developing specialty shelters will reduce shelter capacity. Although the idea is appealing because it combines the advantages of shelter services with intensive social services, this approach could further institutionalize the homeless population within yet another unregulated and underfinanced layer of service provision. Moreover, the availability of such shelters could act as a further incentive for public officials to use the shelters as a secondary health and welfare system.

Whether specialty shelters should replicate the functions of existing public authorities already designated to care for low-income populations deserves careful consideration. For example, there is a public mental health system and a substance abuse treatment system that are supposed to provide services to many of the homeless and near homeless, but whose insufficient capacity and inadequate program design play a role in promoting residential instability. By replicating those services in the shelters rather than increasing access and quality in the existing health care system, officials may be unwittingly adding a third tier to an already unequal two-tier (private versus public) system of health care provision, thereby reinforcing some of the underlying causes of homelessness.

Therefore, although this reform seems like a humane measure, it could be interpreted as an unnecessary accommodation to the remediable problems of other public service delivery systems, as an incentive for referring more people to the shelters, and as ignoring the contradiction of trying to reduce shelter capacity and expenditures while increasing the quality of shelter services.

Conclusion

The shelter system has evolved over the last 10 years with little direction or coherent purpose. Predictably, as the system has grown to consume a larger share of public resources, attempts have been made to better manage this system. However, because shelters had no clear design from the outset, reformers must confront the contradictions of this secondary welfare system and answer fundamental questions about its purpose. Whether the shelter system is to be an emergency or custodial system of care and whether it is to be a temporary or permanent organizational adaptation to the crisis in the welfare state are perhaps the most important initial questions to answer before reforms can be considered.

Given the impetus behind the reforms described in this article, it seems increasingly clear that cities would like to reduce their shelter systems, if not ultimately eliminate them. To do so they must reduce the incidence rate of homelessness and the length of stay of persons in shelter. It therefore appears that cities would prefer an emergency system of care that is a temporary adaptation to the crisis in the welfare state. Assuming that to be the case, some conclusions can be reached regarding the effectiveness of reform efforts and the need for alternative approaches.

Attempts to manage the homeless problem that focus solely on the population that is homeless at any given time appear to be both shortsighted and bound for failure. I have found that there is significant turnover in the homeless population, as much as six persons per bed per year in Philadelphia, and other research has shown that shelter use is just one facet of the broader experience of residential instability among poor people.[29] Therefore, efforts to reduce shelter capacity that do not consider the larger population of near homeless will empty shelter beds only to fill them again by others. Although there is an immediate need to assist families and individuals who are currently homeless, shelter capacity can only be reduced by providing assistance to both those who are currently homeless and those at risk of homelessness. Providing housing subsidies and specialized social services just for homeless people risks creating an incentive to use the shelters as a secondary welfare and housing system, thereby increasing demand for shelter. This contradiction provides perhaps the clearest evidence of the limits of shelter-focused interventions to end homelessness.

Shelter capacity can be reduced by reducing length of stay, but such efforts do not affect the incidence rate of homelessness. Moreover, although requiring homeless people to save money and pay for shelter may act as a disincentive for long shelter stays, these efforts may simply reinforce residential instability by pressuring some people back into the streets or into other tenuous or dangerous living arrangements. Therefore, a reduction in the length of stay of persons in shelter ought not to be a goal in and of itself. Reduced length of stay is successful only if it will benefit the clients, for example, through reduced residential instability, which will, in turn, reduce the potential for readmissions to shelter. There is a potential contradiction in trying to reduce demand for shelter while pressuring people into marginal or unstable living arrangements.

Preventive efforts such as emergency assistance and rent subsidies remain the best hope of reducing shelter demand in the long term. Indeed, a broad housing subsidy program may have to be considered to avoid the perverse incentives created by a means test. However, such a program will be costly and would require more active management of the supply and pricing of housing than appears possible in the current political climate. The lack of political will for such an effort is one of the underlying causes of the housing crisis, and thus remains a major obstacle in ameliorating the homeless problem.[30]

Finally, the need to improve conditions in the shelters is compelling but may detract from the more important need to reform the housing, health care, and welfare systems, which, unaddressed, make sheltering the homeless necessary in the first place. Specialty shelters, smaller facilities, and more programs in the shelters are proposals that deserve some attention for their short-term potential. However, these efforts do not represent a viable long-term approach for reducing shelter demand because they do not address the underlying causes of homelessness.

In conclusion, the ability of shelters to serve as homeless management agencies is constrained by the structural causes of the homeless problem.[31] Without renewed commitments from public agencies responsible for the treatment of mental illness and substance abuse, for reintegrating recently paroled persons in the community, and for promoting child welfare, affordable housing, and income maintenance, the shelter system will remain overburdened and unmanageable. The fate of the shelter system is therefore tied to the functioning of the social welfare system and will be more determined by its policies than the policies that govern the behavior of shelter clients and providers.

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