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Testing a Typology of Family Homelessness Based on Patterns of Public Shelter Utilization in Four U.S. Jurisdictions: Implications for Policy and Program Planning

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Abstract

This study tests a typology of family homelessness based on patterns of public shelter utilization and examines whether family characteristics are associated with those patterns. The results indicate that a substantial majority of homeless families stay in public shelters for relatively brief periods, exit, and do not return. Approximately 20 percent stay for long periods. A small but noteworthy proportion cycles in and out of shelters repeatedly. In general, families with long stays are no more likely than families with short stays to have intensive behavioral health treatment histories, to be disabled, or to be unemployed. Families with repeat stays have the highest rates of intensive behavioral health treatment, placement of children in foster care, disability, and unemployment.

The results suggest that policy and program factors, rather than family characteristics, are responsible for long shelter stays. An alternative conceptual framework for providing emergency assistance to homeless families is discussed.

Keywords: Demographics; Families and children; Homelessness

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Introduction

Research on typologies of homelessness among unaccompanied or single adults has identified distinct patterns of shelter utilization that are associated with theoretically consistent population characteristics (Kuhn and Culhane 1998). The identification of a pattern of chronic homelessness, in particular, has shown that a small subset (10 percent) of single adults who become homeless stay in shelters over extended periods. Nearly all of them have some disability or significant behavioral health problem that limits their ability to make a stable exit from homelessness without subsidized housing and social supports. Another group (10 percent) uses shelters episodically over several years, and half of that group also has potentially disabling behavioral health problems. Alternatively, most adults (80 percent) experience short-term, temporary homelessness and would appear to be candidates for prevention or rapid relocation programs. Most of them make sustained and independent exits from homelessness without formal rental assistance, and most do not have significant behavioral health treatment histories.

No research has investigated whether a parallel typology for homeless families has similar validity. If the differential patterns by which families experience homelessness are likewise associated with differences in characteristics and needs, then it may be possible that subpopulations of shelter users could be matched to alternative housing and service interventions that better meet their needs in a more cost-effective manner than the current shelter system and with fewer negative impacts on children. Replicating the methodology that was applied for unaccompanied single adults, this article explores the feasibility and appropriateness of a typology of family homelessness based on patterns of public shelter utilization and examines the implications of the results for policy and program planning.

Literature review

Epidemiological and survey research has consistently pointed out fundamental differences in characteristics between unaccompanied (single adult) homeless individuals and homeless family households, consisting of one or more adults and dependent children. Next to the presence of children, the most readily apparent differences between adults from individual and family households are demographic. Heads of homeless families are overwhelmingly female, while homeless individuals are predominantly male. And looking just at women, the heads of homeless families are substantially younger than their unaccompanied counterparts (Burt and Cohen 1989; Metraux and Culhane 1999). Further, compared with their single counterparts, adults in

homeless families are much less likely to have mental health and substance abuse problems, more likely to have completed high school, more likely to have recently worked, and more likely to have regular contact with members of their social network (Burt and Cohen 1989; Burt et al. 2001; Fischer and Breakey 1991; North and Smith 1993; Shinn and Weitzman 1996).

A handful of longitudinal studies comparing homeless families and their poor-but-housed counterparts who receive public assistance have also been conducted (Bassuk et al. 1997; Shinn et al. 1998). Multivariate analyses have found relatively few behavioral health differences between the two groups. Homeless mothers are no more likely to have mental health or substance use disorders or symptoms than poor mothers who are not homeless. No strong or consistent differences between homeless and housed mothers with respect to educational attainment, work history, or criminal history have been found. It could be argued that the differences that *have* been found are confounded with the selection effects of the homelessness process, including a greater degree of residential instability among homeless mothers, comparable but more strained social networks, more common separations of mothers from children and other family members, and higher rates of domestic violence. Other differences seem to suggest that homeless families have fewer instrumental resources than other poor families, including lower income, lower rates of housing assistance (public or other subsidized housing), and lower rates of welfare receipt.

In sum, the literature does not indicate that adults who are homeless with their children are as beset by personal and social barriers as unaccompanied single adults, nor does the level of such personal and social barriers distinguish homeless families from other poor-but-housed families. Homeless families are, however, poorer than other poor families and less likely to have recently lived in subsidized housing.

Less is known about subtypes within homeless families. Some presumably have characteristics that distinguish them from other homeless families. Longitudinal studies have primarily investigated factors associated with rates of shelter exit and reentry (Kelly, Mitchell, and Smith 1990; Rog et al. 1995; Shinn et al. 1998; Wong, Culhane, and Kuhn 1997; Wong and Piliavin 1997; see Wong 1997 for a review). These studies have found that larger families, whether they have more adults or more children, take longer to exit shelter than other families (larger families may need larger rental units, which are scarcer). Families with an older head of household, and, in some cases, black families, have been found to stay longer in shelter than other families. Pregnant women and women leaving abusive situations tend to exit shelter more quickly, but are also more likely to return. Other predictors of return

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to shelter include exiting without a housing subsidy and lower educational attainment or work history.

Thus, some combination of family composition (larger, older, black), predicament (domestic violence, pregnancy/newborn status), and resources at exit (housing subsidy) seem to account for some of the differences between households that exit shelter quickly and those that do not—and those that return to shelter and those that do not.

The ability to identify clearly distinct subpopulations of homeless families on the basis of their patterns of exit and reentry is potentially confounded by the social welfare functions of the public shelter system itself. Metraux et al. (2001) found that across seven jurisdictions with shelter tracking system databases, families had longer episodes of shelter use than single adults without accompanying children. This is in contrast to cross-sectional, self-report data that show higher proportions of long-term homelessness among single adult populations (Burt et al. 2001). Aside from the differences in how the data were gathered, a possible explanation for this discrepancy is that single adults are more likely to spend periods of time as "homeless" in situations other than shelter, such as on the streets or in other makeshift arrangements.

At least two policies have likely contributed to longer stays in shelters for families. As families joined the ranks of the urban homeless in the 1980s, public shelter was generally provided to them in sparse, congregate facilities much like the model prevailing (then, as now) for unaccompanied single adults, or in hotels and motels. As federal policy shifted in the late 1980s and early 1990s, and as federal spending on homelessness increased significantly, especially during the early years of the Clinton administration, local advocates and providers sought to reform the objectionable conditions in which homeless children were forced to sleep. In 1990, advocates won a legal challenge that mandated New York City to provide single units with private bath and kitchen facilities as the minimum standard of "emergency shelter" for families (Culhane, Metraux, and Wachter 1999).

Nationally, a more service-enriched and physically accommodating model of shelter for families also emerged, labeled variously as transitional shelter or transitional housing. This shift was made possible by funding from the U.S. Department of Housing and Urban Development's (HUD's) Supportive Housing Program, authorized originally as a demonstration project (P.L. 100–77) and later as an ongoing program within the McKinney-Vento Act (P.L. 102–550).

Accompanying this new shelter model was an implied longer stay, with the federal limit set at two years (waivers can be obtained for stays up to three

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years). In some cases, these reforms were accompanied by a growing professionalization among service providers, as well as an emergent ideology that cast homeless families as distinctively needier than other families, ostensibly requiring residential support services to prepare them to become housing ready (Gerstel et al. 1996). This shift in service provision and the accompanying ideology could also be understood as an accommodation to a stubbornly intransigent (and growing) housing affordability problem. Shelter providers and homeless advocates could not readily solve the underlying affordability problem, so they shifted their attention to improved shelter facilities, services, and, ultimately, a professional identity and ideology that fit this new and expanded role (Barrow and Zimmer 1999; Gerstel et al. 1996).

A second factor has similarly led shelters into filling an expanded social welfare function for families and has likewise increased the length of time that some families stay in shelter. Before a change in the law in 1998 (P.L. 105–276), federal housing policy required that homeless families be given priority for federally assisted housing (public housing and Section 8 housing). In addition to being an attractive alternative to closed (or practically closed) waiting lists for assisted housing, many public shelter systems have served as the de facto queuing system for the limited federal or state subsidized housing opportunities that become available. Whatever circumstances may have brought families to shelter in the first place, many may have remained for long periods simply waiting for a housing assistance slot. In some cases, transitional shelter providers may have acted as a screening system for local housing authorities, "graduating" only those families that met their standards of fitness for tenancy and screening out other families through either attrition or outright eviction (Barrow and Zimmer 1999; Gerstel et al. 1996). Although the federal preference was lifted in 1998, some local housing authorities have retained the priority on a voluntary basis, and many shelters have likely sustained the practices that grew around it (long shelter stays and screening procedures). Paradoxically, these practices could result in longer stays for families with relatively fewer barriers to housing stability and shorter or repeat shelter stays for families with more barriers.

Methods

The research questions our study attempted to answer are as follows:

1. Do longitudinal shelter utilization data indicate robust patterns of family homelessness?
2. Are differential patterns of family shelter utilization associated with distinguishing characteristics of the head of household?

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Data

This study used administrative data on public shelter utilization from four jurisdictions: Philadelphia, New York City, Columbus (OH), and the state of Massachusetts. Varying time frames were selected for each data source to ensure the maximum provider coverage and a minimum two-year observation period for all families admitted to shelter for the first time (in Philadelphia and New York, a three-year period was available). While each source generally includes reliable and complete data on demographic characteristics, some sources (Massachusetts) were better than others in terms of the completeness of the information on income, disability, and employment. Each had limitations and varied in its coverage of providers. Ideally, all data sources would be standardized with regard to completeness, coverage, and accuracy and would have common reporting periods. However, we chose to include the four sites here to increase the geographic diversity represented and to permit assessment of the robustness of the cluster characteristics, the limitations associated with any single source notwithstanding. Potential biases associated with the limitations of a particular source are considered in the "Results" and "Discussion and implications" sections.

Other health and social service utilization data were integrated with shelter records to determine whether the families or the heads of household had a history of service involvement indicative of a need for significant or ongoing service engagement. Again, data availability varied by the jurisdiction and the period covered. In New York City, only child welfare data were included, and in Philadelphia and Massachusetts, child welfare records and behavioral health services were included. At the time of this study, no additional data were available for Columbus (OH). While the availability of the service data did vary, the results for each jurisdiction are shown to permit an assessment of the robustness of any patterns that might exist across sites.

Philadelphia. Families that entered publicly funded shelters in Philadelphia for the first time between 1999 and 2000 were selected for inclusion in the study (N = 1,673) (families with previous shelter admission records back to 1990 were excluded). Shelter utilization was tracked for three years. Public shelters in Philadelphia are administered through a single point of access and are tracked and funded by the Office of Supportive Housing (OSH), formerly the Office of Emergency Shelter and Services. The data include identifiers and demographics (race, sex). Other data elements do not reach 90 percent or more completion rates and are therefore not included here. (Certain indicators for mental health or substance abuse may be flagged by intake workers based on interviewer assessment or self-report, but are not audited for completeness or accuracy.)

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The Philadelphia records do not include all shelters in the city. Overall, nontracked units represent 15 percent of the total emergency and transitional shelter system, resulting in 85 percent coverage by the OSH data (Metraux et al. 2001). However, many of the family transitional housing units were not tracked in the OSH system during the study period. This would likely result in an underestimate of the proportion of families with long shelter stays, an underestimate of the average length of stay, and an underestimate of costs.

Philadelphia's shelter data were integrated with three additional data sources to identify the potential service needs of the families. Department of Human Services data track families that receive child protection or foster care services. For this study, all foster care records from 1996 to 2003, comprising records on 38,867 individuals with type of service received and date, were included. For this study, families with a child in an out-of-home placement at any time were identified as having a history of "intensive social service involvement." State eligibility and claims files were abstracted for all persons who received behavioral health treatment through Medicaid from 1990 to 2003. Household heads with a record of inpatient care for mental disorders (defined as International Classification of Diseases [ICD]–9 codes from 290 to 319, except for 303 to 305) or for a substance use disorder (defined as ICD–9 codes 303 to 305) were identified as having a history of "intensive behavioral health service involvement."

New York City. Families that entered publicly funded shelters there for the first time between 1997 and 1998 were selected for inclusion in the study (N = 10,461) (heads of family households with shelter admission before this period, back to 1986, were excluded). Families' shelter utilization was tracked for three years. New York City's Department of Homeless Services (DHS) maintains a single point of entry to the shelters it funds. The data include identifiers and demographics, as well as the reason for homelessness and the type of exit. Other data on family characteristics during this period were incomplete. As in Philadelphia, not all facilities in the jurisdiction were tracked at the time of the study, with the DHS facilities estimated to represent 86 percent of the total shelter units available for families (New York City Coalition on the Continuum of Care 2006).

These shelter data were integrated with data from the city's child welfare agency—the Administration for Children's Services (ACS)—to identify foster care involvement among children from households in shelters. The data covered the period from 1995 through 2002. The ACS data track prevention and placement services. For this study, the out-of-home placement of a child is used as an indicator of intensive social service involvement. The foster

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care population under ACS custody was 41,969 in 1995 but had declined to 25,471 by 2002.

Columbus, OH. The Columbus Shelter Board (CSB) tracks admissions and discharges for its publicly funded shelters and has done so since 1990. However, the CSB changed its tracking system in 2002, and implementation issues created gaps in data coverage during that year. To ensure at least a two-year observation period following this gap, only families admitted to shelter between July 2003 and July 2004 were selected for inclusion (N = 674). Families with a previous shelter history were again excluded from the analysis, although it is possible that some families may have had a 2002 shelter record that was not recorded by CSB. Coverage is estimated at more than 80 percent (Metraux et al. 2001). Data on demographics and shelter utilization were available, but did not contain information to assess families' service needs.

State of Massachusetts. The state Department of Transitional Assistance commenced complete tracking of emergency and transitional housing facilities for families in December 2003. The state does not maintain an inventory of all facilities for families, so it is not possible to determine either the data coverage or the proportion of facilities funded by the state and tracked in its database. However, it is believed that there are very few facilities for families that are not funded and tracked by the state and that coverage likely exceeds 80 percent of beds. To allow for a minimum two-year observation period for each case, only households admitted to shelter for the first time from December 2003 through February 2004 (a three-month period) were included in the study (N = 494). The data include identifiers and demographics, as well income sources, disability status as measured by receipt of supplemental security income (SSI), and employment status.

Shelter records were merged with public behavioral health and human service records to identify families with a history of intensive service involvement. The Department of Social Services, which tracks child protection and placement services, identified households in which a child had been placed in out-of-home care. Data from the Department of Mental Health (DMH) and the Department of Public Health (DPH) were merged with shelter records to identify the use of behavioral health services by the heads of the family households in this study. Inpatient mental health care was identified by the presence of a DPH record for a Medicaid-reimbursed inpatient hospital claim for mental health (defined as ICD–9 diagnoses ranging from 290 to 311 and excluding 303 to 305 [substance abuse/dependency]). "Intensive" substance abuse treatment was identified based on the presence, in the DPH data, of either a Medicaid-reimbursed inpatient hospital claim for substance

abuse (defined as an ICD–9 diagnosis of 303, 304, or 305) or a record in the DMH data of receiving "acute treatment services."

Analysis

Cluster analysis was used to explore the existence of unique subsets of homeless families on the basis of the number of homeless episodes and the number of cumulative shelter days during the observation period. The number of shelter days was computed by tallying the total number of days a household stayed in shelters over the course of all stays in either a two-year (Massachusetts and Columbus) or three-year (New York City and Philadelphia) period starting with the initial entry. Shelter stays were collapsed into discrete episodes using a 30-day-gap exit criterion, meaning that all stays in which the gap from one exit to the next entry is less than 30 days are considered to be part of one discrete episode. This helps ensure that multiple episodes do not merely reflect temporary respites from shelter in which housing remains tenuous and that only sustained exits of a specified duration (30 days or more) are identified as distinct exits.

The cluster analysis procedures used here were designed to replicate those used in Kuhn and Culhane (1998) to assign single adults to three specific clusters. In this method, nearest centroid sorting constructs unique clusters from a set number of clusters. Using the criteria of days in shelter and number of episodes, the cluster analysis procedure (PROC FASTCLUS in SAS statistical software [SAS Institute 1999]) sorts the observations in a manner that provides well-defined and robust divisions between clusters. This procedure initializes the seeds for each cluster so that few iterations of the procedure are required and large data sets can be processed efficiently. The procedure is relatively insensitive to outliers. To give number of days and number of episodes equal weight in determining cluster assignment, both variables were rescaled such that the mean was zero and the variance was 1. In summary, while this process is much more systematic, the end result is analogous to looking at a graph where total days and total episodes are charted and drawing circles around the main groupings.

After cluster analysis produced distinct subsets of homeless families, demographic characteristics, shelter episodes, and extent of other public services use were compared for unique clusters. Although considerable data on other service system usage are available for some of the sites, only indicators of intensive service use, including inpatient stays for behavioral health services and out-of-home (foster care) placement for child welfare services, are denoted here.

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Results

Cluster characteristics: Proportions of households and system days

Cluster analyses reveal relatively comparably sized groupings among the jurisdictions, with some minor deviations. In each jurisdiction, the largest cluster is composed of families with a single episode of shelter use of relatively short duration—akin to the "transitional homeless" cluster in the single adults' typology (table 1). The vast majority of families fall within this cluster, which represents 72 to 74 percent of households in New York City, Philadelphia, and Massachusetts and 80 percent in Columbus. A second, smaller cluster of families with fewer than 1.5 episodes of shelter use of relatively long duration represents 20 to 21.5 percent of the households in New York City, Philadelphia, and Massachusetts and 17.9 percent in Columbus. This cluster could be considered consistent with the "chronic homeless" cluster for single adults, at least with regard to the length of shelter stay (the consistency of this label with their service needs and characteristics will be considered at greater length later). Finally, the smallest group, from 5 to 8 percent in New York City, Philadelphia, and Massachusetts and 2.1 percent in Columbus, experiences repeated shelter stays (3 to 3.5 on average) of relatively short duration.

Broadly speaking, shelter use patterns are fairly consistent with published results from the single adults' typology, with the vast majority in the temporary category (although there are slightly fewer proportionally among families than among single adults), a significant minority in the long-stay category (although it is about twice as large proportionately among families), and a small group in the episodic category (about half the size of the cluster among single adults).

In terms of the relative use of shelter system resources, the groups again exhibit fairly comparable results across sites. In all four jurisdictions, approximately half of the total bed days are used by the roughly one-fifth of family households in the long-stay category. The short-stay, or temporarily homeless, families use between 32 percent (Philadelphia) and 43 percent (Massachusetts) of the system days. The episodic shelter users account for the most variable proportion of days, but the fewest overall, with a range from 5 percent to 13 percent.

While the cluster distributions appear to be fairly robust, even given some of the data limitations and the differences in local systems and policies, jurisdictions vary more significantly with regard to the average stays associated with each of the clusters. Both the number of shelter stays and their average duration are difficult to compare across jurisdictions since the clus-

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Table 1. Cluster Statistics for Family Shelter Stay Patterns in New York City, Philadelphia, Massachusetts, and Columbus, OH, with Episodes Defined as Ending with a 30-Day Gap in Shelter Use

	Philadelphia			
	Temporary	Episodic	Long Stay	Total
Number of cases	1,207	131	335	1,673
Average number of episodes	1.1	3.5	1.4	1.4
Average number of days	52	202	327	119
Average days per episode	47	60	259	91
Total days used	62,964	26,477	109,680	199,121
Percentage of clients	72.2	7.8	20.0	100.0
Percentage of total days used	31.6	13.3	55.1	100.0
Mean cost per family, in 2006 dollars	4,900	19,043	30,812	11,213
	New York City			
	Temporary	Episodic	Long Stay	Total
Number of cases	7,681	529	2,251	10,461
Average number of episodes	1.1	3.3	1.3	1.3
Average number of days	139	385	552	240
Average days per episode	131	118	467	202
Total days used	1,067,659	203,665	1,242,552	2,513,876
Percentage of clients	73.4	5.1	21.5	100.0
Percentage of total days used	42.5	8.1	49.4	100.0
Mean cost per family, in 2006 dollars	13,900	38,500	55,200	24,000
	Columbus, OH			
	Temporary	Episodic	Long Stay	Total
Number of cases	539	14	121	674
Average number of episodes	1.1	3.1	1.3	1.2
Average number of days	33	148	187	63
Average days per episode	30	47	144	52
Total days used	17,846	2,078	22,692	42,616
Percentage of clients	80.0	2.1	17.9	100
Percentage of total days used	41.9	4.9	53.2	100
Mean cost per family, in 2006 dollars	3,828	17,168	21,692	7,308
	Massachusetts			
	Temporary	Episodic	Long Stay	Total
Number of cases	365	30	99	494
Average number of episodes	1.0	2.0	1.0	1.1
Average number of days	105	195	444	179
Average days per episode	105	98	444	169
Total days used	38,491	5,859	43,977	88,327
Percentage of clients	73.9	6.1	20.0	100.0
Percentage of total days used	43.6	6.6	49.8	100.0
Mean cost per family, in 2006 dollars	11,550	21,450	48,440	19,690

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ters are determined on the basis of a three-year observation period in New York City and Philadelphia versus a two-year observation period in Columbus and Massachusetts. Comparing New York City and Philadelphia shows that the average number of episodes across clusters is almost identical, but that the average length of stay in New York City is substantially longer for each cluster type, with the temporary clusters staying on average 139 and 52 days, respectively, and the long-stay clusters staying an average of 552 days (1.5 years) and 327 days, respectively. Days stayed in untracked transitional shelters in Philadelphia may partially explain this difference.

The jurisdictions with the two-year observation periods, Columbus and Massachusetts, have similar average numbers of stays for their temporary (1.1 and 1.0, respectively) and long-stay clusters (1.3 and 1.0, respectively), but for the episodic groups, the average number of stays in Columbus is 3.1, compared with 2.0 in Massachusetts. A Massachusetts policy that prohibits families from reentering shelter until one year after discharge likely explains this difference. Average lengths of stay are also longer across all groups in Massachusetts, compared with Columbus. Longer stays in Massachusetts and New York may reflect tighter housing market conditions in these jurisdictions as well.

Because shelter days can be readily converted into estimated costs based on jurisdictional reimbursement rates, estimated average household costs by cluster are provided in table 1. The long-stay groups have an average cost of $21,692 in Columbus ($116 per day), $30,812 per family in Philadelphia ($94.23 per day), $48,440 in Massachusetts ($110 per day), and $55,200 in New York ($100 per day). The short-stay households have substantially lower average costs per family, at $3,828 in Columbus, $4,900 in Philadelphia, $11,550 in Massachusetts, and $13,900 in New York City. With the exception of Columbus, these costs are likely significant underestimates in that they do not include the additional resources that providers receive beyond their per diem reimbursements, including service contracts with other public agencies, HUD McKinney-Vento grants, and private sources such as voluntary contributions. In Philadelphia, the data do not reflect most of the transitional housing facilities, which have a different (usually higher) cost structure than facilities designated for emergency shelter only.

Demographic characteristics and histories of intensive service use

The demographic characteristics by cluster (race/ethnicity, sex, and age of the head of household) are provided in table 2. A few trends are evident. For race and ethnicity, households headed by a black person are more likely to be represented among the episodic cluster in New York City and

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Table 2. Demographic Characteristics by Cluster for Family Shelter Users in New York City, Philadelphia, Columbus, OH, and Massachusetts

	Philadelphia				
	Temporary N = 1,207	Episodic N = 131	Long Stay N = 335	Test Statistics	Total N = 1,673
Race					
Black	86.3	90.8	91.3	3.7*	87.7
Hispanic	7.0	3.8	3.9	2.8	6.1
Other	6.7	5.3	4.8	0.9	6.2
Sex					
Female	95.0	93.9	94.9	0.2	94.9
Age (mean)	28.6	26.7	29.9	7.6***	28.7
	New York City				
	Temporary N = 7,681	Episodic N = 529	Long Stay N = 2,251	Test Statistics	Total N = 10,461
Race					
Black	60.0	69.6	60.7	9.6***	60.6
Hispanic	36.3	27.8	35.4	8.0***	35.7
Other	2.7	2.5	3.9	4.3*	2.9
Sex					
Female	93.2	94.3	88.3	31.2***	92.2
Age (mean)	26.9	23.1	29.9	27.4***	27.4
	Columbus, OH				
	Temporary N = 539	Episodic N = 14	Long Stay N = 121	Test Statistics	Total N = 674
Race					
Black	69.2	78.6	70.3	0.6	69.6
Hispanic	2.0	0.0	1.7	0.4	1.9
Other	28.8	21.4	28.1	0.4	28.5
Sex					
Female	85.2	57.1	85.1	8.2*	84.6
Age (mean)[a]	32.7	34.7	30.6	3.4*	32.4
	Massachusetts				
	Temporary N = 365	Episodic N = 30	Long Stay N = 99	Test Statistics	Total N = 494
Race					
Black	26.2	36.7	36.7	5.1	29.0
Hispanic	30.5	13.3	39.8	8.1*	31.0
Other	43.7	50.0	23.5	14.5***	40.1
Sex					
Female	89.9	100	90.8	3.4	90.7
Age (mean)	30.0	27.3	31.8	3.5*	30.2

Note: For the Race and Sex categories, test statistics are chi-square values with two degrees of freedom. For the mean age, *t*-tests were performed, and the corresponding statistic is displayed.
[a] Sixteen heads of household (3.4 percent) had invalid data for age and were not included in calculating the mean age or evaluating differences among clusters.
$^{*}p < 0.05$. $^{**}p < 0.01$. $^{***}p < 0.001$.

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underrepresented among the temporary cluster in Philadelphia. Households headed by a Hispanic person are overrepresented among the temporary cluster in New York and overrepresented among the long-stay cluster in Massachusetts. Regarding the sex of the head of household, only two sites had a significant difference, with both New York City and Columbus showing an overrepresentation of male-headed households in the long-stay cluster and episodic cluster, respectively. However, the size of these demographic effects is relatively small. Finally, across all of the sites except Columbus, there is a consistent pattern in the age of the head of household, with the episodic cluster having the youngest heads and the long-term clusters having the oldest.

Partial results suggest a consistent trend across service domains, although data on intensive behavioral health and social services use, disability, and employment status were not equally available in all of the study sites and Massachusetts and Columbus had relatively few cases, thereby limiting the statistical power. (See table 3.) In general, episodic shelter users have the highest rates of intensive service utilization (figures 1 through 4), disability and unemployment (figure 5), and foster care involvement (figures 1, 3, and 6). The families with temporary stays have the next highest rates of identified need or service history. And contrary to what might be expected given their extent of shelter use (or as chronic homeless in the single adults' typology), the group with long-term shelter stays has rates of intensive service use, disability, and unemployment that are lower than or not significantly different from those of the short-stay, temporary cluster.

In Philadelphia, while 27 percent of the heads of family households in shelter have a history of either inpatient treatment for mental health or substance abuse or foster care placement of children, the rate is 43 percent among the episodic cluster and is nearly half that for the other two clusters (figure 2). In Massachusetts, 26.7 percent have an intensive service history, while the rate is 33.3 percent among the episodic cluster, 28.7 percent among the temporary cluster, and 17.4 percent among the long-stay cluster (figure 4). The same pattern prevails among each of the components, including psychiatric inpatient or substance abuse inpatient history (figures 1 and 3), and foster care involvement (figures 1, 3, and 6). Although the pattern is robust across domains and the differences are marked, none of these individual service domains achieves statistical significance in Massachusetts, owing to the low statistical power associated with so few cases in the episodic category.

In Massachusetts and Columbus, where reliable information on income was available, disability, as reflected by SSI income, conforms to this same pattern (though neither is statistically significant, possibly because of low power in both cases). And consistent with this trend, the employment rate in

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Table 3. Histories of Intensive Behavioral Health and/or Social Services Use by Cluster for Family Shelter Users in Philadelphia, New York City, Columbus, OH, and Massachusetts

	Philadelphia					
	Temporary N = 1,115	Episodic N = 130	Long Stay N = 324	Overall Test Statistics[a]	Pairwise Comparison[b]	Total N = 1,569
Medicaid psychiatric inpatient	14.6	30.8	8.3	19.1***	A, B, C	14.7
Medicaid substance abuse inpatient	4.7	8.5	3.7	2.4		4.8
Foster care	12.2	20.0	15.7	3.9*	A	13.6
Number of services						
Any one service	26.0	43.1	23.8	9.8***	A, B	27.0
Any two services	5.0	13.1	3.4	9.1***	A, B	5.4
All three services	0.5	3.1	0.6	5.8**	A, B	0.7
	New York City					
	Temporary N = 7,681	Episodic N = 529	Long Stay N = 2,251	Test Statistics[a]		Total N = 10,461
Foster care	8.0	18.9	12.1	47.1***	A, B, C	9.4
	Columbus, OH					
	Temporary N = 539	Episodic N = 14	Long Stay N = 121	Test Statistics[a]		Total N = 674
SSI receipt	13.9	21.4	9.1	1.4		13.2
Employment	17.8	14.3	11.6	1.4		16.6
TANF receipt	23.2	7.1	36.4	5.9**	C	25.2
	Massachusetts					
	Temporary N = 366	Episodic N = 30	Long Stay N = 98	Test Statistics[a]		Total N = 494
SSI receipt	16.1	20.0	15.3	0.2		16.2
Employment	21.6	10.0	43.9	12.7***	B, C	25.3
TANF receipt	79.2	86.7	87.8	2.2		81.4
Medicaid psychiatric inpatient stay[d]	4.6	10.0	2.0	NA[c]		4.5
Substance abuse treatment[e]	11.8	20.0	7.1	2.1		11.4
Foster care	19.1	20.0	12.2	0.9		17.8
Number of services						
Any one service	28.7	33.3	17.4	3.0		26.7
Any two services	5.7	13.3	3.1	1.7		5.7
All three services	0.8	6.7	0	NA*[c]	C	1.0

[a] Overall test statistics are all with two degrees of freedom.
[b] The pairwise comparison column provides the location of differences between groups significant at the $p < 0.05$ level: A = temporary versus episodic; B = episodic versus long stay; C = temporary versus long stay.
[c] Fisher's exact test was used because of scarcely populated data fields; SAS software does not compute chi-square statistics for Fisher's exact test. Pairwise comparisons were not performed because of scarcely populated data fields.
[d] Reflects an inpatient hospital stay with an ICD–9 diagnosis ranging from 290 to 311 and excluding 303 to 305 (substance abuse/dependency) diagnoses.
[e] Reflects having a substance dependency diagnosis in conjunction with a Medicaid-reimbursed inpatient claim and/or a record of receiving "acute treatment service" reimbursed by the state Department of Public Health.
NA = not available.
* $p < 0.05$. ** $p < 0.01$. *** $p < 0.001$.

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Figure 1. Prevalence of Intensive Behavioral Health and Social Service Use by Clusters among Homeless Families in Philadelphia (N = 1,569), by Type of Services

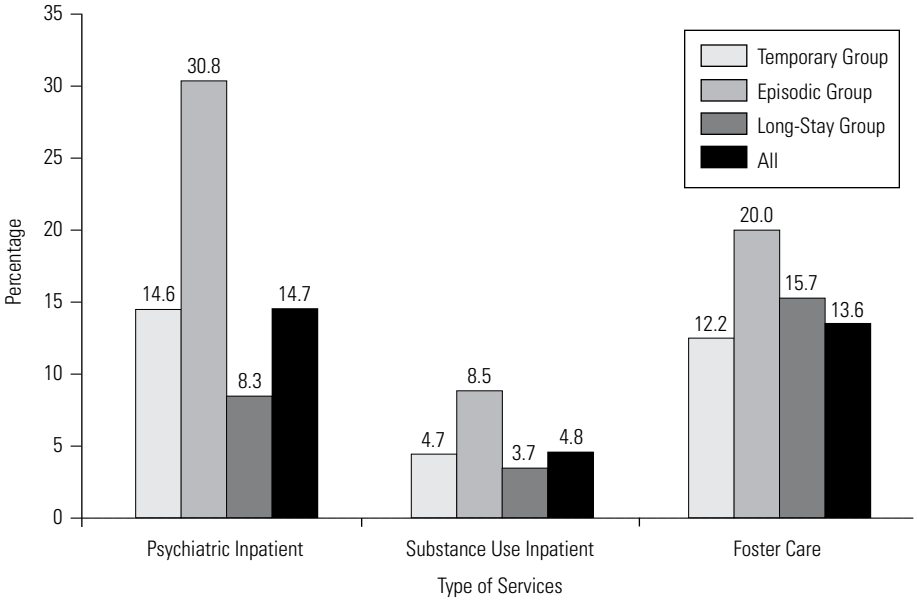

Figure 2. Prevalence of Intensive Behavioral Health and Social Service Use by Clusters among Homeless Families in Philadelphia (N = 1,569), by Number of Services

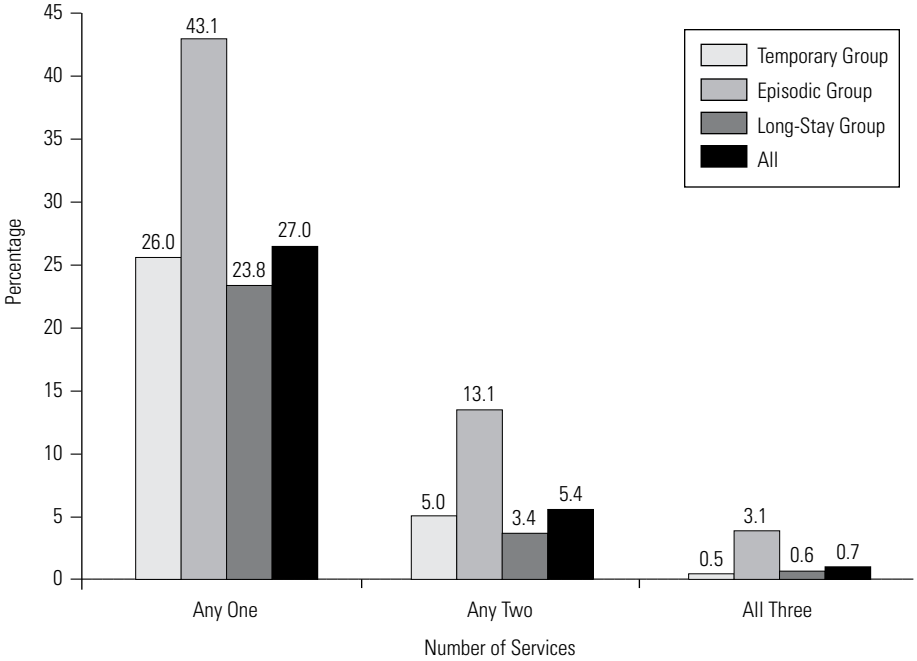

Figure 3. Prevalence of Intensive Behavioral Health and Social Service Use by Clusters among Homeless Families in Massachusetts (N = 494), by Type of Services

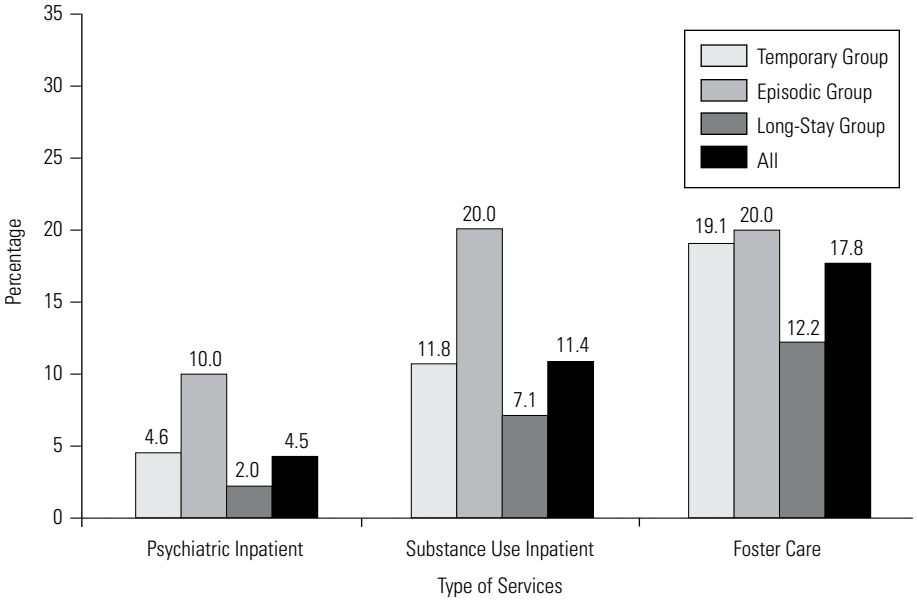

Figure 4. Prevalence of Intensive Behavioral Health and Social Service Use by Clusters among Homeless Families in Massachusetts (N = 494), by Number of Services

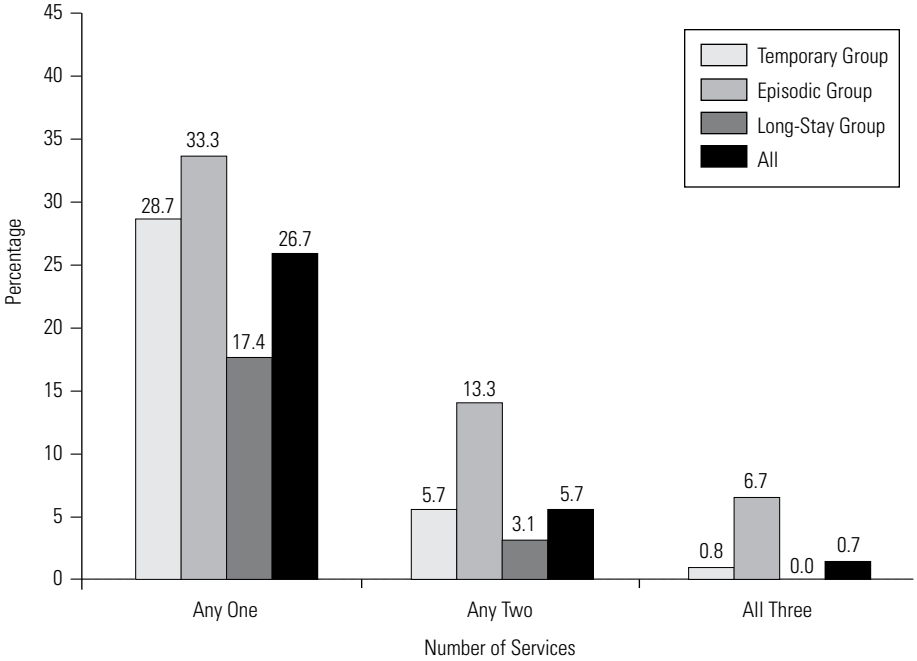

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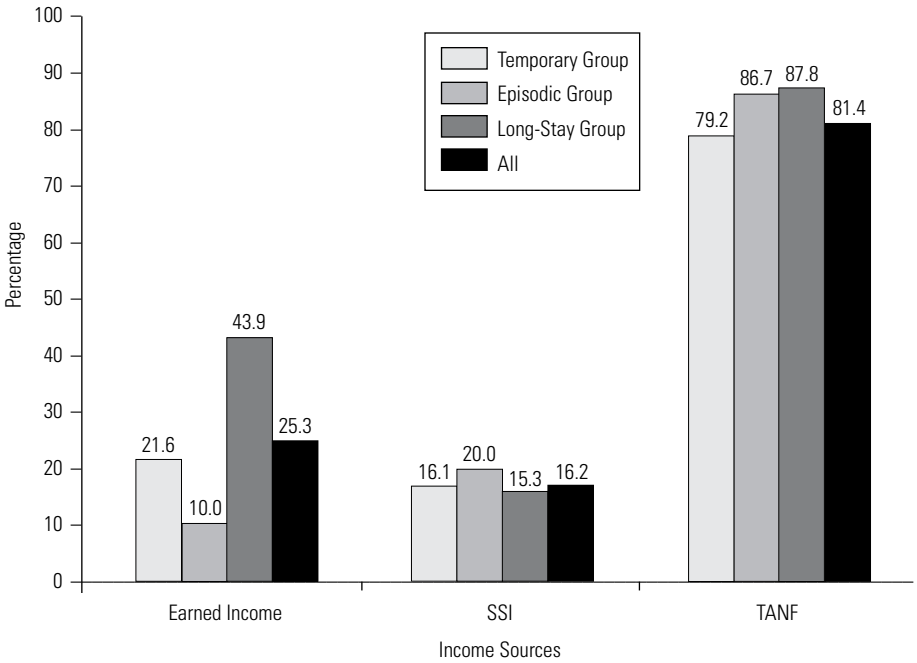
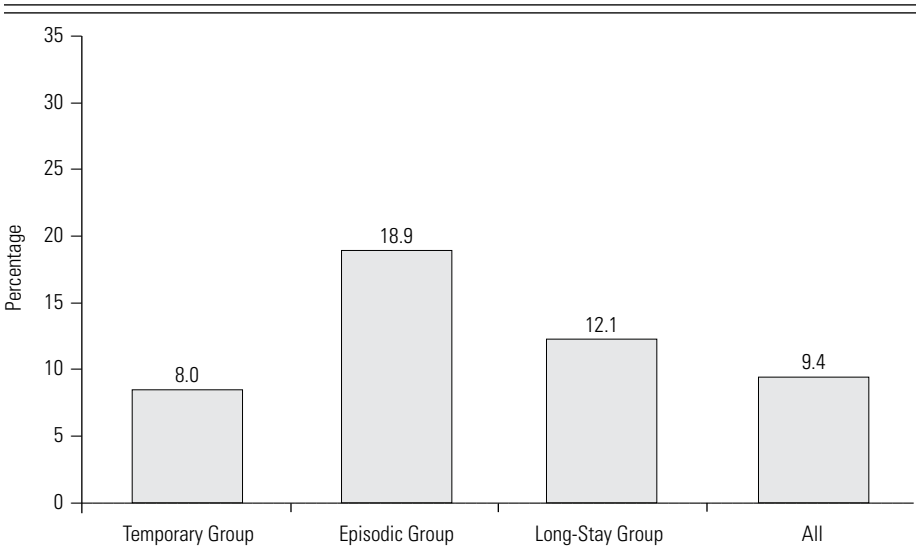
Figure 5. Prevalence of Receiving Income, from SSI, Employment, and TANF, by Clusters among Homeless Families in Massachusetts (N = 494)



TANF = Temporary Assistance for Needy Families

Figure 6. Prevalence of Foster Care Involvement by Clusters among Homeless Families in New York City (N = 10,461)



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Massachusetts operates inversely (long-term shelter stayers have the highest rate of employment, followed by the temporary cluster and then the episodic cluster) (figure 5). It should be noted that employment could have occurred at any time during the shelter stay, and families in the long-stay cluster had a longer period in which to achieve this outcome. They may also have received placement services or supportive services such as day care, thereby improving their employment prospects. There are no significant differences in employment among the Columbus findings, but employment status is recorded only on intake, not throughout the stay, as is done in Massachusetts. In Columbus, long-stay families have significantly higher receipt of Temporary Assistance for Needy Families (TANF) benefits at admission.

In the one deviation from this overall pattern, while the rate of foster care placement is highest in the episodic cluster in both Philadelphia and New York (figures 1 and 6), the rate is slightly higher among the long-term cluster than among the temporary cluster in both cities (reaching statistical significance only in New York City). This could be a result of the families with long-term stays having a longer exposure to supervision in a residential setting (transitional shelter), which can include systematic child welfare risk assessments and referrals. It is also possible that lengthy shelter stays have a detrimental effect on family stability even after more stable housing has been achieved (Park et al. 2004). The lower rate of foster care placement in New York City relative to Philadelphia likely reflects its declining foster care placement rate overall during this period.[1]

The group whose service histories are most striking are the episodic shelter users. As many as half of them could even be considered chronically homeless according to HUD's homelessness history and disability criteria, exhibiting both repeat homelessness and evidence of intensive behavioral health or social service history. The episodically sheltered families in Philadelphia had a 31 percent rate of inpatient psychiatric treatment (figure 1). Similarly, in Massachusetts this is the cluster with the highest rate of disability as measured by SSI receipt, at 20 percent (figure 5). Consistent with previous research, inpatient substance abuse treatment history, at 8.5 percent

[1] The combined prevalence of foster care and in-home preventive service use in both cities (not reported in the tables here) is very similar (20.3 percent in Philadelphia versus 19.9 percent in New York City), indicating that a higher proportion of homeless families receive preventive services in New York City. Preventive services might play a bigger role in reducing children's entry into foster care there. Another noteworthy fact is that homeless families involved with foster care had an average of 1.8 children placed in foster care in both cities. The sample of 10,461 homeless families in New York City had 1,723 children placed in foster care, and the 1,569 homeless families in Philadelphia had 385 children placed in foster care.

in Philadelphia (figure 1) and 20 percent in Massachusetts (including other acute treatment) (figure 3), is certainly much lower in the episodic group than has been recorded in single adults, among whom more than half had a comparable treatment history. The episodic group is also composed of relatively younger heads of household, which may indicate less emotional maturity and less willingness to remain in supervised residential programs.

It is noteworthy that the episodic group is relatively small overall, comprising 529 and 130 families admitted to shelter for the first time in New York City and Philadelphia shelter systems, respectively, over the two-year enrollment period (265 and 65 annually, respectively). In Columbus, 14 families fit in this category over the one-year enrollment period, and in Massachusetts, 30 families fell into this category over the three-month enrollment period (120 annually).

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Discussion and implications

Having applied the same methodology to family shelter use as was applied to single adults and having found roughly similar overall utilization patterns, the results nevertheless suggest very different interpretations and implications for policy and program design. Unlike the case among single adults, where the evidence strongly suggested that long-term or chronic shelter use was attributable to disabilities and other behavioral health barriers, long-term shelter use among families is not associated with evidence of more intensive service needs or personal barriers to housing stability. Indeed, on some measures, the long-stay cluster has the lowest proportion of intensive service users, although the differences between the temporary and long-stay clusters are not large. Alternatively, episodic shelter use *does* appear to be associated with a subset of families that have significantly higher rates of intensive service use. Notably, however, relatively few of the families with such barriers are among the episodic cluster.

It could be argued that these results are partly consistent with the idea that family shelters serve as queuing systems and proving grounds for housing placement opportunities (subsidies or transitional housing placement). Under this interpretation, "graduates" (the longest-staying households) are likely to be those that have cooperated with program requirements and in some cases may have been recruited or eligible for long-stay programs on the basis of their relative stability and functioning (sometimes referred to as "creaming") (Barrow and Zimmer 1999; Gerstel et al. 1996). Correspondingly, families that are the least cooperative and are the most likely to have personal barriers to housing stability would be the least likely to be placed in

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transitional programs, the most likely to be evicted or otherwise discharged (including voluntarily), and quite possibly to have repeat shelter stays. The evidence from our study suggests that positive selection bias (creaming) is likely to be modest, given the roughly similar proportions of intensive service use among the temporary and long-stay clusters. A negative selection effect ("screening out"), however, could well be reflected in the repeated stays of the episodic cluster families that have distinctively higher rates of intensive service use.

It could also be argued that the results are consistent with a system effect, where long shelter stays are driven primarily by the relatively greater availability of service-intensive transitional shelters for families compared with their single adult counterparts. Twice as many family households proportionately are in the long-stay cluster as in the corresponding chronic cluster among single adults, despite the fact that the literature consistently reports that families overall have significantly fewer barriers to housing stability than single adults. The emergence of a much expanded supply of service-intensive transitional shelters for families in the 1990s likely explains this counterintuitive result. Transitional shelters have an implicitly longer stay associated with their program model, with the federal program guidelines permitting stays of up to two years.

Further evidence for such a system effect is also suggested by the uneven distribution of households with long-term stays among specific shelter facilities, as found in some exploratory post hoc analyses. In New York, for example, 31 of the city's 74 family shelters (excluding facilities serving fewer than 30 families in the reporting period) accounted for 75 percent of the long-stay households at the time of discharge. In Philadelphia, 4 of the city's 14 family shelters (29 percent) accounted for half of the long-stay families at time of discharge. In Columbus, of the families that were identified as having long-term shelter use patterns, 96 percent got transferred from the initial intake shelter while only 33.8 percent of the families in the other two clusters were transferred. In Massachusetts, facilities identified as transitional were the primary shelter for only 11 percent of all families, but were the primary shelter for 31 percent of those in the long-term cluster. While it is possible that some as yet unidentified characteristics are differentially associated with families' assignment to particular facilities, the results of these post hoc analyses combined with the study findings indicate that practices of the homeless service system play a stronger role in sustaining long-term shelter stays than the characteristics of the families themselves. This area deserves further study.

Local and state homelessness service systems did not evolve based on a theory or typology of family homelessness, nor were they based on a clear

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conceptual framework for the most cost-effective, optimal ways to address the problem. Instead, these systems emerged in most communities from the fits and starts of voluntary organizations struggling to make sense of a growing crisis with limited resources and very limited data.

Given the lack of congruence between shelter use patterns and household needs indicated here, it could be argued that the current system is both inequitable and inefficient. Half of the system's resources are being used by a relatively small group of long-staying families, at a very significant cost per unit, although these families do not have a compellingly distinct profile of need relative to the other clusters.

Most social welfare systems are organized such that the highest volume of cases, and usually the least complicated, receives the services with the lowest per unit cost, whereas the highest-cost services are reserved for the comparatively fewer but needier, more complex cases. Consistent with this principle, the vast majority of households followed here do use the shelter system on a relatively short-term basis, and most of them (and most of the homeless families overall) do not have intensive behavioral health or social service histories that might represent a significant barrier to exit and housing stability. At issue is whether these comparatively short shelter stays (and the long stays among households with few or no apparent barriers to exit) could be made even shorter if a different and possibly more efficient form of emergency assistance were available.

For example, a relocation assistance program could include resettlement grants, housing and employment search services, budget counseling, and various kinds of mediation assistance with landlords and others (family members, employers, etc.). Several jurisdictions around the country have been experimenting with such "housing first" models, and their success has been very encouraging (National Alliance to End Homelessness 2006).[2] While the jurisdictions studied here spend varying amounts on temporary shelter stays, even the relatively lower average costs per household of $3,800 in Columbus and $4,900 in Philadelphia might be able to support an alternative relocation approach at a similar cost per case, or even with a modest increase in cost per case, assuming that a brief shelter stay will still be required for many families.

[2] This document describes the experiences of Boston; Westchester County (NY); New York City; Hennepin County (MN); Washington, DC; and Chicago. Some of these jurisdictions (Westchester, New York City, and Boston) have recently had successful experiments with shelter diversion projects or other relocation strategies. Others (Hennepin County and Washington, DC) have had policies or programs in place to provide alternatives to shelter for more than a decade. Beyond Shelter, a Los Angeles provider, has been using rapid relocation as its primary approach to family homelessness for more than 15 years.

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Massachusetts and New York City, at $11,550 and $13,900, respectively, in average spending per case for families in the temporary cluster, could potentially achieve some reductions in per household costs, depending on the structure of the relocation benefit (especially the duration of the rental assistance) and the amount of shelter that continues to be required before relocation.

For those families that have some or even several significant barriers to exit, at issue is whether long-term or intermediate shelter stays are indicated or whether a more effective and more efficient community-based alternative might exist for them as well. The study results suggest that at least 25 percent of households have some intensive service history, including 2 to 4 percent that without an alternative set of interventions have both repeat spells of homelessness and an intensive service history. One option would be to reserve eligibility for transitional shelter for those households that have a demonstrated pattern of episodic shelter use and that appear to have significant service needs. However, some cautions should be considered in this regard.

First, it deserves noting that most households with a history of intensive service use are in the temporary cluster; they leave the shelter system relatively quickly and do not return (in the near term, anyway). Only a small fraction of families with intensive service needs are in the episodic group. It is possible that many of the returning families could likewise be prevented from repeating if appropriate relocation and community support services were provided. Second, it is not clear that transitional shelter or long shelter stays would have a demonstrable benefit for these episodically homeless households, particularly given that their current shelter use pattern indicates some potential reluctance to stay in such facilities (to the extent that some of these exits are voluntary). Further, there is little evidence to suggest that long shelter stays themselves have "treatment" effects, particularly with respect to housing outcomes (Shinn, Rog, and Culhane 2005).

The evidence shows that families that exit shelter with subsidies almost universally do well with respect to their housing outcomes, regardless of the length of their stay. But research has not specifically focused on the small proportion of families with bad housing outcomes (repeat homeless spells) despite a housing subsidy, and this deserves further study. Moreover, the Massachusetts results do suggest that longer shelter stays are associated with better employment outcomes. This may be partly explained by some positive selection effects suggested by the Massachusetts data (lower rates of disability and intensive service use among the long-stayers). But it is probably more strongly associated with both the longer observation period presented by such stays (more time to become employed), and the possibility that long-stay facilities support employment through day care and job search services.

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In either case, it is not clear that the long shelter stay *itself* is responsible for this effect. Moreover, it is not known whether this effect could be demonstrated for members of the episodic cluster. This area needs more research, and with the ready supply of such facilities, it could be explored relatively quickly and without much new funding.

Given the high costs associated with long-term shelter, alternatives should also be considered for their comparative efficiency. Our study findings indicate that long-term stays conservatively consume between $22,000 and $55,000 per household and represent half of the total family shelter system reimbursements in the jurisdictions studied. One family's long-term shelter stay is equivalent to several years of a federal housing subsidy for that family or to at least providing four or more families with such a subsidy in a given year, depending on the jurisdiction. If current resources were thus reinvested, many more households could be served, or the same number of households could be served for much longer periods and in more normalized settings.

The prospects of such real gains in efficiency and of families living in more normalized housing environments should compel systematic experimentation in this area. Several potential packages of rental assistance and services could be tested, ranging from a few months of rental assistance with temporary services only, to multiyear subsidies with ongoing services provided. An important goal of future research should be to find the optimal match between household needs and the various packages of rental assistance and services that maximize families' self-sufficiency in the most cost-efficient and equitable manner.

Any such approach to the broad restructuring of homeless services for families would have to be mindful of some cautions:

1. The idea of matching families and housing service packages is conditional on the existence of valid instruments capable of distinguishing types of families and their needs.

2. Converting the existing shelter system into a more flexible emergency assistance system would require significant change, and such change is very difficult to undertake in any environment, but particularly in one where funding sources are complex and diverse, as homeless program funding is in most communities. In particular, the needs and resources of shelter provider organizations whose current business models could be disrupted by a change in approach would have to be taken into consideration. These facilities could be repositioned to provide transitional or supportive housing to other populations, including women reuniting with children after prison stays, women

in residential treatment for substance abuse, or other intensive family preservation programs. (Shifting these facilities to such uses would have the added benefit of helping prevent homelessness over the long term.) These programs may be more appropriately funded through mainstream social welfare system sources and could require some retraining and relicensure.

3. Any new system will have to be wary of unintended consequences and to consider the moral hazard of a new benefit program or protect against the unnecessary use of relocation programs, which may be perceived as having a lower barrier to entry than shelter and a higher potential gain.

4. Finally, alternative homeless program ideas have to be understood in the context of the housing market. Longer shelter stays in New York versus Philadelphia, and Massachusetts versus Columbus, could well reflect housing market conditions (though exactly how much of this variability is so explained needs further investigation). Presumably, anything that is done to increase the supply of affordable housing and the supply of subsidies targeted at low-income people reduces the population of households at risk for homelessness. However, while the homeless system cannot be expected to solve the overall housing affordability problem, emergency interventions should move in the direction of addressing the gap in housing costs and income, even if the role of the emergency system is appropriately temporary.

With regard to families on public assistance (like most homeless families), the single largest contributor to the housing affordability gap has been the declining value of cash assistance over the past 35 years, due to the lack of adequate inflation adjustments (cost-of-living increases) by states. The average maximum value of states' Aid to Families with Dependent Children/TANF cash assistance benefit for a family of three declined by 41.5 percent nationally from 1970 to 2003 (U.S. House of Representatives 2004). Participation among eligible households has also declined by nearly half, from 86 percent to 48 percent, since the passage of welfare reform in 1996 (Parrott and Sherman 2006).

Given that rent is the single largest expenditure for households on public assistance, the declines in value and TANF participation have had the net effect of a substantial reduction in rental assistance for poor families with children. Thus, providing some emergency or transitional rental assistance benefit in the form of relocation grants or time-limited subsidies (as well

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as connecting people to employment development activities and mainstream services) would seem to be an appropriate role for public assistance agencies. It would also compensate directly for what may be the single largest cause of homelessness among poor families. The current system of providing temporary shelter in lieu of rental assistance would appear to be relatively inefficient, since it is a less direct method of addressing the affordability gap and since, compared with independent housing, it carries such significant administrative and facility costs in addition to the social costs of disruptive shelter stays on families and children.

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Conclusion

This study tested a typology of family homelessness based on patterns of shelter utilization and was only partially successful in explaining stay patterns on the basis of household characteristics. With the possible exception of some families in the episodic cluster, these characteristics seem to play a secondary role in determining utilization patterns, whereas program and policy factors appear to play a primary role in shaping shelter utilization. Those factors have created a system that could be said to distribute resources inequitably relative to need and possibly inefficiently relative to more direct housing relocation and subsidy programs. Given the substantial resources currently spent in this manner, alternative methods for providing emergency assistance should be tested. These should more closely match needs and resources and provide more flexible, community-based alternatives to shelter, including relocation grants and various types of rental assistance, coupled with services as appropriate.

Future research should develop and test assessment instruments that identify subpopulations of families to be matched with various packages of housing and services. These new program models should be systematically tested against prevailing shelter-based practices.

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